Public Services

Health

Open Government Partnership Global Report

DEMOCRACY BEYOND THE BALLOT BOX

Open Government Partnership

Key points

OGP members have taken an extremely varied approach to dealing with health, from citizen monitoring of local expenditures to bringing members of the public into major regulatory and policy decisions. Major areas for future initiatives may include improving universal health coverage and primary care, reproductive health (including prenatal, maternal, and neonatal care), and improving the general budget and integrity. A general overview of key points is below:

- **Data on the policy area**

  Health outcomes data and data on reproductive health lag far behind data on inputs. OGP members may consider commitments to centralize and make comparable data on health facilities, outcomes, and reproductive health, with special focus on disaggregation by gender and at local levels.

- **Information on the policy process**
  - *Universal healthcare planning and tracking:* The majority of OGP members covered by the World Health Organization's Universal Health Coverage database have plans in place to achieve this goal, but a minority regularly publish data on progress. While methods vary on measurement, OGP members may consider publishing performance metrics and monitoring toward universal health coverage.
  - *Health procurement:* According to in-country experts, most OGP members did not have fully open, competitive bidding processes. Notably, about one-third did have strong systems. OGP members may address this by expanding user-centered open-contracting systems for key elements of the health system.
  - *Program-level budgeting:* Most OGP members had program-level budgeting, but fewer reported on expenditures and outcomes. Most reporting focused on inputs and outputs, rather than performance. OGP members wishing to focus on this area may work on disaggregating budget data and introducing output tracking into these systems.

- **Participation and accountability**

  OGP members, where they do focus on improving participation and accountability in health, have largely focused on citizen input into policy and strategy. A smaller group has focused on budget and supply tracking. Four governments have focused on accountability for patient outcomes. Where OGP members wish to focus on improving systems of accountability, actions can focus on creating the institutions for social accountability within the context of other more formal systems of accountability such as ombudsman's offices and auditors.

There is a global consensus that tackling health issues is not only key to development, but also to ensuring inclusive, sustainable growth across all economies. An argument for the importance of universal coverage and access to quality healthcare is beyond the scope of this report. However, it is sufficient to say that improving health outcomes is a globally agreed-upon goal. (For beginners in this field see “Good to know: Health policy for generalists.”)

Opening government is one of many possible means of tackling the complexity of today’s health challenges, including achieving bold goals like universal access to care and successfully addressing the specific challenges of particular illnesses.

As with other public services, open government approaches to health, while broad, can fall roughly into three major categories:

1. Data on health inputs and outcomes: This includes data on major diseases, reproductive health outcomes, and facilities for decision-making.
2. Information on the policy process: This includes policy-making, budgetary decisions and prioritization, and procurement and implementation.
3. Participation and accountability: These approaches include improving public means of giving input, hearing feedback, and getting government response to concerns.

Newborn boy rests next his mother in the maternity ward at the Princess Christian Maternity Hospital, in Freetown Sierra Leone. (Photo byDominic Chavez/World Bank)

Families wait to see a nurse to vaccinate their children in Beirut, Lebanon. (Photo by Dominic Chavez, World Bank)

The majority of OGP members with action plans have included health as a focus area in their action plans (43 of 85), as of the time of writing. In total, of more than 3,000 commitments, 120 health-related commitments have been included in action plans since OGP's beginning, with 54 commitments active in 25 countries or localities. This means health-related commitments are relatively common within OGP. In comparison with other policy areas, health is the second-most common public service-related category after education.

Of the 120 commitments, OGP countries focus on the following (in non-exclusive categories):

- **Data:** Seventy-five commitments (63%) concern data publication on performance of the health sector (e.g., patient outcomes) and other digital services that improve health sector transparency and service delivery.
- **Participation:** Forty commitments (33%) involve citizens participating in decisions about health, such as clinic construction or policy design.
- **Accountability:** Fourteen commitments (12%) are about accountability (for example, Kigoma Ujiji implemented social audits of medicine delivery to the public hospital). This is lower than the overall average in other sectors, which is 24%.

A smaller subset of health data commitments have–sometimes unintentionally–dealt with privacy, a necessary companion to any discussion on openness, especially when it is affecting the release of patient or local data. For example, the UK commitment on National Health System data provided an important opportunity for discussion of privacy in healthcare. (See "Lessons from Reformers: UK" later this section.)

GOOD TO KNOW

Findings by health policy area

Much of this section is structured around the types of contributions open government approaches can make to health policy and practice through transparency, participation, and accountability. Consequently, it is organized around open government values of access to information (data and non-data information), public participation, and accountability.

For health practitioners, it may be useful to look at the specific health areas featured in this section organized by topic. These were decided based on a combination of their universal applicability to OGP countries and the availability of data. The section includes data on the following topics (sources in parentheses):

1. **Health facilities and inputs**
    a Availability of open data on facilities and budgets (Open Data Watch)
    b Program based budgeting in middle and low income countries (International Budget Partnership and the Overseas Development Institute)
    c Public integrity of health procurement (World Justice Project)
2. **Universal health coverage and primary care**
    a Universal healthcare policy and monitoring data (World Health Organization)
3. **Quality of care**
    a Availability of open data on health outcomes (Open Data Watch)
    b A review of community scorecards and other social accountability interventions (various organizations)
    c Performance monitoring of health programs (International Budget Partnership)
4. **Reproductive health**
    a Availability of open data on reproductive health access and outcomes (Open Data Watch)
    b Budget transparency for reproductive health (Population Action International and International Planned Parenthood Foundation)

Hotel des Invalides, Paris. (Photo by Michael Evans, Adobe Stock)

GOOD TO KNOW

Health policy for generalists

Photo by Xixinxing, Adobe Stock

Ensuring that everyone has access to quality health services and results is a core responsibility of modern democracies. Achieving this requires efforts by multiple layers of government, private sector actors, academics, community and nonprofit organizations, and individual citizens.

The sheer breadth of the field can be overwhelming for non-health specialists, and while some challenges are universal, others are particular to individual countries. The final design of interventions, of course, will depend on the public priorities of each locale:

Healthcare interventions can address any of the following focus areas:

Health facilities and inputs

- Primary healthcare, including "patient-centered healthcare"
- Reproductive, maternal, newborn, child, and adolescent health (RMNCAH)
- Pandemics
- Nutrition
- Infectious diseases
- Non-communicable diseases
- Mental health
- Medical research

Within any of these focus areas, there are specific policy and implementation areas which can be addressed:

- Policy and rules
- Standards enforcement (accountability around behavior)
- Budget and resource management
- Procurement and pricing
- Human resource management (staffing, training, attitudes)
- Service delivery
- Health insurance, universal health coverage, and healthcare registration

Actors may include:

- Policy makers (including legislatures and independent commissions)
- State-run facilities
- Autonomous state-sponsored organizations (such as medical research agencies)
- Private sector (for-profit) actors

- Workers
- Patients and their families or communities
- Nonprofit actors (including secular, religious, community-based, or international organizations)

Given the multiplicity of goals, levels of decision-making, and actors, reforms in OGP will need to target opening up those decisions within the highest-impact focus areas. While in one country, non-contagious diseases may be the greatest contributor to morbidity and mortality, another may deal with the acute problem of pandemics or ensuring universal access to primary care. It is beyond the scope of this report to carry out a problem assessment for each country, but only to offer a list of possible focus areas.

