



EUROPEAN COMMISSION

HEALTH & FOOD SAFETY DIRECTORATE-GENERAL

Health systems, medical products and innovation

Performance of national health systems

EXPERT GROUP ON HEALTH SYSTEMS PERFORMANCE ASSESSMENT

21ST MEETING

26 FEBRUARY 2020, 09:00 – 15:45

ALBERT BORSCHETTE CONFERENCE CENTRE

36 RUE FROISSARTSTRAAT, 1040 BRUSSELS

MEETING MINUTES

Participants: Austria, Belgium, Croatia, Czech Republic, Finland, France, Germany, Hungary, Ireland, Lithuania, Malta, Norway, Poland, Romania, Slovakia, Spain, the European Observatory on Health Systems and Policies, the OECD, the WHO Europe and the European Commission

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1. OPENING OF THE MEETING

The Chair (Andrzej Ryś, European Commission) opened the meeting with presenting health policy related priorities of the new College of the European Commission that took office as of December 2019. They are the digital agenda, including Artificial Intelligence and its use in health care; continuous work on antimicrobial resistance; preparation of the new pharmaceutical strategy and keeping focus on vaccinations, including vaccination hesitancy.

2. MEASUREMENT AND ASSESSMENT OF HEALTH SYSTEM RESILIENCE

Filip Domański (European Commission) presented the current draft of the report on health system resilience. Members of the Expert Group were then asked to provide their feedback and come up with specific conclusions to the report in an interactive exercise.

Regarding the conclusions, members suggested to focus on the importance of a common definition of resilience, as well as to highlight the role of governance, co-ordination and monitoring. They agreed that health systems are resilient or not to some specific crisis or constrain. This makes resilience assessment very context-specific.

In addition, members provided a number of specific suggestions for improvement, which will be taken into account by the HSPA Secretariat in revising the report.

In light of the current COVID19 outbreak, members suggested to publish the report soon and follow up with a case study later in the year, where the resilience concept is applied to the coronavirus response.

The Expert Group agreed to send additional written comments to the draft report by 4 March 2020.

3. HEALTH AT A GLANCE: EUROPE 2020

Gaetan Lafortune (OECD) presented a list of indicators that the OECD would use when producing *Health at a Glance: Europe 2020* report. The report will be published in autumn 2020, as the first step of the third *State of Health in the EU* cycle. The members of the Expert Group had an occasion to share their views on the indicators, including suggestions of adding or subtracting some of these.

The Expert Group discussed following issues:

- Use of simple or weighted averages
There are pros and cons of using each of them. Since some bigger Member States spend higher proportion of their GDP on health care than smaller ones, weighted EU average is also higher. On the other hand, this average in the *State of Health in the EU* allows for presenting EU-wide values.
- Measuring accessibility of health care services
Adding FTE to number of health professionals would make the picture complete. However, such data is available only for a number of countries and only in case of hospital care. This makes heads count the main indicator in use.
Affordability of health care in general and of specific services (e.g. dental care) should be added, in order to present accessibility better. Catastrophic out-of-pocket expenditure update should help as well.
- Use of technologies
MRI and CT exams present use of technologies in diagnostics. They are not modern technologies anymore; therefore, it would merit adding data on PET scanning.

4. MEASUREMENT AND ASSESSMENT OF ACCESS TO HEALTH CARE: UP-DATE ON COMMISSION'S WORK AND SUMMARY OF THE SURVEY RESULTS

Katarzyna Ptak Bufkens (European Commission) debriefed the Group on progress in the Commission's work on the accessibility measurement framework since the last HSPA meeting. She summarised the building blocks of the work on access indicators, which DG SANTE proposed to the SPC Indicators Subgroup at the meeting on 23 January 2020. Building on the conclusions of Chapter 3 of the *2019 State of Health in the EU Companion Report*, the proposed work includes four elements:

- Patient vignette (2020-21): to explore gaps in coverage in terms of groups and areas when access is suboptimal. This would help to understand similarities and differences

of patient characteristics and use of care informing further efforts to improve access, taking into account leading causes of disease and equity disaggregation.

