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Increasing the efficiency of government spending

Improving policies and institutions in developing countries is fundamental to reaching the Millennium Development Goals. Even if health care spending rises dramatically, the intended outcomes are not likely to be achieved without addressing weaknesses in government institutional capacity. To improve the effectiveness of government health spending, many of the instruments used to develop, implement, and assess policies, such as poverty reduction strategy papers, poverty reduction support credits, medium-term expenditure frameworks, and public expenditure reviews, need to be strengthened, and decentralization strategies need to be linked more closely to sector strategies. Country experiences using these instruments to address weaknesses in health sector performance have been mixed at best, and adjustments are needed to make the instruments more effective.

Consensus is emerging in the international community that current health expenditure levels in developing countries are too low. Often overlooked, however, are the other conditions that must be in place for countries to progress. Strong growth in national income, improvements in infrastructure quality and capacity, high literacy rates, and a host of other factors also drive health outcomes. Moreover, while much of the global debate focuses on the amount of additional resources required to meet the Millennium Development Goals, there is also a need to carefully examine the extent to which the policy environment and institutional capacity at the country level facilitate the efficient and equitable allocation of increased resources to the health sector.

This chapter first discusses the importance of the policy environment at the country level. Clearly, good public sector management and institutional capacity are important for government expenditures to be effective. The chapter then turns to the instruments and policy options available to governments to improve expenditure performance. These instruments include poverty reduction strategy papers (PRSPs), poverty reduction support credits (PRSCs), medium-term expenditure frameworks (MTEFs), public expenditure reviews (PERs), and public expenditure tracking surveys (PETS). Recommendations include:

- Ensure that the PRSP sets out clear priorities and criteria and that the priorities are reflected in the guidelines and ceilings sent to line ministries to guide budget preparation.
- Implement an iterative process for budget preparation in which proposals for sector plans and allocations are prepared by line ministries, scrutinized by central authorities, and adjusted in light of national priorities.
- Ensure that the MTEF reflects the annual budget for the first year and that the chart of accounts is structured in such a way that spending priorities for achieving the goals can be identified.
- Implement an annual review of sector-level progress and identify domestic and foreign finance requirements for the coming period, which should be timed to feed into the budget preparation cycle.
- Establish a system to ensure that carefully prepared budgets that are in line with nationally important goals receive favorable treatment in the final overall budget and the timely and full release of funds. This system would be maintained under the authority of the ministry of finance and the cabinet.
- Encourage line ministries to reallocate resources from lower-priority areas without fearing that their budgets will suffer as a result, by developing a system for the ministry of finance to provide credible medium-term assurances of sectoral budget levels or shares.

Decentralization of key functions is often advocated as a means of strengthening public sector management and improving overall health system performance. This chapter closes with an evaluation of country experiences with decentralization. Recommendations include:

- Before undertaking decentralization, ensure strong political backing at both the central and local levels, with stakeholder ownership of both the plan for decentralization and the process of organizational capacity building.
- Support political objectives with an appropriate legal and institutional framework, structure of responsibility for service delivery, and system of intergovernmental fiscal transfers.
- Delineate responsibilities among stakeholders and formally codify responsibilities in legislation, regulations, or other binding instruments.
- Although decentralization generally involves a diminished role for the central government in service delivery, certain functions are likely to be most efficiently undertaken at the central level—research and dissemination of research findings, national public goods, health information, standards, regulations, and accreditation. Decentralization still requires a strong central capacity for monitoring and enforcement of regulations and standards.

- Because local governments may have limited revenue-generating capacity and therefore are likely to remain reliant on transfers from the central government, determine intergovernmental transfers openly and objectively, ideally by a clear, simple, and verifiable formula.
- Link local financing and fiscal authority to service provision responsibilities and functions so that local politicians can deliver on their promises and bear the costs of their decisions.

Institutions and policies at the country level

One of the most significant constraints on the performance of health systems in developing countries is weak public sector management, particularly at the district or municipal level (Mills, Rasheed, and Tollman forthcoming). Within the health sector, weak public sector management manifests itself in poor planning, budgeting, and oversight at the central and district level, limited capacity for regulation, insufficient linkages with civil society, and excessive reliance on donor program management systems (Hanson and others 2003).

Mills, Rasheed, and Tollman (forthcoming) note that government institutional capacity constraints limit what the health sector can change on its own. The UN Millennium Project argues that reaching the Millennium Development Goals is primarily a financing problem, but it also recognizes the need to address institutional constraints and calls for a “governance plan” as a key element of country proposals for reaching the Millennium Development Goals (Foster 2005). The UN Millennium Project also suggests that this plan needs to address how increased spending will be carried out, as well as how to cover budget monitoring, audit, evaluation, oversight (with an explicit role for civil society), access to services for women and ethnic minorities, and plans to fight corruption and enhance the rule of law.

The World Bank’s *Global Monitoring Report* also emphasizes the importance of improving governance—in particular, upgrading public sector management and controlling corruption—as an overarching agenda (World Bank 2005a). Although some aspects of governance are getting better in most countries, reforms need to be accelerated in others. Sub-Saharan Africa, for example, has seen encouraging progress on political representation, but less progress on public sector management and institutional effectiveness (World Bank 2005a). These management and institutional issues affect access to essential health interventions at all levels, from the local health center to community and national issues of public policy and environment.

