Promoting Growth, Ending Poverty
ASIA2015
www.asia2015conference.org

**Session 3: Realising the Potential for Poverty Reduction**

**Parallel Group 3B: Topic Paper 2**

# Human Development and Service Delivery in Asia

**Nazmul Chaudhury and Shantayanan Devarajan**

# *Human Development and Service Delivery in Asia*[*]

Nazmul Chaudhury and Shantayanan Devarajan[+]

February 2006

[*] Background paper for a conference on "Asia 2015: Promoting Growth, Ending Poverty," London, March 6-7, 2006.
[+] Education Economist and Chief Economist, respectively, South Asia Region, World Bank. We are grateful to Tamar Manuelyan, Julian Schweitzer and Adam Wagstaff for helpful comments on an earlier draft. The views expressed are our own and not necessarily those of the World Bank.

# *I. Introduction*

Asia's rapid economic growth over the past decade masks stark and growing inequities in human development. Home to the world's fastest-growing economies, fueled by surging manufacturing and service exports that require highly productive and skilled people, Asia exhibits some of the worst levels of human deprivation on the planet. No country exemplifies this better than India, which exports computer software, high-tech medical services and pharmaceuticals, and yet has levels of child under-nutrition nearly double those in Sub-Saharan Africa. Other rapidly-growing countries, such as Pakistan and Cambodia, are making very slow progress on child survival, primary enrolment--especially for girls--and other dimensions of basic human development. These countries are unlikely to meet any of the human-development Millennium Development Goals by 2015. In India and China, the unevenness in economic growth is reinforced by even more unequal human development. Four states in India account for half the child deaths in the country, while five are home to 71 percent of India's out-of-school children. Child mortality rates in the western provinces of China are three to five times higher, and falling more slowly, than in the coastal provinces.

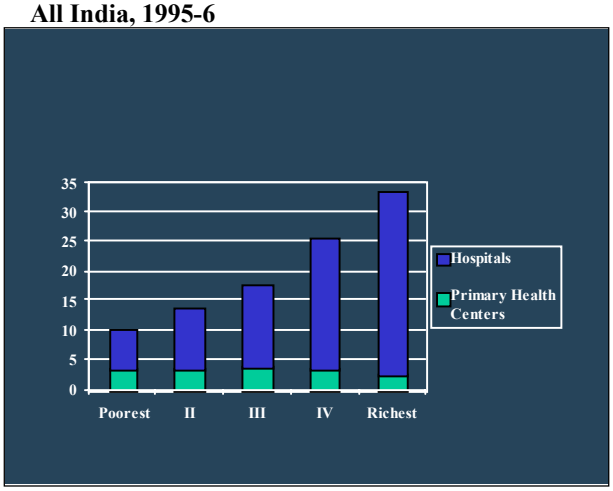
Meanwhile, countries that have made progress in basic human development—Sri Lanka, Bangladesh, Indonesia, Philippines, Thailand—are facing significant second-generation problems of quality and equity. In Sri Lanka, despite universal primary enrolment, two-thirds of the students completing primary school lack basic language and mathematics skills. As populations age and consumption rises, Asian countries are seeing a rapid increase in rich-country health problems--obesity, diabetes, cancers--putting new pressures on public health systems. Asian tertiary education consumes large amounts of public resources and, with some exceptions such as the IITs in India, delivers poor-quality training. Finally, killer diseases such as malaria, HIV/AIDS and avian flu threaten to undermine recent gains in living standards. Unless there is a significant improvement in these health and education outcomes, Asian countries are unlikely to be growing rapidly in 2015.

This paper offers a common framework for addressing Asia's varied human-development challenges by observing that, for the most part, they stem from a systematic failure in the delivery of services--health, education, water, sanitation, and electricity--especially to poor people. We argue in section II that the reason for poor service delivery is a failure of accountability at different points in the service-delivery chain. In section III, we describe various efforts by Asian countries to strengthen accountability in order to improve service delivery and hence human-development outcomes. While there are some encouraging early results, these efforts have also turned up some new challenges in addressing Asia's human-development problems. In section IV, we consider three of those challenges--politics, decentralization, and the role of impact evaluation. Section V concludes.

## *II. Service Delivery and Accountability*

Throughout Asia, the services that are critical for human development--education, health, water, sanitation, electricity--are a public responsibility. Yet, with some exceptions, Asian governments are failing to fulfill that responsibility, especially to poor people (World Bank [2003], [2006]). The lion's share of public spending in health and education goes to the non-poor. In India, over 33 percent of health care subsidies are enjoyed by the richest 20 percent of the population, while less than 10 percent goes to the poorest quintile (Figure 1, Mahal et al. [2002]).

