

Working Paper Series

No 11

Claudia Baez-Camargo

Eelco Jacobs

**A Framework to Assess Governance of
Health Systems in Low Income Countries**

GOVERNANCE

BASEL INSTITUTE ON GOVERNANCE

Basel Institute on Governance

The Basel Institute on Governance is an independent non-profit institution devoted to interdisciplinary research and policy advice in the areas of public, corporate and global governance, as well as international judicial cooperation and asset recovery. The Institute acts as a centre of competence by combining scientific methodology with hands-on practical experience to provide applied solutions to concrete problems. Based in Switzerland and associated with the University of Basel, the Institute is composed of internationally recognised academics as well as practitioners with long-standing experience in the field of anti-corruption. It further relies on a wide network of partners from around the world and works with all stakeholder groups concerned.

Governance of Health Systems

The concepts and methods described in this manuscript have been developed within the “Governance of Health Systems” research project that is currently being undertaken jointly by the Basel Institute on Governance and the Swiss Tropical and Public Health Institute. This project is funded by the Swiss National Science Foundation (grant number K-13K1-122277/1) and has the goal to contribute an analytical framework to assess governance in the health systems of low-income countries, with the view of proposing ideas for new and more effective governance-enhancing interventions.

Working papers

In this working paper series the Basel Institute on Governance publishes reports by staff members and invited international experts, covering critical issues of governance theory and practice. For a list of publications, please visit www.baselgovernance.org.

Acknowledgements

The authors wish to express their sincere appreciation to Inez Mikkelsen-Lopez, Don de Savigny, Kaspar Wyss, Mark Pieth and Max Bergman for the very valuable comments and insights they contributed during the development of the conceptual framework described in this working paper.

Claudia Baez-Camargo, Eelco Jacobs

July 2011

Responsibility for the views expressed and for any errors of fact or judgment rests with the authors alone.

Basel Institute on Governance, Steinenring 60, 4051 Basel, Switzerland

www.baselgovernance.org

info@baselgovernance.org

ISSN: 2624-9650



Abstract

As awareness of the role governance in the performance of health systems has increased, so has the need to come up with systematic means to evaluate governance shortcomings to develop adequate interventions. This working paper describes a framework to assess governance in the health systems of low-income countries that is intended to have empirical applicability with a problem-driven approach. The analysis is grounded on a re-categorization of governance dimensions for greater heuristic power, with an emphasis made on the importance of strategic systems design and accountability. The proposed methodology includes mapping of both formal and informal institutions, actors and networks. This underscores the idea that in order to properly address governance weaknesses it is of utmost importance to have an insight into whether the interplay of formal and informal norms facilitates or undermines system performance.

About the authors

Claudia Baez-Camargo, who is lead researcher in the project, holds a PhD in political science from the University of Notre Dame and a graduate degree in economics from the University of Cambridge. Before joining the project she was professor of political science and history at William Paterson University in the US. Her professional experience also includes work with the Mexican federal government in developing poverty alleviation programs as well as research activities with the UN's Economic Commission for Latin America and the Caribbean, and consultancy work on health systems' governance in Sub-Saharan Africa.

Eelco Jacobs holds an MSc in State, Society and Development from the School of Oriental and African Studies (SOAS) in London and is currently pursuing his PhD in Political Sociology at the University of Basel. Before joining the governance of health systems research project Eelco worked as a freelance analyst and consultant on public and global governance for think tanks, NGOs and multilateral organisations in Britain, Tanzania and the Netherlands. He also has experience from the Organization for Security and Cooperation in Europe in Kyrgyzstan, working on anti-corruption projects and the International Labour Organization in Geneva, tracking the implementation of the One UN reforms. His current research interests include the political economy of health reform and variation in local governance in Tajikistan.

Dr Claudia Baez-Camargo, University of Basel, Basel Institute on Governance, Steinenring 60, 4051 Basel, Switzerland, claudia.baez-camargo@baselgovernance.org

Mr Eelco Jacobs, Basel Institute on Governance, Steinenring 60, 4051 Basel, Switzerland, eelcojacobs@gmail.com

Table of Contents

1. Introduction	5
2. An analytical framework for assessing governance in the health sector	6
3. Application of the governance of health systems framework	10
4. Concluding remarks	14
References	16
Appendix I: Stakeholder identification and characterization tool	19
Appendix II: Sample semi-structured interview questionnaire for stakeholders in a public sector medicine supply chain assessment	20
Appendix III: Sample semi-structured interview questionnaire for accountability assessment	22

1. Introduction

Responding adequately to the health needs of a population requires not only medical breakthroughs but also timely and efficient delivery of preventive and curative services. This is all the more meaningful as it is often found that in those settings where health needs are the greatest, the administrative capacity of the state to implement policy is limited. The acknowledgement that successful healthcare delivery requires effective institutions and management has led government officials, academics and international donors alike to emphasize governance as a key element in the quest for practical solutions for strengthening health systems.

