world development report 2004

Overview

Making Services Work for Poor People

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Contents of the World Development Report 2004

*These spotlights are reprinted at the end of the overview text.

Overview

I go to collect water four times a day, in a 20-liter clay jar. It's hard work! . . . I've never been to school as I have to help my mother with her washing work so we can earn enough money. . . . Our house doesn't have a bathroom. . . . If I could alter my life, I would really like to go to school and have more clothes.

Elma Kassa, a 13-year-old girl from Addis Ababa, Ethiopia

Too often, services fail poor people—in access, in quantity, in quality. But the fact that there are strong examples where services do work means governments and citizens can do better. How? By putting poor people at the center 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. Scaling up will require both a substantial increase in external resources and more effective use of all resources, internal and external. As resources become more productive, the argument for additional resources becomes more persuasive. And external resources can provide strong support for changes in practice and policy to bring about more effective use. The two are complementary—that is the essence of the development partnership that was cemented in Monterrey in the spring of 2002.

The *World Development Report 2004* builds an analytical and practical framework for using resources, whether internal or external, more effectively by making services work for poor people. We focus on those services that have the most direct link with human development—education, health, water, sanitation, and electricity.

Governments and citizens use a variety of methods of delivering these services—central government provision, contracting out to the private sector and nongovernmental organizations (NGO)s, decentralization to 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. Foreign-aid donors should reinforce the accountability in these relationships, not undermine it.

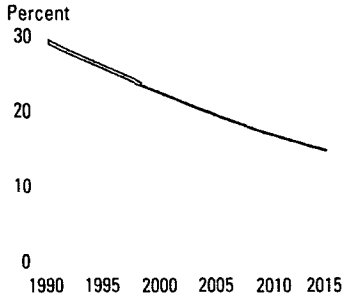
Increasing poor clients' choice and participation in service delivery will help them monitor and discipline providers. Raising poor citizens' voice, through the ballot box and widely available information, can increase their influence with policymakers—and reduce the diversion of public services to the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

Innovating with service delivery arrangements will not be enough. Societies should learn from their innovations by systematically evaluating and disseminating information about what works and what doesn't. Only then can the innovations be scaled up to improve the lives of poor people around the world.

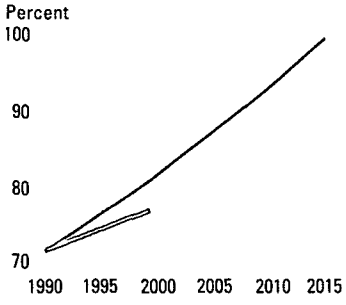
The challenge is formidable, because making services work for poor people involves changing not only service delivery arrangements but also public sector institutions. It also involves changing the way much foreign aid is transferred. As governments, citizens, and donors create incentives for these changes, they should be selective in the problems they choose to address. They should be realistic about implementation difficulties. And they should be patient.

Figure 1 Progress in human development: off track

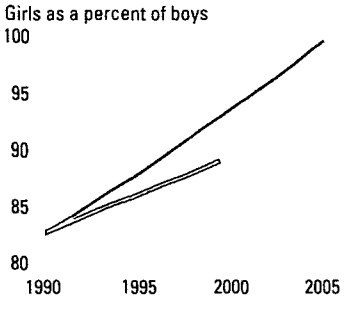
People living on less than $1 a day



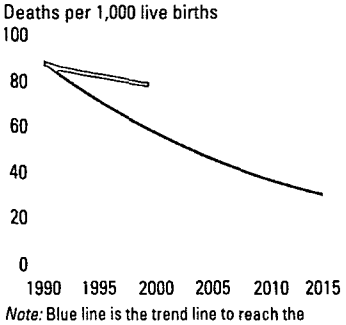
Primary school completion rate



Ratio of girls to boys in primary and secondary school



Under-five mortality rate



Note: Blue line is the trend line to reach the Millenium Development Goal. The red line shows the actual progress to date.
Source: www.developmentgoals.org.

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, the international community's unprecedented agreement on the goals for reducing poverty (box 1). The multidimensional nature of poverty is also reflected in the World Bank's two-pronged strategy for development—investing in people and improving the investment climate. That five of the eight goals and one of the two prongs of the strategy for development 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 goals for primary education, gender equality, and child mortality.

To reach all of these goals, economic growth is essential. But it will not be enough. The projected growth in per capita GDP 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 enrollment goal and none of them to reach the child mortality goal. If the economic growth projected for Africa doubles, the region will reach the income poverty goal—but still fall short of the health and education goals. In Uganda, despite average annual per capita GDP growth of 3.9 percent in the past decade, child mortality is stagnating—and only partly due to the AIDS epidemic.[2]

Because growth alone will not be enough to reach the goals, the international community has committed itself—in a series of recent meetings in Monterrey, Doha, and

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 living on 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 behavior, 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 all the Millennium Development Goals

		People living on less than $1 a day		Primary school completion rate		Under-five mortality	
	Annual average GDP per capita growth 2000–2015* (percent per year)	Target (percent)	2015 growth alone (percent)	Target (percent)	2015 growth alone (percent)	Target (per 1,000 births)	2015 growth alone (per 1,000 births)
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

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

Johannesburg—to greater resource transfers by developed countries and better policies and institutions in developing countries. The level of resource transfers is difficult to calculate precisely. Some estimates are converging around a figure of $40 billion to $60 billion a year in additional foreign aid—so long as the money is accompanied by policy and institutional reforms to enhance the productivity of domestic and external resources.[3]

Focusing on the human development goals, this Report describes the reforms in services needed to achieve them. 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 Armenia and Cambodia, child mortality rates for the poorest fifth of the population are two to three times those for the richest fifth. Only about 60 percent of the adolescents in the poorest fifth of the population in the Arab Republic of Egypt and Peru have completed primary school, while all those from the richest fifth have (figure 2).

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.

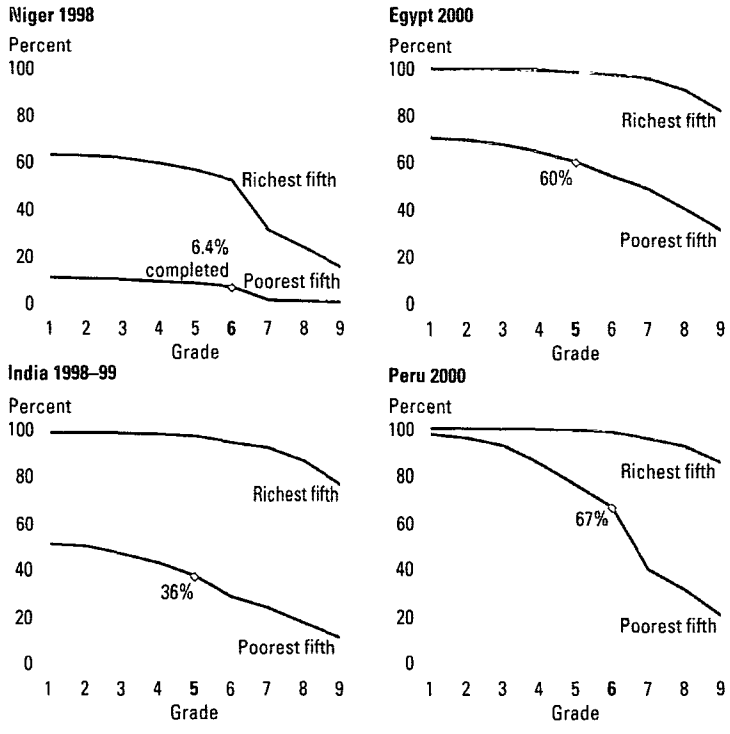
Services are failing poor people in four ways

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, they spend very little of it on poor people—that is, on the services poor people need to improve their health and education. Public spending on health and education is typically enjoyed by the nonpoor (figure 3). In Nepal 46 percent of education spending accrues to the richest fifth, only 11 percent to the poorest. In India the richest fifth receives three times the curative health

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 neighbor'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, 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.

