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Strengthening health system accountability: a WHO European Region multi-country study

Edited by:

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Abstract

This report takes stock of the measures that Member States of the WHO European Region have put in place to strengthen health system accountability since the Tallinn Charter: Health Systems for Health and Wealth (2008) and the Health 2020 policy framework (2012) were adopted. These last years have been undoubtedly marked by significant challenges facing the health systems in the Region, including international and national environments affected by an economic crisis, increased health needs, as well as resource scarcity. However, and in spite of the challenging context, Member States across the Region have taken abundant and significant steps to improve health system accountability. This report summarizes the experiences of Member States strengthening health system accountability in the context of the momentum created by the Tallinn Charter and Health 2020 through rigorous goal setting, as well as health system performance measurement and review.

Keywords

ACCOUNTABILITY

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This study was designed and coordinated by Juan Tello (WHO Regional Office for Europe) who edited the report jointly with Claudia Baez-Camargo (Basel Institute on Governance, Switzerland). Key contributors to the study are Elke Jakubowski, Belinda Loring and Maria Skarphedinsdottir (WHO Regional Office for Europe); Franziska Stahl (Basel Institute on Governance) and Regina Winter (WHO consultant). Jarno Habicht (WHO Regional Office for Europe) reviewed part of this report. Language editing was performed by Nancy Gravesen.

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Abbreviations

CNAM	National Health Insurance Company (Republic of Moldova)
EU	European Union
HSPA	health system performance assessment
HTP	Health Transformation Programme (Turkey)
JAR	joint annual review
KASTE	National Development Plan for Social Welfare and Health Care 2012–2015 (Finland)
MTBF	medium-term budgetary framework
NCDs	noncommunicable diseases
NGO	nongovernmental organization
NHP	national health plan
NHS	National Health Service
NHSP	national health strategy, policy and plan
OECD	Organisation for Economic Co-operation and Development
PERFECT	PERFormance, Effectiveness and Costs of Treatment
SEE	South-eastern Europe
SWAp	sector-wide approach
TB	tuberculosis
THL	National Institute for Health and Welfare (Finland)
Valvira	National Supervisory Authority for Welfare and Health (Finland)

Executive summary

This report takes stock of the measures that Member States of the WHO European Region have put in place to strengthen health system accountability since the Tallinn Charter: Health Systems for Health and Wealth was adopted in 2008, and the further momentum created by the adoption of the Health 2020 policy framework.¹ These last six years have been undoubtedly marked by significant challenges facing the health systems in the Region, including international and national environments affected by economic crisis, scarcity of resources and increased health needs. However, and in spite of the challenging context, Member States across the Region have taken abundant and significant steps to improve health system accountability.

This report summarizes the experiences of Member States in strengthening health system accountability along the following dimensions:

- priority-setting
- performance measurement
- performance review.

The relevance of focusing on these three dimensions stems from the fact that they are necessary components of a systematic process through which key decision-makers may steer the health system towards improved performance (i.e. health outcomes) in an evidence-based and effective manner.

Firstly, setting overarching outcomes for the health system is one of the most crucial aspects associated with its governance function. The existence of clear mechanisms to articulate the outcomes towards which programmes, resources and efforts should be emphasized to advance the health and well-being of citizens is a first component required to define the essential criteria with regards to which responsible decision-makers may be held accountable. This overview shows that at least 43 out of the 53 Member States of the Region define outcomes for the health system within a national health strategy, policy and plan (NHSP) or target programme. In fact, in recent years, an increasing number of European Member States have undertaken activities towards formulating national health strategies, and an increasing number of recent strategies take their inspiration from the WHO European policy framework for health and well-being, Health 2020, with its strong focus on health inequalities, whole-of-government and whole-of-society approaches. In addition to NHSPs, the report describes other goal-setting mechanisms including health systems reform initiatives and agenda setting pertaining to specific institutions with a prominent role in the health sector, such as the health ministry.

Secondly, in order to keep track of the progress in attaining the stated health system's outcomes, it is necessary to have accurate and reliable information pertaining to performance of the health system as a whole. Comprehensive packages of system-level indicators to measure health system performance exist in at least 32 Member States. As this report illustrates, there are several different ways to define the dimensions that must be measured in

¹ Health 2020. A European policy framework and strategy for the 21st century. Copenhagen: WHO Regional Office for Europe; 2013 (<http://www.euro.who.int/en/health-topics/health-policy/health-2020-the-european-policy-for-health-and-well-being/publications/2013/health-2020-a-european-policy-framework-and-strategy-for-the-21st-century>, accessed 24 March 2015).

order to track performance. Such differences are reflected in an observed variation in depth and breadth across the indicators used by Member States. In some countries, for instance, measuring is confined to health system reform processes. In others, it is a defined and regular national activity, whereas in others, measurement takes place mostly in the context of national strategies or programmes.

Finally, the process of reviewing and assessing health systems performance against stated outcomes enables decision-makers to develop and implement the necessary measures to assure continued improvement of health outcomes in an evidence-based manner. Systematic reviews of health systems performance are conducted in practice in at least 18 Member States, albeit with different formats and emphasis. Some reviews are explicitly associated to NHSPs, while others refer to reform programmes and yet others are conducted as ex-post, standalone undertakings such as the health system performance assessment (HSPA).

This report also illustrates in a more extensive manner the achievements and challenges to exercising health systems accountability as illustrated by three case studies: Finland, the Republic of Moldova and Turkey. These country experiences illustrate the manner in which the process of exercising health system accountability is contingent on the institutional and administrative organization prevailing in the health sector, as well as each country's unique historical experiences and socioeconomic circumstances. Thus, the case studies clearly demonstrate that while international guidelines and good practice can strengthen health system performance, there is no one-size-fits-all approach to developing effective accountability mechanisms for health systems.

In sum, Member States across the European Region have met the challenge of addressing the expressed commitments towards *smart* governance (2) in a context of economic hardship through different strategies and means. Six years after signing the Tallinn Charter and the momentum generated by the adoption of the Health 2020 policy framework, this report seeks to illustrate the diversity and richness of approaches through which Member States have risen up to the challenges of the times.

1. Health system accountability in the European context

1.1 Rationale of the study

In 2008, European health ministers adopted the Tallinn Charter: Health Systems for Health and Wealth, committing to work towards strengthening health systems to become high performing. WHO European Member States and partners emphasized that “health systems need to demonstrate good performance” and that health policy-makers must be committed to “promote transparency and be accountable for health system performance to achieve measurable results”. Meanwhile, WHO committed its support to European Member States in the “development of their health systems and will provide cross-country coordination in implementation of the Charter, including the measurement of performance and the exchange of experiences”. In the Tallinn Charter, WHO and its Member States across the Region have thus intended to advocate for and commit to strengthening health system accountability (1).

In 2012, the adoption of Health 2020 as a common policy framework for action to promote health and well-being for people in the European Region² provided a source of inspiration for countries to endorse evidence-based values, principles and approaches that promote health using whole-of-government and whole-of-society approaches (2).

In line with this, during recent last years, Member States have developed and implemented a variety of measures to strengthen health system accountability, including measures aimed specifically at: the introduction or update of national health strategies, policies and plans (NHSPs), the development or update of health system monitoring frameworks and the introduction or strengthening of health system performance reviews.

However, since the adoption of the Tallinn Charter in 2008 and the endorsement of Health 2020 in 2012, Member States have faced new challenges and opportunities for strengthening governance of health systems.

Throughout the WHO European Region, health care costs have grown at a faster rate than the gross domestic product primarily driven by the supply side, such as new treatments and technologies, but also due to people’s rising expectations of protection from health risks and access to high-quality health care (2). The economic downturn, which has persisted since 2009 in many countries of the Region, has posed a threat to health and health system performance (3). In some countries, this situation has contributed to a worsening of some critical health indicators, such as infant mortality rates, suicide rates and incidence of mental disorders such as depression and anxiety, in particular among those population groups whose financial situation has been most severely affected (4–5). While more evidence is needed to fully comprehend the impact of the financial crisis on national health indicators, findings indicate that it has contributed significantly to an increase in health inequalities (4).

2 WHO Regional Committee for Europe resolution EUR/RC62/R4 on Health 2020 – The European policy framework for health and well-being.

Thus, while the demand for health care has continued to increase, public funding available for the health sector has diminished or remained constant. Therefore, many countries must find ways to contain costs while ensuring sufficient safeguards for mitigating the financial risks of ill health and providing social protection. In addition, establishing robust information systems for monitoring and evaluation of health systems performance and the impact on health outcomes continues to be challenging, since health is the resultant of many determinants outside the health sector. Nonetheless, finding the right approaches to ensure that the best health outcomes can be attained through effective and efficient use of the available resources is a vital task in times of economic hardship. Therefore, strengthening accountability to increase transparency for health systems performance becomes an imperative towards society.

Thus, by highlighting the need to strategize and innovate, the global financial crisis has also generated new opportunities to improve health systems performance. The imperatives of catalysing investments in health, optimizing health system performance and protecting the poor have triggered new quests on ways to ensure accountability and transparency in the allocation and execution of health budgets. Moreover, crises offer the opportunity to reaffirm health system values, priorities and objectives if the constraints imposed by the economic situation are harnessed to catalyse and reinforce the commitment to equity, solidarity, financial protection and universal coverage while protecting the health sector from budget cuts (5). This emphasizes the importance of strengthening the governance function in health systems in order to assure adequate and efficient use of existing resources.

1.2 About this report

This report seeks to provide an overview of the main initiatives that have been adopted, and the progress made towards the fulfilment of the Tallinn Charter commitments and within the scope of the Health 2020 policy framework. It takes stock of the various ways in which Member States have developed and increased health system accountability by strategically setting overall objectives, and measuring and reviewing health system performance.

The report is structured in six chapters. Chapter 1 provides the background and rationale of the study underlying this report. Chapter 2 sets out the scope of the study, describes the conceptual framework used and details the research methods applied. Chapter 3 is devoted to the results of the study concerning the multi-country overview analysis on setting health system objectives, measuring health systems performance and undertaking performance reviews. Chapter 4 provides an in-depth analysis of system accountability for the health sector in three case studies: Finland, the Republic of Moldova and Turkey. Chapter 5 presents a general discussion of challenges to strengthening accountability arrangements in health, and some reflections and a way forward. Finally, Chapter 6 provides concluding remarks.

2. Conceptual considerations and methodology

2.1 Study scope and objectives

The study underlying this report aimed at highlighting the diverse arrangements through which Member States have approached their commitment declared in the Tallinn Charter to “promote transparency and be accountable for health system performance to achieve measurable results” (1). Such steps aimed at developing and strengthening adequate accountability mechanisms are also in line with the Health 2020 policy framework (2), which recognizes the importance of *smart* governance, re-emphasizes certain principles underlying European health systems, and acknowledges that public health needs to take a higher priority in health systems. Strengthening accountability mechanisms, thus, is conducive to supporting policies and actions across governments in line with the Health 2020 objectives to “significantly improve the health and well-being of populations, reduce health inequalities, strengthen public health and ensure people-centred health systems that are universal, equitable, sustainable and of high quality” (6).

The study encompasses information compiled from Member States across the Region and aims to provide a broad overview of different modalities, in nature, scope and depth, through which accountability arrangements have been developed and implemented mainly over the past six years up to December 2014. The focus is on accountability arrangements relating to the health system as a whole. Therefore, accountability related to specific functions of the health system (i.e. prevention, service delivery, financing, human resources for health, technologies, pharmaceuticals, etc.) are not covered in this multi-country study.

2.2 Conceptual framework

In order to capture the relevant information pertaining to health system accountability while still taking into account the variation in approaches currently in place across the European Region, this report adopts a conceptual framework that identifies core dimensions involved in ensuring health system accountability. This section presents this conceptual framework and provides definitions of relevant concepts.

For the purpose of the study, a health system is understood as “the ensemble of all public and private organizations, institutions and resources mandated to improve, maintain or restore health” (1).

Accountability is defined as a process within a principal–agent relationship³ through which the behaviour and performance of the agent is evaluated against predetermined standards by the principal, and where actions required to improve performance are enforced. When applied to public service provision, accountability can be understood as “the spectrum of

3 A principal–agent relationship refers to the arrangement that exists when one person or entity (called the agent) acts on behalf of another (called the principal).

approaches, mechanisms and practices used by the stakeholders concerned with public services to ensure a desired level and type of performance” (7). Accountability is considered a key objective in health system governance, with the assumption that strengthening accountability will improve other governance dimensions such as transparency, control of corruption and efficiency (8).

As health systems are characterized by dispersal of responsibility and activities across the public, private and not-for-profit sectors and along national, regional and local divisions, developing operational and effective accountability arrangements is undoubtedly a complex task. Health system stewards must, therefore, seek ways to influence the motivations and behaviours of multiple actors and their diverse agendas, finances and organizational structures forming coherent arrangements for health system accountability.

Owing to the high complexity of relationships between actors across European health systems, an all-embracing analysis of accountability arrangements in several countries would have been beyond the scope of this report. For that reason, the focus is on those dimensions meant to enable accountability at system level, i.e. *from the perspective of the main steward to the health system*. In other words, the intention is to provide an overview of those accountability arrangements that allow the steward to steer the health system towards its outcomes by providing tools to track the performance of the health system at the macro level, contrast actual performance to established priorities and enable rectifications where needed.

This report identifies three core dimensions that capture the essence of the critical actions needed to exercise accountability at the systems level and, on the other hand, are general enough as to allow for institutional diversity to be captured:

- setting health system outcomes
- measuring health system performance
- reviewing health system performance.

Health systems are expected to achieve multiple outcomes. *The world health report 2000* defined overall health system outcomes as improving health and health equity, in ways that are responsive, financially fair, and make the best, or most efficient, use of available resources (9). There are also important intermediate outcomes: the route from inputs to health outcomes is through achieving greater access to and coverage for effective health interventions, without compromising efforts to ensure provider quality and safety (10).

Health system outcomes are often made explicit in health strategies, policies or plans, which also set out values, principles and directions for the health system. However, outcomes are more precise and should fulfil certain criteria such as being measurable, assignable and time-related. Explicitly defining outcomes in health systems is an important component needed in order to ensure health system accountability when they are used as a measurable operationalization of health system principles and values. Health system’s outcomes and strategies represent an important aspect of any health system’s capability to ensure

accountability to the extent that they provide the criteria along which distribution of mandates and resource allocation may take place.

Thus, the first of the three main accountability dimensions covered in this study refers to the manner in which countries across the European Region define outcomes for their health systems responding to the conditions prevailing in their specific contexts. Attention was given to outcomes embedded in NHSPs, outcomes established for and by the institutions responsible for governing the health system and outcomes associated with broad health sector reform initiatives. However, it should be recognized that countries may deploy other means to define system outcomes, and that there may be other ways to transform values and principles into actionable and measurable commitments.

Setting out health system outcomes is only the first step towards ensuring health system accountability. Attainment in relation to these outcomes provides the basis for measuring the performance of health system (9).

Health systems performance measurement is usually based on a package of indicators carefully defined to yield information on achieved results along different dimensions such as inputs and internal processes, outputs, outcomes and impacts (11).

