



World Health  
Organization

REGIONAL OFFICE FOR Europe

# CASE STUDIES ON HEALTH SYSTEM PERFORMANCE ASSESSMENT

## A LONG-STANDING DEVELOPMENT IN EUROPE





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## **ABSTRACT**

Health system performance assessment (HSPA) is a country-specific process of evaluating and communicating the achievement of high-level health system goals based on health system strategies. The scope of the assessment is the health system as a whole. Growing interest in HSPA as a health governance tool is reflected in the increasing number and variety of national experiences across the WHO European Region. This report presents the findings of the country case studies for Armenia, Belgium, England, Estonia, Kyrgyzstan, Portugal and Turkey. There are a number of approaches to HSPA, suggesting ample opportunity to benefit from the lessons learned in those countries implementing HSPA.

## **Keywords**

OUTCOME AND PROCESS ASSESSMENT (HEALTH CARE)

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# INTRODUCTION AND SUMMARY

## Setting the scene: what health system performance assessment is and what it can do

In recent years health authorities in the WHO European Region have shown growing interest in health system performance assessment (HSPA) as a governance tool. HSPA has been used to build a common vision of the priorities for strengthening health systems, to provide a platform for dialogue between programmes and between sectors and to create an understanding of how joint actions affect health outcomes. Moreover, HSPA helps policy-makers and politicians ensure accountability and liability for their decisions as they work towards better, more equitable health outcomes as well as other health system objectives such as productivity, financial protection and responsiveness.

HSPA is a country-specific process of monitoring, evaluating, communicating and reviewing the achievement of high-level health system goals based on health system strategies. A fully developed HSPA approach builds on a limited number of quantitative measures, or performance indicators, and incorporates analytical tools. The scope of the assessment is the health system as a whole. In this respect HSPA differs from programmatic monitoring and evaluation or institutional performance management schemes targeting service providers.

Growing interest in HSPA as a system governance tool is reflected in the increasing number and variety of national experiences across the region. Noteworthy advances in collecting, interpreting and using information for policy-making have been achieved; however, there are numerous questions regarding different HSPA methodologies and applications of HSPA data to increase transparency, manage performance and inform policy decisions (1). What is the optimal frequency for monitoring and reporting on health system performance, for instance? Who should be in charge of conducting HSPA, the health ministry or an independent body? How can synergy be developed between HSPA and other governance tools such as national health plans and policies? How can HSPA be applied at the subnational level?

## Methods

This report presents the findings of the country case studies in alphabetical order. The selection of the seven countries was based on practical considerations, such as a strong working relationship between HSPA experts at the WHO Regional Office for Europe and the HSPA implementing team, as well as each country's level of interest in participating in the study. The countries were also selected to represent a variety of experiences in different contexts across the region. The authors plan to extend the case study work in the future to include additional countries that have systematically embarked upon HSPA.

The seven case studies were developed from October 2010 to August 2011 on the basis of telephone interviews with up to six informants in each country. The interviews were semi-standardized, following a questionnaire that focused on the following areas: key features; policy context, objectives and the role of stakeholders; conceptual framework and operational model; processes and outputs including data collection, dissemination and impact; future prospects; and lessons learned (see Annex 1). The selection of informants followed a snowball approach, whereby one key informant, usually the principle author of the HSPA, was identified for each country and then recommended other informants who had been involved in the HSPA.

The telephone interviews were the most important source of information for the case studies. In addition, journal articles, books, reports and web sites were reviewed and referenced on the basis of recommendations by the informants. Before finalization, the case studies were reviewed during a peer workshop in May 2011 in Copenhagen (see Annex 2). The information gathered in this process was used to produce this technical report and a shorter brochure in narrative form for wider dissemination. In so doing, the authors hope to share HSPA experiences in the region and encourage additional countries to embark upon similar approaches.

### **An overview of the individual HSPA approaches**

There are a number of approaches to HSPA; each has its weaknesses and strengths. In light of the growing body of experience with HSPA in the region, there is ample opportunity to benefit from the lessons learned in those countries implementing HSPA. The seven case studies presented here are Armenia, Belgium, England, Estonia, Kyrgyzstan, Portugal and Turkey. The following section summarizes their approaches.

*Kyrgyzstan* has developed a regular monitoring and evaluation scheme in the context of reporting to donors on the progress of its health sector reform programme. Thus, a well-defined institutional framework exists, with a policy analysis centre responsible for evaluation and the Ministry of Health responsible for annual monitoring of performance indicators. All the actors involved in system monitoring and evaluation meet regularly to analyse and discuss their progress. The institutionalization of monitoring and evaluation functions has improved the infrastructure and increased the capacity of the ministry and other health institutions for collecting, interpreting and using data. Furthermore, it has contributed to the development of a culture of evidence-based policy-making. The challenge facing Kyrgyzstan will be to sustain this heightened capacity and continue to make progress when external funding is phased out.

The situation is similar in *Armenia*, where the government has a strong sense of ownership of HSPA and is preparing its third HSPA report, focusing on regional performance. HSPA in Armenia is also an excellent example of cooperation between national and international experts and institutions. Enthusiasm and consistency in the HSPA working group have been key factors in its success. Now there is an interest in extending HSPA expertise beyond the working group,

securing government funding for HSPA and customizing HSPA more effectively to the needs of policy-makers.

In *Belgium* three national institutions lead the work on HSPA. They reached consensus on the conceptual performance framework by involving international and national experts and engaging health authorities at local, regional and national levels. The Belgian case is unique in its pragmatic approach and the modest scale of its objectives. Belgian health authorities aimed to increase their use of the readily available databases in Belgium and to provide common monitoring tools for all levels of health administration in the country. Thus, building consensus on definitions and attributes of performance and identifying indicators and data gaps have been notable achievements in the Belgian HSPA.

*Estonia* had a very small and committed team for its first HSPA report. Synergies in data collection and interpretation between the HSPA and the national health plan were a clear advantage in this small country with limited staffing resources. The WHO Conference on Health Systems: Health and Wealth, hosted by the Government of Estonia in 2008, was a catalyst for HSPA in Estonia; but the process took longer than anticipated owing to difficulties in developing the HSPA agenda, particularly in defining its objectives. A key factor in the success of this process was that the two staff members who undertook the bulk of the technical HSPA work consulted regularly with leaders of the key health policy institutions in Estonia and thereby obtained valuable feedback at each stage in the development of the HSPA report.

*Portugal*, like Estonia, benefited from synergy between the HSPA process and the evaluation of its National Health Plan (NHP) for 2004–2010 and preparation for its next National Health Plan (NHP 2011–2016). Most of the HSPA was undertaken by a team of WHO and international experts working with a Portuguese expert committee to select the HSPA framework and performance indicators. One of the most important achievements of the Portuguese HSPA was that it mobilized experts and policy-makers. Moreover, it introduced new dimensions of system performance (and terminology) that the team working on the new NHP could use. Portugal's challenge is to institutionalize HSPA, given that the country is currently experiencing budget cuts and governmental changes in the context of a prolonged economic crisis.

HSPA in *Turkey* has benefited from institutional support at the highest level, which helped draw together all system stakeholders in the HSPA process. Like Armenia and Kyrgyzstan, Turkey uses HSPA as an instrument for reporting on progress in its Health Transformation Program, a health system reform programme funded by the World Bank. Turkey is currently finalizing its first HSPA report, which is likely to influence the development of the monitoring and evaluation scheme in the next Strategic Plan prepared by the Ministry of Health. While HSPA in Turkey is still in its early stages, it is likely to gain momentum as an integral part of the government's health reform and planning programmes.

*England* has a long-term culture of target-setting and performance management within the National Health Service (NHS). HSPA builds on a tradition of assessing the needs of the population, prioritizing health outcomes, procuring products and services and managing service providers under a national policy and performance framework. The results of target-setting and performance measurement have been impressive, particularly in the reduction of waiting times for receiving health services, for example. Nevertheless, the English case also demonstrates some of the pitfalls and challenges of target-setting: the tension between centrally planned target and performance management frameworks and local health priorities; the predominance of management and process indicators, with less emphasis on health outcomes and steps to address newly identified problems; and the fear among managers of failing to meet targets and losing their jobs as a consequence. A new set of outcome measures has been developed under the new NHS Outcomes Framework for use in 2013. It will cover a wide range of quality of care indicators, measuring effectiveness, patient experience and safety.

### **HSPA at a comparative glance: commonalities and differences**

HSPA is a relatively recent and continuously evolving governance tool. The majority of the case study countries that have recently embarked upon HSPA have followed a similar framework and methodology based on the World Health Organization's functional concept of health systems performance. Although there are similarities in the HSPA framework and choice of performance indicators, however, the seven cases also exhibit substantial differences in policy context, objectives, the specific HSPA framework deployed and number of core indicators (Table 1).

HSPA objectives are tailored to the policy context of each country and its particular tradition of health system governance, capacity and needs. The methodological approach and objectives in England, for example, use information for performance management and align regional and local organizations towards a national framework of outcome measures. In this way, the English case differs substantially from countries that have used HSPA reporting for informational purposes. Enhancing accountability is an objective explicitly stated by Armenia, Belgium, Estonia, Kyrgyzstan, Portugal and Turkey – in Kyrgyzstan to ensure accountability to donors concerning the use of grants and loans and in Armenia, Belgium and Turkey to increase transparency. Enhancing stewardship, identifying policy priorities, identifying problem areas and informing policy development are also common objectives associated with HSPA. In Armenia, Kyrgyzstan and Turkey HSPA complements the health sector reform programmes; while in England, Estonia and Portugal it accompanies the national health strategies or plans. The number of indicators ranges from 40 to 80, and in most cases these were selected from a much longer list of indicators.

Table 2 offers a comparative view of the role of actors and institutional arrangements in HSPA, thereby also providing an indication of the level of the political support in each country. The arrangements for institutional HSPA implementation; the composition of working groups,

**Table 1. Stated objectives, policy context, performance dimensions and indicators at a glance**

Countries	Stated objectives	Existence of a national strategy or sector reform programme, time span	HSPA performance dimensions	Number of core indicators (most recent report)
<b>Armenia</b>	<ul style="list-style-type: none"> <li>Enhance stewardship</li> <li>Accountability</li> <li>Transparency</li> <li>Identify policy priorities</li> </ul>	Health system modernization project, Phase 1: 2004 to 2010 Phase 2: 2007 to 2014	7 health system functions (information systems, human resources, stewardship, efficiency, access to services, quality and safety of services, risk factors/health promotion/disease prevention) and 3 health system goals (equity in financing and protection, health status and distribution, responsiveness).	40
<b>Belgium</b>	<ul style="list-style-type: none"> <li>Transparency and accountability</li> <li>Comparisons with other countries</li> <li>Performance monitoring over time</li> </ul>	No	3 functional tiers: health status, non-medical determinants of health and the health system (including health promotion, preventive care, curative care, long-term care, end of life care). Performance dimensions for care include quality, accessibility, efficiency, sustainability/ endurance. Equity is an overarching dimension across all tiers.	55
<b>England</b>	<ul style="list-style-type: none"> <li>Performance management of NHS trusts and strategic health authorities (management of health care performance)</li> </ul>	Our Healthier Nation (1999) Choosing Health (2004)	No overarching and single health system performance framework but performance measurement focuses on issues such as health improvement, fair access to services, delivery of care and waiting times. The NHS Outcomes Framework 2011/12 incorporates measures of patient and carers' experience of aspects of NHS services.	About 50
<b>Estonia</b>	<ul style="list-style-type: none"> <li>Enhance accountability</li> <li>Enhance stewardship</li> <li>Provide a monitoring scheme for the NHP</li> </ul>	National Health Plan (2009 to 2012)	4 functions (stewardship, resource generation and allocation, service provision, financing) matched to 4 intermediate goals (equity in access and coverage, responsiveness and choice, efficiency, quality and effectiveness) and goals (health, financial risk protection, consumer satisfaction). Performance dimensions include health status, health behaviour and promotion, determinants of health, responsiveness, equitable financing, access to services, quality and safety).	About 80
<b>Kyrgyzstan</b>	<ul style="list-style-type: none"> <li>Monitor progress and impact of the health sector programmes</li> <li>Accountability to donors</li> <li>Identify potential policy problem areas</li> </ul>	Manas program: 1995 to 2005 Manas Taalimi: 2006 to 2010	Regular tracking of health sector programme outputs, impacts (improved health status) and outcomes (access, financial protection, efficiency, quality and transparency).	52
<b>Portugal</b>	<ul style="list-style-type: none"> <li>Accountability</li> <li>Inform policy</li> </ul>	National Health Plan 2004 to 2010	4 functions (stewardship, resource generation, service provision, financing) matched to 5 intermediate objectives (access, coverage, quality and safety, healthy behaviour, efficiency) and goals (health, social and financial risk protection, responsiveness).	51
<b>Turkey</b>	<ul style="list-style-type: none"> <li>Provide a monitoring and evaluation scheme for the Health Transformation Program</li> <li>Transparency and accountability</li> <li>Support the development of evidence-based policy-making</li> <li>Guide governmental policy development</li> <li>Identify policy priority areas</li> </ul>	Health Transformation Program phase I (2003–2009) and phase II (2010–2013)	Health outcomes defined as ultimate objectives, achieved through 3 intermediate objectives: healthy environments and lifestyles; efficient and comprehensive personal services (accessible, of high quality, and effectively used) and fairness in financial contribution. These are matched to 4 system functions (service provision, resource generation, financing, governance and leadership).	55

advisory groups and expert panels; and the role of international experts vary widely. Belgium, for instance, has opted for a national expert organization to take the leading role, whereas leadership for HSPA in Estonia and Portugal resides with the ministry responsible for health, in the case of Portugal with the High Commissioner for Health, who is responsible for the National Health Plan. The composition and role of the advisory group also vary, but most countries have worked with one or more expert technical panels.

**Table 2. Sponsors<sup>1</sup>, working group members, advisory groups and experts at a glance<sup>2</sup>**

Countries	Main sponsors	Working group members	Advisory group	Expert panel
<b>Armenia</b>	Head of the National Health Information Analytical Centre	6 core members from the National Institute of Health, World Bank and WHO Regional Office for Europe	Members of the Ministry of Health	Technical expert panel on framework and indicators
<b>Belgium</b>	Head of the Belgian Health Care Knowledge Centre	Representatives of the Health Care Knowledge Centre, National Institute for Health and Disability Insurance, and National Institute of Public Health	Regular political feedback in 3-monthly joint meetings with health administrations at federal and regional levels; and once a year through a meeting of high-level political representatives	One expert panel for the whole process on performance framework, and indicators
<b>Estonia</b>	Minister of Social Affairs	Staff of the Ministry of Social Affairs; WHO Regional Office for Europe	Head of the National Institute for Health Development and the Chair of the Estonian Health Insurance Fund; international consultant at the beginning of the process	No
<b>Portugal</b>	High Commissioner of Health	Staff of the Office of the High Commissioner of Health; National Coordinators of the National Health Plan; WHO Regional Office for Europe	Interministerial Steering Committee for the National Health Plan	Technical expert panel advising on indicators and review of performance assessment report
<b>Turkey</b>	Minister of Health, Deputy Secretary of State; Head of TUSAK	Member of TUSAK and staff of the Ministry of Health; members of WHO Regional Office for Europe and the World Bank; national and international consultants	Representatives of the Treasury and Ministry of Finance, Ministry of the Environment and Forestry, the Turkish Statistical Institute, the Higher Education Council, Ministry of National Education, and State Planning Organization	Experts from various institutions and the ministries to build consensus on the performance framework, set of indicators and to facilitate gathering of data from various sources

- 1 A sponsor is an organization or individual who will have overall responsibility for the project and accountability for the end product.
- 2 Excluding England and Kyrgyzstan.

Table 3 exhibits major differences in timing and human resource estimates. In most cases it took countries on average two years for the first HSPA to be completed, from the time of the initial agreement to conduct the HSPA to the launch of the report. For countries that have drafted more than one report, HSPA reports have been issued every three years, every two years or every year. In terms of human resources, the Belgium HSPA is estimated to have

involved more than 10 staff members, albeit not working full-time, while in Turkey some working group members have been hired explicitly for HSPA.

**Table 3. Timing and human resource estimates at a glance<sup>1</sup>**

Countries	Year of the first report	Year of second report	Time estimate between initiation of process and first report	(Planned) Time between last two reports	Estimates of human resources
<b>Armenia</b>	2007	2009	2 years	3 years (a third report is planned for publication in 2012)	6 core members
<b>Belgium</b>	2009	-	1 ½ years	3 years (a second report is planned for publication in 2012)	11 (authors of the HSPA report)
<b>Estonia</b>	2010	-	About 2 years	2 years (a second report is planned for publication in 2012)	1 core staff member of the Ministry of Health and Social Affairs
<b>Kyrgyzstan</b>	2002	2003	Annual reporting	1 year	Roughly 1 staff member at the ministry, 1 WHO resident policy adviser, and up to 4 researchers at HPAC
<b>Portugal</b>	2010	-	1 ½ years	-	1 core international staff, 2 international consultants
<b>Turkey</b>	Forthcoming 2011	-	2 years	-	6 core staff, 1 staff specifically hired for HSPA

1 Excluding England.

# HSPA IN ARMENIA

## LEADING THE WAY TOWARDS REGULARIZATION OF HSPA

### Introduction

Armenia has been involved in HSPA activities since 2005, when a department for HSPA was established within the National Institute of Health. This department was the result of a joint initiative by local experts from the World Bank, WHO and the Ministry of Health of Armenia. Since then the Armenian experience has been characterized by significant progress in capacity-building, awareness of HSPA methodologies and development of appropriate HSPA objectives. To date Armenia has released two HSPA reports and is now initiating a third report, which will examine regional performance in health system management. The work of the HSPA working group is funded by a World Bank loan for the Health Sector Transformation Program and the Biennial Collaborative Agreements between the WHO Regional Office for Europe and the Government of Armenia.

