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Assessing System Performance for Health Governance
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Introduction

1. The Tallinn Charter (2008) stresses the importance of fostering transparency and accountability on the basis of progress against measurable results. It commits each Member State to strive to enhance the performance of its health system to achieve the goal of *improved health on an equitable basis*. The analysis of performance for informed decision-making on policy is a central theme of the Charter, linked closely to the message of moving “from values to action”. Countries honouring this commitment will have acted to measure, analyse and publicly report on the performance of their health systems and/or the effects of specific reform measures (Interim report on implementation of the Tallinn Charter, WHO 2011).

2. The interdependence of health system functions calls for a coherent approach and coordinated action, as also recognized in the Tallinn Charter. Better governance requires more skilled use of systems thinking to transcend complexity (Frenk 2008). There is a recognition of the need to apply more holistic approaches which do not concentrate on analysis of only one or more parts of the system, but incorporate all the sub-systems and their interconnections (de Savigny and Taghreed 2009). This is necessary because an isolated action taken within the context of part of the system may upset the current equilibrium of the whole system and cause other sub-system elements to resist the action and defeat it. Many of the most pressing present and future policy challenges affecting public health involve dealing with complex problems. Issues related to e.g. nutrition or the environment transcend the mandate of a single organization or governmental sector, and must be addressed through the consolidated and combined effort of multiple organizations.

3. Thus, a key governance challenge confronting governments is to lead the health systems in a manner that ensures that all constituents fully understand the vision and priorities for change, support them in embracing their roles and responsibilities in contributing to the desired changes, and encourage mutual accountability to enable movement towards better, higher performing health systems. Information on the achievement of health system goals (improving the level of health and equity), intermediate outcomes (e.g. distribution of risk factors or healthy behaviours) and how the health system functions to achieve these is required when facilitating an evidence-informed dialogue between all actors (including citizens). National health plans and strategies as well as strategy-based health system performance assessments provide critical material to align stakeholders and hold them jointly accountable. This is of utmost relevance in settings where health systems remain fragmented although horizontal and participatory governance are gaining recognition.

4. Though it does not preclude specific in-depth analysis of part of the system and continuous monitoring of programmes, an assessment of the performance of the health system demands a coherent evaluation scheme to understand how the system as a whole

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Box 1. “The health system’s 6 building blocks alone do not constitute a system, any more than a pile of bricks constitute a functioning building. It is the multiple relationships and interactions among the blocks – how one affects and influences the others, and it is in turn affected by them – that converts these blocks into a system.” (de Savigny et al. 2009).
meets its objectives. In this information note, we will present initiatives which address the whole of the health system as scope of analysis (at the national, subnational or local level) and discuss how such approaches might support effective governance for better health outcomes. Indeed, experience in Member States indicates that performance assessment is an effective governance tool. Not only is it a prerequisite for transparency and accountability, it also serves to crystallize lessons learnt from the implementation of policies and provides a process through which stakeholders can be engaged and dialogue and alignment can be fostered.

5. In this regard, health system performance assessment (HSPA) is a recognized approach in the WHO European Region. HSPA measures the achievement of high level health system goals (i.e. health outcomes, responsiveness, financial protection) based on health system strategies. A fully developed HSPA mechanism extends beyond a list of indicators and targets. It builds on an organized set of quantitative measures (performance indicators) and incorporates qualitative analysis as well. It is comprehensive and balanced in scope, encompasses the entire health system and is not limited to specific programmes, objectives or levels of care.

Box 2. A (country-specific) HSPA framework, illustrating relationships and linkages among the areas of the health system as well as key forces outside of the health system such as social determinants and other sectors of government, helps to both decompose the health system into manageable dimensions for the HSPA as well as find a way to represent the whole. When the analysis of performance indicator results is performed, the framework helps to focus it as a “formative evaluation” – one that leads naturally to highlighting opportunities for strengthening. The HSPA framework provides insight into how strengths or weaknesses in some areas have an impact on performance in other areas and in achieving ultimate objectives. The framework helps to ensure that the HSPA and the performance indicators that are used are reflective of the whole health system (as defined in the scope). It guides the analysis and interpretation of results and through illustrating relationships among areas identified opportunities for strengthening.

