

# **POSSIBLE CRITERIA FOR SELECTING PRIORITISED AREAS FOR COMPARISONS AND ASSESSMENT**

## **version 2.1**

Brussels, 24 August 2012

The purpose of this document is to present some criteria to select priority areas for health systems comparison and assessment. Criteria are presented in a short way, providing examples and evidence on possible sources wherever possible. The structure of the document reflects the discussion that took place within the working group at the meeting of 31 May 2012.

The first section presents some criteria to focus comparison and assessment in areas where potential interventions may have the largest impact; the first chapter briefly presents indicators by which impacts on health status can be assessed, while the second one focuses on indicators related to economic impact. A third chapter has been added after the group's discussion, to take into account potential impacts of policy interventions on equity.

The second section is presenting some reflections on methodological criteria, such as possibility of intervention, reaction time, stewardship, and priorities in the political agenda. These criteria can be combined with those presented in the first part, in order to obtain a more comprehensive analysis.

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## A. IMPACT CRITERIA

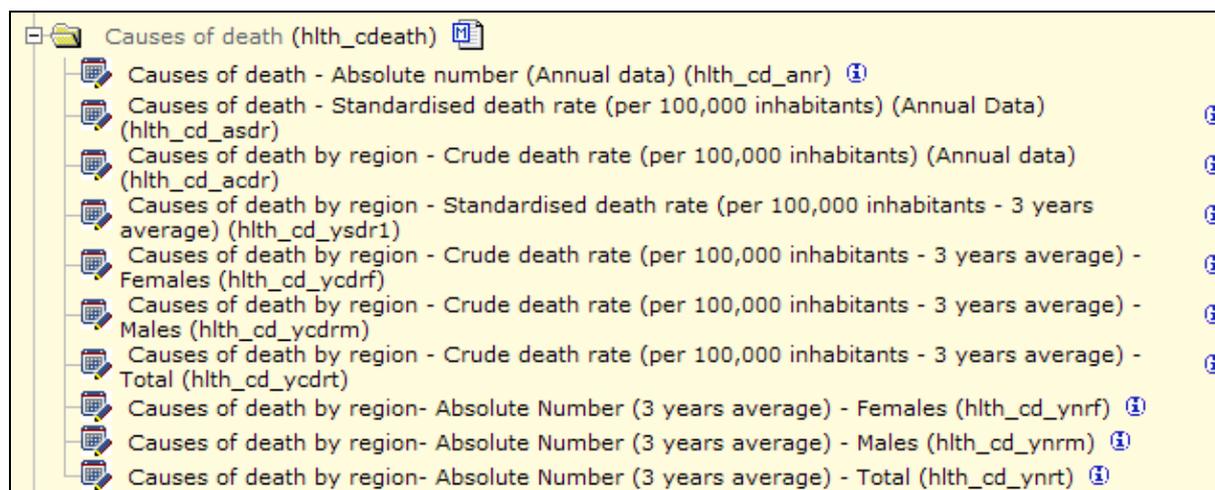
### 1. Impact of policy interventions on population health (health outcomes)

Impact on population health can be measured by focussing on mortality, morbidity, or a mixed measure of them. The following paragraphs present the main options which are available at present time.

#### *Mortality by disease*

It is probably the easiest factor to measure and to monitor. Reliable and comparable statistics on mortality by ICD condition are updated annually. Eurostat presents in its Statistical database figures on absolute number of deaths (national and regional), crude death rate and standardised death rate, as shown by Figure 1.

