

## SPOTLIGHT 8

# Service delivery: Education and health

Improving access to health services and ensuring that students learn are essential to expanding opportunities for all citizens. Various market failures explain the need for collective action to deliver these services. However, power asymmetries often prevent the successful implementation of policies that improve health and education.

## Public interventions: Needed for investments in human capital

Various market failures may make individuals underinvest in health and education. First, certain aspects of health and education are public goods, and many individuals can benefit from investments in them without paying. For example, spraying against mosquitoes in a neighborhood benefits all residents; those who do not pay for spraying cannot be excluded. As a result, some residents may free-ride and not pay for the spraying because they will benefit from it anyway. If all residents adopted this logic, spraying would ultimately not be funded.

Second, investments in human capital present externalities: the benefits to society from educating or promoting the health of individuals can be larger than their private benefits. Some may argue, for example, that education matters not only because of the economic gains it produces, but also because of its contribution to shaping civic behavior (Andrabi, Das, and Khwaja 2015). In addition, some levels of

education may be optimal only if all actors move together. Individuals may not invest in skills if they think that firms are not investing in complementary technologies, and firms may not invest in new technologies if they think they will not be able to find skilled workers (Acemoglu 1998). In some instances, such as the fight against communicable diseases, an individual has no incentive to invest in his or her own welfare if others do not invest as well.

Third, failures in other markets affect investments in human capital: individuals may not be able to borrow to make investments, or they may be misinformed about the gains from them. This is especially true for poorer or disadvantaged individuals. For example, because of credit constraints only those who have enough wealth may be able to invest in education. And because of lack of information, poorer children may be more likely to underestimate how wages increase with education, as a study in the Dominican Republic found (Jensen 2010).

## Education: The challenges of delivering learning for all

The problems outlined in chapter 6 hamper education systems from achieving their goals. Bureaucratic forms do not necessarily serve their intended functions, often because power relationships prevent systems from promoting student learning equitably and efficiently. Moreover, norms consolidate power further and prevent laws and policies from being implemented as written.

In 2014 in Mozambique, 45 percent of primary school teachers and 44 percent of directors were absent from school during an unannounced visit by

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*WDR 2017 team, based on inputs from Paolo Belli and Halsey Rogers.*

survey enumerators of the Service Delivery Indicators (SDI) initiative. However, even if schools managed to reduce teacher absenteeism to zero, pupils would not be able to learn what their teachers do not know. The survey found that in Mozambique only 65 percent of mathematics teachers could calculate 86 minus 55, and just 19 percent of teachers were able to develop a sound lesson plan.

### **Power dynamics undermine education reforms**

In many cases, although policies seem to be in place to improve educational outcomes—for example, governments train teachers or carry out national assessments of student learning—such policies are nevertheless ineffective in improving outcomes.

Reforms have failed because they were thwarted by power dynamics. Indeed, reforms for hiring contract teachers have failed frequently. The idea behind hiring contract teachers is to reduce class size and employ teachers who are easier to sanction (thanks to the threat of firing or at least contract nonrenewal). Thus these teachers face stronger incentives.

However, teachers and their unions are a potent political force. When contract teachers ally with civil service teachers, they also become a potent political force that can lobby to be absorbed into the civil service. Over the last decade or two, large numbers of contract teachers have been “regularized” (given civil service status) in Kenya, Peru (Webb and Valencia 2006), Indonesia, and other countries. As discussed in chapter 6, this power dynamic demonstrates that, although policy makers should monitor teachers to ensure they deliver better learning, policy makers may in fact be dependent on teachers for political support. This dependence diminishes the willingness of policy makers to monitor and enforce performance.

This example reveals that if policy design ignores the power dynamics, a reform can leave the system worse off than before the reform. Teachers hired on contract are often less qualified than civil servant teachers, at least in terms of formal qualifications. Yet, schools, communities, and governments are willing to hire these contract teachers because they are willing to trade qualifications for effort. In the end, though, they have received the worst of both worlds from a service delivery perspective: once the less qualified contract teachers have been incorporated into the civil service, the country ends up with the same low effort, lower skills, and a higher budgetary cost.

### **Difficult education reforms can be effectively adopted and implemented**

How can reforms change the power dynamics to improve the outcomes of education systems? Despite the gloomy picture overall, change can happen, most likely when reforms are successful in changing the incentives of teachers and policy makers, involving new actors in the policy bargaining arena, and changing norms.

