

Health system assessment and health system performance assessment

An overview



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Ellen Nolte

London School of Economics and Political Science
London School of Hygiene & Tropical Medicine

European
Observatory 
on Health Systems and Policies
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Health system assessment (HSA) vs. health system performance assessment (HSPA):

What is the difference?



Assessing National Health Systems: Why and How *(Bennett & Peters, 2014)*

- Review of national health systems assessments (HSAs)
- Identifies 4 rationales of HSAs
 - i. to motivate health systems reform
 - ii. to promote harmonisation and alignment across actors in the health system
 - iii. to help translate health systems reforms into meaningful ways to track *performance*
 - iv. to facilitate learning through cross-country comparisons
- *Does not differentiate between HSA and HSPA as such; the main difference is the rationale or purpose that drives assessment*



Uses of health system assessments

Use	Likely Instigator of Assessment	Data Collection Method and Focus of Analysis	Examples
To motivate health systems reform	Government	In-depth assessment, most likely with long-term, strategic view, that seeks to identify health systems weaknesses and propose reform measures to address them	Bhore Committee Report (1946), ⁶ India Lalonde report (1974), ⁷ Canada High Level expert group on Universal Health Coverage (2011), ¹⁵ India National Health Insurance in South Africa (2011) ¹⁶
To promote consistency across actors	Government and development partners	Routine review, conducted on a regular (typically annual or biennial) basis, focus upon reviewing implementation and delivering on health system commitments	Joint Annual Reviews, conducted under International Health Partnership program
To translate health reforms into demonstration of systems performance	Government and/or NGOs and civil society	Routine review, publication of data that tracks indicators of health systems performance, may be disaggregated to district or provincial level, disseminated among multiple stakeholders to inform decision making and/or evaluate reforms	District Health Barometer, South Africa ¹⁷ Balanced Scorecards, Afghanistan ¹⁸
To promote learning through cross-country comparisons	International organizations, international researchers	Make use of varied formats, from databases of key indicators to in-depth profiles of health systems. Aims to provoke comparative analysis that casts insights on desirable health systems features	European Observatory Health in Transition series OECD and WHO databases on health systems ³ Commonwealth Fund profiles of health systems ¹⁹



Are HSA and HSPA different?

- HSA tools reviewed for this face-to-face meeting tend to have more of a *'diagnosis'* character
 - Describe what a given system does well and does not do that well
 - Identify areas for improvement
- HSPA in its original intention seeks to *“monitor, evaluate and communicate the extent to which various aspects of the health system meet their key objectives”* (Smith et al., 2009)

However...

- HSPA exercises across Europe are often at the 'diagnosis' stage (~ HSA)
 - Monitoring and evaluation element comes with the continuing process of assessment, and only a few countries have as yet entered this continuing process (e.g. Netherlands, Belgium, England)



2014 review of the HSPA initiative in Belgium

- Aims of HSPA vary across countries as does its influence on the policy process
 - to promote the accountability of national institutions
 - inform policy
 - improve transparency and understanding
 - hold devolved entities to account
- Nature and extent to which HSPA influences policy also varies
 - direct impacts: feeding into governmental decision-making
 - indirect mechanisms: informing the political debate
- Stimulation of new data collection efforts in a number of countries
- Use of international datasets (e.g. OECD) providing opportunity to draw attention to gaps in national data
- **But:** identifying appropriate ways of linking HSPA with policy processes remained underdeveloped
 - approaches likely to vary depending on institutional arrangements



Reported impacts of HSPA on national policy making, 2014

Country	Impact of HSPA on national policy making
Austria	HSPA provides an important source for identifying areas of action for policy makers. It provided the analytical background for target-setting within the 2013 Austrian health reform (“Health System Governance by Objectives”) for policy makers but it remains a challenge to embed the current HSPA framework more deeply in the policy making process to facilitate target setting based on HSPA analyses
Belgium	The HSPA report aims to provide a transparent and accountable view of and inform health authorities about the performance of the health system. While supporting policy making was not an objective at the outset it has progressively become an issue. Reports provide recommendations for policy-makers and point out priorities, also for data collection; the usefulness of reporting for decision-making has as yet to be demonstrated.
Malta	National HSPA framework in process of development and link with policy cycle yet to be established. The aims are to monitor the health system’s ability to cater for the nation’s health needs, to increase accountability, transparency and sustainability of health system and to determine future policy directions.
The Netherlands	HSPA reports are used for agenda setting and for accountability of the ministry of health to parliament. While the reports are well embedded in a network of expert researchers and health care professionals, it remains a major challenge to improve its policy impact and ‘actionability’.
Portugal	HSPA supports efforts of the Ministry of Health to improve the performance of the health system and contributes to gathering the critical evidence base to inform the national health plan. It motivated key experts and policy-makers to engage in the development of the new national health plan and it helped to clarify system goals, so introducing a health system perspective into the national plan. Gaps in health information remain a major challenge, limiting the capacity to support transparency and accountability through public reporting of results.
Sweden	HSPA reports are used to inform decision-making locally (county councils) and nationally. The development of indicators and measures can inform local improvement work. It remains a challenge to prioritise among different measures and to determine how to best translate the information being compiled into health care improvement.
United Kingdom (England)	The Outcomes Framework for the NHS is aimed at holding NHS England (the national public body leading the NHS in England) to account for improving health outcomes and reducing health inequalities; two further outcomes frameworks for public health and for adult social care seek set out to improve and protect the public’s health and to support transparency and local benchmarking. It may be challenging to establish how improvements have been arrived at.



What *is* the purpose of HSPA?

- Growing concern about *accountability* as a key driver behind many efforts to measure and evaluate performance of health services and system
 - help holding various actors to account by informing stakeholders and so enabling them making decisions
- Performance assessment should *support policy action* helping policy makers to
 - select interventions and policies in response to different health problems
 - decide the allocation of resources considering different priorities and demands, with a short, medium or long-term perspective
- Other objectives
 - enabling the identification of areas of poor performance and centres of excellence
 - facilitating the selection and choice of providers by service users and purchasers of health care
 - encouraging provider behaviour change
 - providing epidemiological and other public health data
- Challenges remain regarding the design and implementation of performance assessment initiatives, in terms of scope, policy usefulness and impact.



Defining 'performance'

- Initial focus: inputs and activity
- World Health Report 2000: Efficiency
 - extent to which resources used by a given health system achieve the system's objectives
- “Multidimensional concept that, along with **efficiency**, incorporates dimensions of **quality** (safety, effectiveness, quality of services rendered [appropriateness, timeliness] and perceived quality of services [responsiveness]) and **equity**.” (*Girard & Minvielle 2002*)
- Performance measurement “seeks to monitor, evaluate and communicate the extent to which various aspects of the health system meet their key objectives” (*Smith et al. 2009*)



What are the objectives of health systems?

