Health Systems Performance Assessment And Improvement In The Region Of The Americas

Pan American Health Organization
Pan American Sanitary Bureau, Regional Office of the
World Health Organization

HEALTH SYSTEMS PERFORMANCE ASSESSMENT AND IMPROVEMENT IN THE REGION OF THE AMERICAS

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Foreword

The seminal work of Marc Lalonde and his Canadian colleagues codified the determinants of health outcomes and subsequent efforts have only served to reorganize and attempt to give various weightings to those determinants. This area is of fundamental importance to us as we seek to assist the countries of the Americas in their efforts to reduce the inequalities in health outcomes. The aforementioned is critical to examine not only the differences in outcomes that can be designated as representing inequity, but also the inequalities in these determinants. Although there has been appropriate emphasis on the social and physical environments that influence health outcomes, there has been increasing attention to the health systems as also being an important determinant.

The World Health Report (WHR) 2000: Health Systems: Improving Performance was dedicated to a critical examination of those attributes of the health systems that should be evaluated, and if necessary, improved as a means of improving health outcomes. The *Report* quite accurately defined health systems as consisting, «of all the people and actions whose primary purpose is to improve health». This definition is important as it separates those resources that might affect health incidentally from those whose primary purpose is to improve health. This theoretically allows us to define with a certain precision the appropriate boundaries of the systems and how their performance should be assessed. It should permit a definition of those functions that are essential in the systems and measures for assessing them in their various dimensions.

The publication of the WHR promoted considerable debate. Much of it, unfortunately focused on various measurements of performance, and not enough on the quite elegant description of the nature of the systems, their organization, their financing and the important role of the State in guiding or steering the manner in which they are organized.

This debate led us to develop a series of events at the regional level so that our Member States could examine in more detail the issues involved and discuss the approaches that would be more appropriate for them to assess the performance of their health systems. Perhaps, it was equally important that they should indicate the kind of technical cooperation that they would expect from the Pan American Health Organization (PAHO) in this area. This collection of papers represent the result of the discussions held in our Region as well as in our Governing Bodies and is presented as a matter of record, and also to provide some input into the ongoing important debate on the best manner to evaluate the performance of health systems and the steps needed to improve them.

I hope you find it interesting, and more importantly, of use in examining how we might literally improve health for all.

George A.O. Alleyne
Director

Introduction

The World Health Report 2000: Health Systems: Improving Performance, which compared the performance of the health systems of WHO's 191 Member States, created an unprecedented level of interest and debate within countries, international organizations, and research institutions.

Such debate led to the adoption of Resolution CD42.R5, entitled *The World Health Report 2000* by the 42nd Directing Council of the Pan American Health Organization (PAHO) on 26 September 2000. The resolution urged Member States to mobilize national intelligence, represented by their respective Ministers of Health, universities, research institutions, and similar organizations, to monitor and evaluate their own health systems.

Likewise, on 19 January 2001 the 107th Session of the Executive Board of the World Health Organization adopted Resolution EB107.R8, entitled «Health Systems Performance Assessment». The aforementioned resolution determined that to help Member States contribute to the WHO assessment of their health systems performance on a regular basis a technical consultation process be established bringing together personnel and perspectives from Member States in different WHO regions. The region of the Americas held the first of a series of regional technical consultations on health systems performance assessment.

The Regional Consultation of the Americas on Health Systems Performance Assessment was held on the dates of May 8 through May 10, 2001 at PAHO Headquarters in Washington, D.C. The objectives of the meeting were to:

a) Discuss different conceptual and methodological approaches to assess the performance of the health systems;

b) Take stock of different country and regional experiences in the Americas related to health systems performance assessment;

c) Identify the critical issues for furthering the conceptual and methodological development of a framework for measuring the performance of health systems which could be applied by countries on a regular basis and informed to WHO periodically;

d) Discuss the linkage between health systems performance assessment practices and health systems policy and managerial decision-making processes; and

e) Come up with an agenda of international technical cooperation in support to countries' efforts to measure the performance of health systems.

The Regional Consultation brought together 70 experts from 19 countries. Other participants included professionals from PAHO/WHO, WHO Headquarters, USAID, The World Bank, the Hipólito Unanue Accord, and from CARICOM. Representatives from the WHO regional offices in Europe and Western Pacific participated as observers. The Consultation produced a report which was transmitted to the WHO Headquarters to be incorporated into the recommendations made by other regions and into the final document that will be presented on this matter to the WHO Executive Committee in January 2002.

After the Regional Consultation took place a work group was organized that met in Ottawa, Canada on September 4-6, 2001 to undertake an in-depth analysis of the subject matter and expand the recommendations made in the Regional Consultation.

Finally, the outcome of both meetings was presented in a special session scheduled during the 43rd PAHO/WHO Directing Council Meeting in September 2001 in order to inform the delegations of the Member States and to organize a discussion forum on the topic. The results of this discussion were also transmitted to WHO Headquarters.

This publication contains the documents that were presented and produced in the aforementioned three meetings, as well as the list of participants to the first two meetings. It also includes a provisional summary of the discussions that took place in the Directive Council on Health Systems Performance Assessment.

We hope that such discussions will contribute to the improvement of performance assessment, and of the performance of the health systems in the Region of the Americas.

I. Regional Consultation on Health Systems Performance Assessment[1]

1.1 Critical Issues in Health Systems Performance Assessment-Background Paper

1.1.1 Introduction

The World Health Report 2000 (WHR) sought to summarize 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).

[1] Meeting took place in PAHO Headquarters, Washington, D.C., 8-10 May 2001.

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 governments' 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 summarizes 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 1.1.2, questions relating to future development of the framework in section 1.1.3, and practical policy and managerial issues related to HSPA in section 1.1.4.

1.1.2 Conceptual and Methodological Issues

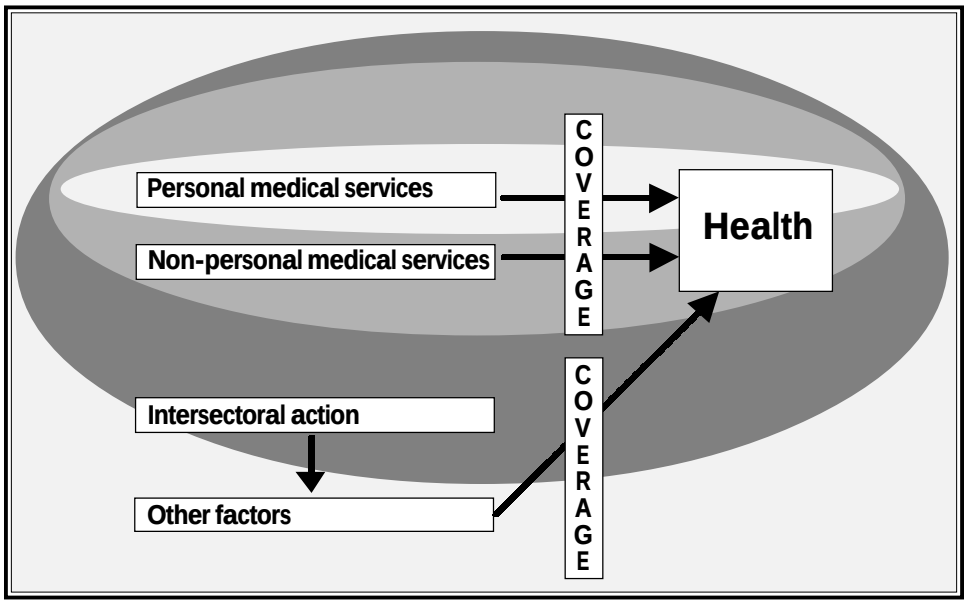
1.1.2.1 Boundaries of the Health System

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.

1.1.2.2 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 labeled «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 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 HSPA. 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.

1.1.2.3 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 was held in September 2001.

1.1.2.4 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.

1.1.2.5 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» 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.

1.1.2.6 Universal Weights

The WHR combined five 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.

1.1.2.7 Socially Desirable Goals

Considerable debate has focused on the appropriateness of the three 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 eight 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 eight domains but show very different patterns of use—there might be only one contact with the system per person per year in the first compared to four 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 HSPA 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 HSPA. The implications of routine performance assessment for health information systems is an important issue that is discussed in a later section.

1.1.2.8 Practical Policy Implications

Health system performance assessment 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 functions 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 1.1.4.

1.1.3 Furthering the Framework for Health Systems Performance Assessment: Gaps and Challenges

1.1.3.1 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.

1.1.3.2 The Need to Measure Functions and Progress

In section 1.1.2, 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[2] 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[3] 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.

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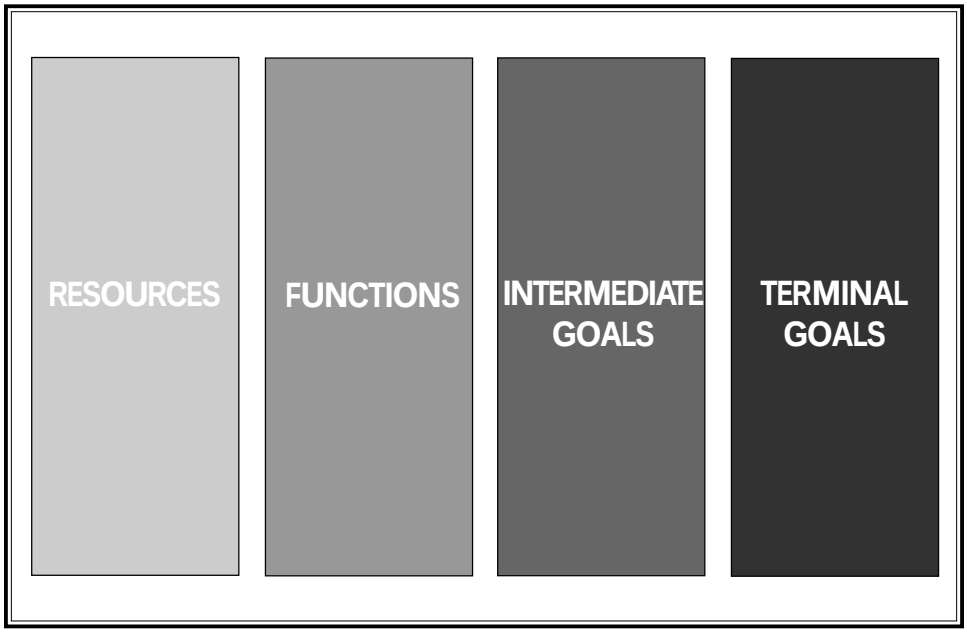
[2] National Research Council. Health Performance Measurement in the Public Health Sector: Principles and Policies for Implementing an Information Network. E. B. Perrin, J. S. Burch, and S. M. Skillman, eds. Washington D.C.: National Academy Press, 1999.

[3] 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.

This approach is consistent with a «dashboard» 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.

Figure 2: A Possible Way to Characterize Health Systems 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 1.1.4.

1.1.3.3 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.

1.1.3.4 Measuring the Performance of Functions

Section 1.1.2 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.

1.1.3.5 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[4] 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.

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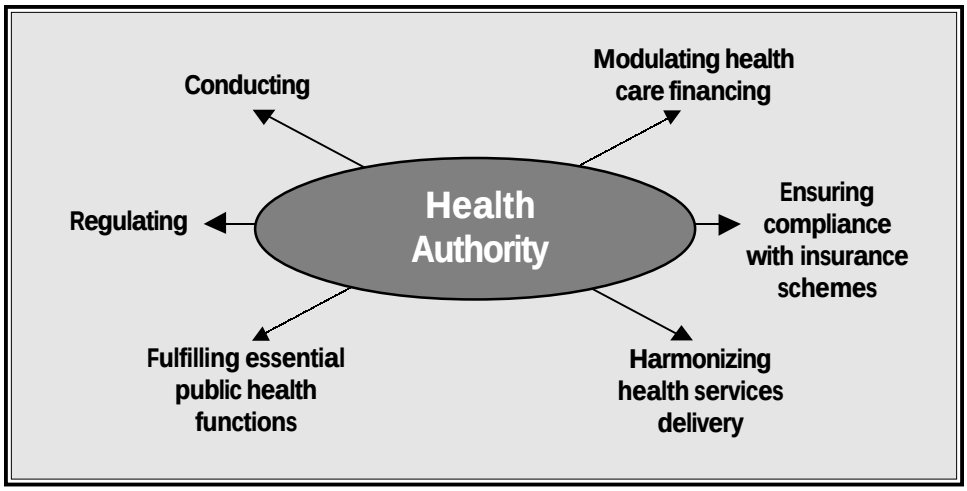
[4] PAHO/WHO. Steering Role of the Ministries of Health in the Processes of Health Sector Reform: CD40/13. Washington D.C., September 1997.

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.[5]

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).

1) Health Situation Monitoring and Analysis

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

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

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.

1.1.3.6 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 1.1.2 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[6,7]. 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).

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.

1.1.3.7 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 1.1.2, and these issues are explored again briefly. Clearly the choice of performance indicators does not

[6] 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.

[7] 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.

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.

1.1.3.8 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.

1.1.4 Linking Health Systems Performance Assessment to Policy-Making and Managerial Decision-Making

1.1.4.1 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.

1.1.4.2 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 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).

1.1.4.3 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 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.

1.1.4.4 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.

1.1.4.5 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 HSPA 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.

1.2 Report of the Regional Consultation of the Americas on Health Systems Performance Assessment

1.2.1 Introduction

The Regional Consultation of the Americas on Health Systems Performance Assessment called together 70 experts and political decision-makers from 19 Member States. Also present were staff members of the Pan American Health Organization/Regional Office for the Americas of the World Health Organization (PAHO/AMRO), the Cluster of Evidence and Information for Policy of the World Health Organization (WHO-HQ), the U.S. Agency for International Development (USAID), the World Bank, the World Bank Institute, the «Convenio Hipólito Unanue» and the Caribbean Community (CARICOM). Observers from the WHO Regional Office for Europe and WHO Regional Office for the Western Pacific were also present (Annex 1-A).