Figure 1: Eurostat data on causes of death

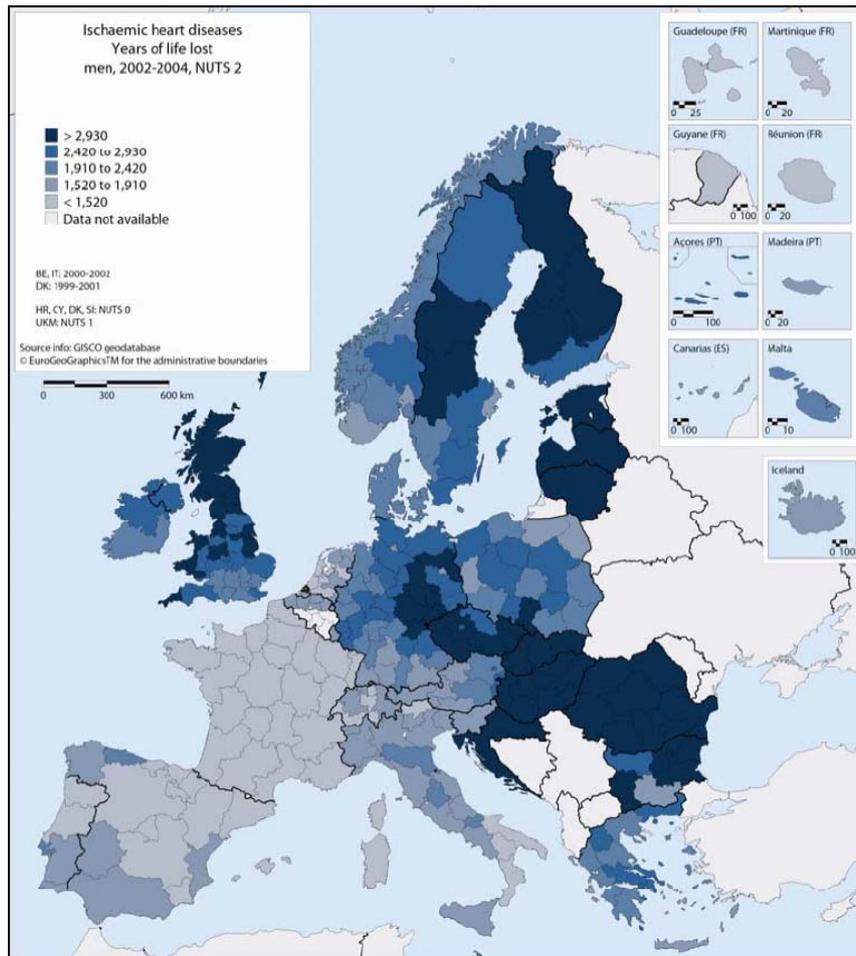


#### *Years of life lost*

They represent the total number of years not lived by an individual with comparison to his/her residual life expectancy at age of death. Years of life lost (YLL) weight mortality, age at death and the population structure. They are not calculated regularly by Eurostat; although all needed elements are present in Eurostat database. In 2009 Eurostat published a special edition of “Statistics in focus” presenting some figures and analysis on “Who dies of what in Europe before the age of 65”<sup>1</sup>. Figure 2 shows an example of the information provided in the study.

<sup>1</sup> [http://epp.eurostat.ec.europa.eu/cache/ITY\\_OFFPUB/KS-SF-09-067/EN/KS-SF-09-067-EN.PDF](http://epp.eurostat.ec.europa.eu/cache/ITY_OFFPUB/KS-SF-09-067/EN/KS-SF-09-067-EN.PDF)

