UN Capacity Development Workshop on Engaging Citizens to Enhance Public Service Delivery and Strengthen Accountability: Accelerating Progress toward the Millennium Development Goals
Vienna, Austria
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Panel 6, 12 July 2011

Slide 1
Much of my research over the past 10 years has been on the topic of corruption in the health sector, and how to prevent it. The purpose of my presentation is to suggest approaches for building accountability in health care services, especially but not only as a means to prevent corruption. First, I’ll describe why I think it is important to tackle corruption in order to meet the health MDGs, and how accountability and corruption are related. And secondly, I’ll summarize some of the findings from the literature evaluating the effect of public engagement on corruption and accountability.

Slide 2
Health provides us with a special opportunity and a challenge for accountability. People care deeply about health. They see it as precious—it is about life itself. This can be the spark, the issue that makes them willing to engage in accountability work. But on the other hand, the value people put on health makes them more willing to engage in corruption, to pay bribes if that is what it takes to get the medicines or the services they need. As one informant in Albania told me: You must give something to the doctor, because he will never forget the face of someone who has not paid him.1

Power and class differentials between citizens and health care providers can make it hard for average citizens or consumers of health services to hold officials accountable. Technologies like text messaging and the internet are levelers of this power differential. Using these technologies, people can obtain information and voice concerns they might not have an opportunity to say in person, and that can be a good thing for accountability.

Aidspan (www.aidspan.org) is a web site that is worth perusing. I am one of the 7,000 subscribers from 140 countries who receive the weekly newspaper from this non-governmental Kenya-based watchdog organization whose mission is to reinforce the effectiveness of the Global Fund to Fight AIDS, Tuberculosis and Malaria. It was through a whistleblower to Aidspan in 2005 that corruption in Uganda’s five Global Fund grants was uncovered. This led to the unprecedented action of the Global Fund suspending disbursements. (This billboard shows A white man, representing the international donor community, handing over a pile of cash in a box labeled “Global Fund” to a corrupt Ugandan official. The Ugandan official's wife looks approvingly over his shoulder at the money.)

Slide 3
The World Health Organization has created a model of six building blocks essential for strong health systems, including good governance and leadership. The big movement in the health sector now is to try to avoid pouring resources through vertical programs focused on specific diseases, and to strengthen health systems in general so that countries can effectively deliver all kinds of care that all kinds of people need. It is certainly easier for a donor or a government to manage a vertical program—an AIDS program, a maternal mortality program--and be responsible for only a limited subset of results. But those vertical programs don’t address the needs of all citizens like integrated systems do.

Corruption threatens these health system building blocks. It weakens health systems, and weak health systems are in turn more vulnerable to corruption in a downward spiral. When health systems are weak, it is difficult to demonstrate accountability because we lack data on health outputs, systems for accounting for expenditures, procedures for choosing the right drugs to procure in the right quantities and delivering them on time, and clear and enforceable rules and roles for all partners. Corruption is not the only constraint to achieving the MDGs, but where health systems are weakened by corruption, simply feeding more money into the system will not result in progress.

Slide 4
Increasing accountability is one of the levers we can use to strengthen health systems, both to reduce the risk of corruption and to improve performance. Rwanda provides an example. Ten years ago, the productivity of health workers was low and citizens could not afford to access services. Officials in government cared about those facts and were interested in making changes to address them, which is important. So they put in place a system of community-based insurance coupled with financial incentives which reward providers based on volume and quality of care. The system could not have worked without public engagement, as community members had to be willing to enroll in the system, and played important roles in managing the insurance schemes, including educating members about their rights, overseeing fee collection. The combined incentives of the community based insurance and pay reforms for health workers have resulted in increased uptake of services. People who are covered by the insurance are twice as likely as non-members to seek care for fever, 3 times as likely to bring children in for treatment of diarrhea, four times more likely to make 4 or more prenatal visits, and twice as likely to sleep under an insecticide treated bed net. The system is still vulnerable to corruption in the form of fraudulent reporting by the health facilities to get more insurance reimbursement, highlighting the fact that every reform creates new opportunities for abuse, and we must be constantly vigilant to manage risks.

Slide 5
Yesterday we discussed supply-side and demand-side initiatives to increase government accountability. I want to mention my own experience in evaluating a public expenditure reform in Lesotho which was designed to increase accountability, definitely a supply side
The reform was a failure for many reasons, including the fact that the design was too complex and inappropriate for the country’s capacity, and that none of the basic systems were in place to support the output-based budgeting which was the key lever for accountability. But what I was struck by was how professional silos were a barrier to accountability. I asked doctors and nurses on the management committee how they interacted with the accounts office staff, which they needed to do in order to justify how spending was related to performance objectives. “These things, they concern finance,” said a district medical officer. “It’s not really a health reform.” The Matron responsible for nursing put it more succinctly: “We work the wards, they go to meetings.”