The objectives of the Consultation were:

a) To discuss different conceptual and methodological approaches to assess the performance of the health systems;

b) To take stock of different country and regional experiences in the Americas related to HSPA;

c) To identify the critical issues for furthering the conceptual and methodological development of a framework for measuring the performance of the health systems that could be applied by countries on a regular basis and informed to WHO periodically;

d) To discuss the linkage between HSPA practices and health systems policy and managerial decision-making processes;

e) To define an agenda of international technical cooperation in support of countries' efforts to measure the performance of the health systems.

Participants received a document entitled «Critical Issues in Health Systems Performance Assessment» as reference material. Both the agenda of the meeting and the document were prepared jointly by the Evidence and Information for Policy Cluster (EIP cluster) from WHO Headquarters and by the Division of Health Systems and Services Development of PAHO/AMRO (Annex 1-B). During the plenary sessions of the first two mornings, the program permitted experts with various perspectives to examine methodological and conceptual matters related to the World Health Report 2000 as well as the broader topic of measurement of health systems performance. The presentations were followed by open discussions that reflected the various viewpoints of the experts and participants.

There was a concerted effort to orient the debate towards the future and to contribute to the development of a clear definition of a performance assessment framework and

sound data that are useful to countries. The Director of PAHO/WHO, Dr. George Alleyne, set the tone by inviting a respectful, constructive and open debate that would help move the process forward. The first two morning sessions covered the topics of: a) Conceptual Basis and Scope of Health Systems Performance Assessment, and b) Furthering the Framework for Health Systems Performance Assessment used in the World Health Report 2000: Gaps Identified and Challenges Ahead. Discussant panels followed respective presentations by Dr. Christopher Murray and Dr. Daniel Lopez-Acuña.

During the first two afternoons, the participants were divided into four groups in order to respond to a series of discussion questions (Annex 1-C). Both of the first two days ended with a presentation by a rapporteur of the main issues discussed in each group. The third day included presentations of country experiences. The afternoon session dealt with linking performance assessment to political and managerial decision-making. The final session included a summary of the principal discussions of the working groups. The Director of PAHO/AMRO, Dr. Alleyne, closed the meeting.

This report summarizes the principal issues that were raised during the consultation, including discussions at both the plenary sessions and the working groups. The document is organized into two sections. In the first section, the principal lessons learned from the World Health Report 2000 Health Systems Performance Assessment Framework are summarized. In the second section, recommendations to review WHO conceptual framework and the indicators used to evaluate the performance of health systems are formulated.

1.2.2 Health Systems Performance Assessment Framework: Lessons Learned

1.2.2.1 General Observations

Definitions of the health system, its boundaries, and its objectives vary from country to country and are related to different societal values. In many countries these definitions are part of legal frameworks (Constitutions, Health Laws and others). Therefore, there are important limits to the country's comparison in terms of the performance of their health systems when the latter are defined in so many different ways.

Health Systems Performance Assessment has to be linked to political and managerial decision-making on the health system and not be viewed as an academic exercise. Many participants were of the opinion that a gap exists between the World Health Report 2000 and its use by those responsible for the political decisions in the health sector. It was suggested that this gap might be partly due to the fact that the indicators included in the report did not allow policy makers to directly assess what steps they could take to improve performance in the short term.

It was suggested by some participants that both at the national and international levels, the criteria for assessing the performance of health systems, as well as the indicators used should be established by consensus. This extensive consultation should lead to a transparent framework, data collection and criteria for analysis.

Otherwise, the polemics on the criteria and the indicators tend to cloud the results of the assessment and its possible use by policy makers and other interested actors.

The equating of «performance» with «efficiency» as included in the World Health Report 2000 was considered to be too narrow. It was suggested that performance should be defined as «the set of activities and programs that are carried out in order to achieve objectives and goals that have been previously established.» Consequently performance assessment should be seen as «the quantitative and qualitative appraisal that shows the degree of achievement of the objectives and the goals.»

It was suggested that efficiency is one among several of the possible dimensions of the performance of health systems. Accordingly, the revision of the conceptual framework should stem from a careful review of the dimensions of performance, particularly intermediate goals and indicators that mediate between inputs and the outcomes to which the system contributes.

1.2.2.2 Objectives and Results of the Health Systems

Improving health is the ultimate goal to which societies expect their health systems to contribute to. Depending on the perspective one takes responsiveness and fair financing may be considered final goals of the health systems but not the ultimate goal or may rather be perceived as attributes of the health system or intermediate goals.

The delivery of personal and non-personal services and intersectoral actions are only one way of improving the health of the population. Factors linked to the political and socioeconomic condition, the environment, genetics, and the individual and collective behavior have a powerful influence on health. It is necessary therefore to advance knowledge of how these factors interact, how they influence the health status of individuals and populations and therefore how they contribute to the attainment of the ultimate goal of the health system over and above the performance of the system itself.

The «time factor» makes the previous analysis even more complex and significantly influences the analysis of performance. Poor health status may be the result of decisions made fifteen years ago and its influence on the present situation may not always be easy to establish.

All of the above emphasizes the importance of paying particular attention to the functions and intermediate objectives of health systems (what health systems are actually doing and what they could do better) and not just focusing performance assessment on some distant final objectives (what «should be done»).

1.2.2.3 The Boundaries of the Health System and the Definition of Responsibility and Accountability

There was considerable discussion about the relationship between the boundaries of the health system and the accountability of government for its performance. A number of participants argued that each country defined its own system differently, and expected government to be responsible in different ways. They argued that it was not possible to define a common framework to HSPA. On the other hand, other participants argued that

international comparisons were useful, using a common framework, even if individual countries would want to modify the framework for their own internal purposes.

Related to the variation in legal definitions, which can be imprecise or outdated, but also to the identification of actors and the flow of financial and non-financial resources of the system, most definitions tend to minimize the importance of the subsystems of self-care and informal care. The initiative to prepare National Health Accounts, currently in progress in numerous countries, can help to fine tune the definition.

In most countries, those responsible for health policy tend to be accountable for actions linked to the delivery of personal and non-personal health services.

Greater variability among countries exists in those policies where the health system is only one among various sectors involved. Those responsible for health policy often try to take the lead in inter-sectoral actions, with strong impact on the health of populations, but they do not always achieve it. Thus, the accountability of the effects of these policies is often times not clear.

Finally, there are situations (for example, war and peace, social violence, and others), and policies (for example, economic policy), which strongly influence health status. They are outside of the health system's immediate realm of responsibility. At the most, those responsible for the health system can develop a certain advocacy role, but it is the entire government (or even the society at large) who is the one responsible. Again, there was no general agreement about how broadly or narrowly to define the system and the areas of accountability of policy makers.

1.2.2.4 Comparability among the Health Systems of the Countries

Unlike the comparison of the performance of the health system of a country with itself over time, the comparability of the performance of the health systems between countries was seen as something desirable but difficult to carry out for technical and political reasons.

In order for it to serve as stimulus for the formulation of health policies in the countries, the terms of comparison (the conceptual framework, the variables that operationalize it and the indicators of measurement) should be subject to consensus among those who are going to be compared.

The three dimensions of evaluation utilized in the World Health Report 2000 were discussed.

In the first place, it was considered that the use of Disability Adjusted Life Expectancy (DALEs) to measure the ultimate final goal of health does not directly include dimensions of positive health nor of the quality of life related to health. It was suggested that its role as the only indicator used for assessing the attainment of the ultimate goal of health be reviewed.

Secondly, it was considered that the current concept of «responsiveness» encompasses some dimensions of quality of care but deals only with the demand side. It does not take into account for example, the technical quality of the supply side. It does not include direct measures of the degree of response to health seeking behaviors of the populations

or of user satisfaction, nor does it take into account the cultural variability among the countries and within the same country.

Thirdly, discussion took place on the concept and measure of «fair financing». It was considered that it concentrates exclusively on one side of the problem, the share of household expenditures devoted to health. It does not take into account the effect of public expenditure in public health and personal care. It does not permit to assess how progressive or regressive is the financing of the health system, and, consequently, does not refer to the full spectrum of financial protection with respect to health.

Finally it was considered that from an ethical perspective the concept is debatable since it assumes that fair financing is the same thing than pure proportional financing.

It was suggested that other instruments and already existing measures should be examined. The measures can serve as secondary sources and/or as support measures to revise the framework of analysis of the performance of health systems and to refine the underlying concepts. It was considered that the challenge consists precisely in being able to integrate data from various sources in a way that generates relevant knowledge for decision-making that is capable of improving the performance of health systems.

The usefulness of a single composite index in constructing a scale of attainment for classifying the performance of the health systems of the countries, as was employed in the World Health Report 2000, was widely discussed.

The opinions included criticisms of the usefulness of the composite index to feed the policy design, implementation and evaluation; of the methodology used for its calculation, and of the appropriateness of its publication when the calculations are based on estimates and projections rather than on actual data. Some participants considered though that summary indexes may be utilized politically for ensuring that attention is gained for the health system.

The aggregate index of performance and the scale of attainment that ranks countries according to the index raises questions such as: Who does the ranking? What is the ranking for? Both can detract from the substance of the debate: to compare in order to improve.

It was also stressed that the policymakers need to be able to identify the contributions of the different components of the health system. For example, they need to have the capacity to be able to separate the contribution of personal services, non-personal services and inter-sectoral actions to the performance of the system and to the ultimate final goal of health. This would help them decide if they should allocate resources in a different manner, commensurate to the type of contribution identified in the performance assessment exercises.

1.2.3 Recommendations for Furthering the Conceptual Framework and the Indicators Utilized by WHO to Assess the Performance of the Health Systems

1.2.3.1 Introduction

The opinion was expressed during the meeting that Health Systems Performance Assessment should include a broad range of activities instead of equating the term performance with efficiency. This will allow the users of performance assessment to consider whether progress is being made with regard to specific goals and if the appropriate activities are being undertaken to promote the achievement of these goals.

The value of this would be in identifying the problem areas that may require special attention as well as the best practices that can serve as models. Thus, the performance assessment could also be a tool for regulation and resource allocation.

It was proposed by PAHO/AMRO that performance assessment could be compared to a «dashboard,» equipped with multiple gauges, that makes possible the scrutiny of different dimensions of the performance of the health systems. This could allow for assessing the degree of attainment of the intermediate goals and the different ways in which the functions of the systems operate.

1.2.3.2 The Multiple Dimensions of Health Systems Performance

The case was made for multiple measures that can be related to actions for which responsible national agencies could be held accountable. They should be pragmatic and connected with policy and managerial decision making in the health sector. They should rely on the identification of indicators of performance measurement for the different dimensions of the health systems: resources, functions, intermediate goals and final goals.

In order to evaluate the intermediate goals many suggestions were made. Some included:

- ✧ Access (if patients receive the services needed in the right place and at the right time);
- ✧ Relevance (if the provision of the service is relevant to the needs and if it is based on an established standard);
- ✧ Continuity (how the services are related among themselves, including coordination, integration and conduction);
- ✧ Sustainability (capacity of the systems to provide infrastructure, such as work force, establishments and equipment, in addition to being innovative and responsive to the needs that can arise);
- ✧ Efficiency (this often is conceived as technical efficiency or the capacity to achieve better results at the lowest cost);
- ✧ Competence (providers with knowledge and aptitudes that are appropriate for the care they provide);

- ✧ Acceptability (how efficient are the health systems with regard to the expectations of the citizens).

It was considered important to define procedures to measure the performance of the function of the steering role of the health authorities, taking into account the roles assumed in the majority of the countries at the central, intermediate and local levels of government.

It was noted that performance measurement of essential public health functions, as currently being done in the Region of the Americas, illustrates the potential of a tool for assessing the institutional capacities of the health authority. It measures one specific domain within the stewardship/steering role function of the health system. It may be used for continuous improvement of public health practice and for reorienting resource allocation into public health actions. It does it through a participatory and transparent process within each country in which 11 essential public health functions are measured. The results do not include a global indicator, and it is not oriented towards the construction of a summary measure that compares countries.

1.2.3.3 Rethinking Health Systems Performance Assessment

As part of rethinking and improving HSPA it was considered appropriate to advance a framework that takes into account four dimensions: the inputs and/or resources, the functions, the results or intermediate objectives, and the final objectives of the system.

Health systems performance assessment also has to be linked to both the definition of the desired change contained in health sector reform agendas and the actual possibility of implementing changes.

At present there are some national experiences designed to assess the performance of the health systems in several countries of the Region of the Americas, which should be taken into account and analyzed.

Performance assessment efforts should incorporate the different areas of analysis (national, intermediate, local), the different functions of the systems and consider several potential recipients (political decision makers, other interested actors, the public, etc.)

1.2.3.4 Constructing Relevant Indicators

The indicators should be grouped in relation to the previously selected dimensions. A careful definition of terms is required. Some indicators can be used to evaluate more than one dimension.

A careful balance should be established between information that is available and communicated periodically by the countries and information that is desired but still unavailable. A process for strengthening data collection, and for estimating the costs and the time that are required for making data readily available should be defined. It is necessary to find an equilibrium between all the possible factors that could influence the results, the capacity of the system to produce timely information, and the capacity of the administrators to analyze and process the information.

These indicators should be adaptable to changes in policy and administrative decisions both in the short and in the medium run. The data and methodologies for calculations should be transparent and reproducible.

The implications of the inclusion of HSPA indicators in routine health information systems requires a careful evaluation by experts of the Member States. A central objective of that consultation is to determine the minimum set of indicators that should be monitored routinely, the relationships between quantitative and qualitative indicators, central and complementary indicators, as well as the relationships between indicators collected regularly and the conducting of periodic surveys.

1.2.3.5 Technical Support of WHO to the Countries for Health Systems Performance Assessment

WHO should further develop its capacity to provide technical support in performance assessment of the health systems. This implies continuous discussions between the Organization and the Member States.

Improving the common understanding of the relationships between state of health and health systems is a long-term process that can take many years. In addition to documenting the results of that relationship, future reports should emphasize the process that leads to the development of the framework, the measures and the indicators. In addition, the development of global indicators implies long-term research efforts that should involve those who are responsible for health policies, researchers and other interested actors. WHO should use its leadership in order to make it possible for this to be a more inclusive process.

WHO should reexamine the methodology of the HSPA in close collaboration with the countries and with its own experts in different clusters and regions. The Organization should play a critical role in the development of standards, in bringing together experts in order to compare and contrast different approaches being used in the countries, in building consensus on the best ways to ensure comparability between countries with regard to health status, health expenditure, health systems organization and other relevant dimensions of the systems.