**Figure 2: YLL due to ischaemic heart disease**

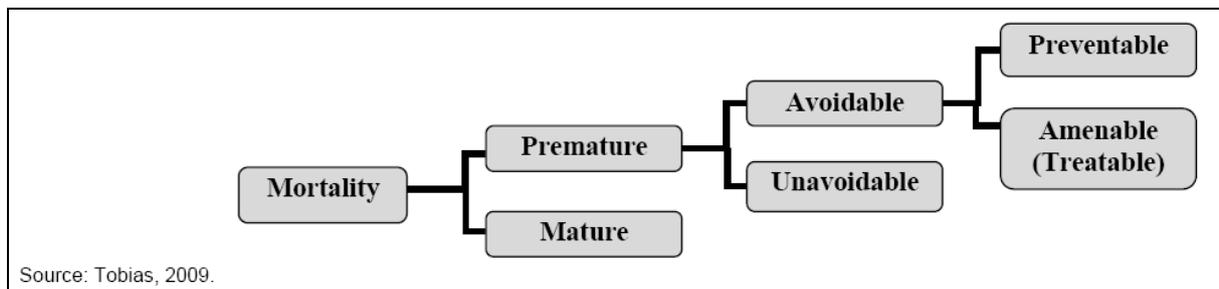


***Mortality amenable to healthcare***

“Mortality amenable to health care” is usually defined as “premature deaths that should not occur in the presence of effective and timely care. It takes into account premature deaths for a list of diseases, for which effective health interventions are deemed to exist and might prevent deaths before a certain age limit (usually 75, though sometimes lower)<sup>2</sup>.”

A simple graphic presentation of amenable mortality is given in Figure 3, where a distinction is made between avoidable and amenable mortality.

**Figure 3: The concept of avoidable and amenable mortality**



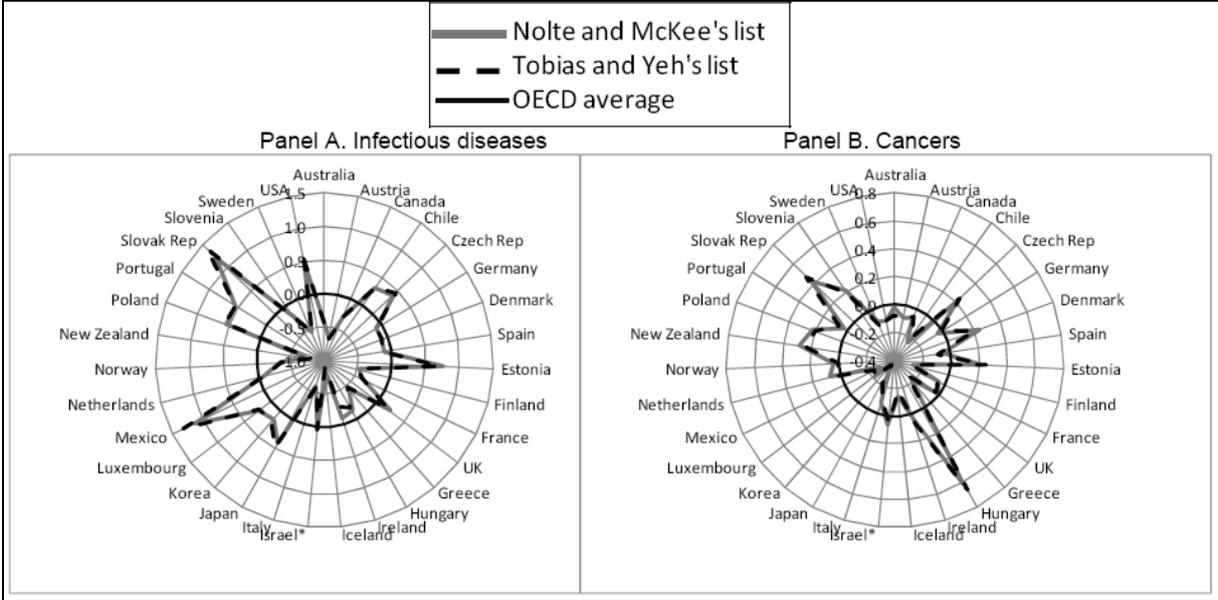
Source: Tobias, 2009.

<sup>2</sup> OECD Health Working Paper No. 55 “Mortality Amenable to Health Care in 31 OECD Countries” – DELSA/HEA/WD/HWP(2011)1

Data on amenable mortality are not regularly collected by international organisations; however, some ad hoc analyses were carried out, as for instance the OECD working paper mentioned in note 2. In this study two main approaches were taken into account (Nolte and McKee, and Tobias and Yeh). International comparison on amenable mortality by selected diseases is presented in the form of

Figure 4.

