How to understand and assess service delivery

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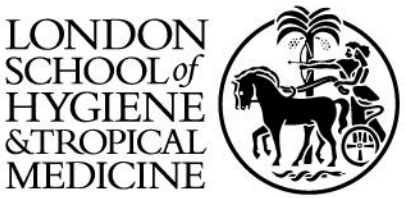
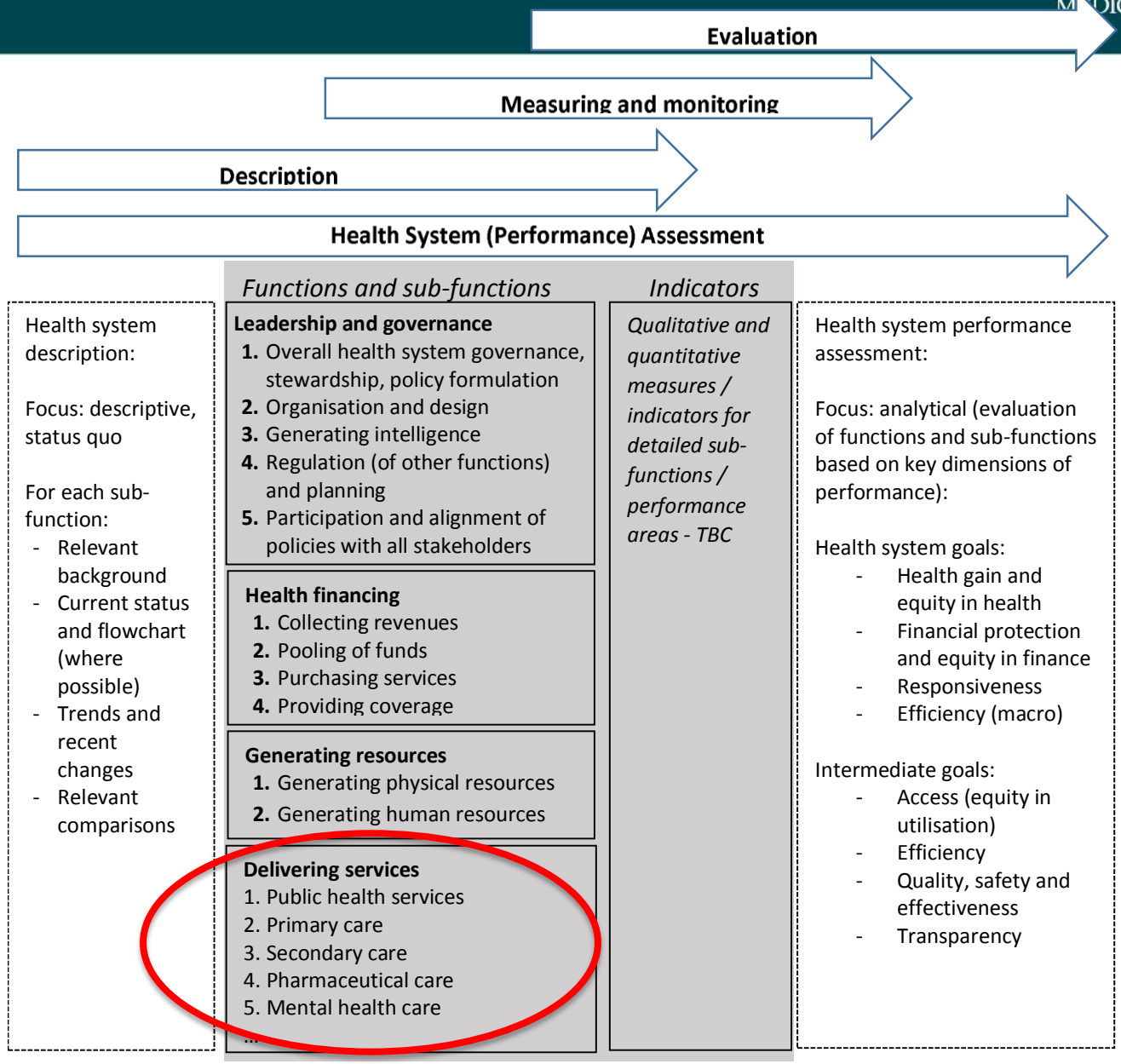
Linking Health Systems Assessments to Performance Dimensions



Geneva, 6 November 2018

Proposed Health System (Performance) Assessment approach



How can we define service delivery subfunctions?

