A NEW DRIVE FOR PRIMARY CARE IN EUROPE:
RETHINKING THE ASSESSMENT TOOLS AND METHODOLOGIES

Report of the Expert Group on Health Systems
Performance Assessment
In the endeavour to improve the health of their citizens, Member States strive to make health systems more accessible for all, more effective in terms of quality outcomes and resilient to changing environments and future challenges. Primary care is the backbone of our healthcare systems as it is the key to integration and continuity between and across levels of care and essential for patients, particularly those with complex needs. Performance assessment has ample potential to strengthen primary care and to contribute to strengthening the health system’s overall performance.

We began our work with several questions, including some basic ones on the state of play of performance assessment in primary care in Europe, its organisation, and its integration in policy processes. We surmised that for primary healthcare professionals and patients to reap the benefits of performance assessment, more progress is needed in developing performance assessment and integrating it into policies.

In our deliberations we took a closer look at tools for performance assessment in primary care, exploring indicators, methodologies and quality assurance. This allowed us to identify the main conditions which should be met to ensure that performance assessment is designed for the benefit of healthcare professionals and patients.

Finally, we sought to understand experience in relation to the impact of performance assessment in primary care. Our conclusion was that performance assessment can be part of the drive for necessary change, whether when transitioning from hospital to community-based care or when building solutions for integrated care, or even in the context of managing resources when account should be taken of the expansion of the uses and roles of primary care.

We hope that the result of our work - this report, will guide policy makers and practitioners in reinforcing the foundations for changes to primary care. We hope that our insights will allow them to move to a higher level of excellence and disrupt old habits
and traditions, when necessary. We are convinced that performance assessment can build solid foundations for change and provide a framework which empowers, engages, and focuses the minds of primary care professionals, be they dentists, dieticians, general practitioners/family physicians, nurses, midwives, occupational therapists, optometrists, pharmacists, physiotherapists, psychologists or social workers to nurture, explore and collaborate towards the desired results.

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This report benefited from valuable inputs and comments from all members of the Expert Group on Health Systems Performance Assessment (HSPA), the OECD, the WHO Regional Office for Europe, and the European Observatory on Health Systems and Policies. The report greatly profited from ideas, reflections and information provided by the voluntary members of the Sub-group on primary care.

Chapter 1 is based on the exhaustive opinion that of the Expert panel on effective ways of investing in health produced about tools and methodologies for assessing the performance of primary care. The team that compiled the opinion was composed by Jan De Maeseneer, Sabina Nuti, Dionne Kringos, Christian Anastasy, Margaret Barry, Liubove Murauskiene, Luigi Siciliani.

Chapter 2 is based on the systematic analysis of a survey on national experiences in assessing primary care, which was prepared by Patricia Sánchez-Villacañas Cabrera and Federico Paoli.

Chapter 3 was prepared by Ellen Nolte (European Observatory on Health Systems and Policies), with valuable contributions and inputs from the participants of the policy focus group.

This report was prepared by Katarzyna Ptak (DG SANTE, European Commission) based on the contribution and inputs from the Expert Group members and under the supervision of the two Chairpersons: Daniel Reynders (Belgian Ministry of Health) and Andrzej Rys (DG SANTE, European Commission). Lieven De Raedt (Belgian Ministry of Health), Federico Paoli and Filip Domanski (DG SANTE, European Commission) also contributed to the preparation of the report in the expert group.

The full list of members of the Expert group on HSPA, the sub-group on primary care and the policy focus group are presented in the annexes.

Comments on the report would be welcome at the following address:

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Executive summary

Strong primary healthcare is the foundation of a health system that is effective, efficient and responsive to patients’ needs. Although not enough appreciated, primary care can handle most of today’s chronic conditions without a specialist referral and produce benefits for the overall healthcare systems. Well performing primary care means less healthcare utilization overall and more focus on quality and achievement of optimal health outcomes.

However, primary care cannot allow itself to remain in status quo. Old models of operating and habits can hold it back, having an impact on the overall health system. To shift perspectives, this report assists policy makers and practitioners in taking a fresh look at performance assessment as a tool to create a drive that reverberates throughout the system of primary care and encourages all the relevant actors, whether dentists, dieticians, general practitioners/family physicians, nurses, midwives, occupational therapists, optometrists, pharmacists, physiotherapists, psychologists or social workers to nurture, explore and collaborate towards higher level of excellence  of primary care services. Performance assessment can inform decisions on relevant resource allocation throughout the healthcare systems, ensuring resources to support the expansion of roles and functions of primary care.

By focusing the core aspects of well-performing primary care systems and their key functions such as access, coordination of care and continuity of care, the report stresses that:

1. **Performance assessment in primary care paves the way for better health outcomes and improves the overall health system.**

2. **Primary care performance assessment systems in Europe vary in strength and though performance measurement is not in its infancy, it could significantly advance.**

The report shows that countries experience difficulties to advance in performance assessment in primary care due to three main challenges: the complexity of the performance aspects of the primary care, a struggle to integrate assessments in policies and pitfalls associated with a culture of excellence. To ensure that performance assessment becomes a "go to" tool, the report recommends to consider a powerful combination of 7 essential elements when building primary care performance assessment:

**1. Improve primary care information systems.** Availability and quality of primary care data for performance assessment needs to advance in most countries. In many cases a set of indicators available to policy makers is insufficient or focused on a subset of dimensions, not including for example measures of clinical performance, equity, workload and workforce satisfaction, efficiency, relevance of doctors’ training, etc. Without producing too much administrative burden, a well-balanced set of indicators should allow a regular screening of the functions of the primary care, focusing on accessibility, continuity and integration. Quality of primary care is also an important dimension which should be measured as a driver of additional gains for the overall healthcare system.

**2. Embed performance assessment in policy processes.** With some exceptions, performance assessments are not systematically embedded in policy processes and their use is not monitored and evidenced. Furthermore, they seem to be mainly addressed to policy makers, less so to healthcare practitioners and even less to the general public and patients. Embedding performance assessment in a legal and/or policy framework will scale up their use by all the concerned actors. Methodologies are also important. They should aim at achieving unprecedented results, aligning all the actors around the performance goals and cultivate courage to progress and discourage from reverting back to old methods and habits.
Building a culture of excellence is also a stepping stone to progress towards the integration of primary care. It can strengthen the team work and make this team work a rewarding experience, because it will foster a consensus to create organisational capacities and a framework which empowers and engages all the primary healthcare professionals, equipping them with the mindset and skills necessary to focus on creating the desired results. For this to happen, performance assessment needs to be holistic and consider such aspects as: education of health professionals, both content and way of organization (e.g. training at community levels rather than in hospitals), changing public perception of primary care, etc.

3. Institutionalize performance system. Embedding in policy framework is a first step to achieve growth or improvement of performance assessment in primary care. To tap into its full potential it needs a robust resources framework and this remains to be developed in most of the Member States. An institutionalized function is crucial to attribute roles and responsibilities, provide necessary tools and guarantee resources to reward and recognize the good performers and to support average performers to move into the high performance category.

4. Ensure accountability. Accountability is not always clearly established. The core is to define it, ensuring the involvement of all the relevant stakeholders, and be realistic ensuring that job satisfaction of providers in primary care is monitored and at good level.

5. Consider patients experience and values. Understanding of the aspects of quality of primary care that patients truly value should be developed. For primary care being the first point of contact, the patients ‘perspective taking into account their experience with services and their values is one of the crucial elements of performance assessment and can help define high quality, curb less successful practices and influence the direction of change. The patients’ perspective is also important for other reasons: more complex care demand, more demand for home-base care, greater diversity of patients linked also to migrations, changing health risks, which all impact particularly powerfully on primary healthcare.

6. Take advantage from adaptability. For performance assessment to become a driving force behind the daily work, it should be adaptable because its objective is exactly to support adaptability in the moment of change for primary care. Primary care is not a static concept and performance assessments for primary care, due to their particular exposure to change, should be living tools and constantly consider the dynamic context of each country, region, commune.

7. Support goal-oriented approach through a better use of professional and contextual evidence. Performance assessment should be more exploited to trigger better results of primary care through finding a more central role for professional and contextual evidence. Professional evidence is not systematised, while its role in achieving the good results in primary care is crucial, because primary care usually deals with patients of varying age, from diverse ethnic and socioeconomic groups, presenting early-stage diseases or undefined illnesses or with varying levels of multimorbidity. Primary care needs also to rely strongly on contextual information to bridge the gap between efficacy (isolated case) and effectiveness (routine practice). Performance assessments, reflecting needs of very varied groups of patients, can make primary care a more impactful segment of healthcare.

This report will hopefully convince policy makers not to settle for status quo, but to build new capacity for growth aligning every actor of primary care to move forward towards new ways of doing things with the benefit for patients.
Introduction

In the endeavour to improve population health, Member States make health systems more accessible for all, effective in terms of quality outcomes and experience, and resilient to changing environments and future challenges. To succeed the importance of a strong primary care cannot be stressed enough. The State of Health in the EU 2017 Companion Report emphasises that strong primary care can contribute to strengthening the overall health system’s performance by, inter alia, providing affordable and accessible care; coordinating care for patients so that they are given the most appropriate services in the right setting; and reducing avoidable hospital admissions. Strong primary care is the key to integration and continuity between and across levels of care, which is essential for patients, particularly those with complex needs. Indeed, primary care should be at the backbone of healthcare systems. However, the process of changing from hospital to community-based health systems is challenging and requires coherent policies. Perhaps this report can be part of the drive for necessary change.

For primary healthcare professionals and patients to reap benefits of performance assessment, there need to be more progress made to embody performance assessment in policies and enhance ownership for them. The report puts into focus the main conditions which should be met to make performance assessment designed for the benefit of healthcare professionals and patients. It guides readers on how performance assessment in primary care can build culture of excellence, disrupting the culture of “doing business as usual”, and reinforcing foundations for change in the moment of change for primary care.

Performance systems can be more strongly embodied in the primary care across Europe. This is a complex challenge. A good set of indicators and methodology are fundamental, but mechanisms to put them in use and mobilize primary healthcare to deliver better outcomes and accelerate necessary transformations of services are not less important. The report taps in available knowledge and experience structured around 3 chapters.

The first chapter summarizes the opinion of the Expert Panel on effective ways of investing in health: Tools and Methodologies for Assessing the Performance of Primary Care. The Panel provided valuable input and support to the work of the HSPA group. Its opinion defines a performance assessment system for primary care, focusing on characteristics of the organisation of the primary care and looks at "outcomes" of primary care according to relevance, equity, quality and financial sustainability. These dimensions are translated into comparative key indicators related to key domains of primary care and descriptive additional indicators. It considers recent experiences from European countries, on the basis of the survey led by the EU Expert Group on Health Systems Performance Assessment and formulates recommendations for further development of the framework in the European Union.

The second chapter looks at experiences in performance assessment across the EU on the basis of the questionnaire. The survey was carried out by the EU Expert Group on health systems performance assessment following the functional approach to the concept of primary care, addressing the key functions of primary care such as access, coordination of care, continuation of care. It allowed to explore problems, approaches, issues which are common to all countries or very specific in the context of key characteristics of the primary care, including organisational framework, institutional settings, mechanisms of involvement of stakeholders, models of provision of services, the range of services available, accessibility and integrated care parameters etc. Looking at experiences in assessing the performance

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1 Communication from the Commission on effective, accessible and resilient health systems; COM(2014) 215
2 The State of health in the EU 2017 Companion Report
3 Jan De Maeseneer: Family Medicine and Primary Care at the crossroads of societal change (2017)
of primary care, the survey feedbacks on the ways the assessments are organised, their scope, breath, frequency and use in policy design and implementation.

