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Belgian Health Care Knowledge Centre

KCE REPORT 313S

PERFORMANCE OF THE BELGIAN HEALTH SYSTEM – REPORT 2019

SUPPLEMENT

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HEALTH SERVICES RESEARCH

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PERFORMANCE OF THE BELGIAN HEALTH SYSTEM – REPORT 2019

SUPPLEMENT: REJECTED INDICATORS

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APPENDIX REPORT

LIST OF TABLES

1. REJECTED INDICATORS

Hereafter are the lists, ordered by chapter, of indicators that have been considered but not selected, with an explanation of the reason for their exclusion.

Table 1 – Quality of care – safety: rejected indicators

Indicator	Reason for exclusion
Excessive polymedication (9 or more different medicines within last 24 hours) (% pop aged 65+)	No recent data available

Table 2 – Accessibility of care: rejected indicators

Indicator	Reason for exclusion
Individuals with a private health insurance (% of the population)	For the 2019 performance report, there were discussions on the interest of evaluating the proportion of individuals with private health insurance. Nevertheless, current data do not allow us to calculate this indicator appropriately (e.g. double counting for individuals having a voluntary insurance both with a private company and with a sickness fund). More precise data on this indicator would, however, be useful in the future, as it is included in European databases (OECD, Eurostat) with numerous limitations, showing a misleading picture of the Belgian situation (overestimation).
Nursing hours per patient day (NHPPD)	For the 2019 performance report, there were discussions on the interest of reporting nursing hours per patient day as principal indicator, in addition to the patient-to-nurse ratio. Nevertheless, since 2016, the registration of the nursing hours is no longer compulsory. NHPPD was therefore only reported as secondary indicator in the patient-to-nurse ratio technical fiche.
Unmet dental needs	Available data do not seem reliable.

Table 3 – Sustainability of the healthcare system: rejected indicators

Indicator	Reason for exclusion
S-12 W.A.I.T indicator for innovative medicines (in days)	W.A.I.T indicator for innovative medicines is not anymore reported in the Performance report 2019 for the following reasons: Firstly, this indicator is currently based on data coming from industry (European Federation of Pharmaceutical Industries and Associations) and the report is no longer public (only a PowerPoint presentation is available). This makes difficult to assess the reliability of data provided. Secondly, the coverage rate is underestimated due to methodologic choices: To carry out the study, they selected 145 medicines that obtained a marketing authorization by EMA between January 2014 and December 2016 (145 out of 232). Details on how the selection was done and which pharmaceutical products were selected were not published. Of these 145 drugs, 68 (47%) were on the list of drugs reimbursed in December 2017 (datum of the analysis). However, the reasons for non-inclusion in the list on December 2017 can be various: 1) the company has not yet applied in Belgium, 2) the reimbursement was refused, or 3) the procedure is still in progress. This low percentage in Belgium could therefore simply be explained by the fact that companies wait some months before introducing a demand in Belgium (as shown by the second indicator of the report). Without having the list of these 145 selected drugs, we cannot perform more in-depth analysis to have a precise estimation of the coverage rate. We therefore decided to not report this coverage rate and to make calculations by ourselves for the next report. Thirdly, the delay between EU marketing authorisation (MA) and national accessibility is more dependent of the pharmaceutical companies' strategies than on the "performance" of Belgian procedures. Once companies have introduced a reimbursement request, the minister has 180 days to provide a decision. This delay is set by law in accordance with the European Transparency Directive. What has an impact, therefore, is the delay between the MA and the introduction of a reimbursement request by the company. Even if this reflect the capacity of the Belgian market to attract innovative pharmaceuticals, a long delays is not due to a lack of "performance" of the Belgian procedures. As showed by the study, pharmaceutical companies choose first to introduce pharmaceuticals in large and advantageous countries such as Germany.

