

For Official Use

DELSA/HEA/HCQ/M(2009)1

Organisation de Coopération et de Développement Économiques
Organisation for Economic Co-operation and Development

07-Jun-2010

English - Or. English

**DIRECTORATE FOR EMPLOYMENT, LABOUR AND SOCIAL AFFAIRS
HEALTH COMMITTEE**

Cancels & replaces the same document of 29 July 2009

Health Care Quality Indicators

SUMMARY RECORD OF THE HEALTH CARE QUALITY INDICATOR EXPERT GROUP MEETING

**Held 4-5 June 2009
OECD Conference Centre, 2 rue André Pascal, 75775 Paris, France**

**Contact: Mr Ian BROWNWOOD, Administrator
Tel: + 33 (0)1 45 24 94 75; e-mail: ian.brownwood@oecd.org**

JT03284989

**Document complet disponible sur OLIS dans son format d'origine
Complete document available on OLIS in its original format**



**DELSA/HEA/HCQ/M(2009)1
For Official Use**

English - Or. English

TABLE OF CONTENTS

ITEM 1: WELCOME AND ADOPTION OF THE DRAFT ANNOTATED AGENDA 3
ITEM 2: ORAL STATEMENT BY COORDINATOR OF THE OECD HCQI PROJECT..... 3
ITEM 3: UPDATE FROM PROJECT PARTNERS..... 4
ITEM 4: OVERVIEW OF 2009 HEALTH AT A GLANCE 4
ITEM 5: OVERVIEW OF PROPOSED CHAPTER ON QUALITY OF CARE..... 5
ITEM 6: INTRODUCTION..... 5
ITEM 7: CARDIOVASCULAR CARE..... 5
ITEM 8: CANCER CARE 6
ITEM 9: PATIENT SAFETY 7
ITEM 10: PRIMARY CARE (CARE FOR CHRONIC CONDITIONS)..... 8
ITEM 11: MENTAL HEALTH CARE..... 9
ITEM 12: INJURY CARE AND INFECTIOUS DISEASES..... 10
ITEM 13: REVIEW OF DAY 1 AND INTRODUCTION TO DAY 2 11
ITEM 14: ANALYTICAL WORK ON CANCER CARE PERFORMANCE 11
ITEM 15: WORK ON RESPONSIVENESS/PATIENT EXPERIENCES..... 12
ITEM 16: ENHANCING NATIONAL INFORMATION INFRASTRUCTUREs FOR MEASURING
QUALITY INDICATORS..... 12
ITEM 17: CONCLUSIONS 13
ANNEX 1. LIST OF PARTICIPANTS..... 15

SUMMARY RECORD HEALTH CARE QUALITY INDICATORS EXPERT GROUP MEETING

ITEM 1: WELCOME AND ADOPTION OF THE DRAFT ANNOTATED AGENDA

1. Niek Klazinga, Coordinator, OECD Health Care Quality Indicators Project, welcomed the participants to the meeting. A list of participants is provided in Annex 1. Presentations given at the meeting, referred to in this summary record, have been circulated to participants and are available on request from the Secretariat.
2. The Secretariat's proposal for Edward Sondik (United States) to chair the meeting was supported by the participants.
3. The draft agenda (DELSA/HEA/HCQ/A(2009)1/REV1) was adopted without comments from the participants.

ITEM 2: ORAL STATEMENT BY COORDINATOR OF THE OECD HCQI PROJECT

4. Niek Klazinga provided an overview of the current status of the Health Care Quality Indicators project, giving particular emphasis to the progress made since the last HCQI Expert Group meeting in October 2008 and the forward agenda for 2009. The Coordinator noted that the advice from the Expert Group regarding information systems improvement priorities was well received by the Health Committee at its meeting in November 2008 and that a proposal for further work by the Secretariat to identify strategies to facilitate enhanced national information infrastructures will be considered during the second day of the meeting.
5. The process undertaken to implement the data collection on the agreed set of established and new (*i.e.* patient safety, mental health and health promotion, prevention and primary care) indicators was outlined and the merits of the regular teleconferences with countries to resolve data issues were identified. It was stressed how the first day of the meeting would be largely taken up with the consideration of the draft text and charts for the proposed quality of care chapter in the 2009 publication of OECD's *Health at a Glance* that had been subsequently prepared by the Secretariat. He noted that the new indicators had already been considered by the various expert subgroups (*i.e.* patient safety, mental health and health promotion, prevention and primary care) during a series of teleconferences and their key comments had been integrated into the materials presented at the meeting.
6. In line with the decision taken at the October 2008 meeting of the HCQI Expert Group to strengthen the analytical focus of the HCQI project, the Coordinator outlined the recent work undertaken to develop a methodological basis for exploring the relationships between organisational and financing factors and cancer outcomes. He indicated that this work would be considered in the second day of the meeting with a view to further work in 2009 should the approach taken to date be endorsed.
7. The key milestones for 2009 were identified, namely: to present the key outcomes of the HCQI project to the Health Committee in early July, to finalise the quality of care chapter for publication in *Health at a Glance* in November and continuation of analytical work on cancer and consideration of strategies for enhancing national health information infrastructures. Scheduled meetings of the various expert subgroups were also noted:
 - Responsiveness/Patient Experiences (Paris) – 25 September 2009
 - Health Promotion, Prevention and Primary Care (Paris) – 22 October 2009
 - Patient Safety (Paris) – 23 October 2009

ITEM 3: UPDATE FROM PROJECT PARTNERS

8. Agnieszka Daval-Cichon, Health and Consumers Directorate General, European Commission, provided a brief presentation outlining the strengthened role of the Commission's Working Group on Patient Safety and Quality of Care and the work on the Council's Recommendation on Patient Safety which is anticipated to be adopted in the near future. It was noted that amidst other issues, the recommendation promotes the development of a set of patient safety indicators at the country level and the Commission is keen to promote harmonisation with the OECD work in this area, where possible. In addition, Ms Daval-Cichon indicated that a reflection paper on EU action on safety and quality is likely to come forth in the second half of 2009.