OGP and health

There is no comprehensive or systematic data on the existence or quality of healthcare participation or accountability in OGP countries. In the absence of such information, we can only suggest that the frontiers of participation and accountability exist at multiple levels, and in a number of types of decisions. Without third-party data, this report cannot assess the "revealed" need of OGP countries, but with OGP-Independent Reporting Mechanism data, this report can evaluate the "expressed" emphasis of OGP countries.

In preparation for this OGP Flagship Report, the authors reviewed dozens of commitments focusing on improving public voice and accountability in decision-making. The evidence suggests that there is a definite emphasis within action plans. The emphasis is largely at the national level and there is a strong emphasis on general monitoring, especially performance monitoring. The full list of commitments by category is available in "Civic participation and public accountability commitments in health" next page. The principal categories of commitments are:

- **Advisory councils and citizen policy-making:** The largest group of commitments (nine in total) deal with citizen policy-making or input into programming of healthcare delivery.
- **Public monitoring of performance:** Six commitments cover public monitoring of agency performance. Of which, three are local. The remaining three were in Brazil's second action plan.
- **Budget and expenditure tracking:** Five commitments cover public monitoring of expenditures.
- **Conflicts of interest policies:** Two countries dealt with conflicts of interest in health policy (Argentina generally and Mexico for the specific issue of obesity).
- **Social accountability:** Two action plans focused on scaling up social accountability at the community level (Mongolia and Uruguay).
- **Public science:** The United States has had a number of commitments on public science.
- **Patient empowerment:** Beyond feedback mechanisms (in Buenos Aires), no action plans dealt with empowering patients (whether through a system of ombudsman's offices or patient advocates), improving liability regimes, or patients' rights.

Photo by Casfotoarda, Adobe Stock

LESSONS FROM REFORMERS

Civic participation and public accountability commitments in health

OGP commitments undertaken to improve public input and accountability in health are below. These can help inspire other countries to adapt similar commitments as appropriate.

- **Advisory councils and citizen input into policy:** These commitments deal with citizens giving input into regulation, policy, and programs around healthcare practice.
  - Colombia (2nd action plan) – Develop initiatives to deal with health and other issues, especially with marginalized communities through the "Bank of Initiatives," a citizen proposal platform.
  - Denmark (1st action plan) – Create digital opportunities for public input to identify efficiencies in key welfare services, including health.
  - Indonesia (5th action plan) – Create citizen complaint tools and a framework for participation including in the health sector.
  - Paraguay (3rd action plan) – Improve citizen involvement in policy formation and resource allocation for the health sector.
  - South Korea (4th action plan) – Enhance the operation of the food safety inspection committee through a public petition system.
  - Spain (2nd action plan) – Create the multistakeholder Spanish Council on Drug Dependence.
  - Sri Lanka (1st action plan) – Form an advisory council to improve safe and affordable medicines for all.
  - Uruguay (2nd action plan) – Develop a Dialogue Table to advise on the use and distribution of health data nationally.
  - Uruguay (3rd action plan) – Public dialogue on the policy to provide personal assistance for people with disabilities.

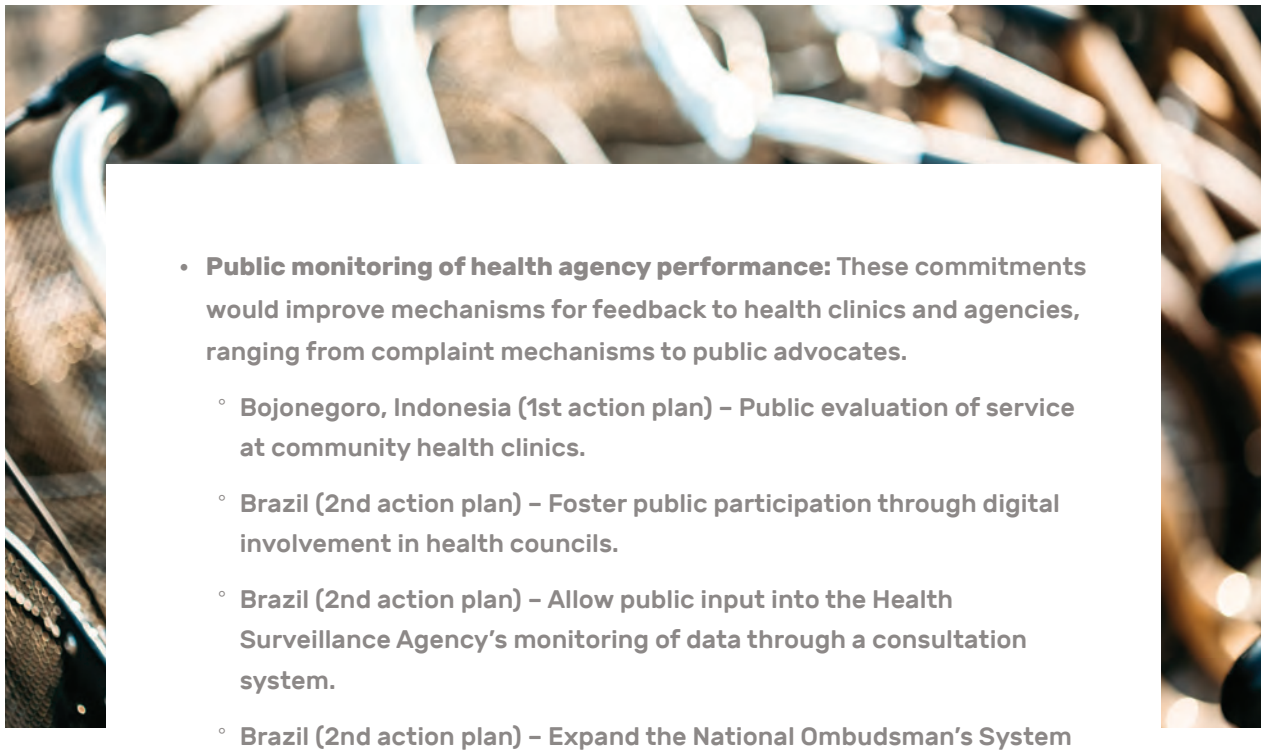


Photo by Grigory Bruev, Adobe Stock

- **Public monitoring of health agency performance:** These commitments would improve mechanisms for feedback to health clinics and agencies, ranging from complaint mechanisms to public advocates.
  - Bojonegoro, Indonesia (1st action plan) – Public evaluation of service at community health clinics.
  - Brazil (2nd action plan) – Foster public participation through digital involvement in health councils.
  - Brazil (2nd action plan) – Allow public input into the Health Surveillance Agency's monitoring of data through a consultation system.
  - Brazil (2nd action plan) – Expand the National Ombudsman's System to improve the system for public participation in health.
  - Buenos Aires, Argentina (1st action plan) – Create an integrated portal for citizens to report on sexual and reproductive health services.
  - Tbilisi, Georgia (1st action plan) – Create citizen feedback mechanisms on basic city services.
- **Budget and expenditure tracking:** These commitments involve the public in budgeting and ensuring that expenditures match delivery of goods and services.
  - Brazil (2nd action plan) – Establish a public budget monitoring system to track expenditures for food and nutrition security.
  - Burkina-Faso (1st action plan) – Establish citizen committees to monitor racketeering in health provision.
  - Guatemala (2nd action plan) – Empower multi-sectoral technical advisory committees to monitor corruption in the health sector.
  - Indonesia (3rd and 5th action plans) – Establish participatory mechanisms to monitor the allocation and use of public health subsidies ("Health Contribution Assistance").
  - Peru (2nd action plan) – Involve the public in accountability efforts for allocation and spending on the school food program, "Qali Warma."
- **Medicine tracking:** These commitments track the delivery of medicine to hospitals and clinics to ensure their arrival.
  - Elgeyo Marakwet, Kenya (1st and 2nd action plans) – Involve the public in tracking medical drug supply chains.

