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COUNTRY HEALTH DELIVERY PROFILES (DELPROs) AND INNOVATIONS IN HEALTH CARE DELIVERY

Summary Report on a WHO Workshop

Valencia, 5–6 April 1995

ABSTRACT

The Workshop was convened by the WHO Regional Office for Europe and hosted by the Instituto Valenciano de Estudios en Salud Pública (IVESP) and the Regional Ministry of Health of Valencia in order to discuss the further development of country health delivery profiles (DELPROs), which will facilitate understanding of the characteristics and contexts of health care innovations and their effect on health outcomes. This was the third meeting on the WHO project Partnership for Health Care Innovations, whose main goal is to devise ways of assessing the effectiveness of innovations in the organization, financing, management and delivery of health care. With a view to improving the DELPROs, the participants made recommendations on additional topics to include and on items that should be expanded. The profiles will support the WHO Conference on European Health Care Reforms, to be held in Ljubljana from 17 to 20 June 1996, by providing technical documentation, including descriptions and analyses of innovations in the different health care services in Europe.

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TARGET 27

HEALTH SERVICE RESOURCES AND MANAGEMENT

By the year 2000, health service systems in all Member States should be managed cost-effectively, with resources being distributed according to need.

TARGET 28

PRIMARY HEALTH CARE

By the year 2000, primary health care in all Member States should meet the basic health needs of the population by providing a wide range of health-promotive, curative, rehabilitative and supportive services and by actively supporting self-help activities of individuals, families and groups.

TARGET 29

HOSPITAL CARE

By the year 2000, hospitals in all Member States should be providing cost-effective secondary and tertiary care and contribute actively to improving health status and patient satisfaction.

Keywords

HEALTH CARE REFORM
DELIVERY OF HEALTH CARE – trends
DATA COLLECTION
EUROPE

Introduction

Health care systems in Europe are undergoing extensive changes to cope with the shortage of resources, to provide better care adjusted to community needs, and to make better use of technologies, including information systems. Currently, innovations in the organization and delivery of health services seem to be unregulated and unevaluated, and little is known about the effects of these changes or innovations on the health status of the population. Innovations can potentially be either harmful or beneficial. Since they involve the use of scarce resources it is important to ensure that they lead to positive outcomes.

Several factors trigger innovation in services: a desire to improve cost–effectiveness, a demand by the public for changes in the delivery of care, and the enthusiastic promotion of new technologies by commercial parties. Judgements on the usefulness of innovations, however, are all too often based on subjective impressions rather than established facts.

Innovations in health care can be defined as changes to improve the structure, process, or outcome of care. Some good evidence exists regarding the cost–effectiveness of innovations; for example, from randomized trials (e.g. the provision of care attendants for elderly patients discharged from hospital), non-randomized studies (e.g. hospital at home schemes) and particular cases (e.g. specialist outreach). The question, however, is whether the results of these studies can be generalized.

The outcome of innovations in health services may vary considerably and may be influenced by subtle changes in how services are organized. The enthusiasm of innovators is unlikely to be emulated in routine care. Thus, those who are engaged in innovation are not necessarily well equipped to evaluate their own work.

Ten innovations in six European countries (France, Germany, Slovenia, Spain, Sweden and the United Kingdom) were selected for review at the Workshop. Country delivery profiles were prepared as background papers to facilitate understanding the characteristics and contexts of the innovations as well as the health care delivery systems in which they occurred.

The 16 participants were selected for their expertise in developing innovations or for their contributions to the development of the country delivery profiles of their respective countries. The main aim of the Workshop was to further develop the outline of the country health delivery profiles and to identify central issues in analysing innovations and their potential in bringing about positive health outcomes.

Discussion

The participants discussed innovations in health care delivery from the perspective of health gain and covered such topics as the development of a Regional Office clearing-house on innovations, the role of innovations in health care reforms as well as how to evaluate innovations, and reorienting health care for health gain through innovative managerial approaches. The discussion led to how innovations in the health sector could be categorized for analysis, mainly in relation to the following two groups.

- *Medical technologies* (including devices, procedures and drugs). Problems with some drugs (e.g. Thalidomide) have influenced the evaluation of their worth in terms of improving health. Although the scientific paradigm evaluates medical technologies, it is questionable whether it evaluates health gain as well. The scientific evaluation of medical technologies is based on the measurement of effectiveness, efficacy and safety but should also include efficiency to take into account their value in comparison with the costs incurred in their development.

- *Organization of health care delivery*. The scientific paradigm can be useful. Research determinants include waiting-lists and substitution policies. The methodology used, however, is non-standardized, and it is difficult to assess health gains. Innovations in health care delivery should take place at different levels: local level (e.g. palliative care in a community; purchasing of specialist care) and national level (e.g. purchaser/provider split).

Understanding innovations and their meaning implies first understanding the health care delivery system in which the innovations are developed.

To complement the project on Partnership for Health Care Innovations and the country health delivery profiles, the development of a clearing-house database was envisaged. This database should provide information on:

- the relevance of an innovation to the policy or health care reform of a country;
- innovation transferability (potential to be imported or exported);
- whether innovations are in conformity with the health for all targets;
- new methods for evaluating and analysing innovations; and
- innovation classification and storage.

