# Making Services Work for India's Poor

*This paper builds an analytical and practical framework for using resources more effectively by making services work for poor people. It focuses on services that have the most direct link with human development – education, health, water, sanitation and electricity – and uses examples of service delivery from India, elsewhere in south Asia and the world to illustrate the framework.*

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Too often, services fail poor people in India – in access, in quantity, in quality. But the fact that there are strong examples where services do work means the government and citizens can do better. How? By putting poor people at the centre of service provision: by enabling them to monitor and discipline service providers, by amplifying their voice in policymaking, and by strengthening the incentives for providers to serve the poor.

Freedom from illness and freedom from illiteracy – two of the most important ways poor people can escape poverty – remain elusive to many. To accelerate progress in human development, economic growth is, of course, necessary. But it is not enough. To meet the challenge of poverty on the scale of India requires much more effective use of public resources, domestic and foreign, as well as substantial increase in such resources. This paper, based on the 2004 World Development Report, *Making Services Work for Poor People,* builds an analytical and practical framework for using resources more effectively by making services work for poor people [World Bank 2003b]. We focus on those services that have the most direct link with human development – education, health, water, sanitation, and electricity – and use examples of service delivery from India, elsewhere in south Asia, and the world to illustrate the framework.

Governments and citizens use a variety of methods of delivering these services – central government schemes, contracting out to the private sector and nongovernmental organisations (NGOs), decentralisation to state and local governments, community participation, and direct transfers to households. There have been spectacular successes and miserable failures. Both point to the need to strengthen accountability in three key relationships in the service delivery chain: between poor people and providers, between poor people and policymakers, and between policymakers and providers.

Increasing poor clients' choice and participation in service delivery will help them monitor and discipline providers. Raising poor citizens' voice, through the ballot box and widely available information, can increase their influence with policymakers – and reduce the diversion of public services to the non-poor for political patronage. By rewarding the effective delivery of services and penalising the ineffective, policymakers can get providers to serve poor people better.

Innovating with service delivery arrangements will not be enough. Society and governments at all levels should learn from their innovations by systematically evaluating and disseminating information about what works and what does not. Only then can the innovations be scaled up to improve the lives of the quarter of a billion poor people in India. The challenge is formidable, because making services work for poor people involves changing not only service delivery arrangements but also public sector institutions. As governments and citizens create incentives for these changes, they should be selective in the problems they choose to address. They should be realistic about implementation difficulties. And they should be patient.

## I The Problem

Poverty has many dimensions. In addition to low income (living on less than $1 a day), illiteracy, ill health, gender inequality, and environmental degradation are all aspects of being poor. This is reflected in the Millennium Development Goals (MDGs), the international community's unprecedented agreement on the goals for reducing poverty (Box 1). That five of the eight MDGs concern health and education signals how central human development is to human welfare.

But progress in human development has lagged behind that in reducing income poverty (Figure 1). The world as a whole is on track to achieve the first goal – reducing by half the proportion of people living on less than $1 a day – thanks mainly to rapid economic growth in India and China, where many of the world's poor live.[1] But the world is off track in reaching the MDGs for primary education, gender equality, and child mortality. While India has made substantial progress towards achieving better social indicators over the past two decades, the rates of improvement have not been sufficient to achieve the targets set in the Tenth Five-year Plan (which are even more ambitious than the MDGs). There is also evidence of divergence in per capita incomes across states, with poverty increasingly concentrated in the country's slower growing states [World Bank 2003a].

To reach all of these goals, economic growth is essential. But it will not be enough. The projected growth in per capita GDP

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will by itself enable five of the world's six developing regions to reach the goal for reducing income poverty (Table 1). But that growth will enable only two of the regions to achieve the primary enrolment goal and none of them to reach the child mortality goal. In India, despite average annual GDP growth of 5.8 per cent over the 1990s, maternal and child mortality have hardly improved [World Bank 2003a]. Furthermore, the Indian government and UNAIDs estimates of slightly less than 1 per cent of the adult population being infected with HIV mean that India will soon have the largest number of HIV-positive people in the world.

Ensuring basic health and education outcomes is the responsibility of the state (Box 2). But many governments are falling short on their obligation, especially to poor people. In India, child mortality rates for the poorest fifth of the population are three times those for the richest fifth. And only 36 per cent of the adolescents in the poorest fifth of the population in India have completed primary school, while more than 95 per cent from the richest fifth have [World Bank 2003b].

To meet this responsibility, governments and citizens need to make the services that contribute to health and education – water, sanitation, energy, transport, health, and education – work for poor people. Too often, these services are failing. Sometimes, they are failing everybody – except the rich, who can opt out of the public system. But at other times, they are clearly failing poor people.

## Services Are Failing Poor People in Four Ways

How do we know that these services are failing poor people? First, while governments devote about a third of their budgets to health and education, this public spending is typically enjoyed by the non-poor (Figure 2). In India the richest fifth receives three times the curative health care subsidy of the poorest fifth [Peters et al 2003:218]. In Nepal 46 per cent of education spending accrues to the richest fifth, only 11 per cent to the poorest. Although critical to health outcomes, clean water is accessible mainly to rich households (Figure 3).

Second, even when public spending can be reallocated toward poor people – say, by shifting to primary schools and clinics – the money does not always reach the frontline service provider. In the early 1990s in Uganda the share of nonsalary spending on primary education that actually reached primary schools was 13 per cent. This was the average: poorer schools received well below the average [Reinikka and Svensson 2001].

Third, even if this share is increased – as the Ugandans have done – teachers must be present and effective at their jobs, just as doctors and nurses must provide the care that patients need. But they are often mired in a system where the incentives for effective service delivery are weak, wages may not be paid, corruption is rife, and political patronage is a way of life. Highly trained doctors seldom wish to serve in remote rural areas. Since those who do serve there are rarely monitored, the penalties for not being at work are low. Recent statewide surveys based on unannounced visits to primary schools and health care clinics show that absence rates for teachers and health care workers in public facilities are very high in India (Tables 2 and 3). The average absence rate for teachers was 25 per cent in India, with particularly high rates in poorer states such as Bihar (38 per cent) and Jharkhand (39 per cent) [World Bank (2003b): Muralidharan et al (2004): and Hammer et al (2004)]. A similar survey of primary health care facilities in Bangladesh found the absence

### Box 1: The Eight Millennium Development Goals

With starting points in 1990, each goal is to be reached by 2015:

1 Eradicate extreme poverty and hunger
- Halve the proportion of people with less than one dollar a day.
- Halve the proportion of people who suffer from hunger.

2 Achieve universal primary education
- Ensure that boys and girls alike complete primary schooling.

3 Promote gender equality and empower women
- Eliminate gender disparity at all levels of education.

4 Reduce child mortality
- Reduce by two-thirds the under-five mortality rate.

5 Improve maternal health
- Reduce by three quarters the maternal mortality ratio.

6 Combat HIV/AIDS, malaria and other diseases
- Reverse the spread of HIV/AIDS.

7 Ensure environmental sustainability
- Integrate sustainable development into country policies and reverse loss of environmental resources.
- Halve the proportion of people without access to potable water.
- Significantly improve the lives of at least 100 million slum dwellers.