By sector/organisational arrangement

- Public health services
- Primary care
- Specialised care
- Pharmaceutical care
- Mental health care
- Long-term care
- ....

By population/disease area

- MNCH
- HIV/AIDS, TB
- Malaria
- Diabetes
- .....
- Cancer

By type of intervention/service

- health promoting intersectoral
- public health measures
- preventive
- diagnostic
- therapeutic
- rehabilitative
- ....

Dimensions of performance

- Available
- Accessible
- Timely
- Comprehensive
- Coordinated
- ….

Example: MNCH

Available

- Skilled health care workers
- Physical infrastructure (incl. availability of drugs, diagnostic equipment, storage facilities, etc.)

…

Accessible

- Affordability of MNCH services
- Population covered by MNCH services
- Geographical access / distribution of services/providers

….

Timely

- Rapid access
- Timely treatment

….

Comprehensive

- Health promotion => rehabilitation

….

Coordinated

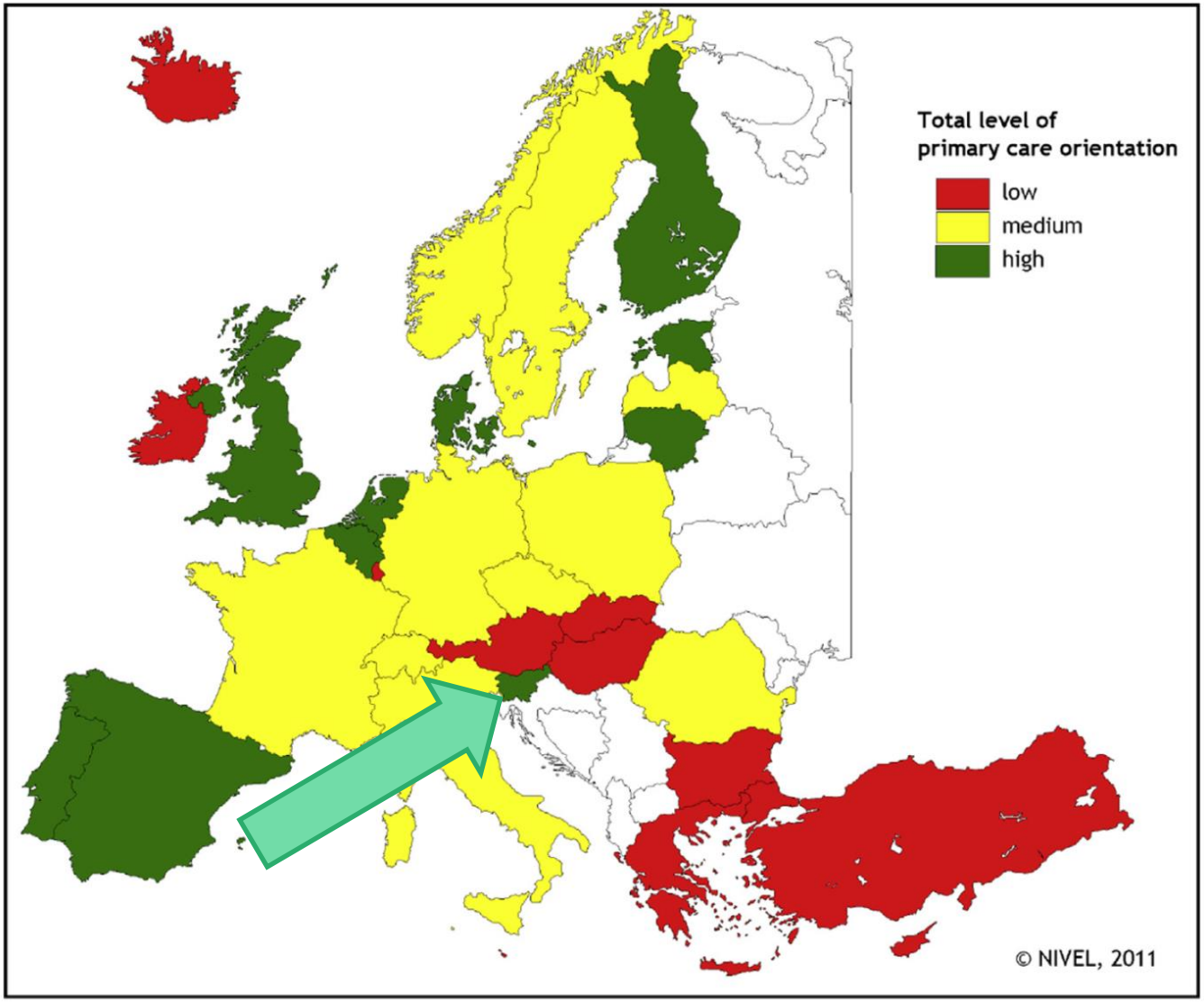
- Effective referral systems in place
- Linked/integrated with mental health and community services

