Accounting for accountability: a critical review of Health Information Systems (HIS) potential to improve democratic accountability in decentralised Primary Health Care in Developing Countries.

There is general consensus that accountability is a critical aspect of the health sector reform agenda, put forward at the Alma Ata Declaration (1978), which focused on Primary Health Care delivery (PHC) for developing countries. A central effort to achieving these goals has been through the use of Health Information Systems (HIS). In theory, such systems should support the multi-layer process of health policy-making, including planning and resource allocation, implementation and monitoring the health status of patients (WHO, 1994, 2004; Scott, 2005; Madon and Krishna, forthcoming). Potential for HIS to support the routine or non-routine reporting of data is assumed to build and strengthen health institutions by creating more accountable healthcare systems.

The HISP initiative for monitoring PHC in Late Developing Countries (LDCs), attempts to provide sustainable software platforms to accumulate local information on diseases so policy-makers can move beyond government funded periodic surveys[1]. HISP plays an increasingly important role in supporting policy planning, for example, by improving the allocation of resources to localities where HISP information shows disease outbreaks (WHO, 1994, 2004; Schott, 2005; Madon et al., 2010).

This essay deconstructs accountability in PHC, and the ways in which HISP can potentially improve health institutions particularly through *democratic accountability*. Secondly, through analysis of the literature this essay draws attention to the fact that HISP, so far, has not universally improved democratic accountability in the reporting of data. Finally, through attempting to explore New Democratic Spaces (NDS), an initiative to increase democratic accountability, the essay emphasises the importance of local knowledge in supporting the reporting of data through the HISP hierarchy. A central argument is that while increasing democratic accountability is critical, NDS initiatives require some level of rational and responsible action on the

[1]See www.hisp.org

part of decision-makers in order to improve the reporting of data – and make critical reforms to PHC in LDCs.

(De)constructing Accountability

In light of the increasing traction of 'accountability' in development debates it is important to have a grounded understanding beyond its common use as a 'buzzword in a long line of ineffectual quick fixes' (Brinkerhoff, 2004:372). Particularly because the connotations it conjures changes with context and agenda (Newell and Bellour, 2002; Newell, 2006). A common denominator of accountability is *transparency,* yet this term does not encapsulate its complexity and multi-dimensionality. For instance, governments might be meeting transparency targets on paper, yet the data they disclose does not offer citizens greater access to that data (Peixoto, 2013). Therefore, transparency may be considered a pre-requisite of accountability. The contemporary understanding of accountability can be de-constructed into two key elements; *answerability*, which means providing an account of actions taken and *enforceability,* the punishment or sanction for poor performance (Schedler et al.,1999).

Brinkerhoff (2003:7) recognises that accountability in healthcare is comprised of three separate dimensions. First, *financial accountability* refers to tracking and reporting on the allocation, distribution and use of financial resources and second, *performance accountability* focuses on services, outputs and results thus makes actors demonstrate their performance in terms of agreed-upon targets. Finally, *democratic accountability* means,

> 'the institutions, procedures, and mechanisms that seek to ensure that government delivers on electoral promises, fulfils the public trust, aggregates and represents citizen's interests, and responds to on-going and emerging societal needs and concerns' (Brinkerhoff, 2003:7).

Therefore strong democratic accountability in PHC means that the health needs and priorities of LDC citizens are met by decision-makers.

Building democratically accountable health systems is important because they form part of the institutional fabric of a society. It has long been established that democratically accountable institutions are important for development, both in economic terms and generally (see for example, Brett, 1999; Przeworski, 2000; Rodrik 2007; North et al. 2009; Acemoglu and Robinson, 2012). Indeed, as Newell (2006:37) highlights, accountability 'is central to ensuring that political and market institutions responds to the needs of the poor'. However, as Madon et al. (2010) point out democratic accountability in the healthcare institutions of LDCs is almost always very weak.

In summary, it is important to recognise the importance of improving democratic accountability in PHC for two primary reasons; first, it is central to the development of effective healthcare institutions. Second, it is important to change the interactions between health service providers and the people who are entitled to benefit from such services.

Potential of HISP

Many agree that HISP has the potential to play a fundamental role in improving democratic accountability by 'acting as a repository for information generation and analysis at the local level so that the PHC can address the dynamic, unpredictable and idiosyncratic elements of primary healthcare planning in developing countries' (Madon et al., 2010:257).

Despite the extensive literature on the benefits of HISP, and its adoption in various countries since its inception in South Africa (1994), Chilundo and Aanestad (2004) have shown they have yet to provide support for analysing the priorities of local health centres to improve planning and allocation of resources to PHCs. Critically, this is one reason why evidence has shown HISP implementation in developing countries has *not* universally improved democratic accountability (see for example, Jacucci et al. 2006; Braa et al. 2007). Madon et al. (2010), in a study of HISP in Karnataka (South India) investigated the nexus between decentralisation, as a key policy prescription for the role out of PHC, and democratic accountability. They find

that, democratic accountability is a relatively neglected issue and there remained weak linkages between the community and local health facilities.

