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# 'By papers and pens, you can only do so much': views about accountability and human resource management from Indian government health administrators and workers

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## SUMMARY

Although accountability drives in the Indian health sector sporadically highlight egregious behaviour of individual health providers, accountability needs to be understood more broadly. From a managerial perspective, while accountability functions as a control mechanism that involves reviews and sanctions, it also has a constructive side that encourages learning from errors and discretion to support innovation. This points to social relationships: how formal rules and hierarchies combine with informal norms and processes and more fundamentally how power relations are negotiated. Drawing from this conceptual background and based on qualitative research, this article analyses the views of government primary health care administrators and workers from Koppal district, northern Karnataka, India. In particular, the article details how these actors view two management functions concerned with internal accountability: supervision and disciplinary action. A number of disjunctures are revealed. Although extensive information systems exist, they do not guide responsiveness or planning. While supportive supervision efforts are acknowledged and practiced, implicit *quid-pro-quo* bargains that justify poor service delivery performance are more prevalent. Despite the enactment of numerous disciplinary measures, little discipline is observed. These disjunctures reflect nuanced and layered relationships between health administrators and workers, as well as how power is negotiated through corruption and elected representatives within the broader political economy context of health systems in northern Karnataka, India. These various dimensions of accountability need to be addressed if it is to be used more equitably and effectively. Copyright © 2009 John Wiley & Sons, Ltd.

KEY WORDS: accountability; supervision; motivation; human resource management; corruption

## INTRODUCTION

With just over one million people, Koppal district persistently ranks the lowest in terms of health and development indicators for Karnataka, India. Although working conditions of health workers in Koppal are not ideal, some investments have

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improved infrastructure and drug supplies. Karnataka's government health services are better than many of its north Indian counterparts and in some districts even on par with some of its south Indian neighbours. Yet performance in terms of health service delivery is mediocre. Some health workers work very hard, but many are indifferent. As one medical officer confessed, 'Usually whoever gets posted here, only stays 6 months. I am here 9 months running, so they congratulated me for lasting so long. Somehow I am still here. Actually I am least bothered about my job. I am simply doing it' (Medical Officer 2).

So what explains such low morale and performance? Reforms that address vacancies, enable training, improve drug supplies, facilitate transport and support infrastructure provide important inputs for functioning health services. Nonetheless their effect on health worker performance may not be proportional. As a district consultant noted, 'If a place has 50% vacancies, there should be 50% work, but instead we see only 24% result' (*Taluka*[1] Meeting). In order for such inputs to effectively improve health worker performance, the catalytic influence of underlying organizational relationships that determine health system accountability must also be addressed. From this basis, this paper details how accountability functions internally within the health department from the perspectives of government health administrators and health workers. In particular, it examines how two key human resource management functions concerned with internal accountability, supervision and disciplinary action, are implemented in Koppal's government primary health care services.

## METHODOLOGY

Field research was informed by anthropological work on the social relations that determine primary health care service delivery (Nichter, 1984; Aitken, 1994; Kamat, 1995; Atkinson *et al*., 2000; Gupta, 2001; Pinto, 2004). I also drew guidance from political scientists who highlighted how field workers cope with their everyday work lives by simplifying complex policy directives into routines, rationales and labels for beneficiaries that justify the care given (Lipsky, 1980; Goetz, 2001). Although the resulting biases are not excusable, they also reflect the constraints and discrimination experienced by health workers (Jewkes *et al*., 1998).

This kind of contextual analysis of the engagement of health providers with the health systems they are embedded in, led me to examine health systems as a set of social relationships (Mackintosh and Gilson, 2002; Bloom *et al*., 2008). These relationships are not mechanistically determined, but are dynamically negotiated by actors involved in implementation (Elmore, 1979–1980; Barrett and Fudge, 1981; Hjern and Porter, 1981). Not only do I reframe health worker motivation as one of professional struggle and practical survival within the broader constraints of strained health systems (Kyaddondo and Whyte, 2003), but I also seek to broaden how accountability is understood from the perspectives of health workers.

[1]Sub-district administrative block.



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Data supporting this paper were mainly collected in 2004 and are based on four research efforts. The first involved 9 months of participant observation of government primary health care service delivery and management activities. This encompassed multiple outpatient clinics, tubectomy camps, antenatal clinics, health education sessions, village outreach efforts, polio supervision tours and 23 staff meetings at PHC, *taluka* (sub-district) and district levels. In addition, I undertook semi-structured interviews with 32 district level officials (medical officers, programme officers, senior district officials) and 10 state level health department officials. I overlapped with four district health officers (DHOs) during the 5 years that I undertook various research activities in the district. Lastly, I drew on qualitative responses from a survey administered to 60 government paramedical staff (health auxiliaries, nurses, health educators and laboratory technicians), which I designed and jointly supervised with my colleague, Aditi Iyer.

The qualitative data collected were analysed using the grounded theory approach (Miles and Huberman, 1984; Strauss, 1987), which bases theoretical analysis on the data collected. Interview data along with observation notes were reviewed and grouped into broad categories. Analytical notes were then made on the basis of detailed coding. As the data were reviewed, further comparisons were made, codes were refined, consistency checks made and variations assessed in order to further elaborate and corroborate the analysis that evolved.