The initial report in 2007, prepared by the ministry of health in collaboration with the WHO Regional Office for Europe and the World Bank, focused on selected areas of performance, particularly primary care reforms, reduction of excessive hospital infrastructure and improving maternal and child health services. While the initial report focused on these specific priorities, the second report in 2009 had a broader scope, focusing on the performance of the health system as a whole and using the findings of the 2007 report as a baseline for measuring subsequent improvements in performance. The second report also took into account Armenia's rapid economic growth since 2000 and emphasized the relationship between health system performance and reform and the importance of identifying indicators to measure the impact of reform programmes.

An innovative technique in both HSPA reports is the use of field surveys on health status and health service utilization by population-wealth quintile. The field surveys were introduced in the first HSPA report and provided new information on the extent of health equity and access to health care according to socioeconomic status. The second report also references a more detailed assessment of Armenia's health information system and provides recommendations for strengthening health information management in the country.

### Policy context, objectives and stakeholders

Armenia has undergone a fast-paced process of health system reform since achieving independence. Initial reform efforts focused mainly on privatizing health care services, reducing excessive hospital infrastructure and strengthening primary care. The government has also emphasized the importance of achieving the United Nations Millennium Development Goals by 2015.

Before HSPA, however, Armenia lacked a coherent health system reform strategy to facilitate coordination of different strategies across sectors, including primary care, tertiary care and specific programmes such as maternal and child health care. Evaluation efforts targeted specific programmes and activities. There was no systematic performance assessment of the Armenian health sector as a whole. Even though health statistics were regularly updated and health reports produced, they were not used systematically to inform policy decisions and resource allocation. In addition, the data were not always reliable or useful, as they reflected readily available information rather than the specific information needed by policy-makers.

HSPA was introduced to provide an integrated framework for measuring and demonstrating the impact of reforms on health system performance in areas such as equity in care, access to services and efficiency and quality of services. More ambitious in scope than the initial 2007 report, Armenia's 2009 HSPA report identifies the following objectives:

- to assess the level of attainment for core health system goals and monitor changes in the system;
- to provide a summary assessment of health system performance;
- to situate the performance of the health system at the center of national health policy;
- to enhance to effectiveness of health system stewardship;
- to enable evaluation of the efficiency of the health system;
- to facilitate communication and promote accountability;
- to indicate which areas of health system performance are priorities for improvement; and
- to stimulate the search for better data and better data analysis throughout the system.

The 2009 report also serves as a critical component in monitoring the changes that occur in the health system as a result of government policies, health system reform initiatives and the underlying socioeconomic changes of the past decade, during which Armenia experienced very rapid economic growth.

The HSPA in Armenia was undertaken by a working group of six core members from the Armenian National Institute for Health, the World Bank and the WHO Regional Office for Europe. The leading institution is the National Health Information Analytical Centre, a unit of the National Institute for Health established in 2005. The Regional Office provided technical guidance for the

framework of the Biennial Collaborative Agreement 2008–2009 between the Regional Office and the Government of Armenia. The group began operating under the name Health System Performance Assessment Working Group, and its composition has not changed significantly since 2005. The group worked under the supervision of the Health System Modernization Project, a credit programme between the Government of Armenia and the World Bank (Box 1). Government officials were not directly involved in preparing the 2009 report but provided data and feedback as needed.

#### **Box 1. The Health System Modernization Project in Armenia**

The Health System Modernization Project is a World Bank lending programme to support Armenia's health sector reform. Phase one of the project has supported the modernization of hospitals in the country's 10 regions, improving access to hospital services and efficiency of hospital service delivery. The main objective of phase two, currently underway, is to further improve procurement of hospital technologies and equipment, train hospital staff on case management, improve accessibility of primary care services to the most vulnerable groups, improve the governance and management structures of health care facilities and pilot-test a case-based hospital financing system and different schemes for the licensing and quality assurance of medical facilities. The World Bank approved funding for a US\$ 19 million loan in December 2010, reaching a total commitment of US\$ 1.4 billion so far.

Thus, the decision to engage in HSPA and the process of drafting the HSPA reports were driven by donors and development partners, with involvement and technical contributions from the World Bank and the Regional Office. Since the bulk of funding came from the World Bank, it will be a challenge to sustain the HSPA process when external funding is phased out. The Government of Armenia, however, has committed funds for the third HSPA report, currently in progress.

### **Development of the HSPA framework and operational model**

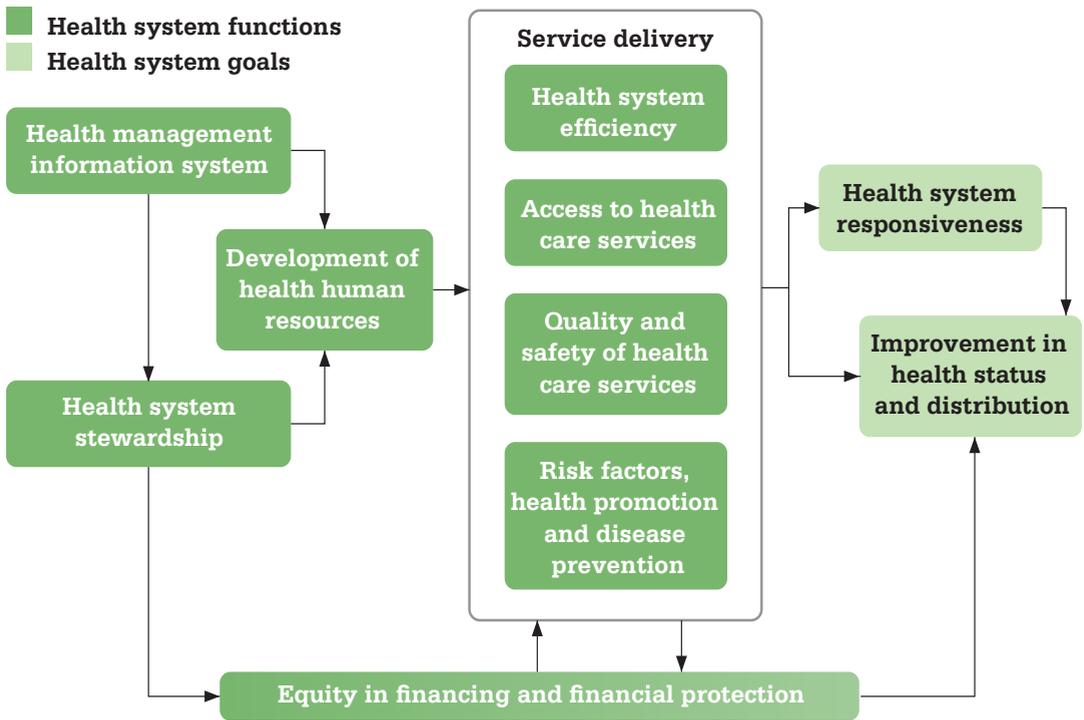
The Armenian HSPA builds on the framework for health systems outlined by WHO in *The world health report 2000* (2). According to this framework, a health system has three ultimate goals: better health, responsiveness and equity in financing. These goals relate to the health system functions of stewardship, resource generation, financing and service delivery. This framework was adapted to Armenia's health system strategies and reforms. Ten performance dimensions related to the functions and goals of the health system were defined in order to focus the assessment on the role of health system policy and policy development. Fig. 1 illustrates the 10 performance dimensions and how they relate to health system functions, goals and objectives.

## **HSPA IMPLEMENTATION AND THE WAY FORWARD**

### **Milestones and activities**

Four WHO technical missions were conducted between May 2008 and September 2009. During the first mission, policy-makers in the Ministry of Health worked with WHO staff members to

**Fig. 1. Health system performance dimensions for Armenia**



Source: Armenia health system performance assessment 2009 (3).

develop a health system strategy map, building on the framework described above. The health system strategy map for Armenia articulated four ultimate goals for the health system and nine strategic health themes, reflecting Armenian health system objectives and reform strategies. This strategy map was used to frame the selection of approximately 40 performance indicators during a workshop with technical experts in July 2008.

The selection of indicators was based in part on the availability of data. Between August 2008 and June 2009, the working group revised an ad hoc survey funded by the current World Bank loan in order to fill in existing data gaps due to limitations in routinely collected data. The survey was carried out in spring 2009 by the National Statistical Service, using a sample size of 1600 households for national estimates. The resulting data were released to the HSPA working group in summer 2009. During the WHO mission of June 2009, the working group, with the support of WHO experts, proposed organizing the strategy map's 13 strategic goals and health themes into the 10 performance dimensions for the final HSPA report (see Fig. 1). The drafting

process lasted from June to September 2009. A first draft of the present report was reviewed in detail during the final WHO mission at the end of September 2009.

Several institutions are involved in the collection of population and health data. The National Health Information Analytical Centre is the clearinghouse for routine information reported annually by public and private health care facilities, including hospitals. The State Health Agency is responsible for collecting information from contracted hospitals regarding their activities and finances. The National Statistical Service has two data-gathering departments: the Department of Demography and Census, which conducts the decennial census and classifies causes of death according to the International Statistical Classification of Diseases and Related Health Problems (ICD-10) and the Department of Household Surveys, which conducts regular and ad hoc surveys of health expenditure, service utilization and health risk factors. Finally, the Department of Civil Status Registry manages the vital registration system.

### **Findings and recommendations**

The 2009 HSPA report identifies a number of areas in which progress has been lower than expected and recommends prioritizing reform efforts in these areas. Early detection of cancer, for example, has not increased significantly since 1989. Progress in prevention of noncommunicable diseases, improvements in quality of care and raising awareness of inequity within health programmes have also fallen short. Having identified these functional shortfalls, the report identifies six priorities for health system improvement and the expected impact of implementing these measures. These priorities are listed in Table 4 (3).

### **Institutionalization**

HSPA has an institutional home in the HSPA department that was established in 2005 as part of the National Health Information Analytic Centre of the National Institute of Health. This department collaborates with the HSPA working group, which has benefited from continuous participation by the same members over the past five years. Other key factors that support the institutionalization of HSPA in Armenia are a clear institutional mandate, continuous activity since 2005, a sizeable funding base with recent governmental commitment to co-funding and a well-established technical partnership between national institutions and the World Bank and the Regional Office.

The third HSPA report will be produced in 2012 with World Bank funding, and the Government of Armenia is committed to co-funding the work on this report, which will focus on the performance of regional health systems.

### **Dissemination and impact**

The 2009 HSPA report was launched at a large conference covered by the media and attended by government representatives, donors, partners, nongovernmental organizations and regional

health authorities. The participants discussed the most effective ways to use HSPA systematically as a tool for policy development and evaluation.

The data, findings and recommendations of HSPA have been used to good effect in other health system reports, including the annual report of the Ministry of Health. HSPA findings have also contributed to the development of a number of policies and programmes. One example is the National Tobacco Control Program (2010–2013), which has used statistics on the prevalence of smoking among men under 60. Information from the 2007 and 2009 HSPA reports informed policy documents and was used as evidence for legal changes in tobacco advertising, eventually resulting in a total ban on all types of tobacco advertisements in 2011. Other examples are the concept paper on the prevention, early detection and treatment of the most prevalent non-communicable diseases (2009–2013), the national programme for the prevention, early detection and treatment of noncommunicable diseases, the national programme for cardiovascular disease control (2011), the national programme for cancer control and the national programme for disease control.

**Table 4. Key priorities for performance improvement**

Key priority	Expected impact on the health system
Addressing prevalence of behavioural risk factors, particularly smoking among males, and focusing programmes on those in lower-income households	Will decrease the incidence of noncommunicable diseases and the burden of these diseases, particularly on lower-income households
Reforming the basic benefit package in terms of its content, the depth of its financial protection and, by shifting to means-tested eligibility criteria, the population groups it covers; and reinforcing the package with continued increases in government funding	Will remove financial barriers; better align incentives for health professionals to deliver quality services; and improve equity in financing
Continuing implementation of primary health care reforms and hospital optimization, and addressing development of professional hospital management	Will improve the efficiency, quality and effectiveness of health care spending and maximize the value of government investment in health
Developing standards and key indicators for the quality and safety of health care services, including such services' adherence to clinical guidelines	Will monitor the impact of increased efficiency on services and develop payment mechanisms that reward service quality
Developing an overall strategy and vision for the health system, supported by a health policy and planning unit in the Ministry of Health	Will coordinate and provide coherence to primary care reform, hospital optimization, health workforce planning and dismantling of financial barriers to access
Increasing capacity for health system information management through implementation of the HIS strategic plan, and through improved access to data and information	Will improve the use of information and evidence in carrying out the stewardship function, and will promote transparency and accountability

Source: Armenia health system performance assessment 2009 (3).

## KEY LESSONS LEARNED

- The government needs to have full ownership of the process, especially when HSPA is the result of an international partnership and is supported by external funding.
- Developing a sense of ownership is a long-term process resulting from intensive capacity-building and careful consideration of the objectives, challenges and benefits of undertaking HSPA.
- An important achievement of HSPA is that it provides a new, comprehensive set of national health system performance indicators, which should become part of the catalogue of indicators collected by the National Statistics Office.
- Stability in the membership of the working group over the past five years has helped ensure the continuity that the HSPA process requires.
- While a small working group is likely to reach consensus more quickly and efficiently than a large working group, there may nevertheless be advantages to expanding participation in the working group, perhaps even to experts in fields beyond the health sector.
- Effective collaboration between national and international partners is a key factor for success. It is important to select enthusiastic participants who have experience with teamwork, strong communicative and problem-solving skills and a positive attitude towards HSPA.
- Building synergistic relationships between sectors can enhance the process – for example, synchronizing the collection of financial data with milestones in the development of and reporting on national health accounts.
- In the absence of a firm governmental commitment to utilize HSPA findings to inform policy decisions, an important challenge for the future will be to find ways of raising the profile of the HSPA among political leaders, perhaps by customizing HSPA to the perspective of high-level policy-makers.

# HSPA IN BELGIUM

## WORKING TOWARDS A PARTICIPATORY PROCESS BETWEEN HEALTH INSTITUTIONS AND AUTHORITIES AT NATIONAL AND REGIONAL LEVELS

### Introduction

Belgium started to work on HSPA in March 2008 at the request of the National Institute for Health and Disability Insurance with a view to monitor the performance of the health system at a national level and vis-à-vis international comparators. The first report was produced in collaboration between the Belgian Health Care Knowledge Centre (Box 2), which took the technical lead, the National Institute for Health and Disability Insurance and the Scientific Institute of Public Health. It was published in 2010 (4).

A number of procedural features and the utilization of the report make the Belgian HSPA unique. First, this experience provides a model of a country-wide participatory process, with three national agencies collaborating and effectively involving both political actors and the health authorities responsible for social affairs and public health at regional, community and federal levels. In a highly decentralized health system, HSPA builds a common understanding among different institutions of how the system performs and helps build consensus on priorities for the future.

Second, the HSPA process involved a systematic inventory of existing information in Belgium and in other countries on health system performance. This inventory of currently available databases facilitated the selection of a practical set of indicators to complete a holistic HSPA framework. At the same time, the selection of indicators limited the scope of the assessment and may require further refinement in the future.

Third, HSPA aims to strengthen performance monitoring and transparency by improving the quality and use of available information. To date HSPA has been rooted in a governmental commitment to sustain performance monitoring for increased transparency. It is not primarily aimed at policy change per se, although the first HSPA has already had a number of policy effects. Whether HSPA in Belgium systematically informs policy decisions in the future will depend on optimizing the methodology and addressing the remaining data gaps.

### Policy context, objectives and stakeholders

The Belgian HSPA was prompted by two important developments. One was the adoption of an agreement by the coalition government in 2008 stipulating a governmental commitment to

**Box 2. The Belgian Health Care Knowledge Centre**

The Belgian Health Care Knowledge Centre (KCE) is a semi-governmental institution that has a limited connection to government and also enjoys autonomy in technical areas. The KCE was established in 2003 to provide policy studies and scientific reports to inform health policy-makers in Belgium. As an advisory body, the KCE is not involved in decision-making. The main strands of the KCE's work are analysing clinical practice and developing recommendations for clinical practice, health technology assessment and health services research.

Source: Belgian Health Care Knowledge Centre (5).

assess health system performance regularly on the basis of measurable objectives. Belgium has also signed *The Tallinn Charter: Health Systems for Health and Wealth* (6) committing the government to transparency and accountability for health system performance with measurable results.

The 2009 HSPA was the first comprehensive health system performance assessment of its kind in Belgium. Previously the notion of “performance” in the health sector had been a sensitive topic. Assessing performance could create anxiety among health system stakeholders, particularly the traditional decision-makers. Regional and local governments, for instance, have traditionally been strong actors in the Belgian health system. Moreover, the system is becoming even more decentralized with regard to long-term care, disability care and rehabilitation care. Health care providers have long enjoyed a comfortable position with limited external scrutiny of quality of care and performance, because most policy decisions regarding volume of care and reimbursement are determined by negotiation with insurers. Assessing performance at the national level could result in changes in the traditional roles of federal, regional and local actors in evaluating performance and facing the consequences of low levels of performance. Such changes, it was feared, could affect the distribution of funds between regions or health care providers.

Defining institutional consequences for performance, however, was not an explicit objective of the first Belgian HSPA. Rather, its purpose was to create collaborative relationships in order to ensure a common understanding of system performance among health care providers, insurers and administrators in charge of social affairs and public health at local, regional and federal levels. In addition, the HSPA aimed to provide a platform for identifying health system objectives for the future.

