CIHR Healthcare Renewal Policy Analysis
Health system performance assessment and comparison: analysis for policy

Background: The European Observatory on Health Systems and Policies (Observatory) is an international partnership that supports and promotes evidence-based health policy-making through comprehensive and rigorous analysis of the dynamics of health systems in Europe and by engaging directly with policy-makers\(^1\). A more detailed overview of the Observatory is at Annex 1.

The Observatory in collaboration with the CIHR Institute of Health Services and Policy Research will support a project under CIHR’s Healthcare Renewal Policy Analysis programme. This policy analysis opportunity will support a partnership between a Canadian research team (comprising a Principal Investigator and Principal Knowledge User) and the Observatory to carry out analysis as part of the Observatory’s programme on performance (details at Annex 2).

The Healthcare Renewal Policy Analysis grant will support research that can draw upon the Observatory’s established methodologies and will cover time spent in Europe to meet the deliverables of the grant (i.e., the generation of a policy brief; a policy dialogue / roundtable and policy options for Canada). This will enable the research team to draw on an existing international body of work to illuminate choices for Canadian policy and decision makers and to foster further development of comparative health policy analysis research. It is hoped the initiative may be linked to an overlapping CIHR Science Policy Fellowship.

Specific areas: The initiative links to the priorities of CIHR’s Evidence-Informed Healthcare Renewal (EIHR) initiative and the Healthcare Renewal Policy Analysis relevant research areas of:

- **Governance and accountability:** the proposed work is on comparative performance assessment as a means of: highlighting what works (i.e. what is optimal and suboptimal delivery practice); and facilitating accountability to citizens, patients and payers for the actions and outcomes of the health system. It will also support policy makers in learning from international experience, better designing appropriate health system reforms and making the case for investing in health care.

- **Health system sustainability:** the proposed work also relates directly to health system sustainability. Measurement is key to capturing and assessing efficiency and improving it – which in turn is central to delivering a health system which is affordable in the long term and seen as legitimate by the population.

Project: The Observatory leads a performance programme which aims to help governments, regulators, citizens and commentators better understand the comparative performance of their health systems, improve measurement and analysis, and help in the design and evaluation of initiatives to strengthen health systems. This Policy Analysis grant will support work that fits within the overarching programme and which focuses on a single performance domain reflecting the expertise

---

\(^1\) The Observatory’s Partners are the WHO European Regional Office for Europe, the Governments of Belgium, Ireland, Finland, the Netherlands, Norway, Slovenia, Spain, Sweden and the Veneto Region of Italy, the European Commission, European Investment Bank, World Bank, Union nationale des caisses d'assurance maladie of France (UNCAM), the London School of Economics and Political Science (LSE) and the London School of Hygiene and Tropical Medicine (LSHTM). The Observatory is hosted by WHO and has hubs in Berlin, Brussels and London.
and policy priorities of the research team and its other governance and accountability and/or health system sustainability undertakings. The Healthcare Renewal Policy Analysis team will choose to work on one performance domain from the following:

- Efficiency
- Health system responsiveness
- Financial protection
- Equity of health and access to health services

Efficiency is the theme most favoured by the Observatory Partners but the other domains are also pertinent and valued.

**Key deliverables of the Healthcare Renewal Policy Analysis grant:** To help the research team achieve the key deliverables outlined in the Healthcare Renewal Policy Analysis grant (and highlighted below), the Observatory has a number of established knowledge packaging evidence products with distinct methodologies and niches that the team may utilize:

1. **Draft policy analysis report:** This specific piece of analysis will involve
   - Specification of the domain and related issues
   - Framing of the (Canada) relevant policy questions
   - Collecting and marshalling the best available synthesized research evidence around both the policy issue at hand and a number of prospective policy options for tackling the issue, using systematic and transparent methods to ensure confidence in the material
   - Extensive review with particular reference to the completeness of the content, the potential of the performance measures reviewed, their limitations and the policy implications
   - “Testing” through presentation at a policy roundtable / dialogue and subsequent revision (below).

   The work will be integrated within the Observatory’s wider performance programme and underpinned by the established Observatory methods for policy briefs and domain reports. It will be done in collaboration with the Observatory’s performance programme leader and supported by a range of Observatory research staff.

2. **Policy analysis roundtable:** This policy event (interactive knowledge sharing mechanism) will
   - Be developed to create the opportunity for dialogue and feedback on the policy analysis report (outlined previously)
   - Use an iterative framing process to develop a policy relevant agenda and to identify appropriate evidence inputs
   - Use participative approaches to review the research evidence around both the policy issue and the prospective policy options and to elicit inputs
   - Help to further strengthen the policy analysis report so that it is best placed to contribute to the shaping of future action on performance measures for policy and for health system strengthening.

   The work may draw on the methodologies used by the Observatory for its highly regarded policy dialogue series. It will be facilitated by the Canadian Nominated Principal Applicant and the Head of the Observatory and supported by a range of Observatory knowledge brokering staff and is expected to involve key stakeholders agreed with the research team. It will also bring in European and other expertise and perspectives to support Canadian healthcare renewal.