Box 3. A fully developed HSPA approach meets the following attributes:
- It is regular, systematic and transparent. Reporting mechanisms are defined a priori and cover the whole assessment. It is not bound in time by a reform agenda or national health plan end-point, though it might be revised at regular intervals to better reflect emerging priorities and revise targets in view of their attainment.
- It is comprehensive and balanced in scope. It covers the whole health system and is not limited to specific programmes, objectives or levels of care. The performance of the system as a whole is not equivalent to adding up the performance of each of its constituents.
- It is analytical and uses complementary sources of information to assess performance. Performance indicators are supported in their interpretation by policy analysis, complementary information (qualitative assessments), and reference points (trends over time, local, regional or international comparisons, or comparisons to standards, targets or benchmarks).

Source: The European health report 2009
HSPA for accountability and transparency

Key messages:

- Accountability and redress lie at the heart of the Right to Health. Political/democratic accountability has to do with the institutions, procedures, and mechanisms that ensure that the government delivers on electoral promises, fulfils the public trust, aggregates and represents citizens’ interests, and responds to societal needs and concerns (Brinkerhoff 2003).

- Performance assessment is also a central pillar of the Tallinn Charter (2008). The accountability to deliver high value for money was further reiterated in the context of the financial crisis.

- Improved accountability brings performance improvement through three pathways: altruism (merely by understanding sources of under-performance), markets (when allowing patients/citizens to choose to best providers/systems), and reputation (by putting under-performers on a “burning platform”) (Bevan 2010). At the system level though, the first and third pathways (“altruism” and “reputation”) are most relevant.

- There is no optimal approach. Numerous mechanisms are being used, such as targets and contractual agreements, or reporting to the public—with a substantial role being played by the media—or to parliamentary commissions. To foster ownership of evaluation results and focus on performance improvement (rather than “blame and shame”), not only should indicators results be reported but an analysis of the reasons for variations and proposed actions should also be reported.

- International comparisons have drawn much attention but also highlighted methodological and statistical issues. This does not preclude the use of indicators and comparative analysis but calls for a cautious and dynamic approach to continuously learn from experience in using them. The current trend indicates that benchmarking and shared evaluation are generally regarded as the more appropriate approaches, as opposed to the known limitations of performance ranking.

- By including a time dimension, health system performance assessment can even provide incentives for policies with long-term effects, as these will be recognized in the short term.

6. Regular, open publication of performance results at all levels will contribute to improved responsiveness vis-à-vis public expectations and effective, evidence-informed policy-making. Most countries in the European Region have established mechanisms whereby the Minister of Health reports to the Parliament or parliamentary commissions on health. Accountability for health system performance has been enhanced by the release of publicly available scorecards on the relative performance of national health systems, often with international rankings (Smith et al 2010). The English NHS, the Netherlands and the Nordic countries have been paving the way with publications on the web of quality indicators, surveys of patient experiences, and information about hospital waiting times for various treatments. Performance information is made available to empower patients.

Box 4.
Nordic Council of Ministers Quality Project: Even for common indicators as survival and mortality rates for breast cancer, colorectal cancer and lung cancer etc., it is difficult to yield data that are representative to the international nations as a whole. It seems that modern health care systems are not able to document their quality. At national and international level we need to invest in quality measurement systems and in international collaboration” (Mainz et al. 2008).

The Netherlands, “Dare to compare”: Comparing health items between 27 European countries sometimes resembles comparing apples and oranges (or apples and pears). Different languages, cultures and health systems indeed complicate comparisons and, apart from the international comparisons in this report, the question is raised whether data are actually available and technically comparable. However, exercises like these are very informative and valuable and we are convinced that the combined efforts of EU-funded projects, Eurostat, OECD, WHO and individual Member States have largely contributed (and will continue to do so) to increased data quality and more valid comparisons (Harbers et al. 2008).
and consumers when selecting providers of better quality as well as to support providers or professionals at the local levels in their quality improvement efforts, and for health services research purposes. Patient requests for information will grow with increased citizen awareness and participation as well as with increased patient mobility (especially between EU countries or between regions within countries). This is exemplified by the increasing media and consumer reports, even though these have often been challenged on methodological grounds.