There is a 'fair degree of consensus' that health system objectives can be summarised under a defined set of headings
(Smith et al. 2009)

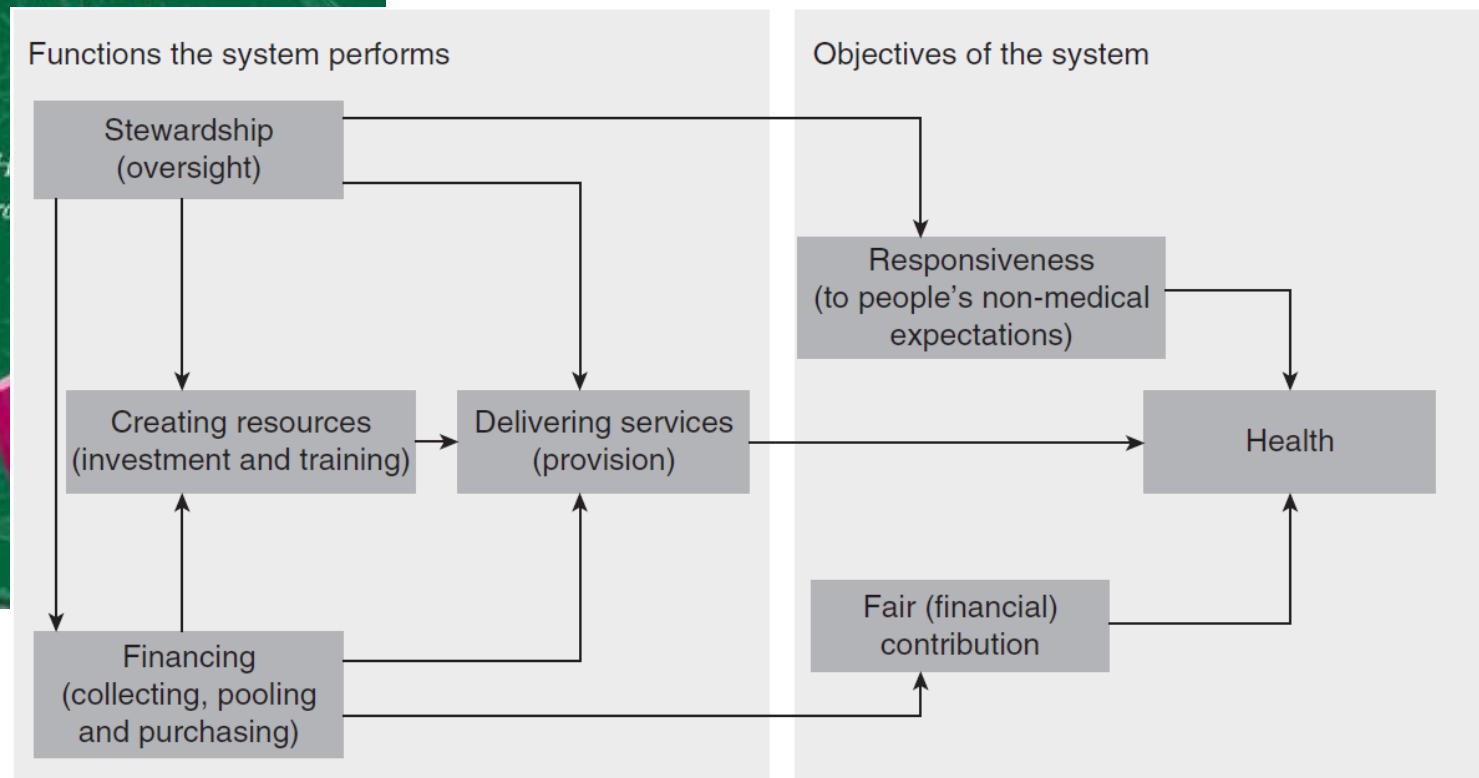
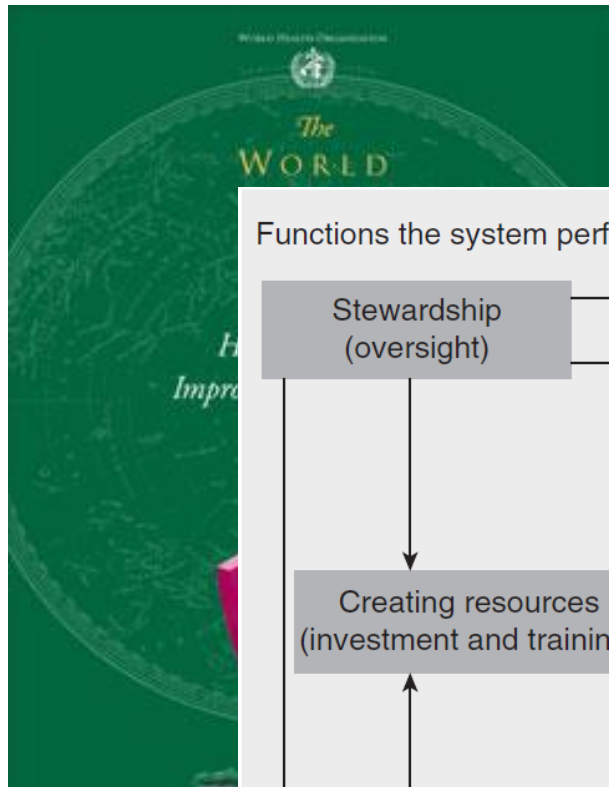
- Health conferred on citizens
- Responsiveness to the legitimate expectations of the population
- Protection against the financial risk of illness
- Productivity, i.e. the extent to which resources are used efficiently