ITEM 4: OVERVIEW OF 2009 HEALTH AT A GLANCE

9. Gaetan Lafortune, coordinator of OECD's publication *Health at a Glance*, explained the structure and composition of the publication, the new features included this year, such as a brief chapter on access to care and an expanded chapter on health professionals. He stressed the specific requirements in terms of style and target audience, highlighting the wide dissemination approach taken in *Health at a Glance*, aimed to policy makers and the broader audience. The presentation of indicators in the so called "two-pagers" format (one page for text, definitions deviations and findings and another for charts presenting the data) is considered optimal for the aims of the publication and, thus, it imposes certain limits to the amount of information and technicalities that can be included. The need to preserve the current size of the publication with a view to maintaining its "at a glance" nature, was also underlined. He described the production process aligning all chapters, including the chapter on quality of care:

- December-February 2009: Data collection process
- March-April 2009: Data validation/checking
- May-June 2009: Draft chapters prepared
- End June/Early July 2009: Draft publication sent to Health Committee and Health Data/SHA/HCQI Experts, for review and comments
- End of July/August 2009: Comment from countries received and incorporated
- November 2009: Release of *Health at a Glance 2009*

10. Experts requested further information on the plans to drop current sections of *Health at a Glance* in order to leave room for further new sections or enlargement of existing ones such as quality of care. They were informed about the foreseen exclusion of the Demographic and Economic information section (5 two-pagers) and the shifting of the Statistical annex (60 pages) from the publication to OECD.stat, left only for reference. These two sections accounted for a third of the 2007 publication.

11. Experts also expressed their interest in increasing the availability and free dissemination of *Health at a Glance*, beyond the current selling strategy. The Secretariat mentioned potential strategies to increase the free of charge availability of the 2009 publication, notably, the posting of an e-book version retrievable in chapters from the website and the wide distribution of pdf versions among experts and relevant networks. In addition, experts suggested the possibility of making available a pdf including just the chapter on quality of care for uploading to relevant quality websites in their respective countries. The distribution of several hard copies per expert was also mentioned as part of the dissemination strategy.

ITEM 5: OVERVIEW OF PROPOSED CHAPTER ON QUALITY OF CARE

12. Soeren Mattke, consultant to the HCQI project, provided an overview of the structure of the chapter and introduced the innovations with respect to the chapter prepared for the previous *Health a Glance 2007*, such as methodology and definitions improvements and quality of data assurance (see presentation *Item 5. QoC Overview.ppt*).

ITEM 6: INTRODUCTION

13. The Secretariat presented the contents of the two draft introductory pieces, one for effectiveness indicators and the other for patient safety indicators (see presentation *Item 6. Introduction.ppt*).

14. Experts' general view was that the introduction lacked focus and failed to highlight the purpose of these indicators: help improving quality of care by rising flags to get to light issues that otherwise may have gone unnoticed. They advocated an approach centered on the actual indicators presented in the chapter: limitations, appropriate use and interpretation; the Secretariat was advised to use more efficiently the limited space available in stressing data quality issues and drawing political attention to the steps needed in improving health information systems to enable quality of care measurement. Suggestions were also made to include in this section a note on the lack of comparability between the new data and the data presented in 2007 due to the methodology improvements and refining of definitions that have been introduced in 2008/2009 data collection.

15. Regarding the specific introductory part for patient safety, countries expressed their support to its inclusion preceding the patient safety indicators' *two-pagers*.

ITEM 7: CARDIOVASCULAR CARE

16. The Secretariat presented the analysis conducted to inform this draft section including the 3 case fatality rates for AMI, hemorrhagic and ischemic stroke (see presentation *Item 7. Cardiovascular.ppt*). The presentation showed the data quality and coverage for each of the 4 different specifications of each indicator, outlined the comparability issues detected and presented the decisions made regarding data selected for publication. Aspects of the comparability between the new data for these 3 indicators and the data presented in 2007 were also presented (methodology improvements and refining of definitions introduced in 2008/2009 data collection.)

17. Experts advised for the inclusion in each section of a note flagging the lack of comparability of these data to those in the 2007 edition. The implementation of age and sex standardization to the OECD 2005 truncated population was perceived as a step forward in enhancing cross-country comparisons in this edition. However, it was noted that the standardization to internal disease populations - built from countries' disaggregated data - should be the next step, attainable for the next round of data collection. A third suggestion was made to include crude rates alongside standardized rate with the view to make readers aware of how standardized rates are artificial figures built for the purpose of cross-country comparison, and thus, should not be taken literally.

18. Country experts were asked to comment on their own results and provide information helpful in interpreting the indicators findings:

- Swedish experts described how the average time to hospital in their country is about 10-15 minutes for patients suffering AMI and stroke. This fast access might partly explain the low case fatality rates registered

- German experts commented on the relatively high case-fatality rates reported for AMI and suggested two potential factors: the impact of standardization and the efficiency of the emergency transportation system (individuals that would have died before reaching the hospital make it to admission but die shortly after)
- The Canadian expert supported this view that case fatality rates might be penalizing countries with especially efficient emergency transportation systems, as could be the case for Canada.
- The US delegate addressed the possible relation between ALOS and case fatality rates. He made the case of shorter stays decreasing the probability of dying in the hospital. As an example he cited that Nordic countries generally have longer ALOS than the USA. He suggested the interest of looking into this possibility as a factor explaining part of the differences across countries.
- The Korean delegate suggested a possible explanation for the relatively low stroke case fatality rates. Apparently normal practice includes patients' referral from acute hospitals to small sub-acute centres; the rates reported include both types of centres. Rates were much higher when calculated based exclusively on acute hospitals.