Governance as it applies specifically to health systems' performance has however remained a complicated topic to conceptualize and operationalize, especially in terms of producing practical advice and solutions.¹ In recent years several health sector frameworks assessing governance have been proposed (Siddiqi et al. 2009, Lewis and Pettersson 2009, Brinkerhoff and Bossert 2008, Vian, Savedoff, and Mathisien 2010), which offer insights into how governance may impact health outcomes and suggest which elements associated with governance are important to consider.

Nevertheless, a need remains for an approach that goes beyond accurately depicting the state of formal governance in a given place and time. What most of the governance frameworks and assessments of health systems lack is an explicit acknowledgement of the important role played by the political context in which health systems are embedded.² In this article we propose a framework to assess health systems' governance that incorporates political power and influence analysis to provide a more comprehensive understanding of the motivations and incentives underpinning the actions of major stakeholders in the health sector. The ultimate goal is to generate rich contextual information based upon which adequate and effective health systems' strengthening interventions can be developed.

We do not intend to present a one size fits all model to evaluate governance. We recognize that health systems are complex and can vary significantly from case to case, so that the specific arrays of institutions and actors impinging on any given governance related outcome are impossible to determine beforehand. For this reason, more than a universalistic recipe to carry out governance assessments, we present a methodological approach that is based on theory and clear analytical definitions, which can be applied and modified by the researcher depending on the particular circumstances in each case.

¹ One of the major challenges to assess governance in the health systems of low income countries is that empirically it is almost impossible to distinguish the degree to which observed poor performance may be attributable to weak governance, technical inefficiencies or simply to lack of sufficient financial resources.

² Most of these frameworks are designed to provide a general overview of the state of key governance indicators across entire health systems. This type of approach is useful for comparative analysis, to rank or categorize countries, or to track changes in governance performance through time.

The development of this framework begins with the acknowledgement that substantially different definitions and approaches to governance exist across disciplines. In the international development community the emphasis tends to remain centred on the concept of good governance, which is usually preoccupied with adequate formal and technical prescriptions to improve the performance of the public sector (UNDP 2011, World Health Organization 2011, World Bank 2007, Ruger 2007). In academia, however, governance is increasingly conceptualised in terms of the informal but structured and systematic interactions of actors (often non-state actors), which yield collective solutions to specific needs (Booth 2011, Benz et al. 2007, Draude 2007, Foerster and Koechlin 2011). In our work, we believe strongly that both perspectives shed light into important dimensions that affect the performance of health systems. Therefore, it is important to work towards implementable research tools that bring together the strengths of both disciplines as a necessary first step to begin conceptualising more effective avenues for health systems strengthening.

This article is organized as follows. Section II describes the proposed analytical framework for governance of health systems. Section III describes how the framework can be applied to assess the formal and informal institutions of the health system from a structured governance perspective across different levels of analysis. Section IV reflects on remaining methodological challenges and on future directions to continue the development of theory and tools for advancing the understanding of the governance of health systems.

2. An analytical framework for assessing governance in the health sector

The analytical approach presented here is based on the conviction that to correctly assess the performance of the formal institutions of the health system in low income countries it is necessary to address both the formal and the informal dimensions underpinning the actions of key stakeholders. In other words, because it is quite evident that sometimes even well designed formal systems fail to work as expected in practice, a comprehensive research agenda should strive to provide insights into where substantial gaps between formal and informal practices may exist. We believe both aspects should be evaluated in unison because formal and informal norms, rules and beliefs are often deeply intertwined in reality. For this reason, we have developed a framework that includes analytical tools to trace the formal and informal elements impacting the governance of health systems.

Because both health systems and governance are broad concepts, we begin by clarifying what is meant by each of these terms and how they are brought together in this framework. The World Health Organization (WHO) has broadly defined health systems as “all organizations, institutions and resources that are devoted to producing health actions” (World Health Organization 2000, Murray and Frenk 2000). In a step to increase analytical clarity, WHO has further advanced the notion that health systems can be disaggregated into six major sub-systems or building blocks: 1. Governance; 2. Financing; 3. Human Resources; 4. Information; 5. Medicines and Technologies; and 6. Service Delivery (WHO, 2007). These categories, while helpful in identifying and tracing key functions that any health system should be able to perform,

nevertheless do not represent mutually exclusive boundaries. Rather, as De Savigny and Adam (De Savigny and Adam 2009) have pointed out, special attention needs to be given to the interactions and relationships among those building blocks. Ultimately, it is those dynamic linkages that make up the system because in practice all building blocks affect each other and need each other to produce the desired outputs. Because of the interconnectedness of the building blocks, rather than advocating the analysis of the different functions of health systems, we find it more useful and empirically relevant that the point of departure for the analysis be one previously identified governance related shortcoming of the health system and to then trace its causes across the different building blocks. As our framework explicitly concerns governance of health systems we view governance as a cross cutting dimension across all other building blocks, with service delivery providing the central outputs of the system and the other building blocks providing the required inputs.

With regards to the field of governance studies, there is a very diverse understanding of the concept depending on which discipline one looks at (Chhotray and Stoker 2009). For this framework we adopt an approach to governance that draws from both political economy and sociology research as well as from the more pragmatically oriented international development organizations.

