



# Generating Evidence of Governance Contributions to Health Outcomes

HFG Workshop

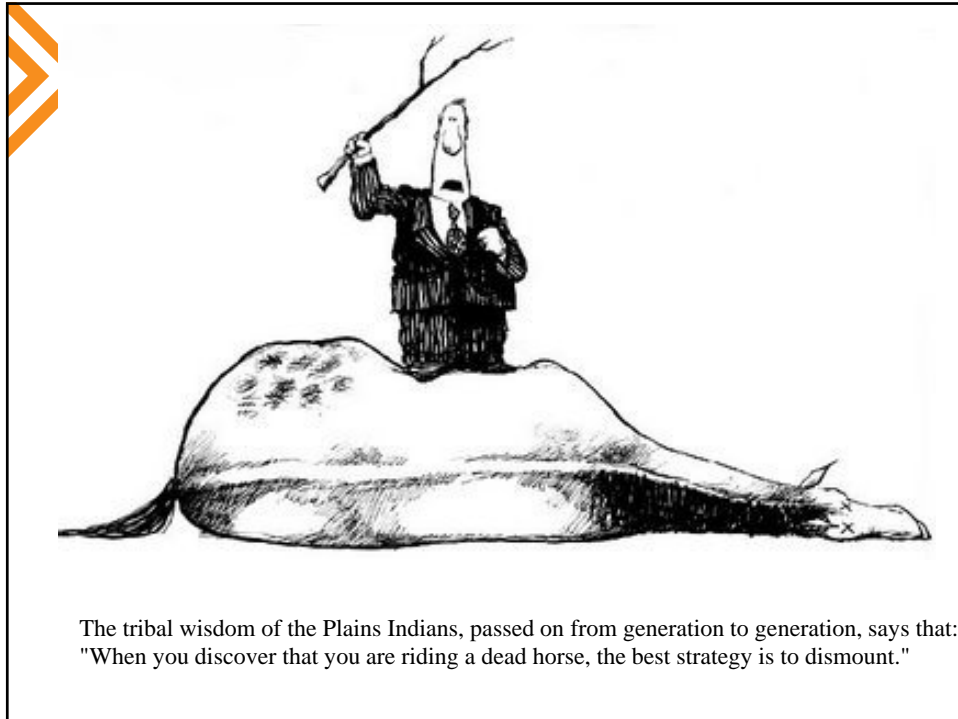
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 Abt Associates Inc. in collaboration with:  
Broad Branch Associates | Development Alternatives Inc. (DAI) | Futures Institute | Johns Hopkins Bloomberg School of Public Health (JHSPH)  
Results for Development Institute (R4D) | RTI International | Training Resources Group, Inc. (TRG)

## Session 1: The Current State of Evidence

### A Landscaping of the Evidence on Governance in the Health Sector of Low and Middle Income Countries

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## However, in government more advanced strategies are often employed:

- » Buying a stronger whip
- » Changing riders
- » Appointing a committee to study the horse
- » Visiting other countries to see how other cultures ride dead horses
- » Reclassifying the horse as "living-impaired"
- » Providing additional funding or training to improve the performance of the dead horse
- » Rewriting the expected performance requirements of all horses
- » Promoting the dead horse to a supervisory position

Source; <http://pambazuka.org/en/category/cartoons/83351>  
*Pambazuka news, Pan-African voices for freedom & justice*



## Outline

- » Definitions and frameworks
- » How governance affects health: what do we know?
- » Framing research around governance and health: what do we need to know and how do we find out?
- » Concluding reflections



