



A NEW DRIVE FOR PRIMARY CARE IN EUROPE: RETHINKING THE ASSESSMENT TOOLS AND METHODOLOGIES

**Report of the Expert Group on Health Systems
Performance Assessment**

The information contained in this publication does not necessarily reflect the opinion or the position of the European Commission.

Neither the European Commission nor any person acting on its behalf is responsible for any use that might be made of the following information.

**Europe Direct is a service to help you find answers
to your questions about the European Union**

**Freephone number (*):
00 800 6 7 8 9 10 11**

(*) Certain mobile telephone operators do not allow access to 00 800 numbers or these calls may be billed.

More information on the European Union is available on the Internet (<http://europa.eu>).

Cataloguing data can be found at the end of this publication.

Luxembourg: Publications Office of the European Union, 2018

Electronic version:

ISBN 978-92-79-77725-7

doi:10.2875/58148

Catalogue number: EW-04-18-013-EN-N

Paper version:

ISBN 978-92-79-77726-4

doi:10.2875/748088

Catalogue number: EW-04-18-013-EN-C

© European Union, 2018

Reproduction of the texts of this report is authorised provided the source is acknowledged. For reproduction or use of the artistic material contained therein and identified as being the property of a third-party copyright holder, permission must be sought directly from the copyright holder.

© Photos: <http://www.istockphoto.com/>, Directorate-General for Health and Food Safety

FOREWORD

In the endeavour to improve the health of their citizens, Member States strive to make health systems more accessible for all, more effective in terms of quality outcomes and resilient to changing environments and future challenges. Primary care is the backbone of our healthcare systems as it is the key to integration and continuity between and across levels of care and essential for patients, particularly those with complex needs. Performance assessment has ample potential to strengthen primary care and to contribute to strengthening the health system's overall performance.

We began our work with several questions, including some basic ones on the state of play of performance assessment in primary care in Europe, its organisation, and its integration in policy processes. We surmised that for primary healthcare professionals and patients to reap the benefits of performance assessment, more progress is needed in developing performance assessment and integrating it into policies.

In our deliberations we took a closer look at tools for performance assessment in primary care, exploring indicators, methodologies and quality assurance. This allowed us to identify the main conditions which should be met to ensure that performance assessment is designed for the benefit of healthcare professionals and patients.

Finally, we sought to understand experience in relation to the impact of performance assessment in primary care. Our conclusion was that performance assessment can be part of the drive for necessary change, whether when transitioning from hospital to community-based care or when building solutions for integrated care, or even in the context of managing resources when account should be taken of the expansion of the uses and roles of primary care.

We hope that the result of our work - this report, will guide policy makers and practitioners in reinforcing the foundations for changes to primary care. We hope that our insights will allow them to move to a higher level of excellence and disrupt old habits

and traditions, when necessary. We are convinced that performance assessment can build solid foundations for change and provide a framework which empowers, engages, and focuses the minds of primary care professionals, be they dentists, dieticians, general practitioners/family physicians, nurses, midwives, occupational therapists, optometrists, pharmacists, physiotherapists, psychologists or social workers to nurture, explore and collaborate towards the desired results.

A handwritten signature in black ink, appearing to read 'D. Reynders', with a large, sweeping horizontal stroke above the name.

Daniel Reynders

Belgian Ministry of Health and Social Affairs
Head of General Services International
Relations and Public Health Emergencies

A handwritten signature in blue ink, appearing to read 'A. Ryś', with a large, sweeping horizontal stroke above the name.

Andrzej Ryś

European Commission – DG Health and
Food Safety
Director for health systems, medical
products and innovation

Brussels, 23 February 2018

ACKNOWLEDGEMENTS

This report benefited from valuable inputs and comments from all members of the Expert Group on Health Systems Performance Assessment (HSPA), the OECD, the WHO Regional Office for Europe, and the European Observatory on Health Systems and Policies. The report greatly profited from ideas, reflections and information provided by the voluntary members of the Sub-group on primary care.

Chapter 1 is based on the exhaustive opinion that of the Expert panel on effective ways of investing in health produced about tools and methodologies for assessing the performance of primary care. The team that compiled the opinion was composed by Jan De Maeseneer, Sabina Nuti, Dionne Kringos, Christian Anastasy, Margaret Barry, Liubove Murauskiene, Luigi Siciliani.

Chapter 2 is based on the systematic analysis of a survey on national experiences in assessing primary care, which was prepared by Patricia Sánchez-Villacañas Cabrera and Federico Paoli.

Chapter 3 was prepared by Ellen Nolte (European Observatory on Health Systems and Policies), with valuable contributions and inputs from the participants of the policy focus group.

This report was prepared by Katarzyna Ptak (DG SANTE, European Commission) based on the contribution and inputs from the Expert Group members and under the supervision of the two Chairpersons: Daniel Reynders (Belgian Ministry of Health) and Andrzej Rys (DG SANTE, European Commission). Lieven De Raedt (Belgian Ministry of Health), Federico Paoli and Filip Domanski (DG SANTE, European Commission) also contributed to the preparation of the report in the expert group

The full list of members of the Expert group on HSPA, the sub-group on primary care and the policy focus group are presented in the annexes.

Comments on the report would be welcome at the following address:

Secretariat of the Expert Group on Health Systems Performance Assessment

European Commission

Directorate General for health and Food Safety

Unit B1- Performance of national health systems

B-1049 Brussels

E-mail: SANTE-HSPA@ec.europa.eu

CONTENTS

| | |
|---|-------------|
| Executive summary..... | p.6 |
| Introduction..... | p.8 |
| Chapter 1: Opinion of the Expert Panel on Effective Ways of Investing in Health on tools and methodologies for assessing the performance of primary care | p.10 |
| Chapter 2: Findings of the survey on national experiences on performance assessment of primary care | p.19 |
| Chapter 3: Understanding the policy impacts of performance assessment..... | p.26 |
| Chapter 4: Conclusions | p.38 |

Executive summary

Strong primary healthcare is the foundation of a health system that is effective, efficient and responsive to patients' needs. Although not enough appreciated, primary care can handle most of today's chronic conditions without a specialist referral and produce benefits for the overall healthcare systems. Well performing primary care means less healthcare utilization overall and more focus on quality and achievement of optimal health outcomes.

However, primary care cannot allow itself to remain in status quo. Old models of operating and habits can hold it back, having an impact on the overall health system. To shift perspectives, this report assists policy makers and practitioners in taking a fresh look at performance assessment as a tool to create a drive that reverberates throughout the system of primary care and encourages all the relevant actors, whether dentists, dieticians, general practitioners/family physicians, nurses, midwives, occupational therapists, optometrists, pharmacists, physiotherapists, psychologists or social workers to nurture, explore and collaborate towards higher level of excellence of primary care services. Performance assessment can inform decisions on relevant resource allocation throughout the healthcare systems, ensuring resources to support the expansion of roles and functions of primary care.

By focusing the core aspects of well-performing primary care systems and their key functions such as access, coordination of care and continuity of care, the report stresses that:

1. Performance assessment in primary care paves the way for better health outcomes and improves the overall health system.

2. Primary care performance assessment systems in Europe vary in strength and though performance measurement is not in its infancy, it could significantly advance.

The report shows that countries experience difficulties to advance in performance assessment in primary care due to three main **challenges**: the complexity of the performance aspects of the primary care, a struggle to integrate assessments in policies and pitfalls associated with a culture of excellence. To ensure that performance assessment becomes a "go to" tool, the report recommends to consider a powerful combination of 7 essential elements when building primary care performance assessment:

1. Improve primary care information systems. Availability and quality of primary care data for performance assessment needs to advance in most countries. In many cases a set of indicators available to policy makers is insufficient or focused on a subset of dimensions, not including for example measures of clinical performance, equity, workload and workforce satisfaction, efficiency, relevance of doctors' training, etc. Without producing too much administrative burden, a well-balanced set of indicators should allow a regular screening of the functions of the primary care, focusing on accessibility, continuity and integration. Quality of primary care is also an important dimension which should be measured as a driver of additional gains for the overall healthcare system.

2. Embed performance assessment in policy processes. With some exceptions, performance assessments are not systematically embedded in policy processes and their use is not monitored and evidenced. Furthermore, they seem to be mainly addressed to policy makers, less so to healthcare practitioners and even less to the general public and patients. Embedding performance assessment in a legal and/or policy framework will scale up their use by all the concerned actors. Methodologies are also important. They should aim at achieving unprecedented results, aligning all the actors around the performance goals and cultivate courage to progress and discourage from reverting back to old methods and habits.

Building a culture of excellence is also a stepping stone to progress towards the integration of primary care. It can strengthen the team work and make this team work a rewarding experience, because it will foster a consensus to create organisational capacities and a framework which empowers and engages all the primary healthcare professionals, equipping them with the mindset and skills necessary to focus on creating the desired results. For this to happen, performance assessment needs to be holistic and consider such aspects as: education of health professionals, both content and way of organization (e.g. training at community levels rather than in hospitals), changing public perception of primary care, etc.

3. Institutionalize performance system.

Embedding in policy framework is a first step to achieve growth or improvement of performance assessment in primary care. To tap into its full potential it needs a robust resources framework and this remains to be developed in most of the Member States. An institutionalized function is crucial to attribute roles and responsibilities, provide necessary tools and guarantee resources to reward and recognize the good performers and to support average performers to move into the high performance category.

4. Ensure accountability. Accountability is not always clearly established. The core is to define it, ensuring the involvement of all the relevant stakeholders, and be realistic ensuring that job satisfaction of providers in primary care is monitored and at good level.

5. Consider patients experience and values. Understanding of the aspects of quality of primary care that patients truly value should be developed. For primary care being the first point of contact, the patients' perspective taking into account their experience with services and their values is one of the crucial elements of performance assessment and can help define high quality, curb less successful practices and influence the direction of change. The patients' perspective is also important for other reasons: more complex care demand, more demand for home-base care, greater

diversity of patients linked also to migrations, changing health risks, which all impact particularly powerfully on primary healthcare.

6. Take advantage from adaptability. For performance assessment to become a driving force behind the daily work, it should be adaptable because its objective is exactly to support adaptability in the moment of change for primary care. Primary care is not a static concept and performance assessments for primary care, due to their particular exposure to change, should be living tools and constantly consider the dynamic context of each country, region, commune.

7. Support goal-oriented approach through a better use of professional and contextual evidence.

Performance assessment should be more exploited to trigger better results of primary care through finding a more central role for professional and contextual evidence. Professional evidence is not systematised, while its role in achieving the good results in primary care is crucial, because primary care usually deals with patients of varying age, from diverse ethnic and socioeconomic groups, presenting early-stage diseases or undefined illnesses or with varying levels of multimorbidity. Primary care needs also to rely strongly on contextual information to bridge the gap between efficacy (isolated case) and effectiveness (routine practice). Performance assessments, reflecting needs of very varied groups of patients, can make primary care a more impactful segment of healthcare.

This report will hopefully convince policy makers not to settle for status quo, but to build new capacity for growth aligning every actor of primary care to move forward towards new ways of doing things with the benefit for patients.

Introduction

In the endeavour to improve population health, Member States make health systems more accessible for all, effective in terms of quality outcomes and experience, and resilient to changing environments and future challenges¹. To succeed the importance of a strong primary care cannot be stressed enough. The State of Health in the EU 2017 Companion Report emphasises that strong primary care can contribute to strengthening the overall health system's performance by, inter alia, providing affordable and accessible care; coordinating care for patients so that they are given the most appropriate services in the right setting; and reducing avoidable hospital admissions. Strong primary care is the key to integration and continuity between and across levels of care, which is essential for patients, particularly those with complex needs². Indeed, primary care should be at the backbone of healthcare systems. However, the process of changing from hospital to community-based health systems is challenging and requires coherent policies³. Perhaps this report can be part of the drive for necessary change.

For primary healthcare professionals and patients to reap benefits of performance assessment, there need to be more progress made to embody performance assessment in policies and enhance ownership for them. The report puts into focus the main conditions which should be met to make performance assessment designed for the benefit of healthcare professionals and patients. It guides readers on how performance assessment in primary care can build culture of excellence, disrupting the culture of "doing business as usual", and reinforcing foundations for change in the moment of change for primary care.

Performance systems can be more strongly embodied in the primary care across Europe. This is a complex challenge. A good set of indicators and methodology are fundamental, but mechanisms to put them in use and mobilize primary healthcare to deliver better outcomes and accelerate necessary transformations of services are not less important. The report taps in available knowledge and experience structured around 3 chapters.

The first chapter summarizes the opinion of the Expert Panel on effective ways of investing in health: Tools and Methodologies for Assessing the Performance of Primary Care. The Panel provided valuable input and support to the work of the HSPA group. Its opinion defines a performance assessment system for primary care, focusing on characteristics of the organisation of the primary care and looks at "outcomes" of primary care according to relevance, equity, quality and financial sustainability. These dimensions are translated into comparative key indicators related to key domains of primary care and descriptive additional indicators. It considers recent experiences from European countries, on the basis of the survey led by the EU Expert Group on Health Systems Performance Assessment and formulates recommendations for further development of the framework in the European Union.

The second chapter looks at experiences in performance assessment across the EU on the basis of the questionnaire. The survey was carried out by the EU Expert Group on health systems performance assessment following the functional approach to the concept of primary care, addressing the key functions of primary care such as access, coordination of care, continuation of care. It allowed to explore problems, approaches, issues which are common to all countries or very specific in the context of key characteristics of the primary care, including organisational framework, institutional settings, mechanisms of involvement of stakeholders, models of provision of services, the range of services available, accessibility and integrated care parameters etc. Looking at experiences in assessing the performance

¹ Communication from the Commission on effective, accessible and resilient health systems; COM(2014) 215

² The State of health in the EU 2017 Companion Report

³ Jan De Maeseneer: Family Medicine and Primary Care at the crossroads of societal change (2017)

of primary care, the survey feedbacks on the ways the assessments are organised, their scope, breadth, frequency and use in policy design and implementation.

In the third chapter Dr Ellen Nolte explores the key requirements for health system performance assessment to successfully support and inform policy action in the European context with a particular focus on primary care. This piece of work draws from a review of the documented evidence and insights from experts from European countries that took part in a structured policy focus group of the Expert Group on HSPA. It has illustrated cases of how HSPA has supported policy action, drawing on examples from primary care assessments, and suggested some factors perceived by experts to be core to effect policy change. It further proposes a way that can help convert HSPA into a strategic tool in the policy process.

The last part of the report identifies recommendations for policy action. They draw from the analysis which identified common patterns, challenges, successful solutions applied in different countries. The conclusions build also on the analysis of pitfalls and burdens countries have to face in assessing and monitoring the performance of their primary care systems.

Year 2018 is marking the 40th anniversary of Alma-Ata Declaration on Primary Health Care, reinstating calls from the WHO for a return to the principles and approaches of primary health care as the best way to organize health services and achieve the Universal Health Coverage. Hopefully this report will give an impetus to the discussions on the renewed focus on primary care.

Chapter 1. Opinion of the Expert Panel on Effective Ways of Investing in Health on tools and methodologies for assessing the performance of primary care

The core element of the Expert Panel's mission is to provide the Commission with sound and independent advice in the form of opinions in response to questions (mandates) submitted by the Commission on matters related to health care modernisation, responsiveness, and sustainability. The areas of competence of the Expert Panel include, and are not limited to, primary care, hospital care, pharmaceuticals, research and development, prevention and promotion, links with the social protection sector, cross-border issues, system financing, information systems and patient registers, health inequalities, etc.

This chapter builds on the opinion on Tools and Methodologies for Assessing the Performance of Primary Care⁴. It emphasizes elements which are crucial to make performance assessment in primary care successful experience. Given a crucial role of primary care in delivering outcomes for the reference community and its responsibility for individuals along all their life, and ways of operating in synergy with every other care setting, the task of the Expert Panel was very complex. However the panel managed to define a performance assessment system for primary care, focusing on characteristics of its organisation and looking at "outcomes" of primary care according to relevance, equity, quality and financial sustainability.

Challenges ahead performance assessment in primary care

Measuring the performance of primary care is more challenging than measuring the performance of the healthcare

⁴https://ec.europa.eu/health/expert_panel/sites/expertpanel/files/docsdir/opinion_primarycare_performance_en.pdf

systems overall. It is linked to the **complexities of the primary care** in relation to the range of actors, mix of organisational models, dispersed nature of services. All this poses challenges in **data collection**. Indicators for the performance assessment of primary care require further development. A lot of indicators are constructed not taking into account the specific and fundamental contribution made by the primary care when indexing for example the access and quality of care. Data on workforce tends to be presented in the form of composite indicators not distinguishing between various segments of healthcare. Moreover, measures of performance of primary care should include variation in context, e.g. data on characteristics of the population, health system, social welfare system. Methods of data collection matter too and the Panel notes that the use of administrative data instead of data reported by institutions would speed up the collection process and decrease the possibility of errors. Finally, it is noteworthy that new disease patterns with multi-morbidity and chronic conditions call for an improvement of the comprehensiveness of the data, including data that are gathered by the inter-professional team and this brings into the debate the question of co-existence and choice of appropriate classification systems.

A right balance of indicators and targets

is another driver of an effective performance system in primary care. Both an excessive and a scarce number of performance indicators can result in a performance paradox expressed by a weak correlation between performance indicators and performance itself.

The Expert Panel also stresses the challenge of **reconciliation of goals defined from the individual patients' perspective with the performance assessment at population level**. Patient's goal approach is particularly relevant for multi-morbidity patients. In this context a lot of data is collected in the vertical disease oriented programmes isolating the data related to the interventions for a single condition.

Moreover the Expert Panel stresses a challenge in **combining outcome and process** and a challenge of the influence on data of the context/aim they are collected for. The latter is especially the case for "pay-for-performance" and "pay-for-quality" data which can be "adapted" to the "desired standards".

How to make the performance assessment in primary care comprehensive

The Panel is considering the very **comprehensive definition of the primary care** which is the entry level and cornerstone of many health systems and it is at the core of providing accessible person-centred, appropriate and equitable care from a population-based perspective. It responds to a wide range of health needs, both preventive and curative covering the complete life-cycle and including Long Term Care services. The Panel in their consideration also emphasises the spill over effects of primary care, which except for improving the health of population, contributes to the population well-being.

The opinion refers also to some **preconditions for well performing primary care** emphasising the provision of services that are: 1) universally accessible,

2) integrated, 3) person-centred, 4) comprehensive and community oriented, 5) provided by a team of professionals accountable for addressing a large majority of personal health needs. These services should be delivered in a 6) sustained partnership with patients and informal caregivers, in the context of family and community, and play a central role in the overall 7) coordination and 8) continuity of people's care".

With regards to the primary care workforce, the Expert Panel lists, among others, the following health professionals that should work in multidisciplinary teams: dentists, dieticians, general practitioners/family physicians, nurses, midwives, occupational therapists, optometrists, pharmacists, physiotherapists, psychologists and social workers.

The opinion looks also at conditions necessary to arrive at a good approach in performance assessment, emphasising in particular: multi-dimensionality, shared design, evidence-based, benchmarking of results, timeliness and transparent disclosure.

The Expert Panel draws the conclusion that what emerges from the definition of the primary care is its intrinsic complexity, related to its multiple dimensions, stakeholders and governance levels. Defining dimensions and domains to be taken into consideration in assessing the performance of primary care, the Panel proposes to include some more classical dimensions of HSPA that can be applied to the assessment of primary care (1-8 in the table) and domains that are specific to primary care (9-10 in the table):

| Domains and dimensions in Primary Care (PC) | |
|---|---|
| Domains | Primary care dimensions |
| 1) Universal and accessible | <ul style="list-style-type: none"> • 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 | <ul style="list-style-type: none"> • 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 | <ul style="list-style-type: none"> • 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 |
| 4) Comprehensive and community oriented | <ul style="list-style-type: none"> • 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) | <ul style="list-style-type: none"> • 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 | <ul style="list-style-type: none"> • 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 |
| 7) Coordination of people's care | <ul style="list-style-type: none"> • 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 | <ul style="list-style-type: none"> • 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 |

| | |
|-------------------------------------|---|
| 9) Primary Care Organisation | <ul style="list-style-type: none"> • 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); • Organisational components of coordination and integration: structure and dynamics (job descriptions and team functioning, management and practice governance, clinical information management, organisational adaptability 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 | <ul style="list-style-type: none"> • 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 |

Based on Hogg et al., 2008; Kringos et al., 2010; Bitton, 2017.

Not to lose any of these dimensions from focus, the Expert Panel proposes to use as a **reference framework**, the one outlined by Donabedian, which indeed allows multiple dimensions to be addressed when assessing performance (1988) on the basis of the causal relationships between *Structure*,

Process and *Outcomes* of care. Structure and process are linked in a continuous interaction and shape the care outcome. The model allows contextualising the primary care in the overall healthcare systems and thus to assess the overall contribution of the primary care in terms of value for money.

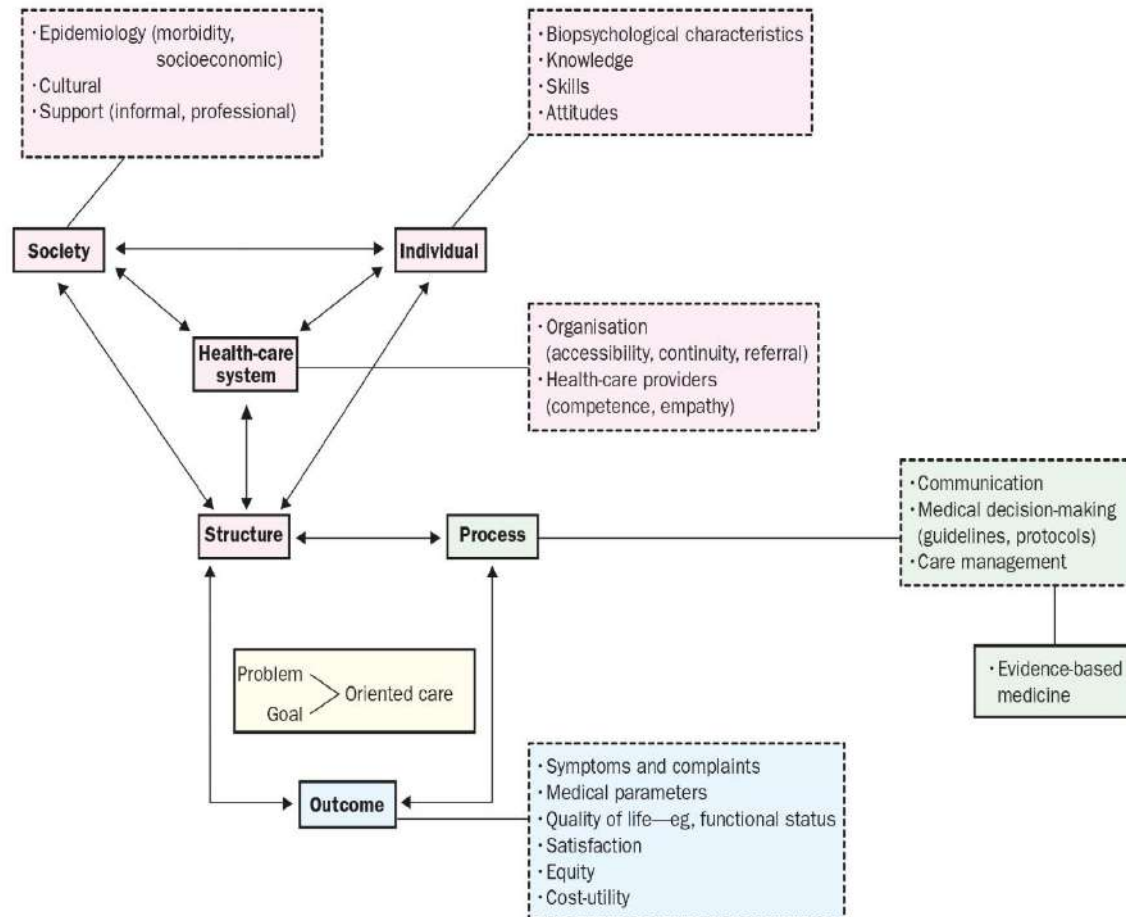


Figure : Theoretical framework of structure, process, and outcome (De Maeseneer et al., 2003; courtesy The Lancet)

The opinion draws the attention to the importance of assessing the **structure** of the primary care setting by measures related to how **access** to primary care services occurs (EXPH, 2016), **how providers of primary care are organised** and **how resources are managed** in the system. These dimensions should be kept in the performance assessment, because the access to primary care can be impaired by both financial and non-financial barriers and because of the risk of possible failures in responding to patients' needs in case of the lack of organisation in primary care. Resources are also crucial with the health workforce being at the core of provision of services, provider payment and remuneration affecting the overall resources and incentives to ensure the appropriate care and the size of a primary care practice affecting its capacities.

Considering how to assess the **processes through which primary care services are**

delivered, the Panel emphasises the nature of service delivery, which is complex due to a multiplicity of providers operating in different types of networks. The performance assessment should look at consistency and coordination across various types of providers, settings and governance levels with a view of improving outcomes and reducing waste of resources.

Looking at **outcomes of primary care** in performance assessment, the opinion puts into spotlight: relevance, equity, quality of care and financial sustainability.

Key elements to assess processes

The core measures of consistent and co-ordinated performance should include integration with a number of aspects: the ability of a practice to coordinate and synthesize care received from external sources, integration between primary and secondary care (appropriateness of referrals), integration in relation to social care. The indication of the performing mechanisms of horizontal and vertical coordination can be for example the existence of case management practice or shared care plans or both financial and non-financial incentives. ICT health information systems for sharing information between providers have also assumed a key role in facilitating this process. Other fundamental elements are the continuity of care in all its forms (longitudinal, informational and relational continuity) and the responsiveness to population and community specificities.

Key elements to assess outcomes

Relevance is about care “that matters”, contributing to the achievement of the life-goals of the person. When it comes to equity, it is important to assess how primary care affects it in all its meanings and dimensions such as health inequities in access based on need, and fairness of financing. Quality in the context of primary care includes dimensions such as accurate diagnosis and appropriate treatment for acute and chronic conditions, quality of care for chronic conditions, quality of maternal and child healthcare, effective health promotion and primary and secondary prevention, appropriateness of care, quality of person-centred care entailing both shared decision-making and patient engagement, the degree of patient-provider respect, trust and cultural sensitivity, quality of family-centred care and patient safety and advocacy. Financial sustainability concerns the efficient and effective allocation of resources to support equity and quality of care. Three types of evidence are required to assess outcomes of performance of primary care: professional (knowledge of the health condition), contextual (patient-specific aspects of medical care) and policy evidence (policy strategies to guarantee equity and appropriate use of resources, including avoiding waste).

Examples of indicators for performance assessment

Considering the complex context in which primary care operates, the Panel **systemises the approach to indicators** which could be used in the performance assessment of primary care through splitting them into two categories: comparative key-indicators and descriptive additional indicators. Comparative key-indicators are those whose score may be evaluated in comparison with a target or a benchmark (e.g., waiting time for first visit by a physician). Descriptive (observational) indicators are those whose score provides useful information for decision makers but whose interpretation may be ambiguous, for example, the rate of frail people who receive

domestic help at home depends on both organisational features of the healthcare system and other certain social characteristics (e.g., the family role). Descriptive indicators should therefore be correctly contextualized in a specific health system. Indicators are clustered around ten domains proposed by the Panel. Examples are provided in the table.

| Examples of comparative key-indicators along its key domains | |
|---|---|
| Domains | Examples of Indicators |
| 1) Universal and accessible | <ul style="list-style-type: none"> • % 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 |
| 2) Integrated | <ul style="list-style-type: none"> • 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? |
| 3) Person-centred | <ul style="list-style-type: none"> • 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. |
| 4) Comprehensive and community oriented | <ul style="list-style-type: none"> • 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? |
| 5) Addressing personal health needs (provide high quality PC) | <ul style="list-style-type: none"> • % 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 |
| 6) Sustained partnership with patients and informal caregivers | <ul style="list-style-type: none"> • % 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 |
| 7) Coordination of people's care | <ul style="list-style-type: none"> • 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. |
| 8) Continuity of people's care | <ul style="list-style-type: none"> • 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? |

| | |
|--|---|
| 9) Primary care organisation | <ul style="list-style-type: none"> • 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? |
| 10) Human resources in primary care | <ul style="list-style-type: none"> • Average number of working hours per week of GPs/nurses/pharmacists/social worker. • Average age of practising providers in PC • Total number of active GPs as a ratio to total number of active physicians • Total number of nurses active in PHC compared to total number of nurses in PHC, secondary and tertiary care |

The opinion stresses that the choice of indicators should be guided by, at least, the following criteria: alignment with policy objectives, ability to routinely collect the information, either from administrative sources or from specifically-designed surveys, and reliability of information. Finally, an appropriate understanding and interpretation of the data often requires an additional qualitative data collection.

Word of caution: performance paradox

There might be no automatic uptake of assessment framework for primary care and in extreme cases assessment framework may lead to dysfunctional performances (also called performance paradoxes) such as perverse learning - i.e., when actors have learned how measurement works they can manipulate their performance results.

The Panel identified on the basis of the literature review some conditions which are key to put the assessment framework into the appropriate use.

Multi-dimensionality including organisational, institutional, financial, quality and equity aspects, is an important characteristic to account for the complexity of the primary care system. **Shared design** of the evaluation system (involving evaluators, managers, policy-makers and clinicians) can drive an easier acceptance of the system. **Evidence-based** data collection and information provision is crucial and comparability of indicators across countries and regions creates an added value. Shift from monitoring to **evaluation**, that includes systemic **benchmarking** of results among providers and geographic areas and, if it is possible, against shared standards is a way to progress to better performance levels. **Timeliness** is also a core element of every performance evaluation system as it determines the promptness of decisions. **Transparent disclosure** to stimulate data peer-review stimulates long-term improvements, provided the performance evaluation is appropriately contextualized (e.g. through information on case-mix). The **engagement of health professionals** is indispensable, because healthcare problems cannot be solved by experts from other fields. Finally, when choosing the indicators that should be used to assess primary care performance in a specific context, policy-makers should ensure that the set of indicators: is consistent with strategies; considers different dimensions of performance; includes indicators measurable over time; includes indicators measured in a systematic way.

Recommendations of the Panel

The Expert Panel acknowledges that strengthening primary care will contribute to improved population health and wellbeing and greater social cohesion in the European Union.

The first recommendation is to distinguish clearly the primary care from the broader healthcare system through performance assessments tailored to specificities of primary care. The tools and methodologies which are used should **encapsulate the essence of primary care in the framework of the broader health care system**. On top of 8 dimensions, that are derived from the definition of primary care formulated in its opinion: "Definition of a frame of reference in relation to primary care with a special emphasis on financing systems and referral systems" (EXPH, 2014), the Expert Panel suggests to add 2 dimensions which are critically important: "primary care organisation" and "human resources". Therefore, the **10 domains** that Expert Panel proposes are: universality and accessibility, integration, person-centeredness, comprehensiveness and community orientation, a team of professionals that addresses the larger majority of personal health needs, sustained partnership with patients and informal care givers, coordination of people's care, continuity of people's care, primary care organisation and human resources.

The second recommendation of the Expert Panel is to set indicators associated with 10 domains, which include both **comparative key-indicators** and **descriptive additional indicators**. They should meet three criteria: alignment with objectives of health system, ability to routinely collect data and reliability of information. The Panel notes that indicators in current use are very much restricted to the functioning of GPs/FPs, and it will be essential to broaden the scope to the inter-professional Primary Care Team.

Moreover a lot of indicators are related to specific diseases, overlooking the need for a comprehensive approach. Finally, new outcome indicators should be able to look at strengths, capabilities of people and include dimensions like happiness at the individual level and social cohesion at the broader societal level.

Thirdly, the Panel suggests **scaling up activities in relation to performance assessment of primary care**. The Panel is suggesting the creation of **a widespread EU learning community** to support development of appropriate tools and methodologies for assessing the performance of primary care and inform the public on the findings. The European Pillar of Social Rights and the Sustainable Development Goals create some momentum to strengthen the policy framework to develop these activities and build on experience of the EU expert group on Health Systems Performance Assessment.

The Panel also stresses the importance of **human resources** in primary care, which should be subject to performance measurement in a way encompassing professionals' motivation and engagement, good working conditions, management skills to organise and manage the correct use of performance information and to put in place strategies and actions to enhance primary care.

Chapter 2. Findings of the survey on national experiences on performance assessment of primary care

This chapter builds on the survey conducted by the EU Expert Group on health systems performance assessment in March 2017. What emerges from the survey is that countries can learn from each other and that performance assessment can help make the primary care the cornerstone of the modern health services.

The survey collected information on national experiences in performance assessment of primary care. Twenty-two countries replied to the survey and given the difference in the organisation of care across countries, the questionnaire considered primary care as first contact care, provided by a team of professionals accountable for addressing a large majority of personal health needs. This chapter presents the findings from the survey.

Main characteristics of the performance assessment systems

Almost all respondent countries do carry out recurrent assessments of primary care but their experience varies according to the objectives, scope and technical parameters, such as the type of indicators used, methodologies, etc. Some systems are more advanced than the others and there is certainly scope for reinforcing them overall across Europe. The plans for the future vary across countries, depending on how developed the primary care assessment is. Nonetheless, almost all respondents have stated their intentions to enhance the efforts in this regard.

The majority of countries who took part in the survey have an assessment system in place that specifically targets the performance of primary care, or important parts of the primary care system. Just in few countries, the primary care assessment is part of an assessment of the health system in general, but even in those cases, the assessments include aspects that mirror primarily activities in primary care (e.g. use of medicines for diabetic care, data on

waiting times, rate of registers users in local primary health care, etc.). Eight countries put a priority on a specific dimension of primary care (Belgium, Estonia, Finland, Luxembourg, Netherlands, Portugal, Slovenia, and Spain); the most frequently mentioned are care for specific diseases, delivery of preventing services, uptake of vaccination and immunisation programs and prescribing.

There is some untapped potential for performance systems to strive for better results of primary care. Monitoring of policy actions, general reporting and accountability are reported by almost all of the countries as a reason behind monitoring the performance of primary care. In some cases performance assessments feed into performance-based reimbursement schemes and comparative benchmarking. Only three respondents reported performance-based reimbursement schemes as the main purpose when assessing the performance of primary care (Belgium, United Kingdom and France).

Some important stakeholders may drop off from the targeted audience. While almost all respondents address their primary care assessment to policy makers, healthcare managers and clinicians are the second main group targeted by primary care assessments. To a lesser extent, the reports are intended to reach the public and patient's users. Restricting audience may in some cases limit the benefits which various stakeholders could reap from the performance assessment. The involvement of stakeholders in the design of the system or its elements may also be beneficial. In France for example the professionals are involved in the selection of indicators measuring the quality of medical practice.

Differences exist on the type of primary care that is considered when assessing the performance of the primary care system. The scope of assessments tends to be limited to the narrow spectrum of professionals of primary care. Almost all the countries that

presented their experiences in the survey assess the performance of General Practitioners and Family practice in order to monitor the performance of the primary care system. Only some countries extend the scope of the assessment to other areas such as midwifery, nursery, paediatrics, gynaecology, preventive services, pharmacy and social workers.

Reporting mainly takes place at national and regional levels, though with different nuances. Some countries just report on national level (France, Latvia, Luxembourg, Malta, and Slovenia). In few cases, the assessment is carried out at provider level (Finland, Italy).

Scope of primary care assessment, few examples

Norway, through SAMDATA Municipalities establishes a comparative data system on health and social care services at municipality level (mostly input and process indicators) with the main purpose of monitoring resources, accessibility and quality of primary care services. Home care (nursing care and social care are integrated services), institutional long term care and institutional short term care (rehabilitation after treatment or planned rehabilitation) GP's, physiotherapist, school nurses, health services for new-borns and preschool children, social services to support the persons possibilities to be active and participate in society, are all services targeted by this report. *In the Netherlands*, the Netherlands Institute for Health Services Research (NIVEL) and the Dutch Healthcare Authority (NZA) gather data of Individual GP practices, out of office GP's care centres, primary mental care, pharmacists, physiotherapists, speech therapists and dieticians. *In Slovenia*, the National Institute of Public Health (NIJZ) and National Health Insurance Institute (ZZZS) collect data on individual GP/family medicine practices, paediatric practices and women reproductive health practices at primary healthcare level, dental services for children and adolescents, preventive services for children and for adults, community nurse services, primary mental care, speech therapist and physiotherapist services.

Geographic level of reporting, few examples

Finland carries out different performance assessments of primary care. Among them, the *Survey on Customer/patient satisfaction* is done at provider and practice level whereas *Access to primary health care* and *Register on Primary Health Care Visits* are done at national, regional, provider and practice level.

In *Italy*, the level of reporting is both regional and sub-regional: LEA (*Livelli Essenziali di Assistenza*) grid indicators are computed at the regional level, while PNE indicators (outcome indicators) are computed at province or health care district level. Moreover, variability among general practitioners is also measured.

In *Sweden* the development of performance assessment has been increasing based on extensive cooperation between the national level, the county councils and the medical professions. Both open regional comparisons and evaluations have for many years presented data on county council and hospital level. The main focus has so far been primarily on the county council population level.

In the *Netherlands*, healthcare performance indicators on national website (VZ-info) are done at national level, whereas other assessments (NZA, NIVEL, Monitor Voorschrijfgedrag.) are done at national and regional level.

There is less variation in practice related to the governance of the performance assessments. As a norm, Ministries of Health are commissioning the assessments carried out in primary care. Likewise, the assessments were in large part carried out by Public Health institutes, quality measurement agencies, or other similar entities.

Indicators and data collection

Descriptive information about providers, access and patient-centeredness are the main dimensions considered by most of the Member States when assessing the performance of primary care. Clinical performance is measured by half of the respondents. Aspects such as equity, workload and workforce satisfaction in primary care are less frequently reported.

Almost all respondents do have in place indicators providing descriptive information about providers and utilisation of care. Examples are: the amount of carried out check-ups for different age groups, the average number of patients served per day at a GPs practise and the number of patients who have had a dental check-up in a given year (Latvia); the number of maternal and child health checks by municipality, users of home nursing help or institutional care for the elderly, waiting, times and some patient experience measures (Norway).

Most of the countries do consider access when measuring the performance of primary care. Some indicators are: the supply of providers, the availability of specific assistance agreements, geographical access (Poland); the access during out-of-office hours (Cyprus); waiting times and financial barriers, including out-of-pocket payments (Malta).

Patient centeredness is also considered by some countries when measuring performance of primary care. Indicators include satisfaction rates with GP, availability of essential patient information in records, communication, chronic care management, continuity of care and patient safety were measured in this regard.

Cost, waste and efficiency, on the other hand, are just measured by few Member

States (Belgium, Finland, Spain, Portugal, UK, the Netherlands and Slovenia). Indicators measured under this category include expenses for prescribed medication with user reimbursement (Portugal), prescription in accordance to Guidelines (Netherlands), and use of emergency department for cases that could be treated in primary care (Spain and Malta).

Clinical performance is also considered to a lesser extent (Estonia, Finland, France, Italy, Latvia, Lithuania, Portugal, Slovenia, Spain, and UK), with indicators like immunisation rates for various diseases, number of patients who have been advised/consulted by GP or nurse to change their unhealthy habits. A small set of respondents explicitly address equity in primary care. Malta breaks down access, quality, or outcome indicators by specific population groups (gender, socio-economic status, education or ethnic background). Slovenia performed extensive qualitative survey on barriers for access to primary care and preventive services for de-privileged/vulnerable individuals. In the UK, the numbers of patients registered at GP practices is available by single year age band.

Workload and workers satisfaction is considered in the assessment of the performance of primary care by just eight respondents (Belgium, Finland, Netherlands, Portugal, Slovenia, Spain, Sweden, and Tuscany region). Spain and Slovenia, for instance, report on the ratio of users per quota and the burden of chronicity/patients in order to assess the primary care workload. In Spain, a survey on the work environment is carried out in some autonomous communities in order to assess work satisfaction. In most cases, the information on workload and workers satisfaction is not measured by primary care assessment, but is the focus of other types of investigation.

For virtually all respondents the selection of indicators was done through standard methodology and the involvement of different advisory boards composed by external independent experts, senior health managers, clinicians, health care professionals, academics, and in some cases patients.

Survey respondents reported mainly routine data obtained from administrative and national registries. It is usually not specified if administrative registries were set just for primary care assessment or also for other purposes.

Impact on policy making

Usually, survey respondents assess the performance of primary care to inform policy making. However, in most of these cases countries do not monitor how the assessment impacts on policy making – also because of the long time lags. Some exceptions are presented in the box.

Impact on policy making, few examples

In *Slovenia*, several assessments of different dimensions and services at primary health care have been conducted with the aim to provide the evidence for developing the National Healthcare Plan, the Strategy for development of Primary Health Care, the upgrading of the national program for prevention of NCDs and reducing inequalities in health, and others.

In *Finland*, some indicators considering access have been used in the current debate on reforming health and social services; thus, data is used to support reforms. Moreover, the information on health centre recruitment situation has been used to motivate the increase in enrolment to medical schools. Finally, the vaccination monitoring system highlighted low rates for measles in some areas to the extent that the herd immunity is endangered.

In *Latvia*, by reporting to the Cabinet of Ministers information on primary care assessment, the post-graduation training program on team work (GP +nurse/ physician assistant) for GP practices was developed and realised.

In *Italy*, in the region of Tuscany, considering the results of annually performance at primary care level, regional and local policy makers can decide to promote some interventions and services to shift to a different organisational model. In Lazio, primary care quality indicators are systematically used by the Health Plan Directorate to evaluate health patterns for chronic conditions to set clinical and organisational objectives for healthcare providers and to link the level of achievement of these objectives to annual budget or contract extension of healthcare professionals.

In *Spain*, performance indicators have helped to target strategic areas of improvement in health centres. Various national strategies have been developed after assessments were conducted: chronicity, health promotion, ischemic heart disease, chronic obstructive pulmonary disease, diabetes and stroke (among others). There is evidence of a slight improvement in some of the health problems which were prioritised.

Linkage between function of the performance assessment and type of indicators

The linkage between function of the performance assessment and type of indicators is of crucial importance. The choice of indicators will depend on its

objectives and will affect the chances for impactful performance assessment. The practices vary a great deal across Europe, but there are also some common patterns emerging. Some examples show different angles.

Belgium, who runs **performance-based reimbursement schemes**, uses a set of indicators ranging from indicators measuring access (supply of providers, availability of specific care arrangements e.g. disease-management programmes, case management, access during out-of-office hours, financial barriers e.g. out of pocket payments, geographical access, unmet needs), indicators measuring clinical performance (periodic check-ups of chronically ill, prescription or referrals in accordance with guidelines, use or availability of clinical protocols and patient safety procedures, indicators measuring patient-centeredness or responsiveness (patient experiences with provider-patient communication), indicators measuring costs, waste or efficiency (e.g. unnecessary tests, referrals, medication, etc., prescription of generics, procedures taking place in secondary care that could have been taken place in primary care, use of emergency department for cases that could be treated in primary care), indicators measuring equity (access, quality or outcome indicators broken down by specific groups, e.g. gender, socio-economic status, education or ethnic background), general descriptive information about providers or organisations, quality (presence of accreditation certificates).

France applies performance assessment to design **performance-based schemes covering mainly clinical organisation and quality of medical practice**. The scheme of an annual payment based on public health objectives called ROSP (Remuneration sur Objectifs de Santé Publique), provides incentives for practitioners on the basis of the indicators measuring: clinical organisation (information system for care coordination, patient's file, and treatment improvement), quality of medical practice (chronical diseases monitoring, prevention, efficiency).

Ireland's Health Services uses a set of indicators to examine the **performance against resource planning frameworks**: the National Service Plan 2017/ Primary Care Division Operational Plan 2017. They include indicators measuring access (supply of providers, availability, waiting times access during out of office hours), clinical

performance (use or availability of clinical protocols and patient safety procedures), costs, waste or efficiency (spending per patient of specific categories on medicines, overhead spending), equity (access, quality or outcome indicators broken down by specific groups, e.g. gender, socio-economic status, education or ethnic background; indicators related to the care of specific de-privileged groups such as homeless people, asylum seekers, illegal immigrants, etc.). They are complemented by general descriptive information about providers or organisations: activity in visits, group and community (e.g. number of practice consultations; home visits per time unit); consultation length; range of services provided, Community Intervention Teams (CITs) record the number of referrals, admission avoidance, hospital avoidance, early discharge, and unscheduled referrals from community sources. Public Health Nurse data refers to targets for home visits with in defined times.

Italy applies performance assessment for both **comparative benchmarking between providers in local districts and GPs practices** and for **other professions performance-based reimbursement schemes** (in this case, some of the indicators are used as the base of performance schemes). The indicators which feed into the assessments include measures of: access (GPs involvement on the Chronic Care Model and waiting times for GPs visits and outpatient visits), clinical performance (prescription or referrals in accordance with guidelines), patient-centeredness or responsiveness (patients satisfaction and experience with their GP in terms of involvement, communication, chronic care management, continuity of care), costs, waste or efficiency (prescription of generics drugs, compliance to treatment, use of emergency department for minor disease, appropriateness of secondary care and diagnostic and laboratory exams), general performance such as ACSCs hospitalization rate. Moreover, indicators related to GPs practices organisation in terms of GPs satisfaction and experience supplied by regional online survey are used.

Latvia uses performance assessment in **general reporting** and **performance-based reimbursement schemes** with the following set of indicators: general descriptive information about providers or organisations, (e.g. the amount of carried out check-ups for different age groups, average number of patients served per day at a GPs practise, number of patients who have had a dental check up in a given year), outcome indicators that may be related with primary care performance, including both access and quality (e.g. hospitalization rates for ambulatory care with sensitive conditions), indicators measuring patient-centeredness or responsiveness (e.g. satisfaction rates with GPs), indicators measuring clinical performance (e.g. immunization rates for various diseases, number of patients who have been advised/consulted by GP or nurse to change their unhealthy habits), indicators measuring access: supply of providers. In the framework of the annual GP's performance assessment, Latvia uses the following mix of indicators: health check-up of the newly registered patients, health check-up of the patients 18 years of age and older, children's immunisation coverage, health check-up for children from 2 years old to 18 years of age, mammography and cervical cancer screening, percentage of the patients registered within GP who have had an occult blood test, glycohemoglobine measurement for patients with type 2 diabetes, microalbuminuria quantitative determination for patients with type 2 diabetes, cardiovascular risk evaluation, Determination of LDL cholesterol, expiratory peak flow in asthma patients; number of Emergency medical service team's visits to GP's patients.