Figure 2 The poor are less likely to start school, more likely to drop out
15- to 19-year olds who have completed each grade or higher



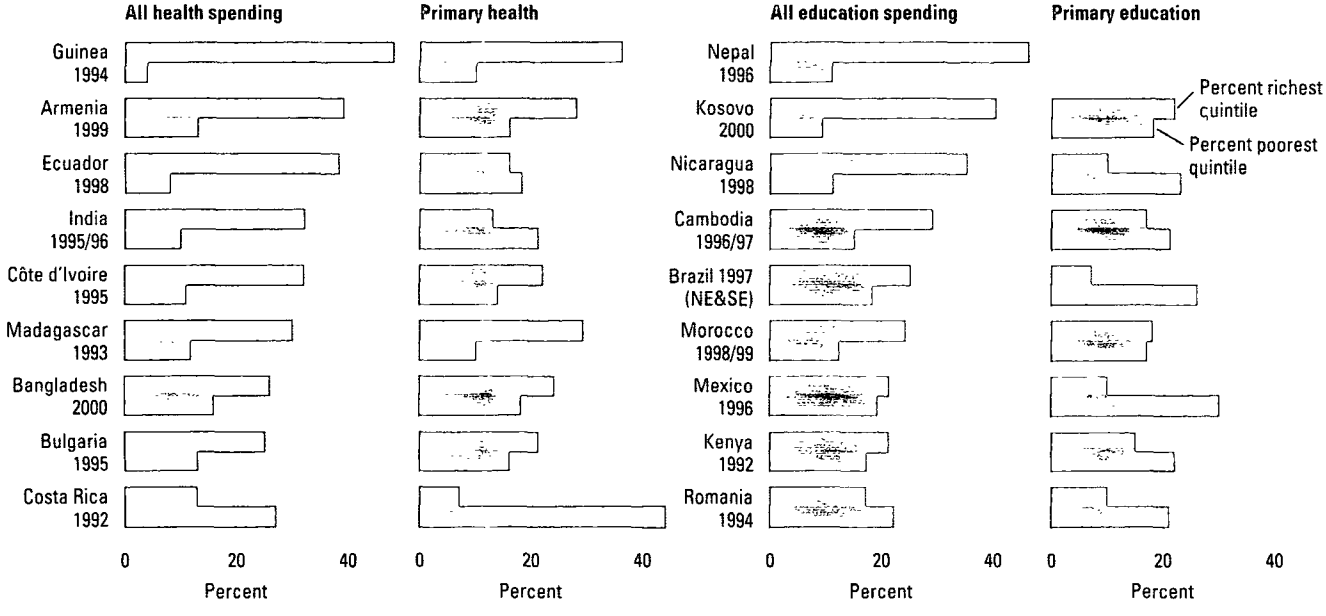
Note: The grade number boldfaced denotes the end of the primary cycle (grade 5 for Egypt and India; grade 6 for Niger and Peru).
Source: Analysis of Demographic and Health Survey data.

care subsidy of the poorest fifth.[4] Even though clean water is critical to health outcomes, in Morocco only 11 percent of the poorest fifth of the population has access to safe water, while everybody in the richest fifth does (figure 4).

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 percent. This was the average: poorer schools received well below the average.[5]

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. A survey of primary health care facilities in Bangladesh found the absentee rate among doctors to be 74 per-

Figure 3 More public spending for the rich than for the poor
Share of public spending that accrues to the richest and poorest fifths



Source: Compiled from various sources by World Bank staff.

cent.[6] When present, some service providers treat poor people badly. "They treat us like animals," says a patient in West Africa.[7]

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—and with few resources—clinics without drugs, classes without textbooks.[8] 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 work force.

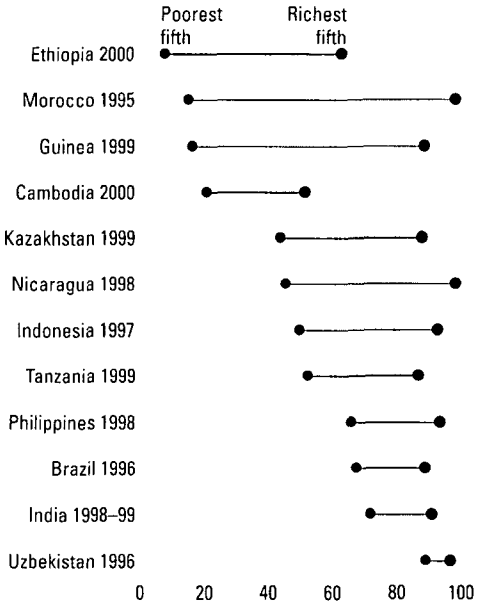
The fourth way services fail poor people is the lack of demand. Poor people often don't send their children to school or take them to a clinic. In Bolivia 60 percent of the children who died before age five had not seen a formal provider during the illness culminating in their death. Sometimes the reason is the poor quality of the service—missing materials, absent workers, abusive treatment. At other times it is because they are poor. Even when the services are free, many poor rural families cannot afford the time it takes to travel the nearly 8 kilometers to the nearest primary school in Mali or the 23 kilometers to the nearest medical facility in Chad.[9]

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 (70 percent of nurses and midwives in rural Niger had been 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.

Figure 4 Water, water everywhere, nor any drop to drink
Percent of households who use an improved water source, poorest and richest fifths



Note: The poorest fifth in one country may correspond to the standard of living in the middle fifth in another country. Within-country inequalities reflect inequality in access to water and in the variable used to construct quintiles. An "improved" water source, as defined by UNICEF, provides adequate quality and quantity of water (that is, a household connection or a protected well, not an unprotected well or bottled water).
Source: Analysis of Demographic and Health Survey data.

- Some governments contract services out—to the private sector, to nongovernmental organizations (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.[10] 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. Privatizing water in Cartagena, Colombia, improved services and access for the poor. A similar

sale in Tucuman, Argentina, led to riots in the streets and a reversal of the concession. Overall, though, privatizing water in Argentina, by expanding access of poor communities to clean water and sewage treatment, appears to have had a favorable effect on health. One study estimates that it prevented about 375 deaths of young children a year.[11]

- 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 redistribution sometimes outweighing the benefits from greater local participation. Local-government delivery of infrastructure in South Africa improved service provision in a short time.[12] But decentralizing social assistance in Romania weakened the ability and incentives of local councils to deliver cash transfers to the poor.[13] The program is now being recentralized.
- Responsibility is sometimes transferred to communities—or to the clients themselves. El Salvador's Community-Managed Schools Program (Educo) gives parents' associations the right to hire and fire teachers. That, plus the monthly visits to the schools by the parents' associations, has reduced teacher—and student—absenteeism, improving student performance.
- Still other programs transfer resources and responsibility to the household. Mexico's Education, Health, and Nutrition Program (Progresa) gives cash to families if their children are enrolled in school and they regularly visit a clinic. Numerous evaluations of the program show consistently that it increased school enrollment (eight percentage points for girls and five for boys at the secondary level) and improved children's health (illness among young children fell 20 percent).[14]

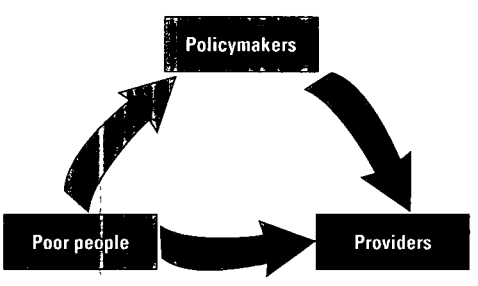
With all these innovations, of course, comes the challenge of understanding what works—where, how, and why—so that, with enough resources, successful results can be replicated on a broad scale.

The framework of relationships—between clients, providers, and policymakers

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, and the relationships between them examined (figure 5). Poor people—as patients in clinics, students in schools, travelers on buses, consumers of water—are the clients of services. They have a relationship with the front-line providers, with schoolteachers, doctors, bus drivers, water companies. Poor people have a similar relationship when they buy something in the market, such as a sandwich (or a samosa, a salteña, a shoo-mai). 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 sandwich; and if he is dissatisfied, he has power over the provider with repeat business or, in the case of fraud, with legal or social 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 (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.

Figure 5 The framework of accountability relationships



Consider the first of the two relationships along the long route—the link between poor people and policymakers or politicians (figure 5). Poor people are citizens. In principle, they contribute to defining society's collective objectives and they try to control 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.

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 Program, in which schools receive a grant based on the number of girls they enroll) enable clients to exert influence over providers through choice. El Salvador's Educo program and Guinea's revolving drug scheme (where co-payments inspired villagers to stop theft) are ways for client participation to improve service provision (see the spotlight on Educo).