Photo by Nito, Adobe Stock

    - Honduras (2nd and 3rd action plans) – Involve the public in tracking spending on medicine and other medical supplies.
- **Conflicts of interest policies:** These commitments seek to improve ethical guidance around the formation of health policy.
    - Argentina (3rd action plan) – Improve transparency and participation in health policy-making through guidance on conflicts of interest.
    - Mexico (3rd action plan) – Develop conflict of interest guidelines around policies dealing with obesity as a public health issue.
- **Social accountability:** These commitments involve local citizens monitoring and advocating for improved health service delivery.
    - Mongolia (2nd action plan) – Local citizens can use social accountability tools to nurture dialogue at the local level for health and education services.
    - Uruguay (1st action plan) – Newly-trained social accountability activists are calling on the government to respond to their healthcare needs and improve service delivery. Trainees who evaluated medical procurements in their community identified potential savings equivalent to ten percent of the health budget.
- **Public science:** These commitments aim to make publicly funded research and regulatory processes more transparent and publish the results of such processes.
    - United States (1st and 2nd action plans) – The Food and Drug Administration and other scientific regulatory bodies will encourage expert feedback through ExpertNet and other proactive participation tools.[1]
    - United States (3rd action plan) – Members of the public and experts will be able to give input into the President's Precision Medicine Initiative.

Little Gevorg at eye check-up, Kotayk region. Armenia. (Photo by Armine Grigoryan, World Bank)

The Frontiers of health governance in OGP

Using the typology of open government interventions listed previously, we can get a better sense of where the current binding constraints (or "pain points") are for OGP members, based on third-party data. Data on health sector governance–especially open governance–is currently a patchwork and not as comprehensive as in other public service sectors. Nonetheless, this section aims to identify where the most effective interventions might be for the typical OGP member in data availability, information on decision-making, public participation, and accountability measures.

Data for decision-making

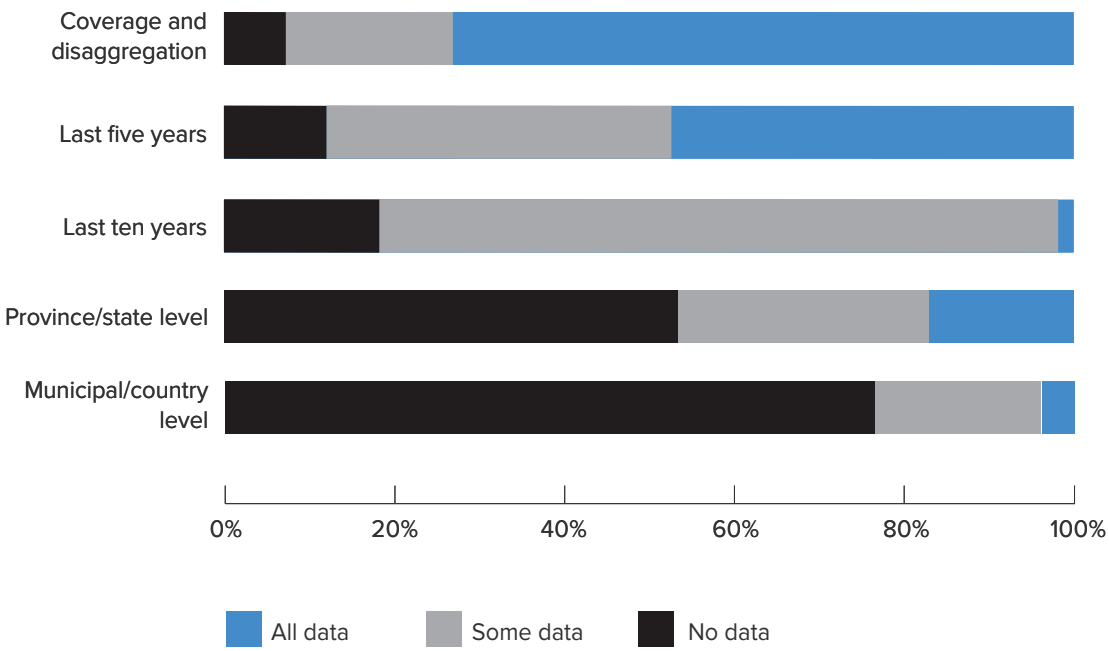
Open data advocates from a number of organizations have mapped the coverage, disaggregation, and openness of data for health. Open Data Watch's Open Data Inventory (ODIN) gives the most complete picture of the state of open data for health in all of OGP's national-level membership.[2] ODIN aggregates all available statistics from each OGP member's national statistical organization (NSO) around more than 20 policy areas, including health. The advantage to this data, in comparison with many other data sources, is that it is sourced entirely from national websites. The data does not speak to data quality beyond elements of coverage and availability. Making sure that data is trustworthy and accurate is beyond the scope of this report or the currently available data. Even so, the mere availability of data, however flawed, increases the likelihood of cross-comparison with other sources and audit opportunities by experts, practitioners, and the public. This section looks at the availability of public data on health facilities, health outcomes, and maternal and reproductive health.

Health facilities data

Data on health facilities tracks the inputs that make much of healthcare possible. It includes the number and type of facility, staffing, and beds or budget data. Most OGP countries collect and publish data on health facilities. (See Figure 1 for specific numbers.)

- **Availability and disaggregation:** In three-fourths of OGP countries, the data covers public, private, and nonprofit facilities or disaggregates by types of facilities (e.g., hospitals and clinics). A few countries do not make this data available or do not disaggregate this data. (See Figure 1, top row.) For this subset of countries, collecting and publishing this data could be a useful contribution.
- **Time series data:** As with many public services examined while preparing this report, while the data is available for the most recent year (2017), less data is available over the course of the last several years, and there are many gaps. Few OGP countries (less than one in 20) provide data for most of the last decade. This makes tracking improvements and comparisons difficult. (See Figure 1, rows 2 and 3.) A significant portion of this is because data was published in different formats or publications (such as pages of larger government reports in .pdf format) or was not available at all for prior years. Hopefully, now that many governments are publishing in open formats, all future data will also be open.
- **Geographic disaggregation:** A small minority of OGP countries have this data disaggregated at the provincial or "level one" administrations (municipal or county level). Most have no disaggregated data, while a few have patchworks of data for subnational territories. (See Figure 1, row 4 and 5.)

