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Foreword: why this unique tool for health consumer empowerment?

Europe integrates. People, services and goods cross borders to get improve quality of life and economic growth – two critical welfare society indicators. By the ruling of the European Court of Justice, patients can go to another country to access the best health care. The Union advocates improved health information promoting numerous eHealth initiatives. There is an EU patient card, and there will most likely be electronic health records improving care procedures and patient knowledge.

But still the European health consumer of Europe lacks relevant information to for navigate navigating the health care system – at regional, national and still more at EU level. Having to right of mobility is excellent – but how is one to exercise it? Where and how is one to access care reducing waiting times and medical risks, optimising outcomes and consumer satisfaction?

Transparency among the European health care systems is a key quality not only to consumers but to every health care stakeholder. Transparency reveals flaws and malfunctions requiring action. Every sophisticated service industry – and health care is very much an operation of that kind – is driven by informed consumer decisions and by the dialogue between the user and the provider. Europeans are of the opinion that their access to information improves the quality of care. To use the full potential of the health care systems, European trans-national information is an essential resource.

For the second year in succession, publishing a national health consumer index in Sweden, we notice how fast comparisons among health care systems become legitimate, focussing on improvements. Figures on the table, very few systems owners are satisfied with staying at the bottom end of such a publicly exposed ranking setting a quality mark.

We now aim to put this consumer empowerment tool into an European Union context. Taking a strong consumer view, the 2005 EuroHealth Consumer Index wants to add to already existing evaluations by institutions like WHO and OECD. Introducing a different perspective, our Index ranks how user-friendly the national healthcare turns out in the twelve largest European countries (expanding in 2006 to cover every EU-25 member system, and to be annually updated and developed).

This first attempt is very much a tool to be improved. We advise you not to hook onto every single indicator or figure but rather on the tendencies and systems connections. We hope for a critical but forward-looking discussion following on the launch, sharing insights and ideas to support the development of health consumer empowerment around Europe.

Brussels, June 15, 2005

Johan Hjertqvist
President, Health Consumer Powerhouse
1. **Content summary**

Among the twelve national health care systems compared by the EuroHealth Consumer Index for 2005, three stand out as superior regarding consumer value, namely those of the Netherlands, Switzerland and Germany. In the Index they are awarded with 46 – 48 points out of potentially 60 obtainable. This means these three perform fairly well but with certain limitations. Not surprisingly, countries with healthcare systems which are traditionally built on a pluralistic approach to funding and providing healthcare score high on a Healthcare Consumer Index. The existence of many alternatives for healthcare insurance, which in turn do not discriminate between providers’ legal or ownership structures, is probably the basic reason why the three “medallists” seize the top positions.

The EHCI does take into account the service quality measured as outcomes. Inferior scores on this sub-set of indicators handicaps a country such as Belgium, which otherwise scores high on issues of consumer-friendliness. Sweden, which is the “winner” on medical quality, misses the medallists’ podium mainly due to poor accessibility.

In southern Europe, Spain and Italy do provide excellent healthcare services. Real excellence in southern European healthcare seems to be a bit too much dependent on the consumers’ ability to afford private healthcare as a supplement to public healthcare for these countries to reach top scores.

A mixed performance is shown by the U.K., which wins out on healthcare information, but the overall U.K. score is dragged down by waiting lists and uneven quality performance.

The three eastern European EU member states – Poland, Hungary and Estonia – are doing surprisingly well, considering their much smaller healthcare spend as % of GDP. However, readjusting from planned to consumer-driven economies does take time. Estonia, being the smallest ship to turn around, seems to lead this subgroup.
2. Where does the European health consumer in 2005 find the most user-friendly care system?

2.1 General overview of European conditions

The current (2002) situation for European healthcare systems is commented on the following quote from the WHO European Health Report:

“Health systems and services are undergoing major transformations in the European Region. First, countries are striving to better balance sustainability and solidarity in financing. Most western European countries maintain relatively high levels of solidarity. While the CCEE (former centrally planned economies of Eastern Europe) and NIS (new states, formerly parts of the Soviet Union) are also committed to solidarity in finance, problems with the economic sustainability of new insurance mechanisms lead in many cases to considerable reductions in the accessibility and affordability of health services. Second, there is an increasing trend towards strategic purchasing as a way of allocating resources to providers to maximize health gain, including separating provider and purchaser functions, moving from passive reimbursement to proactive purchasing, and selecting providers according to their cost-effectiveness. Contracting mechanisms and performance-based payment become central to effective purchasing. Third, countries are adopting more aggressively updated or new strategies to improve efficiency in health service delivery. Fourth, effective stewardship is proving central to the success of health system reform. The government mostly plays this role, involving health policy leadership, appropriate regulation and effective intelligence, but stewardship may also involve other bodies such as professional organizations.”

This, and several other reports provide thorough descriptions of the public health situation in European countries.

There is less good availability of reports on the actual performance of healthcare systems, expressed in “customer value” terms such as quantitative and qualitative output, service and information levels and value for money spent, are less readily available. The statistics on European healthcare systems tend to focus on quantitative resource inputs such as staff numbers, beds and bed occupancy, and at best statistics on procedures such as “needle time” or “% of patients receiving thrombolysis treatment”.

For a country like the USA, where healthcare financing and provision has been looked upon as a service industry, statistics on performance quantity and quality are abundant.