From political economy and sociology we derive our interest in the rules through which different societies arrive at collective decision making and therefore we adopt a non-normative definition of governance such as that by Brinkerhoff and Bossert (2008, 3): “Governance is about the rules that distribute roles and responsibilities among societal actors and that shape the interactions among them.” The rules may be formal or informal, written or unwritten, but their centrality lies in that they provide incentives and constraints to certain types of behaviour to the relevant actors and stakeholders. As applied to health systems this understanding of governance refers to the institutions that define and regulate the processes through which health systems manage human resources, acquire and distribute medicines and technologies, generate and disseminate information, and provide means to finance the provision of health services to the population.

From the leading organizations in international development and health we share the interest not just in the rules formally governing health systems, but also in how those rules are actually implemented. The assumption is that when formal rules and processes are defined and implemented correctly social outcomes should be improved.

One of the first challenges to empirical governance research arises while seeking to operationalize the term governance into dimensions and indicators that are measurable (Grindle 2007).³ A review of the literature makes it clear that different organisations give emphasis to different governance dimensions. Table 1 provides an overview of several of the many elements that have been associated with public governance according to different institutions.

³ For example, some authors addressed this problem by using one single dimension, such as corruption, as a proxy for overall governance (Lewis 2006).

Table 1 Relevant governance dimensions according to different institutions⁴

Institution	Dimensions of Governance	
World Bank Institute (Worldwide Governance Indicators, WGIs)	<ul style="list-style-type: none"> • Voice and Accountability • Political Stability and Absence of Violence • Government Effectiveness 	<ul style="list-style-type: none"> • Regulatory Quality • Rule of Law • Control of Corruption
United Nations	<ul style="list-style-type: none"> • Participation • Rule of Law • Transparency • Responsiveness • Consensus Orientation 	<ul style="list-style-type: none"> • Equity • Effectiveness and Efficiency • Accountability • Strategic Vision
Overseas Development Institute/ World Governance Assessment	<ul style="list-style-type: none"> • Participation • Fairness • Decency 	<ul style="list-style-type: none"> • Accountability • Transparency • Efficiency
Mo Ibrahim Foundation/ Ibrahim Index of African Governance	<ul style="list-style-type: none"> • Safety and Rule of Law • Participation and Human Rights 	<ul style="list-style-type: none"> • Sustainable Economic Opportunity • Human Development

We nevertheless find this approach unsatisfactory because, however important each of these principles may be, at closer examination it seems quite unlikely that any could be plausibly considered as a stand alone category. Rather, we make two assumptions with regards to these governance dimensions: first, that not all of them share the same qualitative nature, so it is not possible to establish comparability among them on a basis of equal assumptions and, second, that many of these frequently cited dimensions of governance are in fact closely interrelated. We believe that categorizing these dimensions and providing theoretically informed presumptions about causality links among them is a first step to give governance analysis greater explanatory power and to therefore increase its potential for having empirical applicability.

Thus, for analytical purposes we have divided the components of good governance into three groups:⁵

⁴ Sources: World Bank at <http://info.worldbank.org/governance/wgi/index.asp>, United Nations at www.unescap.org/pdd/prs/ProjectActivities/Ongoing/gg/governance.asp, ODI at www.odi.org.uk/work/projects/00-07-world-governance-assessment/Framework.html, Mo Ibrahim Foundation at www.moibrahim-foundation.org/en/section/the-ibrahim-index.

⁵ We make a conscious decision to not include as desirable features of governance overtly political considerations (such as political stability and violence) for several reasons. First, because they are qualitatively different to our understanding of what dimensions of governance are since they are not attributes of governance but rather background conditions that predispose, or explain governance performance (they are explanatory rather than dependent

1. **Governance inputs:** these refer to how and by whom are the institutions and rules governing the health system constructed. Analysing governance inputs entails answering the following questions: Who are the stakeholders involved in defining and designing health policy? (participation) To what extent do government and state officials cooperate with or involve other stakeholders in terms of goal setting and policy design for public health decisions? (consensus orientation). Are the institutions of the health system set up in a manner conducive to the attainment of the health policy goals? (strategic vision and systems design). The importance of governance inputs cannot be underestimated because even impeccable execution of faulty policies will fail to bring adequate benefits to the population. Properly addressing the health needs of a population requires a complex mix of medical, scientific, technical, political and organizational requirements and skills to come together. Therefore, coherent policy design backed by sound evidence, technical expertise and cooperation or consultation with relevant stakeholders is an essential prerequisite for successful public sector performance.
2. **Governance processes:** these are basic attributes characterizing the implementation of the rules and administrative procedures governing the health sector. They refer to the manner in which operations and regulations are executed and can be assumed to have important **implications** for the quality of the outcomes produced. The governance processes emphasized in this framework are accountability, transparency and control of corruption, all three of which are closely interrelated. The presumption being that, if accountability is improved, then corruption is diminished and agents are induced to be transparent in their actions.⁶
3. **Governance outcomes:** these refer to positive qualities that health system outputs should generate once rules and processes have been **designed** and implemented. They are criteria that can be used to assess the social desirability of health services because the ultimate goal of health systems is to have a significant positive impact on the well being of the population based on their health needs. The governance associated health system outcomes that are emphasized in this framework are: responsiveness of the health system to the needs of the population, equitable access of all groups to health services, and efficiency in the use of resources.

