Draft for Comment

Voice Interventions and the Quality and Responsiveness of Public Services in Low- and Middle-income Countries (LMICs)

Does Voice Improve Quality and Responsiveness

Gary Gaumer, Ph.D.
Brandeis University and Simmons College

Joanne Beswick, M.A.
Binod Sah, M.A.
Jenna Sirkin, Ph.D. Candidate
Brandeis University

July, 2008

Abstract

Voice interventions of various kinds have been widely used to create accountability in managers of public programs. We reviewed the evaluation literature to understand the findings with regard to the impact of voice interventions on quality and responsiveness of public services. The literature on ‘voice’ interventions is broad, but very few studies focus on quantitative outcomes that bear on impacts of ‘voice’ interventions. Most of the literature represents case studies relating the design or implementation of projects, and the evaluation work is most concerned with fostering participation. While there is some evidence of these interventions not working at all, the primary finding is that voice may well build citizen participation and some measure of accountability of service providers, but there is little measurable evidence that service quality has improved. The studies do not really permit a comparative effectiveness assessment of different kinds of ‘voice’ interventions, even though the positive effects appear most pronounced for ‘community scorecard feedback’ types interventions.

Key Words
Voice, accountability, public services, literature review

This analysis was funded by a grant from the Bill and Melinda Gates Foundation. The views expressed are those of the authors and any errors or omissions are theirs.
1.0 Background and Summary

A literature review is not needed to document the poor service quality and general unresponsiveness of public services to community needs in developing countries. Data and anecdotes abound concerning accessibility issues, corruption, ineffective management, disrespectful treatment, absenteeism of professionals, stock outs, flagrant discrimination, unresponsiveness to suggestions and complaints, and other issues. Captive audiences for education, health, housing, pension, and other public services, coupled with recipients’ economic vulnerability and low political status create a situation prone to poor service quality and unresponsiveness to improvement or change over time.

Why is poor service quality so pervasive? One author describes the problem of poor government service quality as a product of the selfish motive of ‘capture’. Paul (1991) defines the concept of capture as a public service manager’s presumed desire to “control the allocation of public services to engage in rent seeking” (iv). He argues that public service managers are essentially a small and organized “club” of public servants who collude to control and redirect the supply of public services for their own use and for the use of others they choose. Paul argues chronic deterioration in customer service quality within public service organizations results from the ‘capture’ of a growing portion of public services by government officials; these officials are motivated to extend their well being at the expense of the larger body of citizens for whom the benefits were originally intended. This capture tendency is especially strong when government is a monopoly provider of services. In addition to the obvious opportunity for corrupt and illegal misappropriations, civil servants in low-income countries often receive preferential shares of public services. Examples of this type of corrupt allocation of services include: health insurance benefits that are not available to others, access to out-of-country health services, admission to the best schools, preferential land purchase rights, special treatment regarding various permits, free utilities, and access to scarce phone lines. These kinds of benefits are made available to public servants through law, or informal reciprocity agreements. Figure 1 depicts the situation prevalent in the public service sector of many developing countries. At the point of service provision (POS) resources are diverted from the intended customers by corruption, ineffective management, capture and other problems.

This paper reviews the available literature about certain types of voice interventions that aim to offset the “capture” incentives and other problems, and thereby improve the quality and responsiveness of publicly supplied services. We are interested in interventions that enhance the service supplier’s accountability to the consumers they serve (rather than making officials more...
accountable to themselves). Public accountability is defined as the extent to which the systems – and the people

Figure 1: The Problem

that manage and deliver public services – are motivated to deliver the desired types of services in the most appropriate and effective fashion and to seek to improve the level of performance (Paul, 1991, p. 2). Specifically, we focus on evidence pertaining to interventions that empower community stakeholders and customers through enhancing their ‘voice’. Voice “… is about poor people expressing their views and interests in an effort to influence government policies and governance processes” (O’Neil, Foresti, & Hudson, 2007, p. v).

