# HEALTH SYSTEMS PERFORMANCE SCORECARD

A TOOLKIT TO BENCHMARK THE PERFORMANCE OF HEALTH SYSTEMS

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**INTRODUCTION:**

The Health System Performance Scorecard is useful in measuring the progress of each of the building blocks of the health system towards resilient attributes – consequently helping to visualize the areas of strength, and those that require investment. This toolkit uses descriptive milestones on the essential health system sub-components, to help in establishing critical performance benchmarks, and can be very useful in prioritizing, ideating, and designing health systems strengthening interventions. It is developed for use by NGOs and International Agencies, Donors, Governments and other health sector actors in benchmarking the health system.

Globally, there are a just few tools that can be used to score components of the health system, especially with the purpose of understanding their placement within the spectrum of a resilient health system. Most of the existing tools rely on the pre-existence of data, and uses indicator clustering functions for the analysis, which then becomes challenging to apply in environments where complete sets of data (on defined indicators), do not exist at the national, state or district level. This Tool joins this small range of instruments allowing countries, states, counties and districts to have a complete picture of its health system, and to identify opportunities for improvements, investments, replication, and up-scaling through a highly participatory process with health actors at various levels. The result should be a scorecard rating of the various system components, and a clarity of actions that are required to improve a health system's Surge Capacity; and to grow the scope and quality of the continuum of care.

Properly used, the tool can help governments and organizations to consider factors that make the health system resilient, assess its own strengths and gaps considering those factors, map out a prioritized plan for sustaining its strengths and addressing its weaknesses, and measure its progress against the goals it sets for itself. The tool is meant to **complement** other methods of system diagnosis, and will have greatest impact where it is used in a participatory manner with health actors at all levels.

**Objective**

- *Measure health system performance using various predefined qualitative parameters, and consequently prioritize system strengthening interventions:* This tool should be considered as a framework for examining the status of the health systems. It is an essential diagnostic tool. It can identify problems; it can help players identify strategic actions; and it can recognize

progress. It can help reinvigorate the health system by displaying direction, both graphically and analytically. It can help coordination within the system by promoting understanding of how each of the many pieces of the organization fit together.

**Tool composition**

The toolkit is comprised of two main tools;

- **The Health Systems Benchmarking Framework:** This is a descriptive matrix of qualitative attributes against which ranking is done. In a participatory process, actors discuss and agree on scores within a range of Zero (0) to Four (4) - with the option of fractional scores such as *0.25, 0.50, 0.75,* etc. In the process of scoring, discussions will yield valuable insights, and generate additional information on the health system, which have potential to further enrich a health systems diagnosis process. However, prior to considering the details of the framework, it may be useful to review its overall structure, and (if necessary) align the descriptive milestones to the context.

*The health system benchmarking framework;*

| Component | Criteria For Each Progressive Stage | | | |
|---|---|---|---|---|
| | Forming | Developing | Consolidating | Resilient |
| | 0 1 | 2 | 3 | 4 |
| **LEADERSHIP & GOVERNANCE** | | | | |
| **Administrative Structures** | Administrative structures are adhoc. Structures are unclear and all health decisions are made by a small group of individuals in the Ministry, and a few key stakeholders | There is a defined structure at some levels (national, state, district, etc), however roles are not very well defined and there are incidences of overlaps in functions across administrative levels. | There are operational structures at National/Regional and District levels. However, there are gaps in the coordination of policies, strategies and plans. | There is a perfectly functioning operational body at National/Regional and District level (with well defined roles) for managing health operations, and which effectively coordinates and supervises the implementation of policies, strategies and plans |
| **Policies and Regulations** | There is a shortage of laws, policies, plans, and procedures, and the available ones are neither implemented, nor reviewed. | The existing laws, policies, plans, and procedures are inadequate in managing the deivery of healthcare services, despite the fact that some have been implemented. | There are laws, policies, plans, and procedures which are adequate in managing healthcare, but which are not being fully implemented. The policies are neither monitored nor reviewed periodically. | There are laws, policies, plans, and procedures which are adequate in managing healthcare, and which are being implemented, and are reviewed consistently. |
| **Participation** | Planning for programs and activities is top-down | The participation of Stakeholders in planning is widened with contributions to decision making. | Communities and stakeholders provide information for planning but are excluded from decision making. | Communities and Stakeholders contribute to planning decisions along the Ministry of Health Leadership.<br>Non-health sector actors are involved in the development and implementation of the health policy |

