

**WHAT ARE THE MOST EFFECTIVE STRATEGIES FOR  
UNDERSTANDING AND CHANNELLING  
THE PREFERENCES OF SERVICE USERS  
TO MAKE PUBLIC SERVICES MORE RESPONSIVE?**

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# **WHAT ARE THE MOST EFFECTIVE STRATEGIES FOR UNDERSTANDING AND CHANNELLING THE PREFERENCES OF SERVICE USERS TO MAKE PUBLIC SERVICES MORE RESPONSIVE?**

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## **1. INTRODUCTION**

There are a number of alternative channels of communication between public service providers and users, which providers can potentially use to increase their understanding of the preferences of users and the factors that influence their choices, and users can access to make their views known to service providers and decision makers. The apparent failure of public sector service providers to respond to the views of users and of elected representatives to hold those providers to account has led to attempts to increase the opportunities for citizens to exercise voice and demand and call providers to account, but it is argued here that the traditional or existing channels neither have been nor should be abandoned. In this paper, a range of alternative channels for expressing voice and deepening understanding of user preferences on the part of service providers are identified and their strengths and weaknesses reviewed. The discussion will be illustrated by a selection of material from recent research on institutional reform in the context of structural adjustment, urban poverty and governance, and increasing voice and responsiveness in service delivery. A systematic consideration of the determinants of provider responsiveness is beyond the scope of this paper and the discussion will be confined to a few general comments. It will be concluded that there are a number of possible channels of communication between users and providers which can be used to convey information, make demands and secure accountability. They all have potential. However, there is insufficient evidence to assess their relative effectiveness in different contexts. It appears that the effectiveness of most of the alternatives is limited at present in many situations and a greater understanding of the constraints and how they might be reduced is needed.

## **2. ALTERNATIVE CHANNELS FOR THE EXPRESSION OF USER PREFERENCES**

In liberal theory, individual users express their preferences through market demand and the vote. While both have a role to play, their limits when applied to essential services, in situations of widespread poverty and as sources of specific inputs into the design of particular services are widely acknowledged. Given widespread public sector failure to deliver adequate and appropriate basic health, education and water and sanitation services (as well as public transport, electricity, telecommunications etc), opening up provision to private providers and the commercialisation of delivery mechanisms was expected to provide more open channels for users to exercise choice and express satisfaction. Through market demand and the introduction of multi-party democracy, it was suggested, users would be able to signal their preferences and service providers would be forced to respond or, alternatively, go out of business or be voted out of office. As the constraints on rapid and universal private sector involvement, the potentially adverse effects of more market-like pricing, and the limits of achieving these outcomes became evident, attention shifted to ways of making the public sector more responsive with respect to both its direct and indirect provider roles, in particular by increasing the opportunities for service users to express their demands, through both voice

and consumption behaviour. Liberal and pluralist theories of democracy, together with beliefs in the virtues of direct democracy and grassroots action united development practitioners and donor agencies behind a quest for improved service delivery through increased voice.

Public sector failure was attributed to a 'supply driven' approach. It would, it was expected, be overcome by a shift to 'demand driven' provision. It was recognised that such a re-orientation would require economic, political and operational changes, although the need for and nature of the desirable reforms was contested by many of those involved in service delivery. Each of the types of change was associated with different mechanisms for users to express their preferences: economic solutions to service deficiencies expected individual consumers to purchase services of their choice; it was anticipated that (enhanced) democratisation would provide new channels through which to influence decision making; and reformed service providers were expected to interact more directly with their clients and as a result pay more attention to the needs of the poor.

Seven channels for the expression of user preferences can be identified. The strengths and weaknesses of each will be considered here, with some illustrations drawn from two recent research projects. The first examined progress with and outcomes of the institutional reforms supposedly accompanying structural adjustment, and the second the extent to which urban governance is responsive to the poor. Amongst other things, the first of these analysed reforms in the health and urban water sectors in four countries: Ghana, Zimbabwe, India and Sri Lanka, using qualitative research to ascertain user views of water and health services<sup>1</sup>. The second studied the relations between poor residents of ten cities in the South and other urban political actors (governments, especially local governments, and civil society organisations, including NGOs, residents' associations and business associations) and the ways in which these relations influenced their access to land and services (Devas et al, 2001). Additional material will be drawn from a comparative study and recent workshop which considered alternative mechanisms for increasing voice, responsiveness and accountability (Goetz and Gaventa, 2001; One World Action, 2002).

## **2.1 Market demand: privatisation or commercialisation of public supply**

The strengths and weaknesses of expressing demand through purchases in the market have been well-rehearsed and need only be briefly summarised here. The market is likely to supply adequate and appropriate services where there can be competition between multiple suppliers, externalities are limited, and the service in question has private goods characteristics (i.e. it is rivalrous and excludable). Market failure is likely when the service is a natural monopoly, there are extensive positive and/or negative externalities, and the service in question has public and merit goods characteristics (Kessides 1993). In these circumstances, economic arguments support public sector involvement to ensure that supply is adequate, provision does not increase social costs in the quest for private profits and access to essential services is equitable and available to the poor. The arguments have been about the need for public sector provision to redress historic inequities and compensate for limited

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<sup>1</sup> 45 Focus Group Discussions were held in eight cities and towns in the four countries (Harare, Bulawayo and Kariba in Zimbabwe; Kumasi and Accra in Ghana; Colombo and Kandy in Sri Lanka; and Pune in India) and in rural areas in Tamil Nadu. The groups were selected to incorporate socially representative groups of low and middle income service users, taking into account ethnicity, religion and gender. Groups were identified in areas affected by changes in the delivery of a service, or characterised by different types of supply (Rakodi 1996; Mutizwa-Mangiza 1997; Silva et al. 1997; Rakodi 1998).

private sector capacity, the extent to which services such as water or health have public and private goods characteristics, and the potential for commercialisation of public provision to introduce market-like characteristics into the relationship between public providers and users.

The political and practical reasons for public sector provision after independence were sidelined when the failings of public sector monopoly provision became clear, but continue to have some validity, especially in the eyes of local political actors, who frequently resist PSP because of a belief that service provision is a government responsibility, the desire to retain significant decision making power or patronage opportunities, a lack of confidence in formal private operators and NGOs, and failure to recognise the potential of small scale and informal operators and residents' organisations. In addition, the complex characteristics of services such as education, health and water and sanitation prevent them being clearly identifiable as either public or private goods (Kessides 1993; Nickson 1997).

With commercialisation of publicly provided services, individual preferences may also be expressed by consumer decisions to purchase. However, the signals are clouded by the vital need for services such as water and health care regardless of the inadequacies of public supply and the limited alternatives available (see Box 1). They are also influenced by the presence of subsidies designed to ensure access by the poor (which are often hijacked by other groups) and the limited capacity of public sector providers to enforce payment (which may result in increased default but continued consumption).

### **Box 1: Paying for water – now and in the future**

Underpricing of water, regressive tariffs and charges unrelated to the quality for the service are usually diagnosed as the main reasons for ineffectiveness, inefficiency and inequity in urban water supply. In the cities studied in 1997/8 water supply was a public sector responsibility, although the precise arrangements varied and the extent and quality of supply was uneven in most. Resource shortfalls were the single most important explanation of supply deficiencies (Amis 1996; Franceys 1997; Mudge 1997; Batley 1998; Franceys and Sansom 1999). The FGDs were designed to explore the attitudes of low and middle income users to paying for their existing supply and their views on the financial implications of their preferred improvements (Rakodi 2000).

Users generally understood and accepted the need to pay for piped water, although they resented perceived inequalities, including higher tariff rates which hurt the poor, or (in Zimbabwe) inequalities between cities. Also, perceived inconsistencies and unfair practices in charging and collections systems gave rise to frequent complaints. In particular, residents resented paying bills which varied little in size even when water consumption varied (e.g. when water is cut off for an extended period). Although this concern over the relationship between consumption and charges would appear to favour metering, there was also a widespread belief that, during interruptions, the flow of air through the pipes is registered by the meter, and this is also resented. Engineers varied in their willingness to admit that users are correct in this belief. Respondents also complained about irregular billing, which hinders household budget management. Residents in Pune, for example, which had subcontracted meter reading and bill distribution, were unaware of the new arrangements and still complained of irregular billing.

