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Report

The technical is political

What does this mean in the health sector?

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Key messages

- The characteristics of service delivery sectors help explain the different types of political dynamics these sectors attract, even within a single national context. This helps explain variation in accountability, collective action and, ultimately, performance.
- Within the health sector, the impact of these characteristics can vary in important ways depending on the service involved. This helps explain key differences between curative and preventative health; critical and chronic care; and other important subtypes.
- Applied to specific health service delivery activities, the characteristics complement analysis of contextual features to provide an analytical framework that can help governance and sector specialists go beyond technical design approaches to understand and unlock the underlying incentives for different actors.

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1 Introduction

It is now generally accepted that governance and political economy factors are key to the effective delivery of public goods and services in specific sectors. However, efforts to capitalise on this received wisdom are, in practice, hampered by the fact that governance and sector specialists tend to approach the key issue of mutual interest – the widespread failure of public services – from different starting points. While there is no doubt different specialisms have the potential to provide complementary insights, capitalising on this has, in many cases, been hindered by the different terminology, language and analytical approaches used.

This brief, the fourth in a series, aims to help bridge the gap between governance and sector specialists by examining the politics and governance of the health sector through a 'sector characteristics' lens. The characteristics of sectors have largely been considered technicalities, but new research is illustrating they also have political implications. Mcloughlin, with Batley (2012) identifies an initial set of four types of characteristic that influence the politics of service delivery within and across sectors:

- **Nature of the good being produced:** Can a service be delivered by the market or does it require public intervention?
- **Market failure characteristics:** What is the rationale for public intervention?
- **Task-related characteristics:** How does the way a service is produced and delivered affect relationships of control and accountability?
- **Demand characteristics:** How does the nature of the service provided affect the form of user demand and provider control?

A complete analysis of the implications of sector characteristics for the full range of issues currently under debate in relation to health services and health outcomes is beyond the scope of this brief. However, drawing upon findings from a series of consultations with health sector specialists[1] and recent illustrative literature, we explore how such an approach could help us understand and interpret some of the persistent problems in building the health sector in the developing world.

[1] Consultations were held at the offices of the Overseas Development Institute (ODI) in London in March 2014. Participants were drawn from a variety of backgrounds, including academia, non-governmental organisations (NGOs) and other practitioner organisations.

2 What do the characteristics of the health sector suggest about the political challenges of inclusive delivery?

In some cases, the characteristics suggested in the framework resonated directly with the knowledge and observed experience of the participants. Sections 2.1, 2.2 and 2.3 provide an outline of the way sector characteristics can interact and affect the various accountability relationships (direct, political and organisational) on which effective service delivery can be seen to depend (World Bank, 2004, in Mcloughlin, with Batley, 2012).

Participants also suggested a number of notable additions and refinements to the application of this approach in the health sector. Sections 2.4, 2.5 and 2.6 outline three of the most striking variations to the approach outlined by Mcloughlin with Batley. Finally, participants felt strongly that the sector characteristics that are the focus of this approach needed to be understood as complementary to and interacting with other aspects of the context (i.e. key features of the local political economy). This is indeed a core feature of the approach, with characteristics operating as a filter on contextual factors. In Section 2.7, we pick up on how these connections might be seen in the health sector.

2.1 The direct user–provider accountability relationship is strongly affected by characteristics that are particularly acute in the health sector

As is well documented elsewhere (Arrow, 1963), though not necessarily always appreciated, as evidenced by recent debates on the Affordable Care Act in the US, health care displays a number of characteristics that mean it is not a good or service like any other.[2]

[2] See, for example, the discussion of whether and how the purchase of health care is different from the purchase of broccoli: http://www.brookings.edu/research/opinions/2012/04/02-health-care-economics-aaron.

First, **health services are often consumed in a moment of urgent need.** This feature almost inevitably raises challenges for forms of accountability that rely on service users having sufficient time, information and bargaining power to consider the relative merits and costs of alternative providers (primarily the 'short route', where this is interpreted as the market). This is particularly true for forms of emergency care.

