UNIVERSITY OF BIRMINGHAM

Report

Service characteristics and engagement with citizens

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Key messages

- Despite progress in the delivery of public services over the past two decades, in many developing countries the average citizen continues to suffer from gaps in provision and poor performance of even the most basic services, like health care or access to water.
- Performance of these services depends not just on resources and the capacity of service providers but on their relationships with users (i.e. citizens), prompting significant interest in the potential of social accountability.
- However, too often support for social accountability remains generic, and does not distinguish between the different opportunities and constraints faced within and across different services.
- Using examples from curative health care and urban networked water supply, this briefing note provides some guidance on how services differ, and what this means for efforts to strengthen relationships between citizens as users and service providers.

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1 Aim and summary of the briefing note

Despite significant progress in a range of public services over the past two decades, in many developing countries the average citizen continues to suffer from gaps in provision and poor performance of even the most basic services. For example, staff absenteeism and medicine stock-outs are severe problems in many countries, and poor relations between health workers and service users are a persistent barrier to effective health care. Over-burdened networks and poor maintenance limit access to safe, clean drinking water, resulting in citizens having to travel long distances or use riskier sources. How best to address these problems, and improve the performance of services, is one the major challenges facing citizens and governments across the developing world.

Crucially, performance in service delivery depends not only on resources and the capacity of service providers but also on their relationships with users (i.e. citizens) and different levels of government – what demands providers face and how they are monitored and supported. There is rising interest in the potential of social accountability to shape these relationships and improve the delivery of public services. Social accountability is understood here as the extent and capability of citizens to hold the state accountable and make it responsive to their needs.[1] Can citizens voice grievances over staff performance, and do authorities take actions to resolve these issues? Understanding of social accountability is becoming more sophisticated, with an increasing appreciation of the major role context plays in shaping accountability relationships and outcomes, and so the need to adapt strategies accordingly.[2] However, approaches to improving social accountability often remain generic in not distinguishing between the different opportunities and constraints faced within and across different services.

The idea that services are distinct seems obvious, but often the implications for accountability are not clearly understood. But consider how a service such as hospital health care raises different issues of power and accountability compared with urban water supply. Patients place themselves individually in the care of doctors and nurses, often knowing little about their treatment and unlikely to feel empowered to dispute it. On the other hand, water users have a good idea of what they should expect from the supplier; they share their daily experience of the service with other users and can represent their opinions at a neighbourhood level.

This briefing note therefore aims to provide some practical guidance on how different services can offer differing opportunities and challenges for improving service performance through increased accountability and, especially, citizen engagement. It illustrates an approach to identifying these opportunities, using examples from two services: curative health care and urban networked water supply. This approach can be used to map where, when and how social accountability mechanisms may be effective in improving service performance.

[1] See World Bank (forthcoming).

[2] See, for example, Gaventa and McGee (2013) and Wild and Wales, with Chambers (2014)

2 Using sector characteristics to understand and improve performance

Analysis and diagnosis have a tendency to assume that issues of accountability and political context are similar, regardless of whether we are looking at water shortages, health worker absenteeism or other sector issues. Acknowledging these can have very different dynamics, in terms of demand, user mobilisation and user–provider relationships, provides us with a powerful tool to tailor guidance on entry points for and barriers to reform.

This is true not only for different public services but also for different aspects within them. For example, within water service delivery, networked (i.e. piped) water has a different set of characteristics from non-networked water (such as communal wells). There is also potential to draw out parallels across services where there are shared accountability challenges. For instance, issues of absenteeism in health may be reflected in education; similarly, issues underlying problems in the distribution of medicines may inform interventions on textbooks.

This briefing note draws on a framework laid out in Mcloughlin with Batley (2012)[3] for comparing the characteristics of services. This framework draws on sources from economics, management and social science and interprets service characteristics as having not only economic and managerial but also political implications. The Annex describes and explains each characteristic.

Characteristics can be grouped into four categories: the nature of the good (public or private); market (and government) failures; task-related characteristics; and demand characteristics (see Figure 1). Across these groups, different combinations of characteristics define a service's political salience, defined as whether there is an incentive for political leaders to provide services to those able to offer political (electoral or clientelistic) returns. Salience is particularly a product of the measurability and visibility of a service (which together allow politicians to claim the service is attributable to them), and of the characteristics that generate user demand. While salience arises also from contextual factors, it is at least partly a product of the nature of the service itself. In assessing the potential for citizen mobilisation and accountability, we are also interested in the market, task-related and demand characteristics that shape the potential for collective action and citizen monitoring or, on the other hand, the extent of service provider impunity.