19. **Decision:** These indicators were deemed appropriate for publication in *Health at a Glance 2009* with the inclusion of crude rates alongside the standardized ones.

ITEM 8: CANCER CARE

20. The Secretariat presented the analysis made to inform this draft section, including the 3 types of indicators considered: screening rates, survival rates and mortality rates (see presentation *Item 8. Cancer indicators.ppt*). The presentation showed the data quality and coverage for each of the indicators; it also analysed the inappropriate *time-lag* between data available for the 3 types of indicators and how this hampered appropriate joint interpretation; it further outlined the comparability issues detected for screening rates and presented the decisions made regarding data selected for publication. Aspects of the comparability between the new data and the data presented in 2007 were also presented (methodology improvements and refining of definitions introduced in 2008/2009 data collection as compared with 2006/2007).

21. Experts advised to include in each section a note flagging the lack of comparability of these data to those presented in 2007 edition. The discussion addressed potential issues of national representativeness of cancer survival rates; the main topic was whether it was acceptable to consider rates based on just one regional registry as nationally representative (as is the case in the EURO CARE studies). As a result of the discussion German delegates recommended the exclusion of their survival rates, based on just one regional registry.

22. Regarding screening rates, reference was made to the indicative minimum threshold of 75% coverage of the target population set within the European cancer screening guidelines for cervical and breast cancer. This threshold was regarded as an appropriate minimum goal in assessing OECD countries performance in this matter.

23. Country experts were asked to comment on their own results and contribute information helpful in interpreting the indicators findings:

- The French delegate pointed out that they have reported breast cancer screening rates from two different sources; the first one is a national survey, and probably overestimates the number of women screened due to recall bias. However, the second source provided programme data and includes both organized programmes and opportunistic testing performed by gynecologists; thus, this second source was regarded as preferable though the resulting rates are lower

- In Japan the reported data do not include local authorities' activity, which conduct the bulk of screening in the country. Therefore, underestimation is presumed and may explain the reported low rates
- A similar explanation was provided for Hungary, where still most of the activity is opportunistic and therefore not registered
- The Korean delegate focused on explaining the increase in colorectal mortality rates detected in her country; she argued the progressive westernization of diet in the last decade as a factor
- The Swedish delegates apologized for having reported survival rates based on a suboptimal source and committed to deliver the correct ones in one week

24. **Decision:** These indicators were deemed appropriate for publication in *Health at a Glance 2009*

ITEM 9: PATIENT SAFETY

25. Saskia Droesler, consultant to the HCQI project on Patient Safety, presented the findings of data collected on PS indicators. Patrick Romano, also consultant for this part of the HCQI project, outlined the analysis conducted to test comparability across countries and, in particular, the findings from the different forms of standardization tried and the findings obtained from adjusting rates by the mean number of secondary diagnosis in each country's hospital administrative database (see presentation *Item 9. Patient Safety.ppt*).

26. Several countries expressed high level of discomfort with the publication of the patient safety indicators in *Health at a Glance*, the main issue being the feeling that the data reflect more coding and registration practices than actual differences in patient safety. Experts acknowledged the importance and rigour of the developmental work carried on for the last 3 years and the achievements in validating the indicators at the international level, improving countries' ability to report them. The merits of sharing this wealth of knowledge and the propitious political momentum were recognized; however this could not offset the reservations as to whether the data were already reliable enough to compare countries. The publication in *Health at a Glance* was perceived as entailing a high risk of misinterpretation; mislead reading of the data would be unavoidable and, regardless the clarification efforts, it may come through as cross-national comparison of the safety of care rather than comparison of the quality of the data.

27. The Secretariat proposed a compromise to reach a balance between political relevance and data limitations along the following lines:

- Further analysis to be presented at October Patient Safety Subgroup meeting; discussion at the meeting of the draft of the complete technical report on patient safety indicators data collection.
- Full technical report on patient safety indicators to be released in November, at the same time or just preceding the publication of *Health at a Glance*.
- Rewording of the patient safety section in *Health at a Glance* to stress both the right interpretation of the data presented and the recommendations for information systems enhancement yielded by the analysis. Inclusion of a reference to the technical document, available at that time, providing all the technical details that *Health at a Glance's* format would not allow for.

28. Countries supported this proposal, though, after discussion, they agreed on restricting the indicators to be published in *Health at a Glance* to the obstetrics indicators. These two indicators were

judged as not dependent on the number of secondary diagnosis and less sensitive to coding issues than the rest.

29. **Decision:** Only two of these indicators (Obstetric trauma - vaginal delivery with instrument and Obstetric trauma - vaginal delivery without instrument) were considered ready for publication in *Health at a Glance 2009* with some outstanding reservations. The final decision as to their publication was left to the Secretariat once reassessed the possibility of including more technical analysis along with the presentation of the data.

ITEM 10: PRIMARY CARE (CARE FOR CHRONIC CONDITIONS)

30. The Secretariat presented the analysis made to inform this draft section documented in DELSA/HEA/HCQ(2009)1/ANN1 (see presentation *Item 10. Primary Care.ppt*).

31. The discussion focused on the complementary analysis made to advance factors affecting performance across countries. Some delegates expressed their surprise at the lack of impact of the magnitude of the problem (measured as prevalence of the condition) on the reported avoidable admission rates. A point was made as to the better suitability of incidence as a measure of the magnitude of the problem. Some delegates rejected the notion of prevalence/incidence explaining the difference on the basis that, despite the number of cases, they should be managed appropriately outside the hospital and thus, admission rates should be low. The Secretariat noted that the denominator of these rates is general population, rather than disease population and thus, the magnitude of the problem could be relevant in explaining differences.

32. Delegates also discussed some possibilities to reflect the supply elements in the analysis by including, for instance, overall utilization indicators (consultation rates and others) to account for additional resources in the supply side.