Second, even where health services are not 'emergency services' as typically defined, **user needs often arise unpredictably.** Again, the degree to which this is true varies according to the specific service required. There is plenty of lead time to consider options for end of life care for the aged and, generally, somewhere in the neighbourhood of nine months to consider birthing arrangements and postnatal care; however, even in many non-emergency cases, a relatively rapid onset of symptoms is not something easily foreseen by the service user. This contributes to at least two challenges. First, it limits the capacity of the service user to act as an informed 'consumer' with respect to the particular condition that arises and, therefore, to make an educated choice among alternative providers (if they exist). Second, users often find it difficult to get collective support because of a tendency for the population to consider service delivery choices only when confronted with the unpredictable.

Third, with some exceptions (see discussion of chronic care below), **health services are usually used individually and infrequently.** Chaudhury et al. (2006) suggest this helps distinguish the forms of accountability that might operate in the health sector from those in, for example, the education sector:

> *'If a teacher does not show up regularly, a class full of pupils, and potentially their parents, will know about it. On the other hand, it is much harder for patients, who presumably come to health care centers irregularly, to know if a particular health care worker is absent frequently.'*

Previous efforts to fill this information gap in fairly technocratic ways generated mixed results (Banerjee et al., 2008).

These characteristics of health service use (infrequent individual consumption, low levels of predictability and high levels of urgency) are often used to make the case for forms of health financing (typically insurance mechanisms) that help pool risk and mitigate potentially catastrophic impacts on service users. However, it is clear these characteristics also have important political implications that present a real challenge to prevalent models of service delivery in which users (both individually and collectively) hold providers to account.

To these characteristics it is important to add the particularly **acute incidence of information asymmetry in the health sector.** Information asymmetries can work to the advantage of service providers in some cases by reducing scrutiny of their discretion in the treatment of patients; however, they can also create suspicion and worsen relations between providers and users of services. Research on the deployment of health workers in Nepal found that unrealistically high expectations of the benefits of medical treatment had led to violence against health workers in the event of patients not recovering. This dynamic was noted as particularly problematic in remote rural areas where people were less educated as to the risks and potential of treatment (Harris et al., 2013).

Participants suggested there was evidence that information campaigns might mitigate information asymmetries, although behaviour change might take long periods of time. One participant gave the example of a 10-year citizen education programme run by the Egyptian government on appropriate medicine usage to

change the culture away from demanding multiple pills. Other participants noted more short-term measures that had had an impact on citizen satisfaction but not necessarily changed the characteristics of the good. For example, a community scorecard programme in Afghanistan had helped explain to people that, although all the pills prescribed looked identical, they did in fact have different contents and purposes. Therefore, it was not the case that doctors were providing poor care and supplying the same drug in all cases. Indeed, multiple participants pointed out the potential benefits community scorecard approaches could have in narrowing information asymmetries and improving relations; they create mechanisms for health professionals to explain issues to the general public and making it possible to uncover and deal with areas of confusion.

Information asymmetry issues were also raised in terms of their interaction with economic and social inequality. The greater knowledge of some groups may mean they are better able to discern when they are receiving high- or poor-quality treatment and so allow them to challenge health professionals and obtain better care. These may similarly create an incentive for political actors to channel resources to high-knowledge groups, as they are in a better position to understand and take advantage of improvements. Serving them, rather than less well-informed or less organised groups, is to the benefit of political actors.

2.2 Heterogeneity of need can create coordination and accountability challenges, creating space for influence by external forces

Some aspects of health care are, or should be, universal (or nearly so) and fairly homogeneous across populations, leaving little room for **discretion** on the part of the provider. For example, not only can vaccinations be provided relatively homogenously, but also their success as investments in health depends on achieving as close to universal provision as possible. Everyone needs vaccinations. However, as health systems continue to develop, governments and other providers are forced to make difficult decisions regarding the use of scarce resources for health service provision. While organisations like the National Institute for Health and Care Excellence (NICE) in the UK can contribute evidence on the cost effectiveness of interventions, these decisions are in fact heavily political and reflect contestation among a number of actors. Where universality and homogeneity of need do not apply, the size and strength of the constituency for delivery begins to have important effects on prioritisation.

