

RESULTS OF THE EUROSAI SURVEY OF HEALTH CARE PERFORMANCE AUDITS

1 Introduction

At the EUROSAI Governing Board Meeting in Helsinki in March 2015, three areas of cooperation in which SAIs could have mutual information interests were agreed on. One of these areas was health care, in which practical coordination is the responsibility of the National Audit Office of Finland.

In all EU countries, health expenditure has been growing faster than national income during most of the second half of the 20th century. In addition to increasing health care costs, ageing, globalisation and the general financial situation pose a challenge to the funding base of health care in terms of its economic sustainability and availability of services. Findings on wasteful use of resources have been reported in a number of studies. These include sub-optimal setups for the delivery of care, inefficient provision of acute hospital care, fraud and corruption in health care systems, substantial and unexplained variation in the quality and quantity of care between and within countries and sub-optimal mix of preventive versus curative care.¹ Each country is endeavouring to resolve the problems and challenges within the context of its own health care system. Even though there is a wide variety of different public health care systems, there are nevertheless practices that could be shared by a large number of countries.

This paper presents the results of the survey conducted among the EUROSAI members in the summer of 2015. The purpose of the survey was to gather new ideas and new innovative approaches with which EUROSAI could help its member SAIs to better respond to accountability and audit challenges in health care. The survey is also an attempt to produce an overview of the problems in the health care systems in different countries and to determine whether political decisions made during the past few years have had an effect on the viability of the systems. The questionnaire was sent to 47 countries and 26 of them submitted responses. The response rate was thus 60.5 per cent.

2 Results

2.1 The mandates of SAIs to audit public health care

Almost all SAIs have the right to audit public health care. Only one SAI out of 26 reported that it does not have such a mandate. In the SAI of Luxembourg the control of the public health care institutions falls under the responsibility of the "Inspection of public health care" (Inspection générale de la sécurité sociale) of the Ministry of Public Health Care.

Six SAIs reported some limitations to their mandate to audit public health care. The National Audit Office of Finland and the Swiss Federal Audit Office have the right to audit health care at central government level but their right to audit health care at local government level is limited to special cases. This is also the case with the Supreme Audit Office of the Czech Republic which noted that its mandate does not include audit of financial resources or the property of municipalities. Furthermore, the Czech SAO does not have a mandate to evaluate the quality of health care as a whole as the services are provided by different entities (state and non-state). However, it has the right to audit the man-

¹ Efficiency estimates of health care systems. Economic Papers, June 2015. European Commission.

agement of state property and financial resources collected under the law for such purposes as health and social insurance.

2.2 Political decisions affecting health care

The SAIs were asked to report what kind of political decisions concerning health care had been taken in their countries during the past five years. The political decisions on health care were grouped in six different areas: decisions that concerned funding of health care, method of organisation, actors, availability of services and use of open data in the promotion of health policy objectives.

Funding

According to the responses, there has been an increase in public health care expenditure in all countries in recent years. The changes in the increase in expenditure have been greater than in other administrative branches of the general government and this trend has been particularly noticeable in Poland. In many countries, lack of sustainability in the health care funding base is connected with the economic downturn. There have been efforts to strengthen the funding base of health care by making changes to existing funding practices. For example, in Germany, the federal government now accounts for a lower share of public health care funding. There have also been efforts to strengthen the funding base by changing the manner in which medicines are priced. For example, Bulgaria has revised its price regulation scheme, while in Poland the value added tax on medicines has been lowered.

Method of organisation

According to the responses submitted by the SAIs, many countries are in the process of reforming their health care systems or are planning to introduce reforms. Major health care reforms are under way in such countries as Finland and Ukraine and the purpose of these changes is to impact health care funding, as well as health care services and their use.

By introducing new ways of providing services, countries are also endeavouring to change the division of labour among health care personnel. For example, in Estonia and Finland, job descriptions of nurses have been changed and nurses now play a more important role in care work.

Service structures have also been overhauled in many countries. Reducing inpatient care and putting more reliance on outpatient services has been one of the most effective reforms. For example, in Latvia patients are now provided with diagnosis, surgery and therapy services on an outpatient basis. This has shortened the duration of hospital stays, reduced the number of treatment days and helped to cut costs.

Health care services have also been reorganised by harmonising the range of services offered by the public sector. For example, in Cyprus and Denmark, unified treatment paths have been determined for a number of diseases.

In some countries health care reforms have led to the establishment of entirely new organisations. For example, Austria has introduced a statutory sickness insurance scheme, while Moldova has introduced a health insurance scheme. The aim in both systems is to steer the funding and organisation of health care.

Advances in health care technology have also made the reorganisation of services easier. For example, in Kazakhstan, the introduction of new cardiology technology has led to a reduction in the number of first response units.

Furthermore, patients' freedom of choice has been an important factor guiding Nordic countries in their health care reforms. By providing patients with more choice countries also aim to improve service quality and make the services more widely available.

