Health systems performance assessment - what is it all about?

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Structure

1. Background and history of HSPA
2. Why do HSPA?
3. The contents of HSPA
4. How to present HSPA
5. The impact of HSPA
6. The process of HSPA
7. Concluding comments

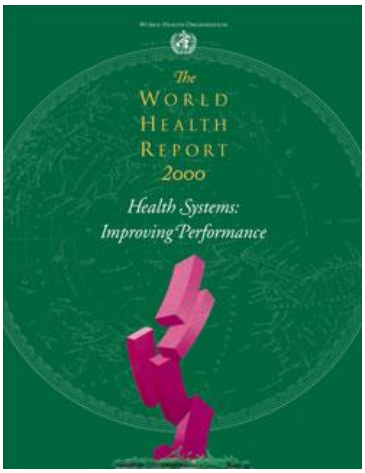
1. Background and history of HSPA

Florence Nightingale: the "Passionate Statistician"

- *International Statistics Congress, London, 1860*
- "… Miss Nightingale's scheme for Uniform Hospital Statistics should be conveyed to all governments represented."

Source: D. J. Spiegelhalter: *Journal of the Royal Statistical Society. Series A (Statistics in Society)*, Vol. 162, No. 1, (1999), pp. 45-58

World Health Report 2000



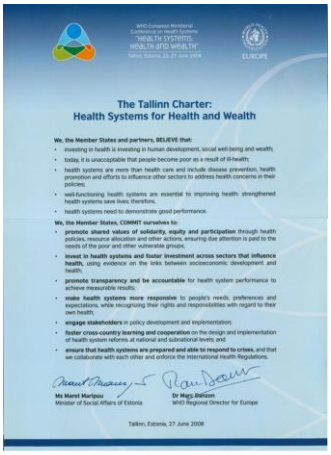
- The health system:

  "… all the activities whose primary purpose is to promote, restore or maintain health."

WHO 2000 Efficiency Rankings

OVERALL PERFORMANCE				
Rank	Uncertainty interval	Member State	Index	Uncertainty interval
1	1 – 5	France	0.994	0.982 – 1.000
2	1 – 5	Italy	0.991	0.978 – 1.000
3	1 – 6	San Marino	0.988	0.973 – 1.000
4	2 – 7	Andorra	0.982	0.966 – 0.997
5	3 – 7	Malta	0.978	0.965 – 0.993
6	2 – 11	Singapore	0.973	0.947 – 0.998
7	4 – 8	Spain	0.972	0.959 – 0.985
8	4 – 14	Oman	0.961	0.938 – 0.985
9	7 – 12	Austria	0.959	0.946 – 0.972
10	8 – 11	Japan	0.957	0.948 – 0.965
11	8 – 12	Norway	0.955	0.947 – 0.964
12	10 – 15	Portugal	0.945	0.931 – 0.958
13	10 – 16	Monaco	0.943	0.929 – 0.957
14	13 – 19	Greece	0.933	0.921 – 0.945
15	12 – 20	Iceland	0.932	0.917 – 0.948
16	14 – 21	Luxembourg	0.928	0.914 – 0.942
17	14 – 21	Netherlands	0.928	0.914 – 0.942
18	16 – 21	United Kingdom	0.925	0.913 – 0.937
19	14 – 22	Ireland	0.924	0.909 – 0.939
20	17 – 24	Switzerland	0.916	0.903 – 0.930

Tallinn Charter, 2008



The Tallinn Charter:
Health Systems for Health and Wealth

We, the Member States and partners, BELIEVE that:

- investing in health is investing in human development, social well-being and wealth;
- today, it is unacceptable that people become poor as a result of ill-health;
- health systems are more than health care and include disease prevention, health promotion and efforts to influence other sectors to address health concerns in their policies;
- well-functioning health systems are essential to improving health: strengthened health systems save lives; therefore,
- health systems need to demonstrate good performance.

We, the Member States, COMMIT ourselves to:

- **promote shared values of solidarity, equity and participation** through health policies, resource allocation and other actions, ensuring due attention is paid to the needs of the poor and other vulnerable groups;
- **invest in health systems and foster investment across sectors that influence health,** using evidence on the links between socioeconomic development and health;
- **promote transparency and be accountable** for health system performance to achieve measurable results;
- **make health systems more responsive** to people's needs, preferences and expectations, while recognizing their rights and responsibilities with regard to their own health;
- **engage stakeholders** in policy development and implementation;
- **foster cross-country learning and cooperation** on the design and implementation of health system reforms at national and subnational levels; and
- **ensure that health systems are prepared and able to respond to crises,** and that we collaborate with each other and enforce the International Health Regulations.

Ms Maret Maripuu
Minister of Social Affairs of Estonia

Dr Marc Danzon
WHO Regional Director for Europe

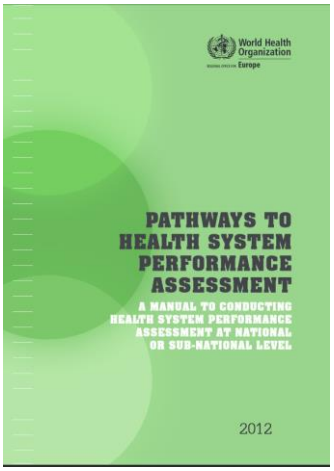
Tallinn, Estonia, 27 June 2008

- ❑"We, the member states, commit ourselves to:
  - Promote shared values of solidarity, equity and participation ...
  - Invest in health systems, and foster investment across sectors that influence health ...
  - Promote transparency and be accountable ...
  - Make health systems more responsive ...
  - Engage stakeholders ...
  - Foster cross-country learning and cooperation ...
  - Ensure that health systems are prepared and able to respond to crises ..."

The WHO vision of Health System Performance Assessment

- "... a country-specific process of monitoring, evaluating, communicating and reviewing the achievement of high-level health system goals based on health system strategies."

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: WHO Regional Office for Europe.



