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Bringing Hirschman Back In A Case of Bad Government Turned Good

Judith Tendler and Sara Freedheim

MORE THAN thirty years ago, Albert Hirschman chided development economists for being too optimistic about the capacities of developing-country governments to manage economic development.¹ This put him at odds with the enthusiasm of those times for central government planning and "balanced growth." Today, Hirschman's early skepticism about the capacity of government would seem to place him in good company with the new generation of development economists and political economists: they are singularly negative about the capacity of developing countries to govern and to invest wisely, and of individuals to act in the public interest—even more skeptical than Hirschman was in that earlier period. But this interpretation of Hirschman's early works and their relation to the development thinking of today represents only half the story.

Shortly after issuing his early words of caution about developing-country governments to the industrialized world, Hirschman turned toward the developing countries and chided them for being too *pessimistic*. They were ignoring the accomplishments of their own governments, he told them, and giving undue prominence to their failures. He issued these warnings on three separate occasions over an eighteen-year period, starting only five years after his earlier message of skepticism.² Perhaps because of this chronology, his writings about developing countries are viewed as "hopeful" rather than skeptical, an interpretation that he himself encouraged by entitling his first book of collected essays *A Bias for Hope*. That the skepticism seemed to give way to hope, however, does not represent a change of heart. Today, he

would be just as critical of development economists for their pessimism, after all, as he was for their optimism thirty years ago.

A more accurate interpretation of the skepticism followed by hope is that they always coexisted, and represent the long-standing and intricate *balance* with which Hirschman chronicled development processes, despite his reputation as the inventor of the concept of "unbalanced growth." Hirschman's balance did not necessarily yield the simple and elegant theories of today's development economics and political economy, with their corresponding spinoffs in terms of policy advice. At the same time, his work was in many ways more grounded than this recent literature in observing how the economies and the governments of developing countries actually worked.

This chapter represents a small attempt to describe the world with balance or, more simply, to celebrate Hirschman's approach to it. It was provoked, in part, by the current imbalance of the development field in the direction of skepticism about the nature of governments and human beings. This is where the chapter starts, just as Hirschman's treatise thirty years ago was provoked, in part, by the optimism of that earlier period. In what follows, we confess to a bias toward the positive. But that does not worry us because it may help to counterbalance the stronger bias toward the negative in the sea of literature that surrounds us.

Today's negative views on the public sector of developing countries have grown out of keen disappointment over the failures of governments to cope with corruption, persistent poverty, and problems of macroeconomic management. Regardless of how customary poor performance in the public sector actually is, however, it has become customary to expect it. This is partly because it has been so well documented and so elegantly explained by the recent theories of public and rational choice, particularly those of "rent-seeking elites."³

Out of the convergence of the disappointment and the new theories has come a familiar litany of the causes of poor performance: public officials and their workers pursue their own private interests, rather than those of the public good; government spending and hiring is over-extended; clientelistic practices are rampant, with workers being hired and fired for reasons of kinship and political loyalty rather than merit; workers are poorly trained and receive little on-the-job training; and, tying it all together, badly conceived programs and policies create myriad opportunities for graft and other forms of "rent seeking."

These explanations have generated a corresponding body of policy advice oriented toward reducing the role of the public sector as much as possible. This more cautious view of the role of government, together with the theoretical attempt to explain the problem of poor public sector performance, represents a healthy evolution away from the simpler, more optimistic views criticized by Hirschman in the 1950s and 1960s. Although these new theories have been good at explaining why governments so often do badly, they are remarkably silent about the occasions when governments perform well.

The lopsidedness of development thinking in explaining government performance represents more than the understandable failing of a good theory that throws important new light on a problem but cannot explain everything. It also means that developing countries and the donors that advise them have few models of good government that are grounded in these countries' own experiences. The revolutionary transformations of the last decade in Eastern Europe and the former Soviet Union, moreover, have brought considerable urgency to the task of providing good advice about good government. To continue with the current empirically thin basis for advice represents, in certain ways, as naively optimistic a view about the capacity of "the market" or marketlike approaches to solve problems as was the view of the earlier period about the capacity of government to solve those same problems.

This chapter offers some explanations for why developing-country governments sometimes do well. The idea for the research reported on here started with our reading of an article published in the *Economist* in December 1991. Three pages of a special supplement on Brazil were devoted to the remarkable accomplishments of two successive governments in one of the country's poorest states, Ceará, an area of 150,000 square kilometers with nearly 7 million inhabitants.

The *Economist* article was followed by similar ones over the next two years, in *Newsweek*, *Time*, the *Christian Science Monitor*, the *Washington Post*, and the *New York Times*, as well as various Brazilian newspapers and magazines. The stories told of how the state increased tax revenues markedly by collecting taxes already on the books, freed the public payroll of thousands of "phantom" workers, and introduced some outstanding programs in the area of preventive health, public procurement from informal sector providers, and an emergency employment-creating public works program in the face of severe drought.

The Ceará stories were striking because this particular state government belongs, with eight other states, to the country's poorest region—Northeast Brazil—where one third of the population of 45 million lives in absolute poverty. The governments of the nine northeast states, which occupy an area the size of France, are legendary for their chronic poor performance and clientelistic practices.⁴ How could a poorly performing state "suddenly" do so well that, as the news coverage reported, it became a "model" of public administration sought out by other states in Brazil and other countries of Latin America and was feted by international institutions like the World Bank?

This question became the topic of a research project in Ceará, in which Judith Tendler worked together with seven research assistants looking into six programs that showed varying degrees of good performance.⁵ Certain themes ran across the explanations for good performance of each case, even though the cases involved different sectors. The most clear-cut case of success was a rural preventive health program, created by the state in 1987, and the subject of this chapter.⁶ After only a few years, the program had contributed to a 36 percent reduction in infant deaths from one of the highest rates in Brazil (from 102 per 1,000 to 65 per 1,000). It also tripled vaccination coverage for measles and polio from the lowest rate in Brazil, 25 percent of the population, to 90 percent.⁷ Only 30 percent of the state's counties had a nurse before the program started, let alone a doctor or health clinic, but the program was operating in virtually all the state's 178 counties five years later.⁸ For these accomplishments, Ceará won the UNICEF Maurice Paté prize for child support programs in 1993, the only Latin American government to do so since the prize's inception twenty-seven years ago.⁹

We chose the health case to illustrate the more general findings about public performance because, of the six better-performing programs, its achievements were most institutionalized, reached the largest number of people, and involved by far the largest number of public workers: 7,300 health agents and the 235 nurses who supervised them. This kind of public service involves considerable unsupervised contact between workers and clients—the health agents met formally with their supervisors only once a month—similar to other "street-level bureaucracies" like agricultural extension, policing, social work, and teaching.¹⁰ The state hired this veritable army of workers from

scratch, moreover, at the same time that it was shedding hundreds of "phantom" workers.

The large contingent of workers, their mass hiring over a short period of time, and the unsupervised nature of their contacts would seem to create numerous opportunities for the patronage hiring practices and rent-seeking behavior explained and predicted by the new theories.¹¹ That such a large field-based bureaucracy did not become the rent-seeking nightmare of the current literature requires some explanation. In attempting one, we hope to contribute to the understanding of public sector performance in developing countries and to a more grounded basis for advice.