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—stronger voice

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 ideological lines, placing less weight on public services when evaluating politicians; or they may not believe the candidates who promise better public services—because their term in office is too short to deliver on the promise—and they vote instead for candidates who provide ready cash 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 to the suburbs.[15]

In 1989 Mexico introduced PRONASOL (Programa Nacional de Solidaridad, or National Solidarity Program), a poverty alleviation program that spent 1.2 percent of GDP annually on water, electricity, nutrition, and education construction in poor communities. Assessments of the six-year program found that it reduced poverty by only about 3 percent. Had the budget been distributed to maximize its impact on poverty, the expected decline would have been 64 percent with perfect targeting. It would have been 13 percent 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 6).[16]

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 has reduced

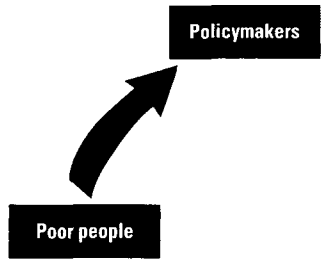
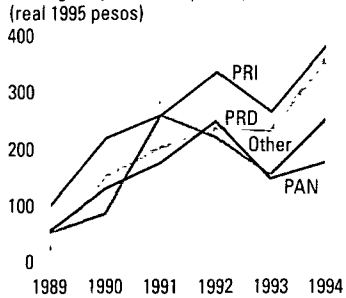


Figure 6 It paid to vote for PRI
PRONASOL expenditures according to party in municipal government



Note: PRI = Institutional Revolutionary Party; PRD = Party of the Democratic Revolution; PAN = National Action Party.
Source: Estévez, Magaloni, and Diaz-Cayeros (2002).

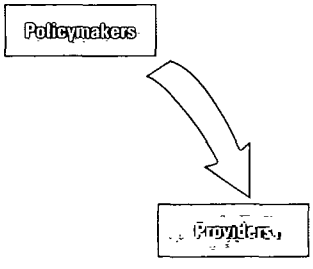
infant mortality dramatically, and achieved nearly universal primary enrollment. To be sure, in China, cases during the earliest phase of the outbreak of severe acute respiratory syndrome (SARS) in 2002 were not openly reported, thus making its further spread almost inevitable.[17] And Cubans, who had high levels of health and education in the 1950s, remain poor on other dimensions.

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."

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.

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 percent of recurrent spending for primary education was arriving in primary schools, it launched a monthly newspaper campaign on the transfer of funds. That campaign galvanized the populace, inducing the government to increase the share going to primary schools (now over 80 percent) 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.[18] The more people who can read, the stronger the influence of the media. In Kerala, India, this led to a virtuous cycle of literacy leading to better public services, which raised literacy even more.



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, India, know that government services are dismal, and know that everyone else knows that—and yet most do not feel free to complain.[19]

Policymakers and providers—stronger compacts

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, 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 privatizing water incites riots in the streets of Cochabamba.

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 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 penalized depending on performance. The compact may be an explicit contract with a private or nonprofit organization—or between tiers of government, as in Johannesburg, South Africa (see the 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, India, 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.[20] The separation usually happens because of a fiscal crisis (Johannesburg), a major political change (decentralization 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.[21]

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 percent less than government and private for-profit staff, and yet provide a significantly higher quality of care than the public sector.[22] 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 percent).[23] 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, India, 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.[24]

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 program 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—more choices, more participation

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.[25] 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' enrollment in many 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 came from the weekly visits of the community education association to schools. Each additional visit

reduced student absenteeism (due to teacher absenteeism) by 3 percent.[26]

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 enroll creates implicit competition among schools for students, increasing students' choice.

School voucher programs—as in Bangladesh, Chile, Colombia, Côte d'Ivoire, and the 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.[27] When the voucher is restricted to poor or disadvantaged groups, the effects are better.[28] The Colombian program showed lower repetition rates and higher performance on standardized tests for students participating in the scheme—with the effect for girls higher than that for boys.[29] Even in network systems such as urban water provision, it is possible to give poor communities choice—by allowing the poor to approach independent providers, introducing flexibility in service standards such as lifeline rates, 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, India, 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."[30]

Donors and recipients—strengthening accountability, not undermining it

Improving service outcomes for poor people requires strengthening the three relationships in the chain—between client and provider, between citizen and policymaker, and between policymaker and provider. In their zeal to get services to the poor, donors often bypass one or more of these relationships. The typical mode of delivering aid—a project—is often implemented by a separate unit outside the compact, bypassing the relationship between policymakers and providers. The project is typically financed by earmarked funds subject to donor-mandated fiduciary requirements. It and other donor initiatives, including global "funds," bypass the citizen-policymaker relationship where the budget is concerned. To be sure, when the existing relationship is dysfunctional, it may be necessary to go around it. But the cases where the benefits outweigh the costs are probably fewer than imagined.

Recognizing the gap between ends and means, some donors and recipients try to use foreign aid to strengthen, not weaken, the links in the service delivery chain. One

approach is to incorporate donor assistance in the recipient's budget, shifting to the recipient's accountability system. In Uganda assistance from Germany, Ireland, the Netherlands, Norway, the United Kingdom, and the World Bank is all part of the country's budget, the outcome of a coordinated and participatory process.

Another approach is for donors to pool their assistance in a single "pot" and to harmonize their fiduciary standards around that of the rest of the government. The sectorwide approach (SWAp) to health, education, transport, and other sectors is a step in this direction. Possibly the biggest payoff comes when donors help generate knowledge—as when donor-financed impact evaluation studies reveal what works and what doesn't in service delivery, or when donors pool technical assistance resources at the retail level, as in the multidonor Water and Sanitation Program. Knowledge is essential to scaling up service delivery. Although it emerges locally, it is a global public good—precisely what aid is designed to finance.

What not to do

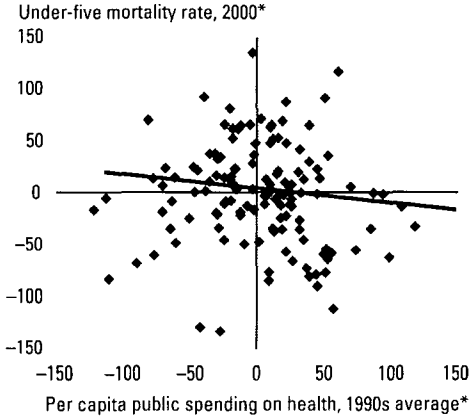
The picture painted so far of the difficulties in government-led service delivery may lead some to conclude that government should give up and leave everything to the private sector. That would be wrong. If individuals are left to their own devices, they will not provide levels of education and health that they collectively desire (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 is clearly not desirable.

Some aid donors take a variant of the "leave-everything-to-the-private-sector" position. If government services are performing so badly, they say, why give more aid to those governments? That would be equally wrong. There is now substantial research showing that aid is productive in countries with good policies and institutions, and those policies and institutions have recently been improving.[31] The reforms detailed in this Report (aimed at recipient countries and aid agencies) can make aid even more productive. When policies and institutions are improving, aid should increase, not decrease, to realize the mutually shared objective of poverty reduction, as specified in the Millennium Development Goals.

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.

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 7). That is not surprising: most public spending on health and education goes to the non-poor, much of it fails

Figure 7 Increased public spending is not enough



*Public spending and child mortality are given as the percent deviation from 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: GDP per capita and public spending data, World Development Indicators database; under-five mortality, UNICEF.

to reach the frontline service provider, and service providers face weak incentives to deliver services effectively.

Linked to the "simply increase public spending" approach is one that advocates for more foreign aid without accompanying measures to improve the productivity of foreign aid. This can be just as misleading—and not just for the same reasons that simply increasing public expenditure is misleading. Sometimes the modes of delivering foreign aid, by undermining rather than strengthening service delivery in the recipient country, can reduce the productivity of public spending in the medium run.

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 schoolchildren, 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.[32] Lack of knowledge about the right technical solution is probably not the binding constraint. What is needed is a set of institutional arrangements that will give policymakers, providers, and citizens the incentives to adopt the solution and adapt it to local conditions.

yes

What can be done?

Pro-poor?

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 immunization campaigns.

no

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 counterproductive—if there are serious problems elsewhere in the service delivery chain. In water 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 democratic local governments. Finally, countries, and regions within countries, vary enormously in the conditions that make service innovations work. A failed state mired in conflict 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 this Report, 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 geared toward pro-poor public services—and how much does it suffer from clientelist politics and corruption? This is the most difficult dimension for an outside actor, such as a donor, 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.
- 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 subsidized 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.

- Third, better information—that makes citizens more aware of the money allocated to their services, the actual conditions of services, and the behavior 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 immunization. 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 decentralizing 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 decisionmaking. The appropriate policy will then involve local-government decisions in a decentralized 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' socioeconomic status or parental involvement. More easily monitored are immunizations 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.

