

Governments should make services work

chapter 2

The responsibility that governments take on for basic health and education can be discharged in many ways—among them, fostering economic growth, increasing public spending, and applying technical interventions. Each can contribute to better outcomes. But if they are not supporting services that work—services that result from effective institutional arrangements—they will not make a large sustainable difference. Making services work requires changing the institutional relationships among key actors. Subsequent chapters of this Report develop and apply a framework to understand how and why those relationships play out for different services.

Economic growth, though a major determinant of human development outcomes, would need to be substantially faster than it has been in most countries to make dramatic improvements through that channel alone. Public spending makes improvements possible, but the improvements will fall short if spending fails to reach poor people—either because it goes for things the poor do not use or because it is diverted along the way—or if services are not made more productive. Applying technical interventions—combining inputs to produce outputs and outcomes more effectively—is also important. But simply adjusting inputs without reforming the institutions that produce inefficiencies will not lead to sustainable improvements.

A public responsibility

Governments—and the societies they represent—often see improving outcomes in health and education as a public responsibility. They are supported in this by the international endorsement of the Millennium Development Goals (see Overview). A variety of reasons lie behind this responsibility: clas-

sic welfare economics arguments for government intervention, political economy reasons for intervention in key social sectors, appeals to fundamental human rights. Governments demonstrate their responsibility by financing, providing, or regulating the services that contribute to health and education outcomes. The services come in many shapes and sizes: building and staffing schools, subsidizing hospitals, regulating water and electrical utility companies, building roads, providing cash transfers to individuals and households. Making these services work means that governments are meeting their responsibility.

Public spending

This responsibility is often reflected in government spending. Health and education alone account for about a third of aggregate government spending, with the average slightly lower in poorer countries and regions (table 2.1). But there are wide variations across countries, even within the same region. Health and education spending accounted for 13 percent of public spending in Sierra Leone in 1998 but 34 percent in Kenya—18 percent in Estonia in 1997 but 59 percent in Moldova in 1996. Social security and welfare spending, much of it directed to improving health and education, typically makes up another 10–20 percent of aggregate spending.¹⁰⁸

Governments contribute a large share of the financing for schools and clinics. Wages and salaries on average account for 75 percent of recurrent public spending on education—and often for almost all the spending (96 percent in Kenya).¹⁰⁹ Most teachers and many health workers are civil service employees. Salaries aside, government subsidies can make up a large share of a facility's budget.

Public provision

In education, health, water, and electricity the public sector is a major provider (if not a monopoly) as well as a funder of services. The Indonesian government operates more than 150,000 primary schools and 10,000 junior secondary schools that cover 85 percent and 60 percent of the respective enrollments.¹¹⁰ The Ugandan government operated 1,400 primary level facilities and close to 100 hospitals in 1996.¹¹¹ The Indian public sector runs almost 200,000 primary health facilities and 15,000 secondary and tertiary facilities.¹¹² But wide public provision does not always translate into substantial use. In Uganda government health facilities handled just 40 percent of treatments sought in facilities.¹¹³ In India, even with the huge organization of public health facilities, the private sector accounts for 80 percent of outpatient treatments and almost 60 percent of inpatient treatments.¹¹⁴

Reasons for public responsibility

Economics gives two rationales for public responsibility. First, because of market failures, the amount of services produced and consumed would be less than optimal from society's standpoint without government intervention. Market failures can be externalities. The fact that an immunized child reduces the spread of disease in society is an incentive to immunize more children. Basic education might benefit others besides the graduate, another externality. Individuals have little incentive to build and maintain the roads that are crucial to promoting access to services, but communities and societies do. "Public goods" (goods that, once produced, cannot be denied to anyone else and whose consumption by one person does not diminish consumption by others) are an extreme form of market failure. Mosquito control in a malaria-endemic area is an example. There is no market incentive to produce public goods, so government intervention is required.

Other market failures relate to imperfect information. Different information about individuals' risk of illness can lead to a breakdown in the market for health insurance. Lack of knowledge about the benefits of hand washing or of education can lead to less than desirable investment and consumption.¹¹⁵

Table 2.1 Public expenditures on health and education: large but varied

Education and health spending as a share of government expenditures and as a share of GDP, in 2000 or latest year available (percent)

	Share of public expenditures			Share of GDP		
	Average	Minimum	Maximum	Average	Minimum	Maximum
East Asia and Pacific	27	12	53	6	2	11
Europe and Central Asia	31	18	59	10	4	17
Latin America and Caribbean	33	14	52	8	4	13
Middle East and North Africa	23	13	39	7	4	12
South Asia	21	16	25	5	4	8
Sub-Saharan Africa	25	13	34	7	2	12
Low-income countries	25	12	59	6	2	17
Middle-income countries	29	13	53	8	4	14
High-income countries	33	20	56	11	3	15

Note: Of the 135 countries included, 52 have data for 2000, 8 for 2001, 30 for 1999, 17 for 1998. The remaining 28 have data from earlier in the 1990s.

Source: World Development Indicators database.

These market failures call for government intervention, but they do not necessarily call for public provision: it could well be that the proper role is financing, regulation, or information dissemination.

The second economics justification for public responsibility is equity. Improving health and education outcomes for poor people, or reducing the gaps in outcomes between poor people and those who are better off, is often considered a responsibility of government. There are a variety of social justice reasons behind this. Some see this responsibility as rooted in the belief that basic education and basic health are fundamental human rights (box 2.1). The United Nations Universal Declaration of Human Rights asserts an individual's right to "a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care" and a right to education that is compulsory and "free, at least in the elementary and fundamental stages."¹¹⁶ Subsequent international accords have expanded the set of health and education rights.¹¹⁷ Many national constitutions have guarantees for health and education.

BOX 2.1 *Most governments take responsibility for health and education—often appealing to human rights*

Debates on health care and education in developing countries often appeal to human rights. Rooted in the broader context of social justice, these rights are set forth in the Universal Declaration of Human Rights (1948) as well as other international conventions, such as the International Covenant on Economic and Social Rights (1966). Several international and bilateral agencies have endorsed a human rights orientation. In addition, the constitutions and laws of many countries include references to rights to education and health care (a review of constitutional rights in 165 countries with written constitutions found that 116 referenced a right to education and 73 a right to health care; 95 stipulated free education and 29 free health care for at least some services to some groups). With education and health central to rights, the

practical implications of approaches based on rights complement welfare economics.

An approach based on rights emphasizes equality in dignity and equality of opportunity. It highlights the need to look at outcomes for all individuals and groups, especially the legally and socially disadvantaged. It makes explicit a consideration that economics incorporates with difficulty: many psychological repercussions to poverty result in poor people's inability to avail themselves of health care and education services, even when such services are available.

