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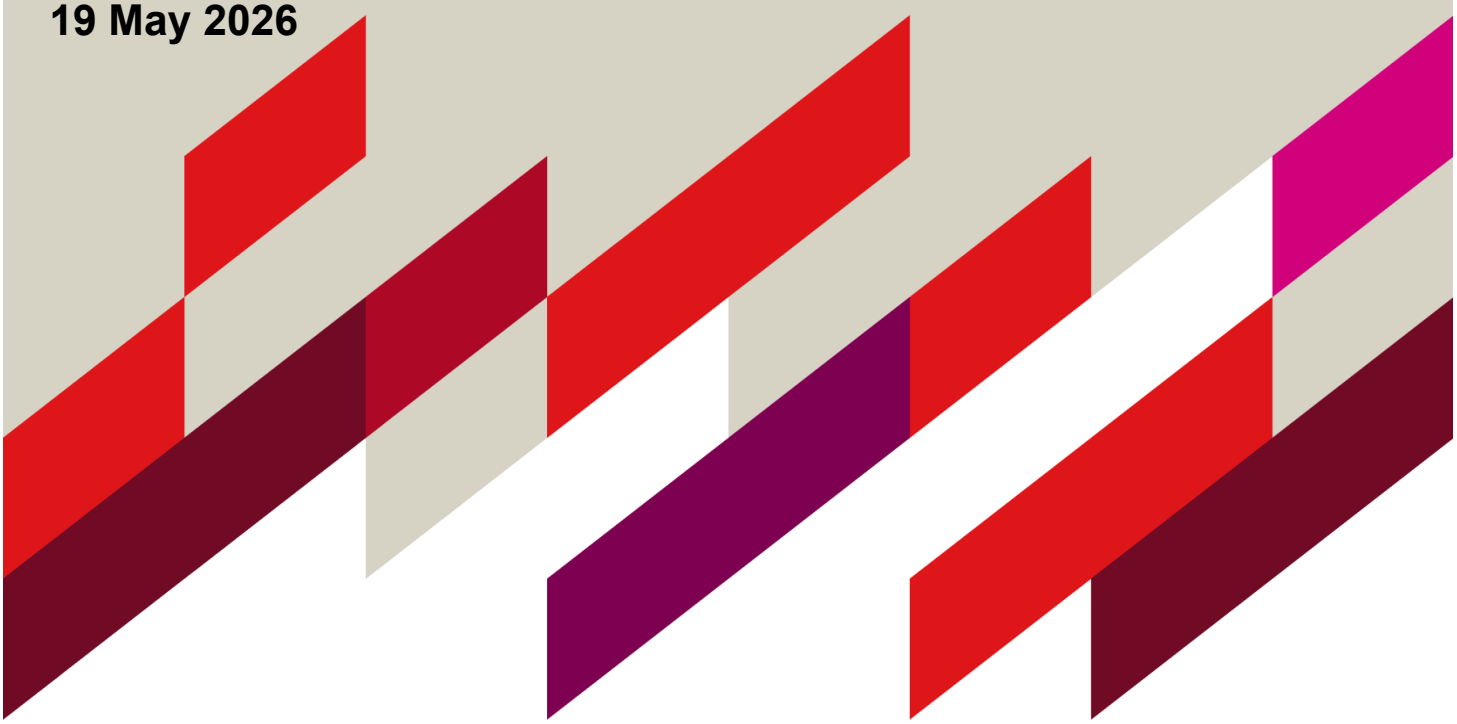

Health Reform Evaluation Models: A Comparative Case Study of Australia, Denmark, Canada, England, Norway, and Sweden

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Table of Contents

List of Tables

EXECUTIVE SUMMARY

Purpose and scope

This report compares how large-scale national health reforms are evaluated across six countries – Australia, England, Canada, Denmark, Norway, and Sweden – and asks a central question: are evaluation models aligned with what reforms claim they are trying to achieve? The report uses an adapted WHO Health System Performance Assessment (HSPA) framework (Functions, Intermediate Objectives, Final Goals) as the common lens for mapping: (1) each reform's intended outcomes and (2) the indicators and methods used to evaluate progress.

Methods in brief

The study is a mixed-methods document review and policy analysis drawing primarily on government and major agency/independent organisation sources in each country (in English plus Scandinavian languages to capture primary legislative/policy records). Records were screened against inclusion criteria and extracted into a structured charting template, then mapped to WHO HSPA domains and categories through iterative team consensus.

What reforms targeted (the 'policy intent' picture)

Across the six countries, reforms consistently targeted core system Functions **–** resource generation, financing, and governance – reflecting a shared emphasis on strengthening foundational inputs (workforce, infrastructure, financing arrangements, and stewardship).

Most reforms also targeted multiple Intermediate Objectives (effectiveness, safety, user experience, access, utilisation, efficiency, equity), though with variation: Australia, England, Canada, and Norway were mapped as targeting all seven intermediate categories; Sweden targeted six; Denmark five.

The largest divergence appeared at the level of Final Goals (people-centredness, health improvement, financial protection, system efficiency, system equity). Australia, England and Canada were mapped as targeting all five final-goal categories, while Norway and Sweden targeted four and Denmark three – suggesting that reforms often articulate broad end-states, but with uneven specificity or breadth across countries.

What evaluations measured (the 'measurement reality' picture)

Indicators cluster in Functions and Intermediate Objectives; Final Goals are weaker

When the report maps evaluation indicators to WHO HSPA categories, a clear pattern emerges. For health system Functions and Intermediate Objectives, there is comparatively strong coverage across countries (especially for financing, access, utilisation, and efficiency). For health system Final Goals, coverage is patchier and more variable – especially for financial protection, and in some cases health improvement and system efficiency/equity.

This finding is important because it means that *many evaluations are better at measuring what systems do (inputs/activities and near-term performance) than what reforms ultimately deliver (population health, people-centredness, equity, and protection from financial hardship).*

A recurring misalignment: ambitious reform components lack 'a priori' metrics

A prominent example is Australia's National Health Reform Agreement (NHRA) mid-term review: the evaluation was extensive and mixed-methods, but it found that the Australian Health Performance Framework was not fit to evaluate NHRA objectives because indicators remained siloed and overly hospital-activity focused. The review therefore drew heavily on external indicators and proposed an Interim Quantitative Performance Framework to better align measurement with reform intent.

In practical terms, this highlights a common problem across reforms: *aspirational priorities (integration, joint planning, value-based care, health literacy, system-wide coordination) are often the least "indicator-ready," forcing evaluations to rely on consultations rather than measurable baselines and trends.*

Methods are mixed, but independence and benchmarking vary

Across the six evaluation models, the report identifies a broad methodological repertoire spanning stakeholder consultations, document review, performance-data analysis, progress reporting, program-specific evaluations, and international comparisons, with notable variation in whether a formal framework was used or planned.

A key comparative message is that evaluation architecture differs markedly: some countries embed evaluation in routine system performance infrastructures, while others rely on discrete, time-limited reviews or program evaluations. This variability affects transparency, comparability over time, and the ability to attribute changes to the reform (versus background system pressures or concurrent policies).

Cross-cutting lessons and implications

Strength at 'what we can count'; weakness at 'what we ultimately value'

The report's mapping implies a structural bias toward indicators that are available, standardised, and routinely collected (activity, access, utilisation, spending) rather than those that capture people-centredness, equity, prevention, cross-sector integration, and longer-term outcomes. This is not merely technical, it shapes incentives: reforms may drift toward what is measured, and evaluation may under-detect unintended consequences or distributional harms.

Data access and system fragmentation constrain evaluation – especially for primary care and digitalisation

Sweden's evaluation illustrates a modern constraint: difficulty assessing the overall impact of digitalisation and prevention when national statistics are incomplete (e.g., digital visits) and when significant portions of primary care are privately operated, limiting consistent oversight and data access.

This signals a broader challenge likely shared elsewhere: without interoperable, comprehensive data across primary, community, and hospital sectors, evaluation will systematically under-measure integration and substitution effects (whether new models replace or merely add demand).

Governance and accountability can be blurred when evaluators are also implementers

A governance risk raised in the Swedish material is that central bodies may hold **dual roles** (supporting implementation while monitoring compliance), creating perceived conflicts and reducing evaluative objectivity; similarly, non-state actors involved in design/monitoring may not be subject to transparency requirements. This matters for credibility: reform evaluation must be seen as both methodologically rigorous and institutionally independent enough to sustain trust.

Forward directions suggested by the report's findings

Although country contexts differ, the report's comparative mapping supports several practical directions:

- **Design evaluation 'with' the reform (not after it):** define measurable outcomes and baselines for integration, value-based care, equity and people-centredness at the time reforms are launched, rather than mid-stream (Australia's interim framework development illustrates the need once gaps become visible).
- **Use WHO HSPA as a common backbone** to ensure reforms and indicators jointly cover Functions, Intermediate Objectives and Final Goals – especially to prevent evaluation 'drop-off' at the final-goal level.
- **Strengthen primary care, community care, and digital data infrastructures** (definitions, national minimum datasets, linkage capability, and coverage of private provision) so evaluations can detect substitution, quality, equity and unintended consequences.
- **Clarify governance and independence arrangements** – including who sets indicators, who owns the data, and how evaluators avoid self-review – so accountability mechanisms are transparent and trusted.
- **Standardise and benchmark where possible** (within-country longitudinally and cross-country comparatively), using the same conceptual categories to enable learning across systems and avoid purely bespoke measurement approaches.

The bottom line

Across six national reforms, the report finds that evaluation practice is strongest where data are mature and routine (financing, activity, access, utilisation), and weakest where reforms are most ambitious and complex (integration, people-centredness, equity, prevention, and long-term outcomes). The WHO HSPA framework is presented as a pragmatic way to standardise evaluation design and benchmarking, but the comparative cases show that indicator readiness, data access (especially primary care and digital), and governance independence are the decisive enablers of high-quality reform evaluation.

INTRODUCTION

Across 152 nations, every health system we have examined is aiming for reform, propelled by an ambition to transition toward universal, integrated, and person-centred models of care that are both data-driven and environmentally sustainable (Braithwaite et al., 2016, 2018). These whole-of-system transformations involve more than incremental change; they represent a fundamental restructuring of health system pillars, including the integration of primary and acute services to manage aging populations, the large-scale deployment of digital health interoperability frameworks, and the adoption of value-based payment models that prioritise health outcomes over activity volume (Braithwaite & Fisher, 2024; OECD, 2024).

As nations undergo these broad-scale reforms they need to navigate the complexities inherent in modern healthcare, from climate-related health risks to chronic disease burdens. To make progress, evaluation becomes paramount. Rigorous assessment of both implementation processes and longitudinal outcomes is essential to identify how systems are successfully meeting the quadruple aim: better outcomes, improved patient experience, lower costs, and clinician well-being. Accomplishing this requires deep system learning and stakeholder trust (Best et al., 2012; Pawson & Tilley, 1997; Ovretveit, 2014).

However, a significant discrepancy persists between these high-level reform ambitions and their actual on-the-ground progress. While these transformations can disrupt every facet of system functionality, all-too-often there is a pervasive lack of longitudinal, systematic evaluation against their primary objectives. Notwithstanding that every country is trying to sustainably to improve their care systems, there remains an absence of state-of-the-art, independent evaluation models for international healthcare reforms (Braithwaite et al., 2016). This creates a critical accountability gap. The ‘on-the-ground’ progress of multi-billion-dollar (euro, pound, krone) reforms remains largely unmonitored and disconnected from the original strategic goals they were designed to achieve (Braithwaite & Fisher, 2024).

How are large-scale health reforms evaluated?

While many countries have published health system performance assessment frameworks to monitor the functioning of their health system (e.g., England’s National Health Service Outcomes Framework [NHS England, 2025] and Canada’s Health System Performance Measurement Framework [CIHI, 2026]), there is a disconnect between those frameworks and reform progress. Traditional reform evaluations often focus on narrow subsets of clinical indicators, such as mortality rates or waiting times, which may capture isolated improvements but fail to account for the broader changes underway (Fatimah et al, 2023; Braithwaite et al, 2017). To bridge this gap, nations can adopt a comprehensive conceptual framework, such as the World Health Organisation Health System Performance Assessment (WHO HSPA) framework (adapted version in Figure 1) to guide whole-of-system evaluations (Papanicolas et al, 2022). Such frameworks provide the necessary structure to track how changes in one sector, such as primary care, affect another, e.g., acute hospital services, so that unintended consequences may be properly assessed

The strategic use of such conceptual frameworks can facilitate system learning and track progress over time. By moving beyond one-dimensional metrics and integrating HSPA principles into a reform lifecycle, policymakers can foster a ‘learning health system’ that values longitudinal progress over short-term outputs (Best et al, 2012; Reich et al, 2024).

This kind of integrated approach not only identifies which components of a reform are succeeding but can also build essential stakeholder trust by providing a standardised roadmap for continuous improvement and sustainable system-wide transformation.

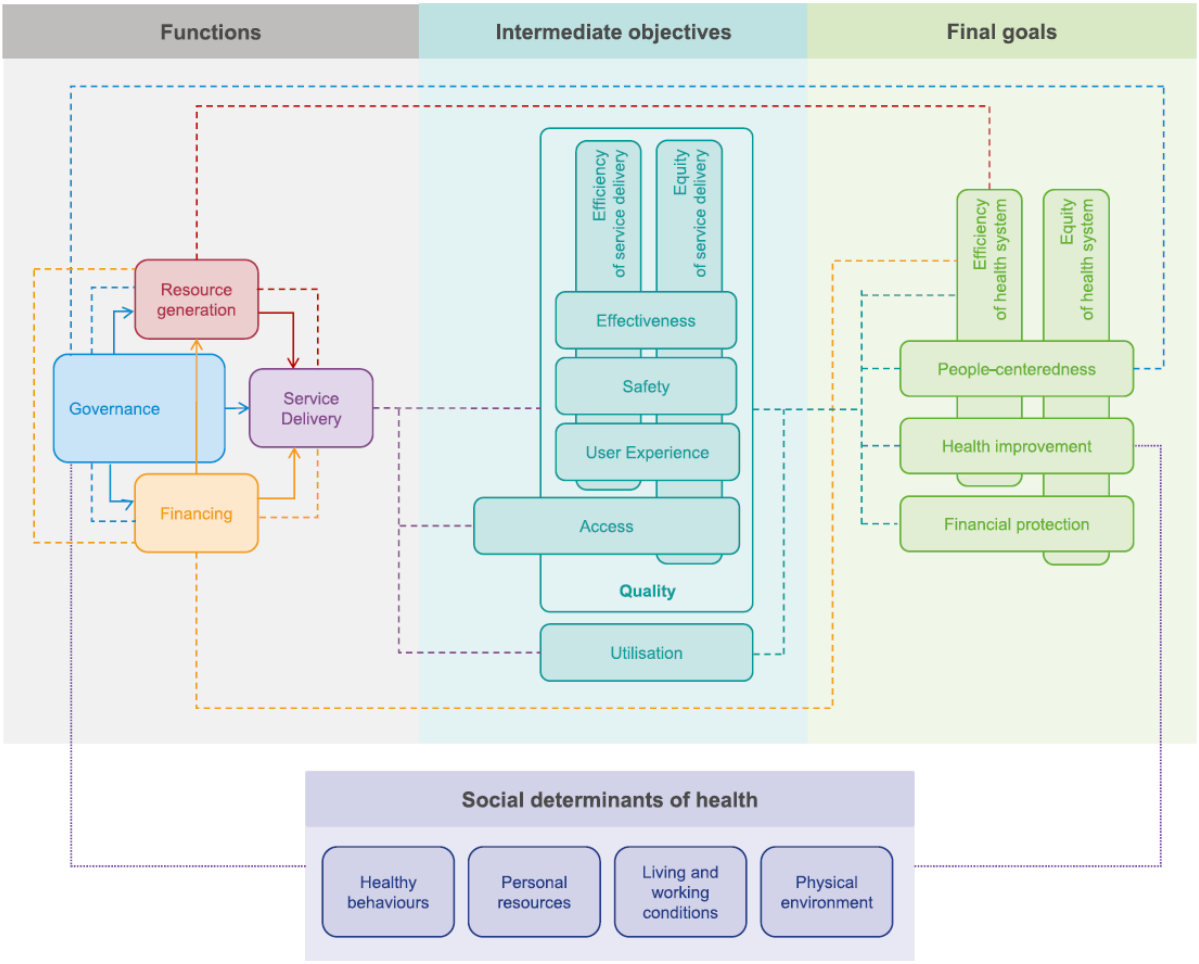

Figure 1. Adapted Health System Performance Assessment (HSPA) Framework, World Health Organisation (Fatimah et al., 2023; Health Policy, https://doi.org/10.1016/j.healthpol.2023.104933).

Operationalising standardised evaluation of large-scale reforms

There are three aspects of evaluating reforms that are of critical importance: standardisation, transparency, and benchmarking. Standardised evaluations allow comparison longitudinally, within the country. Transparency helps multiple stakeholders understand what is happening. Benchmarking facilitates cross-country comparisons. The WHO HSPA framework (adapted version in Figure 1) is uniquely suited for this purpose. It offers a comprehensive multidimensional lens that conceptualises clear causal pathways between system actions and outcomes. Its primary strength as a global benchmark lies in its adaptability to diverse national contexts, allowing for a consistent mapping of performance indicators across varying jurisdictional structures.

The adaptability of the WHO HSPA framework is anchored in its logical architecture, which organises the intricate components of healthcare into foundational ‘building blocks’ and overarching ‘goals’. The building blocks identify essential system inputs including governance, financing, and service delivery, while the goals distinguish between immediate

system-level results, such as access, quality, and safety, and broader societal impacts such as population health, financial protection, and person-centeredness (Papanicolas et al, 2022).

The 2022 revision of the WHO HSPA framework further enhanced its utility by emphasising that resilient system strengthening depends on the linking of inputs with these ultimate health objectives. By optimising specific functions such as the health workforce, a system can drive performance in critical domains such as service quality and equitable access. The framework underscores that achieving both intermediate and long-term milestones requires integrated engagement across government and society, reinforcing the interdependencies between a system's internal operational performance and the reforms intended to transform it (Fatimah et al, 2023; Papanicolas et al, 2022). The WHO framework remains a powerful tool for reform because it acknowledges the external influence of social determinants in shaping final health outcomes.

Objectives of this report

To understand how reforms are being evaluated in different settings, we purpose-selected for an analysis the national evaluation models of six countries: Australia, Canada, Denmark, England, Norway, and Sweden. We wanted to know how these models were being designed and executed, and how they were being evaluated.