The inability of water providers to understand what information consumers would like in order to understand what they are paying for, and how it should be presented, causes frequent problems, with respondents reporting a lack of information on tariff structures or the reasons for increases. They also complained of customer-unfriendly attitudes and procedures, including provider attempts to enforce payment, especially when non-payment is due to poverty.

### **Attitudes towards future improvements**

In some of the case study cities, modest reforms designed to increase the efficiency and effectiveness of water providers had been implemented at the time of the study, with Zimbabwe closer to the goal of delivering efficient, effective and sustainable urban water supply than the others.

The services to which residents have become accustomed have a significant influence on both their expectations and their attitudes towards organisational responsibilities and payment for improvements. Users accustomed to public sector provision utilised private arrangements to compensate for deficiencies in the public supply or to obtain a better service if they could afford to do so, but they generally supported continued public sector provision and opposed alternative arrangements, especially full-scale privatisation. This preference for continued public sector provision seemed to be based on a mixture of underlying beliefs and experiences of privatisation in other sectors. The former included beliefs that users have an entitlement to basic services and governments a moral and political responsibility to ensure that basic needs are met. PSP was associated in respondents' minds with profit at the expense of consumers and they lacked confidence in the ability and/or integrity of private enterprises. These beliefs had been reinforced by experiences of privatisation in, for example, electricity or public transport, which were felt to have left users worse off, with services which were more expensive but no better. Moreover, despite the limited use made of political channels by users and doubts about their efficacy, there did seem to be a feeling that consumers could have more influence on public (especially local) than private providers. Nevertheless, despite their support for continued public sector provision, users did have serious doubts about the capacity of many public sector providers to achieve the desired improvements.

Although many participating in the FGDs held the view that water should be free, an acceptance that piped water provision costs money and has to be paid for was more common. However, users' willingness to pay depends on the delivery of services which are perceived by them to offer 'value for money'. Where water prices were closest to full cost prices and had increased in the recent past (Zimbabwe), resistance to paying more was widespread. In Sri Lanka, the longstanding welfarist policies of the government and a prevalent view of water as a free and abundant natural resource rather than a commodity (explained in part by many urban residents' continued access to ground water and their preference for ground over tap water for certain uses) underlay the belief amongst government, water providers and consumers alike that water is a public good, which is a right and should be subsidised. However, in a related contingent valuation survey those without an individual piped supply stated a willingness to pay modest charges for a connection (Franceys 1997). Elsewhere, where water was provided at highly subsidised prices at the time of the surveys, participants indicated that they would be prepared to pay charges closer to cost recovery levels, provided that appropriate improvements were delivered first or simultaneously<sup>2</sup>.

Using the purchase of services at market prices to indicate preferences assumes that demand is accurately expressed through decisions to purchase. However, poor people's limited effective demand precludes them from consuming sufficient full cost services – their purchases do not fully reflect their preferences, let alone the wider and longer term social benefits of ensuring minimum levels of health and education. With respect to water, for example, the health benefits to all may justify consumption of more water than consumers are willing and able to purchase; on health and equity grounds, access to a minimum supply, even by the poorest, is desirable; and generally, although sometimes private household arrangements (wells or boreholes), common pool resources (rivers or lakes) or privately sold water (tankers or informal sector vendors) are available, residents tied to a particular location, especially in urban areas, have little or no choice between suppliers of piped water (Box 2).

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<sup>2</sup> The results from the FGDs were borne out by separate contingent valuation surveys where these were available (Benneh et al. 1993; Mani 1997)

In addition, consumer preferences expressed through individual purchasing decisions are insufficient to either ensure accountability or provide sufficiently detailed information for providers to improve critical aspects of their performance.

### **Box 2: Purchasing water: choice or desperation**

In all the cities where water supply was unavailable, shared or intermittent, consumption of water is restricted and a variety of compensatory strategies adopted. Many of these alternatives involve either capital investment or recurrent costs over and above the cost of obtaining water from the public system. In the case study cities they included, in order of frequency of adoption

- a) household storage, with the choice of containers related mainly to their cost in relation to household income and the frequency/duration of interruption and/or low pressure, but also, in some places, the effect on the taste of water.
- b) purchase of water from neighbours, vendors or tanker operators. While in Sri Lanka, it is considered unethical to sell piped water, elsewhere residents without their own supply or access to a free communal supply commonly purchase water by the container. In Ghana, the approximate price paid per litre for water purchased by the bucket was between five and 16 times as much as the charge for a public supply, even though women and children often had to walk a long distance to purchase the water. The potential hazards faced in the process by girls in particular were a source of concern. In Pune, low income purchasers of water from their neighbours paid Rs 17-68/kl, compared to the sale price of metered water to middle and upper income households of Rs 2-2.5/kl.
- c) Restricting the use of piped water to drinking and cooking
- d) Use of ground and surface water, instead of or to supplement piped supply. Water is obtained from streams, ponds or wells/boreholes and may be used occasionally or regularly. In Colombo and Kandy, large numbers of people had access to streams and wells, which they maintained because of interruptions to the piped supply and a preference for bathing with stream or well water.
- e) In Pune, water was taken from leaking pipes, if no other service was available. Also some residents of unserved peripheral areas had been forced to move back into the centre of the city, leaving their apartments empty.

## **2.2 Quasi-market demand through the introduction of competing providers**

Just as public sector reforms may seek to increase efficiency by introducing quasi-market elements into public service delivery, so an attempt may be made to improve responsiveness by providing users with a choice of suppliers, in addition to the public provider, with or without subsidies. These may include for-profit and/or not-for-profit providers.

Such a strategy is most feasible for services such as public transport, certain forms of which do not have natural monopoly characteristics, have relatively low entry barriers, are rivalrous and excludable. Arguably, however, if prices increase, users on low incomes may be further disadvantaged by their inability to afford public transport at all; private operators are unlikely to invest in the more capital intensive forms of public transport necessary in growing cities without significant public sector leverage; private operators rarely bear the full social costs of their operation; and regulatory failures result in services falling far below desirable standards.

Users may indeed have choices, but the consumption decisions they make do not necessarily fully express their needs and preferences. Often, choices between alternative providers

reflect deficiencies in the first choice provider rather than a positive preference for the chosen provider. While they can be analysed to reveal the complicated trade-offs on which consumer decisions are based, they reflect a negative lack of choice rather than a set of positive signals. The use of ground water when piped supply is intermittent or unregulated private providers when public health facilities are too distant, crowded or understocked with drugs are examples (Boxes 2 and 3). Although there may be a case for introducing elements of competition into aspects of service delivery, given the natural monopoly characteristics of services such as water and differences in effective demand between income groups and districts, the real choices available to low income consumers and residents in remote poor districts are likely to be limited or non-existent.

### **Box 3: Alternative health care providers: choices and perceptions (Rakodi 1999)<sup>3</sup>**

#### **Choice of health care provider**

The choice of curative health care provider is not a once-off decision, but a sequence. Users judge the relevance and value of the care provided by particular providers against alternatives, trading off anticipated benefits against costs of time and money. They also judge the nature and severity of their complaints and take into account the socio-economic status of their household, the position within it of the patient and their religious beliefs. The FGDs were used to construct 'typical' sequences of the health care seeking choices of middle and low income households.

Generally, on the onset of illness, especially mild or common complaints, sufferers try self-medication, using home remedies, buying medicine from a dispensary (Ghana) or provision store (India), and choosing between western and ayurvedic medicine (Sri Lanka). Women in rural India may obtain basic drugs from the community health worker. In Sri Lanka, the poor are more likely first to try self-medication than the middle income. If this initial treatment is ineffective, the patient may seek more effective over-the-counter drugs, especially where the private pharmacy sector is poorly regulated.