Welfare economics provides tools for assessing priorities and possibilities for intervening when budgets are limited—and offers a metric for doing so. Several aspects of economic analysis provide instruments for implementing rights, complementing a rights-based approach.

More generally, the approaches overlap on many of their practical policy consequences. Both are skeptical that electoral politics and the market provide enough accountability for effective and equitable provision of health and education services—so there is a need for government and community involvement. An economics approach to making services work—such as the one in this Report—is informed by the guidance on participation and empowerment that international human rights instruments provide. In addition, rights reinforce poor people's claims on resources overall and on those allocated for basic services in particular—key elements of the effective “voice” of poor people discussed here.

Source: Gauri (2003).

The notion of health and education as basic human rights provides a strong basis for public responsibility, but ambiguities remain. Does a right to medical care imply that government must provide it or even finance it? The human rights to “periodic holidays with pay” or “equal work for equal pay,” as mentioned in the United Nations declaration, are generally not interpreted to imply government subsidies.¹¹⁸ Although free elementary education is asserted as a right, parents also have a right “to choose the kind of education that shall be given to their children”—suggesting that universal public provision is not required.¹¹⁹ Social equity and fundamental human rights suggest a responsibility for government but leave open the ways of discharging that responsibility. Importantly, enshrining these notions as rights legitimizes the demands of citizens—especially poor citizens—that government take responsibility for making services work.

Market failures and social justice are normative justifications for public responsibility—they describe why governments should be involved. They do not always give much guidance on how. Why governments actually get involved provides insight on how public responsibility is discharged. Education has long been a battleground for beliefs, ideas, and values. The late 19th and early 20th centuries offer many stories of this battle, from the movement for secular primary education in France to a

public education system focused on nationalism after the Meiji restoration in Japan.¹²⁰

Much of this involvement is high-minded: a coherent public education system probably contributes to social cohesion, particularly important in fractionalized societies.¹²¹ Post-colonial states embraced public provision of education as a strategy for nation building. But public provision can also be the rational manifestation of a state's desire to inculcate a particular set of beliefs. Tanzania's 1967 education reforms were wrapped up with *Ujama* and African Socialism. Indonesia's mass education campaign was closely tied to nation-building and national ideology codified in *pancasila*—principles whose teaching was enforced in every school until the fall of the New Order government.

Beyond nation building and social cohesion, services operate fully in the political realm: free education and free health care are electoral rallying cries in many countries, popular with many voters. In 1997 Uganda's President Museveni campaigned on a platform of free universal primary education. The message was extremely popular—he won—and within a short time official enrollments nearly doubled (see spotlight).¹²² Uganda is not unique: many politicians identify themselves with their stance toward public provision of services. But success is hard: few politicians have been able to transform these political platforms into outcomes. Ser-

vices operate in the political realm in yet another way. Many politicians use jobs in the large bureaucracies associated with services to reward supporters or to build power.

Growth, though essential, is not enough

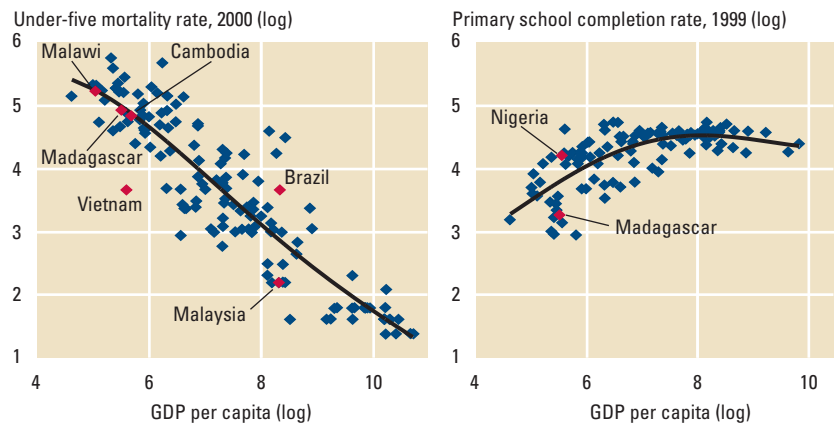
Given the responsibility to promote education and health outcomes, what can governments do? One approach is hands-off: rely solely on economic growth since higher national income is strongly associated with lower child mortality and higher primary school completion (crate 1.1 and figure 2.1). Among low-income countries, 10 percent more income per capita is associated, on average, with a 6.6 percent lower child mortality rate and a 4.8 percent higher primary school completion rate. Among middle-income countries 10 percent more income per capita is associated with 7.7 percent less mortality but little improvement in primary completion.

At low levels of income relatively small differences in per capita income can mean big differences in outcomes. Per capita income was only about \$90 higher in Madagascar than in Malawi in the 1990s, but there were almost 50 fewer child deaths per 1,000 births in Madagascar in 2000.¹²³ The association between income and health and education outcomes works both ways: more income leads to lower mortality and more children completing primary school; better health and education can lead to higher productivity and incomes. Studies have tried to disentangle these relationships, and they typically still find income to be a robust and strong determinant of outcomes.¹²⁴

But income is not the whole story: at any given income there are wide variations in achievement. With average incomes of just under \$300 per capita in the 1990s, Vietnam had a child mortality rate of about 40 per 1,000 in 2000 and Cambodia of 120. At per capita incomes around \$4,000 in the 1990s, Malaysia had a child mortality rate of about 12 per 1,000 in 2000 and Brazil of just less than 40. Similarly, Madagascar and Nigeria both had per capita incomes close to \$300 in the 1990s, but by the end of the decade the primary completion rate was 26 percent in Madagascar and 67 percent in Nigeria.¹²⁵

How much reduction in child mortality and improvement in primary school comple-

Figure 2.1 National income and outcomes are strongly associated, especially in low-income countries



Note: The GDP per capita is based on a 1990s average, 1995 U.S. dollars. Lines show outcomes as predicted by a non-linear function of GDP per capita.