Finally, as stated by WHO (11), annual health sector reviews are the leading mechanism for planning, assessing progress and, ultimately, determining the extent to which the health system has accomplished its stated objectives (12). Thus, systemic performance reviews provide the opportunity to analyse actual performance with previously set outcomes. In this manner, performance reviews represent the final step in the process of exercising accountability over the health system, linking stated outcomes with actual performance by means of the analysis and interpretation of the impact of decision-making for the health system as a whole in light of available information. It is precisely this analytical review process that can identify strengths and shortcomings and that can inform, if necessary, a redefinition of outcomes and reforms aimed at optimizing health system performance to ensure health gains and well-being.

2.3 Sampling, data sources and research design

The multi-country study underpinning this report covers the period 2008–2014.

Research was conducted following a four-step approach. Firstly, a desk research – based on an extensive literature search for the period 2008–2014 – was conducted for all countries in the Region. The literature search was conducted on a country-by-country basis and along the preliminary identified areas: health system outcomes, performance monitoring frameworks, health systems assessments and reviews. Four sources were used as a first documentation scanning:

- Health Systems in Transition profiles of the European Observatory on Health Systems and Policies, with profiles since 2008 available for at least 30 countries;

- official websites from national institutions, e.g. health ministries, national boards of health and national health institutes;
- international organizations other than WHO such as the European Investment Bank, the Joint United Nations Programme on HIV/AIDS, the Organisation for Economic Co-operation and Development (OECD), the United Nations Children's Fund, the World Bank and European Union (EU) institutions; and
- selected electronic databases (MEDLINE,⁴ PubMed and the Cochrane Methodology Register).

Secondly, other relevant material was collected by means of a systematic review of the reference lists from all documents and articles previously identified.

As a result, 55 references for those countries with a WHO country office (29 Member States) were identified. Of these, 19 were Health Systems in Transition reports published since 2007. An additional 21 documents, including journal articles and reports, were incorporated upon recommendation of the heads of WHO country offices. While most of the latter reports stemmed from ministries and health organizations, some were draft documents explaining why they were not of public access. Eighteen were identified through the reference lists. For the remaining 24 Member States without a WHO country office, 61 references were identified, including 14 updated Health Systems in Transition reports. In addition, biennial collaborative agreements and ongoing country cooperation strategies between WHO and Member States were also consulted.

Thirdly, telephone interviews were conducted with WHO staff in 26 of 29 Member States with WHO country offices. The interview questionnaire is in Annex 1.

Finally, field missions to three selected countries were conducted in order to carry out in-depth interviews with local key stakeholders. The interview questionnaire is in Annex 2.

Three countries, Finland, the Republic of Moldova and Turkey, were selected for more in-depth research based on the following criteria:

- an interesting experience on health system accountability, for instance, track record of national health strategy, health system monitoring or health system performance reviews;
- regional balance;
- diversity in approaches to strengthen specific accountability relationships;
- diversity in the institutional structure and state organization (level of decentralization); and
- diversity in intersectoral and sectoral approaches to strengthen health system performance.

2.4 Methodological limitations

The study aims to illustrate indicative activities that WHO European Region Member States have undertaken in order to strengthen accountability in their health systems. Thus, the report

⁴ In MEDLINE, filters were applied for a combination of selected key words: monitoring, health system performance, strengthening health systems, national health system, health system results, definition of health system outcomes and objectives, national health plan, national health strategy, national health target programme, national health system framework, health system indicators and health system framework.

is not intended to provide an exhaustive account of all measures taken across WHO European Region Member States to that effect.

In order to bring a consistent analytical lens to the research, the focus was kept on those accountability arrangements deployed by the main steward of the health system. This is admittedly less clear in countries with decentralized health systems. Also, as a consequence of that choice, the study could not capture other kinds of mechanisms by which countries may have chosen to improve accountability, such as parliamentary accountability reports, press releases or public conference formats.

Furthermore, in countries without a WHO country office, the literature search may have only partially captured the arrangements, considering that the keyword search focused on the English language.

3. Health system accountability: a multi-country overview

3.1 Setting health system outcomes

The process of setting priorities and defining outcomes for health systems is both intricate and multidimensional, with many different ways to go about it that will vary from context to context. Such diversity is well appreciated in the manner in which countries of the Region have put in place mechanisms aimed at setting outcomes for their health institutions.

Many countries develop NHSPs or equivalent documents to provide direction and coherence to their efforts towards improving the health and well-being of their populations (11). These serve as tools to enhance accountability in the health sector to the extent that they operationalize health system principles and values into strategic health outcomes and targets. Other mechanisms through which national health outcomes are set among countries in the Region involve working with policy instruments such as national health targets, a set of national health priorities or focus areas, and system-wide reform objectives and targets embedded in a wider sector reform programme for the health system.

In the following sections, some selected examples are presented, representative of the diversity of approaches to set health system objectives prevailing among countries in the Region.

3.1.1 NHSPs

NHSPs are meant to give direction and coherence to a country's efforts to improve health and are usually periodically revised. The underlying mechanisms for developing NHSPs are varied, as are the nature and scope of the outcomes set in them.

In line with the commitments of the Tallinn Charter (2008), the impetus created by the 2012 adoption of the Health 2020 policy framework invited countries to “develop and update, where appropriate, their policies, strategies and action plans for health development taking full account where relevant of the regional Health 2020 policy framework and the underlying evidence” (13). Member States that have developed, adopted or renewed comprehensive NHSPs in the past six years include: Bulgaria, Croatia, the Czech Republic, Estonia, Finland, France, Georgia, Ireland, Israel, Kyrgyzstan, Latvia, Lithuania, Malta, Norway, Poland, Portugal, the Republic of Moldova, Romania, the Russian Federation, Switzerland, the former Yugoslav Republic of Macedonia and Ukraine. Examples of countries that are currently in the process of developing NHSPs include: Armenia, Kazakhstan and Uzbekistan.

In several countries, an important aspect of the development of a NHSP continues to be the effort towards improving and refining the process of priority setting itself. Portugal is an example of a country that has continued to develop and enhance its NHSP through a systematic

process. The Portuguese National Health Plan (NHP) 2004–2010 defined strategic guidance for the health system, establishing priorities, targets, and concrete actions (14), which in turn were derived from technical health programmes. In the past 10 years, Portugal has moved to streamline the process, reducing the number of technical health programmes from originally more than 40 to less than 15. Furthermore, a WHO-led evaluation of the NHSP (15) contributed to the formulation of a second NHP covering the period 2012–2016 (16).

Some of the countries that have adopted revisions to their NHSPs have done so with the intent of, among other things, bringing national health priorities in line with the Health 2020 agenda. These NHSPs are increasingly multisectoral, rather than health sector specific. For instance Norway, in pursuing the redefinition of national health outcomes after its 2007–2010 NHP, has planned to develop a new national strategy based on health in all policies (17). Similarly, Iceland had a plan covering 2004–2010 (18) and has recently drafted a new NHP also inspired by Health 2020. Other countries following a similar approach include Israel, Kyrgyzstan, Malta and Turkey.

It should be noted that, in addition to the Tallinn Charter commitments and Health 2020 guidelines, for some countries, membership in the EU has been a key driver to embark on developing a NHSP. The EU requirement for countries to have an approved NHP, in order to access structural funds, has led to a flurry of new NHSPs being developed in 2014 in countries such as Bulgaria, Croatia, Malta and Romania; for many of these countries, this has been a relatively new process. The Croatian Government, for example, drafted its first national health strategy for 2007–2012 and has a second version covering 2012–2020 that puts forward eight “strategic development directions, priorities and measures” developed on the basis of a strengths, weaknesses, opportunities and threats analysis (19). Bulgaria, in turn, has to date implemented two national health strategies with support from WHO and the World Bank; the first covers 2001–2008 and the second 2008–2013, which includes nine strategic outcomes. The current third national health strategy is available online and was designed as a strategic policy framework to improve the health of the nation from 2014 to 2020 (20).

One of the key dimensions along which NHSPs vary across countries refers to the nature of the outcomes defined for the health sector. For example, in some countries, the emphasis is on targeting specific diseases and health issue areas. Other countries define outcomes for the health system targeting a mix of health concerns and health systems performance areas. Such is the case of Latvia where the third national health strategy covering 2011–2017 defined six strategic objectives: reduction of health inequalities; reduction in morbidity rates of communicable diseases; reduction in morbidity rates of noncommunicable diseases (NCDs); improvement of mother and child health; improvement of occupational health; and effective management of care (21). In Italy, outcomes are defined in essential levels of care and targets (22).

Another group of countries have set outcomes defined in terms of health systems performance outcomes. Such is the case in Bosnia and Herzegovina where, although there is no health strategy at national level due to the coexistence of two political entities, each entity has

developed its own strategies and objectives. In the Federation of Bosnia and Herzegovina, general strategic objectives relate to health systems outcomes. These include increasing access, enhancing safety and quality of health services, improving efficiency and increasing solidarity. The strategic objectives are to be attained through 13 specific objectives with determined timelines, responsible institutions and expected results (23). The Republika Srpska has, in turn, developed a draft health strategy in which policy outcomes are targeted at reducing health inequalities, controlling diseases, promoting a healthy and supporting health environment, strengthening user orientation in care, improving public health capacity and adopting health in all policies (24).

Lithuania has a tradition of using national health strategies in the health sector. The last strategy focused on public health and covered 2006–2013; the current one runs until 2023 and was developed on the basis of a review of the impacts of recent health system reforms. The Lithuanian health programme has a strong emphasis on values such as universal coverage, equity, solidarity, and access to and acceptability of health care services, focusing on equity and intersectoral action to address the socioeconomic determinants of ill health and inequalities. The implementation plan also has a strong focus on building capacity for cross-sector action and investment in health (25).

Another example is Kazakhstan where the State Health Care Development Programme, “Salamatty Kazakhstan”, aims to improve population health by various means including strengthening intersectoral cooperation and improving access to primary health care (26).

The observed approaches to goal setting among the WHO European Region countries through the development of a NHSP also vary in the degree to which outcomes are associated with specific and measurable targets. The Estonian NHP, for example, sets a comprehensive sector strategy for 2009–2020 containing six health objectives, of which most have associated quantitative and qualitative targets (27).

Poland’s National Health Programme 2007–2015 (28) contains four general strategic outcomes: improve population health, adapt to demographic change, become on par with EU population health averages and increase health system effectiveness, supported by 16 objectives, tasks and activities for some of which targets have been set (29).

In contrast, Slovakia has the “National Health Concept”, which is updated on a four-year time span, is more intentional in nature and does not include national health or system targets. Slovakia has, however, targets and indicators for specific health programmes, as well as for the different segments of care. Additionally, Slovakia has drafted a Strategic Framework for Health 2014–2030 (30), taking into account aspects of Health 2020 (17).

Some countries have more than one strategic policy document where health systems outcomes are set. For instance, the Republic of Moldova has two strategic policy documents. The first one, the *National Health Policy 2007–2021*, is oriented towards health promotion and prevention, takes an intersectoral approach to health and provides broad directions, but

does not contain targets (31). The second document, the *Healthcare System Development Strategy for the period 2008–2017* (9), is more detailed, based on the health system outcomes and functions defined in *The world health report 2000* (32), is care-oriented and has targets for some (but not all) areas. The objectives are clearly defined in terms of improvement of population health; financial risk protection; reducing inequalities in the use and distribution of health services; enhancing user satisfaction and improving performance.

A number of countries, including the Czech Republic, Georgia, Iceland, Serbia, the former Yugoslav Republic of Macedonia and Uzbekistan, are currently working on or anticipate the development of a new national health strategy. In Armenia, a concept paper for the development of a national health strategy was developed by December 2013.

A number of others, e.g. Kyrgyzstan and Slovakia, which recently adopted new NHSPs, are developing detailed implementation plans.

3.1.2 Institution- and reform-driven health objectives

A different approach taken by some countries involves setting institutional performance objectives that affect the strategic directions of their health systems in those areas in which the health ministry has a mandate for planning. For instance, the health ministries of Azerbaijan, Cyprus and Turkey have strategic plans covering a medium-term timeframe of 5–6 years.

Such plans are meant to set out the strategic directions for the ministries but contain wider institutional and health system objectives that are implemented in different ways. The 2011–2015 strategic plan of the Ministry of Health in Azerbaijan provides a framework for achieving health system objectives through technical programmes (33). The Government of Cyprus, on its part, adopted the Health Strategic Plan 2007–2013 in 2006 to highlight priorities, objectives and timelines for reforming certain organizational and financial features of the health system (34). In the case of Turkey, the first strategic plan of the Ministry of Health (2010–2014) served as a strategic health development plan (35). It put forward priority objectives, such as increasing the number of health facilities serving disadvantaged population groups and improving people's right to choose their primary health care provider, and also contains elements of performance-based budgeting (36). The current second strategic plan (2013–2017) is based on the review of the first one and takes into account findings from an evaluation of Turkey's ambitious Health Transformation Programme (HTP) (2003–2011) (37–38).

Similar strategic health care development plans are in place in Bosnia and Herzegovina and in Slovenia. These plans set out principles, objectives and targets for the development of health care services with objectives and targets that span over several years (Bosnia and Herzegovina 2008–2018 (23); Slovenia 2008–2013 (39)).

In some cases, the overarching outcomes of health systems are crystallized in the intent and content of sector wide reform initiatives. For instance, the Semmelweis Plan for the Rescue of Health Care 2011–2018 in Hungary has set out system-wide reform plans that, among other things, redefine administrative and institutional frameworks through the creation of eight health care regions with oversight from regional health care centres (40). In addition to having a national health strategy, Ireland has also adopted a reform strategy for their National Health Service (NHS) spanning the period 2012–2015, and setting out objectives that are outcome-oriented at the health system level, such as improved health and well-being, faster and fairer access to care, improved management of chronic illness and improved long-term care at home (41).

Azerbaijan does not have an overarching national health strategy as such. It has, however, determined objectives on stewardship, resource generation, service delivery and health financing defined in the Health Sector Reform Project, which is the national framework for state health programmes. Each of the programmes includes an implementation plan with clear objectives, targets and dedicated funding (42).

Finland, France, Greece and the United Kingdom have recently launched health reforms featuring concrete milestones and objectives for their health systems.

In many countries of the EU, health reforms are triggered by the new system of fiscal and economic governance introduced by the European Semester in 2010 and framed in national reform programmes and stability/convergence programmes. Ireland, Greece, Portugal and Cyprus have adopted economic adjustment programmes that resulted in prescriptive guidance influencing policy developments in their health systems (43).

3.1.3 Health 2020 adding impetus to strengthening strategies, policies and plans

Health 2020, the European policy framework for health and well-being adopted in September 2012, has been increasingly a source of guidance to countries across the European Region in their actions towards setting health systems outcomes.