7. Such scorecards have raised interest in how health systems are performing at all levels. Moreover, by drawing public and media attention to differences between health systems, intra- and inter-national comparisons have become a powerful tool in alerting local or national policy-makers to deficiencies in their own health systems and prompting remedial action. Such comparisons may also force health system stewards to publicly explain the reasons for variations and their own system’s potentially lower scores in given areas. The responses to, for example, the World Health Report 2000 or the Organisation for Economic Co-operation and Development’s “Health at a Glance” publication, is an indication of the power of such comparisons.

8. Such initiatives as well as practice benchmarking networks (e.g. the Nordic Council of Ministers Quality Project) and the use of international comparators in national assessment systems (e.g. The Dutch ‘Date to compare”) increased awareness of issues regarding data availability, data quality and reliability for international comparisons as well as methodological issues regarding indicator development. In this context, 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 is one of the objectives of the European Observatory program of work on comparative assessments of health systems.

9. As highlighted above, public reporting of performance is a response to the exercise of the right to information and political accountability. A commitment to accountability is not only for the benefit of external audiences, but also a constructive tool for organizational development, enhancing management practices, self-evaluation and strategic planning (Broadbent Report 1999). More specifically, it has been demonstrated that building coherence between strategy, performance management and accountability through performance measurement can lead to performance improvement and increased value for health systems (European Health Report 2009). HSPA conforms to a performance accountability approach grounded in management science, which aims at demonstrating and accounting for performance in light of agreed-upon performance targets (Brinkerhoff 2003) and, as such, differs from accountability for compliance with procedures and rules (also known as hierarchical control). It holds stakeholders to account for both the performance of their national/regional/local health systems towards better and more equitable health and for their own performance improvement actions. In complement to publishing results on indicators, a self-reported analysis of the reasons for variation and proposed remedial actions or policy will foster ownership of evaluation results and focus on performance improvement (rather than “blame and shame”).

10. The existence of a national health plan, including targets, is a core obligation deriving from the right to the highest attainable level of health (Comment 14, Committee on Economic, Social and Cultural Rights, 2000, Human rights to the highest level of attainable health). The introduction of the concept of targets into the health sector is often traced back to 1981 with the publication of WHO’s Health for All strategy (Srivastava and McKee 2008). The Regional Office for Europe proposed 21 targets in its 1998 update “Health21”. Member States are also committed to achieving the Millennium Development Goals (MDG), many of
which are directly related to health. Both the Health for All and MDGs have contributed to
the strengthening of information systems, as illustrated by the widely used Health for All
database. The Health for All process stimulated many governments to develop strategies to
improve health by also tackling the social determinants of health, and a growing number of
these strategies included some form of targets (Mc Kee and Beman 2000, in Srivastava and
McKee 2008).

11. While there is some uncertainty as to which aspects of performance management
arrangements are effective under which circumstances, there is evidence that tightly-drawn
targets can lead to unintended consequences and gaming. Targets have recently been
criticized for creating a “deliverology” culture which focuses on improving the measures and
loses sight of what really matters – the patient (Brown and Calnan 2011). The recognition of
wicked problems and uncertainty in health challenges simple linear causal models between
process and outcomes and hence undermines the theoretical foundation of targets. In other
words, targets often suppose a reductionist and simplistic view of health systems. But targets
– such as the MDGs – may also be a great tool to raise awareness and bring
political/organizational support. Therefore, the target-setting process for identifying priorities
and building consensus is instrumental. It is also advised to set up a dynamic incentive
scheme which is regularly revised to incorporate findings.