Examples of the potentially perverse effects of this prioritisation dynamic might include the fate of neglected tropical diseases (NTDs) (see Box 1). Such examples suggest understanding the political effects of **heterogeneity of need** or, conversely, **variability** and **discretion in treatment** might best be considered in terms of how it overlays on demographic, economic, social and cultural distinctions. They also suggest that, where coordination problems prevent service users from coming together to express their needs, prioritisation processes can be affected by sets of powerful actors. These might include not only other groups in need of different health services, but also supply-side interests (e.g. where pharmaceutical companies may affect treatment options) and other actors (e.g. global organisations, vertical health funds, etc.) driven by political constituencies and motivations external to the context in which services are used. One example cited in the discussion was the manner in which global health funding has disproportionately focused attention and effort on a particular set of health issues (e.g. HIV and AIDS, tuberculosis and malaria) at the expense of other, less favoured issues, including NTDs, though there may be positive spill over effects on certain parts of health systems.

Politically, focus might then be directed to potential forms of coordination and organisation that link similar types of user or patient groups with overlapping interests, so as to generate greater constituencies for reform. This could include exploring the potential of patient groups with specific conditions to act not only to support each other but also to improve the political power of service users. Examples of such practices, while reflecting very different contexts, include recent political mobilisation by European cancer patients around demands for entitlements as a part of a disease-specific patients' bill of rights, and activities of some HIV-positive networks.

Box 1: Neglected tropical diseases

NTDs exemplify a number of the challenges raised where heterogeneity of service provision is very high. Previous reviews in this area have highlighted 'neglect' where heterogeneity occurs not only by individuals but also by socioeconomic and gender group, for example where NTDs tend to disproportionately affect populations with low visibility and little political voice.

They may also suggest something about how to move forward in light of these problems. Progress in addressing NTDs in cost-effective ways has been associated with the development of coalitions that include the sorts of additional actors that might otherwise be seen as spoilers (given limited financial returns to addressing NTDs in the short-term): major pharmaceutical companies, often in partnership with NGOs and governments.

Source: Samuels and Rodriguez-Pose, 2013

2.3 Professional dominance may derail accountability relationships; improved performance may need to come from within

Participants noted that health sector service providers often had vested interests in maintaining information asymmetries, leading to outcomes like the slow adoption of simple diagnostic tools. However, providers are also generally enmeshed in highly political relationships with government. In these relationships, providers in the health sector often demonstrate significant professional dominance. As defined by Mcloughlin, with Batley (2012), **professional dominance** refers here not to whether service providers are behaving professionally, but rather to whether provider groups are able to organise politically in ways that allow them to exert influence over government and resist efforts for reform.

Evidence from Nepal (see Box 2) and other contexts (Mills et al., 2001; Palmer 2006; Balabanova et al. 2008) suggests that, where health workers are able to organise and gain significant professional and political leverage, this can have significant impacts on service delivery regulation and outcomes. How this happens and the precise nature of those impacts are clearly linked to aspects of the wider context, including the way in which political competition creates perverse incentives to manipulate the transfer system, but the effects are rooted in a collective professional dominance that exists across contexts.

This is not to suggest an organised group of providers is necessarily a bad thing for effective service delivery, as it may help insulate providers from political demands that might otherwise subvert efficient, effective and equitable provision. However, it can have negative effects (Mills et al., 2001). What is critical is whether the way in which organisations of health professionals (often linked to government and regulatory bodies) solve collective action problems allows them to pursue their own

interests rather than maintain standards. It is the latter that would ensure benefits to service users.

Box 2: Managing professional dominance through alternative approaches to human resources for health in Nepal

Nepal provides an interesting example that demonstrates both sides of the provider performance debate. Research by Harris et al. (2013) suggests the dominance of organised and influential professional groups (health workers unions) is a key feature undermining efforts to improve access to qualified health workers in remote rural areas through the management of a rotational posting system. Politically connected (and often party-affiliated) unions help facilitate transfers to preferred postings or further training in the Kathmandu Valley for connected health workers. That collective action takes place in this way, rather than in pursuit of improved conditions in service in remote rural postings, appears to be a key factor in understanding the impact professional dominance has on health service delivery.

Yet Nepal is also a country that has seen impressive reductions in maternal mortality across the population, achievements that have been tied to timely access to appropriate human resources. How can these be reconciled? Work by Engel et al. (2014) suggests popularisation of the female community health volunteer (FCHV), a locally employed position that sits outside of the rotational scheme, enabled policymakers to effectively bypass many of the problems generated by professional dominance.

