IPA III Results Framework Indicator Methodology Note

1. Indicator code and name

IPA III RF 4.1.3.2: Number of health reforms promoting (i) improved accessibility or (ii) improved standards of care a) developed/ revised, or b) under implementation with EU support

2. Technical details

OPSYS and Results Dashboard code: 260942, 260943, 260945, 260946.

Unit of measure: Number of (#)

Type of indicator: *Quantitative: Numeric; Actual (ex-post); Cumulative (not annual).*

Level of measurement: The indicator corresponds generally to an outcome level result.

Disaggregation:

The indicator is to be used at intervention and reporting levels according to whether the health reforms…. are:

a) developed/ revised with EU support or

b) under implementation with EU support.

Furthermore, where relevant / possible, please disaggregate according to the level of implementation:

- Fully implemented
- Partially implemented
- Initial stage of implementation

And should be disaggregated according to its aim or type of reform: Improved accessibility / Improved standard of care / Both improved accessibility and standard of care /Other.

DAC sector codes:

12110; 12220; 12230; 12240; 12250; 12261; 12262; 12263; 12264; 12281

Main associated SDG: **SDG 3** Good health and well-being.

Other associated SDGs: n/a .

Associated IPA III Level 1 indicator:

- Universal Health Coverage (UHC) Index (Source: SDG 3.8.1) (Ind. 4.1.3)

Associated IPA III Level 3 indicators: .

- Amount and share of EU-funded external assistance directed towards supporting social inclusion and human development

3. Policy context and Rationale

- **IPA III PF: Window 4** Competitiveness and inclusive growth**, Thematic priority 1** Education, employment, social protection and inclusion policies, and health.
- **Chapter of the *Acquis*.** The indicator responds to the need for candidate countries and potential candidates to participate actively in addressing key public health challenges, consistent with **Chapter 28 *Acquis* on Health**, and EU Health Policy.

- The rationale for interventions that support health reforms derives from Article 168 of the TFEU https://eur-lex.europa.eu/legal-content/EN/TXT/HTML/?uri=CELEX:12008E168&from=EN, and in the context of EU enlargement from Chapter 28 *Acquis*. IPA supports "…a high level of health protection... strong health systems are of crucial importance for the security of society as a whole. IPA III may contribute to reinforcing the robustness of health systems in the IPA III beneficiaries." (IPA III Programme Framework).
- However, EU action in these fields is in complementarity to those of member states (and therefore also to that of candidate countries and potential candidates), public health remaining a primarily national responsibility.
- *IPA III will also support, where appropriate, the alignment with and implementation of EU acquis in the field of public health, including on health security. It should also contribute to health systems reforms with regard to raising the coverage and standards of care provided to the population as a whole while paying attention to the elderly and people belonging to vulnerable groups. In addition, in light of lessons learnt from tackling the COVID-19 pandemic, IPA III will support beneficiaries in strengthening their public health systems preparedness and resilience to cross-border health threats.* (IPA III PF, p. 49)

4. Values to report

All of the following values must be determined according to the definitions provided in Section 5 below.

- **Reporting values in the logframe:**
  - **Baseline value**: The value assumed by the indicator at time t0, against which progress will be assessed.
  - **Reporting of current value** is done at least once a year: actual latest value on the total number of health reforms by the time of reporting and according to the applicable definitions provided in section 5 of the note. Values will be reported cumulatively across the whole implementation period.
  - **Final target value**: estimated total number of health reforms by the target year and according to the applicable definitions provided in section 5 of the note.
- **Intermediate targets (milestones).** A tool has been developed in OPSYS to automate the generation of intermediate targets[1].
  - For outputs, the intermediate targets are generated using a linear interpolation between the baseline and target values because it is assumed that outputs materialise sooner and more progressively over implementation (than outcomes).
  - For outcomes, the expected progression over the course of implementation will vary across interventions. During the creation of a logframe, the expected outcome profile

[1] This has been done in the framework of the **Intervention Performance Assessment.** Two composite indicators have been developed to provide an overall assessment of an intervention's current implementation and future prospects. These scores will be calculated for all NEAR interventions participating in the annual results data collection exercise.

