PATHWAYS TO HEALTH SYSTEM PERFORMANCE ASSESSMENT
A MANUAL TO CONDUCTING HEALTH SYSTEM PERFORMANCE ASSESSMENT AT NATIONAL OR SUB-NATIONAL LEVEL

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**ABSTRACT**

Health system performance assessment is a country-specific process of evaluating and communicating the achievement of high-level health system goals based on health system strategies. Many countries are planning or undertaking assessment of their health systems in order to chart national health plans and strategies and/or prepare health reforms. This manual may support these countries in this exercise by outlining the principles and practical steps to develop health system performance assessment as a tool to allow countries to strengthen their health systems and ultimately bring better health outcomes to European populations.

**Keywords**

OUTCOME AND PROCESS ASSESSMENT (HEALTH CARE)  
HEALTH SYSTEMS PLANS – organization and administration  
PROGRAM EVALUATION – methods  
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The signing of the Tallinn Charter: Health Systems for Health and Wealth in 2008 committed the 53 Member States of the WHO Regional Office for Europe to increasing the transparency and accountability of their health systems. Furthermore, the new European Health Policy “Health 2020” calls for a person-centered health system and the creation of alliances with actors outside the health sector. In this context, a continuous assessment of health systems is a function that governments need to reinforce for steering the sector towards better performance.

In accordance with this, the Regional Office encourages Member States to conduct health system performance assessment (HSPA), a participatory, country-specific process that has been shown to bolster a common vision of health policy, strengthen the dialogue among stakeholders and health agents, improve decision-making and increase transparency and accountability.

One of the main roles of the World Health Organization is to help its Member States develop strategies and policies to improve the performance of their health systems. In order do this, it is critical to generate the most accurate and up-to-date local evidence to ensure that technical advice is informed by evidence for improved decision-making.

The Division of Health Systems and Public Health of the WHO Regional Office for Europe has gained valuable experience from its support of HSPA in different countries throughout the European Region. This experience, shared through ongoing dialogue with Member States and partners, will contribute to making health systems increasingly responsive, efficient and equitable.

The purpose of this document is to serve as a resource for setting up and conducting a country-based HSPA by proposing guiding principles and practical steps. In general terms, the manual seeks to support and improve health system governance. The guide’s title, Pathways to Health System Performance Assessment, draws an analogy between the process of HSPA and a pathway. Herewith let me wish you a very rewarding journey along that path.

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Division of Health Systems and Public Health
The WHO Regional Office for Europe
The WHO Regional Office for Europe thanks the international experts, country representatives and representatives of other organizations that contributed to the development of this publication. The manual is based on the findings and recommendations of three technical meetings held in Barcelona (January 2010), Copenhagen (May 2011) and Ljubljana (December 2011). The WHO Regional Office for Europe thanks all the meeting participants for their support and advice (Appendix 1).

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This document is a practical manual and companion for the journey that a growing number of countries are making, or are planning to make, towards health system performance assessment (HSPA). The manual’s sights are not set exclusively on an intermediary destination – the production of a guide. Because the process of developing an HPSA is itself crucially important to strengthening health governance, this manual emphasizes key questions to be addressed throughout the process, from inception to dissemination of results.

The manual consists of four chapters. Chapter One provides a general orientation and introduction to HSPA. It aims to support the countries that are asking such questions as, “Is HSPA right for my country?” or “Why would it make sense to implement HSPA in my country?” The chapter explains what HPSA is (and what it is not); why it is necessary; and how it has been used by various countries in the WHO European Region.

Chapter Two presents the five principles that orient the development and implementation of HSPA: a system perspective, a strategy-based HSPA, a participatory approach, integrating an equity perspective and complementing the scope of the assessment with depth of analysis. This chapter builds upon the general orientation and highlights strategic issues.

Chapter Three is built as a road map of the journey towards an HSPA report, prompting questions, setting milestones and listing key deliverables to be produced at each step or milestone. This chapter takes the reader through the development of HSPA, from its inception to the finalization of a report. It proposes generic steps that can be modified to fit the local context. While the first two chapters establish a theoretical foundation, this chapter offers practical suggestions.

Chapter Four calls for tailoring HSPA to the unique needs and capacities of each individual country. This chapter considers “life beyond the report” and comes full circle to reaffirm that HSPA is a tool for strengthening health system governance. The challenges of HSPA are discussed here, along with ways to overcome obstacles and balance competing elements (centralization versus participation or stability versus dynamism, for instance). Pursuing the analogy of HSPA as a pathway, or journey, we could say that a good companion, instead of blindly following the map, will propose shortcuts and sightseeing tours adapted to the specific needs of the vehicle and its driver.

This document is aimed at those who would sponsor or lead the implementation of HSPA at the national or subnational level. The principles and orientations are useful for assessing health systems at any level – a country, a province or even a local community. The scope, purpose,
content and implementation strategy of HSPA may be adapted to specific local needs and capacities.

As the title suggests, there are different approaches to HSPA, illustrated by the diverse experiences of countries across the European Region in recent years. To inspire and support its Member States in developing HSPA, the WHO Regional Office for Europe has published three documents, including this manual. The manual is accompanied by a case-by-case analysis of HSPA experience in seven European countries (1) and an advocacy brochure highlighting the beneficial effects of HSPA in those countries (2). The analytical case studies, the advocacy brochure and this manual were designed to support and complement one another. The material provided in this manual is based on the lessons learned from the case studies as well as the recommendations from three consultation meetings of renowned experts, country representatives and other international organizations (Appendix 1).
**CHAPTER ONE: SETTING THE STAGE**

**WHAT IS HSPA AND WHAT CAN IT DO?**

**Key messages:**

- HSPA is a tool to strengthen health systems and in particular health system governance. To achieve this, local ownership and high levels of participation in the process are necessary. HSPA is a process, not a report. The report is one milestone in the process.

- HSPA is one approach among many within the wide universe of performance measurement. In HSPA, the health system is evaluated as a whole, and health outcomes (both the average level and distribution) are linked to strategies or functions, with a limited number of quantitative indicators.

- HSPA does not replace other governance tools. It creates synergies between and with other tools. Of particular interest are the synergies created between HSPA and national health plans and strategies.

- HSPA has been used successfully by health authorities to inform policy decisions; align stakeholders and build dialogue towards a common goal; and increase transparency and accountability.

- HSPA responds to today’s new and pressing health challenges. The important role of HSPA has been recognized in a number of charters and declarations.

**Introduction**

It is widely acknowledged both within and beyond the public health sector that self-assessment is a vital component of any health system. In all societies, people take stock of their lives from time to time, searching for ways to improve the important aspects of their lives, including health. Through assessment, monitoring and evaluation of their own performance, they learn how to build a healthier future. The universe of performance assessment includes a large number of activities, serving different purposes and diverse end-users (Box 1).

**Defining attributes: What HSPA is and what it is not**

HSPA measures the achievement of high-level health system goals based on health system strategies. Fully developed HSPA systems expand beyond a list of indicators and targets. They build on an organized set of quantitative measures (performance indicators) and incorporate analytical tools. They are comprehensive and balanced in scope, covering the whole health system rather than specific programmes, objectives or levels of care. HSPA results are reported to the public and/or stakeholders on a regular basis and are used to inform the decision-making process.
HSPA is just one galaxy in the universe of performance measurement. HSPA is distinguished by the following defining attributes. The importance of each of the defining attributes is explained in Chapter Two.

- HSPA provides an assessment of the health system as a whole, using a limited number of indicators linking outcomes and functions, or strategies.

- HSPA is a country-owned, participatory process that is locally grown and nurtured. HSPA is embedded in a national or subnational policy process and is based on a country-specific framework. It is linked to national health plans or strategies wherever possible.

- The quantitative indicators are complemented by qualitative information or in-depth evaluations in order to move from performance measurement to performance assessment and to identify policy options.
There are other galaxies in the performance measurement universe, such as reporting on achievement of international targets, such as the United Nations Millennium Development Goals (UN MDGs) and Health for All; monitoring the implementation of health reforms and accountability to donors; and answering ad hoc requests or providing baseline assessments to prepare a programme, develop a plan or justify a budget. All of these tools have certain traits in common with HSPA and complement it. All are critical to support the governance and leadership of the health system (See Box 2).

Box 2: The universe of performance assessment: complementary tools to strengthen health governance

Reporting on international commitments (such as MDGs)

• Why not HSPA? This is not a country-owned process. The scope of assessment is limited. It looks at ultimate goals and outcomes but does not link them to national or subnational strategies.

• Complementarities with HSPA? There is a strong consensus – or even a commitment – to improve on MDGs. Also, information systems have been put in place to measure these, and it is expected that the data will be accessible and of high quality and that international reference points will be available for them. Hence, MDGs are often incorporated as key indicators into (sub)national HSPAs.

Monitoring of health reform implementation

• Why not HSPA? Often, it focuses on implementation of reforms or programmes according to plans, as a tool for accountability to the donors. It is a critical source of information, but it needs to be supplemented. Indeed, if the scope of an assessment is limited to previous reforms, it will provide little insight into the need for reorientation of future reforms. For this, monitoring should be complemented with evaluation and review. Conversely, this type of monitoring might rely on a much larger set of indicators than HSPA can accommodate. It goes into greater detail regarding the implementation of specific activities and might lack a holistic perspective. Finally, it is limited in time to the period of implementation of the reforms, while HSPA is proposed as an ongoing, sustainable process.

• Complementarities with HSPA? Some high-level indicators of health reform implementation monitoring will be introduced into the HSPA as reflecting strategic priorities.

Answers to ad hoc requests

• Why not HSPA? HSPA is more than an assessment report; it is a continuous process in which indicators are based on a country-specific framework. Hence, HSPA requires a relatively stable list of indicators, which cannot easily be changed to adapt to ad hoc requests. Moreover, the scope of such requests is usually narrower than the scope of HSPA but requires more depth and detail than HSPA can offer.

• Complementarities with HSPA? HSPA might give rise to policy questions or flag issues for further analysis, which will then be formalized as ad hoc requests for additional studies. Conversely, the main findings of ad hoc, in-depth evaluations may be incorporated in an HSPA report as background analytical or qualitative information in order to give more depth to the HSPA findings.

Baseline assessment to prepare a programme, develop a plan or justify a budget

• Why not HSPA? HSPA provides the “big picture.” It is situated at a strategic level and not at an operational level.

• Complementarities with HSPA: HSPA serves as a critical input to the situational analysis for programmes or plans. HSPA will help identify policy options or define general recommendations but will not go into sufficient depth to define operational elements in a plan.
HSPA does not replace other governance tools. Instead, it creates synergies between and with them. For instance, it adds value to programmatic monitoring and evaluation by fostering a system perspective. It highlights the connections between the different elements of the health system and outside the health system, supporting intersectoral dialogue. HSPA builds upon and contributes to monitoring systems, “the routine tracking and reporting of high priority information about a program or project, its input and intended outputs, outcome and impact” (4). It also draws upon additional sources of information, such as qualitative evaluation studies, to assess how the system performs. “Evaluation is the rigorous, scientifically based collection of information about a program or intervention activities, characteristics and outcome that determines the worth of the program or intervention” (4).

**Rationale for HSPA: Why should I implement HSPA?**

The first question is why the policy-makers of a country should want to assess the performance of their health system in the first place. In short, HSPA can support health authorities in three main functions:

- to inform health system reforms and policy planning;
- to align stakeholders from different sectors behind strategic health system goals and to create a dialogue about health system performance; and
- to foster transparency and accountability.

Performing these functions is critical for responding to today’s new and pressing health challenges. The key role of HSPA has been recognized and expressed in a number of official charters and declarations. Improving health system performance is a high-priority issue across the European Region, particularly in the current economic climate, in which achieving the highest value from existing resources is paramount. In this regard, HSPA is a recognized approach among the Member States of the WHO European Region (5). The 2008 Tallinn Charter: Health Systems for Health and Wealth reaffirmed the commitment of Member States to increase transparency and accountability of the health system (5).

**Responding to today’s health challenges**

There is an overarching need to re-examine health policy in light of the main trends that have shaped it and the world in which we live today. These trends include globalization, migration, urbanization, environmental pollution and mounting evidence of climate change. At the same time there are widening inequities in the distribution of wealth and in access to health and...
social services. In many ways, these trends will have a profound impact on health and health equity, as well as on the ways in which society responds to health challenges. Today’s challenges differ greatly from the health challenges facing society less than one generation ago. While many infectious diseases are on the wane, a new epidemic of noncommunicable diseases is on the rise: obesity, diabetes, cardiovascular conditions and mental illness. Often these diseases are related to the way people live and the conditions in which they live – in other words, the social determinants of health. Given these circumstances, it is imperative that health systems be ready and able to respond. They have to be “fighting fit” for the contests ahead.

Formal and informal mechanisms are needed to help ministries of health develop intersectoral policy responses to current and emerging health challenges (5). Successful advocacy with other sectors about the relevance of health in their policies is based on new and innovative ways of framing health information, which contribute to raising the profile of health issues in the media, in the public eye and in policy-making circles (6). Recent experiences with HSPA highlight the significant contribution of the HSPA process to strengthening health system governance by engaging stakeholders, fostering intersectoral dialogue, mainstreaming evidence on equity gaps, promoting a common vision across programmes or levels and establishing mechanisms for solidarity across regions.

Many public health problems are not amenable to a hierarchical approach but respond to effective networks and partnerships. For this reason, civic engagement and horizontal governance have gained prominence. The importance of engaging stakeholders, including citizens, at all stages of the HSPA process – from the definition of the country-specific framework to the interpretation of results – is widely recognized across Europe. Regular publication of performance results at all levels contributes to improved responsiveness vis-à-vis public expectations and effective, evidence-based policy-making. Requests for information grow with increased public awareness and participation as well as with increased patient mobility, especially between European Union countries or between regions within a country.

Converting values into action

Public reporting of performance results is a response to the right to information and political accountability. The existence of a national health plan, including targets, is a core obligation of government, deriving from the right of the population to enjoy the highest attainable level of health (7). The introduction of the concept of targets into the health sector is often traced back to 1981 and the publication of the World Health Organization’s Health for All strategy (8). The WHO Regional Office for Europe proposed 21 targets in its 1998 update, Health21 (9). Member States also committed to achieving the UN MDGs, many of which are directly related to health.
Both Health for All and the UN MDGs have contributed to the strengthening of information systems, as is illustrated by the widely used Health for All database.

More recently, the set of values established in the 2008 Tallinn Charter (10) and reflected in the new health policy of WHO Regional Office for Europe, Health 2020 (11) stresses the importance of fostering transparency and accountability on the basis of measurable results. It commits each Member State to strive to enhance the performance of its health system to achieve better, more equitable health. The analysis of performance for informed policy-making is a central theme of the Tallinn Charter, linked closely to the message of moving from values to action. This report focuses on HSPA as the essential tool for converting those values into action in order to reach a higher standard of health in all societies.

Expected impact of HSPA: How has HSPA been used?

Experience suggests that there is a temptation to use HSPA as a “magic bullet” for informing policy decisions, aligning stakeholders, creating dialogue and fostering transparency and accountability all at once. As in the case of Estonia (1), it can be difficult to formulate objectives for the initial HSPA because it may be unclear at the beginning of the process precisely what can be achieved through HSPA. Learning from the experiences of other countries can help policy-makers identify appropriate objectives. What objectives can the decision-makers and other stakeholders realistically hope to achieve through HSPA, based on previous HSPA experience throughout the European Region?