Table 4 – Preventive care: rejected indicators

Indicator	Reason for exclusion
Incidence rate of pneumococcal infection in nursing homes	No readily available data
Proportion of the population with a "contact with a dentist for preventive care" 2 different years during the last 3 years	Preventive care are not always registered if the dentist gives curative care (underestimation)
Cervical cancer screening (P-8)	No validated methodology to calculate the coverage at the Belgian level
Colorectal cancer screening (P-9)	No validated methodology to calculate the coverage at the Belgian level

Table 5 – Mental health care: rejected indicators

Indicator	Reason for exclusion
Proportion of patients committing suicide while in mental health treatment	To avoid confusion, the indicator of the previous report (Deaths due to suicide (/100 000 pop), MH-1) was kept.
Psychiatric care hospital beds per 100,000 inhabitants	Contextual indicator, few added value compared to indicator *Number of hospitalisation days in psychiatric hospital wards (/1000 pop)* (MH-10)
Proportion of children with antidepressants prescriptions over the year	Included in the indicator *Use of antidepressants (% of adult population, at least once in the year)* (MH-7)
Proportion of psychiatric patients with paid employment	Not possible to identify psychiatric patient in the indemnity datamart (IMA – AIM).
Follow-Up After Hospitalisation for Mental Illness (7-Day Follow-Up)	Data coupling (RPM – MPG with IMA – AIM) is not possible
Excess mortality schizophrenia/etc.	OECD indicator; currently no Belgian data available.
Patient satisfaction/experience (Vlaamse patiënten Peiling)	No national data available at the moment; mentioned in the main report

Table 6 – Care for the elderly: rejected indicators

Indicator	Reason for exclusion
Average length of stay in residential facilities for the elderly (RIZIV-INAMI data)	This indicator is difficult to interpret, there is no international comparison and long stays might be necessary as people might live longer and hence stay longer.
Percentage of population aged 50+ who received professional services at home (help with personal care, help with domestic tasks, meals-on-wheels or help with other activities)	Concerns services outside the healthcare system.
Percentage of population aged **50+** who r**eceived help from others from outside the household (a family member that does not live with the patient, or a colleague or neighbour) for practical household assistance, help in paperwork or personal care within 12 months preceding the survey** (SHARE data)	Overlap with indicator ELD-3 Informal carers (% of population aged 50+)
Percentage of population aged 50+ who received help from a person within the household for personal care and assistance in basic activities (washing, clothing, getting up) received daily, or almost daily within three months preceding the survey (SHARE data)	Overlap with indicator ELD-3 Informal carers (% of population aged 50+)
Medication stops in 75+ according to STOPP criteria. Stop of at least one of the following groups: lipid lowering drugs, NSAIDs, antipsychotics, antidepressants, PPIs (EPS data)	Indicator was retained but data were not available
Prescription of statins in patients 80+ (start/stop/globally)	Overlap with previous indicator on medication stops

Table 7 – Mother and new-born: rejected indicators

Indicator	Reason for exclusion
Proportion of pregnant women who get pertussis maternal vaccination	The e-Vax data still suffer from important methodological weaknesses that do not make them yet comparable to the data available in Flanders. In addition, it is difficult to interpret this indicator in terms of health system performance.
Ultrasound foetal assessments of pregnancy.	Redundant with the selected indicator on the number of antenatal consultations. In addition, **u**ltrasounds are under-recorded.
Percentage of women who deliver without health insurance coverage	Weaknesses in the assurance type coding in RHM-MZG make this indicator difficult to interpret.
Percentage of new-born who are discharged from hospital at the same time as the mother	Not measurable
Teenage pregnancies	In addition to data on deliveries, data on voluntary termination of pregnancy would be necessary. However these data are not available in Belgium since 2012. In addition, it is difficult to interpret this indicator in terms of health system performance.
Breastfeeding percentage at 3 or 6 months	Only partial data are available
Prenatal consultations during 1st trimester of pregnancy	Impossible to identify the 1st trimester of pregnancy in IMA-AIM database, as some pregnancies last less than 9 months
Incidence of (third- and fourth-degree) tears to the perineum	Unavailability of data
Presence of the paediatrician at delivery	No national guideline, not always required presence, and highly dependent of hospital's protocols