Clients and providers

chapter 4

The well-being of poor people is the point of making services work. The value of public policy and expenditure is largely determined by the value the poor attach to it. When publicly provided and funded housing is left vacant,[174] when food supplies are not eaten, when free but empty public health clinics are bypassed in favor of expensive private care,[175] this money is wasted.

Improving services means making the interests of poor people matter more to providers. Engaging poor clients in an active role—as purchasers, as monitors, and as co-producers (the "short route")—can improve performance tremendously.

How can public policy help poor people acquire better services through this route? By expanding the influence of their own choices. By having the income of providers depend more on the demands of poor clients. By increasing the purchasing power of poor people. And by providing better information and a more competitive environment to improve the functioning of services. Where such choice is not feasible, governments can expand consumer power by establishing procedures to make sure complaints are acted on.

Sad to say, governments and donors frequently neglect the possible role of poor clients in sustaining better services—or treat that role merely as an instrument for achieving a technically determined outcome. Neither governments nor donors are accustomed to asking the poor for advice. Recent initiatives have begun to redress this through a variety of ways to increase participation by communities and civil society. But the potential for improvement has not yet been adequately tapped.[176]

In short, the key is to enhance the power of poor clients in service provision. This Report and this chapter try to give the term "empowerment" a precise and concrete interpretation. Specifically, the chapter discusses the potential for poor people to influence services by:

- Increasing their individual purchasing power.
- Increasing their collective power over providers by organizing in groups.
- Increasing their "capacity to aspire"[177]: allowing them to take advantage of the first two by increasing the information needed to develop their personal sense of capability and entitlement.[178]

When will strengthening the client-producer link matter most?

In the framework of chapter 3, improving client power—the short route of service delivery—can overcome various weaknesses of the long route (figure 4.1), even when services remain the responsibility of government. The clearest case is monitoring providers. Clients are usually in a better position to see what is going on than most supervisors in government hierarchies—who provide the compact and management. When the policymaker-provider link is weak because of scarce or difficult-to-manage supervisory staff, clients may be the only ones who regularly interact with providers. As discussed several times in this Report, improvements in basic education have often depended on participation by parents. Although parents cannot monitor all aspects of education, they can monitor attendance by teachers and even illiterate parents can tell if their children are learning to read and write.

Citizens as clients can also make up for shortcomings in the voice or politics relation-

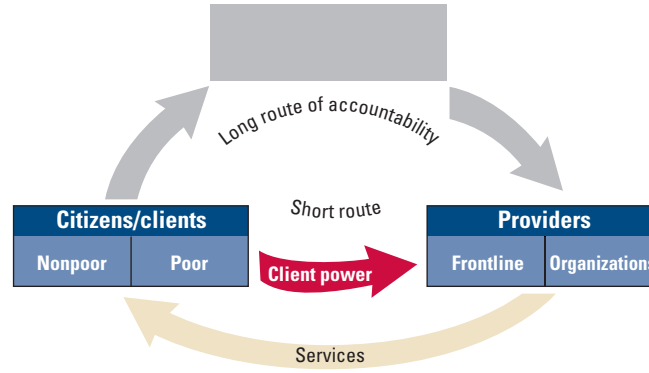
ship. If governments cannot or will not try to determine and act on the desires of the public, or if the desires of poor people are systematically ignored, there may be few options for poor communities but to develop mechanisms for getting services some other way.

The greater the differences among clients—their heterogeneity—the more that direct client power is likely to have an advantage relative to the "long route." The greater the individual differences in preferences for the type and quality of services provided, the greater the importance of discretion on the part of providers and the more difficult it is to monitor the use of this discretion centrally. Sometimes preferences differ geographically, so different levels of government may reflect this variation. But for many services, the heterogeneity of preferences applies all the way down to the individual. Take courtesy and comfort (caring) relative to technical skill (curing) in health delivery—or farmers with constraints on their time and other workers in the same community with different constraints. Certainly people differ in the amounts of water and electricity they want, given their other needs. Government structures may not be flexible enough to accommodate this variety. And where local preferences vary systematically between the poor and others, honoring poor people's preferences over those of the better-off can be a challenge.

For some collective action problems, governments may not be located at the correct level to solve them, no matter how willing they are to pursue the interests of the poor. The boundaries of the political jurisdiction may not correspond to the boundaries of the problem. So schools are often the most appropriate unit for management and operation. Sanitation services need community pressure to ensure that everyone uses fixed-point defecation, but they are often organized around communities that are larger or smaller than villages, depending on the density of population. A more active role for communities is needed in such cases.

It is important to avoid romanticizing either form of increasing client power—neither choice nor participation is sufficient for all services. Market failures and concerns for equity lead societies to want to improve or extend these services in the first place. There is no reason to believe they are all self-corrective through replicating aspects of the free market.

Figure 4.1 Client power in the service delivery framework



Similarly, some settlements constitute communities with sufficiently congruent interests among members, egalitarian norms to protect the poor, mutual trust, and the ability to mobilize information and to act collectively—that is, they have social capital.[179] But some clearly do not. How many villages and urban neighborhoods are there in the developing world? Hundreds of thousands? Millions? And how many kinds of social structures are represented? Ensuring that poor people have a say in this variety of circumstances demands that policies be examined and designed with a great deal of local knowledge and an understanding of local conflicts and inequalities. Pretending otherwise will almost certainly do real harm.

And some services, particularly for health and modern water and sanitation, need technical inputs to be successful. Patients—as individuals or health boards—are good judges of courtesy and attendance. But they are much less able to judge clinical quality or the appropriate mix of curative and preventive services. And some health problems have effects that spill over community boundaries. Large pest-control initiatives and other forms of infectious disease control may seem a low priority for any one group of citizens, yet will be effective only when all participate. Ultimately, some wide-scale government intervention is necessary. Still, emphasizing the power of clients is a welcome tonic for the top-down, technocratic orientation that has characterized much development thinking until now.

Increasing client power through choice

The most direct way to get service providers to be accountable to the client is to make whatever they get out of the transaction depend on their meeting client needs and desires. That is, money (usually) or other benefits from providing the service should follow the client—the enforceability of a relationship of accountability, discussed in chapter 3.