EU expert group on health systems performance assessment

Four objectives:

- To provide a forum to European countries for the exchange of experiences in HSPA
- To support policy makers in their HSPA activities
- To define criteria for identifying policy priorities where to focus performance assessment
- To intensify cooperation with international organisations in this field.

Federico Paoli et al (2019) “An EU approach to health system performance assessment”, 123, 403-407, https://doi.org/10.1016/j.healthpol.2019.02.004

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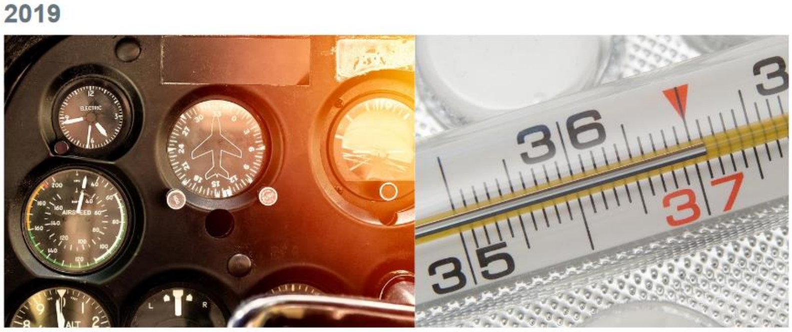
Belgian Health Care Knowledge Centre

PERFORMANCE OF THE BELGIAN HEALTH SYSTEM – REPORT 2019



2019 www.kce.fgov.be

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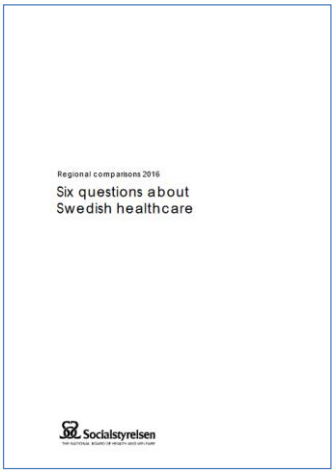
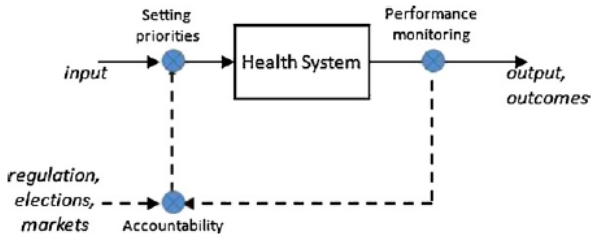
Contrasting approaches (and longevity): Netherlands and Sweden



Some broadly accepted principles of HSPA

- 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.

A cybernetic model of health system leadership and governance



Smith, P., Anell, A., Busse, R., Crivelli, L., Healy, J., Lindahl, A. K., Westert, G. and Kene, T. (2012), "Leadership and governance in seven developed health systems", *Health Policy* 106 (1) 37– 49.

2. Why do HSPA?

Objectives of HSPA

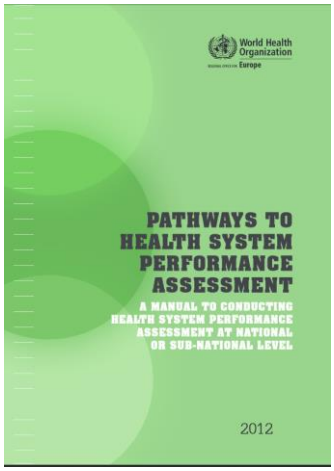
- Many related to planning, accountability, transparency, comparison, understanding the system, expressing values, setting priorities, etc.
- Ultimate goals
  - Improvement in health
  - Improved use of health system funds
  - Sustainability of health system
- Objectives are needed to design the content and dissemination of HSPA

Goals of HSPA

- *Armenia*: Enhance stewardship; Accountability; Transparency; Identify policy priorities.
- *Belgium*: Transparency and accountability; Comparisons with other countries; Performance monitoring over time.
- *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 Program; Transparency and accountability; Support the development of evidence-based policy-making; Guide governmental policy development; Identify policy priority areas.

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.

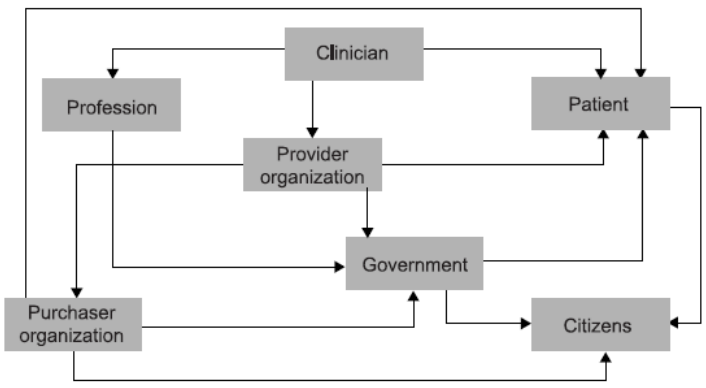
The WHO vision of Health System Performance Assessment



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.

Map of some important accountability relationships in the health system



Smith, P., Mossialos, E. and Papanicolas, I. (2011), "Performance measurement for health system improvement: experiences, challenges and prospects" in McKee, M. and Figueras, J. (eds) *Health systems, health, wealth and societal well-being: assessing the case for investing in health systems*, Maidenhead: McGraw-Hill, pp 247-280.

Five key questions

"The world sorely needs a 'third voice' that receives general attention and reports how things are going."