12. Holding the health system accountable to outcome indicators supposes that the outcome
is attributable to the organization/policies. Methodologically, the question of attributability
represents a significant challenge. Researchers are actively searching for metrics which allow
a more direct causal link; this has led to the development of the concept of mortality
amenable to health care. In practice, outputs measured at one point in time will have been
influenced by inputs of a previous time period, and similarly inputs in a current time period
will influence outputs in a future time period. Excluding this aspect from an assessment
framework incorrectly attributes all performance to current actions and holds stakeholders
accountable for past actions for which they may not have been responsible. By including a
time dimension, health system performance assessment can even provide incentives for
policies with long-term effects, as these will be recognized in the short term. For example,
while pulmonary cancer incidence is hardly attributable to current policies, smoking
prevalence, or the proportion of smokers who has recently quit, is more reactive in the short-
term to policy action. 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, known from research evidence to be associated with future
outcomes, to be used as predictors of future performance.
HSPA for evidence-informed policy: informing national health plans and strategies

**Key messages:**

- Member States have been increasingly producing and using health evidence in decision-making as well as searching for effective ways to institutionalize this activity into their governance structures.
- Health system reviews focus on measuring how the health system functions. Targets embedded in National Health Plans often focus on how health systems meet the ultimate goals of improved health on an equitable basis and intermediary objectives such as a more equal distribution of opportunities to be healthy through prevention.
- Embedding the evaluation of outcomes into an evaluation of process creates value by informing the policy-makers on how to potentially (re-)adjust their action to progress towards the objectives.
- A strategy-based assessment framework that relates to national, subnational or local strategic priorities or health reforms and shows how these lead to a strengthened health system can set the stage for future strategic health system planning and also for reporting back to the public on the impact of these reforms on the health system.
- Understanding the reasons for under-performance and building policy recommendations require complementing the breadth of scope covered by the performance assessment with in-depth analysis or qualitative evaluation studies. Informing answers to the policy question requires going beyond indicators and moving into evaluation research.
- In order to make evaluation results count, a participatory process engaging policy-makers at all steps will facilitate ownership and thereby adherence to assessment results.
- Integrating HSPA into the governance structure of Member States allows HSPA to become an ongoing activity with programmatic and funding consequences.

13. Member States have increasingly been producing and using health intelligence in decision-making as well as searching for effective ways to institutionalize this activity into their governance structures. Countries that have achieved a shift in culture towards a more evidence informed approach have succeeded in establishing three key pillars over time: (i) regular demand for health evidence by policy-makers, (ii) a supply of high quality health evidence, and (iii) sustainable institutional solutions linking demand and supply.

14. Health system reviews focus on measuring how the health system functions. Targets embedded in national health plans focus on how health systems meet the ultimate goals of improved health on an equitable basis and more intermediate objectives of reducing risk factors and amenable mortality. The monitoring and evaluation systems implemented in Kyrgyzstan and the strategic maps developed in Georgia, Armenia and Estonia bring together both sides of the WHO health system framework, i.e. the functions and the intermediate objectives and goals. This approach is more coherent with the definition of accountability “for actions taken to meet objectives”. Also, by embedding the evaluation of outcomes into an evaluation of process, it adds value in informing policy-makers on how to potentially (re-) adjust their action to progress towards the objectives.

15. A country-defined HSPA framework that builds on strategic priorities or health reforms and shows how they lead to a strengthened health system can set the stage for future strategic health system planning and also for reporting back to the public on the impact of these reforms on the health system, as experienced for instance in Portugal and Kyrgyzstan (box 5). It is far 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 can be strengthened when measures used in the health system performance framework are directly applied to assess the performance of specific parts of the health care system, pertaining to both services and individuals (Klazinga 2010).