To facilitate this analysis, we adopt the adapted version of the WHO HSPA framework proposed by Fatimah et al. (2023). This iteration is particularly valuable because it explicitly incorporates utilisation as a distinct category under the intermediate objectives. By positioning utilisation alongside access, quality, and safety, the framework more effectively captures the critical transition from system capacity to actual service uptake – a primary target of most large-scale reforms. The specific domains and categories employed to evaluate these six international reforms are detailed in Table 1.

Table 1. WHO HSPA framework domain and category definitions

DOMAIN/Category	Definitions
FUNCTIONS	
Resource generation	The availability, distribution/mix and maintenance of a qualified *health workforce*, the physical *infrastructure and equipment* necessary for effective service delivery, and the essential *pharmaceuticals and consumables* required for patient care.
Financing	The flow of monetary resources through the health system, including *revenue raising, pooling resources*, and *purchasing goods and services*.
Governance	The *policy and vision, stakeholder voice, information and intelligence*, and *legislation and regulation* that guide the governing of the health sector.
Service delivery	A health system function and an outcome of the governance, financing and resource generation functions, linking directly into intermediate objectives.
INTERMEDIATE OBJECTIVES	
Effectiveness	Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and misuse, respectively).
Safety	Care that protects patients from medical errors and does not cause harm.
User experience	Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.
Access	The opportunity to reach and obtain appropriate health care services in situations of perceived need for care.
Utilisation	Volume and type of services delivered across the health system.
Service efficiency	Maximising health service objectives (quality and access) given the resources available (at the level of individual services or providers).
Service equity	The fairness and distribution of specific services, ensuring equal access regardless of personal characteristics such as gender, ethnicity, geographic location and socioeconomic status.
FINAL GOALS	
People-centredness	Approach to care that consciously adopts the perspectives of individuals, carers, families and communities. It organises care around a person's full needs, not just their diseases, while respecting their social preferences.
Health improvement	Health Improvement refers to the improvement of the health of the population. Where health refers to health at different parts of the life cycle, morbidity and premature mortality.
Financial protection	Safeguarding people against the financial hardship associated with paying for health services.
System efficiency	Maximising the final health system objectives (health improvement, people centeredness and financial protection) given the resources available (at the level of broader health system).
System equity	The fairness of health outcomes (health improvement and people-centredness) across the population as a whole, as well as the level of financial protection.

Source: Fatimah et al. (2023)

METHODS

Study design

We employed a mixed-methods document review and policy analysis designed to examine health reform and evaluation models across the included countries. The review followed a structured process to systematically assess the alignment between each country's reform objectives and their corresponding evaluation models. First, a comprehensive search was conducted to identify relevant documents on each country's health reforms and their evaluation models. Second, a framework analysis was conducted to analyse the design, implementation and evaluation of the health reforms.

Data sources and search strategy

To identify key documents, we conducted targeted searches of governmental and non-governmental organisation websites. The search strategy followed a two-stage process: first, we identified official policy reports for the most recent national reform that had undergone at least some degree of formal evaluation. Second, we performed supplementary searches to gather key details regarding the specific reform design and its corresponding evaluation model. The data sources utilised by the research team are presented in Table 2.

Table 2. Targeted data sources

Source type	Specific sources
Federal government	Official government websites of Australia (Department of Health and Aged Care), England/United Kingdom (Department of Health and Social Care [DHSC]), Canada (Health Canada), Denmark (Ministry of Interior and Health), Norway (Ministry of Health and Care Services), Sweden (Ministry of Health and Social Affairs).
Government agency	Government agencies in Australia (Australian Institute of Health and Welfare), England/United Kingdom (NHS England), Denmark (Danish Health Authority), Norway (Norwegian Directorate of Health and Office of the Auditor General of Norway), and Sweden (National Board of Health and Welfare).
Independent organisation	Independent organisations in England (The Health Foundation, Nuffield Trust, King's Fund), Canada (Canadian Institute for Health Information), Denmark (VIVE, The Danish Center for Social Science Research) and Norway (Research Council of Norway, Evaluation of Medicine and Health).
International organisation	World Health Organisation, Commonwealth Fund, Organisation for Economic Cooperation and Development, European Observatory of Health Systems and Policies.
Research institute	Karolinska Institutet (Sweden).

Document selection and inclusion criteria

All identified documents were centralised in a Microsoft Teams repository for systematic screening. To ensure the rigor and relevance of the comparative analysis, specific inclusion and exclusion criteria were applied (Table 3). To be included, records were required to provide full-text information on the most recent large-scale national reform or its associated evaluation model; consequently, abstracts, meeting minutes, and conference proceedings were excluded. The geographic scope was strictly limited to Australia, England, Canada, Denmark, Norway, and Sweden, focusing on system-wide or cross-sectoral settings rather than isolated health sub-sectors. To ensure linguistic accuracy and access to primary policy documents, we included records published in English, Danish, Swedish, and Norwegian.

This approach was essential for capturing the legislative nuances of the Scandinavian reforms that may not be fully represented in English-language academic databases.

Table 3. Inclusion and exclusion criteria for record selection

Criterion	Inclusion criteria	Exclusion criteria
Text type	Full text available; reports, publications, books/book chapters	Abstract; conference/ workshop/meeting proceedings
Language	English, Danish, Swedish, Norwegian	Languages other than English, Danish, Swedish, Norwegian
Country	Australia, England, Canada, Denmark, Norway, Sweden	Not Australia, England, Canada, Denmark, Norway or Sweden
Setting	Health system; cross sector	Not focused on health system, or within one health sector only
Focus	Includes information about most recent large-scale reform and/or its evaluation approach	No information about the reform and/or its evaluation approach

Data extraction and synthesis

Data from all records were appraised and charted using a purpose-designed Excel data charting form (see data items extracted in Table 4). The research team categorised data on the health reforms and their evaluation models according to the domains and categories of the adapted WHO HSPA framework[1]. To ensure methodological rigor, the categorisation process was guided by the WHO HSPA handbook (Papanicolas et al. 2022) and the structured approach outlined by Fatimah et al. (2023). The research team engaged in iterative discussions throughout the charting phase to resolve any discrepancies and maintain accuracy in the mapping of reform features to their respective HSPA domains and categories. SS, KH, FTS, JM and GF met regularly to discuss discrepancies and reach consensus on categorisation and synthesis. Consensus-building teamwork during the analysis phase helped confirm the trustworthiness of the resulting categorisations.

Table 4. Data items extracted from included records

Category	Extracted data items
THE HEALTH REFORM	
Identification	Reform name, year introduced
Strategic intent	Key national goals and/or priorities
Innovation and scope	Focus areas and/or reform streams, novel features
Institutional context	Supporting organisations, governance and reporting arrangements
Targeted outcomes (WHO HSPA framework domains and categories)	
Functions	Reform initiatives targeting *resource generation, financing, governance*
Intermediate objectives	Reform initiatives targeting *effectiveness, safety, user experience, access, utilisation, service efficiency, service equity*
Final goals	Reform initiatives targeting *people-centredness, health improvement, financial protection, system efficiency, system equity*

[1] The *service delivery* category of the Functions domain was excluded from data categorisation and synthesis due to its high variability across nations and organisations, combined with the term's inherent ambiguity in referring to both the process and the product of care (WHO, 2022), would undermine comparative consistency.

THE HEALTH REFORM EVALUATION	
Evaluation approach	Overall evaluation design, including stages/phases, purpose and focus of each evaluation stage/phase
Evaluation entities/bodies	Bodies and individuals responsible for leading evaluation, including independent organisations and commissioned bodies
Evaluation methodologies	
Process evaluation	Methodologies used to evaluate process of reform implementation
Outcome evaluation	Methodologies used to evaluate results of reform over time
Targeted outcomes (WHO HSPA framework)	
Functions	Evaluation indicators targeting *resource generation, financing, governance*
Intermediate objectives	Evaluation indicators targeting *effectiveness, safety, user experience, access, utilisation, service efficiency, service equity*
Final goals	Evaluation indicators targeting *people-centredness, health improvement, financial protection, system efficiency, system equity*

AN OVERVIEW OF THE SIX NATIONAL HEALTH REFORMS

Six national health reforms were identified across the target countries covering the period 2000 to 2025. These reforms varied in their approach, yet all shared a common objective of addressing the rising complexity of chronic disease and the poor integration of primary and specialist care. These were the health reforms identified:

1. AUSTRALIA: National Health Reform Agreement (NHRA) 2020-25
2. ENGLAND: National Health Service (NHS) Long Term Plan
3. CANADA: Working Together to Improve Health Care for Canadians
4. DENMARK: Municipal Reform (Kommunalreformen)
5. NORWAY: Coordination Reform (Samhandlingsreformen)
6. SWEDEN: Good and Close Care (God och nära vård)

Targeted outcomes of health reforms

Table 5 displays the types of outcomes targeted by the six health reforms, mapped to the domains and categories of the WHO HSPA framework. All six reforms comprehensively targeted outcomes in the Functions domain, introducing initiatives for resource generation, financing and governance. The reforms of Australia, England, Canada and Norway targeted outcomes across all seven Intermediate Objectives categories: effectiveness, safety, user experience, access, utilisation, service efficiency and service equity. Sweden's reform targeted outcomes in six of these categories, and Denmark's reform targeted outcomes in five categories. For Final Goals, the reforms of Australia, England and Canada targeted outcomes in all five categories, including people-centredness, health improvement, financial protection, system efficiency and system equity. Norway and Sweden targeted outcomes in four of the five Final Goals categories, and Denmark targeted outcomes in three categories. Tables 6-13 illustrate selected initiatives across all six reforms mapped to the WHO HSPA framework domains and categories.

Table 5. Targeted outcomes across six reforms mapped to the WHO HSPA framework domains and categories.

DOMAIN / Category	AUSTRALIA	ENGLAND	CANADA	DENMARK	NORWAY	SWEDEN
FUNCTIONS						
Resource generation	✓	✓	✓	✓	✓	✓
Financing	✓	✓	✓	✓	✓	✓
Governance	✓	✓	✓	✓	✓	✓
INTERMEDIATE OBJECTIVES						
Effectiveness	✓	✓	✓	✓	✓	✓
Safety	✓	✓	✓	✓	✓	✗
User experience	✓	✓	✓	✗	✓	✓
Access	✓	✓	✓	✓	✓	✓
Utilisation	✓	✓	✓	✓	✓	✓
Service efficiency	✓	✓	✓	✓	✓	✓
Service equity	✓	✓	✓	✗	✓	✓
FINAL GOALS						
People-centredness	✓	✓	✓	✓	✓	✓
Health improvement	✓	✓	✓	✗	✓	✓
Financial protection	✓	✓	✓	✗	✗	✗
System efficiency	✓	✓	✓	✓	✓	✓
System equity	✓	✓	✓	✓	✓	✓

AUSTRALIA: National Health Reform Agreement (NHRA) 2020-25

Australia is a federation of six States and two Territories with a population of 27 million and a mixed public-private health system. Introduced in 2020 (Council on Federal Financial Relations, 2020), the NHRA 2020-25 represented a strategic commitment between the Federal government and State/Territory governments to improve health outcomes through shared funding and system-wide accountability. Central to this agreement was the transition toward value-based healthcare, moving beyond traditional activity-based funding to reward outcomes and patient experiences. The reform prioritised long-term systemic issues such as reducing avoidable hospital admissions, enhancing health data integration, and fostering nationally cohesive health technology assessments. By emphasising joint planning and funding at the local level, the NHRA aimed to create a more sustainable, integrated system capable of addressing the rising prevalence of chronic disease.

Functions

The NHRA established 32 strategic initiatives aimed at strengthening core health system Functions. As detailed in Table 6, these initiatives were distributed across the three Functions categories of the WHO HSPA framework: resource generation (9 initiatives), financing (12 initiatives), and governance (11 initiatives).

Table 6. Key *NHRA 2020-25* initiatives targeting health system Functions.

FUNCTIONS
Resource generation (9 key initiatives)
Workforce 1. National Aboriginal and Torres Strait Islander Health Workforce Strategy to increase the capacity and cultural safety of the Indigenous health workforce. 2. Health workforce planning, capacity building and needs assessments. 3. Teaching and training across states to ensure a sustainable supply of health professionals. 4. Establishing remuneration, employment terms and conditions for the workforce within Local Hospital Networks.
Infrastructure and equipment 5. Capital planning and funding of public hospital infrastructure, including buildings and major medical equipment. 6. Nationally Cohesive Health Technology Assessment roadmap reform to streamline how the system evaluates, prioritises, and invests in new medical technologies and equipment.
Pharmaceuticals and other consumables 7. Pharmaceutical Reform Arrangements governing the supply of pharmaceuticals to patients in the hospital setting. 8. High-cost, highly specialised therapies: A specific funding and governance framework for the introduction of complex, emerging therapies (e.g., gene therapies). 9. Funding of the Pharmaceutical Benefits Scheme as the primary Federal mechanism for generating access to essential medicines across the broader health system.
Financing (12 key initiatives)
Revenue raising 1. Commonwealth (Federal) Funding Contribution of 45% of the efficient growth in activity-based services. 2. State and Territory Funding Contribution of 55% (or more) of funding for public hospital services. 3. Commonwealth (Federal) Funding Cap (6.5%) on the annual growth of the Federal government financial contribution.

4. Private patient cost-shift protections to ensure the system correctly sources revenue from private health insurance rather than duplicating Federal government hospital funding.
Pooling resources 1. National Health Funding Pool introduced to combine Federal and State government contributions before distribution. 2. High-cost, highly specialised therapies shared fund to share the high financial risk of emerging gene and cell therapies between jurisdictions. 3. National Health Funding Body oversight to ensure all pooled funds are accounted for and transparently reported.
Purchasing 1. Activity Based Funding purchasing services based on the specific volume and complexity of patient cases (using the National Efficient Price). 2. Block Funding purchasing services for small rural hospitals or teaching and research where volume-based models are not applicable. 3. Paying for Value and Outcomes roadmap initiative to transition purchasing from volume to value. 4. Bundled payments reform exploring the purchase of an entire 'episode of care' (including follow-up and recovery) as a single package. 5. Safety and quality purchasing adjustments that reduce payment for services resulting in hospital-acquired complications or avoidable readmissions.
Governance (11 key initiatives)
Policy and vision 1. Shared Stewardship of whole health system by all governments, rather than stewardship of traditional silos. 2. Long-term Health Reforms Roadmap document outlining the vision for the system through 2030, endorsed by all Health Ministers. 3. National Health Reform Council as a peak body to steer high-level policy and ensure jurisdictions remain aligned with the Agreement's vision.
Stakeholder voice 1. Joint planning and priority setting between Local Hospital Networks and Primary Health Networks to ensure local community needs and clinician voices influence service planning. 2. Empowering People through Health Literacy initiative specifically designed to bring the patient's voice and capability to the forefront of care decisions. 3. Aboriginal and Torres Strait Islander leadership in the co-design of workforce and service strategies to ensure cultural safety
Information and intelligence 1. Performance reporting framework developed, managed by the AIHW and NHFB, to provide transparent, public intelligence on system performance against agreed targets. 2. Data transparency and sharing initiative aimed at breaking down data silos between the Federal (Medicare) and state-based health facilities to improve care journeys.
Legislation and regulation 1. Independent Health and Aged Care Pricing Authority as statutory regulator using legislative power to determine the National Efficient Price. 2. Australian Commission on Safety and Quality in Health Care as peak body regulating national clinical standards and the safety and quality financial adjustments. 3. Addendum Dispute Resolution Process as formal conflict-resolution process between the Federal government and State governments regarding the Agreement.

Intermediate Objectives

The NHRA 2020-25 introduced 21 initiatives that targeted Intermediate Objectives of health systems. As detailed in Table 7, these initiatives were distributed across the seven Intermediate Objectives categories of the WHO HSPA framework: effectiveness (4 initiatives), safety (3 initiatives), user experience (3 initiatives), access (4 initiatives), utilisation (2 initiatives), service efficiency (3 initiatives) and service equity (3 initiatives).

Table 7. Key *NHRA 2020-25* initiatives targeting health system Intermediate Objectives.

INTERMEDIATE OBJECTIVES
Effectiveness (4 key initiatives)
1. Paying for Value and Outcomes roadmap shifting funding from volume-based to outcomes-based models to ensure clinical effectiveness. 2. Nationally Cohesive Health Technology Assessment ensuring that new technologies and equipment used in the system are clinically effective before national adoption. 3. High-cost, highly specialised therapies governance framework specifically for life-changing, effective genomic and cell therapies. 4. Health research coordination commitment aiming to align research activities with clinical needs to improve evidence-based practice.
Safety (3 key initiatives)
1. Hospital-acquired complications funding adjustment, issuing financial penalties for hospitals where specific avoidable complications occur. 2. Avoidable hospital readmissions funding adjustment targeting the safety and quality of the initial discharge and treatment process. 3. Clinical quality registries development to monitor the safety and performance of specific clinical procedures and devices.
User experience (3 key initiatives)
1. Empowering People through Health Literacy roadmap initiative to ensure patients can understand and navigate their own care. 2. Individualised care plans as part of the Chronic Disease Management reform focusing on personalising the patient journey. 3. Patient-Reported Outcome Measures (PROMs) and Patient-Reported Experience Measures (PREMs) promoted and formally integrated into assessment of the Agreement.
Access (4 key initiatives)
1. Public hospital funding guarantees ensuring that regardless of activity levels, a baseline of funding exists to maintain service availability. 2. Pharmaceutical Reform Arrangements ensuring patients in various settings have immediate access to necessary medications. 3. National Funding Pool transparency, ensuring funds reach Local Hospital Networks promptly to maintain service availability. 4. Private patient protections ensuring that the presence of private patients does not reduce access for public patients within public facilities.
Utilisation (2 key initiatives)
1. Prevention of avoidable hospital admissions through initiatives aimed at managing chronic conditions in the community to prevent unnecessary hospital use. 2. Enhanced information and data sharing to provide clinicians with a better understanding of patient history, preventing duplicative or unnecessary service use.
Service efficiency (3 key initiatives)
1. Activity Based Funding / National Efficient Price as a core mechanism that incentivises hospitals to provide services at or below the national benchmark of efficiency. 2. Bundled payments reform exploring a single payment for a whole episode of care to reduce administrative waste and fragmented service delivery. 3. Joint planning between primary and acute care sectors to improve care integration and reduce duplication.
Service equity (2 key initiatives)
1. National Aboriginal and Torres Strait Islander Health Workforce Strategy to target the gap in culturally safe and equitable resource distribution. 2. Block funding for small rural and remote hospitals to ensure continued operations and sustain geographic equity.

