ISSN 1977-7973

European Commission

Peer Review in Social Protection and Social Inclusion

Health System Performance Assessment

SYNTHESIS REPORT

Belgium, 19-20 May 2014

Social Europe

This publication is supported by European Programme for Employment and Social Innovation «EaSI» 2014-2020 ".

The European Programme for Employment and Social Innovation «EaSI» 2014-2020 is a European-level financing instrument managed directly by the European Commission to contribute to the implementation of the Europe 2020 strategy, by providing financial support for the Union's objectives in terms of promoting a high level of quality and sustainable employment, guaranteeing adequate and decent social protection, combating social exclusion and poverty and improving working conditions.

For more information: *http://ec.europa.eu/social/main.jsp?catId=1081&langId=en.*

Health System Performance Assessment

PETER SMITH
Imperial College Business School

Synthesis Report

ACKNOWLEDGEMENT

The author would like to thank the Belgian HSPA team for the clear presentations of their work, all participants in the Peer Review process for their helpful and perceptive contributions, and Renate Haupfleisch and Monika Natter at ÖSB for their helpful guidance throughout. Any errors or misrepresentations in this report nevertheless remain the responsibility of the author.

European Commission

Directorate-General for Employment, Social Affairs and Inclusion
Manuscript completed in July 2014

This publication has been prepared for the European Commission by

Further information on the Peer Reviews is available at:
http://ec.europa.eu/social/main.jsp?catId=1024&langId=en.

More information on the European Union is available on the Internet (http://europa.eu).
Cataloguing data can be found at the end of this publication.

Luxembourg: Publications Office of the European Union, 2014

ISBN 978-92-79-39636-6
ISSN 1977-7973
doi: 10.2767/39073

Table of contents

Executive Summary		5
A.	Policy context at the European level	7
B.	The Belgian good practice under review	12
C.	Policies and experiences in peer countries	16
D.	Main issues discussed during the meeting	18
E.	Conclusions and lessons learned	21
References		23

Executive Summary

The World Health Organisation (WHO) defines health system performance assessment (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". The broad aim of HSPA is to promote strategic accountability for health system actions. Specific objectives might include: setting out the goals and priorities for a health system; acting as a focus for policymaking and coordinating actions within the health system; measuring progress towards achievement of goals; informing public debate on the health system amongst stakeholders and citizens. Countries in the WHO European Region signed up to the 2008 "Tallinn Charter", which included a commitment to promote transparency and accountability to citizens and other legitimate stakeholders for the way that health system money has been spent.

Many Member States have started to introduce HSPA initiatives. These have taken a variety of forms, and been undertaken for a variety of purposes. The common theme features are that HSPA should focus on the health system as a whole, and not just health services; that performance 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; and that progress should be quantified using reliable metrics and associated analytic techniques. There is nevertheless a widespread belief that the exact form of HSPA should be a matter of choice for individual countries.

The Belgian HSPA initiative was the subject of this Peer Review. It was commended by participants as being a good model for other countries seeking to introduce or enhance a HSPA process. Particularly noteworthy are the clarity of objectives, the clear conceptual framework, the independent rigour of the analysis, the emphasis on equity, and the commitment to a continuing HSPA process. Work is continuing to identify the appropriate way of linking the Belgian HSPA with policy processes. This aspect of HSPA is underdeveloped in most countries and likely to vary depending on institutional arrangements.

Peer Review participants discussed a wide range of institutional and technical issues associated with HSPA, summarized in this report, under the broad headings of institutional arrangements for HSPA; objectives; data sources; methodology; dissemination; the role of HSPA in the policy process; and the role of action on HSPA at the European level. Particular unresolved issues include:

- The processes for setting HSPA goals and methods;
- What should be the basis of comparison in HSPA (international; regional; trends over time);
- How to choose performance indicators;
- The treatment of health system efficiency within HSPA;
- The treatment of equity (fairness);
- Data gaps and inconsistencies;
- How to disseminate HSPA
- How to integrate HSPA into the policy process.

Existing action at the international level includes the preparation of long-running data series by the Organisation for Economic Cooperation and Development (OECD), and the compilation of comprehensive descriptions of health systems (including some outside Europe) according to a standardized template by the European Observatory for Health Systems and Policy. The World Health Organisation (WHO) European Region has undertaken several HSPA initiatives at the invitation of member countries. All three organisations also publish widely on general policy issues relevant to HSPA.