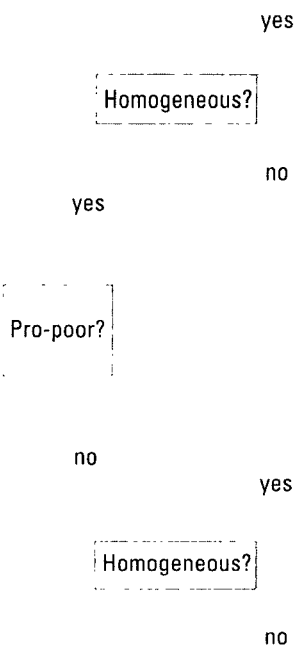
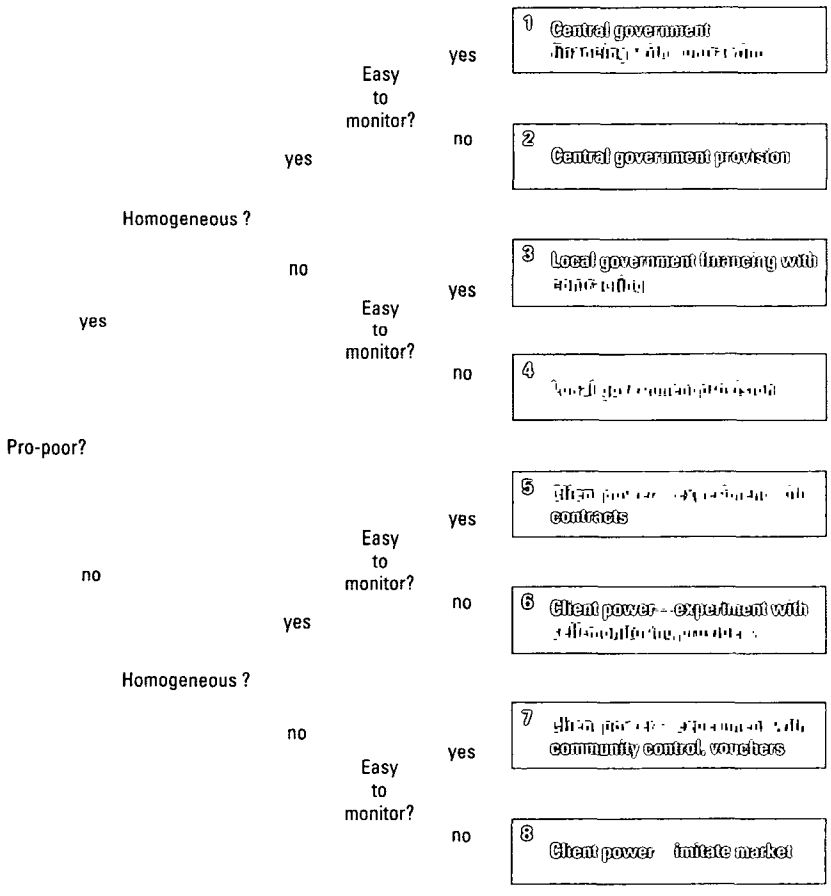


Figure 8 Eight sizes fit all?



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 8). To be sure, none of the characteristics can be easily divided into such clean categories, because countries 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 favorable political context, with agreement on what government should do, an easy-to-monitor service such as immunization could be delivered by the public sector, or financed by the public sector and contracted out to the private or nonprofit sector, as with primary health centers in 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 some 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 realized outcomes.

These preconditions do not exist in many developing countries, so the template of these reforms cannot be used mechanically.[33] 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, centralized public sector is the appropriate delivery system. The French education system, which administers a uniform service centrally, is one of the best examples.[34] 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.

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.

Local 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 program. 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 programs, 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 policymaker 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 immunization. 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 nonprofit organizations) can ameliorate the problem. In extreme cases, it may be that only community groups or altruistic nonprofits can effectively provide these services to poor people.[35]

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 where the state is failing (often countries in conflict) 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 percent. 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 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 nationalized 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 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 tradeoff 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 tradeoff is sharper when the concern is the quality of education rather than the quantity. In Indonesia centralized 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 immunizations, 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 subsidize production and distribution. There are few advantages to the government's providing the service itself, which explains why the past decade has seen many privatizations, 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 com-

pany 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 subsidized, because the sizable rents from this subsidy—the benefits of below-market-rate services—can be captured by politicians, who use them to curry favor with their rich clients rather than the poor.

Sanitation is different because individuals can offload their refuse onto their neighbors. 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 will have a chance of meeting the Millennium Development Goals? First, as noted at the beginning of this Report, additional resources—external and internal—will be needed to capitalize 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, decentralization, and public administration reform. It also means that a well-functioning public sector is a crucial underpinning of service delivery reform. In the same vein, there should be reform in donor practices—such as harmonizing procedures and making more use of budget support—to strengthen recipient countries' efforts to improve service outputs.

Third, a recurring theme in this Report 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, India have increased public demand for service reform. The surveys have been 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.

Beyond surveys, the widespread and systematic evaluation of service delivery can have a profound effect on progress toward the Millennium Development Goals. 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. Governments are constantly trying new approaches to service delivery. Some of them work. But unless there is some systematic evaluation of these programs, there is no certainty that they worked because of the program or for other reasons. Based on the systematic evaluations of Progresa, the government has scaled up the program to encompass 20 percent of the Mexican people.

The benefits of systematic program evaluation go beyond the program 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.[36] If these evaluations are global public goods, the international community should finance them. One possibility would be to protect the 1.5 percent 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.

BOX 3 *Why is this WDR different from all other WDRs?*

This *World Development Report* builds on previous WDRs while venturing into some new areas. Starting from the decennial WDRs on poverty, it applies the 2000 WDR's theme of empowerment to the 1990 WDR's emphasis on health and education as important ways of escaping poverty. In so doing, it extends the 1993 WDR on health—which prescribed a technical solution (cost-effectiveness analysis) to improving outcomes for poor people—by examining the institutional factors that may give rise to the correct technical solutions. It also complements the 1994 WDR on infrastructure—which presciently focused on private-sector participation in the sector—by addressing the politics of infrastructure provision for poor people. It expands on one aspect of the 1997 WDR on the role of the state—the state's responsibility for basic services. And it builds on the two most recent WDRs—on institutions for markets and institutions for collective action—by identifying the incentives for reforming institutions to make services work for poor people.

Rather than prescribe policies or design the optimal institution, this Report describes the incentives that will give rise to the appropriate institution in a given context (box 3). Decentralization 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. Selectivity is not just about choosing from the available design options—it is about choosing with an eye toward options that can be implemented.

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."

spotlight on *Cambodia*

Contracts to improve health services—quickly

Cambodia began experimenting with different forms of contracting to improve health services in 1998. The lesson—thanks to good evaluation—is that contracting can help increase the coverage of some key services in a short time.

More than 25 years of conflict left Cambodia with little health infrastructure. In the late 1990s its health indicators were among the worst in Southeast Asia. Average life expectancy at birth was less than 55 years. Infant mortality was 95 per 1,000 live births. And maternal mortality was 437 per 100,000 live births.[1] The public health care system remained rudimentary: average facility use was 0.35 contacts per person per year, and patients complained of very low quality.

Then in 1998 the government contracted with nongovernmental entities to provide health services in several districts. The contracting increased access to health services—and not at the expense of equity.

Contracting primary health care services(in and out)

Intervention and control areas consisted of randomly selected rural districts, each with 100,000 to 200,000 people.[2] Contractors were chosen through a competitive process based on the quality of their technical proposal and their price. Three approaches were used.

- *Contracting out.* Contractors had full responsibility for the delivery of specified services in the district, directly employed their staff, and had full management control (two districts).
- *Contracting in.* Contractors provided only management support to civil service health staff, and recurrent operating costs were provided by the government through normal government channels (three districts).
- *Control areas.* The usual government provision was retained (four districts).

A budget supplement was provided to contracted-in and control districts to make recurrent expenditures roughly equal in these districts.

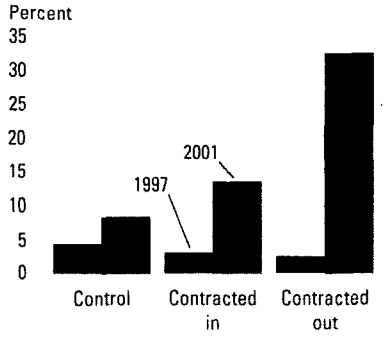
Performance indicators were measured for all the districts by household, and health facility surveys were conducted in 1997 before the experiment. No district had more than 20 percent of its planned health facilities functioning. All had very poor health service coverage. And all were comparable in their socioeconomic status.

