

# Policymakers and providers

## chapter 6

Educated children. Good health. Clean, reliable, and convenient water. Safe neighborhoods. Lighted homes. That is what citizens, poor and rich, want from services. If policymakers take responsibility for delivering services, they must also care about these outcomes and be sure that services providers care about them, too. Chapter 5 discussed the first challenge: inducing policymakers to reflect the interests of poor people. This chapter takes up the second: inducing providers to achieve the outcomes of interest to poor people. How? By choosing appropriate providers. By aligning incentives with those outcomes. And by ensuring that policymakers do at least as well as the clients themselves in creating those incentives.

### Compacts, management, and the “long route” of accountability

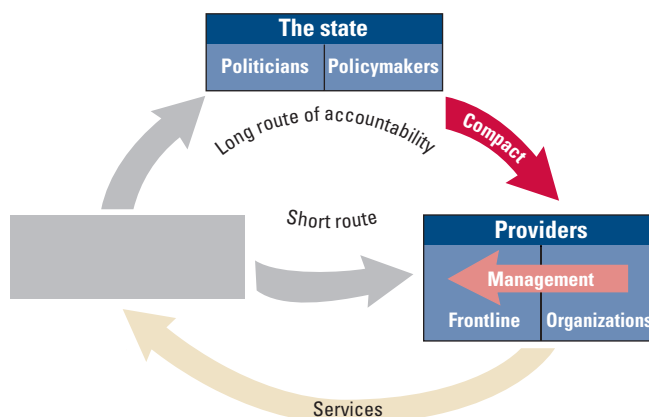
The “compact” introduced in chapter 3 is composed of relationships of accountability necessary for increasing the power of incentives for good performance (figure 6.1). Instructions to provider organizations must

be clear and backed with sufficient resources for adequate and regular compensation. Good information on the actions of providers and the outcomes of those actions must get to the policymaker. And remuneration must be tied as closely to these outcomes as possible. Accountability is improved by:

- Clarifying responsibilities—by separating the role of policymaker, accountable to poor citizens, from that of provider organizations, accountable to policymakers.
- Choosing the appropriate provider—civil servants, autonomous public agencies, NGOs, or private contractors. Competition can often help in this choice.
- Providing good information—an essential step. Just monitoring the performance of contracts requires more and better measures. Keeping an eye on the prize of better outcomes also requires more regular measurement. It also requires finding out what works by rigorously evaluating programs and their effects.

These steps are neither easy nor straightforward. Political pressures often make it impossible for policymakers to claim independence from the performance of service providers. Compacts for the kind of services discussed here cannot be complete or have perfectly measured outcomes. Finding enough staff, regardless of their precise employment agreements, is a real challenge for many developing countries because of international migration and, for Sub-Saharan Africa, HIV/AIDS. And finding out what works—determining the link between policies and inputs and outcomes—is difficult, not just for technical reasons. Governments, donors, and provider organizations fre-

Figure 6.1 Compact and management in the service delivery framework



quently don't want to know—or don't want to take the risk of finding out—what doesn't work.<sup>281</sup>

It may be difficult to measure the outcomes of health, education, and infrastructure services, but it is possible. Improvements cannot be measured as precisely as tons of steel. But the outcomes of these services are far more amenable to measurement than many core functions of government. Mortality rates, literacy rates, and the purity of water are observable in ways that “advancing the international interests of the nation,” the goal of a foreign ministry for example, are not.<sup>282</sup> And technical knowledge for rigorous evaluation of programs to reach the poor is certainly available.

A word on “compacts” versus “management.” The focus of this chapter is the compact between the policymaker and the provider organizations, not the details of the management of frontline providers by a provider organization. Appropriate management needs to be tailored to local circumstances. Focusing on the details of management detracts from the more crucial relationship of the compact and indulges the tendency to micromanage. Here the emphasis is on the principles for designing incentives. But management cannot be ignored entirely. Much of the (very thin) literature on what works and what doesn't—on provider responses to changes in incentives—deals with management reforms, so these experiences must form the limited empirical base.

### *Misaligned incentives and service failures*

Failures to reach poor people with effective services can usually be attributed to a misalignment between the incentives facing providers and outcomes. A private market left to itself cannot provide appropriate services to poor people. It will tend to serve clients who possess the purchasing power for a fairly narrow set of services. Modern, private medical care by skilled professionals and private education are largely used by the better off. Water is an exception, with substantial middle-class capture of public water, leaving poor people to buy from expensive private sellers. The range of services the private sector will provide on its own is limited to, well,

private goods. Private providers may be contracted by the public sector for services to poor people or for true public goods (where a private sector is impossible, even in principle). But they cannot be relied on to provide them on their own. That is why the public sector should assume responsibility for basic services, especially for poor people.

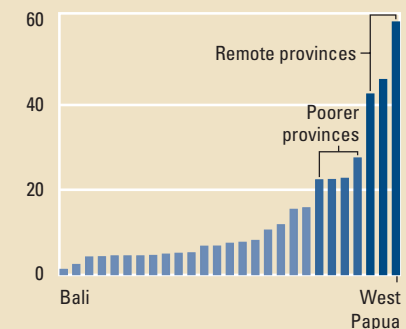
The public sector has its problems, too. Chapter 5 asked whether, in fulfilling this responsibility, policymakers have the incentive to “do the right thing.” The answer is often “no.” But even if policies are properly designed, it is difficult to get personnel to staff facilities in poor or remote areas. Vacancy rates for doctors in Indonesia range from near zero in Bali to as high as 60 percent in West Papua (formerly Irian Jaya), the province farthest from Java (box 6.1).

The difficulty in staffing such places varies by job. It is greatest for the most highly educated people with the best alternative employment prospects. Educated people in countries with few such people are almost always urban born and bred. In Niger 43 percent of the parents of nurses and midwives were civil servants, and 70 percent of them

#### **BOX 6.1** *A good doctor is hard to find*

Public health centers in desirable locations have modest vacancy rates, as low as 1.2 percent in Bali and near 5 percent in most of the provinces in the population centers of Java and Sumatra. For such remote areas as West Papua the vacancy rate reaches 60 percent, and for central Kalimantan more than 40 percent.

**Percentage of health centers without doctors, by province, Indonesia 1992**



Source: World Bank (1994b).

had been raised in the city.<sup>283</sup> It is only natural for them to want the same for their children. And it is naïve to simply say “pay them more.” Doctors in Indonesia would require multiples of current pay levels to live in West Papua.<sup>284</sup> And giving providers too much discretion over where they serve may hurt the poor, as in rural schools in Zambia (box 6.2).

