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Regional Office for Europe

MEASURING HOSPITAL PERFORMANCE TO IMPROVE THE QUALITY OF CARE IN EUROPE: A NEED FOR CLARIFYING THE CONCEPTS AND DEFINING THE MAIN DIMENSIONS

Report on a WHO Workshop
Barcelona, Spain, 10-11 January 2003

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ABSTRACT

The World Health Report 2000 stressed that the organization, configuration and delivery of services impact on the performance of the overall health system performance. The current restructuring of health care services among European countries – both Western and Eastern countries – highlights the importance of efficient hospital organization throughout Europe. The development of new common policy orientations, focusing on the demand for accountability and quality improvement strategies, and a growing interest in patient satisfaction assessment, are incentives for developing hospital performance assessment.

A workshop organized in Barcelona by the WHO European Office for Integrated Health Care Services the 10-11 January 2003 discussed conceptual issues, definitions and concepts of hospital performance measurement and practical issues as the principles for designing and developing benchmarking networks dedicated to measure hospital performance and promote the improvement of quality of care.

The following conclusions were reached: need to have generic definitions adapted to the context of this project; definitions of key dimensions of hospital performance promoting a comprehensive model of hospital performance measurement; and recommendations regarding the design of a benchmarking network allowing participants to compare their own performance to peer hospitals through relevant performance indicators.

The group of experts agreed on six key dimensions for assessing hospital performance:

- Clinical effectiveness
- Safety
- Patient centredness
- Production efficiency
- Staff orientation
- Responsive governance

The original papers of the workshop will be available on the website of the WHO European Office for Integrated Health Care Services (***http://www.euro.who.int/ihb***).

Keywords

HOSPITALS – standards
QUALITY INDICATORS, HEALTH CARE – standards
QUALITY OF HEALTH CARE
DELIVERY OF HEALTH CARE
HEALTH POLICY – trends
EUROPE

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Introduction

As discussed in the World Health Report 2000, the organization, configuration and delivery of services impact on the performance of the overall health system (*1*). This report introduced the concept of stewardship, stating that governments "should ensure that their country's health care system provides the optimal health services for its population" (*2*). To achieve this, emphasis should be put on the development of systems monitoring and regulating the performance of health care providers, especially hospital performance, as such systems are still poorly developed throughout Europe (*3*).

In that perspective, hospitals deserve special attention:

> Hospitals are an important part of any health system: they provide complex curative care that, depending on their capacity, acts as a first referral, secondary or last referral level curative care facility; they also provide emergency care for the severely injured or the critically ill; they are centres for the transfer of knowledge and skills; they constitute an essential source of information and power; and they generally spend the major part of national health resources (*4*).

Hospitals account for the largest share of overall health expenditure, generally between 50% and 70 % of health care expenditure throughout Europe. Common trends during the ten last years in Europe include a major reduction in the number of beds (even though hospital admissions are not decreasing) and shorter lengths of stay.

During this period, the volume of ambulatory care rose (*5*). Hospitals had to continue to adapt themselves to changes in their internal and external environments in the general context of restructuring systems (*6*).

The development of new policy orientations, such as the demand for accountability and quality improvement strategies, or a growing interest in patient satisfaction assessment, are also incentives for developing attention to hospital performance assessment. The concept of performance brings together the concepts of quality, efficiency and effectiveness of health care services.

Performance indicators can be used for internal and/or external reasons. Internal reasons are related to the various management functions of the hospital as a health services delivery organization and the indicators are used as management information to **monitor, evaluate or improve** the functions in the long term (strategy) or short term. External reasons are related to **accountability** questions asked by other stakeholders such as the financier (either insurer or State), patients/consumers and the public at large.

> Many nations have now integrated hospital accreditation programmes into their health care systems. The basic concept of hospital accreditation among nations is similar but in fact is maturing and changing in those countries where the programmes have long been in place. Hospital accreditation has always been about structure, process, and outcome but has focused mostly on the structure and process aspects. It is now the case in the United States, Australia, Canada, Europe and some other countries where the emphasis is increasingly on outcomes. It needs to be recalled, however, that the identification of a bad outcome is an indicator that there is a problem in the process or the structure. For example, in the measurement of post-operative infection, there is absolutely no meaning other than that some aspect of the process or structure lies at the root of the cause.

In order to develop hospital accreditation, health services need to develop close links with allies like health services research, legislators and the media. No least the latter because of the need to transfer complicated scientifically based information to decision makers and to the public (*7*).

