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U4 BRIEF

Using financial performance indicators to promote transparency and accountability in health systems

This case-based brief presents experiences of district health management teams in South Africa, where interventions to improve district health planning and reporting, including the integration of financial data and service utilization statistics, proved helpful in increasing transparency and focusing attention on areas most vulnerable to abuse.

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Financial corruption in health facilities can take many forms. Corrupt officials may divert patient fee revenue or siphon off funds from the facility budget. Fee exemptions meant for the poor and especially vulnerable may instead be granted to family and friends. Agents may create false invoices for supplies never received, or collude with suppliers to create inflated invoices for procured items, with the procurement agent pocketing the government payment or kickback. Drugs and supplies beyond what is needed may be purchased from the public budget then diverted for re-sale or private use. Government officials may also ignore the spending priorities stated in public policies or strategy documents, instead channeling funds to pet programs or favored geographic regions. Corruption may be a greater problem in decentralized systems, where agents are sometimes given greater discretion without sufficient control systems in place, or in countries where public sector employees may engage in private practice, which adds ambiguity to responsibility structures.

Problems such as the ones described are hard to detect, in part because record keeping is often weak. For example, studying 23 countries with hospital user fee systems, Barnum and Kutzen (1993) found that in only two countries did hospitals keep records which would allow fee collection information to be matched to service utilization.1 Virtually no hospitals kept track of total patients exempted. A study in Kenya found that 78% of fees actually earned by one provincial hospital went uncollected. In other words, there was no record that the patients paid the fees they were supposed to pay for the services they received, or, if they did pay, that the fees were received by facility. Similarly, in government facilities in Guinea it was impossible to determine collection rates because patients who cannot pay are not registered as having received services.2

Prevention and detection of corruption requires both transparency and accountability. Accurate information on the generation and use of resources must be produced and shared with senior managers and oversight bodies in a timely fashion so that performance can be reviewed and prompt action taken where necessary. Such performance can only be measured properly by combining financial and service data to produce indicators of average revenue and cost per service. Using these indicators, actual revenue and cost per service are then compared over time and against performance targets, or compared with performance at other facilities. Monitoring performance in this way not only indicates possible areas of corruption but also helps to identify inefficiency and waste.

Monitoring financial performance is part of an overall set of management control systems. Improved controls can help to increase the probability that anomalies will be identified, and can help quantify the magnitude of the problem. Stronger management control and reporting can help curb not just corruption, but inefficiency as well, providing incentives for more rigorous and accountable management. Studies have shown that as transparency (and the probability of detection that comes with it) increases, corruption declines.[3] Simply put, what we measure affects what people do.

Yet, this type of performance monitoring is rarely done, as it requires the integration of financial information and service statistics. These systems are traditionally managed separately, with finances being the responsibility of financial managers and service delivery the responsibility of technical managers. In addition, weaknesses in health information systems, bookkeeping, and lack of management training make it hard to produce accurate, timely indicators and use them properly. Transparency and accountability can only be achieved when systems are improved and appropriate indicators produced, and when responsibility for financial performance is clearly vested in designated managers.

CASE

The USAID-financed EQUITY project worked with the Department of Health in South Africa from 1997-2003, with the goal of expanding equitable access to quality primary health care services in the country. Focusing in the Eastern Cape, North-West, and Mpumalanga Provinces, covering around 30% of the country's population (approximately 13 million people), the project's goal was to build the capacity of district health teams to use resources efficiently and effectively to address priority health needs, including HIV/AIDS. In addition to public health programs such as immunization, reproductive health care, health promotion, and disease control, the district health teams manage hospital- and health center-based clinical care at hundreds of public facilities.

Four years after the fall of apartheid, the centrally-controlled South African health care system had many governance problems, including a lack of citizen input and spending patterns that did not reflect the true health needs of the population. Seventy-five percent of health expenditures were in the hospital sector, budgeting was arbitrary, and record keeping systems did not provide data to hold officials accountable for performance.

At the district level, systems for planning, budgeting, accounting, and health information each existed, but they were weak and operated as silos, without cross-communication. Service plans were created each year, then rarely referred to again. Budgets were compiled, then slashed, so that the resulting numbers didn't correspond to the actual cost of services the districts were expected to provide. Reams of paper were used to complete required reporting; yet, there was no information to monitor performance in relation to the plans or budgets. As one district manager put it, "We had to change. We were frustrated with the health care system, and had no useful information to base management on. This had a radical impact on our ability to provide quality health services."

ACTION PLAN

Accountability for health care system performance demands that public officials wisely use resources to achieve objectives. To provide transparency on this process, you must look at expenditure in relation to what was produced. The District Manager, Information Officer, and Finance Officer needed to work together to see the relationships between how resources are allocated and how they are used to produce services. The key to increasing accountability in district health management would be to link planned and actual services to the resources used to achieve them, and to compare performance over time, with targets and across similar facilities. Because many of the staff in health districts were untrained in management, it was important to start with a simple system.

The project began by introducing a District Health Planning and Reporting System (DHP) which centered around an annual review and analysis of health services and financial performance. The analysis included a number of

1 Barnum, H. and J. Kutzin, Public Hospitals in Developing Countries: Resource Use, Cost, Financing. Baltimore, MD: Johns Hopkins University Press. 1993.

2 W. Newbrander, D. Collins, and L. Gilson. 2000. Ensuring Equal Access to Health Services: User Fee Systems and the Poor. Boston, MA: Management Sciences for Health.

3 DiTella, R. and W. Savedoff, eds., Diagnosis Corruption: Fraud in Latin America's Public Hospitals. Washington, DC: Inter-American Development Bank. 2001.

key indicators such as the number of services per day (in total and per nurse), cost per patient visit and bed day (total and supplies), cost of staff, drugs and maintenance, and user fee revenue per patient discharge. These indicators were compared over three years, with targets and across similar facilities.