## LITERATURE REVIEW

Concerns about accountability are voiced by many ranging from radical social movements to the World Bank (Goetz and Gaventa, 2001; World Bank, 2004). As a result, accountability mechanisms like patient charters, hospital boards, village or municipal health committees, right to information acts, consumer courts, contracting, accreditation and franchising are being implemented worldwide. These measures support a broad range of activities that include information dissemination, monitoring, norm setting, peer pressure, mediation, contestation and 'institutionalized co-production' between various actors in both public and private sectors (Brugha and Zwi, 1998; Mackintosh, 1999; Goetz and Gaventa, 2001; Mackintosh and Gilson, 2002; Joshi and Moore, 2004; Bloom *et al*., 2008; Peters and Muraleedharan, 2008).

Accountability through these mechanisms serves mostly to regulate relationships between service providers and patients. Nonetheless, accountability relationships are also at play between different levels of health care service delivery, health and finance ministries, donors and funding recipients, elected representatives and health officials, and elected representatives and voters, etc. The literature on accountability distinguishes between political, fiscal, administrative, legal and constitutional accountability and between vertical (external mechanisms used by outsiders against government) and horizontal types of accountability (internal mechanisms between different branches and levels of government) (O'Donnel, 1999; Schedler, 1999; Newell and Bellour, 2002).



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Due to such diverse use, accountability takes on different meanings. In the academic literature, accountability has been conceptually defined as consisting of two main elements: *answerability* and *enforceability* (Schedler, 1999). This entails the obligation to inform and explain through transparency, as well as compliance through review and sanctioning mechanisms. From this basis, accountability sometimes translates into monitoring and policing mechanisms, at times resembling accounting or control systems.

Several researchers suggest going beyond such an actuarial view of accountability to support more democratic and responsive service delivery cultures (Cornwall *et al*., 2000; George, 2003; Goetz and Jenkins, 2004; Murthy and Klugman, 2004). Accountability, more broadly defined, encapsulates normative ideals. It expects service delivery to be more responsive through more transparency; clearer rights, roles and responsibilities amongst a broader range of participants; with consequences for inaction or inappropriate action. The World Bank offers another normative characterization of accountability relationships by detailing market and government failures in accountability whether it follows short or long routes between clients, providers and policymakers (World Bank, 2004). Whether from a rights or an efficiency perspective, judgements are made about whether accountability is either strong or weak, existent or absent (Jing, 2006).

I argue that these stylized expectations about accountability ideals do not reflect how accountability functions in practice. Brinkerhoff (2004) recasts accountability as a managerial tool that ideally acts to reduce abuse, improve adherence to standards and foster learning for improved performance. This requires a shift from enforcing 'an accountability for control, with its focus on uncovering malfeasance and allocating 'blame'' to 'an accountability for improvement which emphasizes discretion, embracing error as a source of learning, and positive incentives' (Brinkerhoff, 2004, p. 374).

In addition, I argue that accountability cannot be seen as a set of disembodied rules, standards and enforcement mechanisms. People are ultimately responsible for enforcing rules by providing information, acquiescing, disobeying, avoiding or circumventing rules. From this perspective, accountability entails a cooperative process that like other regulatory processes includes 'a mixture of formal rule setting and explicit contractual agreements, or formal regulation, and of informal understandings and established behaviour patterns, the latter based in norms, ethics and mutually understood principles' (Mackintosh, 1999, p. 163).

Lastly, at its core accountability aims to counter the arbitrary use of power by those who wield it (Newell and Bellour, 2002; George, 2003; Goetz and Jenkins, 2004; Murthy and Klugman, 2004). As such, apart from being a normative ideal and a managerial tool, accountability is also a fluid social phenomena characterized by dynamic social actors and power relations located in specific political economy contexts (George, 2007).

Despite the emerging importance of accountability, few (Cornwall *et al*., 2000; Cornwall *et al*., 2006; Jing, 2006) have critically examined how accountability actually operates in health care. This article reviews how health administrators and workers view internal aspects of accountability with particular attention to supervision and disciplinary action. As mentioned, there are many different dimensions to



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accountability. While it is crucial for health service delivery to be externally accountable to patients, such accountability cannot be realized in the absence of internal accountability between health administrators and workers, the latter being the focus of this article.

## SUPERVISION

### *Current practice*

Government primary health care (PHC) services are structured according to a hierarchy of services based in theory on population norms. In terms of management, government services at the district level follow an organizational hierarchy that cascades downwards from the DHO to programme officers, PHC medical officers and other PHC staff (male and female health auxiliaries, health educators, laboratory technicians and peons) (Figure 1). While the DHO and programme officers are dedicated full time to management, PHC medical officers combine clinical duties with administrative responsibilities, the latter adding up to 8–10 days of the working month.

At a broader level, district level health administrators and health workers report to both higher level health officials in the state health department, as well as to elected representatives at the *zila, taluka* and *gram panchayat*[2] level. Financial relationships can be complex, as budgetary allocations are derived from district, state and federal levels of government, through the health department, autonomous societies and elected bodies. Internal oversight of government health services is exercised by the DHO's office through information systems based on reporting forms and registers, monthly staff meetings and field visits.

A large amount of data is routinely collected for monitoring, requiring considerable time and effort. PHCs are responsible for 21 reporting forms with 812 data elements, while a female health auxiliary maintains 13–15 registers on a daily basis (Erin Consultants, 2004). Health auxiliaries consolidate data into monthly reports, which are bundles of paper sent upwards from the PHC, to *taluka*, district and state levels. There is no computerization that would enable the data to be processed and analysed, except for aggregate tabulations.