FIGURE 1. **Most OGP countries' NSOs publish recent health facilities data (hospital beds, budgets, personnel), but it is rarely disaggregated or available over longer time periods**



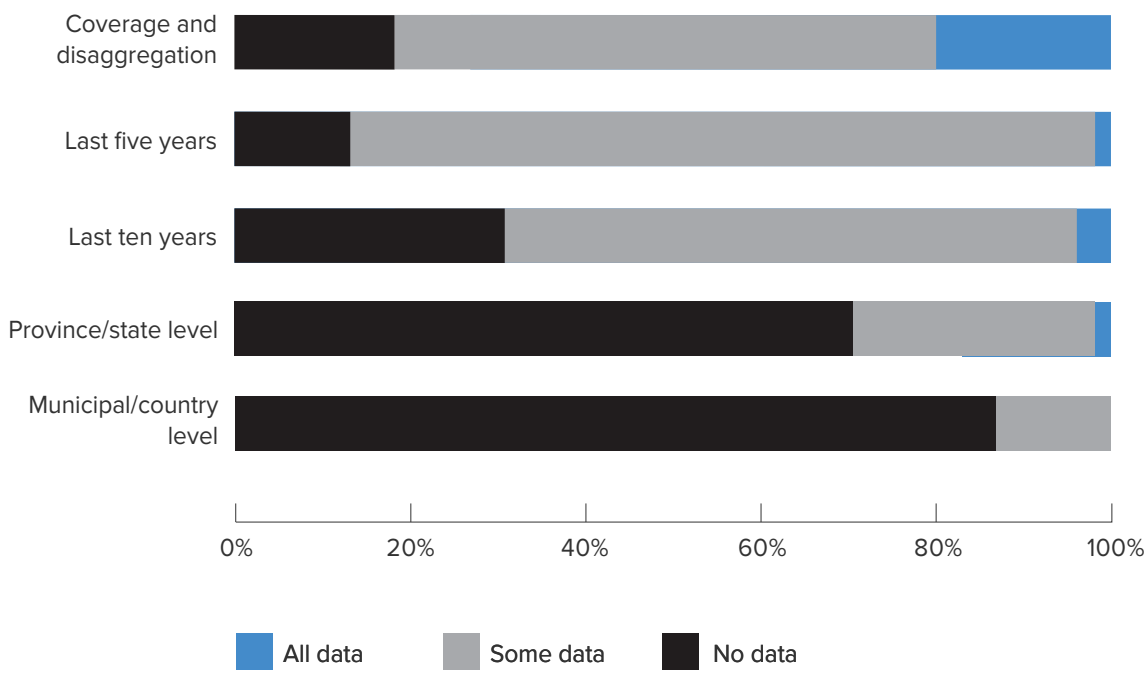
Source: Open Data Watch Open Data Inventory 2017, Health facilities (n=79)

Health outcomes data

Most OGP countries collect and publish data on some health outcomes, but few publish data on immunization rates, disease prevention, and health maintenance.

- **Availability and disaggregation:** In the majority of OGP countries, at least one dataset (immunization, disease prevention, and health maintenance) are available, although only 1 in 8 has all three datasets available. An equal number of countries do not make this data available at all. (See Figure 2, top row.)
- **Time series data:** Before 2018, data is patchy. Almost all OGP countries have some of the data for three of the last five years or five of the last ten years, but very few have annual coverage. (See Figure 2, rows 2 and 3.)
- **Geographic disaggregation:** One OGP country has data available for all provinces. Another 25% have partial coverage. The vast majority have no disaggregated data by geography. (See Figure 2, rows 4 and 5.)

FIGURE 2. **Few OGP countries' NSOs publish comprehensive data on immunization, disease prevention and health maintenance**



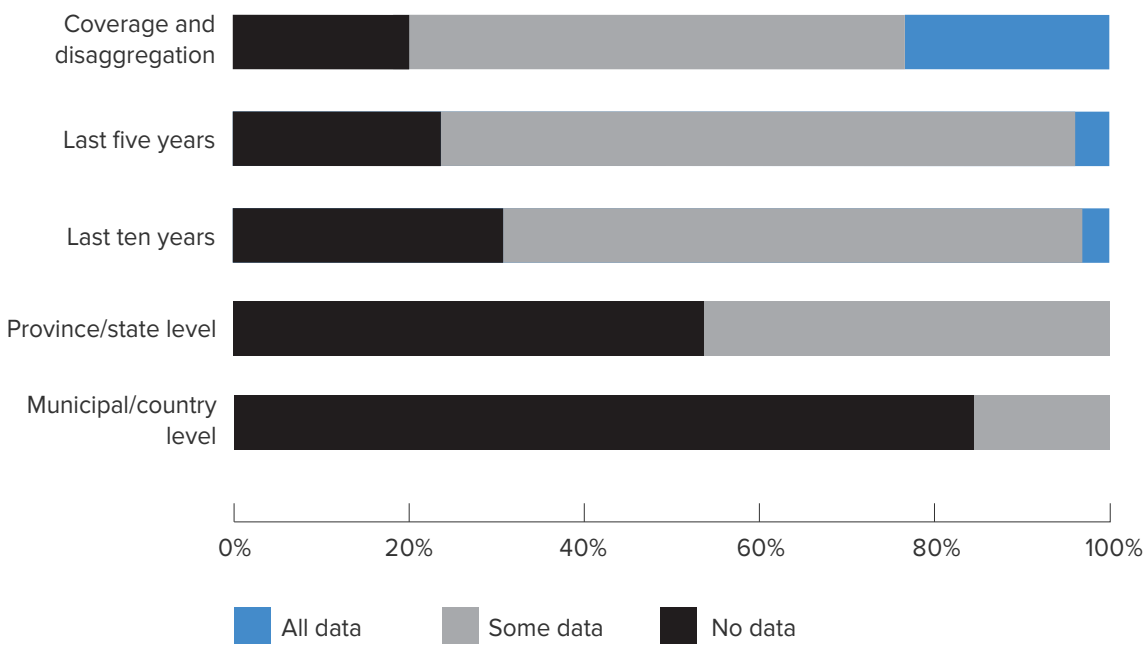
Source: Open Data Watch Open Data Inventory 2017, Health outcomes (n=79)

Reproductive health data

Reproductive health data, at a minimum, covers maternal mortality, infant mortality, under-five mortality rates, fertility rates, contraceptive availability, and adolescent birth rates. Again, most OGP countries have some of this data, but most do not have all of this data.

- **Availability and disaggregation:** In the majority of OGP countries, this data is available in some form, although only 1 in 8 has all three datasets available. An equal number of countries do not make this data available at all. The remainder have some data (See Figure 3, row 1.)
- **Time series data:** Of the countries that had data for 2017, only one-in-four had available data covering the prior years. (See Figure 3, rows 2 and 3.)
- **Geographic disaggregation:** No OGP country has made all reproductive health data available at the provincial level. Nearly half have some datasets available at that level. The vast majority have no disaggregated data by geography, especially below the provincial level. (See Figure 3, rows 4 and 5.) This is likely in many cases because the data is decentralized, and may not be standardized, or does not exist.

FIGURE 3. **Roughly a quarter of OGP countries' NSOs publish comprehensive data on reproductive, maternal, neonatal and child health. It is rarely disaggregated, nor is it available over time.**



Source: Open Data Watch Open Data Inventory 2017, Reproductive health (n=79)

LESSONS FROM REFORMERS

Trust, privacy, and openness in UK health reform

The National Health Service (NHS) remains an immensely popular part of the public welfare system in the UK, but most citizens also agree that it could be more effective and efficient. Citizens want to know their options for the best possible care and some budget-minded politicians seek to cut costs and identify a role for private providers.

Since OGP's founding, the UK has put improving health outcomes and efficiencies at the center of its OGP efforts. Indeed, making health outcome data usable by the public has been a major initiative between 2011 and 2016 in UK OGP action plans.

