



Health system
performance assessment

Reporting and Communicating



Practical guide for policy makers

HSPA Policy Paper

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This paper benefits from the contributions of several members of the Expert Group on Health Systems Performance Assessment, who commented a draft version and greatly improved it with their remarks. Tom de Smedt, from DG SANTE's Communication Unit, also provided useful comments and corrected some inaccuracies.

However, the views expressed in this paper are those of the author and do not necessarily correspond to positions of the Expert Group on Health Systems Performance Assessment, the Directorate-General for Health and Food Safety or the European Commission.

Brussels, September 2017

Summary

This paper is addressed to policy makers who are assessing the performance of their health system. It provides them with practical tips and advices to effectively report and communicate the findings of their assessment. It was developed to respond to a request from the EU Expert Group on Health Systems Performance Assessment (HSPA), and benefitted from the discussion in the group.

For an effective communication of findings, four main steps are identified; the first is the definition of the goal of the HSPA exercise; whilst the overall goal of every HSPA exercise is to improve the performance of the health systems, and ultimately to improve the health of the population it serves, there may be several reasons to carry out an assessment; here we present the main ones.

The second step is the identification of the target audience we want to reach with our information and the analysis of the stakeholders that are active in the field.

The third step is the actual reporting and communicating the findings of the analysis, which represents the core of this paper and is further analysed according to its main dimensions: the format of the report itself, the information included in the report, the way the information is displayed (how to reconcile complex analyses with simple presentations), and how the report's findings are disseminated.

The fourth and final step is the design and implementation of monitoring and evaluation actions to provide effective feedbacks and regularly fine-tuning targets and communication activities. For each step and sub-step, few examples are provided to give some initial hints, but without any ambition to be exhaustive.

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performance assessment

**Reporting and
Communicating**



**Practical
guide for
policy makers**

HSPA Policy Paper

1.

Background and introduction

This paper is addressed to policy makers who are engaged with health systems performance assessment (HSPA). It presents practical tips and advices to effectively report and communicate the findings of their assessment.

During the meetings of the EU expert group on HSPA, several experts expressed their interest to look at specific practical topics that could be of interest to policy makers, e.g. how to present HSPA findings, simplicity of the communication *vis-à-vis* complexity of the analysis, etc.

Responding to this suggestion, we briefly present here the principal phases that lead to the production of an assessment report and the dissemination of its findings.

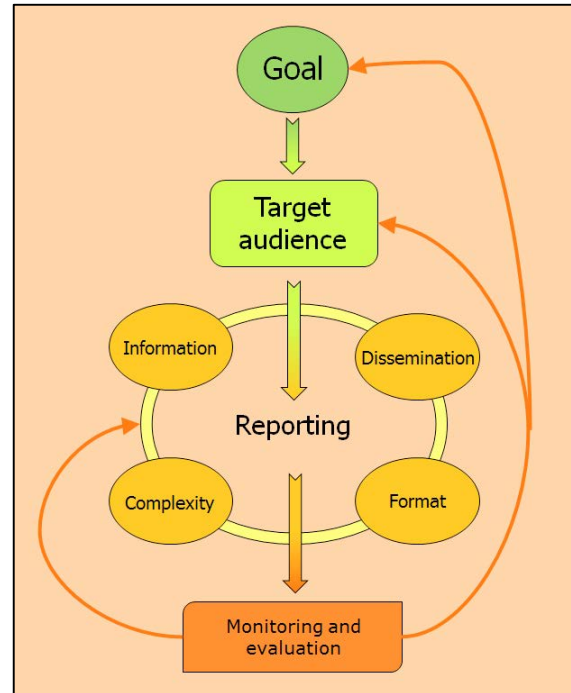
HSPA is a complex combination of activities that range from the involvement of stakeholders, the building of a political supportive environment, the definition of indicators, and the collection of reliable and comparable data – just to name few of them.

In this paper we focus on a single component of HSPA: its presentation is deliberately limited to the aspects that have a direct influence on the reporting and communication of results.

For the purposes of this analysis, the process that leads to the production of an assessment report and the dissemination

of its findings can be summarised in few steps.

Figure 1: Main steps in reporting and communication of HSPA findings



The first step is the definition of the goal of the assessment: why are we producing an HSPA report? Reasons can be diverse and lead to different choices with regard to reporting and communication.

Linked to the definition of the goal is the identification of the target audience: the groups of stakeholders to whom the report is addressed. This is the second step in our simplified process.

The third step is the very activity of reporting, which can be further analysed according to its main dimensions: the format of the report itself (a book, a web-based interactive tool, etc.), the information included in the report (its 'content'), the way the information is displayed (how to reconcile complex analyses with simple presentations), and

how the report's findings are disseminated.

Finally, the communication cycle is closed by monitoring and evaluation activities. They feedback into all other steps and help fine-tune the communication actions along the process, gauge the impact at the end of the campaign, and define the targets and ambitions for a next cycle.

