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Claudia Baez-Camargo

Accountability for better healthcare provision: A framework and guidelines to define understand and assess accountability in health systems

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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.

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Claudia Baez-Camargo
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Basel Institute on Governance, Steinenring 60, 4051 Basel, Switzerland
www.baselgovernance.org
info@baselgovernance.org

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Abstract

Strengthening accountability in public service provision is increasingly recognised as a precondition to improve the performance of the health sector in low-income countries. However, progress in this field has been hampered to a great extent because of empirical difficulties in measuring and assessing accountability. This article provides a clear operational definition of the concept and discusses how and why accountability in public health service provision presents distinct challenges to the institutional capabilities of most developing countries. On the basis of both elements a set of guidelines to empirically assess accountability in health services is offered.

About the author

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.

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

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1. Introduction

Governance as a critical factor to improve institutional performance has become an area of interest across many disciplines (Van Kersbergen and Van Waarden, 2004; Chhotray and Stoker, 2009) including public health, where its potential impact in the well being of large segments of the population is enormous (WHO, 2008). However, consensus on meanings and measurements of governance has proved elusive, with many different elements of public function often mentioned as indicators or dimensions of good governance (Grindle, 2007; Baez-Camargo et al., forthcoming). Among these elements, accountability is increasingly regarded as a key lever for reform (George, 2003; Brinkerhoff, 2004; Hammer et al, 2007; Lewis and Pettersson, 2009), one that when targeted can generate important spill over effects into the other elements associated with good governance.

This paper argues for and develops in detail the idea that accountability is a key target for governance strengthening interventions in health systems. The premise is that, when accountability is strengthened and improved upon, the opportunity space for corruption to take place is diminished and governance outcomes of the health system such as responsiveness, equity and efficient use of resources are also affected positively.

Accountability, however, suffers at the expense of its own success. Its exact meaning has remained a contested issue, with an ensuing proliferation in interpretations, definitions, uses, misuses and abuses of the concept (see Linberg, 2009 for an excellent literature review of this phenomenon). One of the main reasons for this state of confusion is that accountability is a complex concept and, as such, hard to pin down. It is prone to conceptual stretching (Sartori, 1970) and this, in turn, generates lack of analytical clarity and serious problems as to how to deal with accountability in empirical analyses.

Accountability is indeed a broad concept that covers and permeates a vast array of relationships involving power and decision making authority across sectors and organizational strata of society and government. However, that does not mean that the obstacles to adequately define and operationalize this concept cannot be tackled in a systematic manner.

The goals of this paper are threefold: a) to contribute an operational definition of accountability that takes into account its different dimensions, b) to discuss the main institutional challenges to accountability involved in the provision of public health services and, with that as a basis, c) to propose general guidelines for a better empirical application of this concept. These guidelines to empirically assess accountability are expected to help in pinpointing when and why accountability relations in the health sector may be weak and are therefore potentially useful as a tool for intervention design in health systems strengthening.

In this paper attention is paid mainly to the case of low-income countries, where urgent health needs often coexist with less than optimal governance conditions in the public sector. The arguments will

focus on institutional requirements for better accountability in public healthcare provision. This represents a first step in conceptualizing routes to improve health system performance.[1]

Finally, it should be noted that assessing accountability is not understood as an end in and of itself. It should be an important part of a broader toolkit for assessing quality of governance and should be taken into consideration alongside other critical governance dimensions (for example strategic vision and policy design) that also have a substantial impact on governance outcomes such as responsiveness, equity and allocative efficiency which are the ones that ultimately have a direct effect on the social impact of public health service provision.

2. Definition of accountability and components

Following Lindberg (2009: 5) accountability can be understood as one of several concepts that fall under the more general category of 'methods of limiting power' (of which others are devolution of power, violence, economic pressure, public shame, and so forth). Specifically, accountability necessarily involves decision-making power that is delegated, and the means to prevent the misuse or abuse of such power.[2]

Accountability is here defined as a process within a principal-agent relationship[3] through which the behaviour and performance of the agent is evaluated against predetermined standards by the principal and where misdeeds are sanctioned.[4] When applied to public service provision, accountability can be understood as 'the spectrum of approaches, mechanisms and practices used by the stakeholders concerned with public services to ensure a desired level and type of performance' (Paul, 1992: 1047).

