

Local Government Accountability for Service Delivery in Nigeria

Stuti Khemani¹

Development Research Group, The World Bank

1818 H Street NW, Washington, DC 20433

skhemani@worldbank.org

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1. Introduction

How accountable are locally elected governments for the delivery of local public goods? What is the impact of intergovernmental fiscal relations on local accountability? These questions are of increasing importance as several developing countries are beginning to decentralize responsibility for local public services to local institutions, and, in the absence of sufficient local revenue potential, to explore ways of financing this decentralization through intergovernmental transfers. Nigeria is one of the few countries in the developing world to have significantly decentralized both resources and responsibilities for the delivery of basic health and education services to locally elected governments.² Local governments in Nigeria are constitutionally entitled to a share of about 20 percent of federal revenues, which in recent years of oil price booms has implied substantial resource flows to local governments. Local government responsibility for primary health care services, in particular, is emphasized in a recently revised health policy document formulated in the 1980s. However, there is little systematic evidence on how these institutions of decentralization work in practice. This paper presents evidence on local accountability for health services delivery from a survey of local governments and primary health facilities in the states of Kogi and Lagos, and draws general lessons for the design of intergovernmental fiscal relations to promote accountability.

A survey of 30 local governments, 252 public primary health facilities, and over 700 health care providers was carried out in the states of Kogi and Lagos in the latter part of 2002.³ The most striking phenomenon uncovered by this survey is the extensive non-payment of salaries of public health personnel in the state of Kogi—42% of staff respondents report not receiving any salary for 6 months or more in the past year at the

² Although recently many developing countries have implemented or are implementing decentralization reforms, the Nigeria experience is rare in terms of both the length of time that locally elected governments have existed, and in terms of substantial revenue devolution to local governments for the discharge of their responsibilities. India, for example, which has a longer standing democracy than Nigeria, adopted a constitutional amendment as recently as 1993 to create locally elected governments, compared to Nigeria where local governments were constitutionally recognized in 1976; India has still not provided systematic sources of revenue to its local governments, whereas Nigerian local governments are constitutionally entitled to substantial untied grants from the federal government.

³ Adeniyi and Oladepo (2003) describe the survey in detail. The Appendix to this paper provides a brief summary description.

time of the survey. This problem appears to be an endemic one for basic service delivery in Nigeria (with a similar problem of non-payment of primary school teacher salaries creating a public outcry in the 1990s), and has been argued to be the result of federal institutional arrangements where local governments are overwhelmingly dependent on federal revenue transfers for the discharge of their responsibilities. While some argue that the problem is lack of adequate resource transfers to local governments to finance their expenditure responsibilities, others argue that over-dependence of local governments on federal transfers has undermined local accountability and created perverse incentives at the local level to misallocate public resources (Olowu and Erero, 1995; Ekpo and Ndebbio, 1998; The World Bank, 2002).

Analysis of the survey data reveals that there is no correlation between non-payment of staff salaries and local government revenues or budgeted spending on staff salaries. Regression analysis shows that per capita local government revenues and per facility local government spending on health personnel are not able to explain variation in non-payment of salaries across local governments. Using the survey data, actual staff costs per facility in each sampled local government in Kogi was estimated and compared to what the local government reported as actual spending towards staff salaries per facility within its jurisdiction. This comparison shows that even when budget allocations were sufficient to cover estimated actual costs, the staff survey revealed non-payment of salaries for several months in the year before the survey. The paper argues that the pattern of evidence shows that non-payment of salaries cannot be explained by lack of resources available to local governments. The evidence therefore suggests that there is a general problem of accountability at the local government level in the use of public resources that are transferred from higher tiers of government, and about which local citizens may not be well informed since they are not the tax-payers.

The survey data also enabled an analysis of the impact of non-payment of staff salaries on service provision. Although there is no discernable impact on health services provided, in terms of the number of patients served on average per staff, the greater is the extent of non-payment of salaries the higher is the likelihood that facility staff in fact behave as private providers, with more services provided outside the facility through

home visits, and with essential drugs being privately provided, either funded by staff own resources or expropriated from facility stocks.

This evidence might be construed as running counter to the conventional wisdom in many development policy circles that by “bringing government closer to the people” decentralization will have a beneficial effect on the allocation and use of public resources. However, in and of itself, this analysis cannot address the question of whether decentralization is good or bad—that is, whether more centralized delivery in the hands of the state or federal government would be better—because we are unable to compare outcomes across more or less decentralized systems. But the overall policy lesson that the analysis does provide is that of strengthening local government accountability, particularly when local governments are overwhelmingly dependent on federal transfers.

What can be done about this? The paper argues that the technical design of intergovernmental transfers is unlikely to have the desired impact on the general problem of local accountability, and that larger political economy solutions need to be explored to promote better public service delivery by local governments.

The rest of the paper is organized as follows. Section 2 provides a brief overview of local government institutions in health service delivery in Nigeria; Section 3 reports evidence of non-payment of staff salaries and argues that this is evidence of limited accountability of local governments; Section 4 analyzes how non-payment of salaries impacts primary health care services; Section 5 concludes by exploring policy lessons for this problem of local accountability in the delivery of basic services. A summary description of the survey upon which this analysis is based is provided in the Appendix to this paper.

2. Decentralization to Local Governments

Nigeria has been organized as a federal country since 1954 with the responsibility for providing most public goods being concurrently shared between the federal and state governments. In 1976, Local Government Authorities (LGAs) were established and recognized as the third tier of government, responsible for participating in the delivery of most local public services along with state governments, and entitled to statutory revenue

allocations from both the federal and state governments for the discharge of their responsibilities. In the late 1980s there was a national initiative to overhaul the primary health care system through the adoption of a new national health policy, in the context of which the federal and state governments issued directives giving LGAs full jurisdiction over the delivery of primary health care services (Olowu and Erero, 1995; National Primary Health Care Development Agency, 2001).