Source: GDP per capita data from World Development Indicators database; under-five mortality from UNICEF (2002); primary completion rates from Bruns, Mingat, and Rakatomalala (2003).

tion can be expected from income growth alone? Cutting child mortality by two-thirds between 1990 and 2015 (one of the Millennium Development Goals) means reducing it by 4.4 percent a year. Low-income countries would need sustained per capita income growth of 6.7 percent a year to reduce mortality by two-thirds by 2015. Senegal would have to boost per capita income from about \$650 to \$3,500—close to the level in Panama. Brazil would need an increase from almost \$5,000 to \$20,000—close to the per capita income in New Zealand.¹²⁶

Similarly, achieving universal primary school completion through income alone would require massive economic growth. In Mauritania, where primary school completion was 46 percent in 1990, per capita income growth would need to average 6.5 percent a year. So while income and outcomes are strongly associated, especially in low-income countries, reaching the Millennium Development Goals will require dramatically high—perhaps unrealistically high—growth rates if growth is the only channel for achieving the goals. Policies that do more than increase growth are required.¹²⁷

More public spending alone is not enough

If growth is not enough, what else can governments do to improve outcomes? One approach is to spend more. Increasing public

BOX 2.2 *The Fast-Track Initiative—providing assistance for credible national education strategies*

With more than 100 million children not in primary school, the “Fast-Track Initiative” (FTI) was launched in June 2002 to accelerate progress toward Education for All in low-income countries. Under the FTI national education plans are assessed against an indicative framework of policy benchmarks, prospects for scaling up, and allowances for flexibility and learning by doing. To ensure that education goals are embedded in an overall national strategy and consistent with countries’ medium-term expenditure framework, a criterion for FTI eligibility is a national commitment to a formal Poverty Reduction Strategy.

The FTI supports countries in addressing key policy, capacity, data, and financing constraints to universal primary completion by 2015, net intake into first grade of 100 percent of girls and boys by 2010, and improved learning outcomes. An initial group of 23 countries was invited to join the initiative, and all accepted.

The FTI was inspired by the Monterrey Consensus—that better results accrue when development support is targeted to countries that accept clear accountability for results and adopt appropriate policy reforms. The FTI was conceived as a process for countries with sound education policies, embedded in an agreed-on macroeconomic framework, to receive added support from donors.

Clear impacts—and obstacles

Less than a year into the process the FTI has had some clear positive impacts. First, it has demonstrated that the new framework of mutual accountability is accepted by developing coun-

tries. With impressive speed countries have ensured that their sector plans meet the new tests for credibility and sustainability. And the donors have increased resources for FTI countries, seconded staff to an international secretariat for the initiative (in the World Bank), and agreed on FTI operating principles and guidelines.

More generally, the FTI has:

- Raised the political profile of Education for All, and increased awareness of the need for faster progress to reach education goals.
- Sharpened developing countries’ focus on primary school completion and quality (not just coverage) and on the importance of getting policies right.
- Brought field-based donors into a unified policy dialogue with governments, improving coordination.
- Mobilized more resources for primary education (a 60 percent increase in official development assistance commitments to the first FTI countries).

But the experience with FTI has also highlighted some obstacles. At the country level these include difficulties in ensuring that resources reach the service delivery level; a need to consider a variety of service delivery modes—including community-run schools, NGO-run schools, and faith-based schools—and the complexities of public support to this range of providers; the need to make difficult reforms to increase efficiency and ensure sustainability; and the need for better data systems to support “real-time” tracking of education results.

Some problems for donors

Despite some progress donor procedures are not yet harmonized, and much financing remains fragmented. Some donor assistance under the FTI continues to be input-driven, subject to a “donor discount,” with resources earmarked for contractors in donor countries rather than providing flexible support for core expenditures.

Too much aid still flows to historically preferred countries, rather than good performers. Although the donors have mobilized additional funding for FTI countries case by case, there remain some “donor orphans.” Without pooled funding to support these countries, the FTI will not be able to deliver on the donors’ commitment that “no country with a credible plan for Education for All will be thwarted for lack of external support.” The momentum of FTI could easily be lost if a fundamental principle of the compact—assistance supporting effective policies—is not honored.

The FTI is a major part of international responses—including the G8 process, the Monterrey Consensus, and the New Economic Partnership for African Development—to provide momentum for universal primary completion by 2015, perhaps the most achievable of the Millennium Development Goals. Success will require that developing countries pay attention to policy reform and human and financial resources. It will also require that donors coordinate better and honor their side of the bargain by assisting performing countries.

Source: FTI secretariat.

spending can be a critical part of promoting improvements in health and education. For example, it may be necessary to spend more on interventions to reduce mortality or on education reforms that underpin increases in primary completion rates—and part of this spending might require international assistance (box 2.2). But the large variation in the effectiveness of using funds makes it hard to find a consistent relationship between changes in spending and outcomes—highlighting the importance of spending money well.

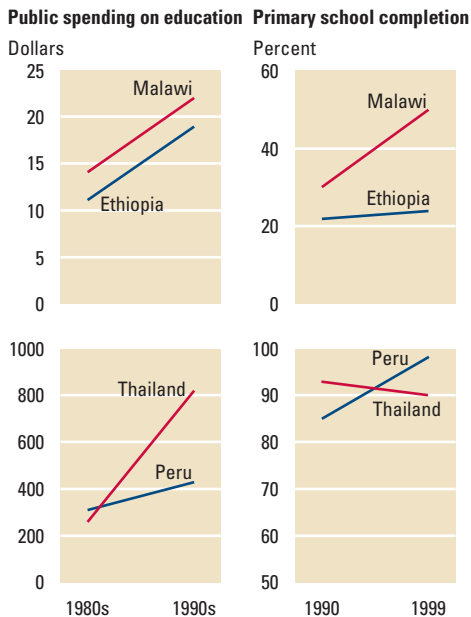
Just how variable is the association between public spending and outcomes? A glimpse at a handful of countries provides an indication.

- Between the 1980s and 1990s total public spending on education in Ethiopia and

Malawi increased by \$8 per child of primary school age.¹²⁸ In Ethiopia primary school completion stagnated, going from 22 percent in 1990 to 24 percent in 1999, while in Malawi it rose from 30 percent to 50 percent (figure 2.2).

- Per capita public spending on health fell between \$1 and \$5 in Côte d’Ivoire and Haiti from the 1980s to the 1990s: child mortality worsened substantially in Côte d’Ivoire but improved in Haiti—though remaining high (figure 2.3).
- Thailand increased public spending on primary schooling more than Peru did, yet primary school completions fell in Thailand and increased in Peru.
- Public spending on health diverged in Mexico and Jordan, yet reductions in child mortality were similar.

Figure 2.2 Changes in public spending and outcomes are only weakly related: schooling



Note: "Spending" refers to total annual public spending on education per child of primary school age, in 1995 U.S. dollars averaged for the 1980s and the 1990s. Primary school completion rates are calculated on the basis of 6 years in Ethiopia (primary plus two years lower secondary), 8 years in Malawi, 6 years in Thailand, and 6 years in Peru.

