Regional Consultation of the Americas on Health Systems Performance Assessment

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Critical Issues in Health System Performance Assessment

Pan American Health Organization
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A. INTRODUCTION

The World Health Report 2000 (WHR) sought to summarise the best available evidence on ways to improve the performance of health systems, and found that in many areas the evidence was limited and at best mixed. This was partly because there had been no agreement on the goals and objectives of health systems to guide analysis, and partly because the analysis had often focused on process rather than outcomes. The WHR, therefore, outlined a framework for assessing the performance of health systems which it proposed to use consistently across settings.

Comparison of performance across countries and over time can provide important insights into policies which improve performance and those which do not. This required defining a parsimonious set of outcome indicators to measure performance at the country level based on the framework. The annex tables were the first attempt to use these indicators to measure performance in a consistent fashion even though actual data were available for only some countries.

The release of the WHR stimulated vigorous debate on the processes surrounding the release of the report and on its scientific content. It was discussed at the 107th session of the Executive Board (EB) in January 2001. In her opening address, the Director-General reported that because of the importance of the topic and the interest from Member States, she would report on health sector performance at two yearly intervals, the next one to be released in October 2002. Before its release, she would take the following steps:

- Establish a technical consultation process bringing together personnel and perspectives from Member States in each of the WHO Regions;
- Ensure that WHO consults with each Member State on the best data to be used for performance assessment and provides advance information on the indicator values that WHO obtains using those data;
- Complete the next round of performance assessment in May 2002 for publication in October 2002. All Member States would receive the compilations before they are available to the general public;

- Establish a small advisory group, including members of the EB and the Advisory Committee on Health Research, to help her monitor WHO's support for health system performance assessment (HSPA).

The EB endorsed these steps and requested the Director-General to:

1) initiate a scientific peer review of health systems performance methodology as part of the technical consultation process including updating on methodology and new data sources relevant to the performance of health systems;

2) ensure that WHO consults with Member States and shares the results of the scientific peer review and its recommendations;

3) develop a multi-year plan for further research and development of the framework and its relevant indicators to assess the effectiveness and efficiency of health systems as part of the technical consultation process;

4) develop a plan to improve data quality to be used to assess health systems performance;

5) report to Member States on the impact of health systems performance reports on member States' policy and practice;

6) provide the reports to health authorities of Member States 15 days before the intended date of publication.

Accordingly, regional consultations will be held in each WHO region. This is the first such consultation. The participants are representatives of government from Member States as well as regional scientific experts. The objective is to provide technical input on HSPA as described above.

A number of topic-specific technical consultations have also been programmed covering summary measures of population health; health inequalities; fair financing; responsiveness; methods to enhance cross-population comparability of survey results; measuring efficiency; stewardship; and effective coverage. The results of all consultations will feed into the Peer Review group, in sufficient time for its report to be made available to the EB in January 2002.

This background paper summarises some of the major debates that have emerged since the release of the WHR2000. It does not seek to be all inclusive or to take a position on the debates. It presents the issues that have been raised most frequently in discussions with government and scientific experts. Participants in this consultation may raise other issues as well. The paper is organized around three themes. Conceptual and methodological issues relating to the current framework and indicators are considered in section B, questions relating to future development of the framework in section C, and practical policy and managerial issues related to HSPA in the last section.