Lithuania uses performance assessment for **general reporting, comparative benchmarking and performance-based reimbursement schemes**. The following dimensions are screened though a relevant set of indicators: population care coverage with a view of promoting regular check-ups, performance of cancer screening programmes, prophylactic examinations, hospitalisation of patients with schizophrenia (to monitor performance of the outpatient

mental health care), hospitalisation of patients with chronic diseases (to monitor performance of outpatient care for people with chronic diseases), performance of dental healthcare. Lithuania defined a list of services which should be incentivised and are monitored through performance assessment. At the moment there are 18 groups of services/examinations (total 68 services/examinations) which are considered as the incentive services, for example: blood clotting condition tests: prothrombin activity test and INR test; test to assess blood coagulation system and to determine an individual's ABO/D type for patients admitted for elective surgery; vaccination of high risk patients against influenza; glycated haemoglobin test for patients suffering from diabetes; early diagnostic of cancer; regular care of pregnant women; provided care for children under 1 year; home care of disabled; timely immune-prophylaxis of children; regular health check-ups for schoolchildren; performance of Mantoux tuberculin skin test for children at risk groups; care provided by the community at patient's home; provision of care and specific tests (e.g. serological screening test for syphilis; T. pallidum haemagglutination test (if serological test was positive; HIV serological test; anti-HCV antibody tests) for patients receiving substitution treatment; performance of rapid antigen tests for group A streptococcus for 2-7 years children with diagnosis of upper respiratory tract infection; treatment of patients suffering from tuberculosis.

Feedback on challenging issues

The most common constraints encountered when assessing the performance of primary care are lack of routinely collected data for primary care, problems with data quality (low reliability), and appropriateness of indicators used. Some other limitations highlighted by participants include for example:

- Performance information does not have a clear position in the policy cycle;
- Lack of permanent dashboards, and therefore difficulty to monitor indicators over time;
- Monitoring systems operating in silos; no data linkages;
- Some stakeholders remain excluded from the process;
- Lack of resources;
- Activities link to primary care are difficult to assess through registries;
- Data collection systems developed for payment and therefore not tailored to the needs of patients/ public;
- Insufficient development of indicators that refer to multiple chronic conditions and indicators that reflect multi-professional care;
- Insufficient development of indicators that reflect outcome of care instead of process of care;
- Providers that are identified as poor performers are more likely to question the validity of the data, particularly when the results are first released;
- Problem with registration and integration of information systems among care levels and with other care actors.

A way forward

Countries are interested and ready to further develop their performance assessment systems for primary care. Specifically, those countries that have done efforts in the development of primary care performance assessment emphasize the need to further develop indicators (increasing the indicators focusing on health outcomes) and overcoming the reported limitations. At the

same time, countries that informed being on a more preliminary stage in the assessment of primary care performance, report their intentions to start collecting and publishing indicators.

Chapter 3. Understanding the policy impacts of performance assessment

Prepared by Dr Ellen Nolte^e

A key driver behind many efforts to measure and evaluate the performance of health services and systems has been a growing concern about accountability.¹ An important role of performance measurement and reporting is thus to help hold various actors to account by informing stakeholders and so enabling them making decisions.² Performance assessment should support policy action by helping policy makers to select interventions and policies in response to different health problems, and to decide the allocation of resources considering different priorities and demands, with a short, medium or long-term perspective.³ Other objectives include enabling the identification of areas of poor performance and centres of excellence; facilitating the selection and choice of providers by service users and purchasers of health care; encouraging provider behaviour change; and providing epidemiological and other public health data.⁴ Much progress has been made nationally and internationally, but many challenges remain regarding the design and implementation of performance assessment initiatives, in terms of scope, policy usefulness and policy impact.⁵

This chapter aims to identify the key requirements for HSPA to successfully inform and support policy action within European settings, with a particular focus on primary care policy. It does so through, first, synthesising the existing evidence base on the use of health system performance assessments in the policy process more generally and within primary care specifically. This draws on a rapid assessment of published evidence around performance assessment and the public reporting of data on provider performance as identified from an iterative search of the PubMed database and Google Scholar, as well as the author's own work. It further

draws on the survey conducted in March 2017 among key informants in countries participating in the EU Expert Group on HSPA and reported in chapter 3. The rapid review of the existing evidence presented does not attempt to be exhaustive. Instead it focuses on some of the main key issues around the policy impacts of HSPA as highlighted in the identified literature. Second, we explore the main barriers for HSPA to inform policy and discuss options to overcome these challenges. This second element of the chapter builds, mainly, on insights from experts from 17 European countries that took part in a structured policy focus group of the Expert Group on HSPA (Box 1)

The policy focus group approach builds on a similar exercise undertaken as part of the work by the Expert Group on quality of care (2016)⁶ and on integrated care (2017).⁷ The main objective of the present focus group was to generate in-depth discussion and provide suggestions and recommendations for key requirements for health system performance assessment to successfully inform and support policy action, the main mechanisms whereby HSPA might affect national policy, and the possible role HSPA can play as a tool to monitor and evaluate reform of primary care and of the health system more broadly.

It is important to note that much of the discussion on the core opportunities and challenges for HSPA to influence policy presented in this chapter is not confined to primary care specifically. This is illustrated both in the synthesis of the wider literature which we describe below as well as many of the discussion points made by focus group participants. This is perhaps not surprising, given that the design and implementation of many HSPA initiatives continue to evolve across Europe and elsewhere, as noted above.⁵ Thus, many of the insights provided in this chapter will have wider applicability beyond the context of primary care. However, we will draw on specific examples

^e The European Observatory on Health Systems and Policies

within primary care policy to illustrate specific discussion points and options.

Box 1 Policy Focus group – sub-group Primary Care

The policy focus group brought together experts with in-depth knowledge on their respective health systems performance assessment processes from 17 countries in Europe, as well as representatives of the European Commission Directorate General for Health and Food Safety and the OECD. By means of a semi-structured facilitated discussion coordinated by the European Observatory on Health Systems and Policies, experts reflected on key requirements for health system performance assessment to successfully inform and support policy action, with particular consideration of how HSPA can successfully influence primary care policy, and the enablers and barriers for this to be translated into practice. It further considered the main mechanisms whereby HSPA might affect national policy, and the possible role HSPA can play as a tool to monitor and evaluate reform of primary care and of the health system more broadly.

Focus groups are frequently used in qualitative research to explore topics that are not easy to observe or that are sensitive, to ascertain perspectives and experiences from people on a topic in a short time span, or to gather preliminary data and clarify findings from another method, among other uses.⁸

Focus group participants were provided with background documentation prepared by the European Observatory, which synthesised evidence from the peer-reviewed and grey literature on the use of health system performance assessments in the policy process. This material was shared with participants in advance to the meeting of the policy focus group, held on 18 September 2017 in Brussels. *Subsequent to the meeting, focus group participants were given the opportunity to consult with other experts in their countries and provide additional comments and insights and, where appropriate and relevant, documented empirical evidence subsequent to the policy focus group meeting. Additional comments and suggestions received were incorporated into the present report to ensure that it appropriately reflects country's experiences.*

Policy impact of performance assessment activities at national or regional system level

How to integrate HSPA into the policy process remains one of the unresolved issues that Member States and countries elsewhere continue to struggle with. A 2014 review of the HSPA initiative in Belgium explored relevant experiences in a set of peer countries (Austria, Malta, the Netherlands, Portugal, Sweden and the United Kingdom (England)) and found that as the aims of HSPA varied across countries, so did its influence on the policy process.⁹ Reviewed HSPA approaches variously sought to promote the accountability of national institutions, inform policy, improve transparency and understanding, and/or hold devolved entities to account (Table 1).

Perhaps reflecting this diversity of aims, the nature and extent to which HSPA supported policy action in the reviewed countries at that

time also varied, ranging from more direct impacts, for example, feeding into agenda or priority setting at national level (such as in Malta and the Netherlands; Table 1), including the development of national strategies (e.g. Portugal), to more indirect mechanisms, such as informing the political debate (e.g. Austria, Belgium). The review noted that HSPA had stimulated new data collection efforts in a number of countries and the use of international datasets such as those collected through the OECD Health Care Quality Indicators project provided opportunity to draw attention to gaps in national data. Overall, however, the review highlighted that identifying appropriate ways of linking HSPA with policy processes remained underdeveloped in most countries at that time; approaches are also likely to vary depending on institutional arrangements.

Table 1. Reported impacts of HSPA on national policy making, 2014

| Country | Impact of HSPA on national policy making |
|--------------------------|--|
| Austria | HSPA provides an important source for identifying areas of action for policy makers. It provided the analytical background for target-setting within the 2013 Austrian health reform ("Health System Governance by Objectives") for policy makers but it remains a challenge to embed the current HSPA framework more deeply in the policy making process to facilitate target setting based on HSPA analyses |
| Belgium | The HSPA report aims to provide a transparent and accountable view of and inform health authorities about the performance of the health system. While supporting policy making was not an objective at the outset it has progressively become an issue. Reports provide recommendations for policy-makers and point out priorities, also for data collection; the usefulness of reporting for decision-making has as yet to be demonstrated. |
| Malta | National HSPA framework in process of development and link with policy cycle yet to be established. The aims are to monitor the health system's ability to cater for the nation's health needs, to increase accountability, transparency and sustainability of health system and to determine future policy directions. |
| The Netherlands | HSPA reports are used for agenda setting and for accountability of the ministry of health to parliament. While the reports are well embedded in a network of expert researchers and health care professionals, it remains a major challenge to improve its policy impact and 'actionability'. |
| Portugal | HSPA supports efforts of the Ministry of Health to improve the performance of the health system and contributes to gathering the critical evidence base to inform the national health plan. It motivated key experts and policy-makers to engage in the development of the new national health plan and it helped to clarify system goals, so introducing a health system perspective into the national plan. Gaps in health information remain a major challenge, limiting the capacity to support transparency and accountability through public reporting of results. |
| Sweden | HSPA reports are used to inform decision-making locally (county councils) and nationally. The development of indicators and measures can inform local improvement work. It remains a challenge to prioritise among different measures and to determine how to best translate the information being compiled into health care improvement. |
| United Kingdom (England) | The Outcomes Framework for the NHS is aimed at holding NHS England (the national public body leading the NHS in England) for improving health outcomes and reducing health inequalities; two further outcomes frameworks for public health and for adult social care seek set out to improve and protect the public's health and to support transparency and local benchmarking. It may be challenging to establish how improvements have been arrived at. |

Source: adapted from Peer Review Health System Performance Assessment (Brussels, 19-20 May 2014), country questionnaires⁹⁻¹⁵

Recent work on the use of OECD Health Care Quality Indicators at national and regional levels documented over 160 quality or performance reports that were identified from a survey of experts in 15 OECD countries.¹⁶ Around one-third of the reports had a general system focus while about half concerned a specific health condition or disease/group, such as diabetes, cardiovascular disease, cancer or respiratory disease. According to survey respondents, most reports aimed at general reporting to inform decision makers, while others focussed more specifically on target setting

or the provision of comparative quality performance information to patients or payers. The analysis did not report on the degree to which quality or performance reports did influence policy or led to improvements in health system performance or in the quality of care in the area concerned.

An evaluation of the implementation and impact of a health system strategy-based performance card in Ontario, Canada, found that the regular monitoring of a core set of performance indicators by decision-makers at the Ontario Ministry of Health and Long-Term

Care helped refocus its role on health system outcomes and its overall stewardship function.¹⁷ The process for developing the health system scorecard, which separated the process of strategy mapping (conducted by policy makers) from the process of indicator selection (undertaken by experts) and that of negotiating local health system performance improvement targets (by the ministry and local health system leads), was found to help building credibility and trust for health system performance assessment and improvement. Challenges remained, however. These related to continued difficulties in defining, measuring and regularly monitoring the performance of the health system; providing concise information to policy makers about complex systems such as a health system; and, importantly, systematically linking performance information to the decision-making cycle of the ministry.

Overall, there remains a gap in our understanding about whether and how HSPA does indeed impact policy more generally. It is conceivable that the impacts of national

reporting that aims to hold governments and those in charge of the health system to account can be powerful, but these are difficult to measure. Impacts include scrutiny of performance reporting by the parliament,^{18 19} media reporting to the citizenry (Box 2),²⁰ and, possibly, elections.⁵ In addition, the reporting on health system performance by international agencies, such as the World Health Report 2000,²¹⁻²³ and, in some countries, the international health policy surveys by the US-based Commonwealth Fund,²⁴ can be highly influential in stimulating policy action. Whether any of these types impacts are always beneficial or indeed useful remains open to debate however. For example, as White (2014)¹⁹ has highlighted, in relation to parliamentary scrutiny, “most individuals, bodies and institutions engaged in scrutiny do not have any power to compel the government to change what it is doing” (p. 9) and, importantly, measurement of the impact of scrutiny can have unintended consequences the same way as performance measurement itself.

Box 2 Media reporting of international health system performance comparison: experience in Canada

In Canada, the Canadian Institute for Health Information (CIHI) carried out methodological work to communicate results of international health system performance comparisons using OECD data at national and sub-national level and to measure the reactions of the public and health system stakeholders to the release of such comparisons.²⁰ CIHI systematically documented media uptake and coverage of the resultant *Learning from the Best 2011* analytical report²⁵ through monitoring of all media outlets and through examining the way in which key media outlets, commentators and experts covered and reacted to the report.

The monitoring of the media response was reported to have been “strong (...) with nearly 60 mentions in the six days following the release, by far the strongest coverage received associated with the release of OECD health indicators in Canada” (p. 143). This included national and local television and radio news broadcast interviews with CIHI executives, national newspaper articles, and social media coverage (twitter).

The analysis identified a number of impacts that were attributed to the release of the report. These included requests from the federal Ministry of Health for CIHI to calculate indicator results at the level of the provinces and to develop related performance profiles (subsequently released as an interactive online tool²⁶). Also, the report had highlighted comparatively poor cancer outcomes, which were however linked to the timeliness of related data. The level of attention raised by the public comments on these results was reported to have led to improvements in the data submission processes across Canada.

Box 3 Quality measurement and improvement

Provider behaviour change is considered to be key to help improving the overall quality of care.³⁴ Berwick et al. described two principal pathways through which measurement and reporting can induce behaviour change.³⁵ In one pathway ('improvement through selection') users are provided with knowledge about quality that will enable them to select providers. Users include patients, who can, based on this information, exercise informed choice of provider,³⁶ as well as payers and regulators who may use the knowledge to inform decisions on payment, for example, rewarding high or penalising low performers. In the second pathway ('improvement through change'), quality improvement is achieved through changes in provider behaviour. Information on the quality of care is expected to help providers to identify areas of underperformance and reporting can then act as a stimulus for improvement. These pathways are linked through a provider's intention to maintain or increase reputation and, in a competitive context, market share.³¹ Quality improvement may therefore occur even if patients make limited use of information systems and provider choice.³⁷

Providers are direct users of information (for example, to inform their decision at the point of referral) as well as the main target audience of reporting, and their response to the publication of such data will determine quality improvement. In this context, a recent survey of a random sample of GPs in France (n=503; response rate 56%) about their perceptions and use of comparative hospital quality indicators made available by public services and the media may be relevant.³⁸ It showed that between 84 and 89% of GPs responding to the survey had never used public comparative indicators to guide their patients' hospital choices. They did however perceive quality indicators as useful in principle, as a means to improve the quality of care and to enhance the transparency of public services.

Understanding the impacts of measuring and reporting the performance of institutions and practitioners in health care

While the impacts of national reporting of the performance of the health system as such remain difficult to assess, there is a small, albeit increasing body of work that has examined the impact of performance measurement of institutions and practitioners and the public reporting of related findings. Much of the published work centres on the reporting of performance data of hospitals²⁷, including, in the US and the UK, individual surgeons²⁸, and, more recently, long-term care²⁹, while similar efforts within primary care are only emerging.³⁰ Public reporting of the performance of institutions and practitioners is meant to promote high quality, efficient health care delivery and to increase the transparency of quality information (Box 3). The evidence of whether the public release of performance data achieves any of these objectives remains inconsistent however.³¹⁻³³ This is, in part, because of lack of rigorous evaluation of many major public reporting systems.

Early evidence from the USA suggests that users as well as purchasers or payers of services rarely search out publicly available information and do not understand or trust it.³⁹ Conversely, managers and some providers increasingly use comparative information, with hospitals in particular most responsive to publicised data and some evidence pointing towards improvements in care where public reporting occurred.^{39 40} Hibbard and colleagues (2005) demonstrated that hospitals improved in clinical areas following the public release of performance data on those areas,⁴¹ a finding confirmed in more recent reviews.^{33 42} There is also some evidence that the public release of data on the performance of individual surgeons (largely cardiac surgery) can provide an incentive for low performing surgeons to improve quality, although there is also some suggestive evidence from the USA of adverse selection of patients.²⁸ A meta-analysis of the

impact of public reporting on clinical outcomes as explored in hospital-based studies of mortality mostly following cardiac surgery found a significant reduction in mortality (risk ratio RR 0.85; 95% confidence interval 0.79-0.92).⁴³ However, included studies used mainly an observational (before-after) design, and it is difficult to disentangle observed effects from other system changes that might have had as much or an even greater impact on performance as public reporting.⁴⁴

A review of the impact of annual performance ratings of NHS providers in England between 2001 and 2005 indicated that the assessment system did improve reported performance on key targets such as hospital waiting times.⁴⁵ However, the analysis also revealed that in some cases these improvements were made at the expense of clinical areas where performance was not measured or were undermined by different forms of gaming such as data manipulation.

While this evidence provides important insights in the 'uses and abuses' of performance data, the focus of much of the work has been on impacts on providers and services users, in terms of behaviour change as assessed through improvement efforts on part of providers,⁴⁶ or the use and usefulness of quality and performance information by service users.^{47 48} There is little published evidence on the impact of such reporting mechanisms on policy as such.

A recent study from Australia examined barriers to the effective implementation of public reporting of hospital performance data, using interviews with 41 expert informants, representing service user, provider and purchasers' perspectives across Australia's public and private health sectors.⁴⁹ The study identified a wide range of barriers, including:

- Conceptual: unclear objective, audience and reporting framework
- System-level: lack of service user choice, lack of service user and clinician involvement, jurisdictional barriers, lack of mandate for private sector reporting

- Technical and resource related: including data complexity, lack of data relevance, consistency, rigour
- Socio-cultural: including provider resistance to public reporting, poor service user health literacy, lack of service user empowerment

The authors called for greater alignment between the primary objective of public reporting, its audience and the information needs of audiences. They also suggested that more than one system of public reporting might be required to meet different audience needs and objectives.

Policy impact of primary care performance assessment at national or regional health system level

Reflecting the dearth of evidence of policy impacts of health system performance assessment activities more widely, there is little systematic evaluation of the policy impacts of primary care performance assessments at national or regional health systems as documented in the published literature. This also reflects, at least in part, that many countries are only beginning to more systematically assess the performance and governance of primary care as a key driver of health system performance more broadly.⁵⁰⁻⁵⁴

The survey of national experiences on performance assessment in primary care carried out as part of the work of the EU Expert Group on HSPA in March 2017 found that among the 22 countries responding to the survey, nine reported using the assessment to inform general policy making (Finland, Italy, Latvia, Malta, the Netherlands, Portugal, Slovenia, Spain, and Sweden). Of these, Finland, Italy, Latvia, Slovenia and Spain also provided concrete examples of how primary care performance assessment impacted policy (Table 2).

Table 2. Reported impacts of primary care performance assessment on policy making, 2017

| Country | Impacts of primary care performance assessment on policy making |
|----------|--|
| Finland | <p>While it is not possible to judge whether reporting on primary care performance as such has impacted policy, selected indicators have informed various policy debates and actions. Examples include:</p> <ul style="list-style-type: none"> • The debate on reforming health and social services. Relevant data is used to strengthen the argument and supporting reform needs. • Information on health centre recruitment has been used to encourage an increase in enrolment to medical schools. • Reporting on the level of vaccination rates for measles, which in some areas has fallen to levels that endanger herd immunity has reignited the national debate on vaccination rates. |
| Italy | <p>Performance measurement is strongly embedded within the policy process. Examples include the following:</p> <ul style="list-style-type: none"> • Tuscany: the results of annual performance assessments at the primary care level helped inform decisions by regional and local policy makers on the promotion of some interventions and services to shift to different organisational models. • Lazio: primary care quality indicators are systematically used by the Health Plan Directorate to evaluate health patterns for chronic conditions to set clinical and organisational objectives for health care providers and to link the level of achievement of these objectives to annual budget or contract extension of health care professionals. • Data on people with diabetes or COPD have been used to plan the clinical pathways allowing to actively identify potential patients and include them in a scheduled programme of follow up according to evidence based practices. |
| Latvia | <p>The reporting to the Cabinet of Ministers of information on primary care performance has led to the development and implementation of a post-graduation training programme on team work (involving GPs and nurses/physician assistants) for GP practices.</p> |
| Slovenia | <p>Primary care performance assessment serves as a basis for drafting the national strategy for primary care development in 2017-2025.</p> |
| Spain | <p>Performance indicators have helped to target strategic areas of improvement in health centres. Assessment has also informed the development of various national strategies around chronic diseases, health promotion, ischemic heart disease, chronic obstructive pulmonary disease, diabetes and stroke (among others). Available evidence suggests that this can be associated with a slight improvement in some of the health problems that have been prioritised; a stable tendency of cost-containment and efficiency gains; and progressive improvements and evolution in benefit catalogues and coordination between levels.</p> |

It is conceivable, as illustrated by country experiences listed in Table 2, that the policy impact of primary care performance assessment as such may be difficult to disentangle from wider policy developments although it may be possible to isolate the impacts of selected indicators as we shall see in the next section.

What are the key requirements for health system performance assessment to successfully influence (primary care) policy? Insights from the policy focus group

Considering the documented evidence on the policy impacts of HPSA (or lack thereof) as presented in the preceding sections and reflecting on their own experiences in health system performance assessment more broadly, policy focus group discussions centred on three interlinked areas: (i) countries' understandings of HPSA and policy impacts, (ii) the main barriers to and enablers for HPSA to influence policy, and (iii) how to locate HPSA in the policy process to ensure that assessment will be effective and inform decision-making. It is important to reiterate that much of the discussion on the core opportunities and challenges for HPSA to influence policy discussed by the policy focus group, and reflected upon below, is not specific to primary care. Thus, while many of the insights shared will have wider applicability, we will draw on specific examples within primary care policy to illustrate specific discussion points and options.

Health system performance assessment is one among several policy instruments to achieve health system improvement

Policy focus group discussions highlighted the diversity of aims, and the nature and extent to which HPSA supports policy action in different European countries. Participants described different perspectives on the policy impacts and uses of HPSA, ranging from the degree to which HPSA places a particular problem or a set of problems on the policy agenda to examples of impacts that are often linked to specific indicators. It was suggested that impacts are easier to achieve (or to identify) where assessments are more specific, and participants pointed to performance assessment of primary care, and specific components within primary care, to illustrate this. One example of the latter is the documentation of localised measles outbreaks in Finland, a country with traditionally high vaccination coverage,⁵⁵ and the reporting of a fall in vaccination rates to levels that risk undercutting the threshold for herd immunity,⁵⁶ which has been related to renewed debate at national level about vaccination rates (see Table 2). Belgium provides an example where the assessment of the performance of general medicine published in 2012⁵⁷ identified a set of core challenges that led to policy action in a number of areas around access, workforce ageing, and quality of care (Box 4).

Box 4 Policy action following the 2012 report on the performance of general medicine in Belgium

In 2012, the Belgian National Institute for Health and Disease Insurance (NIHDI; INAMI-RIZIV) published a balanced scorecard on the performance of general medicine, with a focus on three components seen to be core to the delivery of high quality care⁵⁷:

- (i) patient focus: geographical and financial accessibility, patient empowerment, satisfaction, continuity and integration of health care
- (ii) appropriateness: treatment that is appropriate, efficient, of high quality and safe
- (iii) capacity and professionalism: an appropriate number of skilled and motivated physicians

The balanced scorecard identified three main areas where general medicine performance was found to be in need for improvement. These related to access to care in urban areas; an ageing general practitioner workforce; and certain shortcomings in the quality of care such as around appropriateness of care and chronic care.

A series of policy actions have since been taken to address the challenges identified in the 2012 report. These included the drafting of a Green paper on access to care in Belgium, which involved a wide range of stakeholders from across the sector, and which led to the publication of a White Paper on access to care in 2016,⁵⁸ although political action on the recommendations is yet to follow. Regarding the GP workforce, efforts are underway to increase the number of physicians overall, with the proportion of GPs to be increased to 40%.⁵⁹ Multiple efforts are also underway to address the quality of care provided by GP practices. These include the creation of a new 'Effective Care' unit at the NIHDI to coordinate various activities to enhance the effectiveness and efficiency of care, among other activities.⁶⁰

It has been argued elsewhere that while performance measurement is an important means to assess whether and to what extent a given health sector achieves its goals, it is only *one* instrument for system improvement. Indeed, Smith et al. (2009) noted that for performance measurement to be effective it needs to be aligned with other levers for improvement such as financing, market structure, accountability arrangements and regulation.⁶¹

It is against this background that policy focus group participants highlighted the need to be clear about the 'unique features' of HSPA. These were summarised as follows:

- HSPA views the performance of the system as a whole and provides a direction about how the system is performing in its entirety
- HSPA is a 'service' to help steer policy
- HSPA provides for an analytical and actionable tool to inform decision-making
- HSPA has the potential to be both predictive and prescriptive

There was agreement that each of these unique features needed to be developed further for HSPA to effectively support policy action.

There are a number of challenges for HSPA to overcome if it is to support policy action

Policy focus group participants discussed a range of challenges or barriers that can prevent performance assessment from effectively supporting policy action⁶. The size and nature of these challenges vary however by country and aim of the assessment. For example, it was argued that in decentralised systems the national ministry of health does not necessarily hold the mandate for acting upon HSPA findings. This is particularly the case for sectors that are organised and governed by other institutions or at regional or municipal level, such as primary care in Austria or Finland (please see Box 5 for an example from France). Participants noted

that in these cases, national reporting of primary care performance may be of limited impact. It was suggested that a common framework for assessment may help 'standardise' HSPA approaches in highly decentralised systems. At the same time, it was recognised that ownership will be key to ensure that reporting will inform policy action, an issue which we will come back to below. A related issue highlighted by participants was a widely perceived assumption that there is strong leadership driving HSPA. However, this may not (always) be the case, and this will then influence whether or not the assessment will impact policy.

⁶ HSPA reporting and communicating
https://ec.europa.eu/health/sites/health/files/syst_ems_performance_assessment/docs/2017_hspa_reportingcommunicating_en.pdf

Box 5 Primary care assessment in France

In France, primary care is broadly under the responsibility of the national health Insurance (NHI), except for emergency services, which are provided by hospitals and which, in turn, are the responsibility of the state.

Every year, the NHI present to the Government and Parliament a report "Charges et Produits", which details analyses about the evolution of practices and expenses, and which serves as a basis for the NHI to propose ways to improve quality and efficiency of primary care and the use of resources.⁶²

For instance, in its report for the year 2017, the NHI presented proposals six priority areas:

- Smoking prevention and education
- Lumbago treatment and prevention
- Shoulder surgical treatment
- COPD prevention and early detection
- Diabetic foot care
- Physiotherapy

There was a perception, among some focus group participants, that policy instruments such as HSPA that are embedded in legislation may have a greater leverage in terms of informing policy action. It was noted that only a small number of countries have incorporated HSPA in their regulatory framework although there was uncertainty about the degree to which giving a formal mandate to carry out HSPA would indeed enhance the impact of HSPA. There was agreement that any such association would likely vary across countries and it could be useful to map the regulatory framework for HSPA against perceived or reported impacts (where available) to better understand these links.

A separate set of concerns discussed by focus group participants revolved around the nature of the performance assessment. There was a shared perception that HSPA exercises that only describe problems without offering options for improvement are likely to undermine the value of assessment and its potential to support policy action. A related, although distinct concern voiced by a small number of focus group participants was the potential for 'dilution' of key messages where a wide range of stakeholders are involved. It was however recognised that involving key stakeholders in HSPA will be important both in relation to generating ownership and ensuring that findings will inform policy (see also next subsection). It

was advanced that HSPA could add value by helping to uncover the root causes of problems and use modelling approaches to help identify policy options. It was noted that such an approach may be challenging because of the nature of available data and actual capacity to carry out more advanced modelling exercises, in particular with regard to whole system approaches. Overall there appeared to be agreement among focus group participants that while HSPA should propose policy options it should offer a balance between being descriptive and prescriptive.

Key requirements for HSPA to effectively support policy action

The reflection about the balance between the descriptive and prescriptive scope of HSPA led to a wider discussion around the location of HSPA in the overall policy process and the key requirements for performance assessment to effectively support policy action. In many ways, this discussion can be seen to be the mirror image of the challenges to be overcome by HSPA as identified in the preceding section. Thus, there was agreement that if HSPA is to support policy action, there needed to be a dedicated mandate by government or parliament for carrying out the assessment and political will and commitment to support the process. Such mandate and political commitment was reported for Belgium, Hungary and Portugal and seen to be key for initiating HSPA at

national level. However, it was also noted that while a dedicated mandate and political can be seen to form a necessary condition for HSPA to be policy relevant, this would by no means be sufficient, if there is no interest in taking action or change.

We noted earlier that the involvement of key stakeholders was also seen as an important requirement for HSPA to successfully support policy action, but it was highlighted that this needed to be linked to ownership of or responsibility for the process and actionability. Thus, as Smith et al. (2009) have highlighted, a key requirement will be to develop a clear vision and framework of how performance assessment sits within the overall accountability relationships if measurement is to ultimately improve health system performance.⁶¹ It may be instructive, in this context to look at recent experience in New Zealand, with the introduction, in 2016,

of a new approach to measuring and monitoring health system performance, the 'Systems Level Measures Framework'.⁵² While seen to provide substantial opportunity to drive health system improvement and for health sector organisations to engage in learning about how best to achieve desired health system outcomes, incentives for organisations to change may be relatively weak in the context of broader policy and funding settings, which is likely to undermine the potential of the new framework.

Considering the location of HSPA in the policy process, focus group participants highlighted that HSPA itself should be seen as a process rather than a one-off exercise. It should start from the diagnosis of a system (or a subsystem within) to prioritisation to policy action and implementation as illustrated in Figure 1.

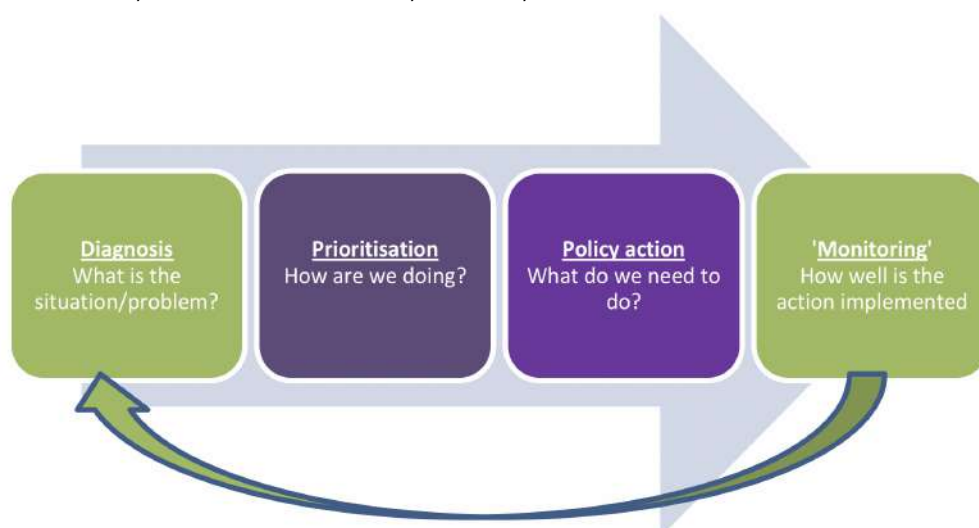


Figure 1. Location of HSPA in the policy process

This simplified process map identifies the different steps required in the idealised process which involves different actors at different stages and with different responsibilities as highlighted by the different colouring of individual stages. The 'diagnosis' and 'monitoring' elements present the core tasks of the HSPA process that are of a more technical nature but that should support the entire process along the way. Prioritisation (or targeting) and policy action are considered separate steps to be undertaken by policy makers. A core element of the process is the feedback loop; HSPA is

required to understand whether there has been (systemic) change and its impacts on outcomes.

The nature of stakeholders to be involved will vary by country context and purpose of assessment. As indicated earlier, for HSPA to effectively support policy action it will be of key importance to understand the various stakeholders' motivations for engaging in the process as well as their incentives to (implement) change. It is likely, especially in smaller countries, that the various actors involved in the process are the same; the key defining feature here is that their role in

the process varies according to the stage. It is also important to note that each element of the process is a multi-layered system in itself and which will have to be taken into account.

Importantly, and reflecting earlier discussions of the policy focus group, which suggested that policy impacts are easier to achieve (or to identify) where assessments are more specific, it was noted that given the whole system perspective of HSPA overall, the process of assessment may best be viewed as a 'puzzle', that is the process is composed of a series of specific assessments that will then inform the whole. Thus, the process depicted in Figure 1 could relate to any performance assessment exercise within the wider system, such as the performance of primary care, mental health care, acute care, long-term care, etc., each with its own indicators and specific policy actions to achieve system improvement overall.

What's next?

This chapter has explored some of the key requirements for HSPA to successfully inform and support policy action within European settings, with a particular focus on primary care policy. It has done so through a review of the documented evidence and drawing on insights from experts from European countries that took part in a structured policy focus group of the Expert Group on HSPA. It has illustrated cases of how HSPA has supported policy action, drawing on examples from primary care assessments in selected European countries, and suggested some factors perceived by experts to be core to effect policy change. It further proposes a way that can help convert HSPA into a strategic tool in the policy process, as illustrated in Figure 1.

Based on the discussions described above, there appeared to be emerging consensus among policy focus group participants that

more could be done to promote a more strategic role for HSPA to effectively inform system improvement. These can be summarised as follows:

- Strengthen HSPA advocacy
 - HSPA experts should take leadership in the active communication of the work to help advance discussion on the use and usefulness of HSPA in policy
 - The European Commission could do more to 'push' HSPA as a key tool for system improvement, going beyond the technical level and promote its role at the policy/political level
- Learning from experiences in countries to make HSPA an effective policy instrument
 - A number of Member States have valuable experiences that can help inform the further development of HSPA as a policy instrument and the EU Expert Group can provide an important platform to further enable systematic exchange
- Degrees of ambition
 - Promote the suggestion of HSPA as a process that has the potential to further advance improvement at the system level through taking a prospective and forward-looking role
 - Explore the possibility of incorporating more strategically predictive or modelling approaches to help identify policy options
- Map HSPA alongside other policy instruments to identify the future directions it should take
- Carry out an 'impact assessment' of HSPA to better understand the various impacts of HSPA and how can this be measured.

Chapter 4. Conclusions

Strong primary healthcare is a foundation of a well-performing health system. Professor De Maeseneer in his book *Family Medicine and Primary Care* makes a strong case for primary care at many levels: individual, community, society, socio-economic⁷. Although not enough appreciated, primary care can handle most of today's chronic conditions without a specialist referral. Expansion of the roles and functions of primary care requires relevant resources, but well performing primary care means less healthcare utilization overall. Performance assessment can therefore inform decisions on the allocation of resources throughout the healthcare systems, adapt them according to the evolving status of primary care, with a high probability to ultimately reduce total costs of healthcare.

Better performing primary care is associated with better health outcomes and more opportunities for efficiency of healthcare overall. Performance assessments applied in primary care pave the way for better health outcomes and improve the overall healthcare systems.

Primary care lives in a dynamic environment and is challenged by a need to constantly adapt to patients' needs. The change of primary care can be supported by a well-functioning performance assessment, embracing all relevant health professionals working in multidisciplinary teams: dentists, dieticians, general practitioners/family physicians, nurses, midwives, occupational therapists, optometrists, pharmacists, physiotherapists, psychologists and social workers. The more embodied in the organizational culture and mission, the better for the results of performance assessment. Indeed performance assessment can move primary care from the status quo to higher levels of excellence, putting into focus the core aspects of well-performing primary care systems and fulfilling their key functions such as access, coordination of care and continuity of care.

Reforms of primary care require a holistic approach, taking into account various aspects, including for example training of professionals (both its content and the way it is organized), public perception of primary care which often narrows the role of primary care to a gatekeeper. Performance assessment can support a holistic approach to reforms.

Primary care performance measurement is not in infancy stage in Europe, but could advance. Countries carry out assessment of primary care in general or of some important aspects of it. However, just few countries extensively assess performance of services provided by all segments of primary care.

Successful systems of performance assessment in primary care share three essential elements.

Primary care systems in Europe vary in strength and though performance measurement is not in infancy, it could significantly advance. Three main challenges in the horizon are: how to deal with the complexity of the performance aspects of the primary care, how to integrate assessments in policies and how to drive for culture of excellence.

First, they have to take into account the complexities of primary care, **addressing many elements as interrelated components**. When it comes to the design of the assessment models, there is a challenge to align methodologies, indicators with the organizational structure of primary care and relations between various stakeholders. When it comes to the application of performance assessment, it involves commitment and capacities to handle the measurement processes, accountability for results achieved upon assessments and driving change and

⁷Jan De Maeseneer: *Family Medicine and Primary Care at the crossroads of societal change* (2017)

transformation on the basis of achieved results. There is no one best way to achieve the performing primary care.

Secondly, performance assessment needs to be **integrated in policy processes**. Identifying the best ways of doing it remains a challenge in most countries along a gap in the understanding how the performance assessment impacts policies.

Thirdly, accelerating performance thanks to performance systems will not be possible without **building a culture of excellence**. A culture of excellence builds solid foundations for change as it fosters a consensus to create organisational capacities and a framework which empowers, focuses and engages all the primary healthcare professionals, equipping them with the mindset and skills necessary to focus on creating the desired results. This culture disrupts “business as usual” approach which may inadvertently set mediocre expectations through the outdated ways of providing primary care in the moment of change for it, for example through not keeping electronic medical records, working in silos without collaboration between segments of primary care, not adapting education models to tasks substitutions at various levels of primary care and between specialists and general practitioners, etc.

Recommendations

Building blocks...

- **Improve primary care information systems.** Availability of good quality data remains a tremendous challenge. In many cases the set of indicators available to policy makers is insufficient or focused on a subset of dimensions. Most Member States consider in their primary care assessments descriptive information on providers, access and patient-centeredness. Clinical performance is measured much less and aspects such as equity, workload and workforce satisfaction, efficiency and waste are reported to much lesser extent. It is noteworthy that in most of the cases the information is not collected through the structured primary care assessments, but through independent collection systems.

Availability and quality of primary care data for performance assessment needs to advance in most countries.

The scope of data needed to run performance assessment in primary care is quite significant, because indicators should reflect both outcomes of care and processes of care. Reporting on organisation of after office hours, organization of home care or data on experience of patients having a family doctor and not having family doctor might provide an important feedback for better organisation of services. Certain aspects of primary care may also require temporarily more attention, because they are in transition in case of for example taking over new functions or a shift of care for chronic diseases from hospitals to primary care. In this situation an additional set of indicators can help accelerate progress or adapt the change on the basis of the solid feedback.

The most common challenges in information systems include: limitations of data linked to outdated indicators which do not catch up with new realities of primary healthcare; lack of data on important aspects such as integration of mental care, relevance of doctors’ training, health inequalities; use of data from patients’ survey especially in case of low health literacy; underdeveloped systems and e-health solutions.

Without producing too much administrative burden a well-balanced set of indicators should allow a regular screening of the functions of the primary care, focusing on accessibility, continuity and integration. Quality of primary care is also an important dimension which should be measured as an important driver of additional gains for the overall healthcare system.

- **Performance assessment methodology should be designed to move primary healthcare to higher excellence levels.** Methodologies should cultivate courage to progress and not to set for status quo. Quality of indicators involving risk adjustment methods and internal variability pose a challenge in the selection of the optimal set of measures. However, methodologies should aim at achieving unprecedented results of all the actors of primary care and align everybody around the performance goals ensuring that they do not revert back to old methods and habits. It is crucial to capture the performance of the current methods and habits, like for example activity in visits, range of services, co-ordination between all the levels and integration of services, continuity of care, practice of referrals, prescriptions, accessibility of care, level of quality. All these aspects should be assessed from the perspective of efficiency, equity, effectiveness. Benchmarking is a possible methodology to deal with complexities across the various layers of primary care and reference performance identifying the bottlenecks. Finally, a good methodology should enable measuring of health in final and intermediate outcomes, impact on lifestyles and on life quality. Therefore, measuring influence and impact of performance assessment should be at the back of mind for methodological considerations.

Methodologies need to strike the right balance between the quality of information and complexity of issues, not losing sight of the objective of transforming the primary care and reverting professionals from old habits.

Preconditions to make the performance systems work in the world of the primary care...

If the objective is to increase the uptake of performance assessment in primary care, there are some conditions to be met:

- **Use for policy actions:** performance assessments in Europe seem to be mainly addressed to policy makers, less so to healthcare practitioners and even less to general public and patients. With some exceptions, they do not seem to be systematically embedded in policy processes and their use is not monitored and evidenced in most of the cases. There is certainly scope to scale up the use of performance assessments prompting policymakers to change sometimes well-established ways in which they understand challenges in primary healthcare. A key driver of a stronger take up is the recognition of the performance assessment through the legal and/or policy framework involving planning of necessary resources to carry out processes and evaluate the impact. High quality of performance assessment is also a precondition of its use. Finally, readiness for longer-term timeframes of change may be crucial to ensure that the potential of performance assessment is fully exploited for policy actions.

Primary care performance assessments should be systematically embedded in policy processes and their use in policy making should be scaled up and their impact evaluated.

- **Institutionalization of the performance system:** performance systems require an institutionalized function for evaluation of results. Lack of such function hampers the ability to assess progress and adjust reforms or accelerate change. Institutionalization also means that feedback from the system is shared transparently in an effort to inform decision makers. Improvements themselves can be achieved if there is a readiness to provide additional resources or optimize the use of existing resources to reward and recognize the good performers and to support average performers to move into the high performance category.

A comprehensive strategic and analytical approach to primary care performance assessment, including evaluation and a robust resources framework, remains to be developed in most of the Member States.

Financing models of primary care indeed can create such mechanisms and encouraging the performance in the top down approach, they will stimulate better excellence at all levels and segments of primary care and will produce more collaborative environment, not leaving any reason to protect individual roles, projects and expertise. But this may not happen without necessary resources for improving performance, either through training of primary care professionals or equipping them with tools to carry out their tasks. This is a critical element often missed in organisations, while relevant education and tools may transform primary care practitioners with respect to engaged leadership, continuity of care, team-based care and engagement in practice improvement.

- **Accountability:** it goes without saying that accountability is at the core of performance assessment. While accountability mechanisms may vary across the delivery models, the core is to define them clearly ensuring the involvement of the relevant stakeholders. Instruments used to enforce accountability like compensation mechanisms through expenditure policy or contractual agreements may not be sufficient. There might be a need to define associated improvement strategies. Finally, accountability must be realistic and a key to it is to ensure that job satisfaction of providers in primary care is monitored and at good level.

As obvious as it seems, accountability is not always clearly established.

- **Patients experience and values:** for primary care being the first point of contact, the patients' perspective taking into account their experience with services and their values is one of the crucial elements of performance assessment and can help define high quality, curb less successful practices and influence the direction of change. The patients' perspective is also important for other reasons: more complex care demand, more demand for home-base care, greater diversity of patients linked also to migrations, changing health risks, which impact particularly powerfully on primary healthcare. Development of patient-related-experience-measures and patient-related-outcome-measures through patients specific surveys including also aspects of issues such as safety and responsiveness may be useful. Patients' experience in Europe is not widely used to improve healthcare services. The Commission co-funded OECD Patient-Reported Indicators Survey (PaRIS) will be filling this major knowledge gap within the next few years. Looking outside Europe, Canada provides an example of how patients can be involved. In the framework of the QUALICOPC research, Canadian patients provide valuable information on their experience with various dimensions of primary care, such as waiting times, appraisal of their communication with physicians, but also on which aspects of primary care are important to them. The result shows that patients in Canada point that the most valued aspects of primary care are: continuity and coordination, communication and patient-centred care, patient activation and access.

Understanding of the aspects of quality of primary care that patients truly value should be developed.

- **Adaptability:** primary care is not a static concept, evolving over time to adapt to demographical and epidemiological trends, technology, encompassing an ever growing set of interventions. The risk of losing focus due to constant change is therefore higher for primary care than for other health segments. This is calling more than ever for performance assessment in primary care to become a tool to support adaptation to change. It is noteworthy that performance assessments for primary care, due to their particular exposure to change, are not set in stone and should be living tools and constantly adapt to the context of each country, region, commune.

Performance assessment should be adaptable and should support adaptability in the moment of change for primary care.

- **Building a culture of excellence:** to make it work all the stakeholders in primary care must understand the vision and objectives of the performance assessment and to adhere to it. They also need to know their roles, responsibilities and actions expected from them, ensuring that performance is a driving force behind their daily work.

Staff policies are crucial to support the culture of excellence. The Commission will continue to encourage EU level activities in health workforce planning and forecasting, so as to support Member States in addressing critical health workforce problems such as supply, distribution and a traditionally oriented skill mix. Health workforce planning and forecasting can help countries to put the right number of health professionals in the right place at the right time.

Embedding the performance assessment in primary care is an opportunity to strengthen the team work of various actors and make this team work a rewarding experience, because it will reduce administrative burden, duplicated tasks, will create conditions to focus the energy on result-oriented tasks and it will enlarge the spectrum of good practices, inspire mutual learning, naming just few benefits of teaming up. Performance assessment should therefore drive the team work in primary care and activities which are less constrained by organisational boundaries, but more oriented towards creating value for patients.

Building a culture of excellence is a stepping stone not only to make the performance assessment work, but to progress towards the integration of primary care.