However, if the illness is more severe or self-medication fails, treatment is sought from a medical practitioner. Typically, this is allopathic treatment, and the choice between a public and private provider depends on the relative importance of time, cost and perceived availability and quality of care. The relative importance of these factors differs between family members. Time and certainty of a rapid and effective cure take priority over cost for those in work (typically male household heads). In addition, men tend to be more mobile, and women tied to the village or residential area. Low income men are, therefore, more likely to use a private provider (individual practitioner, clinic or hospital out-patients department) than women, who are more likely to use the local public facilities. For middle income people, the time saving and higher quality of care offered by private facilities often outweigh the additional cost; for low income people, likewise, the increased time needed to reach remote public facilities and then queue was often reported to outweigh the cost of using closer private or NGO facilities. Children are likely to be taken for treatment more promptly than adults, to

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<sup>3</sup> The study considered user views of basic curative health care provision in urban areas in Zimbabwe, Ghana and Sri Lanka and rural areas of Tamil Nadu in India and, to a lesser extent, their views of maternal and child health (MCH) and family planning (FP) services. They examined the way in which choices of health care providers are made by middle and low income residents, their perceptions of alternative providers and their reactions to past and potential future reforms. In all four countries, users had, in principle, a choice of public, private for-profit and not-for-profit and 'traditional' services and within each of these between alternative suppliers. However, private not-for-profit provision was unimportant in Sri Lanka and Tamil Nadu and concentrated in rural areas in Ghana and Zimbabwe, so was not a choice available to most respondents in the study.

public clinics if these are considered reliable (Zimbabwe) or to a private doctor if a rapid diagnosis is considered critical (Sri Lanka).

If private facilities are confined to outpatient care, patients with illnesses they judge sufficiently serious to require admission may refer themselves directly to public hospitals (Sri Lanka, Zimbabwe). In India, the centrally funded basic local facilities (Primary Health Centres) were established primarily to provide MCH and FP services. Although they were also supposed to have a doctor on the staff and to provide basic curative and emergency services, these were poorly funded and availability had declined in recent years, so patients were increasingly likely to bypass the PHC in favour of a government hospital or private provider.

Respondents in India and Ghana reported that, because of the deteriorating quality and increasing cost of public provision in recent years, they were more likely to choose a private provider, because of the reduced cost differential and considerable time saving. In India, in addition, declining use of home remedies and increasing purchase of drugs for self-medication, as well as declining use of ritual treatment for some conditions were reported. In Zimbabwe, the main change in treatment seeking behaviour since user fee increases at the beginning of the 1990s (unless the family had medical aid or health insurance) was delay in seeking treatment. In Sri Lanka government facilities continued to be used by both middle and low income patients because they were free, accessible, provided a range of services and were considered to provide competent care. The poor rarely used other facilities, although middle income people sometimes sought private treatment.

Within the public sector, the choice between a local lower level facility and more distant higher level facility (typically a hospital outpatients department) is influenced by accessibility, perception of the seriousness of the illness (and thus the need for emergency treatment and/or likelihood of referral) and operation of the referral system. People's judgements are based on the likelihood that appropriate services (doctor, drugs, diagnostic equipment, specialist knowledge, inpatient beds etc) will be available at the lower level facility, the time and effort which will be saved by bypassing it, and the likelihood that appropriate treatment will be accessed more promptly.

Within the private sector, choosing between an allopathic and non-allopathic practitioner is often not an either/or choice: patients distinguish between the symptoms and causes of illness or accident, and between types of illness. In some instances (Ghana) resort is made to a traditional healer if other treatments have failed. Some patients follow up allopathic with non-allopathic treatment to ensure that all potential causes of the disease are covered. In other cases, non-allopathic treatment or practice of rituals is pursued in parallel with allopathic treatment, or is sought for ailments not considered amenable to allopathic treatment. Religious beliefs are an important influence, and choices may be made between allopathic practitioners depending on the type of condition they deal with, the type of treatment offered, cost and the reputation of an individual practitioner.

### **Perceptions of alternative health care providers**

User assessment of the performance of alternative health care providers can be divided into perceptions of structural quality (location, quality of facilities, availability of equipment) and process quality (technical and interpersonal skills) (Gilson et al. 1994), although these are inter-related and some services expected of health care facilities (e.g. diagnosis, drug supply) require both to be effective. User perceptions of the curative care offered by public and private providers were remarkably consistent across case study countries and locations. A summary comparison is given in Table 1.

**Table 1 Summary comparison of user perceptions of public and private sector health facilities**

<b>Public facilities</b>	<b>Private facilities</b>
Free for all or some (India, Sri Lanka, Zimbabwe) or cheaper (but unofficial charges)	Expensive, but charging practices open and service delivery assured once payment made;

common – Ghana, India)	sometimes seen as more concerned with profits than treatment
Hospitals have many facilities and a full range of equipment (although may be in poor condition)	Lack lab equipment (Ghana, Zimbabwe) and facilities for emergencies
East referral; hospitals provide a final referral point, a range of expert opinion and 24 hour emergency care	Have to refer to public facilities (and sometimes delay) and often not open 24 hours (except in India)
Slow, but consultation often hurried	Prompt service, but more time given to patient
Quality of treatment varies	Quality of treatment good
Diagnostic practices poor	Diagnoses reliable
Well qualified staff (including specialists) but not always available, especially doctors, and especially in PHCs (India), clinic (Ghana)	Doctors (sometimes including specialists) available when needed, but often reliant on one doctor's opinion
Quality and quantity of drugs unsatisfactory, although some examples of improvement e.g. Tamil Nadu	Quality and availability of drugs satisfactory, although they may have to be purchased from a pharmacy rather than the facility, with some reservations over prescribing practices
Often dirty (except Zimbabwe)	Clean
Staff attitudes poor	Staff attitudes positive
May discriminate e.g. against the poor, those without contacts, low caste people (India)	If patients can pay there is no discrimination

The main advantage of public sector facilities was considered to be their relative cheapness, despite the prevalence of unofficial charges. In some of the countries studied, services were, in theory, wholly or partly free at the point of delivery, in spite of attempts to introduce user fees and charges for drugs. They were regarded as accessible to the poor, although invariably slow because of the mismatch between resources and demand. However, widespread unofficial charging and failure of exemptions systems meant that, in practice, free services were limited and most had to pay for curative care. They were also considered to provide effective treatment and ease of referral when all the necessary resources were available. However, satisfaction varied between countries and levels of dissatisfaction were often high, with complaints centring on the patchy availability of resources (staff, drugs, working equipment) as well as process problems (poor motivation, poor interpersonal skills of staff, rushed consultations, favouritism to those with contacts, discrimination against some social groups including the poor, dirty conditions).

Private facilities offer a service which is superior in some respects to public facilities (less equipment but in working order, prompt service, sufficient time for consultations, courteous treatment, cleanliness) but at higher (often considerably higher) cost, even allowing for unofficial charges in public facilities. Some users may be willing and able to pay the higher cost when this is outweighed by the advantages (including the control it gives them over decision making), but for many the higher cost rules out private treatment despite its perceived advantages. People were, however, aware of the drawbacks of private provision, which were thought to include a limited range of equipment, limited opening hours, absence of accident and emergency facilities, delayed referrals, excessive and costly diagnostic tests and prescriptions for drugs.

### 2.3 The representative political system

The representative political system is expected to provide channels for the expression of both individual and collective voice, the former through voting and contact with elected representatives, the latter through the aggregative function of political parties, the contestation of elections around policy agendas and lobbying. Democratisation was expected to result in leaders and policies more responsive to voters' priorities and democratic

decentralisation in particular to more effective, appropriate and accountable service provision because of local authorities' responsibility for operation and maintenance and their greater accessibility to citizens. Of course, elections provide citizens with choices between competing leaders and representatives. However, whether they also provide an indication of service delivery preferences depends on the extent to which they are fought on the basis of competing ideologies or policy platforms, as well as on the freedom to manoeuvre elected governments have once in power. In western political thinking, the main way in which individual preferences are aggregated into a policy platform is through political parties which are, therefore, as critical to a democratic political system as the universal franchise. Moreover, not only do competing political parties need to exist and to secure the lasting allegiance of individual candidates, elected representatives and their members, to develop policy agendas they also need

- a. an identity based on a particular ideology
- b. a desire to achieve policy goals, and
- c. the capacity to develop a policy platform as a basis for campaigning and action once in government.