Source: Engel et al., 2013; Harris et al., 2013

Where professional dominance undermines organisational accountability and direct accountability is hampered by the sector characteristics outlined in Sections 2.1 and 2.2 above, what might this mean for improved provider performance in the health sector? One option is to consider whether there are opportunities to build and draw on intrinsic motivation among health professionals. While our consultations did not raise this issue, this is an area the health and development community has explored (e.g. work by Frederike Paul (2009) in relation to the relationship between extrinsic and intrinsic motivations). Additional work on remuneration, hiring practices and other human resource management practices might usefully explore the potential to maximise the impact of intrinsic motivation among health workers.

Another option is to pay more attention to the incentives that drive particular forms of coordination and cooperation among health sector professionals. Complementing a growing body of examples of effective performance-based pay incentives (e.g. work by Rodriguez Pose and Samuels (2011) on improvements in maternal health in Rwanda), there may well be opportunities to develop, inculcate and strengthen professional standards and norms that encourage self-policing. Indeed, evidence from contexts in Latin America points to successes in pursuing equity- and efficiency-oriented social sector reforms through opportunistic interventions that played on the professional reputation of organised provider groups (Grindle, 2001).

In the health sector, formal mechanisms, like medical board certification and sanction mechanisms, in combination with more informal practices, such as adherence to the Hippocratic Oath, provide a basis for thinking about how to establish standards and norms of behaviour that contribute to a professional reputation in which various types of health workers have a collective interest. Batley and Larbi point to work on the Nurses and Midwives Council of Ghana, which 'had responsibility for registration standards, and curriculum development and examinations in training institutions. This council and the wider membership had a strong reputation for their motivation, *collective pride* and proactivity' (2004: 200, emphasis added). Other examples from recent practice might include the

Shasthya Sena social franchising initiative to establish professional standards among community doctors in Bangladesh, which encouraged improved performance in the absence of centrally governed institutions (Albrecht, 2013), and effective social franchising of family planning and reproductive health services by Social Marketing Pakistan, which franchised private clinics and pharmacies to use the Green Star brand, if they underwent training and maintained standards (Palmer, 2006). While not necessarily directly transferrable across country contexts as ready-made solutions, these institutions may provide some indication of opportunities to help ensure better performance, even where traditional accountability models are challenged.

2.4 Visibility, attribution and therefore political salience are flexible attributes

In the health sector, **visibility** of service provision has been recognised as a critical factor in the politics of service delivery, particularly in relation to the state-building agenda. For example, authors have often drawn attention to the differential impacts on state credibility and legitimacy depending on whether the state or NGOs are the provider of visible services (Eldon et al., 2008). Participants spoke of widespread experience of politicians favouring investments in highly visible, physical infrastructure (e.g. hospitals and clinics) over less visible aspects of health service provision, particularly human resourcing of such facilities and investments in public health. Eldon et al. (2008) cite similar dynamics applying to issues of routine maintenance and other recurrent costs.

The notion of visibility as an inherent characteristic of goods and services was also nuanced through the consultation, confirming early thinking by the authors that these and the other identified sector characteristics might best be thought of as structural tendencies. Several participants noted the potential to use high-profile propagandising around particular aspects of service provision to generate greater knowledge or awareness among users, or to create an association between an improvement or deterioration in the quality of that aspect and a political actor – thus amplifying the extent to which it was attributable. In other words, there are opportunities for elites to manipulate visibility and attribution to generate political outcomes (rather than these being a fixed feature of some activities or something to be raised through information campaigns to the benefit of users).

These are interesting points and augmentations to the model, though it should be noted that the basic visibility and attributability characteristics of services will affect how easy this form of activity is for politicians and, therefore, the possible payoffs from engaging in this form of activity. There is a tendency towards invisibility of soft services delivered in closed spaces (schools, clinics), but this does not mean that visibility and attribution cannot be raised; rather, it pinpoints the problem that needs to be addressed.

2.5 The idea of intrinsic 'lootability' helps explain service delivery politics

One idea participants raised was the question of whether the framework should address or classify goods and services by the ease with which they could be channelled or translated into political or economic rents – an idea they called 'lootability'. Although a wide range of examples can be thought of from health and political economy literature, participants gave a particular example from Helmand province of Afghanistan. The main tribal group in this region was able to take over state health services as part of a wider power-sharing agreement. This secured them access not only to health resources and investments but also, crucially, to lucrative

posts and positions within the health service. The extent to which a good or service, or elements thereof, may be used for the generation of political or economic rents is therefore likely to have an impact on the willingness of political actors to invest in them.

