Information to Improve Value for Money in Health

Recent developments—from a leveling out of resources for health to a greater emphasis on value for money and accountability for results—underscore the need for more and better information on the effectiveness of current health spending. Reducing inefficiencies in the use of existing resources is also important to those advocating for more resources, as inefficiencies will detract from returns to any additional resources for health. This makes achieving and demonstrating value for money more important than ever. In addressing information needs for improving value for money, a first step is to focus on value—interpreted as improved quality and performance of health service delivery; value for money will follow.¹

**Trends in Resources Available for Health:** Governments are the largest source of health spending in developing countries. In 2010 aggregate government spending on health in Africa was estimated at 3.5 times higher than total development assistance for health in Africa.² After experiencing vast increases in the 1990s–2000s, government health spending has now stagnated in 20 African countries. Given the uncertain economic climate facing developing and developed countries alike, it is unlikely that past increases in government and aid spending will be repeated.³

In recent years there have been highly visible calls for improved value for money for health spending, most recently the Tunis Declaration on Value for Money.⁴

**Linking Financing to Results:** This is a trend that is on the rise in Africa at multiple levels. Examples range from changes in the way officials are rewarded (e.g. performance-based contracting of senior officials; performance-based financing of health facility staff) to the way governments or partners finance sectoral programs (e.g. performance–linked agreements between ministries of finance and sectoral ministries; cash-on-delivery aid; the World Bank’s Program-for-Results financing instrument).

**Calls for Improved Accountability:** The MDGs are a strong example of accountability for government effectiveness. Central to the success of the race to the MDGs is that it made governments’ performance targets public and performance was tracked in the public domain by non-experts. An initiative aimed specifically at tracking progress on the health-related MDGs is the Commission on Information and Accountability for Women’s and Children’s Health.⁵

---

**KEY MESSAGES**

- A recent leveling out of resources for health, alongside highly visible calls for greater results and accountability, underscores the need for information on value for money in health spending.
- While there has been significant progress in health data quality, including better expenditure and health outcome data, important gaps remain in the quality, timeliness, and comparability of data. There is also too little timely data on service delivery and insufficient information for accountability.
- Impact evaluation has expanded the information base on service delivery, but routine program monitoring data remains weak—a potential missed opportunity.
- Financing is increasingly linked to results. When information is used to reward performance or quality, data credibility and methodological rigor are essential.
- Information can both inform and spur action; learning from failure is critical, as is adaptation of implementation as informed by this learning process.
DO OUR DATA MEET THE CURRENT CHALLENGES?

There have been significant improvements in certain types of information. For example, the availability and quality of expenditure data has improved over recent years. While important gaps remain, governments and international agencies (notably WHO and the Institute for Health Metrics and Evaluation) produce annual reports on government and donor health spending. Comparable cross-country data on health outcomes have progressively improved through better disease surveillance systems and household surveys. In fact, the Demographic and Health Surveys have become the gold standard for measurement of health indicators including infant mortality, under-five mortality, and fertility, among others. Despite these improvements, some challenges remain:

- **Data quality and third-party verification.** Over the past few decades we have seen vast investments in health management information systems (MIS). When information is used to reward performance or quality, self-reported MIS data often lack credibility and methodological rigor. For example, vast differences in estimates of immunization coverage from MIS and survey data have raised serious questions about the use of MIS data as evidence for performance-based reimbursements.

- **Time dimensionality of data.** Data are only useful if available for analysis and use within the timeframe required for decision-making. Some decisions are made quarterly, some annually. Whether the data source is an MIS or a survey, it is only valuable if it is available to decision-makers on time.

- **Comparability of data and repetition of surveys.** Lots of data are collected through various once-off surveys. However, the full returns to the investment are realized only when a repeat survey allows trends to be observed and performance to be tracked. Moreover, comparison across information sources and tracking over time requires consistent definition of indicators. The value of data collection lies exactly in the ability to compare and assess trends. The lack of comparability results in considerable inefficiency when tracking performance over time or across sub-national or national boundaries.

- **Information on Service Delivery.** Improving efficiency requires better service delivery at the facility level. As facility data often lack comparability, WHO and USAID recently led the development of a survey tool called Service Availability and Readiness Assessment (SARA). This has been an important step toward standardization of indicators of service availability and readiness, although some gaps remain in indicators of service delivery performance (see box on Service Delivery Indicators).

- **Information for accountability.** The Commission on Information and Accountability emphasized that without information there can be no accountability. Without accurate measurement, it is hard to reward performance or hold stakeholders accountable. But health data efforts usually serve supply-side needs. The demand-side—from parents and consumers of services to parliamentarians and advocates concerned with improved accountability for public resources—is often overlooked. Information about service delivery performance and quality is seldom communicated in simple terms through popular media. In fact, this information is frequently regarded as confidential. However, there are signs of change. The Kenyan Ministry of Information, Communications and Technology has implemented the Kenya Open Data Initiative, a visionary effort to make key government data publicly available through a single online portal. Even this bold initiative has had difficulties with government ministries on sharing information about sectoral results.