In market transactions, this is done by a buyer paying money to a seller. But that is not the only way. Payments by government to schools (and the pay of teachers) can depend on the number of students enrolled and continuing. The vast majority of primary education in the Netherlands is paid for by government but delivered by private schools compensated in this way. Capitation lists are the dominant method of pay for general practice medical providers in several European systems, particularly the United Kingdom. Overall consumer satisfaction can be expressed through the possibility of changing general practitioners, determining their income.

Vouchers issued to consumers are another method of linking service provider compensation to consumer choices, even though the consumer is not the original source of funds. All health insurance with some choice of provider is a form of voucher—one conditional on being sick. And intrinsically motivated providers, whose sense of self-worth depends on having a large demand for their services, try for more patients under any payment system. The essence of each of these methods is that client well-being translates directly into provider well-being—the incentives are aligned.

Many service problems can be improved by making sure that payment follows clients. Most of the evidence for this comes from studies examining the effect of fees on the behavior of private providers (who must, of course, operate this way) but it applies to all such methods. Payment can have four kinds of beneficial effects:

- Improve provider behavior.
- Increase supply and sustainability.
- Increase vigilance and a stake in receiving better service from each transaction.
- Make better choices about which services to demand.

The first two work through providers, the second two through clients.

Provider behavior

Discourtesy, social distance, abruptness of care, discrimination against women and ethnic minorities, service characteristics mismatched to individual tastes—all are associated with provider behavior. And all can improve with the purchasing power of clients. Indeed, that is why the private sector is often seen as preferable to a public sector with staff paid by salaries (box 4.1). These differences are echoed in studies from countries as diverse as Bangladesh, China, India, Lao PDR, Thailand, and Vietnam.

For courtesy, caring, and convenience the private sector usually has a distinct advantage. Private practitioners usually provide services more convenient to the client. Limited hours in public facilities (only in the morning in farm communities) is often the reason people go to a private practitioner.[180]

What accounts for the difference? Not the training but the motivation: ". . . the same government doctor who was not easily or conveniently accessible, whose medication was not satisfactory and whose manner was brusque and indifferent transformed into a perfectly nice and capable doctor when he was seeing a patient in his private practice."[181] Why? Because the doctor wants the client to return. If the staff is paid through salaries, there is no strong incentive to be accommodating. This is not lost on clients: "Anyhow, they will get their money, so they don't pay much attention."[182] Discrimination, particularly against ethnic minorities and women, and social distance are barriers to services even when the services are free, barriers that frequently yield to market forces.[183] The artificial scarcity of free services—ensuring excess demand—induces rationing by some other means (social status, personal connections, ethnicity), and poor people rarely have these other means. Groups coping with social stigma—such as prostitutes, who need to be part of the battle against HIV/AIDS—often prefer the confidentiality and more considerate behavior in private clinics.

The scarcity of commodities due to low pricing may lead to other commonly reported problems—illicit sale of materials and the demand for under-the-counter payments. Indeed, "free" public services are often very expensive. Many countries have serious diversions of pharmaceuticals from the public stock into private markets, where they instantly become expensive. In general, services that most directly resemble market goods have a greater problem of diversion and implicit privatization.

In Eastern Europe the health systems are often ranked among the most corrupt of public services (box 4.2). Under-the-table payments and pharmaceutical sales to open markets are the main elements in this assessment. If directives against such practices cannot be enforced, countervailing pressure is needed (see box 3.6). Formalizing fees and putting purchasing power in the hands of poorer clients is one possible source of such pressure.[184]

Exemptions from fees can have perverse effects by reducing this purchasing power. In Benin a measure to raise female school enrollment—waiving fees for girls—led teachers to favor the enrollment of boys and to raise informal fees for girls.[185] Of course, the problem could have been solved by abolishing fees for everyone (if the teachers could continue to be paid) or by closer monitoring and enforcement by education officials. But in a system that has problems paying teachers and weak administrative capacity, bolstering the ability of girls to pay with vouchers seems more likely to succeed.

Increase and sustain supply

Greater purchasing power may simply increase supply and overcome bottlenecks due to supply problems. In Bangladesh the Female Secondary School program awards scholarships to girls if they attend school regularly and gives secondary schools a grant based on the number of girls they enroll. Secondary school enrollment in Bangladesh is increasing, and faster for girls than for boys. It also led to the establishment, at private expense, of new schools. Desires for single-sex schools and separate toilet facilities for girls were mysteriously accommodated when girls' attendance meant more money. True, there remain problems, such as ensuring the quality of the newly established schools, but these are secondary to getting girls to school.

The revenues that providers raise from charges at the point of collection are often the reason some services can continue at all. Much of the success of the Bamako Initiative in West Africa (see spotlight) stems from the supply of pharmaceuticals made possible by charging users for them. Bamako Initiative villages usually have drugs, other villages usually don't. Sustainability in piped water systems is almost always equivalent to financial

BOX 4.1 ***The private sector is preferred in Andhra Pradesh, India***

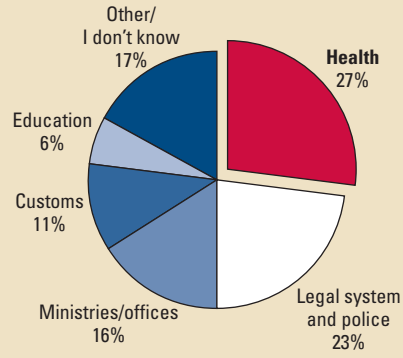
A study of consumer and producer attitudes was conducted in six districts in the southern Indian state of Andhra Pradesh. The study included 72 in-depth interviews and 24 focus groups.