The key here is that there are 'intrinsic' vulnerabilities in certain activities (e.g. management of human resources, procurement decisions and control of highly transportable goods) that will be more or less relevant across services and sectors. The form and extent of exploitation of these vulnerabilities will be heavily dependent on context, as the ability to capture rents may be different at different levels of goods provision. So the extent to which those allocating funds can benefit from or use rent allocation may have a strong influence on investment decisions. For example, large contracts for medical centres or hospitals may be very lootable at a high level by politicians through kickbacks, whereas community-constructed health centres may not offer high rewards, given their small scale. Medicines may be lootable at the health facility level but not as much so at the central level, and so investment choices may vary depending on the ability of those allocating resources to gain a share of these spoils.

Similarly, the ability to give control over staffing positions and decisions at a regional level to a particular group, which can coincide with professional domination and political links, may be used as an element of a power-sharing agreement. This may also spur limitations to the expansion of health staff in that area if the group in control at the centre is not profiting from the expansion of positions.

In this sense, it may be useful to connect analysis of sector characteristics with the application of value chain analysis to issues of governance in service delivery. Work in this area (e.g. Campos and Pradhan, 2007) looks precisely for weak links in the chain, from policy to implementation, that might indicate risk of corruption, but has given little emphasis to sectoral distinctions and similarities.

2.6 Subsector distinctions matter for analysis of political dynamics

In their original paper, Mcloughlin, with Batley (2012), begins with the basic point that distinguishing between sectors helps nuance understandings of the politics of service delivery that is unavailable when 'service delivery' is treated as an undifferentiated whole. Extending this logic reveals sectors themselves are often composed of multiple subsectors that fall in different places on the spectrums indicated by the various characteristics identified in the paper. For example, in water and sanitation services, the politics surrounding large networked urban systems vary in important ways from those surrounding household- or community-level rural systems. Making this type of distinction at the subsector level has been an important feature of each of the previous sector consultations.

Our identification of subsectors within the health sector originally focused on the distinction between curative and preventative health care. The logic behind the approach was based on the observation that key characteristics were likely to vary between these two types of health service. For example, curative care may attract more political attention owing to the relatively simple and direct (visible, measurable and therefore attributable) connection between a specific service provider and a targetable patient with a recognised health care need. In contrast, characteristics of preventative care, such as the frequent presence of significant externalities (benefits accruing to members of the population other than the service user), the low visibility and attribution arising from indirect connections between

intervention and outcomes and the lack of a clear set of organised and connected providers, might lead to reduced political salience.

However, the consultation helped reveal the subtlety of subsector distinctions and warn against simple dichotomies that underestimate the complexities of delivering different types of curative care. Of particular note are the distinctions between one-off cases (e.g. treatment for a broken leg) and care for chronic conditions. A number of sources have documented the increased incidence and impact of chronic conditions as a part of the disease burden in developing countries (Allotey et al., 2011). Historically, this has been associated with the demands non-communicable diseases (NCDs), such as cardiovascular disease, cancers, respiratory diseases and diabetes, are putting on health systems (Maher et al., 2012). Increasingly, treatment options mean some infectious diseases, such as HIV, are now also displaying increased chronicity, changing the nature of demands on the health system (see Box 3).

Box 3: Chronic care for HIV in Uganda

Advances in diagnosis and treatment for conditions that have formerly been considered fatal, with short life expectancy from the point of diagnosis, mean issues of chronic care are increasingly important in developing countries. One example of this trend is the changing nature of HIV treatment in Uganda and the associated change in expectations. Highly active antiretroviral therapy (HAART) coverage has reached 16% of the HIV-positive population, moving the treated few from the category of acute to chronic. As described by Nixon et al. (2011):

> *The expectation follows of a lifelong commitment to the already treated few, with an implicit promise to manage the remaining 84% as funds become available. Without ongoing global health funding, and in view of the cost of HAART and the cost to the health system of lifelong treatment, it is hard to imagine that this situation will be sustainable.*

A sector characteristics approach suggests that, while funding concerns are clearly important, the chronicity may also entail a shift in the politics of HIV treatment as patients live longer, experience care repeatedly and, potentially, come to know one another.