Following the World Bank's seminal (2004) discussion, there are five components that need be present for accountable relations to take place in public governance: delegation, financing, performance, information about performance, and enforceability. By defining accountability in the above manner and spelling out these components, it becomes clear that several distinct steps need to be taken in order to achieve an accountable agent-principal relationship. Figure 1 illustrates the

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1 However, it should also be acknowledged that, especially in developing countries, informal institutions and networks often play a role in shaping behaviours and decisions that affect the degree to which stakeholders in health systems are accountable to each other (for a methodological discussion on how to evaluate informal accountability relationships see Jacobs, forthcoming).

2 Though it could be argued that mutual accountability, as seen between donors and recipient countries, does not necessarily imply such vertical subordination.

3 A principal-agent relationship refers to the arrangement that exists when one person or entity (called the agent) acts on behalf of another (called the principal).

4 Though in this broad sense accountability is a concept that can be applied to any relationship where a delegation of functions is involved, within the discussion of accountability as a governance attribute the attention here goes to the often political and power-laden relationships among citizens, politicians and government officials, and providers of public services.

components for achieving accountability in a principal-agent relationship

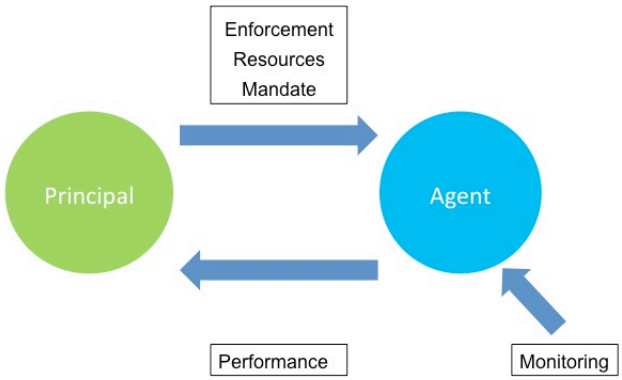

Figure 1 Components for Accountable Principal-Agent Relations, author based on World Bank (2004)

The first step is delegation. This entails that there is an explicit mandate about what is expected from the agent. Communicating the tasks and duties that are delegated to the agent falls within the responsibility of the principal (or a representative of the principal). Defining how public services will be supplied involves clearly specifying duties, expected targets, outcomes and guidelines for the accepted methods to attain them.

Secondly, financing, or availability of resources, is also an essential ingredient for accountability because there must be a minimum of congruence between ends and means when delegating any function. In other words, the principal should endow the agent with adequate and sufficient resources to carry out the mandate. If the agent lacks the means and resources to perform as specified, then a basic foundation in the agent-principal relationship is lacking and enforcing sanctions for lack of compliance would be both unreasonable and unfair.

Third, after the agent has been given a mandate and resources to carry it out, then it is up to the agent to actually perform as agreed upon. The actual results or deliverables from performing the delegated tasks are at the heart of the principal agent relationship.

A separate but equally important component of the accountability relationship is the transmission of information to the principal about how the agent has performed the mandate. This involves monitoring performance and target achievement in a transparent manner (which can be carried out by a third party), but also an active process through which the agent can explain its decisions and justify its actions.

Enforceability comes as the final step on the side of the principal. Once the agent is given a mandate and the resources to carry it out, there also have to be means available to sanction non-compliance and/or wrongdoing for the principal-agent relationship to be meaningful. Without effective enforcement mechanisms and sanctions, accountability is lacking an essential component.

By looking at its different components, it becomes evident that accountability is a multidimensional concept, one that describes an ongoing process between stakeholders involving several qualitatively different steps. Building on from this definition, the following section discusses how accountability can be better understood for the specific case of public provision of health services.

3. The long and short routes: an institutional map of accountability in public health service provision

The health sector is one that naturally suffers from many instances of market failure, especially regarding the needs of the most vulnerable groups in society. For this reason, it is an observable fact that the state across the world is involved, in many different forms and degrees, in the provision of healthcare. However, by its very nature, this role of the state as an intermediary between patients and health service providers generates serious challenges.

Figure 2 illustrates an expanded version of the World Bank's model of accountability in public services. The diagram describes two routes of accountability, short and long.