Figure 4: relative position of countries in relation to OECD average for selected diseases



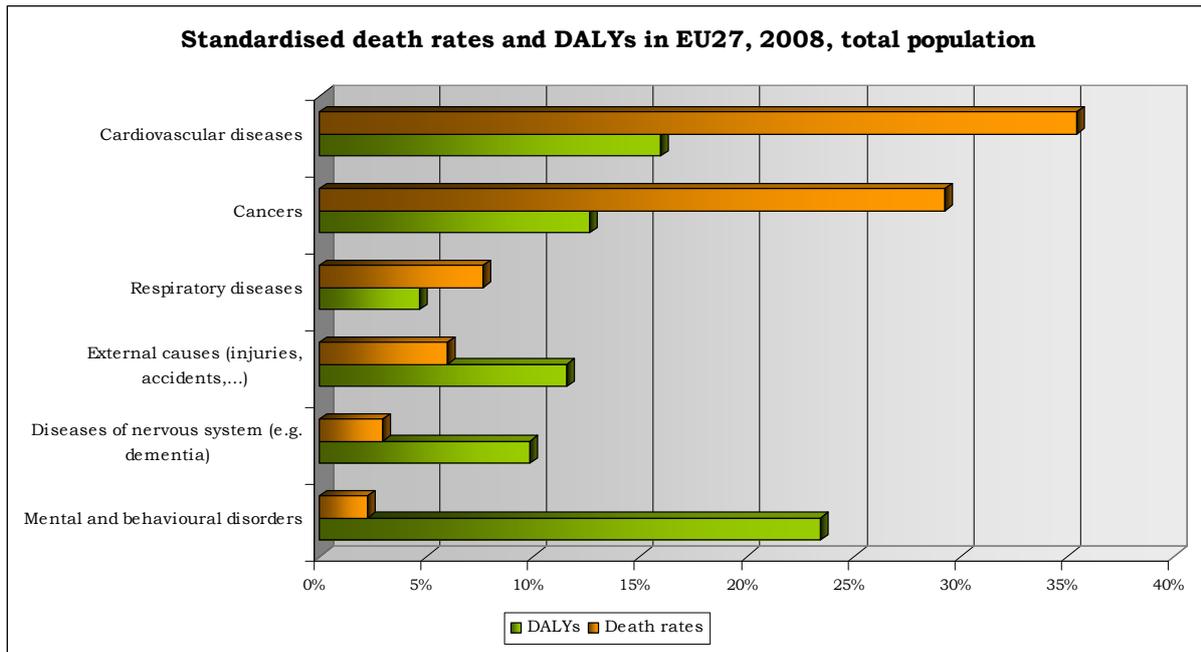
**DALYs**

According to the WHO, one DALY can be thought of as one lost year of "healthy" life. The sum of these DALYs across the population, or the burden of disease, can be thought of as a measurement of the gap between current health status and an ideal health situation where the entire population lives to an advanced age, free of disease and disability.

DALYs for a disease or health condition are calculated as the sum of the Years of Life Lost and the Years Lost due to Disability (YLD) for incident cases of the health condition. WHO presents a detailed international analysis of DALY by diseases<sup>3</sup>; however the data refer to 2004. A simple comparison between DALYs and standardised death rates is presented, at much aggregated level, in Figure 5. More refined analysis is possible, with data by gender, large age group, and ICD-10 2-digit code.

<sup>3</sup> [http://www.who.int/healthinfo/global\\_burden\\_disease/estimates\\_country/en/index.html](http://www.who.int/healthinfo/global_burden_disease/estimates_country/en/index.html)