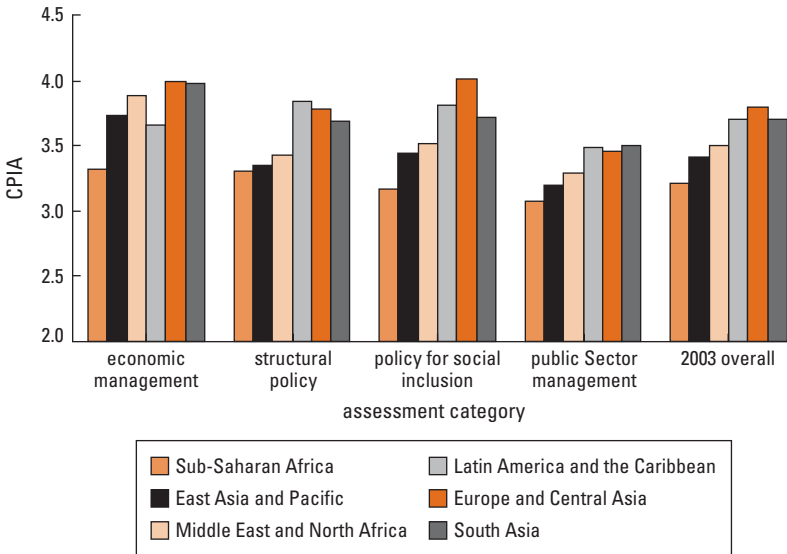
Results of a study presented in *Rising to the Challenges* (Wagstaff and Claeson 2004) that measured the quality of policies and institutions in countries by the World Bank’s Country Policy and Institutional Assessments (CPIA) Index, indicate the importance of institutions and governance in enabling effective health

policy. The CPIA Index assesses how conducive the policy and institutional framework is to fostering poverty reduction, sustainable growth, and the effective use of development assistance. The index covers four broad categories: economic management, structural policies, policies for social inclusion and equity, and public sector management and institutions. Countries are rated on several performance criteria with scores ranging from 1 (poor performance) to 5 (as of 2004 the top of the range was expanded to 6).

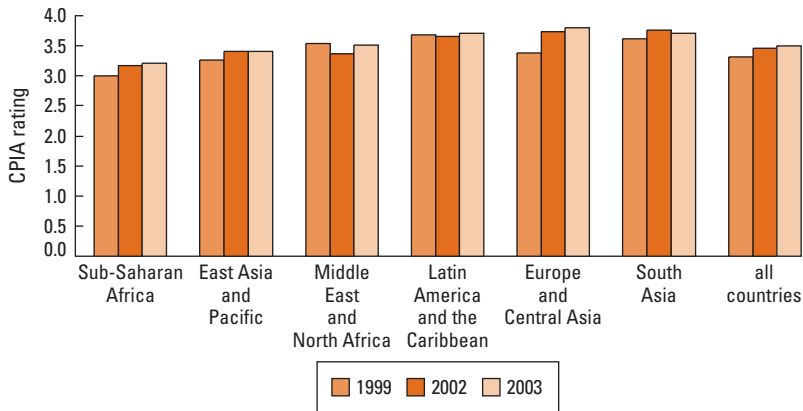
Empirical analysis found that the elasticity of health outcomes to expenditure depended on a country’s CPIA score. Spending had a larger impact on health outcomes at the margin in better-governed countries. For example, at a CPIA score of 4 (one standard deviation above the mean), a 10 percent increase in the share of GDP devoted to government health spending results in a 7.2 percent decline in the maternal mortality ratio. At CPIA levels below 3, the impact of increased spending is statistically insignificant (not different from zero). Clearly, policies matter.

Comparing CPIA scores across regions and through time indicates clearly that while some overall progress has been made—particularly in Africa—in strengthening policies and institutions in countries, public sector management remains the weakest component of the CPIA (figures 6.1 and 6.2). On average in every region, a country’s capacities in rule-based governance, budgetary and financial management, revenue mobilization, public administration, transparency, accountability, and corruption in the public sector were all judged to be less conducive to growth

FIGURE 6.1 Country policy and institutional assessment scores by indicator and region, 2003



Source: World Bank data.

FIGURE 6.2 Country policy and institutional assessment scores by region over time, 1999–2003

Source: World Bank data.

and poverty reduction than the country's policies and institutions for economic, structural, or social management.

Policy instruments to improve public sector management

The importance of policies and institutions is clear. But what instruments or policies are available to governments to improve public sector management? The remainder of this chapter discusses the role of instruments, such as PRSPs, PRSCs, MTEFs, PERs, and PETS in improving key public sector management functions. The roles of targeting mechanisms and decentralization are also discussed.

Poverty reduction strategy papers

Starting in the mid-1990s the World Bank and International Monetary Fund (IMF) began to radically change both the focus and the tools for providing development assistance to poor countries. In response to the high level of indebtedness in some of the poorest countries in the world, as well as criticism that previous development assistance efforts were ineffective, the World Bank and IMF focused on debt forgiveness, poverty reduction, and improved economic growth in the most heavily indebted poor countries. The quid pro quo for debt forgiveness required countries to reprogram the bulk of the savings from forgiven debt back into social programs such as health and education.

These efforts were formalized in 1999 when the World Bank and IMF stipulated that all concessionary assistance to some 81 eligible poor countries—through the World Bank's International Development Association (IDA) and the IMF's Poverty Reduction Grant Facility—would need to be based on a poverty reduction strategy as embodied in a PRSP. This new approach was intended to

strengthen country ownership; enhance the poverty focus of country programs; provide a comprehensive and coordinated framework for the World Bank and the IMF, as well as other development partners; improve public governance and accountability; and strengthen priority setting. The principles underlying the PRSP process are country driven, involving broad-based participation, results-oriented and focused on outcomes that benefit the poor, comprehensive in recognizing the multidimensional nature of poverty, partnership-oriented, and based on a long-term perspective.

The PRSP process has made poverty reduction the top priority issue for development. Macroeconomic and sectoral strategies need to be formulated around the PRSP. Thus, health reform strategies for low-income countries must be embodied in PRSPs and focus on the poor. As of August 2005, 49 countries had developed PRSPs, which are serving as the basis for World Bank and IMF financing in these countries.

