SEPTEMBER 24, 2002

WORLD DEVELOPMENT REPORT 2004

MAKING SERVICES WORK FOR POOR PEOPLE

Introduction to the Outline of the World Development Report 2004, "Making Services Work for Poor People"

Why is freedom from illness and illiteracy—two ways poor people say the escape from poverty can be most meaningful—denied to so many? Health and education outcomes depend on many factors, but effective delivery of basic services, such as education, health, water and sanitation, is clearly one of them. These services have often failed poor people. Where societies have improved services, it has usually been because poor people or their advocates—the clients—have played an active role. Learning from failures and successes, the 2004 *World Development Report* seeks to understand how health, education, water, and sanitation services—services that have a direct impact on improving health and education outcomes—can be made to work for poor people.

Health and education outcomes depend, among other things, on the incomes of the poor, choices households make, and technological change. Economic growth alone will not be enough to reach the Millennium Development Goals, especially those for health, nutrition, education, gender equality and environmental sustainability. Spending more money—badly needed in many parts of the world—will also not be enough. Public funds are often spent on the wrong services and people; are sucked away by corruption; and, when they are not, reach teachers and health workers mired in a system where they have little incentive to do their jobs. In many countries, teachers are absent 50 percent of the time.

Governments, societies, and donors can—and should—change this. To do so will require a shift in the way we think about services. The traditional mode of service delivery, where a centralized public agency provided the service with little involvement of the client, has been extremely successful—even for poor people—when the service is relatively uniform and can be measured with quantitative targets, e.g., the post office and vaccination campaigns. But when the nature of the service varies across clients (maternal and child health, for instance), and it is the quality rather than the quantity that matters (learning outcomes rather than school enrolment), then the traditional mode often breaks down. For these services, the client must be at the center of process—in determining the mix and quality of services, as well as in holding service providers and policymakers accountable for effectively delivering the service. Many governments are trying to achieve this shift by decentralizing services to local governments, community-driven development and using private or NGO providers. Some, but not all, of these efforts have been successful in improving services for poor people.

The *WDR* proposes to shed light on the successes and failures of the traditional and alternative approaches, by unbundling service delivery into three sets of actors in the service chain—*clients, providers* (public or private), and *policymakers.* In low-income countries, there is a fourth actor: *donors.* Each of these actors responds to different institutional *incentives,* to produce services that either work or do not work for the poor. The *WDR* will seek to show how the relationships between policymakers, providers,

clients, and donors can be strengthened by the *choice* of financing, regulation, production, and monitoring arrangements. Public provision, contracting out, decentralization, community-based- and private-provision with or without subsidies can each make sense depending on the context and circumstance. Finally, the *WDR* will examine ways in which *accountability* for service outputs and their monitoring can be strengthened. Giving choice to clients by bringing competition to the client-provider relationship, and strengthening their voice and participation—better public disclosure rules, well-functioning courts, an independent media—can help. Community driven co-production initiatives can make sense where institutions are weak all around, enhancing client ownership as an entry point for making local services work.

Fundamental shifts in thinking and action do not come easily. Achieving systemic, institutional reform in basic services—as distinct from managerial or technocratic changes—is very difficult because of history, politics, and social norms; because it changes power relationships among the key actors; because it often requires sweeping reforms in budget management and the civil service, as well as in donor practices; and because sometimes making services work for poor people requires making services work overall.

Applying the 2004 *WDR*'s proposed message of *incentives*, *choices*, and *accountability* to make services work for the poor will yield reform agendas for education, health, water, and sanitation services. Making education services work for poor people will require national-government oversight and high-quality providers with autonomy, but the biggest payoff is likely to come from strengthening the power of citizens to discipline the system through voice and choice. In health, the biggest payoffs will come when the accountability of policymakers, providers, and households shifts to improving outcomes; greater use of pro-poor contractual arrangements, better information to households, and enhanced civil-society oversight will help. In water and sanitation, where client willingness-to-pay is high, the key will be to achieve a genuine separation between policymakers and service providers, freeing up the latter to be far more responsive to what clients and communities, large and small, want. All of these services will benefit from more widely available information on the performance of services.

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[1] In addition to the customary use of examples to illustrate various points, this WDR will have a set of ten or so case studies or "intermezzos" that will appear between chapters. Each intermezzo will attempt to present a balanced view of a particular service delivery experience or outcome, drawing on evidence from evaluation research, to emphasize that the underlying story can have many more facets than a simple example might suggest. The tentative list of intermezzos is indicated in the Table of Contents.

Part III: A Reform Agenda

Intermezzo: History of service delivery in Norway and Estonia

Chapter 7: Public-Sector Underpinnings for Sector Reform

Intermezzo: NGOs in education in Bangladesh

Chapter 8: Education Services

Intermezzo: Bamako initiative in West Africa

Chapter 9: Health and Nutrition Services

Intermezzo: Johannesburg

Chapter 10: Water and Sanitation

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Conclusion

Opening Vignettes: Services can work for poor people

I. Services have failed poor people …

A. Example of people with no access to water

B. Example of lack of materials within a health facility

C. Example of teacher absenteeism and lack of professionalism when at work

D. Example of lack of demand for investing in education

II. … but they can work.

A. Example of a successful large-scale increase in school enrollments

B. Example of drug revolving funds

C. Example of large scale mobilization (with supply and demand components) to improve health outcomes

D. Example of successful demand subsidies

Chapter 1: Poverty, Human Development, and Outcomes

Services have frequently failed poor people, but governments and citizens can—and should—make them work better. This report focuses on services that affect health and education outcomes, which are important dimensions of human welfare as well as investments in human capital. Income growth is an important determinant of improved outcomes, but by itself will only achieve so much. For example, projected growth will not be enough to reach several of the Millennium Development Goals (MDGs). While many factors determine health and education outcomes—ranging from individual and household actions to global technological change—publicly regulated, financed or provided services are one set of determinants that governments can directly affect. These services are often lacking or of low quality, especially for the poor. In some instances, however, governments and citizens have improved outputs by innovative service arrangements. Scaling up these innovations will be necessary for improving human development outcomes. Among the various services that contribute to outcomes, this report concentrates on those services that fall under public responsibility; that do not primarily work through income generation; and contribute directly or indirectly to health and education outcomes. This leads to a focus on health, education and water and sanitation services, with some treatment of rural transport, public security and social protection.

I. Why are human development outcomes important?

A. Health and education are central to welfare and various dimensions of poverty in their own right

1. Poor people frequently identify poor health and illiteracy as dimensions of poverty

2. International endorsement of MDGs recognizes health and education outcomes as priorities for action

3. The view of health and education as human rights.

B. Health and education are critical investments in human capital. Moreover, they are key instruments for empowering poor people.

1. Good health and quality education contribute to higher productivity

2. Empowerment and overcoming exclusion based on gender, disability, caste, ethnicity, religion, tribe, etc.

C. The Millennium Development Goals

1. Outcome-based orientation for assessing progress (comparison with non-outcome based approaches)

2. Different countries, particularly where progress towards meeting basic goals is largely achieved, may need to adapt the specific outcomes relevant for their circumstances.

3. All countries care about outcomes beyond the MDGs (e.g., quality of education, popular participation, social cohesion)

4. Population-wide improvements are synonymous with reductions in within-country inequalities (income, gender, ethnicity, location)

D. Relationships between income and outcomes

1. Outcomes typically improve as national income increases

2. But there is still a lot of variation at any given level of income

3. The causality in the income-health and education outcomes relationship can go in both directions

II. There are many determinants of health and education outcomes

A. Demand: individuals and households

1. Demand for
    a) schooling
    b) health care
    c) water and sanitation

2. Households as mediators between services and individuals
    a) Knowledge and practices of adults in households
    b) Intra-household allocation
        (1) Role of gender
        (2) Other aspects of intra-household allocation

3. Linkages between various outcomes at the individual level
    a) Education effects on health and nutrition
    b) Effect of health and nutrition on capacity to learn
    c) Role of water quality and sanitation on health

B. Supply: From global to local communities, to services

1. Global developments:
    a) Research and technological innovations

b) Financing

2. National governments
   a) Public spending can lead to, but does not ensure, improved outcomes
      (1) Successes and failures of country experiences of expanding financing
      (2) Cross-country associations between public spending and human development outcomes and attempts at identifying causation
      (3) Lesson: *How* money is used is crucial to ensuring effectiveness
   b) Public sector reform
      (1) Public expenditure management
      (2) Governance
   c) Political and economic failures (conflicts, economic crises, etc.) lead to bad human development outcomes.
   d) Importance of multi-sector, multi-year vision for improving human development outcomes

3. Local institutions: government and communities
   a) Can be accountable to local demands, but also potentially vulnerable to capture
   b) More and more called on to take budgetary authority. Are they any more likely to allocate sufficient financial resources to human development? To use resources more effectively?
   c) Are poor areas and sub-groups more easily excluded from the national mainstream?

4. Services. Much of the remainder of the report is on services, but examples here of:
   a) Effective services leading to improvements in outcomes
   b) Bad services resulting in deterioration in outcomes

III. Services have often failed, but they can be made to work

A. Why services?

1. Services frequently fail poor people
   a) Benefit incidence studies typically show that only a small share of public resources reach poor people
   b) Poor quality of services

2. What are services that work?
   a) Services that work share certain characteristics: e.g. accessibility, affordability, quality, …

b) Services that actually contribute to improving health and education outcomes

3. Governments and citizens can make services work for poor people.
    a) Opening up budget processes to civil society
    b) Linking the budget to an explicit poverty strategy, such as PRSP
    c) Decentralization.
    d) Private-public partnerships.
    e) Community-Driven Development

B. Why these services?

Among the various services that contribute to health and education outcomes, the *World Development Report 2004* concentrates on health, education, water, and sanitation services, with some treatment of rural transport, public security, and social protection.