**Figure 5: standardised death rates and DALYs in EU27**

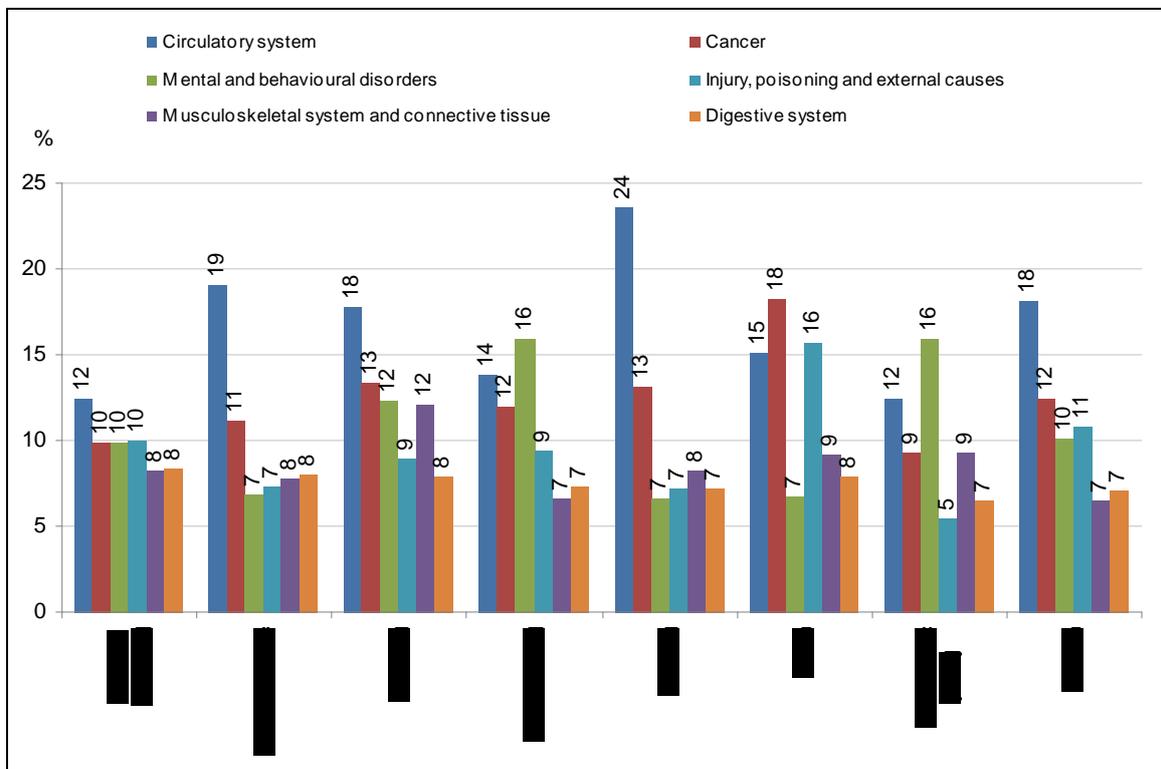


## 2. Economic impact (economic outcomes, efficiency)

### *High burden on public finances*

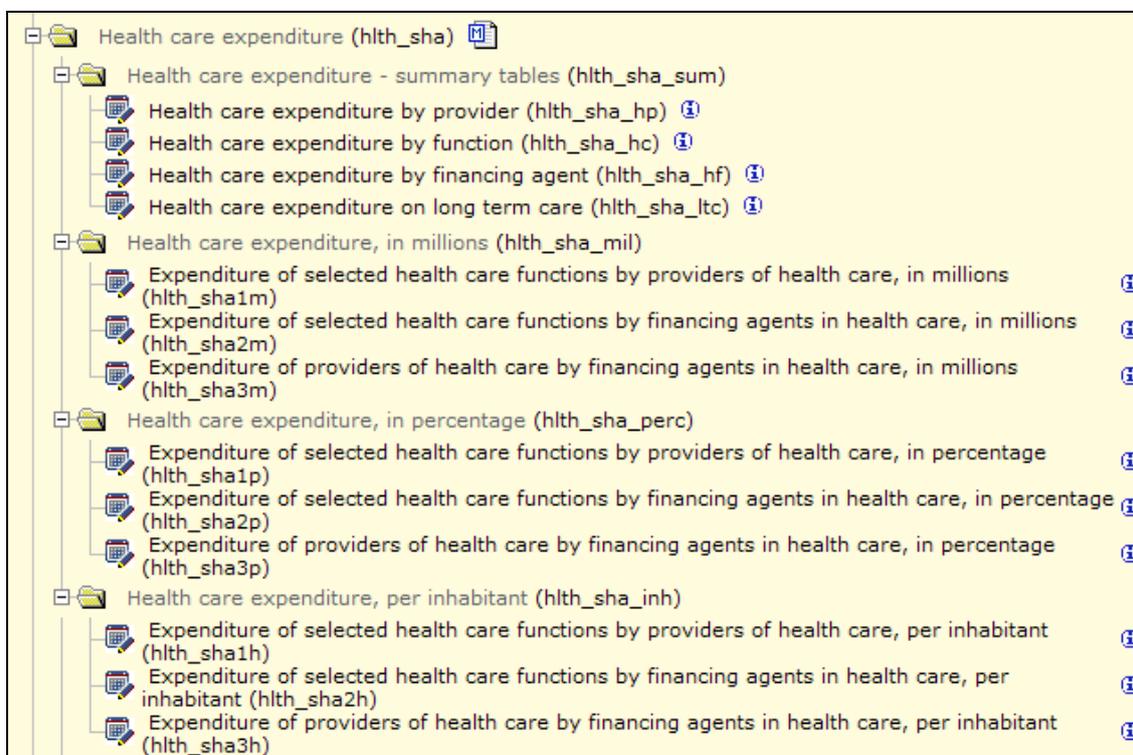
International data on health expenditure by disease is very scarce. OECD's Health at a Glance 2009 published some data on this topic, as shown in Figure 6, though at very general level.

**Figure 6: Share of hospital in-patient spending by main diagnostic category (2006)**



Expenditure data are more detailed and more easily available when they are related to the main categories of the System of Health Accounts<sup>4</sup>: providers (hospitals, nursing and residential care facilities, centres of ambulatory care, etc.), functions (curative care, rehabilitative care, long term nursing care, etc.), or financing agent (general government, social security funds, private social insurance, etc.). Figure 7 shows the availability of health expenditure data in the Eurostat database.

**Figure 7: Eurostat data on health expenditure**



### ***Economic effect outside the health system***

Another way of looking at potential economic implications of health interventions is to look at their broader impact on the economy, rather than at the cost incurred in by the health system (e.g. by cost resulting from the utilisation of services). Systematic collection of evidence is not in place in this field; however, just to give an example, a report presented at the World Economic Forum in 2010<sup>5</sup> gives some global estimation on direct and indirect costs of the main non-communicable diseases (where indirect costs are mainly referring to losses in productivity). Figure 8 shows the cost estimation for mental health conditions; it appears clear that indirect costs far prevail over direct ones.