The Health Consumer Powerhouse is presenting the “EuroHealth Consumer Index, version 1.0” as a first pilot attempt, to measure and rank the national healthcare systems of 12 European countries from the patient/customer’s point of view.
2.2 The Index outcomes

As is illustrated by the Index Matrix, EHCI 1.0 consists of a total of 20 indicators in five sub-areas, describing 12 national healthcare systems. The aim has been to select such indicators, which should be relevant for describing a healthcare system viewed from the consumer/patient’s angle.

The performance of the respective national healthcare systems was graded on a three-grade scale for each indicator, where the grades have the rather obvious meaning of green = good (+), amber = so-so (=) and red = not-so-good (–).

Red, amber and green grades were converted to a simple numerical score by being made equivalent to 1, 2 or 3 points respectively.

The possibility was discussed of introducing weight coefficients, *i.e.* selecting certain indicators as being more important than others and multiplying their scores by numbers > 1. This option will be kept in mind for later versions of the index, after a thorough analysis of which indicators should be considered for higher weight. The outcomes indicators seem to be the main candidates for higher weight coefficients. Here, as for the whole of the Index, we welcome input on how to improve the Index methodology.
<table>
<thead>
<tr>
<th>Patient rights and information</th>
<th>Belgium</th>
<th>Estonia</th>
<th>France</th>
<th>Germany</th>
<th>Hungary</th>
<th>Italy</th>
<th>Netherlands</th>
<th>Poland</th>
<th>Spain</th>
<th>Sweden</th>
<th>Switzerland</th>
<th>United Kingdom</th>
</tr>
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<tbody>
<tr>
<td>Patients’ Rights Law</td>
<td>+</td>
<td>+</td>
<td>-</td>
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<td>+</td>
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<td>-</td>
<td>-</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
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<tr>
<td>Provider catalogue with quality ranking</td>
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<td>-</td>
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<tr>
<td>Direct access to specialist care</td>
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<td>=</td>
<td>+</td>
<td>+</td>
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<td>+</td>
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<td>No-fault malpractice insurance</td>
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<td>-</td>
<td>=</td>
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<td>-</td>
<td>+</td>
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<td>Right to second opinion</td>
<td>+</td>
<td>=</td>
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<td>+</td>
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<td>=</td>
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<td>=</td>
<td>+</td>
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<tr>
<td>Access to own medical record</td>
<td>-</td>
<td>+</td>
<td>=</td>
<td>+</td>
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<td>=</td>
<td>+</td>
<td>=</td>
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</tr>
<tr>
<td>Country position on “Health care to be treated as a service included in the proposed Service Directive”</td>
<td>-</td>
<td>+</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>+</td>
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<td>n.a</td>
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<tr>
<td>Waiting time for treatment</td>
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<tr>
<td>Family doctor same day service</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>=</td>
<td>-</td>
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<td>+</td>
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<td>+</td>
</tr>
<tr>
<td>Knee/hip joint</td>
<td>+</td>
<td>=</td>
<td>+</td>
<td>+</td>
<td>-</td>
<td>=</td>
<td>=</td>
<td>n.a</td>
<td>=</td>
<td>-</td>
<td>+</td>
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<tr>
<td>Cancer</td>
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<td>=</td>
<td>+</td>
<td>+</td>
<td>=</td>
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<td>=</td>
<td>=</td>
<td>+</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Heart bypass/PTCA</td>
<td>+</td>
<td>=</td>
<td>+</td>
<td>+</td>
<td>=</td>
<td>=</td>
<td>n.a</td>
<td>=</td>
<td>-</td>
<td>+</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Outcomes</td>
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<tr>
<td>Heart infarct mortality &lt;28 days after hospital</td>
<td>=</td>
<td>-</td>
<td>=</td>
<td>-</td>
<td>=</td>
<td>+</td>
<td>-</td>
<td>=</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>+</td>
</tr>
<tr>
<td>Maternal deaths/100,000 live births</td>
<td>=</td>
<td>-</td>
<td>=</td>
<td>=</td>
<td>+</td>
<td>=</td>
<td>=</td>
<td>+</td>
<td>+</td>
<td>=</td>
<td>=</td>
<td>=</td>
</tr>
<tr>
<td>Breast &amp; colon cancer mortality</td>
<td>=</td>
<td>=</td>
<td>=</td>
<td>=</td>
<td>+</td>
<td>+</td>
<td>+</td>
<td>=</td>
<td>=</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>MRSA infections</td>
<td>=</td>
<td>+</td>
<td>-</td>
<td>=</td>
<td>=</td>
<td>-</td>
<td>+</td>
<td>=</td>
<td>-</td>
<td>+</td>
<td>n.a</td>
<td>-</td>
</tr>
</tbody>
</table>
### Outcomes Summary

A major purpose of this first attempt at creating a comparative index for national healthcare systems has been to evaluate whether it is at all possible to find indicators, where data are also available, to make the entire exercise meaningful.

Subsequent versions will in all likelihood have a modified set of indicators, as more data becomes available.

#### 2.3.1 Country scores

There are no countries, which excel across the entire range of indicators. The national scores seem to reflect more of “national and organisational cultures and attitudes”, rather than mirroring how large resources a country is spending on healthcare. The cultural streaks have in all likelihood deep historical roots. Turning a large corporation around takes a couple of years – turning a country around can take decades!

Countries with pluralistic financing systems, e.g. offering a choice of health insurance solutions, which also provide the citizen with a choice between providers regardless of whether these are public, private, non-profit or for-profit, generally score high on Patient rights and information issues. Under this sub-set of indicators countries like the Netherlands and Sweden score high on openness and patient access to their own medical information. Scores of countries like Germany and France suffer from what seems to be an expert-driven attitude to healthcare, where the patient access healthcare information with healthcare professionals as intermediaries rather than directly.