## Definitions of Governance

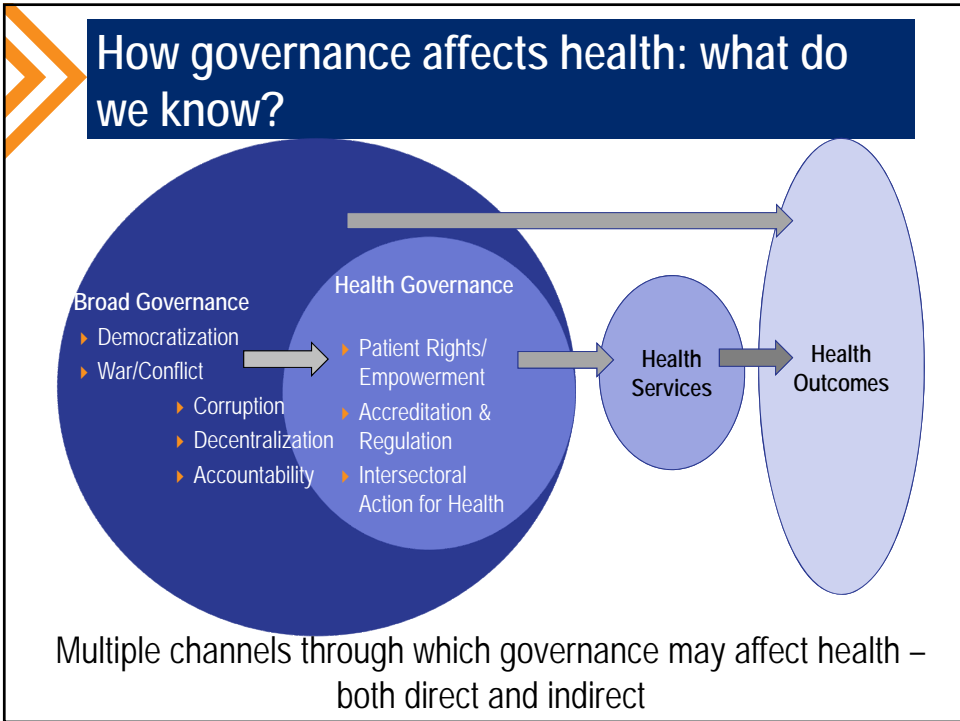
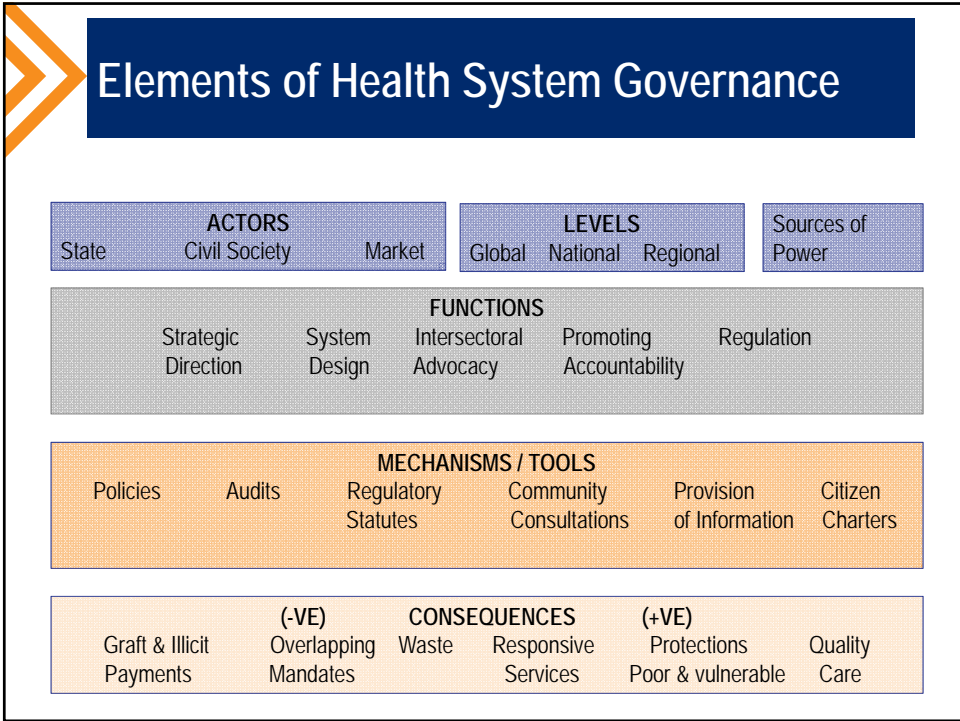
- » "The exercise of political, economic and administrative authority in the management of a country's affairs at all levels" (UNDP 1997 non-specific to health)
- » "The careful and responsible management of the well-being of the population" (WHO WHR 2000 - stewardship)
- » "The complex mechanisms, processes, relationships and institutions through which citizens and groups articulate their interests, exercise their rights and obligations, and mediate their differences" (WHO EURO 2006)