8 Develop a global partnership for development
- Raise official development assistance.
- Expand market access.

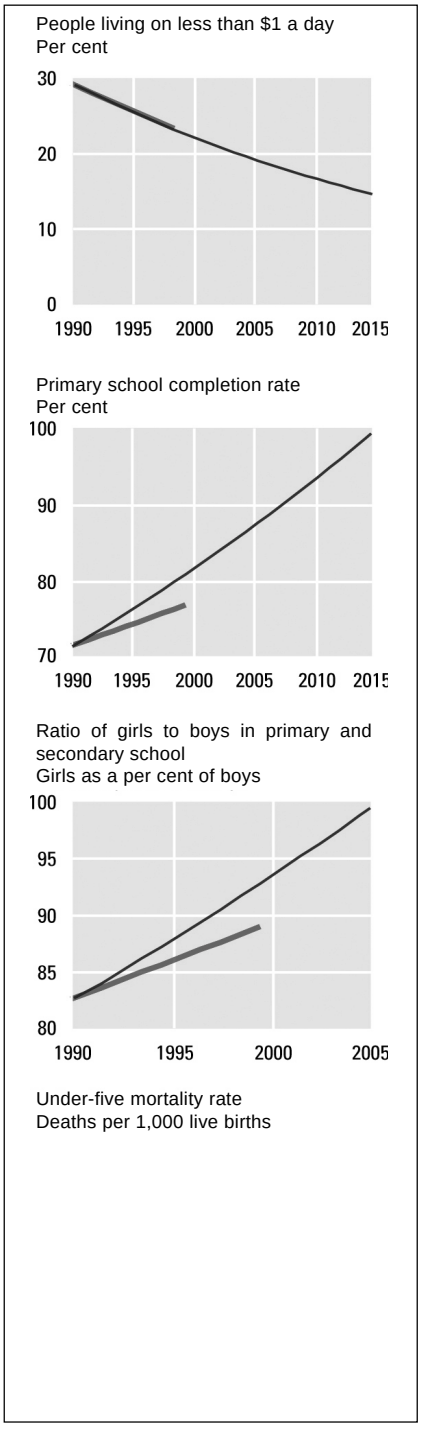
Three points about the Millennium Development Goals. First, to be enduring, success in reaching the goals must be based on systemwide reforms to support progress. Second, focusing on these outcomes does not imply focusing on education and health services alone. Health and education outcomes depend on too many other factors for that to work – everything from parents' knowledge and behaviour, to the ease and safety of reaching a health clinic or school or the technology available for producing outcomes. Third, in countries that have already achieved universal primary completion or low infant and maternal mortality rates, the spirit of the Millennium Development Goals – time-bound, outcome-based targets to focus strategies – remains important.

**Table 1: Economic Growth Alone Is Not Enough to Reach Millennium Development Goals**

| Regions | Annual Average GDP Per Capita Growth 2000-2015* (Per Cent Per Year) | People Living on Less than $1 a Day | | Primary Completion Rate | | Under-5 Mortality Rate | |
|---|---|---|---|---|---|---|---|
| | | Target (Per Cent) | 2015 Growth alone (Per Cent) | Target (Per Cent) | 2015 Growth alone (Per Cent) | Target (Per 1,000 Births) | 2015 Growth alone (Per Cent) |
| East Asia | 5.4 | 14 | 4 | 100 | 100 | 19 | 26 |
| Europe and Central Asia | 3.6 | 1 | 1 | 100 | 100 | 15 | 26 |
| Latin American and the Caribbean | 1.8 | 8 | 8 | 100 | 95 | 17 | 30 |
| Middle East and North Africa | 1.4 | 1 | 1 | 100 | 96 | 25 | 41 |
| South Asia | 3.8 | 22 | 15 | 100 | 99 | 43 | 69 |
| Africa | 1.2 | 24 | 35 | 100 | 56 | 59 | 151 |

*Note*: Elasticity assumed between growth and poverty is –1.5; primary completion rate is 0.62; under-5 mortality is –0.48.
*Sources*: GDP growth projections from World Bank (2003) and Devarajan (2002).

**Figure 1: Progress in Human Development Off Track**




*Note:* The thin line is the trend line to reach the Millennium Development Goals. The thick line shows the actual progress to date.
*Source:* World Bank (2003b).

rate among doctors to be 74 per cent [Chaudhury and Hammer, 2003]. When present, some service providers treat poor people badly. "They treat us like animals", says a patient in West Africa [Jaffre, Olivier, and de Sardan 2002].

By no means do all frontline service providers behave this way. Many, often the majority, are driven by an intrinsic motivation to serve. Be it through professional pride or a genuine commitment to help poor people (or both), many teachers and health workers deliver timely, efficient, and courteous services, often in difficult circumstances – collapsing buildings, overflowing latrines, late salary payments – and with few resources – clinics without drugs, classes without textbooks [PROBE Team in association with Centre for Development Economics 1999; Rosskam 2003]. The challenge is to reinforce this experience – to replicate the professional ethics, intrinsic motivation, and other incentives of these providers in the rest of the service workforce.

The fourth way services fail poor people is the lack of demand. Poor people often don't send their children to school or take them to a clinic. In Bolivia 60 per cent of the children who died before age five had not seen a formal provider during the illness culminating in their death. Sometimes the reason is the poor quality of the service – missing materials, absent workers, abusive treatment. Only about 5 per cent of sick children in the Sheikhupura district of rural Punjab in Pakistan were taken for treatment to rural primary health care facilities; half went to private dispensaries, the rest to private doctors [Pakistan Institute for Environment Development Action and Project Management Team 1994]. At other times it is because they are poor. In Pune, low-income

**Box 2: Services – A Public Responsibility**

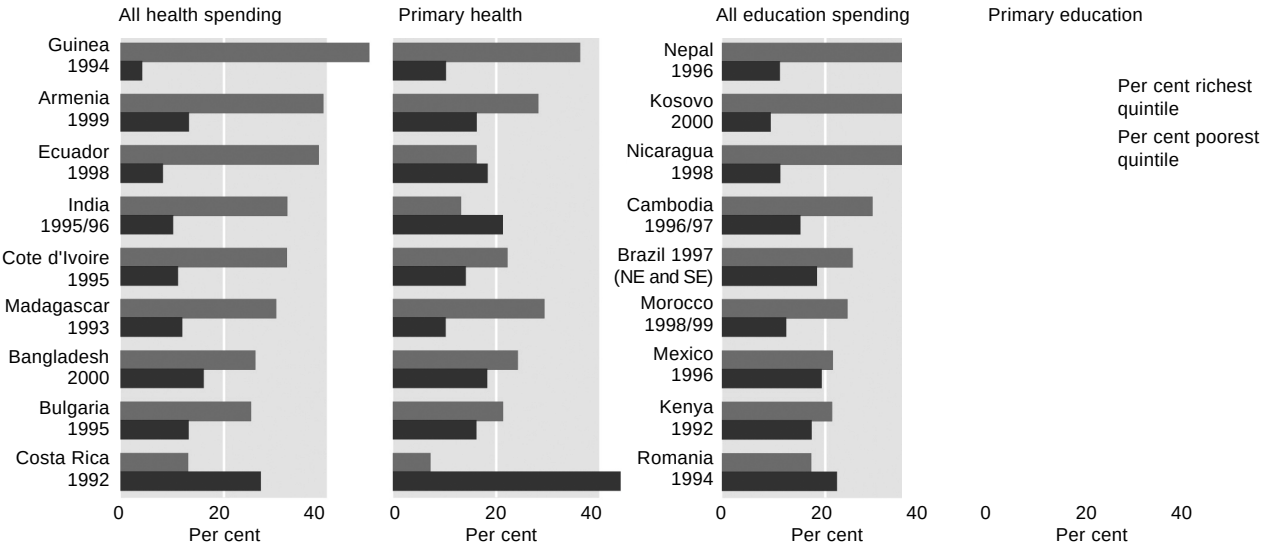
By financing, providing, or regulating the services that contribute to health and education outcomes, governments around the world demonstrate their responsibility for the health and education of their people. Why? First, these services are replete with market failures – with externalities, as when an infected child spreads a disease to playmates, or a farmer benefits from a neighbour's ability to read. So the private sector, left to its devices, will not achieve the level of health and education that society desires. Second, basic health and basic education are considered fundamental human rights. The 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…medical care...[and a right to education that is]…free, at least in the elementary and fundamental stages." No matter how daunting the problems of delivery may be. So the public sector cannot walk away from health and education. The challenge is to see how the government – in collaboration with the private sector, communities, and outside partners – can meet this fundamental responsibility.