<sup>4</sup> [http://www.oecd.org/document/8/0,3746,en\\_2649\\_37407\\_2742536\\_1\\_1\\_1\\_37407,00.html](http://www.oecd.org/document/8/0,3746,en_2649_37407_2742536_1_1_1_37407,00.html)

<sup>5</sup> The Global Economic Burden of Non-communicable Diseases – a report by the World Economic Forum and the Harvard School of Public Health, September 2011: [http://www3.weforum.org/docs/WEF\\_Harvard\\_HE\\_GlobalEconomicBurdenNonCommunicableDiseases\\_2011.pdf](http://www3.weforum.org/docs/WEF_Harvard_HE_GlobalEconomicBurdenNonCommunicableDiseases_2011.pdf)

**Figure 8: global cost of mental health condition in 2010 and 2030 (billion USD)**

	Low- and Middle-Income Countries			High-Income Countries			World		
	Direct Costs	Indirect Costs	Total Cost of Illness	Direct Costs	Indirect Costs	Total Cost of Illness	Direct Costs	Indirect Costs	Total Cost of Illness
<b>2010</b>	287	583	870	536	1,088	1,624	823	1,671	2,493
<b>2030</b>	697	1,416	2,113	1,298	2,635	3,933	1,995	4,051	6,046

### **3. Impact on equity**

A long discussion took place within the working group, on whether to consider equity a dimension of health systems performance - on the same level of health outcomes and efficiency - or rather to consider it a meta-concept, which can be applied to any dimension of performance. According to this latter definition, we may talk of equity in health outcomes, but also of equity in access to care, financial protection, effectiveness of care, and so on.