The HSPA process involved the KCE, the National Institute for Health and Disability Insurance and the Ministry of Health. The HSPA drafting team included several renowned experts. There was strong political support for HSPA and systematic involvement of the stakeholders. This is

partly due to the fact that HSPA was initiated with an emphasis on facilitating participation and feedback during the process. Technical staff worked on the report, while a political working group met every two to three months with representatives from the federal and regional administrations. Progress was also discussed twice a year by the inter-ministerial conference on health, a political forum involving all ministers aimed at discussing major health issues and taking joint decisions. In this way all relevant parties were kept informed and were able to contribute to the process.

### **Development of the HSPA framework and operational model**

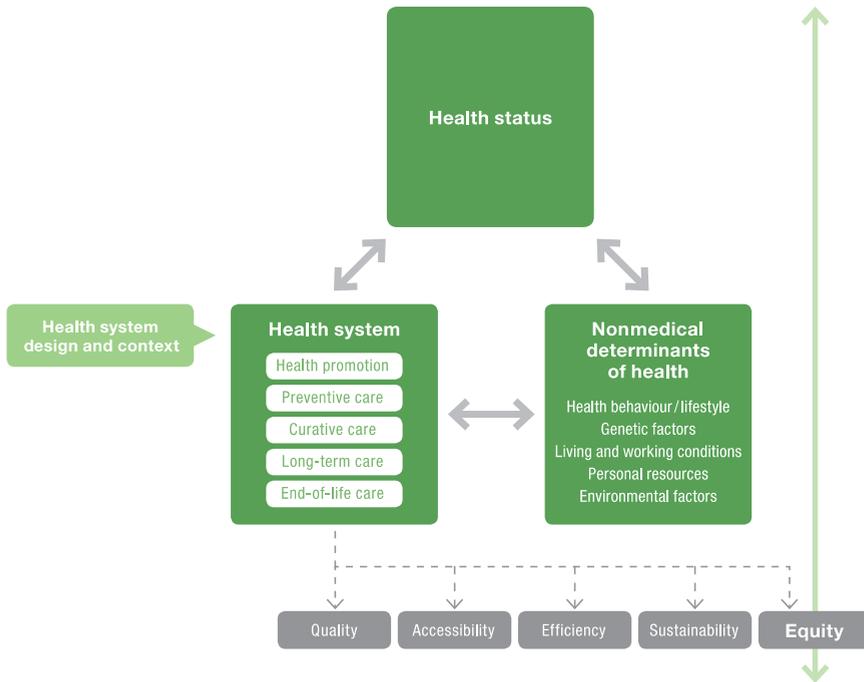
The HSPA framework was developed in consultation with experts and informed by a review of international HSPA experiences in Australia, Canada, England, New Zealand, the Netherlands, Sweden, the United States of America and international organizations including the Organisation for Economic Co-operation and Development (OECD), the Commonwealth Fund, the European Commission and WHO. An important step was the initial consultation with external experts who made the following recommendations for the Belgian HSPA (4).

- The end users of the HSPA should be clearly defined.
- The objectives should be clearly specified and presented in order of priority.
- The scope should cover the whole health system spectrum, not only health care.
- The framework should integrate national, regional and local perspectives on performance.
- The framework should combine elements of the Dutch and Canadian frameworks and add performance dimensions on human resource management, sustainability, governance, integration of all health authorities in the country and integration of health into all government policies.

Thus, the Belgian HSPA framework builds on international experience and tailors it to the Belgian health system context. Three interconnected tiers were identified: health status, non-medical determinants of health and the health system. The health system consists of five domains: health promotion, preventive care, curative care, long-term care and end-of-life care. The performance of the health care system is grouped into four main dimensions: quality, accessibility, efficiency and sustainability. Quality of care is further subdivided into five sub-dimensions: effectiveness, appropriateness, safety, patient-centeredness and continuity. Equity is an overarching dimension, presented across all tiers, as illustrated in Fig. 2.

The main disadvantage in starting from a theoretical model of HSPA in Belgium was that some dimensions, such as patient-centeredness, continuity of care and equity, were not covered.

**Fig. 2. HSPA framework of Belgium**



Source: Vlayen J et al. (4).

Moreover, the assessment did not target primarily the problems that required immediate policy attention in Belgium. The methodology, including identification and use of performance data, requires further refinement if HSPA in Belgium is to systematically inform policy changes.

### Implementation of HSPA and the way forward

#### Stages of the HSPA process

The HSPA process in Belgium followed a well-prepared sequence of stages (see Fig. 3). In the conceptual phase, a review of literature revealed valuable information on previous international experiences with performance measurement. This review was followed by consultation with international experts on specific HSPA experiences. Building on the analysis of international experiences, the matrix for a conceptual framework was developed, presented and discussed at the first meeting of external experts in October 2008.

Following recommendations by the external experts, a performance framework was put forward and reviewed by the expert group in December 2008. A set of core indicators was identified by the KCE in consultation with various experts at federal and regional levels. Selection of indicators was based in part on the availability of data. A survey was conducted across local, regional and federal levels to test the feasibility of collecting data relevant for the selected indicators, reinforcing the importance of using a common tool that can be shared between administrations.

**Fig. 3. Key stages of the HSPA process in Belgium**



### Data sources

The National Institute for Health and Disability Insurance provided data on financial indicators, patient characteristics, utilization of services and hospitalizations. Health interview surveys conducted every four years provided proxy measures of morbidity, use of medicines and medical procedures. The regional and community administrations collect health data on their own populations. Regulations on regional authority over data disclosure and interpretation were reinforced in order to allow better utilization of regional data at the national level.

The HSPA has prompted a formal procedure to standardize the definitions of medical doctors and a coordinated process between the ministry of health and national institutions to gather data on medical doctors for policy use.

Data on ambulatory care and morbidity data are still widely lacking, with the exception of specific diseases that are subject to management programmes such as chronic renal failure and diabetes mellitus. Similar problems with data availability apply to health determinants and equity. Data on the quality of cancer care have been subject to a series of studies conducted by KCE in the context of implementation of the National Cancer Programme 2008–2010. These studies are also the basis for the HSPA indicators on quality of care in selected cancer treatments. Addressing data gaps and improving the interoperability of data sources will be a priority for future HSPA efforts.

### **Findings and recommendations**

The first HSPA report presents mixed results. On the one hand, most indicators show improvement, especially in raising immunization coverage, reducing the incidence rate of methicillin-resistant *Staphylococcus aureus* (MRSA) infections and improving inpatient safety. Performance in some areas, on the other hand, lags behind and requires improvement in order to catch up with European regional averages. Two examples are the relatively high out-of-pocket expenditure as a proportion of total health expenditure and the relatively long length of stay in hospitals. In addition, exposure to medical radiation from X-ray and CT scanning is comparatively high and increasing. This is a powerful indicator of the level of appropriateness of the use of medical technology and thus performance, as it varies significantly between regions and between cities.

Furthermore, indicators related to cancer prevention and treatment show the system's weakness in this area. Rates of cancer screening are lower than those in other countries. There is considerable variation in cancer screening coverage between regions, since policies on screening are determined mainly at the regional level. The HSPA therefore recommends scaling up efforts to improve cancer screening coverage. The five-year survival rates for certain cancers were unavailable for the 2010 report; similarly, national mortality rates for cancer were largely unavailable. The reporting of these data, however, is expected to improve after the conclusion and evaluation of the National Cancer Plan 2008–2010 and with progress in reporting mortality causes and data on the morbidity of cancer through cancer registries.

### **Policy effects**

The findings and recommendations in the 2010 HSPA report have had direct and indirect policy implications. Strong performance on lowering MRSA infection rates and the HSPA recommendations in this area, for instance, have contributed to the decision to continue public health campaigns on the appropriate use of antibiotics.

Belgium has also reinforced national information campaigns to raise awareness among patients and providers of the high level of medical radiation exposure caused by CT scans and X-rays. The HSPA recommends using alternative technologies such as ultrasound or magnetic

resonance imaging (MRI) to limit doses of radiation while also bolstering patients' empowerment and their ability to take an active role in personal health care decisions. The HSPA might have had an impact by prompting research on regional variations on medical radiation and raising awareness on the high degree of medical radiation through X-ray and CT scan imaging among medical professionals and the general population.

The 2010 HSPA has helped improve coordination between national and regional health administrations in Belgium and has also raised the profile of intersectoral dialogue on health. In addition, the national HSPA process has contributed to greater awareness of regional variations in health care programmes.

An important achievement was the political commitment to undertake HSPA regularly every two years, and this commitment is likely to be upheld in spite of current efforts (as of 26 July 2011) to form a new government as well as future changes of government.

### **Limitations of the Belgian approach and the way forward**

Most of the limitations of the HSPA in Belgium relate to the availability of data. Indicators were pragmatically selected on the basis of international comparators, not in strict accordance with the requirements of the conceptual performance framework. For this reason some of the dimensions and subdimensions in the framework (such as patient-centeredness, continuity of care, equity and determinants of health) are not adequately covered by the selected indicators. In light of the decentralized nature of decision-making in Belgium, it has been difficult to maintain, as an indicator, equity in resource utilization and health outcomes between regions and between communities. In addition, data in certain health care domains (such as end-of-life care and the care of chronically ill, elderly and psychiatric patients) are not systematically or accurately reported. In effect, 11 of the 55 performance indicators lack data to be presented in the HSPA report. A priority for the future will be to develop more specific, relevant indicators while continuing to measure health system trends over time and compare trends in Belgium to those in other countries.

Overall, the Belgian authorities have found the results encouraging and have decided to continue using HSPA. Work has begun on another, more comprehensive report to be completed in 2012 with two main objectives. The first objective is to refine and adapt the set of indicators to make it more specific to the Belgian health system while monitoring of performance trends over time continues. The second objective is to add domains and dimensions not covered in the 2010 report and in particular to extend the relatively narrow operational approach from health care to the broader determinants of health and integration of health in all policies (7).

Thus, the next iteration of HSPA will focus on sustaining the political commitment to making HSPA a regular process, making the health system transparent to its users and increasing the

accountability of health institutions. Further intense discussion is anticipated for the next HSPA report at the federal level and especially the regional level. To paint a more complete picture of system performance, the next HSPA will need to address data gaps and take into account regional differences in public policies and programmes (including long-term care, primary care and mental health care) when interpreting the data. It is possible that HSPA findings and recommendations could be used more explicitly in policy-making after the methodology has been further refined. HSPA results may, for example, support a shift in activities and input-based reimbursement towards a higher share of pay for performance.

## KEY LESSONS LEARNED

- With respect to international consultation, the critical review of HSPA approaches in other countries enabled the Belgian HSPA team to save considerable time and resources, although doing so led to compromises on the dimensions covered. In the future it will be important to focus more closely on country-specific indicators. In addition, the next HSPA will deploy theme-specific working groups.
- Starting with explicit targets is not a prerequisite for beginning the HSPA process.
- Involvement of experts and active collaboration among national, regional and local authorities were critical factors in the development, perception and utilization of the HSPA report. Strengthening this collaboration may require tailoring HSPA objectives to the different levels, using more subnational data and taking into account regional differences in policies and the provision of care when measuring performance.
- As a collaborative process, HSPA has developed a common understanding of health system performance at national and subnational levels, Belgium's performance in comparison to other countries, key issues requiring policy attention, objectives for health system improvement and existing gaps in health system data.
- Data gaps and shortcomings in the framework limited the scope of the first HSPA report, which focused mainly on the health care system and neglected other determinants of health and equity. The next report will encompass these previously neglected determinants of health and equity and will consider the contributions of other sectors beyond health care.
- Finally, the 2010 HSPA has generated discussion and critical reflection on the nature of the data to be shared at the international level as well as the optimal use of existing databases in Belgium to create a standardized informational tool for use by local, regional and national authorities.

# HSPA IN ENGLAND

## **LOOKING FOR THE GOLDEN THREAD TO ALIGN LOCAL PERFORMANCE TO NATIONAL MANAGEMENT OBJECTIVES AND TARGETS WITHIN THE NHS**

### **Introduction**

The following case study focuses on the history of target-setting and performance monitoring in the English NHS, using Vital Signs (2007–2011) as an illustration. In contrast to the other case studies, the focus here is on performance monitoring of individual providers and strategic health authorities through performance information rather than on a holistic assessment of health care delivery at the national level. The decision to present this experience was based on a number of key features. First, it focuses on the uses of a performance framework rather than on the development of the framework. Second, Vital Signs, the set of performance indicators applied from 2007 to 2011 within the NHS Operating Framework, exemplifies the alignment of performance schemes at different levels (national requirement, national priority for local delivery and local action) and the challenges involved in achieving this alignment. It highlights how strategic priorities shape the performance framework.

Three important overall conclusions derive from this case. First, using targets to monitor performance fosters accountability on the part of health service managers and commissioners committed to focusing on national priorities. This is achieved by tying local service delivery processes and achievements to national targets, which may have motivating as well as demotivating effects. There is still considerable controversy around the use of targets for performance monitoring in England. Second, selecting the right balance of indicators in a target-setting approach remains an ongoing challenge. In England performance monitoring has progressively developed so as to incorporate health outcome information, measures of clinical quality and both patient and provider experience, upon which elements the new NHS Outcomes Framework is based. This framework will come into effect in 2013. During the transition period, the NHS Operating Frameworks 2011–12 and 2012–13 signalled the move towards a focus on outcomes (8–10). More generally, the English experience with a long history of using performance information for performance management highlights the dynamics of the process. It shows that a performance monitoring scheme cannot remain static. It needs to evolve, taking into account the observed responses of providers and health authorities to the performance management scheme and incorporating new priorities. Third, although performance monitoring can help identify strengths and weaknesses in the service delivery chain, it does not necessarily lead to a better understanding of what needs to be done in order to remedy those weaknesses.

In view of the unique character of the English experience, this case study has a different structure compared to the other countries. The next section provides a short historical overview of the evolution of target-setting and monitoring in England. This is followed by an examination of the Vital Signs scheme (2007–2011), the most recent example of a governmental health target monitoring programme. This section includes a critical analysis of using Vital Signs in the Primary Care Trust of Tower Hamlets as well as a summary of the main strengths and weaknesses of the programme. There follows an introduction to the new NHS Outcomes Framework, published in 2010, which will come into operation in 2013, and a concluding section to summarize the lessons learned in the English case.

### An overview of the evolution of the target-setting approach

For at least three decades England has used a target-setting approach to measure health system performance at the national and subnational levels. This approach is becoming increasingly outcome-oriented and quality-oriented (Box 3).

#### Box 3. Chronology of the target-setting experience in England

1983:	NHS performance indicators with a first round of indicators
2000:	NHS Plan with a second, more limited list of performance indicators
2001:	Star rating system
2006:	Annual Health Check
2007:	Vital Signs
2010:	NHS Outcomes Framework published

The first systematic approach to measuring performance in the NHS by means of target-setting was launched in 1983 with the *NHS high-level performance indicators*, following a period when policy-makers attempted to avoid strong centralized governmental interference in the NHS. They contained more than 500 process and input indicators, most of which were clinical in nature. Many critics felt that they were too numerous. The NHS performance indicators later contributed to the *NHS Plan* (2000) with a more limited number of indicators. The NHS Plan contained two rounds of institutional performance indicators for about 100 health authorities and 275 NHS hospitals. *The traffic light system* (11) was also designed in 2000 to periodically assess, classify and reward NHS organizations (local health authorities) and NHS providers according to their performance based on the NHS Plan; this scheme was later subsumed under the star rating system.

The *star rating system* (2001–2005) rated NHS hospitals annually from zero stars to three stars, based on performance against a limited number of key targets and a wider range of targets and indicators in a balanced scorecard. The scheme contained about 40 clinical performance indicators and targets. The indicators in the star rating system were designed to reflect the national targets set out in the Public Service Agreements (PSAs) of the Department of Health.

PSAs were public sector agreements between the treasury and each individual government department. Introduced in 1998, they were valid for three years and reflected the spending review cycle. They were meant to ensure policy and service alignment across government, and they entailed agreement on objectives that were measurable as targets to be achieved within a designated time frame. PSAs were intended to place greater emphasis on the outcomes of public services than on the activities, to make management of public services more transparent and to carry out governmental priorities by providing departments with specific objectives (12).

The star rating scheme was initially applied to acute trusts in 2001 and extended to ambulance trusts in 2002. Primary care trusts, the commissioning side of the NHS, were included in the star rating system in 2003. The system was tied to a managerial scheme of rewards for three-star ratings and punishments for zero-star ratings, such as increased or decreased financial autonomy. Managers of trusts rated as zero risked losing their jobs (12,13). The idea of the star rating system was to build on providers' ambitions through a process of "naming and shaming," rewarding successes and penalizing failures (12). There were measurable effects of the star rating system in some of the target areas, such as waiting time (13). The number of patients waiting longer than the targeted 4 hours in accident and emergency departments decreased from 23% of patients in 2002 to 5.3% in 2004 (13). There were also marked improvements in the number of trusts achieving the 75% target for emergency care calls attended within 8 minutes; and the number of patients waiting for elective hospital admission dropped substantially during the application of the star rating scheme (12,13).

There has been considerable controversy around target-setting and whether targets have done more harm than good in the NHS (13,14). Bevan has compared the United Kingdom countries and found better performance on ambulance response times and hospital waiting times in England under the star rating scheme as compared to Scotland, Northern Ireland and Wales, which had much laxer policies on ambulance response and hospital waiting times (15). Bevan, however, has also called attention to the risks of target-setting, such as "neglect of what has not been targeted (such as value for money), manipulation of data (for waiting times and ambulance response times), and hitting the target but missing the point (for example by cancelling and delaying follow-up outpatient appointments which were not targeted)" (12,14). Opponents of the star rating system criticized what they viewed as an arbitrary means of calculating performance by focusing on numbers and devaluation of local and professional leadership by relying on central control (14). They also pointed out the risk of undermining professional autonomy for the sake of achieving managerial objectives and the risk of distorting clinical priorities and clinical behaviour. Another criticism is that targets may lead to a selective view of performance, focusing on certain aspects rather than the system as a whole (14).