| Component | Criteria For Each Progressive Stage | | | |
|---|---|---|---|---|
| | Forming | Developing | Consolidating | Resilient |
| | 0 1 | 2 | 3 | 4 |
| **Accountability** | There is no known form of public accountability, nor are there procedures or structures for community engagement. | The public are sometimes not informed of major decisions and actions in the health system. Community engagement structures are not clear. | The public are sometimes not informed of major decisions and actions in the health system. Community engagement structures are clear and are understood by all. | The public are always informed and involved of major decisions and actions in the health system. Their contribution is often sort. Community engagement structures are clear and are understood by all. |
| **Coordination** | There's no written record of actors, or their activities. Health stakeholders meetings are rare and they are convened by actors to discuss specific issues | Some of the activities of actors are mapped, and are mostly aligned to health sector priorities, strategies and plans. Stakeholder meetings are inconsistent. The MoH have no finances to convene stakeholder meetings and have to rely on partners to do so. | Activities of key actors are clearly mapped, and are aligned to health sector priorities, strategies and plans. Stakeholder meetings are consistent but follow up action is minimal. | Activities of key actors are clearly mapped, and are aligned to health sector priorities, strategies and plans. Health Stakeholder meetings held frequently and consistently and actions are closely monitored. |
| **HEALTH FINANCING** | | | | |
| **Mobilization and Allocation of Resources** | Joint Annual Work Plans and targets not developed, budgeting not based on annual work plans | Joint Annual Plans developed at the National level but not cascaded to the District level. Plans are rarely used as budgeting tools, rather, planning is based on specific funding streams | Annual plans are developed and approved jointly by the Ministry of Health and stakeholders. The plans are used as a tool for resource mobilization, allocation/redistribution | Budgeting is used as a tool for annual planning and management. Joint Annual plans are comprehensive and specific enough to permit accurate resource allocation, and flexible enough to be modified as warranted. The plans are reviewed each year. |

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|---|---|---|---|---|
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| | 0 1 | 2 | 3 | 4 |
| **Payments for Services and Health System Costs** | Procurement procedures do not exist and single sourcing is prevalent | Procuring /contracting procedures exist but they are rarely followed especially at the lower levels | Procuring /contracting for health service delivery and other health system functions done based on well defined procedures. However, MoH delays in paying suppliers/contractors, and the relationship with suppliers is weak. | Procuring /contracting for health service delivery and other health system functions done based on well-defined procedures at all times. Payment of suppliers is done promptly. |
| **Financial Management** | Financial resources are mainly controlled by donors. Internal controls are weak. | Financial procedures are established, but still are not fully implemented. | Financial procedures are systematic and established to support operational management. Documented procedures facilitate ongoing controls. | Control is an internal management function. The Ministry does not perceive controls as being excessive. |
| **HEALTH WORKFORCE** | | | | |
| **Workforce Planning** | Too few staff fill a broad range of skills and positions | Specialists with the required core skills have been hired, but critical gaps remain | All core skills areas are covered with personnel and external experts, but the distribution is uneven. | Planning of health workforce deployment and development is realistic and needs-based |
| **HR Policies** | No formal personnel policies and systems (job descriptions, recruitment and hiring procedures, etc.) exist. | Some necessary personnel systems exist. Informal practices exist. | Virtually all necessary personnel systems are institutionalized. Occasionally informal mechanisms are used | Formal personnel systems are institutionalized, understood by all health workers and redress can be pursued |