Source: Spending data from World Development Indicators database; primary school completion data from Bruns, Mingat, and Rakatomalala (2003).

For each country there is a story about why public spending contributed to improving outcomes or why it did not. That is the crux: the effectiveness of public spending varies tremendously.¹²⁹ In-depth studies confirm this variability—for example, an analysis of Malaysia over the late 1980s found little association between public spending on doctors and infant or maternal mortality.¹³⁰ A major improvement in the incidence of public education spending on poor people in South Africa has been slow to translate into better outcomes.¹³¹ But an impact evaluation of the expansion of public school places in Indonesia in the 1970s found a significant positive impact on school enrollments.¹³²

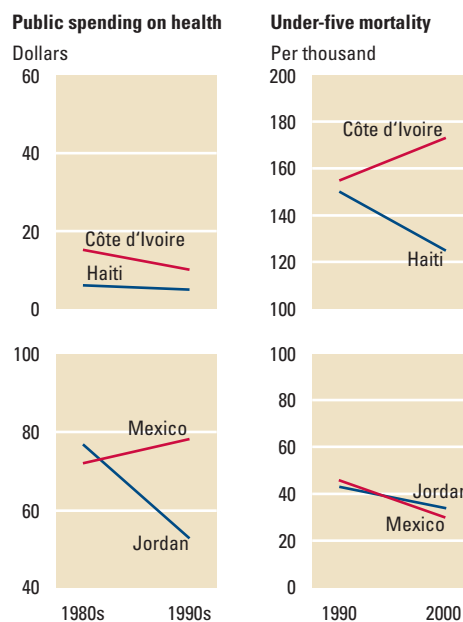
Another way to look at the impact of public spending is in a cross-section of countries. In general, countries that spend more public resources on health have lower child mortality, and countries that spend more on education have higher completion rates. But this association is driven largely by the fact that public spending increases with national income. After controlling for national

income, public spending and outcomes are only weakly associated (figure 2.4)—both substantively (in the sense that the correlation is small) and statistically (in the sense that the correlation is indistinguishable from zero).¹³³ With similar changes in spending associated with different changes in outcomes, it should come as no surprise that the cross-country association is so weak.

Why does public spending have different impacts?

Deeper analysis of the relation between public spending and child mortality finds results varying from statistical significance to insignificance—for four main reasons. First, some countries might spend more because they need to spend more to remedy urgent underlying health problems. The resulting cross-sectional association would be uninformative since more spending would appear to be associated with worse outcomes. Using statistical techniques that exploit the variation in spending that depends on factors unrelated to mortality

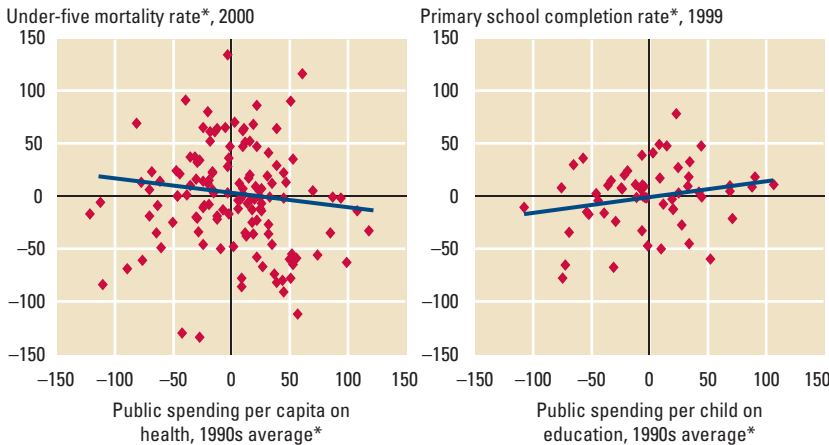
Figure 2.3 Changes in public spending and outcomes are only weakly related: child mortality



Note: "Spending" refers to total annual per capita public spending on health in 1995 dollars averaged for the 1980s and the 1990s.

Source: Spending data for 1990s from World Development Indicators database. For Jordan and Côte d'Ivoire, spending data for the 1980s are from World Bank sources. For Haiti and Mexico, spending data for the 1980s are from Govindaraj, Murray, and Gnanaraj (1995). Child mortality data are from UNICEF (2002).

Figure 2.4 The association between outcomes and public spending is weak, when controlling for national income



* Public spending, child mortality rate, and primary school completion are given as the percent deviation from rate predicted by GDP per capita.

Note: For the under-five mortality regression, the coefficient is -0.148 and the t-statistic is 1.45 . For the primary completion regression, the coefficient is 0.157 and the t-statistic is 1.70 .

Source: GDP per capita and public spending data, World Development Indicators database; under-five mortality, UNICEF; primary completion rate, Bruns, Mingat, and Rakatomalala (2003).

outcomes still produces an insignificant relationship.¹³⁴ Those techniques are not universally accepted, however, and it is possible that governments are adjusting what they spend in response to underlying health conditions.

Second, spending may affect different groups in society differently. Public spending could affect child mortality among poor families without having a large overall impact. Studies allowing for this effect have found a stronger association between spending and outcomes for poor people—but the result is only weakly significant and not robust.¹³⁵

A third strand of the research on this issue focuses on the composition of spending: does more spending on primary rather than tertiary health activities have a different impact on mortality? The cross-national statistical evidence is weak.¹³⁶ A fourth strand investigates factors that might modulate the effectiveness of public spending. It finds that corruption, governance, or urbanization might play a role, but the results are inconsistent from one analysis to another.¹³⁷

Two methodological issues are important for interpreting these analyses. First, the sample of countries in a study affects the results. A sample of a few countries that have spent a lot and achieved a lot—and a few countries that have spent little and achieved little—will yield a significant association between more spending and lower mortality. A different

sample might yield no association. The number of countries in studies that have addressed this question varies dramatically—from 22 to 116—so different results should not be surprising.¹³⁸

