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Governance of Infrastructure Provisioning and Healthcare Services for Enhancing Health Service Utilization

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In most developing countries, the public sector is the largest provider of health infrastructure and healthcare services. Even when health clinics are geographically accessible, many barriers continue to impede access to quality healthcare services. Some of these barriers are structural, such as the rural-urban disparity in infrastructure provisioning. Although service infrastructures are more concentrated in urban areas compared to rural areas, urban residents are more likely to encounter certain problems at local clinics due to higher population density and greater service demand in urban areas. Sufficient health resources—physical infrastructure, staff, budget allocation, and supplies—do not guarantee that people receive quality services. Massive infrastructure projects are not always a cost-effective solution to this end because of corruption and other governance issues. For the optimum use of limited resources, we need to address the governance issues for removing barriers to service utilization.

Empirical evidence from 34 African countries surveyed by Afrobarometer during 2011–2013 suggests that while health infrastructure was quite widespread in these countries, service utilization was not. About 53 percent respondents reported that they had to go without medicine or medical care at least once over the year prior to the survey. About 43 percent of those who went to a public clinic said that it was difficult or very difficult to receive services; 33 percent said the services were too expensive for them; 37 percent reported absent doctors; 43 percent reported lack of medicine or other supplies; 42 percent reported lack of attention or respect from the staff; 62 percent reported a long waiting time; 32 percent reported that the facilities were dirty; and 15 percent said that they had to pay a bribe for receiving services.

Absent doctors, insufficient medical supplies, unaffordable services, unsanitary facilities, informal payments, and such other problems that people often encounter with their local clinics are some examples of the lack of governance in the health sector. Such poor governance lowers people's health service utilization level by contributing to ghost and absent healthcare workers, informal payments for services, siphoning off of medical supplies to informal market, and elite capture of healthcare services. Corruption often diverts resources away from health service delivery and biases resource allocation toward major infrastructure projects because of opportunities for financial kickbacks. Additionally, corruption in construction lowers the standard of the infrastructure and requires expensive repair and maintenance, and the loss of revenue and diversion of public funds associated with this may cause governments to spend less on human resource development, better pay, improvement of working conditions, and providing

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necessary health resources at the service point. Together, this situation contributes to low morale amongst healthcare workers; they often neglect their duties at public clinics and work in the private sector for additional income. Low pay is one reason, but empirical studies on Bangladesh, Ecuador, India, Indonesia, Peru, and Uganda offer evidence that poor working conditions and lack of accountability and monitoring at the facility level are the main cause of such absenteeism (Chaudhury et al. 2006; Chaudhury and Hammer 2004).

Empirical evidence clearly shows that investing in healthcare workers' training for human resource development, improving working conditions, establishing accountability to public, and closely monitoring activities at the service point help retain healthcare workers and enhance service utilization at public clinics. The Indian state of Kerala is a well-known success story in this regard (Evans 1995). My own experience as a monitoring officer for a UNICEF-supported "safe motherhood" project in Bangladesh provides further evidence. In the early 2000s, a few public hospitals at the sub-district level initiated a 24/7 cell phone hotline as well as an emergency ambulance service to ensure safe child delivery at the hospital. Healthcare workers received training and mass communications activities were undertaken to make people aware of these initiatives. Regular monitoring and reporting mechanisms were established with the involvement of community leaders, local press as well as health authorities from national, division, and district levels. The project helped to establish a relationship of accountability and appreciation between service providers and service utilizers. It not only improved maternal and child health within a short period but also helped to ensure that healthcare workers were present at the service point on call.

Simple and cost-effective interventions like this are much needed at the service utilization level. These interventions have played an important role in the rapid improvement of maternal and child health in countries like Bangladesh. Similar interventions can be undertaken elsewhere, such as in African countries, where the issues of infrastructure provisioning, governance and health service utilization are pertinent.

Source:

Quamruzzaman, Amm. 2017. "Infrastructure Provisioning and Health Service Utilization in Africa: Does Governance Explain the Gap?" *Sociology of Development* 3(1): 47–69.

References and Further Reading:

Chaudhury, Nazmul, and Jeffrey Hammer. 2004. "Ghost Doctors: Absenteeism in Rural Bangladeshi Health Facilities." *World Bank Economic Review* 18(3):423–41.

Chaudhury, Nazmul, Jeffrey Hammer, Michael Kremer, Karthik Muralidharan, and F. Halsey Rogers. 2006. "Missing in Action: Teacher and Health Worker Absence in Developing Countries." *Journal of Economic Perspectives* 20(1):91–116.

Evans, Peter. 1995. *Embedded Autonomy: States and Industrial Transformation*. Princeton, NJ: Princeton University Press.

Greer, Scott L., Matthias Wismar, and Joseph Figueras (eds). 2016. *Strengthening Health System Governance: Better policies, stronger performance*. Berkshire, UK: Open University Press.

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