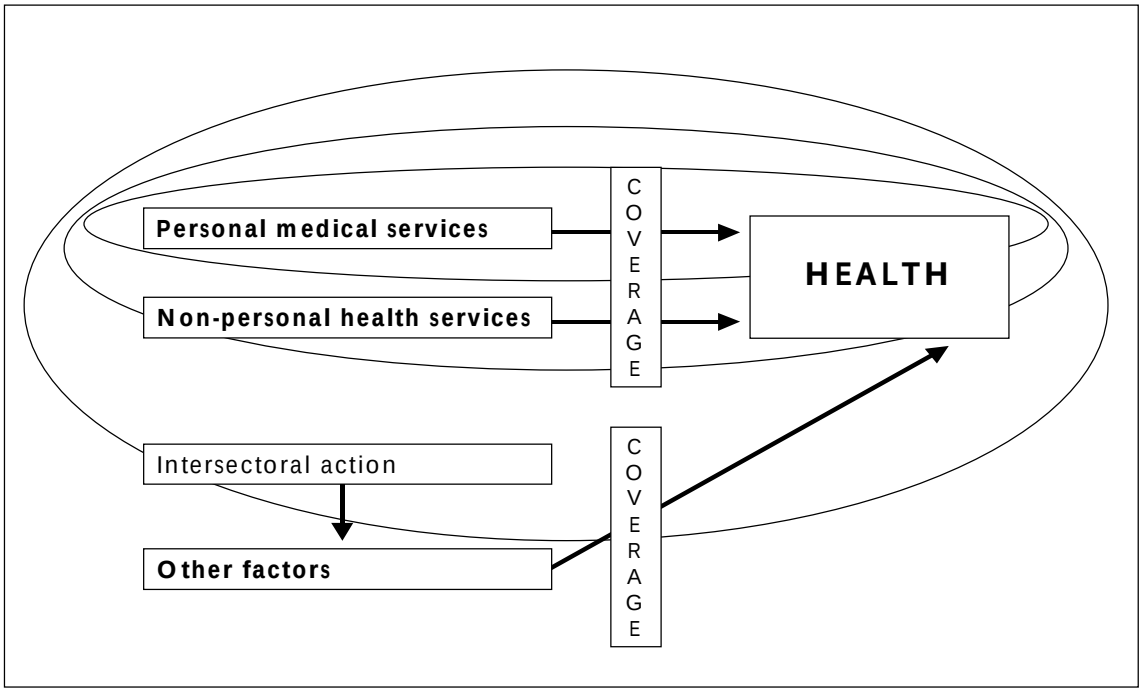
B. CONCEPTUAL AND METHODOLOGICAL ISSUES

1. Boundaries of the Health System

Emerging from the discussion of the WHR are a number of competing concepts of the health system. The narrowest definition draws the boundaries tightly around the activities under the direct control of the Ministry of Health. In some countries this may include mainly personal medical services and is depicted by the small circle in Figure 1. Many activities that are aimed specifically at improving health, such as the marketing of insecticide impregnated mosquito nets or taxes designed to reduce the use of tobacco or alcohol products, are excluded from this definition. In some countries it would also exclude many personal health services which are provided by other government departments, missions, NGOs or the private sector.

The second definition is a little more inclusive, corresponding to the second smallest circle in figure 1. In it, the system is defined to include personal medical and non-personal health services but not inter-sectoral actions designed to improve health. Traditional public health interventions such as spraying for mosquitoes or health information dissemination would be included, but the type of inter-sectoral actions in which WHO has long been engaged, such as safe water and sanitation programmes would not be.

Figure 1: Defining the Health System



The third definition is again more inclusive and considers any action where the primary intent is to improve health as part of the health system. This is broader than medical and non-personal health services, including inter-sectoral actions such as advocacy for regulation designed to reduce fatalities from traffic accidents. This is depicted by the largest circle in Figure 1.

The final option is to include all actions that contribute to improving health in the definition of the health system. This essentially includes every box in Figure 1 because virtually all areas of human activity—e.g. education, industrial development, environment—influence health. There is no longer any operational distinction between the health and the education systems, for example, or the health and agricultural systems, because improving education or agricultural production would also have an effect on health.

Which definition is appropriate is inextricably linked to the concept of accountability. To the extent that the stewards of the health system should ensure the delivery of key personal and non-personal health services and should be advocates for inter-sectoral activity on a range of actions aimed specifically at improving health—e.g. seat belt legislation and enforcement—the third definition of the health system is appropriate (the largest circle in Figure 1). This definition would encourage health policy-makers to think beyond personal medical services about how to advocate and encourage ways to improve population health in areas such as changes in diet, tobacco consumption or road safety regulations. They would be held accountable for that part of health which they could influence by their actions, whether in the provision of services, stewardship of private providers, or through advocacy for inter-sectoral action.

If the role of the stewards of the health system is simply to ensure that the resources under their direct control are used appropriately, a narrower definition might be proposed such as the first or second circle in Figure 1. Health policy-makers would perceive their roles as simply focusing on health services. In the very narrow definition, they would see themselves as accountable for improving only that part of population health that is determined by personal medical care in the public sector.

2. Causal Attribution

Many actions, including those that are not designed specifically to improve health, affect health either positively or negatively. In Figure 1, the box labelled “other” captures activities relating to education, environment, agriculture, industry etc., which influence the health of individuals or populations. The debate since the release of the WHR has revealed two competing approaches to separating the influence of the health system from those of these other activities.

The first is to define partial indicators of overall goal attainment which build into the measure a set of hypothesized causal relationships. So only the outcomes largely determined by the activities of the Ministry of Health or health policy-makers would be measured and monitored as part of health system performance assessment. For example, child mortality due to vaccine preventable diseases would be measured in preference to overall child mortality because the Ministry of Health can control the coverage of routine vaccination programmes but

cannot control the fact that some children die from malnutrition associated with poverty. Preventable deaths would be measured instead of total mortality on the grounds that the health system cannot be held responsible for all deaths. This approach focuses the attention of Ministry of Health decision-makers on issues directly under their daily control and on a limited set of well defined determinants of health.