[3] See Mcloughlin, with Batley (2012) for a review of the literature and the development of the service characteristics approach. For sectoral reports and a cross-sectoral synthesis, see Batley and Harris (2014); Harris et al. (2013); Harris et al. (2014); Mason et al. (2013); Mason et al. (2014).

Figure 1: Service characteristics and their combined effects

Market-related characteristics		Task-related characteristics	Demand characteristics
Nature of the good: public or private	**Market (and government) failures**		
Rivalry Excludability	Monopoly tendency Positive or negative externalities Information asymmetry Merit good	Measurability Visibility = *Attributability* Discretion of front-line staff Transaction intensity Variability of treatment Professional autonomy	Frequency and predictability of use Territoriality Choice Targetability
Likelihood of competitive provision	*Access to or exclusion of users from provision*	*Monitorability by policymakers, managers and users*	*Users' capacity to organise demands*
Political salience and incentive to provide			

The short summaries below are intended to provide a guide to how service characteristics have combined political effects, particularly affecting the potential for social accountability interventions, using two services as examples:

- Curative health services – most purely and simply these would be the health treatment supplied in hospitals; primary health care typically offers both preventative and curative medicine; and
- Urban networked (piped) water supply.

The examples indicate how service characteristics affect politicians' and users' incentives and ability to hold providers to account, and then how characteristics may affect internal organisational monitoring.

The nature of the good (public or private) influences whether independent providers are likely to emerge as rivals to state provision; whether market dynamics will affect the incentives and behaviour of politicians, providers and users; and whether service provision is inclusive. In the case of both curative health and urban piped water, it is possible for service providers to exclude individuals from accessing the service (e.g. for non-payment), meaning it is feasible (and in fact common) for the market to provide a service or, in the case of piped water, for market alternatives to exist (e.g. water carriers, tanker trucks).[4] This makes it easier for citizens to seek individual solutions to problems with service provision (provided they can afford them) and can make it harder to mobilise users collectively. Such services may also be more easily susceptible to informal (corrupt) charging for access and politically based exclusions. Politicians may prefer to provide individual solutions to users (e.g. ensuring a water pipe connection is formalised, ensuring medicines for a particular patient), rather than pursuing systematic change that is harder to secure and less easily attributable to their efforts.

Both services also have a degree of 'club good' characteristics. This means that, while a decision to access curative health care or piped water does not immediately create a negative effect on another's access, if too many people are using a limited service then there will be a negative effect. For instance, hospitals become overcrowded or

[4] An example of a contrasting service is community sanitation – which requires collective organisation and action (as it cannot be provided individually) with little possibility of market provision.

there are water shortages. So, collective provision may be feasible for a limited population but, where the service is provided on a larger scale, there may be resource trade-offs.

'Market failures' (inefficiencies in pricing, access and exclusion) present problems whether provision is by the market or by the state. While monopoly provision of curative health care is rare, the economies of scale in piped water mean monopoly provision is relatively common.[5] For both health and piped water, insulation from market forces and a lack of accessible alternatives can create a culture of non-responsiveness that makes providers less accountable to users.

The position is reversed in the case of information asymmetries, understood as where one actor (e.g. a doctor) has greater knowledge and information (e.g. of the best treatment or how appropriate their actions are) than other actors (e.g. patients or public service managers). Users of piped water are easily able to judge whether they are receiving water as and when they need it, and can make general judgements about quality (e.g. the smell, taste and colour of the water) – meaning they are more able to mobilise on these issues. Users of curative health services will almost certainly lack the expert knowledge of health professionals – creating large information asymmetries that mean they cannot assess the quality of the health care they are receiving and reducing their ability to mobilise collectively. Curative health is also marked by significant public health externalities (particularly in terms of preventing the spread of communicable diseases and maintaining a productive labour force), which are not directly experienced by users and so may be given a lower priority by individuals until the point of crisis, reducing the likelihood of mobilisation.