3. **Final policy analysis report:** This final report will be
   - Completed in light of the policy roundtable
Published in the appropriate Observatory series
Published on CIHR’s website, and
Disseminated widely across Canada and Europe.

As is noted in the Policy Analysis funding opportunity, the research team may use a mix of methods and tools to undertake their analysis. This could include mapping and review of data sources (quality, coverage, regularity, disaggregation); stakeholder mapping; assessment of measurement methodologies and their constraints (alignment of data specification, collection and interpretation; policy applicability); assessment of comparative performance domain attainment; or other.

**Ensuring relevance to and dissemination in Canada:** While the proposal is for a grant for work with a European partnership it will have significant impact in Canada. It will
- Allow for Canadian researchers to be engaged in work in London and to participate in European networks
- Strengthen existing links between the Observatory and Canadian academic counterparts
- Include a roundtable in Canada with the support of international inputs and experiences
- Disseminate publications widely in Canada
- Raise the profile of Canada in Europe and in the international field of performance comparison.

**Duration and links:** The project and grant will last 12 months. The intention is to integrate the work of the Canadian policy analysis grant holder with that of the Observatory and it is expected an investigator will spend some time with the Observatory in London. The project will also draw on core Observatory staff time and other resources and may be supported by a CIHR Science Policy Fellowship on the same theme.

**Use of grant funds:** It is recommended that interested applicants review the “allowable costs” section in the funding opportunity and the “Use of Grant Funds” section of the Tri-Agency (CIHR, NSERC and SSHRC) Financial Administration Guide.

**Practical information:** Canadian applicants interested in exploring a partnership with the Observatory are encouraged to contact Suszy Lessof or Laurel Taylor.

A letter of support is required from the Observatory, and must be included as part of your full application to CIHR. Interested teams must contact Laurel Taylor for specific requirements for obtaining a letter of support. **Note: August 22, 2012 is the deadline for interested teams to contact the Observatory for a letter of support.**

Laurel Taylor, PhD
Assistant Director
Institute of Health Services and Policy Research
Canadian Institutes of Health Research
Tel: 514.398.6038
Email: ltaylor.ihspr@mcgill.ca

Suszy Lessof
Director of Management
European Observatory on Health Systems & Policies
WHO European Centre for Health Policy
Rue de l’Autonomie 4, 1070 Brussels
Tel: +32-(0) 2525 0930
Email: szy@obs.euro.who.int
www.healthobservatory.eu
ANNEX 1

The European Observatory on Health Systems and Policies

<table>
<thead>
<tr>
<th>Box 1: The European Observatory on Health Systems and Policies:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Is a unique partnership of national and regional governments and international agencies</td>
</tr>
<tr>
<td>• Covers all of the WHO European Region and key developed countries beyond Europe</td>
</tr>
<tr>
<td>• Generates the highest quality evidence on public health and public health developments</td>
</tr>
<tr>
<td>• Is a public good</td>
</tr>
<tr>
<td>• Publishing evidence on an open access basis so decision-makers and citizens can access it</td>
</tr>
<tr>
<td>• Working face to face with Ministers, State Secretaries, Director Generals and their advisors</td>
</tr>
<tr>
<td>• Running a web site that brings policy-makers, the public and the evidence together</td>
</tr>
<tr>
<td>• Offers a mechanism to provide sustained and excellent evidence for public health and policy.</td>
</tr>
</tbody>
</table>

What the Observatory is: The European Observatory on Health Systems and Policies is a partnership that brings together national governments, international organizations and others to generate evidence for decision-makers. The Partners identify the priorities that are most relevant to policy-making in the European Region. The Observatory’s core staff and its networks provide country and topic specific research and analysis to meet those priorities. They equip Europe’s policy-makers and their advisors with the frameworks, information and comparative evidence they need to take the best choices possible.

What it does: The Observatory has four core functions country monitoring; analysis, assessing the comparative performance of health systems and dissemination.

- **Country monitoring** gives a systematic overview of each of the national health systems in Europe (and in key countries beyond) in the form of Health in Transition profiles. These ‘HiTs’ give an analytical review of each country explaining how the health system is organized and what it does and assessing costs, benefits, efficiency and quality. All HiTs are available on the web and in summary. A National Lead Institutions network is now piloting real time updates that capture reforms and insights into the policy process in selected countries. All HiTs are disseminated at launches and through translations.