- The **implementation score** reflects the relevance, efficiency and effectiveness already achieved by the intervention. The information on relevance is provided by the Operational manager's response to a question in a survey. The information on efficiency and effectiveness is provided by the logframe data, if sufficiently available, or the response to a question in a survey, if not.
- The **risk score** reflects expectations regarding the most probable levels of relevance, efficiency, effectiveness and sustainability to be achieved by the intervention in the future. In this case, all the information is provided by the Operational manager's responses to questions in a survey.

must be selected (OPSYS offers four options[2]) and this selection triggers the generation of intermediate targets for all 30 June and 31 December dates between the baseline and target dates for all output and outcome quantitative indicators. All automatically generated intermediate targets values and dates can be subsequently modified by the Operational Manager or the Implementing Partner with the approval of the Operational Manager.

5. Calculation of values

The value for this indicator is calculated by counting the **Number of health reforms**, using the Technical Definitions and Counting Guidance provided below. Please double check your calculations using the Quality Control Checklist below.

Technical Definitions

Health Reform. For the purposes of this pair of indicators (a - developed/ revised; b- under implementation) health reform is understood as health care reform, i.e. significant changes to the architecture or operation of the health care system. Note that IPA support to health care reform will generally focus on changes to areas relevant to pre-accession, including areas relevant the relevant EU *acquis*, to the Copenhagen criteria, and in line with EU Health policy and actions:

- Public health policy;
- horizontal issues (including ehealth, and other horizontal issues such as health policy, health financing, health capacity, and work with relevant EU or international bodies such as ECDC, EMA, WHO, UNICEF or similar);
- tobacco control,
- communicable diseases,
- blood, tissues, cells and organs,
- patients' rights in cross-border healthcare,
- pharmaceuticals (medicines for human use and medicines for vet use, and AMR),
- cosmetics,
- medical devices,
- mental health,
- drug abuse prevention;
- health inequalities;
- nutrition; alcohol related harm reduction; promotion of safety;
- cancer screenings;
- healthy environments including prevention of injury;
- rare diseases.

Improved accessibility is understood as the possibility to reach or enter the health system and its supports, at any level: primary, secondary (hospital) or specialised. Health care reform is often designed to make the system more accessible, useable, by the general population or particular groups.

[2] a. Constant: The outcomes are achieved continuously throughout implementation; b. Accelerating: The outcomes are achieved towards the end of implementation; c. At the end: The outcomes are mostly achieved at the end of implementation; d. None of the above.

Standard of care, for purposes of this indicator, refers to the level and quality of care that is available within a health system to patients. This will differ according to pathology. In well-functioning health system standards of care are generally defined to a "high" level of quality. Note that there is no single standard of care for any pathology across IPA beneficiaries though there is a large consensus around standards among like-minded partners. It is likely standards of care will vary, even for the same pathology across and within IPA beneficiaries.

Level of indicator. The indicator corresponds generally to an outcome level result.

Counting Guidance

- To count against the indicator a health reform that seeks to (i) improve accessibility or (ii) improve standards of care, (iii) both, (iv) other must:
    - (a) have been developed or revised ; or
    - (b) be under implementation.
- A reform may be reported within the intervention according to successive stages of (a) development or revision and (b) implementation. Note that in such case, the reporting is done under two different indicators a) first, and then b).
- There is some **risk of double counting** when the intervention supports the same reform and same stage over several reporting periods. To avoid this, the same reform must be reported only once against the relevant indicator.

Quality Control Checklist

1. Has double counting been avoided as indicated in the Counting Guidance above?
2. Have all relevant disaggregations been reported?
3. Has the baseline and final target been encoded with the right dates?
4. Did you encode the latest current value available?
5. Did you use the comment box to inform on the values encoded?