At least two key characteristics are relevant with respect to the political implications of chronicity. First is the fact that chronic conditions almost by definition necessitate long-term care. While van Olmen et al. (2011) argue for moves towards greater self-management of chronic conditions in low-income countries, in most cases increasing chronicity probably entails additional **repeated transactions** with service providers over time, **shared experiences** among patients and much higher levels of **predictability.** This is likely to offer more scope for user agency, whether by making informed decisions about searching out alternative providers or through forms of organisation like the creation of communities of people with common ailments that may be able to overcome collective action problems and create a constituency for better care.[3]

These issues are areas that must be explored in greater depth, though participants disagreed regarding whether it was generally possible or useful to divide analysis of the health sector in this manner. Some participants felt a whole systems approach needed to be encouraged, arguing curative and preventative services were now

[3] It is also possible that these characteristics might negatively engender isolation and stereotyping of a class of people. The question is always how the characteristic is used in practice – whether to encourage or suppress agency.

generally closely intertwined and so separation was difficult in practice. Others argued the tendency of these to be viewed in silos was still very much apparent, particularly in the case of international aid and the design of vertical programmes for service delivery. At the very least, this approach suggests levels of chronicity may be a useful subsectoral distinction to make when considering the politics of health service delivery.

2.7 Sector characteristics complement social norms, expectations of provision and local understandings of quality

The sector characteristics as proposed in Mcloughlin, with Batley (2012), and discussed above, are not intended to fully explain the politics of health service delivery in any particular context, independently from an understanding of the context. Rather, for this analysis to be most useful, it needs to be complemented by locally grounded political economy analysis (PEA)-type work, as interactions between the two types of inquiry are important. This point is recognised in related work on the identification of key governance blockages and on problem-driven PEA.

Consultation with health sector specialists suggested social norms interact particularly strongly with health services. An area of major concern consultation participants mentioned frequently was the need to understand how social norms affect demand for and access to health care among different groups, and how they shape expectations in terms of who will provide certain services and what constitutes quality medical care.

For example, social norms may be connected to demand directly in terms of who the appropriate actors are for delivering health care, and so affect the political incentives for provision, depending on where the pressure of demand falls. The specific examples participants noted focused on the cultural differences between the UK and the US: the former has a strong culture and expectation of public provision of health services; the latter has a strong aversion to state involvement in health provision. These issues are also clearly present in many developing countries, with research findings suggesting demand for specific health services is affected by a tendency for communities to favour traditional birth attendants over state clinics and, in some cases, traditional healers over modern medicine (Box 4).

Several participants noted the limitations power relations place on the ability of women to demand and access health services and treatment in a variety of Sub-Saharan African and South Asian contexts. The capacity of these individuals and groups to demand health care is muted by the control of household financial and medical decisions by some family members (often male) over others. This may be in some ways analogous to the issues of derived or proxy demand that were noted in the education sector consultation – in this case with actors other than the patient making major decisions and so adding another layer of complication to the analysis. In this case, social differentiation is likely to be particularly important because the sector's characteristics allow for **variability** and **discretion** in treatment, creating opportunities for providers to prioritise some needs or cases over others.

Box 4: Social preference for traditional birth attendants

A number of studies have documented social and cultural norms that have an impact on patient–provider relationships in relation to maternal and child health. In Tanzania, communities have been found to have a high degree of trust in the services of traditional birth attendants, making use of their services in parallel with formal health care providers even in areas where the latter are easily accessible. Late attendance at formal facilities, which is associated with higher maternal mortality rates, has been linked to this practice (Vyagusa et al., 2013). In Malawi, Cammack (2012) notes the way the practices of some religious groups promote unsafe birthing practices, citing churches in Ndirande whose followers refuse health care, including both antenatal clinics and birthing in the presence of qualified birth attendants, on the grounds that health professionals may do bad things to them through witchcraft.

Such norms add a layer of complexity to understanding of sector characteristics as demand does not necessarily translate into political pressure in circumstances where the locus of demand is not the state and expectations of its regulatory role are limited.

