Inspecting the quality of care in changing healthcare systems

An international comparison

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Prof. dr. Roland Bal

Dr. Kim Putters

Dung Ngo, MSc

Eelko den Breejen, MSc

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Introduction

- Goals and questions
- Framework
- Case descriptions
  - Organisation of the system of health care
  - Institutional structure of inspecting healthcare quality
  - Practices of inspections
- Analyses and conclusions

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Research goal and question

- Goal of the research: *providing insight in the structure of inspection of quality and patient safety in European healthcare systems*

- Question: How are quality assurance and patient safety organised in several European countries and what lessons can be learned from this comparison?

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Sub questions

- How is the inspection on quality and patient safety organised in 7 selected countries? How do different inspectorates and supervisors relate to each other?
- How does this system of inspection work, and under what conditions/circumstances?
- What tensions and dilemmas arise and how can we understand and explain them?
- How do different European healthcare systems cope with these tensions and dilemmas and what lessons are to be learned?

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Theoretical Framework

		Level of self regulation of collective actors	
		-	+
Level of state intervention	+	Regulation from the state	Negotiation between representative societal bodies (corporatism)
	-	Contracts at the market	Self regulation from the medical profession (shared norms/protocols)

Research Methods

- Literature
  - Scientific literature
  - Policy documents
  - Relevant websites
- Expert interviews
  - E.g. with the Ministries of Health, Inspections for healthcare, scientists and stakeholders from the field of healthcare.
- Comparative research
  - 7 case studies

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Case selection

		Level of self regulation of collective actors	
		-	+
Level of state intervention	+	**State/regulation** France UK Norway Spain	**Society/negotation (corporatism)** Germany
	-	**Market/Contract** Netherlands	**Professional self regulation (Shared norms)** Switzerland

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Variables

- The institutional context
  - Public/private mix; market/state/society/ medical profession
  - Federal/unitary state structure
- Health care system characteristics
  - Bismarck/Beveridge
- Regulations on quality and patient safety
- Supervision instruments (state regulations, negotiations, self-regulation, contracts)
- Practices of inspection

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Important issues in the case studies

- What is the relationship between public and private domain in quality assurance and patient safety?
- How is inspection of healthcare organised within the healthcare system (central, regional, local)?
- What instruments are being used for the inspection tasks and how do relevant stakeholders use them?
- Is there any overlap in inspection tasks within the healthcare system and how is this overlap dealt with?
- Practices of inspection, i.e. assurance vs. improvement; proactive vs. reactive

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The Netherlands - System

- **Unitary state; parliamentary democracy**
  - National government (huge responsibilities by constitution)
  - Decentralisation: more focus on local government
  - Privatisation: more focus on private responsibilities for quality

- **Bismarckian health care system**
  - Huge interdependencies between public, private and professional stakeholders
  - Introduction of regulated competition causes a lot of dynamics: shifting roles and responsibilities (also for quality and patient safety)

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The Netherlands - Inspection

- Quality Assurance is a *shared responsibility* at the national, organisational and individual level. The national law on quality sets the general (minimal) goals (for providers, insurers, professionals). Next to that self regulation by the medical profession and healthcare organisations is important (protocols, accreditation).

- A huge variety of external and internal *stakeholders and supervisors*: politics, patients, ministry, inspectorates (quality and safety, market functioning, etc), Boards of trustees.

- A huge variety of inspection *instruments*: vertical/ horizontal; proactive/reactive; ‘phased inspection’, thematic inspection.

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The Netherlands - Practice

- Division of tasks and roles between the Inspection and competition authorities (e.g. mergers) based on protocols and (in)formal negotiations.
- Trend from reactive tot proactive inspection, based on risk evaluations
- Strong role of incidents (e.g. Radboud case; deteriorating quality in nursery care).
- Trend towards more assurance type inspections, but improvement still strong
- Greater emphasis on transparency of inspections

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France – System

- Unitary state
- Jurisdiction in terms of health policy and regulation of health care is divided between the state, statutory health insurance funds and, to a lesser extent, local communities (particularly at department level). However, shift towards growing role of regions since Juppe reforms in 1996!
- Bismarckian roots: predominantly funded through tax revenues and social health insurance contributions
- All legal residents are covered by public health insurance
- Free choice of provider

France – Inspection

- Inspection générale des affaires sociales (IGAS): inter-ministerial; ensures compliance with and implementation of regulation and verifies proper use of public funds and donations

