Health services research at work for national health policy

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Chapter 12

Health services research at work in Case III
The last case in this thesis concerned the development of an instrument for national health system performance measurement. We provided research assistance to the Dutch Ministry of Health (MoH) for developing a framework of performance indicators. The health services research group consisted of public health specialists, medical doctors, health scientists, epidemiologists and a political scientist. This research work was commissioned directly by the department at the Ministry of Health responsible for developing the instrument. A working group at the MoH regularly provided feedback on our work.

The initial content question (developing a performance indicator framework) is addressed in Chapter 10 [1]. Based on Lalonde’s model for determinants of health [2] and on Kaplan and Norton’s Balanced Scorecard [3], our proposal links the public health perspective with the management of health care perspective to measure the performance of the entire health system. We also described the interactive development process and some of the stakeholders in this process.

In addition to the question answered in Chapter 10, we developed a combination of four content-, context- and process-focused research questions: 1) What are the organizational and policy context and processes that influence, and potentially interact with, the development of the performance indicator framework? (presented in Chapter 11 [4]), 2) To what extent are decisions about reimbursement by the Dutch Sickness Fund based on cost-effectiveness information? [5], 3) What are useful and feasible performance indicators for mental health? [6] and 4) How can patient experiences with health care be measured as an indicator of the health care system’s responsiveness? [7]. The results of additional questions 2, 3 and 4 are not presented in this thesis. In Chapter 11, we identified several political and policy processes that influenced the development progress of the performance indicator framework [4]. While some processes contributed to its growth, others obstructed this.

Inclusion of additional research questions

As described in Chapters 10 and 11, the development of the performance indicator framework was a very interactive process involving frequent interactions with the policymakers at the Ministry of Health over a three-year period. This created the opportunity to observe the actual policymaking process at close proximity. Therefore, to address the context and process addressed in Chapters 10 and 11, no additional resources or data were used other than those already available to us. During the development process we felt that for certain potential indicators, an extra boost in terms of additional studies might help the MoH develop these indicators. As a result, we formulated three additional research questions. One regarded the efficiency of allocation of resources, a second addressed measuring the performance of mental health care and a third question studied how patient experiences could be measured. The first two studies were carried out by graduate students who were supported by our team as well as their own academic environment [5] [6]. Both research papers were brought to the attention of the relevant stakeholders at the ministry. The study of the measurement of patient experiences was formulated in a proposal by the Netherlands Institute for Health Services Research (NIVEL) and was separately commissioned by the MoH.
Interactions with policymakers and other actors

Because we took a highly interactive and collaborative approach to developing the framework, we were able to closely observe those policy dynamics at the ministry that influenced the progress of the framework. We became regular visitors to the ministry as guest members of the project group that dealt with all policies concerning information and information management within the Ministry of Health. This working group was called Beter Weten (in English, ‘Knowing Better’, and was later called Beter Werken or ‘Working Better’, when there was a push to put the discussions into practice) [8]. Good cooperation with the MoH at different levels allowed for assessing the larger context and processes we perceived to be relevant to the development of the framework. Also, our primary liaison at the MoH for developing the framework participated in our research meetings at the University of Amsterdam. The fact that the liaison was preparing a PhD thesis on policy aspects of the steering and control mechanisms of the government regarding hospitals [9] benefited our cooperation. Specific working groups were formed when the individual indicators in each of the four perspectives of the balanced scorecard had to be defined by MoH staff (see Chapter 10). We participated in these working groups to support the development of the framework. In the ‘financial perspective’ working group we presented the additional study on allocative efficiency. Both the studies on indicators for mental health and measurement of patient experiences were presented in the ‘consumer perspective’ working group.

Follow-up of events and developments

Since January 2005 (the time locus of the last chapter in this case), several developments have taken place regarding the performance indicator framework. Firstly, at national level, the framework has officially been chosen as the basis for a new document, the Zorgbalans 2006 (in English, the ‘2006 Balance of Health Care’) [10]. This Zorgbalans will be the MoH’s accountability document to the Dutch parliament and will provide a comprehensive picture of the performance of the entire Dutch health system [11]. Since then, the National Institute for Public Health and the Environment (RIVM) has proposed a format for presenting the performance indicators that is different from the suggestions we have presented in this thesis. The initial combination of Lalonde’s model and the Balanced Scorecard has been adapted into a set of 26 indicator areas grouped into three perspectives in concordance with three public goals of the Dutch health care system: ‘quality’, ‘accessibility’ and ‘affordability’, and does not include the Lalonde model for determinants of health in one framework [12]. The first Zorgbalans was presented by the minister of health in May 2006 and a website is now available, providing all of the information about the 26 indicator areas and the underlying 125 indicators [13].

Secondly, also at national level, the development of the indicator for consumer and patient satisfaction that followed after NIVEL’s study of the measurement of patient experiences [7] evolved in an impressive spin-off: the translation and adaptation of the United States’ Consumer Assessment of Health Plan Surveys® (CAHPS) [14] into the Dutch context. Combining these questionnaires with existing Quote questionnaires [15] in the Netherlands now
seems to have become the standard by which government, insurers, providers and patient organizations want to measure experiences with health care on a large scale [16;17].

Thirdly, at international level our work regarding the framework evolved as well. We had studied the conceptual basis of indicator frameworks that existed elsewhere as a first and necessary step in developing the performance indicator framework for the Netherlands [17]. Arah and colleagues [18;19] have continued to work on this topic encouraged by the Dutch participation in the Organisation for Economic Co-operation and Development’s (OECD) Health Care Quality Indicators project [20]. This has resulted in the OECD’s adoption of the framework developed for the Zorgbalans as the basis for its own performance indicator framework [21].

In conclusion, our work has directly contributed to the development of performance measurement of the entire health system in the Netherlands. The conceptual framework that we jointly developed with the MoH was used by the RIVM to develop the first Zorgbalans, which was sent to parliament by the minister of health in May 2006 [13]. At international level, this work has contributed to the development of the conceptual framework for the OECD Health Care Indicators Project. Less clear is the way the additional work on resource allocation and mental health indicators has influenced the policymaking process. Overall, we showed that the final product was developed within, despite and because of a dynamic political policy context and process.

Reference List


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