The *Annual Health Check* approach replaced the star rating system in 2006. This was a balanced scorecard model that encouraged NHS organizations to develop their mission-specific

set of performance measures, retaining an emphasis on financial objectives. More specifically, the Annual Health Check examined a broader range of issues than the previous targets, by including information from the people who used and provided health care services. In addition, annual *Quality Accounts* have been required since 2009. The *Quality Accounts* are annual reports from NHS providers to the public about the quality of the services they provide (16). They include a broader spectrum of performance measurement in the area of clinical quality and place greater emphasis on self-reporting and local scrutiny. In addition, they separate clinical performance from financial performance.

### **The case of Vital Signs: policy context, objectives and criticisms**

The annual NHS Operating Framework contains guidance on national priorities. Vital Signs was the set of indicators used by the NHS Operating Frameworks from 2007 to 2011 to monitor progress towards these national targets by primary care trusts and NHS trusts. Each year the NHS Operating Framework requires NHS organizations to set out their plans in relation to selected priorities.

The Vital Signs indicators were introduced in 2007 as the set of key measures for delivery of health services in the NHS Operating Framework for 2008–2009, including directions for a period of three years until 2010. Vital Signs aimed to provide a set of measures for health authorities and NHS trusts to use in the development of their operational plans in order to deliver against and report on national priorities (17). At the time, this was a new approach to planning and managing health priorities nationally and locally. In particular, it aimed to grant greater autonomy to managers and clinicians in local target-setting. The Vital Signs indicators comprised three tiers of measures of progress, illustrated in Fig. 4.

The targets defined in tier one spelled out national requirements, which were mandatory and subject to centralized reporting to the Department of Health. They were applied to all primary care trusts (PCTs) across England, which were required to monitor progress against these targets using the set of indicators set out in tier one. For the period from 2008 to 2009, five national priority areas were defined for the tier one targets:

- improving cleanliness and reducing the incidence of infections related to health care;
- improving access to services;
- keeping adults and children well, improving their health and enhancing health equity;
- enhancing patient experiences, satisfaction and engagement; and
- improving emergency preparedness.

**Fig. 4. The three tiers of Vital Signs**



In contrast to tier one targets, which applied to all PCTs, tier two targets were specific to each PCT. They defined actions and targets for local delivery on national priorities. The operational plans of each PCT for achieving tier one and tier two targets were subject to approval by its Strategic Health Authority (SHA). Interventions by the Department of Health on tier two target achievements were limited to underperforming PCTs, whereas strongly performing organizations were able to progress without intervention from the SHA. Tier three targets were local-level targets on local priorities, and these were left to the discretion of the PCTs in collaboration with their SHAs. To define and achieve these targets, PCTs were expected to form new local partnerships and engage with their local communities, staff and stakeholders regarding priorities and performance measures. Table 5 summarizes performance measurements for the three tiers of Vital Signs.

The difference between tier one indicators and tier two indicators was related to the degree of centralization and national focus in the protocol for performance management. Tier one indicators reflected national commitments that cascaded down to the PCT level. One example from tier one was the maximum wait of 18 weeks for elective care from referral to treatment, which applied to all PCTs across England. Tier two indicators reflected national commitments with some flexibility in the methods used to meet those commitments at the local level. Monitoring trends in mortality rates, for example, depended on demographic factors that differed from community to community but shared a national target for demonstrating improvement. Although tiers one and two were considered the most important tiers, the Department of Health

**Table 5. Targets and performance monitoring across three tiers in Vital Signs**

Tiers	Targets	Performance management
<b>Tier 1</b> <b>National requirements ("must dos")</b>	Set nationally Cascaded down to SHA or SHA level	PCT plans agreed by SHAs and signed off by Department of Health. Monitoring and performance management by SHAs.
<b>Tier 2</b> <b>National priorities for local delivery</b>	Agreed locally and signed off by SHAs	PCT plans signed off by SHAs. Performance management by Department of Health focused on weak areas of PCTs only
<b>Tier 3</b> <b>Local action</b>	Priorities and any corresponding targets agreed locally	Department of Health not involved in performance management

Source: *Operational plans 2008/2009–2010/11 (17)*.

reserved the right to intervene in any of the tiers in Vital Signs and occasionally requested feedback on progress in tier three.

It is important to note that Vital Signs was designed as a monitoring scheme. It was not designed to provide insight into the causes of poor performance or to offer remedies to address the problems. Rather, it focused exclusively on meeting the targets. Some indicators in the Vital Signs programme became major issues in the national election campaign of 2010. Several targets were used as visible political commitments and resonated with the general public. One such target was for 98% of patients to be treated within four hours of arrival at an emergency department. Another was for 90–95% of patients to receive elective treatment within 18 weeks of referral from a general practitioner.

### Using Vital Signs: the East London experience

Tower Hamlets, one of three PCTs within the area covered by the East London Strategic Health Authority, introduced Vital Signs in 2009. Findings for 2009–2010 included the following achievements (18).

Satisfaction with general practitioner (GP) access improved from 69% to 82%, the highest improvement rate in England.

- Breast cancer screening increased to 66%, which was above the London average of 64.5%.
- Tower Hamlets had the highest rate of teenage pregnancy reduction in London and the third highest rate of reduction in the country, with a reduction of 42% from the 1998 baseline.

- More than 2000 people were helped to give up tobacco, making Tower Hamlets the fifth most successful PCT in England for that year.
- Over 8000 young people (15–24 years old) were screened for chlamydia.
- Childhood immunization rates continued to improve and were among the 10 highest in London.
- Mental health targets were consistently approached or met.

These results were made public, as were the shortfalls in target achievement. Tower Hamlets PCT fell short of the targets for reducing cancer mortality and increasing cervical and breast cancer screening; reducing childhood obesity; improving patient experience; improving access to dental health services; and improving the quality of life of people living and working in Tower Hamlets.

### **The strengths and challenges of Vital Signs**

It was widely agreed that the government's commitment to increase accountability and transparency at the national level was legitimate and well-meaning. In addition, by measuring target achievements, SHAs and commissioners were able to monitor how effectively their organizations were performing. This information could be used for a better understanding of weaknesses in their local systems. It is also undisputed that certain problems, such as long waiting times in emergency, ambulatory and elective care, have been improved substantially by performance management interventions. Vital Signs, along with other performance management schemes, has contributed to the development of a performance management mentality in England.

One challenge at the local level was that the bulk of investment went into tier one and tier two activities, so that most expectations for service delivery were based on national priorities, leaving more limited resources to tailor services to local needs. Vital Signs is also said to have contributed to the atmosphere of anxiety among poorly performing executive managers, who feared the personal consequences (demotion or termination) of failing to meet their targets from the previous star rating system. Like the star rating scheme, Vital Signs was criticized for distorting clinical priorities and neglecting to provide incentives for meaningful change in health service delivery.

Vital Signs was considered input- and process-oriented. Targets for mental health services and activities funded under tier two, for example, concentrated on inputs such as the number of early intervention services, the number of mental health staff, the number of patients with a

mental health plan and the number of patients receiving follow-up care. Nevertheless, Vital Signs also fostered discussions on how to use process and outcome data on the quality of services and patient experiences. England's long history of target-setting shows that performance monitoring and management are dynamic processes that need to be revisited and adjusted regularly in order to build on existing strengths and address the shortcomings of any particular scheme.

### The way forward

The *NHS Outcomes Framework* is a set of outcome measures spanning the three-part definition of quality (effectiveness, patient experience and safety) first set out as part of the NHS Next Stage Review in 2008. The framework is designed to move away from process measures to focus on outcomes, with a strengthened focus on health care inequalities. A second key feature of the plan is to remove rigid central planning and, within the framework, to negotiate locally expected results with local organizations. Another innovation is a stronger, integrated approach to social and health care for adults, in the domain of long-term care, for instance (19). In addition, there are plans to publish a national performance overview of England's results in relation to international comparators, which is a new feature.

The first NHS Outcomes Framework was published in December 2010 and set out the indicators and outcome measures that would be used to track the progress of the NHS (9). Not all of the indicators in framework have been defined, however; during 2011–2012 the definition of indicators will be completed. The framework is expected to come into use in 2013, and work is also underway to develop an outcomes framework for public health (8,9,20,21). The NHS Outcomes Framework will be updated annually to make sure that the indicators being used are the best measures of outcomes. The NHS Commissioning Board will be responsible for translating national outcome measures set out in the NHS Outcomes Framework into outcomes and indicators that are meaningful at a local level in the new Commissioning Outcomes Framework.

The NHS Outcomes Framework 2012–2013 contains 60 indicators, with 12 overarching indicators and 27 indicators defined as “improvement areas.” A remaining challenge is to ensure that health outcome measures reflect recent activities, as most of them reflect policies from more than a decade ago. It is likely that, in future, process indicators will remain one source of reference for improving performance in the English NHS.

## KEY LESSONS LEARNED

- Performance-based management approaches based on PSA targets and the NHS operating framework have been a central element in the health policy cycle and the political discourse in England. These approaches have succeeded in shaping the priorities and delivery of

health services at all levels, from national to local, and contributed to the development of a performance management mentality. They have paved the way for a more outcome- and quality-oriented focus within the current NHS framework.

- Performance monitoring by means of target-setting increases the accountability of health service managers and commissioners towards nationally agreed priorities, by tying local service delivery processes and achievements to national targets. This has motivated high-achieving managers and further enhanced their performance. Low-achieving managers have been known to use the target-setting culture as an excuse for poor performance in other areas related to quality of care. Therefore, it is important to elaborate a comprehensive set of indicators covering all of the important components of performance. The target-setting approach runs the risk of neglecting certain unmeasured aspects of performance, such as clinical priorities, and distorting the behaviour of some managers and providers.
- The selection of indicators for measuring and managing performance is a challenge. Striking a balance between comprehensive assessment and choosing a targeted set of indicators is difficult. Arguably, Vital Signs may have focused more on processes than on outcomes. Measures of quality of care (encompassing effectiveness of care, patient experience and safety) are included in the NHS Outcomes Framework as part of an outcome-oriented approach. Length of waiting time, for example, is thus presented as an aspect of patient experience. Process and input indicators of performance are also needed, however, to assess outcomes indirectly in areas where outcomes are difficult to measure, slow to develop (for example, mortality rates) or influenced by factors outside the health sector.
- Vital Signs was introduced as a performance management scheme that identified poor performance but failed to identify either causes or remedies for it, demonstrating the need to complement quantitative measures (a set of indicators) with other tools in order to understand the reasons behind low achievement levels and to formulate recommendations to address observed weaknesses.

# HSPA IN ESTONIA

## FOSTERING SYNERGIES BETWEEN HSPA AND NATIONAL HEALTH PLAN MONITORING

### Introduction

In summer 2010 Estonia launched its first health system performance report as part of the biennial collaborative agreement between WHO and the Ministry of Social Affairs. The report was developed from 2008 to 2010 by a small group of experts from the Ministry of Social Affairs in collaboration with WHO and in periodic consultation with a number of high-level policy-makers from some of the most important policy institutions in Estonia.

The HSPA framework is based on the WHO framework of health system functions, goals and objectives with measurable performance indicators and targets (22). It was adjusted to include health system contextual dimensions such as macroeconomic, labor and social conditions. The Estonian HSPA builds on a number of performance monitoring activities, such as experiences in assessing targets in population health programmes, monitoring system reforms and the practices of health institutions in monitoring institutional performance.

The main national objectives were to develop a comprehensive health system perspective facilitating the prioritization of policy interventions; to monitor the impact of health system reforms; and to introduce HSPA as a tool to ensure accountability of the key policy-making institutions for improving health system outcomes and performance. The process was inspired by the WHO Ministerial Conference on Health Systems, Health and Wealth in 2008. Furthermore, the HSPA process also initiated a debate on how to use the framework to develop a monitoring and reporting system for Estonia's National Health Plan 2009–2020, which was drafted at the same time and adopted in 2008 (Box 4).

### Policy context, objectives and stakeholders

Policy-makers in Estonia as well as international health policy experts viewed Estonia as a pilot country for the introduction of HSPA, for several reasons. Estonia has had a number of national public health strategies in place since the mid-1990s and has a track record of assessing performance and using the results to revise these strategies and programmes. Recently Estonia has also launched its third National Health Plan (NHP) 2009–2020, which includes intersectoral governance mechanisms and a scheme for regular monitoring and reporting. The plan is a governmental commitment that is both action-oriented and target-oriented. Reporting on health system achievements is a mandatory element of the NHP.

#### **Box 4. The National Health Plan 2009–2020**

The National Health Plan 2009–2020 is a comprehensive national health strategy that was adopted in 2008 and came into effect in 2009. The goal of the plan is to increase healthy life expectancy to 65 years for women and 60 years for men and total life expectancy to 84 years for women and 75 years for men. The plan defines actions in five different fields: social cohesion, children's and young people's health, the environment, healthy lifestyles and health care. To monitor progress, performance indicators have been identified and targets defined for four consecutive four-year cycles until 2020. The plan provides a common framework for presenting various pre-existing health strategies and programmes and sets out a number of new activities for targeting achievements.

The timing of the development of the third NHP overlapped with timing of the HSPA process, which led to both challenges and opportunities for the HSPA. The Ministry of Social Affairs was responsible for both the NHP and the HSPA. The NHP took precedence, as it represented a binding legal commitment by the Government of Estonia. For this reason, resources for the HSPA were limited. At the same time, however, synergy developed between the HSPA and the NHP. The same data sets, for instance, were used for both processes, and the NHP indicator framework contributed to the HSPA report, even though the NHP is broader in scope and contains more areas of performance (see Table 6).

Another factor that aided the introduction of HSPA in Estonia was the country's tradition of the performance assessment systems in public institutions, including the Ministry of Social Affairs and the Health Insurance Fund. These institutions, therefore, have considerable experience with performance indicators and targets, regular monitoring and annual reports. The annual report (in Estonian and English versions) of the Health Insurance Fund, for example, provides data on volumes of service in health promotion, disease prevention and clinical care, as well as financial indicators and four-year action plans (23). The Fund measures institutional performance, which is linked to performance assessments for each individual department and worker. In light of this experience, Estonian policy-makers were receptive to the concept of HSPA when it was first introduced by WHO in 2000.

When *The world health report 2000 (2)* first introduced HSPA as an instrument of health system governance, it raised considerable interest among policy-makers in Estonia. They felt that HSPA could support a more holistic view of the individual strategies and institutes by integrating the sector-specific perspectives that had been promoted by vertical health strategies and programmes. There were also various influential policy assessments launched between 2003 and 2008 to accompany reforms in primary care, hospital care, public health services and health financing. These assessments proved to be instrumental in decision-making on specific dimensions of the Estonian health system. This meant that there were high expectations of the HSPA, in that it would need to add value to existing performance-related activities. It was

**Table 6. Comparison of features of the HSPA and NHP**

	HSPA	NHP
<b>Format</b>	HSPA report	NHP strategy document and NHP implementation plan (2009–2012)
<b>Declared goals</b>	None	Defined as “general objective”: increase healthy life expectancy and life expectancy specific to male and female
<b>Declared objectives</b>	The objectives changed over time. The final report states the following objectives: <ul style="list-style-type: none"> <li>• provide an overview of the performance of the Estonia’s health system;</li> <li>• set the stage for further development and integration of health system performance assessment within the decision-making process of the Ministry of Social Affairs; and</li> <li>• provide a framework for a monitoring and reporting system for Estonia’s NHP 2009–2020.</li> </ul>	Defined as five “strategic objectives” <ul style="list-style-type: none"> <li>• SO1: Social cohesion has improved, health inequalities have decreased (5 targets)</li> <li>• SO2: Mortality, primary morbidity from mental and behavioural disorders has decreased, young people report positive assessments of their health (5 targets)</li> <li>• SO3: Health risks from the living, working and learning environment have decreased (8 targets)</li> <li>• SO4: Physical activity of the population has increased, diet has become more balanced and level of risk-taking behaviour has decreased (8 targets)</li> <li>• SO5: All people have access to high-quality health care services through optimal use of resources (5 targets)</li> </ul>
<b>Number of indicators</b>	More than 80	31
<b>Areas addressed</b>	According to performance dimensions: <ul style="list-style-type: none"> <li>• health status (level and distribution)</li> <li>• health behaviour and health promotion</li> <li>• broader determinants of health</li> <li>• responsiveness of the health system</li> <li>• fair financing, financial protection and coverage</li> <li>• efficiency and effectiveness of the health system</li> <li>• access to health care services</li> <li>• quality and safety of health care services</li> </ul>	According to five thematic themes: <ul style="list-style-type: none"> <li>• social cohesion and equal opportunities</li> <li>• ensuring healthy and secure development for children</li> <li>• healthy living, working and learning</li> <li>• healthy lifestyles</li> <li>• an efficient and patient-centred health care system</li> </ul>
<b>Data sources</b>	<ul style="list-style-type: none"> <li>• Adult health behaviour survey</li> <li>• School children health behaviour survey</li> <li>• Health interview survey</li> </ul>	<ul style="list-style-type: none"> <li>• Adult health behaviour survey</li> <li>• School children health behaviour survey</li> <li>• Health interview survey</li> </ul>
<b>Timespan</b>	Retrospective 2004 to 2010	Prospective 2009 to 2020

expected, for instance, that HSPA would connect the different reform elements and measure their impact from a holistic health system perspective.

Finally, there were international dynamics that put Estonia in the spotlight as a pilot case for HSPA. A draft memorandum between WHO and the Government of Estonia proposes designating Estonia an official hub (or potentially a WHO collaborating centre) for HSPA, although this agreement has not been finalized or implemented. The most important international stimulus for introducing HSPA in Estonia was the WHO Ministerial Conference on Health Systems, Health and Wealth hosted by Government of Estonia and the preparation of the Tallinn Charter in which Member States commit themselves to transparency and accountability for measurable results in health system performance. Initially, it was planned to launch the Estonian HSPA

in time for the Tallinn Conference, but the process took longer than anticipated owing to a number of activities related to the selection of the framework, the scope of the assessment, the objectives and the indicators.

