



INSTITUTIONAL ARRANGEMENTS, INCENTIVES AND HEALTH DISTRICTS

Health districts in Africa: Progress and Prospects 25 years after
the Harare Declaration – a Regional conference,
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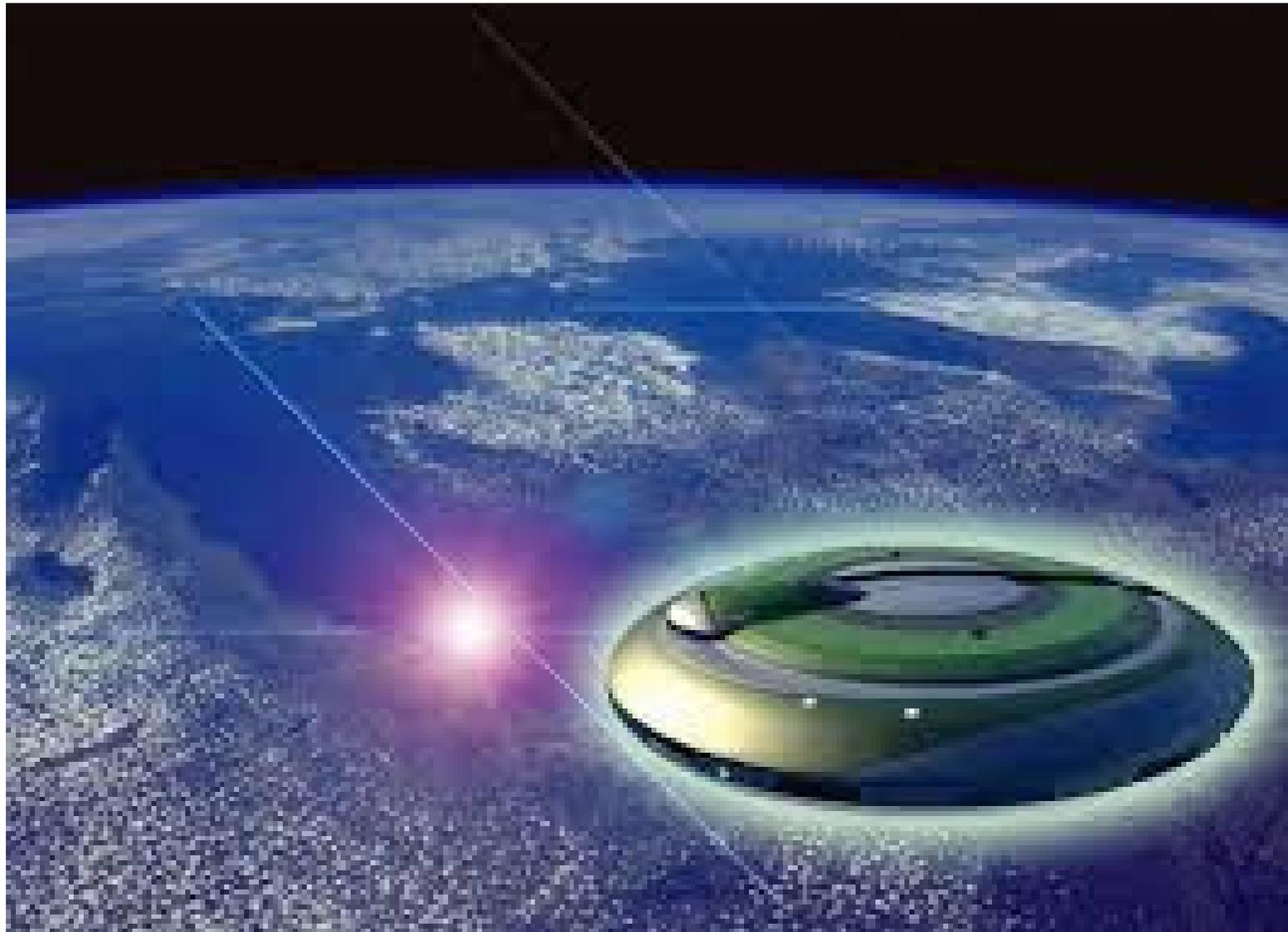
Messages

1. Institutional arrangements shape incentives, which affect health actors' behaviours, and thus determine their performance.
2. This reality was overlooked 25 years ago... and it is partly because of economics!
3. This overlook probably partly explains some dissatisfactory results.
4. We have to work on that. = the 'strengthening health system' reform agenda.