…

Assessing primary-secondary care coordination: Diabetes care in Slovenia

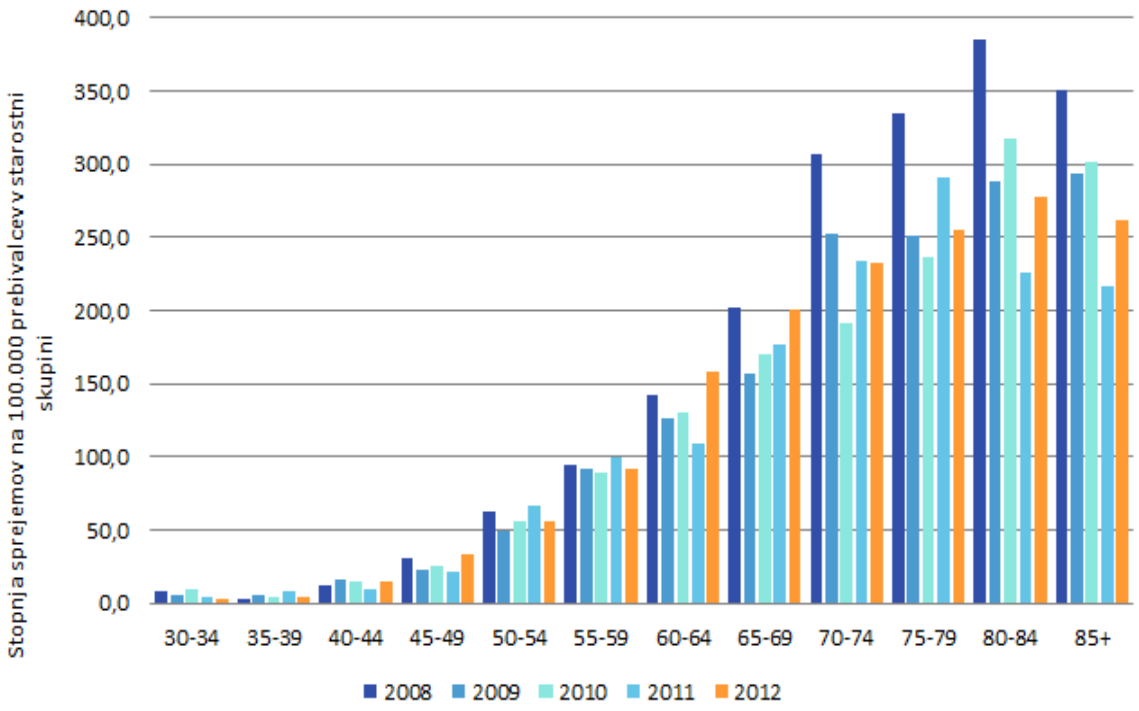
- Prevalence of diabetes in Slovenia estimated to be 10 per cent of the population aged 20-79 years in 2014
  - Comparatively high in Europe; associated with substantial costs (at least €120 mln in 2012 (NIPH, 2014))
- Diabetes Prevention and Care Development Programme 2010-2020
- International Diabetes Federation (2014): Slovenian health system evaluated to be strong in diabetes treatment and prevention of secondary complications but challenges in providing equal access to prevention and early diagnosis

Slovenia generally rated to have a strong primary care system



Source: Kringos et al. (2013)