Estonia and Latvia have both developed national health policies consistent with the vision and principles of Health 2020. Turkey's national strategic plan 2013–2017 is strongly aligned with the values and principles of Health 2020, and the country is now implementing a national Health 2020 vision through a combination of health systems strengthening, action on the social determinants of health and improved intersectoral governance for health. Switzerland developed a national Health 2020 strategy, launched in January 2013 (44). Detailed progress reports are publicly available online in order to improve the transparency of the strategy and foster public accountability and engagement in health. In Israel, the Healthy Israel 2020 initiative is a whole-of-government process for defining Israeli policy in disease prevention and health promotion (45). Led by the Ministry of Health, it establishes intersectoral targets

and strategies to improve the health of the population and reduce health disparities, drawing on Health 2020 objectives and priorities.

In 2013, Spain sought to strengthen the alignment of its new national strategy for health promotion and prevention to the Health 2020 policy framework. Kyrgyzstan approved a new national Health 2020 strategy as a whole-of-government vision to improve the health and well-being of the population, with a commitment from the Prime Minister to chair an interministerial committee to oversee the strategy. Health 2020 was helpful in Italy to promote the development of the new national public health and prevention plan for 2014–2018 (46). Luxembourg is preparing an ambitious new cancer strategy aligned to the principles of Health 2020, covering the full spectrum from prevention to rehabilitation, with strong emphasis on health promotion and prevention. The strategy was developed in a highly inclusive process, including civil society. The Croatian *National Health Care Strategy 2012–2020* is an umbrella document that spells out specific priorities, outcomes and measures to be taken up to 2020 (19). A main contextual objective of the Strategy was to address challenges and opportunities linked to Croatia's accession to the EU in July 2013. The Strategy has taken its inspiration from Health 2020 in several ways: First, the fundamental values and principles of the strategy are consistent with those of Health 2020. Second, collaboration with other sectors is spelled out as explicit strategic objective. Third, the time horizon was explicitly chosen to parallel Health 2020.

Slovakia's strategic framework for health 2014–2030 (30) is based on Health 2020 priorities and values as is Lithuania's 2014–2023 national health policy (25) and Portugal's NHP (16), for which the Government is working with WHO in order to prepare an implementation strategy.

Healthy Ireland is another national health policy strongly aligned with Health 2020, launched by the Prime Minister in March 2013 (47). Since its implementation, the high political profile of the strategy has been maintained and, during its first year, it strategically focused on developing the relationships, structures and building blocks to assure effective implementation. As part of that effort, a new directorate of health and well-being has been established, and an outcomes framework has been developed. Implementation of Healthy Ireland is a standing item on the agendas of the senior officials' group on social policy and the Cabinet Committee on Social Policy. Recruitment is underway for the national Healthy Ireland Council, a multistakeholder council that will serve as a national advisory forum to support implementation of the strategy, consisting of Government and civil society representatives. In the context of the recent financial crisis, Healthy Ireland has been a positive focus for both politicians and the public, with its emphasis on empowering them to make positive changes to their lives.

The Russian Federation approved in April 2014 a State Programme of Healthcare Development 2014–2020 with the overall objective of ensuring access to health care and improving the efficiency of health, services, their volume, types and quality, which should correspond to the level of morbidity and needs of the population and to the latest achievements of medical science (48).

In the South-eastern Europe (SEE) Health Network countries, the Health 2020 policy framework was also used as a foundation for incorporating health into the SEE 2020 growth strategy while developing a health strategy based on Health 2020 outcomes. The strategy, adopted at the end of 2014 and focusing on collective actions that promote health and well-being for people living in the SEE subregion, could not have been achieved by countries acting on their own. Bulgaria, Hungary and Romania are also examples of countries that have all recently developed new national health strategies based on Health 2020.

Overall, during the biennium 2014–2015, over 20 countries have expressed interest to develop or to reorient their NHSPs towards the Health 2020 policy framework. Uzbekistan, for example, in keeping with its manifested interest in developing a new national health policy in line with Health 2020, convened a whole-of-government workshop on Health 2020 in May 2014 to initiate this process. The former Yugoslav Republic of Macedonia intends to prepare a new overarching national operational plan for health in 2014, based on Health 2020 and incorporating action plans on environment and health, NCDs and public health strengthening as core components. Albania has also signalled its intention to develop a new national health policy informed by Health 2020 and the results of a comprehensive national epidemiological assessment by 2015. The Parliament of the Czech Republic passed a resolution in March 2014 requesting the development of an action plan to implement the new Czech Health 2020 National Strategy for Health Protection and Promotion and Disease Prevention by the end of 2015 (49). Work has commenced by an existing intersectoral committee on health and a specially convened Ministry of Health working group. France is preparing a new national health policy 2015–2020 to respond to a new law on reducing health inequities by improving access both to health services and prevention. Iceland has been preparing a health strategic plan for Health 2020 and has also established a committee of four ministers on public health, which will be chaired by the Prime Minister. Malta finalized in December 2013 a new health sector strategy, which makes explicit reference to Health 2020 and reflects many of its concepts and principles.

3.1.4 Involvement at subnational level

The process of setting outcomes for the health system also varies in terms of the extent to which actors at different administrative levels are involved. Several cases stand out in this respect, especially with regard to adoption of the Health 2020 agenda on the part of subnational and regional agencies.

In Denmark in 2012, the Danish Healthy Cities Network and the Copenhagen City Council organized a Health 2020 alignment launch event. In Sweden, the local level is especially important when it comes to implementing action on the social determinants of health, and four local authorities have now established their own so-called Marmot commissions; the Region of Skåne has launched Health 2020 with the Swedish Healthy Cities Network. In Spain, Health 2020 has been highlighted and discussed at regional level, for example, in the Autonomous Community of Andalusia. In Italy, several regions have also expressed interest

in working towards implementing Health 2020, while in Belgium the Wallonia Region is integrating Health 2020 values and concepts as part of health sector reform.

At subnational level in Bosnia and Herzegovina, the Republika Srpska introduced a Health 2020 policy in November 2012, focusing on reducing inequities and NCDs through multisectoral policies to promote health and address the underlying determinants. The Federation of Bosnia and Herzegovina has endorsed two specific strategies drawing on Health 2020 values and approaches: on the protection and promotion of mental health; and on the prevention, treatment and control of cancer. In Serbia, work is under way to integrate Health 2020 into local health policies developed by newly established municipal health councils.

3.1.5 Intersectoral and multistakeholder approaches

In recognition of the multiplicity of factors that impinge on health outcomes and the necessity for a comprehensive approach that extends beyond what is traditionally understood as the health sector, increasing numbers of countries are adopting an intersectoral approach to defining health objectives and outcomes. Such holistic view is also consistent with the involvement of a broad range of actors and stakeholders from across the public-private divide, which is also reflected in the participatory mechanisms included for health system goal setting in some countries.

Austria and Germany are examples of such countries, where responsibility for system level goal setting and decision-making is shared among different autonomous levels of government, health institutions and stakeholders.

In Austria, the Federal Ministry of Health is pursuing 10 framework health outcomes during the period 2012–2032, which have been collaboratively developed with participation of more than 30 institutions and more than 4000 citizens (50). In turn, since 2003, Germany has worked with a collaboration of more than 120 institutions to adopt and update seven national health targets. The evaluation of the targets between 2013 and 2015 is expected to feed into a new national health target programme (51). Besides national targets, numerous target-setting projects are followed at regional, district and municipal levels.

The health policy of Israel, Healthy Israel 2020, was similarly developed by an interdisciplinary approach engaging hundreds of professionals. Objectives are of intersectoral nature and focus on health conditions, individual health behaviours and environmental factors.

Finland traditionally has strong ties between the health and social sectors, and adopted a new strategy for social and health policy in 2011 (52). The strategy reinforces the health in all policies approach, builds on universal access to preventative care and occupational health, formulates commitment to tackle inequalities in health and welfare, and promotes customer-oriented services. These commitments are accompanied by integrated welfare and health objectives and targets, and measured through a comprehensive set of indicators.

Since 2003, Sweden has followed objective domains that are intersectoral in nature in its health policy. These include participation, economic and social requisites, childhood and adolescent conditions, occupational health, environment and products, health promoting health services, communicable diseases protection, sexual and reproductive health, physical activity, eating habits and risk behaviour.

A number of Member States, including Azerbaijan, Bulgaria, Kyrgyzstan and Tajikistan, have been developing national multisectoral strategies for NCDs prevention and control based on the Health 2020 framework. Georgia and Turkmenistan are also developing national NCD strategies, and Turkmenistan agreed to set up a multisectoral committee tasked with oversight of their national strategy.

3.1.6 Increasing capacity for whole-of-government approach

Numerous Member States have made efforts to increase their capacity to take a whole-of-government approach to health. Montenegro and Serbia have both conducted assessments of governance for health. Workshops on whole-of-government approaches have been held in a number of countries, including Bosnia and Herzegovina and the Republic of Moldova. Health 2020 components are strongly present in Finland's policies, programmes and ways of work, especially in relation to health in all policies and inequalities. Health and social well-being are treated jointly in Finland, where discussions are underway on developing an umbrella national health and social well-being policy to replace the expiring national health policy. Beyond policy frameworks, much work in Finland has focused on setting up the institutions, structures and mechanisms for health and well-being in all policies. Health 2020 is being taken forward in France to reduce health inequities and strengthen a whole-of-government approach. France has established a whole-of-government interministerial committee on health, to be chaired by the Prime Minister.

3.2 Health system performance measurement

Developing mechanisms for measuring health systems performance involves defining which indicators and measures are to be compiled, and ensuring the appropriate information is collected and aggregated. Determining which indicators are most appropriate to obtain the necessary information that can allow an adequate appreciation of performance at system level is, therefore, a complex task since the causal chain of results is also affected by factors that rely outside the health system, or because many factors may concur to influence one performance attribute.

Overall, at least 32 countries in the Region have national repositories or platforms of health system performance information with packages of indicators that are regularly measured over time. The number of indicators varies from about 26 in Austria to more than 1000 in Finland.

Many countries have performance measurement strategies that are associated to the outcomes set out in a NHSP or to general health system's outcomes in the absence of a NHSP. For instance, Kyrgyzstan has about 80 indicators to measure the implementation of the health system transformation strategy. This number has progressively been reduced from originally more than 100. Several departments within the Ministry of Health are responsible for measuring.

Similarly, Tajikistan regularly measures the implementation of its National Health Strategy 2010–2020. This is the responsibility of the department of reforms at the Ministry of Health and Social Protection. The purpose of the measurement is to inform policy-makers precisely about achievement of targets and progress.

Kazakhstan has six main target indicators associated with the State Health Care Development Programme, “Salamatty Kazakhstan” (53). These target indicators are linked to outcomes, such as increases in life expectancy and decreases in infant mortality rates, and are further disaggregated into a package of about 100 indicators that follow objectives and intermediate objectives of the programme. The indicators are monitored twice a year and are regularly updated. Management of the monitoring package is the responsibility of the department of strategic development within the Ministry of Health and Social Development.

In Germany, the health information system monitors indicators associated with the national health outcomes derived from around 100 data sources. The indicators cover all relevant sectors of the health system including: public health surveillance; demographic and socioeconomic conditions; environmental and lifestyle-related health risks; diseases and health conditions; and health system financing and expenditures.

Serbia produces health indicators related to eight broad areas (demography and other socioeconomic indicators, mortality, morbidity, lifestyles, environment, health resources, use of health services, and maternal and child health), which are associated to the public health strategy.

Croatia measures health system performance through a set of indicators related to the areas of finance, quality and management of care as set out in its NHSP.

In Ireland, health system performance is measured through a package of indicators associated to the national health policy Healthy Ireland. These indicators are disaggregated along the following categories: disability, older people, acute services, mental health, social inclusion, children and families, palliative care and primary care including health promotion. Measurements on these indicators are submitted to the Department of Health on a monthly basis.

Austria is now three years on with its targets for health in all policies and whole-of-government health targets. In Austria, although there is no NHSP, a package of 26 key indicators has been developed in association to the 10 national health outcomes. The process constitutes the framework for the national health promotion strategy that is part of nationwide health reform.

Accordingly, 10 headline targets have been formulated, reflecting the objectives of Health 2020, through a cross-sectoral, highly participatory endeavour lasting over two years. The process is coordinated by the Federal Ministry of Health but involves a plenum of 40 actors, including other ministries, institutions, organizations and civil-society representatives. Similarly, in the Netherlands, are three broad stated outcomes for the health system (access, quality and costs) that, in turn, have 13 indicator domains associated to them for monitoring purposes.

Sweden is another example of a country that has not specified a NHSP as such, and where performance measurement is conducted using indicators associated with the guidelines for certain conditions, while others are published together with the county council organization. Taken together, Sweden produces information on more than 800 distinct indicators.

The United Kingdom has in place framework indicators, which have been designed precisely to provide national-level accountability for the outcomes that the NHS delivers. This database performs a clear role in articulating an accountability function since it provides a national-level overview of how well the NHS is performing, linking the Secretary of State for Health and NHS England, and acting as a catalyst for quality improvement throughout the NHS while encouraging changes in culture and behaviour (54).

Another dimension to take into account relates to the extent to which the degree of centralization of the health system shapes the package of indicators used for monitoring in each country. This has to do with the administrative level at which decisions on the types of indicators compiled are made, which in turn may affect the national coverage and extent to which such sets of indicators are homogeneous across regions.

Finland provides an example of a highly decentralized health system: monitoring is driven by the regions and 320 municipalities and, as a result, the number of indicators compiled is very high (over 1000). However, the coverage across regions is not necessarily uniform, and the frequency and depth of monitoring activities varies significantly from one municipality to another, depending largely on local capacities and commitment.

Spain measures a set of 110 indicators, published every three years, reporting data on areas such as population health, health determinants, health resources and expenditures. These indicators are selected by consensus among the administrative levels represented in the Spanish Interregional Council of the National Health System. The development of such indicators is also the result of collaborative work with the autonomous communities.

In Denmark, the Ministry of Health defines some health system performance indicators alone, while others in cooperation with the regions.

The process of measuring is sometimes designed to target information in areas undergoing reforms. Examples of countries using packages of health system performance indicators specifically to measure progress in health system reform processes include Bosnia and Herzegovina, where a package of indicators is under development to accompany the health

sector enhancement project; in Iceland, monitoring and performance evaluation of the health system takes place along four dimensions that monitor the health system's reform project.

Hungary has moved from a situation in which health systems monitoring efforts were based on secondary analysis of existing routine databases (55), to the development of a comprehensive monitoring tool embedded in the organizational process for HSPA, which has been thoroughly institutionalized.⁵

Finally, some countries work with so-called indicator domains. This is the case in Belgium where there is no overarching NHSP but a strong emphasis on equity as a guiding principle for the health system. Thus, Belgium has developed health systems performance monitoring indicators along five domains: health promotion, preventative care, curative care, long-term care and end of life care with a total of 74 indicators. Furthermore, each of the five domains can be evaluated on the dimensions accessibility, quality, efficiency and sustainability.

In countries of the EU, the concept of health systems monitoring and assessment was introduced in 2004 as part of the open method of coordination framed under the "ageing agenda" (56) and further strengthened under the auspice of the Council of the EU (57).

