Making Services Work for Poor People

The poor need more control over essential services

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POVERTY HAS many dimensions. In addition to low income (living on less than $1 a day), illiteracy, poor health, gender inequality, and environmental degradation are all aspects of being poor. This is reflected in the eight Millennium Development Goals (MDGs), the international community's unprecedented agreement on the goals for reducing poverty (see page 47). But progress in human development is lagging progress in reducing income poverty (Chart 1). While the world as a whole (with the exception of sub-Saharan Africa) is on track for the first goal—reducing by half the proportion of people living on less than $1 a day by 2015—it is not on track for reaching the goals for primary education, gender equality, and child mortality. Furthermore, there are large discrepancies between rich and poor in the same countries with respect to health and educa-

tion outcomes. In Bolivia, under–5 mortality is about 30 per 1,000 live births for the richest fifth of the population and 140 for the poorest fifth. Whereas almost all adolescents from the richest fifth of Peru's population have completed primary school, less than 67 percent of the poorest fifth have.

Economic growth is necessary for reaching the MDGs, but it is not sufficient, especially for the health and education goals. Africa will reach the income-poverty goal if forecast per capita growth on the continent doubles, but it will fall short of the primary education and child mortality goals if it relies on this higher growth rate alone. Accelerating progress toward the MDGs will require a substantial increase in external resources and more effective use of internal and external resources. For the human development goals, more effective use of resources means improvements in the delivery of services—such as water, sanitation, energy, transport, health care, and education—that contribute to health and education outcomes.

Improving services is critical

Too often, these services are failing poor people. First, governments spend very little of their budgets on poor people—that is, on the services poor people need to improve their health and education (Chart 2). Second, even when public spending can be reallocated toward the poor—say, by shifting resources to primary schools and clinics—the money does not always reach frontline service providers. In the early 1990s in Uganda, only 13 percent of nonsalary spending on primary education actually reached the primary schools. This was the average: poorer schools received even less. Third, increasing the share of spending that goes to poor schools—as Uganda has done—is not enough. For education outcomes to improve, teachers must show up at work and perform effectively, as doctors and nurses must do for health outcomes to improve. But these service providers are often mired in a system where the incentives for effective service delivery are weak, corruption is rife, and political patronage is a way of life. A survey of primary health care facilities in Bangladesh found the absenteeism rate for doctors to be 74 percent.

Because central governments have not delivered as expected, societies around the world have tried to find alternatives. The results have been mixed.

• In the aftermath of a civil war, Cambodia introduced contracting for the delivery of primary health care in some dis-

Chart 1

Reaching the Millennium Development Goals

Progress in human development is lagging progress in reducing income poverty.
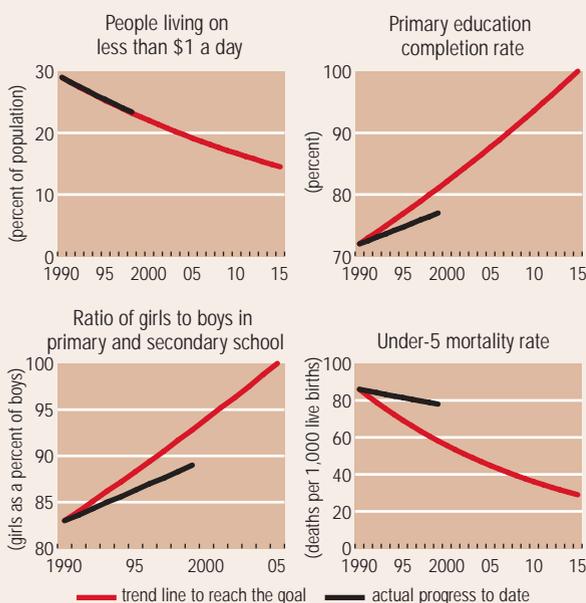
Source: www.developmentgoals.org