Moreover, the electorate must expect parties to have these aims and functions. Further, although both corporatist and pluralist political theories accept that individual and collective lobbying of political parties and elected representatives is a valid political activity, they assume that the rules governing elections and lobbying will provide safeguards against corruption, that all social groups have the (albeit unequal) capacity to organise themselves, and that the social contract which emerges will be reasonably inclusive.

In practice, in recently (re)-democratised countries, none of these assumptions can be taken for granted. In some countries political parties are stable and well organised, reflect (explicitly or implicitly) the policy preferences of their supporters, and fight elections on ideological or policy platforms. Party-affiliated or independent candidates may also do so. However, even in these countries, elections occur too infrequently to provide guidance on many policy decisions (and too frequently for others e.g. long term investment in water supply); manifestoes are too general to provide much information on preferences with respect to particular services; and the room for manoeuvre of elected governments may be significantly constrained by global economic trends, the conditionalities of external financial institutions or their dependence on the support of powerful domestic groups.

Moreover, in the majority of developing countries, political parties are merely campaign vehicles without lasting allegiances on the part of politicians or members, are based on ethnic or religious identity and lack the capacity to develop coherent policy platforms. In the absence of ideologies or policies to form a basis for support and accountability, the relationship between citizens and elected politicians tends to be clientelistic. Sub-Saharan Africa is generally held up as the most extreme example. Its political history, in which colonialism was marked by a disjuncture between the civic and 'primordial' public realms has, it is argued, resulted in the former lacking a moral underpinning, opening the door to clientelist 'spoils' politics under authoritarian, single party and multiple party regimes alike. However, clientelist politics is also pervasive in Latin America, Asia and the transition economies. Moreover, even where party and campaign financing and anti-corruption rules are clear and enforced, economic power is associated with political influence and regimes are likely to be influenced by powerful international and domestic economic actors and significant taxpayers to a much greater extent than the poor, however numerous their votes. In local politics, not only do the same inequalities affect political processes, but they are also

complicated by struggles for pre-eminence between local and other levels of political power, the policy objectives of local and central government, and local and national economic interests (Box 4). Thus in allocating resources to meeting the service demands of economic enterprises, urban and middle income consumers who already have services and wish to protect their supply and poor users with inadequate or no access, the formal political system is unlikely to favour the latter.

#### **Box 4 Politics in Bangalore**

In Bangalore, two ‘circuits’ of politics and administration are evident: an ‘upper’ circuit of corporate interests, formal planning and national and State administration, and a ‘lower’ circuit of councillors and lower level officials. State politicians concerned with economic development work closely with corporate economic interests and maintain a high degree of control over city-level decision making by the establishment of powerful bodies on which local interests are under-represented. The mega-infrastructure and construction projects favoured by the Bangalore Development Authority, in particular, ride roughshod over the interests of low income residents, while local representation on the boards of the state water and sewerage utility, public hospital management committees etc is also limited.

Although the city government has limited resources and powers, it does provide low income residents with political representation which they can supplement through more informal political activity. Benjamin and Bhuvanewari have characterised the processes involved as ‘politics by stealth’. Through persistent pressure and ‘vote bargaining’, poor groups are often able to make claims on land or resources and subvert formal regulations. They do this through Ward Councillors, together with local leaders, who use their connections with the lower level bureaucrats in favour of poor groups in return for electoral support. While such a political process tends to reinforce dependency and clientelistic relationships between residents, politicians and lower level bureaucrats, it has been effective for many poor groups, who have been able to consolidate their land claims, protect themselves against ‘zoning violations’ enforcement, and obtain essential services (Benjamin 2000; Benjamin and Bhuvanewari 2000; Benjamin 2001; Devas et al. 2001).

The greatest promise for consolidated democracy, in which access to services is by entitlement rather than patronage, electorates expect rival candidates and parties to have explicit policy agendas, the policies adopted by elected governments are pro-poor and incumbents are held to account for their success or failure in fulfilling their electoral promises at subsequent elections seem to be those countries where organised civil society played a significant role in the struggle against authoritarian rule, such as Brazil, South Africa or the Philippines. Although all face problems, the process of struggle seems to have both increased the understanding of democratic politics of the electorate at large in such countries and also resulted in constitutional recognition of organised civil society, winning it rights of representation in both national and local forums which the main elected bodies are mandated to take into account. The extent to which organised civil society represents the interests of the poorest, of course, is likely to vary: trade unions’ priority is to defend the interests of wage workers, NGOs may advance their own agendas rather than those of citizens at large, and the capacity of the poor to organise to take advantage of the political opportunities is generally limited (Devas et al. 2001; Rakodi 2001; Rakodi 2001; One World Action 2002).

The design of electoral systems also influences the extent to which they can be effective channels for political voice: poor groups, women and minorities may be under-represented in first-past-the-post and closed party list electoral systems, and as a result of gerrymandering. Often the democratic deficit (expressed in terms of the representative:constituent ratio) is greatest in large cities. In addition, the political capacity of disadvantaged groups determines

their ability to influence the political agenda, increase their representation and use political office effectively if elected.

The constitutional settlements following extensive civil society involvement during the transition to multi-party politics have often given greater representation to previously excluded social groups by the design of a variety of components of the electoral system (e.g. proportional representation to assure minorities a political voice; quotas to ensure the representation of under-represented groups, especially women; ward-based systems at local level which secure greater responsiveness and accountability than party list systems). The effectiveness of such design features seems to depend on parallel efforts to increase political capacity, in which NGOs may play an important role (e.g. BATMAN in the Philippines, NOWODE in Uganda) (One World Action 2002). A representative political system is therefore necessary but insufficient to provide accessible and effective channels for the expression of service users' preferences. However, if there is political commitment at the top coupled with political influence by citizen groups, there is scope for designing them to provide greater opportunities for the voices of poor service users to be heard. Nevertheless, there are limits on the extent to which responsiveness and accountability with respect to service delivery can be achieved through the formal electoral system.

## **2.4 Accountability mechanisms**

Performance with respect to electoral promises is only one of the factors taken into account by voters and is itself complex to assess, given the incomplete and asymmetrical information available to them and the need to balance past performance against anticipated future performance (Manin et al. 1999). To ensure the accountability of elected government to citizens and service delivery agencies to elected government, therefore, a range of complementary mechanisms is needed. The selection of accountability mechanisms and their use can also serve to indicate service user priorities and levels of satisfaction

Accountability involves upward (or horizontal) accountability, involving mechanisms internal to the system: political accountability of executives to legislatures, administrative responsibility of bureaucracies to elected representatives (secured also by internal hierarchies of supervision and other bureaucratic mechanisms), fiscal accountability (accounting for and auditing of public resources), and legal accountability (the use of the judiciary in defining and enforcing the rules). Dissatisfaction with the downward (or vertical) accountability of elected representatives and bureaucrats to citizens (the former through the vote, the latter indirectly) has increasingly given rise to calls for increased direct accountability of service delivery agencies to residents at large and their clients in particular (Polidano and Hulme, 1997). For individual service users, accountability also requires a system for securing responses to complaints and a means of obtaining redress for grievances.

Responsiveness implies that a service delivery agency should be receptive to the views of service users. However, the differing capacity of groups of service users to influence public agencies and their different interests may result in a cacophony of conflicting demands, responding to which may undermine the supposed impartiality of public officials. A decision making system capable of balancing those interests in order to allocate resources appropriately is still needed, the core of which should be the democratically elected government. A distinction should be made, therefore, between responsiveness to citizens and accountability to elected representatives (Blair 2000). Nevertheless, dissatisfaction with the record of such representatives in holding bureaucracies to account and in channelling user views into decision making has reinforced attempts to enable citizens to hold bureaucrats to

account directly (Goetz and Gaventa 2001). Accountability, therefore, has multiple dimensions, meaning that answering the question ‘accountability by whom, to whom, for what and how’ is by no means easy.

Blair concluded from an earlier study that the most effective channels for ensuring accountability are political parties, elections and ‘civil society’, with mechanisms such as public meetings and the media apparently less effective (Blair 2000). However, reservations about the role of political parties have been expressed above, and Blair fails to distinguish between the roles of different types of civil society organisations. Goetz and Gaventa (2001) identify a number of examples of attempts by citizens, public sector agencies and the two together to strengthen voice, responsiveness and accountability.