<table>
<thead>
<tr>
<th>Box 2: What the Health Systems in Transition (HiT) series has achieved:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• HiTs systematically and consistently describe health systems capturing issues of public health, access, quality, regulation, physical and human resources, patient empowerment and so on</td>
</tr>
<tr>
<td>• All 27 EU Member States are covered by a current (and by past) profiles</td>
</tr>
<tr>
<td>• All eastern European countries have current and past HiTs including Belarus, Moldova, the Russian Federation, Ukraine and the whole of the Caucasus and central Asia</td>
</tr>
<tr>
<td>• Key OECD countries outside Europe also have HiTs which allow their models to be explored</td>
</tr>
<tr>
<td>• A standard template1 has been developed, validated and kept up to date allowing clear, comparable descriptions of all countries however differently they approach a service or issue</td>
</tr>
<tr>
<td>• A network of National Lead Institutions has been established to embed ownership of profiles in countries and to address the need for ongoing updating and rapid sharing on reforms</td>
</tr>
<tr>
<td>• A comprehensive glossary of health systems terms has been set out with clear definitions</td>
</tr>
<tr>
<td>• Over 100 HiT profiles are available with summaries and translations (in Albanian,</td>
</tr>
</tbody>
</table>
Bulgarian, Estonian, French, Macedonian, Russian, Spanish and Turkish amongst others).

- Recent and forthcoming updates cover Bulgaria, Canada, Denmark, Hungary, Portugal, Poland, Russian Federation, Spain and the United Kingdom (England).

- **Analysis** allows core health system and policy issues to be explored in depth. The Observatory brings together teams of academics and practitioners from different institutions, countries and disciplines to ensure really authoritative meta-analysis and secondary research on the issues that matter most to European decision-makers. The evidence is all ‘open access’ so that it can be used in practice.

**Box 3: Some Observatory analytical outputs:** The Observatory leads studies and collaborates with others to generate evidence where there are gaps in understanding:

- **Financing for access, efficiency and quality:** The Observatory has delivered a range of analysis from its seminal volume on funding Europe’s health care and on lessons from transition to reviews of social, voluntary, and private health insurance mechanisms that provide evidence on the barriers to access that systems create and the levers policy-makers can use to ensure high quality, accessible yet efficient services.

- **Public health and health services:** The Observatory is involved in a huge range of other areas of concern to policy-makers and citizens. Issues like health trends, migration and health, mental health, primary care, communicable and chronic diseases, diagnosis related groups and pharmaceuticals, are covered by detailed studies. Evidence is also “unpacked” so that it can be used more easily with, for example, policy briefs on mental health, access to care and screening.

- **Fixed, human and social capital:** The Observatory has delivered and continues to produce analysis that is highly pertinent in resource allocation and resource generation including volumes on hospitals, human resources, capital allocation and readily accessible case studies on human resource and mobility.

- **Governance issues:** Many of the Observatory’s studies address governance issues whether at a system wide level as with its work on health and wealth or the more specific as with its volume on hospital governance.

- **EU Presidencies:** The Observatory works closely with Member States on evidence to support their EU Presidency health theme providing workshops, analysis and publications. Examples support to the Finnish Presidency (Health in all Policies), Slovenia (public health responses to cancer), Czech Republic (financial sustainability) and Sweden (anti-biotic resistance).

- **The impact of EU decision making:** The Observatory research and analysis helps the European Commission capture how decision making impacts health and to extend the influence of public health into other policy areas. Initiatives include studies of health impact assessment (HIA) and support to consultation on Community action on health services.

- **Performance:** The Observatory has had a long standing interest in this area dating back to one of its earliest volumes on how purchasing can improve performance and developed as a part of the focus for the WHO Ministerial Conference at Tallinn conference. It has now established an extensive programme of comparative and methodological work in response to country needs and has another forthcoming study, a series of domain reports and a set of methodological papers underway.

**Box 4: Performance assessment - methodological papers**

- Anchoring vignettes to adjust self-reported data
- Methods for health system comparisons of financial protection
- Financial barriers to access in catastrophic health spending
- Measurement of income inequalities in unhealthy behaviours
- Data envelopment analysis and multiple efficiency indicators
- Reliability and comparability of published inequality estimates
- Treating Prevention as a Capital Investment
- Explaining Variations in Life Expectancy
- Understanding mortality and age-period-cohort analysis

- **Dissemination** means engaging with policy-makers and communicating the right information at the right time. The Observatory combines an extensive publications programme with face to face and electronic dissemination to get across the evidence of what works better or worse in different contexts.

**Box 5: Some Observatory approaches to dissemination**

- **Involving the key people:** Observatory face-to-face dissemination includes
  - **Policy dialogues** which are perhaps the most important tool for reaching top level decision-makers. Some 10-15 of these intense facilitated sessions take place a year, bringing together key decision makers from Ministers, Deputies, Director Generals and Directors of Public Health to senior figures in Insurance Funds and finance ministries. The objectives are to marshal support for key decision points and to inform the decision making process with expert evidence. The key to their success is their size and timing. They are tailored to the specific circumstances in countries and are a direct (and rapid) response to national needs.
  - **Tailored briefings and updates** for ministerial networks, committees, MPs and MEPs.
  - **Launches** to present key conclusions and messages from publications and stimulate debate
  - **Presentations:** including annual sessions at the European Health Forum Gastein, EHMA, EUPHA and APSHER and literally hundreds of focussed and key note speeches and papers.
  - **Open access to publications:** The Observatory tailors formats to different audiences including
    - A series of policy briefs and summaries through the joint HEN-OBS series
    - A quarterly newsletter Eurohealth reaching 35,000 people
    - Articles in peer reviewed and more general journals.
  - **The web** is a key tool and the site at [http://www.healthobservatory.eu](http://www.healthobservatory.eu) has over a million hits a year and more than 150,000 downloads. There is also a list-serve/e-alert and a twitter account.