At the EU-level, the European Commission has created the European Core Health Indicators (ECHI) initiative, which assembles 88 indicators relevant to HSPA. In 2011 the Council of the European Union set up a reflection process to identify effective ways of investing in health which concluded that Member States should use HSPA for policymaking, accountability and transparency. Social Protection Committee (SPC) and its Indicators Subgroup are exploring the feasibility of adapting the Joint Assessment Framework (JAF) methodology to the area of health systems as a "first-step screening device to detect possible challenges in health systems, with a specific focus on issues related to access, quality and equity".

Peer Review participants identified strong arguments for action at a European level to nurture and sustain HSPA, for example in securing international agreement on the scope of data collection efforts, the specification of data definitions and standards, the promotion of data collection and dissemination by international agencies, and sharing best practice on the use of the information. It was also pointed out that HSPA should generally be a national undertaking, tailored to local needs.

A. Policy context at the European level

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* (WHO, 2000), and further developed in the WHO report *Everybody's business: strengthening health systems to improve health outcomes* (WHO, 2007). It defined the health system as "… all the activities whose primary purpose is to promote, restore or maintain health." The World Health Organisation 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" (WHO, 2012). 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 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 (WHO, 2012). 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 (WHO 2009).

Box 1: Key features of HSPA (WHO 2009, p141)

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 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, utilization, and workforce (OECD 2013a). 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 (OECD 2014). 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 (OECD 2013b, OECD 2012).

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 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 (European Commission 2014). This prepares graphs, maps or bar charts, showing trends in indicators, or allowing comparison between chosen countries or groups of countries.

At a global level, other data repositories include the World Bank's World Development Indicators, the World Health Organisation'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 (Hofmarcher 2013).

There are a number of other potential resources for quantitative comparison. These include the annual surveys of the Commonwealth Fund, a New York based charitable foundation, and the private Swedish organisation Health Consumer Powerhouse, which produces a 'EuroHealth Consumer Index'.

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 (European Observatory on Health Systems and Policies 2014). Its Health Systems in Transition (HiT) series offers comprehensive descriptions of health systems (including some outside Europe) according to a standardized template. The Observatory also publishes books on important policy issues, including a volume on the principles and practice of performance measurement in health (Smith 2010) and a volume specifically examining the issues associated with health system performance comparison (Papanicolas 2013).

The Directive on the application of patients' rights in cross-border care[1] set a further basis for the assessment of health systems in the EU, in that it requires Member States to cooperate on standards and guidelines on quality and safety, and to exchange relevant information. According to the Directive, national contact points should be in charge of information exchange.

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 (EXPH 2014). It recommends the 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.

In April 2014 the Commission published a Communication on effective, accessible and resilient health systems, in which it proposed a EU agenda to strengthen effectiveness, increase accessibility and improve the resilience of health systems in EU Member States[2]. HSPA is seen as an essential tool to strengthen the resilience of health systems, and a proper health information system is identified as an important element of resilience.

Lastly, the Social Protection Committee (SPC) and its Indicators Subgroup explored the feasibility of adapting the Joint Assessment Framework (JAF) methodology[3] to the area of

[1] Directive 2011/24/EU of the European Parliament and of the Council, of 9 March 2011.

[2] Communication from the Commission on effective, accessible and resilient health systems, 4.4.2014, COM(2014) 215: http://ec.europa.eu/health/healthcare/docs/com2014_215_final_en.pdf

