Peer Review Belgian Health System Performance Assessment (Brussels, 19-20 May 2014)

Discussion Paper[1]

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Setting the Scene

This discussion paper has been prepared in advance of the Peer Review of the Belgian Health System Performance Assessment initiative, part of the European Commission's "Peer Review in Social Protection and Social Inclusion" programme. Part A sets out current international developments. Part B offers a preliminary assessment of the Belgian HSPA, and develops a set of questions that might be addressed by the peer review.

A.1 Policy Framework

Health system performance assessment (HSPA) is becoming a central instrument in the governance of modern health systems. The notion of the health system was first given concerted attention in the *World Health Report 2000*[2], and further developed in the WHO report *Everybody's business: strengthening health systems to improve health outcomes*[3]. It defined the health system as "… all the activities whose primary purpose is to promote, restore or maintain health." The World Health Organization then defines HSPA as "a country-specific process of monitoring, evaluating, communicating and reviewing the achievement of high-level health system goals based on health system strategies"[4]. The prime objectives of HSPA are:

- To set out the goals and priorities for a health system;
- To act as a focus for policymaking and coordinating actions within the health system;
- To measure progress towards achievement of goals;
- To act as a basis for comparison with other health systems;
- To promote transparency and accountability to citizens and other legitimate stakeholders for the way that money has been spent.

HSPA was given a further stimulus in the WHO European Region by the signing of the "Tallinn Charter on Health Systems for Health and Wealth" in 2008. The 53 Ministers of Health from the European region made a commitment "to promote transparency and be accountable for health systems performance to achieve measurable results". HSPA is seen as an important mechanism for fulfilling that

[1] Prepared for the Peer Review in Social Protection and Social Inclusion programme coordinated by ÖSB Consulting, the Institute for Employment Studies (IES) and Applica, and funded by the European Commission.

[2] World Health Organization, *The World Health Report 2000. Health systems: improving performance*, 2000, Geneva: World Health Organization.

[3] World Health Organization, *Everybody's business: strengthening health systems to improve health outcomes*, 2007, Geneva: World Health Organization.

[4] World Health Organization, *Pathways to health system performance assessment: a manual to conducting health system performance assessment at national or sub-national level*, 2012, Copenhagen: World Health Organization Regional Office for Europe.

commitment. As envisaged by WHO, it is primarily a country-specific process for which there is no single accepted template, although there are many generally accepted principles of best practice in developing a specific HSPA[5]. Some of these include:

- HSPA should focus on the health system as a whole, including health promotion and public health as well as health services;
- Health systems goals should be expressed in terms of outcomes such as improved health and reduced exposure to financial risk, rather than processes such as workforce size or numbers of treatments;
- Wherever feasible, progress should be quantified using reliable metrics and associated analytic techniques;
- HSPA should be a regular process, embedded in all aspects of health policymaking;
- The exact form of HSPA should be a matter of choice for individual systems, although its effectiveness is likely to be maximized by the adoption of metrics and methods that enjoy widespread international use.

Despite differences in how objectives are expressed and measured, there is almost universal agreement that any HSPA should reflect health system goals related to the following:

- The improvement in health that can be attributed to the health system as a whole;
- The health system's responsiveness to citizens' preferences;
- The financial protection offered by the health system;
- The productivity, or value-for-money, of the health system.

Furthermore, many formulations of HSPA make reference to the issue of fairness, or equity, in how attainment of its goals is distributed across different population groups.

There is less consensus on how to incorporate health system functions into HSPA. These might include: service delivery; workforce; information resources; medical products, vaccines and technologies; financing; and stewardship. Such functions are the fundamental building blocks of any health system, and how they are deployed can have a major influence on health system outcomes. However, they are often difficult to compare across different types of health system, and a focus on functions can sometimes inhibit progress towards new ways of promoting the ultimate goals of the health system, such as a shift away from treatment towards prevention of disease. It is for this reason that HSPA should focus primarily on outcomes. Assessment of functions may be an important diagnostic tool for understanding reasons for progress (or lack of progress) towards health system goals, but should not be the prime focus of HSPA. Box 1 summarizes the key features of HSPA, as envisaged by the WHO[6].

[5] World Health Organization, *Pathways to health system performance assessment: a manual to conducting health system performance assessment at national or sub-national level*, 2012, Copenhagen: World Health Organization Regional Office for Europe.

[6] World Health Organization, *The European health report 2009. Health and health systems*, 2009, Copenhagen: World Health Organization Regional Office for Europe.

Box 1: Key features of HSPA[7]

HSPA is regular, systematic and transparent. Reporting mechanisms are defined beforehand and cover the whole assessment. It is not bound in time by a reform agenda or national health plan end-point, although it might be revised at regular intervals better to reflect emerging priorities and to revise targets with the aim of achieving them.

HSPA is comprehensive and balanced in scope, covers the whole health system and is not limited to specific programmes, objectives or levels of care. The performance of the system as a whole is more than the sum of the performance of each of its constituents.

HSPA is analytical and uses complementary sources of information to assess performance. Performance indicators are supported in their interpretation by policy analysis, complementary information (qualitative assessments) and reference points: trends over time, local, regional or international comparisons or comparisons to standards, targets or benchmarks.

In meeting these criteria, health system performance assessment needs to be transparent and promote the accountability of the health system steward.

A.2 Progress with HSPA

Since the *World Health Report 2000* there have been an increasing number of efforts to implement HSPA. In Canada and Australia, national agencies are developing common reporting mechanisms at the federal level. In the United States, the Commonwealth Fund has developed a report card for comparison of states[8]. Nordic states are seeking to develop common approaches to HSPA. England has developed a series of national performance reporting frameworks. The Netherlands was an early adopter of the principle of HSPA. The World Health Organization[9] summarizes experiences in seven contrasting countries of their Europe region, including Belgium, Estonia and Portugal, that are part of the Peer Review.

It is important to distinguish between the objectives of HSPA and those of the many other approaches to performance measurement that exist in the health system. The focus of HSPA is on accountability to populations, identifying priorities, developing strategy and tracking progress. It is not intended to offer operational guidance on individual providers or treatments, but is rather a high-level instrument of health system governance. Implementations of HSPA can nevertheless have a variety of strategic objectives. The World Health Organization[10] identifies the following for the seven countries it surveys.

- *Armenia*: Enhance stewardship; Accountability; Transparency; Identify policy priorities.
- *Belgium*: Transparency and accountability; Comparisons with other countries; Performance monitoring over time.