Actors

The new ways of organising health care have led to an increase in the number of supervisory authorities. For example, Sweden has established a social welfare and health care supervisory agency and a unit for assessing occupational health care and treatment services. Malta has established a separate agency for monitoring the implementation of the national health strategy, while Kazakhstan now has an agency the task of which is to ensure that citizens can make use of their right to freely select a hospital. Austria has established a supervisory unit that steers health care reforms in the nine states.

New health care services also require new types of health care actors. For example, Moldova has established a separate agency specialising in the procedures concerning the purchasing of medicines and medical equipment.

Availability of services

Many countries have improved the availability of services by giving patients the right to choose their place of treatment and by introducing a treatment guarantee (access to treatment by a specific deadline). Especially in the Nordic countries, availability of services has been improved by using both approaches.

In Malta, the focus in availability improvements has been on basic health care but efforts have also been made to improve the availability of cancer treatments in recent years. This has been achieved by using operating rooms more efficiently.

In Finland, the availability of services has been improved by providing nurses with a limited right to prescribe medicines. At the same time, more use is now made of technology in care and treatment work and in services supporting independent living. In Portugal, too, services have been made more widely available by introducing new medical technologies.

Use of open data in health promotion

Uniform health care ICT services are deemed to bring substantial improvements in health care quality and to reduce costs. For this reason, many countries have developed electronic information systems to promote citizens' health. In many countries, the development work is not yet complete. For example, the only result of an e-Health development project carried out in Lithuania between 2007 and 2015 was a report detailing how information systems could be used in health care. In some countries, the development of electronic information systems has not progressed as planned. For example, in Germany the development work has been hampered by technological problems, opposition by hospitals and doctors and disagreements on costs.

In some countries, there has been progress in the development of electronic information systems. For example, Finland has introduced electronic prescriptions, electronic client and patient documents, mobile entries and client plans, teleconsultations and an online reservation system. In Estonia, the electronic health care system has been in use since 2012. In Latvia, the first electronic prescriptions and patient forms were introduced at the start of this year as part of an e-Health service reform. There are also plans to introduce an electronic health card. In Switzerland and Bulgaria, the aim is to introduce a system for electronic patient documents at some point.

An electronic patient portal in which information about the patients is shared between patients and health care professionals is already in use in Portugal but still under development in Kazakhstan.

In Denmark, electronic services are also used in research. An example of this is “Sundhedsprofil 2010”, a nationwide health survey conducted every four years, in which information about citizens’ smoking habits, mental health, weight and physical exercise is collected.

2.3 Different types of health care audits conducted between 2005 and 2015

The SAIs conducted a large number of audits of health care between 2005 and 2015. The total number of audits was 983 (see Table 1).

Table 1. Number of health care audits conducted between 2005 and 2015

Performance audits	481
Compliance audits	441
Fiscal policy audits	61
Total	983

The SAIs reported 481 performance audits dealing with issues relating to health care. The number of compliance audits was 441. The largest number of performance audits of health care (117) was reported from Poland. The total number of fiscal policy audits was 61. The largest number (31) was reported from Lithuania where NAOL conducts annual fiscal policy audits of the Ministry of Health of the Republic of Lithuania and the Compulsory Health Insurance Fund. In addition to the auditing by SAIs, ECA has also published a special report on the European Union’s public health program 2003-2007 (Special Report 2/2009).

2.4 Health care in the current audit plans

Altogether 24 SAIs out of 26 stated that health care is included in their current audit plans. Most of the planned audits were conducted in 2015 or will be conducted in the near future (in 2016 and, in some cases, in 2017). The topics of the audits vary greatly. However, some common themes can be identified on the basis of the responses. They include

- the efficient use of human resources in health care (3 audits)
- the equal quality of care in different parts of the country (2 audits)
- managing the waiting lists/access to medical services (4 audits)
- mental health care services (8 audits)
- children’s health care (5 audits)
- reimbursement of medicines (3 audits)
- services for the disabled (4 audits)
- information security and reliable use of health data (2 audits)

Other topics include the reimbursement of dental care, coordination of care for diabetes, prevention of cancer, subsidies for home care and emergency medical services. There is also a great deal of variety in the audited actors. In most countries, the audits are conducted in the Ministry of Health. Other common actors are health insurance funds, national institutes for health development and national agencies for medicines.

2.5 Problems related to health care system and their estimated gravity

The respondents were presented with statements listing different types of problems related to health care systems. The statements were grouped into five areas: services, costs and funding, steering, personnel and information. Each area was further divided into more specific statements. The respondents were asked to indicate for each statement how serious the problem was in their country's health care system.