**Box 5.** In Portugal, an external evaluation of the National Health Plan (NHP) and the HSPA were done in parallel and mutually devoted to supporting the health ministry’s efforts to improve the performance of the Portuguese health system. HSPA provides a whole health system perspective and thereby complements the NHP that is more focused on measuring performance in population health improvements. HSPA was implemented through use of quantitative and qualitative methods. The qualitative dimension comprised a functional review of the Portuguese health system through expert missions related to reviewing the four functions of the health systems. Techniques included: interviews with policy makers, service providers and health system stakeholders including interest groups at national, regional and local levels; visits to health facilities from the public and the private sectors; and analysis of selective policy papers identified through a literature review. Additional reviews on specific subjects were requested by the Office of the High Commissioner for Health. The package, including NHP evaluation, HSPA and additional reviews, served as important contributions to enhancing the evidence base and policy options for development of the next National Health Plan 2011 to 2016. This experience suggests that there is merit in including perspectives at all different levels (including at regional and local levels) and working with the research community as much as possible and in a mixed team of national and international experts.

In Kyrgyzstan, assessment is a country-led continuous activity with ad-hoc institutional arrangement. 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 between the ministry of health, wider government and development partners. Health system performance monitoring in Kyrgyzstan labels the regular tracking of health sector program outputs (direct results from implementing program activities), outcomes (program results), and impacts (program effects) by the ministry of health through record-keeping and reporting on the basis of a table of measurable characteristics (indicators). The conclusions of the annual reviews of sector performance are documented in Joint Annual Review Notes which contain not only a statement of progress but also agreed policy, programmatic and budget consequences. The ongoing annual nature of this process is its strength. In turn, the consequences of performance assessment lead to efforts to improve the quality of the process.

16. Producing evidence or knowledge in the expectation that they will be adopted and acted upon is simplistic and naïve. A lesson from the evidence-based medicine movement is that the acquisition and application of knowledge are themselves complex, context-based activities. The terms “evidence-influenced” or “evidence-informed” policy –which recognize that policy is an inherently political process in which evidence is a fundamental factor, but not the only one– are gaining ground. Even where evidence exists, getting it into policy and practice poses significant challenges. A crucial aspect of performance management is translating performance information in ways that are simple and clear to policy-makers (Lavis, 2006). But this is not sufficient and the results might be challenged by those who have not been involved in the process. In order to make evaluation results count, a participatory process engaging policy-makers at all steps will facilitate ownership and thereby adherence to the assessment results. However, this needs to be carefully balanced against the aim of objectivity; this has been justification for outsourcing (in part) the evaluation process in Portugal. As illustrated by countries’ experiences (box 5), there is no single best approach (e.g. internal vs. external, ad-hoc vs. continuous) and each HSPA needs to be tailored to the country context and circumstances at the time. The Kyrgyz example indicates that integrating HSPA into the governance structure of Member States allows HSPA to become a regular ongoing activity with programmatic and funding consequences. It has also helped to build

**Box 6.** “Successful organizations turn information into information that cannot be ignored” (Collins, 2001)

**Box 7.** Data can help move the debate to a more honest and consensual understanding of the options available, so that myth, ideology and group interest will not dominate and drive the debate.... But data or information alone cannot reconcile conflicting positions based on genuine value differences (Roberts et al. 2004).
capacity and foster a culture of evaluation. In the Portuguese experience, WHO’s role as external evaluator was highly valued.

17. Due to the many value judgments that are implicit in performance assessment exercises (e.g. in the choice of indicators or the relative importance attached to different objectives), they can provide valuable arenas for different actors and stakeholders to debate their different perspectives and preferences and learn from one another. The synergies which can ensue can be invaluable in furthering the pursuit of shared societal goals. By their very nature, health policy problems such as the interrelated obesity and cardiovascular disease epidemics are characterized by complexity, uncertainty, high stakes, and conflicting values. In the face of these challenges, policies must be implemented as large scale experiments in which monitoring and evaluation efforts provide an essential mechanism for the policy community to learn from the experiences acquired in practice, and adapt accordingly (Interim report on implementation of the Tallinn Charter, WHO 2011).

