

6. Analysis of Community Monitoring

March 2, 2010

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Community monitoring and quality of health services

A major concern in both developing and developed country health systems is how to ensure the quality of health services provided and monitor patients' degree of satisfaction with the services they consume. Quality control can be managed in large organizations, governmental or non-governmental, by endowing more senior officials or managers with the responsibility of monitoring the performance of their subordinates and punishing or incentivizing their behavior appropriately. However, this system is often plagued by an absence of information, given that higher officials are not well poised to be fully informed about day-to-day operations under their control, and may also raise the question: who monitors the monitors?

In a developing country's system, the weakness of government bureaucracies and the prevalence of corruption makes internal monitoring even riskier, and has led to increased interest in empowering the consumers of health services to monitor the quality of the services they receive. Community monitoring is hypothesized to have two major advantages. First, patients who are visiting a health facility or seeing a doctor have the best possible information about some crucial features of the facility's quality: whether health personnel are present, whether the facility is appropriately supplied and these supplies are made available to the patients at the prescribed price; the length of wait times, and the frequency with which patients are turned away. Second, the community that is dependent on a particular facility or provider for all health needs should have particularly strong incentives to take any necessary action to improve its quality, more so than a government official or monitoring staff member appointed for that purpose.

Needless to say, community monitoring also carries major risks. First and foremost, health is a complex topic, and difficult to learn about outside a formal education system (or even within it.) Patients may not be well-informed about what an appropriate standard of care is and how to judge different types of care; they may also fail to draw correct inferences about the validity of treatment when their health improves or deteriorates seemingly independently of treatment received. They may also lack significant social standing, coordination or information to effectively discipline health industry members or other responsible parties, particularly if the latter are more educated and control the flow of information.

These are problems in developed countries as well, but the disjuncture is often particularly acute in poor countries where the gap in education is large and information availability limited.

In a recent study, two researchers sought to test this theory by implementing a system of community monitoring and observing the nature of the outcome. Bjorkman and Svensson (2009)¹ implemented a field research project in which they worked with fifty dispensaries (basic clinics) in the rural part of the country. In half of these areas, a non-governmental organization sought to boost the potential for community monitoring by providing the community with a “report card” summarizing information about the performance of the local clinic, holding a meeting to disseminate and discuss this meeting, and facilitating a discussion about how to improve service delivery that resulted in a signed contract between care providers and the community. A year later, they examined differences in the operation of those clinics in communities that had participated in this process and those that had not. They found that clinics that had participated in community monitoring displayed lower rates of staff absenteeism, shorter waiting times, a more sanitary environment, and greater availability of drugs. Utilization of the facilities is higher, and health outcomes have improved, with a 35% decrease in the child mortality rate and a significant increase in weight-for-age, a measure of adequate nutrition, among infants.

These results are significant and encouraging. A relatively short-term and straightforward intervention with limited resources has led to a significant improvement in the quality of health services and measured health outcomes. The cost of the program is \$3 per household, or approximately \$300 per child life saved, an estimate that compares favorably to the average cost of a child life saved through integrated delivery of other proposed mechanisms for reducing child survival, estimated to be \$857.² This suggests that implementing mechanisms of public accountability could be an important tool in improving the performance of health systems. However, there are obvious caveats. Two other papers focusing on public services (health and the building of infrastructure) have found that community monitoring is in fact ineffective.³ Though this particular study has shown different results, it is not obvious if the differences are the result of a systematic difference between health and other types of services, or a particular characteristic of this community. Social cohesion, ethnic and linguistic composition, and the social relationship of care providers to the communities in which they work all have the potential to impact the effectiveness of monitoring systems in both developed and developing countries. Accordingly, further research on the most cost-effective ways to implement monitoring and quality control systems in both developing and developed country health systems could be valuable in further refining our understanding of how best to improve health services.

¹ Bjorkman, Martina and Jacob Svensson. “Power to the People: Evidence from a Randomized Field Experiment on Community-Based Monitoring.” *The Quarterly Journal of Economics* 124:2 (May 2009): 735-769.

² Bryce, Jennifer, Shams el Arifeen, George Pariyo, Claudio F. Lanata, Davidson Gwatkin, and Jean-Pierre Habicht, the Multi-Country Evaluation of IMCI Study Group, “Reducing Child Mortality: Can Public Health Deliver?” *Lancet*, 362 (2003), 159–164.

³ Banerjee, Abhijit, Angus Deaton, and Esther Duflo, “Wealth, Health, and Health Services Delivery in Rural Rajasthan,” *American Economic Review*, 94 (2004), 326–330. See also Olken, Benjamin A., “Monitoring Corruption: Evidence from a Field Experiment in Indonesia,” *Journal of Political Economy*, 115 (2007), 200–249.