As reports are neither complete nor accurate, staff meetings mainly focus on numerically checking these reports (Erin Consultants, 2004). Since it is impossible to review all the data collected, supervisors cope with this maze of documentation, by using predetermined formulae to verify the completion of targets. As one programme officer explained, 'In every 1000 people there should be about 132–160 eligible couples aged 15–49 for family planning...take the total number of pregnancies and subtract 10%, which are wastage pregnancies due to abortion or miscarriage, then you arrive at your immunization target' (Meeting Observation).

### *Ideals*

Although supervision is dominated by checking documentation, health workers also mentioned examples of supportive supervision that empathized with health workers'

[2]District, sub-district and village level elected bodies.



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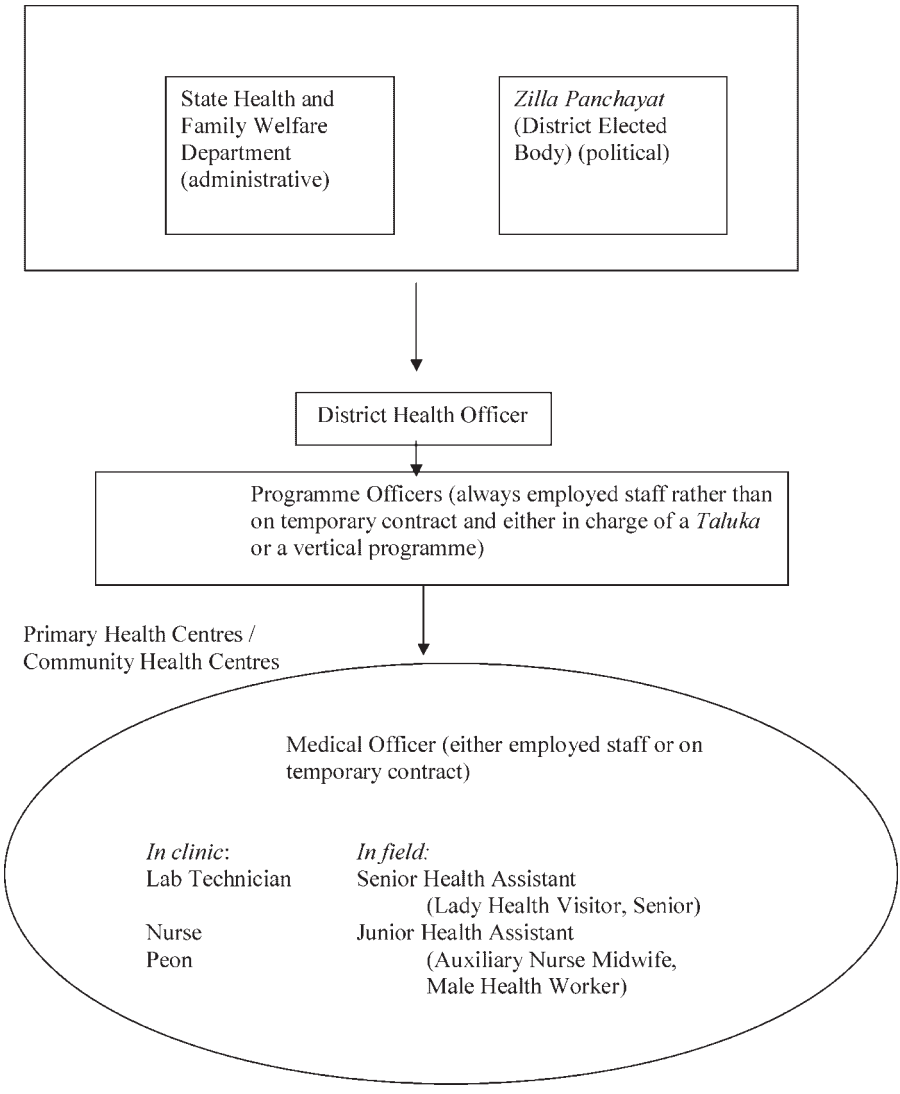


Figure 1. Supervisory authority cascades downwards

problems. Senior programme officers noted that effective supervision cultivates informal norms and personal relationships. 'After basic training it is how one is initiated into service that matters. Supervision and disciplinary action should be routine, not on an ad hoc basis. We need to nurture our PHC workers and instil in them a sense of ownership. One must listen to their problems. Within limits you should sort out their problems, so that their mind is free and their work is without interruptions' (Programme Officer 6).

Other programme officers echoed the importance of supportive enquiry, personal guidance and empathy with an egalitarian spirit that went beyond formal government



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procedure. Joking and eating with peons, inviting subordinates to their homes and helping staff with loans or with applications was considered essential in developing good staff relations. Although formal lines of authority are actively maintained in government services, informal relationships need to be cultivated on a 24-h basis, in order to elicit respectful and responsive team efforts. One programme officer emphasized, 'As a medical officer, one can command respect but that is not how one receives respect... Your work is never over at 5 pm' (Programme Officer 2).