**How the Observatory is governed and organized:** The Observatory’s make up reflects some of the influences that shape decision-making. The Partners understand from direct experience the complexity of the choices policy-makers face and the lack of accessible evidence. They have therefore shaped the Observatory to be policy relevant and to communicate, bridging the gap between ‘scientific research’ and the practical demands of decision-makers.

**Box 5: The European Observatory Partners:** The Observatory is hosted by WHO. Its Partners are
- WHO European Regional Office for Europe
- Government of Belgium
- Government of Ireland
- Government of Finland
- Government of the Netherlands
- Government of Norway
- Government of Slovenia
- Government of Spain
The Observatory offices and staff team are in Brussels (Ministry of Health), Berlin (Technical University) and London (LSE and LSHTM) so it stays close to relevant European and expert networks. It also relies heavily on external networks of policy-makers and academics as well as on organizations like the OECD, the ECDC, and EUROSTAT to ensure a coordinated approach to the field.

In summary: The Observatory brings together all the main players in health systems and policies to understand what works better or worse in different environments and to communicate the evidence. It is a public good for all the people that take decisions for Europe’s health and for the people that use Europe’s public health services. The Observatory’s unique characteristics as a partnership and its wide networks of experts and practitioners allow it to fill an important niche in the European arena. It bridges the gaps between theory and practice; between Western Europe, the CEE and NIS; and between evidence and action.

Sample publications

i Rechel, Thomson, van Ginneken Health system in transition Template for authors (2010)


iii Kutzin, Cashin, Jakab Implementing health financing reform: Lessons from countries in transition (2010)


vii Thomson, Foubister, Mossialos Financing health care in the EU: Challenges and policy responses (2009)

viii Mladovsky, Allin, Masseria, Hernandez-Quevedo et al. Health in the EU: Trends and analysis (2009)

ix Rechel, Mladovsky, Devillé, Rijks, Petrova-Benedict and McKee (eds) Migration and health in the EU (2011)


xi Saltman, Busse, Figueras (eds) Primary Care in the Driver’s Seat (2006)

xii Coker, Atun, McKee (eds) Health systems and the challenge of communicable diseases (2008)

xiii Nolte and McKee (eds) Caring for people with chronic conditions – a health system perspective (2008)

xiv Nolte, Knai, McKee (eds) Managing chronic conditions – experiences in eight countries (2008)

xv Busse, Geissler, Quentin, Wiley Diagnosis related groups in Europe (2011)


xvii Policy brief: Mental health I – Key issues in developing policy and practice across Europe (2004)


Policy brief: Mental health III – Funding mental health in Europe (2004)
Policy brief: Health care outside hospitals: Accessing generalist and specialist care in 8 countries

Policy brief: Screening in Europe

Dubois, McKee, Nolte (eds) Human Resources for Health in Europe (2006)
Rechel, Wright, Edwards, Dowdeswell, McKee Investing in hospitals of the future (2009)
Rechel, Dubois, McKee (eds) Health Care Workforce in Europe: learning from experience (2006)

Figueras, McKee Health systems, health, wealth and societal well-being. Assessing the case for investing in health systems (2011)

Saltman, Duran, Dubois Governing public hospitals. Reform strategies and the movement towards institutional autonomy (2011)

Thomson, Foubister, Figueras, Kutzin, Permanand and Bryndová Addressing financial sustainability in health systems Policy summary (2009)
Fernandez, Forder, Trukeschitz, Rokosova McDaid How can European states design efficient, equitable and sustainable funding systems for long-term care for older people Policy brief (2009)

Mossialos, McKee (eds) EU Law and the Social Character of Health Care (2002), PIE Peter Lang
Mossialos, Permanand, Baeten and Hervey Health Systems Governance in Europe: The role of EU law and policy CUP (2010)
Wismar, Maier, Glinos, Dussault, Figueras (eds) Health professional mobility and health systems. Evidence from 17 European countries (2010)
Saltman, Busse, Mossialos (eds) Regulating entrepreneurial behaviour in European health care systems (2002)
Figueras, Robinson, Jakubowski (eds) Purchasing to improve health systems performance (2005)
Smith, Mossialos, Papanicolas, Leatherman Performance measurement for health system improvement: experiences, challenges and prospects CUP (2009)
1. Background

The 2008 Tallinn Charter underlined the importance attached to strengthening health systems by WHO European Region member states. It included a commitment to promoting ‘transparency and accountability for health system performance, to produce measurable results’. Individual nations are also increasingly seeking to introduce more systematic ways of assessing the performance of their health systems, and of benchmarking performance against other countries. However, most health systems are in the early stages of performance measurement efforts, and there are many challenges involved in the design and implementation of measurement schemes.