Annual per capita recurrent spending by donors and government was higher in the contracted districts: $2.80 in the contracted-in district, $4.50 in contracted-out districts, compared with $2.90 in control districts.[3] These differences are large and represent less than 20 percent of the health expenditures (including private and excluding capital investments from the government) in all of the districts.

Contracting for better results

All districts improved service coverage in a short time. After only 2.5 years of the four-year experiment, all districts had achieved their contractual obligations for most of the evaluation indicators.[4] The use of health services among the poorest half of the populace increased by nearly 30 percentage points in the contracted-out district (figure 1). One possible explanation is that the contracted-out districts did not charge official user fees; they also discouraged health care workers from taking "unofficial" user fees by paying

Figure 1 Use of district health services increased most in districts that contracted out
Percentage of illnesses treated at a health facility for people in the poorest half of the populace



Source: Bhushan, Keller, and Schwartz (2002).

significantly higher salaries to providers than in the other types of districts.

The pattern of increases is similar across a variety of service and coverage indicators (figure 2). The contracted-out districts often outperformed contracted-in districts, which outperformed control districts. But not all indicators were as responsive. The share of deliveries assisted changed by only a small amount in all three districts. And there was no difference between contracted-in and contracted-out districts in the increase in vitamin A coverage. The level of immunization in contracted districts also remained quite modest, peaking at only 40 percent.

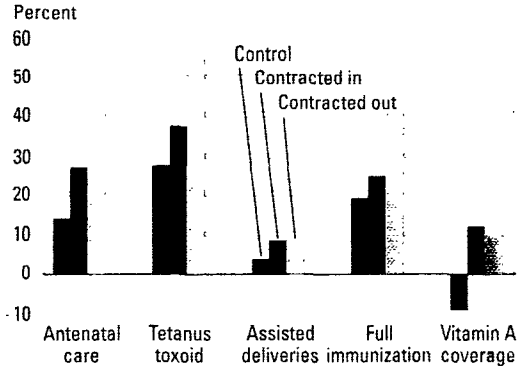
Out-of-pocket expenditures on health care services fell dramatically in the contracted-out districts but increased slightly in contracted-in and control districts. The reduction was especially marked among the poor ($35 a year, or 70 percent), indicating better targeting and more efficient transfers of subsidies.

Even though the health ministry encouraged all districts to implement official user fees, only one contracted-in district established a formal user fee system and used the receipts from the system to reward health care workers with monthly performance and punctuality bonuses. That could account for slightly higher spending for this type of district.[5]

There are several possible reasons for these pro-poor outcomes in the contracted districts.

- The regular availability of drugs and qualified staff strengthened service provision at health centers in the villages, where most poor people are concentrated.
- The contracted nongovernmental organizations (NGOs) used a market-based wage and benefits package to attract and retain health care providers.
- A reduction in the private out-of-pocket cost of services and a more predictable and transparent fee structure increased

Figure 2 Coverage for many services increased in contracted areas with variation across services
Percentage point increase in coverage of selected health indicators between 1997 and 2001 in control and contracted districts of Cambodia



Source: Bhushan (2003).

the demand for health care services by the poor.

- The availability of health services in villages reduced travel expenditures to seek health care, and NGOs enforced rules against informal payments by patients.

Agreements on deliverables—and enforceable contracts

Contracting health services to NGOs can expand the coverage for poor people. In Cambodia it took agreements on deliverables and an enforceable contract, which in turn required an independent performance verification system. Once targets for 13 key health indicators were agreed on—for poor people—progress toward achieving them was measured through independent household surveys and spot checks by government staff. Payments were linked to achieving targets, with bonuses for better-than-agreed-on performance.

Improving health services for the poor requires that health workers be adequately compensated and effectively supervised and supported. The NGOs working in contracted-out districts revised the salaries of health care providers, bringing them in line with average salaries in the private sector. In return, the NGOs required the providers to work full time in health facilities and to have no private practice.

In the contracted-in districts, the NGOs supplemented provider salaries with their own funds and, in one district, allocated a larger share of user-fee income. The control districts, left to their own devices, allowed workers to pursue private income-maximizing behavior through unofficial fees and private practice, to the detriment of the public health care services for the poorest of the poor.

Transparent and predictable fee structures are important in improving access to health services. Official user charges were introduced in only one contracted-in district, in consultation with communities, to provide incentives to health workers. To remove ambiguity about charges, a schedule of user fees was prominently displayed in all health facilities. This discouraged private practice and helped bring "under-the-table" payments formally into the system. Out-of-pocket spending on health fell in that district. No user fees were introduced in the other two contracted-in districts, or in the control districts, where out-of-pocket spending did not come down.

Contracting health services to NGOs can be difficult for policymakers to accept. But the Cambodian experience shows that it can be effective and equitable. It helped convince policymakers that the model could be adopted on a larger scale. They are extending contracting to 11 poor and remote districts, where the public provision of services is dismal.

spotlight on *Educo*

Educación con Participación de la Comunidad en El Salvador

By contracting directly with communities, El Salvador dramatically increased the primary school enrollment of children in poor and remote areas—without reducing the quality of learning.

El Salvador was wracked by civil war throughout the 1980s. Some 80,000 people died—in a total population of roughly 5 million—and many more were wounded and disabled. Income per capita fell almost 40 percent between 1978 and 1983.[1] In 1989 the conservative Republican Alliance Party won a majority in the national assembly, with Alfredo Cristiani as president. Despite contentious negotiations, a peace accord was signed in January 1992.[2]

The war had severely damaged the educational system. Communication between the central ministry and schools broke down, supervision collapsed, and many teachers, viewed by some as government "agents" and by others as agents of social opposition, abandoned their posts. By 1988 more than a third of the country's primary schools had closed.[3] And by the end of the war some 1 million children were not in school.[4]

Establishing Educo—Education with the Participation of Communities

The Ministry of Education quickly identified expanding access to basic education and raising its quality as central goals—both to rebuild national unity and to promote long-term economic development. Minister of Education Cecilia Gallardo de Cano, a reform proponent from the "modernizing" wing of the Republican Alliance Party, was intent on lessening the distrust between former combatants.

But skepticism was high. The Ministry of Education was distrusted in many parts of the country and by organized groups such as the National Association of Teachers. Expansion of the traditional education system was viewed suspiciously as a covert means of reasserting national control and building political support in opposition-dominated areas.[5]

During the war many communities had recruited local teachers and established community schools, bearing the cost themselves and paying teachers when they could. The government seized on this model of community-based schooling as the basis for a formal program that would be financially and administratively supported by the ministry: Educación con Participación de la Comunidad, or Educo, with the goal of encouraging the establishment of preschools and primary schools, or classrooms in existing schools.

Begun in 1991, Educo targeted 78 of the country's poorest rural municipalities (of 221 urban and rural municipalities). By 1993 the program was expanding to all rural areas, including many areas formerly under opposition control. But not all of the "*popular* schools" established during the war were incorporated into Educo. Some observers claimed there was selective inclusion based on political favoritism; others saw not incorporating *popular* schools into a government program as a way of sustaining spontaneous community-based education.[6]

Each Educo school (or section within a traditional school) is operated by a Community Education Association (ACE)—an elected committee made up primarily of students' parents—that enters into a one-year renewable agreement with the ministry. The agreement outlines rights, responsibilities, and financial transfers. The Ministry of Education oversees basic policy and technical design. Using the money directly transferred to them, ACEs select, hire, monitor, and retain or dismiss teachers. Teachers at Educo schools are hired on one-year renewable contracts. Parents are taught about school management and how to assist their children at home.[7]

Three-quarters of new enrollments

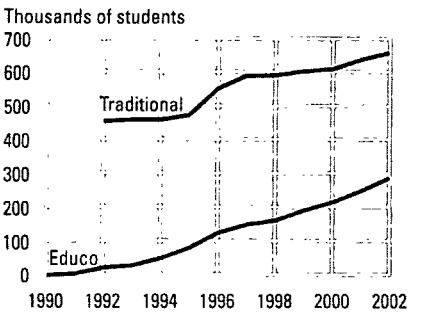
Educo succeeded in many respects. From a pilot phase of six ACEs in three departments, it scaled up nationally to all of the country's departments by 1993. Rural primary enrollments increased from 476,000 in 1992 to 555,000 in 1995—with over 75 percent of the new students enrolled in Educo schools (figure 1). By 2001 there were almost 260,000 students enrolled in Educo primary schools, 41 percent of all students enrolled in rural schools—and more than 100,000 children enrolled in Educo preschools, 57 percent of all children in preschool.