18. Both examples above also highlight the need to complement quantitative methods with qualitative evaluation to add depth to breadth of evaluation through specific studies. While quantitative indicators provide a useful snapshot of performance in a given area, they rarely tell the story of the underlying causes and the potential solutions. Put another way, indicators can describe change, but they cannot explain it. Informing answers to the policy question requires going beyond indicators and moving into evaluation research.

19. Experience suggests that HSPA also has the added benefit of building capacity for generating and using health information and intelligence by providing opportunities for individuals to actively use health information. Second, HSPA also helps in identifying health information gaps and understanding the quality of data through active use of health information and identifying where the health information infrastructure falls short in answering key performance questions, either through lack of data or poor quality. Third, many countries have extensive monitoring systems in place, but often organized for the needs of each specific program rather than the system as a whole. Often, a huge volume of data is collected, but the organization and analysis of this information do not serve either management or policy decision-making. For example, countries that do not have data that technically enables a link to be made between health and social conditions or in which access is limited also face an increased likelihood of bias in reporting of health inequalities and a potential mismatch in subsequent policy responses and programme investment (Hernandez Aguado et al. 2010). Limited availability or limited use of data disaggregated by sex, socio-economic status or geographical area present a major barrier to more in depth analysis to illustrate health and gender equity gaps in performance. HSPA brings together information from different sources and therewith might help alleviates with the fragmentation of information systems and bring added value by bringing those together.

**Box 8.** “While National Health Plan (NHP) is a vision and action plan, and the NHP reports against those actions, then the HSPA has added value to be more analytical and show the achievements and problems.” Participant in the launch of the HSPA report in Estonia

**Box 9.** “This is the first time that such a comprehensive assessment is made of the health system in Georgia. It is a very important exercise: it delivers critical information on overall efficiency of the national health system that we need to know. It shows our commitment to transparency and accountability. It demonstrates that we are ready to take action to make our system better. To do so, we need the facts, we need the evidence. This report is a first step for the Ministry of Labour, Health and Social Affairs to utilize the evidence available to make better policies. At the same time, it points to a lack of reliable data and we are committed to resolve this issue. A health system cannot be managed or improved if there is no good information available.” Minister of Labour, Health and Social Affairs, Georgia

**Box 10.** Monitoring systems have proven essential for improving the knowledge base of social determinants of health. They illustrate the importance of indicators that capture the health impact of public policies so as to better redefine and reorient policies towards equity. (Hernández-Aguado et al. 2010)
HSPA for horizontal and participatory governance

**Key messages:**

- Better understanding of the complex interplay of the various determinants of health, in particular the role of economic and social factors and ways in which resources and influence are distributed across society, requires new approaches to health governance.

- In particular, despite declines in overall mortality for all social groups, socially determined health inequalities remain a serious challenge and concern for policymakers in the European Region. Left unchallenged, their negative consequences on vulnerable populations will also impose costs on society as a whole and potentially undermine existing health and development gains.

- 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 contributes to moving health higher up the media, public, and policy agenda. There is an opportunity to use HSPA to drive public debate on health outcomes and policy options (both in the health and non health sector) to improve these.

- Recent experiences highlight significant contribution of HSPA process to governance by engaging stakeholders, fostering intersectoral dialogue, mainstreaming evidence on equity gaps, promoting a common vision across programmes or levels, or establishing mechanisms for solidarity across regions.

- These objectives will shape the scope and process of assessment. The translation of the level of achievement on high-level health outcomes in policy recommendations calls for comprehensive frameworks of analysis. Such frameworks have recently gained recognition across Europe.

- Equity measures need to be at the core of a sound health system performance assessment. It is important to integrate a health and gender equity focus within the scope of the HSPA. It may represent an opportunity to enhance visibility and mainstream equity considerations, building on the public attention to performance reports.

- The role of engaging stakeholders –including citizens– at all steps of the HSPA process (from the definition of the country-specific framework to the interpretation of results) has been recognized in many different experiences across Europe.