**Table 2: Absence Rates among Teachers and Health Care Workers in Public Facilities**
*(Per cent)*

| | Primary Schools | Primary Health Facilities |
|---|---|---|
| Bangladesh | – | 35 |
| Ecuador | 16 | – |
| India* | 25 | 40 |
| Indonesia | 18 | 42 |
| Papua New Guinea | 15 | 19 |
| Peru | 13 | 26 |
| Zambia | 17 | – |
| Uganda | 26 | 35 |

*Notes:* The absence rate is the percentage of staff who are supposed to be present but are not on the day of an unannounced visit. It includes staff whose absence is "excused" and "not excused", and so includes, for example, staff in training, performing nonteaching "government" duties, and shirking.
* Averages for primary schools in 19 states and primary health facilities (doctors and non-doctors) in 17 states.
— indicates data not available
*Source*: World Development Report 2004, 'Making Services Work for Poor People'.

**Figure 2: Share of Public Spending Accruing to Richest and Poorest Fifths**




*Source:* World Bank (2003b).

purchasers of water paid up to 30 times the sale price of the metered water that middle- and upper-income households receive [Radoki 2003]. Even when the services are free, many poor rural families cannot afford the time it takes to travel to the nearest primary school or medical facility. In India, people in the poorest quintile of the population on average travel about 4 times further to reach the nearest rural health facility as compared to those in the richest fifth [World Bank 2003b: Table 1.1].

Weak demand can also be due to cultural factors, notably gender. Some parents refuse to send their daughters to school. Husbands have been known to prevent their wives from going to clinics – even for deliveries. And the social distance between poor people and service providers (the majority of health care professionals in many countries are raised in the city) is often a deterrent.

## Alternative Service Delivery Arrangements

Ensuring access to basic services such as health, education, water, energy, and sanitation is a public responsibility today, but it has not always been. Nor do governments discharge this responsibility solely through central-government provision. Throughout history and around the world, societies have tried different arrangements – with mixed results. Even when government provision is extensive, this may not translate into substantial use. The Indian public sector runs almost 200,000 primary health facilities and 15,000 secondary and tertiary facilities, but it is the private medical sector that accounts for 80 per cent of outpatient treatments and almost 60 per cent of inpatient treatments [Peters et al 2003].

Some governments contract services out – to the private sector, to NGOs, even to other public agencies. In the aftermath of a civil war Cambodia introduced two forms of contracting for the delivery of primary health care ('contracting out' whole services and 'contracting in' some services). Randomly assigning the arrangements across 12 districts (to avoid systematic bias), it found that health indicators, as well as use by the poor, increased most in the districts contracting out [Bhushan, Keller, and Schwartz 2002]. Whether this can be scaled up beyond 12 districts in Cambodia is worth exploring.

Governments also sell concessions to the private sector – in water, transport, electricity – with some very good and some very bad results. Privatising electricity distribution in Delhi reduced power cuts [Sagar 2003] and helped the incumbent government get re-elected. Privatising water in Tucuman, Argentina, led to riots in the streets and a reversal of the concession.

Some societies transfer responsibility (for financing, provision, and regulation) to lower tiers of government. Again, the record has varied – with potentially weaker capacity and greater political patronage at the local level and the reduced scope for redistri-

**Table 3: Absence Rates for Teachers and Health Care Workers in Government Facilities in Selected Indian States, 2003**
*(Per cent)*

| | Primary Teachers | Doctors | Other Health Workers |
|---|---|---|---|
| Andhra Pradesh | 25.2 | 45.8 | 32.3 |
| Assam | 33.5 | 45.7 | 60.0 |
| Bihar | 38.3 | 66.7 | 49.7 |
| Chhattisgarh | 30.9 | 40.3 | 18.0 |
| Gujarat | 17.0 | 41.0 | 52.9 |
| Haryana | 21.2 | 46.7 | 39.8 |
| Himachal Pradesh | 21.2 | – | – |
| Jharkhand | 39.3 | 56.5 | 41.3 |
| Karnataka | 20.5 | 38.2 | 41.6 |
| Kerala | 20.3 | – | – |
| Madhya Pradesh | 16.5 | 28.2 | 27.5 |
| Maharashtra | 14.5 | 29.9 | 30.3 |
| Orissa | 23.1 | 32.5 | 29.4 |
| Punjab | 35.7 | 38.8 | 43.8 |
| Rajasthan | 23.6 | 45.8 | 36.7 |
| Tamil Nadu | 21.4 | 57.0 | 33.5 |
| Uttar Pradesh | 25.5 | 52.1 | 39.6 |
| Uttaranchal | 32.8 | 46.2 | 41.8 |
| West Bengal | 24.8 | 38.8 | 34.6 |
| All-India Weighted | 24.5 | 44.4 | 39.0 |

*Notes:* The absence rate is the percentage of staff who are supposed to be present but are not on the day of an unannounced visit. It includes staff whose absence is 'excused' and 'not excused', and so includes, for example, staff in training, performing non-teaching 'government' duties, and shirking.
– indicates data not available.
*Source:* World Development Report 2004, *Making Services Work for Poor People* and papers presented at the 'Tackling Absence of Teachers and Medical Personnel', GDN Conference Workshop, January 25-26, 2004, New Delhi.

bution sometimes outweighing the benefits from greater local participation and social capital. Local-government delivery of infrastructure in South Africa improved service provision in a short time [Ahmad 1999]. But decentralising social assistance in Romania weakened the ability and incentives of local councils to deliver cash transfers to the poor [World Bank 2002]. The programme is now being recentralised.

Responsibility is sometimes transferred to communities – or to the clients themselves. Maharashtra used to subsidise latrine construction to households but found that close to 45 per cent of the latrines were not being used. So it shifted its subsidy to a competitive programme (the Sant Gadge Baba scheme) that rewarded communities for good sanitation practices, using an information campaign and publicising the names of winning villages [Water and Sanitation Programme-South Asia 2002]. For every rupee of state resources, local spending on sanitation and related infrastructure increased by 35 rupees [World Bank 2003b]. Community-based nutrition programmes have often improved nutritional status through information exchanges, as in Tamil Nadu.

Still other programmes transfer resources and responsibility to the household. Mexico's Education, Health, and Nutrition Programme (Progresa) gives cash to families if their children are enrolled in school and they regularly visit a clinic. Numerous evaluations of the programme show consistently that it increased school enrolment (8 percentage points for girls and five for boys at the secondary level) and improved children's health (illness among young children fell 20 per cent) [Behrman and Hoddinott (2001) and Gertler and Boyce 2001].

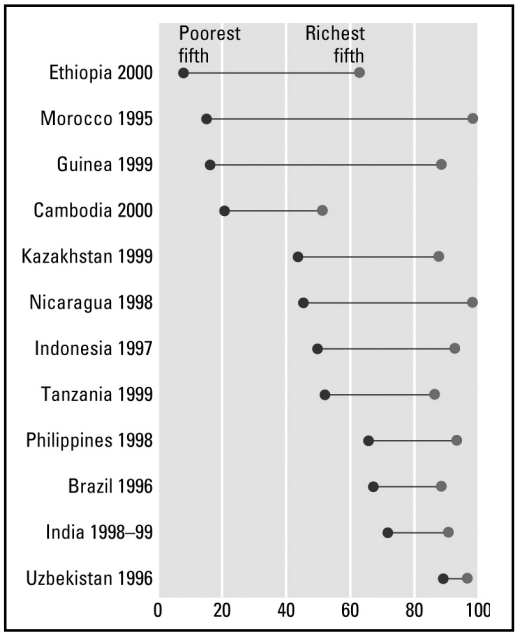
## II
## Framework of Relationships

To help understand the variety of experiences with traditional and alternative service delivery arrangements, the service delivery chain can be unbundled into three sets of actors (Figure 4). Poor people – as patients in clinics, students in schools, travellers on buses, consumers of water – are the clients of services. They have a relationship with the frontline providers, with schoolteachers, doctors, bus drivers, water companies. Poor people have a similar relationship when they buy something in the market, such as a samosa (or a sandwich, a kilo of rice, a metre of cloth). In a competitive-market transaction, they get the 'service' because they can hold the provider accountable. That is, the consumer pays the provider directly; he can observe whether or not he has received the samosa or the cloth; and if he is dissatisfied, he has power over the provider with repeat business or, in the case of fraud, with social or legal sanctions.