In an attempt to summarize the main features of the scoring of each country included in the EHCI 1.0, the following table gives a somewhat subjective synopsis. To the care consumer – i.e. most of us – describing and comparing health care will require some simplifications. (To a medical information system dealing with scientific evidence such
as individual diagnosis or medication guidelines of course require very strict criteria; the Index is consumer information).

<table>
<thead>
<tr>
<th>Country</th>
<th>Scoring Synopsis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belgium</td>
<td>Excels at accessibility, suffers on outcome quality</td>
</tr>
<tr>
<td>Estonia</td>
<td>It takes more than a dozen years to change a top-down planned economy to become a customer-driven one. Estonia, its population of 1½ million people, seems to be catching up faster than bigger nations. Good on MRSA infections and efficient financial administration of pharmaceuticals.</td>
</tr>
<tr>
<td>France</td>
<td>The WHO (2000) world’s #1 on healthcare system performance; technically efficient. Slightly authoritarian and not fantastic outcome quality. You want healthcare information – ask your doctor!</td>
</tr>
<tr>
<td>Germany</td>
<td>The customer rules! Would be really great with more openness (Datengesetz?) of information. You want healthcare information – ask your doctor!</td>
</tr>
<tr>
<td>Hungary</td>
<td>It takes more than a dozen years to change a top-down planned economy to become a customer-driven one. Not very good on outcomes in spite of 60 years of publicly financed healthcare.</td>
</tr>
<tr>
<td>Italy</td>
<td>Surprisingly low performer, also on outcomes quality except maternal deaths. Better score in EHCI 2.0 (2006)?</td>
</tr>
<tr>
<td>Netherlands</td>
<td>Openness, many financing options and good on outcomes quality. Top scorers!</td>
</tr>
<tr>
<td>Poland</td>
<td>It takes more than a dozen years to change a top-down planned economy to a customer-driven one. Poor access to new drugs – a cost saving measure?</td>
</tr>
<tr>
<td>Spain</td>
<td>Up and coming? Private healthcare still has a very strong position.</td>
</tr>
<tr>
<td>Sweden</td>
<td>Excels at outcome quality and openness. Really bad at accessibility and service.</td>
</tr>
<tr>
<td>Switzerland</td>
<td>Running outside of EU competition. In a consumer Index, a system based on individual responsibility since time began does score high. Good but expensive.</td>
</tr>
<tr>
<td>United Kingdom</td>
<td>Mediocre overall performer. Good on heart problems. Star performer on healthcare information! The new Freedom of Information Act will hopefully improve score on openness indicators.</td>
</tr>
</tbody>
</table>
2.3.2 National and organisational cultures

Some indicators seem to reflect national and organisational culture streaks rather than formal legislative or financial circumstances.

Waiting times, usually considered to be of vital interest to healthcare consumers, seems to be one such indicator area. As is also observed by Siciliani & Hurst of the OECD Health Group, the existence of waiting times is strongly correlated to the presence of regulations forcing the patient to access specialist care by going through a primary care procedure in order to get a referral to a specialist (the “gate-keeping” function). In general, countries with gate-keepers exhibit waiting lists – countries where patients are allowed direct access to specialists do not.

In general, countries which have a long tradition of plurality in healthcare financing and provision, i.e. with a consumer choice between different insurance providers, who in turn do not discriminate between providers who are private for-profit, non-profit or public, show common features not only in the waiting list situation, but also in the readiness to allow the seeking of healthcare in other countries than the patient’s homeland.

3. Expert comments

Mr Rodney Elgie, President, GAMIAN-Europe:

"Health Consumer Powerhouse has been brave and adventurous to tackle such a difficult subject, yet one that is of great interest and relevance to patients on a pan-European wide basis. It is only natural that patients and their family members wish to be aware of standards of care in the widest sense in their country and how these standards compare with other European countries. This is particularly so with the recent introduction of the notion of patient mobility in EU Member States and the desire of patients to secure the best quality care as the earliest possible opportunity.

One of the basic problems with such an exercise is comparing like with like and ensuring the data are up to date. Many European countries are endeavouring to improve their national health systems and significant changes may have been introduced after the date used for the collation of comparative data. For example, in the UK, patients now have the right to unfettered access to their medical records but the star rating of hospitals offers no indication of the skill of surgeons or their success rate for operations. France has a significant budget deficit in the healthcare field which is being actively reduced and will undoubtedly have an adverse impact on how patients view their treatment from 2005 onwards. Other problems over producing reliable data also exist. In Spain, each region can set its own reimbursement prices and prescribing restrictions and the regions use their own drug ranking systems relative to current therapies. So is the Spanish data the mean average with significant regional variations?
Other practical difficulties exist. As the authors point out, how does one measure waiting times for a selection of treatments? How accurate are such measurements and have these measurements been distorted by national governments for political reasons and to satisfy the demands of the electorate? Does one have to succeed in getting on to a particular waiting list in the first place before the waiting time that is formally recorded actually commences? One suspects that many patients in the countries included in this survey can provide the authors with an infinite list of such practices that distort the actual experiences of those using the particular healthcare system.

Notwithstanding these limitations, the survey produces a useful analysis of the delivery of care across a number of states for comparison purposes with both cultural and geographical differences taken into account. It provides a useful starting point and is to be applauded on that basis. As the report concludes, the 2006 version will be considerably more sophisticated than the initial one. However, given the difficulty of securing meaningful pan-European data sets, this is a gallant first attempt which can only serve to provide invaluable experience and expertise for similar future initiatives."