Getting Satisfaction

Given the prevailing low expectations of government in developing countries today—let alone the mediocre history of Ceará's public service—anyone who accompanied this research could not fail to be surprised by the high performance and commitment to their work of such a large number of public servants. In numerous interviews, the health agents and their nurse-supervisors revealed a distinct sense of satisfaction and personal fulfillment from their work. Issues of "job commitment" and "worker productivity," however, hardly appear in the current literature on reform of the public sector in developing countries. Much of the focus is on how to "shed labor," on which functions would be better performed outside government, and on arrangements that simulate market competition between agencies or introduce marketlike pressures on public agencies to perform. As one Brazilian state secretary of planning said, in a typical lament, "We've succeeded in shedding some of our excess labor, but the poor quality of what remains stands out as even more of a problem. Nobody seems to be dealing with that."

The relative unimportance of worker-commitment issues in the public sector literature on developing countries stands in stark contrast to the centrality of these issues—and the rich treatment of them—in the current literature on industrial performance, competitiveness, and workplace transformation in the industrialized countries.¹² This body of research and thought concerns "reform" in the *private* sector—including a variety of now widely known subjects such as decentralization, flexible specialization, total quality management, worker teams,

trusting customer-supplier relationships, and reengineering. Although some of the concepts of this literature have started to spill into the thinking on the public sector, this has happened mainly with respect to the public sectors of already industrialized countries.¹³

It was only against the background of these literatures that we were able to discern the threads of worker satisfaction and increased performance that ran through the health case and the others. This does not mean that we found total quality management or worker-management teams flourishing in the backlands of Ceará, where the health program unfolded. Rather, the explanations people gave for why they liked their jobs better, and of how their work was different from normal, had much in common with the explanations of the industrial performance literature for why these practices have been associated with better performance in the industrialized world. The way citizens talked about the public workers who served them in the health and other programs, in turn, was reminiscent of the way this literature describes the relations of "trust" between customers and the firms they buy from, or between customer firms and their subcontractors.¹⁴ As in the development field, moreover, those concerned with industrial performance are paying considerable attention to "labor shedding" and how to do it. In these debates, however, labor shedding stands out as only one of a *variety* of approaches being discussed to improve productivity in the private sector, including also worker teams, decentralized management, job "enlargement," quality circles, total quality management, and just-in-time inventory systems.

These comparisons between the fields of development and industrial performance are not meant to suggest that the public sector of developing countries should adopt the best practices of firms in industrialized countries—although many are proposing just that for the U.S. public sector.¹⁵ Rather, and more simply, the contrasts serve to reveal the narrowness of the development field's approach to improving performance in the public sector, dominated, as it is, by issues of labor shedding, reduction of the spectrum of government functions, and introduction of marketlike pressures to perform. Now that poor performance is so much better understood and considerable labor shedding, privatization, and other reforms have already taken place, there may be more room in the development field for concern about the conditions under which workers providing public services show high commitment to their work and perform well.

The Workings of the Ceará Health Program

Ceará's rural health program started in 1987 as part of a temporary response to the unemployment caused by one of the periodic droughts that afflict this semiarid state every four to seven years. For its first twelve months, the program was financed by temporary disaster-relief funds from the federal government. Unlike the typical public works jobs offered to the unemployed during these droughts, the jobs for community health agents were available mainly to women. Although the health-agent jobs never amounted to more than 5 percent of the temporary jobs offered by the state during the drought, the program was so successful that the state decided to fund it permanently in 1989, after the drought and the emergency funding for it had ended. By 1993, the program's 7,300 paraprofessional health agents visited 850,000 families in their homes every month—about six per day per agent—providing assistance and advice and collecting information about oral rehydration therapy, vaccination, prenatal care, breast feeding, and growth monitoring.

Program costs averaged US\$2 per capita served—totaling approximately \$7 to \$8 million a year—compared with the \$80 estimated per capita costs of Brazil's existing health care system.¹⁶ About 80 percent of the costs represented payments to the health agents, mostly women who lived in the communities where they worked and earned the minimum wage (US\$60 a month with no fringe benefits); nurse-supervisors earned an average of five times the minimum wage, \$300 a month, often higher than they would have earned in urban clinics and hospitals.

The health program represented a first move toward the decentralization of health services, with municipalities required to hire a nurse-supervisor, pay her salary (about 15 percent of program costs), and support the program in other ways.¹⁷ The state paid the lion's share of program costs (85 percent), covering the wages of the health agents and their uniforms and supplies. A nine-member coordinating team ran the program out of the state Department of Health and traveled extensively in the interior. It recruited and hired the agents and supervised the program with a strong hand; at the same time, it gave considerable discretion to the supervising nurses. After a rigorous selection process by the state, as discussed below, the newly hired agents re-

ceived three months of training and substantial on-the-job training; nurse-supervisors had three days of orientation and numerous subsequent meetings with the coordinating team.

The health agents of the new program constituted the most visible public sector presence in the communities where they worked, and often in the towns where the program was headquartered. They wore "uniforms" of white T-shirts emblazoned with the name of the program, blue jeans, and blue backpacks with supplies.¹⁸ Mindful of the critical appraisals of earlier preventive health programs run by non-government organizations, the program insisted on ministering to community members in their households rather than out of a health center. Although this was done in order to achieve better health coverage, it had another significant effect on program performance. The health agents were constantly seen by the community moving from house to house and, for their more rural visits, traveling by bicycle, donkey, and even canoe.

The health program's achievements were clearly striking, most notably its rapid growth throughout the state and the dramatic changes in the indicators reported above. Furthermore, the program represented an unusual success in "paraprofessionalization." It overcame the typical resistance of physicians and nurses to the introduction of less skilled workers and, in so doing, brought down the costs of service drastically.¹⁹ The explanation for why the program worked so well is complex, but we focus here on the following themes, which, in one way or another, reveal a work environment that differed substantially from the way the work of public sector agencies is often organized, or how experts think it should be organized.

—Both health agents and nurses saw their jobs as giving them more prestige and status than usual, particularly in the communities where they worked.

—The state government played an unusual role, sometimes inadvertently, in contributing to this prestige by creating a sense of "calling" around these particular jobs—through publicity, the hiring process, the training of workers, and prizes for good performance.

—Although the health program *seemed* to represent a case of successful decentralization from state to municipal government, the actions of the more centralized state government seemed more important to an explanation of the program's success.

—The approach to decentralization, together with the state's public relations efforts around the program, succeeded in heading off the opposition to such programs that frequently occurs, from professionals resisting the use of paraprofessionals in health care and from mayors resentful of the state's usurpation of their powers to hire municipal health workers.

—Workers voluntarily took on a larger variety of tasks than was normal, often in response to their perception of what clients needed. These included tasks that are usually viewed as not what an agency or worker is "supposed" to do and as representing bad practice.

—Although these "self-enlarged" jobs and their vaguer limits would seem to make supervision more difficult and to provide more opportunities for misbehavior, certain mechanisms came into play that hemmed public employees in with pressures to be accountable from *outside* their agencies.

The Unskilled Meritocracy

Existing accounts of civil servants working in health programs similar to Ceará's often convey the same sense of hopelessness as the broader literature on public sector performance in developing countries.²⁰ Because of that, along with the generally stressed environment of Ceará's public administration, it surprised us to encounter such profound satisfaction among the program's health agents and supervising nurses. As one agent reminisced, in a typical comment, "This town was nothing before the health program started. I was ready to leave and look for a job in São Paulo, but now I love my job and I would never leave—I would never abandon my community." This kind of satisfaction went along with the intense dedication, unpaid after-hours work, and voracious learning observed among a large number of the agents and nurses working in the program. It is worth noting, in this context, that the health agents (as distinct from the nurses) received only the minimum wage and were hired without the job security that public sector employment usually offers. What accounted for this commitment and the high performance associated with it?