Final Goals

The NHRA introduced 18 initiatives that targeted Final Goals of health systems. As detailed in Table 8, these initiatives were distributed across the five Final Goals categories of the WHO HSPA framework: people-centredness (4 initiatives), health improvement (4 initiatives), financial protection (3 initiatives), system efficiency (4 initiatives) and system equity (3 initiatives).

Table 8. Key *NHRA 2020-25* initiatives targeting health system Final Goals.

FINAL GOALS
People-centredness (4 key initiatives)
1. Empowering People through Health Literacy initiative to ensure the system is designed so that people can effectively participate in their own care. 2. Personalised care pathways for chronic disease to enable multidisciplinary care that follows the patient across different settings. 3. Implementation of PROMs and PREMs to ensure the system is held accountable to the consumer experience. 4. Consumer and community engagement frameworks that require Local Health Networks to involve consumers in the design and delivery of hospital services.
Health improvement (4 key initiatives)
1. National Preventive Health Strategy integration to link NHRA reforms to broader preventive health goals to reduce chronic disease prevalence. 2. High-cost, highly specialised therapies that aim for significant long-term health gains for people with rare diseases. 3. Safety and quality financial adjustments intended to reduce clinical harm and improve overall patient recovery outcomes. 4. Data-driven clinical improvement utilising national data sets to identify and scale clinical best practices across jurisdictions.
Financial protection (3 key initiatives)
1. Public hospital service guarantee for Medicare-eligible patients to receive public hospital services free of charge based on clinical need. 2. Pharmaceutical Benefits Scheme and Pharmaceutical Reform Arrangements to ensure that hospital-initiated medications remain affordable or free for public patients. 3. Protection against private patient out-of-pocket costs through clauses informing patients of financial implications.
System efficiency (4 key initiatives)
1. Activity Based Funding and the National Efficient Price as a benchmark price to drive technical efficiency across the national hospital system. 2. Paying for Value and Outcomes initiative to ensure the system invests in interventions that provide the highest value per dollar spent. 3. Harmonisation of governance and reporting to reduce the administrative burden and duplication of effort between State and Federal government bureaucracies. 4. Health Technology Assessment rationalisation to ensure the system only invests in cost-effective technologies.
System equity (3 key initiatives)
1. National Aboriginal and Torres Strait Islander Health Workforce Strategy to address health inequities through a culturally capable workforce. 2. Block funding providing additional financial support to small rural and remote hospitals to ensure geographic equity of service. 3. Ensuring the Federal government provides a consistent level of funding support to all states regardless of their individual fiscal capacity.

ENGLAND: National Health Service (NHS) Long Term Plan

England is a country within the United Kingdom with a population of ~58.6 million and a predominantly tax-funded National Health Service (NHS) providing universal coverage with most care free at the point of use, alongside a smaller private sector. Launched in 2019 (NHS England, 2019), the NHS Long Term Plan outlined a 10-year vision to stabilise the health service by shifting the focus from reactive acute care to proactive community-based support. A cornerstone of this reform was the establishment of Integrated Care Systems, which legally mandate collaboration between hospitals, general practitioners, and local councils to manage the health of their specific populations. The plan leveraged digital transformation and non-clinical, community-based supports to reduce health inequalities, with a focus on improving outcomes for cancer, cardiovascular disease, and mental health. By integrating primary and specialist services, the reform aimed to alleviate pressure on Emergency Departments and ensure the NHS remained viable for future generations. Table 9 displays selected reform initiatives mapped to the WHO HSPA framework domains and categories.

Table 9. Selected *NHS Long Term Plan* initiatives mapped to WHO HSPA domains and categories.

DOMAIN/ Category	Selected reform initiatives
FUNCTIONS	
Resource generation	*Workforce*: Investing in the growth of nursing apprenticeships and wider apprenticeships in clinical and non-clinical jobs in the NHS. *Infrastructure and equipment:* Accelerating roll out of Electronic Patient Record systems and apps to support modern IT hosting, storage and cyber security. *Pharmaceuticals and other consumables:* Delivering better value from the £16 billion annual spend on medicines with support from Pharmacy and Medicines Optimisation Team and Medicines Value Programme.
Financing	*Pooling resources:* Moving from small Clinical Commissioning Groups to 42 larger Integrated Care Systems, for better redistribution of funds to higher-needs areas. *Purchasing:* Spending at least £2.3bn more a year on mental health care, specifically for children and young people's mental health.
Governance	*Policy and vision:* Working with national partners to review opportunities to reduce carbon, waste and water use in line with Climate Change Act targets. *Stakeholder voice:* Working with people with lived experience to publish and clarify a quality assurance framework. *Information and intelligence:* Introducing Quality Markers framework for primary care that highlight best practice in carer identification and support. *Legislation and regulation:* Working with the Care Quality Commission to strengthen existing oversight arrangements for commissioners.
INTERMEDIATE OBJECTIVES	
Effectiveness	Preventing 14,000 premature deaths through evidence-based heart exercise programmes.
Safety	Releasing a new Patient Safety Incident Response Framework as part of the National Patient Safety Strategy.

User experience	Upgrading staff support for care home residents to create a personalised, comprehensive and seamless experience for residents.
Access	Expanding access to multidisciplinary footcare teams and diabetes inpatient specialist nursing teams for enhanced diabetes specialist care.
Utilisation	Integrating digital tools and mental health therapists into general practice for more efficient depression and anxiety treatment.
Service efficiency	Expanding community-based urgent care services to provide a locally accessible and convenient alternative to emergency settings.
Service equity	Expanding support for all veterans and their families as they transition out of the armed forces.
FINAL GOALS	
People-centredness	Ensuring women are cared for by the same healthcare team throughout pregnancy, birth, and the postnatal period.
Health improvement	Saving 55,000 lives annually through early cancer diagnosis.
Financial protection	Increasing funding for primary/community care by £4.5bn (reducing out-of-pocket reliance).
System efficiency	Developing rapid community response teams to prevent unnecessary hospital admissions.
System equity	Engaging with nationally commissioned services to improve outcomes for people engaged in the health and justice systems.

CANADA: Working Together to Improve Health Care for Canadians

Canada is a federation of 10 provinces and three territories with a population of ~40.5 million and a decentralised, universal publicly funded system ("Medicare")—administered primarily by provinces/territories and framed by the Canada Health Act, with medically necessary hospital and physician services generally free at point of use. The 2023 agreement between federal and provincial/territorial governments (Health Canada, 2023) marked a significant reinvestment in Canada's publicly funded health system to address post-COVID-19 systemic fragilities. The reform was designed to be structured around four shared priorities: expanding access to family health services, supporting the health workforce, improving mental health and substance use services, and modernising health data systems. Through bilateral agreements tailored to the specific needs of each province, the plan aimed to reduce surgical backlogs and wait times while ensuring that every Canadian has access to a multidisciplinary primary care team. The focus on data interoperability was particularly strong, intended to allow patients and providers to access seamless health records across the country. Table 10 displays selected reform initiatives mapped to the WHO HSPA framework domains and categories.

Table 10. Selected *Working Together* initiatives mapped to WHO HSPA domains and categories.

DOMAIN/ Category	Selected reform initiatives
FUNCTIONS	
Resource generation	*Workforce*: Implementing strategies for recruitment, retention, and training of healthcare professionals (e.g., nurses, physicians, personal support workers). *Infrastructure and equipment:* Supporting the implementation and adoption of electronic health records, telehealth, and other digital solutions. *Pharmaceuticals and other consumables:* Improving accessibility of rare disease medications via a National Strategy for Drugs for Rare Diseases.
Financing	*Pooling resources:* Providing of $25 billion over 10 years to provinces and territories to support shared health priorities through tailored bilateral agreements. *Purchasing:* Reforming how primary care providers are compensated to encourage team-based care, quality outcomes, and improved access
Governance	*Policy and vision:* Integrating mental health and substance use care into the broader healthcare system, shifting toward a 'whole-person' care model. *Stakeholder voice:* Requiring provinces to publish action plans that are developed in consultation with local stakeholders. *Information and intelligence:* Enhancing the ability to track mental health and substance use service utilisation and outcomes to inform planning. *Legislation and regulation:* Establishing structures to better plan, coordinate, and manage primary healthcare services at regional or local levels.
INTERMEDIATE OBJECTIVES	
Effectiveness	Expanding availability of evidence-based therapies, harm reduction services, and supports for individuals and families.
Safety	Ensuring long-term care homes meet or exceed national safety standards for infection prevention, resident-centred care, and physical environment.

User experience	Improving digital patient portals enabling patients to have secure access to their personal health records, including prescriptions and test results.
Access	Expanding access to a range of community-based services and treatment options, helping people age with dignity, closer to home.
Utilisation	Increasing the number of surgeries and diagnostic procedures by investing in capacity and innovative approaches.
Service efficiency	Addressing existing backlogs in surgeries and diagnostic procedures exacerbated by events like the COVID-19 pandemic.
Service equity	Increasing the availability of mental health and addiction supports in local communities, reducing reliance on hospital-based care.
FINAL GOALS	
People-centredness	Improving continuity of care and access to preventative services by ensuring more Canadians have a regular primary care provider.
Health improvement	Reducing the burden of mental illness and substance-related morbidity through improving access to quality mental health and addictions services.
Financial protection	Ensuring that medically necessary services remain free at the point of care by strengthening funding support for provinces and territories.
System efficiency	Optimising the distribution and recruitment of the workforce through creating a Centre of Excellence on health worker data.
System equity	Bridging the geographic equity gap in service availability through targeting the expansion of family health services in rural and remote areas.

DENMARK: Municipal Reform (Kommunalreformen)

Denmark is a unitary state with five regions and 98 municipalities, a population of ~6.0 million, and a universal, largely tax-funded health system that is decentralised across regions/municipalities with limited user charges and optional complementary insurance. Denmark's 2007 *Municipal Reform* (Danish Ministry of the Interior and Health, 2006) fundamentally reorganised the structure of the public sector to strengthen local government capacity, improve coordination across administrative levels, and ensure high-quality public services. The reform consolidated the number of municipalities from 271 to 98 and replaced 14 counties with five regions, establishing a clearer division of responsibilities between state, regions, and municipalities. Municipalities were assigned responsibility for a broad range of citizen-oriented services, including prevention, rehabilitation, social care, and follow-up services for patients with mental illness, while regions became responsible for hospital services, including specialised psychiatric treatment. This division of responsibilities reflected an intention to ensure clearer accountability while improving coordination across sectors, particularly for patient groups requiring services across both health and social care.

This decentralisation aimed to foster stronger linkages between social services and primary healthcare, ensuring that larger, more financially robust administrative units possessed the professional capacity to manage increasingly complex welfare tasks. A central objective of the reform was to eliminate service fragmentation, particularly at the critical interface of health, employment, and social services. By creating larger catchment areas, the government sought to reduce unwarranted geographical variation in service delivery and ensure clearer accountability for patient groups requiring multi-sectoral support. While the reform was anchored in the principles of universal access and geographically distributed services, it is notable that equity was not explicitly operationalised through targeted policy instruments or specific distributional metrics. Tables 11-13 display reform initiatives mapped to the WHO HSPA framework domains and categories.

Functions

The Municipal Reform introduced structural and system-level initiatives to strengthen resource capacity, financing mechanisms, and governance arrangements across the health system. These focused on consolidating service delivery, aligning financial incentives, and establishing clearer institutional responsibilities.

Table 11. Key *Municipal Reform* initiatives targeting health system Functions.

FUNCTIONS
Resource generation (6 key initiatives)
Workforce 1. Initiating geographical placement and state responsibility for health education programmes. 2. Implementing national planning of hospital specialisation to ensure sufficient patient volume and clinical competencies.
Infrastructure and equipment 3. Introducing national requirements for information technology standards to enable integrated electronic patient records and high-quality health registries. 4. Establishing a new hospital structure with fewer, larger, and more specialised units. 5. Introducing municipal prevention, rehabilitation and community-based health care organised in health centres. 6. Dividing mental healthcare between hospital-based psychiatry (regions) and community-based services (municipalities).

Financing (2 key initiatives)
Revenue raising 1. Introducing multi-source regional healthcare financing with incentive elements: Regional healthcare financed through a combination of state block grants, municipal contributions and activity-based payments.
Pooling resources 2. Implementing municipal contributions to regional healthcare financing to create shared financial responsibility and incentives across sectors.
Governance (9 key initiatives)
Policy and vision 1. Merging municipalities, abolishing counties and establishing regions responsible for healthcare. 2. Mandatory health agreements to ensure coordination of patient pathways, prevention and rehabilitation. 3. Centralised (national) planning to define service levels and ensure quality through volume and expertise. 4. The state defines the overall regulatory and strategic framework for regions and municipalities. 5. Municipalities act as the main entry point for citizens in relation to welfare and health-related services.
Stakeholder voice 6. Greater decision-making authority allocated to municipalities to strengthen local democracy.
Information and intelligence 7. Development of a Danish model for quality improvement and accreditation. 8. Central authorities tasked with monitoring performance across the health system based on shared standards.
Legislation and regulation 9. Strengthening the resilience of Danish decentralised governance model by consolidating institutional structures i.e. allocating more decision-making authority to the municipal level.

Intermediate Objectives

Reform initiatives targeted improvements in system performance primarily through enhanced coordination, expanded municipal responsibilities, and financial incentives influencing service delivery. No specific initiatives were identified for user experience or service equity.

Table 12. Key *Municipal Reform* initiatives targeting health system Intermediate Objectives.

INTERMEDIATE OBJECTIVES
Effectiveness (2 key initiatives)
1. Assigning municipalities an expanded role in prevention, rehabilitation and care to improve task performance. 2. Assigning municipalities responsibility for rehabilitation service provision not provided during hospitalisation.
Safety (1 key initiatives)
1. Establishing regional state offices responsible for supervision and complaints handling.
Access (3 key initiatives)

1. Positioning municipalities as the primary public entry point to services for citizens and businesses. 2. Increasing system capacity through enabling municipalities to establish local solutions for prevention and rehabilitation (e.g. health centres). 3. Assigning municipalities responsibilities for individual-level prevention, rehabilitation, substance use treatment, and social care.
Utilisation (1 key initiatives)
1. Introducing municipal co-financing of admissions to incentivise prevention and reduce hospital admissions.
Service efficiency (1 key initiatives)
1. Reorganising the financing of regional healthcare to a multi-source system, combining block grants and activity-based incentive elements to support efficient service provision.

Final Goals

The reform was primarily oriented towards strengthening system efficiency and administrative sustainability. Broader goals related to equity and people-centredness were implicitly embedded but not operationalised through specific policy instruments. There were no specific initiatives identified for health improvement or financial protection.

Table 13. Key *Municipal Reform* initiatives targeting health system Final Goals.

FINAL GOALS
People-centredness (1 key initiatives)
1. Enabling municipalities to manage direct citizen-oriented tasks and act as the primary interface with the public sector.
System efficiency (3 key initiatives)
1. Ensuring that administrative units are financially sustainable and possess the necessary professional expertise and accountability to deliver high-quality services. 2. Enabling municipalities to develop the structural and administrative capacity required to manage an expanded portfolio of welfare and health-related responsibilities. 3. Consolidating administrative units and service structures to improve utilisation of specialised staff and resources.
System equity (2 key initiatives)
1. Embedding equity considerations in the broader universal welfare model to strengthen the public sector's capacity to invest in people and future welfare. 2. Creating sustainable administrative units with clear responsibility for delivering high-quality welfare services, supporting more uniform capacity across geographical areas.

NORWAY: Coordination Reform (Samhandlingsreformen)

Norway is a unitary state with a population of ~5.65 million and universal health coverage funded mainly through general taxation plus payroll contributions, with municipalities responsible for primary care and regions responsible for specialist care (with capped copayments for many services). Introduced in 2012, Norway's *Coordination Reform* (Norwegian Ministry of Health and Care Services, 2009) sought to address fragmentation between primary and specialist care by shifting responsibility toward municipalities, strengthening prevention, and reducing avoidable hospital use. The reform articulated a clear vision of equitable access to services regardless of geography or personal finances, while emphasising early intervention, improved coordination, and strengthened municipal capacity.

Table 14 displays selected initiatives from the Norwegian reform mapped to the WHO HSPA framework domains and categories. There were no specific initiatives identified for the final health system goal of financial protection.

Table 14. Selected *Coordination Reform* initiatives mapped to WHO HSPA domains and categories.

DOMAIN/ Category	Selected reform initiatives
FUNCTIONS	
Resource generation	*Workforce*: Joint competence development (ambulatory teams, shared positions, rotation schemes). *Infrastructure:* Establishing 24/7 community-based acute beds.
Financing	Transferring financial resources from hospitals to municipalities to reflect new responsibilities.
Governance	Developing the National Health Plan as an operational tool for coordinated prioritisation across the health and care sector.
INTERMEDIATE OBJECTIVES	
Effectiveness	Implementing standardised patient pathways to improve targeted outcomes.
Safety	Introducing joint discharge planning procedures to prevent safety issues caused by fragmented clinical information.
User experience	Enhancing patient access to their health information, empowering users to participate more effectively in shared decision-making.
Access	Prioritising municipal services, including early intervention and low-threshold services closer to home.
Utilisation	Using co-financing mechanisms and discharge reimbursement rules to shift activity from hospitals to municipalities and promote appropriate service use.
Service efficiency	Redistributing tasks to municipalities and establishing community-based alternatives to hospital care to reduce unnecessary hospital stays i.e. 24/7 community-based acute beds.
Service equity	Strengthening dialogue with minority and Sámi populations about health service needs and design.
FINAL GOALS	

People-centredness	Introducing legally mandated care coordinators for patients with complex needs.
Health improvement	Strengthening upstream municipal public health responsibility through the Public Health Act to promote prevention and address population health challenges earlier.
System efficiency	National Health Plan for prioritisation - A mechanism to support coordinated prioritisation and resource allocation across levels of care.
System equity	Promoting equal access to services regardless of place of residence, socioeconomic background, or minority status.