Theories focused on quality improvement highlight various determinants of quality and motives for choosing to improve quality within the context of public programs. Examples of relevant institutional or contextual factors include:

1. Specificity and intent of laws that establish the authorities to tax and deliver such services
2. Scope and specificity of the relevant policies and regulations developed by the government
3. Sufficiency of budgets, compensation arrangements, and the other resources that money buys
4. Quality of management, management training, and management support
5. Adequacy of governance structures and monitoring tools
6. Adequacy of the distribution networks for delivery of services to all that qualify for them
7. Clarity of the locus of authority to make changes and adaptations required to meet local needs

These institutional arrangements – along with the site-to-site variance and unexpected situations that arise – represents the volatile context within which point-of-service (POS) managers must deliver services to communities and individuals. While there may not be a formula for improving government provided services in the face of situational disparities, there are certainly various interventions that have aimed to improve the quality of public service provision. Many kinds of interventions, including voice, can motivate public servants to pay more attention to the needs of their customers. They include: (1) creating financial (budget) incentives; (2) improving the responsiveness of management at the point of service through decentralization and increased autonomy; (3) deliberately enhancing choice for consumers by developing alternative supply sources, resulting in competition for government’s monopoly leverage; and (4) empowering customers and community stakeholders to voice concerns and interests, thus increasing management responsiveness. In addition, enhancing consumer knowledge (often through social marketing) is viewed in the literature as an intervention that may promote both choice and voice. These are shown in Figure 2.

**Autonomy.** Managers need to be able to (1) understand the needs of customers, and (2) to be able to make changes in response to market pressures or voice pressures. Decentralization or creating more local authority for managing services may improve aspects of quality through ‘voice’ to the extent that officials with authority (e.g., the municipal manager, the local government director) who live and work locally have access to information about quality problems (through official channels, neighbors, or even family). This may increase the likelihood of remedial action (by a policy change, a resource allocation change, or a management change). Autonomy of the local management structure to make changes and move resources around (hire, fire) is also critical. Bossert refers to this aspect of decision autonomy as “decision space”. It is an enabling factor which will largely determine whether pressure, however applied, can be effective in producing change.

**Incentives.** Direct budget incentives can be a mechanism for improving service quality and for tying the performance of the organization to the interests of customers. Incentives may be effective in instances when reliable measurable performance indicators exist, and where the POS managers have sufficient autonomy to act in response to those incentives. Bonus systems and pay-for-performance incentives require the government to identify the aspects of quality that are most important; these identified determinants of quality are then incentivized (often with cash incentives) to encourage POS managers to improve performance and quality of service delivery.

**Choice.** Interventions that fall within the ‘choice’ category influence POS managers and agencies because they are exposed to more competition with other service providers. Officials who are able to provide better quality services often are able to attract and maintain more customers—and retain or enlarge their span of control and prestige. If customers have options for getting services, then they can “vote with their feet” as a mechanism for voicing their dissatisfaction. Certainly, the power of pressure by Voice will be greater if there is also freedom of choice. Choice may also be a powerful source of pressure on POS managers if their performance appraisal is dependent on volumes of services provided. In many countries the educational and health sectors permit consumers a choice between government provided services and the private sector. In many situations, the flow of resources to government facilities is not impeded by low capacity utilization. In other cases, POS budgets suffer if the government services do not fare well in competition to the private sector. Mechanisms of policy can
create choice: setting up competing private suppliers by means of contracting by the government, or by deregulating or privatization. Vouchers (or portable insurance cards) are also ways of supporting more choice for public service.

Figure 2: Categories of Quality and Responsiveness Improvement Interventions

Autonomy at POS
- Decentralization
- Flexibility to manage
- Capacity to manage

Choice
- Vouchers
- Contracting
- Private competition
- Transparency of quality information

Incentives
- Budget incentives
- Performance awards

Voice
- NGO/GRO or advocate organizations
- Consumer rights organizations
- Ombudspersons
- Participatory Budgeting
- Building community knowledge
- Community scorecard feedback

**Voice.** Empowering communities and consumers through ‘voice’ aims to increase service provider accountability through direct pressure from consumers and the community. Individual consumers or community stakeholders may utilize various channels of influence to pressure the POS agents improve quality of services. For example, a community group may petition the local health department to keep the clinic open later on Friday nights – this is the self-identified aspect of “quality” that consumers are “voicing” to health officials.

There are hundreds of published studies of voice interventions, our subject here. Most describe community interventions and offer no more than self-serving expectations of program designers or managers about the intended results. Some offer an attempt at evaluation, but often fall short of providing a service quality impact assessment; such studies generally conclude that
participatory processes involved in the intervention are, by the nature of participation, evidence of a positive outcome. We focus on the literature which attempts to measure the intervention’s impact on service quality, health outcome, or customer satisfaction.