Each step – goal definition, target audience identification, reporting, monitoring and evaluation – is presented in a dedicated chapter.

This paper highly benefits from the discussions that took place during the meetings of the HSPA expert group on the 23rd of September and on the 14th of December, 2016, where group members had the occasion to comment draft versions and greatly improve them with their remarks.

2. Defining the goals of HSPA

The overall goal of every HSPA exercise is to improve the performance of the health systems, and ultimately to improve the health of the population it serves.

However, beyond these overarching objectives, there is not always a unique reason to set up an HSPA system. In fact, assessing the performance of a health system is a means that could serve different goals.^{1,2,3} Some of them are listed below; it is clear that these goals are

not in contradiction with one another. On the contrary, they are often complementary and even mutually reinforcing.

Figure 2: Goals of HSPA



Policy-making – Knowing how the system works is the necessary precondition to improve it. Any sound policy action is based on a proper assessment of the existing situation and a reliable forecast of the introduced measures – this information can be provided by an effective HSPA system. HSPA can also be set as the standard instrument to monitor and evaluate the impact of the reforms that are put in place; in this case, targets are usually presented in the assessment framework.

Quality assurance and improvement – Performance assessment, and in particular quality measurement, can be used to pursue quality assurance and improvement. Knowing what is the level of quality that a provider delivers – both in absolute terms and in comparison with

peers and benchmarks – is by itself a major driver of improvement. The very fact of being measured provides a simple emulation and self-improvement stimulus; in addition, quality measurement can be coupled with support measures such as technical assistance and tailored coaching or advice.

Management / financial incentives – HSPA can be used as a management tool to define financial incentives or foster organisational change. Health system performance indicators can contribute to design career pathways of healthcare managers, healthcare providers, or other individual health professionals. They can also be applied to define the level of funding of different providers, or different sectors of care.

Accountability – Assessing the performance of the health system can be a way for the system manager to be answerable and liable to stakeholders. Furthermore, since the majority of healthcare in Europe is financed by public funds, HSPA contributes to show how efficiently and properly taxpayers' money is used. Finally, HSPA is a means to provide citizens with the information of what they can and should expect from the health system.

Patient empowerment – Most experts do not see patient empowerment as a goal for HSPA. However, when information is released, citizens use it. Policy-makers are responsible to provide citizens with the tools for using this information in the best possible way. The collection and dissemination of information on the functioning of the health system can be a key element allowing patients to use

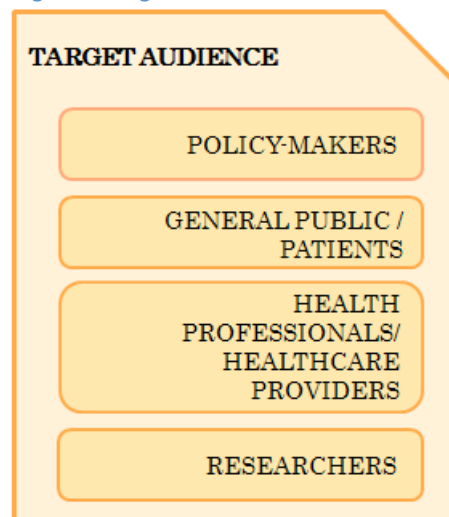
broader knowledge for more educated choices.

Finally, we shall stress that the goal of the HSPA exercise is not to be confused with the goal of the communication strategy. The latest could be, for instance, informing stakeholders, involve them, provoke reactions, etc.

3. Identifying the target audience for HSPA

Logically, once the goal of HSPA is clearly defined, the next step is to identify the target audience: the group of stakeholders to whom to bring the findings of the assessment. The definition of the target audience is strictly – though not deterministically – influenced by the declared HSPA goal. Possible groups of stakeholders are presented below.

Figure 3: Target audience



Policy makers – If the goal of HSPA is to support the policy-making process, the

most relevant audience is obviously composed of policy makers. This definition is however quite broad and ranges from politicians to technocrats. It can include representatives from industry, civil societies and social actors.

Patients / broader public – The information collected in assessing the performance of the health system can be addressed to the general public. This may be the result of an accountability exercise, or can be instrumental to empower patients and enable them to make better informed choices about the healthcare providers and the treatments they may ask for. However, in most situations it would be unrealistic to reach directly the general public; instead it is usually more feasible and effective to address 'information multipliers' – such as patient associations, NGOs, or media – which can indirectly convey the message to the general public.

Professionals / healthcare providers – HSPA findings can be addressed (exclusively, primarily, or partially) to healthcare providers. In this context, the definition includes individual health professionals such as general practitioners or nurses, as well as institutions such as hospitals, ambulatories and health centres. Performance data on health providers can be disclosed to the whole audience in a transparent way; alternatively each provider may be made aware of her/his performance level alone (possibly in comparison with averages or anonymised benchmarks).