Even as enrollments increased rapidly, there is little evidence that learning quality suffered. A survey of 30 Educo primary schools and 101 traditional schools in 1996 found no significant differences in average math and language test scores among third graders in the two types of schools.[8] A follow-up study in 1998 found that grade promotion and repetition were similar across the two types of schools as well.[9] As the innovation matured, the institutional arrangements that it introduced took hold and ensured rapid expansion of school places and enrollment of poor children, seemingly without a substantial cost in quality.[10]

Parent visits to classrooms made much of the difference

That Educo schools served the poorest of El Salvador's students, in the poorest areas, makes these results all the more astonishing. How did they do it? Using retrospective

Figure 1 Enrollment in Educo schools has been increasing rapidly
Number of students enrolled in traditional rural and in Educo primary classes



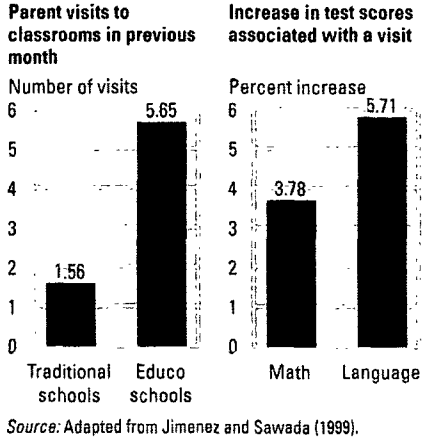
Note: Figures for 2002 are estimates.
Source: El Salvador Ministry of Education.

data that allow controls for child, household, teacher, and school characteristics—and statistically adjusting for the fact that unobserved abilities of children might systematically differ between the two types of schools—researchers found that community involvement explains much of Educo's success.

Parents are more active in Educo schools (figure 2). And their involvement affects learning. Each classroom visit by parents was associated with significantly higher math and language test scores regardless of the type of school. Parents were more active informally as well: they were more likely to meet with teachers or to assist teachers in monitoring attendance or maintaining school furniture.[11]

How did Educo and parent involvement affect test scores? At least part of the story is that teachers were less likely to be absent in Educo schools (averaging 1.2 days of absence a month rather than 1.4 days). Students in Educo schools were also absent less (three fewer days a month) than students in traditional schools.[12] In addition, Educo's more flexible compensation scheme resulted in greater variability in teacher earnings, which suggests that parent associations used compensation to motivate greater effort among teachers.[13] Offering or withholding future employment itself was an incentive, and one that ACEs used. Turnover among Educo teachers was high, which suggests that job loss was not an idle threat.

Figure 2 Educo promoted parent involvement



Source: Adapted from Jimenez and Sawada (1999).

Converging with traditional schools

Educo's administration has become embedded in the Ministry of Education, and Educo has developed into a major schooling model in the country. Aspects of traditional and Educo schools have been converging. Traditional schools now have more parent participation in school governance and management and are more autonomous with supporting block financing. Similarly, the pay packages of teachers are more similar: Educo teachers receive the same salaries and benefits as teachers in traditional schools. Even so, a key distinction remains: Educo teachers are hired (and potentially fired) by parent committees while those in traditional schools are not.

Is the Educo model applicable elsewhere?

Educo's achievements might appear idiosyncratic. The end of a bloody civil war that had thrown the traditional education system into chaos opened up a unique opportunity to change the way schools were managed. Based in part on coping strategies during the civil war, El Salvador had a history of community involvement in school management. Indeed, the community associations appear to have worked better in places that had experience in community organization.[14] In addition, in the aftermath of the war there was an unusually large pool of educated people without jobs (coinciding with the rapid expansion of university places fueled by opening higher education to the private sector).

These factors suggest that the Educo model might not be directly replicable in a different setting. But some lessons are general. First, with political will it is possible to change the relationships between the actors in basic education. Second, schools can be transformed to work in ways that promote enrollment, participation, and learning—even for children from the poorest households. Third, getting parents to participate effectively in managing schools can help overcome some of the potential pitfalls in the provision of education services—especially monitoring schooling in remote areas. Fourth, it is possible to scale up small innovations to have a significant impact on national outcomes.

spotlight on *Johannesburg*

Accountability in city services

In 1999 the Transformation Lekgotla, the political body directed to address the financial and institutional crisis of Johannesburg, South Africa, appointed a new city management team. The team's task was clear: not to fix street lights but to fix the institutions that fix street lights.[1] The solution was a three-year plan—iGoli 2002—to reconfigure city services.[2]

By most developing world standards Johannesburg is not a poor city. But it faces serious development and service delivery challenges. Apartheid made sure that exclusive white suburbs were well serviced, forcing black residents into sprawling underdeveloped slums. Poverty, unemployment, and homelessness are all worsened by the deeper problem of inequality.

The Johannesburg Metropolitan Municipality was democratically elected in 1995 to address the service imbalances. It quickly found itself in a fiscal and institutional crisis.

Johannesburg was not one institution but five, with an overarching Metropolitan Council and four primary-level councils. Each could decide its priorities and approve its budget. But responsibilities for key services were split between the two levels, and the operating budgets of the councils had to balance only in aggregate. That meant each council could blissfully spend on the assumption that its shortfalls would be offset by surpluses in another.

The arrangement was a recipe for disaster. Each municipality went on a spending spree, and ambitious infrastructure plans were rolled out without the necessary finance. Deteriorating revenues—due to a service-payment boycott culture left over from anti-apartheid struggles, poverty, and poor credit control—made the situation worse. The city was forced to delve into its reserves, but these could go only so far, and by late 1997 major creditors could no longer be paid. At the peak of the crisis, the city had an operating deficit of R314 million.

Johannesburg was in serious trouble. Having decentralized responsibilities, the national government followed the intergovernmental rules and would not bail the city out. So Johannesburg had to dig itself out of its own crisis.

Two years of harsh cutbacks followed. Blaming officials for the crisis, politicians took a much tighter rein over day-to-day decisions, ending management discretion. They slashed capital and operating budgets, and even expenditures needed to maintain minimum service levels. They froze posts, causing huge increases in workloads as despairing officials began to drift away. And they began to explore public-private partnerships.

The city of gold—iGoli 2002

The new city management team realized that Johannesburg needed a new system of accountability for service delivery within a dramatically different institutional architecture. To address fragmentation and the severe moral hazard, the city had to be reunified. Political debate focused on two models of metropolitan coordination:

- Defining more clearly the rules of budgeting, fiscal transfers, and service delivery between the metropolitan and municipal tiers, strengthening both
- Creating a one-tier metropolitan government.[3]

Johannesburg chose a hybrid. It centralized political authority, treasury management, and spatial planning under one metropolitan government. But it organized service delivery through decentralized structures. This meant merging five separate councils into one overarching municipality, creating integrated service delivery structures with new incentives.

Accountability in service delivery

Under one metropolitan council, iGoli 2002 split the institution for policy formulation and regulation from the institutions for implementation. On one side, a core administration remained responsible for strategic planning, contract administration, and such corporate services as finance, planning, and communication. On the other, two sets of operating entities were established: 11 new regional administrations for libraries, health, recreation, and other community services; and financially ring-fenced, semi-independent, single-purpose entities to overhaul larger municipal services.

These operating entities were the major innovation of iGoli 2002.

- Three utilities were established for user-charge-based services—water and sanitation, electricity, and waste management.
- Two agencies were established—for parks and cemeteries, and for roads and storm water—where expenditure would still have to be covered by tax revenue.
- Smaller corporatized units were set up for facilities like the zoo and the civic theater.

All were established as new companies, with the council as sole shareholder.

Two key units would guide and oversee the new entities: a corporate planning unit to do citywide strategic planning, and a contract management unit to regulate the operating utilities through a range of new instruments, including licensing agreements and annual service level agreements.

One size does not fit all

Since the operating entities are not bound by overarching administrative rules, they have scope to differentiate. Each could set up different management structures, reporting lines, delegations, job descriptions, performance management systems, and operating procedures. Each could configure its internal accountability to suit a specific service delivery environment. Three examples.

- The water and sanitation departments were merged into one department and under the Company's Law converted into a city-owned utility with a board of directors. The assets and workers of the departments were transferred to the utility, which was put under a five-year management contract with a private company.