The literature covers are large number of types of voice interventions through which consumers of government services have enhanced their ‘voice’ through participation in various forms: (1) participatory institutions (e.g., partial community ownership, village councils), (2) direct governance in the form of consumer boards, (3) customer evaluation/satisfaction surveys that provide feedback to management, (4) the enlistment of ‘voice’ agents (e.g., consumer rights groups, NGOs, Ombudsmen), (5) empowerment of consumers through knowledge and training, and (6) consumer rights organizations.

Results

Building Consumer Information and Knowledge about Specific Service Offerings

An extensive body of literature describes interventions that empower individuals with information about available services, the skills to utilize the services themselves (or encourage other community/ family members to do so) and the knowledge and skills to demand better quality services and accountability from public officials. Some others, using community-based interventions tend to focus on fostering consumer knowledge about a particular type of service (e.g., health services, education, or other social services). Research on the effectiveness of those interventions are reviewed in this section.

Studies have shown that providing consumers with more service-specific information – and guidance on how to put the knowledge into practice (i.e., skills) – results in positive community health outcomes. A malaria prevention program in Thailand developed women’s knowledge and skills to prevent malaria while also increasing their self-esteem and confidence to empower others in the community (Geounuppakul, Butraporn, Kunstadter, Leemingsawat, & Pacheun, 2007). Results showed that the ten-session group trainings increased women’s self-esteem and confidence to develop and implement strategies to control and prevent malaria in their respective communities. The villages where the group meetings occurred significantly increased use of insecticide treated bug nets compared to the control villages. A similar malaria prevention program in Papua New Guinea empowered village members to take responsibility for the acquisition, distribution and effective use of WHO approved Malaria nets (Fitzpatrick & Ako, 2007). The authors found that empowering community members increased community knowledge, which resulted in an increase in bed net use and a decrease in Malaria-related morbidity and mortality in the community (compared to pre-intervention). Both of these health interventions empowered groups of women with the knowledge, skills and leadership roles to enhance community knowledge about malaria prevention; the participatory trainings provided the women with both the ‘voice’ and the support to implement strategies to improve community prevention efforts.

1 Ombudsmen are typically persons hired or appointed to represent the interests of citizens or consumers by investigating and resolving complaints.
2 A second section below reviews the results of interventions that more broadly build consumer empowerment in the community.
Findings from Mozumder and Marathe’s (2007) multi-country work also demonstrates the correlation between consumer information, service use and outcomes. They constructed a panel data set of 70 countries to study the correlation between local communication and information networks and the incidence of malaria related deaths. Results showed that the intensity of local communication and information networks was significantly associated with decreased probability of deaths among the malaria-infected populations (Mozumder & Marathe, 2007). These results demonstrate the importance of collective knowledge about timely care and available services for the treatment of malaria.

Although many of the aforementioned studies have impressive outcomes, they lack evaluation at the level of POS delivery, and thus are not able to conclude that the knowledge interventions necessarily increase the accountability of service providers or changes the demand for services. They do show that by giving citizens a ‘voice’ to strategize and implement their own initiatives, collective action can have important results—results that would not have occurred absent the ‘voice’ intervention. Interventions to improve the amount and quality of information provided to consumers and to increase consumer knowledge about a particular intervention seem to be effective at making the consumer a more savvy, sophisticated and pro-active demander and user of the specified health services. There have been increases in both demand for and proper use of technologies and results have shown improvements in important health indicators. However, these studies have not demonstrated that improvements that are aimed at increasing consumer knowledge about specific interventions or services have any affect on the quality of services provided.

A group of studies evaluating results at the POS level have found that enhancing community knowledge does result in increased service use. A randomized-controlled trial conducted in India evaluated an intervention informing the resource-poor about their entitled health and education services and village governance requirements (Pandey, Sehgal, Riboud, Levine, & Goyal, 2008). Results showed that the intervention villages significantly increased their utilization of health-related services (prenatal services, tetanus and infant vaccinations, and prenatal supplements), educational services (decreased excess of school fees) and improvements in community governance (more reported village council meetings).

Similarly, another randomized trial in rural Nepal evaluated an intervention where local women’s groups had identified local perinatal problems, formulated the appropriate strategies to address the issues, and implemented these strategies in their respective communities (Manandhar et al., 2004). Comparison of intervention to control sites showed a significant decrease in neonatal mortality and maternal mortality where the interventions took place; women in the intervention villages also utilized more health services (e.g., antenatal care, institutional delivery and trained birth attendants) than their counterparts in the control villages.