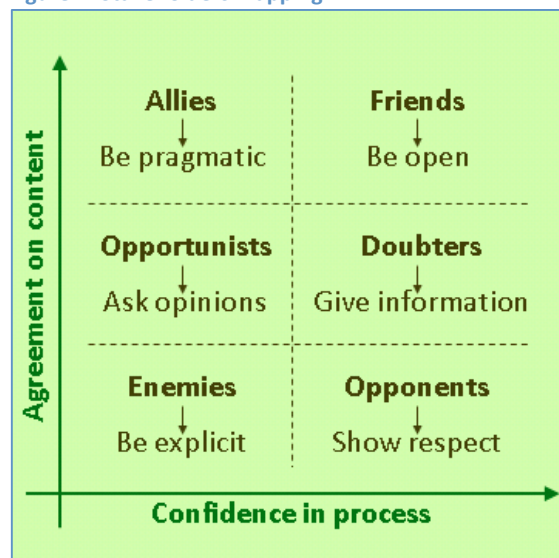
Researchers – Data and information produced by HSPA can be addressed to the research community. The involvement of researchers can help improve the

methodology of analysis and the reliability and comparability of indicators. Considering this audience is usually a means to consider state-of-the-art tools and methodologies in one's own HSPA exercise. Researchers need access to more detailed and more complex information than other categories. HSPA reports addressed to researchers should provide the possibility to look at these details.

In general, differences among target audiences exist but should not be over-estimated: HSPA reports are by their nature a tool for communication and information; they are not clinical manuals neither scientific essays and should be accessible to the broadest audience.

Anyway, to fine tune the communication, all relevant stakeholders should be mapped, to find out whom they represent, which position they take in the political debate, which reaction should we expect from them, how they could contribute to communicate the findings of the assessment, etc.

Figure 4: Stakeholders mapping



Adapted from Jipping, Masterclass EUPRIO 2012

Finally, the target audience of HSPA reports is always an active player in the

health system, being it a policy maker, a service provider, or a patient. Every communication should therefore be intended as a two-way communication, where feed-backs from the audience are fundamental in redesigning, customising and fine tuning the reports.

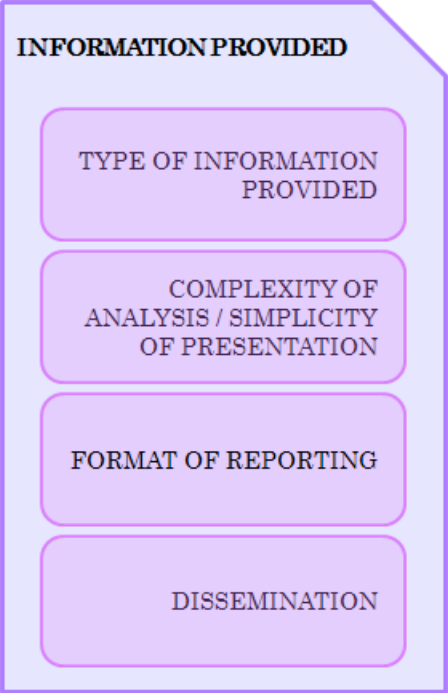
4. Reporting

Allowing for some level of simplification, the next steps after having defined the goal of the HSPA exercise and its target audience are to collect information, analyse it and report to the target audience.^{4,5} As anticipated, in this section we do not enter in the technical aspects of collecting and analysing information, but focus on reporting and on the different questions one should answer so as to define the most effective ways of communicating HSPA findings.

These questions can be meaningfully clustered into four main groups, which cover the type of information provided, the trade-off between complexity of analysis and simplicity of communication, the format of reporting, and the ways of dissemination.

For each group we present few examples from national and international experiences. To make them more easily recognisable, examples are distinguished by a grey background. Examples are by definition not exhaustive: they only intend to provide some quick hint to better explain the content of the preceding paragraphs.

Figure 5: Information provided



4.1. Type of information provided

HSPA reporting can provide the following types of information:

Simple presentation of data and information – The easiest and more straightforward solution is to provide the statistics and indicators as they are collected, leaving the target audience with the task to perform the necessary analysis and interpretations to fit their purpose.

Example
Standard tables presented in statistical databases, such as Eurostat, the WHO Health for All, and the OECD Health Statistics (see references).

Figure 6: Eurostat table on HLY (part.)