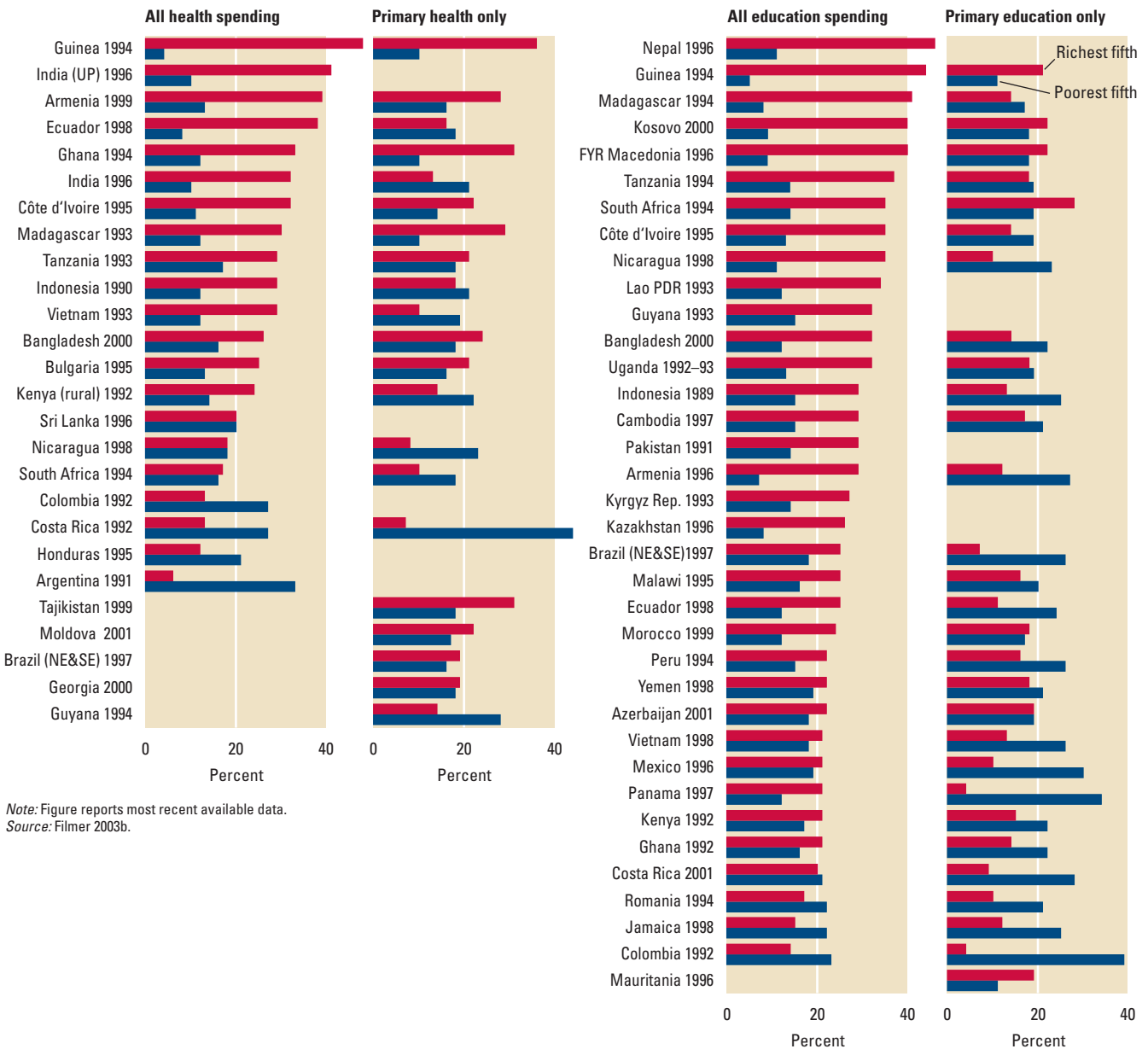
Second, the specification in the analysis can change the assessment of the result. For example, controlling for adult literacy in addition to income in the associations illustrated in figure 2.4 yields an association and a significance level that are even closer to zero.

The message from these studies is not that public funding cannot be successful. It is that commitment and appropriate policies, backed by public spending, can achieve a lot. Infant mortality was high in Thailand in 1970 at 74 per 1,000 births, and the use of community hospitals and health centers was low, in part because quality was low. But the government's commitment to reduce infant mortality was strong. Health planners took stock, analyzing information on service use and from household surveys. Thailand doubled real per capita public spending on health between the early 1970s and the mid-1980s. But it also did more. It built facilities in remote areas, directed more services to poor areas and poor people, improved staff training, provided incentives for doctors to locate in remote areas, and promoted community involvement in managing health care delivery. The oversight of doctors was strengthened. And the authority for various programs was devolved to the provincial level, freeing the central Ministry of Public Health to concentrate on planning, coordination, and technical support. By 1985 infant mortality had fallen to 42 per 1,000 births, and today it is 28 per 1,000.¹³⁹ Similar stories are playing out 20 years later in other parts of the developing world.

Public spending on services fails to reach poor people

Most poor people do not get their fair share of public spending on services, let alone the larger share that might be justified on equity grounds. Public expenditure incidence analysis—matching who uses publicly financed services with how much governments spend per user—provides a snapshot of who benefits from government spending. Results typically show that the

Figure 2.5 Richer people often benefit more from public spending on health and education
Share of public spending on health and education going to the richest and poorest fifths



Note: Figure reports most recent available data.
Source: Filmer 2003b.

poorest fifth of the populace receives less than a fifth of education or health expenditures, while the richest fifth receives more. In Ghana for example, the poorest fifth received only 12 percent of public expenditures on health in 1994, whereas the richest fifth received 33 percent (figure 2.5).

One reason for this imbalance is that spending is skewed to services disproportionately used by richer people. Public spending on primary education tends to reach poor people. The poorest fifth of

Armenians got almost 30 percent of the benefit of public spending on primary education in 1999. But not all spending on primary services is pro-poor. While public spending on primary health care tends to be more pro-poor than overall spending, it does not always disproportionately reach the poor. The poorest fifth of the populace in Côte d'Ivoire benefited from only 14 percent of public spending on primary health facilities in 1995 (compared with 11 percent from all health spending).¹⁴⁰

Orienting public spending toward services used by poor people helps, but it does not help unless the spending reaches the frontline, where it benefits poor people. A study in Uganda found that in the early 1990s only 13 percent of government primary education capitation grants made it to the intended destination, primary schools. The rest went to purposes unrelated to education or to private gain. Poor students suffered disproportionately, as schools catering to them received even smaller shares of the grants (see spotlight).¹⁴¹

The story in health is the same. Drugs intended for health clinics often never get there. In the mid-1980s more than 70 percent of the government's supply of drugs disappeared in Guinea.¹⁴² Studies in Cameroon, Tanzania, and Uganda estimated that 30 percent of publicly supplied drugs were misappropriated—in one case as much as 40 percent were “withdrawn for private use.”¹⁴³

Private and public sectors interact

Public spending has trouble creating quality services and reaching poor people. So why be surprised that spending is only weakly associated with outcomes? But there is another reason for the weak association: private and public sectors interact, and what matters is the net impact on the use of services. Increasing public provision may simply crowd out, in whole or in part, equally effective services obtained from nongovernment providers.