- **Support goal-oriented approach through better use of professional and contextual evidence:**

Professional evidence is not systematised, while its role in achieving the good results in primary care is crucial, because primary care usually deals with patients of varying age, from diverse ethnic and socioeconomic groups, presenting early-stage diseases or undefined illnesses or with varying levels of multimorbidity. Primary care needs also to rely strongly on contextual information to bridge the gap between efficacy (isolated case) and effectiveness (routine practice). This is a case where for example functional status and living conditions become an important frame of reference in the patients' goal-setting process, and when professionals are confronted with increasing social inequities. Performance assessments should reflect needs of very varied groups of patients to make primary care a more impactful segment of healthcare.

Performance assessment should trigger better results of primary care through finding a more central role for professional and contextual evidence.

The Expert Panel who feeds in this report sees a need for a stronger push from the European level to advance things. Fortunately, investments in primary care are ranked as important areas for investment by most EU Member States and the need to improve the performance of primary care systems is perceived as an important challenge by a majority of them. This creates a momentum for further efforts to contain potential distortions, such as inefficient use of resources and the predominant role of secondary care and, in general, of curative care over more cost-effective solutions such as primary care.⁸

This report will hopefully be an important building stone and will assist key actors in leading transformation of the primary care and moving it to a higher level of excellence, keeping the right focus and ability to react to change. It will hopefully help to reduce waste driven by sometimes outdated models and, last but not least, improve health.

⁸ Joint Report on Health Care and Long-Term Care Systems & Fiscal Sustainability, European Commission (2016)

References

Chapter 3

1. Nolte E, McKee M. Measuring and evaluating health system performance. In: Smith R, Hanson K, eds. *Health systems: a political-economy perspective*. Oxford: Oxford University Press 2012:49-75.
2. Smith P, Mossialos E, Leatherman S, et al. Introduction. In: Smith P, Mossialos E, Leatherman S, et al., eds. *Performance measurement for health system improvement*. Cambridge: Cambridge University Press 2009:3-24.
3. EXPH (EXpert Panel on effective ways of investing in Health). Definition and endorsement of criteria to identify priority areas when assessing the performance of health systems. URL: https://ec.europa.eu/health/expert_panel/sites/expertpanel/files/002_criteriapperformancehealthsystems_en.pdf (accessed 1 September 2017). 2014
4. Nutley S, Smith PC. League tables for performance improvement in health care. *Journal of Health Services Research and Policy* 1998;3:50-7.
5. Papanicolas I, Smith P, editors. *Health system performance comparison. An agenda for policy, information and research*. Maidenhead: Open University Press, 2013.
6. Expert Group on Health Systems Performance Assessment. So what? Strategies across Europe to assess quality of care. Luxembourg: European Union, 2016.
7. Expert Group on Health Systems Performance Assessment. Blocks. Tools and methodologies to assess integrated care in Europe. Luxembourg: Publications Office of the European Union, 2017.
8. Kahan J. Focus groups as a tool for policy analysis. *Analyses Social Issues Public Policy* 2001;1:129-46.
9. Smith P. Health system performance assessment. Synthesis report. Luxembourg: Publications Office of the European Union, 2014.
10. Brown R. Peer Review Health System Performance Assessment (Brussels, 19-20 May 2014). United Kingdom. URL: <http://ec.europa.eu/social/main.jsp?catId=89&langId=en&newsId=1890&moreDocuments=yes&tableName=news> (accessed 1 September 2017). 2014
11. Hanning M, Schmidt I. Peer Review Health System Performance Assessment (Brussels, 19-20 May 2014). Sweden. URL: <http://ec.europa.eu/social/main.jsp?catId=89&langId=en&newsId=1890&moreDocuments=yes&tableName=news> (accessed 1 September 2017). 2014
12. Directorate-General of Health. Peer Review Health System Performance Assessment (Brussels, 19-20 May 2014). Portugal. URL: <http://ec.europa.eu/social/main.jsp?catId=89&langId=en&newsId=1890&moreDocuments=yes&tableName=news> (accessed 1 September 2017). 2014
13. van den Berg M, Achterberg P. Peer Review Health System Performance Assessment (Brussels, 19-20 May 2014). The Netherlands. URL: <http://ec.europa.eu/social/main.jsp?catId=89&langId=en&newsId=1890&moreDocuments=yes&tableName=news> (accessed 1 September 2017). 2014
14. Grech K, Calleja A. Peer Review Health System Performance Assessment (Brussels, 19-20 May 2014). Malta. URL: <http://ec.europa.eu/social/main.jsp?catId=89&langId=en&newsId=1890&moreDocuments=yes&tableName=news> (accessed 1 September 2017). 2014
15. Turk S. Peer Review Health System Performance Assessment (Brussels, 19-20 May 2014). Austria. URL: <http://ec.europa.eu/social/main.jsp?catId=89&langId=en&newsId=1890&moreDocuments=yes&tableName=news> (accessed 1 September 2017). 2014
16. Rotar A, van den Berg M, Kringos D, et al. Reporting and use of the OECD Health Care Quality Indicators at national and regional level in 15 countries. *Int J Qual Health Care* 2016;28:398-404.
17. Veillard J, Huynh T, Ardal S, et al. Making health system performance measurement useful to policy makers: aligning strategies, measurement and local health system accountability in Ontario. *Healthc Policy* 2010;5:49-65.
18. Paun A, Barlow P. Civil service accountability to Parliament. URL: <https://www.instituteforgovernment.org.uk/sites/default/files/publications/civil%20service%20accountability%20to%20parliament.pdf> (accessed 23 October 2017). 2013
19. White H. Parliamentary scrutiny of government. URL: <https://www.instituteforgovernment.org.uk/sites/default/files/publications/Parliamentary%20scrutiny%20briefing%20note%20final.pdf> (accessed 23 October 2017). 2015

20. Veillard J, Moses McKeag A, Tipper B, et al. Methods to stimulate national and sub-national benchmarking through international health system performance comparisons: a Canadian approach. *Health Policy* 2010;112:141-7.
21. Frenk J. The World Health Report 2000: expanding the horizon of health system performance. *Health Policy Planning* 2010;25:343-5.
22. McKee M. The World Health Report 2000: 10 years on. *Health Policy Planning* 2010;25:346-8.
23. World Health Organization. The World Health Report 2000. Health systems: improving performance. Geneva: World Health Organization, 2000.
24. The Commonwealth Fund. International health policy surveys. URL: <http://www.commonwealthfund.org/topics/current-issues/international-surveys> (accessed 23 October 2017). 2017
25. Canadian Institute for Health Information. Learning from the best: Benchmarking Canada's health system. URL: https://secure.cihi.ca/free_products/learning_from_thebest_en.pdf (accessed 23 October 2017) 2011
26. Canadian Institute for Health Information. OECD Interactive Tool: International Comparisons. Comparing the provinces with OECD countries. URL: <https://www.cihi.ca/en/oecd-interactive-tool-international-comparisons> (accessed 23 October 2017). 2013
27. Cacace M, Ettelt S, Brereton L, et al. How health systems make available information on service providers: Experience in seven countries. Available at http://www.rand.org/content/dam/rand/pubs/technical_reports/2011/RAND_TR887.pdf. Santa Monica: RAND and London School of Hygiene & Tropical Medicine, 2010.
28. Behrendt K, Groene O. Mechanisms and effects of public reporting of surgeon outcomes: A systematic review of the literature. *Health Policy* 2016;120:1151-61.
29. Rodrigues R, Trigg L, Schmidt A, et al. The public gets what the public wants: experiences of public reporting in long-term care in Europe. *Health Policy* 2014;116:84-94.
30. Rechel B, McKee M, Haas M, et al. Public reporting on quality, waiting times and patient experience in 11 high-income countries. *Health Policy* 2016;120:377-83.
31. Fung C, Lim Y, Mattke S, et al. Systematic review: the evidence that releasing performance data to the public improves quality of care. *Ann Intern Med* 2008;148:111-23.
32. Ketelaar N, Faber M, Flottorp S, et al. Public release of performance data in changing the behaviour of healthcare consumers, professionals or organisations. *Cochrane Database Syst Rev* 2011;11:CD004538.
33. Totten A, Wagner J, Tiwari A, et al. Closing the quality gap: revisiting the state of the science (vol. 5: public reporting as a quality improvement strategy). Rockville (MD): Agency for Healthcare Research and Quality, 2012.
34. Shekelle P. Public performance reporting on quality information. In: Smith P, Mossialos E, Papanicolas I, et al., eds. Performance measurement for health system improvement. Cambridge: Cambridge University Press 2009:537-51.
35. Berwick D, James B, Coye M. Connections between quality measurement and improvement. *Medical Care* 2003;41(Suppl 1):I30-38.
36. Kreisz F, Gericke C. User choice in European health systems: towards a systematic framework for analysis. *Health Econ Policy Law* 2010;5:13-30.
37. Schneider EC, Lieberman T. Publicly disclosed information about the quality of health care: response of the US public. *Quality in Health Care* 2001;10:96-103.
38. Ferrua M, Sicotte C, Lalloué B, et al. Comparative Quality Indicators for Hospital Choice: Do General Practitioners Care? *PLoS One* 2016;11:e0147296.
39. Marshall MN, Shekelle PG, Leatherman S, et al. The public release of performance data: what do we expect to gain? A review of the evidence. *JAMA* 2000;283:1866-74.
40. Chassin MR. Achieving and sustaining improved quality: lessons from New York State and cardiac surgery. *Health Affairs* 2002;21:40-51.
41. Hibbard J, Stockard J, Tusler M. Hospital performance reports: impact on quality, market share, and reputation. *Health Affairs* 2005;24:1150-60.
42. Mukamel D, Haeder S, Weimer D. Top-down and bottom-up approaches to health care quality: the impacts of regulation and report cards. *Annu Rev Public Health* 2014;35:477-97.
43. Campanella P, Vukovic V, Parente P, et al. The impact of Public Reporting on clinical outcomes: a systematic review and meta-analysis. *BMC Health Serv Res* 2016;16:296.
44. Roland M, Dudley R. How financial and reputational incentives can be used to improve medical care. *Health Serv Res* 2015;50(Suppl 2):2090-115.
45. Bevan G, Hood C. Have targets improved performance in the English NHS? *BMJ* 2006;332:419-22.
46. Cassel C, Conway P, Delbanco S, et al. Getting more performance from performance measurement. *N Engl J Med* 2014;371:2145-7.

47. Schlesinger M, Kanouse D, Martino S, et al. Complexity, public reporting, and choice of doctors: a look inside the blackest box of consumer behavior. *Med Care Res Rev* 2014;71(5 Suppl):38S-64S.
48. Paddock S, Adams J, Hoces de la Guardia F. Better-than-average and worse-than-average hospitals may not significantly differ from average hospitals: an analysis of Medicare Hospital Compare ratings. *BMJ Qual Saf* 2015;24:128-34.
49. Canaway R, Bismark M, Dunt D, et al. Perceived barriers to effective implementation of public reporting of hospital performance data in Australia: a qualitative study. *BMC Health Serv Res* 2017;17:391.
50. Foster M, Henman P, Gable A, et al. Population health performance as primary healthcare governance in Australia: professionals and the politics of performance. *Policy Studies* 2016;37:521-34.
51. Carter R, Riverin B, Levesque J, et al. The impact of primary care reform on health system performance in Canada: a systematic review. *BMC Health Serv Res* 2016;16:324.
52. Chalmers L, Ashton T, Tenbensen T. Measuring and managing health system performance: An update from New Zealand. *Health Policy* 2017;121:831-5.
53. Langton J, Wong S, Johnston S, et al. Primary care performance measurement and reporting at a regional level: Could a matrix approach provide actionable information for policy makers and clinicians? *Healthc Policy* 2016;12:33-51.
54. Stange K, Etz R, Gullett H, et al. Metrics for assessing improvements in primary health care. *Annu Rev Public Health* 2014;35:423-42.
55. Seppälä E, Zöldi V, Vuorinen S, et al. A cluster of measles linked to an imported case, Finland, 2017. *Euro Surveill* 2017;22: 30595.
56. National Institute for Health and Welfare. Vaccination coverage good among young children in Finland, but measles epidemics possible. URL: <https://www.thl.fi/fi/web/thlfi-en/-/while-vaccination-coverage-among-children-in-finland-is-good-measles-epidemics-are-possible> (accessed 23 October 2017). 2017
57. Meeus P, Van Aubel X. Performance of general medicine in Belgium, a check-up. Brussels: Belgian National Institute for Health and Disease Insurance (NIHDI), 2012.
58. De Cock J. White Paper on access to care in Belgium: NIHDI and Médecins du Monde, 2016.
59. De Geest A, Steinberg P, Vivet V, et al. Rapport Annuel de la Commission de Planification - Offre Médicale. URL: http://organesdeconcertation.sante.belgique.be/sites/default/files/documents/rapport_annuel_2016_fr_0.pdf (accessed 23 October 2017) 2017
60. Institut national d'assurance maladie-invalidité. Davantage d'efficacité dans les soins de santé. URL: <http://www.inami.fgov.be/fr/themes/qualite-soins/Pages/efficacite-soins-sante.aspx#.We4LaohrySR> (accessed 23 October 2017). 2017
61. Smith P, Mossialos E, Papanicolas I. Performance measurement for health system improvement: experiences, challenges and prospects. Copenhagen: World Health Organization on behalf of the European Observatory on Health Systems and Policies, 2008.
62. L'Assurance Maladie. Rapports Charges et produits pour les années 2013 à 2017. URL: <https://www.ameli.fr/l-assurance-maladie/statistiques-et-publications/rapports-et-periodiques/rapports-charges-produits-de-l-assurance-maladie/rapports-charges-et-produits-pour-2013-a-2017/rapport-charges-et-produits-pour-l-annee-2017.php> (accessed 23 October 2017). 2017

Annex: Members' lists

A. Members of the Expert Group on HSPA

Chair persons:

Belgium: Daniel Reynders

DG SANTE: Andrzej Rys

Austria: Herwig Ostermann; Patrizia Theurer; Florian Bachner; Eva Kernstock

Belgium: Pascal Meeus; Lieven De Raedt

Bulgaria: Petko Salchev, Zlatimira Dobрева; Ivelina Georgieva; Ivian Benishev

Cyprus: Vastos Scoutellas; Pavlos Pavlou; Anna Demetriou

Czech Republic: Tomas Troch

Germany: Ines Läufer

Denmark: Mads Bager Hoffmann; Charlotte Hougaard Clifford

Estonia: Ulla Raid; Eleri Lapp

Greece: Georgios-Filippos Tarantilis

Spain: Angeles Gogorcena Aoiz; Elena Bartolomé Benito

Finland: Liisa-Maria Voipio-Pulkki, Ilmo Keskimäki

France: Félix Faucon; Eric Trottmann; Johann Gutton

Croatia: Dijana Cimerá; Sanjica Dolovski; Jasna Mesarić

Hungary: Balázs Babarczy; Péter Mihalicza

Ireland: Muiris O'Connor; Rhona Gaynor; Patrick Black

Italy: Marina Davoli

Lithuania: Rima Vaitkienė; Justina Januševičienė; Edita Bishop

Luxembourg: Anne Calteux; Françoise Berthet

Latvia: Laura Boltāne; Kristine Klavina

Malta: Kenneth Grech

The Netherlands: Patrick Jeurissen, Margoleen Honcoop; Luc Hagenaars

Poland: Kamila Malinowska; Andrzej Tolarczyk

Portugal: Andreia Jorge Silva; Sofia Mariz

Romania: Alexandru Rotocol

Sweden: Olivia Wigzell; Ingrid Schmidt; Mona Heurgren; Birgitta Lindelius; Maria State

Slovenia: Dusan Josar

Slovak Republic: Martin Smatana; David Balla

The United Kingdom: Caroline Lee; Uma Moorthy

Norway: Beate Margrethe Huseby; Birgitte Kalseth

The OECD: Gaetan Lafortune; Niek Klazinga; Ian Forde; Francesca Colombo; Ian Brownwood; Michael Van Den Berg

The European Observatory on Health Systems and Policies: Ellen Nolte; Josep Figueras

WHO Euro: Elke Jakubowski; Hans Kluge

DG SANTE: Sylvain Giraud; Federico Paoli; Filip Domanski; Matthias Schuppe; Giulio Gallo

DG ECFIN: Santiago Alvaro Calvo Ramos; Benedetta Martinelli; Boriana Goranova

DG EMPL: Virginia Maestri

DG RTD: Katarina Krepelkova, Sasa Jenko, Leslie Pibouleau

ESTAT: Marleen De Smedt

The Committee of the Regions: Alexandra Kranixfeld; Dorota Tomalak

B. Members of the sub-group on primary care

Austria: Andrea Schmidt

Belgium: Pascal Meeus, Lieven De Raedt, Daniel Reynders

Spain: Elena Bartolomé

Finland: Ilmo Keskimäki, Pasi Pohjola, Tiina Hetemä

France: Michel Varroud-Vial

Ireland: Rhona Gaynor

Italy: Mariana Davoli

Latvia: Marika Petrovica

The Netherlands: Michael Van Den Berg; Dionne Kringos

Slovenia: Pia Vracko, Dusan Josar, Vesna Zupancic

The WHO Euro: Juan Tello

The European Observatory on Health Systems and Policies: Ellen Nolte

The OECD: Gaetan Lafortune, Ian Forde
DG SANTE: Sylvain Giraud, Federico Paoli, Filip Domanski

C. Members of the policy focus group on primary care performance assessment

Austria: Patrizia Theurer, Andrea Schmidt
Belgium: Pascal Meeus, Lieven De Raedt, Daniel Reynders
Cyprus: Anna Demetriou
Germany: Ines Läufer
Estonia: Eleri Lapp
Spain: Elena Bartolome
Finland: Ilmo Keskimäki
France: Felix Faucon
Greece: Georgios Filippou Tarantilis
Croatia: Delfa Radic-Kristo
Hungary: Barbaczy Balazs
Ireland: Rhona Gaynor, Partick Black
Italy: Marina Davoli
Lithuania: Giedre Medziausaitė
Luxembourg: Franciose Berthet
Latvia: Kristine Klavina, Laura Boltane, Marika Petrovica
Malta: Kenneth Grech
Norway: Beate M.Huseby, Birgitte Kalseth
The Netherlands: Margoleen Honcoop
Poland: Jacek Putz
Portugal: Andreia Jorge Silva da Costa
Romania: Diana Stoica
Sweden: Ingrid Schmidt, Birgitta Lindelius
Slovenia: Pia Vracko, Vesna Zupancic
Slovak Republic: David Balla
The United Kingdom: Uma Moorthy
WHO Europe: Elke Jakubowski
The European Observatory on Health Systems and Policies: Ellen Nolte
IFIC: Nick Goodwin
CoR- Commission for Natural resources (NAT): Dorota Tomalak
University of Gent: Jan DeMaesseneer
OECD: Ian Brownwood
DG SANTE: Andrzej Rys, Sylvain Giraud, Federico Paoli, Filip Domanski, Matthias Schuppe
DG ECFIN: Borianna Goranova

Annex: replies to the questionnaire on national experience on performance assessment of primary care available only on the website:

https://ec.europa.eu/health/systems_performance_assessment/overview_en.

ANNEX

Replies to the survey on the assessment of primary care

Rev 29 September 2017

The EU Expert Group on health systems performance assessment conducted in March 2017 a survey, for collecting information on national experiences in performance assessment of primary care. Twenty-one countries replied to the survey; this annex presents the full replies. In appendix, it presents the blank questionnaire, as it was originally circulated.

Contents

| | |
|---|----|
| BELGIUM | 4 |
| CYPRUS..... | 7 |
| ESTONIA | 10 |
| FINLAND | 13 |
| FRANCE..... | 21 |
| GERMANY..... | 24 |
| IRELAND | 27 |
| ITALY (country level) | 31 |
| ITALY (Lazio) | 35 |
| ITALY (Tuscany)..... | 38 |
| ITALY (Veneto)..... | 48 |
| LATVIA | 52 |
| LITHUANIA..... | 57 |
| LUXEMBOURG | 66 |
| MALTA..... | 69 |
| THE NETHERLANDS | 78 |
| NORWAY (Norwegian Directorate of Health)..... | 82 |
| NORWAY (Norwegian Institute of Public Health)..... | 87 |
| NORWAY (Statistics Norway (SSB): KOSTRA Municipality-State Reporting) | 91 |

| | |
|--|-----|
| POLAND..... | 95 |
| PORTUGAL..... | 99 |
| SLOVAKIA..... | 107 |
| SLOVENIA | 110 |
| SPAIN..... | 125 |
| SWEDEN | 134 |
| UNITED KINGDOM | 138 |
| Appendix: questionnaire submitted to Member States | 145 |

BELGIUM

| |
|--|
| Question 1 |
| Are there any recurrent or one-off assessments carried out of the performance of (parts of) the organisation and/or functioning of primary care in your country? |
| general report on GP practice and specific feedbacks on quality indicators (specialists and GP) |
| Question 2 |
| Please provide a brief description of these assessments (name and type of product) |
| http://www.riziv.fgov.be/SiteCollectionDocuments/brochure_MG_2012_EN.pdf http://www.riziv.fgov.be/nl/professionals/individuele zorgverleners/artsen/kwaliteit/feedback/Paginas/verslag-activiteit-huisarts-2013.aspx#.WOJ7eK3r3cs <p>In order to measure performance, the NIHDI (INAMI-RIZIV) (Belgian National Institute for Health and Disease Insurance) has drawn up a balanced scorecard (a measurement and management instrument) with three key focuses (see Conceptual Framework, p. 4). By using this tool, the NIHDI wishes to translate General practitioner (GP) practice into readable indicators and to provide accurate and relevant information. The aim is to encourage GPs to reflect on their performance, both as part of a peer review group and individually. The methodology adopted for defining performance is the same as that of the KCE (Belgian Health Care Knowledge Centre) report "A first step towards measuring the performance of the Belgian health care system". The NIHDI used a number of databases in order to carry out this study: => the production data banks detailing the actions carried out and prescribed (volume and amounts) by health care providers, or by recipients in the context of health care insurance (e.g.: number of patients or of contacts etc.) => Descriptive data characterising the health care providers (e.g. geographical location, accreditation data, etc.) => outside sources of information (e.g. health survey by interview) The experts of the Belgian National Quality Promotion Council and its General Medicine working group, together with many volunteer experts working in general medicine, collaborated intensively in the conduct of this study (conceptual phase and validation).,</p> |
| Question 3 |
| For each assessment, please specify: |
| 3.1. Is the report – or part of it – done because of legal requirements? If not, what is the main reason to carry it out? |
| No, improvement and policy information |
| 3.2. When did it take place? |
| Report was in 2012, feedbacks are provided every 2 years |
| 3.3. Which organisation commissioned the assessment? |
| NIHDI, NRKP (nationale raad voor kwaliteits promotie) |
| 3.4. Which organisation carried it out? |

| |
|--|
| NIHDI with GP's representatives |
| 3.5. What other stakeholders were involved and how? |
| professional organisations, and the Belgian Healthcare Knowledge Centre (no patient organisations) |
| 3.6. Which types of primary care were parts of the assessment? |
| general practice |
| 3.7. Which is the level of reporting? |
| national , regional, + provider level |
| 3.8. What is the focus of the assessment? |
| general practice (quality, access, sustainability, inequalities , efficiency) |
| 3.9. What is the function of the assessment? |
| up to now general reporting and comparative benchmark .In the future, CPD + P4Q |
| 3.10. To which target population is the assessment primarily addressed? |
| policy makers and clinicians |
| 3.11. How is performance information fed back to primary care providers? |
| Yes, there are personal feedbacks and also benchmark were provided based on quality indicators |
| 3.12. Has the assessment been presented in a publicly accessible document or website? |
| yes , see above |
| Question 4 |
| At what level of aggregation are the data published? |
| the report is published at national and regional level (and provinces level) Individual feedbacks are summarised and publicly published at peer review level (see: http://www.inami.fgov.be/nl/professionals/individuelezorgverleners/artsen/kwaliteit/feedback/Paginas/lok-feedback.aspx#.WOJ_A63r3cs) |
| Question 5 |
| What types of indicators are reported in the assessment? |
| mostly quality indicators based on drug prescription, on latest prescription, on medical imaging |
| Question 6 |
| Have workload and job satisfaction of primary care providers been measured and reported? |
| If yes, how and on what scale? |
| Yes, satisfaction was about 80%. There are also indicators which relate to job attractiveness (e.g. median income and replacement rate) |
| Question 7 |
| Please present your methodological approach. In particular, please explain how are the indicators developed, what risk adjustment methods are being used (if any), how is internal variability being addressed, etc. |

| |
|--|
| Indicators are calculated on the whole population. Reference pattern are FTE GP |
| Question 8 Which procedures are in place to promote the validity, reliability and relevance of the assessment? |
| Peer reviews |
| Question 9 To what degree is performance assessment embedded in the policy process? |
| This report is actually a standalone process. Some indicators are in the general HSPA list, but there is no link with budget process at this moment. However, there are plans to link to P4Q |
| Question 10 What is the evidence that the assessment has impacted on policy? |
| No evidence yet. Targets were given on the 2015 feedback but couldn't be evaluated yet |
| Question 11 Please summarise (briefly) the major limitations and main strengths of assessments of primary care performance in your country. |
| Link to strategic HSPA. Indicators are reported at all levels |
| Question 12 What are the future plans with regard to primary care assessment? |
| Enlargement of the list of indicators since follow-up of the patient is possible. New CPD , P4Q |

CYPRUS

| |
|--|
| Question 1 |
| Are there any recurrent or one-off assessments carried out of the performance of (parts of) the organisation and/or functioning of primary care in your country? |
| We currently carry out performance assessments on the organization of the public primary care delivery in Cyprus. We have developed a restructuring plan, which includes the following major reforms. Clustering of smaller primary health care centres mainly in the rural areas and create group practices with extended working hours and upgraded services. We emphasize on strengthening the multidisciplinary teams by extending the prehospital care (Ambulance service). Furthermore we are working on expanding the Community Nursing services to cover almost all areas. We started working on quality assessments too. We have developed primary care clinical guidelines including Diabetes Mellitus, Hypertension, Osteoporosis, Depression, Dyspepsia and osteoarthritis. These guidelines were adopted from the NICE guidelines with the support and cooperation of the National Institute of Health and Care Excellence in the UK (NICE). More than 300 doctors and nurses working in primary care were trained on these guidelines. |
| Question 2 |
| Please provide a brief description of these assessments (name and type of product) |
| Assessment on accessibility, including public transportation to the Health care Centres. Availability of the services to the people. Currently the majority of primary health care centres follow the Civil-servant working hours i.e. from 7:30-15:00. This reduces the availability of PHC to the public. We are planning to introduce quality of care assessments, including the collection of primary care indicators and clinical audit practices on a national basis. We also evaluate access during out-of-working-hours for the healthcare centres that provide services on a 24hour schedule. |
| Question 3 |
| For each assessment, please specify: |
| 3.1. Is the report – or part of it – done because of legal requirements? If not, what is the main reason to carry it out? |
| Yes, the whole restructuring plan for primary care is being carried out in the framework of the legislation for the introduction of the National Health Insurance system. The public primary care network needs to adapt to the upcoming changes so that it will be viable in the new competitive environment. |
| 3.2. When did it take place? |
| In 2015-2016 |
| 3.3. Which organisation commissioned the assessment? |
| The Ministry of Health |
| 3.4. Which organisation carried it out? |
| The Ministry of Health, the Medical Services and the Services of Public Health |
| 3.5. What other stakeholders were involved and how? |
| Public consultations were carried out with members of the parliament as well as the local authorities of the communities involved. |

| |
|---|
| 3.6. Which types of primary care were parts of the assessment? |
| General practice, Pharmacy, Ambulance services, Community nursing, |
| 3.7. Which is the level of reporting? |
| National |
| 3.8. What is the focus of the assessment? |
| Primary care in general, the report targeted mainly the primary care organizations |
| 3.9. What is the function of the assessment? |
| This was a general restructuring report |
| 3.10. To which target population is the assessment primarily addressed? |
| The report targeted policy makers |
| 3.11. How is performance information fed back to primary care providers? |
| N/A |
| 3.12. Has the assessment been presented in a publicly accessible document or website? |
| Yes part of it is published on the Ministry's webpage: http://www.moh.gov.cy/moh/moh.nsf/80878538DB6EC625C22577BD00288147/\$file/2015_01%20Creating%20a%20Service%20Delivery%20Model%20for%20Providing%20and%20Managing%20Primary%20Health%20Care.pdf |
| Question 4 |
| At what level of aggregation are the data published? |
| National level |
| Question 5 |
| What types of indicators are reported in the assessment? |
| <ul style="list-style-type: none"> - access during out-of-office hours - geographical access - availability of essential patient information in records use of emergency department for cases that could be treated in primary care Activity in visits, group and community (e.g. no. of practice consultations; home visits per time unit); consultation length, |
| Have workload and job satisfaction of primary care providers been measured and reported? |
| If yes, how and on what scale? |
| This has been measured and reported in several studies carried out for academic purposes |
| Question 7 |

| |
|--|
| Please present your methodological approach. In particular, please explain how are the indicators developed, what risk adjustment methods are being used (if any), how is internal variability being addressed, etc. |
| N/A |
| Question 8 Which procedures are in place to promote the validity, reliability and relevance of the assessment? |
| N/A |
| Question 9 To what degree is performance assessment embedded in the policy process? |
| With the introduction of the National health System we are planning to introduce quality assurance methods such as clinical audit and collection of indicators. Also a methodology for extra payments for Family doctors who will be registered with the NHS, based on their performance has been developed. Such activities eligible for extra payments will be: adherence to clinical protocols, percentage of vaccinations delivered, prescription and referral behaviour patterns. |
| Question 10 What is the evidence that the assessment has impacted on policy? |
| N/A |
| Question 11 Please summarise (briefly) the major limitations and main strengths of assessments of primary care performance in your country. |
| The main strength of primary care in Cyprus is the relatively small size of Cyprus. The majority of the remote rural are only up to one hour and 30 minutes driving from the nearest main hospital. |
| In the Primary Health Care Centres we have a multidisciplinary team including: General Practitioners, Pharmacists, Nurses, Health Visitors, Community nurses, Psychiatrists, Community mental health nurses, and dentists. In some health care centres we have visiting specialists: Paediatricians and cardiologists |
| Our main limitations are: Lack of trained Family Doctors. A big percentage of the doctors working in primary health care centres are without specialty in General Practice/ Family Medicine. Another limitation is the lack of electronic patient record or a general IT system from which we could extract reliable data. |
| Question 12 What are the future plans with regard to primary care assessment? |
| In the framework of the introduction of the National Health System, an electronic patient file will be developed. We also plan to collect and publish indicators in primary care both for accessibility, prescription patterns, referral pattern and quality of care |

ESTONIA

| |
|--|
| Question 1 |
| Are there any recurrent or one-off assessments carried out of the performance of (parts of) the organisation and/or functioning of primary care in your country? |
| Primary care performance assessment conducted once a year. Family physicians are required to insert / present data online at the end of the next year first quarter. These performance assessments used for monitoring, target setting and / or accountability. Results are published on the website of Estonian Health Insurance Fund (EHIF) and available for all interested groups. The bonus payment for primary care treatment to a health care provider for the results of quality assessment per one list and for the quality management per one list was added. At the moment there is no opportunity to monitor health indicators measured over time, appropriate dashboard required. |
| Question 2 |
| Please provide a brief description of these assessments (name and type of product) |
| Disease-prevention activities (vaccination, examination of up to 3 years children and pre-school children); Monitoring patients with chronic diseases (hypertension, diabetes, hypothyreosis, myocardial infarction, and prescribed medicaments); Additional professional competence (gynaecological examination, monitoring of pregnancy, minor surgical interventions); Quality management and quality assessment of the primary health care provider. Periodic assessment of data/claims presented to EHIF. |
| Question 3 |
| For each assessment, please specify: |
| 3.1. Is the report – or part of it – done because of legal requirements? If not, what is the main reason to carry it out? |
| Performance assessment is described in legislation and contract agreed between EHIF and primary health care provider |
| 3.2. When did it take place? |
| Once a year (family physicians present data online to EHIF, which is subsequently analysed and published on EHIF website), there is opportunity to appeal the results |
| 3.3. Which organisation commissioned the assessment? |
| Family physicians present data to Estonian Insurance Fund, payment is provided according to the results |
| 3.4. Which organisation carried it out? |
| Estonian Health Insurance Fund |
| 3.5. What other stakeholders were involved and how? |
| Association of Estonian family physicians |
| 3.6. Which types of primary care were parts of the assessment? |

| |
|--|
| Family practice, prescribed medicaments |
| 3.7. Which is the level of reporting? |
| National, regional |
| 3.8. What is the focus of the assessment? |
| Disease-prevention activities; Monitoring patients with chronic diseases; Additional professional competence; Quality management system |
| 3.9. What is the function of the assessment? |
| - general reporting - comparative benchmark (e.g. between providers) - performance-based reimbursement schemes |
| 3.10. To which target population is the assessment primarily addressed? |
| Primary healthcare service providers and patients |
| 3.11. How is performance information fed back to primary care providers? |
| Reports are published on the website of EHIF and all providers (and not only providers) may compare own results with other providers |
| 3.12. Has the assessment been presented in a publicly accessible document or website? |
| On website |
| Question 4 |
| At what level of aggregation are the data published? |
| National, regional, provider, practice levels |
| Question 5 |
| What types of indicators are reported in the assessment? |
| Indicators measuring access, clinical performance, patient-centeredness or responsiveness, general descriptive information about providers or organisations |
| Question 6 |
| Have workload and job satisfaction of primary care providers been measured and reported? If yes, how and on what scale? |
| Not |
| Question 7 |
| Please present your methodological approach. In particular, please explain how are the indicators developed, what risk adjustment methods are being used (if any), how is internal variability being addressed, etc. |
| Indicators were developed in cooperation with Estonian Association of Family Physicians, and approved by Ministry Of Social Affairs |

| |
|--|
| Question 8 |
| Which procedures are in place to promote the validity, reliability and relevance of the assessment? |
| Scientific knowledge provided by University of Tartu, Faculty of family medicine and public health. |
| Question 9 |
| To what degree is performance assessment embedded in the policy process? |
| Quality indicators and their assessment and financial issues presented in the regulation of List of health care services of Estonian Health Insurance Fund (https://www.riigiteataja.ee/akt/130122016013), and regulation of The insured persons payment obligation of the Estonian Health Insurance Fund over the health care providers and the methodology for calculating the remuneration (https://www.riigiteataja.ee/akt/125112011004) |
| Question 10 |
| What is the evidence that the assessment has impacted on policy? |
| Based on the results of the assessment required changes, improvements, suggestions are considered |
| Question 11 |
| Please summarise (briefly) the major limitations and main strengths of assessments of primary care performance in your country. |
| Since 2006, the Health Insurance Fund with the Estonian Association of Family Physicians has developed a quality system for primary health care. In 2016, 100% participation was achieved. In primary health care there is sufficient number of indicators set for measuring performance. The bonus payment for primary care treatment to a health care provider for the results of quality assessment per one list and for the quality management per one list were added. At the moment there is no opportunity to monitor health indicators measured over time, appropriate dashboard required. |
| Question 12 |
| What are the future plans with regard to primary care assessment? |
| Further development of quality system, adding quality terms for the developing primary health centres and assessment of health outcomes |

FINLAND

Question 1

Are there any recurrent or one-off assessments carried out of the performance of (parts of) the organisation and/or functioning of primary care in your country?

There are several registers and surveys focused on primary care in Finland. Please, see below.

According to the Health Care Act the municipalities has to publish the waiting times to non-urgent appointment to GP at health station (practice) level at their websites in every fourth month. The waiting time indicator required is the third next available appointment to GP.

The Patient Data Repository offers citizens the opportunity of examining their own medical records on their computer, easily and regardless of time and place. In the Repository internet service (My Kanta) the patients can see electronic prescriptions, records related to their treatment, laboratory tests and X-ray examinations. However, the following answers in this survey are mostly based on administrative registers and surveys, which are well-established and nationwide.

In addition, there are quality network for clinical conditions, such as diabetes, atherosclerosis and atrial fibrillation. The network is coordinated by a private company, Conmedic Ltd., and it covers 38 health centres out of 150 with a catchment area of around 20% of the total country population.

Question 2

Please provide a brief description of these assessments (name and type of product)

Register of Primary Health Care Visits: The statistics contain data on service providers, population's service use, access to services, population's health problems, epidemic development, client's/patient's municipality of residence and gender, visits by age group, outpatient visits by service type, reasons for visit, procedures and follow-up care, medication and vaccinations as well as check-ups to promote the health of children, young people and pregnant women. The register is maintained by the National Institute for Health and Welfare (THL).

National Vaccination Register and Seasonal influenza vaccination coverage database. Maintained by THL.

Access to primary health care: The statistics include survey-based data on access to non-urgent treatment in primary and oral health care in health centres as well as in the Finnish Student Health Service. Maintained by THL.

Survey on customer/patient satisfaction run by ... Maintained by THL.

Register on Prescribed (filled) prescription medicines: The register is used for individual feedback information on prescription practices for physicians. The register and feedback services are managed by the Social Insurance Institution. The register is based on health insurance reimbursement data which means that it covers only filled/purchased prescriptions in ambulatory care.

The Finnish Medical Association collects statistics on physicians and run an annual survey to chief physicians in health centres. The survey includes information on e.g. recruitment situation at health centre level.

Question 3

| |
|---|
| For each assessment, please specify: |
| 3.1. Is the report – or part of it – done because of legal requirements? If not, what is the main reason to carry it out? |
| <p>Register of Primary Health Care Visits: Statutory.</p> <p>National Vaccination Register and Seasonal influenza vaccination coverage database: Vaccination records have been collected continuously as part of the national social and health care reporting (Avohilmo) data collection.</p> <p>Access to primary health care: Statutory</p> <p>Prescribed prescription medicines by physician category: The report enables an analysis of the expenses for medication reimbursed through the health insurance scheme via the pharmacies and the number of prescriptions for different groups of doctors. The data can be analysed for the whole country or by the specialisation of the doctor who prescribed the medicine. If desired, the medicines to be analysed may be restricted to medicines prescribed by doctors who work at a municipal health centre.</p> <p>Survey on customer/patient satisfaction: To have customer feedback</p> <p>The Finnish Medical Association's statistics on physicians and the survey to health centre chief physicians: Collect data on physician workforce in general, a physician shortage in health centres and outsourcing.</p> |
| 3.2. When did it take place? |
| <p>Register of Primary Health Care Visits: In pilot municipalities in 2008–2009. At the national level, the data collection on primary health care in the public sector started in 2011, covering all health centres in Finland.</p> <p>National Vaccination Register and Seasonal influenza vaccination coverage database: the current system has been operating since 2012</p> <p>Access to primary health care: since 2011</p> <p>Register on Prescribed prescription medicines: since 1995</p> <p>Survey on customer/patient satisfaction: Maternity clinics pilot 2013, then every other year since 2014 nationwide, child health clinics pilot 2014 and nationwide 2016, oral/dental care pilot 2014 and nationwide 2016 and health centre pilot 2016</p> <p>The Finnish Medical Association's statistics on physicians and survey to health centre chief physicians: since 1986 by the Finnish Medical Association</p> |
| 3.3. Which organisation commissioned the assessment? |
| <p>Register of Primary Health Care Visits: Ministry of Social Affairs and Health</p> <p>National Vaccination Register and Seasonal influenza vaccination coverage database: Ministry of Social Affairs and Health</p> <p>Access to primary health care: Ministry of Social Affairs and Health</p> <p>Register on Prescribed prescription medicines: the Social Insurance Institution.</p> <p>Survey on customer/patient satisfaction: Ministry of Social Affairs and Health</p> <p>The Finnish Medical Association's statistics on physicians and survey to health centre chief physicians: voluntary managed by the Finnish Medical</p> |

| |
|--|
| Association. |
| 3.4. Which organisation carried it out? |
| <p>Register of Primary Health Care Visits: the National Institute for Health and Welfare</p> <p>National Vaccination Register and Seasonal influenza vaccination coverage database: the National Institute for Health and Welfare</p> <p>Access to primary health care: the National Institute for Health and Welfare</p> <p>Register on Prescribed prescription medicines: the Social Insurance Institution.</p> <p>Survey on customer/patient satisfaction: the National Institute for Health and Welfare</p> <p>The Finnish Medical Association's statistics on physicians and survey to health centre chief physicians: Since 1986 by the Finnish Medical Association and after 2004 the Association in collaboration with the Ministry of Social Affairs and Health, National Institute for Health and Welfare, and Local Government Employers.</p> |
| 3.5. What other stakeholders were involved and how? |
| <p>Register of Primary Health Care Visits: none - primary data in the Register collected at the health centres</p> <p>National Vaccination Register and Seasonal influenza vaccination coverage database. none - primary data in the Register collected at the health centres</p> <p>Access to primary health care: professional, Regional State Administrative Agencies, direction and oversight of health care services</p> <p>Register on Prescribed prescription medicines: none - the Register is based on health insurance reimbursement data</p> <p>Survey on customer/patient satisfaction: professionals in health centres informed patients about the survey</p> <p>The Finnish Medical Association's statistics on physicians and survey to health centre chief physicians: professional organisations see 3.4.</p> |
| 3.6. Which types of primary care were parts of the assessment? |
| <p>Register of Primary Health Care Visits: visits to general practitioners and public health nurses, health counselling, preventive work and vaccinations, oral/dental health care, maternity and child health clinics, school and student health care, occupational health care (partly), home nursing.</p> <p>National Vaccination Register and Seasonal influenza vaccination coverage database: vaccinations of the National Vaccination Programme and for influenza</p> <p>Access to primary health care: GPs, dentists</p> <p>Register on Prescribed prescription medicines: reimbursed prescription medicines</p> <p>Survey on customer/patient satisfaction: Maternity and child health care clinics, oral/dental health care and GP consultation</p> <p>The Finnish Medical Association's statistics on physicians and survey to health centre chief physicians: GP</p> |
| 3.7. Which is the level of reporting? |

Register of Primary Health Care Visits: national level, regional level, practice level, provider level
 National Vaccination Register and Seasonal influenza vaccination coverage database:
 Access to primary health care: national, regional level, provider and practice level,
 Prescribed prescription medicines by physician category: national, regional level, the specialisation of the doctor who prescribed the medicine or by doctors who work at a municipal health centre.
 Survey on customer/patient satisfaction: Provider and practice level
 The Finnish Medical Association's statistics on physicians and survey to chief physicians in health centres: national, regional and provider level

3.8. What is the focus of the assessment?

Register of Primary Health Care Visits: primary care in general
 National Vaccination Register and Seasonal influenza vaccination coverage database: Vaccination
 Access to primary health care: access to care
 Register on Prescribed prescription medicines : prescribing
 Survey on customer/patient satisfaction: primary care in general, patients satisfaction
 The Finnish Medical Association's statistics on physicians and survey to health centre chief physicians: medical doctor workforce in primary care

3.9. What is the function of the assessment?

Register of Primary Health Care Visits: general reporting, benchmarking
 National Vaccination Register and Seasonal influenza vaccination coverage database: general reporting, statistics
 Access to primary health care: benchmarking, general reporting, supervision
 Register on Prescribed prescription medicines : benchmarking, feedback for physicians, general reporting, statistics
 Survey on customer/patient satisfaction: general reporting, benchmarking
 The Finnish Medical Association's statistics on physicians and survey to health centre chief physicians: general reporting, industrial /labour market interests for the Finnish Medical Association

3.10. To which target population is the assessment primarily addressed?

Register of Primary Health Care Visits: policy makers, health care managers
 National Vaccination Register and Seasonal influenza vaccination coverage database: policy makers, health care managers
 Access to primary health care: policy makers, health care managers
 Register on Prescribed prescription medicines : health care managers, policy makers, prescribing physicians
 Survey on customer/patient satisfaction: policy makers, health care managers, population

The Finnish Medical Association's statistics on physicians and survey to health centre chief physicians : health care managers, policy makers

3.11. How is performance information fed back to primary care providers?

Register of Primary Health Care Visits: yes

National Vaccination Register and Seasonal influenza vaccination coverage database. Yes

Access to primary health care: yes

Register on Prescribed prescription medicines : not on practice level, but the doctors get summary on their own prescribed prescriptions compared to those of other doctors in the same category they belong to

Survey on customer/patient satisfaction: yes

The Finnish Medical Association's statistics on physicians and survey to health centre chief physicians : yes

3.12. Has the assessment been presented in a publicly accessible document or website?

Register of Primary Health Care Visits: yes www.thl.fi/tietokantaraportit

National Vaccination Register and Seasonal influenza vaccination coverage database: yes https://www.thl.fi/en/web/thlfi-en/statistics/statistical-databases/database-reporting#Primary_care

Access to primary health care: yes <https://www.thl.fi/en/web/thlfi-en/statistics/statistics-by-topic/primary-health-care-services>

Register on Prescribed prescription medicines : yes http://raportit.kela.fi/ibi_apps/WFServlet?IBIF_ex=NIT056DL&YKIELI=E

Survey on customer/patient satisfaction: yes <https://www.thl.fi/fi/web/sote-uudistus/palvelujen-tuottaminen/asiakkaat-ja-osallisuus/asiakaspalaute>

The Finnish Medical Association's statistics on physicians and survey to health centre chief physicians : yes

https://www.laakariliitto.fi/site/assets/files/1268/tk_julkaisulista2016.pdf

Question 4

At what level of aggregation are the data published?