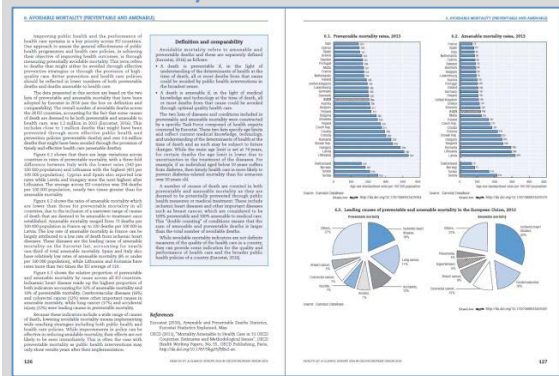
Year	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
EU (28 countries)	82.07	82.07	82.4	82.07	82.07	82.07	82.07	82.1	82.1	82.1	81.9
EU (27 countries)											
EU area (28 countries)											
Belgium	83.4	82.94	83.2	83.3	84.1	83.7	83.6	83.6	83.7	83.7	83.7
Bulgaria	71.97	71.9	71.9	71.9	71.9	71.9	71.9	71.9	71.9	71.9	71.9
Czech Republic	80.7	80.9	80.9	81.4	81.4	81.4	81.4	81.4	81.4	81.4	81.4
Denmark	85	84.4	84.2	84.4	84.9	84.4	84.4	84.4	84.4	84.4	84.4
Germany	81	81.4	81.4	81.4	81.4	81.4	81.4	81.4	81.4	81.4	81.4
Greece	73.97	73.4	73.4	73.4	73.4	73.4	73.4	73.4	73.4	73.4	73.4
Ireland	84.2	84	84	84	84	84	84	84	84	84	84
Italy	80.07	80.1	80.1	80.1	80.1	80.1	80.1	80.1	80.1	80.1	80.1
Spain	82.07	82.4	82.4	82.4	82.4	82.4	82.4	82.4	82.4	82.4	82.4
France	81.3	81.3	81.3	81.3	81.3	81.3	81.3	81.3	81.3	81.3	81.3
Croatia											
Holy	71.97	71.9	71.9	71.9	71.9	71.9	71.9	71.9	71.9	71.9	71.9
Poland	80.07	80.07	80.07	80.07	80.07	80.07	80.07	80.07	80.07	80.07	80.07
Lithuania	80.07	80.07	80.07	80.07	80.07	80.07	80.07	80.07	80.07	80.07	80.07

Analysis – HSPA reports can present a simple or more sophisticated analysis of the information collected. For instance: time trends, clustering, statistical regressions, comparison to benchmarks and targets, etc.

Examples

The OECD's Health at a Glance report⁶ presents for each topic a page with key indicators and a page with main findings from their analysis.

Figure 7: Health at a Glance Europe 2016, page on Avoidable mortality



The Belgian HSPA report⁷ presents for each topic a list of the main indicators, with visual aid to show trends and class of performance (good, average, bad).

Figure 8: Belgian HSPA report 2015, preventive care indicators

Indicator	Belgium	Year	Target	Flanders	Wallonia	Brussels	Source	EU-15 (mean)
Vaccination coverage								
P-1	30 99.0	2012	WHO: 90	99.2	99.2	99.1	WHO - ISP	96.2 (1)
P-2	10 95.5	2012	10 95	95.6	95.6	95.6	WHO - ISP	93.2 (1)
P-3	45 91.3	2012	40 90	91.3	91.3	91.3	WHO - ISP	91.3 (1)
P-4	56.4	2013	75	60.6	60.1	47.8	IMA - AM	55 (1)
Infectious diseases preventable by vaccination								
P-5	6.1	2014	1 per million	7.8	1.9	8.8	WHO - ISP	—
Cancer screening								
P-6	62.7	2012	75	68.0	68.6	52.9	IMA - AM	64.3 (1)
P-7	52.5	2012	75	49.6	7.2	10.2	IMA - AM	—
P-8	53.6	2012	—	52.3	56.0	52.9	IMA - AM	60.1 (1)
P-9	16.5	2013	—	16.2	16.4	19.9	HIS	—
Over-screening cancer								
P-10	35.1	2013	—	28.3	45.6	44.2	IMA - AM	—
Oral health – contacts with dentist								
P-11	50.8	2012	—	47.3	56.0	55.3	IMA - AM	—

Comments and guidance to the readers – Furthermore, the information can be commented and explained, providing the target audience with theoretical frameworks to interpret it. For instance, a given indicator may have assumed a specific value because of a methodological change, demographic or epidemiological factors, or a tailored policy action that took place.

Examples

Several national HSPA reports present their reference assessment framework, which includes dimensions and domains under assessment.