Health System Performance Assessment: international and national frameworks

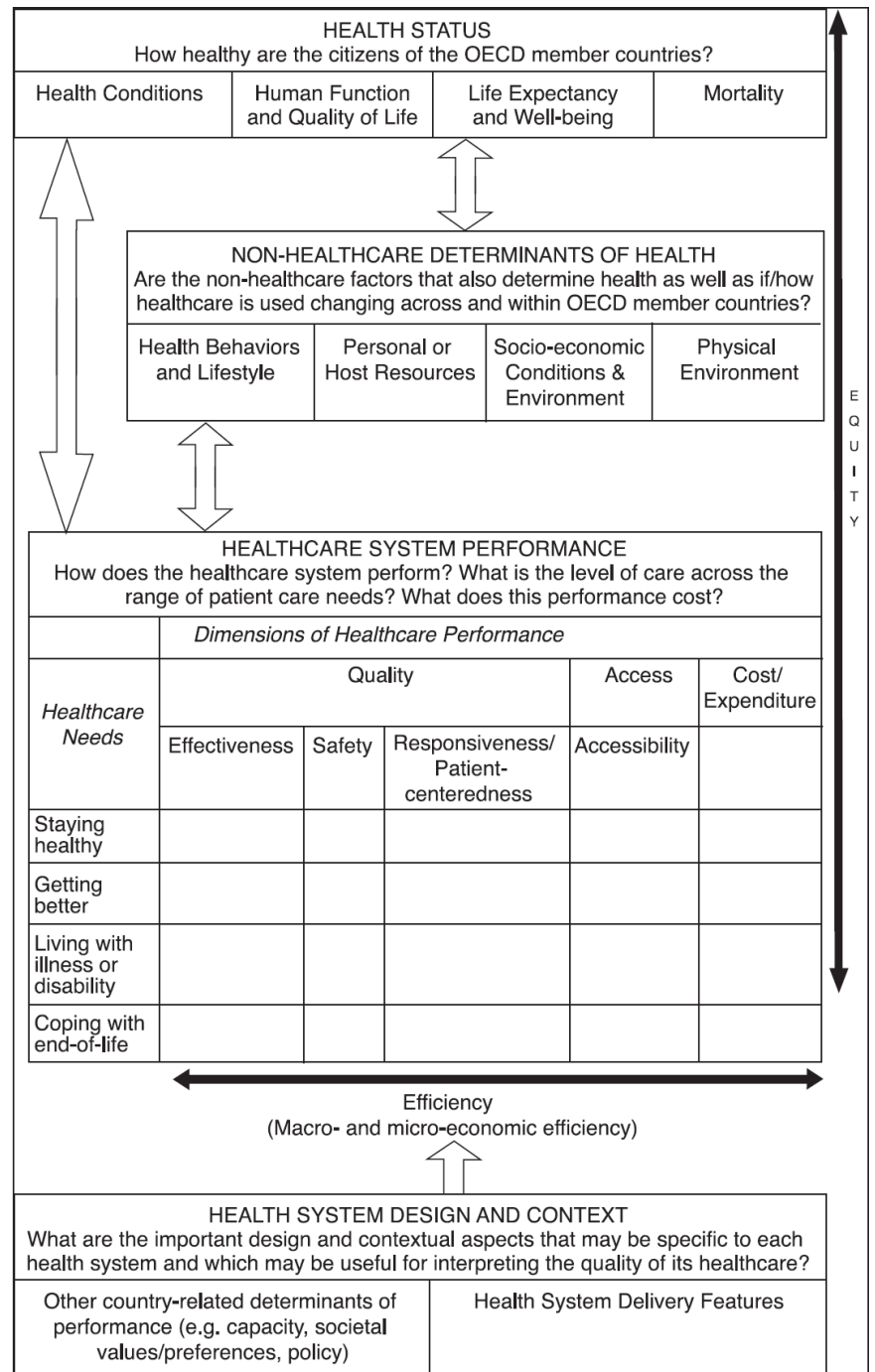


World Health Report 2000

Health systems: improving performance



Framework OECD Health Care Quality Indicator Project





Donabedian framework to assess performance

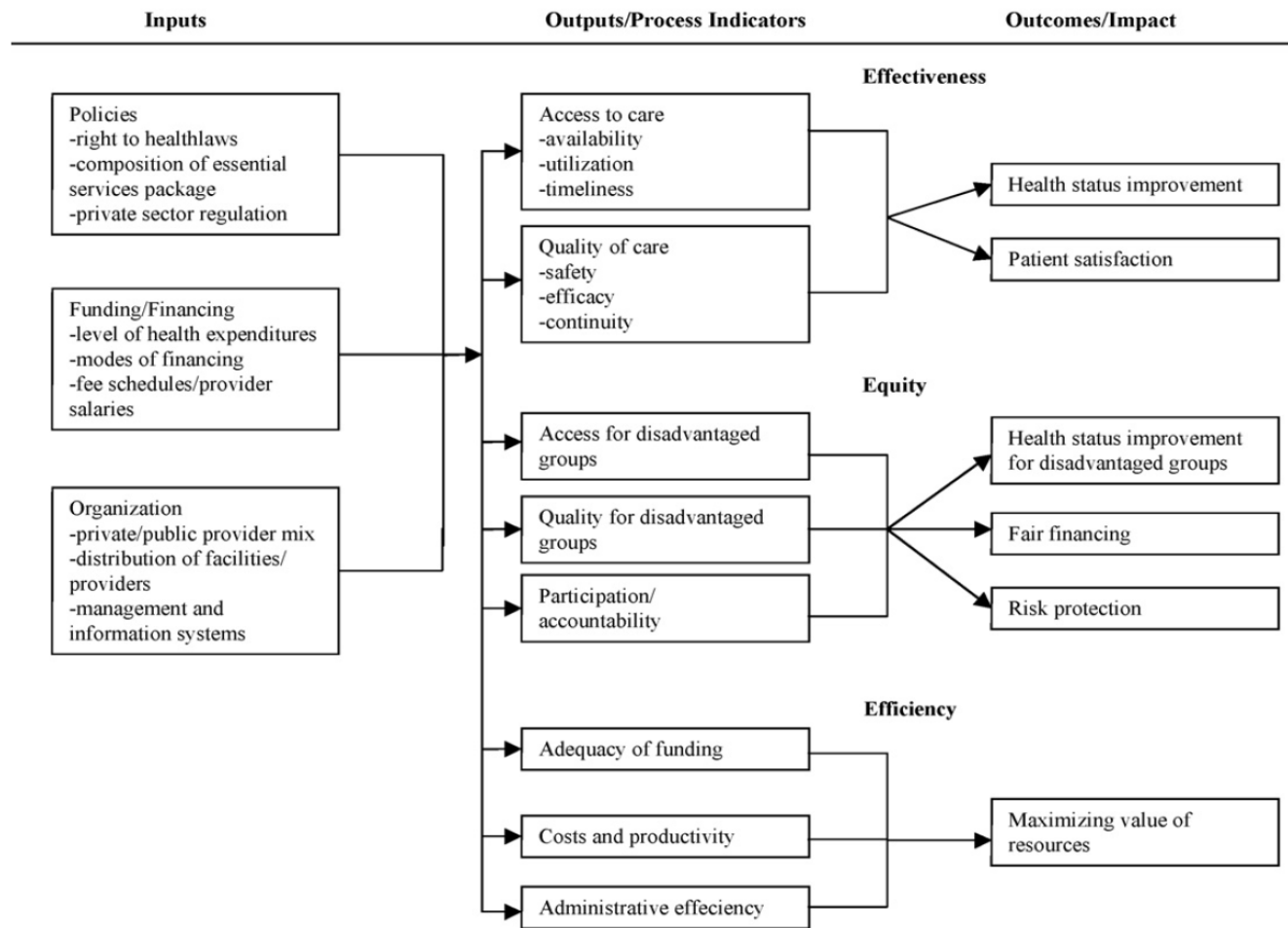
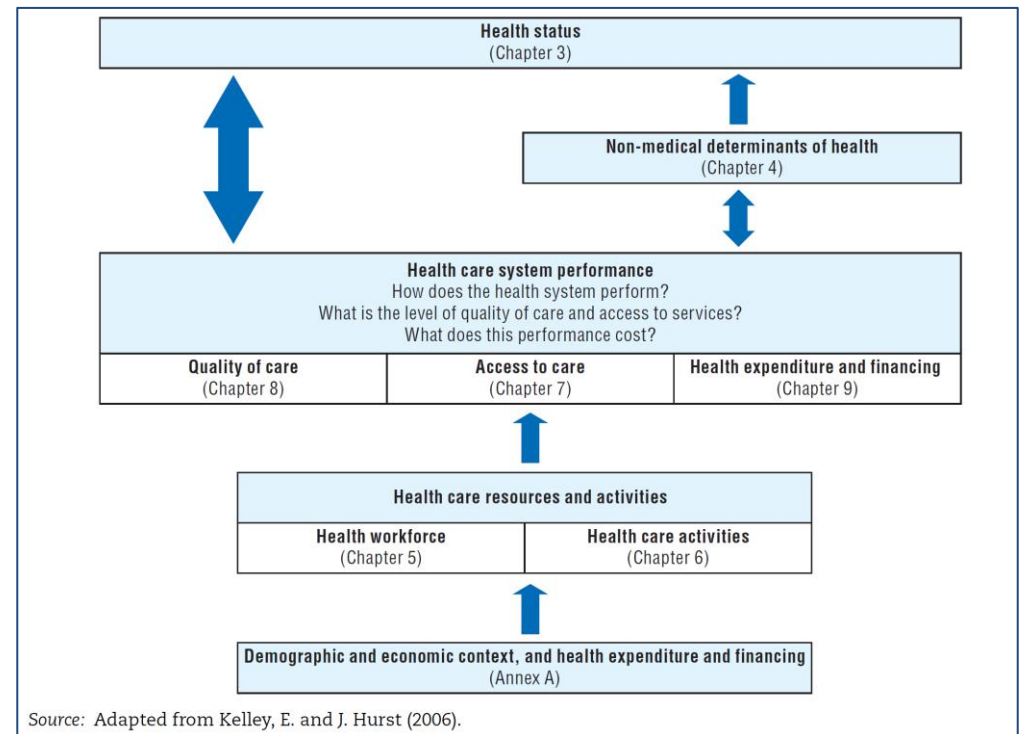