A literature review by Laverack (2006) generally argues that women’s participation in groups strengthened their social networks, support groups and increased their interaction with providers: “By participating in support groups, they were better able to define, analyze, and then, through the support of others, articulate and act on their concerns regarding childbirth” (p. 115). Thus, empowering groups of women increased community knowledge and participation about
prenatal services, which resulted in positive outcomes for both service utilization and maternal and neonatal mortality rates.

These studies that examined increasing consumer knowledge at the POS show an increase in utilization which led to improved health outcomes. There is a little bit of “evidence” suggesting that it may also increase the quality of services provided through consumers’ improved ability to define, analyze, articulate and act on their concerns – hence they might be acquiring the ability to demand better quality of services in addition to demanding any services at all.

Other studies point to the effectiveness of providing knowledge to the public about particular services and the importance of political accountability. Eckardt (2008) used household survey data to test the hypothesis that increasing public bureaucrat political accountability (through sanctions on non-compliant bureaucrats or providing more transparent information to the public) would create incentives for officials to reduce corruption and improve quality of service delivery. Empirical findings from local governments in Indonesia support the hypothesis that improving political accountability enhances the quantity and quality of public service provision through improved government decision-making, resource distribution and allocation. A similar econometric study in Uganda showed that increasing household knowledge about reporting corruption and unsatisfactory services was associated with reduced citizen participation in bureaucrat corruption (i.e., people were significantly less likely to pay bribes) and improved the overall service quality (Deninger & Mpuga, 2005). The authors found that knowledge about reporting inappropriate bureaucrat behavior and unsatisfactory services was significantly associated with greater satisfaction with service delivery and perceived improvements in education and health services.

In summary, efforts to increase service-specific community knowledge to empower marginalized community members resulted in increased utilization of public services and often had a positive impact on community members that were not direct recipients of the intervention. This suggests that general improvements in information availability and community empowerment programs may have improved public official accountability and the quality of service provision. Sanctions, transparency and ability to report bad behavior have the potential to empower citizens to both hold their government officials and providers accountable and also to behave better themselves. If effective accountability mechanisms are in place to ensure that the accountability system will work for them, citizens may not feel the need to resort to bribes or other bad consumer behaviors.

General Community Knowledge and Empowerment Interventions

While the interventions we reviewed above focus on service specific knowledge and behaviors to improve outcomes in specific domains or for particular services (e.g., health, education, local governance), there are also programs that aim to promote more general community knowledge building and empowerment. In a literature review of community empowerment programs, Laverack defines community empowerment from the program context as “… a process in which individuals, groups, and communities progress towards more organized and broadly based forms of action” (2006, p. 113). He reviews the literature, identifying various ‘empowerment domains’ that have been shown to impact
community health outcomes, including: participation, community-based organizations, local leadership, resource mobilization, asking ‘why’, problem assessment, links with other people and organizations, role of outside agents, and program management.

One example is the case of a community-based organization in Samoa, Polynesia that addresses the health needs of women at a local level. Although the self-help organization is operated through women’s committees and is based on extensive neighborhood support networks, the government supported the development of the organization through resource allocation and capacity building (e.g., skills training) of the organization’s members. Qualitative analyses of the organization demonstrated the women’s improved ability to organize as a group and mobilize resources to build sanitary and health facilities in their communities (Laverack, 2006).

An evaluation of The Ghana Community-based Health Planning and Services (CHPS) found that community participation was one of the key components in the initiative’s success (Nyonator, Awoonor-Williams, Phillips, Jones, & Miller, 2005). The pilot experiment in Ghana mobilized the traditional system of leadership, communication, and governance to increase accessibility to services and enhance accountability of providers. The planning process for CHPS involved additional stakeholders such as traditional leaders and community health committees; community entry involved dialogue with community leaders and residents; and the development of community health compounds required combined community ownership. The results suggest that community participation was increased by mobilizing the traditional community system of leadership to help increase accessibility of services and increase accountability of providers. This was accomplished through the creation of a sense of ownership within the community through members’ participation in planning and helping to build community facilities.

A study from the Development Research Center (DRC) on Citizenship, Participation, and Accountability also suggests that involving people directly in decision-making along with elected representatives can strengthen the state (Eyben & Ladbury, 2006). Research findings from Latin America suggest that it is important to create the opportunities for poor citizens to hold the state accountable for service provision. Both of these studies demonstrate the importance of involving community members as stakeholders in decisions about local service provision, encouraging a sense of joint ownership among the population and greater accountability among service providers.