## Governance Frameworks 1 – Non-health Specific

USAID – Democracy, human rights & governance (DRG) strategic framework ( <i>USAID strategy on democracy, human rights and governance 2013</i> )	UNDP Principles of good governance ( <i>UNDP 1997</i> )	World Bank ( <i>Kaufman et al 2005</i> )
Participation, representation & inclusive political process and institutions	Legitimacy & Voice (participation, consensus orientation)	Voice & accountability
Accountability of institutions & leaders to citizens & the law	Direction (strategic vision)	Political stability & lack of violence
Promote & protect universally recognized human rights	Performance (effectiveness & efficiency)	Government effectiveness
Integrate DRG principles and practice across development portfolio	Accountability (accountability and transparency)	Regulatory quality
	Fairness (equity & inclusiveness, rule of law)	Rule of law
		Control of corruption

## Governance Frameworks 2 – Health Specific

Health Governance Principles ( <i>Siddiqi et al 2009</i> )	WHO – domains of stewardship ( <i>Travis et al 2002</i> )
Strategic vision	Generation of intelligence
Participation & consensus orientation	Formulating strategic policy direction
Rule of law	Ensuring tools for implementation: powers, incentives & sanctions
Transparency	Building coalition & partnerships
Responsiveness	Ensuring a fit between policy objectives and organizational structure and culture
Equity & inclusiveness	Ensuring accountability
Effectiveness & efficiency	
Accountability	
Information & intelligence	
Ethics	





## Effects of Broad Governance Factors on Health Services & Health Outcomes

- ▶▶ Cross-sectional studies have explored the effect of governance measures (eg. CPIA) on health:
  - ❖ Aid and public sector spending is more effective in achieving desired outcomes in contexts of good governance (*Burnside & Dollar 2004*)
  - ❖ Increased health spending reduces <5 mortality only where governance (CPIA) is sound (*Wagstaff & Claeson 2005*)
  - ❖ Good governance does not have a direct effect on health, but has significant indirect effects via (*Klomp & de Haan 2008*):
    - ▶ Improved health care (staff ratios, vaccine rates)
    - ▶ Income
  - ❖ Public health spending lowers child mortality rates more in countries with good governance (*Rajkumar & Swaroop 2008*)



## Democratization

- ▶▶ Substantial evidence that democratization associated with higher levels of public health (eg. better infant mortality, life expectancy, immunization coverage) (*Lake & Baum 2001; Zweifel & Navia 2000*)
- ▶▶ Democratization, through electoral competition, can spur the development of Universal Health Coverage (*Grepin & Dionne 2013*)