Dr. Delon Human, Immediate Past Secretary General of the World Medical Association:

“Congratulations to Health Consumer Powerhouse for this remarkable tool to help improve the standard of health care and level of health information European patients have access to.

There is no doubt that the “Informed Patient” is able to make better choices in terms of lifestyle, health care products and services and this ultimately leads to a healthier and a more productive person. In turn, this will ensure a vibrant and growing Europe.

For this reason the EuroHealth Consumer Index is a fresh and innovative way to measure the effectiveness of health care systems in Europe. The fact that it is a health consumer-centred measurement instrument makes it even more relevant in a rapidly changing health care environment. For too long health consumers have not been adequately consulted on how they perceive and experience health care services and this type of quantitative and qualitative measurement can greatly contribute to higher levels of care.

The Index also offers to governments in Europe an additional metric to be used in evaluating their health care systems, which goes beyond party-political ideology. Because it is based on consumer views in different countries, it provides powerful feedback which can be used by policy-makers to study positive reviews of other health care systems and help correct problem areas in their own.

Anticipating that this is but the start of a very constructive way to measure progress in health care systems, we all wish Health Consumer Powerhouse well in further developing this excellent instrument”.

Mr Christofer Fjellner, Member of the European Parliament:
“In Sweden I have had the opportunity to follow the work of the Health Consumer Powerhouse from the start and I am impressed by your impact to our healthcare system in a short period of time.

In Sweden for the second consecutive year your do-tank has recently launched a national Index from a consumer point of view comparing the public healthcare among the 21 county councils – the regional health bodies. The first year – 2004 – many politicians and bureaucrats labeled this approach as “unscientific” or “fragmented”. But as patient organizations and more clever counties started using this Health Consumer Index as a measure and indicator whether they were forming their healthcare system in a good, consumer friendly way the tone in the debate have radically changed. Already in the second year – 2005 – most counties start adjusting to the Index parameters understanding the power of ranking.

No one wants to stay in the bottom, the policy of the winners attract attention! And the media impact gives no one the chance of saying they have not paid attention!

Today your Swedish Index is an important factor helping us all in Sweden to designing a better healthcare system. By this challenging step the Health Consumer Powerhouse has initiated a promising development. I firmly believe that the European index approach will achieve the same positive effects.

Elected to promote European mobility I have had the chance of taking initiatives in the Parliament to support health consumers and health service integration. Still the weak link is consumer information providing the individual with the opportunity to take action. This is a first step to fill this gap. I hope that by launching this empowerment tool you will provoke a healthy and constructive debate of what is really important for the consumers and how we all really get the healthcare we want and deserve”.

4. This is how the 2005 EHCI was constructed

4.1 Strategy

In April 2004 we first launched the Swedish Health Consumer Index (www.vardkonsumentindex.se, also in a translation to English). By ranking the 21 county councils (the regional parliaments responsible for funding, purchasing and generally also providing health care) by 12 basic indicators concerning the design of “systems policy”, consumer choice, service level and access to information, we introduced benchmarking as an element in consumer empowerment. The presentation of the second annual update of the Swedish index on May 17, 2005 exposed to Swedes the low average ranking of most councils revealing the still weak consumer position.

There is a pronounced need for improvement. The very strong media impact around Sweden of the Index all over Sweden confirmed that the image of health care is rapidly moving from rationed public goods into consumer-related services measurable by common quality perspectives,
For the pan-European index in 2005, the Health Consumer Powerhouse has been aiming to basically follow the same approach, *i.e.* selecting a number of indicators describing to what extent the national healthcare systems are “user-friendly”, thus providing a basis for comparing different national systems. Our aim has been to present an European ranking list of the systems concerned.

Though still this remains a controversial standpoint, the Powerhouse advocates that quality comparisons within the field of healthcare is a true win-win situation: a) to the consumer, who will have a better platform for informed choice and action and, b) to governments, authorities and providers the sharpened focus on consumer satisfaction and quality outcomes will support change. This goes not only for evidence of shortcomings and method flaws but also to illustrate the potential for improvement. With such a view the EHCl will, as been intended, become a useful benchmark system supporting interactive assessment and improvement.

The Index does not take into account whether a national healthcare system is publicly or privately funded and/or operated. The purpose of the EHCl is health consumer empowerment, not the promotion of political ideology. Aiming for dialogue and co-operation, the ambition of the Powerhouse is to be looked upon as a partner in developing healthcare around Europe.

Initially, the key targets for the Index are opinions brokers and policy-makers like journalists, experts and politicians. Gradually, as our services develop, health consumers can become main users along with service providers, payers and authorities. Such a development will ask for user-friendly services and a deep knowledge of consumer values. Interactivity with users and others parts of the European health care society will be another key characteristic.

### 4.2 Main content of "EuroHealth Consumer Index 1.0"

#### 4.2.1 Which nations?

States having been included in the EHCl 1.0: Belgium, Estonia, France, Germany, Hungary, Italy, the Netherlands, Poland, Spain, Sweden, the United Kingdom and, for comparison, Switzerland.

Initially, the healthcare systems of eleven EU member states, plus Switzerland, are compared. Including all 25 member states right from the start would be a very difficult task, particularly as many memberships are fresh, and would present dramatic methodological and statistic difficulties. Already this initial, limited selection has in itself been an ambitious undertaking, and the project has been drawing on existing knowledge and data in cooperation with existing organisations, to inspire good ideas, share knowledge, warn about previous mistakes and errors and provide leads to valuable sources of information.

The project has been seeking for a representative sample of large and small, long-standing and recent EU membership states.