[7] World Health Organization, *The European health report 2009. Health and health systems*, 2009, Copenhagen: World Health Organization Regional Office for Europe, p141.
[8] Radley, D., et al., *Rising to the Challenge: Results from a Scorecard on Local Health Performance, 2012*, 2012, New York: The Commonwealth Fund.
[9] World Health Organization, *Case studies on health system performance assessment. A long-standing development in Europe*, 2012, Copenhagen: World Health Organization Regional Office for Europe.
[10] World Health Organization, *Case studies on health system performance assessment. A long-standing development in Europe*, 2012, Copenhagen: World Health Organization Regional Office for Europe.

- *England*: Performance management of public sector organizations.
- *Estonia*: Enhance accountability; Enhance stewardship; Provide a monitoring scheme for the National Health Plan.
- *Kyrgyzstan*: Monitor progress and impact of health sector programmes; Accountability to donors; Identify potential policy problem areas.
- *Portugal*: Accountability; Inform policy.
- *Turkey*: Provide a monitoring and evaluation scheme for the Health Transformation Programme; Transparency and accountability; Support the development of evidence-based policy-making; Guide governmental policy development; Identify policy priority areas.

It is noteworthy that these WHO case studies place quite different emphases on the various possible objectives of HSPA set out above, although promoting accountability and transparency of some sort is a common theme. Given the intended strategic focus of HSPA, it is doubtful whether the English case study – with its emphasis on internal management of the health system – falls within the usual definition of HSPA.

A cornerstone of HSPA is comparison with other systems, either through the use of quantitative indicators or using more qualitative descriptions. In some circumstances the focus can be on a system's trends over time (comparison with itself), or comparisons of regions or other subsystems within the overall system (comparison within itself). However, the principal analytic focus of many HSPA initiatives has been comparison with other health systems. If undertaken persuasively, such comparisons can be one of the most powerful instruments for securing media interest, engaging policymakers, and encouraging reform. However, such comparison can be contentious and analytically complex for a number of reasons. These include: non-comparability of concepts (e.g. different definitions of disability), different data collection mechanisms, and the need to adjust for different contextual factors (e.g. the age distribution of the populations).

A variety of resources have been developed to facilitate comparison and support HSPA, in the form of information systems and descriptions of health systems. The longest established dataset for high income countries is the OECD Health Data, which includes data series from 1961 covering health outcomes, health service resources, utilisation, and workforce[11]. More recently, the OECD has established a Health Care Quality Indicator (HCQI) project that is identifying and collecting a series of comparable indicators of the quality of specific aspects of health services[12]. The OECD has also been instrumental in developing the System of Health Accounts (SHA), the standard framework for producing consistent and internationally comparable financial data on health systems. Various perspectives on the OECD data sources are presented in the OECD "Health at a Glance" publications, which include a publication dedicated to the situation in all the EU Member States[13].

The European Commission has created the European Core Health Indicators (ECHI) initiative, which assembles 88 indicators relevant to HSPA, for over 50 of which data are readily available and reasonably comparable. The indicators are grouped

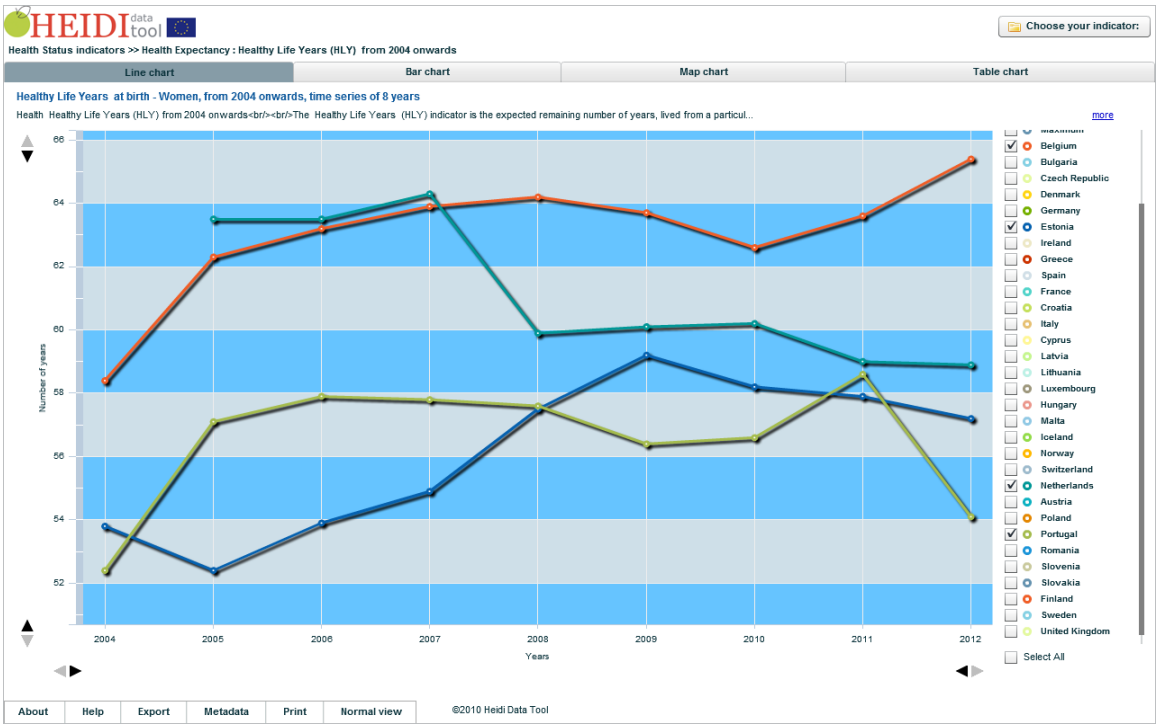
[11] Organization for Economic Cooperation and Development, *OECD Health Data 2013*, 2013, Paris: OECD.

[12] Organization for Economic Cooperation and Development. *OECD Health Care Quality Indicators*. 2014, 4 March 2014; Available from: http://www.oecd.org/health/health-systems/healthcarequalityindicators.htm

[13] Organization for Economic Cooperation and Development, *Health at a glance 2013: OECD indicators*, 2013, OECD: Paris; Organization for Economic Cooperation and Development, *Health at a Glance: Europe 2012*, 2012, OECD: Paris.

into five broad areas: demographic and socio-economic factors, health status, determinants of health, health services, and health promotion. The ECHI indicators can be analysed using the web-based HEIDI tool[14]. This prepares graphs, maps or bar charts, showing trends in indicators, or allowing comparison between chosen countries or groups of countries. An example showing trends in female healthy life expectancy at birth since 2004 in the four countries featured in this paper (Belgium in red) is in Figure 1 below.