33. The discussion then turned to the interpretation of these indicators. Several Nordic countries requested the text to be very explicit about what these indicators evaluate and how limited they are in assessing primary care. They saw the need to highlight the HCQI project's commitment to develop indicators directly assessing primary care. Sweden also expressed some concern about the utility of asthma admission rates in assessing chronic conditions management.

34. Germany and Sweden expressed some reservations about the amputations indicators due to variations in the definition of low extremity amputation. Another observation was made about the fact that the countries not reporting uncontrolled diabetes rates were those with the best developed information systems, such as the Nordic countries, which have considered their own data as poor quality and thus unreportable; that raised some skepticism as to the rates reported by other countries. The Secretariat clarified that the ability to report this rate is linked to the availability of a code for uncontrolled diabetes in the ICD version used by each country and, therefore, not dependent on how sophisticated were the information systems. ICD9 includes this code and several countries using ICD10 have added a specific code in the country version in use; where this had not been the case the rate could not be reported. Coding issues are discarded since the algorithm provided for codes was very clearly specified.

35. Patrick Romano, consultant to the HCQI project and to AHRQ, advanced the possibility of some of the indicators reflecting variation in medical practice rather than access to and quality of ambulatory care. As an example he explained how angina without procedure or hypertension related rates are very low in the US; in his view, the reason behind these figures might be that the likelihood of a patient admitted to a hospital not getting some procedure is very low in US, to the point that a "without procedure"

specification may be rare in regular practice. However chronic heart failure, chronic obstructive pulmonary disease and diabetes admission rates may be more reflective of quality and access.

36. Country experts were asked to comment on their own results and contribute information helpful in explaining the findings for these indicators:

- Norway and Korea corrected their prevalence for hypertension.
- The Korean delegate also corrected the prevalence of diabetes reported and described some data quality problems. She also provided the low prevalence of chronic heart failure (CHF) condition in Korea as explanation for the low admissions rate; regarding the female/male ratio she noted that the main cause of CHF in Korea is rheumatic heart disease which is more prevalent among women.
- The Danish delegates reported the detection of double counting of patients for the calculations that deemed their data wrong. They committed to resubmit correct rates in one week.

The discussion regarding the selection of indicators for publication was postponed for day 2. Based on previous day's discussion, the Secretariat put forward the following proposal for delegates' consideration:

37. **Drop** the following indicators:

- Respiratory diseases: Asthma mortality
- Diabetes: long term complications admissions, uncontrolled diabetes admissions and retinal eye exams
- Cardiovascular: hypertension admissions, angina with and without instruments admissions

38. **Retain** the following indicators

- Respiratory diseases 1 two-pager including: COPD, Asthma admissions and Smoking rate
- Diabetes 1 two-pager including: Amputation rates and Acute (short term) complications admissions
- Cardiovascular diseases 1 two-pager including: CHF admissions

39. **Decision:** The Experts supported the proposal above; however, several countries advocated the retention of hypertension admissions due to the interest of the possible explanations behind differences and their utility in illustrating the functioning of these indicators. The final decision was left to the Secretariat's assessment of suggested further analysis.

ITEM 11: MENTAL HEALTH CARE

40. The Secretariat presented the analysis made to inform this draft section documented in DELSA/HEA/HCQ(2009)1/ANN1 (see presentation *Item 11. Mental health.ppt*)

41. The discussion started with a remark by the Danish expert, supported by the Swedish, about how the countries reporting highest rates were also those having in place unique patient identifiers (UPI). The Secretariat clarified that the basis for calculations across all the reporting countries were identical and referred to individual patients readmitted to the same hospital. The reason behind the adoption of this specification of the indicator (as opposed to the one that included readmissions to any hospital) was precisely the need to assure comparability across countries notwithstanding whether they have UPI

implemented or not. All the reporting countries have the ability to track individual patients within each institution. The debate focused then on two issues:

- a. The interpretation of the indicators: some experts challenged the interpretation of high unplanned readmission rates as a sign of poor quality of the mental health care in a country. It was suggested that the indicators reflected variability in practice rather than in quality of care. Several countries with high rates, such as Finland or Denmark, reported the use of “interval care” protocols to place unstable patients into hospital care for short periods. The Secretariat acknowledged this explanation of the high rates as plausible and agreed to reflect it in the text; however, this shift of practice towards supplementing or substituting community-based services with in-hospital care in certain countries is in conflict with the existing broad consensus that community-based care is preferable to in-hospital care where possible. For the time being, these indicators allow for comparison across countries. In the absence of a comparable measure of outcomes across countries, the alternative in-hospital-oriented approach is difficult to assess. The enhancement of mental health related information systems will be necessary to make this type of comparative information readily available.
- b. The complementary analysis made to identify factors affecting performance across countries was discussed. The lack of correlation between average length of stay (ALOS) and unplanned readmissions was considered a surprising finding. The Secretariat noted that the evidence available pointed to correlation between readmissions and length of stay at the individual level (including the study published last year by the Canadian Institute of Health Information on patients with schizophrenia), rather than the system approach taken in this analysis and the use of ALOS. Experts suggested further analysis to investigate eventual correlation between the total number of admissions and the unplanned readmission rates.

42. **Decision:** These indicators were deemed apt for publication in *Health at a Glance 2009*

ITEM 12: INJURY CARE AND INFECTIOUS DISEASES

43. The Secretariat presented the analysis made to inform this draft section (see presentation *Item 12. Infectious Diseases.ppt*).

44. The only injury care indicator available was waiting time for hip fracture surgery; though initially considered for inclusion in the chapter, it was finally judged as too poor a reflection of injury care standing alone; in addition, a limited number of countries were able to report it and there were some pending issues regarding the variability in counting waiting time that led the Secretariat to the decision not to propose it for publication.

45. The findings for children vaccinations indicators were seen as straightforward with the exception of hepatitis B vaccination. Some experts noted that this vaccination is not mandatory for children in their countries and only recommended for high risk groups; this justifies the low rates reported. In some other countries such as Canada this vaccine is a regular item in the vaccination calendar but normally administered later in the children life. The Secretariat noted this information and agreed to include it in the text or in the form of foot notes where appropriate.