2.5.1 Health care ensemble

The results showed that the most serious problem in health care concerns the funding and costs of health care. Even though the problems related to health care services were deemed to be moderate, in this area there were wider differences between the SAIs' responses than in other areas. At the same time, the number of respondents stating that information-related problems are minor or moderate was substantially higher than the number of respondents considering them serious or overriding. In the problems concerning personnel and the steering of the health care systems, the SAIs were clearly divided into two groups. Some of the SAIs were of the view that the problems concerning personnel and steering are moderate whereas others deemed them to be serious. (Figure 1)

The results also showed that the seriousness of the health care problems varies within a country and within specific problem areas. For example, in some SAIs, most of the problems concerning health care were considered to be serious or overriding, whereas the problems related to personnel and information were deemed to be minor or moderate. As regards personnel-related problems, many respondents were of the view that personnel shortages are a serious or overriding problem whereas professional skills were not seen as a problem at all.

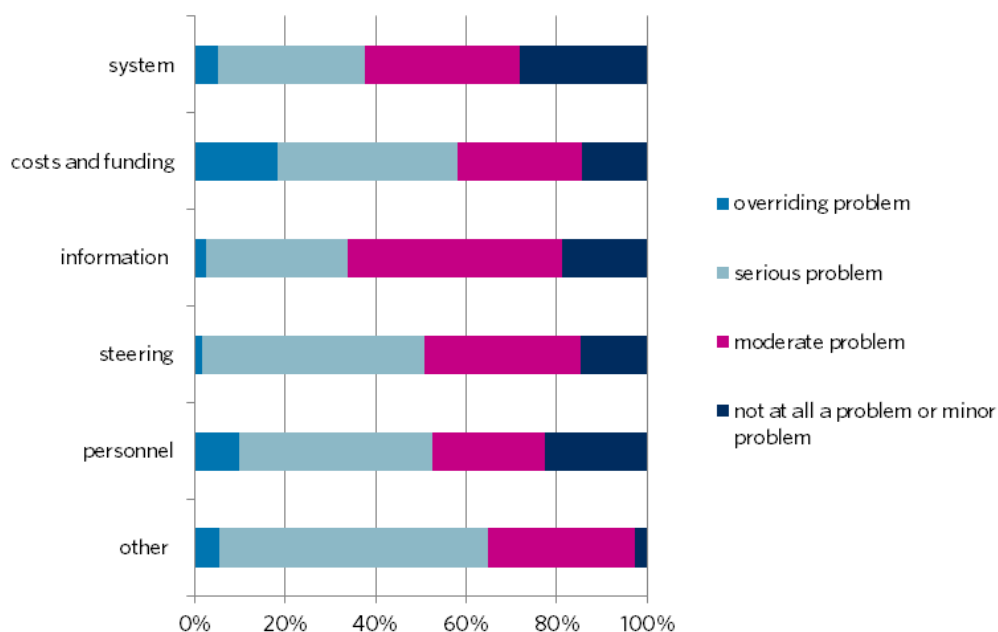


Figure 1. Problems related to health care ensemble and their estimated gravity

2.5.2 Health care services

The results for specific statements within each area are presented in figures 2-6. The results show that nearly all SAIs submitting responses (16 out of 21) were of the view that the problems concerning the use of electronic information systems are of serious nature. Moreover, almost half (45%) of the SAIs stated that corruption and abuses are a serious problem in health care. However, at the same time more than half of all the SAIs responding to the survey were of the view that only a small number of patients attempt to obtain services or transfer payments on the wrong grounds or that the problem does not exist at all in health care. Poor patient safety and inadequate control of health hazards appearing in the living environment were also deemed to be minor problems. At the same time, however, nearly half of all SAIs submitting responses were of the view that insufficient quality control over services produced by private service providers and the mismatch between supply and demand for services are moderate problems. (Figure 2)