Figure 1: Example of graphical output, HEIDI analytic tool[15]



At a global level, other data repositories include the World Bank's World Development Indicators, the World Health Organization's Global Health Observatory, and Institute of Health Metrics and Evaluation's Global Health Data Exchange. The coverage, completeness and reliability of these series is highly variable. The European Commission has also funded several projects under its FP7 programme that identify and analyse health data from the perspective of cross-country comparisons. These include EuroREACH, EuroHOPE and ECHO. EuroREACH developed a "Health Data Navigator" that helps potential users to secure access to and analyse comparable data sources across Europe[16].

The prime source for informed and comparable descriptions of health systems is the European Observatory on Health Systems and Policies, a partnership between the European Commission, the World Bank, the WHO, and certain member states[17]. Its

[14] European Commission. *European Core Health Indicators (ECHI)*. 2014, 4 March 2014; Available from: http://ec.europa.eu/health/indicators/echi/index_en.htm

[15] European Commission. *European Core Health Indicators (ECHI)*. 2014, 4 March 2014; Available from: http://ec.europa.eu/health/indicators/echi/index_en.htm

[16] Hofmarcher, M.M. and P. Smith, eds. *The Health Data Navigator. A toolkit for comparative performance analysis. A EuroREACH product*. 2013, European Centre for Social Welfare Policy and Research: Vienna.

[17] European Observatory on Health Systems and Policies. *European Observatory on Health Systems and Policies*. 2014 4 March 2014]; Available from: http://www.euro.who.int/en/about-us/partners/observatory

Health Systems in Transition (HiT) series offers comprehensive descriptions of health systems (including some outside Europe) according to a standardised template. The Observatory also publishes books on important policy issues, including a volume on the principles and practice of performance measurement in health[18] and a volume specifically examining the issues associated with health system performance comparison[19].

In 2011 the Council of the European Union set up "a reflection process ... to identify effective ways of investing in health, so as to pursue modern, responsive and sustainable health systems". The Working Party on Public Health at Senior Level led this process and reported in 2013. Five subgroups were established, of which the fifth examined "measuring and monitoring the effectiveness of health investments". It focused on the role of member states and the Commission in promoting HSPA. As part of its work, the subgroup undertook a survey of the use of HSPA by member states. Of 17 respondents, 13 reported having some sort of HSPA in place at national or regional level (Belgium, Croatia, Sweden, England, Finland, Greece, Lithuania, Portugal, Slovakia, Slovenia, Spain, Austria, Denmark).

In its conclusions on this reflection process, the Council included a recommendation that member states should "use health system performance assessment (HSPA) for policymaking, accountability and transparency" and that the Commission should support member states in that endeavour. It further urged improvement in the coordination of HSPA by member states and the Commission by:

- streamlining the debate on the theoretical HSPA framework and identifying useful methodologies and tools to support policy maker in taking decisions;
- defining criteria for selecting priority areas for HSPA at EU level and improving the availability and quality of relevant data and information. (Council Conclusions adopted 10 December 2013.)

The Union's Expert Panel on effective ways of investing in Health (EXPH) has prepared a commentary on the subgroup's proposals that raises some key technical and implementation issues[20]. It recommends development of a clear conceptual framework that defines the scope of the health system to be assessed. This would facilitate a stepped approach to the model development and testing. The EXPH highlights a number of methodological and practical considerations that have been identified in the international literature that should be taken into account, and outlines a number of practical possibilities.

Lastly, the Social Protection Committee (SPC) and its Indicators Subgroup explored the feasibility of adapting the Joint Assessment Framework (JAF) methodology[21] to the area of health systems[22]. This quantitative methodology is seen as a "first-step

[18] Smith, P., et al., eds. *Performance measurement for health system improvement: experiences, challenges and prospects*. 2010, Cambridge University Press: Cambridge.

[19] Papanicolas, I. and P. Smith, eds. *Health system performance comparison: an agenda for policy, information and research*. 2013, Open University Press: Maidenhead.

[20] EXPH (Expert Panel on effective ways of investing in Health), *Definition and Endorsement of Criteria to Identify Priority Areas When Assessing the Performance of Health Systems*, 2014, Brussels: European Union.

[21] Joint assessment framework is a methodology agreed by Employment Committee, Social Protection Committee and Commission to monitor progress on Europe 2020. It is also applied to the areas of employment, social inclusion, education. More information available at: http://ec.europa.eu/social/main.jsp?langId=en&catId=89&newsId=972&furtherNews=yes

[22] Social Protection Committee Indicators Sub-group, *Developing an assessment framework in the area of health based on the Joint Assessment Framework methodology: final report to the SPC on the first stage of implementation*, 2013, Brussels: European Commission Social Protection Committee.