Mosquera, Zapata, Lee, Arango, and Varela (2001) studied two institutional state mechanisms in Columbia that were designed to channel citizen participation into the health sector: user associations and customer service offices. The analysis revealed various degrees of uncertainty about user participation among both public and private institutions, consumer groups and citizens; although efforts had been made to increase citizen participation, the authors found that health care users still had a very limited role in the decision making process.

Golooba-Mutebi (2004; 2005) found that in Uganda community participation, though popular and enthusiastic in the beginning, does not have the same intensity in a long run due to participation fatigue. Village councils initially established to facilitate community participation atrophied after a decade. The proposed reason for fatigue was that participation exerts a heavy toll on the time and livelihood of an overworked and poor populations (Golooba-Mutebi, 2004). He also found that in Uganda, the assumption that community members have the motivation and
capacity to participate in initiatives did not hold true due to presence of a weak state and inconsistent regulation (Golooba-Mutebi, 2005).

These results suggest that general (not service specific) approaches to knowledge building and empowerment may be useful in creating citizen participation and sense of ‘ownership’ in some instances, but there is no evidence that the result is improvement in service quality. Much of the power behind these initiatives stems from the “group” aspect of organizing and mobilizing. One individual can have a little effect, but the more people who participate, the potentially better the outcome. The ideas and rationale behind these initiatives make sense, but unfortunately, there is not much hard evidence to say anything about effectiveness in improving service quality.

**Community or Customer Performance Reporting**

Another means of holding providers accountable for the quality of customer service is through the use of a community or customer scorecard. Scorecards – often referred to as report cards or performance reports – are composed of information solicited from consumers evaluating the quality of a particular service. The information is generally summarized and either made public or utilized for quality improvement at the POS. The impact of public reporting on bureaucratic or provider behavior has been extensively studied in developed countries, but the study of community scorecards in the developing countries has been limited.

Based on evidence from decentralization efforts in Latin America, Fuhr (2000) suggests that citizen-government (horizontal) relationships have the potential to provide incentives for greater cooperation, accountability, and local performance:

> Recent evidence from Latin America, particularly Colombia, suggests that once local policymakers are held accountable for their actions and made aware that their jobs depend to a large extent on citizens’ assessments of their performance, they tend to be much more concerned with the quality…(Fuhr, p. 30)

Other studies have also shown improvements in POS behavior when consumer assessment information is made available to bureaucrats, providers or more generally to the public. McNamara (2006) provides a comprehensive assessment of provider-specific report cards, which is based on examples from published and gray literature in developed countries and the review of key informants from the developing countries. The findings suggest that in the developed countries, while the use of report cards encourages the providers to improve their quality of care, they have little impact on consumer selection of providers3. McNamara also found that in developing countries, use of report cards shows an increase over time in the satisfaction ratings that consumers give to providers. This suggests that providers improved the quality of their services. Report cards can also increase public awareness of quality.

---

3 Consumers tend not to utilize report cards when choosing their provider and health plan, because they do not trust the source of the report cards (generally the health plans). Another proposed reason for poor utilization is that most of the consumers have difficulty interpreting the rates in the report cards – i.e., they are not “consumer-friendly”. Most consumers make decisions based on the recommendations from family, friends, or attending physicians, while choosing for health plans or providers (CITE)
Findings from the developing countries suggest that use of report cards have positive outcomes for both the providers (improvements in service quality) and for the consumers (awareness and provider selection) (McNamara, 2006). For example, an assessment of the Yellow Star Program in Uganda, Africa indicated that the average service quality score for providers increased. Similarly, in Bangalore, India, use of report cards resulted in increased public awareness and improved quality of public services. However, the literature also cautions the negative effects of provider report cards (undocumented), such as: encouraging physicians to select healthier patients in order to improve their quality ranking and to provide unnecessary services to achieve “target rates” health care interventions (McNamara, 2006).

Balakrishnan and Sekhar’s (2004) study of the Citizen Report Card initiative in Bangalore, India found that report cards resulted in significant improvements in service delivery. Enabling factors seem to be competencies, resources, preparedness of local governments, and capacity of local institutions. The researchers analyzed a sample survey that collected feedback on various service delivery systems (e.g., electricity, water, sewerage, and city government); findings were then disseminated in the public domain and to the service providers. The findings from this initiative suggest that there were substantial improvements in various services. For example, only 6% of the general households were satisfied with the electricity services in 1993, while this figure rose to 47% in 1999, and to 85% in 2003. Similarly, in 1993 only 4% of the general households were satisfied with water and sewerage services, which increased to 42% in 1999, and to 68% in 2003.