For the services considered here – such as health, education, water, electricity, and sanitation – there is no direct accountability of the provider to the consumer. Why not? For various good reasons, society has decided that the service will be provided not through a market transaction but through the government taking responsibility (see Box 2). That is, through the 'long route' of accountability – by clients as citizens influencing policymakers, and policymakers influencing providers. When the relationships along this long route break down, service delivery fails (absentee teachers, leaking water pipes) and human development outcomes are poor.

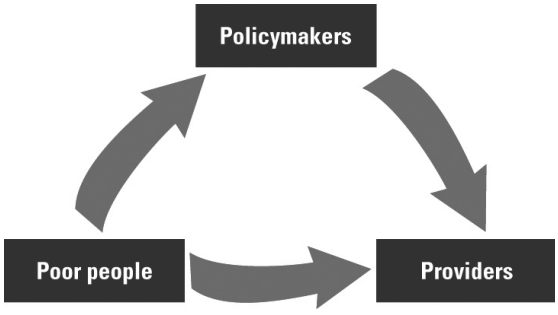
Consider the first of the two relationships along the long route – the link between poor people and policymakers or politicians (Figure 4). Poor people are citizens. In principle, they contribute to defining society's collective objectives, and they try to control

**Figure 3: Per Cent of Households Using Improved Water Source**




*Source:* World Bank (2003b).

**Figure 4: The Framework of Accountability Relationships**




public action to achieve those objectives. In practice, this does not always work. Either they are excluded from the formulation of collective objectives or they cannot influence public action because of weaknesses in the electoral system. Free public services and "no-show" jobs are handed out as political patronage, with poor people rarely the beneficiaries.

Even if poor people can reach the policymaker, services will not improve unless the policymaker can ensure that the service provider will deliver services to them. In Cambodia, policymakers were able to specify the services required to the NGOs with whom they contracted. But for many services, such as student learning or curative care, the policymaker may not be able to specify the nature of the service, much less impose penalties for underperformance of the contract. Teacher and health-worker absenteeism is often the result (Tables 2 and 3).

Given the weaknesses in the long route of accountability, service outcomes can be improved by strengthening the short route – by increasing the client's power over providers. School voucher schemes (Colombia's PACES) or scholarships (Bangladesh's Female Secondary School Assistance Programme, in which schools receive a grant based on the number of girls they enroll) enable clients to exert influence over providers

through choice. Maharashtra's Sant Gadge Baba scheme and Guinea's revolving drug programme (where co-payments inspired villagers to stop theft) are ways for client participation to improve service provision [See Spotlight on Educo and Bamoko Initiative in World Bank 2003b]. Turn now to a closer look at the individual relationships in the service delivery chain – why they break down, how they can be strengthened.

## Citizens and Politicians/Policymakers

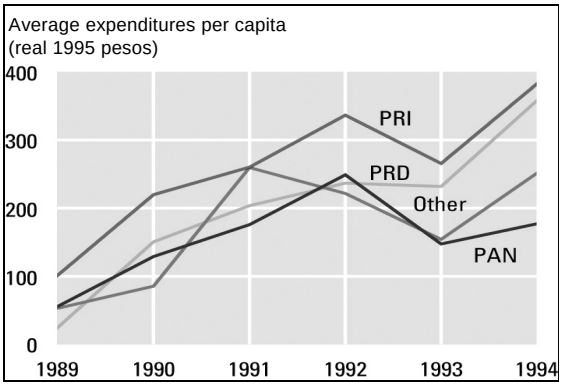
Poor citizens have little clout with politicians. In some countries the citizenry has only a weak hold on politicians. Even if there is a well-functioning electoral system, poor people may not be able to influence politicians about public services. They may not be well informed about the quality of public services (and politicians know this); they may vote along ethnic or caste lines, placing less weight on public services when evaluating politicians; or they may not believe the candidates who promise better public services – for example, because their term in office is too short to deliver on the promise – and they may vote instead for candidates who provide ready cash, personal favours, and jobs.

As a result, public services often become the currency of political patronage and clientelism. Politicians give 'phantom' jobs to teachers and doctors. They build free public schools and clinics in areas where their supporters live. Former Boston mayor James Curley strengthened his political base by concentrating public services in the Irish Catholic areas while denying them to the Protestants, who eventually moved out of the city to the suburbs [Glaeser and Shleifer 2002].

In 1989 Mexico introduced Programa Nacional de Solidaridad, or National Solidarity Programme (PRONASOL), a poverty alleviation programme that spent 1.2 per cent of GDP annually on water, electricity, nutrition, and education construction in poor communities. Assessments of the six-year programme found that it reduced poverty by only about 3 per cent. Had the budget been distributed to maximise its impact on poverty, the expected decline would have been 64 per cent. It would have been 13 per cent even with an untargeted, universal proportional transfer to the whole population. The reason becomes apparent when one examines the political affiliation of communities that received PRONASOL spending. Municipalities dominated by the Institutional Revolutionary Party (PRI), the party in power, received significantly higher per capita transfers than those voting for another party (Figure 5) [Diaz-Cayeros and Magaloni 2002].

Just as a well-functioning democracy does not guarantee that poor people will benefit from public services, some one-party states get good health and education outcomes – even among the poor. Cuba has among the best social indicators in Latin America – at a much lower income than its peers, such as Chile and Costa Rica. China reduced infant mortality dramatically, and achieved nearly universal primary enrollment. To be sure, in China, cases during the earliest phase of the outbreak of severe acute respiratory syndrome in 2002 were not openly reported – thus making its further spread almost inevitable. And Cubans, who had high levels of health and education in the 1950s, remain poor on other dimensions [Spotlight on Costa Rica and Cuba in World Bank 2003b]. The lesson seems to be that the citizen-policymaker link is working either when citizens can hold policymakers accountable for public services that benefit the poor, or when the policymaker cares about the health and education of poor people. These politics are 'pro-poor'.

**Figure 5: PRONASOL Expenditures according to Party in Municipal Government**




*Note:* PRI = Institutional Revolutionary Party; PRD = Party of the Democratic Revolution; PAN = National Action Party.
*Source:* World Bank (2003b).

What can be done when the politics are not pro-poor? Societies can still introduce various intermediate elements to make public institutions more accountable. Participatory budgeting in Porto Allegre, Brazil, started as a means for the citizens to participate in budget formulation and then to hold the municipal government accountable for executing the budget. Led by NGOs, participatory budget analysis is being tried in Ahmedabad, Bangalore, Delhi, Jaipur, and other places in India.

Perhaps the most powerful means of increasing the voice of poor citizens in policymaking is better information. When the government of Uganda learned that only 13 per cent of recurrent spending for primary education was arriving in primary schools, it launched a monthly newspaper campaign on the transfer of funds. That campaign galvanised the populace, inducing the government to increase the share going to primary schools (now over 80 per cent) and compelling school principals to post the entire budget on the schoolroom door.

The media can do much to disseminate information about public services. Higher newspaper circulation in Indian districts is associated with better local-government performance in distributing food and drought relief [Besley and Burgess 2002]. The more people who can read, the stronger the influence of the media. In Kerala this led to a virtuous cycle of literacy leading to better public services, which raised literacy even more [World Bank 2003b: Spotlight on Kerala and Uttar Pradesh].

But information is not enough. People must also have the legal, political, and economic means to press demands against the government. Most citizens in Uttar Pradesh know that government services are dismal, and know that everyone else knows that and yet most do not feel free to complain or their complaints have not been effective. The recent passage of right to information and public disclosure laws in India hold the potential of substantially enhancing the power of information to improve public service delivery.