Such empathetic, reciprocal and egalitarian ideas are not just wishful platitudes. They underscored the supervisory approach of some staff meetings, albeit rare ones. Out of 23 meetings observed, four elicited feedback, comments or complaints from participants, of which three led to local problem solving. Out of 12 PHC meetings observed, in three supervisors ensured that participants understood the logic of certain health practices by asking why they were organized that way and in one a medical officer sought to comprehend misunderstandings amongst health volunteers and discuss clinical follow up of patients. At the other extreme, in six meetings senior officials insulted and/or threatened the health department staff.

### *Distortions*

Despite the supervision ideals expressed by administrators, in practice there is very little proactive field supervision in the form of working alongside health workers to assist them in improving their work. Medical officers and senior health assistants primarily carry out supervision during monthly staff meetings when junior health assistants submit registers, diaries and monthly reports for inspection. Although elements of training are undertaken in these staff meetings, it tends to be in the form of reciting certain health norms and formulae, with little room for clarification or discussion.

Medical officers themselves felt oppressed by supervision meetings dominated by numerical checking. A medical officer diagnosed monthly meetings with the following clinical acronym: CST (continue the same treatment). He explained, 'These meetings are simply a waste of time. Every month, it is the same meeting with the same subjects, same reports and same faces. All they are interested in is whether you fill in the reports and comply with targets. If you do not have cases or only have two, then there will be problems for you. They are not interested in the work you actually do, only in the reports you submit. Almost 10 days each month goes to these meetings. They should leave us alone so that we can do our work' (Medical Officer 2). On another occasion, the same medical officer noted, 'These meetings are held to discuss their problems, not our problems. We just come to have tea and biscuits' (Medical Officer 2).

Not all medical officers dismissed staff meetings. Some felt strongly that they could be important forums for coordinating work, mutual learning and two-way communication, even if they were not so at present. A programme officer agreed, 'In each meeting you should learn something. It should not be this charade: Did you report? I will report. Did you do? I will do' (Programme Officer 8).

Some attribute this mode of supervision to the lack of field experience and management preparation given to young medical officers posted at PHCs. Their consequent unfamiliarity with national programmes results in an over-reliance on



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target completion in aggregate terms (State Official 2). Nonetheless, reliance on inspecting records and grilling health workers at the PHC level reflects more than managerial inexperience. As suggested by medical officers' experiences as subordinates, it also mirrors patterns of supervision and management at higher levels.

When a senior state health department official visited Koppal due to an outbreak of gastro-enteritis reported by the press, he displaced the DHO from his desk and addressed the assembled programme officers, 'People are not reporting cases. What surveillance have you done? What action? How many PHCs are affected? What is an epidemic? Do you not know what an epidemic is? What are you supposed to do in case of a death? Events are not being reported. No one is taking things seriously. They are only reporting admitted cases. You should investigate the cause of the infection. Make arrangements for treatment. What do you want to do for your district? Who is responsible for follow up'? (Meeting Observation). The programme officers listened quietly, knowing that they could not interrupt or contradict a state level officer.

At another stressful time due to the reporting of polio cases in the area, one DHO unexpectedly arrived at one PHC meeting. He displaced the medical officer from his chair and started reviewing health workers' registers and diaries. A clerk took minutes and in particular detailed the decisions taken. The DHO from time to time would dictate, 'Health worker x has been found to not be doing y. Reasons given unsatisfactory'. When health workers would try to defend themselves by pointing out some of their difficulties, he responded by saying that their problems would be dealt with after the meeting, not while he was talking (Meeting Observation).

Health workers are often presumed guilty until proven innocent. In a PHC meeting, a programme officer rebuked the male health auxiliary, 'Usually about 15% of the population at anytime have fever. Either you are not doing surveillance properly or there really are no cases' (Meeting Observation). Another programme officer told health assistants, 'If you are not reporting cases, it is because you are hiding something or you are not knowing. Ultimately, this means that you are not working' (Programme Officer 9).

Managers themselves are frustrated by not being able to demonstrate progress. As one DHO explained, 'There is no proper monitoring. We do not know where the outcome is. There is need for quality improvements all around, but instead we do pessimistic management and negativism. Why have you not done this? Why have you not done that? How many cases have you got for this? In the end, the staff is left feeling that the DHO is upset with them or they themselves feel fed up. They should instead have a clear idea of what they should be doing and be motivated to do that. There should be a positive feeling to move forwards' (District Official 3). A senior health department official concurred, 'Now there is less guidance and more rebuking' (State Official 1).

Not only do health workers perceive that supervisors follow a general approach that tars everyone with the same brush, but they also feel that supervisors do not address problems they may be facing with working and living conditions. A female health auxiliary reported, 'Even though we do not have proper bus facility, they ask us to complete the job. They are not bothered about our situation' (Survey Respondent 6).

One key reason why local problems are not addressed is because of the lack of administrative authority that some supervisors have. Many of the PHC medical



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officers in Koppal are hired on a contract basis. They have no administrative authority to either discipline health workers by withholding salary payments or to resolve minor problems with working conditions. Some of the problems faced by health assistants, like inadequate housing, irregular drug supplies and infrequent bus schedules, are beyond the remit of lower level supervisors. By enquiring into problems that require cooperation from powerful actors that are beyond their control, supervisors only raise false expectations and expose the futility of their roles.