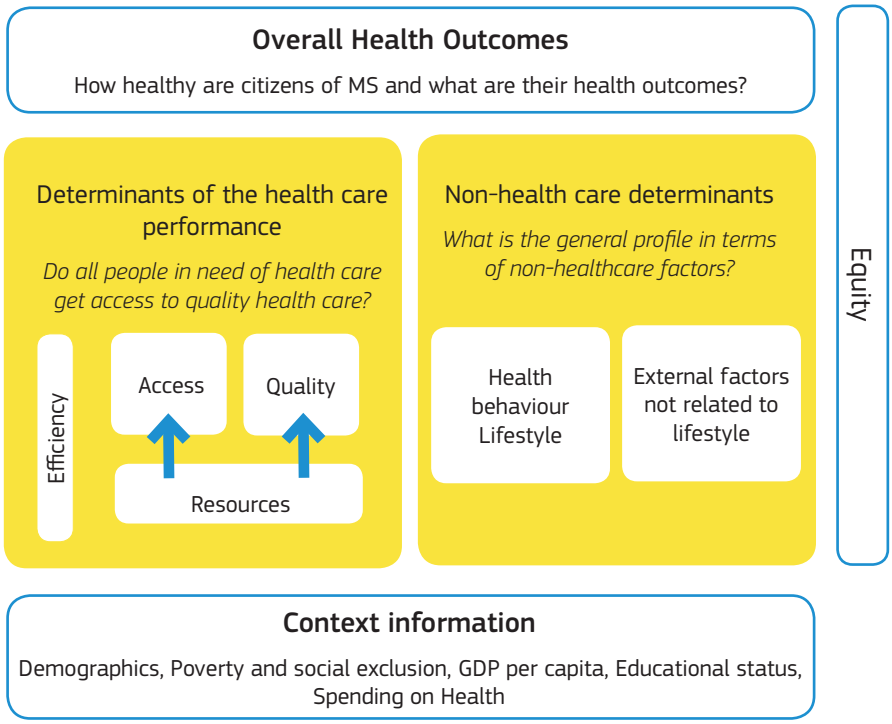
[3] Joint assessment framework is a methodology agreed by Employment Committee, Social Protec-

health systems (Social Protection Committee Indicators Sub-group 2013). This quantitative methodology is seen as a "first-step 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 1. 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.

Figure 1: Proposed model of the JAF framework in the area of health



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"[4], funded by the Commission and carried out by the Dutch National Institute for Public Health and the Environment (RIVM).

tion 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

[4] 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

B. The Belgian good practice under review

The adoption in 2008 of the Tallinn Charter by all countries in the WHO European Region was an important milestone in the move towards HSPA in Belgium. The Charter underlines the importance of health as an investment to promote economic development and solidarity, and signatories committed to the adoption of health system performance assessment. On 18 March 2008, following a recommendation of the Tallinn Charter (WHO) the Belgian governmental agreement on public health formulated an agreement that: "The performances of our health system (including quality), are to be assessed on the basis of measurable objectives."

Belgian health authorities asked their health administration - scientifically supported by the Health Care Knowledge Centre (KCE), the Institute of Public Health (IPH) and the National Institute for Health and Disability Insurance (NIHDI) – to test the feasibility of a Health System Performance Assessment report (HSPA) in Belgium. Since then the following reports have been published:

- two full HSPA reports (2009, 2012) ;
- an intermediate report assessing the evolution of HSPA in Belgium (2014);
- a thematic report on general practice (2010).

In the future, Belgium will publish HSPA every four years with intermediate reports every two years. The next report is expected to be published in December 2015.

The Belgian HSPA report explicitly pursues two strategic objectives (Gerkens 2010):

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

A further implicit yet concrete reason to prepare an HSPA report was to answer the question posed by the National Insurance Institute, namely "Can we objectively say that expenses in the Belgian health system are correctly spent (value for money)?" There was also a desire to collect and compare data on quality of care, inequities and unmet needs. Supporting policy was not an objective of HSPA at the outset, but following the publication of several reports, it is progressively becoming an issue.

Alongside HSPA, there has been in Belgium increased interest in the development of performance measurement based on a more thematic issue (e.g. general medicine). This kind of initiative, designed in cooperation with field experts, was used to define and share priorities between the practitioners and the authorities, to compare organisations (benchmarking), to improve quality of care and encourage continuous professional development, innovation and to inform incentives.

Internationally, several organisations provide resources to benchmark Belgium against other European countries on health status and healthcare indicators, including the WHO

"World Health Report 2000", the biannual report "Health at a glance Europe" resulting from a collaboration of OECD and the European Union, the EU website of the ECHI indicators and the Euro Health Consumer Index. One perspective on the Belgian HSPA initiative is that it acts as a means of seeking to interpret those reports, helping Belgium to fill gaps and shorten the delays in data collection associated with international comparisons. Belgium is also interested in building an international network to share best practices with countries with comparable health system design.

Belgium has a holistic approach to the assessment of the health system performance that is similar to the proposed JAF approach, according to a conceptual framework embracing five dimensions of performance: quality; accessibility; efficiency; sustainability; and equity. The 2012 report uses a total of 74 indicators 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.