Figure 1 illustrates the categorization of governance dimensions discussed above, shown against the backdrop of the interlocking building blocks of health systems. The illustration suggests some of the key relationships and interactions involved in the governance of public health service delivery.⁷

variables). Second, their inclusion contributes to a perpetuation of the view of governance assessments as normative impositions.

⁶ The centrality of accountability in determining governance outcomes has extensively been acknowledged in the literature. See for example, (Paul 1992), (Brinkerhoff and Bossert 2008), (Lewis and Pettersson 2009), (Hammer, Aiyar, and Samji 2007), (George 2003).

⁷ It should be noted that this model is not intended to illustrate governance as a purely linear process. Like any system, its different components act, react and interact with and to each other (De Savigny and Adam, 2009). Governance

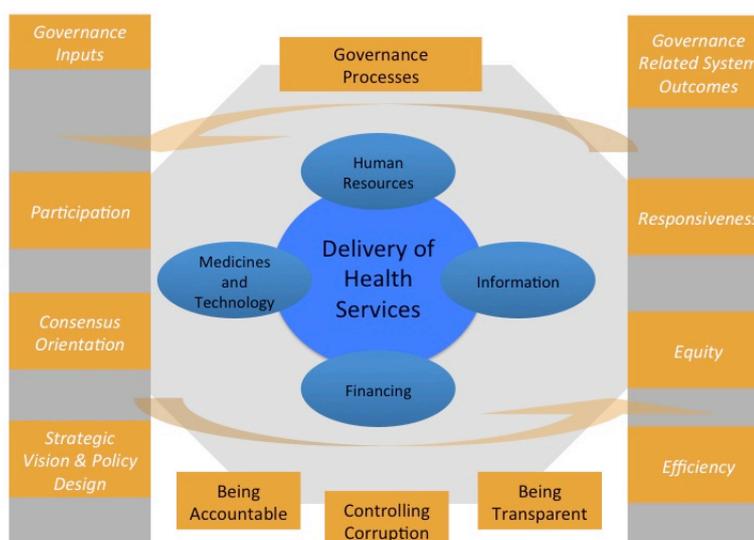


Figure 1 Key governance dimensions and interactions across health systems

In this framework we want to underscore the idea that to adequately assess governance inputs and processes it is crucial to take into account both formal and informal elements that affect health systems performance. Because formal rules governing the health system are in many cases not effectively applied in spite of adequate formal regulations, it is critical that a methodology to assess health system performance should include an understanding of informal institutions and actors (Jacobs 2011).

The importance of informal institutions in relation to the state in developing countries has been extensively researched and described from a variety of approaches (Jacobs, 2011).⁸ Here we advocate an approach that is based on a power and influence analysis that helps to reveal discrepancies between formal and informal decision making power and accounts for how different forms of political regimes and legitimation modes can have an impact on observed governance performance of health systems.

3. Application of the governance of health systems framework

The framework involves assessing health policies and strategic institutional design (governance inputs), and performing an accountability evaluation (governance processes) at critical institutional

structures affect behaviour, which in turn affects the structures and system outcomes affect successive inputs. With a recognition that these complexities and the limitations that any two-dimensional model poses to conveying a real life situation or process this figure merely illustrates the variety in governance dimensions and their qualitative differences.

⁸ This has given light to notions such as ‘economy of affection’ (Hyden 2006), ‘strong societies and weak states’ (Migdal 1988), ‘politics of the belly’ (Bayart, Ellis, and Hibou 1999) (Bayart 1993).

junctions with an emphasis in understanding both the formal and informal determinants underpinning the quality of governance. The ultimate goal is to generate insights into possible routes to improve health systems outcomes such as responsiveness, equity and efficiency. The analytical tools to implement this approach involve combining institutional and stakeholder mapping with rational choice assumptions.⁹ The data collection methods include a desk review phase, and two rounds of interviews with relevant stakeholders. This section begins with two clarifications on theory and methods and then presents detailed steps to implement our proposed governance of health systems assessment.

