

# **India Rural Governments and Service Delivery**

**Volume II: Policy Note**  
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### List of Abbreviations and Acronyms

APL	Above Poverty Line	NGO	Non Governmental Organization
ARWSP	Accelerated Rural Water Supply Program	O&M	Operation and Maintenance
BG	Beneficiary Group	PC	Partially covered habitation
BP	Block <i>Panchayat</i>	PHC	Primary Health Center
BPL	Below Poverty Line	PHED	Public Health Engineering Department
CHC	Community Health Center	PRI	<i>Panchayat Raj</i> Institution
CSS	Centrally Sponsored Schemes	RGNDWM	<i>Rajiv</i> Gandhi National Drinking Water Mission
DP	District <i>Panchayat</i>	RSM	Rural Sanitary Mart
DRDA	District Rural Development Agency	RWSS	Rural Water and Sanitation Service
EAS	Employment Assurance Scheme	SC	Scheduled Caste
GO	Government Order	SFC	State Finance Commission
GOI	Government of India	SGRY	<i>SampoornaGrameen Rozgar Yojana</i>
GP	<i>Gram panchayat</i>	SGSY	<i>Swaranjayanti gram swarozgar yojana</i>
HRD	Human Resource Development	SHG	Self-Help Group
IEC	Information, Education, Communication	SIPRD	State Institute of <i>Panchayati Raj</i> and Rural Development
JRY	<i>Jawahar Rozgar Yojana</i>	SRP	Sector Reform Project
KILA	Kerala Institute of Local Administration	SSA	<i>Sarva shiksha abhiyan</i>
KWA	Kerala Water Authority	SSK	<i>Shishu shiksha karmasuchi</i>
M&E	Monitoring and Evaluation	ST	Scheduled Tribes
NC	Not covered habitation	TSC	Total Sanitation Campaign
NCRC	National Commission for the Review of the Constitution	VWSC	Village Water and Sanitation Committee
		WDR	World Development Report

#### ***Glossary***

Crone	1,000,000
<i>Gram sabha</i>	assembly of voters at ward level
Lakh	100,000
<i>Panchayat</i>	rural local government body
Taluk	block
Zilla	district

**Currency Equivalents: Indian Rupee (Rs.) US\$1.00 = Rs. 44.64 (March 31, 2006) Fiscal Year (FY): April 1 – March 31**

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## Introduction

This study addresses the roles of different levels of government and the institutional arrangements involved in the provision of key services. The focus throughout is on disadvantaged rural areas. This is the third and last of a series of studies on rural decentralization carried out since 1999 by the Bank. The first study, *Overview of Rural Decentralization in India* (2001), is an internal Bank document on the emerging institutional landscape and issues. The second study, *Fiscal Decentralization to Rural Governments in India* (2004) describes *panchayat* finances in Kerala and Karnataka, and an analysis of those issues in the fiscal framework for local governments that hamper effective functioning.

The present study intends to assist the Government of India and state governments in defining the role of *panchayats* in the delivery of key services to rural people. To this end, it proposes a conceptual framework, then applies the criteria elicited from this framework to four key sectors: health, education, drinking water and sanitation, and employment programs. But this is not a study *about* those services/ programs. Taking rural decentralization for granted, it is a study on what the various levels of *panchayats* could do in the delivery of those services within the government structure created by the 1993 Amendment to the Constitution of India and relevant state-level legislation. The study demonstrates the approach for a small number of sectors that have been “devolved” to rural governments (*panchayats*), but it is immediately applicable to any other sector of the 29 subjects eligible for devolution.

The study focuses on Kerala, Karnataka, West Bengal and Rajasthan -- four states that cover a range of situations in India. Since the assignment of responsibilities to local governments is a state responsibility, Indian states have followed different approaches. All four states examined by this study have shown commitment to devolution in principle; but they differ considerably in the characteristics and pace of reforms (see Volume III, Box I.3).

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## Policy Note

### 1. The problem of service delivery

#### *Introduction*

**This study intends to assist the Government of India and state governments in defining the role of *Panchayats* in the delivery of key services to rural people.** It proposes a framework for answering this question and then applies the methodology to four key sectors: health, education, drinking water and sanitation, and anti-poverty programs<sup>1</sup>. But this is not a study about education, health or drinking water. It is a study on what the various levels of *Panchayats* could do in the delivery of these services within the decentralized government structure created by the 1993 Amendment to the Constitution of India. The study demonstrates the approach for a small number of sectors that have been “devolved” to rural governments (*Panchayats*), but it is immediately applicable to any other subject of the 29 eligible for devolution.

**It focuses on four states.** The study focuses on Kerala, Karnataka, West Bengal and Rajasthan -- four states that cover a range of situations in India. Since the assignment of responsibilities to local governments is a state responsibility, Indian states have followed different approaches. All four states examined by this study have shown commitment to devolution in principle, but they differ considerably in the characteristics and pace of reforms

#### *The context*

**India has made bold efforts to strengthen the voice of the rural poor through decentralization to local governments.** The 1993 Constitutional Amendment created a decentralized government structure. Bringing government closer to the rural people improves the match between diverse local preferences and public services. It strengthens the voice of local people and the accountability of public sector decision-making to them, through the democratic process, and because of greater transparency since local actions is more visible to local people. In a country as large and diverse as India along ethnic, linguistic, geographical, resource endowments, climate and economic development, it is hard to conceive how central and state level programs could succeed in addressing and responding to this diversity. Decentralization thus became the critical core of India’s strategy to improve service delivery. The 73<sup>rd</sup> Constitutional Amendment of 1993 created three tiers of democratically elected sub-state rural governments -- at the district level (district *panchayat* or DP); the block level (block *panchayat* or BP) and the village level (*gram panchayat* or GP). The Amendment specifies a list of 29 subjects that states can choose to devolve to rural governments at the district, block or village levels. Since decentralization was defined as a state subject, different states have pursued varying strategies to empower rural governments.

**India is and will continue to be a rural country for a long period of time.** Seven hundred million people still live in rural areas, most in villages; and of these, about 400 million are poor, the largest number in a single country in the world. In response to the needs of the rural poor, the central and state governments have been the major providers of basic public services since Independence. The primary responsibility was to rest with state governments; centrally sponsored

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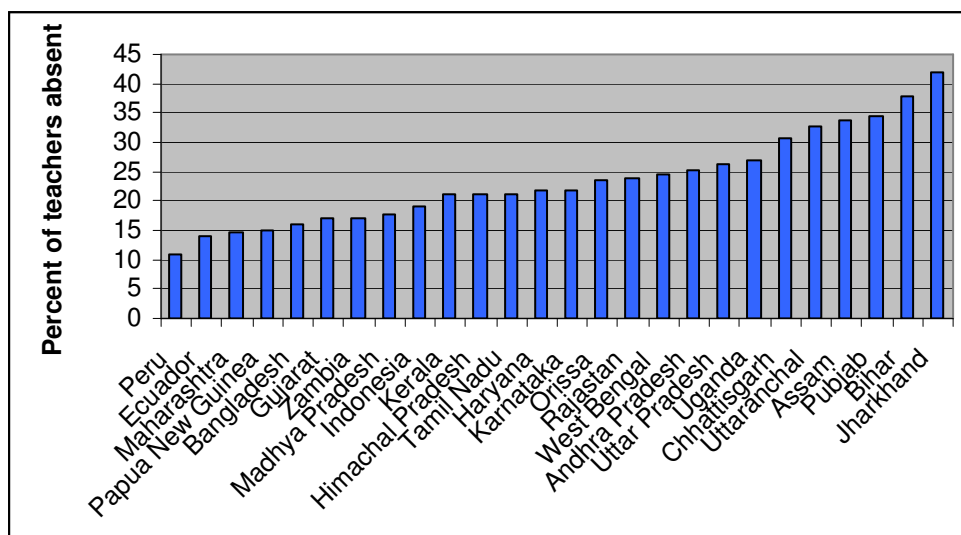
<sup>1</sup> When we started this study and subsequently the surveys, National Rural Employment Guarantee Act (NREGA) had not been approved. Hence this report looks at Sampoorna Grameen Rozgar Yojana (SGRY) only. In the main report (Vol. I, II & III) we have a box on NREGA and how it differs from SGRY.

schemes (CSS) were also introduced to complement the physical efforts and financial resources of the state governments.

**But key services are failing.** Basic education, health, water and sanitation, employment programs and others – are still not reaching disadvantaged rural people. Illiteracy is high and teacher’s absenteeism rampant. Local public clinics and other government run curative services do not match demand, and 80% of these services are now provided by the private sector, imposing costs on the rural poor. Quality of drinking water leaves much to be desired, and sanitation campaigns have for the most part failed. The reach of employment programs is not commensurate with the level of expenditures in them. The main reason for failure is the delivery system -- a centralized system used by both center and state to implement programs via civil servants mapped into sectoral line agencies. This situation is serious. It not only threatens to leave India behind on the MDGs, but it could once again jeopardize the younger generations that comprise about half of India’s population, making India miss once again the opportunities for fast and equitable growth.

**The evidence shows that the current state of basic education delivery in rural India is far from effective -- in attainment, in provision of the basic services, and in learning achievement.** The 1999 Public Report on Basic Education in India (PROBE) found considerable evidence of similar absenteeism and “non-teaching.” Subsequent nationwide studies<sup>2</sup> using large samples and careful methodologies confirmed that teacher absenteeism in India is very high in comparison with other developing countries (see Figure 1). Almost 25 percent of teachers are absent from work at a given time in India.<sup>3</sup> While Kerala did relatively well compared to other states, its absence rate was still higher than any other country in the sample (except Uganda). Another indicator of service failure is the low educational attainment, which, measured as years of schooling completed, is low. This is most apparent for the poor; and the combination of being poor, rural and female produces particularly appalling attainment rates. Learning achievements are also poor and highly variable and not commensurate with the amount of public expenditure that goes to education.

**Figure 1: Teacher absence: a comparison of multi-country figures and the four states**



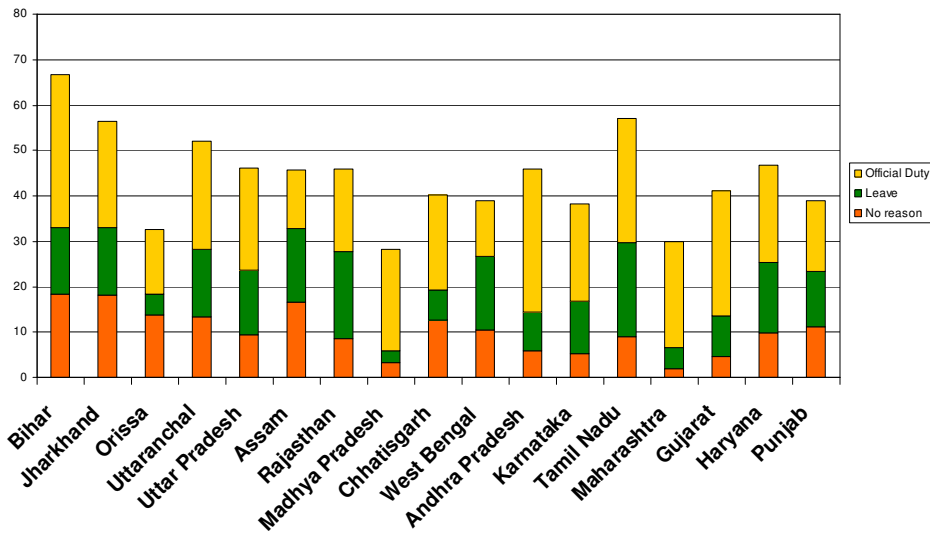
<sup>2</sup> Such as Kremer et al, 2004.

<sup>3</sup> The percentage is likely to be even higher if a rural-only sample is taken.

**In the health sector too, indicators of failing service are high absenteeism in doctors, low quality in clinic care, low satisfaction levels with care (clinical and with regard to courtesy, amenities etc.) and rampant corruption<sup>4</sup>.** This has led to mistrust of the system, a rapid increase in use of the private sector and its attendant problems: high out of pocket expenditures that take a serious toll from families and quality of care that is highly variable (from much worse to much better than in public facilities). At least one quarter of hospitalized Indians fall below poverty line because of hospital expenses. An important reason for this appalling health scenario has been the lack of accountability in the public health services.

**Let us consider absenteeism<sup>5</sup> among medical care providers.** Figure 2 shows the results of a large scale study of surprise visits to health facilities in all major states. The first thing to notice is the very high average level of absenteeism for the country as a whole.. There are legitimate reasons for being away from posts such as leave or official duty. However, the numbers claimed for being on leave are much higher than are legitimate given leave rules. The study also found that absenteeism was worst in the smaller sub-centers (for staff that were not supposed to be on home visits), followed by the primary care centers. The lowest absenteeism was in the few Community Health Centers (small hospitals) in the sample.

**Figure 2: State-wise absentee rates in primary health care facilities**



**Moreover health subsidies are regressive across income groups.** Figure 3 shows the incidence of public subsidy in health in each of the states. The data is from the 1995 NSS, so this picture of the health system is prior to the move towards decentralization.<sup>6</sup> The only state for which we might expect a difference between then and now is Kerala. We observe a regressive pattern of subsidy across the states. More important for the use of public finance is the pattern of subsidy across income groups. Who benefits more from public spending in healthcare, the poor or the better off? In general, the health care system in India is regressive: more public money goes to the

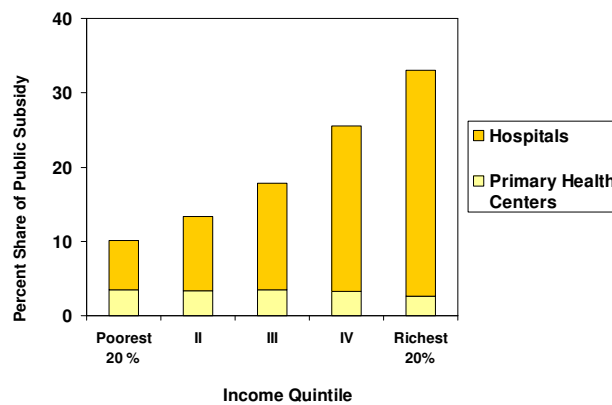
<sup>4</sup> Transparency International (2005), Chaudhury et al, (2006a, b), J. Das and Hammer (2005, 2006), Vishwanathan

<sup>5</sup> Chowdhry, 2005.

<sup>6</sup> All the data for the NSS analysis and the calculations of public subsidies comes from Mahal et al, 2002.

relatively well off than to the relatively poor. This is particularly true of Rajasthan, where the system appears to be transferring income from the average taxpayer to doctors and to relatively well off patients. Predictably, the main exception is Kerala, where the overall usage of the health system -- public or private – is much higher than elsewhere. Moreover, the share of visits to public facilities in Kerala falls by income for primary care, unlike India as a whole or any of the other states.<sup>7</sup> Even in the case of hospital visits, the difference across income groups is quite small in the rural areas in Kerala, in contrast to every other state studied and the all-India average. Further, Kerala charges substantially higher rates for the relatively well off, and this helps to make the overall incidence of health spending neutral or slightly progressive.

**Figure 3: Incidence of public subsidy in health in India and the four states**



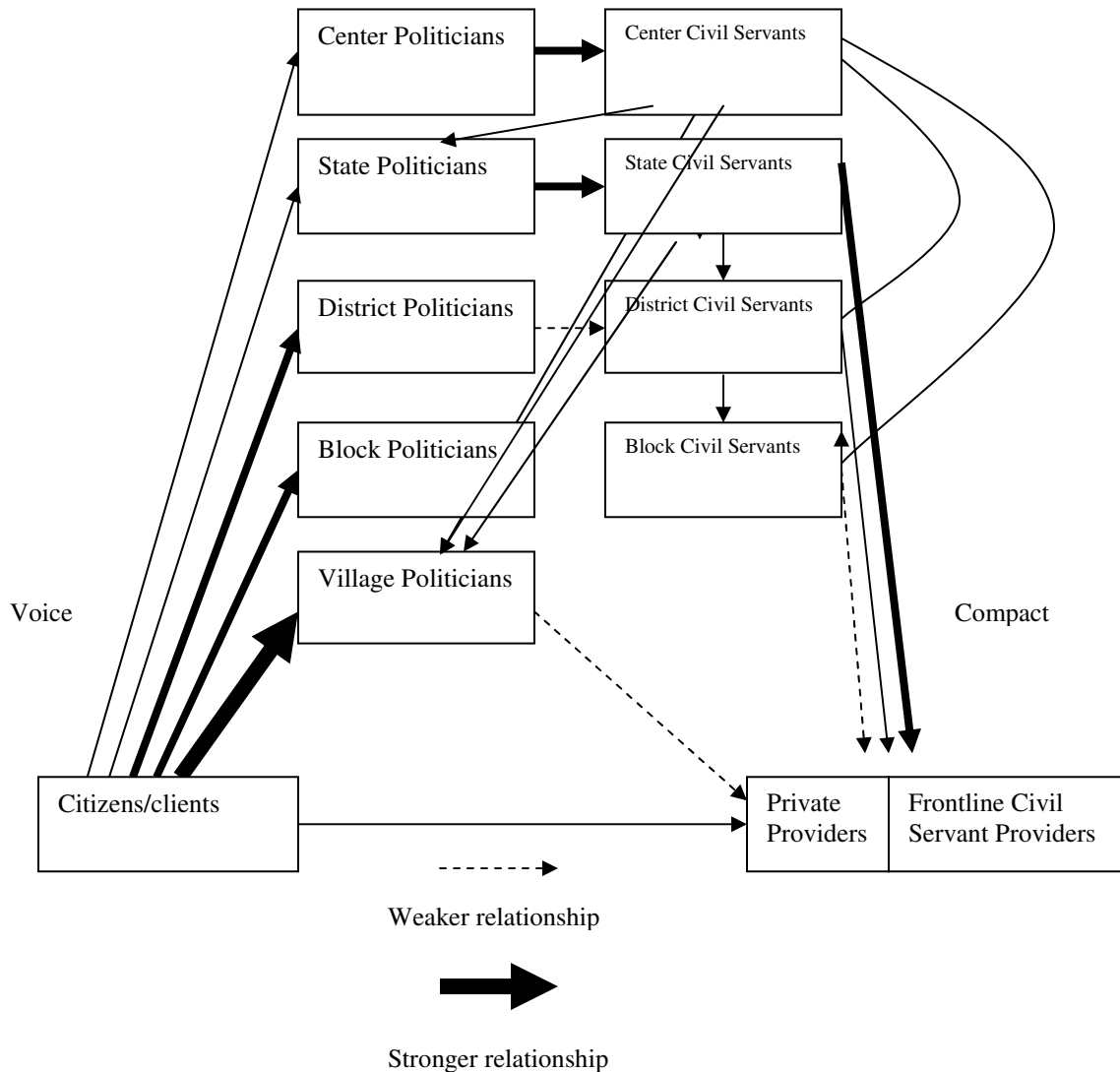
**Services are failing because accountability is failing.** Three of the problems plaguing service delivery are: first the confused, overlapping and incomplete responsibilities of different tiers of government; second lack of accountability to citizens, specially the rural ones, and third weak and/or ineffective systems for the “contracting” of service providers to provide these services. Confused responsibilities undermine accountability to rural people, since if the delivery of one service such as drinking water fails, people will not know whom to blame and threaten to remove from office through the democratic process. Elected representatives can evade their responsibilities since they can easily point the finger at politicians at a different level of government. Overlapping reduces the incentives in the system to improve service delivery. But even where responsibilities for service provision have been clearly defined, accountability fails because providers are not accountable to clients (e.g. teachers to parents) or to their local representatives (e.g. locally elected representatives). The weak rules for holding service providers accountable make it easy for these providers to get away with no or low quality delivery and increases transaction costs. But roles should not be assigned arbitrarily. Certainly village governments can do some things better while state line agencies have other advantages.

**One reason for lack of accountability is because there is confusion with the assignment of roles to the public sector, and within it to different levels of government).** All levels of government seem to intervene in the provision of the same services. For example, a recent count in Karnataka listed 24 programs for drinking water supply and 72 programs for the welfare of tribal people; five levels of government were involved in the provision of these programs. Again, there are close to 500 different public programs in health, running through five levels of

<sup>7</sup> Karnataka is difficult to classify on this ground.

government. Moreover, the failure of these has led to around 80 percent of expenditure in the sector being with private providers. How then is India to renew its commitment to the decentralization model and take it forward? The first step is to define what local governments are supposed to do. This means defining roles vis-à-vis the state and the center, and what is to be done by the public sector and the private sector.

**Figure 4: Accountability relationships for rural people: Can it work in India?**



**Though India made bold efforts to decentralize to local governments (e.g. amending the Constitution), the civil service bureaucracy was not dismantled or restructured.** Thus the centralized and decentralized models continued to co-exist, with states oscillating between the two approaches. In most states the numerous problems of the centralized model persist: centralized and canalized resources, centralized delivery mechanisms bound by rules; weak, tightly controlled information; accountability that flows only upward. As a result, the pattern of systemic failure continues to emerge across sectors -- project designs lack beneficiary involvement; responses are geared to "need," as perceived by higher level bureaucrats, not to

demand better services; and the pressure for cost-efficiency and actual delivery of services is lacking. More importantly, the continuing overwhelming presence of the state sectoral machinery has not opened a space for local governments to emerge and grow.