Hospital Performance Project

The strategic orientations of WHO promote a comprehensive approach to measure hospital performance and encompass different dimensions of performance such as responsiveness, evidence based best practices and organization, continuity and integration of health care services and health promotion, focusing on patients' needs.

The aim of this project is to identify, based on best practices, a framework, key dimensions to measure hospital performance and a set of valid and reliable indicators related to these dimensions, on which they could assess voluntarily.

The aim is not to produce normative indicators, but to enhance the value of comparison to peer hospitals in order to promote the performance of services delivered to the patients in a voluntary process.

Within this context a working group was set up in November 2002, gathering together European and North American experts. The mandate of this working group was to build and validate a flexible and comprehensive model of hospital performance assessment, allowing the implementation of benchmarking networks on hospital performance at the national or international level. Voluntary quality improvement is the overarching purpose of these networks.

In the first meeting of the working group several issues were discussed:

a) conceptual issues as definitions of hospital performance assessment;

b) key dimensions and sub-dimensions of hospital performance; and

c) different models of hospital performance. The expected outcome of the workshop was to agree on a comprehensive and flexible frame for measuring and assessing hospital performance.

Background

Models of hospital performance assessment

Different models of hospital performance assessment were presented during the meeting and discussed.

The Canadian experience

The balanced scorecard model (Ontario Hospitals Association, OHA) integrates customer, financial, internal business process, learning and growth – but these four dimensions remain separate, not integrated.

The Ontario Hospitals Association has developed a workable framework, which:

- is provider driven
- has voluntary participation
- is risk adjusted for fair comparisons
- uses publicly available methodology
- protects medical data and patient confidentiality
- ensures that indicator selection is scientifically valid
- has a range of report levels e.g. public, private, research and internal (*8*).

Researchers from the University of Montreal developed a second model (*9*). Based on Parson's social system theory, each organisation has to:

1. adapt to environment: respond to social values, resource acquisition, community support, innovation and learning, market presence etc;
2. attain goals: stakeholder satisfaction, effectiveness, efficiency;
3. produce services: productivity, service volume, quality, coordination; and
4. maintain culture and values: consensus, organizational climate, workplace health.

This model addresses the lack of integration between the dimensions of the different models by including the perspective of alignment between the different perspectives. The different kinds of alignment are strategic, resource allocation, tactical, contextual, operational, and legitimization. The good performance of the model will be the result of the capacity of the organization to maintain the alignment between the different dimensions of performance. It is compatible with the European Foundation for Quality Management (EFQM) framework.

The Danish model focuses on the patients´ pathway with three different perspectives:

- a clinical perspective: admission, assessment, investigation, evaluation, discharge, follow-up;
- the patient's perspective: information/communication, coordination, continuity, patients´ rights, patient safety; and
- an organizational perspective: e.g. public information, leadership, human resources, research, education, risk management.

The model developed by French researchers is a simplified version of the model developed by the University of Montreal. This model incorporates three main dimensions (without alignments): achievement of goals (clinical and epidemiological quality), optimum use of resources and ability to adapt to change and innovate. The French experience is not aiming for a single model, merely for a framework to ensure that legitimate dimensions are included and available to participating hospitals.

The experience of the "Quality Indicator Project" (QIP, Maryland, USA)

This multinational project, originated in Maryland 18 years ago, gathers now about 2000 participants from all continents. The driving force of the implementation of the QIP was accountability: the project was dedicated to produce indicators for hospital boards (*10*). The "Quality Indicator Project" is not based on any specific model, but on epidemiology of performance (not current thinking on health service structure) and the assumption that all measurement is comparative. The project began with acute care but moved to ambulatory, long term, mental health etc. It also now extends to patient safety, including error rates, to provide epidemiology of risk management.

The project is voluntary and confidential; it does not make definitions or rates public and no judgments are made of participating organizations. Individual reports are produced four times a year for all participants. Taking into consideration that all interpretation (or evaluation) is local, local coordinators are designated in the different hospitals participating in the QIP. Peer hospitals are stratified according to 40 characteristics.

Different dimensions of hospital performance measurement

Different dimensions of hospital performance and their classification were discussed. The model used by the Ontario Hospitals Association (balanced scorecard framework) includes 4 main dimensions: financial, patient perspective, clinical utilization, system integration and change. The model developed by the researchers of the University of Montreal encompasses goal attainment, production, adaptation and culture and values (*9*).