Firstly, to make best use of the framework we suggest a problem-driven approach; with the starting point for the analysis being a particular issue of concern (or tracer) related to health system performance. Therefore, our approach does not involve mapping the entire array of institutions and stakeholders in the health system but only those that have a direct link with the outcome of interest, allowing for a more detailed understanding of the main problems at stake.¹⁰

Secondly, as is widely acknowledged, stakeholder maps are not neutral tools (Aligica 2006). Rather, very different stakeholder maps can be constructed depending on which dimensions and characteristics of the stakeholders are highlighted, the choice of which should be driven by clear and sound theoretical considerations. In this case, rational choice assumptions have been chosen because they are useful to reveal informal linkages, for example by prompting the researcher to inquire about sources of power, sources of support as well as sources of revenue and benefits for different stakeholders. The rational choice approach helps to analyse incentives for different stakeholders in a way that reveals how implementation of rules and regulations as well as enforcement of formal accountability lines may be distorted by incentives to serve the interests of those agents that have decision making power affecting the stakeholders' career path and material benefits.¹¹

⁹ The underlying notion is that institutions (formal and informal) play a substantial role in shaping behaviours (North 1990) and that institutionalism can fruitfully be complemented with assumptions about individual service providers and public sector employees who, as rational actors, will seek to pursue the course of action that better promotes their personal interests. More concretely, politicians can be expected to prefer strategies that either perpetuate or strengthen their political power (including the institutional clout of their organization within the structures of the state and government), while bureaucrats and health sector workers can be expected to follow strategies that maximise their expected income and career advancement prospects. See (Scharpf 1997) for an extensive description of how this combination can be implemented.

¹⁰ For example, assuming the tracer issue is continued stock out rates of essential medicines in public health facilities, the pertinent institutional/stakeholder mapping would be of the public sector medicine supply chain.

¹¹ Rational choice assumptions also help to underscore that successful intervention design should be underpinned by an understanding of the motivations and interests of major stakeholders involved to improve success and sustainability. Furthermore, stakeholder analysis that acknowledges context-specific realities permeated by different interests, values and traditions may unveil informal power structures when real decision-making power is actually exercised outside or instead of the formal legal-regulatory framework (Nash, Hudson, and Lutrell 2006, Boesen 2008, Olivier de Sardan 2009, Kelsall 2008, 2009).

The application of our framework to assess governance in health systems involves three steps to compile and analyse information to evaluate governance inputs and processes as discussed above.

1. Desk review covering the literature on the case with the following three aims:

- a. Gaining an understanding of the basic features of the political context.

To adequately frame the rational choice elements of the analysis into a correct interpretation of the incentives and constraints to action faced by major actors in a health system it is necessary to take into consideration the contextual peculiarities of the political environment, including type of political regime and modes of political legitimation. Clearly, stakeholders' power and influence will be expressed differently in a context characterized by democratic elections, political freedoms and effective law enforcement than in a context characterized by authoritarian, patrimonial traits, where popular mobilization tends to be discouraged and enforcement of the law is weak or merely a tool for particularistic power-building. Keeping in mind concepts such as neo-patrimonialism and clientelism can help to better understand informal power linkages. Clientelist and patronage networks are common mechanisms through which neo-patrimonial regimes often legitimise themselves in power and distribute tangible benefits to their constituencies. Often, they pervade, partly replace, or distort formal but ill-functioning institutions of democratic representation.¹² Clientelist networks can pervade politics and society to the extent that they often come to be regarded as the only means to access supposedly public services (see for example Auyero 2001).

Specific questions on political context to be researched include:

- How can the political regime be characterized?
 - What mechanisms of political legitimation are prevalent?
 - How is civil society organized and incorporated into the system?
 - What is the distribution of effective political power?
- b. Drafting a first version of an institutional/stakeholder map based on the formal institutional organization as well as main rules and regulations governing the system in the issue area of interest.

The fact that health systems in developing countries frequently have close ties to international funding and development agencies means that the institutional mapping will involve agencies and actors (state and non-state) at the international, national as well as local level. Appendix 1 provides a stakeholder identification and characterisation tool that

¹² The concept of neo-patrimonialism is inspired by Max Weber's ideal type tripartite classification of authority, referring to the coexistence of patrimonial and legal-bureaucratic elements constituting the state (Bratton and van de Walle 1997, Brinkerhoff and Goldsmith 2002, Eisenstadt 1972, Clapham 1985, Medard 1982, Jacobs 2011). In this framework it serves to describe a general state of politics in which informal power networks, including but not limited to clientelist relations, thrive within the formal institutions of the state (Siddiqi et al. 2009, 6).

outlines the parameters to what information is to be collected on each stakeholder.

The mapping exercise should be a starting point to investigate the following issues:

- Where are the critical institutional junctions in the system where governance concerns pose the greatest systemic risks? These refer to particular positions within an institutional arrangement where governance weaknesses have the greatest impact on systemic performance. Or in other words, areas in which governance weaknesses have an essential impact on the entire process.
 - Who are the most powerful and influential stakeholders whose actions have a decisive effect on performance? The power and influence can be expressed as the ability to change the system, to delay changes to the system, or to disrupt system performance.
- c. Compiling a preliminary list of relevant stakeholders who should be interviewed.

2. First round of interviews

The first round of interviews with the identified stakeholders has two distinct goals:

- a. Validation of the institutional and stakeholder map
- b. Compilation of the perceptions of different stakeholders on the distribution of effective power and influence across the influence area.

An example of an interview questionnaire that would be relevant to obtain the information described above for an assessment of a medicine supply chain is presented in Appendix 2.