**Figure 1: Distribution of Health Care Subsidies All India, 1995-6**

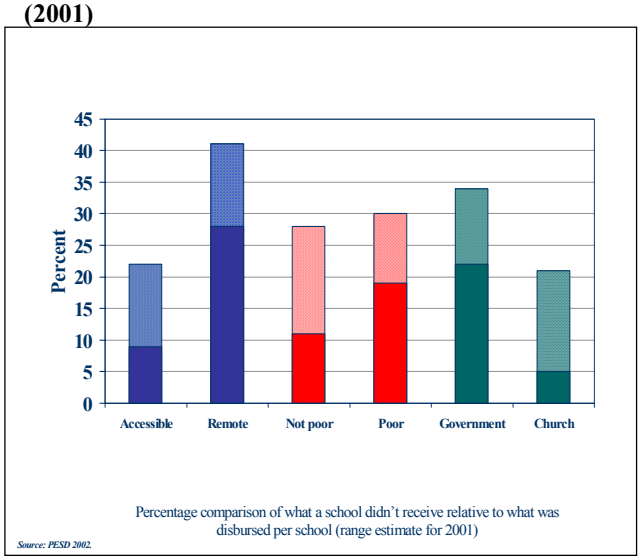



Most of the public health budget is spent on hospitals, which are located in urban areas; spending on primary health care is only a small fraction of the budget. Furthermore, what is allocated to primary health or education often fails to reach the frontline service provider. In Papua New Guinea, about 25 percent of primary education subsidies "leak" before reaching primary schools; in remote areas, the leakage is 40 percent (Figure 2, Filmer [2005]). Even when the money reaches the schools or clinics, the quality of the service is extremely poor. In Bangladesh, the absentee rate of doctors in rural primary health clinics is 74 percent (Chaudhury and Hammer [2005]). In poor neighborhoods of Delhi, qualified public doctors give worse treatment than unqualified private-sector doctors (Das and Hammer [2005]).

Of course, some countries such as Sri Lanka and China, as well as states such as Kerala in India, appear to have met their responsibility, by achieving universal primary and secondary enrolment, as well as low average levels of child mortality, with publicly-financed and –provided services. These countries are now facing second-generation challenges, such as quality (in Sri Lanka) or sharp inequality (China).

As we show below, these problems also stem from service-delivery failures, albeit different ones from those afflicting countries facing "first-generation" problems.

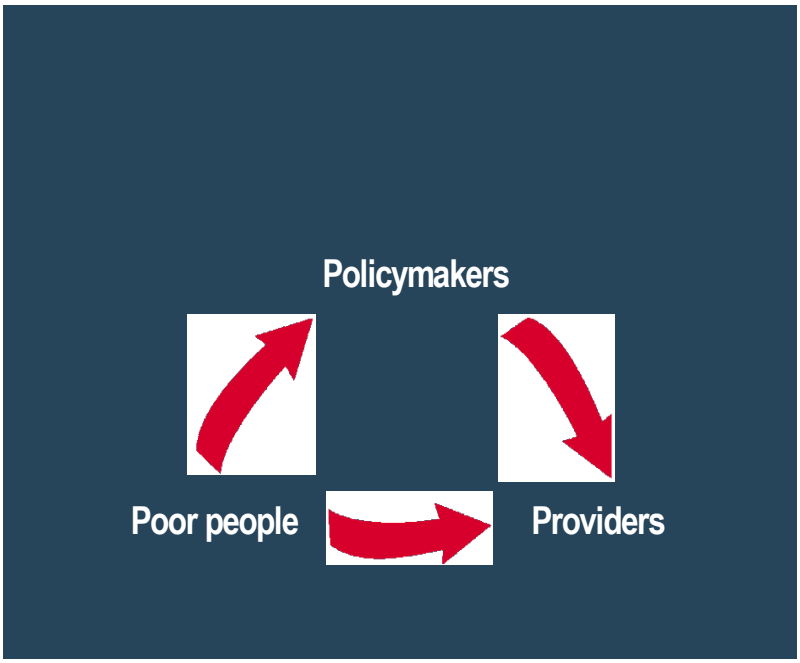
**Figure 2: Variability in leakage of the school subsidy (2001)**




Service-delivery failures arise because of a fundamental problem with accountability. In a private market transaction, the seller or provider is directly accountable to the customer or client. When the service is the responsibility of the government, the accountability between the client and the provider is an indirect one, intermediated by the state. The client as citizen influences policymakers or politicians, usually through the ballot box.

Since the policymaker is not the one providing the service, he or she in turn has to influence the service provider in order for the service to be delivered. As a result, there are at least two places in which this chain of accountability can break down (Figure 3).

**Figure 3: A framework of relationships of accountability**




Consider the first link in the chain, the accountability of politicians to citizens. In principle, this is the democratic system, where citizens hold politicians accountable through elections. In practice, these systems work imperfectly, with poor people often the losers. For instance, the reason why the lion's share of public health spending goes to hospitals, as opposed to primary health care, is that most Asian countries lack a universal health insurance system. Rich and poor people need protection from catastrophic health expenses, whereas only poor people need publicly-provided immunization and other basic services (the rich will always inoculate their children). Free tertiary hospital care acts as a substitute for health insurance[1]. Consequently, the non-poor, being politically more powerful, are able to lobby for more public spending on hospitals, at the expense of primary health spending. The same reasoning applies to education, where governments spend up to 2 percent of GDP on tertiary education, even though most of the beneficiaries are from rich households.

Even if citizens are able to hold politicians accountable for spending on public goods or services that benefit the poor—and several Asian countries have done this—there may be problems with the second link in the accountability chain, namely, between politicians and service providers. The politician or policymaker is often unable to monitor and discipline the provider. The Minister of Health cannot observe whether or not a doctor is present in a rural clinic. And the doctor gets paid whether or not he is present. The result is an absence rate for doctors in Indian public primary health clinics of 40 percent.