1. Services that are perceived as a public responsibility
    a) Welfare economics (market failure and redistribution are rationales for government intervention)
    b) Political economy
        (1) People demand—often through the vote—public sector involvement (provision, financing, or regulation)
        (2) Governments often want to control them. For example, most governments are providers of education even if there may be a less compelling case on the basis of welfare economics.

2. Shared characteristics of these services
    a) Discretionary (providers make numerous independent decisions at the point of delivery)
    b) Transaction intensive
    c) Do not work primarily through income

Chapter 2: A Framework for Service Reform

The typical mode of service delivery, centralized public-agency production, has had successes and failures. Governments around the world are introducing alternative service delivery arrangements, including decentralization, contracting out, participatory methods, etc. To understand the successes and failures of the typical mode, and to evaluate the alternatives, this chapter proposes a framework for analyzing service delivery. The framework distinguishes among three groups of actors in the service delivery chain: policymakers, providers and citizens. In low-income countries, there is a fourth actor: donors. Effective services result from policymakers, providers, and citizens interacting in well-structured, institutional relationships. Weaknesses in any of the three relationships can result in failures. The alternative arrangements can be seen as attempts to strengthen one or more of the relationships in order to make the chain more effective. Achieving systemic or institutional reform (as opposed to mere managerial reform) in public services is difficult because of history, politics, and social norms; because it changes power relationships among the key actors; because it often requires sweeping public-sector reforms; and because sometimes making services work for poor people requires making services work overall.

I. The typical mode of the provision of services, "public agency direct production," has had successes and failures

A. Description: Centralized, no unbundling of roles within government provision (e.g. no arms-length regulation of public sector providers), individuals are civil service employees who lack either rewards or punishments for performance, emphasis on control and uniformity.

B. Examples of successes—particularly in "logistical tasks," i.e., tasks for which uniformity is acceptable (homogeneous demand, physical targets).

1. Vaccination campaigns and their (near) global success.

2. The vast expansion in the quantity of schooling.

3. Improvements in physical infrastructure for water.

C. But services have failed in many cases.

1. Failure in logistical tasks (places where basic services are not being delivered)

2. Failure to move to the next stage (quality schooling, health services, maintaining effective water services).

II. Reforms of and alternatives to centralized public agency production are available

Alternative institutional modes of public *responsibility* for services		
Arrangement	Description	Examples
Centralized Public Agency Production	Budget resources are transferred exclusively to government agencies (or parastatals), services are provided by government employees.	The typical mode of delivery
Contracting In	Separating clearly the role of the government as a "policymaker" and as a "provider" and an approach that focuses budgets and internal controls and regulation on the outputs of public agencies.	New Public Management, Transforming ministries to take on monitoring and policy making functions while deconcentrating front-line service delivery Performance based management.
Contracting Out	Government specifies a contract with a provider organization which could be either a publicly owned entity, or a non-profit organization, or a private firm.	Autonomous hospitals, performance based contracts with universities, water companies.
Decentralization	A smaller than national unit is made responsible for the provision of dimensions of services (usually with some arrangements for central involvement in financing)	Fiscal decentralization, "municipalization".
Single or Multi-sector Participatory	Communities and local groups are given greater power in the provision of services.	Community Driven Development, Social Funds
Demand-Side Subsidies	Public resources are transferred directly to individual who have their choice of providers. Government role is designing the transfers and the regulation of provider quality.	Single payer health insurance (e.g. Canada, school "vouchers" in Chile, Holland)
Market	Individuals choose their own providers with their own resources, government involvement is limited to background regulation (e.g. safety, certification, prevention of fraud).	Service provision when individuals "opt out" of publicly controlled or subsidized provision (private schools, private medical practitioners, private water).

III. An analytical framework is needed to investigate why the typical mode succeeds and fails, and to choose the appropriate alternative—matched to the service and local conditions.

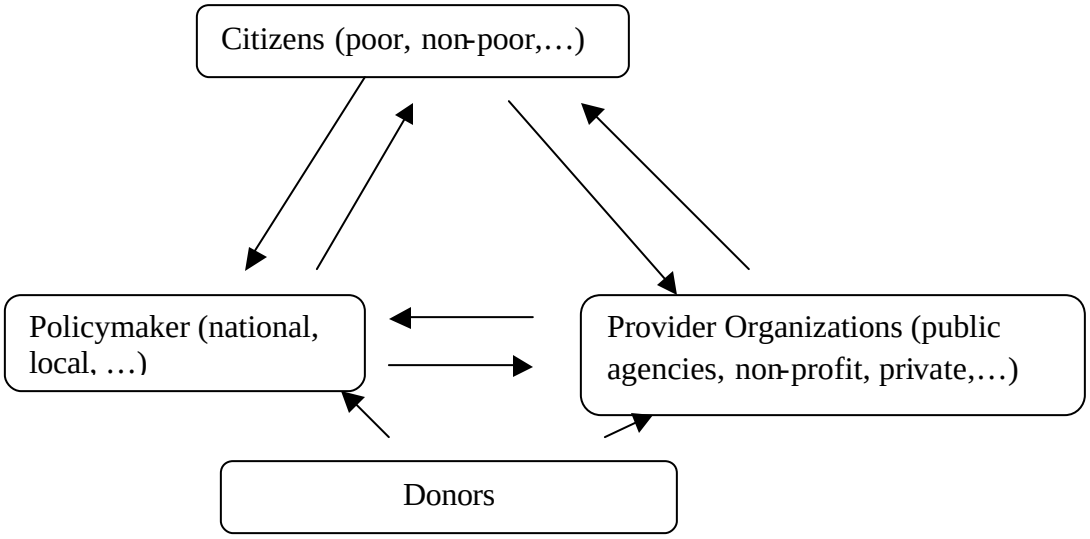
A. The delivery of every service requires a complex process with many levels, which we divide into three *roles*: "policymakers" "providers" and "citizens." In low-income countries, there is another set of relationships—between donors and policymakers and providers—that plays an enabling or limiting role by how it affects the other three relationships.

1. By *policymaker* we mean whoever controls and discharges the fundamental power of the state. This could be an executive or legislative agent (or a combination of the two). The policymaker sets the fundamental "rules of the game" within which all providers operate. Even

for a single service, there may be several policymakers. For instance, in many decentralized countries, both a national and a local policymaker is involved in service delivery.

2. By *provider* we mean whoever manages the delivery of the services—providers can be a public sector agency (e.g. the Ministry of Education can be an organizational provider of educational services), an autonomous public enterprise (e.g. autonomous hospitals), a non-profit (e.g. religious schools), or for profit (e.g. private hospitals). Currently many line ministries play the role of policymaker and provider without any clear separation. There could be multiple *types* of providers (public, non-profit and profit) and multiple providers of each type delivering the same service in a country. (By "providers" we do not only mean the *front line* service providers, but also the organization (if any) these providers work for).

3. *Citizens* are the residents who both ultimately control the policymaker and who are the direct clients of services. Citizens are not homogeneous. The distinction between poor and other citizens is particularly important. Also, in health and education services, differentiating citizens along gender and ethnic dimensions may be salient.



B. The institutional arrangements for the provision of services are embodied in the formal and informal relationships between these three classes of actors: *policymakers, providers,* and *citizens.* The way donors interact with the recipient often affects these relationships.

1. Policymaker-Provider: Even the most committed policymaker cannot perfectly monitor and control the service provider. Hence, the relationship between policymaker and providers, whereby the former devises the set of

rules (incentives, rewards, punishments) under which the latter operate, is a crucial component in the service-delivery chain.

2. Client-Provider: The policymaker will not be able to specify all the actions of the provider in the "contract". Thus citizens play two, critical roles: in revealing their demand for services, and in monitoring the provider.

3. Citizen-Policymaker: When the policymaker is not committed to improving the welfare of the poor, citizens need to exert their influence to ensure that the policymaker will have an incentive to respond to their preferences. This relationship includes both formal mechanisms, such as the elections and informal ones, such as the use of advocacy groups and public information campaigns.

C. Using the framework to understand successes and failures of centralized public agency production, as well as in evaluating alternative arrangements

1. Centralized public agency production does work, and does so very well, to accomplish purposes of the state when: (a) the state is capable, (b) the service to be delivered is relatively simple, in that the process of sustained service delivery requires little discretion, (c) demand for the service is relatively homogenous across citizens (e.g. post office, East Asia).

2. Centralized public agency production also has failed in many ways:
   a) When the policymaker-provider relationship is strong but citizen voice weak, the state can deliver what citizens do not want, e.g., apartheid.
   b) When the state, providers and citizens are all weak then few public services are delivered at all and, even for purely logistical functions, operational delivery fails.
   c) When the citizen-policymaker link is weak, but the public sector and providers politically (though not necessarily professionally) strong, public agencies can become bloated, overly responsive to provider concerns, and services fail entirely (a public sector job becomes a sinecure).
   d) When the service to be delivered is complex, then centralized public agency production tends to discourage innovation and initiative by providers and stifles the development and use of professional autonomy and hence undermines the development of strong providers.
   e) When there is heterogeneous demand (across individuals or communities) the top-down, rules based, mechanisms of control defeat local input (e.g. imposing inappropriate water systems on communities).

3. Public sector institutional reforms through the "three-relationships" lens

a) Many attempts at improving existing public services fail because they do not alter incentives.

b) Institutional reforms of public agency production need to strengthen the focus on accountability (to policymakers and citizens) for outputs.

4. Alternative arrangements viewed through the "three-relationships" lens

a) Contracting out: strengthening the policymaker-provider link

b) Decentralization: strengthening the citizen-provider and citizen-policymaker links

c) Single-sector participatory (CDD, Social Funds): strengthening the citizen-provider link

d) Demand-side subsidies: linking policymakers with citizens directly, to improve provider performance

IV. Achieving systemic reform that improves public services is difficult.

A. Managerial reforms within the public sector agency mode of production are sometimes not enough. They focus on the proximate causes of service delivery failure which presumes that organizational forms are viable and management is interested in performance. In contrast, fundamental, institutional reforms create the conditions for service provision from which good management and effective service provision organizations emerge as an outcome. Sometimes the failures of public services are incidental but sometimes they are institutional.[2] Public sector managerial reforms are a common, continuous part of the operation of any organization and are usually popular but ineffective. Fundamental reforms are rarer, more difficult and, because they change fundamental power relationships among actors, are necessarily politically difficult.