The World Bank (2000) conducted a report card survey in collaboration with Social Weather Stations, which was distributed across four regions in Philippines. The survey asked 1,200 poor households about awareness of, access to, use of and satisfaction with public services. The various sectors of public service in the survey included: health care, primary education, housing, water, and subsidized rice distribution. While the responses from this report card survey showed high level of dissatisfaction among the poor Filipinos, it emerged as a powerful tool because the findings were addressed in the subsequent development plans.

Based on these findings, public reporting of quality performance seems to be a powerful tool for encouraging government officials and service providers to increase their accountability for service delivery and quality. The use of scorecards to evaluation performance of bureaucrats and providers creates a demand-side incentive to improve the quality and delivery of services. Report cards that report on quality of services seem to encourage government officials and medical providers to increase their accountability for delivery and quality.

Consumer Representation in Governance

Studies of two aspects of governance are found in the literature; consumer representation on a board of directors, and consumer participation in the budgeting process. The literature is quite sparse on both types of governance interventions.

Only one relevant study was found on citizen boards (e.g. a community board of directors to advise management). A multi-stage sampling scheme in the Philippines sought to analyze the role of local health boards in enhancing community participation and empowerment (Ramiro et al., 2001).
Results suggest that the local organizations with functioning health boards had more consultations with the community, more fund-raising activities for health, and more health-related activities (beyond what was approved by the Department of Health’s core programs) compared to their counterparts. There were also improvements in the use of health services. This is encouraging, but more research is needed to confirm the utility of consumer boards in improving service quality.

Participatory budgeting is another aspect of governance, where consumer voice is represented in the resource allocation (planning) process. Cabannes (2004) considers participatory budgeting as an area of democracy and local development that responds to individual demands. According to his 2004 estimate, participatory budgeting had been applied in 25 cities, mainly in Latin America and in Europe. Merits of participatory budgeting include transparent management, and more access to the municipal processes, acknowledgement of citizen’s right of direct participation, transparency, and some evidence of reallocation of resources across locations. However, there is no evidence of impact on public service quality or customer satisfaction, and some evidence that many projects have been terminated, challenging long-term sustainability. There is also a lack of evidence regarding participation of traditionally excluded social groups (Cabannes, 2004).

**Ombudsman**

An Ombudsman is an official or employee charged generally with representing consumers and customer interests in resolving complaints, and other duties. There are reported to be 127 countries now using Ombudsmen around the world as agents for citizens who consume public services (Iftekharuzzaman, 2007). In the U.S., the Medicare program has an Ombudsman’s office, as does the NHS in Great Britain. Unfortunately, the literature is very limited and only one citation relates to the impacts of an intervention of ombudsmen in the developing world. Paul (1991) cites a study of Ombudsmen (and help phone lines) in Tanzania. Here, the Ombudsman services were not used by villagers, and primarily served the interests of the elite citizens.

**Consumer Rights Organizations**

Consumer rights organizations advocate and lobby for consumer rights and protections, and often educate consumers about their rights. Many of these organizations are NGOs, usually founded and populated by consumers, sometimes very disappointed ones. These organizations offer knowledge and experience to others, or bring pressures of voice or choice to bear on governments or suppliers. These organizations are often issue or problem oriented (parents with autistic children, association for improvements in the maternity services, stillborn and neonatal death society). Others formed as a deliberate national attempt to give voice to consumers (Ugandan National Health Users Organization). In Europe these groups are usually formed and unified by common experience or common struggle (Allsop et al 2004). Most health consumer groups rely on collating and disseminating lay knowledge; “most run help lines and produce pamphlets for the general public” and view themselves as “repositories of expertise” (Allsop, et al 2004).

There appear to be official (government sponsored or supported) consumer protection organizations all over the world, though there are no known listings of the countries where such
organizations exist. The United Nations publishes guidelines and model legislation for consumer organizations to support a global need for information (U.N. 2003). Donors (like DFID, USAID, and World Bank) also sponsor activities (like workshops and conferences) to support consumer protection activities in countries and regions (see Goulden and Schulte, 2004). And, there are regional organizations that meet and provide guidance and support for member countries (see Consumers International, 2006).