Figure 9: Performance framework adopted by the Dutch HSPA report⁸

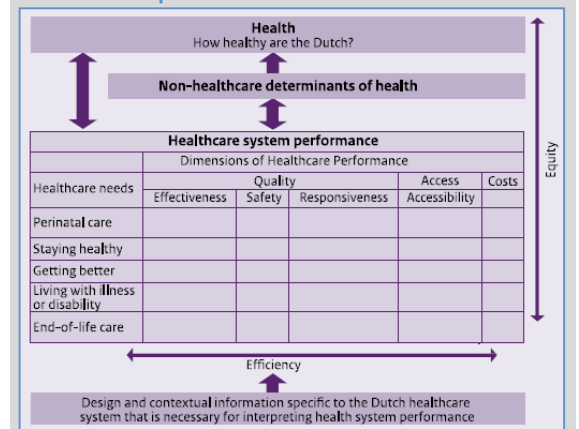


Figure 10: Performance framework adopted by the Maltese HSPA report⁹



Figure 11: Performance framework adopted by the Belgian HSPA report

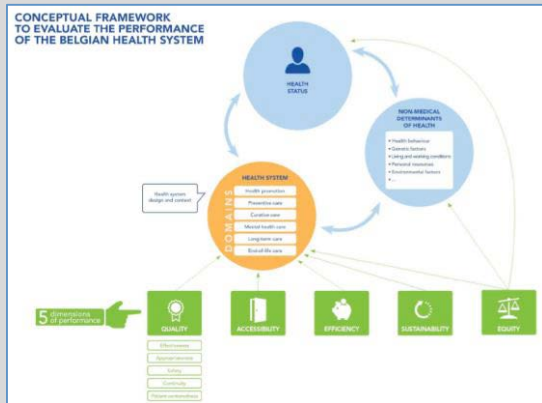
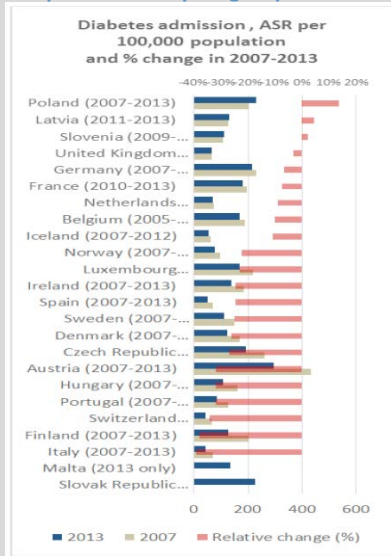


Figure 12: Diabetes hospital admission; "So What?" report of the expert group on HSPA



The "So What?" report¹⁰ of the Expert Group on HSPA (above) presents the findings of a policy focus group to explain

cross-national variability of selected quality indicators.

Recommendations – Finally, the report can provide recommendations, suggestions, or advice on how to change the situation according to defined policy goals (for instance, calling healthcare providers to change their practice habits, or calling politicians to raise awareness and boost active prevention strategies).

Examples

The Belgian HSPA report presents detailed recommendations to policy makers to improve the performance in areas where it detects room for improvement.

Figure 13: Recommendations from the Belgian HSPA report

RECOMMENDATIONS

Recommendation 1 to policymakers: define measurable health objectives. The concept of performance is implicitly linked to the attainment of objectives, most of which are currently lacking in Belgium. In the absence of quantifiable objectives, this report describes the current situation and trends in Belgium, compares these where possible with international targets and benchmarks. However, this approach presents some shortcomings: the confrontation with country-specific objectives would give this report an important added value to support the agenda setting. Policymakers should therefore define health (system) objectives that are measurable, set deadlines by which these objectives should be attained, and appoint accountable organisations. Quantified targets should be proposed along with specific objectives.

Recommendation 2 to policymakers: be aware of the warning signals and tackle the problems. One objective of the performance report is to inform policymakers on areas that require attention. The concerned institutions and bodies are advised to take the warning signals (described in Box 8) into account for their agenda setting.

Recommendation 3 to health administrations: continue to improve the integration of health information systems. The data quality and timeliness are essential for the relevance of the indicators. To the attention of the FOD – SPF Public Health:

- Continue efforts started on the integration of several health information sources.
- Use a Unique Patient Identifier (UPI) allowing linkage of RHM – MZG and RPM – MPG with mortality data from the Crossroads Bank for Social Security (Kruispuntbank van de sociale zekerheid – Banque Carrefour Sécurité Sociale). The UPI allows to follow-up patients after discharge through the entire health system. Linkage with mortality data and follow-up after discharge would allow the computation of a number of international quality indicators, which cannot be computed for the moment.
- Accelerate access to administrative databases (for instance, reduce the delay in access to the Minimum Hospital Data).

Figure 14: Policy options from the EC/EPC report on health systems

- Policy options to improve the sustainability of health care systems
- 4.1. Addressing the challenges of health care systems
 - 4.2. Ensuring sustainable financing
 - 4.3. Ensuring good budgeting practices
 - 4.4. Evaluating reforms systematically
 - 4.5. Monitoring and benchmarking of health system performance
 - 4.6. Ensuring an adequate health workforce
 - 4.7. Improving the performance of primary care systems and fostering integrated care
 - 4.8. Increasing the sustainability of hospital care
 - 4.9. Improving the efficiency and affordability of medicines
 - 4.10. Improving health system governance
 - 4.11. Improving data collection and information channels
 - 4.12. Aligning incentives in the system
 - 4.13. Fostering public health policies

The Joint EC/EPC report¹¹ on health care and LTC systems (above) presents policy options that may be undertaken by health

systems in the EU to improve their sustainability.