The current national health policy document, revised in 1996, indicates that local governments are expected to be the main implementers of primary health care policies and programs, with the federal government responsible for formulating overall policy and for monitoring and evaluation, and state governments for providing logistical support to the LGAs such as personnel training, financial assistance, planning and operations. To quote:

“With the general guidance, support and technical supervision of State Health Ministries, under the aegis of Ministries of Local Government, Local Government Councils shall design and implement strategies to discharge the responsibilities assigned to them under the Constitution, and to meet the health needs of the local community.” (page 26, National Health Policy)

Yet, the current Constitution (1999) of Nigeria is ambiguous with regard to the authority and autonomy of local governments in providing basic services, such as primary health, for which they have been assigned responsibility through sectoral directives. The Fourth Schedule of the Constitutions lists the functions of LGAs as follows:

“The functions of a local government council shall include participation of such council in the Government of a State as respects the following matters: (a) the provision and maintenance of primary, adult and vocational education; (b) the development of agriculture and natural resources, other than the exploitation of minerals; (c) the provision and maintenance of health services; and (d) such other functions as may be conferred on a local government council by the House of Assembly of the State.”

This implies that according to the Constitution, it is the state governments that have principal responsibility for basic services such as primary health and primary

education, with the extent of participation of LGAs in the execution of these responsibilities determined at the discretion of individual state governments. The constitutional existence of state-level discretion might lead to disparities across local governments or across states in the extent to which responsibility for primary health is effectively decentralized. In the face of such constitutional ambiguity, the survey of LGAs and health facilities upon which this paper draws attempts to assess the extent of actual decentralization of primary health services to local governments.

The survey asked respondents at both the LGA and facility level which agency, choosing *one* amongst the federal government, the state government, the LGA, community-based organizations, and facility head or staff, was the *principal decision-maker* for each of the following areas of PHC service provision in health facilities:

- Undertaking new construction, such as facility expansion
- Acquiring new equipment
- Making drugs and medical supplies available
- Setting charges for drugs and treatment
- Use of facility revenues from treatment and consultation
- Disciplining staff
- Transferring staff between facilities

The overwhelming majority of respondents indicated the LGA, amongst the three tiers of government, as the principal decision-maker for most of the areas of facility-level provision of primary health services.⁴ There was no systematic variation across local governments in the extent of decentralization of responsibility—the state and federal governments were indicated by a trivial number of respondents as principal decision-makers for any area of decision-making. Staff management in particular was almost unanimously indicated as the responsibility of local governments as shown in Table 1. This evidence for the health sector is a striking contrast to available evidence for service

⁴ In addition to the LGA, community based health committees and facility head and staff were indicated as principal decision-makers for several areas. Community participation was much more significant in Kogi than in Lagos.

delivery in other sectors—such as primary education, water and sanitation—that are characterized by considerable overlap and confusion with regard to the sharing of responsibilities between the three tiers of government, often at the expense of undermining LGA responsibility and accountability (Olowu and Erero, 1995; Khemani 2001; The World Bank, 1996).

Table 1		
Local Government Responsibility for Managing Health Staff		
Staff Discipline^a		
Principal Decision-Maker	Frequency of Response	Percentage of Respondents
Federal Government	1	0.4
State Government	5	1.98
Local Government	210	83.33
Community	9	3.57
Facility Head/Staff	21	8.33
Missing Response	6	2.38
Staff Transfers^a		
Principal Decision-Maker	Frequency of Response	Percentage of Respondents
Federal Government	1	0.4
State Government	8	3.17
Local Government	233	92.46
Community	3	1.19
Facility Head/Staff	2	0.79
Missing Response	5	1.98
Who pays staff salary?^b		
Agency	Frequency of Response	Percentage of Respondents
Federal Government	10	1.4
State Government	10	1.4
Local Government	681	95.65
Community	5	0.7
Individuals	2	0.28

Other/Missing Response	4	0.56
<p>a. The question “Who is the principal decision-maker for ...” was posed to the facility head or assigned facility-level respondent, and the respondent had to choose one from a list of agencies</p> <p>b. This question was posed to individual staff respondents.</p> <p><i>Source: Survey data</i></p>		

Local government expenditure responsibilities are financed largely through statutory allocations from the federal government, with LGAs regularly receiving about 20 percent of total revenues in the divisible pool called the Federation Account. Since oil revenues are part of the Federation Account, LGAs receive substantial revenues on account of this statutory allocation.⁵ LGAs are also entitled to a share of federally collected VAT revenues (outside of the Federation Account). In addition, LGAs are supposed to receive statutory allocations from state government revenues, but the rules related to this are less strict and not always enforced (Ekpo and Ndebbio, 1998). LGAs also have recourse to significant own tax bases, although studies have shown that these have not been explored to full potential, and that internally generated revenues are a small proportion of total LGA revenues (Olowu and Erero, 1995; Khemani, 2001).

The survey collected data on LGA revenues and health expenditures for 1999 and 2000 from available actual budget documents. It was not possible to collect budgetary data beyond 2000 because of the general non-availability of recent budget documents. Table 2 shows summary statistics on per capita revenues in the two states. Average per capita revenues in both states doubled in 2000, owing to the country-wide increase in oil revenues which led to greater allocations to LGAs from the Federation Account. The facility survey has therefore been undertaken at a time when LGA revenues have been substantial and rising. Although the levels of per capita revenues are not significantly different across the two states, there is greater variation across LGAs in Lagos state, with the richest LGA (Ibeju-Lekki) having more than 10 times the per capita revenues of the poorer LGAs.