The selection has been influenced by a desire to include all member states with a population of ~40 million and above, along with the above-mentioned mix of size and
longevity of EU membership standing. As the Nordic countries have fairly similar healthcare systems, Sweden was selected to represent the Nordic family, purely because that the project team members had a profound knowledge of the Swedish healthcare system.

Already indicated the selection criteria had nothing to do with healthcare being publicly or privately financed and/or provided. For example, the element of private providers is specifically not at all looked into (other than potentially affecting access in time or care outcomes). But of course there are political dimensions of measuring health care policy. We do rate the position among governments on the matter of health care services being included into the Service Directive, as proposed by the European Commission. We find this a parameter indicating in a broader sense the systems attitude to accessibility, openness and freedom of choice – important values to health consumers. We understand though that such an indicator might be controversial.

This is the initial “pilot heat”. In 2006 we hope for the final EU-25 contest, with potentially a different set of winners.

4.2.2 Preliminary selection of indicator areas for study

The aim has been to select a limited number of indicators, within a definite number of evaluation areas, which taken together can present a telling tale of how the healthcare consumer is being served by the respective systems. The work started with a “long-list” of indicator areas as given below:

Information to the healthcare consumer
Is there a national healthcare information service, which fulfils requirements x, y and z?
Is there a publicly available description of healthcare providers, with indicators of result and outcomes?
Are patient/consumer rights clearly defined and easily accessible?

Treatment accessibility
Waiting times for a representative selection of treatments (measured how?)
Can doctor appointments be struck conveniently?
Can prescriptions be renewed over the Internet?
Accessibility of a selection of best practice-therapies (operations, tests, drugs)? Or: What is the official policy in these respects (red tape etcetera)?

Medical standards and safety
Maltreatment frequencies (MRSA in hospitals, etcetera.)
“System information”
Patient rights (comprehensive and available?)
Provider listings (complete, convenient?)
Procedure for filing a complaint (are there meaningful and established channels, or: Is there information on how to proceed?)
Are regular citizen/consumer polls on healthcare quality/accessibility/satisfaction made (by whom, at what level)?

“Legal position”
Funding alternatives; “opt-out” options?
Patient access to medical records (national byelaws?)
Patient choice of caregiver (level?)
Right and procedure for appeal (of what decisions?)
Compensation for maltreatment (cancellations and/or maltreatment)

“Risk information” (can patients access information about):
MRSA in a certain hospital?
Maltreatment statistics of hospitals (how?)
State of the art/best practice-treatment in various hospitals (three representative diagnoses)?
Substandard treatments (certain diagnoses/methods; measured how)?

Service/attention
Can patients book appointments by e-mail (offered by >x % of caregivers)
Prescription renewal ~”~
Prescription validity (time)?
Single room in hospital (extra charge)?
Healthcare information service (level, telephone, web)?

Accessibility
Waiting times for treatment (three representative diagnoses)?
Time lapse/policy for introduction of new drugs (definition European Observatory?)?
Pharmacy shop hours
Accessibility to family doctor/equivalent (level; several variables)
4.2.3 Project Manager

Project Management has been executed by Dr. Arne Björnberg, Senior Researcher at the Health Consumer Powerhouse.

Dr. Björnberg has previous experience from Research Director positions in Swedish industry. His experience includes service as CEO of the Swedish National Pharmacy Corporation (“Apoteket AB”), Director of Healthcare & Network Solutions for IBM Europe Middle East & Africa, and CEO of the University Hospital of Northern Sweden (“Norrlands Universitetssjukhus”, Umeå).

4.3 Production phases

EHCI was constructed under the following project plan:

4.3.1 Phase 1

Mapping of existing data

Initially, the major area of activity was to evaluate to what extent relevant information is available and accessible for the selected countries. The basic methods were:

websearch

- telephone and e-mail interviews with key individuals
- personal visits when required

Websearch

- a) Relevant byelaws and policy documents
- b) Actual outcome data in relation to policies

Information providers:

- a) National and regional Health Authorities
- b) Institutions (EHMA, Cochrane Institute, Picker Institute, University of York Health Economics, others)
- c) Patient associations (“What would you really like to know?”)
- d) Private enterprise (IMS Health, pharmaceutical industry, others)

Interviews (to evaluate findings from earlier sources, particularly to verify the real outcomes of policy decisions).

- a) Phone and e-mail
- b) Personal visits to key information providers
4.3.2 Phase 2

Data collection and Panel recruitment

- Data collection be undertaken to assemble presently available information to be included in the EHCI.
- Identification of vital areas, where additional information needed to be assembled was performed.
- Collection of raw data for these areas

The EuroHealth Panel was recruited with the assistance of the Powerhouse organisation. EHP members received an initial questionnaire by e-mail. Additional questions were mailed when the result of the first questionnaire was evaluated.

Experience from the two consecutive annual Swedish Health Consumer Index has been evaluated and applied when designing the EHCI.

4.3.3 Phase 3

- EHCI construction
- Web solution building
- EHP feedback

Preliminary assembly of first set of evaluation parameters
Building website for EHCI accessibility
Round of consultation with EHP
Consulting European patient advocates and citizens through Powerhouse surveys, performed by external research facilities (Patient View, Sifo, Health Consumer Diagnosis/Mihok Consult SRL).

4.3.4 Phase 4

Project presentation and reports

- Presentation of EHCI 1.0 at Health Consumer Summit
- A report describing the principles of how the EHCI is constructed
4.4 Indicators selected for EHCI 1.0, with indicator definitions

The project work on the Index proved to become a compromise between which indicators were judged to be most significant for providing information about the different national healthcare systems from a user/consumer’s viewpoint, and the availability of data for these indicators. This is a version of the classical problem “Should we be looking in the dark alley for the 50-dollar bill, or under the lamp-post for the dime?”