Private	Public
ATTITUDES OF DOCTORS	
"They speak well, inquire about our health." "Ask about everything from A to Z." "Look after everyone equally." "They take money . . . so give powerful medicine . . . treat better."	"Does not talk to me, does not bother (about my feelings or the details of my problems)." "Don't tell us what the problem is, first check, give us medicines and ask us to go." "They are supposed to give us Rs. 1000 and 15 kg of rice for family planning operations; they give us Rs. 500 and 10 kg rice and make us run around for the rest." "Anyhow they will get their money so they don't pay much attention."
CONVENIENCE	
"Treat us quickly. . . ." "We spend money but get cured faster." "I know Mr. Reddy. He is a government doctor but I go to him in the evening." "Can delay payment by 5–10 days. He is OK with that, he stays in the village itself."	"Do not attend to us immediately." "Have to stand in line for everything." "Doctor is there from 9 a.m. to 4 p.m.—when we need to go to work." "I have not been there, but seeing the surroundings . . . I don't feel like going."
COST	
"Recent expenses came to Rs. 500 for 3 days . . . had to shell out money immediately." "We have to be prepared to pay, you never know how much it is going to cost you."	"While coming out, compounders ask us for 10–20 Rs." "Anyhow, we have to buy medicines from outside."
ADVANTAGES	
"Even if I have to take a loan I will go to private place, they treat well."	"Malaria treatment—they come, examine blood, give tablets." "For family planning operations." "Polio drops." "In case I do not get cured in private hospital, but it is very rare."

Source: Probe Qualitative Research Team (2002).

BOX 4.2 *Bribery in Eastern Europe*

Surveys in nine transition countries of Eastern and Central Europe* asked: "In your opinion, in what area is bribery most common, widespread?" Health systems rank highest overall, but with answers ranging from 11 percent in Bulgaria to 48 percent in Slovakia. Since there has been an overall contraction in public services with that in economic activity, the most likely reason is that these marketable services are naturally easy to charge for and difficult to maintain without infusions of funds from patients.



*Bulgaria, Croatia, Czech Republic, Hungary, Poland, Romania, Slovakia, Slovenia, and Ukraine. The diagram summarizes results averaged over these countries (weighted by population).
Source: GfK Praha—Institute for Market Research (2001).

sustainability. There might be some subsidy element included in pricing, but systems to get water to a private home depend on charges for that water.

Increased client stake—and vigilance

The third argument for having money follow clients: when people buy things they make sure they get them, and they pay more attention to the quality of what they get. Money is a profound source of power for poor people. When Zambian truck drivers were expected to pay into a road fund, they took turns policing a bridge crossing to make sure overloaded trucks did not pass. Their money would have to be used to fix the bridge. Women living in slum areas of Rio de Janeiro proudly display bills they paid for water and sanitation—it proves their inclusion in society and their right to services.[186] Farmers in southern India expect the same from irrigation services (box 4.3).

Making better choices

For some services consumer discretion is important for allocating resources efficiently. Households determine water and electricity use, scarce goods that have costs associated with them. And facing marginal costs is the only way to ensure efficient use. The alternatives: wasted water leading to shortages, unreliable service with serious consequences for the safety of the water supply, and periodic cuts in electricity familiar to most people in developing countries. Protecting the poor in network services can be achieved (assuming that meters work) with "lifeline" subsidies, in which the first few essential units are free but full marginal costs are paid beyond this level.

In health care, as in water and electricity, more is not always better. Restricting demand for curative services by pricing frees up providers, particularly public providers, to do preventive health, for which there is little private demand.[187] As the director of a prominent nongovernmental organization providing health care to the very poorest in Bangladesh puts it: "Of course you must charge at least a token amount for services, otherwise you keep seeing people with paper cuts and other minor things."[188] Similarly, crowding at outpatient clinics at public hospitals can be curtailed by charging enough so that people use a cheaper level of service.

All these advantages can be obtained in ways other than charging fees at the point of service. As long as clients consider the resources used as belonging to them, the discipline of market-like mechanisms can be enforced. The Singapore Medical Savings Accounts do this by allowing people to apply funds not used for primary medical care to other purposes, such as pensions.[189] Countries with scarce administrative personnel and supervisory capacity may certainly want to enlist clients as monitors, and market mechanisms are one way of doing it.

For any of these mechanisms to work, however, there must be a real choice with real options. Otherwise, giving schools pay-

BOX 4.3 ***Payment and accountability***

A conversation with farmers in Haryana state in India, who had been to see what had happened in reforming Andhra Pradesh (AP):

Q: "What did you learn when you visited AP?"

A: "That the farmers are much poorer than us, but that they pay four times as much for water"

Q: "The farmers in AP cannot be happy about that…."

A: "They are happy, because now the irrigation department is much more accountable to them …they know where the money goes and they have a say in how it is spent…."

Q: "So then, you much richer farmers would be willing to pay more?"

A: "Only if the irrigation department makes the same changes, otherwise we will refuse to pay."

Q: "Ah, but this is just because there is a particular Chief Minister who is pushing that now … once he goes it will all go back to the same old way."

A: "We also wondered about that, and so we asked the farmers in AP about that. They told us that 'no matter who is elected as CM, we will never allow the government to again give us free water.'"

Source: World Bank staff.

ments on the basis of enrollments is not far from what happens now in centrally owned and managed school systems, with all the problems we are trying to fix. Conversely, market mechanisms with a natural monopoly don't improve matters either. There is no denying that sparsely populated rural areas—where many of the world's poor people live—are much more constrained by competitive supply than urban areas. But even these markets may be "contestable" in the sense that other providers would be able to enter the market if the current provider abused monopoly power or if monopolies were periodically granted on the basis of competitive bids.

Policies to improve choice

Choice-based improvements alone cannot be a solution to the problem of bad services for the poor, though some may remain as instruments in a longer-run strategy by government. In some cases the market would be expected to wither away as the state increases its capabilities. In the meantime, three categories of policies can make the most out of clients acting on their own behalf:

- Increasing the power of the poor over providers by providing them with finance directly.
- Increasing competition.
- Increasing information about services and providers.

Increasing the purchasing power of the poor. The big problem with services that can, in principle, be provided in markets is that poor people don't have enough money to pay for them. For market mechanisms to help the poor, their purchasing power must be increased. The voucher mechanisms discussed are a direct way of handling this for specific services. But additional mileage can come from more flexible transfers that can be used for purposes that the family chooses.

