Helpdesk Research Report: Effects of decentralisation on social spending

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**Query:** What is the evidence of numerically quantifiable benefits from development interventions that have created or strengthened local elected councils? In particular, is there any evidence that locally elected or newly devolved councils have, through their oversight role on budget allocations and expenditure increased the amount spent on social sectors, e.g. education and health?

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1. Overview

Decentralisation and devolution to locally elected forms of government is often promoted as a means of: 1. giving local citizens and their representatives more decision-making power (political decentralisation); 2. redistributing authority, responsibilities and resources among different levels of government (administrative decentralisation); and 3. localising authority over raising revenues and decision-making in expenditures (fiscal decentralisation). Support to the development of local government structures, including assistance for local elections, technical assistance and direct budgetary support is a common feature of international assistance for supporting democratic governance, particularly in fragile and post-conflict states.

Evidence of the effectiveness of decentralisation, and particularly fiscal decentralisation, on improving governance and social spending is limited. For instance, Burgess (no date) notes: 'In terms of concrete empirical evidence we are not in a good position to answer critical questions such [as] is a decentralized system more efficient than a centralized system. The empirical basis for choosing decentralization over centralization (or vice versa) is thus weak'. Shah, Thompson and Zou (2004: 12) further note: 'While in theory, [decentralisation] is expected to have positive impacts on the efficiency and equity of public service provision, in practice, these outcomes
depend upon the existing institutional arrangements (including power relations) and coherence of decentralisation policies to create the proper incentive environment for bottom-up accountability.’

In fact, as the literature below shows, most of the outcomes are mixed, emphasising that devolution is not automatically beneficial. Rather, a number of factors influence the success of local government structure in improving social spending. These include:

- The institutional framework: the differences in professional capacities among public servants, the legal framework, the management systems, and the technical infrastructure (Cabrero and Carrera, n.d.).
- The interrelationship between political, administrative and fiscal decentralisation: progress in one area without concurrent decentralisation in others is unlikely to reap benefits. Evidence shows that central governments have been slow generally to devolve fiscal responsibility particularly, so local governments’ expenditure autonomy remains limited (Dabla-Norris 2006).
- In terms of fiscal decentralisation, the relationship between revenue and expenditure is important, e.g. transferring unrestricted, general-purpose revenues without negotiating expenditure responsibilities carries dangers (Peterson 1997).
- The source of revenue itself is important, for instance, whether a budget is made up of locally-collected taxes or central allocations. In many countries, local governments have limited local tax capacity and are highly dependent on transfers from the central government, yet studies (e.g. Govil 2011) have shown that fiscal decentralisation through assignment of taxation powers is more effective in achieving desired outcomes as compared to transfer of grants.
- There is a need for effective coordination between the different levels of government, particularly in federal systems. For instance, Nigeria’s constitution provides for the participation of all three tiers of government in the delivery of core public services, such as education and health. This makes policy coordination an important pre-condition for effective and efficient service delivery (Freinkman 2007).
- The benefits of recent fiscal decentralisation can be distributed unevenly across sub-national governments, depending on the relative wealth of different states/regions in federal systems and how funds are allocated. For instance, in Nigeria, 54 per cent of federation account funds are distributed equally across states, which works against more populous states, and the allocation of oil revenues primarily benefits only four states (Freinkman 2007).

As the annotated bibliography below shows, different studies display a variety of findings. However, evidence of numerical benefits is very limited, and by and large, most studies indicated mixed results, largely due to the factors highlighted above. The limited selection also points to a lack of local-level data on decentralised social spending, which makes in- and cross-country analysis difficult to achieve, a limitation that is often recognised in the literature.
2. Evidence of benefits


This paper assesses the effect of fiscal decentralisation of health expenditure on infant mortality rates in Colombia. Infant mortality rates for 1,080 Colombian municipalities over a 10-year period (1998-2007) were related to fiscal decentralisation, measured as the locally controlled health expenditure as a proportion of total health expenditure. The researchers also evaluated the effect of transfers from central government and municipal institutional capacity, and compared the effect of fiscal decentralisation at different levels of municipal poverty. They found that fiscal decentralisation decreased infant mortality rates. However, this effect was stronger in non-poor municipalities than poor ones. The results suggested that fiscal decentralisation decreased infant mortality by 12.6 per cent in non-poor municipalities, while this effect was just 8.1 per cent in the poor ones. The researchers conclude that while devolving the allocation of responsibilities to municipalities decreased infant mortality rates, this improved health outcome effect depended greatly on the socio-economic conditions of the localities.