### *Outcomes*

The overemphasis on checking targets as a means of bureaucratic compliance, results in demoralization. A medical officer reported, 'If you do well in leprosy, they will ask about tuberculosis. If you do well in tuberculosis, they will ask about polio. If you do well in polio, they will ask about malaria. You will work with great motivation, working day and night, motivating patients, doing field visits and therefore surpass your target. Instead of 130 you get 160. Then they will say that you placed your original target low so that you could take things easy. They will fix your target at 160 and you will not have the motivation to complete it, so you will get talked to and receive memos for not reaching your target the next year' (Medical Officer 11).

A female health auxiliary concurred, 'We have problems from supervisors and medical officers in the department. Even if we go beyond our target, they do not give us cooperation or encouragement. They scold everybody, those who work and those who do not work. People who work sincerely go on working, while others do nothing. No action is taken against those sitting idle. That is why people become lazy. Whatever we do, we get the same salary. Why should we struggle'? (Survey Respondent 21). One health assistant concluded, 'Targets are given by supervisors to avoid any nagging from higher officers. We do the work whether known or unknown, while the supervisors do their work in a careless manner' (Survey Respondent 22).

These negative experiences of supervision and unresolved working conditions lead to health assistants losing confidence in their seniors and also to a justification for poor work. As one health assistant explained, 'First, we tell our seniors. If they do not inform the doctor, I tell the doctor. If the doctor does not solve our problem, we do not break our head over it. We take it easy' (Survey Respondent 30). This response reflects a *quid pro quo* bargain, as health assistants feel that they should only do as much work as they are supported to do, whether in the form of supplies or supervision. In Soviet Russia, health workers had a similar understanding: 'We pretend to work and they pretend to pay us' (Rivkin-Fish, 2005, p. 61). Similar implicit understandings underline how disciplinary action is deployed and perceived, as discussed in the following section.

## DISCIPLINARY ACTION

### *Ideals*

Formal disciplinary action mechanisms start with writing memos, a copy of which is filed in the confidential report of each health worker. In response, a health worker can



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reply with a letter addressed to the person issuing the memo, responding to the remarks made in the memo and copied to the same file. Depending on the complaint made, some supervisors can withhold salaries or benefits. A more serious level of disciplinary action is suspension. Finally, the most severe form of disciplinary action is dismissal, which, in contrast to other forms of disciplinary action, hardly ever occurs, even with contract staff.

Appeals to these formal mechanisms permit substantial leeway for negotiation, which if used appropriately can support constructive learning. As one programme officer claimed, 'I give them warnings through an alarming letter. If this does not work, one can discipline a health worker by withholding increments, their salary or their travel allowance. They should have some fear. But I do not hold any grudges against health workers. If they give me an apology letter, I record it and give them the money, then I forget the reprimands. Every time I have to take action, I give information or some training. One should give them work, facilities and clear job instructions. Only then can we hold them accountable' (Programme Officer 9).

Nonetheless, some supervisors hesitate to use formal mechanisms of disciplinary action. One supervisor stated, 'If any of our staff members do not work properly, we take disciplinary action, but in a good way: by talking to them in a friendly way and asking them to work better. We inspire them by telling, 'Your work should always be ahead of all the others'. We do not issue any memos, because such actions will spoil our relationships and then the work will not be good' (Survey Respondent 57). A programme officer concurred as, 'A good working atmosphere is important. By papers and pens, you can only do so much. Papers and memos, they will not work. You have to see who is on track. Those who are not on track, you have to try and change by taking them into confidence' (Programme Officer 7). Another programme officer said, 'Punishment is not treatment or any salvation. If you suspend someone, you actually increase the deficiencies in that staff member. . . People need to see that you have a pistol; they need not know that you will actually not use it. They should be afraid of getting punishment, without necessarily getting the punishment' (Programme Officer 3). These statements suggest that the effectiveness of formal mechanisms relies not in their actual use, but in the informal relationships that underlie them. The following experiences confirm this.

### *Memo wars*

One form of disciplinary action where substantial negotiation exists is when memos are issued. Supervisors spend significant amounts of time in memo wars: threatening to issue them, having health workers respond to them and then cancelling them. Subordinates see humility as essential in resolving memo wars. One male health assistant explained, 'Once I took 3 days leave to go to my native place, as one of my relatives was not keeping well. It became an emergency situation and I could not come back. I could not send a leave extension note, so the officer deducted 10 days salary from me. After I returned, I apologized and humbly requested that my salary not be cut. After 3 months, they gave me those 10 days of salary back. We can complain to any of the concerned officers, DHO or THO, but there is an increase in problems by complaining... Only when we are humble can problems be sorted out'



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(Survey Respondent 18). Another health assistant confirmed, 'If we have any problems we should humbly request solutions. If we talk about complaints and such things, they will just tread on us all the way to hell' (Survey Respondent 22). In these and other examples provided by health assistants, personal excuses were used to get out of predicaments. Disciplinary action is therefore not necessarily used as a mechanism to identify and resolve systemic problems. It can instead be a private dispute mechanism between individuals that does not lead to public organizational learning or systemic changes in organizational functioning (Bartunek *et al*., 1992).

### *Distortions*

As mentioned earlier, informal relationships are important because in some instances, formal mechanisms of disciplinary action are not always effective by themselves. For instance, not all supervisors have the administrative authority to apply financial sanctions to back up disciplinary actions. The lack of financial consequence also dulls the threat of suspension, as suspended health workers still draw 70% of their salary.