SWEDEN: Good and Close Care (God och nära vård)

Sweden is a unitary state with a population of ~10.7 million and a predominantly tax-funded universal health system in which 21 regions are responsible for financing, organising and delivering most healthcare, while 290 municipalities manage key elements of long-term and social care. Sweden's 2019 *Good and Close Care* reform (Socialdepartementet, 2019) reform represented a historic paradigm shift from a hospital-centric model to one centred on primary care provision. Driven by the need to manage an aging population and increasing chronic illness, the reform mandated that the patient primary care providers serve as the coordinator for all health interactions. It emphasised accessibility, continuity, and the 'nearness' of care – utilising digital health tools and mobile integrated teams to deliver specialist-level care in the patient's home. The reform's key goal was to enhance the proactive and person-centred nature of the system, ensuring that hospital resources were reserved only for the most acute cases.

Table 15 displays selected reform initiatives mapped to the WHO HSPA framework categories and domains. There were no specific initiatives identified for the final health system goal of financial protection.

Table 15. Selected *Good and Close Care* initiatives mapped to WHO HSPA domains and categories.

DOMAIN/ Category	Selected reform initiatives
FUNCTIONS	
Resource generation	*Workforce:* Implementing digital solutions to reduce the workload of healthcare professionals. *Infrastructure:* Implementing new information technology systems to improve accessibility to digital care.
Financing	Integrating more services into primary care and digital health services through a 2,430,000,000 SEK (261,954,000 USD) investment.
Governance	Reallocation of some responsibilities from hospitals to community-based services and home care (e.g., post-acute rehab, mental health follow-ups).
INTERMEDIATE OBJECTIVES	
Effectiveness	Standardising care pathways to strengthen evidence-based treatment and improve targeted outcomes.
Safety	Reducing unwarranted clinical variation and errors through standardising clinical treatment pathways.
User experience	Introduction of patient contracts to ensure patient involvement in care, continuity, and a designated care provider/contact.
Access	Improving the waiting time guarantee for medical assessment in primary care from seven to three days.
Utilisation	Improving primary care competencies to avoid preventable hospitalisations.
Service efficiency	Investing in and reallocating resources to primary care to reduce avoidable hospital admissions and emergency care utilisation.
Service equity	Ensuring equal regional access to care by improving local care and digital health services.
FINAL GOALS	

People-centredness	Introduction of patient contracts to clarify care pathways.
Health improvement	Patient contracts including agreements between the patient and care provider regarding the patient´s own responsibilities for lifestyle interventions.
System efficiency	Reallocating resources to primary and community care.
System equity	Ensuring timely and equitable access to healthcare by strengthening digitalisation and primary care services to reduce regional disparities.

NATIONAL HEALTH REFORM EVALUATION MODELS

Methodologies

Across all six health reforms, a range of evaluation methodologies were used to assess both the implementation (process) and outcomes of the reforms (impact). To evaluate the *process of reform implementation*, a variety of qualitative methods were employed to understand how the reforms were implemented and to identify any challenges or successes. These methods included stakeholder consultations in the form of workshops, targeted interviews, and meetings with key individuals and groups. To evaluate *reform impact*, a combination of qualitative and quantitative methods was used. The qualitative methods included stakeholder consultations, such as case studies, surveys, interviews, and written submissions, to gather perspectives on the reforms' impact. Additionally, quantitative methods were utilised to retrieve and analyse performance data to measure the reforms' effectiveness, track financial spending, and conduct economic evaluations.

Targeted outcomes of evaluation models

The six reform evaluation models varied in how comprehensively they assessed their intended priorities across the Functions, Intermediate Objectives and Final Goals domains. In terms of quantitative assessment utilising indicators, Table 16 illustrates whether the six reform evaluation models incorporated indicators to assess outcomes in the domains and categories of the WHO HSPA framework (2022). An in-depth analysis of indicator comprehensiveness was conducted for the Australian reform and the Danish reform to develop a blueprint for mapping reform initiatives against quantitative assessment methods (Tables 17-19 and 23-25, respectively). Tables 20-22 and 26-28 display selected indicators across all six reform evaluation models mapped to the WHO HSPA domains and categories.

Table 16. Targeted indicators across six reform evaluations mapped to the WHO HSPA domains and categories.

DOMAIN / Category	AUSTRALIA	ENGLAND	CANADA	DENMARK	NORWAY	SWEDEN
FUNCTIONS						
Resources	✓	✓	✓	✓	✓	✓
Financing	✓	✓	✓	✓	✓	✓
Governance	✗	✓	✓	✓	✓	✓
INTERMEDIATE OBJECTIVES						
Effectiveness	✓	✓	✓	✓	✓	✓
Safety	✗	✓	✓	✓	✓	✓
User experience	✓	✓	✓	✓	✓	✓
Access	✓	✓	✓	✓	✓	✓
Utilisation	✓	✓	✓	✓	✓	✓
Service Efficiency	✓	✓	✓	✓	✓	✓
Service Equity	✓	✓	✓	✗	✓	✓
FINAL GOALS						
People-centredness	✓	✓	✓	✓	✓	✓
Health improvement	✓	✓	✓	✓	✓	✗
Financial protection	✓	✓	✓	✗	✗	✗
System Efficiency	✓	✓	✓	✓	✗	✓
System Equity	✓	✓	✓	✓	✗	✓

AUSTRALIA: National Health Reform Agreement (NHRA) Mid-Term Review

Evaluation approach

The 2020-25 Addendum to Australia's National Health Reform Agreement (NHRA) underwent an external mid-term review in 2023, representing the primary strategic evaluation of the agreement's progress. Commissioned by the Health Ministers of the Federal government and all State and Territory governments, the review was led by two independent reviewers – Ms. Rosemary Huxtable AO PSM and Mr. Michael Walsh PSM – with technical support from the management consultancy Deloitte (Huxtable, 2023). This broad, consultative process combined qualitative stakeholder submissions with quantitative health system data. It focused particularly on ensuring the NHRA's funding, planning, and governance structures were fit-for-purpose amidst Australia's changing healthcare landscape, especially regarding how different care sectors interface (Jackson, 2024).

Evaluation methodologies

The mid-term review employed a comprehensive, mixed-methods evaluation that assessed both the implementation process and systemic outcomes. The process evaluation focused on assessing the operational progress of the 2020-25 Addendum. It conducted stakeholder consultations, which included jurisdictional workshops, targeted interviews with various organisations, and a public call for written submissions. This qualitative data provided insights into the real-world challenges and successes of implementation. To ensure accountability, this information was supplemented by regular progress reports and presentations delivered to key governance bodies, such as to a Reform Implementation Group.

The outcomes evaluation measured the reforms' impact on health system performance. This began with a document review to understand the policy objectives, followed by an analysis of quantitative data retrieved from seven primary custodians (Australian Institute of Health and Welfare, Productivity Commission, Australian Commission on Safety and Quality in Health Care, Independent Health and Aged Care Pricing Authority, National Health Funding Body, Commonwealth Department of Health and Aged Care and Australian Bureau of Statistics). This data was used to develop an Interim Quantitative Performance Framework to measure the achievement of the NHRA's goals. The same stakeholder consultations used for the process evaluation also informed the outcomes analysis, providing qualitative context to the quantitative data. Both the process and outcomes evaluations were enriched by international insights from expert consultations, thereby providing a global perspective on health system performance. A key recommendation for measuring outcomes was the development of joint reporting and accountability arrangements between local organisations.

Evaluation shortcomings and learnings

The NHRA 2020–25 was designed with the intention of using the Australian Health Performance Framework (AHPF) as the single, primary reporting mechanism to evaluate the success of the Agreement. However, the mid-term review found that the AHPF was ill-equipped for this task. It failed to provide meaningful insights into the effectiveness of the NHRA in meeting its core objectives, largely because its indicators remained siloed, focusing heavily on hospital activity rather than capturing the critical interactions across different healthcare sectors (see Tables 17-20).

Because the AHPF was deficient, the review leveraged a broader range of methodologies to conduct a comprehensive assessment. This included synthesising performance data from a variety of external sources and jurisdictions; most of the key indicators used to judge the Agreement's progress were sourced from outside the AHPF (Tables 17-20).

A primary learning from this process was the urgent need to modernise national reporting. The experience highlighted that for evaluation to be successful, indicators must be aligned with the specific goals of health reform: efficiency, effectiveness, sustainability, and equity. Consequently, the review took the step of designing an Interim Quantitative Performance Framework. This interim structure was developed specifically to ensure that the next iteration of the NHRA possesses a robust, targeted measurement system, moving away from retrospective activity counts toward a clearer understanding of what data is being collected and its direct relevance to health outcomes.

Evaluation indicators

The evaluation of the NHRA 2020–25 via quantitative indicators was characterised by a divide between established funding mechanics and aspirational policy reforms. While the mid-term review successfully utilised robust data to assess hospital efficiency and financial protections, it found the national reporting framework largely inadequate for measuring long-term strategic goals. Core objectives such as health literacy, joint planning, and value-based care lacked the necessary a priori metrics required for a rigorous performance assessment. The sections below provide further detail on the extent to which the NHRA initiatives were comprehensively evaluated using quantitative indicators.

Functions

Resource generation. The NHRA aimed to evolve the health system’s inputs by exploring innovative care coordination roles, building workforce capability for health literacy, and streamlining Health Technology Assessments. It further sought to guarantee access to medicines through Pharmaceutical Reform Arrangements and the Pharmaceutical Benefits Scheme. In practice, the evaluation of these reforms was inconsistent. There were no quantitative indicators used to measure progress on the development of new workforce models, the cohesion of Health Technology Assessments streamlining, or the clinical impact of dispensed medications. Instead, the mid-term review relied on headcount data for the Indigenous Workforce Strategy and gross expenditure/volume data for pharmaceuticals. Consequently, the success of structural resource reforms was assessed primarily through qualitative stakeholder consultations, as the indicators failed to capture the transition from simple supply to strategic capability.

Financing. Improving system outcomes through shared funding was the most quantitatively robust priority of the NHRA. The agreement established a dual-funding model utilising Activity Based Funding and Block Funding, governed by the National Efficient Price and National Efficient Cost. It implemented the National Health Funding Pool to provide transparent, real-time tracking of contributions. The mid-term review successfully utilised a wide range of quantitative indicators for these components, including the 6.5% funding growth cap and reconciliation of actual activity against efficient prices. However, value-based financing remained unmeasured; the review found no national quantitative indicators for the Paying for Value and Outcomes or Bundled Payments initiatives. While financial mechanics were transparently tracked, the impact of financing on value emerged only through consultations.

Governance. The NHRA's governance initiatives aimed to shift toward shared stewardship of the whole health system, guided by the Long-term Health Reforms Roadmap and steered by the National Health Reform Council. Despite these strategic intentions, the mid-term review found that no quantitative indicators were used to evaluate these core policy and vision components, nor were they used to measure the success of Joint Planning between Local Hospital Networks and Primary Health Networks. Similarly, the Empowering People through Health Literacy and Data Transparency initiatives lacked any a priori metrics, preventing an objective assessment of patient journeys or cross-sector integration. Evaluation was most robust with regards to Legislation and Regulation and Information. For example, quantitative indicators successfully measured the performance of statutory regulators, specifically the Independent Hospital and Aged Care Pricing Authority's determination of the National Efficient Price. Furthermore, there was only a limited assessment of the extent to which stakeholder voices were included in governance initiatives; the review highlighted that Aboriginal and Torres Strait Islander organisations were not consulted with sufficiently during the life of the Agreement.

Intermediate Objectives

Effectiveness. The NHRA prioritised strengthening the evidence base for population-wide prevention and implementing value-based care models. However, the mid-term review highlighted that the lack of specific indicators—such as population-wide screening rates or chronic disease risk indicators—presented a significant barrier to understanding the true effectiveness of value-based care. While high-cost, highly specialised therapies were quantitatively monitored via 50/50 cost-sharing expenditure data, clinical patient outcome data remained insufficient. Other core effectiveness initiatives, such as Nationally Cohesive Health Technology Assessment (HTA) and Health Research Coordination, were evaluated only qualitatively; the review found limited evidence of systematic alignment with clinical needs and a continued fragmentation across jurisdictions. Consequently, the evaluation of effectiveness relied heavily on consultations, where stakeholders confirmed that the lack of proactive metrics constrained any assessment of long-term health improvements.

Safety. The NHRA sought to strengthen safety through financial levers and clinical oversight. Safety was evaluated using quantitative indicators; the review utilised data on hospital-acquired complications and avoidable hospital readmissions to measure the impact of financial penalties on clinical environments. However, while these 'lag' measures provided a snapshot of harm, the review noted a disconnect in proactive governance. It found that while authorities like the Australian Commission on Safety and Quality in Health Care possess the expertise to monitor safety, NHRA structures did not fully facilitate their involvement in strategic reform. Furthermore, while Clinical Quality Registries exist, they were not quantitatively integrated into national funding or safety performance models.

User experience. The NHRA aimed to enhance user experience through initiatives like Empowering People through Health Literacy and Individualised Care Plans. The evaluation of these reforms was significantly hindered by a total absence of national quantitative indicators. The review found that Patient-Reported Outcome Measures (PROMs) and Experience Measures (PREMs), while promoted in the Agreement, have not been formally integrated into the performance framework or funding models. As a result, the evaluation of user experience was relegated to qualitative consultation outcomes, which highlighted that current metrics remain focused on clinical activity (volumes) rather than the actual quality of the consumer journey.

Access. The NHRA aimed to secure access through Public Hospital Funding Guarantees, Pharmaceutical Reform Arrangements, National Funding Pool transparency, and Private

Patient Protections. The mid-term review successfully evaluated the financial aspects of these initiatives using quantitative indicators, such as the 6.5% funding growth cap and the Administrator's monthly payment reports. However, these indicators focused almost exclusively on the mechanics of the system rather than the experience of the patients. The review noted that existing metrics, such as emergency department wait times, masked operational realities through 'target-satisfying' practices, and that the absence of data regarding the underlying reasons for patients awaiting discharge meant the evaluation could not reflect real-time clinical barriers or patient needs.

Utilisation. The NHRA targeted utilisation by seeking to reduce duplicative services through enhanced data sharing and integrated care. In practice, the evaluation relied on a narrow set of quantitative indicators: Potentially Preventable Hospitalisations data provided a window into misutilisation but acted as a retrospective lag measure. The review found that the more granular utilisation goals—such as the use of linked datasets to track patient movements across the system—were not met because there were no quantitative metrics to measure the success of data interoperability or the reduction of service duplication.

Service efficiency. The review utilised the National Efficient Price and Activity Based Funding (ABF) data to evaluate how hospitals manage unit costs. However, efficiency in integrated care settings remained unevaluated. Initiatives such as bundled payments and joint planning lacked comparative quantitative indicators because they did not move beyond small-scale pilots. Instead, the review relied on narrow measures like the proportion of hospital beds occupied by patients ready for discharge but did not evaluate the success of the specific reform models proposed.

Service equity. The NHRA targeted service equity through block funding and the National Aboriginal and Torres Strait Islander Health Workforce Strategy. These were evaluated using quantitative data: the National Efficient Cost was used to ensure the financial viability of small rural hospitals, and workforce headcount data was used to track progress toward parity. However, the review found that beyond these input metrics, there were no dedicated indicators to measure equitable outcomes. The report noted that the current framework lacks culturally relevant indicators for First Nations people and fails to quantitatively measure whether rural block funding actually results in equitable service quality compared to metropolitan areas.

Final Goals

People centredness. The NHRA sought to achieve people-centredness by prioritising health literacy as a mechanism for patient empowerment. It further aimed to implement personalised care pathways and consumer engagement frameworks to ensure the system was responsive to individual needs. The mid-term review revealed that the NHRA did not include formal quantitative indicators to measure these shifts. A significant gap in the reform's ability to demonstrate success was that PROMs and PREMs, while intended to hold the system accountable, had not been formally integrated into the performance framework. Consequently, there was no systematic data to prove whether these initiatives actually improved the consumer experience.

Health improvement. The NHRA prioritised health improvement by emphasising National Preventive Health Strategy integration to reduce chronic disease prevalence and utilising high-cost, highly specialised therapies for long-term clinical gains. To drive these outcomes, it promoted data-driven clinical improvements to scale best practices. While the review noted that safety and quality financial adjustments were used to measure clinical harm for priority populations, these indicators were not explicitly identified. Furthermore, the review noted the

lack of specific indicators to measure the actual impact of preventive efforts or highly specialised therapies on long-term health outcomes. Evaluation of these final goals remained partial, as the system relied on ‘lag’ indicators like hospitalisation rates rather than proactive health gain metrics.

Financial protection. The NHRA targeted financial protection through the public hospital service guarantee, ensuring Medicare-eligible patients received care free of charge. It also utilised the Pharmaceutical Benefits Scheme and Pharmaceutical Reform Arrangements to improve access to medications for public hospital patients. The mid-term review evaluated access to medicines and high-cost, highly specialised therapies in public hospitals using quantitative expenditure and volume data. However, the review revealed the lack of sufficiently granular indicators to measure long-term financial protection for private patients; it relied on high-level administrative audits that failed to capture the real-world financial burden experienced by individual consumers.

System efficiency. The NHRA targeted system efficiency by implementing Activity Based Funding and the National Efficient Price to drive technical efficiency across hospitals. It also proposed HTA rationalisation and value-based funding models to optimise resource allocation. While the Agreement successfully measured technical efficiency and funding transparency through the National Health Funding Pool, it failed to evaluate the final goal of allocative efficiency. Because the review found no quantitative indicators for the Paying for Value initiative or the harmonisation of governance, it could not adequately assess whether the system delivered the right care in the right place or effectively incentivised high-value patient outcomes.

System equity. The NHRA targeted system equity by mandating Block Funding for small rural hospitals and implementing the National Aboriginal and Torres Strait Islander Health Workforce Strategy. The mid-term review successfully utilised quantitative indicators, such as the National Efficient Cost and workforce headcount parity targets, to show that the system's financial inputs were distributed equitably. However, the review revealed that the Agreement failed to implement indicators for equitable health outcomes. It highlighted a lack of culturally relevant metrics and regional outcome data necessary to determine whether funding models closed the health gap for high-needs cohorts and First Nations groups.

Table 17. Comprehensiveness of indicators for *NHRA 2020-25* initiatives targeting Functions.