WHO should support the countries' efforts in order to develop capacities to:

- ✧ Dialogue on national health policies.
- ✧ Evaluate the resources, functions, intermediate objectives and final objectives of the health systems, as well as the degree of achievement of the desired changes.
- ✧ Examine the pertinence of current health information systems to generate the necessary data.
- ✧ Undertake the measurement of the performance at the national and subnational levels.
- ✧ Develop appropriate policy responses.

WHO should make better use of its collaborating centers, other national institutions, as well as strengthen the exchange of information among its different units and regional offices.

1.2.3.6 Further Steps

The results of the Consultation will be taken into account in the work undertaken in this area in the region of the Americas. Equally, they will be transmitted to the World Health Organization Headquarters to be incorporated into the recommendations made by other regions to the formulation that will be presented on this matter to the Executive Board in January 2002.

PAHO/AMRO will organize a work group that, before the end of September will undertake an in depth analysis of the subject matter and expand the recommendations made in the Consultation.

The result of both discussions will be presented to a special session to be scheduled during the Directive Council Meeting which will take place during the last week of September 2001. The objective of this session will be to inform the delegations of all the Member Countries and to hold a forum for debate that will also be conveyed to the WHO headquarters.

Annex 1-A: List of Participants of the Regional Consultation of the Americas on Health Systems Performance Assessment

ARGENTINA

Dr. Ginés González
Rector del Instituto Universitario ISALUD
Argentina
Tel.: (54-11) 4334-7766
Fax: (54-11) 4334-0710 (directo), 4334-1736
correo@isalud.com

Dr. Francisco Martini
Jefe del Gabinete de Asesores del Ministro de Salud
Ministerio de Salud de la Nación
Av. 9 de Julio 1925, 8vo Piso
(1332) Capital Federal
Tel.: 4379-9085/9012
Fax: 4379-9143

Sr. Javier Vilosio
Subscretario de Programas de Prevención y Promoción
Secretaría de Atención Sanitaria
Ministerio de Salud de la Nación
Av. 9 de Julio 1925, 8vo Piso
(1332) Capital Federal
Tel.: 4379-9085/9012
Fax: 4379-9143
jvilosio@msal.gov.ar

BARBADOS

Ms. Elsie Le Franc
Professorial Fellow
Sir Arthur Lewis Institute of Social and Economic Studies
University of West Indies
Cave Hill Camous, P.O. Box 64
Bridgetown, Barbados
Tel.: 264-417-4478
Fax: 246-424-7291
elefranc@uwichill.edu.bb

BOLIVIA

Dr. Fernando Lavadenz
Gerente General del Proyecto de Reforma de Salud
Ministerio de Salud y Previsión Social
Calle Batallón Colorados, Piso 3
La Paz, Bolivia
Tel.: 591-2-442-666/442-543
Fax: 591-2-440-732
refsalud@ceibo.entelnet.bo

BRAZIL

Dr. Joaquim Gonçalves Valente
Investigador
Escuela Nacional de Salud Pública
FIOCRUZ
Rua Leopoldo Bulhoes 1480
Rio de Janeiro, Brasil 21041-210
Tel.: 5521-598-2541/42
Fax: 5521-290-0484

Sra. Celia Landman
Investigadora
Escuela Nacional de Salud Pública
FIOCRUZ
Rua Leopoldo Bulhoes 1480
Rio de Janeiro, Brasil 21041-210
Tel.: 5521-598-2541/42
Fax: 5521-290-0484

Dra. Claudia Travassos
Investigadora
Escuela Nacional de Salud Pública
FIOCRUZ
Rua Leopoldo Bulhoes 1480
Rio de Janeiro, Brasil 21041-210
Tel.: 5521-598-2541/42
Fax: 5521-290-0484

CANADA

Mr. Richard Alvarez
President and CEO
Canadian Institute for Health Information
90 Eglinton Avenue East, Suite 300
Toronto, Ontario
Canada M4P 2Y3
Tel.: (416) 481-2002
Fax: (416) 481-2950
ralvarez@cihi.ca

Dr. Indra Pulcins
Manager Health Indicators
Canadian Institute for Health Information
90 Eglinton Avenue East, Suite 300
Toronto, Ontario
Canada M4P 2Y3
Tel.: (416) 481-2002
Fax: (416) 481-2950

Mr. Michael Wolfson
Assistant Chief Statistician, Statistics Canada
Social and Econmic Studies Division
RH Coats, Floor: RHC26K
RH Coats Building Holland Ave. and
Scott Street Tunney's Pasture
Ottawa, Ontario, Canada K1A OT6
Tel.: (613) 951-8216
wolfson@statcan.ca

CARICOM

Mr. James St. Catherine
Program Manager in Health
CARICOM Community Office
Bank of Guyana Building
Guyana
Tel.: 592-225-1960
Fax: 592-225-8039
jamessc@caricom.org

CHILE

Dr. Claudio Farah
Escuela de Salud Pública
Universidad de Chile
Independencia 939
Casilla 70012, Correo 7
Santiago, Chile
Tel.: 562-678-6149
Fax: 562-735-5582

Dr. Fernando Muñoz
Presidente
CLAISS
José Miguel de la Barra 412, Piso 3
Santiago, Chile
Tel.: 562-664-9375/3684/4375
Fax: 562-664-3624
claiss@ctcreuna.cl

COLOMBIA

Dra. Angela González Puche
Instituto Nacional de Salud de Colombia
Colombia
Tel.: 571-222-3111
Fax: 571-368-8928

CONVENIO HIPÓLITO UNANUE

Sr. Mauricio Bustamante
Director Ejecutivo
Organismo Andino de Salud
Convenio Hipólito Unanue
Av. Paseo de la República 3832, 3er Piso
Lima 27, Perú
Tel.: 511-221-0074
Fax: 511-440-9285
mabusta@conhu.org.pe

COSTA RICA

Dra. María Elena López
Directora Dirección Servicios de Salud
Ministerio de Salud
Apartado Postal 158-1200
Pavas, San José, Costa Rica
Fax: 506-258-5830 (OPS-COR)
melopez@racsa.co.cr

ECUADOR

Sr. Ramiro Echeverría
Juan Figueroa 1230 y Ave. Occidental
Condominio Kazu - II C-6
Quito Norte, Ecuador
Tel.: 593-259-100
Fax: 593-294-372
Cell.: 593-282-7670
recheverria@andinanet.net

EL SALVADOR

Dra. Lydia Eugenia de Nieto
Directora de Planificación
MSPAS
San Salvador, El Salvador

GUATEMALA

Sr. Dr. Julio Molina Aviles
Vice Ministro de Salud Pública y
Asistencia Social
Ministerio de Salud Pública y
Asistencia Social
6ta. Avenida 3-45, Zona 11
Ciudad de Guatemala, Guatemala
Fax: 502-475-2168

JAMAICA

Mr. Stanley Lalta
Health Economist
Ministry of Health
Oceana Building
2 - 4 King Street
Kingston 5, Jamaica

Dr. Barrington Wint
Executive Chairman of the Board
South East Regional Health Authority
Ministry of Health
Ocean Building, 2 King Street
Kingston, Jamaica
Tel.: 876-967-1101
Fax: 876-922-8862

MEXICO

Dr. Miguel Angel Lezana Fernández
Coordinador de Asesores del
Secretario de Salud
Ministerio de Salud de México
Tel.: 525-553-7306
Fax: 525-250-0925
miguelan@cenids.ssa.gov.mx

Sr. Enrique Ruelas Barajas
Subsecretaría de Innovación y Calidad
Secretaría de Salud
Mexico

PAN AMERICAN HEALTH ORGANIZATION (PAHO)
525 Twenty-Third Street, N.W.
Washington, D.C. 20037

Mr. Bernt Andersson
Regional Advisor, HSP/HSO
Tel.: (202) 974-3212
Fax: (202) 974-3641
anderssb@paho.org

Dr. Pedro Brito
ProgramCoordinator, HSP/HSR
Tel.: (202) 974-3295
Fax: (202) 974-3612
britoped@paho.org

Dr. Juan Antonio Casas
Director, HDP
Tel.: (202) 974-3210
Fax: (202) 974-3652
casasjua@paho.org

Dr. Carlos Castillo-Salgado
Program Coordinator, SHA
Tel.: (202) 974-3327
Fax: (202) 974-3674
castillc@paho.org

Dr. César Gattini
Regional Advisor, HSP/HSO
Tel.: (202) 974-3225
Fax: (202) 974-3641
gattinic@paho.org

Dr. Alberto Infante
Regional Advisor, HSP/HSO
Tel.: (202) 974-3818
Fax: (202)-974-3641
infantea@paho.org

Dr. Enrique Loyola
Regional Advisor, SHA
Tel.: (202) 974-3130
Fax: (202) 974-3674
loyolaen@paho.org

Dr. Oscar Mujica
Regional Advisor, SHA
Tel.: (202) 974-3974
Fax: (202) 974-3674
mujicaos@paho.org

Dr. Mirta Roses Periago
Assistant Director
Tel.: (202) 274-3404
Fax: (202) 974-3601
rosesmir@paho.org

Dr. Priscilla Rivas-Loria
Consultant, HSP/HSO
Tel.: (202) 974-3876
Fax: (202) 974-3641
rivaspri@paho.org

Mr. Hernán Rosenberg
Regional Advisor
Tel.: (202) 974-3195
Fax: (202) 974-3641
rosenbeh@paho.org

Dr. Karen Sealey
Chief, DAP
Tel.: (202) 974-3187
Fax: (202) 974-3604
sealeyka@paho.org

Ms. Patricia Schroeder
Assistant to the Health Sector Reform Project, HSP/HSO
Tel.: (202) 974-3239
Fax: (202) 974-3641
schroedp@paho.org

Dr. César Vieira
Program Coordinator, HDP/HDD
Tel.: (202) 974-3235
Fax: (202) 974-3675
vieirace@paho.org

Dr. Edwina Yen
Consultant, HSP/HSO
Tel.: (202) 974-3866
Fax: (202) 974-3641
yenedwin@paho.org

Dr. José Luis Zeballos
Program Coordinator, HSP/HSO
Tel.: (202) 974-3215
Fax: (202) 974-3641
zeballoj@paho.org

PARAGUAY

Dr. Roberto Dullack
Director General de Planificación
Ministerio de Salud Pública y Bienestar Social
Pettirossi y Brasil
Asunción, Paraguay
Fax: (59521) 206-885

PUERTO RICO

Dra. Elena Batista
Asesora, Secretario de Salud
Departamento de Salud
San Juan, Puerto Rico
Tel.: (787) 617-0475 764-5701
Fax: (787) 250-7064

UNITED KINGDOM

Prof. Azim Lakhani
Director
National Centre for Health Outcomes Development
Health Services Research Unit
London School of Hygiene and Tropical Medicine
Keppel Street
London WCIE 7HT, UK
Tel.: 44-20-7927-2366
Fax: 44-20-7580-8183
azim.lakhani@lshtm.ac.uk

UNITED STATES OF AMERICA

Dr. Ivan Barofsky
Johns Hopkins Bayview Medical Center
4940 Eastern Avenue
Baltimore, MD 21224
Tel.: 410-550-0162
Fax: 410-550-8035

Ms. Karen Becker
Epidemiologist
Health and Human Services
Washington, D.C., USA
Tel.: (301) 443-1774
Fax: (301) 443-6288

Dr. Peter Berman
PHPOPSTD
Harvard School of Public Health
677 Huntington Ave.
Boston, MA 02115
Tel.: (617) 432-4616
Fax: (617) 432-2181
pberman@hsph.harvard.edu

Ms. Karen Cavanaugh
USAID
1300 Pensylvania Ave.
Washington, D.C. 20523
Tel.: (202) 712-5859
Fax: (202) 216-3702

Dr. Janet M. Corrigan
Director
Board on Health Care Services
Institute of Medicine
National Academy of Sciences
2101 Constitution Avenue NW –Room TJ1020
Washington, D.C. 20418
Tel.: (202) 334-2165
Fax: (202) 334-2862

Mr. Charles Derby
Agency for Health Care Research and Quality
Executive Office Center
2101 East Jefferson St.
Rockville, MD 20852
Fax: (301) 594-2168

Mr. Paul Halverson
Centers for Disease Control (CDC)
4770 Buford Hwy, Mail Stop K-39
Atlanta, GA 3034-3724
Tel.: (770) 488-2527
Fax: (770) 488-2489
pch4@cdc.gov

Dr. Wade Hanna
Centers for Disease Control (CDC)
4770 Buford Hwy, Mail Stop K-39
Atlanta, GA 3034-3724
Tel.: 770-488-2527
Fax: 770-488-2489
pch4@cdc.gov

Dr. David Hotchkiss
Abt. Associates, Inc.
4800 Montgomery Lane, Suite 600
Bethesda, MD 20814-5341
Tel.: (301) 913-0500
Fax: (301) 913-0562

Dr. Dean Jamison
Professor, Program on Global Health
University of California
Los Angeles, CA
Tel.: (310) 206-0223
Fax: (310) 206-4018
djamison@isop.ucla.edu

David McQueen
Centers for Disease Control (CDC)
4770 Buford Hwy, Mail Stop K-39
Atlanta, GA 3034-3724
Tel.: (770) 488-2527
Fax: (770) 488-2489

Dr. David Nicholas
Project Director
Quality Assurance Project
Center for Human Services
7200 Wisconsin Ave., Suite 600
Bethesda, MD 20814-4811
Tel.: (301) 941-8408
Fax: (301) 941-8427

Thomas Novotny, M.D., M.P.H.
Deputy Assistant Secretary and Director
Office of International and Refuge Health
5600 Fishers Lane, Room 18-105
Rockville, MD 20857
Tel.: (301) 443-1774
Fax: (301) 443-6288

Dr. Mary Paterson
Abt. Associates, Inc.
4800 Montgomery Lane, Suite 600
Bethesda, MD 20814-5341
Tel.: (301) 913-0500
Fax: (301) 913-0562

Dr. Edward B. Perrin
Professor Emeritus
Health Services
University of Washington
Seattle, WA, USA
Tel.: (206) 616-2982
Fax: (206) 543-5318