Another reason why disciplinary action can sometimes be blunted is because of the lack of moral force behind it. When disciplinary action is implemented inconsistently, it not only fails to be convincing, but also contributes to demoralization. One female health auxiliary stated, 'Nobody takes a serious view of disciplinary action. If the doctor himself is right, he can take action against us. But here in this PHC patients are left waiting. The doctor left at 1.00pm and will not come back until 4.00pm. The doctor is not sincere. Our higher officers do not do their work properly, so what should we do? To whom do we complain'? (Survey Respondent 21). Understood in this light, rather than support constructive learning or act as a deterrent, disciplinary action serves as a mechanism through which double standards are affirmed.

The force of disciplinary action is also corroded when enquiries and reinstatements after suspension are undertaken in a lengthy and non-transparent manner, often compromised by corruption. A programme officer reported that he had conducted an enquiry into allegations of corruption made against a medical officer. Although he found no evidence of corruption and recommended that the charges be dropped, the medical officer under investigation had to pay a DHO and the complainant before being able to clear his record. The programme officer argued that the only ways in which disciplinary action could be appealed were through webs of corruption and/or political influence.

A senior officer confirmed, 'Unfortunately suspension is a weapon. If a DHO accepts money to revoke it, the mistake lies with the DHO' (State Official 1). Consequently, medical officers categorize disciplinary action as a form of harassment. As one medical officer explained, 'Disciplinary action is ok, but if you are not having all the facilities or manpower then such actions are harassment. Some doctors are working very hard, but still do not get the outcomes required. If you discipline them, it is harassing them. When a programme officer visits, if he wants to solve a problem, he will tell the medical officer directly. If he wants to cause problems, he will tell a DHO. If you tell a DHO, it will definitely not get solved' (Medical Officer



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4). Medical officers perceived that reporting problems to higher authorities only gives those officials an advantage to blackmail lower level workers for more money or leaves them vulnerable to being used as scapegoats to protect the reputation of higher-level authorities. In these instances, formal mechanisms of disciplinary action are seen to be not just ineffective, but also dangerous.

Administrators therefore can become defensively dependent on formal procedures as a means of bureaucratic survival. As one programme officer explained, 'All I can do is issue memos copied to the DHO and other concerned authorities to which the doctors should respond. This does not necessarily have any effect, but at least there is proof that I have tried to take action' (Programme Officer 8). In an environment where there is pressure to demonstrate accountability but where disciplinary action is abused due to corruption and politics, one needs to have written proof that one has procedurally complied with the rules.

Some senior officers maintained that disciplinary action can still be effective, provided that higher officials remain honest. As one officer reminisced, 'When I was DHO, I took disciplinary action against 30 candidates, but there was never any complaints against me, as they were all for justifiable cause. If the foundation is right, they will not argue. Moreover, I would not harass health workers after taking disciplinary action. Within 2 months, I would reinstate them without harassing them. I would not ask them for money to reinstate them, they would respect me, because they knew I had no ulterior motive' (State Official 2). Another programme officer concurred, 'Once you start taking money you lose all moral authority. Where is your voice then'? (Programme Officer 9).

Although the deployment of disciplinary action could be seen as responsive management, in the absence of fair enquiries that investigate and change the systemic problems faced by health workers, disciplinary action comes to be seen as a means of harassment. Sanctions are critical for enforcing standards, but they cannot be relied upon exclusively to promote systemic change. In the absence of positive mechanisms and rewards to support change, sanctions can become a means to pacify public opinion by scapegoating individuals, while covering up institutional problems (Freedman, 2003).

Those lower down the line are easily victimized. For example, when a large number of people began to die due to a gastro-enteritis outbreak in Koppal district, two clerks were suspended for not bringing the reports to a DHO's attention, even though the DHO had various information streams highlighting signs of the outbreak. Similarly, when a maternal death was brought to the attention of a DHO, the DHO chastized the ANM for not properly keeping her antenatal care register, even though this would not have saved the woman's life. By misusing hierarchy to offload responsibility and victimize lower level health department personnel as scapegoats, efforts to seek accountability are distorted and unjust organizational hierarchies are maintained.

### *Dissent*

Just as organizational hierarchies are constantly asserted, they can also be subverted. With few avenues for effective appeal in an overly bureaucratic and corrupt system,



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health workers sometimes resort to indirect methods to protect their interests. For example, one DHO was reported to run administrative meetings late into the night, regularly insulted medical officers and was corrupt. His subordinates got him transferred by accusing him of casteism.

Health workers also use corruption to protect themselves from administrative oversight. Various respondents reported that payments are made to DHOs to ensure that disciplinary action is not pursued, despite violations of health department norms. Protection or collusion money of this kind allows health workers to avoid staying in their posts and to regularly accept money from patients for services rendered within government facilities. A district official confirmed, 'Even if the programme officer recommends action, medical officers will pay some bribe to the DHO to prevent disciplinary action. So it is better for the programme officer to just write a memo and do nothing more' (District Official 7).

Although higher level officials command formal authority, it does not mean that the disciplinary actions they take are implemented in a straightforward manner. Substantial negotiation exists directly through memo wars and enquiries, but also indirectly through non-cooperation of subordinates, allegations of casteism, corruption and political interference from elected representatives. Before concluding, these two latter factors are discussed in more detail in the following sections.