46. Regarding flu vaccination for elder people, experts highlighted the relevance that this indicator may gain in the current situation of flu epidemic and suggested to build the link within the text

47. **Decision:** These indicators were deemed apt for publication in *Health at a Glance 2009*

ITEM 13: REVIEW OF DAY 1 AND INTRODUCTION TO DAY 2

48. The Coordinator, Mr Klazinga, provided a brief overview of the outcomes of Day 1 and an introduction to Day 2, which was devoted to the consideration of future indicator development priorities and the ongoing analytical work of the HCQI Project.

ITEM 14: ANALYTICAL WORK ON CANCER CARE PERFORMANCE

49. Michel Coleman, Professor of Epidemiology and Vital Statistics at the London School of Hygiene and Tropical Medicine and coordinator of the CONCORD study, provided an overview of the scope of the work undertaken in the study; he presented the findings and their policy relevant implications as well as the future plans for the initiative (see presentation *Item 14. Coleman CONCORD.pdf*).

50. The Secretariat laid out the proposed conceptual framework guiding the analysis of the quality of cancer care and presented the outcomes of the exploratory analytical work undertaken to date, the data issues detected and outlined the forward plan, documented in DELSA/HEA/HCQ(2009)2 (see presentation *Item 14. Analytical work on cancer care.ppt*).

51. Experts valued the CONCORD study as a very solid piece of work on the comparison of survival rates across countries and appreciated the insights on the interpretation of these indicators derived from the analysis presented. The experts welcomed the idea of exploring further some form of link and sustained collaboration with the CONCORD initiative.

52. The proposed line of work on cancer care performance was generally welcomed as the right next step for the project. It was regarded as useful in deeming the set of indicators policy relevant by using a disease specific approach.

53. Experts were very positive to the conceptual model proposed. A couple of observations were made as to the use of dichotomous variables in characterizing cancer registries or prevention policies; some quantitative formulation, such as percentage of coverage for the registry or the policy, was suggested as more informative and entailing more discriminative power.

54. Considerations were made as to the work plan being slightly too ambitious given the exposed data limitations. However, establishing a network of cancer experts to support the data collection was regarded as appropriate in overcoming this paucity. The approach and the work plan were endorsed as follows:

Step 1: 2nd half 2009

- Network of national cancer care experts
 - Refining operationalisation of the conceptual model
- Building partnership with cancer expert international initiatives *i.e.* CONCORD
- Develop questionnaire to fill in data gaps
 - Key organisational and financial factors
 - Longer time-series for HCQI cancer indicators (survival and screening rates)
 - Survival rates for lung cancer and leukaemia

Step 2: 2010

- First semester:

- Data collection
- Data analysis
- Presentation of results at HCQI Expert Group Meeting (June 2010)
- Second semester:
 - monograph on performance of cancer care systems to feed into the Ministerial meeting (end 2010)

ITEM 15: WORK ON RESPONSIVENESS/PATIENT EXPERIENCES

55. The Secretariat presented the progress made to date in the work on responsiveness/patient experiences and outlined the plans forward in preparation for the Expert Subgroup meeting in October, documented in DELSA/HEA/HCQ(2009)3 (see presentation *Item 15. Patient Experiences.ppt*).

56. Experts noted the progress made in this line of work and supported the approach taken and the plans outlined as followed:

1. Development of new population based survey instrument
 - Limited number of questions (approximately 10-20)
 - Addressing the domains of access, communication and autonomy
2. Development of a cross national plan for cognitive testing & validation of psychometric properties of the instrument
3. Consideration of the draft instrument and testing plan by the Patient Experiences Subgroup on 25 September
4. If endorsed, the instrument will then be considered by The Commonwealth Fund for field testing of the questions in conjunction with their planned population based survey in early 2010.

57. The Nordic countries highlighted the number of complementarities and affinities that they could see with work done in measuring patient experiences within the Nordic Council of Ministers. The Secretariat acknowledged the relevance of this work to the developments ahead and committed to seek ways of direct communication by mutual participation in the meetings of the respective work subgroups at OECD HCQI and the Nordic Council.

58. The immediate next steps endorsed in preparation to the Subgroup meeting in October were:

- Work with Diana Delnoij, Centre for Consumer Experience in Health Care (Netherlands) and other experts to develop the first draft of the new instrument and testing plan.
- Explore opportunities to extend field testing of the new instrument to other countries not planning to be involved in The Commonwealth Fund survey.

ITEM 16: ENHANCING NATIONAL INFORMATION INFRASTRUCTURES FOR MEASURING QUALITY INDICATORS

59. The document DELSA/HEA/HCQ(2009)4 was provided as a background paper for discussion and further agenda setting in the OECD Health Care Quality Indicator (HCQI) project on how enhancements in the national information-infrastructures can be made to increase the potential for measuring quality of care through indicators. The Secretariat suggested 4 strategies for endorsement by the HCQI Expert Group (see presentation *Item 16. Information Infrastructures.ppt*):

1. Use of Electronic Health Records (EHRs) for data collection for population-based quality indicators
2. Exchange mutual expertise on coding
3. Monitoring of the use of UPIs
4. Link with the planned ministerial meeting in 2010

60. Some Experts contributed briefly the experience in developing EHRs and other initiatives to enhance national information infrastructures in their respective countries. A point was made on the utility of guidelines on privacy issued by this group in supporting the countries that are currently improving their information systems and/or facing privacy issues in making use of the information.

61. Experts endorsed the proposed strategies and stressed how the enhancement of information infrastructures should crosscut all OECD work, exceeding the measurement of quality of care. The US expert expressed his country's willingness to be a partner in resourcing this line of work.