Register of Primary Health Care Visits: national, regional, practice level

National Vaccination Register and Seasonal influenza vaccination coverage database: national, regional, practice

Access to primary health care: regional, practice level

Register on Prescribed prescription medicines : national, regional

Survey on customer/patient satisfaction: national, regional, practice level

The Finnish Medical Association's statistics on physicians and survey to health centre chief physicians : national, regional, health centre

Question 5

| |
|---|
| What types of indicators are reported in the assessment? |
| <p>Register of Primary Health Care Visits: General descriptive information about providers or organisations, Indicators measuring access</p> <p>National Vaccination Register and Seasonal influenza vaccination coverage database: Indicators measuring clinical performance</p> <p>Access to primary health care: Indicators measuring access</p> <p>Register on Prescribed prescription medicines : Indicators measuring clinical performance, Indicators measuring costs, waste or efficiency</p> <p>Survey on customer/patient satisfaction: Indicators measuring patient-centeredness or responsiveness</p> <p>The Finnish Medical Association's statistics on physicians and survey health centre chief physicians: General descriptive information about providers or organisations, Indicators measuring access</p> |
| <p>Question 6</p> <p>Have workload and job satisfaction of primary care providers been measured and reported?</p> <p>If yes, how and on what scale?</p> |
| <p>A survey on staff resources at the maternity and child care clinics and school and student health care has been carried out nearly every year in 2004-2016. A large part of the municipalities has carried out surveys on job satisfaction and work conditions or are participating in a survey (KUNTA 10) on these issues organised by the Finnish Institute of Occupational Health every other year since 1997.</p> |
| <p>Question 7</p> <p>Please present your methodological approach. In particular, please explain how are the indicators developed, what risk adjustment methods are being used (if any), how is internal variability being addressed, etc.</p> |
| <p>Methods vary depending on the service. Most data and indicators are obtained from administrative registers. For instance, the Register of Primary Health Care Visits i.e. outpatient primary health care visits in the public sector has collected since 2011 with an online data transfer using the Avohilmo Register and collecting data directly from patient records. The municipality responsible for organising primary health care is also responsible for submitting data to THL even in cases where the service has been purchased from, for instance, a private service provider.</p> <p>The reliability of the data depends on the quality and correctness of the data submitted by those who provided the data, such as health centres. Once submitted to THL, the data are routinely checked and, where necessary, health centre units providing the data are requested to correct or re-submit data. The rules for checking and correcting data are described in the HILMO guidelines and on THL's website (www.thl.fi/hilmo).</p> <p>Methods to refine the indicators published vary but most indicators are relatively straightforward and risk adjustment and other advanced analytical methods are not used.</p> |
| <p>Question 8</p> <p>Which procedures are in place to promote the validity, reliability and relevance of the assessment?</p> |

See also Q7. The register used for the assessment is mainly part of the national health information system in which there is several procedures to promote the data quality. The content of the data gathering is usually negotiated with expert panels and updated regularly. The aim is to organise data collection electronically and using the electronic information systems of the service providers. The architecture of the national system also includes a centralised internet code server securing the use correct and up-to-date codes, such as ICD 10, type of visit, provider codes, in the registers. In addition, for some purposes, such as the quality network of chronic care operated by the Conmedic Ltd, scientific advisory boards or similar advisory bodies are used.

Question 9

To what degree is performance assessment embedded in the policy process?

Most assessment instruments are directly or indirectly commissioned by the Ministry of Social Affairs and Health and are part of the national health statistics and information system. Most systems are also operated by government agencies (THL or the Social Insurance Institution) which have an advisory role on the Ministries and central government policy makers.

Question 10

What is the evidence that the assessment has impacted on policy?

It is not possible to judge if a separate assessment or quality reporting has impacted on policy but for instance in the current debate on reforming health and social services access to services has been a constant topic. The waiting time data from the monitoring system have been used to strengthen the arguments supporting to reforms needs.

Another example is the information on health centre recruitment situation which has been used to motivate the increase in enrolment to medical schools.

Un upcoming topic is the vaccination rates, particularly for measles. The follow-up system has produced reports on local low vaccination rates for measles in some areas to the extent that the herd immunity is endangered. The topic is currently publicly debated and it is potential that national and/or local measures will be implemented to promote to the vaccination programme for measles.

Question 11

Please summarise (briefly) the major limitations and main strengths of assessments of primary care performance in your country.

Assessment systems in place are national covering all providers with a strong mandate on data gathering and management of the information systems. The systems are established with a clear production structure which is producing assessments on reasonable intervals.

As a downside, the systems are partly operating in silos issuing assessment information on specific topics (waiting times, vaccination rates) but a comprehensive strategic and analytic approach to give overall assessment on the performance of primary care providers is not strongly developed.

Question 12

What are the future plans with regard to primary care assessment?

The reform of the health care and social welfare system has been attempted in Finland for several years. The current Government has proposed a

reform which would change the structure of the system completely; for instance by transferring the responsibility to organise the services from the municipalities to the counties (not yet existing at the moment), and introducing a new funding system based on central government allocations, increased role for private provision, corporatisation of a large part of public provision and a wide provider choice for the patients. The reform would change the operation environment of primary health care substantially. The Government proposal also contains a comprehensive change in the monitoring system including close follow-up of the performance of the counties and health and social care providers. If implemented the reform would delegate the responsibility of the monitoring and performance assessment to the National Institute for Health and Welfare. Preliminary planning of the assessment framework is currently ongoing and the first pilots on indicators will be launched in 2017.

FRANCE

GLOBAL ASSESSMENT:

In general terms, in France, primary care is broadly under the responsibility of the National Health Insurance (NHI), except for emergency services which are provided by hospitals, themselves under State's responsibility.

Every year, NHI provides to Government and Parliament a report called "Charges et Produits" (Income and expense of the year). In this report, are presented analyses about the evolution of practices and expenses, from which the NHI proposes ways to improve quality and efficiency of treatments, and use of resources.

For instance, in its report for the year 2017, the NHI expresses proposals about priority areas such as:

- Smoking prevention and education;
- Lumbago treatment and prevention;
- Shoulder surgical treatment;
- COPD prevention and early detection;
- Diabetic foot treatment;
- Physiotherapy.

INDIVIDUAL ASSESSMENT:

Since 2009, a contract between NHI and individuals (GPs) has been implemented, and progressively transformed to become an annual payment based on public health objectives called **ROSP** (Remuneration sur Objectifs de Santé Publique), which is an additional payment, in town practitioners having the largest part of their income from fee for service.

The ROSP now has been extended to all kinds of practitioners, with a variable range of indicators.

The panel of indicators are used to cover two main dimensions:

Clinic organisation: information system (especially for care coordination, patient's file, and treatment improvement); all types of physicians are concerned;

5 indicators:

- Documentary proof of an existing information system able to manage patient's file and input individual clinical data;
- Documentary proof of using a certified prescription assistance software;
- Existence of a remote data transmission system;
- Display the opening hours and disabled accessibility of the clinic on-the-spot and on the NHI website;
- Only for the GPs: Annual synthesis from the electronic individual patient's file transmitted to the NHI.

Quality of medical practice: with 3 areas (chronical diseases monitoring, prevention, efficiency); the list of indicators is agreed by the professionals and the NHI from the recommendations of the National health Authority (HAS); for the moment, only GPs, cardiologists, and hepato-gastroenterologists are concerned.

24 indicators dedicated to GPs:

- 9 linked with chronicle diseases: 8 for diabetes (blood glucose control; hyperglycaemia reduction-2 indicators; LDL cholesterol measuring-2 indicators; fundoscopic surveillance; statin treatment for high cardiovascular risk diabetic patient-secondary prevention; low dose aspirin treatment for high cardiovascular risk diabetic patient-primary prevention); 1 for hypertension surveillance;
- 8 related to prevention priorities: 2 for seasonal influenza vaccination; 1 for breast cancer screening; 1 for uterine cancer screening; 1 for good use of antibiotherapy; 3 for drug-related-iatrogenia;
- 7 related to efficiency: 5 for generic medicinal products prescription; 1 for angiotensin converting enzyme (ACE) inhibitor / sartans family; 1 for good use of platelet aggregation inhibiting drugs.

9 indicators for cardiologists:

- 2 linked with chronicle diseases: 1 for myocardial infarction; 1 for heart failure;
- 5 related to prevention priorities: 1 for antiplatelet therapy; 3 for arterial hypertension; 1 for myocardial infarction;
- 2 related to efficiency: both for generic medicinal products prescription.

8 indicators for hepato-gastroenterologists:

- 4 linked with chronicle diseases: 2 for inflammatory bowel chronicle diseases surveillance; 2 for operated colorectal cancer surveillance;

- 3 related to prevention priorities: 1 for helicobacter pylori infection posttreatment surveillance; 1 for post polypectomy surveillance; 1 for colonoscopy quality;
- 1 related to efficiency: coordination with the patient's GP.

Valuation and payment: Every practitioner chooses his indicators from the list. Each indicator shows a result depending on practitioner's activity and assigning related number of points. At the end of the year, the total number of points is converted to define the payment.

ROSP ASSESSMENT AFTER 5 YEARS

Each year, the NHI assesses the results of the ROSP.

The last report shows that, between 2012 and 2016:

- An overall positive trend (+ 17,2 points), with a greater effect on prescriptions optimisation (+ 23,3 points) and clinic organisation (+ 23 points);
- The improvement of surveillance and disease prevention for diabetic patients;
- The improvement of generic medicinal products prescription;
- Mixed results for prevention objectives, with a progress for antibiotic drugs prescription, and no progress or low regression for vaccination and cancer screening.

This global improvement leads to a parallel with the increasing of payments: in 2016, 56 724 physicians were involved and the average remuneration due to the ROSP's results reached 6619 € (+ 3.4% comparing with 2015).

GERMANY

| |
|--|
| Question 1 |
| Are there any recurrent or one-off assessments carried out of the performance of (parts of) the organisation and/or functioning of primary care in your country? |
| The National Association of Statutory Health Insurance Physicians publishes annual quality reports together with the individual associations of statutory health insurance physicians, see http://www.kbv.de/html/1748.php |
| Question 2 |
| Please provide a brief description of these assessments (name and type of product) |
| Annual quality report, printable and accessible at http://www.kbv.de/html/1748.php ; refers to office-based physicians and psychotherapists |
| Question 3 |
| For each assessment, please specify: |
| 3.1. Is the report – or part of it – done because of legal requirements? If not, what is the main reason to carry it out? |
| The publication of the quality report follows from the regulatory responsibility stipulated in section 135b SGB V (Social Code Book V), according to which the associations of statutory health insurance physicians are required to conduct, document and publish outpatient quality assurance measures. |
| 3.2. When did it take place? |
| |
| 3.3. Which organisation commissioned the assessment? |
| Statutory requirement, see above |
| 3.4. Which organisation carried it out? |
| National Association of Statutory Health Insurance Physicians and the individual associations of statutory health insurance physicians |
| 3.5. What other stakeholders were involved and how? |
| |
| 3.6. Which types of primary care were parts of the assessment? |
| Office-based physicians and psychotherapists |
| 3.7. Which is the level of reporting? |
| Federal and Land (regional) level |
| 3.8. What is the focus of the assessment? |
| For new examination and treatment methods adopted by the Joint Federal Committee (Gemeinsamer Bundesausschuss – G-BA), cf. section 135 (2) SGB V; for interventions determined by the G-BA, cf. section 136 (2) SGB V (e.g. the Quality Assessment Guidance for Arthroscopy -Qualitätsbeurteilungs-Richtlinie Arthroscopie - QBA-RL) |

| |
|--|
| 3.9. What is the function of the assessment? |
| General reporting |
| 3.10. To which target population is the assessment primarily addressed? |
| The report is universally accessible |
| 3.11. How is performance information fed back to primary care providers? |
| |
| 3.12. Has the assessment been presented in a publicly accessible document or website? |
| Annual quality report, printable and accessible at http://www.kbv.de/html/1748.php |
| Question 4 |
| At what level of aggregation are the data published? |
| At the Federal and Land (regional) level |
| Question 5 |
| What types of indicators are reported in the assessment? |
| Generally, these requirements only refer to process and structural quality. By contrast, the indicators given in the questionnaire are not used in the outpatient sector. |
| Question 6 |
| Have workload and job satisfaction of primary care providers been measured and reported? |
| If yes, how and on what scale? |
| |
| Question 7 |
| Please present your methodological approach. In particular, please explain how are the indicators developed, what risk adjustment methods are being used (if any), how is internal variability being addressed, etc. |
| |
| Question 8 |
| Which procedures are in place to promote the validity, reliability and relevance of the assessment? |
| |
| Question 9 |
| To what degree is performance assessment embedded in the policy process? |
| |
| Question 10 |

| |
|---|
| What is the evidence that the assessment has impacted on policy? |
| |
| Question 11 |
| Please summarise (briefly) the major limitations and main strengths of assessments of primary care performance in your country. |
| |
| Question 12 |
| What are the future plans with regard to primary care assessment? |
| <p>Explanatory note: Quality assurance in outpatient care is predominantly based on the quality assurance agreements concluded by the National Association of Statutory Health Insurance (SHI) Physicians and the National Association of Statutory Health Insurance (SHI) Funds, as partners to the quality assurance agreements pursuant to section 135 (2) SGB V, pursuant to the Federal Collective Agreement (Bundesmantelvertrag). Moreover, quality assurance measures are in place for select service areas. These measures take the form of guidance documents issued by the Joint Federal Committee (G-BA) pursuant to section 135 (1) SGB V (on examination and treatment methods) or pursuant to section 135b (2) SGB V (criteria for quality assessment in care provided by SHI-accredited physicians).</p> <p>Please note that the collection of information on structural and process quality has generally been a practice in outpatient care. Moreover, we wish to call your attention to the fact that the answers given here do not take account of the G-BA's Guidance on cross-institutional and cross-sectoral quality assurance (Qesü-RL).</p> <p>While it is true that, in this framework, data on pre-determined quality indicators are also generally collected in the outpatient sector, these actually refer to interventional procedures (e.g. cardiac catheter procedures and other operations that are only done by specifically listed groups of specialists). We do not include this area in primary care. Where DMPs have been referred to, these do not fit in the table, since DMPs are special forms of care that do not only belong in the primary care setting but are cross-sectoral.</p> <p>DMPs are services that are voluntarily provided by the health insurance funds; participation by the medical profession and patients is voluntary as well. DMPs are in place for six conditions (Type II and Type I diabetes mellitus, coronary heart disease, asthma, COPD and breast cancer). The requirements are laid down by the G-BA in the form of guidance documents (cf. section 137f SGB V). The DMPs also include quality assurance measures. For more details (in German), please visit: https://www.g-ba.de/informationen/richtlinien/zum-unterausschuss/10/.</p> <p>Since the DMPs are cross-sectoral by design, the approach to quality assurance measures is cross-sectoral as well.</p> |

IRELAND

| |
|---|
| Question 1 |
| Are there any recurrent or one-off assessments carried out of the performance of (parts of) the organisation and/or functioning of primary care in your country? |
| The Health Service Executive's (HSE) annual National Service Plan (NSP) describes the services to be provided by the HSE within the funding levels allocated by Government. The NSP includes a suite of performance indicators (PIs) across all service areas, including primary care. The primary care services and associated indicators are fully detailed in an annual operational plan. THE HSE measures and reports on performance against these indicators as part of the monthly performance reporting cycle. (See links below) |
| (A) http://www.hse.ie/eng/services/publications/serviceplans/Service-Plan-2017/2017-National-Service-Plan.pdf |
| (B) http://www.hse.ie/eng/services/publications/serviceplans/Service-Plan-2017/Operational-Plans-2017/Primary-Care-Division-Operational-Plan-2017.pdf |
| (C) http://www.hse.ie/eng/services/publications/performance-reports/October-December-Performance-Report-2016.pdf |
| (C) http://www.hse.ie/eng/services/publications/performance-reports/December-2016-Management-Data-Report.pdf |
| Question 2 |
| Please provide a brief description of these assessments (name and type of product) |
| The HSE measures and reports on performance against these indicators as part of the monthly performance reporting cycle. There is a monthly performance management monitoring process between the Department of Health and the Health Service Executive. |
| Question 3 |
| For each assessment, please specify: |
| 3.1. Is the report – or part of it – done because of legal requirements? If not, what is the main reason to carry it out? |
| Under the Health Act 2004, the HSE must prepare a service plan within 21 days after the publication by Government of the Estimates for supply services for the financial year. There is no such legal requirement for reporting. The Department of Health holds the HSE to account through a monthly performance management process between it and the HSE. |
| 3.2. When did it take place? |
| Performance Reports are produced monthly. |
| 3.3. Which organisation commissioned the assessment? |
| The HSE |
| 3.4. Which organisation carried it out? |
| The HSE |

| |
|---|
| 3.5. What other stakeholders were involved and how? |
| Department of Health and the HSE |
| 3.6. Which types of primary care were parts of the assessment? |
| As reported under the Primary Care Operational Plan 2017 - see link at (B) under Q1 |
| 3.7 What is the level of reporting? |
| Reporting may be at regional and/or national level. |
| 3.8. What is the focus of the assessment? |
| Appendix 3 of the Operational Plan covers the suite of services on which assessment is focused - see link at (B) under Q1 |
| 3.9. What is the function of the assessment? |
| To examine the performance of the HSE against the performance indicators laid out in the National Service Plan 2017/ Primary Care Division Operational Plan, 2017 |
| 3.10. To which target population is the assessment primarily addressed? |
| The performance of those in the delivery of Primary Care services and how this relates to the patient, i.e. health care managers, clinicians and patients. |
| 3.11. How is performance information fed back to primary care providers? |
| As this function is performed by the HSE, the Department is unable to comment at this time. |
| 3.12. Has the assessment been presented in a publicly accessible document or website? |
| See link at (C) under Q1 above |
| Question 4 |
| At what level of aggregation are the data published? |
| National and/or regional |
| Question 5 |
| What types of indicators are reported in the assessment? |

| |
|---|
| <p>Indicators measuring access</p> <ul style="list-style-type: none"> - Supply of providers - Availability - Waiting times - Access during out of office hours <p>Indicators measuring clinical performance</p> <ul style="list-style-type: none"> - Use or availability of clinical protocols and patient safety procedures <p>Indicators measuring costs, waste or efficiency</p> <ul style="list-style-type: none"> - spending per patient of specific categories on medicines - overhead spending <p>There is monthly management reporting against agreed budgetary templates for the Primary Care Reimbursement Service</p> <p>Indicators measuring equity:</p> <ul style="list-style-type: none"> - Access, quality or outcome indicators broken down by specific groups, e.g. gender, socio-economic status, education or ethnic background; - indicators related to the care of specific de-privileged groups such as homeless people, asylum seekers, illegal immigrants, etc.; <p>These are assessed by the HSE as provided for in the NSP/Operational Plan and monthly Performance Reports.</p> <p>General descriptive information about providers or organisations</p> <ul style="list-style-type: none"> - Activity in visit's, group and community (e.g. no of practice consultations; home visits per time unit); consultation length; - Range of Services provided <p>Community Intervention Teams (CITs) record the number of referrals, admission avoidance, hospital avoidance, early discharge, and unscheduled referrals from community sources. Public Health Nurse data refers to targets for home visits with in defined times.</p> |
| <p>Question 6</p> <p>Have workload and job satisfaction of primary care providers been measured and reported? If yes, how and on what scale?</p> |
| <p>While job satisfaction is not reported upon, the performance (which includes workload) of the HSE is reported monthly - See link at (C) under Q1 above. PRCRS (Primary Care Reimbursement Service) reports monthly, and includes data on under/overspend.</p> |
| <p>Question 7</p> <p>Please present your methodological approach. In particular, please explain how are the indicators developed, what risk adjustment methods are being used (if any), how is internal variability being addressed, etc.</p> |
| <p>Indicators are developed through discussions between the Department and the HSE</p> |
| <p>Question 8</p> <p>Which procedures are in place to promote the validity, reliability and relevance of the assessment?</p> |
| <p>The HSE has rigorous systems in place to see how KPIs are developed and this include the use of guidelines and metadata templates.</p> |

| |
|--|
| Question 9 |
| To what degree is performance assessment embedded in the policy process? |
| Performance monitoring can identify problematic areas where reassessment or development of services or investment could be required. Information on numbers waiting for a service and length of wait times can highlight the need for alternative methods of service delivery and inform new policy. |
| Question 10 |
| What is the evidence that the assessment has impacted on policy? |
| <p>Example 1. Waiting lists for speech and language therapy, particularly for children, highlighted the need for action. Additional funding was provided to recruit additional staff. Waiting list data has led to the establishment of Service Improvement Initiatives to develop standardised models of care for the delivery of various therapies throughout the country.</p> <p>Waiting lists for audiology services was among the factors which led to a review by the Health Service Executive of its audiology services in 2011. The recommendations of the Review resulted in new structures and additional resources for the service being put in place with the support of the Department of Health.</p> <p>The assessment allows for regular discussion and analysis of expenditure trends on medicines in the primary care setting which impact on medicines policy.</p> |
| Question 11 |
| Please summarise (briefly) the major limitations and main strengths of assessments of primary care performance in your country. |
| <p>Strengths: frequency and speed/efficiency of reporting, geographical area covered, areas covered by healthcare professionals, input of information into budgetary issues, efficiency and waste identified.</p> <p>Limitations: Occasional over reporting of information, no reporting of patient experience or patient outcomes in the primary care setting, no reporting of internal HSE assessments and quality management, occasional inconsistency of information.</p> |
| Question 12 |
| What are the future plans with regard to primary care assessment? |
| The HSE will continue to implement its HSE Performance and Accountability Framework. The HSE will develop data gathering, reporting processes and systems to support the Performance and Accountability Framework |

ITALY (country level)

Question 1

Are there any recurrent or one-off assessments carried out of the performance of (parts of) the organisation and/or functioning of primary care in your country?

A national information system specifically focused on primary care is not yet active in Italy; consequently, a national performance assessment system purely focused on primary care is not currently ongoing. Two broad national systems include indicators indirectly expressing performance of primary care: 1. The National Monitoring system of the essential levels of care (LEA Grid); 2. The National Outcome Evaluation Programme (PNE). LEA Grid indicators include general hospitalisation rate, hospitalisation for ambulatory care sensitive conditions, outpatient services overuse (number of MRI by population), primary prevention (behavioural risk factors, vaccination rates in paediatric and elderly population). National Outcome Evaluation Programme (PNE) aims at benchmarking among health providers and investigates the heterogeneity of access to health care across both geographical areas and hospitals; heterogeneity of hospitalisations for specific conditions are monitored at sub-regional geographical level, indirectly measuring performance of primary care organisation. Some Italian regions do have specific primary care assessment systems.

Question 2

Please provide a brief description of these assessments (name and type of product)

The LEA Grid is a quantitative system designed to monitor the actual provision of Essential Levels of care (LEA), homogeneously within the Italian territory: it consists of a system of indicators monitoring regional performance in providing the LEA and focusing on 4 levels of care: prevention, outpatient and community care, hospital care, and emergency care. The main objectives of PNE are the benchmarking among health providers. PNE investigates the heterogeneity of access to health care across both geographical areas and hospitals, focusing on those health care interventions for which evidence of effectiveness is available and it is possible to measure indicators using the available information systems.

Question 3

For each assessment, please specify:

3.1. Is the report – or part of it – done because of legal requirements? If not, what is the main reason to carry it out?

Both monitoring systems are ongoing since State-Regions agreements.

3.2. When did it take place?

The LEA grid was implemented since 2005; PNE since 2010

3.3. Which organisation commissioned the assessment?

They are both commissioned by the Ministry of Health

3.4. Which organisation carried it out?

The LEA grid is directly carried out by the Ministry of Health. PNE is carried out by the National Agency for Regional Health Services, on mandate by the Ministry of Health, with the support of the Department of Epidemiology of the Lazio Region.

| |
|---|
| 3.5. What other stakeholders were involved and how? |
| The LEA grid is agreed with Regions' representatives. PNE involves professional organizations and the technical staff of the Regions in the discussion of the indicators. |
| 3.6. Which types of primary care were parts of the assessment? |
| Both LEA grid and PNE indirectly measure family practice and specialist community care performance, as expressed through avoidable hospitalization; LEA grid also includes indicators of primary prevention, as well as community care not specifically attributable to a specific type of primary care (home care, residential care activity etc.). |
| 3.7. Which is the level of reporting? |
| LEA grid indicators are computed at the regional level, while PNE indicators (indirectly expressing primary care) are computed at provinces or health care districts level |
| 3.8. What is the focus of the assessment? |
| The focus of both systems is primary care in general; specific dimensions of primary care (as, for example, outpatient services prescriptions or primary prevention) are indirectly measured by the LEA grid, which also focuses on community care. |
| 3.9. What is the function of the assessment? |
| Both systems are used for comparative benchmarking: the LEA grid for benchmarking among regions, PNE among health care districts. The LEA grid is used at national level to identify regions not fulfilling the LEA criteria for which a part of the health care fund will not be assigned. PNE identify the health care districts which should undertake requalification plans because of bad quality standards. Some regions do use these quality standard for defining incentives or penalties for healthcare managers |
| 3.10. To which target population is the assessment primarily addressed? |
| Policy makers, health care managers and clinicians |
| 3.11. How is performance information fed back to primary care providers? |
| Results of LEA grid are presented to Regions and published by the Ministry of Health. Results of PNE are presented to the different Regions but there is no national specific feedback to primary care providers. Given the type of evaluation it is not possible to go back to the specific provider |
| 3.12. Has the assessment been presented in a publicly accessible document or website? |
| Results of both systems are published on public institutional website |
| Question 4 |
| At what level of aggregation are the data published? |
| The LEA grid indicators are computed and published at regional level, while PNE publishes data at the sub-regional level (health care district) |
| Question 5 |
| What types of indicators are reported in the assessment? |

As for LEA grid (2015 version), admissions for ambulatory care sensitive conditions (child gastroenteritis and asthma, adult COPD, diabetes complications and heart failure); outpatients services prescriptions (number of MRI by population unit); primary prevention (behavioural risk factors, vaccination). As for PNE, admissions for ambulatory care sensitive conditions (asthma, COPD, diabetes, heart failure, child gastroenteritis); an indirect measure of adherence to evidence based treatment (one year MACCE after discharge for AMI).

Question 6

Have workload and job satisfaction of primary care providers been measured and reported?
If yes, how and on what scale?

No

Question 7

Please present your methodological approach. In particular, please explain how are the indicators developed, what risk adjustment methods are being used (if any), how is internal variability being addressed, etc.

Admissions for ambulatory care sensitive conditions are measured with reference to resident population and adjusted for age and gender. All the other indicators measured by LEA grid are unadjusted and related to resident population. PNE measures sub-regional variability using the Median Odds Ratios

Question 8

Which procedures are in place to promote the validity, reliability and relevance of the assessment?

LEA grid indicators are shared with Regions within the Permanent Committee for Monitoring Provision of Essential Levels of Health Care (LEA Committee), established within the Ministry of Health (within the General Directorate for Health Planning). PNE indicators are discussed with health care professionals and within a committee in which both regional methodological experts and external expert in evaluation are represented. There is a continuous process of auditing on quality of data followed by clinical and organizational auditing when data are confirmed.

Question 9

To what degree is performance assessment embedded in the policy process?

Performance is strictly embedded with the policy process due to its use in identifying regions and/or health districts will not be assigned part of the health care budget. However the latter use has been regulated by law but not been yet put in place

Question 10

What is the evidence that the assessment has impacted on policy?

We have evidence of reduction of avoidable hospitalization but given the absence of a specific system of primary care evaluation we cannot assume that this corresponds to better primary care

Question 11

Please summarise (briefly) the major limitations and main strengths of assessments of primary care performance in your country.

Major limitations are related to the absence of national reliable data on GPs activity and to the current use of indirect measures of primary care, together with limitations in quality of coding which can explain geographical differences.

Question 12

What are the future plans with regard to primary care assessment?

Several activities aimed at setting a national information system on primary care are being carrying out: an interinstitutional working group of experts in primary care (at national and regional level) was constituted in order to identify information on clinical activity of general practitioners and paediatricians, patients' needs and determinants of access, prescriptions issued and factors related to the effective implementation of new organization models and related to monitoring of appropriateness, quality, effectiveness and efficiency. Moreover, a new wide national HSPA, assessing all Regions and Autonomous Provinces, is being designed: the project aims at extending the number of indicators for each level of care, including primary care, specifically focusing on efficiency, clinical and organizational appropriateness, safety, perceived quality/patient humanization and equity dimensions; this new system will include a specific focus on sub-regional heterogeneity.

ITALY (Lazio)

| |
|---|
| Question 1 |
| Are there any recurrent or one-off assessments carried out of the performance of (parts of) the organisation and/or functioning of primary care in your country? |
| In the Lazio region (about 5,500,000 residents), primary care performance assessments are systematically conducted. |
| Question 2 |
| Please provide a brief description of these assessments (name and type of product) |
| The Regional Outcome Evaluation Program (P.Re.Val.E.) is a comparative evaluation of regional healthcare outcomes, including a large set of structure, process, and outcome indicators for measuring performance in primary care, among which adherence to long-term therapies in patients with chronic diseases, the gap between clinical practice and clinical guidelines in monitoring disease progression in patients with diabetes or COPD, the use of antibiotics in paediatric outpatients, the rate of "avoidable" hospitalizations, and other primary care indicators. For each indicator, time trend and geographic variation are measured. |
| Question 3 |
| For each assessment, please specify: |
| 3.1. Is the report – or part of it – done because of legal requirements? If not, what is the main reason to carry it out? |
| P.Re.Val.E. is an outcome research program conceived mainly as a tool for promoting discussion among healthcare managers and professionals in the Lazio region. Moreover, P.Re.Val.E. aims to identify the priority axes for action (such as general practitioners, local health districts, and other primary care providers) to improve adherence to clinical guidelines and equity in health care. In other words, P.Re.Val.E. aims to move from real world data to real world evidence for healthcare policy decision-making. |
| 3.2. When did it take place? |
| P.Re.Val.E. started in 2008, and is systematically updated every six months. |
| 3.3. Which organisation commissioned the assessment? |
| The assessment was commissioned by the Health Plan Directorate of the Lazio region. |
| 3.4. Which organisation carried it out? |
| The Outcome Evaluation Program is carried out by the Department of Epidemiology, Lazio Regional Health Service. |
| 3.5. What other stakeholders were involved and how? |
| Before defining indicators, analysis of data and public release of results, the Department of Epidemiology shares the P.Re.Val.E methods and results with different groups of clinicians and healthcare providers, to promote discussion and encourage contributions and critical assessments. |
| 3.6. Which types of primary care were parts of the assessment? |

| |
|--|
| According to the P.Re.Val.E. approach, the gap between daily practice and clinical guidelines in primary care is a multidimensional problem determined by the interaction of patient-related factors, physician-related factors and health system-related factors. General practice, paediatrics, pharmacy and Health District Directorate are involved in the assessment process. |
| 3.7. Which is the level of reporting? |
| The level of reporting is both regional and sub-regional. As regards the sub-regional level, results are produced by local health unit and local health district. Moreover, variability among general practitioners is also measured. |
| 3.8. What is the focus of the assessment? |
| The assessment framework is broad in scope. P.Re.Val.E. focuses on chronic disease management in primary care, secondary prevention of acute clinical events, prescribing, organization and performance of general practice. |
| 3.9. What is the function of the assessment? |
| P.Re.Val.E. allows for a wide set of "functions": general reporting, comparisons between healthcare providers, comparisons with the "average" regional performance, comparisons with best performers, time-trend analysis, analysis of geographic variation in healthcare quality. |
| 3.10. To which target population is the assessment primarily addressed? |
| The assessment is primarily addressed to clinicians, healthcare managers, and policy makers. |
| 3.11. How is performance information fed back to primary care providers? |
| Each healthcare provider can compare its own results against those of other providers and can use the functions previously described (see "paragraph" 3.9). |
| 3.12. Has the assessment been presented in a publicly accessible document or website? |
| Results are available on the P.Re.Val.E. website, after receiving username and password from the Department of Epidemiology. |
| Question 4 |
| At what level of aggregation are the data published? |
| Data are published at different levels of aggregation: the highest level is the "regional level", whereas the lowest level is the "provider level" (i.e. local health unit and local health district). Variation among general practitioners is also measured. |
| Question 5 |
| What types of indicators are reported in the assessment? |
| Geographical access; periodic check-ups of chronically ill; prescription or referrals in accordance with guidelines; overtreatment; admissions for ambulatory care sensitive conditions. |
| Question 6 |
| Have workload and job satisfaction of primary care providers been measured and reported? If yes, how and on what scale? |

| |
|--|
| Workload of primary care providers has been measured and reported. No information was collected on job satisfaction. |
| Question 7 Please present your methodological approach. In particular, please explain how are the indicators developed, what risk adjustment methods are being used (if any), how is internal variability being addressed, etc. |
| The indicators are calculated using information collected from regional health information systems covering the whole Lazio population. Multivariate regression models and direct standardization procedures are used to control for potential confounding due to individual characteristics. Empirical Bayes Estimators and mixed effect models have been used to account for internal variability in the data. |
| Question 8 Which procedures are in place to promote the validity, reliability and relevance of the assessment? |
| As regards the selection of relevant clinical areas, the choice of individual indicators and their definition, a scientific advisory board is regularly convened. Moreover, specific studies are performed to verify data by means of audit procedures. |
| Question 9 To what degree is performance assessment embedded in the policy process? |
| The primary care quality indicators are systematically used by the Health Plan Directorate of the Lazio region to evaluate healthcare patterns for chronic conditions, to set clinical and organizational objectives for healthcare providers, and to link the level of achievement of these objectives to annual budget and contract extension of healthcare professionals. |
| Question 10 What is the evidence that the assessment has impacted on policy? |
| The data on diabetic and COPD population have been used to plan the clinical pathways; in order to actively identify potential patients and include them directly in a scheduled programme of follow up according to evidence based practices. |
| Question 11 Please summarise (briefly) the major limitations and main strengths of assessments of primary care performance in your country. |
| Regular feedback on primary care quality seems to increase the accountability of providers, which are sensitive to public image; it can also spur quality improvement activities in health care organizations, especially when underperforming areas are identified. However, providers that are identified as poor performers are more likely to question the validity of the data, particularly when the results are first released. |
| Question 12 What are the future plans with regard to primary care assessment? |
| To develop a set of new, specific primary care indicators which may play a major role in implementing an effective and efficient "chronic care model". |

ITALY (Tuscany)

Question 1

Are there any recurrent or one-off assessments carried out of the performance of (parts of) the organisation and/or functioning of primary care in your country?

In 2004, Tuscany Region entrusted the Scuola Superiore Sant'Anna of Pisa to design a multidimensional performance evaluation system to monitoring the results of Local Health Authorities in terms of clinical quality and appropriateness both for the hospital setting and for the district setting (Nuti et al 2012; Nuti et al 2015). Starting from 2007, the performance indicators within the PES were presented in benchmarking across the healthcare providers and available on a web platform for top managers and professionals. Starting in 2013 selected performance indicators within the PES were also calculated at General Practitioners practices level (Barsanti and Nuti 2016). The assessment focus on general results and performance of the health care system, considering all level of care and only regional strategic interventions (such as the implementation of the Chronic Care Model).

Question 2

Please provide a brief description of these assessments (name and type of product)

The Tuscan PES encompasses a large set of indicators (primary care indicators are listed in "list of indicators sheet") grouped into about 30 indexes. Indicators are defined in regular meetings with regional administration and GPs representatives. Performance indicators for quality assessment are included in the PES to provide comparability within and between providers, to identify good practice, or, on the contrary, flawed clinical processes (Vainieri et al 2016). Clinical indicators are measured through the use of regional administrative data which provide electronic records of all inpatient and outpatient activity, as well of pharmaceutical consumption for all residents from 2009-2016. The indicators are groups in different domains: B. regional strategy on primary care; C. Chronic care management and continuity of care; D. Satisfaction and experience of patients; E Satisfaction and organization of GPs; F Diagnostic and pharmaceutical care appropriateness. PES indicators that are considered as evaluation measures are assigned performance assessment ratings for benchmarking reporting across GPs practices or district level. For each evaluation measure, five different performance levels are derived for defining the performance of each AFT, from worst to best. These five evaluation tiers are associated with different colours, from dark green (excellent performance), to red (poor). Indicators are presented with the metaphor of the target (refer to sheet "target").

Question 3

For each assessment, please specify:

3.1. Is the report – or part of it – done because of legal requirements? If not, what is the main reason to carry it out?

The PCPA has a dual nature. Considering the regional law n. 40/2005, it stated that performance assessment in health care is a mandatory requirement for the regional health care system at regional and local level. Moreover, the national agreement by which the minister of health manages the GPs, appeals to measures to monitor the GPs' care. However, the large development of the Tuscany PCPA is also inspired by a general awareness of the need of a structured, comprehensive and coherent assessment system for all setting of care on a voluntary basis.

3.2. When did it take place?

| |
|---|
| The Performance Evaluation System of Tuscany health care system was implemented for the Local Health Authorities in 2005; since 2007 it was implemented also at local district level, considering outpatient and primary care level and finally in 2013 the PES was implemented coherently in primary care, considering GPs practices level. |
| 3.3. Which organisation commissioned the assessment? |
| Tuscany Region commissioned the assessment (Health Department). |
| 3.4. Which organisation carried it out? |
| Laboratorio Management e Sanità (MeS), Institute of Management, Scuola Superiore Sant'Anna di Pisa (Italy) and Agenzia Regionale di Sanità (ARS) of Tuscany Region |
| 3.5. What other stakeholders were involved and how? |
| Different stakeholders at different level of involvement took part in the PCPA. Firstly health care managers and policy makers at regional and local level and professional organizations were involved in the definition and development phases of the PCPA (i.e. definition of the framework, indicators, assessment system). Others professional, such as specialist or social workers, were involved subsequently. Patients were involved in the implementation phase, considering the satisfaction and experience assessment with primary care services surveys (i.e. testing the survey). |
| 3.6. Which types of primary care were parts of the assessment? |
| Considering the local district level of assessment, all professionals are involved (specialists, GPs, nurses, Paediatrics, Pharmacy, social workers). Considering the system developed for GPs practices, the main focus is on General Practitioners. |
| 3.7. Which is the level of reporting? |
| The system has different level of reporting coherently with the responsibility and governance system: 1. regional; 2. LHAs level; 3. district level; GPs practises level; single GP level. |
| 3.8. What is the focus of the assessment? |
| In order to start monitoring and comparing GPs' performance with respect to PC activities and responsibilities including: (i) management of chronic disease; (ii) prevention of avoidable hospitalization and inappropriate diagnostic tests; (iii) preventive care and home care for elderly; (iv) drugs prescriptions; (vi) practice organization and (vii) patients experience (Barsanti and Nuti 2016). It also considers al district level of care specific care pathway, such as mental health, maternal care and health prevention and promotion. |
| 3.9. What is the function of the assessment? |
| The system is comprehensive in assessment primary care activities and governance. The PCPA is used both for combative benchmarking between providers (local district and GPs practices) and for GPs and other professionals performance-based reimbursement schemes (in this case, some of the indicators are used as the base of performance schemes). |
| 3.10. To which target population is the assessment primarily addressed? |

The PCPA is addressed mainly to policy makers, health care managers of LHA and health care district at local level and to clinicians, with a specific support of GPs practices coordinators.

3.11. How is performance information fed back to primary care providers?

Information and data are compared benchmarking providers at different level. Measures are compared between 1 LHAs level; 2. District level; 3.GPs practises level; 4.single GP level. Considering single GP, information is anonymized.

3.12. Has the assessment been presented in a publicly accessible document or website?

The assessment is presented both in an accessible website and on a printed document. Only single GP' information are anonymized and accessible only for GPs coordinators practices.

Question 4

At what level of aggregation are the data published?

The system has different level of reporting coherently with the responsibility and governance system: 1. regional; 2. LHAs level; 3. district level; 4.GPs practises level; 5.single GP level. Only single GP' information are anonymized and accessible only for GPs coordinators practices.

Question 5

What types of indicators are reported in the assessment?

The PCPA considers almost all types of indicators report in this document (sheet "types of indicators): 1. Indicators measuring access such as GPs involvement on the Chronic Care Model and waiting times for GPs visits and outpatient visits; 2. Indicators measuring clinical performance are the mostly used indicators such as prescription or referrals in accordance with guidelines (e.g. percentage of patients with diabetes with haemoglobin test; this type of indicators are calculated by ARS); 3. Indicators measuring patient-centeredness or responsiveness such as patients satisfaction and experience with their GP in terms of involvement, communication, chronic care management, continuity of care (these indicators are developed by structured surveys with GPs practices level representativeness; 4. Indicators measuring costs, waste or efficiency such as prescription of generics drugs, compliance to treatment(i.e.), use of emergency department for minor disease, appropriateness of secondary care and diagnostic and laboratory exams (i.e.); 5. Indicators related with primary care performance in general such as ACSCs hospitalization rate. Moreover, the PCPA considers also indicators related to GPs practices organization in terms of GPs satisfaction and experience; these indicators are measured from regional online survey to all GPs. Principal indicators are listed in "list of indicators sheet" with an example of reporting system of an indicator.

Question 6

Have workload and job satisfaction of primary care providers been measured and reported?

If yes, how and on what scale?

Workload and job satisfaction of primary care providers are measured and reported in the PCPA of Tuscany Region. Almost every two years, online survey on GPs satisfaction and experience with other professionals and colleagues and with services in general are carried out by MES. Results of the survey are analysed and assessed in the primary care performance system at GPs practices level. Example of indicators are GPs practices quality meetings, clinical audit meeting, overall GPs practices' satisfaction, collaboration with others colleagues, Knowledge and Dissemination of the performance system and results. In 2014/2015 more than the 40% of GPs replied to the survey.

Question 7

Please present your methodological approach. In particular, please explain how are the indicators developed, what risk adjustment methods are being used (if any), how is internal variability being addressed, etc.

Indicators are developed with professional and health managers. Starting from international literature and experiences, indicators are contextualized and measured, with specific standardized process. All clinical indicators are risk adjusted considering age and sex of patients or with indirect standardization process (i.e. hospitalization rate) or with specific weights for the population (i.e. drugs consumption). With this adjustment, indicators are allowed to be compared between providers in order to monitor internal variability. In particular, variability is addressed also by comparing indicators with the local and regional means for each indicator using also confidence intervals (i.e. ARS report).

Question 8

Which procedures are in place to promote the validity, reliability and relevance of the assessment?

In order to promote statistical robustness of indicators, evaluators used different procedures that consider peer reviews (such as group of professionals that developed and assess indicators) indicators developed international literature and experiences, considering scientific board. Others indicators are directly developed with health care managers and policy makers in order to assess regional projects and interventions.

Question 9

To what degree is performance assessment embedded in the policy process?

The PCPA is annually reported the regional minister for health and regional policy makers in order to evaluated results of the whole health care system and involved professionals. Most of performance indicators are linked to local annual incentive schemes for health care district managers and some performance indicators, with a specific focus on chronic care management and drugs expenditure, are linked to local GPs contracts.

Question 10

What is the evidence that the assessment has impacted on policy?

Considering results of annually performance at primary care level, regional and local policy makers may decide to promote some interventions and/or services to shift to different organizational model. In this contest, the Chronic Care Model developed in Tuscany Region since 2010 has been assessed in PCPA and regional policy makers developed with professionals specific chronic care pathways. Some others services or setting of care have been incentivized, such as home care for older. Furthermore, considering assessment criteria such as internal variability, level of performance and trend, policy makers at regional level and GPs coordinators at local level are able to set targets and priorities.

Question 11

Please summarise (briefly) the major limitations and main strengths of assessments of primary care performance in your country.

Considering Tuscany PCPA, limitations mainly regard: 1. low development of indicators that refers to the multiple chronic conditions instead of one single conditions and indicators that reflects the multi-professional care instead of separated setting of care; 2. low development of indicators that reflect outcome of care instead process of care (i.e. level of haemoglobin instead of haemoglobin test done or not done); 3. Use of administrative data flow since GPs data reporting system is very scarce in quality and completeness. Strengths mainly regards: 1. simple way of reporting and assessment system using the metaphor of the target; 2. consistency of the indicators with all levels of responsibility and governance; 3. GPs and health care district managers point of view included in the system and continuously development and implementation of the system with professionals.

Question 12

What are the future plans with regard to primary care assessment?

Further improvements considered the development of indicators that refers to formal or informal network of professionals; 2. Development of indicators of management of multiple chronic care condition and continuously improvements of algorithms that reveal chronic care conditions; 3. Implementation of PROMs survey for some conditions; 4. Development of equity measures.

Barsanti S, Nuti S (2016) *Il sistema di valutazione della performance delle AFT toscane*. Anno 2015. Edizioni Del Gallo, Perugia (Italy)

Nuti S, Seghieri C, Vainieri M, Zett S. 2012 Assessment and improvement of the Italian healthcare system: first evidence from a pilot national performance evaluation system. *J Healthc. Manag.* 2012 May-Jun;57(3):182-98; discussion 198-9.