[1] Health insurance is hardly a panacea, and universal health insurance will not be introduced for a long time in most of Asia.

The low quality of education in countries like Sri Lanka and Indonesia with universal primary enrolment is another reflection of this accountability failure. The central ministries of education were able to monitor student enrolment. Public financing and provision of primary education seemed to be working. But because the central ministries could not observe what these students were learning (not to mention whether the teacher was present or not), the quality of education suffered.

Similarly, with tertiary education, the fact that it is by and large provided free of charge means that the student has no means of holding the provider (faculty) accountable. The quality of education is determined with little notion of "demand". Worse still, as the students' interest in the education wanes, they become easy targets for political parties to capture.

Many Asian countries have recognized these accountability failures and taken steps to address them. The next section describes how different countries are attempting to strengthen accountability, both along the direct route of clients to providers, and the indirect route of clients to politicians to providers.

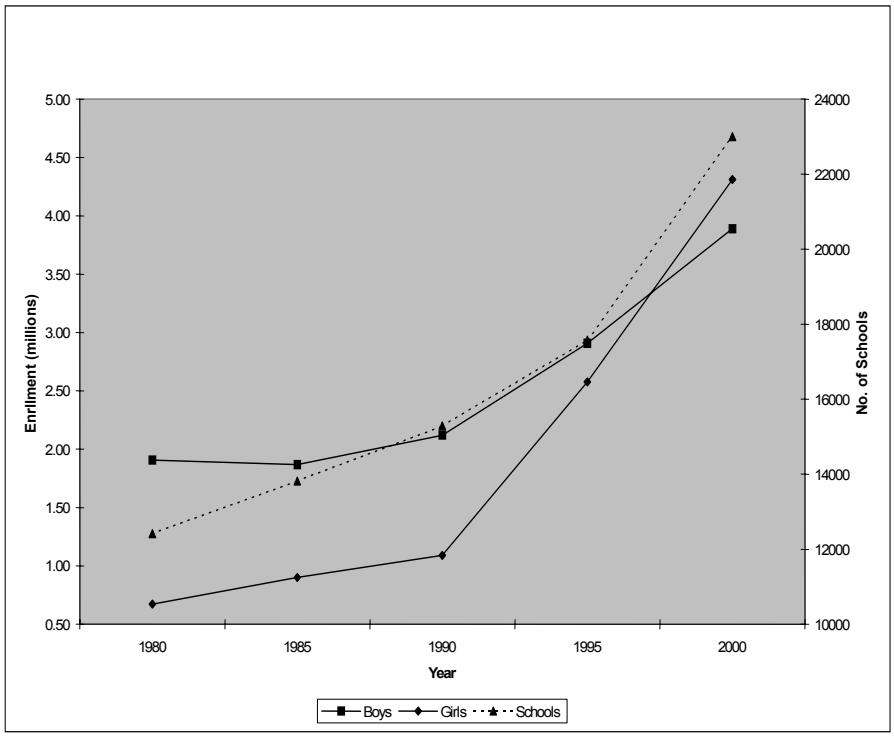
# III. Making services work by strengthening accountability

## *A. Client power: strengthening the direct link between clients and providers*

Even if the central minister of education cannot observe what is going on in the classroom, there is someone else who can: the student, or the parents of the student. Some Asian governments have made use of this simple fact by giving clients the ability to monitor and discipline service providers. One example is the use of vouchers—where clients exercise discipline by voting with their feet—as practiced in female secondary schooling Bangladesh, or midwife services in Indonesia.

The Bangladesh female secondary school stipend program illustrates the benefits and limitations of this approach. The program provides stipends and tuition waivers to close to four million girls from non-municipal areas, conditional upon their maintaining regular attendance, passing grades, and remaining unmarried while in secondary school. As long as the girl maintains eligibility, she can attend any school of her (parent's) choice—public or private, secular or religious. This demand-side intervention is complemented by one on the supply side: the school receives a stipend based on the number of girls it enrolls. The combination of the two means it is effectively a voucher system. Not only has this program resulted in a massive increase in female enrolment—their share of total enrolment went from 33 percent in 1990 to 50 percent in 2004—but it induced one of the most remarkable private supply responses ever documented (Figure 4). Historically all-male madrassa (religious) schools switched to coed schools to attract females. Today, females account for 47 percent of enrollment in madrassa schools--a phenomenon unparalleled in any other Muslim society.

**Figure 4: Enrollment and Schools (1980-2000)**



The female stipend program reflects a more general phenomenon in Bangladesh: publicly-financed but privately-provided secondary education. Over 81 percent of students attend private schools. Public financing is contingent upon the school maintaining basic quality requirements. While the Ministry of Education (MOE) pays teacher salaries in these private schools, none of these teachers is a public sector employee. Teacher contracts are school-specific and renewable contingent upon performance, making it (theoretically) easier for school management and parents to hold these teachers directly accountable.