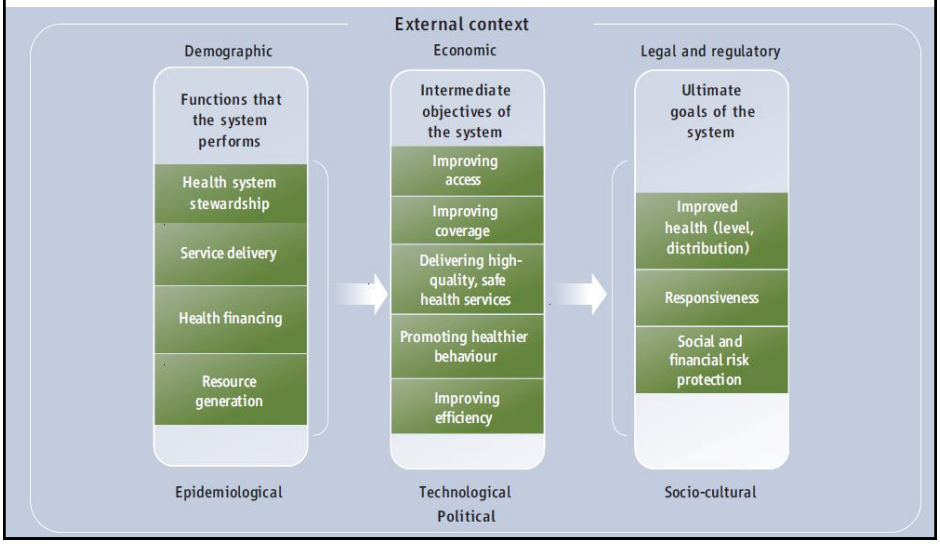
1. Who is reporting?
2. To whom are they reporting?
3. What are they reporting?
4. How are they reporting?
5. What is the effect of reporting?

Lasswell, H. D. (1972). Communications research and public policy. *Public Opinion Quarterly*, 36(3), 301-310. https://doi.org/10.1086/268012

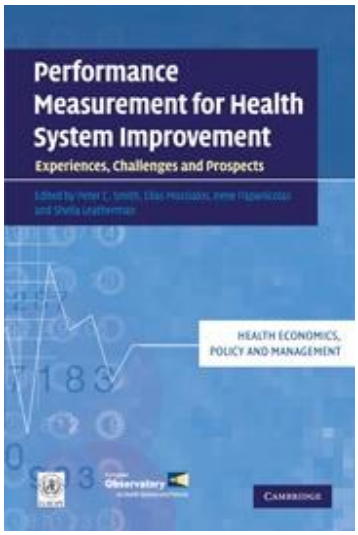
3. The content of HSPA

- Structuring information – need for a framework
- Choosing and aggregating the indicators
- Treatment of the external influences on attainment
- Basis of comparison:
  - International
  - Regional
  - Time trends
- Handling constraints in availability and comparability of data

Conceptual Framework for Portuguese HSPA Report



Domains of performance measurement



- Population health
- Clinical quality and appropriateness
- Responsiveness
- Financial protection
- Equity
- Efficiency

Table 4 – Indicators on safety of care

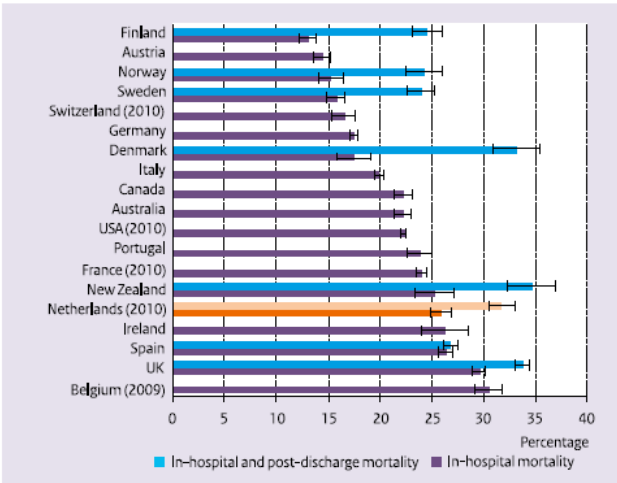
(ID) Indicator			Belgium	Year	Flanders	Wallonia	Brussels	Source	EU-15 (mean)
Healthcare-associated infections									
QS-1	Prevalence of healthcare-associated infections (% of hospitalised patients)	ST	7.3	2017	-	-	-	Sciensano	6.4%(1)
QS-2	Incidence of hospital-acquired MRSA (per 1000 hospital admissions, median)	+	0.7	2016	0.5	**1.2**	0.5	Sciensano	-
QS-7 *NEW*	Proportion of methicillin-resistant *Staphylococcus aureus* (MRSA) in acute care hospitals (%, median)	+	15.0	2016	10.9	**21.2**	10.3	Sciensano	(3)
QS-8 *NEW*	Proportion of *Escherichia coli* with reduced susceptibility to 3rd or 4th generation cephalosporins (3GC/4GC I/R *E. coli*) in acute care hospitals (%, median)	−	9.1	2016	8.1	9.3	10.9	Sciensano	(3)
Complications after surgery[a]									
QS-3	Incidence of post-operative pulmonary embolism or deep vein thrombosis, after hip or knee replacement (/100 000 hip or knee surgery discharges)	+	352	2014	247	**498**	**576**	MZG – RHM	401(2) [BE: 354]
QS-4	Incidence of post-operative sepsis after abdominal surgery (/100 000 abdominal surgery discharges)	+	1717	2014	**2230**	**1443**	715	MZG – RHM	2122(2) [BE: 1717]
Complications during hospitalisation – quality of nursing care									
QS-5*	Prevalence of hospital-acquired cat II-IV pressure ulcers (% of patients hospitalised)	●	5.1	2012	4.0	**7.7**	**5.9**	FRKVA-CFQAI	-
Polymedication									
QS-6	Polypharmacy among the elderly (5 or more drugs of >80 DDD per year) (% of insured population 65+)	+	39%	2016	37%	**44%**	35%	Pharmanet Sciensano	—

Good (●), average (●) or poor (●) results, globally stable (ST), improving (+), deteriorating (-) or trend not evaluated (empty).