But, whether NGOs or policy-initiated organizations, virtually nothing is known about the effects of these “rights” groups on government service quality, though many, if not most, find their common purpose to effect change in the delivery of public services4. A particularly strong sector for consumer reform is that of Financial Services. Here, the World Bank and others have actively encouraged transparency and consumer oriented institutions and regulations to promote better market functioning. For the Social Sector, there may be some useful models of assessment and remedy in this sector (World Bank, 2007).

There are several papers that deal generally with the operations and effectiveness of consumer rights organizations. Baggott and Forster (2008) analyzed the role played by health consumer and patients’ organizations in the policy process in Europe. Despite political, cultural and health system variations, the authors found an increasing engagement between these organizations and policy makers and other institutions. Some of the obstacles faced by health consumer and patients’ organizations include lack of capacity and financial resources, fragmentation and dependency on pharmaceutical industry and professionals. Looking across Health Care Patient Organizations (HCPO) in Europe they say “several delegates raised concerns about representitiveness, “notably, researchers from the Czech Republic, Spain, and Germany. Even where memberships were reportedly high (in Finland for example) concern was expressed about the ability of HCPOs to represent patients, users and carers effectively”(Baggott, 2008).

A second paper (Allsop, et al 2004) reviews health consumer groups in the UK and their history since the 1980’s. Authors document their increasing leverage, lobbying activity and influence on key policy changes in areas of childbirth care and payment for caregivers. They also note government response to activism in terms of pathways provided for dispute resolution, the value of advocacy of ‘expert patients’.

But, they understand the limits of their work on understanding the impact of such groups: and the ‘movement’ they represent

“It may simply be that inclusion in the policy process leads to incorporation. That is, health consumer groups could simply be actors in a process that provides enhanced legitimacy to governments as they pursue their own larger agenda. It is useful to bring in health consumer groups to curb the monopoly powers of health professionals and to build public support for particular health policies. Apart from seeking alliances with more powerful interests, health consumer groups, whether acting individually or in combination, have few power resources except possibly through the mobilization of media support……..Nevertheless, ….health care

---

4 The most active area of consumer protection policy and research is banking and other financial services. See Benston (2000) for a summary of this area.
politics have been significantly changed by the presence of a new set of actors within the health policy process” (Allsop, 2004)

“As governments have also increased the opportunities for [citizen] participation, this has the potential for patients and carers [informal caregivers] to shape services in ways more responsive to their needs” (Allsop 2004).

In Uganda, the “Uganda National Health Users’/Consumers’ Organization”, and in South Africa, the “National Consumer Forum” represent national NGOs established to give voice to consumers and patients. Both organizations suffer from under funding and lack of consistent government support. The South African (National Consumer, 2008) organization is a general one, with a credo of “putting consumer issues on the agenda”. It has published a tabloid newspaper, runs consumer fairs, runs advocacy campaigns, offers consumer tips and other interventions. Annual reports (since 2000) detail activities and self assessed impacts.

The Ugandan health consumer organization is active in three core activities: research, community sensitization at the grassroots and national advocacy. They also claim impacts improved usage patterns, better practitioner-patient relations, and reduced patient abuse in the five district they are operating in. The Uganda National Health Users’/Consumers’ Organization helped to foster a health rights dialogue in national policy and are working on developing a patients’ right charter to present to parliamentary committees (Smith, 2005).

There are no studies of effectiveness of these programs, nor any evaluation research on the impacts of these organizations.

The Australian Competition and Consumer Commission (ACCC) is an example of a government sponsored organization to promote and extend consumer rights. It has a broad mandate across many sectors including health, environment, retailing, transportation, education and many others. There are not documented evaluations of the impact of this organization on service quality, but some attributive results are claimed: as an illustration, patients and carer rights in the area of mental health services were said to have improved in the following ways:

1. The establishment of formal entities to represent the interests of consumers of public sector local mental health services
2. The allocation of duns to projects led by consumers and careers in order to strengthen their voice
3. The enactment of amendments to mental health legislation of most states and territories in order to protect the right of people with mental illness
4. The inclusion of careers and consumer in all working groups dealing with national issues
5. The issuing of national standards or the protection of consumer rights in mental health services
6. The creation of a national medial campaign to increase understanding of mental health and reduce stigma

In summary, giving voice to consumers through consumer rights organizations, both private and publicly sponsored, may be effective in pressuring governments to be more accountable and improve service quality. This claim is not supported by a body of research.
Summary studies by a couple of groups of authors cited above are cautious about this fact, though the significant popularity of these public and private organizations of consumers and advocates is documented as a vehicle for giving ‘voice’ to consumers and their interests. Clearly, ‘giving voice’ has value to consumers, even if the impact on product and service quality is unknown.