The specific operational objectives of the 2012 report were:

- 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 Belgian HSPA experience has prompted a number of important debates that are of general relevance in the development of a country's HSPA. A first point of discussion in Belgium was whether to include "health status" to measure the outcomes of the system, in contrast to physical health system outputs. However it was considered that the link between health status as an outcome and the performance of the health system remains unclear, and more evidence will be needed before it can be used reliably.

Another point of discussion was the treatment of "non-medical determinants of health". Belgium's choice was not to include these in the framework, as the scope of the HSPA is the "health system". However, it remains unclear where to draw the boundary. For example, health promotion belongs definitively to health systems and interacts with health behaviour and life style. The discussion remains open, and is related to the debate on "health in all policies", which implies looking outside the health sector for cost-effective policies that can generate better health and reduce the demand for health services.

Belgium went a step further than the SPC recommendations by adopting a specific approach that encompasses the different aspects of the health system (and not only acute care), namely: health promotion, preventive care, curative care, long-term care and end-of-life care. This was found to be helpful, although of course the details of the approach are likely to be different from country to country depending on the health system design (degree of specialisation of health services), country organisation (centralisation/regional), and governance (Ministry of Health including – or not – social affairs). It is nevertheless recognised that the design of the framework should in no way be driven by existing data (international data are mainly based on hospital acute care) and a broader approach – including social affairs and insurance data as in Belgium – can inform a better understanding of inequalities issues.

The final section of the 2012 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.

Like all countries, Belgium has struggled with an absence of good definitions and a good framework for analysing "efficiency" and "equity". The interconnection between effectiveness, appropriateness and efficiency also requires clarification. The role of health promotion and non-health determinants must also be further explored in the context of HSPA.

Comparison with international experience suggests that Belgium's HSPA can be improved in several aspects:

- Health insurance coverage is not enough to analyse financial accessibility. Some aspects of the depth of coverage should be included, and it is essential to analyse the issues of both equity and inequalities.
- Efficiency needs to be analysed in depth especially when the economic situation is problematic.
- From the resilience point of view5, "good governance" and "adequate costing" are also issues that should be strengthened in Belgium's HSPA.
- The appropriate analysis of quality is also a point of discussion since some aspects are sometimes too detailed.

The Belgium HSPA has hitherto been used mainly for accountability. However, the belief is that it can contribute to a rapid improvement of the health system. Those charged with developing the Belgian initiative offer the following observations, in the light of their experience:

[5] According to the resilience factors identified in the Communication from the Commission on effective, accessible and resilient health systems, 4 April 2014, COM(2014) 215

1. HSPA should provide a global balanced overview which enables aligning views between

- health, social affairs and economic affairs;
- the field and decision makers.

2. It is essential that values – like quality, access, equity, on the one hand, and sustainability and efficiency, on the other hand – are shared between stakeholders.

3. It's also essential to analyse the health system as a whole encompassing

- acute, and also chronic and mental care;
- hospital (residential) care and also primary care;
- health system and also health promotion and health in all policies.

4. The set of indicators should remain comprehensive and elaborated enough to assess the system as a whole.

5. The report must lead to concrete recommendations which should be translated into action(s).

6. Many aspects still need further development, like

- dimension analysis (outcome of the health system , efficiency, inequalities, ...);
- ways to improve data collection (upi, electronic data , linking data);
- elaborate good indicators for primary care, mental care, chronic care , end of life;
- improve international benchmarking;
- improve data reporting;
- ways to improve health systems (prioritise, targets, incentives).

7. There is a need to develop a European network on HSPA.

C. Policies and experiences in peer countries

As part of the Peer Review process, a questionnaire was circulated to participating countries requesting the following information:

1. A brief description of the country's approach to HSPA.

2. The thematic priorities that have been selected

3. How benchmarks are chosen (for assessing what is good and what could be improved), and how the main indicators for drawing key conclusions are selected.

4. What targets are used for measuring improvement, and whether progress is quantified using reliable metrics and associated analytic techniques.

5. Whether and how HSPA influences national policy making. How the main results of the report are communicated to the general public, and whether HSPA is used to change policy.

6. An assessment of the strengths and weaknesses of the country's HSPA: the challenges that are faced and the priorities for improving the HSPA system.

