

Effectiveness of Decentralization on Service Delivery

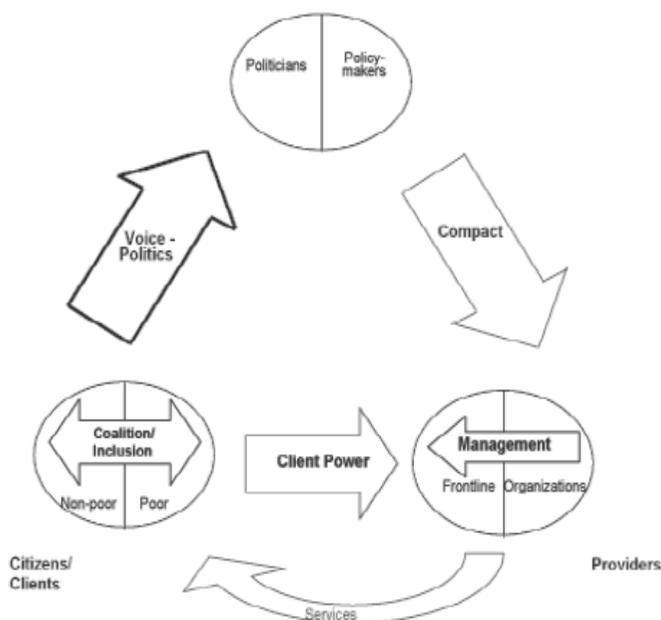
Accountability and Efficiency

There are two distinct but related elements that have been put forward as arguments in favour of greater role for local governments in delivering public services. The first is the extensive literature on ‘fiscal decentralization’ following the works of Tiebout (1956), Oats (1972) and others. This line of argument has been reviewed intensively by various studies. However, the other element that has received relatively little attention from economists working in the area of public finance is the recent literature on public service delivery lays great emphasis on fixing the governance and accountability of service provision – especially in health and education.

Pritchett and Pande (2006) put forward the proposition that ‘effective decentralization’ (in the context of elementary education in India) will not be possible until the principles of public finance are harmonized with the principles of accountability in the design of the decentralization strategy itself. It is currently the accepted wisdom that decentralization provides an answer to increasing participation of the users (‘voice’) and enhancing monitoring by the community or the user group at the service provider level (‘client power’). In that sense, there is a direct line of accountability between the decentralized institutions.

Following the analytical framework discussed in Chapter 1, laid down by the World Development Report (2004), we can visualize the accountability framework below:

There are four basic external elements of accountability corresponding to citizens (or clients), the state (politicians/policymakers) and service providers (education/health) – voice, compact, management and client power. In the general case, citizens elect their representatives to national/state legislatures, who are in a compact with service providers made up of national or state government employees. The latter are supposed to provide service to the citizens in terms of delivery of education and health care. However, in this model, the route to accountability is ‘long’, implying that if the citizens are not satisfied with the service providers, they would need to wait until the next electoral cycle to vote on their preferences. Citizens can exercise little control over the compact and, therefore, suffer from weak client power.



Source: *World Development Report 2004*

The WDR (2004) provides examples of why the ‘long route’ to accountability is the cause of many of the government-provided service delivery failures in the developing world, including India. The most common accountability failure is that of absenteeism among frontline providers such as teachers, doctors and nurses. Without enhancing the ‘client power’, the basic cause of accountability failure will not be addressed. The ‘short route’ to accountability lies in doing exactly this – to devise a decentralized system wherein the principles of public finance (funds following functions) and the principles of accountability (functionaries and funds controlled by local government) are the two pillars of service delivery reform.

This accountability mechanism is reflected in the choice citizens make when they are allowed to exercise their choice through the electoral mechanism. Therefore, instead of a long route to accountability, i.e. from citizens to state/central legislature and then to service providers, decentralization provides a mechanism to enforce a short route to accountability where the citizens vote over the performance of the grass-roots level political institutions, such as the panchayats in the case of India.

Even if the principles of public finance are in place and citizens can vote in panchayat and urban local body elections, there are four relationships of accountability which cut across voice, compact, management and client power.