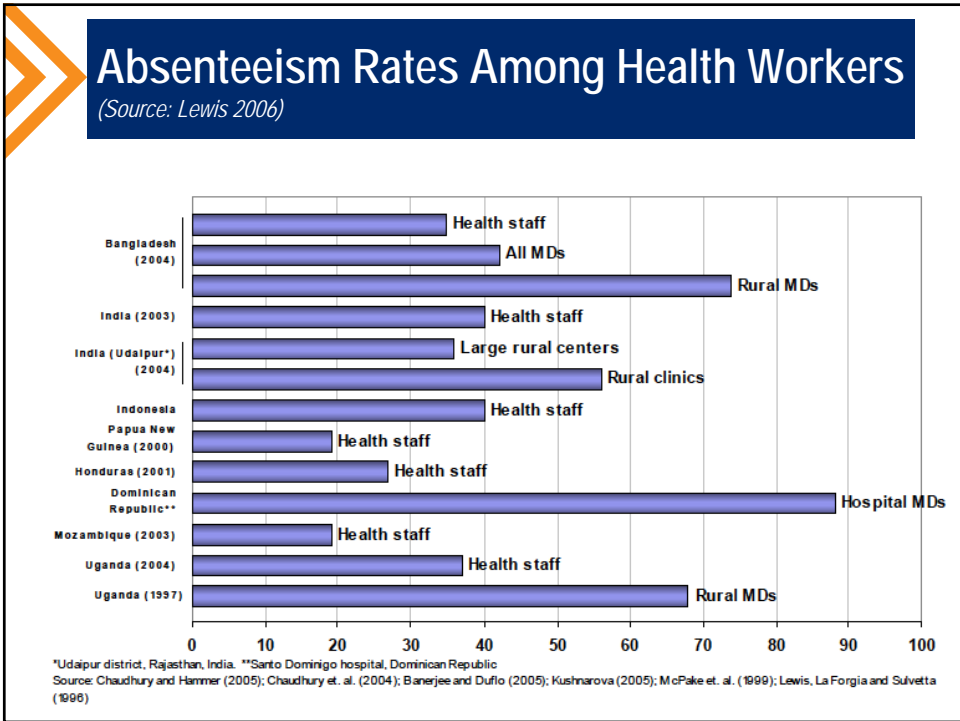
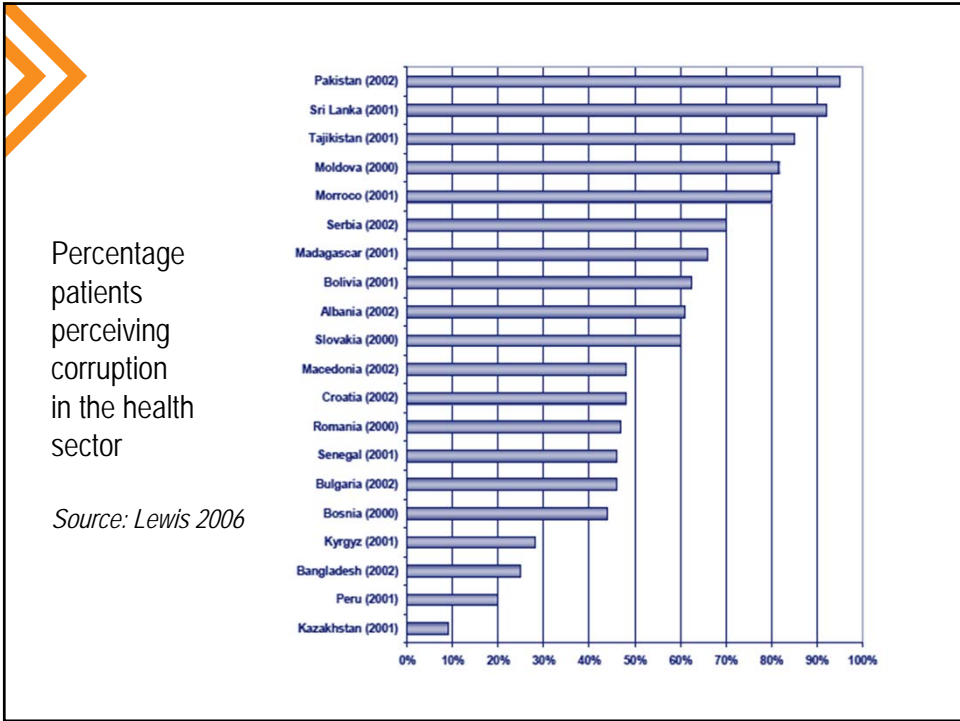
## War & Conflict, & Health

- ▶▶ Conflict related death & injury is a major contributor to the global burden of disease
  - ❖ Evidence is weak regarding magnitude of death/morbidity, especially indirect effects (*Murray et al 2002*)
  - ❖ Indirect effects through raised incidence of infectious disease (HIV, Malaria) and reduced health spending may have twice the impact of direct effects (*Ghobarah 2004*)
- ▶▶ Substantial focus in health, on how to rebuild health systems post-conflict



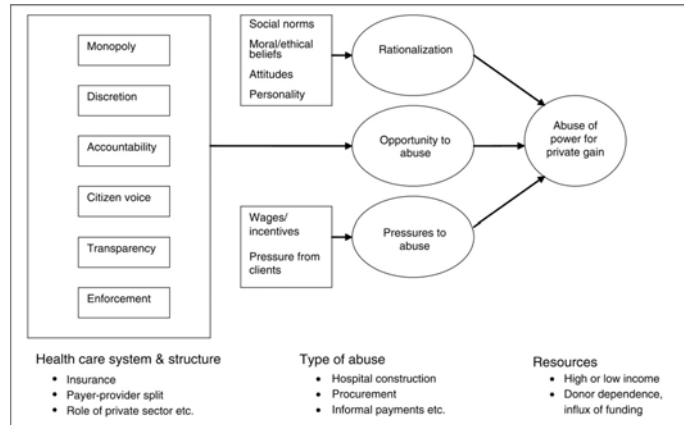
## Corruption & Weak Financial Management