[a] Patient Safety Indicators based on hospital discharge data

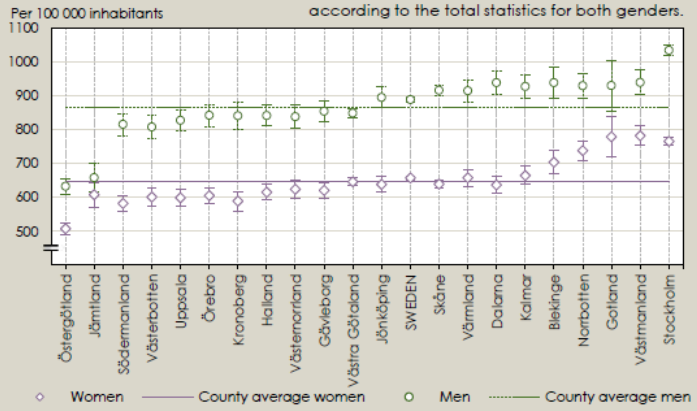
*(1) Excluding Denmark and Sweden (2) OECD Health at a Glance 2017 (3) Belgium has an intermediate position across EU-15 countries for a similar indicator (see the technical sheet in appendix for details), * this indicator will be updated on the website (https://www.healthybelgium.be/) when recent results become available.*

Figure 4.8b: Percentages of people aged 45 or older deceased within 30 days of hospital admission (including day-patient admissions) for haemorrhagic stroke, age- and sex-standardised to the 2010 OECD population aged 45+ admitted to hospital for haemorrhagic stroke, with 95% confidence intervals (data for 2011, unless otherwise indicated) (source: OECD, 2013a).



9.2. County. Avoidable hospitalisation due to heart failure, diabetes, asthma or COPD

Number of hospitalisation periods for diagnoses of heart failure, diabetes, asthma or COPD per 100 000 inhabitants aged 20 years or over. Age-standardised statistics, 2013-2015. **Women and men** - counties are sorted according to the total statistics for both genders.



Source: National Patient Register, National Board of Health and Welfare

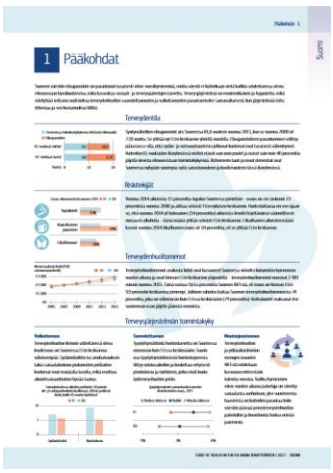
HSPA: the technical problem areas

- Data: availability; consistency; timeliness
- Population health
  - Adjusting for 'uncontrollable' social determinants
  - How much is attributable to the local health system?
  - Mental health
- Equity
  - What dimension of disadvantage to use (?income)
  - National groupings or regional groupings?
  - Complexity of presentation
- Efficiency
  - An overarching concept, or just another (bad) output?
  - Treat as an unexplained residual, or try to measure?
- Clinical services
  - Capturing 'unmet' need

4. How to present HSPA

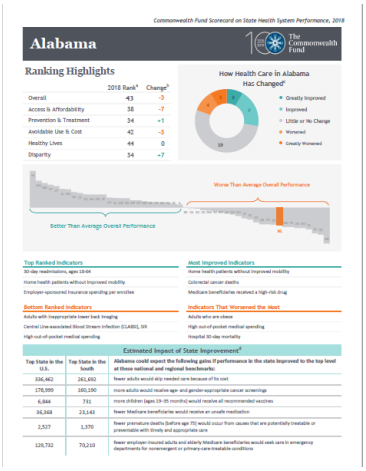
- Numerous examples, little research
- To some extent will depend on the intended audiences
- Should health system 'functions' be included as well as outcomes?
- To what extent should explanations and analysis supplement the information?
- Balance between data provision and structuring information
- Many alternatives to the 'heavy' reports mentioned earlier
- Very few examples exploiting social media or other 'new' media

Example 1: Observatory/OECD Health Profiles: 20 pages of data, comparison and narrative



https://ec.europa.eu/health/state/country_profiles_en

Example 2: Commonwealth Fund's Scorecards on State Health System Performance (Part 1)



Commonwealth Fund Scorecard on State Health System Performance, 2018

Alabama

The Commonwealth Fund

Ranking Highlights

	2018 Rank[a]	Change[b]
Overall	43	-3
Access & Affordability	38	-7
Prevention & Treatment	34	+1
Avoidable Use & Cost	42	-3
Healthy Lives	44	0
Disparity	34	+7

How Health Care in Alabama Has Changed[c]

Top Ranked Indicators

30-day readmissions, ages 18-64
Home health patients without improved mobility
Employer-sponsored insurance spending per enrollee

Most Improved Indicators

Home health patients without improved mobility
Colorectal cancer deaths
Medicare beneficiaries received a high-risk drug

Bottom Ranked Indicators

Adults with inappropriate lower back imaging
Central Line-associated Blood Stream Infection (CLABSI), SIR
High out-of-pocket medical spending

Indicators That Worsened the Most

Adults who are obese
High out-of-pocket medical spending
Hospital 30-day mortality

Estimated Impact of State Improvement[d]

Top State in the U.S.	Top State in the South	Alabama could expect the following gains if performance in the state improved to the top level at these national and regional benchmarks:
336,462	261,692	fewer adults would skip needed care because of its cost
178,995	180,190	more adults would receive age- and gender-appropriate cancer screenings
6,844	731	more children (ages 19–35 months) would receive all recommended vaccines
34,368	23,143	fewer Medicare beneficiaries would receive an unsafe medication
2,527	1,370	fewer premature deaths (before age 75) would occur from causes that are potentially treatable or preventable with timely and appropriate care
120,732	70,210	fewer employer-insured adults and elderly Medicare beneficiaries would seek care in emergency departments for nonemergent or primary-care-treatable conditions