3.3 Health system performance review

As discussed above, it is by assessing health systems performance against the outcomes that decision-makers can gather the required information to take actions conducive to steering the health system towards achieving the desired health outcomes for the population.

Reviews often involve the participation of a broad range of stakeholders in defining the rationale and processes underpinning the assessment framework, in selecting relevant indicators and in analysing the results.

In the surveyed countries, this report identified two general formulations commonly used to review health system performance: evaluation of NHSPs and stand-alone/ex-post HSPAs.

3.3.1 Evaluation of NHSPs

In Kazakhstan, the most comprehensive sector review is, in fact, the annual report of the Ministry of Health and Social Development. This report is based on a review of all health system components and their measurement against indicators of achievement, which are defined in the national programme. The last of such reports to have been produced is the results of the work of the Ministry of Health and Social Development Republic of Kazakhstan for 2013 and tasks for 2014. This assessment was undertaken by a wide group of stakeholders including the Prime Minister, Parliament and nongovernmental organizations (NGOs). A similar situation is observed in many former Soviet Union countries.

⁵ The institutional framework for HSPA is regulated by the Ministry of Human Capacities decree 36/2013 V.24 that requests the National Institute for Quality and Organizational Development in Healthcare and Medicines to produce a biannual report. The Ministry of Human Capacities decree 19/2013 V.24 provides the rule for the functioning of the HSPA working group.

Other examples of countries where annual reviews are associated to NHSPs are Poland, where a yearly report on implementation of the national health programme is produced and delivered to the Council of Ministers, and Spain, where the data on the indicators compiled through the monitoring mechanism provide input to the interterritorial council of the national health system.

Some countries conduct health sector joint annual reviews (JARs), which are generally designed to review the implementation of national health sector plans, or to assess sector performance and to agree on actions to address constraints in implementation or to improve performance. JARs were established in the early 1990s as part of implementing sector-wide approaches (SWAp). In some countries, JARs started when government and sector partners found sufficient common ground to jointly support the sector without a formal SWAp in place, or in response to a national drive for more transparency and open dialogue (58).

In Tajikistan, a JAR of the NHS is routinely carried out by the Ministry of Health and Social Protection and development partners. It is a process that informs revisions and updates of indicators and targets in the National Health Strategy 2010–2020 but also fosters further in-depth policy evaluations (59). During the JAR meeting on 3 December 2013 in Dushanbe, over 200 representatives from key ministries and agencies, educational institutions and universities, NGOs, the heads of state and private health facilities from the region, and development partners participated in group and plenary sessions leading to a draft action plan for 2014, and a meeting resolution to document progress and difficulties experienced in 2013.

Kyrgyzstan, following a similar process, has undertaken a Joint Assessment of National Health Strategies and Plans in support of the health sector strategy “Den Sooluk” (60). This assessment involves an evaluation of about 80 indicators in a monitoring package and is the responsibility of all departments in the Ministry of Health. Results are published annually and discussed during a formal annual joint health system performance review taking place over one or two weeks, with participation of the Government, stakeholders and development partners. Discussions during the joint assessments sometimes are heavily debated but do usually lead to a consensus or a compromise and to concrete policy decisions. This annual dialogue is very valuable as the conclusions of the review drive policy, programmatic and funding decisions throughout the year. Planning based on the monitoring scheme is strongly supported by the international community, and an independent institution is mandated to undertake in-depth policy evaluations complementing the regular performance monitoring.

Albania produces two main reports associated with their health systems review; one is a report on process, last produced in 2012, and one is a report on performance, last delivered in 2011.

Some countries complement their regular health sector reports and reviews with commissioned studies to that effect whenever deemed necessary. For example, in Lithuania, while the Ministry of Health and the State Health Insurance Fund report annually on the implementation of their strategic plans, in 2012 the Minister of Health commissioned, in

addition, a health system analysis and assessment. Poland, on its part, has conducted an inventory of its national health policies, strategies and laws applying a Health 2020 lens, with a view to informing the development of a new national health policy in 2015. Hungary conducted a national review of social determinants of health and health inequities, and will be holding follow-on policy dialogues to discuss policy interventions in 2014.

3.3.2 HSPA

An ex-post assessment methodology, the HSPA, focuses on key health systems outcomes and core functions with an emphasis on evaluating systems-wide performance and achievements, as opposed to focusing on specific programmes. For that reason, it can be used to inform policy decisions.

Among the countries that have carried out HSPAs are Armenia, Azerbaijan, Belgium, Estonia, Georgia, Kyrgyzstan, Portugal, Turkey and the United Kingdom. Of these countries, however, only some have institutionalized the assessment or have full national ownership of the HSPA mechanism. For instance, Armenia has a national HSPA programme and a designated institution responsible for performance assessment and reporting. The HSPA, undertaken every 2–3 years, is linked to financial commitments. In fact, the Armenian HSPA is now an integral part of an evidence-based policy and management cycle, and used as one of the means to hold stakeholders to account.

Another country that has institutionalized the HSPA is Georgia, which in 2012 produced its last review and also approved a ministerial decree to that effect. The HSPA can be applied and tailored so as to track progress with recently implemented programmes or interventions. For instance, implementation of the Georgian Universal Health Coverage Programme started in February 2013, and it has been foreseen to conduct a first assessment post-completion of the first year of the Programme in spring 2014.

More recently, Hungary has also institutionalized a multistakeholder process for implementation of the HSPA, with several specialized agencies taking part in the assessment and validation of the findings, including a standing working group of the Ministry of Human Capacities dedicated only to the HSPA. It is foreseen that this Hungarian Ministry will publish HSPA reports biannually, with a standard version including only indicators that will be updated every year.

In Portugal, one HSPA was undertaken in which targets set forth by the NHP 2004–2010 were reviewed and measured regularly several times a year through an intersectoral review committee and in collaboration between the national Government (the High Commissioner for Health) and the Portuguese regions. Furthermore, it has been acknowledged that the HSPA helped the Portuguese health authorities prepare the NHP 2012–2016 by motivating engagement of key stakeholders and clarifying system outcomes (36).

Belgium has published two HSPAs, the first in 2010 and the second in 2012, on the basis of a regular review of the set of health systems indicators, which takes place every three years.

In Turkey a comprehensive HSPA was conducted in 2011 and facilitated by high-level support of the Minister of Health. The 2013–2017 strategic plan of the Turkish Ministry of Health stipulates that a Turkish HSPA shall be developed and institutionalized by 2017.

3.4 Summary of health system accountability in Member States

Since the Tallinn Charter was adopted in 2008 and the Health 2020 policy framework was approved in 2012, Member States across the Region have undertaken significant and diverse measures to strengthen health system accountability. Table 1 summarizes the findings presented in this report.

Table 1. Overview of most recent health system accountability activities in WHO European Member States^a

Country	NHSP	Health system performance	
		Measurement	Review
Albania	National Strategy for Health 2007–2013 (61)	-	Based on process and performance
Andorra	Strategic Health Plan 2008–2011 (62)	-	-
Armenia	Health System Development Concept Paper 2013–2020 ^b	Yes	HSPA 2007, 2009, 2012
Austria	10 National Health Targets 2012–2013 (50)	26 indicators	-
Azerbaijan	Strategic plan of the Ministry of Health 2011–2015 (33)	46 indicators including 13 main indicators	-
Belarus	-	-	-
Belgium	-	5 indicator domains	HSPA 2010, 2012
Bosnia and Herzegovina	Strategic Plan for Health Care Development in the Federation of Bosnia and Herzegovina 2008–2018 (23)	Associated to reform package	Currently planned
	Policy for improvement of health of the population by 2020 (24)		
Bulgaria	National Health Strategy 2014–2020 (20)	-	-

Table 1 contd

Country	NHSP	Health system performance	
		Measurement	Review
Croatia	National Health Care Strategy 2012–2020 (19)	36 indicators including 5 basic indicators	-
Cyprus	Health Strategic Plan 2007–2013 (34)	-	-
Czech Republic	Health 2020 - National Strategy for Health Protection and Promotion and Disease Prevention 2014–2020 (49)	-	-
Denmark	-	Yes	-
Estonia	National Health Plan 2009–2020 (27)	80 indicators	HSPA 2010, an update is in progress
Finland	National Development Programme for Social Welfare and Health Care (KASTE) 2012–2015 (63)	Over 1000 indicators	Only in some municipalities, not systematically
France	National Health Strategy 2013 (64)	Yes	-
Georgia	National Health Care Strategy 2011–2015 (65)	-	HSPA 2009
Germany	National Health Targets since 2000 (66)	297 indicators	-
Greece	National Health Reform Programme 2013–2015 ^c	-	-
Hungary	Semmelweis Plan for the Rescue of Health Care 2011–2018 (40)	Yes	HSPA
Iceland	National Health Plan 2004–2010 (18)	-	-
Ireland	Healthy Ireland: A Framework for Improved Health and Well-being 2013–2025 (47)	Yes	Monthly performance reports
Israel	Healthy Israel 2020 (45)	Yes	-
Italy	National Health Plan 2011–2013 (22)	Yes	-
Kazakhstan	State Health Care Development Programme "Salamatty Kazakhstan" 2011–2015 (26)	About 100 indicators	-
Kyrgyzstan	Den Sooluk National Health Reform Programme 2012–2016 ^d (60)	About 80 indicators	JAR

Country	NHSP	Health system performance	
		Measurement	Review
Latvia	Public Health Strategy 2011–2017 (21)	Yes	-
Lithuania	National Health Programme 2014–2023 (25)	Yes	Ministry of Health and State Health Insurance Fund regular reviews and ad hoc commissioned ones
Luxembourg	-	-	-
Malta	National Health Systems Strategy 2014–2020 (67)	Yes	Ongoing
Monaco	-	-	-
Montenegro	Health Policy until 2020 (68)	-	-
Netherlands	-	13 indicator domains	Reporting every 2 years with changing focus areas
Norway	National Health and Care Services Plan 2011–2015 (69)	-	-
Poland	National Health Programme 2007–2015 (28)	Yes	Yes
Portugal	National Health Plan 2012–2016 (16)	Yes	HSPA 2010
Republic of Moldova	National Health Policy 2007–2021 (31)	-	Institutionalized for intersectoral programmes
Romania	National Health Strategy 2014–2020 (70)	-	-
Russian Federation	State Programme of Healthcare Development 2014–2020 (48)	110 indicators	-
San Marino	-	-	-
Serbia	Development Plan for Serbian Health System 2010–2015 (71)	Yes	-
Slovakia	Strategic Framework for Health 2014–2030 (30)	Limited to primary, secondary and tertiary care	-
Slovenia	National Health Plan 2008–2013 (39)	-	-
Spain	-	110 indicators	-
Sweden	-	Yes	-

Table 1 contd

Country	NHSP	Health system performance	
		Measurement	Review
Switzerland	Health-policy Priorities – Health 2020 (44)	-	-
Tajikistan	National Health Strategy 2010–2020 (59)	218 indicators	JAR
The former Yugoslav Republic of Macedonia	Health Strategy 2020: Safe, efficient and just healthcare system (72)	-	-
Turkey	Strategic Plan 2013–2017 (37)	55 indicators	HSPA 2011
Turkmenistan	State Programme for Development of Healthcare 2012–2016 (73)	-	-
Ukraine	Health 2020 Ukrainian Dimension (74)	-	-
United Kingdom	-	About 150 indicators	HSPA
Uzbekistan	State Programme for Health Development 2007–2010 (75)	150 indicators	-

- indicates missing information and not necessarily lacking activities.

^a The most recent activities are listed.

^b In process of approval.

^c WHO, Greece sign agreement on support programme for health reform (22 July 2013). In: WHO Regional Office for Europe [website]. Copenhagen: WHO Regional Office for Europe; 2015 (<http://www.euro.who.int/en/countries/greece/news/news/2013/07/who,-greece-sign-agreement-on-support-programme-for-health-reform>).

^d Kyrgyzstan's new health strategy, Den Sooluk 2014–2020, was adopted in May 2014.

4. Health system accountability: in-depth country cases

4.1 Finland

4.1.1 Health system overview

The Finnish health system is characterized by traditionally strong ties between the health and social sectors and by a high level of decentralization, with 320 municipalities responsible for service provision. This governance arrangement is the main driver of the health system.

In the early 1990s, demands for more local autonomy led to the dissolution of the National Board of Health and Welfare and a shift of responsibilities to the municipalities. The idea was that a decentralized system would enhance accountability towards citizens by bringing decision-making closer to them. However, in terms of exercising accountability for the performance of the health system as a whole, the decentralized accountability of the Finnish health system poses singular challenges.

One such challenge involves ensuring effective collaboration and coordination among a multiplicity of health and social system actors and stakeholders. At the national level, a large number of governmental agencies⁶ and NGOs⁷ play a role in shaping the agenda and influencing priorities of the health system. At the municipal level, health services and social care are provided by the 320 municipalities, which are organized in 20 hospital districts for providing secondary and tertiary level hospital care.

A system with both national and municipality public financing and challenges in policy development faces trade-offs to keep overall efficiency and equity in the provision of services.

4.1.2 Health system accountability

At the national level and according to the Finnish Constitution, “the public authorities shall guarantee for everyone ... adequate social, health and medical services and promote the health of the population” (76). In terms of the operational implementation of such prescription, it is the responsibility of the municipalities to organize these services as established in the Act on Primary Health Care (66/1972) and the Act on Specialized Medical Care (1062/1989) (77–78). Secondary care level is provided by hospitals organized at the regional level.

In addition, the Act on the Status and Rights of Patients (785/1992) includes provisions on patients’ (procedural) rights when receiving health care and medical services, such as the right to self-determination, the right to be informed, and the right to get health care and medical care without discrimination (79). The Health Care Act (1326/2010) contains provisions on the individual’s right to primary health care services and specialized medical care (80).

6 Finnish Competition and Consumer Authority, Finnish Institute of Occupational Health (FIOH), Finnish Medicines Agency (Fimea), National Audit Office, National Institute for Health and Welfare (THL), National Supervisory Authority for Welfare and Health (Valvira), Parliamentary Ombudsman, regional state administrative agencies (ELYs and ALYs), Social Insurance Institution of Finland (Kela)

7 Association of Finnish Local and Regional Authorities (Kuntaliitto), Finnish Medical Association, Finnish Medical Society Duodecim, Union of Health and Social Care Professionals (Tehy), local government employers, health care employers, insurance companies

As the national level and the municipalities share responsibilities for the health sector, health system accountability mechanisms are also organized at both levels.

4.1.3 Health system outcomes and priority-setting

At the national level, the Ministry of Social Affairs and Health is in charge of developing health policy, preparing key reforms, issuing framework legislation on health and social care policy, and defining outcomes for their implementation. However, due to the high level of decentralization, the Ministry of Social Affairs and Health is mostly perceived as a legislator, while the municipalities have lots of freedom when it comes to implementation.