B. Altering institutional arrangements for delivering services is difficult because of history, politics and local social norms.

[2] Every system of services provision will produces incidents of failure (teachers that shirk, incompetent doctors, corrupt policemen). In otherwise well functioning systems reducing the frequency of incidental failures is a matter of better management—e.g. changes in training, motivation, monitoring, logistics. However, at other times the failures in the efficacy or efficiency of service provision are so pervasive as to be institutional and hence needs be addressed with institutional reform. The same management reforms that can address incidental failures are powerless against institutional failures. Reducing teacher absenteeism from 9 percent to 7 percent is a management issue, reducing teacher absenteeism from 50 percent is an institutional issue (evidence from the surveys). Improving medical practitioner diagnostic recognition of specific diseases is a management issue, reducing widespread mistreatment of routine conditions is an institutional issue (evidence from India study).

1. History creates difficulties because building a sufficiently large "change coalition" requires overturning entrenched interests.

2. Policymakers and providers are often well organized and influential relative to citizens.

3. Social norms constrain the feasible set of institutional arrangements.

C. To make services work for poor people, we may need to make services work overall.

1. Improving services for poor people requires the support of at least the broad middle class, which may mean making services work for everybody while ensuring that poor people have access to those services.

2. For many services such as primary education, since it is the poor who are currently left out, improvements in the system are likely to disproportionately benefit the poor.

3. Some services need to be tailored to the poor and disadvantaged groups (such as in situations of ethnic or gender exclusion), which is even more difficult .

D. Sector-specific reforms usually need to be embedded in an overall public-sector reform program

1. Empirical evidence

2. Cases where this may not be true (e.g., low-income countries under stress [LICUS])

E. Some arrangements, especially those taking an "enclave approach" to delivering services to the poor, even if they lead to improved outcomes in the short-run, may not be sustainable in the long-run.

V. To apply the framework and overcome these difficulties, societies need to tailor the institutional arrangements for providing services to the particular service and setting.

A. In some cases, the desirable arrangement is to strengthen the weakest link. For instance, if it is the policymaker-provider link that is weak, contracting out services, such as the use of NGOs for primary health services in Cambodia, may be the preferred arrangement.

B. In other cases, when most of the links are extremely weak, strengthening the strongest link may be the solution. Community participation in health service provision in Guinea would be an example.

C. In yet other cases, where the whole service-delivery chain is so weak, the only solution is for outsiders (e.g., donors) to intervene by setting up parallel structures to the public service delivery system. Such arrangements are found in LICUS countries, such as Haiti.

Chapter 3: Clients and Providers

Reliable quality services are a recurrent theme in consultations with clients, but poor people too often face an environment in which defaulting providers prevail. Physical access to services remains a major obstacle for many rural disadvantaged populations, and reluctance of qualified staff to work in remote areas constrains service delivery in most low-income countries. But even when close to home, services may fail to serve poor people because of inadequate service mix, low quality, high prices and inadequate attention to constraining demand factors. Partnerships with communities, improved public-private mix, innovative service delivery and pricing design as well as appropriate training and incentives to staff to better serve the poor are promising alternative strategies to scale up better services for the poor. Enhancing self-regulation of providers through professional associations may contribute to this goal. But strengthening the involvement of clients—in revealing demand and monitoring performance—is the main response to the growing cry of citizens for better quality and more accountable services. Accountability of providers to citizens and communities through co-management is particularly crucial in contexts where citizens' voice in policymaking is weak and policymakers can exert only limited control over providers.

I. Context: what do the poor say about providers?

A. Case studies/stories: Clients confronting services

1. A seven year-old girl going to school in Cambodia

2. Fetching water for daily needs in rural Nigeria

3. Getting a passport in India

B. Voices of the poor and client consultations

1. Which mix of services do poor people ask for?

2. What are the obstacles to services use according to the poor? What are trends and variations between regions and countries

C. What does "services working for poor people" mean ?

1. Perceptions of providers

2. Dimensions of services performance: predictability, access, friendliness/respect, quality, etc.

II. The citizen-provider dynamic

A. Who are we talking about?

1. Range of clients: e.g. users, communities, poor people, vulnerable groups (age, gender), minorities

2. Range of providers: public/private, private not-for-profit, individual, organization

3. Different set of interactions and incentives depending on the client and the type of provider: e.g. profit-maximizing, altruistic, salaried employee

B. Citizens' behavior can create incentives for better services from providers: a client-centered approach.

1. Clients' can influence providers through demand and empowerment but providers are most often at an advantage in terms of knowledge and power structure

2. A client-centered approach requires the citizen to control critical incentives

3. Clients have a unique role in affecting some key dimensions of service performance: availability of resources, access, some aspects of quality, price etc..

C. Implicit or explicit agreements: the nature and difficulties of the contractual relationship between clients and providers

1. Implicit agreements: are they speaking the same language ?

2. Clients expectation of complete contracts: accountability for results or for means (example of prepayment schemes in health)

3. Making contracts explicit

III. Unveiling the problems: where does it go wrong?

A. The costs of providers not listening to clients

1. Services may not be close to home

2. Services may be skewed away from poor people
   a) Concentration of private and public sector providers in urban, richer areas
   b) Priority of funding given to infrastructure in wealthy areas

c) Promotion of standardized service delivery modes may hamper development of innovative approaches

(1) Health: facility, hospital-based model
(2) Education: standard age classes
(3) Water: focus on utilities

3. The mix of services may be wrong or not tailored to local conditions
   a) Water: Bangladesh, Andhra Pradesh water authority.
   b) Health: "Doctors for the rich, drug peddlers for the poor"

4. Technical inefficiencies (wrong mix of inputs) may paralyze delivery
   a) General evidence (cross-country)
   b) Incentives in public sector (and donor practices) lead to insufficient funds for operations and maintenance.
      (1) Education: schools without chalk, textbooks; perceived lack of demand may be due to poor quality (separate latrines for girls in Senegal); comparison with private schools.
      (2) Health:
         (a) Missing drugs. reason why India's and Africa's poor bypass free public clinics to go to fee-charging private sector.
         (b) Financing of staffing low relative to investment (Africa)
      (3) Water: experience with government-supplied tube wells

5. Poorer quality of services for the poor
   a) Social distance e.g. lack of empathy in patient-doctor relationship ("They treat us like animals")
   b) Services not tailored to (heterogeneous) clients, especially excluded groups (e.g.; lack of confidentiality in AIDS clinic, AIDS education campaigns; lack of privacy for women clients; female providers).
   c) Lack of demand may be due to poorly-delivered services (expectant mothers in Peru).

B. Clients lack of involvement leads to imperfectly-monitored services

1. Reasons why policymaker cannot monitor perfectly (cross-reference to Chapter 5).

2. Clients can monitor, but may not have incentive to
   a) Insufficient knowledge (e.g., links to health outcomes)
   b) Insufficient leverage

(1) To whom do they complain? Kenyan parents' associations
(2) Fear of harassment

c) Monitoring is a public good—collective action failure

C. Intrinsic motivation of providers and self-regulation can also pull providers away from serving the poor

1. Training oriented towards addressing needs of richer groups/ models of richer countries may be inadequate

2. Technical "Gold Standards" may not be adequate to country setting

3. The cost of listening too much to the client: e.g self protection against litigation may lead to unreasonable expectations in relation to context

IV. Strengthening the client-provider link: what have we learned ?

A. Make providers accountable

1. What does accountability mean ?

2. Promote self monitoring of providers (building on intrinsic motivation)
   a) through the setting of professional and technical standards
   b) promoting the rules of the game including ethics
   c) improving quality standards (accreditation, quality assurance)

3. Clients as monitors
   a) Examples: parents' associations in Kenya, Uganda, El Salvador (EDUCO); patients' associations in Argentina, Poland; community sanitation associations in Bangladesh, community health associations in Africa, mother support groups in Philippines
   b) Additional benefits: enhancing individuals' abilities to act, to be better regulator of services
   c) The role of community-based services and participatory approaches (CDD, etc.) in enhancing clients' abilities and willingness to monitor service provision

4. Solving the collective-action problem of monitoring
   a) Role of information campaigns
      (1) Public-expenditure tracking in Uganda
      (2) Other information, media campaigns; "right to information" bill in India
   b) Other instruments: technical experts, etc. (violence against shirking ambulance and truck drivers in West Bengal, Kerala)

B. Give clients a choice

1. Full public subsidies with choice of providers
   a) Single-payer health schemes: Thailand's "Low income" card, Africa vouchers for mosquito nets
   b) Experience with demand-side subsidies, education vouchers
   c) Effects of competition
      (1) Matches services to demand
      (2) Disciplines providers

2. Partial public subsidies with choice of providers
   a) Examples (Thailand voluntary health card, revolving drug funds, housing vouchers in South Africa, sanitation vouchers in Bangladesh)
   b) Do out-of-pocket payments induce greater monitoring by clients?

3. Full or partial subsidies without choice of providers
   a) In water, which is closest to a private good, the experience has been most favorable.
      (1) Moving from "free" to full-cost pricing can be costly politically (Cochabamba, India experience)
      (2) Experience with poor services make people reluctant to pay unless they are guaranteed improved services (Ahmedebad)
      (3) In Buenos Aires, the poor in remote areas are paying more than the rich, but still less than they were paying for private water sellers.
   b) In health, the experience is much more mixed.
      (1) For income-elastic, private goods, user fees may improve welfare
      (2) User fees usually improve quality of services and can lead to increases of utilization among the poor: Litvack on Cameroon , Diop on Niger
      (3) But the very poor may be excluded, unless alternative mechanisms such as exemptions and third party payments can be implemented (Ghana, Benin, Kenya, Zambia in Gilson et al.)
      (4) Role of informal payments: When they are under-the-table, user fees are less potent as preference-revealing or monitoring devices.
   c) In primary education, the consensus is that user fees may do more damage than good.
      (1) Early estimates of demand elasticities were low

(2) But elimination of user fees contributed significantly to large (two-fold) increases in enrolment in Malawi and Uganda.
(3) Experimental evidence (uniforms in Kenya) showed substantial responses to lowering prices.
(4) Nevertheless, some disturbing signs of quality declines in Uganda and Malawi.

d) Bottom line: Should not have a blanket policy on user fees. Sector-by-sector approach.