  Instruments: inspection, advice, evaluations

- Direction Regionale des Affaires Sanitaires et Sociales (DRASS): regional; analyses need, determines priorities, evaluates functioning of regional health care

  Instruments: inspection, control, evaluation

- Haute Autorité de Santé (HAS): independent, scientific, public authority with own legal identity; advises government, national health insurance fund, providers, and patients

  Instruments: accreditation, guidelines, advice

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France – Practice

- Inspection is mainly based on assurance, e.g. health care organisations are generally sanctioned in case of malpractice; in case of accreditation health care organisations are financially rewarded (i.e. higher reimbursement rates)

- Overlap does exist between IGAS (national level) and DRASS (regional level), even though in formal sense tasks have been divided. This may lead to tensions between the two organisations because of clash of interests

- Inspection is mainly reactive, but since crises like the heat wave (and the enormous media attention) inspection tends to have become more proactive

Norway – System

- Unitary state, but to lesser extent because of levels of decision-making:
  - State: national health policy and regulation
  - 5 health regions: specialist health care
  - 431 municipalities: primary health care
  - 19 counties: dental care
- Beveridge structure: welfare state, national health system, predominantly tax based
- Trend towards emphasising choice of provider

- Built on the principle of equal access to services

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Norway – Inspection

- Norwegian Board of Health Supervision: national supervisory authority with responsibility for general supervision, ensures that health and social services ar provided in accordance with statutory requirements

  Instruments: system audit, reporting system adverse events, complaint system

- Governmental Regional Board: county level; carries out supervision and reports to Norwegian Board of Health Supervision

Norway – Practice

- Emphasis of inspection is on improvement. A coercive fine has been introduced, but not to punish the health care organisation. Rather, it is a means to meet statutory requirements, and a fine can thus be avoided

- In general, no overlap. Inspection in counties is carried out by the Governmental Regional Board, and they report to the Norwegian Board of Health. But tensions between regional and national authorities do arise

- Very proactive inspection. The Norwegian Board of Health uses several instruments to ensure quality and safety in health care, e.g. the introduction of supervision teams. Also, health care professionals should provide care of sound professional standard according to health law.

United Kingdom – System

- Unitary state, but organization is moving towards local decision-making, breaking barriers between primary and secondary care and enabling greater patient choice
- Beveridge structure: National Health Service (NHS), a free and comprehensive health care service available to the entire population
- Mainly funded through taxation
- Internal market emphasises more choice of provider

- Primary care is provided in Primary Care Trusts
- Secondary care is provided in general NHS Trusts, small-scale community hospitals and private hospitals

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United Kingdom – Inspection

- Healthcare Commission: responsible for regulation and inspection of NHS

  Instruments: annual health check for all NHS Trusts in England, overall assessment

  Monitor: Independent Regulator of NHS Foundation Trusts: competition and (financial) management of trusts

- Changes to health and regulatory context:
  - increased discretion by clinicians and managers at local level
  - new regulator replacing Commission for Social Care Inspection, Mental Health Act Commission, and Healthcare Commission in April 2009

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United Kingdom – Practice

- Inspection aims at improvement, but name and shame mechanisms have been introduced (e.g. Star rating system)
- In general no overlap since the Healthcare Commission is responsible for inspection of the NHS, whereas Monitor is responsible for NHS Foundation Trusts only, but in practice boundary conflicts do occur
- Proactive inspection, especially since e.g. the Bristol case
- But inquiries still also much used instrument

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Spain (Catalonia) – System

- Parliamentary monarchy and decentralized into 17 Autonomous Communities.
- Catalonia and the Bask country tend to asymmetric federalism, where the rest of Spain supports symmetric federalism; powers devolved to the regional tier vary across the Autonomous Communities.

- Spain has a Beveridgian healthcare system, with a National Health Service.
- Catalonia has the Catalan Health Service (CatSalut), also free at point of use.

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Spain (Catalonia) – Inspection

- National Ministry of Health and Consumer Affiars sets the goals. But the Catalan Ministry of Health is mainly responsible as the executive body, in collaboration with independent audit agencies.

- Inspection on quality is (nationwide) mainly by accreditation with quality standards set at national level. The National Quality Plan set up to share experiences between the regions.
- The Catalan Ministry of Health is the accrediting body (mandatory for hospitals and voluntary for primary health care service).
- Accreditation is given after self evaluation and technical audits.

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Spain (Catalonia) – Practice

- Emphasis of Inspection is mainly on Improvement; by discussing the outcomes with the hospitals. Although it has an assurance function because the outcomes are used as contracting criteria (with CatSalut).

