

COMMENTARY

The *World Health Report 2000*: expanding the horizon of health system performance

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Introduction

Anniversaries offer the opportunity to revisit events that have been enriched by the passage of time. They help to balance disagreements, create new consensuses and re-launch promising discussions. The decennial of the *World Health Report 2000* (*WHR 2000*) may be such an auspicious occasion (WHO 2000).

There are two aspects of the *WHR 2000* that are worth considering: the context and the content. The key event regarding the context of the report was the election in 1998 of a new Director General for the World Health Organization (WHO), which took place in the midst of a leadership crisis. For the first time in the history of this organization, a former head of government, Gro Harlem Brundtland, was elected to the top position. In this role she had the vision to firmly place health at the centre of the development agenda, the ability to reposition WHO in the global health arena, the skill to transform an agency mostly focused on providing technical assistance to developing countries into an institution relevant to the entire world, and the commitment to promote evidence-based health policy. This last pledge was expressed in the creation of a new Cluster on Evidence and Information for Policy, a unit explicitly charged with developing a scientific foundation for decision making and undoubtedly one of the most important initiatives during Brundtland's tenure.

The first major product of this unit was precisely the *WHR 2000*, an ambitious undertaking aimed at transforming the way we think about, measure and compare health systems performance assessment. On the conceptual front, the report proposed a comprehensive framework to expand the view on health systems by addressing five fundamental questions (Murray and Frenk 2000):

- (1) What are the boundaries of the health system?
- (2) What are health systems for?
- (3) What is the architecture of a health system in terms of its functions?
- (4) How good is a health system in terms of its performance?
- (5) How can we relate health system architecture to performance?

The first question deals with the thorny issue of what is inside and outside of the health system. Traditionally, every country tended to adopt a rather arbitrary definition of its health sector, more in terms of administrative or political expediency than of any rigorous conception. In contrast, the *WHR 2000* proposed that the boundaries be set according to the criterion of 'primary intent'. Thus, the health system encompasses the resources and actors related to the financing, regulation and provision of any health action, which in turn may be defined as any set of activities whose primary intent is to improve or maintain health. The emphasis on actors makes it possible to adopt a relational perspective on the health system that includes not only the institutional or supply side, but also the population (Frenk 2010).

The second question refers to its *goals*, the attainment of which underpins the whole notion of performance. Until 2000, most discussions had been focused exclusively on the goal of improving health. The *WHR 2000* expanded this conception by including not only the average level of health attainment in a population, but also its distribution, so that reducing health inequalities became a central dimension of performance. The *WHR 2000* also added two other intrinsically valued goals of a health system: responsiveness to the legitimate expectations of the population and fairness of financial contribution. In turn, responsiveness has two major components: (a) respect for persons (including dignity, confidentiality and autonomy of individuals and families to decide about their own health); (b) client orientation (including prompt attention, access to social support networks during care, quality of basic amenities and choice of provider). Fairness of financial contribution means that every household pays a fair share of the total health bill for a country, which implies that everyone is protected from financial risks due to health care.

The third question deals with the *functions* that a health system must perform. Again, the *WHR 2000* expanded the conceptual horizon by going beyond the direct provision or delivery of services to include also the enabling functions of stewardship, financing and resource generation (Frenk 2010).

With the building blocks represented by goals and functions, the *WHR 2000* was able to answer the last two questions. By measuring how well each goal is achieved, given the level of health expenditure and other determinants of health status, such as wealth and education, it becomes possible to evaluate the *performance* of a system, the first step towards its purposeful transformation. Analysis of the way in which the functions are carried out allows us then to relate different health system architectures to the wide variations in performance that are empirically observed. Explaining these variations provides some of the foundations needed to build a science of health systems, making evidence the basis for the design, implementation and evaluation of national policies and programmes.

The expansion of the goals of a health system, the attention placed on other health system functions in addition to service delivery, and the idea of evaluating the performance of a health system by measuring the attainment of its intrinsic goals relative to resources, were all important conceptual contributions of the *WHR 2000*. These ideas are still worth discussing and enriching, given the current interest in strengthening health systems to achieve the Millennium Development Goals.

However, the debate that followed the publication of the *WHR 2000* paid little attention to its conceptual contributions and to the use of its framework to develop national policies, and instead centred overwhelmingly on its empirical component, namely, the attempt to measure the performance of every single national health system and the construction of a worldwide ranking. A large part of this debate referred to specific methodological issues, especially the construction of an aggregate index of health system performance. In addition, the discussion reflected a deeper divergence on the very nature of information that multilateral organizations can use and their role in holding national governments to account. What follows is a summary of the main concerns expressed by some governments and the rationale that motivated the leadership of WHO to move ahead with this controversial exercise:

- (1) *WHO should report whatever figures governments produce without correcting them.* Since their earliest days, UN and Bretton Woods institutions have compensated for well-known limitations in national information systems by applying accepted statistical procedures to correct figures reported by governments. If information is to be a global public good useful for national policy making, it must be as credible as possible. The UN system has a duty to improve the validity and reliability of information, while working with countries to strengthen their capacities in this area.
- (2) *WHO should only use official sources of data.* For many years, multilateral agencies, national governments and academic institutions have made use of surveys and other sources of information to complement routine vital and administrative statistics reported by governments. They also use research results to improve the quality of information.
- (3) *WHO should not introduce composite summary measures that most people cannot understand.* Actually, composite measures have been around for a long time. The fact that most people (including well-informed policy makers and professionals) do not know the technical details of how they are constructed has not limited their widespread use.