The alternative is to separate the concept of outcome measurement from the assessment of causal attribution, whether from the health system and other determinants. Overall child mortality and changes in it would be measured and then the causes would be explored. The extent to which the health system has contributed to reducing child mortality would be evaluated as part of this process which identifies and accounts for all possible determinants. Multivariate statistical analysis allows this to be done, in the same way that econometricians have long explored and separated the various determinants of economic growth. This approach allows all possible hypotheses to be tested rather than restricting attention to pre-selected determinants. It focuses the attention of health policy-makers on the fact that they can improve health by encouraging action on a broader array of inter-sectoral areas than those directly under their control.

3. Mediating Factors

Clearly the simple provision of medical and health services and inter-sectoral actions, as depicted in the left hand side boxes of figure 1, does not automatically get translated into improved population health. A number of mediating conditions are required and there has been considerable debate about what these factors are and how they can be measured. The coverage of critical medical services and public health interventions certainly influences how effectively health actions are translated into health, which is the reason for showing it in figure 1, but there might well be others. Measuring effective coverage poses many challenges as it incorporates concepts such as physical access, affordability, utilization, effectiveness, and quality. It also requires the identification of a set of key interventions (or tracer conditions) for which coverage would be routinely measured.

Given the importance of coverage of critical interventions in mediating the effects of personal and non-personal health services, WHO plans to incorporate into the health system performance work a major effort to monitor coverage of critical health interventions. Information on coverage, access and utilization is needed not only at the national but the sub-national level to be an effective aid to national decision-making. A number of technical challenges must be overcome if coverage is to be monitored in a valid, reliable and comparable way. Two of the most important challenges are incorporating non-governmental and private providers in the assessment of coverage and validating the coverage implied by service delivery data. In addition, coverage may vary considerably within a country not only by region but also by sub-component when the system is segmented (private, ministry of health, social insurance schemes etc.) To further stimulate the development of coverage monitoring as part of performance assessment, a technical consultation will be held in August 2001.

4. Performance and Time

Efficiency (the word was used interchangeably with performance in the WHR) is the extent to which the health system makes the maximum achievable contribution to the defined social goals given available health system and non-health system resources. Two competing concepts of how this maximum should be defined have emerged from the debate around the WHR. The first is that it should represent the maximum that could be achieved by the Ministry of Health with its resources this year. This is consistent with the narrow definition of accountability and the narrow definition of the health system defined above. Estimating efficiency would require controlling for all possible non-health system determinants and the impact of health actions taken in the past. This approach clearly identifies who is responsible for current poor performance but it does not provide health policy-makers with incentives to think about broader actions that could improve health—i.e. to be stewards of population health as a whole.

The alternative is to define a higher maximum, the maximum that the observed levels of resources (health and non-health system) could have produced had the appropriate mix of policies been followed. This maximum would not necessarily be achievable this year, but shows what would be possible with existing resources. Under this definition, low performance reflects the fact that the system is not achieving what it could have achieved in the presence of appropriate policies and programmes. It might be the result of decisions taken 15 years ago or those taken today. It might be the results of the failure to take inter-sectoral action to discourage smoking or the failure to provide medical services to poor people. This approach sets a goal for policy-makers, encourages them to think beyond personal medical services, and to be aware that their actions today can affect population health for several decades. It is also consistent with the way efficiency is measured in the wider economics literature, where no attempt is made to adjust current estimates of airline efficiency, for example, for mistakes made by managers in the past. Efficiency comparisons simply indicate that a company is not achieving the maximum possible today, and managers seek to find ways to improve efficiency.

In the first approach, the question of timing is critical as some of the current attainment on the different goals is a result of actions taken in the past. Moreover, some of the impact of current actions, such as smoking cessation programmes, will not be felt for a considerable period into the future. In the second approach, timing is less critical because the goal is to indicate what could have been achieved in total from the measured inputs and to give managers incentives to take a broad view and a long term view.

Both are technically feasible. The choice depends partly on the purpose of health system performance analysis. If it is to determine if the Ministry of Health performed well this year, the former is appropriate. The information would help Ministry policy-makers focus on short term ways of improving efficiency and attainment in areas within their direct remit. On the other hand, if the purpose is to indicate what could have been achieved with an efficient use of available resources, both inside and outside the health system, and to encourage policy-makers to think long term and to think beyond personal medical services, the latter encourages this broader vision.

5. The Scope of Performance

In the WHR, the term performance was used interchangeably with efficiency. Efficiency was defined as the extent to which the health system makes the maximum achievable contribution to the defined social goals, given the resources (health system and non-health system resources) used. In general use, and certainly in the quality of care literature, performance is often defined more broadly to encompass a range of activities around the use of evidence to maximize outcomes or goal attainment. An important issue is, therefore, whether WHO should change its terminology to be consistent with the broader use. This would mean defining "health system performance assessment" (HSPA) as a set of activities which includes:

- measuring goal attainment;
- measuring the health system and non-health system resources used to achieve these outcomes;
- estimating the efficiency with which the resources are used to attain these outcomes;
- evaluating the way the functions of the system influence observed levels of attainment and efficiency;
- designing and implementing policies to improve attainment and efficiency.