FUNCTIONS	Indicators (Yes/No/Partial)
Resource generation (9 key initiatives)	
Workforce	
1. National Aboriginal and Torres Strait Islander Health Workforce Strategy to increase the capacity and cultural safety of the Indigenous health workforce.	P
2. Health workforce planning, capacity building and needs assessments.	P
3. Teaching and training across states to ensure a sustainable supply of health professionals.	Y
4. Establishing remuneration, employment terms and conditions for the workforce within Local Hospital Networks.	N
Infrastructure and equipment	
5. Capital planning and funding of public hospital infrastructure, including buildings and major medical equipment.	N
6. Nationally Cohesive Health Technology Assessment roadmap reform to streamline how the system evaluates, prioritises, and invests in new medical technologies and equipment.	N
Pharmaceuticals and other consumables	
7. Pharmaceutical Reform Arrangements governing the supply of pharmaceuticals to patients in the hospital setting.	Y
8. High-cost, highly specialised therapies: A specific funding and governance framework for the introduction of complex, emerging therapies (e.g., gene therapies).	Y
9. Funding of the Pharmaceutical Benefits Scheme as the primary Federal government mechanism for generating access to essential medicines across the broader health system.	Y
Financing (12 key initiatives)	
Revenue raising	
1. Commonwealth (Federal) Funding Contribution of 45% of the efficient growth in activity-based services.	Y
2. State and Territory Funding Contribution of 55% (or more) of funding for public hospital services.	Y
3. Commonwealth (Federal) Funding Cap (6.5%) on the annual growth of the Commonwealth's financial contribution.	Y
4. Private patient cost-shift protections to ensure the system correctly sources revenue from private health insurance rather than duplicating Federal government hospital funding.	P
Pooling resources	
5. National Health Funding Pool introduced to combine Federal and State government contributions before distribution.	Y
6. High-cost, highly specialised therapies shared fund to share the high financial risk of emerging gene and cell therapies between jurisdictions.	Y
7. National Health Funding Body oversight to ensure all pooled funds are accounted for and transparently reported.	Y
Purchasing	

8. Activity Based Funding purchasing services based on the specific volume and complexity of patient cases (using the National Efficient Price).	Y
9. Block Funding purchasing services for small rural hospitals or teaching and research where volume-based models are not applicable.	Y
10. Paying for Value and Outcomes roadmap initiative to transition purchasing from volume to value.	N
11. Bundled payments reform exploring the purchase of an entire 'episode of care' (including follow-up and recovery) as a single package.	N
12. Safety and quality purchasing adjustments that reduce payment for services resulting in hospital-acquired complications or avoidable readmissions.	Y
Governance (11 key initiatives)	
Policy and vision	
1. Shared Stewardship of whole health system by all governments, rather than stewardship of traditional silos.	N
2. Long-term Health Reforms Roadmap document outlining the vision for the system through 2030, endorsed by all Health Ministers.	N
3. National Health Reform Council as a peak body to steer high-level policy and ensure jurisdictions remain aligned with the Agreement's vision.	N
Stakeholder voice	
4. Joint planning and priority setting between Local Hospital Networks and Primary Health Networks to ensure local community needs and clinician voices influence service planning.	N
5. Empowering People through Health Literacy initiative specifically designed to bring the patient's voice and capability to the forefront of care decisions.	N
6. Aboriginal and Torres Strait Islander leadership in the co-design of workforce and service strategies to ensure cultural safety	P
Information and intelligence	
7. Performance reporting framework developed, managed by the AIHW and NHFB, to provide transparent, public intelligence on system performance against agreed targets.	Y
8. Data transparency and sharing initiative aimed at breaking down data silos between the Federal (Medicare) and state-based health facilities to improve care journeys.	N
Legislation and regulation	
9. Independent Health and Aged Care Pricing Authority as statutory regulator using legislative power to determine the National Efficient Price.	Y
10. Australian Commission on Safety and Quality in Health Care as peak body regulating national clinical standards and the safety and quality financial adjustments.	Y
11. Addendum Dispute Resolution Process as formal conflict-resolution process between the Federal and State governments regarding the Agreement.	Y

Table 18. Comprehensiveness of indicators for *NHRA 2020-25* initiatives targeting Intermediate Objectives.

INTERMEDIATE OBJECTIVES	Indicators (Yes/No/Partial)
Effectiveness (4 key initiatives)	
1. Paying for Value and Outcomes roadmap shifting funding from volume-based to outcomes-based models to ensure clinical effectiveness.	N
2. Nationally Cohesive Health Technology Assessment ensuring that new technologies and equipment used in the system are clinically effective before national adoption.	N
3. High-cost, highly specialised therapies governance framework specifically for life-changing, effective genomic and cell therapies.	Y
4. Health research coordination commitment aiming to align research activities with clinical needs to improve evidence-based practice.	N
Safety (3 key initiatives)	
1. Hospital-acquired complications funding adjustment, issuing financial penalties for hospitals where specific avoidable complications occur.	Y
2. Avoidable hospital readmissions funding adjustment targeting the safety and quality of the initial discharge and treatment process.	Y
3. Clinical quality registries development to monitor the safety and performance of specific clinical procedures and devices.	N
User experience (3 key initiatives)	
1. Empowering People through Health Literacy roadmap initiative to ensure patients can understand and navigate their own care.	N
2. Individualised care plans as part of the Chronic Disease Management reform focusing on personalising the patient journey.	N
3. Patient-Reported Outcome Measures (PROMs) and Patient-Reported Experience Measures (PREMs) promoted and formally integrated into assessment of the Agreement.	N
Access (4 key initiatives)	
1. Public hospital funding guarantees ensuring that regardless of activity levels, a baseline of funding exists to maintain service availability.	Y
2. Pharmaceutical Reform Arrangements ensuring patients in various settings have immediate access to necessary medications.	P
3. National Funding Pool transparency, ensuring funds reach Local Hospital Networks promptly to maintain service availability.	Y
4. Private patient protections ensuring that the presence of private patients does not reduce access for public patients within public facilities.	P
Utilisation (2 key initiatives)	
1. Prevention of avoidable hospital admissions through initiatives aimed at managing chronic conditions in the community to prevent unnecessary hospital use.	N

2. Enhanced information and data sharing to provide clinicians with a better understanding of patient history, preventing duplicative or unnecessary service use.	N
Service efficiency (3 key initiatives)	
1. Activity Based Funding / National Efficient Price as a core mechanism that incentivises hospitals to provide services at or below the national benchmark of efficiency.	Y
2. Bundled payments reform exploring a single payment for a whole episode of care to reduce administrative waste and fragmented service delivery.	N
3. Joint planning between primary and acute care sectors to improve care integration and reduce duplication.	N
Service equity (2 key initiatives)	
1. National Aboriginal and Torres Strait Islander Health Workforce Strategy to target the gap in culturally safe and equitable resource distribution.	P
2. Block funding for small rural and remote hospitals to ensure continued operations and sustain geographic equity.	N

Table 19. Comprehensiveness of indicators for *NHRA 2020-25* initiatives targeting Final Goals.

FINAL GOALS	Indicators (Yes/No/Partial)
People-centredness (4 key initiatives)	
1. Empowering People through Health Literacy initiative to ensure the system is designed so that people can effectively participate in their own care.	N
2. Personalised care pathways for chronic disease to enable multidisciplinary care that follows the patient across different settings.	N
3. Implementation of PROMs and PREMs to ensure the system is held accountable to the consumer experience.	N
4. Consumer and community engagement frameworks that require Local Health Networks to involve consumers in the design and delivery of hospital services.	N
Health improvement (4 key initiatives)	
1. National Preventive Health Strategy integration to link NHRA reforms to broader preventive health goals to reduce chronic disease prevalence.	N
2. High-cost, highly specialised therapies that aim for significant long-term health gains for people with rare diseases.	N
3. Safety and quality financial adjustments intended to reduce clinical harm and improve overall patient recovery outcomes.	N
4. Data-driven clinical improvement utilising national data sets to identify and scale clinical best practices across jurisdictions.	N
Financial protection (3 key initiatives)	
1. Public hospital service guarantee for Medicare-eligible patients to receive public hospital services free of charge based on clinical need.	Y
2. Pharmaceutical Benefits Scheme and Pharmaceutical Reform Arrangements to ensure that hospital-initiated medications remain affordable or free for public patients.	Y
3. Protection against private patient out-of-pocket costs through clauses informing patients of financial implications.	P
System efficiency (4 key initiatives)	
1. Activity Based Funding and the National Efficient Price as a benchmark price to drive technical efficiency across the national hospital system.	Y
2. Paying for Value and Outcomes initiative to ensure the system invests in interventions that provide the highest value per dollar spent.	N
3. Harmonisation of governance and reporting to reduce the administrative burden and duplication of effort between State and Federal government bureaucracies.	N
4. Health Technology Assessment rationalisation to ensure the system only invests in cost-effective technologies.	N
System equity (3 key initiatives)	
1. National Aboriginal and Torres Strait Islander Health Workforce Strategy to address health inequities through a culturally capable workforce.	P
2. Block funding providing additional financial support to small rural and remote hospitals to ensure geographic equity of service.	Y
3. Ensuring the Federal government provides a consistent level of funding support to all states regardless of their individual fiscal capacity.	Y

Table 20. Selected *NHRA 2020-25* indicators mapped to WHO HSPA domains and categories.

DOMAIN/ Category	Selected evaluation indicators
FUNCTIONS	
Resource generation	- Net growth in health workforce (medical practitioners, nurses and midwives, dental practitioners, allied health practitioners) per 100,000 population. - Proportion of all Pharmaceutical Benefits Scheme (PBS) medicines dispensed by public hospitals either on discharge or in the outpatient setting.
Financing	Proportion of total health spending by public and private sectors across a ten-year period (e.g., 2010–11 to 2020–21).
Governance	Time lag between when costs are incurred by jurisdictions and when they are reflected in the National Efficient Price (to measure performance of statutory regulators).
INTERMEDIATE OBJECTIVES	
Effectiveness	Rate of provision of high-cost, highly specialised therapies to patients appropriately classified by diagnosis as requiring them, compared to those not classified as requiring them.
Safety	Rate of hospital-acquired complications since previous NHRA implementation.
Access	Average wait-time (in days) for hospital discharge for National Disability Insurance Scheme participants.
Utilisation	Number of hospital patient days for those eligible and waiting for residential aged care.
Service efficiency	Proportion of hospital beds nationwide filled by older patients clinically ready for discharge.
Service equity	Proportion of First Nations' people who left or were discharged from hospital against medical advice.
FINAL GOALS	
Financial protection	Rate of growth in out-of-pocket patient costs for non-bulk billed services.
System efficiency	Number of hospital patient days (per 1000 patient days) across Australia for those eligible and waiting for residential aged care.
System equity	Number of hospital patient days (per 1000 patient days) for those eligible and waiting for residential aged care in major cities compared to regional and remote settings.

NB: No indicators were identified to evaluate NHRA initiatives targeting user experience, people-centredness or health improvement.

BOX 1: Australia's adaptation to evaluation challenges: From the Australian Health Performance Framework to the Interim Quantitative Performance Framework

A core goal of Australia's National Health Reform Agreement (NHRA) 2020-2025 was to improve transparency and reporting on health care performance across sectors. A key enabler for this objective was the Australian Health Performance Framework (AHPF), intended to serve as the primary framework for system-wide health performance reporting, fostering cross-sector learning and improvement.

However, the 2023 mid-term review of the NHRA identified significant challenges in the AHPF's ability to facilitate the measurement of the reform's progress. These measurement difficulties stemmed from several inherent limitations of the AHPF, such as:

- Lack of clarity on why data were being collected and reported.
- Potentially outdated indicators in the context of the contemporary digital environment.
- Absence of culturally relevant indicators to understand differences in health outcomes, access to care, and cultural safety for First Nations' people.
- A predominant focus on hospital activity in metrics, overlooking interactions and outcomes at the interface between health sectors.
- Insufficient patient-reported outcome and experience measures.

To address these identified gaps and ensure continuous progress measurement, an Interim Quantitative Performance Framework was subsequently developed. This new framework is designed to offer more detailed insights into performance changes aligned with the NHRA's objectives of efficiency, effectiveness, sustainability, and equity. Furthermore, it aims to guide collaborative development efforts in crucial areas such as patient-reported outcome and experience measures, culturally sensitive quality and safety indicators, workforce data consistency, and primary care access.

This case study underscores the importance of developing and maintaining robust performance frameworks that can effectively support comprehensive reform evaluation and ongoing system improvement. The experience with the AHPF highlights the need for frameworks that are not only well-conceived but also adaptable and clearly aligned with their intended evaluative purpose.

ENGLAND: National Health Service (NHS) Long Term Plan 2019 Evaluation

Evaluation approach

The evaluation approach for the NHS Long Term Plan (2019) was designed as a multi-layered, longitudinal assessment integrated into the transition towards Integrated Care Systems. The evaluation was guided by a phased Implementation Framework, which established the strategic roadmap for local and national performance tracking. The mixed-methods strategy combined statutory oversight from NHS England's Annual Reports with a quantitative foundation of performance metrics to track both clinical priorities and systemic goals like digital transformation. The design prioritised formative evaluation, allowing for real-time adjustments through specific clinical reviews and operational reviews. A prominent example of this was the clinically-led review of NHS cancer standards (2022), which modernised access metrics to align with the plan's focus on earlier diagnosis. The evaluation was supplemented by independent evaluations from the King's Fund, Nuffield Trust, and the Health Foundation. More recently, in March 2025, NHS England released the Review of NHS performance and delivery, a comprehensive assessment providing audited detail on the reform's impact over its initial five-year period.

Evaluation methodologies

The evaluation methodologies employed a blend of quantitative performance tracking and qualitative contextual analysis to capture the complexities of large-scale health reform. Quantitative assessment was structured around indicators within the NHS System Oversight Framework and NHS Long Term Plan Implementation Framework, which utilised approximately 80 standardised metrics to categorise system performance across multiple domains (see Table 21). These metrics served as the data foundation for annual performance reports, most notably the NHS England Annual Report and Accounts, which provided audited statutory oversight of the plan's headline targets and financial delivery. This data-driven approach allowed for longitudinal benchmarking and the identification of regional variations in service delivery.

To capture the ground-level reality often missed by data alone, the framework utilised methodological triangulation, combining high-frequency operational data with qualitative tools such as semi-structured interviews, clinician surveys, and case studies. Beyond broad system tracking, the methodology included program-specific evaluations for clinical priorities like cancer and mental health, with findings consolidated into annual thematic reviews by national transformation boards. Furthermore, the methodology included mandatory Equality and Health Inequalities Impact Assessments to identify the reform's impact on high-risk groups, ensuring that the systems-oriented feedback loops remained aligned with statutory requirements for equity and public accountability.

Evaluation shortcomings and learnings

Evaluations of the NHS Long Term Plan have highlighted several critical shortcomings, most notably the 'unrealistic' nature of its initial financial and workforce assumptions (Nuffield Trust, 2019). Analysts from The King's Fund and the Health Foundation pointed out that while the plan's vision for integrated care was sound, it was launched without a comprehensive workforce strategy, leaving the service to struggle with chronic staff shortages that undermined the delivery of new community-based models (The Health

Foundation, 2021; The King's Fund, 2019; Alderwick & Dixon, 2019). Furthermore, the evaluation process itself was reported to be hindered by a failure to implement lessons from the past, and by a reliance on narrow metrics—such as hospital utilisation—which failed to capture the nuances of preventative care or the slow-moving benefits of health inequality initiatives.

A major learning from these reviews is the interdependency of health and social care; the failure to secure a long-term funding settlement for social care concurrently with the Long Term Plan put pressure back onto hospitals, negating much of the plan's intended shift toward community care. Ultimately, the COVID-19 pandemic served as a massive external shock that both exposed these underlying frailties and provided a forced 'accelerator' for digital transformation, teaching policymakers that future plans must be more resilient to volatility and better supported by capital investment in crumbling infrastructure.

The evaluation approach demonstrated a divergence between policy objectives and the quantitative indicators prioritised in formal evaluations (see Table 21). At the level of health system Functions, reporting was consistent regarding the mechanical implementation of the reform. Metrics tracking workforce indicators aligned with the NHS People Plan – including retention and diversity data – provided a consistent record of structural progress. Similarly, reporting on digital maturity, such as the expansion of the NHS App and the Digital Weight Management Programme was consistent and comprehensive. However, there was limited evidence linking these functional achievements to direct improvements in patient outcomes. Governance and statutory duties, particularly regarding health inequalities, were frequently assessed through proxy measures such as the establishment of new leadership frameworks and partnerships.

Regarding intermediate objectives, the NHS System Oversight Framework provided a structure for measuring access and quality. While data on emergency admissions and elective recovery volumes were comprehensive, other safety indicators, such as fall-related injuries in the elderly, were sometimes omitted. In some instances, specific quality measures were substituted with volume-based targets, such as tracking total care encounters for severe mental illness rather than specific clinical outcomes. Access and utilisation indicators were consistently reported for traditional throughput metrics, such as the four-hour A&E standard. Some user experience data was reported (e.g., for patients in general practice), these metrics appeared secondary to clinical and target-driven indicators.

The assessment of long-term goals was consistent for several key population health outcomes. There was strong reporting of trajectories in maternal health, including reductions in stillbirths and neonatal deaths, alongside improved rates for early cancer diagnosis and survival, but lack of reporting on other priorities such as childhood obesity. Evaluations of mental health and person-centredness tended to rely on process-oriented data, including the uptake of personal health budgets, which provide a necessary structural foundation for tracking the system's transition toward more personalised, patient-led care. Lastly, the Equality and Health Inequalities Impact Assessment provided a framework for tracking equity, yet definitively attributing changes in healthy life expectancy to the 2019 reforms remained a complex challenge.

Table 21. Selected *NHS Long-Term Plan* evaluation indicators mapped to WHO HSPA domains and categories.

DOMAIN/ Category	Selected evaluation indicators
FUNCTIONS	
Resource generation	Annual staff retention rate across National Health Service.
Financing	Annual cash-releasing productivity growth rate.
Governance	Implementation of agreed waiting times/clinical standards for urgent and emergency care, elective care, cancer and mental health.
INTERMEDIATE OBJECTIVES	
Effectiveness	Proportion of cancer patients diagnosed at stage one or two compared to previous decade.
Safety	Proportion of cardiac arrest patients who had resuscitation continued or commenced by an ambulance service and were later discharged alive from the hospital.
User experience	Proportion of patients reporting a positive experience of contacting their general practitioner.
Access	Proportion of patients seen within 2 hours of referral to urgent care teams.
Utilisation	Rate of preventative health screenings and immunisations.
Service efficiency	Number of accident and emergency attendances admitted, transferred or discharged within four hours.
Service equity	Rate of learning disability physical health checks for people aged over 14 years.
FINAL GOALS	
People-centredness	Proportion of patients reporting health gain post-surgery for hip and knee replacements.
Health improvement	Proportion of women who were known to be smokers at the time of delivery.
Financial protection	Number of people eligible for fully funded care provided by the National Health Service for individuals with significant ongoing healthcare needs.
System efficiency	Proportion of Out of Area Placements in mental health services for adults in acute inpatient care due to lack of available hospital beds.
System equity	Proportion of people on general practitioner severe mental illness registers who received a comprehensive physical health check at least once a year.