7. What kind of EU level support would be needed to support national level HSPA.

Completed questionnaires were received from six Member States: Austria, Malta, Netherlands, Portugal, Sweden and the United Kingdom (England). In addition, although it does not formally undertake HSPA at the national level, Germany responded with a description of activities in Germany related to HSPA processes.

Where appropriate, responses for certain headings are summarized in Table Annex 1 (appended). The broad conclusions drawn from the questionnaire responses can be summarized as follows:

1. There is a general commitment to HSPA amongst all the responding countries.

2. Countries are at different stages of development in their HSPA systems.

3. The aims of HSPA vary between countries, reflecting different emphases towards (a) promoting the accountability of national institutions (b) informing policy (c) improving transparency and understanding and (d) holding devolved entities to account.

4. The processes of HSPA vary between countries, for example in terms of
   - Who instigates and drives forward the demand for HSPA
   - How stakeholders' differing priorities are resolved
   - Who funds HSPA
   - Who undertakes HSPA
   - The format and contents of HSPA
   - Whether HSPA is a continuing and sustained process.

5. All systems have adopted some sort of analytic framework for undertaking HSPA, although these differ somewhat, mainly in details. The major differences relate to the assumed scope of the health system, principally the extent to which the HSPA focuses solely on health services or takes a broader societal perspective.

6. The basis for comparison varies between countries, but there is heavy reliance on international comparison, as well as some consideration of national trends over time and regional comparisons within the country.

7. The extent and nature of HSPA influence over health policy differs between countries. In some it has directly fed into governmental decision-making, whilst in others it has a less direct influence through informing political debate.

8. Most HSPA efforts are at an early stage of development. Achievements include acting as a framework for reporting progress, identifying key data weaknesses, and identifying priorities for health system action. Principal challenges relate to data weaknesses and identifying the most appropriate means of transmitting results to relevant stakeholders, including the public.

9. There is an important role at the European level for nurturing exchange of ideas and promoting the availability and comparability of relevant data.

D. Main issues discussed during the meeting

These and other issues were elaborated on by country representatives and other stakeholders at the Peer Review meeting. The meeting included presentations examining the international HSPA context and giving details of the specific Belgian initiative under scrutiny. These were followed by general discussions of all participants on the goals of HSPA; methodology; impact and monitoring; governance of HSPA; and the role of support at the European level.

There were presentations on activities and policy needs relevant to HSPA from representatives from the European Commission in DG EMPL, DG SANCO and DG ECFIN, reflecting the importance of HSPA across policy domains. Representatives from the Organisation for Economic Cooperation and Development (OECD) and the European Observatory on Health Systems and Policy described their relevant activity at the European level, and their joint working with the Commission.

The meeting did not seek a consensus, and there was not unanimity on all issues. However, the following summarizes some of the issues raised at the meeting.

1. HSPA can help to frame our thinking about health systems, which are highly complex structures. Internationally consistent data sources are a crucial resource for any HSPA.

2. The precise format for HSPA is essentially a matter for individual countries, as there are legitimate variations in the perspective to be adopted and the goals of the HSPA.

3. The demand for HSPA comes from a variety of sources. Government may be the main drivers, but stakeholders with a range of different interests may also be involved. Consensus on the aims of HSPA is easier to achieve in some countries than in others.

4. The funding of HSPA can raise issues concerning its independence.

5. HSPA should be descriptive rather than prescriptive. Although its findings may lead to recommendations for improving a health system, these should best be formulated outside the direct HSPA process.

6. Comparisons are fundamental to all HSPA exercises. These may look at international or regional differences. Such comparisons can help identify problems and inefficiencies within national or local healthcare provision. Comparison of trends over time can also help to identify the impacts of reforms.

7. The selection of indicators used in HSPA will affect its outcome. While some selection is inevitable, concerns were expressed about approaches that strongly compress the number of indicators.

8. Data weaknesses are a common constraint, with information on certain areas of activity either absent, weak, unreliable or out-of-date. Certain thematic areas such as mental illness present special difficulties.

9. HSPA exercises are in themselves a means of improving the quality and scope of data. In a number of countries, HSPA has stimulated new data collection efforts. In particular, use of international datasets may draw attention to gaps in national data.

10. There is a particular concern about the absence of useful indicators of system efficiency.

11. The technical difficulty of developing appropriate indicators of equity of health and access to health services between social groups was also noted.