ITEM 17: CONCLUSIONS

62. Niek Klazinga, coordinator of the HCQI project summarised the discussion and the decisions made as follows:

1. The next two months will focus on the finalisation of the quality of care chapter for *Health at Glance 2009*. Relevant corrections or additional data should be submitted by 30 June at the latest.
2. A complete technical report on the patient safety indicators, summarising all the work and analysis done to date should be ready for discussion at the Patient safety Expert Subgroup in October, with a view to publish the document in November simultaneously to the release of *Health at Glance 2009*.
3. The proposed analytical work on cancer was endorsed with 3 immediate aims:
 - a. Fill the detected information gaps
 - b. Strengthen the links with cancer experts seeking their active involvement
 - c. Complete consolidated expert network and data collection with a view to deliver results by June 2010
4. The analytic work on diabetes and cardiovascular diseases is on hold until further resources can be freed for that purpose.
5. As for the work on patient's experience/responsiveness, the first draft of the set of questions will be discussed at the September meeting and links will be sought with the Nordic Council work.
6. The October meeting of the promotion prevention and primary care expert subgroup will be devoted to extend the debate about what other areas not currently covered in *Health at a glance* should be envisioned for the future and to explore the feasibility of other indicators in the field
7. The group endorsed the strategies on enhancement of health information infrastructures and agreed on scheduling a separate day in the next HCQI expert Group meeting (June 2010) to share experiences on implementation and use of EMR.

8. Three specific contributions to the ministerial meeting were envisioned
 - a. A paper on national information infrastructures enhancement
 - b. A paper on cancer care performance
 - c. A paper on developments in measuring patient safety across countries

Depending on the final format of the ministerial, specific input from the HCQI work through a high level Quality Forum and general publication is foreseen.

9. The next meeting of the HCQI Expert Group to be held 3-4 June 2010.
63. Experts endorsed these conclusions.

ANNEX 1. LIST OF PARTICIPANTS

HCQI EXPERTS' GROUP MEETING, PARIS, 4-5 JUNE 2009

Austria/Autriche

Ms. Jeannette KLIMONT
Directorate Population
Statistics Austria
Guglgasse 13
Vienna
Austria

Tel: +43 (1) 711 28-8277
Fax: +43 (1) 711 28-7445
Email: jeannette.klimont@statistik.gv.at

Belgium/Belgique

Ms. Margareta HAELTERMAN
FPS Health, Food Chain Safety and Environment
Organisation of Healthcare Establishments
Acute Chronic and Care for elderly people centre
Place Victor Hortaplein 40
Box 10
1060 BRUSSELS
Belgium

Tel: +32 2 524 8568
Email: margareta.haelterman@health.fgov.be

Dr. Pascal MEEUS
Coordinateur national du rapport performance du système des soins de
santé
Research, Development and Quality
Institut national d'assurance maladie invalidité
Département Recherche, Développement et Qualité
Avenue de tervueren-laan 211 T 653
1150 Bruxelles

Tel: +32 2 739 78 71
Email: pascal.meeus@riziv.fgov.be

Canada/Canada

Dr. Indra PULCINS
Director, Indicators and Performance Measurement
Canadian Institute for Health Information
4110 Yonge Street, Suite 300
M2P 2B7 Toronto

Tel: 416 549 5404
Email: IPulcins@cihi.ca

Czech Republic/République Tchèque Mr. Frantisek VLCEK
Vice Director, Czech Accreditation Committee; Advisor, Ministry of Health
Ministry of Health
Palackeho nam. 4
128 01 Prague 2
Czech Republic

Tel: + 420 602 408 863
Email: frantisek.vclek@sakcr.cz

Denmark/Danemark Ms. Frederikke BEER
Head of section
Ministry for Health and Prevention
Slotsholmsgade 10-12
Copenhagen K
Denmark

Tel: + 45 722 69681
Email: fbe@sum.dk

Ms. Mette Thorup ERIKSEN
Adviser
National Board of Health
Islands Brygge 67
2300 København S
Denmark

Tel: +45 72227570
Email: mee@sst.dk

Dr. Jan MAINZ
Professor of Quality Improvement, M.D., Ph.D.
National Board of Health
Islands Brygge 67
DK-2300 Copenhagen S

Tel: +45 25 57 90 33
Email: jan.mainz@rn.dk

Finland/Finlande Dr. Päivi HÄMÄLÄINEN
Director of Department
National Institute for Health and Welfare
P.O. Box 30
FI-00271 Helsinki
Finland

Tel: +358-20 610 7665
Fax: +358-20-610 7443
Email: paivi.hamalainen@thl.fi

France/France

M. Patrick DOSTES
Conseiller
Délégation Permanente
5 rue Oswaldo Cruz
75016 Paris
France

Tel: +33 1 43 17 57 01
Fax: +33 1 43 17 58 32
Email: patrick.dostes@diplomatie.gouv.fr

Mme Claire BERTHIER
Chargée de mission
Représentation Permanente de la France auprès de l'OCDE
5 Rue Oswaldo Cruz
75016 Paris 16
France

Tel: +33 1 43 17 57 03
Email: claire.berthier@diplomatie.gouv.fr

Dr. Juliette BLOCH
Responsable du Département des Maladies Chroniques et des
Traumatismes
Institut de Veille Sanitaire
12, rue du Val d'Osne
94415 Saint-Maurice
France

Tel: + 33 1 41 79 68 29
Email: j.bloch@invs.sante.fr

Dr. Aude-Emmanuelle DEVELAY
Service IPAQH
HAS- Direction Amélioration de la Qualité
2, avenue du Stade de France
93218 Saint-Denis La Plaine Cedex
France

Tel: +33 1 55 93 72 07
Fax: +33 1 55 93 74 33
Email: ae.develay@has-sante.fr

Mme Sophie FEGUEUX
Chef de bureau, Infection et autres risques liés aux soins
Direction générale de la santé
Ministère de la Santé, de la Jeunesse et des Sports
Bureau des infections et autres risques liés aux s
14, avenue Duquesne
75350 PARIS
France