Task-related characteristics affect the ability of policymakers, managers and citizens (both users and non-users) to monitor the tasks providers of services perform. The differences between curative health care and piped water provision are particularly stark in this area and so have clear implications for accountability relationships. Curative health presents severe problems of monitoring providers from the viewpoint of both organisational managers and service users. Because needs for treatment differ from patient to patient, the service cannot be delivered in a standardised manner. Health staff are expected to exercise professional skills with a high degree of discretion and autonomy in deciding the appropriate action. These aspects reduce organisational control and monitoring as strict guidelines are hard to enforce, and can be counterproductive. It is also hard to gather enough information to measure performance accurately – particularly as individual patients use the system only occasionally. For users, similar problems exist in terms of assessing the quality of care, but are added to by the degree of professional autonomy health care workers exercise. This can create a 'fear factor', given worries that complaints may be met by poor treatment or a refusal of treatment in the future.

These issues are less relevant in piped water supply: the service is highly standardised in terms of delivery to service users, its outputs are easy to measure and variability between users is limited. Monitoring of service access and quality by managers and users should therefore be easier, and issues detected more rapidly.

Both curative health and piped water provision also suffer from a tendency for visible outputs, which are easy for service users to attribute to a political actor, to be prioritised over those that are harder to attribute. In the case of health, this can lead to priority being given, for example, to construction of health centres over improved deployment practices for qualified staff. For water, it can mean the prioritisation of household connections and low water prices over the maintenance of water systems.

Demand characteristics affect the ability of citizens and users to organise their demands and to hold providers to account. This may be influenced by the frequency with which the service is used, whether it is shared by users within a limited territory, whether it is used predictably or in crisis and whether there is choice between providers. Both curative health care and piped water services are territorial in the sense that they serve a particular locality or community, but the experiences of users of curative health care are likely to vary significantly: their usage is generally irregular, unplanned and at moments of crisis, which make mobilisation difficult. In contrast, users of piped water receive a rather standard service and use it very regularly; with shared experience and knowledge of future needs it is relatively easy for users to frame collective demands. It is particularly easy where users share a common facility (e.g. a standpipe) covering a small territory; on the other hand, users of network services

[5] This is not to say access to piped or networked water is anywhere near universal. In most cities in the developing world, sizeable populations are excluded from networked water and so must find more expensive and less safe or convenient alternative sources. However, the networks themselves often operate under a single monopoly provider.

experience their service in the privacy of their own homes and may be less aware of the experience of other users over a wider area.

This analysis gives us insight into how the nature of the sector can shape the opportunities and challenges for social accountability. It is important to note that sector characteristics condition rather than determine relations of accountability. Other factors intervene. The institutional structure of the sector, the political and institutional context and levels of agency will all shape the effects of characteristics. The approach therefore does not provide the basis for universal prescription but can identify entry points for analysis of local issues, organisational reforms and policy responses.

3 What does this mean for social accountability?

The role this framework can play for social accountability interventions is two-fold. First, it provides a guide as to whether a given service and problem is likely to be best addressed through the use of social accountability tools or through other mechanisms (e.g. internal reforms to the state administration) that may more effective. Second, where social accountability can address an issue, the approach suggests the barriers and opportunities likely to arise from the nature of the sector, which can then be considered when designing and implementing interventions.

This section takes the analysis of service characteristics for curative health care and urban networked water in the previous section and outlines their implications for the use of social accountability and citizen engagement mechanisms.

3.1 Curative health care

There are many barriers to users mobilising to improve curative health services:

- Most users access services irregularly, unpredictably and in a state of urgency, and so it may not be a priority or feasible for them to mobilise.
- There are alternative providers: private health facilities and pharmacies mean not all users have to use public facilities and so may not be interested in mobilising to improve them.
- Health care is complex and treatment varies case-by-case, making it hard for users to judge whether they are receiving a good quality of care.
- Health staff have a high degree of discretion in their actions and this can deter citizen mobilisation owing to fear of reprisals for making public criticisms.

However, some service characteristics do offer entry points for mobilisation:

- Health facilities are territorial and some (particularly primary health centres) serve distinct communities that allow for citizen mobilisation through existing social structures.
- Particular groups access health care services more frequently or predictably, such as the elderly, pregnant women and those with chronic conditions. They may create opportunities for user organisation and even act as a catalyst for engagement of the wider community. On the other hand, these are particularly vulnerable groups that may find it difficult to mobilise.
- Acting collectively can ameliorate concerns over reprisals by anonymising cases.

Monitoring health workers and evaluating the quality of care is challenging for users, policymakers and service managers – making upward and downward accountability difficult:

- Information asymmetries and variation in treatment between patients makes it hard for users to make complex assessments of health worker performance.
- Information gaps limit organisational monitoring and accountability, as well as the need not to infringe on necessary professional autonomy.