These are issues related to delegation, financing, information and enforceability. Pritchett and Pande provide examples of mismatch between these instruments and the outcomes from decentralization (voice, compact, etc.) in the context of education. For example, even if elementary education has been devolved to local bodies, it might be unclear with many competing priorities (execution, monitoring of civil works, mid-day meals, teacher attendance, teacher appointment). Similarly, for financing, school budgets do not depend on school performance such as learning levels on the basis of standardized tests, and there is insufficient power to reward/punish teachers. Moreover, information on performance may not be enough to increase voice and client power, especially when performance is endogenous and parents do not have the ability to attribute performance with effort. This was brought out through a randomized experiment of an information campaign to build the capacity of the Village Education Committee (VEC) in Jaunpur district of Uttar Pradesh. In spite of repeated efforts to increase their voice and client power, participation of parents and PRI members in VEC meetings remained low (Banerjee et al., 2008). Therefore, the emerging empirical literature throws up a mixed picture of the accountability elements of a decentralized service delivery system and the instruments required to make it function.

It is not always the case that the 'short route' to accountability is the most effective or efficient. Certainly it is preferred to the 'long route', but the latter can also be made more responsive incorporating the principles of public finance and accountability (Table 8.1). This can be achieved through clear delegation of powers, untied financing, adequate information and strict enforceability, as provided in Table 8.2:

Table 8.1: The four relationships of accountability – need for 'short route'

	Voice	Compact	Management	Client power
Elements of a relationship of accountability:	Citizens to state	State to organizational providers	Organizational provider to frontline providers	Citizen to organizational provider (in public sector)
Delegation	Education one of a myriad of issues	Unclear delegation with many competing priorities	Teachers are burdened with many responsibilities and not given adequate autonomy in classroom	Parents want to delegate but objectives are diffused

Table 8.1 continued

Table 8.1 continued

Financing	Little connection between taxes paid and services expected	Financing unrelated to goals— inadequate to achieve target, not allocated across interventions	Budget at school level is tied into wages of teachers plus a variety of ‘schemes’	No connection between school budget and performance; (regular) teachers are paid very well
Information	Little useful benchmarked information for citizens to judge performance of state	Little useful information utilized in judging performance of ministry	Little attempt to measure performance of individual teachers	Parents know some dimensions of quality of teaching very well (e.g. attendance) but not others; parents don’t participate in school committees
Enforceability	Electoral accountability, but hard to relate to performance.	Ministry budgets are unrelated to sector performance in outputs.	Ministries have little control over teachers—nearly impossible to reward good performance— or penalized bad performance.	Parents have little or no ability to enforce – reward good teachers or penalize bad teachers
Performance	Endogenous	Endogenous	Endogenous	Endogenous

Source: Pritchett and Pande, 2006.

Table 8.2: How the elements of ‘long-route’ accountability in government schools are strengthened in a well-designed decentralization

	Voice	Compact	Management
Elements of Accountability Relationship	Citizens to state	State/District/GP to organizational providers	Organizational provider to frontline providers

Table 8.2 continued

Table 8.2 continued

Delegation	Education a clear responsibility of GP – citizens able to compare performance of their GP over time and compared to other GP (with reporting and state monitoring)	Schools and teachers given clear curricula, learning objectives	Teachers are empowered and professionalized with greater autonomy within the classroom and greater flexibility over within school budgets
Financing	Amount of total finance to schooling in GP and its sources clear and simple (per eligible child basis)	Amount of financing is clear, regular, formula based	The amount of funding that can be devoted to non-wage expenditures much higher
Information	State can create benchmarked reports about GP progress on key learning indicators	Goals are clear	The information that is generated daily by observing teacher performance (e.g. attendance) can be incorporated
Enforceability	Citizens have to hold very local politicians accountable for results, both through participatory processes (school specific, GS, and GP)	Those closest can monitor performance of schools. Higher level jurisdictions can monitor lower levels	Teachers can be rewarded for good performance (not just seniority)
Performance			Teacher autonomy and performance evaluation

Source: Pritchett and Pande, 2006.

