Interview: Ladislav Dusek – Director, Institute of Health Information and Statistics, Czech Republic



The data of the reimbursement providers must be linked with healthcare providers ... the system must be interconnected!

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The director of the Institute of Health Information and Statistics in the Czech Republic explains his mandate to implement a national health information system and reviews its potential impact. He also identifies how his work will help solve the challenges in the current healthcare system and bring quality healthcare to patients.

You inherit two roles in the Czech healthcare and life sciences environment. One as the director of the Institute of Biostatistics and Analyses Masaryk University and the second one as Director of the Institute of Health Information and Statistics. Could you please give us a brief overview of the significance of both institutes and the synergies created in between them?

Both institutes' mission and goals project a certain degree of common ground. The institute of Biostatistics and Analyses is one of many research parts of the Masaryk University. As such, its main mission and goal is education. The institute covers a wide range of different educational activities with the most significant being in the area of healthcare— hospital management for instance— and many of those programs combine healthcare studies with applied statistics. This means, we equip our students with the skills and tools to calibrate cost effectiveness models in healthcare, to evaluate healthcare technologies, constructing software application for hospital information systems or to manage the urban elements of e-health; simply put: the skills and tools

needed in the future of healthcare. The most important aspect in all of these programs is that we enable our students and the physicians alike to speak a common language, therefore creating immense synergies between the field of medicine and the field of mathematical and computer science. The need for professionals of this area is Pan-European and we witness this need in the Czech Republic just as much. The Czech healthcare system is too fractioned in terms of speaking the same language. The health insurance companies have their own data collection systems, the government institutes have a different information system, the hospitals and general practitioners—again—a different information system and so on. It is impossible to control the medical, pharmaceutical and economic aspects of healthcare information. As university we educate the stakeholders of tomorrow and we aim at producing hundreds of students for this market and the market need for them is clearly present.

The Institute of Health information and Statistics is a governmental institution. We are the national authority which is responsible to standardize data collection throughout the healthcare system, we cultivate and calibrate a national healthcare information system based on more than 50 basic components. The latter include healthcare registries, quality assurance systems, quality control systems, organizing national screenings and of course registering the economic aspects of the health insurance companies; or as I prefer to call them: reimbursement providers. Once fully established, we will make this data available to all stakeholders in the Czech Republic and shed light to the system.

One of the challenges is that it isn’t simple to acquire talent willing to work in this institute at standard academic salaries. The only chance to cultivate this system is by collaboration with students and academics from universities just as it is common in many western European countries. And I believe this completes the picture. Two different institutes with two distinguished missions, nonetheless significant synergy potential.

How does the national health information system fit into the plan of the national strategy on health 2020 issued by the ministry of health?

Frankly speaking, I can’t distinguish the mission and content of the National Strategy on Health 2020 (Health2020) and the mission of national health information system (NHIS) because its mission is a duplicate. Health2020 is all about supporting preventive programs, equity of care and quality, eradicating imbalances of the system, making healthcare accessible to all social classes, organize healthcare interventions, develop an e-health system and much more. All of the topics of Health2020 correlate with the topics of the NHIS and all of these topics—therefore both strategies combined—translate into a program of improving healthcare. I would like to highlight, that in

between both programs communication, support and collaboration is excellent—just another clear sign that both programs go hand-in-hand.

Is the full establishment of the national health information system to be expected soon?

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Absolutely not, however, we have come a long way thus far. When I assumed position of the institute in 2014 the information collection situation was disastrous. Most of the data was still collected in paper form—in 2014! More than 70,000 sheets of paper distributed throughout the healthcare system collecting the data manually. There was no control whatsoever because, obviously, there's no method to control paper. We already completed the transition into a technology based method of data collection—the first revolution complete—so everything is imported on-line electronically and electronic feedback is sent to the reporting unit whether it be the hospital, healthcare provider or reimbursement provider.

As one of the leading experts involved in Czech healthcare, what are the challenges you identify in the current healthcare system?

There are too many to count.

What are the most significant challenges?

First and foremost, utilizing the already existing data. This data was collected and stored within numerous institutions without any link in between them, therefore this data doesn't provide the value it should provide. The data of the reimbursement providers must be linked with healthcare providers for instance; the system must be interconnected!

The second challenge is that this data can only be interlinked via personal identification codes which, unfortunately, is limited by current legislation. However, if we can't implement these identification codes we will not be able to interpret the data as some data is stored with the reimbursement providers, some with the ministry, some with the individual hospitals and some with all the other different stakeholders thus not allowing the data to be interpreted. Of course no analysis must be done where the individual patient can be identified! However, in the current situation the system protects the individual data more than the individual itself which results in feeble availability of information to interpret. Therefore, the current legislation must be changed in order to allow us to connect the data of individuals for analysis whilst protecting their identity.

Thirdly, we must move forward from evidence based medicine to clinical based evidence—a journey of utmost significance! Clinical based evidence means the collection of data of real world practice in order to give feedback to the different providers—whether it be reimbursement or healthcare providers—which treatments, methods and tools are effective and necessary and which should be neglected. We can't just rely on evidence based trials of already published papers in Japanese or US journals. We must collect real world—or real Czech—data! This is the challenge: interconnecting the registries in order to produce reports which can be consumed by the physicians providing much needed data without any barriers.

The fourth challenge is that the strategy of assessing and analyzing investment in innovation must be reviewed and remodeled. It doesn't matter if it is regarding new molecules or a new surgical technique; health technology assessment must be prepared and consumed in a normal, real life process. What we need is some form of risk sharing strategy or procedure, because we need to classify and categorize these technologies in comparison with relevant comparative approaches and techniques thus being able to recognize weaknesses and strengths of the innovation in question. If such a risk sharing model isn't established, then soon innovation –for the benefit of all Czech patients—can't be financed anymore; an issue we share with economies such as Germany or the UK. We need to utilize real world data to create a win-win risk sharing model which allows us to negotiate with pharmaceutical companies on common ground.