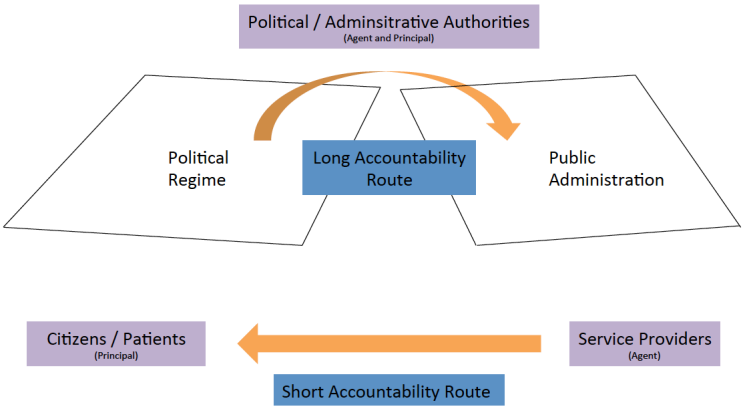

Figure 2 Model for accountability routes in the provision of public health services, author based on World Bank (2004)

The short route, or direct accountability, is where client power is exercised directly, where the principal can effectively enforce accountability in the relationship. An example of direct accountability is provided by competitive market relationships where consumers have access to alternative sources of provision of goods and services. Consumers in that context can hold providers directly accountable because, if they find that the quality of the goods and/or services

provided is not acceptable, they can directly sanction the provider by taking their business elsewhere.

However, as mentioned before, uncoordinated market competition in healthcare can fail to provide these goods and services in socially desirable quantities, especially for the most vulnerable groups. States, therefore, typically take on a large responsibility for the regulation, provision and financing of health services. As Figure 2 illustrates, in this indirect accountability route the policy makers act as intermediaries between the citizens/patients and the providers of health services, thereby creating a two-step process.

The first step involves that the demands and needs of patients be made known to the policymakers so that they can be incorporated into the formulation of policy objectives. This is often captured in the way of political electoral platforms over which political parties compete for votes, but is also closely related to how and by whom the information regarding the health needs of the population is compiled. In other words, this part of the process refers to whether citizens have a say with regards to the public provision of health services, and whether they have the ability to react and to discipline policymakers when and if they fail to fulfil their political mandate. The ability of citizens to bring authorities into account is related to the character of the political regime (degree of democracy or authoritarianism) that operates in any given context.

The second part of the long accountability route involves the process through which the authorities implement the policies and regulations to address the health needs of the population and ensure that service provision is performed in a satisfactory manner. This is related to public administration and the manner in which the public institutions of the health sector are setup.

The long and short routes present different and substantial challenges to the implementation of accountable provision of public health services, especially in the case of lower income countries. These challenges are discussed next.

4. The long accountability route: high institutional complexity and stability requirements.

The long accountability route in public services involves two sets of principal/agent actors: with government officials and policymakers being simultaneously agent and principal vis-à-vis the citizens and the service providers respectively. These relationships, on the “regime” side and on the “public administration” side of the public service provision model, are qualitatively different and therefore the accountability mechanisms that are relevant for each are different as well.

On the regime side, accountability involves broad institutional mechanisms through which government officials and citizens interact and which are mostly determined by the political characteristics of each regime. The literature on political regimes and regime transitions is vast and it shows that many different political configurations through which societies interact with their political authorities can emerge out of

complex patterns of historic-cultural trajectories.[5] These political patterns determine who participates and how in the political process and the means through which government officials exercise power. On the public administration side, the accountability relationships between government officials and service providers are mostly determined by processes internal to the state which can be affected by regime type, but may also operate on a different political and technical rationale.

It is important to note that in the case of the provision of public services, the performance component of accountability in the regime side is displaced to the realm of action of a different set of agents; the service providers. Thus, while political authorities should in principle remain accountable to citizens for provision of basic services, the actual delivery is performed by agents who respond to incentives embedded in the public administration side of the long accountability route.

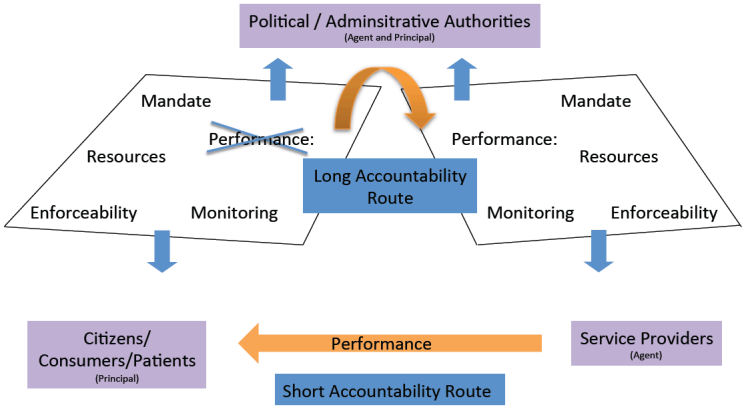

Figure 3 Model for the long accountability route in the provision of public health services, author based on World Bank (2004).

