Local Government Accountability for Health Service Delivery in Nigeria

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Decentralisation to locally elected governments has recently become popular as a means to improve incentives of public providers for service delivery to poor people. Yet, empirical evidence on how decentralisation initiatives work in practice is lagging. This paper provides new survey evidence from the health sector in Nigeria, one of the few countries in the developing world to have significantly decentralised both fiscal resources and service delivery responsibilities, on how locally elected governments actually function in delivering basic health services to their citizens. We find evidence of limited accountability at local levels, specifically reflected in the non-payment of salaries of health workers, variation in which cannot be explained by appealing to lack of resources available to local governments. Faced with this evidence, we explore solutions in the context of on-going policy discussions on intergovernmental fiscal relations in Nigeria.

1. Introduction

A great deal of attention in development research and policy circles has recently focused on the efficacy of public expenditures in providing basic services to poor people, and on how actually making services work for the poor is constrained by weak incentives of public agents (The World Bank, 2004; Fosu and Ryan, 2004). In this context, decentralisation to locally elected governments has been explored as a means of strengthening incentives of public providers for improved service delivery (Bardhan, 2002). How accountable are locally elected governments for the delivery of

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local public services? Although this question is of increasing importance as several developing countries are beginning to decentralise responsibility for local public services to local institutions, actual empirical evidence on local government accountability for service delivery is lagging. This paper attempts to fill this gap by providing evidence from Nigeria, one of the few countries in the developing world to have significantly decentralised both resources and responsibilities for the delivery of basic health and education services to locally elected governments.

We interpret accountability as follows — a public agent is accountable for a particular aspect of service delivery if: (1) the agent assumes and is assigned responsibility for that aspect of service delivery; (2) the agent has some minimum resources and capacity for that aspect of service delivery; and (3) the agent actually undertakes appropriate actions towards service delivery, given resource and capacity constraints. In Nigeria, formal rules exist on paper defining the roles and responsibilities of local governments for the delivery of primary health care services; yet there is ambiguity inherent in the language of these rules, and uncertainty about how local governments function in experience. This paper presents new evidence on local accountability for health services delivery — how responsible are local governments for service delivery, what resources they have and what they allocate to service delivery, and how well they perform their functions — from a survey of local governments and primary health facilities in the states of Kogi and Lagos. Using this evidence, it draws policy lessons in the context of on-going discussions in the country on intergovernmental fiscal relations.

A survey of 30 local governments, 252 public primary health facilities and over 700 health care providers was carried out in the states of Kogi and Lagos in the latter part of 2002.[2] The design of the survey allows us to focus on a particular aspect of primary health care services — the functioning of public primary health care facilities. Local government officials and facility managers were asked to identify the public agents primarily responsible for different aspects of service delivery in primary health care facilities; data on actual local government revenues and expenditures was directly obtained from local government financial records; questions were asked of facility

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[2] Adeniyi *et al*. (2003) describe the survey in detail. The Appendix to this paper provides a brief summary description.

staff about the functioning of health facilities, especially in those areas where responsibility rests with local governments. Linking the evidence from these different sources — local government records, local officials and facility staff — allows the paper to draw inferences about accountability of local governments for service delivery.

One area of service delivery that falls squarely under the direct responsibility of Local Government Authorities (LGAs) and is determined directly by their decisions and actions is that of payment of salaries of health staff. This paper will focus on payment of staff salaries to draw lessons about accountability of LGAs. While this focus on staff salaries might appear odd in a general context, non-payment of salaries has been identified as an endemic problem in basic service delivery by local governments in Nigeria, where a problem of non-payment of primary school teacher salaries created a public outcry in the 1990s. While some contend that there are perverse incentives at the local level to misallocate public resources, others maintain that the problem is lack of adequate resource transfers to local governments to finance their expenditure responsibilities (Olowu and Erero, 1995; Ekpo and Ndebbio, 1998; The World Bank, 2002). This paper is the first, to the best of our knowledge, to provide any rigorous evidence on this issue.