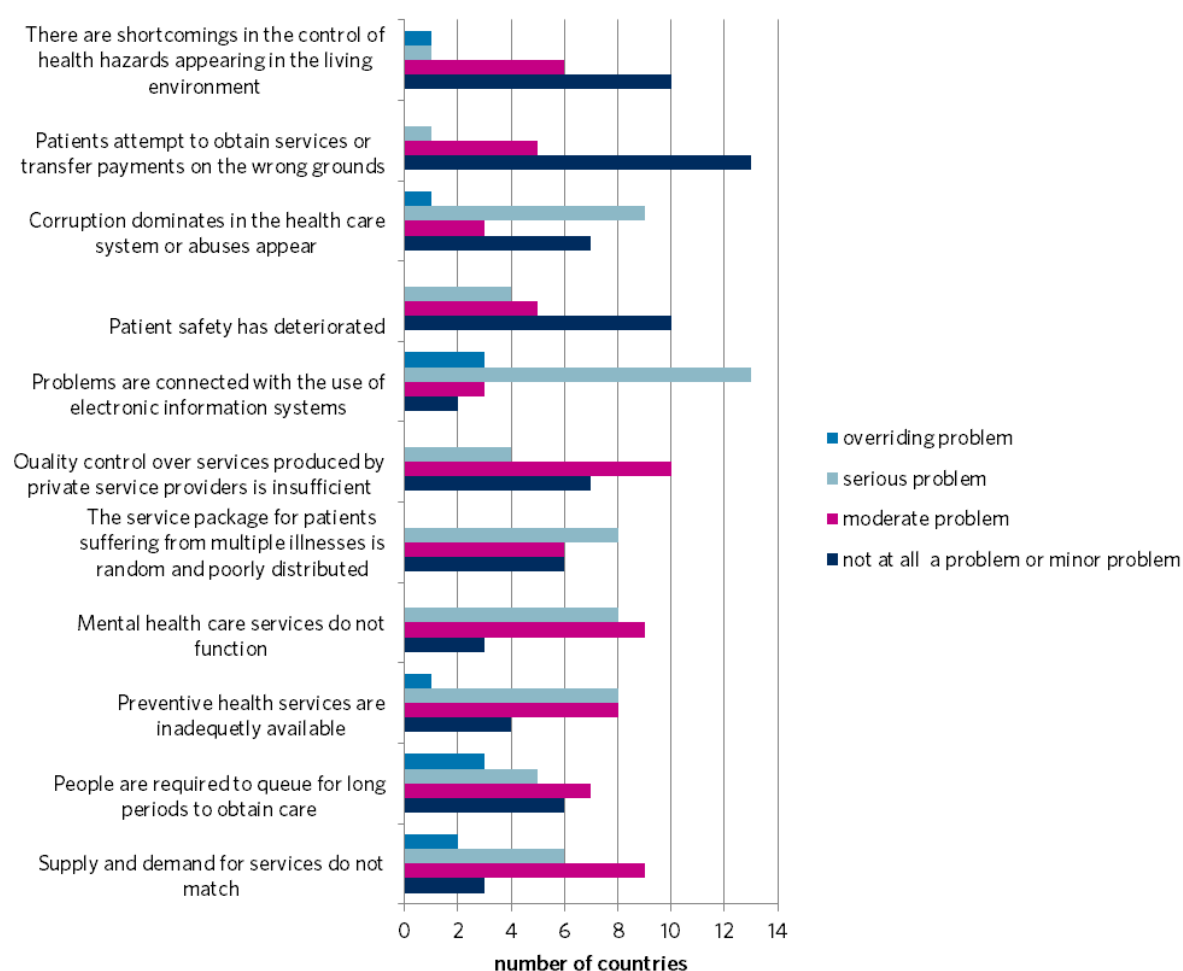


Figure 2. Problems related to health care services

2.5.3 Health care costs and financing

Increase in the costs of long-term nursing resulting from ageing was overwhelmingly (71% of the respondents) seen as a serious problem in health care services. Unsustainable health care funding base and the costs arising from the introduction of new technology were also deemed to be serious problems. Even though new technology helps to make operations more cost-effective it is also expensive, which in turn adds to the costs of the services. (Figure 3)