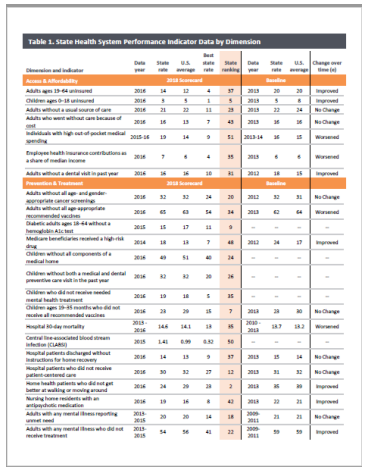


Table 1. State Health System Performance Indicator Data by Dimension

Dimension and Indicator	Data year	State rate	U.S. average	Best state rate	State ranking	Data year	State rate	U.S. average	Change over time (e)
Access & Affordability		**2018 Scorecard**					**Baseline**		
Adults ages 19–64 uninsured	2016	14	12	4	37	2013	20	20	Improved
Children ages 0–18 uninsured	2016	3	5	1	5	2013	5	8	Improved
Adults without a usual source of care	2016	21	22	11	29	2013	22	24	No Change
Adults who went without care because of cost	2016	16	13	7	43	2013	16	16	No Change
Individuals with high out-of-pocket medical spending	2015-16	19	14	9	51	2013-14	16	15	Worsened
Employee health insurance contributions as a share of median income	2016	7	6	4	35	2013	6	6	Worsened
Adults without a dental visit in past year	2016	16	16	10	31	2012	18	18	Improved
Prevention & Treatment		**2018 Scorecard**					**Baseline**		
Adults without all age- and gender-appropriate cancer screenings	2016	32	30	24	20	2012	32	31	No Change
Adults without all age-appropriate recommended vaccines	2016	65	63	54	34	2013	62	64	Worsened
Diabetic adults ages 18–64 without a hemoglobin A1c test	2015	15	17	11	9	–	–	–	–
Medicare beneficiaries received a high-risk drug	2014	18	13	7	48	2012	24	17	Improved
Children without all components of a medical home	2016	49	51	40	24	–	–	–	–
Children without both a medical and dental preventive care visit in the past year	2016	32	32	20	24	–	–	–	–
Children who did not receive needed mental health treatment	2016	19	18	5	35	–	–	–	–
Children ages 19–35 months who did not receive all recommended vaccines	2016	23	29	15	7	2013	28	30	No Change
Hospital 30-day mortality	2015-2016	14.6	14.1	13	35	2010-2013	13.7	13.2	Worsened
Central line-associated blood stream infection (CLABSI)	2015	1.41	0.99	0.52	50	–	–	–	–
Hospital patients discharged without instructions for home recovery	2016	14	13	9	37	2013	15	14	No Change
Hospital patients who did not receive patient-centered care	2016	30	32	27	12	2013	31	32	No Change
Home health patients who did not get better at walking or moving around	2016	24	29	18	2	2013	35	30	Improved
Nursing home residents with an antipsychotic medication	2016	19	16	8	42	2013	22	21	Improved
Adults with any mental illness reporting unmet need	2015-2015	20	20	14	18	2009-2011	21	21	No Change
Adults with any mental illness who did not receive treatment	2015-2015	54	56	41	22	2009-2011	59	59	Improved

https://www.commonwealthfund.org/publications/fund-reports/2018/may/2018-scorecard-state-health-system-performance

Commonwealth Fund's Scorecards on State Health System Performance (Part 2)

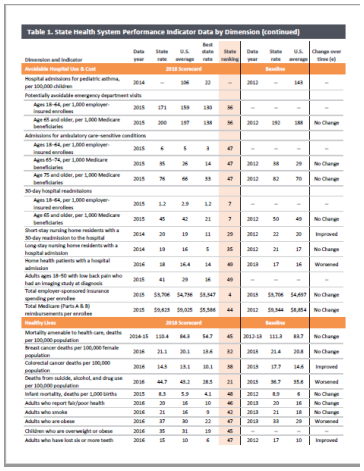


Table 1. State Health System Performance Indicator Data by Dimension (continued)

Dimension and Indicator	Data year	State rate	U.S. average	Best state rate	State ranking	Data year	State rate	U.S. average	Change over time (e)
Avoidable Hospital Use & Cost		**2018 Scorecard**					**Baseline**		
Hospital admissions for pediatric asthma, per 100,000 children	2014	–	104	22	–	2012	–	143	–
Potentially avoidable emergency department visits									
Ages 18–64, per 1,000 employer-insured enrollees	2015	171	159	130	36	–	–	–	–
Age 65 and older, per 1,000 Medicare beneficiaries	2015	200	197	138	36	2012	192	188	No Change
Admissions for ambulatory care-sensitive conditions									
Ages 18–64, per 1,000 employer-insured enrollees	2015	6	5	3	47	–	–	–	–
Ages 65–74, per 1,000 Medicare beneficiaries	2015	35	26	14	47	2012	38	29	No Change
Age 75 and older, per 1,000 Medicare beneficiaries	2015	76	66	33	47	2012	82	70	No Change
30-day hospital readmissions									
Ages 18–64, per 1,000 employer-insured enrollees	2015	1.2	2.9	1.2	7	–	–	–	–
Age 65 and older, per 1,000 Medicare beneficiaries	2015	45	42	21	7	2012	50	49	No Change
Short-stay nursing home residents with a 30-day readmission to the hospital	2014	20	19	11	29	2012	22	20	Improved
Long-stay nursing home residents with a hospital admission	2014	19	16	5	35	2012	21	17	No Change
Home health patients with a hospital admission	2016	18	16.4	14	40	2013	17	16	Worsened
Adults ages 18–50 with low back pain who had an imaging study or diagnosis	2015	41	29	16	49	–	–	–	–
Total employer-sponsored insurance spending per enrollee	2015	$5,706	$4,796	$3,347	4	2013	$5,706	$4,697	No Change
Total Medicare (Parts A & B) reimbursements per enrollee	2015	$9,623	$9,025	$5,566	44	2012	$9,344	$8,854	No Change
Healthy Lives		**2018 Scorecard**					**Baseline**		
Mortality amenable to health care, deaths per 100,000 population	2014-15	110.4	84.3	54.7	45	2012-13	111.3	83.7	No Change
Breast cancer deaths per 100,000 female population	2016	21.1	20.1	13.6	42	2013	21.4	20.8	No Change
Colorectal cancer deaths per 100,000 population	2016	14.3	13.1	10.1	38	2013	17.7	14.6	Improved
Deaths from suicide, alcohol, and drug use per 100,000 population	2016	44.7	40.2	28.5	21	2013	36.7	35.6	Worsened
Infant mortality, deaths per 1,000 births	2015	8.3	5.9	4.1	48	2012	8.9	6	No Change
Adults who report fair/poor health	2016	20	16	10	46	2013	20	16	No Change
Adults who smoke	2016	21	16	9	42	2013	21	18	No Change
Adults who are obese	2016	37	30	22	47	2013	33	29	Worsened
Children who are overweight or obese	2016	35	31	19	45	–	–	–	–
Adults who have lost six or more teeth	2016	15	10	6	47	2012	17	10	Improved