**This study builds on other studies.** This study addresses the issue of the roles of different levels of government and the institutional arrangements involved in the provision of key services. This is the third of a series of three studies on rural decentralization carried out by the Bank since 1999. The first study, *Overview of Rural Decentralization in India* (2001), is an internal Bank document on the emerging institutional landscape and issues. The second study, *Fiscal Decentralization to Rural Governments in India* (2004) provides a description of *panchayat* finances in Kerala and Karnataka, and an analysis of those issues in the fiscal framework for local governments that hamper effective functioning. This study does not finish the work. The operational relevance for government and donors, the transitional arrangements, and the costing out of the proposed recommendations still need to be carried out to identify a viable way forward.

## 2. The conceptual framework

### Criteria for analysis

**Key public services are services for which there is broad consensus that some type of government action is necessary, desirable, and/ or inevitable.** They include essential functions ranging from ensuring law and order to development programs with a strong rationale for public sector involvement -- such as irrigation, sanitation, improved water supply, and components of education and health. Even if the private sector can, in principle, provide these services, it is unlikely that the government can escape assuming responsibility in cases of failure.<sup>8</sup>

**This study aims at making recommendations on responsibilities within the decentralized government structure in rural India.** For example, how do we decide how to allocate responsibilities to the various levels of government for the array of unbundled activities involved in providing a system of primary education? Who should be responsible for buying desks? The state, the district, the block or the GP?

**We use two related frameworks that advance criteria for deciding which level of government should do what.** One criterion stems from public finance and welfare economics, the other from the principal/agent problem elaborated in WDR 2004.

### Public finance criteria

There are four traditional public finance criteria for choosing the size of the jurisdiction that should be responsible for a public service:

- Economies of scale or scope: Since the unit cost of production declines as the scale of production increases, the general rule in public finance is to allow for a sufficiently large market and avoid inefficient production costs.
- Scope of the externality: An “externality” refers to a consequence of one person’s action on another. The geographic extent of an externality can range from very local (the impact of one person’s radio on his neighbor’s sleep), to the global (the impact of one country’s emissions of greenhouse gases on another country’s climate). The general rule in public finance is to

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<sup>8</sup> California’s recent electricity crisis is one such example.


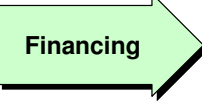



make the geographic extent of the jurisdiction coping with a problem large enough for the “external” effect to be “internalized” in the jurisdiction. For instance, if adjacent cities share a river, sewage dumped by one affects the citizens of the city downstream; while if it were one city, the effects are “internal” to the city.

- Equity: Education is a good example of this welfare economics criterion. In India, for instance, the goal of universal elementary education is enshrined in the Constitution, the law, and the policy pronouncements of both central and state governments. Thus the system being designed cannot, in theory, be planned to be less than universal.
- Heterogeneity of demand: Decentralization is expected to improve service delivery when it allows a better correspondence between local conditions and preferences, and the activities undertaken by the government.

### **Accountability criteria**

**Accountability is a relationship among actors that has five features: delegation, finance, performance, information about performance, and enforceability.** Relationships of accountability can be as simple as buying a sandwich or going to a doctor – and as complex as running a democracy. For example, in buying a sandwich you ask for it (delegation) and pay for it (finance). The sandwich is made for you (performance). You eat the sandwich (which generates relevant information about its quality). And you then choose to buy or not buy a sandwich another day (enforceability). Similarly, in going to a doctor, you go to the clinic to be treated (delegation), you pay the doctor for the treatment (finance), the doctor tries to cure your ailment (performance). You follow the doctor’s advice (which generates information about how good his treatment was) and see if you are feeling better. And you go to him next time (if he was good) or choose to go somewhere else if not (enforceability). This is shown in Figure 5 below.

Figure 5: Demystifying Elements of Accountability Relations

What is 'Accountability'? – Demystifying the Elements of the Accountability Relations			
There are Five Features to Any Accountability Relationship			
Feature	What	Example 1: Buying a Sandwich	Example 2: Going to a Doctor
 Delegation	You give a task to the accountable 'agent'	<ul style="list-style-type: none"> <li>You ask for a sandwich</li> </ul>	<ul style="list-style-type: none"> <li>You go to the doctor to be treated</li> </ul>
 Financing	You give the 'agent' the money to do the task	<ul style="list-style-type: none"> <li>You pay for the sandwich</li> </ul>	<ul style="list-style-type: none"> <li>You pay the doctor for the treatment</li> </ul>
 Performing	The 'agent' does the assigned task	<ul style="list-style-type: none"> <li>The sandwich is made for you</li> </ul>	<ul style="list-style-type: none"> <li>The doctor treats you to try cure your ailment</li> </ul>
 Informing	You find out how well the 'agent' has done the work	<ul style="list-style-type: none"> <li>You eat the sandwich which informs you of its quality</li> </ul>	<ul style="list-style-type: none"> <li>You see if you are feeling better – you assess the performance of the doctor</li> </ul>
 Enforcing	You reward good performance and punish bad performance	<ul style="list-style-type: none"> <li>You choose whether to buy a sandwich from the seller the next time, affecting his profits</li> </ul>	<ul style="list-style-type: none"> <li>You go to him next time (if he was good) or choose to go somewhere else if not</li> </ul>

**One important point emerge from this framework: all aspects must be present.** First, weaknesses in any aspect of accountability can cause failure. One cannot strengthen enforceability – holding providers responsible for outputs and outcomes – in isolation. If providers do not receive clear delegation, precisely specifying the desired objectives, increasing enforceability is unfair and ineffective. If providers are not given adequate resources, holding them accountable for poor outcomes is again unfair and ineffective. Second, putting finance as an important step in creating a relationship of accountability stresses that simply caring about an outcome controlled by another does not create a relationship of accountability.

**For a public good or in the case of a market failure, the government may decide to step in and act as an intermediary between the buyer (a patient, a student, etc.) and the seller (the health worker, teacher etc.).** Whenever it does so and expects to do better than the market transaction it is replacing, it has to make sure that the provider has the same or better incentives to satisfy the needs and desires (the demand) of the client. For a government, this means that two steps are necessary for providers to satisfy consumers—(i) the government (the policy maker) has to have a clear understanding of what the citizenry wants. We hope that the citizenry includes the poor - especially if the reason the government has stepped in is for improving equity; and (ii) the policy maker must be able to transmit these demands to the actual provider of services and to make sure that the incentives for these providers are aligned with the ultimate preferences, or well-being more generally, of the citizens. The minister of health does not personally give vaccinations. S/he sets up rules, personnel policies, issues directives, payment and management

systems, etc., to have these vaccinations done. The vaccinations themselves are given by real people with real constraints and preferences of their own. The trick is to ensure that the incentives to the provider continue to reflect citizens' interests.

**This two step process (i.e is people to Government, and Government to service providers) and its comparison with the direct transaction through a market was the essence of the WDR approach to accountability.** Figure 6 outlines the relationships of accountability<sup>9</sup>. Each of the three accountability relationships (voice, compact, and client power) has the five features: delegation, finance, performance, information and enforceability. In what ways do relationships of accountability decide how public services should be delivered? Elaborating on this set of accountability criteria, WDR 2004 argues that failures in service delivery can be traced to the weak accountabilities in the current system of institutional structures involved in the delivery of a service. This systemic approach implies that attempts to improve education or health that deal only with “proximate determinants” of learning, and expand the “business as usual” format, are bound to have only marginal impact. If the system creates no incentives for effective learning, then no budget increase or new knowledge is likely to improve conditions.

**The study first unbundled the four sectors into services and activities.** These activities have different characteristics that could make them candidates for assignment to different levels. Unbundling also allows a better characterization of who is doing what and helps identify where key failures are happening.

**The second step was to interpret the implications of legislation.** This is important, given the debate on whether existing legislation clearly mandates devolution, or is broad enough to allow different forms of service provision.

**The third step was addressing the question of how services are actually being delivered.** Two aspects of service delivery were covered: the behavior of agents engaged in service delivery, including civil servants, politicians, and providers at different levels, to decide whether actions are consistent with legislation; and an overview of service delivery outcomes from these sets of behaviors.

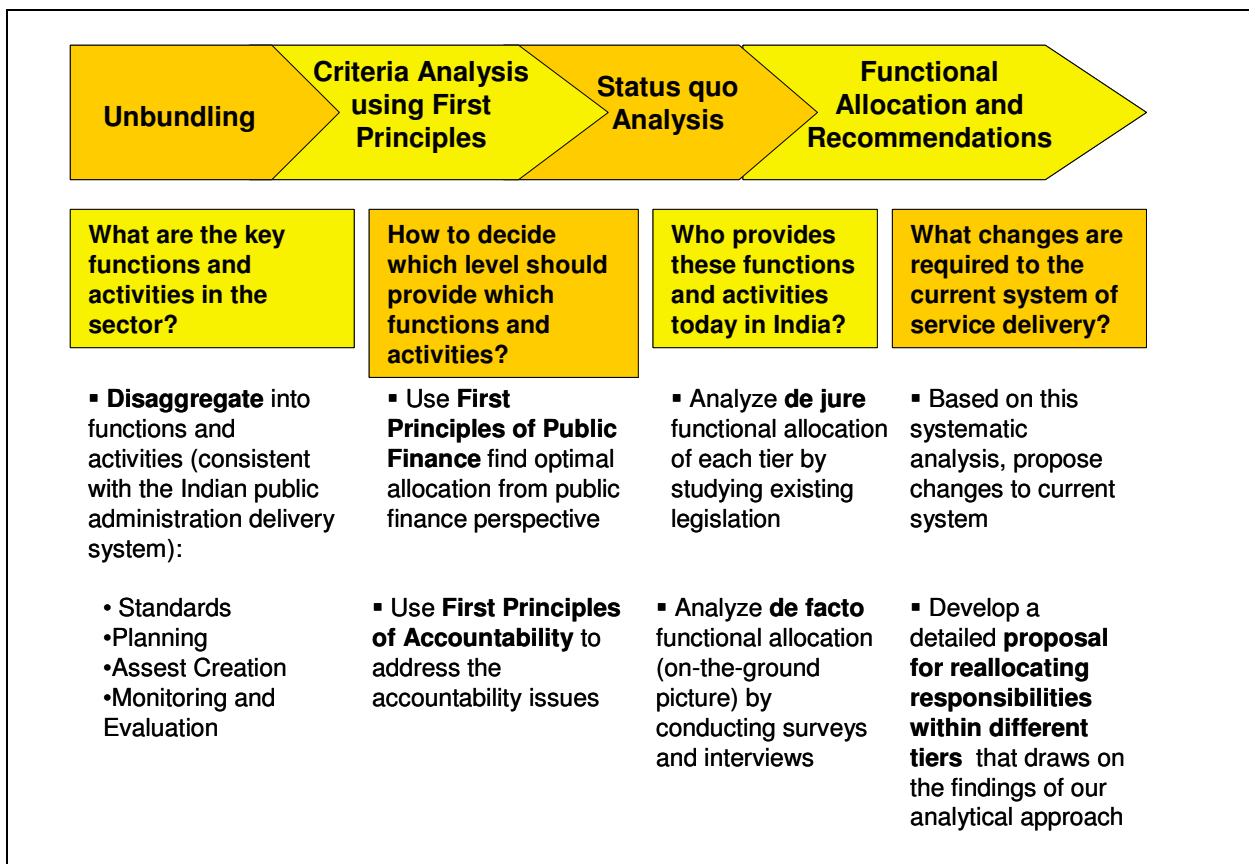
**The fourth step was applying the first principles drawn from welfare theory, as well as the relationships of accountability, to provide some guidance about who should provide which services.** In fact these two sets of principles are similar and yield the same conclusions; they are a way of looking into the issues with different lenses.

**The underlying hypotheses are that there are three main mismatches in the Indian system.** There is a mismatch between what is desirable in terms of responsibility of different government tiers for delivering activities necessary for a service. There is a mismatch between what is desirable and what the Indian and state legislation says. And there is a mismatch between what the legislation says and what is being implemented. To address service delivery government will need to align the principles, the legislation and the practice.

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<sup>9</sup> In this picture, lines of accountability are illustrated for the two ways to make sure that services are delivered. Services, of course, go from provider to clients/citizens. But the accountability mechanisms to ensure these services get delivered can go in one of two ways: directly to the provider as in a market or through the state (the policy-maker in the diagram). We call these the “short-route” and the “long-route” of accountability respectively.

**Figure 6: An Analytical Approach to Effective Decentralization**



### 3. Unbundling services to assign responsibilities

#### Basic definitions: sectors, services and activities

The exercise of breaking down services into their components – or unbundling – calls for some basic definitions.

Sectors: A sector refers to a collection of services that share aspects of a technical discipline and are expected to lead to a certain outcome in terms of human well-being. Rural education, health, drinking water and sanitation, and welfare are sectors; the outcomes these sectors are expected to have are healthy, educated, and less poor people.

Services: Services are components of the sector, separable in the sense that each service can contribute positively to the sectoral outcome even in the absence of other services. Thus rural health would include services such as immunization, vector control, primary curative care and secondary curative care (hospitals). Even without other services, immunization would improve health outcomes, though not as much as it would if these other health services were also present. Education would include services such as primary, secondary and tertiary education and vocational training.

Activities: Services are made of activities. These cannot be separated from each other; unless all are carried out, an outcome of the desired quality is unlikely. One example of an activity is the

building or repair of schools – essential for the provision of quality education. This classification is, of course, arbitrary and for ease of exposition. Building a school could also have been called a service. Thus it is apparent that defining an activity is not easy. Activities, as used here, are very sector-specific. For example, operating a local health clinic is an activity specific to health. There are many different ways of unbundling services into activities, depending on the characteristics of the service and the purpose of the exercise. But it is useful to identify identical activities across different sectors. Since our ultimate objective is to improve outcomes, the unbundling of a service into activities should be down to a level that enables those in charge to produce a determined output or product. For example, if one necessary output for an education outcome is a school, then one of the unbundled activities is building and repairing schools. Most activities in all sectors can be grouped in this way into five activity groups:

- Policy and standards;
- Planning;
- Asset creation;
- Operation; and
- M&E.

The next question is how these five categories can be applied to each sector (See Table 1).

**Table 1: Matrix of services and activities in the key sectors**

Categories	Sector					
	Education	Health		Sanitation	Employment Programs	Water
		Curative/ Preventive	Primary Health Care			
<b>Policy/ Design Standards</b>	Curriculum design	Budgeting for health education	Budgeting relative to other health interventions	Identify Priority Areas	Rules of Implementation	Identify Priority Areas
	Learning achievement standards		Criteria for location of facilities	Define Programs & Budgets	Targeting	Define Programs & Budgets
			Pricing Policy	Standard Setting	Budgeting Standards	Standard Setting
<b>Planning</b>	Plans for physical expansion	Formulation of communication strategies	Choice of location/ capacity of facilities	Identify Priority Villages	Activity prioritization/ Action plan	Identify Priority Villages
	Plans for quality improvement	Identification of priority locations	Development of operational protocols Determination of eligibility of patients		Activity selection	Determine Service Provider
<b>Asset Creation</b>	<i>Human capital</i>	<b>Human Capital</b> in-service training	Human Capital	<i>Human Capital</i> Creation of demand	<i>Human Capital</i> Skill development	<i>Human Capital</i> Confirmation of Demand
	<i>Social Capital</i>	<b>Social Capital</b>	<b>Social Capital</b>	<i>Social Capital</i> Formation of user group	<i>Social Capital</i> Information dissemination	<i>Social Capital</i> Formation of user group
	<i>Physical Capital</i>	<b>Physical Capital</b>	<b>Physical Capital</b>	<i>Physical Capital</i>	<i>Physical Capital</i>	<i>Physical Capital</i>

Categories	Sector					
	Education	Health		Sanitation	Employment Programs	Water
		Curative/ Preventive	Primary Health Care			
	School Construction		Facility construction Equipment purchase	Ownership of infrastructure Technical Sanction of Investment Design of a Latrine Location / Quality of Construction Financial Approval	Public works	Ownership of Infrastructure Technology/source selection Asset Design Technical Sanction of Investment Quality of Asset Construction Financial Approval
<b>Operation</b>	<b>Beneficiary Selection</b> Choice of students for targeting programs Enrolment  <b>Recurrent</b> Textbook choice/purchase Learning materials  Pre-service training  Hiring of teachers  Assignment of teachers to specific schools/classes Performance evaluation  In-service training Promotion Timing <b>Personnel</b>  Supervision  <b>Maintenance</b>	<b>Beneficiary Selection</b>  <b>Recurring</b> Purchase of Instructional material Incentives to staff  <b>Personnel</b> Deployment  Payment of staff  <b>Maintenance</b>	<b>Beneficiary Selection</b> Identifying beneficiaries  <b>Recurring</b> Purchase of Materials-Drugs Purchase of Materials-other consumables Patient scheduling/ intake & registration Patient record keeping Referral  Handling of reportable illness  <b>Personnel</b>  <b>Maintenance</b> Maintenance of specialized equipment Routine maintenance	<b>Operations</b> System operation  Financial management <b>Staff</b> Hiring/Firing of staff Salary  <b>Maintenance</b> Major repairs / replacement Financing	<b>Beneficiary Selection</b> Identification of beneficiaries  Awareness Raising <b>Recurring</b> Provision of wages/ food grains Supervision & Quality control  <b>Personnel</b> Hiring/ Firing  <b>Maintenance</b> Accounting & Financial Mgt  Repairs	<b>Recurrent Spending</b> Tariff Setting Billing/Collection Operation of system  Water Quality: Sampling Testing Response Water Resource: Testing Response Payment to bulk providers Financial management <b>Personnel</b> Hiring/Firing Salary  Training Assignment/Transfer

Categories	Sector					
	Education	Health		Sanitation	Employment Programs	Water
		Curative/ Preventive	Primary Health Care			
	Maintenance of school buildings/facilities Monitoring of school processes					<i>Maintenance</i>  Minor repairs  Major repairs / replacement Financing
<b>Monitoring and Evaluation</b>	Tests of learning achievement	Supervision of staff  Assessment of knowledge  Formal evaluation	Quality control of medical advice Population based assessment of incidence of illness Formal evaluation of health status effect	Program/Scheme Status  Status of service delivery  Audit of Accounts	<i>Assets</i>  Record of Assets  Physical verification of assets created  <i>Audits</i> Financial Audit Social Audit	Program/Scheme Status  Status of service delivery  Audit of Accounts

#### 4. The *de jure* situation: what the law says

The 73<sup>rd</sup> Amendment set in motion the process of institutionalizing *Panchayat Raj Institutions (PRIs)* in the Indian governance structure. But actual practice of its provisions has varied across states because of the non-mandatory nature of functional devolution, and has resulted in a fuzzy assignment of responsibilities over activities.

##### *The provisions of the Constitutional Amendment*

The 73<sup>rd</sup> Amendment defined *panchayats* as institutions of self-government that are elected for a period of five years on the basis of universal adult franchise. It gave PRIs a mandate in the delivery of key services – including primary education, primary health, water and sanitation, and employment programs. The process of transfer, and the specific role for PRIs in these subjects, was left to individual state governments. The Amendment is complemented by a complex body of legislation that includes State *Panchayat Acts*, Central and State Sectoral Acts, Government Orders, Guidelines of Centrally Sponsored Schemes, and a large number of rulings of the judicial system up to the Supreme Court. On political aspects, on the other hand, the Amendment has a number of mandatory provisions. It mandates the creation of a uniform three-tier system of local government -- at the village, intermediary and district levels. Crucially, the Act accords legal status to the *gram sabha*. In addition, the Amendment deals with four main issues: the composition of *panchayats*; powers and authority; elections; and relationship with other laws. Among the important implications of these provisions are elections; the reservation of seats for Scheduled Castes/ Scheduled Tribes (SCs/ STs) and women; and the mandated

appointment of state finance commissions to make recommendations on principles of tax sharing, grants-in-aid and any other financial matter of *panchayats*.

### **The readings of provisions**

Mandatory vs. non-mandatory: Legal specialists have interpreted the Amendment in different ways. The mandatory reading of the Amendment's relevant articles argues for the autonomous function of PRIs. The non-mandatory reading however, endorsed by the commission reviewing the Constitution, empowers state governments to decide on the role of PRIs in rural development.

Concurrence: The absence of the word "exclusive" in Article 243G makes it clear that state governments have exclusive powers over the schemes and matters specified, while *panchayats* only have derivative powers.

Relationship with other legislation: In the absence of exclusive powers to the *panchayat*, there can be no conflict between the *panchayat* and a parallel body exercising the same powers. *Panchayat* functions are also governed by state/ central legislations.

### **The readings translated into practice**

Non-mandatory nature: State governments have taken full advantage of this "non-mandatory" nature of the Act: the role *panchayats* can be expected to play in service delivery is entirely dependent on the regime that controls the state government. As a result, the devolution of powers has remained weak in most states. Devolution also varies widely across states. Some, such as Karnataka and West Bengal, have chosen to devolve all 29 functions to PRIs, indicating their attempts at moving PRIs towards self-government. Others, such as *Rajasthan*, have been relatively conservative in their interpretation of the role of PRIs in rural development.