In the third chapter Dr Ellen Nolte explores the key requirements for health system performance assessment to successfully support and inform policy action in the European context with a particular focus on primary care. This piece of work draws from a review of the documented evidence and insights from experts from European countries that took part in a structured policy focus group of the Expert Group on HSPA. It has illustrated cases of how HSPA has supported policy action, drawing on examples from primary care assessments, and suggested some factors perceived by experts to be core to effect policy change. It further proposes a way that can help convert HSPA into a strategic tool in the policy process.

The last part of the report identifies recommendations for policy action. They draw from the analysis which identified common patterns, challenges, successful solutions applied in different countries. The conclusions build also on the analysis of pitfalls and burdens countries have to face in assessing and monitoring the performance of their primary care systems.

Year 2018 is marking the 40th anniversary of Alma-Ata Declaration on Primary Health Care, reinstating calls from the WHO for a return to the principles and approaches of primary health care as the best way to organize health services and achieve the Universal Health Coverage. Hopefully this report will give an impetus to the discussions on the renewed focus on primary care.
Chapter 1. Opinion of the Expert Panel on Effective Ways of Investing in Health on tools and methodologies for assessing the performance of primary care

The core element of the Expert Panel’s mission is to provide the Commission with sound and independent advice in the form of opinions in response to questions (mandates) submitted by the Commission on matters related to health care modernisation, responsiveness, and sustainability. The areas of competence of the Expert Panel include, and are not limited to, primary care, hospital care, pharmaceuticals, research and development, prevention and promotion, links with the social protection sector, cross-border issues, system financing, information systems and patient registers, health inequalities, etc.

This chapter builds on the opinion on Tools and Methodologies for Assessing the Performance of Primary Care\(^4\). It emphasizes elements which are crucial to make performance assessment in primary care successful experience. Given a crucial role of primary care in delivering outcomes for the reference community and its responsibility for individuals along all their life, and ways of operating in synergy with every other care setting, the task of the Expert Panel was very complex. However the panel managed to define a performance assessment system for primary care, focusing on characteristics of its organisation and looking at “outcomes” of primary care according to relevance, equity, quality and financial sustainability.

**Challenges ahead performance assessment in primary care**

Measuring the performance of primary care is more challenging than measuring the performance of the healthcare systems overall. It is linked to the complexities of the primary care in relation to the range of actors, mix of organisational models, dispersed nature of services. All this poses challenges in data collection. Indicators for the performance assessment of primary care require further development. A lot of indicators are constructed not taking into account the specific and fundamental contribution made by the primary care when indexing for example the access and quality of care. Data on workforce tends to be presented in the form of composite indicators not distinguishing between various segments of healthcare. Moreover, measures of performance of primary care should include variation in context, e.g. data on characteristics of the population, health system, social welfare system. Methods of data collection matter too and the Panel notes that the use of administrative data instead of data reported by institutions would speed up the collection process and decrease the possibility of errors. Finally, it is noteworthy that new disease patterns with multi-morbidity and chronic conditions call for an improvement of the comprehensiveness of the data, including data that are gathered by the inter-professional team and this brings into the debate the question of co-existence and choice of appropriate classification systems.

A right balance of indicators and targets is another driver of an effective performance system in primary care. Both an excessive and a scarce number of performance indicators can result in a performance paradox expressed by a weak correlation between performance indicators and performance itself.

The Expert Panel also stresses the challenge of **reconciliation of goals defined from the individual patients’ perspective with the performance assessment at population level**. Patient’s goal approach is particularly relevant for multi-morbidity patients. In this context a lot of data is collected in the vertical disease oriented programmes isolating the data related to the interventions for a single condition. Moreover the Expert Panel stresses a challenge in **combining outcome and process** and a challenge of the influence on data of the context/aim they are collected for. The latter is especially the case for "pay-for-performance" and "pay-for-quality" data which can be "adapted" to the "desired standards".

**How to make the performance assessment in primary care comprehensive**

The Panel is considering the very comprehensive definition of the primary care which is the entry level and cornerstone of many health systems and it is at the core of providing accessible person-centred, appropriate and equitable care from a population-based perspective. It responds to a wide range of health needs, both preventive and curative covering the complete life-cycle and including Long Term Care services. The Panel in their consideration also emphasises the spill over effects of primary care, which except for improving the health of population, contributes to the population well-being.

The opinion refers also to some **preconditions for well performing primary care** emphasising the provision of services that are: 1) universally accessible, 2) integrated, 3) person-centred, 4) comprehensive and community oriented, 5) provided by a team of professionals accountable for addressing a large majority of personal health needs. These services should be delivered in a 6) sustained partnership with patients and informal caregivers, in the context of family and community, and play a central role in the overall 7) coordination and 8) continuity of people’s care”.

With regards to the primary care workforce, the Expert Panel lists, among others, the following health professionals that should work in multidisciplinary teams: dentists, dieticians, general practitioners/family physicians, nurses, midwives, occupational therapists, optometrists, pharmacists, physiotherapists, psychologists and social workers.

The opinion looks also at conditions necessary to arrive at a good approach in performance assessment, emphasising in particular: multi-dimensionality, shared design, evidence-based, benchmarking of results, timeliness and transparent disclosure.

The Expert Panel draws the conclusion that what emerges from the definition of the primary care is its intrinsic complexity, related to its multiple dimensions, stakeholders and governance levels. Defining dimensions and domains to be taken into consideration in assessing the performance of primary care, the Panel proposes to include some more classical dimensions of HSPA that can be applied to the assessment of primary care (1-8 in the table) and domains that are specific to primary care (9-10 in the table):
<table>
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<tr>
<th>Domains and dimensions in Primary Care (PC)</th>
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<tbody>
<tr>
<td><strong>Domains</strong></td>
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| 1) Universal and accessible | - Population covered by PC services  
- Affordability of PC services  
- Geographic access and availability of PC services  
- Accommodation of accessibility; acceptability of PC services  
- First-contact accessibility and availability; accommodation  
- Timeliness and responsiveness of PC services (e.g. PC consultations) |
| 2) Integrated | - Integration of public health services and approach in PC: e.g. community-oriented primary care  
- Integration of pharmaceutical care in PC  
- Integration of mental health in PC  
- Integration between PC and social care |
| 3) Person-centred | - Person-centred care, shared decision making, focusing on the "life goals" of the patient  
- Patient-provider respect and trust; cultural sensitivity; family-centred care  
- Consider patients/people as key partners in the process of care  
- Maintain a holistic eco-bio-psycho-social view of individual care |
| 4) Comprehensive and community oriented | - Comprehensiveness of services provided (e.g. health promotion, disease prevention, acute care, reproductive, mother and child health care, childhood illness, Infectious illness, chronic care (NCDs...), mental health, palliative care)  
- PC takes into account population and community characteristics  
- PC is integral part of the local community |
| 5) Provided by a team of professionals for addressing a larger majority of personal health needs (quality) | - Quality of diagnosis and treatment in PC for acute and chronic conditions  
- Quality of chronic care, maternal and child health care  
- Composition of the inter-professional team  
- Health promotion; primary and secondary prevention  
- Patient safety  
- Advocacy |
| 6) Sustained partnership with patients and informal caregivers | - Policies for coordination between professionals and informal caregivers  
- Policies to support informal caregivers  
- Patient engagement over time  
- Participation of informal care givers/citizens in the development of PC services  
- Participatory power of patients/informal care givers/citizens |
| 7) Coordination of people’s care | - Coordination between primary and secondary care: appropriateness of referrals, gatekeeping, integrated patient records, protocols for patients with chronic conditions  
- Coordination between primary and social care  
- Policies for respite care |
| 8) Continuity of people’s care | - Continuity of care (longitudinal, informational and relational)  
- The provision of care throughout the life cycle  
- Care that continues uninterrupted until resolution of an episode of disease  
- Role of PC in continuity and interaction with Emergency Departments |
9) Primary Care Organisation

- Accountability: a formal link between a group of providers and a defined population (list-system, geographical area ...)
- Primary care payment and remuneration system (e.g. capitation, FFS, P4P);
- The presence and strength of market forces in PC;
- Office and facility infrastructure (e.g. information systems and medical technology, Point-Of-Care testing);
- Organisational components of coordination and integration: structure and dynamics (job descriptions and team functioning, management and practice governance, clinical information management, organisational adaptability and culture (traditional command-and-control versus Complex Adaptive Systems Approach), team-based organisation;
- Volume and duration of PC provider consultations, home visits, and telephone consultations;
- Organisational aspects of referrals to medical specialists; referrals to specialised trajectories (e.g. in mental health, occupational health...)
- Quality of management
- Primary care budget in relation to total health care budget

10) Human Resources

- Needs, supply, profile and planning of PC workforce;
- Status and responsibilities of PC disciplines; role of academic institutions and professional associations;
- Training and skill mix;
- Human resources management, including provider well-being, competence and motivation;
- Role of nurses (task delegation and substitution, competency sharing);
- Role of community pharmacists in PHC and pharmaceutical care;
- Role and function of managers
- Income of PC workforce;
- Development of undergraduate and post-graduate specific (interprofessional) training

Based on Hogg et al., 2008; Kringos et al., 2010; Bitton, 2017.

Not to lose any of these dimensions from focus, the Expert Panel proposes to use as a reference framework, the one outlined by Donabedian, which indeed allows multiple dimensions to be addressed when assessing performance (1988) on the basis of the causal relationships between Structure, Process and Outcomes of care. Structure and process are linked in a continuous interaction and shape the care outcome. The model allows contextualising the primary care in the overall healthcare systems and thus to assess the overall contribution of the primary care in terms of value for money.
The opinion draws the attention to the importance of assessing the **structure** of the primary care setting by measures related to how **access** to primary care services occurs (EXPH, 2016), **how providers of primary care are organised** and **how resources are managed** in the system. These dimensions should be kept in the performance assessment, because the access to primary care can be impaired by both financial and non-financial barriers and because of the risk of possible failures in responding to patients’ needs in case of the lack of organisation in primary care. Resources are also crucial with the health workforce being at the core of provision of services, provider payment and remuneration affecting the overall resources and incentives to ensure the appropriate care and the size of a primary care practice affecting its capacities.

Considering how to assess the **processes through which primary care services are delivered**, the Panel emphasises the nature of service delivery, which is complex due to a multiplicity of providers operating in different types of networks. The performance assessment should look at consistency and coordination across various types of providers, settings and governance levels with a view of improving outcomes and reducing waste of resources.

Looking at **outcomes of primary care** in performance assessment, the opinion puts into spotlight: relevance, equity, quality of care and financial sustainability.
**Key elements to assess processes**

The core measures of consistent and co-ordinated performance should include integration with a number of aspects: the ability of a practice to coordinate and synthesize care received from external sources, integration between primary and secondary care (appropriateness of referrals), integration in relation to social care. The indication of the performing mechanisms of horizontal and vertical coordination can be for example the existence of case management practice or shared care plans or both financial and non-financial incentives. ICT health information systems for sharing information between providers have also assumed a key role in facilitating this process. Other fundamental elements are the continuity of care in all its forms (longitudinal, informational and relational continuity) and the responsiveness to population and community specificities.

**Key elements to assess outcomes**

Relevance is about care “that matters”, contributing to the achievement of the life-goals of the person. When it comes to equity, it is important to assess how primary care affects it in all its meanings and dimensions such as health inequities in access based on need, and fairness of financing. Quality in the context of primary care includes dimensions such as accurate diagnosis and appropriate treatment for acute and chronic conditions, quality of care for chronic conditions, quality of maternal and child healthcare, effective health promotion and primary and secondary prevention, appropriateness of care, quality of person-centred care entailing both shared decision-making and patient engagement, the degree of patient-provider respect, trust and cultural sensitivity, quality of family-centred care and patient safety and advocacy. Financial sustainability concerns the efficient and effective allocation of resources to support equity and quality of care. Three types of evidence are required to assess outcomes of performance of primary care: professional (knowledge of the health condition), contextual (patient-specific aspects of medical care) and policy evidence (policy strategies to guarantee equity and appropriate use of resources, including avoiding waste).

