

Governance of health systems:

a data journey

INTRODUCTION

Health systems embody people, institutions, and resources arranged together following policies established by a government to improve the health of the population it serves¹. Within the health sector, arrangements are intended to improve health system performance - equity in the use of health services, service quality and financial protection. Most countries have pluralistic health systems, where a mix of public and private entities deliver health related goods and services. This may include a large variety of private entities, from small not-for-profit providers to large multinational private for-profit companies.

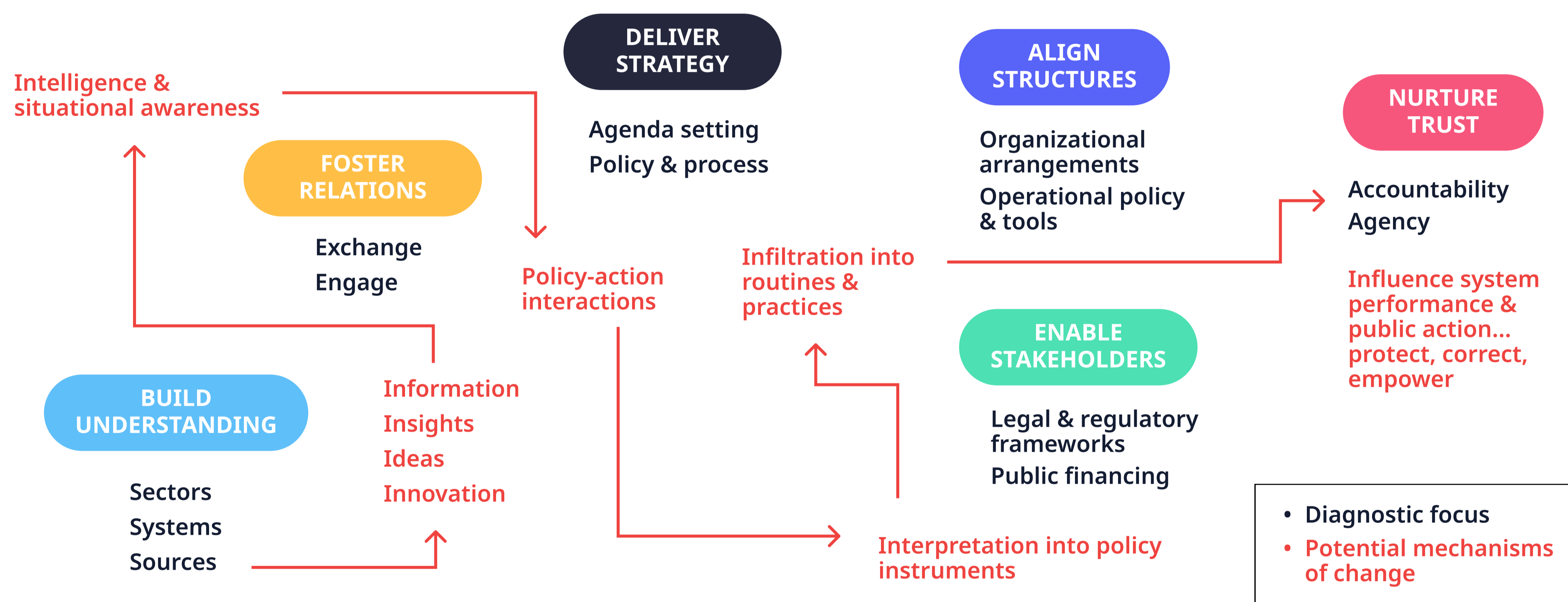
Despite increasing recognition of the importance of the private sector in health for public health goals, there remains little consensus on how to develop and implement inclusive health policy. Many countries do not have explicit policy related to the private sector in health nor the role of component entities in national health systems. In the absence of clear direction, a policy vacuum may coalesce in which the growth, form, and function of the private sector in health are left to other forces, to the detriment of efficiency, quality, and equity.² As part of inclusive health policy, 'situational awareness' and the generation of intelligence is needed by governments on the private sector in health. Additionally, to perform specific governance functions, such as contracting, more explicit information on the private sector is required.

Many LMIC governments have attempted to address health system information requirements through the collection of more, better, and different types of data on the private sector; increasingly, this is done in a routine manner, through national health information systems. Alongside these efforts, other sources of information may exist, such as programmatic, financial, geospatial, survey and other structured or unstructured data sets. Innovations in data capture and interoperability between information sources, as well as advanced analytics using machine learning and artificial intelligence techniques are also increasingly available and being tested in LMICs as part of a broader toolkit of tech solutions. Despite these advances, data and information may not be used to govern the private sector or build understanding with component entities. The WHO's Thirteenth General Programme of Work (GPW13)³ recognises this challenge and has called to deliver measurable health impacts for people at the country level.