Tel: +33 1 40 56 60 76
Email: sophie.fegueux@sante.gouv.fr

Jean-Marc NADAL
chargé des indicateurs de qualité
Ministère de la Santé, de la Jeunesse et des Sports
bureau de la qualité et sécurité des soins en étab

Email: jean-marc.nadal@sante.gouv.fr

Mme Michèle PERRIN
Chargée de la sécurité des patients
Ministère de la Santé, de la Jeunesse et des Sports
Bureau de la qualité et sécurité des soins en établissements de santé
8, Avenue de Ségur
75700 PARIS
France

Tel: + 33 1 40 56 59 53
Email: michele.perrin@sante.gouv.fr

Mme Valérie SALOMON
chef de bureau
Bureau de la qualité et sécurité des soins en établissements de santé
Ministère de la Santé, de la Jeunesse et des Sports
8, Avenue de Ségur
75700 PARIS
France

Email: valerie.salomon@sante.gouv.fr

Mme Amélie SCHMITT
Délégation aux affaires européennes et internationales
Ministère de la santé, de la jeunesse, des sports et de la vie associative
Bureau international santé et protection sociale
8, Avenue de Ségur
75700 PARIS
France

Tel: +33 1 01 40 56 78 22
Email: amelie.schmitt@sante.gouv.fr

Germany/Allemagne

Dr. Christa SCHEIDT-NAVE
Department of Epidemiology and Health Monitoring
Robert Koch Institute
Division of Non-Communicable Disease Epidemiology
D-12101 Berlin
Germany

Tel: 001-1888-754-3168 / -3165
Email: scheidt-navec@rki.de

Dr. Saskia DRÖSLER
Niederrhein University of Applied Sciences
D-47800 Krefeld
Germany

Email: saskia.droesler@online.de

Hungary/Hongrie

Mr. Barnabás MARGITAI
Director
Institute for Healthcare Quality Improvement
Diós árok 3.
1125 Budapest
Hungary

Tel: +36 1 356 1522
Fax: +36 1 375 7253

Japan/Japon

Mr. Yasuhiro HIMENO
First Secretary
Health & Social Affairs
Permanent Delegation
11, avenue Hoche
75008 Paris
France

Tel: +33 1 53 76 61 32
Fax: +33 1 45 63 05 44
Email: himeno@deljp-ocde.fr

Dr. Tomoko KODAMA
Chief of International Section
Department of Human Resources Development
National Institute of Public Health
2-3-6 Minami
Wako-shi
3510197 Saitama
Japan

Email: tkodama@niph.go.jp

Korea/Corée

Ms. LuNa BYON
Deputy Director
Statistics Planning and Survey Team
Ministry of Health and Welfare
1, Joong ang-Dong
42N-N21 Gwacheon-Si
Korea

Tel: +82 2 2110 7706
Fax: +82 2 503 7517
Email: star@mohw.go.kr

Ms. Sun Mean KIM
Commissioner
Health Insurance Review & Assessment Service

Tel: + 82 2 2182 2298
Email: kimsunmin@hiramail.net

Mr. Jongwoo PAIK
assistant Professor
School of Medicine
Kyung Hee University

Email: paikjw@khu.ac.kr

Mr. Choon Seon PARK
Senior Researcher
Health Insurance Review & Assessment

Email: parkcs@hiramail.net

Luxembourg/Luxembourg

Mme Marianne SCHOLL
Inspection Générale de la Sécurité Sociale
B.P. 1308
L-1013
Luxembourg

Tel: (352) 2478 6362
Fax: (352) 2478 6225
Email: marianne.scholl@igss.etat.lu

New Zealand/Nouvelle-Zélande

Mr. Vladimir STEVANOVIĆ
Team Leader, Clinical Advisory Services and Principal Technical Specialist
Information Strategy & Architecture, Information Directorate
Ministry of Health
P.O. Box 5013
Wellington
New Zealand

Email: Vladimir_Stevanovic@moh.govt.nz

Norway/Norvège

Mrs. Torunn-Omland GRANLUND
Adviser
Ministry of Health and Care Services
Einar Gerhardesens plass 3
0030 Oslo
Norway

Tel: +47 22 24 87 52

Fax: + 47 22 24 95 78

Email: tog@hod.dep.no

Ms. Marit Sissel KISE
Senior Advisor
The Norwegian Directorate of Health
P.O Box 8054 Dep.
0031 Oslo
Norway

Tel: + 47 24 16 3113

Email: msk@helsedir.no

Mr. Daniel NGUYEN
Adviser
Norwegian Patient Register
The Norwegian Directorate of Health

Tel: +47 930 28 331

Email: Daniel.Nguyen@helsedir.no

Mr. John-Arne ROTTINGEN
Director General
Norwegian Knowledge Centre for the Health Services
Boks 7004
St Olavs plass
N/0130 Oslo
Norway

Tel: + 47 959 80 589

Email: john-arne.rottingen@kunnskapssenteret.no

Poland/Pologne

Ms. Ewa DUDZIK URBANIAK
Specialist
National Center for Quality Assessment in Health Care
Kapelanka 60 str
Krakow 30-347
Poland

Email: dudzik@cmj.org.pl

Portugal/Portugal

Ms. Margarida FRANCA
DGS Consultant/Expert
Direccao Geral da Saude
Alameda Alfonso Henriques
Lisbon
Portugal

Tel: +351 96 46 43 027

Email: mfranca@mail.telepac.pt

**Slovak Republic/République
slovaque**

Ms. Denisa MEDVEDOVA
Third Secretary
Permanent Delegation
28, avenue d'Eylau
75016 Paris
France