## Policymakers and Providers

Strengthening poor people's voice can make policymakers want to improve services for the poor. But they still may not be able to. Well-intentioned policymakers often cannot offer the incentives and do the monitoring to ensure that providers serve the poor. The absenteeism of teachers, the rude treatment of patients, and the siphoning of pharmaceuticals are symptoms of the problem.

Even in the private sector, where the incentives presumably are better aligned, performance is not much better – for the same reasons that private markets are not the solution to these problems in the first place. Private providers fail to reach the very poor. Weak regulation leads to poor-quality health services in India's private sector. Ineffectively privatising water incites riots in the streets of Cochabamba in Bolivia. In the former Soviet Union, state and party control over providers ensured compliance with delivery norms for free services. Services worked, and levels of health status, particularly for the poorer central Asian republics, were much higher than for other countries at their level of income. But the breakup of the Soviet Union weakened state control over providers, and health and education services collapsed.

Solving the problem requires mentally, and sometimes physically, separating the policymaker from the provider – and thinking of the relationship between the two as a compact. The provider agrees to deliver a service, in return for being rewarded or penalised depending on performance. The compact may be an explicit contract with a private or nonprofit organisation – or between tiers of government, as in Johannesburg, South Africa [World Bank 2003b: Spotlight on Johannesburg]. Or it could be implicit, as in the employment agreements of civil servants.

Separating the policymaker from the provider is not easy, for those who benefit from the lack of separation may resist it. Teachers' unions in Uttar Pradesh blocked an attempt to put teacher hiring, firing, and attendance under the control of the village panchayat. On the other hand, health professionals in Brazil participated in a national coalition that prepared the plan for health reforms and municipal health councils [ILO 2002]. The separation usually happens because of a fiscal crisis (Johannesburg), a major political change (decentralisation in Latin America), or a legacy of history (public regulation of water providers in the Netherlands).

Even with a separation of policymaker and provider, the compacts cannot be too explicit. It is difficult to specify precisely what the schoolteacher should do at every point in the day. Too much specificity can lead to inflexibility. Parisian taxi drivers, to make a point about excessive regulations, sometimes meticulously follow the rules in the *Code de la route* – slowing traffic in the French capital to a snail's pace [Scott 1998].

Since the contract cannot be fully specified, policymakers look to other means of eliciting pro-poor services from providers. One way is to choose providers who have an intrinsic motivation to serve the poor. A study of faith-based health care providers in Uganda estimates that they work for 28 per cent less than government and private for-profit staff, and yet provide a significantly higher quality of care than the public sector [Reinikka and Svensson 2003]. Another way is to increase incentives to serve the poor or work in underserved areas. But one study of Indonesia shows that it would require multiples of current pay levels to get doctors to live in West Papua, for instance (where the vacancy rate is 60 per cent) [Chomitz and others 1998]. A third way is to solicit bids for services and use the competition in the bidding process to monitor and discipline providers. Many water concessions are managed this way. A recent innovation in Madhya Pradesh allows NGOs to compete for concessions to primary schools, with payments conditional on higher test scores based on independent measurement.

As with the citizen-politician relationship, a critical element in the policymaker-provider relationship is information. The policymaker can specify a contract based only on what he can observe – on what information is available. There has to be a method for monitoring providers and for having that information reach the policymaker. New technologies, including e-government, can make this easier. Computerisation of land registration in Karnataka has reduced the transaction time to an average of 30 minutes and largely eliminated the payment of bribes, which had risen to 25 to 50 times the registration fee [Lobo and Balakrishnan 2002].

So can some ingenious methods using human beings. When Ceará, Brazil, hired a cadre of district health workers, the government sent their names to the applicants who were not selected, inviting them to report any problems with service in the health clinics. More fundamentally, these output-based incentive schemes require rigorous impact evaluation, so that the policymaker knows and understands what is working and what isn't. Evaluation-based information, important not only for monitoring providers, also enables the rest of the world to learn about service delivery.

## Clients and Providers

Given the difficulties in strengthening the long route of accountability, improving the short route – the client-provider relationship – deserves more consideration. There is no question that this relationship is broken for hundreds of millions of poor people. *Voices of the Poor* and other surveys point to the helplessness that poor people feel before providers – nurses hitting mothers during childbirth, doctors refusing to treat patients of a lower caste [Narayan and Pettesch 2002 and Koenig, Foo, and Joshi 2000]. Unlike most private providers, public water companies funded through budgetary transfers often ignore their customers. These are but symptoms of the larger problem: many service delivery arrangements neglect the role of clients, especially poor clients, in making services work better.

Clients can play two roles in strengthening service delivery. First, for many services, clients can help tailor the service to their needs, since the actual mix cannot be specified in advance. In some parts of Pakistan, girls are more likely to attend school if there is a female teacher. The construction of separate latrines for girls has had a strong effect on girls' enrolment in primary schools. When the opening hours of health clinics are more convenient for farmers, visits increase. Second, clients can be effective monitors of providers, since they are at the point of service delivery. The major benefit of Educo, a community-managed school program in El Salvador, came from the weekly visits of the community education association to schools. Each additional visit reduced student absenteeism (due to teacher absenteeism) by 3 per cent [Jimenez and Sawada 1999].

How can the role of clients in revealing demand and monitoring providers be strengthened? By increasing poor people's choice and participation in service delivery. When clients are given a choice among service providers, they reveal their demand by 'voting with their feet'. Female patients who feel more comfortable with female doctors can go to one. The competition created by client choice also disciplines providers. A doctor may refuse to treat lower-caste patients, but if he is paid by the number of patients seen, he will be concerned when the waiting room is empty. Reimbursing schools based on the number of students (or female students) they enrol creates implicit competition among schools for students, increasing students' and parents' choice.

School voucher programmes – as in Bangladesh, Chile, Colombia, Côte d' Lvoire, and Czech Republic – are explicitly

aimed at improving education quality by increasing parents' choices. The evidence on these schemes is mixed, however. They seem to have improved student performance among some groups. But the effects on the poor are ambiguous because universal voucher schemes tend to increase sorting – with richer students concentrating in the private schools [Hsieh and Urquiola 2003]. When the voucher is restricted to poor or disadvantaged groups, the effects are better [Gauri and Vawda 2003]. The Colombia programme showed lower repetition rates and higher performance on standardised tests for students participating in the scheme – with the effect for girls higher than that for boys [Angrist et al 2002]. Even in network systems such as urban water supply, it is possible to give poor communities choice – by allowing the poor to approach independent providers, introducing flexibility in service standards such as free lifeline water allowances followed by volumetric user charges (as in Johannesburg), and so on.

When there is no choice of providers, increasing poor people's participation in service provision – giving them the ability to monitor and discipline the provider, for example – can achieve similar results. Clients can play the role of monitors since they are present at the point of service. But they need to have an incentive to monitor.

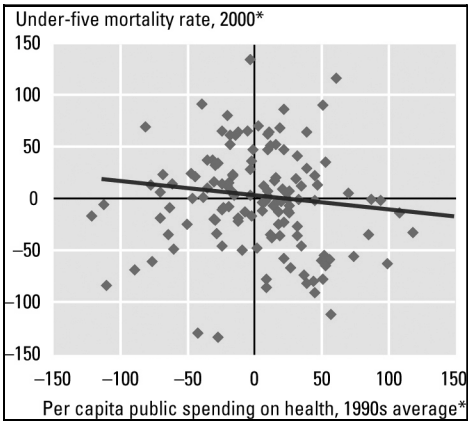
In Bangladesh, thanks to reduced import tariffs, households were able to purchase tubewells that tapped ground sources – shallow aquifers – for drinking water. Unfortunately, no one arranged for the monitoring of water quality – a public good – so the arsenic in the water went undetected. If the stakes are high enough, communities tackle the problem. When the Zambian government introduced a road fund financed by a charge on trucks, truck drivers took turns policing a bridge crossing to make sure that overloaded trucks did not cross. Of course such co-payments or user fees reduce demand – and so should not be used when the demand effects outweigh the increase in supply, as in primary education. But for water, electricity, and other services whose benefits are enjoyed mainly by the user, charging for them has the added benefit of increasing the consumer's incentive to monitor the provider. Farmers in Andhra Pradesh are finding that, when they pay for their water, the irrigation department becomes more accountable to them. In the words of one farmer, "We will never allow the government to again give us free water" (interview by John Briscoe).