Even when people accept jobs in poor areas, their absenteeism is often astonishing (see tables 1.2 and 1.3 in chapter 1). The reasons vary, but alternative earning opportunities are a major one for professions with easily marketable skills.<sup>285</sup> This applies to doctors and other medical personnel and to teachers offering independent tutoring. Again, the day-to-day imperatives for people to make a living run counter to increasing services to poor people. This is particularly true where civil service pay is much less than private sector pay for the same skills.

Even when people are on the job, their performance can compromise the outcomes

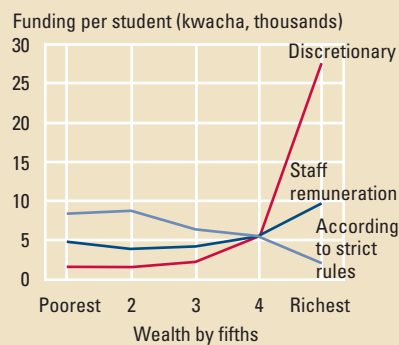
for poor people. The lack of conscientiousness, the mistreatment of students and patients, and the loss of skills with time (chapter 1)—all can be attributed to a combination of the failure of incentives and a service ethos. Salaried workers with no opportunity to advance and no fear of punishment have little incentive to perform well. Chapter 4 argued that discourtesy depended on incentives, not training. If income does not come from clients, the policymaker must hold providers accountable, particularly in monitoring and rewarding good behavior.

Corruption—unauthorized private gain from public resources—is common in many services and also attributable to competing incentives. In Eastern Europe under-the-table payments to public servants and general corruption undermine the legitimacy of all government services. They are particularly costly to poor people (box 6.3). Pharmaceutical mismanagement is everywhere: thefts from public stores supply much of the private market in Côte d’Ivoire, India, Jordan, Thailand, and Zambia. Corruption responds to monetary incentives, but it also requires a lack of information on hidden activities and an inability to impose sanctions. As Captain Shotover in George Bernard Shaw’s *Heartbreak House* put it, “Give me deeper darkness. Money is not made in the light.” Open information can reduce both the incidence of corruption and its corrosiveness.<sup>286</sup>

Community pressure can also subvert the incentives to fulfill the primary responsibilities of public providers. In many places the public servant is a permanent member of the community, facing substantial social pressures to bend rules to the benefit of local preferences. Sometimes this is good—it shows the flexibility to respond to local needs. But for some services, particularly those with punitive characteristics, it can compromise the core duties of the provider. For example, forestry agents who are part of a community may be reluctant to report illegal logging by their neighbors.<sup>287</sup> A form of community pressure particularly harmful to the poor is the capture of services by local elites. In Northern Ghana young, inexperienced, and poorly paid facilitators for participatory projects found such pressure a major impediment.<sup>288</sup>

### BOX 6.2 *Provider discretion can hurt the poor*

#### Funding of rural primary schools in Zambia from different sources



Rural schools in Zambia obtain resources in cash and in kind (personnel). Cash transfers allocated by strict rules of per capita funding are distinctly progressive. Rural areas give significantly higher discretionary cash allocations to rich schools. Per-pupil teacher compensation increases with the wealth of children attending the school, reflecting higher staffing ratios and the gravitation of senior staff to richer areas.

Source: Das and others (2003).

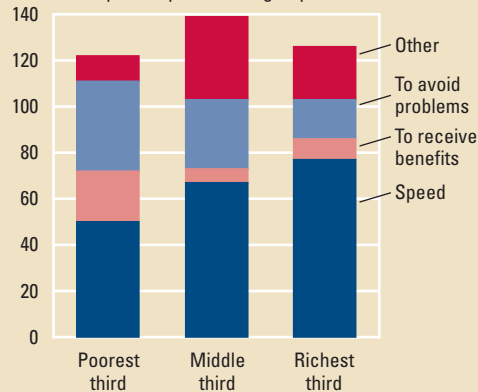
### BOX 6.3 *Bribery hurts the poor*

To gain access to health, education, and the justice system in Kazakhstan, poor people pay bribes simply to receive services they are entitled to (and to avoid “problems” getting them) while richer people pay to speed up service.

In Romania, the poor pay substantially higher fractions of income in bribes.

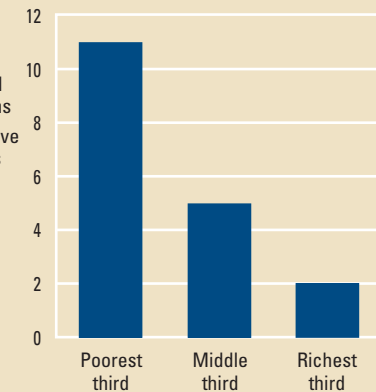
#### Kazakhstan: reasons for paying bribes to health, education, and justice systems

Percent responses per income group



#### Romania: Percent of income paid in bribes (of those paying bribes)

Percent



Note: Numbers add to more than 100 percent due to multiple responses.

Source: Anderson, Kaufmann, and Recanatini (2003).

Many, and usually most, providers in the public sector are dedicated people whose interests are largely compatible with the public good. But their own needs of looking after a family, ensuring their well being, having friendly relations with neighbors—all prevent them from providing sufficient services to benefit poor people. If the scale of operations needs to be increased to reach the poor, even more incentives need to be changed at the margin, whether monetary or not.<sup>289</sup>

### Increasing accountability: separating the policymaker from the provider

The many incentives that providers face blur the focus on outcomes. Making a clear separation between the role of the policymaker and the provider organization is essential for aligning the incentives for the provider with the final outcomes that policymakers want for citizens. Who is the policymaker, and who is the provider organization? The policymaker is the person directly accountable to the citizenry, preferably the poorer citizenry. And the provider organization is responsible

for delivering services. In many cases, the policymaker is the legislature or a central ministry, the provider organization a line ministry. So many of the activities of the head of the “provider organization” will look like policymaking. But these are “internal policies” of the organization to achieve the overall goals focused on here. (The literature on public management explicitly cautions against separating<sup>290</sup> policymaking from implementation, but that literature is concerned with management within the “provider organization” and not the separation proposed here.)

Clear separation lends itself to much simpler and less ambiguous accountability for the provider organization. When the policymaker is the provider organization, day-to-day pressures of management compromise attention to outcomes on the ground. Take the desire to find and fix problems (see the spotlight on Johannesburg). When the policymaker takes a separate role from the provider, it is easier to say “I don’t care what your problem is, just tell me the vaccination rates. Or the test scores. Or crime rates.” When roles are mixed, bureaucracies become insular and tend to hide mistakes.