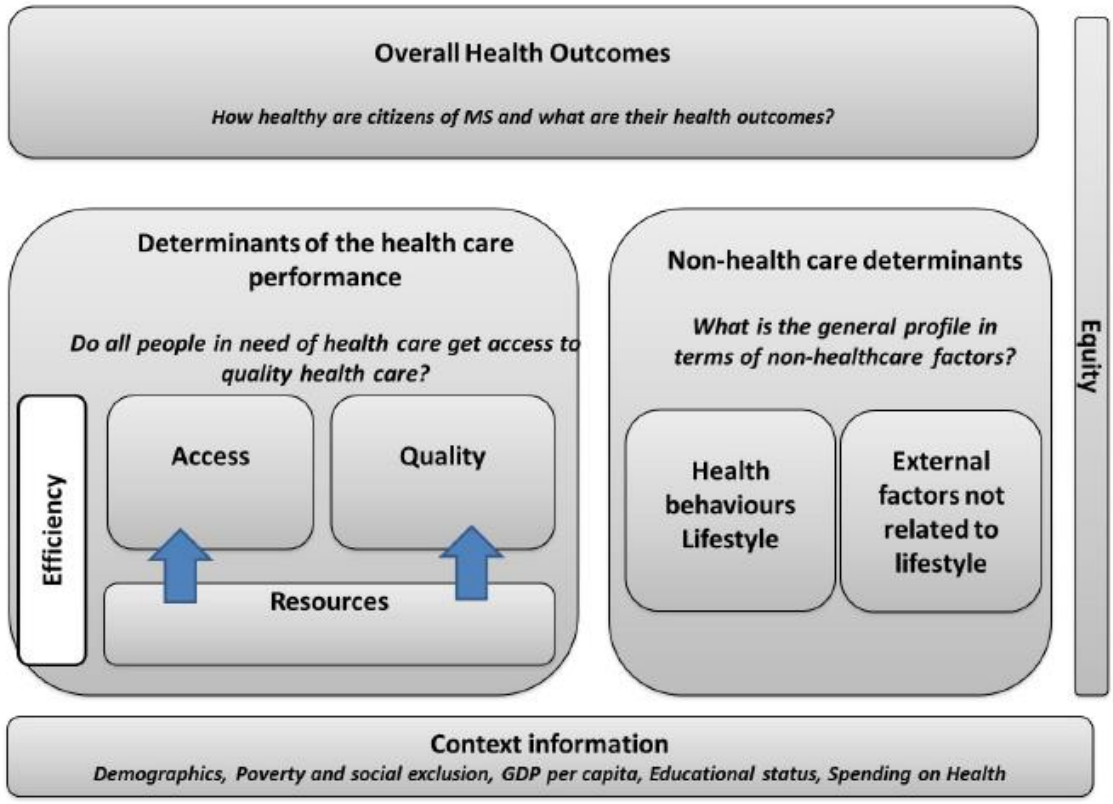
screening device to detect possible challenges in MS's health systems, with a specific focus on issues related to access, quality and equity". It is intended that this should be followed up with a more qualitative assessment intended to "verify and deepen the understanding of the challenges identified by this first screening". The proposed model is illustrated in Figure 2. The distinctive features are:

- a strong focus on equity,
- measuring overall health outcomes (including mental health),
- a focus on the performance of health care services (access, quality and resources),

as well as contextual factors. As acknowledged in the sub-group's report, the area of efficiency is the least well developed. The approach is being tested during 2014.

In order to develop methodology to assess health systems' efficiency, the Commission will undertake a joint project with OECD on this issue. This will complement the ongoing study "A Life Table Analysis: health system cost-effectiveness assessments across Europe"[23], funded by the Commission and carried out by the Dutch National Institute for Public Health and the Environment (RIVM).

Figure 2: Proposed model of the JAF framework in the area of health



[23] The study is expected to be finalised by the end of 2014, for more information see: http://ec.europa.eu/eahc/documents/health/tenders/2013/EN/EAHC_2013_05_Specifications.pdf

Assessment of the Belgian HSPA

B.1 Summary of the main features of the Belgian HSPA

The Belgian HSPA report under review was released in 2012, building on publication of an earlier report in 2010 entitled "A first step towards performance assessment". The 2012 report was commissioned from an external team of independent experts[24]. The stated strategic objectives of the Belgian HSPA process are:

- To inform the health authorities of the performance of the health system and to be a support for policy planning;
- To provide a transparent and accountable view of the Belgian health system performance, in accordance with the commitment made in the Tallinn Charter;
- In the longer term, to monitor the health system performance over time.

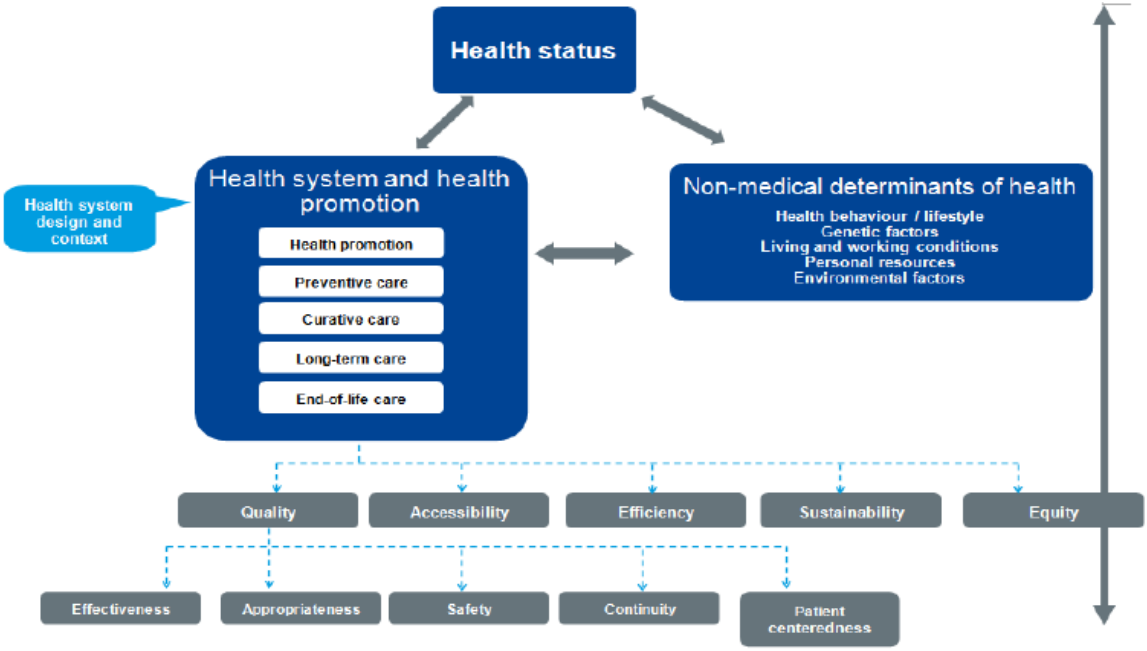
The specific operational objectives of the 2012 report are:

- To review the core set of 55 indicators of the previous report, with a special focus on the 11 indicators for which there were no data in 2010;
- To enrich the core set with indicators from the following domains: health promotion, general medicine, mental health, long-term care, end-of-life care; to add indicators on patient-centeredness and continuity of care (two sub-dimensions of quality); and, finally, to propose indicators on equity in the health system;
- To measure the selected indicators, when possible, or to identify gaps in the availability of data;
- To interpret the results in order to provide a global evaluation of the performance of the Belgian health system by means of several criteria, including international benchmarking when appropriate.

The report presents a 'conceptual framework' that forms a basis for the HSPA, as shown in Figure 3. This embraces five dimensions of performance: quality; accessibility; efficiency; sustainability; and equity. A total of 74 indicators are then chosen to assess levels of performance at the national level. Considerable attention is paid to accessible presentation of the results, and Belgian attainment is assessed in relation to the other EU-15 countries. Many of the indicators are disaggregated according to factors such as gender, region, socio-economic status. Where they exist, data gaps and weaknesses are acknowledged. The presentation of data concludes with an overall assessment of the strengths and weakness of the Belgian health system based on the reported indicators.