⁵ The respective shares of the three tiers of government in the Federation Account is currently under flux, but LGAs are likely to continue receiving 20 percent. Given the recent Supreme Court ruling on so-called “first charges” from the Federation Account, the amount of revenues in the divisible pool is going to increase, with all proceeds from oil, company income tax, and customs duty and excise being shared between the three tiers of government. Thus the total amount of revenues accruing to local governments is likely to increase.

Table 2 Per Capita LGA Revenues				
KOGI:	Mean	Std. Dev.	Minimum	Maximum
1999 Per capita revenues	1018.6	599.6	443.4	2391.8
2000 Per capita revenues	2191.2	1218.2	1190.6	5634.8
LAGOS:				
1999 Per capita revenues	1266.4	1623.1	465.1	6753.7
2000 Per capita revenues	2352.3	3428.1	582.8	14412.1
<i>Source: Survey Data. 2000 data is for 15 LGAs in each state; 1999 data is for 13 LGAs in Kogi (missing values for 2 LGAs) and 14 LGAs in Lagos (missing values for 1 LGA).</i>				

Figures 1a and 1b show the composition of LGA revenues on average for each of the two states. Local governments in Kogi are overwhelmingly dependent on statutory allocations from the Federation Account and VAT, which together constitute 99 percent of LGA revenues. Revenue sources of local governments in Lagos are more diversified—bulk of their revenues comes from the Federation Account and the VAT, but a significant amount (8 percent) is also internally generated from local tax bases. This is as one would expect given that Lagos state is the urban center of Nigeria, while Kogi is a largely rural state.

Figure 1b: KOGI: Composition of 2000 Revenues

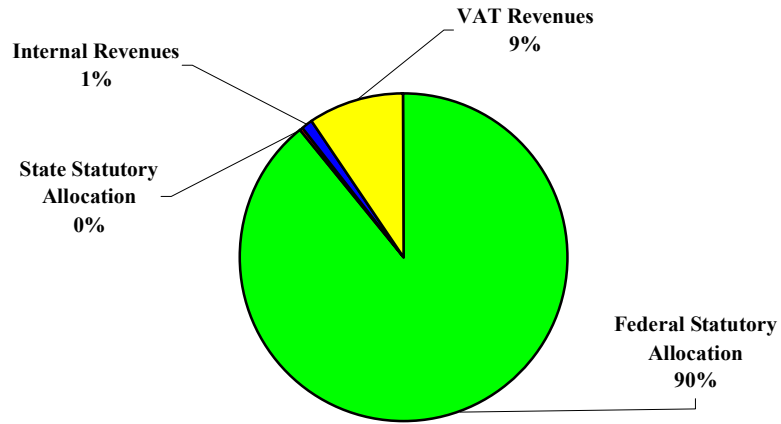
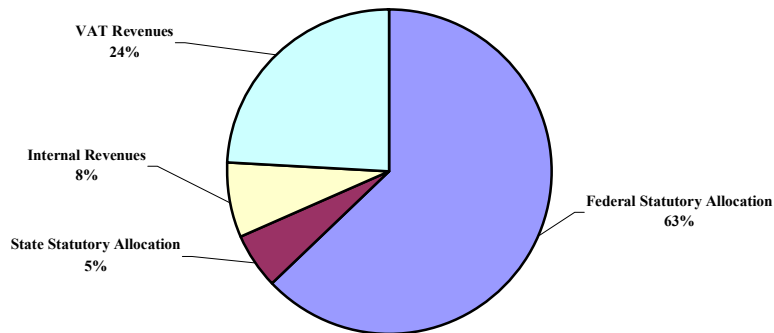


Figure 1b: Lagos: Composition of 2000 Revenues



The survey attempted to collect budgetary data on health expenditures of local governments, which was a difficult exercise because budget documents and categories across local governments, both within and across states, are not uniform. During the field testing of the survey instruments it was observed that numbers on total health expenditures were either not easy to find or simply not available in LGA budget documents. However, three categories of expenditures that appeared to show-up more consistently across LGAs were expenditures on health personnel, overheads, and capital

projects. These also appeared to be exhaustive categories for the budgeting of health expenditures. Hence, data was collected on these three categories of health expenditure, which we add-up here to estimate total health expenditures by local governments. There are several missing values for this estimate of total health expenditures, arising whenever any one of the three categories—personnel, overheads, and capital—are missing. In total, we have missing values for total health expenditures for 7 LGAs in Kogi and 1 LGA in Lagos for the 1999 budget, and for 4 LGAs in Kogi and 3 in Lagos for the 2000 budget.

Table 3 shows summary statistics for per capita total health expenditures in the two states, and the proportion of total local government revenues spent on health. For the sample for which data is available, Kogi LGAs spend more per capita and as a proportion of total revenues on health than do Lagos LGAs. However, this comparison is to be interpreted with caution because of potential bias introduced by several missing observations. Lower public expenditures on health in Lagos LGAs may be because of greater availability of private health care in the substantially more urban state.

Table 3				
Local Government Health Expenditure				
KOGI:	Mean	Std. Dev.	Min	Max
Tot. Health Exp. Per Capita, 1999	240.7	235.5	92.4	800.2
Tot. Health Exp. Per Capita, 2000	379.5	261.6	191.8	1121
Proportion of revenues spent on health, 1999	26%	16%	13%	62%
Proportion of revenues spent on health, 2000	22%	15%	6%	61%
LAGOS:				
Tot. Health Exp. Per Capita, 1999	154.2	152.1	48.5	624.8
Tot. Health Exp. Per Capita, 2000	251.2	304	60.2	1162.7
Proportion of revenues spent on health, 1999	14%	7%	8%	37%
Proportion of revenues spent on health, 2000	12%	9%	5%	41%
<i>Source: Survey Data. 2000 data is for 11 LGAs in Kogi and 12 in Lagos; 1999 data is for 8 LGAs in Kogi and 14 in Lagos.</i>				

Figures 2a and 2b shows the average composition of health expenditures in terms of capital, overheads, and personnel expenditure in 2000 for each of the states. Bulk of LGA health expenditures are allocated to staff salaries—in Kogi in 2000, LGAs on

average spent 78% of health expenditures on salaries, while in Lagos, LGAs spent 65% on average on staff salaries.

