A neo-institutionalist framework for the analysis of steering processes in integrated care: turning answers into questions

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Background
There is increasing knowledge internationally regarding steering processes for integrated care. However, transferring successful policy concepts between countries is difficult. A theoretical basis is needed to put specific outcomes into generalizable frameworks. Neo-institutional concepts are suitable for this purpose.
Methods
Outcomes of a transnational comparative research project on national and local steering processes for integrated (dementia) care in England and The Netherlands were analysed with the help of neo-institutionalist concepts. Specific outcomes were turned into generalized questions to build an analytical and empirical framework for comparative research and policy on steering processes for integrated care.
Results
Neo-institutional concepts allow framing structural and cultural institutional contexts which give shape to steering processes for integrated care. Models were developed for the analysis of (i) national steering processes for integrated care, (ii) local steering processes and integrated care outcomes, and (iii) specific areas of integrated care (e.g. dementia) and their national characteristics.
Conclusions
Although steering processes regarding the development and delivery of integrated care are complex and diverse, it is possible to conceptualize such processes in a general way so as to enhance the comparability and transferability of research outcomes from various countries. Further research is needed to complement, refine and further develop the initial models proposed.

European aid policy in health: why is an alternative needed?

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Issue
The European Union (EU) aid policy for health (e.g. its strategy on health & poverty reduction in developing countries) tends to allocate disease control to public and health care to private services, while neglecting health systems and access to care. This policy is neoliberal in that it:

- does not allow competition between a (subsidized) public sector and the private sector for services for which there is a demand in the market;
- attempts to derive as much public funds as possible towards the private sector.

We critically analyse the impact of this policy summarizing four own studies (of which two recently published).
Description
To assess the impact of EU aid policy on access to decent quality health care, we examined the health policies of three countries with contrasted approaches to show that health care privatization failed in Latin America (Colombia, Chile) and that an alternative health policy is possible (Costa Rica, Chile). We then present relevant epidemiological trends of target diseases (AIDS, tuberculosis, and malaria). To understand the failure of controlling these diseases, we performed simulations to estimate the success likelihood of malaria control in Africa under EU aid principles.
Lessons
In Latin America, countries performing best in health care delivery follow a health policy which, by EU aid standards, is not politically correct. In Africa, the observed failure to control diseases was unavoidable as programmes lacked the patients' pool necessary for early detection and continuity of care.
Conclusions
We formulate principles for an alternative aid policy. Instead of supporting disease control programmes, the European Aid could instead finance non for-profit, publicly oriented health services delivering health care and disease control in an integrated way. Managerial contracts would be useful to operationalize such support whilst securing democratization of such services.

Track E5: Workshop: How to use the European strategy for child and adolescent health and development

Chairpersons: Auke Wiegersma, President of the EUPHA section on Child and Adolescent Public Health, The Netherlands
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Following the WHO European strategy on child and adolescent health and Development, this workshop intends to look at how this strategy can be used for national activities and how EUPHA—as an European organization—could become active in this area. After the presentation of the WHO/EURO strategy, both a national and EUPHA reaction will be given after which a general discussion will take place as to the necessity of the strategy.

A European strategy for child and adolescent health and development

Mikael Ostergren

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This presentation will provide a brief overview of main health issues among children and adolescents in the WHO European region as well as the CAH strategy and accompanying tools for National policy and strategy development and implementation.

Balancing population, professionalism, and politics—expertise, application, and autonomy

Michael Rigby

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This presentation will analyse the requirements for successful progressing of the Child and Adolescent Health and Development Strategy, will identify that a balance of external evidence and national application is needed, and consider how international bodies such as EUPHA can promote both sides of the equation.

What role for EUPHA?

Auke Wiegersma

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In this presentation, we will examine what role EUPHA should play in the further implementation of the European strategy on child and adolescent public health and development.

Track E6: Quality of care

The effectiveness of computerized guidelines in medical practice: an international systematic review

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Background
Reducing undesirable practice variations in care has long been promoted for its potential to improve the quality of health care. Besides, Computerized Clinical Decision Support Systems, designed to help physicians in clinical decision making and based on patient-specific recommendations, are widely spreading. Due to these two issues, computerized guideline (CG) implementation strategies have been considered as useful means of improving health outcomes, optimizing resource utilization and patient care quality. This study carried out a systematic review of scientific articles to evaluate the effectiveness of CG on clinicians' behaviour, patients and organization outcomes.
Methods
Our literature search was carried out through electronic databases, using keywords, hand searching and analysis of further references from the bibliographic citations for each article meeting selected criteria. Analytical and experimental studies published in five languages, in adult population without time restriction. All studies were scored for methodological quality (MQ) on a previously validated scale. Proportions of studies reporting an improvement on physician, patient, and organization outcomes and their 95% confidence intervals (CI) were calculated. A logistic regression model, adjusted for study MQ, was used to investigate association between the outcomes of interest and study-specific covariates (i.e. degree of automation, user training, type of electronic suggestion).
Results
Out of 3672 articles found according to chosen keywords, 39 matched our criteria. Thirty were set in the USA, 6 in Europe, 2 in Asia and 1 in Australia. CG improved physician performance in 23 (67%), 95% CI = 51.9–83.4, of the 34 studies assessing this outcome. Out of 17 articles assessing patient and organization outcomes 8 trials (47%), 95% CI = 23.3–70.8, reported improvements for both issues. Studied covariates showed no association with outcomes.
Conclusions
Our initial results suggest that CG improve physician performance. The effects on patient and organization outcomes remain understudied and, when studied, inconsistent, so that further researches are needed.

Has the UK's new 'pay-for-performance' scheme for family practitioners led to good clinical practice or encouraged gaming?

Tim Doran

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Issue
In 2004, the UK National Health Service introduced a scheme to increase family practice income by up to 25%, dependent on performance against 146 quality indicator targets. To avoid inappropriate treatment, practices may exclude certain patients, e.g. the terminally ill, from the target calculations. However, this provision may be abused: practices can maximize their income by excluding appropriate patients for whom they have missed the targets.
Description
We analysed data from clinical computing systems in English family practices ($n = 8576$) in the first year of the pay-for-performance scheme, data from the UK Census, and data on characteristics of individual family practices. We report performance on clinical quality indicators for 10 chronic conditions. We examine whether the socio-economic, demographic and health characteristics of practice populations, and the characteristics of practices themselves, affect the quality of clinical care provided. We also assess the extent to which practices achieved high scores by excluding patients from target calculations.
Lessons
Practices achieved the clinical quality targets for a median 83.4% of eligible patients. Socio-demographic characteristics of the patients (age, socio-economic features), and practices (size of practice, number of patients per physician, age of physician) had modest but significant effects on performance. The exclusion rate was generally low (median 6%), but was the strongest predictor of achievement, and a small number of practices (1%) excluded >15% of patients.
Conclusions
Most UK family practices, including those serving deprived populations, attained high levels of achievement in the first year of the new pay-for-performance scheme. Practices could increase scores by excluding patients for whom, in their judgement, a quality indicator was not clinically appropriate. Further investigation of the few practices with high exclusion rates is needed to determine whether exception reporting was used for sound clinical reasons or in order to increase income.

Using unplanned admission to an ICU as a measure of patient safety

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Background
Measuring patient safety has been a constant matter of interest for researchers. The number of studies looking at mortality–morbidity, adverse events and critical incidents is substantial. New measurement methods have been recently developed: clinical indicators. Taking their roots in industrial engineering theory, they offer promise as quantitative measures of patient safety. Their number is however limited and their validity as patient safety measurement tools largely unproven. There is an