The first and second UK OGP action plans aimed to address these issues by publishing open data and seeking feedback from the public. The efforts, in some respects, have been clear successes. In other respects, the NHS stumbled upon a much more complex set of issues around the limits of transparency.[3]

The Reforms

Improving healthcare was a central part of the UK story in OGP. Indeed, at the initial launch of the Partnership, the UK touted the release and impact of clinical performance data in improving surgical outcomes. The first OGP action plan set up ministry-level "transparency councils" which had various stakeholders (providers, members of the public, and officials) to identify high-priority datasets to release. The second action plan, beginning in 2013, had two commitments that aimed to improve NHS performance. They covered:

- Publication of clinical and other performance indicators,
- Implementation of a patient recommendation tool, and
- A "Patient-Centred Outcome Measurement" (PCOM) tool on services available for rare and complex medical conditions.

Glasgow Royal Infirmary (Photo by Colin & Linda McKie, Adobe Stock)

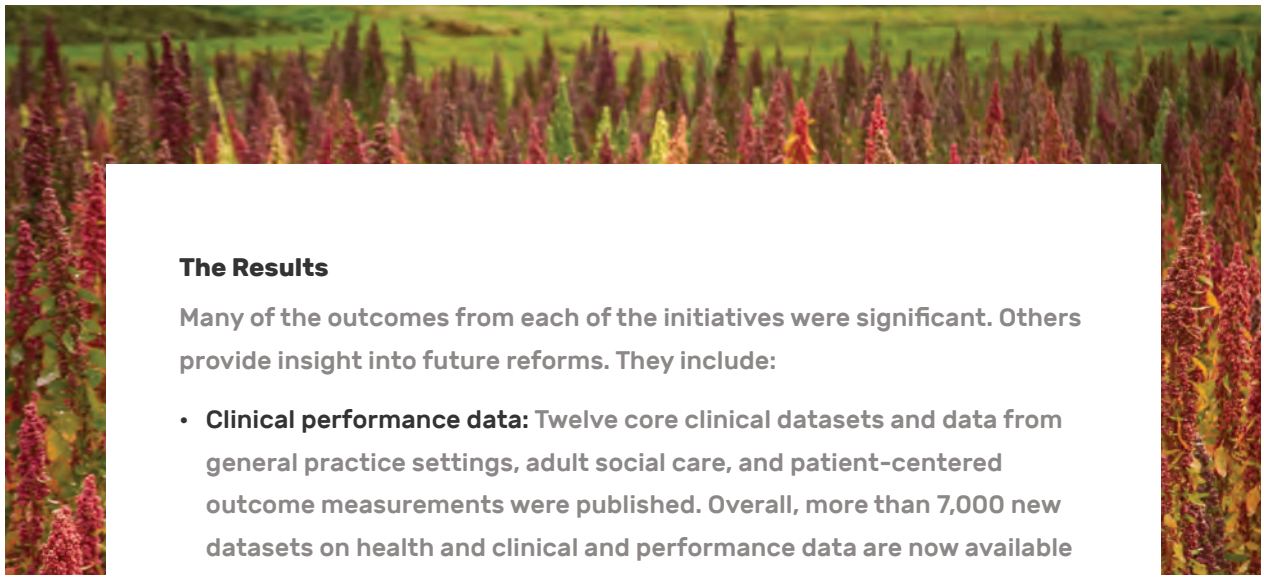


Photo by Fotos 593, Adobe Stock

The Results

Many of the outcomes from each of the initiatives were significant. Others provide insight into future reforms. They include:

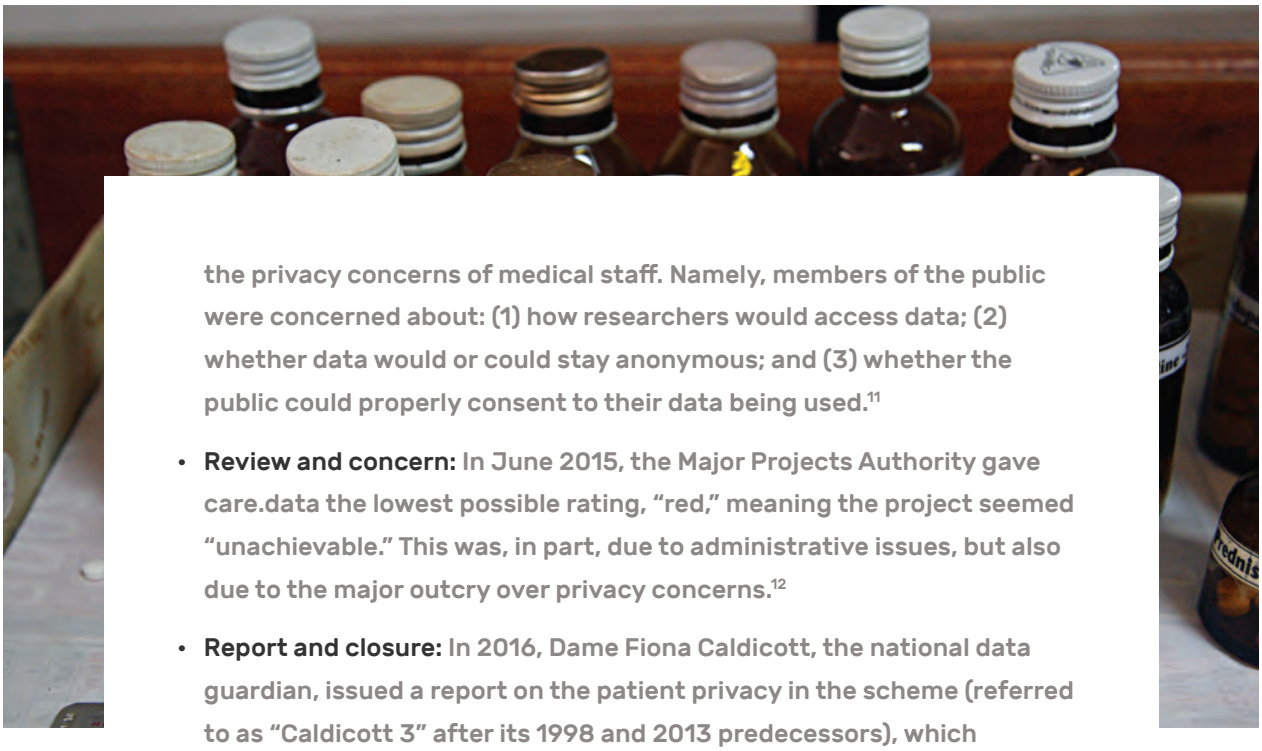
- **Clinical performance data:** Twelve core clinical datasets and data from general practice settings, adult social care, and patient-centered outcome measurements were published. Overall, more than 7,000 new datasets on health and clinical and performance data are now available on an easily searchable data platform. In March 2015, the NHS reported that it had achieved coverage of 97% of practices and clinics. NHS England was working toward "better open data."[4]
- **Social care data:** Progress on the release of information about social care services was slower. The government "proposed to re-baseline the ambition to achieve 8,750 by April 2015 and 10,000 by April 2016," through work with partners like home care providers.[5]
- **Public feedback:** The Friends and Family Test, piloted in 2013, was rolled out across all care settings. The published aggregate data included over five million pieces of feedback. The NHS Insight Team is using this data to feed into service improvement. NHS England claims the changes have helped drive up healthcare standards leading to "many improvements, large and small, across the country," but there was no clear evidence for how these changes fed into broader improved standards.[6]

The Setback

Care.data was a cornerstone of this bundle of reforms. It aimed to centralize patient data through the General Practice Extraction Service which covers more than 9,000 primary care clinics in the UK. [7] Patients would need to opt out of their data being shared, otherwise it would be shared with the public database.