1. A few concepts

- Institutional arrangements
- How they influence our behaviours.
- Why they are important.



What is this?



What is this?



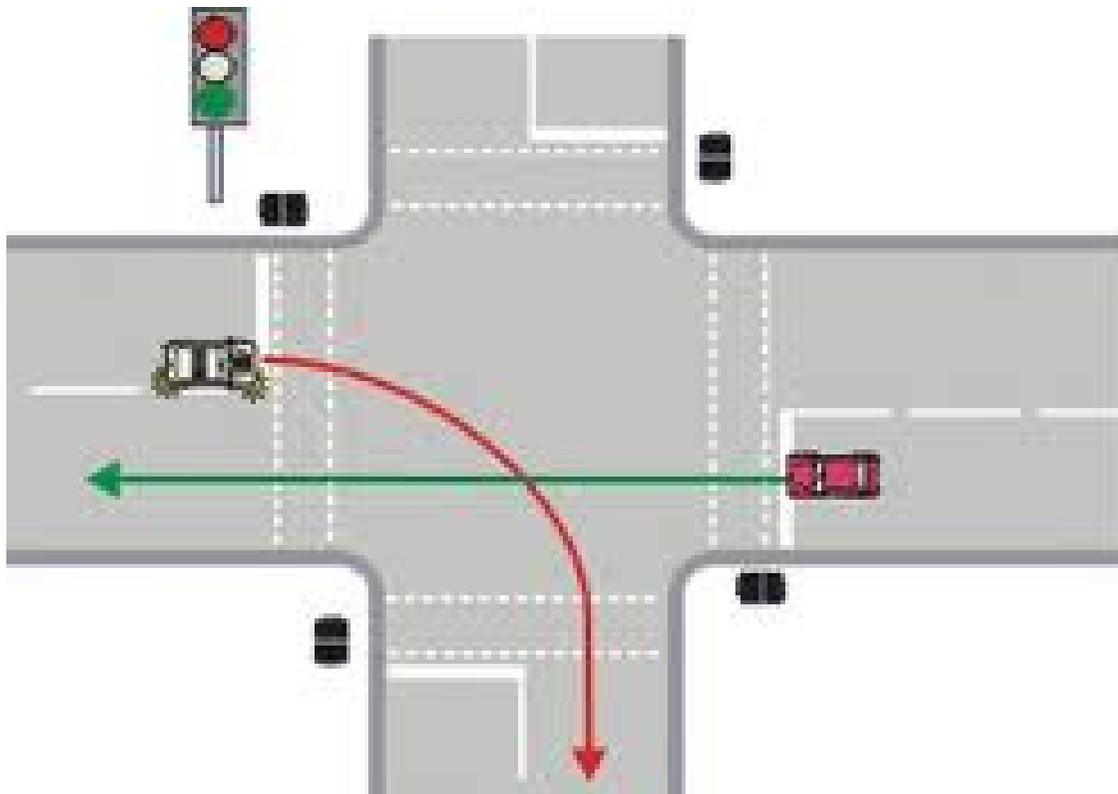
The boring New
Institutional Economist:

*A mechanism to enforce
an institution*

Which institution?

- *Here should come a movie where Marvin the little martian is observing during 15' the traffic at the cross-road.*

Which institution?



The boring New
Institutional
Economist:

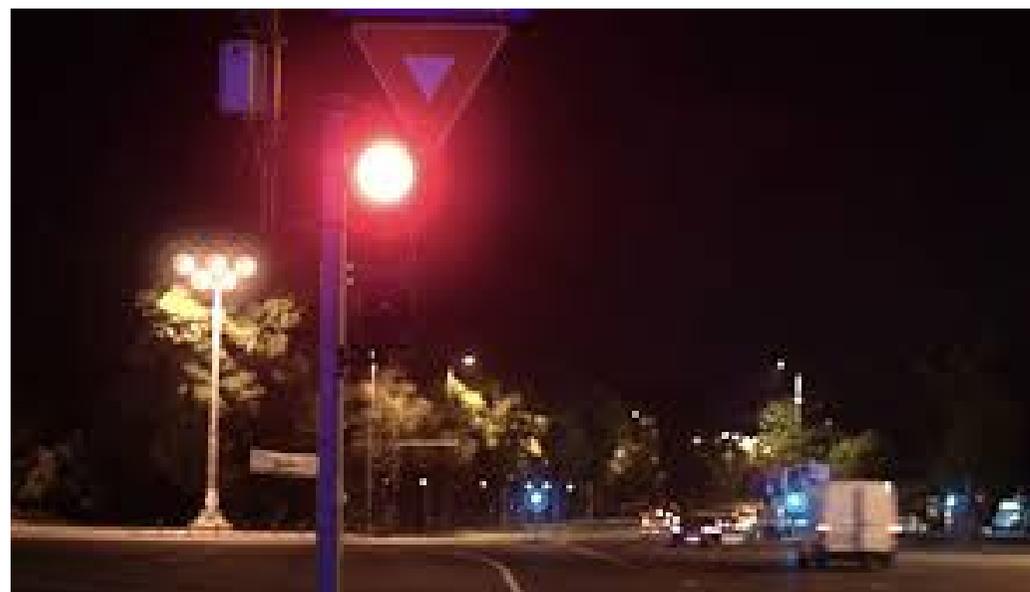
*an institution is a
pattern of
behaviours*

How does it work?



An institution 'works' because the pattern is known, expected and respected by most agents involved in the specific interaction.

The test...



Why?

- **The boring NIE:**

We are social beings. We have coordination problems. We need mechanisms to solve these problems in an efficient way in order to create wellbeing.

Institutions remove uncertainty.