- ▶▶ Corruption: "Abuse of entrusted power for private gain" (*Vian 2008*)
- ▶▶ A widespread problem in the health sector, from petty to large scale
  - ❖ Counterfeit drugs market US\$75 billion pa worldwide
  - ❖ Leakage of non-salary recurrent expenditures in Ghana 80%, Uganda 70% (*2000 PETS*)
  - ❖ Widespread informal payments, can be 5-10 times greater than formal salary (*Cambodia, Barber et al 2004, Bangladesh, Killingsworth et al 1999*)
- ▶▶ Major implications for service quality and efficiency – not just loss of money





## Framework of Corruption in the Health Sector



Source: Vian, T. *Health Policy Plan.* 2008 23:83-94; doi:10.1093/heapol/czm048

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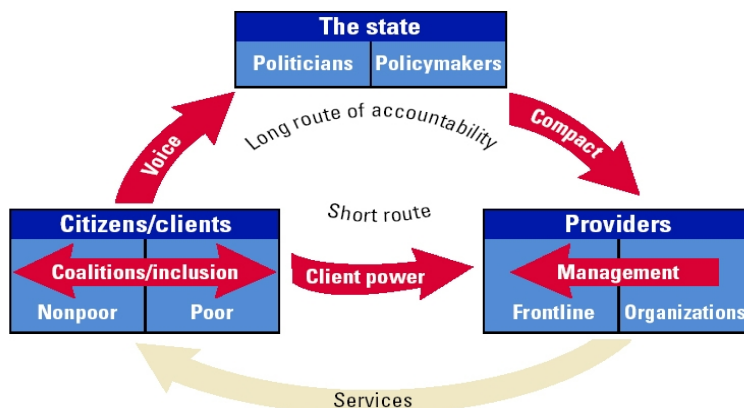
Health Policy  
and Planning

## Decentralization

- ▶▶ Effects of decentralization on access to and quality of health services highly debated:
  - ❖ *Robalino et al 2001* – financial decentralization had positive effect on IMR especially in poor countries and those that promote political rights
  - ❖ Some individual country studies, eg. Tanzania (*Hutchinson 2002*), & Uganda (*Jeppson & Okunzi 2000*), note positive effects – others, (*Blas and Limbambala 2001*) note negative effects.
- ▶▶ Multiple efforts to identify different dimensions of decentralization (eg. *Bossert 1998 & 2002 decision space*)

## Accountability, Patient Rights & Empowerment

Key relationships of power



Source: World Bank 2003

## Community Accountability 1

- ▶▶ Multiple mechanisms:
  - ❖ Information dissemination: eg. District Health Barometer (South Africa)
  - ❖ Community/Village health committees
  - ❖ Community monitoring
  - ❖ Possibly supplemented by information technology
- ▶▶ RCTs have demonstrated that interventions to promote accountability of providers to communities *can* have significant positive effects on health outcomes
  - ❖ Eg. *Bjorkman and Svensson 2009* (35% reduction in child mortality)



## Community Accountability 2

- ▶▶ Studies of routine processes to promote voice and accountability (eg. Village health committees) more mixed
  - ❖ *Molyneux et al (2012)* review 19 such studies, 4 demonstrate positive findings, others more mixed
- ▶▶ Challenges
  - ❖ Community structures may not be inclusive
  - ❖ Community accountability mechanisms may not function in a sustainable and institutionalized fashion
- ▶▶ Challenges of transferability given heterogeneity of mechanisms and contexts within which they work (*McCoy et al 2011*)
- ▶▶ Evidence on public report cards and patients' rights charters very limited (Molyneux found 1 LMIC study each)




## Upward Accountability

- ▶▶ More substantive evidence around upward accountability mechanisms:
  - ❖ *Performance based financing* – 4 systematic reviews on these schemes, suggest substantial variation in design and effectiveness “devil is in the detail”
  - ❖ *Contracting for health services* – 2 systematic reviews suggest that contracting can increase access and utilization of services, but evidence on quality (and perhaps accountability) not clear
  - ❖ *Balanced scorecards* – no systematic reviews, one study shows promising outcomes in Afghanistan