The arguments for improved performance measurement are manifest. Without measurement, it becomes difficult to identify good and bad delivery practice (or ‘what works’), to design health system reforms, to identify good and bad practitioners, to protect patients or payers, and to make the case for investing in health care. Furthermore, there is little accountability to citizens, patients and payers for the actions and outcomes of the health system.

Over the last decade the capacity for measurement and the associated analysis has increased enormously, driven in part by massive changes in information technology and associated advances in measurement methodology. The state of current developments is comprehensively surveyed in the book Performance Measurement for Health System Improvement arising out of the Tallinn conference (Smith, Mossialos, Papanicolas and Leatherman, 2009). In addition, the book identified important sources of international comparison undertaken in international agencies (such as OECD, WHO, the European Commission), researchers and foundations (the Commonwealth Fund and several research consortiums) and groups of countries (such as the Nordic collaboration).

However, many performance assessment initiatives have hitherto been limited both in their scope as well as in their policy usefulness. These shortcomings are all the more important in light of the growing appetite for cross country performance comparisons and benchmarking by Member States, citizens and the media. The volume shows the difficulties of interpreting the many comparative sources of performance information from a health system policy perspective. Moreover, the focus of most existing initiatives partial aspects of performance can lead to serious policy misconceptions if not accompanied by a careful commentary on the implications of variations for health system improvement and reform. These methodological difficulties are sometimes compounded by political constraints when Member States face unfavourable results.

In sum, country comparisons of performance may constitute a rich source of evidence and powerful influence on policy when properly conducted. However, the current gap in this field is sometimes filled by initiatives offering poorly validated measures and biased policy interpretations that in many instances may lead to seriously adverse policy and political impacts.

There is therefore more than ever a need to harness the benefits of comparative health systems performance assessments building on credible initiatives and strengthening both the methodologies and the policy analysis. In doing so, there is a need to highlight not only the policy ‘uses’ but also the policy ‘abuses’ of comparisons. In other words, as well as drawing out the information content and potential of performance measures, researchers should indicate what cannot be inferred from the analysis, showing the limitations of current measures and suggesting fruitful future improvements. This note describes a programme of work at the Observatory to complement its existing work and
the work of others by establishing the capacity to comment authoritatively on comparative health system performance. In doing so, it seeks to contribute a new dimension to the Observatory’s mission to ‘support and promote evidence-based health policy-making through comprehensive and rigorous analysis of the dynamics of health care systems in Europe’.

This program is intended to be carried out in close collaboration with the Observatory’s partners, notably the WHO in support of its Tallinn follow up mandate, the EC in its support to its Member States among others with the Open Method of Coordination, as well as many of its national partners engaged in comprehensive HSPA exercises. Equally the Observatory seeks to strengthen its links and set out collaborative arrangements with the OECD, notably to work closely with its quality indicators initiative, and with the Commonwealth Fund. Securing transparent communication, extensive links and full complementarity with existing initiatives and optimizing new joint efforts to support Member States will be fundamental to the success of the programme.

2. The proposed programme

The overarching goal of the programme is:

“to help governments, regulators, citizens and other commentators gain a better understanding of the comparative performance of their health systems, to improve approaches to measurement and analysis, and to help in the design and evaluation of initiatives intended to strengthen health systems.”

The intention is to offer a scientifically sound, overarching view of comparative system performance that is relevant and understandable to the various stakeholders. Throughout, the focus will be on measurement that casts light on system-level design and performance issues, illuminating what we know, and explaining what we do not know. Knowledge gaps will be highlighted, and where appropriate links with relevant research will be established, or new research undertaken. Research in specific clinical areas will be followed up only where it offers general insights into system design. Furthermore, there is no intention within this programme of work to undertake detailed country benchmarking – the programme will offer comparisons across European countries, or a subset of countries, and not seek to undertake highly detailed performance assessment in individual countries. However, the work will of course feed into the Observatory HiT series (see below) and benchmarking activities by other organizations.

The Observatory is well-placed to undertake this work, which plays to its strengths. It already enjoys extensive policy links with relevant stakeholders in countries and international agencies, has a highly regarded series of health system profiles, and a worldwide network of researchers, reflected in the contributions to its series of books and papers on important health system topics. The Observatory can:

· Give an overview of the ‘shape’ of the field
· Identify the conceptual, methodological and data gaps in existing work
· Facilitate coordination between the experts and stakeholders who will continue to lead in different areas of the field
· Act as a forum, bringing together those involved with specification, collection, dissemination and interpretation of data, and supporting their dialogue and links with policy makers
· Comment on the existing evidence base from a policy perspective
· Bridge the gap between theory and practice.

The intention is to act as a nimble, non-partisan, scientifically rigorous nexus of comparative health system performance efforts.
The core activities undertaken to support these objectives will be:

1. Mapping and commenting on the validity and interpretation relevant data sources;
2. Assessing existing measurement methodologies, and where relevant commissioning work to help improve methodologies;
3. Liaising with international agencies, representatives from European member states, researchers and other relevant stakeholders to help facilitate the alignment of data specification, collection and interpretation efforts;
4. Commenting on the comparative attainment in five specific performance domains of health systems across Europe and over time;
5. Augmenting and strengthening the existing work of the Observatory by contributing to health system profiles, books and other outputs.