The consequence is that substantial institutional requirements are needed from the public sector and the broader political system for this long accountability route to function properly. Figure 3 illustrates the components for accountable relationships between the relevant sets of principal/agents involved in the provision of health services. This model suggests that accountability in public service provision requires differentiated functional capabilities of the state apparatus, which poses a tremendous challenge to states with weak and/or ill functioning state institutions and bureaucracies. There are at least three reasons for this:

First, the 'long accountability route' increases the institutional space through which public service delivery must take place and thus also increases the probability of breakdown or "government failure" along the way. As Hammer et al. (2007: 4052) point out, there are two types of possible government failure within this framework: 1) when the policymaker does not successfully capture or act in accordance to what people want and need; 2) when policy makers are unable to generate the

[5] The volume of works on political systems, their origins, character and direction is enormous. However, key works relevant to the nature and direction of political regimes in developing countries and democracy in particular should include (Carothers, 1999; Dahl, 1971; Diamond, Linz, Seymour Martin Lipset, 1988; Diamond, 1999; O'Donnell and Schmitter, 1986).

incentives needed for public servants and service providers to appropriately address the interests of the people.

The first type can involve not only cases of lack of responsiveness due to the undemocratic nature of the regime, but also cases where due to failures in adequate data generation and collection the authorities do not possess accurate information of actual health needs among the population.

The second type includes the case where the state lacks the ability to effectively exercise the oversight and monitoring function over service providers as well as where the state lacks the ability to enforce sanctions.

Secondly, the modern state is composed of a highly intricate web of institutions throughout which decision-making power is dispersed. Thus, potential accountability links are abundant. The issue then becomes elucidating which configuration of state institutions is adequate to optimize good, accountable provision of public health services. The current post-colonial state in many developing countries is characterized by highly centralized decision making and restricted democratic practices, which is a combination that poses serious difficulties to the effectiveness of health service delivery.

Where democratic processes are limited or weak, the governments tend to be accountable (if at all) to networks of already privileged actors (capitalists, the landed, labour aristocracy) who can exercise political pressure at the central level. The centralized decision making that often characterises less than democratic regimes works against poor people having voice and being empowered principals, as their entry point to the public health system is with community or district level service providers who have the least incentives to be accountable to them, being all the way down in a centralized decision making structure.[6]

Thus, the question is whether the adequate incentives exist for both government officials and health service providers to be accountable to citizens/patients.

A third challenge to accountable provision of public health services is the need for institutional stability. Accountability is an on-going, dynamic process involving repeated interactions between principals and agents. On the one hand, information needs to flow in both directions with a clear mandate to the agents and information provided back to the principals about the agent's performance. On the other hand, the principal (or a representative of the principal) is required to perform an assessment of whether the observed outcomes are actually in line with the original mandate, including the evaluation of results and whether the proper steps or rules were followed in attaining the results. After that exchange is completed the principal may determine which actions (whether sanctions or rewards) are in order. The fact that this process of information transmission, evaluation and execution needs to be repeated regularly through time places high demands on institutional stability that many regimes in the developing world lack. The question is, then,

[6] This is not to say that the formal structures of the state in developing countries are centralized. Quite the contrary, in countless examples delivery of public health services is extremely decentralized. The argument here is that political decision making power is typically quite centralized in less than democratic countries, which does not promote direct accountability of health service providers to patients in the public sector.

whether there is sufficient stability and continuity in the institutional setup and the actors involved in public health service delivery to allow the process of accountability to take place in an adequate manner.

In sum, the long accountability route in the delivery of public health services necessitates well functioning complex institutional configurations that adequately provide incentives for accountability of decision makers vis-à-vis patients and that are stable.

5. The short accountability route: market failure and enforcement challenges

Because of high demands on institutional performance that full accountability along the long route pose, the case is often made that efforts should be focused on strengthening the short accountability route. This approach, also associated with the concept of social accountability, has been increasingly gaining acceptance among development practitioners (see for example, Agarwal, Heltberg and Diachok, 2009) and involves empowering citizens to enforce accountability directly from providers.

The concept of strengthening the ability of communities and grassroots movements to enforce accountability from service providers makes particular sense in the context of weak state institutions, where reforms to improve and consolidate institutions of the state involve too many uncertainties and can take too long to show results, but where nonetheless urgent health needs demand more immediate action. There are, however, challenges involved in establishing direct accountability links between citizens/consumers and public service providers that should also be taken into consideration. Understanding these challenges requires examining the ways in which direct accountability can be implemented. Paul (1992:1048) has pointed out that there are two main mechanisms through which direct accountability may be exercised: voice and exit.