- The roads department was converted into a city-owned agency with a professional board and divided into two departments—for planning and for contracts. The contracts department operated against specific outcomes set by the planning department, with the threat that failing to meet benchmarks could lead to contracting tasks out to the private sector.
- The gas company was sold to the private sector.

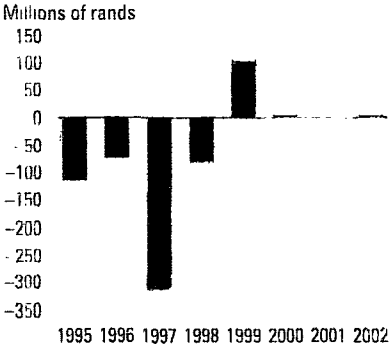
The reforms gave operating entities management independence. For example, salaries have been adjusted to attract top-flight skills, and new systems have been procured for everything from human resource management to remote water-pressure metering—increasing productivity and service efficiency. And they have introduced innovative staff development programs and performance-linked pay schemes.

The entities operate at arm's length from the council, but accountability has been strengthened because the primary mechanism is no longer the impossible-to-digest committee report on everyday operational matters. Now councillors focus on strategic oversight, and officials are responsible for outcomes clearly defined in service-level agreements. Reporting goes through structured channels, either to the contract management unit or to company boards of directors, which include external specialists capable of probing service results.

The operating entities have also set up user forums allowing communities to communicate needs, raise complaints, and even participate actively in service provision. Officials are much more sensitive to ever changing service delivery challenges.

These management improvements are already translating into better service delivery. Waste collection has been extended to poorer neighborhoods for the first time. Fleets of new buses now serve outlying communities. In addition, expenditure on water infrastructure has increased and water services have expanded. Results are also apparent in the city's financial standing, with dramatic improvement in both operating and capital budgets (figure 1).

Figure 1 Getting back to an operating surplus—thanks to iGoli 2002
Operating surplus/deficit



Source: Allan, Gotz, and Joseph (2001)

Engaging other stakeholders

Labor: Despite protracted negotiations with organized labor, iGoli 2002 did not get its endorsement. According to labor groups, the city's crisis was not a result of a failure of institutional design. Instead it was a result of "a lack of skills and experience, and management's unwillingness to [establish] functional organizations and . . . financially unsound decisions."[4]

National Government: The team negotiated a R500 million restructuring grant with the National Treasury to support iGoli 2002 in exchange for a commitment to timely and steadfast implementation of its key elements. It is a key accountability mechanism between the national and city governments and has became an incentive scheme to catalyze citywide restructuring throughout the country.

Capital Markets: On the strength of the reforms, management sought a new credit rating, aiming to win back the confidence of the city's banking community. As the city shifted from a large deficit to a balanced budget, capital expenditure financed by the markets went from R300 million to well over a billion in two years.

Risks and prospects

Will Johannesburg maintain the separation between policymaking, providers, and regulators? The roles of client and contractor are still evolving. Some implementation capacity remains within the core administration. As in the past, managers occasionally get hauled into councilors' offices to explain their actions. There are also unresolved governance debates, with the council arguing for a greater councilor representation on the boards of operating entities.

Five factors will be critical in sustaining the commitment to the principles of iGoli 2002:

- Keeping the monitoring and regulatory units of the operating entities within the city administration; they are not legally and administratively independent.
- Maintaining the contract management unit's operational autonomy and capacity—and thus the independence of the operating entities.
- Benchmarking service delivery standards, monitoring these over time, and making the information available.
- Ensuring that fiscal and financial decentralization remains binding. Municipalities relying primarily on their own revenue sources to fulfill their democratic duties without national guarantees are more likely to be accountable to their citizens. The current intergovernmental system has devolved authority and accountability to the cities; this needs to remain.
- Both councilors and officials consistently adhering to a clear, courageous, and farsighted strategy. Sustaining momentum will require greater citizen voice at all levels. The decentralized operating entities and the administrative regions have mechanisms for engaging citizens. Using them will be critical for sustaining iGoli 2002.

Endnotes

Overview

1. Taking the world as a whole hides the fact that Sub-Saharan Africa is off track in reaching the income poverty goal.
2. Walker, Schwarlander, and Bryce (2002).
3. Devarajan, Miller, and Swanson (2002).
4. Peters and others (2002), p. 218.
5. Reinikka and Svensson (2001).
6. Chaudhury and Hammer (2003).
7. Jaffré, Olivier, and de Sardan (2002).
8. Probe Team in association with Centre for Development Economics, 1998; Rosskam (2003),.
9. Analysis of Demographic and Health Survey Data (see table 1.1 of the Report). See also U.K. Department for International Development (2002).
10. Bhushan, Keller, and Schwartz (2002).
11. Galiani, Gertler, and Schargrodsky (2002).
12. Ahmad (1999).
13. World Bank (2002b).
14. Behrman and Hoddinott (2001), Gertler and Boyce (2002).
15. Glaeser and Shleifer (2002).
16. Diaz-Cayeros and Magaloni (2002).
17. World Health Organization (2003)
18. Besley and Burgess (forthcoming).
19. When asked why he did not complain, one villager replied, "I could meet with an accident on the road. I could be put in the brick kiln oven. My bones could be broken."
20. International Labour Office (2002)..
21. Scott (1998).
22. Reinikka and Svensson (2002).
23. Chomitz and others (1998).
24. Computerization of land registration in Karnataka, India, reduced the transaction time to 30 minutes and eliminated the payment of bribes, which had risen to 25 to 50 times the registration fee.
25. Koenig, Foo, and Joshi (2000).
26. Jimenez and Sawada (1999).
27. Hsieh and Urquiola (2003).
28. Gauri and Vawda (2003).
29. Angrist and others (2002).
30. Interview by John Briscoe.
31. World Bank (1998) and World Bank (2002a).
32. Even a recommendation to apply 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).
33. Schick (1998).
34. Realizing that the central education system has led to underrepresentation of students from low-income families, one of the prestigious French grandes écoles, L'institut des études politiques ("Sciences Po") has begun to use separate admissions criteria for students from poor neighborhoods.
35. Leonard (2002).
36. Another reason is that most project managers are not interested in investing in knowledge that might show their program to have been a failure.

spotlight on Cambodia

1. Cambodia National Institute of Statistics and ORC Macro (2001)
2. The operations research was funded by the Asian Development Bank.
3. Bhushan, Keller, and Schwartz (2002)
4. There is only one instance, that of vitamin A coverage, in which one district had not increased coverage at the time of the midterm evaluation.
5. Soeters and Griffiths (2003).

spotlight on Educo

1. World Bank (2002c).
2. Eriksson, Kreimer, and Arnold (2000).
3. This assessment of the position of teachers and school closings is from Reimers (1997).
4. Action learning program on participatory processes for Poverty Reduction Strategy Papers (2003).
5. Action learning program on participatory processes for Poverty Reduction Strategy Papers (2003).
6. For an example of this critique see Davies (2000) and a discussion in Reimers (1997).
7. Initial studies suggested that few of these "Parent School" programs took hold. But they were made an official program—with financial support—in the past five years, and they appear to have expanded since then.
8. Jimenez and Sawada (1999).
9. Jimenez and Sawada (2002).
10. Indeed, one early assessment based on a survey of 140 schools in 1993 found little difference between different types of schools (Reimers 1997).
11. El Salvador Evaluation Team (1997).
12. Jimenez and Sawada (1999).
13. Sawada (1999).
14. Reimers (1997).

spotlight on Johannesburg

1. Allan, Gotz, and Joseph (2001).
2. iGoli means "city of gold."
3. Ahmad (1996).
4. Allan, Gotz, and Joseph (2001).

References

The word "processed" describes informally reproduced works that may not be commonly available through libraries.

Ahmad, Junaid. 1996. "The Structure of Urban Governance in South African Cities." *International Tax and Public Finance* 3(2):193–213.

———. 1999. "Decentralizing Borrowing Powers." World Bank PREM Note 15. Washington, D.C.

Allan, Kevin, Graeme Gotz, and Carmel Joseph. 2001. *Johannesburg: An African City in Change.* Johannesburg: Zebra Press.

Angrist, Joshua, Eric Bettinger, Erik Bloom, Elizabeth M. King, and Michael Kremer. 2002. "Vouchers for Private Schooling in Colombia: Evidence from a Randomized Natural Experiment." *American Economic Review* 92(5):1535–58.