Chart 2

Inequitable public spending

Some developing countries spend more on health care and education for the richest fifth than for the poorest fifth of their populations.
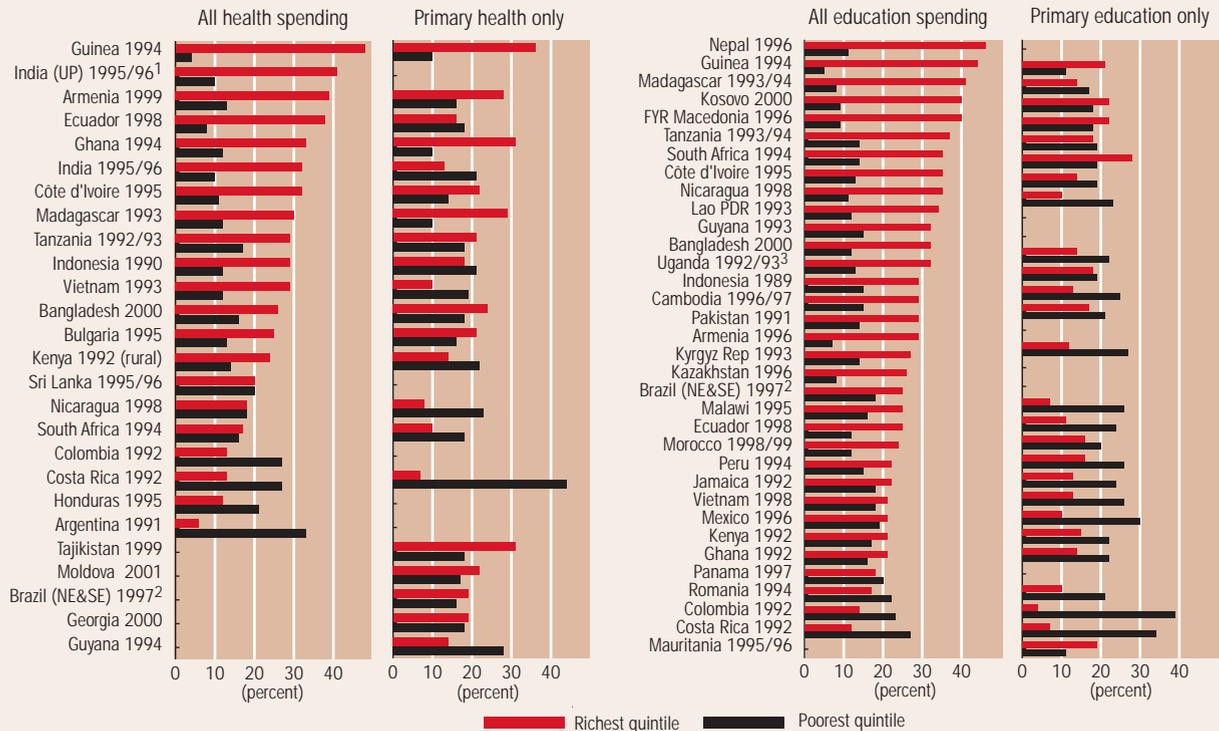
Source: Compiled from various sources by World Bank staff.
Note: Missing bars mean data not available.
[1]Uttar Pradesh.
[2]Northeast and southeast.
[3]Budgeted expenditures, not actual expenditures, which were even more regressive.

tricts, retaining government provision in others. Randomly assigning the arrangements across 12 districts, it found that health indicators, as well as use by the poor, increased most in the districts where services were contracted out.

• Selling water concessions to the private sector in Cartagena, Colombia, improved services and access for the poor. But a similar sale in Tucuman, Argentina, led to riots in the streets and a reversal of the concession.

• Transferring responsibility for infrastructure to local governments in South Africa improved service provision in a short time. But decentralizing social assistance in Romania weakened the ability and incentives of local councils to deliver cash assistance to the poor. Romania's program is being recentralized.

• El Salvador's Educo program gives parents' associations the right to hire and fire teachers. That, plus the associations' monthly school visits, has reduced teacher and student absenteeism and improved student performance.

• Mexico's Progresa program gives cash to families if their children are enrolled in school and they regularly visit a clinic. Numerous evaluations show that the program has increased school enrollment and improved children's health.

Some of these experiments are being adopted elsewhere. Ecuador has introduced a new program along the lines of Progresa; Uganda is starting to contract health services as in Cambodia; and Educo-style school management committees are being developed in Nepal.

Framework of relationships

We can interpret the variety of experiences with traditional and alternative service delivery arrangements by unbundling the service delivery chain into three sets of actors and examining the relationships between them (Chart 3, page 50). Poor people—as patients in clinics, students, travelers on buses, consumers of water—are clients. They have a relationship with frontline providers—doctors, teachers, bus drivers, water companies. Poor people have a similar relationship when they buy something in the market, such as a sandwich. In a competitive-market transaction, they get the service because they can hold the provider accountable. That is, consumers pay the provider directly; they know whether or not they have received the service they paid for; and, if they are dissatisfied, they have power over the provider—they can refuse to do repeat business with him or her.

For services such as health care, education, water, electricity, and sanitation, however, the provider is not directly accountable to the consumer because society has decided that these particular services will be provided by government—that is, through the "long route" of accountability—clients/citizens influence policymakers and policymakers influence providers. When the relationships along this long route break down, service delivery fails, and human development suffers.

Consider the first of the two relationships along the long

Accountability in service provision

The three key relationships are between poor people and providers, poor people and policymakers, and policymakers and providers.