Although disillusion with the probity of politicians and the capacity of government agencies is widespread, there are numerous attempts by civil society and governments to re-negotiate citizen-state relationships and there is some evidence that spaces for influence which citizens have demanded and claimed for themselves or which have been jointly constructed by citizens and the state are more effective in increasing voice and accountability (One World Action 2002). In Uganda, for example, Budget Conferences, Project and School Management Committees, and central government monitoring are beginning to play a role in increasing accountability, although their effectiveness and degree of institutionalisation is patchy, depending on local political circumstances and capacities (Grant 2002).

Any such attempts to improve accountability require transparency – none can be effective without the disclosure of relevant information. In this context, research by citizens’ organisations needs to be complemented by greater government openness. Most effective in this context is Right to Information legislation (Goetz and Gaventa 2001; One World Action 2002), while monitoring and auditing through citizen or joint state-citizen initiatives can also produce positive results, for example in budget analysis initiatives in South Africa or Uganda, monitoring quality in the public food distribution system in India, public hearings to monitor government expenditure on and implementation of local construction works, vigilance committees which monitor Municipal Councils in Bolivia or periodic public meetings at which politicians or bureaucrats are required to appear.

Citizen and media campaigning can also play a role in enhancing accountability - campaigns backed up by good information and thorough research have greater credibility and influence than mere protest (One World Action 2002). Such information can be generated by, for example, systematic reviews of user satisfaction, carried out by the delivery agency itself, or by independent NGOs, networks of grassroots organisations or researchers. The report card system initiated by an NGO in Bangalore and emulated elsewhere in India is an example of ‘naming and shaming’ (Paul and Sekhar 1997). The extent to which feedback and publicity alone can produce greater responsiveness and efficiency in service provider agencies does not yet seem to have evaluated.

Traditionally, consumer satisfaction with water supply is judged from the volume of complaints, expressed in relation to the number of connections, perhaps disaggregated into complaints related to different aspects (quality, interruptions, billing/cost). Nickson’s reservations are that the propensity to complain varies between countries and that utilities have different policies on recording complaints (Nickson 1996). His concern that responsiveness to formal complaints is a poor indicator was borne out by the study referred to above, which showed the strong deterrent effect of provider failure to respond on propensity

to complain. Piped water users in the cities under study commonly reported that they attended to minor repairs themselves, to avoid delays and red tape, or that they had to provide materials or cash to under-resourced maintenance crews. Responsiveness to formal complaints appeared to vary in relation to the overall performance of the utilities under study, with respect to technical capacity as much as customer orientation. Better performance in Zimbabwe was attributed to a traditionally strong commitment to technical efficiency, reinforced by a democratic local electoral system, and, in Bulawayo, strong residents' associations (Batley 1998). Elsewhere, use of local political channels to obtain redress was limited, especially in Ghana (where the water utility was a national corporation) and Pune (where individual clientelist relations with councillors seemed to be needed to secure results).

## **2.5 Consumer roles in operation and maintenance**

The limited effects of service users exercising their purchasing power, right to vote or limited role in monitoring and auditing on the delivery of services, together with the limited capacity of providers to extend adequate and appropriate services to all low income users, have led to attempts to involve users directly in operation and maintenance. Such involvement may take the form of

- Contribution of additional resources of cash or labour for construction of facilities or infrastructure (e.g. constructing clinics or classrooms, digging trenches for pipes) or maintenance (e.g. of communal water supply). The hope is that such contributions will (a) increase users' sense of ownership and responsibility for maintaining the infrastructure, (b) make the limited resources of public agencies go further, by reducing the subsidy otherwise needed to reach low income users and (c) result in less capital intensive and more appropriately designed facilities. Earlier ideas which focused on mobilising unskilled labour have developed into 'community contracting' arrangements for local infrastructure installation, operation and maintenance, incorporating a variety of commission and supervisory roles for communities as well as direct labour and cash contributions.
- Identification of workers from within the user communities who take responsibility for certain components of delivery, working unpaid, paid at less than regular rates by the agency, or reimbursed in some way by the community from which they come. Community health workers and frontline maintenance persons for communal water supply are examples.
- The establishment of user groups (such as Village Health or Water Committees) established to take responsibility for operating or guiding the operation of local facilities, for example, a community dispensary or water kiosk, in liaison with the main provider.

If the delivery, operational and maintenance arrangements are devised in consultation with users, these forms of involvement may improve service levels in poor and isolated communities, provide better channels of communication with provider agencies and lead to modifications to service delivery which result in more appropriate service design, better maintenance and more user-friendly procedures. However,

- the opportunity costs of a requirement to contribute free labour may be considerable for poor residents, especially in urban areas;

- residents may resent requirements for such contributions when higher income users do not face similar demands (but may still be getting subsidised facilities) or when no improvements in service quality result;
- the operational and financial sustainability of community level services has often been difficult to achieve; and
- user groups may not represent the interests of all users and may regard their participation as an opportunity to secure personal rather than community benefits.

Above all, involvement of users in operation and maintenance does not give them the right to a say in the design of service delivery or overall allocation of resources.

## **2.6 Participation in decision making**

For this reason, direct participation in decision making (in addition to the indirect participation theoretically provided by the formal political system) is regarded by many as necessary to ensure pro-poor policies and services.

Traditionally, participation in decision making has been advocated at the project or community action planning level. Participatory approaches can be ranged along a continuum from tokenism (when the decision makers restrict user inputs to insignificant decisions or choose to give them less weight than the views of professionals, elected representatives or more powerful political groups) to user-determined decisions. The latter are relatively uncommon in the delivery of basic services, because of their dependence on large scale investment and professional expertise, and the need to reconcile competing needs and demands, and the need to ensure systematic coverage. Instead, so-called ‘partnership’ arrangements are increasingly in vogue, involving some combination of individual users, organised communities, NGOs and public sector agencies. However well intentioned such arrangements, fractionalised communities, unequal power relationships, failure to delegate real decision making authority<sup>4</sup>, uneven capacity between partners and the absence of a tradition of joint working can threaten both progress and the achievement of pro-poor objectives. ‘Partnerships’ do not necessarily give a determining voice to the poor, who may feel that they have little choice but to accept the essentially supply-driven initiatives of government or NGOs, on whose financial and other resources they depend. Government or donor planning and financial rules which require time limited and clearly specified activities, may also favour blueprint approaches to project planning, restricting the scope for users to make decisions. Nevertheless, some research has indicated that increased participation by business communities can help to improve local government operations which in turn can benefit poor people (Devas 2002) and there is evidence that projects that incorporate genuine opportunities for participation by the poor are both more successfully implemented and more likely to have pro-poor outcomes (Kessides 1997).

Projects, however, only constitute part of development activity. Direct or participatory democracy has traditionally been regarded as infeasible at city, district or national levels and scale obviously places limitations on its use (barring occasional referenda). However, in recent years the desire to increase opportunities for engagement in decision making has given rise to experiments which have varied both in their outcomes and the extent to which they have become institutionalised. Many are not, strictly speaking, direct democracy – instead

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<sup>4</sup> See Hoddinott for a recent airing of these long-recognised issues (Hoddinott 2002)

they provide parallel channels for individuals, elected representatives other than local councillors or members of parliament, and organised interests to participate in priority setting and strategic planning as well as playing a role in implementation – participatory, deliberative or delegated democracy. At the city level, they include visioning exercises, city development strategies (especially under the auspices of UN-HABITAT and World Bank supported programmes), and participatory budgeting. There have been few independent evaluations of attempts at inclusive city development strategy preparation. Those that exist reveal strengths but also weaknesses, arising from the nature of the external agencies' involvement as well as tensions between the representative political system and the strategy preparation process, and problems arising from resource and capacity constraints. Participatory budgeting evolved in Brazil, where evaluations have shown positive outcomes at the margins in terms of pro-poor resource allocation but also tensions with the party political system in some cities (Souza, 2000). Brazil's political and civic history is essential to the success of PB and attempts to transfer the practice and variations on it to other countries are still too recent to fully assess.

Users may also be 'represented' on the boards of specialist agencies such as utilities or hospitals. Assessments show that their ability to exercise real influence is limited by their minority position and lack of expertise and experience. In addition, arrangements for providing them with user views and ensuring their accountability to users are often deficient.