## ELECTED REPRESENTATIVES

### *Political interference due to corruption*

Elected representatives are closely involved in refereeing disciplinary action, sometimes blocking administrative orders. One district official reported that he faced political interference from elected representatives from morning to evening. Before he can write a memo to discipline a worker, a politician will call him asking him why he is bothering people from the politician's caste group (District Official 7). Another senior state level official advised that it was better never to write anything in the confidential report. He explained, 'It is not confidential. When I write something, a clerk files it and unless you can control him 100%, by the time I reach my house I will receive a phone call from a politician asking me why I have spoiled someone's file' (State Official 1).

Transfers are another way in which elected representatives are involved in corrupting PHC management. In addition, elected representatives use their authority to demand money outright. Two officers independently reported that a DHO was collecting a quota of cash from each medical officer to turn over to the *Zilla Panchayat* (District Government) (Programme Officers 1 and 8). One of them explained, 'We are under their authority. Who knows what they will write about us. They may send some letter to the department or put something in our confidential report. It is better to give them the money and live in peace' (Programme Officer 1).

Lastly, elected representatives also reportedly use their authority to abscond with development funds. Each *taluka* is allocated a budget for repairing government infrastructure. Health facilities are reported to be white washed and the large



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difference in funding for infrastructural improvement pocketed by the authorities. These diversions are not without consequences, as some of the health facilities continue to function without basic amenities like running water.

*Political interference due to representation*

Although elected representatives use the health department to arrange transfers, influence disciplinary action and abscond with funds designated for infrastructural improvements, they are not impervious to public pressure. Their actions, although involving personal profit, also reflect the need to be seen as responsive to people's needs. In Koppal, a large number of government facilities are sanctioned in the native villages of politicians or in the wealthier areas of the district, disregarding health-planning norms or health needs.

Medical officers frequently mentioned that elected representatives come to health facilities to ensure that medical officers prioritize certain patients. The pressure elected representatives exert in prioritizing which patients get care can be problematic. In one district meeting, a DHO reprimanded a medical officer for abandoning a woman in need of suturing due to an emergency delivery, in order to assist a *Zilla Panchayat* member's sister who had a normal delivery an hour later (Meeting Observation).

During one visit to a PHC, I met a local politician with a party youth member who needed medical care. He openly discussed various legal and illegal practises carried out by medical officers in his area and even claimed to have helped to arrange the marriage of one medical officer. Local leaders are well informed of the volunteer efforts, or, conversely, misdemeanours and even intimate details of the public servants posted in their area.

The influence of elected representatives is not always negative. Just as politicians profit from transferring medical officers to larger towns or city-based facilities, they also play a key role in ensuring that certain specialists and senior programme staff are posted to their district. Well-respected officers, known for their integrity and effective public service, were posted to Koppal with the support of elected representatives. As one officer explained, 'If you are really good and honest, they will respect that. They may say publicly that you are a waste, because you are not generating money, but they will not harass you' (District Official 7).

Politicians can also police themselves. One health minister recognized the harm caused by the sale of transfers, which led to a distribution of personnel that did not match health needs. It was reported that during his tenure, he was able to put a hold on other politicians indulging in the business of transfers. However, as one officer alleged, his interest and power to do so, was also because, 'for him transfers were too cheap a source of money, he had better sources of money. All ministers are making money somewhere' (State Official 5).

In summary, elected representatives are powerful interlocutors in the health system. Although they can play positive roles in representing public interests in the health sector, they also sell their public influence for individual, private gain that contradicts public goals. Both kinds of politics influence the relationships that sustain health systems, yet neither is taken into consideration by management reforms.



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## CORRUPTION

### *Transfers*

Since Koppal district was founded 11 years ago in 1997, it has had 10 different DHOs. The tenure of programme officers in Koppal is slightly better. While some lasted a few months, a few lasted almost 2 years. During the same period at the state level, although the commissioner and director of health services' posts remained relatively stable, 11 different people filled the reproductive and child health (RCH) project director post. Between 2001 and 2004, no one completed a year in the RCH project director post and four people were in charge for 3 months or less. Such high rates of turnover in key leadership posts do little to ensure sustained attention to the severe public health challenges facing a backwards district like Koppal. Stability in key management posts is not monitored as a key indicator of health system functioning.

In theory, bureaucratic guidelines serve to constrict management discretion in terms of posting personnel. Promotions are based solely on seniority, in theory restricting the number of eligible candidates. Furthermore, transfers take place routinely only every 3 years. However, one officer commented that, in practice, 'If someone wants to move to here and displace me, all that needs to be done is to make a payment. In order to stay here, I need to make another payment' (Programme Officer 2). One therefore needs to look under the surface of formal guidelines to the social pressures that distort them.

Payments vary according to the people and placements involved. As one officer explained, 'It depends on the personal contacts you have. If you have connections then there is less money involved, as it is more direct. You need both the money and the personal contacts. It is like when you want to reach a certain village. If you have the jeep but no road, you will not reach. You need both the transport and the way there' (Programme Officer 3).

### *Petty, instrumental and wholesale corruption*

Corruption permeates many facets of government administration beyond transfers. Officers confirmed that, 'To get anything done in government, one payment has to be made. That is the only way in which any action happens' (Programme Officer 2). Those who are corrupt, wield their administrative power (DHO, THO, clerks) in order to demand cuts on every disbursement made. As one medical officer confessed, 'In the end it saves you time to pay Rs.50 rather than wait 2–3 months for your salary' (Medical Officer 3). Corruption in this form becomes ingrained in the everyday transactions of bureaucratic life.