**Examples of indicators for performance assessment**

Considering the complex context in which primary care operates, the Panel systemises the approach to indicators which could be used in the performance assessment of primary care through splitting them into two categories: comparative key-indicators and descriptive additional indicators. Comparative key-indicators are those whose score may be evaluated in comparison with a target or a benchmark (e.g., waiting time for first visit by a physician). Descriptive (observational) indicators are those whose score provides useful information for decision makers but whose interpretation may be ambiguous, for example, the rate of frail people who receive domestic help at home depends on both organisational features of the healthcare system and other certain social characteristics (e.g., the family role). Descriptive indicators should therefore be correctly contextualized in a specific health system. Indicators are clustered around ten domains proposed by the Panel. Examples are provided in the table.
### Examples of comparative key-indicators along its key domains

<table>
<thead>
<tr>
<th>Domains</th>
<th>Examples of Indicators</th>
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| 1) Universal and accessible                  | • % of the population fully covered or insured for PC costs and medicines prescribed in PC  
• Total expenditure on PC as % of total expenditure on health  
• Amount patients have to pay for a GP/PC consultation and amount reimbursed  
• % of patients who rate GP/PC Team care as not very or not at all affordable  
• Difference between region, province or state with highest and with lowest GP/nurse/social worker/... density  
• Average number of days waited to see a GP/PC provider when confronted with a health problem                                                                                                                                  |
| 2) Integrated                                | • Extent to which GPs/PC Teams carry out preventive activities such as: Testing for sexually transmitted diseases; Screening for HIV/AIDS; Influenza vaccination for high-risk groups; Cervical cancer screening; Breast cancer screening; cardiovascular risk assessment.  
• Is there a structured cooperation between PHC and social care?  
• Does the pharmaceutical care integrate the contribution by GP/community pharmacist/nurse e.g. through an integrated pharmaceutical record?  
• To what extent are disciplines like occupational therapy, physiotherapy, speech therapy,... integrated in PC Teams?                                                                                                          |
| 3) Person-centred                            | • Duration of regular visit (minutes) of different types of providers  
• % of patients who rate that they i) trusted the GP/nurse/social worker/...; ii) were involved in shared decision making ; iii) were satisfied with PC visit.                                                                                                                              |
| 4) Comprehensive and community oriented      | • Extent to which patients visit a GP for first-contact care for specific health conditions; people with a first convulsion; suicidal inclinations; alcohol addiction problems.  
• Is FP/GP the only medical discipline in PHC?  
• Are there activities related to Community Oriented Primary Care?  
• Is there palliative care at home organised?                                                                                                                                                                                                                                           |
| 5) Addressing personal health needs (provide high quality PC) | • % of infants vaccinated within PC against e.g. diphtheria; tetanus; pertussis; measles; hepatitis B; mumps; rubella; % population aged 60+ vaccinated against flu; HPV vaccinations  
• The defined daily doses of antibiotics use in ambulatory care per 1000 inhabitants  
• Percentage of individuals with COPD or asthma who have had a lung function measurement during the last year  
• Percentage of diabetic population with blood pressure above 140/90 mm Hg observed in the last 12 months  
• Percentage of patients stating that the treatment contributed to achievement of their life-goals                                                                                                                               |
| 6) Sustained partnership with patients and informal caregivers | • % of informal caregivers who receive support from primary care  
• % of patients reporting help by informal care givers  
• Presence of organisations of informal caregivers in a community                                                                                                                                                                                                                       |
| 7) Coordination of people’s care             | • Is there a gate-keeping system (access to specialists through referral)?  
• Do patients need a referral to access the paramedical and nursing disciplines, to access social care?  
• Is it common for GPs to have regular (electronic) face-to-face meetings (e.g. at least once per month) with the following professionals? Other GP(s); Practice nurse(s); Nurse practitioner(s); Home care nurse(s); Midwife/birth assistant(s); PC physiotherapist(s); Community pharmacist(s); Social worker(s); Community mental health workers; medical specialists. |
| 8) Continuity of people’s care               | • Do GP-practices have a patient list system? Or another form of defined population?  
• % of patients reporting to visit their usual PC provider for their common health problems  
• % of GPs/PC Teams keeping electronic clinical records for all patient contacts routinely.  
• % of patients who are satisfied with their relation with their GP/PC provider  
• Do PC practices receive information within 24 hours about contacts that patients have with out-of-hours services?                                                                                                                 |
### 9) Primary care organisation

- PC payment system, revenues, and operating costs
- Percentage of income of GPs through FFS, Capitation, Salary, P4P
- Average income of 1FTE GP compared to average income of specialist; of PC nurse compared to hospital nurse,…
- Quality control audits
- Clear Vision and Mission statements of PC Teams
- Existence of continuous quality improvement processes
- Is there an organisation at meso-level of the support structures for PC, e.g. in Primary Care Zones,…
- Is there an organisation at macro-level of PC e.g. a regional/national Institute for PC?

### 10) Human resources in primary care

- Average number of working hours per week of GPs/nurses/pharmacists/social worker.
- Average age of practising providers in PC
- Total number of active GPs as a ratio to total number of active physicians
- Total number of nurses active in PHC compared to total number of nurses in PHC, secondary and tertiary care

The opinion stresses that the choice of indicators should be guided by, at least, the following criteria: alignment with policy objectives, ability to routinely collect the information, either from administrative sources or from specifically-designed surveys, and reliability of information. Finally, an appropriate understanding and interpretation of the data often requires an additional qualitative data collection.

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**Word of caution: performance paradox**

There might be no automatic uptake of assessment framework for primary care and in extreme cases assessment framework may lead to dysfunctional performances (also called performance paradoxes) such as perverse learning - i.e., when actors have learned how measurement works they can manipulate their performance results. The Panel identified on the basis of the literature review some conditions which are key to put the assessment framework into the appropriate use.

**Multi-dimensionality** including organisational, institutional, financial, quality and equity aspects, is an important characteristic to account for the complexity of the primary care system. **Shared design** of the evaluation system (involving evaluators, managers, policy-makers and clinicians) can drive an easier acceptance of the system. **Evidence-based** data collection and information provision is crucial and comparability of indicators across countries and regions creates an added value. Shift from monitoring to evaluation, that includes systemic **benchmarking** of results among providers and geographic areas and, if it is possible, against shared standards is a way to progress to better performance levels. **Timeliness** is also a core element of every performance evaluation system as it determines the promptness of decisions. **Transparent disclosure** to stimulate data peer-review stimulates long-term improvements, provided the performance evaluation is appropriately contextualized (e.g. through information on case-mix). The **engagement of health professionals** is indispensable, because healthcare problems cannot be solved by experts from other fields. Finally, when choosing the indicators that should be used to assess primary care performance in a specific context, policy-makers should ensure that the set of indicators: is consistent with strategies; considers different dimensions of performance; includes indicators measurable over time; includes indicators measured in a systematic way.
Recommendations of the Panel

The Expert Panel acknowledges that strengthening primary care will contribute to improved population health and wellbeing and greater social cohesion in the European Union.

The first recommendation is to distinguish clearly the primary care from the broader healthcare system through performance assessments tailored to specificities of primary care. The tools and methodologies which are used should **encapsulate the essence of primary care in the framework of the broader health care system**. On top of 8 dimensions, that are derived from the definition of primary care formulated in its opinion: "Definition of a frame of reference in relation to primary care with a special emphasis on financing systems and referral systems" (EXPH, 2014), the Expert Panel suggests to add 2 dimensions which are critically important: "primary care organisation" and "human resources". Therefore, the **10 domains** that Expert Panel proposes are: universality and accessibility, integration, person-centeredness, comprehensiveness and community orientation, a team of professionals that addresses the larger majority of personal health needs, sustained partnership with patients and informal care givers, coordination of people's care, continuity of people's care, primary care organisation and human resources.

The second recommendation of the Expert Panel is to set indicators associated with 10 domains, which include both **comparative key-indicators** and **descriptive additional indicators**. They should meet three criteria: alignment with objectives of health system, ability to routinely collect data and reliability of information. The Panel notes that indicators in current use are very much restricted to the functioning of GPs/FPs, and it will be essential to broaden the scope to the inter-professional Primary Care Team. Moreover a lot of indicators are related to specific diseases, overlooking the need for a comprehensive approach. Finally, new outcome indicators should be able to look at strengths, capabilities of people and include dimensions like happiness at the individual level and social cohesion at the broader societal level.

Thirdly, the Panel suggests **scaling up activities in relation to performance assessment of primary care**. The Panel is suggesting the creation of a **widespread EU learning community** to support development of appropriate tools and methodologies for assessing the performance of primary care and inform the public on the findings. The European Pillar of Social Rights and the Sustainable Development Goals create some momentum to strengthen the policy framework to develop these activities and build on experience of the EU expert group on Health Systems Performance Assessment.

The Panel also stresses the importance of **human resources** in primary care, which should be subject to performance measurement in a way encompassing professionals' motivation and engagement, good working conditions, management skills to organise and manage the correct use of performance information and to put in place strategies and actions to enhance primary care.
Chapter 2. Findings of the survey on national experiences on performance assessment of primary care

This chapter builds on the survey conducted by the EU Expert Group on health systems performance assessment in March 2017. What emerges from the survey is that countries can learn from each other and that performance assessment can help make the primary care the cornerstone of the modern health services.

The survey collected information on national experiences in performance assessment of primary care. Twenty-two countries replied to the survey and given the difference in the organisation of care across countries, the questionnaire considered primary care as first contact care, provided by a team of professionals accountable for addressing a large majority of personal health needs. This chapter presents the findings from the survey.

Main characteristics of the performance assessment systems

Almost all respondent countries do carry out recurrent assessments of primary care but their experience varies according to the objectives, scope and technical parameters, such as the type of indicators used, methodologies, etc. Some systems are more advanced than the others and there is certainly scope for reinforcing them overall across Europe. The plans for the future vary across countries, depending on how developed the primary care assessment is. Nonetheless, almost all respondents have stated their intentions to enhance the efforts in this regard.

The majority of countries who took part in the survey have an assessment system in place that specifically targets the performance of primary care, or important parts of the primary care system. Just in few countries, the primary care assessment is part of an assessment of the health system in general, but even in those cases, the assessments include aspects that mirror primarily activities in primary care (e.g. use of medicines for diabetic care, data on waiting times, rate of registers users in local primary health care, etc.). Eight countries put a priority on a specific dimension of primary care (Belgium, Estonia, Finland, Luxembourg, Netherlands, Portugal, Slovenia, and Spain); the most frequently mentioned are care for specific diseases, delivery of preventing services, uptake of vaccination and immunisation programs and prescribing.

There is some untapped potential for performance systems to strive for better results of primary care. Monitoring of policy actions, general reporting and accountability are reported by almost all of the countries as a reason behind monitoring the performance of primary care. In some cases performance assessments feed into performance-based reimbursement schemes and comparative benchmarking. Only three respondents reported performance-based reimbursement schemes as the main purpose when assessing the performance of primary care (Belgium, United Kingdom and France).

Some important stakeholders may drop off from the targeted audience. While almost all respondents address their primary care assessment to policy makers, healthcare managers and clinicians are the second main group targeted by primary care assessments. To a lesser extent, the reports are intended to reach the public and patient’s users. Restricting audience may in some cases limit the benefits which various stakeholders could reap from the performance assessment. The involvement of stakeholders in the design of the system or its elements may also be beneficial. In France for example the professionals are involved in the selection of indicators measuring the quality of medical practice.