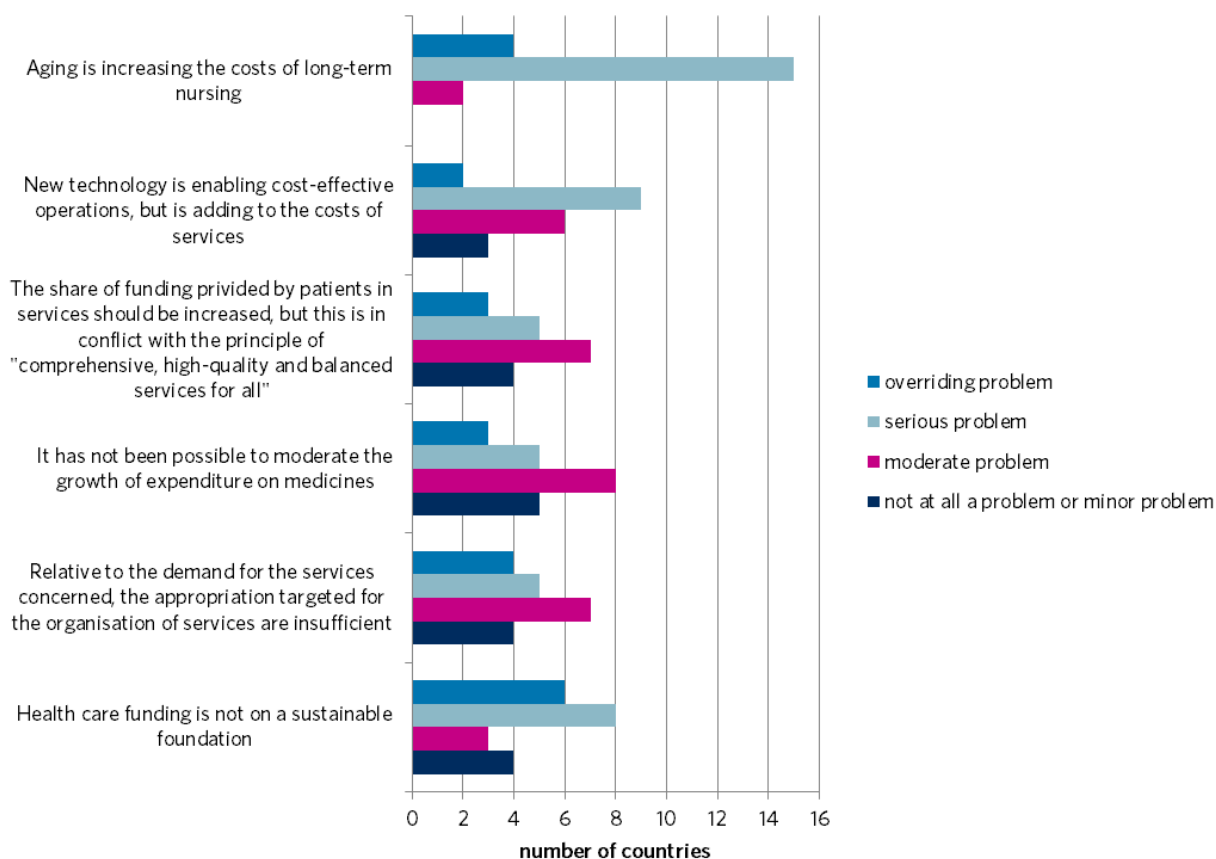


Figure 3. Problems related to health care costs and funding

2.5.4 Information

The results suggest that in health care, problems concerning information are not deemed to be of paramount importance in the same manner as the problems in the other areas listed in the questionnaire. The majority of the SAIs submitting responses were of the view that information-related problems are moderate, except for the comparability of information used for steering. This was the only information-related statement where the responses were more or less equally divided between the three degrees of seriousness. (Figure 4)

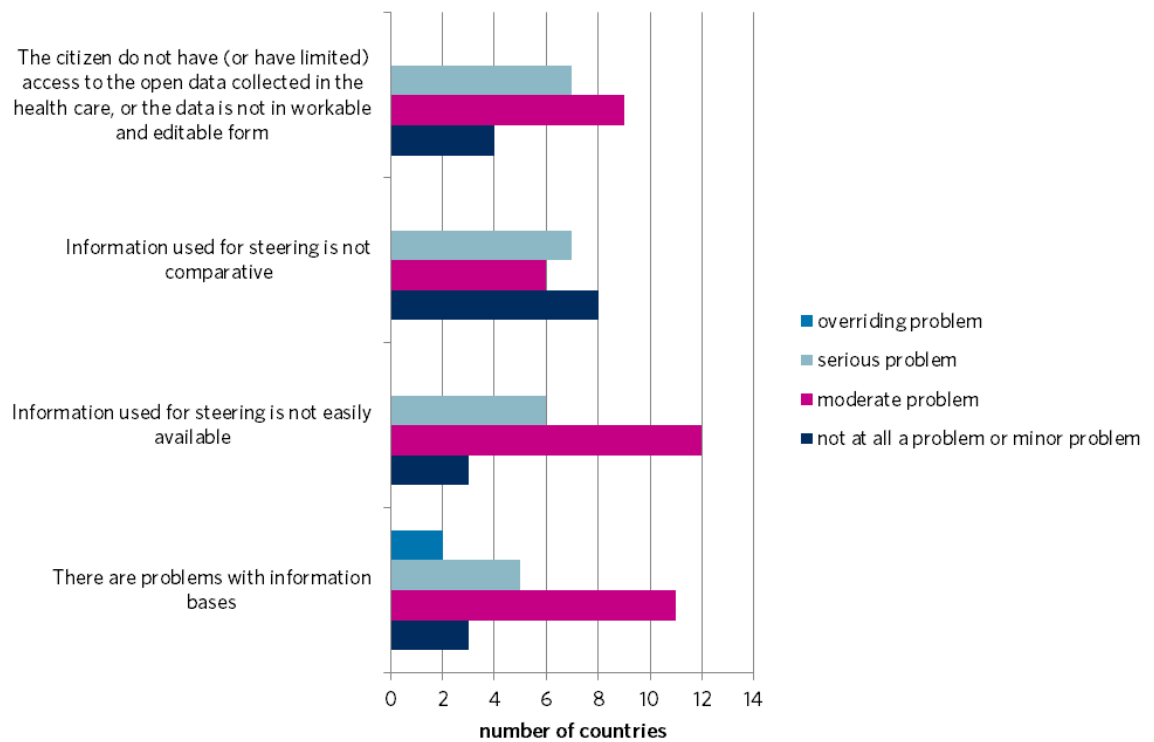


Figure 4. Problems related to information

2.5.5 Steering

The problems concerning health care steering were deemed to be moderate. The majority of the SAIs submitting responses (57%) were of the view that the failure to prevent/control chronic illnesses is a serious problem. Half of SAIs were also of the view that there are serious problems in the national guidelines regarding health care. (Figure 5)