- Aligning EHIS with EU SILC (2020-21) through statistical matching to get more granular data on characteristics of people reporting unmet needs.
- Expanding EU SILC (2020-23) through collection of data on additional characteristics and reasons of forgone needs due to financial problems (lack of coverage, incomplete coverage, high cost sharing requirements), availability of services and goods and reasons of hurdles for the most disadvantaged groups (stigma, discrimination, etc.).
- Including in EUROMOD in-kind health benefits (2020-21) to better capture the redistribute effect of healthcare, taking into account various mark ups to capture redistributive effects across the life cycle, from rich to poor, from those who are in good health to those who are in poor health.

She explained the added value of each of these proposals and state of play of implementation. She also drew attention of the participants to another development, which created another opportunity to get a more granular picture of those who suffer most from barriers in access to healthcare. This is a follow-up to the adoption of the Recommendation on access to social protection and work in progress on the monitoring framework which will help capture better problems with formal and effective access to social protection (also healthcare) according to type of employment. She stressed that it is important to link HSPA and SPC processes to ensure synergies and invited ideas on how this could be achieved.

In the second part of her presentation, Katarzyna presented conclusions of the survey carried out by the Commission with the HSPA Group after the meeting in December. Appreciating the valuable input from participating countries, she presented the main findings. She showed dimensions of accessibility covered by HSPA, giving good examples of dimensions least covered. She assessed the state of play in terms of capturing complexities of access to healthcare according to various personal and clinical characteristics, showing a wide spectrum of practices across Europe. She also summarised how HSPA is used to assess the completeness of healthcare coverage and the impact of other barriers to access. Finally, she showed how HSPA makes an impact on healthcare coverage policies. Her conclusions confirmed that there is some room to exploit more sensitive metrics to capture various layers of vulnerability in access to healthcare, that there are many good examples and approaches on how to capture complex accessibility issues and that countries found many good ways to circumvent the limited choice of comparable indicators. She stressed that the HSPA report has a huge potential in inspiring the work on access indicators at Commission's level.

In the follow-up discussion it was inquired to what extent the summary of the findings of the survey is complete, as countries could serve as an example in many other categories summarised on slides, having similar problems or solutions as those quoted in the presentation. Katarzyna explained that for the sake of conciseness of the presentation, slides refer often to selected examples. It was suggested that the SWOT analysis should include in threats data protection and related risk of stigmatisation of people according to some personal characteristics. It was agreed to include data protection in the SWOT analysis. It was also

inquired about a possibility to propose a composite indicator of access. The feasibility of the index indicator has already been explored and due to lack of EU comparable data this approach is not feasible. However, the vignette approach would ensure a more comprehensive way to look at access problems.

5. MEASUREMENT AND ASSESSMENT OF ACCESS TO HEALTH CARE CONT.: PILOT PATIENT VIGNETTE

Ewout Van Ginneken (European Observatory on Health Systems and Policies) presented the conclusions from the pilot vignette project. He explained why available metrics do not provide sufficient details on challenges in access to healthcare, including among others widening inequalities, access to expensive treatments. He stressed that understanding of reasons behind problems with financial protection is also limited as the metrics does not provide any data on underlying causes, including insurance, lacking benefits, variations, impact of individual characteristics. He explained the methodology of the pilot, which was based on the targeted survey sent to the Observatory's Health Systems Policy Monitor (HSPM) experts in the EU, Norway and to the European Patients Forum. He noted that if the project is scaled up the participation of patient organisations in the definition of vignettes should be more prominent, because in the pilot it was very limited and basically only the Mental Health Organisations responded to the questionnaire.