Differences exist on the type of primary care that is considered when assessing the performance of the primary care system. The scope of assessments tends to be limited to the narrow spectrum of professionals of primary care. Almost all the countries that
presented their experiences in the survey to assess the performance of General Practitioners and Family practice in order to monitor the performance of the primary care system. Only some countries extend the scope of the assessment to other areas such as midwifery, nursery, paediatrics, gynaecology, preventive services, pharmacy and social workers.

Reporting mainly takes place at national and regional levels, though with different nuances. Some countries just report on national level (France, Latvia, Luxembourg, Malta, and Slovenia). In few cases, the assessment is carried out at provider level (Finland, Italy).

Scope of primary care assessment, few examples

Norway, through SAMDATA Municipalities establishes a comparative data system on health and social care services at municipality level (mostly input and process indicators) with the main purpose of monitoring resources, accessibility and quality of primary care services. Home care (nursing care and social care are integrated services), institutional long term care and institutional short term care (rehabilitation after treatment or planned rehabilitation) GP’s, physiotherapist, school nurses, health services for new-borns and preschool children, social services to support the persons possibilities to be active and participate in society, are all services targeted by this report. In the Netherlands, the Netherlands Institute for Health Services Research (NIVEL) and the Dutch Healthcare Authority (NZA) gather data of Individual GP practices, out of office GP’s care centres, primary mental care, pharmacists, physiotherapists, speech therapists and dieticians. In Slovenia, the National Institute of Public Health (NIJZ) and National Health Insurance Institute (ZZZS) collect data on individual GP/family medicine practices, paediatric practices and women reproductive health practices at primary healthcare level, dental services for children and adolescents, preventive services for children and for adults, community nurse services, primary mental care, speech therapist and physiotherapist services.

Geographic level of reporting, few examples

Finland carries out different performance assessments of primary care. Among them, the Survey on Customer/patient satisfaction is done at provider and practice level whereas Access to primary health care and Register on Primary Health Care Visits are done at national, regional, provider and practice level.

In Italy, the level of reporting is both regional and sub-regional: LEA (Livelli Essenziali di Assistenza) grid indicators are computed at the regional level, while PNE indicators (outcome indicators) are computed at province or health care district level. Moreover, variability among general practitioners is also measured.

In Sweden the development of performance assessment has been increasing based on extensive cooperation between the national level, the county councils and the medical professions. Both open regional comparisons and evaluations have for many years presented data on county council and hospital level. The main focus has so far been primarily on the county council population level.

In the Netherlands, healthcare performance indicators on national website (VZ-info) are done at national level, whereas other assessments (NZA, NIVEL, Monitor Voorschrijfgedrag.) are done at national and regional level.
There is less variation in practice related to the governance of the performance assessments. As a norm, Ministries of Health are commissioning the assessments carried out in primary care. Likewise, the assessments were in large part carried out by Public Health institutes, quality measurement agencies, or other similar entities.

**Indicators and data collection**

Descriptive information about providers, access and patient-centeredness are the main dimensions considered by most of the Member States when assessing the performance of primary care. Clinical performance is measured by half of the respondents. Aspects such as equity, workload and workforce satisfaction in primary care are less frequently reported. Almost all respondents do have in place indicators providing descriptive information about providers and utilisation of care. Examples are: the amount of carried out check-ups for different age groups, the average number of patients served per day at a GP’s practise and the number of patients who have had a dental check-up in a given year (Latvia); the number of maternal and child health checks by municipality, users of home nursing help or institutional care for the elderly, waiting times and some patient experience measures (Norway).

Most of the countries do consider access when measuring the performance of primary care. Some indicators are: the supply of providers, the availability of specific assistance agreements, geographical access (Poland); the access during out-of-office hours (Cyprus); waiting times and financial barriers, including out-of-pocket payments (Malta).

Patient centeredness is also considered by some countries when measuring performance of primary care. Indicators include satisfaction rates with GP, availability of essential patient information in records, communication, chronic care management, continuity of care and patient safety were measured in this regard.

Cost, waste and efficiency, on the other hand, are just measured by few Member States (Belgium, Finland, Spain, Portugal, UK, the Netherlands and Slovenia). Indicators measured under this category include expenses for prescribed medication with user reimbursement (Portugal), prescription in accordance to Guidelines (Netherlands), and use of emergency department for cases that could be treated in primary care (Spain and Malta).

Clinical performance is also considered to a lesser extent (Estonia, Finland, France, Italy, Latvia, Lithuania, Portugal, Slovenia, Spain, and UK), with indicators like immunisation rates for various diseases, number of patients who have been advised/consulted by GP or nurse to change their unhealthy habits. A small set of respondents explicitly address equity in primary care. Malta breaks down access, quality, or outcome indicators by specific population groups (gender, socio-economic status, education or ethnic background). Slovenia performed extensive qualitative survey on barriers for access to primary care and preventive services for deprived/vulnerable individuals. In the UK, the numbers of patients registered at GP practices is available by single year age band.

Workload and workers satisfaction is considered in the assessment of the performance of primary care by just eight respondents (Belgium, Finland, Netherlands, Portugal, Slovenia, Spain, Sweden, and Tuscany region). Spain and Slovenia, for instance, report on the ratio of users per quota and the burden of chronicity/patients in order to assess the primary care workload. In Spain, a survey on the work environment is carried out in some autonomous communities in order to assess work satisfaction. In most cases, the information on workload and workers satisfaction is not measured by primary care assessment, but is the focus of other types of investigation.

For virtually all respondents the selection of indicators was done through standard methodology and the involvement of different advisory boards composed by external independent experts, senior health managers, clinicians, health care professionals, academics, and in some cases patients.
Survey respondents reported mainly routine data obtained from administrative and national registries. It is usually not specified if administrative registries were set just for primary care assessment or also for other purposes.

**Impact on policy making**

Usually, survey respondents assess the performance of primary care to inform policy making. However, in most of these cases countries do not monitor how the assessment impacts on policy making – also because of the long time lags. Some exceptions are presented in the box.

**Impact on policy making, few examples**

In Slovenia, several assessments of different dimensions and services at primary health care have been conducted with the aim to provide the evidence for developing the National Healthcare Plan, the Strategy for development of Primary Health Care, the upgrading of the national program for prevention of NCDs and reducing inequalities in health, and others.

In Finland, some indicators considering access have been used in the current debate on reforming health and social services; thus, data is used to support reforms. Moreover, the information on health centre recruitment situation has been used to motivate the increase in enrolment to medical schools. Finally, the vaccination monitoring system highlighted low rates for measles in some areas to the extent that the herd immunity is endangered.

In Latvia, by reporting to the Cabinet of Ministers information on primary care assessment, the post-graduation training program on team work (GP + nurse/physician assistant) for GP practices was developed and realised.

In Italy, in the region of Tuscany, considering the results of annually performance at primary care level, regional and local policy makers can decide to promote some interventions and services to shift to a different organisational model. In Lazio, primary care quality indicators are systematically used by the Health Plan Directorate to evaluate health patterns for chronic conditions to set clinical and organisational objectives for healthcare providers and to link the level of achievement of these objectives to annual budget or contract extension of healthcare professionals.

In Spain, performance indicators have helped to target strategic areas of improvement in health centres. Various national strategies have been developed after assessments were conducted: chronicity, health promotion, ischemic heart disease, chronic obstructive pulmonary disease, diabetes and stroke (among others). There is evidence of a slight improvement in some of the health problems which were prioritised.

**Linkage between function of the performance assessment and type of indicators**

The linkage between function of the performance assessment and type of indicators is of crucial importance. The choice of indicators will depend on its objectives and will affect the chances for impactful performance assessment. The practices vary a great deal across Europe, but there are also some common patterns emerging. Some examples show different angles.
Belgium, who runs performance-based reimbursement schemes, uses a set of indicators ranging from indicators measuring access (supply of providers, availability of specific care arrangements e.g. disease-management programmes, case management, access during out-of-office hours, financial barriers e.g. out of pocket payments, geographical access, unmet needs), indicators measuring clinical performance (periodic check-ups of chronically ill, prescription or referrals in accordance with guidelines, use or availability of clinical protocols and patient safety procedures), indicators measuring patient-centeredness or responsiveness (patient experiences with provider-patient communication), indicators measuring costs, waste or efficiency (e.g. unnecessary tests, referrals, medication, etc., prescription of generics, procedures taking place in secondary care that could have been taken place in primary care, use of emergency department for cases that could be treated in primary care), indicators measuring equity (access, quality or outcome indicators broken down by specific groups, e.g. gender, socio-economic status, education or ethnic background), general descriptive information about providers or organisations, quality (presence of accreditation certificates).

France applies performance assessment to design performance-based schemes covering mainly clinical organisation and quality of medical practice. The scheme of an annual payment based on public health objectives called ROSP (Remuneration sur Objectifs de Santé Publique), provides incentives for practitioners on the basis of the indicators measuring: clinical organisation (information system for care coordination, patient’s file, and treatment improvement), quality of medical practice (chronical diseases monitoring, prevention, efficiency).

Ireland’s Health Services uses a set of indicators to examine the performance against resource planning frameworks: the National Service Plan 2017/ Primary Care Division Operational Plan 2017. They include indicators measuring access (supply of providers, availability, waiting times access during out of office hours), clinical performance (use or availability of clinical protocols and patient safety procedures), costs, waste or efficiency (spending per patient of specific categories on medicines, overhead spending), equity (access, quality or outcome indicators broken down by specific groups, e.g. gender, socio-economic status, education or ethnic background; indicators related to the care of specific de-privileged groups such as homeless people, asylum seekers, illegal immigrants, etc.). They are complemented by general descriptive information about providers or organisations: activity in visits, group and community (e.g. number of practice consultations; home visits per time unit); consultation length; range of services provided, Community Intervention Teams (CITs) record the number of referrals, admission avoidance, hospital avoidance, early discharge, and unscheduled referrals from community sources. Public Health Nurse data refers to targets for home visits with in defined times.

Italy applies performance assessment for both comparative benchmarking between providers in local districts and GPs practices and for other professions performance-based reimbursement schemes (in this case, some of the indicators are used as the base of performance schemes). The indicators which feed into the assessments include measures of: access ( GPs involvement on the Chronic Care Model and waiting times for GPs visits and outpatient visits), clinical performance (prescription or referrals in accordance with guidelines), patient-centeredness or responsiveness (patients satisfaction and experience with their GP in terms of involvement, communication, chronic care management, continuity of care), costs, waste or efficiency (prescription of generics drugs, compliance to treatment, use of emergency department for minor disease, appropriateness of secondary care and diagnostic and laboratory exams), general performance such as ACSCs hospitalization rate. Moreover, indicators related to GPs practices organisation in terms of GPs satisfaction and experience supplied by regional online survey are used.
Latvia uses performance assessment in general reporting and performance-based reimbursement schemes with the following set of indicators: general descriptive information about providers or organisations, (e.g. the amount of carried out check-ups for different age groups, average number of patients served per day at a GPs practise, number of patients who have had a dental check up in a given year), outcome indicators that may be related with primary care performance, including both access and quality (e.g. hospitalization rates for ambulatory care with sensitive conditions), indicators measuring patient-centeredness or responsiveness (e.g. satisfaction rates with GPs), indicators measuring clinical performance (e.g. immunization rates for various diseases, number of patients who have been advised/consulted by GP or nurse to change their unhealthy habits), indicators measuring access: supply of providers. In the framework of the annual GP's performance assessment, Latvia uses the following mix of indicators: health check-up of the newly registered patients, health check-up of the patients 18 years of age and older, children's immunisation coverage, health check-up for children from 2 years old to 18 years of age, mammography and cervical cancer screening, percentage of the patients registered within GP who have had an occult blood test, glycohemoglobin measurement for patients with type 2 diabetes, microalbuminuria quantitative determination for patients with type 2 diabetes, cardiovascular risk evaluation, Determination of LDL cholesterol, expiratory peak flow in asthma patients; number of Emergency medical service team's visits to GP's patients.