An index as familiar as life expectancy at birth is really a complex measure that summarizes in one number the age-specific mortality rates of a synthetic cohort. The Gross Domestic Product (GDP) is another salient example of a composite measure that is widely used despite the fact that most people have little idea of the variables or procedures used in its calculation. The Human Development Index (HDI) is one more example of the long list of composite measures that many countries find useful.

- (4) *WHO should not compare countries with each other because this can embarrass some governments.* There is always a comparative element in any table reporting on any variable. Even if countries are listed alphabetically, a table showing, for example, infant mortality rates has an implicit ranking that can be easily made explicit. Furthermore, most countries are interested in assessing their situation relative to their peers, as this helps to focus on critical areas for policy intervention. If anything, the approach used by the *WHR 2000* made inter-country comparisons more fair and informative than was the case. Standard practice was limited to comparisons on *absolute* levels of attainment. The report introduced the concept of performance, which is *relative* to the resources available to a health system and to the general level of development of each country.
- (5) *The data are of such poor quality that composite measures are invalid.* There is clearly a lot of scope to improve the quality of data. But to simply discard what is available would be a mistake. The *WHR 2000* used a variety of sources to obtain the best possible evidence. It also introduced what was then a major innovation in reporting practice at WHO: the use of uncertainty intervals. If such intervals are wide, this points to priorities for future improvements in the quality of information. Rather than despairing at data limitations and abandoning the whole enterprise, this strategy generates a dynamic process to use existing information, quantify its limitations and thereby create the demand for its improvement. This is the only way to break the vicious cycle whereby data are not used so there is no pressure to improve them.
- (6) *WHO should not estimate missing data.* Since the degree of completeness of information is correlated with the overall level of development, this suggestion would exclude the countries most in need of improvement. Instead, methods to estimate missing data of critical importance are routinely employed in widely used measures like the GDP. The indices presented in the *WHR 2000* were in this sense aligned with well-established practices.
- (7) *It is reductionist to use a single number to characterize health system performance.* The WHO Health System Performance Index was aimed at synthesizing a large amount of information in order to focus attention on critical issues. It did not claim to represent the full complexity of health systems. Instead, it was seen as a diagnostic tool to illuminate areas where deeper analysis was needed. In this sense it was no different than other widely used composite measures like the Human Development Index or GDP, which clearly do not capture all dimensions of development and yet are very valuable tools to understand and act upon reality. In addition, the *WHR 2000* presented not only

the final composite measure but also its components. It then used these numbers to guide a deeper qualitative analysis of performance. Thus, it not only described but also attempted to explain the determinants of performance. It is this combination of quantitative and qualitative approaches that can best empower decision makers at all levels to mobilize evidence towards the improvement of health system performance. In fact, several countries, including Mexico, followed this approach to promote comprehensive reforms and used their poor performance rankings to neutralize conservative opposition to such reforms (Frenk 2006). However, additional efforts should have been made to *translate* the concepts and messages of the report to guarantee a wider use by local policy makers.

The passionate discussions around the strength of the methodologies used to measure the performance of health systems and the availability of appropriate information to implement this type of exercise eventually evolved into a constructive scientific debate that involved the participation of scientists and policy makers from more than 70 countries (Murray and Evans 2003). As a result, methods and instruments have been improved, and several international surveys have generated better primary information for a more objective assessment of inputs, processes, outputs and outcomes. This debate has also strengthened the conceptual component of the *WHR 2000* with the introduction of the effective coverage of interventions as an intermediate goal of health systems, the measurement of which provides useful clues for immediate improvement.

In the end, the rationale behind the assessment of health system performance was the conviction that stewards of national health systems must be accountable not only for the management of resources and processes, but ultimately for the health benefits delivered to populations (Brundtland *et al.* 2003). This conviction, shared by many international agencies, has permeated the global health agenda to the point of considering evaluation mandatory and a top priority (Oxman *et al.* 2010; *The Lancet* 2010). It has also prompted the creation of specialized institutions devoted to the evaluation of national programmes, policies and systems, and of international initiatives, such as the Institute for Health Metrics and Evaluation.

There are four main reasons why revisiting the *WHR 2000* is useful at this particular juncture: first, to sustain interest in global health by demonstrating results from the increased investments in this field; second, to build a solid knowledge base of what really works and may be transferred across countries when it is culturally, politically and financially

reasonable; third, to support the development of national capacity to think and act comprehensively about health systems; and fourth, to promote the values of transparency and accountability as essential ingredients of democratic governance at both the national and the global levels. Therein lies the legacy of the *World Health Report 2000*.

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Conflict of interest statement

As Executive Director of the WHO Cluster on Evidence and Information for Policy from 1998 to 2000, the author was directly involved in the design and execution of the *World Health Report 2000*.

References

- Brundtland GH, Frenk J, Murray CJL. 2003. WHO assessment of health systems performance. *The Lancet* **361**: 2155.
- Frenk J. 2006. Bridging the divide: global lessons from evidence-based health policy in Mexico. *The Lancet* **368**: 954–61.
- Frenk J. 2010. The global health system: strengthening national health systems as the next step for global progress. *PLoS Medicine*. **7**(1).
- Murray CJL, Evans D. (eds). 2003. *Health Systems Performance Assessment: Debates, Methods and Empiricism*. Geneva: World Health Organization.
- Murray CJL, Frenk J. 2000. A framework for assessing the performance of health systems. *Bulletin of the World Health Organization* **78**: 717–31.
- Oxman AD, Bjorndal A, Becerra-Posada F *et al.* 2010. A framework for mandatory impact evaluation to ensure informed policy decisions. *The Lancet* **372**: 427–31.
- The Lancet*. 2010. Evaluation: the top priority for global health. *The Lancet* **375**: 526.
- WHO. 2000. *World Health Report 2000. Health Systems: Improving Performance*. Geneva: World Health Organization.