Ms. Patricia Pittman
Senior Manager, International Projects
Academy for Health Services Research and Health Policy
1801 K St. NW Suite 701-L
Washington, D.C. 20006
Tel.: (202) 292-6712
Fax: (202) 292-6800
pittman@ahsrhp.org

Dr. Marc Roberts
Harvard School of Public Health
677 Huntington Ave.
Boston, MA 02115
Tel.: (617) 432-0807
Fax: (617) 432-3699

Dr. Gerald Rosenthal
MSH
165 Allandale Rd
Boston, MA 02130-340
Fax: (614) 524-2825

Dr. Ed Sondick
Director
National Center of Health Statistics
Hyattsville, MD 20782-2003
Tel.: (301) 458-4500
Fax: (301) 458-4020

Ms. Mary Lou Valdez
Office of International and Refugee Health
U.S. Department of Health of Human Services
Maryland, USA
Tel.: (301) 443-4549
Fax: (301) 443-4549

URUGUAY

Dr. Eduardo Touya
Director General de la Salud
Ministerio de Salud Publica
Av. 18 de Julio 1892
Montevideo, Uruguay
Tel.: (598 2) 409-7800/ 400-1002
Fax: (598 2) 401-3870

VENEZUELA

Sr. Oscar Feo
Comisión Presidencial para la Reforma de la Seguridad Social
Apartado Postal 4810
Maracay, Venezuela
Fax: (582) 753-5859

WORLD BANK

Mr. Gilles Dussault
World Bank Institute
1818 H Street, N.W.
Washington, D.C. 20433
Tel.: (202) 477-1234
Fax: (202) 676-0961

Ms. Ann Johansen
World Bank Institute
1818 H Street, N.W.
Washington, D.C. 20433
Tel.: (202) 477-1234
Fax: (202) 676-0961

Mr. Alex Preker
Health, Nutrition, and Population
World Bank
1818 H Street, N.W.
Washington, D.C. 20433
Fax: (202) 522-3234

Dr. Paul Shaw
Health Sector Leading Specialist
World Bank Institute
1818 H Street, N.W.
Washington, D.C. 20433
Tel.: (202) 473-3441
Fax: (202) 676-0961

Dr. Adam Wagstaff
Lead Heath Economist
World Bank
1818 H Street, N.W.
Washington, D.C. 20433
Fax: (202) 473-0566
awagstaff@worldbank.org

WORLD HEALTH ORGANIZATION (WHO)

Dr. Orvill Adams
Director
Department of Health Systems
World Health Organization
20 Avenue Appia
Geneva 27, Switzerland
Tel.: (41-22) 791-2889
Fax: (41-22) 791-4747
adamso@who.ch

Dr. David Evans
Director a.i.
Global Programme on Evidence
for Health Policy
World Health Organization
20 Avenue Appia
Geneva 27, Switzerland
Tel.: (41-22) 791-3970
Fax: (41-22) 791-4781

Dr. Kei Kawabata
Coordinator, FAR/GPE
World Health Organization
20 Avenue Appia
Geneva 27, Switzerland
Tel.: (41-22) 791-3970
Fax: (41-22) 791-4781

Ms. Suszy Lessof
The World Health Organization
Regional Office for Europe (EURO)
8, Scherfigsvej
DK-2100 Copenhagen 0
Denmark
Tel.: 45 39 171717
Fax: 49 39 17181

Dr. Christopher Murray
Executive Director
Evidence and Information for Policy Cluster
World Health Organization
20 Avenue Appia
Geneva 27, Switzerland
Tel.: (41-22) 791-2111
Fax: (41-22) 791-0746
murrayc@who.int

Dr. Soe Nyuntu
The World Health Organization
Regional Office for the Western Pacific
(WPRO)
P.O. Box 2932
1000 Manila
Philippines
Tel.: (632) 528-8001
Fax: (632) 521-1036
rona@who.org.ph

Dr. Sam Tien
The World Health Organization
Regional Office for South-East Asia (SEARO)
World Health House
Indraprastha Estate
Mahatma Gandhi Road
New Delhi 110002, India
Tel.: 91-11-331-7804
Fax: 91-11-331-8607

Annex 1-B: Program of the Regional Consultation of the Americas on Health Systems Performance Assessment

FIRST DAY, MAY 8, 2001

09:00 - 09:15 Opening Address: *Dr. George A. O. Alleyne,* Director PAHO/AMRO

FIRST PLENARY SESSION

09:15 - 10.00 "The Conceptual Basis and the Scope of Health Systems Performance Assessment"
Dr. Christopher Murray, Executive Director, Evidence and Information for Policy Cluster, WHO-HQ

10:00 - 10:45 Discussants
Dr. Claudio Farah, Professor, School of Public Health, University of Chile, Santiago, Chile
Dr. Paul Shaw, Health Sector Leading Specialist, World Bank Institute, Washington D.C., USA
Dr. Marc Roberts, School of Public Health, Harvard University, Boston, Massachusetts, USA
Dr. Michael Wolfson, Assistant Chief Statistician, Analysis and Development, Statistics Canada, Ontario, Canada

10:45 - 11:15 Coffee Break

11:15 - 12:15 Open Debate

12:15 - 12:30 Summary of issues to be discussed in the working groups

12:30 - 14:00 Lunch Break

14:00 - 15:30 Working Groups

15:30 - 16:00 Coffee Break

16:00 - 17:00 Working Groups (continuation)

17:00 - 17:30 Plenary Presentation of Working Groups Conclusions

SECOND DAY: MAY 9, 2001

SECOND PLENARY SESSION

09:00 - 09:45 "Furthering The Framework for Health Systems Performance Assessment used in the WHR 2000: Gaps Identified and Challenges Ahead"
Dr Daniel López–Acuña, Director, Division of Health Systems and Services Development, PAHO/AMRO

09:45 - 10:30 Discussants:
Dr. Claudia Travassos, Public Health Researcher, Fundación Oswaldo Cruz, Rio de Janeiro, Brazil
Dr. Ed Sondick, Director, National Center of Health Statistics, Maryland, USA
Dr. Fernando Muñoz, President, "Centro Latinoamericano de Investigación de Sistemas de Salud" (CLAISS), Santiago, Chile
Dr. Edward Perrin, Professor Emeritus, Department of Health Services, University of Washington, Seattle, Washington, USA

10:30 - 11:00 Coffee Break

11:00 - 12:15 Open debate

12:15 - 12:30 Summary of issues to be discussed in the working groups (rapporteur)

12:30 - 14:00	Lunch Break
	Working Groups on Second Plenary Session
14:00 - 15:30	Working Groups
15:30 - 16:00	Coffee Break
16:00 - 17:00	Working Groups (continuation)
17:00 - 17:30	Plenary Presentation of Working Groups Conclusions

THIRD DAY, MAY 10, 2001

THIRD PLENARY SESSION

Country and Regional Experiences in Health Systems Performance Assessment in AMRO

09:00 - 09:30	"Canadian Experience in Performance Assessment of the Health System" *Mr. Richard Alvarez,* President and CEO, Canadian Institute for Health Information, Ontario, Canada
09:30 - 10:30	"A Framework for Monitoring Health Outcomes, as part of Performance Assessment in England" *Dr. Azim Lakhani,* London School of Hygiene and Tropical Medicine, London, Ingland
10:30 - 11:00	Coffee Break
11:00 - 11:30	"The Mexican Experience of Health Systems Performance Assessment" *Dr. Miguel Angel Lezana,* Coordinator of Advisors to the Secretary of the Ministry of Health, Ministry of Health, Mexico
11:30 - 12:00	"United States National Report on Quality of Care" *Dr. Janet M. Corrigan,* Director, Board on Health Care Services, Institute of Medicine, Washington D.C., USA
12:00 - 12:15	Questions and Answers
12:15 - 12:30	Summary of main issues raised during the session (rapporteur)
12.30 - 14:00	Lunch Break

FOURTH PLENARY SESSION

14:00 - 14:45	"Linking Health Systems Performance Assessment to Policy Making and Managerial Decision Making" *Dr. Orville Adams,* Director, Department of Health Systems, WHO/HQ
14:45 - 15:30	Discussants: *Dr. Ginés González,* Rector, University Institute ISALUD, Buenos Aires, Argentina *Dr. Peter Berman,* Harvard School of Public Health, Boston, Massachusetts, EUA
15:30 - 16:00	Coffee Break
16:00 - 16:45	Open debate
16:45 - 17:00	Summary of issues raised during the session (rapporteur)
17.00 - 17:30	Concluding remarks: *Dr. George A. O. Alleyne,* Director of PAHO/AMRO

Annex 1-C: Guidelines for Working Groups Discussion

SESSION 1

MAY 8, 2001

1. Which goals and primary outcomes of the health system should be considered when we assess its performance?
2. Where should we establish the boundaries of the health system? Who formulates that definition and how comparable are performance measurements when the definitions of health systems vary?
3. How do the goals of the current WHO framework align with Member States' goals?
4. Should health policy makers and stewards of the health system be equally accountable for what they are directly responsible (personal and non-personal services), for what they are only partially responsible (intersectoral action), and for what they are not directly responsible?
5. Which other instruments/measures pertaining to other constituent parts of human development that have an influence on health should be developed?
6. What is the comparability of the measures of responsiveness and financial fairness among countries?

SESSION 2

MAY 9, 2001

1. What are we referring to when we discuss health system performance? What does it encompass?
2. Is performance assessment of the health system best served by the calculation of a single combined index subject to weights given to each variable, or by a series of indicators that can provide information on the different domains of health system performance (resources, functions, intermediate goals and final goals)? How can they be more directly linked to action?
3. What are the key indicators of functions and intermediate goals that should be developed to assess the performance of health systems so they provide meaningful information for the improvement of the health system?
4. How does WHO data sources and methodologies improve Member States' abilities to move from data to action and actually impact policies and programs?
5. What research and development is needed to support the performance measurement of intermediate goals and health system functions?

II. Work Group of the Region of the Americas on Health Systems Performance Assessment, Report of the First Meeting[8]

2.1 Introduction

The Workgroup of the Region of the Americas on Health Systems Performance Assessment (HSPA), held its first meeting in Ottawa, Canada from September 4-6, 2001. The group was comprised by representatives of Brazil, Cuba, Canada, Jamaica, Mexico, and the United States as well as PAHO/AMRO staff members. WHO Headquarters was invited to participate, but could not attend the meeting.

The Workgroup reaffirmed what was discussed at the Regional Consultation of the Americas on HSPA, held in May 2001: the main objective of HSPA activities is to provide information to the countries themselves to improve the performance and ultimately the quality of their health systems.

Therefore, the work needs to be targeted towards something that is «actionable» at the national and local level. In addition, given that health systems are very rooted in the unique historical and social circumstances of each country, it is unlikely that a single assessment process will be applicable and useful across all nations.

It was also agreed that there is great benefit in developing the methodologies for doing assessments within an international context and that there are likely to be some set of activities that will be of interest across all countries and possibly a larger group that would apply to groups of countries with similar characteristics and needs. It would be highly desirable for these to be done in a comparable and consistent way. PAHO and WHO should facilitate these activities.

Additional work was done on the extremely complex but important task of clarifying the components of the health systems in terms of functions and characteristics. More work is needed in terms of standardizing terminology, conceptualizing the components, fitting them together, and on how they can be measured.

The «dashboard» concept, introduced at the Regional Consultation of the Americas Meeting, was reaffirmed and additional work was done to clarify how to use this concept in the assessment. A variant of the framework being used in Canada was discussed which contains four major domains: Health Status, Non-Medical Determinants of Health, Health Care System, and Community and Health System Characteristics (Resources).

There was considerable discussion, which needs to continue, about where specific components fit. There was consensus that the third level, Health Care System, was most directly related to performance assessment, with special emphasis on the delivery of care, and is the focus of the activity. Other levels of the framework are critically important

[8] This meeting took place in Ottawa, Canada, 4-6 September, 2001.

and provide needed context. Issues of equity should be addressed at all levels of the framework.

There was also considerable discussion of how the nations should collaborate on these activities and how they should relate to WHO at country, regional and headquarters level in terms of the collection, analysis and dissemination of information on HSPA. Greater involvement of the Member States in these activities is desired. PAHO/AMRO's contributions in areas, such as strengthening national information systems infrastructure and capabilities, helping the countries to establish the limits and conditions of comparability, sharing/disseminating information and other initiatives related to HSPA from other regions, and establishing schemes of technical cooperation among countries (TCC) were widely discussed.

2.2 Conclusions and Recommendations

The Work Group discussions resulted in the following conclusions and recommendations:

2.2.1 On General Matters

The main purpose of HSPA is to improve the performance and quality of the health system. In doing so, the effort should contribute to improve the health of the population. HSPA is not an end, in and of itself.

A composite index for ranking countries' health systems does not necessarily contribute to the improvement of the performance and quality of the health system at the national level.

The notion that there is a need to develop intermediate goals indicators has been re-emphasized.

Survey information for HSPA must be properly articulated with the information generated at the country-level on a regular basis and should involve an active participation of Member Countries.

Fair financing and responsiveness are not health system final goals in the same manner that health status is the ultimate final goal or outcome. They are instrumental and, therefore, fall within the realm of intermediate goals.

It is crucial to connect the HSPA framework [categories, variables and indicators] with policy decision-making. The concrete needs of policy makers as main users have to be taken into consideration and met.

There was consensus on having the HSPA framework be a national self-evaluating tool, to have the instrument discussed and designed jointly, and not to have an externally designed instrument applied.

Equity is a transversal dimension to be highlighted in any HSPA framework. Otherwise, it could be easily neglected or missed.

2.2.2 On Reporting Health Systems Performance Assessment Data to WHO Headquarters

Concerns were raised on data sources used by WHO Headquarters EIP Cluster for calculating or updating national data to be published in the World Health Report 2001.

Concerns have also been raised on the nature of the direct relationship between the WHO EIP Cluster and health authorities and technical units at the national level regarding this initiative, and the short-term deadlines established by Geneva.

Data used for HSPA should be provided by the country, the sources need to be known, the calculations be transparent and peer-reviewed, the final figures discussed and their use clarified before published. This is something required for official international organization documents except when there are good reasons to think national official data are not accurate and/or reliable. In such case, a clear explanation is needed.