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| **Performance Management/Motivation** | Little or no recognition of staff performance. Health Worker "burn-out" is common. | Performance recognized informally, but no formal mechanisms exist. Support supervision is weak and ad hoc | Formal performance reward system established, but health workers do not participate fully in target setting. Support supervision mechanisms exist | Health workers participate in setting of targets and know what is expected of them. Formal system exists that matches rewards to health worker performance. Support supervision is well structured and well executed |
| **Training and Education** | Little on-the-job training provided. No focus given to managing the quality of preservice training programs. | Some training provided. Quality of preservice training programs not managed. | Health workers receive adequate training, and mentoring, but planned staff development still not integrated into Ministry. Quality of pre-service training programs somehow managed. | Healthworkers with the requisite clinical, technical, and management skills are produced. The quality of pre-service training programs is properly managed. |
| **ACCESS TO ESSENTIAL MEDICINES** | | | | |
| **Logistics Management Information System** | Non-existent LMIS system, purchase is inconsistent, and distribution is through prepackaged kits (a push system) | Non-existence of computer based LMIS system, however data is gathered manually and rarely used inform purchase and need based distribution | Presence of an LMIS system but which generates accurate data, but data is often unutilized | Accurate and timely essential data on, stock on hand, rate of consumption, and losses and adjustments is generated and utilized to inform purchases and supplies of essential products |
| **Pharmaceutical Policy, Laws, and Regulations** | There is a shortage of pharmaceutical laws, policies, plans, and procedures, and the available ones are neither implemented, nor reviewed. | The existing laws, policies, plans, and procedures are inadequate in regulating pharmaceuticals, despite the fact that some of them are being implemented. | There are laws, policies, plans, and procedures which are adequate in managing pharmaceuticals, but which are not being fully implemented, nor reviewed consistently. | There are laws, policies, plans, and procedures which are adequate in managing pharmaceuticals, and which are fully implemented, and reviewed consistently. |

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| **List of Essential Drugs** | A list of essential drugs has not been updated in more than 12 months | A formal list of essential medicine developed and updated consistent with population health priorities. However, products are not distributed based on the list. | A formal list of essential medicine developed and updated consistent with population health priorities. Products are selected in line of the list but there are frequent stock outs. | A formal list of essential medicine developed and updated consistent with population health priorities. Selecting products in line with the endorsed essential medicine list. |
| **Storage, Inventory management and distribution** | Storage is not sufficient at all levels and inventory not regularly updated. Absence of laid down procedures for cold chain Management | Sufficient storage at all levels and distribution procedures are well described. Inventory is kept but distribution is still based on pre-packed kits. There is a structure for cold-chain management – but with shortage of staff or cold boxes | Essential supplies are stored and distributed. Waste of essential medical products (either due to expiration, damage, or corruption), has somehow been eliminated. There is a functional structure for cold-chain management | Essential supplies are stored and distributed. Waste of essential medical Products (either due to expiration, damage, or corruption), has fully been eliminated. Data is used to inform distribution of products, and the cold chain is effectively managed. |
| **INFORMATION SYSTEMS** | | | | |
| **Indicators** | Indicators are insufficient and are not properly tracked | Indicators are insufficient though often tracked. Data on some critical indicators is not collected. | Indicators are sufficient and flexible, and are consistently gathered. However, results are not regularly used to inform, policy nor in planning, nor resource allocation. | Evidence on population health needs is fully used to inform policy, planning and resource allocation decisions. |