Several agencies operating under the administrative branch of the Ministry of Social Affairs and Health are involved in priority-setting and decision-making for the health sector. The National Institute for Health and Welfare (THL) is to “study, monitor, assess, develop and guide social welfare and health care activities and to provide expert assistance for the implementation of policies, procedures and practices that promote welfare and health” (81). THL further functions as a statistical authority (82), maintains databases and registers, and promotes the utilization of its knowledge base. Based on its mandate and as a research and development institute under the Ministry of Social Affairs and Health, THL has the potential to enhance accountability throughout the Finnish health system although, in order to do so, its relation via-à-vis the municipalities would need to be revised.

The National Supervisory Authority for Welfare and Health (Valvira) is a centralized body operating under the Ministry of Social Affairs and Health. Its statutory purpose is to oversee and provide guidance to health care and social services providers, alcohol administration authorities and environmental health bodies (83). It is also in charge of authorising health professionals and grants national licences for private health service provision.

In addition, many specialized agencies also have an impact on policy- and decision-making, e.g. the Finnish Medicines Agency (Fimea) or the Finnish Institute of Occupational Health. Some research and expertise are also provided by the Social Insurance Institution of Finland (Kela), which operates under direct supervision of the Parliament to support the development of social security and health systems.

Two overarching policy documents provide directions in the health sector: the *National Development Programme for Social Welfare and Health Care 2012–2015* (63), known as the KASTE programme, and the public health programme *Health 2015* (84).

The KASTE programme is the central strategic steering tool used to manage and reform social and health policy. It defines the key social and health policy targets, priority action areas for development activities and monitoring, as well as essential legislation projects, guidelines and recommendations to enhance the implementation of the programme. The outcomes are defined by the Ministry of Social Affairs and Health, based on the expertise and knowledge

produced by the research institutions under its administrative branch. In addition, citizens' inputs that are brought to the Ministry's attention are also taken into account.

The KASTE programme is reviewed and updated by the Government every four years, and the budget allocated to the programme is revised annually. The current second plan covers the years 2012–2015, and comprises a separate implementation plan that specifies the timeframes for the implementation and the division of responsibilities between the different stakeholders. Regional management groups for the KASTE programme are in charge of developing regional implementation plans.

According to the current plan, the targets of the KASTE programme are to reduce inequalities in well-being and health, and to organize social welfare and health care structures and services in a client-oriented and economically sustainable way. Municipalities may, on a voluntary basis, participate in the KASTE programme that provides limited programme management and project funding for developmental projects.

The municipal councils have the main decision-making power and are responsible for setting priorities at municipal level. For instance, health is planned and organized by the municipal health committees and municipal councils. However, resources and capacities at municipal level are not homogenous and, in light of that, guidelines for implementation of the national legislation seem sometimes to be insufficient.

The decision-making process poses an additional challenge due to the trade-offs between providing guidance and restricting municipal autonomy. This has been taken into account by the Ministry of Social Affairs and Health with recent legislation specifying the services guaranteed.⁸

Furthermore, the mandate of the regional state administrative agencies has been broadened to monitor the implementation of national legislation by municipalities. Valvira ensures that the guidance provided by these different agencies is coherent throughout the country.

The public health programme Health 2015 serves as long-term health policy. Health 2015 seeks to tackle inequalities in health and welfare and to promote customer-oriented services.

The consistency in the outcomes shared by both KASTE and Health 2015 reinforces commitments that are accompanied by integrated welfare and health objectives and targets, and measured throughout a comprehensive set of indicators.

The Health 2015 programme outlines eight targets further specified by action statements. These action statements set quantified targets for improving the health of different population groups, plus targets relating to the whole population, health services, the environment and reducing inequalities (85).⁹ The implementation and monitoring of Health 2015 is coordinated by the Advisory Board for Public Health together with the Ministry of Social Affairs and Health. Further stakeholders from related sectors are involved in the implementation of Health 2015. Responsibilities linked to the implementation of Health

8 For example, the Health Care Act (1326/2010) explicitly stipulates when patients should be treated in primary health care centres and secondary and tertiary care hospitals.

9 The targets are designed to be as concrete and measurable as possible. For instance, smoking by young people is to decrease to less than 15% among those aged 16–18 years by 2015.

2015 have only been specified for the Ministry of Social Affairs and Health and not for other sectors and municipalities.

One major accountability challenge is linked to resource allocations for the health system. Since 1993, municipalities receive a general share of the state budget, based, inter alia, on demographic criteria developed by THL, but there is no earmarking for the health sector. As a consequence, while financial incentives to improve the effectiveness of health services have become stronger, this does not enhance accountability in terms of health service quality or health service accessibility.

4.1.4 Monitoring mechanisms for health system performance

The implementation of the KASTE programme is actively monitored through mid-term reports and a final report. For instance, KASTE 2008–2011 was evaluated based on 19 indicators. These indicators were developed by the Ministry of Social Affairs and Health based on consultations with different stakeholders, especially THL and municipalities.

The monitoring and implementation of Health 2015 is coordinated by the Advisory Board for Public Health together with the Ministry of Social Affairs and Health at national level.

However, overall health indicators and statistics have so far proven to be of limited use to assess the performance of the health system and to develop future policy decisions. This is partly due to the fact that they are developed at different levels and by different institutions without national guidelines that would determine standards and facilitate comparability.

At the national level, THL is the leading statistical authority and, as such, has a central role in national data collection and reporting. It monitors and evaluates health and social welfare, as well as related services and carries out research and development in those fields. For example, the PERformance, Effectiveness, and Costs of Treatment episodes (PERFECT) project aims at developing indicators and models that can be used to systematically monitor the effectiveness, quality and cost–effectiveness of treatment episodes in specialized medical care across regions, hospitals and population groups.

At the regional level, state administrative agencies are responsible for the oversight of services provided in their respective districts. The division of responsibilities between Valvira and regional state administrative agencies is laid down in supervision programmes.

At the local level the Health Care Act (1326/2010) stipulates that hospital districts, consortiums of municipalities, “shall provide expert consultancy and support for local authorities by organising training, by compiling health and welfare statistics, and by introducing local authorities to evidence-based operating models and best practices for preventing illnesses and problems” (80) and “shall publish information about waiting times...online at four-

monthly intervals” (Section 55 in (80)). Furthermore, the Association of Finnish Local and Regional Authorities (Kuntaliitto) produces statistics for benchmarking that can support the monitoring process.

No clear rationale connects the data collection efforts at all three levels, which makes national level evaluation problematic. Furthermore, indicators are not systematically used, neither to inform policy-making nor linked to regulations of budgets. Outcome indicators are very limited; in fact to date, outcome measurement remains non-existent for about 90% of all activities. For example, most service contracts only focus on the price rather than quality due to the lack of this type of indicator.

From a bottom-up perspective, complaints-based mechanisms have been put in place to address deficiencies. Citizens can issue complaints to the Regional State Administrative Agency or, in severe cases, to Valvira and can appeal to the administrative court. Every organization providing medical treatment must have a paid patients’ ombudsman to whom patients can refer. This complaints-based monitoring has led to some progress in addressing long waiting lists, and complaints about elderly care have raised a lot of public debate and might eventually result in policy changes.

To improve indicators and their use for evaluations and decision-making purposes, several projects have been launched to develop new sets of indicators. One example is the project “utilitas sanitas”. It is driven by the municipalities, endorsed by the Ministry of Social Affairs and Health and involves stakeholders such as THL, labour unions and associations of health professionals, NGOs, etc. The envisaged system is based on 70 indicators used in Sweden, complemented with further indicators currently being developed by all stakeholders. This project could potentially allow comparison across municipalities, and pool municipalities facing similar challenges.

4.1.5 Health system performance evaluation

THL is the principal actor mandated with performance assessment. THL currently conducts a research project on the performance, effectiveness, and costs of basic services (comprising both health and social services) and covers the same period as the second KASTE programme, i.e. 2012–2015. The study aims to develop indicators for the comparison of provider organizations and geographical regions. However, reports prepared by THL have an uncertain impact on policy-making at the national level and questionable impact at the municipal level as no systematic feedback mechanisms are in place.

The outcome of health system reviews has a limited impact on funding decisions regarding specific development projects with earmarked budget allocations within the KASTE programme: if a review reveals that problems in one area have decreased, targeted funding can be redirected.

It can be said that the performance of the health system is under continuous review through the KASTE programme. Information from various stakeholders (municipalities, private service providers, etc.) is gathered and feeds into the social and health report presented to Parliament every four years.

Evaluations are also carried out at the level of the municipalities on ad hoc basis. Most municipalities commission consulting agencies such as the Finnish Consulting Group, the Nordic Health Care Group or universities to conduct evaluation activities. For instance, at the Finnish Consulting Group, a consultancy set up by the Association of Finnish Local and Regional Authorities, a minimum of two independent experts review data received from hospitals and national registries and assess indicators, mainly by using the OECD, World Bank and WHO-developed indicator potential years of life lost, assessing avoidable premature mortality. Results are first consulted with the municipalities' administrators in charge before reports are presented to the municipal councils.

Thus, a challenge to improve accountability of the Finnish health system remains to develop and refine workable links between the national level and the municipalities, which can meet a balance between maintaining enough local level flexibility to foster responsiveness while ensuring a minimum set of standards and performance indicators across municipalities to enable centralized oversight, and ultimately, the exercise of accountability for the health system at the national level. A reform agenda, launched by the Finnish Government in March 2013, and projects aimed at developing more reliable indicators, such as the project *utilitas sanitas*, could provide good insights on how to overcome this gap by centralizing reporting, monitoring and evaluation mechanisms.

4.1.6 Current reform and impact

In March 2014, the Government decided to implement a comprehensive reform of social welfare and health care services in Finland, which seeks to address several of the challenges outlined above. The reform aims at safeguarding the provision of vital welfare services over the forthcoming decades, seeks to reflect a growing trend of urbanization and envisages a centralization of services to improve equity in service provision. All responsibilities for organizing social welfare and health care services will be shifted from the municipalities to five new social welfare and health care regions, organized around the five university hospitals.

The reform is remarkable, first, because it separates health and social care reform from the overall reform of the municipal system, and second because it could potentially lead to an actual and functioning purchaser–provider split, which has so far never been operational in Finland. Thus, the reform from a decentralized system to a relatively centralized one will likely have far-reaching impacts, not only on service provision but also on decision-making structures.

At the same time, the reform could lead to a stronger national steering mechanism that is needed for the development of performance measurement in Finland, and a national

programme may also be needed. It seems likely that funding will also be centralized in the scope of the reform, which would require further developed accountability mechanisms, ideally leading to more centralized monitoring and reporting structures.

4.2 Republic of Moldova

4.2.1 Health system overview

The introduction of primary health care in the Republic of Moldova in the late 1990s marks the beginning of a comprehensive reform process that continues until today. A mandatory health insurance system was introduced in 2004. More recently, two strategies, namely the National Health Policy 2007–2021 and the Healthcare System Development Strategy for the period 2008–2017, were set up to guide development of the sector (31–32).

In 2009, the reform process scaled up when the Republic of Moldova embarked on comprehensive reforms to promote economic development and align to EU policies. Specifically in the field of health, the Republic of Moldova expressed strong interest in aligning to the Health 2020 policy framework. And the National Public Health Strategy 2014–2020 (88) is one concrete example to have development in public health area. International partners have supported the Government in the introduction of many of the new policies, strategies and programmes.

In 2012, the Government adopted the *Moldova 2020 National Development Strategy*, an intersectoral strategy aimed at promoting socioeconomic development (86). It outlines the major constraints to economic growth and incorporates a whole-of-government approach to address the identified priority areas. It serves as the umbrella strategic planning document under which sector policy documents are to be developed. Health, however, is not among the outlined seven priority areas and only features as an intersectoral challenge, which bears the risk of blurring responsibilities and weakening political support.

In parallel to the intersectoral approach guiding *Moldova 2020*, several intersectoral programmes introduced as elements of a major health sector reform by previous governments for instance the Health Policy in 2007 and the Healthcare System Development Strategy in 2008 persist. At the time, the Republic of Moldova was very involved in the consultative process for the Tallinn Charter: Health Systems for Health and Wealth and, consequently, the health system reform was developed in the same spirit.

A shortcoming of the different strategy documents for the health sector is that parallel structures for monitoring and evaluation exist and are insufficiently linked. Currently, initial steps are being taken in order to align the strategies and national programmes. In support of this process, annual national health forums have been organized since 2012, with the support of development partners to foster policy debate among the major national and international stakeholders and decision-makers in health, inter alia, focusing on health system performance.

4.2.2 Health system accountability

Several strategies and policy documents that aim at steering health system development coexist in the Republic of Moldova. As a consequence, different governance and accountability mechanisms and monitoring structures are in place for the respective strategies, and various lines of accountability persist.

Governance and accountability mechanisms in health have not always been adjusted to the shifting priorities, reform and restructuring. The major challenge for the coming years is, thus, to find ways to better link the existing systems to enhance accountability throughout the sector, and increase efficiency and synergies to exploit the system's full potential.

4.2.3 Health system outcomes and priority-setting

Various guiding policy documents and national strategies put in place over the last years by different governments and coalitions currently exist in parallel. The overarching documents of relevance to the health sector are:

- the *Activity Programme of the Government of the Republic of Moldova 2011–2014*, outlining the political commitments of the coalition and the annual workplan for the Ministry of Health, comprising short-term actions at broad level on national public health and health care strategies and action plans, as well as institutional development strategies (87);
- the overarching *Moldova 2020 National Development Strategy*, developed in 2012 and featuring health as a cross-cutting issue (86);
- the *National Health Policy 2007–2021*, a sector-programme to promote health for all, introduced by the former Government and endorsed by all subsequent coalitions (31);
- the *Healthcare System Development Strategy for the period 2008–2017*, a sector-programme to improve public health (32);
- the *Ministry of Health Action Plan*, including priority actions by quarters of the year, responsible units and reporting practices;
- the *National Public Health Strategy 2014–2020*, an intersectoral programme approved by the Government to improve public health (88);
- almost 20 national programmes including intersectoral programmes for specific areas (e.g. immunization, reproductive health, road safety, NCDs, tobacco control, alcohol control, blood transfusion, etc.) and diseases (such as tuberculosis (TB), HIV, viral hepatitis, mental health, cardiovascular diseases, etc.) applying also whole-of-government and whole-of-society approaches; and
- institutional strategies, a relatively new feature such as the *Institutional Development Strategy of the National Health Insurance Company 2014–2018* and its updates (89).

All of these overarching policy guidelines provide for governance and accountability mechanisms of differing scope and degree of effectiveness.

Generally speaking, goal-setting and priority-setting mechanisms are well developed, and consultation processes for policy-making are very comprehensive, involving all concerned stakeholders. To improve accountability, the Ministry of Health has started to develop policies with clear aims and objectives, as well as including monitoring and evaluation elements in all policies (90).

Furthermore, policy papers developed by the Ministry of Health strictly follow the structure outlined in guidelines for policy papers drafted by the State Chancellery. These guidelines have recently been updated by the State Chancellery and will be approved once the Parliament has adopted a new law on normative acts, currently being prepared by the Government. The new guidelines detail the process, as well as the structure and requirements for policy documents, putting more emphasis on the development of indicators. For this purpose, annexes with methodologies on ex-ante impact analysis and ex-post assessment were added. This new structure will be applied coherently to all sectors and has already been piloted with some policy papers.