Is this separation really necessary? Is it achieved in rich countries? Education, for example, is frequently administered through central ministries, which employ all teachers directly with little monitoring from central staff agencies (such as finance). Perhaps separation is not necessary for successful services.

But rich countries benefit from a long evolution of the relationships between the state and frontline providers. Almost all services provided directly to individuals in the now-rich countries were originally provided privately. They were eventually absorbed or consolidated by a state institution that had been separate from the existing provider organizations. The state began as an independent outside monitor and regulator of private activities. It largely retained that independence as a monitor after the same activities became public (box 6.4).

For the developing world the desire for rapid expansion of public financing and provision short-circuits this historical development. Both the monitoring and the provision are taking place simultaneously. This is not necessarily a bad thing—the poor might otherwise have to wait much longer for services to reach them. But it does show that the current institutional features of rich countries may not transfer directly to poor countries without the establishment of a complementary regulatory structure, a structure that may need to be established beforehand. Without this structure progress may be slow—possibly slower than if a not-for-profit or private sector were allowed to develop and later brought under the supervisory wing of the government.

Separating the policymaker from the provider organization also helps to increase the accountability of providers. But if the policymaker knows what services to deliver, why can't providers just be given instructions—in a contract—to do them? That is, why can't outputs just be specified and paid for accordingly?

### Limits to accountability

All public services face three problems that make this solution impossible: providers face multiple principals, undertake multiple tasks, and produce outcomes that are hard to observe and hard to attribute to their actions.<sup>291</sup>

### Multiple principals

The instructions of the policymaker to providers are not the only ones that count. Public servants have to serve many masters. Education providers are under pressure from parents of poor children (with the policymaker representing them), parents of children other than the poor, teachers' unions, potential employers, various groups in society that want (or don't want) particular items on the curriculum, and others. Power and water providers are under pressure from different segments of the market to cross-subsidize them, from producers to buy specific types of equipment, from people who want more extensive connections, and from others who want more reliable, continuous operation. The day-to-day pressure of local demand for health care can compromise efforts in disease prevention and other public health activities that are not demand-driven.<sup>292</sup> Whom is a provider to listen to?

#### BOX 6.4 *Learning to regulate*

Although the state pays for health care in most Organisation for Economic Co-operation and Development (OECD) countries, private practitioners still provide it (exceptions on the finance side include the United States; exceptions on the provision side, the United Kingdom). The state carries out the insurance function in these countries but not the services. It is the insurance market that is hampered by severe market failure. In Germany, the current system is a consolidation, begun under Bismarck in 1883, of a system of guild-based insurance schemes.

For most OECD countries, the current system of public ownership or control dates from a time after World War II when they had incomes at least as high as the upper-middle-income countries today. Before these programs were brought under public management, the state already had regulatory powers over the medical profession. The timing was fortuitous since it was only in the 20th century that technical changes in medicine made public oversight essential.

Universal public education is also fairly recent. It came out of a conflict between church and state. In the period of expansion of public facilities, the main mechanism was

incorporating private schools into the public network after a system of managing individual schools had already developed.

Even the core networked services of water, electricity, gas, and railways—services now thought of as natural monopolies—began as purely private activities. In the United Kingdom early water systems were sometimes developed with duplicate pipes laid by competing firms. Only after coverage was substantial were these rationalized—and then for reasons of public health rather than duplication. German railways also began with duplicate lines. In other cases, companies worked out agreements that divided markets without the duplication experienced in the railway markets in the United States and England—for example, bus systems in many large urban areas and German natural gas transport. These were then brought under a regulatory regime but only after reaching quite high service penetration.

In each of these cases the independent regulatory capacity of the policymaker preceded the incorporation of private providers into a public system.

Source: Klein and Roger (1994).

### *Multiple tasks*

Personnel in health clinics are supposed to provide curative care to people who come to them. They are also to provide immunizations, health education, and other preventive measures to everyone, whether they come in on their own or not. And they are to keep statistics, attend training sessions and meetings, and do inspections of water and food. Police officers have to deal with everyone from lost children to dangerous criminals. They are, at various times, investigators of crimes, social workers intervening in neighborhood and family disputes, and disseminators of information. This diffusion naturally blunts the precision of incentives.

### *Measuring and attributing outcomes*

The most difficult problems, particularly for the social sectors, are the dual problems of measuring outcomes and attributing these outcomes to the actions of providers. Test scores may adequately reflect certain educational goals, but abstract thinking and social adaptability are not so easily measured. The alleviation of pain is a subjective judgment of the patient. Many outcomes, even when observable to the patient and the doctor, are not “contractible” in the sense that, if a dispute arises, compliance can be proved to a judge or other mediator. And attributing impacts to provider actions is difficult in almost all social services.

These problems make it impossible to have performance contracts that make payments to

individual frontline providers depend on outcomes. All contracts will necessarily be incomplete, requiring at least some payment of wages independent of outputs. When the actions of the provider are specified in great detail, the results are often less than optimal because of inflexible response to local variation. The impossibility of specifying such rules ahead of time is illustrated by “work-to-rule” strikes, in which strikers bring an activity to a “grinding halt” by following rules entirely to the letter (box 6.5). The balance between control and flexibility is not easily struck.

Further, since the provider does many things, some or all of them hard to observe by the policymaker, there is the ever-present risk that payments for measured outcomes will displace hard-to-measure tasks (box 6.6). This risk has been discussed in the education literature as “teaching to the test.” When teacher compensation (pay or promotion prospect) is measured by students’ performance on a standard test, there will be a tendency to downplay those aspects of pedagogy not covered by the test and to concentrate on those that are. In Kenya teachers manipulated test scores by offering tutoring sessions aimed specifically at these tests. There was no improvement in other indicators of quality, such as homework assignments, teacher absences, or teaching methods.<sup>293</sup>

Several industrial countries, in reforming the civil service or other providers of public services, have tried to use performance contracts. The evidence of success is mixed:<sup>294</sup> many problems are tied to the dependence of the policymaker on information the agency provides—a problem closely related to the regulation of private firms. Some information used for performance contracts can be easily falsified or, less pejoratively, presented in too favorable a light. For example, when education reforms were instituted in the United Kingdom, trauancies were redefined as excused absences.<sup>295</sup>

### **Overcoming the limits**

Separating policymakers from provider organizations can help sharpen incentives to help poor people. Assigning policymakers the role of devising a compact for the provider organization and assigning provider organizations the responsibility of management can

#### **BOX 6.5** *Be careful what you wish for—part 1*

“Anyone who has worked in a formal organization—even a small one strictly governed by detailed rules—knows that handbooks and written guidelines fail utterly in explaining how the institution goes about its work. Accounting for its smooth operation are nearly endless and shifting sets of implicit understandings, tacit coordinations, and practical mutualities that could never be successfully captured in a written code. This ubiquitous social fact is useful to employees and labor unions. The premise behind what are tellingly called work-to-rule strikes is a case in point. When Parisian taxi drivers want to

press a point on the municipal authorities about regulations or fees, they sometimes launch a work-to-rule strike. It consists merely in following meticulously all the regulations in the Code routier and thereby bringing traffic throughout central Paris to a grinding halt. The drivers thus take tactical advantage of the fact that the circulation of traffic is possible only because drivers have mastered a set of practices that have evolved outside, and often in contravention, of the formal rules.”