Figure 2a: Kogi--Composition of Health Expenditures, 2000

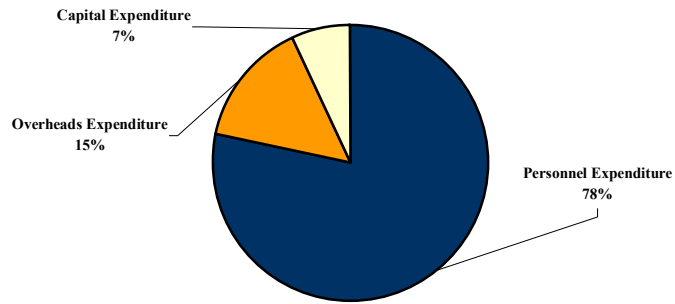
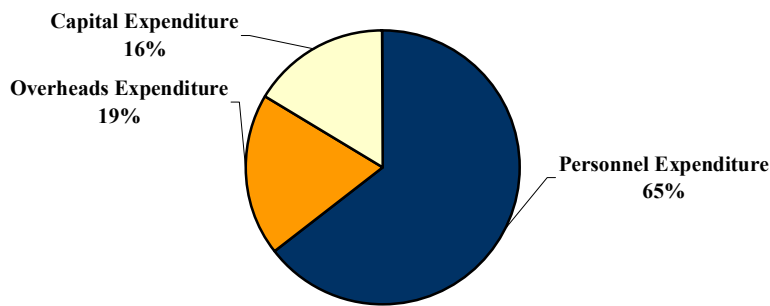


Figure 2b : Lagos--Composition of Health Expenditures, 2000

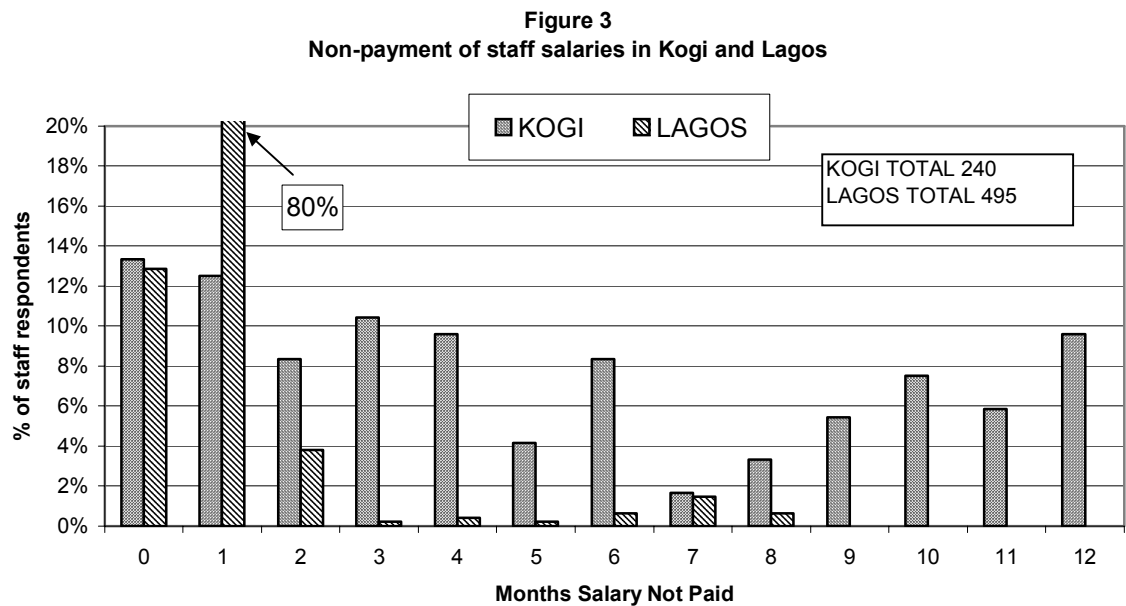


To summarize the above discussion—the survey data confirms that local governments are indeed responsible for primary health care services, and particularly so for decisions related to health staff management; in Kogi, local governments are overwhelmingly dependent on federal transfers for their revenues (receiving 99 percent of total revenues from the federal government), whereas in Lagos, 8 percent of total local

government revenues are internally generated; in both Kogi and Lagos the bulk of local government health expenditures is on staff salaries.

3. Non-payment of salaries

Despite substantial budgetary allocations to staff salaries in Kogi, the survey of health facility staff revealed that non-payment of salaries is a serious concern in the state—42% of staff respondents in Kogi report not receiving any salary for 6 months or more in the past year at the time of the survey. Figure 3 shows the distribution of staff against the months in the past year for which their salary has not been paid for each state—the distribution of Kogi staff, in contrast to that of Lagos, clearly shows that non-payment of salaries is a pervasive problem in Kogi state.