Interestingly, the origins of the commitment can be traced back to what happened *before* the health agents started working—namely, the hiring process. The program carried out a remarkable process of merit hiring, which, when it occurs at all or is respected, usually involves

jobs in the more professionalized echelons of government agencies rather than those of unskilled workers like the health agents. Merit hiring, moreover, is difficult to find in rural areas, where mayors customarily hire the few municipal employees under their control according to considerations of patronage.

In the Ceará setting, the hiring of the health agents represented much more than a routine civil service procedure. Given the chronic unemployment in the northeast interior, with its low-productivity agriculture and its periodic droughts, the hiring of 7,300 workers became an event of major significance in the lives of the job seekers and the dozens of towns where they were to work. The state-level coordinating team for the new health program went through three stages to hire each worker. It first required written applications from all applicants (family members and friends helped the less literate applicants fill out their forms), from which it culled out a list of people to be interviewed. Two members of the team (usually a nurse and a social worker) then traveled to each town for an interview with each applicant on the list, which was followed by a meeting with all applicants as a group. A subsequent round of individual interviews was often held with those likely to be selected.

For most applicants, regardless of their age, this was the first time they had applied for a job or, at least, been interviewed for one. Many were perspiring and trembled with fear during their interview. In the small interior towns where the interviews took place, townspeople saw the hiring "event" as boding well for the town's future: important professionals from the state capital would stay for more than a few hours—indeed, overnight—to run a competition that seemed to herald a new public service for the community. The coming of the state team thus inspired widespread curiosity and comment, not to mention eavesdropping from outside the open windows and doors where the meetings with applicants were held.

Why would the state have lavished so much attention on the hiring of a large force of unskilled, minimum-wage workers without civil service status—and for a program that was perhaps only temporary and, in essence, local? Clearly, this kind of hiring process must have helped the hiring committee select the best applicants and, hence, partly explains the program's success. But this is not the main reason we bring it up: the hiring process, as "staged" by the state government, had a

major impact on the way the program was subsequently perceived by the communities where it operated and on the way its workers viewed their jobs.

The state government advertised the program and the jobs widely in the regions where hiring was taking place through health centers, hospitals and, particularly important, on the radio, the most broadly used medium of communication in the interior. Even though the hiring of the new agents was often phased over a year or more, the number of jobs offered at any particular hiring was frequently the largest one-time public sector hiring in these rural towns, perhaps twenty, thirty, or forty jobs at a time. Later, as already mentioned, the "uniformed" health agents became the most conspicuous and numerous public sector presence in the area.

The health program was also unusual for the interior towns in that it hired mainly women (95 percent), because of the focus of its health messages on mothers and children. Many of these women had seldom had paid employment, not even the temporary employment of the periodic drought-relief programs; others had worked as primary school teachers for the municipality, typically earning less than the minimum wage. This situation is quite common in rural Brazil, where teachers themselves frequently have no more than an elementary school education. In earning the minimum wage, the new women agents were receiving up to twice the wage paid to male agricultural labor, the principal occupation of the poor population of these areas.²¹

In retrospect, the state seemed to be using the hiring process quite cleverly as an opportunity to educate the community—the program's "customers"—about the new service. In interviewing the job applicants, the state committee took just as much care to inspire and inform those whom it would *not* hire—the overwhelming majority, of course—as those whom it did hire. It provided strongly inspirational messages about what the program could do to improve people's lives and how the community could—in taking the program seriously—gain control over its destiny. "This program is yours," the state team told the assembled applicants, "and it is you who will determine its success, whether you get the job or not." The community "does not have to" lose so many of its infants, they continued, and sickness did not have to be so common; it was not "right" to have high infant mortality, a community "could do better," it had a "right" to demand support for such a program from its municipal leaders.

The program's coordinating team also told the applicants that it would be an immense "honor" to be hired. Just as significant for the program's future performance, job applicants were also told that it had been an "honor" for them simply to have applied and been interviewed; participating in the process had proven their "commitment to the community" and their status as "leaders." This was so, the team told them, even if they were *not* hired.

Because the hiring took place in stages, the "image creation" around the process was even more effective. In a *município* slated for 150 health agents, for example, the first competition might call for only 30. Three or four subsequent competitions would hire the rest over as much as a three-year period, each time in the same way. In addition to introducing a large new program at a manageable pace, the phased hiring sustained the image creation around the program and its agents well into the implementation period.

FROM REJECTS TO MONITORS. The state's approach to the hiring process also helped, ultimately, to subject the program to strong pressures to perform, as well as to legitimate its workers. "Those of you who are *not* selected," the traveling committee advised, "must make sure that those who are chosen abide by the rules." This turned a group of 200 or 300 unsuccessful applicants into informed public monitors of a new program in which the potential for abuse was high. Among other requirements, the applicants were told, health agents had to live in the area where they worked, work eight hours a day, visit each household at least once a month, attend all training and review sessions, and not canvass for a political candidate or wear or distribute political propaganda. Although all these requirements certainly do not seem out of the ordinary for such a job, they are not often observed in Brazil or in many other countries. "If these rules are breached," the committee warned the assembled applicants and eavesdroppers, "we want to hear about it." The warning was clinched with the admonition that "we are keeping all the applications, just in case any of those we hire do not perform well."

For those who were hired as agents, the specter of reprisal for malfeasance and of the waiting line of eager replacements formed by the rejected applicants translated itself into pressure to perform well. The drama of the hiring process, in turn, had created an informal and powerful monitoring presence in the community at large. Community

members, indeed, subsequently reported to nurse-supervisors when agents were violating the rules and not, for example, living in the community where they worked (these agents were fired). Less drastically, a family that had not seen its health agent in more than a month would often let the nurse-supervisor know.

The image of disgruntled job seekers watching the job winners like hawks for one false step is certainly not one usually associated with increased worker commitment and productivity. Indeed, it smacks more of the "scab-labor" tactics reviled by labor unions. But the dynamic created by these instructions and admonitions was more complex and more positive. Rather than merely create opportunities and incentives for individuals to "whistle-blow" behind people's backs, the hiring process and advertising around the program fostered a sense of *collective* responsibility for it among the community and its workers.

The educational process had endowed prestige on those who won the job competition, and on the program itself, not only in the eyes of those who lost but among the users of the program and the community at large. In addition, the selection committee's instructions to job applicants who were not chosen made them feel involved with the program, so that they also reported to the nurse-supervisors when they were *satisfied* with what a particular agent was doing. Finally, the hiring process and its warnings—far from intimidating the new workers—made them feel they had the *support* of the state government should they have to deal with local politicians who might want to divert the program to their political ends. They now had an excuse to say no, and someone more powerful to whom they could report an abuse; they also knew they could not be fired by the mayor, as was common, for refusing to go along with political or personal abuse of the program.

The importance of "protection" for dedicated public servants crops up frequently in case studies of successful programs like this one—protection from local politicians, as in this case, or from another arm of government or the public.²² In these studies protection is usually conveyed as making it possible for a group of "apolitical" and highly educated technocrats to carry out programs in the public interest, shielded from political meddling. In this case, however, it was *unskilled* workers who were being protected, and among the protectors were the politicians themselves, namely, the state's governors.²³ Regardless of these differences, one of the conclusions to be drawn from these studies, together with the health story, is that a public agency's performance

at any one moment is partly dependent on the balance of power between "protectors" and "spoilors," as well as between dedicated and self-serving public workers.