Voice refers to the ability of patients (customers) to participate or protest to induce service providers to perform. However, for voice to be effective it is necessary that the providers and/or public sector be responsive to begin with. Not surprisingly, the effectiveness of voice as a mechanism to improve direct accountability is directly linked to the incentives and constraints given by the overall institutional framework dictating policymaking and health service provision. The nature of the political regime determines the availability and effectiveness of participatory channels through which patients might be able to express their needs and demands. It also determines the responsiveness of policymakers to discontent at the grassroots level. The degree to which decision making in the public health sector is centralized and the ability of the public sector to enforce its decisions across the public sphere also plays a big part on whether service providers are responsive to patient discontent.

Also, the use of voice can be problematic as a tool to enforce accountability because it can be unequally distributed among the population as a function of income, education and related attributes, biasing the situation against the most vulnerable groups.

Therefore, the effectiveness of voice as a mechanism to strengthen direct accountability hinges on two factors: 1) are the relevant decision makers receptive to participatory methods of demand articulation from patients? and 2) are patients empowered sufficiently to be able to adequately voice their concerns and demands?

Exit refers to whether competing sources of supply for service provision exist and is easily observed in well-functioning markets. Through competition and choice of provider, patients (customers) are able to punish or reward performance directly and effectively; if the good or service is not satisfactory they simply take their business elsewhere.

Exit is a very effective mechanism because it provides immediate enforceability: it involves a very clear and direct sanctioning or punishment to providers who do not perform according to standard. From the providers' perspective, this generates strong incentives to commit to customer satisfaction. Also, exit as an enforcement mechanism in direct accountability has the great advantage relative to the long accountability route that it takes information on performance, monitoring and enforceability to the micro (individual) level, eliminating many of the macro institutional demands on the generation and diffusion of performance information, monitoring, enforceability, and so forth.

However, exit as a means for enforcing accountability in public sector provision can be difficult to attain where the provision of public goods is particularly vulnerable to market failure. As Paul (1992: 1050) also points out: 'Exit is more efficient, and hence more likely to be used in services least affected by market failure whereas voice is relatively more efficient as market failure increases.' As is clear in many instances exit can simply not be an option where resource constraints and/or geographical characteristics impede the ability of patients to access other providers.

Thus the dilemma is the following: where market failure is a problem, empowering patients/consumers through greater participatory channels to articulate their demands and concerns can be a means to improve direct accountability. Voice is, however, a potentially less effective mechanism to establish direct accountability because it does not necessarily involve the ability to enforce a sanction or punishment when performance is not satisfactory and the ability to exercise it can be unequally distributed among the population with a bias against the more vulnerable groups.

For voice to work as a mechanism to improve direct accountability there has to be a) responsiveness on the part of the service providers and/or authorities and b) local groups need be adequately empowered through effective participatory channels as well as accurate information about their rights. These two dimensions in turn, are likely to be related to the institutional rules governing the political and well as the public administration arena.

6. Assessing accountability: methodology and rationale

As it is clear from the preceding two sections, both the long and short accountability routes present distinct and potentially substantial

challenges. Neither one is a priori better than the other from a purely conceptual point of view. Rather, from an implementer's perspective the relevant question is, for a given case, which areas across the two routes present the best opportunities to improve the delivery of health services?

Therefore, in order to assess accountability in public health service provision through both the long and short routes, it is necessary to map out and evaluate the critical institutional junctions in the health sector where accountability provisions are most likely to have a systemic impact on performance, while taking into account the political realities of each case to evaluate the feasibility of potential intervention entry points. This section begins the discussion on how to correctly conduct an empirical assessment of accountability in public health services.

As has been argued above, accountability is not an output or an outcome, but rather a process. This implies that assessing accountability should involve looking at whether the different steps involved in achieving accountability within an institutional relationship are present or not. So far this paper has proposed to define accountability as a dynamic process in a principal-agent relationship that, in order to be effective in public governance, must include five essential components (delegation, financing, performance, monitoring and enforceability). Also, in the previous discussion, the requirements for accountable relationships in public service provision have been reviewed from an institutional perspective, addressing what are the institutional requirements and challenges for accountability to be effectively observed. Building on these two elements this section establishes concrete criteria to evaluate accountability in the provision of public health services.

At the most general level, the aim of the researcher is to evaluate how the institutional status quo fares in terms of making health service provision responsive to patients' needs in an accountable manner. The methodology proposed here involves combining institutional analysis with rational choice assumptions on the behaviour of public officials and service providers (see Scharpf, 1997 for an extensive description of this type of methodological approach).