While MOE has succeeded in expanding the quantity of secondary schooling by emphasizing public financing rather than public provision, it has not been as successful in monitoring or improving quality. Less than 10 percent of students entering sixth grade complete 12$^{th}$ grade. Only 50 percent of students manage to pass the 10$^{th}$ grade exam. Even among those who pass, many leave without having acquired adequate numeracy or literacy skills. In essence, there has been no government monitoring of these private schools--schools have continued to receive public financing despite failing to meet basic quality standards. Besides MOE oversight (rarely do inspectors ever visit these schools), there is supposed to be community supervision as these private schools are managed by School-Management-Committees (SMCs) comprising of influential parents and community members. Unfortunately many SMCs have been captured by local politicians who dole out teaching jobs at these schools based upon nepotism or bribes--and not based on whether the teacher has the qualifications or the desire to teach.

As part of a new budget support arrangement with the World Bank, MOE has made the commitment to strengthen institutional accountability and quality by enforcement of school accreditation standards, greater transparency in teacher recruitment, increasing community involvement in SMCs, and reforming the textbook production and procurement process. For example, the parliament has introduced legislation for creating an independent teacher registration and certification body (National Teacher Registration and Certification Authority) which has already begun to screen all new secondary school teacher applications. Furthermore, an independent third-party will cross-check and scrutinize the selection process of the NTRCA itself. This process is sending a strong signal throughout the secondary school system that policymakers are serious about teacher quality and various sources will be monitoring the hiring process. It remains to be seen whether this reform program does indeed bring about meaningful improvement in school quality. The Bangladesh example highlights the fact that policymakers need to play a vigilant role in monitoring provider quality in both the public and private sectors. Enforcement of minimum standards is critical – particularly in health. In many Asian countries there is a wide spectrum of health care providers in the private sector, many of whom practice without any official certification or supervision. In some situations, policymakers might rightfully want to restrict citizen choice over certain private health care providers.

Another way of strengthening the accountability between clients and providers is to increase community oversight. Indonesia has a long and rich tradition of empowering communities to provide basic services to poor people (World Bank [2006]). Recognizing failures in top-down development projects, in 1997 the government introduced the Kecamatan Development Program which provided block grants to communities for building bridges, roads, wells and supporting small-scale economic activities. Based on community proposals, resource allocation decisions were made by a sub-district forum including village delegations. Initial results showed that the community projects had lower costs, were better maintained and less likely to fail. A subsequent assessment by the Indonesian planning agency, Bappenas, show that these and other community participation programs achieved cost-savings of between 23 and 66 percent (Table 1).

Nevertheless, some of the results have been mixed, mainly because the decision-making processes of these communities lacked transparency, and were sometimes subject to elite capture.

**Table 1: Economic Benefits from Community Managed Basic Infrastructure Programs***

| Project Name | Total Value ($million) | % community contribution | % cheaper than contractor-executed construction |
|---|---|---|---|
| P2D (phase 3) | 200.0 | Not recorded | 23% |
| Water Supply for Low | 106.7 | 23% | 49% |
| Income Communities2 | | | |
| Kecamatan | 310.0 | 21% | 55% |
| Development Project 2 | | | |
| Urban Poverty Project | 100.0 | 35% | 66% |

*Source: Findings of Post-Construction Economic Impact Analysis, Bappenas, Jakarta, 2005. TF-05382IND.

Nepal is currently engaged in the most ambitious effort to date in handing over management of the public school system to the community[2]. Prior to nationalization of schools in 1972, Nepal relied almost exclusively on community-managed, and to a large part, community-financed schools for primary education. In 1972, the government took over the community-managed schools with the expectation that increased government funding and technical support would improve the overall quality of education. While there has been an increase in government funding, there have been no concurrent improvements in quality and efficiency. Rather, there has been a gradual erosion of governance and accountability and both policymakers and the public have realized that the quality of public schools has deteriorated (only teacher unions seem to be oblivious to this fact). In addition, the Maoist insurgency movement has rendered huge swaths of the rural area outside of effective government control, limiting the government's ability to manage schools in a centralized fashion.

[2] Even in a country such as the Netherlands, where primary schools are publicly financed and for the most part privately managed, there are very few schools which are managed by the 'community' itself – rather the management is by Catholic and Protestant Churches who 'serve' their respective communities.

In 2002, the Education Ministry embarked on a pragmatic policy reform to devolve school management responsibilities all the way down to the community. So far, 2,400 schools have completed the process. Community "ownership" empowers the school management committee, consisting of parents and influential local citizens, with various staffing and fiscal decisions. Despite strong resistance from teacher unions, community managed schools have been given the right to fire government teachers who do not adequately perform their duties. No other country has ever given such direct authority to communities. Furthermore the community can directly hire and fire community-recruited teachers, and index teacher salaries to school performance. The community managed schools (CMS) are also given more un-tied block grants so that the management committee has more control over discretionary spending (including additional grants if they are able to attract more female teachers and pupils from disadvantaged groups).