Nuti S, Vola F, Bonini A, Vainieri M Making governance work in the health care sector: evidence from a 'natural experiment' in Italy. *Health Econ Policy Law*. 2016

Vainieri M, Vola F, Soriano Gomez G. Nuti S (2016) How to set challenging goals and conduct fair evaluation in regional public health systems. *Insights from Valencia and Tuscany Regions* 2016 Health Policy Volume 120, Issue 11, Pages 1270–1278

B - Regional strategy compliance

B7 Vaccine Coverage

| | | |
|------|----------------------------------|------|
| B7.1 | Flu vaccine coverage for elderly | x100 |
|------|----------------------------------|------|

B24 Homecare

| | | |
|----------|--|------|
| B24T.1.1 | Percentage of elderly provided with homecare | x100 |
|----------|--|------|

| | | |
|----------|--|------|
| B24T.2.9 | Percentage of homecare plans for the elderly with a care intensity coefficient of > 0.13 | x100 |
|----------|--|------|

| | | |
|-----------|--|------|
| B24T.2.10 | Percentage of assistants with an home care access within 3 days from discharge | x100 |
|-----------|--|------|

| | | |
|-----------|--|------|
| B24T.2.11 | Percentage of elderly with at least 2 hospitalizations (non-surgical) during the homecare plan | x100 |
|-----------|--|------|

| | | |
|-----------|---|------|
| B24T.2.12 | Percentage of elderly with admissions to Emergency Departments during the homecare plan | x100 |
|-----------|---|------|

B26 GP follow Chronic Care Model

| | | |
|-------|--|------|
| B26.1 | Percentage of GP follow Chronic Care Model | x100 |
|-------|--|------|

C - Chronic care management and continuity of care

| | | |
|------------|---|--------|
| C1 | Hospitalization | |
| C1T.1 | Standardized by age and sex hospitalization rate | x1.000 |
| C1T.1.1 | Standardized by age and sex hospitalization rate of acute inpatients | x1.000 |
| C1T.1.2 | Standardized hospitalization rate for Day Hospital | x1.000 |
| C1T.2 | Standardized hospitalization rate of acute medical DRG's (0-64 years) | x1.000 |
| C1T.3 | Percentage of readmissions 31-180 days following discharge | x100 |
| C16 | Preventable Hospitalization | |
| C16T.4 | Standardized hospitalization by age and sex for Ambulatory Care Sensitive Conditions rate | x1.000 |
| C16T.5 | Percentage of patients with 2 hospitalizations for ACSC within a year | x100 |
| C12 | Management of Heart Failure | |
| C12T.2a | Percentage of patients with heart failure with creatinine test in the 12 preceding months | x100 |
| C12T.2b | Percentage of patients with heart failure with Potassium Sodium test in the 12 preceding months | x100 |
| C12T.3 | Percentage of patients with heart failure currently treated with an ACE-I or ARB | x100 |
| C12T.4 | Percentage of patients with heart failure currently treated with beta blockers | x100 |
| C25.1 | Percentage of patients with heart failure that follow beta blockers therapy (compliance) | x100 |
| C25.2 | Percentage of patients with heart failure that follow ACE inhibitors therapy (compliance) | x100 |
| C14 | Management of Diabetes | |
| C14T.2 | Percentage of patients with diabetes with haemoglobin test in the preceding 12 months | x100 |
| C14T.3 | Percentage of patients with diabetes with oculist visit in the preceding 24 months | x100 |
| C23 | Management of Hypertension | |
| C23T.1 | Percentage of residents with hypertension with at least one measurement of Lipid Profile | x100 |
| C26 | Access to Emergency department | |
| C26.1 | Standardized by age and sex access to emergency department | x1.000 |
| C26.2 | Standardized by age and sex access to emergency department for minor injuries | x1.000 |
| C24 | Follow up Heart stroke (IMA) | |
| C24.3.1 | Percentage of patients with heart stroke that follow beta blockers therapy within 90-180 day after inpatients | x100 |
| C24.3.2 | Percentage of patients with heart stroke that follow ACE inhibitors therapy within 90-180 day after inpatients | x100 |
| C24.3.3 | Percentage of patients with heart stroke that follow both statins and aggregation inhibitors within 90-180 day after inpatients | x100 |

D - Patient satisfaction

D1 Access Satisfaction

- D1.1 Opening Hours
- D1.2 The GP answers the Phone/mobile
- D1.3 The GP reads texts/emails
- D1.4 Availability on Saturday mornings

D2 Overall satisfaction

- D2.1 Willingness to recommend
- D2.2 Proactivity
- D2.3 Time commitment
- D2.4 Involvement

D3 Chronic patients' Satisfaction

- D3.1 Being more informed
- D3.2 Being more independent
- D3.3 Monitoring the pathway of the disease
- D3.4 Continuity with the specialist
- D3.5 Sharing of pharmaceutical therapy
- D3.6 Monitoring medication adherence

E - Satisfaction and organization of GPs

E1 Response rate for GP survey

x100

E2 Comprehensive AFT satisfaction

x100

E3 GP practices' meetings

x100

E3.1 Number of monthly meetings

x100

E3.2 GPs' participation

x100

E3.3 Usefulness of the meetings

x100

E4 Targets

| | | |
|-----------|--|------|
| E4.1 | Knowledge of Target Scheme by GPs | x100 |
| E4.2 | Sharing of Target Scheme by GP practices coordinator | x100 |
| E5 | Clinical Audit | x100 |
| E6 | Clinical Governance | |
| E6.1 | Sharing of clinical guidelines | x100 |
| E6.2 | Integration with district and community level | x100 |
| E6.3 | Quality assessment meetings | x100 |
| E6.4 | Appropriateness assessment meetings | x100 |

F - Diagnostic and pharmaceutical care

| | | |
|------------|--|----------------|
| C20 | Diagnostic Tests' Appropriateness | |
| C20T.1 | Ambulatory service rate | x1.000 |
| C20T.2 | Standardized by age and sex diagnostic tests rate | x1.000 |
| C20T.2.1 | Standardized by age and sex CT rate | |
| C20T.2.2.1 | Standardized by age and sex Magnetic resonance imaging of skeletal muscle disease rate for elderly | x1.000 |
| C20T.2.2.2 | Percentage of elderly re-doing Magnetic resonance imaging of back (lumbar) | x100 |
| F1 | Antacid therapy | |
| C9.1 | Consumption of Proton Pump Inhibitors | Dosage Unit |
| F2 | Antihypertensive therapy | |
| C9.3 | Incidence of sartans (Antihypertensive) | x100 |
| F12a.3 | Percentage of expired patent ACE inhibitors (Antihypertensive) | x100 |
| F12a.6 | Percentage of expired patent dihydropyridine derivatives (Antihypertensive) | x100 |
| F12a.7 | Percentage of expired patent ACE inhibitors combined with other molecules (Antihypertensive) | x100 |
| F12.11a | Percentage of Losartan on sartans combined with other molecules | x100 |
| F12.22 | Percentage of expired patent of Perindopril | x100 |
| F3 | Antidepressant therapy | |
| C9.4 | Consumption of antidepressant | DDDx1.000 |
| C9.5 | Consumption of other antidepressant | DDDx1.000 |
| C9.9.1 | Over-prescription of antidepressant | x100 |
| C9.9.1.1 | Percentage of patients that drop antidepressant therapy | x100 |
| F12a.10 | Percentage of other expired patent antidepressants (Antidepressants) | x100 |

| | | |
|-----------|--|-----------|
| F4 | Statins therapy | |
| C9.6.1.1 | Over-prescription of statins | x100 |
| C9.6.1.2 | Percentage of patients follow statins therapy | x100 |
| | | Dosage |
| C9.6.1.3 | Consumption of statins | Unit |
| F12a.2 | Percentage of expired patent statins | x100 |
| F5 | Antibiotics therapy | |
| C9.8.1.1 | Consumption of antibiotics | DDDx1.000 |
| C9.8.1.2 | Incidence of injectable antibiotics | x100 |
| F12a.9 | Percentage of expired patent fluoroquinolone (Antibiotics) | x100 |
| F6 | Polypharmacy | |
| C9.10.1 | Percentage of elderly for Polypharmacy | x100 |
| F8 | Pain-related medicine consumption | |
| B4.1.1 | Outpatient Opioids consumption | x100 |
| B4.1.3 | Outpatient morphine consumption | x100 |
| B4.1.5 | Morphine incidence | x100 |

Figure 1: Example of indicator evaluation for GP practices (Percentage of older in home care) Source: Laboratorio MeS, Scuola Sant'Anna di Pisa

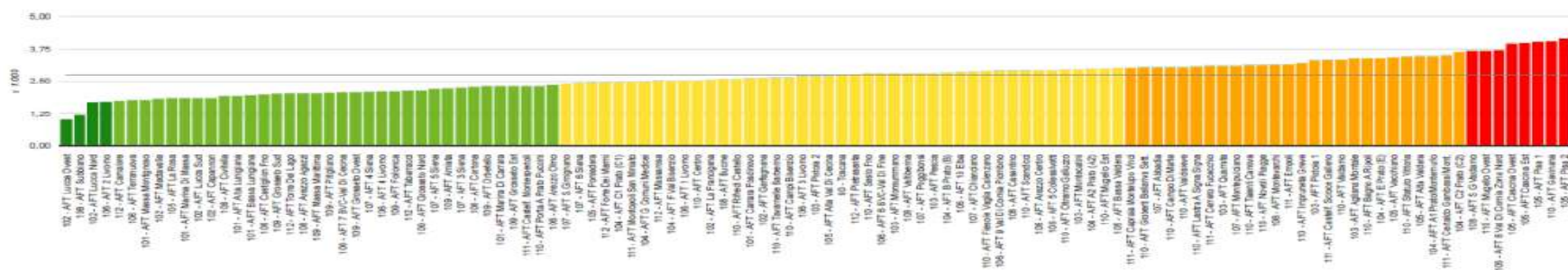


Figure 2 Example of indicator representation Source: Agenzia Regionale di Sanità

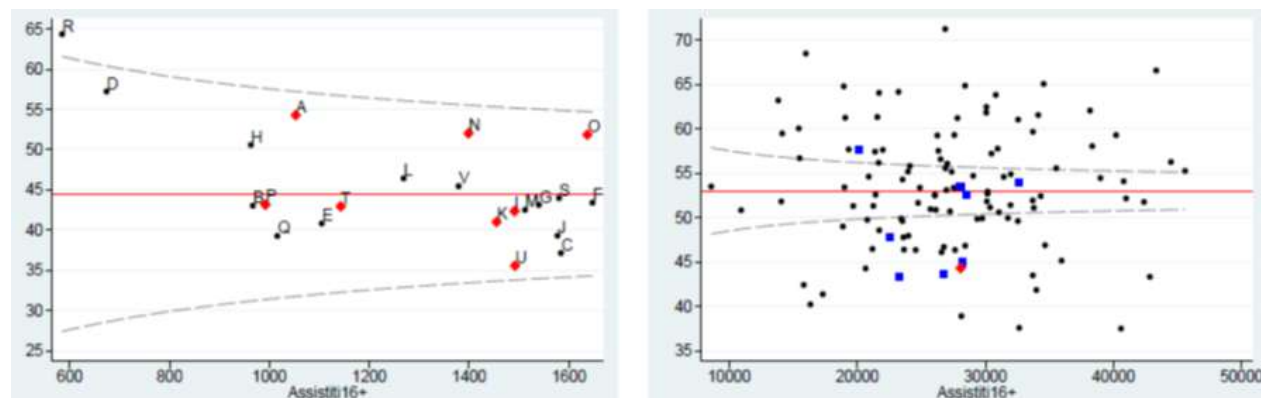
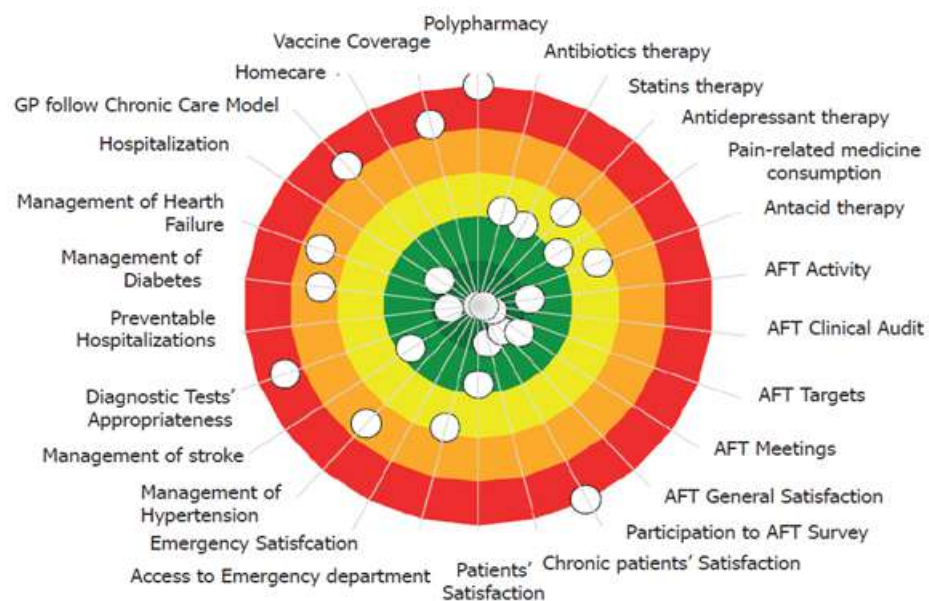


Figure 3: Target for GP practice



ITALY (Veneto)

Question 1

Are there any recurrent or one-off assessments carried out of the performance of (parts of) the organisation and/or functioning of primary care in your country?

In Veneto Region there are:

- AUR (Regional register of GP/PFC)
- "TAVOLO - CRITE" Authorization
- Regular Report of the "CdE" objectives
- "ACN" data flow

Question 2

Please provide a brief description of these assessments (name and type of product)

- **AUR (Regional register of GP/PFC):** It represents a collection of information related to GP/PFC and patient, structured on a regional infrastructure. Content data include: medical practice opening hours, address, software used, the nursing and administrative service presence, activity picking, call centres, connection to the reservations system of specialist examinations.

- **"TAVOLO - CRITE" Authorization:** It represents a procedure for assessing the conformity of projects of advanced forms of association (Medicine di Gruppo Integrate) than the regional standard contract - (DGR n. 751/2015)

- **Regular Report of the "CdE" objectives:** It represents the monitoring mode on the achievement of individual targets in the regional standard contract (CdE) agreed between the Local Health Unit and GPs subscribers. Specifically, are monitoring the objectives relating to prevention areas (adherence to vaccination and screening programs as regional planning), chronicity area (application of the regional clinical pathways "PDTA": COPD - DIABETES - TAO / NAO - HEART FAILURE), training area (participation in educational meetings and audit), computerization area and good keeping of medical records, governance area (hospitalization rate, cost of pharmaceuticals per capita, specialist visit per capita, etc.).

- **"ACN" data flow:** The GPs ensure transmission to its local health unit, elementary information (hospitalization request for confirmed diagnosis, diagnostic hypothesis or problem - access to the medical practice, with or without medical examination - home visits - home care, etc.)

Question 3

For each assessment, please specify:

3.1. Is the report – or part of it – done because of legal requirements? If not, what is the main reason to carry it out?

For "ACN" data flow, the indication is in the National agreement of the GPs; all other are a Regional provisions of the System governance

3.2. When did it take place?

| |
|---|
| <ul style="list-style-type: none"> - "ACN" data flow: since 2010 - AUR (Regional register of GP/PFC): was started in 2014 - "TAVOLO CRITE" Authorization: was started in September 2015 - Regular Report of the "CdE" objectives: just begun (April 2017) |
| 3.3. Which organisation commissioned the assessment? |
| Veneto Region |
| 3.4. Which organisation carried it out? |
| Veneto Region ("Unità organizzativa Cure primarie e LEA") and Local Health Unit |
| 3.5. What other stakeholders were involved and how? |
| <ul style="list-style-type: none"> - professional organisations - trade union organisations of general medicine - patient organisations (only as members of regional commissions and for the definition of some indicators) |
| 3.6. Which types of primary care were parts of the assessment? |
| - General practice / family practice |
| 3.7. Which is the level of reporting? |
| - Regional and local health unit level |
| 3.8. What is the focus of the assessment? |
| <ul style="list-style-type: none"> - Primary care in general; - Prevention activities; - Assistance to the chronically ill (Clinical pathways); - Training; - Computerization; - Participation in the governance - Accessibility |
| 3.9. What is the function of the assessment? |
| <ul style="list-style-type: none"> - General report - point of reference and comparison - incentive systems linked to the achievement of the goals - Internal Audit - Local and regional mapping |
| 3.10. To which target population is the assessment primarily addressed? |

| |
|---|
| <ul style="list-style-type: none"> - policy makers - healthcare managers of the Local Health Units |
| 3.11. How is performance information fed back to primary care providers? |
| <ul style="list-style-type: none"> - Internal Audit at health district level (*), local health units level and regional level. <p><i>(*) Primary care services are delivered by health districts, the operative branches of Local Health Unit. Multidisciplinary teams of professionals (GPs and paediatricians, specialists, nurses, social assistants, social care staff and other technical and administrative staff) work within Health Districts to provide different types of services to meet community needs.</i></p> |
| 3.12. Has the assessment been presented in a publicly accessible document or website? |
| With regard to the "AUR", the results of the monitoring data are presented during the conference; for the other indicators, data collection has hardly started. |
| Question 4 |
| At what level of aggregation are the data published? |
| <ul style="list-style-type: none"> - With regard to the "AUR", at health district level, local health units level and regional level |
| Question 5 |
| What types of indicators are reported in the assessment? |
| <p><i>Indicators measuring access:</i></p> <ul style="list-style-type: none"> - supply of providers; - the availability of specific assistance agreements (CdE) - geographical access (accessibility standards) <p><i>Indicators measuring clinical performance:</i></p> <ul style="list-style-type: none"> - regional "PDTA" indicators; - clinical parameters <p><i>Indicators measuring patient-centeredness or responsiveness:</i></p> <ul style="list-style-type: none"> - Completeness of data registration, related to the patient Information <p><i>Indicators measuring costs, waste or efficiency:</i></p> <ul style="list-style-type: none"> - hospitalisation rates, - number of specialised assistance services - pharmaceutical cost <p><i>General descriptive information about providers or organisations:</i></p> <ul style="list-style-type: none"> - home visits activities - range of services provided (Service Charter) |

| |
|---|
| Question 6 |
| Have workload and job satisfaction of primary care providers been measured and reported? If yes, how and on what scale? |
| Currently, it is not monitored in a systematic manner but only through some local experiments. |
| Question 7 |
| Please present your methodological approach. In particular, please explain how are the indicators developed, what risk adjustment methods are being used (if any), how is internal variability being addressed, etc. |
| It was negotiated at the regional level, a regional standard contract (CdE), with the related goals. Later, at the local health unit level, are negotiated indicators and threshold value, related to the incentive of GPs adhering to an associative form. |
| Question 8 |
| Which procedures are in place to promote the validity, reliability and relevance of the assessment? |
| Under construction |
| Question 9 |
| To what degree is performance assessment embedded in the policy process? |
| It is incorporated in support of regional planning |
| Question 10 |
| What is the evidence that the assessment has impacted on policy? |
| The policy has inserted into Regional Law No 19/2016 (<i>reorganization of the regional health system</i>), specific objectives of adhesion of the GPs to the most advanced association forms (Medicine di Gruppo Integrate): 60% by 31/12/2017 and 80% by 12/31/2018. In the Law, it was also arranged that the mayors of the municipalities have an active role in the planning and implementation of the "Medicine di Gruppo Integrate". |
| Question 11 |
| Please summarise (briefly) the major limitations and main strengths of assessments of primary care performance in your country. |
| <p>Limitations:</p> <ul style="list-style-type: none"> - System under construction - difficulty of dialogue and concertation with the Trade Unions organization of General Medicine - difficult to accept the assessment as a tool for improvement <p>Strengths:</p> <ul style="list-style-type: none"> - Audit to improve the organization, sharing and discussion among different Professionals and critical-event management. |
| Question 12 |
| What are the future plans with regard to primary care assessment? |
| Improve the monitoring system, currently under construction, and make it routine. |

LATVIA

Question 1

Are there any recurrent or one-off assessments carried out of the performance of (parts of) the organisation and/or functioning of primary care in your country?

Yes.

Question 2

Please provide a brief description of these assessments (name and type of product)

1. Primary care assessment carried out on February, 2014. Based on the assessment the Primary Health Care Development Plan 2014-2016 was developed. Primary Health Care Development Plan is a short-term policy document, which was developed on certain criteria. The assessments made within the plan were: evaluation of waiting times to meet with GP (accessibility); evaluation of high hospitalisation rates (quality of health services in primary care); evaluation of low vaccination rates (organizational aspects); assessing potential solutions for increase of satisfaction rates with GPs (organizational aspects).
2. Primary health care assessment carried out in 2015-2016 as a part of an assessment of the health system in general. Primary health care assessment was carried out in 2015-2016 as a part of an assessment of the health system in general and was done by World Bank to assist the Ministry of Health and National Health Service (NHS) of Latvia in the development of a comprehensive national health strategy to address priority disease areas (cardiovascular disease, cancer, maternal and perinatal health, and mental health) and manage key health system challenges. Based on this assessment the health care system reform plan is elaborated.
3. Annual GPs' performance assessment. Based on that the annual GP's performance payment is calculated and payed. Annual GP's performance payment is a part of the GP's revenue (applies only to GP's providing state financed health care services).

Question 3

For each assessment, please specify:

3.1. Is the report – or part of it – done because of legal requirements? If not, what is the main reason to carry it out?

1. The Primary Health Care Development Plan (in accordance with the legislation an *ex-ante* assessment is an integral part of the policy planning document) was created based on the Cabinet of Ministers Order No. 504, which approved the guidelines of the Public Health for 2011 to 2017 (hereafter – guidelines) and which aimed to extend the Latvian population life expectancy. To achieve this, the guidelines defined sub-goal – to ensure quality health care services and equal access to them for all citizens.
2. See the Question 2.
3. The annual GPs' performance assessment is done in accordance with the legal requirements (Regulations of the Cabinet of Ministers) on the financing of family doctors.

3.2. When did it take place?

| | |
|--|-------------------|
| 1. The assessment was carried out on February, 2014. The 2010 - 2013 year data were analysed. Primary health care assessment as a part of an assessment of the health system in general was carried out in 2015-2016. since 2013. | 2. 3. Annually |
| 3.3. Which organisation commissioned the assessment? | |
| 1. Ministry of Health. 2. Ministry of Health, National Health Service. 3. National Health Service | |
| 3.4. Which organisation carried it out? | |
| 1. Ministry of Health, National Health Service, Health Inspectorate, Disease Prevention and Control Centre. 2. World Bank 3. National Health Service | |
| 3.5. What other stakeholders were involved and how? | |
| 1. In the assessment process, multiple NGOs and professional organisations were involved (for example, Latvian Nurse Association, Latvian General Practitioners Association, etc.), to give insights and proposals on the primary health care system and its improvement possibilities. 2. NGOs - focus group discussions. 3. In the development of the primary health care assessment indicators GP's professional organisations were involved (as members. | |
| 3.6. Which types of primary care were parts of the assessment? | |
| 1. Assessments were made in following parts of primary care: - General practice / family practice; - Midwifery; - Pharmacy; - Dentistry. 2. General practice / family practice, Paediatrics. 3. General practice / family practice. | |
| 3.7. Which is the level of reporting? | |
| 1., 2., 3. National level. | |
| 3.8. What is the focus of the assessment? | |
| Primary care in general. | |
| 3.9. What is the function of the assessment? | |
| 1., 2. General reporting. 3. Performance-based reimbursement schemes | |

| |
|---|
| 3.10. To which target population is the assessment primarily addressed? |
| Policy makers. |
| 3.11. How is performance information fed back to primary care providers? |
| 1.,2., 3.No. |
| 3.12. Has the assessment been presented in a publicly accessible document or website? |
| <p>Yes. 1. The information and results regarding carried out assessment was published in national policy planning database (http://polsis.mk.gov.lv/documents/4735) and in Ministries of Health official website (www.vm.gov.lv). 2.</p> <p>The analytical products developed by the World Bank on Latvian health system assessment are publicly accessible on NHS website http://www.vmnvd.gov.lv/lv/esf-projekts/zinojumi.</p> <p>3. No.</p> |
| Question 4 |
| At what level of aggregation are the data published? |
| 1.,2. The data were published at national level (see question 3.12.) |
| Question 5 |
| What types of indicators are reported in the assessment? |
| <p>1.,2.In the assessment process, various indicators were used, for example:</p> <p>1.1.General descriptive information about providers or organisations, e.g.:</p> <ul style="list-style-type: none"> - the amount of carried out check-ups for different age groups; - the average number of patients served per day at a GPs practise; -number of patients who have had a dental check up in a given year; <p>1.2.Any outcomes indicators that may be related with primary care performance in general (sometimes both access and quality), e.g.:</p> <ul style="list-style-type: none"> - hospitalization rates (for ambulatory care with sensitive conditions); <p>1.3.Indicators measuring patient-centeredness or responsiveness, e.g.:</p> <ul style="list-style-type: none"> - satisfaction rates with GPs; <p>1.4. Indicators measuring clinical performance, e.g.</p> <ul style="list-style-type: none"> - immunization rates (for various diseases); -number of patients who have been advised/consulted by GP or nurse to change their unhealthy habits; - etc. <p>1.5. Indicators measuring access:</p> <ul style="list-style-type: none"> -supply of providers. <p>Data sources: patient surveys and National Health Service payment database.</p> <p>3.Indicators (areas) measured in the framework of the annual GP's performance assessment: health check-up of the newly registered patients, health</p> |

check-up of the patients 18 years of age and older, children's immunisation coverage, health check-up for children from 2 years old to 18 years of age, mammography and cervical cancer screening, percentage of the patients registered within GP who have had an occult blood test, glycohaemoglobin measurement for patients with type 2 diabetes, microalbuminuria quantitative determination for patients with type 2 diabetes, cardiovascular risk evaluation, Determination of LDL cholesterol, expiratory peak flow in asthma patients; number of Emergency medical service team's visits to GP's patients.

Question 6

Have workload and job satisfaction of primary care providers been measured and reported?

If yes, how and on what scale?

The patients' satisfaction with GPs as well waiting time were measured using the prevalence survey.

Question 7

Please present your methodological approach. In particular, please explain how are the indicators developed, what risk adjustment methods are being used (if any), how is internal variability being addressed, etc.

To develop the indicators used in the assessment, scientific literature (in form of various researches) was used, which gave understanding of the need to develop specific indicators for better data acquisition.

Question 8

Which procedures are in place to promote the validity, reliability and relevance of the assessment?

Using national data bases in health care and peer reviews.

Question 9

To what degree is performance assessment embedded in the policy process?

1., 2. By reporting to the Cabinet of Ministers.

Question 10

What is the evidence that the assessment has impacted on policy?

- 1) The post-graduation training programme on team work (GP + nurse/physician assistant) for GPs practices were developed and realised.
- 2) The right of the pharmacies to provide certain health self-supporting services for patients (detection of the cholesterol and triglyceride levels in blood, detection of glucose levels in blood with a blood glucose monitor, measurement of the pulse frequency and arterial blood pressure, and determination of the body mass index) as well as requirements that must be fulfilled to provide these services determined in national legislation.
- 3) The information system was introduced where State Emergency Medical Service (SEMS) informs the GP if the emergency medical team has visited the GP's patient and the person was not hospitalised. In such cases no later than the next day after the information from SMES was received GP is obliged to contact the named person to agree on the future health care of the patient.

| |
|--|
| Please summarise (briefly) the major limitations and main strengths of assessments of primary care performance in your country. |
| Limitations: insufficient resources Strengths: in accordance with the OECD Latvia has high quality of the health information infrastructure however it is not fully used. |
| Question 12 What are the future plans with regard to primary care assessment? |
| Future plans regarding health system performance assessment are related to the changes in organisations of the process around the assessment. |

LITHUANIA

Question 1

Are there any recurrent or one-off assessments carried out of the performance of (parts of) the organisation and/or functioning of primary care in your country?

Health Information Centre of Institute of Hygiene is responsible for Health statistics and collects data on main health care indicators. Health Information Centre of Institute of Hygiene produces statistical yearbooks, data on internet (<http://www.hi.lt>), and data on Health statistics data portal (<http://stat.hi.lt>). But Institute of Hygiene is not doing assessments of functioning of primary care. Also, Lithuania carries out periodic measurement of performance indicators achieved by primary healthcare institutions as well as changes of those achievements. The dynamics of the number of provided incentive services is evaluated on regular basis also. Summarized assessment results are published on the webpages of the National Health Insurance Fund (NHIF) as well as in periodic publications of the NHIF:

<http://www.vlk.lt/veikla/veiklos-sritys/sveikatos-prieziuros-paslaugos/pirmines-ambulatorines-asmens-sveikatos-prieziuros-paslaugos/Documents/0506%20PAASP%202015%20interneto%20svetainei.pdf>

Question 2

Please provide a brief description of these assessments (name and type of product)

Publication "Health of Lithuanian population and activities of health care institutions" (in Lithuanian, <http://www.hi.lt/lt/lietuvos-gyventoju-sveikata-ir-sveikatos-prieziuros-istaigu-veikla-2013-m.html>): the number of primary health care institutions, family physicians, visits by municipalities and by specialities.

Publication "Health Statistics of Lithuania" (in English and Lithuanian <http://www.hi.lt/lt/lietuvos-sveikatos-statistika-health-statistics-of-lithuania.html>): the number of primary health care institutions, family physicians, visits.

Health statistics data portal (in Lithuania for a while, online): data on visits by speciality, institutions, municipality; morbidity by primary care institutions, admissions by primary care institutions.

Lithuanian Health Indicators Presentation System (English version, online http://sic.hi.lt/html/en/dl_dpsen.htm): all data by municipalities: number of family physicians, avoidable admissions, participation in screening programmes.

The reimbursement system for the primary healthcare in Lithuania is mixed: the capitation fee accounts 73.45% of the total funding for the primary healthcare. The remaining part consists of the fee for service payment for incentive services, P4P payment for good activity results as well as additional capitation fee for those living in the rural regions as well for patients listed to the family doctor.

In order to achieve better performance results and intensify the provision of high quality services the extra payment (P4P) for achieved good activity/performance results was introduced in 2008.

The performance indicators used for payment for primary care:

Population care coverage (the aim of Care coverage indicators is to promote people visiting their family doctor at least once per year. The NHIF calculates the share of population who visited their family practitioner at least once per year from the total number of listed population in different age groups):

1. Children care coverage – the aim of such incentive is to encourage children's health care and to promote that a child shall visit his family doctor at least once per year
2. Adult care coverage – the aim of such incentive is to encourage adults' health care and to promote that each adult person shall visit his family doctor at least once per year

Performance of cancer screening programmes (Performance indicators of cancer screening programmes assess intensiveness of cancer screening. We measure the number of people who were invited and who participated in the screening programmes from the total target population)

3. Cervical cancer screening programme
4. Prostate cancer early detection programme
5. Breast cancer screening programme
6. Colorectal cancer screening programme

Intensity of prophylactic examinations

7. Intensity of children prophylactic examinations – the aim is to ensure that all children could undergo prophylactic check-ups performed by their family doctors in order to detect the possible diseases as soon as possible.

Mental health care good performance indicator

8. Hospitalization of patients with schizophrenia – the aim is to improve the out-patient care of the patients suffering from schizophrenia

Dental health care good performance indicator

12. Intensity of children dental care examinations – the aim is to promote intensity of children dental screening.

The separate payment (FFS) for incentive services was introduced in 2003. The aim:

- to encourage family doctors to intensify the provision of the services and to carry out preventive activities,
- to achieve the higher quality level of PHC services and improve their availability.

The number of such services has increased gradually. At the moment there are 18 groups of services/examinations (total 68 services/examinations) which are considered as the incentive services, for example:

1. blood clotting condition tests: Prothrombin activity test and INR test;
2. test to assess blood coagulation system and to determine an individual's ABO/D type for patients admitted for elective surgery;
3. vaccination of high risk patients against influenza;
4. glycated haemoglobin test for patients suffering from diabetes;
5. early diagnostic of cancer;
6. Regular care of pregnant women;
7. Provided care for children under 1 year;
8. Home care of disabled
9. Timely immunoprophylaxis of children;
10. Regular health check-ups for schoolchildren;
11. Performance of Mantoux tuberculin skin test for children at risk groups;
12. Care provided by the community at patient's home;
13. provision of care and specific tests (e.g. serological screening test for syphilis; T. pallidum haemagglutination test (if serological test was positive; HIV serological test; anti-HCV antibody tests) for patients receiving substitution treatment
14. performance of rapid antigen tests for group A streptococcus for 2-7 years children with diagnosis of upper respiratory tract infection;
15. treatment of patients suffering from TB.
16. Etc.

Question 3

For each assessment, please specify:

3.1. Is the report – or part of it – done because of legal requirements? If not, what is the main reason to carry it out?

Publications and internet data is published according to the Official statistics working programme adopted yearly by Statistics Lithuania and according to working plan of Institute of Hygiene adopted by Ministry of Health.

3.2. When did it take place?

Publications and internet data is published according to the Official statistics working programme and the release calendar approved by Director of Institute of Hygiene

| |
|---|
| 3.3. Which organisation commissioned the assessment? |
| Ministry of Health of the Republic of Lithuania and the NHIF. |
| 3.4. Which organisation carried it out? |
| NHIF and territorial health insurance funds (THIFs) |
| 3.5. What other stakeholders were involved and how? |
| PHC providers |
| 3.6. Which types of primary care were parts of the assessment? |
| Family practice, nursing, midwifery, paediatrics |
| 3.7. Which is the level of reporting? |
| Most of data is reported on municipality and national level. |
| 3.8. What is the focus of the assessment? |
| Primary care in general, care for a specific disease, primary care midwifery. |
| 3.9. What is the function of the assessment? |
| General reporting, comparative benchmark, performance-based reimbursement schemes. |
| 3.10. To which target population is the assessment primarily addressed? |
| Data are provided to the Ministry of Health and other institutions according to the demand (policy makers, healthcare managers) |
| 3.11. How is performance information fed back to primary care providers? |
| PHC provider could compare performance results with other providers |
| 3.12. Has the assessment been presented in a publicly accessible document or website? |
| All publications and data are accessible free of charge on internet site of Institute of Hygiene. Summarized assessment results are published on the webpages of the National Health Insurance Fund (NHIF) as well as in periodic publications of the NHIF. The result of the report are discussed between the PHC providers and representatives of the NHIF and THIF |
| Question 4 |
| At what level of aggregation are the data published? |
| In publications: national, regional (counties), local (municipalities). In Health statistics data portal: national, regional (counties), local (municipalities), provider level. |
| Question 5 |
| What types of indicators are reported in the assessment? |
| The reimbursement system for the primary healthcare in Lithuania is mixed: the capitation fee accounts 73.45% of the total funding for the primary healthcare. The remaining part consists of the fee for service payment for incentive services, P4P payment for good activity results as well as additional |

capitation fee for those living in the rural regions as well for patients listed to the family doctor.

In order to achieve better performance results and intensify the provision of high quality services the extra payment (P4P) for achieved good activity/performance results was introduced in 2008.

The performance indicators used for payment for primary care:

Population care coverage (the aim of Care coverage indicators is to promote people visiting their family doctor at least once per year. The NHIF calculates the share of population who visited their family practitioner at least once per year from the total number of listed population in different age groups):

1. Children care coverage – the aim of such incentive is to encourage children's health care and to promote that a child shall visit his family doctor at least once per year
2. Adult care coverage – the aim of such incentive is to encourage adults' health care and to promote that each adult person shall visit his family doctor at least once per year

Performance of cancer screening programmes (Performance indicators of cancer screening programmes assess intensiveness of cancer screening. We measure the number of people who were invited and who participated in the screening programmes from the total target population)

3. Cervical cancer screening programme
4. Prostate cancer early detection programme
5. Breast cancer screening programme
6. Colorectal cancer screening programme

Intensity of prophylactic examinations

7. Intensity of children prophylactic examinations – the aim is to ensure that all children could undergo prophylactic check-ups performed by their family doctors in order to detect the possible diseases as soon as possible.

Mental health care good performance indicator

8. Hospitalization of patients with schizophrenia – the aim is to improve the out-patient care of the patients suffering from schizophrenia

Hospitalization of patients with chronic diseases – the aim is to improve the out-patient care of the patients suffering from chronic diseases and reduce unnecessary hospital admissions

9. Hospitalization of patient with arterial hypertension
10. Hospitalization of patient with diabetes
11. Hospitalization of patient with asthma

Dental health care good performance indicator

12. Intensity of children dental care examinations – the aim is to promote intensity of children dental screening.

The separate payment (FFS) for incentive services was introduced in 2003. The aim:

- to encourage family doctors to intensify the provision of the services and to carry out preventive activities,
- to achieve the higher quality level of PHC services and improve their availability.

The number of such services has increased gradually. At the moment there are 18 groups of services/examinations (total 68 services/examinations)

which are considered as the incentive services, for example:

1. blood clotting condition tests: Prothrombin activity test and INR test;
2. test to assess blood coagulation system and to determine an individual's ABO/D type for patients admitted for elective surgery;
3. vaccination of high risk patients against influenza;
4. glycated haemoglobin test for patients suffering from diabetes;
5. early diagnostic of cancer;
6. regular care of pregnant women;
7. provided care for children under 1 year;
8. home care of disabled
9. Timely immunoprophylaxis of children;
10. Regular health check-ups for schoolchildren;
11. Performance of Mantoux tuberculin skin test for children at risk groups;
12. Care provided by the community at patient's home;
13. provision of care and specific tests (e.g. serological screening test for syphilis; T. pallidum haemagglutination test (if serological test was positive; HIV serological test; anti-HCV antibody tests) for patients receiving substitution treatment
14. performance of rapid antigen tests for group A streptococcus for 2-7 years children with diagnosis of upper respiratory tract infection;
15. treatment of patients suffering from TB.
16. Etc.

Question 6

Have workload and job satisfaction of primary care providers been measured and reported?
If yes, how and on what scale?

Question 7

Please present your methodological approach. In particular, please explain how are the indicators developed, what risk adjustment methods are being used (if any), how is internal variability being addressed, etc.

The international practice and proposals of professional organisations are taken into account when new indicators or incentive services are introduced. The PHC providers receive additional payment depending from their performance achievements. The PHC providers' performance results are evaluated in points according to each indicator. Each indicator has its own grading scale (the number of points PHC provider receives for its achievements):

Question 8

Which procedures are in place to promote the validity, reliability and relevance of the assessment?

Question 9

| |
|--|
| To what degree is performance assessment embedded in the policy process? |
| <p>The assessment of the performance results and extra payment for achievements was introduced in order to intensify the provision of high quality services as well as to encourage PHC providers to improve the out-patient care of the patients suffering from chronic diseases and reduce unnecessary hospital admissions.</p> <p>The main strength of such assessment is possibility to compare results between different providers and promote them to seek better achievements</p> |
| Question 10 |
| What is the evidence that the assessment has impacted on policy? |
| <p>The assessment of the performance results and extra payment for achievements was introduced in order to intensify the provision of high quality services as well as to encourage PHC providers to improve the out-patient care of the patients suffering from chronic diseases and reduce unnecessary hospital admissions.</p> <p>The main strength of such assessment is possibility to compare results between different providers and promote them to seek better achievements</p> |
| Question 11 |
| Please summarise (briefly) the major limitations and main strengths of assessments of primary care performance in your country. |
| <p>The assessment of the performance results and extra payment for achievements was introduced in order to intensify the provision of high quality services as well as to encourage PHC providers to improve the out-patient care of the patients suffering from chronic diseases and reduce unnecessary hospital admissions.</p> <p>The main strength of such assessment is possibility to compare results between different providers and promote them to seek better achievements</p> |
| Question 12 |
| What are the future plans with regard to primary care assessment? |
| <p>„In this year in the Ministry of Healthcare of Lithuania will be started the project „To Develop Key Performance Indicators System for Health Care Institutions Network“, which will be supported by Lithuanian Governance Institutions and European Social Fund Agency.</p> <p>The implementation of this project and the development of basic health care institutions performance (services) indicators system will enable an objective data based personal health care performance measurement and relevant provisions for this performance improvement. Based on the outcomes of indicators system, we will seek to improve health care institutions performance, policy development and its implementation and contribute to the improvement of health care services quality, accessibility and acceptability.”</p> |

QUESTION 7 - addendum

The international practice and proposals of professional organisations are taken into account when new indicators or incentive services are introduced. The PHC providers receive additional payment depending from their performance achievements. The PHC providers' performance results are evaluated in points according to each indicator. Each indicator has its own grading scale (the number of points PHC provider receives for its achievements):

| | Indicator | Numerator | Denominator | Results |
|------|--|--|---|--|
| 1 | Population care coverage | | | |
| 1.1. | Children care coverage ¹ | No of children (under 18) who visited PHC institution at least once per year | Total number of children registered with PHC institution | 95% and more – 5 points From 95% to 85% - 4 points From 85% to 70% - 2 points 70% and less – 0 points |
| 1.2. | Adult care coverage ² | No of adults who visited PHC institution at least once per year | Total number of adults registered with PHC institution | 65% and more – 5 points From 65% to 50% - 4 points From 50% to 45% - 2 points 70% and less – 0 points |
| 1.3. | Children health check-ups | No of children (under 18) who visited family doctor or paediatrician for health check-up | Total number of children (under 18) registered with PHC institution | 85% and more – 3 points From 85% to 70% - 2 points From 70% to 60% - 1 points 60% and less – 0 points |
| 1.4. | Intensity of children dental care examinations | Number of children (under 18) in whom prophylactic dental screening was performed at least once per year | Total number of registered children | 85% and more – 3 points From 85% to 50% - 2 points From 50% to 30% - 1 points 30% and less – 0 points |
| 2. | Performance of cancer screening programmes | | | |
| 2.1. | Cervical cancer prevention program | No of women aged 25-60 who received Pap smear taking and test results evaluation services once per 3 years | Total no of women aged 25-60 registered with PHC institution | 50% and more – 3 points From 50% to 30% - 2 points From 30% to 15% - 1 points 15% and less – 0 points |
| 2.2. | Prostate cancer prevention program | No of men aged 50 (or 45 for men at high risk)–69 who were given information on the program and received prostate specific antigen test once per 2 years | Total no of men within the age group, specified in the program, registered with PHC institution | 35% and more – 3 points From 35% to 25% - 2 points From 25% to 15% - 1 points 15% and less – 0 points |
| 2.3. | Mammographic | No of women aged 50-69 who were | Total no women aged 50-69 | 70% and more – 3 points |

¹ The indicator does not include visits related with mental health care, dental care and dental sealant services.

² The indicator does not include visits related with mental health care and dental care.

| | | | | |
|-----------|--|---|--|--|
| | screening program | given information on the program and were referred for mammography once per 2 years | registered with PHC institution | From 70% to 50% - 2 points From 50% to 30% - 1 points 30% and less – 0 points |
| 2.4. | Colorectal cancer screening program | No of patients aged 50-74 who were given information on the program and received faecal immunochemical test results evaluation service once per 2 years | Total no of patients aged 50-74 registered with PHC institution | 45% and more – 3 points From 45% to 30% - 2 points From 30% to 20% - 1 points 20% and less – 0 points |
| 3. | Hospitalization of patients with chronic diseases | | | |
| 3.1. | Hospitalization of patients with arterial hypertension | Number of hospitalizations due to arterial hypertension per year | Total number of registered patients having arterial hypertension | 1,39% and less – 3 points From 1,4% to 1,69% – 2 points From 1,7% to 2,19% - 1 point 2,2% and more – 0 points |
| 3.2. | Hospitalization of patients with diabetes | Number of hospitalizations due to diabetes per year | Total number of registered patients having diabetes | 1,49% and less – 3 points From 1,5% to 3,99% – 2 points From 4,0% to 7,99% - 1 point 8,0% and more – 0 points |
| 3.3. | Hospitalization of patients with asthma | Number of hospitalizations due to asthma per year | Total number of registered patients having asthma | 1,49% and less – 3 points From 1,5% to 3,99% – 2 points From 4,0% to 7,99% - 1 point 8,0% and more – 0 points |
| 3.4. | Hospitalization of patients with schizophrenia | Number of patients hospitalized at least once per year due to schizophrenia | Total number of registered patients having schizophrenia | 30% and less – 3 points From 31% to 40% – 2 points From 41% to 50% - 1 point 51% and more – 0 points |

The total amount of points for every PCH institution is calculated as follows: the number of point according to every indicator is summarized and then multiplied from the average annual number of listed population. After that, this amount is multiplied from the 1 point value in Eur.

LUXEMBOURG

| |
|--|
| Question 1 |
| Are there any recurrent or one-off assessments carried out of the performance of (parts of) the organisation and/or functioning of primary care in your country? |
| One-off assessment |
| Question 2 |
| Please provide a brief description of these assessments (name and type of product) |
| Patient experience survey on ambulatory care done in 2011 (no recurrence to date) |
| Question 3 |
| For each assessment, please specify: |
| 3.1. Is the report – or part of it – done because of legal requirements? If not, what is the main reason to carry it out? |
| No legal requirement - Main reason: objectivise the quality of the patient experience in primary care |
| 3.2. When did it take place? |
| 2011 |
| 3.3. Which organisation commissioned the assessment? |
| Ministry of Health |
| 3.4. Which organisation carried it out? |
| Service provider (professional surveys) |
| 3.5. What other stakeholders were involved and how? |
| none |
| 3.6. Which types of primary care were parts of the assessment? |
| GP, medical specialists having a practice (outside of hospital) |
| 3.7. Which is the level of reporting? |
| national |
| 3.8. What is the focus of the assessment? |
| patient experience in primary care |
| 3.9. What is the function of the assessment? |
| general reporting and comparative benchmark with other countries (use of the OECD questionnaire) |
| 3.10. To which target population is the assessment primarily addressed? |

| |
|---|
| clinicians |
| 3.11. How is performance information fed back to primary care providers? |
| no |
| 3.12. Has the assessment been presented in a publicly accessible document or website? |
| yes - media, ministerial website |
| Question 4 At what level of aggregation are the data published? |
| national |
| Question 5 What types of indicators are reported in the assessment? |
| access, patient-centeredness, equity |
| Question 6 Have workload and job satisfaction of primary care providers been measured and reported? If yes, how and on what scale? |
| no |
| Question 7 Please present your methodological approach. In particular, please explain how are the indicators developed, what risk adjustment methods are being used (if any), how is internal variability being addressed, etc. |
| use of an existing questionnaire (validated), translation in national language |
| Question 8 Which procedures are in place to promote the validity, reliability and relevance of the assessment? |
| none on the national level |
| Question 9 To what degree is performance assessment embedded in the policy process? |
| no performance assessment embedded in the policy process |
| Question 10 What is the evidence that the assessment has impacted on policy? |
| no evidence (results were considered good) |
| Question 11 Please summarise (briefly) the major limitations and main strengths of assessments of primary care performance in your country. |

| |
|---|
| no systematic assessment based on robust indicators |
| Question 12 |
| What are the future plans with regard to primary care assessment? |
| no plans currently |

MALTA

Question 1

Are there any recurrent or one-off assessments carried out of the performance of (parts of) the organisation and/or functioning of primary care in your country?

1.1 Training Assessments for nursing staff in Primary Health Care.

1.2 With regards to the Shared Care Programme in Diabetes, a clinical audit is carried out every two years.

1.3 Performance audit done by NAO, determining the cost of the General Practitioner (GP) function within the health centres across Malta and Gozo.

1.4 Within the 3-year Specialist Training Programme in Family Medicine (STPFM), GP trainees undergo Work-Based Assessment (WBA).

1.5 Mystery Shopping Exercise in the Community Care adopted in 2016.

1.6 A Costings exercise was carried out analysing the various services provided and delivered from Paola Health Centre to derive the average cost per patient per service.

1.7 Infection Prevention and Control Audits.

Question 2

Please provide a brief description of these assessments (name and type of product)

2.1 Venepuncture practical and theoretical assessments for new nursing staff on a yearly basis and Training Needs Analysis (TNA) for nurses in January 2016.

2.2 We look at parameters such as HbA1c, the number of patients on insulin, cholesterol levels and co-morbidities. We also follow outcomes and performance in general from different health centres. Hospital admissions are also recorded.

2.3 The costing exercise analysed the GP service provided by all health centres as well as peripheral clinics in Malta and Gozo. A case study approach on a limited period of time of 2014, to determine the average unit cost of the services by GPs.

2.4 GP Trainees' WBA comprises of video consultations, case-based discussions, trainee reviews (by GP trainer, hospital supervisors, colleagues, patients), clinical experiences records (case logs, reflective diary).