The lesson I learned—and this applies both to supply side and demand side interventions to increase accountability—is that people will engage if they can overcome educational and professional boundaries. Being accountable for performance means understanding both finance and health delivery indicators. For public engagement, we need to help citizens develop financial literacy and be informed about health and finance issues.

Let me now turn to the second part of my presentation, which is to summarize the literature on effectiveness of citizen engagement. I will describe 4 studies, 3 of which were in the health sector—two with positive outcomes and two which showed little effect from the intervention.

**Slide 6**

The first evaluation studied 30 hospitals in Bolivia and found that citizen voice, as measured by active participation on health boards, had a statistically significant effect on lowering informal payments for services and reducing overpayment for supplies. The researchers’ hypothesis was that participatory approaches would work better on practices directly involving service users, such as informal payments. They were surprised, therefore, that citizen activism was also effective in reducing input prices, because input pricing is generally hidden. Perhaps the board members questioned medicines spending more closely or requested reports which shined light on this hidden area of management.

A second example of an intervention that worked is from a 500-bed public hospital in Kenya. Administrators had received complaints from patients about clerks stealing official user fee revenue and letting their friends in for free. In response, the hospital obtained donor funding to install electronic cash registers. The cash registers improved accountability by allowing the hospital management team to see financial indicators in real time, that is, daily and cumulative monthly revenue. The system helped to detect corruption by facilitating the comparison of reported revenue with expected revenue, based on prices and number of patients or services provided. It increased transparency by

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providing patients with an itemized receipt, so they could verify that the correct charges had been levied and change given.

Within 3 months, user fee revenue increased 47%. The policies in place allowed the additional revenues to be spent on hospital quality improvements and bonuses for staff. But then another problem arose. Citizens and staff began to complain about how the hospital officials were spending the user fee revenue, that they weren’t increasing quality or staff compensation in ways that were visible or fair. The hospital management committee, which had representatives from the general public, the district government, and the Ministry of Health, had to develop better guidelines for spending. Over the next 3 years, annual collections increased 400%, due mainly to better revenue controls, and the complaints about spending went down.

Several factors were critical to the success of that initiative. First, the approach combined participatory approaches with hierarchical controls, and was fully supported by the hospital management team and the Board of Directors. Secondly, the management team had sufficient autonomy that it could remove fee collection agents who resisted the new system. Without this level of autonomy in personnel management, unhappy staff could have sabotaged the reform.

Slide 7
A third study from Indonesia compared community monitoring with government audit, to see which type of control activity got better results in terms of reducing corruption. Benjamin Oken of MIT worked on a team which conducted the randomized field experiment of 600 village road projects. The participatory approach was accountability meetings: villagers were invited to attend meetings where project officials had to account for how they spent funds. In some of the villages, the meeting participants were also given comment forms they could fill in anonymously.

Oken’s study found that grassroots participation in monitoring had little average impact in reducing corruption. He attributed this to two problems: elite capture of the community monitoring system, and the “free-rider” problem. Elite capture happened as the neighborhood leaders distributed invitations and comment forms to villagers who were predisposed to be favorable to the project. Where the invitations and community comment forms were distributed through schools, a more objective distribution channel, the opinions were less favorable to the project. The “free rider” problem is basically that community monitoring has a cost to the individual monitors, but everyone gets to benefit. Some villagers weren’t willing to come to the accountability meetings or fill out the comment forms. They hoped that work would be done, they just didn’t want to do it themselves.

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The fourth example of a participatory approach is an intervention which was used in government health clinics in Rajasthan, India to try to reduce staff absenteeism⁶. This was also implemented as a randomized controlled field trial in 143 villages. A member of the community was paid to check once a week, on unannounced days, whether the auxiliary nurse-midwife was present. Using this monitoring information, it was thought that villagers might choose to put explicit pressure on the nurse-midwife or shame her by exposing her absences. They might even promise an explicit reward. In the end, absence rates were 44% in the intervention clinics, and 42% in the control clinics, showing that the monitoring had no effect. The team conducting the research concluded that community monitoring does not work if the community lacks formal authority to reward or punish providers.

To summarize: hospital boards in Bolivia were effective in reducing rates of informal payments and overpayment of supplies. They were part of a solution in Kenya which decreased theft of user fees and increased hospital quality. But participatory approaches to reducing absenteeism in Indian health clinics, and reducing corruption in road construction projects in Indonesia were not effective.

Factors important to the success of interventions included the introduction of formal, authorized mechanisms for citizen voice such as the health boards and committees; management autonomy to discipline corrupt staff or take actions based on citizen complaints; funding to support initial investment in technology; and the interest of government officials in working with citizens to improve services.

Factors which impeded success of participatory approaches included the possibility of elite capture; power differentials between citizens and the officials they are supposed to monitor; and the free-rider problem which decreases individual motivation to get involved in community monitoring.

Thank you.

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