[24] Vrijens, F., et al., *Performance of the Belgian Health System. Report 2012*, 2012, Brussels: Belgian Health Care Knowledge Centre (KCE).

Figure 3: Conceptual Framework for Belgian HSPA Report



The final section of the report reflects on the contribution of the 2012 report itself. It considers that the major contributions relative to 2010 are: improved data availability; a more comprehensive set of indicators offering a more comprehensive view of the system; simplification of the structure of the set of indicators to facilitate easier understanding; more systematic analysis of the data; better use of existing information; and improved communication of results. The acknowledged weaknesses relate principally to continued data shortcomings, including data coverage, timeliness and reliability.

B.2 Three other HSPA examples

This section briefly summarises three alternative and contrasting HSPA endeavours from the EU countries that will present their approaches at the Peer Review meeting, namely: Estonia, Netherlands and Portugal. The intention is to draw out the differences and commonalities between the initiatives. Each description highlights the objectives of the HSPA, the analytic framework adopted, and the mode of presentation.

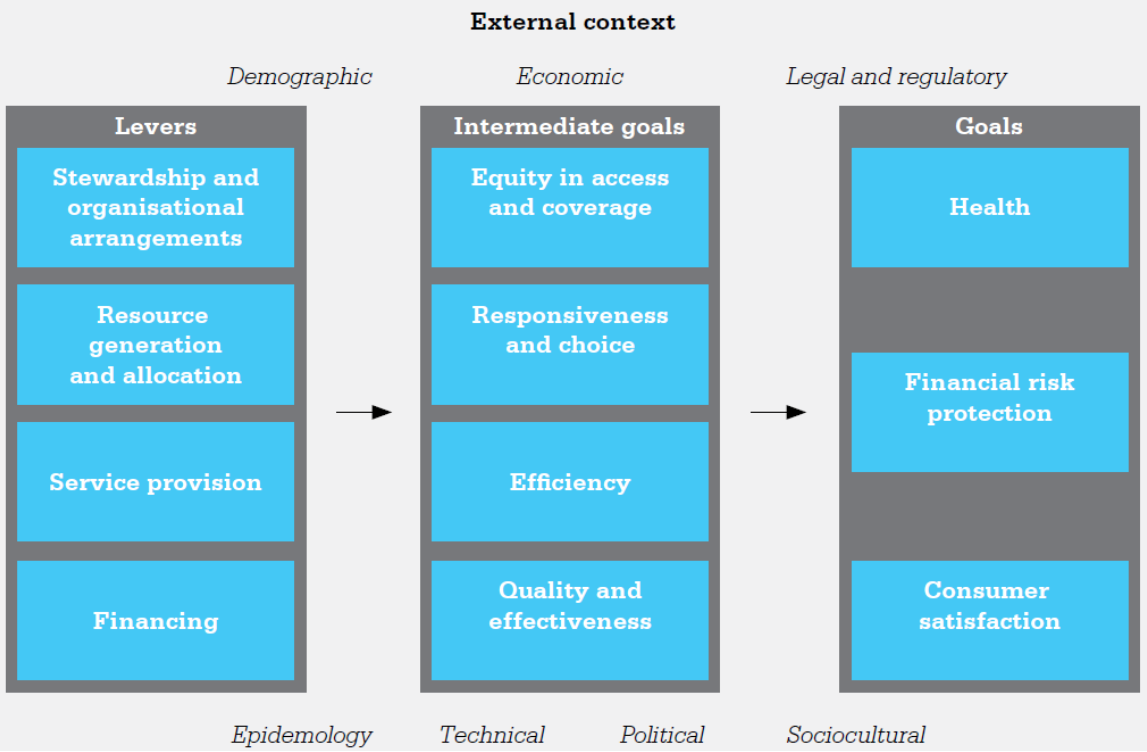
Estonia

The Estonian HSPA was a collaborative initiative of the WHO and the Estonian ministry of social affairs. It reported in 2010[25]. The objectives were to: "present international evidence supporting the use of health system performance measurement for performance assessment and improvement; propose an initial set of performance indicators with related findings; and put forward ideas about how to strengthen accountability in order to stimulate performance improvement". The HSPA Report built on an existing analytic tradition in Estonia that embraced performance measurement, targets and evaluation, and was intended as a first step

[25] Veillard, J., T. Lai, and G. Bevan, *Estonia Health System Performance Assessment 2009 Snapshot*, 2010, Copenhagen: World Health Organization.

towards embedding HSPA into the stewardship of the health system. The conceptual framework adopted is shown in Figure 4.

Figure 4: Conceptual Framework for Estonian HSPA Report



The report uses over 50 performance indicators, organised under the following headings:

- health status;
- health behaviour and health promotion;
- broader determinants of health;
- responsiveness of the health system;
- fair financing, financial protection and coverage;
- efficiency and effectiveness of the health system;
- access to health care services;
- quality and safety of health services.