Improving health system performance would become a broad term to encompass the entire set of activities. The terms "attainment" and "efficiency" would have precise definitions as components of that set.

6. Universal Weights

The WHR combined 5 indicators of attainment into a composite attainment score. The best available evidence at that time suggested that the weights survey respondents put on the different indicators did not differ substantively across groups of respondents. Overall attainment was, therefore, constructed by attributing 50% of the total score to health attainment, 25% to responsiveness and 25% to the fairness of financing. The question of whether all countries have the same weights or preferences has subsequently been discussed. To compare overall attainment across countries requires some consistent weighting system but the question of whether weights vary across settings is one that can be tested empirically.

If they do, in fact, differ substantively across countries, one option is to use two types of weighting systems for overall attainment and efficiency. One would take the average observed across countries, and the other would use the varying country weights. This would allow an assessment of the extent to which overall attainment and efficiency estimates were sensitive to the variation in country weights. Whether weights do vary substantively across countries will be informed by the series of household surveys under way this year in many countries that include questions on the importance of different goals.

7. Socially Desirable Goals

Considerable debate has focused on the appropriateness of the 3 goals defined in the WHR - health, responsiveness and fair financing. It is clear from figure 1 that health levels are not just a function of the activities of the health system, unless of course the system is defined as encompassing every action that could possibly improve health. In terms of any other definition, health is a social goal to which the health system contributes but which is also influenced by other factors.

No one has disputed that the system exists primarily to improve health and that this is the defining goal. Most commentators on the WHR have also agreed that health systems should contribute to other social goals in addition to improving health. The concept of "caring", as distinct from improving health, has commonly been raised in this context. This is the idea that responsiveness tries to capture, by defining the 8 domains of dignity, autonomy, confidentiality (together comprising respect for persons), prompt attention, quality of basic amenities, access to social support networks during care and choice of provider (comprising client orientation). It has been suggested that this definition does not fully capture some dimensions of caring. For example, two systems might score equally well on the 8 domains but show very different patterns of use - there might be only 1 contact with the system per person per year in the first compared to 4 in the second. Can it be argued that the two systems are equally responsive, and if not, how should differential coverage be incorporated into the definition? There might well be other dimensions of caring that should also be included in the definition of responsiveness. There will be a technical consultation on responsiveness.

To date, most survey respondents have indicated that they value some form of equity in the way the system is financed. They express preferences for systems which do not put people at risk of financial catastrophe because of ill health, and where financial contributions to the system are progressive. However, some commentators have questioned whether a concern with financial fairness is socially desired in their countries and others have questioned whether the financial fairness indicator used in the WHR reflects people's concerns with progressive contributions . The existence or otherwise of preferences for financially fair systems is an issue which should be tested empirically through household surveys, and other technical questions surrounding the choice of indicator will be the subject of a technical consultation shortly.

Arguments have also been made that the health system contributes to a range of social goals in addition to those outlined in the WHR, including increasing economic growth and encouraging community participation. To include these as goals in the health system performance assessment framework depends partly on whether the health system makes a large enough contribution to them to justify routinely monitoring the impact of the system on those outcomes. If the health system makes only a small difference to the rate of economic growth, for example, it would not be feasible or necessary to monitor its contribution to economic growth as part of periodic health system performance assessment. The implications of routine performance assessment for health information systems is an important issue that is discussed in a later section.

8. Practical Policy Implications

Health system performance assessment (HSPA) is not undertaken for its own sake. It is important only to the extent that it provides the evidence required to develop better policies, strategies and programmes. A number of suggestions have been made about ways to improve the links between the measurement part of HSPA and the component relating to the development of policies to improve performance. This requires strengthening the work on functions of the system—resource generation, financing, provision and stewardship. Little is known about how they are currently undertaken in countries and indicators of the contributions of each function to performance do not exist. It is generally agreed that this area requires more work, and that policy-makers require ways of monitoring if they are performing these functions appropriately, and whether a change in the way one or more function is undertaken would improve attainment and efficiency. This is discussed further in the next section, but specific technical consultations have been planned on the functions of stewardship and financing.

A second strand of this discussion has been that while it is useful to measure and monitor overall system performance, policy-makers also need to be able to identify the contributions of the different components of the health system—to be able to separate the contribution of personal medical services from that of inter-sectoral actions, for example. This would help them decide if they should transfer resources to inter-sectoral action from personal medical services, or from one type of personal medical service to another. A way of providing this information is to strengthen the links between HSPA and cost-effectiveness analysis, something that is currently under way in WHO. The practical implications of routine HSPA is considered further in section D.