Concurrencies in the law: The concurrence of powers is, in many ways, enabling for *panchayats*, and ensure a more efficient delivery of services. Schedule XI presents a range of subjects that require a complex interaction of institutions at different levels of government so that all schemes/ functions and matters related to the subject are implemented efficiently. In practice, however, this does not take place, and concurrence of powers manifests itself as a problem in most states. This is because concurrence extends to the activity level (e.g. repairing schools) and results in different levels of government doing exactly the same things, rather than exploring their relative advantages within broad services.

Relationship with other legislation: With the exception of Kerala, which has chosen an enabling interpretation of legislation, the problem of contradictory legislation is prevalent. The presence of these contradictions and ambiguities in Articles 243G and Article 243N has meant that in many cases, functions devolved to *panchayats* are also governed by state or central legislations.

### ***The State Panchayat Acts***

#### **Functions**

**In some states such as *Rajasthan* and *West Bengal*, *Panchayat Acts* have devolved broad functions to PRIs.** This has led to the overlap of functions, and ambiguities in the specific role to be played by the different tiers. This in turn has meant that the state government has the power to assign and negate functions and powers to PRIs at its own discretion. Kerala and Karnataka present a different story, having systematically attempted to unbundled the broad subjects listed

in Schedule XI, and devolves activities across government tiers using the principle of subsidiarity.

**There can be no legal conflict between the *panchayat* and a parallel body exercising the same powers.** In states where the *Panchayat* Acts have devolved certain subjects from Schedule XI to the PRIs, it could be argued that any existing state law that contradicts this would be in violation of the *Panchayat* Act and must be repealed. But this analysis does not hold from the perspective of jurisprudence: the mere existence of two separate laws empowering parallel institutions with the same functions cannot be said to render the two Acts in conflict. The Supreme Court of India has upheld this understanding of the law -- any legislature is entitled to enact two separate laws providing for two different sources of power. In a case which dealt with a potential inconsistency between a state and central Act (*Lal vs. the State of Uttar Pradesh*, 1984), the Supreme Court held that “...there is no legal bar to creating two sources of power. And there is no authority in principle or precedent for contending that one source of power is more valid than the other.”<sup>10</sup> The court argued that one of the tests of inconsistency is whether the provisions of one Act can be followed without disobeying the mandate of any other law. In other words, the provisions of Schedule XI and the State *Panchayat* Acts would be in conflict with other laws only if the Schedule and Acts confer exclusive powers to the *panchayat*.

**The presence of these contradictions and ambiguities in Articles 243G and Article 243N has meant that in many cases, functions devolved to *panchayats* are also governed by state or central legislations.** For instance, primary education in West Bengal is governed by two main Acts, the Primary Education Act and the state’s *Panchayat* Act. The Primary Education Act focuses on the developmental as well as regulatory aspects of the delivery of primary education. Its key objective is to “make better provision for the development, management and expansion of primary education with a view to fulfilling the goal of universal, free and compulsory education.”<sup>11</sup> Among other things, the Act mandated the creation of the West Bengal Board of Primary Education, a body responsible for most of the key functions related to primary education, ranging from setting policy standards and asset creation to operational functions.

**In 1994, the West Bengal State *Panchayat Raj* Act (1973) was modified to bring it in conformity with the provisions of the 73<sup>rd</sup> Amendment.** Primary education was one of the functions devolved to the PRIs, and the *Panchayat* Act states that the “the *gram panchayat* shall also perform other functions as the state may assign in respect of primary education.”<sup>12</sup> A role has been envisaged for the DP and the BP as well -- they have the authority to “undertake schemes or adopt measures including the giving of financial assistance relating to the development of primary education.”<sup>13</sup> Thus the West Bengal Board of Primary Education, the state department for education, as well as the PRIs, are legally empowered to perform similar functions in primary education.

**The problem of concurrency is prevalent in most states.** But Kerala has chosen to interpret Article 243N in an enabling way. Based on the recommendations of the Committee on Decentralization of Powers (1997), Kerala amended its Acts to eliminate concurrency over powers devolved to *panchayats*.<sup>14</sup> As many as 44 Acts dealing with issues ranging from

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<sup>10</sup> Supp SCC 28, 1984.

<sup>11</sup> West Bengal Primary Education Act, 1973.

<sup>12</sup> West Bengal *Panchayat Raj* Act, 1973.

<sup>13</sup> Ibid.

<sup>14</sup> The amendments were formally accepted in March 2000.

entertainment tax, land development and education were amended, and the Kerala State Development Board Act (1971) and the Kerala Hackney Carriages Act (1963) repealed.

**In sum, the general case is that functional allocations overlap across government tiers, leading to confusion in the specific role to be played by each tier of government.** The devolution of subjects to PRIs has been undertaken subjectively, with different states choosing to adopt different perspectives on the role of PRIs in development. The specific role of each *panchayat* tier in matters pertaining to the subjects devolved remains ambiguous. In practice, this has generally meant that the state government takes over the responsibilities of matters listed in Schedule XI despite the State *Panchayat* Acts mandating the devolution of subjects to the PRIs.

## **Funds**

**Article 243H, which addresses the issue of tax assignments to *panchayats*, enables the state legislature to authorize and set up procedures through which a *panchayat* may levy and collect taxes.** It also does the same for grants-in-aid from the consolidated state fund; and for the creation of a *panchayat*-level fund that regularizes the flow of *panchayat* funds. Again, the role of the state government in assigning financial powers to PRIs is conditioned by the use of the word “may” in the Article -- highlighting its directory rather than mandatory nature. And again, the implications for the *panchayat* level are similar. State governments have complete discretion over the financial powers to be devolved to the *panchayats*; and, in most cases, these are limited. On examining the condition of *panchayat* finances across India, the NCRC concluded: “By giving blanket powers to the state government, the said article has been made practically sterile. It is not capable to serve its purpose since the state governments do not want to share their fiscal powers with the local government institutions.”<sup>15</sup>

**Not surprisingly, there are wide variations in the taxation powers of PRIs across states.** *Rajasthan*, for example, has a *Panchayat* Act with weak taxation powers; unlike Kerala’s, which has a strong tax base. Though *Rajasthan* has devolved all 29 functions to the PRIs, the state’s Act assigns only areas with low revenue potential to *panchayats*. The GP has the powers to impose taxes “subject to the rules and orders made by the state government in this behalf.”<sup>16</sup> In contrast, the Kerala *Panchayat* Act demonstrates an attempt to devolve an innovative list of taxation powers to GPs. The GPs can collect property tax, professional tax, entertainment tax and advertisement tax. In addition, the GPs receive a share in the taxes imposed by the state government -- such as vehicles tax, stamp duty and land tax.

The state finance commission mandate: Article 243I, considered one of the most innovative and important provisions of the 73rd Amendment, mandates the establishment of a state finance commission (SFC) with powers to review the financial position of *panchayats* every five years. The SFC has the power to recommend principles for tax sharing and tax assignments between state governments and *panchayats*, and for devolving grants-in-aid from the state consolidated fund to *panchayats*. In order to incorporate SFC recommendations in the Central (or Union) Finance Commission, Article 280 was amended in conjunction with the 73rd Amendment. Article 280(bb) was introduced to mandate that the Finance Commission recommend “the measures needed to augment the Constitutional consolidated fund of a state to supplement the resources of the *panchayats* in the state on the basis of the recommendations of the SFC.”<sup>17</sup> Perhaps the most

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<sup>15</sup> GOI, 2002c.

<sup>16</sup> *Rajasthan Panchayat Raj* Act, 1994.

<sup>17</sup> The Indian Constitution.

significant aspect of Article 243I is its use of the word “shall” -- indicating the mandatory nature of the provision. Consequently, all states in India have formed SFCs.<sup>18</sup>

**Given the mandatory nature of Article 243I, what has been the experience in practice?** Assessments indicate that implementation has been fraught with problems.

- Most states have experienced delays, both in constituting SFCs and submitting SFC reports.
- The SFCs lack a common approach in the methodology for making recommendations. In most cases, they have confined themselves to the existing tax sharing structure.<sup>19</sup>
- From a legal perspective, part of the problem is that the preceding Article 243H, articulating the financial capabilities of the *panchayats*, is non-mandatory. This allows SFCs the flexibility to not assign taxes from the state level to local bodies. The result is significant disparity in the recommendations of the SFCs. While some SFCs (West Bengal and Karnataka) have chosen to make a concerted effort to strengthen the fiscal capabilities of *panchayats*, others (*Rajasthan* and Uttar Pradesh) have chosen to provide minimal finances to *panchayats*.<sup>20</sup>
- While Article 243I indicates that setting up the SFC is mandatory, it does not do the same for the implementation of SFC recommendations. This has meant that these recommendations have been rejected by the state legislatures in some states.<sup>21</sup>

The impact of central schemes on panchayat finances . Any discussion of the legal framework for *panchayat* finances would be incomplete without an examination of the impact that CSS have on *panchayats*. The nature of Indian fiscal federalism grants the central government most of the critical revenue raising powers while the state governments are responsible for the majority of expenditures in key development areas such as education and health. To compensate for this financial imbalance, the Constitution allows for certain statutory provisions to transfer resources from the center to the states. A proportion of central revenues are thus transferred to states through the Consolidated Fund of the States. These are untied grants to the states distributed according to a formula incorporating measures of need and backwardness. Another provision allows the center to give the states grants-in-aid.<sup>22</sup> Since the 1970s, these have taken the form of CSS that transfer funds from the relevant line ministries at the GOI level to state governments, to implement programs based on guidelines prepared at the center. Most of the CSS have to do with the subjects listed in the state list and Schedule XI; and in most cases they dominate the plan component of state budgets for these respective subjects. A recent report (2004) by a GOI-appointed task force pointed out that there are as many as 154 CSS that deal with subjects devolved to PRIs.

## Functionaries

**Along with the transfer of functions and funds comes the issue of administering them.** If *panchayats* are to fulfill their role as agents of development, they need the ability to participate in the process as administrative functionaries. The 73<sup>rd</sup> Amendment does not explicitly address the issue of *panchayat* functionaries so that the decision is left entirely to the state governments.

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<sup>18</sup> [www.Panchayat.nic.in](http://www.Panchayat.nic.in), website of the Ministry of *Panchayats*, GOI.

<sup>19</sup> Aiyar, 2001; GOI, 2002c; World Bank, 2004a.

<sup>20</sup> GOI, 2002c; Oomen, 2003.

<sup>21</sup> Aiyar, 2001; GOI, 2001b.

<sup>22</sup> As articulated in Articles 275-280 of the Indian Constitution.

Currently, all administrative obligations of *panchayats* are fulfilled through staff deputed by and accountable to the state government. This raises two issues:

- Just as in the case of funds, there is a disjoint between the transfer of functions and functionaries. *Panchayat* Acts in states such as West Bengal and Karnataka do allow PRIs to hire functionaries up to a certain level, to manage their day-to-day affairs. The West Bengal *Panchayat* Act gives power to the GP to “appoint such officers as may be required by it” but subject to “rules as may be made by the state government.” Thus the state government indirectly controls even the limited freedom of the GP over its staff. In Karnataka, the State Act allows GPs to recruit their own staff provided they are paid for through the GPs’ “own revenues.” This naturally limits the GPs’ powers to appoint staff since own revenues are limited.
- PRIs have no authority over the deputed staff, including the authority to hire, transfer or take disciplinary action. The issues of recruitment and dismissal are determined by Articles 310 and 311, which grant these powers to the state governments. Thus the *panchayat* has no administrative control over its employees.<sup>23</sup>

### ***Implications for key sectors***

The readings of legal provisions, and their translation into actual practice, have implications for the key sectors.

Education: Kerala serves as an example with its amendments to harmonize existing legislation with the mandate of its *Panchayat* Act. West Bengal has a nominal role for PRIs, and Karnataka has weak delegation. In *Rajasthan*, there is ambiguity of roles. In sum, with the exception of Kerala, the delegation of functions is inadequate and concurrent responsibilities exhibit themselves as a problem.

Health: Despite the delivery of primary health being constitutionally entrusted to the states, the central government has been implementing most programs for health and family welfare as well as disease control. On the whole, the legal position on the delivery of health services has led to the predominance of the state and central governments in all stages of delivery, from planning to implementation. The PRIs remain insignificant in several ways. Kerala does give limited responsibility to GPs, but even this exception shows a lack of administrative powers.

Rural water and sanitation: While some water and sanitation functions have been assigned by legislation to the local governments, in practice, the roles and responsibilities assigned to these tiers are often circumscribed by either GOI guidelines for various CSS and associated state government orders.

Employment programs: Programs such as SGRY are implemented on the basis of policy guidelines developed by the central government. For this reason, the *de jure* allocation of responsibilities is determined by these guidelines rather than by State or Sectoral Acts.

### ***Conclusion: Does the legal framework enable PRIs?***

**In general, the legal framework for institutionalizing PRIs (Constitutional Amendment and State *Panchayat* Acts) has not created an enabling environment for them.** This conclusion needs to be seen in the broader context of a Federation. Prescribing the exact features of

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<sup>23</sup> Kingdon and Muzammil, 2000.

decentralization would undermine to some extent the powers of the states. Thus the Constitutional Amendment has enabled PRIs politically, but has given states the mandate to create an enabling environment for *Panchayats* in functional, fiscal and administrative matters. An analysis of the legal framework highlights the following:

- The devolution of functions to PRIs is neither mandatory nor exclusive. Some states have devolved fewer functions, or devolved them in broad terms. The powers of PRIs over these are considerably reduced, and there is an overlap of functions across all tiers of government.
- The 73<sup>rd</sup> Amendment cannot be interpreted to mandate that laws in contravention to *Panchayat* Acts should be repealed. This has led to concurrencies within the law.
- Some states have moved comprehensively (Kerala) while others have done it only for specific sectors such as rural water and sanitation.
- Funds do not follow functions. Since state governments are not obliged to transfer funds to *panchayats*, the fiscal capabilities of *panchayats* are weak.
- *Panchayats* do not have administrative control over functionaries, and in most states, functionaries deputed to the *panchayats* continue to be accountable to their employer, the state government.
- Several major central schemes are implemented across the key sectors, and the *de jure* responsibilities for these schemes are determined by central guidelines rather than by *Panchayat* or Sectoral Acts.

## **5. The reality on the ground: key services at the local level**

**Across sectors, the state line departments continue to play a predominant role in the delivery of public services even where these have been devolved to *Panchayats*.** The ability of PRIs to influence outcomes is limited because of the unclear allocation of responsibilities, practices that do not follow the spirit of the law, the inadequate access to discretionary funds, the lack of powers over state-level functionaries, and inadequate local capacity.

### **The link between the legal framework and ground reality**

**The study's survey of the *de facto* status across the unbundled sectors reveals that in all four study states, the *de facto* is often in contradiction with the *de jure*.** While the legal framework has not unequivocally defined a role for *Panchayats* in all states, it has done so in at least one state (e.g. Kerala) and some sectors (e.g. drinking water and sanitation). However, even in these cases, the state machinery continues to dominate service delivery. The state government plays a predominant role in implementing most of the key functions in service delivery, even where state legislation mandates devolution. The allocation of responsibility to PRIs is limited, and is not supported by either financial or administrative powers. Across sectors, this means weaker relationships of accountability, and services that do not meet local expectations.

### ***Key findings: primary education***

**Implementation:** The state government plays the predominant role in implementing key functions, with some exceptions such as education infrastructure in Kerala. In Kerala, there is a variation between the two parameters of infrastructure activities and the teaching sector, with the latter being perceived as the responsibility of the state – possibly because the teachers are essentially state government employees and the former the responsibility of *Panchayats*. In West Bengal, where delivery is through two parallel systems, the implementation of the alternative para-teacher scheme *Shishu shiksha karmasuchi* (SSK) shows a stronger role for PRIs than in mainstream

education policies and programs. In Karnataka, the state bureaucracy plays the key role in the implementation of all activities related to primary education.

**Quality:** The analysis of the *de facto* situation indicates that the current state of basic education delivery in rural India is far from effective in provision of the basic services, in attainment/completion, and in learning achievement. Teacher absenteeism is rampant. The combination of being poor, rural and female produces particularly appalling attainment rates. Learning achievement is equally dismal – across the states, about 80-95 percent of children do not have adequate primary schooling competencies. An accountability-based analysis indicates that the critical missing accountability relationship in primary education is between clients (parents) and teachers (providers). A diagnostic of this relationship using the five features of accountability indicates the following:

- **Financing:** The lack of adequate teacher compensation is not an issue since India's government schoolteachers are well paid in comparison with other developing countries.
- **Performing:** The evidence of teacher absenteeism – among the highest in the world – and “non-teaching” shows that “performing” is a big problem.
- **Informing:** Parents have little information about participatory bodies such as Parent Teacher Committees and Village Education Committees, and do not take active part in them.
- **Enforcing:** This seems to be the weakest feature of the accountability relationship as client parents have little power to reward good teachers and punish non-performing ones.

Given these missing links, one question is whether existing central reform schemes such as the *Sarva shiksha abhiyan* (SSA) does enough, particularly in addressing the issues of compact (relationship between policy-makers and teachers) and weak client power.

### ***Key findings: health***

Four key findings emerge from an analysis of the health sector:

- **The domination of state civil servants in the public sector:** The state is responsible for most public health care provision, and certainly most decisions that involve expenditure allocations. Moreover, important functions are not specifically assigned to anyone. The study survey indicates that though they have little influence over it, GP members know about medical care; but they are not familiar with the importance of disease prevention and health promotion. Thus these public responsibilities – probably best carried out locally – are not recognized by local governments to be theirs.
- **The dominance of private health care provision in India:** The private sector's share dominates primary health care provision in all the states. West Bengal has the largest private share for primary care, and Kerala the largest for private hospital care.
- **More public health services for the relatively rich:** The incidence of public subsidy in health shows a regressive pattern of subsidy across the states – more public money goes to the relatively well off.
- **Varying types/ extent of PRI involvement across the states:** The way in which PRIs have functioned in the context of state policies varies across the states. Karnataka seems to be quite typical of much of the rest of the country, while *Rajasthan* has made less progress than most. West Bengal has a somewhat clearer division of responsibilities, and is also attempting innovations such as granting GPs the authority to buy services from the private sector. This is a good example of “contracting up,” in this case to the private sector to serve several villages acting cooperatively to hire a qualified doctor. Kerala has certainly gone much further than

any other state in decentralizing health services. Several features may account for these results, including the size of its GPs, and more important, the relatively direct accountability of GP members to their constituency associated with some degree of local autonomy and local taxation and fees.

***Key findings: rural water and sanitation***

The performance of rural water supply and sanitation delivery in the study states has major weaknesses:

- Service provision is generally undertaken at levels of government higher than that specified by either legislation or government orders.
- The PRIs are assigned many of the functions, but most of these are, in effect, performed by state functionaries. This is exacerbated by the secondment of state employees to the DP and BP.
- Though the functionaries of state line agencies are often formally under the control of the PRIs, they do not have effective control over these deputed functionaries.
- There is some confusion and overlap in the role of the GP vis-à-vis the User Groups in actual service delivery.

In Kerala, there are four models of service delivery for water supply, and the operational performance of two of the models – where actual service delivery has been transferred to the User Groups – is much better. In West Bengal, *de facto* the BP, resourced with engineers, plays the major role in water service delivery; but since these engineers are de-concentrated state functionaries, dual lines of accountability are created. In Karnataka, the Village Water and Sanitation Committee (VWSC) has been assigned the function of service provision, but its role is negated by its complete dependence on the GP.

In sanitation, Kerala has the highest latrine coverage, but poor sanitation quality, indicating a significant failure in solid and liquid waste disposal. In both Kerala and Karnataka, usage appears to be much higher in the case of latrines constructed through private household initiative. This indicates the weakness of the high-subsidy total sanitation campaign.

***Key findings: employment programs***

**As in the other sectors, the delivery of employment programs is also dominated by central and state agencies, and the role of PRIs in planning and implementation is limited.** The findings, specifically for the SGRY program, but applicable to other employment programs, indicate that implementation is marked by:

- The predominance of line department officials in critical aspects such as work identification and beneficiary selection;
- The involvement of multiple central/ state ministries, causing delays in the release of grants, grains and food, and payments at the local level<sup>24</sup>;
- Modification of wages at the local level<sup>25</sup>;

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<sup>24</sup> It is also possible that delay in release of funds and foodgrains by the Ministry of RD is due to non fulfillment of conditions laid down in guidelines. Conditions are to ensure checks and balances in financial management. Delay in release of State share (25% of Central share) in the case of some states is due to their financial constraints.

- All pervasive central guidelines, with the central government responsible for all key decisions, and the states often implementing programs that do not necessarily apply to their local conditions; and
- The hiring of contractors against the guidelines;

The delivery of employment programs is hampered by several weaknesses in the states, including works not reflecting local needs and priorities; beneficiary lists not including many of the poorest; weak relationships of accountability; and top-down monitoring and evaluation.