(1) providers informing clients in a complete and transparent way about user fees,
(2) difficulties in administering user fees at the provider level, etc.

V. Monitoring Performance: scaling up client's involvement in assessing services performance

A. Which dimensions can and should be monitored?

B. Information as an empowerment tool

C. Roles of user's associations and experiences with community-based participative monitoring of services (West Africa, India, East Asia)

Chapter 4: Clients and Policymakers

Strengthening citizens' voice and participation in policymaking can make public spending more pro-poor and hold policymakers more accountable for service outputs that affect poor people. Traditional voice mechanisms, such as voting and elections, are important and should be strengthened; but, in an imperfect world, these mechanisms are not sufficient to make governments yield effective services for the poor, and many approaches are needed to strengthen citizen voice and participation, even as no single approach can guarantee results. Information and public disclosure can create reputational competition within government and in politics, and can counter the influence of powerful social groups. NGOs and other intermediary organizations can generate and sustain citizen action to demand accountability and better service performance. Decentralizing to local government can improve incentives for local accountability and meeting local needs, even though it by no means guarantees it.

I. Making services work for poor people is not easy when the citizen-policymaker link is weak.

A. There are often large gaps between what a government says it will do for its poor citizens and what it does; between its formal rules and the real ones. (Actual primary teacher attendance is often very different from their required or even recorded presence; social sector budget allocations often do not match stated national priorities).

1. Even when they firmly believe in improving the welfare of the poor, politicians and policymakers face obstacles to making and implementing government policies that are responsive to the poor. These obstacles—often institutional, electoral, and informational in nature—can vary in significant ways from country to country.

2. The resulting performance gaps show up in basic services that do not work for the poor as a result of corruption, capture, lack of exit options, and bias in budget allocations and in service design and delivery (informal payments for schooling, preference for brick & mortar investments over making existing facilities work, skewed incidence of overall public health & education spending). This is compounded by accountability failures related to the weak voice of poor citizens.

B. Attempts to improve public sector performance and make it more responsive to the poor often fail.

1. Too often reforms are based only on providing technical assistance and altering formal rules (autonomous boards that effectively have no independence, failed civil service reforms). Changing the *underlying incentives* and the relevant *institutional framework* is far more important

than managerial changes in improving policies that policymakers and providers formulate and implement.

2. But aligning incentives and institutions is hard for political-economy reasons. Even with good design and intentions, this takes much time, political effort, and administrative capacity and the overcoming of entrenched interests. One size does not fit all.

C. Democratization and voter choice do not automatically lead to policymakers who are responsive to the service needs of the poor.

1. Increasing democratization worldwide has meant greater political competition and contestability. Democratic choice and the priority-setting and oversight functions of elected representatives should be strengthened.

2. But increasing democratization and the fact that more poor people now vote do not necessarily yield budgets and policymakers that are responsive to the service needs of the poor.

a) Citizens vote infrequently, they have incomplete information, multiple client groups have conflicting interests, elections are imperfect disciplining devices, and electoral rules emphasize party rather than individual accountability.

b) Parliamentarians often face perverse incentives that are not easy to address (e.g. whether they belong to the ruling party or the opposition, how elections are financed, how conflicting client interests can be resolved), in addition to problems of oversight capacity.

II. Strengthening citizens' voice can help make services work for poor people, particularly when supported by effective public accountability institutions.

A. When the poor can share in universally provided services, the voice of all citizens needs to be strengthened to make policymakers more responsive.

B. Much more difficult—but often necessary when competing social groups vie for influence and resources—the voice, participation, and alliances of poor people need to be strengthened and the intrinsic motivation of policymakers harnessed to make services work for the poor.

C. Greater vigilance in national budget setting and monitoring can be supported by pro-poor citizen groups—particularly those that are budget literate—working with the media, parliaments, and other accountability institutions (International Budget Project, South Africa, Uganda, Karnataka, Porto Alegre).

D. Information-intensive advocacy and accountability efforts by citizens that build on public disclosure, user feedback, and data collection; and use public

accountability institutions, the media, support for reform champions in government, and reputational competition to demand better services. Such efforts can help overcome weak links in other parts of the service chain, e.g. in the horizontal accountability between policymakers and providers.

1. The poor participating in formulating and monitoring national Poverty Reduction Strategies and in monitoring mechanisms for service delivery for the poor (Pakistan I-PRSP). Informing electoral choice by citizens (Poder Cuidadano, Argentina) and establishing the right to citizen information (MKSS in Rajasthan, India).

2. Monitoring service delivery (citizen report cards, Uganda service delivery surveys, Quality-of-Service-Delivery Surveys).

E. Giving control of resources to grassroots organizations through community-driven development (CDD) initiatives and social funds that produce social and infrastructure-related local public goods in partnership with NGOs, firms, and local and central agencies. CDD programs ideally give greater voice to the poor, tend to work best when integrated with ongoing decentralization, and face the challenge of scaling up, not crowding out local government, sustaining recurrent costs, and surviving the exit of external support.

F. Citizen-policymaker partnerships (implementing medium-term expenditure framework in South Africa) and examples of policymaker responsiveness (standard setting using citizens' charters, patients' bill of rights, etc.).

III. Strengthening the citizen-policymaker link: improving information access

A. The access to and use of information is crucial

1. Access to salient information can greatly strengthen the citizen-policymaker link and create conditions for political and reputational competition (disclosure laws and regulations, parliamentary requirements for timely budget information, and patients' bill of rights.) New information technologies and e*governance applications can help reduce information asymmetries.

2. Citizen groups need to have credibility, and this is based in part on the impartiality of their information and analysis.

3. An independent media plays a vital role, particularly the vernacular press, in leveraging information and bridging voice to greater accountability (press in India).

B. The characteristics of the service, clients, policymakers, and alternative service providers have a lot to do with what information is needed to strengthen

the voice of citizens and the responsiveness of policymakers (different solutions for face-to-face delivery in health clinics vs. detached delivery of health regulation; long-term relationships in schools, vs. one-off visits to hospitals). Unbundling these characteristics within the service-chain is important for understanding what information is salient.

IV. Strengthening the citizens-policymaker link: collective action and citizen and NGO initiatives.

A. Overcoming collective action, capacity problems, and exclusion

1. Coordinating voice is difficult. Citizens groups need organizational capacity and leadership to overcome coordination and collective action problems and to leverage information. Multiple citizen groups have competing interests. The role of social capital and shared social expectations is important (overcoming these problems among AIDS-related NGOs in Thailand, EDUCO in El Salvador).

2. Need enabling legal and regulatory environments for citizen groups to form, sustain advocacy, and seek redress through appropriate public accountability institutions.

3. Citizen groups need to have internal accountability and clarity of mandate for policymakers to respond to them without fearing state capture.

4. Replicating and scaling up ad hoc and fragmented voice and participation initiatives is not easy. Even with many voice initiatives, enforcing policymaker accountability and commitment to change can be difficult (health micro-insurance schemes in Senegal).

B. Changes in the policymaker–provider relationship that create incentives for responding to citizen voice and participation. Decentralization has come to be one of the most important policy actions in this regard. CDD takes decentralization to the grassroots level.

V. Decentralization is advancing in most developing countries and holds much promise in strengthening citizen links with policymakers and providers, but also poses many problems for service delivery.

A. The economic objectives of decentralization are clear, even if it is often driven by a more political agenda:

1. Greater allocative efficiency—matching local preferences in service delivery (region and ethnicity-specific health problems within a country—

pre- and post-decentralization consistency between local preferences and expenditures in Bolivia).

2. Greater technical efficiency—greater local accountability, better implementation, greater participation in financing and monitoring services (health care decentralization in Burkina Faso, social funds).

3. Devolution and separation of powers to create contestability for resources and a central government that has greater incentives to hold sub-national governments accountable for service delivery.

B. Decentralization is not a panacea, and certainly not simple (health service decentralization in Philippines and Indonesia). Some potential problems:

1. Design problems
   a) Not devolving far enough down to make a difference in terms of preferences and local accountability, or too far down to make delivery difficult.
   b) Authority/autonomy of local officials to respond to local preferences limited.
   c) Imbalanced political, fiscal, and administrative decentralization because of coordination difficulties and often-dominant political push for decentralization.
   d) Limited local access to information hampers citizen voice and influence

2. Capacity, capture, and equity problems
   a) Weak local administrative capacity, and authority without local accountability, lead to services that don't work (Ethiopia health care)
   b) Asymmetric information and power can lead to local capture by elites
   c) Decentralization can exacerbate existing equity problems if local resources are largely controlled by those already in power.

C. Decentralization is proceeding apace for political and other reasons: how to manage it to makes services work? The devil is in the details:

1. Depends heavily on initial conditions, political drivers, and policy design (e.g. assignment of functions between center and local), so few cookie-cutter solutions

2. Local voice, participation, and accountability are needed to make hard budget constraints within the intergovernmental system yield services that work, otherwise end up with declining service quality standards and coverage (India vs. Cuba)

3. Rules of the game to put pressure on local governments to be responsive and accountable downward to clients:

a) Establish clear fiscal rules

b) Match local financing authority with service provision to ensure accountability

c) Provide adequate autonomy and incentives to match implementation to design

d) Foster administrative capacity using the Center to transfer skills and create environment favorable for endogenous local capacity growth

e) Make information disclosure about budgets, costs and service standards routine (grant information in newspapers in Uganda)

f) Promote participation by ensuring that citizen voice will have impact

g) Ensure alignment between economic and political aims (e.g. sensible legal framework, clarity of standard setting, recognizing inter-jurisdictional spillovers)

4. What comes first, decentralization or building local capacity, local participation and local accountability? Certainly, decentralization without accountability does not work, but sequencing is never perfect, and managing the mismatches is key to demonstration effects, increasing local buy-in, and scaling up.