Tel: +33 1 56 26 50 96

Fax: +33 1 56 26 50 92

Email: denisa.medvedova@mzv.sk

Sweden/Suède

Mr. Max KOSTER
Researcher
Centre for Epidemiology
Socialstyrelsen, The National Board of Health and Welfare
SE 10630 Stockholm
Sweden

Tel: +46 75247 3459

Fax: + 46 75 247 3327

Email: max.koster@socialstyrelsen.se

Ms. Marie LAWRENCE
The Health Care and Medical Services Department
National Board of Health and Welfare
SE 10630 Stockholm
Sweden

Tel: +46 75 247 35 06

Fax: +46 75 247 33 46

Email: marie.lawrence@socialstyrelsen.se

Dr. Rickard LJUNG
Centre for Epidemiology
Socialstyrelsen, The National Board of Health and Welfare
SE 10630 Stockholm
Sweden

Tel: + 46 75 247 33 07
Fax: + 46 75 247 33 27
Email: rickard.ljung@socialstyrelsen.se

Mr. Mats TALBACK
Socialstyrelsen, The National Board of Health and Welfare
SE 10630 Stockholm
Sweden

Tel: +46 75 247 31 56
Fax: + 46 75 247 3327
Email: mats.talback@socialstyrelsen.se

Switzerland/Suisse

Mr. Manfred LANGENEGGER
Head of Quality Management
Federal Office of Public Health
Schwarzenburgstrasse 165
BAG
3003 Bern
Switzerland

Tel: +41 (31) 322 90 42
Fax: +41 (31) 322 90 20
Email: manfred.langenegger@bag.admin.ch

Turkey/Turquie

Ms. Beste PEHLIVAN SUN
First Secretary
Permanent Delegation
9, rue Alfred Dehodencq
75116 Paris
France

Tel: +33 1 42 88 50 02
Fax: +33 1 45 27 28 24
Email: beste.pehlivan@mfa.gov.tr

Dr. Feray KARAMAN
Ministry of Health
Saglik Bakanligi
Mithatpasa cad. No:3
Sihhiye
06434 Ankara

Email: feray.karaman@usak.saglik.gov.tr

Mr. Menderes TARCAN
Head of Department
Ministry of Health
Saglik Bakanligi
Mithatpasa cad. No:3
Sihhiye
06434 Ankara

Email: menderestarcan@gmail.com

**United Kingdom/Royaume-
Uni**

Mr. Gerrard ABI-AAD

Email: Gerrard.Abi-Aad@healthcarecommission.org.uk

Mr. Jonathan HOPE
Senior Information Analyst
The Information Centre
1 Trevelyan Square
Boar Lane
Leeds LS1 6AE
United Kingdom

Email: Jonathan.Hope@nhs.ic.uk

Mr. Adam MILLICAN-SLATER
Statistician
Department of Health
Richmond House
79 Whitehall
SW1A 2NS London
United Kingdom

Email: Adam.Millican-Slater@dh.gsi.gov.uk

Ms. Sunita SHIER
Statistician
Department of Health
Room 551C Skipton House
80 London Road
London SE1 6LH
United Kingdom

Email: Sunita.Shier@dh.gsi.gov.uk

Ms. Sheena VEERAPEN
Statistical Officer
Department of Health
Skipton House
80 London Road
London SE1 6LH
United Kingdom

Email: Sheena.Veerapen@dh.gsi.gov.uk

United States/États-Unis

Mr. Edward J. SONDIK
Director
National Center for Health Statistics, CDC
6525 Belcrest Road - Room 1140
20782 Hyattsville, MD
United States

Tel: + 1 301 436 7016

Fax: + 1 301 436 5202

Email: efs2@cdc.gov

EC/CE

Ms. Agnieszka DAVAL-CICHON
Policy Officer
Health and Consumers Directorate General
European Commission
Rue Breydel 4
1040 Brussels
Belgium

Email: Agnieszka.DAVAL-CICHON@ec.europa.eu

Mr. Artur FURTADO
Project and Policy Officer
Unit C2 Health Information, Directorate C Public Health and Risk
Assessment Directorate-General Health and Consumer Protection
European Commission
Office 0/84 HITEC building
11, Rue E. Ruppert
L 2920 Luxembourg
Luxembourg

Tel: +(352) 430135827

Email: artur.furtado@ec.europa.eu

Estonia/Estonie

Ms. Liis ROOVÄLI
Head of Department
Health Information and Analysis Department
Ministry of Social Affairs of Estonia
Gonsiori 29
15027 Tallinn
Estonia

Tel: +372 626 9158
Fax: +372 699 2209
Email: Liis.Roovali@sm.ee

**Business and Industry
Advisory Committee
(BIAC)/Comité consultatif
économique et industriel
(BIAC)**

Dr. John J. COHRSEN
Consultant
17 bis, avenue Parmentier
75011 Paris
France

Tel: +33 1 43 38 71 17/+1 202 747 2199

Email: john.cohrsen@health-law.info

Other/Autre

Professor Michel COLEMAN
Professor of Epidemiology and Vital Statistics
CR UK Cancer Survival Group, Room 103,
Keppel Street,
London WC1E 7HT,
UK

Tel: +44 (0)20 7927 2478
Fax: +44 (0)20 7436 4230
Email: Michel.Coleman@lshtm.ac.uk

Dr. Eng Kok LIM
Deputy Director
Clinical Benchmarking
Ministry of Health
College of Medicine Building
College of Medicine Building
16 College Road
169854 Singapore
Singapore

Tel: +65 63251282
Email: lim_eng_kok@moh.gov.sg

Dr. Soeren MATTKE
Bain & Co.
131 Dartmouth St
02116 Boston
United States

Email: soeren.mattke@bain.com

Professor Patrick ROMANO
UC Davis Division of General Medicine
University of California
4150 V Street; Suite 2400
CA 95817 Sacramento
United States

Tel: +1 916 734-7237
Fax: +1 916 734-2732
Email: psromano@ucdavis.edu