2.5 A patient -observer approach was adopted where the observer could investigate in detail the shortcomings and the ongoing process in health centres from the patients' perspective. The observations were done objectively, so that the data collected reflects the actual service experienced by the mystery shoppers. Where shortcomings were found, recommendations were identified and forwarded to the Primary Care Management in order to rectify any shortcomings.

2.6 The scope of the exercise was to derive the average cost per patient for each service being provided and delivered at Paola Health Centre. The calculation of the average cost was based on payroll costs, recurrent expenditure (both direct and indirect), and the cost of pharmaceuticals and medicines procured from Central Procurement and Supplies Unit. The determination of the average unit cost of each clinic takes into consideration the combined deployment of GPs, nurses, consultants or allied health professionals as required in the running of each specific clinic.

2.7 Full scale infection prevention and control audits done biannually in all health centres.

Question 3

| |
|--|
| For each assessment, please specify: |
| 3.1. Is the report – or part of it – done because of legal requirements? If not, what is the main reason to carry it out? |
| <p>3.1.1 Venepuncture theoretical and practical assessments are carried out to ensure competence. TNA carried out to ascertain and meet training needs and plan training initiatives.</p> <p>3.1.2 The audit is carried out as part of the agreed protocol between primary care and secondary care. The clinical audit is the method used to assess the performance of the clinics with regards to patient's clinical safety and GP performance in general.</p> <p>3.1.3 The report was not done for legal requirements. The main reason for the audit was to determine the cost and efficiency of the GP service in the Public sector.</p> <p>3.1.4 GP Trainees' WBA is required by the STPFM.</p> <p>3.1.5 The report was not done for legal requirements. The main reason for the audit was to determine any shortcomings in the service provided by the Primary Care Department.</p> <p>3.1.6 This assessment was an internal exercise carried out by PHCD to have the average cost of the services being provided using Paola Health Centre as an indicative health centre operating on a 24 x 7 basis.</p> <p>3.1.7 The audits are not legally required; however, these are done in view of the department's obligations to ensure provision of quality care and patient safety.</p> |
| 3.2. When did it take place? |
| <p>3.2.1 Venepuncture yearly basis and January 2016.</p> <p>3.2.2 2015.</p> <p>3.2.3 Audit done in 2016 - data determined from GP statistics and costings of 2014.</p> <p>3.2.4 GP Trainees' WBA takes place on an ongoing basis through the 3-year training programme.</p> <p>3.2.5 Audit done in 2016 and early 2017.</p> <p>3.2.6 Exercise was carried out during 2016 using recurrent expenditure and salaries for the financial year ending 2015 and extrapolating patient contact volumes based on March 2016 statistics.</p> <p>3.2.7 During the first half of 2016.</p> |
| 3.3. Which organisation commissioned the assessment? |
| <p>3.3.1 Both Venepuncture assessments and TNA are organised by the Practice Development Unit of the Primary Health Care Department.</p> <p>3.3.2 In house clinical audit.</p> <p>3.3.3 Primary Health Care Department.</p> <p>3.3.4 GP Trainees' WBA is required by the STPFM drawn up by the Malta College of Family Doctors (MCFD) and approved by Malta's Specialist Accreditation Committee (SAC).</p> <p>3.3.5 Primary Health Care Department.</p> <p>3.3.6 Primary Health Care Department.</p> <p>3.3.7 Primary Healthcare Department Infection Prevention and Control Unit and Senior Administration.</p> |

| |
|--|
| 3.4. Which organisation carried it out? |
| <p>3.4.1 Practice Development Unit of the Primary Health Care Department.</p> <p>3.4.2 Primary Health Care Department.</p> <p>3.4.3 NAO (National Audit Office).</p> <p>3.4.4 GP Trainees' WBA is organised by the Postgraduate Training Coordinators in Family Medicine on behalf of the Primary Health Care Department.</p> <p>3.4.5 Grant Thornton.</p> <p>3.4.6 The exercise was compiled internally by the Finance Section of PHCD.</p> <p>3.4.7 Infection Prevention and Control Unit.</p> |
| 3.5. What other stakeholders were involved and how? |
| <p>3.5.1 Nursing Staff within the Primary Health Care Department.</p> <p>3.5.2 None.</p> <p>3.5.3 Primary Health Care Department stakeholders assisted NAO throughout the audit by providing statistical and financial data.</p> <p>3.5.4 The MCFD is the stakeholder in the STPFM responsible for the drafting of the training programme and for the final exit examination (of which the WBA is an integral part).</p> <p>3.5.5 None.</p> <p>3.5.6 Stakeholders involved included Paola Health Centre, Senior management including GP, Nursing and Allied Health, and the Finance Section.</p> <p>3.5.7 Practice Nurse - Infection Prevention and Control Nurse performed the audits. Area and senior management - handed over report and discussed issues involved.</p> |
| 3.6. Which types of primary care were parts of the assessment? |
| <p>3.6.1 Nursing.</p> <p>3.6.2 Diabetes clinics in Primary Care.</p> <p>3.6.3 General practice.</p> <p>3.6.4 General / family practice is assessed in GP trainees' WBA.</p> <p>3.6.5 All the services that fall under the remit of the Primary Health Care Department.</p> <p>3.6.6 All clinics operating at Paola Health Centre, namely ECG, Diabetes, Review, GP, Walk-in, Prescription, ACC-POC, Wound, Renal, Treatment, MCC, Cervical and Gynae, Ophthalmic, Orthopaedic, Well Baby, Bloodletting, Physiotherapy, Podiatry, X-ray walk in, Speech Language Pathology, Immunisation, Home visits and District Clinics.</p> <p>3.6.7 All healthcare areas and services provided were audited.</p> |
| 3.7. Which is the level of reporting? |
| <p>3.7.1 Departmental.</p> <p>3.7.2 Internal perusal.</p> <p>3.7.3 National.</p> <p>3.7.4 GP trainees' WBA is carried out at a national level with Malta's STPFM.</p> |

| |
|--|
| 3.7.5 National. |
| 3.7.6 Departmental. |
| 3.7.7 All reporting was done at intra-departmental level. |
| 3.8. What is the focus of the assessment? |
| 3.8.1 Training. |
| 3.8.2 Care of patients with Diabetes in Primary Care. |
| 3.8.3 Efficiency and cost of the GP Service in the public Primary Care. |
| 3.8.4 GP Trainees' WBA focuses on general / family practice. |
| 3.8.5 The patients' perspective regarding the services delivered by the Primary Health Care Department. |
| 3.8.6 The focus is the costing of the various services being delivered by GP, nurses, consultants and allied health professionals at Primary Health Care. |
| 3.8.7 The main focus was to ensure that the department provides a safe environment and safe patient care to all patients. |
| 3.9. What is the function of the assessment? |
| 3.9.1 Competence and Training plans. |
| 3.9.2 General reporting. |
| 3.9.3 Performance and costing exercise. |
| 3.9.4 WBA is a mandatory component of GP trainees' assessment during specialist training. |
| 3.9.5 General reporting by patients on the PHCD services. |
| 3.9.6 The function of the assessment is for general reporting serving as a benchmark to compare average costs between service providers. |
| 3.9.7 The function of the audit is to identify problem areas in infection prevention and control which may pose a risk for patient safety and issuing of recommendation to resolve the situation. It also specifies a target date for re-audit to ensure that compliance with recommendations has been achieved. |
| 3.10. To which target population is the assessment primarily addressed? |
| 3.10.1 Nurses. |
| 3.10.2 Health Care Managers. |
| 3.10.3 Health Care Managers. |
| 3.10.4 WBA in the STPFM addresses GP trainees. |
| 3.10.5 Health Care Managers. |
| 3.10.6 The assessment was targeted for PHCD Management. |
| 3.10.7 Clinicians, Area and Senior Management. |
| 3.11. How is performance information fed back to primary care providers? |

- 3.11.1 Feedback to the providers.
- 3.11.2 There is only one Primary Care provider and we compare our results to those of other countries with similar populations and having the same shared care diabetes programmes.
- 3.11.3 The expense of the GP service in the Public sector was compared with that in the Private sector.
- 3.11.4 Performance information gathered by WBA within the STPFM is logged in the GP trainees' ePortfolios.
- 3.11.5 Feedback from the mystery shoppers is given to the PHCD Management.
- 3.11.6 Information was distributed and discussed by management during management meetings.
- 3.11.7 An audit report is done and emailed to the area and senior management, highlighting problem areas and for which recommendations are highlighted to resolve every issue. Dates for a re-audit to ascertain compliance with recommendations are also specified.

3.12. Has the assessment been presented in a publicly accessible document or website?

- 3.12.1 No.
- 3.12.2 No.
- 3.12.3 Yes, the assessment has been presented in a document and published on NAO website.
- 3.12.4 No.
- 3.12.5 No.
- 3.12.6 No.
- 3.12.7 No.

Question 4

At what level of aggregation are the data published?

- 4.1 Departmental level.
- 4.2 Departmental level.
- 4.3 National level.
- 4.4 Within the Training Programme.
- 4.5 Departmental level.
- 4.6 Data has been compiled and presented by the Finance Section within Primary Health Care.
- 4.7 Provider and practice level.

Question 5

What types of indicators are reported in the assessment?

- 5.1 Indicators measuring access (TNA) and general descriptive indicators (competency venepuncture skills).
- 5.2 Indicators measuring clinical performance.
- 5.3 Indicators measuring costs and efficiency of the GP service in the Public sector.
- 5.4 Indicators used by GP trainee WBA reports are video consultations, case-based discussions, trainee reviews and clinical experiences
- 5.5 Indicators measuring access (waiting times and other barriers) and Indicators measuring patient centeredness or responsiveness.
- 5.6 The indicators measure the cost and efficiency of each service by deriving the average cost per patient for each clinic.
- 5.7 Quality indicators.

Question 6

Have workload and job satisfaction of primary care providers been measured and reported?
If yes, how and on what scale?

- 6.1 No.
- 6.2 No.
- 6.3 Workload of the GPs was measured through statistical data collected in a period of time in 2014. Job satisfaction was not the aim of the audit.
- 6.4 GP trainees are required to complete evaluation forms after each clinical placement in family and hospital practice.
- 6.5 No.
- 6.6 The workload was assessed.
- 6.7 No.

Question 7

Please present your methodological approach. In particular, please explain how are the indicators developed, what risk adjustment methods are being used (if any), how is internal variability being addressed, etc.

- 7.1 Theoretical assessment (MCP questionnaire with 80% pass mark) following theoretical training and practical assessment based on competency assessment tool (reflecting steps in departmental evidence-based clinical guidelines for venepuncture). Training Needs Analysis carried out via Online Survey (based on international literature and on the current Primary Health Care Department method of service delivery).
- 7.2 Clinical parameters are chosen e.g. HbA1c. A minimum of 1000 patients are followed up at random from any health centre and these are assessed for control of HbA1c levels between 6 and 6.4%.
- 7.3 The methodology employed by the NAO was to determine the unit cost of the various GP services. This was done by collecting and analysing data related to three main variables: the patient contacts, doctors hours utilised, and the cost to provide these services.
- 7.4 GP training WBA reports are specified by the STPFM drawn up by the MCFD.
- 7.5 A patient -pair approach was adopted where the observer could investigate in detail any shortcomings and the process in health centres from the patients' perspective. The observations have been done objectively, so that the data collected reflects the actual service experienced by the mystery shoppers. Where shortcomings were found, recommendations were identified and forwarded to the actual Primary Care Management to deal with the

cases concerned.

7.6 The unit cost was determined through main variables being patient contact volumes, human resources available hours, and direct and indirect expenditure related to the health centre and clinics. Patient contacts were based on actual attendances for a particular month and extrapolated over a year to derive the annual attendance for each clinic. Man minutes for the delivery of services were calculated on the actual duty hours of GP, nurse, consultant or allied health professionals. These were then extrapolated to annual man minutes according to the weekly sessions and staff complement. Man minutes were costed according to the average gross pay for each category. Direct expenditure related to the health centre was identified, while indirect expenditure for the health centre was allocated according to the activity levels of each clinic. Overall indirect payroll and expenditure throughout PHCD was allocated on the basis of the activity levels of the health centres. Average cost of vaccines and pharmaceuticals supplied by CPSU was attributed according to the health centre activity levels.

7.7 An audit is done in the area on a specific date without prior notice. An audit report is done and emailed to the area and senior management, highlighting problem areas and recommendations to resolve any issues. Dates for a re-audit to ascertain compliance with recommendations are also specified.

Question 8

Which procedures are in place to promote the validity, reliability and relevance of the assessment?

8.1 The tools used were based on international literature.

8.2 Peer reviews.

8.3 External review by the National Audit Office.

8.4 The Postgraduate Training Coordinators in Family Medicine compile a yearly quality management report based on WBA gathered during the annual appraisal process.

8.5 The study was done by an auditing firm (Grant Thornton).

8.6 Peer review.

8.7 The Infection Control Nurses Association audit tools are used 'AUDIT TOOLS FOR MONITORING INFECTION CONTROL GUIDELINES WITHIN THE COMMUNITY SETTING 2005'. Link: www.healthcareinformed.com/ufiles/5dbcd95a47c5/AuditTools2005.pdf (Accessed on 07/04/17). This enables identification of compliance level comparison between one area and another and also over a period of time.

Question 9

To what degree is performance assessment embedded in the policy process?

9.1 TNA for nurses determines the training needs and investment required in training.

9.2 By holding an inter-disciplinary meeting and noting results with the aim of improving clinical performance.

9.3 Report was brought up to the Public Accounts Committee and its recommendations are being endorsed by the PHCD.

9.4 GP trainees' WBA is a mandatory requirement for the completion of specialist training in family medicine.

9.5 Results of the analysis are being endorsed by PHCD for improvement of its services.

9.6 The outcome of the exercise was linked to the drafting of the annual financial plans for both payroll and recurrent expenditure. The average cost is

being used as an indicator for business process re-engineering of current services and expansion of new services through better utilisation of available resources.

9.7 All issues are discussed at senior management level and tackled according to priority namely, depending on the level of patient safety risk involved.

Question 10

What is the evidence that the assessment has impacted on policy?

10.1 Budget allocated to training for nurses.

10.2 Diabetes clinics in health centres have provided easy access to Diabetologists, more frequent clinic visits by GPs, reduced waiting time for new cases to be seen and reduction in co morbidities through early detection by obligatory screening for Diabetic retinopathy and micro / macro vascular disease. We also had a decrease of hospital admissions and an improvement of surgical interventions in these patients.

10.3 This exercise provided data of where the GP service can be rendered more efficient and cost effective and on expansion of chronic disease management. This has been done by the introduction of the Chronic Disease Management Clinic & Anticoagulant clinics amongst others.

10.4 For a doctor to work as a General Practitioner with the Government's Primary Health Centres, s/he must be in possession of a certificate of completion of specialist training in family medicine issued by Malta's SAC.

10.5 The exercise is being utilised to improve the services that PHCD delivers (mostly regarding communication skills courses for its employees).

10.6 The exercise is being used in decisions related to the business process re-engineering of services.

10.7 A re-audit of problem areas confirmed that these have been rectified within a short time frame. As an example, hand hygiene facilities have been upgraded in some clinics and damaged upholstery repaired or changed.

Question 11

Please summarise (briefly) the major limitations and main strengths of assessments of primary care performance in your country.

Limitations:

1. HR
2. Expertise
3. Time constraints
4. Data not always available or at least not always available in electronic format
5. Lack of proper IT software (e.g. Access Dimensions) in the financial sector of PHCD

Strengths:

1. A relatively small population to study
2. Well known population demographics
3. A robust Health Information and Research Unit
4. Well organised public Primary Care System

Question 12

What are the future plans with regard to primary care assessment?

Invest further to address the limitations outlined in the previous questions to analyse further the performance of Primary Health Care in Malta.

| |
|--|
| Indicators measuring access |
| e.g. <ul style="list-style-type: none"> - waiting times - Percentage of discharged patients with a length of stay at the Accident & Emergency Department of less than 4 hours; waiting time for outpatient clinics; waiting time for outpatient investigations; - financial barriers (e.g. out of pocket payments) - unmet need for medical care due to financial barriers (SILC) - geographical access - unmet need for medical care due to distance (SILC) - unmet needs - unmet need for medical care (SILC) |
| Indicators measuring clinical performance |
| e.g. |
| Indicators measuring patient-centeredness or responsiveness |
| e.g. |
| Indicators measuring costs, waste or efficiency |
| e.g. <ul style="list-style-type: none"> - use of emergency department for cases that could be treated in primary care - Self-referrals to A&E |
| Indicators measuring equity |
| e.g. <ul style="list-style-type: none"> - Access, quality or outcome indicators broken down by specific groups, e.g. gender, socio-economic status, education or ethnic background.-all indicators above available by gender, age, country of origin |
| Any outcomes indicators that may be related with primary care performance in general (sometimes both access and quality) |
| e.g. <ul style="list-style-type: none"> - Admissions for ambulatory care sensitive conditions (such as diabetes, COPD, etc.) - Avoidable hospital admission rates (standardised by age and sex) for asthma Avoidable hospital admission rates (standardised by age and sex) for CHF Avoidable hospital admission rates (standardised by age and sex) for COAD |

THE NETHERLANDS

Question 1

Are there any recurrent or one-off assessments carried out of the performance of (parts of) the organisation and/or functioning of primary care in your country?

1. Scan of the primary care market by the Dutch health care authority (Nederlandse Zorgautoriteit)
2. Primary care registrations by Nivel.
3. Healthcare performance indicators on national website (VZ-info), as part of wider assessment: <https://www.volksgezondheidenzorg.info/prestatie-indicatoren-voor-gezondheidszorg/overzicht-indicatoren>.
- 4: monitor voorschrijfgedrag huisartsen (monitor prescription by GPs)

Please provide a brief description of these assessments (name and type of product)

Scan of the primary care market by the Dutch health care authority (Nederlandse Zorgautoriteit - NZA): provides information about the market. Who are the healthcare providers, how many are there, how many healthcare insurers, how do they select and buy healthcare, what are their selection criteria, and the clients/patients: how often do they go to the healthcare providers,

Primary care registrations by Nivel: The NIVEL (National institute for primary care) maintains a constant monitor of primary care. Via a direct connection with the information systems of GP's the NIVEL has an up-to-date link with developments in primary care. provides information about the characteristics of the patients (age, gender, etc.), the amount of care used by patients, type of healthcare problems, quality indicators for care for chronically ill (diabetes, COPD, asthma, cardio-vascular diseases)

VZ-info: PREMS and avoidable hospitalisations (OECD indicators)

monitor voorschrijfgedrag benchmarking of regions for series of prescription indicators

Question 3

For each assessment, please specify:

3.1. Is the report – or part of it – done because of legal requirements? If not, what is the main reason to carry it out?

NIVEL: no, but paid for with public funds. It is carried out to give all interested parties an up to date overview of developments in primary care.

NZA: partly, the Nza has the public task to regulate health care, stemming from this public task they produces their reports. VZ-info: financed by Ministry of Health, no legal requirement, Monitor voorschrijfgedrag: no legal requirement

3.2. When did it take place?

- Scan of the GP-market by the Dutch Health care authority (Nederlandse Zorgautoriteit): last time was in 2012, the next one will be published in 2017. A general scan of the primary care transitions was conducted in 2016.
- Primary care registrations by Nivel: continuously. Publishing takes place on a regular basis (each year). The last time was in 2016.13:13: VZ-info: bi-annual update, new figures in 2017. monitor voorschrijfgedrag: annual report

3.3. Which organisation commissioned the assessment?

NIVEL, VZ-info, monitor voorschrijfgedrag: ministry of health.
NZA: public task given by ministry of health

3.4. Which organisation carried it out?

Nivel, Nza, RIVM, National institute for public health and the environment (VZ-info), IVM, Dutch Institute for Rational Use of Medicine (Monitor)

3.5. What other stakeholders were involved and how?

NIVEL: direct connection with GP information systems and increasingly including more professionals into their monitor. Professional organisations involved in governance commissions.
NZA: their monitors are produced using data from the professionals, but also research institutes and data institutes like the Statistics Netherlands, from the specific field within primary care the monitor is about VZ-info: experts are consulted occasionally. Monitor voorschrijfgedrag: not mentioned in report, I will ask

3.6. Which types of primary care were parts of the assessment?

NIVEL and NZA: Individual GP practices, out-of-office GP's care centres, primary mental care, pharmacists, physiotherapists, speech therapists, dieticians.
VZ-info: mainly general practice, monitor voorschrijfgedrag: general practice, pharmacists

3.7. Which is the level of reporting?

NZA, Nivel, monitor voorsch.: national and regional. VZ-info: national

3.8. What is the focus of the assessment?

NIVEL: primary care in general (number of professionals, number of treatments, number of subscriptions, etc.).
NZA: specific sector within primary care, VZ-info: overall assessment and monitoring, Monitor voorsch.: specifically prescription in primary care

3.9. What is the function of the assessment?

NIVEL: constant up to date information for everybody interested (e.g. Policy makers).
NZA: creating overview over specific sector in order to be able to regulate those sectors, VZ-info: general reporting and agenda setting, Monitor voorschrijfgedrag: monitoring, promoting quality of prescribing by feeding results back to the prescriber. The last one has been used by insurers in negotiations with providers, but this was not the purpose of IVM.

3.10. To which target population is the assessment primarily addressed?

| |
|--|
| NIVEL: policy makers, but also specific organizations within primary care, researchers NZA: policy makers and regulators VZ-info: professionals and policy makers, Monitor voorschrijfgedrag: general practitioners ; VZ-info: policy makers, professionals and everyone interested; IVM: policy and professionals |
| 3.11. How is performance information fed back to primary care providers? |
| Not in NZA monitor. But the information system which is used by the health care insurers for reimbursement does provide comparison in individual level with a benchmark. NIVEL reports back to individual provider who can benchmark own results against overall scores. VZ-info: n.a.; IVM: yes, healthcare providers can log in and benchmark their own data with those of others. This is one of the main goals. |
| 3.12. Has the assessment been presented in a publicly accessible document or website? |
| Yes, all four |
| Question 4 At what level of aggregation are the data published? |
| NIVEL, NZA, VZ-info: national level; monitor voorschrijfgedrag: national and regional, overall variation between providers (individual level only accessible for the provider) |
| Question 5 What types of indicators are reported in the assessment? |
| NZA: Mostly: quality, affordability and access. Nivel also reports about patient satisfaction/patient centeredness. VZ-info: OECD-indicators about avoidable hospital admissions, patient experiences, prescription. VZ-info: indicators about volume of prescription and prescription in accordance with guidelines (28 indicators) |
| Question 6 Have workload and job satisfaction of primary care providers been measured and reported? If yes, how and on what scale? |
| Not in these assessments. The workload and job satisfaction of primary care was measured by the union of the primary care providers. And by several studies of NIVEL |
| Question 7 Please present your methodological approach. In particular, please explain how are the indicators developed, what risk adjustment methods are being used (if any), how is internal variability being addressed, etc. |
| VZ-info: indicators regarding primary care mainly from OECD, but also validated by national experts. Risk adjustments done by standardisations in line with OECD algorithms. IVM: development of indicators with intensive review by experts. NZA: overview of a lot of different data, different methods used: e.g. survey data, also existing studies are being used. Claims data. NIVEL: information from routinely collected data in primary care. |
| Question 8 |

| |
|--|
| Which procedures are in place to promote the validity, reliability and relevance of the assessment? |
| NZA: mostly quantitative data (number of physicians, number of practices, number of quality licenses etc.). Nivel also uses of a Delphi method with a patient panel. Several advisory boards in place. Continuous stream of studies on specific data. VZ-info: panel of experts (minimum of two) per indicator reviews indicator. |
| Question 9 To what degree is performance assessment embedded in the policy process? |
| The reports of the Nivel and the NZA are sent to the Ministry and the Parliament. Indicators from VZ-info are used in the National State of the health and healthcare, which is the most important source for figures on healthcare for the MOH. IVM: the monitor is being used by health insurers and in pharmaco-therapeutic meetings between pharmacists and GPs. There is no legal obligation. |
| Question 10 What is the evidence that the assessment has impacted on policy? |
| Figures are very often used by the minister in answering questions from the parliament. The recent rise of smoking among pregnant women in lower educational groups leads to a national campaign. In the publication of the National budget this year (September) several indicators will be published from VZ-info. |
| Question 11 Please summarise (briefly) the major limitations and main strengths of assessments of primary care performance in your country. |
| The landscape is somewhat fragmented, performance information does not have a clear position in the policy cycle, this is in contrast with data on public health, which is a legal obligation and has a formal role in the policy cycle. There is a comprehensive network of primary care registries from NIVEL, which produces lots of valuable information. The IVM monitor has a really good coverage and a user friendly tool to access your own data. |
| Question 12 What are the future plans with regard to primary care assessment? |
| No plans, also depends on the new minister. |

NORWAY (Norwegian Directorate of Health)

Question 1

Are there any recurrent or one-off assessments carried out of the performance of (parts of) the organisation and/or functioning of primary care in your country?

Yes. In Norway publicly financed primary care is the responsibility of the municipalities (Dental care as an exception- county level). There are four different publication sources containing relevant information for assessing primary care services. All publications use a range of data sources. One perspective when monitoring primary care is the resources, accessibility and quality of primary care services directly. Another perspective is to also monitor public health indicators that might be influenced by the accessibility and quality of primary care. The first perspective is covered by publications (reports and Web) by Statistics Norway and the Norwegian Directorate of Health. The public health perspective is covered by the Norwegian Institute of Public Health (reports and Web).

Question 2

Please provide a brief description of these assessments (name and type of product)

- a) National Quality Indicator System (NQIS. Established in 2013: Scope is the whole health care system: Using data from different registries.
- b) SAMDATA Municipalities- Established 2017: Comparative data on health and social care services at municipality level (mostly input and process indicators) - Using data from different registries. New web service is closely related to the establishment of a new Norwegian Registry for primary care (KPR).

For each assessment, please specify:

3.1. Is the report – or part of it – done because of legal requirements? If not, what is the main reason to carry it out?

- a) National Quality Indicator System (NQIS)- Scope is the whole Health care system: Yes, legal requirements
- b) SAMDATA Municipalities- Comparative data on municipalities: Not legal requirements

3.2. When did it take place?

- a) National Quality Indicator System (NQIS)- Scope is the whole Health care system: Yes, legal requirements: Every year since 2013
- b) SAMDATA Municipalities- Comparative data on municipalities: First time published March 2017- also commissioned for next year

3.3. Which organisation commissioned the assessment?

- a) National Quality Indicator System (NQIS)- Ministry of Health
- b) SAMDATA Municipalities- Comparative data on municipalities: Ministry of Health

3.4. Which organisation carried it out?

The Norwegian Directorate of Health

3.5. What other stakeholders were involved and how?

| |
|--|
| <p>a) National Quality Indicator System (NQIS)- working group with different stakeholders - representatives from municipalities and national interest organisation for municipalities (KS), Researchers, the Directorate of Health</p> <p>b) SAMDATA Municipalities - Comparative data on municipalities: Developed by the Directorate of Health. Further development will involve the municipalities and the Norwegian Association of Local and Regional Authorities (KS).</p> |
| 3.6. Which types of primary care were parts of the assessment? |
| <p>a) National Quality Indicator System (NQIS) - Municipalities: so far Institutional Health care and home care, Social services to support the persons possibilities to be active and participate in society.</p> <p>b) SAMDATA Municipalities: Home care (Nursing care and social care are integrated services), Institutional long term care and institutional short term care (rehabilitation- after treatment or planned rehabilitation), GP's , Physiotherapists, School Nurses, Health services for new-borns and preschool children, Social services to support the persons possibilities to be active and participate in society.</p> |
| 3.7. Which is the level of reporting? |
| <p>a) National Quality Indicator System (NQIS)- Municipality level</p> <p>b) SAMDATA Municipalities- Municipality level</p> |
| 3.8. What is the focus of the assessment? |
| <p>2) the Norwegian Directorate of Health</p> <p>a) National Quality Indicator System (NQIS)- Scope is the whole Health care system:</p> <p>b) SAMDATA Municipalities- Comparative data on municipalities:</p> |
| 3.9. What is the function of the assessment? |
| <ul style="list-style-type: none"> - Municipalities can monitor their own development on different areas and compare with other municipalities - General reporting - Policy makers and health care managers at local, regional and national level can use the data for planning and organisational development |
| 3.10. To which target population is the assessment primarily addressed? |
| <p>a) Quality indicator system: Policy makers, healthcare managers, clinicians, patients/users</p> <p>b) SAMDATA Municipalities: Policy makers, healthcare managers, clinicians, patients/users</p> |
| 3.11. How is performance information fed back to primary care providers? |
| <p>a) National Quality Indicator System (NQIS): report generator on web for visualization and extraction of data: Can compare at municipality level</p> <p>b) SAMDATA Municipalities- Paper report (This year) and report generator on web for visualization and extraction of data. Can compare at municipality level- tick off the municipalities you wish to compare.</p> |
| 3.12. Has the assessment been presented in a publicly accessible document or website? |
| See over |

Question 4

At what level of aggregation are the data published?

2) The Norwegian Directorate of Health

a) National Quality Indicator System (NQIS)- Scope is the whole Health care system: Municipality level, national level

b) SAMDATA Municipalities- Comparative data on municipalities: Municipality level, regional level, national level

Question 5

SAMDATA Municipalities- Comparative data on municipalities - Health and social care services comprising

- Nursing homes (long term care and short term care (rehabilitation))
- organizationally integrated home services (nursing, social care, rehabilitation outside institutions)
- General Practitioners (users and contacts): Indicators adjusted for population need characteristics

Type of data/indicators

- Resources and resource utilization per capita(expenditures, man-years): Indicators adjusted for population need characteristics
- Service utilization Primary Health and social care: Indicators adjusted for population need characteristics
- Service utilization Specialist Care: Indicators adjusted for population Case mix
- Non-communicable diseases NCDs
- Length of Hospital Stays and Re-admissions
- Data on patient-flow between Community Health care and Hospital care

National Quality Indicator System (NQIS) - 12 indicators on primary health and social care

- People living in nursing homes examined by a doctor the last twelve months
- People living in nursing homes examined by a dentist the last twelve months
- Re- and habilitation at home based on an individual plan
- Re- and habilitation at institution based on an individual plan
- Transport to education or work
- Transport to culture or recreational activities
- Personal assistance for education or work
- Personal assistance for culture or recreational activities
- Waiting times for home care services
- Waiting times for support person
- Waiting times for day-care activities
- Waiting times for long-term nursing homes

3 more in development; so far no indicators on GP services, but there are work in progress

Question 6

| |
|---|
| Have workload and job satisfaction of primary care providers been measured and reported? If yes, how and on what scale? |
| 2) the Norwegian Directorate of Health a) National Quality Indicator System (NQIS)- Scope is the whole Health care system: No b) SAMDATA Municipalities- Comparative data on municipalities: No |
| Question 7 Please present your methodological approach. In particular, please explain how are the indicators developed, what risk adjustment methods are being used (if any), how is internal variability being addressed, etc. |
| a) National Quality Indicator System (NQIS): Not relevant for some of the indicator (e.g. waiting time). The indicators are not clinical indicators. b) SAMDATA Municipalities- Comparative data on municipalities: Indicators on costs and utilisation of services at municipality level are adjusted by a need-index for each municipality. This index is used in the transfer of finances from the State to the municipalities. Other indicators are adjusted by age and sex where relevant. |
| Question 8 Which procedures are in place to promote the validity, reliability and relevance of the assessment? |
| a) National Quality Indicator System (NQIS)- NO b) SAMDATA Municipalities- Comparative data on municipalities: NO |
| Question 9 To what degree is performance assessment embedded in the policy process? |
| a) National Quality Indicator System (NQIS): Not embedded in the policy process directly. b) SAMDATA Municipalities: Not embedded in the policy process directly. |
| Question 10 What is the evidence that the assessment has impacted on policy? |
| 2) the Norwegian Directorate of Health a) National Quality Indicator System (NQIS)- Scope is the whole Health care system: b) SAMDATA Municipalities- Comparative data on municipalities: |
| Question 11 Please summarise (briefly) the major limitations and main strengths of assessments of primary care performance in your country. |
| Norway has, in many areas, a good system to provide information on primary care regarding access, utilisation, costs and descriptive information about providers or organisations. Still, the information systems underpinning primary care is underdeveloped, but there are important developments going on. So far there has been a lack of information on practice variation and quality for all primary health care- and particularly scarce information on activity and quality of GP services. For a good description of status of primary care in Norway, see: http://www.oecd.org/publications/oecd-reviews-of-health- |

Question 12

What are the future plans with regard to primary care assessment?

In 2015 a parliamentary white paper on primary health and care services for the future (Meld. St. 260, 2014-2015), had a section describing a new primary health care registry. It stated that the primary objective of the registry should be to support the improvement and development of a coherent, safe, equitable and efficient high quality health and care service as seen through the eyes of the patient and citizen. To achieve these goals, the registry must;

- Provide necessary information to enforce national policies in health and care services by central authorities
- Provide necessary information to local (municipal) government for planning, providing, improving and evaluation purposes
- Provide necessary information to patients, clients and the public in the results and activities of the health and care services
- Create better conditions for improvement and patient safety measures by local management and health and care service staff
- Provide more data for research and innovation
- Provide data to other registries and databases to rationalize data collection from those providing health care services.
- Provide necessary information for monitoring diseases and factors influencing diseases and public health, and be prepared for acute health threats.

In December 2017 the first version of the new register will be launched, and is named **Norwegian Registry for primary care**. This register will merge data from three different data sources in the first version, these are:

- a) KUHR is the name of the system that processes reimbursements claims from general practitioners (GPs), physiotherapists and other professionals providing primary health care services. The database from KUHR is the result after processing reimbursement claims and includes information on patient consultations and procedures.
- b) IPLOS is a national registry that captures data on the needs and provisioning of care services to inhabitants in the municipality. The registry, established in 2006.
- c) The Norwegian Prescription Database contains a complete listing of all prescription drugs dispensed by pharmacies to individuals in Norway. Drugs supplied to hospitals and nursing homes are partially included, but not at an individual level. The Norwegian Prescription database can be used to provide information on prescriptions and prescription patterns among GPs.

The new register will provide support the process of developing new indicators for assessment of primary care, relevant for the clinical level and policy level.

NORWAY (Norwegian Institute of Public Health)

| |
|---|
| Question 1 Are there any recurrent or one-off assessments carried out of the performance of (parts of) the organisation and/or functioning of primary care in your country? |
| Yes. In Norway publicly financed primary care is the responsibility of the municipalities (Dental care as an exception- county level). There are four different publication sources containing relevant information for assessing primary care services. All publications use a range of data sources. One perspective when monitoring primary care is the resources, accessibility and content of primary care services. Another perspective is to monitor public health indicators that might be influenced by the accessibility and quality of primary care. The first perspective is covered by publications (reports and Web) by Statistics Norway and the Directorate of Health. The public health perspective and some process indicators (e.g. vaccination) are covered by the Norwegian Institute of Public Health (reports and Web). |
| Question 2 Please provide a brief description of these assessments (name and type of product) |
| 1. Public Health Profiles for municipalities, counties and city districts in the four largest cities. Unique short reports about public health factors on each geographical level. Data are taken from person-identifiable registers, among others data from the primary care system and health surveys. Established in 2012, updated annually. 2. Online databank of statistics. Same data as in Public Health Profiles, and more: The whole times series, divided by sex and age groups etc. Additional indicators. Can create own tables and figures. Can compare municipalities with counties and country. Metadata - information about the data. |
| Question 3 For each assessment, please specify: |
| 3.1. Is the report – or part of it – done because of legal requirements? If not, what is the main reason to carry it out? |
| This work is based on the 2012 Public Health Act, which obliges Norwegian counties and municipalities to have sufficient overview of the population's health and the positive and negative factors that may influence this. The Norwegian Institute of Public Health shall make information available as a basis for the municipalities' and county authorities' overviews. The health statistics are available in the form of Public Health Profiles and Statistics Banks. |
| 3.2. When did it take place? |
| Every year since 2012 |
| 3.3. Which organisation commissioned the assessment? |
| Ministry of Health |
| 3.4. Which organisation carried it out? |
| The Norwegian Institute of Public Health |
| 3.5. What other stakeholders were involved and how? |

| |
|---|
| The Norwegian Directorate of Health has had an important role in the process of making the Public Health Profiles. Collaboration with the data providers are also important regarding the data provided and data quality. |
| 3.6. Which types of primary care were parts of the assessment? |
| The reports and Banks of statistics include data from general practice, emergency care and pharmacy. |
| 3.7. Which is the level of reporting? |
| Municipalities, counties and city districts in the four largest cities. |
| 3.8. What is the focus of the assessment? |
| The main focus is to monitor and improve public health by making information available to the municipalities and counties so that they can have sufficient overview of the population's health and the positive and negative factors that may influence this. https://www.fhi.no/en/hn/statistics/statistics-from-niph/ |
| 3.9. What is the function of the assessment? |
| <ul style="list-style-type: none"> - The health statistics are available in the form of Public Health Profiles and Statistics Banks so that municipalities and counties can monitor their own development on different areas and compare with other regions as a part of their responsibility to have sufficient overview of the population's health and the positive and negative factors that may influence this. - General reporting - Policy makers at local, regional and national level. |
| 3.10. To which target population is the assessment primarily addressed? |
| Public health workers, policy makers and planners in the municipalities and counties. |
| 3.11. How is performance information fed back to primary care providers? |
| Report generator on web for visualization and extraction of data and a Public health profile for every municipality/county. |
| 3.12. Has the assessment been presented in a publicly accessible document or website? |
| Public Health Profiles and Banks of statistics are available online on the Norwegian Institute of Public Health's website. |
| Question 4 |
| At what level of aggregation are the data published? |
| Municipalities, counties and city districts in the four largest cities. |
| Question 5 |
| What types of indicators are reported in the assessment? |

- **Demographics**
- **Living conditions** – e.g. share of children living in low-income-households
- **Environmental issues**
- **Education:** e.g. level of pupils dropping out of secondary school
- **Life-style:** e.g. Physically active teenagers
- **Health status:** e.g. Life expectancy and difference in life-expectancy among low and high educated
- **Health determinants** e.g.
 - o Smoking in women
 - o Overweight in male recruits
- **Health and illness** e.g.
 - o Mental disorders/illness, primary care
 - o Mental disorders, medication
 - o High blood pressure, primary care
 - o Cholesterol-lowering drugs
 - o Cardiovascular disease, hospital data
 - o COPD/asthma, medication
 - o Diabetes 2, medication
 - o Diabetes 2, primary care
 - o Cancer, new cases in total
 - o Cancer of the bowel, new cases
 - o Hip fractures, hospital data
 - o Musculoskeletal symptoms, primary care
 - o Vaccination coverage, MMR, 9-year-olds
- **Public health barometer and bank of statistics**
- **Indicators on:** Municipality level, county level

Question 6

Have workload and job satisfaction of primary care providers been measured and reported?
If yes, how and on what scale?

Not relevant to this assessment.

Question 7

Please present your methodological approach. In particular, please explain how are the indicators developed, what risk adjustment methods are being used (if any), how is internal variability being addressed, etc.

| |
|--|
| The public health indicators are selected within the fields that are emphasized in the Norwegian Public Health Act, and developed in collaboration with experts. Indicators are standardized by age and sex if relevant. Statistical deviance (or not) from national mean are illustrated graphically. |
| Question 8 Which procedures are in place to promote the validity, reliability and relevance of the assessment? |
| <p>Relevance. The public health indicators are selected within the fields that are emphasized in the Norwegian Public Health Act. Indicators for a specific purpose (such as health promotion in municipalities) are selected and developed so that they correspond to the public health challenges that are relevant for interventions at the municipal level.</p> <p>Reliability. Much of the public health indicator system focus is on enabling regional and local authorities to identify health related challenges in their own populations through comparisons with the rest of the country, other regions etc. Allowing comparisons over time is likewise of the essence. Due to emphasis on comparability, reliability is one of our main concerns. The procedure to promote reliability consists in assessing reliability as an integral part of development of indicators, in collaboration with experts, and can be re-assessed upon feed-back from users.</p> <p>Validity. Many of the public health indicators are mainly valid for only a segment of the population of interest, and their validity for the population as a whole is often less certain. In the cases where the validity for the population as a whole is less certain we communicate clearly that there are some limitations concerning the validity? The procedure to promote validity consists in assessing validity as an integral part of development of indicators, in collaboration with experts, and can be re-assessed upon feed-back from users.</p> <p>More studies to assess reliability and validity of specific indicators would strengthen the public health indicator system.</p> |
| Question 9 To what degree is performance assessment embedded in the policy process? |
| The Public health profiles are released to the population in general, and we have no specific system to report to national authorities. See also the next question. |
| Question 10 What is the evidence that the assessment has impacted on policy? |
| Norwegian counties and municipalities are obliged to have sufficient overview of the population's health and the positive and negative factors that may influence this, and use the Public Health Profiles in this work. The counties and municipalities overview to inform their plans and policies. |
| Question 11 Please summarise (briefly) the major limitations and main strengths of assessments of primary care performance in your country. |
| Not relevant to this assessment. |
| Question 12 What are the future plans with regard to primary care assessment? |
| In the future we hope that all data from primary care, including general practice, emergency care, dental care and school health care will be included in the new person-identifiable register from the primary care system. |

NORWAY (Statistics Norway (SSB): KOSTRA Municipality-State Reporting)

| |
|--|
| Question 1 |
| Are there any recurrent or one-off assessments carried out of the performance of (parts of) the organisation and/or functioning of primary care in your country? |
| Yes. In Norway publicly financed primary care is the responsibility of the municipalities (Dental care as an exception- county level). There are four different publication sources containing relevant information for assessing primary care services. All publications use a range of data sources. One perspective when monitoring primary care is the resources, accessibility and quality of primary care services directly. Another perspective is to also monitor public health indicators that might be influenced by the accessibility and quality of primary care. The first perspective is covered by publications (reports and Web) by Statistics Norway and the Directorate of Health. The public health perspective is covered by the Norwegian Institute of Public Health (reports and Web). |
| Question 2 |
| Please provide a brief description of these assessments (name and type of product) |
| The key figures in KOSTRA (Municipality-State-Reporting) provide information on most of the municipal and county municipal activities, including economy, schools, health, culture, the environment, social services, public housing, technical services and transport and communication. |
| Question 3 |
| For each assessment, please specify: |
| 3.1. Is the report – or part of it – done because of legal requirements? If not, what is the main reason to carry it out? |
| As part of fulfilling the general requirements to Statistics Norway from the Law of statistics. |
| 3.2. When did it take place? |
| 1. Statistics Norway (SSB): KOSTRA Municipality-State Reporting: Every year since 1995 |
| 3.3. Which organisation commissioned the assessment? |
| Part of fulfilling the general requirements to Statistics Norway from the Law of statistics. |
| 3.4. Which organisation carried it out? |
| Statistics Norway |
| 3.5. What other stakeholders were involved and how? |
| Working groups involving representatives from the municipalities, Ministry of Health etc. |
| 3.6. Which types of primary care were parts of the assessment? |
| Nursing and care (Home Care, Institutional care, rehabilitation) and Municipal health care service (GP, Midwife, School Nurse, etc.) |
| 3.7. Which is the level of reporting? |

| |
|--|
| Municipality |
| 3.8. What is the focus of the assessment? |
| Primary care and community care in general |
| 3.9. What is the function of the assessment? |
| KOSTRA (Municipal State Reporting) started up as a project in 1995 with the intention to provide relevant and up-to-date information about allocation of resources, priorities and meeting targets in municipalities and counties. The goal is to collect data in a co-ordinated way, and make the information flow a one time delivery per year for all steering-information needed by municipality. The number of municipalities and counties was gradually increased until the reporting year of 2001, and then all municipalities were included in the KOSTRA. KOSTRA is a national information system providing public information about the local government. The information about services provided by the municipalities and the use of public resources is registered, and comparisons made to provide decision makers at both the local and national level with relevant governing information about the local government. The information collected aims at providing basic information for research, analysis, planning and governing purposes. |
| 3.10. To which target population is the assessment primarily addressed? |
| |
| 3.11. How is performance information fed back to primary care providers? |
| Thru reports and report generator on web for visualization and extraction of data. In the StatBank you will find detailed figures and time series. It is flexible when it comes to choosing municipalities and years. It is possible to make selections of the variables and save these in "My page". The data indicators show means for the municipality groups, county authorities and national figures |
| 3.12. Has the assessment been presented in a publicly accessible document or website? |
| WEBSITE: See English version: https://www.ssb.no/en/offentlig-sektor/statistikker/kostrahoved |
| Question 4 |
| At what level of aggregation are the data published? |
| Municipality level, national level |
| Question 5 |
| What types of indicators are reported in the assessment? |

General descriptive information about providers or organisations and utilisation of care

KOSTRA mainly contains data on input indicators and activity. In addition to workforce and expenditure, its primary care-related content consists of the number of maternal and child health checks by municipality, users of home nursing help or institutional care for the elderly, waiting times and some patient experience measures.

Examples:

- Man-years by physicians per 10 000 inhabitants, municipal health service
- Man-years by physiotherapists per 10 000 inhabitants, municipal health service
- Percentage of users of home-based services aged 67 or over
- Percentage of beds in municipality in single rooms in institutions
- Percentage of inhabitants in institutions aged 80 or over
- Adjusted gross operating expenditures, institutions, per municipal bed

Statistics Norway also publish specific data on utilisation of GP and general emergency services

- General practitioners consultations, by age, sex and diagnosis (2012 - 2015)
- General practitioners consultations, by age and sex (C) (2010 - 2015)
- General practitioners consultations, by age and level of education (2010 - 2015)
- General practitioners consultations, by age and immigration category (2010 - 2015)
- Immigrants' consultations at general practitioners, by age and country of origin

Question 6

Have workload and job satisfaction of primary care providers been measured and reported?
If yes, how and on what scale?

No

Question 7

Please present your methodological approach. In particular, please explain how are the indicators developed, what risk adjustment methods are being used (if any), how is internal variability being addressed, etc.

Indicators are mainly per capita-measures without risk/need adjustments. Utilisation of services etc. can be distributed by age and sex (grouped).

Question 8

Which procedures are in place to promote the validity, reliability and relevance of the assessment?

Ongoing working groups with stakeholder representatives

Question 9

To what degree is performance assessment embedded in the policy process?

KOSTRA is a fundamental information source for policy makers and administration on municipal, on county and ministerial level. It is used in the budget processes locally and in the National Budget. Kostra is officially monitoring the development of services.