Sharing the main results of the vignette pilot project, Ewout explained that the vignette approach is a way to look for more granularity of data and understanding of problems in access in relation to personal status, health status, socio-economic characteristics and legal status. He referred to the main problems with population coverage, which include: loopholes in legislation, unstable rights, non-compliance with administrative requirements leading to limitations in access to healthcare, separate schemes for certain groups, problems of most vulnerable groups (asylum seekers, irregular residents, homeless, prisoners, third country nationals). Providing insights into problems with service coverage, he referred to services, which tend to be excluded from statutory benefits baskets: optical treatments, hearing aids, physiotherapy, mental care, reproductive health services or expensive treatments. He also referred to issues with cost coverage like increased out-of-pocket payments and ways to provide for smart co-pay design. This happens through special arrangements for low-income groups, patients with accumulation of user charges, spending on pharmaceuticals, costs incurred by chronically ill or patients with mental health problems, user charge exemptions, reductions, annual caps, impact of extra billing for specific and non-contracted providers. Finally, he referred to other barriers, related to availability, navigation in the system and discrimination.

In conclusions, Ewout stressed that the most significant barriers in access to healthcare seem to be associated with social and income status, rather than specific medical conditions. However, clinical and social vulnerability often coincide and trigger each other and groups like mentally ill, homeless, frail elderly or undocumented migrants are more likely to face multiple layers of exclusion and complex barriers to access healthcare.

When it comes to the scaling up of the project, Ewout stressed that the rapid response mechanism is not the best way to carry on, and that adequate resources are required. He provided feedback from the HSPM meeting network, which showed interest in small-scale vignettes: dental care (already in progress with 10 countries involved), Dutch project focused on medical devices; shortages of mental health professionals (large group of countries interested in it).

The discussion confirmed the broad support to the vignette approach. However, some concerns were raised:

- need to think of the feasibility of this approach and its potential in capturing real problems and consideration of a possible link with clinical pathways;
- need to include citizens' perspective (engage with people) and think of the communication strategy, as an important success factor;
- need to make the vignette useful it is necessary to get to individual level and therefore have very detailed patient vignettes. It is also important to distinguish between statutory problems with access and understanding if people really use care;
- the vignette is good to show individual circumstances, but aggregation of data is an issue, therefore aligning and improving European surveys may be a better way to improve data on access to healthcare.

More positive stances pointed at:

- interest in including in the scope of the vignette physical and geographical availability;
- feasibility of the vignette approach, but vignettes should not be too specific (e.g. getting data on ethnicity may not be possible due to data protection);
- measuring accessibility should take into account patients' awareness of how much they have to pay for healthcare.

Ewout stressed that the qualitative assessment of access barriers is more feasible than the quantifiable approach due to the lack of indicators. Scaling up vignettes would require a lot of work and research to capture differences between countries.

In conclusions, it was not ultimately decided which clinical conditions should be included in the vignette project, but dental care, end of life care and access to mental care were spelled out clearly. For the purpose of the HSPA report, it was suggested to include about five vignettes. These five cases will be discussed at the next meeting of the HSPA Expert Group. The Commission will work with the Observatory to make a proposal to be discussed at the next HSPA meeting.

6. MEASUREMENT AND ASSESSMENT OF ACCESS TO HEALTH CARE CONT.: NATIONAL EXPERIENCE IN BETTER CAPTURING CHALLENGES IN ACCESS

Pascal Meeus (National Institute for Health and Disability Insurance, Belgium) presented a methodology used in Belgium to assess adequacy of access to healthcare through putting into perspective demand, supply and use of healthcare services at subnational level. Dimensions

included in the analysis are financial access, availability of qualified workforce, waiting times for consultations with specialists and geographical accessibility. A new indicator added to the spectrum of measures allows putting into perspective the use of healthcare services is: percentage of people with insurance (by age, gender, location, social status) with at least one contact with a health professional (type of professional) per year, which allows comparing variation in utilisation of healthcare with the practice variation. The tool developed in Belgium allows therefore analysing the following factors of access together: epidemiology, health literacy, affordability, density of professionals, health system organisation and design. On this basis, it is possible to understand better trends in using healthcare according to the social gradient and patients' needs and to draw conclusions on adaptations of the system to minimise the use of acute care services due to decisions to deter care.