A similar framework for health has been put forward by Hammer, Aiyar and Samji (2006). They situate the PRIs in the context of the ongoing health system reform through the National Rural Health Mission, and the elements of decentralization that are embedded in the programme design. These include formation of user groups (Rogi Kalyan Samiti, RKS) at the health facility level, panchayat's role in appointment of village level health staff called ASHAs, and

community mobilization for provision of public goods such as immunization, prevention of communicable diseases and sanitation. While this is the first best option, it may also happen that greater citizen's voice may lead to higher level of curative (as opposed to preventive) care, since its impact is readily visible while the other is not – although prevention is most effectively done at the community level. Similarly, client power might be low due to the technical nature of the health sector. However, the basic accountability question remains – whether the frontline providers are being paid on the basis of their performance, proxied by attendance.

Governance reform in delivery of education and health: Redefining the accountability relationship between provider and client

Over the last decade, a significant body of literature pointed to the dismal state of education and health service delivery, especially in rural India. Starting with the PROBE team (1999), a series of studies have pointed out that both education and health suffer from systemic inefficiencies both in terms of infrastructure as well as human resources.¹ The major reason was the lack of accountability among frontline service providers such as teachers, nurses and doctors, and the incentive structure in public services that dissociated reward and punishment from performance.

The policy prescription consisted to: (i) decentralize the delivery of public services to increase monitoring by local community and lower tiers of government; and (ii) change the structure of incentives by giving power to the panchayats to appoint and retain teachers and health workers. If teachers and health workers are under the control of the panchayats, it was argued that the problem of accountability and incentives would both be solved at the same time. This is because instead of a compact between the state and the service provider (schools, health centres, etc.), the 'long route of accountability' was shortened significantly if the compact is between the local government. Concurrently, since local governments are more sensitive to local needs and demands, parents whose children were in school and local patients accessing the health centre would demand that the teacher or the health worker is at least present and attending to them. Therefore, if both voice and compact are strengthened at a lower level of the administrative structure, the conjecture was that outcomes will increase significantly.

To do that, however, the assumption is that local governments are at least fiscally capable, that is, they have sufficient revenue to cover the responsibility that are entrusted to them. There is again a large body of literature which indicates that this is not so – the revenue raising power of the local governments is limited, and

¹ Banerjee, Deaton and Duflo (2004a,b); Kremer et al. (2005); Duflo and Hanna (2005).

adequate fiscal devolution to augment their revenue base has not happened. The PRIs are, therefore, not independent entities with control over their funds and functionaries – two main items of decentralization.²

It is in this context that the structural reform of education and health service delivery through SSA and NRHM assumes significance. These two programmes have become the primary vehicle to ‘universalise quality elementary education through district-based, decentralized, context-specific planning and implementation strategies’ and ‘making public health delivery system fully functional and accountable to the community’.³ In spirit, this is close to the provisions of Article 243G (a) and (b) of the Constitution discussed in the previous section.

In both SSA and NRHM, the vision is to initiate the planning process through the Village Education Committee (VEC) and the Village Health and Sanitation Committee (VHC). The district SSA and NRHM plans are supposed to be an amalgamation of the village education and health plans, which would be further consolidated at the state level to arrive at the State SSA and NRHM plans. On the other hand, the VEC/VHC and other facility level groups such as School Management Committees (SMCs), Parent Teacher Associations (PTAs) and Rogi Kalyan Samitis (RKS) are entrusted with the task of monitoring the implementation of the scheme and take action, if required.

It has to be noted that the funds that are devolved to the school are in bank accounts where the head of SMC/PTA/RKS is a signatory. Furthermore, these entities have been created through the design of the scheme and are not part of the panchayat system unlike VEC/VHCs. This immediately puts into question the effectiveness of this arrangement in ensuring accountability. Since the funds are managed by the facility level groups, the VEC/VHC which are constituted under the State Panchayat Acts and therefore are legal entities, have less power of oversight and grievance redressal than SDMCs and RKSs. Except in a few states, habitation-level planning is not carried out, which implies that the PRI structures have very little role in either planning or implementation of SSA and NRHM. In doing so, both these schemes encourage ‘partial decentralization’ where voice and compact are not aligned. This aspect of governance and accountability of PRI vis-a-vis community groups mandated by the flagship schemes has not yet been explored in depth in the context of India.⁴

² Rao and Singh (2003); World Bank (2004); Rao and Singh (2005).

