

7. How the EHCI was built

7.1 Strategy

Canadians will be well served by better understanding the range of possibilities for healthcare that exist in Europe. The Index will make it possible for consumers to approach healthcare as critically as they do other vital services, and this can only benefit everyone involved. Responsive, consumer friendly healthcare with excellent outcomes is possible – it is being achieved in the top performing states in Europe, and can be achieved in Canada as well.

In April 2004, HCP 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 providing healthcare) by 12 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 third annual update of the Swedish index on May 16, 2006, again confirmed for 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 of the index throughout Sweden confirmed that the image of healthcare is rapidly moving from rationed public goods to consumer-related services that are measurable by common quality perspectives.

For the Euro Health Consumer Index, the Health Consumer Powerhouse aimed to follow the same approach, *i.e.*, selecting a number of indicators that described to what extent the national healthcare systems are user-friendly, thus providing a basis for comparing different national systems.

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

In the initial years of index building, opinion brokers and policy-makers – like journalists, experts and politicians – will be the key audience for the index. Gradually, the health consumer could become the main user along with service providers, payers and authorities. Such a development will require user-friendly services and a deep knowledge of consumer values. Interactivity with users and other parts of the European healthcare society will be another key characteristic.

The Euro-Canada Health Consumer Index is a step toward bringing consumer-friendly healthcare to Canada. Primarily, the very existence of the Index will produce an atmosphere in which Canadians can see how their system succeeds and fails. Canada lacks a culture in which consumers have high expectations of healthcare services, and significant reform is unlikely without this.

7.2 The starting point: Euro Health Consumer Index 2007

7.2.1 Preliminary selection of indicator areas for study

The aim was to select a limited number of indicators within a definite number of evaluation areas that when taken together show how the healthcare consumer is being served by the respective systems.

The work on the EHCI 2007 began with the 2006 index with the desire to retain the main structure so that the possibility of making comparisons over time would not be destroyed. In addition to the indicator changes described in section 5.1 above, the following indicators were considered for inclusion. The Euro-Canada Index was developed in harmony with the EHCI 2007, using parallel methods and data gathering.

7.3 Production phases

EHCI 2007 was constructed under the following plan:

7.3.1 Phase 1

Mapping of existing data

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

- Web search
- Telephone and e-mail interviews with key individuals
- Personal visits when required

Web search

- a) Relevant bylaws 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) Patients' 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) Visits to key information providers

7.3.2 Phase 2

- Data collection was undertaken to assemble information to be included in the EHCI 2007.
- Identification of vital areas where additional information needed to be assembled was performed.
- Collection of raw data for these areas
- Visits by the EHCI researchers to health ministries and/or state agencies for supervision and/or quality assurance of healthcare services.

7.3.3 Phase 3

- Score update sheet sent out by e-mail.

On June 20, 2007, all 29 states received their preliminary score sheets (with no reference to other states' scores), which asked for updates/corrections by July 31. The e-mail was sent to contacts at ministries/state agencies as advised by the states during the spring of 2007. Two reminders were sent out: one on July 19 and one on August 3. Corrections were accepted until September 10, by which time replies had been received as listed in section 5.5.2 above.

- EHCI construction
- Web-solution building
- Consulting European patient advocates and citizens through HCP surveys performed by external research facilities (PatientView, U.K.).

The 2007 survey was dedicated to the Waiting times and **Readily accessible register of legitimate doctors** indicators. Four hundred and eighteen patient organizations responded. The lowest number of organizations responding from any one country was four. The consistency between responses from different organizations was surprisingly good, as was the consistency with data from public sources. This survey was therefore used as the main data source for the Waiting times indicators.

For the **Readily accessible register of legitimate doctors** indicator, the survey responses showed a slightly negative bias. For states such as Bulgaria and Italy, where web-based registries of legitimate specialists (Bulgaria did not include speciality qualifications) are readily accessible, most organizations said that this information was difficult to access. In cases like these, it was decided to be generous in the awarding of country scores.

7.3.4 Phase 4

Project presentation and reports

- A report describing how the EHCI was constructed
- The presentation of EHCI 2007 at various events on October 1 and the following weeks in Brussels and other cities.

Online launch on www.healthpowerhouse.com

7.3.5 Phase 5

The inclusion of Canada

- A partnership between HCP and FCPP was created in order to integrate Canada into the EHCI 2007.
- FCPP staff studied HCP's methodology and prior indexes.
- A list was compiled of equivalent or comparable metrics to allow Canada to be evaluated in parallel with the 29 countries in the EHCI 2007.
- Data collection and verification.

Much information about the EU member states has already been harmonized and prepared in a consistent format. Some Canadian data were not quite in identical format, for example the calculation of infant mortality, and where this was the case, every effort was made to ensure that the comparison between Canada and the 29 European countries was fair.

All Canadian data were collected from publicly available sources, including government data from all three levels of government, public and private institutions for the study of healthcare and health policy and existing literature and research. The results of this data collection were further examined in the context of existing literature, as well as the experience of practitioners, consumers and administrators, to verify that they correspond reasonably well with the reality of healthcare "facts on the ground." Data were obtained from publications online, published periodicals, government documents and correspondence with sources.

The first Euro-Canada Index had its virtual release at www.healthpowerhouse.com and www.fcpp.org and it was launched January 21, 2008, in Ottawa and Brussels and throughout Canada in subsequent days and weeks.

Additionally, the first intra-Canadian index, which compares the healthcare systems of all 10 provinces, will be released later in 2008. The extension of index methodology into assessing the strengths and weaknesses of provincial healthcare regimes will shed further light on Canada's best and worst health policy practices.