However, citizen monitoring can play a role in narrowing information gaps in state monitoring for particular issues:

- Citizens can monitor basic aspects of health facility performance (e.g. health worker presence, inventory of medicines/equipment, basic procedures such as making a record of patient details, attitudes of health workers).
- Credible and usable information may be channelled through state systems (where they are functional) to improve existing oversight mechanisms and so basic discipline. This could reduce the risks of reprisal for complaints presented directly by users.

Health workers' professional autonomy and discretion may create opportunities for local-level problem-solving:

- Issues such as staff rudeness or irregular opening hours can have major adverse effects on citizens' willingness to use services, but are also areas where health staff can exercise their discretion to change practice.
- Programmes that offer venues for users and providers to exchange information on grievances can provide a platform for solving problems in a mutually beneficial manner at the local level without involving higher levels of authority. This may particularly be the case where issues can be solved through co-production (e.g. users engaging in constructing or maintaining staff houses as part of agreements to reduce absenteeism).

In the case of curative health care, it is also important to understand there may be limitations to what social accountability can achieve:

- Political incentives may lead politicians to prioritise individual solutions with very specific beneficiaries (e.g. provision of medicine to a particular patient or facility) or visible inputs (e.g. building clinics, providing equipment etc.), rather than finding more complex collective solutions (e.g. solving drug supply issues).
- Health care is a private good that can easily become a field for rent-seeking opportunities – the illegitimate targeting and selling of the service – that will set up barriers to accountability reforms. This is particularly the case for components (such as medicines) that are highly 'lootable' (i.e. private goods that are easy to steal and transport and valuable to sell).

Programmes seeking to engage with citizens need to understand the possible nexuses of political, provider and wider commercial interests whose interests may thwart citizen engagement. Thus, while citizen engagement and social accountability may be useful in improving basic issues at the local level, systemic change will require longer-term alliance-building and reform within the state.

3.2 Urban networked water supply

There are fewer barriers to users mobilising to improve urban piped water:

- Water services are used regularly and predictably, and users of a particular source are likely to be geographically concentrated.
- Options for exit to private providers of water are expensive (e.g. acquisition of water tanks) or inconvenient (e.g. bottled water), making collective action more of a priority.
- Users can judge the quality of the service they receive relatively easily.

However, there may still be barriers to overcome:

- Users' experience of piped water, particularly in urban areas, is at the household level and, while services are geographically concentrated, users may not know the boundaries of the service. This complicates community mobilisation, particularly where the boundaries of the service do not match existing political or administrative boundaries or contain a highly heterogeneous group of service users.
- The tendency to monopoly in urban piped water can lead to unresponsiveness on the part of providers, even where citizens are mobilised, unless pressure can be built through alliances with powerful political actors.

Monitoring of most aspects of service performance is straightforward for users, policymakers and service managers, so organisational monitoring and accountability should be effective:

- Information, particularly on the quantity, quality and price of water supplied, is highly visible in many cases and relatively easy to measure.
- Networked water supplies are delivered in a fairly uniform manner with little room for provider discretion.
- Information is easy for the state to gather and act on.

However, the characteristics that make piped water easy to monitor can also enable politicians to manipulate the structures for short-term gains, and can exacerbate users' collective action problems:

- The highly political nature of water and water pricing creates incentives for politicians to expand networks, while restricting prices or only selectively enforcing sanctions for non-payment. This can lead to overstretched water systems and shortfalls in revenue, leading to neglect of less visible aspects such as maintenance.
- Citizens face collective action problems: while they have a desire for reliable access to good quality water, they generally also want to avoid water charges, price increases and limits on their consumption.

Social accountability programmes therefore seem to have significant potential for addressing issues with urban piped water. However, questions arise: can a viable community of users be mobilised? How can a balance be struck between the competing priorities of expansion, maintenance, water quality and price in a manner that is sustainable and satisfactory for all users? Social accountability on its own may not provide an adequate response and so issues of water supply, delivery and consumption are likely also to require internal reforms within the state.

Tables 1 and 2 give an overview of the blockages to and entry points for social accountability in these two sectors.