## Regulation and Accreditation

- ▶▶ Regulation often thought to be critical given scale of private health sector, but:
  - ❖ Widely thought to be ineffectual (eg. *Sheikh 2013, Kumanarayake et al 2000*)
  - ❖ Very limited evidence about strategies to strengthen regulation or regulatory capacity
- ▶▶ Very limited developing country evidence on accreditation (just 1 out of 198 studies in *Totten et al 2012* systematic review)



## Enhancing Core Government Governance Functions

- ▶▶ Widely acknowledged that government requires capacity for core functions such as:
  - ❖ Designing mixed (public/private) health systems
  - ❖ Working intersectorally to promote health
- ▶▶ Often these functions imply new skills and capacities such as partnership building, system thinking, strategic planning, & conflict resolution
- ▶▶ Very limited evidence on how to effectively build such capacities in MOH



## Governance - A Neglected Area of Research

- » Widely acknowledged to be critical to the achievement of health outcomes, but probably the least studied/understood function in a health system
- » Evidence across virtually all of the areas covered above is very weak



## Criteria for Identifying Future USAID Evidence Investments

- » What will have maximum impact on USAID programming?
- » What are other actors investing in?
  - ❖ Not much!
  - ❖ IDRC “Governance for equity in health systems” initiative – only LMIC researchers
  - ❖ 3iE window on transparency and accountability (not health specific)
- » What is feasible, doable and likely to deliver practical guidance?

Research question should drive study design

## Research questions should guide study design

- » Questions regarding influence or effects of interventions
- » Descriptive and exploratory questions
- » Explanatory questions

## Possible study designs 1 – questions regarding influence or effects

Study Questions	Study designs	Strengths & Weaknesses
Does X reform influence service outcomes/coverage?	Randomized control trials ( <i>eg. Bjorkman VHC</i> ) Before/after, time series analysis	High quality evidence on impact Does not explain mechanisms through which impacts occurred Expensive
Is good governance associated with better service outcomes?	Cross-sectional (cross-country) statistical analysis ( <i>eg. Rajkumar and Swaroop</i> )	Provides high quality evidence on associations Typically does not explain mechanisms through which impacts occurred

## Possible study designs 2 – Descriptive & exploratory questions

Study Questions	Study Design	Strengths & Weaknesses
How do health workers perceive corruption?	Ethnographic research or other qualitative methods (Stringhini 2009 provider attitudes to informal payments)	Can explore and explain phenomena, correct misperceptions, offer insights into why things happen
To what extent is community decision making about health inclusive?	Participatory action research	Good at describing complex social phenomena. Can help build theory
How does MOH structure support or undermine health in all policies?	Case studies	May have limited transferability to other contexts

## Possible study designs 3 – Explanatory questions

Study Questions	Study design	Strengths and Weaknesses
Under what circumstances are community accountability mechanisms effective?	Mixed methods – convergence of qualitative and quantitative data, Pragmatic trials.	Combine rigor of quantitative approach to measuring impact with ability to explain mechanisms
How can we make regulatory interventions more effective?	Implementation research, plan, do, study, act cycles	Can help guide implementation strategies, providing "real time" data



## Final Reflections 1

- » Governance in health – a wide and largely untouched canvas
- » Untouched due to multiple challenges:
  - ❖ Lack of conceptual clarity, differing definitions & frameworks
  - ❖ Political sensitivities, eg. work on corruption
  - ❖ “difficult” area for effective research and action (mission interviews)
- » Need for focus, and need to demonstrate early wins – studies that assist implementation, or impact of other programs



## Final Reflections 2

- » Governance inherently complex phenomenon
- » Public health & development community emphasis on narrow “scientific rigor” (eg. RCTs) has some from negative effects:
  - ❖ Underplays need to understand *why* effects occur
  - ❖ Focus on discrete interventions rather than whole governance system
  - ❖ Neglect questions of scale up and feasibility
  - ❖ May fail to recognize rigor (albeit of a different sort) in alternative, qualitative methods





Thank you

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