4.2. Complexity of the analysis versus simplicity of the presentation

A common conundrum in HSPA reporting is how to transform complex analysis into information that is simple to understand and feasible to act upon, without losing rigour and explanatory value of the evidence. This trade-off has different dimensions:

Clear, univocal conclusions – Reports, especially when addressed to policy makers could present clear messages with possible actions to adopt. They can be complemented with several layers of explanations and in-depth information that can be accessed for further analysis. It is worth noting that clarity and transparency can be mutually excluding: the higher the level of transparency, the less clear the final message can result. The use of multi-layer information tools is an effective solution to this trade-off.

Use of graphs – The easiest and most frequently used method to present complex data in simple ways is to make use of graphs.

Examples

Several national HSPA reports present different graphs to support and explain more clearly the findings of their analysis.

Figure 15: Thematic map from the Dutch HSPA report; driving times to GP

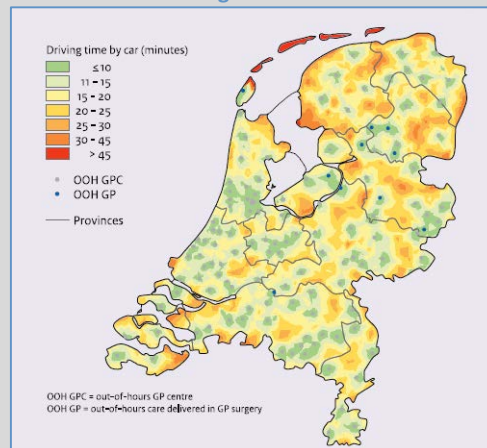


Figure 16: Standardised mortality rates; Portuguese HSPA report¹²

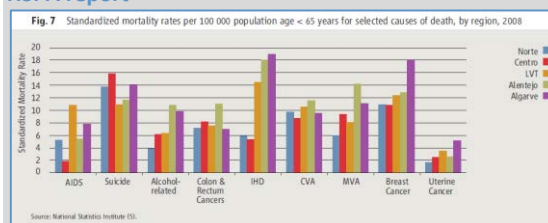
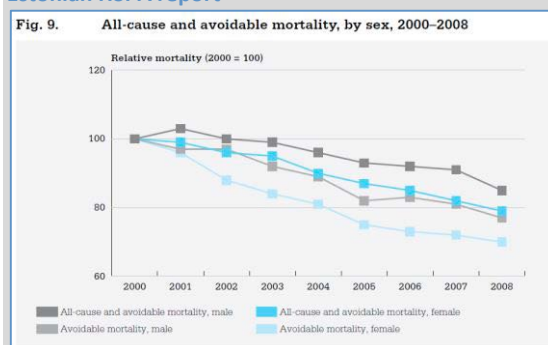


Figure 17: All causes and avoidable mortality rates; Estonian HSPA report¹³



Pre-filled tables/graphs versus open databases – When providing indicators in online web applications, there is the possibility either to display pre-compiled tables, or to leave the users the flexibility to compile the table from a menu of choices. Eurostat, for instance, gives both possibilities in its website. Providing pre-

filled tables makes things easier both for producers and users of data, but reduces the richness of information that can be made available.

Example

Figure 18: Structure of the Eurostat Database



The Eurostat database presents a double option in its opening page: for each topic where data are collected, users can browse the database by themes and build their own customised table, or alternatively go for prefilled standard tables.

Composite indicators/index versus dashboards – Complex and multidimensional phenomena can be displayed with dashboards of indicators, or with composite, synthetic indices that summarise a larger amount of information. The latter are much easier to communicate, but hide the complexity of

the underlying situation while making reliable interpretations and decision taking more difficult.

Examples

Sets of indicators can be represented in radar plots, spider plots or similar graphics. Recently, innovative graphic solutions have been tested, as the spie chart and the dartboard.