A policy change of 1997 in the Central Indian province, Madhya Pradesh, whereby the power to collect royalty and lease rents on minor mineral mines and fishing ponds was transferred to village governments served as a natural experiment enabling the comparison of social outcomes in villages endowed with such natural resources with those totally dependent on transfer grants from the state and central government for their development needs. The findings demonstrate that performance of local governments depends not only on the resources available for development expenditures and provision of public goods, but also on the sources from which these revenues are financed. Greater own-source revenues resulted in better outcomes than transfer grants.

3. Mixed results

This paper provides an in-depth analysis of the relationship between fiscal decentralisation and pro-poor outcomes, based on the role of fiscal incentives in Viet Nam between 2002 and 2006. It assesses the effectiveness of the Vietnamese system of fiscal decentralisation for achieving pro-poor outcomes through a devolved system of fiscal incentives. The study shows that fiscal decentralisation may contribute to poverty reduction outcomes, but does not provide evidence that fiscal decentralisation is inherently pro-poor: aggregate expenditure has increased for all provinces over time but has not become more pro-poor, while fiscal transfers have become both larger and more pro-poor. Though the time period is not long enough to make definitive conclusions, it is possible to infer that fiscal decentralisation has not been inherently pro-poor from the expenditure perspective. However, decentralisation has been responsive to pro-poor outcomes, by making use of fiscal transfers to compensate and target development outcomes in poorer provinces over time.

http://heapol.oxfordjournals.org/content/18/4/357.full.pdf+html

This article examines decentralisation, allocation choices made by local authorities, and the performance of health systems in Zambia. Indicators such as the utilisation of health services, immunisation coverage and family planning activities showed little variation during the period 1995-98 except for a decline in immunisation coverage, which may have also been affected by changes in donor funding. Performance since decentralisation has not shown much difference, and did not respond to differences in income or urbanity, so it is likely that decentralisation did not change the initial distribution of expenditures very much. Overall, the researchers found no clear evidence that decentralisation has had a positive or negative impact on the Zambian health system. This indicates that even in a poor country with declining health budgets, allowing district health officials a moderate degree of choice for many key functions has not led to radical increase in inequalities among districts, and has not reduced utilisation of health services. It also suggests that when implementing decentralisation, attention should be paid to the details of allocation decisions and capacity to collect funds from local sources. The findings also suggest the need to pay more attention to the process and degree of decision space allowed to local authorities.


This study considered the impacts of decentralisation on education, health and agriculture in Kenya, Uganda and Tanzania. It found that decentralisation has not been implemented as the only mode of service delivery and multiple external factors have impacted on the level of service delivery over the past 5-10 years. Furthermore, all the countries display hybrid rather than ‘pure’ models of decentralisation, with features of both centralised and decentralised service delivery. This is despite clear policies to decentralise by devolution in particularly Uganda and Tanzania.
Primary education has generally achieved significant quantitative improvements with substantial increases in school enrolment, facilities and equipment in all three countries, but this has first and foremost been the result of significant increases in funding. There is also general agreement amongst various stakeholders that elements of decentralisation and institutional arrangements for local service delivery have both promoted or constrained positive developments in the three countries. Performance of the health sector is also primarily explained by levels of funding and not substantially by the patterns or degree of decentralisation. However, the health sector has in all three countries introduced systems of transparent fiscal transfers to districts and enabled technical staff in districts to plan more responsive to local needs, however the involvement of district politicians at district level has been limited and virtually non-existent at sub-district level.

Schneider, A., 2002, Decentralisation and the Poor, Institute of Development Studies, Brighton
http://www.dfid.gov.uk/R4D/PDF/Outputs/Mis_SPC/R76163.pdf
Patterns of decentralisation and pro-poor policy outputs are studied in 67 countries. The wide variety of indicators of decentralisation clustered around fiscal, administrative, and political dimensions, and these dimensions had independent relationships with social policy. The results of regression analysis demonstrate that dimensions of decentralisation have independent, and at times, opposite effects on pro-poor policy. The impact of political decentralisation was consistently in the direction of less pro-poor policy. Administrative decentralisation at times had positive effects, and fiscal decentralisation did not appear statistically significant in any analysis. Consistent with much of the decentralisation literature, administratively decentralised countries showed greater attention to social spending. However, fiscal decentralisation showed no relationship to social policy. Further, politically decentralised countries spent less on social policy. In particular, the negative relationship associated with political decentralisation suggests a need to look deeper into the impact of political decentralisation on the ability of the poor to advance demands.