This works through two channels. First, individual demand in both public and private sectors will respond to a change in the public sector. A review of the impact of price increases in public health clinics in seven countries found that a substantial percentage of visits to public providers deterred by price increases are redirected to private ones—although the magnitude of the effect varies across settings.¹⁴⁴ Second, private providers may respond to changes in public provision. An experiment in increasing fees in public facilities in Indonesia in the early 1990s found that the number of private dispensaries and hospitals increased substantially, and that this resulted in only small changes in health outcomes.¹⁴⁵

Unless resources support services that work for poor people, they will be ineffective. The efficacy of spending is so varied that it is

hard to associate a cost with achieving any target improvement in outcomes, as with the Millennium Development Goals (box 2.3).

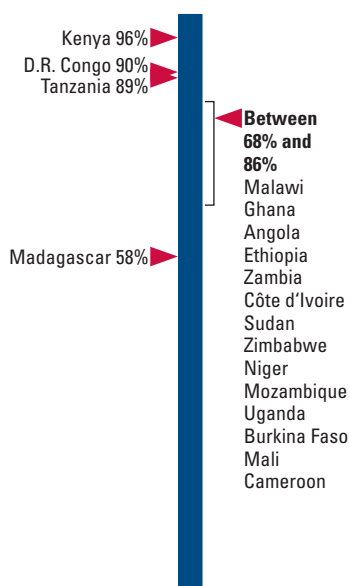
Technical adjustments without changes in incentives are not enough

If more public money is spent on services—and more of that money is spent on services used by poor people and makes it to the intended school or clinic—how the money is used still determines its efficacy. Consider recurrent spending on education in Sub-Saharan Africa. Of 18 populous Sub-Saharan African countries with data, most spend substantially more than the recommended 66 percent on teachers (figure 2.6).¹⁴⁶ And this isn't just a central government phenomenon. In Nigeria wages account for about 90 percent of local government recurrent expenditures on primary education. No one would deny that teachers are a key part of the schooling process and that paying them adequately is important. But if there is no money left to pay for other important inputs, such as textbooks, learning will suffer.

Why does such a large share of education spending go to teachers? Spending on teachers is the result of balancing technical issues with political jockeying by parents, teachers, the rest of the civil service, and advocates of spending priorities outside of the education sector. Spending on other inputs often loses out to spending on teachers—who are often vocal, organized, connected, and contractually obligated to be paid. It happens where spending is fairly high—Kenya spends more than 6 percent of GDP on education—and fairly low—Tanzania spends less than 2 percent of GDP on education. The purpose is not to single out Sub-Saharan Africa—the phenomenon is widespread—or to pick on teachers. It is to suggest that fixing the problem requires dealing not just with technical or managerial questions of how much to spend on one input relative to others, but with the institutional and political contexts that generate these decisions in the first place.

Identifying what contributes to an effective classroom or appropriate medical treatment is important for decisionmaking. In well-functioning systems service provision

Figure 2.6 The dominant share of recurrent spending on education goes to teachers (selected Sub-Saharan countries)



Note: Data refer to primary school-level spending and primary school teachers.
Source: Bruns, Mingat, and Rakatomalala (2003).

BOX 2.3 *Why it's so hard to "cost" the Millennium Development Goals*

How much will it cost to reach the Millennium Development Goals? That question, crucial for governments and donors who have committed to the goals, is extremely difficult to answer.

What cost? For universal primary education completion, does "costing" mean putting a price tag on enrolling all primary-age children in public schools? With more than 100 million children of primary school age not in school, multiplying the number in each country by average public spending per primary student yields a total "cost" of about \$10 billion. But this number overlooks a simple point: children not in school might be harder to induce to come to school, so the marginal cost of enrolling a child could be higher than the average cost. These children might have higher opportunity costs, so it might require a larger subsidy to get them into school. Or they might live in remote areas, where it would cost more to build schools or to compensate them for traveling to more central locations. In addition, this approach implicitly assumes that spending on a particular target can be earmarked separately from other spending in the sector. Though that is possible, it is not easy.

Efficiency gains. The average cost calculation also ignores the weak overall association between spending and outcomes. Additional spending will be associated with only small increases in outcomes if the additional funds are spent with the average observed efficiency (figure 2.4). That means it will take astronomically high amounts to achieve the goals. But what if the money is "well spent"?

A country-by-country simulation of spending in 47 low-income countries adjusted the proximate determinants of primary completion success—public spending as a share of GDP, the share of spending that goes to teachers, the level of teacher salaries, pupil-teacher ratio, average repetition rate. It found that average external resources of about \$2.8 billion a year would be needed. (Since the simulation included domestically mobilized resources as a policy lever, the model yields the amount of external resources required).¹⁴⁷ The average-cost approach to enrolling out-of-school children in these 47 countries yields a total incremental cost of \$3.1 billion a year.¹⁴⁸

"Costing" a change in proximate determinants is useful for identifying the fiscal implications of a change in policy, but it says little about the success

or failure of turning that spending into outcomes. This does not mean "if this amount of money were spent, the Millennium Development Goals will be met." It means "if the goals are met, here is what it will have cost."

Financing transitional costs. If institutional reforms are necessary for sustainable improvements in outcomes, the costs of those reforms should be counted: for example, the cost of repurposing physical infrastructure or compensating redundant staff. These costs are determined by country conditions. For example, the cost of a severance package will depend on a country's labor market, civil service regulations and norms, and other local factors. Given the uncertainty surrounding costs, it makes little sense to estimate transitional costs on a global basis.

Interdependence and double counting. Progress on each Millennium Development Goal feeds back into the others. Safe water and good sanitation contribute to better health. Good health enhances the productivity of schooling. Education promotes better health. Interventions that promote one goal promote all of them. If the cost of reaching each goal is assessed independently, and the results are totaled across goals, there is double counting.¹⁴⁹

Multiple determinants. But the goals do not just depend on each other—their determinants are multiple, cutting across many sectors. Little is known about the relative contribution of each factor to outcomes or about the magnitude of potential interaction effects (see crate 1.1 in chapter 1). For example, the impact of sanitation on mortality depends on access to safe water. The effectiveness of vaccines, and thus their contribution to lowering mortality, depend on preserving the "cold chain," which depends on roads, other transport, and energy infrastructure. Precise estimates of these independent and interactive effects are not easy to come by.