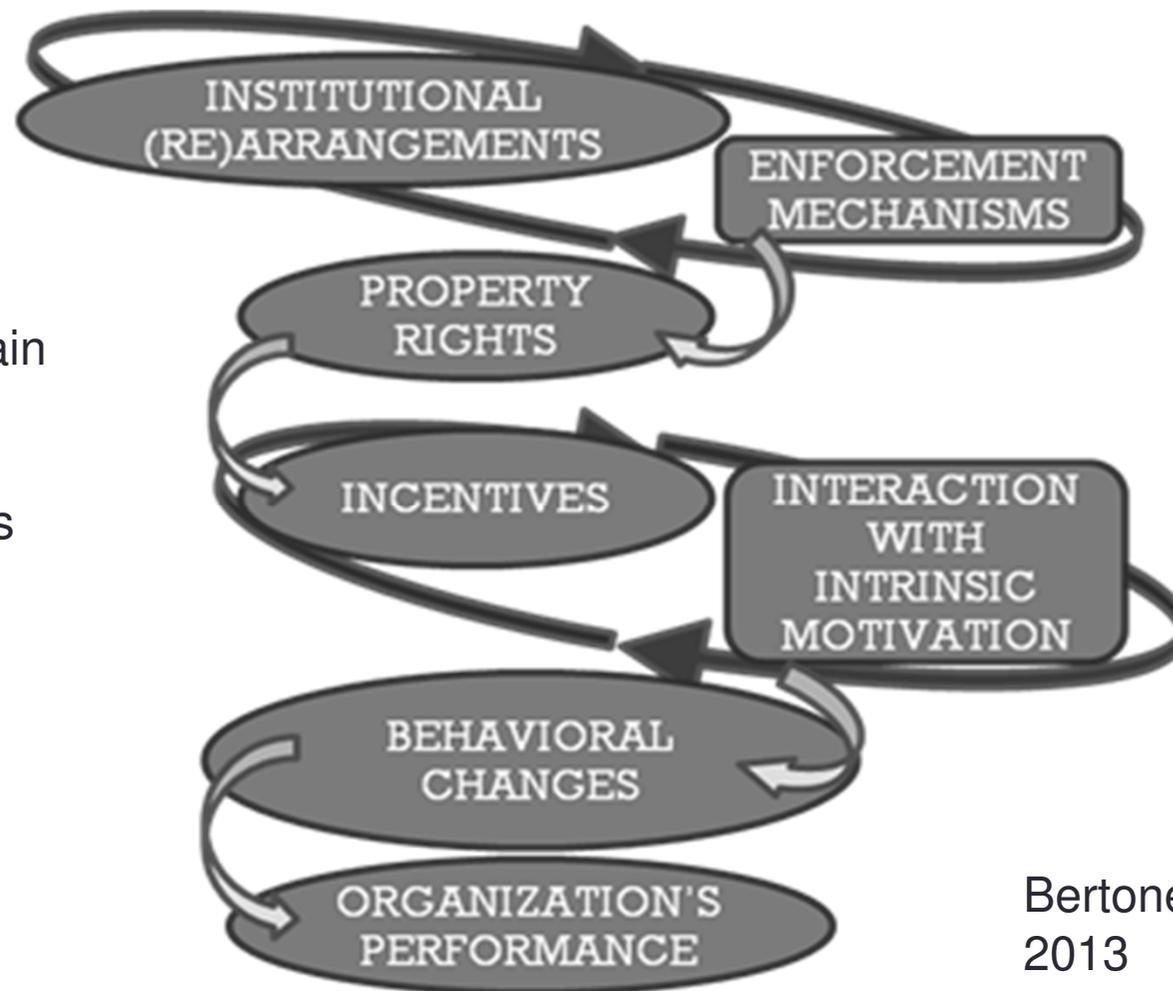


A nexus of institutions

- Example:
 - Traffic light
 - Accident report
 - Insurance contract
 - Language...
- All give access to opportunities and things we value.
- Human beings are rational enough to appreciate these configurations and take action accordingly.
- By shaping institutions, you can shapes **incentives**.
 - Incentive ≠ bonus

A framework to look at social systems

In an uncertain environment where information is costly



Bertone & Meessen
2013

In a nutshell

- We face coordination challenges.
- We want to solve them in an efficient way in order to maximise our wellbeing.
- Specific patterns of behaviours – *institutions* – are set up.
- They are supported by enforcement technologies.
- Sometimes there are technological innovation.
- It is time to adapt your institutions.
- Not that easy because one has to look at the whole nexus of institutions.
- But there are very helpful institutions: **contracts**, which are easier to change.

2. Why this was overlooked 25 years ago?

- Health district = planning & administration theories of the eighties.
- Economists did not pay attention to institutions (neo-classical economics – Thatcher/Reagan).
- Theoretical toolbox was not ready yet. Rapid expansion since then.
- At least 6 Nobel Prizes related to this domain since 1987.