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                    ┌──────────────┐
                    │ Policymakers │
                    └──────────────┘
          ↗                              ↘
┌──────────────┐                    ┌──────────────┐
│ Poor people  │ ────────────────→  │  Providers   │
└──────────────┘                    └──────────────┘
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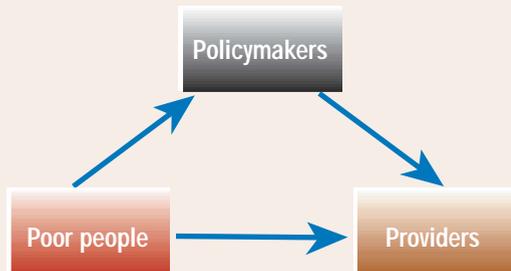
route—the link between poor people and policymakers or politicians. Poor people are citizens who contribute to defining society's collective objectives, in principle. In practice, this does not always work. Free public services and "no-show" jobs are handed out as political patronage, with poor people rarely the beneficiaries. In 1989, Mexico introduced Pronasol, a poverty alleviation program that spent 1.2 percent of GDP annually on water, electricity, nutrition, and school construction in poor communities. Assessments of the six-year program found that it reduced poverty by only about 3 percent. If it had been perfectly targeted, it could have reduced poverty by about 60 percent. The reason for the program's dismal performance becomes apparent after examining the political affiliation of the communities that received Pronasol spending. Municipalities dominated by the Institutional Revolutionary Party, the party in power, received significantly higher per capita transfers than those voting for another party.

Even if poor people can reach policymakers, services will not improve unless policymakers ensure that service providers really deliver. In Cambodia, policymakers were able to specify the services required to the nongovernmental organizations with which they contracted. But policymakers may not be able to specify the nature of many services, much less impose penalties for underperformance. Given the weaknesses in the long route of accountability, service outcomes can be improved by strengthening the short route—by increasing the client's power over providers. School voucher schemes and scholarships such as Bangladesh's Female Secondary School Assistance Program, where schools receive a grant based on the number of girls they enroll, offer clients choices and enable them to exert influence over providers. El Salvador's Educo program is a way for client participation to improve service provision.

Strengthening accountability with aid

Improving service outcomes for poor people requires strengthening the three relationships in the chain—between client and provider, between citizen and policymaker, and between poli-

cymaker and provider. In their zeal to get services to the poor, foreign-aid donors often bypass these relationships.

Donors weaken the relationship between policymakers and providers when they bypass the former to work with the latter. Some aid agencies choose to work with line ministries. Others engage local governments. And others go directly to frontline providers, such as health clinics or schools. As a result, the recipient country's policymakers lose control of the program. Incoherent spending allocations and uneven coverage of services ensue.

Some donors and recipients try to use foreign aid to strengthen the links in the service delivery chain. One approach is to incorporate donor assistance in the recipient's budget, making service providers accountable to the recipient country rather than to the donor. The assistance Uganda receives from Germany, Ireland, the Netherlands, Norway, the United Kingdom, and the World Bank is all part of the country's budget, the outcome of a coordinated participatory process.

What can be done?

Experience with traditional and innovative modes of service delivery shows that there is no single solution. In different sectors and countries, different relationships need strengthening. In education, the biggest payoff may come from strengthening the client-provider link, as Bangladesh's Secondary School Assistance Program is designed to do. But that may not be so in easily monitored services with spillover effects, such as immunization campaigns. Does this mean that there are no general lessons about making services work for poor people? No. But there is no one-size-fits-all solution (see box). The three questions below can provide us with guidance in coming up with solutions that are appropriate to different services and circumstances.

• *Are the country's policies propoor or are they the result of "clientelist" politics?* If politicians are likely to capture the rents from free public services and distribute them to their preferred clients ("clientelist politics"), an arrangement that reduces the rents may leave the poor better off. This might include transparent and publicly known rules for allocation, such as per-student grants to schools or conditional transfers to households, like the transfers made through Mexico's Progresa program. In some cases, a suitable arrangement may include fees to reduce subsidies and, hence, incentives for politicians to redirect services to their clients.

• *Are clients homogeneous or heterogeneous?* Students with disabilities have special needs for education but not for immunization. Heterogeneity is also defined by preferences. Whether a girl goes to school may depend on whether there are separate latrines for boys and girls. The more people differ in their desires, the greater the benefits from decentralizing service provision.

• *Are the services easy or hard to monitor?* The answer depends on the type of service and on the government's institutional capacity to do the monitoring. A doctor has much more discretion in treating a patient than an electrician does

Eight sizes fit all?

Based on our three questions, we need at least eight different solutions flexible enough to be tailored to individual cases.