Source: Cammack, 2012; Palmer, 2006; Vyagusa et al., 2013

Expectations of health care are also strongly conditioned by social norms and may not be compatible with medical best practice. Research in Tanzania (see USAID, 2011), for example, has found that that doctors often over-prescribe as high-quality care is associated with receiving multiple medicines (see also Box 4 above). Participants noted additional examples from some parts of South India, where there is a preference for injections, and from China, where patients often expect to receive intravenous therapy as part of treatment. These challenges might best be seen as **information asymmetries** and cultural expectations interacting to create issues with accountability relationships.

3 Conclusion

Our analysis does not systematically present all the characteristics identified in the original paper by Mcloughlin, with Batley (2012). In this brief, rather than attempt to provide a blueprint for the design of policies or programmatic approaches across the whole of the health sector, we have focused on a subset of issues that illustrate the way the characteristics can shed light on the political dilemmas that underpin a selective sample of the key challenges in the sector.

Some consultation participants felt it would be most useful to create a typology linking particular settings and issues in an explanatory framework leading to the identification of particular levers capable of influencing reform processes. Others felt there were real dangers of becoming too mechanistic, if it was turned into a simple 'if A, B and C, then use intervention option D' exercise, by setting it up as a manual. We agree it would be wrong to automate the application of this thinking. In our view, recognition of the interaction between sector characteristics and aspects of the local political economy context makes such attempts undesirable, particularly as consensus emerges around the need for local solutions.

We suggest the most promising avenue is to see an understanding of sector characteristics as one lens among others through which one might analyse context and sector to understand the incentives at work to inform programming. The approach should help analysts be alert to the possibility of particular risks and opportunities that might then be addressed through policies (e.g. on awareness raising and budgetary commitments to low-visibility sectors) and organisational reforms (whether, for example, these are directed at keeping politicians at a distance in some decisions and bringing users in, or vice versa). Consideration of sector characteristics in this way can then help identify specific implications for the effectiveness of options for organisational change or policy responses that attempt to effect improvements in health service delivery.

Participants noted that the theories of change behind many interventions in the sector did not but should distinguish between aspects of service provision on the basis of the political implications of sector characteristics. For example, drawing on the framework suggests the effectiveness of the various social accountability mechanisms deployed in recent years in the sector is likely to vary significantly across tasks. For example, community scorecards may be most effective for a subset of service delivery issues that demonstrate high levels of visibility and are not subject to the worst of information asymmetries.

This raises questions about the applicability of such initiatives in the health sector as the patient–provider relationship is bedevilled by severe information asymmetries, preventing informed judgements about some dimensions of the quality of care (e.g. choice of treatment, appropriate medication, etc.), and other tasks requiring specialist knowledge (e.g. identification of counterfeit medicines).

However, there is a range of health service delivery tasks that have characteristics that are more conducive to direct accountability, such as the highly visible physical state of facilities, health worker attendance and whether or not patients feel as though they are treated with respect.

Our consultations suggest that, in many cases, sector specialists are often aware of these underlying dynamics, even if they do not describe them using the terminology of the framework. However, they do not use them to inform interventions or to communicate with colleagues working on complementary issues. We therefore hope this paper, and others in the series, will also be of use in bridging gaps between specialists working in a number of service sectors and between sector specialists and governance specialists seeking to understand differentiated policies, approaches and outcomes across those sectors.

Finally, we emphasise that a process of development, selection, refinement and adaptation is inevitable as specialists in different disciplines engage with the material and the ideas are applied in new contexts. Feedback on the utility of the approach and how it can be refined will be crucial and is most welcome.

References

Albrecht, P. (2013) 'Local Actors and Service Delivery in Fragile Situations'. Report 2013:24. Copenhagen: DIIS.

Allotey, P., Reidpath, D.D., Yasin, S., Chan, C.K. and de Graft Aikins, A. (2011) 'Rethinking Health Care Systems: A Focus on Chronicity'. *Lancet* 377(9764): 450.

Arrow, K.J. (1963) 'Uncertainty and the Welfare Economics of Medical Care'. *American Economic Review* 53(5): 941-973.

Balabanova, D., Oliveira-Cruz, V. and Hanson, K. (2008) 'Health Sector Governance and Implications for the Private Sector'. Discussion paper prepared for the Rockefeller Foundation, November.