Extensive evaluations of PRSPs have painted a mixed picture (World Bank 2004a; IMF 2003; IMF and World Bank 2005). Evaluations suggest that

- PRSPs have the potential to encourage the development of country-owned, long-term strategies for poverty reduction and growth, but there are still tensions concerning ownership among countries and external partners. Many partners have not adapted the processes of their assistance programs in a coordinated manner around the PRSP processes. Better frameworks for accountability of both countries and partners are needed.
- Although broad-based participation in development efforts has improved, there is still room for much greater inclusiveness. Moreover, the PRSP has not strengthened domestic institutional policy-making processes or accountability.
- The PRSP process is an improvement over previous processes because it encourages a results-oriented approach to development, a focus on poverty reduction, and a long-term perspective.
- Although the PRS approach has initiated the intended fundamental change in the relationship between low-income countries and donors, it has fallen short as a strategic reform roadmap, especially in guiding structural reform, promoting economic growth, linking PRSPs with medium-term expenditure frameworks and budgets, integrating sectoral strategies into the macroeconomic framework, assessing the social impacts of macro strategies, understanding micro-macro linkages, and linking medium- and long-term operational targets.
- Capacity constraints have been serious impediments to effective implementation. There has been little focus on capacity building.
- Monitoring and evaluation is still a significant weakness.

Specific evaluations of the health components of PRSPs raise many of the same problems (WHO 2004). The treatment of health in new PRSPs has tended to be

more extensive, but it is too soon to evaluate impact given the relative newness of the process and the learning curve for countries and partners. However, a recent study on the treatment of reproductive and adolescent health issues in PRSPs provides insight into some of the concerns related to health components of PRSPs (World Bank 2004b). The study found that

- Despite having to cover many topics, the PRSPs pay a reasonable level of attention to population and reproductive health issues. However, scope and quality vary enormously, and there is no exemplary PRSP as it relates to population and reproductive health issues.
- Participation by key population and reproductive health stakeholder groups in the PRSP process is uneven, and the process could better represent the interests of women, youth, and poor people. The participatory process can be strengthened and should give more voice to these groups and to civil society.
- Although PRSPs are not implementation documents, many basic implementation elements are missing from PRSP-related population and reproductive health policies. Only half of the recorded policies specify an institution responsible for implementing the policy, 44 percent of policies denote a basic timeline for implementation, and 17 percent of policies have a budget. Few policies (under 6 percent) include all three elements.
- The country assistance strategies reviewed address population and reproductive health issues, but in less detail than in the PRSPs.

Overall, PRSPs are still a work in progress. Although health and education strategies tend to be better developed than other sectors—due to the requirements for debt forgiveness in the heavily indebted poor countries, as well as the key roles that health and education play in poverty reduction and meeting the Millennium Development Goals—there has tended to be a focus on disease- and intervention-specific programs and less emphasis on systemic issues, such as human resources. The linkages to other sectors and to growth have been tenuous at best.

As more development partners join the process, and as increasing amounts of development assistance are funneled through PRSPs, the effectiveness of these development instruments and processes will depend on numerous factors, including countries' commitment and capacity and partners' flexibility and funding commitment.

Poverty reduction support credits

The World Bank introduced PRSCs in May 2001 as one of IDA's main vehicles to support low-income countries in implementing their poverty reduction strategies. The PRSC is a programmatic approach to development policy lending in low-income countries. It typically consists of three or four annual, single-tranche operations, phased to support the government's medium-term development

objectives. The overarching goal of the PRSC approach, and particularly of reinforcing the country ownership embedded in the initiative, was to be achieved through several mutually reinforcing objectives (World Bank 2005b):

- *Flexible medium-term support.* To support a medium-term reform program that builds on and draws from the priorities and objectives of the government's PRSP through World Bank financing, policy dialogue, and analytic work.
- *Donor harmonization.* To support the medium-term reform program in coordination and harmonization with development partners, particularly with donors that provide budget support and with the IMF through its Poverty Reduction Growth Facility.
- *Resource predictability.* To improve resource predictability in well-performing countries through medium-term commitments that are disbursed in line with domestic planning, budgeting, and review processes.
- *Country ownership.* To reinforce country ownership by using policy-based and focused conditionality that reflects an understanding with governments on the priorities of their reform programs.

There are currently 18 countries with PRSCs, representing less than half of the 49 countries that have full PRSPs. The PRSC has emerged as a significant share of new operations and commitments. In fiscal 2004, PRSCs composed 46 percent of development policy lending to the poorest countries (those eligible for highly concessional lending through the IDA arm of the World Bank). While the number of PRSC programs has grown, the overall weight of World Bank investment lending has not changed significantly. Since PRSCs were introduced, the share of IDA development policy lending has hovered at around 27 percent of total IDA lending, an increase from the 16 percent in fiscal 2000, but matching the average share of development policy lending seen in the early 1990s.

A World Bank review of PRSCs and a review of country experiences with PRSPs and PRSCs in the context of the health sector (World Bank 2005b; Foster 2005) draw several important conclusions related to PRSCs:

- In general, PRSCs are closely aligned with country PRSPs, with some variation depending on how well the PRSP prioritizes and operationalizes the government's medium-term development program. One drawback of this close link is that because PRSPs tend to be optimistic, using their targets in PRSCs tends to result in failure to meet the PRSC conditions for disbursement of credit.
- PRSCs have helped to improve coordination between central and line ministries and between central and local governments. Many cross-sectoral reforms, along with preparation and execution of the budget, have required close collaboration among various parts of the government.
- Since the launch of PRSCs, there has been a concerted effort to limit to a few priority actions the number of conditions related to the country's reform

agenda. Although the number of conditions has varied from a high of 44 in Vietnam to as low as 6 in Tanzania, the average number of PRSC conditions has decreased substantially from 30 in fiscal 2001 to approximately 12 in fiscal 2004.