Consistent with this picture of salary non-payment being a problem in Kogi relative to Lagos, regression analysis, reported in Table 4, shows that variation across local governments in the extent of non-payment of salaries (as measured by LGA-level average number of months that staff report salary not being paid) is largely explained by an indicator variable for Kogi (Column 1). If non-payment of staff salaries is due to lack of resources available to local governments then much of the rest of variation should be explained by local government revenues. In particular, we should see a negative correlation between the average number of months of non-payment of salaries reported

by staff sampled in an LGA and the amount of LGA revenues—an LGA which is constrained by lack of revenues is likely to have staff that have not been paid for a greater number of months in the year. However, Column 2 of Table 4 shows that per capita local government revenues is an insignificant predictor of non-payment of salaries.⁶

It might be that demands on limited local government resources are so overwhelming and urgent that even essential expenditures such as salary payments get neglected. This would account for the lack of significant negative correlation between revenues and non-payment of salaries, and yet explain non-payment of salaries by appealing to insufficiency of local resources. A variable that might capture demand for LGA resources, and why resources might be thinly spread, and therefore account for non-payment of salaries, is the number of health facilities owned by an LGA. In the largely urban and densely populated environment of Lagos there is a significant private market even for primary health services, whereas in mostly rural Kogi, with dispersed settlements, health services appear to be largely provided in public facilities.⁷ In Lagos, the majority of all health facilities is privately owned (61%) whereas in Kogi only 7% belong to the private sector. Column 3 of Table 4 shows that the larger the number of facilities, the greater is the extent of non-payment of salaries. Yet, even after controlling for this measure of demands on local resources, there is no significant relationship between local revenues and non-payment of salaries.

Above all else, what should really explain variation in non-payment of salaries is variation in actual local government spending on health personnel. Local governments which were able to spend less on health personnel, either due to limited revenues or due to competing urgent demands on their scarce resources, should have staff reporting greater number of months of non-payment of salaries. Although the survey was not able to collect strictly contemporaneous actual budgetary data—staff respondents report non-

⁶ The time frame for the salary payment data (reported by respondents for the year preceding June-August 2002) and the budgetary data (actual revenues and expenditures for fiscal year 2000 from budget documents) are not identical. Yet, given that local government revenues have been increasing since 2000 because of a global oil price boom, revenue data for 2000 is likely to be either a close approximation for 2001-2002 numbers or an underestimate.

⁷ This analysis only refers to services provided through health facilities, and is deduced from the data obtained on the population of registered health facilities, by ownership, from the local government authorities.

payment of salary between 2001 and 2002, whereas the actual budget numbers are available only for 2000—expenditure allocation in 2000 should be a decent approximation of allocation trends in 2001-2002 given that revenues were increasing in this time period, and there is no compelling reason to expect a significant shift in expenditure composition. Column 4 of Table 4 shows that there is no significant correlation between average months of non-payment of salary in an LGA and the reported budget allocation for salaries of health workers. This evidence of the lack of correlation between local revenues, actual expenditures, and non-payment of salaries is not consistent with any explanation rooted in lack of resources available to local governments.

Table 4				
Explaining Variation in Salary Non-Payment Across Local Governments^{a, b}				
	(1)	(2)	(3)	(4)
Indicator for Kogi state	3.84** (0.66)	3.84** (0.67)	2.07** (0.66)	2.03** (0.78)
Local Government Revenues (per capita)		-0.00001 (0.0001)	-0.000001 (0.00001)	0.00001 (0.00004)
Number of health facilities owned by Local Government			0.05** (0.02)	0.04** (0.02)
Local Government Spending on Health Personnel (per facility)				-0.0000001 (0.0000001)
Constant	1.22** (0.1)	1.23** (0.18)	0.81** (0.19)	1.21** (0.61)
R-sq	0.55	0.55	0.71	0.70
Number of observations	30	30	30	26
<i>a. Dependent variable: Average number of months of non-payment of salary reported by staff</i>				
<i>b. OLS regression with robust standard errors reported in parentheses; ** significant at 1-5% level</i>				

Further analysis, with back-of-the-envelope calculations, was undertaken LGA by LGA for Kogi to estimate whether this problem of non-payment of staff salaries could be due to inadequate budgetary allocations towards salaries in the LGA health budget. The

survey data from staff respondents in individual facilities is used to estimate actual staff costs per facility, on average, in each LGA. Data collected from local government officials is used to estimate average budgetary allocation to staff costs per facility.

We use the sample average of staff monthly salary from the salary reported by staff in each LGA as an estimate of average monthly salary per staff in an LGA, and the sample average of total number of staff in a facility (as reported by the facility head in the facilities surveyed in each LGA) as an estimate of average number of staff per facility in an LGA. The product of these two sample averages multiplied by 12 thus gives an estimate of the average annual salary cost per facility in each LGA. The average across the 15 LGAs in Kogi of this estimated salary cost per facility is 1.4 million Naira, ranging from a minimum of 0.3 million Naira to a maximum of 7.5 million Naira.

We then estimate each LGA's average annual budget allocation towards staff salaries per facility. From the LGA respondents data, we divided actual budgetary allocation to staff salaries for the year 2000 by the number of facilities that the LGA reported as owning within its jurisdiction, to get an estimate of the average LGA budget allocation to staff salaries for a typical health facility in the LGA. Data on budgetary allocation towards salaries of health personnel was missing for one LGA in Kogi—Mopa Muro. The average across the 14 LGAs, for which data is available, of the estimated budgetary allocation for salaries per facility is 1.2 million Naira, ranging from a minimum of 0.2 million Naira to a maximum of 8.1 million Naira.

On average across Kogi LGAs, the estimated actual annual salary cost per facility is 1.6 times the estimated annual budget allocation for salaries per facility. This statistic by itself may suggest that the problem of non-payment of salaries arises due to inadequate budgetary allocations.⁸ However, it may also be reasonable to expect that the estimate for average actual salary cost per facility is an overestimate of actual costs since the average monthly salary is reported by staff of higher grades that were selected for the interview, and then applied to all the staff in the facility. In fact, similar calculations for Lagos state, with no significant problem of non-payment of salaries, show the estimate of

⁸ Although, even this interpretation is indicative of mismanagement at local levels as it begs the question of why LGAs do not restructure personnel hires in line with available resources.

actual salary costs to be 1.3 times, on average, the estimate of budget allocations per facility.