Due process of Regional Offices and Headquarters with national authorities needs to be carefully followed (i.e. letters' wording, appropriate signature and channels, and realistic datelines).

2.2.3 On Information Systems and Data Collection at the National Level

Very frequently there is no clear connection between personnel who prepare health reports and those who work to collect primary data at the national level. The former normally works with what they have, but rarely contribute to improve the way the latter works.

There is a clear need to incorporate the private sector for routine data collection and processing. Also, to include health services issues and other socioeconomic data pertinent to health into general household surveys.

In most countries, vital statistics is the most developed area, followed by discharge hospital information and national register conditions information. Less developed areas are pharmaceuticals and costs associated to clinical processes information. The weakest areas tend to be primary health care, home care, and long term care institutions.

Managerial agreements and program contracts used for resource allocation practices open a window of opportunity to get information and feedback for health managers.

In terms of HSPA some issues, to be taken into account are: a) several sources of information, b) different types of information, c) diverse institutional and general cultures in terms of transparency, accountability, internal monitoring and evaluation, use of and relevance of health information, d) different users of the information and practical health information needs.

Even though some health sector reform efforts have put some financial resources and incentives for information technology and data collection, much more needs to be done. Moreover, there is a clear need to link health sector reform and decentralization initiatives to health information collection for HSPA.

2.2.4 On the "Dashboard" Approach to Health Systems Performance Assessment

There was consensus on the use of a dashboard approach for HSPA, so that the different domains that are involved are properly accounted for.

The guidelines to be used for the HSPA should center on domains that will give us the most poignant areas of information needed.

Cross-country comparisons should center on comparing indicators by domains of the health system.

Each country must develop indicators for health care delivery according to its key health problems in order to ascertain how well is the health care delivery system providing services to solve priority health problems.

Indicators should emphasize distribution issues, such as sex, gender, social class, etc. This requires assessing equity as a transversal dimension. Equally, it is important to have a measure of coverage of critical interventions. Such measure should center on «functional» rather than nominal coverage. The concept of «effective» coverage raises conceptual and methodological problems that could make implementation at the national level cumbersome and could make international comparisons difficult.

A first approach for the «dashboard» was initially advanced:

Health Systems Performance Assessment Dashboard Approach

Health Status			
Health Conditions	Human Function	Well-Being	Death
Non-Medical Determinants of Health			
Health Behaviors	Living & Working Conditions	Personal Resources	Environmental Factors
Health Care System			
Stewardship/Steering Role (Policy Formulation, Regulation, Essential Public Health Functions) ↓	Financing (Distribution and Equity, Exclusion or Inclusion) ↓	Insurance (Degree of Coverage by a Portfolio of Entitlements for Different Groups of the Population) ↓	
Delivery of Health Care (Clinical Care, Preventive Care, Long-Term Care) Accessibility, Effectiveness & Quality (Safety, Acceptability, Continuity, Competency, Apropriateness) Efficiency, Sustainability			
Community and Health System Characteristics (Resources)			
Demographic characteristics; human, financial, and material resources; outputs of the health care delivery system.			

2.2.5 On Responsiveness and Coverage

Responsiveness was not seen either as a final goal of health systems or as a single concept or dimension. As defined in WHO 2000, it includes heterogeneous aspects related to patient rights, free choice of provider and prompt attention, among others. Some of them are value-driven, therefore it is very difficult to advance international comparisons in this area. Notwithstanding, responsiveness is seen as an important attribute of health systems. So, it should be developed in the future as a component of a performance research agenda but not included as a single indicator for international comparisons at the present time.

Given financial and institutional restrictions to provide health services in the countries, it would probably be more useful to include a tighter concept of responsiveness, more useful to managers and policy-makers. Appropriateness was seen as an integral component of responsiveness.

Patient rights/humanization as a component of responsiveness should be included. However, the difficulty of constructing a valuable indicator for it at the present time was recognized. The concept of patient centerdness as a possible concept to incorporate as well as cultural, social, and ethnic variations was also mentioned.

How much can we measure, at what cost? We will not be able to determine at this point how the indicators will be used across the countries. We have to choose the indicators for their intrinsic value, but also for the operationalization of the indicators cross-nationally and at the sub-national level.

2.2.6 PAHO/AMRO's Role in Support of Health Systems Performance Assessment

Emphasize the purpose of the HSPA exercise in order to support country's health systems performance assessment rather than to produce rankings or league tables. Comparisons should be done just among comparable dimensions and comparable systems.

Strengthen information systems capability in the countries. Convey periodically the health system work group to discuss ways and approaches to build countries institutional capacity to assess the performance of the health system, particularly in relation to the development of information systems, data analysis, and infrastructure.

To produce trustworthy data to be shared among different institutions within the countries, and among countries.

Strategies for comparisons among countries could be developed after proper agreement with countries have been achieved. It was considered that countries develop capacity to do HSPA within the countries themselves is of greater importance.

Technical cooperation among countries' schemes (TCC) should be put in place in order to develop the countries capabilities in this field.

Annex 2-A: Terms of Reference of the Work Group of the Region of the Americas on Health Systems Performance Assessment

BACKGROUND

1. The Regional Consultation of the Americas on Health Systems Performance Assessment took place between the dates of May 8 and 10, 2001 in the Pan American Health Organization/Regional Office of the Americas of the World Health Organization (PAHO/AMRO) Headquarters, Washington DC.

2. Among the recommendations, included in the Consultation Final Report, is that PAHO/AMRO would organize a Regional Work Group on Health Systems Performance Assessment (RWGHSPA) that, around August 2001, would undertake an in-depth analysis of the subject matter.

3. The results of the Consultation and RWGHSPA discussions would be presented to a Special Session to be scheduled during the Directive Council Meeting in September 2001. The objective of the aforementioned special session is to inform the delegations of all the Member Countries, and to hold a forum for debate that will also be conveyed to the WHO headquarters.

OBJECTIVES

1. Further the recommendations and conclusions of the Regional Consultation on Health Systems Performance Assessment (HSPA).

2. Make recommendations for future actions of PAHO in the field of HSPA.

WORK GROUP COMPOSITION

1. Representatives from the United States, Canada, Cuba, Bolivia, Mexico, Jamaica, and Brazil.

2. One representative from the Evidence and Information for Policy Cluster of the World Health Organization, Geneva.

3. Five staff members from PAHO/AMRO.

EXPECTED RESULTS

1. The RWGHSPA would produce a Report to be summarized and distributed during the PAHO/WHO Directive Council, September 2001.

   The Report should include the following:

   - ✧ A summary of the most relevant discussions generated from the WHR2000.
   - ✧ Main issues raised by the HSPA Regional Consultation Background Paper and Final Report.
   - ✧ An in-depth proposal on HSPA to include the following:
     - ◆ The multiple dimensions of HSPA.

- The relationship of the multiple dimensions of HSPA with the four domains discussed during the Regional Consultation namely, resources, functions, intermediate goals, and final goals.
- A selection of the most relevant domains for policy decision-making at the country level.
- An implementation strategy that is acceptable and useful to the countries of the Americas.

Annex 2-B: List of Participants of the Work Group of the Region of the Americas on Health Systems Performance Assessment

BRAZIL

Dr. Claudia Trasvassos
Researcher
Escuela Nacional de Salud Pública - FIOCRUZ
Rua Leopoldo Bulhoes 1480
Rio de Janeiro, Brasil 21041-210
Tel.: 5521-598-2541/42
Fax: 5521-290-0484
claudia@fiocruz.br

Dr. Célia Landmann Szwarcwald
Researcher
Escuela Nacional de Salud Pública - FIOCRUZ
Rua Leopoldo Bulhoes 1480
Rio de Janeiro, Brasil 21041-210
Tel.: 5521-598-4366
Fax: 5521-290-0484

Secretario Jose Marcos Viana Nogueira
Coordinador de la Asesoria de Asuntos Internacionales
Ministerio de Salud
Esplanda dos Ministerios
bloco G - sala 426
70.058-900 - Brasilia - DF, Brasil
Tel.: (61) 315-2813
Jviana@saude.gov.br

CANADA

Dr. John Millar
Vice President
Research and Population Health
Canadian Institute of Health Information
377 Dalhousie Street, 2nd Floor
Ottawa, K1N 9N8
Tel.: (613) 236-1349
Fax: (613) 241-8120
jmillar@cihi.ca

Mr. Nick Previsich
Senior Science Advisor, International Affairs Directorate
Health Canada
Brooke Claxton Building Room 830B
Tunney's Pasture
Ottawa, Ontario
K1A 0K9 Canada
Tel.: (613) 957-7316
Fax: (613) 952-7417
nick_previsich@hc-sc.gc.ca

Mr. Francois L. Sauvé
Senior Policy Analyst
OECD Health Conference on Performance, Measuring and Reporting
Canadian Secretariat
Ottawa, Canada
Tel.: (613) 954-8530
Fax: (613) 946-1792
Francois_L_sauve@hc-sc.gc.ca

Ms. Sally Thornton
Director, Accountability Implementation
Information, Analysis and Connectivity Branch
Applied Research and Analysis Directorate
Health Canada
Ottawa, Ontario, Canada K1A 0K9
Tel.: (613) 946-2087
Fax: (613) 946-3166
sally_thornton@hc-sc.gc.ca

Dr. Ronald Wall
Policy Analyst, Accountability Implementation
Information, Analysis and Connectivity Branch
Applied Research and Analysis Directorate
Health Canada, NCR 4602B
2nd Floor, Cooper St., 400 Cooper St.
Ottawa, Ontario, Canada K1A 0K9
Tel.: (613) 946-3169
Fax: (613) 946-3166
ron_wall@hc-sc.gc.ca

Mr. Michael Wolfson
Assistant Chief Statistician, Statistics Canada
Social and Econmic Studies Division
RH Coats, Floor: RHC26K
RH Coats Building Holland Ave. and
Scott Street Tunney's Pasture
Ottawa, Ontario, Canada K1A OT6
Tel.: (613) 951-8216
wolfson@statcan.ca

CUBA

Dr. Eduardo Zacca Peña
Director Nacional de Estadísticas
Ministerio de Salud
La Habana, CUBA
Tel.: 53 7 553325 553398
Fax: 53 7 333236
zacca@infomed.sld.cu

JAMAICA

Dr. Stanley Lalta
Health Reform Unit
Ministry of Health
Kingston, Jamaica
Tel.: (876) 967-7607
slalta@epi.org.jm

MEXICO

Dr. Rafael Lozano
Director General de Información y
Evaluación del Desempeño
Leibnitz 20 3er piso
Col Anzures CP 11590
Mexico DF, 52500925
rlozano@mail.ssa.gob.mx

PAN AMERICAN HEALTH ORGANIZATION (PAHO)

Dr. César Gattini
Regional Advisor
Division of Health Systems and Services
Development
Pan American Health Organization
525 23rd Street., N.W.
Washington, D.C. 20037
Tel.: (202) 974-3225
Fax: (202) 974-3641
gattinic@paho.org

Dr. Alberto Infante
Regional Advisor
Division of Health Systems and Services
Development
Pan American Health Organization
525 23rd Street, N.W.
Washington, D.C. 20037
Tel.: (202) 974-3818
Fax: (202) 974-3641
infantea@paho.org

Dr. Daniel López-Acuña
Director, Division of Health Systems and
Services Development
Pan American Health Organization
525 23rd Street., N.W.
Washington, D.C. 20037
Tel.: (202) 974-3221
Fax: (202) 974-3641
lopezdan@paho.org

Dr. Priscilla Rivas-Loria
Consultant, Division of Health Systems and
Services Development
Pan American Health Organization
525 23rd Street., N.W.
Washington, D.C. 20037
Tel.: (202) 974-3876
Fax: (202) 974-3641
rivaspri@paho.org

UNITED STATES OF AMERICA

Dr. Jennifer H. Madans
Associate Director for Science
National Center for Health Statistics
6525 Belcrest Road
Hyattsville, MD 20782-2003
Tel.: (301) 458-4500
Fax: (301) 458-4020
JMadans@cdc.gov

Dr. Ed Sondick
Director
National Center for Health Statistics
6525 Belcrest Road, Room 1140
Hyattsville, MD 20782-2003
Tel.: (301) 458-4500
Fax: (301) 458-4020
ESondik@cdc.gov

Annex 2-C: The Canadian Initiative on Health Systems Performance Assessment

As major new investments are made in Canada's health care system by governments at all levels, Canadians want to know whether those investments are leading to meaningful improvements in the performance of the health care system. In September 2000, First Ministers (The Prime Minister and the Premiers (leaders of Provinces)) directed Health Ministers to provide comprehensive and regular public reporting on the health programs and services they deliver, on health system performance and the development of a framework for reporting, using jointly agreed comparable indicators addressing:

- ✧ Health status (i.e., life expectancy, infant mortality, low birth weight, people reporting their health as excellent);
- ✧ Health outcomes (i.e., change in life expectancy, improved quality of life, reduced burden of disease and illness); and
- ✧ Quality of service (i.e. waiting times for key diagnostic and treatment services, patient satisfaction, hospital re-admissions, access to 24/7 first contact health services, home and community care services, the adequacy of public health surveillance and health protection and promotion activities).

An informal process of interchanging experiences and views among 5 English speaking OECD countries (Canada, United Kingdom, United States, Australia and New Zealand) has recently started. Looking at a framework that captures health status, non-medical determinants of health, health system performance and community and health system characteristics. The focus of efforts pursuant to this framework are on refining/defining those indicators used to measure health system performance, including measures of acceptability, accessibility, appropriateness, competence, continuity, effectiveness, efficiency, and safety.

The 1999 federal budget provided $95 million to the Canadian Institute for Health Information (CIHI) Roadmap Initiative to strengthen the capacity of CIHI and Statistics Canada to: report regularly on the health of Canadians and the functioning of the health care system; provide comprehensive and reliable health information for the use of Canadians, health care providers and all orders of government; and foster greater accountability to the public on how the health care system is serving them. Results have included two new reports Health Care in Canada 2000 - A First Annual Report by CIHI, and How Healthy Are Canadians by Statistics Canada published in the spring of 2000. The second reports from these organizations came out in the spring of 2001.