- While the number of conditions has decreased, the length of the policy matrix has increased. Government officials often find the policy matrix to be overloaded, particularly when it is driven by efforts to harmonize specific donor preferences. There are cases where the PRSC matrix seems to be overwhelmed by sector-specific detail. This is counterproductive to the intent of PRSC to concentrate on multisectoral issues or reforms that require multisector support.
- PRSC triggers or targets must be chosen appropriately. Governments do not control outcomes (mortality rates, literacy), just inputs (schools built, nurses trained). PRSCs should not hold governments responsible for something outside their control.
- Information on key PRSC results is often outdated because of countries' weak monitoring and evaluation capacity. PRSCs need to provide some support for governments to strengthen monitoring and evaluation systems, including linking the various ministries to the coordinating center.
- In almost all PRSC countries, but particularly in Africa, the PRSC has become a useful platform to facilitate donor coordination and harmonization within the common framework provided by countries' PRSPs. The aim is for governments to negotiate effectively one comprehensive reform program, with lower costs in terms of time, effort, preparation, reporting, and monitoring.

Medium-term expenditure frameworks

According to the World Bank's *Public Expenditure Management Handbook* (1998, p. 46), the MTEF "consists of a top-down resource envelope, a bottom-up estimation of the current and medium-term costs of existing policy and, ultimately, the matching of these costs with available resources . . . in the context of the annual budget process." The top-down resource envelope is fundamentally a macroeconomic model that indicates fiscal targets and estimates revenues and expenditures, including government financial obligations and high-cost governmentwide programs, such as civil service reform.

To complement the macroeconomic model, the sectors engage in bottom-up reviews that begin by scrutinizing sector policies and activities (similar to the zero-based budgeting approach), with an eye toward optimizing intrasectoral allocations. MTEFs are receiving renewed attention in the formulation of poverty reduction strategy papers as an appropriate instrument for incorporating PRSP strategies into public expenditure programs. The basic characteristics of MTEFs are described in table 6.1.

In practice, not all MTEFs have focused sufficiently on achieving a strategic shift in expenditures toward national priorities. The MTEFs in Cambodia and

TABLE 6.1 Stages of preparing a medium-term expenditure framework

Stage	Characteristics
Development of macroeconomic and fiscal framework	Macroeconomic model that projects revenues and expenditure in the medium term (multiyear)
Development of sectoral programs	Agreed sector objectives, outputs, and activities Review and development of programs and subprograms Estimated program cost
Development of sectoral expenditure framework	Analysis of inter- and intrasectoral trade-offs Consensus-building on strategic resource allocation
Definition of sector resource allocations	Medium-term sector budget ceilings (cabinet approval)
Preparation of sectoral budgets	Medium-term sectoral programs based on budget ceilings
Final political approval	Presentation of budget estimates to cabinet and parliament for approval

Source: World Bank 2002b.

Ghana and to some extent in Tanzania, for example, are based on detailed bottom-up activity costing, resulting in bulky documents that make it difficult or impossible to see how the changes in budget allocations relate to higher-level goals and targets. In addition, the effort devoted to preparing an MTEF can seem fruitless if the annual budget is not implemented, and the medium-term priorities are not respected. Cambodia, where health centers receive less than 10 percent of their budgets, is an extreme example.

Although there have been no evaluations of the MTEF experience specific to the health sector, it is useful to examine the general experience of governments with MTEFs. MTEFs have not been such a useful mechanism for detailed expenditure planning. Excessively detailed activity-based costing makes links to higher-level objectives difficult and obscures the main strategic choices that have to be made (Cambodia, Ghana, Malawi, Tanzania). A second constraint is that the program and activity basis on which the MTEF is prepared is often impossible to reconcile with the line-item basis by which the annual budget is reported and accounted (Benin, Ghana). This can make it difficult or impossible to know whether the budget priorities have been respected in budget execution and impossible to undertake disaggregated comparisons of the results achieved for the funds expended.

The technical problems of budget reporting can be solved as reforms to the chart of accounts and improvements in computer-based financial management systems. However, these improvements need to be accompanied by a simplified and standardized presentation wherein fewer activities are identified, thereby allowing easier aggregation for a more strategic analysis of shifting priorities.

An evaluation of MTEFs for the Africa region found no clear evidence that MTEFs have been successful in achieving the desired objectives (table 6.2). This evaluation suggests that in addition to the need to improve the quality of PRSPs and PRSCs, there is a need to improve the quality of MTEFs and to link them better to sector strategies. Although this example highlights the improvements needed, there are also examples of good practices, obtained from an analysis of 14 countries that have implemented PRSPs, PRSCs, and MTEFs (Foster 2005). This study found examples of good practices in countries where:

- The sectoral priorities of the PRSP and the allocations eventually agreed on in the budget are the outcome of an iterative process in which proposals for sector plans and allocations are prepared by line ministries, scrutinized by the central authorities, and adjusted in light of national priorities.
- The PRSP sets out clear priorities and criteria, and the priorities are reflected in the guidelines and ceilings sent to line ministries to guide budget preparation.
- The MTEF that is approved reflects the annual budget for the first year, and the chart of accounts is structured in such a way that spending priorities of particular importance for achieving the goals can be identified.
- There is an annual process for reviewing sector-level progress and the domestic and foreign finance requirements for the coming period, timed to feed in to the government budget preparation cycle.
- The ministry of finance provides credible medium-term assurances of sectoral budget levels or shares to encourage line ministries to reallocate resources from lower-priority areas without fear that their budget will suffer as a result. Credibility can be built through a medium-term track record of success, with year one of each year’s budget preparation taking year two of the previous MTEF as the starting baseline. Agreements with external partners on the share of spending to be devoted to health are also widely used and helpful in reinforcing the confidence of line ministries in their likely future budget share.