Kimmo Parhiala (Finish Institute for Health and Welfare) presented how the administrative data from various registers (biobanks, patient and prescription data repository, national health and social care registers, health and social care statistics, socio-economic data) is used through linking those registers in evaluations and research. Based on current experience it is planned to design the health and social care information system, which would combine various sources of data: data from service providers and authorities, regional data, health and social care authorities' databases, national client/patient data repositories, national statistics and registers, and other (genomics data, biobanks, scientific publications, supervision registers). The project in the pipeline will allow the secondary use of social and healthcare data through linking systems registering use of services and payment for services and data on income, education, gender, age and other possible variables. He also referred to the HSPA system at regional level, which provides many useful data, for example on timely access to hospital care for various socio-economic and education groups. He stressed the importance of legal and technical feasibility to adapt similar solutions, along data protection issues, which required adoption of the legal act on the secondary use of health and social data. Risks in misuse of data can potentially be addressed by licensing and restricted access in research data centres.

Robert Mooney (Department of Health in Ireland) presented the planned measures to improve accessibility of healthcare for people with mental health issues, which will feed into the revision of the existing mental health policy. The planned change of the system should address persisting challenges related to unsustainability of current solutions with low availability of services especially in rural areas, weaknesses in co-ordination of services and continuity of care, lack of involvement of patients in the design of service delivery, weak primary prevention and early intervention, problems in getting access to interventions at community level, lack of digital interventions, concerns about quality and patient safety, and weaknesses in reporting. The envisaged solutions should bring various services together, provide for population-based planning of services, ensure involvement of patients at early stage, fill the gaps in early prevention services, and support planning of necessary resources to meet the needs. The overall objective is to maximise access to early interventions and minimize use of acute care. The system would adapt primary healthcare settings through the use of digital health solutions, talking therapies, peer support and social prescribing (referrals to social, non-clinical services), expansion of community mental healthcare teams with relevant therapists, combination of

primary care and community support. As far as the implementation of the new model is concerned, it envisages cross-departmental co-operation, involvement of relevant actors, clear governance and accountability arrangements, and linking funds with outcomes.

The discussion in groups, which followed the presentations, showed that presented practices are good examples and hold some potential for inspiring solutions in other countries.

One group discussed the added value of presented practices. When it comes to the Belgian practice, the group concluded that it provides for better understanding of available data on access to healthcare that is effectively used for decisions on the design of the system. Its strength is also the use of multifactorial data, which puts into focus all the important factors affecting access to healthcare along the patient's pathway. The developed tool allows also make a better use of data on health utilisation to improve access to healthcare. The Finish example similarly shows the use of multi-factorial data to support a more holistic view and comprehensive policies. As far as the Irish example is concerned, the use of phone lines was considered to add value through complementing services provided in institutional arrangements.

Another group discussing success factors for implementation of presented solutions highlighted for the Irish example a key importance of effective engagement with relevant stakeholders, sufficient funding, along the focus on early intervention and multiple points of access providing for more complete and tailored-made services.

Another group explored if presented practices could be implemented in other countries. Access to data, incomplete or no data from private providers, lack of political will were mentioned as obstacles to disseminate the Belgian or Finnish solution. In relation to the Irish one, systems' organisation was mentioned as an obstacle (for example in countries which remain hospital centric, it would be impossible to have a several entry points at local level for mentally ill people).

Another group discussed what is missing in order to disseminate the presented solutions. The main barriers to disseminate Belgian and Finish examples seem to be: public/private split with fragmented data, sensitivity about linking data on the socio-economic status with data on the clinical status, which is not just a technical issue, no analytical capacity to analyse the huge amount of data. As far as the Irish case is concerned, the main problem is the underdeveloped community-based care.