BOX 2: England's adaptive, systems-oriented approach to learning and improvement in the National Health Service Long Term Plan

Evaluating a complex, long-term strategic plan like the NHS Long Term Plan presents a significant challenge, requiring a multifaceted approach to assess both progress against its ambitious goals and its real-world impact. While a single, comprehensive evaluation framework for the entire plan might not exist, various methodologies have been, and continue to be, used by a range of stakeholders including NHS England, academic institutions, think tanks, and independent bodies.

The NHS Long Term Plan evaluation model involves an adaptive and systems-oriented approach to evaluation. Recognising the inherent complexity of healthcare systems, the Long Term Plan's implementation was designed to be iterative. Early implementation efforts in Integrated Care Systems and Primary Care Networks actively informed subsequent adjustments, using methodologies such as real-time data feedback, rapid cycle improvement, 'test and learn' approaches, and the evaluation of pilots and vanguard sites.

This systems-oriented approach extended to the evaluation of Population Health Management, a core tenet of the Long Term Plan. The plan emphasises a shift towards proactive Population Health Management within Integrated Care Systems, and its evaluation is focused on understanding how these integrated systems function. Specifically, evaluation examines how effectively systems are utilising data to understand local population needs, identify at-risk groups, and design integrated services tailored to those needs. The methodologies for this include the analysis of population-level health outcomes, service utilisation patterns, and the development of 'integration indices,' all of which reflect a systemic view of health delivery.

This case study demonstrates the importance of adaptive, systems-oriented approaches for evaluating complex, large-scale health reforms. By embedding iterative learning and improvement methodologies within a flexible, multi-pronged strategy, these approaches provide ongoing performance insights that are more effective than static, single-framework methodologies.

CANADA: Working Together to Improve Health Care for Canadians Evaluation

Evaluation approach

The evaluation approach for Canada's Working Together to Improve Health Care for Canadians initiative was centred on a model of collaborative accountability and federal-provincial transparency. Through bilateral agreements, provinces and territories defined and implemented action plans tailored to their regional needs, evaluating their programs and services in alignment with their respective evaluation policies (Canadian Mental Health Association, 2024). Jurisdictions committed to a set of common performance indicators (Table 22) developed by the Canadian Institute for Health Information and were required to regularly share comparable data through a process to track national progress led by the Canadian Institute for Health Information (Canadian Mental Health Association, 2024). This strategic approach treated health reform as a dynamic evolution, prioritising intermediate milestones (e.g., workforce expansion, surgical throughput) as essential precursors to improved population health. By linking federal funding to the public reporting of these standardised metrics, the approach sought to enhance accountability and a culture of continuous learning across the diverse Canadian health landscape.

Evaluation methodologies

The methodologies employed to evaluate the Working Together initiative utilised a mixed-methods, data-driven design that prioritised longitudinal performance tracking and comparative analysis. Retrieval and analysis of performance data was done across four priority areas: primary healthcare, health workforce and surgeries, mental health and substance use, and electronic health information. A set of 12 common indicators published annually by the Canadian Institute for Health Information, focused on home and community care and mental health services, were supplemented by eight additional indicators to enable assessment of these reform priorities and provide regular 'snapshots' of cross-jurisdictional view of system performance (Table 22).

Complementing this, qualitative and program-specific evaluations were conducted to capture the contextual nuances of implementation. This process was supported by annual progress reports and joint federal-provincial-territorial reviews, which ensured consistent oversight of the bilateral agreements. Furthermore, the methodology integrated data modernisation and interoperability roadmaps to improve the flow of information across the health system. This triangulation of data, bolstered by joint reporting on tailored indicators, allowed evaluators to move beyond financial auditing to provide a functional assessment of how structural shifts impacted patient-level outcomes such as service equity and access.

Evaluation shortcomings and learnings

The evaluation framework of the Working Together initiative faced several structural and methodological challenges that complicated the assessment of its true impact. Critics have pointed to a lack of rigorous measurement and transparency, noting that inconsistent performance metrics and restricted public access to foundational data, such as the Statistics Canada survey results, have obscured the actual value of federal investments (Zhang, 2025; Canadian Mental Health Association, 2024). This data fragmentation was reportedly exacerbated by Canada's decentralised health stewardship; the autonomy of thirteen distinct jurisdictions created significant barriers to harmonisation, where divergent regional

methodologies and privacy constraints in smaller territories hinder comparative analysis. Furthermore, inter-jurisdictional tensions emerged regarding the utility of the federal indicators themselves. Some provinces, most notably Alberta, have expressed concern that the current emphasis on service utilisation, or system outputs, fails to capture meaningful patient outcomes and experiences, ultimately limiting the system's capacity to respond proactively to emerging health trends (Canadian Mental Health Association, 2024).

While the reform successfully modernised aspects of the national data infrastructure – consistently reporting on electronic record access and virtual care uptake – it notably lacked indicators for health data interoperability (Wolfson, 2024). Governance initiatives intended to improve data collection and interoperability standards were largely monitored through process-based milestones in annual reviews rather than standardised metrics, which limited inferences regarding the robustness or accountability of new structures. Similarly, the evaluation of care reforms intended to improve effectiveness, such as enhanced planning and expanded access to evidence-based mental health and substance use services, relied mostly on access and utilisation metrics without determining how such data informed planning or led to targeted care that improved clinical outcomes. While reform initiatives targeting safety in aged care were successfully documented through the reporting of fall rates and inappropriate prescribing, it was less effective at evaluating the priority of helping citizens age with dignity closer to home.

The assessment of final goals was similarly limited in depth and scope. Although reducing mental health morbidity was prioritised in the Working Together initiative, evaluation seemed largely confined to access and utilisation statistics. Efforts to maintain free care and subsidise territorial travel potentially supported financial protection, yet quantitative evidence of their impact on patient costs was scarce. Conversely, the drive for efficiency through reduced administrative duplication and electronic record access was relatively well measured via tracking provider engagement with digital health information and its perceived utility.

Table 22. Selected *Working Together* indicators mapped to WHO HSPA domains and categories.

DOMAIN/ Category	Selected evaluation indicators
FUNCTIONS	
Resource generation	Nurse practitioners entering and leaving the workforce per 10,000 population.
Financing	Proportion of funds spent on prescribed drugs per capita.
Governance	Proportion of health professionals who share patient information electronically.
INTERMEDIATE OBJECTIVES	
Effectiveness	Rate of potentially avoidable hospitalisations from ambulatory care sensitive conditions per 100,000 people under 75 years.
Safety	Number of falls in the last 30 days in long-term care.
User experience	Proportion of Canadians who were satisfied with the wait time to access a health provider when they were sick or concerned.
Access	Canadians who reported being able to see a health provider on the same day or next day when they were sick or concerned.
Utilisation	Proportion of Canadian youth aged 12-25 years who accessed integrated youth services.
Service efficiency	Proportion of Canadians who received hip and knee replacements within 26 weeks.
Service equity	Rate of potentially avoidable hospitalisations for Canadians living in the lowest-income neighbourhoods.
FINAL GOALS	
People-centredness	Proportion of Canadians who reported being treated with dignity and respect regarding culture, language, gender and sexual orientation by a health provider.
Health improvement	Not identified.
Financial protection	Proportion of Canadians with a diagnosed mental health condition that reported not getting mental health care due to cost.
System efficiency	Annual change in surgical volumes since start of COVID-19 pandemic.
System equity	Proportion of Canadians living in rural or remote areas with an unmet mental health need compared to Canadians living in urban areas.

NB: No indicators were identified to evaluate *Working Together* initiatives targeting health improvement.

BOX 3: Prioritising System Equity and Cultural Safety in the Working Together Initiative

The Working Together to Improve Health Care for Canadians initiative, launched in February 2023, established a framework of collaborative accountability that sought to embed system equity and patient-centredness within its core architecture. A critical component of this reform involved a specific 2 billion dollar investment dedicated to Indigenous health, intended to ensure access to culturally safe health services. The evaluation design, coordinated by the Canadian Institute for Health Information (CIHI), attempted to transition beyond generic performance metrics toward a model that identified disparities in service delivery for diverse populations.

The methodology prioritised the disaggregation of indicator data by population characteristics, such as income and ethnicity, to identify inequities in how the healthcare system performed for different groups. By triangulating quantitative performance data with qualitative stakeholder engagement, the initiative aimed to provide a real-time assessment of whether service delivery changes improved access for marginalised communities. This approach represented a significant shift towards a data-driven model that attempted to bridge the accountability gap through standardised public reporting on service equity.

However, the implementation of this equity-focused framework encountered substantial structural and methodological challenges. While the investment in Indigenous health was substantial, the development of robust, standardised indicators for cultural safety lagged behind other technical milestones. Critics noted that without specific metrics to define and measure cultural safety, the actual impact of federal funding on the unique challenges faced by Indigenous Peoples remained difficult to quantify. Furthermore, the decentralised nature of Canadian health stewardship led to data fragmentation, where divergent regional methodologies and privacy constraints often hindered the national harmonisation of equity-based data.

Inter-jurisdictional tensions also emerged regarding the capacity of the chosen metrics to reflect nuanced patient perspectives. Some regions argued that the heavy emphasis on system outputs and service utilisation failed to capture meaningful patient-reported experiences or the qualitative aspects of culturally appropriate care. This disconnect suggested that while the initiative successfully tracked the mechanics of the system, its ability to reflect the diverse cultural and socioeconomic realities of the Canadian population remained constrained by a lack of mature, patient-centred indicators.

DENMARK: Municipal Reform (Kommunalreformen) Evaluation

Evaluation approach

The evaluation of the 2007 Danish Municipal Reform was characterised by an incremental and retrospective approach to indicators, as no predefined evaluation framework or success criteria were established at the time of implementation. Instead, evaluation activities were developed gradually and conducted in multiple phases by a combination of government bodies and external institutions (Danish National Audit Office, 2012; KORA, 2015); KREVI, 2009; Ministry of the Interior and Social Affairs, 2009). Early follow-up focused primarily on implementation status, administrative restructuring, and budget developments, rather than on outcome measurement. Overall, the evaluation approach evolved from ad hoc implementation monitoring towards a more structured, but still fragmented, performance measurement system.

A more comprehensive evaluation was commissioned by the government in 2012 and published in 2013, which utilised indicators designed to measure system efficiency and institutional sustainability within the new regional structure (Tables 23-26) (Ministry of the Interior and Economic Affairs, 2013). This evaluation assessed how the reorganisation of responsibilities across municipalities and regions supported the development of an efficient and sustainable public sector.

The 2013 evaluation was preceded by a series of thematic sub-reports prepared by working groups and external contributors. The final report was produced through an interministerial process involving central government ministries, Local Government Denmark (KL), and Danish Regions, reflecting a predominantly government-led and system-oriented assessment approach rather than an independent impact evaluation. In parallel, specific aspects of the reform - particularly its impact on local democracy - were evaluated through independent research studies using survey data, electoral statistics, and case-based analyses.

From 2016 onwards, the introduction of national goals for the healthcare system established a more structured and continuous performance monitoring framework. While not originally designed as part of the reform evaluation, these indicators provided an important proxy for assessing longer-term system performance and reform-related developments.

Evaluation methodologies

The evaluation combined elements of process evaluation (focusing on implementation and institutional change) and outcome-oriented analyses, although without a formal causal evaluation design. The evaluation applied an institutional and governance-oriented analytical approach rather than a formal impact evaluation design. It focused on the organisation of responsibilities across municipalities, regions, and the state, and on the functioning of coordination and steering mechanisms. Overall, the evaluation approach evolved from ad hoc implementation monitoring towards a more structured, but still fragmented, performance measurement system. Methodologically, the evaluation relied on a combination of qualitative and quantitative data sources, including:

- Semi-structured interviews and stakeholder consultations with municipalities, regions, and central authorities

- Analysis of public expenditure and financing data across administrative levels (2007–2011).
- Review of existing reports, literature, and administrative materials.
- Quantitative analyses of variation in healthcare utilisation across municipalities.
- Case studies of municipal practices, including prevention efforts, task distribution, and intergovernmental cooperation.
- Thematic analyses of specific sectors, including rehabilitation, specialised social services, and psychiatry.

The evaluation explicitly examined interface challenges between sectors, particularly in relation to coordination between municipalities, hospitals, and general practitioners. Interface issues in psychiatry were addressed through the work of a separate government-appointed committee on services for people with mental illness (Ministry of the Interior and Economic Affairs, 2013a; Ministry of the Interior and Economic Affairs, 2013b).The impact of the structural reform on local democracy was examined through multiple studies and methods included a variety of surveys, an assessment of electoral participation, and a descriptive case study of participatory practices (KREVI/KORA, 2009; KORA, 2013; Danish Ministry of the Interior and Housing, 2022).

Evaluation shortcomings and learnings

The evaluation of Denmark's 2007 Municipal Reform faced structural and methodological challenges that limited the ability to measure its true impact. A central limitation of the Danish evaluation approach was the absence of clearly defined goals, success criteria, and evaluation design at the point of reform implementation. Several of the reform's core objectives, including professional sustainability, efficiency, and equity, were broadly formulated and not operationalised into measurable indicators. Consequently, the reform's influence on clinical outcomes and social equity remained implicit rather than directed by concrete, trackable policy targets.

The delayed development of an evaluation framework in the Danish evaluation resulted in a lack of baseline data, limiting the ability to assess causal effects and changes over time. As a result, the evaluation focused predominantly on the functioning of new administrative structures and institutional performance rather than the reform's impact on intended outcomes such as service quality, prevention, or equity.

Data fragmentation further constrained the scope of the evaluation. In particular, insufficient data from municipalities and the primary care sector made it difficult to assess progress in key areas such as coordination, prevention, and collaboration between sectors. In addition, the absence of systematic follow-up requirements for health agreements between municipalities and regions led to a lack of comparable, high-quality data across jurisdictions.

Overall, while the evaluation demonstrated strong capacity to assess institutional reorganisation and administrative efficiency, it proved significantly weaker at measuring long-term health improvements, clinical effectiveness and equity. These gaps underscore the necessity of embedding rigorous, data-driven evaluation frameworks and specific health outcome mandates into the initial design of large-scale system reforms.

These limitations reflect the structural nature of the reform itself, which primarily targeted administrative organisation, governance, and resource allocation rather than explicitly defined health outcomes. As a result, indicators were more readily available for system inputs and institutional performance than for intermediate and final health system outcomes.

Evaluation indicators

The evaluation of the Danish Municipal Reform was characterised by an uneven distribution of indicators across domains (see Table 26 for selected indicators identified). Measurement capacity was strongest for system inputs, financing, and administrative structures, where data were readily available through national registries and administrative systems.

In contrast, intermediate and final health system objectives—such as effectiveness, equity, and long-term health improvement—were only partially captured, often relying on proxy indicators or qualitative assessments. Several reform objectives, particularly those related to coordination, prevention, and cross-sectoral integration, lacked clearly defined metrics and were therefore primarily assessed through case studies and stakeholder consultations.

The gradual introduction of national performance indicators after 2016 improved the availability of outcome-related data, but these were not explicitly aligned with the original reform objectives and therefore only partially supported evaluation of reform effectiveness.

Functions

Resource generation: The reform fundamentally reconfigured system capacity through hospital centralisation, national planning of specialised care, and the transfer of rehabilitation and individual-level preventive responsibilities to municipalities. Evaluation focused primarily on structural outputs—particularly hospital consolidation and distribution of services—while key elements such as workforce alignment, municipal capacity building, and health information technology infrastructure were only partially or not systematically measured. As a result, the evaluation captured changes in system configuration rather than the development of functional capacity.

Financing: The introduction of multi-source financing, including municipal co-financing and activity-based elements, was among the most systematically evaluated components. Financial flows, expenditure levels, and activity-related incentives were well documented. However, the evaluation did not establish clear links between these financing mechanisms and behavioural changes in care delivery, coordination, or patient outcomes.

Governance: Governance restructuring, including municipal mergers, the establishment of regions, and mandatory health agreements, was extensively evaluated, primarily through qualitative assessments and stakeholder surveys. These analyses provided detailed insights into institutional arrangements and coordination challenges. However, there were no quantitative indicators to assess whether governance reforms translated into improved system performance, limiting conclusions to perceived rather than demonstrated effects.

Intermediate Objectives

Effectiveness: Effectiveness was assessed indirectly using clinical quality indicators and utilisation measures (e.g. readmissions). While these provided insight into aspects of care quality, they were not explicitly linked to reform components such as the transfer of rehabilitation responsibilities to municipalities. Consequently, the evaluation could not determine whether observed changes reflected the impact of the reform.

Safety: Safety was evaluated using existing monitoring indicators, including prescribing practices and the use of coercion in psychiatric care. The establishment of regional supervisory bodies and complaint systems was assessed only partially, primarily at the structural level. No indicators were used to evaluate whether these governance changes improved patient safety outcomes.

User experience: User experience was measured through national patient satisfaction surveys and indicators of patient involvement in both physical health and psychiatric care. However, these measures were not derived from reform objectives and were not linked to specific reform initiatives. As a result, while user experience was evaluated, it was not possible to assess whether the reform improved patient-centred aspects of care.

Access: Access was evaluated using indicators such as waiting times, compliance with treatment guarantees, and completion of cancer pathways. These measures captured system responsiveness but were not explicitly aligned with reform elements, such as the expansion of municipal responsibilities or the establishment of health centres. The evaluation therefore provided limited insight into whether structural changes improved access.

Utilisation: Utilisation was one of the most robustly evaluated domains. Indicators capturing hospital admissions, outpatient activity, and utilisation patterns among patients with chronic conditions provided insight into system use and reflected the incentive effects of municipal co-financing. However, these indicators functioned primarily as retrospective measures and were not directly linked to intended reform mechanisms.

Service efficiency: Efficiency was assessed using indicators such as length of stay and hospital productivity. While these measures captured technical efficiency within hospitals, they did not assess cross-sector efficiency or the impact of improved coordination between municipalities and regions. As a result, evaluation of efficiency remained partial and sector-specific.