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| | 0 1 | 2 | 3 | 4 |
| **Data collection** | Little data is collected, and completion and timelines are off the mark | Some data is frequently and consistently collected from health facilities at all levels. However, there are challenges with timelines, completeness and accuracy with the data collected | Most but not all data is collected in a manner that is timely, complete and accurate. | All required data is collected at all levels in a manner that is timely, complete and accurate. Data collected includes (but not limited to); census data, civil registration data, population-based survey data, data to monitor notifiable diseases ("individual records"), service records/clinical data, etc. |
| **Analysis and Dissemination** | Data gathered is rarely analyzed unless triggered by information demand | Data is sometimes analyzed at higher levels of the structure and feedback shared based on need | Data is routinely analyzed and synthesized at most levels and results often shared with policy makers, managers, providers, and other stakeholders at all levels and across agencies/departments | Data is routinely analyzed and synthesized to produce useful information about population health status and needs and health system performance. Information is routinely shared with policy makers, managers, providers, and other stakeholders at all levels and across agencies/departments |
| **Data Quality Audit** | DQAs are rarely conducted. HMIS do not have capacity to conduct rigorous DQAs | DQAs are sometimes conducted but results are not utilized to improve the system. Capacity of staff to conduct DQAs is somewhat adequate | There is adequate capacity and resources for staff to conduct, DQAs are routinely conducted, but results are not utilized to improve the system. | Systematic data quality audits are well conducted, and used to continuously improve information systems (e.g., identifying and reducing unnecessary reporting burdens, simplifying processes, and/or utilizing ICT to strengthen processes) |