Finally, another group discussed what they found surprising in the presented case studies. As far as the Belgian case is concerned, it was suggested to use in comparisons less-served areas and not Brussels and include nurses in the analysis of access vs use of services. Showing divergence between vulnerable groups and standard population was found original. As far as the Finish case is concerned, it was acknowledged that maps providing quite granular data can be a good tool for planning and are not used enough. As far as the Irish case is concerned, social prescribing was found to be a high area of demand and not taken enough into considerations in the design of services for mentally ill.

Participants also stressed that the visualisation and communication matters, presenting how problems can be resolved is important. It was also highlighted that understanding of challenges and problems with access is not possible without the use of data; data loses its potential if it is not used for policy design. They concluded also that there is a need for public-private data arrangements, that data from private providers should be collected and legal solutions should be in place to enable linking various sources of data. It was also stressed that mental health is on the agenda everywhere, presenting an opportunity for improving the evidence on barriers in access to healthcare.

7. MEASUREMENT AND ASSESSMENT OF ACCESS TO HEALTH CARE CONT.

Katarzyna Ptak Bufkens (European Commission) presented possible content of the report on access to healthcare. The report could be structured around three chapters: (1) introductory chapter setting the scene at European level, (2) chapter on national experience on the basis of the results of the survey, (3) chapter with building blocks of the expanded patient vignette and if possible some assumptions for minimum baskets. She also proposed the timetable of work on each chapter:

Chapter 1

- end of April 2020 – the draft version sent to the Group
- 15 May 2020 – deadline comments from the Group
- 24 June 2020 – short discussion on the revised chapter during the Expert Group meeting
- September 2020 – finalisation of the chapter at the meeting of the Expert Group

Chapter 2

- 9 March 2020 – possible further inputs to the survey
- 23 March 2020 – deadline for sending to the Expert Group draft chapter
- 3 April 2020 – deadline for comments from the Group
- 24 June 2020 – short discussion on the final version of the chapter at the meeting of the Expert Group

Chapter 3 – the timetable is provisional and can be changed on the basis of the feasibility analysis

- 15 May 2020 – deadline for sending to the Expert Group of the first version of the chapter prepared on the basis of the patient vignette
- 24 June 2020 – dedicated session on the selection of expanded vignettes taking place at the meeting of the Expert Group
- 17 July 2020 – deadline for sending to the Expert Group for comments of the draft complete version of the chapter

- End of August 2020 – deadline for the Expert Group for sending the comments
- September 2020 – finalisation of the chapter during the meeting of the Expert Group

8. AOB

Filip Domański (European Commission) informed the Expert Group about content of the opinion of the Expert Panel on effective ways of investing in health on [options to foster health promoting health systems](#). The experts' recommendations concern • importance of health promotion; • strategic leadership in promoting health; • ensuring sustainable financing mechanisms; • developing capacity to implement health promoting health systems; • investments in health promotion research; • strengthening health promotion partnerships in Europe; • and supporting social mobilisation strategies.

He also reminded the members of the Expert Group that its activities may go beyond drafting reports on priority topics that relate to all member countries of the Group; they could be more country-specific. The latter means e.g. organising dedicated workshops and other similar events with HSPA experts in order to discuss health systems performance in national context. It was the case in the past – these events were starting points for developing national HSPA frameworks or were occasions to debate already published HSPA reports. All interested authorities should contact the HSPA Secretariat (SANTE-HSPA@ec.europa.eu) for more details.

Gabriele Pastorino (WHO Europe) announced recent publication of reports on affordability of health care in [Poland](#), [Sweden](#) and in [other WHO Europe region countries](#). WHO Barcelona Office plans to publish in the near future reports on (in alphabetical order that may be different from the publication order) Belgium, Bulgaria, Cyprus, France, Greece, Ireland, Hungary, the Netherlands, Portugal, Slovenia and Spain.

9. CONCLUSIONS OF THE MEETING

The next meeting of the HSPA Expert Group will take place in Madrid on 24 June 2020.