Fig. 1. Framework for health systems performance measures.

Source: Krug & Freedman 2008



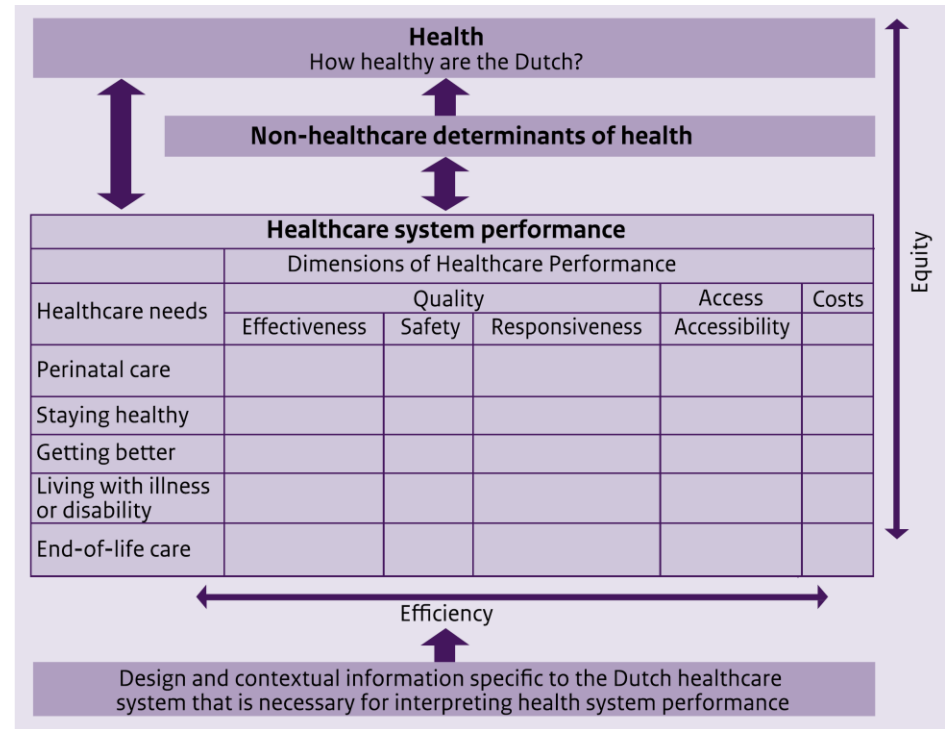
Bi-annual Health at a Glance reports



Source: Adapted from Kelley, E. and J. Hurst (2006).



Dutch Health Care Performance report





Performance of the Belgian health system



NIHDI

KCE REPORT 259C



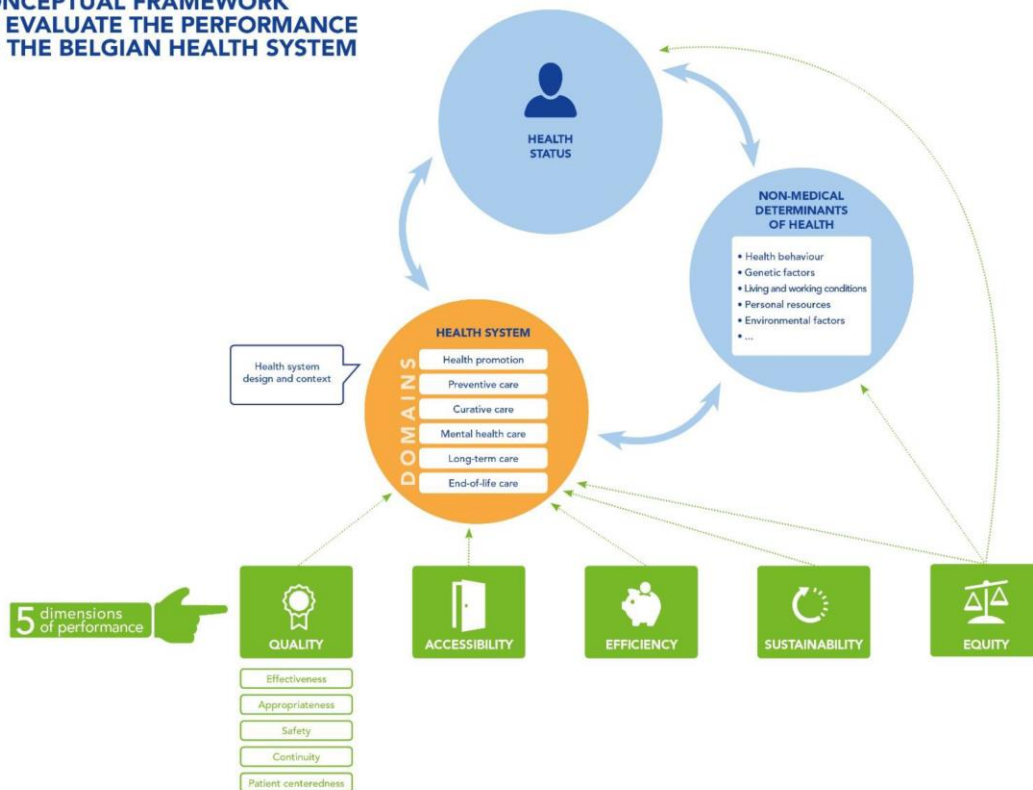
Federaal Kenniscentrum voor de Gezondheidszorg
Centre Fédéral d'Expertise des Soins de Santé
Belgian Health Care Knowledge Centre