In sum, costing the goals requires an estimate that distinguishes between marginal and average cost, incorporates the policy and institutional changes required to make this additional expenditure effective, does not double- or triple-count given the interdependence of the goals, and takes into account the multiple determinants of each goal. No wonder that coming up with costs of reaching the goals is so difficult.

can be improved through better teaching materials, more reliable availability of drugs, better training of health workers—that is, through technical improvements in the proximate determinants of successful service provision. And management reforms may reduce the frequency of shirking teachers or

incompetent doctors or corrupt police. But trying to make services work in weak systems by an effective and least-cost solution—applying a codified set of actions or simply training providers—will end in frustration if politicians do not listen to citizens or if providers have no incentive to perform well.

To understand why, it is important to distinguish between institutional and managerial reforms. Reducing teacher absenteeism from 9 percent to 7 percent is a management issue; reducing teacher absenteeism from 50 percent to 9 percent is an institutional issue. Improving diagnostic recognition of specific diseases is a management issue. Reducing widespread mistreatment of routine conditions is an institutional issue.

Institutional reforms seek to strengthen the relationships of accountability among various actors so that good service provision outputs emerge—with all their proximate determinants, including active management. Institutional arrangements need to take advantage of the strengths of the market—with its strong customer responsiveness, organizational autonomy, and systemic pressures for efficiency and innovation. And the strengths of the public sector—with its ability to address equity and market failures and its power to enforce standards. This is not about reducing or avoiding key public responsibilities. It is about creating new ways to meet public responsibilities more effectively. This might include alternatives to public production, but it could just as easily include institutional changes to make public agencies perform better.

Understanding what works and why—to improve services

To produce better health, better skills, and better standards of living, service beneficiaries, providers, and the state must work together. How? Understanding what works, why, in what context—and how to spread successful approaches—is the subject of this Report. Many successful institutional innovations worldwide show clearly that services need not fail. They offer lessons to guide replication and to scale up solutions. A variety of stories illustrate the potential—and the challenge.

Citizen report cards in Bangalore, India.

In the early 1990s public services in Karnataka's capital city were in bad shape. A technology boom unleashed rapid growth. Services were of low quality and corruption was rampant, affecting all income groups. To monitor the government's failure to

address these problems, and to motivate change, a civil society group introduced report cards in 1994 rating user experiences with public services. The results—revealing poor quality, petty corruption, lack of access for slum dwellers, and the hidden costs of outwardly cheap services—were widely publicized by an active press.

The report cards gradually opened a dialogue between providers and user groups—and eventually got a positive response from the managers of public agencies. The state's chief minister set up a task force to improve city governance. Follow-up activities—such as an in-depth report card for hospitals—dived deeper into problems with individual services. In 1999 a report card rated some services substantially higher, though scores on corruption and access to grievance systems remained low. The initiative was so successful that the Public Affairs Centre (which conducted the survey) collaborated with local partners to prepare similar studies in other Indian cities.¹⁵⁰ And other countries (the Philippines, Ukraine, and Vietnam) are adopting the approach.

Participatory budget formulation in Porto Alegre, Brazil.

The city of Porto Alegre, with a population of more than a million, developed an innovative model of budget formulation. Citizen associations propose projects, which are then publicly debated. The proposals are combined with technical assessments, and the procedure is repeated to determine final budget allocations. The city made substantial strides. Access to water went from 80 percent in 1989 to near universal in 1996, and access to sewerage, from less than 50 percent to 85 percent. School enrollments doubled. And with greater citizen willingness to pay for better services, city revenue increased by 50 percent. To make the process pro-poor, the poorest people had more voting power than others. The approach has proved a resounding success for the inhabitants (and for the political party, which repeatedly won elections). Several other cities have since adopted similar procedures.¹⁵¹

Different stories point to other innovations: greater transparency of school fund-

ing in Uganda, citywide reform in Johannesburg, South Africa, cash transfers to households in Mexico, statewide reform of health services in Ceará, Brazil (see spotlights). Only one of these innovations was evaluated using an experimental design (Mexico's Progresá). And not all have clear measures of change in outputs or outcomes. But all hint at ways forward.

The various stories raise questions. Why were the innovations implemented? Whom did they affect? What made them work—

and what makes some other innovations fail? Can they be replicated? To examine these questions systematically—that is, to learn from such examples—the Report develops a framework that incorporates the main actors—service beneficiaries, the state, and providers—and describes how each is linked by relationships of accountability (chapters 3 to 6). It then applies these principles to specific reform agendas, exploring how those relationships play out in different sectors (chapters 7 to 11).

One nation, worlds apart

States in one federal nation—following the same constitution, laws, and intergovernmental finance system, and subject to the same election cycles—Kerala and Uttar Pradesh remain worlds apart in human development. Their different worlds mean dramatic differences in the quality of life for millions—Uttar Pradesh, with 175 million people, is larger than all but six countries in the world (Kerala has 32 million people).¹⁵² This is a story of achievement and failure, the power of public action, and the burden of official inertia.

Women born in Kerala can expect to live 20 years longer on average than women born in Uttar Pradesh. Uttar Pradesh's infant mortality rate is five times higher than Kerala's (table 1). At the start of this century, one in three girls in Uttar Pradesh had never been to school: Kerala has universal enrollment. Kerala's total fertility rate is 1.96 births per woman (lower than 2.1 in the United States and just above 1.7 in high-income European countries); Uttar Pradesh's fertility rate is 3.99 (substantially higher than the average of 2.85 for India and 3.1 for low-income countries).

Education and health services in the two states echo these differences. Studies suggest that public facilities in Kerala are likely

to be well supplied, adequately maintained, and regularly staffed by teachers or physicians. Not so in Uttar Pradesh.¹⁵³ A primary health center in Kerala left unstaffed for a few days may lead to public protests at the nearest district office.¹⁵⁴ But a rural school in Uttar Pradesh can be nonfunctional for years and produce no civic protest.¹⁵⁵

Women's participation differs widely in the two states: more than 70 percent of primary school teachers in Kerala are women, only 25 percent in Uttar Pradesh.¹⁵⁶

Why did Kerala succeed where Uttar Pradesh failed?

History helped. Even though its consumption-related poverty was among the highest

in India, Kerala already led in human development in 1956 when it was reconstituted as a new Indian state. Longstanding social movements against caste divisions, its culture (including matrilineal inheritance in certain communities), and openness to foreign influences (including missionary-led education) all helped.

But history is not all. Much of Kerala's spectacular achievements came after the mid-1950s. Adult literacy has risen from around 50 percent in 1950 to more than 90 percent now and life expectancy at birth from 44 years to 74. The birth rate has fallen from 32 to 18. In 1956 the Malabar region of Kerala lagged substantially behind the two "native" states (Travancore and Cochin) with which it was combined to form the new Kerala state. Today, the differences have disappeared.