TABLE 6.2 Preliminary impact assessment of medium-term expenditure framework reforms in Africa

Expected outcomes	Actual outcomes
Improved macroeconomic balance, especially fiscal discipline	No clear empirical evidence of improved macroeconomic balance
Better inter- and intrasectoral resource allocation	Some limited empirical evidence of reallocations to subsets of priority sectors
Greater budgetary predictability for line ministries	No empirical evidence of links to greater budgetary predictability
More efficient use of public monies	No evidence that MTEFs are developed enough to generate efficiency gains in sectoral spending

Source: World Bank 2002b.

Public expenditure reviews

Few developing countries take a comprehensive and systematic approach to their budget process. Public resource allocation decisions often do not reflect sound economic policy, and fiscally irresponsible subsidies often account for a significant part of the public budget. In such cases a PER can provide an important objective analysis of a country's public spending issues.

PERs typically analyze and project tax revenues, determine the level and composition of public spending, assess inter- and intrasectoral allocations (agriculture, education, health, roads), and review financial and nonfinancial public enterprises, the structure of governance, and the functioning of public institutions. Studies of public expenditure reviews over the past 10 years have suggested that the quality of analysis has been uneven, although their coverage has been comprehensive. General findings suggest that

- Most PERs do not examine the rationale for public intervention. Basic public economics concepts of market failure, public goods, and externalities are seldom used to analyze the efficiency of the public budget allocation.
- Most PERs do not integrate capital and recurrent expenditures and so sidestep the issue of the future recurrent cost implications of the capital budget. This introduces uncertainty regarding the sustainability of policies and projects. Such segmented analysis reinforces capital-led budgeting, which distorts public spending in favor of capital spending.
- Less than a quarter of recent PERs adequately focused on institutional issues, such as budget management or incentives in the public sector. Attention was restricted to incomplete (and often superficial) economic analysis of public expenditures.

Specific to the health sector, PERs provide important information on budget execution. For example, according to a PER in Latvia, late and uncertain budgets in the health sector undermine the health care institutions' accountability to live within their annual revenue limits (World Bank 2002a). The response of health institutions to budget constraints in this environment is to defer expenditure in the hope of budget increases later in the fiscal year. When no increase is forthcoming, health care institutions are forced to finance overspending by accumulating debts to tax agencies and suppliers. Moreover, when budget cuts occur, they are perceived as arbitrary, made without explicit analysis of what outputs will be forgone or where efficiency gains will be made. Earmarked revenue for health is set on a basis that explicitly does not cover some elements of health care costs. In the absence of any decision about how these costs will be financed, or any accountability, costs are shifted to consumers in an ad hoc way or financed by arrears.

PERs also find that resources disbursed in the health sector do not always correspond to those budgeted through the MTEF. For example, in Nicaragua, total

central government budget execution averaged 106 percent in 1997–8, but only 90 percent in the health sector. This low rate is attributable mainly to an inordinately low capital budget execution ratio of only 39 percent, which may reflect problems of absorptive capacity.

Uganda provides a second example of how PERs can show that resources disbursed in the health sector do not correspond to those budgeted through the MTEF. There, the budget performance for the health sector was 87 percent in 2003, compared with 90 percent the previous year. The underperformance was due to below-program (75 percent) wage releases to referral district hospitals, which, in turn, resulted from unfilled vacancies due to staff shortages. Nonwage recurrent releases to the health sector were at 94 percent, because of the late submission of accountability returns from local governments to the Ministry of Health (World Bank 2004c).

Public expenditure tracking surveys

Government resources for health care services often flow through several layers of bureaucracy down to the service facilities that are charged with responsibility for spending.¹ Information on public spending at the level of service delivery, however, is seldom available in developing countries. PETS follow the flow of government resources to determine how much of the originally allocated resources actually reach the service delivery point. They provide information on leakage of funds, corruption, and problems in the deployment of human and in-kind resources, such as staff, textbooks, and drugs.

PETS have uncovered considerable leakages in resource flows in the education and health sectors, and the surveys have led governments to improve institutional arrangements to address the leakages. A survey in Uganda in 1996 found that only 13 percent of the annual per student grant from the central government reached schools in 1991–5. Eighty-seven percent either disappeared for private gain or was captured by district officials for purposes unrelated to education. Almost three-quarters of schools received very little or nothing. About 20 percent of teacher salaries were paid to ghost teachers—teachers who never appeared in the classroom. In response to these findings the government required improved monitoring and reporting of the flow of funds. Although in 2001 schools were still not receiving the entire grant, leakage was reduced from an average of 80 percent in 1995 to 20 percent in 2001; the policy change accounted for two-thirds of this massive improvement.

A review of PETS carried out in African countries found leakage of nonwage funds on a massive scale in the health and education sectors. Salaries and allowances also suffer from leakage, but to a much lesser extent. Given that the availability of books and other instructional materials is key to improving the quality of schooling, the fact that between 87 percent (Uganda) and 60 percent (Zambia) of the funding for these inputs never reaches the schools makes leakage

a major policy concern in the education sector. In designing interventions to reduce leakage, country experiences show that it may be more efficient to target reforms and interventions at specific problem spots within the public hierarchy instead of instituting more general public sector reforms. For example, the PETS pointed to the fact that nonwage expenditures are more prone to leakage than salary expenditures. The surveys also demonstrated that leakage occurred at specific tiers within the government. This knowledge can be exploited to design more efficient interventions.