PERFORMANCE OF THE BELGIAN HEALTH SYSTEM REPORT 2015



2015

CONCEPTUAL FRAMEWORK TO EVALUATE THE PERFORMANCE OF THE BELGIAN HEALTH SYSTEM



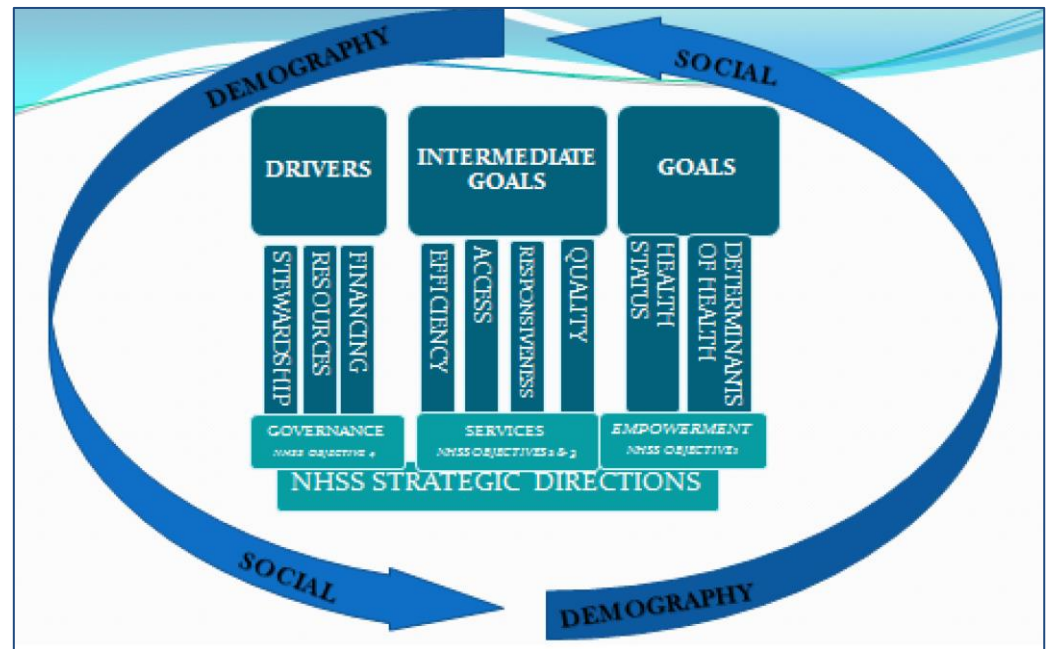


Performance of the Maltese health system

Ministry for Energy and Health
Parliamentary Secretary for Health

Report on the Performance of the Maltese Health System

2015



European Commission Expert Group on Health Systems Performance Assessment



European
Commission

The Commission Communication on Effective, Accessible and Resilient Health Systems proposes the following:

EU agenda for effective, accessible and resilient health systems

Strengthening effectiveness

Health systems
performance assessment

Patient safety and quality
of care

Integration of care

Increasing accessibility

A fit-for-purpose health
workforce

Access to innovative
medicines

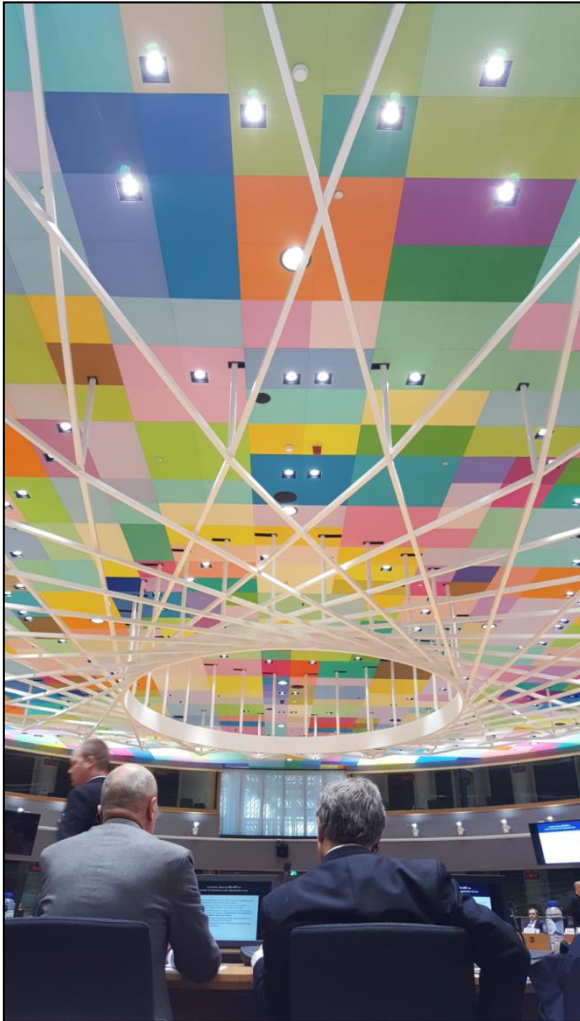
Optimal implementation of
2011 Directive on cross-
border healthcare

Improving resilience

Health technology
assessment (HTA)

Information for better
governance

eHealth, mHealth



The Council working party on public health at senior level invited the Commission in 2014 to set up an **expert group on health systems performance assessment**.