Table 1: Entry points and blockages for social accountability in curative health

Social accountability for curative health		
Characteristic	**Entry points**	**Blockages**
Nature of the good; and market and government failures	• Targeting areas where health facilities serve a specific geographical community or where there are fewer private facilities may aid collective action.	• Lack of monopoly power for health care means there is a range of exit options. The private good aspect of health services makes individual and targeted solutions easier for both citizens and politicians. These factors reduce the incentive for collective action and systemic reform. • Asymmetric information between user and provider makes it hard for citizens to hold providers to account.
Task-related characteristics	• Potential for citizen monitoring to close state information gaps, particularly on issues that are easier to monitor, e.g. absenteeism, corruption and simple procedures. • Professional discretion creates potential for collective action solutions at the local level by providing links and a platform for discussion.	• High degree of professional discretion and variability creates disincentives for citizens to mobilise owing to the potential for reprisals, and makes organisational oversight harder.
Demand characteristics	• Interest groups with more regular or predictable health care needs (e.g. elderly, chronic conditions etc.) can act as a rallying point for mobilisation. • Primary health units can act as a more local and frequently used base for information and organisation covering also tertiary health care.	• Unpredictable and infrequent demand reduces the incentives for collective action. • Tertiary curative services (hospitals) have wide-ranging territories that make user organisation difficult. • Different groups of users may have priorities and interests that are both overlapping (e.g. increasing staff attendance) and competitive (e.g. allocations of fixed drug and equipment budgets).

Table 2: Entry points for and blockages to social accountability in urban networked water

Social accountability for urban networked water		
Characteristic	**Entry points**	**Blockages**
Nature of the good; and market and government failures	• Strong potential for collective action owing to limited exit options, territorial nature of provision and ease of information collection and dissemination.	• Tendency to monopoly, lack of competitive provision and expense or inconvenience of exit options can limit suppliers' responsiveness. • Private good aspects create incentives for politicians to invest in expansion and improvements that can be targeted, while giving low priority to collective benefits (e.g. water quality) and resisting applying water tariffs that improve service viability.
Task-related characteristics	• Visibility and measurability of service facilitate both citizen monitoring and organisational oversight. • Low variability of service and limited professional discretion make state oversight easier.	• The ease of monitoring and relative lack of provider discretion makes manipulation by political actors for short-term gains easier.
Demand characteristics	• Frequent and predictable demand that is territorially concentrated enhances potential for collective action. • Use of dialogue platforms and other mechanisms for brokering and facilitation may be able to overcome trade-offs between expansion, maintenance, water quality and price.	• Demand is high but may pull in different directions (in terms of quality, quantity and charging), creating collective action problems for users. • Water pricing is highly political and can create incentives for low prices or selective enforcement of sanctions that undermine service quality.

4 Summing up

The previous section illustrates why we need to take into account the nature of specific services in identifying problems and opportunities for social accountability and in designing strategies. While the effects of these characteristics are mediated by the contexts in which services are operating, taking a step back and exploring the differences in these more rarefied examples can give us a useful starting point for diagnosing and addressing issues.

In a stylised fashion, we can see the differences in a simple example – comparing the failure to receive medicine after a visit to the doctor and the failure to receive water from a tap. In the former case, the service user does not really know if they are supposed to have received medicine for the problem or if its absence was due to shortages, poor logistics or theft. Complaining to a higher-level health official is not only risky (the doctor may find out and refuse treatment in future) but may also not have any impact. Officials face similar questions – was medicine supposed to be given, were there shortages and why? – as well as administrative difficulties – should medicines always be given out and can such a rule be practically enforced? Mobilisation is therefore difficult and local administrations cannot always adequately respond. So programmes might best focus on enabling joint working between users and providers to resolve problems, and on providing information about users' experience to official monitoring systems, where these work adequately.

In contrast, water is more straightforward – its absence is clearly a deficiency, the responsible party (the provider) is clear, risks of reprisals for reporting are small and top-down enforcement can be used to ensure leaks are closed or pumping restarted. Mobilisation and enforcement should be relatively easier than in the case of health care. However, if there are systematic incentive problems underlying water shortage or leakage problems, these may require still deeper reforms within the state or actions to resolve competing priorities between citizens.

Recognising that sectors and specific services have distinct bundles of characteristics can therefore be of clear value. Differences between services may contribute to explanations of their politics and performance, and similarities or complementarities may generate opportunities for cross-sectoral learning.

The service characteristics approach goes further than recognising that difference and similarities exist. It provides a framework for understanding how service specificities influence relationships of accountability and hence service performance. This briefing note has focused on the two sides of social accountability: the ability of citizen and users to organise their demands and engage with the state; and the ability of politicians and providers to respond. Networked water supply and health care have different characteristic profiles, suggesting different constraints and opportunities for bringing improved engagement with citizens. Exactly how these play out depends also on context, which will condition what constraints can be addressed and whether opportunities can be seized.