## III
## What Not to Do

The picture painted so far of the difficulties in government-led service delivery may lead some to conclude that government should give up and leave everything to the private sector. That would be wrong. If individuals are left to their own devices, they will not provide levels of education and health that they collectively desire (see Box 2). Not only is this true in theory, but in practice no country has achieved significant improvement in child mortality and primary education without government involvement. Furthermore, as mentioned earlier, private sector or NGO participation in health, education, and infrastructure is not without problems – especially in reaching poor people. The extreme position of leaving everything to the private sector is clearly not desirable.

At the same time, simply increasing public spending – without seeking improvements in the efficiency of that spending – is unlikely to reap substantial benefits. The productivity of public spending varies enormously across countries. Ethiopia and Malawi spend roughly the same amount per person on primary education – with very different outcomes. Peru and Thailand spend vastly different amounts – with similar outcomes.

**Figure 6: Public Spending on Health and Child Mortality**




Public spending and child mortality are given as the per cent deviation from the rate predicted by GDP per capita.

*Note:* For the regression line shown, the coefficient is –0.148 and the t-statistic is 1.45.

*Source:* World Bank (2003b).

On average, the relationship between public spending on health and education and the outcomes is weak or nonexistent. A simple scatter plot of spending and outcomes shows a clear line with a significant slope – because richer countries spend more on health and education and have better outcomes. But controlling for the effect of per capita income, the relationship between public spending on health and under-five mortality rates is not statistically significant (Figure 6). That is not surprising: most public spending on health and education goes to the non-poor, much of it fails to reach the frontline service provider, and service providers face weak incentives to deliver services effectively.

Finally, when faced with disappointing health and education outcomes, especially for poor people, it is tempting to recommend a technical solution that addresses the proximate cause of the problem. Why not give vitamin A supplements, de-worm school-children and train teachers better? Why not develop a 'minimum package' of health interventions for everybody? Although each intervention is valuable, recommending them alone will not address the fundamental institutional problems that precluded their adoption in the first place.[2] Lack of knowledge about the right technical solution is usually not the binding constraint. India does not lack the technical skills to put in place 24 × 7, continuous water supply in many of its cities, an arrangement that can achieve better health outcomes, improve consumer satisfaction and water resource management, and reduce public expenditures [Water and Sanitation Programme-South Asia 2003]. What is needed is a set of institutional arrangements that will give policymakers, providers, and citizens the incentives to adopt the right solution and adapt it to local conditions. The problem is not one of fixing the pipes, but of fixing the institutions that should be fixing the pipes.

## IV
## What Can Be Done?

The varied experience with traditional and innovative modes of service delivery clearly shows that no single solution fits all services in all countries. The framework of accountability

relationships explains why. In different sectors and countries, different relationships need strengthening. In education the biggest payoff may come from strengthening the client-provider link, as with vouchers in Colombia or scholarships for girls in Bangladesh. But that may not be so in immunisation campaigns.

Furthermore, poor people are often trapped in a system of dysfunctional service-delivery relationships. Making just one link more effective may not be enough – it may even be counter-productive – if there are serious problems elsewhere in the service delivery chain. In water, urban solid waste, or curative health care, tightening the policymaker-provider link could make providers respond more to the demands of their superiors – and less to their poor clients. Relying on user groups, often generously funded by donors, may inhibit the development of genuinely responsive local governments. Finally, countries, and regions within countries, vary enormously in the conditions that make service innovations work. A failed state mired in conflict or lawlessness will be overstretched in resources and institutional capacity, and able to manage only certain interventions. Countries with high prevalence of HIV/AIDS will require short- and long-term adaptations of service delivery systems.

Does this mean there are no general lessons about making services work for poor people? No. The experience with service delivery, viewed through the lens of the framework in this paper, suggests a constellation of solutions, each matching various characteristics of the service and the country or region. While no one size fits all, perhaps eight sizes do. Even eight may be too few, which is why some of the 'sizes' are adjustable, like waistbands. The eight sizes can be arrived at by answering a series of questions.

## Pro-Poor or Clientelist Politics?

How much is the political system in the country or the state geared toward pro-poor public services – and how much does it suffer from clientelist politics and corruption? This is the most difficult dimension for almost anyone to address: the recipient of the advice may also be the source of the problem. And politics do not change overnight.

Even so, at least three sets of policy instruments can be deployed where the politics are more clientelist than pro-poor.

First is choosing the level of government responsible for the service. Countries differ in the patronage politics and capabilities of different tiers of government – and this should inform the service delivery arrangement. A key objective of Pakistan's devolution process is improving basic services at the local level.

Second, if politicians are likely to capture the rents from free public services and distribute them to their clients, an arrangement that reduces the rents may leave the poor better off. This might include transparent and publicly known rules for allocation, such as per-student grants to schools, or conditional transfers to households, as in Progresa. In some cases it may include fees to reduce the value of the politicians' distribution decisions. India's power sector was nationally owned and run because it was a network (and therefore not amenable to head-to-head competition). But the huge rents from providing subsidised electricity have been diverted to people who are not poor – all within a parliamentary democracy. Reducing those rents by raising power tariffs or having the private sector provide electricity, even if it violates the principles of equity – they are already violated in the existing system – may be the only way of improving electricity services to the poor. India is already moving in this direction.

Third, better information – that makes citizens more aware of the money allocated to their services, the actual conditions of services, and the behaviour of policymakers and providers – can be a powerful force in overcoming clientelist politics. The role of a free and vibrant press and improving the level of public discourse cannot be overstated.

## Homogeneous or Heterogeneous Clients?

The answer to this question depends on the service. Students with disabilities have special needs for quality education but not for immunisation. Heterogeneity is also defined by regional or community preferences. Whether a girl goes to school may depend on whether there are separate latrines for boys and girls. If that depends on local preferences, the village should have a say in design. Previously homogeneous societies, such as Sweden and Norway, are changing with increased immigration. They are giving more discretion to local communities in tailoring the education system to suit the linguistic abilities of their members.

The more that people differ in their desires, the greater the benefits from decentralising the decision. In the most extreme case – when individual preferences matter – the appropriate solution will involve individual choices of service (if there is the possibility of competition) and such interventions as cash transfers, vouchers, or capitation payments to schools or medical providers. If there are shared preferences, as in education, or free-rider problems as in sanitation, the community is the correct locus of decision-making, as in the Sant Gadge Baba community sanitation scheme in Maharashtra. The appropriate policy will then involve local-government decisions in a decentralised setting – or depending on political realities, community decisions (as for social investment funds) and user groups (such as parents in school committees).

## Easy or Hard to Monitor?

Services can be distinguished by the difficulty of monitoring service outputs. The difficulty depends on the service and on the institutional capacity of government to do the monitoring. At one extreme are the services of teachers in a classroom or doctors in a clinic. Both transactions allow much discretion by the provider that cannot be observed easily. A doctor has much more discretion in treating a patient than an electrician switching on a power grid. And it is difficult to know when high-quality teaching or health care is being provided. It may be possible to test students. But test scores tell very little about the teacher's ability or effort, since they depend at least as much on students' socio-economic status or parental involvement. More easily monitored are immunisations and clean latrines – all measurable by a quantitative, observable indicator.

Of course it depends on who is doing the monitoring. Parents can observe whether the teacher is in attendance, and what their children are learning, more easily than some central education authority. Better management information systems and e-government can make certain services easier to monitor. And monitoring costs can be reduced by judicious choice of providers

– such as some NGOs, which may be trustworthy without formal monitoring. In short, the difficulty of monitoring is not fixed: it can vary over time and with policies.