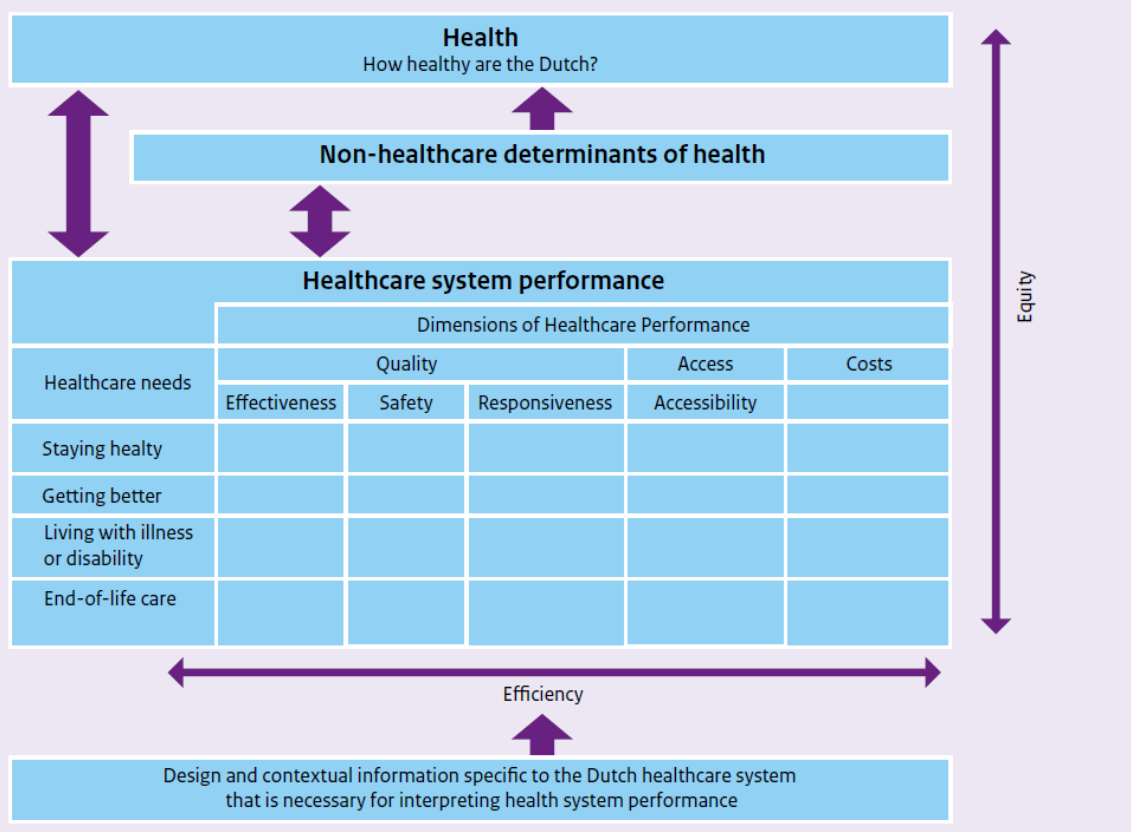
Performance is discussed under these headings, with the indicators introduced where necessary to support the narrative. Comparisons are made over time, and where feasible with other EU countries. Extensive analysis of regional variation within Estonia is reported. As described in the report (page 12), the main strengths of the system include: "improving the health status of the population in recent years, improving the coverage of the population, increasing the efficiency of the health system, and to a higher level of health care services". Weaknesses "include low disability-free life expectancy, gender and regional inequality and risk factors challenging recent progress in population health". Gaps in the information resources are also noted, particularly in relation to access to and quality of health services. There are also few systematic indicators describing variations by social group – an exception is out-of-pocket spending by income group. The Report ends with an

extensive discussion of how the HSPA principles can be used to enhance accountability throughout the entire health system, by creating an agreed set of goals and priorities, offering clarity on who is responsible for performance, providing performance metrics by which those actors can be held to account, and forcing those who are accountable to take action when performance problems arise.

Netherlands

The Netherlands HSPA is reported every four years (previously every two years) by the Dutch National Institute for Public Health and the Environment (RIVM)[26]. The third report was produced in 2010, and the 2014 report is in preparation. It is presented to Parliament as a means of holding the health ministry to account for its stewardship of the health system, and therefore plays a role similar to national audit reports in many other countries and parts of the public sector. The 2010 report comprised 125 indicators organised according to the three strategic objectives for which the ministry bears statutory responsibility: quality, accessibility and costs/efficiency. The indicators are organised according to a conceptual framework developed for the OECD[27] and illustrated in Figure 5.

Figure 5: Conceptual Framework for Netherlands HSPA Report



The 2010 report contains an extensive discussion on the findings, with an assessment of the performance of the Dutch system relative to previous levels of attainment, international comparators, quality standards and legal entitlements. It

[26] Westert, G., et al., eds. *Dutch Health Care Performance Report 2010*. 2010, National Institute for Public Health and the Environment: Bilthoven.
[27] Arah, O., et al., *A conceptual framework for the OECD Health Care Quality Indicators Project*. International Journal for Quality in Health Care, 2006. 17(1): p. 5-13.

finds generally good standards of care quality (subject to some variation) and good levels of access to needed care. Expenditure and efficiency give more cause for concern. There is little systematic reporting on variations by social group, other than geographical variations.

The Dutch report also seeks to assess the impact on system performance of recent reforms implemented by the health ministry. It acknowledges the difficulty in evaluating the impact of specific reforms, but underlines the importance of continued monitoring and efforts to evaluate. The report finds little difference in quality from neighbouring countries, and no substantial changes in quality or accessibility since 2006. However, it expresses a concern with rising costs, and notes continuing inadequacies in the information needed by purchasers and citizens to make informed choices about health services.

The 2010 Report ends with an assessment of its limitations and priorities for development for the 2014 Report. Particular data weaknesses are highlighted, for example in the areas of mental health and disparities in access to services. In the curative sector, there is an absence of measures of the outcomes of treatment (as opposed to the processes of care). The report notes the importance of being able to make comparisons, either over time, or internationally, or with a policy standard. The potential for international comparison is a current weakness in this respect, particularly in relation to indicators of the patient experience. It is asserted that the Report's "most important reference point ... is its usefulness for strategic policymaking" (page 239). To improve this it declares a need for:

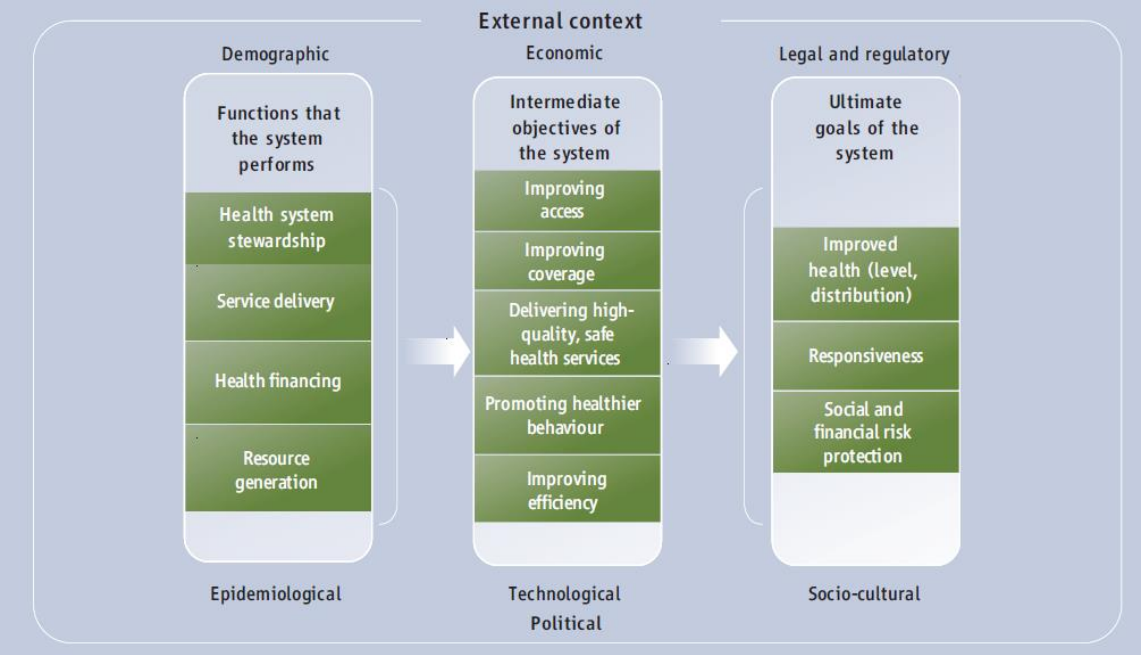
- strengthening the analytical, diagnostic and future-oriented function of the DHCPR;
- strengthening discussions on the findings of the DHCPR within and outside the Health Ministry;
- if need be, interim (annual) updates of a series of key indicators.