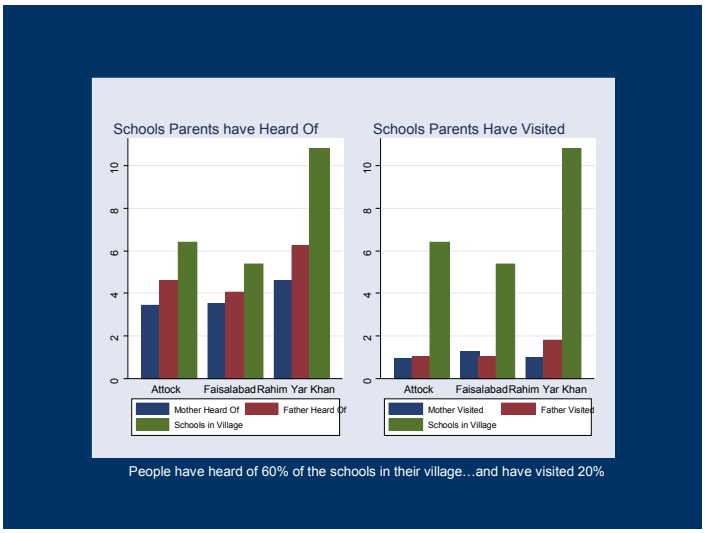
Nepal's school decentralization reform program is predicated on the belief that communities can do a better job than the government in managing schools and in being more responsive to local needs. While there are numerous examples from across the world on the association between greater community or parental involvement and better school performance, the international experience with community management of schools is mixed. Furthermore, in reality there has been very little government oversight of most primary schools in Nepal (particularly in rural and remote areas). This is a move from *de facto* community management to formal community oversight. The impact of the reform program on access, equity, governance, and quality, is currently in the process of being rigorously evaluated by the World Bank and the Government of Nepal. Just because a community is given a right, it does not mean it will be able to traverse the fault lines shaped by class, ethnicity, and assorted path-dependent historical factors to effectively exercise that right. For example, in one state of India, village level education committees have been given the responsibility of certifying teacher attendance--a teacher will not get paid if her attendance is not certified. Most committees sign off without any attempt to verify teacher attendance.

Again, we will have to learn from more rigorous evaluations before we can say something more consistent about community-based management of education and health services. The previous cases were examples of strengthening the direct link between clients and service providers. As we saw, there are limits to this approach. Asymmetric information between the client and provider could result in unscrupulous and weakly-regulated providers inducing demand for their services.

There is evidence from Punjab, Pakistan that parents have heard of only 60 percent of the schools in their village, and have visited less than 20 percent of them (Figure 5, Das et al. [2005]). Accordingly, many governments attempt to improve service delivery by strengthening the links along the long route of accountability, namely between citizens and policymakers, and between policymakers and providers.

### *B. Strengthening the link between policymakers and providers*

**Figure 5: Parental knowledge of schools in the village**




Oblique and often opaque civil-service regulations make it difficult for even altruistic policymakers to hold public-sector providers accountable for service delivery. Local newspapers in South Asia are rife with Kafkaesque stories of providers flaunting the fact that the system cannot hold them accountable. Recently, some teachers in India who had been absent for years working in the Middle East, came back and openly demand back-salary and benefits in the courts.

One possible way of circumventing bureaucratic inertia and government capacity constraints is by contracting-out services to NGOs and private providers. Cambodia has had some success with this approach. The Cambodian health system was devastated during the murderous reign of the Khmer Rouge. Even though the international donor community has since provided considerable financing (accounting for two thirds of public spending on health) to revitalize the government health system, delivery of health services by the public system continues to suffer from severe institutional failures. Most health care providers in the government system fail to show up for work, drawing upon the nominal government salary but instead focusing on private practice. Funds and medicines rarely make it to public rural clinics due to widespread corruption.

Recognizing that these structural problems would be difficult to address within the bureaucratic confines of the public sector, the Health Ministry took a pragmatic decision to hand over health system management to NGOs, primarily international health NGOs. These NGOs not only receive government financing, they actually charge a modest fee for services. They have been remarkably successful in instilling coherence and discipline in a formerly dysfunctional health system. They have introduced incentives (higher and performance-based pay, integrating private practice within service at clinic) to attract formally absentee doctors and nurses back to work.

The NGOs in turn are paid based on their performance in improving services such as immunization, prenatal care, and child births at health centers. Rigorous evaluation by the World Bank and other international researchers has shown that districts managed by the NGOs are much more successful in improving health services (and health outcomes) than districts run by the government. The NGO-run clinics charge lower fees than any other private alternative in those districts. Also the NGOs have managed to signal a strong sense of trust and credibility. Better management and affordable pricing has in turn attracted the rural poor back to these previously dysfunctional clinics.

In Bangladesh, domestic NGOs have taken the lead in providing services in underserved sectors. Bangladesh has some of the largest and most dynamic education and health NGOs in the developing world. Some have evolved to multi-service entities, such as BRAC, which successfully runs specialized schools for formerly out-of-school children, has an extensive system of health clinics, and provides micro-credit to the poor (besides running chicken cooperatives, boutiques, commercial lending operations, etc). While the government has not contracted-out the services of these major NGOs, they have allowed them to operate without too much interference--as long as they refrain from explicit political activity (one NGO, Proshika, was sanctioned by the government for being too closely associated with the opposition party). In fact, the major NGOs have resisted any explicit contractual arrangements with the government. They are to some extent contracted-out by the international donor community (particularly bilateral donors) which provides considerable funding directly to major NGOs. Some of these NGOs might not be able to function at full capacity if there is a significant reduction in donor funding. Also, there is a drive by some donors to shift their assistance to budget support. If donors stop directly funding these NGOs, these NGOs will be forced into contractual arrangements with the government or have to find more profitable ways to raise funds[3].