Source: Scott (1998).

enable the use of higher-powered incentives to align the interests of the frontline provider with those of the policymaker representing the poor, for the following three reasons. First, policymakers, balancing political pressures, can help insulate providers from the problem of satisfying masters with conflicting aims and offer unambiguous instructions. Second, provider organizations can face performance-based payments when individuals cannot. Third, managers of the provider organizations, if they have flexibility over operational decisions, can supervise staff and choose the appropriate form of remuneration that best reflects local conditions.

### *Insulating providers from politics*

That providers have to satisfy many masters reflects the inability of government to insulate them from political pressures. While policymakers for education need to address concerns of potential employers, teachers' unions, or interest groups who want to influence curricula, there is no reason why this should affect day-to-day activities in a school, or indeed any organization of frontline providers. If the policymaking function can be separated from the provider organization, the policymaker can handle the politics of the overall objectives of education while the provider can be given more precise instructions and be held accountable to the policymaker. Poor people might legitimately delegate to policymakers curriculum development as well as the responsibility to balance their interests with those of unions.

### *Organizations and individuals*

Individual providers will not accept performance contracts that leave them exposed to excessive risk. But the variability of aggregate performance over all providers in an organization—say, those dealing with infant mortality for a district—is very much smaller, which provides a way of sharing the risk. While a single doctor may not be able to absorb the risk to income of the bad luck of any particular patient, a district health board would. Teams—schools, school districts, health boards, city police departments—can be the recipients of performance-based incentives where teachers, nurses, and policemen cannot (see spotlight on Costa Rica and

#### **BOX 6.6** *Be careful what you wish for—part 2*

The Sears Corporation lost a \$48,000,000 class action suit in which its automobile repair department was accused of deliberately sabotaging customers' vehicles. The corporation was held responsible, having instructed its employees that bonuses would be paid to those branches with the

most repeat business. That the intention of the instruction was to encourage courteous behavior did not impress the court.

*Source:* Sears Automotive Center Consumer Litigation, Action No. C-92-2227, U.S. District Court, San Francisco.

Cuba). What can be considered measurable varies by the size of the organization—larger ones being easier to hold to account.

The problem of multiple tasks is partly a problem of economies of scale as well. Some tasks can be divided into groups of complementary activities—all immunizations as a group, say, or all health education activities based on home visits (chapter 8). Then a fairly homogeneous organization can be charged with the responsibility to carry out a simpler set of tasks, with clear standards of accountability.

Reform in Johannesburg, South Africa (see spotlight), was in large part a reevaluation of the appropriate set of services to be grouped together to deliver specified outputs. Departments were reorganized so that their outputs were clearly identifiable and verifiable, with the department's CEO able to retain any savings over contract expenditures. At one extreme, commercial enterprises—such as the athletics stadium, the airport, and metro gas—were simply sold to the private sector and directly faced the forces of the market, where payment is very much dependent on outcomes.<sup>296</sup>

### *Management flexibility*

Each of these potential effects depends on managers in provider organizations having the flexibility and authority to design the incentives for the frontline providers in their organizations. This allows them to adapt to local (or sectoral) variation to see whether performance pay or salaries with supervision works better. Flexibility for the manager is essential, a major part of "institutional capacity." Managers must have control over the pay scheme or the sanctions for poor performance.

Salaried systems work as long as there is the ability either to fire or to grant raises on

the basis of merit. The worst case is when salaried workers face neither sanctions for poor performance nor increased pay or prestige for good performance. Civil servants in Singapore enjoy high salaries and a lot of prestige, but also work under a credible threat of being fired. A problem with some of the recent reforms in developed countries instituting contractual relations with providers is that they undermine the public service ethos. (“If I am to be treated as a mercenary, I might as well act like one.”) Increased accountability through monetary incentives was partly offset by reduced accountability through internal motivation.<sup>297</sup> Developing countries that have instilled this sense of duty should be wary of compromising it. But they should be brutally honest with themselves before declaring this a major consideration.

Sometimes performance pay is appropriate and necessary but should be a matter for local experimentation. Several health interventions have benefited greatly by introducing performance-based incentives for workers (box 6.7). In other contexts, those incentives are precisely what is needed to obtain particular desired results. In the British National Health Service most general practitioner pay is determined on the basis of capitation pay-

ments—for how many people sign up with the doctor. But it is supplemented by specific additional payments for the provision of immunizations to counter any incentive to skimp on this priority service.

### *New providers for expanding supply*

Where will the providers of services come from? One possibility is that competition for compacts will attract more provider organizations. The benefits from competition are reduced costs, greater effort, and better information—even when public provision is the dominant form, as long as public and other provider organizations are treated even-handedly. Three types of competition are relevant for services: competition in the market, competition for the market, and benchmarking.

**Competition.** Competition *in* the market simply means allowing private providers. For health and education, such providers are everywhere, and in many places larger players than the government (chapter 4). Recent technological advances have made it possible to open services formerly believed to be natural monopolies to competition. Independent power producers, for example, can be used to sell electricity to a larger grid. The cost of allowing free entry into natural monopolies is the risk of inefficient duplication of investments. Efficient regulation is necessary but complicated. If political and administrative limitations on the independence and effectiveness of regulators are severe, allowing the duplication may be the lesser of two evils.<sup>298</sup>

The impact of competition can go both ways: the presence of the public sector can impose indirect discipline on the private sector, both on prices and on quality. In Malaysia a credible public health system has kept price rises modest in the private sector.<sup>299</sup> The benefits of public provision extend beyond the numbers of patients treated publicly. Similarly, the presence of qualified medical personnel can force quality improvements in private markets.<sup>300</sup>

If natural monopolies exist, there can be competition *for* the market. Potential competitors bid for concessions—compacts—to provide the service. Much government pro-

#### **BOX 6.7** *Incentive pay works for specific health interventions*

The Bangladesh Rural Advancement Committee (BRAC), one of the largest NGOs in Bangladesh, paid workers to teach mothers how to use oral rehydration therapy for children with diarrhea. Independent of the providers, bonuses were paid on the basis of surveys of random samples of 5–10 percent of the mothers. The greater the number of women who could explain how to make and use the rehydration solution, the higher the payment. More than half of total compensation was paid as a bonus.