Hospital admissions for chronic complications of diabetes, 2008-2012



- Declining levels of admissions among 70+ between 2008 and 2010
- Small increase from 2011 but overall levels lower than in 2012
- Better access to treatment or earlier detection or both?
- Trend follows steep decline in diabetes mortality from 2003

Assessing primary-secondary care coordination: Diabetes care in Slovenia

- Fragmentation of service organisation and delivery remains major challenge
  - conducted interviews and focus groups and a survey of providers and stakeholders in the Slovenia health system
  - to explore the factors that prevent health care providers to deliver good quality care in line with the 2011 national diabetes guidelines at the different levels of the system

- Key factors identified
  - organisational constraints, capacity & infrastructure, professional autonomy, external constraints

Assessing primary-secondary care coordination: Diabetes care in Slovenia

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Organisational constraints

- Lack of clarity about roles and responsibilities
  - Differing views among family physicians and secondary care specialists (e.g. diabetologists) about who should lead on patient education and support
  - Some scepticism about the new roles assumed by nurse practitioners in primary care in patient education, which previously had been the task of the family physician
- Lack of continuity in primary care, and of communication between primary and secondary care
- Lack of opportunity of having more direct access to decision support such as joint consultations with secondary care specialists:

  "The thing I miss is when people take medicine, there is not a possibility of consulting the secondary level … We often deal with polymorbid patients. Why can't I consult someone at that moment, when the patient is in front of me [to] help me get out of that situation? This would mean many fewer referrals and hospitalisations; patients would feel safer, and I would feel safer." (family physician #3)

Assessing primary-secondary care coordination: Diabetes care in Slovenia

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Capacity and infrastructure

- Lack of appropriate information technology, in particular adequate clinical information systems

  Problems arise when a patient has multiple chronic diseases and is seen by several specialists; each one of them writes his/her own medication and nobody coordinates all these medications (specialist outpatient physician #2.1)

- Lack of standardised processes and procedures for the handover of patients between providers and care levels
  - Lack of standardisation of discharge papers seen to pose considerable challenges in ensuring continuing care especially for vulnerable people who are being discharged from hospital
- Perceived need for better guidance and protocols to help meet the multiple needs of complex older patients; recognition that implementation of such guidance might be faced with professional resistance
  - Need to involve frontline staff in the development of processes and procedures

Assessing primary-secondary care coordination: Diabetes care in Slovenia

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Professional autonomy

- Lack of autonomy perceived as major obstacle by community nurses: acute service delivery on doctor's orders; reimbursement rules

  [W]e can visit patients only if they are alone and socially endangered… I cannot visit an elderly man in a family, check his blood pressure, his glucose level, activate his personal doctor, activate a specialist clinic at the primary level and warn that this person is living in circumstances where diabetes cannot be treated and managed appropriately because he does not have food, or water to wash legs at the primary ulcer stage. We could do many things, but our hands are tied. (community nurse #1)

External constraints

- Current reimbursement structure perceived to incentivize acute health problems and interventions over advising or counselling patients

  Quick services are valued most by [Insurance]; for instance, when a person comes with angina and you indicate a check-up, this will be substantially better financed than someone for whom you took an hour and solved many problems, which will be financially positive for the state in long-term, because such patient also present a smaller burden for health care. But it is catastrophically evaluated, which is completely illogical! (family physician #6)

Proposed measurement domains for integrated care

Raleigh et al. (2014); WHO (2015)

- Community well-being and population health at system level
  - e.g. amenable mortality; healthy lifestyles; mortality from chronic diseases; % of physically active and inactive adults
- Service proxies for health outcomes
  - e.g. emergency admissions; 'avoidable' admissions for selected conditions; persons discharged from hospital for rehabilitation
- Personal health outcomes
  - e.g. % people feeling supported to manage their own (chronic) condition; injuries due to falls in people aged 65+; self-reported quality of life
- Organisational processes and structures
  - e.g. delayed transfers of care from hospital; medication review in older people; attendance at A&E
- Resource use
  - e.g. bed days for selected patient types; # receiving long-term social care relative to population; relative spend on primary, community, secondary and tertiary care
- User and carer experience
  - % people reporting improved experiences of care;
    Involvement in decisions about own care