6. Examples of calculations

In IPA beneficiary A an intervention supports three health reforms: e.g. (1) in neo-natal health care (2) in the organisation of primary health care.

In IPA beneficiary B an intervention supports two health reforms: (1) in infectious diseases and (2) in the organisation of primary health care.

Let us assume each intervention starts implementation at start of Year 1.

By end of Year 1:

In IPA beneficiary A: all three reforms are underway in terms of planning only (i.e. development and revision of legal texts, protocols, planning documents).

In IPA beneficiary B: both reforms are underway in terms of planning only (i.e. development and revision of legal texts, protocols, planning documents.

By end of Year 2:

In IPA beneficiary A: neo-natal care are still in planning stage but primary health care reform is under implementation (on the ground)

In IPA beneficiary B: infectious diseases reform is still in planning stage but primary health care reform is under implementation.

By end of Year 3:

In IPA beneficiary A: all three reforms are under implementation

In IPA beneficiary B: both reforms are under implementation

The values reported in the logframe of the intervention are summarised below. Annual figures are presented in () for clarity. Remember that logframe values in the case of this indicator are cumulative figures.

	IPA beneficiary A Intervention		IPA beneficiary B Intervention	
	Values for Indicator 4.1.3.2.a) Reform in development / revision	Values for Indicator 4.1.3.2.b) Under implementation	Values for Indicator 4.1.3.2.a) Reform in development / revision	Values for Indicator 4.1.3.2.b) Under implementation
Baseline	0	0	0	0
Year 1	3 (3)	0 (0)	2 (2)	0 (0)
Year 2	3 (0)	1 (1)	2 (0)	1 (1)
Year 3	3 (0)	3 (2)	2 (0)	2 (1)
Final Target	3	3	2	2

Note that in total there are 5 reforms over 2 IPA beneficiaries. All are driven by the aim of improving standards of health care – except one, i.e. In IPA beneficiary A, the health system (objective render it more universal). But this reform aims to widen accessibility to health care by reforming the health care system (and extending coverage) so even the most vulnerable will not be deterred from going to their doctor (i.e. improving access to health care). So, in this case, all 5 issues meet the terms of the indicators. Note however that it is possible that other worthy healthcare reforms may not e.g. training of hospital managers etc. The IP will need to be attentive to this issue at reporting stage.

7. Data sources and issues

Data sources in the logframe:

- Data for this indicator must derive directly from the intervention, i.e. intervention internal monitoring and reporting systems from implementing organisations (e.g. governments, international organisations, non-state actors).
- Other possible sources include studies carried out in the framework of the interventions and external monitoring and/or evaluation reports.

Data source categories specified in OPSYS:

- EU intervention monitoring and reporting systems (Progress and final reports for the EU-funded intervention)

8. Reporting process & Corporate reporting

Who is responsible for collecting and reporting the data?

- The implementing partner (i.e. the entity responsible for delivering the results) will need to ensure the counting starts at the lowest level of intervention and is reported upwards and aggregated for the entire intervention in the framework of regular monitoring and reporting systems.

- Data verification:
  - For indirect management by beneficiary countries, the National IPA Coordinator will verify the data.
  - For other modes of implementation, the Operational Manager in HQs/EUD will verify the data.
- It is then the responsibility of DG NEAR to centrally receive and verify data for this indicator from all relevant interventions and to eventually ensure aggregation within and across all IPA Beneficiary countries.

This indicator is used for corporate reporting in the following contexts:

- *IPA III via the Annual Report*

9. Other uses

IPA III RF 4.1.3.2 can be found in the following groups of EU predefined indicators available in OPSYS, along with other related indicators:

- IPA III RF Window 4: Competitiveness and inclusive growth (IPA III W4)

For more information, see: Predefined indicators for design and monitoring of EU-funded interventions | Capacity4dev (europa.eu)

10. Other issues

None