The mothers’ knowledge increased dramatically—to 65 percent of those taught two years after the training. Most important, the teaching techniques that the workers used changed from standard lectures to more hands-on demonstrations. Rather than have the right teaching technique specified for them from on high, workers developed the best way to achieve the measured outcome—finding out for themselves what worked in their context.

In Haiti, NGOs were given performance-based contracts, directly from the U.S. Agency for International Development, to provide preventive health care services such as immunizations, health education, prenatal care, and family planning. Again, an independent monitor, l’Institut Haitien de l’Enfance, a local survey research firm, was used to verify performance. Immunization rates increased dramatically along with several other outputs. Interestingly, some of the NGOs experimented with performance pay themselves but found lower morale and performance when workers (low paid themselves) faced such risky incomes. The NGOs, while satisfied with the high-powered incentives by which they were paid, found better ways to pay frontline providers in accordance with local circumstances.

Sources: Chowdhury (2001) and Eichler, Auxilia, and Pollock (2001).



curement in richer countries uses this model. It requires the ability to let, monitor, and enforce the explicit contracts for the winner. Recent innovations in the state of Madhya Pradesh in India allow NGOs to compete for concessions to primary schools. Payments are conditional on improved test scores based on independent measurement. One advantage the developing world has over earlier experience in Europe is that it has firms with good reputations and experience in the supply of water, power, and transport—and international courts for dispute resolution.<sup>301</sup> But the recent experience of Enron in India's Maharashtra State provides a reality check on over-enthusiasm for these benefits.

*Benchmark* or yardstick competition can be used when different providers are given parts of a larger system to run. Even when the public sector is the main provider of services, information from varying experiences can be valuable. Information on costs of production may be much cheaper to obtain by simple observation of one's own activities than from detailed technology assessments. Information on consumer preferences may be cheaper to obtain by counting customers than by conducting market research.

For road construction in Johannesburg, an explicit contract was made between the city manager and an autonomous public agency, the Johannesburg Road Agency, to build a given number of kilometers of road for a negotiated price. The basis of the negotiation was the set of historical costs in the public agencies. The manager of the autonomous agency then used both the public works department and private sector firms as contractors. Competition among the contractors determined subsequent allocations of funds. Even though it was not possible to fire personnel from the public agency, competition for funds ensured that the public agency would match the efficiency of the private firms (which it did for many contracts). There could be a gradual shift to private provision, but only on the basis of proven performance.

*Limits to competition and the search for suppliers.* For contracts that cannot be complete, aspects of delivery outside the contract will remain a matter of trust. For the provision of services to poor people, this trust

is particularly important because there are fewer “perks” for working in poor areas—private earnings after working hours (for medical personnel and teachers) are lower, living conditions harsher.

In the long run, a public sector with a strong ethos of public service will be needed. In many places it already exists. It does no good to pretend, however, that expanding the civil service under current recruitment and incentive regimes will attract those best suited to serving poor people. In Nepal an anthropological study showed that health staff's view of their jobs often differed from the official view.<sup>302</sup> Many staff saw the health program solely as a source of employment. A broader set of potential providers is needed to accept the compacts.

NGOs—so much a part of the African scene and active in several other countries, such as Bangladesh—are possible candidates. They are a varied group. Many are not directly involved in service provision, and many combine service with advocacy. Those that provide services often have a great deal of autonomy, choosing where and how to deliver services. To that extent, they might be treated the same as the rest of the private sector in planning public services. The government should not be in the business of displacing them.

NGOs that have a tradition of altruistic service can frequently be lower-cost producers. In a recent study, religious NGOs providing health care in Uganda were found to offer higher-quality service than their public sector counterparts. They also paid lower wages than the private sector and very much lower than the public sector. Unlike the private sector, they were more likely to provide public health services (as opposed to simply medical care) and to charge less. And they used an extra cash grant to lower fees and provide more services, such as laboratory tests, whereas the public sector used the grant to increase pay.<sup>303</sup>

NGOs are often, though not always, better able to reach poor people. A substantially higher fraction of the clientele of NGOs providing health care in Zambia comes from poorer segments of society than does the clientele of government facilities or private providers.<sup>304</sup> But even they have a hard time reaching the very poorest. NGOs may also be in a better position, with their greater flexibility and their internal motivation, to bring services

to otherwise excluded groups (box 6.8). And smaller organizations can reach niche populations that a broad-based bureaucracy may find hard to serve.

In combating AIDS, community outreach often needs to deal with prostitutes, drug users, and very sick, stigmatized people. The same difficulties in assigning public personnel to remote areas have been found in reaching these subgroups. In Brazil, however, NGOs competing for government funds were able to reach high-risk segments of society that usually avoid public programs (such as prostitutes), to distribute 2.6 million contraceptives, and to take 11,000 hotline calls. The relative independence of NGOs from the core of the public service may make it easier for them to fund their activities from public resources by granting policymakers an extra layer of deniability.

The altruistic motives of people working in NGOs can overcome the incompleteness of contracts. NGO providers are generally less likely than for-profit providers to exploit the difficulties of monitoring contract terms for their own benefit. Their altruism may partly outweigh a reluctance to locate in difficult, remote, rural areas that are hard to staff with civil servants. This possibility has led one analyst, thinking of Africa, to conclude that services to poor people may, for the time being, have to be left to such groups, particularly the church.<sup>305</sup>

Once again, patience is called for. Donor enthusiasm has led to a massive proliferation of NGOs, many of them not at all motivated by

altruism.<sup>306</sup> Indeed, many appear to be run by former civil servants who have lost their jobs as a result of the downsizing of public sectors but who know how to approach donors and government contracting agencies. A rapid expansion of contracts for NGOs will tend to attract the same people, and their motives may be exactly the same as those of a for-profit firm—requiring the same monitoring and care in contract enforcement. NGOs with a track record of good performance and dedication to poor people are potentially very important elements of a strategy to extend services to the neediest people. But establishing a track record, by its very nature, does not happen as fast as donors would like. The development of trust takes time.

*New challenges to supply.* Although there may be ways to extend the supply of providers by promoting competition and efficient contracting with NGOs and the private sector, two recent trends in developing countries are making skilled professionals scarcer, or more expensive. First, professionals—doctors, teachers, and engineers—are increasingly part of integrated global markets and recruitment needs to compete at world wage rates. And it is not only the rich countries that staff are emigrating. Botswana, for example, has been recruiting teachers from other, poorer English-speaking countries. The global market for services is changing rapidly due to international agreements and could lead to new sources of supply. Whether this turns out to help or hinder services in developing countries remains to be seen (see box 6.9).