Even more recently, at national level, the attempt by external agencies to ensure that PRSPs reflect the needs and priorities of poor people has given rise to a number of innovations designed to increase their voice and involvement in national planning, although the extent to which they will have a real influence on decision making is likely to be limited, given the relative power and resources available to national government, national assemblies, and external agencies and poor people's dependence on intermediary organisations to 'represent' them in such national fora. Finally, at an intermediate level, attempts to provide direct channels for participation appear to be limited, although there is some evidence that scaling up PB to State level may be feasible in Brazil (Schneider and Goldfrank 2002)

## **2.7 Consultation**

There are real limitations, then, on the extent to which planning processes at city or district level or above can provide for the direct involvement of citizens and service users in decision making. Much so-called participation is, in practice, consultation. Nevertheless, it should not be devalued or disregarded – rights to be consulted and well designed consultation processes can have a major and beneficial influence on decision making, especially when they are implemented in conjunction with a democratic political system and opportunities for direct participation. Consultation processes can take a variety of forms, but generally involve the soliciting of user views, either directly by the service provider or through intermediaries. Some of the examples given above for improving the information base for strengthening accountability, such as report cards, are relevant here. At the national level the use of sample household surveys and PPAs has, in some instances, influenced priority setting in PRSPs in favour of poor people.

The potential value of traditional consultation mechanisms used by willing agencies and the potential role of independent researchers in representing poor people's views should also be recognised. For a provider aiming to enhance its responsiveness and performance, information relevant to planning, monitoring and evaluation may be gathered through a variety of instruments. Information may be solicited from individuals or groups, in private or in public. Public hearings may be used to obtain feedback on user satisfaction, inputs into

regulatory reviews or information to assist investment decisions. More commonly used, however, are quantitative and qualitative methods for obtaining information from actual and potential users.

A review by UNCHS in 1994 identified only 20 studies of demand for urban water and concluded that systematic information on demand for water by the urban poor, including the amount they pay, where they obtain water and how they would react to changes in prices or supply was still scarce at that time (United Nations Centre for Human Settlements 1995). Since then, the use of two main survey-based methods in planning for water supply has become more common.

- ***Hedonic studies***: Surveys of what consumers already pay, typically in areas dependent on water vending, have been used to indicate that consumers dependent on privately purchased water generally pay more than the full marginal cost of (or charges for) a piped supply. It may be suggested that actual payments made for water indicate ability and willingness to pay. However, demand is price-inelastic – residents may be forced to spend a higher proportion of their incomes on water than they would choose if alternative sources were available, sacrificing welfare from necessity rather than choice (Kjellen and McGranahan 1997), especially where shortages enable vendors to make excess profits (Swyngedouw 1995). In addition, as noted above, users may be willing to pay less than they currently pay for a piped supply if it is not considered good value for money (especially if it is unreliable) or requires a regular monthly payment when households have irregular incomes. Thus the value for planning of survey data on actual prices paid for water is uncertain.
- ***Contingent valuation***: Surveys of what people would be prepared to pay for improved services. A series of studies which have tested this method for bias and introduced methodological refinements to overcome the problems have concluded that well-designed studies of specific user groups can identify demand for specific supply characteristics and relate them to household characteristics (Whittington et al. 1990; Whittington et al. 1992; Griffin et al. 1995; McGranahan et al. 1997), although some users consider that the method has limitations (e.g. (Mani 1997).

These methods can help to overcome the tendency to either overestimate willingness-to-pay (especially by external agencies keen to promote new technologies or delivery arrangements) or to underestimate it (especially by governments). They capture willingness to pay for the individual benefits of improved water supply but exclude its merit good aspects and externalities, which have to be assessed in other ways. Contingent valuation surveys (with modes sample sizes) can provide information of value in assessing demand for specific potential improvements and in formulating policy, especially on pricing. However, they are technically demanding and potentially costly, because local characteristics and circumstances strongly influence willingness to pay for specific improvements at the local level, preventing extrapolation from one site to another and necessitating a series of surveys (Griffin et al 1995).

Similarly, sample surveys of users can be used to ascertain patterns of use, reasons for choices and, generally using attitudinal scales, levels of satisfaction. They may be relatively undemanding if used for straightforward monitoring but require more financial and technical resources if subject to complex analysis. However, their potential shortcomings include a tendency to yield superficial responses and generate little contextual information. In

addition, they provide little scope for users to influence either the questions asked or the interpretation of answers,.

Qualitative data collection methods have been developed both to overcome some of these difficulties and potentially to engage research ‘subjects’ more actively in data generation, analysis and use, to produce more accurate information and a direct link to participatory decision making. These methods are technically demanding, but relatively low cost, deliver results quickly, can report the views of users in their own words, provide opportunities for the unexpected to be revealed and are rich in contextual information (Narayan 1993; Narayan 1996; Booth et al. 1998). A range of methods is available, including those grouped under the heading of ‘participatory appraisal’. Experience has demonstrated, for example, that focus group discussions work well and generate useful information on attitudes, opinions, experiences and perspectives. Although the researcher has less control over data generation than in individual interviews, there is no certainty that individual behaviour mirrors group self-reported behaviour, and the data generated cannot be regarded as representative in any statistical sense, the surveys of health and water users used to illustrate this paper indicate that the focus group method can provide insights into users’ experiences, perspectives and opinions which are reliable and nuanced, is relatively cheap and quick, and can complement (or even substitute for) larger scale sample surveys, especially contingent valuation surveys, in generating information of use in policy debates and provider decision making (Boxes 1, 5 and 6).

Consultation, therefore, is initiated, administered and reported externally to the user groups, affects decision making directly only if commissioned and used by the provider, and generally treats users as objects rather than subjects. As the use of PA methods has spread, more measured evaluations have tempered some of the early enthusiasm, showing that PA methods still reflect the preconceptions of the facilitators, give unequal weight to all participants and need careful selection and adjustment for use in different situations. Moreover, even if consultative exercises are undertaken at local or national level in the course of planning and programme preparation, resolution of conflicts between interests and priorities will reflect the wider balance of political and economic power and is, in practice, unlikely to favour poor people without political change, whatever the official policy documents say.

#### **Box 5: Perceptions of quality in water service delivery**

Findings from the study of user views demonstrate that low and middle income urban residents appreciate the link between water supply and health and want access to a piped supply. However, access is considered insufficient unless the service is also of good quality. Quality, in the eyes of users, implies, most importantly, reliability (i.e. regularity, adequate pressure and predictability of supply). Users in Sri Lanka, Ghana and India generally expressed high levels of dissatisfaction with the reliability of the piped supply. As well as daily or prolonged interruptions to supply, residents commonly complained of low pressure, although in Pune residents seemed to have accepted scarcity of drinking water as a fact of urban life, and the time-rationing system operated by the Pune Municipal Council was taken for granted. Indeed, Pune residents receiving more than four hours supply a day were reasonably satisfied, providing that the supply was (a) reliable (i.e. provided every day at the same time), (b) at good pressure, and (c) timely – residents complained at the disruptive effect on sleep patterns of water flowing only in the early hours of the morning. Where supply was available erratically, for insufficient time, at inappropriate times and/or at insufficient pressure, residents complained of the waste of time used in queuing, the tendency for arguments to break out in queues, or the stampedes to obtain tanker water. The cost implications of unreliability include the

monetary and time opportunity costs to users of compensatory strategies, including storage, pumping, rescheduling of activities and home treatment of water, as well as the costs of the consequences (the direct and opportunity costs of water-related diseases). In cities with severe shortfalls in the supply of piped water, especially in Ghana and India, the cost of accessing water varies enormously within the city, greatly increasing existing inequality.