Lithuania uses performance assessment for general reporting, comparative benchmarking and performance-based reimbursement schemes. The following dimensions are screened though a relevant set of indicators: population care coverage with a view of promoting regular check-ups, performance of cancer screening programmes, prophylactic examinations, hospitalisation of patients with schizophrenia (to monitor performance of the outpatient mental health care), hospitalisation of patients with chronic diseases (to monitor performance of outpatient care for people with chronic diseases), performance of dental healthcare. Lithuania defined a list of services which should be incentivised and are monitored through performance assessment. At the moment there are 18 groups of services/examinations (total 68 services/examinations) which are considered as the incentive services, for example: blood clotting condition tests: prothrombin activity test and INR test; test to assess blood coagulation system and to determine an individual’s ABO/D type for patients admitted for elective surgery; vaccination of high risk patients against influenza; glycated haemoglobin test for patients suffering from diabetes; early diagnostic of cancer; regular care of pregnant women; provided care for children under 1 year; home care of disabled; timely immune-prophylaxis of children; regular health check-ups for schoolchildren; performance of Mantoux tuberculin skin test for children at risk groups; care provided by the community at patient’s home; provision of care and specific tests (e.g. serological screening test for syphilis; T. pallidum haemagglutination test (if serological test was positive; HIV serological test; anti-HCV antibody tests) for patients receiving substitution treatment; performance of rapid antigen tests for group A streptococcus for 2-7 years children with diagnosis of upper respiratory tract infection; treatment of patients suffering from tuberculosis.
**Feedback on challenging issues**

The most common constraints encountered when assessing the performance of primary care are lack of routinely collected data for primary care, problems with data quality (low reliability), and appropriateness of indicators used. Some other limitations highlighted by participants include for example:

- Performance information does not have a clear position in the policy cycle;
- Lack of permanent dashboards, and therefore difficulty to monitor indicators over time;
- Monitoring systems operating in silos; no data linkages;
- Some stakeholders remain excluded from the process;
- Lack of resources;
- Activities link to primary care are difficult to assess through registries;
- Data collection systems developed for payment and therefore not tailored to the needs of patients/public;
- Insufficient development of indicators that refer to multiple chronic conditions and indicators that reflect multi-professional care;
- Insufficient development of indicators that reflect outcome of care instead of process of care;
- Providers that are identified as poor performers are more likely to question the validity of the data, particularly when the results are first released;
- Problem with registration and integration of information systems among care levels and with other care actors.

**A way forward**

Countries are interested and ready to further develop their performance assessment systems for primary care. Specifically, those countries that have done efforts in the development of primary care performance assessment emphasize the need to further develop indicators (increasing the indicators focusing on health outcomes) and overcoming the reported limitations. At the same time, countries that informed being on a more preliminary stage in the assessment of primary care performance, report their intentions to start collecting and publishing indicators.
A key driver behind many efforts to measure and evaluate the performance of health services and systems has been a growing concern about accountability. An important role of performance measurement and reporting is thus to help hold various actors to account by informing stakeholders and so enabling them making decisions. Performance assessment should support policy action by helping policy makers to select interventions and policies in response to different health problems, and to decide the allocation of resources considering different priorities and demands, with a short, medium or long-term perspective. Other objectives include enabling the identification of areas of poor performance and centres of excellence; facilitating the selection and choice of providers by service users and purchasers of health care; encouraging provider behaviour change; and providing epidemiological and other public health data. Much progress has been made nationally and internationally, but many challenges remain regarding the design and implementation of performance assessment initiatives, in terms of scope, policy usefulness and policy impact.

This chapter aims to identify the key requirements for HSPA to successfully inform and support policy action within European settings, with a particular focus on primary care policy. It does so through, first, synthesising the existing evidence base on the use of health system performance assessments in the policy process more generally and within primary care specifically. This draws on a rapid assessment of published evidence around performance assessment and the public reporting of data on provider performance as identified from an iterative search of the PubMed database and Google Scholar, as well as the author’s own work. It further draws on the survey conducted in March 2017 among key informants in countries participating in the EU Expert Group on HSPA and reported in chapter 3. The rapid review of the existing evidence presented does not attempt to be exhaustive. Instead it focuses on some of the main key issues around the policy impacts of HSPA as highlighted in the identified literature. Second, we explore the main barriers for HSPA to inform policy and discuss options to overcome these challenges. This second element of the chapter builds, mainly, on insights from experts from 17 European countries that took part in a structured policy focus group of the Expert Group on HSPA (Box 1). The policy focus group approach builds on a similar exercise undertaken as part of the work by the Expert Group on quality of care (2016) and on integrated care (2017). The main objective of the present focus group was to generate in-depth discussion and provide suggestions and recommendations for key requirements for health system performance assessment to successfully inform and support policy action, the main mechanisms whereby HSPA might affect national policy, and the possible role HSPA can play as a tool to monitor and evaluate reform of primary care and of the health system more broadly.

It is important to note that much of the discussion on the core opportunities and challenges for HSPA to influence policy presented in this chapter is not confined to primary care specifically. This is illustrated both in the synthesis of the wider literature which we describe below as well as many of the discussion points made by focus group participants. This is perhaps not surprising, given that the design and implementation of many HPSA initiatives continue to evolve across Europe and elsewhere, as noted above. Thus, many of the insights provided in this chapter will have wider applicability beyond the context of primary care. However, we will draw on specific examples from the literature to illustrate the points we make.
within primary care policy to illustrate specific discussion points and options.

Box 1 Policy Focus group – sub-group Primary Care

The policy focus group brought together experts with in-depth knowledge on their respective health systems performance assessment processes from 17 countries in Europe, as well as representatives of the European Commission Directorate General for Health and Food Safety and the OECD. By means of a semi-structured facilitated discussion coordinated by the European Observatory on Health Systems and Policies, experts reflected on key requirements for health system performance assessment to successfully inform and support policy action, with particular consideration of how HPSA can successfully influence primary care policy, and the enablers and barriers for this to be translated into practice. It further considered the main mechanisms whereby HSPA might affect national policy, and the possible role HSPA can play as a tool to monitor and evaluate reform of primary care and of the health system more broadly.

Focus groups are frequently used in qualitative research to explore topics that are not easy to observe or that are sensitive, to ascertain perspectives and experiences from people on a topic in a short time span, or to gather preliminary data and clarify findings from another method, among other uses.8

Focus group participants were provided with background documentation prepared by the European Observatory, which synthesised evidence from the peer-reviewed and grey literature on the use of health system performance assessments in the policy process. This material was shared with participants in advance to the meeting of the policy focus group, held on 18 September 2017 in Brussels. Subsequent to the meeting, focus group participants were given the opportunity to consult with other experts in their countries and provide additional comments and insights and, where appropriate and relevant, documented empirical evidence subsequent to the policy focus group meeting. Additional comments and suggestions received were incorporated into the present report to ensure that it appropriately reflects country’s experiences.

Policy impact of performance assessment activities at national or regional system level

How to integrate HSPA into the policy process remains one of the unresolved issues that Member States and countries elsewhere continue to struggle with. A 2014 review of the HSPA initiative in Belgium explored relevant experiences in a set of peer countries (Austria, Malta, the Netherlands, Portugal, Sweden and the United Kingdom (England)) and found that as the aims of HSPA varied across countries, so did its influence on the policy process.9 Reviewed HSPA approaches variously sought to promote the accountability of national institutions, inform policy, improve transparency and understanding, and/or hold devolved entities to account (Table 1). Perhaps reflecting this diversity of aims, the nature and extent to which HSPA supported policy action in the reviewed countries at that time also varied, ranging from more direct impacts, for example, feeding into agenda or priority setting at national level (such as in Malta and the Netherlands; Table 1), including the development of national strategies (e.g. Portugal), to more indirect mechanisms, such as informing the political debate (e.g. Austria, Belgium). The review noted that HSPA had stimulated new data collection efforts in a number of countries and the use of international datasets such as those collected through the OECD Health Care Quality Indicators project provided opportunity to draw attention to gaps in national data. Overall, however, the review highlighted that identifying appropriate ways of linking HSPA with policy processes remained underdeveloped in most countries at that time; approaches are also likely to vary depending on institutional arrangements.
Table 1. Reported impacts of HSPA on national policy making, 2014

<table>
<thead>
<tr>
<th>Country</th>
<th>Impact of HSPA on national policy making</th>
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<tbody>
<tr>
<td>Austria</td>
<td>HSPA provides an important source for identifying areas of action for policy makers. It provided the analytical background for target-setting within the 2013 Austrian health reform (“Health System Governance by Objectives”) for policy makers but it remains a challenge to embed the current HSPA framework more deeply in the policy making process to facilitate target setting based on HSPA analyses.</td>
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<tr>
<td>Belgium</td>
<td>The HSPA report aims to provide a transparent and accountable view of and inform health authorities about the performance of the health system. While supporting policy making was not an objective at the outset it has progressively become an issue. Reports provide recommendations for policy-makers and point out priorities, also for data collection; the usefulness of reporting for decision-making has as yet to be demonstrated.</td>
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<tr>
<td>Malta</td>
<td>National HSPA framework in process of development and link with policy cycle yet to be established. The aims are to monitor the health system’s ability to cater for the nation’s health needs, to increase accountability, transparency and sustainability of health system and to determine future policy directions.</td>
</tr>
<tr>
<td>The Netherlands</td>
<td>HSPA reports are used for agenda setting and for accountability of the ministry of health to parliament. While the reports are well embedded in a network of expert researchers and health care professionals, it remains a major challenge to improve its policy impact and ‘actionability’.</td>
</tr>
<tr>
<td>Portugal</td>
<td>HSPA supports efforts of the Ministry of Health to improve the performance of the health system and contributes to gathering the critical evidence base to inform the national health plan. It motivated key experts and policy-makers to engage in the development of the new national health plan and it helped to clarify system goals, so introducing a health system perspective into the national plan. Gaps in health information remain a major challenge, limiting the capacity to support transparency and accountability through public reporting of results.</td>
</tr>
<tr>
<td>Sweden</td>
<td>HSPA reports are used to inform decision-making locally (county councils) and nationally. The development of indicators and measures can inform local improvement work. It remains a challenge to prioritise among different measures and to determine how to best translate the information being compiled into health care improvement.</td>
</tr>
<tr>
<td>United Kingdom (England)</td>
<td>The Outcomes Framework for the NHS is aimed at holding NHS England (the national public body leading the NHS in England) for improving health outcomes and reducing health inequalities; two further outcomes frameworks for public health and for adult social care seek set out to improve and protect the public’s health and to support transparency and local benchmarking. It may be challenging to establish how improvements have been arrived at.</td>
</tr>
</tbody>
</table>

Source: adapted from Peer Review Health System Performance Assessment (Brussels, 19-20 May 2014), country questionnaires 9-15

Recent work on the use of OECD Health Care Quality Indicators at national and regional levels documented over 160 quality or performance reports that were identified from a survey of experts in 15 OECD countries. 16 Around one-third of the reports had a general system focus while about half concerned a specific health condition or disease/group, such as diabetes, cardiovascular disease, cancer or respiratory disease. According to survey respondents, most reports aimed at general reporting to inform decision makers, while others focussed more specifically on target setting or the provision of comparative quality performance information to patients or payers. The analysis did not report on the degree to which quality or performance reports did influence policy or led to improvements in health system performance or in the quality of care in the area concerned.