Besides contracting out to NGOs or the private sector, there are other instruments with which policymakers can hold providers accountable. South Korea used stringent controls over teachers during authoritarian regimes to signal its strong commitment to basic education. Putting aside authoritarian measures, policymakers can experiment with performance-based incentives. An experiment in an Indian state gives cash bonuses to public school teachers based upon better attendance and pupil performance. There is also experimentation with non-pecuniary incentives. One district of Indonesia has rewarded the best-performing English teachers with overseas training and study visits. Given that most of these experiments have either been on a small scale, have not been properly evaluated, or in the process of being evaluated, there is no consistent body of work that can guide performance-based incentive strategies in Asian countries[4].

The fundamental problem is that policymakers are good at building schools and clinics, hiring staff, and financing basic inputs. Rarely do they make the effort to monitor staff effort--whether the teacher is present, how well he teaches, whether he extorts levies from poor children, etc. As long as policymakers do not monitor performance and credibly enforce standards, there is only so much that can be accomplished by marginal incentives.

[3] One major Bangladeshi NGO which has always been independent of donor or government funding is GSK, one of the largest health service providers outside of the public health system. GSK finances its operating costs by successfully running various for-profit ventures such as medical schools and pharmaceutical companies--and by charging user-fees. They charge according to the client's ability to pay, but even the very poor make a token payment.

[4]There is, however, considerable work on performance-based incentives in OECD countries (Cardona [2002]). The applicability of these lessons to Asian countries is still an open question.

### *C. Strengthening the link between citizens and politicians*

Why do politicians prefer to build schools rather than monitor teachers? More generally, why is it that even in democracies where poor people are a majority, services still fail them? The answer lies in the electoral process, the way in which citizens hold politicians accountable. In principle, if the majority of citizens are receiving poor-quality services, they should vote the incumbent politician out. In practice, there are so many imperfections in the electoral process that some politicians who consistently provide poor services continue to get re-elected. Two of the more common imperfections are that voters are not fully-informed, and they may vote along caste or ethnic lines rather than on service-quality lines.

*Information.* Voters may not be fully-informed in the sense that they are not able to attribute poor-quality service delivery to a particular politician's performance. Politicians exploit this fact by taking credit for those things that voters do attribute to them, and neglecting those things that voters do not. So politicians open new school buildings and health clinics to much fanfare, but pay no attention to whether the teacher or doctor is present or whether the clinic has medicines. Worse still, some politicians offer no-show jobs to teachers and doctors in return for canvassing during election time. The net result is low-quality services with the incumbent politician re-elected.

Similarly, if voters vote along particular ethnic or caste lines, and the politician knows this, he has an incentive to provide targeted private goods--such as public-works jobs--to his particular ethnic group, rather than public goods such as primary education or primary health services, which anybody can use. Again, the quality of public services suffers, but the politician gets re-elected.

What can be done in these situations to improve the delivery of services? If the problem is lack of information, then increasing the amount of information available may help. Civic organizations can play an effective role in gathering information on the quality of local services and disseminating it directly to the wider public.

The Public Affairs Centre (PAC) in Bangalore, India, has recently drawn a lot of national and international attention after it did a survey of local services and effectively communicated its finding to politicians and the public. While it remains to be seen whether this has brought about any real improvements in the quality of services, PAC's efforts have definitely invigorated the public debate and focused attention on quality and accountability issues. These subjective measures of client satisfaction, however, have their limitations when comparing qualitative responses across heterogeneous groups. For example, PAC has now moved beyond Bangalore, and is conducting surveys of client satisfaction in states across India. It found that citizens of Kerala (the poster-child of development) rank their education and health services *worse* than citizens in the turbulent state of Bihar (the epitome of bad governance). The reason is that citizens in Kerala
expect a lot from their politicians, police, teachers, and doctors--while citizens in Bihar expect much less from their public servants: dissatisfaction is masked by apathy.

*Decentralization.* A second possible way to strengthen the accountability of politicians to citizens is to decentralize decision-making to lower tiers of government. Not only will local elections better reflect local citizens' preferences, but citizens will have better information and can more readily hold local politicians accountable. This is the reasoning behind the wave of decentralization running through Asia, from Pakistan to India to Indonesia to the Philippines. In practice, decentralization has had a mixed record of strengthening citizen-politician accountability (Ahmad et al. [2005]). Although citizens may have better knowledge of local politicians and their actions, surveys show that they are still misinformed about local and national governments. In India, voters hold state governments responsible for services that are the responsibility of the local government. In the Philippines, voters rely on national newspapers for information about national government, but on local social networks for information about local governments.

If the source of the problem is ethnic cleavages in society, then decentralizing down to more homogeneous groups may improve accountability. However, in India, within-village inequality is higher than overall inequality. Furthermore, there is some evidence from Indonesia that local elites find it easier to mobilize and capture public resources at the local level. Finally, decentralization can lead to underinvestment in local externalities and public goods—where some of the beneficiaries live outside the jurisdiction. In China, local leaders devote resources to goods that benefit local citizens, at the expense of public health programs such as surveillance. Indonesia has seen the reemergence of polio and decline in immunization rates coinciding with the decentralization process.

# IV. Three inter-related issues

The preceding discussion showed that Asian countries are attempting to strengthen all three links in the accountability chain in order to improve service delivery and ultimately human development. In so doing, they are encountering many problems that can be classified into three, interrelated categories.