In addition to reliability, quality characteristics of importance to users were identified as purity (lack of contamination), cleanliness (absence of suspended sediments) and taste. Residents based their assessment of the purity of drinking water mainly on experience, but also on their (not necessarily well-founded) confidence in the water utility. In Zimbabwe, for example, traditional high standards of municipal supply had produced a high level of confidence in the quality of water, and even though recent problems in some places had led to a perceived deterioration in quality, this had not yet started to erode that confidence. In Sri Lanka, residents were clearly aware of the health implications of poor quality water and boiled either piped or ground water if they thought it was contaminated, especially for sick people, and where the cost of fuel in relation to incomes is not excessive. In Pune, publicly supplied water had been poor quality for a long time, users seemed well aware of the resulting health hazards, and compensatory measures (boiling or filtering) were commonly practised. Respondents' strategies for dealing with water they perceived as being of poor quality therefore revealed both a general level of awareness of the health implications and the importance of constraints on the compensatory strategies adopted, including the cost of fuel in relation to incomes and limited technical knowledge of the efficacy of home-based water storage and treatment practices in ensuring water is safe to drink.

#### **Box 6: User perceptions of past and future health sector reforms**

Because of the piecemeal nature of the health sector reforms in all four countries at the time of the study, respondents were asked what reforms had been implemented to their knowledge and with what outcomes, as well as their preferences for future reforms, especially with respect to the balance between public and private provision and charges.

Most participants were of the view that public services had deteriorated rather than improved. In Ghana, with the exception of drug supply, few users perceived improvements in the public sector provision since provisions for increased cost recovery had been introduced. In Zimbabwe, health sector reforms were occurring in the context of declining real incomes and the results of increased charges were reported to include delays in seeking treatment, failure to purchase all the drugs prescribed and reduced use of oral contraceptives. The changes had exacerbated the impact of structural adjustment on poorer households, especially as the exemptions systems was neither well designed nor properly implemented. User resentment of increased costs was strengthened by their failure to result in improved quality of care or drug supply. In Sri Lanka, liberalisation of the health care sector had been under way since 1977 and at the time of the study, the private sector was providing half of all curative care. Although levels of satisfaction with both public and private services were high, respondents enumerated a series of deficiencies requiring attention. In India, more than half of all services are provided by a large unregulated private sector supplying allopathic and non-allopathic care, both of questionable quality. Moreover, unofficial charges and the need to purchase drugs mean that publicly provided care is not free.

Most low and middle income people had accepted the need for payment, despite the financial hardship and debt that result, and there was quite a widespread feeling that, without payment, treatment is unlikely to be efficacious and good quality. However, users resent having to pay unofficial charges for poor quality public services. Despite the acknowledged inadequacies of public provision, they strongly supported a continued public sector role in provision, above all because of the perceived shortcomings of private services and concern that poor people should have access to adequate care. In Ghana, most opposed any further increase in private sector provision because of its

high cost, difficulties of regulation, and the tendency of private providers to give priority to profits at the expense of patients' health. In Sri Lanka, users wanted increased regulation of the private sector, including restrictions on the number of hours government doctors are permitted to work privately and on fees. Although respondents in several places recognised that allowing government doctors to practise privately increased the availability of services and also allowed the latter to supplement their inadequate public sector salaries, they also wanted such private practices to be regulated. In India, users would also like to see regulation of prescribing practices. All wanted improvements in public provision, generally related to process improvements, and many stressed the need to improve staff pay and working conditions to achieve this. Many also stressed the potentially important role of local and neighbourhood PHC facilities and services and suggested increased and improved provision, which would relieve pressure on the hospital outpatient departments which it is often rational for patients to use at present.

The few users who were willing to pay higher fees (e.g. middle income households in Ghana, some groups in India) were only willing to do so for improved quality services – in India people accept the need to pay but wish to pay official charges for the services of their choice and not unofficial charges for unreliable services and shabby treatment by the staff of public facilities. Unwillingness to pay more for publicly provided curative health care services was explained by widespread concern for the impact of increased charges on access to health care by poor people, lack of confidence in the capacity of public providers to improve quality and/or a belief that people are entitled to free services and governments responsible for providing them.

#### **4. CONCLUSIONS**

Channels for improving communication of user preferences to service providers may be either direct or indirect, and initiated by either users or providers. Direct user-provider channels reviewed in this paper include market mechanisms, user satisfaction surveys, complaints systems and some types of direct action. The extent to which they give adequate expression to the preferences of poor users depends in part on who takes the initiative and what the incentives are for the provider to respond. Indirect channels include the representative political system, parallel democratic mechanisms, and research on user views of current and future services. They are mediated by politicians, bureaucrats, community leaders, NGOs, consultants or researchers. Their operation and effectiveness and the extent to which they (a) represent the interests of the poor and (b) produce responses from providers depends on the motives, characteristics and role of the intermediary. Advocacy on behalf of poor people is ultimately paternalist (and often patriarchal). In principle, then, direct citizen engagement is preferable. However, in practice, the need for representative mechanisms to cope with large populations and the complex trade-offs involved in decision making with respect to service delivery means that intermediaries are likely to play a role even if the capacity of citizens to organise and express their preferences collectively is strengthened.

User preferences are least likely to be taken into account when there is a combination of public sector monopoly of service provision and an undemocratic political system. That such a combination is not necessarily associated with poor delivery, however, shows that performance is related to a range of factors other than public provision and the presence of formal representative democracy. These may be related to the character of the service in question, the need for leaders even in undemocratic systems to legitimate their rule by achieving certain developmental goals, the use of alternative methods for ascertaining user preferences and the capacity of public providers to deliver.

Nevertheless, there is a general view that a democratic political system is both a right and more likely to increase responsiveness to the poor and accountability. Even with improved design and progress towards consolidated democracy, however, the channels provided by the formal representative system are unlikely to be sufficient to adequately represent the voices of the poor to individual service delivery agencies and to hold the latter to account. Complementary mechanisms are needed and all those reviewed in this paper have a role to play. This is not to say that the more channels there are available, the greater the influence of poor people on service providers and the greater the increase in efficiency and equity of provision. All the potential channels have both strengths and weaknesses, there is relatively little evidence of their impact on the policies and behaviour of service providers, and even less on what combination of mechanisms is likely to be most effective in obtaining efficient, sustainable and pro-poor service provision in which administrative and political circumstances and at which levels of government.

The evidence available on user preferences shows that the key factors influencing choice and satisfaction are, in general terms, cost, quality, ideology/beliefs, accessibility and previous experience. These are, of course, inter-related and it is the relative importance attributed to each and the trade-offs between them that influence choices, levels of satisfaction and preferences for future improvements. Often, users are willing to consider paying more for services if, according to the criteria they consider most important, those services offer ‘value for money’. Lack of confidence in the capacity of public providers to improve services does not lead users to the view that the public sector should reduce its future role, since their experience of private sector provision is mixed and even those prepared to pay more have genuine concerns about the implications of higher costs for those poorer than themselves. It does mean that any increase in user charges should be (a) phased and accompanied by visible improvements in service performance, to maintain political legitimacy, and (b) designed so that the poorest people are ensured access to a basic level of essential services.

Responsiveness is vital to achieve appropriate and sustainable services, but it can also give rise to significant tensions without mechanisms for the resolution of conflicting interests and competing demands on resources. In unconsolidated democratic systems, these mechanisms are weak, so that responses in a more open political system may or may not result in more efficient and pro-poor services – clientelist responses to particular groups are likely to have adverse impacts on performance and systematic coverage, and the voices of the poor may be less influential than those of corporate or middle income interests. In addition, there are often severe constraints on the capacity of the public sector to respond. Increased voice without increased capacity to respond is a recipe for social tension and political disillusion. However, consideration of possible means of increasing the incentives for and capacity of public agencies to respond is beyond the scope of this paper. In dynamic political systems, there is always potential for increasing user voice and provider accountability and responsiveness. Despite the mixed experience and lack of evidence, some points to appropriate ways forward have been identified, including

- i. developing the capacity of citizens to engage directly in decision making and calling governments to account, over and above their roles as voters, clients or beneficiaries
- ii. strengthening the representative democratic system and the capacity of poor people to exercise their political rights within it

- iii. establishing mechanisms for consultation, participation and accountability which complement the representative political system, while recognising that tensions between the two are possible, and that such mechanisms are not inherently pro-poor
- iv. pursuing initiatives which involve both users and government in processes of dialogue and collaboration and therefore have the potential to contribute towards a re-negotiation of state-society relations, while recognising that one-sided initiatives such as protest, 'naming and shaming' and consultation may also have a contribution to make.