The paper is organised as follows. Section 2 provides a brief overview of the formal definitions of the roles and responsibilities of local governments, and resources available to them for health service delivery in Nigeria, as provided in the Constitution (Federal Republic of Nigeria, 1999) and the National Health Policy (Federal Ministry of Health, 1996); Section 3 presents survey evidence on responsibilities actually assumed by local governments, and attributed to local governments by facility managers, and on resources actually available to local governments and allocated by them to health services; Section 4 focuses on payment of staff salaries, given LGA resource constraints, to assess accountability of local governments in service delivery; Section 5 concludes by exploring policy lessons in the Nigerian context.

2. Institutional Decentralisation of Responsibility and Resources to Local Governments

Nigeria has been organised as a federal country since 1954 with the responsibility for providing most public goods being concurrently

shared between the federal and state governments. In 1976, LGAs were established and recognised as the third tier of government, responsible for participating in the delivery of most local public services along with state governments, and entitled to statutory revenue allocations from both the federal and state governments for the discharge of their responsibilities. In the late 1980s there was a national initiative to overhaul the primary health care system through the adoption of a new national health policy, in the context of which the federal and state governments issued directives giving LGAs full jurisdiction over the delivery of primary health care services (Olowu and Erero, 1995; Adeniyi *et al.*, 2001).

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

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

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

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

Such language implies that according to the Constitution, it is the state governments that have principal responsibility for basic services such as primary health and primary education, with the extent of participation of LGAs in the execution of these responsibilities determined at the discretion of individual state governments. The constitutional existence of state-level discretion might lead to disparities across local governments or across states in the extent to which responsibility for primary health is effectively decentralised. In the face of such constitutional ambiguity, the survey of LGAs and health facilities asked questions of respondents at both levels about the extent to which service delivery responsibilities are actually assumed by local governments.

Both states and local governments are constitutionally entitled to a share in the Federation Account, a divisible pool of federally collected revenues including oil revenues, which forms the bulk of all government resources in Nigeria. The exact percentage of resources accruing to the different tiers of government is subject to review and revision every five years by the National Assembly upon advice from the Revenue Mobilisation Allocation and Fiscal Commission (RMAFC). LGAs are also entitled to a share of federally collected VAT revenues (outside of the Federation Account). These statutory allocations from the federal government are the main source of financing of local government expenditure responsibilities.

Between 1999 and 2002 LGAs were entitled to 20% of the total revenues in the Federation Account, and in 2002 the formula was revised with local governments entitled to a slightly higher percentage.[3] Although these allocations are meant to be general purpose revenue transfers, untied to any particular sector, there are several deductions made from them, the largest and most contentious of which is deductions for the payment of primary school teacher salaries for which LGAs are responsible. Many LGAs claim that these 'deductions-at-source' in essence imply that they get 'zero-allocations' (The World Bank, 2003). Hence, although there exists a regular channel of substantial revenue flows to local governments, there is once again uncertainty about the extent to which resources

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[3] However the share of local governments is likely to be even higher in substantive terms because of a 2002 Supreme Court ruling that prohibited the federal government from making so-called 'first charges' on the Federation Account, which had thus far effectively reduced the amount of revenues going into the divisible pool.

actually reach the local government to be used at their discretion. The survey evidence addresses this uncertainty by providing information, from actual financial records of LGAs, of what they report as actually receiving as revenues.

LGAs are also supposed to receive statutory allocations from state government revenues, but the rules related to this are less strict and not always enforced (Ekpo and Ndebbio, 1998). The Constitutions also provides for significant own tax bases for LGAs, but studies have shown that these have not been explored to full potential, and that internally generated revenues are a small proportion of total LGA revenues (Olowu and Erero, 1995; Khemani, 2001).

In addition to the general fiscal resources available to local governments the National Health Policy also provides guidelines to all three tiers of government to prioritise resource allocation in favour of preventive health services and primary health care, the cornerstone of the national health program. In this spirit of prioritisation, the federal and state governments are expected to provide logistical and financial assistance to the LGAs, primarily for procuring drugs, vaccines and essential equipment, and for the implementation of programs of national importance such as the National Program of Immunisation, or controlling the spread of HIV/AIDS. The federal budget in recent years has included programs of facility construction in local governments. However, there are no established rules or policies for the provision of financial assistance from the higher tiers of government, and it is not clear how well any assistance that is forthcoming is coordinated with LGA budgets and plans for primary health services. Although this survey has not provided any concrete data with regard to coordination between the three tiers, interviews with agencies at different tiers of government suggest that there is often lack of clarity, and lack of ownership of local governments, in efforts that require coordination between all three tiers of government (Khemani, 2001).