Although the portrayal of public workers as being "liberated" by their protectors to serve the public good is common in case studies, it is inconsistent with the theoretical view of civil servants as inherently self-seeking; or, at least, it complicates that view. It also points toward a different explanation for some of the *poor* performance in the public sector, as well as the good.

PUBLICITY AND ITS BY-PRODUCTS. The esteem and support heaped on the preventive health program and its workers by the hiring process extended well into the implementation period because of the staged expansion of the program. Other actions by the state had this same effect without, interestingly, necessarily intending to. Seeking additional financial and other support for the program, the state Department of Health successfully approached large private firms to raise funding for radio and television campaigns advertising the program and its preventive health messages and for the training of existing curative care personnel in vaccination and oral rehydration therapy. The state also successfully lobbied the medical schools operating there to require that medical students take courses in preventive health care as a requirement for board certification. The resulting blitz of publicity about the program and, later, its eventual successes—on radio and television and in the newspapers and newsmagazines—placed the health agents and their nurse supervisors in an unusual spotlight of recognition and praise.

The state also awarded prizes—again, with much fanfare—to the municipalities achieving the best immunization coverage. By 1992, 43 of the state's 178 municipalities had received prizes for the best DPT-III coverage (diphtheria, pertussis, and tetanus).²⁴ The prizes were set up partly with the goal of getting program personnel to take seriously the collection of health data, which is always a problem in such programs. At the same time, the fanfare and the recognition surrounding the prizes were immensely satisfying to the workers in these programs, enhancing their prestige in the communities where they worked and lived.

By 1993 the state's constant publicizing of the health program and its other achievements had attracted highly laudatory press coverage.

It is not clear, however, if the state understood the positive impact of this publicity on the program's workers and their performance, because it had other reasons for making the program well known. First, as mentioned earlier, the publicity was meant to get people to adopt preventive health measures. Second, and assuming greater importance as the program wore on, the publicity simply reflected the effort by a state government to capitalize politically on its own successes. The two governors who reigned over the program in succession had political ambitions nationally; by the early 1990s, the first had become president of an important recently formed Social-Democratic party, and the second was highly conspicuous on the national political scene. Their administrations had been clever and aggressive at publicizing all their accomplishments, not just health, throughout Brazil and abroad.

More skeptical observers of these two state administrations questioned the reality of their claims, suggesting that the publicity exaggerated their accomplishments. Whether or not this was the case is not relevant to our argument: regardless of the intentions, the publicity would have had the same powerful effect of bestowing public recognition on the health program and its workers. Indeed, attention to the other ends served by the publicity may well have helped to cause this particular result to go unnoticed, preventing the state *and* its critics from seeing the value of publicity for these other purposes.

Perhaps it would not have taken much to get good performance from a newly hired contingent of rural women workers, most of whom had no more than a sixth-grade education and had never before had paid employment. But the nurse-supervisors talked about their feelings of "being respected by the community" just as much as the health agents they supervised did. Not only were these nurses trained professionals, but many had left previous jobs in hospitals in larger cities to work for the program.

The Good Professional

The quality of supervision in preventive health and other programs deploying large paraprofessional field staffs is key to their success. Evaluations of poorly functioning preventive health programs routinely cite the absence of good supervision.²⁵ Any study of the achievements of Ceará's program, then, must ask why supervision was better than in most such programs. In addition, physicians and nurses often object to preventive health programs like Ceará's, or simply have no

interest in promoting them. This resistance or lack of interest—sometimes even from previously trained groups of paraprofessionals themselves—contributes to the difficulty of getting the public sector to pay adequate attention and funding to preventive health, as compared with curative health programs. Part of the resistance is due to a genuine concern about compromising professional standards and jeopardizing the health and safety of the patient. Another part, of course, speaks worries about losing power, professional distinction, remuneration, and access to jobs. From the glowing reports of the supervising nurses of Ceará's health program, it is clear that a large number of a key group of potential resisters to the program became its ardent advocates. This also requires explanation.

In the urban clinics and hospitals where many of the nurse-supervisors had worked previously, they had been inferior in status to the doctors they assisted, who treated them as subordinates rather than coprofessionals. Now, each nurse was supervising and training an average of thirty paraprofessional agents, who referred to their supervisor as "doctor" and hung on her every word. She suddenly felt herself an important local personage in the community and local people addressed her as "doctor" when they passed her on the street.

In addition, the nurse-supervisors felt that in their previous jobs they had really not been able to "practice nursing." Many hospitals had given them more and more administrative work and met nursing needs by hiring less-trained and lower-paid paraprofessional workers. Not only were the trained nurses less able to practice nursing, then, but they were angered by the lack of "professionalism" in the way nursing was run in their hospitals—using less-skilled workers, for example, to assist physicians at surgery. This led to various protest meetings, which were of little avail and left the nurses feeling powerless, alienated from their work, and ignored as professionals. Similarly, evaluation studies of preventive health programs in various countries have found that the poor quality of supervision, usually by nurses, is a result of their not being called upon to participate in the planning of the programs they administer or of their being allowed little discretion in managing the programs.²⁶

In Ceará's preventive health program, the situation was quite different. Although the nurse-supervisors may not have been practicing nursing directly, they had virtual control over the way the program ran in their municipality. As a result, they were able to put into practice

their ideas about how public health programs should work. One important sign of the nurse-supervisors' newly gained discretion was the variation in the details of each program from municipality to municipality. Some nurse-supervisors, for example, believed their agents should know how to give shots and take out stitches; others were adamantly against teaching these "curative" tasks; others believed family-planning messages should be central to the agents' advice giving. (Indeed, one nurse-supervisor initiated family planning into her municipality when she found, in conversations with her own agents, that many of them had sexually transmittable diseases and did not know how to prevent or treat them.) The state deliberately allowed this variation from one municipality to the next, not pressing standardization too strictly, in order to give the supervising nurses the autonomy that would cause them to "own" the program they were responsible for.

All this was a far cry from the nurses' subordinate relation to the physicians of their previous jobs and their exclusion from decisions that were central to their identity as professionals. Although they may not have been practicing nursing in their new jobs any more than in their old jobs, they felt more "like a professional" because they were making decisions about how to run a program of public health and saw direct health effects of their work. That their salaries in the preventive health program were higher than in their previous urban jobs must have clearly been important in attracting some of the better nursing professionals and ensuring their dedication. But the dramatic increase in status from being near the bottom of a professional hierarchy, and their new place as health "professionals" at the center of decisionmaking about a program, must certainly have made a difference as well.

It is ironic that the nurse-supervisors, who had criticized the use of paraprofessionals in their previous jobs in urban hospitals, were now feeling more professionally fulfilled in a job that involved the supervision of a large group of just such workers. In addition, the nurse-supervisors adamantly defended the use of paraprofessionals in the preventive health program against the predictable criticisms that eventually came from their urban colleagues in nursing. The new power of the health program's nurses to decide what the unskilled workers could or could not do was key to the change in their view about paraprofessionals.²⁷ More generally, the nurses supported the program and provided quality supervision because they were given a more central

role in planning and operating a health program than they had been in their previous jobs.