A PETS was used in Honduras to evaluate civil servant behavior in the health and education sectors. The survey found that 2.4 percent of staff on the government payroll in the health sector were not working at all. Some 8.3 percent of general practitioners and specialists and 5.1 percent of staff were ghost workers. Absenteeism was also discovered to be a major concern; 39 percent of staff were absent without justifiable reason. This amounted to a productivity loss of 10 percent of total staff time.

Targeting health expenditures

Increasingly, governments are targeting resources in the health sector to specific priorities. The priorities may be based on geographic location, specific health care needs (immunization, antiretroviral therapy), household income levels, or demographic characteristics (Coady, Grosh, and Hoddinot 2004), among others. This section provides an overview of some of the key results from three types of targeting: geographic, levels of care, and bottlenecks. Issues related to targeting interventions with donor funding are covered in chapter 4.

Geographic targeting

In Mozambique, Zambezia receives seven times less government spending on health per capita than Maputo City. In Lesotho, the poorest district receives only 20 percent of the amount the capital city receives in per capita allocations of public expenditures on health. This inequity is not resolved by accounting for non-governmental services. In Peru, per capita allocations through the regional budget (which excludes teaching hospital allocations) are 66 percent higher in the Lima region than in the very poor regions. In Bangladesh, more developed districts receive more per capita than less developed districts (Wagstaff and Claeson 2004).

As noted below in the section on decentralization, a well-designed, well-specified resource allocation formula can reduce such government spending disparities across regions. These formulas have an equity angle—they ensure that the poor also benefit from government spending. But they also have an efficiency angle—resources can be diverted from areas where the marginal benefit is fairly low (such as in high-tech hospitals in the capital city) to those where the marginal benefit is likely to be high (immunization programs in rural areas). Such formulas have narrowed regional gaps in developed countries and are beginning to be used in developing

countries. They have been used, for example, as part of Bolivia's decentralization efforts since 1994, and in its allocation of newly available resources from debt forgiveness, Bolivia allocated funds to municipalities according to poverty indicators, with the mandate that municipalities spend such resources on specified health, education, and other social programs.

Changing the allocation of spending across levels of care

Developing countries allocate a surprisingly high share of health spending to secondary and tertiary infrastructure and personnel, despite low bed-occupancy rates. Armenian hospitals, for example, receive more than 50 percent of the government budget for health. Health clinics and ambulatory facilities—the preferred service providers for sick people in the poorest 20 percent of the population, according to household surveys—received just over 20 percent of expenditures. This pattern is also seen in low-income countries. In Tanzania, government spending in hospitals accounted for about 60 percent of the budget in 2000, compared with only 34 percent of spending on preventive and primary care facilities. Recent government efforts to change this brought the respective proportions to 43 percent and 48 percent in 2002.

Simply reallocating the budget toward primary care need not result in higher payoffs to government health spending in lowering child and maternal mortality and malnutrition. In many instances, service providers have failed to deliver quality care or to use resources efficiently. Thus, even though many key interventions for the Millennium Development Goals can be and are delivered at lower levels of the health care system, simply redirecting money toward these facilities will not necessarily yield higher returns. The trick is to couple expenditure reallocations with measures to improve the performance of primary care facilities and district hospitals and measures to ensure that households actually demand the relevant interventions.

Targeting spending to remove bottlenecks

Another approach is to assess—at the country level—the health sector impediments to faster progress, to identify ways to remove them, and to estimate both the costs of removing them and the likely impact of their removal on Millennium Development Goal outcomes. Work along these lines has begun in several African countries and in India. In Mali, for example, a number of key impediments to supporting home-based practices and delivering both periodic and continuous professional care were identified. These included low access to affordable health care supplies and the need for community-based support for home-based care, inadequate geographic coverage of preventive professional care (immunization, vitamin A supplementation, and antenatal care), shortages of qualified nurse-midwives, and an absence of effective third-party payment mechanisms for the poor for continuous professional care. Removal of these impediments would cost an estimated \$12 per capita between 2002 and 2007 and might reduce under-five mortality by as

much as 20–40 percent and maternal mortality by as much as 40–80 percent, depending on the poverty level of the region (Wagstaff and Claeson 2004).

If the estimates of these and other bottleneck costing exercises turn out to be right (validation will have to await the results of the program's implementation), the message is clear—higher returns to government health spending in terms of progress on the Millennium Development Goal indicators can be achieved by focusing marginal spending on the removal of carefully identified constraints.

Coady, Grosh, and Hoddinot (2004) provide a good summary of targeting programs in developing countries. As country incomes and inequality rise, so does the targeting performance of antipoverty interventions. Targeting seems to work better in higher-income countries because of their greater capacity to design and implement finer targeting methods. It also works better in countries having greater income inequality, perhaps because they recognize greater potential gains from targeting and have a greater ability to differentiate among households along different parts of the income distribution. Targeting is also better in countries where government accountability is better; this is consistent with the a higher level of accountability for the effectiveness of poverty reduction programs.

A review of targeting programs in developing countries (Coady, Grosh, and Hoddinot 2004) emphasized several lessons:

- Targeting can work. The best programs can concentrate a high level of resources on poor individuals and households. For example, a public works program in Argentina was able to transfer 80 percent of program benefits to the poorest 20 percent.
- Practice around the world is highly variable. Although median performance was good, targeting was regressive in approximately 25 percent of cases, so that a random allocation of resources would have provided a greater share of benefits to the poor.
- There is no clearly preferred method for all types of programs or all country contexts. More than 80 percent of the variability in targeting performance is due to differences within targeting methods, and only 20 percent to differences across methods.
- Interventions that use means testing, geographic targeting, and self-selection based on a work requirement are all associated with an increased share of benefits going to the bottom 40 percent, compared with targeting that uses self-selection based on consumption.
- Implementation matters tremendously to outcomes. Some, but by no means all, of the variability was explained by country context. Targeting performance improved with implementation capacity, the extent to which governments are held accountable for their actions, and the degree of inequality. Generally, using more targeting methods produced better targeting. Unobserved factors, however, explained much of the differences in targeting success.