*Changing the incentives of policy makers and teachers through public awareness.* Information is often viewed as a way in which policy makers can better monitor providers. However, information as a purely technical tool may not be enough. Rather, information is useful when it can be easily understood and targets those with incentives to act.

Improving public awareness of the unacceptably low levels of learning in many areas of a country has proven to be a successful policy for changing the incentives of teachers and policy makers and improving the quality of education. This idea underlies citizen-led assessments of student learning, such as the ASER Centre program in India and the Uwezo program in East Africa, both of which aim to improve data on and public awareness of the levels of learning. The same theory inspired efforts such as the SDI initiative in Sub-Saharan Africa. The SDI gathers data on both inputs and outcomes in representative samples of schools in many countries, and its data are useful for diagnosing problems and targeting support. But ultimately, the SDI effort is not just about fine-tuning an education system by turning technocratic dials, but also about shifting the equilibrium by marshaling public awareness to support reform.

*Combining information and sequencing to build support for reforms.* Many important education reforms have taken place over the last two decades, including in settings in which teacher unions play important roles. Policy makers who want to implement reforms can reach out to build support from other actors by first using information on student performance and directly communicating with the public. In some cases, such as in Ecuador, Mexico, and Peru, the resistance to efforts to reform education has been strong. But in Chile, where policy makers had high credibility with the unions because they were traditional allies, a process of continual negotiation paved the way for the passage of important reforms, such as bonus pay, including by bundling them with higher spending on education (Bruns and Luque 2015).

*Bringing new actors into education policy: The role of parents.* Directly involving parents in school policies is another way to change the power dynamics. However, it can work only when parents can credibly enforce sanctions. For example, why did giving more power to parents through school-based management (SBM) reforms work in Honduras but fail in Guatemala? Ganimian (2016) argues that in Honduras teachers' unions focused on higher-order problems such as wages, and the investment from the national government was small, especially in the beginning. As a result, SBM was able to endure through different administrations. In Guatemala, by contrast, the high cost of maintaining the program made it more vulnerable to special-interest groups, who managed to organize and successfully advocate to revert the reform.

*Changing norms.* Changing education systems also means promoting norms that support better behavior and promoting teachers who share these norms. Many teachers throughout the developing world make heroic efforts to educate children in extraordinarily difficult circumstances, contending with a lack of learning materials, student absenteeism, and threats to their safety. They do this at times out of altruistic concern for children, but they also may subscribe to a norm of teacher professionalism and a sense of duty. Ensuring that more such teachers are selected into public service and rewarded appropriately can help shift the composition of the teacher body and change the power dynamics.

## Health: The challenges of improving access

Investments in health early in life are key to health later in life, as well as for education and learning outcomes (Almond, Chay, and Lee 2005; Black, Devereux, and Salvanes 2007). However, in many developing countries, and especially in low-income countries, the quality of health care is poor. As discussed in chapter 6, doctors are absent, and when they are present, they exert little effort or make mistakes in diagnosing and treating patients.

The state of Madhya Pradesh in India illustrates the challenge of poor availability and quality of care (Chaudhury and others 2006; Das and Hammer 2007). In a representative sample of rural areas of Madhya Pradesh, 40 percent of doctors in public health facilities were absent at any given time. Doctors in public facilities spent on average 2.4 minutes with a patient and completed only 16 percent of a checklist

of examination items and questions on medical history. The same doctors performed better when they were in the private sector, indicating the importance of incentives. Nevertheless, virtually no doctors conducted all the examinations indicated when a child had diarrhea. Meanwhile, patients were much more likely to receive an unnecessary treatment than a correct one. Only 3 percent of doctors gave a correct treatment (Das and others 2015).

In addition, household out-of-pocket expenditures dominate health financing in low-income countries and in many middle-income countries (World Bank 2007). Ukraine illustrates the problem of out-of-pocket expenditures—including a gap between formal rules and actual practice. As in several other countries of the former Soviet Union, all Ukrainians have a constitutional right to access free health services. Nevertheless, direct payments by patients account for more than 40 percent of total health expenditures and are a heavy burden for the majority of Ukrainians.<sup>1</sup> De facto, patients pay an informal fee for almost every service offered by public health providers. These informal payments seem to be partly pocketed as informal income and split among the care providers (physicians and nurses), other health care personnel (chief doctors, hospital administrators), and political authorities at various levels. They are also used to finance the recurrent expenses of health facilities such as various supplies, refurbishment, and reconstruction (Belli, Dzhygyr, and Maynzyuk 2015).