12. "Patient vignettes" (describing how an otherwise identical case is treated in different systems) may be another possible means of comparison, but they are currently little used.

13. Some constraints on access to data exist. Real or perceived threats to privacy have become a major issue in some countries, and health data are particularly sensitive in this regard. Various anonymisation techniques may help to overcome resistance to data collection for legitimate research purposes.

14. A number of technical challenges remain. The concept of equity in health provision is difficult to capture in metrics. Access to care is an important concern here, notably the coverage of health insurance systems and whether or not co-payments are required from patients. The measurement of efficiency also raises some questions. Should inefficiencies be treated simply as money badly spent, or should an effort be made to measure bad outputs? Nor is it always easy to determine whether health outcomes, such as life expectancy, are attributable to the health system or to other causes. However, some progress is being made on this, through the development of concepts such as "avoidable mortality" and "avoidable [hospital] admissions". Patient-reported outcome measures[6] (PROMs) can assist the reporting of outcomes other than mortality. The generic EQ-5D outcome measure, developed with EU funding, could be used to check if people with chronic long-term conditions, such as diabetes, enjoy a different quality of life in different countries.

15. Accountability is key to the success of HSPA. But of whom to whom? And how? Is it the accountability of governments to parliaments? Or of governments to citizens? Or of healthcare providers to patients? This needs further consideration, as it will determine the nature and content of HSPA.

16. Are targets and rankings legitimate aims of HSPA? They are likely to draw more attention, but will this be productive attention? It was agreed that any cross-border benchmarking should maintain maximum flexibility.

[6] Patient reported outcomes are standardised questionnaires that ask patients about their health-related quality of life before, during, or after treatment (Smith 2013). They can be either disease-specific or generic (applicable across a wide range of disease areas). The EQ5D is a generic PROM instrument that has been developed by the EuroQol group and applied in a wide range of settings. It can be used either to assess improvements in quality of life following treatment, or to monitor ongoing health-related quality of life. www.euroqol.org/

17. Dissemination of HSPA findings is important, and research may be needed to identify the best methods. Full HSPA reports are unlikely to appeal to a non-specialist readership. Peer reviewers noted the Belgian practice of publishing a summary report for a wider public. They particularly praised Belgium's use of tables with "smileys" to present the results in an easily understandable way.

18. The meeting considered some key criteria for assessing a HSPA initiative:

- Does it 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 a clear conceptual framework for the HSPA?
- Does it focus on the health system as a whole, including health promotion and public health as well as health services?
- Are system goals 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?
- Is the HSPA adequately disseminated and promoted?
- Is it a regular, sustainable process, with suitable arrangements for reviewing and updating?
- Is HSPA fully embedded within health policy-making?

19. European and international action to promote HSPA is desirable. However, participants voiced the opinion that creating a European HSPA would be challenging, notably because health systems are a national competence and are structured differently in each country and thus could be difficult to compare. So the focus of HSPA in each Member State will not necessarily be the same, although there may be scope at some stage in the future for developing a more standardised format. Bilateral and multilateral cooperation between countries can also provide important HSPA resources.

20. A joint review of health-related, country-specific recommendations will be carried out in 2014 by the EU Social Protection Committee (SPC). A public consultation on the EU's 2020 strategy is underway and will remain open until October. This is an opportunity to provide reflections on the role of health systems in that strategy.

21. The EU is encouraging all Member States to report health expenditure through the system of health accounts (SHA), in order to improve the data and make them comparable. A number of countries are now using the SHA. The Commission also monitors the financial sustainability of healthcare expenditure items.

22. The EU is already providing forums for sharing experience on HSPA, and a number of European and international indicator, data and methodology sources are available or in preparation, as discussed in Part A above. The sub-group of the reflection process in charge of HSPA suggested setting up an expert group to identify tools and methodologies for HSPA in support of national policy-makers.

E. Conclusions and lessons learned

HSPA is an important undertaking that should provide a framework for assessing how a health system is performing, improving transparency, providing accountability for the money spent, and identifying priorities for action. It is difficult to see how publicly funded health systems can justify their expenditure to finance ministries, parliaments and the general public without seeking to demonstrate that the money for which they are responsible is well spent. This principle was articulated in the 2008 Tallinn Charter, to which all European Member States are signatories, and has become even more important in the light of the financial challenges currently faced by many countries.