## *A. Politics*

Not surprisingly, efforts at strengthening the policymaker-provider link, such as contracting-out services or making pay based on performance, are being resisted by the original public-sector providers. In India, teachers' unions have succeeded in opposing various attempts at making teachers accountable to schools or the local community. The fact that these teachers are also active in politics makes their opposition all the more powerful. Medical unions have resisted attempts to make doctors accountable to patients, that is, by having "money follow the patient." One small step in that direction, namely to make doctors in an Indian state employees of the local government, rather than the state government, has been systematically blocked. The close connection between the state health ministry and the medical unions makes this resistance almost impossible to overcome. A syndrome observed first in Latin America may be permeating parts of the Asian continent. Trade liberalization in Latin America greatly weakened the power of manufacturing labor unions (Grindle [2004]). This power has since shifted to public service unions, which mainly produce nontradable goods. As trade barriers in Asia continue to fall, the same phenomenon may be happening there.

Resistance to service-delivery reforms does not only come from public-sector providers and their unions. Since some of the reforms, such as the introduction of vouchers or user fees, resemble market-like mechanisms, they attract criticism and often violent opposition from groups that believe that market mechanisms hurt the poor. The most common example is the reform of water services, where it is often the absence of user fees that leaves the poor without water (since the water pipes go to neighborhoods where political payoffs are greater). Yet attempts at reforming these services are blocked by groups claiming that the poor will be even worse off than before. Recently, a World Bank loan to reform the Delhi Water Board was cancelled because of the political opposition it elicited[5].

[5] The suspicion of market-like mechanisms in the health sector may stem from the problem of asymmetric information between patient and doctor. As a result, efforts to inject market discipline in the health sector have come under intense criticism—from China's recent attempt, to President's Bush's plan for the U.S. Veteran's Administration (Krugman [2006]).

Finally, political forces on the donor side sometimes militate against service-delivery improvements. In some cases, the focus is on the volume of aid, rather than its effectiveness (Sachs [2005]). This may not seem like a bad thing, as many service-delivery institutions are starved of money, and more money may relax a binding constraint. However, as we have seen, accountability-strengthening service-delivery reforms are deeply political. When the donors' focus is on the volume of aid, it is tempting for the government official in the recipient country to put aside the difficult reforms, and concentrate on the money. Sometimes, the availability of the money makes it possible to postpone these difficult reforms. Worse still, when the promised aid fails to materialize, it is very easy for the government to blame the donors, rather than point the finger at the failure to undertake the necessary reforms. In other cases, responding to domestic political pressures, donors focus on single-issue, vertical programs, such as HIV/AIDS, malaria, etc. Although these diseases are serious problems, the insistence on spending in these particular, narrow areas distorts spending, weakening health systems, and leading to a vicious circle: weak systems lead to worse outcomes leading to even more vertical programs, weakening systems further and even worse outcomes.

### *B. Decentralization*

Politics also contributes to difficulties in making decentralization improve service delivery. As mentioned earlier, devolving responsibility to lower levels of government may improve service delivery. Such empirical evidence as we have is mixed. One evaluation from Argentina suggests that learning outcomes of poor children deteriorated after the school system was decentralized, while another evaluation from Nicaragua finds that devolving key management tasks from central to local councils improved student performance.

The bigger problem seems to be that the groups that benefited from the centralized system--typically the higher-level government politicians and bureaucrats--resist decentralization. Government teachers in Nepal find it an insult to be under the control of poor parents in community managed schools, and have vigorously resisted devolution.

Furthermore, since capacity at the local level is typically weak, the state government sometimes resists giving discretion to the local government because it may lead to deterioration in service delivery. But the reason why local capacity is weak is that local governments have never had discretionary resources, and therefore never had an incentive to build capacity in resource management. On the one hand, by denying these local governments discretionary resources--even if it is on the grounds of improving service delivery--the state governments may be perpetuating the situation. On the other hand, if they do give the local governments the resources and service delivery deteriorates, this gives the opponents of decentralization further ammunition to stop it, or even re-centralize certain functions.

The bottom line is that we do not know if decentralization will improve service delivery. On any given day in India, 40 percent of doctors in rural health clinics don't show up for work. Neither does one out of every four teachers. If control over providers were devolved to local governments (*gram panchayats*), could they do any worse? Probably not. We are forced to employ the language of probability because no local government in India has been given credible powers over public providers for us to evaluate the impact. Local governments are constitutionally "responsible" for primary health care centers and primary schools in India. That rhetoric of empowerment has not been matched by the transfer of real administrative and fiscal powers to these local governments. Over 90 percent of recurrent expenditure in education goes towards teacher salaries. But government teacher salaries are not under the control of the local government. Have poor parents in rural Nepal been able to make better educated and higher-caste teachers show up to class more frequently and put more effort into teaching after devolution? We have to wait for the evaluation.