Even without having reached a consensus on how to deal analytically with this concept, the group agreed that we should keep attention on equity impacts of the measures we intend to assess. A third category of impact criteria should therefore refer to this area.

## **A. METHODOLOGICAL CRITERIA**

### **4. Possibility of intervention**

Once that an area of intervention has been identified according to the criteria described in part A, one should check that it is effectively possible to intervene to modify and improve the situation. Few criteria to assess the possibility to act are presented in the remaining of this chapter.

#### ***Gaps between knowledge and practice***

It mainly refers to the introduction of new medical technologies; but it can also refer to the adoption of new organisational models (e.g. integrated care, home care) or to innovative financing schemes.

Clearly, no regular production of evidence is available in this area; evaluation of existing gaps should be responsibility of relevant players such as academia, ministry of health, national health institutes, etc.

#### ***Existence of experimented solutions***

New measures are typically introduced in one country (or even in a sub-national health system), before proving to have a positive impact on the performance, and then being adopted by other systems.

Spreading and sharing of experiences usually takes form of bilateral contacts, networking events (such as conferences and seminars) and operation/intervention of international organisations.

Structured presentations of experimented solutions (best practice) is usually done via reports; WHO, OECD, EC and the European Observatory are all active players in this field.

### ***Large variations between countries***

It is easier to identify room for improvement in some field, if there is evidence that someone else is doing already better. The main reason for international comparable indicators to be in place is to highlight where significant variations between countries (or regions<sup>6</sup>) exist, and to consequently call for their explanation and possible filling.

As shown in previous reflection document produced for this working group, several sets of international comparable health indicators are already available.

### **5. Political agenda**

In selecting the topics to cover in our HSPA exercise, we cannot avoid considering the political agenda. In principle, the criteria that will bring an item high on political agendas are those which are already mentioned within this paper. But in practice, given the complexity of the political processes, it may be that even topics that would not fulfil sound impact criteria will be brought at the highest attention of policy makers (e.g. for emotional reasons, or because of media campaigns).

In these cases we consider as very useful that sound HSPA exercises are carried out, to provide policy-makers with effective tools to support their decisions and their actions.

