



# WORLD HEALTH ORGANIZATION

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## Health systems performance assessment

### Report by the Secretariat

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

### **DEVELOPMENT OF THE FRAMEWORK FOR ASSESSING HEALTH SYSTEM PERFORMANCE**

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

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

4. The purpose of the framework was:

- to support Member States, together with the international public health community, in monitoring and analysing their health systems methodically, using a set of critical health system outcomes;

- to establish a foundation for building a solid body of evidence on the relationship between the organization and outcomes of health systems in order to provide governments with information for health policy development;
  - to enable users to understand better the functions of health systems and to access information about the extent to which health system outcomes are attained.
5. The framework covers the boundaries, goals, functions and performance of health systems.
6. **Health system boundaries.** All resources, organizations and actors that undertake or support health actions (that is, every action whose primary intent is to protect, promote or improve health) are considered to be part of the health system. Education, however, although it is identified as a key determinant of health outcomes, is not defined as a part of the system.
7. **Health system goals.** Three goals are specified: good health; a health system that responds well to the legitimate expectations of the public; and fairness in financial contribution.
8. **Health system functions.** The framework identifies four functions that are critical to the achievement of these goals: financing (including revenue collection, fund pooling and purchasing); provision of personal and non-personal health services; resource generation; and stewardship. This last function, that is the oversight and guidance of the whole health system – private as well as public – so that it performs optimally, includes leadership, direction (health policy) and influence (regulation and advocacy), all based on the best available health information.
9. **Health system performance.** Ministers of Health and other decision-makers need to know the degree to which the health system contributes to the attainment of the overall outcomes; whether that contribution could be increased through changes in the investment of currently available resources (*efficiency* of the health system); and whether, if changes have been made (e.g. within the context of health sector reform), they have resulted in better performance of health systems).

## INDICATORS, METHODS AND DATA USED TO ASSESS PERFORMANCE

10. WHO has introduced the above framework as a basis for comparable assessments of health system performance. The three health system goals translate into five distinct outcomes: the level of health attained in a population; equity of health within that population; responsiveness of the health system; equity in responsiveness; and fairness in financial contribution. Performance assessment calls for clearly defined indicators of each outcome, methods to measure them, strategies for collecting data, and procedures for the synthesis and regular reporting of results.
11. **Level of health.** Drawing on 15 years of work, WHO introduced *healthy life expectancy*, based on life expectancy at birth, but including an adjustment for time spent in poor health, as the measure of the level of health attained in a population. Measurement of *mortality* depends on age-specific mortality data obtained from vital registration systems, surveys of child and adult mortality, and sample registration systems. Measurement of *time spent in poor health* depends on studies of burden of disease and standardized results from cross-sectional survey instruments developed using the International Classification of Functioning and Disability (ICIDH).
12. **Distribution of health.** WHO proposes that countries measure the distribution of healthy life expectancy within populations using both vital registration and cross-sectional survey data. Even

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

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

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

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

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

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

## FIRST REPORT ON PERFORMANCE OF HEALTH SYSTEMS

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

19. This information was collated in the annexes of *The world health report 2000* on improving the performance of health systems.

## COMMENTS ON *THE WORLD HEALTH REPORT 2000*

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

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

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

23. Several ministers have pointed out the limited number of countries for which representative data were available. For example, there were 35 countries in the key informant survey for responsiveness. Microeconomic data on household income and health expenditures, needed for the indicator of fairness of financial contribution, were only available from 21 countries. However, the valuation of this indicator also requires empirical data on the fraction of out-of-pocket expenditure that goes towards health. These data were available from 170 countries.

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

25. Some concerns have been expressed that ranking data on social outcomes, particularly if the ranking is based on a composite index, is demotivating and unlikely to produce improvements. There are, however, several examples that show that ranking, particularly in social fields, can encourage

analysis, aid the identification of best practices, and help to build up an evidence base about successful interventions. The report breaks new ground by indicating uncertainty intervals for all measures - both the actual levels and the ranks. The width of the uncertainty intervals that result from the use of estimates is clearly visible.

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

## **FUTURE PLANS AND ACTION**

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

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

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

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

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

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

**ACTION BY THE EXECUTIVE BOARD**

33. The Board is invited to note the report.

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