

## Round Table Discussion

### Information is not only for managers

Richard E. Cibulskis<sup>1</sup>

The product described by Shaw — a simplified health information system implemented on a national scale — is not new (1, 2). What is interesting is the bottom-up process, as it is quite unusual for systems originating in one district to take hold over a wide geographical area. This may be because some districts are reluctant to use a system designed by other districts or because they do not have the same resources for implementation. Whatever the circumstances, bottom-up processes can produce a variety of incompatible information systems, each competing to be adopted as a national standard. South Africa does not appear to have succumbed to this problem, but it is still not clear if its system really works. It would be instructive to learn more about its reporting rate from institutions. This is a good indicator of an information system's performance as it requires several basic processes to be fulfilled, such as a complete listing of reporting units, compliance with reporting requirements and processes for monitoring compliance. A good reporting rate is also critical to the eventual interpretation of indicators.

Whether a top-down or bottom-up approach is preferred, the design of health information systems requires a clear understanding of why data are being collected; ultimately they should influence the behaviour of those in control of resources in ways that will enable the health sector to achieve its objectives. Data should certainly be used by health managers to plan and monitor programmes, enabling them to allocate resources to priority health problems or populations. The information required for this task, however, is wider than that provided by routine health information systems. Some relevant data systems — for population, finances, and staffing — are managed by other government departments, while some information is collected through censuses or surveys (particularly if many services are delivered through non-government providers). An optimal information strategy needs to consider how the different sources of information will work together. For example, it should be clear about the definitions of indicators and the coding systems used for geographical units. Some form of centrally coordinated approach seems inevitable. Such coordination should not be mistaken as being set up for the purpose of supplying central level managers with information: although they might benefit from information, they rarely have the capacity or authority to respond to large quantities of data. Rather, central coordination is primarily to bring together data from districts so that they can be summarized in such ways that districts can compare their performance with that of others.

Health managers are often ineffective users of information, despite efforts to train them, encourage them or provide them with new information systems. Time and again, inequities or inefficiencies in the use of resources go unheeded. This may be because health managers have little influence over key

decisions in government or perhaps because they are not motivated to respond. There is a growing awareness that if we are interested in enhancing the performance of the health sector then external uses of information can carry greater weight than internal uses (3). Thus, public disclosure of information can help “politicians, patients and citizens to scrutinize the operations which they are financing” (4) and in this role it can encourage managers to be more responsive to their clients' needs. Similarly, information can be used by health managers to lobby external authorities for greater support. If external uses of information have greater impact than internal uses, should not the health sector take this into account when designing its minimal data sets? It may be that the minimal data set for politicians, citizens and the treasury are the same as that for health managers, but not necessarily so. Citizens may be more interested in learning whether basic inputs such as staff and drugs are available, whereas a ministry of finance may be interested in learning whether national development priorities are being delivered. Whatever the final content, minimal data sets need to begin with the key users and uses of information and they should not remain the preserve of health managers. ■

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### Indicators for a health information data set in Ghana

Sam Adjei<sup>2</sup>

A health information system handles the recording, storage, retrieval and processing of health data. Broadly defined, the health information system should cover such data sources as vital registration, censuses, routine service-generated statistics, population-based surveys and research information, in order to provide evidence for decision-making in the health system.

Assessments of health information systems have given rise to several misgivings. Foremost among them is the fact that multiple data sources are not linked to each other; indeed, different instruments may generate different data on the same person or event. Routine service data are collected with the needs of higher-level programme managers and donors in mind; in addition, they may be incomplete or of doubtful quality, and timeliness can be a problem. Surveys are useful, but they tend to be expensive and donor driven and are often not linked to routine service data. Research data are generally available but are rarely included as part of the health information system because research is conducted outside the scope of ministries of health. Dissemination of the information collected is usually

<sup>1</sup> Monitoring and Evaluation Advisor, World Bank Office Jakarta, Jakarta Stock Exchange Building Tower 2, 12th floor, Jl Jenderal Sudirman Kav 52-53, Jakarta 12190, Indonesia (email: rcibulskis@worldbank.org).

<sup>2</sup> Deputy Director-General, Ghana Health Service, Private Mail Bag, Ministries, Accra, Ghana (email: sam.adjei@hru-ghs.org).