Flexible transfers can help to overcome the weakness of the citizen-policymaker link by giving poor people more direct say in what gets delivered than even the political process would give them—the transfers become *their* money. Substantial work in South Africa has shown the beneficial effects of cash pension payments on the health and well-being of all members of a family.[190] For services with large externalities, demand for the service may not be great enough, even when the service is free, so the Bolsa Escola program in Brazil paid families to send their children to school, as did the secondary school program for girls in Bangladesh, while the Education, Health, and Nutrition Program (Progresa) in Mexico paid families to use preventive health care (see spotlight).

Cash payments have problems though. First, giving unconstrained cash transfers to poor people is often not politically palatable. Second, cash payments always have to be administratively targeted, which requires determinations of eligibility. Everyone likes money, so self-targeting of cash transfers is not possible. If a government has a hard time getting goods and services into the hands of the poor, it may well have an even harder time getting cash, or cash equivalents, to them.

Increasing the scope of competition. Sometimes increasing competition merely means allowing a private sector to emerge where laws previously restricted entry. Jordan, after years of prohibition, allowed private universities in 1990. Ten years later, enrollments in these institutions accounted for one-third of all university students. Bangladesh has had a similar experience in the past decade. This increase in competition allows governments to increase enrollments without extremely regressive subsidies to public universities.

Competition can also be encouraged by allowing subsidies to the poor to be portable between public and private providers. Private providers may not exist simply because the public sector is free. Governments can increase competition by changing the form of subsidy from zero price to competitive prices, with cash or voucher payments to compensate. University education government loans, usable at any eligible institution, can increase competition, improve quality in public facilities, and reduce subsidies for all but students from poor families.

In some cases competition is not possible, at least not without substantial regulation. Health insurance markets are notoriously prone to failure, and competition within them can lead to both inefficient and inequitable outcomes, since firms can compete by excluding the sick, not by being more efficient. Network services are also hard to run without a monopoly. But in each case these markets can be contestable, capturing much of the benefit of competition.

Some readers may think that the foregoing arguments are just an attempted justification for user fees. This is wrong, for all the reasons put forth here. So, to make things as clear as possible, the pros and cons of user fees in general are laid out in box 4.4. There are times when user fees are appropriate—and some when they are not. Based on the primary goal of making services work for poor people, this Report argues against any blanket policy on user fees that encompasses all services in all country circumstances.

Increasing information to improve choices by consumers. One critical limit to well-functioning competitive markets is the consumer's awareness. The private sector is a mixed bag. Private "medical" providers vary from quite good doctors (including senior specialists from government hospitals in their off-hours) to totally unqualified, untrained people, some of whom are downright dangerous.[191] Private or NGO schools may cater to specific skills not provided in public schools (foreign language, religious studies, arts and music) or they may just be profiteers. An essential part of improving peoples' choices is to provide information about these providers. Many times, people simply don't know enough to choose better or worse services. And sometimes they identify good medical care with powerful medicines—which is quite wrong and potentially dangerous.

Information can be advice to families on how to choose schools or medical caregivers[192] or on how to take care of themselves. This might be supplemented with various certification programs, standard setting, and laboratory checks (say, for water purity). Scorecards of public services should also be extended to private or NGO providers. On the other side of the market, government may want to directly improve the quality of private services. Training, "partnership" arrangements, contracting, and other means of engagement can all be tried. But attempts to increase information should be subject to rigorous evaluation (chapter 6).

Increasing consumer power through participation

The accountability of providers to clients can also be achieved when people voice their concerns. In this case, enforceability is not through clients' money but through their direct interaction—encouragement and complaints. The scope for poor people to voice complaints individually is very small. In rich countries individuals get help from systems of tort law that can handle individual litigation and from government-sponsored offices of consumer protection or ombudsmen. But these are rare to nonexistent for the poor in developing countries (they don't always work so well for the poor in rich countries either).

Some problems for which voice might be expected to work are intractable. One example is corruption: the public might

resent under-the-table payments, but there may be no incentive to complain if, say, a doctor is using public facilities and materials at the same time. Clients know that the service is still cheaper than if they had to go to the market, and so do not complain.[193]

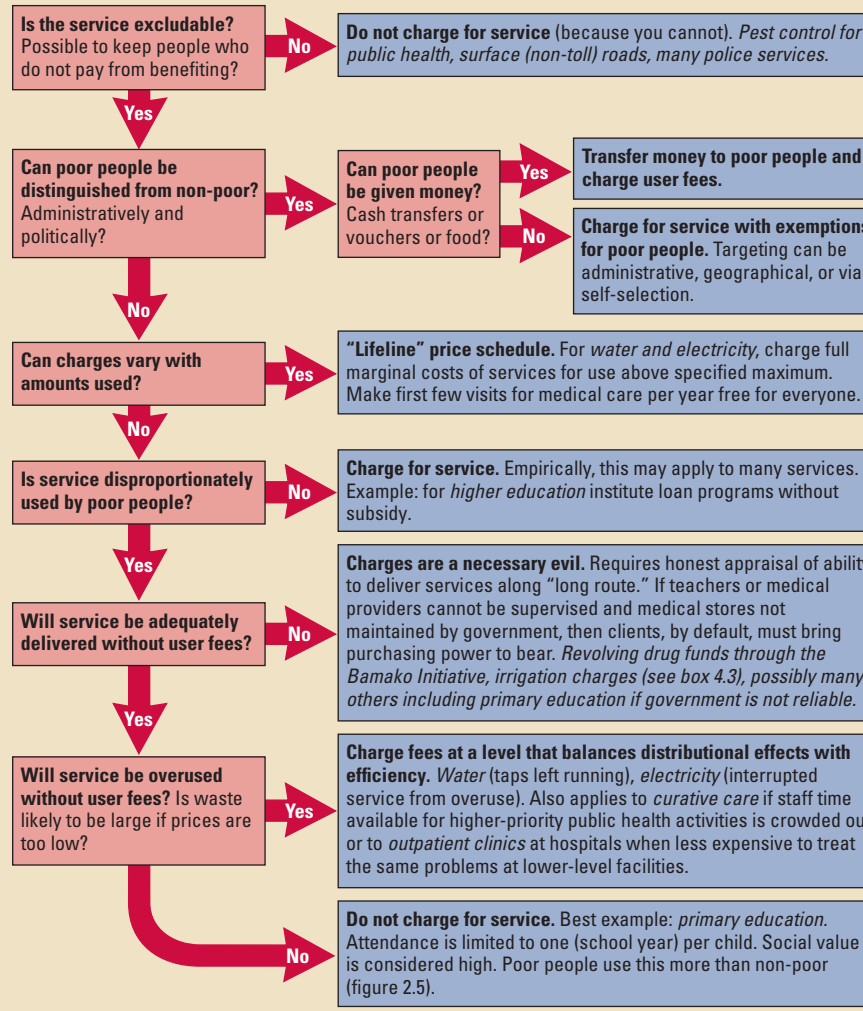
There is a deeper constraint: even when there is an opportunity to redress complaints, monitoring and follow-through are public goods—the benefits accrue to the entire group while the costs are borne by a few. This is true for communities as well as individuals, but groups of people generally find it easier to elicit support from members than from individuals going it alone. So client power expressed outside market transactions will almost always be expressed through collective action.