The case studies of HSPA in seven European countries show that HSPA has been used in the following ways (1).

- **HSPA is used to create a common understanding and vision among stakeholders of the priorities for strengthening the health system.**
  
  In Belgium “… stakeholders and decision-makers have been questioned. They stress the importance of using a common tool that is shared between administrations” (12). The Belgian HSPA provides a model of a country-wide participatory process led by three collaborating national agencies. It involves political actors as well as public authorities responsible for social affairs and public health at federal, regional and local levels. Technical staff worked on the report, while a political working group met every two or three months with representatives of the federal and regional administrations. In addition, progress was discussed twice a year at the interministerial conference on health, a political forum of ministers from all sectors aimed at joint decision-making on major health issues. In a highly decentralized health
system, HSPA contributes to a common understanding of health system performance and builds consensus on priorities for the future.

In Turkey HSPA has been an important tool for supporting intersectoral cooperation in order to achieve higher-level goals. The process leading to the publication of the first HSPA report was marked by broad participation by all the relevant organizations both inside and outside the Ministry of Health. The assessment framework, presented as a strategy map, was instrumental in aligning stakeholders towards a common vision. In order to reinforce the importance of health equity, performance against each indicator was assessed not only in terms of overall improvement but also in terms of distribution.

- **HSPA is used to support evidence-based policy-making and priority-setting by providing a source of reference on the performance of the system.**

  In Portugal parallel external evaluations of the National Health Plan (NHP) and the HSPA were conducted in order to support the health ministry’s efforts to improve the performance of the health system. HSPA provides a holistic system perspective and complements the NHP, which focuses on measuring performance in population health improvements. The package of NHP evaluation, HSPA and additional reviews strengthened the evidence base and policy options for development of the next National Health Plan (2011–2016).

  In Armenia HSPA findings have contributed to the development of a number of policies and programmes such as the National Tobacco Control Program (2010–2013) and the concept paper on the prevention, early detection and treatment of the most prevalent noncommunicable diseases (2009–2013).

- **HSPA is used as a platform for dialogue between programmes and between sectors to understand how joint actions influence health outcomes.**

  In Estonia child obesity was highlighted in the HSPA as a major health problem. Data were available before HSPA but came from different sources, so the picture was fragmented. When the HSPA brought together data from different sources on obesity, diet and physical activity, the true scope of the problem became clear and prompted policy action. HSPA provides a systemic overview that is general enough for direct application to the policy-making process. In this case HSPA served as the catalyst for directives on healthy food in schools and kindergartens, increased funds for dietary and physical education and increased funds for infrastructure such as cycling tracks, walking paths and physical activity groups for children.

- **HSPA is used to monitor the effects of health system reforms and national health strategies and to provide a basis for modifying reforms and strategies as needed.**

  In Kyrgyzstan assessment is an ongoing, country-led activity with ad hoc institutional arrangements. It consists of annual health and health system monitoring, a complementary
system of policy studies and an annual review of progress in health system performance by the Ministry of Health and other partners in government and development organizations. Health system performance monitoring in Kyrgyzstan tracks health sector programme outputs (direct results from implementation of programme activities); outcomes (programme results); and impacts (programme effects) by means of record-keeping and reporting on the basis of a table of measurable indicators. The conclusions of the annual reviews of sector performance are documented in the Joint Annual Review Notes, which contain not only a progress statement but also policy, programme and budget consequences. The strength of the process is its ongoing, regular nature. In turn, the consequences of regular performance assessment lead to efforts to further improve the effectiveness of the process.

• **HSPA is used to foster understanding of areas in the system where improvements in efficiency or equity are needed.**
  The Estonian HSPA clearly showed that the economic downturn and resulting budget cuts had led to longer waiting lists for specialist care. The evidence provided by the HSPA was one of the incentives that helped protect, and even increase, the budget for this area.

• **HSPA is used to manage performance at subnational levels (provincial, regional and local) and to hold subnational health authorities accountable for achieving measurable results.**
  England uses a target-setting approach to measure performance within the health system and has a complex history of target-setting activities at different national and subnational levels. One incentive for implementing HSPA was the introduction of public services agreements (PSAs) across government in 1998. In 2007 Vital Signs aimed to provide a set of measures for health authorities and National Health Service (NHS) trusts to use in the development of their operational plans in order to deliver against and report on national priorities.

• **HSPA is used to foster transparency in the health system.**
  Most countries in the European Region have established mechanisms whereby the minister of health reports to the Parliament or a parliamentary commission on health. Accountability for health system performance has been enhanced by the public release of scorecards describing the relative performance of national health systems, often with international rankings. The Netherlands has paved the way with its Dare to compare! report (13), which compares scores on health indicators for 27 European countries. While the report highlights the challenges of comparing different health systems, it also identifies opportunities for improvement and motivates further efforts in that direction.

• **HSPA is used to exploit available databases, identify information gaps and improve data availability and access.**
In Belgium the HSPA has generated discussions and critical reflection on the nature of the data to be shared at the international level. It has also stimulated debate on the optimal use of existing databases in the country to create a standardized tool for the use of local, regional

Further readings for Chapter One:
The performance measurement universe


Responding to today’s health challenges


HSPA in action:

Reviews


Country examples

- Harbers MM et al. Dare to compare!: benchmarking Dutch health with the European Community Health Indicators (ECHI). RIVM Rapport 270051011, 2008.
and national authorities. The Belgian performance assessment framework is based on international experience, tailored to the needs of the Belgian health system. The availability of information was not a factor in deciding on the performance dimensions, which resulted in data gaps in the assessment results.

HSPA in Armenia provided a comprehensive set of national health system performance indicators, which is expected to become part of the catalogue of indicators collected by the national statistics office. Field surveys on health status and health service utilization by population-wealth quintile were used in both HSPA reports (2007 and 2009), providing new information on the extent of health equity and differential access to health care based on socioeconomic status. The second report also provides specific recommendations for strengthening the health information system in the country.
CHAPTER TWO: GETTING STARTED

FIVE PRINCIPLES

Key messages:

HSPA fosters a system perspective.
- Improving performance demands a coherent approach involving coordinated action on multiple system functions. It is not sufficient to set the gathered data sets side by side; dialogue is critical to integrate all the pieces of information coming from different perspectives.

A strategy-based HSPA is reflected in a country-defined performance framework.
- The performance framework ensures that the HSPA reflects the whole health system. A performance framework illustrating the links among parts of the health system as well as key forces outside of the health system, such as social determinants of health and other sectors of government, separates the health system into manageable components. This facilitates performance measurement.

HSPA is a participatory process.
- HSPA is more than a group of technical staff gathering results on indicators and producing a report. HSPA is a movement, or process, of engaging stakeholders in order to raise awareness, develop capacity and foster a common understanding. It creates a shared sense of ownership and acceptance of the HSPA results.

HSPA integrates an equity perspective.
- An equity lens can and should be systematically introduced into HSPA at each step of the process, from development of the framework to analysis of the data, which are stratified according to relevant groups, and formulation of policy recommendations.
- Differences in health outcomes by level of education or income can be influenced by the way services are developed and delivered. Equity is part of health system performance and is required in order to improve health outcomes in both level and distribution.

HSPA should be supplemented by in-depth analysis and evaluation research.
- Informing answers to the policy questions requires going beyond indicators and moving into evaluation research.

Introduction

What kind of “animal” is a health system? Like all creatures, a health system is more than the sum of its parts, all of which are interconnected and interdependent. It is vital, therefore, to have a perspective that views the system as a whole, rather than a collection of parts. Equally essential is the involvement of all the system’s stakeholders from the very beginning. This chapter emphasizes the importance of a system perspective in order for HSPA to be an effective governance tool. The system perspective is the first of five principles, or attributes, of effective governance.
HSPA. These are key principles that shape the overall assessment. Apart from a system perspective, the other four principles are: strategy-based assessment built on a country-specific performance framework; integration of an equity perspective; adopting a participatory approach; and complementing the scope of the HSPA with in-depth analysis. Each of these is summarized below.

**The first principle: a system perspective**

A children’s story based on a folk tale dating back at least 2000 years offers insight into what happens when an encompassing view is not taken in studying a problem (Box 3). This story demonstrates the value of a system perspective when evaluating options.

**Box 3: An illustration of the limitations of fragmented perspective**

In a folk tale, six blind men encounter an elephant and each gives his analysis of the creature. Their assessments are based on the part of the elephant they happen to touch. The first blind man touches the animal’s sturdy side and declares the elephant to be very much like a wall. The second blind man feels the elephant’s tusk and declares the elephant to be like a spear. The third blind man grasps at the squirming trunk and declares the elephant to be like a snake. The fourth blind man slides his hands along the elephant’s broad knee and declares the elephant to be like a tree. The fifth blind man examines the elephant’s ear and declares the elephant to be like a fan. Finally, the sixth blind man grabs at the elephant’s swinging tail and declares the elephant to be like a rope.

In one version of the story, the blind men with conflicting perceptions of the elephant enter into a violent conflict. Similarly, in the context of HSPA, it is not sufficient to set the gathered information side by side. Dialogue is of critical importance to integrate all the pieces of information coming from different perspectives. A system perspective also recognizes the interdependencies in any assessment:

The health system’s six building blocks alone do not constitute a system, any more than a pile of bricks constitutes a functioning building … It is the multiple relationships and interactions among the blocks – how one affects and influences the others, and is in turn affected by them – that converts these blocks into a system (14).

The Tallinn Charter also notes that “… health system functions are interconnected; therefore, improving performance demands a coherent approach involving coordinated action on multiple system functions” (10). Performance assessment should recognize and embrace those interdependencies. This requires more than simply examining certain indicators side by side; it requires understanding how they all fit together as a system to contribute to better and more equitable health.

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2 http://en.wikipedia.org/wiki/Blind_men_and_an_elephant
Successful health system reform relies on the alignment of strategies and targets across different parts of the system. Without a clear picture of which activities are contributing to the success or failure of high-level strategic goals, policy-makers will have difficulty focusing reform on the areas of weak performance. In order to achieve this, policy-makers need a solid performance assessment framework that highlights the expected causal relationships between the different performance dimensions.

**The second principle: a strategy-based HSPA reflected in a country-defined performance framework**

The performance framework ensures that the HSPA reflects the whole health system. A performance framework illustrating relationships among the components of the health system as well as key forces outside of the health system, such as social determinants of health and other sectors of government, helps separate the health system into manageable dimensions for the measurement of performance while maintaining a holistic perspective on the system.

The performance framework illustrates the relationships among performance dimensions and guides the analysis and interpretation of indicators. It provides insights into how strengths or weaknesses in some areas have an impact on other areas. This insight is the first step in the transition from simple descriptive observation of performance levels towards diagnosis of specific problems and their causes. The diagnosis then needs to be confirmed by means of various activities that are discussed later in this manual.

The performance framework is locally adapted, or country-specific. This means it is based on an explicit or implicit vision that reflects national, subnational or local strategic priorities or health reforms. It shows how attending to these priority areas can contribute to a strengthened health system and can set the stage for future strategic health system planning. The framework also enables reporting back to the public on the impact of health system reforms.

A country’s performance assessment is tailored to the country’s unique set of priorities, which are reflected in the indicators chosen for the assessment. This is critical for establishing national ownership of the assessment and increasing the likelihood of subsequent policy action. The performance framework can be based at the national, subnational or local level; but these levels need to be aligned. England’s Vital Signs scheme (Box 4) provides a good illustration of a “cascading” performance framework to keep the focus on national priorities while responding to local needs. An alignment of values, commitments and priorities agreed at a supranational level, as described in international charters or resolutions, is also required.

Some countries have used strategy maps to maintain focus on the vision while highlighting the interdependencies in the strategies. A strategy map is a formal, visual articulation of the
hypothesized cause-and-effect relationship between the strategic goals of the health system. The strategy map is one approach. Other countries have adopted performance frameworks derived from widely accepted international frameworks developed by the World Health Organization (16, 17) or the Organisation for Economic Co-operation and Development (OECD) (18).

Whichever approach is chosen, the development of the performance framework is a critical stage which cannot be bypassed, as it will drive the selection of the indicators (rather than the other way around). The performance framework provides the foundation for much of the HSPA process: the selection of indicators, the interpretation of results and the development of the recommendations and strategies for strengthening the health system. Without the structure provided by the performance framework, the availability of certain data will drive decision-making, and areas of importance might be neglected. Without a structure, it will also be harder to present and share information. Indeed, the structure provides the purpose for the measurement exercise and is more important than the measurement itself. The framework is like a

In the Vital Signs scheme (2007–2011), targets defined in tier one spell out national requirements, mandatory and subject to centralized reporting to the Department of Health. They were applied to all Primary Care Trusts (PCTs) across England, which were required to monitor progress against these targets. Tier two targets were specific to each PCT. They defined actions and targets for local delivery on national priorities. The operational plans of each PCT for achieving tier one and tier two targets were subject to approval by its Strategic Health Authority (SHA). Tier three targets were local-level targets on local priorities, left to the discretion of the PCTs in collaboration with their SHAs. To define and achieve these targets, PCTs were expected to form new local partnerships and engage with their local communities, staff and stakeholders regarding priorities and performance measures.

**Box 4: Cascading performance framework: the three tiers of Vital Signs (15)**

National requirement

National priority for local delivery

Local action
bookshelf; measures and methods, like books, may be altered or moved while the framework remains stable. Some shelves might remain empty for some time and be filled at a later stage. Certain books may be removed from the shelf in order to make room for new, more relevant books in the limited space available.

**The third principle: a participatory approach**

Many public health problems are not amenable to hierarchical approaches but respond to effective networks and partnerships. As a governance tool, HSPA should reflect the same approach to identify and tackle those public health problems. It is vital to engage stakeholders at all stages of the HSPA process; this principle is intrinsic to inclusive governance. A participatory approach to HSPA development and implementation increases the sense of ownership of the results and improves the chances of seeing policy action based on those results.

From the earliest consideration of HSPA in any country, it is crucial to have the greatest possible stakeholder involvement, across all sectors of the health system and beyond, into the general population. A shared ambition and understanding of what is to be achieved, as well as how it is to be achieved, must be fostered and sustained throughout the process. Involving the stakeholders in the HSPA process from the beginning increases its effectiveness, as was repeatedly shown in the lessons learned from the seven European case studies.

**Process matters**

HSPA goes far beyond producing a final report. Supporting health system governance is a means as well as an end. Ownership is critical, and ownership develops gradually during the HSPA process. In short, the process matters as much as the output.

The process is important because it creates a valuable culture of evaluation and a demand for evidence; a better understanding of the strengths and limitations of information systems; the building of a dialogue; and the sharing of data between constituents of the health system. Participating in HSPA is a learning experience for those involved. It introduces a holistic picture of the health system, the relationships among the various parts of the system and the strengths and weaknesses in the system. Moreover, due to the subjective nature of performance assessment – reflected, for instance, in the choice of indicators or the relative importance attached to different objectives – this process provides a forum for stakeholders to share their perspectives and learn from each other.