Question 10

What is the evidence that the assessment has impacted on policy?

same as over

Question 11

Question 12

What are the future plans with regard to primary care assessment?

POLAND

Question 1

Are there any recurrent or one-off assessments carried out of the performance of (parts of) the organisation and/or functioning of primary care in your country?

The analysis of the primary healthcare was presented in Healthcare Needs Maps (HNMs) in 2016. The analysis was carried out for 16 voivodeships. It was the first edition of HNMs but these assessments are planned to be recurrent and its contents are planned to be expanded with each new edition.

Question 2

Please provide a brief description of these assessments (name and type of product)

Healthcare Needs Maps present functioning of the primary health care on the basis of data reported to the National Health Fund. It means that only publicly funded services were taken into account in HNMs. Scope of analysis contains: number of patients, demographic, territorial characteristics, number of providers, number of provided health services. N

Question 3

For each assessment, please specify:

3.1. Is the report – or part of it – done because of legal requirements? If not, what is the main reason to carry it out?

The obligation of creating Healthcare Needs Maps comes from the art. 95c paragraph. 9 of the Act of 27 August 2004 on Healthcare provisions financed from public funds (Dz.U. 2004 no 210 poz. 2135). It defines that Health Care Need Maps for primary healthcare will be prepared in 2021, however according to negotiations with EU; Poland was obliged to prepare Healthcare Needs Maps for primary healthcare in 2015-2017.

3.2. When did it take place?

First analysis concerning primary care was published on 31 of December 2015 in Oncological and Cardiac Healthcare Needs Maps. On 31 of December 2016 Healthcare Needs Maps dedicated to 15 groups of diseases have been published; they expanded analysis of primary care and were based on recent data.

3.3. Which organisation commissioned the assessment?

The process of preparing Healthcare Needs Maps was introduced by Polish law. Also it was required by EU to provide additional financing for Polish health care system.

3.4. Which organisation carried it out?

Healthcare Needs Maps are prepared by the Ministry of Health

3.5. What other stakeholders were involved and how?

Other stakeholders involved in creating Healthcare Needs Maps:

- National Institute of Public Health – National Institute of Hygiene (NIPH – NIH) - preparation data about mortality,
- The National Health Fund - transfer data about patients and health service,
- Centre of Information Systems in Health Care - transfer data about hospitals, hospitals wards, number of beds etc.

| |
|---|
| - medical experts in primary care - meetings with experts to consult the results of analyses |
| 3.6. Which types of primary care were parts of the assessment? |
| In the analysis there was assessment of services provided by: - General practice / family practice physicians, - Nurses, - Midwives, - facilities dedicated for providing services at night and during holidays. |
| 3.7. Which is the level of reporting? |
| Analysis was carried out on the regional and national level. |
| 3.8. What is the focus of the assessment? |
| The focus of the assessment: - primary healthcare in general, - types of care: midwifery primary care, nursing in primary care and general practice - usage of other medical services (ERs, admissions, night time primary care) by patients enrolled at certain primary care providers. In Poland in order to utilise services from a publicly funded primary care provider a patient is obliged to enrol to such a provider (only one). Thus measurement of usage of ERs, admissions and night time primary in mild cases was used to compare efficiency of certain providers. |
| 3.9. What is the function of the assessment? |
| The function of the assessment is to present general reporting in the primary healthcare and to present the differences between regions. |
| 3.10. To which target population is the assessment primarily addressed? |
| The assessment primarily is addressed to: - policy makers, - healthcare managers. |
| 3.11. How is performance information fed back to primary care providers? |
| Documents of Healthcare Needs Maps are publicly available on the website: www.mapypotrzebzdrowotnych.mz.gov.pl . Data presented in section about primary health care allow comparing data at the regional level. |
| 3.12. Has the assessment been presented in a publicly accessible document or website? |
| Yes, the document was published on the website of the Ministry of Health: www.mapypotrzebzdrowotnych.mz.gov.pl . |
| Question 4 |
| At what level of aggregation are the data published? |

The data has been aggregated at:

- national level
- regional level (voivodeships, county)
- provider level (usage of ERs, admissions and night care was presented for selected providers - providers with highest values of this indicator were highlighted so that appropriate measures could be taken)

Question 5

What types of indicators are reported in the assessment?

Indicators measuring access:

- supply of providers
- geographical access
- quality indicators

Question 6

Have workload and job satisfaction of primary care providers been measured and reported?

If yes, how and on what scale?

No, due to limited reporting in the primary healthcare we haven't measured those indicators. No surveys have been performed; HNMs were prepared using only administrative data.

Question 7

Please present your methodological approach. In particular, please explain how are the indicators developed, what risk adjustment methods are being used (if any), how is internal variability being addressed, etc.

The analysis was prepared on the basis of the data from National Health Fund, i.e. financed from public resources. It involves the risk of not including services financed out-of-pocket or by private insurances. The main limitation in developing indicators is access to data and poor reporting in primary healthcare.

Most indicators are straightforward - the number of providers, the number of patients, and the number of visits are self-explanatory.

The only more sophisticated indicator developed for HNMs is the usage of ERs, admissions and night time care by patients in certain voivodeships, powiats, as well as enrolled at certain providers. The indicator was constructed as follows (in the provider version): First all visits to ERs, admissions and night time primary care of patients enrolled to a certain provider were extracted from the database. Consequently the visits resulting from hospitalization were excluded and the remaining number of visits was recorded. No further risk adjustments were performed. Finally the recorded number of visits was divided by the number of patients and multiplied by 100. Thus the indicator could be described as the yearly number of visits to ERs, admissions and night time primary care that did not result in hospitalization per 100 patients enrolled at a certain providers.

Question 8

Which procedures are in place to promote the validity, reliability and relevance of the assessment?

Preparing the analysis of primary healthcare was consulted with medical experts, in particular with voivodeship consultants in the specialty of primary

| |
|--|
| care. |
| Question 9 To what degree is performance assessment embedded in the policy process? |
| According to the law and agreements with EU Commission Healthcare Needs Maps will be used to create health policy and to provide financing from EU. |
| Question 10 What is the evidence that the assessment has impacted on policy? |
| The information from the analysis of primary healthcare will be used to access projects that apply for financing from EU. |
| Question 11 Please summarise (briefly) the major limitations and main strengths of assessments of primary care performance in your country. |
| The major limitation is reporting in primary healthcare. Not every provider is obliged to report every visit and data being reported has low reliability. Main strength is that HNMs is the first document in Poland ever to propose and publish the results of quality indicators for primary care in Poland. |
| Question 12 What are the future plans with regard to primary care assessment? |
| The analysis of the healthcare will be included in the Healthcare Needs Maps in 2017; however it will have the same limitations as current analysis. Our goal is to provide more detailed analysis, so we are working on the plan of such analysis. |

PORTUGAL

Question 1

Are there any recurrent or one-off assessments carried out of the performance of (parts of) the organisation and/or functioning of primary care in your country?

- In the Portuguese health system coexist three systems: the National Health Service (universal, for all citizens, tendentiously free), special insurance plans for some professions (health sub-systems) and private voluntary health insurances. It's a mix system, combining public and private deliverers and public and private financing.
- The Portuguese National Health Service is structured in 5 health regions, which include Groups of Primary Health Care Centers, (ACES), integrating several types of Primary Health Care Units Health Primary Care exists also at the Local Health Units, integrating Groups of Primary Health Care Centers and their reference Hospitals.
- Portugal has also two autonomous Regions: Madeira and Azores. Concerning Madeira, the Institute of Administration of Health and Social Affairs, IP-RAM (IASAÚDE, IP-RAM), is a Public Institute, integrated in the indirect administration of the Autonomous Region of Madeira, under superintendence and tutelage of the Regional Health Secretariat. With administrative and financial autonomy and its own assets, it is a body with jurisdiction over the entire territory of the Region. Concerning Azores, the Regional Secretariat for Health has powers in the area of health and its vital role in the sustainability of the Regional Health Service, the Regional Secretariat for Health will also be responsible for the policies directed to the combat and prevention of dependency and the area of Civil Protection.
- In 2010, external contracting with the newly created Groups of Primary Health Care Centers (ACES) was made operational for the first time. It was established that the contracting was based on 14 indicators defined at national level, 4 selected at regional level and 2 at local level and defined the implementation of two provisional instruments: the Performance Plan (PD) and Contract Program (CP). These instruments arose due to the need to promote the empowerment and accountability of providers to better respond to the health needs of populations.
- Health care providers shall publish and disclose, each year, a detailed report on access to the care they provide, which can be audited, annually, by the General Inspection of Health Activities.
- The report includes the global information of each entity, in the chapters that apply to it. The entities that integrate several units, e.g. Groups of Primary Health Care Centers and Local Health Units (integrating Groups of Primary Health Care Centers and their reference Hospitals) should only produce one report.
- The Groups of Primary Health Centers and Local Health Units must make the report available on its website, when it exists.
- The Regional Health Administrations, shall also make available on their website the reports of the Groups of Primary Health Care and Local Health Units of their region. The Groups of Primary Health Care Centers functional units, including Family Health Units (USFs), Personalized Care Units (UCSPs), Community Care Units (UCC), Public Health Units (USP) and Shared Assistance Resources Units (URAP) annually contract indicators for care delivery. Each Functional Unit (UF) is based on a multi-professional team, with organizational and technical autonomy. These performance assessments may be used for monitoring, target setting and / or accountability.

| |
|--|
| <p>These performance assessments may be used for monitoring, target setting and / or accountability.</p> <p>Please provide a brief description of these assessments (name and type of product)</p> <ul style="list-style-type: none"> • Report "Region Health Plan" <ul style="list-style-type: none"> o Identifies and communicates, inside and outside the health sector, the main population health needs. o Expresses a commitment to well define health goals for the next three years. • Report of the Central Administration of Health System <ul style="list-style-type: none"> o Describe the identity card indicators contractualization proposals for each year for the Groups of Primary Health Care Centers and Local Health Units. • Dashboard Health: <ul style="list-style-type: none"> o It's a monthly monitoring tool of the health status of its population. Fulfills the objective of providing concrete and real data with full transparency. o Its implementation begins with a restricted set of seven indicators that will gradually be extended. The integration of new indicators depends on regular access to data, the analysis of the historical site and the accuracy of the methodology used. It is expected, in the first months, the current set of indicators is broken down by regions. o The information in this web tool is updated regularly, at least every month. When the indicators don't have updated information (in principle the previous month), the respective display will reference the last month with complete information. For this reason not all indicators have the same date. |
| <p>Question 3</p> <p>For each assessment, please specify:</p> |
| <p>3.1. Is the report – or part of it – done because of legal requirements? If not, what is the main reason to carry it out?</p> <p>The report is done on behalf of the Action Plan elaborated by each Region (Contratos-Programa). The action plan should also meet the health strategy defined for each Region.</p> |
| <p>3.2. When did it take place?</p> <p>Annually.</p> |
| <p>3.3. Which organisation commissioned the assessment?</p> <ul style="list-style-type: none"> • Central Administration of Health Services • Regional Health Administration |
| <p>3.4. Which organisation carried it out?</p> <ul style="list-style-type: none"> • Regional Health Administration • Primary health care |
| <p>3.5. What other stakeholders were involved and how?</p> <ul style="list-style-type: none"> • Directorate-General of Health • Shared Services of the Ministry of Health • Central Administration of Health Services |

| |
|---|
| 3.6. Which types of primary care were parts of the assessment? |
| <ul style="list-style-type: none"> • General Medicine and Family • Health consultations Childlike • Health consultations Maternal • Planning Family • Surveillance of Diabetic patients • Surveillance of Patients Hypertensive • Doctor's appointments At home • Nursing At home |
| 3.7. Which is the level of reporting? |
| National, regional and local level. |
| 3.8. What is the focus of the assessment? |
| <ul style="list-style-type: none"> • Primary care in general <ul style="list-style-type: none"> o General and Family Medicine o Children's health o Family planning o Continued care at home • Care for a specific disease or category of diseases: <ul style="list-style-type: none"> o Diabetes o Diabetic Foot Consultation o Hypertension o Smoking cessation • Type of care: <ul style="list-style-type: none"> o Wounds treatments o Immunization o Early diagnosis (foot test) • Specific dimension of primary care <ul style="list-style-type: none"> o Prescribing o Parenting Preparation Course o traveller Advice o Dentist consultation and oral hygiene o Medical boards o School Health |

| |
|---|
| 3.9. What is the function of the assessment? |
| <ul style="list-style-type: none"> • General reporting • Financial incentives according to the indicators achieved • Comparative benchmark between providers |
| 3.10. To which target population is the assessment primarily addressed? |
| <ul style="list-style-type: none"> • Policy makers • Clinicians • Healthcare managers • Patients |
| 3.11. How is performance information feedback to primary care providers? |
| <ul style="list-style-type: none"> • Information is provided to primary care providers by the Executive direction supported by clinical board. |
| 3.12. Has the assessment been presented in a publicly accessible document or website? |
| <ul style="list-style-type: none"> • Yes, it has been presented in a publicly accessible document and website. |
| Question 4 |
| At what level of aggregation are the data published? |
| <ul style="list-style-type: none"> • National level • Regional level • Local level |
| Question 5 |
| What types of indicators are reported in the assessment? |
| <p>First of all, it should be noted that there are two types of contracting with the Primary Health Care:</p> <ul style="list-style-type: none"> • External: carried out between the Direction of the Groups of Primary Health Care Centers and the Regional Health Administration; • Internal: carried out between the Direction of the Groups of Primary Health Care Centers and their functional units. <p>At external contractual level, and only for Family Health Units and Personalized Health Care Units, the indicators to be monitored and evaluated are:</p> <ul style="list-style-type: none"> • 14 indicators selected at national level, capable of evaluating health gains and in line with internal contractual objectives for each Group of Primary Health Care Centers. They are transversal to all Groups of Primary Health Care Centers and are valid for at least the duration of the Action Plan (3 years). • 4 indicators chosen by the Regional Health Administration that meet the regional programs or the health priorities defined regionally and that have not been filled by the indicators of the national axis. • Each Group of Primary Health Care Centers has the possibility, together with the Regional Health Administration, to define specific indicators |

according to local health needs that have not been filled by national or regional indicators.

There are specific indicators for each type of functional unit: Family Health Units and Personalized Health Care Units (are the same because are similar Units), Community Care Units and Public Health Units. There are about 200 indicators that can be selected by the parties involved in the contract process (internal and external) and according to the type of functional unit. Examples of Family Health Units and Personalized Health Care Units indicators are:

Indicators measuring access

- Rate of use of medical consultations
- Rate of utilization of nursing consultations
- Rate of nursing homes per 1,000 subscribers
- Rate of medical household per 1,000 subscribers

Indicators measuring clinical performance

- Rate of registered users in Groups of Primary Health Care Centers and Local Health Units
- Rate of local Groups of Primary Health Care Centers and Local Health Units who started the cervical cancer screening program
- Rate of Percentage of Groups of Primary Health Care Centers and Local Health Units who initiated the breast cancer screening program
- Rate of Percentage of Groups of Primary Health Care Centers and Local Health Units from the Northern Region with Consultations to Support

Smoking Cessation

- Rate of Groups of Primary Health Care Centers and Local Health Units of the region with Local Health Plan
- Rate of Pentavalent Vaccine Coverage (DTPaHibVIP) in the cohort born in the year 2016
- Rate of vaccination coverage with VASPR II vaccine in the cohort born in 2011
- Rate of vaccination coverage with influenza vaccine in institutionalized elderly, in the influenza season 2016/2017
- Rate of local Groups of Primary Health Care Centers providing emergency contraception
- Percentage change in the number of active users without a family doctor enrolled in Groups of Primary Health Care Centers and Local Health Units of the region, compared to that observed at the end of last year
- Occupancy rate of contracted places with Integrated Continuous Care Team (integrating PHC centres) in the region
- Percentage change in the number of diabetics identified by family physicians in the enrolled population
- Percentage of Groups of Primary Health Care Centers from the region that initiated the screening program for diabetic retinopathy
- Diabetic Proportion with last HgbA1c $\leq 8.0\%$
- Proportion of children with 2yo, with National Vaccination Program completed up to 2yo
- Proportion of Home nursing visits at weekend and holiday
- Proportion of users assessed by multidisciplinary team in the first 48h
- Rate in effectiveness of the prevention of pressure ulcers
- Rate of healing of pressure ulcers

Indicators measuring costs, waste or efficiency

- Expenses for Prescribed Medication with User Reimbursement (PVP)

Question 6

Have workload and job satisfaction of primary care providers been measured and reported?

If yes, how and on what scale?

- The Family Health Units annually carry out the evaluation of the satisfaction of health professionals.

Question 7

Please present your methodological approach. In particular, please explain how are the indicators developed, what risk adjustment methods are being used (if any), how is internal variability being addressed, etc.

- Like the former population Health Plan, the methodology is based upon the so called classic health planning theory and, more specifically, upon the "Referential for the building up of population Health Plans".
- Consensus around this Referential was obtained between the regional Public Health Department and the local Public Health Units (at the Groups of Primary Health Care Centers) and it was applied and tested during the Local population Health Plans building and implementation process.
- It begins by a Health Diagnosis of the region population, identifying its main health problems. Then, it assesses the technical health needs, in terms of mortality, morbidity and health determinants. This assessment was based upon the available epidemiological information, with the participation of other Departments, experts and political advisors of the Region Health Administration.

Question 8

Which procedures are in place to promote the validity, reliability and relevance of the assessment?

- In order to promote the main stakeholders participation in the felt health needs assessment and prioritization, a Delphi panel was conducted. Different organizations, inside and outside the health sector, were invited to participate, involving the:
 - o public and private health sectors;
 - o local governments;
 - o relevant health professionals' associations;
 - o academia and science sectors;
 - o unions/syndicates;
 - o social sector;
 - o consumers and patients associations, amongst others.

Question 9

To what degree is performance assessment embedded in the policy process?

- Linking to local contract

Question 10

What is the evidence that the assessment has impacted on policy?

- As already mentioned, the process begins with a Health Diagnosis of the region population, identifying its main health problems. Then, it assesses the technical health needs, in terms of mortality, morbidity and health determinants. This assessment was based upon the available epidemiological information, with the participation of other Departments, experts and political advisors of the Region Health Administration.
 - By combining the analysis of the prioritized felt and technical health needs, taking into consideration the national health priorities, the final assessment and prioritization of the population health needs was made, in terms of mortality, morbidity and health determinants. The health needs highlight not only the national health priorities, but also the specific regional ones. They should be regarded as a whole, since they belong to common causality webs which can only be artificially separated.

Question 11

Please summarise (briefly) the major limitations and main strengths of assessments of primary care performance in your country.

- Strengths:
 - o Possible to monitor
 - o Possible to address specific interventions based on results
- Limitations:
 - o Impossible to involve all stakeholders
 - o Impossible to have all the indicators desired
 - o Not all Indicators are comparable between regions

Question 12

What are the future plans with regard to primary care assessment?

- Implement three key recommendations of the main stakeholders:
 - o communicates to implement;
 - o obtain health gains in a sustainable way;
 - o develop TOGETHER the strategies which have the biggest impact on population health needs.
- Last but not least, includes a monitoring and evaluation plan, which includes three kinds of indicators:
 - o evaluation indicators;
 - o monitoring indicators;
 - o some indicators of the National Health Plan.

SLOVAKIA

| |
|---|
| Question 1 |
| Are there any recurrent or one-off assessments carried out of the performance of (parts of) the organisation and/or functioning of primary care in your country? |
| Ministry of the Health (MoH) is currently working on a general primary care assessment paper. National Centre for Health Information (NCHI) collects data from different inpatient providers on yearly basis. Moreover, health insurance companies carry out their own internal assessment of a fulfilment a minimum network of doctors. Currently, it is more about collecting data than evaluating data; however, MoH would like to come to the evaluation phase. |
| Question 2 |
| Please provide a brief description of these assessments (name and type of product) |
| Every assessment paper consists of the following main parts: number of treated patients in particular ambulatory care based on age (group), region and diagnosis (ICD 10) (e.g. gynaecology, paediatrics, psychiatry, GP practices, dental care and so on) |
| Question 3 |
| For each assessment, please specify: |
| 3.1. Is the report – or part of it – done because of legal requirements? If not, what is the main reason to carry it out? |
| NHIC carries this assessment out every year based on existed legal partnership with MoH -> mainly reporting reason |
| 3.2. When did it take place? |
| 1997 |
| 3.3. Which organisation commissioned the assessment? |
| NCHI - National Health Information Centre, please keep in mind it is more about collecting and monitoring data than evaluation, however, MoH is about to assess performance in primary care |
| 3.4. Which organisation carried it out? |
| NCHI - National Centre for Health Information |
| 3.5. What other stakeholders were involved and how? |
| None |
| 3.6. Which types of primary care were parts of the assessment? |
| GPs for adults and children (paediatricians), gynaecologists (two documents one general and other one about post-natal care), stomatologists |
| 3.7. Which is the level of reporting? |
| National and regional |
| 3.8. What is the focus of the assessment? |

| |
|---|
| GPs for adults and children-> number of visits treated by doctors and nurses according to age and region, number of preventive check-ups and examinations according to age and region, the same service for handicapped patients, number of full breastfeeding children, number of patients according to ICD based on age, sex and region, number of vaccinated patients aged 2 against TBC |
| Gynaecology -> number of ambulances, number of women and pregnant women until 12 weeks as well as with risk delivering, number of preventive check-ups, diagnostic and therapeutic examinations according to regions, number and types of gynaecological examinations, number of women using contraception (2 types) during the last 20 years, number of women with certain disorders, number of women with suspicion of being attacked |
| Stomatology -> number of visits according to region based on age, number of people with preventive check-ups, number of treated patients during preventive check-ups based on age, oral health of 5 years old children, index of oral health of 12 and 15 years old children, number of certain procedures in ambulances, number of certain procedures in outpatient services |
| 3.9. What is the function of the assessment? |
| General reporting |
| 3.10. To which target population is the assessment primarily addressed? |
| Good question, mostly to policy makers and clinicians |
| 3.11. How is performance information fed back to primary care providers? |
| No, cannot compare each other |
| 3.12. Has the assessment been presented in a publicly accessible document or website? |
| Documents are placed on the website of NIHC |
| Question 4 |
| At what level of aggregation are the data published? |
| National and regional |
| Question 5 |
| What types of indicators are reported in the assessment? |
| Most of them already stated in the question number 3.8. |
| Question 6 |
| Have workload and job satisfaction of primary care providers been measured and reported? |
| If yes, how and on what scale? |
| No |
| Question 7 |
| Please present your methodological approach. In particular, please explain how are the indicators developed, what risk adjustment methods are being used (if any), how is internal variability being addressed, etc. |
| Not informed about these processes |

| |
|--|
| Question 8 |
| Which procedures are in place to promote the validity, reliability and relevance of the assessment? |
| None |
| Question 9 |
| To what degree is performance assessment embedded in the policy process? |
| Performance assessment of primary care is not placed in policy process yet |
| Question 10 |
| What is the evidence that the assessment has impacted on policy? |
| None |
| Question 11 |
| Please summarise (briefly) the major limitations and main strengths of assessments of primary care performance in your country. |
| Currently, the primary care is more about collecting data and monitoring information. However, the scope of collected data is large as well as validity of data have high level. |
| Question 12 |
| What are the future plans with regard to primary care assessment? |
| Firstly, start benchmarking providers in primary care. Afterwards, the result might be displayed on the interactive website. |

SLOVENIA

Question 1

Are there any recurrent or one-off assessments carried out of the performance of (parts of) the organisation and/or functioning of primary care in your country?

Context of primary care in Slovenia: Primary care in Slovenia provides first contact care to patients close to their homes. It comprises the following services: general practice/family medicine, paediatrics, gynaecology, emergency medical aid, preventive and curative dental care for children and adults, home nursing, physiotherapy, occupational therapy, mental health, speech and language therapy, paediatric development care, services for disease prevention and health promotion, laboratory and other diagnostic facilities. Primary health services are delivered at the local level by community health care centres and individual concessionaries (private providers in public health care network). It is under the jurisdiction of local communities, who are owners of primary care institutions and are responsible for health care policy development at local level. In view of complexity of primary care in Slovenia there are attempts to establish comprehensive monitoring and assessment of primary care. There have been several partial assessments performed in past, especially during development of National health care plan in 2015 and during current development of National strategy for primary care development in Slovenia. Hereinafter we present assessments carried out to date. One of the most comprehensive assessments was performed by the MoH, together with WHO and European Observatory in 2015.

Question 2

Please provide a brief description of these assessments (name and type of product)

- (1) University of Ljubljana, Medical Faculty, Family medicine chamber (2017). Quality analysis of family medicine model practises (Final report). Ljubljana: University of Ljubljana.
- (2) Performance assessment of primary care in the process of drafting the National strategy for primary care development in Slovenia 2017 - 2025
- (3) Albrecht et. al. (2016). Slovenia Health system review. Health Systems in Transition, 18(3):1–207.
- (4) Nolte et al. (2015). Analysis of the health system in Slovenia. Optimizing Service Delivery (Final Report). Ministry of Health Slovenia, WHO and European Observatory for Health systems and policy.
- (5) Panteli et al. (2015). Analysis of the health system in Slovenia. Purchasing and Payment Review (Final Report). Ministry of Health Slovenia, WHO and European Observatory for Health systems and policy.
- (6) Rotar Pavlič et al. (2015). Slovenia. In: Kringos et al. (eds.). Building primary care in a changing Europe. Case studies. World Health Organization (acting as the host organization for, and secretariat of, the European Observatory on Health Systems and Policies).
- (7) Farkaš Lainščak et al. (eds.). (2015). The conclusions of needs assessment of users and providers of prevention programs for adults. Findings of qualitative research and the views of the expert working groups. Ljubljana: National Institute of Public Health.
- (8) Ogorevc. (2010). Access to health care at the primary level. Ljubljana: Institute for Economic Research.
- (9) WHO. (2008). Quality management in Primary care Slovenia. Copenhagen: WHO.
- (10) Zaletel et. al. (eds.). (yearly published). National Health Statistical Yearbook. Ljubljana: National Institute of Public Health.

(11) Annual reports about the plan and the realization of health services. Ljubljana: Health Insurance Institute of Slovenia.

Question 3

For each assessment, please specify:

3.1. Is the report – or part of it – done because of legal requirements? If not, what is the main reason to carry it out?

- (1) Quality analysis of family medicine model practises (Family medicine chamber, 2017): In 2011, a new approach – “model practices” – was introduced into existing family medicine practise. These practices include, in addition to the regular nurse (i.e. associate professional nurse), a further part-time (0.5 full-time equivalent) registered nurse who has received additional training and whose tasks include screening for chronic disease risk factors and preventive counselling for patients aged 30 and over, as well as the care coordination of all registered patients with stable chronic diseases (e.g. arterial hypertension, diabetes type 2, asthma, chronic obstructive pulmonary disease, osteoporosis and depression). “Model practices” are a relatively new initiative and evaluations are now available on their performance or impact on prevention and population health status. After five years of operation, it was necessary to conduct a comprehensive evaluation of introduced innovations. At the end of 2017, the project will end with model practises becoming national standard. The main purpose of the evaluation was to obtain relevant information about the real state of operation according to the 29 quality indicators in order to continuously improve quality of services, develop an action plan for further work and set realistic financial construction for funding
- (2) The legal basis for the comprehensive assessment of primary care in Slovenia and for the preparation of the National strategy for primary care development in Slovenia 2017 - 2025 is the National Healthcare Plan 2016-2025.
- (3) Hit provides a detailed description of a country's health system and of reform and policy initiatives in progress or under development. This analysis of the Slovene health system reviews recent developments in organization and governance, health financing, health care provision, health reforms and health system performance. The survey included the assessment of the primary health care.
- (4) The report is not done due to legal requirements. The report is a part of comprehensive analysis of the health system in Slovenia, carried out on behalf of the Ministry of Health Slovenia. It provided a starting point for development of National Health Care Plan.
- (5) The report is not done due to legal requirements. The report is a part of comprehensive analysis of the health system in Slovenia, carried out on behalf of the Ministry of Health Slovenia. It provided a starting point for development of National Health Care Plan.
- (6) The survey was part of an international research WHO: Building Primary Care in a changing Europe. The main purpose of the research was to assess the situation in the field of primary care in Slovenia on the basis of domains that enable international comparison: the context of the primary care system; the governance and economic conditions of the system; the development of the primary care workforce; how primary care services are delivered; and the quality and efficiency of the primary care system. An overview of the results and their implications, and reflects on the situation of primary care in Europe, including suggested priority areas. Furthermore, options and requirements for future monitoring of primary care in Europe are addressed.
- (7) No, the report is not done due to legal requirements. The assessment was performed in the frame of larger project aiming to upgrade NCDs prevention programs and improve health equity at primary care. Needs assessment was the first step of the project.
- (8) The report presents an analysis of certain indicators of the availability and effectiveness of primary health care services that could be assessed on the basis of regularly and routinely collected data in Slovenia.
- (9) This report summarizes the main results of the WHO Primary Care Quality Management Tool, which was implemented on a pilot basis in Slovenia in

2007 in the framework of the 2006-2007 Biennial Collaborative Agreement between the WHO Regional Office for Europe and the Ministry of Health of Slovenia, an agreement that lays out the main areas of work for collaboration between the parties. The basic question was “What does quality care mean at this level and what are the strategies, mechanisms and tools to ensure that it can be maintained, assessed and improved?» The Tool consists of three parts: a questionnaire for national-level policy experts, a questionnaire for managers of primary care facilities and a questionnaire for general practitioners (GPs). The Tool was pilot tested in 2007 in two regions of Slovenia: Gorenjska region and Ljubljana region. Questionnaires were completed by national policy experts from different stakeholder organizations of the health system, and by managers and GPs from the two pilot regions. The results rely strongly on self-reported behaviour rather than on direct observations or registrations. The purpose of the research on primary care quality management in Slovenia was: to improve service delivery at the first level of care, supplemented with evidence compiled through the development and application of tools tailored to primary care.

(10) Yes, there is legal requirement for the HIIS to collect data and to publish reports on health care services delivered by public providers.

(11) Yes, there is legal requirement for the HIIS to collect data and to publish reports on health care services delivered by public providers.

3.2. When did it take place?

(1) Analysis of services provided and care quality in family medicine model practises was carried out from January to March 2017.

(2) Started in March 2016, ongoing at the time of writing this report.

(3) The analysis of the Slovene health system was carried out from 2015 until 2016.

(4) In 2015.

(5) In 2015.

(6) Monitoring of primary care in a changing Europe was carried out from 2014 until 2015

(7) In 2014, report written in 2015.

(8) in 2010.

(9) The PHAMEU study (Primary Health Care Activity Monitor for Europe) was carried out from 2007 until 2010. In Slovenia was conducted from 2007 to 2008.

(10) Yearly.

(11) Yearly

3.3. Which organisation commissioned the assessment?

- (1) Ministry of Health commissioned the assessment Quality analysis of family medicine model practises
- (2) Ministry of Health of the Republic of Slovenia.
- (3) The Observatory cooperated with the National Institute of Public Health of Slovenia (NIPH), which is a member of the Health Systems and Policy Monitor (HSPM) network
- (4) Ministry of Health of the Republic of Slovenia.
- (5) Ministry of Health of the Republic of Slovenia.
- (6) The project was supported by the WHO Regional Office for Europe, the European Forum for Primary Care, the European Public Health Association, and the European General Practice Research Network.
- (7) Ministry of Health and Government Office for Development and European Cohesion Policy, under commission of the Norwegian Financial Mechanism.
- (8) National Institute of Public Health.
- (9) The project WHO Primary Care Quality Management was supported on a pilot basis in Slovenia in 2007 in the framework of the 2006-2007 Biennial Collaborative Agreement between the WHO Regional Office for Europe and the Ministry of Health of Slovenia, an agreement that lays out the main areas of work for collaboration between the parties. Further partners were the Netherlands Institute for Health Services Research (NIVEL) – a WHO Collaborating Centre – and the Department of Family Medicine, University of Ljubljana, Slovenia
- (10) Health Insurance Institute Slovenia.
- (11) Health Insurance Institute Slovenia

3.4. Which organisation carried it out?

- (1) The Quality analysis of family medicine model practises providers was form Family medicine chamber in Faculty of Medicine University of Ljubljana and National Institute for Public Health, where the project office for the project
- (2) Ministry of Health of the Republic of Slovenia in collaboration with National Institute of Public Health and representatives of key stakeholders.
- (3) National Institute of Public Health of Slovenia, Ministry of Health, Slovenia, National Health Insurance Institute of Slovenia, Berlin University of Technology, European Observatory on Health Systems and Policies.
- (4) Ministry of Health of the Republic of Slovenia.
- (5) Ministry of Health of the Republic of Slovenia in collaboration with WHO Euro and European Observatory for Health Systems and Policies.
- (6) Researches for monitoring of primary care was form Family medicine chamber in Faculty of Medicine University of Ljubljana and National Institute for Public Health
- (7) National Institute of Public Health.
- (8) Institute for Economic Research.
- (9) WHO Primary Care Quality Management in Slovenia (WHO, 2008) providers was National Institute of Public Health of Slovenia, Ministry of Health, Slovenia, European Observatory on Health Systems and Policies.
- (10) Health Insurance Institute Slovenia.
- (11) Health Insurance Institute Slovenia.

3.5. What other stakeholders were involved and how?

- (1) Other stakeholders were involved in The Quality analysis of family medicine model practises: patients, providers (physicians, nurses) and National Institute for Public Health, where the project office for the project.
- (2) Involved stakeholders: - representatives of the Ministry of Health, representatives of primary care institutions, - representatives of healthcare professionals, of various professions, public sector employees and concessionaires: physicians (general/family medicine, paediatricians, gynaecologists and dental physicians at primary care), nurses, district nurses, physiotherapists, occupational therapists, psychologists, preventive centres professionals, representatives of healthcare managers, representatives of national public health insurance fund (Health Insurance Institute Slovenia), representatives of academic institutions, representatives of patient organisations. The involved stakeholders were members of the Working Group (providing data and information and co-writing the document), the Steering Committee (liaising strategic directions of the future primary care development), or attended one or several of the four procedural workshops aimed to identify challenges and to confront and align opinions of key stakeholders.
- (3) WHO Regional Office for Europe
- (4) Ministry of Health of the Republic of Slovenia in collaboration with WHO Euro and European Observatory for Health Systems and Policies.
- (5) Involved stakeholders: representatives of the Ministry of Health, representatives of healthcare providers, representatives of healthcare professionals, of various professions, public sector employees and concessionaires, representatives of healthcare managers, representatives of national public health insurance fund (Health Insurance Institute Slovenia), representatives of academic institutions, representatives of unions of professionals in healthcare, representatives of patient organisations. The involved stakeholders were members of working groups, providing data and information and co-writing the report.
- (6) Statistical Office of the Republic of Slovenia Data and the data of the research results from the scientific articles were used in monitoring of primary care and Health System review.
- (7) Deprived / vulnerable users of health care services, selected healthcare professionals, involved in delivery of preventive services at primary care
- (8) No other stakeholders were involved.
- (9) Statistical Office of the Republic of Slovenia Data and the data of the research results from the scientific articles were used in monitoring of primary care (WHO, 2008, 2015) and Health System review.
- (10) All healthcare providers within the public healthcare network report data on service delivery.
- (11) All healthcare providers within the public healthcare network report data on service delivery.

3.6. Which types of primary care were parts of the assessment?

- (1) family medicine "model practices "
- (2) This was a comprehensive assessment of primary care, considering:
 - (a) Services delivered at primary care, based on the patients' needs,
 - (b) Financing and organisation of primary care providers, and
 - (c) Identifying measures to be implemented to strengthen primary care in Slovenia.
- (3) general description of primary care system and services from a bird's perspective, public and contracted providers, primary care health professionals, preventive care, family medicine model practises, gatekeeping
- (4) involved stakeholders: representatives of the Ministry of Health, - representatives of healthcare providers,- representatives of healthcare professionals, of various professions, public sector employees and concessionaires,- representatives of healthcare managers, representatives of national public health insurance fund (Health Insurance Institute Slovenia), representatives of academic institutions, representatives of unions of professionals in healthcare, representatives of patient organisations. The involved stakeholders were members of working groups, providing data and information and co-writing the report.
- (5) Payment systems for healthcare services, including primary care services, and for physicians in Slovenia.
- (6) Generally, Health promotion, Preventive care, Medical technical procedures, Treatment and follow-up of diseases, First-contact care.
- (7) NCDs prevention programs for adults.
- (8) General / family practice and paediatrics at primary care.
- (9) Primary care in general, GPs (both public and private, 18% being private), Directors of PHC Units + Heads of GP teams in PHC, National experts
- (10) All healthcare service providers, i.e. all providers at primary care.
- (11) All healthcare service providers, i.e. all providers at primary care.

3.7. Which is the level of reporting?

- (1) National level of reporting, regional level, level of Health centres, providers
- (2) National
- (3) National level
- (4) The assessment was performed by interviews with selected individuals from all-over the country (purposive sampling). Examples of organizational bottlenecks and of particular examples of good practice were sought after. The level of investigation was national, with representation of individual local or regional specificities.
- (5) National.
- (6) National level
- (7) National.
- (8) National, the document is addressed to the MoH
- (9) different levels of reporting:
 - (a) At National level, based on interviews with national experts,
 - (b) At managerial level, based on experiences and opinions of primary care managers,

(c) At GP level, based on experiences and opinions of GPs

(10) National.

(11) National

3.8. What is the focus of the assessment?

(1) The content analysis of the performance of family medicine model practises were included NIJZ reports and surveys on employee satisfaction nurses, doctors and analysis of data collected on the basis of certain quality indicators and registries of patients with chronic diseases.

(2) The assessment considers primary care in general as well as all specific types of care and services. It also considers organisational and managerial dimensions.

(3) organization and governance, financing, physical and human resources, provision of services, principal health reforms, assessment of the health system (Population and demographic indicators, Economic context, Political context, Health status)

(4) The assessment is comprised of three components:

(a) the primary-secondary care interface, by assessing key indicators of 'avoidable' hospitalizations and by exploring the day-to-day challenges experienced by healthcare providers in the management of chronic disease, using diabetes as a case study,

(b) pathways for people with multiple care needs, exploring core challenges and examples of good practices as perceived by different professional perspectives and assessing the processes and procedures for discharge planning from the perspective of healthcare providers, and

(c) the interface between health and long-term care, by describing the current long-term care arrangements that are in place in Slovenia.

(5) The assessment focuses on purchasing and payment mechanisms of the health care system in general. It includes primary care.

(6) The governance and economic conditions of the system; the development of the primary care workforce; how primary care services are delivered; and the quality and efficiency of the primary care system.

(7) NCDs prevention programs for adults and barriers for access to primary care services for deprived / vulnerable individuals.

(8) Availability and effectiveness of general / family practice and paediatrics at primary health care.

(9) different focuses of the assessment:

(a) Context of primary care: Development and economy, Population's health, Characteristics of the health care system,

(b) Structure of the primary care system (primary health governance, Economic conditions of primary care, Primary care workforce development,

(c) Primary care process (Access to primary care services, Continuity of primary care services, Coordination of primary care services, Comprehensiveness of primary care services,

(d) Outcome of the primary care system (Quality of primary care, Efficiency of primary care)

(10) All services delivered at primary care.

(11) All services delivered at primary care.

3.9. What is the function of the assessment?

- (1) Based on the assessment of the planned future policy in ensuring the sustainability and development of innovations in primary health care level.
- (2) The function of the assessment is to set the starting point for further development of primary care in Slovenia.
- (3) HiTs seek to provide relevant information to support policy-makers and analysts in the development of health systems in Europe. They are building blocks that can be used: (1) to learn in detail about different approaches to the organization, financing and delivery of health services and the role of the main actors in health systems; (2) to describe the institutional framework, the process, content and implementation of health reform programmes; (3) to highlight challenges and areas that require more in-depth analysis; (4) to provide a tool for the dissemination of information on health systems and the exchange of experiences of reform strategies between policymakers and analysts in different countries; and (5) to assist other researchers in more in-depth comparative health policy analysis.
- (4) The function of the assessment was to set starting point for the healthcare reform in Slovenia. The assessment was the first step of the reform, defining the current state.
- (5) The function of the assessment was to set starting point for the healthcare reform in Slovenia. The assessment was the first step of the reform, defining the current state.
- (6) This book provides an updated overview of the state of primary care in 31 European countries.
- (7) Needs assessment that serves as starting point for designing and development of upgrade of existing NCDs prevention programs for adults.
- (8) The assessment focused on spatial distribution of providing institutions, services and providers' teams for the implementation of general / family medicine, the age distribution of physicians, and workload of teams. The function was assessment of current state and needs assessment.
- (9) Recommended policy action
- (10) Monitoring the implementation of health care services, required by the payer.
- (11) Monitoring the implementation of health care services, required by the payer.

3.10. To which target population is the assessment primarily addressed?

- (1) policy makers for planning future development and funding of model practises as national standard for family medicine practises
- (2) The assessment is continuously communicated back to involved stakeholders, with whom the MoH collaborates in identifying the key measures for the Strategy. The document will be given in public and political debate before the final version will be adopted by Slovene Parliament.
- (3) decision makers, experts, providers, researchers and other interested public
- (4) The assessment was primarily addressed to the policy decision makers, the Ministry of Health Slovenia as well as the whole Government and other sectors, who are the key decision-makers to support the proposed healthcare reform. It was also aimed to address all other political stakeholders as well as professional stakeholders and general public.
- (5) The assessment was primarily addressed to the policy decision makers, the Ministry of Health Slovenia as well as the whole Government and other sectors, who are the key decision-makers to support the proposed healthcare reform. It was also aimed to address all other political stakeholders as well as professional stakeholders and general public.
- (6) Decision makers, experts, providers, researchers and other interested public
- (7) Policy makers (inter-sectoral), healthcare managers, healthcare professionals, public health professionals, and patients.
- (8) The assessment is addressed to policy makers.

- (9) Decision makers, experts, health care managers, physicians
- (10) To policy makers, to HIIS Supervisory Board, to healthcare providers, to other interested public.
- (11) To policy makers, to HIIS Supervisory Board, to healthcare providers, to other interested public.

3.11. How is performance information fed back to primary care providers?

- (1) feedback loop is not finished yet
- (2) The assessment is continuously communicated back to involved stakeholders, with whom the MoH collaborates in identifying the key measures for the Strategy. The document will be given in public and political debate before the final version will be adopted by Slovene Parliament.
- (3) There is no direct informing, but public. Information in Slovenian language is limited.
- (4) The outcome of the assessment was communicated widely to all political, professional and general public. This report as well as reports of other parts of assessment are published and freely accessible to every interested person at the MoH homepage. Providers could, therefore, compare their own working practices to those presented in the report.
- (5) The outcome of the assessment was communicated widely to all political, professional and general public. This report as well as reports of other parts of assessment are published and freely accessible to every interested person at the MoH homepage. Providers could, therefore, compare their own working practices to those presented in the report.
- (6) There is no direct informing, but public
- (7) The report is published and freely accessible to every interested person at the NIPH homepage. The results of the assessment were widely published at scientific and other meetings in Slovenia.
- (8) This assessment was not intended to be presented to individual providers. However, it is publicly available on web.
- (9) There is no direct informing, but public. Information in Slovenian language is limited.
- (10) The report is published and freely accessible to healthcare providers at the HIIS homepage. Providers can, therefore, compare their own working results to the results of other providers.
- (11) The report is published and freely accessible to healthcare providers at the HIIS homepage. Providers can, therefore, compare their own working results to the results of other providers.

3.12. Has the assessment been presented in a publicly accessible document or website?

- (1) is not yet publicly available, but will be available providers. findings will be published in scientific articles.
- (2) After being scrutinized in public debate and the final version adopted by the Slovene Parliament, the document will be published and freely accessible to every interested person at the MoH homepage.
- (3) The findings are published in the publication, which is freely available on the web. This publication was written in English.
- (4) This report as well as reports of other parts of assessment are published and freely accessible to every interested person at the MoH homepage.
- (5) This report as well as reports of other parts of assessment are published and freely accessible to every interested person at the MoH homepage.
- (6) The findings are published in the publication, which is freely available on the web. This publication was written in English.
- (7) The report is published and freely accessible to every interested person at the NIPH homepage.
- (8) Yes, the document is publicly available on web.

- (9) The findings are published in the publication, which is freely available on the web. This publication was written in English.
- (10) The report is published and freely accessible at the HHS homepage.
- (11) The report is published and freely accessible at the HHS homepage.

Question 4

At what level of aggregation are the data published?

- (1) Data are published at the national level (analysis of employee satisfaction, comparison of the values of individual indicators between public healthcare institutions and private providers with concession) at 10 regional units of the Health Insurance Institute.
- (2) National level, with individual examples of good practices at provider level.
- (3) Data are published at national level, in the context of international comparisons.
- (4) The data presented is aggregated at national level, with international comparisons. In addition, there are individual examples of good practices at provider level.
- (5) The data published are aggregated at the national level with international comparisons.
- (6) Data are published at the national level, the level of health care provider, by professional group, etc.
- (7) The data and information were collected in focus groups with selected individuals. The data cannot be generalized to practice / regional / national level.
- (8) The analysis is based on various geographical levels with main level being the Health Insurance Institute Regional Unit, but also at level of municipalities and postal districts.
- (9) Data are published at regional level (pilot study in 2 regions).
- (10) The data are presented on level of provider and aggregated to regional and national levels.
- (11) The data are presented on level of provider and aggregated to regional and national levels.

Question 5

What types of indicators are reported in the assessment?

- (1) Indicators measuring clinical performance: Periodic check-ups of chronically ill (e.g. diabetes, cardiovascular diseases, etc.); Indicators measuring patient-centeredness or responsiveness and satisfaction: availability of essential patient information in records, cooperation; Any outcomes indicators that may be related with primary care performance in general (sometimes both access and quality): Admissions for ambulatory care sensitive conditions (such as diabetes, COPD, etc.); Outcomes indicators that may be related with primary care performance in general (sometimes both access and quality): GPs' involvement in delivery of various primary care services, patient satisfaction with aspects of care provision (Relation with PC physician, Consultation, duration, Interest of PC physician in personal situation PC physician's, explanation)
- (2) All types of indicators proposed in the overview, except clinical performance indicators that are not subject to this assessment.
- (3) only general description of primary care services, providers, organization, payment mechanisms, etc.
- (4) The assessment reports the following types of indicators: - outcomes indicators that may be related with primary care performance in general (trends in avoidable hospitalizations), indicators measuring patient-centeredness or responsiveness, - descriptive information about providers or organisations.