It was deemed important to have a mix of indicators in different fields; areas of service attitude and customer orientation as well as indicators of a “hard facts” nature showing healthcare quality in outcome terms. It was also decided to search for indicators on actual results in the form of outcomes rather than indicators depicting procedures, such as “needle time” (time between patient arrival to at A&E department and trombolytic injection), % of heart patients trombolysed or stented, etcetera.

Intentionally de-selected were indicators measuring public health status, such as life expectancy, lung cancer mortality, total heart disease mortality, diabetes incidence etc. Such indicators tend to be primarily dependent on lifestyle or environmental factors rather than healthcare system performance. They generally offer very little supportive of information to the consumer wanting to choose among therapies or care providers, waiting in line for planned surgery, or worrying about the risk of having an post-treatment complication or dissatisfied with the restricted information.

After research and discussions with key persons in European institutions, the following indicator areas and indicators were picked for the EHCI version 1.0. The performance of the respective national healthcare systems were graded on a three-grade scale for each indicator, where the grades have the rather obvious meaning of green = good (+), amber = so-so (=) and red = not-so-good (=).

<table>
<thead>
<tr>
<th>Indicator area</th>
<th>Indicator</th>
<th>Indicator threshold values</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients’ Rights Law</td>
<td>– is there national healthcare legislation clearly based on the rights of the patient?</td>
<td>+ = Yes; = = not really, but there are various kinds of patient charters or similar byelaws; – = No</td>
</tr>
<tr>
<td>Provider catalogue with quality ranking</td>
<td>– can patients easily access lists of care providers</td>
<td>+ = Yes; = = not really, but nice attempts under way; – = No</td>
</tr>
<tr>
<td>Direct access to specialist care</td>
<td>– without a referral from a GP</td>
<td>+ = Yes; = = not really, but quite often in reality; – = No</td>
</tr>
<tr>
<td>No-fault malpractice insurance</td>
<td>– can patients get compensation without the assistance of the judicial system in proving that medical staff made mistakes?</td>
<td>+ = Yes; = = Fair; &gt; 25% invalidity covered by the state; – = No</td>
</tr>
<tr>
<td>Right to second opinion</td>
<td>– for nontrivial conditions</td>
<td>+ = Yes; = = yes, but difficult to access due to bad information, bureaucracy or doctor negativism; – = No</td>
</tr>
<tr>
<td>Category</td>
<td>Indicator</td>
<td>Yes</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>---------------------------------------------------------------------------</td>
<td>-----</td>
</tr>
<tr>
<td>Access to own medical record –</td>
<td>for patient</td>
<td>+</td>
</tr>
<tr>
<td>Health care a service? Country</td>
<td>position on “Health care to be treated as a service included in the proposed Service Directive” is the indicator used. Here we assess only two options: “Yes” or “No”.</td>
<td>+</td>
</tr>
<tr>
<td>Waiting time for treatment</td>
<td>Family doctor same day service – if I wake up in the morning feeling awful, but not lethally ill; can I count on seeing my (a) doctor today?</td>
<td>+</td>
</tr>
<tr>
<td>Knee/hip joint replacement</td>
<td>operation</td>
<td>+</td>
</tr>
<tr>
<td>Cancer radiation or surgical</td>
<td>treatment</td>
<td>+</td>
</tr>
<tr>
<td>Heart bypass/ PTCA; waiting time</td>
<td>between diagnosis and surgery</td>
<td>+</td>
</tr>
<tr>
<td>outcomes</td>
<td>Heart infarct mortality &lt;28 days after hospitalisation</td>
<td>+</td>
</tr>
<tr>
<td></td>
<td>Maternal deaths/100 000 live births</td>
<td>+</td>
</tr>
<tr>
<td></td>
<td>Breast &amp; colon cancer mortality, arithmetic mean</td>
<td>+</td>
</tr>
<tr>
<td></td>
<td>MRSA infections; EARSS statistics - % of patients admitted for surgical</td>
<td>+</td>
</tr>
<tr>
<td></td>
<td>procedures</td>
<td>+</td>
</tr>
<tr>
<td></td>
<td>Convenience of payment deferral for care not paid for by basic public</td>
<td>+</td>
</tr>
<tr>
<td></td>
<td>systems</td>
<td>+</td>
</tr>
<tr>
<td></td>
<td>Prescription renewal without doctor appointment</td>
<td>+</td>
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<tr>
<td></td>
<td>Web or 24/7 telephone healthcare info</td>
<td>+</td>
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<tr>
<td>Pharmaceuticals</td>
<td>Rx subsidy % - share of prescription drug cost borne by public subsidy</td>
<td>+</td>
</tr>
<tr>
<td></td>
<td>Access to new drugs – average time between registration of new drug and</td>
<td>+</td>
</tr>
<tr>
<td></td>
<td>inclusion in subsidy plan</td>
<td>+</td>
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<tr>
<td></td>
<td></td>
<td>+</td>
</tr>
</tbody>
</table>
4.4.1 Threshold value settings

It has not been our ambition to establish a global, scientifically based principle for threshold values to score green, amber or red on the different indicators. Threshold levels have been set after studying the actual parameter value spreads, in order to avoid having indicators showing “all green” or “totally red”. No rule without exception though.