A participatory process includes the following elements:

- building a consensus on the performance framework;
Box 5: Lessons learned and key actors in selected countries (1)

Armenia: The fruits of a committed approach

- The government needs to have full ownership of the process. Ownership does not come immediately but rather grows out of ongoing capacity-building, learning and discussion of the objectives and benefits of undertaking HSPA.
- Consistency in staffing has helped provide the continuity that HSPA requires. While a small working group will probably reach agreement and be more efficient than a larger group, there may also be merits in expanding participation to other experts, perhaps even beyond the health sector.
- A key factor for success is the collaboration of national and international participants in the HSPA work. It is important to select participants who are used to collaboration and have an optimistic, problem-solving attitude towards HSPA.

Estonia: Going hand-in-hand

- Combining responsibility for HSPA and monitoring a national health policy in one technical unit can be a sensible way to create synergies in data collection. At the same time, international organizations can provide added value by providing technical support, facilitating the debates and ensuring the impartiality of the assessment.
- The Estonian case shows the merit of using a small, committed group of people to test out implementation of HSPA while consulting policy-makers at key stages of the process.

Kyrgyzstan: Monitoring and evaluation – a powerful joint tool

- When external funding and actors are involved, it is important that one institution takes a coordinating lead and all partners accept a common monitoring and evaluation process.
- It can be beneficial to separate health system monitoring functionally and institutionally from evaluation to maximize institutional capacity, make it more flexible and promote objectivity and timeliness of evaluation results for policy decision-making.

Portugal: Facilitating national policy planning

- HSPA should not consist of a central level exercise but needs to include perspectives at different levels, particularly the regional and local levels. The HSPA team should consider various approaches to integrating the different levels.
- There is merit in applying an international approach when implementing HSPA. Nevertheless, it is essential that the members of an international team have excellent linguistic skills to ensure that the HSPA builds on the cultural underpinnings of the national system; that political sensitivities are taken into account; and that the body of national literature is utilized.

Turkey: Support at the highest level

- High-level political commitment and support has been essential to the success of HSPA in Turkey.
- A broad participatory process helps ensure acceptance and ownership of HSPA.
- A standing committee may be an effective way to get stakeholders to contribute rapidly as needs emerge; but it is important to report periodically to the committee on progress. Having the same team members throughout the process supports the continuity of the work, if the choice is to work with a core team.
- Cooperation with international organizations and consultants helps increase transparency and reliability in addition to equipping local staff with international technical expertise. HSPA is an excellent instrument for working in partnership with different national and international entities.

- making explicit and confronting values to make judgements;
- incorporating a broad base of “intelligence,” or background knowledge, to give depth to selected indicators;

Pathways to health system performance assessment
• developing a common “storyline” of interweaving indicators; and

• jointly discussing policy questions and policy options to provide balanced and comprehensive solutions to public health problems.

**Actors matter: What are the key roles?**

The HSPA organizational structure describes who will be involved in the process and how each actor is expected to contribute. Sharing the organizational structure with all participants helps to ensure that they understand their roles and the roles of others in the process. During the selection of participants, it is important to consider not just those actors whose contributions are required, but also the capacities that are intended to be built, given that HSPA should be an enabling learning experience for those involved.

The generic roles often required for successful completion of an HSPA project are the key HSPA sponsor; a core group of dedicated staff during the critical phases of the project, responsible for moving the work forward; an advisory council to provide input from a range of sources and to review progress; and expert panels with varying roles and compositions. The positioning and composition of these roles are described in Thematic brief 1.

Since the choice of a health system framework and performance indicators reflects the values and perspectives of system stakeholders and the general public, the membership of the expert panels should constitute a representative sample of the spectrum of values held by the stakeholders. A representative sample might include experts from health authorities, suppliers and custodians of health data, employees of analytical and reporting agencies, researchers and other users of health information.

**The fourth principle: integrating an equity perspective**

An equity perspective can and should be systematically introduced into an HSPA at each step of the process, from the development of the framework to the data analysis, stratified according to relevant groups, and policy recommendations.

Financial protection, or fairness in financial contribution, is a commonly accepted dimension of performance, as illustrated in the WHO framework (16). In an equity-sensitive health system there is a need to go beyond this financial dimension of equity to ensuring equity in actual treatment, services and outcomes. Equity means equal access to services for equal need, equal utilization for equal need and equal quality of care for all, with a focus on health outcomes. These ideas have been summarized as follows:
Equity in health implies that ideally everyone should have a fair opportunity to attain their full potential and, more pragmatically, that no one should be disadvantaged from achieving this potential, if it can be avoided. Based on this definition the aim of policy for equity and health is not to eliminate all health differences so that everyone has the same level of health, but rather to reduce or eliminate those, which result from factors which are considered to be both avoidable and unfair. Equity is therefore concerned with creating opportunities for health and with bringing health differentials down to the lowest levels possible (19).

The distinction between health inequalities and health equity is highlighted in Box 6.

**Box 6: From observing differences to generating evidence of health inequity**

**Health inequalities:**
- describe differences or differentials that may or may not be due to factors that are avoidable and unfair. Older people, for example, have a higher standardized mortality rate than young people; and men in most European countries have a lower life expectancy than women.

**Health equity:**
- implies that ideally everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that no one should be prevented from achieving this potential (20);
- involves analysis and a decision about whether the differences are due to factors that are avoidable and unfair, based on gender norms or socioeconomic status, for example.

**Equity matters**

Despite declines in overall mortality for all groups, socially-determined health inequities remain a serious concern for policy-makers in the European Region. The negative consequences of inequity on vulnerable populations impose costs on society as a whole and undermine existing health and development gains.

Within the WHO European Region there is an unequal distribution of the social determinants of health, which means the opportunities to be healthy are not equally distributed across populations. People in the most disadvantaged groups, for example, face greater risk not only because they have less access to health services but also because they have fewer resources to enable them to make and sustain healthy lifestyle choices. These resources include education, employment, housing, participation in civic society and control over their lives. A key message of the European Action Plan for Non-Communicable Diseases 2012–2016 (21) is that society should create health-supporting environments, thereby making it easier for people to make healthy lifestyle choices.

Recognition of the relationship between social determinants of health and equity is fundamentally important. Equity is much more than an aspiration to achieve better health for the entire population, particularly those disadvantaged socially, economically or educationally. There will
always be lingering questions about the effectiveness of a health system if it does not reach all its intended beneficiaries and have the same expected benefits for all population groups. Many studies have shown the marked differences in health outcomes between population groups, and there is also evidence that some of these differences are preventable. The difference in outcome can be narrowed by improving the health system, particularly the way services are developed and delivered. Thus, equity makes good sense in terms of the effectiveness and performance of the health system.

Generating evidence on differences and gaps between population groups

Indicators that capture the health impact of public policies are critical to redefine and reorient policies towards equity. The Commission on the Social Determinants of Health identified the reduction of inequity in health as lying at the heart of good governance and proposed a minimum equity surveillance system (Box 7). Countries lacking information systems that technically enable a link between health and social conditions face an increased likelihood of bias in reporting health inequalities and a potential mismatch in subsequent policy response and programme investment (22). Limited availability or limited use of data disaggregated by sex, socioeconomic status and geography continues to present a major barrier to illustrating the extent of gaps in health system performance.

Data limitations for some indicators may restrict the ability to stratify and report results for regions or subpopulations of interest. Where these limitations exist and stratified results cannot be obtained for the HSPA report, it is important highlight the problem as a priority for future development of information systems. Where stratified results are available for previous time periods, the extent to which variation seems to have increased or decreased can be examined to provide evidence of the impact of reforms on a regional basis or on specific subgroups.

Opportunities to integrate a health and gender equity focus in HSPA: from the identification of disparities to assessment of inequities and elaboration of pro-equity policies

Based on an equity surveillance system as outlined in Box 7, integration of a health and gender equity focus within HSPA represents an opportunity to enhance visibility and mainstream equity considerations, building on the public attention to performance reports. Equity measures are integrated in most current HSPA frameworks, either as a transversal dimension or as an objective of the health system. Equity is an overarching dimension presented across all tiers of the OECD framework (18) and also applied in the Netherlands (24). In Turkey, for each dimension (related to health system goals, intermediate objectives and the four health system functions), the assessment of average achievement is “mirrored” by an assessment of the gaps between

http://www.euro.who.int/__data/assets/pdf_file/0008/88613/E91438.pdf
Stratification of results should be focused on the equity policy questions identified in the HSPA strategy. Observing differences between population subgroups, through disaggregated data analysis, is a first step and minimum requirement for integrating an equity perspective in HSPA. Sex and measures of socioeconomic status, such as household income quintile, are often important in assessing equity in health and population health. Regional results are also important, especially if some aspects of resource allocation and/or management and delivery of health services are organized on a regional basis. An average picture, or result, could mask significant problems in certain areas of the country, such as lower rates of immunization in remote or rural areas.

The next step consists of assessing and understanding the differences so as to identify those which are unfair and avoidable. Hence, an equity analysis supposes that there is some explicit agreement on what is considered unfair or avoidable. The third and final step takes place during consideration of the policy options in the HSPA report. At this stage some policy recommendations should be identified for how to address the observed inequities and determine what the

Box 7:  **Minimum equity surveillance system** (adapted from *Closing the gap in a generation: health equity through action on the social determinants of health* (23))

A minimum health equity surveillance system provides basic data on mortality and morbidity by socioeconomic and regional groups within countries.

All countries should, as a minimum, have basic health equity data available that are nationally representative and comparable over time. Ideally, mortality is estimated on the basis of complete, high-quality registries of vital events, while morbidity data could be collected using health interview surveys.

**Health outcomes:**

**Mortality:** infant mortality and/or under-five mortality, maternal mortality, adult mortality and life expectancy at birth;

**Morbidity:** at least three nationally relevant morbidity indicators, which will vary between country contexts and might include prevalence of obesity, diabetes, undernutrition and HIV/AIDS; self-rated mental and physical health.

**Measures of inequity:**

In addition to population averages, data on health outcomes should be stratified by sex, at least two social markers (such as education, income/wealth, occupational class and ethnicity/race) and at least one regional marker (such as rural/urban, province).

At least one summary measure of absolute health inequities between social groups and one summary measure of relative health inequities between social groups should be included.

High-quality data on the health of indigenous peoples should be included, where applicable.
trade-offs might be for taking an equity perspective. It is also important to consider the potential impact on equity of any policy recommendation proposed in the HSPA report. This should be discussed explicitly. Finally, it will be important for the HSPA to include two or three macro-indicators of inequity issues within the country, such as level of unemployment, as part of the broader context.

Experience suggests that the integration of an equity perspective in HSPA is a gradual process. Countries are invited to start this process of integration by selecting a few high-priority health indicators (including both mortality and morbidity indicators, if possible) which lend themselves to an equity analysis. Data on these indicators are used to begin reporting stratified results and to develop the capacity for analysing the results and making policy recommendations with an equity perspective. The initial objective is to cross-link sex- and age-disaggregated data for four to five health outcomes (a balance of mortality and morbidity) with at least two to three of the markers of inequity available from existing data systems. Then a similar type of analysis is repeated for intermediate objectives. Lastly, process and structure (such as health reform strategies or health policies) are assessed through the equity lens.

The fifth principle: complementing the scope of HSPA

Understanding the reasons for underperformance and building policy recommendations require complementing the scope of the performance assessment with in-depth analysis or qualitative evaluation studies. Informing answers to the policy questions requires going beyond indicators and moving into evaluation research.

HSPA reports on a set of core indicators with a broad scope. Findings on those core indicators are summarized in scorecard format or in tables with short text. To give greater meaning to the indicators, an additional “cloud” of indicators is provided in the text of the report. This can also be supplemented by qualitative analysis or illustration of interventions that were implemented during the assessment period. Preliminary results might be discussed at a meeting of stakeholders with the advisory committee or expert panel, to tell the story behind the figures. In addition to this analytical exercise at the core of HSPA, the report itself will generate questions that might trigger further in-depth evaluation of indicators which were flagged as “immediate action required” or “further scrutiny needed.”

Complementing the scope of HSPA requires going beyond the initial results to understand what contributes to the differences between countries and regions; to reference targets; or to an unexpected increase or decrease over time. To interpret the meaning of the observed results, to identify weaknesses requiring policy action and to formulate options for solving problems all require complementing performance measurement with other resources, in-depth knowledge and a hypothesis of attribution or causation, along with its related assumptions. A decrease in
the infant mortality rate, for instance, might be caused by the introduction of a new package of clinical measures that include antenatal care. Another example is an increase in the rate of suicides among working-age men, which might be the result of the economic crisis and significant changes to the social welfare system. The underlying causes would not be evident from HSPA results alone.

Sex-disaggregated data show inequalities between men and women but do not explain the reasons for these differences. Without knowledge of the underlying causes, the health system cannot formulate appropriate responses. Gender-sensitive indicators and gender analysis of sex-disaggregated data are needed. Gender-sensitive indicators are measures that track women’s and men’s health over time and can include determinants of health, health experiences, specific health concerns such as gender-based violence, access to and use of health services, contribution to health care (paid and unpaid), and processes and health outcomes that lead to gender equality and health equity. Gender analysis is illustrated in Box 8.

**Box 8: From identifying a gap between men’s and women’s health to gender analysis**

Gender analysis in health examines the consequences of gender inequality with respect to health and well-being and contributes to understanding health differences and disparities among and between groups of men and women in the following areas:

- risk factors and vulnerabilities;
- patterns of disease, illness and mortality;
- health effects of policies, legislation or programmes;
- access to services and resources, such as health care, education and information; and
- decision-making processes related to health and the organization of health systems.

Gender analysis can be applied to:

- health policies, legislation, programmes, services and research;
- specific health conditions and problems; and
- human resources, planning, budgeting and operational planning.

Gender analysis can increase health system effectiveness by:

- ensuring the right to health of different groups of men and women;
- recognizing and reducing the constraints women and girls face in protecting and promoting their health;
- addressing how gender norms, roles and relationships may harm the health of men and boys;
- reducing inappropriate and ineffective services, programmes or policies that ignore the realities of women’s and men’s lives;
- identifying and reducing gender bias in the health system;
- developing and implementing gender-responsive services, policies and programmes; and
- improving health information, documentation and use.
Further readings for Chapter Two:

**Accountability and transparency**


**Horizontal governance**


**System perspective**


**Participation**

- See material and references on public participation at http://www.iap2.org/

**Integrating an equity perspective**

CHAPTER THREE: YOUR COMPANION THROUGH THE JOURNEY

SIX STEPS FOR ADAPTATION WITH CHECKLIST

Introduction

This chapter aims to support those who will be responsible for conducting HSPA by providing practical suggestions. The chapter is built as a road map of the journey to the finalization and dissemination of the HSPA report: it identifies the critical steps and milestones and at each step prompts questions and proposes a list of key deliverables.

The proposed process is generic. It builds on the lessons learned from experienced countries and recommendations garnered from experts during three consultation meetings. It encourages the interested reader to think about the process in his or her own country in a systematic way. It does not provide all the answers; on the contrary, it points to further questions. The process needs to be modulated to local capacities and needs; therefore, elaborating a project charter is critically important. This first step will set the tone for the remaining steps in the process towards the publication of an HSPA report: building the performance framework, selecting the indicators, collecting and understanding the data, interpreting the indicators, organizing the report and presenting and disseminating the results.

This journey takes us to the finalization and dissemination of the HSPA report, both of which are critical to ensure transparency. Nevertheless, the HSPA report is only one milestone, a concrete deliverable in the HSPA process. The report is a starting point, feeding into the policy cycle and contributing to performance management in the long term. Those aspects are discussed in Chapter Four.