Fiscal decentralisation is financially attractive to national governments because part of the burden of financing services can be shifted to sub-national governments and private providers. This study of fiscal decentralisation in South Africa reveals three fundamental features. Firstly, the national government has a specific responsibility for spearheading action and creating a positive framework, while sub-national governments have a vital role to play in meeting the needs of residents through the delivery of basic social services such health, education, water, sanitation and housing. Secondly, the allocation of revenue-raising capacity among sub-national governments is uneven, which necessitates compensation between levels of government (vertical) or among the sub-national governments themselves (horizontal). Thirdly, the success of public service delivery is still limited, suggesting a need for a strong social policy environment based on equity and socioeconomic justice. It concludes that for most sectors that are of particular relevance to poverty reduction, such as health and education, there is, in fact, no strong evidence that fiscal decentralisation helps reduce poverty.
4. Negative impacts

http://www.uneca.org/atpc/Work%20in%20progress/58.pdf

The South African federal system is characterised by a relatively high degree of fiscal decentralisation in terms of expenditure responsibilities and administration. However, owing to historical imbalances across provinces and municipalities, constitutional and institutional arrangements allow for extremely limited revenue autonomy. On average provincial expenditure on education as a percentage of their total expenditure amounted to about 40 per cent, while health expenditure was about 25 per cent. Since around the year 2000, the share of education and health in total provincial expenditure has been slowly declining (to about 35 per cent and 20 per cent, respectively). This decline is perhaps a reflection of the fact that demand for education and health services increase with development up to a certain point, after which demand for other services become more important. Once that point is reached governments will be inclined to spend relatively more of their revenue on services other than education and health, although education and health still account for more than 60 per cent of total expenditure.

The researchers also compare the nine South African provinces in terms of per capita GDP, own revenue as a percentage of total revenue, and the shares of education and health in total provincial expenditure. In most cases there appears to be a direct relationship between the share of own sources revenue in total revenue and the share of education. But there is no clear relationship between own source revenue and the share of health in total expenditure. This suggests that as provinces endeavour to collect more revenue from local sources, they tend to raise spending on basic services other than health. It is also possible that to meet higher demand for education and other services, provinces tend to collect more revenue locally.

http://heapol.oxfordjournals.org/content/16/2/187.short

This paper explores changes to budget allocations for health during the decentralisation process in Uganda, which was introduced in 1992, with financial decentralisation through unconditional block grants arriving in 1995/6. When the districts were given the authority to allot their own budgets, allocations for health were reduced considerably. The shadow budget projected an allocation of 4 billion Ugandan shillings for primary healthcare but district administrations only allocated 1.1 billion shillings. In the following financial year (1996/7) their allocation rose to 2.6 billion shillings, which was still far below the shadow budget’s allocation. Reasons for this include: district officials feel healthcare is very expensive and its needs are difficult to satisfy; healthcare planning is a highly technical issue from which local politicians feel excluded; other sectors (e.g. education, infrastructure) contribute to health so objectives cannot be obtained without a holistic and integrated approach; and there is a perception that the health sector is already well-funded through donor commitments.

This paper focuses on how far decentralisation produces improvements in service delivery for the poor, drawing on evidence from numerous studies. For instance, it highlights a comparative review of educational decentralisation in four Latin American countries in the 1980s – Argentina, Chile, Colombia, and Mexico – which concluded that decentralisation of education did not lead to discernible quality improvements, but rather produced negative equity effects, with the result that the gap between better off and worse off schools actually widened. Educational expenditures fell in three of the four countries (with the exception of Argentina) on account of sharp decreases in teachers’ salaries, under conditions of fiscal austerity. Regarding healthcare, evidence from six Latin American countries indicates that the quality of service provision has worsened under decentralisation. Transfer of financial resources and staff to lower levels of government neither improved service delivery nor reduced the costs of care.

The evidence from sub-Saharan Africa is very limited. Despite the inclusion of decentralisation in public sector reform efforts in the 1980s and early 1990s by countries such as Uganda, Botswana, Nigeria, Ghana, Côte d’Ivoire, Kenya and Tanzania, one commentator stated that ‘there are no real success stories as far as improved development performance at the local level is concerned’.

Evidence from Asia is also scarce. Country studies of healthcare spending under decentralisation in China, India, Indonesia and the Philippines point to a decline or stagnation after decentralisation started in these countries. In China and India, local governments were unable to fulfil their new responsibilities for healthcare provision in the absence of inadequate resource transfers from central government. But in contrast, health outcomes in Indonesia and the Philippines improved significantly during decentralisation, reflected in a sharp decline in the under-five mortality rate, largely because of reforms in healthcare funding. Drawing on survey data from 33,000 households in villages across India, Mahal et al. (2000) demonstrate that decentralisation of public service delivery in primary healthcare and education services is positively correlated with improved child mortality and school enrolment. However, health and education services in India are generally under the jurisdiction of state governments and local councils have limited influence over the use of resources or deployment of personnel.

5. References


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http://www.cesifo-group.de/portal/pls/portal/docs/1/1193506.PDF

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