An evaluation of the implementation and impact of a health system strategy-based performance card in Ontario, Canada, found that the regular monitoring of a core set of performance indicators by decision-makers at the Ontario Ministry of Health and Long-Term
Care helped refocus its role on health system outcomes and its overall stewardship function. The process for developing the health system scorecard, which separated the process of strategy mapping (conducted by policy makers) from the process of indicator selection (undertaken by experts) and that of negotiating local health system performance improvement targets (by the ministry and local health system leads), was found to help building credibility and trust for health system performance assessment and improvement. Challenges remained, however. These related to continued difficulties in defining, measuring and regularly monitoring the performance of the health system; providing concise information to policy makers about complex systems such as a health system; and, importantly, systematically linking performance information to the decision-making cycle of the ministry.

Overall, there remains a gap in our understanding about whether and how HSPA does indeed impact policy more generally. It is conceivable that the impacts of national reporting that aims to hold governments and those in charge of the health system to account can be powerful, but these are difficult to measure. Impacts include scrutiny of performance reporting by the parliament, media reporting to the citizenry (Box 2), and, possibly, elections. In addition, the reporting on health system performance by international agencies, such as the World Health Report 2000 and, in some countries, the international health policy surveys by the US-based Commonwealth Fund, can be highly influential in stimulating policy action. Whether any of these types impacts are always beneficial or indeed useful remains open to debate however. For example, as White (2014) has highlighted, in relation to parliamentary scrutiny, “most individuals, bodies and institutions engaged in scrutiny do not have any power to compel the government to change what it is doing” (p. 9) and, importantly, measurement of the impact of scrutiny can have unintended consequences the same way as performance measurement itself.

**Box 2 Media reporting of international health system performance comparison: experience in Canada**

In Canada, the Canadian Institute for Health Information (CIHI) carried out methodological work to communicate results of international health system performance comparisons using OECD data at national and sub-national level and to measure the reactions of the public and health system stakeholders to the release of such comparisons. CIHI systematically documented media uptake and coverage of the resultant *Learning from the Best 2011* analytical report through monitoring of all media outlets and through examining the way in which key media outlets, commentators and experts covered and reacted to the report.

The monitoring of the media response was reported to have been “strong (...) with nearly 60 mentions in the six days following the release, by far the strongest coverage received associated with the release of OECD health indicators in Canada” (p. 143). This included national and local television and radio news broadcast interviews with CIHI executives, national newspaper articles, and social media coverage (twitter).

The analysis identified a number of impacts that were attributed to the release of the report. These included requests from the federal Ministry of Health for CIHI to calculate indicator results at the level of the provinces and to develop related performance profiles (subsequently released as an interactive online tool). Also, the report had highlighted comparatively poor cancer outcomes, which were however linked to the timeliness of related data. The level of attention raised by the public comments on these results was reported to have led to improvements in the data submission processes across Canada.
Box 3 Quality measurement and improvement

Provider behaviour change is considered to be key to helping improve the overall quality of care.\textsuperscript{34} Berwick et al. described two principal pathways through which measurement and reporting can induce behaviour change.\textsuperscript{35} In one pathway (‘improvement through selection’) users are provided with knowledge about quality that will enable them to select providers. Users include patients, who can, based on this information, exercise informed choice of provider,\textsuperscript{36} as well as payers and regulators who may use the knowledge to inform decisions on payment, for example, rewarding high or penalising low performers. In the second pathway (‘improvement through change’), quality improvement is achieved through changes in provider behaviour. Information on the quality of care is expected to help providers to identify areas of underperformance and reporting can then act as a stimulus for improvement. These pathways are linked through a provider’s intention to maintain or increase reputation and, in a competitive context, market share.\textsuperscript{31} Quality improvement may therefore occur even if patients make limited use of information systems and provider choice.\textsuperscript{37}

Providers are direct users of information (for example, to inform their decision at the point of referral) as well as the main target audience of reporting, and their response to the publication of such data will determine quality improvement. In this context, a recent survey of a random sample of GPs in France (n=503; response rate 56\%) about their perceptions and use of comparative hospital quality indicators made available by public services and the media may be relevant.\textsuperscript{38} It showed that between 84 and 89\% of GPs responding to the survey had never used public comparative indicators to guide their patients’ hospital choices. They did however perceive quality indicators as useful in principle, as a means to improve the quality of care and to enhance the transparency of public services.

Understanding the impacts of measuring and reporting the performance of institutions and practitioners in health care

While the impacts of national reporting of the performance of the health system as such remain difficult to assess, there is a small, albeit increasing body of work that has examined the impact of performance measurement of institutions and practitioners and the public reporting of related findings. Much of the published work centres on the reporting of performance data of hospitals,\textsuperscript{27} including, in the US and the UK, individual surgeons,\textsuperscript{28} and, more recently, long-term care,\textsuperscript{29} while similar efforts within primary care are only emerging.\textsuperscript{30} Public reporting of the performance of institutions and practitioners is meant to promote high quality, efficient health care delivery and to increase the transparency of quality information (Box 3). The evidence of whether the public release of performance data achieves any of these objectives remains inconsistent however.\textsuperscript{31-33} This is, in part, because of a lack of rigorous evaluation of many major public reporting systems.

Early evidence from the USA suggests that users as well as purchasers or payers of services rarely search out publicly available information and do not understand or trust it.\textsuperscript{39} Conversely, managers and some providers increasingly use comparative information, with hospitals in particular most responsive to publicised data and some evidence pointing towards improvements in care where public reporting occurred.\textsuperscript{39, 40} Hibbard and colleagues (2005) demonstrated that hospitals improved in clinical areas following the public release of performance data on those areas,\textsuperscript{41} a finding confirmed in more recent reviews.\textsuperscript{33, 42} There is also some evidence that the public release of data on the performance of individual surgeons (largely cardiac surgery) can provide an incentive for low performing surgeons to improve quality, although there is also some suggestive evidence from the USA of adverse selection of patients.\textsuperscript{28} A meta-analysis of the
The impact of public reporting on clinical outcomes as explored in hospital-based studies of mortality mostly following cardiac surgery found a significant reduction in mortality (risk ratio RR 0.85; 95% confidence interval 0.79-0.92). However, included studies used mainly an observational (before-after) design, and it is difficult to disentangle observed effects from other system changes that might have had as much or even a greater impact on performance as public reporting.

A review of the impact of annual performance ratings of NHS providers in England between 2001 and 2005 indicated that the assessment system did improve reported performance on key targets such as hospital waiting times. However, the analysis also revealed that in some cases these improvements were made at the expense of clinical areas where performance was not measured or were undermined by different forms of gaming such as data manipulation. While this evidence provides important insights in the ‘uses and abuses’ of performance data, the focus of much of the work has been on impacts on providers and services users, in terms of behaviour change as assessed through improvement efforts on part of providers, or the use and usefulness of quality and performance information by service users. There is little published evidence on the impact of such reporting mechanisms on policy as such.

A recent study from Australia examined barriers to the effective implementation of public reporting of hospital performance data, using interviews with 41 expert informants, representing service user, provider and purchasers’ perspectives across Australia’s public and private health sectors. The study identified a wide range of barriers, including:

- Conceptual: unclear objective, audience and reporting framework
- System-level: lack of service user choice, lack of service user and clinician involvement, jurisdictional barriers, lack of mandate for private sector reporting
- Technical and resource related: including data complexity, lack of data relevance, consistency, rigour
- Socio-cultural: including provider resistance to public reporting, poor service user health literacy, lack of service user empowerment

The authors called for greater alignment between the primary objective of public reporting, its audience and the information needs of audiences. They also suggested that more than one system of public reporting might be required to meet different audience needs and objectives.

**Policy impact of primary care performance assessment at national or regional health system level**

Reflecting the dearth of evidence of policy impacts of health system performance assessment activities more widely, there is little systematic evaluation of the policy impacts of primary care performance assessments at national or regional health systems as documented in the published literature. This also reflects, at least in part, that many countries are only beginning to more systematically assess the performance and governance of primary care as a key driver of health system performance more broadly.

The survey of national experiences on performance assessment in primary care carried out as part of the work of the EU Expert Group on HSPA in March 2017 found that among the 22 countries responding to the survey, nine reported using the assessment to inform general policy making (Finland, Italy, Latvia, Malta, the Netherlands, Portugal, Slovenia, Spain, and Sweden). Of these, Finland, Italy, Latvia, Slovenia and Spain also provided concrete examples of how primary care performance assessment impacted policy (Table 2).
Table 2. Reported impacts of primary care performance assessment on policy making, 2017

<table>
<thead>
<tr>
<th>Country</th>
<th>Impacts of primary care performance assessment on policy making</th>
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<tr>
<td>Finland</td>
<td>While it is not possible to judge whether reporting on primary care performance as such has impacted policy, selected indicators have informed various policy debates and actions. Examples include: &lt;ul&gt;  * The debate on reforming health and social services. Relevant data is used to strengthen the argument and supporting reform needs.  * Information on health centre recruitment has been used to encourage an increase in enrolment to medical schools.  * Reporting on the level of vaccination rates for measles, which in some areas has fallen to levels that endanger herd immunity has reignited the national debate on vaccination rates.&lt;/ul&gt;</td>
</tr>
<tr>
<td>Italy</td>
<td>Performance measurement is strongly embedded within the policy process. Examples include the following: &lt;ul&gt;  * Tuscany: the results of annual performance assessments at the primary care level helped inform decisions by regional and local policy makers on the promotion of some interventions and services to shift to different organisational models.  * Lazio: primary care quality indicators are systematically used by the Health Plan Directorate to evaluate health patterns for chronic conditions to set clinical and organisational objectives for health care providers and to link the level of achievement of these objectives to annual budget or contract extension of health care professionals.  * Data on people with diabetes or COPD have been used to plan the clinical pathways allowing to actively identify potential patients and include them in a scheduled programme of follow up according to evidence based practices.  * Data on people with diabetes or COPD have been used to plan the clinical pathways allowing to actively identify potential patients and include them in a scheduled programme of follow up according to evidence based practices.</td>
</tr>
<tr>
<td>Latvia</td>
<td>The reporting to the Cabinet of Ministers of information on primary care performance has led to the development and implementation of a post-graduation training programme on team work (involving GPs and nurses/physician assistants) for GP practices.</td>
</tr>
<tr>
<td>Slovenia</td>
<td>Primary care performance assessment serves as a basis for drafting the national strategy for primary care development in 2017-2025.</td>
</tr>
<tr>
<td>Spain</td>
<td>Performance indicators have helped to target strategic areas of improvement in health centres. Assessment has also informed the development of various national strategies around chronic diseases, health promotion, ischemic heart disease, chronic obstructive pulmonary disease, diabetes and stroke (among others). Available evidence suggests that his can be associated with a slight improvement in some of the health problems that have been prioritised; a stable tendency of cost-containment and efficiency gains; and progressive improvements and evolution in benefit catalogues and coordination between levels.</td>
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It is conceivable, as illustrated by country experiences listed in Table 2, that the policy impact of primary care performance assessment as such may be difficult to disentangle from wider policy developments although it may be possible to isolate the impacts of selected indicators as we shall see in the next section.
What are the key requirements for health system performance assessment to successfully influence (primary care) policy? Insights from the policy focus group

Considering the documented evidence on the policy impacts of HPSA (or lack thereof) as presented in the preceding sections and reflecting on their own experiences in health system performance assessment more broadly, policy focus group discussions centred on three interlinked areas: (i) countries’ understandings of HSPA and policy impacts, (ii) the main barriers to and enablers for HSPA to influence policy, and (iii) how to locate HSPA in the policy process to ensure that assessment will be effective and inform decision-making. It is important to reiterate that much of the discussion on the core opportunities and challenges for HSPA to influence policy discussed by the policy focus group, and reflected upon below, is not specific to primary care. Thus, while many of the insights shared will have wider applicability, we will draw on specific examples within primary care policy to illustrate specific discussion points and options.