The United Kingdom performance assessment framework developed by the Department of Health to measure each hospital trust in England sets out measures in six main areas: improvement in people's health; fair access to services; the delivery of effective care; efficiency; the experiences of patients and their carers; and health outcomes (*2*).

The dimensions of equity and accessibility could be logically included in the dimensions of hospital performance, but it is debatable whether these dimensions are more related to the overall performance of the health care system than to the performance of individual hospitals.

The dimension of patient safety should also be stressed, considering the current interests of WHO.

A first summary of the different dimensions discussed by the experts, oriented to WHO goals, included effectiveness (including prevention and health promotion), patient centeredness, safety, innovation, community responsiveness (both needs and demands) and integration in the overall delivery system.

Conclusions

Definitions

A preliminary definition of hospital was accepted in the context of this project: "A hospital can be defined as an organized effort to provide a specific set of medical services, usually physically located in one or several buildings, and related to specialized cure (diagnosis and treatment) and care (as opposed to the primary care level) with the input of health professionals, technologies and facilities." This definition will be further discussed and slightly re-defined during the next workshop. Even if a generic definition of hospitals should be used in the context of this programme, the use of local definitions should complement this approach.

A definition of the term 'performance' was also proposed:

> "Performance is the achievement of desired goals. High hospital performance should be based on professional competences in application of present knowledge, available technologies and resources; efficiency in the use of resources; minimal risk to the patient; satisfaction of the patient; health outcomes. Within the health care environment, high hospital performance should further address the responsiveness to community needs and demands, the integration of services in the overall delivery system, and commitment to health promotion. High hospital performance should be assessed in relation to the availability of hospitals' services to all patients irrespective of physical, cultural, social, demographic and economic barriers".

This definition will also be further discussed during the next workshop.

In order to define a relevant strategy to promote the improvement of quality of care through the measurement of hospital performance, it should be admitted that performance is contingent. Indeed, criteria regarding the best or sufficient set of indicators of performance are based on the values and preferences of actors. Consequently, WHO should provide guidance to hospitals through policy orientations that influence the choice of relevant dimensions, sub-dimensions and the selection of reliable indicators.

The difference between performance (value-free) and quality (evaluated, normative) was stressed (*11*). The experts agreed that performance had no value in it: performance measurement is generic while evaluation is more local. Three elements should be included in the design and development of a performance assessment model: functioning, measurement methods, judgment and evaluation of results (or 'observations') of hospitals.

The current definition of the term 'assessment', proposed by ISQUA (2002), was discussed:

> "Assessment is the process by which the characteristics and needs of clients, groups or situations are evaluated or determined so that they can be addressed. The assessment forms the basis of a plan for services or action."(*12*).

A distinction was made between assessment (putting a value on the measurement of performance) and measurement (act of measuring, without putting any value on the 'observation'). The purpose of this project is to help organizations to understand (internally) and improve their practices rather than to provide accountability (externally). Hence, a distinction is made within this project between hospital performance measurement (building a tool to help hospital measuring their performance) and hospital performance assessment (assessment, or evaluation, is made locally).

The key dimensions of hospital performance measurement

The different dimensions proposed by the experts of the workshop were discussed. A consensus was found around six key dimensions. **(Table 1)**

Table 1:Key dimensions of hospital performance as proposed by the group of experts

Dimension	Including
Clinical effectiveness	Technical quality, evidence-based practice and organization, health gain, outcome (individual and population)
Patient centeredness	Responsiveness to patients: client orientation (prompt attention, access to social support, quality basic amenities, choice of provider), patient satisfaction, patient experience (dignity, confidentiality, autonomy, communication)
Production efficiency	Resources, financial (financial systems, continuity, wasted resource), staffing ratios, technology
Safety	Patients and providers, structure, process
Staff	Health, welfare, satisfaction, development (e.g. turnover, vacancy, absence)
Responsive governance	Community orientation (answer to needs and demands), access, continuity, health promotion, equity, adaptation abilities to the evolution of the population's demands (strategy fit)

The exclusion of potential dimensions should not be interpreted as WHO denial of the importance of specific issues such as workforce health, non-technical quality or teaching and learning. The choice was to focus on patient care in acute care hospitals and to stress on dimensions of performance that hospitals can concretely affect.

Organizational culture was considered as a determinant of hospital performance, and not as a dimension. Nevertheless, relevant indicators dealing with organizational culture could be included in the future frame of hospital performance measurement.