With regards to priority-setting for health, one drawback of the Healthcare System Development Strategy is that cooperation with other sectors is not yet institutionalized. This topic needs to be further debated, with regards to specific coordination mechanisms and the adequate level for a potential coordinating authority. Importantly, the principles identified in the Strategy are still being followed despite several changes of leadership since 2007.

Since 2009, the Government has increasingly emphasized intersectoral strategies, and there have been increased linkage of policies to development partner support. For the drafting of the *Moldova 2020 National Development Strategy*, all concerned national authorities were consistently consulted. The State Chancellery coordinated the drafting of the *Moldova 2020 National Development Strategy*, and assisted in the drafting of related sector strategies where no previous strategies were in place, e.g. for the education and transportation sectors. Feedback on sector policy papers is provided by all concerned ministries, mandatory by the Ministry of Finance and the Ministry of Justice, before documents are passed on to Government and where relevant to Parliament for approval.

The most important mechanism for policy-making and budgeting are working groups, comprised of all concerned institutions. For instance, working groups tasked with developing policies for the health sector include representatives from the Ministry of Health; the State Chancellery's Policy Coordination and Strategic Planning Division; the National Health Insurance Company (CNAM); the Ministry of Finance; the Ministry of Agriculture and Food Industry; the Ministry of Education; the Ministry of Labour, Social Protection and Family; hospitals and clinical staff; and representatives of NGOs and civil society. Working groups are coordinated by the ministry in charge and, once priorities are jointly set, presented to be included in the medium-term budgetary framework (MTBF). Policies for the health sector require approval by the Ministry of Health's Advisory Committee, which is followed by a comprehensive consultation processes with all concerned ministries and related working

groups, before the policy document is presented to the State Chancellery to be checked and prepared for approval by Government or Parliament.

The Republic of Moldova receives significant support from international development partners who, therefore, influence policies and priority-setting to a certain extent. This creates an additional layer of accountability, and in 2008, a donor council on health was introduced to improve coordination among development partners and Moldovan institutions. The donor council's regulation was strengthened in late 2013 and in the last years, the health sector councils have been chaired by the Minister of Health and a WHO Representative. To ensure transparency, contribute to development effectiveness and increase predictability, the publicly available annual foreign assistance mapping was improved in 2011 to help improve alignment of development partner support with national strategies. Donor support cycles sometimes create challenges for sustainability but are increasingly reflected in the MTBF. As a middle-income country, the Republic of Moldova is graduating from foreign assistance in the medium term and changing the modality of funding to improve the alignment with allocations from domestic resources.

A further major achievement refers to budgeting. Programme-based budgeting was introduced by the Ministry of Finance in 2012 and is already implemented by the Ministry of Health. The working groups developing policies participate in the Ministry of Finance's annual budget group where the budget is negotiated, and can this way assure that priorities for the health sector receive funding. In addition, the State Chancellery can issue recommendations for funding to the Ministry of Finance.

Priorities for national intersectoral programmes are developed in a whole-of-society approach and implementation of key programmes is coordinated through intersectoral commissions which comprised of members from the concerned ministries, NGOs and civil society and chaired by the Deputy Prime Minister responsible for social and health sectors. This approach allows for a regular exchange of opinions, settlement of competing interests of different sectors and consensus development on the division of responsibilities. Consequently, intersectoral programmes are a good mechanism at national level, and progress reports are delivered regularly. For instance, priorities for the intersectoral programme on tobacco and alcohol were discussed with all concerned stakeholders at national level, and it was subsequently decided to amend the legislation.

The implementation of intersectoral programmes faces more challenges at the district level. While the general budget for national programmes is adopted by the Government, the concerned sectors do not always contribute financially. This is especially the case where sectors join a programme at a later stage and were not involved in the priority-setting process. However, the intersectoral programmes do not provide for mechanisms to reinforce commitment, and the ministry in charge of the programme can only set the agenda.

With support from development partners, the health financing system has been reformed, and strong accountability mechanisms for policy planning have been introduced for

CNAM. A rolling five-year strategy 2014–2018 has been introduced that is reviewed annually (89).

While goal and priority setting is generally very comprehensive in the Republic of Moldova, this overview reveals that these mechanisms are not consolidated. There remains the possibility to further coordinate strategies, policies and plans including the related governance mechanisms to enhance accountability of the Moldovan health system.

4.2.4 Monitoring mechanisms for health system performance

While comprehensive processes have been established for policy-making and priority-setting, the thoroughness of monitoring mechanisms varies. On the one hand, monitoring mechanisms for sector programmes are quite developed, whereas accountability for the *Moldova 2020 National Development Strategy* seems less straightforward, lacking clear definitions of monitoring, review and evaluation and reliable data. As a consequence of the above, ensuring accountability has become a key concern of the Ministry of Health (90).

Currently, the *Moldova 2020 National Development Strategy* and the Government action programme are monitored by the State Chancellery. The Ministry of Health's Division of Policy Analysis, Monitoring and Evaluation reports quarterly and annually on actions outlined in the Government programme of activities and to some extent in the *Moldova 2020 National Development Strategy*. This feeds back into policy planning at the level of the State Chancellery. In addition, the planning, allocation of resources, monitoring and reporting on accomplished actions are performed annually (86).

To enhance coordination and monitoring of all programmes, several mechanisms have been put in place by the Ministry of Health. At the national level, annual meetings are held at the Ministry of Health during the first quarter of each year to discuss and review the progress of the past one. In addition, each minister presents the main developments and achievements made in the respective sector at an annual Government meeting.

In order to improve linkages to the local level, local authorities annually report on their progress at regional meetings, which are also attended by a representative of the Ministry of Health. In the same vein, annual reporting takes place regularly in the territorial agencies of other health institutions, e.g. CNAM.

While the structures for reporting are clearly outlined in the respective policy documents, the quality and content of delivered reports is sometimes substandard, reporting on indicators is weak and data are of low quality. The State Chancellery actually has limited track record of the reports delivered by the Ministry of Health. Communication channels between the monitoring divisions of the Ministry of Health and the State Chancellery have been established, but monitoring by the State Chancellery is limited to observing deadlines for reporting and submission of requested information.

To improve the monitoring structure in 2008, policy analysis units were set up in all ministries, and the State Chancellery recently adapted mandates regarding monitoring and evaluation. These units are tasked with the monitoring of policies, and training modules for concerned staff are provided by the Academy of Public Administration annually. Nonetheless, more training methodologies are needed to overcome deficiencies regarding statistics, information and communications technology knowledge, and the quality of reports.

Beginning in 2010, reporting mechanisms for the sector strategies were put in place and, since then, every policy document includes details on specific actions, deliverables, objectives, responsibilities and deadlines and specifies targets, output and outcome indicators. However, not all indicators have a clear methodology. As a consequence, monitoring is only based on the limited raw data received. This problem is being addressed through the revised guidelines for policy papers, which include improved descriptions of indicators and methodologies for outcome and impact indicators.

The MTBF provides for a functional planning mechanism to negotiate (with the Ministry of Finance and the whole Government) and fix the budget for periods of three years, but allowing for annual review and adaptations. It comprises detailed information on envisaged actions, allocated resources, expenditures and indicators for performance, outcomes and efficiency. In the last years, capacity building has been supported by the World Bank and WHO to ensure better linkage of financial resources and planning of individual actions (under national programmes, various institutions and regulative initiatives). In addition, national health accounts support the decision-making with regards to financial issues.

Furthermore, mechanisms for performance assessment of service providers have been put in place by CNAM. Today, contracts specify service providers' obligations, costs, reporting and normative aspects. Pay for performance in primary health care has been introduced to complement per capita payments and is based on primary health care reports, including 22 performance indicators that are evaluated quarterly and through which good performance triggers additional payments to providers. The institutional annual reporting is available since 2007, and internal accountability mechanisms are constantly improved to ensure the implementation of the corporate strategy by the central and regional branches.

To improve the available data, electronic reporting mechanisms to monitor patients' treatment were introduced in hospitals in 2014, and complemented by an electronic reporting system for drugs and prescriptions. Within CNAM, the department of control is in charge of monitoring. Where objectives are not met, sanctions apply and CNAM can lower the amount charged by service providers if agreed-upon services are not satisfactorily provided. In fact, the experience shows that each year this leads to significant reductions in costs due to underperformance by service providers.

In the Republic of Moldova, a series of treatment protocols including, for example, protocols for NCD management are linked to accreditation of facilities and to pay for performance. Calls for civil-society organizations to play a more substantial role in the monitoring and

implementation of policies by the Ministry of Health have increased as NGOs benefit from a high level of trust. For instance, in the field of TB, positive experiences have been made in the cooperation with NGOs to promote monitoring.

In order to improve accountability vis-à-vis citizens, several complaints procedures have been introduced, including a petition system and a 24/7 complaints line. The Minister of Health is informed about major complaints on a daily basis. In addition, the national health insurance agency has recently opened a free of charge line for complaints.

4.2.5 Health system performance evaluation

Performance assessments are a new mechanism in the Republic of Moldova and yet need to be fully implemented. The Ministry of Health is in charge of performance assessment of sector programmes and of national intersectoral programmes in such as those targeting TB and HIV, as well alcohol and tobacco control.

In the framework of the Healthcare System Development Strategy, it was envisaged that the Deputy Prime Minister responsible for social and health sectors initiates a mid-term evaluation of policies and programmes to develop recommendations for future programmes. However, due to the elections in the fall of 2014, the assessment was postponed.¹⁰

To date, existing mechanisms seem not sufficiently institutionalized to ensure that evaluations and performance assessments feed back into future policy-making and programme decisions. So far, adjustments of programmes and implementation plans have been limited to minor changes in legislation, but no substantial changes have been made.

A further challenge is that evaluations and reporting are in some cases carried out by the implementers themselves, thereby influencing their credibility. To improve this, the Deputy Prime Minister or any public authority could task independent specialists or audit institutions with the assessments, but existing resources allocated seem not sufficient; the Ministry of Health does not have an extra budget specifically allocated to performance assessment. Currently, the evaluation of individual strategies is supported by international organizations. For example, mid-term evaluations and reviews were carried out for the Reproductive Health Programme (2010), the HIV Programme (2011), the TB Programme (2009 and 2013), Tobacco Control Programme (2015) with assistance of WHO alone or in partnership with other organizations.

Feedback mechanisms are more functional when it comes to the financial accountability towards the Ministry of Finance. The introduction of programme-based budgeting has made budgets and spending more transparent and shifted the focus from the financing of institutions to focusing on results. Reporting on 2013 for the MTBF has recently been finalized, detailing achievements, constraints and reasons for shortcomings. This is taken into account for the planning of the upcoming years. Thus, budgets are regularly revised, and annual action plans are reviewed

¹⁰ At the moment of publishing this report, it is acknowledged that the new Government since 2015 has omitted the position while dialogue on the further inter-sectorial governance mechanisms on individual health programmes is being launched.

annually and adjusted if needed. A persisting weakness regarding budgeting is that where plausible arguments for shortcomings are provided, no penalties or reductions are to be expected.

Performance assessments are more established with regards to intersectoral programmes. These programmes usually cover a period of five years and comprise action programmes outlining concrete actions, as well as monitoring and evaluation of indicators and targets. Frequently, the institutions responsible for development of diseases specific programmes are responsible for their evaluation. For instance, the Institute of Physiopneumology is in charge of evaluation and performance assessments of the national programmes for TB, and the Hospital of Dermatology and Communicable Diseases assesses HIV interventions. Assessments are informed by field visits of staff of the institute in charge of TB, and results feed into the planning of future programmes. Joint assessments are also performed. A mid-term evaluation of the TB programme to identify deficiencies was conducted in 2013 by WHO together with local experts. Disease-specific programme performance evaluations are the responsibility of each health institution, which leads to challenges in exercising accountability at the national level.

The funding for performance evaluation is a major challenge for intersectoral programmes as there are no clear responsibilities and no extra funds provided. As a consequence, most institutions in charge of intersectoral programmes face insufficient capacities and resources to conduct proper evaluations of policies. For instance, the institute in charge of steering and coordinating the national TB programme (Institute of Physiopneumology) is a clinical institution and only receives funds from CNAM for service provision, not technically for monitoring and evaluation activities. In addition, funding for intersectoral programmes is subject to the contributing sectors and do not feature as independent items in the MTBF. As a result, intersectoral programmes are constantly underfunded and lack mechanisms for performance-based budgeting.

4.2.6 Current reform and impact

Currently, the Republic of Moldova is undergoing a public administration reform that envisages, inter alia, enlarging the strategic planning department to include specialized divisions for policy analysis, monitoring and evaluation. While no extra resources will be made available for the implementation of the structure, it is expected to increase efficiencies and help monitoring, which will eventually result in reductions of cost in the future.

At a more systemic level, it appears to be evident that lack of continuity and, moreover, a superimposition of new policies and plans over pre-existing ones has led to a situation where it is very difficult to point to a main overarching set of outcomes for the health system as a whole and what would be their supporting sets of indicators and evaluation strategies. Rather, what prevails is a multiplicity of parallel and sometimes overlapping policy, reporting and evaluation mechanisms. It would, therefore, be desirable for future reform initiatives to focus on programme and policy consolidation, adapting data collection criteria to be in

line with major policy outcomes, and developing processes and institutional frameworks for performance evaluation and evidence-based revisions to existing plans and policies.

4.3 Turkey

4.3.1 Health system overview

Since 2003, Turkey embarked on a comprehensive reform programme in the health sector, HTP, which aimed at improving governance, efficiency and quality across the health system, facilitated by the renewal of outcomes for the sector. Ten years later, the Turkish health system has recorded significant improvements in key outcomes such as maternal and child mortality indicators, enhanced responsiveness reflected in increased general satisfaction with the provision of health services, and optimized utilization of services enabled in part by a major investment made in human resources (91).¹¹

Overall, the Turkish health system remains centralized and typified by directive control from the Ministry of Health. Similar to other Turkish ministries, the Ministry of Health is represented in the 81 provinces by governors appointed by the central Government. However, this situation has begun to change, responding to increasing evidence on the effectiveness of governance arrangements that allow regions greater flexibility to assess and respond to local health needs (92). HTP has catalysed the first steps towards strengthening provinces by establishing public health departments in addition to the existing hospitals departments under the Provincial Directorate for Health. This new structure has reportedly increased efficiency and effectiveness, and has helped to facilitate the conduct of national surveys.

4.3.2 Health system accountability

The structural changes introduced between 2003 and 2011 enabled the separation of the stewardship, financing and service provision functions within the Turkish health system. The creation of new divisions reinforced the Ministry of Health's stewardship role regarding policy and strategy development, intelligence, oversight of accountability and intersectoral coordination (93).

In 2011, a HSPA was carried out to measure the achievements of the HTP (94). The Turkish School of Public Health was in charge of coordinating national and international public health work on behalf of the Ministry of Health and took the technical lead.