## Eight Sizes Fit All...

Now examine different combinations of these characteristics, to see which service delivery arrangement would be a good fit – and which would be a misfit (Figure 7). To be sure, none of the characteristics can be easily divided into such clean categories, because countries, regions, and services lie on a continuum. Even so, by dividing the salient characteristics, and looking at various combinations, the 'eight sizes fit all' approach can be applied to the considerations spelled out earlier.

*Central government financing with contracting (1)*: In a favourable political context, with agreement on what government should do, an easy-to-monitor service such as immunisation could be delivered by the public sector, or financed by the public sector and contracted out to the private or nonprofit sector, as with primary health centres in Cambodia [World Bank 2003b: Spotlight on Cambodia]. Infrastructure services could be managed by a national utility or provided by the private sector with regulatory oversight.

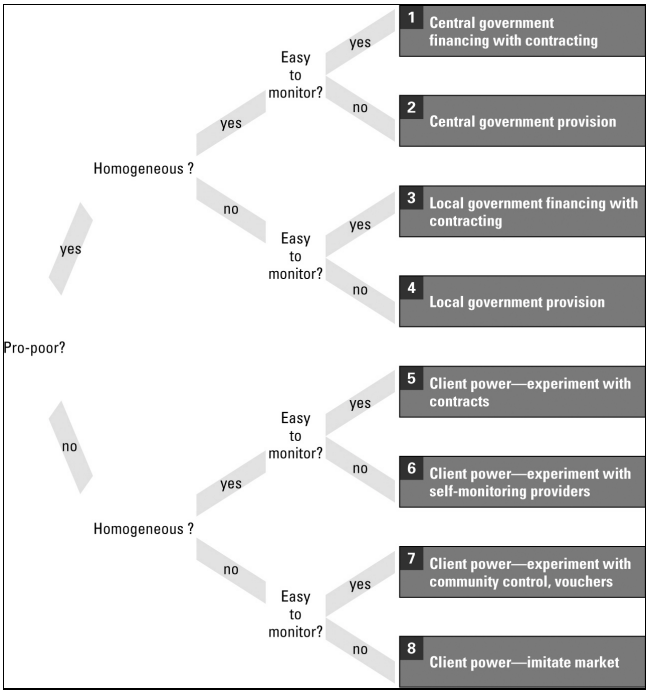
Note that the particular configuration in which this arrangement will work is special. In the developed countries there is much discussion of a set of reforms, started in New Zealand, that involve greater use of explicit contracts – either from the government to the private sector, or from central ministries to the ministries responsible for specific services. The New Zealand reforms are justified by a well-established public sector ethos, reasonable management information systems, and supporting institutions, including legal systems, to allow contract enforcement. These features increase the 'monitorability' of certain services by reducing the gap between contracted and realised outcomes.

These preconditions do not exist in many developing countries, so the template of these reforms cannot be used mechanically [Schick 1998]. If there is no good legal system and the civil service is subject to bribes (a form of clientelist politics), private sector contracts might be a major source of corruption. In these countries, government should perhaps be even more output-oriented – not as a means of tweaking a well-functioning system but as a way of getting the system to provide much greater improvements in services and generating new information.

*Central government provision (2):* When the service is difficult to monitor – explicit contracts are difficult to write or enforce – but the politics are pro-poor and clients homogeneous, the traditional, centralised public sector is the appropriate delivery system. The French education system, which administers a uniform service centrally, is one of the best examples.[3] But too many countries fall into the trap of thinking that just because the service is difficult to monitor, it must be delivered by the government. When students are heterogeneous, when the politics of the country are not geared toward poor people, government control of the education system – with no participation by students, parents, or local communities – can leave the poor worse off. Examples of this thinking and the resulting poor service delivery for poor people abound in south Asia.

*Local government financing with contracting (3):* With heterogeneous preferences, local governments should be involved in services. When local politics are pro-poor (but national politics aren't), local governments could be more reliable financiers of services, and vice versa. Easily monitored services such as water or electricity can be contracted out to public or private utilities, as in Johannesburg.

**Figure 7: Eight Sizes Fit All?**




*Local government (or deconcentrated central government) provision (4):* For difficult-to-monitor services, such as education (for quality), management responsibility might be ceded to parent groups when the politics are conducive, as in the Educo programme. Giving clients a choice through vouchers enables them to express their heterogeneous preferences. And the competition created by clients having a choice may improve service quality – as with water vouchers in Chile or sanitation vouchers in Bangladesh.

*Client power (5, 6, 7, 8):* When publicly financed services are subject to capture – the politics are not pro-poor – the best thing to do is to strengthen the client's power as much as possible. But that can be difficult. Even means-tested voucher schemes or subsidies could be diverted to the non-poor. Transparent, rule-based programmes, such as Progresa in Mexico, are needed to make it difficult to hide middle-class capture.

In services such as water and electricity, governments intervene to regulate monopoly providers and protect the poor – and not because there are significant externalities. So separating the policy-maker from the provider, and making the provider accountable to the client through prices, can strengthen client power and lead to better results. Poor people can be protected from high prices if charges rise with use (with an initial, free amount). Allowing small, independent water providers to compete with the local monopoly can also discipline provision and keep prices down.

But prices – without accompanying subsidies or transfers to poor people – cannot be used to strengthen client power in education because of the externalities in primary education. A market-based allocation would not be in society's interest. The same applies to health services with externalities, such as immunisation. In curative health care, the asymmetry of information between client and provider makes strengthening client power problematic. Better information on preventive care or on

how to choose medical providers (possibly disseminated by non-profit organisations) can ameliorate the problem. In extreme cases, it may be that only community groups or altruistic non-profits can effectively provide these services to poor people [Leonard 2002].

These service delivery arrangements represent efforts to balance problems with the long route of accountability (clientelist politics, hard-to-monitor services) with the short route. The reason societies choose the long route is that there are market failures or concerns with equity that make the traditional short route – consumers' power over providers – inadequate. But the 'government failures' associated with the long route may be so severe that, in some cases, the market solution may actually leave poor people better off.

## ...With Adjustable Waistbands

The foregoing simplified scheme captures only part of the story. At least two features are left out.

*Failed states:* Countries or subnational states where the state is failing (often countries in conflict or states with massive misgovernance) need service delivery arrangements different from those where the state is fairly strong. Primary school completion rates in Senegal and the Democratic Republic of Congo are about 40 per cent. In Senegal – a stable democracy – the reforms in education, including those that strengthen client-provider links, would go through the government (to strengthen the policymaker-provider links as well). In the Democratic Republic of Congo – where conflict has significantly weakened the state – ways should be found to empower communities to improve education services – even if it means bypassing government ministries in the short to medium term. Social funds and community-driven development are examples. They can be effective in improving service outcomes, but concerns about their sustainability and scalability – and whether they crowd out the growth of local government capacity – should not be overlooked.

*History:* The country's or a state's history can also have a bearing on which service delivery arrangements are likely to succeed. Until the 19th century, the education systems of Britain and France were private and the church was the dominant provider. The government had an incentive to develop an oversight mechanism to ensure that the schools taught more than just religion. That proved valuable when education was nationalised in these countries: the systems continued to run with strong regulatory oversight.

Water providers in the Netherlands started as private companies, making the concept of water as an economic good, and charging for it, acceptable. When the system was shifted to municipal ownership, pricing remained. Even if the Dutch never introduce private participation in water, they have achieved the separation between policymaker and provider. In sum, a country's or a state's history can generate the incentives for certain institutions to develop – and those institutions can make the difference in whether a particular service arrangement succeeds or fails.

## Sectoral Service Reforms

What do these conclusions tell us about the reform agenda in individual sectors? In education there is a trade-off between the need for greater central authority to capture societywide benefits, such as social cohesion, and the need for greater local influence because student learning is difficult to monitor at the central level. The trade-off is sharper when the concern is the quality of education rather than the quantity. In Indonesia centralised public delivery of education has enrolled children in schools, but it has been less successful in teaching them valuable skills. To increase the quality of education, therefore, reforms should concentrate on increasing the voice and participation of clients – but not neglect the importance of central government oversight. In practical terms, this would call for more community management of schools and demand-side subsidies to poor people, but with continuing stress on nationally determined curricula and certification.