GOVERNANCE BEHAVIOURS

The governance behaviours were conceptualised as part of the WHO strategy report “Engaging the private health service delivery sector through governance in mixed health systems”. Launched in 2020, this strategy contributes a specific focus on the private sector as part of health systems governance and systems strengthening. The governance behaviours break down what have tended to be long lists of governance activity, i.e., “ensuring [that] strategic policy frameworks exist and are combined with effective oversight, coalition-building, regulation, attention to system design and accountability.”⁴ They reinforce the notion of governance as practice, with activity determined through day-to-day decision making and improvisation by actors at multiple levels.⁵ Linked with this, there is an emphasis on governance as involving negotiation of networks rather than hierarchical authority.⁶ Foundational to improvisation and interaction is data for governance.

Given that data is fundamentally raw information and as such, may not be in a form that can be used to govern, we elaborate on the data-to-information-to-intelligence pathway as part of a theory of change using the governance behaviours as a strategic frame. Of note, our definition of private sector are those entities directly involved in service delivery. This includes private-for-profit and not-for-profit entities, both local and international, including primary care clinics, maternity/nursing homes, pharmacies (in their service extension role) and hospitals. It does not include other private entities operating along the healthcare value chain. Additionally, we focus on data generated at a national level and not through global or regional initiatives (while acknowledging that this is an important body of information which could be used for governance of the private sector in health).



BUILD UNDERSTANDING: Availability of data and its conversion into information

Data can come from multiple systems and sources. These can be combined or remain as fragmented strands of data. **Information** is data that has been organized into a format that is meaningful. This can take multiple forms, which may or may not include the private sector. Examples of data systems, sources and products are outlined below. These are not exhaustive and are likely to vary by country and region. Other examples are provided under related governance behaviours.

- **Systems:** Health information system, health facility registry, surveillance/reportable disease system, maternal death surveillance and response system, logistics management information system, human resource systems
- **Sources:** Reporting forms, registers, surveys, assessments, research, mapping, etc.

- **Products:** Service reports, programme reports, benchmarking and trend analysis (e.g., league tables, scorecards), research papers and studies, advanced analytics, (info)graphics, dashboards, maps, etc.

An important feature of build understanding is how data is converted to information and insights. **Insights** are the interpretation of information, based on context, knowledge and experience. **Ideas** are generated through insights and may motivate action. **Innovation** (in our theory of change) relates to data capture and interoperability between information systems and sources as well as the use of novel formats to convey information. While information, insights, ideas, and innovation are introduced under build understanding, as with other mechanisms of change, they work across the governance behaviours.

FOSTER RELATIONS: *How information is exchanged and used to foster engagement*

The conversion of information to insights and ideas is facilitated through exchange as the basis for engagement and coalition building. Engagement may be sectoral or intersectoral, formal or informal, virtual or in-person. It may be routine or event-based, through technical working groups or public-private dialogue mechanisms. It should result in shared understanding of the situation – or “situational awareness” - defined as a well-informed interest in a situation or development. The availability of information is critical to developing such an awareness and generating intelligence. Indeed, a function of governance is ensuring that all health system actors have access to the information they need to contribute to public policy and system performance.⁷

Examples of mechanisms and formats for engagement and exchange are outlined below. While situational awareness and intelligence are introduced under foster relations, as with other mechanisms of change these inform other governance behaviours.

- **Mechanisms:** meetings, online platforms, associations, federations, syndicates, group chats, etc.
- **Products:** manifestos, memos, briefs, communiqués, minutes, action plans, etc.

DELIVER STRATEGY: *How intelligence is reflected in public policy*

Deliver strategy is fundamentally about policy and the policy-making process. Here we consider how information is converted into “formal” intelligence (the evidence base) and included in the policy arena. Information in the policy arena may be used instrumentally, to identify priorities and inform decisions, or strategically, to support pre-existing decisions.⁸ Both uses are legitimate, and both approaches may be apparent in policy making. Factors affecting the use of intelligence and evidence include perceived credibility, accessibility, and the support base.⁹ Our theory of change suggests a linear approach to policy, that information informs policy and drives implementation. However, the policy making process does not necessarily occur in linear, sequential stages.¹⁰

Intervention itself may activate the policy cycle, providing the basis for intelligence gathering and policy formulation. This may be driven by policy entrepreneurs outside of government, including the private sector, using intelligence and evidence generated through multiple sources, not solely government systems. Examples of mechanisms and products to deliver strategy are outlined below.