- (5) Descriptive information about purchasing and payment mechanisms at all levels of healthcare.
- (6) All types of indicators in the proposed overview; General descriptive information about providers or organisations: average consultation length at general practice, range of services provided, presence of accreditation certificates, etc.
- (7) Indicators measuring access, Indicators measuring patient-centeredness or responsiveness, Indicators measuring equity.
- (8) Indicators measuring access, Indicators measuring costs, waste or efficiency
- (9) All types of indicators in the proposed overview.
- (10) Indicators measuring costs, waste or efficiency.
- (11) Indicators measuring costs, waste or efficiency.

Question 6

Have workload and job satisfaction of primary care providers been measured and reported?

If yes, how and on what scale?

- (1) Yes, with developed and validated questionnaire (once a year).
- (2) To the degree presented in previously conducted assessments.
- (3) No.
- (4) Job satisfaction of PC providers has been investigated and reported, as perceived by the individual providers interviewed.
- (5) No, this is not the subject of this assessment.
- (6) No.
- (7) Yes, in focus groups with providers of preventive services, on individual provider scale.
- (8) No
- (9) Reflections of GPs on conditions for quality improvement ("I spend sufficient time on various activities to improve my professional skills", etc.).
- (10) No
- (11) No

Question 7

Please present your methodological approach. In particular, please explain how are the indicators developed, what risk adjustment methods are being used (if any), how is internal variability being addressed, etc.

- (1) The assessment is based on the available reports by individual providers (annual reports on curative and preventive services delivered, patient satisfaction, provider's satisfaction, and quality indicators) and HII Slovenia data. Quality indicators are being developed in the project team. The indicators are mutually agreed and provide good basis for monitoring the performance of model practises of family medicine.
- (2) The assessment is based on the available reports of previous assessments and on the data and information provided by involved representatives of stakeholders. The goal was to involve all stakeholders.
- (3) Descriptive data was collected from published literature, various reports and input of individual experts.
- (4) The assessment used mixed quantitative and qualitative methodology approach. The presented indicators were prepared according to OECD methodology, the interviews and focus groups were conducted according to standard methodology.
- (5) The assessment is descriptive. The information was gathered by inputs of working group members, representing key stakeholders in purchasing and payment processes in Slovenia.
- (6) A systematic literature review was undertaken to identify the key dimensions of primary care for The European Primary Care Monitor.
- (7) The needs assessment was performed with focus groups of different professionals, delivering preventive services. The methodology used was standard focus groups methodology.
- (8) The indicators of the availability and effectiveness of primary health care services were developed on basis of regularly and routinely collected data in Slovenia.
- (9) The Tool consists of three parts: a questionnaire for national-level policy experts, a questionnaire for managers of primary care facilities and a questionnaire for general practitioners (GPs). The Tool was pilot tested in 2007 in two regions of Slovenia: Gorenjska region and Ljubljana city. Questionnaires were completed by national policy experts from different stakeholder organizations of the health system, and by managers and GPs from the two pilot regions. The results rely strongly on self-reported behaviour rather than on direct observations or registrations.
- (10) The data is collected from all public health service providers. The reporting of data is precondition for reimbursement of delivered services.
- (11) The data is collected from all public health service providers. The reporting of data is precondition for reimbursement of delivered services.

Question 8

Which procedures are in place to promote the validity, reliability and relevance of the assessment?

- (1) Peer reviews, questionnaires were validated by project team members prior to their applications.
- (2) Peer reviews, Steering Committee review, public debate.
- (3) Peer reviews, Scientific advisory board, provided by European Observatory for Health Systems and Policies
- (4) Scientific advisory board, provided by European Observatory for Health Systems and Policies.
- (5) Scientific advisory board, provided by European Observatory for Health Systems and Policies.
- (6) Peer reviews, Scientific advisory board
- (7) No such procedures were applied.
- (8) No such procedures were applied.
- (9) On the basis of the information and feedback from the preparatory meeting, the draft versions of the questionnaires were revised. The revised versions were then forwarded to the meeting participants for comment and possible suggestions for change (clarity, omissions, terminology)

(10) Legal control, performed by HIIS.

(11) Legal control, performed by HIIS.

Question 9

To what degree is performance assessment embedded in the policy process?

(1) Linking to annual work plan and budget. It will be used as starting point for upgrading of existing programs.

(2) It serves as a basis for drafting the National strategy for primary care development in Slovenia 2017 - 2025.

(3) The report provides general overview of the current state of the healthcare system in Slovenia and has been frequently considered in various policies processes.

(4) It serves as a basis for developing the National Healthcare Plan 2015 - 2025.

(5) It serves as a basis for developing the National Healthcare Plan 2015 - 2025.

(6) The aim of the assessment was not to be used in the policy process.

(7) It is used as starting point for upgrading of existing programs. The upgrade of programs was developed and is in the process of implementation at national scale, by support of MoH.

(8) No information.

(9) The assessment served for improving the quality of family medicine practices. It also provided a basis for development of quality assurance system in the National healthcare plan.

(10) Linking to annual work plan and budget.

(11) Linking to annual work plan and budget.

Question 10

What is the evidence that the assessment has impacted on policy?

(1) The survey findings are intended to be used in the policy later this year. Initiatives to enforce additional funding are very strong and this report provides evidence on efficiency and good performance of model practices.

(2) n/a

(3) Data often used for healthcare policy making, as evident by referring to the data and healthcare policy documents.

(4) The National Healthcare Plan 2015 - 2025, based on the present assessment, has been adopted by Slovene Government. The changes in healthcare legislation, implementing the measures listed in the NHP, are in the process of adoption in time of writing this report.

(5) The National Healthcare Plan 2015 - 2025, based on the present assessment, has been adopted by Slovene Government. The changes in healthcare legislation, implementing the measures listed in the NHP, are in the process of adoption in time of writing this report.

(6) The report serves in policy processes related to primary care, as evidenced by its citations.

(7) The upgrade of NCDs prevention programs for adults was developed on the basis of this assessment and is in the process of implementation at national scale.

(8) No evidence.

- (9) The report serves in policy processes related to primary care, as evidenced by its citations.
- (10) Data often used for healthcare policy making, as evident by referring to the data in healthcare policy documents.
- (11) Data often used for healthcare policy making, as evident by referring to the data in healthcare policy documents.

Question 11

Please summarise (briefly) the major limitations and main strengths of assessments of primary care performance in your country.

- (1) Limitations: Analysis was conducted on the basis of existing data. Any additional research was carried out to support findings. There were difficulties in provision of standardized IT supported data collection from all providers (653).
Strengths: A lot of data collected for further interpretation and action. Based on predefined quality indicators.
- (2) Strengths: Involvement of representatives of all stakeholders. Limitation: The data needed to clarify the underlying causes of identified challenges are frequently not available.
- (3) Limitations: The chapter on primary care is not presented in depth. Data on the performance assessment are rather sparse.
Strengths: Assessment of primary care is presented as part of the assessment of the performance of the healthcare system as a whole.
- (4) Strength: The assessment assessed the key challenges of the healthcare service delivery, also involving primary care. It was based on qualitative assessment, which provided useful information from the field. Limitation: According to the aim of the assessment, the PC was not assessed comprehensively; rather limited characteristics of PC were assessed.
- (5) Strengths: Good description of purchasing mechanism at primary care level for physicians and their teams, and of the role of the National Health Insurance Fund in the purchasing process. Limitation: The purchasing and payment mechanisms for providers at primary care are limited to physicians and their teams and do not consider other healthcare workforce.
- (6) Limitations: Very little data is available about the quality of primary care in Slovenia.
Strengths: It is very complex view of Primary Care in Slovenia with information on its development over time.
- (7) Limitation: The results of this assessment were not validated. Strengths: The focus groups were performed with many diverse groups of users and of providers of prevention services. A lot of valuable 'from the field' information was collected.
- (8) Limitations: It doesn't assess other professionals working at primary care, only general / family physicians and partially also paediatric dispensers.
Strengths: It assesses all relevant aspects for defining and planning the general / family medicine network in Slovenia.
- (9) Limitations: It is a study in two regions, so data cannot be generalized.
Strengths: The survey findings are a good basis for further work.
- (10) Limitations: Difficult to find the data you need. Strengths: Very complex and comprehensive. Raw data published, so you can calculate indicators by yourself. Reliable.
- (11) Limitations: Difficult to find the data you need. Strengths: Very complex and comprehensive. Raw data published, so you can calculate indicators by yourself. Reliable.

Question 12

What are the future plans with regard to primary care assessment?

Quality assessment of model practices of family medicine will be continuously performed in the future.
The Strategy for the development of primary care foresees a governmental body dedicated to systematic and comprehensively planned monitoring and evaluation of primary health care and its development. For quality and safety assurance new legislation is being prepared by Ministry of Health of the Republic of Slovenia.

SPAIN

Question 1

Are there any recurrent or one-off assessments carried out of the performance of (parts of) the organisation and/or functioning of primary care in your country?

In Spain performance evaluation is carried out, at National Level by the Ministry of Health, Social Services and Equality. At Regional level through the evaluation of the Management Contract that is defined annually for that purpose. This one measures activity, budget execution and other dimensions such as: effectiveness, efficiency, citizen satisfaction, technical scientific quality (Services Portfolio) and accessibility.

Question 2

Please provide a brief description of these assessments (name and type of product)

At national level, the evaluation is based on quantitative and qualitative data provided by different sources of data by the Autonomous Communities and information is published in Statistical Site of the MoH; it includes population data (number of people assigned to primary care teams), ratios professional/inhabitants, resources, activity data, clinical indicators as well as other information like pharmaceuticals consumption and results as mortality by cause). Likewise some compilation reports are available (Portfolio of Common PC Services, PC Procedures and accesses to tests). Surveys as National Interview Survey or Health Barometer are other source of information. Through them general citizen's perception on their health status or user's satisfaction and perception of the first level of health care are known.

- a) Catalogue of primary and emergency care centres
- b) Portfolio of Common Services
- c) SIAP (Primary Health Care Information System)
- d) BDCAP (Primary Health Care Clinical Database)
- e) Catalogue of procedures and access to clinical procedures
- f) Health Barometer
- g) ENSE- National Health Interview Survey
- h) CMBD - Hospital Discharge Minimum Data Set - for preventable admissions
- i) Annual report of the NHS
- j) Evaluation of Management Contracts or Contracts Programs (at Regional Level - Under Autonomous Health Authorities)

For each assessment, please specify:

3.1. Is the report – or part of it – done because of legal requirements? If not, what is the main reason to carry it out?

Law 16/2003 of May 28 of cohesion and quality of the National Health System, in its article 55 establishes the creation of a Health Information System and designates the Institute of Health Information at the MoH as the unit responsible for such Information System. In the Autonomous Communities there is also legislation that establishes the need to create a Health Information System.

In the Autonomous Communities, a contractual relationship is established annually with the Health Centres / Centres (according to Autonomous Communities) for performance evaluation.

- a) Catalogue of primary and emergency care centres – Information
- b) Portfolio of Common Services – Information – Statistics
- c) SIAP (Primary Health Care Information System) – Statistics
- d) BDCAP (Primary Health Care Clinical Database) – Statistics
- e) Catalogue of procedures and access to clinical procedures – Information
- f) Health Barometer – Statistics
- g) ENSE- National Health Interview Survey – Statistics
- h) CMBD - Hospital Discharge Minimum Data Set - for preventable admissions – Statistics
- i) Annual report of the NHS – Information
- j) Evaluation of Management Contracts or Contracts Programs (at Regional Level - Under Autonomous Health Authorities) – One-off

3.2. When did it take place?

- a) Catalogue of primary and emergency care centres – Annual
- b) Portfolio of Common Services – Every 5 years
- c) SIAP (Primary Health Care Information System) – Annual
- d) BDCAP (Primary Health Care Clinical Database) – Annual
- e) Catalogue of procedures and access to clinical procedures – Every 4 years
- f) Health Barometer – Annual
- g) ENSE- National Health Interview Survey – Every 5 years
- h) CMBD - Hospital Discharge Minimum Data Set - for preventable admissions – Annual
- i) Annual report of the NHS – Annual
- j) Evaluation of Management Contracts or Contracts Programs (at Regional Level - Under Autonomous Health Authorities) – Autonomous Communities

3.3. Which organisation commissioned the assessment?

- a) Catalogue of primary and emergency care centres – Ministry
- b) Portfolio of Common Services – Ministry
- c) SIAP (Primary Health Care Information System) – Ministry
- d) BDCAP (Primary Health Care Clinical Database) – Ministry
- e) Catalogue of procedures and access to clinical procedures – Ministry
- f) Health Barometer – Ministry

- g) ENSE- National Health Interview Survey – Ministry
- h) CMBD - Hospital Discharge Minimum Data Set - for preventable admissions – Ministry
- i) Annual report of the NHS – Ministry
- j) Evaluation of Management Contracts or Contracts Programs (at Regional Level - Under Autonomous Health Authorities) – Autonomous Communities

3.4. Which organisation carried it out?

- a) Catalogue of primary and emergency care centres – Ministry and Autonomous Communities
- b) Portfolio of Common Services – Ministry and Autonomous Communities
- c) SIAP (Primary Health Care Information System) – Ministry and Autonomous Communities
- d) BDCAP (Primary Health Care Clinical Database) – Ministry and Autonomous Communities
- e) Catalogue of procedures and access to clinical procedures – Ministry and Autonomous Communities
- f) Health Barometer – Ministry of Health + Institute of Sociological Research
- g) ENSE- National Health Interview Survey – Ministry of Health + National Statistical Office
- h) CMBD - Hospital Discharge Minimum Data Set - for preventable admissions – Ministry and Autonomous Communities
- i) Annual report of the NHS – Ministry and Autonomous Communities
- j) Evaluation of Management Contracts or Contracts Programs (at Regional Level - Under Autonomous Health Authorities) – Autonomous Communities

3.5. What other stakeholders were involved and how?

- a) Catalogue of primary and emergency care centres – Any
- b) Portfolio of Common Services – Any
- c) SIAP (Primary Health Care Information System) – Any
- d) BDCAP (Primary Health Care Clinical Database) – Any
- e) Catalogue of procedures and access to clinical procedures – Any
- f) Health Barometer – Any
- g) ENSE- National Health Interview Survey – Any
- h) CMBD - Hospital Discharge Minimum Data Set - for preventable admissions – Any
- i) Annual report of the NHS – Any
- j) Evaluation of Management Contracts or Contracts Programs (at Regional Level - Under Autonomous Health Authorities)– Any

3.6. Which types of primary care were parts of the assessment?

- a) Catalogue of primary and emergency care centres – All professionals
- b) Portfolio of Common Services – All professionals
- c) SIAP (Primary Health Care Information System) – General practice/Paediatrics/Nurses
- d) BDCAP (Primary Health Care Clinical Database) – All professionals
- e) Catalogue of procedures and access to clinical procedures - General practice/Paediatrics
- f) Health Barometer - Population sample

- g) ENSE- National Health Interview Survey - Population sample
- h) CMBD - Hospital Discharge Minimum Data Set - for preventable admissions - All professionals
- i) Annual report of the NHS - All professionals
- j) Evaluation of Management Contracts or Contracts Programs (at Regional Level - Under Autonomous Health Authorities) - All professionals

3.7. Which is the level of reporting?

- a) Catalogue of primary and emergency care centres – National/Regional
- b) Portfolio of Common Services – National/Regional
- c) SIAP (Primary Health Care Information System) – National/Regional
- d) BDCAP (Primary Health Care Clinical Database) – National/Regional
- e) Catalogue of procedures and access to clinical procedures – National/Regional
- f) Health Barometer – National/Regional
- g) ENSE- National Health Interview Survey – National/Regional
- h) CMBD - Hospital Discharge Minimum Data Set - for preventable admissions – National/Regional
- i) Annual report of the NHS – National
- j) Evaluation of Management Contracts or Contracts Programs (at Regional Level - Under Autonomous Health Authorities) – Regional/Local

3.8. What is the focus of the assessment?

- a) Catalogue of primary and emergency care centres - Structure/Resources
- b) Portfolio of Common Services - Organization/General Issues
- c) SIAP (Primary Health Care Information System) - Resources/Activity
- d) BDCAP (Primary Health Care Clinical Database) - Morbidity/Patients profiles/use of Specialized services/prescription
- e) Catalogue of procedures and access to clinical procedures - Resources/Accessibility
- f) Health Barometer - Opinion/perception PC services/professionals
- g) ENSE- National Health Interview Survey - Health self-reporting/Health Determinants/Use of services (PC/Day Services/Emergency/Hospital/Pharmaceuticals)
- h) CMBD - Hospital Discharge Minimum Data Set - for preventable admissions - Impact of primary care
- i) Annual report of the NHS - Primary care in general
- j) Evaluation of Management Contracts or Contracts Programs (at Regional Level - Under Autonomous Health Authorities) - Effectiveness, efficiency, citizen satisfaction, technical scientific quality (Services Portfolio) and accessibility.

3.9. What is the function of the assessment?

- a) Catalogue of primary and emergency care centres – General reporting
- b) Portfolio of Common Services - Comparative benchmark
- c) SIAP (Primary Health Care Information System) – General reporting
- d) BDCAP (Primary Health Care Clinical Database) – General reporting

- e) Catalogue of procedures and access to clinical procedures – General reporting
- f) Health Barometer – General reporting
- g) ENSE- National Health Interview Survey – General reporting
- h) CMBD - Hospital Discharge Minimum Data Set - for preventable admissions – General reporting
- i) Annual report of the NHS – General reporting
- j) Evaluation of Management Contracts or Contracts Programs (at Regional Level - Under Autonomous Health Authorities) - Performance-based reimbursement schemes

3.10. To which target population is the assessment primarily addressed?

- a) Catalogue of primary and emergency care centres – General population, clinicians and healthcare managers and policy markers
- b) Portfolio of Common Services – General population, clinicians and healthcare managers and policy markers
- c) SIAP (Primary Health Care Information System) – General population, clinicians and healthcare managers and policy markers
- d) BDCAP (Primary Health Care Clinical Database) – General population, clinicians and healthcare managers and policy markers
- e) Catalogue of procedures and access to clinical procedures – General population, clinicians and healthcare managers and policy markers
- f) Health Barometer – General population, clinicians and healthcare managers and policy markers
- g) ENSE- National Health Interview Survey – General population, clinicians and healthcare managers and policy markers
- h) CMBD - Hospital Discharge Minimum Data Set - for preventable admissions – General population, clinicians and healthcare managers and policy markers
- i) Annual report of the NHS – General population, clinicians and healthcare managers and policy markers
- j) Evaluation of Management Contracts or Contracts Programs (at Regional Level - Under Autonomous Health Authorities) – General population, clinicians and healthcare managers and policy markers

3.11. How is performance information fed back to primary care providers?

- a) Catalogue of primary and emergency care centres – Not individual providers (teams/professionals)
- b) Portfolio of Common Services – Not individual providers (teams/professionals)
- c) SIAP (Primary Health Care Information System) – Not individual providers (teams/professionals)
- d) BDCAP (Primary Health Care Clinical Database) – Not individual providers (teams/professionals)
- e) Catalogue of procedures and access to clinical procedures – Not individual providers (teams/professionals)
- f) Health Barometer – Not individual providers (teams/professionals)
- g) ENSE- National Health Interview Survey – Not individual providers (teams/professionals)
- h) CMBD - Hospital Discharge Minimum Data Set - for preventable admissions – Not individual providers (teams/professionals)
- i) Annual report of the NHS – Not individual providers (teams/professionals)
- j) Evaluation of Management Contracts or Contracts Programs (at Regional Level - Under Autonomous Health Authorities) – Yes (mostly)

3.12. Has the assessment been presented in a publicly accessible document or website?

- a) Catalogue of primary and emergency care centres – Yes
- b) Portfolio of Common Services – Yes
- c) SIAP (Primary Health Care Information System) – Yes
- d) BDCAP (Primary Health Care Clinical Database) – Yes
- e) Catalogue of procedures and access to clinical procedures – Yes
- f) Health Barometer – Yes
- g) ENSE- National Health Interview Survey – Yes
- h) CMBD - Hospital Discharge Minimum Data Set - for preventable admissions – Yes
- i) Annual report of the NHS – Yes
- j) Evaluation of Management Contracts or Contracts Programs (at Regional Level - Under Autonomous Health Authorities) – Variable according to Autonomous Community

Question 4

At what level of aggregation are the data published?

In general, national and regional levels. In the evaluation of management contracts at local and provider level.

Question 5

What types of indicators are reported in the assessment?

Indicators measuring access

Indicators measuring clinical performance

Indicators measuring patient-centeredness or responsiveness

Indicators measuring costs, waste or efficiency

Indicators measuring equity

Any outcomes indicators that may be related with primary care performance in general (sometimes both access and quality)

General descriptive information about providers or organisations

Question 6

Have workload and job satisfaction of primary care providers been measured and reported?

If yes, how and on what scale?

Ratio of users per quota.

Burden of chronicity/patients (various systems)

In some Autonomous Communities, a survey on the work environment is carried out.

Some EFQM Model evaluations are carried out having into account this aspect directly or indirectly among others

Question 7

| |
|---|
| Please present your methodological approach. In particular, please explain how are the indicators developed, what risk adjustment methods are being used (if any), how is internal variability being addressed, etc. |
| The indicators are generally based on a consensus procedure, taking into account historical and feasibility elements. Crude rates are usually obtain and sometimes adjusted for age and sex. |
| Question 8 Which procedures are in place to promote the validity, reliability and relevance of the assessment? |
| Pear reviews and scientific advisory board are common |
| Question 9 To what degree is performance assessment embedded in the policy process? |
| By reporting to the Minister or the Parliament at set times Linking to annual budget or national/local contract Coordination between Ministry and Autonomous Communities (Inter-territorial Council) through national strategies |
| Question 10 What is the evidence that the assessment has impacted on policy? |
| More than 30 years of Primary Health Reform in Spain has had as a consequence a high level of citizen's satisfaction with primary health care services. This is the result of a high technical scientific quality of PC professionals working with health programs. Areas to improve are communication with the patient, investment in the comfort of health centres, or improvement of administrative issues which are usually not as well evaluated in surveys. Annual evaluations of Contract Programs lead to include key indicators for potential strategic lines of work in health centres. Adherence to them and the results found are also a sign of positive impact as well as the stable tendency of spending containment and efficiency at the same time there is a slight improvement in certain health problems prioritized (Cardiovascular diseases, COPD ..). Health promotion and knowledge of health determinants are also improved areas. It is remarkable the various national strategies developed: chronicity, health promotion, Ischemic Heart disease, chronic obstructive pulmonary disease, Diabetes, Stroke, among others launched after an initial deep evaluation of the situation as well as a necessity study. Progressive improvements and evolution in benefit catalogues and coordination between levels can be also noticed. A School of patients has also been launch in the national patient safety strategy as well as other regional functional structures coordinating such strategy |
| Question 11 Please summarise (briefly) the major limitations and main strengths of assessments of primary care performance in your country. |

| |
|---|
| <p>Regarding resources, there is still a problem of computerization (registration) and integration of information both among care levels and with other institutions as well as those providing social care. This affects not only national but also regional.</p> <p>The different health policies, besides the existence of a national health council (inter-territorial board), causes regionally oriented evaluations rather than national avoiding sometimes a whole picture.</p> <p>Another of the limitations is the lack of standardization of data, both at regional and national level, apart from the lack of coordination between them in terms of dimensions on which assessments are performed:</p> <p>Equity and resilience are difficult to assess and scarcely evaluated</p> <p>Effectivity is scarcely explored and reported</p> <p>Efficiency is especially explored in the pharmaceutical consumption and expenditure but it should be studied in other aspects</p> |
| <p>Question 12</p> <p>What are the future plans with regard to primary care assessment?</p> |
| <p>To address evaluation exercises to outcomes and health outputs and to the sustainability of the health system as well</p> |

REFERENCES - PRIMARY HEALTH CARE ASSESSMENT AVAILABLE INFORMATION

There is a General Law (Ley 16/2003) on Cohesion and Quality for the National Health System where (Art 55) establishes a Health Information System under the responsibility of the Ministry of Health

Statistical Site - Ministry of Health

<http://www.msssi.gob.es/en/estadEstudios/portada/home.htm>

Contents:

- Rules:
 - o Primary Health Districts: Health General Act (14/1986)
 - o Primary Health Teams: Royal Decree 137/1984
- Resources – Activity Statistics
 - o Primary Health Centers Catalogue and Portfolio
 - <http://www.msssi.gob.es/en/ciudadanos/prestaciones/centrosServiciosSNS/hospitales/home.htm>
 - <http://www.msssi.gob.es/en/estadEstudios/estadisticas/estadisticas/estMinisterio/siap.htm>
- Clinical DataBase on Primary Health – population based

- <http://www.msssi.gob.es/estadEstudios/estadisticas/estadisticas/estMinisterio/SIAP/home.htm>
- Pharmaceutical co-payment regulation:
 - <http://www.msssi.gob.es/profesionales/farmacia/home.htm>

- **Citizen opinion**

- **Health Barometer:**

http://www.msssi.gob.es/estadEstudios/estadisticas/BarometroSanitario/home_BS.

(Spanish)

Specific indicators – other sources

CMBD (Minimum basic Data Set – Hospitals) -> Preventable hospitalization

Available in: Model of Hospital Indicators (interactive tool):

<http://icmbd.es/login-success.do> (English)

Health Interview survey

- Self-perception Health study.
- Health determinants

Autonomous Communities – Regions Health Authorities

- <http://www.msssi.gob.es/en/organizacion/ccaa/directorio/home.htm> (Spanish)

Patient Safety in Primary Health Care Centers – Estudio APEAS 2008 in:

- <http://www.msc.es/organizacion/sns/planCalidadSNS/resumenEstudioApeas2008.htm>

SWEDEN

Question 1

Are there any recurrent or one-off assessments carried out of the performance of (parts of) the organisation and/or functioning of primary care in your country?

Health care in Sweden is decentralized to a major degree, though controlled by several laws e.g. the Health Care Act and the Patient Act. Thus the development of performance assessment has been increasingly developed based on extensive cooperation between the national level, the county councils and the medical professions. Both open regional comparisons and evaluations have for many years presented data on county council and hospital level. The main focus, however, has so far been primarily on the county council population level. The national reports, based on indicators, mainly reflects performance on a general system level, as the indicators measuring outcomes often include activities both in primary care and specialist care. Some of the reports do include performance aspects which mirrors primarily activities in primary care, for example drug use, diabetic care etc. National patient surveys covers primary care but not regularly every year. Also data on waiting times are collected from primary care. Restricted by law the national level is not allowed to have a national register for activities in primary care, as we have on specialized care.

Question 2

Please provide a brief description of these assessments (name and type of product)

For example on regional comparisons and evaluations on compliance to guidelines, please follow the links below
<http://www.socialstyrelsen.se/publikationer2013/2013-5-7> <http://www.socialstyrelsen.se/publikationer2014/2014-3-18> Descriptions of Swedish quality assessment in general is also available in the "So what"-report. Please note that much of the information given in this questionnaire relates to quality measurement in general in Sweden, not only primary care (see also above)

Question 3

For each assessment, please specify:

3.1. Is the report – or part of it – done because of legal requirements? If not, what is the main reason to carry it out?

There is no binding regulation requiring assessment reporting on the National or regional level. However e.g. The National Board of Health and Welfare has, as a part of its instruction, the task of follow up and evaluating health and social care. Furthermore, the regional level (the health care providers) is also expected to evaluate health care activities on regional and local level. This is stipulated in the overall health care law. Sweden has a long tradition of measuring and publishing data in a transparent way. Some reporting to the national registers are required by law, though.

3.2. When did it take place?

Not relevant

3.3. Which organisation commissioned the assessment?

Not relevant

3.4. Which organisation carried it out?

| |
|--|
| Not relevant |
| 3.5. What other stakeholders were involved and how? |
| Not relevant |
| 3.6. Which types of primary care were parts of the assessment? |
| As mentioned earlier there are no legal requirements. Reports that are published still include data from many different parts of health care. |
| 3.7. Which is the level of reporting? |
| The assessments in general are performed both on the regional level and on the national level. Sometimes hospitals and municipalities are compared. |
| 3.8. What is the focus of the assessment? |
| |
| 3.9. What is the function of the assessment? |
| Mainly general reporting and comparative benchmark. There are two different kinds of reports with different kind of processes and objectives. Regional comparisons and evaluations on compliance to national guidelines. The national level does not use comparisons for reimbursement as financing and responsibility for health care is a county matter in Sweden. |
| 3.10. To which target population is the assessment primarily addressed? |
| Policy makers, health care managers and clinicians. It depends on the report |
| 3.11. How is performance information fed back to primary care providers? |
| Not by reading the actual reports but websites makes it possible to some extent |
| 3.12. Has the assessment been presented in a publicly accessible document or website? |
| In general, all reports on health system assessment are publically available. |
| Question 4 |
| At what level of aggregation are the data published? |
| Mainly on national and regional/local level. Sometimes on hospital level. As we do not have primary care registers we cannot publish data on primary care provider level. Except for some information from patient surveys and on waiting times. |
| Question 5 |
| What types of indicators are reported in the assessment? |
| Please see the links to reports |
| Question 6 |
| Have workload and job satisfaction of primary care providers been measured and reported? |
| If yes, how and on what scale? |
| Sweden takes part in the Commonwealth Funds surveys that covered this subject last year |
| Question 7 |

| |
|--|
| Please present your methodological approach. In particular, please explain how are the indicators developed, what risk adjustment methods are being used (if any), how is internal variability being addressed, etc. |
| <p>The process of developing indicators differs depending on which publication and purpose.</p> <p>Indicators produced for evaluation of national guidelines are based on the central recommendations made within the guideline. These are developed using a proven method with scientific studies as a basis and an assessment of evidence in accordance with GRADE. Delphi processes are arranged when needed. Regional open comparisons use indicators from guidelines but are also complemented by other indicators based on suggestions from professionals responsible for the different registers, including the registers at NBHW. They are included after consideration concerning coverage and overall quality. Every year the indicators are considered, bearing in mind new evidence, new guidelines and input from the ones who use the indicators</p> |
| Question 8 |
| Which procedures are in place to promote the validity, reliability and relevance of the assessment? |
| See above |
| Question 9 |
| To what degree is performance assessment embedded in the policy process? |
| See above, The reports from NBHW are generally targeting both the national government, as well as the county councils. The government use some of the indicators in their budget process. The government can also assign the National Board of Health and Welfare to write a report on a certain subject and develop indicators for that area. An example on that for 2017 is an indicator based report on health care for addiction, an assignment from the ministry. |
| Question 10 |
| What is the evidence that the assessment has impacted on policy? |
| There are qualitative evaluations made on the effects on policies. Trends indicates that transparency and guidelines has effect on the results in health care |
| Question 11 |
| Please summarise (briefly) the major limitations and main strengths of assessments of primary care performance in your country. |
| <p>The possibilities to assess health care in general is quite good and Sweden. For example The national Board of health and welfare hosts several National registers. Furthermore, a large number of quality registers have been developed within different health care settings by the medical professions. A quality registry contains in general individualized data on patient safety and complications, medical interventions, and outcomes after treatment. The last few years the government has financed a substantial part of the development. However, some areas are lacking and activities limited to primary care are difficult to assess through registers. These assessments are complemented with surveys, e.g. national patient surveys etc. Also other methods are used.</p> |
| Question 12 |

What are the future plans with regard to primary care assessment?

From the national point of view we intend to continue to measure primary care, more in a proxy way. Though we still have the possibility to use the pharmaceutical register for describing how primary care works with prescriptions. We will also continue to use patient surveys and data on waiting times. There is some regional work going on that might be used on a national level in the near future.

UNITED KINGDOM

| |
|--|
| Question 1 |
| Are there any recurrent or one-off assessments carried out of the performance of (parts of) the organisation and/or functioning of primary care in your country? |
| Yes |
| Question 2 |
| Please provide a brief description of these assessments (name and type of product) |
| QOF - Quality and Outcomes Framework - Data on prevalence, achievements and exceptions for GP practices in England GP Contract Services - Also known collectively as 'Enhanced Services' - Data on achievement for other services (not part of QOF) |
| Question 3 |
| For each assessment, please specify: |
| 3.1. Is the report – or part of it – done because of legal requirements? If not, what is the main reason to carry it out? |
| Secondary use of payment and administrative data |
| 3.2. When did it take place? |
| Annually for the most part |
| 3.3. Which organisation commissioned the assessment? |
| NHS England, NHS Employers, NICE |
| 3.4. Which organisation carried it out? |
| NHS Digital |
| 3.5. What other stakeholders were involved and how? |
| Working groups with above organisations, including BMA, GMC, RCGP |
| 3.6. Which types of primary care were parts of the assessment? |
| General practice |
| 3.7. Which is the level of reporting? |
| QOF - Practice level, also CCG, Region, National GP Contracts - Practice level |
| 3.8. What is the focus of the assessment? |

| |
|---|
| Management of long term conditions Uptake of vaccination and immunisation programmes management information on other services, e.g. health checks for those with learning disabilities, alcohol |
| 3.9. What is the function of the assessment? |
| predominantly performance based reimbursement |
| 3.10. To which target population is the assessment primarily addressed? |
| policy makers clinicians public/patients |
| 3.11. How is performance information fed back to primary care providers? |
| All data is made publicly available through word, excel and CSV formats. Comparisons can be carried out. |
| 3.12. Has the assessment been presented in a publicly accessible document or website? |
| Yes - all published http://www.content.digital.nhs.uk/qof http://content.digital.nhs.uk/pubs/gpprac1516 |
| Question 4 At what level of aggregation are the data published? |
| QOF - Practice level, also CCG, Region, National GP Contracts - Practice level |
| Question 5 What types of indicators are reported in the assessment? |
| There are 150 indicators+ please see the publications for full details |
| Question 6 Have workload and job satisfaction of primary care providers been measured and reported? If yes, how and on what scale? |
| Unknown |
| Question 7 Please present your methodological approach. In particular, please explain how are the indicators developed, what risk adjustment methods are being used (if any), how is internal variability being addressed, etc. |
| Developed as part of NICE process - https://www.nice.org.uk/standards-and-indicators |

| |
|--|
| Question 8 |
| Which procedures are in place to promote the validity, reliability and relevance of the assessment? |
| Checked at least annually by healthcare professionals, used as part of annual GP contract negotiations |
| Question 9 |
| To what degree is performance assessment embedded in the policy process? |
| Unknown - NHS England may be able to advise on policy - |
| Question 10 |
| What is the evidence that the assessment has impacted on policy? |
| Unknown - NHS England may be able to advise on policy - |
| Question 11 |
| Please summarise (briefly) the major limitations and main strengths of assessments of primary care performance in your country. |
| Not enough data. QOF is the largest data 'collection', but is severely limited in as is used for payment and is therefore tailored to the needs of payments and simplicity of collection, not just the needs of patients/public |
| Question 12 |
| What are the future plans with regard to primary care assessment? |
| Unknown |

| | Name of data source or document | published by | frequency | link |
|-------------------------------------|---|--------------|-----------|---|
| Indicators measuring access | | | | |
| e.g. | | | | |
| - supply of providers | General and Personal Medical Services, England As at 31 Dec 2016 | NHS Digital | Annual | https://www.gov.uk/government/statistics/general-and-personal-medical-services-england-as-at-31-dec-2016 |
| - access during out-of-office hours | Extended access to general practice (see above - General | NHS England | bi-annual | https://www.england.nhs.uk/statistics/statistical-work-areas/extended-access-general-practice/ |
| - geographical | | | | |

| | | | | |
|---|--|---|--------------------------------------|---|
| access | and Personal Medical Services, England As at 31 Dec 2016) | | | |
| Indicators measuring clinical performance | | | | |
| e.g. - Periodic check-ups of chronically ill (e.g. diabetes, cardiovascular diseases, etc.) - prescription or referrals in accordance with guidelines - use or availability of clinical protocols and patient safety procedures - clinical parameters (e.g. hba1c, BMI) - patient related outcome measures (PROMS) | Quality Outcomes Framework (See 'QOF' sheet) Public Health Outcomes Framework (PHOF) NHS Outcomes Framework | NHS Digital Public Health England NHS Digital | various various Annual | http://content.digital.nhs.uk/qof-online http://healthierlives.phe.org.uk/topic/mortality https://www.gov.uk/government/publications/nhs-outcomes-framework-2016-to-2017 |
| Indicators measuring patient-centeredness or responsiveness | | | | |
| e.g. - Patient experiences with provider-patient | GP Patient Survey | NHS Digital | Annual | https://www.england.nhs.uk/statistics/statistical-work-areas/gp-patient-survey/ |

| | | | | |
|---|--|--------|---|--|
| communication - other patient reported experiences about whether care meets expectations - availability of essential patient information in records - adequate transfer of information, e.g. when discharged from hospital | | | | |
| Indicators measuring costs, waste or efficiency | | | | |
| e.g. prescription of generics | <p>1) Costs of medicines in the community, including costs and use of generics: Prescriptions Dispensed in the Community, Statistics for England - 2005-2015: http://content.digital.nhs.uk/catalogue/PUB20664</p> <p>2) Underlying data on costs by drug and drug category: PCA data: http://www.nhsbsa.nhs.uk/PrescriptionServices/3494.aspx</p> <p>3) Information on efficiency and range of primary care performance indicators: Medicines Optimisation Dashboard: https://apps.nhsbsa.nhs.uk/MOD/AtlasCCGMedsOp/atlas.html</p> <p>4) Medicines waste report: https://www.england.nhs.uk/wp-content/uploads/2015/06/pharmaceutical-waste-reduction.pdf</p> <p>In particular, 3) the medicines optimisation dashboard provides a huge range of primary care data and indicators in one place and at a granular level</p> | | | |
| NHS Payments to General Practice, England, 2015/16 | NHS Digital | Annual | https://www.gov.uk/government/statistics/nhs-payments-to-general-practice-england-2015-to-2016 | |
| Investment in General Practice 2011-12 to 2015-16, England, Wales, Northern | NHS Digital | Annual | https://www.gov.uk/government/statistics/investment-in-general-practice-2011-12-to-2015-16-england-wales-northern-ireland-and-scotland | |

| | | | | |
|---|--|---|---------------------------------|---|
| | Ireland and Scotland | | | |
| Indicators measuring equity | | | | |
| e.g. - Access, quality or outcome indicators broken down by specific groups, e.g. gender, socio-economic status, education or ethnic background. - Indicators related to the care for specific de-privileged groups such as homeless people, asylum seekers, illegal immigrants, etc. | Numbers of patients registered at GP practices is actually available by single year age band as well and will be published monthly from April. (also see above under GP Patient Survey) | NHS Digital | annual | https://data.gov.uk/dataset/numbers_of_patients_registered_at_a_gp_practice |
| Any outcomes indicators that may be related with primary care performance in general (sometimes both access and quality) | | | | |
| e.g. - Admissions for ambulatory care sensitive conditions (such as diabetes, COPD, etc.) | CCG Outcomes indicator framework NHS Outcomes Framework CCG Improvement and | NHS Digital NHS Digital NHS England | various Annual Annual | http://content.digital.nhs.uk/ccgois https://www.gov.uk/government/publications/nhs-outcomes-framework-2016-to-2017 https://www.england.nhs.uk/commissioning/ccg-assess/iaf/ |

| | | | | |
|---|---|--------------------------------|---------------------------|---|
| | Assessment Framework Hospital outpatient activity | NHS Digital | Annual | https://www.gov.uk/government/statistics/hospital-outpatient-activity-2015-16 |
| General descriptive information about providers or organisations | | | | |
| e.g. - range of services provided, - presence of accreditation certificates | NHS Choices (see above under Supply of providers) National Performers List | NHS England NHS England | various continuous | https://www.performer.england.nhs.uk/ |

Appendix: questionnaire submitted to Member States

Sheet 1: General Information

Questionnaire to collect national experiences on performance assessment of primary care

for the EU Expert Group on health systems performance assessment

Background

The purpose of this questionnaire is to collect information on national experiences in performance assessment of primary care. The face of primary care - for instance: organisational structures, activities, and type of professionals - differs between countries, as well as the position of primary care in the health system as a whole. So, information about primary care should be understood in the context of each country.

In this questionnaire, primary care is considered to be first contact care, provided by a team of professionals accountable for addressing a large majority of personal health needs. The professionals active in primary care teams include, among others, dentists, dieticians, general practitioners/family physicians, nurses, occupational therapists, optometrists, pharmacists, physiotherapists, psychologists and social workers (see http://ec.europa.eu/health/expert_panel/sites/expertpanel/files/004_definitionprimarycare_en.pdf)

Sheet 2: Questions

Question 1

Are there any recurrent or one-off assessments carried out of the performance of (parts of) the organisation and/or functioning of primary care in your country?

Note: Primary care performance assessments: publications (on paper or online) that systematically report on the performance of primary care in general, or important parts of the primary care system. These performance assessments may be used for monitoring, target setting and / or accountability. The focus of assessments is rather broad than detailed. Assessments do not include studies that evaluate specific interventions or programmes or studies that were solely done for academic purposes. A primary care assessment may also be part of an assessment of the health system in general.

Question 2

Please provide a brief description of these assessments (name and type of product)

| |
|--|
| |
| Question 3 |
| For each assessment, please specify: |
| 3.1. Is the report – or part of it – done because of legal requirements? If not, what is the main reason to carry it out? |
| |
| 3.2. When did it take place? |
| |
| 3.3. Which organisation commissioned the assessment? |
| |
| 3.4. Which organisation carried it out? |
| |
| 3.5. What other stakeholders were involved and how? |
| e.g. - professional organisations - patient organisations - etc. (more types of stakeholders can be added by the respondent) |
| |
| 3.6. Which types of primary care were parts of the assessment? |
| e.g. - General practice / family practice - Midwifery - Paediatrics - Pharmacy - Etc. (more types can be added by the respondent) |
| |
| 3.7. Which is the level of reporting? |
| e.g. - national - regional - Etc. (more levels can be added by the respondent) |
| |

| |
|--|
| 3.8. What is the focus of the assessment? |
| e.g. - primary care in general - care for a specific disease or category of diseases (e.g. mental health in primary care) - type of care (e.g. primary care midwifery, general practice) - specific dimension of primary care (e.g. patient safety, prescribing, etc.) - Etc. (more focuses can be added by the respondent) |
| 3.9. What is the function of the assessment? |
| e.g. - general reporting - comparative benchmark (e.g. between providers) - performance-based reimbursement schemes - Etc. (more functions can be added by the respondent) |
| 3.10. To which target population is the assessment primarily addressed? |
| e.g. - policy makers - clinicians - healthcare managers - patients - Etc. (more target populations can be added by the respondent) |
| 3.11. How is performance information fed back to primary care providers? |
| e.g. Could providers compare they own results to those of other providers? |
| 3.12. Has the assessment been presented in a publicly accessible document or website? |
| Question 4 |
| At what level of aggregation are the data published? |

| |
|---|
| e.g. - national level - regional level - practice level - provider level |
| Question 5 What types of indicators are reported in the assessment? Note: please refer to the "Types of indicators" sheet for an overview |
| Question 6 Have workload and job satisfaction of primary care providers been measured and reported? If yes, how and on what scale? |
| Question 7 Please present your methodological approach. In particular, please explain how are the indicators developed, what risk adjustment methods are being used (if any), how is internal variability being addressed, etc. |
| Question 8 Which procedures are in place to promote the validity, reliability and relevance of the assessment? e.g. - peer reviews - scientific advisory board - specific methods such as Delphi - specific studies to verify data - etc. |
| Question 9 To what degree is performance assessment embedded in the policy process? |

| |
|--|
| e.g. - by reporting to the Minister or the Parliament at set times - linking to annual budget or national/local contract - etc. |
| Question 10 What is the evidence that the assessment has impacted on policy? Please give one or more examples where possible |
| Question 11 Please summarise (briefly) the major limitations and main strengths of assessments of primary care performance in your country. |
| Question 12 What are the future plans with regard to primary care assessment? e.g. - introduction of new tools, products, websites - changes in organisations of the process around the assessment. |

Sheet 3: Types of indicators

| |
|--|
| Indicators measuring access e.g. - supply of providers - availability of specific care arrangements (e.g. disease-management programmes, case management) - waiting times - access during out-of-office hours - financial barriers (e.g. out of pocket payments) - geographical access |
|--|

- unmet needs

Indicators measuring clinical performance

e.g.

- Periodic check-ups of chronically ill (e.g. diabetes, cardiovascular diseases, etc.)
- prescription or referrals in accordance with guidelines
- use or availability of clinical protocols and patient safety procedures
- clinical parameters (e.g. hba1c, BMI)
- patient related outcome measures (PROMS)

Indicators measuring patient-centeredness or responsiveness

e.g.

- Patient experiences with provider-patient communication
- other patient reported experiences about whether care meets expectations
- availability of essential patient information in records
- adequate transfer of information, e.g. when discharged from hospital

Indicators measuring costs, waste or efficiency

e.g.

- e.g. spending per patient of specific categories (such as diabetics)
- overtreatment (e.g. unnecessary test, referrals, medication, etc.)
- prescription of generics
- overhead spending
- procedures taking place in secondary care that could have been taken place in primary care
- use of emergency department for cases that could be treated in primary care

Indicators measuring equity

e.g.

- Access, quality or outcome indicators broken down by specific groups, e.g. gender, socio-economic status, education or ethnic background.
- indicators related to the care for specific de-privileged groups such as homeless people, asylum seekers, illegal immigrants, etc.

Any outcomes indicators that may be related with primary care performance in general (sometimes both access and quality)

e.g.

- Admissions for ambulatory care sensitive conditions (such as diabetes, COPD, etc.)

General descriptive information about providers or organisations

e.g.

- Activity in visits, group and community (e.g. nr. of practice consultations; home visits per time unit); consultation length,
- range of services provided,
- presence of accreditation certificates

HOW TO OBTAIN EU PUBLICATIONS

Free publications:

- via EU Bookshop (<http://bookshop.europa.eu>);
- at the European Union's representations or delegations.
- You can obtain their contact details on the Internet (<http://ec.europa.eu>) or by sending a fax to +352 2929-42758.

Priced publications:

- via EU Bookshop (<http://bookshop.europa.eu>).

Priced subscriptions:

- via one of the sales agents of the Publications Office of the European Union (http://publications.europa.eu/others/agents/index_en.htm).