Together, steps 1 and 2 provide information to assess governance inputs (who and how participates in the system, strategic vision, systems and policy design). After the first round of interviews the researcher should be able to do the following:

- Fill out the stakeholder identification and characterization tool.
- Identify the critical institutional junctions for governance risks.
- Identify systemic flaws. Health systems are complex and may evolve out of piecemeal reforms through time, sometimes leading to systemic design problems such as duplication of functions or conflicting mandates across state agencies.¹³
- Identify inconsistencies between formal and informal division of roles, decision making power and accountability lines.
- Identify stakeholders at the critical institutional junctions that should be interviewed (or re-interviewed) for the accountability analysis.

¹³ See (Booth 2010) for a discussion of institutional design flaws in Sub Saharan African cases.

3. Second round of interviews

The second round of interviews is intended to focus on the actors situated in critical institutional junctions. The primary aim of these interviews is to carry out a comprehensive assessment of the conditions necessary to hold key stakeholders accountable for their performance. This assessment entails researching two different aspects shaping the incentives and constraints facing key stakeholders.

- First, the formal components that are necessary for effective accountability to be enforced: clarity of mandate, availability of adequate resources to carry out the mandate, monitoring, and enforcement of sanctions for non-compliance.¹⁴ The goal is to determine relative strengths and weaknesses in the institutional and regulatory framework that have a potentially adverse impact on the incentives of sector officials and health care providers.
- Informal incentives to serve the interest of agents or constituencies other than the ones to which the agent should be formally accountable to. This analysis is an extension of the previous one described in step 2 and has the intent to further assess whether formal accountability lines reinforce or rather conflict with informal power structures.

An example of an interview questionnaire designed to shed light into these issues can be found in Appendix 3.

Insights from the accountability assessment may suggest different interventions depending on the sources of major weaknesses identified. For instance, the policy implications will be quite different if the system experiences problems due to: a) staff lacking information on duties and responsibilities; or b) staff lacking the necessary resources to carry out the mandate properly; or c) low incentives of staff to perform due to lack of monitoring; or d) there is information about deviations from performance targets but these go unsanctioned. Alternatively, at the informal level it is important to be aware of whether observable governance weaknesses are in fact an expression of power relations that distort the incentives of agents to pursue the formal goals required of them by the rules and regulations governing their positions.

4. Concluding remarks

This paper contributes to the understanding of governance in the health systems of low-income countries by providing a practical conceptual framework to carry out assessments that may aid in developing better-informed reforms and interventions. In bringing forward this approach, we want to convey the strong belief that to improve performance in systems as complex as those governing the health sector, it is necessary to understand governance as a multidimensional concept and that among its different dimensions there are linkages and trade-offs to be considered.

¹⁴ (Baez-Camargo 2011) provides a detailed discussion of the elements needed for effective accountability to be implemented, as well as of the challenges involved in enforcing accountability in the specific case of public health services.

Thus, we argue for a problem-driven approach that, while ultimately searching for practical answers, also acknowledges the interconnectedness of actors and functions in health systems across different levels of analysis. While recognizing the importance of addressing formal governance, the approach also underscores the relevance of informal institutions and stakeholder networks as significant phenomena affecting public governance processes, especially in many low-income countries.

The implementation of the framework is based on an evaluation of governance inputs and processes with due attention to the influence of informal institutions and networks on performance.

In developing this framework, we have made a conscious effort to develop an approach that incorporates some of the most meaningful lessons stemming from academic research while at the same time striving to retain the pragmatic quest for applicability that characterizes the work of the development community. The mechanism connecting both approaches has been to give emphasis to how institutions and norms (formal and informal) influence the choices available, and therefore the behaviours, of key actors in health systems.

In any context a mix of formal and informal incentives pervade the every life choices of people. But, especially where multiple sets of norms and rules coexist in strong competition for shaping the incentives of public officials, the methodological challenge becomes greatest. For the researcher, the task is to firstly, correctly identify the set(s) of norms defining the alternative routes of actions open to the decision maker and, secondly, develop criteria to understand under which circumstances one or the other set of rules prevails in determining observed outcomes. This should be seen as an important aspect of theory development to be addressed in future work but it is also clear that the relative merit of any methodological approach will only become evident once it has been validated by its empirical usefulness after being tested in field research. This working paper is therefore first of all a contribution on the conceptual side of the dialectic process of dialogue between theory and practice.