Decentralizing health care

Decentralization of key functions is often viewed as a means of improving performance. The motivations behind decentralization are numerous. From a political standpoint, decentralization is seen as bringing decision making closer to the people, thereby increasing “democratization.” From an efficiency standpoint, it is seen as a way of removing layers of bureaucracy or diseconomies of scale and of incorporating local information into decision-making processes. This section reviews the evidence on the impact of decentralization on the performance of health systems.

Generally, decentralization in the health care sector refers to the transfer of authority from central government to local government. Decentralization can take several forms (Bossert and Beauvais 2002):

- *Deconcentration* is the transfer of decision-making authority to regional, district, or subdistrict offices within the structure of the ministry of health.
- *Devolution* is the transfer of decision-making authority from the central to provincial or municipal governments.
- *Delegation* is the transfer of decision-making authority from central government to semiautonomous agencies.
- *Privatization* is the transfer of ownership from central, provincial, or municipal governments to private entities.

Each form of decentralization has different implications for the level of autonomy of the subnational authority. Moreover, in evaluating the impact of decentralization, it is important to track which functions are decentralized and which are not. Bossert and Beauvais (2002) identify these key health systems functions as finance (revenue generation, expenditure allocation), service organization (hospital autonomy, payment mechanism, contracts with private sector), human resources (salary setting, hiring and firing, terms of work), access rules (targeting), and governance rules (regulation, monitoring). Thus, in evaluating country experiences with decentralization in the health sector, it is important to consider the form of decentralization as well as the specific decision-making powers that are decentralized.

Proponents of decentralization argue that it improves health system performance through several channels (Bossert and Beauvais 2002; Khaleghian 2004; Hutchinson and LaFond 2004; Chernichovsky and Chernichovsky forthcoming). First, decentralization is thought to improve technical efficiency by making local governments more cost conscious and allowing more freedom in contracting with providers. Second, improved allocative efficiency can be realized by better aligning the mix of services and expenditures with the preferences of the local community. Third, decentralization is believed to improve equity, as local authorities are better able to target expenditures and services to vulnerable groups. Fourth, it also promotes service delivery innovations through experimentation and adaptation of service and financing models to unique settings. Finally, decentralization is

thought to improve quality, transparency, accountability, and legitimacy as community involvement in decisions increases.

However, critics of decentralization point to the potential for diseconomies of scale and reduced investment in key public goods, such as research and development at the local level (Khaleghian 2004). Having separate administrative structures to manage health care provision and financing at the subnational level leads to duplication and inefficiency. With smaller populations covered by a particular health financing mechanism, risk pooling may become more difficult. Moreover, there is no clear evidence that local governments are better at targeting marginalized groups than central governments are. There is a potential for elites to “capture” decentralized authorities and prevent them from serving the interests of the needy.

The impact of decentralization

Of particular interest in examining evidence of the impact of decentralization on outcomes is the impact on efficiency and equity in two key areas of health systems: health service delivery and health financing. Several analysts note the paucity of sound evaluations of decentralization policies and the need for research in several areas.

Health service delivery. In general, the evidence base on the impact of decentralization on service delivery is weak, with few studies examining specific services. In general, experiences seem country specific, and it is difficult to draw general conclusions on the impact of decentralization on technical efficiency.

Khaleghian (2004) shows that decentralization (measured by the presence of subnational governments having certain powers, treated as a binary variable) increases the rate of immunization coverage in developing countries. On average, countries with decentralized governments have an 8.5 percent higher rate of immunization coverage. The results are based on cross-country time series data and rely heavily on cross-country variation. However, an analysis of the relationship does not hold for middle-income countries, and the author suggests several explanations. For example, local authorities in low-income countries may have more control over health care programs than local authorities in middle-income countries, even when both are decentralized. In addition, community members may play a more high-profile, pragmatic role in immunization campaigns in low-income countries than in middle-income countries.

Hutchinson and LaFond (2004) found that in Uganda, decentralization provided district governments the freedom to contract with nongovernmental organizations (NGOs) for service provision. The NGOs provided higher-quality care at lower cost in their facilities. They found similar results in Cambodia: NGOs proved more efficient at providing services—both in quality and quantity—than government facilities (box 6.1). In these cases, decentralization was associated with some improvement in technical efficiency in services. Other countries have

BOX 6.1 *Contracting nongovernmental organizations in Cambodia*

Cambodia has experimented with two models of contracting for health services. Districts were selected randomly and assigned to “contracting out” (two districts), “contracting in” (three districts), or “control” (four districts). In the contracting-out sample, NGOs were given full responsibility for the delivery of specified services in a district, including drug procurement and the hiring and firing of staff. In the contracting-in sample, NGOs worked within the existing system to strengthen district administrative structures. Control districts received only a small subsidy toward service delivery. Based on household and facility surveys 2.5 years after contracts started,

contracted districts outperformed control districts in terms of predefined coverage indicators, such as immunization and attended deliveries.

The contracting-out model outperformed the contracting-in model. Much of the increase in health care utilization in contracted-out districts was attributed to increased use by households of low socioeconomic status. Because funding flows differed between the districts (contracted-out districts received larger per capita payments), some of the observed differences could have reflected differences in access to and levels of available resources.

Source: Mills, Rasheed, and Tollman forthcoming.

reported improvements in technical efficiency or quality through decentralization. In Tanzania, service use per facility was considerably higher in decentralized districts (Hutchinson and LaFond 2004).