Second, HIV/AIDS, particularly in Sub-Saharan Africa, has dealt a major blow to the ranks of service providers. More teachers died of AIDS in Malawi in 2000 than entered the profession (see box 1.2). Botswana's search for teachers, originally to meet a burgeoning demand for education, was given greater urgency by the country's AIDS problem. And just as demands for health service workers are increasing, their supply is being cut.

When a factor of production becomes scarcer, its use must be conserved—in one of two ways. First, techniques that are less skill-intensive can be chosen. Distance learning, while not ideal for pedagogical purposes, may need to be explored to save scarce teaching time. Similarly, it may be appropriate to use

### BOX 6.8 *NGOs can be more flexible than government*

One advantage that NGOs may have over the public sector is the freedom from fixed civil service rules or standard operating procedures. In some ways this reduces accountability, but it can avoid unnecessary constraints.

A social worker in a family protection program calls on a family threatened with having a child removed for neglect. She's greeted by the mother, who says "If there is one thing I don't need in my life right now, it's one more social worker telling me what to do. You know what I really need? To get my house cleaned up."

The social worker, who happened to be a highly trained clinical psychologist, responded by saying, "Would you like to

start in the kitchen?" While the two women were cleaning, they had a terrific conversation about what was going on in that family. When I told the story at a meeting, I was interrupted by the head of a university clinical psych department who said, "What that therapist did was unprofessional."

Well, all I can say is if we want effective interventions that have transformative effects on people, then we had better redefine what is professional, or allowable in the expenditure of public funds.

(from *Common Purpose* by Schorr, 1997)

In many countries there is no way for publicly employed social workers to violate the opinions of the university professor, but more independent NGOs could do so.

water systems that require less technical inputs for maintenance. Second, some kinds of services that happen to be highly skill-intensive may be reduced. Curative medical services that require trained professionals may be cut back relative to public works or public health education, more intensive in capital and unskilled labor. It is possible that these interventions (low-maintenance water systems, use of village health workers or traditional healers) may always have been under-

used. Recent trends may merely have made this misallocation more costly.

### *Monitoring and performance*

All contracts—both compacts and management relationships within provider organizations—need to be monitored with independence and objectivity. With the separation of the policymaker and the provider organization, the policymaker will want to know whether compact provisions are satisfied.

#### **BOX 6.9** *Is the GATS a help or a hindrance?*

For a new agreement that has so far not had much impact on actual policy, the WTO's General Agreement on Trade in Services (GATS) is viewed with a surprising degree of both hope and trepidation. In the current Doha agenda negotiations, some look to the GATS to deliver much-needed reform of services from which the poor will also benefit, while others see it as a threat to regulatory sovereignty and pro-poor policies.

In principle, multilateral negotiations can foster reform in services, as in goods, by eliminating or reducing protective barriers through mutual agreement and by lending credibility to the results achieved through legally binding commitments. The expectation is that more open markets and greater predictability of policy will lead to the more efficient provision of services. That is the rationale for the GATS. We address three questions: How much market-opening has happened so far under the GATS? Does the agreement prevent recourse to the complementary policies needed to ensure that the poor have access to essential services in liberalized markets? Could the GATS process lead to liberalization before other necessary reforms, and how can this be prevented?

The GATS is certainly wide in scope. It applies to virtually all government measures affecting trade in almost all services, including educational, health, and environmental services. Moreover, in recognition of the fact that many services require proximity between consumers and suppliers, trade in services is defined to include not only cross-border supply but also foreign investment and the temporary migration of service consumers and providers. The broad reach of the GATS contrasts with the flexibility of its rules. The generally applicable rules merely require of each country that its trade-affecting measures be transparent and not discriminate among its trading partners. Thus, if a country were to prohibit all foreign supply and make this fact public, then it would have met its general obligations.

The extent of *market openness* guaranteed by a country depends on its sector-specific com-

mitments. These promises to eliminate or limit barriers to foreign supply were mainly the outcome of negotiations—but some were volunteered, particularly in telecommunications. Most existing commitments entailed little liberalization beyond existing market conditions. Many countries committed on tourism, financial, business, and telecommunication services, but relatively few in health, education, and environmental services. Of the 145 WTO member countries, only 43 (12 developing) have made commitments in primary education, 52 (24 developing) in hospital services, and none on water distribution (which was not an explicit part of the original negotiating list of services sectors).

The most serious charge against the GATS is not its meager harvest of liberalization—but that it deprives governments of the freedom to pursue pro-poor policies. It is argued that the rules of the agreement threaten public education, health, and environmental services; outlaw universal service obligations and subsidized supply; and undermine effective domestic regulation. These charges do not seem well founded for three reasons. First, services supplied in the exercise of governmental authority are excluded from the scope of the GATS, although the definition—services that are not supplied on a commercial basis or competitively—offers scope for clarification. Second, even in sectors that have been opened to full competition, the agreement does not prevent the pursuit of domestic policy objectives, including through subsidies or the imposition of universal service obligations as long as these do not discriminate against foreign suppliers. Finally, the agreement recognizes the right of members, particularly developing countries, to regulate to meet national policy objectives, and its current rules on domestic regulations are hardly intrusive.

However, the concerns noted above are not so much about what the GATS *is* but what it *may become* after the current (and any future) round of negotiations—which will aim for more liber-

alizing commitments and new rules in areas such as domestic regulation. Informed debate would undoubtedly help ensure that future GATS rules and commitments reflect broader development concerns and not just the dictates of domestic political economy or external negotiating pressure.

At this stage, however, the main issue is not so much what the GATS forces countries to do or what it prevents them from doing, but that it does not—indeed cannot—ensure the complementary action that is needed to deliver pro-poor liberalization. This raises a legitimate concern: *in a complex area like services, trade negotiations alone could lead to partial or inappropriately sequenced reform*. One possibility—already visible in some cases—is that less emphasis will be placed on introducing competition than on allowing a transfer of ownership of monopolies from national to foreign hands or protecting the position of foreign incumbents. Another is that market opening will be induced in countries that have not developed regulatory frameworks and mechanisms to achieve basic social policy objectives. These flaws could conceivably make the poor worse off. The problem is accentuated by the difficulty in reversing inappropriate policy choices that have been translated into legally binding external commitments.