Chapter 5: Policymakers and Providers

Improving service delivery requires effective organizations of skilled and motivated people. The appropriate organizational form generates incentives for the right people to provide the right services to the right (poor) people. This will vary by the nature of the service and a multitude of country circumstances.

I. Providers do not always perform as expected by the policy maker.

A. In the public sector:

1. Inappropriate services: geographical placement and different types of services vary to the extent they help poor people (good [Malaysia, Cuba?] and bad examples).

2. Even when the right services are chosen and planned to be in right places, absenteeism is a serious problem and biased against the poor (high opportunity cost professions [e.g., doctors] make this particularly difficult). Evidence on absenteeism rates, counterexamples of nurses, or teachers in Zambia and PNG.

3. Even when providers are present behavior on the job is problematic, usually to the detriment of poor people

   a) rude treatment/ abuse of students, patients
   b) loss of skills—little motivation to remain current
   c) corruption
      (1) Evidence from PETS
      (2) Under-the-table payments (Eastern and Central Europe)
      (3) Siphoning of pharmaceuticals

B. In the private sector (i.e. let's not romanticize it)

1. Narrow set of services
   a) Lack of coverage in (especially) rural areas
   b) Limited range of services (curative, demand-driven)

2. Limited capacity for regulation by the public sector
   a) Low quality, particularly for the poor (India—treatment in Delhi)
   b) Problem of joint provision of service and doctrine by NGO's

II. Getting a handle on the problem

A. Who are we talking about?

1. Range of policymakers and providers—national/local, staff/line, legislature/executive, public/private

2. Within public agencies, the definition of who is a policy maker and who a provider varies by country.

3. Similarly, oversight of private providers can take place at different levels of government.

B. Separation of roles of policymaker and provider

1. Examples of problems when the distinction of the roles of direct provider and independent regulator is muddy.

2. Mixed motives of policymakers when they are also providers—loss of focus on outcomes of services and results on the ground versus management of organizational hierarchy and lack of interest in finding and fixing problems

3. Historical experience of developed and developing countries
   a) Evolution of government provision from private provision, where the separation between provider and government as regulator was natural. Subsequent nationalization could work because principle of oversight was established.
   b) Variety of roles of NGOs in different contexts: sometimes arising as a watchdog with service provision following advocacy, sometimes filling the gap when public services failed, and church-initiated services.

C. Clear rules of the game

1. Accountability requires clarity of areas of responsibility, discretion of judgment and legitimacy of sanctions.

2. Intergovernmental relations (sometimes clarify roles, sometimes confuse them—e.g., by introducing concurrent responsibilities)

III. Making the relationship between the policymaker and provider organizations work.

A. With the separation of roles, we can examine the nature of agreements between policymakers and provider organizations as if they were contracts.

1. Some such agreements are formal, explicit contracts with private (for profit or not) organizations

2. Some are implicit
    a) in the employment arrangement with civil servants providing services directly
    b) in the regulation or accreditation of private providers acting on their own

3. Contracts are necessarily incomplete
    a) Don't want them to be complete: if determined at too central a level of government there must be flexibility for local variation
        (1) Water in Andhra Pradesh
        (2) "Work-to-rule" strikes: Parisian taxi drivers bring traffic to a halt by following rules exactly
    b) Can't be complete—nature of the services we're discussing is that there is a lot of discretion necessary at operational level. It is not possible to foresee all contingencies and day to day decisions. Necessity of autonomy of provider. Police deal with everyone from lost children to dangerous criminals as investigators, social workers, public information disseminators and apprehenders.
    c) Social sectors pose particular problems—ultimate outcomes are hard to observe, hard to prove to a third party and hard to attribute to the service provided (student background and effort, income, education and environment effects on health).

B. Choosing among providers

1. Range of providers (data on the relative share of markets of the following)
    a) Civil servants (arms length regulation requires complementary system of justice and contract enforcement; inflexibility of work reassignment, pay structure, disciplinary action mean less control; role and influence of civil-service unions)
    b) Autonomous public agencies (pros and cons, experience—e.g., specialized hospitals, water companies, universities)
    c) NGOs (definition, range of types of organizations, motivation, role of trust)
    d) Profit making private sector—both formal and informal (direct contracting for public functions or recognition of role in absence of direct use)

2. Role of competition
    a) by the market (providers compete for services to individuals and exist side-by-side). Need to understand the nature of the market. Private sector made up of public providers in off-hours is more collusive than competitive.

b) for the market (public solicits bids for concessions particularly for natural monopolies). Sometimes, it is a transfer of a monopoly to someone outside the government.
c) yardstick competition (use of comparative data from different providers—possibly local monopolies, possibly a public provider used for reality checks)

C. What to ask of providers

1. How high-powered can incentives be?
a) Why do we want high-powered incentives and why can't we have them? (problems of multi-tasking in social services, examples of getting what you pay for (and regretting it)—e.g., Sears car repair service.
b) Optimal degree of unbundling services (vertical programs in health, specific client coverage, main characteristics of good service—e.g., Johannesburg transport)

2. Non-monetary incentives and harnessing altruism. Forms of contracts to elicit more services from altruistic providers. Limits to altruism? (Example of church health services in Zambia—much better than government, but fail to reach the poorest)

3. Experience with provision of different types of services (to draw out lessons for what kinds of services can be covered by what kinds of contracting arrangements)
a) Autonomous water companies
b) Specialized hospital
c) Routine versus discretionary services

4. Labor markets: can you get enough people to take the job in the first place?
a) brain drain of professionals (international)
b) health and education professions versus other professions
c) patronage politics interfering with the labor market

D. Monitoring and enforcement

1. Improving supervision and administrative monitoring and enforcement
a) Who does the monitoring? If the separation of policy maker from provider is clear, the policy maker should do the monitoring. If the separation is not clear, independence of the regulator needs to be ensured by placing the monitoring function outside of the responsible ministry.
b) Examples of improved monitoring mechanisms
c) Role of new technologies

2. Peers and competitors
    a) Morale and mutual obligations (and how it is limited—example from Indian health care)
    b) Self regulation
        (1) Setting professional, ethical and technical standards
        (2) Professional associations can monitor providers and improve quality via accreditation and professional sanctions
    c) Competitors: in market and by design (Ceara health workers)

3. Communities

4. The role of supporting institutions—grievances, appeals and adjudication

IV. The role of rigorous impact evaluation

A. Output based incentives require program evaluation separate from routine monitoring.

B. An important role for the public sector is to generate information on the true impact of policies.

1. For use by public

2. For use by policy makers in designing future programs and decisions about scaling up

3. For use by providers to appraise their own performance

V. The bottom line

A. Tailoring agreements to settings

1. Characteristics of services—routine/complex, homogeneous/variable

2. Characteristics of countries—administrative capacity, size and depth of private (formal, informal, NGO/profit) markets in sectors, professionalism and trust

B. Scaling up

1. Not all successful experiences are replicable—due to charismatic leaders, particularly cooperative communities or other local, fixed factors

2. Expanding services towards universality will necessarily mean reaching marginal, excluded, unpopular groups. Will programs that work for the majority reach these groups?

C. Feedback to policy priorities: given what we learned here, how would we modify the setting of public priorities to include implementation capacity?

Chapter 6: Donors and Recipients

Increasing foreign aid without improvements in service delivery is unlikely to improve human development outcomes unless aid strengthens, not weakens, the three critical relationships among policymakers, service providers, and clients. When donors circumvent these critical relationships, aid can undermine the delivery of services. Donors can realign their internal incentives for better service delivery by pooling their financial and knowledge transfers in line with the recipients' development strategy and budget process. Recipients need to reciprocate and can speed up the transformation of aid delivery by strengthening their citizens' voice and the accountability of the public sector.

I. Strengthen not weaken key relationships in service delivery

A. The client-service provider relationship: Donors increasingly by-pass the service delivery system and contract client groups directly in an attempt to ensure that services reach poor people. The unintended consequences of this approach include

1. Difficulties in scaling up: Largely donor-driven, CDD initiatives and social funds risk remaining as enclaves because the same political-economy forces that cause donors to choose the CDD approach in the first place prevent its scaling up.

2. Risk of local elite capture when donors involved, with an example from a Sahelian country (Platteau 2002)

B. The citizen-policymaker relationship: Donors support both traditional ways of electoral participation in recipient countries, as well as additional measures to strengthen information and citizen voice in policymaking and public spending. The unintended consequences of aid include:

1. If aid is not seen as an integral part of the recipients decision-making process, it falls outside its budget process, contestability in public spending, and systematic parliamentary oversight. Aid is monitored primarily by donor parliaments or organizations (OECD/DAC).

2. Parallel funding mechanisms create large asymmetries in information between citizens and the policymaker, thus weakening accountability.

3. Conditionality attempts to replace weak voice of clients to discipline the policymaker. Strong evidence that promises (ex ante conditionalities) do not work as they tend to undermine ownership of the reform.

C. The policymaker-service provider relationship: Donors want to increase access to and improve quality of services. Each donor typically deals directly with the provider (ministry, local government, NGO) and packages its financial and knowledge transfers in sector-specific investment projects. Donors prefer investment funding and often contract service providers directly. The unintended consequences of these practices in aid include:

1. At the country level, imposes high transaction and compliance costs, and creates distortions, particularly on recipients with limited administrative capacity. Leads to conflicting policy advice and fragmentation in the recipient's spending programs (new evidence to quantify fragmentation).

2. At the international level, creation of new thematic global funds (AIDS, TB, malaria, Education for All, WWF, etc.) can create incompatibility at the country level, particularly with the recipient's macroeconomic and budget management.