## **6. The assignment of functions, functionaries and funds: applying the conceptual framework**

**How should functions, functionaries and finance for key services be assigned to the different tiers of government?** And how should the relationship between these tiers and frontline service providers is addressed? In response to these questions, public finance criteria and accountability criteria were applied to the unbundled activities of key sectors. In general, services can be improved with decentralization if increased autonomy can be matched with greater accountability.

### *Primary education: towards a coherent delivery system*

Fixing size jurisdiction: The first step in discussing the allocation across jurisdictional levels is to fix sizes. The foundational unit is the service delivery unit where providers and consumers of services physically meet. In education this is particularly easy as the delivery unit is a primary or elementary school. Each school has a catchments area -- the area from which it is likely to draw students.<sup>26</sup> A similar approach would apply to a local public or private clinic. A key concern in decentralization is balancing the costs and benefits of allocating responsibilities for various levels. Such a balance hinges on the sizes of those jurisdictions. In this context, Table 2 makes three simple points:

- The populations of Indian states are as large, or larger, than most countries in the world. West Bengal would be the world's 12th largest country, just smaller than Mexico and larger than Germany. Karnataka and *Rajasthan* are roughly the size of France, Italy or Egypt, and considerably larger than Korea, Spain or Canada. Even the smallest state under consideration, Kerala, is larger than 120 of the 150 countries in the world.
- With a population of around two million, even districts in India are large units compared to some countries, regions or cities elsewhere. For instance, New Zealand has a population of 3.6 million and Costa Rica 3.3 million; and many of the new countries from the former Soviet Union are even smaller. In many countries of this size, there are vigorous debates about the extent to which education should be decentralized from the national level. Another comparison is to counties in the USA, which often assume many governmental functions including, in many instances, schooling. The median size of an American county in 1990 was only 22,000 people, and only eight of more than 3,000 counties had a population greater than two million. Less than 50 of the 3000 counties were larger than the smallest district in the four India states under study (781,000). Such comparisons indicate that while decentralization to the district is often considered to be a very "low" level in the Indian context, we are still looking at a large unit of jurisdiction.

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<sup>25</sup> In principle the wages are fixed by the State Government but we found through the surveys that this may not always be true.

<sup>26</sup> These areas obviously have "fuzzy" borders and overlap.

- The typical catchments area of the services discussed in this Report, whether primary education, health or drinking water, is very small relative to the jurisdictional size. In education, for example, districts have primary enrollments of more than 100,000 students and contain more than 1,000 schools. Even a block typically contains more than 100 schools, and a GP more than one school.

**Table 2: Sizes and enrollments of state, district and block-level schools**

			<i>Karnataka</i>	<i>West Bengal</i>	<i>Rajasthan</i>	<i>Kerala</i>
State	Pop (millions)		52.8	80.2	56.5	31.8
	Number of schools (2)		49,674	52,835	38,342	6,758
District School	Pop (3)	High	4,215,000	8,934,000	2,182,000	3,234,000
		Specific	2,027,000	5,867,000	1,674,000	1,954,000
		Lowest	965,000	2,537,000	851,000	781,000
	Pop (enrolled 000) (1)	High	2,685,000	1,178,000	271,000	262,000
		Specific	300,000	1,101,000	58,000	168,000
		Low	71,000	431,000	84,000	85,000
	Schools (2)	High	18,527	9,622	2,205	869
		Specific	1,537	3,099	817	464
		Low	419	0 (?)	357	161
	Students per school(2)	High	300	350	312	500
		Specific	195	355	70	362
		Low	140	143	67	327
BP	Popln. (3)	High	682,000	283,000	663,000	137,000
		Specific	415,000	189,000	153,000	76,000
		Low	210,000	150,000	67,000	28,000
	Schools (4)	High	381	242	323	121
		Specific	232	100	74	109
		Low	96	79	30	40
1) Enrolled Population: DISE District report cards, <a href="http://www.dpepmis.org">www.dpepmis.org</a> , 2) <a href="http://www.indiastats.com">www.indiastats.com</a> , (3) 2001 Census, (4) Estimated using population percentages						

## Economies of scale

How many efficiently sized service delivery units, along with their catchments areas, fit in the jurisdiction of a *Panchayat Raj* Institution (PRI)? In the education example, there are few economies of scale beyond the single modestly sized school. This is completely different, say, from urban piped water supply. In the latter, the economies of scale in the networked nature of service distribution (that is, the pipes that carry the water to households), imply that the economically efficient solution will be large relative to even a large jurisdiction. The economically efficient thing would be to have one set of pipes reaching any given household or neighborhood; the only question is the arrangement for the ownership and management of the assets of this “natural” monopoly. In contrast, declining average costs of the provision of instructional services does not drive provision by a single large supplier (such as the government) covering a large number of schools.

Are there economies of scale involved in the key service of primary education?

- The typical empirical evidence of cost effectiveness is not that larger school systems are more effective than small systems. There appears to be a trade-off between many small school systems (which creates benchmark competition among public sector producers), and the potential economies of scale of larger districts.
- There is a large and growing private market for primary education supplied by for-profit producers. If there were economies of scale to the production of elementary education, one would expect the emergence of a few large firms responsible for a significant share of the market -- as the cost advantages would be enormous. Instead, it is apparent that though there are economies of scale in the development of learning materials (e.g. textbooks), or in the setting of standards, or in the provision of testing (e.g. testing services), the typical non-government school system is a small affair. A single stand-alone school is not an unusual form of production.
- Elementary education is a sequenced curriculum across a number of topic areas brought together into a single classroom due to economies of scope. If there were economies of scale intrinsic to the production technology of instructional services,<sup>27</sup> once again, one would expect a few large firms to dominate service provision in a competitive market. Yet this does not hold true for any of these industries. Instead, all these types of instructional services are provided by an overwhelming number of independent, competing producers – as is evident in any medium to large sized city in India.
- By analogy from a similar market and production technology for instructional services, the long history of elite educational institutions suggests an absence of economies of scale. In many other industries, the acknowledged leading firms capture increasingly large shares of the market. In contrast, it appears that the top suppliers of instructional services do not expand. While this could be so because they are “not for profit” organizations, it is also true that growth is a powerful organizational imperative that has little to do with profits *per se*. Another conjecture is that the basic features of the provision of instructional services create disadvantages for large organizations that are not offset by lower costs.

There are, however, four activities within education that have potentially substantial economies of scale.

- There are some economies of scale in curriculum design and service standard setting, though the existence of one-school producers suggests that these are not determinative. When drawing on an already developed curriculum, the incremental costs are not substantial.
- Coordination issues in plans for expansion make for some economies of scale at the system level, though they are not, perhaps, apparent at the unit level. Again, this is only a concern in elementary education when the coordination ability of a market mechanism is weak. For instance, if each individual producer chooses school location on the basis of market potential, this is a powerful coordination mechanism if the market is “thick” or “dense” with a large number of “demanders” in a given area. In rural areas, however, the spatial separation of villages implies some gains to coordination.
- There are economies of scale in evaluation. Developing test instruments that are valid assessments of the desired learning standards is a technically difficult endeavor requiring specialists. Hence it is a costly exercise for any one unit. This would suggest that in a completely open market, there would be small schools and school systems, but a few large testing enterprises that would contract to these school systems and schools.

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<sup>27</sup> But instructional services in elementary education are not different in kind from the instructional services in many other areas – from language instruction to training in computers to private tutoring for examinations. See Chapter 2.

- There are similar issues in the development of textbooks and learning material. There are economies of scale in textbook development, but this suggests there would be fewer textbook manufacturers than there are schools choosing which textbook and textbook series to use. This, in and of itself, is no reason why the two activities have to be integrated in the same enterprise/ organization or level of government.

## Externalities

There are two points relative to the scope of externalities in allocating responsibilities for elementary education.

- Most parents in India correctly perceive that the private monetary and non-monetary value of education is high. The extent to which parental demand for education is “too low” because they do not incorporate externalities that accrue at a higher level of aggregation (e.g. district, state), is almost certainly minimal.<sup>28</sup>
- The two functional areas in which there are some externalities are in setting curricula and standards, particularly with regard to the benefits of socialization and preparation for citizenship; and in M&E, as evaluating multiple jurisdictions on the same standards can provide citizens with valuable information.

## Equity

**Both central and state governments have always been committed in principle to universal primary education – a goal enshrined in the Indian Constitution. Given this commitment, elementary education cannot be planned to be less than universal.** The reality, of course, does not quite measure up to this ideal. A commitment to equalizing educational opportunity may imply financial support to education at a geographic scope that allows for redistribution of resources. But it does not imply anything about the size or ownership of the units responsible for the production of education.

## Heterogeneity

**Heterogeneity is limited by the fact that all communities must at least plan for universal enrollment.** But different communities or schools make different choices about the approach to instructional styles, pedagogical practices and the general vision of the school. Research around the world shows better performance when educators perceive greater autonomy in putting their vision into practice in school environments. Obviously this can happen only when individual schools or sets of schools are allowed to choose their approach, when teachers are allowed to move, and leaders of schools allowed some flexibility in choosing staff. Moreover, there is heterogeneity in the demand for the socialization element of schooling. As primary schooling is an important component of the socialization of children, these elements are important to both parents and governments. This can create a tension between “centralizing” tendencies wanting to impose a socialization that creates a common national identity (language, culture, history, or “ascriptive identity”) and more local forces that want schooling tailored to local preferences on those same dimensions.

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<sup>28</sup> There is a great deal of debate about whether there are externalities to education at all, and there is a rough consensus that the *economic* externalities are small relative to the private benefits of education (see Pritchett, 2005). This is not to deny the many *non-monetary* benefits of education, such as the effect of the mother’s education on child health; but generally, these are not “external” to the household, and the externality impact is likely to be limited to a local level.

## Accountability criteria applied to primary education

**The various functions elementary education can be assessed on are the criteria of discretion, transaction-intensity and observability.** This will help inform what is the appropriate jurisdiction for these functions/activities based on the criteria of accountability. Figure 7 points to the fact that highly discretionary, transaction-intensive, and locally observable activities like Asset Creation and Operations (especially teacher operations) should be done under local jurisdiction.

The *operations* function of elementary education also falls into this category – it requires lakhs of teachers teaching crores of students in lakhs of Indian villages (transaction-intensive), and what and how the teacher teaches, what pedagogical technique he/she applies depends to a large extent on the teacher (discretionary).

**What about observability?** In the context of primary education, observability is a combination of (a) actually observing the action and (b) knowing whether the action was appropriate. For instance, teacher absenteeism is a particularly easy case. If the teacher is intended to be present and is not, then it is clear to any direct observer of the school (e.g. students, parents, other teachers) that the appropriate action for learning performance is not being undertaken. But someone who is not physically present cannot observe absenteeism.

**A more difficult case is pedagogy.** For instance, “child centered learning”— easy to observe, hard to know if it is the “right” technique that a teacher should be applying. Are parents capable of knowing whether a teacher is doing a “good” job based on available observation? There are some who argue that locally elected officials should not have any say over schools because they might have “backward” attitudes relative to the “advanced” views of educational “experts.” However, on the scale of “observability” our judgment is that a parent who wants to be informed can form a reasonably good idea of the quality of learning activity in a given school (especially given that the major problem is that half of the time no learning activity at all is going on, which is easy to observe).

The responsibility for *setting standards, deciding on curriculum* should remain at the *state* level (in collaboration with the centre).

**In a decentralized environment the important *additional* responsibility of the state is to create a system of monitoring the achievement of the learning achievement standards.** The *state* level government assumes responsibility for setting learning standards and goals and for monitoring progress towards those goals for each school, GP, and district.

The *Gram Panchayat* (working with school specific or village/habitation specific committees as member bodies of the GP) should be responsible for *proposing* new school facilities, for supervising the construction of such facilities, for *all* operational decisions at the school level (over maintenance, budget, utilization of non-wage expenditures, purchase of learning materials, etc), and for the *assignment* of teachers to specific schools.

The overwhelming bulk of the resources to education should then flow primarily in untied form to GPs who, together with the school staff and the school and/or village specific (VEC) or school specific (SMC) committees to make essentially *all* operational decisions<sup>29</sup>.

The district should play a facilitating role of (a) providing the pool of qualified teachers from which GPs can choose (b) providing for the *technical* aspects of improving pedagogical practice through in-service training, (c) coordinate the planning when necessary to prevent an over-expansion of the system, and (d) supervise compliance with the *processes* of GP and school decision making.

### **In summary: towards a coherent primary education delivery system**

The current system does not give autonomy to the front-line service organizations and providers; nor does it create accountability for performance. Thus all education reform proposals should be judged against the criteria of cost-effective improvement of the level and distribution of learning achievement. The key problem in elementary education in India is the high per student cost of instruction. A greater push towards decentralization would create an opportunity for both substantial cost reduction and quality improvement -- but the political costs of the reform will be high and the period of transition long. Overall, the analysis indicates that the following allocation of responsibilities would help in the move to a more coherent rural education delivery system:

- The operation of the schools should be pushed to the lowest possible level with the greatest possible autonomy – in financial control, the assignment of teachers, and asset creation.
- The district should be responsible for planning, coordination of asset creation, hiring and providing technical and pedagogical support to teachers.
- The state should be responsible for setting standards for learning achievement, monitoring performance, and disseminating information.

### ***Health services***

**Applying the conceptual framework to health services involves addressing several critical issues – including the focus of public spending; the large externalities associated with the control of communicable diseases and the failure of the insurance market; and the role of the private sector, particularly in primary curative care.** Most funds, public and private, go to medical services (see Volume III, Chapter 4). But is this a desirable allocation? The principles of comparing the market to government failures can help sort out the priorities for public expenditure and indicate what the relative spending across categories should be. The other area of concern consists of the two characteristic market failures of the sector -- the large externalities associated with communicable disease control and the inherent failures of the insurance market.

### **The public good nature of the activity:**

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<sup>29</sup> The scheme in West Bengal chose to use SMCs (which are school specific) instead of VECs (which are village specific), which many believe work better as a tool for ensuring teacher accountability. It is also possible that SMCs are less politicized (and more focused in its role) than VECs (which are much more closely related to the Gram Panchayat and hence to local politics) and hence a GP with SMCs would provide the right mix.

**In the extreme case, many activities used to combat infectious disease are almost pure public goods – goods in which there cannot be a private sector even in principle.** Vector control, such as area spraying for mosquitoes, elimination of snails, rats and other carriers of disease, often cannot be privately done since everyone benefits, whether they pay for the service or not. That there are large externalities associated with communicable disease control is reflected in the fact that most studies, including many in India,<sup>30</sup> find that these interventions have considerable effects on health status, even when it is not possible to find an effect of publicly provided health care. Communicable diseases disproportionately hurt poor people. The incidence of TB, for example, is seven times as high among the poorest decile of the population as it is in the richest decile. For malaria, the poorest decile is about four times the richest; while for chronic illnesses such as cataract, the ratio is only three to two.<sup>31</sup> Any reallocation away from infectious disease control towards the treatment of non-communicable diseases would hurt the poor. So for both efficiency and equity reasons, the role of government has to be quite high in communicable disease control. In this context, we need to note that very little of the public health rupee appears to be allocated to pure public health activities

Insurance failures: This leaves almost everyone exposed to catastrophic loss of income if treatment is sought for expensive-to-treat illnesses. Expensive, a relative term, refers to the size of the financial burden that out-of-pocket expenditures impose. The welfare loss is the risk premium that people would be willing to pay, but cannot, because of the lack of health insurance. In India, rough calculations on this welfare loss have been calculated for different levels of service.<sup>32</sup> Using average costs in the private sector as a benchmark, the welfare gain for covering the typical hospital stay was fully 60 percent of the expected cost of the service<sup>33</sup> in comparison with a relatively poor person's income, as opposed to five percent in the case of primary health care. The former is certain to cover administrative costs for insurance; the latter is unlikely to. Insurance programs are notoriously hard to administer, however. While it is certainly the direction in which India's health care system should be going,<sup>34</sup> it is probably very difficult to adopt at this time. In the absence of insurance, the main public policy available is capped fees in public hospitals.<sup>35</sup> Publicly provided hospital services comprise a reasonable, second best, option – if the incentive problem discussed above is solved. But the ground realities of public/ private involvement in the two categories of curative care – primary health care and hospital-based care – need to be taken into account.

Public/ private involvement in primary curative care: Most curative care is already in the private sector (see Volume III, Chapter 4). Most people can afford to pay the small amounts required for primary care. Very few can afford to pay the much larger sums associated with hospital care. There are state differentials in the relative size of the private sector in primary and hospital care, but in general, the share of the private sector is much larger in outpatient than inpatient care – a direct result of the inadequacy of the insurance market. On efficiency grounds, then, primary care services do not rank high on the list of public responsibilities.

Implementation ability: If primary care were easy to accomplish, the limited role of government in providing cheap curative care might be overlooked. But there is considerable evidence of severe implementation problems in primary health care. A recent study, for example, showed

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<sup>30</sup> World Bank, 1998.

<sup>31</sup> Ibid.

<sup>32</sup> World Bank, 1998.

<sup>33</sup> The actuarial fair cost of insurance.

<sup>34</sup> Peters et al, 2002.

<sup>35</sup> Optimal pricing for insurance is to have a small deductible and a cap on expenditure up to a maximum corresponding to "adequate" treatment and full payment for expenditures beyond that maximum. See Zeckhauser, 1970.

absentee rates of approximately 40 percent across states when surprise visits were made (mostly) to primary care facilities.<sup>36</sup> In short, the incentives to ensure attendance in public facilities are inadequate. On grounds of implementation ability, hospital services also have an edge over primary care. Absentee rates are always lower in larger facilities because it is easier for senior staff to monitor the attendance of more junior staff. Also, there are non-monetary benefits to serving in hospital settings for medical professionals. Job satisfaction is higher when providers can use the skills they are trained for and have colleagues to confer with.<sup>37</sup> These are present in hospitals far more often than in PHCs.

Distributional grounds: The one main drawback of public involvement in hospital care is on distributional grounds. In general, the pattern of public subsidy across the states has been regressive (see Volume III, Chapter 4).<sup>38</sup> The poor rarely use public hospitals, mainly because hospitals tend to be in urban areas where incomes are higher, but also because referral systems to higher-level public facilities tend to be biased against the poor.

In sum, based on both the size of market failure and the problems of public implementation capacity, there should be strong emphasis on traditional public health activities and serious policy discussions on how to handle the catastrophic health care costs that hospitalizations impose. How these services should be divided between different levels of government is our next concern.

### **Services and the appropriate level of government**

#### Population-based services: case-by-case basis allocation

**Population-based public health services comprise a mixed bag as far as the variety of services is concerned, as well as the most efficient scale for such services.** Therefore, responsibilities for specific programs will need to differ across levels of government. For example, many mosquito control activities such as noticing and eliminating areas of standing water where mosquitoes breed are as local a “public good” as imaginable. Similarly, water quality can vary substantially between sources, sometimes within the same type of source such as public standpipes in villages. Testing, maintenance and other remedial action (arsenic control in West Bengal, for example) all require substantial local responsibility and control. Other services in this category are subject to substantial economies of scale or to spillover effects -- where actions in one village, or even larger jurisdictions, can affect its neighbors, and need to be monitored, coordinated or implemented by some higher level of government. One idiosyncratic form of “scale” in the health sector is the need for relatively scarce, highly technical personnel handling specialized problems. Investigative epidemiologists,<sup>39</sup> or some laboratory testing facilities (particularly for reportable infectious diseases), are not likely to be available or desirable in villages. It is not possible, therefore, to be too sweeping and dogmatic in judging the appropriate level of government for these activities. They must be treated on a case-by-case basis, balancing the monitoring ability of different governments against considerations of technical efficiency of scale.

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<sup>36</sup> None of the four study states is nearly as bad on these grounds as Bihar or Jharkhand, but all of them show fairly similar figures. This may be a little surprising given the good reputation that Kerala has in running its health system. See Chaudhury et al, 2004.

<sup>37</sup> WDR 2004; Feedback Ventures, 2004.

<sup>38</sup> The case of Kerala in these figures shows that the bias against the poor is not inevitable. The state seems able to charge higher fees to richer people as well as have a larger private sector with a much larger share of better-off people. This leaves public hospital care to serve the poor.

<sup>39</sup> People who track the emergence, spread and causes of disease outbreaks.

**The two justifications for the involvement of higher level governments – spillover effects and scale economies** -- differ on one important dimension relevant to funding and the direction of authority. The former is a purely “supply-driven” concern of the higher level of government. The higher level sets standards and guidelines to ensure action by individual units of lower government tiers. So sanitation disposal of an upriver community for the benefit of the downriver community must be handled without the upriver community (at least) asking for help.