With this **mission**:

- ① Facilitate the exchange of knowledge
- ② Identify tools and methodologies to support national policy-makers
- ③ Focus on priority areas
- ④ Strengthen cooperation with international organisations



European
Commission

The Expert Group on Health Systems Performance Assessment



OECD



WHO



European Observatory





European
Commission

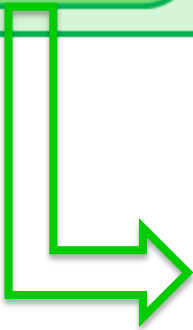
Expert group on HSPA Strands of activity

Annual
work on
priority
areas

Sharing of
national
experiences

Tailored
country-
specific
activities

HSPA
advocacy



2015:
Quality of care

2016:
Integrated care

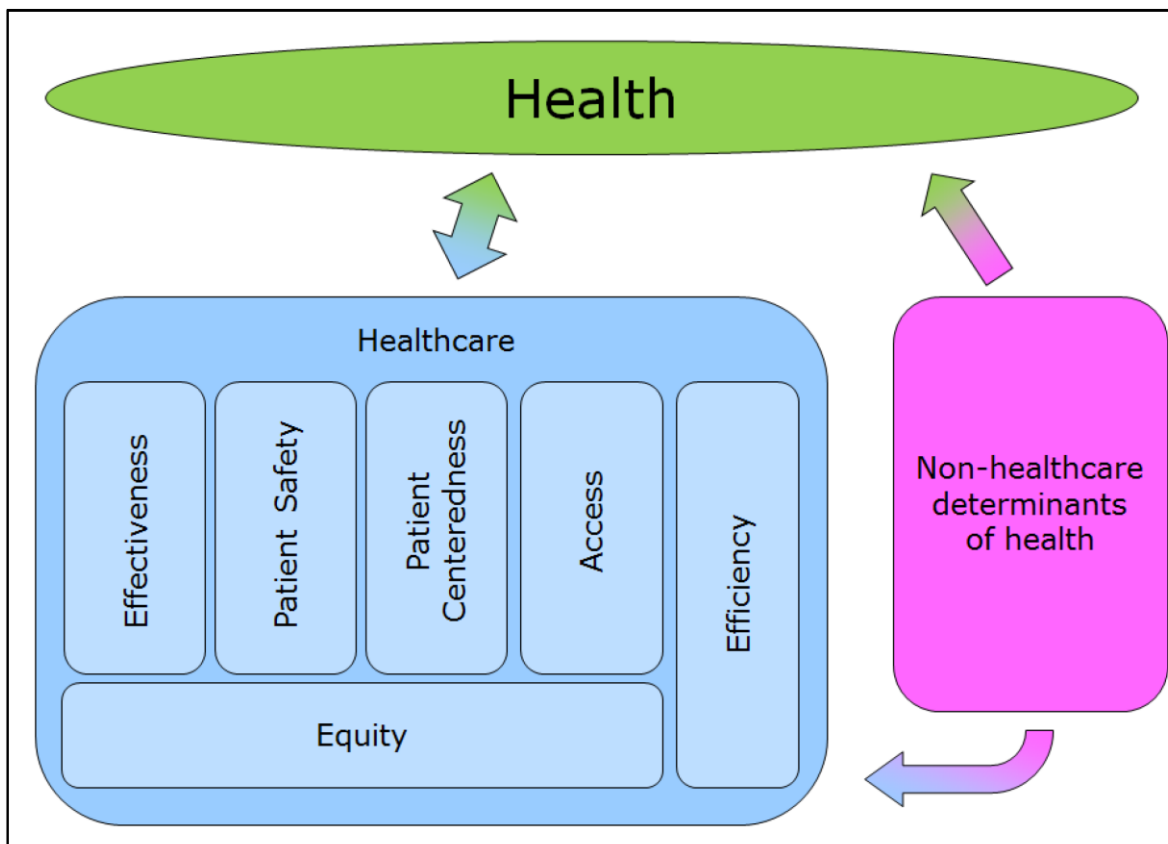
2017:
Primary care

2018:
Efficiency

2019:
Resilience



EC Expert Group on HSPA: A simplified version of the OECD framework

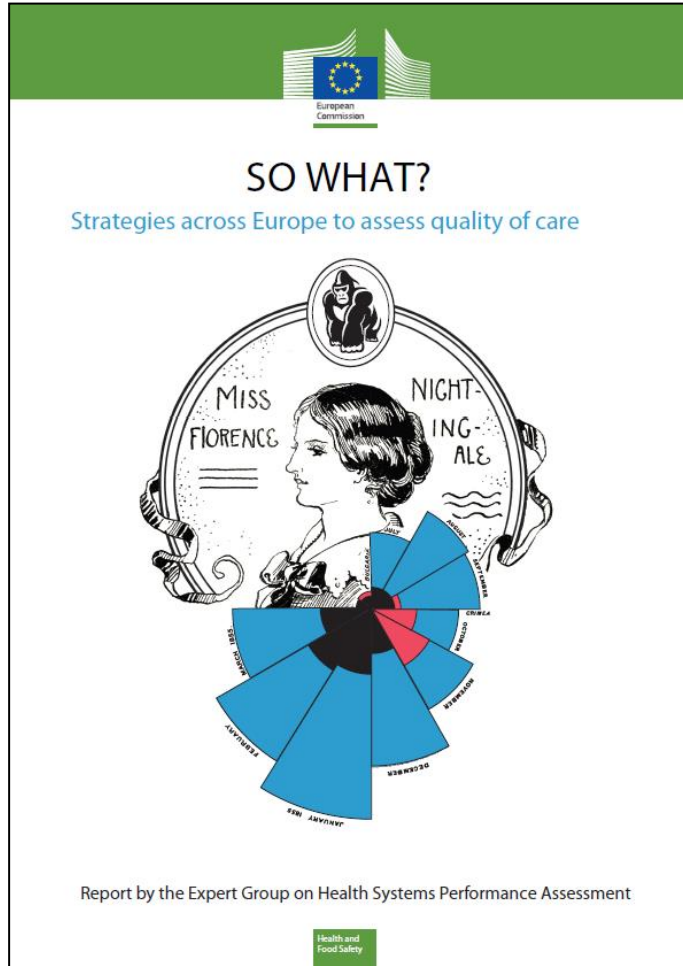


HSPA reports



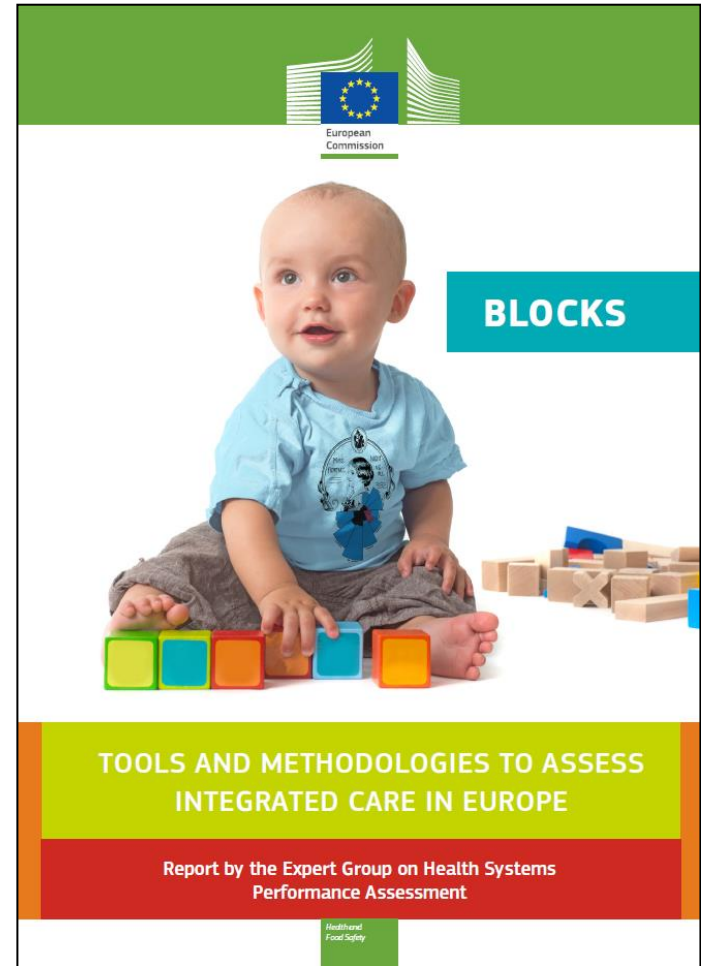
European
Commission

April 2016



http://ec.europa.eu/health/sites/health/files/systems_performance_assessment/docs/sowhat_en.pdf

March 2017

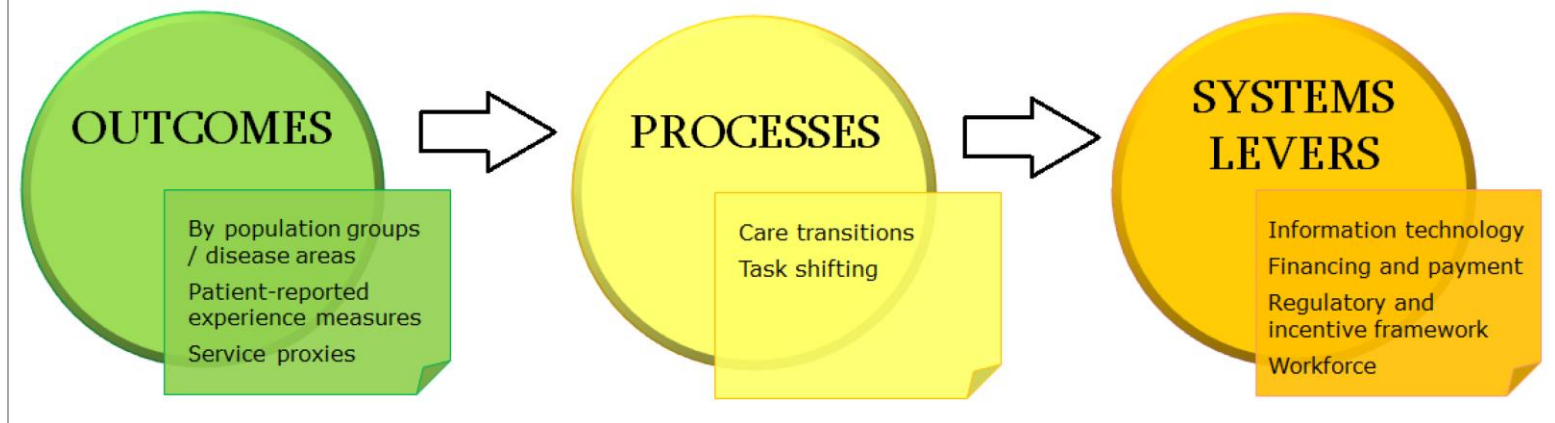


https://ec.europa.eu/health/sites/health/files/systems_performance_assessment/docs/2017_blocks_en_0.pdf



Donabedian framework to assess performance

Figure 5: Proposed approach to conceptualise the measurement of the performance of integrated care





Performance assessment is one among several (policy?) instruments

- Performance assessment is an important means to assess whether and to what extent a given health sector achieves its goals, but it is only one instrument for system improvement
- For performance measurement to be effective it needs to be aligned with other levers for improvement such as financing, market structure, accountability arrangements and regulation
- A key requirement will be to develop a clear vision and framework of how performance assessment sits within the overall accountability relationships if measurement is to ultimately improve health system performance
 - New Zealand 'Systems Level Measures Framework' (2016) (*Chalmers et al., 2017*)
 - substantial opportunity to drive health system improvement and for health sector organisations to engage in learning about how best to achieve desired health system outcomes
 - but: incentives for organisations to change may be relatively weak in the context of broader policy and funding settings

Thank you!

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Analysing Health

Systems and Policies





Conceptual problems

➤ Definitions

- What is a health system?
- Attribution of outcomes to activities in the health system



