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Working for a World
Free of Poverty

STRATEGIC IMPACT EVALUATION FUND (SIEF)

IMPACT EVALUATION CLUSTER NOTE:

HEALTH SYSTEMS AND SERVICES DELIVERY

I. Background.

Health, nutrition and population policies play a fundamental role in economic and human development and poverty alleviation. Better health outcomes of individuals and populations can contribute to economic growth, which in turn can contribute to better health and again have a positive impact on economic growth, and so on. The ultimate objective of World Bank work in Health, Nutrition and Population (HNP) is to improve the health conditions of the people in client countries, particularly the poor and the vulnerable, in the context of its overall strategy for poverty alleviation.

Less than five years remain to attain the Millennium Development Goals (MDGs) and much has been achieved since the goals were set. Progress has been substantial in achieving the MDGs for gender parity in primary and secondary education, completion of primary education, access to safe drinking water, and eradicating extreme poverty and hunger, in that order. Progress is too slow, however, on health-related outcomes— such as child and maternal mortality and access to sanitation— so the world will likely miss these MDGs by 2015. Most regions are lagging on these health goals, although East Asia and the Pacific, Latin America and the Caribbean, and Europe and Central Asia are doing better than other regions. The Global Monitoring Report (GMR) reckons that 105 out of 141 countries will miss the target of reducing mortality of children under five by two-thirds. In addition, 94 out of 124 countries will likely miss the target of reducing the maternal mortality ratio by three-quarters. (GMR 2011)

As 2015 approaches, calls for greater development effectiveness are taking on increased urgency. Spending on health both from donors and from governments has risen to unprecedented amounts, but as the global crisis is squeezing budgets, it is critical to examine the effectiveness of health spending. The disconnect between financing and outcomes stems in part from a narrow focus on financing inputs that has ignored other parts of the causal chain that links spending to changes in health outcomes. The causal chain shows that incentives facing both service providers and consumers, as well as underlying social and cultural norms and patterns including gender relations, are critical in ensuring the effectiveness of investments, yet policies have often failed to sufficiently account for them. Not surprisingly, therefore, one of the strong lessons emerging from impact evaluations is that continuing to increase provision of traditional inputs will have only limited impact if issues of service delivery and consumer behavior are not addressed. (GMR 2011)



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The World Bank's 2007 Strategy for Health, Nutrition and Population (HNP) makes the case for concentrating the Bank's contributions on its comparative advantages, particularly in health system strengthening, health financing, and health economics. The systems approach contrasts with a focus on a single-disease, or single-intervention, often implemented through a vertical program. To function well, even single-disease interventions need functioning health systems. An efficient health system is one that effectively manages resources, inputs, and institutions (financing, governance, insurance, logistics, provider payment and incentive mechanisms, appropriate and well-targeted information, health workforce, basic infrastructure and supplies) to ensure equitable access to effective health, nutrition and population interventions and a continuum of care possibly involving both public and private providers. (HNP Strategy 2007)

At the same time, wider literature points out that systemic interventions in the health sector need to be coupled with better understanding of behaviors and social and cultural norms that promote or undermine health, and how to affect them. Many changes that are essential to achieving improved health outcomes lie outside the health system altogether and include but are not limited to education, income, traditional practices, gender relations, discrimination against particular groups, violence against women, etc. There are also specific barriers that reduce access to healthcare such as transport constraints and costs. Within the health sector, appropriateness of services, confidentiality, non-discrimination and factors such as opening hours and location are also critical. Many of the barriers faced by women are often magnified for adolescent girls. The wider governance context for health also plays a role, including political commitment and legal frameworks. The evidence on these areas is emerging and there is much scope to increase the global evidence base.

II. Description of cluster and ongoing research.

The cluster will support evaluations that prioritize interventions on effective service delivery, demand for health services, and health-related behaviors as key intermediate steps to improving health outcomes. Therefore, the health cluster will principally evaluate (i) reforms to the mechanisms that govern health systems, including financing, governance, insurance, logistics, provider payment and incentive mechanisms, information, training, basic infrastructure and supplies, legal frameworks, as well as interventions that aim to build political commitment for health; (ii) interventions that work on changing health-related behaviors, including interventions that affect constraints to healthy behaviors, social practices and norms, or demand for health services.