Immediately, the program met with resistance, eventually leading to its closure. A broad range of concerns included:

- **Medical professionals concerns:** In 2014, 40% of general practices opted out of the scheme due to lack of confidence in the program's ability to maintain their standard of "total confidentiality."[10]
- **Civil society concerns:** Within OGP, the involved civil society organizations refused to engage with the commitment, as they shared



the privacy concerns of medical staff. Namely, members of the public were concerned about: (1) how researchers would access data; (2) whether data would or could stay anonymous; and (3) whether the public could properly consent to their data being used.[11]

- **Review and concern:** In June 2015, the Major Projects Authority gave care.data the lowest possible rating, "red," meaning the project seemed "unachievable." This was, in part, due to administrative issues, but also due to the major outcry over privacy concerns.[12]
- **Report and closure:** In 2016, Dame Fiona Caldicott, the national data guardian, issued a report on the patient privacy in the scheme (referred to as "Caldicott 3" after its 1998 and 2013 predecessors), which confirmed privacy concerns,[13] and the program closed immediately. The report confirmed that there had been sale of private data for years.[14]

Care.data lessons

For other countries looking into opening health data, the lessons of care.data are three-fold. It seems that, however controversial, there were adequate checks in place to ensure accountability in the end.

- **Protections of privacy:** There needed to be adequate protections ex-ante to ensure the protection of personal data, and assurances of appropriate re-use.
- **Deliberation and trust:** There was little involvement of the public or service providers in the discussion of how such data might be properly anonymized. The "Caldicott 3" report identified this as a major solution to restoring trust and seeing if this could go forward at all.
- **Public watchdogs:** The Major Projects Authority's annual report as well as the National Data Guardian's report both provided public opportunities for a reckoning with the considerable risks and costs of these major data initiatives.

Photo by Simone D. McCourtie, World Bank

Keeping accounts, Kegalle Provincial Health Services Department, Sri Lanka. (Photo by Simone D. McCourtie/World Bank)

Transparency in policy and budgets

Beyond data, opening decisions in the health sector requires the public to know about decisions–what they are, when they are made, who makes them, and whether they are implemented. When it comes to health, it is difficult to make system-wide conclusions about the state of openness in decision-making.

In short, there is not yet a global dataset (or sets) on health system governance and which decisions are public. There are, however, scattered indicators across a number of global assessments that begin to paint a picture of the level of transparency within the sector.[15] Gathering data on national-level systems is difficult as stakeholders come from different parts of society, decision-making takes place at multiple levels, service delivery is carried out by for-profit, nonprofit, and government agencies, and issues can be complex and highly technical. Of course, that is not unique to the issue of health. There are successful cross-national sectoral reviews in other fields, environment[16] or press freedom[17] for example, that also involve complex ecosystems with actors at multiple levels. Such cross-national comparisons do not exist in a comprehensive fashion for the governance of the health sector. Though tools have been developed and deployed to assess corruption risk[18] or to track budgets and expenditures[19] they have not been taken to scale as they have in the water sector.

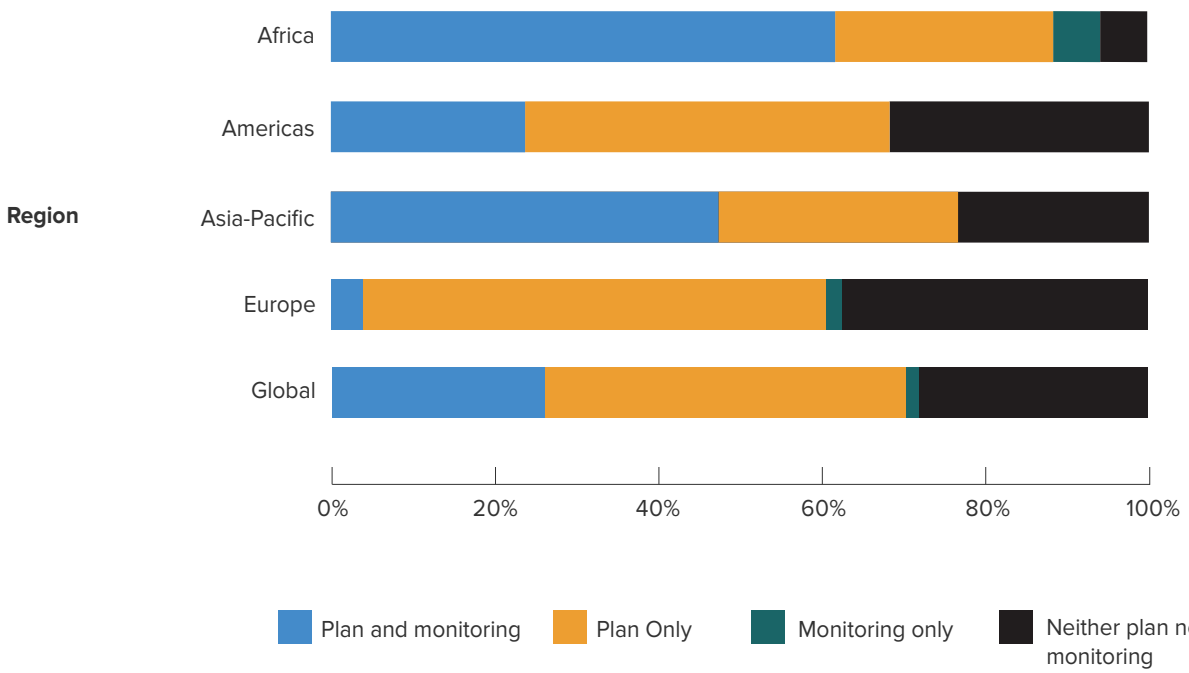
At the risk of introducing some amount of "availability bias," this report presents the data around decision-making in the health sector for OGP countries in three aspects of health of decision-making: (1) universal health coverage policies, (2) procurement data, and (3) budget transparency.

Universal health coverage policy transparency

One of the challenges for the majority of countries globally is achieving universal access to quality primary care. There is accessible data on the coverage and quality of healthcare at the national level available for many OGP countries (see prior section), but comprehensive health policy information is less available to the public. While there are many debates on the definition of quality care, a precursor to identifying different definitions could be to identify the different approaches to providing access and defining or measuring quality.