Civil Service as a Calling

Through a conspicuous civil service hiring "event," the state created a sense of public "calling" or "ministry" around a particular set of public jobs and the program of which they were a part. Merit-hiring processes are valued, however, for other reasons: they ensure better-quality candidates and public servants and protect the public sector from patronage hiring. In the United States and other industrialized countries, moreover, merit or civil service hiring is so accepted that it is taken for granted; indeed, it is often criticized for being too rigid and for stifling creativity. But in developing countries, where patronage influences public sector hiring to a much greater degree, the hiring process described above represents an outstanding accomplishment.

Good public managers in Brazil often fight major battles to have meritocratic hiring procedures followed in their agencies. In a previous research project, for example, Tandler interviewed successful public managers of infrastructure and agriculture agencies in the Northeast on what they considered to be their most significant achievements. Rather than referring to program accomplishments like getting roads built or wells dug, several reminisced about victories in getting merit-hiring procedures for a particular set of new workers, usually after a battle against political pressure to do otherwise.²⁸

The health story shows, in addition, that such conspicuously merit-based hiring can cause newly hired workers to start out viewing their jobs and themselves *differently*—and hence lead them to behave differently—because of the prestige accorded to them by the selection process. Getting the job is, in a sense, like being awarded a public prize. That the selection process itself could bestow prestige and influence performance is not, of course, new or unique to Ceará's health program. Professionals who work in public agencies known for serious merit-hiring procedures often cite this fact, like an item on their curriculum vitae, even when the competition took place many years ago; they proudly and disdainfully set themselves off from others in the public sector who were not hired in this way. In Brazil, Bank of Brazil managers talk this way, as do professionals in the National Development Bank. Outside of Brazil, the Indian Administrative Service pro-

vides another excellent example of civil servants who feel themselves an elite simply for having won their jobs.

The health program's hiring process differed from these typical cases of meritocratic public agencies in three interesting ways. First, by publicizing the hiring so intensely in the interior communities, the program conferred status on the job in the very communities where the agents worked. Second, the hiring process and the accompanying publicity around the program linked the prestige not just to the particular individuals who passed the rigorous competition, but also to the program's "noble" mission—bringing the community "into the twentieth century" by reducing infant mortality and disease. In other words, in contrast to the meritocratic cachet among other public servants, the prestige and the glory lay not so much with the public agency into which one was drafted, but with the impact one's work would have on the future of a community.

Part of this difference had to do with the fact that the responsibility for the program was split between the state Department of Health and the municipalities. Although the state clearly maintained the upper hand in the hiring process and supervision of the program, the municipalities hired the nurses; and the agents worked under the nurses' supervision, even though the agents were hired and paid by the state. This meant that neither the agents nor their supervisors "belonged" to the health agency that conferred so much prestige on them. Their prestige, rather than being grounded in the reputation of an agency that hired them, derived from the "mission" of their program in the community, as defined and declared repeatedly by the state government in advertising the program and in hiring and training its workers.

Third, the status the health agents enjoyed was not, as distinct from the more typical case of meritocratic public service, the result of their being an educated elite. The reward for their having passed the competition, in turn, did not come in the form of job tenure. As had become the practice of other fiscally strapped state governments in the 1980s, Ceará had gone out of its way to "contract" these new workers rather than hire them, so as to make it clear that they were not winning a permanent home in the state's public sector.²⁹ Indeed, the governor customarily stressed this as one of the keys to the program's success, proudly noting that he had always resisted pressures to turn the agents into "state employees." "If you [do so]," he liked to say, "this programme will die".³⁰

Unlike the other cases, then, the winning of these jobs was not a result of "being educated." Rather, education was something that the job would *confer* on these workers as a reward for their having been "chosen." It took the form of the program's three-month training period (unusually long, particularly for unskilled, minimum-wage workers), subsequent training, and substantial feedback from supervisors. For most people living in Ceará's interior, access to this kind of training was beyond the realm of possibility.

Workers in low-paid jobs requiring no initial skills often perceive no opportunity for upward mobility in their work. This is a recurrent theme in the attempts to explain poor productivity and worker performance in the industrialized countries.³¹ Ceará's program seemed to avoid the productivity problems resulting from paying low wages and providing no job security by giving its health agents substantial ongoing training and conferring status on them from the start. Together, these two attributes of the program were enough to make these workers highly dedicated to their jobs.

Distrust and Respect

It is ironic that selling the idea of the "good public servant" would have been possible at a time when the public sector was so discredited in Brazil and elsewhere. In the 1960s and 1970s, the image of public service had become heavily tarnished because of its association with the military government that took over in the mid-1960s and gave up power to a civilian and democratically elected government only twenty years later. The repressive tactics of the military government, whose targets included peasant organizations in the interior of states like Ceará, created a profound distrust and fear of government agents, which persisted even after the civilian government took over in 1984.

Partly because of the distrust, the health agents found it quite difficult to gain access to people's homes when they started working. Mothers would not answer the agent's knocks on the door, or would hide their children when the agent crossed the threshold. Needless to say, this is a frequent problem for health programs in areas like rural Ceará, where people rely more on traditional medicine and local faith healers.³² But in Ceará's case, as in many others, this reaction was also a legacy of the mistrust of anything coming from the "government."

Although the public associated the "bad" public servant with the military government, the democratic opening that everyone yearned

for unleashed a new wave of contempt for the public servant. Starting in the late 1970s with the first gubernatorial elections and culminating in the first presidential elections of the mid-1980s, the return of democratic politics was said to have brought with it a "recommencement" of patronage politics and its ways of hiring for public sector jobs. An analysis of employment trends in the 1980s, for example, noted a marked increase in public sector employment in the Northeast in the early 1980s, in relation to the rest of the country, and linked it to the gubernatorial elections there for the first time in eighteen years.³³

During the years when Ceará was hiring its new army of health agents, the next president of Brazil was successfully campaigning on a promise to "get rid of the 'maharajas' (*marajás*)"—public sector workers who lived off the income and perquisites of their jobs without doing much work. He portrayed himself as being particularly qualified for this task, because of his alleged success in reducing public sector employment in the small state of Alagoas, where he had been governor. His failure as president of Brazil to make substantial inroads on the turf of the "maharajas" and, more important, his involvement in major corruption scandals himself led, in 1992, to a successful public outcry for his impeachment by a disappointed electorate now more cynical than ever about public service.

In the late 1980s and early 1990s this environment of public skepticism about government, together with fiscal stringency, generated widespread popular support for reformist politicians to carry out, like Ceará's two governors, "lean-and-mean" policies in running the state's public sector. Like the presidential candidate just described, the two governors claimed they were going to reduce the state's public employment substantially by getting rid of "phantom workers" (*fantasmas*)—those who received paychecks but did not appear at work. After succeeding in eliminating several thousand such phantoms from the state's payroll, the state made good political capital out of publicly advertising that feat. It was in this same environment, however, that the state hired a large contingent of new workers for the health program and was able to create an image of "the good public servant" around them. Remarkably, the state succeeded in convincing the public, as well as the new workers, that a dedicated army of new public servants was, in those sorry times, perfectly imaginable.

The Central in the Decentralized

Standard diagnoses of poor performance of developing-country governments point, among other things, to the overcentralization of government functions.³⁴ Over the last decade, therefore, decentralization from central to local governments has become an important item on the agenda of development research and advice. This literature and its accompanying prescriptions have focused considerable attention on the responsibilities, capacities, weaknesses, and virtues of municipal government as well as other local institutions.