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Rigorous evidence on the impact of system reforms in developing countries is growing but still limited, especially at a scale where generalizable lessons can emerge from replicable evaluations in a variety of settings. For example, in the last decade impact evaluations have generated substantial evidence of efficacy for a variety of health interventions. Holla and Kremer (2009) review evidence from randomized evaluations of varying user fees and subsidies for a variety of health inputs such as deworming medicine, insecticide-treated bednets and vaccines. While micro-level evaluations yield valuable information about behavioral responses in a tightly-controlled experimental environment, there is little rigorous evidence on the impact of similar large-scale, government implemented or initiated interventions that cannot be so tightly controlled. These tightly controlled experiments often generate evidence on delivering services in optimal situations. In that sense, they serve as a “proof of concept” – demonstrating the effects of such programs once we can assure that the services are delivered.

In contrast, rigorous impact evaluations of system reform at scale are not as common. Several factors explain this. First, such studies are typically more expensive and risky than studies of tightly controlled experiments, because they require larger sample sizes and are faced with more uncertainty. Second, to evaluate a systemic reform, one needs to be able to implement a systemic reform, and unlike small-scale interventions, such a reform cannot be implemented by researchers in universities or research institutes. However, since an increasing number of World Bank loans and credits focus on system reforms, there is a unique opportunity to build upon the Bank’s work with Governments on system reform, and dynamically build knowledge on the impact of those reforms.

At the policy level, the questions of **effective health service delivery and demand for health services** are critical and often poorly understood. For example, we may know that providing quality prenatal care and safe institutional deliveries is critical for maternal and child health, but increasing the availability of such quality care through the health system, and supporting women to use them is not straightforward. Outcomes will depend on the interactions of many elements, including whether providers are motivated and equipped to provide the care, whether the care is affordable to women, how much decision-making power women and girls have in the household, and whether women and girls feel it is worth their effort to come in for care. There is little at-scale evidence on how to stimulate demand for health services and promote health from within communities. A recent review by DFID finds encouraging evidence of the value of integrating maternal and newborn care in community settings, for example, by working through Community Health Workers. Further evidence would be needed on the conditions that would make these types of approaches successful at a larger scale. (DFID 2011)

Even when evidence is available on health system reform, it is even scarcer on the **cost-effectiveness of system reforms** because comparing the costs of alternative interventions is usually impossible. Few



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impact evaluations explicitly incorporate cost analysis into their design, and it is not necessarily clear how to do this. Using funding from the Health Results Innovation Trust Fund (HRITF), the World Bank is currently developing a set of tools that can be used as a “minimum package” of data collection tools for cost effectiveness. With additional funding, these tools could be expanded to include a wider array of impact evaluations.

Finally, emerging evidence points to the importance of understanding drivers of individual and household behaviors when it comes to health. For example, in Malawi small stipends paid directly to teen girls have had a powerful impact not only on their school attendance but also on the onset of sexual activity. (Baird et al. 2010)

III. Outline for research agenda.

Knowledge gaps relevant for effective policy are numerous, as previously mentioned. They are often specific to the particular health system dimension – financing, governance, health workforce, etc. Each evaluation proposal will need to be accompanied with an assessment of the evidence available from existing evaluations and other studies in the proposed area of study, as well as a review of ongoing evaluations relevant to it.

The cluster will build upon **ongoing and completed evaluations** in the health systems area. Previous World Bank IE work in the health sector has focused on specific themes (disease or other) that highlight important aspects of health systems.