Governments intervene in health to control communicable diseases, protect poor people from impoverishing health expenditures, and disseminate information about home-based health and nutrition practices. Each of these activities is different, yet they are often provided by the same arrangement, such as a central government public health system. They should be differentiated.

– Information about hand washing, exclusive breastfeeding, and nutrition can be delivered (and even financed) by NGOs and other groups, delivery that works best when reinforced by the community.

– Outreach services, such as immunisations, can be contracted out but should be publicly financed.

– Clinical care is the service the client is least able to monitor, but the case in which government failures might swamp market failures. Where the politics are extremely pro-rich, even public financing of these services (with private provision) can be counterproductive for poor people. The non-poor can capture this financing, leaving no curative services for the poor – and no room in the budget for public health services. Strengthening client power, through either demand-side subsidies or co-payments, can improve matters for poor people, even if there is asymmetric information between client and provider.

In the infrastructure sectors – such as water, sanitation, transport, and energy – the rationale for government intervention is different from that in education and health, and so should be the policy responses. The main reason for government involvement in water and energy provision is that those services are provided through networks, so direct competition is not possible. Governments also intervene to ensure access by poor people to these services. So the role of government is to regulate and in some cases subsidise production and distribution. There are few advantages to the government's providing the service itself, which explains why the past decade has seen many privatisations, concessions, and the like in water and energy.

Whether delivered by a private or public company, the service needs to be regulated. Who that regulator is will determine service outcomes. At the very least, when the company is public, the regulator should be separate from the provider (when the policymaker and provider are indistinguishable, making this separation is all the more difficult). The situation is worse when water or energy is subsidised, because the sizeable rents from this subsidy – the benefits of below-market-rate services – can be captured by politicians, who use them to curry favour with their rich or middle-class clients rather than the poor.

Sanitation is different because individuals can offload their refuse onto their neighbours. So subsidies to individual households will not solve the collective action problem. Instead, using community-level subsidies, and giving communities the authority

to allocate them, puts the locus of authority where the external effects of individual behavior can be contained.

## Scaling Up

How can all these reforms be scaled up so that developing countries in general, and India in particular, will have a chance of meeting the MDGs? First, as noted at the beginning of this paper, additional resources – domestic and external – will be needed to capitalise on these reforms. Second, these reforms must be embedded in a public sector responsible for ensuring poor people's access to basic services. This means that the sectoral reforms must be linked to ongoing (or nascent) public sector reforms in such areas as budget management, decentralisation, and public administration reform. It also means that a well-functioning public sector is a crucial underpinning of service delivery reform.

Third, a recurring theme in this paper is what information can do – as a stimulant for public action, as a catalyst for change, and as an input for making other reforms work. Even in the most resistant societies, the creation and dissemination of information can be accelerated. Surveys of the quality of service delivery conducted by the Public Affairs Centre in Bangalore have increased public demand for service reform. The surveys have been replicated in 24 Indian states. The public expenditure tracking survey in Uganda is another example, as is the PROBE report on India's education system. Recent teacher – and health worker – absence studies in India and Bangladesh are beginning to trigger an active discussion among policymakers and the public on possible solutions to this multifaceted and institutionally complex problem.

Beyond surveys, the widespread and systematic evaluation of service delivery can have a profound effect on progress toward national human development goals or the MDGs. Evaluations based on random assignments, such as Mexico's Progresa, or other rigorous evaluations give confidence to policymakers and the public that what they are seeing is real. Based on the systematic evaluations of Progresa, the government has scaled up the programme to encompass 20 per cent of the Mexican people. A remedial education programme, organised by the government and an NGO, hired local women in Vadodara and Mumbai to teach catch-up classes for students who were falling behind. The programme was inexpensive – less than Rs 250 a child a year. A rigorous evaluation based on the randomised design of the programme found it to be very effective at boosting learning, especially among poorer children. At the margin, extending the programme would be five times more cost-effective than hiring new teachers. The programme is implemented now in 20 Indian cities, reaching tens of thousand of children [Banerjee 2003].

The benefits of systematic programme evaluation go beyond the programme and the country. These evaluations tell policymakers in other countries what works and what doesn't. They are global public goods – which might explain why they are so scarce.[4] If these evaluations are global public goods, the international community should finance them. One possibility would be to protect the 1.5 per cent of World Bank loans that is supposed to be used for evaluation (but rarely is), so that this sum – about $ 300 million a year – could be used to administer rigorous evaluations of projects and disseminate the results worldwide.

In addition to creating and disseminating information, other reforms to improve service delivery will require careful consideration of the particular setting. There is no silver bullet to improve service delivery. It may be known how to educate a child or stop an infant from dying. But institutions are needed that will educate a generation of children or reduce infant mortality by two-thirds. These do not crop up overnight. Nor will a single institutional arrangement generate the desired results. Everything from publicly financed central government provision to user-financed community provision can work (or fail to work) in different circumstances.

Rather than prescribe policies or design the optimal institution, the *2004 World Development Report* describes the incentives that will give rise to the appropriate institution in a given context. Decentralisation may not be the optimal institutional design. But it may give local governments the incentives to build regulatory capacity that, in turn, could make water and energy services work better for poor people. NGO service provision might be effective in the medium run, as it has been in education in Bangladesh. But the incentives it creates for the public sector to stay out of education make it much harder to scale up or improve quality – as Bangladesh is discovering today. Many of these institutions cut across the public sector – budgetary institutions, intergovernmental relations, the civil service – which reinforces the notion that service delivery reform should be embedded in the context of public sector reform.

In addition to looking for incentives to generate the appropriate institutions, governments should be more selective in what they choose to do. The experience with service delivery teaches us the importance of implementation. Singapore and Nigeria (both former British colonies) have similarly designed education systems. But in implementation, the outcomes, especially for poor people, could not be more different. Governments and donors often overlook implementation difficulties when designing policies. There may be benefits to having the central government administer schools (such as social cohesion). But the problems with central provision of a hard-to-monitor activity such as primary education are so great, especially among heterogeneous populations, that the government should rethink its position of centrally controlled schools.

That there is no silver bullet, that we should be looking for incentives that give rise to appropriate institutions, that we need to be more realistic about implementation in choosing among options – all imply that these reforms will take time. Even if we know what is to be done, it may be difficult to get it done. Despite the urgent needs of the world's poor people, and the many ways services have failed them, quick results will be hard to come by. Many of the changes involve fundamental shifts in power – something that cannot happen overnight. Making services work for poor people requires patience. But that does not mean we should be complacent. Hubert Lyautey, the French marshal, once asked his gardener how long a tree would take to reach maturity. When the gardener answered that it would take 100 years, Marshal Lyautey replied, "In that case, plant it this afternoon". EPW

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## Notes

[The authors are part of the research team that wrote the 2004 World Deevlopment Report on Making Services Work for Poor People, on which this paper is based. The findings, interpretations, and conclusions expressed

in this paper are entirely those of the authors and do not necessarily represent the views of the institution to which the authors are affiliated.]

1 Taking the world as a whole hides the fact that sub-Saharan Africa is off track in reaching the income poverty goal.

2 Even a recommendation to apply those interventions that pass a social benefit-cost analysis test will not be enough. Social benefit-cost analysis is concerned with valuing an intervention's outputs and inputs at the right set of shadow prices [Bell and Devarajan 1987, Dreze and Stern 1987]. Yet the problem is that the inputs often do not translate to the desired output because of weak incentives. The same point applies to recommendations of using 'cost-effective' interventions in health World Bank (1993).

3 Realising that the central education system has led to under-representation of students from low-income families, one of the prestigious French grandes écoles, Ecole polytechnique ('Sciences Po') has begun to use separate admissions criteria for students from poor neighbourhoods.

4 Another reason is that most project managers are not interested in investing in knowledge that might show their programme to have been a failure.

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