Banerjee, A., Glennerster, R. and Duflo, E. (2008) 'Putting a Band-aid on a Corpse: Incentives for Nurses in the Indian Public Health Care System'. *Journal of the European Economic Association* 6(2-3): 487-500.

Cammack, D. (2012) 'Peri-urban Governance and the Delivery of Public Goods in Malawi, 2009-11'. Africa Power and Politics Programme Research Report 3. London: ODI.

Campos, J.E. and Pradhan, S. (eds) (2007) *The Many Faces of Corruption: Tracking Vulnerabilities at the Sector Level*. Washington, DC: World Bank.

Chaudhury, N., Hammer, J.S., Kremer, M., Muralidharan, K. and Rogers, F.H. (2006) 'Missing in Action: Teacher and Health Worker Absence in Developing Countries'. *Journal of Economic Perspectives* 20(1): 91-116.

Eldon J., Waddington, C., and Hadi, Y. (2008) 'Health System Reconstruction: Can It Contribute to State-building?' London: Health and Fragile States Network.

Engel, J., Glennie, J., Adhikari, S.R., Wagle, Bhattarai, S.W., Prasai, D.P. and Samuels, F. (2013) 'Nepal's Story: Understanding Improvements in Maternal Health'. London: ODI.

Grindle, M. (2001) 'Despite the Odds: The Political Economy of Social Sector Reform in Latin America'. KSG Faculty Research Working Paper RWP01-021. Cambridge, MA: JFK School of Government, Harvard University.

Harris. D., Wales. J., Jones. H., Rana. T., and Chitrakar. R.L. (2013) 'Human resources for health in Nepal: The politics of access in remote areas'. London: ODI.

Mcloughlin, C., with Batley, R. (2012) 'The Effects of Sector Characteristics on Accountability Relationships in Service Delivery'. Working Paper 350. London: ODI.

Mcloughlin, C. and Harris, D., (2013) 'The Politics of Progress on Water and Sanitation in Colombo, Sri Lanka'. Working Paper. London: ODI.

Maher, D., Ford, N., Unwin, N. and Frontières, M.S. (2012) 'Priorities for Developing Countries in the Global Response to Non-communicable Diseases'. *Global Health* 8(1): 14.

Mills, A., Bennett, S. and Russell, S. (2000) *The Challenge of Health Sector Reform: What Must Government Do.* Palgrave E-book, http://www.palgraveconnect.com/pc/doifinder/10.1057/9780230599819.

Nixon, S., Hanass-Hancock, J., Whiteside, A. and Barnett, T. (2011) 'The Increasing Chronicity of HIV in Sub-Saharan Africa: Re-thinking "HIV as a Long-wave Event" in the Era of Widespread Access to ART'. *Globalization and health* 7(1): 1-5.

Palmer, N. (2006) 'An Awkward Threesome – Donors, Governments and Non-state Providers of Health in Low Income Countries'. *Public Administration and Development* 26(3): 231-240.

Paul, F.A. (2009) 'A Qualitative Study on Health Worker Motivation and the Rwandan Performance Based Finance Initiative in District Hospitals'. *LSE IDS Working Paper Series* 44(8): 1-35.

Rodriguez Pose, R. and Samuels, F. (2011) 'Rwanda's Story: Progress on health in Rwanda: Leadership, performance and health insurance'. London: ODI.

Samuels, F. and Rodriguez-Pose, R. (2013) 'Why Neglected Tropical Diseases Matter in Reducing Poverty'. London: ODI.

USAID (US Agency for International Development) (2011) 'Tanzania Health System Assessment 2010'. Report. Bethesda, MD: Health Systems 20/20 Project, Abt Associates Inc.

Van Olmen, J., Ku, G.M., Bermejo, R., Kegels, G., Hermann, K. and van Damme, K. (2011) 'The Growing Caseload of Chronic Life-long Conditions Calls for a Move towards Full Self-management in Low-income Countries'. *Global Health* 7: 38.

Vyagusa, D.B., Mubyazi, G.M. and Masatu, M. (2013) 'Involving Traditional Birth Attendants in Emergency Obstetric Care in Tanzania: Policy Implications of a Study of Their Knowledge and Practices in Kigoma Rural District'. *International Journal for Equity in Health* 12: 83.

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