Strengthening participation along the client-provider link can fix problems in the long route of government provision. So community groups that take on complaining, monitoring, and other means of making sure things work properly would be expected at some point to become institutionalized within government (most likely local government), or possibly to be supplanted by government as it improves. After all, collective

BOX 4.4 *No blanket policy on user fees*

The wide range of services and country circumstances discussed in this Report makes it impossible to claim that a particular level of user fees or none at all is appropriate in every case. User fees, as with other public policy decisions, must balance protection of the poor, efficiency in allocation, and the ability to guarantee that services can be implemented and sustained. The following flowchart summarizes the arguments and references in the text and raises most of the issues necessary in determining whether user fees of any sort are appropriate in a given case. Three points:

- First, "efficiency" is shorthand for standard principles of public economics (see any textbook) that often but not always require prices that equal social marginal cost and may include subsidies, taxes, or other interventions independent of their distributional effects. For example, infectious disease control measures will have a subsidy element because of their external effects regardless of their impact on poor people.
- Second, it is assumed that all subsidies are paid for by taxes. The net effect on poor people depends on their contribution to tax revenue (possibly substantial when taxes are based on agricultural exports) and on their share of the deadweight loss that taxes impose on the economy.
- Third, even when prices are not charged at point of service, communities may want to make contributions to capital costs by, say, helping to construct or maintain schools.



action is expensive—people, especially poor people, have more pressing things to do with their time. They will want to transfer this responsibility to permanent structures as fast as they can.[194]

But local inputs and knowledge from direct participation may be needed for some time, possibly permanently, and government can help make those inputs more effective. Education provides many of the better illustrations. Parents are in the best position to see what is happening in schools, and schools are usually the unit in which decisions are most effectively made. So giving parents power to influence school policies often has beneficial results. In the example of El Salvador's Community-Managed Schools Program (Educo—see spotlight), it was the right to hire and fire teachers and the regularity of visits from the local education committee, staffed in part by parents, that led to the increases in teacher and student attendance and in test scores.

Madhya Pradesh, India, has seen substantial improvement in test scores, completion rates, and literacy.[195] Community involvement is strong in recruiting teachers, getting new schools built, and encouraging neighbors to enroll their children. Parents have been helped by the ability to hire local, less-than-fully-trained teachers at a fraction of standard pay scales for government teachers—with better results.

This last aspect of the program complicates scaling up. The ability to avoid confrontation with public sector unions has been a great advantage. Will teachers' unions allow such recruitment to become standard?[196] Do teachers hired at low wages expect to be converted into full public servants? For now, however, the involvement of communities in Madhya Pradesh, which is much greater than in other states, has made a big difference in performance.

Other policy initiatives that can also make client voice more effective include offering more convenient venues to air complaints. Several studies have shown that the relationship between parents and teachers is important: it should be supportive, respectful, and cooperative, not punitive and confrontational. The success of local communities in improving education can thus be compromised by too aggressive a stance. This is true for other professionals as well. In Kerala, maintaining staff at a health center became difficult when local residents made too many demands on providers' time.[197]

Beyond monitoring, communities can be the appropriate locus for more direct inputs, in effect becoming co-producers of services. Some services cannot be delivered by state agencies very well because the environment is too complex and variable—and the cost of interacting with very large numbers of poor people is too great.[198] Sanitation programs often benefit from local participation and inputs, since social relations in communities are often the best guarantors of compliance with sanitation policies and compliance must be universal if the community is to reap the health benefits.

Local perspective and knowledge are critical in transmitting needed information. The acceptability of messages on health-related habits, preventive health measures, hygiene, sexual conduct, and other sensitive issues is much greater when those messages are conveyed through informal face-to-face contact in discussions among small groups of individuals with similar backgrounds. For instance, organized discussions among informal women's groups can enhance the credibility and impact of behavior change efforts. It is possible, but unlikely, that outsiders may learn enough of local mores to influence local conversations on these subjects.[199]

Tapping local social capital

Many communities have evolved means of solving longstanding problems requiring collective action. When the benefits of cooperation are great enough, there is a way to enforce rules, and where there are no private alternatives, organizations often emerge on their own.[200] Communities have solved irrigation, forestry management, nutrition, and other problems. Recently, governments (sometimes with help from donors) have started to learn from this experience, and have funded projects and programs that rely on, and require, the formation of local user groups and committees to choose and implement development projects. Rather than give transfers of income to individuals, which can be both

politically and administratively difficult, governments have channeled money through community groups. The various approaches that have been tried address two possible weaknesses in the "long route" of accountability through governments: implementation, or the "compact" by single-purpose user groups, and "voice," which allows communities to decide on projects to undertake.

A recent evaluation of six early social funds, most initiated in response to crises, found that the programs were progressive, though more between than within regions.[201] Special-purpose user groups have been more common. In water supply and sanitation particularly, there are numerous cases of better implementation through such groups. In Côte d'Ivoire, when responsibility for rural water supply shifted from central government to user groups, breakdowns and costs were reduced.[202] Some local communities have used local contractors, improving accountability and increasing efficiency through explicit contracts.[203] When governments, especially local governments, are severely hampered in delivering services, these methods have the potential to bring about marked improvements.