Service equity: Service equity was not operationalised through specific indicators. Although some analyses examined variation across municipalities and regions, these were not framed within an explicit equity framework, and no systematic assessment of distributional outcomes was conducted.

Final Goals

People-centredness: People-centredness was indirectly assessed through patient experience and involvement indicators. However, these measures were not linked to core reform elements, such as the positioning of municipalities as the primary entry point. The evaluation therefore did not demonstrate whether the reform improved responsiveness to patient needs.

Health improvement: Health improvement was measured using population-level indicators, including life expectancy and disease-specific outcomes. These indicators provided important contextual information but were not designed to evaluate the reform and could not be causally attributed to it.

Financial protection: Financial protection was not evaluated, reflecting its limited role within the reform design.

System efficiency: System efficiency was assessed partially through financial and productivity indicators, as well as qualitative analyses of coordination and interface challenges. However, no comprehensive framework existed to evaluate whether the reform improved overall system efficiency or resource allocation across sectors.

System equity: System equity was not directly evaluated. While variation across municipalities and regions was documented, there were no indicators assessing whether the reform reduced inequalities in access, quality, or outcomes.

Table 23. Comprehensiveness of indicators for *Municipal Reform* initiatives targeting Functions.

FUNCTIONS	Indicators (Yes/No/Partial)
Resource generation (6 key initiatives)	
Workforce	
1. Geographical placement of health educations	N
2. National planning of hospital specialisation to ensure sufficient patient volume and clinical competencies.	P
Infrastructure and equipment	
3. National requirements for IT standards to enable integrated electronic patient records and high-quality health registries.	N
4. Hospitals concentrated in fewer, more specialised units	Y
5. Municipal prevention, rehabilitation and community-based health care organised in Health Centres.	P
6. Mental health care is divided between hospital-based psychiatry (regions) and community-based services (municipalities).	P
Financing (2 key initiatives)	
Revenue raising	
1. Multi-source regional healthcare financing with incentive elements: Regional healthcare is financed through a combination of state block grants, municipal contributions and activity-based payments.	Y
Pooling resources	
2. Municipal contributions to regional healthcare financing create shared financial responsibility and incentives across sectors.	Y
Governance (9 key initiatives)	
Policy and vision	
1. Municipal mergers and abolition of counties, with establishment of regions responsible for healthcare.	Y
2. Mandatory health agreements to ensure coordination of patient pathways, prevention and rehabilitation	Y
3. Centralised (national) planning to define service levels and ensure quality through volume and expertise.	P
4. The state defines the overall regulatory and strategic framework for regions and municipalities.	Y
5. Municipalities act as the main entry point for citizens in relation to welfare and health-related services.	N
Stakeholder voice	
6. More decision-making authority is allocated to municipalities to strengthen local democracy.	Y
Information and intelligence	
7. Development of a Danish model for quality improvement and accreditation	Y
8. Central authorities are tasked with monitoring performance across the health system based on shared standards	Y

Legislation and regulation	
9. strengthen the resilience of Danish decentralised governance model by consolidating institutional structures i.e. allocating more decision-making authority to the municipal level.	Y

Table 24. Comprehensiveness of indicators for *Municipal Reform* initiatives targeting Intermediate Objectives.

INTERMEDIATE OBJECTIVES	Indicators (Yes/No/Partial)
Effectiveness (2 key initiatives)	
1. Municipalities are assigned an expanded role in prevention, rehabilitation and care to improve task performance	N
2. All rehabilitation not provided during hospitalisation is assigned to municipalities	P
Safety (1 key initiatives)	
1. Establishment of regional state offices responsible for supervision and complaints handling.	P
Access (3 key initiatives)	
1. To position municipalities as the primary access point for citizens and businesses in relation to public services	N
2. Municipalities are enabled to establish local solutions for prevention and rehabilitation (e.g. health centres).	P
3. Municipalities take over responsibilities for prevention, rehabilitation and substance use treatment.	P
Utilisation (1 key initiatives)	
1. Activity-based financing and municipal contributions create incentives related to healthcare activity.	Y
Service efficiency (1 key initiatives)	
1. Financing model combining block grants and activity-based elements to support efficient service provision.	Y

N = no, P = partial, Y = yes

Table 25. Comprehensiveness of indicators for *Municipal Reform* initiatives targeting Final Goals.

FINAL GOALS	Indicators (Yes/No/Partial)
People-centredness (1 key initiatives)	
1. Municipalities handle direct citizen-oriented tasks and act as the primary interface with the public sector.	N
System efficiency (3 key initiatives)	
1. Ensuring that administrative units are financially sustainable and possess the necessary professional expertise and accountability to deliver high-quality services.	P
2. Enabling municipalities to develop the structural and administrative capacity required to manage an expanded portfolio of welfare and health-related responsibilities.	N

3. Consolidation of administrative units and service structures to improve utilisation of specialised staff and resources.	P
System equity (2 key initiatives)	
1. To enhance the capacity of the public sector to invest in human development and long-term societal well-being.	N
2. Creation of sustainable administrative units with clear responsibility for delivering high-quality welfare services, supporting more uniform capacity across geographical areas.	P

N = no, P = partial, Y = yes

Table 26. Selected *Municipal Reform* evaluation indicators mapped to WHO HSPA domains and categories.

DOMAIN/ Category	Selected evaluation indicators
FUNCTIONS	
Resource generation	Number and distribution of hospitals and emergency departments following structural reorganisation.
Financing	Total municipal and regional spending on health care, and the effect of municipal co-financing.
Governance	Perceived satisfaction and perceived barriers to coordination in rehabilitation, prevention, mental health, and health information technology, completed by regions and municipalities.
INTERMEDIATE OBJECTIVES	
Effectiveness	Rate of early mobilisation after hip fracture surgery (Danish Clinical Quality Registries).
Safety	Implementation of the Shared Medication Record (nationwide real-time prescription database).
User experience	Patient satisfaction ratings for somatic and psychiatric care, via annual nationwide patient satisfaction surveys.
Access	Rate of diagnostic assessment and treatment occurring within maximum time limits (e.g. standardised cancer care pathway completion within set time).
Utilisation	Number of hospital admissions and outpatient visits for patients with chronic conditions.
Service efficiency	Average length of stay per hospital admission.
FINAL GOALS	
People-centredness	Patient-reported experience of involvement in somatic care and mental health care.
Health improvement	Five-year cancer survival and survival after cardiac arrest.
System efficiency	Rate of reported coordination and interface challenges across sectors for elderly and chronic patients.
System equity	Rate of excess mortality for patients with mental illness.

NB: Although there were no specific reform initiatives targeting user experience and health improvement, indicators were identified for these categories.

BOX 4: Monitoring local democracy in structural reform – the Danish experience

The 2007 Danish Structural Reform explicitly identified democratic governance as a guiding principle, aiming to preserve and strengthen local democratic control while restructuring responsibilities across sectors such as health, education, and employment. By reducing the number of municipalities from 271 to 98 and replacing 14 counties with five regions, the reform sought to improve administrative efficiency and coordination. At the same time, it raised concerns about increased distance between citizens and political decision-makers, particularly in geographically larger municipalities.

To assess these concerns, local democracy has been examined across multiple studies using repeated survey data and complementary analytical approaches. Survey-based evaluations measured citizens' perceptions of local democracy, including political trust, political self-confidence, interest in municipal politics, and perceived knowledge and competencies related to local governance. These measures provide insight into both citizens' confidence in political institutions and their perceived ability to engage in local decision-making processes.

In addition, administrative and geographic analyses were conducted to assess representation within merged municipalities. Using parish-level data, studies examined the residential distribution of municipal council members and found that political representation remained broadly geographically distributed following the reform.

Electoral participation has also been monitored as an indicator of democratic engagement. Following a decline in voter turnout in the 2009 local and regional elections, national and local actors - including the government, Local Government Denmark (KL), and Danish Regions - implemented initiatives aimed at strengthening electoral participation. These efforts have been repeated in subsequent elections, with voter turnout remaining relatively high in an international perspective.

More recent policy developments suggest that findings from these evaluations have informed subsequent reforms. The 2024 Danish healthcare reform includes plans to establish new locally governed health councils with delegated responsibilities for prioritisation and resource allocation, indicating a continued emphasis on democratic governance and local influence.

This case illustrates how democratic governance, although not a standard focus in health system performance assessment, can be systematically incorporated into the evaluation of large-scale structural reforms. The Danish experience demonstrates the value of combining repeated citizen surveys, administrative data, and geographic analyses to monitor democratic legitimacy over time. It also highlights how sustained measurement of democratic dimensions can inform subsequent policy development, even in areas traditionally evaluated through clinical or economic indicators.

NORWAY: Coordination Reform (Samhandlingsreformen) Evaluation

Evaluation approach

The Norwegian Coordination Reform was evaluated through a stepwise and multi-actor approach rather than a single consolidated evaluation framework. Evaluation responsibility was distributed across national institutions, primarily the Office of the Auditor General of Norway, the Research Council of Norway (Evaluation of Medicine and Health programme), and the Norwegian Directorate of Health through annual monitoring of the National Quality Indicator System.

The most comprehensive independent evaluation was conducted by the Office of the Auditor General in 2016, examining whether the reform contributed to reduced growth in hospital admissions and strengthened municipal services. Parallel to this, the Research Council's Evaluation of Medicine and Health programme conducted register-based and field-based research assessing implementation, municipal capacity development, financing mechanisms (including municipal co-financing), and effects on emergency admissions and service utilisation patterns.

Since 2012 the Directorate of Health has published annual monitoring reports using the National Quality Indicator System, which includes indicators across municipal services, specialist health services, emergency services, and mental health care. In 2024, the monitoring framework comprised 147 indicators (39 municipality-related, 38 mental health-related, 10 emergency care, and 70 acute hospital indicators), reflecting ongoing system performance tracking (selected indicators displayed in Table 27).

Evaluation methodologies

Norway's evaluation architecture employed a comprehensive mixed-methods approach, distinguishing between process evaluation and outcomes evaluation.

Process-oriented analyses focused on reform implementation, governance mechanisms, and intersectoral collaboration. Various methodologies were used to assess implementation of legally mandated cooperation agreements, development of 24/7 community-based acute beds, intermunicipal collaboration models, and municipal preparedness to assume expanded responsibilities. Methods included:

- Surveys of all municipalities and regional health authorities
- Surveys of General Practitioners (GPs)
- Semi-structured interviews with municipal leaders, hospital representatives, ministry officials, and directorate staff
- Systematic field observations in selected municipalities
- Case-based data collection assessing local implementation practices
- Document analysis of cooperation agreements, legislation, strategic plans, and budget documents
- Facilitated working meetings and structured stakeholder consultations

Outcome assessment relied heavily on quantitative registry and administrative data analysis. The National Quality Indicator System, adapted from the Organisation of Economic Co-operation and Development (OECD) Health Care Quality and Outcomes (HCQO) framework, provided the structural basis for annual outcome monitoring. Indicators spanned

workforce capacity, infrastructure, patient pathways, waiting times, safety outcomes (e.g., postoperative infections, use of coercive measures), and health outcomes (e.g., 5-year cancer survival, lower extremity amputations among patients with diabetes).

Methods included:

- Retrieval and analysis of registry data from Statistics Norway and the Directorate of Health
- Difference-in-Differences analyses examining emergency admissions per disease group (e.g., diabetes, chronic obstructive pulmonary disorder, heart failure)
- Analysis of hospital readmission rates and discharge patterns
- Monitoring of municipal full-time equivalents in mental health and care services
- Analysis of utilisation of community-based acute beds
- Monitoring of financing mechanisms, including municipal co-financing and financial responsibility for ready-to-discharge patients.

Evaluation shortcomings and learnings

The Office of the Auditor General identified several limitations in Norway's capacity to measure reform effects. Key challenges included:

- Limited data on quality development in municipal health and care services
- Overrepresentation of specialist-care indicators relative to municipal service indicators
- Limited indicators directly measuring coordination outcomes
- Unclear evidence regarding whether community-based acute beds substituted hospital admissions as intended
- Effect measurement depends heavily on external research; systematic internal evaluation is weak
- Reporting provided insufficient information, particularly prior to 2014.

While the National Quality Indicator System provides extensive monitoring of clinical effectiveness, safety, and access, it does not systematically measure financial protection, macro-level system efficiency, or outcome-based system equity. Moreover, the monitoring framework does not include explicit indicators within the Social Determinants of Health domains.

A central learning emerging from the Norwegian evaluation experience is that structural and financial reform mechanisms – such as municipal co-financing, discharge reimbursement rules, and legally mandated cooperation agreements – were monitored in terms of implementation and activity patterns, but less consistently evaluated in terms of long-term outcome effects. The monitoring system demonstrates strong performance measurement capacity at the service and clinical level, yet comparatively weaker alignment between reform intentions (decentralisation, prevention, equity) and system-wide outcome indicators.

Table 27. Selected *Coordination Reform* evaluation indicators mapped to WHO HSPA domains and categories.

DOMAIN/ Category	Selected evaluation indicators
FUNCTIONS	
Resource generation	*Workforce*: Full-time equivalents in municipal health and care services (home care, nursing homes, mental health and substance use services). *Infrastructure:* Number and occupancy rate of municipality-based acute beds.
Financing	Consistency of municipal co-financing of selected hospital services.
Governance	Implementation and revision of legally required cooperation agreements between municipalities and hospitals.
INTERMEDIATE OBJECTIVES	
Effectiveness	Number of emergency admissions per disease (e.g., diabetes, chronic obstructive pulmonary disorder, heart failure).
Safety	Postoperative infection rates for key priority conditions (e.g., caesarean section, colon surgery, hip arthroplasty).
User experience	Patient-reported experiences with regular general practitioners and general practice offices.
Access	Number of people/citizens without a regular general practitioner.
Utilisation	Number of consultations with regular general practitioner.
Service efficiency	Occupancy rates in municipality-based beds.
Service equity	Access to interpreter services in emergency primary care.
FINAL GOALS	
People-centredness	Duration of regular general practitioner and patient relationships
Health improvement	Dental status and the prevalence of caries among a) 5-year old children b) 12-year-old children, and c) 18-year-olds.

NB: No indicators were identified to evaluate Coordination Reform initiatives targeting system efficiency or system equity.

BOX 5: Norway - Measuring the shift from hospital to municipal care and from treatment to prevention

The Norwegian Coordination Reform (*Samhandlingsreformen*) sought to rebalance the health system by shifting responsibility and activity from hospitals to municipalities and by strengthening prevention and early intervention. Financial incentives (municipal co-financing and discharge reimbursement), legally mandated cooperation agreements, and the nationwide introduction of municipal acute beds were intended to reduce growth in hospital services and support care closer to home.

Norway established a comprehensive evaluation architecture combining independent audit, research-based analysis, and continuous national performance monitoring. This structure generated detailed knowledge about implementation: the establishment of municipal acute beds, expansion of municipal workforce capacity, changes in discharge practices, and the activation of financial incentives. Activity patterns and service utilisation were closely tracked, and registry data enabled robust analyses of emergency admissions, readmissions, and disease-specific hospital use.

However, the Norwegian experience illustrates a core challenge in evaluating structural decentralisation reforms: documenting implementation does not automatically demonstrate system transformation.

Although hospital length of stay declined following the reform, overall hospital admissions did not show a clear and sustained reduction attributable to municipal substitution. Research findings suggest that municipal acute beds may function effectively in selected contexts and may reduce hospital admissions for specific patient groups, but substitution effects vary by local organisation, staffing models, and patient mix. At a national level, evidence of a consistent system-wide shift from hospital to municipal care remains mixed rather than definitive.

Similarly, while prevention and early intervention were central ambitions, the national monitoring framework has been stronger in measuring clinical effectiveness, safety, and access than in capturing long-term preventive outcomes or social determinants of health. Indicators explicitly measuring prevention effects or structural shifts in population health remain limited.

The Norwegian case demonstrates that structural reform instruments - financial incentives, decentralised responsibilities, and cooperation mandates - can be monitored in terms of implementation and activity. Yet measuring whether these instruments produce sustained shifts in service balance or long-term health outcomes requires evaluation frameworks explicitly designed to capture substitution effects, preventive impacts, and system-level efficiency.

For countries pursuing hospital-to-community or treatment-to-prevention reforms, Norway’s experience underscores a critical lesson: strong monitoring of inputs and activity does not, by itself, provide evidence that the intended structural transformation has occurred.

SWEDEN: Good and Close Care (God och nära vård) Evaluation

Evaluation approach

The Swedish Agency for Health and Care Services Analysis was tasked by the government to conduct independent evaluations of the 2019 Good and Close Care reform on an annual basis, and an extensive final report was provided in 2025. These ongoing evaluation reports were used not only for evaluation but also to guide implementation and inform policy adjustments. The evaluation included an overall assessment of the measures that the government, the regions, and the municipalities implemented to transform health care into good and close care, and whether the objectives of the reform had been achieved. This approach intended to describe the chain between the starting point and the objectives of the reform, the governance put in place to achieve the desired results, the measures carried out, and their effects. Outcomes and effects were monitored from the perspectives of patients, professionals, and the health system.

The evaluation included reports from the National Board of Health and Welfare's to gather information on the measures implemented by the regions and municipalities. To access funds, each region (with the National Board's support) had to submit reports covering implemented measures, associated costs, and results achieved, on all three development areas: 1) Transition to good and close care, 2) monitoring accessibility to primary care, and 3) patient contracts and other ways to promote care coordination, sector collaboration, and increased patient participation. These reports were the backbone for monitoring implementation and evaluating effects. Further, case studies from three regions and surveys of health care professionals and patients were carried out, and the system perspective was tracked using a set of continuously monitored indicators (see Table 28 for selected indicators). Finally, the evaluation included a review of the reform's supervision by the Health and Social Care Inspectorate and audits conducted by regional auditors in ten regions.

Evaluation methodologies

A central resource was the systematic review of policy and governance documents. The evaluators analysed the government's reform agreement, six national agreements between the government and the Swedish Association of Local Authorities and Regions, regional budgets, annual reports, and rulebooks that govern the commissioning of health centres. Reports from the National Board of Health and Welfare, the Health and Social Care Inspectorate, and regional audit offices were also reviewed to assess governance and oversight.

Surveys were a major tool for gathering broad input. National surveys from the National Board of Health and Welfare and the Swedish Association of Local Authorities and Regions were used and complemented with the evaluator's own targeted questionnaires. These included surveys to municipalities via medically responsible nurses and nurses responsible for rehabilitation, to health centre managers, and representatives of patient and user organisations. A population panel survey was also carried out to reflect patient perspectives, with results compared to previous national and international surveys.