However, HSPA is also a complex undertaking. Modern health systems represent one of the most complex sectors of the economy, seeking to address a huge diversity of health needs using many types of interventions. Furthermore, although improved health and reduced inequalities are a prime objective of all health systems, there is a continuing debate about the extent to which health outcomes can be attributed to health system actions. This uncertainty has led to some debate about the correct definition of the health system, and the extent to which it should embrace broad social determinants of health such as diet and other health-related behaviour.

There was a widespread sentiment amongst participants (previously also expressed by the World Health Organisation) that the form of HSPA is fundamentally a matter for national governments. This is both for practical reasons (institutional arrangements differ substantially between countries) but also due to the need to respect local autonomy. Similar arguments apply within countries, often making it harder to implement national HSPA in a federal state than a unitary state.

The Belgian HSPA initiative was nevertheless commended by the Peer Review participants as being a good model for other countries seeking to introduce or enhance a HSPA process. Particularly noteworthy are the clarity of objectives, the clear conceptual framework, the independent rigour of the analysis, the emphasis on equity, and the commitment to a continuing HSPA process. Work is continuing to identify the appropriate way of linking the Belgian HSPA with policy processes. This aspect of HSPA is underdeveloped in most countries and likely to vary depending on institutional arrangements.

There are strong arguments, as expressed amongst Peer Review participants, for action at a European level to nurture and sustain HSPA. The feasibility and effectiveness of HSPA depends crucially on the existence of extensive comparable and reliable data sources, collected on a consistent basis from as many countries as possible. A crucial role at the international level is to secure international agreement on the scope of data collection efforts, the specification of data definitions and standards, the promotion of data collection and dissemination by international agencies, and sharing best practice on the use of the information.

The technical work of the Social Protection Committee in developing a health policy area within the Joint Assessment Framework appears to be aligned with the HSPA initiatives being developed by individual Member States. The proposed framework is consistent with many of the frameworks already adopted by Member States, and has a strong focus on

equity, a persistent concern within many HSPA initiatives. As with all HSPA efforts to date, the SPC has not developed the efficiency aspect of the framework in any detail, and this would appear to be a priority. It is important to underline that identification of inefficiency is important not just because it represents a poor use of resources. A failure to use resources efficiently may often result in denial of treatment for some patients because the resources they need are wasted elsewhere, leading directly to a loss of health caused by inefficiency.

The Peer Review nevertheless highlighted concerns that HSPA should be a national undertaking, tailored to local needs, and therefore the context in which JAF Health is used should be clearly stated and explained carefully. There are coherent arguments for adopting consistent reporting practices across countries (particularly if those countries actively agree to participate). However, the history of HSPA (notably the World Health Report 2000) illustrates the risks of seeking to assess health systems according to a single template, and the associated potential for undermining the commitment to HSPA.

Ultimately, failure of health systems to be properly accountable for the use of their resources may lead to a reluctance on the part of governments and citizens to continue to support publicly funded health services. The breakdown of solidarity in the health domain could lead to many adverse consequences, in the form of reduced health, increased exposure to financial risk, and diminished equity. Undertaken effectively, HSPA has the potential to contribute significantly to that need for accountability, and there is a compelling argument to promote the principles of HSPA and support best practice.

References

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

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.

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.

Gerkens, S. and S. Merkur, Belgium: Health system review, 2010, Copenhagen: World Health Organization, on behalf of the European Observatory on Health Systems and Policies.

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.

Organization for Economic Cooperation and Development, Health at a Glance: Europe 2012, 2012, OECD: Paris.

Organization for Economic Cooperation and Development, OECD Health Data 2013, 2013a, Paris: OECD.

Organization for Economic Cooperation and Development, Health at a glance 2013b: OECD indicators, 2013, OECD: Paris.

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.

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

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

Smith, P. and A. Street, On the uses of routine patient reported health outcome data. Health Economics, 2013. 22(2): p. 119-131.

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.

World Health Organization, The World Health Report 2000. Health systems: improving performance, 2000, Geneva: World Health Organization.

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

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

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.