The key dimensions were compared to the different theoretical models of performance in organization theory. It led to the conclusion that the key dimensions selected captured most of the aspects of performance. ***(Table 2)***

Table 2: Link between the key dimensions of hospital performance and the different theoretical models of performance according to the sociology of organizations

Dimension	Corresponding theoretical model of performance
Clinical effectiveness	Rationale of professionals
Patient centeredness	Rationale of patient experience and patient satisfaction
Production efficiency	Internal resources model + resources acquisition model
Safety	Fault-driven model
Staff	Human relations model
Responsive governance	Strategic constituencies model + social legitimacy

Expansion of dimensions and sub-dimensions

The sub-dimensions proposed by the experts of the workshop were discussed in smaller groups. The discussion concluded that WHO should provide guidance on policy orientations to permit a better choice of sub-dimensions. The sub-dimensions will be further discussed and validated during the next meeting. Nevertheless, a first draft was proposed in order to analyse the relevance and the feasibility of gathering reliable data for selected sub-dimensions. ***(Table 3)***

Table 3: Analysis of dimensions and sub-dimensions of hospital performance: relevance and feasibility (0 star for not relevant, 3 stars for very relevant; 0 star for not feasible, 3 stars for very feasible)

Dimensions and sub-dimensions	Relevance	Feasibility
Clinical effectiveness		
Re-admission rate x days	***	***
Mortality	***	*
Complication rate	***	
Appropriateness	***	
Length of stay disease specific	***	***
Quality improvement progress	***	**
Evidence based processes	***	(*)
SF 36 etc.	**	
Patient centredness		
Waiting time (elective surgery)	***	*
Equity of access	***	
Patients rights	***	*
Patients perception	***	*
Production Efficiency		
Length of stay disease specific	***	***
Safety		
Hospital-acquired infections	***	
Falls	***	*
Bed sore	***	*
Staff orientation		
Turnover	***	***
Absentee rate	***	***
Responsive governance		

Recommendations

1. Benchmarking networks. The frame developed in this project could be applied in a European benchmarking network on hospital performance assessment according to the following principles:

- the participation in the European network designed and coordinated by WHO EURO would be voluntary;
- the indicator information is primarily to be used for internal management purposes and all data will be kept confidential;
- it is up to the participating hospitals to choose the areas where they want to benchmark each other;
- the indicators are not normative; the priority is to foster the comparison of hospital performance and consequently to improve the quality of care provided; and
- different baskets of indicators (basic / intermediate / advanced) will be proposed in order to allow countries with less developed information systems to use the hospital performance database.

In many countries, hospitals have become weary of indicator projects. It is important to build on existing measures and systems, and to identify and assess standards of data quality.

2. Selected indicators should be based as much as possible on data availability. An assessment on country data availability should be made before selecting validated indicators, especially the common content of minimum data sets for patients discharges from hospital and accuracy.

3. A profile of countries concerned by the pilot testing phase ("environmental assessment phase") should be provided to the participants for the next meeting.

4. Several countries covering different health systems, cultures and levels of development were chosen: Albania, Denmark, France, Georgia, Germany, Lithuania, the Netherlands, Spain and United Kingdom for the piloting phase.

5. Role of coordinators designated for the pilot test. The coordinators designated will have to fulfil the following tasks:

- to select / gather a group of national experts to comment the proposals of the core group of international experts set up by WHO;
- to coordinate and summarize the comments of the national experts;
- to be the focal point for assessing the availability of relevant indicators;
- to participate in a first meeting to design a questionnaire for the pilot-test and select limited but representative number of hospitals to pilot test the model of hospital performance (September 2003);
- to gather, summarize and analyse the outcomes of the pilot-test at national level. Organize a meeting with representatives from the hospitals involved to discuss the final outcomes of the pilot test (April 2004); and

- To participate in a second meeting of the project:
    a) to discuss the outcomes of the pilot test at national level with the other pilot countries;
    b) to discuss the possibilities and relevance of international comparisons;
    c) to establish recommendations on the key issues and the way forward for the core group of experts.

6. The next workshop will examine the values and policy orientations WHO wants to promote through the selection of the sub-dimensions, will discuss the sub-dimensions of hospital performance, define the terms in use in the context of this project, and consider the method to use for a global review of validated indicators and at least will specify the purpose of the pilot testing phase. It will take place in Barcelona, 21-22 March 2003.