Step One: Defining and elaborating a project charter

A project charter represents a solid foundation for HSPA and is critical for the continuity of the process beyond the production of the first report. It clarifies the rationale and objectives, strategic alignment, roles and responsibilities, timeline and resources. It conveys what HSPA is and why the decision was made to implement it. The first critical step is using the project charter to build, through dialogue, a common understanding and vision shared by all actors in the process. Carefully laying out all the essential elements in written form clarifies each actor’s role and
prepares the ground for the next steps of the process. The project charter also helps develop convincing applications to donors for financial support.

As Chapter Two emphasized, it is crucial from the earliest consideration of an HSPA in any country to have the greatest possible stakeholder involvement across all sectors of the health system and beyond, including the general population. A shared ambition and a shared understanding of what is to be achieved – as well as how and why – has to be fostered and sustained throughout the process.

The diverse practical experiences in the European Region suggest a number of different pathways or approaches. The answers to the key questions below will help modulate the HSPA process to meet the capacity and needs of the individual country and integrate it in the local policy context.

1. **Rationale and objectives:** Why does it make sense to implement HSPA in your country at this time? What is the mandate for HSPA? What is expected to be gained from the HSPA process? The first opportunity to involve important actors is to consult with key individuals to define the rationale and objectives for HSPA. Chapter One outlined a proposed rationale and demonstrated how some countries have used HSPA. The HSPA sponsor or initiating organization should draft initial answers to these questions to be shared with a wider audience of stakeholders for comments and feedback. The consensus developed around the rationale and objectives helps determine the most appropriate group of actors to be involved in the HSPA.

2. **Policy context and strategic alignments:** What are the strategic priorities for health system strengthening and in particular for strengthening governance and leadership? How does HSPA build on or contribute to other governance tools, such as national health plan monitoring and evaluation, performance management at subnational level or programmes and accountability to donors? How does it support strategic priorities within the health system? What are the other important policy initiatives and what are the opportunities or threats to implementing HSPA in this context? At this early stage, it is necessary to identify current health system initiatives (and related initiatives outside the health sector) that have a bearing on the objectives of the HSPA. These might include the development of a national health strategy or plan; the implementation of performance-based budgeting; monitoring and evaluation of major reforms or comprehensive programmes; and reorganization of the structure of governance of the health system, such as regionalization along with delegation of authority and responsibility.

3. **Roles and responsibilities:** Who are the main stakeholders? Who are potential partners and what are the opportunities for collaboration? How can the need for ownership and the
need for technical independence be balanced? Who will be responsible and accountable for delivering the HSPA report? Who will organize and plan the HSPA work? What institutions are active in the system and what are their roles? Who has the motivation, capacity, resources, credibility and technical independence to lead or support the implementation? How and where could those qualities be developed? Who generates and analyses the data? The project charter presents the key roles, as described in Chapter Two and in Thematic brief 1: project sponsor, working group on HSPA (core group of dedicated staff leading implementation), an advisory committee and an expert panel. A first step in identifying HSPA stakeholders and participants and their roles is to consider the organization of the country’s health system.

4. **Resources, timeline and process:** What are the key deliverables? When should those be delivered and by whom? What are the milestones? What is the planned cost? What are the funding sources?

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### Checklist for Step One

**Actions:**
- Understand the value of HSPA.
- Learn from other countries.
- Decide who will be responsible and accountable.
- Engage a wide spectrum of stakeholders.
- Build a consensus on scope and objectives.
- Foster a common language and framework.
- Agree on a time frame and identify resources.

**Deliverable:**
- Project charter

**Milestone:**
- Seminar or conference to launch the HSPA process

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### Step Two: Building the performance framework

The objective at this step is to define the performance dimensions and how they relate to each other and link the system’s strategies and health outcomes. The attributes of a highly performing health system are described. How does an effective health system function and what outputs and outcomes does it produce? The performance framework should represent what really matters rather than what can be easily measured.

The process described below does not take into account availability of data. This issue will be discussed as part of a later step. It is critical to distinguish between the theoretical framework,
which will guide the HSPA process over several years, and the set of indicators, which is driven by the framework but may be modified as new data become available or priorities change.

Countries differ in how they begin to build their performance framework. One approach is to take an internationally accepted framework and adapt it to reflect the local policy context by modulating intermediary objectives or subdimensions. In Estonia, Portugal and Kyrgyzstan, for example, the country-specific framework is based on the WHO framework of health system functions, goals and objectives (16, 17). The Dutch (24), Belgian (25) and OECD (18) frameworks constitute another “family” of frameworks. In Belgium, following a review of frameworks used internationally, an external expert group invited by the HSPA core team recommended using a combination of the Dutch and Ontario frameworks and adding specific dimensions. This process of defining a performance framework made particular sense in the Belgian context, where responsibilities for health are distributed across different actors and levels (federal, regional and local) without a comprehensive national policy. The interested reader can find a comprehensive review of performance frameworks by Smith et al. (26).

A second approach is to base the performance framework on a national health strategy or reform programme and then use international frameworks as a quality-check to ensure that no important function or dimension of performance has been overlooked. This approach has been chosen in England, Georgia and Turkey. It ensures that the framework is highly relevant to the national context and aligned with the monitoring and evaluation component of the national health strategy. Although they are in alignment, monitoring and evaluation of the national health strategy and the HSPA performance framework should not be identical. HSPA frameworks are designed to remain valid after the end date of the national health strategy. HSPA should include some factors outside the realm covered by the national health strategy in order to inform future revision of the national health strategy. It is also critical that the HSPA framework encompasses strategies (structures and process) as well as outputs, outcomes and impacts. The link between national health strategies and HSPA is discussed the accompanying case studies on Portugal and Estonia (1).

In both approaches, answering the following questions provides material for building the country-specific framework. What are the national health priorities? What are the key health policy questions? How can those be translated into performance dimensions? What are the related goals and core health system functions? This is illustrated with an example from Georgia in Box 9.

This review of the health system goals and policies aims at understanding the problems and challenges the health system is trying to address, the results expected from the stakeholders’ strategic activities and the expected direction of progress. The next stage requires the identification of broad themes that best reflect the issues, in order to define the dimensions and
subdimensions. Dimensions should be comprehensive enough to include all relevant issues but distinct enough to address different sets of issues. The objectives are then articulated by translating the subdimensions into specific, actionable and measurable objectives. Objectives should be realistic and time-limited. They will determine the performance indicators used in step three.

<table>
<thead>
<tr>
<th>National health priority</th>
<th>Related health system strategy</th>
<th>Related goal and core function</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensuring the overall affordability of basic health services and protecting the general population from catastrophic financial health risks</td>
<td>Improving equity and financial protection of the population</td>
<td>Fair financing</td>
</tr>
<tr>
<td>Ensuring the quality of medical services by creating and enforcing the necessary regulatory environment</td>
<td>Improving the quality of health services and clinical outcomes</td>
<td>Health service provision</td>
</tr>
<tr>
<td></td>
<td>Improving health system stewardship</td>
<td>Stewardship</td>
</tr>
<tr>
<td>Ensuring the accessibility of quality medical services by continuous development of medical infrastructure and competent human resources</td>
<td>Improving geographical and informational accessibility to the health system</td>
<td>Health service provision</td>
</tr>
<tr>
<td></td>
<td>Improving financial accessibility to the health system</td>
<td>Health financing</td>
</tr>
<tr>
<td></td>
<td>Ensuring efficient allocation of the health system resources</td>
<td>Resource generation</td>
</tr>
<tr>
<td>Increasing health system efficiency by capacity-building of the ministry and its subordinate institutions, and through introduction of sound managerial principles</td>
<td>Ensuring efficient allocation of health system resources</td>
<td>Resource generation</td>
</tr>
<tr>
<td></td>
<td>Improving efficiency and effectiveness of health services</td>
<td>Health service provision</td>
</tr>
<tr>
<td></td>
<td>Improving health system stewardship</td>
<td>Stewardship</td>
</tr>
</tbody>
</table>

Some countries have adopted strategy maps to keep the focus on the vision while highlighting the interdependencies in the strategies. A strategy map is a formal, visual articulation of the hypothesized cause-and-effect relationship between the strategic goals of the health system. This means that the next task is to reorganize the health system strategies and related goals so as to highlight the expected cause-and-effect relationship between them. To do this, a top-down approach may be employed, beginning with the overall goal (better health for the population) and then arranging strategic goals in a logical sequence. Arrows are then drawn from left to right to indicate cause-and-effect relationships.

One strategy can contribute to several objectives; conversely, one objective can be met through a combination of strategies. This could give rise to a very complicated strategy map. The art of building a strategy map, or framework, lies in extracting the core elements to maintain focus and clarity. It also requires linking strategies to performance dimensions (Figure 1). Sometimes
difficult decisions are required, which might bring to the forefront differences in the priorities of various actors. A small operational taskforce can carry out the initial review of policy documents and strategic priorities summarized in a table, initial comprehensive diagrams with all dimensions and expected relationships and the proposal for a consolidated performance framework. Finalization of the performance framework, however, requires consultations and eventually a high-level meeting to reach consensus. The consensus meeting is a key milestone for obtaining input and feedback from health system stakeholders on the goals and objectives and therewith to foster ownership of the performance framework. Involving key players from different parts of the system ensures broad-based acceptance of the system’s strategic themes.

**Fig. 1:** Linking indicators to the strategic framework provides the evidence needed to determine progress. Strategies are linked to performance dimensions, and performance dimensions are linked to indicators in this example from Ontario, Canada (28).

---

**Checklist for Step Two**

**Actions:**
- Review the health system’s goals and policies and **perform environmental scan.**
- Identify dimensions and subdimensions of performance.
- Validate and articulate goals and objectives for the system.
- Design the performance framework, which might be visualized as a strategy map.

**Deliverable:**
- A country-specific performance framework (set of interlinked performance dimensions) that is locally accepted and in accordance with international best practices

**Milestone(s):**
- Consensus meeting(s) with key stakeholders on the performance framework
Step Three: Selecting indicators

There is no one-size-fits-all set of indicators. The country-specific performance framework together with the country’s data collection and reporting capacity drive the selection of the health system performance indicators. This helps keep the focus on the health system’s strategically important and most relevant areas. It also allows the identification of health information gaps and fosters continuous improvement in health information systems. Figure 2 proposes a generic process for selecting the indicators used to assess health system performance.

This process illustrates a starting point adaptable to a particular country and the organization of its HSPA. Many potential indicators covering a wide range of possibilities are gradually reduced to those eventually selected. An initial long list of indicators can be generated from various national and international sources and then filtered down through standard steps using predefined selection criteria (Thematic brief 2). Questions that can help identify whether an

Fig. 2: Generic process for selecting a core set of performance indicators

A. Define on methodology, including A1, A2, A3
A.1. Identify sources for indicator inventory
A.2. Agree on selection criteria at different stages
A.3. Elaborate structure of indicator passports (concise and detailed versions)
B. Inventory potential indicators from various sources à inventory
C. Map indicators to the performance dimensions à long-list
D. Pre-select indicators à short list
E. Draft concise indicator passports for indicators on short list
F. Convene an expert panel to develop consensus on set of indicators (e.g. Delphi à experts listechine or similar)
G. Elaborate detailed indicator passports for all those included in the experts lists
H. Review and refine the indicator set as needed
I. Validation and consensus with high level policy-makers

- Set of core indicators (with detailed indicator passports)
- Information gaps to be filled in by priority (for next report)
- Report documenting process
indicator is useful for measuring performance in one of the dimensions of the framework include the following:

- If the results for this indicator were to increase or decrease, what would it say about performance in a particular dimension?
- Has a target been attached to this indicator within a national health policy or within another policy document or programmatic document associated with this performance dimension?
- Would the results of the indicator provide answers to the policy question(s) associated with the performance dimension?

Indicators with clear definitions should be selected, while “reinventing the wheel” on indicator definitions should be avoided. The selection of indicators and interpretation of their results are based on international evidence. An indicator passport that documents the characteristics of each preselected indicator will be developed under the supervision of the core HSPA team and then used by an expert panel to inform indicator selection decisions. The indicator passports have three purposes: summarizing relevant information about the indicator necessary to assess against selection criteria and ultimately to decide whether it will be included; documenting data sources and definitions to facilitate data collection for the initial report and ensure consistency in monitoring the indicators for subsequent reports; and gathering evidence to guide the interpretation of results and highlight policy implications. Examples of indicator passports can be found in the Ontario Health System Scorecard Technical Report (28).

For preselected indicators, several considerations will guide the formulation of the operational definition and the selection of data sources: burden of data collection, quality of data, availability of historical data to report trends, the existence of targets set nationally or subnationally, the capacity to report stratified results and the availability of international comparative data. If gender, income, education and urban versus rural or other regional differences are identified as important to understanding equity in the health system, then the availability of data for stratification according to these characteristics should be taken into account when defining the indicator. These considerations might lead to using self-assessed status from a survey as a measure of health status, for instance, since surveys often include items on income, gender and education. This stratification could be more difficult with an indicator such as potential years of life lost. Another challenge is deciding when to use locally-defined indicators to measure performance aspects important to the country, rather than standard international measures; or when to use data that is more valid but perhaps less recent.

While it may be relatively easy to identify good indicators for two or three dimensions (like health status or health system financing), it can be very difficult to find good indicators for
other dimensions (such as those related to coordination of care or health system information). There may be some dimensions for which no indicator meets all the criteria; but the expert panel should identify at least one or two indicators to be used in each of the dimensions. For those dimensions where there may be many appropriate indicators, the panel could consider selecting between two and four indicators that are best.

Next, the working group will review the set of indicators to ensure that it provides good coverage of the entire performance framework, that a proper balance is achieved between structure, output, outcome and impact indicators or domains (Figure 3) and between backward- and forward-looking indicators (Figure 4). The whole set of indicators also needs to be reviewed to assess the burden of data collection or data retrieval and analysis for the set as a whole, considering the balance of “off the shelf” indicators versus those that require development.