3. Donor preference for investment funding affects the composition of public spending and hence the policy-maker-provider relationship. Examples: schools without teachers or textbooks, and clinics without qualified staff (Africa, South Asia).

4. Donor preference for directly contracting frontline providers (both public and private). Leads to unequal regional coverage of services and monitoring problems.

5. Donors often circumvent the recipient's delivery system and establish project implementation units (PIUs). These undermine local capacity and ownership, and create labor market distortions (ECA and LAC Regions' studies on PIUs)

II. Donors can realign their incentives for better service delivery

A. New initiatives to scale up and address the unintended consequences

1. CDF and PRSP seek to change the relationship between donors and recipients and to promote a stronger citizen-policymaker relationship.

2. Sector programs: experience to date

3. Global public goods.

B. Useful to separate the decision to provide aid (which is done on the basis of good policies and institutional reforms) from delivery mechanism for aid (which should respect the critical relationships in service delivery).

C. Moving to budget support to scale up.

1. Addresses the problems created by aid for the policymaker-provider relationship. Allows contestability of public spending, a better alignment of donor and government priorities, and a more prominent role for the recipient's Parliament and budget institutions.

2. Reduces compliance costs due to fragmentation. Dialogue moves to overall allocations and key constraints rather than "how is my project doing?"

3. Allows a move away from separate project implementation units to working directly with the recipient's service delivery system and, by so doing, gives them space to develop.

4. Risks weakening the recipient's bargaining power vs. the donor community.

D. Pooling donor support

1. Donors to agree on priorities for financial support with governments through an open and transparent process to ensure coordination. Assures the recipient of support and provides some constraint on donors doing lower priority things.

2. Move to joint supervision of overall and sector programs. Reviews should engage government as well as other actors (NGOs, churches, private sector). One key time for a donor visit is before budget is finalized so that donor concerns are registered and addressed.

3. Donors to agree with government on the areas where technical assistance is needed and provide it from the best available source. Technical assistance as currently practiced needs to be severely limited and the recipient capacity should be relied on much more.

4. These issues are relevant for most recipients, except for LICUS countries where by-passing government remains a relevant option.

5. Institutions to ensure realignment of diverse donor objectives and incentives. Examples: Water Supply Program, City Alliance, ESMAP

E. Knowledge transfer

1. Joint analytic work including impact evaluation to ensure better feedback and quality. Cannot afford a lot of disparate views and

recommendations that confuse weak capacity governments and dissipates effort.

2. Analytic work drawing on in-country capacity (universities, ministries, private sector, etc) to the extent feasible.

F. Donors to consider "silent partnerships." Too many actors are currently involved in key social services. Donors should combine forces and share technical staff.

III. Recipients can reciprocate by strengthening citizens' voice and accountability in their public sector

A. The role of parliament in the PRSP process

B. Increasing citizen voice

C. Increasing accountability in the public sector (see Chapter 7)

Chapter 7: Public-Sector Underpinnings for Sector Reform

To make services work for poor people, in addition to improving service outputs, governments need to have the incentives to choose the right mix of services. Getting this mix right involves fundamental reforms in the budget process—to ensure that budgetary allocations reflect the determinants of health and education outcomes. Furthermore, some of the changes needed to improve service outputs—such as restructuring of the civil-service, procurement, and financial-management systems—are cross cutting, and require reform of the public sector as a whole.

I. The composition of public spending and health and education outcomes

A. Empirical evidence

1. Recap evidence on determinants of health and education outcomes

2. How well do budgetary allocations reflect these determinants?

B. Why budgetary allocations may not reflect the determinants of HD outcomes: Weaknesses in the budget system and citizen-policymaker relationship

1. Lack of outcome orientation

2. Lack of informed debate about expenditure decisions, budget allocation inertia, poor expenditure analysis and poverty diagnostics, and absence of medium-term framework

3. Political economy
   a) Conflicting interests of budget actors: Cabinet (focus on spending levels rather than tradeoffs), finance ministries (controlling authority with asymmetric information), line ministries (overbidding, year-end spending sprees), parliaments (variable incentives and capacity for critical analysis), civil society (barriers to budget literacy), and vested interests (state capture)
   b) How to make budgets more pro-poor: Improving performance of budget systems overall and ensuring that interests of the poor are being addressed; difficult to sustain islands of budget excellence.

II. Reforming budgetary processes

A. Principles

1. Public economics
   a) Rationale for government intervention

b) Given the rationale, what is the best instrument—public finance or public provision—to offset market failure or improve distributive outcomes?

c) Given instrument, choice of delivery mechanism; crucial role of monitoring service delivery performance, feedback, and impact analysis

2. Public expenditure management principles

a) Predictability: necessary if autonomy and decentralization are to improve service delivery

b) Comprehensiveness, so as to be able to balance across time (hidden commitments), sectors (tradeoffs made apparent), funding sources (domestic vs. donors), and project cycles (capital vs. recurrent costs)

c) Accountability for results: focus on performance rather than control

d) Transparency of policy process: not just generating information but enabling its use to support policy and managerial decisions and their internal and external accountability

3. Citizen participation: Lifting the veil of secrecy on budget formulation and the shroud of apathy on budget outcomes

B. Practice

1. Australia and New Zealand

2. Uganda and Tanzania

C. What can governments do?

1. Examples from outcome-oriented budgetary reforms (MTEF) and from linking the budget to an explicit poverty strategy, such as a PRSP, with clearly identified spending programs that can be protected.

2. Decentralization

3. Other efforts at reform

III. Other public sector and financial management reforms to align incentives for improved service delivery

A. Civil-service reform

B. Procurement reform

C. Anti-corruption

D. Financial management

E. Monitoring and evaluation

IV. Obstacles and challenges to reform

A. Domestic political economy

B. Donor practices

Chapter 8: Education Services

High quality education systems can be arranged in many forms but require citizens who discipline the system through choice and voice, high quality teachers with professional autonomy, and policymakers with the capacity to impose national quality control. In many circumstances, the biggest payoff will come from strengthening the power of citizens to discipline the system.

I. Some features of the education sector in developing countries

A. Why Juanita can't read.

B. Problems faced in the education sector

1. Access and attainment vary
   a) Between levels of education and between countries
   b) Between poor, between urban and rural, and other disadvantaged groups

2. *Quality* of education is a concern at all levels

   a) Concerns about teacher availability (e.g. absenteeism)
   b) Even when teacher are present the quality of instruction is low
   c) Raising quality of instruction up to meet global standards

3. Financing and costs

   a) Inequality of the educational subsidy (e.g. the huge per student subsidies to tertiary education)
   b) Allocation of spending across items—with limited budgets meeting payrolls often crowds out all else.
   c) Adequacy of fiscal effort to meet goals

C. The features of education

1. There are differences in the objectives of schooling between policy makers and parents/students and *among* citizens with different views—particularly on the socialization and "nation building" role of schools.

2. Schooling has multiple outputs (socialization, skills) and learning is complex so simple "pay for performance" for teachers and principals is unworkable, but a total lack of connection between incentives and performance allows wide variation in the performance of front line workers—both excellent teachers performing well in adverse circumstances and those that never show up.

3. To be most effective instructors must tailor instruction to the classroom setting and students—but this discretion makes monitoring of quality difficult.

4. Some characteristics of education systems vary widely
   a) Size of private sectors
   b) Public emphasis on different levels of education (primary, secondary, higher, technical, etc.)
   c) Organization of services and degree of decentralization of the various aspects of education (curriculum, standards, instruction)

II. Links between clients, providers, and policy-makers: key issues

A. Clients and providers: Choice and Voice

1. Choice can be increased through direct financial transfers to parents, allowing their children to select among public schools, or between public and private schools. But choice requires competition.

2. Publicly-funded choice of private schooling is politically infeasible in many jurisdictions—but there can be choice within the public system. The essence is competition, not the public/private distinction.

3. When choice is inconsistent with policy objectives then mechanisms of enhancing citizen voice in schooling are necessary
   a) This will require parents with both the knowledge and the power to affect change
   b) Communities are capable of managing schools and greater integration of local and community systems with the formal schooling is a feasible mode of expansion.
   c) Ensuring that the poorest do not loose out in this process is important

4. Effective resources with local autonomy for schools: with increased accountability through voice and/or choice schools need to exercise control over adequate financial resources in order to perform well.

5. How can decentralization contribute to enhancing client voice in education?

B. Policymakers and providers: Ensuring quality: the structure of the employment relationship and compensation should encourage the attraction, retention, and promotion of high quality teaching.

1. Getting capable and motivated teachers.

a) High powered incentives to individuals—e.g. individual based "pay for performance" or "merit pay"—not an attractive option for teaching.
b) Nevertheless, compensation should reward good teachers and good teaching, not just longevity.
c) The ability to weed out the worst performers is crucial
d) Skills development schemes can help promote both higher capabilities as well as intrinsic motivation. But the experience with "teacher training" is frequently disappointing as it does not affect classroom practice. Teachers need to have the training they feel lets them do their job better whether pre- or in-service training.

2. Strong formal professional organizations of teachers are a frequent feature of the profession
   a) These organizations can promote educational goals
   b) But, by their nature, they emphasize resources for teachers relative to other inputs
   c) They have a tendency to reduce performance when they become overly politicized.

C. Clients and policymakers: A national consensus of basic standards, a core curriculum, and adequate resources are necessary

1. Quantity and quality of education
   a) Rapid expansions in enrollments are possible—but are they sustainable and do rapid expansions in enrollments come at the expense of quality?
   b) Autonomy can only be effective if it is adequately resourced--if schools are publicly subsidized then arrangements need be in place to ensure that schools get what they are equitably due
   c) Locally raised funding is frequently a necessity
   d) How has the decentralization process affected resource availability and are there lessons learned for how to make this work better?
   e) Will improved results yield greater citizen support for resources from government?