Health system performance assessment is one among several policy instruments to achieve health system improvement

Policy focus group discussions highlighted the diversity of aims, and the nature and extent to which HSPA supports policy action in different European countries. Participants described different perspectives on the policy impacts and uses of HSPA, ranging from the degree to which HSPA places a particular problem or a set of problems on the policy agenda to examples of impacts that are often linked to specific indicators. It was suggested that impacts are easier to achieve (or to identify) where assessments are more specific, and participants pointed to performance assessment of primary care, and specific components within primary care, to illustrate this. One example of the latter is the documentation of localised measles outbreaks in Finland, a country with traditionally high vaccination coverage, and the reporting of a fall in vaccination rates to levels that risk undercutting the threshold for herd immunity, which has been related to renewed debate at national level about vaccination rates (see Table 2). Belgium provides an example where the assessment of the performance of general medicine published in 2012 identified a set of core challenges that led to policy action in a number of areas around access, workforce ageing, and quality of care (Box 4).

Box 4 Policy action following the 2012 report on the performance of general medicine in Belgium

In 2012, the Belgian National Institute for Health and Disease Insurance (NIHDI; INAMI-RIZIV) published a balanced scorecard on the performance of general medicine, with a focus on three components seen to be core to the delivery of high quality care:

(i) patient focus: geographical and financial accessibility, patient empowerment, satisfaction, continuity and integration of health care
(ii) appropriateness: treatment that is appropriate, efficient, of high quality and safe
(iii) capacity and professionalism: an appropriate number of skilled and motivated physicians

The balanced scorecard identified three main areas where general medicine performance was found to be in need for improvement. These related to access to care in urban areas; an ageing general practitioner workforce; and certain shortcomings in the quality of care such as around appropriateness of care and chronic care.

A series of policy actions have since been taken to address the challenges identified in the 2012 report. These included the drafting of a Green paper on access to care in Belgium, which involved a wide range of stakeholders from across the sector, and which led to the publication of a White Paper on access to care in 2016, although political action on the recommendations is yet to follow. Regarding the GP workforce, efforts are underway to increase the number of physicians overall, with the proportion of GPs to be increased to 40%. Multiple efforts are also underway to address the quality of care provided by GP practices. These include the creation of a new ‘Effective Care’ unit at the NIHDI to coordinate various activities to enhance the effectiveness and efficiency of care, among other activities.
It has been argued elsewhere that while performance measurement is an important means to assess whether and to what extent a given health sector achieves its goals, it is only one instrument for system improvement. Indeed, Smith et al. (2009) noted that for performance measurement to be effective it needs to be aligned with other levers for improvement such as financing, market structure, accountability arrangements and regulation.61 It is against this background that policy focus group participants highlighted the need to be clear about the ‘unique features’ of HSPA. These were summarised as follows:

- HSPA views the performance of the system as a whole and provides a direction about how the system is performing in its entirety
- HSPA is a ‘service’ to help steer policy
- HSPA provides for an analytical and actionable tool to inform decision-making
- HSPA has the potential to be both predictive and prescriptive

There was agreement that each of these unique features needed to be developed further for HSPA to effectively support policy action.

**There are a number of challenges for HSPA to overcome if it is to support policy action**

Policy focus group participants discussed a range of challenges or barriers that can prevent performance assessment from effectively supporting policy action6. The size and nature of these challenges vary however by country and aim of the assessment. For example, it was argued that in decentralised systems the national ministry of health does not necessarily hold the mandate for acting upon HSPA findings. This is particularly the case for sectors that are organised and governed by other institutions or at regional or municipal level, such as primary care in Austria or Finland (please see Box 5 for an example from France). Participants noted that in these cases, national reporting of primary care performance may be of limited impact. It was suggested that a common framework for assessment may help ‘standardise’ HSPA approaches in highly decentralised systems. At the same time, it was recognised that ownership will be key to ensure that reporting will inform policy action, an issue which we will come back to below. A related issue highlighted by participants was a widely perceived assumption that there is strong leadership driving HSPA. However, this may not (always) be the case, and this will then influence whether or not the assessment will impact policy.

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Box 5 Primary care assessment in France

In France, primary care is broadly under the responsibility of the national health Insurance (NHI), except for emergency services, which are provided by hospitals and which, in turn, are the responsibility of the state. Every year, the NHI present to the Government and Parliament a report “Charges et Produits”, which details analyses about the evolution of practices and expenses, and which serves as a basis for the NHI to propose ways to improve quality and efficiency of primary care and the use of resources. For instance, in its report for the year 2017, the NHI presented proposals six priority areas:

- Smoking prevention and education
- Lumbago treatment and prevention
- Shoulder surgical treatment
- COPD prevention and early detection
- Diabetic foot care
- Physiotherapy

There was a perception, among some focus group participants, that policy instruments such as HSPA that are embedded in legislation may have a greater leverage in terms of informing policy action. It was noted that only a small number of countries have incorporated HSPA in their regulatory framework although there was uncertainty about the degree to which giving a formal mandate to carry out HSPA would indeed enhance the impact of HSPA. There was agreement that any such association would likely vary across countries and it could be useful to map the regulatory framework for HSPA against perceived or reported impacts (where available) to better understand these links.

A separate set of concerns discussed by focus group participants revolved around the nature of the performance assessment. There was a shared perception that HSPA exercises that only describe problems without offering options for improvement are likely to undermine the value of assessment and its potential to support policy action. A related, although distinct concern voiced by a small number of focus group participants was the potential for ‘dilution’ of key messages where a wide range of stakeholders are involved. It was however recognised that involving key stakeholders in HSPA will be important both in relation to generating ownership and ensuring that findings will inform policy (see also next subsection). It was advanced that HSPA could add value by helping to uncover the root causes of problems and use modelling approaches to help identify policy options. It was noted that such an approach may be challenging because of the nature of available data and actual capacity to carry out more advanced modelling exercises, in particular with regard to whole system approaches. Overall there appeared to be agreement among focus group participants that while HSPA should propose policy options it should offer a balance between being descriptive and prescriptive.

**Key requirements for HSPA to effectively support policy action**

The reflection about the balance between the descriptive and prescriptive scope of HSPA led to a wider discussion around the location of HSPA in the overall policy process and the key requirements for performance assessment to effectively support policy action. In many ways, this discussion can be seen to be the mirror image of the challenges to be overcome by HSPA as identified in the preceding section. Thus, there was agreement that if HSPA is to support policy action, there needed to be a dedicated mandate by government or parliament for carrying out the assessment and political will and commitment to support the process. Such mandate and political commitment was reported for Belgium, Hungary and Portugal and seen to be key for initiating HSPA at...
national level. However, it was also noted that while a dedicated mandate and political can be seen to form a necessary condition for HSPA to be policy relevant, this would by no means be sufficient, if there is no interest in taking action or change.

We noted earlier that the involvement of key stakeholders was also seen as an important requirement for HSPA to successfully support policy action, but it was highlighted that this needed to be linked to ownership of or responsibility for the process and actionability. Thus, as Smith et al. (2009) have highlighted, a key requirement will be to develop a clear vision and framework of how performance assessment sits within the overall accountability relationships if measurement is to ultimately improve health system performance. It may be instructive, in this context to look at recent experience in New Zealand, with the introduction, in 2016, of a new approach to measuring and monitoring health system performance, the 'Systems Level Measures Framework'. While seen to provide substantial opportunity to drive health system improvement and for health sector organisations to engage in learning about how best to achieve desired health system outcomes, incentives for organisations to change may be relatively weak in the context of broader policy and funding settings, which is likely to undermine the potential of the new framework.

Considering the location of HSPA in the policy process, focus group participants highlighted that HSPA itself should be seen as a process rather than a one-off exercise. It should start from the diagnosis of a system (or a subsystem within) to prioritisation to policy action and implementation as illustrated in Figure 1.

Figure 1. Location of HSPA in the policy process

This simplified process map identifies the different steps required in the idealised process which involves different actors at different stages and with different responsibilities as highlighted by the different colouring of individual stages. The ‘diagnosis’ and ‘monitoring’ elements present the core tasks of the HSPA process that are of a more technical nature but that should support the entire process along the way. Prioritisation (or targeting) and policy action are considered separate steps to be undertaken by policy makers. A core element of the process is the feedback loop; HSPA is required to understand whether there has been (systemic) change and its impacts on outcomes.

The nature of stakeholders to be involved will vary by country context and purpose of assessment. As indicated earlier, for HSPA to effectively support policy action it will be of key importance to understand the various stakeholders’ motivations for engaging in the process as well as their incentives to (implement) change. It is likely, especially in smaller countries, that the various actors involved in the process are the same; the key defining feature here is that their role in
the process varies according to the stage. It is also important to note that each element of the process is a multi-layered system in itself and which will have to be taken into account.

Importantly, and reflecting earlier discussions of the policy focus group, which suggested that policy impacts are easier to achieve (or to identify) where assessments are more specific, it was noted that given the whole system perspective of HSPA overall, the process of assessment may best be viewed as a ‘puzzle’, that is the process is composed of a series of specific assessments that will then inform the whole. Thus, the process depicted in Figure 1 could relate to any performance assessment exercise within the wider system, such as the performance of primary care, mental health care, acute care, long-term care, etc., each with its own indicators and specific policy actions to achieve system improvement overall.

**What’s next?**

This chapter has explored some of the key requirements for HSPA to successfully inform and support policy action within European settings, with a particular focus on primary care policy. It has done so through a review of the documented evidence and drawing on insights from experts from European countries that took part in a structured policy focus group of the Expert Group on HSPA. It has illustrated cases of how HSPA has supported policy action, drawing on examples from primary care assessments in selected European countries, and suggested some factors perceived by experts to be core to effect policy change. It further proposes a way that can help convert HSPA into a strategic tool in the policy process, as illustrated in Figure 1.

Based on the discussions described above, there appeared to be emerging consensus among policy focus group participants that more could be done to promote a more strategic role for HSPA to effectively inform system improvement. These can be summarised as follows:

- **Strengthen HSPA advocacy**
  - HSPA experts should take leadership in the active communication of the work to help advance discussion on the use and usefulness of HSPA in policy
  - The European Commission could do more to ‘push’ HSPA as a key tool for system improvement, going beyond the technical level and promote its role at the policy/political level

- **Learning from experiences in countries to make HSPA an effective policy instrument**
  - A number of Member States have valuable experiences that can help inform the further development of HSPA as a policy instrument and the EU Expert Group can provide an important platform to further enable systematic exchange

- **Degrees of ambition**
  - Promote the suggestion of HSPA as a process that has the potential to further advance improvement at the system level through taking a prospective and forward-looking role
  - Explore the possibility of incorporating more strategically predictive or modelling approaches to help identify policy options

- **Map HSPA alongside other policy instruments to identify the future directions it should take**

- **Carry our an ‘impact assessment’ of HSPA to better understand the various impacts of HSPA and how can this be measured**.
Chapter 4. Conclusions

Strong primary healthcare is a foundation of a well-performing health system. Professor De Maeseneer in his book Family Medicine and Primary Care makes a strong case for primary care at many levels: individual, community, society, socio-economic. Although not enough appreciated, primary care can handle most of today’s chronic conditions without a specialist referral. Expansion of the roles and functions of primary care requires relevant resources, but well performing primary care means less healthcare utilization overall. Performance assessment can therefore inform decisions on the allocation of resources throughout the healthcare systems, adapt them according to the evolving status of primary care, with a high probability to ultimately reduce total costs of healthcare.