20. Despite declines in overall mortality for all social groups, socially determined health inequalities remain a serious challenge and concern for policymakers in the European Region. Left unaddressed, their negative consequences on vulnerable populations will also impose costs on society as a whole and potentially undermine existing health and development gains. The health system has a vital role in contributing to the reduction of these health and gender inequalities by ensuring that how we do our own business does not make inequalities worse (e.g. ensuring equity of access to care and reducing financial risk) and by working with other sectors to create the conditions for all groups in the population on a more equitable basis.

21. A better understanding of the complex interplay of the various determinants of health and causal pathways for health inequalities, in particular the role of economic and social factors including gender and ways in which resources and influence are distributed across society, require new approaches to health governance. A key premise is that multiple determinants must be addressed using cross societal and cross government approaches with the involvement of all relevant sectors and stakeholders. This is the basis of Health in All Policies (WHO 2011, strengthening public health in Europe).
22. Formal and informal governance mechanisms must be put in place to support ministries of health in being instrumental and effective in developing intersectoral policy responses to current and emerging health challenges. Such mechanisms include institutional platforms (e.g. a jointly staffed health policy unit, joint committees and working groups, etc.), incentive and accountability schemes (e.g. joint targets and budgetary mechanisms for joint funding and accountability), and formal requirements to assess the potential health and equity impacts of major policy proposals (WHO 2011, Tallinn Mid-term report).

23. 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 contributes to moving health higher up the media, public, and policy agenda (Hernández-Aguado and Parker 2008). HSPA is one potential tool to contribute to this objective. Indeed, as discussed above, public reporting of performance assessment draws great attention from both policy-makers and citizens. Through this exercise, one does not assess the performance of the Ministry of Health nor the performance of some programmes, but the performance of the health system — all actors with a primary mandate for the improvement of the health of the population. The health indicators (e.g. mortality, morbidity, perceived health, or disability free life expectancy) are the results of the mixed effects of all health determinants which have influenced health during the life course and —with some exceptions— it is not easy to establish a link between any single policy and the health status (Hernández-Aguado and Parker 2008). The issue of attributability is a major consideration if the assessment objective is to be held accountable. However, the multi-factorial explanations of health outcomes are an opportunity if the assessment objective is to highlight the joint governmental responsibility for health and to inform dialogue between stakeholders. For instance, in Estonia, HSPA informed alcohol and nutrition policies. National health plans and strategies spanning settings and population groups might contribute similarly.

24. The translation of the level of achievement of high-level health outcomes in policy recommendations calls for comprehensive frameworks of analysis. Such frameworks have recently gained recognition across Europe. They are widely applied by both national authorities (Netherlands, Belgium, Estonia, Portugal, and Turkey) and international organizations (OECD, ECHIM). The use of such frameworks strongly supports the clear mandate of health ministries to define a broad vision for health, gather intelligence on health and its social, economic and environmental determinants (Tallinn Charter 2008) and to establish a national health equity surveillance system (Commission on Social Determinants of Health 2008).

25. Both the Dutch and Belgian frameworks are built on the OECD framework with 3 interconnected tiers: health status, non-medical determinants of health and the health care system. The health care system includes 5 domains: health promotion, preventive care, curative care, long-term care, and end-of-life care. Portugal, Estonia, Turkey, Georgia, and Armenia built their country-specific frameworks on the WHO framework but expanded it. For instance, Turkey identifies intermediate objectives: utilization effectiveness (access, use and quality of services) and healthy lifestyles and environment (e.g. access to safe water, atmospheric pollution, smoking, obesity, fertility). In addition, assessment of the stewardship function includes a component to assess intersectoral action. All the departments within the Ministry of Health as well as the Ministry of Education, the Ministry of the Environment, and the Social Security Institute were consulted for the development of the strategic framework; they defined indicators, provided data, and validated interpretation and policy.