Figure 19: Spie charts, radar plots, target plots; Stafoggia et al. 2011 (14)

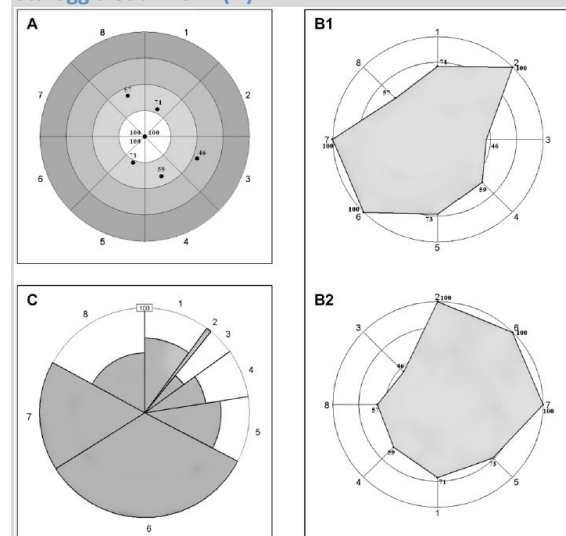
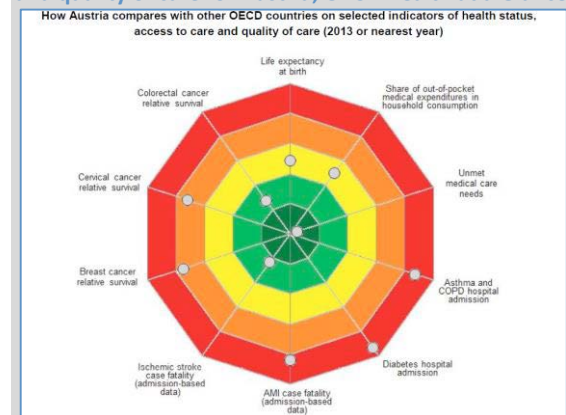


Figure 20: Dartboard on health status, access to care and quality of care for Austria; OECD Health at a Glance



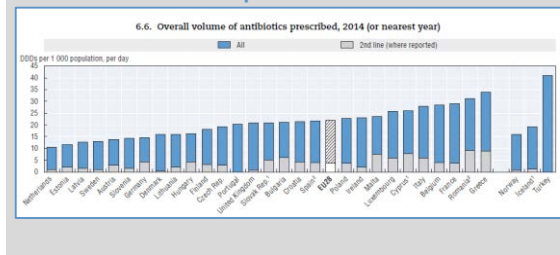
Ordering, benchmarking and ranking – Indicators can be presented neutrally (for instance, with subjects of analysis listed alphabetically) or ordered according to their value; they can also be compared to

benchmarks or reference values, or to defined targets. A numbered ranking is also a possibility, which can be semi-transparent, with a subject seeing its own position but not anyone else's. Comparing single indicators is a more transparent procedure and allows effective decision-making. On the other hand, comparing systems' performance implies adoption of composite indicators, with decisions on their elements and the weights they should have, and lead to less transparent and less actionable results.

Example

The OECD regularly orders its figures on every individual indicator (but no ranking on aggregate indexes).

Figure 21: Overall volume of antibiotics prescribed; Health at a Glance Europe



Use of international comparably data – National or regional reports can make use of international data to allow cross-country benchmarking. International benchmarking is to be considered as a first step in performance assessment: as shown in the HSPA policy focus groups, international variation should be explained with reference to the local context. International benchmarks may be particularly useful when internal targets are not defined or not available.

Reporting on sub-dimensions of HSPA – A way of reducing complexity in the communication is to break down the

analysis in individual sub-dimensions of performance.¹⁵ Overall HSPA reports can be accompanied or alternated by thematic reports on specific dimensions (e.g. quality of care) or areas of care delivery (e.g. primary care).

Example

Belgium issued a specific report on the assessment of the performance of general medicine.¹⁶

Figure 22: Belgian report on performance of general medicine



4.3. Format of reporting

HSPA reports often take the form of written documents, which can be published both electronically and in hardcopy. However, they may also – fully or partially – take the form of interactive repositories and displays of information. A

few of these formatting options are listed below.

Web / online applications – Virtually every report is published on the web in electronic version. This can be done in a static way (e.g. in PDF format) or in interactive mode (such as open databases, customisable graphs, etc.). Electronic formats can also be tailored to specific devices: desktops and laptops, tablets, and smartphones. Electronic reports allow the use of interactive interfaces to present clear highlights and then give the possibility to access deeper information at user's request.

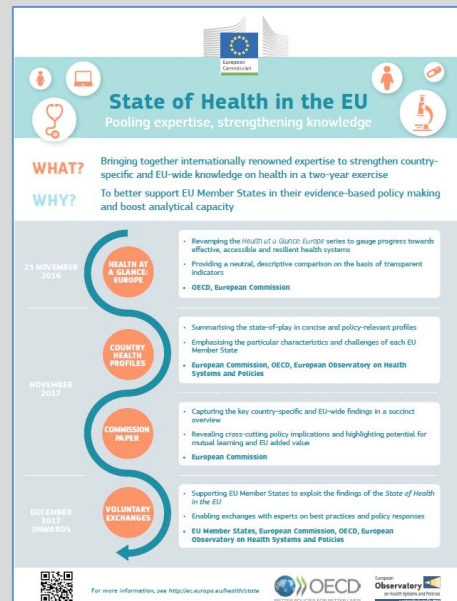
Paper hardcopies – The traditional way to present and circulate reports is to print them and distribute hardcopies. Today, hardcopies are often chosen in complementarity to electronic versions: they can be stored, displayed, easily consulted (even in non-connected environments), and customised with personal notes.