³ SSA Framework of Implementation (2004); NRHM Framework of Implementation (2005).

⁴ Hammer, Aiyar and Samji (2006).

Governance reform in delivery of education and health: Impact on efficiency and equity

Public service delivery reform through decentralization is predicated on the hypothesis that strengthening voice, redefining compact and enforcing client power would finally lead to both efficiency and equity in resource allocation, resource use and resource distribution. This hypothesis is, however, very difficult to test on the ground due to the presence of confounding factors and the lack of opportunity to conduct a natural experiment in the Indian context. Some studies however have tried to use large datasets – both secondary and primary – as well as process analysis to attempt a before-after comparison of decentralization reform in education and health. At the macro-level, Chakraborty, Mukherjee and Amarnath (2010) analyzed data from Finance Accounts and budgetary allocations for three major programmes that are being delivered through decentralization – MGNREGS, SSA and NRHM. These together constitute over 70 per cent of the funds devolved from the Centre to the district level implementation authorities – a major part of which is then transferred to the panchayats for actual delivery of the schemes. Simple OLS regression of per capita direct transfer to districts on per capita GSDP shows a negative and significant gradient, signifying that districts in poorer states get proportionately larger share of direct transfers to the districts.

Looking specifically at SSA transfers from the centre to the states, Mukherjee, Vyas and Aiyar (2009) find that there is a significant correlation between the share of the Central government funds and the share of out-of-school children in the state. As explained above, the state-level plans for SSA and NRHM are supposed to be an outcome of habitation and district level planning process. The decentralized financing framework, therefore, prioritizes districts where the gap in universalization is the highest (UP, Bihar, MP, Rajasthan and West Bengal). While this is a crude measure allocative efficiency, the two studies nevertheless point to the possibility of an increase in efficiency at the Central, state and district levels.

Technical efficiency in the context of decentralization

Studies on technical efficiency in the context of decentralization are still rare. Mukherjee (2007) has reviewed the literature on the econometric evidence of allocative and technical efficiency in education, including both parametric and non-parametric techniques (Data Envelopment Analysis, Free Disposal Hull etc.).⁵ Neither seem to be conclusive on the issue of whether public expenditure on education and health lead to more efficient outcomes. The major gap in

⁵ Afonso, A. and M. St. Aubyn (2004); Afonso, A., L. Shuknecht and V. Tanzi (2003).

cross-country regressions is the fact that they cannot account for the different types of decentralization in service delivery that has been undertaken across the world (see Pritchett and Pande, 2006 for a comparison of education decentralization in Indonesia, Argentina and India).

Even with country level data, measurement of efficiency and its attribution to decentralization is a difficult task, particularly in a federal structure of polity such as India. Different states are at different levels of decentralization which is a confounding factor in cross-state regression. Therefore, the analysis is restricted to the state level, where it is possible to isolate the changes that have taken place as a result of decentralization – especially in the area of human resources. As explained above, one of the most critical changes that have taken place is the appointment of contract teachers in elementary schools and village community level health workers by the PRIs. Therefore, one arm of the accountability relationship – client power – has been strengthened due to this reform.

To isolate the impact of decentralization on technical efficiency at the service provider level, Atherton and Kingdon (2010) have collected a rich dataset from two of the educationally backward states (UP and Bihar) for a sample of 160 elementary schools covering nearly 4,000 students who were tested at the beginning and the end of the school year. On the input side, they collected data on contract teachers appointed by the PRIs at a lower salary as compared to regular teachers. Using school-level fixed effects and allowing both homogeneous and heterogeneous treatment effects of contract teacher appointment, they find that the contract teachers produce higher student learning even though they were paid one-third the salary of regular teachers. Therefore, considering only one input (teacher), the technical efficiency of the school-level production function with learning as the output improves due to decentralization. Unfortunately, we could not find similar technical efficiency study for health, specifically, the impact on health status of appointment of ASHAs by the PRIs.