3. Organization of the programme

There are several ways in which the programme of work could be organized. However, to take advantage of the Observatory’s existing strengths and collaborations, it is proposed to proceed as follows. The cohesion and consistency of the programme will be assured through development of an overarching methodological framework and work plan, coordinated by Peter Smith. We then propose five areas of work, representing the main domains of health system performance. For each domain, there will be a focus on reviewing and commenting on a limited set of key indicators, interpreting them from a policy perspective, and discussing the levels of attainment they indicate in European countries. The domains are:

- Health status
- Health system responsiveness
- Financial protection
- Equity of health and access to health services
- Health system efficiency

We offer a brief commentary on each below.

The overarching framework will build on existing work undertaken by the Observatory, WHO Geneva, WHO Copenhagen, the OECD, the Commonwealth Fund and others. It will develop and keep under review thinking on issues such as the definition and functions of the health system; health system objectives; determinants of outcomes that lie beyond the health system; and potential policy levers. It will seek to give users the broader picture within which they can understand the contribution and limitations of particular pieces of work.

Health status performance measures are the most established indicators of health system performance. They include a wide variety of population health metrics, such as standardized mortality rates and life expectancy. These measures are widely used but suffer from three fundamental problems when used for health system performance comparison: they may have to rely on questionable mortality or population data; standardization and aggregation processes may disguise considerable variations between health systems; and it is usually difficult to infer the specific contribution of the health system to the observed variations. Furthermore, conventional mortality measures make no reference to health-related quality of life, leading to a variety of approaches to adjusting life years for levels of disability, as (for example) in disability-adjusted life expectancy.

One approach to addressing the attribution of the health system to observed mortality is the concept of ‘amenable’ mortality, which refers to death from causes where death should not occur in the presence of timely and effective care. The original aim of amenable mortality was to identify
deaths that would point to specific aspects of care requiring more detailed examination. However, it is also a potentially fundamental indicator of health system performance because it seeks to capture mortality that is (at least to some extent) within the control of the system. A key question is whether the concept may need to be adapted when used in the aggregate to assess the performance of health systems.

More direct measures of the contribution of health services to health status are available in the form of health service quality measures, such as hospital mortality rates. In this context, the OECD quality indicators project will be an important resource. Routine use of patient-reported outcome measures is also being piloted in England. Whilst these measures are much more direct indicators of the performance of individual organizations, international comparison is complicated by different organizational settings.

This thumbnail sketch indicates a rich agenda for seeking to understand the limitations of existing indicators for health system comparative purposes, proposing adjustment methods for securing more meaningful comparison, increased focus on health-related quality of life, and exploring newer metrics such as amenable mortality.

Responsiveness refers to the extent to which “health systems, or their components, are successful in responding to the expectations of the general population or a population subgroup of patients”. It has strong links to the notions of user satisfaction and the patient experience. As developed in the World Health Organization’s World Health Report (WHR) 2000 (WHO, 2000), it comprises:

- Dignity: Respectful treatment and communication
- Confidentiality: Confidentiality of personal information
- Autonomy: Involvement in decisions
- Communication: Clarity of communication
- Prompt attention: Convenient travel and short waiting times
- Quality of basic amenities: Surroundings
- Access to family and community support: Contact with outside world and maintenance of regular activities
- Choice: Choice of health care provider

The WHR2000 relied on very rudimentary measures of responsiveness. However, the subsequent World Health Survey developed the concept into a more concrete and detailed form, and sought to use advanced methodological methods (in the form of ‘anchoring vignettes’) to adjust for the different expectations that exist in different systems. The International Health Policy Survey by the Commonwealth Fund also seeks comparative information on people’s contact with health services.

Traditionally, metrics in this domain have sought to elicit the satisfaction of users or the general public with aspects of the health system. Given their continued widespread use, commentary on satisfaction measures will undoubtedly form part of the work programme on responsiveness. However, the generally accepted principle in this domain is that metrics should focus on what happened during an actual contact rather than directly eliciting a respondent’s satisfaction, which may be conditioned by expectations and cultural norms.

Key issues for comparative performance assessment are: the extent to which individual questions on performance can offer meaningful information on broader health system attainment, how questions can be standardized for use in a wide range of settings, and how survey results should and can be adjusted for differences in expectations and cultural norms amongst different population groups.

Financial protection measures the extent to which people are protected from the financial consequences of illness. The need for financial protection arises from three factors: uncertainty about the need for health care (timing and severity of ill health); the high costs of health care (both
in absolute and relative terms - even low-cost health care may be expensive for poorer households); and the loss of earnings associated with ill health. Much literature, including WHR2000, focuses on the first two factors. However, the third factor is relevant to health system performance, because timely access to good quality health care can reduce the magnitude of lost earnings.