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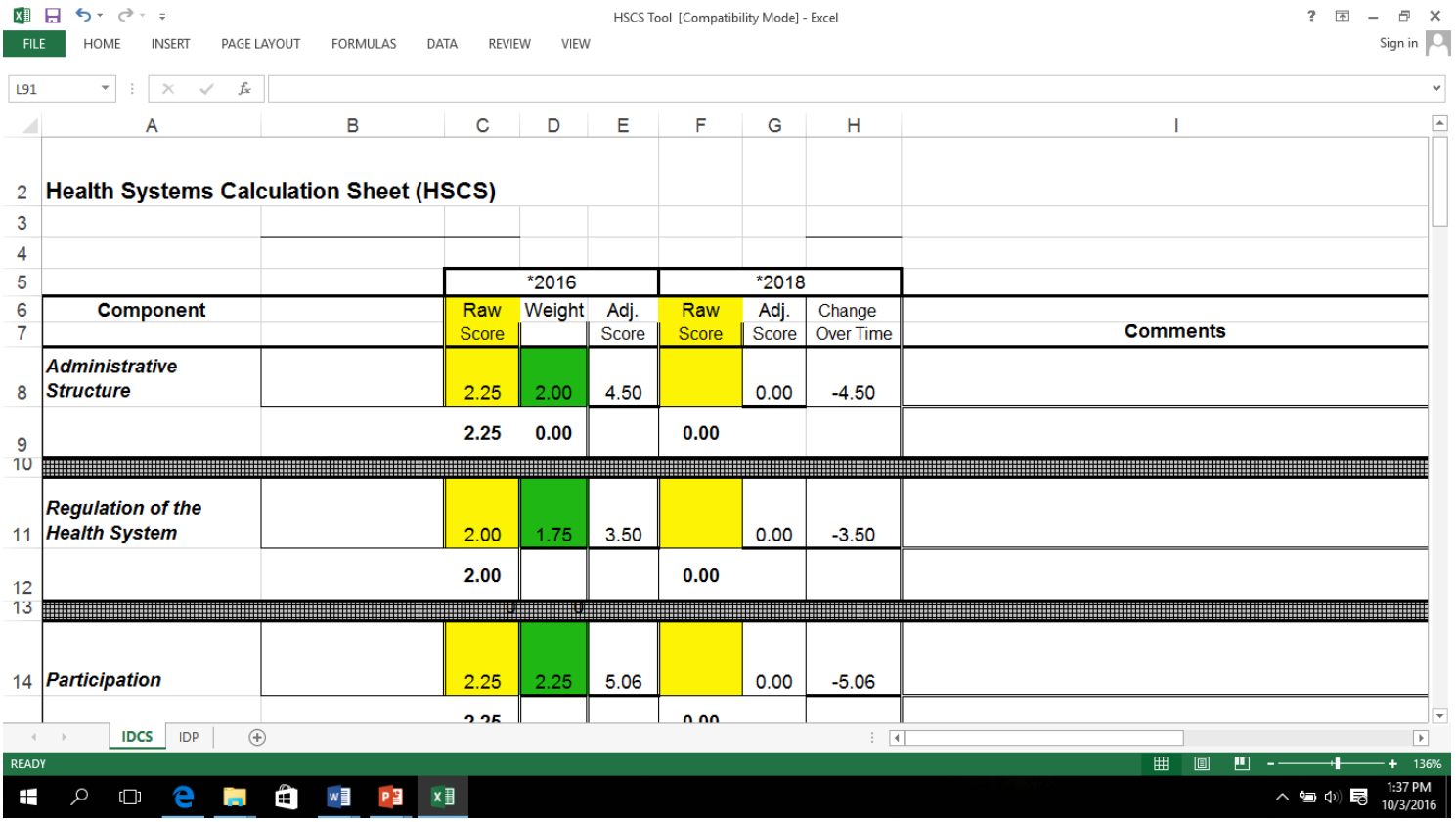
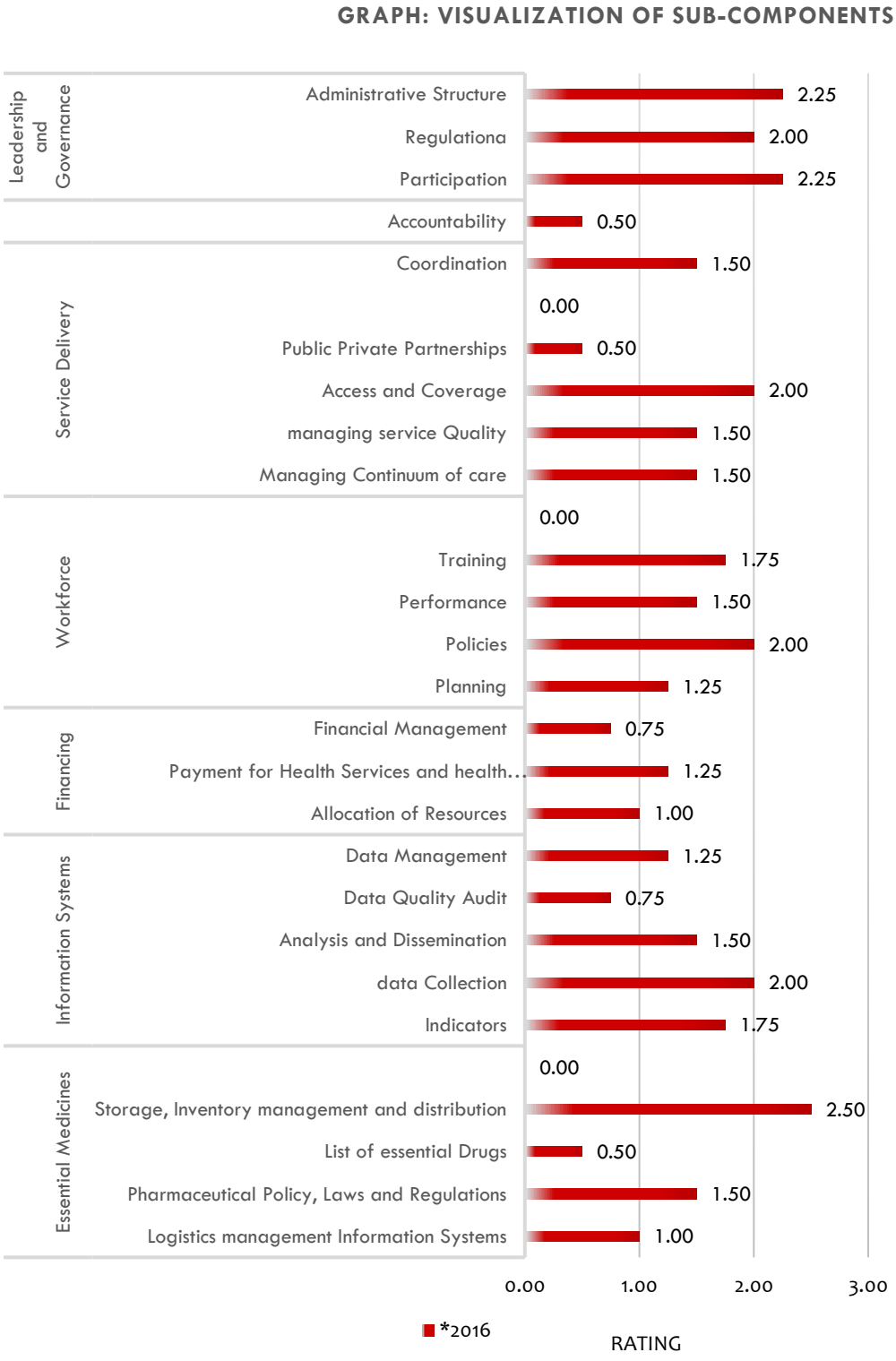
| **Data Management** | There is little or no effort to gather data outside the mainstream HMIS system. Health data exists in many silos | There are efforts to coordinate and integrate data from other sub systems, but such efforts lack form and structure. As a result the sub systems are uncorperative | Data is coordinated and integrated from across some information sub-systems. | Data is routinely coordinated and integrated from across all the different information sub-systems e.g vertical programs |
| **SERVICE DELIVERY** | | | | |
| **Managing Continuum of Care** | Essential services are insufficient, and a reliable referral system is lacking | Essential services are provided to segments of the population. A referral system is established and well maintained, yet it has certain inadequacies | Essential services are fully provided (to all) in a manner that is patient centered. A referral system is established and well maintained, but communities are not fully engaged in service provision. | Essential services are fully provided (to all) in a manner that is patient centered. A referral system is established and well maintained, and communities and NGOs are fully engaged in service provision. |
| **Managing Service Quality** | Clinical quality and patient satisfaction is not monitored. Protocols are inadequate and not monitored for adherence. | Clinical quality and patient satisfaction is inconsistently monitored. The available protocols are sometimes monitored for adherence. | Clinical quality and patient satisfaction is regularly monitored. Service protocols are adequate and somewhat adhered to. | Clinical quality and patient satisfaction is frequently monitored. Protocols are adequate and fully adhered to. |