Given the current enthusiasm for decentralization and its strong association in Brazil and a number of other countries with "democratization" and "grass roots control," it would be easy to interpret the new health program as a fine story about decentralization. But this would be a mistake. While giving considerable discretion to the supervising nurses hired by the municipalities, the state has still maintained iron control over certain aspects of the program, as illustrated by the story of the hiring process, among others. (The programs in some of the municipalities, nevertheless, were weaker than the rest because they lacked the support of the mayor or were poorly supervised.)

The agreement dividing labor between state and local government called on the state to finance 85 percent of the program (health-agent wages mainly, and supplies), and the municipality 15 percent (from one to four nurse-supervisors, usually half-time and working the remaining time in curative care for the municipality).³⁵ The state was responsible for hiring the workers and supervising the nurse coordinators, and the municipality for hiring the nurse-supervisor and paying her salary. These were the only formal commitments required of the municipality.

Before the health program was launched in 1987, most municipalities had no such services. At best, the mayor had an ambulance at his disposal and kept a small dispensary of prescription medicines at his home. Mayors typically doled out these medicines, as well as ambulance rides, to relatives and friends, and to needy constituents in return for political loyalty. The new Brazilian Constitution of 1988 augmented the mayor's access to revenues for health expenditures by increasing the share of federal transfers going to local governments and mandat-

ing that 10 percent of these new revenues be spent on health (plus 25 percent on education).³⁶ Many mayors, however, continued spending less than the mandated amount on health, because enforcement mechanisms were not strong enough; or, if they did increase health expenditures, they continued dispensing services in the traditional clientelistic way. Given this history, the new health program did not enter a municipality without first explaining to the mayor that he would have no control over hiring the health agents and without first obtaining a formal commitment from the mayor to hire and pay a nurse-supervisor half-time.

In a certain way, then, the new program reduced the power of the mayors. They had no control over the hiring of a large number of new public employees in a program under their jurisdiction, and they had to finance part of the program out of funds that they could have used to their political benefit in other areas without such constraints on their power. It was not surprising, then, that some of the mayors were not very enthusiastic about the program when it began. One actually hired his own health agents out of municipal funds to accompany the state-hired agents on their rounds to households so that his agents could also distribute campaign leaflets on these visits—a frequent practice in field-based public services in Northeast Brazil—which the state's health agents were strictly prohibited from doing. Thus the mayors became as strong a potential source of trouble for the new decentralized program as the health professionals who were against the "paraprofessionalization" of health care. In response, the state found an ingenious solution to the problem, which eventually elicited municipal participation and capacity building.

Ironically, the program's division of labor between state and municipality was somewhat of an accident, and "second-best" from the state's point of view. Moreover, this division was nearly the opposite of what might have been expected. That is to say, the Department of Health would have preferred to have had complete control, particularly over the hiring of nurse-supervisors; it understood how crucial good supervision was to such a program, and it was worried about the patronage practices endemic in municipal hiring. But given the cutbacks in the transfers received by the state from the federal government, and the rechanneling of some of them directly to the municipalities, it could not afford to finance the program completely on its own. It also could not go against the political popularity of decentralization, as mandated

in the new constitution. Any program so grounded in the municipality would need some form of at least tacit support from local authorities in order to function smoothly.

Instead of maintaining control over the more technical, supervisory jobs, the state chose to control the hiring and training of the much more numerous *unskilled* jobs of the health agents. Under this arrangement, the hiring (and firing) of the nurses could have been just as subject to patronage and cronyism as the state feared the hiring of the agents would be; or, the mayors could have simply decided not to come up with their 15 percent of the funds. But because the position of supervising nurse played a key role in the program, and because there were only one or two such positions available, it was quite conspicuous in each municipality's program.

In addition, although the mayors may have preferred not to commit municipal funds to a health program so much outside of their control, they were subject to strong pressures from the community to enter the program. These pressures—to initiate the program, to hire qualified nurses, and to run it cleanly—were in themselves a result of the state's flurry of publicity around the program: communities without the program pressured and educated their mayors into getting it and making sure it worked. Once a program was in place, additional pressures and information from the army of health agents, as well as the community, elicited further contributions from mayors for items to which they had not been formally committed, such as bicycles, canoes, and mules for the agents so they could reach more remote households, or chlorine for campaigns against cholera.

As a result of the state's publicity about the program, then, both the state government *and* the community exerted a kind of "scissors" pressure on the mayors that forced them to support the program and to not misbehave. Once the team of thirty or more agents and their nurse-supervisor were ensconced in a municipality, they became a formidable force in educating, as well as pressuring, the local government to live up to its responsibilities for providing health services. Ultimately, the mayors found that when the program operated well, it was quite popular and they could take much of the credit. In creating an informed and demanding community, the state had initiated a dynamic in which the mayors were rewarded politically for supporting the program. This helped it replace the old patronage dynamic with a more service-oriented one.

The state actually saw a certain advantage to having the nurse-supervisors hired by the municipality rather than by the state, which counterbalanced their concern about patronage in hiring. If the nurse-supervisors were to be hired by the state Department of Health, agency managers reasoned, their professional futures might well lie in the capital city and not the communities where they worked. As it turned out, the nurses *did* value their jobs, although for more positive reasons than not having a ticket to higher-level state jobs.

Most decentralized programs are, like Ceará's, a mix of local and central elements. But the literature on decentralization, with its agenda for reducing the disadvantages of centralized government, has focused mainly on the new possibilities and responsibilities of *local* governments and other local institutions and on the new capacities and revenue sources they must acquire. This lack of emphasis on the tasks of the *central* government in the new order is understandable, of course, since local governments are weak and need attention. In addition, asking central governments to do *less* of what they normally do would not seem that demanding or complex, albeit sometimes politically difficult. As the health story shows, however, the state government was not simply doing "less" of what it had been doing before. Indeed, its actions in the health program represented more than it had been doing in the health sector before and consisted of quite different tasks.

The health program also represented a more incremental and indirect path to decentralization than that usually taken or, at least planned. The state surrounded the mayors with community pressure to "voluntarily" take on more responsibility and be more accountable. As a result of the initial lack of enthusiasm of some of the mayors and the voluntary nature of their participation, the program spread through the state at a gradual pace over a period of a few years, in accordance with the rate of requests backed by commitments from municipalities. Rather than being the result of a full-blown decentralization, then, the program's achievements represented some first steps in that direction. By proceeding in this way, and by luring mayors into the program one by one, the program was given increased financing, responsibility, and, ultimately capacity for local control.

The literature concerning decentralization and the proper division of labor between local and more centralized levels of government tends to see central governments as specializing in inputs and services in

which they have a comparative advantage—technical expertise (including supervision and monitoring) and activities with economies of scale (such as financing and capital-intensive facilities). These are usually the more sophisticated, more costly, and "harder" parts of the package. Elinor Ostrom's study of the decentralization of police services in U.S. cities, for example, shows that police headquarters does best at providing evidence labs or vehicle maintenance, while the decentralized local precinct stations do best at managing police patrol and other activities requiring constant contact with the community or "outreach."³⁷

The health program did, indeed, follow this division of labor, with the state providing financing, supervision, and medicines and other supplies. But it was very active in a crucial aspect of the outreach. It created an image around the job and the program and, through this image, gained community support in monitoring the "outreachers." One would not have thought that the management of outreach or something as "soft" as image creation would be such a key function of the central government in a program of decentralized management.