The plans and annual reports were provided to municipal government, other district teams, and the Provincial Department of Health, providing the opportunity for external, peer, and hierarchical review and enhanced accountability. Each facility and district was also required to monitor and report on its performance on a monthly basis and the reports were reviewed quarterly. Additional monitoring systems were introduced, covering related areas such as clinic supervision. With Project assistance, the National Department of Health implemented the district health planning and reporting systems nation-wide, and produced a written manual as a reference tool for district management teams.[4]

RESULTS

The implementation took time, and required a lot of training and technical assistance for planning and budgeting in each of the districts. Management teams eventually produced annual district reports with indicators that merged financial and utilization data, in most cases for the first time.

The results were surprising and provoked discussion. The analysis shown in Table 1, using real data but with disguised district and clinic names, illustrates the medicine cost per visit, across four clinics. The table highlights the high consumption of medicines in Mwanza Clinic, which is over three times the cost per visit in two other centers. While there could be a reasonable explanation for the high expenditure on drugs for Mwanza, such as a different mix of services, without this information it would not be possible to identify the need for an explanation. The information allowed managers to probe for potential abuse or diversion of resources, inefficiencies, or compelling reasons why expenditures should be legitimately different from the average.

Table 1: Tanbela District Medicine Cost per Visit by Clinic

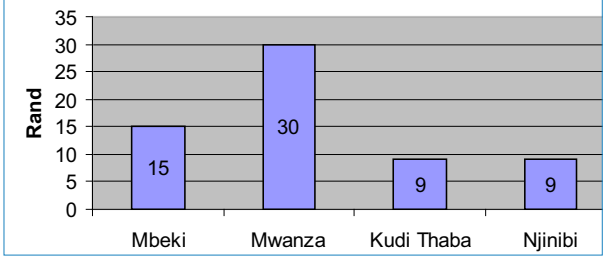

Table 2: Batarana Hospital IP Expenditure per Day

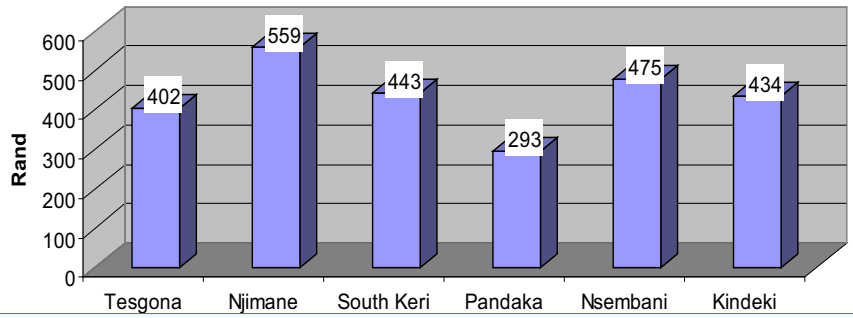

Table 2 shows another graph created by a district management team, this time looking at inpatient expenditure per day. This graph highlights the higher than average expenditure in Njimane Hospital. What are the reasons for this high expenditure? What portion of the costs are "controllable," that is, can the management team actually control through their own decisions? Did the hospital treat less patients than expected in the year, or did they stay for fewer days than expected, thus leading to a higher cost per bed day? Were they less efficient, or did they carry out more tests which resulted in better quality of care? Should the management team be censured or applauded? The table doesn't answer these questions, but for the first time, it allows supervisors to raise them. In this case, the district manager did an additional analysis of food costs and discovered that the cost per meal was highest at Njimane. Recognizing that this could indicate possible problems such as inflated contract prices which are driving up food expenditures, or the procurement of excess food so that some could be diverted, the district manager was able to focus supervision in this area.

The system to monitor performance by combining financial and service data in South Africa was hampered, in some ways, by a lack of appropriate service statistics. For example, while data on total visits was collected through the health information system, the data did not permit managers to drill down by type of visit. Health data systems designed to measure disease prevalence and cure rates may not have adequate data to measure a facility's productivity and efficiency. For the latter purpose, a "tick" register was introduced which had columns showing types of services and number delivered, and which could be easily summarized. Further work was needed in South Africa to report service statistics in a way that will allow managers to "peel the onion" of unit cost data, thus identifying root causes of performance problems and assuring full accountability of government agents in charge.

CONCLUSION

The need for management control systems and tools is increasing as more governments move toward decentralization and contracting out for health services. South Africa's efforts to improve performance and expenditure tracking at provincial and district levels have resulted in better management control, providing useful information with which to hold government agents accountable. The success in South Africa thus far shows that what you measure really does affect what people do. Instead of allowing financial personnel to be accountable for budgets while medical personnel are accountable for services, a system which brings together the locus of responsibility for costs and outputs, holding the service manager accountable, is essential in order to curb corruption.

4 National Department of Health, Republic of South Africa. 2001. Guidelines for District Health Planning and Reporting.

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FURTHER READING

- Management Sciences for Health. The Equity Project 1997-2003: Final Report (50 pages) Boston, MA: Management Sciences for Health. Download by clicking on .pdf file link (2.5 MB) http://www.msh.org/programs/southafrica_equity.html

- National Department of Health, Republic of South Africa. The web site of the Department of Health contains many documents of interest, including Financial Management: An Overview and Field Guide for District Management Teams (April 2002) http://www.doh.gov.za/docs/index.html

- Soeters, Robert and Fred Griffiths. 2003. Improving government health services through contract management: a case from Cambodia. Health Policy and Planning. 18(1): 74-83.

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