4.3.3 Health system outcomes and priority-setting

The Turkish Constitution is the fundamental legal basis articulating a public mandate in the definition of health sector priorities in Turkey. Specifically, the overarching responsibility for

¹¹ The human resources financial allocations rose by an estimated 84.5% throughout the period although total health expenditures, as a percentage of gross domestic product, increased by only 0.6%.

exercising the stewardship role over the health system lies with the Ministry of Health, as established under Article 2(2) of Statutory Decree No. 663 on the Organization and Duties of the Ministry of Health and Affiliated Agencies, which states that “the Ministry manages the health system and identifies the policies” (95).

Therefore, within the scope of the overarching priorities defined by the Government, the Ministry of Health has the main decision-making power for the health sector and is responsible for setting health sector priorities and implementing the related initiatives. New policy proposals are also developed by the Ministry of Health through a Health Policy Advisory Board formed by all the undersecretaries of the Ministry of Health that analyses current operations and makes recommendations to the Minister.

In line with these provisions, five-year strategic plans outline health sector priorities. Strategic planning of policies is an important management tool and is mandatory across all sectors in Turkey. Strategic plans serve as basis for developing the annual operational plans for each sector (36). The first strategic plan for the health sector covered 2010–2014 (35). It was reviewed in 2012 to ensure consistency with the national development plan, policy papers, the Ministry of Health’s strategy and health system needs. The current second Strategic Plan covers 2013–2017 (37). It is aligned to the national development plan, the new organizational structure of the Ministry of Health and international health commitments. The Strategic Plan is a practical document, defining clear objectives revised annually. It is complemented with mechanisms to facilitate performance-based budgeting (36).

Priorities for the health sector are set taking into account previous performance on major health objectives, national trends and the state of population health, but are also informed by discussions with the EU and other international partners.

Additionally, as previously mentioned, the HTP has introduced and rolled out a comprehensive sector-wide reform programme.

Within the Ministry of Health, a clear definition of roles and responsibilities further work to operationalize and streamline the process of goal setting for the health system. For instance, national health policies are developed by the strategic planning department of the Ministry of Health through an inclusive process that includes consultation with all concerned stakeholders (e.g. private and public sector, NGOs, unions, regions). Senior management and undersecretaries in the Ministry are, on their part, responsible for development of sector documents and policies. Finally, cooperation between units is institutionalized with weekly meetings of heads of units together with the undersecretary to present activities and planned activities.

Increasingly, measures are being taken to involve other actors in the definition of health outcomes and policies. Whole-of-government and cross-sector approaches are used to address challenges such as tobacco use and to control zoonotic, vector borne and parasitic diseases, in joint efforts with the Ministry of Food, Agriculture and Livestock. Although no

institutionalized participatory processes exist, attempts have been made at involving NGOs in designing, implementing, monitoring and evaluating health sector programmes.

4.3.4 Monitoring mechanisms for health system performance

Restructuring the Ministry of Health and reorganizing the function of units and affiliates has enhanced the Ministry of Health's monitoring and evaluation capacity. Individual units report every three months on objectives of the Strategic Plan. In addition, it is a legal requirement for all ministries to report to the treasury and the Ministry of Finance every three months on the use of funds. With the HTP, health service related operational and supervisory roles have also been delegated to new quasi-public agencies charged to oversee delivery of public health and personal health services, and the pharmaceutical and medical devices sectors (93).

More specifically, the Strategic Plan comprises a monitoring and evaluation scheme with yearly performance measurement including performance targets, indicators and activities relevant to the implementation of the plan. The Strategic Plan 2013–2017 sets out several mechanisms for monitoring and evaluation, namely:

- annual progress reports to develop a performance programme and an activity report
- HSPAs to be introduced by 2017
- annual activity reports
- an interim report to be issued in mid-2015
- a final report to be prepared in 2018
- special reports on specific outcomes (37).

Progress on the outcomes and targets set out in the Strategic Plan is monitored by the strategic planning department of the Ministry of Health (36).

Performance indicators set out in the Strategic Plan comprise a description of the current situation, objectives, and achievements. While this includes detailed indicators such as measures of implementation success by units, there remains a need to develop and institutionalize ways to make more use of this data for concrete policy development.

Overall, two sets of indicators can be distinguished. A first one comprises indicators set in line with international standards, which are set in cooperation with international partners and in line with international guidelines. These indicators are developed with support from the statistics department and are assessed jointly by the Ministry of Finance, the Ministry of Development and the Social Security Institution. The second set of indicators are determined on the basis of domestic criteria and are reported on by the Ministry of Health's units that receive training to ensure a common understanding of indicators. Furthermore, a routine-notifications system has been set up that directly informs indicators. New software is being tested to further facilitate monitoring of the Strategic Plan, which will allow for automatic reporting.

For the preparations of the first HSPA, stakeholder meetings involving about 60 participants from different sectors and high-level meetings at the Ministry were held. Supported by international partners, decisions on the strategy map, indicator selection and scoring were made by consensus at high-level meetings. Indicators for the strategic map were identified and revised in 2009, and a final version was approved in January 2010. The 282 initial indicators were drawn from the Strategic Plan and from international health performance indicators. The list was gradually reduced to 62 performance indicators, clustered in nine performance dimensions, on the basis of availability, reliability and validity of the data underlying the indicators.

A major challenge regarding monitoring is the availability and quality of data. For the HSPA, detailed descriptions of indicators were developed, including data collection methods, data quality improvements, data interpretation and presentation of findings. A major challenge has been that health data could not be fully disaggregated, and information collected in different parts of the system could not be fully exploited due to severe challenges in terms of comparability and variability in stakeholders' willingness to share data. To address these issues, the HSPA process has been designed to be highly participatory and decentralized, empowering all stakeholders to participate in indicator selection and definition, data analysis, sharing of additional analytical material and identification of relevant policy actions. National data were complemented with available international data. For the 2011 HSPA, the Turkish School of Public Health collated all data, placed it within a systematic health system framework and then reported against the framework.

The Ministry of Health has further attempted to improve the quality and facilitate the sharing of data by introducing Health Net, a system that allows country wide sharing of electronic health records of citizens between institutions through standardized coding systems. Nonetheless, a recent OECD review found that greater effort is needed to increase the robustness of Turkey's information systems at national level, and to harmonize performance measures to OECD and other international comparators (92).

Even though quality indicators have not as yet been integrated into the HSPA, there is an expressed intention to include them into forthcoming iterations of the HSPA framework. As an initial step for the measurement of quality of care, service quality standards for private hospitals have been developed. Initially, this set of standards comprised 100 items that were piloted in 24 hospitals of different types in different sectors and different provinces. In 2007 and 2009, the set of standards was reviewed and now includes 354 standards and 900 subcomponents. A coding system aligned standards with the aim of establishing a statistical recording system.

With regards to financial accountability, a Commission for Monitoring and Evaluation of Health Expenditures has been set up, comprised of the Undersecretary of the Treasury, the Ministry of Finance, the Ministry of Development, the Ministry of Health, and the Ministry of Labour and Social Security. This Commission takes on systematic monitoring and evaluation of the level and execution of health expenditures and facilitates developing the necessary

strategies on the issue. Also it is worth noting that while separate budgets are allocated for internal audit, this is not the case for performance assessment and monitoring measures.

Additionally, a medium-term expenditure framework, internal controls and a performance-based budget system were put in place by the Ministry of Finance to improve financial accountability in the health sector. In addition, a division of internal audit controls monitors processes and whether expenditures are in line with planning. A further mechanism is the Ministry of Finance's e-accounting system Say2000i introduced in 2001.

Vertical and horizontal reporting of data takes places within and across institutions in the Turkish public sector. Ministry of Health units report to the Court of Accounts on a monthly basis. And in turn the Ministry itself reports to the Planning and Budget Commission of Parliament,¹² which receives information on activities, indicators and performance of the health sector.

4.3.5 Health system performance evaluation

A key evaluation instrument for the Turkish health sector is the assessment reports of the HTP that compare the state of health system before and after the reform, and take stock of the reform's policy impact. This tool was complemented by the 2011 HSPA that sought to assess the overall performance of the health system.

In order to ensure consistency, the development of the HSPA framework was guided by the outcomes and priorities of the HTP and the Strategic Plan 2010–2014. These outcomes and priorities were transformed into measurable health sector objectives and organized on a strategy map, encompassing resources, services, outputs and impact on health determinants and health status (36). In return, findings and results of the HSPA informed priority setting for the new Strategic Plan 2013–2017, and identified weaknesses were set as new objectives. Thus, the HSPA's objectives were to provide a comprehensive monitoring and evaluation scheme of the HTP focusing on aspects such as productivity, financial protection, and responsiveness, improve sector transparency and accountability, and develop evidence to inform policy-making.

It is noteworthy that this first HSPA has benefited from institutional support at the highest level, which allowed bringing together all concerned stakeholders. The idea behind this participatory approach was to develop a culture of evaluation throughout the Ministry of Health. It was also expected that this would influence the development of the monitoring and evaluation scheme in the following Strategic Plan, and would gain momentum as an integral part of the Government's health reform and planning programmes.

In addition to these overarching evaluations, other assessments take place. Hospitals are evaluated based on health service access, service infrastructure, process assessment, patient satisfaction measurement and analysis of targeted performance (institutional performance and quality development study).

12 The Commission comprises 25 members of the governing party, as well as 15 members of the opposition party.

4.3.6 Future development of the accountability framework

The Turkish health system has set in place distinct mechanisms and programmes that can be associated with each of the three dimensions for exercising accountability of a health system. First, five-year strategic sector plans in combination with an overarching reform scheme – the HTP – set overarching *outcomes* for the health system. Second, two sets of indicators, one developed internally and another in consultation with international partners, set parameters for data collection on a multiplicity of performance dimensions of the health system (*performance measurement*). The third dimension, *performance review*, is the assessment reports of the HTP. Additionally, a HSPA took place in 2011 (36).

Further measures to strengthen the ability to exercise accountability of the health system can be envisioned. Several steps could be taken to improve the effectiveness of the HSPA, especially given that the Strategic Plan 2013–2017 (subsection 4.2.2) stipulates that, by 2017, the HSPA shall be institutionalized and conducted on an annual basis (37). To ensure the success of future HSPAs, it would be important to continue to stress the linkages with the health system outcomes set in the five-year strategic plans.

Measures could also be taken to improve the infrastructure for data and information sharing. The current performance monitoring frameworks tend to emphasize aspects related to auditing, and could be strengthened by adding a strategic dimensions that explicitly link the goal setting and the evaluation of the health system.

Furthermore, processes and activities should be streamlined and standardized to minimize human and financial resources required. An additional challenge is that new capacity building would be required due to the new structures throughout the sector and the departments' new mandates.

Given the intense long process that a HSPA requires for completion, consideration may also be given to a lower frequency for its implementation; e.g. every five years.

The 2011 HSPA has shown that high-level support is necessary to facilitate a system level performance assessment. While political commitment is always an important enabling element to ensure continuity and congruence in exercising the stewardship function, independence, objectivity and transparency could also be enhanced if an independent agency for accountability and responsiveness were to be commissioned to carry out the assessment.

Given the provincial variations, an HSPA at subnational or provincial level has been largely discussed to address concerns related to equity. A new HSPA should also consider a larger perspective of intersectoral actions to acknowledge the efforts carried out by Turkey to provide a comprehensive package of services including promotion and prevention while tackling the social determinants of health.

Finally, mention should be made that the accountability mechanisms described above are not exhaustive of the initiatives that have been undertaken by Turkey to improve on the exercise

of this key governance dimension. Since 2003, for example, other legislation and institutional mechanisms have been introduced with the intention of strengthening accountability in relation to citizens' right to health insurance and health services. Such measures have been introduced to improve direct accountability of health service providers (93). The directive on patients' rights has stipulated the quality, responsiveness and availability of health services and was complemented in 2004 with the free choice of physician. In addition, a complaints hotline – managed through the Turkish Prime Contact Centre (BIMER) communication system and the Ministry of Health's Communication Centre (SABIM) – has been introduced by the Ministry of Health to identify problems and receive feedback from system users.

Although a recent OECD review recommended to further standardise procedures and more precisely monitor the quality of care, (92) already results are proving to be positive as annual patient satisfaction surveys have shown an increase in patient satisfaction from 39.5% in 2003 to 75.9% in 2011.

5. Health system accountability: challenges and opportunities for strengthening performance

This chapter seeks to identify and reflect on some of the key challenges to developing effective health system accountability mechanisms with the intention of providing insights that may be of use in moving forward with the commitment to make health systems increasingly accountable.

For purposes of analytical clarity, this report has adopted a conceptual framework for the categorization of accountability arrangements that identifies three core dimensions: goal setting, performance measurement and performance review. Needless to say, the challenges involved in developing institutionalized health system accountability arrangements involve not only establishing mechanisms and procedures to operationalize each of those three dimensions, but also developing institutional mechanisms to connect them to one another.

Thus, in the big picture, the overarching process of exercising health system accountability involves a series of interconnected activities: setting outcomes, developing adequate indicators to measure progress on the stated outcomes, collecting the data reflecting health systems performance, analysing and evaluating the data in the light of the stated outcomes, evidence-based subsequent decision-making on goal setting, and disseminating the information obtained in a transparent manner. For this process to be effective, each of the three identified components needs to be conceived of and articulated in a manner that is consistent and reinforcing of the others, and established mechanisms enabling information flows back and forth among relevant actors and stakeholders must exist.

As laid out in the Tallinn Charter: Health Systems for Health and Wealth “improving performance demands a coherent approach involving coordinated action on multiple system functions” (see Article 1 (1)). Health 2020 poses a further challenge to accountability by explicitly expanding the scope of the governance function to health and well-being. Indeed, new policy developments are broadened from traditional approaches on disadvantaged groups to addressing social determinants of health, from a healthy start in life to life-course approach, from financial protection to universal health coverage and, among others, from structural interventions to improving environment and building resilient communities with an increasing numbers of countries setting targets at the subnational levels to better capture and tackle inequities (96).

Consequently, it is clear that a commitment to enhance health system accountability generates significant demands and challenges, some of which are of a technical nature, for instance, accurate performance measurement, and some others of a more purely governance nature, for instance, generating coordination and collaboration across diverse groups of institutions and stakeholders. It should also be underscored that devising and rolling out mechanisms and protocols aimed at introducing greater health system accountability is, in many countries, a relatively recent endeavour. Therefore, in this section, are some of the

challenges involved during the process associated with developing and institutionalizing accountability mechanisms.

One of the most significant technical challenges involved in developing effective accountability mechanisms in health systems is translating health systems outcomes into measurable indicators that are both valid and reliable. This is a key factor since accurate information on the relevant dimensions of health, well-being, social determinants and health care are essential for both evidence-based goal setting, as well as evaluation and ultimately to improve the overall equity and responsiveness of health systems as Member States committed to in the Tallinn Charter and in Health 2020. Challenges for national target-setting are well-acknowledged in the context of Health 2020 with a low number of countries reporting targets defined (96).