2. Ensuring the adequacy of resources requires:
   a) Controls on the allocation between levels of education
   b) Establishing appropriate subsidies by level

3. A national consensus on standards
   a) National standards in core academic subjects are crucial to promoting quality of schooling.
   b) Need social agreement on what national standards should be.

c) National assessment systems are necessary in monitoring achievement of these standards—but there are dangers to high stakes standardized exams.
d) More citizen control over structure and content of curriculum (and over the choice of homogeneity) is crucial to broad based support for public education.
e) How can special efforts for lagging regions or students from poor families be sustained? How can the voice of poor people relative to others be increased?

III. Scaling up Solutions

A. Creating a political coalition for pro-poor educational reforms

B. Reinforcing steps in short, medium and long-run to build on success

C. Educational systems that innovate, evaluate, and replicate.

Chapter 9: Health and Nutrition Services

For health services to make a significant contribution to improving the health of the poor, all key actors—policymakers, service providers, donors as well as communities—need to be made accountable for outcomes. As household behavior and constraints determine much of health outcomes, strengthening the interface between citizens and providers should provide poor households with information and social support, building local partnerships, strengthening clients control through participation and demand side financing as well as ensuring local and participatory monitoring of the performance of services. Strengthening the client's voice can balance and reorient the influence of the policy-maker but also sometimes substitute when the latter is weak. Specific priorities for improving health status and other aspects of welfare in the sector will vary substantially, so that policymakers need to focus on improving outcomes rather than on standardized policy prescriptions: targeting specific diseases or services will not be enough.

Why did Safar Banu die? Case study of a poor pregnant women in Bangladesh

I. Health and the poor: what is the role of health services?

A. The current situation: health services too often fail the poor

1. Current and emerging problems—deteriorating indicators in large parts of Africa as well as Central Asia, particularly nutrition indicators in Africa, major threats (AIDS, TB)

2. Specific problems of the poor: Poorer health outcomes (and other health related aspects of welfare) among the poor; major inequities in use of health and nutrition services

3. Yet some health services can be made to work for poor people.
   a) Key health services can make a major impact on the priority health problems of the poor.
   b) Health services can also have a large impact on the welfare and social inclusion of poor households.
   a) Health services can contribute to empowerment at community level (Africa, South Asia, LAC).

B. Problems underlying poor performance of health services

1. Lack of access and low availability of services is still a rampant problem: human resource shortages (from AIDS, brain drain); fraudulent pharmaceuticals; lack of workers in rural areas, etc..
2. Low quality translating into low demand and poor outcomes affect health services even when accessible and available: poor attitude of

providers (Senegal), inadequate or even dangerous treatments (Cambodia, India)

3. Payments and benefits: major inequities in health financing
    a) Public subsidies benefit richer groups more: benefit incidence studies (Castro-Leal, Demery)
    b) Out-of-pocket spending represents a large share of health expenditures and pushes households into poverty (Cambodia, India, Vietnam)

C. Specific issues in health services: monitoring the performance of health services is particularly challenging due to asymmetry of information, difficulty to assess quality and necessary synergies with other sectors.

1. Health services cover a wide variety of activities, providers, and transaction settings
    a) From food quality monitoring to health insurance, health services vary by the complexity of roles as well as administrative and managerial requirements for their implementation.
    b) Health services vary by the degree of private sector involvement and the degree to which private markets fail.
        (1) the existence of important externalities related to infectious diseases, pest control, sanitation or health education.
        (2) breakdown of insurance markets, leaving people exposed to serious financial risks associated with catastrophic illness.
    c) Health services require a wide range of inputs and evolve rapidly with technological developments

2. Quality of services is difficult to assess
    a) The assessment of the technical quality of health services is complex and requires multiple instruments
    b) Clients cannot monitor services optimally because of asymmetry of information

3. Health services need to work in synergy with other sectors to address the determinants of health outcomes:
    a) Household behavior and constraints
        (1) Household income is a primary determinant of health, but other important household factors include gender, (particularly in South Asia), age, ethnic background (LAC, East Asia), social status/caste, religion, residence, etc.
        (2) Changes in household behavior is a major contributor to improvements in health (Ceara, India, Tanzania, Senegal, Guinea, Mali).

(b) Services contributing to health and the policy levers to influence them often lie outside the health sector: Education, Water, Food security, community based activities for nutrition, Physical infrastructure for transportation, communication, and electrification etc

II. Policymaker-service provider relationship: Focus on outcomes through arrangements that benefit the poor

Policymakers need to have a clear vision of the outcomes to be produced by the health sector and be held accountable for these outcomes**.** Accountability is enhanced by a clear split of responsibilities for policy definition, service provision and monitoring/regulation.

A. What should the policymakers seek?

1. Contracts for outcomes or outputs? Policy intent versus ability to monitor and enforce

2. Alternative provisions for reaching the poor
   a) Universal delivery: limits of universal packages
   b) Targeting pro-poor health interventions: packages of services tailored to respond to the health problems of the poor
   c) Targeting pro-poor health services: bringing the services to the household, alternative means of improving access (outreach, mobile units, etc.); service in rural areas (rotations, specialized cadres)
   d) Targeting poor areas: experience with two-tier allocation and resource allocation working parties
   e) Targeting poor households and communities

3. Balancing performance and needs: soft versus hard contract

B. Creating a conducive environment for serving the poor

1. Current and potential effectiveness of providers in terms of contributing to outcomes, whether the providers are public, private not-for-profit, or private for-profit varies between regions and countries

2. Nature of contractors is broad and payment/incentives schemes need to be made appropriate to each
   a) Civil servants: increasing globalization of health markets, brain drain and emergence of national private markets requires a revisiting of technical profiles needed, training curricula, modes of payments and incentives to work in remote areas

b) Experience in performance based payments and pro-poor purchasing of autonomous public agencies can be disappointing if not associated with carefully designed monitoring systems
c) Contracting NGOs can contribute to repairing the link between policymakers and providers (Cambodia)
d) Contracting with the for-profit private sector requires strong monitoring and regulation capacity from policymakers

3. Stewardship of competitive markets and improving state regulation : making competitive health sectors work for the poor

C. Monitoring and enforcement of agreements

1. Regulation of input markets: pharmaceutical policies, accreditation, etc.

2. Information is needed by the policymaker for management and for policy

3. Improved supervision and administrative monitoring

4. New opportunities via technology

5. Peers and competitors including professional associations, unions, etc.

III. The interface between citizens and providers—through local partnerships and client's participation in management, control as well as monitoring—is critical to providing poor households with the information and social support they need.

A. What demand can do to orient service provision ('the exit option')

1. Improving drug supply: ensuring availability of quality drugs at the periphery can be improved through demand side financing and client controlled drug revolving funds.

2. Improve quality and empathy: more control of users can address the issue of social distance between providers and clients, lack of conscientiousness, discourteous treatment etc. (e.g. Zimbabwe),

3. Ensure services are actually delivered: control of users on presence of providers (Mali),

B. Because of asymmetry of information, providers can affect the demand for services, hence be made accountable for better serving the poor

1. Intrinsic motivation/professional self-regulation and the importance of ethics

2. Services organization and design: the arrangement of work places.

3. Reaching clients: home visits, outreach and community based activities

4. Getting professionals to serve in rural areas (vacancies, attendance)

5. Ensuring conscientious service (monitoring of dispersed services)

6. Enhanced information flows

C. Addressing demand factors and working at protecting the socially and economically disadvantaged

1. Pricing services with targeting for the poor and without such targeting

2. Vouchers (for what services, for what type of providers, and how to price them; targeted or universal, who should administer the distribution of vouchers)

3. Subsidies to insurance premia/capitation fee

D. Improving voice

1. Regulation through civil society, enhanced by information and knowledge.

2. Experience with local health boards.
   a) With and without the power to hire and fire (Zambia, Mali).
   b) With and without a financial stake (Bamako initiative).
   c) Recourse for reporting and enforcing attendance.
   d) Legal support system including consumer courts that provide protection to the clients against erring providers;

3. Information and education of households to affect demand for services as well as production of health by households

4. Increasing decentralization to local authorities and participation of communities in service delivery facilitates the implementation of community based activities (Africa, Brazil).

IV. Client-policymaker relationship: strengthening the client's voice can balance and reorient the influence of the policymaker but also substitute for it when it is lacking

A. Challenges for the policymaker

1. A growing voice of civil society for more accountability of services

2. A growing demand of clients for more quality services linked to better availability of information

B. Making the poor heard in the cacophony of voices : political influence and sector performance

1. Risk of well-off groups capture on sector priorities—epidemiological polarization in both developed and developing countries

2. Unions, other provider groups vis-à-vis client groups—relative power of doctors versus nurses or paraprofessionals, traditional sector versus allopathy

C. Special problems of health: Technical nature of some policy decisions; pharmaceutical

V. Implementing reform

A. History and politics

1. Rich countries started with private health systems whose financing (at least) subsequently was nationalized. This allowed for the evolution of independence between provider and regulator. Poor countries are trying to bypass this evolution. What problems does this induce?

2. Politics
   a) Health care is a private good with a high income elasticity. Markets' failures for insurance provide good reasons for public involvement in financing care for everyone. This combination makes the health sector particularly prone to capture. Systems cannot be made exclusively pro-poor and there will be continuous pressure to service higher income groups.
   b) Social status and education of medical professionals give them political power.

B. Scaling up

1. Lessons learned by large scale experiences:
   a) Highlight the importance of a strong political commitment to outcomes
   b) The household is the client: policies and services to be focused on families and behaviors

c) Services are organized to support and reach out poor households, providing access to quality affordable interventions
d) National policies focused/targeted on maternal and child health ensuring funding for interventions for the poor

2. Expansion of services will involve different sets of incentives as provision in many poor countries relies on mix of altruistic, profit oriented and government providers.

