Comparative and International Benchmarking in Healthcare

Key Themes

- There is increasing activity in the production of national comparative health data sets and increasing interest by those who make use of health data such as policy makers, managers, clinicians, purchasers and consumers.

- There are some gaps in current comparative data sets, most notably in relation to quality and outcome measures, where health status data is sometimes used as a substitute for health outcome data. However, there are efforts to develop outcome data that is more influenced by aspects of the health care system.

- One of the most important considerations in relation to the topic of benchmarking health systems is how the data will be used. Performance data may be used, for example, to inform policy makers at the national level, to assist local managers in understanding variation in performance, and by patients wishing to make informed choices about health care options.

Findings

The three papers that were presented took three approaches to international benchmarking; first, a mapping of the widespread ‘industry’ that now represents international health benchmarking and its interpretation, second, developments in the academic study of health indicators, and third, an update of the significant international programme on assessing the performance of health systems by the World Health Organisation (WHO).

Dr Graham Lister analysed the type of questions that are asked by consumers of international health performance data. International rankings are often undertaken in order to establish ‘the best’ system. Dr Lister outlined how varied are the criteria by which national health systems are judged, from attainment of social goals to how different health systems contribute to patient’s perceptions of the services they receive. If judgements are made about overall system performance it is necessary to combine a range of simple to understand indicators with an understanding of the different character of each system. In this way international benchmark data may be useful tools for policy makers. If they are to be used to make overall comparisons of health systems it is important to spell out the criteria against which systems are to be compared and to use measures and judgements which reflect these criteria.
The WHO assessment has been important in raising awareness of international benchmarking, and specifically in the performance of health systems. Whilst the WHO framework is complex and includes measures of development including education in a country, the users of the framework have concluded that the WHO considers France to have the ‘best’ healthcare system. This indicates some of the issues to be considered when judgements are made about systems on the basis of available measures. There is work to be done in attempting to measure those factors, which are indicated by our understanding of what constitutes a good system, for example, measuring patient responsiveness or primary care focus. Another avenue for inquiry in international benchmarking lies in following up some of the obvious differences between countries and systems such as why the Japanese health system appears so effective despite, or because of, long lengths of hospital stay and high pharmaceutical costs. Benchmarking at the level of health system elements is well established; as examples, accession countries to the European Union are encouraged to study how public health systems work, how patient organisations are fostered and how primary care is organised in different EU member states. These provide useful insights which can be followed up in exchange tours and twinning relationships. It is not yet clear that it will be possible or useful to attempt overall system comparisons but if it is to be done then it should be as a service to policy makers, benchmarking as an analytical tool rather than measurement for its own sake.

The contribution of the organisation of health care to producing health outcomes was the subject of the paper by Professor Peter Smith (drawing on work by Hauck, Rice and Smith at the University of York). Smith’s work illustrates the important contribution of academic study of benchmarks and indicators in health. Economists dominate the field of comparative health data and it is increasingly informing health policy makers and practice. Professor Smith presented new work which focuses on the analysis of data at the small area level (English health authority level) to try and understand variations in health outcomes and assess how much can be explained by aspects of the health care system. The study relates to England, but the approach could be more widely applied.

Performance was judged on the basis of fourteen indicators taken from the Department of Health’s Performance Assessment Framework. They included health outcome measures (mortality rates and long standing illness), clinical quality measures (emergency admissions and deaths following hospital surgery), access to health care (waiting times, accessibility to general practitioners, number of elective surgery episodes), and efficiency (day case rate, length of stay, maternity and psychiatry costs).

The study found that there were some differences in patient outcomes that were driven by aspects of the health care system and that these were observable in comparisons at health authority level. Whilst measures such as mortality were not found to be affected at the health authority level, measures that were included
waiting times for elective surgery, day case rate, waiting time for radiotherapy and number of elective surgical episodes. The results showed outcomes that might be intuitive; variation at health authority level has an effect on activities carried out by the organisation such as surgery. The policy conclusions to be drawn from the study are that those measures such as mortality that were not found to be significantly affected by aspects of the health system should not be used to assess the performance of the broader health system.

The work by economists at the disaggregated level suggests focusing on the individual or unit level can provide greater understanding of comparative performance. To be able to attribute variation in performance to the health system, and then isolate the features of the health system that explains the variation would provide meaningful data and should therefore be a goal for research into health benchmarks.

Mrs Kei Kawabata from the WHO Global Programme on Evidence for Health Policy presented a comprehensive update on the assessment of national health systems performance that is being carried out by the organisation. A worldwide comparison of health system performance was published by WHO in 2000 and it drew significant international attention to comparative performance in relation to health policy. National policy makers, the media and a wide range of actors in health performance discussed and debated the international ranking of health systems. As part of ongoing work being undertaken in improving and updating the comparative effort a peer review report of the WHO Health Systems Performance Framework is currently available on the WHO website.