Country	Broad aims	Basis of comparison	Integration into policy	Achievements and challenges	Priorities for EU
Austria	Improving understanding of performance for politicians and representatives Timely publication of performance data.	Comparison with EU-15 average	Identifying areas of actions to be taken by policy makers. Part of a wider evaluation framework (for the future).	Integrating the current framework into a wider evaluation framework also encompassing public health; Embedding HSPA more deeply in the policy making process.	A set of current, homogenous performance indicators, which are also provided on a regional level could support the national efforts.
Malta	To continually assess the nation's health needs and associated health policy. To enhance accountability, transparency and sustainability of the health care system.	WHO Euro Region and the European Union Member States. EU-15 average	Yet to be established, but likely: • To monitor the health system's ability to cater for the nation's health needs; • To increase accountability, transparency and sustainability of the health care system; • Gauge future policy directions.	Creating an indicator set within the HSPA which mirrors the performance of the health system as a whole and not only its component parts Developing an appropriate IT infrastructure.	Providing expertise and know how in specific areas of development, especially those areas that are most challenging, such as IT systems and networking. Standardising approaches to information collation and comparison between Member States. Promoting best practices, sharing of national experiences and enabling the conduct of benchmarking exercises.

Netherlands	Somewhere between evaluation (accountability) and agenda-setting (for strategic decision making).	Trends over time Selected OECD countries EU15 average	In health policy making, the report is used for agenda setting and for accountability of the ministry to parliament. Results are actively disseminated among policy makers and health care professionals. In recent years, a selection of results is presented via highly accessible information products on a dedicated website.	The DHCP report is well embedded in a network of expert researchers and health care professionals. The major challenge is to improve its policy impact and 'actionability'.	Supporting European networks of national experts in this area, facilitating the exchange of methods and good practices. Support for the work of international agencies such as WHO and OECD, particular for 'poorer' EU countries. Supporting sector specific capacity building (eg long-term care, hospital care, mental health care, primary care, public health).
Portugal	To support the Ministry of Health to improve the performance of the health system Contribute to the critical evidence base necessary to develop the National Health Plan	Individual EU15 countries	Supports the Ministry of Health to improve the performance of the Portuguese health system The main results of the report were communicated to the general public through a media conference and press releases.	The HSPA introduced a health system perspective in national planning; Critical gaps in health information (eg safety and health; socioeconomic inequalities in health). These gaps limit the capacity to support transparency and accountability through public reporting. No decision has yet been made concerning the future institutionalisation of HSPA.	

Sweden	To make the publicly financed healthcare system more transparent; To advance the cause of healthcare management and control To promote quality and availability of data about healthcare performance and outcomes	Mainly within-country; Some international comparisons	Used both in decision-making and development within the county councils Serve as base to decide on national policy initiatives. Contribute to local improvement work Results are communicated to the general public.	A large number of indicators have been developed, with good access to data from various sources How to prioritise among different measures - which are the most important indicators? How can the information be used to secure improvement of health care? Action plan to improve availability and use of data and indicators amongst all actors.	More data available for international comparisons, and for more thematic approaches for HSPA targeting EU countries.
United Kingdom	Provides a national overview of how well the system is performing The primary method by which NHS England is held to account Leads improvements in health outcomes and quality of care.	Mainly within-country; Trends over time; Some international comparisons	Used to hold NHS England to account for improving health outcomes and reducing health inequalities; Data are updated on an annual basis using web based tools.	Has moved the focus away from process, concentrating on those outcomes that matter to people; It can be difficult to establish how improvements have been arrived at; Timeliness of data can be an issue (both availability and affordability); Data is limited in a number of areas	

European Commission

Health System Performance Assessment

2014 — 28 pp. — 17.6×25 cm

ISBN 978-92-79-39636-6
ISSN 1977-7973
doi: 10.2767/39073

This publication is available in electronic format in English, French, German and Dutch.

KE-BF-14-006-EN-N

Health System Performance Assessment

Host country: **Belgium**

Peer countries: **Austria - Estonia - Germany - Luxembourg - Malta - Netherlands - Portugal - Sweden - UK**

Health System Performance Assessment (HSPA) allows decision-makers to measure the performance of health systems as a whole and to report results regularly to the public and relevant stakeholders, but has been developed in relatively few European countries. Belgium, which piloted its first HSPA in 2008, hosted a Peer Review which focused on the methods and tools needed for further developing HSPA within the EU. This report summarises the key issues discussed and the lessons learned.

Publications Office