**However, testing and similar support services where the scale spans individual GP or BP areas may benefit from “contracting up” either to a higher level of government, or even to private firms.** Taking blood smears to check for malaria, for example, may have to be done by personnel responsible to local government (though reporting the results may have to be ensured by the higher tier). However, whether the tests themselves are done in any particular government laboratory, or in a private one, could be a choice by the local government unit on the basis of cost, reputation for reliability, speed of results and other service characteristics. This choice – a “demand-driven” dimension, though the demander is, itself, a level of government – introduces some competition that can keep costs low or reduce delays in reporting. A higher tier of government may play a facilitating role to help GPs cooperate and obtain these services -- as long as it does not steer the GPs to use government facilities when private options are cheaper. Local ability to contract up makes use of a short route of accountability. The local government takes the role of the client with the highest stake in the outcome. It can monitor providers more closely and get better results if it is their money being paid. Whether this can be done in a purely market context, or whether separate GPs (or higher) levels need to band together to generate sufficient demand for a provider, depends on the nature of the service. Again, “contracting up” may be another way of making doctor services available in areas where individual villages are too small to support a qualified physician.

#### Surveillance: involvement of higher tiers

**Surveillance is another important public responsibility that requires the involvement of high tiers of government, either exclusively, or with substantial guidance of and cooperation with other tiers.** Again, there are two aspects of surveillance – one that is widely recognized in current legislation; and one that is essentially left undone. The standard surveillance of disease, particularly of communicable disease, can be done in different ways that will interest different levels of government. Since diseases do not respect political boundaries, state and central government institutes need to be involved and informed of the incidence of diseases so that epidemics can be averted and information flows back to people. This is particularly useful if diseases are preventable. Protection from insects is a long-standing example, and information concerning the spread (and means to prevent) HIV/AIDS is a more recent addition. In India, standard surveillance is hampered in two ways:

- While some states have laws that require private providers to report cases of particular diseases, this is not well enforced. Given the predominance of the private sector as the first contact with health care, and the daunting task of regulating the sector, this is a serious obstacle.
- There are legitimate concerns about the diagnostic ability of medical providers in both public and private sectors.<sup>40</sup>

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<sup>40</sup> See Das and Hammer, 2005, though this is based on a study in an urban area.

The first problem calls for the involvement of a government representative – either a functionary from the higher tier of government assigned to local government offices, or employees of local government with clear reporting responsibilities to higher levels. Which level of government officials are best able to disseminate information to individual private and public providers is unclear.

**The second major aspect of surveillance has barely begun in India. It involves the regular, routine and systematic collection of information on disease incidence, mortality, and the wide range of possible determinants of disease and death.** Discovering the factors that cause illness, and which can be influenced by policy, is a clear “public good” across government levels. Since health determinants are varied and not limited to health services, this monitoring will have to be based on multi-purpose surveys that can identify education, income, sanitation and water among many other household characteristics. No single local body would (and in most cases, could) undertake research that could be useful in areas other than their own. Thus it is the responsibility of the state and central governments to collect, analyze and disseminate the results to local officials and providers.

#### Preventive and promotive health services: the perfect case for decentralized authority

**Preventive and promotive health services are the most amenable to decentralized government authority -- both in principle and in the light of political constraints.** On the one hand, these services are in the greatest need of public intervention. On the other hand, local variation is often important for setting priorities. One substantial constraint on improved health among the rural poor is the persistence of harmful traditional health practices. Standard Information, Education and Communication (IEC) interventions are important to counter such beliefs, but they must be tailored to the specific area. They are also most effective if carried out by people who are part of the community and have their trust. While support in the form of basic information and suggestions on dissemination techniques might come from higher levels of government, this is clearly a local responsibility. One area of preventive care that could be an exception to local government jurisdiction is immunization. The campaign style of immunization appears to work, possibly because the value of this service does not vary much across jurisdictions, making it easy to monitor even by relatively high levels of government. And, once again, there are cross-border effects of mishandled vaccine -- preventable disease.

**Drug purchases could be done at higher tiers of government if buying in bulk allows the public sector to get lower prices. Otherwise GPs could do it.** Technically difficult drug distribution, such as vaccines that require a cold chain, are more easily provided or regulated at higher levels of government with or without extra subsidy (above overall devolved funds). But even in this case, the cooperation of a locally employed and responsible health worker supported by a higher level of government is a more likely route to success.

#### Curative care: primary health services

**“Money follows the patient”:** We have seen that the role of provision of primary health care by government – local or otherwise – is debatable. Even the financing of cheap interventions<sup>41</sup> may not be a high priority, since people already pay substantial sums for curative care, and there is considerable private demand. Governments may want to provide financial support to the poorest, but the principle of “money follows the patient” always requires government to cede the choice of

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<sup>41</sup> In rich countries, while the vast majority of *provision* of services is done by the private sector, the ultimate source of finance is almost always public (with the United States the big exception).

providers to individuals. This is consistent with the need for direct accountability to the entity best able to represent the public's interest. In the case of primary care -- an excludable and rival good -- this entity is likely to be the patient herself. One common problem associated with government health facilities and their monitoring is solved as a by-product of letting people choose facilities. This is the problem of "catchment areas" of primary health facilities not being coincident with political boundaries. If people can go where they want and the money goes with them, the optimal location of facilities will probably arise from providers moving so their location can be convenient enough to attract the most clients. This obviates the need to decide which local government should monitor which facility.

The exceptions – arguments for local control: Two exceptions to the general rule of money following the patient argue for local authority over PHCs. One exception is ambiguous in effect but may argue for a monitoring role for higher levels of government.

- Many rural areas are too small to support competitive markets for qualified doctors. In that case, local government (or a User Group with this delegated authority) may want to choose a provider on a regular, perhaps annual, basis on the understanding that continuation of the contract is contingent on acceptable service. In this case, there is competition for the market (that at each moment may be a monopoly), rather than competition in the market that is not sustainable in sparsely populated areas. Whether the provider (now a monopolist) is paid by salary or by patients, or a combination, is a matter of negotiation.
- The only exception to the rule that primary care providers in rich countries are never paid with salaries is Sweden.<sup>42</sup> But Swedish medical providers are employees of local government -- based on the idea that it is the only level close enough to the point of service to monitor performance adequately. Even then, dissatisfaction with medical services has led to innovative reforms that increase competition and the rule of money following the patient. The reform is limited to Stockholm, which has a large enough market to support competition.<sup>43</sup>

Health care as a "redistributive" device: The other exception to the rule that "money must follow the patient" has ambiguous implications for local government. An obvious objection to out-of-pocket payments for health care is that the very poor simply can't afford quality care. Of course, they can't afford quality food, water, shelter, education, clothing, transportation or electricity either, so equity-based payments to the poor for health care need to be assessed against all other needs. If health care is chosen as a "redistributive" device, the level of government best suited to provide such aid depends on two main, possibly conflicting, characteristics.

- Local governments, say the GPs responsible to the *gram sabha*, may have better knowledge of the community's living conditions, enabling them to identify the most needy.
- In some areas, where caste and ethnic divisions within communities aggravate the problem of poverty, a higher level of government needs to monitor not only performance but also the

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<sup>42</sup> Here a distinction that is important in the framework of the WDR 2004 must be drawn. The lack of a salary payment applies to the provider organization and not necessarily to each individual within the organization. For example, a private practice can require several people on staff and may pay any or all of them with a salary. The nurse that a doctor hires to assist her in the practice might be paid a salary. This is an internal management decision and a choice of the organization. The payment of salary is likely to be chosen and be a successful means of remuneration if close monitoring by a manager (in this case the doctor) is possible.

<sup>43</sup> At three million people, Stockholm is slightly larger than the average district in India and half the size of Midnapur in West Bengal. It was considered too large an area to be adequately monitored by government. This was in a country with among the most competent and honest governments in the world. Transparency International ranked it as having the sixth most honest government. India places 90th in that ranking.

ability of services to reach the most vulnerable. The optimal level of government for this purpose would be the lowest level able to represent the social desire for equity. States are likely to be large enough but may be able to delegate to a lower tier. In any case, making the results of the monitoring exercise public will help mobilize watchdog agencies in civil society.

### Curative care: hospital services

Catastrophic health events: Handling financially catastrophic health events is, in pragmatic terms, associated with economies of scale. The need for extensive care is uncommon enough so that each facility would probably serve numbers larger than villages. Regulating such facilities would naturally fall to higher government levels, commensurate with its degree of specialization (and the population density of the region). One possible division of responsibility is blocks for CHCs, districts for secondary hospitals, and states for teaching hospitals with subspecialties. In the absence of health insurance, hospitals are best handled outside the GP. The GP may, however, want to be responsible for emergency transportation to such facilities. The issue of transportation raises a further difficulty: the rules, procedures and incentives for proper referral to hospitals.

Referrals: Most people do not use a hospital as their first point of contact with the health system, though there are many exceptions.<sup>44</sup> The bypassing of lower level facilities, particularly by city dwellers, is one reason the distribution of public subsidies is skewed so badly towards the relatively well off (see Chapter 4). Achieving the most efficient sorting of patients means handling the problems of referral, as well as the first-line provider level at which treatment is cheaper. Two kinds of mistakes can be made:

- Referrals may be made too readily when providers are either not available or do not want to deal with the patient; and
- Referrals may not be made, even when appropriate, because the provider does not want to lose a customer.

The first is characteristic of public primary care centers, the second of the private sector.<sup>45</sup> The criteria for referral are made at the state level, which is perfectly reasonable. How this gets translated into practice is more complicated. Even if the local government were able and willing to use some of its funds for transportation, they need to be in a position to judge whether the case warrants the referral.

Insurance: If health insurance does become an important part of the Indian health system, it is also likely to be managed at a fairly high level of government. The benefits of insurance are the result of the much smaller variability of overall costs for a large population, relative to the very high variability an individual or a small group would face. Also, since infectious disease is still a major health problem, there is substantial covariate risk for small groups of people subject to the same problem. Epidemics comprise the most dramatic example. The more covariate the risks, the

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<sup>44</sup> Accidents, heart attacks, urbanites near a hospital, and people who assume that they will either be referred to a hospital or that a PHC will not have drugs or staff available. The literature on how people decide on how to seek care is quite large and often points to quite sophisticated strategies concerning expectations about where they will get the most appropriate treatment. See Leonard, 2004.

<sup>45</sup> Das and Hammer, 2005.

larger the insurance pool needed to diversify that risk.<sup>46</sup> However, each of the study states is large enough to reap practically the full benefits of diversification.

**In summary: optimal allocation of responsibility with accountability**

Block grants to GPs: Block grants, much bigger than those currently given, can be managed by GPs for the health and well being of their constituents. Concern that GPs may ask for unwarranted work from local health workers<sup>47</sup> can be handled by recourse to higher levels of government for technical as well as moral support. The monitoring of outcomes and standard auditing practices will also have to come from higher tiers of government.

Public money for “public goods”: Overall, central and state governments should spend more money on real public goods that cannot be provided by the private sector, such as the control of communicable disease and increased surveillance.

- Combating communicable disease with more public money is a two-part process: large-scale pest control that is either monitored and regulated, or implemented, by the appropriate level -- state, district or block; and small-scale, transaction-intensive preventive and promotive activities, such as health education and immunization. These small-scale activities are definitely GP responsibilities, given the variation of needs across areas, and the greater effectiveness of information dissemination among known networks of people. Technical support for local health educators, such as teaching materials, could come from higher tiers. But the workers themselves must be paid by, and be accountable to, local governments.
- Increased surveillance<sup>48</sup> requires data collection from households and not simply from management information systems, since so little curative care is performed in the public sector, and since many determinants of health status are found within the family. This data should be analyzed to determine the causal links between policies and health status, and widely disseminated in an easily understood form.

Where is the extra money for these public goods to come from? One possibility is curative care, particularly since the private sector is thriving in this area.

Primary health services – long-term and short-term possibilities: As far as government role in curative care is concerned, there is a long term and a short-term set of actions that should be considered.

- As India becomes richer, it is likely to pay its providers for the services delivered. This will reduce absenteeism and improve at least the non-clinical aspects of care if a competitive environment is created. This change involves political problems in the short run, but such a reform is necessary for improvement in the public health care system in the long run.
- There are several short-term possibilities available, depending on the level of service. For primary health care, two models (with modifications) are possible. The first is the Kerala

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<sup>46</sup> In case of a perfect correlation of risks, no population size will lead to the diversification of risk needed to justify insurance. In the recent tsunami, for example, the GOI and the government of Tamil Nadu were necessary to provide protection to everyone in all the districts affected.

<sup>47</sup> Anganwadi Worker and Auxiliary Nurse Midwife (ANM) in the current system, though these responsibilities might change as local governments decide on their own mix of needed services.

<sup>48</sup> Standard surveillance, the process of identifying and reporting diseases to control epidemics, is already being expanded.

model in which GPs take on substantial responsibilities for primary care operations. The modification necessary is putting the GP in charge of pay, hiring and dismissing of personnel. The second is the model being introduced in West Bengal – in which GPs join together to hire the previously unaffordable and/ or unavailable services of qualified doctors. This can be a lump-sum grant for the doctor's visits, monitored by GPs or their delegated health committee; but with patients' fees charged on a sliding scale (or any other arrangement mutually agreeable to the provider and the GPs). Alternatively, the GPs may choose to pay for all services from these providers – the discipline coming from renewable contracts. If either of these approaches is adopted, funding must be shifted to GPs from states through block grants.

Hospital services: Until insurance is a viable option,<sup>49</sup> public hospitals will need to continue to be run by levels of government commensurate with the type of services offered, with higher levels taking on the more specialized services. The role of GPs is limited. And so is that of the state government -- as only the most specialized teaching hospitals require direct state-level involvement. The state can help with setting fees as well as better referral guidelines for hospital admission. Treatment can be free (or much cheaper) for those with appropriate referral. The GPs may want to use part of their block grant to provide emergency transport in cases of accidents and complicated deliveries.

### *Water supply and sanitation*

**The domain of water supply involves not only water service delivery, but also water quality and the development and regulation of water resources.** The sanitation service involves environmental hygiene, excreta disposal, wastewater management and solid waste management. High-quality RWSS aims at providing access to these two services taking into account the full range of this domain. The form of water supply provision varies with settings – in some settings, a quality water service may be most reliably provided through individual access to household wells. In other settings it may be hand pumps, or mini-piped schemes or regional schemes. These forms of access should be primarily defined by user preferences, willingness to pay, collective involvement in ownership and management of schemes. In the case of sanitation, there is an even greater need to define the kind of access necessary for a high quality service – given that the present emphasis on latrine provision has not had the desired results. A high quality sanitation service requires a focus on sanitary outcomes as being the provision of a clean and healthy sanitary environment. It is in this context that policy makers have to be involved in defining the quality of access parameters, and in providing an environment in which those parameters might be met.

### **Applying public finance criteria to rural water and sanitation**

#### **Economies of scale**

Appropriate unit of production: What do economies of scale tell us about the appropriate unit of production for RWSS? Larger regional water supply schemes theoretically have the potential to capture economies of scale and facilitate higher levels of service at lower costs. They could also offer long-term solutions to the ground water scarcity and contamination issues faced by many regions. However, the experience in RWS in India suggests that the potential for improved productive efficiency of larger regional schemes has been more than offset by failures to achieve allocative efficiencies in service provision. There have been significant increases in the expertise

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<sup>49</sup> Insurance would have to be administered at a high level of government.

levels and costs associated with more complex schemes, higher coordination costs, greater legal requirements, greater likelihood of leakages and the higher transaction costs. Moreover, larger and more complex schemes do not necessarily incur financial economies of scale in rural India. A World Bank review<sup>50</sup> of the RWS sector in India suggests that the typical per capita costs for regional water supply schemes are significantly higher than those for “small” or “mini” piped water supply schemes. The choice of increasing the unit of production in rural water supply in India is generally not driven by financial considerations. Water quality problems, water resource scarcity and/ or a desire for higher service quality constitute the primary driver for larger schemes.

Centralizing design and production aspects: There are some economies of scale associated with centralizing the design of programs, the setting of standards and the development of standard designs in RWSS. This is also true of more complex forms of water quality testing, and the development and production of IEC materials in sanitation. But in a more comprehensive approach to sanitation, the extent of these economies of scale may not be so significant. There are also some economies of scale associated with centralizing the production of sanitary facilities through rural sanitary marts (RSMs). West Bengal has had considerable success in centralizing the performance of this function at the block level and managing this predominantly from the district level. The service is outsourced to NGOs, hence a higher tier of government is better suited to manage the function.

## **Externalities**

Appropriate level of functional assignment: What can we infer from the externalities in RWSS about the appropriate level of assignment of the functions in service delivery? The most relevant externalities are related to health impacts of poor water quality or lack of sanitation. In water supply, the scope of the externality is dictated primarily by the size of the scheme and proximity of habitations. These health externalities are likely to be reasonably internalized at the village or habitation levels, since within these people are concentrated, but they are far from other villages.

## **Equity**

**The central government and various state governments are committed to delivering a basic level of access of drinking water to all citizens. GOI norms define such a level;<sup>51</sup> in fact, many states have adopted higher standards of guaranteed access.** The demands for a basic “safety net” may call for some cross subsidies for the poor, particularly in areas where costs are prohibitively high. But this does not necessarily infer anything about the size of the unit of production. Ensuring equity of access to sanitary outcomes is a priority in the design, delivery and monitoring of sanitation programs. For instance, the promotion of latrine facilities through targeted subsidies for BPL households has led to these families investing some of their own resources to construct latrines. But in the many situations where the above the poverty line (APL) families have not invested in latrine facilities, the situation for the BPL families is not necessarily any better – especially where the BPL households are located adjacent to the “open defecation” sites. Equity in access to solid waste management “outcomes” implies that the public element of garbage disposal is equitable, rather than the provision of a particular service. For instance, a fixed charge on all households for waste disposal services is disproportionately loaded against the poor, since they generate less solid waste than the rich. Equity in access implies that the garbage

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<sup>50</sup> World Bank, 1999.

<sup>51</sup> Access to a minimum of 40 lpcd per 250 persons, within a single source located at a distance of 1.6 km or 100 m of elevation from every household.

disposal sites are not adjacent to SC and BPL landholdings; and that street sweeping or garbage disposal services (where provided by local government) are available in all areas. Equity in access to bathing facilities and burial sites similarly implies that SCs/ BPL families have commensurate access to facilities, though not necessarily to the same facilities.

## **Heterogeneity**

**The need for RWSS is homogeneous in that everyone requires access to drinking water and a place for defecation; but the demand for facilities is anything but homogeneous. People's choices about the form of their access are heterogeneous.** The combined need to manage externalities while ensuring equitable access suggests multiple responses to heterogeneity of demand – including the provision of a range of choices in the means of accessing services; and the decentralization of decision-making on the form and the functioning of the system so that the “collective” is able to respond to specific local demands.

## **Applying accountability criteria for jurisdictional allocation**

**Tables V.5 and V.6 in Volume III summarize the correlation of function, activity and accountability principles for the allocation of responsibility in RWSS.** Three criteria drawn from WDR 2004 - discretion and transaction intensiveness - suggest the size of the unit for the allocation of functions to different tiers of government.

## **Discretion**

**In water supply, generating demand for the creation of new assets and supporting the formation of User Groups to manage various aspects of service provision requires considerable discretion by the service provider.** The provision of physical capital generally has medium levels of contingency on the local conditions. M&E of levels of access, especially of the poor, requires some discretion. In sanitation, the provision of physical capital exhibits a higher level of contingency on local and individual sanitation practices. Effective demand generation requires a high degree of discretion on the part of the mobilization/ extension workers. Participatory Rural Appraisal (PRA) methodologies require considerable skill and discretionary responses from change agents who seek to embed change within a sustainable social and environmental context.

## **Transaction intensiveness**

**The mobilization of communities and the formation of User Groups for RWSS are extremely transaction-intensive.** Demand-responsive approaches that require consensus decision-making on the selection of water supply technologies, determining the sites for tap-stands and water sources, and determining the appropriate break-up of tariffs, are also highly transaction-intensive. Monitoring the quality of construction of water facilities generally requires a medium number of transactions to deliver quality infrastructure. In most cases, billing and collection is generally not transaction-intensive. Monitoring and evaluating levels of access to water supply is generally not transaction-intensive, but much higher levels of transactions are involved in evaluating the delivery of sanitary outcomes. While some understanding of sanitation can be evaluated through observation, understanding an individual's defecation and hygiene practices requires a medium level of transactions.

## Observability

**Who can best infer performance on water and sanitation?** Clearly the local level since it is where it will be best known whether water is being delivered or not or sanitation needs are being addressed.

## Ensuring accountability

More effective assignment of roles in RWSS requires specific attention to additional three areas: the clear separation of roles; an emphasis on O&M; and the creation of sanitary behavior change in keeping with a total concept of sanitation.

A clear separation of the policy and provider functions can be achieved by delegating down; delegating up; or by delegating out. In all three, the service provision function is accountable to the local government for arbitration, facilitation and oversight. But the service provision function needs to be clearly delineated from the governance function.