Regarding the indicator “Health care a service” (positions have been evaluated by us through official documents, press statements, interviews) a nation can be awarded either a full score (supporting the Commission proposal) or a “minus”. The latter goes for every nation not supporting a yes-vote. Few governments take such a distinctive stand, rather referring to further negotiations, amendment proposals, need for specifications etcetera. We judge these positions in reality equal to not being ready to fully open up for health care mobility, to the gain of the consumers of the European Union. Maybe a harsh assessment – for the 2006 Index we welcome input on how to measure this kind of “political” indicators.

4.5 European data shortage

There is one predominant feature, which characterizes European public healthcare (and other welfare state) systems as opposed to their more industrialised counterparts in countries such as the U.S.A.: there is an abundance of statistics on input of resources, but a traditional scarcity of data on quantitative or qualitative output.

Organisations like the WHO and OECD are publishing easily accessible and frequently updated statistics on topics like:

- the number of doctors/nurses per capita
- hospital beds per capita
- share of patients receiving certain treatments
- number of consultations per capita
- number of MR units per million of population
- health expenditure by sources of funds
- drug sales in doses and monetary value (endless tables)

Systems with a history of funding structures based on grant schemes and global budgeting often exhibit a management culture, where monitoring and follow-up is more or less entirely focused on input factors. Such factors can be staff numbers, costs of all kinds (though not usually put in relation to output factors) and other factors of the nature illustrated by the above bullet list.

Healthcare systems operating more on an industrial basis have a natural inclination to focus monitoring on output, and also much more naturally relate measurements of costs to output factors in order to measure productivity, cost-effectiveness and quality.

The EHCI project has endeavoured to obtain data on the quality of actual healthcare provided. Doing this, the ambition has been to concentrate on indicators, where the
contribution of actual healthcare provision is the main factor, and external factors such as lifestyle, food, alcohol or smoking are not heavily interfering. Thus, the EHCI has also avoided including public health parameters, which often tend to be less influenced by healthcare performance than by external factors.

The chosen quality indicators became:

- Heart infarct mortality <28 days after hospitalisation (de-selecting such parameters as total heart disease mortality, where the Mediterranean states have an inherent, presumably life-style dependent, leading position).

The data used were those from the so-called Monica study, completed with data obtained directly from healthcare authorities of countries not part of Monica.

There are more complete European data. However, as is the case for several areas of medical quality data for disease outcomes/results of healthcare, access to such data is confined to the ranks of the medical speciality associations. The graph shown below is in its original form from material published by the European Society of Cardiology, with the identities of countries not given. In spite of asking through experienced, well-respected academics, it has not been possible to gain access to the country identities.

- Maternal deaths/100 000 live births (presumed to be dependent on the quality of healthcare services to a large degree)
- Breast & colon cancer mortality, arithmetic mean. Survival rates for these cancer forms are largely dependent on early detection and quality of care
- MRSA infections; EARSS statistics - % of patients admitted for surgical procedures hit by infection. This is probably the medical quality indicator, which has the most systematic follow-up and reporting in public form in European healthcare. Unfortunately, Switzerland does not report to EARSS.
One indicator, which would have been of great interest as a measure of the total quality of long-term efforts exerted by entire national healthcare systems (i.e. both primary and specialist care combined), is the complication rate for diabetics. Complication rates can be measured as foot amputations, eye problems (retinopathy), kidney malfunctions (need of dialysis) or heart conditions per 10,000 patients with diabetes.

Such data are readily available for the USA, as is shown in the following graph. After intensive research and interviews to find similar European statistics, one of the persons responsible for the Swedish diabetes register, Professor Christian Berne of the University of Uppsala, confirmed that the corresponding statistics for Europe in fact do not exist in readily available form.

![Map of Major Amputation Rates per 1,000 Diabetic Medicare Enrollees by Hospital Referral Region (1996-97)](image)

Wrobel et al., American Journal of Public Health 24(5), 860

5. **How to interpret the Index results?**

The first, and most important, consideration on how to treat the results is: “With great care and restrictions for drastic conclusions!”

The EHCI 1.0 is a first pilot attempt at measuring and ranking the performance of healthcare systems from a consumer viewpoint. The results definitely contain information
quality problems. There is a shortage of pan-European, uniform set procedures for data gathering.

But again, we find it far better presenting our outcomes to a public, constructive discussion rather than staying with the only too common opinion that as long as health care information is not a hundred percent complete you had better keep it in your closet. Again we want to stress that the Index displays consumer information, not medically or individually sensitive data.

Version 2.0 (2006) will hopefully be considerably more sophisticated. We hope for a debate improving input of ideas and facts offering us the knowledge to build next year a full EU-25 Index. Here every contribution is of value and most welcome. It is high time that health consumer comparisons were moved out of the statistical office into the street!

For many Index indicators, the scores are based on “latest available data”. As an example, this means that the EHCI compares cancer survival data from 1997 from one country with 2003 data from other countries. We sincerely want to wish the national healthcare authorities, the EU DG5, the WHO, the OECD and the medical specialist associations the best of success in their ongoing efforts to provide good quality statistics on the performance of healthcare systems! The better data coverage the more optimistic you can be regarding the potential access by consumer to important information, eventually building knowledge to manoeuvre the health care systems optimizing the outcomes for the individual.

5.1 Compatibility with similar study

As one measure of the connection between EHCI results and reality, we would like to introduce a comparison between the EHCI ranking, and that found in the “Inequality in responsiveness” ranking provided by the European Observatory\(^1\). Based on population surveys, that ranking is:

1. Germany
2. Netherlands
3. France
4. Belgium
5. Finland
6. United Kingdom
7. Spain
8. Ireland
9. Luxembourg
10. Sweden
11. Italy
12. Portugal
13. Greece

The correlation between that study and the EHCI 1.0 is fairly good – the main reason for France and Belgium scoring worse and Sweden scoring better in the EHCI is the inclusion of outcomes quality indicators.