- **Mechanisms:** policy review, policy dialogue tours, monitoring systems, consultation processes, formal petition, etc.
- **Products:** public policy, roadmaps and strategies, progress reports, advocacy and policy briefs, etc.

ENABLE STAKEHOLDERS: *How intelligence is interpreted in policy instruments to enable (or constrain) health entity performance*

This behaviour considers how intelligence and policy are interpreted in policy instruments and public financing arrangements. These, in turn, inform the development of tools for implementation in programmes and services.¹¹ Here, information requirements may be both strategic and operational. Strategically, information on the private sector is needed to guide the development of inclusive policy instruments and financing arrangements. At an operational level, information is needed to develop and implement specific tools, such as accreditation and contracting.

Information may be siloed, limiting its effective use, particularly in contexts where roles are divided across government entities and administrative levels. Information reservoirs may also sit unutilized for governance such as data collected on participating facilities in national or social health insurance, and related information on costing and service provision.

In some contexts, e-governance systems have been introduced to reduce information fragmentation, improve compliance and ease of doing business for private health entities.

- **Sources:** Legislation, regulation, rules and procedures, claim management systems (insurance or vouchers), compliance systems, communication systems (e-governance), etc.
- **Products:** Circulars, guidelines, checklists, expenditure reviews, standards, benefits packages, etc.

ALIGN STRUCTURES: *How policy and related instruments inform the operations of health entities in their service delivery roles*

This behaviour considers implementation of policy instruments and related tools, as well as how these are recognised and distributed across organizational structures, including private health entities. Governance at this level may be devolved to sub-national administrative units and suffer from implementation disconnects with central policy, national programme strategies and information systems. This highlights the need for bi-directional flow of data and information to ensure that policy directives are reflected in service routines and practices (and vice versa), and are inclusive of reporting practices and the maintenance of information. Increasingly routines and practices may extend to digital health and self-care, creating new pools of services and data that may or may not be integrated into health information systems.

At this level, technical and procedural capacities (e.g., technology, skills, processes), values and relationships play a role.¹²

These may facilitate or limit the availability of data; ease of access (to data and data systems); the capacity to use data and convert it into useful information; and generate insights and ideas to improve health system performance.¹³ Research on decision making at this level suggests that “formal” data, through health information systems may be combined with local contextual understanding and experience-based knowledge (a form of information that may not be recognised within information systems). At this level, there may be more reliance on muddling through rather than formal policy or information sources and products, such as those in the examples below.

- **Sources:** routine service statistics, technical working groups, programme/partners, assessments, audits, supervision, self-regulation, peer benchmarking, etc.
- **Products:** plans, presentations, reviews, dashboards, reports, etc.

NURTURE TRUST: *How information is used for accountability and agency, to protect and empower, and correct health system performance*

Both sectors should be accountable to the delivery of quality health services and commit to reduce unnecessary or ineffective care.¹⁴ Information is critical to this intent and may be used to empower and educate users to demand state obligated services, and support health-service actors to recognise and act on these demands (inclusive of the private sector).¹⁵ Furthermore, information may be used to address asymmetries of power and exert pressure on the system. Information and user perspectives (health workers and consumers) may be helpful in generating a system-wide perspective on policy implementation, system performance and the effectiveness of interventions (e.g., regulations, contracting)¹⁶ again reflecting the importance of bi-directional flow of information.

Examples below illustrate the bi-directionality of information sources and products.

Sources: communities, health committees, media, social media, Ombudsman office, parliamentary committees, patient organisations, watch dogs, feedback mechanisms (websites, chalk boards, chat bots, etc.)

Products: codes of conduct, patient charters, social audits and scorecards, reports/directives, community chalk boards, etc.

CONCLUSION

Our data for governance journey will provide the conceptual framework for planned country case study work in 2023. Through a combination of literature review and qualitative research, this work will identify what data and information is currently being collected by governments and how this is used for governance of the private sector in health. Information will consider routine and other data sources, as well as innovations in data science and technology as part of the information landscape. This work will primarily focus on the “build understanding” governance behaviour but will seek to generate insights on information requirements across governance behaviours, as illustrated in the theory of change.

An over-arching synthesis will be prepared to compare and contrast country case studies and illicit insights on data for governance and information requirements. If you have evidence and insights on the data for governance journey in your context, please share these via e-mail to contact@ccpsh.org.

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