The notion of financial protection has superseded the initial WHR2000 focus on ‘fairness of financial contribution’, which does not address the fundamental policy concern. It also gives rise to intractable measurement problems in tax-based health systems, when tax payments for health services cannot be isolated from tax payments for other purposes.

Clearly the notion of financial protection is closely linked to the notion of health ‘coverage’, and can be undermined by gaps in the breadth (universality), scope (range of benefits) and depth (user charges) of coverage. Measure of the incidence and magnitude of user payments for healthcare (both prepaid and out-of-pocket) are likely to play a major role in any metrics. However, hitherto the emphasis has been on the incidence of ‘catastrophic’ health-related payment, based on some arbitrary percentage of household income, and the proportion of households pushed into poverty by health care payments.

Future work should seek to refine such measures, and secure some definitional consensus. Also, current metrics ignore people who are deterred from using health services by the level of payments. This issue is linked to equity of access, but is also an important indicator of lack of financial protection.

Equity is a fundamental goal of most health systems, but is often poorly articulated. It can take a number of forms: equity in financing, equity in responsiveness, equity in health outcomes and equity of access to health services. This theme will address all four, by informing methodology of the other themes. However, it will concentrate on the equity concept under the most direct control of the health system: equity of access to health services. Any measurement instrument should reflect the notion of equal access for equal need, an objective that enjoys widespread acceptance across diverse types of health system. Although there may be debates about the exact formulation of any metric, and the strength of associated preferences, this objective implies that differential access to care is acceptable only if it arises due to different levels of health care needs.

The dominant methods for measuring equity use various forms of regression analysis that indicate observed contact with health services relative to expected contact, given an individual’s circumstances. The level of inequity is then assessed by comparing the cumulative distribution of use with that of needs-adjusted utilization, as in the ECuity project. Whilst this approach enables researchers to develop comparable metrics such as concentration indices across countries, the policy implications of a country’s ranking are difficult to infer. There is much work needed to assist in the interpretation of equity results, and to explore complementary equity metrics that offer more immediate policy guidance. There is also a need to develop approaches that capture ethnic disparities and intergenerational inequities.

The pursuit of efficiency in health services is of concern worldwide, and was the central focus of the World Health Report 2000. Efficiency and productivity have many connotations, but in this initiative we consider them to be synonymous with the notion of ‘value for money’: that is, the ratio of some valued outputs to the costs expended. Making this apparently straightforward concept operational gives rise to severe methodological and practical challenges, but there is a growing academic literature on efficiency measurement. A fundamental question for this programme will be the extent to which reliance should be placed only on partial measures of productivity (such as length of hospital inpatient stay), or whether more ambitious composite measures of overall system efficiency should be pursued.
A well-established research literature has developed that seeks to offer ‘single number’ estimates of the relative efficiency of organizational entities, using methods such as stochastic frontier analysis and data envelopment analysis. These are likely to play some role in any comparative performance assessment. However, their use requires heroic assumptions, and their usefulness for policy purposes is open to question. A key issue is how to adjust for the uncontrollable influences on health system performance, how to handle currency conversion, and how to interpret results with missing or unreliable data. Given the heterogeneity of countries within the European Region, and the variability in data availability, it will certainly be the case that, at first, comparison will be only within groups of countries that reflect some homogeneity in terms of economic development and healthcare expenditure. It is likely that methods will be developed and tested on the countries of western Europe, where data availability is good and health systems broadly comparable.

More generally, it is likely that this programme will – at least initially – rely mainly on less ambitious productivity indicators. The task is to develop partial indicators of system productivity that address important efficiency issues, enjoy widespread acceptance and have real policy relevance. Priorities include: improved measures of capital, and possible treatment of preventive care as capital expenditure in productivity measures; improved use and analysis of microdata; the role of metrics such as ‘effective coverage’ as proxies for longer term outcomes; and more work on the characteristics of systems that give rise to better efficiency.

4. Outputs of the programme

The Observatory is proposing not a single study but rather an integrated programme of work that will culminate in a series of comparative reports addressing the five performance domains outlined above. The intention is to start with some general preparatory work, and then progress to a series of activities under two parallel work streams: data and methodology. These will feed into the third ‘evidence’ stream that will lead to the production of the comparative reports.

Dissemination will also be a central element of the programme, making findings readily accessible on data, methods and the use of performance measures to inform system improvement. In addition to the major reports documented below, it will include policy briefs, a web site, seminars, conference presentations, and integration into relevant policy networks. The outputs of the programme will be designed to serve the objectives of the programme in a timely and accessible fashion. As well as offering new dissemination platforms, they will seek to exploit the Observatory’s existing strengths and networks. The intention is to maximize the impact on (a) policy makers, by helping them shape health system reforms, and (b) on scientific communities, by stimulating and improving research efforts in health system performance measurement.