In conclusion, there are many considerations for balancing the indicator set. These will require work with health information system experts, researchers and holders of data sets in order to

**Fig. 3:** Logical representation and value chain in the IHP+ common M&E framework to distinguish between input and processes, outputs, outcomes and impact (29)

**Monitoring & evaluation of health systems strengthening**

<table>
<thead>
<tr>
<th>Indicator domains</th>
<th>Outputs</th>
<th>Outcomes</th>
<th>Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governance</td>
<td>Infrastructure; Information &amp; communication technologies</td>
<td>Intervention access &amp; services readiness</td>
<td>Coverage of interventions</td>
</tr>
<tr>
<td></td>
<td>Health workforce</td>
<td>Intervention quality, safety</td>
<td>Prevalence risk behaviours &amp; factors</td>
</tr>
<tr>
<td></td>
<td>Supply chain</td>
<td></td>
<td>Responsiveness</td>
</tr>
<tr>
<td></td>
<td>Information</td>
<td></td>
<td>Efficiency</td>
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</tbody>
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<table>
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<tr>
<th>Data collection</th>
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<tbody>
<tr>
<td>Administrative sources</td>
<td>Facility assessments</td>
</tr>
<tr>
<td>Financial tracking system; NHA</td>
<td>Coverage, health status, equity, risk protection, responsiveness</td>
</tr>
<tr>
<td>Databases and records: HR, infrastructure, medicines etc.</td>
<td></td>
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<tr>
<td>Policy data</td>
<td></td>
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<tr>
<td></td>
<td>Clinical reporting systems</td>
</tr>
<tr>
<td>Service readiness, quality, coverage, health status</td>
<td></td>
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<td></td>
<td>Civil registration</td>
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<tr>
<th>Analysis &amp; synthesis</th>
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<tbody>
<tr>
<td>Data quality assessment; Estimates and projections; In-depth studies; Use of research results; Assessment of progress and performance and efficiency of health systems</td>
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<thead>
<tr>
<th>Communication &amp; use</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Targeted and comprehensive reporting; Regular country review processes; Global reporting</td>
<td></td>
</tr>
</tbody>
</table>
In practice, outputs measured at one point in time will have been influenced by inputs in a previous time period. Similarly, inputs in a current time period will influence outputs in a future time period. Excluding this aspect incorrectly attributes all performance to current actions and holds stakeholders accountable for past actions for which they may not have been responsible. For instance, campaigns for smoking cessation will impact on the prevalence of cancer in the future. In another example, the health care work force gradually develops, reflecting previous investments education. By including a time dimension, HSPA can provide incentives for policies with long-term effects, as these will be recognized in the short term. One way to include the time dimension in the framework is to develop contemporary measures of future performance. Including this dimension in the framework would allow for current indicators that are known from research evidence to be associated with future outcomes to be used as predictors of future performance. These indicators include physical capital; human capital (including training); prevention (including effective coverage); preparedness for disasters; financial sustainability (for example, reliance on donors); and population risk factors.

Checklist for Step Three

**Actions:**

- Review list of indicators.
- Assess each indicator according to pre-identified selection criteria.
- Consult expert panel for drafting indicator passports and for selection.
- Validate final set of core indicators with HSPA advisory board.

**Deliverables:**

- Report documenting the process of indicator selection, including list of indicators, sources for definitions, scores on selection criteria and experts involved at each stage of the selection process
- Passport for each indicator selected in the core set, including short rationale, performance dimension and related indicators, definition, primary and/or secondary sources of data, data collection and indicator calculation (roles and responsibilities, methodology and time frame), potential for equity analysis (data availability and rationale for stratification) and national targets or international reference points

**Milestone:**

- Technical expert panels and policy-makers’ review meeting(s): selection of indicators for each dimension and review of the whole set for validity and for balance between dimensions and types of indicators. At this milestone the final set of indicators will be endorsed by the stakeholders, represented by the advisory board.
develop the best set of indicators to represent the country’s health system performance. Any changes or refinements of the indicator set following the in-person panel meeting should be communicated back to the expert panel members. Some adjustments can be made, but ultimately the expert panel’s advice should determine how to make those changes.

The core set of indicators may be complemented with additional indicators at a later stage to give greater breadth to the analysis, as discussed in the fifth principle, complementing the scope of HSPA. The additional indicators are identified in the indicator passports. The selection process for complementary indicators is more adaptable; it will emerge as the process develops and questions arise during analysis of the core indicators. Only the core set of indicators will be represented in the scorecard for regular monitoring and evaluation.

**Step Four: Collecting and understanding the data**

Once the indicator list has been developed, gathering and reviewing results for the indicators can begin in earnest. The two key components of this work are collecting and organizing the results and then reviewing and verifying the results.

There are usually three aspects to the collection and organization of indicator results:

1. **Collecting readily available (“off the shelf”) results from standard sources such as national statistical agencies and reports:** Publicly available information can be pulled together and reviewed easily. Collecting current results that have not yet been reported or more specific or stratified results from the source agency may involve extra work.

2. **Collecting results reported to and available from international organizations such as the European Health for All database (31), WHO Statistical Information System (32) or OECD health data (33):** These data can be used to identify other countries or groups of countries as reference points. Where possible, consistent time periods should be used for comparisons. Although international databases do usually not report data stratified for socioeconomic factors, some indicators are reported by gender. Information for the country is probably also included in the appropriate sources and can be verified against nationally reported results.

3. **Working with agencies and information holders to develop results for indicators not previously calculated:** Although data is available to calculate the results for these indicators, the appropriate numerators/denominators and exclusions/inclusions need to be determined, in cooperation with the agency responsible for the data, to determine results. It is important to confirm with the agency how results are to be presented, including the required stratifications and time periods.
In the review and verification stage, results should be confirmed with the data sources, using a checklist that includes the following questions.

- **Have the results been reported in detail as requested, including stratification and time periods?** In order to understand some indicators, it can be useful to have numerators and denominators reported and available for analysis, as well as the value of the indicator.

- **Do results from national sources match those reported from sources of international comparisons?** If not, do methodological differences account for the different results, and can these be reconciled? Any differences should be reviewed with national agencies.

- **Are results reported for previous years consistent?** If a 2007 result is included in a 2010 report, for example, is it the same as the result originally reported in 2007? Historical results can sometimes be updated or revised based on changes in methodology. Where results have been restated, it is important to note and explain the difference.

- **Are there outliers in the historical trends or in the stratified results?** If the results generate new questions, it is likely the HSPA report audience will have similar questions. Outliers should be reviewed with the agency that reported the results, explanations noted and/or corrections made, if appropriate.

It is important to understand what the data can and cannot show and to be explicit about data limitations. Discrepancies that are not explained or results that appear to be invalid increase the risk of stakeholders dismissing the whole report because they spot a weakness in one of the indicators. One better understands the strengths and limitations of the data when actually making concrete use of them. In this respect, the HSPA exercise helps identify issues of data availability, quality, coverage, fragmentation and timeliness. For this reason it is useful to report on the lessons learned and options for strengthening the health information system (Box 11 and Thematic brief 3).

The indicators that can provide information about health and gender equity should be linked to the performance framework and the approach to assessing equity in the HSPA. Indicator passports that document the feasibility of stratifying indicators are important to help the expert panel select indicators that lead to an assessment of gender and health equity.

**Box 11: Strengthening information systems for HSPA**

Challenges for health information systems have been recognized to involve, in general, three main blocs of determinants: technical, organizational and behavioural (34, 35)
Step Five: Interpreting the data and organizing and writing the report

The HSPA report is more than presenting a collection of indicator results. To build a complete picture, three levels have to be brought together: the individual indicators, the performance dimensions and the overall health system.

The first component is interpretation of the individual indicators in context, identifying reference points, trends and relationships with other indicators. Results for performance indicators...
at one point in time are not useful for assessing health system performance. Results have to be placed in a context of three dimensions.

- How have results changed over time?
- Are the results where they should be?
- How much do the results vary across regions or subpopulations?

The answers to these questions will form a critical part of the analysis. Boxes 12, 13 and 14 describe the key considerations for each of the first two dimensions. This is necessary to build an assessment from a measurement. An assessment incorporates a judgement. This means assessment is always value-based. The choice of reference points (more or less ambitious) and the selection of evaluators will influence the assessment. Results on an indicator are not good or bad per se, but they appear to be better or worse compared to a certain reference point, or standard.

An indicator merely indicates or flags but does not judge. It is the evaluator who makes a judgement based on the indicator results. This degree of subjectivity needs to be recognized and mitigated by the transparency of the process, the explicit nature of all choices (indicator selection, for instance), and systemic planning and implementation (for example, using the same

**Fig. 4:** Graphic representation for individual indicators: Illustration from Estonia: All-cause and avoidable mortality by sex, 2000–2008 (37)
Box 12: How have results changed over time?

- **What historical trend data is available?**
  It may not be possible to report results going back more than a few years. For some indicators related to recently implemented reforms, there may be no historical results at all. Moreover, results from different methodologies cannot be compared directly. Limitations in available historical data should be noted in the analysis.

- **How quickly would results be expected to change?**
  Results for measures of health status, such as life expectancy or potential years of life lost, probably change more slowly than results related to processes within the health system, such as changes in length of hospital stay or the number of ambulatory care visits. So it may be preferable, if the data allow it, to go back further in time when assessing trends in health status results. If, however, the performance indicator relates to the implementation of a recent reform (hospital restructuring, for example), it may be sufficient to report results for a period prior to the reforms and follow the trends that occur after implementation.

The second component is performance dimensions. The individual indicators were selected in order to answer policy questions and assess performance in identified dimensions of the health system. The performance dimensions developed from the framework help to ensure that there are indicators that cover the full health system as it has been defined for the HSPA. In assessing performance for a specific dimension, it is necessary to look at the indicators and related policy questions and determine what the results say about the answers to the policy questions.

**Fig. 5:** Graphic representation for individual indicators: Estimated potential gains in life expectancy (years) from eliminating avoidable mortality, 2008 (37)
Box 13: Are the results where they should be?

Have targets been established for the indicators?

- Often, indicators relate to a policy document, health reform or legislation that establishes a specific target, such as reducing infant mortality by 50%, increasing the nursing density to a specified level or retraining all primary care providers. If targets have been established, then results can be compared directly to this target. This creates a direct link between HSPA and monitoring and evaluation of the national health plan (NHP) or strategy. Not all targets in the NHP should be covered in the HSPA, nor should HSPA only include the NHP. Nevertheless, synergies can be achieved and should be exploited.

What has been achieved in other countries’ health systems?

- The HSPA process may have identified a set of comparator health systems (regional, national or subnational). These could provide some insights into what might be achieved, and where there are opportunities to improve the health system in the country, relative to those in other countries. It is important to note that interpretation of international comparative performance data calls for great caution and requires careful analysis.

- Only through a careful, context-specific comparison and explanation of the reasons for variations can comparative performance data support an intelligent benchmarking function, as is frequently deployed in the corporate sector (30).

- It is important not only to analyse results at one point in time but also to compare trends between countries and between regions. Differences in trends can provide insight into the sources of change and the relative impact of reforms.

- Such an approach highlights the opportunities to compare individual indicators with international reference points. Composite indicators of performance, which assign a single score for a number of indicators within a performance dimension or across the performance framework, place system performance at the centre of the political debate. Using composite indicators, however, raises serious methodological concerns (for instance, regarding the relative weights of the individual indicators) and is of limited value for performance management because it tends to mask the sources of low performance.

One way of doing this is to build a picture of results for each dimension. This picture shows at a glance where individual indicators are placed in relation to trends over time and in relation to targets or results for comparator countries (Figure 7). It helps to point out where performance is strong in a dimension and where health policy should focus on improvement.

The third component relates to the health system overall. Once the results for individual performance dimensions have been assessed, the performance framework, which shows the relationships among the performance dimensions, is used to paint the “big picture” of overall health system performance. The big picture should again refer to the key policy questions developed during the HSPA strategy phase. As with the performance dimensions, a graphic can help to tie results together, particularly when considering the relationships among the dimensions.

The formal HSPA report can be used to tell the story of the results across the whole health system. It develops alongside the review and analysis of individual indicator results and patterns across the performance dimensions of the framework and the health system as a whole. The report should be seen as a high-level overview of the entire health system that points to overall
**Box 14: From an observation of unequal distribution of results to an assessment of equity**

- **Which stratifications are important?** The particular approach to the assessment of equity in the country’s health system during the strategy development phase of the HSPA will already have been considered and should be used to determine which stratifications are important, considering the policy questions. Regional results are often key, especially if some aspects of resource allocation and/or management and delivery of health services are done on a regional basis. Sex and measures of socioeconomic status, such as household income quintile or educational level, are often important in assessing equity in health and population health.

- **Which stratifications are feasible?** Data limitations for some indicators may restrict the ability to stratify and report results for regions or subpopulations of interest. Where these limitations exist, it is important to acknowledge them in the HSPA report and to add concrete recommendations on strengthening information systems.

- **What is the current distribution in results?** There are various ways to present and comment on variation in results (or lack thereof). Examples include presenting the ratio of highest result to lowest, presenting the difference between the worst result and the average, noting whether a particular subpopulation or region is a consistent outlier or considering how variation in the results of one indicator relates to the variation in another (gradient). A consistent approach to picturing the variation in results (for example, by region or income quintile) helps to identify patterns that support interpretation.

- **Has distribution changed over time?** Where stratified results are available for previous time periods, the extent to which variation seems to have increased or decreased can be examined to provide evidence about the impact of reforms on a regional basis or on specific subpopulations.

- **Are the observed gaps or differentials avoidable or considered unfair?** Answering this question requires analysis and a good understanding of the causes of the observed variations. This analysis will inform the decision on whether the differences are due to factors that are avoidable and unfair, such as gender norms or socioeconomic status.
### Fig. 7: Scorecard representation of performance on a single dimension: Illustration from Turkey’s HSPA for the “Healthy lifestyles and environment” dimension (38)

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Average level at national level</th>
<th>Distribution (gender, age, socioeconomic status, regions with available and relevant data)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Access to safe drinking water</td>
<td>On track</td>
<td>On track</td>
</tr>
<tr>
<td>2. Air pollution (PM10* concentration in cities)</td>
<td>On track</td>
<td>Further scrutiny needed</td>
</tr>
<tr>
<td>3. Alcohol consumption</td>
<td>On track</td>
<td>Analysis required</td>
</tr>
<tr>
<td>4. Daily smokers</td>
<td>Further scrutiny needed</td>
<td>Action required</td>
</tr>
<tr>
<td>5. Obese population</td>
<td>Action needed</td>
<td>Action needed</td>
</tr>
<tr>
<td>6. Fertility patterns (pregnancies with at least one biomedical risk factor)</td>
<td>On track</td>
<td>Further scrutiny needed</td>
</tr>
</tbody>
</table>

* PM10 is a measure of particles in the atmosphere with a diameter of less than or equal to 10 micrometers.

directions for policy action and will undoubtedly generate additional questions for follow-up. It cannot supply the definitive answers.