3. Decentralization holds promise but heterogeneity of local conditions may also hinder expansion.

4. Technological progress holds promise for reducing marginal costs.

5. Adjusting reform to country specific situation: matching political promises to implementation abilities

C. The role of donors

1. Limit proliferation of project implementation units using scarce managerial capacity

2. Move towards long-term, multiyear support, is necessary to reducing uncertainty in funding and allow long-term planning

3. Current multiplication of global health initiatives leads to multiplication of criteria and mechanisms for funding: high transaction costs for health ministries are to be reduced by agreeing on broad expenditures programs rather than specific activities

4. Current donor support has led to a major imbalance between investment and recurrent expenditures in health aid-dependent countries: to invest in human capital, donor funding for health services need to focus on recurrent expenditures, including support to human resources development and incentives to serve the poor

5. Commitment to the MDGs and PRSP can provide the framework for supporting outcome-oriented programs to be supported by donors

6. Donors have also a responsibility to address global “regulatory” issues affecting the health of the poor, including drug pricing and failures in labor markets/brain drain

Chapter 10: Water and Sanitation

For network systems, creating accountable, independent service providers across the public and private sectors remains a challenge for service delivery in water supply. Using private sector participation (PSP) to create such service providers has offered an institutional approach that has resulted in significant improvements but is perceived as having fallen short of achieving the expected outcomes. The role of PSP in raising the accountability bar for the public sector has not been tapped sufficiently. For non-network systems, small independent service providers and community managed systems are emerging as the key service providers, but problems of water quality regulation, sustainability and scale up remain. In sanitation change may be inherently slow, and emphasis has to be placed on creating and responding to demand. Significant improvements can be achieved by linking community management to NGOs under the ambit of local governments. In general reforms in water and sanitation cannot be seen in isolation from the public sector reform which strengthens the capacity of the policy maker. Where the decentralization of responsibilities to local governments—the unbundling of roles between different tiers of policy makers—is happening, an important political economy window can emerge for re-aligning the roles between policy makers, providers, and clients. Finally, donors will need to shift away from an enclave approach to reform and focus more on the capacity of the public sector—in particular city and local governments—to manage the process of institutional change. This effort provides the scope for supporting private sector participation, independent providers, and community management to catalyze reform and scale up.

I. Key features of water and sanitation services

A. Despite notable progress, service delivery outcomes for water supply (WS) fall short of the level needed to achieve desirable health and education outcomes.

B. Sanitation: Dismal record worldwide and always given second place in the reform process relative to water yet potentially the highest gain in health outcomes in general and welfare impact in particular for children, girls and women (South Asia and Africa).

C. Organization

1. Dominance of the public sector in service delivery and financing which is expected to remain the norm for some time.

2. In urban centers, lumpy nature of the network infrastructure makes competition in the market difficult.

3. Limited client involvement as accountability of service provider is largely to policymaker.

4. In rural areas, dispersed institutions of delivery with greater emphasis on self provision.

5. In general, poor people increasingly making their own arrangements—at a higher cost.

D. Water and sanitation service provision must differentiate between highly dense settlements (e.g. cities, small towns, some villages in Bangladesh) and dispersed settlements (e.g. rural Niger). The density influences the institutional design of the service provider (from utility as service providers to community-managed or household systems) and therefore the role of the policymaker, service provider and clients. Local-government boundaries are now changing (South Africa and Pakistan) in ways that encompass in one local government boundary cities, towns and villages. The traditional rural-urban divide is therefore giving way to complex settlement

II. Policy Issues

A. Water

1. Institutional Change: Decentralization of assets and responsibilities to local governments, markets (private sector participation, PSP), and communities (community driven development, CDD) is changing the nature of the links between clients, providers and policymakers.

a) Local Governments: As part of general decentralization, WS is being devolved to local governments, and the role of policymakers is thus being unbundled between different tiers of government. In the process there is often loss of scale and fragmentation in service provision, aggravated by limited local-government capacity. Ensuring the compatibility of WS systems and the decentralization process is a key component of ensuring service delivery

b) PSP is an important tool for reforming urban and regional service providers across the world, enabling a credible separation of roles between policymaker and service provider. But impact and sustainability of PSP models are being questioned, particularly as to the capacity of the policymaker to manage PSP; frequency of contract changes; serving the poor, and price increases. There is a need to rethink the approach to PSP and redefine the nature of the contract between the policymaker, the private provider, and the client.

c) Communities: Mostly in rural areas (e.g. India Swajel), but also in informal urban settlements (Mumbai and Pune), CDD, with the community as the service provider and the client has become a model for WS service delivery. The jury is still out on the sustainability and scaling up of this approach.

2. Sewerage: In network systems, issue of high capital cost—pace of sewerage access well behind access to water connection (Manila). In addition, significant informal settlements have developed away from main sewerage lines exacerbating the access issue.

3. Targeting Poor People: Institutional reform will require pricing water as a commodity for supporting the separation of policymakers and service providers and ensuring their greater accountability to clients. Yet, the popular belief remains that pricing of water is anti-poor. The challenge is to ensure that use of pricing to strengthen the relationship between policymakers, providers, and clients is consistent with access to services by poor people.

B. Sanitation: sanitation practices have a dismal record globally (South Asia, Africa). At the client level, service provision that influences collective and household behavior is critical. Whether there are new approaches that adopt these principles and can reverse the dismal trend or whether the improvements will be more gradual remains a critical policy issue.

III. Policymaker and Provider: Increasing responsiveness and accountability to clients and in particular to poor people will require greater separation of roles between policymakers and service providers--by creating a wedge of accountability between different tiers of policymakers, while opening the door to different forms of service providers.

A. Unbundling the policymaker between different tiers of government (Latin America, South Africa, India and Pakistan)

B. Ensuring separation between service provider and policymaker

1. In network systems
    a) Role of multi-tiered governments
    b) Role of PSP (lessons from Latin Africa, Africa, East Asia)
    c) Role of Community Driven Development (South Asia)
    d) Role of competition (Mexico, Manila, Australia)
        (1) Multiple providers, public and private
        (2) Enabling the benchmarking of the sector
2. In non-network systems
    a) Self provision and independent providers: separation already ensured
    b) Has the separation gone too far (privately provided tube-wells in Bangladesh)

C. Challenges

1. Matching technical scale economies to political boundaries (France, South Africa)

2. Managing PSP
    a) Regulatory regimes
    b) The politics of PSP

3. Scaling up and sustainability of CDD (India and Africa)

4. Limited nature of competition in water

5. Regulating water quality in dispersed communities (arsenic in Bangladesh)

IV. Client and Provider: While strengthening the separation between policy maker service provider, pricing and regulation of water are essential policy instruments for orienting service providers towards the client.

A. Focus is on network services

1. Role of pricing
    a) Role of pricing in ensuring accountability of service provider to clients
    b) Poor people already paying for formal service provision failure: WTP high (South Asia and Latin America)
    c) Designing pricing and subsidy strategies to ensure both accountability and protection of poor people (Chile, Colombia, and South Africa)
    d) Externalities: not all costs should be passed on to the consumer
    e) Implementing price increases: smoothing the transition, and cushioning shocks to the poor.

2. Role of regulation
    a) Flexible arrangements for retail delivery to poorer communities e.g. informal settlements (Durban, Ahmedabad)
    b) Flexible standards

B. Non-network services: Is there a need for regulation? (Laos, Africa)

V. Client and Policymaker: The role of client-citizens in network systems has been underplayed. Much can accomplished through formalized structures of voice and ownership in the water sector.

A. Voice

1. In regulatory bodies and consumer associations

2. In local government structures and community structures: Where is capture-probability higher: local governments or water committee? (India: Little Pani, Less Panchayat)

B. Share ownership

1. In formal companies

2. CDD

VI. Sanitation: The sanitation problem is mostly one of policymakers adopting a "supply driven" approach to "creating the demand" for sanitation services at the community level. Service providers with the capacity and motivation to work with communities will provide the ideal partner for policy makers to influence sanitation outputs.

A. Addressing the sanitation problem as one of delivering "latrine technology" has historically failed; igniting demand for sanitation services where possible and responding to existing demand are the challenges for the policymakers.

1. Creating Demand
   a) Ensuring good water service delivery: recognizing the sequencing of demand (Sao Paolo)
   b) Targeting collective behavior not technology of latrines (Bangladesh)
   c) Legislation (in dense settlements)

2. Supporting existing demand: urban setting
   a) In crowded settlements access to land – common property (Pune)
   b) Providing secure tenure (Ahmedabad)
   c) Flexible standards (Latin America)

3. Role of subsidies

B. Choosing the right type of provider

1. Community mobilization

2. Links with local governments

VII. Scaling up change in water and sanitation

A. What are the barriers to reform?

1. The politics of control and patronage through service delivery.

2. The politics of "Unwillingness to Charge" vs. the reality of "Willingness to Pay"

3. The perception of water as a social good rather than a merit good

4. Sanitation: Public intervention targeting private behavior rather than collective action; linkage with water supply not effectively exploited;

5. Why is poor service tolerated?

B. Relocating reform of water and sanitation in the context of the public sector

1. Recognition that public sector control will remain a dominant model for sometime to come and that reform must come with the broader reform of the public sector, not the water and sanitation sector in isolation.
    a) Defining the public sector model—linkage to local government (Johannesburg), autonomy of a public sector operator (Chile), regional utility (LAC, Australia), regulation of dispersed providers
    b) Strengthening the public sector through PSP
    c) Regulation: a critical public sector role: types, approaches, and mechanisms

2. Addressing the sanitation gap:
    a) the public sector challenge
    b) recognizing the separate challenge of sanitation but understanding its linkage to the overall reform of the water system

3. Capturing the potential political economy window of restructuring local governments (Latin America, South Africa, and South Asia)

4. Addressing the cost of transitions: the role of public finance from central governments (South Africa and India)

5. Protecting the poor

6. Delivering and supporting the capacity of local governments during the process of decentralization (South Africa)

7. Recognizing that the local government boundary can encompass various types of settlements suggesting the need to look at how local governments manage small towns and the space in between and whether common institutions can serve both types of settlements (e.g. regional utilities playing the role of service provider and project management units)

C. Role of Donors: Too much effort in creating enclaves rather than supporting systemic change that links public sector reform to water and sanitation and vice-versa.