Thus, there was considerable national and international interest in pilot-testing HSPA in Estonia. Box 5 summarizes the policy factors that created a fruitful ground for undertaking HSPA in Estonia.

**Box 5. Factors promoting HSPA in Estonia**

- The country has had national population health strategies and programmes in place and a systematic track record of assessing their performance.
- The NHP has introduced health objectives and a mandatory reporting scheme for achieving them by means of targets identified in the HSPA.
- There were various policy and health sector assessments (many with the support of WHO) launched between 2003 and 2008 to accompany reforms in primary care, hospital care, public health services and health financing. These proved to be instrumental to decision-making in specific dimensions of the Estonian health system and further promoted the idea of health sector assessments.
- Institutional performance assessment is a common practice in the health sector in Estonia.
- WHO and the Ministry of Social Affairs made HSPA a priority in their formal collaboration during 2008–2009.
- The WHO Tallinn Conference Charter on Health Systems, Health and Wealth commits Member States to transparency and accountability for measurable results in health system performance.

The objectives and indicators of the HSPA were thoroughly discussed and modified over time. The initiation, development and implementation of the HSPA was led by a small working group of staff from the Ministry of Social Affairs and WHO. They consulted with representatives of the key health policy institutions including the Health Insurance Fund and the National Institute for Health Development. The main purpose of this group was to deliver a comprehensive and integrated assessment on system performance with an emphasis on activities relating to public health, health care and intersectoral policies that could be used engage politicians in a dialogue about the strengths of the system, the adequacy of funding and the need for policy reforms. Another important objective was to bring different stakeholders together and develop a common understanding on how to measure health system performance.

In January 2008, the group defined four more explicit objectives for HSPA:

- to demonstrate progress in health system reforms;
- to promote accountability and transparency;

- to identify challenges, gaps and weaknesses in performance improvement; and
- to improve the capacity of the ministry to anticipate health system challenges and develop effective strategies.

The objectives became more specific and less ambitious over time, so that the final version of the report states the following three main objectives for HSPA:

- to provide an overview of the performance of the health system;
- to set the stage for further development and integration of HSPA within the decision-making process of the Ministry of Social Affairs; and
- to provide a possible framework for a monitoring and reporting system for Estonia's NHP 2009–2020.

The development of the objectives over time reflects a degree of uncertainty at the beginning of the process regarding the potential impact of HSPA. The experience in Estonia illustrates that it is difficult to formulate the objectives for the initial HSPA and that one has to expect changes in the objectives over time.

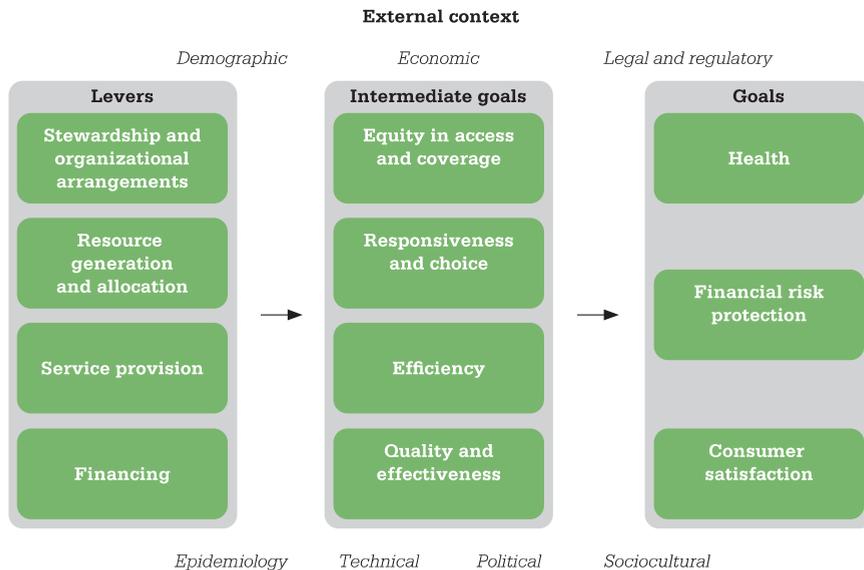
### **Development of the HSPA framework and operational model**

Several activities preceded the selection of the HSPA framework and operational model in Estonia. These included a review of the WHO framework; an appraisal of monitoring and evaluation methods in national health strategies and programmes; an analysis of experiences from HSPA processes in the Netherlands, the United States of America, Portugal, England, Ontario (Canada) and Kyrgyzstan as well as a review of HSPA frameworks used by various international organizations like WHO, UNDP, OECD and the World Bank; and a mapping of values and targets used by Estonian health sector institutions to measure their performance.

It was a given that HSPA should not duplicate existing frameworks, conflict with them or challenge existing frameworks for institutional performance assessment and local-level performance assessment in Estonia. In addition, the current governance mechanisms of the health sector such as standing committees and management boards of institutions were taken into account, so that the HSPA could inform decision-makers without coming into conflict with the governance structures already in place. The framework that was adopted in the Estonian HSPA was based on the WHO framework of health system functions, goals and objectives. The WHO framework was modified by the Estonian working group to include elements from an earlier evaluation of health care reforms and elements from a SWOT analysis of the health system undertaken in 2005 (24–26). This modification placed greater emphasis on equitable access to

health services and coverage by including components of contextual information on demography, macroeconomic conditions, social determinants of health and the legal and regulatory system framework (see Fig. 5).

**Fig. 5. Framework for assessing health system performance in Estonia**



Source: Estonia health system performance assessment: 2009 snapshot (22).

The weight given in the framework to health determinants was echoed in the operational model, which contained a set of performance indicators on health determinants. Table 7 summarizes the set of indicators chosen for the operational model.

Indicators changed frequently during the process. Yet another technical discussion focused on selection of an appropriate comparator – in other words, whether to use the EU12, the EU15, neighbouring countries or a longitudinal perspective of the Estonian health system over time. The final choice was a mixed approach. In addition, there was considerable emphasis on accountability and the link between strategies, institutions, policies and indicators. The difficulty of identifying accountability indicators has proven to be one of the weaknesses of the HSPA framework.

### HSPA implementation and the way forward

The HSPA was initiated by a small group of people including key staff from the Ministry of Social Affairs, who had access to the core data, and staff from WHO (the country office as well as the Regional Office for Europe), with the support of international consultants from WHO and

**Table 7. Summary of performance indicators in the HSPA of Estonia**

Performance dimension	Indicators on:
Health status	Changes in life expectancy Self-assessed health status Changes in infant and child mortality Avoidable mortality Burden of disease
Health behaviour and health promotion	Immunization rates Tobacco and alcohol consumption Overweight Obesity Physical activity
Determinants of health	Level of education Unemployment Clean drinking water Air quality Occupational health
Responsiveness	Level of health expenditure Equity in health system financing in Estonia Protection against the financial risk of ill health Resource allocation Health service coverage
Equitable financing, financial protection, resource allocation and coverage	Technical efficiency Allocative efficiency
Access to health care services	Utilization of health care services Waiting times for health care services Equity in utilization of health care services
Quality and safety	Clinical outcomes Other indicators

the London School of Economics. From the outset, representatives of key policy institutions, mainly the Health Insurance Fund and the National Institute of Health Development, provided technical input and advice.

The expert from the Ministry of Social Affairs is a technical officer in the new health information and analysis department of the ministry that was established in 2007 with a focus on strategic health information. The responsibility for health statistics shifted to the National Institute for Health Development. The new information department thus became the leading national actor in the planning and implementation of HSPA.

It was explicitly decided to keep the process informal, in order to prevent a rigid institutional arrangement or steering committee from complicating the process and preempting the decision about where to institutionalize HSPA in the long run. It was beneficial in the areas of data collection and analysis that work on the NHP started at the same time as HSPA and involved the same people. Over time more people became involved on the basis of initial assessment results.

Beginning with a small team and gradually broadening the scope and number of participants in the process was an effective strategy for HSPA in Estonia. The involvement of WHO was beneficial to for understanding the methodology deployed in other WHO-initiated HSPA frameworks. It also facilitated access to HSPA reference materials, such as those prepared for the WHO Ministerial Conference in 2008, and access to technical expertise at WHO. At the same time, however, it was important that the HSPA was perceived as a national project, with WHO staff playing a supporting role, to create national ownership of the process.

The operational costs of HSPA were reasonable because it was initiated by a small group of people who utilized previously established relationships with key stakeholders. WHO and the Ministry of Social Affairs, however, invested considerable staff time in the process. Some operational funds were allocated to cover travel costs for consultants and to copyediting work. Critical to limiting operational costs was the fact that the implementing team had access to all national health surveys and health data, so the process did not require the collection of new data sets.

Implementation was slowed by the challenge of meeting the high expectations of both policy-makers and the HSPA working group. The process was more conceptually and technically demanding and more time-consuming than expected. Extra time was needed to optimize the methodology and gain leverage through a growing capacity to report on initial results. Following an initial investment in awareness-raising and capacity-building (including regular training courses on health systems, policy and performance measurement organized by the University of Tartu in collaboration with WHO), it will be possible to update the HSPA in about a year.

The HSPA was launched in August 2010 with a seminar involving about 50 policy-makers, parliamentarians and researchers. The report was very well received. During the launch of the report it was suggested that the NHP and the HSPA might be better aligned as governance and accountability tools in the future. It was proposed, for instance, that policy briefs could be used as a framework for this alignment. Another proposal was to form more integrated measurement, monitoring, assessment and reporting mechanisms for the two processes.

The HSPA proved to be an effective tool for engaging with other sectors, particularly the Ministry of Finance. It also facilitated dialogue with other stakeholders, such as employer organizations and the private sector. The report was also presented in Parliament and, along with several other reports, contributed to raising the profile of the health system on the parliamentary agenda. As the HSPA report was published in August 2010, it is still too early to report on its impact on health system performance.

Another question yet to be answered is how to institutionalize HSPA in the Estonian policy context. There have been suggestions to delegate HSPA to a “neutral” institution like a think tank, an academic institution or a nongovernmental organization. This proposal, however, must

be weighed against the need to obtain sufficient insight into governmental policies and plans. In addition, there is interest in strengthening the link between HSPA and accountability mechanisms. An option with some merit is to place responsibility for performance measurement and reporting in the hands of the Ministry of Health and to collaborate with international bodies such as the OECD and WHO on editing and reviewing the HSPA report. In order to sustain HSPA in Estonia, however, the process will likely continue under the auspices of the Ministry of Social Affairs, possibly as one reporting instrument within the NHP and functioning with guidance from an NHP steering committee.

## KEY LESSONS LEARNED

- HSPA and the NHP go hand in hand; for instance, HSPA proposes ways to set priorities in a national health policy and provides a tool to complement monitoring and reporting.
- Implementation of HSPA is complex. The time and resources needed to undertake HSPA must not be underestimated.
- Combining responsibility for HSPA and monitoring a national health policy in one technical unit can be a sensible way to create synergies in data collection. At the same time, international organizations can provide added value by offering technical support, facilitating discussion and ensuring the impartiality of the assessment.
- The Estonian case shows that there is merit in using a small, committed group of people to test implementation of HSPA and to consult policy-makers at key stages of the HSPA process.

# HSPA IN KYRGYZSTAN

## COMPLEMENTING REGULAR HEALTH SYSTEM MONITORING WITH STUDIES AND EVALUATIONS TO REVIEW POLICY OPTIONS AND SYSTEM DIRECTIONS

### Introduction

HSPA in Kyrgyzstan is an ongoing activity in the context of the health sector programmes. It consists of annual health and health system monitoring, an annual review by the Ministry of Health and its development partners and complementary system and policy evaluation studies. Monitoring is undertaken annually by the Ministry of Health and is based on a package of health and health system indicators. The ministry and the development partners involved in funding the health sector programmes jointly carry out a review of progress using the indicators. This review is devoted to analysing progress on the indicator values and target achievements, identifying policy options and reaching agreement on priorities for future research.

The in-depth policy analysis and evaluation work is led by the Health Policy Analysis Centre (HPAC). HPAC is a public foundation independent of the government but with close links to it. The Ministry of Health is part of the supervisory board and participates in the development of HPAC's annual workplan, helping to determine the studies to be carried out. HPAC began as a WHO project in 2000 and became part of the Ministry of Health four years later. It was not until 2009 that it became an independent foundation with primary responsibility for analysing and evaluating health policy. The rationale behind separating monitoring functions from evaluation functions and shifting the latter to a public foundation was to foster the independence and objectivity of the research results without compromising guidance from policy-makers on the scope and coverage of health policy research (Box 6).

#### **Box 6. Definition of health system monitoring and evaluation in Kyrgyzstan**

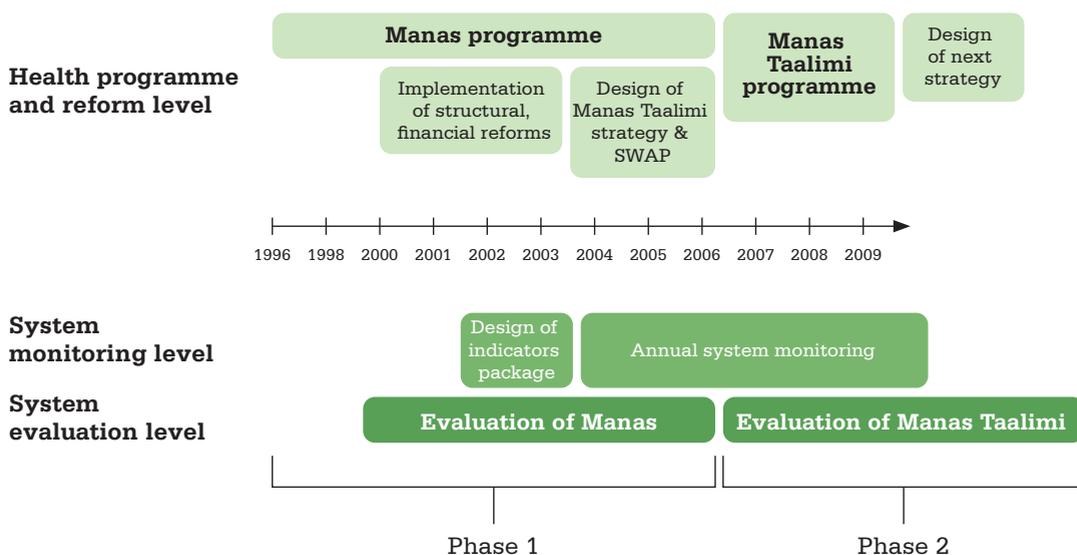
Health system monitoring in Kyrgyzstan is regular tracking by the Ministry of Health of health sector programme outputs (direct results from implementing programme activities), impacts (programme effects) and outcomes (programme results) by means of record-keeping and reporting on the basis of measurable characteristics (indicators).

Health system evaluation in Kyrgyzstan consists of two kinds of activities. First, evaluation takes the form of episodic research activities attributing particular health system outputs to specific policies or interventions. These evaluation studies usually focus on specific health programmes, such as health financing or primary care. Second, evaluation can take the form of episodic health system analysis studies examining specific policy questions, such as analysis of organizational forms of group practices in Kyrgyzstan or analysis of the medium-term financial stability of the state guaranteed package of health care benefits.

## Policy context, objectives and stakeholders

Health sector programmes have been the main catalyst behind health system monitoring and evaluation in Kyrgyzstan over the past 10 years. Two successive health sector programmes have been implemented with international donor support between 1995 and 2010: the Manas programme from 1995 to the end of 2005 and the Manas Taalimi programme from 2006 to 2010. The next health sector programme will start in 2011 (Fig. 6).

**Fig. 6. The main components of health system monitoring and evaluation in Kyrgyzstan**



Source: Jakab M (27).

Interest in health system monitoring and evaluation emerged during the first years of implementation of the Manas programme. One reason was that international donors started to request health system monitoring and evaluation in order to measure the impact of external funding and make decisions on future funding. The World Bank and the Government of Kyrgyzstan agreed to monitor and evaluate the first pilot test on the feasibility of introducing a mandatory health insurance scheme in Issyk-Kul Oblast, which was a prerequisite for additional funding to support extension of the scheme to two other pilot test areas (28). The decision to extend the scheme was eventually taken without a formal evaluation. A World Bank appraisal report, however, recommended a number of indicators to measure the effect of reforms in financing and service delivery. These included, for instance, inpatient admission figures, average length of stay, number of secondary referrals, number of outpatient visits, proportion of health sector resources allocated to primary care, number of beds and health care facilities

closed, number of family group practices formed and the percentage of the population enrolled in family group practices (27).

From 1995 onwards, and especially after 1997, WHO also supported the evaluation of the health financing reforms initiated in Issyk-Kul. Following the approval of the first Manas programme plan in 1996, periodic evaluations of the implementation of health reforms were undertaken by the Regional Office. These were qualitative reviews rather than formal assessments, however. Systematic and rigorous monitoring and evaluation began with a Department for International Development (DFID) health policy project in 2000.

The baseline monitoring and evaluation system was derived from the framework used to evaluate a World Bank project approved in 2000. With DFID support the project was extended to cover the whole health sector. In 2000 DFID funded the employment of a WHO resident policy adviser, who provided technical support and coordinated the efforts of the Kyrgyz policy analysis team and the international experts working together to extend the model of health sector monitoring and evaluation. *The world health report 2000 (2)* provided a conceptual framework by dividing the health system into functions, goals and measurable objectives. Box 7 summarizes the roles of the different stakeholders in promoting the development of the monitoring and evaluation system.