C. FURTHERING THE FRAMEWORK FOR HEALTH SYSTEMS PERFORMANCE ASSESSMENT: GAPS AND CHALLENGES

1. Introduction

In the last section some of the recent debates about the framework and methods for HSPA were summarized. In this section, we build on that by discussing in more depth some of the suggestions for further development of HSPA. As in the previous section, some critical issues for discussion at this consultation are raised.

2. The Need to Measure Functions and Progress

In section B, the scope of performance assessment was discussed and it was suggested that it might best be considered as a broad menu of activities rather than equating it with efficiency. This would allow HSPA to cover consideration of whether progress is being made toward specified goals and whether appropriate activities are being undertaken to promote the achievement of these goals. The value of this would be to identify problem areas that may require special attention and best practices that can serve as a model. HSPA of this form could also be a tool for regulation and resource allocation. Accountability for performance would

consist of an obligation and willingness to be assessed on the basis of appropriate measures of actions and outcomes with regard to the achievement of program and policy purposes. In other words, the broad concept of performance would include the ability to assess whether progress is being made towards specified goals and whether appropriate activities are being undertaken to promote the achievement of those goals. This would be consistent with making a results-oriented management approach a component of HSPA.

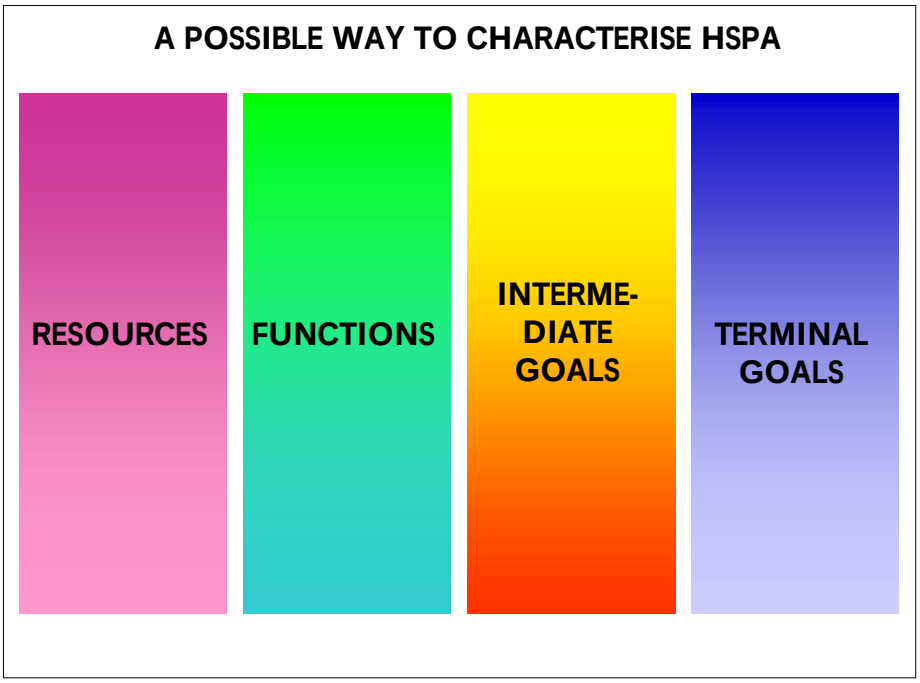
A number of ways of thinking about how this work might be organized and how the appropriate indicators are defined are possible. For example, The United States National Research Council[1] recently argued that performance measurement involves the selection and use of quantitative measures of program capacities, processes, and health outcomes to inform the public or a designated public agency about critical aspects of a program. In an earlier report[2] it had included capacities, processes, risk status, and health outcomes. Its logic was that at the program level, some health outcomes of primary interest, such as reductions of mortality and morbidity, may be difficult to routinely measure. Moreover, there is a time lag between an intervention and changes in those outcomes that is too great for the effects to be observable within the relatively short time frames used to monitor program performance. This was the reason they suggested including measures of risk status as intermediate outcomes. A possible way of depicting this process is found in Figure 2.

This approach is consistent with a "dash board" design of performance assessment, with multiple gauges that can allow for the scrutiny of different dimensions of the performance of the health system by looking at the attainment of intermediate goals and at the way the different functions of the system operate. Its proponents argue that the information supplements the information obtained by measuring the system's contribution to the intrinsic goals.

1 National Research Council. Health Performance Measurement in the Public Health Sector: Principles and Policies for Implementing an Information Network. E. B. Perrin, J. S. Burch, and S. M. Skillman, eds. Washington D.C.: National Academy Press, 1999.

2 National Research Council. Assessment of Performance Measures for Public Health, Substance Abuse, and Mental Health. E. B. Perrin and J. J. Koshel, eds. Panel on Partnerships Grants, Committee on National Statistics. Washington D.C.: National Academy Press, 1997.