This basic policy of transparency is in place in some, but not all countries. The World Health Organization collects data on three basic governance indicators as part of its dataset on universal health coverage. The first determines whether there is legislation to provide universal health coverage. The second two are of direct relevance to open government: the availability of public national planning documents and the availability of monitoring of their implementation. Figure 4 categorizes OGP countries by region with regard to the availability of these two decision-making tools. Globally, nearly three-quarters of OGP countries published a national plan between 2013 and 2017, but only a quarter published their monitoring data. Regionally, there is considerable variation, with much higher rates of monitoring data publication in Africa and Asia-Pacific. In general, few wealthy OECD member countries published monitoring data, even when there was a plan in place. In Europe, fewer than 1 in 10 countries published this data.[20]

FIGURE 4. **Africa and Asia-Pacific publish national health coverage planning and monitoring data more frequently than other regions[505]**



Source: WHO Universal Health Coverage Planning Database 2018 (n=32)

Health procurement

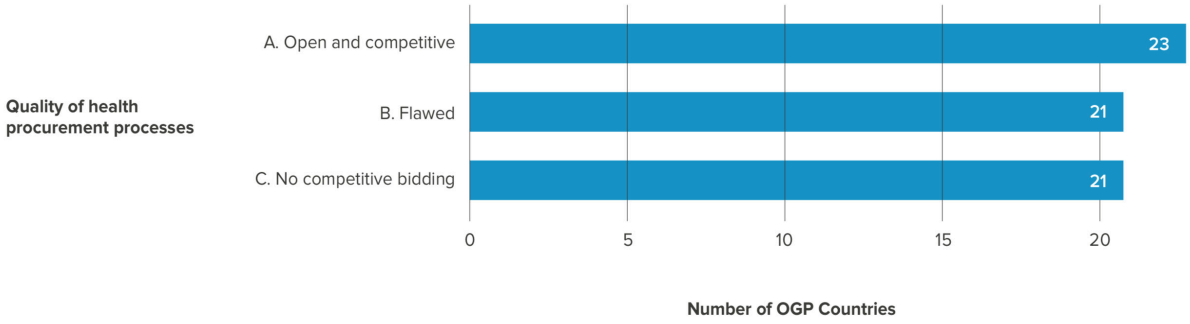
One of the biggest obstacles to achieving the country health commitments made by OGP countries–including Universal Health Coverage (UHC) and improved primary, reproductive, and neonatal health care–is inefficient and ineffective public procurement. According to the WHO, of the 10 leading causes for health systems ineefficiancy, five are procurement related.[20]

Poor procurement can mean that the right health commodities and infrastructure does not get to the right place at the right time, tenders may awarded to contractors that fail to demonstrate value for money or good past performance and following a contract right through to implementation is incredibly difficult. The impact on health provision includes paying higher than necessary prices for medicines, the use of substandard and counterfeit medicines, overuse or problems with supply of equipment, inadequate health service infrastructure, and corruption and waste.[21]

The health procurement value chain has an impact on many of the health commitments made by OGP countries, including public monitoring of performance, budget and expenditure tracking, and citizen decision-making. With almost two-thirds of OGP countries lacking a fair and open bidding process in public health procurement,[22] there is substantial room for improvement in awarding contracts.

There are several organizations working towards improving openness in the Health sector including Transparency International's Open Contracting for Health project, The Open Contracting Partnership, the WHO, and Management Sciences for Health. Governments can leverage on this existing work by using a number if tools and approaches including the Open Contracting Data Standard (OCDS), enabling disclosure of data and documents at all stages of the contracting process by defining a common data model.[23] By publishing more intact and cosistent public health procurement information and promoting the use and analysis of it by government, the private sector, citizens, civil society, and journalists, there is a strong framework in place for better monitoring of service delivery, greater value for money for governments, reduced corruption, and a coherent, trace-able procurement process from budgeting right through to implementation.

FIGURE 5. **In OGP countries, roughly a third of countries have no open bidding, a third have flawed bidding processes, and a third have fair bidding**



Key

Experts chose the statement that was closest to their views on how public health procurement (i.e., money spent on medications, vaccines, medical equipment, buildings, etc.) works in their country:

(a) Most contracts are awarded through an open and competitive bidding procedure

(b) There is a formal bidding procedure, but it is flawed. Several contracts are awarded without competitive bidding, or through ineffective bidding processes, leaving open the possibility of corruption

(c) There is no formal bidding procedure or it is superficial and ineffective. Most contracts are awarded to firms which offer bribes; to firms owned by political supporters; or to firms in which a relevant government officer has a financial stake

Source: World Justice Project Rule of Law Initiative, QRQ150 (n=65)

Health budget transparency

There is no recent cross-country comparison data on budget and spending data in health globally. However, this report does highlight findings from four major studies comparing health budgets over the last decade, one on project-based budgeting in low- and middle income countries, one on reproductive health in Latin America, and another on health expenditure in African countries. The key findings for future budgeting considerations include:

- Budget transparency overall has been perhaps the most successful set of accomplishments of OGP action plans. The next generation of budget transparency reforms could be sector-specific (including health) and, in many cases would benefit from focusing on program-level expenditure.
- These problems can be especially acute in reproductive health, where a lot of government data can require freedom of information requests.

Program-level budgeting in low- and middle-income countries

Project-level budgeting and expenditure data for health reveals national priorities and follow-through on those priorities. A shift toward program-level budgeting aims to balance the emphasis on spending outputs and outcomes with the traditional focus on inputs.[24]

Transparency in these areas allows for national and international actors to understand national emphasis on levels of care (often referred to as "horizontal" interventions such as primary or pre-natal care) and specific interventions (often referred to as "vertical" interventions such as pandemic prevention or smoking cessation). With this budgetary information, one can reconcile policy and political priorities with actual implementation of programs.

The Overseas Development Institute and the International Budget Partnership surveyed budget and spending data for health in seven African Countries in 2013.[25] In surveying documents between 2010 and 2012, the report found:

- **Top line numbers:** Macro-economic data and overall budget versus spending for health was available in all seven countries, although it was not available for all years.
- **Specific expenditures:** When focusing on specific measures such as expenditures on medicines, only two countries had the data (Liberia and Uganda, which is not an OGP member).
- **Subnational data:** Few countries regularly made the data available at a subnational level, although some provinces in South Africa published this data.

The presence of macro-level indicators and the absence of subnational spending data is, unfortunately, consistent with the findings of health facilities and outcomes data in the prior section. While more analysis is needed to identify whether change has been positive over time, it suggests that some health budget transparency problems are persistent for some OGP members. It further suggests that tracking finance at lower levels may be the current priority, if it is not already. The referenced study, however, did not track plans and expenditures to specific programs.

Before 2018, there was no cross-national comprehensive survey of how budgets and spending matched health priorities in a given country. This has changed. The International Budget Partnership carried out a survey of 30 low- and middle-income countries recently to examine whether there was project-level budgeting focused on health.[26] While examining the degree to which health budget transparency meets publicly stated policy aims is beyond the scope of this paper, one can make a furtive analysis of the degree to which budgets match priorities. (The survey did not include data on the timing of the information released or the level of public participation.)

- **Program level transparency:**
  - Examples: Programs range in level of specificity. For example, some are high level: (1) Access to Health Services; (2) Provision of Health Services; (3) Stewardship ("steering and support") of MOH Services. Others are highly specific: (1) Protection against sanitary risks; (2) Regulation and monitoring of healthcare facilities and services; (3) Social assistance and patient protection; (4) Prevention and care for HIV/AIDS and other STIs; (5) 21st Century Medical Insurance.
  - Line items: The results show that all OGP countries have project line items in budgets. On average, OGP countries have nine projects

identified in national budgets, although some have as many as 31 (Mexico) or 27 (Argentina), and others have three (Afghanistan, Burkina-Faso, and Mongolia). All 20 countries have budgets allocated at the program level.