The methodological emphasis on institutionalism derives from the notion that it is through rules and institutions that incentives and constraints are defined (North, 1990), which make them crucial to consider in any governance framework. Thus the task is to figure out, given the institutional status quo, what are the motivations for the relevant agents to be accountable? In other words, evaluating accountability requires first of all determining to whom public sector employees are accountable according to the existing regulatory framework.

The rational choice approach assumes that service providers and public sector employees will seek to pursue the course of action that better promotes their personal interests subject to the incentives and constraints given by the institutional setting in which they must operate. Therefore, it can be assumed that actors will have clear interests to be accountable to those who have decision-making power over their status, career path or wealth.

The institutional framework, by establishing hierarchies, patterns of interaction as well as rules and responsibilities, conveys already an implied distribution of power among the different stakeholders. It is

important to discern this distribution of power because it unveils who are actually endowed with the decision-making ability to affect the behaviour of key health system actors.

More concretely, to assess the elements that make a difference in making public service providers accountable one could start by assessing enforcement abilities, by asking 1) where and by whom decisions are made regarding the career paths of the providers and state officials and 2) how and by whom decisions are made about the flow of resources and staff remuneration (including how payment is linked or not to performance and how prospective wage increases or bonuses are decided).

The responses to these questions will determine which of the accountability routes (long or short) is most likely to make a difference on service providers´ behaviour. For example, when promotion or remuneration decisions are linked to certain performance standards based on customer satisfaction surveys, then the providers will have stronger incentives to be responsive to patients´ needs. If, on the other hand, citizens´ inputs have no connection to remuneration or hiring or promotion decisions, then the providers will have little incentives to be responsive to patients.

Similarly, one should trace the availability of enforcement mechanisms affecting policy makers by determining who are the relevant groups or actors involved in deciding whether policy makers have enough support to stay in power (individually or in partisan terms) and where the resources that fund state activities mostly come from. While in democratic political regimes accountability to citizens will tend to be higher than in authoritarian regimes, even in more pluralist systems political impact of different groups can vary substantially. Likewise, in more centralized systems the accountability of public officials and service providers is likely to point upwards along the bureaucratic hierarchy towards the national level, whereas in more decentralized systems it is possible for local level officials and policy makers to have closer links to citizens/patients.

7. General guidelines for assessing accountability

As discussed in sections IV and V above, there are considerable institutional requirements involved in attaining effective accountability along the long route and substantial challenges in enforcing direct accountability in sectors like healthcare, which are vulnerable to market failure. The discussion above, however, does not suggest that it is necessary that all components function perfectly across entire regimes and health systems to achieve satisfactory accountability. The argument is that improving accountability in key institutional junctions and among key stakeholders can generate important positive effects across large institutional spaces.

Thus, before presenting the guidelines to assess accountability, it should be clarified that, because the institutional web typically involved with the provision of public services is extensive and complex, the number of potential accountability relations in health systems is enormous. Since modern states are comprised of complex institutional networks, the specific elements that will be relevant for accountable relations in each case will vary depending on the particular issue being looked at as

well as the wider country-specific situation. Therefore, it makes no sense to attempt to map all possible principal-agent relations for accountability assessment. Rather, the present guidelines are presented as a tool that can be applied to the analysis of specific instances or institutional junctions where red flags for governance concerns have been detected.

What is here proposed is a problem-driven approach to the empirical assessment of critical accountability relationships. Because the institutional setup among health systems can vary so much and because each country faces unique challenges, the idea is that the starting point for the analysis be with a recognizable health system issue of concern (for example stock outs of essential medicines or access to antenatal care) and, with that as the focus, perform an institutional mapping of the institutions and agents involved in that specific instance or issue area to determine where the key junctions are where the system is more vulnerable and/or where disruptions have greater potential to generate systems-wide problems. At these junctions the accountability analysis is applied to determine more accurately the underlying problems.

The following set of guidelines aims to provide analytical tools for the researcher to adapt according to the specific issue and context being studied. Figure 4 illustrates some of the different functions that need to be carried out by different branches of the state in the long accountability route, as well as some of the interactions between citizens/patients and providers in the short accountability route. This provides a broad map to look at different institutional provisions governing accountability along the long and short routes, and also helps to unveil key stakeholders who may be actually exercising an influential role in determining who is accountable to whom in the health system. For example, looking at the democratic attributes of the regime, it is possible to determine whether political authorities are sensitive in reacting to public opinion, to certain influential pressure groups, or simply to the inner circle of political elites exercising political power. Similarly, looking at the sources determining the health budget, whether it is national level taxes, local level taxes or international donor funds, can give insights as to whom political authorities and service providers feel they need to respond to.