| Component | Criteria For Each Progressive Stage | | | |
|---|---|---|---|---|
| | Forming | Developing | Consolidating | Resilient |
| | 0 1 | 2 | 3 | 4 |
| **Access and Coverage** | Barriers to access, especially for poor and marginalized populations are not well understood, nor are they factored in planning service delivery. | Communities are sometimes made aware of specific services and are encouraged to utilize health services. Barriers to access, especially for poor and marginalized populations are well understood, though it is not clear if they factored in planning service delivery. | Communities are often made aware of specific services and are encouraged to utilize health services. Barriers to access, especially for poor and marginalized populations are well understood, and factored in planning service delivery. | Communities are always made aware of all services and are encouraged to utilize health services. Barriers to access, especially for poor and marginalized populations are well understood, and factored in planning service delivery. Cear mechanism for community engagement exists. |
| **Public Private Partnerships** | Public-private partnerships are not well defined. The Ministry is yet to forge formal partnerships with the private sector | PPPs in health care are beginning to form, there support to health is ad hoc and cannot be quantified. NGOs are engaged in the delivery of health services | Public-private partnerships are established, but information is not gathered on the extent of their contribution. NGOs are engaged in the delivery of health services | NGOs are fully engaged in the delivery of health services. Public-private partnerships are well established to support and deliver services |