Leaflets – The actual report (regardless of its format) can be accompanied by supporting information material such as leaflets, booklets and infographics. Electronic versions can also be distributed in customised USB sticks, often with a clearly recognisable visual identity.

Example

The recent launch of the State of Health in the EU cycle was accompanied by several graphic materials, including leaflets (see references).

Figure 23: Leaflet of the State of Health in the EU cycle



4.4. Dissemination channels

With the target audience in mind, HSPA reports can be disseminated through different channels and in several ways. Some of the main issues that one should take into consideration when disseminating a report are listed below.

Launch of the report – To give more visibility to the publication of the report, one may organise a launch event; this can be a press conference, a workshop, a thematic conference, stands at relevant expositions, etc. If the report is directed to several groups of stakeholders, they may be addressed with different tailored launch events (e.g. associations of doctors, nurses, physiotherapists, etc.).

Use of media for a broader communication – Findings of the reports can be brought more effectively to their

target audience via "classic" media (press and television) as well as social media (e.g. Facebook, Twitter, etc.). Conversely, one may deliberately decide to reduce the visibility of controversial findings by limiting media coverage. Media coverage usually last few days and has no permanent impact on patient behaviour.

Periodicity and predictability of the report – An element that may help the effective dissemination of a report is the degree to which it is expected by its audience, and therefore its readiness to act upon it.

Two-way communication – When feasible, one should put in place feedback loops and methods to receive reactions and comments from the target audience, and to take them on board to fine-tune and improve the communication strategy.

Example

NHS England developed the 'NHS belong to us all' guide to help clinical commissioning groups (CCGs) and other commissioners of health and care services to involve patients and carers in decisions relating to care and treatment, and the public in commissioning processes and decisions.¹⁷

Figure 24: NHS England; the NHS belongs to us all



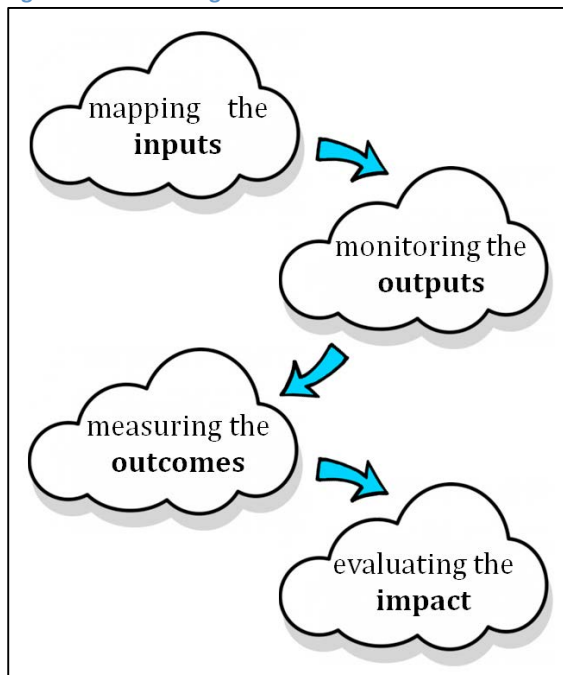
5. Monitoring and evaluation

Monitoring and evaluation is an essential part of the communication cycle. It helps fine-tune the communication actions along the process, gauge the impact at the end of the campaign, and define the targets and ambitions for a next cycle.

Monitoring can only be done when clear and measurable ("SMART") targets are set at the start of the process. Often this goes together with a (formal or informal) analysis of the current situation: how do we perform in terms of awareness, notoriety, reputation or interaction with the target audiences, and to what level do we wish to improve this.

Monitoring the results of a communication action can and should be done at several levels.

Figure 25: Monitoring and evaluation levels



① Mapping the inputs will show what efforts have been done to reach a certain communication ambition; e.g. how many publications were made, how many social media posts were published, etc. This information can be collected through activity reports, log files, budget and staff overviews.

② Monitoring the outputs shows the reach of those activities at the recipients' side: how many clicks or retweets did we get online, how many participants attended a conference, etc. Possible sources of information are web statistics, publication reports, press clippings.

③ Measuring the outcomes of communications is often harder, and may require some market research or stakeholder analysis: did we increase the awareness and understanding for a certain issue, to what extent did the opinions of our audience change, etc. User surveys, stakeholder discussions are effective tools to collect this evidence.

④ The final step is the evaluation of the impact, which can be done through long-term, strategic analyses. Impact evaluation describes the long-term or indirect effects of your outcomes and should help understand if the communication action contributed to reaching your strategic ambitions.

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