The danger of adverse outcomes would be substantially reduced if two types of activities receive greater international support. The first is increased policy research and advice within developing countries and outside to identify the elements of successful reform—and to sift the areas where there is little reason to defer market opening from those where there is significant uncertainty and a consequent need for tempered negotiating demands. An even greater need is for enhanced technical and financial assistance to improve the regulatory environment and pro-poor policies in developing countries. The development community is already providing such support, but a stronger link could be established between any market opening negotiated internationally and assistance for the complementary reform needed to ensure successful liberalization.

Competition among providers helps, since the policymaker will not feel locked into a particular provider, obliged to ignore bad news. If the separation between the two is not achieved, an independent regulator or auditor should be assigned the monitoring activities.

Clear and observable provisions make monitoring easier. When the provisions are not so easily observed, the policymaker may want to enlist the help of other kinds of monitors. The health program in Ceará, Brazil (see spotlight), used applicants to the program who had not been selected as informal monitors.

When monitoring is difficult because of the technical nature of the service, self-monitoring by professionals may be necessary. In Bangladesh attendance by staff is much higher in larger facilities due to informal self-monitoring, among other factors.<sup>307</sup> Professional associations can also serve as self-monitors, establishing professional, ethical, and technical standards for medical care providers, teachers, and engineers. But the risk in self-regulation is that professional groups become effective lobbyists for their members.

A third source of monitors is the public. Even if clients are not the active monitors described in chapter 4—that is, they are not purchasers of services or direct participants in service delivery—soliciting information (as private business often does) can be useful in public services. Publicizing the results of scorecards led to a substantial improvement of many services run by the Bangalore Municipal Corporation. This practice was replicated in most states in India.

When day-to-day monitoring to assess performance is not possible, independent monitoring of the performance of services on an occasional basis can still be valuable—by bringing public information to bear on provider behavior. The Public Expenditure Tracking Survey in Uganda (see spotlight on Uganda) is an example. More regular publicity of service characteristics on several dimensions—such as absentee rates, regular delivery of pharmaceuticals, hours of operation for electricity or water—could all mobilize community concern and informal influence.

### *Evaluation*

Generating and disseminating information are powerful ways of improving service deliv-

ery. They are also clear public goods and core responsibilities of government. Accurate information can motivate the public, particularly the poor, to demand better services—from providers and from policymakers—and arm them with facts. Knowledge of the real impact of programs helps the policymaker set priorities and design better compacts. Knowledge of the impact of different techniques of service delivery helps the provider organization better fulfill its compact. If the means to better service is the alignment of incentives with outcomes, knowing what those outcomes are and how services contribute to them is central.

Good evaluation is the research necessary to assign causality between program inputs and real outcomes. It should be directed at the full impact of programs—not just the direct outputs of specific projects. But few evaluations have been done well, even though most major donors (including the World Bank) have always made provisions for them. Evaluation, though primarily a responsibility of governments, is an area in which donors can help. It costs a small fraction of the programs examined and a small fraction of the value of the information produced, but it does require some expensive technical inputs. And since other countries will use the results, the international community should defray some of the costs.

There are impediments to collecting such information. Provider organizations often do not want to acknowledge their lack of impact (even if it does not affect their pay directly), but knowing when things are not working is essential for improvements. Further, it is necessary to know not just what works but also why—to replicate the program and increase the scale of coverage.

### **Provider incentives in eight sizes**

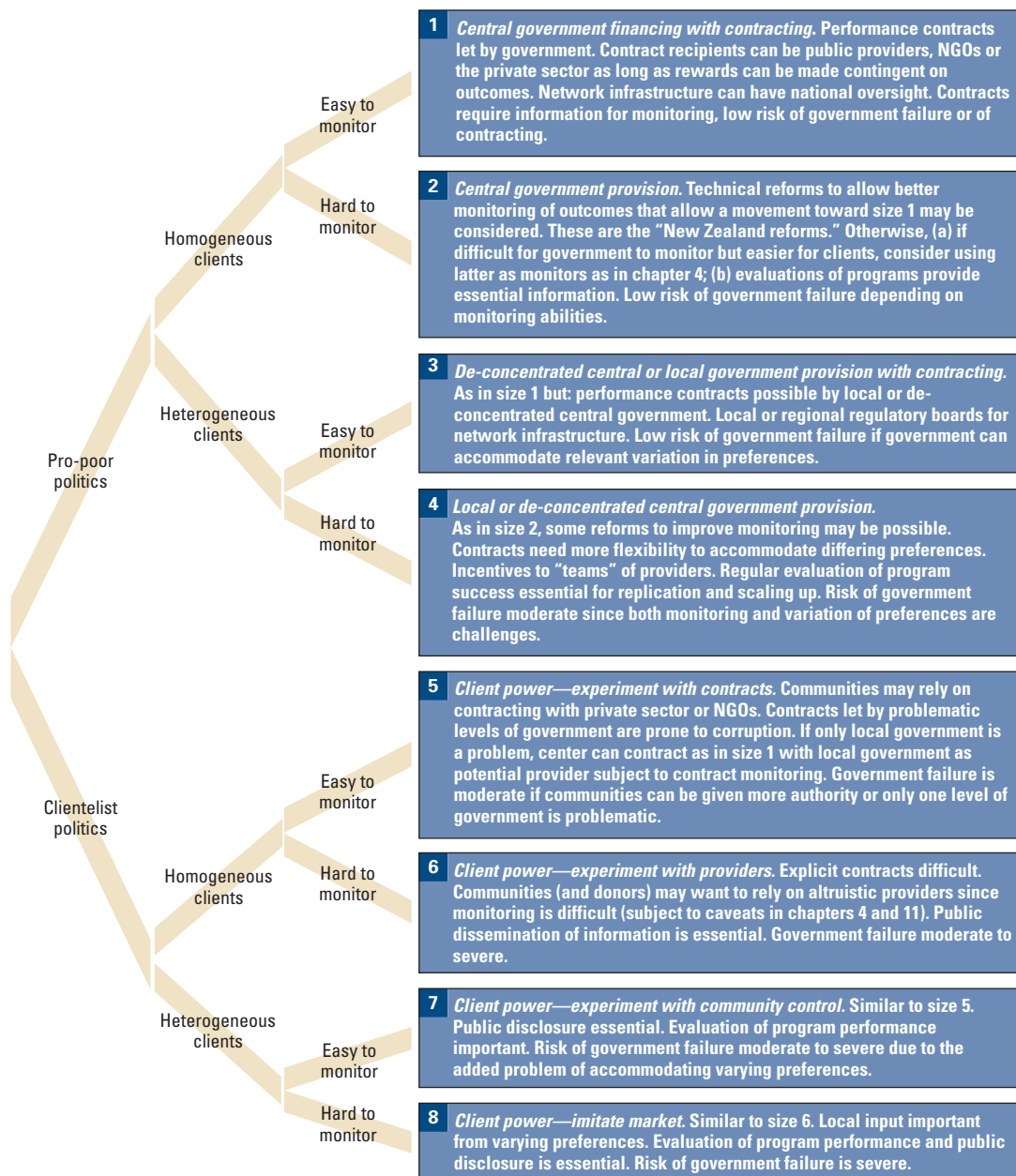
Returning to the decision tree of figure 6.2 from the perspective of provider incentives, the decision concerning the difficulty of monitoring is, of course, key. When monitoring is easy—sizes 1, 3, 5, and 7—opportunities for more explicit incentives and the use of contracts should be explored. However, contracting with a private sector is often a bad idea for sizes 5 and 7. Such contracts are a common source of corruption that governments find harder to manage

and citizens find harder to detect than if services were provided by government.

