Health Quality Assessment
(Association Incorporated under Section 21)

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HQA Industry Results Presentation

Indaba and Panel Discussion
17 September 2013
13h30-15h30

Panel: Dr J Van Zyl, Dr B Ruff, Dr R Patel, Dr J Miot, A Lowe.
Facilitated by Prof Bruce Sparks

The Indaba started with a fascinating video presentation by Prof Hans Rosling on Global Health over 200 years (using GapMinder) which set the scene for the panel discussion around measuring health. The issues raised at the Indaba should be considered alongside the feedback given by the attendees in the remote voting system.
A number of themes ran through the questions and discussion. These included;

1. ***Technical matters***
   - How do we know that the data is reliable and it's not a case of "Rubbish in Rubbish out"? A great deal of work has been done over the past few years to improve on the quality of the data. This has been significantly enhanced by the move to capturing and analysing line by line claims data. Quality of data is dependent on selection of indicators and classification of reliability of data. That is why HQA classifies its data according to 4 levels; level 1, 2, 3a and 3b depending on the underlying coding, with level 1 being of highest reliability.
   - How is it that the Average can be higher than the 75% percentile? The percentiles are based on 14 schemes equally weighted whereas the Industry Average is based on weighted averages of each scheme. That is why Industry benchmark can be higher than 75% percentile (e.g cervical cytology) – ie some of the big schemes have a higher average which is pushing the Industry average up
   - Can we consider other models of measuring in addition to the Donebedian model? How innovative can HQA be in looking at process and structure? It is possible to look at other models and innovative ways of measuring that are appropriate and relevant, however the foundation of measuring would remain as per the Donebedian model.
   - Risk adjustment – why do this? In order to compare apples with apples. Allows adjustment for differences between schemes that is due to patient demographics (ie older patients in one scheme). Have to be practical about what factors can risk adjust for

– full risk adjustment takes time and requires proper accurate clinical data. Process scores are not risk adjusted because patient groups are already pre-specified.

2. ***Role of HQA***
    - What is considered "collusion" in the industry? Is sharing information with schemes that are doing well considered collusion? Discussion indicates this is not.
    - Role of HQA is to provide an industry benchmark with an empirical standard and then see how individual schemes move towards this standard and the industry benchmark. A valuable indicator is for schemes to see how they are doing year-on-year in a particular measure and whether they are improving.
    - The industry can achieve changes but they occur slowly over time. The process of change starts with measuring.
    - There are implications for HQA going forward. What questions can HQA ask that will assist schemes in understanding how their benefit design or structural arrangements are influencing health outcomes
    - What is the "message" that HQA wants to impart based on this report? This is the first time we're putting emphasis on trends and can start to see if the trends are in the right direction. Are patients being treated properly according to evidence based medicine indicators? Report clearly shows what the outcomes of this are.
    - If trends are improving over time are we seeing less adverse events/effects of poor healthcare over time? Would like to see more participation in a non-competitive space.
    - The report highlighted how poorly we manage chronic conditions – how do we manage aging population with multiple chronic conditions? Consider "theme-specific" report which focuses just on this.
    - HQA report gives an indication of care provided in the private sector but also mirrors what could be happening in the public sector – information from HQA could be very useful to the DoH and HQA is already in touch with the OSC in this regard

3. ***Standards and Benchmarks***
    - Why does HQA use NCQA benchmarks/standard? The industry is never going to achieve 100% but it does show what is possible and what we should be striving for. There are individual schemes and plans which are capable of achieving high averages – it is important to understand what they are doing to achieve this so that it can be replicated in other areas. There is a CAB Working Group looking at identifying other standards and norms
    - Standards don't consider structure so cannot say we are comparing apples with apples (ie comparing with the USA where levels of acuity are different), however the international benchmarks can give an idea of where we should be striving for.
    - It would be useful to understand what it is that schemes are doing to achieve higher averages. Would it be possible to see a presentation from schemes that are doing well on how they are achieving this. This is something that HQA could look into.

4. ***Indicator Results***
    - Flu vaccine measures are very low (alongside other screening), is this a benefit design problem? Is this because patients don't want to reduce their MSA/day-to-day benefits with what they consider to be non-essentials? Is this the result of poor care by doctors

who are not advising their patients when they do see them or is it due to a lack of information and education? Discussion suggests it is a combination of all of these factors. Once again, however, some schemes are doing relatively better than others and it would be useful to understand what they are doing to achieve this.

- Out-patient indicators are more likely based on benefit design as these are reliant on day to day benefits. Having these indicators, however, is also reflective of PMB access. Should remember that PMB benefits only kick in when savings or day to day benefits are depleted
- In general, out of hospital benefits are poorly funded and need to be improved. HQA report reflects this.
- OH management of chronic illness is very important. Schemes will continue to score badly in this regard until more focus is put into OH management
- This may be a result of bias towards financial return on investment for management programmes rather than clinical return on investments (which may have longer term implications but fewer short term benefits)
- Often quality of care is not related to cost of options – top costing plans don't always provide best care. Middle options often provide better value for money.
- Reimbursement structures and models influence measures we are seeing in HQA. Schemes have to interrogate this further.

5. Healthcare providers

- How do we change Dr and patient behaviour to improve these outcomes? Achieved through measurement. If chose wrong thing to measure – can create wrong behaviour. Very careful selection of indicators is critical.
- Which schemes have nominated service providers and how does this impact behaviour? Often patients see multiple providers which makes it easier to point blame in another direction. Originally HQA wanted to measure difference in performance between network plans and "go-anywhere" plans but there were problems with obtaining data and not much difference was observed in the data received. Recently HQA has started to focus on collecting and analysing network data again, and will be exploring GP networks further.
- Dutch healthcare system is considered best in the world now – not because of hospital system (similar to other many countries) but because they made some decisions 30 years ago – every pt must have a GP, GPs must be available 24/7, rolled out electronic patient records. Need collaborative, multi-disciplinary approach. How can HQA measure this?
- Outcomes measurements – collecting hospital data in the same time period as the process indicators are collected – ie end up with cross-sectional analysis. For proper outcomes measurements should be doing survival analysis over time. Need to be very careful of linking process measures with outcomes.