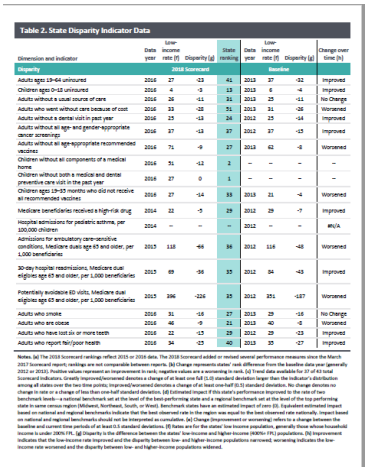


Table 2. State Disparity Indicator Data

Dimension and Indicator	Data year	Low-income rate (f)	Disparity (g)	State ranking	Data year	Low-income rate (f)	Disparity (g)	Change over time (h)
Disparity		**2018 Scorecard**				**Baseline**		
Adults ages 19–64 uninsured	2016	27	-13	41	2013	37	-32	Improved
Children ages 0–18 uninsured	2016	4	-1	13	2013	6	-4	Improved
Adults without a usual source of care	2016	26	-11	34	2013	25	-11	No Change
Adults who went without care because of cost	2016	33	-28	51	2013	31	-26	Worsened
Adults without a dental visit in past year	2016	25	-13	24	2012	25	-14	Improved
Adults without all age- and gender-appropriate cancer screenings	2016	27	-13	37	2012	37	-15	Improved
Adults without all age-appropriate recommended vaccines	2016	71	-9	27	2013	62	-8	Worsened
Children without all components of a medical home	2016	51	-12	2	–	–	–	–
Children without both a medical and dental preventive care visit in the past year	2016	27	0	1	–	–	–	–
Children ages 19–35 months who did not receive all recommended vaccines	2016	27	-14	33	2013	21	-6	Worsened
Medicare beneficiaries received a high-risk drug	2014	22	-5	29	2012	29	-7	Improved
Hospital admissions for pediatric asthma, per 100,000 children	2014	–	–	–	2012	–	–	wn/a
Admissions for ambulatory care-sensitive conditions, Medicare dual eligibles age 65 and older, per 1,000 beneficiaries	2015	118	-46	36	2012	116	-48	Worsened
30-day hospital readmissions, Medicare dual eligibles age 65 and older, per 1,000 beneficiaries	2015	69	-36	35	2012	84	-43	Improved
Potentially avoidable ED visits, Medicare dual eligibles age 65 and older, per 1,000 beneficiaries	2015	396	-226	37	2012	351	-187	Worsened
Adults who smoke	2016	31	-16	27	2013	29	-16	No Change
Adults who are obese	2016	46	-9	24	2013	40	-8	Worsened
Adults who have lost six or more teeth	2016	22	-13	29	2012	29	-23	Improved
Adults who report fair/poor health	2016	34	-15	40	2013	35	-27	Improved

Notes. [a] The 2018 Scorecard rankings reflect 2015 or 2016 data. The 2018 Scorecard added or revised several performance measures since the March 2017 Scorecard report; rankings are not comparable between reports. [b] Change represents states' rank difference from the baseline data year (generally 2012 or 2013). Positive values represent an improvement in rank; negative values are a worsening in rank. [c] Trend data available for 37 of 43 total Scorecard indicators. Greatly Improved/Worsened denotes a change of at least one full (1.0) standard deviation larger than the indicator's distribution among all states over the two time points; Improved/Worsened denotes a change of at least one-half (0.5) standard deviation. No change denotes no change in rate or a change of less than one-half standard deviation. [d] Estimated impact if this state's performance improved to the rate of two benchmark levels—a national benchmark set at the level of the best-performing state and a regional benchmark set at the level of the top performing state in same census region (Midwest, Northeast, South, or West). Benchmark states have an estimated impact of zero (0). Equivalent estimated impact based on national and regional benchmarks indicate that the best observed rate in the region was equal to the best observed rate nationally. Impact based on national and regional benchmarks should not be interpreted as cumulative. [e] Change (improvement or worsening) refers to a change between the baseline and current time periods of at least 0.5 standard deviations. [f] Rates are for the states' low income population, generally those whose household income is under 200% FPL. [g] Disparity is the difference between the states' low-income and higher-income (400%+ FPL) populations. [h] Improvement indicates that the low-income rate improved and the disparity between low- and higher-income populations narrowed; worsening indicates the low-income rate worsened and the disparity between low- and higher-income populations widened.

https://www.commonwealthfund.org/publications/fund-reports/2018/may/2018-scorecard-state-health-system-performance

National gains if all states achieved top rates* of performance

18 million more adults and children insured, beyond those who already gained coverage through the ACA

14 million fewer adults skipping care because of its cost

26 million more adults with a usual source of care

11 million more adults receiving recommended cancer screenings

837,000 more young children receiving all recommended vaccines

1 million fewer Medicare beneficiaries receiving a high-risk prescription drug

440,000[a] fewer hospital readmissions

5.7 million[a] fewer emergency room visits for nonemergency care or conditions treatable with primary care