Quantitative monitoring relied on register data and key indicators (Table 28). Sources included the operational and financial statistics of the Swedish Association of Local Authorities and Regions, as well as patient and pharmaceutical registers maintained by the

National Board of Health and Welfare. These indicators provided measurable outcomes linked to system-level effects of the reform.

Finally, the evaluation incorporated case studies and interviews to capture local realities. Case studies were conducted in three counties where written questions and follow-ups were directed to reform coordinators, health centre managers, and municipal medically responsible nurses and nurses responsible for rehabilitation. Additional interviews with professionals at the provider level provided context on implementation conditions and collaboration.

Evaluation shortcomings and learnings

Each of Sweden's 21 regions were responsible to implement local measures to reach the governments overall goals, which allowed for planning based on local needs and conditions. However, the reform goals were broad, and the intended outcomes were poorly described. As a result, each region's priorities and focus varied significantly. As regions adopted different approaches to achieving the overall goals, the annual status report evaluations also needed to be tailored to the regional context. Each region was responsible for carrying out local follow-up, including data collection for monitoring the effects of its own local initiatives and evaluation of government-funded initiatives. This resulted in a lack of uniform evaluation standards across regions, including different measurement methodologies, incomplete or incomparable results, and inconsistent data collection, which hindered meaningful assessment of effectiveness.

The case study interviews showed a significant need for support in designing local follow-up of the transition. Many respondents (regions and municipalities) requested more concrete guidance on how to prioritise follow-up, given the many goals, as well as guidance on which indicators (Table 28) and data sources were most important or adequate for measuring results. The National Board of Health and Welfare was tasked with developing a framework for performance indicators to reflect progress toward Good and Close Care as a first step toward being able to follow the transition. The indicators, however, were based on the National Board of Health and Welfare's own registers and therefore provided only limited guidance to regions on how they could use their own databases to monitor the transition.

Another challenge was to evaluate the goal of strengthened primary care due to the lack of data to monitor changes. The need for data access from primary care especially privately run facilities (nearly half of the primary care sector), data on the use of digital solutions, and more, made it difficult to track how primary care developed nationally, to assess equity in access, and to evaluate quality beyond simple visit numbers.

Table 28. Selected *Good and Close Care* evaluation indicators mapped to WHO HSPA domains and categories.

DOMAIN/ Category	Selected evaluation indicators
FUNCTIONS	
Resource generation	Educational background of health care workers (number of e.g. nurses, specialist doctors, psychologists), and number of licensed personnel in the municipalities relative to the population size.
Financing	Proportion of total regional healthcare expenditure allocated to primary care.
Governance	Healthcare utilisation over time in primary and specialised care for selected diagnostic groups with reallocated treatment responsibilities to primary care.
INTERMEDIATE OBJECTIVES	
Effectiveness	Proportion of patients who had a health promotion consultation about diet and physical activity.
Safety	Proportion of patient complaints addressing lack of assigned physician, absence of care plans, and discontinuity in primary care services.
User experience	Self-rated experiences of care between patients with good and poor health.
Access	Proportion of patients receiving a medical assessment within three days and being offered to see a doctor at a primary care centre within seven days.
Utilisation	Number of physical doctor visits and other staff categories per 100,000 inhabitants in regional primary care.
Service efficiency	Proportion of patients with a designated regular physician contact in primary care and percentage change in continuity index for physician and total-contact in regional primary care.
Service equity	Number and size of health centres in areas with different socioeconomic challenges.
FINAL GOALS	
People-centredness	Use of individual care plans to facilitate patient-centred decision making.
System efficiency	Proportion of patients receiving antidepressant pharmaceuticals where treatment was initiated in primary care.
System equity	User experience and trust in primary care broken down by gender, age, education level, and self-rated health.

NB: No indicators were identified to evaluate Good and Close Care initiatives targeting health improvement.

BOX 6: Evaluating digital solutions.
In the 2019 Swedish health care reform Good and Close Care, equity was placed at the centre of the agenda with a key objective of ensuring more equal access to care, particularly for people living in rural areas. The vision was to be partly realised through an expansion of digital health services, aiming to bring health care closer to citizens, reduce geographical barriers, and making care more accessible.

Digital tools were also developed to increase patient participation and empower individuals to take greater responsibility for self-care. At the same time, both digital health services and self-care place different demands on patients compared to traditional care. Accessing digital care requires knowledge of digital tools and platforms, as well as the skills to use them effectively. There is a risk that, for some individuals, digitalisation could create a distance rather than closeness to care. This is particularly concerning since people with complex health needs often are explicitly identified as a priority group for digital solutions.

The Swedish evaluation report notes that it is difficult to assess the overall scope and impact of digitalisation and preventive health measures. A major limitation is the lack of national statistics on digital visits, leaving it unclear whether these tools replace physical appointments or add to total care consumption. Further, nearly half of the Swedish health centres are privately operated, meaning regions do not have the same level of oversight/data access. Patient surveys were utilised to evaluate how digital initiatives affect perceived access.

Digital solutions are expected to play an increasingly central role in the future of health care worldwide to enable more scalable and flexible models of care delivery, and to respond to rising demand, workforce constraints, and limited financial resources. At the same time, it is essential to develop robust monitoring and evaluation tools to assess the impact, effectiveness, and unintended consequences of these digital solutions, ensuring that they deliver real value for patients and providers.

DISCUSSION

Summary of key findings

This comparative analysis found that all six national reforms, including Australia, England, Canada, Denmark, Norway and Sweden, share a common reform logic: strengthen foundational health system Functions (resource generation, financing, governance) to enable improvements in Intermediate Objectives (effectiveness, safety, user experience, access, utilisation, efficiency, equity) and ultimately deliver Final Goals (people-centredness, health improvement, financial protection, system efficiency, system equity). Across countries, the reforms themselves were generally broad and multi-domain in intent, with particularly consistent attention to Functions and (for most) multiple Intermediate Objectives.

Conversely, the evaluation models were uneven in their ability to *demonstrate* reform progress across this full pathway. Evaluations frequently combined qualitative approaches (consultations, submissions, interviews, workshops) with performance-data analysis, but they varied in the degree of independence, the use of formal frameworks, and the presence of plans for joint reporting and benchmarking. The most consistent quantitative measurement occurred in domains where data are routinely available and mature (e.g., financing, activity/utilisation, and access). Meanwhile, the least consistently measured areas were those central to contemporary reform aspirations, including system integration, digital transformation, prevention, patient experience and equity, especially when these require linked datasets, shared definitions, and consistent coverage across public/private or regional/local actors.

Interpretation of findings in relation to the HSPA Framework

Using the adapted WHO HSPA framework as the organising lens clarifies where evaluation strength currently lies and where it is lacking. The mapping of targeted outcomes suggests reforms are frequently articulated as whole-of-system transformations, with comprehensive attention to Functions and a wide span of Intermediate Objectives (Australia/England/ Canada/Norway across all seven categories; Sweden six; Denmark five). This is consistent with the idea that large-scale reform is increasingly conceived as a system redesign rather than a discrete program.

However, the evaluation mapping indicates that the causal pathway implied by HSPA – Functions → Intermediate Objectives → Final Goals – is not consistently operationalised in measurement. Put simply, many evaluation designs remain stronger at ‘what we funded and delivered’ than ‘what changed for people and populations’. This is not a criticism of HSPA; rather, the framework makes visible a common structural weakness: the further evaluation moves from inputs and proximate outputs toward ultimate outcomes (people-centredness, health improvement, equity and financial protection), the more likely measurement becomes partial, indirect, or absent.

The Swedish case offers a concrete illustration of this challenge. The report notes that digitalisation and prevention, central to shifting care ‘closer to home’, are difficult to assess when national statistics are incomplete (e.g., digital patient consults), when it is unclear whether digital care substitutes for or adds to overall utilisation, and when private provision limits oversight and consistent data access. These are precisely the kinds of cross-sector, system-level dynamics that the HSPA framework is designed to capture. Yet they are the hardest to measure without deliberate indicator design and robust data infrastructure.

Variability in comprehensiveness across countries

This report demonstrates meaningful cross-country variation in the *comprehensiveness* of evaluation models. This variation is summarised below.

Australia shows a comparatively detailed attempt to connect reform components to measurement, as demonstrated by our assessment of the comprehensiveness of indicators across reform initiatives. This assessment also showed, however, that indicator coverage is uneven for reform ambitions such as value-based purchasing and bundled payments, and for core governance intentions (shared stewardship, joint planning, health literacy, cross-sector data transparency).

England and Canada appear to draw more heavily on performance data and program-specific evaluations, alongside consultations and implementation reporting, with explicit intentions to evaluate outcomes in multiple domains.

Denmark highlights how reforms that are structurally profound (re-assigning responsibilities and reorganising tiers of government) can nevertheless be evaluated with relatively sparse or partial indicators for several Intermediate Objectives and Final Goals, particularly where reforms are framed at the level of overarching direction rather than tightly specified measurable initiatives. The Danish indicator mapping illustrates progress across Intermediate Objectives (e.g., safety, access) and Final Goals.

Norway and Sweden show strong reform intent around coordination and ‘close care,’ but their evaluation capacity is constrained by the complexity of demonstrating system substitution effects (e.g., hospital to community, analogue to digital) and by the dependence on multi-level governance and data-sharing arrangements. The Swedish example on digital and preventive measures sharply underscores this constraint.

Across these differences, a common pattern holds: evaluation is more comprehensive when it can rely on established administrative datasets and well-institutionalised reporting routines, and less comprehensive when measurement requires new indicators, new linkages, or shared accountability across organisational and jurisdictional boundaries.

Disconnect between reform targets and evaluation measures

A core finding is the recurring disconnect between what reforms *target* and what evaluations *measure*. The reforms frequently articulate goals such as integration, person-centredness, prevention, equity, and value-based care; yet indicators often track proxies that are easier to capture (activity, wait times, expenditure) or remain focused in legacy siloes.

This report provides concrete examples of this disconnect. In the Australian mapping, several financing and governance initiatives central to ‘reform intent’ are marked as not supported by indicators – such as ‘Paying for Value and Outcomes’ and ‘Bundled payments’ reform streams, and multiple stewardship/joint planning elements – illustrating how reform rhetoric can outpace evaluative instrumentation. Similarly, the Swedish case notes that without national digital-visit statistics and clarity on substitution versus additive utilisation, it becomes difficult to evaluate whether digital care is delivering the intended system effects (reduced pressure on face-to-face services, improved access, better outcomes) rather than simply increasing demand.

This disconnect is not merely technical; it risks three governance failures:

1. **Accountability gaps** – stakeholders cannot verify whether reforms delivered their intended benefits.

2. **Perverse incentives** – systems may optimise what is measured rather than what matters (e.g., throughput over experience, volumes over value).
3. **Learning failure** – without aligned measures, systems cannot reliably identify which reform components worked, for whom, under what conditions, and at what cost.

Policy implications and future directions

The comparative findings point to several practical directions for strengthening national reform evaluation.

1. **Design evaluation as part of reform architecture.** Large-scale reforms should publish an explicit outcomes map aligned to HSPA domains, by linking Functions to Intermediate Objectives to Final Goals, alongside a minimum indicator set and baseline measurement plan. This reduces the risk that the most ambitious reform components remain unmeasurable until late-stage reviews.
2. **Modernise indicator sets to capture integration, person-centredness and equity.** Evaluation should include a balanced mix of: '*lag' indicators* (e.g., avoidable admissions, outcomes) and '*lead' indicators* (coordination, continuity, patient activation, safety culture, access to team-based care). Patient-reported measures, equity stratifiers, and continuity/coordination measures should be routinely embedded, and not treated as optional enhancements.
3. **Build the data foundations for cross-sector and digital reforms.** The Swedish digital and prevention challenges are likely to generalise globally: without national definitions, private sector data, or linked datasets, reforms cannot be evaluated for substitution effects or unintended consequences. Governments must prioritise interoperability, standardised cross-setting datasets, and robust data governance.
4. **Strengthen independence, transparency, and benchmarking.** The report's cross-country methods table indicates variability in independent evaluation, framework use, and international comparison. Future evaluation models should make independence explicit and prioritise transparent data publication and HSPA-aligned benchmarking – both longitudinal and (where feasible) cross-country.
5. **Adopt joint reporting and shared accountability for cross-jurisdiction reforms.** For federations and decentralised systems, the measurement model must match the governance model. Where reform depends on collaboration (e.g., regions/municipalities; hospitals/primary care), evaluation should specify shared metrics, joint reporting arrangements, and escalation pathways when targets drift.

Limitations

This report's findings, and the inferences made about reforms and their evaluation models, are based on publicly available documents and data sources. While the methods utilised to search for and obtain relevant data were rigorous and comprehensive, we acknowledge that some data may not have been captured (for example, where information was not publicly accessible, was unpublished, or was not readily discoverable). As a result, some information about the reforms and their evaluation models may have been missed. However, a broad range of documents, including authoritative reports from each country's key bodies involved in reform and evaluation, as well as academic literature, was utilised. This ensures a relatively accurate view of how reforms and their evaluations are enacted.

Conclusions

Across six countries, reforms are broadly aligned in ambition to strengthen health system Functions, and to pursue integrated, person-centred, sustainable care. However, evaluation models remain uneven and often lag behind reform intent. The adapted WHO HSPA framework provides a useful scaffold for standardising evaluation and making gaps visible, particularly the frequent drop-off in measurement between Intermediate Objectives and Final Goals. The central implication is that without deliberate ex ante indicator design, stronger cross-sector data infrastructure (including digital and private provision), and transparent, independent evaluation arrangements, large-scale reforms will continue to face an accountability and learning deficit. Closing the disconnect between reform targets and evaluation measures is therefore not a technical “nice-to-have,” but a core requirement for credible stewardship of multi-billion-dollar system transformation.

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APPENDIX: TEAM BIOGRAPHIES

Dr Samantha Spanos

Dr Samantha Spanos, BPsyc (Hons I), PhD, is a leading health systems and services researcher at the Australian Institute of Health Innovation, Macquarie University. Her work leverages complex systems theories, implementation science, and rigorous mixed-methods approaches to improve multi-level health system performance – from frontline clinical practice to macro-level policy and governance. Dr Spanos has built a high-quality body of research, including 33 peer-reviewed publications and 14 authoritative reports for key industry and government bodies, to bridge the gap between research and real-world practice. A global collaborator, she works alongside multidisciplinary experts to design, implement, and evaluate transformative healthcare solutions that improve organisational and population health outcomes.

Dr Kathrine Hald

Dr Kathrine Hald, MSc, PhD, is an implementation scientist and senior researcher at the Center for General Practice and the Danish Center for Health Services Research, Aalborg University, Denmark, and honorary visiting fellow at the Australian Institute of Health Innovation, Macquarie University, Australia. Her work advances implementation science within health services research, focusing on how evidence-based interventions, digital technologies, and health system reforms are implemented and evaluated in real-world settings. She uses mixed-methods approaches to examine implementation processes, contextual determinants, and implementation outcomes in complex healthcare systems, with a particular focus on primary care and cross-sectoral organisation. Dr Hald collaborates with a range of international partners to advance the implementation of evidence-based practices and system-level change.

Dr Julie Mackenhauer

Dr Julie Mackenhauer, MD, PhD, is a consultant in adult psychiatry at Aalborg University Hospital and Clinical Associate Professor at Aalborg University, Denmark. She is a specialist in public health and social medicine, with a research focus on health equity, mental health, and the organisation of healthcare across sectors. Her work applies health services research, epidemiology, and implementation approaches to improve care for vulnerable populations and strengthen coordination between services, from frontline clinical care to system-level organisation and policy. Dr Mackenhauer has built a solid research portfolio, including 25 peer-reviewed journal articles and 11 additional publications including national reports, debate articles, and policy-oriented publications. She collaborates with multidisciplinary partners to develop and evaluate more integrated, equitable, and person-centred health systems.

Dr Freja Sønderby Severinsen

Dr Freja Sønderby Severinsen, MD, is a physician and epidemiological researcher. She obtained her medical degree from Aalborg University in 2025 and has completed research training at Stanford University and the University of California, San Francisco, with a focus on clinical research methods. Her research lies within clinical epidemiology and health

services research, and she has authored three peer-reviewed publications as a pre-PhD researcher. Her current work includes studies on climate change, health systems, quality, and health care disparities.

Dr Georgia Fisher

Dr Georgia Fisher is an implementation scientist and health services researcher at the Australian Institute of Health Innovation, Macquarie University. Her work leverages implementation science methods and frameworks to conduct research that aims to improve the quality and safety of healthcare. Dr Fisher conducts world-leading research into Learning Health Systems, systems that continuously and systematically combine routinely collected health data with digital technologies to learn, improve, and rapidly translate evidence into practice. Her academic work is characterised by impact and global reach, with 29 peer-reviewed publications in elite journals, cited 109% above the global average.

Professor Peter D Hibbert

Professor Peter Hibbert leads the Appropriateness and Patient Safety research stream at the Australian Institute of Health Innovation at Macquarie University. Professor Hibbert conducts research on quality and safety in healthcare and implementation science, leading large programs of research to define and implement evidence-based care across a range of healthcare settings. He has served as an advisor to governments/health services bodies internationally in relation to patient safety, and has contributed to 144 peer-reviewed publications and 51 reports for industry in the last ten years.

Professor Søren Paaske Johnsen

Professor Søren Paaske Johnsen, MD, PhD, is a clinical epidemiologist and health services researcher and founding director of the Danish Center for Health Services Research at Aalborg University & Aalborg University Hospital. The center is a multidisciplinary mission driven research institution focused on finding sustainable and evidence-based solutions to complex health care challenges. The center has been appointed as the national center for health services research in Denmark and will have a key role in evaluating the implementation and effect of the Danish Health Care Reform.

Professor Jeffrey Braithwaite

Professor Jeffrey Braithwaite BA, DipLR&theLaw, MIR (Hons I), MBA, PhD, FIML, FCHSM, FFPHRCP (UK), FAcSS (UK), Hon FRACMA, FAHMS is Founding Director of the Australian Institute of Health Innovation at Macquarie University. An internationally recognised health systems researcher, he studies quality, safety, climate change and resilience in healthcare, applying complexity science to improve system performance. He has authored over 900 peer-reviewed papers and 17 books. He currently serves as Chair of the International Academy for Quality and Safety. He works globally with governments and organisations to strengthen health systems and improve outcomes for patients and populations.