Yet, a comparison, LGA by LGA, of the number of months staff on average reported salaries not being paid, and the ratio of estimated actual costs to budgeted allocations reveals that there are several LGAs where salaries were not paid even when estimated budget allocations were sufficient to cover estimated actual costs. Conversely, there are LGAs where the estimated actual costs are more than twice the estimated budgeted allocations, and yet staff report only a couple of months of non-payment, which could be due to administrative delays alone.

Table 5 reports the average number of months in each Kogi LGA that staff reported not having salaries paid in the past year before the survey, against the ratio of our estimate of the average salary cost per facility in the LGA to our estimate of the average budgeted allocation towards salary cost per facility in the LGA. If the problem underlying non-payment of staff salaries is inadequate LGA budget allocations for this purpose, then we should see a strong positive correlation between these variables—the higher is the estimate of actual salary costs as compared to budgeted allocation the greater should be the number of months of non-payment. In fact, the correlation between these two series is negative.

Furthermore, there are striking examples of LGAs such as Bassa, Idah, Lokoja, and Olamaboro where salaries were not paid for more than 5 months in the year before the survey, yet estimates of salary costs in a typical facility are below or almost equal to what the LGA reports as budgetary allocations towards staff salaries in a typical facility.

All of the analysis described above suggests that the problem of non-payment of staff salaries in Kogi may not be lack of budgetary allocations for this purpose but rather leakage in resource flows at the LGA level. Misuse of public resources by local agents might be particularly rampant when these resources are obtained as transfers from higher tiers of government, and about which local citizens might not be well informed since they are not the direct tax-payers. Conversations with local officials and health workers during field work for the survey in Kogi revealed a widespread opinion that local revenues are siphoned off for private gain by local politicians.

LGA	(1) Months in the year before the survey that salary has not been paid (2001-02)	(2) Ratio of Estimated Average Salary Cost per facility (2002) to Estimated Average Budget Allocation per facility (2000)
Adavi	3	1.9
Bassa	9	0.8
Dekina	10	2.0
Ibaji	2	2.8
Igalamela/Odolu	3	1.9
Idah	5	0.7
Ijumu	6	1.6
Kabba Bunu	6	2.2
Cogí	6	3.1
Lokoja	6	0.5
Mopa Muro	3	N/A
Ogori Magongo	1	0.9
Olamaboro	8	1.2
Omala	4	3.3
Yagaba West	4	1.1
Correlation between columns (1) and (2): -0.15		

4. Impact of non-payment of salaries

What is the impact of non-payment of salaries in Kogi on service delivery outcomes? When staff do not receive salaries for many months, do they stop treating patients? The survey collected data from actual facility records on the number of cases of antenatal care, in-patient deliveries, out-patient consultations, routine immunizations, and home visits (that is, seeing patients in their homes) in the last three months. Table 6a reports regressions at the facility level in Kogi, estimating the impact of average number of months of non-payment of salaries in the facility on services provided on average by

each staff. There is no significant impact of non-payment of salaries on the number of patients seen in the last three months before the survey per staff—for antenatal care (Column 1), in-patient deliveries (Column 2), out-patient consultations (Column 3), and immunizations (Column 4). However, the greater is the average number of months for which staff salaries are not paid in a facility, the greater are the number of home visits by facility staff (Column 5). This is suggestive of health staff providing services privately to households, an interpretation supported by other evidence reported in Table 6b—that the greater the average number of months for which staff salaries are not paid in a facility, the lower the likelihood of the facility being clean, and the greater the probability that essential drugs (chloroquine, paracetamol, and antibiotics) are privately provided by facility staff rather than being facility owned. The available data and evidence does not allow us to distinguish whether the essential drugs are provided by staff out of their personal funds or if they are expropriated from facility stocks for private sale.

In estimating the impact of nonpayment of salaries, we control for type of facility (where an indicator variable captures whether a facility is a Type 2, that is, designed to provide more complex services), distance from LGA headquarters (to proxy for location characteristics), availability of alternate providers, and proxies of LGA-level demographics and wealth (LGA population and internally generated revenues). The only other significant result emerging from including these controls is that lower number of services are provided when there are a greater number of alternate providers in the facility neighborhood. Type 2 facilities are less likely to provide home visits, and more likely to be clean and have drugs that are facility owned rather than privately provided by staff. The impact of non-payment of staff salary is the same even if these controls are excluded.

These results suggest that although non-payment of staff salaries does not lead to an obvious decline in health services provided, it is probably causing staff to provide services privately, in exchange for remuneration from their patients. It should, however, be indicated here that this impact of non-payment of staff salaries is being estimated for facilities that are still functioning and therefore responding to the survey questions, and does not capture whatever impact non-payment may have in terms of closing-down of health facilities. Field-work for the survey in fact revealed that several facilities in Kogi

had been closed down for months due to non-payment of staff salaries (Adeniyi, Oladepo, and Soyibo, 2003).