- Delegating down: Enabling some separation downwards between the local policy-maker and provider can be achieved through institutional separation (e.g. Kerala); role separation (e.g. Maharashtra); or separation by assignment, which enables a balance between performance objectives and standards for staff assigned as local government functionaries.<sup>52</sup>
- Delegating up: A degree of financial capacity and autonomy in determining whether to purchase expertise from higher tiers of government is essential in enabling lower tiers of government to deliver improved services to consumers. The success of any delegation upwards is dependent on the extent to which a local provider can hold a higher-level provider accountable for the delivery of requisite services. The procurement of a professional service needs to be differentiated from that of a professional public institution in one sense: the higher tier of government must be responsive to the client power exerted by the lower tier if the latter is to hold the former accountable.<sup>53</sup>
- Delegating out: In delegating out, government generally performs an oversight function, enabling the appropriate management of services by a higher tier. In West Bengal, most of the provision functions in sanitation are delegated out to the NGO that runs the RSM. The RSMs are hired and monitored at the district level on behalf of the block level.<sup>54</sup>

One of the objectives in separating the policy function from service provision is generating transparency on the quantum of public funds flowing to the provider. In both delegating down and delegating up, ensuring that the client (or client government) can hold providers accountable for high-quality services requires that the provider be placed under some hard budget constraints. In delegating down, a hard budget constraint on a provider strengthens downward accountability to users. Ideally, the GP should support funding only for the public good, and the private good

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<sup>52</sup> There is a need to separate the accountability of local government employees for performance (to their respective tier of local government) from their administrative accountability to higher tiers of government for meeting quality standards. This will ensure appropriate incentives for performance.

<sup>53</sup> In Maharashtra, this is being attempted through a process of corporatization of the state water board, thus seeking to make it dependent on the VWSC for financial survival.

<sup>54</sup> There is strong downward accountability to the clients in this model. This is achieved through an arrangement that aligns the financial viability of the RSM with their mobilization capacity, and the quality of the service that they provide to both BPL and APL consumers. The market forces element in this model could be strengthened if local government invited competitive bids for the right to operate a RSM. This could involve NGOs/ contractors submitting tenders on the lowest price for the establishment of an RSM, or the lowest price per latrine installed. By enabling NGOs/ contractors to innovate in reducing prices, the efficiency of service delivery may be improved significantly.

element should be completely funded by users. In delegating up, hard budget constraint will strengthen the higher tier's accountability to the GP. This also requires some separation between the higher-level service provider and the policy maker. Any financing from the policy function in the higher tier should be transparent and predictable, and less than the revenue receipts of the lower tier service providers.

Information. Once service provision has been separated from policy-making, policy-makers need information to ascertain the achievement of the requisite outcomes.

Performance. In India, the transfer of the O&M responsibility has not been clearly linked to the responsibility for re-investment, and higher tiers of government have incentives to create more assets. Thus there is a tendency to build an asset, run it down, and then rebuild it. But the evidence indicates that the focus should be on sustaining existing assets through improved O&M. The success of this alternative approach<sup>55</sup> to O&M will require moving away from tied funds that favor the creation of assets rather than their operations and maintenance.

The relevant guidelines are as follows.

- Policy and design standards: The governance of the policy and design function for RWSS should be clearly assigned to the state. The role of the center should be to support the states by creating incentives that promote sustainable access to high-quality services.
- Planning: The responsibility for planning for water supply should be assigned to the DP. This should include the provision of a receptive environment for “bottom-up” planning by GPs that “self-select” for the uptake of community-managed water supply schemes. The responsibility for the governance of planning processes for sanitation should reside with the GP, under a system of incentives that prioritize improved sanitation outcomes. The role of mobilizing GPs to take up this responsibility should reside with either the DP or the state.
- Asset creation: The responsibility for governance in the creation of RWSS assets should be clearly assigned to the GP. The GP should then delegate the responsibility for managing asset creation to the relevant sized service provision unit. The responsibility for the governance of HRD, accounting and technical design services – as well as service provision – should be unambiguously assigned to the DP. However, service provision can be either on a supply-driven basis (funds directed to the DP level and services provided to GPs); or on a demand-driven basis (funds flow to the GPs who purchase services from the range of HRD, accounting and design services offered by the DP). The responsibility for the governance of social capital (community mobilization,) should be assigned to the GP.
- Operation and maintenance: The governance of O&M should be clearly assigned to the GP, which in turn should give the actual responsibility to service provision units of appropriate scale.<sup>56</sup> Irrespective of the location of this service unit, the service is provided to the GP on a “fee for service basis.” The responsibility for funding maintenance lies with the User Groups, though the GP may offer loans or grants in the initial stages to help finance major

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<sup>55</sup> In Karnataka, the transfer of the O&M of existing assets to GPs has been funded through an O&M window. Since the state government has begun strengthening the upward accountability of GPs for the use of these funds, GPs find they need to strengthen their downward accountability to consumers. Some GPs are now establishing User Groups at the habitation level to operate schemes and raise revenues from users. At present, these GPs are funding the deficit in the O&M account of the User Groups, but in time the GPs should be able to introduce a hard budget constraint, provide incentives for performance, and re-invest in the upgradation of assets.

<sup>56</sup> A habitation-level user group, for instance, seems appropriate for most single village network schemes. However, private providers (such as farmers for pumped schemes) are also appropriate scale providers of O&M services. For multi-village schemes, complex water testing services and complex maintenance undertakings, the unit of service provision may be appropriately located at the district or state level.

maintenance costs. For sanitation, the GP is appropriately positioned to provide pure public services (street sweeping), while the habitation-level users of open defecation sites are best positioned to manage the public good element of the defecation practices and solid waste management services of individual households.

- **Monitoring and evaluation:** M&E should be assigned to the BP. This may require a small cross-sectoral team that reports to the BP on the performance of a wide range of schemes. The BP then pushes this information, either down to the GP to improve the compliance of User Groups, or up to the DP to bring incentives/ disincentives to bear on GPs for compliance. The role of the state in M&E is predominantly one of impact evaluation, providing support to the BP on the form of M&E, and bringing standards to bear across the state. The governance role of the BP in monitoring does not preclude functionaries at the block level from acting as the de concentrated arm of the DP or the state.

These guidelines for the assignment of activities in RWSS are to be seen in the context of two general guidelines – a shift from the rule-based central schemes predominant in the sector; and supporting the GOI’s incentive programs for state sector-wide reforms.

### **Moving away from rule-based CSS**

Although the relevant CSS are defined by a single set of guidelines, the actual assignment of functions in RWSS service delivery varies considerably across states. Thus while central schemes may be extremely prescriptive about functional assignments, the state has a role in determining such assignment. ARWSP, the most significant inter-governmental transfer in RWS, occurs, for instance, between the center and the states. Though ARWSP should be considered successful in its design to expand infrastructure coverage, the context in which the program now operates indicates that the sustainability of service provision is a more pressing issue, that is ARWSP does not provide incentives for O&M. The guidelines, processes and reporting associated with ARWSP are unsuitable.<sup>57</sup>

The MoU process proposed by the *Rajiv Gandhi National Drinking Water Mission (RGNDWM)*<sup>58</sup> involves the preparation of a time-bound proposal of the intended reforms necessary to define a sector-wide, sustainable structure for the transfer of responsibility for RWSS service delivery to local governments. The major reform incentives RGNDWM can provide states are those that can be leveraged through financing RWSS. In rural water supply, the quantum of the allocation to each state is affected by a state-wise allocation formula, and the share within a state is determined by the 80/20 split between ARWSP and Swajaldhara. This notion -- of developing incentives for states to reform the RWSS sector -- supports one of the conclusions of this study: most of the comprehensive reforms in RWSS appear to have been driven by the state through the compact arrangements with service provider(s) or relations with local governments. Under the proposed MoU arrangement, challenging the state-wise allocation formula might be utilized to create a “carrot” for reforms; while increasing the allocation to Swajaldhara can create the “stick” for states to reform their RWSS service delivery.

Under the existing allocation formula to states, the greatest weightage is given to states with the largest rural and/ or tribal populations, and the highest number of NC/ PC<sup>59</sup> and quality-affected

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<sup>57</sup> Although ARWSP guidelines place a cap of 15 percent on the quantum of funds that might be utilized for O&M, a significant portion appears to subsidize PHED operations and staff.

<sup>58</sup> See Chapter 3, section on water and sanitation.

<sup>59</sup> NC = Not Covered (access to <10 liters per capita per day); PC = Partially Covered (access to between 10 and 40 liters per capita per day).

habitations. However, with India having achieved 95 percent coverage in infrastructural access, a higher NC/ PC percentage might be indicative of the mismanagement of infrastructure rather than an absence of investment. This suggests replacing the NC/ PC indicator. What alternative indicator would best indicate a state's commitment to RWSS reforms? Options include local government revenue receipts as a percentage of state government expenditure on RWSS; GP (VWSC) expenditure on RWSS (devolved funds plus own revenue) as a percentage of the state government expenditure on RWSS; and GP (VWSC) revenue for RWSS as a percentage of total revenue for RWSS. The first of these options seems to offer the simplest system of determining a state's commitment to RWSS reforms. States that have developed a credible reform program and signed the MoU will not be bound by the dictates of central schemes. But for states that have not developed credible reform programs, increasing the Swajaldhara allocation and reducing the ARWSP allocation will help shift them closer to the reform agenda.

### *Employment programs*

**The goal of the SGRY program is to provide additional wage employment, food security as well as asset creation.** The four unbundled activities of an employment program -- targeting, activity selection, asset creation and M&E -- are analyzed by applying the first principles of public finance and accountability to allocate responsibilities across various tiers of government (see Volume III, Tables V.9 and V.10).

### **Economies of scale**

**In the coordination of any CSS, there are significant economies of scale in the setting of standards, and in targeting and budgeting, suggesting that these activities should be undertaken by the center and the state.** Since SGRY is implemented at the DP, BP and GP levels, cost efficiency suggests that both activity selection and asset creation should be localized at the level of implementation. But the economies of scale in M&E lie with higher levels of government for activities such as records of assets as well as financial audits; and with the lowest levels of government for social audits and the physical verification of assets.

### **Externalities**

In food- and wage-for-work programs, externalities are most likely in the actual creation of assets. If a GP decides to build a road connecting a few villages, the social networks of the laborers from these villages are enhanced. And once the road is built, employment opportunities and trade markets in these villages could improve.

### **Equity**

Central schemes bear testimony to the government's commitment to equity through employment programs that reduce poverty. In a caste-dominated country like India, equity issues, including the imbalance of poverty indicators across the states, should be dealt with at the highest level of government. The supervision and the hiring/ firing of personnel should also be dealt with at the highest level to ensure the inclusion of ST/ SC in these programs.

## Applying accountability criteria to employment programs

**Ideally, the relationship between citizens and policy-makers in employment programs should be such that the citizens delegate by choosing the executive in government, participate in planning processes to have a say in policy design, and pay taxes to finance the program.** The policy-makers and service providers perform by implementing schemes. Based on information from BGs on the impact of services, the state/ central and local governments create enforceability by rewarding/ penalizing the providers. In fact, international experience in targeting beneficiaries highlights the possibility of using communities to target benefits to households. Communities have information that can be used by local decision-making structures for better targeting without the high cost of either improving administrative targeting or self-selection targeting. The second relationship is the compact between policy makers and the organizational provider. In the decentralized system of governance, the accountability relationship has to apply to each level.

**But these ideal relationships of accountability remain far from ground realities.** Arguably, SGRY policy design does reflect an attempt to address the issue of accountability. Unlike most central schemes, SGRY emphasizes the role of PRIs in planning and implementation. But the failure to address key issues -- client power and the compact between policy-makers and providers – has led to concurrency, weak delegation and poor performance.

## Analyzing SGRY with the features of accountability

- **Delegating:** Client power is weak, particularly over the DP and BP, which prepare the action plans to commission public work in their respective areas of jurisdiction. The clients (individual beneficiaries in this case) play no role in preparing these plans presented at the *gram sabha*. Participation in the program is, of course, based on need and availability. Hence there is no delegation, and implementing agencies are neither directly aware of client needs, nor responsive to them.
- **Financing:** As a central scheme, SGRY finances are provided by the center and the state. To this extent, they are unrelated to any local-level taxes paid by the client. The providers themselves have no control over the finances, and this takes the client one step further from the financing process.
- **Performing:** The local governments, line departments and, occasionally, the service providers enter into a relationship of accountability with the client by performing their function of implementing the scheme. But the specific role of the PRI/ line department and service provider remains unclear.
- **Informing:** Relatively weak information dissemination means that beneficiaries know little about the scheme guidelines or its benefits.
- **Enforcing:** Given the weakness in the relationship between clients and providers, electoral choices are not necessarily connected to the impact of the scheme. And while there are some provisions for enforceability through social audits, these remain localized at the village level, and citizens have little or no ability to enforce accountability at either district or block level. The relationship between clients and the GP is somewhat stronger. The guidelines require that GPs regularly consult beneficiaries and share information with them through the *gram sabha*. The *gram sabhas* conduct yearly social audits and can lodge complaints at the DP level. The question is to what extent these provisions translate into accountability in practice.

**In sum, the center and the state enter into a “contract” with PRIs by devolving functions and resources as mandated by the guidelines.** The center and state hold the PRIs accountable – financial flows are contingent on the presentation of audited accounts. But several problems are evident:

- The involvement of multiple ministries undermines the clarity of roles and encourages functional overlap or concurrency – hence increasing the possibility of misappropriation (see Volume III, Chapter 4).
- Though the guidelines attempt strong upward accountability relationships,<sup>60</sup> downward and external accountability are missing at the DP and BP levels. Clients are already one step removed from policy makers at the BP and DP levels, and client voice is further weakened by patronage politics.
- The potential for collusion between PRIs and organizational providers is somewhat checked by the weak accountability relationship between PRIs and providers. But this also means that despite the guidelines, the state government controls SGRY implementation in most cases.
- The PRIs have no control over day-to-day activities since they have no administrative power over frontline providers and cannot hold them accountable.

#### **Assigning activities in employment programs: guidelines**

**We have seen that ideally, an employment program has to ensure effective targeting; efficient and labor-intensive activity selection; provide for widespread information dissemination and local capacity building; and ensure functioning monitoring systems.** What then should be the ideal institutional arrangements for the effective implementation of SGRY? We propose a system where the GP, in consultation with the *gram sabha*, has complete authority at every major step – beginning with activity selection and prioritization, asset creation and operationalization, to M&E. This proposal holds even when technical skills are required. In such cases, the GP should be able to outsource these skills.

The GP’s role: The bulk of resources should be transferred directly to the GP,<sup>61</sup> which should make all the major planning and operational decisions in consultation with the *gram sabha*. This implies that the GP will be responsible for the creation of all public works, the planning aspect in particular. All plans should be prepared by the *gram sabha* on the basis of the estimated budgetary allocations before the funds are sanctioned. This will mean a reduction of implementation delays, as only financial sanctions will be required once the funds have been devolved to PRIs. Moreover, the active role of the *gram sabha* in decision-making will localize asset creation. This will promote beneficiary awareness of plans prior to their implementation, leading to effective targeting.

The crucial factor of an effective *gram sabha*: The efficiency of this system is dependent on the effective functioning of the *gram sabha*. There is the possibility -- and the reality -- of the *gram sabha* either not being held; or when held, being ineffective because of poor participation.<sup>62</sup> But giving the GP greater financial powers will help enhance participation, since clients will have greater stakes in the proceedings of the *gram sabha*. There is also the question of the quality of participation. Often, power relations within the *gram sabha* keep the poorest -- the key

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<sup>60</sup> This is critical for addressing the problems associated with patronage politics, particularly because infrastructure related programs like SGRY can be susceptible to patronage politics. See WDR, 2004, pp. 159-163.

<sup>61</sup> This is as opposed to the current distribution of finances, which is 20 percent to DP, 30 percent to BP and 50 percent to GP.

<sup>62</sup> Pande et al, 2005.

beneficiary group -- outside the system. This possibility needs to be met with building the capacity of the GP and the *gram sabha*, as well as monitoring compliance.

**Box 1: NREGA<sup>63</sup> and SGRY- some differences**

- NREGA is a statute. NREGA has legal framework; SGRY is a programme. Therefore accountability towards statutory processes is much more vigorous in NREGA.
- NREGA has a Rights Based frame work
- NREGA is demand based and the beneficiary is expected to be the prime mover of the employment process
- Primary focus of NREGA is employment generation;
- The work selection and planning process of NREGA gives a central role to the PRI's and requires coordination among PRIs
- The village Panchayat has a pivotal role in NREGA processes
- Social audit by the Gram Sabha is a Statutory requirement. A system of Social Audit, supervision, computerized MIS is being put in place to improve the delivery of services at the Village Panchayat.
- Administrative expenses under NREGA take into account the provision of dedicated functionaries at the Gram Panchayat and Block levels for NREGA activities. NREGA administrative expenses also include training of PRIs as well as intensive IEC activity to enhance awareness among the local village community.
- NREGA functions devolved on the Gram Panchayat is backed by an effort to strengthen Gram Panchayat's resources in terms of functionaries and funds.
- NREGA offers an opportunity for capacity building of PRIs (specially the Gram Panchayat) and making their functioning transparent and accountable to the local community.

Capacity building of GPs and *gram sabhas*: The process of strengthening the capacity of GPs and *gram sabhas* involves a phased approach of scaling up the role of state-level training institutions such as SIPRDs by:

- Conducting training in all GPs and ensuring regular follow-up;
- Improving current training modules to focus on the issue of *gram sabha* participation; and
- Creating the skill set *gram sabhas* require to conduct social audits through direct interactions with NGOs, and raising local awareness of the *gram sabha*.

Monitoring compliance: Giving the GP greater financial responsibilities makes monitoring and supervision critical. The DP, and to some extent the BP, have to play an overall supervisory role and ensure that regular and effective *gram sabhas*, and social audits, take place. Creating the right incentives for each of the three tiers to function effectively involves following some guidelines:

- The DP has to undertake regular random visits to ensure that GPs hold *gram sabhas* on the dates agreed upon.

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<sup>63</sup> National Rural Employment Guarantee Act (NREGA) notified on September, 2005 and its coverage of 200 districts with effect from 2<sup>nd</sup> February, 2006. NREGA has now been extended to another 130 districts. The act provides that within five years of its notification it will cover the entire country. SGRY has subsumed in NREGA in the 200 districts and will subsume in the new ones that are covered. Thus the single vehicle for wage employment programme will be the NREGA.

- Based on benchmark performance indicators decided by the state government, GPs holding *gram sabhas* are rewarded with a combination of monetary and non-monetary incentives such as grants and awards.
- One option could be a financial penalty as an incentive for the GP to hold the *gram sabha*.

The role of the BP and DP: Often there are circumstances that call for intervention beyond the jurisdiction of a single GP (or BP). In public finance terms, this is an argument of economies of scale. The roles of BPs and DPs are similar to their current roles, but the voice element between client groups and the BP/ DP must be strengthened. To this end, we propose a system of contracting upward – in which the GP contracts the BP and DP to implement programs in their respective areas of jurisdiction. This would ensure that the BP and DP have proximity to the client through the GP and the *gram sabha*, thus creating conditions for strong accountability.

The role of functionaries: One of the critical gaps in the current system is the weak relationship between providers and PRIs. This leads to the broader issue of the relationship between PRIs and their functionaries -- who are state government employees and thus not accountable to the PRIs. The solution to this problem lies in a broader structural change: functionaries should be transferred to PRIs, and PRIs given complete authority over these functionaries. In the interim, and specifically for SGRY, transferring resources directly to the GP could create a system in which the GP (along with the BP and DP when required) could outsource the necessary technical expertise to a district pool of experts.

The role of the center vis-à-vis the state: Ideally, the state should be responsible for setting standards, and for the design elements of the program (particularly the minimum wage). However, the inherent nature of CSS has meant that the center too plays a role in this process. There are, then, three possible options:

- Offer states a menu of programs: This radical option would allow states to choose programs according to their needs, creating a more transparent system. This is also consistent with giving block grants<sup>64</sup> to states, and moving from a schematic to a thematic approach.
- Identify broad principles: The central government must play a role in addressing equity concerns. But in view of varied conditions in the states, state governments should design their own programs. In addition to reflecting local conditions, these designs must be based on key principles such as targeting SC/ ST populations and women.
- Set flexible guidelines: This option, probably the most feasible one, would have the center set guidelines in consultation with states as it does now. But the state would have flexibility on critical aspects such as wage rates and the form of compensation.

**In sum, the most feasible option has the central and state governments set standards, articulate broad policy guidelines, develop skills, and monitor the program financially.** All other operational decisions and processes are with the GP, with decisions being made in consultation with the *gram sabha*. The BP and DP play a supervisory role and are responsible for holding the GP accountable. Such a setup would enhance voice, compact, client power, and inter-governmental relationships among policy-makers.

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<sup>64</sup> This recommendation has emerged from the GOI. See GOI, 2004c and GOI, 2001b.

### *The assignment of financing*<sup>65</sup>

This study has defined assignment of roles in terms of who is in a better position to deliver quality services in a perfect world, that is, assuming that many other things come into place at the same time. Once expenditure powers are assigned to the level that is best suited to deliver those functions or activities, Government will need to address the financing issue.

**In India, like most developing countries, there is a large imbalance between revenues and expenditures.** The Center collects most revenues, but if the recommendations of this study are implemented, the states, the districts, the blocks and above all the Gram Panchayats, should be responsible for most expenditures. Hence a large proportion of central revenues will need to be passed down to states and lower levels to enable them to meet their responsibilities. The way these funds are devolved down will have substantial implications for how services are delivered.