**Box 7. Roles of stakeholders in promoting the development of the monitoring and evaluation system in Kyrgyzstan**

- Donors requested evidence of the impact of international donor funds in order to make decisions about future levels and directions of funding.
- WHO provided coordination and leadership, conceptual models and technical expertise in health system monitoring and evaluation.
- Kyrgyz policy-makers articulated the need for in-depth studies and capacity-building for health system monitoring.
- Kyrgyz technical experts developed the infrastructure and capacity for health system evaluation.

The first full package of about 200 indicators was developed in 2002. Its goals were to measure progress toward the objectives and the framework of the Manas reform programme and to make this progress transparent to Kyrgyz policy-makers and donors. The package was built around the components of the World Bank project in an inclusive process that involved representatives from the Mandatory Health Insurance Fund, the Sanitary Epidemiological System, the National Health Promotion Center, the Republican Medical Information System, WHO and international donors. Selection of indicators was driven by the availability of data but also led to an agreement to undertake household surveys on health care expenditures, patient surveys on

informal payments and monitoring studies related to the quality of care and utility consumption of hospitals. Monitoring and evaluation became integral components of all subsequent health reform measures, including, for example, the pilot introduction of formal patient co-payments and outpatient drug benefits of insured populations.

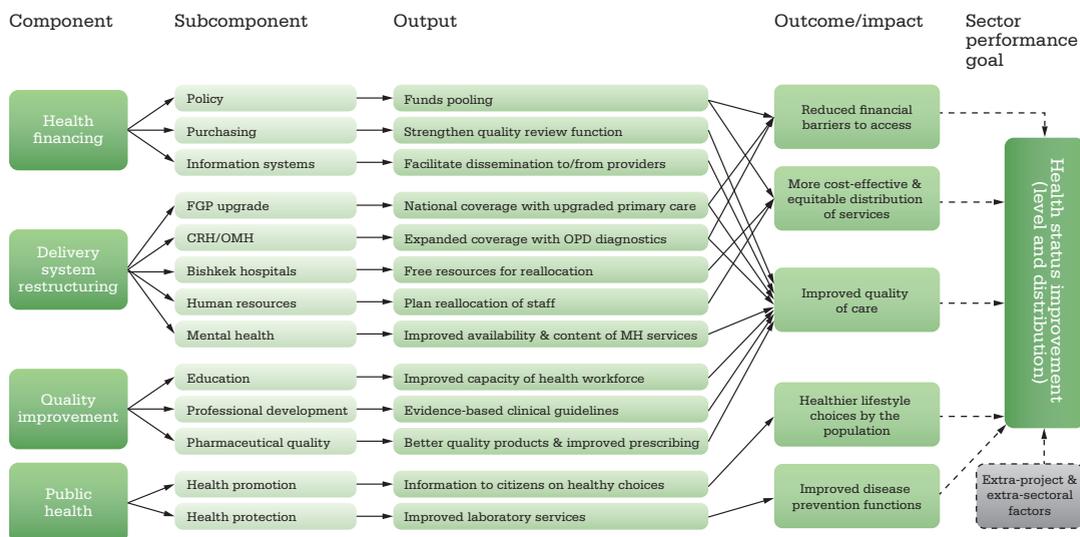
An important achievement in the Kyrgyz case was that all partners in the health sector reform programme agreed on a common monitoring and evaluation process. This now includes a more limited set of indicators, which has been used for the past two years.

### **Development of the HSPA framework and operational model**

The framework for monitoring and evaluation of health programmes in Kyrgyzstan was derived from the World Bank funded project. Health system functions were presented as programme components and then divided into subcomponents (see Fig. 7). Incorporating the HSPA framework presented in *The world health report 2000* effectively extended the World Bank project's framework from project evaluation to sector evaluation. The sector performance goals were derived explicitly from *The world health report 2000*, focusing on poverty and efficiency at the national level (2): improving the health status of the population; improving equity in health status across the population, especially for poor and disadvantaged groups; providing protection from excessive out-of-pocket health expenditures; improving the responsiveness of the health system (with measures reflecting both dimensions of responsiveness, respect for persons and client orientation); and improving the efficiency and long-term financial viability of the system. These broad system performance goals were linked to the project components and subcomponents by defining intermediate objectives, or outcomes (in World Bank terminology), associated with the goals and outputs of the subcomponents. Indicators for outcomes were identified, as were the methods for assessing the factors leading to each outcome (causality). Fig. 7 illustrates the framework as it relates to the performance goals of health status improvement (level and distributional equity). There are similar diagrams showing the links to financial protection and responsiveness.

While the WHO framework provided a coherent approach to health system goals that was acceptable to both the country and the donors, the indicators used in *The world health report 2000* (2) were composites that only related to each of the final health system goals. To adapt the framework to country level, two important steps were taken. One was to define intermediate objectives more closely related to the specific objectives of the Kyrgyz reforms. The other step was to develop a set of causal hypotheses between the reforms planned for introduction and the specific objectives of the Kyrgyz reforms. The latter reflected the evaluation component of the monitoring and evaluation framework, establishing a foundation for the evaluation studies undertaken to support the reforms. The operational model thus deployed both a set of indicators that were specific to the Kyrgyz health system and a series of evaluation studies that were designed to explain the causes of change and provide a basis for adapting the reforms over time.

**Fig. 7. Framework for health system and programme monitoring and evaluation in Kyrgyzstan, illustration of health status improvement**



Source: Kutzin J. (2002). (29).

The final operational model consists of three distinct strands of work which, taken together, result in a comprehensive and regular assessment of health system performance. The monitoring part of the process is built around a set of indicators agreed jointly between donors of the health sector programmes and Kyrgyz policy-makers. The indicators reflect the goals of the sector programme at the impact and outcome levels and are matched to the objectives of the health sector programme. The components of the health sector programme are reflected at the output, process and input levels (see Table 8).

The tripartite approach has achieved full alignment of the monitoring and evaluation framework with national health system reform priorities as well as broad consensus and alignment with the framework for policy-making.

At the same time, this approach gives rise to certain challenges. One weakness is that the monitoring and evaluation system reflects availability of data, which is concentrated in the areas where public investments have traditionally been strongest. Preventive care, for example, is skewed towards the prevention of communicable diseases in spite of the growing burden of noncommunicable diseases in the country. Unfortunately, data availability is limited in many areas amenable to health promotion as well as primary and secondary prevention. Another area with substantial data gaps is quality of care. The existing monitoring system includes selected

**Table 8. Sample indicators at programme impact, outcome and output level from the core indicator package 2009**

Impact indicator	Outcome indicator	Output indicator
Mortality from cardiovascular diseases in the age group 30–39	Quality of care: immunization coverage by the age of 2	Stewardship: number of research projects ordered by the Ministry of Health and used for policy decisions
Child health: under 5 infant mortality	Improved access and equity in access: % not seeking care when needed due to financial and geographical access reasons	Effectiveness of health promotion: quantity (%) of rayon centres and cities covered by health promotion programmes
Maternal mortality: maternal mortality rate	Increased efficiency: direct expenditure of patient care (drugs, medical supplies and food) as % of public expenditures on hospitals	Effectiveness in health protection: % of iron-fortified flour consumption of the first and superior quality
Tuberculosis mortality per 100 000 population	Improved transparency: % of inpatients who make formal payments to medical staff for drugs and medical supplies	Improved medical education: % of accredited family nurses per 10 000 population/their % of total quantity of specialists with secondary medical education

Source: *Kyrgyz Republic manas taalimi national health reform program indicator package 2009 (30)*.

indicators of health behaviour and quality of care but still tends to focus on “measurable” areas and not necessarily on the areas that require greater attention and investment.

### Implementation and impact

Since 2009, monitoring and evaluation have been separate but complementary processes implemented in different institutional settings: monitoring is carried out by the Ministry of Health, while evaluation is carried out by the HPAC. The review of progress takes place in the form of a “summit” with the main national and international partners in the health sector programmes.

The summit meetings take place twice a year. They aim to facilitate agreements on priorities and on directing (or redirecting) activities, to obtain approval for the annual workplans of activities and evaluations and to determine contributions from the different partners in programme implementation. It is also in the mandate of the summits to analyse the reasons for any lack of progress or failure to meet targets. The consequences for lack of progress and failure to meet targets involve collective self-reflection and discussion rather than imposition of penalties. It is important to avoid reverting to the culture of punishment that existed during the Soviet era.

The Department of Strategic Planning and Reform Implementation of the Ministry of Health is responsible for monitoring. It collects routine data by means of pre-existing information systems, mainly the Medical Information Center (RMIC), which collects health and health care

data from health care providers, and the Mandatory Health Insurance Fund, which collects health financing data. Household and patient surveys are carried out regularly, and these data feed into the health financing indicator components of the monitoring tool. Some disease-specific data are provided by specialist centres. International organizations and development agencies called for an integrated and independent information technology (IT) system in the health sector, based in the Mandatory Health Insurance Fund and the Ministry of Health. One obstacle to sustaining leadership support for monitoring is the high turnover of top-level ministerial staff. In addition, there is a need for further capacity-building and training among mid-level ministerial staff.

The unit in charge of evaluation went through three different phases of institutional development before becoming the HPAC in 2009. During these phases, the project was fairly well-staffed with 5–12 policy analysts and relatively low turnover. The unit first functioned as a WHO project with local WHO staff and a WHO resident policy adviser leading the team from 2001 onwards. To sustain system monitoring and evaluation, it was necessary to build up a well-staffed health policy analysis unit to take over monitoring and evaluation after the departure of WHO resident staff. Thus, after four years, system monitoring and evaluation moved towards greater institutionalization in the Kyrgyz health system by becoming part of the Center for Health System Development. This centre operated within the Ministry of Health but maintained a degree of autonomy. Nevertheless, this setting did not provide as much autonomy for the team as was deemed necessary. Consequently, the HPAC was established in 2009.

HPAC is a private not-for-profit organization, autonomous and separate from the Government, with a supervisory board comprised of representatives of the Ministry of Health and the health insurance fund in order to ensure firm links to policy. Making the evaluation function independent of government was intended to enhance the objectivity and timeliness of evaluation results. Since 2001 HPAC has produced 24 policy briefs, 68 research papers and a monitoring package. Its research focuses on the following areas: poverty and equity, health financing, public health sector efficiency, health service delivery, human resources and public health.

It is important to note that the HPAC's managerial and financial autonomy from the Ministry of Health allows it to use contingency funding to mobilize its staff quickly to respond to emerging policy analysis needs and to provide timely evidence for policy-making in a way that might be more difficult for public servants.

Implementing health system monitoring and evaluation in Kyrgyzstan in order to develop HSPA capacity and link policies to health system goals has been a national process, with relatively little involvement from external consultants. At the outset this made the process very time-consuming, but strengthening in-country capacity and self-reliance ultimately helped

institutionalize monitoring and evaluation in Kyrgyzstan to the extent that these functions may well become self-sustaining in the future.

There are numerous examples of monitoring and evaluation results being used in policy decisions. In 2000, for instance, survey data from households and health care providers revealed that most Kyrgyz households were spending a substantial proportion of their disposable income on informal out-of-pocket expenditures for health care. The Ministry of Health used this evidence to help convince the government, the President and the Parliament to support a comprehensive health finance reform. Furthermore, the collection in 2004 of baseline data on indicators such as the financial burden of utilizing health services and the extent of informal payments has made it possible to monitor progress in health finance reform over time. The reform measures included reducing the financial burden of health care, especially for the poorest subgroups; reducing the share of patients making informal payments; equalizing regional distribution of governmental expenditures; increasing funding for primary care; and improving access to primary and hospital care. The monitoring results were also used to explain to the public the rationale for the reforms as well as their rights and responsibilities under the reformed system.

One of the strategic conclusions of subsequent rounds of performance assessment was that general health system strengthening has led to improvements in financial protection, access and efficiency. On the other hand, HSPA's health outcome results in priority areas such as cardiovascular disease and maternal and child health have been disappointing. The new health sector programme therefore aims to tighten the link between health system strengthening and its impact on health outcomes by focusing on improving public health and individual services.

In summary, the monitoring and evaluation of health programmes has succeeded in achieving broad consensus and alignment with national health system development priorities. The model has also contributed to capacity-building for health system monitoring and evaluation and to the development of a culture of evidence-based policy-making. Box 8 summarizes the main success factors of monitoring and evaluation implementation in Kyrgyzstan.

### **The way forward**

Even though the government is committed to continuing health system monitoring and evaluation in the short term, the long-term sustainability of HSPA in Kyrgyzstan is in doubt due to recent political instability as well as diminishing resources. The Ministry of Health has allocated financial resources to health system monitoring and evaluation in its 2011 budget. It is unlikely, however, that future funding will be sufficient to sustain progress at the current rate, in light of the phasing out of DFID funding and the departure of the WHO resident policy adviser. International financial support is needed to sustain health system monitoring and evaluation at its present level, particularly the evaluation studies.

**Box 8. Key factors for success in monitoring and evaluation in Kyrgyzstan**

- The commitment of the Ministry of Health to build capacity and provide consistent and regular monitoring on agreed health and health system indicators
- Complementing monitoring activities with policy-targeted evaluation and analysis in an impartial, independent research environment that is flexible and responsive to changing needs
- A participatory approach to analysing reports and indicators by holding joint summits, addressing problems as they emerge and identifying areas for further in-depth research
- A collaborative and evidence-based approach to problem-solving that ensures accountability but avoids punishment for failure to meet targets
- Alignment of the monitoring and evaluation framework with the national health programme and thus with national health system priorities
- Dedication of all national and international stakeholders to a common model of monitoring and evaluation
- A gradual, stepwise process of institutionalization with regular analysis and assessment
- Consistency of membership in the working groups in charge of monitoring and evaluation
- A consistently high level of external funding
- High-quality, external technical assistance from resident experts including WHO
- Effective donor collaboration

**KEY LESSONS LEARNED**

- The Kyrgyz case illustrates a well-defined process of health system monitoring, complementary reviews and in-depth research studies that is explicitly linked to health programmes and therefore health system priorities.
- In a context involving external actors and sources of funding, it is important for one institution to take a leading role as coordinator and guide all partners toward a common understanding of the monitoring and evaluation process.
- It can be beneficial to separate health system monitoring from evaluation (both functionally and institutionally) in order to maximize institutional capacity, enhance flexibility, promote objectivity and ensure the timeliness of evaluation results for policy decision-making.

# HSPA IN PORTUGAL

## USING HSPA TO CONTRIBUTE TO A NEW NATIONAL HEALTH POLICY

### Introduction

In 2010, WHO and the Ministry of Health of Portugal jointly published two reports resulting from their collaboration between 2008 and 2010. The first report covers an external evaluation of the Portuguese National Health Plan (NHP) by WHO (see Box 9). The evaluation was undertaken between summer 2008 and summer 2010. The second report, the HSPA, carried out between winter 2009 and spring 2010, provides a holistic health system perspective and thereby complements the NHP evaluation, which is focused specifically on measuring performance in population health improvements. Both the HSPA and the NHP evaluation were led by WHO with inputs from Portuguese experts.

#### **Box 9. The Portuguese NHP 2004–2010**

The Portuguese NHP 2004–2010 sets out principles and strategies for individuals and institutions to contribute to improvements in health outcomes in Portugal from 2004 to 2010. The NHP's core strategic goal is linked to health gains, with an emphasis on health promotion, disease prevention and the integrated management of diseases. The NHP gives priority to four national health programmes (cardiovascular diseases, cancer, HIV/AIDS and mental health) and focuses on integrating the other 18 national health programmes by managing chronic diseases more efficiently and promoting health in specific settings such as schools, workplaces and prisons. The NHP is the responsibility of the Office of the High Commissioner for Health, which was created in 2005 within the Ministry of Health for the purpose of developing, implementing, monitoring and evaluating the NHP. An interministerial survey committee established in 2006 supervises implementation. The NHP has been presented and discussed in Parliament.

This case study is concerned with the linkages between the NHP evaluation and HSPA. In particular, it is devoted to illustrating how the HSPA is used to provide the evidence base for the development of the NHP 2011–2016.

### Policy context, objectives and stakeholders

The NHP evaluation and the HSPA are based on the biennial collaborative agreements of 2008–2009 and 2010–2011 between the WHO Regional Office for Europe and the Portuguese Ministry of Health. Both projects are related to health system performance. The evaluation of the NHP is a national planning instrument used in Portugal since 2004 and highlights the role of the NHP in health system performance. The Ministry of Health commissioned the evaluation as part of the monitoring and evaluation component of the NHP. At the Ministry's request, it

was conducted by WHO as an external evaluation. It also highlights the role of national health plans in health system performance.

The HSPA was conducted as a complementary project to the NHP evaluation. The HSPA followed endorsement of The Tallinn Charter on Health Systems: Health and Wealth in 2008, in which the 53 Member States of the WHO Regional Office for Europe committed to improving transparency and accountability for measurable health system performance. The HSPA is a first step towards implementing the Tallinn Charter in Portugal. Thus, both the NHP evaluation and the HSPA support the efforts by the Ministry of Health to improve the performance of the Portuguese health system. They also provided data that was used as an evidence base for analysing policy options for the NHP 2011–2016.

The main objectives of the HSPA were to increase the accountability of the health system to its different constituents and to support decision-making by bringing forth evidence on the strengths and weaknesses of the health system. There were also implicit, secondary objectives, such as fostering ministerial dialogue on the strengths and weaknesses of the system. One of the most important objectives for the Office of the High Commissioner of Health was to contribute to the evidence base for developing the new NHP for 2011–2016.

The HSPA builds on a long-standing culture of health status and health programme monitoring. Policy evaluation and evaluation of selected aspects of health system performance, on the other hand, have traditionally been undertaken by the research community.