Primary care lives in a dynamic environment and is challenged by a need to constantly adapt to patients’ needs. The change of primary care can be supported by a well-functioning performance assessment, embracing all relevant health professionals working in multidisciplinary teams: dentists, dieticians, general practitioners/family physicians, nurses, midwives, occupational therapists, optometrists, pharmacists, physiotherapists, psychologists and social workers. The more embodied in the organizational culture and mission, the better for the results of performance assessment. Indeed performance assessment can move primary care from the status quo to higher levels of excellence, putting into focus the core aspects of well-performing primary care systems and fulfilling their key functions such as access, coordination of care and continuity of care.

Reforms of primary care require a holistic approach, taking into account various aspects, including for example training of professionals (both its content and the way it is organized), public perception of primary care which often narrows the role of primary care to a gatekeeper. Performance assessment can support a holistic approach to reforms.

Primary care performance measurement is not in infancy stage in Europe, but could advance. Countries carry out assessment of primary care in general or of some important aspects of it. However, just few countries extensively assess performance of services provided by all segments of primary care. Successful systems of performance assessment in primary care share three essential elements.

First, they have to take into account the complexities of primary care, addressing many elements as interrelated components. When it comes to the design of the assessment models, there is a challenge to align methodologies, indicators with the organizational structure of primary care and relations between various stakeholders. When it comes to the application of performance assessment, it involves commitment and capacities to handle the measurement processes, accountability for results achieved upon assessments and driving change and

Better performing primary care is associated with better health outcomes and more opportunities for efficiency of healthcare overall. Performance assessments applied in primary care pave the way for better health outcomes and improve the overall healthcare systems.

Primary care systems in Europe vary in strength and though performance measurement is not in infancy, it could significantly advance. Three main challenges in the horizon are: how to deal with the complexity of the performance aspects of the primary care, how to integrate assessments in policies and how to drive for culture of excellence.

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7Jan De Maeseneer: Family Medicine and Primary Care at the crossroads of societal change (2017)
transformation on the basis of achieved results. There is no one best way to achieve the performing primary care.

Secondly, performance assessment needs to be integrated in policy processes. Identifying the best ways of doing it remains a challenge in most countries along a gap in the understanding how the performance assessment impacts policies.

Thirdly, accelerating performance thanks to performance systems will not be possible without building a culture of excellence. A culture of excellence builds solid foundations for change as it fosters a consensus to create organisational capacities and a framework which empowers, focuses and engages all the primary healthcare professionals, equipping them with the mindset and skills necessary to focus on creating the desired results. This culture disrupts “business as usual” approach which may inadvertently set mediocre expectations through the outdated ways of providing primary care in the moment of change for it, for example through not keeping electronic medical records, working in silos without collaboration between segments of primary care, not adapting education models to tasks substitutions at various levels of primary care and between specialists and general practitioners, etc.

Recommendations

Building blocks...

- **Improve primary care information systems.** Availability of good quality data remains a tremendous challenge. In many cases the set of indicators available to policy makers is insufficient or focused on a subset of dimensions. Most Member States consider in their primary care assessments descriptive information on providers, access and patient-centeredness. Clinical performance is measured much less and aspects such as equity, workload and workforce satisfaction, efficiency and waste are reported to much lesser extent. It is noteworthy that in most of the cases the information is not collected through the structured primary care assessments, but through independent collection systems.

  The scope of data needed to run performance assessment in primary care is quite significant, because indicators should reflect both outcomes of care and processes of care. Reporting on organisation of after office hours, organization of home care or data on experience of patients having a family doctor and not having family doctor might provide an important feedback for better organisation of services. Certain aspects of primary care may also require temporarily more attention, because they are in transition in case of for example taking over new functions or a shift of care for chronical diseases from hospitals to primary care. In this situation an additional set of indicators can help accelerate progress or adapt the change on the basis of the solid feedback.

  The most common challenges in information systems include: limitations of data linked to outdated indicators which do not catch up with new realities of primary healthcare; lack of data on important aspects such as integration of mental care, relevance of doctors’ training, health inequalities; use of data from patients’ survey especially in case of low health literacy; underdeveloped systems and e-health solutions.

  Without producing too much administrative burden a well-balanced set of indicators should allow a regular screening of the functions of the primary care, focusing on accessibility, continuity and integration. Quality of primary care is also an important dimension which should be measured as an important driver of additional gains for the overall healthcare system.
• **Performance assessment methodology should be designed to move primary healthcare to higher excellence levels.** Methodologies should cultivate courage to progress and not to set for status quo. Quality of indicators involving risk adjustment methods and internal variability pose a challenge in the selection of the optimal set of measures. However, methodologies should aim at achieving unprecedented results of all the actors of primary care and align everybody around the performance goals ensuring that they do not revert back to old methods and habits. It is crucial to capture the performance of the current methods and habits, like for example activity in visits, range of services, co-ordination between all the levels and integration of services, continuity of care, practice of referrals, prescriptions, accessibility of care, level of quality. All these aspects should be assessed from the perspective of efficiency, equity, effectiveness. Benchmarking is a possible methodology to deal with complexities across the various layers of primary care and reference performance identifying the bottlenecks. Finally, a good methodology should enable measuring of health in final and intermediate outcomes, impact on lifestyles and on life quality. Therefore, measuring influence and impact of performance assessment should be at the back of mind for methodological considerations.

**Preconditions to make the performance systems work in the world of the primary care...**

If the objective is to increase the uptake of performance assessment in primary care, there are some conditions to be met:

• **Use for policy actions:** performance assessments in Europe seem to be mainly addressed to policy makers, less so to healthcare practitioners and even less to general public and patients. With some exceptions, they do not seem to be systematically embedded in policy processes and their use is not monitored and evidenced in most of the cases. There is certainly scope to scale up the use of performance assessments prompting policymakers to change sometimes well-established ways in which they understand challenges in primary healthcare. A key driver of a stronger take up is the recognition of the performance assessment through the legal and/or policy framework involving planning of necessary resources to carry out processes and evaluate the impact. High quality of performance assessment is also a precondition of its use. Finally, readiness for longer-term timeframes of change may be crucial to ensure that the potential of performance assessment is fully exploited for policy actions.

• **Institutionalization of the performance system:** performance systems require an institutionalized function for evaluation of results. Lack of such function hampers the ability to assess progress and adjust reforms or accelerate change. Institutionalization also means that feedback from the system is shared transparently in an effort to inform decision makers. Improvements themselves can be achieved if there is a readiness to provide additional resources or optimize the use of existing resources to reward and recognize the good performers and to support average performers to move into the high performance category.

**Primary care performance assessments should be systematically embedded in policy processes and their use in policy making should be scaled up and their impact evaluated.**

**A comprehensive strategic and analytical approach to primary care performance assessment, including evaluation and a robust resources framework, remains to be developed in most of the Member States.**
Financing models of primary care indeed can create such mechanisms and encouraging the performance in the top down approach, they will stimulate better excellence at all levels and segments of primary care and will produce more collaborative environment, not leaving any reason to protect individual roles, projects and expertise. But this may not happen without necessary resources for improving performance, either through training of primary care professionals or equipping them with tools to carry out their tasks. This is a critical element often missed in organisations, while relevant education and tools may transform primary care practitioners with respect to engaged leadership, continuity of care, team-based care and engagement in practice improvement.

- **Accountability**: it goes without saying that accountability is at the core of performance assessment. While accountability mechanisms may vary across the delivery models, the core is to define them clearly ensuring the involvement of the relevant stakeholders. Instruments used to enforce accountability like compensation mechanisms through expenditure policy or contractual agreements may not be sufficient. There might be a need to define associated improvement strategies. Finally, accountability must be realistic and a key to it is to ensure that job satisfaction of providers in primary care is monitored and at good level.

- **Patients experience and values**: for primary care being the first point of contact, the patients' perspective taking into account their experience with services and their values is one of the crucial elements of performance assessment and can help define high quality, curb less successful practices and influence the direction of change. The patients' perspective is also important for other reasons: more complex care demand, more demand for home-base care, greater diversity of patients linked also to migrations, changing health risks, which impact particularly powerfully on primary healthcare. Development of patient-related-experience-measures and patient-related-outcome-measures through patients specific surveys including also aspects of issues such as safety and responsiveness may be useful. Patients' experience in Europe is not widely used to improve healthcare services. The Commission co-funded OECD Patient-Reported Indicators Survey (PaRIS) will be filling this major knowledge gap within the next few years. Looking outside Europe, Canada provides an example of how patients can be involved. In the framework of the QUALICOPC research, Canadian patients provide valuable information on their experience with various dimensions of primary care, such as waiting times, appraisal of their communication with physicians, but also on which aspects of primary care are important to them. The result shows that patients in Canada point that the most valued aspects of primary care are: continuity and coordination, communication and patient-centred care, patient activation and access.

- **Adaptability**: primary care is not a static concept, evolving over time to adapt to demographical and epidemiological trends, technology, encompassing an ever growing set of interventions. The risk of losing focus due to constant change is therefore higher for primary care than for other health segments. This is calling more than ever for performance assessment in primary care to become a tool to support adaptation to change. It is noteworthy that performance assessments for primary care, due to their particular exposure to change, are not set in stone and should be living tools and constantly adapt to the context of each country, region, commune.
• **Building a culture of excellence:** to make it work all the stakeholders in primary care must understand the vision and objectives of the performance assessment and to adhere to it. They also need to know their roles, responsibilities and actions expected from them, ensuring that performance is a driving force behind their daily work. Staff policies are crucial to support the culture of excellence. The Commission will continue to encourage EU level activities in health workforce planning and forecasting, so as to support Member States in addressing critical health workforce problems such as supply, distribution and a traditionally oriented skill mix. Health workforce planning and forecasting can help countries to put the right number of health professionals in the right place at the right time. Embedding the performance assessment in primary care is an opportunity to strengthen the team work of various actors and make this team work a rewarding experience, because it will reduce administrative burden, duplicated tasks, will create conditions to focus the energy on result-oriented tasks and it will enlarge the spectrum of good practices, inspire mutual learning, naming just few benefits of teaming up. Performance assessment should therefore drive the team work in primary care and activities which are less constrained by organisational boundaries, but more oriented towards creating value for patients.

• **Support goal-oriented approach through better use of professional and contextual evidence:** Professional evidence is not systematised, while its role in achieving the good results in primary care is crucial, because primary care usually deals with patients of varying age, from diverse ethnic and socioeconomic groups, presenting early-stage diseases or undefined illnesses or with varying levels of multimorbidity. Primary care needs also to rely strongly on contextual information to bridge the gap between efficacy (isolated case) and effectiveness (routine practice). This is a case where for example functional status and living conditions become an important frame of reference in the patients’ goal-setting process, and when professionals are confronted with increasing social inequities. Performance assessments should reflect needs of very varied groups of patients to make primary care a more impactful segment of healthcare.

The Expert Panel who feeds in this report sees a need for a stronger push from the European level to advance things. Fortunately, investments in primary care are ranked as important areas for investment by most EU Member States and the need to improve the performance of primary care systems is perceived as an important challenge by a majority of them. This creates a momentum for further efforts to contain potential distortions, such as inefficient use of resources and the predominant role of secondary care and, in general, of curative care over more cost-effective solutions such as primary care.8 This report will hopefully be an important building stone and will assist key actors in leading transformation of the primary care and moving it to a higher level of excellence, keeping the right focus and ability to react to change. It will hopefully help to reduce waste driven by sometimes outdated models and, last but not least, improve health.

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References
Chapter 3


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Annex: Members’ lists

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Annex: replies to the questionnaire on national experience on performance assessment of primary care available only on the website:
The EU Expert Group on health systems performance assessment conducted in March 2017 a survey, for collecting information on national experiences in performance assessment of primary care. Twenty-one countries replied to the survey; this annex presents the full replies. In appendix, it presents the blank questionnaire, as it was originally circulated.
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