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Editorial: **Improving the performance of health systems: the World Health Report as go-between for scientific evidence and ideological discourse**

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Many rich countries rank high on WHO's health system performance indices (WHO 2000). Should low-ranking developing countries appoint ministers of health that exert stronger stewardship? Or should they import the disparate mix of service delivery, input production and financing tactics that prevail in the 'better' performing nations? A look at the World Health Report 2000 reveals that it provides no recommendation whatsoever for fierce head-hunting and disappointingly little evidence for the policy shifts it does recommend – albeit hesitatingly or tacitly.

The Report sets out to measure and compare health system attainments and performances, and to gain an understanding of factors that make a difference. Its attainment index weights five dimensions: average level (25%) and equality or distribution (25%) of health in a country, average level (12.5%) and distribution (12.5%) of health system responsiveness, and fairness in financial contributions (25%). A remarkable effort has been made to define for these concepts derived variables that are empirically measurable, to collate scarcely available information and, at times, to collect new data. WHO experts may share the belief that these complex measurements constitute a non-trivial profile for the underlying concepts, but their validity and reliability can be questioned – and caveats can be found in the Report's small print and technical annexes.

The validity of the constructed variables as such is the first matter of concern. To start with, disability-adjusted life expectancy is used to assess the average level of health in a population. This measure is closely related to disability-adjusted life years (DALYs), whose calculation and use for transregional comparisons have both been criticised (Cooper *et al*. 1998; Wiseman & Mooney 1998). It is also blatantly reductionist with respect to WHO's never-revoked definition of health as 'a state of complete physical, mental and social well-being and not merely the absence of disease'. Equality in health level distribution is subsequently, for lack of other data, calculated on the basis of available or estimated child mortality information only. As a result, high-income developed countries necessarily score highly, whereas substantial intra-country inequalities in adult mortality and morbidity that exist in some rich nations fall by the wayside. Next, the construct-measuring health system responsiveness, i.e. the capacity to meet a population's expectations, excludes attributes such as accessibility of services. Access is very important in its own right (Fein 1972), independently of professionally defined outcome of use. It remains to be secured in a number of developed and developing countries alike. Furthermore, however important 'client orientation' may be, an assessment of responsiveness on attributes that only apply to users of services biases the picture. The measure of fairness of financial contributions is based on the premise that fairness is perfect when the ratio of total spending on health to total non-food spending is the same for all households. In other words, it is judged unfair that the better-off should contribute more. Such a view has been widely challenged for being inequitable (Stefanini 1999). Estimating what people would have spent if they could afford to respond to their health needs would also reveal unfairness (WHO 2000), certainly for particular forms of financing.

Secondly, the data for constructing the derived variables that measure the five dimensions selected for evaluating health service attainment are unreliable or unavailable for the vast majority of member states, developing countries in particular. Estimates had to be derived using indirect techniques plus information on covariates of each variable of interest. No further details are provided in the Report, but interested methodologists will undoubtedly dig up all referenced internal WHO discussion papers and may come up with minute critiques and propose refinements in technical journals. Other stakeholders, particularly health policy makers, are left wondering whether the confidence intervals for the reported estimates allow for imprecision in the measurement of the covariates. More importantly, they may have apprehensions about the choice of covariate sets that could critically affect the returned values.

Thirdly, an internet-based survey of 1006 key informants,

half of them internal staff, provided the weights for combining the five dimensions. A case had already been made for letting other informants, such as users, decide which aspects matter most (Mulligan *et al*. 2000). The involvement of those excluded from access to services seems equally mandatory. Broad participation would probably yield different weighting, including attributes such as accessibility, acceptability and perceived quality of care. A democratic evaluation might rate comprehensive relief from suffering higher than prolonged disability-adjusted life expectancy, as a technocratic assessment does.

Eventually the Report introduces a health level performance index and an overall performance index for the health systems of all member states. They relate life expectancy and overall system attainment to given resources. In essence the indices express the actual achievements as a percentage of the potential ones, which are estimated from per capita health expenditure and level of education. The latter variable is assumed to control for most of the factors outside the health system that contribute to health. This is to describe the current situation: past health policy, levels of funding and investment patterns that may limit or enable what is achieved today are not taken into account. The indices also disregard socio-economic deprivation at macro and micro level and the burden of tropical and poverty-related diseases prevailing in many developing countries. But these factors do affect the actual and potential performance of complex social systems – indirectly, intangibly and nonlinearly. Unsurprisingly, the health systems of rich countries emerge as the most efficient. The largest performance variations seem to occur at low levels of health expenditure, predominantly in poor African countries plagued by the HIV/AIDS epidemic (WHO 2000).

Can the WHO performance indices contribute to understanding why health systems perform as they do? Can they provide a basis for clarifying which specific strategic choices, structural arrangements or management decisions contribute to better health? Not plausibly so: their make-up compromises their validity; they ignore attitudes and performance of the actors at different levels; they neither identify processes nor structural elements that effectively and efficiently transform inputs into desirable health outcomes; they conceal the contributions of subsystems and attainments on specific goals and in specific dimensions; they entangle the complex interactions between exogenous and endogenous factors that condition the functioning of a health system; and they do not capture its specific contribution towards improving health. In the absence of information on what factors may explain performance differences and on empirical evidence of their interactions, the WHO performance indices do not permit conclusions. As their architects Murray & Frenk (2000) admitted, such evidence remains non-existent or at best anecdotal.

The Report tries to circumvent this problem by analysing how selected health systems fulfil their purported essential functions, which are grouped into service delivery, resource generation, financing and stewardship. It presents quite a balanced overview of the key characteristics and of the pros and cons of policy options, but they are examined in isolation and their effect on system performance is hardly clarified. By the same token, insufficient attention is paid to the historical context that led to specific policies being adopted. The transferability of experiences to developing countries in particular is only superficially considered. The – by design – high rankings of rich western countries which predominantly rely on market-orientated approaches to improving health, dominate the picture. This engenders, despite the scanty evidence, tacit to explicit support for setting priorities based on DALYs saved, introducing purchaser–provider splits, institutionalizing decentralization and competition, and promoting private sector involvement. WHO's 'new universalism' eventually hatches as a makeshift merger between the egalitarian concept of primary health care (WHO 1978) and the utilitarian strategy of selective primary health care (Halstead *et al*. 1985), implemented through the medium of a libertarian free market health policy (World Bank 1993).

In conclusion, the WHO World Health Report 2000 collates a wealth of previously not readily accessible data. It also develops, from a narrow representation of what constitutes good health system performance, a methodology for measuring this performance that seems state-of-the-art statistically but is questionable conceptually. It proffers policy advice for designing and managing health systems. Ultimately, this advice is driven by ideology and only weakly supported by scientific evidence. The Report underscores the technocratic approach to health policy formulation and health sector planning advocated by the World Bank. However, the Report constitutes a *de facto* milestone and it does develop some novel and creative routes of thought. Whether it will contribute to restoring WHO's leadership in international health or merely serve to reinforce World Bank views remains to be seen. Hopefully it will inspire a broad, open and genuine scientific debate leading to an evidence-based framework for assessing and improving health system performance. At any rate, substituting goodness for effectiveness, responsiveness for participation, fairness for equity and stewardship for comprehensive state responsibility will not lead to tangible health for all in the absence of drastic adjustments to the current international economic policy.

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