The approach laid out here provides an analytic framework for considering how sector dynamics interact with context to affect relations of accountability. It allows analysis of the barriers and opportunities for engagement with citizens in specific services and contexts in order to generate a suite of possible entry points to address the most critical barriers and seize potential opportunities.

Further, detailed work is needed to apply these ideas practically to different aspects of services and to understand how entry points and barriers vary across contexts. However, this document and approach provide at least a starting point for those seeking to better understand the place and role of social accountability in improving service delivery.

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Appendix

Table A1: Framework for identifying service characteristics

Category	Characteristic	Explanation
Nature of good: public or private	**Rivalry** *Is the service used up by its consumption?*	In private goods, costs increase with each additional consumer, making the good unavailable to those who do not pay. Public goods are not rivalrous, e.g. street lighting or police services.
	Excludability *Can some people be excluded from benefiting?*	In private goods, non-payers can be excluded from benefiting. Public goods are not excludable, e.g. street lighting or vector control of mosquitoes.
Type of market and government failure	**Monopoly tendency** *Do investment costs and economies of scale make it difficult for alternative suppliers to compete?*	High initial investment costs and economies of scale make it difficult for alternative suppliers to compete, e.g. urban water supply.
	Positive and negative externalities *Are there external (public) costs and benefits of individual use or non-use of the service?*	Positive: When one individual's actions confer a benefit on others, e.g. individual immunisation has preventative effects for an entire population. Negative: When one individual's actions impose a cost on others, e.g. poor sanitation in one locality leads to health problems elsewhere.
	Information asymmetry *Are there inequalities of information between parties (consumers, producers, managers, politicians) about the quality or risks of the service?*	Consumers may be less informed than producers (or vice versa) about the quality or risks of a service, e.g. health care (see also measurability of outputs below).
	Merit goods *Are the individual and collective benefits of consumption understood by users and by government?*	Individuals may not act in their own best interests, leading governments to make choices for them, e.g. requiring immunisation and basic education.
Nature of task	**Visibility and measurability of outputs** *How visible, in a physical sense, are the service outputs to citizens (users) and to government?* *Can the outputs be quantified, or measured precisely?* *How much time do improvements in outputs take to reveal themselves?*	Service outputs are relatively easily measured and evaluated where they are quantitative and visible, precise objectives can be imposed and results are quickly apparent, e.g. road construction.
	Discretion of frontline staff *Do frontline staff have autonomy to determine how they perform certain tasks? Which tasks?*	Where objectives are qualitative and difficult to specify, managers and professionals may have greater discretion to determine procedures and outputs, e.g. classroom teaching.
	Transaction intensity *Does implementing the service require frequent, iterative contact between individual consumers and providers?*	Tasks that involve iterative and individual contact between providers and consumers are transaction-intensive, and the quality of interactions may be difficult to monitor, e.g. medical care.

Category	Characteristic	Explanation
	Variability *Are there factors that cause variability in user need? In what ways, therefore, is the service difficult to standardise?*	Tasks that are transaction-intensive and discretionary require a variable response to clients and cannot be standardised.
	Professional organisation *Does delivering the service depend on professional and skill groups that have a commanding presence within the organisation and perhaps extending to political influence?*	Tasks that are discretionary, transaction-intensive and variable are ones that require professional judgement and autonomy. Professionals may therefore organise and exercise control over principals (clients, politicians and managers).
Demand characteristics	**Level of demand** *What is the level of known demand for the service?*	The incentive to provide services is greater where demand is higher.
	Frequency of use *Is the service used regularly or episodically?*	Services may be used regularly (water supply) or episodically (health care), affecting the level of interaction between users and between users and providers.
	Predictability of use *Is the service used routinely or unexpectedly as a result of a crisis or unforeseen events?*	Regularly used services with fixed costs are possible to plan and insure for. Unpredictability occurs particularly in health care but also, to a limited extent, in the demand for water.
	Territoriality *Does the service have a natural boundary of consumption? Is it consumed in common by all residents of a local area?* *What are the physical points of contact between users and government?*	Certain services (water supply, refuse collection) are consumed in *common by all residents of a local area*. Others depend on individual needs served beyond local areas (hospital health care).
Political salience **A composite outcome of all characteristics**	*What are the likely political returns to provision? What are the broader social implications of service use?*	The political salience of a service depends on politicians' calculation of political returns from its provision and on citizens' response.

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