## References

- Amis, P. (1996). Urban Water Supply: Ghana Water and Sewerage Corporation. Birmingham, University of Birmingham, School of Public Policy, Role of Government in Adjusting Economies Paper 21.
- Batley, R. (1998). Urban Water in Zimbabwe: Performance and Capacity Analysis. Birmingham, University of Birmingham, School of Public Policy, Role of Government in Adjusting Economies Paper 33.
- Benjamin, S. (2000). "Governance, economic settings and poverty in Bangalore." Environment and Urbanization 12(1): 35-56.
- Benjamin, S. and R. Bhuvanewari (2000). Bangalore. Birmingham, International Development Department, School of Public Policy, The University of Birmingham.
- Benjamin, S. B., R. (2001). Democracy, Inclusive Governance and Poverty in Bangalore. Birmingham, International Development Department, School of Public Policy, The University of Birmingham.
- Benneh, G., J. Songsore, J. S. Nabila, A. T. Amuzu, K. A. Tutu, Yanyuoro, Y. and G. McGranahan (1993). Environmental Problems and the Urban Household in the Greater Accra Metropolitan Area, Ghana. Stockholm, Stockholm Environment Institute.
- Blair, H. (2000). "Participation and accountability at the periphery: democratic local governance in six countries." World Development 28(1): 21-39.
- Booth, D., J. Holland, J. Hentschel, P. Lanjouw and A. Herbert (1998). Participation and Combined Methods in African Poverty Assessment: Renewing the Agenda. London, Department for International Development, Social Development Division, Africa Division.
- Devas, N. (2002). Local Government Decision-Making: Citizen Participation and Local Accountability: Examples of Good (and Bad) Practice in Kenya. Birmingham, International Development Department, School of Public Policy, University of Birmingham.
- Devas, N., P. Amis, J. Beall, U. Grant, D. Mitlin, C. Rakodi and D. Satterthwaite (2001). Urban Governance and Poverty: Lessons from a Study of Ten Cities in the South. Birmingham, International Development Department, School of Public Policy, University of Birmingham.
- Franceys, R. (1997). Sri Lanka: Urban Water Supply. Birmingham, University of Birmingham, School of Public Policy, Role of Government in Adjusting Economies Paper 17.
- Franceys, R. and K. Sansom (1999). India: Urban Water Supply. Birmingham, University of Birmingham, School of Public Policy, International Development Department, The Role of Government in Adjusting Economies Paper 35.
- Gilson, L., M. Alilio and K. Heggenhougen (1994). "Community satisfaction with primary health care services: an evaluation undertaken in the Morogoro Region of Tanzania." Social Science and Medicine 39(5): 767-80.
- Goetz, A. M. and J. Gaventa (2001). Bringing Citizen Voice and Client Focus into Service Delivery. Brighton, Institute for Development Studies WP 138.
- Grant, U. (2002). Local Government Decision-Making: Citizen Participation and Local Accountability: Examples of Good (and Bad) Practice in Uganda. Birmingham, International Development Department, School of Public Policy, University of Birmingham.
- Griffin, C. C., J. Briscoe, B. Singh, R. Ramadubban and R. Bhatia (1995). "Contingent valuation and actual behaviour: predicting connections to new water systems in the State of Kerala, India." World Bank Economic Review 9(3): 373-95.
- Hoddinott, J. (2002). "Participation and Poverty Reduction: An Analytical Framework and Overview of the Issues." J Afr Econ 11(1): 146-168.
- Kessides, C. (1993). Institutional Options for the Provision of Infrastructure. Washington DC, World Bank, DP 212.
- Kessides, C. (1997). World Bank Experience with the Provision of Infrastructure Services for the Urban Poor: Preliminary Identification and Review of Best Practices. Washington DC, World Bank,

Transportation, Water and Urban Development Department, General Operational Review, Issues Paper.

Kjellen, M. and G. McGranahan (1997). Urban Water: Towards Health and Sustainability. Stockholm, Stockholm Environment Institute, Comprehensive Assessment of the Freshwater Resources of the World.

Mani, D. (1997). "Implications of a demand orientation in planning for water and sanitation in Indian million-plus cities." Government and Adjustment: The Role of Government in Adjusting Economies Newsletter Issue No. 5: 5.

Manin, B., A. Przeworski and S. C. Stokes (1999). Elections and representation. Democracy, Accountability and Representation. Przeworski, A., Stokes, S. C. and Manin, B. Cambridge, Cambridge University Press: 31-54.

McGranahan, G., J. Leitmann and C. Surjadi (1997). Understanding Environmental Problems in Disadvantaged Neighbourhoods: Broad Spectrum Surveys, Participatory Appraisal and Contingent Valuation. Washington DC, World Bank, Urban Management Program WP 16.

Mudege, N. (1997). Urban Water Supply in Zimbabwe. Birmingham, University of Birmingham, School of Public Policy, Role of Government in Adjusting Economies Paper 18.

Mutizwa-Mangiza, D. (1997). The Opinions of Health and Water Service Users in Zimbabwe. Birmingham, University of Birmingham, School of Public Policy, Role of Government in Adjusting Economies Paper 24.

Narayan, D. (1993). Participatory Evaluation: Tools for Managing Change in Water and Sanitation. Washington DC, World Bank, Technical Paper 207.

Narayan, D. (1996). Towards Participatory Research. Washington DC, World Bank, Technical Paper 307.

Nickson, A. (1996). Urban Water Supply Sector Review. Birmingham, University of Birmingham, School of Public Policy.

Nickson, A. (1997). "The public-private mix in urban water supply." International Review of Administrative Science 63(2): 165-86.

One World Action (2002). From Consultation to Influence: Citizen Voices, Responsiveness and Accountability in Service Delivery. London, One World Action.

Paul, S. and S. Sekhar (1997). "A report card on public services: a comparative analysis of five cities in India." Regional Development Dialogue 18(2): 119-32.

Rakodi, C. (1996). The Opinions of Health and Water Service Users in Ghana. Birmingham, University of Birmingham, School of Public Policy, Role of Government in Adjusting Economies Paper 10.

Rakodi, C. (1998). The Opinions of Health and Water Service Users in India. Birmingham, International Development Department, School of Public Policy, University of Birmingham, Role of Government in Adjusting Economies Paper 32.

Rakodi, C. (1999). Water and health care provision: the views of users. Findings in Health, Water, Agriculture and Business Development Sectors. Batley, R. Birmingham, International Development Department, School of Public Policy, University of Birmingham, Role of Government in Adjusting Economies Paper 40: 75-96.

Rakodi, C. (2000). "'Getting the pipe laid is one matter and getting the water flowing through the pipe is another": User views on public-sector urban water provision in Zimbabwe, Sri Lanka, Ghana and India." International Planning Studies 5(3): 365-91.

Rakodi, C. (2001). "Urban governance and poverty - addressing needs, asserting claims: an editorial introduction." International Planning Studies 6(4): 343-56.

Rakodi, C. (2001). Urban Politics and Governance: A Review of the Literature. Birmingham, International Development Department, School of Public Policy, The University of Birmingham.

Schneider, A. and B. Goldfrank (2002). Budgets and Ballots in Brazil: Participatory Budgeting from the City to the State. Brighton, Institute for Development Studies WP 149.

Silva, T., S. Russell and C. Rakodi (1997). The Opinions of Health and Water Service Users in Sri Lanka. Birmingham, University of Birmingham, School of Public Policy, Role of Government in Adjusting Economies Paper 25.

Swyngedouw, E. (1995). "The contradictions of urban water provision: a study of Guayaquil, Ecuador." Third World Planning Review 17(4): 387-406.

United Nations Centre for Human Settlements (1995). Guidelines for Assessing Effective Demand of Communities for Environmental Infrastructure. Nairobi, UNCHS.

Whittington, D., J. Briscoe, X. Mu and W. Barron (1990). "Estimating the willingness to pay for water services in developing countries: a case study of the use of contingent valuation surveys in Southern Haiti." Economic Development and Cultural Change 38(2): 293-312.

Whittington, D., V. K. Smith, A. Okorafor, A. Okore, J. Liu and A. McPhail (1992). "Giving respondents time to think in contingent valuation studies: a developing country application." Journal of Environmental Economics and Management 22: 205-25.