These 'compulsory rather than unofficial payments' (Meeting Observation) may sound benign, but they obstruct service delivery. When investigating why immunization was not being carried out in certain villages, female health auxiliaries stated that it was because their travel allowance was not being fully reimbursed (Meeting Observation). As one medical officer stated, 'They do not really want you to work. It is all a gimmick. If you work, it is your loss. They will not reimburse me petrol. Instead they expect me to go by bus. Even then, they will only reimburse me



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some of the money and that to sometime next year. What is the point'? (Medical Officer 11).

Although accusations of corruption in the mainstream media frequently focus on government doctors taking money from patients for ostensibly free services, less attention is paid to how corruption is internalized into the daily administration of the health department. A few doctors did mention low salaries as a reason for taking money from patients, but others explicitly discounted this line of reasoning. Instead, they argued that corruption was an inherent part of the government administration. All government departments, not just health, were reported as plagued by inefficiencies due to corruption. Moreover, petty corruption by lower level bureaucrats and doctors pales into insignificance compared with the wholesale fraud undertaken by higher level officials. There is widespread awareness about who the corrupt individuals are in the health department and the means by which they embezzle large amounts of money.

At the same time, differing definitions of corruption existed amongst respondents. Some argued that demanding money for services that are usually considered to be free, whether clinical or administrative, was only considered corruption if the recipient did not deliver the service. One officer explained, 'Taking money should not be part of evaluation. There are so many ways of making money. Everyone is involved in some way or the other. The main criteria should be whether you get the work done' (State Officer 5). Another officer commented, 'See, if some people are corrupt you can manage. Perhaps they are 30% corrupt but they still do 70% of the work, if that ratio shifts more though, then you are in trouble' (Programme Officer 10). These statements reflect what several researchers have noted elsewhere: that corruption is so pervasive that there is a lack of consensus as to what counts as corruption (Gupta, 1995, 2005; Ensor, 2004; Shore and Haller, 2005).

The World Bank defines corruption as the abuse of public office for private gain (Amundsen, 2000). Shore and Haller (2005) argue that such a definition is simplistic and misleading. They argue that it restricts attention to the public sector and reduces the problem to a few dishonest individuals who are immoral due to their personal greed and venality. A more productive understanding of corruption should explore the informal social relations that support corruption, with norms and rules that empower some of its participants and marginalize others. It should also unpack the various forms and levels of corruption and social influence, with their ambiguous, subtle and sometimes multi-dimensional meanings (Rivkin-Fish, 2005). The informal understandings that sustain corruption signal the vital characteristics of how an organization works, the bargains that individuals strike to make it function and their moral evaluations of its purposes and functions. Corruption is only one extreme manifestation of the social relations that embed individuals within organizations, which can have both positive and negative synergies.

## CONCLUSION

Based on health administrator's and worker's perspectives in Koppal district, this paper reviewed the functioning of two key human resource management functions



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that are central to internal accountability in government primary health care services: supervision and disciplinary action. It demonstrated that these mechanisms are rarely implemented in a straightforward manner. Instead their implementation is negotiated by health workers in a variety of ways depending on the informal relationships that sustain health systems. Ideally, informal relationships engender supportive environments based on trust that builds on health workers' constructive and creative capabilities to foster responsive innovations to local conditions and needs. This is still sometimes the case in Koppal district.

However, the reality in Koppal district also demonstrates how informal relationships, based on political leverage and corruption, can also deform formal regulatory mechanisms in ways that obstruct service delivery. In these instances formal hierarchies of command are not only ineffective in resolving local problems that hinder service delivery, but are also sometimes perceived to be unfairly used to protect the political and monetary interests of higher officials. In such contexts management becomes a defensive practice that leads to a hyperformalization of procedures to the detriment of the health system goals they are designed to facilitate. A lot of disciplinary action is deployed, with little effect on discipline of staff, let alone on service delivery outcomes.

The majority of monthly staff meetings extend for long hours as higher officers use health formulae to check the reported statistics compiled and recited by health assistants. Linkages between indicators, follow-up of individual patients or problems health workers have in carrying out their work are rarely discussed. Field realities, the villages they work in, the communities they engage with, the health problems they try to address fade away and are superseded by the mathematical coherence and internal validity of their reporting forms. Accountability is feigned by the formal requirements of filling out forms, signing attendance registers to note that field visits have taken place and noting minutes of disciplinary action taken. Although formal accountability mechanisms are frequently enacted, those within the health department are not fooled by these appearances.

As much as formal accountability measures are implemented in a top-down manner, significant informal negotiations also take place by health workers and administrators that blunt their effects with both positive and negative outcomes. This qualifies the effectiveness of formulating accountability primarily as an architecture of administrative rights to curtail the abuse of power. Nor is accountability aptly used as a constructive management tool. While supervision and disciplinary action were used beneficially in some instances, accountability was also deployed as a non-transparent policing tool.

Accountability is therefore best characterized as a nuanced social process, where power relations are negotiated by multiple actors with both positive and negative effects. As a result, accountability relationships do not just operate at the micro-level of health worker–administrator interactions, regardless of how strategic and dynamic they maybe. Their interactions also reflect how power is mediated through corruption and elected representatives within the broader political economy context of health systems in Koppal district, northern Karnataka. These various dimensions of accountability need to be addressed if accountability is to function more equitably and effectively in health systems.



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