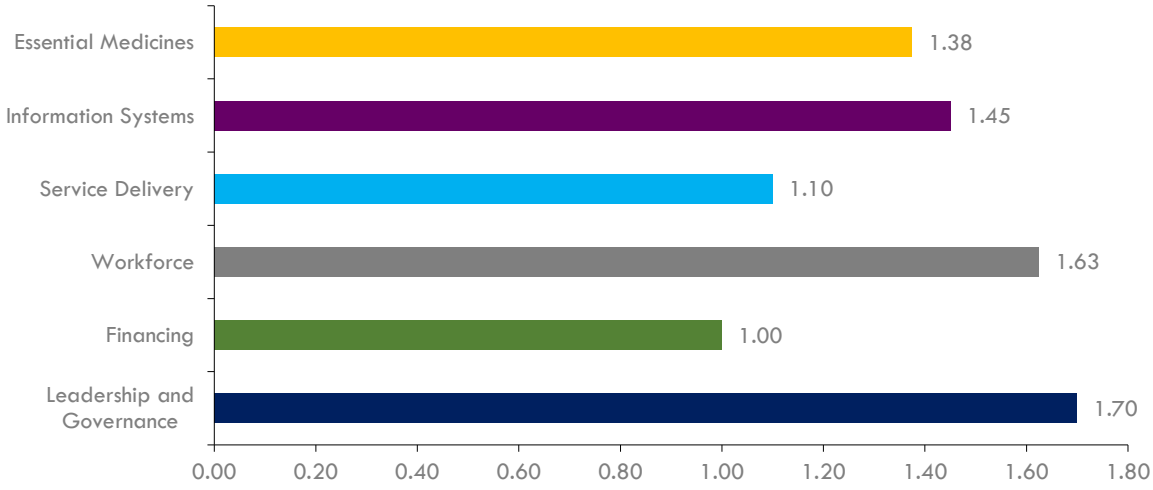
- **The Health Systems Performance Calculation Sheet:** One of the most appealing aspects of this excel based worksheet is its ability to illustrate graphically how the system scores on the various components and building blocks, and visualize progress over time – in a way that can be intuitively be understood. The tool helps to display the performance scores as completed during a pre-test of the tool. The excel based worksheet has formulas which automatically generates graphs, web diagrams, as data is entered in the spreadsheet. Below is an impression of the Health Systems Calculation Sheet (HSCS) – A soft copy of the worksheet is available on request from omondi@capacitiesforhealth.org . A recorded video on how to use the Calculation sheet will soon be made available on the Capacities for Health website – www.capacitiesforhealth.org .



At the end of the process, the worksheet automatically generates visualizations as the ones below;