Defining health system boundaries for performance measurement

Advantages:

- Easier to hold relative stakeholders to account.
- Identifies areas which relative stakeholders have the capacity to make changes.

Medical Care



Health System Boundary



All Determinants

Advantages:

- Provides a more realistic view of all factors that influence health.
- Identifies interactions between sectors, institutions, people that can influence health.

Disadvantages:

- Most factors influencing health are not included in the framework.
- It may be difficult to disentangle the effect health care has on outcomes from other determinants.

Disadvantages:

- Many determinants identified are difficult, if not impossible to change in the short run.
- Does not provide clarity on managerial roles.
- More difficult to assign responsibility and hold stakeholders to account.



What to measure?

➤ Selection of indicators

- Variation in information needs
- Link between measures of input/process of care and health outcomes
- Not all outcomes valued by society measurable

- Availability and comparability of data
- Appropriateness of available data: are we measuring what is important, not just what is available?



Variation in information needs

Stakeholder	Examples of needs	Data requirements
Government	<ul style="list-style-type: none">• Monitoring population health• Setting health policy goals and priorities• Assurance that regulatory procedures are working properly• Assurance that government finances are used as intended• Ensuring appropriate information and research functions are undertaken• Monitoring regulatory effectiveness and efficiency	<ul style="list-style-type: none">• Information on performance at national and international levels• Information on access and equity of care• Information on utilization of service and waiting times• Population health data
Purchaser organisations	To ensure that the contracted providers deliver appropriate and cost-effective health services	<ul style="list-style-type: none">• Information on health needs and unmet needs• Information on patient experiences and patient satisfaction• Information on provider performance• Information on the cost effectiveness of treatments• Information on health outcomes
Citizens	<ul style="list-style-type: none">• Assurance that appropriate services will be available when needed• Holding government and other elected officials to account	Broad trends in, and comparisons of, system performance at national and local level across multiple domains of performance: access, effectiveness, safety and responsiveness



Dimensions of performance (1)