Several other mechanisms for reporting also exist, such as *Toward a Healthy Future: Second Report on the Health of Canadians*, which was released jointly by all Ministers of Health in September 1999 (the first Report on the Health of Canadians was in 1996). This report summarized information we have on the health of Canadians and the factors that influence our health.

Maclean's magazine is running a series of Health reports, reporting on both health outcomes and health system performance, drawing from a range of sources, including CIHI and Statistics Canada, which ranks regions on various items.

Many provincial/territorial governments have also been preparing reports over the last few years on the health status of their population, and the state of their health systems.

III. Discussion on Health Systems Performance Assessment in the 43rd Directing Council, 53rd Session of the Regional Committee of the Pan American Health Organization/ World Health Organization[9]

3.1 Official Document CD43/18 on Health Systems Performance Assessment[10]

This document discusses health systems performance assessment and its importance in guiding actions aimed at improving and developing the sector. It summarizes the principal mandates that have emanated from the Governing Bodies of both the Pan American Health Organization and the World Health Organization in recent months with regard to this topic. It also reports on the Regional Consultation on Health Systems Performance Assessment held in the Region of the Americas in May 2001.

Finally, it raises the possibility of creating a regional working group whose basic function would be to build on the principal conclusions that came out of the regional consultation in order to contribute to the peer review to be carried out by an international expert team, as well as provide recommendations to guide PAHO's future work in this area.

3.1.1 Introduction

The Member States of the Pan American Health Organization (PAHO), like the Member States of other Regions of the World Health Organization (WHO), have recognized the need to move forward with the reform of their health systems in order to enable them to achieve the objectives that society has set for them.

As reorientation of the sector's activities has gained increasing importance, the need to improve institutional capacity to measure and evaluate the performance of health systems has been widely discussed. The ultimate purpose is to build a solid information base that will provide as much objective support as possible for the development of health system reform agendas.

Member States are therefore attaching growing importance to health systems performance assessment (HSPA). Accordingly, they are also giving increasing attention to the conceptualization of HSPA, the implementation of measurement processes, the generation of information for that purpose, and, especially, its use in decision-making

[9] This session took place 25 September, 2001, as agenda item No. 4.14.

[10] The official document hereby presented also contains as annex the document "Critical Issues in Health Systems Performance Assessment" included as section 1.1 in this publication.

relating both to the formulation of health policies and strategic management of the various operations that are part of the system.

The publication of *The World Health Report 2000*—the theme of which was improving the performance of health systems—sparked vigorous debate in the Region of the Americas and in the other regions of the world around the subject of HSPA. The modality used for the report's production and dissemination has been the focus of much discussion, in particular with regard to the ranking of Member States according to their degree of attainment as measured by a composite index that was introduced for the first time in the *Report.* The ensuing debate has revealed the need to better specify the scope and implications of the HSPA exercise carried out by WHO, as well as the extent to which it is linked with national and regional processes that can and should provide feedback for future exercises that WHO may undertake in this area.

3.1.2 Mandates from the 42nd Directing Council of PAHO and the 107th Session of the WHO Executive Board

The 42nd Directing Council of PAHO discussed *The World Health Report 2000* and adopted Resolution CD42.R5, in which it:

- ✧ Urged the Member States to:
  - mobilize national intelligence, represented by their respective ministries of health, universities, research institutes, and similar organizations, to monitor and evaluate their own health systems; and
  - provide technical information to WHO to conduct comparative studies among countries.
- ✧ Recommended that the Director of the Pan American Sanitary Bureau (PASB) transmit to the Director-General of the World Health Organization the request that WHO:
  - promote, with the broad participation of the Member States of the World Health Organization, a review of the framework and methodologies utilized in the comparative performance study of health systems contained in the *World Health Report 200*0; and
  - submit the technical and methodological bases of the next World Health Report for consideration of the WHO Executive Board, before its publication.

That recommendation was followed, and the Director of PASB transmitted the request of the Member States to the Director-General of WHO.

The Member States have mobilized the appropriate institutions to take part in the debate around the subject, and numerous scientific publications on the topic have been produced. This debate has led, inter alia, to the availability of an abundant body of materials and experiences, some of which were assembled for discussion at the Regional Consultation of the Americas on Health Systems Performance Assessment.

At its 107th Session in January 2001, the Executive Board also discussed the subject of HSPA, focusing in particular on the conceptual framework and the methodology

applied in the *World Health Report 2000* and the available information used to calculate the composite performance assessment measure. This measure ranked the countries in terms of the performance achieved by their health systems.

In her opening address, the Director-General said that, because of the importance of the topic and the interest from Member States, she would report on health sector performance at two-year intervals (with the next report to be released in October 2002). However, she also noted that prior to its publication, 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 of the same year. All Member States are to receive the compilations before they are available to the general public; and
- ✧ Establish a small advisory group, including members of the Executive Board and the Advisory Committee on Health Research, to help her monitor the proposal that WHO will make to the 108th Session of the WHO Executive Board regarding how it intends to conduct the next HSPA exercise.

The Executive Board approved these measures and asked the Director-General to:

- ✧ Initiate a scientific peer review of HSPA methodology as part of the technical consultation process, including updating on methodology and new data sources relevant to the performance of health systems;
- ✧ Ensure that WHO consults with Member States and shares the results of the scientific peer review and its recommendations;
- ✧ 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;
- ✧ Develop a plan to improve the quality of the data used to assess health systems performance;
- ✧ Report to Member States on the impact of health systems performance reports on Member States' policy and practice;
- ✧ Deliver the reports to the health authorities of Member States 15 days prior to the intended date of publication.

At the 54th World Health Assembly, the Director-General distributed the text of a letter to Executive Board members in which she summarized the actions taken up to that point to implement resolution EB107.R8, which concerned HSPA (DocumentA54/DIV/7). That letter announced the creation of an advisory group chaired by Dr. Mahmoud Fathalla, Chair of the Advisory Committee on Health Research, and reported on plans to carry out regional consultations on the subject. It also stated that the Director-General would establish an expert team to peer review the HSPA methodology and that the group's work would get under way in October 2001.

Between the months of May and September, regional consultations have been held in each WHO region (the first was the consultation in the Region of the Americas, which took place in Washington, D.C.) with participation by representatives of the governments of the Member States and regional scientific experts. As noted above, the objective of these regional consultations has been to contribute technical input on health systems performance assessment. A number of topic-specific technical consultations have also been programmed on 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 these consultations will feed into the peer review group in sufficient time for its report to be made available to the Executive Board in January 2002. Designation of the members of the peer review team is still pending.

3.1.3 Regional Consultation of the Americas on Health Systems Performance Assessment

The Regional Consultation on HSPA held in the Americas brought together 70 experts and policymakers from 19 countries. Staff from PAHO also participated, as did staff from the Evidence and Information for Policy (EIP) Cluster from WHO Headquarters and representatives of the United States Agency for International Development (USAID), the World Bank, the Hipólito Unanue Agreement, and the Caribbean Community (CARICOM). Representatives from the Regional Offices of WHO in Europe and the Western Pacific attended as observers.

The objectives of the Consultation were:

a) to discuss different conceptual and methodological approaches to assessing the performance of health systems;

b) to take stock of different country and regional experiences in the Americas related to health systems performance assessment;

c) to identify the critical issues for furthering the conceptual and methodological development of a framework for measuring health systems performance which could be applied by countries on a regular basis and reported to WHO periodically;

d) to discuss the linkage between health systems performance assessment practices and health systems policy and managerial decision-making processes; and

e) to develop an agenda for international technical cooperation that will support country efforts to measure the performance of health systems.

As background, the participants received the document «Critical Issues in Health Systems Performance Assessment.» The agenda for the meeting and the document were prepared jointly by the EIP Cluster at WHO Headquarters and the Division of Health Systems and Services Development at PAHO. The meeting enabled a diverse group of experts to examine, from various perspectives, methodological and conceptual issues related to the *World Health Report 2000* and the broader matter of health systems performance assessment. The presentations were followed by open discussions that produced an interesting exchange of views among the experts and other participants.

Although the concepts and methods used in the *World Health Report 2000* elicited attention, there was a concerted effort to orient the discussion towards the future and help to develop clear definitions for performance assessment within a framework supported by solid data that would be useful for the countries. The Director of PAHO invited the participants to engage in a respectful, constructive, and open debate that would help to move the process forward.

The final report summarizes the principal conclusions that came out of the discussions that took place in plenary session and working groups during the consultation. The document is organized into two sections. The first outlines the principal lessons learned from the *World Health Report 2000.* The second section contains recommendations for revising the conceptual framework and the indicators utilized by WHO to assess the performance of health systems.

The following are among the principal conclusions emanating from the Regional Consultation:

- ✧ HSPA should include a broad range of activities rather than simply equating the concept of performance with that of efficiency. Performance assessment would thus look at whether progress is being made toward specific goals and whether appropriate activities are being undertaken to promote the achievement of these goals.
- ✧ Performance assessment can be compared to the design of a «dashboard» 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.
- ✧ In assessing intermediate goals, some key dimensions should be examined, including the following: access, relevance, continuity, sustainability, efficiency, competence, and acceptability.
- ✧ It is important to develop procedures to measure performance of the steering/ stewardship function of health authorities, taking into account the role played by the central, intermediate, and local levels of the State in the majority of countries.
- ✧ Efforts to measure the performance of essential public health functions, such as those under way in the Region of the Americas, were considered useful, both in terms of content and methodology. This line of work illustrates what can be done to measure the performance of one component of the stewardship function of health systems.
- ✧ The possibility of using an approach with multiple measures relating to possible actions by national agencies should be considered. Such an approach could promote the development of accountability practices with regard to the performance of health systems. This approach should be pragmatic, should be related to policy- and decision-making in health sector management, and should be based on the identification of performance measurement tools for the various dimensions of the system: resources, functions, intermediate goals, and ultimate goals.
- ✧ WHO should develop its ability to provide technical support for HSPA. This implies maintaining continuous communications between the Organization and the Member States.

- ✧ Improving the common understanding of the relationship between health status and health systems is a lengthy process that may take 10 years or more. In addition to documenting the outcomes of this relationship, future reports should emphasize the process that leads to the development of the framework, the measures, and the indicators. The development of global indicators implies long-term research that should include those responsible for health policies, investigators, and other stakeholders. WHO should utilize its leadership to ensure that the process is inclusive.
- ✧ WHO should reexamine the HSPA methodology in close collaboration with the countries and with its own experts from the various clusters and regions. The Organization has a critical role to play in developing standards, bringing together experts to compare and contrast the various approaches used in the countries, and building consensus on the best ways to ensure comparability between countries with regard to health status, health expenditure, organization, and other related dimensions of the system.
- ✧ WHO should make better use of its collaborating centers and other national institutions and should also improve information exchange among its various units and the regional offices.
- ✧ WHO should support the countries' efforts to build capacity to:
  - engage in dialogue on national health policies;
  - assess the resources, functions, intermediate objectives, and ultimate objectives of health systems, as well as the degree to which desired changes have been achieved;
  - examine the suitability of current health information systems for generating the necessary data;
  - carry out performance measurement at the national and subnational levels; and
  - develop appropriate policy responses.

The results of the Consultation will be taken into account in the work undertaken in this area in the Region of the Americas. The results of the work in this Region will be transmitted to WHO Headquarters for incorporation into the recommendations made by other Regions for the paper to be presented on this subject to the Executive Board in 2002.

In August 2001, PAHO will organize a working group to conduct an exhaustive analysis of the subject and expand on the recommendations from the Consultation. The results of both exercises will be presented to the 43rd Directing Council in September 2001 in order to inform the delegations of all Member States and provide a forum for debate, whose outcome will be communicated to WHO Headquarters prior to the 109th Session of the Executive Board in January 2002.

3.1.4 Action by the Directing Council

The Directing Council is asked to take note of the report.

Annex 3.1-A: Resolution of the PAHO/WHO 42nd Directing Council on the World Health Report 2000[11]

The 42nd Directing Council,

- ✧ Having analyzed The World Health Report 2000, published by the World Health Organization on 24 June 2000;
- ✧ Considering the importance of health in the development and well-being of the population;
- ✧ Bearing in mind the importance of health systems in improving health conditions and the quality of life;
- ✧ Recognizing the important role of performance evaluations of health systems in improving the quality, equity, and other criteria relevant to these systems; and
- ✧ Recognizing that WHO has an historic and important role to play in conducting these evaluations and issuing recommendations on health policy,

Resolves:

1. To urge the Member States to:
   a) mobilize national intelligence, represented by their respective Ministers of Health, universities, research institutions, and similar organizations, to monitor and evaluate their own health systems;
   b) provide technical information to the World Health Organization to conduct comparative studies among countries.
2. To recommend that the Director of the Pan American Sanitary Bureau transmit to the Director General of the World Health Organization the request that WHO:
   a) promote, with the broad participation of the Member States of the World Health Organization, a review of the framework and methodologies utilized in the comparative performance study of health systems contained in The World Health Report, 2000;
   b) submit the technical and methodological bases of the next World Health Report for consideration of the WHO Executive Board, before its publication.

[11] Washington, D.C., 29 September, 2000 (document CD42.R5).

Annex 3.1-B: Resolution of the WHO 107th Session Executive Board on Health Systems Performance Assessment, Report by the Secretariat[12]

1. WHO has been working to enhance the development of national health systems by supporting the systematic assessment, by ministries of health, of their countries' health system performance. This report describes the framework for performance assessment; the indicators, methods and data used to assess performance; the preparation of an initial report on the performance of the world's health systems *(The world health report 2000)*; the reactions of health ministers to the report; and plans for future work. It summarizes comments transmitted to the Director-General between August and October 2000 by ministers of health of at least 20 countries, and those expressed by ministers and delegates at the Forty-second meeting of the Directing Council of PAHO/Fifty-second session of the Regional Committee for the Americas. A resolution, passed by the Directing Council of PAHO/Regional Committee for the Americas, asked that this subject be placed on the agenda of the Executive Board's 107th session. The issue was discussed by members of the Executive Board at their retreat (Hertenstein, Switzerland, 12 to 14 November 2000).