Central government financing with contracting (1). In a favorable political context, with agreement on what the government should do, an easy-to-monitor service such as immunization could be delivered by the public sector or financed by the public sector and contracted out to the private or nonprofit sector, as Cambodia has done with primary health care.

Central government provision (2). When services are not easy to monitor—say, because explicit contracts are difficult to write or enforce—but the country's policies are propoor and clients are homogeneous, the traditional, centralized public sector is the appropriate delivery system. The French education system, which administers a uniform service centrally, is one of the best examples. But too many societies fall into the trap of thinking that just because a service is difficult to monitor, it must be delivered by the central government. When students are heterogeneous, when the politics of the country are not geared toward poor people, central government control of the education system—with no participation by students, parents, or local communities—can leave the poor worse off.

Local government financing with contracting (3). When clients are heterogeneous and have different preferences, local governments should be involved in providing services. When local politics are propoor (but national politics aren't), local governments could be a more reliable financier of services, and vice versa. Giving clients vouchers enables them to express their heterogeneous preferences. And the competition created may improve service quality.

Local government provision (4). For difficult-to-monitor services, such as education (for quality), management responsibility might be ceded to parent groups, as in El Salvador's Educo program, if the country's politics are propoor.

Client power—experiment with contracts (5). When publicly financed services are subject to capture—the country's politics is not propoor—the best thing to do is to strengthen the client's power. Community user groups could be a source of contracts to the private sector or NGOs.

Client power—experiment with providers (6). This is similar to (5), but explicit contracts are difficult to monitor. Instead, use altruistically motivated providers (such as faith-based NGOs).

Client power—experiment with community participation (7). Similar to (5), but requires discretion by users—through voucher schemes, for instance—although the rules should be transparent to reduce the chances of political capture. The service could be provided through explicit contracts.

Client power—imitate the market (8). Similar to (7), but explicit contracts are not feasible. Evaluating and publicizing efforts in one community may help others.

These service delivery arrangements represent efforts to balance problems with the long route of accountability with the short route. The reason societies chose the long route was that there were market failures or concerns with equity that make the traditional short route—consumers' power over providers—inadequate. But the government failures associated with the long route may be so severe that, in some cases, the market solution may actually leave poor people better off.
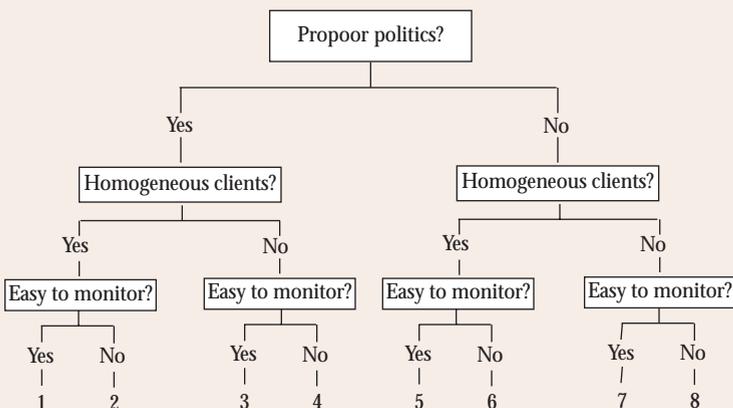
in switching on a power grid. Of course, it depends on who is doing the monitoring. Parents can observe whether teachers are in attendance and what their children are learning more easily than can some central education authority.

Scaling up

How can service reforms go from being innovative experiments to being adopted on a national basis? In addition to tailoring service delivery to service and country circumstances, information can play a critical role—as a stimulus for public action, as a catalyst for change, as an input into making other reforms work. Even in the most resistant societies, the creation and dissemination of information can be accelerated. Surveys of the quality of service delivery conducted by the Public Affairs Center in Bangalore, India, have increased public demand for service reform and been replicated in 24 Indian states.

The systematic evaluation of service delivery can also affect progress toward the Millennium Development Goals. Evaluations based on random assignments give confidence to policymakers and the public that what they are seeing is real. Governments are constantly trying new approaches to service delivery. Some of them work. But unless there is systematic evaluation of these programs, we will not know for sure why some approaches work and others don't. Based on the systematic evaluations of Progresa, the government has scaled up the program to encompass 20 percent of the Mexican people.

Service-delivery reforms will not be easy to implement. The vested interests that block the poor's access to better services will resist reforms, and developing countries have a limited capacity to make radical changes. But the global community has made a commitment to help the world's poor people to reach the Millennium Development Goals. Coupled with additional resources, service reforms can help countries accelerate progress toward these goals. The time to act is now. ■

Shantayanan Devarajan was the Director and Ritva Reinikka the Co-Director of the World Bank's World Development Report 2004: Making Services Work for Poor People *(New York: Oxford University for the World Bank).*