Four working groups, which were formed to discuss the outline of the delivery profiles, pointed to the following central issues in health care delivery:

- the diversification of health care delivery and different options for care (e.g. alternatives to hospitalization);
- problems connected to the introduction of a market economy;
- problems connected to the decentralization of health care delivery;
- the difficulty in setting priorities in the delivery of health services;
- demographic changes and the adaptation of health care;
- ensuring the continuity of care (e.g. relationship between providers, substitution policies);
- the effectiveness of health care delivery (e.g. quality assurance in relation to health outcomes, a continuous evaluation of care, financial constraints);
- the empowerment of patients (e.g. social influence on the health care system and consensus, community involvement);
- waiting-lists;
- research in primary health care and evaluation of reforms; and
- incentives for health professionals (provider payments, qualification of providers, functions of personnel at different levels of the health care chain, breaking barriers between health providers).

Based on the discussions in the working groups the participants agreed that the draft profiles should be reviewed again. Additions should be made to the country descriptions. It was assumed that the difficulties in describing the delivery of services were due to the rapid changes in countries and between subregions in countries. Comments were made on the difficulty of obtaining accurate information.

The participants agreed that cost-containment is an essential element in triggering innovations in health care. Some participants saw cost-containment as the hidden agenda behind most health authority initiatives. Other participants maintained that innovations were in fact induced by more idealistic motives, such as the desire to improve quality, integrate health and social care and enhance patient satisfaction.

The participants acknowledged, however, that the financial aspects of implementing changes could not be ignored. Most participants recognized that the era of innovations with secured funding is past. Most new initiatives must compete with other aspects of health expenditure or other aspects of public expenditure. Some innovations were perceived as not being feasible as they lacked a secure source or maintenance of funding. Other participants (usually the innovators themselves) claimed that as long as the effectiveness of an innovation could be shown and properly marketed, it could influence the political debate and receive necessary funding; however, they also acknowledged that funds had to be taken from other areas of health or public funding.

The shift in the balance of power was another topic explored in most of the innovations presented. While accepting the difficulty of assessing change in this field, it was perceived that some innovations were clearly aimed at changing the balance of power between professional groups, patients, professionals and institutions (hospitals and group practices). In fact, all of the innovations discussed could be viewed as a change in the existing power balance.

The successes and failures of innovations at the health authority level or at the provider level suggested that change either way is possible. Success is defined as the permanence of an agreed innovation and its ability to improve some aspect of health care. However, the approaches used to implement the changes at these two levels were very different (seeking legitimacy in the former, seeking political involvement and support in the latter).

The participants concurred that health care systems that give latitude to experimentation and change are better than health care systems that try to control new developments. This concept was called the tolerance of diversity. It was felt that societal and community development were prerequisites for reaching a high level of such tolerance.

The participants also addressed the issues of assessment and evaluation. A traditional assessment procedure may not be relevant in some cases because time constraints on scientific evaluation procedures do not always fit the calendars of policy-makers, and existing methods for evaluating health care may not be useful for assessing some of the innovations. Independent assessment is essential as innovators may be biased towards an unrealistic assessment of either the expected or the actual results of a given experience. Workshops such as this one are important fora to promote independent assessment.

Most of the participants agreed with the necessity of establishing a database on innovations which could be useful for planners, politicians and researchers and which should be updated regularly. In addition, it should be oriented towards problem-solving. The clearing-house should also give attention to unpublished experiences, which were considered as important as published ones. The possibility was also raised of linking research teams through schools of public health.

The importance of gathering information that would be useful in planning and developing health programmes was also underscored. This Workshop was the first step towards investigating what, where and how innovations occur and what problems arose as a result of their implementation. Other projects

would benefit from this information as it would help them design better steps to ensure successful implementation.

Conclusions and recommendations

1. The country health delivery profiles should include a description of political issues that have a potential impact on health.

2. Key issues (e.g. demographic changes) should be introduced at the beginning of the chapter on delivery to stimulate a critical view while reading the profile.

3. The description of health care policy should be expanded to include whether the focus is on health or disease, whether decentralization is endorsed and at which levels, and whether it is market-oriented.

4. The provision of health care services should be described from different perspectives: political, strategic and operational.

5. The functions of the different providers should be described in detail. Less emphasis should be placed on the description of settings.

6. The profiles should include mention of community care and should consider social actors with a role in health care delivery (rehabilitation, home care, health promotion) and in coordination between health and social care.

7. The description of different substitution policies in countries should be more detailed (e.g. day hospitals, hospitals at home).

8. Ways in which to encourage community participation in the delivery of health care and to empower users should be described in more detail (e.g. the influence of associations, local community groups).

9. More information should be provided on health technology assessment, continuity of care, inequities, accessibility, the user/provider split and current health technology.

10. The profiles should include a glossary of definitions and a list of essential indicators.

11. The description of health programmes should be strengthened, especially those established at national and regional levels.

12. Indicators should be established to evaluate levels of health care.

13. The health care delivery system should be described from the perspective of the user.