	(1)	(2)	(3)	(4)	(5)
	Antenatal Services	Inpatient Deliveries	Outpatient Services	Immunization	Home Visits
Facility-level avg. no. of months in past year salary not paid	-0.14 (0.69)	0.18 (0.14)	0.47 (1.02)	0.05 (1.57)	2.27* (1.31)
Indicator of Type 2 facility	12.31 (9.12)	0.47 (1.8)	8.37 (12.77)	13.04 (19.23)	-11.24* (6.58)
Distance from LGA Headquarters	-0.02 (0.13)	-0.003 (0.02)	0.31 (0.18)	0.15 (0.27)	0.04 (0.13)
Number of facilities in the neighborhood	-0.35 (0.24)	-0.09* (0.05)	-0.55 (0.41)	-1.40* (0.77)	-0.14 (0.59)
LGA population, 1999	0.0001 (0.0001)	0.00003 (0.00002)	0.0001 (0.0002)	0.0001 (0.0002)	0.000 (0.000)
LGA Internally Generated Revenues Per Capita, 2000	1.01 (0.83)	0.04 (0.03)	-0.21 (0.23)	-0.44 (0.34)	-0.10 (0.18)
Constant	-14.61 (22.42)	-0.94 (2.33)	21.69 (23.96)	55.13 (35.91)	15.50 (21.69)
No. of Observations	95	81	117	88	109
R-sq	0.24	0.12	0.09	0.05	0.08
<i>a. OLS regressions with robust standard errors (in parentheses); * Significant at 10% level; ** Significant at 1-5% level</i>					

Table 6b				
Impact of Non-Payment of Staff Salaries on Facility Characteristics in Kogi^a				
	(2)	(3)	(4)	(5)
	1=Facility is Clean	1=Chloroquine is Privately Owned	1=Paracetamol is Privately Owned	1=Antibiotics is Privately Owned
Facility-level avg. no. of months in past year salary not paid	-0.02** (0.01)	0.02** (0.01)	0.03** (0.01)	0.03** (0.01)
Indicator of Type 2 facility	0.19** (0.06)	-0.25** (0.09)	-0.17* (0.10)	-0.11 (0.10)
Distance from LGA Headquarters	0.000 (0.001)	0.000 (0.002)	0.000 (0.002)	0.001 (0.002)
Number of facilities in the neighborhood	0.000 (0.006)	-0.001 (0.005)	0.003 (0.005)	-0.001 (0.005)
LGA population, 1999	0.000 (0.000)	0.000 (0.000)	-0.000 (0.000)	-0.000 (0.000)
LGA Internally Generated Revenues Per Capita, 2000	0.003 (0.002)	-0.001 (0.002)	-0.002 (0.002)	-0.002 (0.002)
Constant	0.74** (0.15)	0.27* (0.16)	0.24 (0.15)	0.24 (0.16)
No. of Observations	141	141	141	141
R-sq	0.11	0.10	0.12	0.11
<i>a. OLS regressions with robust standard errors (in parentheses); * Significant at 10% level; ** Significant at 1-5% level</i>				

5. Policy Lessons and Conclusions

The evidence presented here, correlating the non-payment of salaries with local revenues and spending on salaries, suggests that the problem is one of general accountability of local governments in managing substantial resource transfers from taxpayers outside their jurisdiction. This problem of non-payment of salaries of health staff by local governments is reminiscent of a similar problem of non-payment of teacher salaries in primary schools in the 1990s, when primary education was decentralized to

local governments (Olowu and Erero, 1995). Following nation-wide agitations by teacher unions a policy of deducting primary school teacher salaries from the revenue share of local governments in the Federation Account was adopted (termed “deductions at source”), with the salaries being directly passed-on to the teachers.

This “solution” of essentially converting a portion of an untied federal transfer into a specific purpose grant for teacher salaries, although successful in ensuring that teachers get paid, has unintended pernicious effects of undermining overall accountability of local governments. Local governments claim that deductions at source in essence lead to “zero allocations”, thereby preventing them from carrying out any of their responsibilities for service delivery (The World Bank, 2003). Such uncertainty about resources actually available to local governments facilitates local evasion of responsibility under the guise of fiscal powerlessness. What local governments do receive as transfers is therefore sometimes treated as the personal fief of local politicians (The World Bank, 2002).

The evidence of an overall problem of accountability of local governments suggests that the design of intergovernmental transfers is likely to be a blunt instrument to strengthen incentives for better allocation of public resources. Providing incentives to local governments to improve performance through additional resource transfers (additional to their constitutionally determined share in federal revenues) *conditional* on actual improvements in service delivery, will only have the desired impact if incentives of higher tiers of governments are better aligned to improve services, and if transfers are large enough to persuade local governments to relinquish their capture of existing resources. The literature on conditional or matching grants from other parts of the world usually takes as given that local governments are accountable to local citizens, and the incentive component of the grants is largely intended to make local communities internalize potential spillover effects of local investments for the national good.

The conditions under which local governments, or any elected government for that matter, will have the right incentives to improve the delivery of basic services have been explored in a large political economy literature, and one of the “solutions” to these political constraints suggested by the literature is greater information dissemination about

the roles and responsibilities of government, and the outcomes of public resource allocation (see Keefer and Khemani, 2003, for a review of the literature and suggested solutions). Based on this political economy view of public accountability this paper proposes a specific type of policy intervention to strengthen local accountability, namely, providing citizens with greater information about the resources and responsibilities of their local representatives, so they are empowered to hold them accountable for the delivery of basic services.

A similar information-dissemination strategy, through public radio and other media, was adopted in Uganda after survey evidence revealed that district governments were not transferring budgeted resources to schools. A follow-up survey in Uganda showed that this information dissemination had a substantial impact in preventing leakage of public funds away from purposes intended in public budgets (Reinikka and Svensson, 2001). However, there is very little systematic research evidence on whether information dissemination truly has an impact, or what forms of dissemination are likely to have greater impact; yet, theoretically, it seems to be a reasonable way to proceed. Designing a rigorous impact evaluation component to policy experiments with information dissemination would therefore be valuable to enhance our understanding of what works and what doesn't, and how best to design institutional interventions to improve public accountability.