References

- Aligica, Paul Dragos. 2006. "Institutional and Stakeholder Mapping: Frameworks for Policy Analysis and Institutional Change." *Public Organization Review* 6 (1) (March): 79-90. doi:10.1007/s11115-006-6833-0.
- Auyero, J. 2001. "The Logic of Clientelism in Argentina: and Ethnographic Account." *Latin American Research Review* 35 (3): 55-81.
- Baez-Camargo, Claudia. 2011. Accountability for Better Healthcare Provision: a framework and guidelines to define, understand and assess accountability in health systems. *Working paper No 10, Basel Institute on Governance*; available at www.baselgovernance.org/publications.
- Bayart, J.F. 1993. *The State in Africa: The Politics of the Belly*. New York: Longman.
- Bayart, J.F., S. Ellis, and B. Hibou. 1999. *The Criminalization of the State in Africa*. Bloomington: University of Indiana Press.
- Benz, A., S. Lutz, U. Schimank, and G. Simonis. 2007. *Handbuch Governance, Theoretische Grundlagen und empirische Anwendungsfelder*. Wiesbaden: VS VERLAG FÜR SOZIALWISSENSCHAFTEN.
- Boesen, N. 2008. Analysing and Addressing Governance in Sector Operations. European Commission, Tools and Methods Series. Reference document 4, November.
- Booth, David. 2010. Towards a theory of local governance and public goods' provision in sub-Saharan Africa. Africa Power and Politics Programme working paper 13.
- . 2011. Working with the Grain and Swimming Against the Tide. Africa Power and Politics Programme Working Paper 18.
- Bratton, M., and N. van de Walle. 1997. Neopatrimonial Rule in Africa. In *Democratic Experiments in Africa: Regime Transitions in Comparative Perspective*, 61-96. Cambridge: Cambridge University Press.
- Brinkerhoff, D.W., and T. Bossert. 2008. Health Governance: Concepts, Experience, and Programming Options. U.S. Agency for International Development, Health Systems 20/20, Policy Brief., February.
- Brinkerhoff, D.W., and A. A. Goldsmith. 2002. Clientelism, patrimonialism and democratic governance. ABT Associates Inc.
- Chhotray, V., and G. Stoker. 2009. *Governance Theory and Practice. A Cross Disciplinary Approach*. Hampshire: Palgrave Macmillan.
- Clapham, C. 1985. *Third World Politics: An Introduction*. London: Routledge.
- Draude, Anke. 2007. How to Capture Non-Western Forms of Governance. In Favour of an Equivalence Functionalist Observation of Governance in Areas of Limited Statehood. SFB-Governance Working Paper Series, No.2.
- Eisenstadt, S.N. 1972. *Traditional Patrimonialism and Modern Neopatrimonialism*. London: Sage Publications.
- Foerster, Till, and Lucy Koechlin. 2011. The Politics of Governance: Power and Agency in the Formation of Political Order in Africa. Basel Papers on Political Transformations No. 1, University of Basel, Institute of Social Anthropology.
- George, A. 2003. Accountability in Health Services: transforming relationships nad contexts. Harvard Centre for Population and Development Studies, Working Paper Series 13(1). <http://www.who.int/management/partnerships/accountability/accountabilityhealthservicespdf.pdf>.

- Grindle, M. S. 2007. "Good enough Governance Revisited." *Development Policy Review* 25 (5): 533-574.
- Hammer, J., Y. Aiyar, and S. Samji. 2007. "Understanding Government Failure in Public Health Services." *Economic and Political Weekly* 42 (40): 4049-4057.
- Hyden, G. 2006. *African Politics in Comparative Perspective*. Cambridge: Cambridge University Press.
- Jacobs, E. 2011. Basic Services and Informal Power: An Analytical Framework for Sector Governance. In *Informal Networks, Clientelism and Corruption in Politics, State Administration, Business and Society: case Studies from Central and Eastern Europe Series*. Hannover: Ibidem Verlag.
- Kelsall, T. 2008. Going with the Grain in African Development? Africa Power and Politics Programme Discussion Paper 1.
- . 2009. Game-theoretic models, social mechanisms and public goods in Africa: a methodological discussion. Africa Power and Politics Programme Discussion Paper 7.
- Lewis, Maureen. 2006. Governance and Corruption in Public Health Care Systems. Working Paper 78, Center for Global Development, Washington.
- Lewis, Maureen, and Gunilla Pettersson. 2009. "Governance in Health Care Delivery: Raising Performance." *SSRN eLibrary* (October 1). http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1492554.
- Medard, J.F. 1982. The underdeveloped state in tropical Africa: Political clientelism or neopatrimonialism? In *Private patronage and public power: political clientelism in the modern state.*, 162-192. London: Frances Pinter.
- Migdal, J.S. 1988. *Strong societies and weak states: state-society relations and state capabilities in the third world*. Princeton: Princeton University Press.
- Murray, C.J.L., and J. Frenk. 2000. "A framework for assessing the performance of health systems." *WHO Bulletin* 70 (6): 717-731.
- Nash, R., A. Hudson, and C. Luttrell. 2006. Mapping political context: a toolkit for civil society organisations. Research and Policy Development Programme, Overseas Development Institute.
- North, D.C. 1990. *Institutions, institutional change and economic performance*. Cambridge: Cambridge University Press.
- Olivier de Sardan, J.P. 2009. Research on the practical norms of real governance in Africa. Africa Power and Politics Programme Discussion Paper 5.
- Paul, S. 1992. "Accountability in public services: exit, voice and control." *World Development* 20 (7): 1047-1060.
- Ruger, J.P. 2007. "Global Health Governance and the World Bank." *The Lancet* 370 (9597): 1471-1474.
- De Savigny, D., and T. Adam. 2009. *Systems thinking for health systems strengthening*. Geneva: Alliance for Policy and Systems Research, WHO.
- Scharpf, Fritz W. 1997. *Games real actors play: actor-centered institutionalism in policy research*. Boulder, Colorado: Westview Press.
- Siddiqi, Sameen, Tayyeb I. Masud, Sania Nishtar, David H. Peters, Belgacem Sabri, Khalif M. Bile, and Mohamed A. Jama. 2009. "Framework for assessing governance of the health system in developing countries: Gateway to good governance." *Health Policy* 90 (1) (April): 13-25. doi:10.1016/j.healthpol.2008.08.005.
- UNDP. 2011. Good Governance and Sustainable Human Development. A UNDP policy document. <http://mirror.undp.org/magnet/policy/chapter1.htm>.