Public action—and neglect

Dreze and Sen (2002) suggest that Kerala's success is the result of public action that promoted extensive social opportunities and the widespread, equitable provision of schooling, health, and other basic services. They argue that Uttar Pradesh's failures can be attributed to the public neglect of the same opportunities.

- The early promotion of primary education and female literacy in Kerala was very important for social achievements later on. In Uttar Pradesh educational backwardness has imposed high penalties, including delayed demographic transition and burgeoning population growth.
- Gender equity and the agency of women appear to play a major role in Kerala's success. Uttar Pradesh has a long, well-documented tradition of oppressive gender relations and extraordinarily sharp gender inequalities in literacy and in women's participation.¹⁵⁷
- Basic universal services in schooling, health care, child immunization, public

Table 1 The great divide: human development and basic services in Kerala and Uttar Pradesh
Latest available data, in percent unless otherwise stated

	Kerala	Uttar Pradesh	India
Infant mortality rate (per 1,000 live births)	16.3	86.7	67.6
Total fertility rate (per woman)	1.96	3.99	2.85
Sex ratio (women per 1,000 men)	1,058	902	933
Female school enrollment rate (age 6–17 years)	90.8	61.4	66.2
Male school enrollment rate (age 6–17 years)	91.0	77.3	77.6
Rural girls never in school (age 10–12 years)	0.0	31.7	26.6
Rural women never in school (age 15–19 years)	1.6	49.3	38.7
Immunization coverage rate (age 12–23 months)	79.7	21.2	42.0
Skilled delivery care (% of births)	94.0	22.4	42.3
Rural population in villages with:			
A primary school	90.1	75.1	79.7
A middle school	87.1	31.9	44.6
A primary health center	74.2	4.4	12.9
An all-weather road	79.1	46.0	49.2
Medical expenditure per hospitalization in public facility (Rs.)	1,417	4,261	1,902
Women reporting:			
Health care provider respected need for privacy	93.0	64.0	68.2
Health facility was clean	77.2	31.0	52.1
Skilled attendance at delivery is unnecessary	1.4	42.5	61.3
Poorest 20% of households that prefer a public health facility	55.7	9.5	32.8

Rs = Rupees

Sources: National Family and Health Survey-2, 1998–99; IIPS, 2002; Census of India, 2001; National Sample Survey 1998–99.

food distribution, and social security differ sharply in scope, access, quality, and equitable incidence. In Uttar Pradesh these services appear to have been widely neglected and there has been no particular effort to ensure results, particularly in schools.

- A more literate and better informed public in Kerala was active in politics and public affairs in a way that did not appear to have happened in Uttar Pradesh.
- Informed citizen action and political activism in Kerala—building partly on mass literacy and the emphasis placed on universal services by early communist and subsequent coalition governments—seem to have been crucial in organizing poor people. In Uttar Pradesh traditional caste and power divisions, particularly in rural areas, have persisted through more than 50 years of electoral politics—and such divisions have come to form the core of political discourse and clientelist politics.

Political incentives matter for service delivery and actual development outcomes.¹⁵⁸ Delivering broad, universal basic services has remained a credible political platform in Kerala in contrast to the clientelist, caste, and class-driven politics of Uttar Pradesh.

In Kerala, early governments with economic platforms emphasizing the provision of universal basic services established a political agenda that remained important in the coalition politics that followed. Political competition conditioned on promises to deliver better basic services showed up in early budget allocations (figure 1): education and health services accounted for a much higher share of public expenditures as compared to what was spent on state administration.

By contrast, in Uttar Pradesh caste and class-based divisions, and the absence of compelling political alternatives to transcend these divisions, led to poor political incentives for effective provision of universal, basic services. Political competition revolved around access to instruments of the state to deliver patronage and public employment to specific clients. Public expenditures in the early years were accordingly concentrated in state administration and remained well above expenditures on health and education. More recently, political parties have tended to underplay the program or policy content of their platforms, and instead have publicized the ethnic profile of their candidate lists to demonstrate commitment to proportional representation of ethnic groups in the bureaucratic institutions of the state.¹⁵⁹

Breaking out of vicious cycles

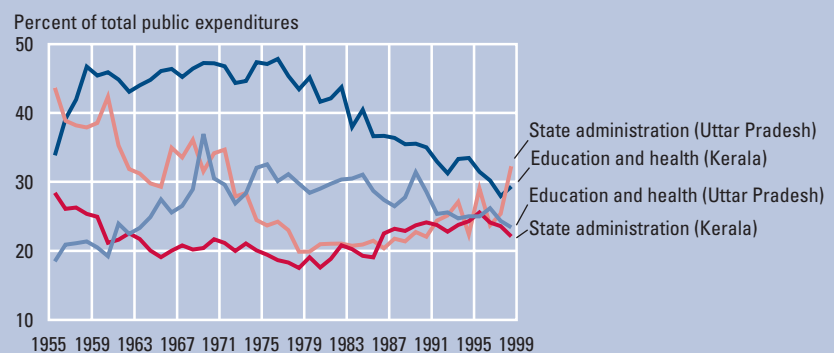
Public action can build on history, break from it, or perpetuate it. Individuals' abilities to press their demands depend on their information, perceived rights, and literacy. Public action—by influencing information that citizens have, their legal protections, and their schooling—influences private

action, especially by the politically weak. And private action loops back to influence public action. One set of reforms can lead to further institutional evolution. A society can be caught in a vicious cycle, as in Uttar Pradesh, or be propelled by a virtuous one, as in Kerala. As Dreze and Gazdar note: "In Uttar Pradesh, the social failures of the state are quite daunting, but the potential rewards of action are correspondingly high, and the costs of continued inertia even higher."¹⁶⁰

As for Kerala, despite the many economic problems that linger and the new ones that have appeared, the remarkable rescript issued in 1817 by Gowri Parvathi Bai, the 15-year-old queen of the erstwhile state of Travancore, certainly seems to have come true in its bold aspirations for the human development of her subjects. The rescript read:

"The state should defray the entire cost of the education of its people in order that there might be no backwardness in the spread of enlightenment among them, that by diffusion of education they might become better subjects and public servants and that the reputation of the state might be enhanced thereby."¹⁶¹

Figure 1 Kerala spent more on education and health, Uttar Pradesh on state administration



Note: Public spending on state administration does not include interest payments.
Source: Reserve Bank of India Bulletins, 1955–1998.