Poor quality of care and high out-of-pocket payments are in part a result of the political equilibrium between the different actors involved in the process of adopting and implementing health policy. The following policy principles, however, can help to guide more effective health care reform.

### **Change the actors involved in health policy adoption and implementation**

*Involve more actors in hiring practices to break patronage.* In Ukraine and other countries, patronage plays a decisive role in the recruitment and placement of doctors, especially for attractive positions—that is, those in which it is possible to extract more and larger informal payments. This scheme consolidates networks of personal connections and erects high entry barriers. Several Ukrainian health workers reported that they had to pay to secure a job or to retain their positions, and also that they had to maintain their discipline and loyalty to their line managers (Belli, Dzhygyr, and Maynzyuk 2015).

The patronage system, especially among doctors, should be reformed. In Ukraine, for example, broadening the set of actors involved in the process of hiring doctors holds promise. Some cities have introduced the requirement that the municipal health care department approve any appointment and dismissal of medical staff to stem the power of chief doctors.

*Involve users, including through good use of information and monitoring.* Involving communities can work to strengthen the quality of care and decrease absenteeism, provided that they have clear mandates and tools to monitor providers. An intervention designed to strengthen local accountability and community-based monitoring in the primary health care sector in Uganda was remarkably successful in improving both health services and outcomes in the participating communities (Björkman and Svensson 2009). The intervention consisted of a series of community meetings facilitated by a nongovernmental organization, using report cards on the quality of services and resulting in action plans. Utilization of outpatient services increased by 20 percent, and there were significant improvements in treatment practices, waiting time, examination procedures, and absenteeism. Most important, the weight of infants increased significantly, and the under-5 mortality rate fell by one-third in the treatment villages.

### **Change the incentives of politicians and providers**

There are limits, however, to how much local control can achieve, in part because important components of the quality of service delivery are not determined locally. It may be necessary to change the incentives at a higher level or through top-down approaches to improve the delivery of health services.

*Better incentives for policy makers can work if effectively implemented.* The example of decentralization is often seen as an attempt to increase accountability because users/voters can better observe the efforts of policy makers. In Brazil, the public health system, which is funded primarily by transfers from the federal government and administered by the states and municipalities, is the main source of health care for the poor. Because of the competition for the votes of the uninsured (poor) who want public health care and the insured (richer) who do not, spending on health care is higher in municipalities where the proportion of poor is higher and where voter turnout is higher (Mobarak, Rajkumar, and Cropper 2011).

Decentralization can, however, be ineffective, simply adding a bureaucratic layer. And that is what happened in Ukraine. In the 1990s, following the

disintegration of the centralized Soviet Union and the collapse of central revenues, most public services financing and administration, including health, were decentralized to the regional, district, and municipal levels. But only the municipal level was governed by elected officials; all other levels were governed by officials appointed from the center, thereby limiting the representativeness of local authorities. In addition, there was no clear assignment of new accountabilities. The process thus increased fragmentation because several levels of government financed, owned, and ran health facilities. Decentralization, then, ended up “crystalizing” the status quo—for example, making it impossible to streamline the excess infrastructure because health services became a source of patronage and informal revenue for local elites and senior doctors (Belli, Dzhygyr, and Maynzyuk 2015).

*Better incentives for providers can work if effectively implemented.* The introduction of performance-based budgeting schemes may improve the level and distribution of key health outcomes and change the incentives of health providers by making them more accountable. More research is needed to assess the effectiveness of these schemes, and their impact may depend on existing conditions. For example, in Ukraine the introduction of program-based budgeting collided with the existing detailed spending requirements and simply added a layer of bureaucracy. On the other hand, in Argentina the introduction of performance incentives to finance a provincial insurance scheme for maternal and child health care (Plan Nacer) improved not only the number of prenatal care visits, but also the quality of prenatal care and delivery. The incidence of low birth weight and neonatal mortality fell (Gertler, Giovagnoli, and Martinez 2014).

## **Note**

1. In 2010, for example, about 60 percent of Ukrainians had at least partially forgone health care services because they could not afford them (Tambor and others 2014).

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