Behrman, Jere R., and John Hoddinott. 2001. "An Evaluation of the Impact of PROGRESA on Preschool Child Height." IFPRI FCND Discussion Paper 104. Washington, D.C. Available on line at www.ifpri.org.

Bell, Clive, and Shantayanan Devarajan. 1987. "Intertemporally Consistent Shadow Prices in an Open Economy: Estimates for Cyprus." *Journal of Public Economics* 32(3):263–85.

Besley, Timothy, and Robin Burgess. Forthcoming. "The Political Economy of Government Responsiveness: Theory and Evidence from India." *Quarterly Journal of Economics.*

Bhushan, Indu, Sheryl Keller, and Brad Schwartz. 2002. "Achieving the Twin Objectives of Efficiency and Equity: Contracting for Health Services in Cambodia." Asian Development Bank, Policy Brief Series 6. Manila.

Bruns, Barbara, Alain Mingat and Ramahatra Rakatomalala. 2003. "A Chance for Every Child: Achieving Universal Primary Education by 2015." World Bank. Washington, D.C.

Bhushan, Indu. 2003. "Contracting Health Services in Cambodia." Background note for the WDR 2004.

Cambodia National Institute of Statistics, Ministry of Health, and ORC Macro. 2001. "Cambodia Demographic and Health Survey 2000." Phnom Penh, Cambodia.

Chaudhury, Nazmul, and Jeffrey Hammer. 2003. "Ghost Doctors: Absenteeism in Bangladeshi Health Facilities." Background paper for the *WDR 2004*.

Chomitz, Kenneth, Gunawan Setiadi, Azrul Azwar, Nusye Ismael, and Widiyarti. 1998. "What Do Doctors Want? Developing Incentives for Doctors to Serve in Indonesia's Rural and Remote Areas." World Bank Policy Research Working Paper 1888. Washington, D.C.

Davies, Ian. 2000. "The Debate over Popular Education in El Salvador." Edgewood College, Madison, Wisconsin: LASA, Miami, Florida, March. Available on line at http://forlang.edgewood.edu/ian/Education.htm. Processed.

Devarajan, Shantayanan. 2002. "Growth Is Not Enough." World Bank. Processed.

Devarajan, Shantayanan, Margaret J. Miller, and Eric L. Swanson. 2002. "Goals for Development: History, Prospects, and Costs." World Bank Policy Research Working Paper 2819. Washington, D.C.

Diaz-Cayeros, Alberto, and Beatriz Magaloni. 2002. "Public Services Mediated by the Political Process." Stanford University. Processed.

Dreze, Jean, and Nicholas Stern. 1987. "The Theory of Cost-Benefits Analysis." In A. J. Auerbach and M. Feldstein, eds., *Handbook in Public Economics, Vol. 2.* Amsterdam, New York: North-Holland.

El Salvador Evaluation Team. 1997. "El Salvador's EDUCO Program: A First Report on Parents' Participation in School-Based Management." World Bank Working Paper Series on Impact Evaluation of Education Reforms 4. Washington, D.C. Available on line at http://www.worldbank.org/research/projects/impact. htm.

Eriksson, Joh, Alcira Kreimer, and Margaret Arnold. 2000. "El Salvador: Post-Conflict Reconstruction." World Bank Evaluation Department, Country Case Study Series: Washington, D.C.

Estévez, Federico, Beatriz Magaloni, and Alberto Diaz-Cayeros. 2002. "The Erosion of One-Party Rule: Clientelism, Portfolio Diversification, and Electoral Strategy." Paper presented at the Annual Meeting of the American Political Science Association Conference, Boston.

Galiani, Sebastian, Paul Gertler and Ernesto Schargrodsky. 2002. "Water for Life: The Impact of the Privatization of Water Services on Child Mortality." Stanford University, Cneter for Research on Economic Development and Policy Reform, Working Paper 154, Stanford.

Gauri, Varun, and Ayesha Vawda. 2003. "Vouchers for Basic Education in Developing Countries: A Principal-Agent Perspective." Background paper for the *WDR 2004*.

Gertler, Paul, and Simone Boyce. 2002. "An Experiment in Incentive-Based Welfare: The Impact of PROGRESA on Health in Mexico." University of California, Berkeley. Available online at http://faculty.haas.berkeley.edu/gertler/. Processed.

Glaeser, Edward, and Andrei Shleifer. 2002. "The Curley Effect." Harvard University and National Bureau of Economic Research. Processed.

Hsieh, Chang, and Miguel Urquiola. 2003. "When Schools Compete, How Do They Compete? An Assessment of Chile's Nationwide School Voucher Program." Princeton University and World Bank. Processed.

International Labour Office. 2002. "Social Dialogue in the Health Services: Institutions, Capacity and Effectiveness," Sectoral Activities Program. Geneva.

Jaffré, Y., J.-P. Olivier, and Olivier de Sardan, eds. 2002. *Les Dysfonctionnements des Systèmes de Soins. Rapport du Volet Socio-anthropologique. Enquêtes sur l'Accès aux Soins dans 5 Capitales d'Afrique de l'Ouest.* Marseille: Unicef-Coopération Francaise.

Jimenez, Emmanuel, and Yasuyuki Sawada. 1999. "Do Community-Managed Schools Work? An Evaluation of El Salvador's Educo Program." *World Bank Economic Review* 13(3):415–41.

———. 2002. "Does Community Management Help Keep Kids in Schools? Evidence Using Panel Data from El Salvador's EDUCO Program." *World Bank Economic Review* 13(3): 415–441.

Koenig, Michael A., Gillian H. C. Foo, and Ketan Joshi. 2000. "Quality of Care within the Indian Family Welfare Programme: A Review of Recent Evidence." *Studies in Family Planning* 31(1):1–18.

Leonard, Kenneth L. 2002. "When Both States and Markets Fail: Asymmetric Information and the Role of NGOs in African Health Care." *International Review of Law and Economics* 22:61–80.

Peters, David H., Abdo S. Yazbeck, Adam Wagstaff, G. N. V. Ramana, Lant H. Pritchett, and Rashmi R. Sharma. 2002. *Better Health Systems for India's Poor: Findings, Analysis, and Options.* Washington, D.C.: World Bank.

Reimers, Fernando. 1997. "The Role of the Community in Expanding Educational Opportunities: The EDUCO Schools in El Salvador." In James Lynch, Celia Modgil, and Sohan Modgil, eds., *Education and Development: Tradition and Innovation: Volume Two—Equity and Excellence in Education for Development.* London: Cassel.

Reinikka, Ritva, and Jakob Svensson. 2001. "Explaining Leakage in Public Funds." World Bank Policy Research Working Paper 2709. Washington, D.C.

Rosskam, Ellen. 2003. "No Pills, No Bandages, Nothing." International Labour Office, Geneva.

———. 2002. "Working for God?" World Bank, Washington, D.C. Processed.

Sawada, Yasuyuki. 1999. "Community Participation, Teacher Effort, and Educational Outcome: The Case of El Salvador's EDUCO Program." William Davidson Institute Working Papers 307. University of Michigan. Available on line at http://eres.bus.umich.edu/web/dwpauth.html.

Schick, Allen. 1998. "Why Most Developing Countries Should Not Try New Zealand's Reforms." *World Bank Research Observer* 13(1):23–31.

Scott, James. 1998. *Seeing Like a State: How Certain Schemes to Improve the Human Condition Have Failed.* New Haven,Conn.: Yale University Press.

Soeters, Robert, and Fred Griffiths. 2003. "Improving Government Health Services through Contract Management: A Case from Cambodia." *Health Policy and Planning* 18(1):74–83.

U.K. Department for International Development. 2002. "Transport's Role in Achieving the Millennium Development Goals." Transport Resource Centre.

Walker, N., B. Schwarlander, and J. Bryce. 2002. "Meeting International Goals in Child Survival and HIV/AIDS." *The Lancet* 360(9329):284–9.

World Bank. 1993. *World Development Report 1993: Investing in Health.* New York: Oxford University Press.

———. 1998. *Assessing Aid: What Works, What Doesn't, and Why.* New York: Oxford University Press.

———. 2002a. *A Case for Aid: Building a Consensus for Development Assistance.* Washington, D.C.: World Bank.

———. 2002b. "Romania: Local Services Delivery Study." World Bank, Washington, D.C.

———. 2003. "Global Economic Prospects and the Developing Countries: Investing to Unlock Global Opportunities." World Bank, Washington, D.C.

———. 2002c. *World Development Indicators.* Washington, D.C.: World Bank.

World Health Organization. 2003. http://www.who.int/csr/media/sars_wha.pdf

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