### *C. Impact evaluation*

At various points in this paper, we have observed that we know very little about whether or not a service delivery innovation has improved outcomes. Improvements in service delivery will come about only if there is a focus on outcomes. Whether or not the service is delivered by a private or public provider, within a centralized or decentralized system, financed by a project or budget support--it is imperative that we focus on actual outcomes, such as student learning or nutritional status. The development community as a whole is culpable for decades of lost opportunity to learn from its successes as well as failures. Given the vast amount of resources that go into implementing a myriad of service delivery interventions world-wide, it is striking that so little analytical effort is devoted towards establishing any causal link between these interventions and actual human development outcomes. Since we know so little about which intervention contribute to outcomes, we need rigorous impact evaluations of service delivery arrangements.

Why is there this paucity of impact evaluations? .

First, there is a severe global shortage of people who have the necessary econometric skills to undertake a proper impact evaluation. The modern science of impact evaluation (or at least the "cutting edge") is essentially dominated by academics based in the United States and Britain[6]. The problem is not only that there are so few rigorous evaluations, but there are so many poor-quality evaluations (including many done by the World Bank). Most developing country policymakers do not have the technical capacity to separate the wheat from the chaff. There are exceptions, particularly in Latin America where over the past years policymakers have devoted considerable attention to learning from rigorous impact evaluations. The impetus behind this was internal to the countries, and therefore difficult to replicate in other countries without external assistance.

If the international community is serious about outcomes, then the leading development partners (such as the World Bank and DFID) need to do the following:

- Acknowledge the problem within the organization
- Strengthen internal evaluation capacity by recruiting staff with necessary analytical skills and devoting more funding to buttress the evaluation agenda
- Work out a coherent strategy with client governments on how to conduct the evaluation:
    - In the short-run, international consultants and staff might have to be involved in the technical design and analysis
    - At the same time, clusters of local researchers and firms with appropriate evaluation skills should be identified
    - Local capacity must be strengthened over time through specific training programs and evaluation workshops
- Greater pooling and leveraging of domestic and international financing since knowledge generated from evaluations is a global public good.

Besides these technical constraints, there is a complex political problem. Some policymakers do not want to support a proper evaluation if they anticipate adverse findings. The opposition might capitalize on negative results. If the project is not renewed, they would lose their rents, including the ability to dole out patronage jobs. Nor is there a culture within leading development organizations of rewarding negative evaluation findings. As long as there are strong external or internal incentives to maintain the status-quo, there will be a tendency to under-report negative findings (or even manipulate the analysis). Ultimately evaluations need to be marketed not as a stand-alone product (e.g., the intervention did not improve teaching quality), but as a dynamic feedback learning process to facilitate recalibration and redesign of interventions to better achieve outcomes.

[6] See for instance the work on Mexico's *Progresa* program done by Paul Schultz, Jere Behrman, Emmanuel Skoufias and others, and the work of Michael Kremer and his colleagues at MIT's Poverty Action Lab. In Britain, the work on the National Health System and education by Carol Propper and others, as well as the work of the Institute of Fiscal Studies are becoming classics in the literature.

## *V. Concluding remarks*

The varied human-development challenges facing Asia--from getting girls into primary schools in Pakistan to preventing non-communicable diseases in Sri Lanka or Indonesia--have a common root. The services required for human development are failing, and especially failing poor people. Because there are numerous market failures, these services cannot, or should not, be provided by a competitive market mechanism. So Asian societies have made them a public responsibility. But these services are now subject to "government failures"--failures in the accountability of politicians to citizens, and providers to politicians. While some governments have attempted to tackle these government failures by strengthening accountability along various dimensions, the results, while encouraging, are not always clear-cut. Moreover, efforts at strengthening accountability have faced resistance, which is not surprising because the original failure was not an accident. Going forward, Asian governments and their development partners will need to find creative ways of addressing the political resistance to service-delivery reforms, strengthen decentralization so that we can find out if this system accelerates human development, and build a culture of impact evaluation, so that everybody remains focused on outcomes.

## References

Ahmad, Junaid et al. 2006. "Decentralization and Service Delivery," in Ahmad, E. and G. Brosio, eds., *Handbook of Fiscal Federalism,* Edward Elgar Press.

Cardona, Francisco, 2002. "Performance-Related Pay in the Public Service," OECD, Paris.

Chaudhury, N. and J. Hammer, "Ghost Doctors," *World Bank Economic Review*, 2004.

Chaudhury, N., J. Hammer, M. Kremer, K. Muralidaran and H. Rogers, "Missing in Action: Teacher and Health Worker Absence in Developing Countries," NBER working paper, 2005.

Das, Jishnu and Jeffrey S. Hammer, 2005. "Money for Nothing: The Dire Straits of Medical Practice in Delhi, India, Policy Research Working Paper No. 3669, World Bank, Washington, D.C.

Filmer, Deon, 2005. "Public Expenditure and Service Delivery in Papua New Guinea," World Bank, Washington, D.C.

Grindle, Merilee, 2004. *Despite the Odds: The Contentious Politics of Education Reform*, Princeton: Princeton University Press.

Krugman, Paul, 2006. "Health Care Confidential," *New York Times,* January 27, 2006.

Mahal, A. et al., 2002. *Who Benefits from Public Sector Health Spending in India,* New Delhi: National Council for Applied Economic Research.

Sachs, Jeffrey 2005. *The End of Poverty*. Penguin Press.

World Bank, 2003. *Making Services Work for Poor People,* World Development Report 2004, Washington, D.C., World Bank.

World Bank, 2006. *Making Services Work for the Poor in Indonesia*, World Bank.