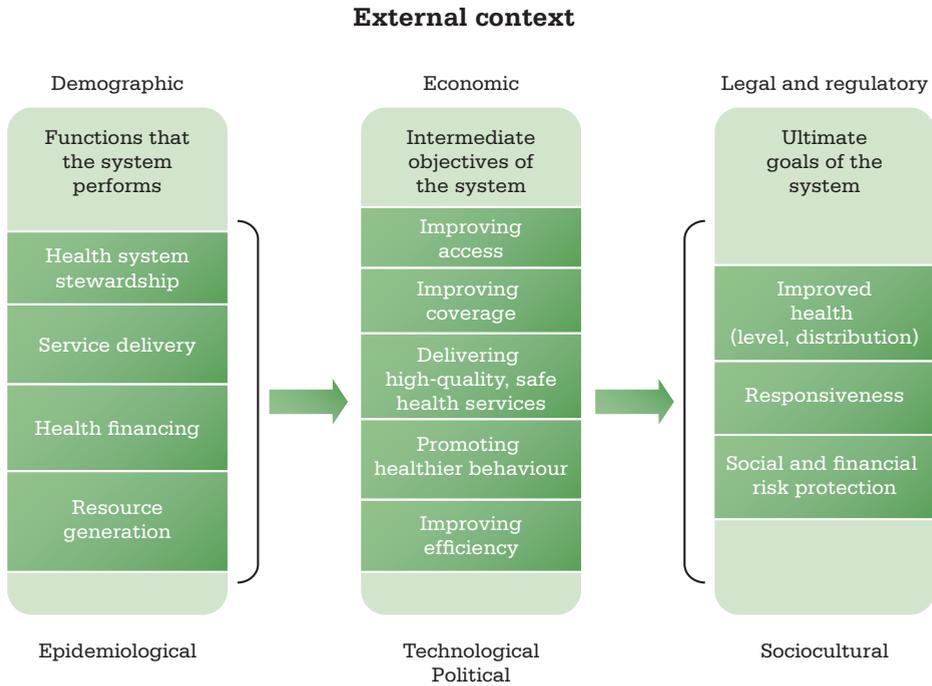
### **HSPA framework and operational model**

The HSPA framework used in Portugal is based on the WHO framework of health system functions, goals and objectives. The WHO framework delineates four health system functions (stewardship, financing, service delivery and resource generation) that contribute to the ultimate goals of the system (improved health in level and distribution, responsiveness, social and financial risk protection). The objectives of the system, in the case of Portugal, are tailored to the objectives laid out in the NHP.

The HSPA was driven by a set of core policy questions on performance in relation to health system goals and their determinants. The assessment was based on a functional analysis using the set of selected indicators to make comparisons of performance over time as well as across the five regions of the country and across socioeconomic levels. Performance at the national level was also compared with other countries and international standards.

The HSPA report presents results in four main sections corresponding to different components of the health system performance framework presented in Fig. 8: achieving better health for the Portuguese population (improved health and distribution of health; health literacy and risk

**Fig. 8. Framework for assessment of the performance of the Portuguese health system**



Source: Portugal health system performance assessment (30).

factors; and impact of broader health determinants); ensuring confidence and satisfaction in high-quality, accessible health services (health system responsiveness; access; quality and safety; and health care outcomes); ensuring social solidarity (social and financial protection; coverage; and inequalities in access to health care services); and health system sustainability and efficiency (health system expenditures; human resources; innovation and health technology; and health system effectiveness and efficiency). Finally, each section closes with a summary of the current situation and assessment, together with recommendations for policies to address weaknesses in performance and to strengthen the health system.

Feedback on the HSPA framework was collected during and after the process and considered in light of the development of the new NHP. Most of the feedback from experts and policy-makers favored the development a more country-specific framework reflecting the values, priorities and regulatory conditions particular to Portugal, in addition to international system performance dimensions.

The operational model was composed of a core set of indicators. The selection of indicators for the operational framework was a milestone in the Portuguese HSPA. Indicators were chosen by an expert panel using a number of criteria, including relevance to health system performance in Portugal and the availability and reliability of data. A key debate during the panel discussion focused on how to measure performance dimensions in sectors other than the health sector. The selection of indicators was particularly difficult for the broader determinants of health such as environmental factors. Another problematic area was quality of care, partly due to lack of data.

### **Implementation, impact and the way forward**

The HSPA was implemented using a combination of quantitative and qualitative methods and was led by a small WHO team. A milestone in implementing HSPA was the organization of a national expert panel that discussed both the framework and the core set of indicators in February 2009. Quantitative data were collected and calculated by various national institutions including the National Statistical Institute, the Central Administration of the Ministry of Health, the Directorate General of the Ministry of Health and the National Institute for Pharmaceuticals. Data collection and analysis built on excellent capacity and experience within the Office of the High Commissioner for Health.

The main qualitative instrument was a functional review of the Portuguese health system by expert missions between October 2008 and May 2009. This review examined information related to stewardship, information management and decentralization; service delivery; and financing and resource generation. It involved numerous interviews with policy-makers, service providers and health system stakeholders, including interest groups at national, regional and local levels. The experts also visited health care facilities in both public and private sectors and analysed policy papers that had been identified in a literature review.

In January 2011 the HSPA report was launched at a press conference and was posted on the web site of the Office of the High Commissioner of Health in January 2011 (31). It is widely acknowledged that the HSPA helped authorities to prepare the NHP 2011–2016. In particular, it created momentum and motivated some of the most important experts and policy-makers in Portugal to engage in the development of the new NHP. It also helped to clarify system goals in light of the objectives for the new NHP. The HSPA introduced a health system perspective and highlighted the limitations of the health system. Indeed, the new NHP follows the health system approach and uses the terminology introduced in the HSPA (Box 10).

No decision has yet been made concerning the future institutionalization of HSPA. In view of the economic constraints facing Portugal in the context of its current financial crisis and long-term commitment to reducing the national debt, it is likely that HSPA will have to find its niche within a well-established institutional setting. HSPA could become an integral part of the regular evaluation of the NHP, for instance.

### **Box 10. Key features of HSPA in Portugal**

- HSPA was undertaken alongside the evaluation of the NHP.
- The coordinators of the NHP were also involved in the HSPA.
- HSPA provided a technical framework within which to consider new priorities for the next NHP 2011–2016.
- HSPA was implemented through a participatory process involving a variety of stakeholders representing the Ministry of Health and other ministries, the Central Health Administration, the regional health authorities, key national health institutions such as the National Institute of Health, the research community, professional bodies and associations and consumers. All participants were encouraged to comment on the HSPA framework and reflect on their role in health system performance.
- Through interviews and consultation with the interministerial survey committee of the NHP, the HSPA created an opportunity for dialogue on the health sector's performance, within the boundaries of the health sector and beyond them.
- The conceptual and operational frameworks for HSPA were developed by a national panel of technical experts.
- Data analysis was facilitated by the excellent capacity for data interpretation in the Office of the High Commissioner for Health.
- Portugal benefited from international expertise in HSPA, including experts from WHO and selected countries such as Canada, Finland and England.
- The HSPA report is concise, and its main messages are expressed clearly and simply.

## **KEY LESSONS LEARNED**

- HSPA should include perspectives on performance at different levels of the health system, including regional and local levels. HSPA participants should reflect carefully on the most effective way to include all levels.
- While international expertise is valuable, it is essential that the HSPA recognizes the specific cultural underpinnings of the country's health system, takes into account political sensitivities and builds upon the national literature that is available.
- HSPA in Portugal has complemented and supported national health planning instruments in priority-setting as well as monitoring and evaluation. Nevertheless, HSPA would be more effective if it had stronger links with other, ongoing analytical and reporting processes like Health System in Transition profiles, national observation reports on the health system, OECD reviews and policy evaluations.

# HSPA IN TURKEY

## MEETING OBJECTIVES THROUGH EXCELLENT PARTICIPATION INSIDE AND OUTSIDE THE HEALTH SECTOR

### Introduction

The work on HSPA was initiated in 2009 by the Minister of Health of Turkey and carried out as a collaborative project of the ministry, led by the School of Public Health (TUSAK), along with technical and financial experts from the World Bank and the WHO Regional Office for Europe. The HSPA has benefited from consistent support at the highest political and technical levels from the beginning of the project. It has been designed in a participatory way involving numerous actors at the Ministry of Health and external stakeholders, including the Social Security Institute, the Ministry of Education, the Ministry of Environment, the Ministry of Finance and the State Planning Organization. The two main objectives of HSPA in Turkey were to document progress on selected health outcomes of the Health Transformation Program (see Box 11), funded by the World Bank, and to provide an evaluation scheme for the next Strategic Plan of the Ministry of Health.

### Policy context and objectives

The development of comprehensive national health strategies and policies evolved gradually in Turkey. The Health Plan Master Plan was launched by the State Planning Organization and the Ministry of Health in 1990, paving the way for health reforms in Turkey. In 1993, the Ministry developed a National Health Policy that focused on environmental health, promoting healthier lifestyles, improving health service delivery and identifying health priorities. Following general elections in 2002, the government developed an action plan to be implemented in phase one of the Health Transformation Program (HTP), which focused on restructuring the Ministry of Health and improving health care services. The second phase of the HTP was initiated in 2009. Tracking the progress of key health outcomes, outputs and resources under the HTP is critical for its ongoing success. It is also important to document and share this progress with the international community.

The HSPA was initiated in order to uphold Turkey's commitment, embodied in the Tallinn Charter, to strengthen capacity for regular monitoring and reporting on performance and to promote transparency and accountability by measurable results. In addition, HSPA is seen as a tool to support the development of evidence-based policies. It will also inform the identification of new priority areas for health system improvement.

The Ministry of Health has identified further progress in capacity-building in monitoring and evaluation as a critical need for the successful implementation of the second phase of the HTP. The ministry developed a Strategic Plan for 2010–2014 and is moving towards

### **Box 11. The Health Transformation Program of Turkey**

The Health Transformation Program, a health system reform programme funded by the World Bank, has been in place since 2003 and consists of two phases (2003–2009 and 2010–2013). The programme focuses on human resources, restructuring the Ministry of Health and encouraging evidence-based policy-making. It targets the senior and middle-level management staff of the ministry.

The Health Transformation Program promotes health system reform in eight areas: improving the supervisory and planning capacities of the Ministry of Health; achieving universal health insurance coverage; providing accessible and friendly health care services (especially in family medicine, primary health care, chains of referral and autonomous health care facilities); motivating the health sector labour force; strengthening education and scientific institutions; providing accreditation for high-quality and effective health care services; promoting rational management of drugs and materials; and improving access to information for the decision-making process by means of a Health Information System. Three new elements were added in 2008: the Health Promotion for a Better Future and Healthy Life programme; multidimensional responsibility for mobilizing the concerned parties and intersectoral collaboration; and cross-border health services to increase Turkey's standing in the international health arena.

performance-based budgeting. This effort is part of the ongoing reform of the public sector in Turkey, a process that requires all sectors, including the health sector, to establish five-year and annual strategic plans and budgets. In such a context, it is critical to develop a culture of performance monitoring and evaluation.

The HSPA framework for Turkey was based on the goals and priorities of the HTP and the Strategic Plan of the Ministry of Health. It translates these goals and priorities into measurable health sector objectives and organizes them along a causal diagram (or strategy map) encompassing resources, services, outputs and impact on health determinants and health status. The HSPA is thus positioned to become part of the ongoing monitoring and evaluation processes of the HTP and the next Strategic Plan of the Ministry of Health. Furthermore, HSPA will be complemented by in-depth evaluations of specific reform components for a better understanding of how and to what degree those policies have had an impact.

### **Institutional arrangements, participants and stakeholders in the HSPA process**

The work on HSPA was initiated in June 2009 as a joint collaborative project involving the Ministry of Health of Turkey, the School of Public Health, the World Bank and the WHO Regional Office for Europe with the explicit objective of measuring the achievements of the HTP on health outcomes. The technical lead was delegated by the Ministry of Health to TUSAK, which undertakes national and international coordination of public health work on behalf of the Ministry of Health. It is part of the Ministry of Health with some degree of autonomy in formulating technical opinions. A core working group of six staff members from the Ministry of Health was established under the leadership of TUSAK. Of those six, one was hired by TUSAK specifically for the HSPA. Resident staff and temporary consultants from the World Bank and WHO as well as independent national and international consultants contributed to capacity-building in TUSAK and served as external reviewers.

The HSPA process is highly participatory and decentralized. It involved numerous actors inside and outside the Ministry of Health through consultations at every stage. Stakeholders inside and outside the health sector were involved from the very beginning in building a consensus on the performance framework and indicators and in facilitating data collection from various sources. The process consisted of stakeholder meetings (about 60 participants), high-level meetings at the ministry (about 20 participants including the minister and undersecretaries) and continuous dialogue and collaboration between experts from the relevant technical programmes and the TUSAK team. Ministry experts on cancer control, performance management and quality improvement, maternal and child health and family planning, pharmaceuticals and pharmacies, human resources for health, tuberculosis and malaria control, strategy development, curative services, information technology, project management and primary care regularly collaborated with experts from the Social Security Institute and TUSAK. Other sectors were also well-represented: the Ministry of Finance, the Ministry of Environment and Forestry, the Turkish Statistical Institute, the Higher Education Council, the Ministry of National Education and the State Planning Organization. Final decisions on the strategy map, indicator selection and scoring were made by consensus at high-level meetings. The World Bank and WHO staff from the country office and the Regional Office for Europe provided additional technical support.

### Development of the HSPA framework and operational model

A strategy map for the Turkish health system was shaped by the identification of the dimensions and subdimension of performance. This framework maps the health system goals in relation to the reform strategies and the core functions of the health system. It was based on the Ministry of Health Strategic Plan for 2010–2014 (Box 12) and the two phases of the HTP (HTP-I and HTP-II), and it was further validated through a series of stakeholder workshops or consensus-building meetings.

The ultimate goal of the Turkish health system as defined in the Ministry of Health Strategic Plan 2010–2014 is that all citizens enjoy a healthy and wealthy life. Improving health outcomes in the service of this goal is to be achieved through three intermediate objectives: healthy

#### **Box 12. The Strategic Plan of the Ministry of Health**

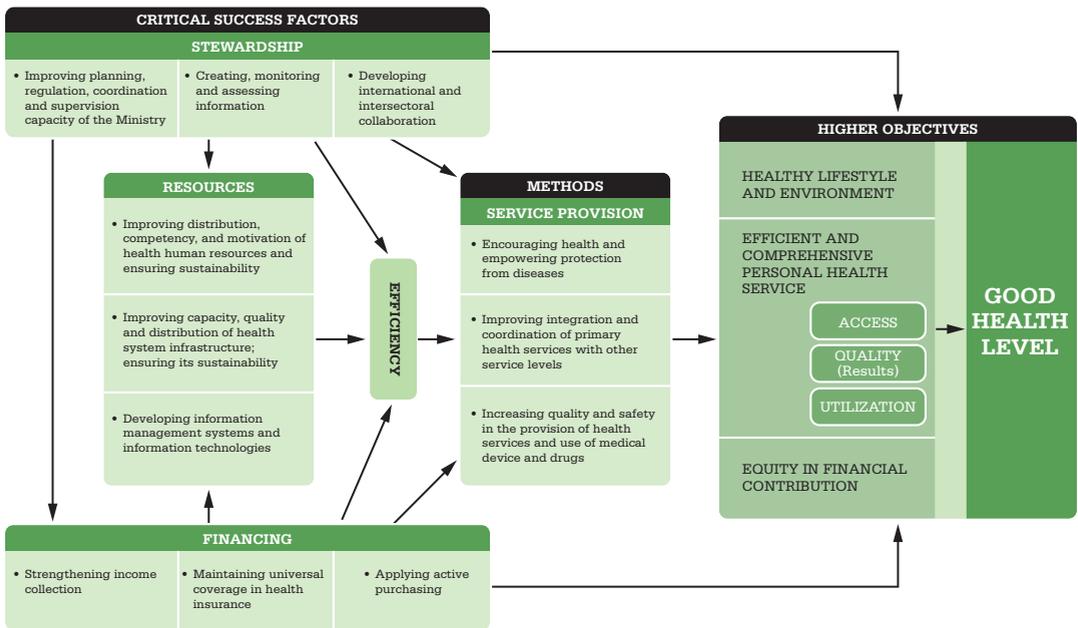
Strategic planning is a mandatory policy instrument for all sectors in Turkey; each strategic plan covers a five-year period and serves as the basis for developing the annual operational plans for the sector. The Ministry of Health Strategic Plan for 2010–2014 addresses a number of priorities, such as increasing the number of facilities serving disadvantaged groups, improving the rights of individuals to select their primary care providers and encouraging individuals to make informed lifestyle choices regarding alcohol and tobacco use. The Strategic Plan also contains elements of performance-based budgeting. The monitoring and evaluation scheme designed for the Strategic Plan 2010–2014 was adapted for use in the HSPA, which was being developed at the same time. The Strategy Development Department of the Ministry of Health monitors progress towards Strategic Plan goals and targets.

environment and lifestyle, efficient and comprehensive health care services and fairness in financial contribution. The strategic map (Fig.9) relates these strategies to each health system function described in *The world health report 2000 (2)*: service provision, resource generation, financing and governance. The operational model consists of a set of indicators matched to each dimension of the strategic map (goals, objectives, strategies and functions). The coverage of data collection for some indicators reflects a minimum 10-year time period for documentation of progress during the implementation of the HTP.

It proved useful to have the HTP and the draft Ministry of Health Strategic Plan guiding the development of the HSPA framework. In fact, the strategy map was included in the final version of the Strategic Plan to highlight how the different elements of the Strategic Plan converge to support better health outcomes. The strategy map was considered by the minister to be an important tool to align the perspectives of the various ministry departments and to build a common vision for better health and more equitable health care for the Turkish population.