- The system has a ‘overlap’ in the quality standards set by the national government and how they relate to regional standards.

- The system is based on pro-active grounds; but in practice also reactive.

Germany – System

- Federal Republic; comprising 16 states (Länder) .
- German has a Bismarckian healthcare system
  - predominance of mandatory Social Health Insurance with multiple competing sickness funds

    private/public mix of providers.

- Strong corporatist policy making: sharing of decision making powers between the Länder, the federal government and legitimized civil society organizations.

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Germany – Inspection

- Federal Joint Committee (FJC) since 2004 responsible for quality assurance: Under responsibility of the FJC the Federal Institute for Quality Assurance (BQS) and the decentralized body on Länder level (LQS).
- BQS and LQS: external quality assurance: performance measurements and hospital reports.
  - structural assessment using indicators (QULIFY instrument) and audits
- The Institute for Quality and Efficiency in Health Care (IQWiG) is another pillar under the responsibility of the FJC
  - mainly focused on new medicines and technologies

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Germany – Practice

- Emphasis is on Improvement of Quality (learning effects), although there is a mandatory public disclosure.
- Inspection on quality is very much in development and this may cause some overlap in practice.
- Mainly moving towards a pro-active system (indicators, audits, visitation model)

Switzerland – System

- Federal Republic, made up of 23 cantons and 3 demi-cantons, resulting in 26 highly sovereign entities
  - The Swiss health care system does not exist; there are 26 slightly different systems.

- Mainly Bismarckian organized health care system. Since the 1996 *Federal* law on health insurance all permanent residents are obliged to purchase compulsory health insurance.

- Cantons are for 75% owner of the hospitals.

Switzerland – Inspection

- Quality is a shared responsibility between national and cantonal level. The cantons mandate privately owned supervisory (certification) bodies. Next to that professional organizations provide quality management themselves and with (other) private bodies.
- There are many differences between the cantons on how quality is controled. And what standards are used for certification.

- *‘The spectrum ranges from nothing to highly sophisticated quality control systems.’*

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Switzerland – Practice

- The emphasis of inspection on quality is on assurance. The results are coupled on the system of contracting with the canton.

- Because of the many supervisory bodies the system is very blurred and not efficient. The IVQ (Interkantonalen Verein fur Qualitatssicherung) is founded in November 2007 to set a common strategy.

- It is a (more or less) pro-active system but again huge differences between cantons.

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Analysis: Institutional level

- There are many differences between countries as to how inspection for health care quality and safety is organized and works in practice
  - Centralized vs. decentralized systems
  - State-led vs. professional or multi-party inspection systems
  - Distance / responsiveness towards the field
  - Pro-active and re-active inspection strategies
  - Level of transparency of inspections
  - Use of formal instruments

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Analysis: Institutional level

- Similarities at institutional level are found between countries, e.g. federal or unitary and Bismarck or Beveridge

- The organisation of a health care system at institutional level influences the organisation of inspection,
  - e.g. in unitary states a high level of state intervention and low level of self-regulation of collective actors can be found, which influences the role and position of inspectorates

- A connection between the ideal types (see theoretical framework) does exist, despite the differences in the organization of inspection

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Analysis: Institutional level

- Formally, different health care inspections within a country have separate inspection tasks and responsibilities
- But in daily practice tensions may occur because of overlap
  - E.g. Netherlands competition authority ←→ healthcare inspectorate
- Different strategies in coordinating tasks
  - Informal talk
  - Representations in common bodies
  - Coordination protocols

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Analysis: Hybridization

- Growing hybridisation of healthcare systems …
  - Beveridgean systems introduce choice and decentralisation
  - Advance of New Pubic Management in many healthcare systems

  … albeit with many remaining differences between systems

  Increasing political (and patient) pressure on safety (decreasing risk acceptance)

- Discourse of inspection shows more similarities across countries, despite different backgrounds and different practices
  - More centralisation / coordination
  - More emphasis on transparency
  - Greater emphasis on pro-active, risk-based approaches

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Analysis: Hybridization

- The inspection discours is often about ideal types. The discussion should be about how to balance ideal types and accommodate hybrid models.
  - Within healthcare systems different ideal types will remain active
  - Responsiveness to changes in the field remain necessary

- Balancing concerns the institutional arrangements, the mixture of inspection functions and the mix of inspection instruments.

Discussion

- Do you recognize the trends and results of our study so far? What trends did we forget?
- Did we specify the most important variables and dilemmas concerning the organistion and practice of quality assurance and patient safety?
- What are your experiences?

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