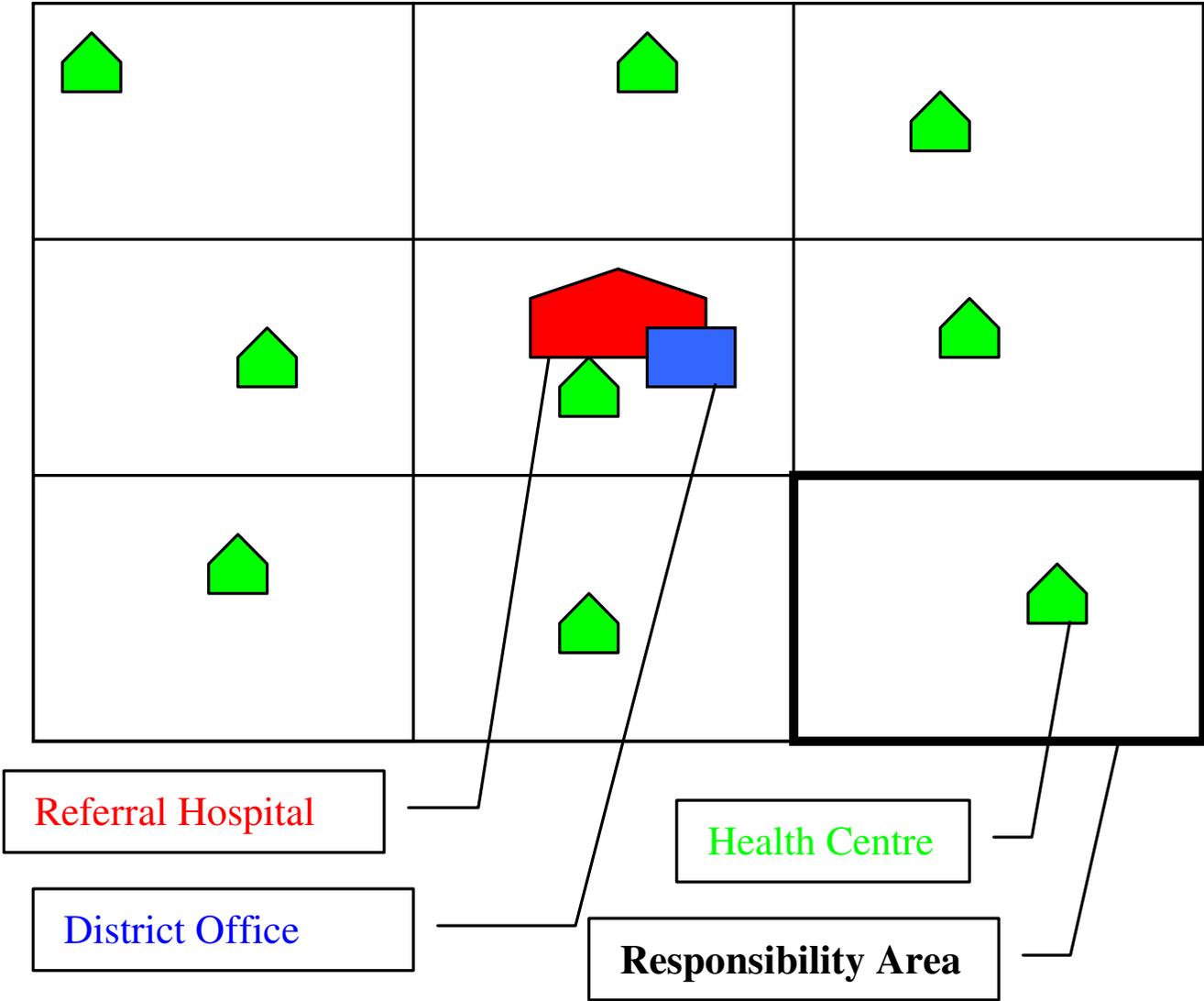
Consequences

- Incentives were out of the picture
 - (1) in the assessment of successful experience,
 - (2) when generic propositions were formulated.
- Cause of some disappointing results!

How can we integrate incentives in the analysis

- We agree on 2 points:
 1. UHC.
 2. It is the responsibility of the State to ensure that health actors align with this goal.
- Our proposition:
 - The State can do that by designing and enforcing institutional arrangements & incentives which ensures such an alignment.

Health district



The equity lense

- **Fair distribution of resources among citizens.**
 - Everyone gets the same units of nurses, buildings, equipment, services....
- **(outcome would be better)**

The efficiency lense

How you are efficient	Rationale	
(+) Economies of scale	The more you produce the lower the cost of the next unit	1 operation theatre / 150,000 inhabitants
(+) Economies of scope	Bundling production of goods A and B > split production	Integration
(+) Decentralisation	Value preferences of citizens	Planning at district level
(-) Monopolies	Lack of competition	Coverage rates to monitor performance; health committee

But this old economic framework did not say anything on **contracts**

- **There can be huge efficiency losses at this level!**
- User fees on curative services, but not on preventive services / bednets.
- Motivation of a chief nurse to innovate on the way to deliver the minimum package of activities.
- Reluctance of DMT to benchmark health centres.
- On the capacity of the State to transfer its resources to the peripheral level.

The supplementary questions for the steward

- Do your **institutional arrangements** (and the supportive enforcement **technology**):
 1. generate information about health priorities
 2. assign clear and non conflicting tasks to the most appropriate actor
 3. give enough autonomy to these actors
 4. gather information about their performance
 5. allow you or other actors to reward good performance and to sanction poor performance
 6. have a satisfactory balance between benefits and losses (in terms of what is valuable)
 7. secure psychological wellbeing, including by mitigating uncertainty
 8. contribute to a coherent health system
 9. are not too costly to enforce?

The health districts as they are are nexus of institutions

- The textbooks were very explicit on some of these institutions and how they connected actors: ‘responsability area’, ‘minimum package of activities’,...
- But they were silent on others!

Conclusion

- Updating our health district vision requires to pay attention to **institutional arrangements**.
- (...) and be aware that incentives are at each 'corner' of any institution.