Figure 2: A possible way to Characterize Health System Performance Assessment



The question is whether the categories of capacities, process, and risk status are the appropriate ones for assessing progress, particularly of sub-components of the system, and if so, how should the indicators be selected. Different ways of selecting indicators are possible, and the U.S. National Research Council, for example, has suggested four basic criteria:

- Measures should be aimed at a specific objective and be result oriented.
- Measures should be meaningful and understandable
- Data should be adequate to support the measure.
- Measures should be valid, reliable and responsive.

Another important consideration might well be the implications of any set of indicators for the health information system of Member States, which is considered in Section D.

3. Resource Availability or Capacity

If the above framework is accepted, indicators of resources and their distribution as well as measures of capacities would constitute a first dimension of HSPA. It has been argued that they provide information that is critical for modifying resource allocation practices and for assessing the efficiency of the system for organizing its functions, for attaining intermediate goals and ultimately for achieving the socially desirable intrinsic goals. How capacity can be measured in a meaningful and comparable way poses challenges at the theoretical and practical levels.

4. Measuring the Performance of Functions

Section B highlighted that debate about the need to define indicators of the way health systems organize themselves to carry out a series of functions that are interdependent and that are necessary for achieving goals. This dimension represents a major challenge in the development of performance assessment frameworks and measurements since it is an area of rapid evolution and constant redefinition. It is a dimension that has as yet little conceptual and methodological operationalization and it is subject to different interpretations very much linked to the nature of the macro-organizational model of the health system.

5. Stewardship

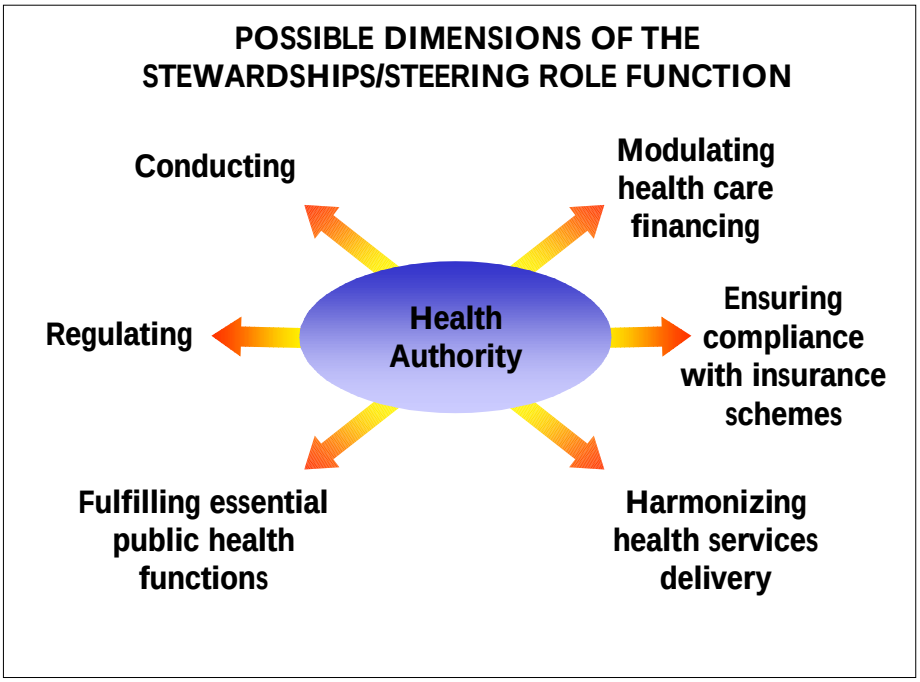
The reform of the State and the decentralization processes have made the redefinition of institutional roles in the health system a priority in the Member States, especially as far as the steering/stewardship role of ministries of health is concerned. The responsibilities of the State are undergoing significant changes in the face of the growing trend toward the separation of financing, risk pooling and service delivery. These changes demand, among other things, a greater capacity to direct, regulate, and carry out the essential public health functions corresponding to the health authority.

This intensifies the need to reconfigure and adapt the responsibilities and operations of the health authorities to strengthen their steering /stewardship role in the sector, so they define better their areas of intervention[3] such as: sectoral management, regulation, implementation of the essential public health functions, modulation of financing, surveillance of insurance coverage, and harmonization of service delivery (see figure 3).

A variety of taxonomies can be adopted in this area that will always be subject to interpretations or classifications. The breadth of the steering/stewardship role of the ministries of health will depend on the degree of public sector responsibility, the degree of decentralization, and the division of labor in the institutional structure of each country. These responsibilities—some old and some new—will require the ministries of health to strengthen and, in many cases, retool their operations, their organizational structure, and the professional profile of their managerial, technical, and administrative staff. The challenge is to define indicators of performance to assess the degree of progress attained by the system in this regard.

[3] PAHO/WHO. Steering Role of the Ministries of Health in the Processes of Health Sector Reform: CD40/13. Washington D.C., Septermber 1997.