- Vian, Taryn, William D. Savedoff, and Harald Mathisien. 2010. *Anti-corruption in the Health Sector: Strategies for Transparency and Accountability*. Boston: Kumarian Press.
- World Bank. 2007. Strengthening World Bank Group engagement on governance and anticorruption. <http://siteresources.worldbank.org/EXTPUBLICSECTORANDGOVERNANCE/Resources/GACStrategyPaper.pdf>.
- World Health Organization. 2000. World Health Report 2000, Health Systems: Improving Performance. <http://www.who.int/whr/2000/en/index.html>.
- . 2011. website on Good Governance for Medicines. www.who.int/medicines/ggm/en/.

Stakeholder identification and characterization tool

Organization Name:

Relevant individual name and position (if applicable)

- Position in institutional Map:
 - Mandate:
 - Main Responsibility in the medicine supply chain
 - To whom is this actor/ organization formally accountable?
 - How does the stakeholder influence the public sector medicine supply system?:
- Resources/power:
 - Access to or control over support mechanisms:
 - Control over budget
 - Ability to mobilize political constituencies
 - Access to/ support from high level political decision makers
 - Visibility/Voice
 - Legitimacy (elected office, standing in community)
 - Access or control over sanctions
 - Law enforcement capabilities
 - Ability to withdraw political support
 - Decision making power over human resources (hiring, firing, career promotions)
 - Decision making power over salaries and financial incentives
 - Veto power

Incentives

- Who decides over remuneration and material rewards for this actor?
- Are these decisions made using clear criteria?
- Who decides over career prospects for this actor?
- Are these decisions made using clear criteria?
- Are formal accountability provisions in place?

Summary:

Critical decision node in system?

Interest in issue area:

Power:

Yes/No

High/Low

High/Low

Sample semi-structured interview questionnaire for stakeholders in a public sector medicine supply chain assessment

Show institutional map. Ask for comments and validation.

Based on that ask following questions:

- How would you characterise the performance of the public sector medicine supply chain?
- Which actors or organization(s) have greatest **influence** on the overall performance of the public sector medicine supply system in its current state?
 - o Describe the nature of that influence, for example:
 - Control over financial resources
 - Control over procurement processes
 - Control over medicine flows
 - Decision making powers over high level appointments
 - Oversight capabilities
 - Enforcement capabilities
- To whom or to which constituency are those influential actors or organizations most responsive?
- Who or what organization has greater **ability to disrupt** the medicine supply chain?
 - o Describe how that disruptive potential can be characterised, for example:
 - Sidestepping rules and regulations
 - Delaying administrative processes
- Who would be in your view the most powerful players (with greatest decision making power) capable of **inducing meaningful change** in the medicine supply chain?
 - o Describe how is the power of those players expressed:
 - Electoral power, power over sanctions, legislative power, popular support/legitimacy, access to media/voice.
- Who would be in your view the most powerful players (with greatest decision making power) capable of **preventing or delaying meaningful change** in the medicine supply chain?
 - o Describe how is the power of those players expressed, for example:
 - Mobilization of opposition
 - Ability to delay administrative or legislative processes
 - Formal veto power
 - Ability to withdraw political support for reform
- From your perspective, which are the **major governance challenges** affecting the drug supply chain?
- From your perspective, what would be the most **meaningful/ high-impact changes** to significantly improve the performance of the drug supply chain?
- What would be in your view **attainable medium term targets** for improvement in performance of the medicine supply chain?

- What would you envision as **feasible interventions** to tackle those problems?

- How does **your organization influence** performance/outcomes of the public sector medicine supply chain?

Sample semi-structured interview questionnaire for accountability assessment

- What are the responsibilities associated with your position?
- What resources do you receive to carry out the tasks you are required to perform in your position?
- Are those resources in your view commensurate to the mandate?
 - o If not, elaborate
- Is your performance at work monitored?
- If so, by whom?
- Is there a mechanism through which you or your organization can justify decisions, actions and performance?
- Can you explain what sanctions for non-compliance apply to your office/ duties?
- Are sanctions enforced?
- Are incentives to good performance present in any form?
- To whom are you/your area/organization accountable?
- How are remuneration levels determined?
- Who controls salary decisions?
- How are human resources decisions made? Is there a clear career development path with articulated milestones and/or performance targets?