**As discussed above, central funds are currently transferred down through two mechanisms: the Consolidated Fund of the States (CFS) and Centrally Sponsored Schemes.** The CFS distributes funds among states as block, untied grants, according to a formula that reflects population, poverty, backwardness and other parameters. Centrally Sponsored Schemes are matching grants to the states, tied to a certain type of expenditure (e.g. drinking water supply) that can be implemented according to a variety of rules that are scheme specific.

**Sometimes the Center also makes small allocations directly to lower levels of government (e.g. 11<sup>th</sup> Finance Commission Grants).** However most revenues of local governments are tied grants from the state. Tied means it is assigned to a quite precisely defined type of expenditure leaving little discretion for local governments to decide on how to spend the funds. Revenues raised by Panchayats range from small to negligible and we do not consider them in this discussion.

One way of categorizing the different ways of transferring central or state revenues down is the following:

- Untied grants--where we leave it up to local governments to decide where to and how to spend the money. For example, given a hard budget constraint, a local government may decide to put up a drinking water system and not another class room for the school.
- Matching grants--where higher level government will share local government expenditures hence creating an incentive for local governments to divert funds into a desired activity.
- Conditional grants--where funds are tied to specific expenditures. For example, teachers salaries or in a more modern set-up tied to outcomes such as attendance in schools.
- Own source revenues--GPs can levy some taxes, notably property taxes, and fees/charges. This is an underdeveloped set of financing sources and more revenue

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<sup>65</sup> This study dealt exclusively with service delivery and expenditure assignment, that is, who should be responsible for which services, which is where the reform of the intergovernmental system should begin. Once assignment is decided, the next step is to address financing issues ("finance follows function"), which will be the subject of a forthcoming reporting using West Bengal as a case study. In this section we offer only a general description of the principles guiding assignment of financing responsibilities.

powers need to be transferred down. At present, it accounts for very little of the financing.

**The central question for the various services discussed through out this report is whether transfers should be made conditional on the provision of those services at certain levels.** When local governments serve as agents of the center or state conditionality is obviously needed. This would apply to services that have very large externalities relative to the value of the benefits accruing locally. Vaccination would be an example.

**On the other hand, where the value of externalities is low compared with the value accruing locally discretion should be left to the local government of whether or not to finance the service, and an untied grant would be appropriate.** This might be the case with a local health clinic or a drinking water pump. These would be a high priority for the local population, therefore an accountable local government would have strong incentives to deliver them from its pool of untied resources; and at the margin it might need to prioritize one versus the other, again in response to local preferences.

Where the value of externalities or positive spillover effects is reasonable, matching grants would be the appropriate form of financing, and in this case the match from the state or center should be commensurate with the value of the externalities associated with the service. For many of the services discussed in this report externalities are relevant and some element of matching would be necessary, for example for school buildings or instructional services.

**The above discussion assumes that all local governments have been equalized in terms of the amount of funds they have at their disposal.** This means that they have been brought to a minimum level of revenues (combining own revenues and equalizing transfers) that enable them to meet a basic level of services.

**For the 5 tier Indian system, the vast majority of services discussed should fall at the state level or below.** This implies that the Consolidated Fund of the States, rather than Centrally Sponsored Schemes, would be the ideal vehicle for the Center to channel funds for those services<sup>66</sup>.

**However, the intergovernmental system is far from perfect and is in transition.** There are many information and governance failures. There are insufficient mechanisms of checks and balances and lines of accountability over decisions. This makes the case for maintaining key CSS to ensure services can happen where they are not being delivered and tying some of the grants going downwards to specific activities and outcomes. It is important that the system move in the right direction, albeit gradually. As an intermediary step the government may consider:

- Substantially reducing the number of CSS at the central level and channel released resources through the CFS.
- Make remaining CSSs thematic rather than tied to specific expenditures. General themes would be primary education, primary clinics, etc. Discretion should be left to lower levels how to manage and operate these.

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<sup>66</sup> Some of the work on financing is being done in the context of an ongoing study—Fiscal Decentralization to Rural Governments in West Bengal—and will present clear guidelines on how to design the transfer system during transition.

- Consider ear-marking certain percentage of the spending on capital and recurrent within this thematic block grant.
- For districts and blocks, which are not real governments since they lack both discretion and autonomy all transfers should be tied (For example for the training of teachers. Some of the state funds now passing to districts could be devolved to GPs, therefore increasing the revenue budget of the lowest level unit

## 7. Towards better rural services: recommendations

The initial hypotheses of this study were that in India there is a mismatch between what would be desirable in terms of responsibilities of different government tiers for service delivery and what the legislation mandates. And there is a mismatch between what the legislation mandates and what is implemented. There is therefore both a problem of design and of implementation.

In terms of design, and taking decentralization as the goal, the study conclusions make a strong case for a general shift to giving the lowest level of government the responsibilities of asset creation and operation and maintenance, while involving it in the planning process through the *gram sabha*; giving the middle tiers responsibility for human capital development; giving higher levels of government the responsibility of policy and standards; and moving away from rule-based CSS towards fiscal transfers through the state's consolidated fund, conditional on reforms.

In terms of implementation the study highlighted the ambiguity of the legislation which allows states to get away without implementing decentralization across sectors, and the lack of mechanisms, other than centrally sponsored schemes to influence state behavior in this regard. Centrally sponsored schemes however are often more part of the problem than the solution because they are rule based and tied to precise expenditures, leaving little discretion at the local level.

As recommendations the study calls for a series of measures that would take into consideration that the system is in transition and that a gradual approach may be necessary; it is however also necessary that this approach move the service delivery towards the right direction, which, for most services, is decentralization.

### *Study conclusions*

**Across the key sectors, the assignment of responsibilities in the law mandates a role for PRIs, but in most cases the law is sufficiently ambiguous to allow for decentralized and centralized modes of service delivery to co-exist.** *The de facto situation* does not match the *de jure* situation. In some cases, where the states have clearly devolved responsibilities to the *panchayats*, the rule-based central schemes that dominate the sector are not necessarily in consonance with state laws. The surveys and analysis of the status quo revealed that all services are still largely being provided in a top-down manner through the state civil service, and that services continue to fail the rural poor. Even where services have unequivocally been devolved to *panchayats*, their ability to influence outcomes is limited because of the lack of financial and administrative control. The various laws and guidelines in place have given rise to the coexistence of different models of public service delivery, often with the involvement of representatives or officials from the five tiers of government.

In summary the study finds the following:

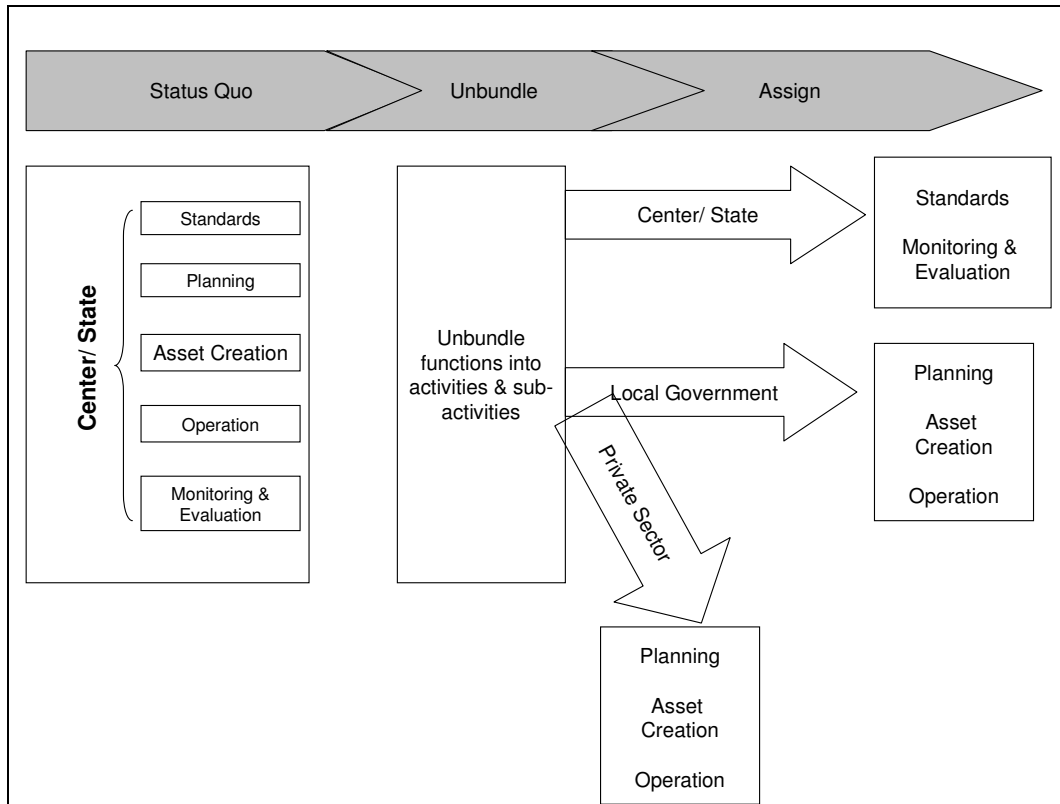
- **Consistent with the decentralization to the states, the Constitutional Amendment gives the states the responsibility for creating the enabling environment for local governments.** Other than on political aspects of decentralization, such as holding of elections, and presence of *Gram Sabhas* and reserved seats, state governments have considerable scope on how to pursue decentralization. As a result, implementation of decentralization varies across states.
- **The Indian legal system allows concurrency and this is good.** This is a positive feature because for complex sectors such as health and education, all tiers of government need to be involved.
- **But at the activity level there needs to be exclusive decision making given to a single tier.** It is not sufficient to attribute roles over broad functions such as primary education or drinking water and sanitation. Decision-making and expenditures in India take place at the level of activity or subactivity (budget item) and responsibilities over these activities (e.g. repairing schools, hiring teachers) need to be unequivocally assigned. With few exceptions this does not happen in India.
- **Legislation defining roles in service delivery is spread over a large number of legal instruments that often contradict each other, but this is allowed in Indian law.** Roles in service delivery, where prescribed (and this does not happen in all states or all sectors), are defined through State *Panchayat* Acts, Central Sector Acts, State Sector Acts, State Government Orders and Central Guidelines in Centrally Sponsored Schemes. The large number of ruling of different tiers of the judicial system up to the Supreme Court adds to this body of jurisprudence. While these various pieces of legislation contain contradictions, in the absence of “exclusivity of powers of *Panchayats*”, overlaps in service provision are permitted in Indian law. States would need to revise both *Panchayat* and sector legislation and related Government Orders to bring consistency, and only Kerala has done so.
- **Centrally Sponsored Schemes are highly distortionary to the institutional and organizational framework adopted by states in support of decentralization.** Centrally Sponsored Schemes follow their own guidelines, often at crossroads with state legislation. And because a large amount of funding reaches the states through CSSs, the institutional arrangements prescribed in them come to dominate the institutional picture.
- **Most states have failed to support devolution of functions with devolution of funds.** The legal framework is weak in fiscal devolution. Although every state needs to set up State Finance Commissions, their recommendations are not mandatory and their capacity, in most cases, as left a lot to be desired. Thus states vary widely in terms of fiscal powers and fiscal role given to *Panchayats*.
- **And no state has devolved responsibility over functionaries to the local level and together with lack of funds this handicaps the ability of *Panchayats* to deliver meaningful services even where legislation assigns to them the main role.** The Constitutional Amendment is silent on the responsibility over functionaries and State *Panchayat* Acts has also evaded this issue. Functionaries thus remain state officials, as they have been historically.

- **.Overall the study finds that practice on the ground is more centralized than what the legal framework prescribes.** Even for states or sectors that have unambiguously decided to devolve activities to the local level, practice lags behind the spirit of the law, with state government staff still in charge of the most relevant decisions in service provision.
- **And that service delivery in rural areas has perverse and systematic problems and outcomes are poor.** Education achievements are poor, particularly for girls in rural areas, and absenteeism among teachers is high despite them being relatively well paid. Expenditures on preventive health are limited and the private sector accounts for 80% of expenditures on curative health, despite the network of clinics and hospitals. Public health services are often regressive benefiting the rich more than the poor. Like for teachers, health workers are often absent from primary clinics. Drinking water quality is poor and there is little effort at operation and maintenance of facilities. Sanitation outcomes lag far behind what would be desirable. Employment programs have failed to have an impact commensurate with the volume of expenditures.

**Recommendations**

**Taking decentralization as the goal, how should responsibilities be allocated among the different levels of government?** The answers to this question have to be based on some rational criteria, and this study has used two main sets of criteria. The first set stems from public finance literature. It looks at economies of scale, externalities, and equity, all three of which would push the service upward; and heterogeneity, which would push the service downward. The second set of criteria is concerned with maximizing the accountability of the service provider to the client, i.e. the people. In the process, the service is examined to determine the extent to which it is discretionary, requiring a judgment related to outcomes; the extent to which it is transaction-intensive, requiring a large number of transactions; and the extent to which it is observable. Table 3 summarizes the recommended main functions of the different government tiers in delivery rural services – in the key sectors of education, health, water and sanitation, and employment programs.

**Figure 7: The Analytical Approach**



**Education**

The lowest level of government: There is a strong case for giving the responsibility of operating schools to the lowest level of government, the GP. There are no economies of scale in operating a school. In fact, each GP would need to contain more than one primary school. Heterogeneity occurs in the need to match teaching style to the teachers’ preferences and socialization. Local forces may want schooling tailored to the local culture, customs and history. Accountability

criteria support this result. Aspects such as teacher absenteeism and students with special needs are more observable at the local level.

Higher levels of government: Curriculum design, textbooks, the development of learning material, and M&E should be the responsibility of higher levels of government. There are economies of scale in curriculum design, evaluation, and textbook and learning material development. Again, there are externalities in curriculum design, the setting of standards, and M&E. The question is how equity considerations are to be addressed. The answer seems to be that the center or the state should make sure of allocating budgets in consistency with the inequalities they want to address.

## **Health**

The role of public funds: In health, the first priority is for most public money to go to preventive and promotive health services in general. This is particularly true for the control of communicable diseases, where there are large externalities. Many of these services (e.g. sanitation) do not fall under the authority of the health department, and reforming towards decentralization would create opportunities to ensure that these services are also provided. The shift of public money to preventive and promotive health services involves a two-part process: large-scale pest control at the appropriate level; and small-scale, transaction-intensive preventive and promotive activities, such as immunization and health education at the GP level. Technical support for local health educators, such as teaching materials, could come from higher tiers. But the workers themselves could be paid by, and be accountable to, local governments. In the case of testing and similar support services, one option is to let local governments contract up for the services of technical specialists. In general, when services are subject to substantial economies of scale and highly technical personnel are required, the higher levels of government need to be involved. For example, the higher levels should set standards for health education activities.

Curative care: As far as government role in curative care is concerned, the long-term option is to pay its providers for services delivered. But in the short term, two models are possible -- the Kerala model of giving GPs substantial responsibilities for primary care operations, but with the modification of administrative control to GPs; and the emerging West Bengal model of GPs joining together to hire qualified doctors. If either of these approaches is adopted, funding needs to be shifted from states to GPs through block grants. The monitoring of outcomes and standard auditing practices will have to be performed by the higher tiers of government.

## **Water supply and sanitation**

Shift of emphasis: In water supply, the priority has to move from access to the O&M of facilities, and the quality of water. The focus in sanitation has to shift from latrine construction, which has not solved the sanitation problem, to creating a healthy environment. The top-down civil service approach to sanitation has to change if this outcome of “total sanitation” is to be achieved.

Local-level involvement: Public finance criteria suggest that the operation of rural water facilities should be at the local level. There are no economies of scale in operating rural water facilities, and larger and more complex systems do not carry a financial advantage in rural India. To some extent, externalities in drinking water are captured at the local level. There is considerable heterogeneity of demand in drinking water -- reinforcing the need to decentralize decisions on the type of design, location and operation to the lowest level. Most activities in sanitation should be carried out at the lowest level – the village or the household. The construction and operation of

sewage systems is, for example, clearly a matter for the village. There are no economies of scale. There are externalities associated with the spread of disease but these are also sufficiently internalized at the local level. There is considerable heterogeneity since sanitation is a private activity characterized by many elements of local customs. Regarding equity, the same considerations as those for water apply here. Distributional issues can be addressed through the fiscal transfer system. Accountability criteria yield similar recommendations to those suggested by public finance criteria. The GP and/ or the users should be responsible for asset creation and O&M; and the DP for human capital development.

Higher levels: As in other sectors, economies of scale occur at the policy and standards level, M&E and human resource development. There are considerable externalities associated with broader water resource management and this should be a responsibility of higher levels of government. The same applies to M&E of drinking water outcomes. Access to drinking water is a universal right in India, and it can be accomplished through appropriate fiscal incentives from higher levels of government. In the case of sanitation, the state should be responsible for policy and planning.

CSS: Accountability criteria suggest moving away from CSS towards the use of fiscal transfers through the state's consolidated fund. Transfers from the center should be untied, and conditional on a set of reforms that have been agreed upon and that can be monitored. This includes the assigning of responsibilities to the appropriate level. At the state and lower levels, GPs should be responsible for asset creation and O&M, the state for policy and standards, and the DP for planning and human resource development. M&E should be placed at the block or district levels.

### **Employment programs**

**There are economies of scale in policy setting, planning and M&E, and externalities in asset creation.** There is a breakdown of accountability relationships in current institutional arrangements – particularly in the critical aspects of downward and external accountability. On this basis, this study recommends a drastic revamping of employment programs away from rule-based CSS. All the major decisions should be delegated to the GP and *gram sabha* levels, and the DRDAs dismantled. Funds should be transferred to the states through the Consolidated Fund. What is needed, above all, is an independent and legitimate system to monitor access to public jobs at the local level. Equally important is monitoring the quality of *gram sabhas* in terms of participation and transparency.



- Cost efficiency in employment programs suggests activity selection and asset creation be localized, while monitoring and evaluation remain with higher levels of government.

### **Sector specific recommendations**

Education: Both public finance and accountability criteria make a strong case for giving the GP the responsibility of operating schools. Curriculum design, textbooks, the development of learning material, and monitoring and evaluation should be the responsibility of higher levels of government. The center or the state should also make sure of allocating budgets in consistency with the inequalities they want to address.

Health: The first priority is for most public money to go to preventive and promotive health services in general, and the control of communicable diseases in particular. This is a two-part process, consisting of large-scale pest control at the appropriate level; and small-scale, transaction-intensive preventive and promotive activities, such as immunization and health education at the GP level. Technical support for local health educators, such as some teaching materials, could come from higher tiers. But the workers themselves could be paid by, and be accountable to, local governments. In the case of testing and similar support services, one option is to let local governments contract up for the services of technical specialists. In general, when services are subject to substantial economies of scale, the higher levels of government need to be involved. For example, the higher levels should set standards for health education activities. As far as government role in curative care is concerned, the long-term option is to pay its providers for services delivered. But in the short term, two models are possible -- the Kerala model of giving GPs substantial responsibilities for primary care operations, but with the modification of administrative control to GPs; and the emerging West Bengal model of GPs joining together to hire qualified doctors. If either of these approaches is adopted, funding needs to be shifted from the states to GPs through block grants. The monitoring of outcomes and standard auditing practices will have to be at the higher levels of government.

Water and sanitation: In place of the current emphasis on access to infrastructure – which has not yielded results – policy-makers have to be involved in defining the quality of access parameters, and in providing an environment in which those parameters might be met. The top-down civil service approach to sanitation has to change if the outcome-oriented approach is to be adopted. Most activities should be carried out at the lowest level – the construction and operation of sewage systems is, for example, clearly a matter for the village. The GP and/ or the users should be responsible for asset creation, and operation and maintenance; the BP for monitoring and evaluation; and the DP for human capital development. The state should be responsible for policy and planning. Finally, accountability criteria suggest moving away from the central schemes predominant in the sector.

Employment programs: The study recommends a drastic revamping of employment programs away from rule-based centrally sponsored schemes. All the major decisions should be delegated to the GP and gram sabha levels, and the District Rural Development Agencies (DRDAs) dismantled. In fact, across sectors, a shift is recommended from central schemes to fiscal transfers through the state's consolidated fund. Transfers from the center should be untied, and conditional on a set of reforms that have been agreed upon and that can be monitored. This set of reforms includes the assigning of responsibilities to the appropriate level. At the state and lower levels, GPs should be responsible for asset creation and operation and maintenance, the state for policy

and standards, and the DP for planning and human resource development. Monitoring and evaluation should be placed at the block or district levels.