WHO work is evolving both in terms of developing new measures and refining existing ones, as well as improving data collection. The health of the poor, responsiveness and stewardship are areas that are currently being developed as part of the ongoing work. WHO work presents aggregate comparative performance data based on a complex methodological framework, although it was pointed out that aggregate measures can be broken down to provide interesting data on individual countries. In considering the framework on which national health systems may be compared the WHO framework uses the goals of health systems, namely, responsiveness (meeting expectations) and fairness (of financial contribution) as a measure against which performance can be judged. It was reported that work to refine these measures is currently being undertaken with reference to a shift towards assessing the functions rather than the goals of health systems.

Areas for Discussion

Following presentation of the papers, Jeremy Hurst, Head of Health Policy at OECD, one of the principal publishers of comparative international health data,
led a wide-ranging discussion on benchmarking in health. Particular areas for agreement and disagreement included the following.

The key question remains how to use the data that is produced on health performance. Going back to the origins of benchmarking in other industries than healthcare, a continuous process was described, which includes measurement and analysis informing action or management in the system. Thus, the production of data can play an important part in reviewing and analysing what activities are carried out within a system and to what effect, in order to make improvements.

It was also acknowledged that performance data can be used to prompt action by policy makers. Health outcome data can be used to trigger investment in particular areas from national policy makers. The example of cancer survival rates that showed British performance falling below its European counterparts was argued to have prompted greater investment by the UK government in the past and the current British government is using the European average of health care spend to benchmark future UK health spending. Researchers have a responsibility therefore to publish independent objective data and play an instrumental role in guiding appropriate policies or actions by government.

There is much work to be done in tackling the broad questions relating to comparative health performance and researchers can play a key part in how to inform action using health data and how to assess the results. There is no doubt that the use of health performance data will grow in the future. Many systems now link performance with reward. The English health system is now rewarding high performing health care providers with more funding and greater autonomy from central control. Researchers can play a part in developing our knowledge of the uses and limitations of the various measures constructed. As an example, one of the significant constraints remains that of disentangling environmental influences on performance from factors that can be attributed to aspects of the health system itself and it is to this effort that Smith et al’s work is directed.

The issue of comparative health benchmarking is multi-layered and encompasses aspects such as the performance of local health organisations with the continuing discussion of what measures to use, and to what end, regarding international comparisons of national health policies. It is doubtful that there currently exists an agreed set of outcome measures at the national level that can be used to judge performance. There was some disagreement as to whether this could be done in the future, or indeed, if it were useful. It was proposed that a short list of outcome measures would not be helpful for policy makers because it does not attempt to answer the preceding question regarding the impact of institutional arrangements. Policy makers need to focus on the specific factors upon which their policies will have an impact otherwise they will not be successful. The choice of what particular instrument or measure to use to assess performance was agreed to require substantial judgement regarding its interpretation and researchers have a role to play in influencing the benchmarking agenda.
Some of the developments in health outcome measures that are currently taking place were reviewed. The OECD is currently developing outcome measures that are more likely to be affected by health systems such as cancer survival rates, survival rates following a major incidence such as heart attack, process measures such as screening and immunisation, and some avoidable mortality measures. We were also informed about new work that is being undertaken on technology diffusion that is producing some interesting variation between countries.

Finally, the development of a European health care market was identified as an important economic driver in the production of comparative health data where the production of comparative unit prices, in particular, was discussed. There will be policy implications for countries where new measures such as the relative costs of individual treatments, procedures or services in each country expose the variation in the costs of health services to even greater scrutiny.

**Conclusion**

In conclusion, participants took the opportunity to reflect on the many issues raised by the increasing interest in health data and international benchmarking of health systems. There are both policy imperatives and economic drivers to the production and use of comparative health data, both at the national and local level; from policy makers seeking to demonstrate the impact their policies are making to the electorate and for managers, analysts, companies and consumers wanting to find out the relative performance of health services in the developing European and global health care market. Researchers have a key role to play in developing health data measures, in establishing analytical frameworks for measures, in commenting on the use of measures and in guiding policy that might result from publication of data. Above all, it is important that the various measures are used as analytical tools, with the same benefits and constraints as any analytical tool. The important policy and practice implications lie in their interpretation and here researchers have a role to play in influencing the constructive development of health policy measures and their use.

**Papers:**

Lister, G. ‘Comparing Health Systems’
Hauck, K., Rice, N., Smith, P. C. ‘Future Possibilities for International Performance Comparison’
Kawabata, K. ‘WHO System Performance’