Discussion

The literature on ‘voice’ interventions is broad, but very few studies focus on quantitative outcomes that bear on impacts of ‘voice’ interventions on service quality and customer satisfaction. Most of the literature represents case studies relating the design or implementation of projects, and the evaluation work is most concerned with fostering participation. While there is some evidence of these interventions not working at all, the primary finding is that voice may well build citizen participation and some measure of accountability of service providers, but there is little measurable evidence that service quality has improved.

By way of summary, there are some positive findings about voice interventions, all based on a rather sparse literature. Programs that empower consumers by providing knowledge about specific issues and providers seem to be effective in improving service quality and satisfaction. This is less true of more general community empowerment interventions. There is also some indication that governance roles for consumers (boards) might be effective. Ombudsmen and participatory budgeting, despite widespread use of these interventions, offer no evidence to date of effectiveness in improving service quality or customer service. The type of ‘voice’ intervention with the most evidence of effectiveness in improving service quality is ‘customer feedback’ or ‘scorecards’. By systematically telling providers and/or other officials what they experience (via some form of scorecard), customers of public services are clearly able to help change POS activities and attitudes for the better. Implementing broad consumer rights organizations is certainly a popular approach in Europe and elsewhere for creating a countervailing consumer voice to the large corporations and government monopolies. But, here again, there is little evidence of effectiveness in improving accountability in service provision in LMICs.

These findings suggest that the impacts of ‘giving voice to consumers’ as a means to encourage behavior changes at the point of service are well understood, and certainly not uniform across types of voice mechanisms. Generalized community awareness building and empowerment interventions seem less likely to create large impacts on provider behaviors regarding service quality than more pointed feedback (showing poor service quality) on the basis of customer surveys. It is possible that the more pronounced effect of focused feedback is more discernible in the short run than other empowerment and knowledge interventions, which may have less dramatic short term effects on provider behavior. It is also possible that those ‘voice’ interventions that are closest to and most directed to particular service quality problems are more likely to work best in getting the attention of providers5.

5 The literature on continuing education for health professionals has long recognized the importance of focusing or directing continuing education interventions on those providers who have exhibited a ‘problem’ with performance in that area of practice. To be effective in changing provider behavior, interventions need to be focused on known deficiencies (Gaumer, 1984 p398-400).
The existing research, as limited as it is in terms of quantity, is not very good. The studies do not really permit a comparative effectiveness assessment of different kinds of ‘voice’ interventions, even though the effects appear most pronounced for the ‘scorecards’. None of the studies heeds the careful analysis of Paul (1991), which points to the importance of understanding interactions of voice, extent of choice, and supply incentives. The effects of a ‘voice’ intervention will, according to the theory, be larger if choice is possible (the government provider is not a monopolist), if there are some financial or prestige incentives facing providers, and if providers have autonomy to change things. These factors, among others, need to be measured in impact studies of ‘voice’. A recent literature review highlighted the inadequacy of evaluation activities for citizen voice interventions:

Quantitative methods and statistical analyses are not frequently used to assess effectiveness …the collective knowledge of the donors [about accountability and voice programs] has much more to say about the types of approach that they should be adopting than about the effectiveness of current models, particularly in terms of broader development outcomes. It is difficult for donors to identify their impact beyond the intermediate level. As such, there is a need for donors to give higher priority to evaluation research, and the development of performance measures and systematic monitoring and evaluation (O’Neil, Foresti and Hudson, 2007, p ix).

There is also little direct evidence about how ‘voice’ interventions may work to improve service quality, if they do this at all. These shortcomings in the literature may be related to lack of studies about the value of citizen participation as a means to pressure service providers to change their behaviors. Consequently, we can only tentatively conclude that ‘voice’ may be a useful compliment to broader forms of community education (i.e., social marketing) and to the use of provider incentives to change observed practice patterns.
References


Australia, 2008, Australia Competition and Consumer Commission


Geounuppakul, M., Butraporn, P., Kunstadter, P., Leemingsawat, S., & Pacheun, O. ( 2007). An Empowerment Program to Enhance Women's Ability to Prevent and Control Malaria in the


http://www.internews.org/siprs/reports/CP_KPI%20PresentationApril04.pdf


National Consumer Forum, South Africa June 2008