The seven HSPA case studies (1) provide examples of how some HSPA reports were developed to address the needs of different audiences. A formal report with targeted presentation materials is one option. Alternatively, the report may include elements such as an executive summary or key messages. One outstanding question is whether to include policy options or recommendations in the report. Including recommendations is useful for feeding HSPA results directly into the policy cycle. Doing so is advisable only under certain conditions, however: the recommendations arise from a policy dialogue organized in the context of the HSPA process, in which stakeholders (especially the advisory group) come together to reflect on the findings; the recommendations are visually distinct within the report (in a separate section, for example); and the process of formulating recommendations is transparent. It is important to distinguish between the descriptive elements, the analytical elements and the political elements in the report. This way, if the policy recommendations or analysis is questioned, the key findings will still be accepted and the report valued.
### Fig. 8: Relating policy questions to key findings and deriving policy recommendations: Illustration from Portugal (39)

<table>
<thead>
<tr>
<th>Policy Questions</th>
<th>Situation</th>
<th>Policy Recommendations</th>
</tr>
</thead>
</table>
| How do individuals perceive the health system in general                         | • Overall satisfaction with the health care system is low in Portugal relative to other EU-15 countries. In a 2002 survey, 80% of Portuguese surveyed said they felt the system required either fundamental changes or should be completely rebuilt. This was the highest level of expression of need for change among the EU-15 countries. By comparison the EU-15 average was 51%. | • Ensure a broader engagement of patients and citizens in health system decision-making and take the leadership in citizen engagement activities across government.  
  • Improve the responsiveness of the health system by regular reporting to the public results on broad responsiveness measures related to dignity, autonomy, confidentiality, satisfaction with health care services, and confidence in the health system. |
| Do the methods of health system financing influence the utilization of health care services? | • Although there is no systematic data with which to assess inequalities in utilization of health care services, an OECD study using 2002 survey data suggests that not only are these inequities present in Portugal, but at a higher level than in other EU-15 countries.  
  • Portugal had the second highest level of inequity in the number of doctor visits among 13 of the EU-15 countries; however, if only visits to specialists are considered, the level of inequity was the highest. Additionally, it was found that level of income was the main factor contributing to inequity for Portugal, to a much greater extent than any other country. | • Develop mechanisms to better allocate resources to improve the distribution of funds among regions as well as proper incentives to reduce geographical imbalances and inequalities in geographical access to care. |
| How effective overall is health care spending in achieving improved health?       | • The rate of mortality due to causes amenable to health care or health promotion interventions has decreased by 25% since 2000, indicating some substantial improvement in health outcomes generated by the health system.  
  • However, this improvement has been less than that in other EU-15 countries, and Portugal slipped from second last to last place in a 2002/03 comparison of amenable mortality across European OECD countries. | • Enhance the role of the Regional Health Authorities in pursuing efficiency and productivity gains at the local level through better planning according to the needs of the populations served. Balance efficiency gains with quality and safety improvements through optimal planning. |
| Is the mix of health human resources in the system appropriate to deliver high quality health services and cover population health care needs? | • Although growth in the overall density of nurses per population was the highest among the EU-15 countries, nursing density still remains low relative to other countries and in relation to physician density.  
  • Total physician density has also increased, however the ratio of general practitioners is low compared to specialists and density of general practitioners is a serious concern from a demographic standpoint.  
  • The ratio of nurses to physicians working in hospitals was roughly 1.5 in 2007, unchanged since 2000. However, there is been significant variability in the ratio among the geographical regions. Of the EU-15 countries, only Greece has a lower ratio of nurses to physicians. | • Develop an integrated health human resources strategy reviewing imbalances in the mix and scope of health human resources, including changes in the scope of practice of professionals and incentives to correct current imbalances.  
  Promote multi-stakeholders collaboration in health human resources development and clarify the role of professional organizations. |
The structure of the formal report – length, format and section topics – and the weight given to the
different sections should be considered carefully in advance. It is likely to be structured as a review
of results for each performance dimension, possibly broken down by policy question. An introduc-
tory chapter describes background and methods, followed by chapters for each performance di-
mension. A table showing individual results for indicators may be included as an appendix.

There is sometimes a tendency to focus primarily on health system weaknesses and shortcom-
ings. The positive aspects should also be highlighted, however. Policies and reforms that have
succeeded can be presented in order to generate options for further development of those
strengths in the future.

The collaboration and support of researchers and stakeholders is critical in making the report
more than a quantitative description. This collaboration is necessary for developing a better
understanding of health system performance and proposing policy developments and reforms.

<table>
<thead>
<tr>
<th>Box 15: Potential elements of the HSPA report</th>
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<tbody>
<tr>
<td><strong>Element</strong></td>
</tr>
<tr>
<td>Executive Summary</td>
</tr>
<tr>
<td>Key Messages (or Findings)</td>
</tr>
<tr>
<td>A graphic summary presentation of results by performance dimension</td>
</tr>
<tr>
<td>A graphic summary presentation of distribution of results for integrated equity perspective</td>
</tr>
<tr>
<td>Performance dimension summaries</td>
</tr>
<tr>
<td>Performance indicator results</td>
</tr>
<tr>
<td>Technical report</td>
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</tbody>
</table>

Chapter Three: Your companion through the journey
It can also be useful to complement the indicator results with a view to the current health system priorities and strategic initiatives. Current reforms might not yet have had an impact on some of the key indicators, but identifying planned reforms and linking them to areas requiring strengthening could provide support for moving forward with changes to the system. To support policy options or recommendations, it is useful to link results to policies for improving areas of weakness or building on successes. Figure 9 provides an example of how such a table was structured in Estonia’s HSPA report.

The writing of the report is a chance to involve health system stakeholders in the analysis and interpretation of results as well as in the development of policy options and recommendations. Options for involving stakeholders that have been used in the HSPA process include:

- establishing a steering committee to oversee and coordinate the development of the report;
- developing the graphic presentation of the indicator results and then discussing the interpretation with an HSPA working group and selected stakeholders, including what the indicators show about the policy questions;
- sharing the analysis and interpretation templates with key stakeholders (in particular the suppliers of data) for comments and feedback on presentation of results, measures to ensure data accuracy and appropriate disclosure of data limitations; and
- organizing workshops (one large or several small ones for each performance dimension, depending on resources and number of participants) with the advisory group (see Thematic brief 1 for discussion of key roles), stakeholders and health policy researchers to discuss the findings and policy options to be included in the report.

**Checklist for Step Five**

**Actions**

- Assess achievements on each individual indicator with regard to evolution over time, to comparisons with targets or international reference points and to distribution across regions or subpopulations.
- Bring together all indicators within a dimension and complementary sources of information to build a comprehensive picture for each dimension.
- Develop the “big picture” and “tell the story” of the performance of the system as a whole by linking all dimensions within the performance framework.
- Provide tentative answers to the initial policy questions or identify new policy questions.

**Deliverables**

- Scorecards by dimension
- List of policy questions and/or options for discussion with the advisory committee
### Step Six: Discussing policy options or recommendations and disseminating the report

HSPA describes the performance of the health system as a whole. As presented in Chapter One, many government departments, agencies and health service providers influence the system’s performance. Although the ministry of health leads the health system, no single organization is responsible for the system’s performance. It is important to grasp the scope for
accountability inside and outside the ministry of health and accept that there are some “grey zones” of shared responsibility across departments, agencies, ministries or other stakeholders. The difficulty of attributing certain results to the actions of a single entity during a defined time period may be viewed as a limitation or as an opportunity for dialogue and alignment of policy positions among the different institutions.

Experience from the country case studies suggests two approaches. The first approach is to develop the HSPA report as a technical document and discuss policy implications at the dissemination stage; the document does not include policy recommendations. The second approach is to identify policy options or provide recommendations within the report. In the latter case, a clear distinction must be made between the policy component and the technical component of the report. This alternative calls for closer involvement of the policy-makers at all steps leading to the publication of the report.

Thus, in developing recommendations and plans for health system strategies stemming from the HSPA, the question is how to work with all the different stakeholders who have a role in improving system performance and, ultimately, health outcomes. The dissemination phase of the HSPA provides an opportunity for all of them, inside and outside the health sector, to participate in developing the findings and policy recommendations for strengthening the health system.

As highlighted in Chapter Two, HSPA should be complemented by in-depth analysis wherever indicators have been flagged as “action required” or “further scrutiny needed.” In many cases, the information derived from the indicators – even if it is supplemented with background information – will not be sufficient to establish an evidence base for policy recommendations. Nevertheless, it can help identify some issues and policy options. Further evidence needs to be collected on the scope of the problem, the causes of the problem and the effectiveness of proposed interventions. Recommendations in the HSPA report could also include plans for mini-assessments, reviews and analyses that delve more deeply into certain aspects of the health system. If the rate of mortality due to cancer, for example, was identified as a major concern during the HSPA, an assessment of the cancer programme (prevention, detection and treatment) could support the development of a strategy to address the areas of weakness within the programme. If the burden of out-of-pocket payments was identified as a barrier to access to care, a more detailed analysis of the subpopulations at risk, together with modelling of potential policy changes, would support the development of strategies to address this concern. More detailed analyses into areas suggested by HSPA findings would also support effective use of the analytical capacity developed during the HSPA process and ensure that this capacity remains in place for the next HSPA cycle.

Wide dissemination of the report is essential to ensure transparency. Dissemination should be guided by the HSPA strategy described in the project charter (see Step One), particularly in...
light of the HSPA objectives. It is important to develop a dissemination plan that supports the objectives (Thematic brief 6).

**Further readings for Chapter 3:**

**Reviews of performance frameworks**


**Examples of indicator passports or documentation sheets**


**Strengthening information systems**


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**Checklist for Step Six**

**Actions**

- Disseminate the draft report and discuss policy questions, identify policy options or build consensus around policy recommendations with the active participation of the advisory committee.

- Write policy options or recommendations as a well-identified section (within the report or as an addendum to the report).

**Deliverable**

- Final report(s) which may consist of two documents, an executive summary and a full report aimed at different audiences.
CHAPTER FOUR: THE “ART” OF HSPA

A TECHNICAL EXERCISE IN A POLITICAL CONTEXT

Key messages:

- There is no one-size-fits-all approach to HSPA. Conducting an HSPA is a balancing act influenced at all stages by the scope of assessment and the actors involved.
- The HSPA process is part of a cycle of health system assessment, recommendations, policy responses, implementation and reassessment that is designed to support health system governance. HSPA should inform policy. Ultimately, HSPA aims at bringing about change towards improved performance of health systems.
- For the knowledge generated through HSPA to be translated into policy, a dialogue between the evaluators and policy-makers is critical, at the outset and at key milestones of the process. Several knowledge translation tools should be considered to complement the HSPA process and the production of the report.
- The next formal HSPA can be supported through a process that seeks feedback and documents the lessons learned from the completed HSPA. A technical report containing documentation of the process, the health system framework and performance indicators provides a concrete reference for stakeholders.

1. A balancing act to adapt to context, needs and capacity

Steps for HSPA development are presented in Chapter Three in a linear process, as in a recipe. The HSPA case studies (1) demonstrate that there are a number of possible variations of the core elements that allow adaptation of the process to the context and needs of each country. The “art” of HSPA lies in adapting the core elements of the process to match a specific context rather than blindly following the recipe. Translation of a generic HSPA process to each country’s reality requires a number of choices and adaptations. The choices are driven by the objectives, policy context and actors involved, as described in the initial step of elaborating the project charter.

Conducting HSPA is a balancing act at all steps of the process. A proper balance is sought when agreeing on the scope of assessment, when deciding on actors to be involved, when selecting indicators and when deciding on the content of the final report. Some of the decisions which need to be made throughout the process have been raised in previous chapters, at the relevant stages. They are further illustrated below, as a reminder of the necessity of embedding the HSPA process within the governance context.
**On the scope of assessment:** Where to set the boundaries?

Depending on where the boundaries are set, the causal responsibility for improving health is assigned to different factors, which affects the ability to hold key health system players to account. With tight boundaries (narrow scope), performance can more directly be attributed to interventions or institutions, and this approach contributes to increased accountability and allows for the definition of targeted and directly actionable policy recommendations. Tighter boundaries are set if the assessment is feeding directly into a performance management system. When the health system is reduced to health care alone, certain factors that have a significant impact on health are excluded, such as education and employment. With wide boundaries (broad scope), a more holistic approach encompasses a wider range of determinants and requires a shared diagnosis. This promotes better understanding of the opportunities for improving health outcomes (average level as well as distribution) and fosters intersectoral dialogue and horizontal governance.

**On the performance framework:** Adopt an international framework or build a new one?

One approach is to use an internationally accepted framework as a starting point and adapt it to reflect the policy context. This process makes sense where there is no shared comprehensive national health policy on which to base a country-specific framework. Most often, there are numerous programmes, reform plans and policy documents to anchor the performance framework. In such a context, a key challenge lies in making latent strategies of government emerge without stigmatizing government for the lack of coherence in its strategies. Basing a performance framework on an explicit national strategy or reform programme ensures that the framework will be relevant to the national context and aligned with the monitoring and evaluation of the national strategy. On the other hand, a framework driven solely by a national health plan and perfectly aligned to the monitoring and evaluation of the reforms runs the risk of overlooking important dimensions of performance that were not included in the reforms or of not being able to identify emerging trends. Hence, it is critical to check the comprehensiveness of the framework against internationally recognized frameworks.

**On the scope of control and actors involved:** Internal or external evaluators?

If the responsibility for conducting HSPA is set at the ministry of health or at an agency at arm’s length from the ministry of health, the link to the policy-making process is tighter. This close link has both advantages and disadvantages. On the one hand, it increases the chance of HSPA results influencing policy decisions. It also multiplies opportunities to develop a culture of evaluation and to build analytical capacity within the ministry of health. It contributes to generating a demand for evidence. On the other hand, the agency might lack objectivity or might be perceived to do so. Also, if capacity within the ministry is lacking, then
outsourcing is an option for production of the first report. Neither outsourcing the entire HSPA process nor conducting HSPA entirely within the ministry of health is an optimal solution, however. Hybrid solutions exploit the best of both approaches, combining close engagement with the ministry of health and valuable contributions from external partners.

The key to success lies in finding the right balance to ensure scientific rigour and political ownership through a participatory process. The Kyrgyz case study (1) describes the rationale for distinguishing between the programme monitoring and evaluation functions and attribution of those functions to different institutions. It also highlights the critical role of the review component of the process. The Portuguese and Estonian case studies (1) show the added value of the World Health Organization as a catalyst for convening international experts and for quality assurance. The last aspect was considered paramount by both countries for ascertaining the level of scientific rigour and technical expertise of the report. In both cases, HSPA was led by a national entity close to or within the ministry of health, with the oversight and technical support of the WHO Regional Office for Europe.

Another hybrid solution consists of outsourcing the production of the report to an independent group while engaging all stakeholders in the process by seeking specific input at each milestone. In other words, thinking about the actors in the HSPA process and the different roles and responsibilities (see Thematic brief 1) helps shift the focus away from the debate over internal versus external assessment towards finding appropriate ways to engage all the key actors.

On the selection of indicators: What is the ideal number of indicators?

On one hand, the set of indicators should be comprehensive and reflect all dimensions identified in the performance framework. The number of indicators will naturally rise as the complexity of the assessment increases with wider boundaries on the scope of assessment. A larger number of indicators improves the content validity for each dimension – for instance, taking into consideration the dynamics of health production (including indicators of past performance and predictors of future performance); balancing types of indicators (inputs, outputs, outcomes and impacts); or combining a generic assessment with the use of disease as tracers. On the other hand, care should be taken to avoid collecting and presenting an overwhelming number of indicators. It is critical that the number of indicators stays within acceptable limits for a reasonable burden of data collection and analysis as well as a smooth and timely process. Most importantly, a large number of indicators can shift attention away from the main trends, which are meant to be the focus of HSPA, towards dealing with the individual indicators.

Solutions to this apparent dilemma lie in the careful organization of indicators. One approach distinguishes between a core set of 30–60 indicators, which is presented in a scorecard and
regularly monitored, and a group of additional background indicators that complement the core indicators and appear in the accompanying text or figures. In a second approach, visual representations are the key to promoting a holistic system perspective while dealing with numerous indicators. A third approach uses composite indicators, but this method should be adopted with great caution, especially if it involves consolidation of different dimensions of the health system. Composite indicators are fraught with technical difficulties (such as determining aggregation weights). Most importantly, composite indicators can mask the source of underperformance, and for this reason they are not directly actionable. Certain composites, such as the disability-adjusted life year (DALY), which have high scientific validity, are generally viewed as acceptable.

The tendency to select a very large number of indicators may reflect overly ambitious objectives for the HSPA. It is advisable to recognize that HSPA will not provide all the answers; on the contrary, HSPA usually raises more questions than it answers. Formulating objectives that are realistic and choosing a modest number of indicators will keep the focus on the main goal of HSPA – to provide a broad assessment with a whole-system perspective. Embedding HSPA in a governance toolbox including evaluation studies, policy briefs, target-setting and fee-for-performance mechanisms is needed in order to go beyond the initial diagnostic findings.