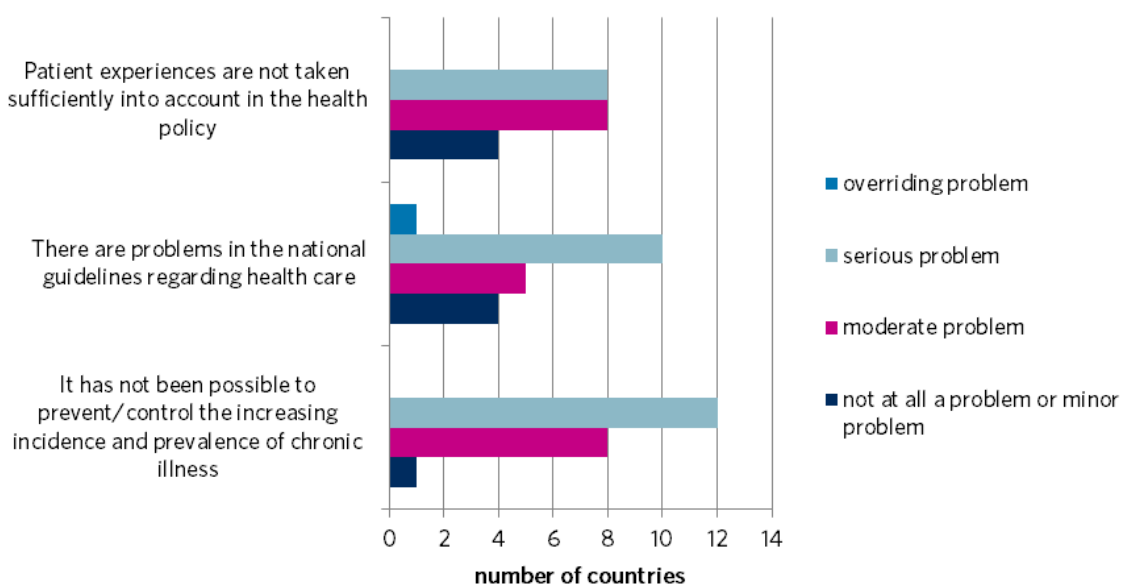


Figure 5. Problems related to steering of health care system

2.5.6 Health care personnel

Most of the problems pertaining to health care personnel concerned the shortage of personnel. Two thirds of the SAIs submitting responses considered the shortage of personnel to be a serious problem, while 14 per cent were of the view that it is the overriding personnel-related problem. Only a small number of countries had serious problems in the recruitment of skilled health care personnel. (Figure 6) For example, in Poland recruitment of skilled personnel to other countries has seriously weakened the availability of health care services. In Denmark, a shortage of psychiatrists has led to a situation where health care districts have been forced to train and hire psychologists to tasks normally performed by psychiatrists.

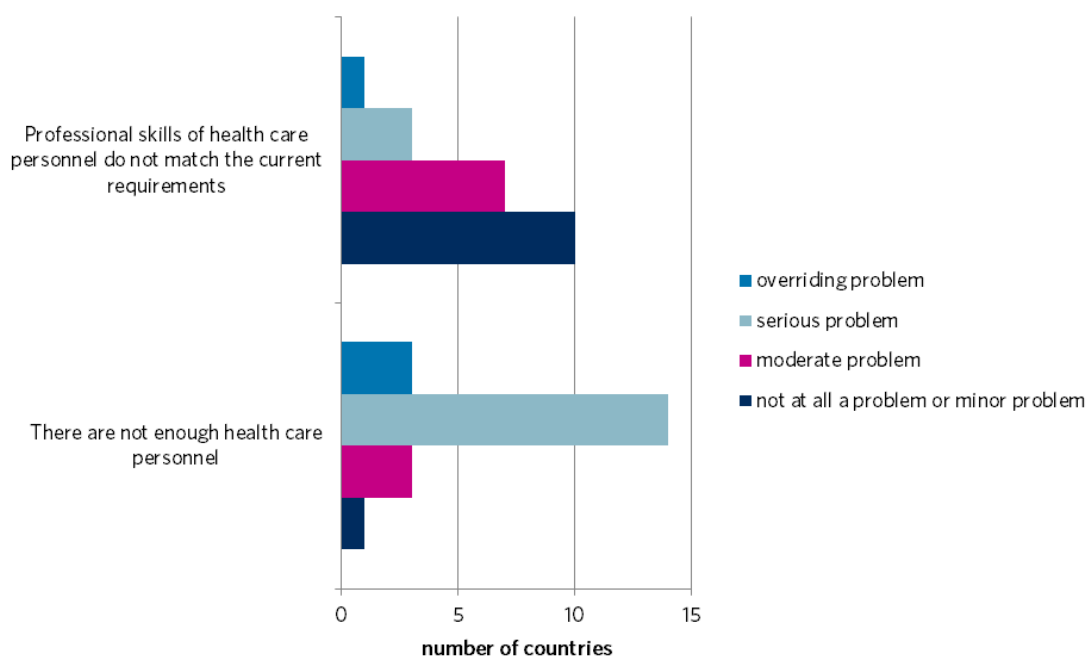


Figure 6. Problems related to health care personnel

2.5.7 Other health care issues

The respondents were also asked about other problems related to health care that were not included in the problems discussed above. Only 12 SAIs (57% of those taking part) submitted responses. Some of the open responses were identical with the responses provided in connection with the above statements.