### **6. Reaction time**

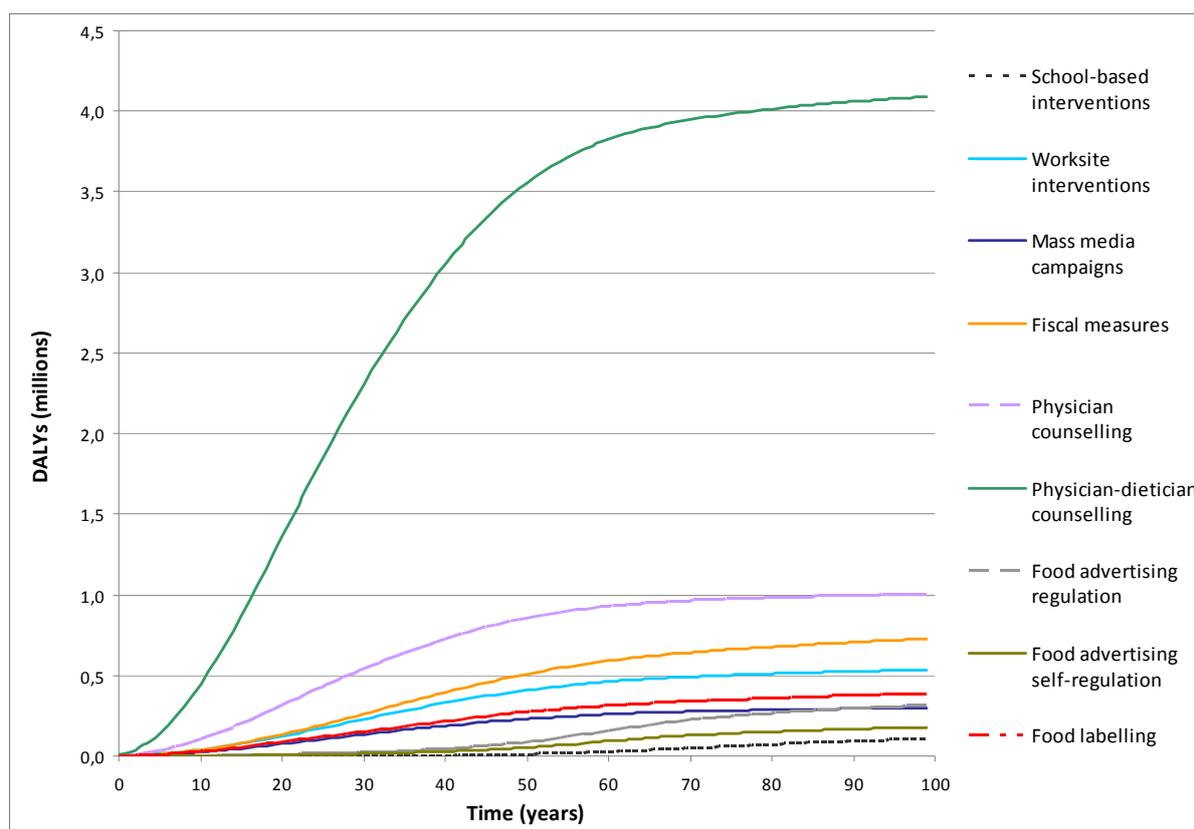
Reaction time has two different dimensions. The first one is the time for the ministry of health, or other relevant decision makers, needs to implement a specific measure aimed to tackle the area of intervention. As an example, the reduction of pharmaceutical prices takes typically a much shorter time than the construction of a hospital.

The second dimension concerns the time for the adopted measure to produce an impact, be it on population health or on economic variables. For example, Figure 9 shows OECD estimations of the impact of different measures to reduce obesity. It appears that physician-dietician counselling has a much faster impact than all other measures, while school-based interventions are the slowest in producing meaningful results.

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<sup>6</sup> see for instance the regional health profiles produced by I2SARE project:  
<http://www.i2sare.eu/Healthprofile.aspx>

**Figure 9: cumulative DALYs saved over time by different interventions**



## 7. Stewardship

As a last criterion discussed, stewardship is intended as the capacity of the Ministry of Health, or other relevant policy maker, to initiate and lead the proposed interventions.

Attention should be given to the role played by other key actors, such as Ministries of Finance and Social Affairs, and to the allocation of decision-making power among them.

Health-in-all-policies principle plays a major part in assessing stewardship; policies with great impact on health can be taken in other sectors (e.g. transport), however, the Ministry of Health can still be essential in bringing the topic on the floor and in steering the process of adoption of appropriate measures.

The table on the next page sums up the whole discussion on selection criteria. It presents impact and methodological criteria on two different axes. For the sake of simplicity, impact on equity is presented among the impact criteria, although it may be measured along a third axis (once the impact in terms of DALY has been measured, we may analyse the distribution of these DALY across the population). For the same reason the political agenda is presented among methodological criteria, even though logically this position may be object of debate.

**Figure 10: Summary grid for evaluation of criteria**

Impact criteria		Methodological criteria	Possibility of intervention			Reaction time	Stewardship	Political agenda
			Gaps between knowledge and practice	Existence of experimented solutions	Large variations between countries			
Impact on population health (health outcomes)	Mortality by disease							
	Years of life lost							
	Amenable mortality							
	DALYs							
Economic impact	Public expenditure							
	Impact outside health							
Impact on equity								