The Self-Enlarging Job

Many of the workers in the municipalities where the health program performed best did things that did not fall strictly within the definition of their jobs. (This finding was repeated in the three other sectors reviewed in the larger research study—agricultural extension, business extension, and drought relief.) These extra tasks fell into three categories: briefly, the carrying out of some simple curative, as opposed to preventive, practices; the initiation of communitywide campaigns to reduce public health hazards; and the assistance to mothers with mundane tasks not directly related to health. In all these areas, the agents took on this larger variety of tasks voluntarily, without being asked by their supervisors, and they liked their jobs better for having done so.

Extra activities of this nature often creep into preventive health programs, as well as other programs in sectors with considerable contact between workers and clients.³⁸ Some health planners would argue that this approach undermines enlightened conceptions of how good health programs should function, just as agricultural planners might argue that such extra activities in agricultural extension merely contribute to the poor performance of extension services. How is it that

such "nonessential" activities could be associated with worker satisfaction and good performance in the eyes of workers and with bad performance in the eyes of experts? The answer may have something to do with recent findings in the literature of industrial performance and workplace transformation: namely, that higher performance and worker satisfaction tend to be *consistent* with enlarged and more varied jobs.

CREeping CURATIVISM. The curative procedures performed by the agents in the Ceará program were quite simple ones: removing stitches, treating wounds, giving shots, providing advice on treating colds and flus, taking a sick child to the hospital. The agents contrasted the immediate results of their curative procedures with the "tedious and frustrating process" of getting people to change their health and hygiene practices: teaching mothers how to take care of themselves during pregnancy and how to take care of the babies after they were born, and convincing people to take their medicines regularly, wash their hands before preparing food, filter their water, and add nutritious foods to their diet. It took considerable patience and perseverance to convince new mothers, who usually preferred bottle feeding, that breast milk was not "sour" and distasteful to their babies or that they should take time out of their day to attend prenatal appointments.

In contrast, the agents viewed their simple curative activities as an "entryway" into preventive care. "I first earned the respect and trust of families by treating wounds or giving a shot," an agent reported, "so that now families listen to me when I talk to them about breast-feeding, or better hygiene or nutrition—things that don't show immediate results." In the same vein, the agents liked administering oral rehydration solutions because they seemed like cures, to the agent as well as the desperate mother: a severely dehydrated baby, seemingly near death, would be happily playing in high spirits only hours after taking the rehydration solution recommended by the health agent. Agents also liked preventive work that, like much of curative care, involved the provision or handling of physical objects, precisely like the mixing together of water, sugar, and salt for oral rehydration.

Finally, with respect to curative tasks, health agents often ended up treating men for minor wounds and other ailments. This went beyond their obligations, given that the program was targeted on pregnant

women and mothers with children under the age of five. The treatment of men for minor wounds won their attention and respect for the program; one man, for example, stopped a health agent on the street to show her, proudly and thankfully, how well his leg, which she had treated after it had been injured in a bicycle accident, was healing. The respect won from the men of the community turned out to be important in helping the agents to gain access to resisting and fearful households, to get their preventive messages taken seriously in the community—to impress upon its inhabitants that the program was not "just for women and children"—and to garner community support for the communitywide actions designed to prevent health problems from developing.

Using curative tasks to get one's foot in the door for the less dramatic, longer haul of changing people's health thinking and practices would seem to represent a quite sensible admixture to a preventive health program, especially if that is what made health agents do better on the preventive side. But curative care can also be "dangerous" because it tends to crowd out preventive care in practice and in funding, even though well-funded programs of this kind cost only a small fraction of a curative care program.³⁹ Moreover, although preventive health programs are meant to complement curative care, the users of health services value curative care more because it shows quick results—as the agents in Ceará themselves said—in contrast to the advice giving that is the bread and butter of preventive care. The "infiltration" of preventive programs by curative care is therefore one of the major concerns of the preventive health field, and with good reason.⁴⁰

Public health reformers throughout the world have criticized the "overemphasis" on curative care as one of the main causes of the neglect of preventive care and its disastrous consequences in the form of disease and death.⁴¹ Critics point to physicians as the culprits. Physicians find curative care more interesting and challenging than preventive care, understandably, and they want to practice medicine with the best diagnostic and treatment facilities they can get, which translates into high-cost, large, urban hospitals. The much less capital-intensive and less high-tech work of preventive care is low status for most physicians and hence of less interest to them, just as road maintenance is less challenging and prestigious to civil engineers than road construction. Because physicians play a prominent role in health planning and in professional pressure groups, the taste for curative care gets translated

into underallocation of resources to preventive care. The Ceará story shows, however, that doctors are not the only villains in the story. Low-tech preventive care workers *themselves* prefer curative care just as much as the doctors do or, at least, some rustic admixture of it with their preventive routines.

Preventive health programs in developing countries are particularly vulnerable to "creeping curativism." Even if they start with only a few curative tasks, the taste for immediate results causes the curative share to get larger and larger through time, squeezing out the preventive work. Clearly, then, one cannot throw caution to the winds and simply allow preventive health agents to do as much curative care as they want, just to keep them and their clients happy. Nevertheless, it is still important to understand the positive impact of curative tasks on the *preventive* agenda in increasing worker and client satisfaction and hence in improving performance.

The creeping curative care in Ceará's preventive program has not gone unnoticed. Nursing professionals in the state's capital have complained that agents should not be dispensing curative care, no matter how minimal, without at least receiving training as nurse assistants. The program's management, in response, has shown some willingness to consider providing formal nurse assistant training to at least some of its health agents. This constructive response raises the specter of another possible problem, which illustrates just how difficult it is for a preventive program to obtain the salutary effects of a "little" curative care without being overtaken by it. The more narrowly defined technical training in curative care now being recommended for Ceará's preventive health program may simply enable the health workers to go too far in the curative direction, which is exactly what preventive health planners worry about.

FROM HOUSEHOLD TO COMMUNITY. Many health agents took on, of their own accord, communitywide activities meant to reduce public health hazards—in addition to their job of visiting households. In one case, for example, agents obtained free air time on the radio in order to name families leaving garbage in front of their homes; in another, agents pressured workers and management in a bakery to wear hair nets and wash their hands; in yet another, agents worked with their supervisor to introduce meetings on family planning and female sexuality, which were not a part of the program. Interestingly, this taking

on of larger causes was in part the result of the program's initial socialization of these workers into public service with images of "doing good" and the dedicated public servant.

Some health managers have worried about the tension that such broader activities often create between the program and local authorities. Or they complain that such activities distract health workers from the more basic tasks of preventive health. But many public health reformers, reflecting a strong current of thinking in the fields of preventive health and medical anthropology, *encourage* preventive health workers to see themselves as "agents of change" and of "empowerment." There is a large literature on this subject, but it does not bear directly on the points being made here.⁴²

Health agents in Ceará also liked their work when they were pulled away from their routine preventive tasks to participate in communitywide campaigns against epidemics of disease, the most recent example being the state's campaign against cholera. Although not always seeing immediate results, the workers who participated in these campaigns felt themselves swept up in a serious and dramatic public mission, in which the topmost officials of the state were intimately involved. This was more exciting than giving mothers the same message over and over again about breast feeding or prenatal care. The same sense of the heroic also explains the sudden bursts of good performance by workers in agricultural extension services during epidemics of crop disease or pest infestation.⁴³

TRUST AND THE MUNDANE. The third area in which health workers went beyond their mandate voluntarily was related to quite mundane activities. Because agents visited homes during the day when mothers were there alone with young children, they sometimes assisted with the cooking, cleaning, or childcare by giving a baby a bath or cutting its fingernails or hair. The mothers, often lonely and overburdened, found considerable solace in this support and in sharing their problems with the agent. "She is a true friend," a mother said of the health agent working in her community. "She's done more for us than she'll ever realize."