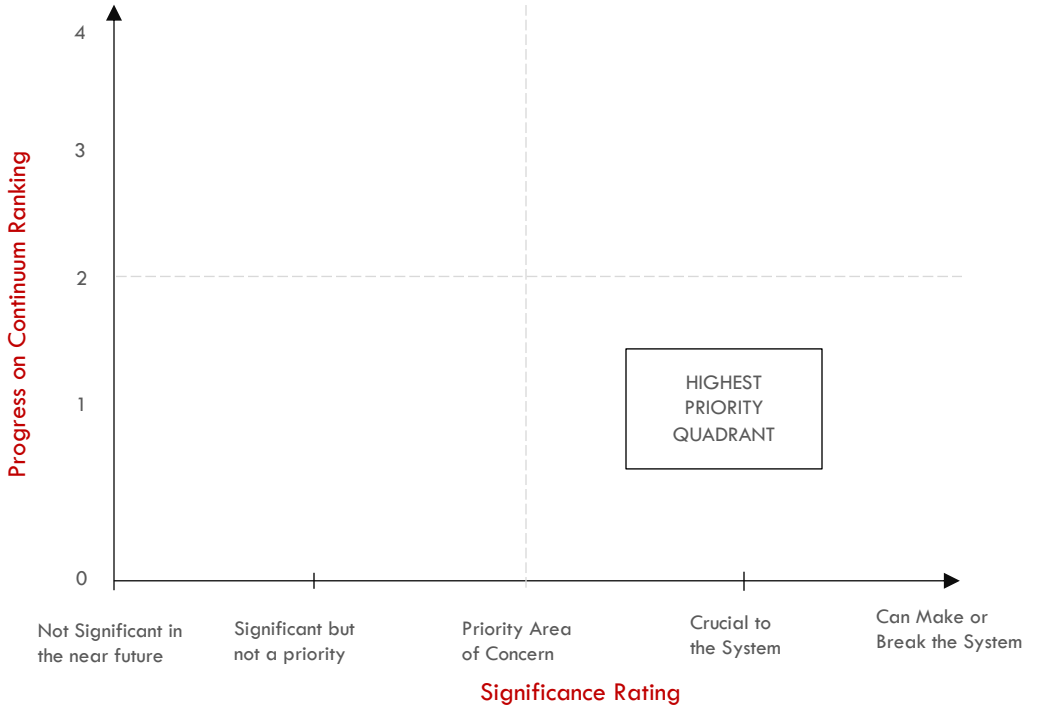


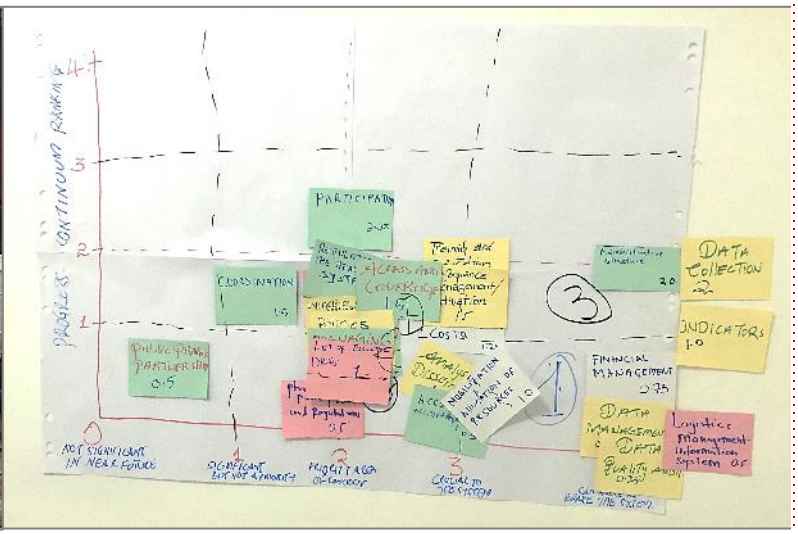
**Graph: Average Score Placement by System Building Block** *(Out of a maximum score of 4 points)*




**Intervention Mapping:** Upon completion of the process above, the next step is to determine which among the components are most important to its future. A number of approaches can be used to facilitate this process. One that has proven useful is to draw up "flip cards" for each of the components included in the *Benchmarking Framework* such as Regulations, coordination, data management, etc. Then list on a wall or floor a scale of 1-4, as illustrated below in the figure below.

In a relatively short time, through a plenary session of a stakeholders workshop, a group can place all the components on the wall and determine their relative importance to the health system. Using phrases such as "Make or Break the system" and "Not Important to Us in the Near Future", may be useful to help the group decide where to place each component. Once again, the cards may be precisely on an integer spot, or in between (that is, scores such as 1, 4, 3.5, or 2.25 are acceptable). These priorities should be established regardless of whether or not there are currently problems in these areas. The purpose of this exercise is to determine which of the components are most important to the success/resilience of the system and create an X-Y relation between such importance and the scores obtained from the benchmarking exercise – as demonstrated in the figure below.



Having identified the areas that need improvement, the stakeholders can set goals and objectives for systems strengthening priorities in the future, such as in six months, a year, two years, or even 5 years.

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