The elements included in this figure are by no means exhaustive, it is only intended that this figure illustrate some areas within the public sector and health system where major accountability shortcomings may be found.

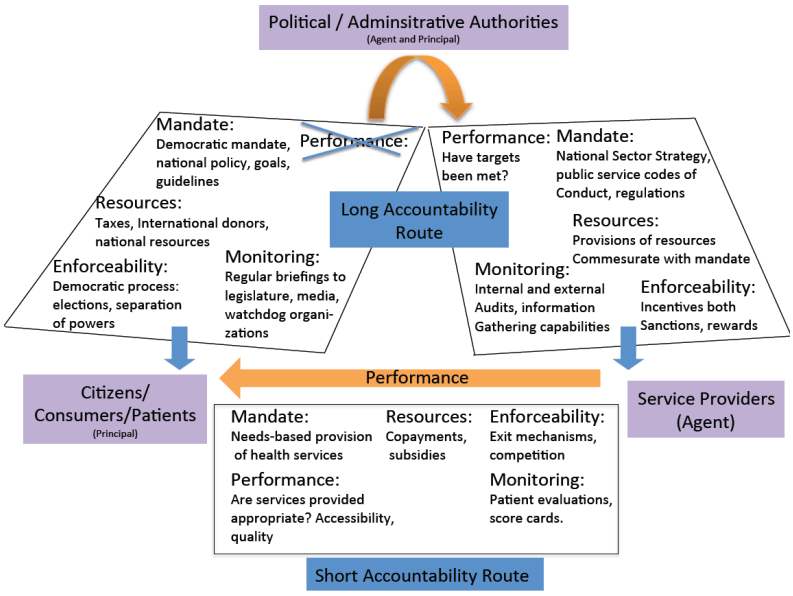

Figure 4 Some functions conducive to promoting accountability along the two routes in the provision of public services, author based on World Bank (2004).

Once critical institutional junctions within the health system have been identified for the issue being researched, a more specific inquiry into the existence of provisions for the five components of accountable relations can be performed. In general, the following points should be taken into consideration when assessing the required components for accountability in a principal/agent relationship:

1) Clarity of the *mandate* is crucial. If the mandate is clear then it can be seen whether it has been correctly funded, can be monitored to see if it has been correctly performed, and a decision can be made about enforcing sanctions. Without a clear mandate the door is open to discretionary power to be misused or abused. So the specific questions to ask include: Is the mandate to policymakers and service providers clear? Is the mandate spelled out in a way that makes goals and the observance of guidelines measurable? Do documents exist with job descriptions that clearly spell out roles, functions and responsibilities? Are agents in key positions aware of what their mandate entails and requires of them? Do they have access to job description and rules and regulations as well as goal setting documents related to their work?

2) Are there adequate mechanisms for financing that mandate? Who controls the budget? What are the main sources for financing health expenditures (for example national taxes, local taxes, insurances or donor funds)? Are the budgeted resources commensurate to the goals of the mandate? Are budgeted funds actually programmed into the disbursement plans of the Ministry of Finance (or relevant funding agency) so that they will be available to the agent in a predictable, timely fashion? Are service providers' remunerations linked in any way to performance and/or patient satisfaction? Are budgeted resources actually transferred and received in the preordained amounts and at the specified intervals?

3) Are there information gathering mechanisms to measure performance and goal attainment that are open and transparent? For example, are services providers required to maintain records of

services rendered, of resources utilized, of days absent from work? Are these records actually kept in an accurate fashion? Is this information then relayed to the principals (or to officials representing the principals) who have the decision making power to evaluate how the mandate has been carried out?

4) Are there transparent monitoring mechanisms to ensure proper behaviour of policymakers and service providers? Here the mechanisms can be multiple and can be internal (the state itself assessing its own performance) such as public audits, or external (external agencies or actors do the monitoring) such as ombudsmen, watchdog organizations, as well as diverse civil society groups and the media. How and to whom are the results and conclusions of the monitoring activities model known? Are monitoring mechanisms operative? Do inspectors show up when they are supposed to? Are there accessible routes for patients to complain/voice their grievances (through the justice system, for example)?

5) Are there mechanisms to enforce disciplinary action when deviations from acceptable behaviour occur? Can government officials be voted out of office? Do service providers face sanctions for failing to attain targets or for acting outside the limits of the regulatory framework? Who is the agent or actor in charge of executing enforcement decisions and what is the information available to this decision maker? Are sanctions actually applied when the circumstances call for disciplinary action to be taken?