Development of the Framework for Assessing Health System Performance

2. The strengthening of sustainable health systems is one of the four directions in WHO's corporate strategy, which was endorsed by the Executive Board at its 105th session in January 2000. The specific objective, which reflects the basic concepts and values of the Global Strategy for Health for All, is to develop "health systems that equitably improve health outcomes, respond to people's legitimate demands, and are financially fair".

3. WHO—Secretariat and Member States—has been establishing a sounder basis for the development of national health systems. The emphasis, since 1998, has been on standardized approaches for assessing the state of health systems. The first stage was to agree on a framework for assessing the performance of such systems.

4. The purpose of the framework was:

   - ✧ to support Member States, together with the international public health community, in monitoring and analysing their health systems methodically, using a set of critical health system outcomes;
   - ✧ to establish a foundation for building a solid body of evidence on the relationship between the organization and outcomes of health systems in order to provide governments with information for health policy development;
   - ✧ to enable users to understand better the functions of health systems and to access information about the extent to which health system outcomes are attained.

[12] Geneva, 14 December, 2000 (document EB107/9).

5. The framework covers the boundaries, goals, functions and performance of health systems.

6. **Health system boundaries.** All resources, organizations and actors that undertake or support health actions (that is, every action whose primary intent is to protect, promote or improve health) are considered to be part of the health system. Education, however, although it is identified as a key determinant of health outcomes, is not defined as a part of the system.

7. **Health system goals.** Three goals are specified: good health; a health system that responds well to the legitimate expectations of the public; and fairness in financial contribution.

8. **Health system functions.** The framework identifies four functions that are critical to the achievement of these goals: financing (including revenue collection, fund pooling and purchasing); provision of personal and non-personal health services; resource generation; and stewardship. This last function, that is the oversight and guidance of the whole health system—private as well as public—so that it performs optimally, includes leadership, direction (health policy) and influence (regulation and advocacy), all based on the best available health information.

9. **Health system performance.** Ministers of Health and other decision-makers need to know the degree to which the health system contributes to the attainment of the overall outcomes; whether that contribution could be increased through changes in the investment of currently available resources *(efficiency* of the health system); and whether, if changes have been made (e.g. within the context of health sector reform), they have resulted in better performance of health systems).

Indicators, Methods and Data Used to Assess Performance

10. WHO has introduced the above framework as a basis for comparable assessments of health system performance. The three health system goals translate into five distinct outcomes: the level of health attained in a population; equity of health within that population; responsiveness of the health system; equity in responsiveness; and fairness in financial contribution. Performance assessment calls for clearly defined indicators of each outcome, methods to measure them, strategies for collecting data, and procedures for the synthesis and regular reporting of results.

11. **Level of health.** Drawing on 15 years of work, WHO introduced *healthy life expectancy*, based on life expectancy at birth, but including an adjustment for time spent in poor health, as the measure of the level of health attained in a population. Measurement of *mortality* depends on age-specific mortality data obtained from vital registration systems, surveys of child and adult mortality, and sample registration systems. Measurement of *time spent in poor health* depends on studies of burden of disease and standardized results from cross-sectional survey instruments developed using the International Classification of Functioning and Disability (ICIDH).

12. **Distribution of health.** WHO proposes that countries measure the distribution of healthy life expectancy within populations using both vital registration and cross-sectional survey data. Even though methods and data sets required to do this are

being improved, data on child survival from such sources are available and can yield measures of inequalities in child survival. For the time being, WHO uses inequality in child survival as the primary indicator of the distribution of health within a population.

13. **Responsiveness level and distribution.** The indicator of health system responsiveness is designed to reflect the autonomy, dignity, confidentiality, and client orientation that characterizes individuals' interactions with different parts of the system. It differs from indicators of *satisfaction* with health services, which are more likely to reflect people's expectations for service: *responsiveness* captures their actual experiences in a way that allows comparison. WHO has developed and field-tested a survey instrument that yields data on responsiveness; it has been designed to ensure cross-cultural comparability of data and tested in many countries. The results have been shown to be both reliable and valid. A systematic household-sample survey is under way in more than 60 countries; data are supplemented with results from low-cost key-informant surveys in nearly all countries. The latter are validated by comparison with the results of the sample surveys.

14. **Fairness in financial contribution.** This indicator, signifying the extent to which resources for health care are generated in ways that reflect people's ability to pay, denotes the fraction of income that each household contributes to the health system after meeting its subsistence needs. Calculation of the contribution takes account of tax, social security, private insurance and out-of-pocket payments. Data for the indicator are drawn from income and expenditure surveys, which are undertaken by nearly all Member States, information from tax and social security schedules, and national health accounts where available.

15. **Resources put into the health system.** Where available, national health accounts also provide a systematic assessment of the resources put into the health system from public and private sectors. Over the past decade, aggregates of health spending in the public and private sectors have become available for nearly all Member States, and national health accounts have been completed in about 60 countries (from all WHO regions); more are planning such exercises.

16. **Measurement of health system efficiency.** National officials need to examine the relationship between their health system's outcomes and the resource inputs in order to measure the efficiency of their country's health system. To interpret results obtained, they need to know the *potential* outcomes that could be achieved with a given level of resource inputs. In theory, this could be assessed by summing the potential impact of all clinical, public health, health promotion and rehabilitation interventions available in a country. WHO, various national technology assessment agencies and many researchers are trying to build the evidence base on the costs and effects of interventions. In practice, it can be estimated through statistical techniques, based on actual experience of health systems. WHO is being advised by a panel of experts in econometrics on the application of these techniques to assessing health systems efficiency. The analysis takes account of non-health system determinants of health, such as education levels.

17. **Utility of performance assessments for gauging the impact of health policy.** The methods proposed by WHO will enable countries to monitor the attainment and efficiency of their health systems. The results will provide ministers of health with a better gauge of the success of policies designed to enhance system performance.

First Report on Performance of Health Systems

18. Based on discussions on the framework for assessing the performance of national health systems, WHO responded to requests from countries about how this might be used in practice. During the latter part of 1999 and the early months of 2000, WHO staff sought to identify indicators of health system performance that could be standardized, methods to evaluate them and data that permitted their estimation. Using these tools and working closely with national officials and researchers to find and analyse as many new data as possible, WHO's staff assessed the performance of health systems throughout the world. Many respondents from a range of communities, within countries and internationally, helped to interpret the data.

19. This information was collated in the annexes of *The World Health Report 2000* on improving the performance of health systems.

Comments on the World Health Report 2000

20. *The world health report 2000* created an unprecedented level of interest and debate within countries, international organizations and research institutions. Three months after the report had been released, more than 30 countries had sought to work closely with the WHO Secretariat to apply the new framework for assessment of health system performance. The intention is that, each time the performance of health systems is assessed, the quality and usefulness of the assessment will improve.

21. In general, ministers of health and their representatives have supported the framework for performance assessment and the choice of indicators. Some asked for clarification on the responsiveness index and the indicators of equity in health and responsiveness. Most of the critical or analytical comments concerned the methods used to evaluate the indicators, the reliability of data, and the ways in which the results were presented.

22. With regard to the methods, several researchers have questioned the underlying theoretical basis and the statistical techniques selected, for example the combination of five key indicators of health outcome into the overall measure of health system achievement. WHO based the weighting used in the overall index on a survey of public health specialists from over 100 Member States, and rated health equity as important in elaborating the new indicators, in line with the views expressed by the governing bodies on many occasions.

23. Several ministers have pointed out the limited number of countries for which representative data were available. For example, there were 35 countries in the key informant survey for responsiveness. Microeconomic data on household income and health expenditures, needed for the indicator of fairness of financial contribution, were only available from 21 countries. However, the valuation of this indicator also

requires empirical data on the fraction of out-of-pocket expenditure that goes towards health. These data were available from 170 countries.

24. As is common practice in the development of information for policy purposes, values for many of the indices were estimated, in this case by accepted statistical methods. The report clearly signals the use of these methods, and gives appropriate references.

25. Some concerns have been expressed that ranking data on social outcomes, particularly if the ranking is based on a composite index, is demotivating and unlikely to produce improvements. There are, however, several examples that show that ranking, particularly in social fields, can encourage analysis, aid the identification of best practices, and help to build up an evidence base about successful interventions. The report breaks new ground by indicating uncertainty intervals for all measures—both the actual levels and the ranks. The width of the uncertainty intervals that result from the use of estimates is clearly visible.

26. In relation to process, some ministers have criticized the limited consultation between WHO staff and national officials during the evaluation of the indicators. One objective of this initial exercise was to bolster countries as they seek internal support for additional investments in their health systems. Several ministers have indicated that the use of the WHO-prescribed methodology increased their ability to draw greater attention to the problems they face. They will now be in a better position to initiate their own assessments of system performance. To this end, some have sought WHO support for assessment of their national health system's performance.

Future Plans and Action

27. WHO will continue to seek expert input to ensure that the best methods are used and are made widely available to Member States. Methodology is being improved through broad engagement of the research community and peer reviews.

28. Working closely with national officials, WHO staff are involved in a major effort to incorporate existing data sources that were not included in *The World Health Report 2000* into the valuation of the health-system performance indicators, so that the assessments can be adjusted where necessary. The Director-General has written to all Member States encouraging them to ensure that the best available evidence is used for assessment of health system performance. Response to the current multicountry survey on health and responsiveness, is one example of the interest of Member States in improved measurement.

29. In order to ensure that the best available evidence is reflected in future comparative assessments of health system performance, each Member State will be consulted on the figures used to evaluate indicators, including data on resource inputs. Furthermore, necessary time for consultation and dialogue will be set aside when preparing subsequent performance reports.

30. *The World Health Report 200*1, on the theme of mental health, will contain, as usual, a statistical annex. The main report and the statistical annex will be launched separately; neither is expected before the end of September 2001.

31. Around 30 countries are now working with WHO staff on a specific initiative to generate better understanding of their health system's overall performance, using the WHO "goals and functions" framework as the common analytic approach, and to link this greater knowledge to strategies to improve performance through long-term strengthening of national capacity to develop health systems.

32. WHO has a long-term commitment to improving health systems development—providing support to countries to measure and analyse health system performance, identify policy options, and implement specific functional improvements in the system. Similar work is being done within countries at regional and provincial levels in order to provide information for framing health policy and managing local health systems.

Action by the Executive Board

33. The Board is invited to note the report.

3.2 Provisional Summary Record of the 3rd Meeting of PAHO/WHO 43rd Directing Council, 53rd Session of the Regional Committee on Health Systems Performance Assessment[13]

Dr. LOPEZ ACUÑA (PAHO) refers to document CD43/18 as well as to two documents distributed this morning: the Final Report on the Regional Consultation on Performance Assessment of Health Systems and the Report of the first meeting of the Working group of the Region of the Americas on Performance of Assessment of Health Systems, that met in Ottawa, Canada, from 4 to 6 September 2001.

Continuing in English, he presented a slide show relating to the topic, stressing that the ultimate purpose of the health system performance assessment was to provide input for health systems reform. It could be particularly useful in decision-making related to policy and management. The topic had received considerable attention as a result of the publication of the World Health Report 2000, which had used a framework for assessing the performance of health systems that was based on the attainment of three goals, namely, health, responsiveness, and fair financing. The controversies that had emerged all over the world with respect to the World Health Report 2000 had focused on the methodology, the process for gathering and/or estimating the data, the degree of involvement of countries, the meaning of a combined index and of the ranking exercise, the involvement of the media, and the impact in countries. As members were aware, a number of mandates had emerged from the Regional Committee, the Directing Council, and the Executive Board of WHO. Specific resolutions had been adopted calling for debate, discussion, and consultation with respect to the methods followed in gathering information related to health systems performance assessment.

Referring to the report of the Regional Consultation on Health Systems Performance Assessment, which was provided as an attachment to document CD43/18, he summarized the objectives and recommendations of the Consultation. In particular, participants had stressed that health system performance assessment should include a broad range of activities rather than equating performance exclusively with efficiency. That would make it possible to consider whether progress was being made with regard to specific goals and whether appropriate activities were being undertaken to promote the achievement of such goals. A number of countries had shared their experiences with performance assessment. The Consultation had also highlighted the need for WHO to further develop its capacity to provide technical support and had stressed that WHO should reexamine the methodology of the health systems performance assessment in close collaboration with the countries and with its own experts in different clusters and regions.

The Consultation had paid considerable attention to what might be characterized metaphorically as the «dashboard» approach to health systems performance assessment, i.e., the use of different gauges for measuring the action of the national health agencies. The Regional Consultation had outlined the desirable scope for the process, stressing the

[13] Washington, D.C., 25 September, 2001 (item 4.14).

need to go beyond a composite index that might be too unspecific and excessively summarize many heterogeneous spheres of action. Performance measurements must make it possible to assess the degree of attainment of primary goals.

The Working Group of the Region of the Americas on Health Systems Performance Assessment (HSPA), which had been established following a recommendation of the Regional Consultation, had met in Ottawa during the first week of September. Among other things, it had stressed that the main purpose of the assessment exercise was to improve the performance and quality of the health system. There had been consensus to the effect that the HSPA framework should be a national self-evaluating tool rather than an externally designed instrument. The conclusions and recommendations of the Workgroup were set forth in the report of that first meeting.

The PRESIDENT opens the floor for discussion.

The BRAZIL delegate read a message from Minister José Serra that mentioned Brazil's surprise with the evaluations of the WHO Secretariat countries based on Health Systems Performance Assessment questioning the methodology used. It dealt with an imprecise academic exercise without the use of a policy development instrument and to a certain point devoid of analytical significance. It wasn't just an emotional reaction to our poor ranking. Brazil, other governments and other important academic centers of the world have tried to understand what the numbers really meant, but the discomfort was generalized. The obsession with the construction of the ranking led to the development of a single indicator, which was developed in a muddled manner and empirically, fails. In addition to being based on obscure methods, that even the technical people from WHO could not explain, it didn't take into account important dimensions for the evaluation of Health Systems Performance Assessment, such as access, service effectiveness, health spending and its distribution, variables aimed at intermediary objectives and that represent what health systems actually do.

The indicator proposed by the WHO focused only on the ranking without measuring any contribution towards the improvement of health systems. Methods without a scientific basis were used so that all the countries would have estimates of indicators used for the ranking and could thereby be classified. The Executive Committee of the WHO later approved a resolution exhorting the Secretariat to review its methods to evaluate health systems through consultation and discussion with the medical community. Until now it appears that the Secretariat of the WHO has not taken any initiative in this regard.