**On setting references for benchmarking:** How high to set the bar?

HSPA seeks to answer the following key question: are we where we could be? Or, alternatively, are we where we want to be? The answer to those questions clearly depends on how high we set the bar. Should we compare our health system to the countries or regions with a similar average income level; compare to neighbouring countries, regions or groups of countries (such as the EU or CIS); compare to countries or regions with similar health system structures (insurance-based, for example); or compare to countries or regions that have implemented reform programmes around the same time? All the options offer useful reference points. Combining elements from the different reference groups is the best way to make a sound comparison and, more importantly, to identify opportunities for improving the health system.

The identification of international or national reference points is a critical exercise during the initial steps of HSPA. It is helpful to consider which countries (or regions) might offer the most relevant experience rather then focusing exclusively on the countries with the greatest similarity to one’s own. The Turkish HSPA, for instance, used the following as reference points: Argentina, Brazil, Bulgaria, the Czech Republic, Germany, Mexico, Poland, Romania, South Africa, Thailand, and the United Kingdom, the EU, the OECD and upper middle-income countries.
It is critical to recognize that scoring performance is value-based and relative to a standard which has been set. It is equally vital to be explicit about the choice of reference points and to systematically use the same reference points between indicators and between years.

**On the institutionalization and regularity of assessment:** Regular or ad hoc assessment?

Another key question is how often to undertake HSPA. Here, also, there is no straightforward, one-size-fits-all answer. The context and the objectives should drive the choice made by government in terms of institutionalization and regularity. Some options are the one-off approach for HSPA development (strategy development model), regular release of public reports for accountability and transparency (accountability model) or periodic release of private government reports for exclusive performance management purposes (stewardship model). Hybrid solutions – like the annual publication of a scorecard, complemented by a full report every three years, or the publication of an HSPA report and thematic reports every second year – are also possible.

2. Building capacity to use HSPA results

The art of HSPA involves designing an assessment system that fits the needs and capacity of the relevant health authorities to govern the health system. This means that the objectives of HSPA, as well as the actors and tools, will evolve as experience with HSPA grows and, more generally, as health information systems are strengthened. Analytical capacity increases, a culture of evaluation develops and, increasingly, mechanisms and tools are set up to help ensure that policy decisions are informed by the best available evidence.

HSPA holds stakeholders to account not only for the system’s progress towards better and more equitable health but also for their own actions to improve performance. HSPA consists of more than issuing national reports on health system performance; it is a systematic management challenge to assess and improve the performance of the system as a whole. These efforts are strengthened when measures used in the HSPA framework are directly applied to assessing the performance of specific parts of the health system, including both services and individuals (40).

Regular publication of performance results at all levels improves responsiveness to public expectations and supports effective, evidence-based policy-making. Patient requests for information will grow as a result of increased citizen awareness and participation as well as increased patient mobility, especially between EU countries and between regions within countries. This phenomenon is illustrated by the growing role of media and consumer reports in calling public attention to the quality of health care providers. Media attention now extends to the wider...
sphere of international health system comparisons. An effective communication strategy for dissemination of HSPA results is necessary in order to contribute to the public debate and increase system responsiveness and transparency in the eyes of the population.

Fostering the use of evidence in the policy cycle is one goal of HSPA. The appropriate use of evidence supports health system governance within a cycle of health system assessment, recommendations, policy responses, implementation and reassessment. Evidence can help to inform not just the policy questions at hand but also the articulation of options for addressing the problems, along with the development of concrete policy responses based on these options, with clearly identified roles and responsibilities for improving performance.

The mere act of producing information does not guarantee that this information will actually be used to inform policy. Policy-makers in a passive role as receivers of results and recommendations are not highly motivated to make the best use of the available information. In contrast, active participation by policy-makers helps to ensure acceptance and ownership of HSPA and increases the chances that the results will be acted upon. As highlighted earlier, the performance framework should build on key policy questions. What do policy-makers need to know in order to make health policy decisions that lead to improved health outcomes? Adequate answers to policy questions require the involvement of the final users of HSPA, starting with the formulation of the performance framework. Strategies to help increase the usefulness of findings for this target group should be considered from the outset of the HSPA process. This is one of the key elements in using research evidence as an input into the decision-making process. A number of tools have been developed for this purpose and are presented in Box 16.

An evidence-informed approach implies a transparent and systematic method for generating and using research and other evidence as an input into the policy-making process. It is clear that policy decisions, especially on broad, systemic and politically sensitive issues such as HSPA, cannot be based solely on evidence. When evidence is used, it should be done appropriately, in accordance with the time frame, materials and other resources available. This enables decision-makers to have confidence in the policy options under discussion as well as to ask critical questions before taking a decision, to demonstrate that they are basing their decisions on the best available information and to understand and communicate to their constituencies what is feasible and why. HSPA, with its emphasis on clear steps and tools driven by the need to be transparent and methodologically sound, is a process throughout which evidence plays a key role.

The HSPA process and findings can be integrated into a multi-year cycle of health system assessment, recommendations, policy responses, implementation and reassessment. Experiences in the European Region reveal different approaches to integrating HSPA and national health policies, strategies and plans. In Belgium HSPA was formulated in the absence of an explicit
Pathways to health system performance assessment

Box 16: Evidence to policy: definition, methods and tools

Evidence-informed health policy-making aims to ensure that decision-making is informed by the best available research evidence. It is characterized by systematic and transparent access to and appraisal of evidence as an input into the policy-making process.

This diagram comes from SUPPORT Tools for Evidence-Informed health Policymaking (STP), a comprehensive series of 18 articles written for people responsible for making decisions about health policies and programmes and for those who support these decision-makers and published in 2009 as a special supplement in Health Research Policy and Systems (http://www.health-policy-systems.com/content/7/S1/S1).

The series is written as a set of individual guides, which can be read chronologically as a complete guide on how to undertake and promote evidence-informed policy making. The series addresses four broad areas: supporting evidence-informed policymaking; identifying needs for research evidence in relation to three steps in the policy-making processes, namely problem clarification, options framing, and implementation planning; finding and assessing both systematic reviews and other types of evidence to inform these steps; and moving from research evidence to decision-making.

national health plan, as the governance of the health system is shared between health authorities at different levels. In such a decentralized context, the HSPA contributed to a common understanding and vision of the priorities for health system strengthening among the different stakeholders. In Portugal the HSPA was used to complement the evaluation of the national health plan and to prepare the new plan. Portugal’s HSPA provided one source of evidence – along with other studies and the evaluation of the plan itself – to inform policy-making and setting of priorities. In Estonia the HSPA and national health plan development were conducted as parallel processes. In Turkey the HSPA was conducted between two policy cycles. The HSPA was initiated as the Ministry of Health’s strategic plan was being finalized; the strategy map developed at the early stage of HSPA fed into the strategic plan. In turn, HSPA experience will feed into the revision of the strategic plan, particularly on the monitoring and evaluation component.
A mechanism is needed to incorporate the key elements of the HSPA into regular planning, budgeting and implementation cycles for performance management purposes. Figure 10 illustrates how this relationship was envisioned in the Canadian province of Ontario. It shows how an HSPA supports multi-year government and health system priorities and strategy development and how it is being used to inform a yearly budgeting and planning cycle, with performance and accountability agreements for achieving results in the province. The diagram shows how performance data is used at different stages of the health ministry’s business cycle.

As highlighted previously, there are technical challenges to HSPA and its use as a governance tool to improve the performance of the health system. It is critical to recognize the value of information and to make substantial investment for strengthening information systems (Box 11). The use of performance information for policy also requires competence and institutional capacity. Building context into the analysis so that decision-makers are empowered to take action on findings is a challenge, as is highlighting priorities for action without taking drastic positions that could alienate some of the actors.

**Fig. 10: Position of HSPA in the policy cycle in Ontario, Canada (41)**
In addition to technical challenges, the political challenges need to be acknowledged from the outset of the process. Evaluations, including HSPA, are political in nature and part of the decision-making process on priorities for strengthening health systems. Resistance among stakeholders at various levels of government, as well as among programme managers and even funders, should be expected. Resistance can be managed by sharing evaluation processes, criteria and methods publicly.

Due to the many value judgements that are implicit in performance assessment (for example, the choice of indicators or the relative importance attached to different objectives), the process can serve as a platform for stakeholders to debate their perspectives and preferences and to learn from one another. The synergies which develop from these exchanges can be invaluable in furthering the pursuit of shared societal goals (42).

**Box 17: Where Politics and Evaluation Meet**

Weiss (43) eloquently highlights the political nature of evaluation:

“Evaluation is a rational enterprise that takes place in a political context. Political considerations intrude in three major ways, and the evaluator who fails to recognize their presence is in for a series of shocks and frustrations:

First, the policies and programs with which evaluation deals are the creatures of political decisions. They were proposed, defined, debated, enacted, and funded through political processes, and in implementation they remain subject to pressures – both supportive and hostile – that arise out of the play of politics.

Second, because evaluation is undertaken in order to feed into decision-making, its reports enter the political arena. There evaluative evidence of program outcomes has to compete for attention with other factors that carry weight in the political process.

Third, and perhaps least recognized, evaluation itself has a political stance. By its very nature, it makes implicit political statements about such issues as the problematic nature of some programs and the unchallengeability of others, the legitimacy of program goals and programs.”

**Further readings for Chapter 4:**

**Evidence to policy:**

REFERENCES


(5) Interim report on implementation of the Tallinn Charter. Copenhagen, WHO Regional Office for Europe, 2011.


(7) Comment 14, Committee on Economic, Social and Cultural Rights, 2000, Human rights to the highest level of attainable health.


(9) Health21: the Health for All policy framework for the WHO European Region (European Health for All series, No. 6). Copenhagen, WHO Regional Office for Europe, 1999.


APPENDIX 1.

CONSULTATION MEETINGS:

LIST OF PARTICIPANTS WITH AFFILIATIONS
(ON THE DATE OF THE MEETING)

Expert technical meeting on health system performance assessment framework, Barcelona, Spain, 20–22 December 2009

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Workshop on health system performance assessment toolkit for the European Region, Copenhagen, Denmark, May 30–31, 2011

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United Kingdom

Representatives of other organizations

Organization for Economic Co-operation and Development
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The Global Fund to Fight AIDS, Tuberculosis and Malaria
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Switzerland
UNICEF Regional Office for CEE/CIS
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World Health Organization Regional Office for Europe

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Workshop on integrating an equity focus in health system performance assessment, Ljubljana, Slovenia, 1–2 December 2011

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Involving the right actors in the HSPA process from the beginning can increase the benefits and help to achieve the objectives of the project. Identifying the most suitable group of actors will be driven by the identification of the objectives and expected impact of HSPA. Given the benefits of participation, it is useful to think broadly about who should be involved in the process. Nevertheless, the core project team should be limited to a manageable size. This can be achieved by identifying the generic roles most often required for successful completion of an HSPA. These roles are described below.

The first step in identifying HSPA participants is to think about the organization of the country’s health system: what institutions are active in the system and what are their roles? How can they be involved in relation to the explicit objectives of HSPA in the country? Additional questions are highlighted in Box 1.

Generic roles are as follows:

1. **The key HSPA “sponsor”**. Although there is a need to involve a number of stakeholders who can contribute to and benefit from the HSPA process, it is important to identify the key project sponsor, an organization or individual who will have overall responsibility for the project and accountability for the end product. The sponsor could be a key individual, existing department or agency or a specially established project steering committee. The main requirement is that the sponsor has the authority and legitimacy to ensure that other groups contribute the financial, human and information resources needed to complete the project. A steering committee could be helpful in gaining consensus and support for project decisions and direction among key stakeholders. On the other hand, a key individual as project sponsor might provide the project with vision, motivation and inspiration.

2. **A core group of dedicated staff during the critical phases of the project, responsible for moving the work forward**. There are a number of possibilities for the composition, duration of function and institutional placement of the core group. The decision on where to house the core group will depend on:

   - where the capacity (skills, experience, expertise in health system policy and measurement) is located among the institutions of the health system;
• where the necessary resources (financial, human and information) are located and who has control over them;

• the degree of independence required, in light of the HSPA objectives; and

• the necessary relationships with decision-makers, the HSPA sponsor individual or organization and other advisory groups.

Possibilities include a group situated within the ministry of health in a policy or analytical unit, within a statistical or data analysis and reporting agency, a special project team outside of the ministry of health or a team attached to a health services research group. It is also important to consider whether the HSPA is intended to be a time-limited project or whether one of the objectives is to establish a more permanent analytical and policy development capacity for ongoing work.

3. An advisory council to provide input to the project from a range of sources and to regularly review progress.

4. Expert panels with varying roles and compositions. In addition to providing important advice and feedback on a number of parts of the process, the use of expert panels at various points in the HSPA process facilitates the involvement of a broader range of stakeholders and fosters a shared sense of ownership for the final report. Expert panels can also provide opportunities for learning and capacity development for the individuals involved. They may be assigned one or more of the following tasks:

• reviewing and providing feedback and advice on the framework for assessing health system performance;

• selecting performance indicators; or

• reviewing and providing feedback on the interpretation and analysis of results.

As the choice of a health system framework and performance indicators reflects the values and perspectives of system stakeholders and the general public, it is worth trying to ensure that the membership of expert panels constitutes a representative sample of the spectrum of values held by stakeholders. Consider experts from health authorities, suppliers and custodians of health data, analytical and reporting agencies, researchers and other users of health information.
The expectations of the expert panels for providing advice and feedback should be explicit and based on the needs and strategy of the HSPA. The panel members may act in an advisory capacity only, or they may be assigned specific decision-making roles. The final selection of performance indicators, for example, is made by individuals outside the expert panels. Moreover, it should be made clear to panelists whether they are participating as representatives of their organizations or they are providing independent opinions as individuals with experience and in-depth understanding of the health system.

Table 1 presents some of the key considerations for choosing individuals to participate on expert panels, taking into account the role of the panel and the objectives of the HSPA. The selection of who sits on different expert panels is critical to ensure that the results of the assessment are considered legitimate and accepted by all health system actors.

**Table 1: Considerations for membership on expert panels**

<table>
<thead>
<tr>
<th>Expert panel function</th>
<th>Implications for expert panel membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reviewing and providing input on the framework for assessing health system performance</td>
<td>Experts on health systems (consider including international experts), individuals responsible for national health strategy, leaders of local or regional health entities</td>
</tr>
<tr>
<td>Selecting performance indicators for the HSPA</td>
<td>Suppliers and custodians of health data, analytical and reporting agencies, researchers and other users of health data and information</td>
</tr>
<tr>
<td>Reviewing and providing input on the interpretation and analysis of results</td>
<td>Selected stakeholders depending on the performance dimension or indicator. For example, include an individual from the organization responsible for National Health Accounts for reviewing indicators related to spending, a representative from a hospital organization for reviewing indicators related to hospital quality and efficiency or a patient safety advocate for reviewing indicators related to patient safety.</td>
</tr>
</tbody>
</table>

**HSPA Goals**

<table>
<thead>
<tr>
<th>Implications for expert panel membership</th>
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<tbody>
<tr>
<td>Transparency</td>
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<tr>
<td>Developing culture of evaluation</td>
</tr>
<tr>
<td>Intersectoral dialogue</td>
</tr>
</tbody>
</table>

**Box 1: Considerations for identifying HSPA stakeholders and participants**

1. What are the key government ministries, departments and/or units with responsibility for health system planning, budgeting and funding?
2. Aside from the ministry of health, which other government ministries and agencies have responsibility for policies affecting health or interacting with the health system? These could include, for example, ministries responsible for finance or treasury, social services, education, transportation, environment and local or regional governments.
3. Are there regional or local authorities with responsibilities for planning and/or funding local health systems or health service delivery?