According to Mills, Rasheed, and Tollman (forthcoming), the evidence related to the effect of decentralization on allocative efficiency is mixed. In some cases decentralization did not result in better alignment of health care service provision with the needs of the population. In the Philippines and Uganda, for example, expenditures were reallocated to curative care and away from primary care at the local level (Bossert and Beauvais 2002). Spending at higher levels of care is very visible and is seen as more politically rewarding for district governments, even though there were indications that primary care services are most needed in several of the developing countries examined.

There are also examples of decentralization leading to improved expenditure allocation across services. In Bolivia, for example, an analysis of expenditure patterns following decentralization showed that local government’s better knowledge of local needs resulted in spending reallocations that improved access to health care services (Hutchinson and LaFond 2004). Decentralization improved equity in Chile and Columbia. In these countries, health care budgets were devolved to provincial or municipal governments on the basis of a per capita formula adjusted for various factors. The gap in health expenditures across income deciles decreased as a result of decentralization. Local government health expenditures on the wealthiest 10 percent decreased from 41 times that of the poorest 10 percent before decentralization to 12 times after decentralization.

One of the main reasons for the success in Chile and Colombia in improving equity is the acceptance and use of a clear formula for allocating resources to local governments that takes into account differences in health care needs. A second critical factor is adequate institutional capacity at the local level. In all positive experiences associated with decentralization, this was one of the key factors (Hutchinson and LaFond 2004). The evidence clearly indicates that having local health care managers who are highly skilled and have adequate support staff with access to high-quality information systems is a necessary condition for effective decentralization.

Capacity constraints have limited the effectiveness of many decentralization efforts. These constraints have included limitations in the absolute numbers of human resources and in their level of training and preparedness for their new functions. To successfully implement a decentralized system, the leadership capacity of new managers must be strengthened, as must the institutional capacity of new systems at the local level. It is clear that capacity building must occur both before and during decentralization.

Health financing—revenue generation and expenditure. Bossert and Beauvais (2002) examine the decentralization experiences, ranging from devolution to delegation, in Ghana, the Philippines, Uganda, and Zambia. They find that in all countries health expenditures increased at the local level and decreased at the central level as a result of the decentralization reforms. However, higher spending at the local level did not result from any significant increase in revenue generation at the level but rather from increased transfers from the central government.

With decentralization comes an increasing need to control costs at the local level. A logical cost center to target with cost control efforts is salaries for health care workers, which are a primary cost driver of health care spending. For example, salaries consume up to 80 percent of government health spending in developing countries (Joint Learning Initiative 2004). However, efforts at the local level to reduce the costs associated with health care workers' salaries are often restricted by unions, which exert political pressure not to change the terms of work or to hire and fire health care workers. In addition, evidence suggests that continued control from the central level over salary and personnel levels severely limits local fiscal autonomy and hinders cost control efforts (Bossert and Beauvais 2002).

Decentralization of revenue generation to district governments diminishes the ability of central authorities to reallocate expenditures. This has the potential to increase regional inequities in health care spending. For example, many Eastern European countries have devolved revenue generation to regional governments. The evidence indicates that in many of these countries the proportion of regional revenue that is collected and reallocated by the central authority has been inadequate, and regional inequality has increased significantly since decentralization (Langenbrunner forthcoming).

Main lessons of decentralization

A review of country experiences (Hutchinson and LaFond 2004) indicates that the main lessons related to decentralization in the health sector concern governance, service delivery, and financing:

Governance

- Decentralization requires strong political backing at both the central and local levels. Stakeholders should have ownership of both the plan for decentralization and the process of organizational capacity building.
- Political objectives must be supported by the legal and institutional framework, the structure of service delivery responsibilities, and the system of inter-governmental fiscal transfers.
- Changes in the roles and responsibilities of the different actors in the health sector, particularly local government health officials, should be accompanied by training and plans for building capacity.
- Decentralization should be accompanied by a clear delineation of responsibilities and mechanisms of accountability among the different stakeholders and should be formally codified in legislation, regulations, or other binding instruments.
- For decentralization to be successful, there must be willingness on the part of the central government to share power and on the part of local governments and communities to assume new responsibilities. In many countries, civil servants have objected to decentralization efforts for fear of status loss when these efforts involve a transfer of personnel from the central to subnational governments.
- Research institutions should monitor and evaluate practical aspects of the decentralization process.

Service delivery

- Although decentralization generally involves a diminished central government role in service delivery, certain activities such as research and dissemination of findings, provision of public goods, the development and enforcement of standards and regulations, and accreditation procedures are likely to be most efficiently undertaken at the central level.
- Communities must have the information on public sector performance that allows them to react and to hold officials and politicians accountable. For example, the costs of services provided at the community level, delivery options, and available resources must be transparent so that decision making can be informed and meaningful.
- There must be binding and credible mechanisms to allow communities to express preferences so that there are incentives for communities to participate.

- Decentralization has been motivated in many cases by theoretical considerations, rather than empirical evidence. The measurement of efficiency gains in decentralized service delivery remains open to empirical investigation, particularly in the developing world, where decentralization programs have been more ambitious and implemented more recently.

Financing

- Even under decentralization, local governments may have limited revenue-generating capacity and therefore are likely to remain reliant on intergovernmental transfers from the central government. Intergovernmental transfers should be determined openly and objectively, ideally by a clear, simple, and verifiable formula.
- Local financing and fiscal authority should be linked to service provision responsibilities and functions so that local politicians can deliver on their promises and be held accountable for their decisions.

Endnote

1. This section on public expenditure track surveys draws heavily from Dehn, Reinikka, and Svensson 2003.

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