These programs are new—and changing as lessons emerge. Because of their potential, rigorous evaluation is a high priority. Which aspects are replicable? How can pitfalls be avoided? Some of the emerging lessons stem from the difference between groups that emerge spontaneously and those that are created from above for the purpose of channeling money.

Capture. Groups constituted as a part of projects funded by outsiders may be particularly prone to capture by elites. Local groups that evolve as a result of long-felt needs may or may not be representative of the poorest people. But when those groups are used by higher levels of government or by donors to channel formerly unheard of sums of money, even representative groups tend to change. In Indonesia, when participation was mandated by national government to go through village councils, the increased participation of some members of communities was found to have a "crowding-out" effect on others, leading to a net reduction of participation.[204] More recent programs in Indonesia have benefited from this experience and have been designed to elicit more widespread participation (see spotlight on the Kecamatan Development Program).

A real risk comes from the speed with which groups are constituted and funds disbursed. Elites can mobilize more quickly, master the rules of submitting applications (if they can read and the majority of the community cannot), and present themselves to the community as an effective conduit for receiving such funds. In one Sahelian country a large fraction of project funds was diverted for personal gain.[205] Much of the blame lies with the speed at which donors want to disburse funds (chapter 11) and with the limits this puts on incentives and abilities to monitor the behavior of leaders. Rushing to create social capital where it does not exist can do more harm than good. If there were ever a case for patience, this is it. It is not merely the creation of participatory formats but the encouragement of the abilities of poor people themselves that will have longer-lasting effects. The policies to look for, then, may be those of education, freedom of expression, transparency, and time.

The problem of capture is not limited to groups created for investment purposes. It also affects existing community groups and local governments. Both elitism and, in many cases, gender (men as opposed to women) can determine who dominates traditional communities and local governments.[206] It is not clear that elite capture is always a problem. Wade (1988) proposes that mobilizing community action may require the leadership of the more educated, connected elite. The lessons, though, are to make sure that either the types of services funded by such methods have substantial public good characteristics (putting health and education in a sort of "gray" area) or that the right to leadership is contestable.

Developing government capacity. Some special-purpose user groups, better funded than local governments, have drawn off more capable officials to administer their funds (the same effect is seen at the national level in other donor initiatives—see chapter

11). One hypothesis is that this slows the development of local government capacity. But the opposite argument has also been made—that such groups are a catalyst for developing local government capacity. In northeast Brazil, social investment funds led villagers to organize and petition higher levels of government to, for example, guarantee a teacher to staff a school built by the community.[207]

Sustainability. Participatory water projects, underway since the 1930s and 1940s, have often improved water supply—at least for awhile. But at some point water pumps and other pieces of expensive equipment break down. Covering the capital cost (which is expensive) and obtaining the technical help (also expensive) have always been the bottleneck for water projects in poor areas. When a new infusion of capital is necessary at short notice, the community must look either to donors or to regular sources of funds, such as taxes or other general revenue. Eight or nine years after the original investment, are the donors still around? Do they have the same priorities they originally had? Can they respond quickly to small individual requests? Often not. These demands will have to be met by local government,[208] and projects have been evolving to work through them.

Such projects may have been a great deal better than relying on inadequate government structures. The argument for them is strongest where the current government system, especially the local government, is weak, with few prospects for changing any time soon.

This should, however, be a tactic that supports a longer-term strategy of developing governmental capacity—strategic incrementalism, discussed in chapter 3. Caution is required when there appears to be a tradeoff between improving services in the short run and undermining delivery capacity in the longer run. And the political consequences of participatory projects should be the subject of careful evaluations. All this complicates bringing these interventions to scale. It may be possible to replicate community efforts in many places, but whether this is the best way to make sure services are delivered to all people is one of the many open questions on the agenda.

Client power in eight sizes

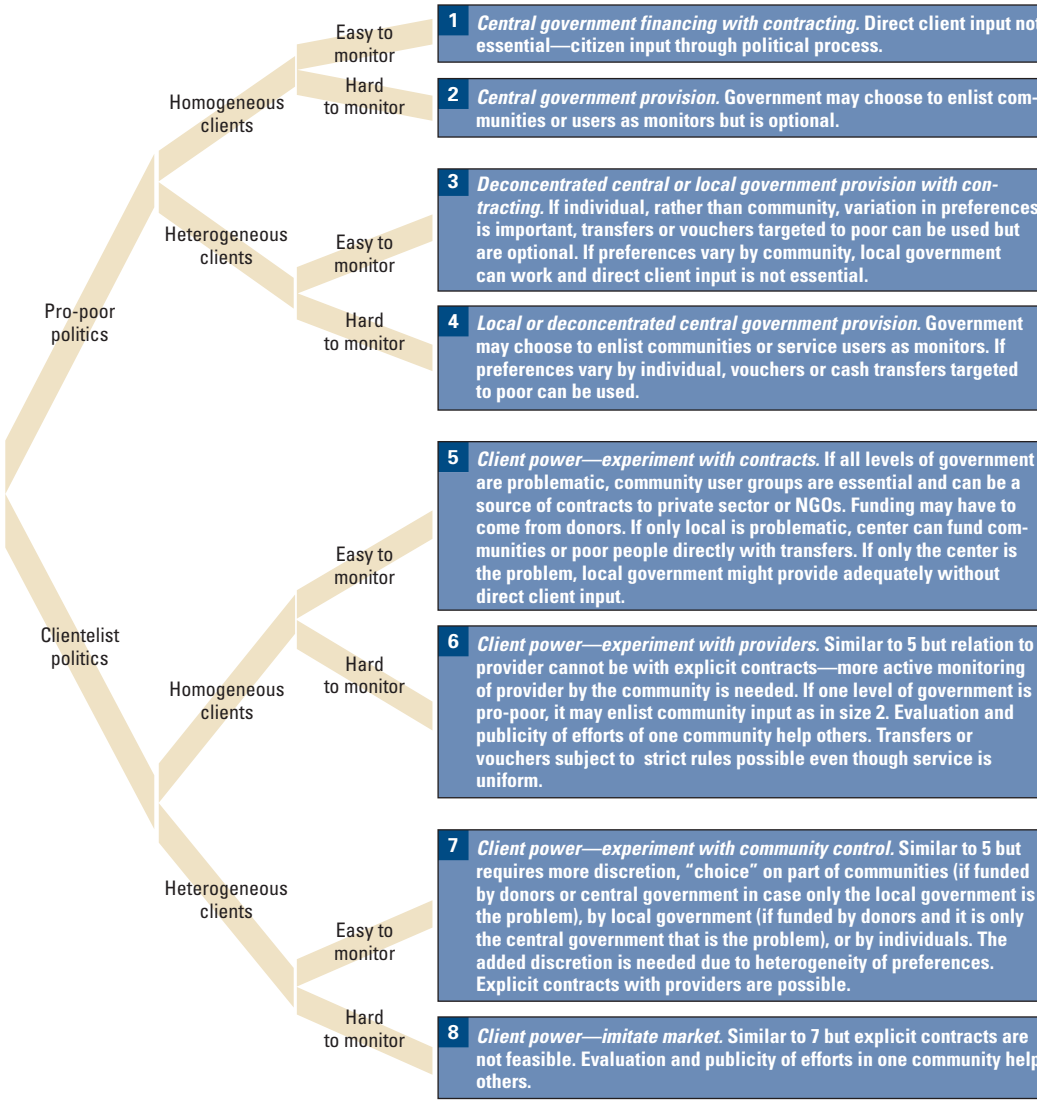
To sum up, increasing client power through improved choice or direct participation will be important when people differ—are heterogeneous in their preferences—or when either of the two legs of the long route to accountability is problematic. In terms of the decision tree (figure 4.2) that determines which of the eight types of solutions is appropriate, client power matters at all three decision points.