  - Results-orientation: Not all countries have specific indicators and targets for programs. 80% of countries in the survey have clear objectives for each program. Most of those (75%) have specific indicators and targets for the program. Only 40% establish a current performance baseline for a program or health policy area. For most of the countries, indicators are based on actions or outputs. Some countries (e.g., Indonesia, Jordan, Mexico, Morocco, Peru, and Serbia) have outcome-based indicators such as reducing new cases of tuberculosis.
  - Enacted budgets: 80% of countries surveyed publish the program-level in the enacted budget. This means that 20% of countries do not publish final spending plans at the program level.

- **Subprogram level transparency:**
  - Examples: This level of transparency breaks down into specific expense types, such as: staff, goods and services; transfers and grants; investment; and capital and facilities.
  - Subprogram line items: Some (60%) have sub-programs (nine on average). Where those subprograms exist, all have budgets allocated.
  - Results-orientation: Subprogram results-orientation is weaker, with just over half (55%) having targets and indicators and a mere 20% having specific targets.
- **Disease-specific transparency:**
  - Line items: 30% of countries have disease-specific programs, and only South Africa has reporting on disease-specific sub-programs. Most budgeted programs are oriented around levels of care, such as primary or emergency care (30%) or units within a ministry (40%).
  - Indicators: Nonetheless, 90% of countries surveyed had indicators for diseases of particular interest.
- **Reconciliation and accountability:**
  - Responsibility: Just over half (55%) of the countries surveyed name the government unit responsible for implementation. 90% budgeted for administrative cost, but only 15% identified cross-ministerial responsibilities.
  - Year-end reporting: Just over half (55%) of countries report financial reconciliation at the end of each year. Only 40% of surveyed countries publish non-financial reporting for each program.

Reproductive health budget transparency in African and Latin American countries

Fiscal tracking of reproductive health budgets has been a major area for action over the last decade. Population Action International works with a large community of activists in developing countries, especially in Sub-Saharan Africa, to mobilize government revenue for family planning. They have recently developed a framework for measuring such expenditures and are tracking resources in order to advocate for resource levels that match the scale of family planning challenges, emphasizing access to information.[27] In addition, this network has been working to get commitments on budget transparency into OGP action plans in the region. They may be reflected in 2019 or 2020 action plans.

A similar effort looked at reproductive health specifically. A 2012 study by Malajovich, et al. surveyed five Latin American countries (El Salvador, Costa Rica, Guatemala, Panama, and Peru) to identify how information on budgets, treatments, and expenditures included reproductive health. (All of the countries are OGP members.) The report found:

- **Open access:** Only Peru had budgetary data available without request on government websites. This data included specific budget lines for integrated reproductive care, skilled attendance at delivery, and emergency obstetric care. In Guatemala, information on integrated reproductive care was publicly available but password protected.
- **Procurement plans:** For Costa Rica, some data was obtainable through procurement plans of the Social Security Department.

Attending midwife training, Tajikhan Village, Afghanistan. (Photo by Graham Crouch, World Bank)

- **Access to information act:** In Costa Rica, Guatemala, and Panama, some information existed, but was obtained only through Access to Information Act filings and specific meeting requests with departments.
- **Refusal:** In El Salvador, budget information was unobtainable or provided so unsystematically that it was not useful.[28]

Despite the age of the research and the limited scope in terms of countries, we can still draw some conclusions about budget transparency around reproductive health data:

- **Systematization:** Budget and spending information, which gives a sense of prioritization and decision-making, is not systematically gathered. Given the piecemeal nature of collection, this makes cross-country comparison impossible.
- **Publication:** Where the data exists, it is often not systematically published with minimal restrictions (i.e., it may be password protected).
- **Information requests:** Where such data exists, advocates needed to either request meetings or file formal access to information requests. Access to information laws remain an important stopgap tool until governments begin proactively publishing such information systematically.

Participation and accountability in health

The absence of accountability and public oversight can limit the impact of transparency. This is especially true where markets are not functioning and patient choice is limited.[29] Ensuring accountability and public input are particularly important in rural areas where there are fewer providers or in cases where there is only one service provider (such as food safety inspection or single-payer insurance).

Growing acceptance of the need for participation and accountability in health

Enabling public input, feedback, and accountability is necessary at a range of levels, from community-level service providers to national policy setting. The political demand and evidence for such interventions has grown in recent years.[30]

The World Health Organization, in its Universal Health Coverage Action Plan, lays out good governance beyond access to information–specifically clear responsibility, public input and collaboration, and accountability–as core building blocks for healthcare:

- **Putting in place levers or tools for implementing policy, including:** design of health system organizational structures and their roles, powers, and responsibilities; design of regulation; standard-setting; incentives; and enforcement and sanctions
- **Collaboration and coalition-building** across sectors and with external partners
- **Ensuring accountability by implementing:** governance structures, rules and processes for health sector organizations; mechanisms for independent oversight, monitoring, review and audit; transparent availability and publication of policies, regulations, plans, reports, accounts; and openness to scrutiny by political representatives and civil society[31]

Internationally, there is an organization specifically working to empower community-level monitoring and accountability. Community of Practitioners of Social Action in Health (COPASAH) focuses on enabling communities facing inequities to assert their rights and to advocate for themselves based on monitoring and local advocacy. A number of OGP governments, such as Mongolia and Uruguay, have also been supporting communities to advocate for themselves, often in partnership with the Global Partnership for Social Accountability (GPSA).

There is much literature dedicated to the role and design of social accountability at the local community level. Recent research has shown the importance of participation and accountability mechanisms in improving the effectiveness of transparency:

- **Transparency without participation:** Without adequate accountability infrastructure, it is likely that transparency-based interventions in health will be ineffective[32] or inefficient and in a few cases, may even be counterproductive to building trust or improving services.[33]
- **Public participation impact:** Research on the instrumental impact of public participation in health is underdeveloped relative to other fields.[34] Research is underway to better isolate and understand the relationship between health outcomes and public transparency and accountability actions.[35]
- **Social accountability impacts:** Recent studies of health interventions showed improvements at the community level using social accountability tools:
    - Community scorecard meta-evaluation: CARE International recently carried out a meta-review of its "community scorecard" evaluations in health and found that they resulted in (in diminishing order of evidence): (1) increased citizen empowerment, accountability, and space for negotiation; (2) greater service availability, access, utilization, and quality; and (3) trust-building. The review showed that inclusion of marginalized groups remained a major challenge.[36]
    - Community scorecard randomized control trials: A randomized control trial of CARE's community scorecard approach for reproductive health found improvements in patient services. Women treated by a clinic that had gone through a community scorecard process were more likely to receive a home visit during and after pregnancy. Health workers were more likely to take action as a result of home visits and women were more likely to use modern contraceptives.[37]
    - Citizen voice and accountability review: World Vision's approach, "Citizen, Voice, and Accountability," includes citizen education, community scorecards, and interface meetings between citizens and officials. A 2019 review showed that, for a number of countries, community-level interventions led to national policy-level scale interventions to institute social accountability measures at a larger level. Armenia adopted the approach for health systems across the country.[38] Given that achieving scale and sustainability has been one of the core challenges at the heart of social accountability's broader success, this suggests room for a positive shift from small-scale interventions to enhance national systems.
    - Null results and vertical approaches: Forthcoming work shows that some social accountability interventions did not have statistically significant changes on citizen accountability.[39] There is some evidence of changed healthcare provider behavior.[40] What the evidence may be pointing to is that purely bottom-up approaches by themselves do not lead to major changes in health system performance. Instead, vertically integrated approaches, which involve political and technical actors as well as citizens, may show greater promise.[41]

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