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**Box 11.** In order to engender confidence in health policies, all stakeholders, and especially citizens and patients, need to be actively engaged. Access to health information and health literacy are crucial to such engagement. Health policies succeed in relation to the sense of solidarity and shared values they foster (Marinker 2006 in Hernández-Aguado and Parker 2008).
recommendations. This strong public health component in the Turkish HSPA reflects the reform priorities for “health promotion for a better future and healthy life programmes” and recognizes that, with the ever-increasing burden of noncommunicable diseases on the health system, dietary habits, lifestyles and activity patterns of people should be considered as a priority.

26. Equity measures are integrated in most HSPA frameworks, either as a transversal dimension or as an objective of the health system. For instance, equity is an overarching dimension which is presented across all tiers of the OECD framework, adopted by Belgium and the Netherlands. In Turkey, the “equity lens” proposes a “mirror” assessment of all dimensions by disaggregating indicators by sex, socio-economic status, education level, urban/rural or region, where relevant and available. This is critical if we are to look beyond average levels of improvement in health and opportunities to be healthy to analysis of the distribution of health gain and distribution of opportunities to be healthy. To do this requires that a health and gender equity focus be integrated into the scope of the HSPA from the outset. HSPA can potentially help generate evidence for action on health and gender inequality issues such as financial access and catastrophic expenditure, geographic variations in health care infrastructure, variations in lifestyle and proximal outcomes (e.g. diet and obesity) by level of education.

27. The role of engaging stakeholders –including citizens– has been recognized in many different experiences across Europe. This was illustrated for instance in Turkey (see above) and in Belgium. In Belgium, the value of having a joint tool, shared by various authorities, was highlighted. The report (2010) was carried out under the auspices of the Belgian Health Care Knowledge Centre, Institute of Public Health and the National Institute for Health and Disability Insurance. The administrations in charge of social affairs and public health, whether regional, community based or federal, were also involved in the project. Probably, the process for developing HSPA is more important than the output of the report. This is an opportunity to bring all the stakeholders to the table to agree on priority dimensions, identify information gap, jointly understand the reasons for variations, and discuss the policy questions or recommendations.

**Conclusion**

28. The experience of Member States with performance assessment and policy analysis indicates that measurement, monitoring and evaluation may also serve to further some principles which are of broad relevance to health governance, and therefore to the development of Health2020.

29. Embedding strategic performance information into decision-making processes supports policy-makers in assessing and re-adjusting strategies, plans, policies and related targets to progress towards the achievement of health system goals. HSPA, linked to an accountability and strategy, supports the health governance function by ensuring that: 1) health systems have a strategic orientation focusing on improving health outcomes for the population and on an equitable basis; 2) policy decisions are informed by appropriate intelligence with regard to health problems and their determinants; 3) all government policies contribute to better health and equity; and 4) healthy public policies are promoted across all aspects of government (WHO, European Health Report 2009).
30. Member States in the Region show wide disparities in terms of availability and quality of data, accountability structures and processes, citizens’ participation, and maturity of information systems and evaluation culture. If accountability relationships are to function properly, no system of performance assessment should be viewed in isolation of the broader design within which it is embedded. In many countries developing HSPA means bringing isolated performance measurement initiatives together, complementing them and making sense of the data already available to assess performance from a health system standpoint and inform strategic priorities, rather than developing an additional parallel system.

**HSPA in action: process matters!**
1. Know and explain why HSPA makes sense in your country
2. Get key actors on board in a transparent and participatory process
3. Be explicit about values and strategic priorities, organize them along a country-specific strategic map or a logic model (the framework for assessment)
4. Equity matters: define the scope and approach to be used in assessing health and equity dimensions at the outset
5. Assess the present performance and understand predictors of future performance
6. Know your indicators; what they can or cannot tell
7. Know your data and identify opportunities for improvement
8. Bring an equity focus from the beginning: disaggregate the data and analyse it to identify the patterns and causes
9. Do not interpret indicators in isolation: identify smart reference points, relate with other indicators
10. Tell a story: complement with analytical information, illustrate with qualitative data; balance breadth and depth
References


Brown PR, Calnan M. The civilizing process of trust: developing quality mechanisms which are local, professional led and thus legitimate. *Social Policy and Administration* 2011;45(1):19-34.


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