Decision 1: Are politics pro-poor? Reliance on client power should vary with the capacity and orientation of government. Also with the question of which level of government is problematic. When governments (central, local, or both) are pro-poor, they may choose to enlist client groups as monitors or solicit their opinions regularly in sizes 3 and 4. Sizes 5 through 8, however, require ways to avoid the problems of government. All four will involve getting information to clients on their entitlements to and the performance of services.

When levels of government differ in their commitment to poor people, the role and sponsorship of user groups differ as well. If central government is a better champion of poor people, they may fund communities (if preferences vary between them) or cash transfers or vouchers (if preferences vary within them) in cases 7 and 8. If local government is better, they can provide or contract for these services. When no level of government is pro-poor, then donors, if they are inclined to be involved at all, might choose to fund community groups or organizations within civil society, being careful not to undermine the development of government capacities.

Decision 2: Does heterogeneity matter? Sizes 3, 4, 7, and 8 directly involve clients. When preferences differ by location then decentralization to local government or to community groups (depending on the capacity and pro-poor orientation of the former) makes sense. If they differ by individual, then purchasing power and compe-

Figure 4.2 Eight sizes fit all



tition for individual business are preferable. Providing information to clients is critical for translating their choices into better services.

Decision 3: Is monitoring easy or hard? When monitoring is easier for clients than for governments (at any level) then client input may be required for sizes 2, 4, 6, and 8. Parents of children, patients, and network service users improve services either by choice in purchasing or by active participation.

It is only in size 1, where government is perfectly capable of providing services directly, that client participation is optional. Possibly size 3 as well if government can accommodate varying needs of clients. For all other cases, the client needs to be placed more firmly at the center of service delivery.

spotlight on *the Bamako Initiative*

Putting communities in charge of health services in Benin, Guinea, and Mali

In some of the world's poorest countries, putting communities in charge of health services, and allowing them to charge fees and manage the proceeds, increased the accountability of local health staff and improved health services for the poor.

The Bamako Initiative in Benin, Guinea, and Mali reconciled traditional community solidarity and provider payments with the objectives of the modern state.[209] How? By strengthening the power of communities over service providers. Policymakers balanced this power with sustained central involvement in subsidizing and regulating services—and in guiding community management.

The initiative improved the access, availability, affordability, and use of health services. Over the more than 10 years of implementation in these three countries, community-owned services restored access to primary and secondary health services for more than 20 million people. They raised and sustained immunization coverage. They increased the use of services among children and women in the poorest fifth of the populace. And they led to a sharper decline in mortality in rural areas than in urban areas.

Despite the various targeting mechanisms, affordability remains a problem for many of the poorest families. But even with limited inclusion of the poorest people, improvements were significant.[210]

Revitalizing health networks

In these three countries, serious disruptions to the situation of health services had occurred during the 1980s as a result of a severe economic recession and financial indebtedness. The health budget in Benin went from $3.31 per capita in 1983 to $2.69 in 1986. In Mali, rural infrastructure was almost nonexistent, and in Guinea, health services had almost totally disappeared—except in the capital city, Conakry—during the last years of the Sekou Toure regime. The vast majority of poor families in the three countries did not have access to drugs and professional health services. National immunization coverage was under 15 percent, and less than 10 percent of families used modern curative services.

The approach focused on establishing community-managed health centers serving populations of 5,000 to 15,000 people. An analysis of the main constraints in the three countries led to emphasis on service delivery strategies focusing on the poor.[211] Priorities included:[212]

- Implementing community-owned revolving funds for drugs with local retention and management of all financial proceeds.
- Revitalizing existing health centers, expanding the network, and providing monthly outreach services to villages within 15 kilometers of facilities.
- Stepping up social mobilization and community-based communication.
- Pricing the most effective interventions below private sector prices, through subsidies from the government and donors and through internal cross-subsidies within the system. Local criteria were established for exemptions (table 1).
- Having communities participate in a biannual analysis of progress and problems in coverage with health services—and in the planning and budgeting of services.
- Tracing and tracking defaulters—and using community representatives to increase demand.
- Standardizing diagnosis and treatment and establishing regular supervision.