However, while in an ideal scenario, the definition of indicators for performance monitoring would follow directly and consistently from the system's overarching outcomes. In reality, decision-makers are confronted with information systems that are already compiling vast numbers of indicators on a wide spectrum of health-related issues, which may or may not provide accurate information on the specific areas that need to be monitored. Introducing new indicators to be compiled may not be cost effective and, therefore, a first question that arises involves making the best use of already available information.

There are also misconceptions about how performance can be measured or compared. A recent volume on health system performance comparisons by the European Observatory on Health Systems and Policies highlights some data-related challenges such as availability and comparability of performance information, concerns over single number measures of whole system performance, and focus on performance indicators irrelevant for the policy context (97). On this complex dimensions, the Tallinn Charter commitment to strengthen cross-country learning could be a mechanism to strengthen information systems and data collection strategies of Member States, based on a constructive process of learning from each other's experiences both positive and negative.

Another element to take into account is that sustaining the commitment to national health strategies, health systems performance measuring and health system reviews can be challenging when frequent changes of government bring about changes in political priorities. Similarly, sustainability of accountability mechanisms may be compromised as a result of difficult budget allocation decisions brought about in a context of economic and financial crisis. Nonetheless, some countries have managed to maintain stability with regards to policy objectives. For instance, in the Republic of Moldova, commitment to the objectives set out in the health strategy adopted in 2007 were sustained in spite of several governmental changes and the impact of the financial crisis (90). In the same vein, in Turkey the comprehensive HTP (2003–2011) has been largely facilitated by governmental continuity.

An additional challenge involved in improving the health system accountability has to do with the ability of the health system steward to coordinate activities and information flows among the relevant stakeholders and actors across sectors and administrative levels.

For example, measurement of some health outcomes among the population may already be undertaken by agencies in non-health sectors or may be the responsibility of decentralized levels of government. Following up on the commitment expressed in the Tallinn Charter and reinforced by the Health 2020 policy framework, to engage stakeholders in this sense should be enabled and complemented with building clear mechanisms of communication, and developing collaborative networks with other relevant actors as a key component to developing efficient performance measurement frameworks. This, in turn, would facilitate capturing the most accurate data available and avoiding duplication of functions, therefore, also contributing to an efficient use of resources, another of the commitments expressed in the Tallinn Charter.

However, engagement and coordination of a broad range of stakeholders may be especially challenging the more decentralized the health system is. One extreme example is Bosnia and Herzegovina, where health system decentralization poses significant challenges to performance strengthening as it requires a multitude of administrative small units to deploy their own monitoring and assessment schemes, making it organizationally more complex and arguably more expensive. Another example is Finland where, as the in-depth case study has shown, health sector priority setting, monitoring and review are largely driven by the decentralized structure of the health system, resulting in wide differences between municipalities. A far-reaching reform announced by the Finnish Government in March 2014 seeks to address this challenge by centralizing decision-making structures and developing a stronger national steering mechanism.

Still, bringing in the perspectives, concerns and opinions of different groups in the communities remains critical, as this is needed to develop a more responsive approach to goal setting for the health system and to create a sense of ownership that is a significant factor, enabling the generation of a demand for accountability. Bringing in the voices of less influential, even marginalized groups is, therefore, an ongoing challenge in need of attention since these groups are especially vulnerable to a variety of health risks and conditions and have the least ability to articulate their voice through mainstream mechanisms available to the general public. Thus, developing mechanisms that foster more representative and meaningful consultation is critical in order to improve accountability vis-à-vis all groups in society and to reduce health inequities.

Furthermore, making the processes associated with goal setting and performance evaluation more participatory and transparent, as well as making the information generated by the assessments easily available to the general public can go a long way in promoting overall good governance and improved health system performance. For instance, the Republic of Moldova provides an example of how a whole-of-society approach has been applied to develop policies for specific health challenges, and Turkey has successfully implemented a whole-of-society-approach in the set-up of the HTP.

Finally, it is clear that the process of institutionalizing new processes and protocols aimed at improving health system accountability involves much more than simply specifying new

mandates and enacting legal and regulatory frameworks. Institutionalization also requires investing in capacity building and attention to demand generation in order to promote sustainability. Therefore, the efforts to strengthen health system accountability must be reinforced with strategies to provide incentives not only to adopt new collaborations among officials across institutions and sectors, but also to retain the human capital that acquires the necessary expertise to carry out the technical functions associated with effective performance measuring and review.

In sum, the Tallinn Charter and Health 2020 policy framework set out a series of commitments towards which Member States have pledged to work, and which are mutually reinforcing. Mainly, these two milestones have created a momentum for strengthening health system accountability, and Member States have responded by scaling up their uptake. What this potentially means, in practice, is that some challenges in developing effective health system accountability mechanisms can actually be harnessed as opportunities to develop and strengthen holistically the shared goal of moving from values to action, and developing health systems that realize the highest attainable standard of health as a fundamental and inalienable human right.

6. Conclusions

Overall, countries in the WHO European Region have undertaken many efforts in strengthening health system accountability since the adoption of the Tallinn Charter: Health Systems for Health and Wealth in 2008, boosted later by the endorsement of the Health 2020 policy framework in 2012. They have done so in various ways. These conclusions are in line with the findings of an ad hoc Member States self-reported survey (96).

This study mainly focused on three aspects related to strengthening health system accountability: setting outcomes; performance measuring through sets of indicators; and reviewing health systems performance.

As documented in this report, much work has been devoted to the development of NHPSs or health targets with at least 35 of the European countries out of the 43 with NHPS having adopted new strategies or updating or renewing existing ones since 2008 and further intensified after the adoption of Health 2020 in 2012. Several countries have explicitly focused on areas key to the Health 2020 policy framework, for instance, health inequalities and intersectoral governance approaches to health. Furthermore, a number of Member States are developing overarching national strategies for health as a whole-of-government responsibility, rather than strategies for the health sector. This raises new challenges when it comes to monitoring health system's performance – as the scope of what could be considered to fall under the definition of the health system becomes broader.

While some countries are using their NHSPs as the standard and blueprint to monitor health system performance, others have developed separate indicator packages based on different criteria. Overall, 32 countries that undertake regular monitoring based on a health system indicator package were identified. The number of indicators varies from around 26 up to 1000, with the majority of countries monitoring around 100 health system indicators.

In terms of health system performance reviews, the report identified at least 18 countries that, in some form or another, undertake such system-wide reviews, including those undertaken in many cases as an ex-post exercise.

The diversity of approaches, methodologies and tools documented here should undoubtedly be understood in light of the different social, economic, and institutional contexts prevailing across the Region. The experiences of three countries – Finland, the Republic of Moldova and Turkey – furthermore complement the cross-national study by illustrating in more detail some of the challenges involved in developing effective accountability mechanisms for complex, real world health systems.

Turkey is an illustrative example of a country where the health system has traditionally been characterized by a significant centralization of decision-making, and where efforts are being put into place to devolve greater decision-making faculties to the regional and

local levels. Finland, in contrast, represents a case where the health system has been notably decentralized, and where efforts to unify approaches and standardize processes are entailing the centralization of some key decision-making spheres. These two country experiences are indicative of one of the most important trade-offs that health system stewards confront when developing strategies to improve performance, and which refers to attaining an optimal balance between centralization – to facilitate system-wide exercise of the stewardship function – and decentralization – to allow enough adaptability to regional variations to preserve adequate responsiveness to local needs.

The case of the Republic of Moldova highlights the experience of many countries that have undergone rapid processes of socioeconomic and political transitions, where systemic change is often reflected at the sectorial level in a succession of programmes and approaches emphasizing different priority areas, policy instruments and strategies. In such contexts, consolidating a unifying direction for the health system with distinct and prioritized objectives and outcomes involves not only the agency of a committed steward but also the alignment of existing institutional frameworks to allow for effective governance, including appropriate instruments to exercise accountability of the health system.

Taken together, the evidence gathered across the WHO European Region since the adoption of the Tallinn Charter and the Health 2020 policy framework strongly suggests that making health systems more accountable, although an undoubtedly complex task, is nevertheless feasible and that already meaningful progress can be observed. The evidence also highlights that there is not a single approach that can be equally effective across national contexts but, rather, that health system stewards must take into account first and foremost the precise and unique circumstances prevailing in their countries while making sensible and informed use of international tools and best practices for strengthening health system accountability and ultimately performance.

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Annex 1. Multi-country analysis: interview questions

A set of questions was defined for each of the three components for interviews with the country officer in countries with a WHO country office.

1. Outcomes

- Does your country have defined outcomes for the national health system?
- Are these defined through a national health strategy/plan?
- Do you use another type of health system performance framework?
- Do the outcomes broadly cover health system goals (health, financial protection and responsiveness) and the main functions of the system (service delivery, resource generation, health financing, and governance)?
- Can you very briefly describe the process used for defining outcomes in a short paragraph?
- Is the definition of outcomes for the health system a regular part of policy work in your country?
- Are the outcomes actively used to guide work in the health system? Can you give an example?

2. Health system monitoring or performance framework

- Has a health system monitoring/performance framework including a defined set of indicators for the health system been defined in your country? By whom?
- Is a health system or performance framework drawn from a NHP or some other overarching policy document? If so which?
- Which broad categories does the framework cover?
- Do the indicators map broadly to main health system outcomes and functions as defined in The World Health Report 2000 WHO framework.¹⁴
- Is it used regularly? By whom?

3. Reviews and systems of HSPA

- Has a review of the health system/the health sector or the NHP/strategy taken place in the past five years?
- Can you broadly describe the process in a short paragraph/interview?
- Which type of actors is involved in your health system review and at which stages?
- Does the outcome of the health system review influence funding, priority setting for policies or programmes?
- Does your country regularly review and report on health system performance?

¹⁴ The world health report 2000. Health systems: improving performance. Geneva: World Health Organization; 2000 (<http://www.who.int/whr/2000/en/>, accessed 30 March 2015).

Annex 2. In-depth case studies: interview questions

General questions on accountability in health systems

Who is most clearly identified as the health sector steward in your country? In other words, who is overall responsible for health systems performance at the national level?

Can you describe the overall health law framework that regulates the application of health system performance? For example, is the right to health established in the constitution?

Health systems outcomes and priority setting

Who is in charge of defining the overall health systems priorities and outcomes?

How are the main tasks associated with defining health systems priorities and outcomes delegated? (e.g. within the health ministry, subordinate institutions or to other public/or actors representing public interest)

On the basis of what criteria are those priorities and outcomes determined?

In which document(s) are those priorities and outcomes stated?

Can you very briefly describe the process used for defining outcomes in a short paragraph?

Is the definition of outcomes for the health system a regular part of policy work in your country?

How often are they updated?

Are the resources allocated to the responsible agency (agencies) for the purpose of defining health systems priorities and outcomes commensurate to the mandate?

If not, explain in which manner resource constraints impact performance.

Generally speaking, how are the outcomes used to guide work in the health system? Can you give an example?

Please briefly summarize which, in your opinion, are the strongest and the weakest areas that can be identified in the process of priority and goal setting for the health systems in your country.

Have there been any substantive reforms to the priority and goal setting process in the past five years? If so please describe.

Monitoring mechanisms for health systems performance

Has a health system monitoring/performance framework including a defined set of indicators for the health systems been defined in your country?

Who is tasked with the development of the monitoring framework? (Involving decisions regarding the relevant areas/dimensions to be monitored)

Who defines the indicators?

Who collects and aggregates the information?

Which broad categories does the framework cover?

Is a health system or performance framework drawn from a NHP or some other overarching policy document? If so which?

Are the resources allocated to the responsible agency (agencies) for the purpose of developing and implementing a performance monitoring mechanism for the health systems commensurate to the mandate?

If not, explain in which manner resource constraints impact performance.

Is the information generated by the performance framework used regularly? By whom? Who has access to the monitoring indicators?

Please briefly summarize which, in your opinion, are the strongest and the weakest areas that can be identified in the process of developing and applying a performance monitoring mechanism for the health systems in your country.

Have there been any substantive reforms to the health system's performance monitoring process in the past five years? If so please describe.

HSPA

Does your country regularly review and report on health system performance?

Has a review of the health system/sector or the NHP/strategy taken place in the past five years?

Can you broadly describe the process in a short paragraph/interview?

How are the main tasks associated with assessing health systems performance distributed?

Which actors are involved in the health system review and at which stages?

Are the stakeholder meetings and activities associated with the health systems performance assessment regularly and predictably scheduled?

Are there established mechanisms enabling communication and transmission of data among the relevant stakeholders involved in the assessment?

Are the resources allocated to the responsible agency (agencies) for the purpose of conducting a performance assessment of the health systems commensurate to the mandate?

If not, explain in which manner resource constraints impact performance.

Does the outcome of the health systems review influence subsequent funding decisions in any way?

Does the outcome of the health systems review influence subsequent priority setting for policies or programmes?

Does the outcome of the health systems review feed into the process of developing institutional reforms of the health sector?

Please briefly summarize which, in your opinion, are the strongest and the weakest areas that can be identified in the process of conducting a performance assessment for the health systems in your country.

Have there been any substantive reforms to the health system's performance assessment process in the past five years? If so please describe.

Annex 3. List of key informants

List of interviewees in Finland

Jutta Järvelin, Senior Researcher, Centre for Health and Social Economics (CHESS), National Institute for Health and Welfare (THL)

Toomas Kotkas, Professor of Jurisprudence and Social Law, Head of Doctoral Programme in Law, University of Eastern Finland

Juhani Lehto, Professor, University of Tampere, School of Health Sciences

Mikko Vienonen, Senior Advisor Public Health, FCG Consulting Ltd

Ilkka Vohlonen, Research Director, Welfare Consulting Services, FCG Consulting Ltd

List of interviewees in the Republic of Moldova

Angela Ciobanu, Public Health Officer, WHO Country Office, Republic of Moldova

Denis Valac, Head of Budget Division, Ministry of Health

Ion Gumene, Head of Policy Coordination and Strategic Planning Division, State Chancellery

Jarno Habicht, WHO Representative, World Health Organization

Liliana Domete, National TB Programme Manager, Institute of Physiopneumology “Chiril Draganiuc”

Marcela Tirdea, Head of Division of Policies Analysis, Monitoring and Evaluation, Ministry of Health

Mircea Buga, Director General, National Health Insurance Company (CNAM)

Oleg Barba, Adviser to the Deputy Prime Minister of Labour, Social Protection and Family, State Chancellery

Svetlana Cotelea, Deputy Minister of Public Health, Ministry of Health

List of interviewees in Turkey

Ahmet Korkut, Internal Control and Analysis Department, Ministry of Health

Banu Ayar, Head of Department, General Directorate of Health Research, Ministry of Health

Hakan Aksu, Deputy President, Department of Strategic Management and Planning, Ministry of Health

Hasan Gökhan Öncül, Head of Department, Department of Strategic Management and Planning, Ministry of Health

Sarbani Chakraborty, Consultant, Former Regional Sector Director, World Bank

Songül Doğan, Head of Department, General Directorate of Health Research, Ministry of Health

Volkan Çetinkaya, Minister’s Consultant, General Directorate of Health Research

Y. Mehmet Kontas, Deputy Head of Country Office, WHO Country Office, Turkey

The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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