It is envisaged that the first year of the programme will be exploratory, used to develop further the overarching framework, and clarify the state of play in the five performance domains. Key issues to be addressed include:

- How is the domain’s concept delineated?
- Are there gaps or disputes in existing approaches?
- What is the key relevant literature and what are the key unresolved issues?
- Who are the key agencies, researchers and networks?
- What are the current data sources: quality; coverage; regularity; disaggregation?
- How useful are current indicators for policy purposes?
- Are there specific issues associated with metrics for lower income countries?
- An assessment of each domain: what we know; what we don’t
- Key policy issues, debates and potential
- Development of a detailed work plan
A report will be prepared for each domain. Work will also start on the development of the programme’s web site.

Subsequent outputs will then be in three categories: data, methods, and evidence.

The data stream will involve seeking out, mapping, systemizing and commenting on relevant data sources, and where feasible contributing to and encouraging improvements in existing endeavours and supporting new data initiatives. This will be facilitated by existing and proposed work at inter alia WHO, OECD, Eurostat, the Commonwealth Fund and relevant ongoing EU-funded projects such as EuroReach or AMIEHS. Appropriate liaison and collaboration with these and other initiatives will be essential to this stream of work. The focus throughout will be on data that offer insights into system performance. The work may include scrutiny of measurement initiatives that are not widely available in the European Region, if such data offer promising new directions for more widespread use in the future. However, there is no intention to initiate major new data collection efforts directly on the part of the Observatory.

The main outputs from the data stream will be overviews of data sources on specific topics, shorter commentaries on the availability, coverage and limitations of data, and web pages pointing to the sources. An important additional output will be appropriate links with research networks, governments, international agencies and other survey organizations to share thinking on necessary improvements in and additions to existing data sources.

The methods stream will seek to offer a critical commentary on the strengths and limitations of existing measurement instruments, to identify priorities for improvement, and to comment on the scope for new measurement methods. The criteria for assessment of measurement instruments will include their scientific validity, the extent to which they adjust for uncontrollable influences on performance, their feasibility, scope, timeliness and collection costs, and the extent to which they offer meaningful information on health system performance.

The main outputs from the methods stream will be scientific reviews. The intention is to inform our commentaries on performance in the evidence stream, and to influence researchers and others involved in the design, collection and analysis of data. There will be no strict template for these reports, but issues to be covered would include:

- How is the concept delineated?
- Data availability and reliability
- Current methods and critiques
- What do we know? What are the gaps?
- How important is the issue from a policy perspective?
- What is the link to eventual system performance and health outcomes?
- Suggestions for future improvement.

Examples of particular topics suitable for inclusion include conceptualizing and improving measurement of issues such as: amenable mortality; efficiency; access to health services; unmet need; avoidable hospitalization; effective prescribing; and measuring patient-reported outcomes. The results will be disseminated widely to the scientific community. Wherever possible, efforts will be made to ensure that the outputs lead to peer-reviewed publications. This is essential to (a) establish the scientific credibility of our work, (b) disseminate to scientific peers and (c) support career progression for younger researchers. In the longer term it might be possible to establish a journal that would act as a focus for findings and associated debate. It may also seek to encourage a more vibrant world community of researchers in the area of health system performance.

The evidence stream will synthesize existing data and methods to offer policy makers an understanding of the current variations amongst countries in specific domains of health system
performance, the level of confidence we have in drawing conclusions, the gaps in knowledge, the implications for policy formulation, and the priorities for future research and policy experiment.

The evidence stream will result in a series of comparative HSPA reports. Each report (probably biennial) will take a domain of performance (health outcomes, responsiveness, financial protection, equity or efficiency) and document the state of knowledge, the measures in use and their value and the initial information they provide on levels of performance for that dimension in different countries. Each report will include a description on existing data resources; (to the extent that data permit) standardized tables of performance metrics by country and across countries; identification of key policy issues that arise; recommendations for future data and methodological enhancements; and a broader commentary on the state of European health systems in the domain under scrutiny.

These reports will draw on the results of the data and methodological streams, and also on relevant comparative policy analysis and country health systems profiles, and on expert groups chosen to offer a good understanding of the differences in performance and possible policy implications. The standardized performance metrics will be integrated into the Observatory HiTs, which will provide a valuable source of country by country policy analysis, and seek to help stakeholders understand the reasons for performance variations.

5. Oversight

The programme will be coordinated by a board chaired by Peter Smith, Imperial College, who will act as coordinator of the programme. Each domain leader will be responsible for the respective outputs, and will be a member of the board. Among others, the board will include Reinhard Busse, Josep Figueras, Suszy Lessof, Martin McKee and Elias Mossialos, and others will be co-opted as appropriate from amongst relevant experts partner organizations (national and international). The board will be responsible for overseeing the content of the programme, assisting with research funding bids by the Observatory, and ensuring proper transparency and communication of results. The partners of the Observatory itself will continue to be responsible for oversight as a whole and for ensuring resources are used appropriately.

In addition to the board there will be a scientific steering group that will focus on the technical content, which will comprise key stakeholders (OECD, WHO, Commonwealth Fund, European Commission, some countries) and international academic experts.

Much of the research work will be provided by OBS research staff, perhaps with additional inputs from the Imperial team. External experts and researchers will be commissioned as appropriate. OBS will underwrite core funding for the first three years and will seek out funds to sustain the initiative thereafter.