6) This exercise aids in evaluating the institutional complexity of the health system in terms of the discussion in sections IV and V, revealing whether there are major legal and institutional gaps that need to be addressed. This analysis can contribute to evaluate not only the mere existence or rules and norms but also their internal consistency for the intended goal of ensuring accountability among key stakeholders. For example accountability can be expected to be higher in situations where those who hold power over career advancement and remuneration also have access to information on performance. If this is not the case, public sector officials will have decreased incentives to act in an accountable manner. In other words, it is not sufficient to generate reliable information on performance, but to ensure that such information is conveyed adequately to those with decision-making power over enforceability.

As part of the institutional assessment, it is important to take into account the degree to which relevant decision-making is centralized. The more centralized decision-making is, the weakest we can assume the incentives of services providers to be receptive and accountable to patients. Accountability links, which are dictated by career and remuneration considerations, will tend to point upwards towards the centralized national level in those circumstances and not in the direction of patients. In these cases, the enforcement abilities of the central administrative decision makers should be strong in order for the long accountability route to be functional.

Also, it should be taken into account that where political instability leads to weak institutional strength it is very unlikely that the repeated and predictable interactions needed to sustain accountability in a principal/agent relationship can be attained. When the key decision makers in the political and bureaucratic spheres have high turnover

rates because of political unrest or instability, the enforcement and monitoring abilities of the state are seriously weakened.

In those cases where the political regime and/or the public administration compact are substantially weak and unstable, where 'government failure' indeed takes place, it is especially relevant to also look at the potential means to strengthen direct accountability.

As discussed in section V, from the perspective of patients/ citizens, the main leverage they tend to have is the threat to exit, and when that is unavailable at least the use of voice to raise awareness and denounce misbehaviours and poor healthcare provision. As discussed above, key to the effectiveness of voice as a direct accountability mechanism are responsiveness of service providers and government officials and empowerment of patients.

The degree of responsiveness of both policy makers and service providers can already be inferred from the analysis for the long accountability route where regime characteristics and sources of funding have been analysed. Additional information on empowerment of patients can be compiled in terms of access to or availability of participatory channels and access to meaningful information on patient rights, and availability and cost of health services.

In sum, the guidelines presented here to assess accountability in the public provision of health services involve a broad mapping of the key institutional features and stakeholders across the short and long accountability routes and performing an accountability analysis evaluating the five components for accountable relations at key institutional junctions. These are guidelines that are meant to be theoretically informed by a sound definition and understanding of the concept of accountability, and still maintain the flexibility to adapt the analysis to each specific case of governance related concerns in the provision of public health services.

8. Conclusion. Accountability and good governance: necessary but sufficient?

Governance is a challenging subject to study and much more so to apply empirically. Yet, it is increasingly acknowledged to be a critical element impacting the success of developing countries' efforts towards reforming their health systems to better address the need of the population. This paper represents an effort to advance the understanding and the empirical applicability of a key governance dimension, accountability, in the specific case of the delivery of public health services.

Given the fact that health systems vary greatly across different countries, what has been proposed here is a set of general guidelines for assessing accountability in the public health system. Thus, it still remains the task of each individual researcher to adapt and tailor the analysis to the specific circumstances of each case.

The guidelines place the emphasis on the assessment of formal institutions of the state and the health system. However, it should be kept in mind that where serious governance concerns exist in spite of a normative framework that is 'technically' conducive to accountable interactions it might be necessary to also evaluate the accountability

relations that exist and take place outside of the formal institutional and regulatory framework. In states with weaker institutional capabilities, gross deviations between rules and observed behaviour can often reflect the importance of informal institutions and relationships.

Finally, a note on the use of accountability analysis within a broader governance research agenda. Accountability is undoubtedly a key element conducive to good governance. Better accountability helps deter corruption and increase transparency in the public sector. However, it should be stressed that accountability, control of corruption and transparency are all attributes of how processes and operations are implemented within established institutions. They say nothing about the 'quality' of the institutional framework itself. That is why also strategic vision in policy making and system design are also hugely important preconditions for good governance outcomes. In other words, an accountability assessment needs be placed in the context of a broader governance analysis to provide a full picture of the challenges to improve on systems performance. Such a governance analysis would include asking questions such as: Does the institutional setup make sense, is it functional and operational? Are social policies that are intended to be redistributive not actually regressive? What is the input of the relevant stakeholders in each policy area for policy design?

Accountability as such is then not an end in and of itself. It is rather a tool to promote, in conjunction with good system and policy design, improved health systems performance that brings benefits to communities in a responsive and equitable manner.

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