Figure 3: Stewardship



Health system reforms face the challenge of strengthening the steering/stewardship role of the health authority, and an important part of that role is exercising the essential functions that correspond to the State at the central, intermediate, and local level. It is therefore critical to improve practice in public health and the instruments for assessing the situation and identifying the areas that require strengthening. In light of this, considerable attention has been focused in the Americas on measuring the performance of what has been termed the essential public health function (EPHF), as the basis for improving practice in public health and for strengthening the leadership of the health authority at all levels of the State.[4]

The EPHF have been defined as conditions (capacities) that permit better public health practice. Indicators and standards for each EPHF were also defined. If the functions are well defined to include all the capacities required for good public health practice, good functioning will be a reliable indication of attainment in each sphere of action or work area of public health.

To help orient the discussion at this consultation, we report the 11 EPHF identified as critical for public health practice in the countries of the Americas and contained in the performance measurement instrument developed by PAHO/AMRO in collaboration with the Centers for Disease Control (CDC) and the Latin American Center for Health Systems Research (CLAISS).

[4] PAHO/WHO 42nd Directing Council. Essential Public Health Functions: CD42/15. Washington D.C., 25-29 Septermber 2000.

1) Health Situation Monitoring and Analysis

2) Public Health Surveillance, Research, and Control of Risks and Damages in Public Health

3) Health Promotion

4) Social Participation and Empowerment of Citizens in Health

5) Development of Policy, Planning, and Managerial Capacity to Support Efforts in Public Health and the Steering Role of the National Health Authority (NHA)

6) Public Health Regulation and Enforcement

7) Evaluation and Promotion of Equitable Access to Necessary Health Services

8) Human Resources Development and Training in Public Health

9) Ensuring the Quality of Personal and Population-based Health Services

10) Research, Development, and Implementation of Innovative Public Health Solutions

11) Reducing the Impact of Emergencies and Disasters on Health

Developing instruments to measure performance of the stewardship function and of EPHF implies a process to define the function whose performance is to be measured, the performance indicators and standards, and the measures and sub-measures that will serve as verifiers. All indicators would require validation to ensure they measured what they were supposed to measure, and tests of reliability and consistency.

There is a debate in the literature about the appropriate choice between acceptable standards and optimum standards. Defining acceptable levels is difficult and partly arbitrary—for example, should the standard be related to the average reality of countries or to a definition of the minimum necessary for exercising a function. Should optimum standards be used as a goal for policy even if they are not achievable in the short run? These are questions important to future work on HSPA.

Measurement of the degree to which the stewardship function and EPHF are being fulfilled is not just an interesting methodological exercise but should lead to an improvement in public health practice, establishing good operating standards and reference points for continuous quality improvement. The process also promotes greater transparency in public health practice and services, while lending greater clarity to the generation of knowledge and evidence-based public health practice. Finally, measurement should lay the foundations for better and greater allocation of resources for public health actions.

Similar challenges exist for other functions of the system if it is agreed that identifying key variables that will permit measurement of the way they are being performed should be part of the agenda for further development of HSPA.

6. Instrumental or Intermediate Goals

Most of the available indicators of attainment of instrumental goals are related to the way in which the function of delivery or provision of non-personal and personal heath services is being carried out. They constitute categories of analysis of different domains of the action of the health system, more directly connected with managerial practices and decision-making processes under the responsibility of health care administrators and public health officials at local, regional and national level. A challenge is to define indicators of how well the stewards of the system are carrying out their inter-sectoral talks, if the broader definition of the health system that was outlined in Section B is accepted.

A myriad of intermediate goals have been suggested over the years, and some are currently applied in countries such as Canada, Australia, United Kingdom and Great Britain[5,6]. They have included:

- Access (whether or not patients can obtain the services they need at the right place and time);
- Effectiveness (how well services work and how they affect our health);
- Appropriateness (whether care is relevant to needs and is based on established standards);
- Continuity (how services fit together, including coordination, integration and ease of navigation);
- Sustainability (systems capacity to provide infrastructure such as workforce, facilities and equipment, and be innovative and respond to emerging needs);
- Efficiency (often conceived as technical efficiency or achieving best results at the lowest cost);
- Competence (knowledge and skills of caregivers appropriate to the care they are providing);
- Acceptability(how well the health systems meets citizens expectations).

5 Hurst, J. and Jee-Hugues, M. Performance Measurement and Performance Management in OECD Health Systems. Labour Market and Social Policy-Occasional Papers No.47. Paris: OECD, 2000.

6 Institute of Medicine. Envisioning the National Health Care Quality Report. M. P. Hurtado, E. K. Swift and J. P. Corrigan eds. Committee on the National Quality Report on Health Care Delivery. Washington D.C.: National Academy Press, 2001.