There is potentially a role for combining conditional transfers with information dissemination. The Nigerian Constitution provides for a commission to be appointed by the President, with members nominated by each state, to advise the President and Parliament upon intergovernmental transfers—the Revenue Mobilization Allocation Fiscal Commission. The RMAFC could serve both as an agency for determining conditional transfers based on costs of providing minimum basic services, and an information dissemination agency, widely publicizing data on costs and service provision used to determine the transfers. Such a strategy would only be effective if the agency determining transfers, and disseminating the information upon which transfers are based, is reasonably independent from the political process. Khemani (2003) provides evidence from India that constitutional rules can enable an independent agency to determine intergovernmental transfers to promote regional equity and curb political influence.

Fiscal federalism in Nigeria is at the heart of a public debate within the country over why its enormous public resources have delivered such poor results in terms of services available to the majority of citizens. A widespread opinion shared by policy arenas, academic circles, and popular media, is that if resources are redistributed between the three tiers of government, by increasing the share of sub-national governments, the problem of wasted public resources will be solved. To this purpose, a new revenue allocation formula has recently been debated within the National Assembly, scrutinized by the Supreme Court for constitutional validity, and is now in the process of being implemented by executive order of the President. This new formula is expected to substantially increase resource flows to states and local governments. The evidence provided in this paper suggests that merely redistributing resources across the three tiers of government is unlikely to solve the problem of public accountability, and that more fundamental interventions rooted in the political economy of incentives of governments are required to make basic services work for the poor.

Appendix

A survey of local governments and primary health facilities in the states of Lagos and Kogi was undertaken in 2002 in partnership by the World Bank and the National Primary Health Care Development Agency (NPHCDA)—the overarching government agency in Nigeria responsible for monitoring and supervising outcomes in primary health care service delivery. The African Regional Health Education Centre at the University of Ibadan was the local agency that implemented the survey.

The survey instruments were developed through an iterative process of discussions between the World Bank team, NPHCDA, and local consultants at the University of Ibadan, over the months of March-May 2002. During May 2002, four questionnaires were finalized through repeated field-testing—1) Health Facility Questionnaire: to be administered to the health facility manager, and to collect recorded data on inputs and outputs at the facility level; 2) Staff Questionnaire: to be administered to individual health workers; 3) Local Government Treasurer Questionnaire: to collect local government budgetary information; and 4) Primary Health Care Coordinator Questionnaire: to collect information on local government activities and policies in primary health care service delivery. The survey was undertaken during June-August 2002, with data collected in 30 local governments in Lagos and Kogi states, 252 health facilities, and from over 700 health workers.

A multi-stage sampling process was employed where first 15 local governments were randomly selected from each state; second, 100 facilities from Lagos and 152 facilities from Kogi were selected using a combination of random and purposive sampling from the list of all public primary health care facilities in the 30 selected LGAs that was provided by the state governments; third, the field data collectors were instructed to interview all staff present at the health facility at the time of the visit, if the total number of staff in a facility were less than or equal to 10. In cases where the total number of staff were greater than 10, the field staff were instructed to randomly select 10 staff, but making sure that one staff in each of the major ten categories of primary health care workers was included in the sample.

A list of replacement facilities was also randomly selected in the event of closure or non-functioning of any facility in the original sample. An inordinate amount of facilities were replaced in Kogi (27 in total), some due to inaccessibility given remote locations and hostile terrain, and some due to non-availability of any health staff. The local community volunteered in these cases that the reason there was no staff available was because of non-payment of salaries by the LGA. This characteristic of the functioning of health facilities in Kogi is a striking result that is analyzed in this paper. Given that the sample selection of facilities in Kogi might be biased due to the replacement of facilities that were non-functional, the results reported here for the non-payment of staff are likely to be underestimated. Details of the survey and related field work is provided in Adeniyi et al (2003).

References

- Adeniyi, J., O. Oladepo, and A. Soyibo. 2003. "Survey of Primary Health Care Service Delivery in Lagos and Kogi: A Field Report." African Regional Health Education Center, University of Ibadan.
- Ekpo, A. and J. Ndebbio. 1998. "Local government fiscal operations in Nigeria," AERC Research Paper No. 73, African Economic Research Consortium, Nairobi: Kenya
- Federal Republic of Nigeria, Federal Ministry of Health. 1996. National Health Policy. Abuja, Nigeria
- Keefer, P. and S. Khemani. 2003. "The Political Economy of Public Expenditures." Background paper for the *World Development Report 2004: Making Services Work for Poor People*, Development Research Group, World Bank, Washington, D.C. Processed.
- Khemani, S. 2003. "Partisan Politics and Intergovernmental Transfers in India", Policy Research Working Paper No. 3016, The World Bank, Washington, DC
- Khemani, S. 2001. "Fiscal Federalism and Service Delivery in Nigeria: The Role of States and Local Governments", Mimeo, Development Research Group, The World Bank, Washington, DC
- Nigeria National Primary Health Care Development Agency, 2001. *The Status of Primary Health Care in Nigeria: Report of a Needs Assessment Survey*
- Olowu, Dele and John Erero, 1995, "Nigeria: Institutional Delivery Mechanisms and the Poor, Faculty of Administration", Background Paper Prepared for the World Bank Poverty Assessment Report, Obafemi Awolowo University, Ife-Ife, Nigeria
- Reinikka, R. and J. Svensson. 2001. "Information and Voice in Public Spending." Mimeo, Development Research Group, The World Bank.
http://econ.worldbank.org/files/15157_PSproject.informationandvoice.reinikka.may1.pdf
- The World Bank. 2003. *Nigeria: State Finances Study*, Sector Report No. 25710, Washington, DC
- The World Bank. 2002. *State and Local Governance in Nigeria*, Sector Report No. 24477, Washington, DC
- The World Bank. 1996. *Nigeria: Poverty in the midst of plenty: the challenge of growth with inclusion: A World Bank Poverty Assessment*, Sector Report No. 14733, Washington, DC