## References

- Ackerman, S.R. 1999. *Corruption and Government: Cause, Consequences, and Reform*. New York: Cambridge University Press.
- Aiyar, M.S. 2002. "Panchayati Raj: The Way Forward." *Economic and Political Weekly*.
- Banerjee, A., S. Cole, E. Duflo and L. Linden, L. 2003. Remediating Education: Evidence from Two Randomized Experiments in India. Unpublished.
- Banerjee, A. and Duflo, E. 2005. Improving Health care Delivery in India. Mimeo, MIT.
- Center for Education Research and Innovation. 1998. Education at a Glance: OECD Indicators 1998, Organization for Economic Co-operation and Development.
- Chaturvedi, I.S. 2004. *Elementary Education in Bihar: Towards Better Management*. MPA/ID SYPA, Kennedy School of Government.
- Chaudhury, N., J. Hammer, K. Muralidharan, M. Kramer, and F.H. Rogers. 2004. Teacher and Health Care Provider Absence: A Multi-Country Study. Unpublished.
- Chatterjee, M. 1989. Primary Education and Primary Health: Directions and Intersections. Paper prepared for the World Bank Country Economic Memorandum on Poverty, Employment and Social Services, The World Bank, Washington D.C., processed.
- Chatterjee, M. 1990. Decentralization of Health Care: How Does Health Policy Fit?. Paper presented at the Conference on Decentralization, National Institute of Advanced Studies, Bangalore.
- Clarke, P. 2003. *Education Reform in the Education Guarantee Scheme in MP, India and Fundescola, Brazil*. World Bank, March 2003.
- Clarke, P., and J. Jha. 2004. Improving Education Service Delivery in *Rajasthan*: Collaborating between Civil Society and Government. Mimeo, The World Bank.
- Constitution of India, Seventy-Third Amendment Act, Article 243 (A-O) of Part IX.
- Coulson, A. 2003. "Implementing Education for All: Moving from Goals to Action." Paper presented at the Fondazione Liberal's Second International Education Conference, Milan, Italy, May 17th, 2003.
- Das, J. and J. Hammer. 2004a. "Which Doctor? Combining Vignettes and Item Response to Measure Doctor Quality." Policy Research Working Paper Series, #3301. The World Bank, forthcoming in *Journal of Development Economics*.
- \_\_\_\_\_. 2004b. "Strained Mercy: Quality of Medical Care in Delhi." *Economic and Political Weekly*, February 28, 2004.
- Dasgupta, A. 2004. "Alternative Policies on Education and Health with Special Reference to the State of West Bengal and India." Presentation made at Harvard University, November 2004.
- Datt, G. and M. Ravallion. 1994. "Transfer Benefits From Public Works Employment: Evidence for Rural India." *The Economic Journal*, Vol.104, No. 427, 1346-1369.
- Deshingar, P. and Johnson. 2003. "State Transfers to the Poor and Back: the Case of the Food for Work Program in Andhra Pradesh." Working Paper 222, Overseas Development Institute, [www.odi.org.uk](http://www.odi.org.uk).

Dobbin, F., forthcoming. "The sociological view of the economy." In F. Dobbin (ed.), *The New Economic Sociology: An Anthology*. Princeton, NJ: Princeton University Press.

Duflo, E. and Hanna, R. 2005. *Monitoring Works: Getting Teachers to Come to School*. Mimeo, MIT.

Feedback Ventures. 2004. *Draft Rural Water and Sanitation Sector Assessment Study of Andhra Pradesh*.

Filmer, D. 2005. *Educational Attainment and Enrollment Profiles: A Resource "Book" based on an Analysis of Demographic and Health Survey Data*. (Periodically updated). *Development Research Group, The World Bank*. see: <http://www.worldbank.org/research/projects/edattain/edattain.htm>

Filmer, D. and L. Pritchett. 1998. *Educational Attainment Profiles of the Poor (and Rich): DHS Evidence from Around the Globe*. Mimeo, The World Bank. (<http://www.worldbank.org/research/projects/edattain/edattain.htm>).

\_\_\_\_\_. 1999. "Educational Enrollment and Attainment in India: Household Wealth, Gender, Village, and State Effects." *Journal of Educational Planning and Administration*, 13(2): 135–64.

Foster, V. 2002. "Ten Years of Water Service Reform in Latin America: Towards an Anglo-French Model." In Paul Seidenstat, David Haarmeyer, and Simon Hakim (eds.), *Reinventing Water and Wastewater Systems: Global Lessons for Improving Management*. New York: John Wiley and Sons, Inc.

Galasso, E. and M. Ravallion. 2003. "[Social Protection in a Crisis: Argentina's Plan Jefes y Jefas](#)." [Policy Research Working Paper Series](#) 3165, The World Bank.

Government of India (GOI). Website of the Ministry of *Panchayats*: [www.panchayat.nic.in](http://www.panchayat.nic.in).

\_\_\_\_\_. Website of the Department of Drinking Water Supply: [www.ddws.nic.in](http://www.ddws.nic.in).

\_\_\_\_\_. 1993. *Eighth Five Year Plan (1992-1997)*. Planning Commission, GOI.

\_\_\_\_\_. 1998. *Ninth Five Year Plan (1997-2002)*. Planning Commission, GOI.

\_\_\_\_\_. 1999a. *Guidelines on Central Rural Sanitation Campaign, Total Sanitation Campaign*.

\_\_\_\_\_. 1999b. *Rajiv Gandhi National Drinking Water Mission*, Department of Drinking Water Supply, Ministry of Rural Development.

\_\_\_\_\_. 2000. *Status of Elementary Teachers of India, Year 2000*. Assessment of EFA, Ministry of Human Resource Development.

\_\_\_\_\_. 2001a. *Review of the Working of the Constitutional Provisions for Decentralization (Panchayats): A Consultation Paper*. National Commission to Review the Working of the Constitution (NCRC), GOI.

\_\_\_\_\_. 2001b. *Report of the Task Force on Devolution of Powers and Functions Upon Panchayati Raj Institutions*. Ministry of Rural Development: Department of Rural Development (*Panchayati Raj* Division), GOI.

\_\_\_\_\_. 2001c. *Tenth Five Year Plan (2002-2007)*, Chapter 5. Planning Commission, GOI.

\_\_\_\_\_. 2002a. *Comptroller and Auditor General of India Report on District Primary Education Program*, Ministry of Human Resource Development.

\_\_\_\_\_. 2002b. *Pradhan Mantri Gram Sadak Yojana: Scheme and Guidelines*. Ministry of Rural Development, GOI.

\_\_\_\_\_. 2002c. Report of the National Commission to Review the Working of the Constitution (NCRC). Ministry of Law, Justice and Company Affairs, Department of Legal Affairs.

\_\_\_\_\_. 2003. Draft MOU Guidelines 06/11/03. *Rajiv Gandhi National Drinking Water Mission*, Department of Drinking Water, Ministry of Rural Development, GOI, <http://ddws.nic.in/Data/Swajal/DO-JS.htm>.

\_\_\_\_\_. 2004a. Annual Report of the Ministry of Rural Development. Government of India.

\_\_\_\_\_. 2004b. Guidelines: *Sampoorna Grameen Rozgar yojana* (SGRY), Ministry of Rural Development, GOI.

\_\_\_\_\_. 2004c. Report of the Task Force of Officials in Charge of *Panchayati Raj* in States to Examine the Centrally Sponsored Schemes. Ministry of *Panchayati Raj*, GOI.

Government of India. 2001. National Human Development Report 2001. Planning Commission, Government of India. 2001

Government of India. 2004. Analysis of Budget Expenditure on Education, Department of Education, Planning and Monitoring Unit, Ministry of Human Resource Development, Government of India

Government of Karnataka. 2001. Government Order No RDP 145 PPM 98 dated 19th June 2001, Department of Rural Development and *Panchayat Raj*.

\_\_\_\_\_. 2002a. Government Order No RDP/384/GPA/2002 dated 23<sup>rd</sup> November 2002, Department of Rural Development and *Panchayat Raj*.

\_\_\_\_\_. 2002b. Report of the Working Group on Decentralization. Department of Rural Development and *Panchayati Raj*.

Government of Kerala. Website of the Department of *Panchayats*:  
<http://www.localgovkerala.net/lsgd/Links/Research/Statusofpanchraj.htm>.

\_\_\_\_\_. 1999. Final Report of Committee on Decentralization of Powers, Part A, October, 1999.

\_\_\_\_\_. 2001. The Kerala Water Supply and Sewerage (Amendment) Act, 1993.

Government of *Rajasthan*. 1999. Pragati Pratedan 1998-99. Department of Elementary and Secondary Education, Jaipur.

Government of West Bengal. 1973a. West Bengal *Panchayat Act*, Law Department, Government of West Bengal.

\_\_\_\_\_. 1973. West Bengal Primary Education Act. Law Department, Government of West Bengal.

Hanushek, E. 1995. "Interpreting Recent Research on Schooling in Developing Countries." *The World Bank Research Observer*, August 1995, pp. 227-246.

Harilal, K.N. 2004. "Reforming Local Governance Structures in India: Lessons from the Kerala Experiment." Paper Presented in the International Symposium, Citizen's Participation in Local Public Policy Making: European Experiences in Global Perspectives, <http://lorc.ryukoku.ac.jp/docs/Harilal-paper.pdf>.

Heaney, J. P., D. Sample and L. Wright. 2000. *Cost Analysis and Financing of Urban Water Infrastructure*, Chapter 10. In R. Field et al (eds.), *Innovative Urban Wet-Weather Flow Management Systems*, Lancaster, PA: Technomics Publishing Co.

Howes, S. and R. Murgai. 2004. *Subsidies and Salaries: Issues in the Restructuring of Government Expenditure in India*. World Bank.

Imami, K. 2000. "Targeting Versus Universalism: An Evaluation of Indirect Effects -- the Employment Guarantee Scheme in India." Department of Economics, Royal Holloway, University of London.

International Institute for Population Sciences. 1999. *India National Family and Health Survey-2*. 1999.

Institute of Development Studies. 1998. *Bringing Citizen Voice and Client Focus into Service Delivery: Education Guarantee Scheme, Madhya Pradesh, India*. University of Sussex, UK.

Isham, J., D. Narayan and L. Pritchett. 1995. "Does participation improve performance? Establishing causality with subjective data." *World Bank Economic Review*, 9(2): 175-200.

Jalan, J. E. and Glinskaya. 2003. *Improving Primary School Education in India: An Impact Assessment of DPEP-Phase I*. Unpublished.

Jenkins, M.W. 1999. PhD thesis, University of California at Davis, Department of Civil Engineering.

Kerala Institute of Local Administration. 2005. *Survey on State of Panchayati Raj Institutions and Public Services in Kerala*. Survey done for World Bank. Kerala Institute of Local Administration. 2005.

Kingdon, G.G. 1996a. "Private Schooling in India: Size, Nature and Equity Effects." *Economic and Political Weekly*, 31, No. 51: 3306-3314, December 1996.

\_\_\_\_\_. 1996b. "Student Achievement and Teacher Pay: A Case Study of India." Discussion Paper No. 74, Development Economics Research Program, STICERD, London School of Economics, August 1996.

Kingdon, G. G. and M. Muzammil. 2000. "A Political Economy of Education in India: The Case of U.P." Mimeo; first half published in *Economic and Political Weekly*, August 11, 2001.

Kremer, M., N. Chaudhury, J. Hammer, K. Muralidharan, and F.H. Rogers. 2004. [Teacher Absence in India: A Snapshot](#). Mimeo submitted to the Journal of the European Economic Association.

Kremer, M., S. Moulin and R. Namunyu. 2003. "Decentralization: A Cautionary Tale." Poverty Action Lab Working Paper.

Leonard, Dutch. 2002. Personal communication cited in L. Pritchett and M. Woolcock, 2004. "Solutions When the Solution Is the Problem: Arraying the Disarray in Development." *World Development*, 32.2 (February 2004): 191-212.

Leonard, K., G.R. Mliga and D.H. Mariam. 2002. "Bypassing Health Centers in Tanzania: Revealed Preferences For Quality." *Journal of African Economies*, vol. 11, issue 4, pp. 441-471.

Mahal, A., J. Singh, F. Afridi, V. Lamba, A. Gumber and V. Selvaraju. 2002. *Who Benefits from Public Sector Health Spending in India*. New Delhi: National Council for Applied Economic Research, 2002.

Mathew, G. et.al. 2000. *Status of Panchayati Raj in the States and Union Territories of India 2000*. Indian Institute of Social Sciences. New Delhi: Concept.

Mathur, O.P. 2000. "State Local Fiscal Relations." In D.K. Srivastava (ed.), *Fiscal Federalism in India: Contemporary Challenges*. National Institute of Public Policy. As quoted in GOI 2001, "Review of the

Working of the Constitutional Provisions for Decentralization (*Panchayats*): A Consultation Paper,” National Commission to Review the Working of the Constitution.

Mehrotra, S. and P. Buckland. 2001. “Managing School Teacher Costs for Access and Quality in Developing Countries – A Comparative Analysis.” *Economic and Political Weekly*, December 8, 2001.

Mehrotra, S. 2002. “Basic Social Services for All? Ensuring Accountability Through Deep Democratic Decentralization.” Background Paper for Human Development Report 2002.

Misra, A. 2005. Report for Expenditure Tracking Exercise for SGRY and Mid-Day Meals. Report prepared for South Asia Rural Development Department, World Bank

Misra, R.K. 1997. National Civil Service System in India: A Critical View. Paper presented at ‘Civil Service Systems in Comparative Perspective’, Indiana University, Bloomington, Indiana, April 5-8, 1997

Murray, C.J.L., K. Styblo and A. Rouillon. 1993. “Tuberculosis.” In D.T. Jamison et al (eds.) *Disease Control Priorities in Developing Countries*. Oxford University Press for the World Bank, New York.

Narayan, D. 1995. “Contribution of People’s Participation: Evidence from 121 Rural Water Supplies Projects, Environmentally Sustainable Development.” Occasional Paper Series, No.1, World Bank, Washington D.C..

Nayak, R., N.C. Saxena and J. Farington. 2002. “Reaching the Poor: The Influence of Policy and Administrative Processes on the Implementation of Government Poverty Schemes in India.” Working Paper.

Oommen, M.A., forthcoming. Fiscal Decentralization to Rural Local Bodies: A Case Study of Kerala. A World Bank sponsored study, 2003.

Pande, R., R. Vijayendra and T. Besely. 2005. Participatory Democracy in Action: Survey Evidence from South India. World Bank.

Peters, D.H., A.S. Yazbeck, R.R. Sharma, G.N.V. Ramana, L.H. Pritchett and A. Wagstaff. 2002. *Better Health System For India’s Poor: Findings Analysis and Options*. World Bank, Washington D.C..

Pritchett, L. 2004. “Towards A New Consensus for Addressing the Global Challenge of the Lack of Education.” Copenhagen Consensus Challenge Paper.

Pritchett, L. and M. Woolcock. 2004. “Solutions When the Solution Is the Problem: Araying the Disarray in Development.” *World Development*, 32.2 (February 2004): 191-212.

PROBE Team. 1999. *Public Report on Basic Education in India*. New Delhi: Oxford University Press.

Ramachandran, V. and H. Sethi. 2000. *Rajasthan Shiksha Karmi Project: An Overall Appraisal*. New Education Division Documents No.7, SIDA, Embassy of Sweden, New Delhi.

Rao, M.G. 2002. “Poverty Alleviation under Fiscal Decentralization.” In M.G. Rao et al (eds.), *Development, Poverty and Fiscal Policy*. Oxford University Press, 2002.

Ravallion, M. and J. Jalan. 1999. “[Income Gains to the Poor from Workfare: Estimates for Argentina's Trabajar Program](#).” [Policy Research Working Paper Series](#) 2149, The World Bank.

Ravallion, M. and Q. Wodon. 1999. “Does Child Labor Displace Schooling? Evidence on Behavioral Responses to an Enrollment Subsidy.” [Policy Research Working Paper Series](#) 2116, The World Bank.

Registrar General of India. 2003. SRS Based Abridged Lefe Tables, SRS Analytical Studies, Report No. 3 of 2003, New Delhi: Registrar General of India

Scott, J. 1998. *Seeing Like a State: How Certain Schemes to Improve the Human Condition Have Failed*. New Haven, CT: Yale University Press.

Sethi, G. (ed.) 2004. *Fiscal Decentralization to Rural Governments in India*. Published for the World Bank by Oxford University Press, New Delhi.

Shariff, A., P.K. Ghosh and K.S. Mondal. 2002. "Indian Public Expenditures on the Social Sector and Poverty Alleviation Programs in the 1990's." Working Paper 169, Overseas Development Institute, [www.odi.org.uk](http://www.odi.org.uk).

Singh, A.S., Jain, V.K., Gautam, S.K.S., and Kumar, S. 2004. Learning Achievement of Students at the End of Class V. Department of Educational Measurement and Evaluation, National Council of Educational Research and Training

Srivastava, P. 2004. "Targeting Measures Used in Anti-Poverty Programs." Discussion Paper No. 5, ADB Institute, [www.adbi.org](http://www.adbi.org).

State Institute of *Panchayati Raj* and Rural Development. 2005. Survey on State of *Panchayati Raj* Institutions and Public Services in West Bengal. Survey done for World Bank. State Institute of *Panchayati Raj* and Rural Development. 2005

The Pratichi (India) Trust. 2001. The Pratichi Education Report.

*The Statesman*, Kolkata, November 23, 2004.

Tilak, Jandhyala B.G. and R. Sudarshan. 2001. "Private Schooling in Rural India." NCAER Working Paper No.76, National Council for Applied Economic Research, New Delhi.

Tooley, J. 2001. "[The Enterprise of Education](#)." Occasional Paper No.6, Liberty Institute, India.

United Nations Development Program (UNDP). 2002. *Rajasthan Human Development Report 2002*, Chapter IV: Primary Education in *Rajasthan*.

\_\_\_\_\_. 2004. West Bengal Human Development Report 2004, Chapter 7: Primary Education in *Rajasthan*.

UNICEF and WHO. 2004. Meeting the MDG Drinking Water and Sanitation Target: A Mid Term Assessment of Progress, August 2004.

United Nations Development Program. 2004. Human Development Report 2004. UNDP

Water and Sanitation Project, South Asia (WSP-SA). 2005. Scaling-Up Rural Sanitation in South Asia: Lessons Learned from Bangladesh, India and Pakistan. WSP Regional Study, May 2005.

Winkler, D. and A.I. Gershberg. 2000. "Education Decentralization in Latin America: The Effects on the Quality of Schooling." LCSHD Paper Series, World Bank.

World Bank. 1996. *India: Primary Education Achievement and Challenges*. South Asia Country Department II, Washington D.C.

World Bank. 1998. *Reducing Poverty In India: Options for More Effective Public Services*. A World Bank Country Study.

World Bank. 1999a. *Project Appraisal Document for Rajasthan Primary Education Project*. Report No: 18934-IN, Education Sector, South Asia Region, Washington D.C.

World Bank. 1999b. *Beyond the Center: Decentralizing the State*. World Bank Latin America and Caribbean Studies Viewpoints, LAC Region, Washington D.C.

World Bank. 2000. *Overview of Rural Decentralization in India – Volume I*, Rural Development Unit, South Asia Region.

World Bank. 2003. *World Development Report 2004: Making Services Work for Poor People*. Washington D.C.

World Bank. 2004a. *India: Fiscal Decentralization to Rural Governments*. New Delhi: Oxford University Press.

World Bank. 2004b. "Project Appraisal Document on a Proposed Credit to Republic of India for an Elementary Education Project."

World Education Forum. 2000. "Education for All: Meeting Our Collective Commitments." The Dakar Framework for Action, UNESCO.

Zeckhauser, R. 1970. "Medical Insurance: A Case Study of the Tradeoff Between Risk Spreading and Appropriate Incentives." *Journal of Economic Theory*, Vol. 2, pp. 10-26, 1970.

#### ***State Acts***

Karnataka Education Act, 1983, amended 1995

Mysore Public Health Act, 1944

Karnataka *Panchayat Raj* Act, 1994

Karnataka Ground Water Regulation Act, 2003

Kerala *Panchayat Raj* Act (amended 1994)

Kerala Education Act, 1958 (now Act 16, 2000)

Kerala Water Supply and Sewerage Act 14, 1986, Amendments and Other Regulations

Kerala Water Supply and Sewerage (Amendment) Act, 1993

Travancore-Cochin Public Health Act, 1955

Kerala *Panchayat Raj* (Construction and Maintenance of Public Latrines, Urinals, Bathing Places and Sanitation of Private Premises) Rules, 1998

*Rajasthan Panchayat Raj* Act, 1994

West Bengal *Panchayat Raj* Act, 1973

West Bengal Primary Education Act, 1973

#### ***Judgments***

C. Rangaswamiah vs. State of Karnataka (1998) 6 SCC 66; State of Punjab vs. Inder Singh (1997) 8 SCC.

Central Inland Water Transport Corporation vs. Brojo Nath Ganguly (1986) 3 SCC 156; DTC v. DTC

Mazdoor Congress (1991) Supp (1) SCC 600.

J. Raghuram Judgment Para 113-126 in Ranga Reddy District Sarpanches Association vs. Government of AP and Ors WP Nos. 12348 and 12356 of 2002, decided on: 29.01.2004, reported as (2004)2 ALD 1.

Secy, State of Karnataka vs. Umadevi (2004) 7 SCC 132.

Lal vs. the State of Uttar Pradesh, Supreme Court Judgment, SUPP SCC 28, 1984.

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