This additional attention might seem to increase the burden of an already heavy work agenda, which required several household visits a day, often to places difficult to reach. Agents reported, however, that

the extra help they offered was crucial to gaining the trust of the mothers, as well as the community in general, which they found to be the most difficult task of their work, at least at the beginning.

In addition, and very important to the understanding of these workers' worlds, they saw their clients not only as subjects whose behavior they wanted to change but as people from whom they wanted respect and trust. Indeed, respect from clients and from "my community" dominated their talk about why they liked their jobs—much more than how they felt about their supervisors and other superiors. Although they prized the relationship with a good supervisor, they had much less contact with that person than they did with their clients. In sum, as workers they seemed to need trusting relationships with their clients as much as they needed to see signs of changed health practices. And the "extra tasks" helped to create those relationships. The satisfaction that these workers felt in being trusted by their clients and the community enabled them to convey preventive health messages most effectively to bring change to the communities where they worked.

Although up to now the development literature has concentrated on the reasons for *mistrusting* public sector workers, as noted earlier, the theme of trust between workers and clients or customers is gaining considerable attention in studies of industrial performance. These studies have found a strong relationship between certain high-performing sectors and firms in the industrialized world and the degree of "trust" between the individual worker and customer, or between the subcontractor and supplier firm. With their extra tasks, Ceará's health agents were building this same kind of trust, and that surely explains in part the program's good performance.

Conclusion

—Government workers in Ceará's successful preventive health program felt a strong commitment to their jobs, which endowed them with new status and prestige. This came from a good relationship not only with their supervisors, but also from the communities where they worked. This latter is rather surprising in view of the general public's growing contempt for the government and its civil servants. The new public recognition, in turn, had a significant influence on the workers' performance.

—The state government's widespread advertising of its programs and their achievements—partly informational and, later, partly sheer boasting about its achievements—contributed to the new prestige. Through a remarkable merit-hiring process for 7,300 health agents, a raising of expectations about progress, and an appeal to the collective sense of the program's workers and the community, the state created an aura of dignity and hope around the program and its workers.

—Workers often did things that fell outside their job definitions, things that were not considered to be "best practice." For example, preventive health workers provided a little curative care or helped mothers with household chores. Rather than being viewed as deviations from standard practice, this broader set of tasks cohered together as a more "customized" way of providing service to clients, which in turn further boosted the public's respect for these workers and formed the basis for relations of trust between workers and citizens.

—Certain new mechanisms from outside the health agencies came into play that hemmed public employees in with pressures to be accountable. This offset the greater ambiguity of their job definitions and the greater difficulties of supervision that it might create. Some of these outside pressures were the flip side of the growing public recognition that health agents were experiencing. The state's collective consciousness-raising about the program and the merit-hiring procedure also served to inform the public about what the programs and their workers should or should not be doing and hence drew the public in as informal outside monitors.

—The key to the success of this partial decentralization to local governments was not to be found only in local governments' new powers, funds, or capacities. Rather, the quality of the program was a direct result of the state's iron control over the hiring process for health agents, its constant messages to the constituents of the municipalities about the mayors' responsibilities to support the program and run it cleanly, and its suggestions that citizens vote against mayors who did not do so. What the *central*, rather than local, government was doing, in sum, proved to be the key to the success of this decentralization.

The findings reported in this chapter might at first blush seem to be relevant only to the health sector, particularly to preventive health programs. They might also seem to be a function of the particulars of the Ceará case—namely, the hiring of so many rural women. Clearly,

this kind of work force would be extremely grateful for its "scarce" public sector employment. Also, these workers experienced that special excitement of participating in a bold new public venture. And in places like the interior of Ceará, where infant mortality is so high, it is not that difficult to make rapid improvements on this front—in comparison with many of the other areas in which preventive health programs struggle to preserve the community's well-being. Most public programs do not operate in this kind of "honeymoon" environment. *Not* getting good performance in this kind of situation, in other words, would be unusual.

Loosely similar findings, however, emerged in some of the other sectors studied as part of this research.⁴⁴ In contrast to the health program, these other programs hired no new workers; on the contrary, the study period was one of personnel cutbacks and fiscal privation for them. With certain sectoral variations, these other workers also reported liking their jobs better for reasons similar to those reported above.

In the new theories of public sector behavior, as mentioned earlier, the main hope for improving performance lies in hemming in civil servants with policies and work environments that restrict their opportunities to misbehave or, failing that, in simply reducing their numbers. In boiling down the study of poor public sector performance to the self-interested individual, surrounded by opportunities to subvert the public good, the current theories ascribe too much determinacy to this outcome. The health story and others like it suggest that things do not work this way. Even when civil servants are surrounded by opportunities to act in their own interest and against the public's, they often do not do so. The story of the health program helps illuminate the circumstances under which public servants will or will not act in the public interest and what governments can do to influence those circumstances.

The way in which Ceará hired and advertised its health program enabled it to *shape* the person who was to become a public worker. This exercise in image creation and its positive effect on worker performance suggests that the self-seeking interest of the public employee is not always as powerful or incorrigible as it is assumed to be. That is to say, if the self-seeking "rational" actor is the basic unit of analysis for predicting behavior, then the person who went through the socialization of the health program as described above would behave no

differently, given the same temptations, than if she had gotten the job through family or political connections.

In arguing along lines that differ from the prevailing view, we are also painting a somewhat different picture of the constraints and opportunities for improvement in public sector performance. In our picture, self-interest can be a variable rather than a constant: a government may be able in some cases to broaden the concept of self-interest to include that of a "public calling." That the image of the public servant could have been so effectively reversed in this particular case suggests that the image itself—whether good *or* bad—may play as important a role in determining workers' behavior as their "innate" self-interests.

To make matters even more indeterminate, some in the public sector actually *enjoy* serving the public good, in addition to the self-serving others. At any moment in time, performance will be partly determined by which group holds power. Governments can, in addition, build pressures and incentives into programs, as in the health case, that can even turn some of those leaning toward self-interested behavior into more public-minded beings. The structure of certain programs and their messages, as the new policy advice suggests, can indeed be designed to hem self-interested public workers in with pressures to be accountable. But certain actions by the government can also be transformative—as they certainly must have been in the health story. Although this interpretation suffers from being less elegantly simple and deterministic than the prevailing theories, it also opens up a wider front of choices for program and policy advice.

RETHINKING THE DEVELOPMENT EXPERIENCE

Essays Provoked by
the Work of
Albert O. Hirschman

LLOYD RODWIN
DONALD A. SCHÖN
Editors

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(for example, parsimony, rationality, balance, and equilibria); for his fondness for "paired opposites"—drawn from folk wisdom and literary aperçus—to serve these aims; for the broad humanism that makes him literate in many bodies of theory and suspicious in all of them, his own as well; for the anthropological eye he has cultivated that makes him avidly interested in the way the socioeconomic world works; for his historical and political perspectives coupled with his pragmatic interest in knowledge useful for action; and for the education of those who seek to play a role in helping societies and their sectoral and subnational components go where they roughly want to go.

Lloyd Rodwin
Donald A. Schön

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