MONITORING & EVALUATION FAILURES PERSIST DESPITE THE IMPACT EVALUATION REVOLUTION—A MISSED OPPORTUNITY?

Ensuring value for money requires that the most effective interventions or programs be implemented. Impact evaluation has emerged as an important tool to provide robust and credible evidence on the impact of a development intervention, and to assess which changes can be attributed to it.
But as impact evaluation designs grow more sophisticated and surveys more detailed, routine program monitoring systems remain weak and underfunded. Yet the latter continue to be important. There have been some positive examples of using programmatic or monitoring information to understand impact evaluation findings. Better program information can also address an often-voiced criticism of impact evaluation, which is that it fails to look into the “black box” of service delivery. It would be a huge missed opportunity if the evaluation expertise and resources of impact evaluations are not applied equally to the monitoring and evaluation needs of a program or project. Results-based financing for health is an example of a large multi-country effort where impact evaluation has been applied alongside efforts to improve information systems for monitoring implementation.

SERVICE DELIVERY DATA: CRITICAL TO ASSESS EFFICIENCY AND VALUE FOR MONEY

One of the gaps identified earlier is the lack of standardized information on the production of services in health centers and hospitals that can be used to assess their technical efficiency. This is critical to assess value for money and examine why health expenditures do not translate into optimal quality services. Figure 1 shows how information from the “black box” of service delivery can identify areas in the service delivery chain where value for money can be improved. In addition to tracking the availability of critical inputs, the choice of service delivery indicators must reflect the understanding that the quality of health services is critically dependent on what health workers know (i.e. knowledge and competence) and what they do (i.e. provider effort).

SERVICE DELIVERY INDICATORS

Service Delivery Indicators is an Africa-wide initiative and partnership of the World Bank, the African Development Bank and the African Economic Research Consortium. It aims to fill the existing gap in standardized data on service delivery with a focus on the knowledge and effort of service providers.

The vision is that this data will be collected every 2 to 3 years, allowing decision-makers to track performance over time and across geographic areas, and aid decision-making as policymakers improve the quality of service delivery and the efficiency of health spending.

The surveys also collect information on facility-level flow of resources, which is often done as part of public expenditure tracking surveys. By combining performance data and expenditure data this data source is an important complement to existing data architecture to address value for money questions.
INFORMATION IS NOT AN END IN ITSELF...

Information can both inform and spur action, or quoting Goethe: "Knowing is not enough, we must apply. Willing is not enough, we must do." There has been much action toward improving quality and effectiveness. Quality requires knowing what to do. This is very effectively done by WHO and others through the establishment of clinical guidelines and the implementation of checklists. Reviews of the health service delivery literature have repeatedly concluded that success requires continuous monitoring and adaptation during implementation. In management, this is called "Learning from failure". Closely linked is the notion that without the correct information we are doomed to repeat failures. The information and communications technology revolution holds tremendous promise to accelerate our ability to learn from both positive and negative experiences. On this topic, World Bank Group President Jim Kim blogged: "I’m convinced that revolutionary advances in communications and information processing, when linked to an enlightened approach to failure, can help transform our pursuit of ability to achieve development results, even in the poorest countries." 

Finally, in a critique of some development policy practitioners (including the World Bank), Bill Easterly made the distinction between "Planners" and "Searchers". A key difference is how they use information—planners use information to devise more detailed plans, and searchers use information to track performance and do mid-course corrections. While good plans rest on good information, tracking implementation is arguably of even greater importance.

QUESTIONS TO MINISTERS

To Ministers of Finance: In your experience, what information or type of analysis has provided the most compelling and credible arguments about value for money of health spending?

To Ministers of Health: How do you think improved information and analysis could contribute to efforts to improve the quality of service delivery?

---

1 Deming contended that quality tends to increase and costs fall over time when people and organizations focus primarily on quality, defined by the ratio: \[ \text{Quality} = \frac{\text{Results of work efforts}}{\text{Total costs}}. \] However, when people and organizations focus primarily on costs, costs tend to rise and quality declines over time. http://en.wikipedia.org/wiki/W._Edwards_Deming.


3 The 2012 report on health expenditure trends has the sub-title “The End of a Golden Era” referring to the likely slowing of increases in future health spending.


5 In 2011 the UN convened the high-level Commission on Information and Accountability for Women's and Children's Health to make countries and their partners accountable for delivery against the Global Strategy for Women's and Children's Health Strategy. The Commission proposed a framework for global reporting, oversight and accountability. The framework included (i) measures to track flow of resources, and (ii) identification of key indicators to track results. (WHO 2011. Keeping Promises, Measuring Results. Commission on Information and Accountability for Women's and Children's Health).


7 As of November 2011, there are close to 390 datasets that have been uploaded to the KODI site, with a plan currently in place to upload more data over the next year. There have been over 17,000 page views and over 2,500 datasets downloaded and embedded to various websites and portals. https://opendata.go.ke/.