However, the SAIs also highlighted four other problems in their open responses. These problems concerned

- the status of patients in health care
- unequal distribution of special health care services inside the country
- lack of information about the use of the funding allocated to health care
- hospitals

2.6 SAIs' interest in participating in cooperation and types of participation

The SAIs were also asked about their interest in health care cooperation. The results showed that there are varying degrees of interest in participating in such cooperation. The majority (15 out of 25) of the SAIs stated that they would be interested in cooperation in the field of health care. Nine respondents were more cautious, stating that they might be interested in participating in such cooperation. Only one SAI stated that it is not interested in any kind of cooperation. The results also showed that East European countries are significantly more interested in taking part in health care cooperation than West European countries.

When the SAIs were asked what kind of cooperation they would be interested in the answers were very clear. Of the different alternatives, knowledge sharing with other SAIs via website and/or workshop attracted the greatest degree of interest (86% of the respondents). Half of the SAIs stated that they would also be interested in taking part in parallel audits. At the same time, there was less interest in cooperation via web seminars. Only eight out of 22 SAIs stated that they would be interested in such new form of cooperation.

The SAIs were able to choose one or several of the cooperation models. The majority of the SAIs stated that they would only be interested in continuing cooperation based on knowledge sharing. At the same time, six SAIs stated that they would be interested in all forms of cooperation listed in the questionnaire. Four SAIs were only interested in cooperation based on knowledge sharing and parallel audits. Two SAIs stated that they would be interested in cooperation via web seminars and knowledge sharing or cooperation that would be exclusively on the basis of parallel audits. (Figure 7)

The SAIs were also asked from which perspective they would be ready to participate in a possible parallel audit. There was a great degree of unanimity among the SAIs responding to this question. In their view, the parallel audit should be conducted from the perspective of performance audit. Six SAIs were also prepared to take part in a parallel audit conducted from the perspective of a compliance audit.

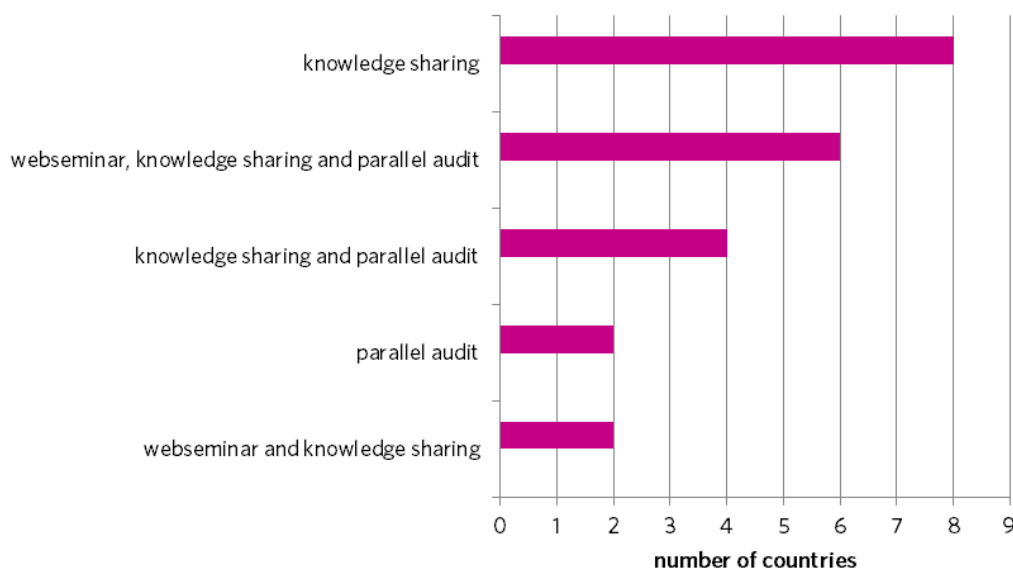


Figure 7. Forms of cooperation in which the SAIs would be interested

2.7 Thematic areas in which the SAIs would be willing to cooperate

The SAIs were also asked to list the health care themes in which they would be willing to cooperate. The responses showed that the interest in cooperation was largely limited to the themes where the SAIs had also identified serious problems. Most respondents were interested in cooperation in matters pertaining to health care funding and service system. Only three SAIs were interested in audit methods.