The comprehensiveness of the performance framework presented a challenge for indicator selection. On the one hand, because of the large number of dimensions and subdimensions, it

**Fig. 9. Strategic map of the HSPA in Turkey**



Source: Turkey health system performance assessment (32).

was difficult to arrive at a manageable number of indicators. On the other hand, data was lacking for certain dimensions; so the availability of data inevitably influenced the choice of indicators. The set of performance indicators will evolve as data gaps are identified and remedied.

### **Implementation of HSPA and the way forward**

The HSPA process began in July 2009, and the strategy map defining the goals, priorities and intermediate objectives of the health system was developed between August and December 2009. The strategy map was reviewed in a series of consensus-seeking workshops with national stakeholders in September, November and December 2009. The final version of the strategic map was approved during a workshop in January 2010. Indicators were inventoried, identified and revised from August to December 2009. The 282 initial indicators were drawn from the Strategic Plan of the Ministry of Health and from international health performance indicators. The list was gradually reduced to 62 indicators, on the basis of availability, reliability and validity of the data underlying the indicators. Another key consideration was whether the available data were likely to contribute to meaningful policy recommendations for improving health outcomes over time. The HSPA team developed indicator “passports,” which are fact sheets describing, for each indicator, the nominator and denominator, data collection methods, data issues, data interpretation and presentation of findings.

The comprehensiveness of the performance framework required data from multiple sources, which presented several challenges. First, it is difficult to make valid comparisons when timelines, definitions and calculation methods differ from source to source. In addition, experience in other countries shows that stakeholders may be reluctant to share their data. This potential stumbling block was addressed in the Turkish case by involving all data “owners” in the HSPA process to create an atmosphere of mutual trust and common purpose. Hence, the whole process was highly decentralized, empowering all stakeholders to participate in indicator selection and definition, data analysis, sharing of additional analytical material and identification of relevant policy actions. The operational definitions and fact sheets, for instance, were developed by the relevant agencies with the support of TUSAK. In this context it was necessary to devote ample time to discussing the data shortfalls and finding solutions. This inclusive approach to problem-solving significantly prolonged the HSPA process but also gave rise to the identification of opportunities for improving information systems.

A series of high-level meetings in April and May 2010 focused on data collection, availability of data, and quality of the selected health performance indicators. The collection of data and calculation of values for the indicators took place between March and June 2010.

The careful selection of stakeholders and definition of their roles has worked fairly well, although the involvement of international consultants located abroad has, at times, created challenges

for the continuity of the process. The HSPA team hopes to engage more national actors, such as universities, in the future.

With the HSPA report set to be finalized in 2011, the Ministry of Health was planning to carry out HSPA on a regular basis in the future. Consideration must be given to sustaining the involvement of national actors at its present high level, given their heavy workload and the competing demands on their time. In this regard it would be helpful to streamline and standardize some of the activities in the process.

General elections were held in June 2011. The initial stages and the different drafting stages were not affected by political considerations, even though reporting on the final HSPA coincided with the election period. It is to be hoped that post-electoral political dynamics will accelerate the uptake and utilization of HSPA results by policy-makers (see Box 13).

#### **Box 13. Key factors for success of the HSPA in Turkey**

- Continuous and ongoing political support at the highest levels, including personal involvement of the Minister of Health
- Engagement of the high-level technical experts from the health sector and beyond
- Leadership of the School of Public Health (TUSAK), which has strong connections to the health ministry, and a well-defined national health reform programme and Strategic Plan of the Ministry of Health, both of which guided the development of the HSPA strategic map
- Development of well-defined objectives for the HSPA
- A broad participatory approach involving actors inside and outside the health sector, leading to a strong sense of ownership of the HSPA process and final product
- Commitment of all stakeholders involved in the identification and selection of performance indicators to spend ample time on finding solutions for problems in data availability and access to available data
- No bottlenecks in financing HSPA

## **KEY LESSONS LEARNED**

- High-level political commitment and support have been essential in launching the HSPA in Turkey.
- The relationship between the HPSA and the national health policy developmental cycle needs to be strengthened. Having a national health reform programme and strategic plan in place facilitates the HSPA as it can use the agreed-upon priorities. If a strategic plan is not yet in place, it is important to align the two processes (HSPA and strategic planning) to ensure development of common priorities, goals and objectives.

- HSPA should not be regarded as a separate policy instrument but as a supplement to existing monitoring and evaluation approaches.
- A broad, participatory process will help ensure acceptance and ownership of HSPA. The Steering Committee might be an option, especially to get stakeholders to contribute rapidly or ad hoc as needs emerge, but it is important to report periodically to them on progress.
- Stability in the membership of the team is important for enhancing the continuity of the process.
- Cooperation with international organizations and consultants provides external technical expertise and maximizes transparency and reliability. HSPA is an excellent instrument for working in partnership with different national and international entities.
- Consideration should be given to sustaining the involvement of national actors, who have a heavy workload due to their regular duties outside the HSPA process. It would be beneficial to streamline the HSPA process, where feasible.
- The different stages of the process require further standardization. The national team should still be able to undertake HSPA, even if international experts are not available. This would require further capacity-building and training.
- HSPA in Turkey has achieved significant results that justify the sizeable investment of time resources.

# CONCLUSIONS

HSPA is at an early stage of development in many countries, but the body of international experience is growing. This series of case studies on Armenia, Belgium, England, Estonia, Kyrgyzstan, Portugal and Turkey illustrates a wide range of options for undertaking and utilizing HSPA as a health system governance tool. The case studies provide insight into effective strategies for different contexts as well as the weaknesses in methodology and application of HSPA in the countries of the WHO European Region. There is no “one-size-fits-all” approach to recommend to those countries that have not yet embarked upon HSPA. The purpose of this report, however, is to present the main challenges involved in using HSPA along with the various solutions implemented by these seven countries. For all their differences, the case studies illustrate a number of common themes, which are described below.

**HSPA is a process that matters.** The seven case studies show that there are different approaches to HSPA – internal versus external, centralized versus participatory and summative versus formative, to name a few. Irrespective of the approach, however, the HSPA process consistently yields results – sometimes unexpected results – such as fostering dialogue, increasing engagement, mobilizing other sectors, identifying data gaps, revealing conflicting health system values or objectives, building consensus on system priorities or simply promoting a culture of striving for better performance. These are valuable outcomes in their own right, whether or not the HSPA findings ultimately have an impact on policy decisions. In this sense, the process matters as much as the product.

**It is critical, though difficult, to set realistic objectives for the HSPA process.** The case studies show that initial HSPA objectives (such as increased transparency and accountability or creating an evidence base to inform policy) tend to be overly ambitious. Countries embarking upon their first HSPA would be well-advised to experiment with HSPA, gradually building up a set of indicators within the performance framework and adapting it as information systems improve in quality and coverage and the analytical capacity to use those indicators develops. A comprehensive framework with a solid indicator base can be complemented by a more flexible set of indicators and in-depth evaluation studies in order to tailor HSPA to the changing needs of a fluid policy environment, in which economic trends or changes of government can influence policy priorities.

**HSPA can build synergies with monitoring, evaluation and review of existing reform programmes and national health policies.** Countries with a national health policy and/or a health sector reform programme have benefited from using HSPA in different ways. In some countries, HSPA was proposed as a complementary tool with a wider scope, linking

strategies to health system outcomes, while the focus of the national health plan was limited to health outcomes for a specific subgroup of the population or to high-priority diseases. In other countries, the HSPA framework provided a solid base to extract and provide a structure for core indicators used in monitoring and evaluation. More generally, HSPA has been a useful tool for modifying existing frameworks, defining the scope for future reform or strategy priorities, introducing health system terminology, adjusting monitoring and evaluation frameworks to new dimensions and simply bringing together different stakeholders to exchange views on future directions to improve health system performance.

**It is important to strike a balance between independence and access to policy-makers.** There are various approaches to the institutionalization of HSPA. An institutional setting within the ministry of health provides the opportunity to develop synergies with existing policy processes such as collection, interpretation and use of data. Moreover, there will be a strong sense of HSPA ownership within the government. An independent institution with connections to the ministry has the advantage of some independence along with a degree of access to policy-makers. Finally, an institution that is entirely independent from the ministry might be appropriate for situations when an external evaluation is sought and independence of the evaluator is paramount – for instance, if the primary objectives are accountability and transparency.

**HSPA requires the enthusiasm and commitment of individuals and governments, in addition to financial and material resources.** The time and resources – financial, material and human – needed for HSPA should not be underestimated. In addition, enthusiasm and stability in the membership of the working group are important factors, as is governmental commitment. Taken together, these investments in the process can create a culture of health system excellence, capacity-building and striving for improved performance, which will help sustain HSPA in the long run.

**HSPA provides an opportunity to identify and address existing data gaps.** HSPA can help improve health system information by identifying data gaps, which is the first step towards addressing issues of data quality and availability. The seven case studies illustrate different levels of data quality and availability, but overall there is a shortage of data on risk factors, behavioural patterns and health inequalities by gender, income and educational level. HSPA has brought to the forefront a number of issues regarding fragmentation of databases and has highlighted the opportunities that arise when data from different sources are brought together.

**HSPA could foster understanding of health system performance at local and regional levels.** A national HSPA is first and foremost a national project with national objectives. Nevertheless, for successful implementation of the process and utilization of the results, local and regional authorities must also understand and accept HSPA. In future the European HSPA

movement should strive to develop assessments that better reflect performance at the local and regional levels.

**Sharing international experiences is crucial for HSPA.** International exchange assists countries in identifying options for HSPA application and generating insights into the pathways by which HSPA can improve health systems. Focusing exclusively on international frameworks and applications, however, can hinder the development of country-specific approaches. It is hoped that the community of countries using HSPA will grow and that sharing HSPA experiences will be an ongoing, evolving process.

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# ANNEX I. INTERVIEW OUTLINE

*The following outline describes the full spectrum of questions that might be posed to the key informant of each of the HSPA exercises. Each country case will have one principal informant and up to 5 key informants representing different aspects of the HSPA. The principal informant will be asked to advise on who should be the other key informants. He/she will also be asked to advice on which sets of questions should be posed to each informant depending on the different role of the informants in the HSPA.*

## **Part 1. Introduction – key facts– (½ page)**

- Could you briefly describe the main elements of HSPA in your country? What are the distinctive features? What is the focus of the assessment? How would you define “your” HSPA?
- How many HSPA reports were produced? How regularly?

## **Part 2. Policy context, objectives and stakeholders (2 pages):**

- What was your role in the HSPA?
- Who initiated the HSPA?
- Questions related to policy context and scope:
  - How is HSPA related to other leadership and governance instruments (e.g. national health policy development, monitoring and evaluation, health technology assessment, policy briefs development, etc.)? Is HSPA part of a coordinated approach to generate evidence and use it for policy-making? In your country, who is responsible for those activities?
  - In your country, is there a tradition/culture/interest in health and health systems monitoring and evaluation? How do you think the HSPA exercise is contributing/has contributed to a culture of evaluation?
  - Was there an explicit or implicit link between the HSPA and national health policy development? (Follow up: does [country X] have a comprehensive national health strategy? From when until when? Was HSPA used at the beginning to inform or at the end to evaluate or non-related?) Do you think this link should have been strengthened? Why yes/no?

- Was there an explicit or implicit correspondence with the electoral cycle? Do you think it might have been a driver for pushing/slowing report development? In this context, how can/should the objectivity of the results be guaranteed?
- What was the scope of the assessment (health care, system, population health)? On what basis was this decided and by whom? Was there a consensus on the desirable scope?
- **Questions related to aims and objectives:**
  - What did you want to achieve with the HSPA at the outset (if the interviewee is not the person responsible for the HSPA: what do you think the promoters of the HSPA aimed to achieve at the outset)?
  - Follow up question on the motives: was [the problem that the HSPA aimed to address] really a problem?
  - Were the objectives of the HSPA made explicit (during the working procedure as well as in the HSPA document)?
  - Do you think that the scope of the HSPA was appropriate to the objectives?
  - Were there specific policy questions that were hypothesized at the beginning of the HSPA process? Did those change? Will those changes in the next iteration of the HSPA report? Is there a process to regularly adapt them?
  - Did the objectives of the HSPA change over time? (Considering both institutional and personal objectives).
- **Questions on roles of stakeholders:**
  - What institution is/was responsible for monitoring/evaluating your health system? Who would be the main actors in this field? Are there any groups that oppose health systems monitoring and evaluation?
  - Was the HSPA sponsored? If yes, by whom?
  - Who were the different actors involved for the different stages of the HSPA process (e.g. promoter/initiator/implementer/expert panels/advisory board)?

- With the benefit of hindsight, do you believe that the right people were asked to take on the right roles? Could the HSPA have been more successful if different actors had been involved in different functions?
- How was the initiative perceived? Did any particular actors or stakeholder groups resist the initiative? Who was particularly supportive and positive?

### Part 3. Development of HSPA operational model

- What framework/operational model was used to design the HSPA? Were any HSPA models from other countries used as a source of inspiration? If yes, were any adaptations made? If yes, what specifically and what was the rationale for this choice?
- In your opinion, what were the strengths and the weaknesses of the framework? If you were to repeat, would you have used the same framework? Would you have added/deleted dimensions or used another structure to organize the dimensions?
- Were there any innovative features? If yes, what generated these specificities in your country?
- How was ownership of the framework ensured? Who developed or amended the framework? How participatory was the process? Do you think the “final product” was truly shared ownership among the stakeholders?
- Is it generally accepted now as an “organizing structure” outside the strict frame of HSPA process? If yes, what do you think were the reasons for this success?
- How was ownership of the choice of indicators ensured?
- How comprehensive is the framework? Does it cover all of the health system performance dimensions? In your opinion, are some over- or under-represented? Does this result from an explicit choice to reflect strategic priorities?
- How does your framework relate to higher/sub-system evaluation frameworks? For instance, do you have national, regional, local evaluation frameworks? Do you have programmatic evaluation frameworks? Do you have a specific framework for public health? Were there any mechanisms in place to assure coherence between those different levels?

## Part 4. Analysis of implementation – Processes and outputs

- **HSPA process:**
  - How many HSPA reports have been produced?
  - Can you shortly describe the process from initiation to the finalization of the HSPA? How long did it take from the initial idea to the finalization of the HSPA report? What were your implementation milestones (e.g. review meetings, launches etc.?)
  - In your opinion, is HSPA currently in your country a process or a project? In other words, is it a continuous process with regular reports/studies? Or is this an ad-hoc project (with just one or two reports). If continuous, how do you maintain the momentum? If ad-hoc, are there plan to make it more sustainable? Do you think it would be advisable?
  - Do you think it is important that the group of people responsible for managing/leading the HSPA process is within the MOH or is independent from the MOH, in your case? Why so? When deciding who would manage the HSPA process, what were the capacities available in what center/organisms, inside or outside the MOH? How did this available capacity intervene in the selection of the group of people/organism responsible for HSPA?
  - With the benefit of hindsight, do you think there were adequate and sufficient resources (both human and financial) invested into the HSPA for it to achieve its objectives?
  - What factors facilitated the implementation? What factors hindered the implementation? Was there any major event that changed the course of the HSPA implementation? Is/was the HSPA implemented as it was planned to be or did things change? And if yes, why?
  - Who has/had the possibility to comment during the process? How participatory was the process? Do you think it should have been more/less? Why? How centralized was it? Did it facilitate the implementation? Or on the contrary, did the decentralization facilitate the shared ownership (for instance)? How independent was it?
- **Data collection:**
  - Who collected the data? Was this externally driven? Who analyzed the data?
  - Did you have data from different sources? Is there a culture of data sharing or data brokering? What were the main difficulties to gather the data from different databases?

- Were any data gaps identified? Were some relevant indicators dropped because the data were not available or were not reliable? Was any ad-hoc data collection made to fill in those gaps? Were any sustainable changes to information system made in the process of data gathering?
- Are the data sufficient to understand inequities? Is it possible to disaggregate data by special groups? Have you identified gaps in data through the HSPA?
- Was the burden of data collection acceptable? What was the existing capacity for data collection and analysis that the HSPA could rely on?
- **Measures of dissemination:**
  - How was the HSPA project advertised? Was it officially launched? Was there any interest on behalf of the media? Was there political interest? Was it reported and discussed in Parliament? Discussed with patient representatives? Do you know whether it was quoted or referred to e.g. by scientists? Professional councils/societies? Politicians? Policy makers?
- **Measures of impact:**
  - Was it perceived to be a legitimate exercise, e.g. did key decision makers recognize the results of the HSPA and make decisions that were compatible with these results?
  - How was the HSPA used? What changes resulted from the HSPA (e.g. change of strategy, new national health plan, new institutions created, new programs initiated...etc.)? Can you think of any concrete mechanisms through which it achieved an impact (e.g. more evidence, better data, better data management, more capacity, trigger for inter-sectoral dialogue)?
  - With the benefit of hindsight, do you think that HSPA was an effective means of [remedying the problem], or could other initiatives/approaches have been more effective ways of addressing the problem? If so, which other initiatives?
  - Looking back at the initial objectives of the HSPA, did it achieve these objectives?
  - Did the HSPA have any unforeseen impacts?

## Part 5. The way forward – Institutionalization and sustainability

- Is there any institutional arrangement for a regular HSPA process?
- What are the perspectives on the sustainability of the process? Has the mandate to conduct future HSPAs been enshrined in any law or regulative?
- Is the HSPA anticipated as an ongoing process? Are there any institutional arrangements and resources set aside for this?

Are there any key “lessons learned” you would like to share on the basis of your experience with HSPA in [country X]?

# **ANNEX 2. WORKSHOP ON HEALTH SYSTEM PERFORMANCE ASSESSMENT TOOLKIT FOR THE EUROPEAN REGION, COPENHAGEN, DENMARK, 30-31 MAY 2011**

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