As for equity, a recent paper by Banerji (2011) presents a case study of the changes that have taken place in elementary education in Bihar over the last five years. The most striking impact has been on the number of out-of-school children, which has dropped from 12 per cent in 2005 to less than 5 per cent in 2010. Since most of these children are the ‘hardest to reach and retain’ category, the paper explains how the Bihar government ensured that special programmes catering to the needs of these children were financed out of both SSA and state government’s own budget to ensure that the goals of universal elementary education could be attained in a time-bound manner. However, the paper also points to the fact that voice does not always translate into concrete action on the part of the community to ensure equity. Therefore, even when all elements of public finance and accountability are satisfied, the efficiency gains may be sub-optimal due to

the lack of community level inputs – participation and monitoring. These are hard to quantify, but it is a critical area for future research in on efficiency and equity in service delivery through decentralization.

Moving towards a results-based financing framework for decentralized service delivery

In spite of the concerns about multiple lines of accountability mentioned above, some changes have, however, come about through SSA and NRHM as far as human resources and result-based financing are concerned. One of the main objectives of both these programmes was to ensure that the frontline service providers – teachers, nurses, community health workers – are de facto employees of the local government, rather than the district or state governments. In that sense, there has been a systemic shift in terms of appointment of teachers in elementary education and community workers (ASHAs) under NRHM. The implications of this strategy of community-based workers filling the human resource gap have been explained in detail in Chapters 6 and 7.

Recent evidence based on extensive field survey in states where large numbers of such para-teachers were appointed, however, points to a mixed message: para-teachers are more likely to be present in the school, give more effort into teaching and are marginally less competent than the regular (trained) teachers.⁶ While attribution of increased accountability for performance is difficult, it can be inferred from the data that the new system of teacher appointment by local government is no worse than the status-quo situation.

In health, as per NRHM guidelines, the VHC and the gram sabha selects the ASHA from among women residents of the village who are preferably in the age group of 25 to 45, with formal education at least until elementary level. The ASHA is not a paid employee with fixed salary, but is eligible for compensation for services provided under various public health, maternal and child health schemes such as immunization, Janani Suraksha Yojana, etc. Therefore, pay is based on performance which is assessed by the panchayat which keeps a revolving fund under NRHM for this purpose. This system is very close to the model of decentralization that improves accountability – the panchayat exercises control over the functionary and has the funds to pay the ASHA, who is aware of her responsibility and the incentive structure. Empirical studies on the impact of this system on outcome have, however, not been undertaken until now.

⁶ Kingdon and Sipahimalani-Rao (2010); Accountability Initiative, PAISA District Survey, 2013.

At the level of education and health personnel, both para-teachers and ASHAs are the first steps towards a result-based financing framework. In this framework, an implementing agency is provided resources on the basis of clearly laid down parameters. In the case of SSA and NRHM, these parameters pertain to quantifiable indicators such as infrastructure improvement (building classrooms, boundary walls, toilets, upgrading health centres, purchase of equipment, etc.), and appointment and training of personnel teachers, ASHAs). However, in its purest form, a result-based framework will evaluate the progress against outcome benchmarks and allocate resources accordingly.⁷ Two outcomes that can be considered for RBF for education and health would be quality of learning in schools and proportion of out-of-pocket expenditure to access health services for the lowest two quintiles reflecting better benefit incidence of public expenditure. Financing will then be tied to monitoring outcomes at the facility level and transfer of funds to local bodies which have administrative control over the facility and would provide incentive for people to participate in local decisions, enhancing their voice.

The result-based financing framework has not yet been used to evaluate the performance of SSA and NRHM until now. It is, however, a very important tool to identify bottlenecks and reward performance. This would constitute the next wave of policy and empirical research on decentralization and service delivery going forward.

⁷ Center for Global Development (2009).