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\(^1\) Social Health Insurance Systems in Western Europe, European Observatory on Health Systems and Policies (2004), page 97.
While by no means claiming that the EHCI 1.0 results are dissertation quality, the findings should not be dismissed as random findings. On the contrary, the Swedish experience reflects that consumer ranking by similar indicators is looked upon as an important tool to display health care service quality. We hope that the EuroHealth Consumer Index results can serve as inspiration for where European healthcare systems can be improved.

6. References

6.1 Main sources

The main sources of input for the various indicators are given in the table below. For all indicators, this information has been supplemented by interviews and discussions with healthcare officials in both the public and private sectors.

<table>
<thead>
<tr>
<th>Patient rights and information</th>
<th>Main Information sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients’ Rights Law</td>
<td><a href="http://www.index-bg.org/Frame/rights/Frame_all.htm">http://www.index-bg.org/Frame/rights/Frame_all.htm</a></td>
</tr>
<tr>
<td>Provider catalogue with quality ranking</td>
<td>Dr. Foster alone in Europe? Nice NL initiatives. <a href="http://www.drfoster.co.uk/home.aspx">http://www.drfoster.co.uk/home.aspx</a></td>
</tr>
<tr>
<td>No-fault malpractice insurance</td>
<td>Swedish National Patient Insurance Co. (All Nordic countries have no-fault insurance)</td>
</tr>
<tr>
<td>Compliance with EU ruling</td>
<td>EU records, Interviews member state officials.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Waiting time for treatment</th>
<th>Main Information sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family doctor same day service</td>
<td>“Patients’ Perspectives of Healthcare Systems in Europe; survey commissioned by HCP 2005”. Personal interviews.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outcomes</th>
<th>Main Information sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart infarct mortality &lt;28 days after hospital</td>
<td>MONICA data. Personal interviews with healthcare officials.</td>
</tr>
<tr>
<td>MRSA infections</td>
<td>EARSS; latest available data 2003/2004</td>
</tr>
</tbody>
</table>
### Customer friendliness

| Web or 24/7 telephone healthcare info | "Patients' Perspectives of Healthcare Systems in Europe"; survey commissioned by HCP 2005. Personal interviews. |

### Pharmaceuticals

| Rx subsidy % | http://www.efpia.org/6_publ/infigure2004h.pdf |
| Access to new drugs | European Federation of Pharmaceutical Industries and Associations (EFPIA) |

## 6.2 Useful links

Websearch exercises have yielded useful complementary information from, among others, these websites:

- [http://www.wrongdiagnosis.com/a/amputation/stats-country_printer.htm](http://www.wrongdiagnosis.com/a/amputation/stats-country_printer.htm)
- [http://www.dekker.com/index.jsp](http://www.dekker.com/index.jsp)
- [http://www.earss.rivm.nl/](http://www.earss.rivm.nl/)
- [http://212.144.4.93/easd/](http://212.144.4.93/easd/)
- [http://www.euro.who.int/observatory](http://www.euro.who.int/observatory)
- [http://www.hospitalcompare.hhs.gov/](http://www.hospitalcompare.hhs.gov/)
- [http://www.hospitalcompare.hhs.gov/](http://www.hospitalcompare.hhs.gov/)
- [http://www.idf.org/home/](http://www.idf.org/home/)
- [http://www.hospitalmanagement.net/](http://www.hospitalmanagement.net/)
- [http://www.lse.ac.uk/collections/LSEHealthAndSocialCare/](http://www.lse.ac.uk/collections/LSEHealthAndSocialCare/)
- [http://www.oecd.org/document/16/0,2340,en_2825_495642_2085200_1_1_1_1,00.html](http://www.oecd.org/document/16/0,2340,en_2825_495642_2085200_1_1_1_1,00.html)
- [http://www.oecd.org/department/0,2688,en_2649_33929_1_1_1_1_1,00.html](http://www.oecd.org/department/0,2688,en_2649_33929_1_1_1_1_1,00.html)
- [http://home.online.no/~wkeim/files/index-bg/](http://home.online.no/~wkeim/files/index-bg/)
- [http://www.index-bg.org/Frame/rights/Frame_all.htm](http://www.index-bg.org/Frame/rights/Frame_all.htm)
- [http://www.pickereurope.ac.uk/](http://www.pickereurope.ac.uk/)
- [http://www.100tophospitals.com/](http://www.100tophospitals.com/)
- [http://www.who.int/topics/en/](http://www.who.int/topics/en/)
- [http://www.waml.ws/home.asp](http://www.waml.ws/home.asp)
7. About the Health Consumer Powerhouse

The Health Consumer Powerhouse wants to become the centre for visions and action promoting consumer-related healthcare in Europe. Following the EU pattern of integration this do-tank has moved from the originally Swedish national level into an European identity.

Tomorrows’s health consumer will accept no traditional borders. To become a powerful actor, building the necessary reform pressure from below, the consumer will need access to knowledge to compare health policies, consumer services and quality outcomes. The Powerhouse wants to add to this development.

We are no regular think-tank, but – it is rather a Brussels “do-tank”, providing not only inspiring ideas but also practical solutions for health consumer information. The Index and other resources of consumer information will be the backbone of our operations.

We are a private company funded mainly by income from selling the systems knowledge we acquire developing index and other information tools as well as access to our market research. During 2005 we hope to present our first services designed directly for the health consumer.