Portugal

The Portuguese HSPA appears to have been a 'one-off' exercise published in 2010 by the WHO European Regional Office as part of its Biennial Collaborative Agreement with the Portuguese health ministry[28]. The purpose was "to assess the performance of the Portuguese health system and to provide policy recommendations to policy-makers to improve overall performance". Specifically, the HSPA was intended to inform development of the next National Health Plan prepared by the ministry. It used a mix of quantitative and qualitative methods. As an organising framework, the assessment used an adaptation of the World Health Organization (2007) conceptualisation of the health system, as illustrated in Figure 6. It is similar but not identical to that used in Estonia.

[28] World Health Organization, *Portugal Health System Performance Assessment*, 2010, Copenhagen: World Health Organization Regional Office for Europe.

Figure 6: Conceptual Framework for Portuguese HSPA Report



This framework gave rise to four broad domains of analysis: health status; health system responsiveness (including satisfaction with, access to, and quality and safety of health services); social and financial risk protection; and sustainability and efficiency of the health system. In the health status domain, the focus on population risk factors such as obesity and smoking is particularly noteworthy. The Report uses approximately 60 performance indicators – some disaggregated by social group such as age, gender, region and income, where feasible. Indicators are introduced and presented so as to inform the Report's narrative, rather than in a pre-determined reporting template. Performance is summarized according to time trends and comparison with the EU15 countries. On many indicators, the Portuguese health system is improving, but remains a relatively poor performer. A particular concern is noted regarding the widespread absence of data with which to make secure judgements. The Report concludes discussion of each domain with recommendations to Portugal's health policymakers.

Comparison of approaches

Table 1 summarises some of the approaches taken in the HSPA reports of the four countries under discussion. There is some variation in objectives. Notably, the focus of the Netherlands and Portugal reports is on helping the health ministry (and possibly enabling it to be held to account) whilst the Belgian and Estonian reports have a broader objective of promoting transparency and accountability to citizens. All except the Portuguese appear to be part of an ongoing process of HSPA. The reports are organised in a variety of ways. Most notably, the Netherlands focuses very strongly on health services, whilst the Portugal and Estonia reports have a stronger emphasis on population health and the broader determinants of health. The Belgian report occupies a position somewhat between these orientations, with a particularly strong emphasis on equity.

There are very strong commonalities between all reports, most notably in the treatment of health services. Moreover, they all employ similar conceptual frameworks. However there are important differences. These in part reflect differences in the target audiences. For example, the Netherlands report is clearly aimed at those with responsibility for stewardship of the health services. The

variations also reflect legitimate differences in priorities. For example, the Portuguese emphasis on financial sustainability reflects the prevailing profound challenges to the country's public finances. However, there is a question mark over whether it is appropriate to include only current strategic priorities within an HSPA. For example, it can be argued that all important aspects of performance should be reported, so that stakeholders can assess whether current priorities are being pursued at the expense of other outcomes. And democratic debate and accountability may require that certain outcomes should be reported even if they are not a concern for the current government. These arguments suggest the need for certain safeguards for the HSPA process:

- An element of independence in the design and preparation of HSPA reports;
- Continuity in the HSPA process, with periodic reporting on a consistent basis;
- Some international consensus on what should be included in HSPA;
- Widespread availability of international indicators prepared with some degree of standardisation.

The basis of comparison varies markedly between the reports. Key decisions to be made include:

- whether to focus on trends over time or cross-sectional international comparison;
- whether to maintain a consistent basis for comparison across all indicators (as in the use of EU15 in Belgium), or to vary comparators depending on the availability and usefulness of data;
- whether to focus on individual countries or some average level of attainment as a basis for comparison; and
- whether to report regional variations in order to identify best local practice within a country.

The best approach is likely to vary depending on context. For example, life expectancy is increasing rapidly, partly independently of the actions of health systems, so national trends are likely to be of limited usefulness. In contrast, there is a clear potential target (of zero) for measures such as hospital-acquired infections, and it may therefore be less important to seek out international comparison.

Whatever the basis for comparison, it is important that the comparator health systems are considered to be genuinely comparable, with no major differences in factors beyond the control of the health system (such as diet or income levels) that are likely to influence performance. This is an area on which little research has been done, and further thinking may be fruitful. Likewise, the indicators used for international comparison have in general been chosen opportunistically rather than systematically. Wherever feasible they should be prepared on a consistent basis, relatively free from influences external to the health system, and available across a reasonable number of health systems, over a number of years. These are very demanding requirements, and further work might offer more systematic guidance on choice of indicators, and how best to make decisions when data are of limited quality. Increased systemisation of such considerations is important not only because it improves the technical reliability of the HSPA, but also because it increases confidence that reporting is not influenced by arbitrary or biased choices regarding the basis for comparison.

Note that the reports emphasise different aspects of health system performance, to some extent reflecting their different purposes. The Netherlands report focuses narrowly on health services quality, access and efficiency, in line with its definition of the health system. In contrast, the Estonia and Portugal reports focus attention

more on population health, although the performance of the health services is embraced as a key determinant of attainment. Those two reports also place importance on financial protection. The Belgian report places an especially important emphasis on national inequalities, with the other reports only occasionally being able to adduce relevant evidence. All reports underline the importance of efficiency, but struggle to find convincing indicators.