4. How are health service providers organized? What are the health human resource professional organizations and what is their role in service delivery, quality, licensing and health human resource planning? Are there organizations or associations of health facilities or institutions? Do they play a role in accreditation or licensing?

5. How are health services financed? If private insurance companies provide coverage, what is their role and do they have an association? If there is a public financing agency and, if so, what is its relationship to the government or ministry of health?

6. Are there public patient advocacy groups or other organizations promoting the interests of those served by the health system that could bring a public perspective to the HSPA?

7. How is health information organized? Are most health-related data sets managed by a single custodian or are there several? Are survey data sets managed separately from administrative data sets? Is there a national statistical agency department that is responsible for producing health information? Is the capacity to analyse health data sets and use them to answer policy questions concentrated in a single group or spread throughout various departments or agencies?

8. Which organization manages national accounts and tracks and reports on health system spending?

9. Who is doing health services and policy research work? Are there a few key researchers, or is there a broader base or health services research department within a national academic institution?
The shortlist of indicators should be evaluated against pre-defined selection criteria. There is a general consensus on some standard criteria for evaluation. Additional criteria may help inform the selection. The core HSPA team will also need to agree in advance on the relative importance of each selection criterion and on the respective thresholds.

Many HSPAs have used selection criteria as described in Box 1. In short, they can be organized around three key questions:

1) What value does it add? Is it useful? Does it reflect on a key dimension of performance? Does it actually measure what it purports to measure? Does it measure something important and relevant? Is there sufficient capacity to influence it through policy interventions and sufficient authority to do so?

**Box 1: Common criteria for indicator selection**

- **Importance.** Is the indicator a measure that is important to improve? For example, while both potential years of life lost and life expectancy are measures relevant to health status, it may be that it is more important to focus on potential years of life lost rather than on life expectancy.

- **Relevance.** How well is the indicator connected to the performance characteristic or dimension of the health system that it is measuring? Is this indicator considered actionable? In other words, can results be improved over a defined time horizon and within the framework of the health system as it has been defined? Have targets been established for the indicator in strategic plans, policies or programmes (for example, to reduce infant mortality by 30% from the 2005 result)?

- **Validity.** How well does the indicator measure what it is intended to measure? For example, hospital length of stay would have validity as a measure of hospital efficiency, but not as a measure of the quality of hospital care.

- **Reliability.** Can the indicator accurately and consistently identify the events for which it was designed across multiple health system settings and over time? In the absence of change in the characteristic being measured, would the performance indicator give consistent results? This supposes that the indicator is objective and quantifiable (not based on a value judgement) and that the definition of the indicators is precise and practicable. Survey-based indicators should be based on a methodology and common questions that are shared by different institutions. Indicators that depend on rare events, such as maternal mortality, may be less reliable because five to ten additional events in one year could triple the incidence rate in the absence of any underlying change in the quality of care provided by the health system. In such cases, the coverage will be particularly important.

- **Feasibility.** The costs of collecting and validating the indicator results should be proportionate to the value of the information the indicator provides. Can results for the indicator be determined from available data sets, or is the collection of additional data required? How easily can they be accessed? Are results readily available (“off the shelf”) or would they require work-up by the agency which holds the data?
2) Are instruments available to measure it in a reliable way? Is it stable enough and/or harmonized at the subnational level or across countries to provide solid reference points?

3) Is the data readily available or is the burden of indicator development and data collection proportionate to the added value this indicator brings to the set of indicators?

It is useful to distinguish between the characteristics of the data (such as registry of mortality and household surveys), the measures (such as mortality amenable to health care and self-assessed health status) and the inference of the indicator (what those measures reveal about the health of the population), as illustrated in Figure 1. In addition, the following questions could be used:

- Can the indicator results be stratified to support an assessment of health system equity?

- Are historical results available for the time frame of the HSPA review (for example, from 2005 forward)? If not readily available, could past results be retrieved?

- Will the data source of the indicator be maintained so that results will be available for future HSPAs?

- Are international comparisons available for this indicator?

- Is the most recent result for this indicator already too old to be useful for the assessment?

These criteria are important to help move from a monitoring of indicators (an observation or description of the current average level) to an assessment based on indicators, including a judgement on whether the current value is low or high, equitably distributed or part of a trend towards improvement or deterioration. Such an assessment helps identify priorities.
Fig. 1: Global and Integrated strategy for assessing health system performance (EGIPSS): Strategy for indicator selection

Adapted from Champagne et al. Un cadre d’évaluation globale de la performance des systèmes de services de santé: Le modèle EGIPSS. Québec, Le Conseil de la santé et du bien-être, 2005.

Box 2: Illustration of set of selection criteria at different stages of the selection of indicators

**Long List (initial inventory)**

*Individual Indicators*
1. Choice of indicators reflects dimensions identified in the HSFA framework.
2. Indicator is objective and quantifiable (not based on a value judgement).
3. The definition of the indicators is precise and practicable.
4. Indicators are straightforward to interpret.

*Set of Indicators*
1. The set of indicators should be comprehensive and reflect all of the dimensions identified in the HSFA framework.
2. The set of indicators accurately measures what it sets out to measure and no dimensions are unrepresented.

**Compendium (short list)**

*Individual Indicators*
1. The indicator exhibits validity, such that it identifies opportunities for improvement in the health system.
2. Choice of indicators should reflect the primary objective of the HSFA exercise and be directed at the appropriate stakeholders.
3. Survey-based indicators should be based on a shared methodology and common questions between institutions.
4. There is sufficient coverage of the indicator, so as to ensure against bias.
Box 2 contd

5. The indicator has undergone some preliminary expert-based judgement on its face validity, the usefulness and relevance of its use for performance assessment.

6. The indicator exhibits reliability.

7. Wherever feasible, levels of uncertainty in the indicator are reported.

8. The costs of collecting and validating the indicator are proportionate to the value of information the indicator provides.

Set of Indicators

1. The set exhibits face/construct validity to the extent that it measures what it sets out to measure and no dimensions are unrepresented.

2. There is a balance in the types of indicators selected (lead/lag, prospective/retrospective, structure/process/outcome and average level/distribution).

3. There is a balance in the data sources from which indicators are selected.

Core Set (final set)

Individual Indicators

1. Survey-based indicators should be based on a shared methodology and common questions between countries.

2. Indicators selected to be used comparatively across countries should be adjusted for contextual factors. Where such a risk adjustment process has been undertaken, the uncertainty relating to the method used should be considered and, if possible, reported.

3. Indicators and definitions are consistent over time.

Set of Indicators

1. The set exhibits face/construct validity to the extent that it measures what it sets out to measure.
Thematic Brief 3:

Health Information and Information Systems for HSPA

Health information is an essential resource for policy-making and a prerequisite for good governance and accountability (1,2). Information generated by efficient information systems facilitates the management of health services by determining situation and needs for planning, design, monitoring and evaluation. It is in this regard that health information has the strategic importance of linking HSPA to the governance function.

The objective of health information systems is to improve health services management through optimal information support. A health information system involves all elements in the information generation process, including information and communications technology infrastructure, human resources and funding. The role of a health information system is to determine what information needs to be collected and tracked, establish mechanisms for collecting it, build and sustain an ongoing process of adding value to the data collected, ensure that it is understood and used and justify its importance so that funding is maintained. The system can have multiple attributes; it can be patient-centered or public-health-oriented, subject-based or task-based. Ultimately, however, these different attributes need to be developed in a standardized and comparable way to allow for their integration.

Health indicators are key outputs of a health information system for monitoring and assessing a given situation and its trends. An important element of health indicators is their ability to reflect complex interconnections between, for example, a health determinant and the resulting health outcome (3). Adequate health indicators and information are usually derived from different data sources, including civil registration and vital statistics, health care systems, surveillance systems, disease registries, surveys and administrative systems. Each of them provides different types of critical health information for assessing the performance of the health system.

In order to allow for robust and continuous HSPA, health information systems need to be adjusted to adequately deliver the valuable health information they are intended to deliver. In the countries of the European Region, key challenges for producing useful health statistics include:
• irrelevance of outdated information in relation to current needs;

• limited coverage and completeness of data;

• duplication and waste among parallel information systems;

• inadequate data quality and use of standards;

• lack of timely reporting and feedback;

• insufficient flexibility to handle new requirements and sources of data from multiple dimensions;

• restricted data integration and exchange without adequate institutional mechanisms;

• poor culture and use of information at different levels of the health system; and

• limited availability of analytical tools and capacities for using the data.

This situation is often the result of years of uncoordinated investments and limited planning. These factors sometimes lead to vertical information systems for specific programmes and quasi-autonomous country institutions, while undermining the development of a sustainable infrastructure based on primary care.

Conducting an HSPA process requires some basic elements to enable success, including:

• clear understanding of the dynamic health process that is going to be assessed as well as key elements such as structural and intermediate determinants and their interconnections and influences on health outcomes and impacts;

• careful consideration of the dimensions and minimal set of indicators required to assess progress – that is, whether indicators are “fit for purpose,” relevant to the needs of different users and sensitive to change (taking into account the impact on already burdened information systems);

• familiarity with sources of data and information, their flow and integration (including interoperability standards); and

• establishment of a mechanism for data exchange between institutions, using a logical and transparent structure.
Developing and improving a national health information system may be a challenging and complex undertaking, including potentially high investments. Nevertheless, countries may learn from others’ experiences to improve their health information systems.

References


The Tallinn interim implementation report states,

There is evidence of national initiatives embedding international comparisons in a national process of performance assessment. In addition to analysing national trends over time, comparator countries provide insights into the level of performance and potential targets. This is assisted through internationally standardized health system indicators (Health for All – HFA, ECHI) and survey instruments (European Community Household Panel – ECHP, the EU Statistics on Income and Living Conditions – EU-SILC, the Survey of Health, Ageing and Retirement in Europe – SHARE and the European Core Health Interview Survey – ECHIS). International comparisons have heightened awareness of issues regarding the availability, quality and reliability of data, as well as methodological questions regarding indicator development (1).

Many health authorities have been confronted with the task of justifying a position in a league table or ranking. In such contexts, benchmarking is experienced as defensive. Nevertheless, constructive alternatives, like practice benchmarking and peer learning networks, offer additional opportunities to understand variations in results and provide insight into how policies affect health system performance.

A key distinction is made between performance benchmarking and practice benchmarking. While performance benchmarking concentrates on establishing performance standards, practice benchmarking seeks to understand the causes for varying levels of performance between entities (countries, regions or service providers). Both benchmarking processes are interrelated, as establishing performance benchmarks is often a prerequisite to understanding the underlying practices (2).

In international practice benchmarking and peer learning networks – as recently proposed by the WHO Regional Office for Europe (3) – participants embark on a constructive process of searching for new ideas and ways of working³. The evaluation process is owned by the peer learning network. It is a formative exercise whereby new ways of doing things are investigated with a view to strengthening governance and improving health outcomes. Member States are invited not only to share performance data but also to jointly analyse the results, test hypotheses for variations (in practice or in context), identify promising practices and share experiences in using performance information for performance improvement. In such contexts, performance

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³ Meeting reports available at http://euro.who.int/health-governance.
indicators are considered a trigger, or catalyst, for methodological, analytical and policy discussions; they are a means rather than an end.

References


Box 1: Key issues that need to be considered in establishing and monitoring performance across countries (4)

- **Specifying indicators using internationally standardized definitions.** Without agreed specification, comparison is immensely complicated, and hitherto there has been a notable lack of uniformity in many metrics.
- **Controlling for differences in population structures across countries.** The attainment of many health outcomes is highly dependent on the demographic structure and the underlying morbidity of the populations under scrutiny. Helpful comparison can usually be achieved only after proper adjustment for differences that are beyond the control of the health system.
- **Adjusting for differences in the ability of information systems to track individual patients.** Proper calculation of many indices used for comparison (such as cancer survival rates) requires tracking patients over a period of time. National systems vary markedly in their ability to do this successfully.
- **Controlling variability of data sources.** In the same vein, there is a need to ensure that the various information sources that must be combined to construct many indicators (such as vaccination rates) are fit for purpose and any shortcomings properly understood.
- **Identifying nationally representative data.** Data for many indicators are often available only for subsets of the population, such as selected regions or voluntary registers. Judgements must then be made about their national representativeness.
- **Determining retrospective completeness of the time series.** Many health outcomes can be properly assessed only after a considerable lapse of time. The extent to which national data sets permit proper assessment of the dynamics of health outcomes varies considerably.
**Thematic Brief 5:**

**Dissemination Plan**

Varying formats have been used for stakeholder workshops in the case studies. The following parameters should be considered in planning a forum or workshop to discuss findings and develop policy recommendations.

- What content should be covered? Should there be a different group or event for each performance dimension?

- What is the timing of the discussion in relation to completion of the report? Is a final draft report that is ready for review and discussion going to be presented, or will input be sought as the core team writes the report?

### Table 1: Example of using HSPA objectives to develop a dissemination plan

<table>
<thead>
<tr>
<th>Objective</th>
<th>Audience (who needs to know about the results to achieve the objective?)</th>
<th>Content/format (what do they need to know and how could this be delivered?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transparency</td>
<td>General public</td>
<td>High-level key messages of findings and recommendations presented in lay language. Through media releases, MoH website, short brochures distributed in health service facilities.</td>
</tr>
<tr>
<td></td>
<td>Health advocacy and special interest groups</td>
<td>Key messages of findings and recommendations specific to interest group. Meetings/discussions with key leaders and groups as appropriate.</td>
</tr>
<tr>
<td>Health system strategy and policy development</td>
<td>Health system researchers</td>
<td>Questions and areas identified for further research and more in-depth analysis and how this will support policy-making. Key meetings to discuss needs for research and evidence to support policy.</td>
</tr>
<tr>
<td></td>
<td>Ministry of Health departments with responsibility for policy development</td>
<td>Full HSPA report documenting findings and policy recommendations. Ongoing meetings/workshops to develop implementation strategies.</td>
</tr>
<tr>
<td>Performance management</td>
<td>Health care providers</td>
<td>Findings highlighting performance changes over time and comparisons to targets or other country results. Key meetings to review results.</td>
</tr>
<tr>
<td>Providing a forum for health system dialogue to improve relationships</td>
<td>Ministries of Health and other sectors that support the health system (such as social services, education and treasury)</td>
<td>Policy recommendations and strategies requiring intersectoral collaboration. Ongoing meetings/workshops.</td>
</tr>
</tbody>
</table>
Who should attend the discussion? Will the discussion be limited to identified key leaders of stakeholder organizations or will there be a general invitation to a more public forum? Will there be different events tailored to different audiences or stakeholders?

Answers will depend on the stakeholders who are included and their relationship with the HSPA. Have they already been involved extensively, or is this their first main exposure? Here, the answers will be driven by what is the best way to support acceptance of the findings and commitment to action.
Pathways to Health System Performance Assessment

A Manual to Conducting Health System Performance Assessment at National or Sub-National Level