Current forms of accountability in HISP are generally not adequate, for example, Brinkerhoff's (2004) and George (2009) highlight how staff meetings alongside HISP, have simply facilitated a flow of inaccurate or incomplete set of data reporting, and offer little space to verify these reports beyond a pre-set formula. Evidence from other studies have shown that without strong mechanisms for *answerability* and *enforceability* local health planners have been dependent on informal soft data not from the formal information system which has lead to delays or inaccuracy in data reporting (Nhampossa et al., 2004; Mutemwa, 2006; Miscione, 2007; Williamson and Kassboll, 2009).

Ostensibly one principle reason for the lack of accountability within HISP is that there is little 'space' for health workers to draw on their local knowledge as information is reported up the hierarchy, and this can result in 'data becoming devoid of meaning' (Madon and Krishna, forthcoming). For instance, Chilundo and Aanestad (2004:16) find evidence of 'incompleteness, inconsistency and incorrectness' in their assessment of a Malaria and HIV program. More data could either mean an outbreak of the disease or simply that better reporting was taking place. Without local knowledge supporting the flow of data it proved difficult to differentiate these outcomes. Thus, HISP systems still have some way to develop before they can be described as making decision makers more democratically accountable to the communities they serve.

Improving Democratic Accountability

The literature has pointed to New Democratic Space initiatives (NDS) as one way in which democratic accountability could be improved. Indeed, such initiatives have become popular in developing countries as a means to support a decentralised model of health service delivery (Madon and Krishna, forthcoming). NDS are 'invited space' where ordinary citizens are 'invited' to participate in the institutional functioning of public service delivery; such spaces may be conceptualized in different ways (see for example, Cornwall, 2004; Newell, 2006; Cornwall and Coelho, 2007).

In theory, NDS initiatives require citizens to use 'voice' to directly hold health service providers to account. In this way, it creates new opportunities for 'participation' outside of the vertical HISP system, for example, community groups created by donor-driven health reformers (Mahmud, 2004).

NDS have been incited by a new concern for rights, power and difference in the debates and ideas that argue for greater 'participation' by citizens in development. Some see NDS as an opportunity to practice more vibrant and deliberate democracy in institutional development (Fung and Wright, 2003). While others have voiced concern that this is a form of co-option, absorbing and neutralising social energy from other types of political participation (Cornwall, 2004).

An example of a NDS initiative has been put forward by Madon and Krishna (forthcoming) in their study of efforts to improve the poor levels of democratic accountability of PHC in India. The initiative is to be delivered through Village Health and Sanitation Committees (VHSC) who should meet on a monthly basis in order to 'reflect the aspirations of the local community especially of the poor households and women' (Guidelines for VHSC, 2011).[2]

Madon and Krishna's (forthcoming:12) exploratory findings signal the importance of social processes in learning about how to improve democratic accountability and they suggest that NDS have become 'active sites for compromise and dissent, decision-making, information provision, education, self-help and problem-solving'. For instance, consider the example of the state of Krishnapura where, VHSC meetings discussed the levels of accuracy of PHC data, for example, antenatal reports and immunization data for mothers and children. By comparing reported data and local knowledge there is space for improved accountability through the reporting of data up the HISP ladder.

Few studies have yet to offer a rigorous evaluation of how far VHSC have really improved answerability and enforceability in HISP systems. Indeed, there is scope

[2]VHSC should constitute at least 50 percent female members and backward classes and tribes. 30 percent representation from the Non-governmental sector (Guidelines for VHSC, 2011).

for concern since the literature largely glosses over the possible negative consequence of realigning democratic accountability to the needs of the community (Anifalaje, 2009:54). For example, in VHSC 'women' are targeted, yet it is not clear if this excludes women from higher castes or income households. This may skew accountability between decision-makers and the community towards the priorities of higher income women away from lower income men or children. Attention needs to be paid to understanding the consequences of improving democratic accountability to different stakeholders and the community level.

Despite such concerns, the case of India signals that there is scope for NDS initiatives to improve democratic accountably. This requires that HISP systems 'invite space' beyond recording data targets, for example, so that community workers can document the realities on the ground and in particular the challenges and reasons *why* they have not reached pre-set targets. Without space for information beyond the qualitative data reporting policy-makers are unable to tackle structural barriers and empower local community workers.

NDS: Answerability and Enforceability

It is assumed once space has been 'invited' it will automatically incite reform, but it remains unclear how this will deliver greater democratic accountability. Recall that accountability is both *answerability* and *enforceability.* It may be argued, NDS offer some level of answerability by improving space for 'answers' to citizens' 'voice' in the reporting of data. However, alone NDS initiatives (such as VHSCs) do not provide communities with the agency to enforce reform; a paradox of changing accountability is that is often left to the prerogative of decision-makers. King Charles I 'invited space' in the form of parliament to discuss the needs of English people but vital reforms were only enforced after his beheading. In many ways, the usefulness of NDS as a tool to increase accountability in HISP goes only as far as such issues are fed back into the structures and institutions of decentralised PHC. As with all aspects of strong institutional development, it will take time to improve the way that citizens are involved in the process of healthcare governance and this process also requires participation from policy makers.

Conclusion

HISP are a potentially powerful tool to improve the accountability of PHC in developing countries. However, it has failed to universally improve levels of democratic accountability in the reporting of data. Indeed, an important precedent learnt from various cases is that without input from the local communities data reporting can simply become meaningless. New Democratic Space initiatives have been put forward as one effective way to achieve greater democratic accountability of service provision to communities. Yet it remains unclear how NDS initiatives will enforce positive reform – the ultimate goal of PHC development.

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