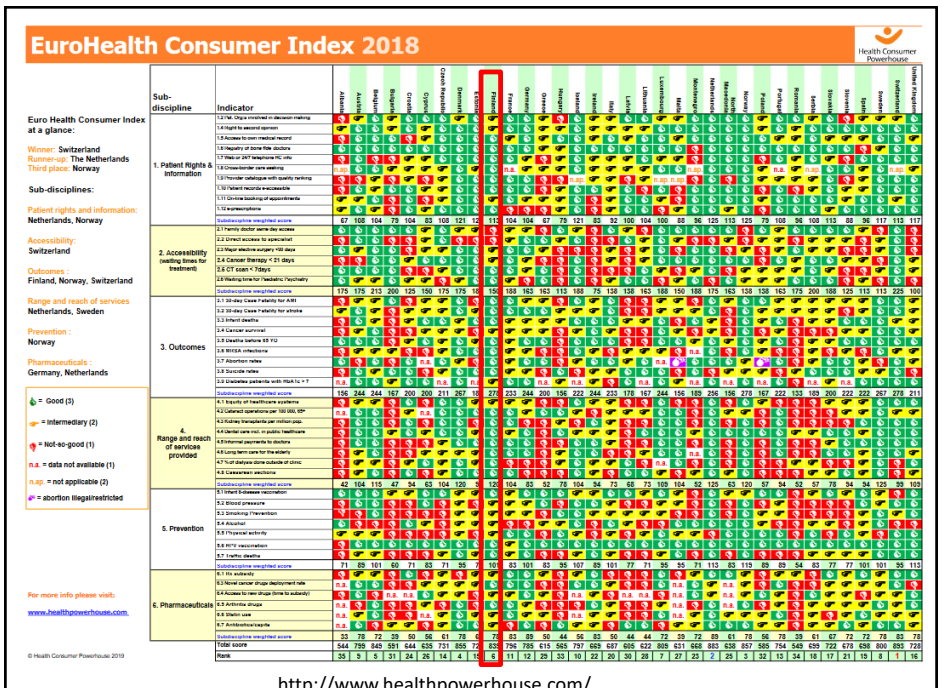
89,000 fewer deaths before age 75 from treatable diseases

* Performance benchmarks set at the level achieved by the top-performing state with available data for this indicator.

[a] Estimate based on working-age population, ages 18–64, with employer-sponsored insurance, and Medicare beneficiaries age 65 and older.

The Commonwealth Fund

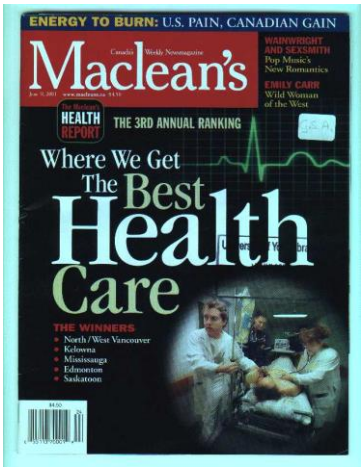
Source: David C. Radley, Douglas McCarthy, and Susan L. Hayes, *2018 Scorecard on State Health System Performance* (The Commonwealth Fund, May 2018).

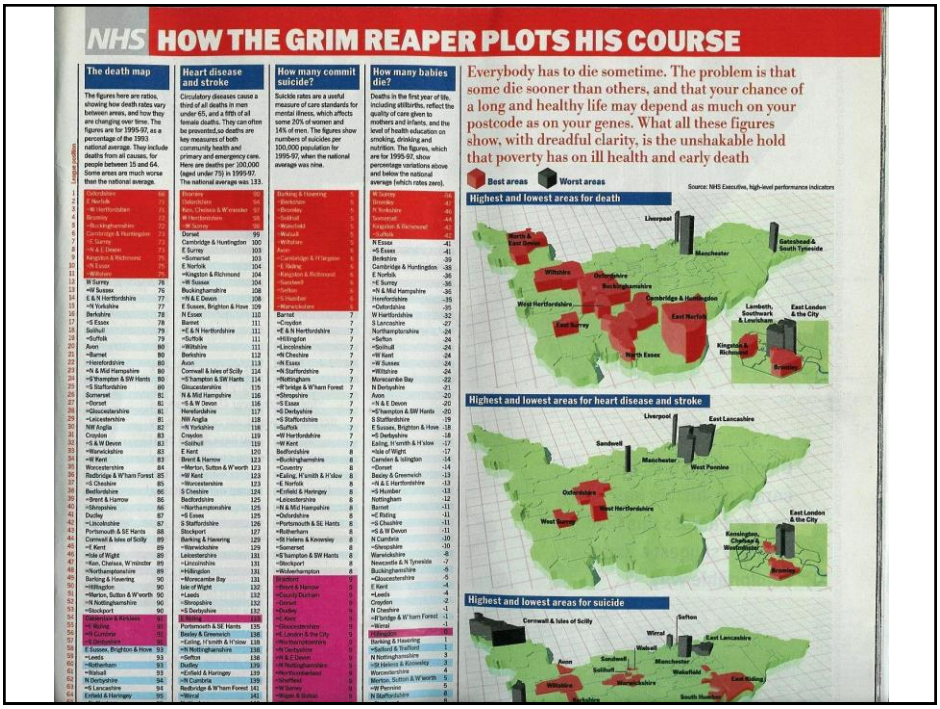


http://www.healthpowerhouse.com/

Example 4:
Mass media

- "… not surprisingly, 13 of the top 20 communities in this year's ranking are university cities with medical schools - precisely where you'd expect to find superior services."





NHS HOW THE GRIM REAPER PLOTS HIS COURSE

The death map

The figures here are ratios, showing how death rates vary between areas, and how they are changing over time. The figures are for 1995-97, as a percentage of the 1993 national average. They include deaths from all causes, for people between 15 and 64. Some areas are much worse than the national average.

Heart disease and stroke

Circulatory diseases cause a third of all deaths in men under 65, and a fifth of all female deaths. They can often be prevented.So deaths are key measures of both community health and primary and emergency care. Here are deaths per 100,000 (aged under 75) in 1995-97. The national average was 133.

How many commit suicide?

Suicide rates are a useful measure of care standards for mental illness, which affects some 20% of women and 14% of men. The figures show numbers of suicides per 100,000 population for 1995-97, when the national average was nine.