Organisation of health care service system

- public and private health care and regulation (National Audit Office of Malta)
- preventive health care (National Audit Office of Estonia)
- organisation and availability of health care across national borders (National Audit Office of Estonia)
- division of labour between care personnel and doctors (Austrian Court of Auditors)
- number, quality and well-being of the personnel (National Audit Office of Bulgaria)
- performance of organisations in emergencies (State Audit Office of Croatia)
- organisation of basic health care: family doctor model (National Audit Office of Lithuania), basic health care in general (National Audit Office of Malta)
- division of competence between the authorities and local health care providers (National Audit Office of Lithuania)
- electronic information systems: developing e-Health in the EU, better management of client information so that quality of care can be improved (State Audit Office of Croatia, The Supreme Audit Office of Poland, National Audit Office of Lithuania)
- making use of hospital premises (Cour des comptes du Grand-Duché de Luxembourg)
- utilization of hospital facilities (Swiss Federal Audit Office)
- programmes of the Ministry of Social Affairs and Health (Cour des comptes du Grand-Duché de Luxembourg)
- organising mental health care (National Audit Office of Estonia, National Audit Office of Lithuania)
- prevention in health care (National Audit Office of Estonia)

Treatment of individual illnesses - organisation and funding

- funding of prevention and protection against contagious diseases (The Accounting Chamber of Ukraine)
- treating cardiovascular diseases and providing funding for the treatment (The Accounting Chamber of Ukraine)
- prevention, diagnosis and treatment of viral hepatitis and funding the process (The Accounting Chamber of Ukraine)
- providing renal replacement therapy and funding the therapy (The Accounting Chamber of Ukraine)
- treatment of chronic illnesses (National Audit Office of Estonia)
- children's health care (National Audit Office of Estonia)
- terminal care (Swiss Federal Audit Office)
- cost of providing medical care for diabetes (Austrian Court of Audit)
- cost impacts of new medicines in institutional care (State Audit Office of Croatia)

Health care funding systems and models

- health care funding models and comparisons between them (Court of Audit of the Republic of Slovenia, Portuguese Court of Auditors)
- compensations paid in private and public health care (Cour des comptes du Grand-Duché de Luxembourg)

- assessing the effectiveness of health care services provided by sick funds (National Audit Office of Lithuania)
- slowing down cost increases (National Audit Office of Finland)
- financial impacts of medical treatments (Swiss Federal Audit Office)
- DRG pricing (National Audit Office of Estonia, Bulgarian National Audit Office)
- funding of preventive health care (Cour des comptes du Grand-Duché de Luxembourg)
- impact of new medicines on expenditure in health care institutions (State Audit Office of Croatia)

Guidelines (quality, treatment paths, pricing)

- classification and pricing of health care services (Swiss Federal Audit Office, National Audit Office of Estonia)
- ensuring the quality of health care services (National Audit Office of Estonia, National Audit Office of Lithuania)
- clinical treatment guidelines and paths (National Audit Office of Malta)
- methods
- cost-effectiveness analyses (Audit Office of The Republic of Cyprus)
- data analyses (Audit Office of The Republic of Cyprus)
- analysis and benchmarking of unit costs in health care (Portuguese Court of Auditors)
- cost-benefit aspects in medicine (Swiss Federal Audit Office)

3 Conclusions and suggestions

Conclusions

The responses submitted by the SAIs showed that even though there are problems pertaining to health care in all countries there are major differences concerning the focus and scope of the problems between and within individual countries. It should be noted that the differences may partially arise from the manner in which the questions are formulated and the respondent's views of the seriousness of the problem. However, it seems that some of the problems in health care are common to all countries, irrespective of the organisation of the health care system. In the majority of the countries, the most serious problems concerning health care are connected with funding and costs. This theme was also highlighted as one of the areas where the SAIs would be willing to cooperate. At the same time, some of the health care problems discussed in the survey are more clearly connected with the economic situation in the countries concerned, which in turn has an impact on the economic resources allocated to health care.

The results also showed that there have been quite a few health care audits during the past ten years. It seems that there is a great deal of interest in health care audits because nearly all of the SAIs taking part in the survey have topics related to health care in their audit plans. Even though the audit plans contain a broad range of different audit topics, there are also common topics such as mental health care services and children's health care.

Finally, the results show that there are varying degrees of interest in cooperation among the SAIs. East European countries are significantly more interested in cooperation than West European countries. This is probably because these countries are deemed to have more serious problems in a larger number of areas listed in the questionnaire and the individual problems within each area are more severe in Eastern Europe. Of the different forms of cooperation presented in the questionnaire, knowledge sharing with other SAIs via website and/or workshop attracted the greatest degree of interest. At the same time, there was little interest in cooperation via web seminars.

Proposals for further action

Health care is becoming an increasingly important audit object from the perspective of economic sustainability. In such a situation, a more centralised way of relaying information between the SAIs might benefit the SAIs, especially in the preparation of the audit design. We recommend that further action could be based on one of the following measures:

- Thematic reports reviewing the activities of different SAIs in specific sectors of health care could be prepared at regular intervals. The Governing Board of EUROSAI could decide on the topics to be reported and the parties responsible for the reports.
- There could be seminars on a small number of important health care topics. The Governing Board of EUROSAI could select the topics and the organisers.
- Parallel audits. Using the information contained in the thematic reports, countries wrestling with similar problems could find a common area of interest and initiate parallel audits of the topic.