We have waited nine months to participate in the scientific peer review as agreed under Resolution EB-107-R8. We hope that there will still be time to do so before the next meeting of the Executive Committee in January of 2002 as we urgently need transparent indicators that are easy to develop and comprehend and most importantly, easy to use in demonstrating the health policy priorities.

PAHO has been making great effort to introduce a minimum of democracy and rationality in the discussion of evaluation methods and the choice of appropriate indicators. In two consultative meetings, last May in Washington, D.C. and a few weeks ago in Ottawa, recommendations were made consistent with document CD 43/18 that proposes a model to evaluate health systems based on procedures that have been developed in countries with extensive experience in this area, such as Canada.

Brazil firmly supports the recommendations of the Working Group on Health Systems Performance Assessment in the Americas annexed in the referenced document. Among the conclusions and recommendations of the Working Group it is worth highlighting the following:

A composite index developed to rank countries does not contribute to improvement of quality of performance of national health systems. It is necessary to have objective, intermediate indicators and it is of fundamental importance to make the connections between the analytical framework of evaluation of performance of health systems and the process of policy development. This analytical framework should be a high level national tool for evaluation discussed and conceived in tandem instead of applying an externally developed document. The data utilized for the evaluation of Health Systems Performance Assessment should be provided by the countries and come from recognized sources. If it is not possible for the countries to provide the required data the calculations developed by WHO to estimate the indicators should be transparent and subject to peer review. The final numbers should be discussed and clarified before publication. When it is not possible to estimate the indicators the estimates should remain blank until the country is capable of providing the necessary data.

For the evaluation of Health Systems Performance Assessment it is recommended that there be a focus on a dashboard approach and not on the development of a single composite index. The comparisons between countries should allow comparisons of results obtained on health service provision. The indicators should focus on aspects such as gender, and social strata and take into consideration the dimension of equity.

It is also important to have measures of coverage and of critical interventions highlighting that the major objective of Health Systems Performance Assessment is the improvement in the quality of services and thereby the health of populations, and not to construct rankings. The comparisons between countries should be encouraged only if the countries are in agreement. It is of utmost importance that each country develop its own capacity to evaluate the performance of its health system. It is also important that the process of evaluation of health systems be organized in a collaborative manner involving WHO, PAHO, and the countries, avoiding unilateral actions that are poorly structured and have problematic financial implications. It is recommended that document CD43/18 be officially sent to WHO by PAHO.

The Minister manifests his concern that the WHO Secretariat surprised once again the countries with a new attempt to publish indicators that cannot be accepted. This refers to Tables 3 and 4 in a group of five tables recently sent that were published as an annex in the World Health Report 2001 dedicated to mental health. These tables contain a group of indicators on health status, one of the dimensions used by WHO to evaluate the performance of health systems in the World Health Report 2000 and reproduced with a few cosmetic modifications and the same deficiencies already pointed out in table five in the WHR 2000 annex. This procedure flagrantly disrespects resolution EB107.R8 approved in January of this year during the 107th session of the Executive Council of WHO. Brazil has already officially declared itself against the publication of these large tables and demands respect for the decisions made by the country members of WHO. The insistence of the WHO Secretariat in publishing the same type of indicators with marginal changes and different names does not contribute to the prestige of the organization in the public opinion.

The Delegate of the UNITED STATES OF AMERICA said that her country strongly supported WHO and PAHO in their efforts to improve the evidence based on measurements of health system performance and to better incorporate health into the political dialogue. The scientific discussions on World Health Report 2000 had contributed fresh ideas and alternative concepts on methodologies for assessing the performance of health systems. The proposed independent peer review would contribute additional expert insights on data sources and methodologies. In order to improve health outcomes and really make a difference, Member States must be confident that the evaluation of their health systems would actually contribute to the improvement of the overall health of the population.

Member States needed to better understand the validity and reliability of the measures used and the extent to which they could inform policy makers for the implementation of improvements. Countries must seek to improve their capacities to better translate outcome measures into actions. Goals for improving health system performance must match national goals, the political environment, and available resources. Countries should be reassured that the measures identified were useful at the national level, that the surveys applied the best methodologies, and that the analyses were transparent. To improve technical and policy capacities, Member States must be active stakeholders in the overall processes. The Regional Consultation and the Working Group on HSPA would be instrumental in bringing about the national ownership which was essential for improving both the inputs and the outputs of any health system.

Although progress had been made, the United States still had questions and concerns regarding data sources, methodologies, the utility of ranking, and the transparency of process. Those questions were useful, however, in that they contributed to the ongoing refinement of the framework itself and helped guide the future direction of the process. Data sources used for any country and any report must be transparent and peer reviewed before they were published. If national official data were not going to be used, a clear explanatory caveat would be needed. Similarly, the analytical method and the World Health Report should be evaluated in terms of the state of the art and their usefulness in improving health system performance.

Her Government wished to encourage WHO to take the time necessary for a regular scientific review process that fully engaged Member States and the research and policy-making communities. She applauded the leadership exercised by WHO and PAHO in such efforts. The United States remained committed to improving and expanding the evidence base for health systems development and improvement of health outcomes.

The Delegate of CANADA said that health care was a priority concern of Canadians. His Government supported the initiative that had been launched by the Director General of WHO in health systems performance assessment, but was extremely unhappy with the implementation of that initiative. The process itself was flawed, as was the communication surrounding it. Nevertheless, it represented a first effort, and the Director General had put in place a process for ensuring that the issues that had been raised in the first implementation process would be dealt with in the second process. His Delegation appreciated the consultation that the Director General had put in place and was particularly pleased at the way PAHO had dealt with the process in the Region. The Consultation has

been thorough, it had been science-based, and it had been inclusive. He hoped that the Director General would give due consideration to the results of the consultations.

Turning to specific aspects of the exercise, he said that first of all, those concerned must clearly understand its purpose, which, in the view of his delegation, was to facilitate the identification of best practices with a view to implementing continuous improvements. Indicators must be relevant to countries, easily understood, and comparable. They must also be credible, they must have technical merit, and be valid, reliable, and interpretable. They must be transparent and based on information that could be verified. A composite indicator rarely met those criteria and was of limited use in identifying specific areas for action.

Secondly, as Dr. LÓPEZ ACUÑA had said, a range of indicators, or «dashboard approach,» was needed. However, the set of indicators must be manageable and must include some which touched broadly on the health of the population, some which measured resources, and some which focused on the services to be delivered.

Thirdly, a distinction must be made between those things that were useful for internal management and those that were useful for cross-country comparison. Agreement on indicators should be linked to priority health issues as defined by participating countries, such as HIV/AIDS screening and immunization for infectious diseases. Indicators must focus on results rather than on process or functions.

Equity issues were also a key and could be addressed by looking at distributions within those measures. It was important to be pragmatic, picking a few indicators to begin with and building on the existing information base with a view to expanding and improving over time. As a regional organization, PAHO could play a role in helping to identify a common, relatively comparable set of indicators in the Region, working closely with the countries and with the World Health Organization.

The Delegate of MEXICO considers that an exercise is being carried out that, although not new, encompasses an enormous potential. From its inception, international cooperation agencies have appreciated the value to standardize methods for collecting information on the countries and preparing comparable indicators, which constitutes one of its central tasks. All the countries have benefited from those indicators and of the comparison exercise itself; it makes it possible for them to know their situation with regard to other countries in respect to results for example, infant mortality. Accordingly, one of the most important results of the collective action has been to be able to generate international standards in order to define indicators and processes for measurement, and, at the same time to participate in a shared learning experience.

He celebrates the spirit with which the observations have been offered. It can be seen that it is building on the legacy from many decades. The exercise of consultation is very advantageous and goes exactly in the direction of the mandates given to the Secretariats, both by the World Health Organization and by its regional offices. He understands that the same activity has been carried out in other regions and that the peer review process has started, a process that requires transparency and is going to result of benefit to all.

It seems to him that there are four levels of analysis that is necessary to distinguish: The first one, broader in value, given to the evaluation exercise and to the regional consultation ratifies the value given by the countries. All are in agreement in that the

health systems should be evaluated in their performance and in that the shared experience is very valuable. The second level is conceptual and false dilemmas should be avoided on the end results being more important than the intermediate results, and the activities more important than the inputs. Each thing has its place but all of them understand the final objectives of a health system. The evaluation provides a framework that is committed to have the countries obtain results as assessed by the society and I this is one of the achievements gained. With regard to the matter of an adequate response, to him it seems to be an intrinsic objective, because in addition to improving the health, the health systems have to respect the human rights of the patients. In third place, there is a level that concretely corresponds to the proposed measurements. Again, he notices that it is necessary to avoid false dilemmas on the indicators. As the Delegate of Canada pointed out, some are more suitable for the comparison between countries and others for the internal management. There is a place for combined indicators and also for disagregated indicators. Simple life expectancy at birth is an indicator that expresses the synthetic evolution of a cohort in relation to age-specific death rates, so that in daily practice daily it is utilized as a different group of measures. What is needed is an approach in which each element has its value. Finally, the fourth and most concrete level is the measurement exercise that was carried out in the year 2000 and on which most of the discussions and discrepancies have centered. Those exercises not only enhance the measurements but they generate a dynamic debate, a refreshing discussion and contributions that enrich all.

He clarifies that he has had the privilege to be on the two sides of the debate. First, when he was a WHO staff member, it was necessary for him to participate actively in the design of the exercise. Now, as one of the individuals, who make decisions with regard to health in Mexico he has seen the great potential of the performance evaluation exercise, not only in retrospective sense, but also in planning the future. His country has aimed at very ambitious goals: it orients the actions of the system toward end results and does the work program; afterwards the necessary actions are defined to achieve those results. In the frame of reference of the Mexican system, which has been decentralized profoundly, it is pointed out that there is value to making the performance evaluation of the units in the states. It has thus entered into a very constructive process that moves them to think about what they want for their health system.

It makes available to all the Member States of PAHO the experience they have had in their country in the concrete application of the exercise, both in programming and in implementing the performance evaluation. It is a very useful process for decision-making, as other delegates have indicated. It congratulates, as a result, WHO and PAHO for creating the opportunity to discuss an issue that is going to benefit all.

The Delegate of the UNITED KINGDOM said that her Government supported WHO and its effort to measure the components of health systems, while at the same time recognizing that there was a need for the methodology to evolve. Bearing in mind that all six regions had held their consultations, she would be interested to know what adjustments or actions were being considered in response to the outcome of those consultations.

Secondly, she would be interested in the concept of measuring coverage by proven interventions both as a proxy for current health system performance and as a predictor of population health in the future. She would appreciate having some feedback on plans for work in that area.

Dr. LOPEZ ACUÑA (PAHO) is grateful for all the observations that have been made by the delegations. He also reiterates PAHO's willingness to continue to delve further into the conceptual, methodological and instrumental debate and to articulating the information systems, the analytical capacity, and the use of the information. All this within a fully participatory framework, where the Member States can have the space required to define a useful common practice for all the countries.

The results of the consultation exercises have been transmitted to the WHO Headquarters. As it was pointed out, there have been other regional consultations, surely information from their Headquarters can be obtained. Furthermore, another world-wide consultation was carried out on the notion of coverage, as one of the elements necessary to take into account among the intermediate goals. The objective was to know how coverage operates with respect to certain priority interventions which vary from one country to another.

He thanks the countries for their active participation and interest around the subject and its continuous response to the regional consultations and to the exercises of exchange of information exchange. Facilitating the constructive discussion, PAHO hopes to positively influence in better form in what constitutes the center of concern of all the countries of the Region and beyond the Americas: transform its health systems to improve their capacity of their response to the needs of health of the population.

Sir George ALLEYNE said that he would like to invite Dr Christopher Murray, Executive Director of the Evidence and Information for Policy (EIP) Cluster of WHO, to respond to some of the specific questions that had been asked, especially those that had been raised by the delegate of the United States.

Dr. MURRAY (WHO), replying to the questions raised by the United Kingdom delegate, explained that the consultation process stemmed from the resolution adopted by the Executive Board in January and was still underway. Six regional consultations had been completed. Two had issued their final reports and four were still in the process of formulating their recommendations or the text of their final report. In addition, eight technical consultations on specific topics had emerged from the regional discussions. Three of those would take place in the next three or four weeks. A couple of them had been delayed by the tragedy in the United States, and the meetings had been rescheduled. The results or reports written by the regional consultations and the technical consultations would be available to Member States and also to the general academic and research communities. That material would go to the peer review group, which would develop specific suggestions that would then be taken by the Director General to the Executive Board. The idea was to find ways to go forward in a consensus-based approach to performance assessment and fulfil the mandate to have another round of performance assessment at the end of 2002.

With regard to the second question from the United Kingdom, on coverage with effective interventions, he said that the topic had come up in all the regional consultations. Reflecting that interest, a technical consultation on the subject had taken place in Rio de Janeiro in Brazil about three weeks ago. The concept seemed to offer a fruitful area for incorporating and expanding the conceptual, methodological and empirical approaches to performance assessment.

The Delegate from BRAZIL made one more comment in the form of a question to Dr. Murray: Will Tables 3 and 4 be published in the Report on Mental Health? Brazil was against the publication of these tables as this disrespects the resolution of the WHO Executive Council.

Sir George ALLEYNE, replying to the Delegate of Brazil, explained that only the Director General of WHO could provide that information, and unfortunately she was not available at the moment. She was the only person who could really say definitively whether the tables would be published or not.

He wished to thank the delegates for the comments they had made. They had emphasized a couple of things which were very important to PAHO. One was the crucial value of appropriate information to allow the Organization to do its business. There might be differences of opinion regarding conceptual aspects, but he did not think there was any difference about the final outcome. It was important to avoid an «either–or» approach to the issue. PAHO would move ahead in the understanding that the Member States would be providing considerable input both on the conceptual and other levels.

PAHO would always strive for improvement, always bearing in mind that the countries had a stake in the exercise and that there must be absolute cooperation within the various levels of the Organization. The comments of delegations had been taken into account in relation to the global process; he wished to point out that the health systems performance assessment was a work in progress, and the effort to improve the information used would continue.