How many babies die?

Deaths in the first year of life, including stillbirths, reflect the quality of care given to mothers and infants, and the level of health education on smoking, drinking and nutrition. The figures, which are for 1995-97, show percentage variations above and below the national average (which rates zero).

Everybody has to die sometime. The problem is that some die sooner than others, and that your chance of a long and healthy life may depend as much on your postcode as on your genes. What all these figures show, with dreadful clarity, is the unshakable hold that poverty has on ill health and early death

Best areas Worst areas

Source: NHS Executive, high-level performance indicators

Highest and lowest areas for death

Highest and lowest areas for heart disease and stroke

Highest and lowest areas for suicide

Example 5:
English NHS interactive performance ‘dashboard’

Performance of CCG | Better health near yo1

Performance of

CCGs | CCG - Better health

Metric Group

Child obesity (1)

- Child obesity (1)
- Diabetes (3)
- Falls (1)
- Personalisation and choice (1)
- Antimicrobial resistance (2)
- Carers (1)
- Health inequalities (1)

Filter by Name

york

Update

Ordered by distance

ercentage of children aged 10-11 classified as overweight or obese

NHS Vale Of York CCG

NHS Vale of York CCG, West Offices, Station Rise, York, North Yorkshire, YO1 6GA

29.10%

overweight or obese

https://www.nhs.uk/service-search/performance/search

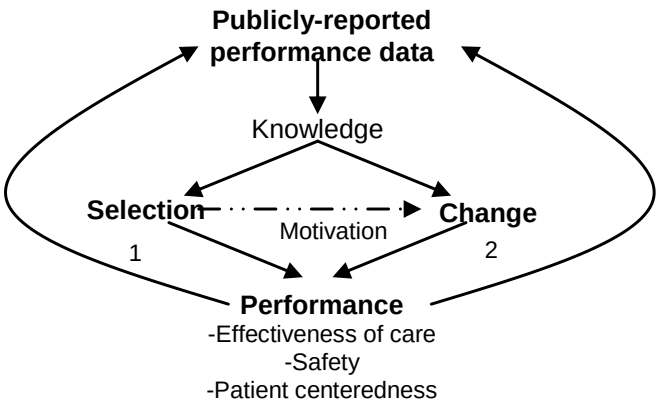
5. The impact of HSPA

- Accountability the key (but of whom to whom?)
- Is 'variation' the main focus of attention?
- Does the HSPA seek to 'explain' the variation?
- Are targets a valid aspect of HSPA?
- Role of composite scores and 'rankings'
- Does the dissemination meet the needs of intended users?

Who is the intended audience?

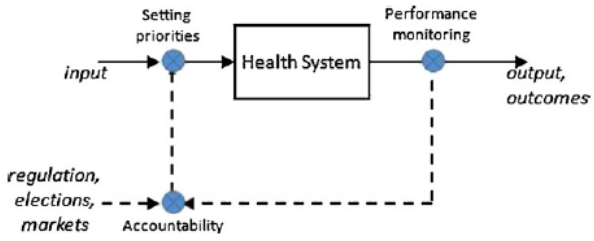
- Each has different perspectives, motivations and information needs
  - The general public
  - Patients and their families
  - Policy makers
  - National politicians
  - Managers and local politicians
  - Health professionals
  - Researchers
  - Media
- Beware unintended as well as intended consequences

The 'selection' and 'change' pathways



Berwick et al (2003) quoted in:
Shekelle, P. (2010), "Public performance reporting on quality information", in Smith, P. Mossialos, M., Leatherman, S. and Papanicolas, I. (eds), *Performance measurement for health system improvement: experiences, challenges and prospects*, Cambridge: Cambridge University Press.

A cybernetic model of health system leadership and governance



Smith, P., Anell, A., Busse, R., Crivelli, L., Healy, J., Lindahl, A. K., Westert, G. and Kene, T. (2012), "Leadership and governance in seven developed health systems", *Health Policy* 106 (1) 37– 49.

Three domains of performance reporting

- Priority setting
  - Although there seems to be reasonable consensus on broad goals of the health system there is variation in approaches to setting priorities.
- Performance monitoring
  - The domain where there is most convergence of thinking, although countries are at different stages of development.
- Accountability
  - Domain where there is greatest uncertainty about the optimal approach … a judicious mix of accountability mechanisms is likely to be appropriate in most settings, including market mechanisms, electoral processes, direct financial incentives, and professional oversight and control.

Smith, P., Anell, A., Busse, R., Crivelli, L., Healy, J., Lindahl, A. K., Westert, G. and Kene, T. (2012), "Leadership and governance in seven developed health systems", *Health Policy* 106 (1) 37– 49.

6. The process of HSPA

- Who instigates and drives forward the demand for HSPA?
- How are stakeholders' differing priorities resolved?
- Who funds HSPA?
- Who undertakes HSPA?
- Format of HSPA: description or recommendations?
- How is the HSPA momentum sustained?
- The political economy of HSPA

HSPA: some stewardship responsibilities

1. Development of a clear conceptual framework and a clear vision of the purpose of performance measurement;
2. Mandating data collection mechanisms;
3. Information assurance and governance;
4. Development of analytic devices and capacity to help understand the data;
5. Development of appropriate data presentational methods;
6. Dissemination and securing attention of all relevant parties;
7. Stimulating action in response to performance measures;
8. Ensuring it is a regular, sustainable process, with suitable arrangements for reviewing and updating.

European Observatory on Health Systems and Policies: performance comparison initiative

- The objectives are
  - "to help governments, regulators, citizens and other commentators gain a better understanding of the comparative performance of their health systems, to improve approaches to measurement and analysis, and to demonstrate how comparative metrics can help in the design and evaluation of initiatives intended to strengthen health systems."
- The initiative is undertaken with the close cooperation of the WHO European Region, the Observatory's partners, the OECD, and other collaborators.

Health Systems Performance Comparison: European Observatory Publications

http://www.euro.who.int/en/about-us/partners/observatory