Table 1: Comparison of HSPA reports

	Belgium	**Estonia**	**Netherlands**	**Portugal**
Objectives	To help with policy planning and to promote transparency and accountability.	To initiate a process of HSPA and strengthen accountability.	To inform the strategic decision-making of the Ministry of Health.	To help the Ministry of Health improve the performance of the health system.
Part of continuing process of HSPA?	Yes (since 2010)	Yes?	Yes (since 2006)	No evidence
Number of indicators	74	About 50	125	About 60
Basis of comparison	EU15 average Trends over time	Trends over time EU average Selected member states (occasional)	Trends over time Selected OECD countries EU15 average	Individual EU15 countries
Organisation of HSPA report	Health status Accessibility Quality of care Efficiency of the healthcare system Health promotion Equity and equality	Health status Health services availability Broader determinants of health Health system responsiveness Fair funding Access to health care services Health services safety and quality Health system efficiency.	Quality of care Access to care Health expenditure and efficiency	Health status Quality of and access to health services Social solidarity (including fair financing) Health system sustainability and efficiency

B.3 Assessment of the Belgian HSPA and Questions for Peer Review

The Belgian HSPA endeavour clearly adheres to the spirit and principles of HSPA as espoused by WHO and other informed commentators. In particular it:

- Has clear strategic objectives;
- Has a clearly articulated conceptual framework that embraces most of the generally accepted objectives of modern health systems;
- Has a focus on outcomes for the population, rather than the functions of the health system;
- Seeks to track progress over time on a consistent basis;
- Seeks to make valid comparisons with other health systems.

In my view, compared to usual practice, the report exhibits numerous strengths, including the following:

- It is prepared by a team at 'arm's length' from immediate stakeholders, such as governments, insurers or providers. The report can therefore offer a credible independent view of the health system.
- The report has an emphasis on quantitative comparison, with an effort made to seek out data even in 'hard to measure' domains of performance. The disaggregation of performance by different population subgroups, where available, is particularly noteworthy;
- It seeks to report on all the chosen areas of performance, even where information is scarce. The decision to report on the 'sustainability' of the system and population risk factors are interesting attempts to introduce a forward looking element to the report;
- The report offers careful and measured commentary and comments candidly on gaps or weakness;
- The report is intended to be part of an ongoing process, and has sought to build on and maintain consistency with the previous report. It has sought to address weaknesses in the earlier report, including discussion of health promotion, mental healthcare, general medicine, long-term care and end-of-life care.

It is infeasible to develop concrete metrics of the effectiveness of a HSPA initiative. However, its likely impact and effectiveness can be assessed by addressing a number of fundamental questions, reflecting the general discussion above:

- Does the HSPA have clear objectives that guide those charged with undertaking the analysis and organising dissemination?
- Is there a clear process for commissioning the HSPA, with guidance on who is accountable for each stage of preparation?
- Is there clear conceptual framework for the HSPA?
- Does the HSPA focus on the health system as a whole, including health promotion and public health as well as health services?
- Are systems goals appropriate? Are they expressed in terms of outcomes such as improved health and reduced exposure to financial risk, rather than processes such as workforce size or numbers of treatments?
- Is progress quantified using reliable metrics and associated analytic techniques? Are the chosen international benchmarks appropriate?
- Does the HSPA use metrics and methods that enjoy widespread international acceptance?
- Is the HSPA adequately disseminated and promoted?

- Is the HSPA a regular, sustainable process, with suitable arrangements for reviewing and updating
- Is HSPA fully embedded in Belgian health policymaking?

Although a full treatment of these questions is beyond the scope of this short report, it is hoped that they can form a useful basis for the peer review. The answers to most of these questions are positive. Some potential limitations at this stage of the process appear to be the following:

- A continued reliance on limited set of metrics, especially in the 'efficiency' dimension.
- The process for determining the precise contents of the report is not clear.
- The extent to which HSPA is fully embedded within ongoing Belgian political debate and health policymaking has yet to be established.
- There is a lack of clarity about what response to the report is required from accountable bodies, such as governments, insurers, public health bodies and providers.

The Belgian report has some distinctive features compared with other HSPA initiatives. It is a part of an ongoing HSPA process that is intended to refine and develop the methods used. This allows stakeholders to assess progress over time and encourages a search to fill gaps in the current evidence base. The report places a relatively strong emphasis on sound analysis and metrics. The data drives the shape and contents of the report, rather than being subservient to the narrative. This is probably a strength, as it forces the authors to address weaknesses in the health system or weaknesses in the evidence. The report successfully places a high emphasis on variations in performance across population groups, a particularly difficult area to analyse, but frequently a high political priority. Finally, the three-pronged objectives of the Belgian HSPA appear to be measured and reasonable, and do not make unreasonable claims for the process.

Many of the principles and methods of the Belgian HSPA are readily transferrable to other national settings, although it is important that other countries should tailor the principles of HSPA to their own requirements. The major concern for countries with limited analytic capacity is the ability to undertake such an extensive review. Furthermore, the Belgian focus on in-country performance variations and equity may be infeasible in some countries.

The Belgian experience highlights the potential importance of the EU and other international agencies in promoting and supporting HSPA. All commentators agree that HSPA should be a process that is driven by national perspectives and priorities. However, international agencies have a role in (a) promoting the principles of HSPA; (b) acting as a forum for sharing experience; and (c) providing 'public goods' on which successful HSPA relies. In particular, a key, persistent weakness of HSPA initiatives has been limitations in the availability, reliability and comparability of data. International comparison is a key resource for making comparisons, assessing performance, evaluating reforms and prompting change. Some information weaknesses result from intrinsic 'hard to measure' aspects of the health system, such as mental health. Here the role of the European Commission might be to commission relevant research to develop suitable metrics of performance. Other weaknesses might arise because international surveys do not seek out relevant data. Here the role of the European Commission is to ensure that relevant validated questions are included in their own surveys. Finally, some weaknesses arise because there is no consistent international protocol for specifying and collecting data, for example relating to levels of disability. The role of the European Commission is to act as a forum for developing such protocols.

Finally, it should be noted that - by its nature - HSPA passes judgement on governments and other accountable entities, and may result in uncomfortable and controversial findings. Therefore, to the extent that is possible, the financing and processes of HSPA should be independent of direct reliance on such stakeholders. In many systems, it may be the case that parliaments are the appropriate guardians of the HSPA process. The magnitude of this difficulty is likely to vary between countries. However, there is a role for the European Commission in making it clear that – whatever form it takes – the transparency inherent in HSPA is an intrinsic part of the accountability demanded by citizens, and that rigorous, ongoing HSPA is becoming standard international practice.