When monitoring is difficult—the even-numbered sizes—one goal is to improve the ability to monitor with the methods discussed in this chapter. More competition, more careful measurement of outcomes, the evaluation of the effect of inputs on outcomes, and the provision of incentives to groups of providers such as schools or districts can all help.

The boxes suggest eight sizes appropriate in different circumstances. They also indicate the relative difficulty of carrying them out—the degree of government failure associated with them. Generally speaking, the severity of the government failure increases with the size number. The degree of market failure needed to justify relatively easy policies to carry out is modest, or, equivalently, the highest-priority policies are those with large market failures or

Figure 6.2 Eight sizes fit all



strong redistributive effects. For the hardest cases such as case 8, market failures must be quite costly to justify intervention, given the many legitimate claims on government.

Including government's ability to implement—that is, the degree of government failure to be expected—can lead to a substantial re-ranking of public policies relative to conventional analyses. For social security systems, for example, there is no particular reason on conventional economic grounds for the public sector to send out checks to pensioners. But many governments with well-developed administrative procedures do it quite well, and there is no compelling reason to change—market failures are not terrible but neither is it hard for government to do. Much of the controversy about whether rich countries should emulate New Zealand's reforms surrounds this point. New innovations in contracting with a private sector or with a government agency might improve the functioning of government somewhat. But if government is already doing tasks acceptably, the gains may be small and possibly not worth the disruption caused by the change itself.

When applied to the health sector some standard prescriptions are reinforced by these considerations while others are challenged. The provision of traditional public health services, such as pest control to prevent infectious disease, is relatively easy to carry out. But staffing and maintaining a large network of primary health centers in remote areas is often hard to do, even though the redistribution effects are potentially beneficial. It might be wiser, until government capabilities improve, to try to get poor people to government facilities, even to much maligned hospitals, than get facilities to poor people. Not only would this address a serious market failure, the absence of insurance for expensive care, but it will be easier to implement since working in less remote areas is more consistent with providers' interests and easier to monitor, with a smaller number of larger facilities.<sup>308</sup>

## Scaling up, scaling back, and wising up

There is no "right" way to make sure services reach poor people. The appropriate technical interventions—and the institutional structures that generate them—vary enormously. Education was expanded dramatically in Chile by markets and vouchers, in Cuba by a central ministry, and in El Salvador by local school committees. Beyond trial and error, scaling up means watching what you're doing, evaluating whether it works, determining why it works or doesn't, replicating success, and evaluating the replications as well. Sometimes things work for idiosyncratic reasons—a charismatic (and literally irreplaceable) leader or a particular (and unrepeatable) crisis that solidifies support for a politically difficult innovation. So one-time successes may not be replicable. Experimentation, with real learning from the experiments, is the only way to match appropriate policies with each country's circumstances.

Scaling up also means scaling back—abandoning failures unless a good, remediable reason for failure is found. Abandoning failures is harder than it sounds. Simply admitting failure is hard enough, particularly for politicians. But with the severe resource constraints in developing countries—they are poor after all—badly performing programs are simply unaffordable. Where programs are intensive in management (and auditors and managerial talent are scarce) or intensive in trained personnel (and teachers and doctors are scarce), states need to let go of programs that are not working and find alternative ways to achieve better outcomes.

If the political will exists, the key to scaling up is information. Beyond evaluating programs and projects, a continuing focus on making services work for poor people—educated children, better health, reliable water, lighted homes, safer streets—depends on the continuing measurement of progress toward these goals. "What gets measured is what counts." This focus on outcomes helps policymakers choose the best options for serving poor people. It helps the providers know when they are doing a good job. And it helps clients judge the performance of both.

## 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.<sup>309</sup> 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.<sup>310</sup> 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.

Performance indicators were measured for all the districts by household, and health facility surveys, which 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-out districts: \$2.80 in the contracted-in districts, \$4.50 in contracted-out districts, compared with \$2.90 in control districts.<sup>311</sup> These differences are large and represent slightly 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.<sup>312</sup> 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 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

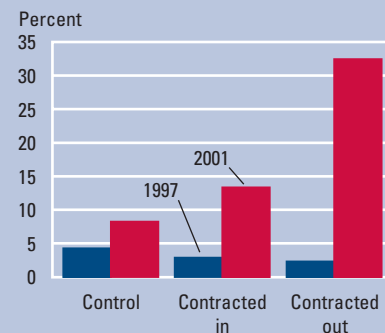
in contracted-in and control districts. The reduction was especially marked among the poor (\$35 a year, or 70 percent), indicating better targeting and more efficient transfers of subsidies.

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.<sup>313</sup>

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

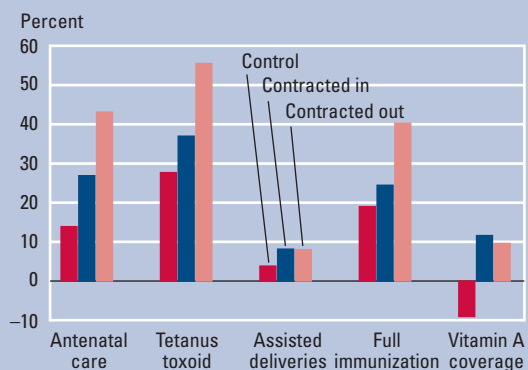
- The regular availability of drugs and qualified staff strengthened service provision at health centers in the villages, where most poor people are concentrated.
- The contracted nongovernmental organizations used a market-based wage and benefits package to attract and retain health care providers.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

**Figure 1** Percentage of illnesses treated at a health facility for people in the poorest half of the populace



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

**Figure 2 Coverage of selected health indicators between 1997 and 2001 in control and contracted districts of Cambodia**



Source: Bhushan (2003).

- 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 house-

hold 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.