Measurement area	Description	Motivation for inclusion	Examples of measures
<i>Population health</i>	Measures of aggregated data on the health of the population	<ul style="list-style-type: none">• Facilitates population health comparisons within and across countries from broad aggregated perspective• May allow for comparative assessment of the contribution of health systems to population health	<ul style="list-style-type: none">• Life expectancy• Age- and cause specific mortality• Morbidity• Avoidable mortality• Health risk factors as predictors of future population health
<i>Health service outcomes</i>	Measures of the services and care patients receive to achieve desired outcomes	<ul style="list-style-type: none">• Facilitates comparative assessment of how health services assist individuals in realising their health potential	<ul style="list-style-type: none">• Health service outcomes• Health service processes
<i>Responsiveness</i>	Measures of the way individuals are treated and the environment in which they are treated during interactions with the health system	<ul style="list-style-type: none">• Facilitates comparative assessment of how satisfied health systems leave the patients with whom they come into contact	<ul style="list-style-type: none">• Patient satisfaction• Patient choice• Respect of patients' dignity• Prompt attention to medical needs



Dimensions of performance (2)

Measurement area	Description	Motivation for inclusion	Examples of measures
Equity	Measures of the extent to which there is equity in health, access to health care, responsiveness and financing	<ul style="list-style-type: none"> • Allows assessment of inequalities in health among different population/ demographic/social groups within and between countries • Allows of inequalities in access and/or utilisation of services among different population/ demographic/ social groups within and between countries • Allows assessment of inequalities in responsiveness of health services among different population/ demographic/social groups within and between countries 	<ul style="list-style-type: none"> • Distribution of health status by population/demographic/social groups • Distribution of access/utilisation of health services by population/demographic/social groups • Progressivity of financing system • Distribution of responsiveness of health services by population/demographic/social groups
Financial protection	Measures of the extent to which citizens are financially protected from the consequences of ill health	<ul style="list-style-type: none"> • Enables comparative assessment of how the health system protects citizens from the financial consequences of ill health 	<ul style="list-style-type: none"> • Out-of-pocket spending • Catastrophic expenditures on health care • Impoverishing expenditures on health care • Fairness of financing
Efficiency	Measures of the extent to which health services are delivered efficiently	<ul style="list-style-type: none"> • Facilitates comparative assessment that allows policymakers to pinpoint which parts of the health system are not performing as well as they should, based on the experience of other health systems 	<ul style="list-style-type: none"> • Value for money of services • Waste of resources • Effective coverage • Disease costs



Examples of indicators for population health

Indicator	Policy uses	Limitations
<p>Generic indicators:</p> <ul style="list-style-type: none"> • Life expectancy • Age-standardised death rates 	Broad indicators of achievement of desired population health outcomes	<ul style="list-style-type: none"> • Broad indicator of population health • Does not consider morbidity • Does not disaggregate for contributions of specific causes of ill health • Requires further disaggregation by age and cause of death
<p>Age/disease-specific indicators:</p> <ul style="list-style-type: none"> • Perinatal/infant mortality • Age-/cause-specific mortality • Survival rates 	Allows more detailed analysis of specific health system and service outcomes	<ul style="list-style-type: none"> • Susceptible to variation in recording and reporting practices • Rely on precise definitions that are not always adhered to in practice (e.g. perinatal death) • Captures the impacts of the broader determinants of health • Can be based on small numbers • Need to be interpreted in the context of risk factors and disease prevalence, as well as policies in other sectors • Survival rates have to be interpreted alongside incidence and mortality rates
<p>Morbidity indicators:</p> <ul style="list-style-type: none"> • Self-report data • Disease notifications • (health service utilisation) 	Available morbidity data provide limited insight into the contribution of health systems to population health; potential of disease registries	<ul style="list-style-type: none"> • Reporting bias of self-reported data • Variation in notification requirements and practice • Population coverage (may exclude private sector, marginalised populations) • Representativeness of utilisation data (only reflects people who access the health service)
<p>Summary indicators:</p> <ul style="list-style-type: none"> • Health-adjusted life expectancy, DALYs 	Indicators of population health that combine the mortality and morbidity experience in population	<ul style="list-style-type: none"> • Methodology under discussion (age and disability-weightings) • Limited availability of required health status data, especially over time



Examples of indicators for health service outcomes

Indicator	Policy uses	Limitations
<i>Hospital outcome indicators:</i> <ul style="list-style-type: none">• Hospital standardised mortality rates• Case fatality acute myocardial infarction, stroke• Hospital readmission rates	Indicators consider the contributions hospitals make to health outcomes over time	<ul style="list-style-type: none">• Hospital standardised mortality rates do not account for preventable deaths and that the majority of deaths are unavoidable• Differences across hospital systems and records challenge comparability within and across countries• Readmission data difficult to interpret because of differences in definitions; also evidence on association between readmission rates and quality of care delivered in hospital remains uncertain
<i>Patient-reported outcome measures (PROMs):</i> <ul style="list-style-type: none">• SF-36• EQ5D	PROMs capture aspects of health that are of most concern to patients; essential for the assessment of patient need and patient-provider communication in routine care	<ul style="list-style-type: none">• Data collection is resource intensive (require interviews)• Comparability issues as it relates to content validity and relative importance of different criteria• May be regarded as 'soft information' by some stakeholders
<i>Indicators for primary care:</i> <ul style="list-style-type: none">• Avoidable hospitalisation• Process indicators	Primary care has a pivotal role in the prevention of illness and premature death and with regard to a more equitable distribution of health in populations	<ul style="list-style-type: none">• Variation in organisation and financing of primary care across countries challenges scope for uniform data collection• Data collection in primary care is lagging behind hospital data collection and often has to rely on hospital administrative systems (e.g. avoidable hospitalisations)• There is good evidence on the usefulness of data on avoidable hospitalisations and selected process indicators for comparative use although data availability remains limited



Examples of efficiency indicators

Indicator	Description	What are the assumptions and what does it ignore?
<i>Emergency department visits</i>	Proportion of ED visits that should have been seen in other settings	Ignores quality of care; depends on definitions
<i>Average length of hospital stay</i>	The number of days per hospital inpatient stay	Assumes that cases are identical, both in terms of outcomes and in terms of intensity
<i>Unit costs</i>	Estimates of costs	Assumes uniform treatment and uniform accounting methods; ignores quality
<i>Case-mix adjusted cost per episode of care</i>	The average costs for treating a certain condition	Assumes that cases are identical, in terms of outcomes and intensity; Assumes uniform treatment and uniform accounting methods
<i>Duplicate medical tests</i>	Number of tests that are done more than once for the same patient	Assumes that any duplicate test is inefficient, regardless of the context
<i>Share of total expenditure spent on administration</i>	Percentage of total health care expenditure dedicated to administration	Assumes that a greater share of administrative expenditure is inefficient without accounting for scale; highly dependent on accounting method used
<i>Disease costs</i>	That average cost per case of treating a certain disease	Can be difficult to calculate without linking patient data across providers; assumes uniform case-mix; highly dependent on accounting measures used
<i>Effective coverage</i>	Share of actual health gains achieved relative to maximum potential health gains for a given intervention	Difficult to measure need and quality