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Annex 1: Scope and purpose

The WHO European Office in Barcelona is organizing a meeting on Hospital Performance from 10-11 January 2003.

The purpose of this first workshop is to discuss different models for hospital performance assessment. The workshop is part of a new WHO initiative to develop a Hospital Quality Improvement Strategy to support Member States in the implementation of Hospital performance assessment strategies and use of key indicators. The project has three main objectives:

1- Collect evidence on the use of hospital performance assessment models to support countries in their implementation.

2- Produce benchmarking tools to allow hospitals from different European countries to compare themselves to peer groups.

3- Build an experts' network on hospital performance assessment to support country implementation and analyze outcomes.

The work will be done in three stages: definition and analysis of different models currently used in Europe, USA and Canada; piloting of the agreed models, validated by groups of experts in 6 different countries; and, development of guidelines to facilitate country implementation.

Participants in the first workshop are experts with experience in performance and quality assessment in the hospital field. It is envisaged that after this first meeting, three working groups will be set up in order to further develop the workshop recommendations. It is expected that the participants will also contribute to one of the three working groups.

The workshop will address the following tasks:

- Definition of model(s) of hospital performance assessment in Europe.
- Glossary of terms used in the model(s) proposed
- Identification of hospital functions in the performance model(s) proposed
- Analysis of advantages and disadvantages of the different models.
- Definition of key criteria to assess hospital performance and selection of indicators (structural, process, outcome).
- Methodological proposals related to the metrology of indicators.
- Classification of acute care hospitals in order to assess hospital performance.

The expected outcomes of the workshop are: (1) to agree on comprehensive and flexible models of hospital performance;. (2) to provide the basis for the development of a framework to describe the different practices in the field of hospital performance and accreditation in Europe.

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Annex 2: Programme

Friday, 10 January 2003

09.00 – 09.15	**Opening and introduction of participants** **Mila Garcia-Barbero, Head of the Office**
09.15 – 09.30	Background and outline of the "Hospital Performance Assessment in Europe" project Jeremy Veillard
09.30 – 10.00	*Discussion* *Chair: Mila Garcia-Barbero, Head of the Office* 1 - Defining the terms used in the field of hospital performance assessment
10.00 – 10.15	Definitions of the terms in use: Summary of the background papers and proposals *Jeremy Veillard*
10.15 – 10.45	Discussion *Chair: Charles Shaw*
10.45 – 11.15	COFFEE BREAK
	2 - Classifying and defining the different dimensions of hospital performance assessment
11.45 – 12.10	The different dimensions of Hospital Performance Assessment: Classification proposals *Johann Kjaergaard and Svend Jorgensen*
12.10 – 13.00	Discussion *Chair: Niek Klazinga, Netherlands*
13.00 – 14.30	Lunch break
	3 - Defining the key dimensions of hospital performance assessment
14.30 – 15.30	Working groups Identification and discussion of the key dimensions of hospital performance assessment
15.30 – 16.00	COFFEE BREAK
16.00 – 16.30	Presentations: conclusions of the working groups
16.30 – 17.00	Discussion *Chair: Vahé Kazandjian*
17.00	Wrap-up (*Svend Jorgensen*) and conclusions from day one (*Jeremy Veillard*)
17.30	**Closure**
20.30	DINNER

SATURDAY, 12 JANUARY 2002

	4 - Discussing different models of hospital performance assessment (interactions between the different dimensions)
09.00 – 09.10	**Johann Kjaergaard, Denmark: a Danish model**
09.10 – 09.20	***Discussion***
09.20 – 09.40	*François Champagne, Canada: Two experiences from Canada*
09.40 – 09.50	Discussion
09.50 – 10.00	*P. Lombrail, France: project of the French Ministry of Health*

10.00 – 10.10	Discussion
10.10 – 10.20	*Vahé Kazandjian, USA: the experience of the IQIP and the model in use*
10.20 – 10.30	Discussion
10.30 – 11.00	COFFEE BREAK
11.00 – 12.00	Working groups*:* Identification and discussion of the advantages and drawbacks of the different models
12.00 – 12.30	Presentations: conclusions of the working groups
12.30 – 13.30	Discussion *Chair: Henner Schellschmidt* ***Validation of the proposal of model(s) of hospital performance assessment***
13.30 – 14.00	***Conclusions*** Wrap up: Itziar Larizgoitia Jauregui Ongoing work: Jeremy Veillard *Closure*
14.00	LUNCH

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