Scaling up incrementally

The Bamako approach was implemented gradually, with the support of UNICEF, WHO, and the World Bank, building on a variety of pilot projects.[213] Since the early 1980s, it was progressively scaled up in the three countries—from 44 health facilities in Benin to 400 in 2002, from 18 in Guinea to 367, and from 1 in Mali to 559. This raised the population with access to services within 5 kilometers to 86 percent in Benin, 60 percent in Guinea, and 40 percent in Mali, covering more than 20 million people. Importantly, a legal framework was developed to support the contractual relationship with communities, the cost-sharing arrangements, the availability of essential drugs, and community participation policies. Community associations and management committees were registered as legal entities with ability to receive public funds.

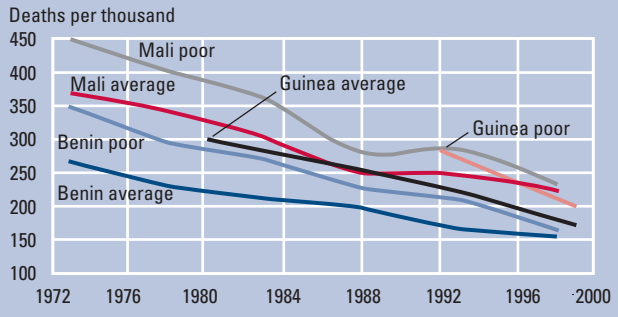
Better health outcomes for poor people

Over the 12 or so years of implementation in Benin and Guinea, and more than 7 years in Mali, health outcomes and health service use improved significantly. Under-five mor-

Table 1 Reaching out to benefit the poorest groups

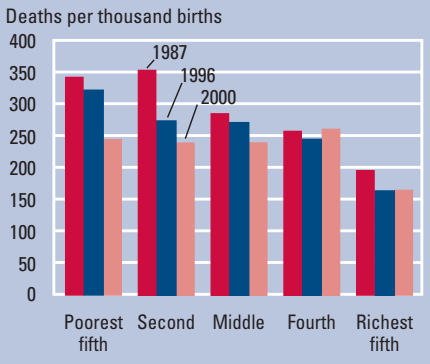
Disease targeting	Geographical targeting	Cross-subsidies	Exempting the poor
Focus on the burden of diseases of the poor: malaria, diarrhea, respiratory infections, malnutrition, reproductive health	Focus on rural areas. Larger subsidies to poorer regions	• Higher markup and co-payments on diseases with lower levels of priority • High subsidies for child health services • Free immunization and oral rehydration therapy as well as promotion activities	• Exemptions left to the discretion of communities • Exempted categories include widows, orphans

Figure 1 Under-five mortality has been reduced in Mali, Benin, and Guinea, 1980–2002



Source: Krippenberg and others 2003. Calculated from Demographic and Health Survey data for Benin 1996 and 2001; Guinea 1992 and 1999; and Mali 1987, 1996, and 2001.

Figure 2 Improvements in under-five mortality among the poor in Mali



Source: Calculated from Demographic and Health Survey data 1987 and 1996 (based on births in the last five years before the survey).

tality declined significantly, even among the poorest. The poor-rich gap narrowed in the three countries (figures 1 and 2). In Guinea, the decline was steepest for the rural population and poorer groups.

Immunization levels increased in all three countries.[214] They are very high in Benin, close to 80 percent—one of the highest rates in Sub-Saharan Africa. Immunization rates are lower in Guinea and Mali, largely because of problems of access (figure 3). Coverage of other health interventions also increased. The use of health services by children under five in Benin increased from less than 0.1 visit per year to more than 1.0. In Mali exclusive breastfeeding and the use of professional services for antenatal care,[215] deliveries, and treatment of diarrhea and acute respiratory infections increased for all groups, including the poorest (figure 4).[216]

In an independent evaluation in 1996 in Benin, 75 percent of informants were satisfied with the quality of care, although 48 percent were not "fully" satisfied. Health care users found the availability of drugs to be high (over 80 percent said drugs were available) and the overall quality of care to be good (91 percent).

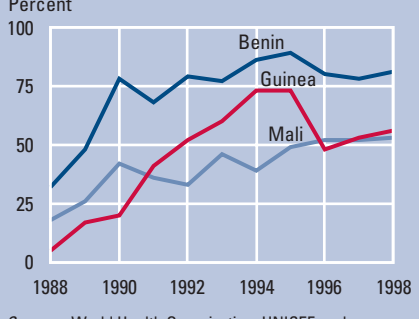
Greater access reduced travel costs, and the availability of drugs reduced the need to visit distant sources of care. Prices have been kept below those of alternative sources. In Benin the median household spending on curative care in a health center was $2 in 1989, less than half that at private providers ($5) or traditional healers ($7).[217]

Poor people still saw price as a barrier.[218] And a large proportion of the poor still do not use key health services in all three countries. In Benin and Guinea the health system allowed for exemptions, and most health centers had revenue that they could have used to subsidize the poorest, but almost none did. Management committees typically valued investment over redistribution.

Community financing—a seat at the table

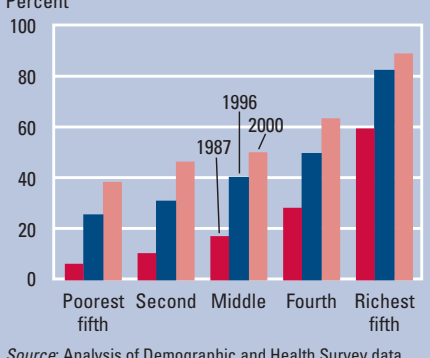
The community financing of key operational costs bought communities a seat at the table. Donors and governments had to systematically negotiate new activities with community organizations. Governments in all three countries, with the support of donors, continued to subsidize health centers, particularly to support revolving drug funds in the poorest regions. In Benin and Mali today the public subsidy to health services is about the same per capita for rich and poor regions. In Guinea, however, public spending has benefited richer groups most. But all three countries face the challenge of emphasizing household behavior change and protecting the poorest and most vulnerable. Establishing mechanisms to subsidize and protect the poor remains a priority of the current reform process.

Figure 3 Evolution of national immunization coverage (DPT3), 1988–1999



Sources: World Health Organization, UNICEF, and Demographic and Health Survey data.

Figure 4 Antenatal care by medically trained persons in Mali by wealth group



Source: Analysis of Demographic and Health Survey data.