Last but not least, we need to establish an appropriate benchmarking model for our healthcare providers. We need to be able to control and incentivize quality care within our dense network of healthcare providers and consequently distribute finances on the basis of quality criteria's.

Another challenge in the Czech healthcare system seems to be its financing. 2016 witnesses the highest budget allocated to healthcare in the history of the Czech Republic and some people argue that allocating more finances will not solve any challenges as long as inefficiencies are not eradicated. How do you assess the financial situation of the Czech healthcare system?

The financial situation of the healthcare system is far from optimal. Currently we still enjoy a period of economic growth, however, investments into healthcare do not correspond with the growing GDP which must be improved; seven percent of GDP invested into healthcare is really low. Nonetheless, I must highlight that the quality of care provided by the system is superb. We currently face a situation where a lot of attributes of the healthcare system are improved whilst on the other side the salaries of healthcare professionals are insufficient. That is an obvious challenge for government and country that must be addressed. Nonetheless, the latter challenge is not

solved by a flat decision to increase finances of each individual hospital but rather on the basis of quality and performance indicators.

That’s another rationale for the existence of our institute and the law will, and has, already in part changed accordingly. The most recent legislation changes were regarding the reimbursement providers which now have to provide their data to us, so that in six months’ time we will be able to analyze the records of all healthcare providers in the Czech Republic—including performance indicators. I would advocate to increase finances on the basis of found performance and quality measures especially the salaries, however, I am not an economist and the latter only reflects my personal point of view.

When we met Mr. Zaloudik he elaborated that the underlining issue of Czech healthcare financing is the lack of transparency, naming you as the man who will solve this issue and thus bring financial salvation to the system. Do you agree with that mission statement?

Yes that is true, that is indeed my mission. I encountered many challenges in my scientific career including roles in many foreign institutes and my personal decision was that I feel equipped enough to encounter this challenge as well and that I should try to excel in this role for the benefit of the whole Czech population. So far we’re well on track and already celebrated the first success in form of the legislation change, now we are patiently waiting for the data of reimbursement providers. The segment of reimbursement is the most in need of transparency in order for us to distribute the finances correctly.

The balance of the Czech health insurance companies stood at plus USD 19 billion in January 2016, nonetheless, the insurance companies said this sum isn’t enough. As you’re looking into the data of the health insurance companies, could you give us a prognosis of what the outcome of your analysis will be?

The truth! I am well aware that the truth will make some stakeholders delighted and others anxious and we will classify and categorize all of the providers according to quality and performance. We will have the power to control performance and we will eradicate what is not cost effective. We will be able to picture the absolute financial situation of the different segments of care, identify which underfunded and which are overfunded, and my careful prediction is that we will see that acute hospital care is heavily underfunded; either way, we will argue for incremental investments into the segments of care in need. Simultaneously we will identify ineffectiveness’s. My, again very careful, prediction is that we will find ineffectiveness’s regarding the density of healthcare providers.

Nonetheless, we will take the picture of truth and showcase the reality.

Many of the stakeholders form the Czech pharmaceutical industry report that the current diagnosis-related group referencing system puts immense challenges in the way of bringing innovative treatments to Czech patients. Your data and information is supposed to be ultimately used to remodel this system too, what can we expect to come?

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Indeed. Which is why I'm the victim—a nightmare. The diagnosis-related group (DRG) referencing is just a tool! Let's skip it and it will necessarily show the economical position and real financing; aside from that I expect many segments of healthcare to be underfinanced, so what to do? I will make a snapshot of reality and let's assume this picture shows a lack of 30 to 35 percent of missing finances. Then the relevant decision makers have to find a solution of closing this gap. My personal point of view is that the most rationale method—and very legal I must say—is to commercialize specific segments of care and simultaneously follow examples of many others countries by implementing some sort of multidimensional tax system. I believe that it is unavoidable to commercialize some segments of healthcare and that it is only a question of time when this will be decided and introduced in the Czech Republic. I'm not a politician and I will never be the one forced to make this decision. Nonetheless, it should be obvious that the financial requirements of healthcare—given the aging population, longer survival rates, new molecules, new diagnostic techniques and much more—will necessarily rise! Patients diagnosed with cancer live 20 percent longer than just ten years ago, that costs a lot of money! I think that people must start to understand health as a value and value has a price. Not only the government but also the individual patient. But as aforementioned: I am not the decision maker, I am not a politician, I am just a photographer taking an unbiased snapshot. What decisions will result from this snapshot is not my decision.

When we come back in five years' time, where will you be?

I don't know yet where I will be in five years' time. The transformation of the Czech health information system is a really demanding job; it's my second year here and I vowed to finish the job! But I am unsure if I will continue running the system after I implemented it. Maybe.

Are there any last words of wisdom you would like to share with us?

Healthcare is not a Western movie. There are no enemies. There shouldn’t be emotions. Pharmaceutical companies, governments, scientists, healthcare providers, reimbursement providers; all of those should try to find common ground, a common language and plan the care of patients together, otherwise they will destroy the balance. Pharmaceutical companies must understand and respect that finances are not unlimited and that the reality of limited finances exists. On the other hand, governments and healthcare stakeholders must respect the value of innovation and must understand that there is a price to it and nonetheless the latter, must understand how significant it is to provide this innovation to their citizens.

All of the players should understand each other’s need and communicate with each other rationally on the grounds of validated data. No enemies. No victims. No Westerns.

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