The first SIEF trust fund focused on impact evaluation, funded by the Spanish government, financed a number of impact evaluations within a **Malaria Cluster**. While the entry point to the cluster involved evaluations of interventions specific to the treatment or prevention of malaria, all of the cluster work dealt substantively with system issues such as innovations in financing and service delivery that make malaria treatment available, including subsidized access to Artemisin Combination Therapy and Rapid Diagnostic Tests through the private sector, and reforms of public sector pharmaceutical supply chains. (Velenyi, Friedman et al., forthcoming)

Similarly, the Spanish-funded impact evaluation fund financed three impact evaluations within an **HIV/AIDS cluster**. The three impact evaluations focused on the prevention of HIV and other sexually transmitted diseases. The evaluations tested demand-side interventions using financial incentives such as conditional cash transfers (CCTs) to incentivize safe sex and reduce the prevalence of sexually-transmitted infections. In Malawi, the results indicate that CCTs linked to school attendance for



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adolescent girls were instrumental in reducing the prevalence of HIV and Herpes Simplex (Baird et al. 2012). In Tanzania, CCTs were directly conditioned on testing negative for a set of curable STIs. After one year, the prevalence of these STIs was reduced by 25% in the study arm that received the highest level of CCT (de Walque et al. 2012).

Finally, the Spanish-funded impact evaluation fund financed impact evaluations of **pay-for-performance** in the health sector in Rwanda, Argentina, Benin, China and India. The Rwanda evaluation shows that paying primary health care providers for performance resulted in substantial increases in institutional delivery, as well as in improvements in the quality of prenatal care. In Argentina, the evaluation of “Plan Nacer” used administrative records in two provinces to show increases in utilization of services, quality of care and birth outcomes. Data from the China and India evaluations are currently being analyzed.

The separate Health Results Innovation Trust Fund (HRITF), financed by DFID and the Government of Norway, continued and expanded the evaluation work in the area of **results-based financing for health**. These evaluations examine the impact of a particular kind of system intervention: payment of providers or households for the production or usage of certain health outputs or outcomes. Evaluations are currently ongoing in Rwanda, the DRC, Benin, Cameroon, Nigeria, Zambia, Afghanistan and Argentina, and evaluations are planned in Laos, Vietnam, India, Sri Lanka, Burkina Faso, Liberia, Burundi, Zimbabwe, CAR, Liberia, Kyrgyz Republic and Tajikistan.

Evaluations that are eligible for financing from the HRITF are excluded from funding from the SIEF Health cluster because they are already fully supported. The SIEF Health cluster, like the HRITF trust fund, will be managed by the Health, Nutrition and Population Hub in the Human Development Network. This will avoid overlap or duplication and ensure that synergies can be fully exploited. For example, the standardized impact evaluation tools that are being developed with HRITF funding will be available to SIEF-funded evaluations.

IV. Research questions and outcomes.

The priority areas to be addressed within the cluster are (i) health systems, and (ii) health-related behaviors.

- (i) **Health Systems.** This area will focus on how **health system reforms** impact health outcomes, as well as intermediate outcomes.



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- What are **effective service delivery** mechanisms for delivering health services? How cost effective are they?
- What institutional and workforce frameworks best support effective service delivery?
- What are effective financing mechanisms for financing comprehensive and equitable health services? How cost-effective are they?
- More generally, which health system reforms improve the efficiency and equity of service delivery (including quality), and what are the circumstances that facilitate this?
- How should these reforms be designed to maximize impact?

(ii) **Health related behaviors.** This area will explore reforms and interventions that affect **individual/household health behaviors** and the impact on health outcomes via behavioral responses.

- **How can interventions that** focus on social norms and practices, education, economic assets and cash transfers, **reducing violence, provision of information, accountability mechanisms**, safe spaces, political commitment etc. improve health behaviors and health outcomes among priority populations defined below?
- What kind of reforms and interventions can increase and support demand for key health services, such as sexual, reproductive and maternal and child care among priority populations defined below?

The cluster will focus on the following **main outcomes** for the evaluations: (i) maternal, newborn and child health outcomes, (ii) sexual and reproductive health outcomes, (iii) health systems performance areas covering all functional building-blocks of health systems, (iv) service utilization indicators at a population level (as opposed to the facility level) and other measures related to accessibility and health systems performance; (iv) quality of care indicators should receive equal prominence to quantity of care where appropriate; (v) financial protection from health shocks; (vi) costs of health system reforms; (vii) health-related behaviors and practices.

Priority will be given to evaluation on: (i) women, (ii) children under five; (iii) adolescent girls; (iv) the poorest; (v) other vulnerable and hard-to-reach populations including young men, remote populations, and segments of the population with particularly poor health outcomes.



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