There are many others. The difficulty is to choose a set which is small enough to routinely monitor and which policy makers can use to monitor their performance without losing track of the big picture. Part of this process would require deciding whether proposed indicators overlap and whether they can be operationalized in a meaningful and valid way. Some of these considerations will be taken into account in developing an initiative in WHO on assessing the functional coverage of a selected group of health interventions. This captures many of the above dimensions and can be used to trace the degree to which the health system carries out critical activities that have an impact on people.

7. Social Values and Final Social Goals

The debates around the definition of socially desirable goals and whether the weights given to them are consistent across settings were introduced in section B, and these issues are explored again briefly. Clearly the choice of performance indicators does not operate in a value-free environment and it needs to be recognized that societies create forms of organizing health systems according to guiding principles and fundamental values shared by their citizens. The important question to consider for future work on HSPA is whether there are other values that have not been adequately taken into account in the current framework and how they should be incorporated. The concepts solidarity, caring, universality and the preservation of healthy environments have been frequently mentioned as aspects that have been omitted. The question of whether they are final social goals, components of final goals, or instrumental goals has received considerable attention, and these and other questions will be considered at this consultation.

8. Practical Implications of Future Developments

Furthering the development of HSPA and its framework along the lines suggested in this section will require considerable collaboration between WHO and its Member States. Some of the greatest challenges relate to how to choose variables, measures and indicators of capacity, functions and progress toward achieving the ultimate social goals to which the system should contribute. This is a medium and long- term agenda in the work of WHO and in the efforts of its Member Countries to improve the development of health systems so they contribute to the attainment of the health for all goal.

D. LINKING HEALTH SYSTEMS PERFORMANCE ASSESSMENT TO POLICY-MAKING AND MANAGERIAL DECISION-MAKING

1. Introduction

Routine HSPA would require national governments to monitor and evaluate the achievements of their health systems, to diagnose the determinants of observed performance based on the functional groupings, and to identify policies and strategies to improve performance. It would require WHO to increase its capacity to provide technical support in these areas. Since the publication of the WHR, many questions have been raised about the

implications of routine HSPA for the work of ministries of health and WHO. Some of these questions are discussed below.

2. Indicators of the Performance of the Functions of the System

The present HSPA framework and tools helps managers measure system performance and compare it with other countries. Improving performance requires that actions are then taken on the four core functions - stewardship, financing, provision and resource-generation, but at present, there are no tools to measure the performance of each function against a set of agreed instrumental goals. This was discussed at length in the previous section and it would be useful to develop a parsimonious set of indicators which mediate between the provision of services and the achievement of goals, and which are amenable to change in the short run through policies and managerial decisions. Effective coverage was discussed in this context in the two previous sections.

If this is this is thought to be desirable, it will be necessary to decide whether a limited set of additional instrumental indicators should be included, how they should be defined and routinely measured. This is not trivial. As stated earlier, the concepts of effectiveness, quality, access, utilization, and appropriateness are all important when considering how to measure coverage or access. The final step for managers is to interpret these instrumental indicators and take appropriate remedial action. Poor coverage, for example, may be related to inefficient performance of health care providers, which is affected by a range of factors—wage rates, quality of education, supervision. Managerial actions will differ depending on the level of accountability for the decisions (wage rates may be set centrally, while supervision may be at institutional levels).

3. Implications for Health Information Systems

National and sub-national health information systems are not currently set up to undertake comprehensive HSPA and WHO does not yet have sufficient capacity to provide technical support. Modification of health information system systems will require considerable discussion with experts from Member States to determine the minimum set of indicators (intrinsic and instrumental) to be monitored routinely, perhaps in conjunction with the judicious use of periodic surveys.

This is a critical issue in the choice of indicators. Having thousands of performance indicators, as currently is the case for the measurement of quality of care, would impose enormous strains on the health information systems of all Member States, but particularly the poorest. It would also make it difficult for managers to sift through the myriad of data. A balance needs to be found between coverage of all possible factors that might affect outcomes, the ability of the system to produce timely information on them, and the ability of managers to digest the information.

4. Engagement of Civil Society

If health policy makers accept the broad role of being stewards of population health, it will require increased interaction with funders and providers of care outside the public sector.

HSPA means assessing the contributions of all parts of the health system, and developing ways of improving the functioning of the private sector, for example, where it is shown to be performing below expectations. Accordingly, it has been suggested that governments will need to have continual policy dialogue with public, private-for-profit and private-not-for-profit stakeholders, as well as with their inter-sectoral collaborators.

5. WHO's Technical Support to Countries

WHO must also build its own capacity to provide technical support for routine HSPA. The forms that this takes is the focus of ongoing discussion in WHO and with Member States, but recent suggestions include:

a) Consultations and review of the health systems performance assessment methodology with countries and their own experts.

b) Helping countries, where invited, to build capacity to:

- Engage in national health policy dialogue;
- Assess the core functions;
- Undertake sub-national measurement and analysis –this would require review of the appropriateness of health information systems for HSPA;
- Develop appropriate policy responses.