3. Survey Evidence on Responsibilities and Resources of Local Governments

The survey addressed a particular aspect of public delivery of health services — the functioning of public primary health care facilities. The Nigerian Health Policy assigns the responsibility of managing two types of health facilities to local governments — Type 1 facilities,

such as health posts, which are village-level facilities, typically staffed by a junior paramedic and an assistant and supplied with the most basic amenities; and Type 2 facilities, the Primary Health Centres (PHCs), which are larger facilities with a more diverse complement of staff and amenities. The survey asked respondents at both the LGA and facility level which agency, choosing *one* amongst the federal government, the state government, the LGA, community-based organisations and facility head or staff, was the *principal decision-maker* for each of the following areas of PHC service provision in health facilities: undertaking new construction, such as facility expansion; acquiring new equipment; making drugs and medical supplies available; setting charges for drugs and treatment; use of facility revenues from treatment and consultation; managing and disciplining staff; transferring staff between facilities.

The overwhelming majority of LGA respondents indicated the LGA as the principal decision-maker for most of the areas of facility-level provision of PHC services. Of the 29 LGAs that responded to these questions, 21 listed the LGA as the principal decision-maker for *all* of the areas listed above. Of the remaining LGAs, seven listed the LGA as the principal decision-maker for most service delivery activities, except one or two areas that were assigned to other agencies in an unsystematic way. For example, the state government was cited by two LGAs as the principal decision-maker for undertaking new construction, by one LGA for setting charges of drugs and treatment, and by one for decisions of transferring staff between facilities, with all other decisions being principally determined by the LGA.[4]

Table 1 shows that the overwhelming majority of respondents at the facility level also indicated the LGA, amongst the three tiers of government, as the principal decision-maker for various aspects of facility-level provision of primary health services.[5] There was no systematic variation across local governments in the extent of decentralisation of responsibility — the state and federal

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[4] Only one LGA, Ibaji LGA in Kogi state, listed an agency other than the LGA, namely, community-based organisations, as the principal authority for the majority of the decisions of day-to-day running of facilities. This LGA had been pointed out during fieldwork for the survey as particularly remarkable for its extent of community participation in health service delivery (Adeniyi *et al.*, 2003).

[5] We have only included a sub-set of the most critical areas in this table, in the interest of brevity.

Table 1: *Facility-Level Responses on Principal Decision-Makers for Facility Functioning*

	KOGI	LAGOS
Who is the principal decision-maker for facility repair and construction?		
Federal Government	0.67	0
State Government	0	1.03
Local Government	57.05	94.85
Community	40.94	4.12
Facility Head/Staff	1.34	0
Who is the principal decision-maker for acquiring new equipment?		
Federal Government	0.66	0
State Government	0	0
Local Government	71.71	96.91
Community	17.11	2.06
Facility Head/Staff	10.53	1.03
Who is the principal decision-maker for making drugs available?		
Federal Government	0.66	0
State Government	0	0
Local Government	59.60	95.83
Community	16.56	2.0
Facility Head/Staff	23.18	2.08
Who is the principal decision-maker for making medical supplies available?		
Federal Government	0.66	0
State Government	0	0
Local Government	68.87	97.94
Community	12.58	1.03
Facility Head/Staff	17.88	1.03
Who is the principal decision-maker for managing/disciplining staff?		
Federal Government	0.67	0
State Government	0	5.21
Local Government	89.33	79.17
Community	4.67	2.08
Facility Head/Staff	5.33	13.54
Who pays staff salary?		
Federal Government	2.5	0.9
State Government	0.4	1.9

Table 1 (*continued*)

	KOGI	LAGOS
Local Government	94.58	96.2
Community	0	1.1
NGO/Donor/Individuals/Other	2.5	0

Values in the columns indicate the percentage of facility respondents that chose the agency listed to the left; the total respondents are an average of 150 respondents for Kogi and 97 respondents for Lagos; Values in the columns for staff salary indicates the percentage of staff respondents that responded 'yes' for the agency listed to the left; the total respondents are 240 staff for Kogi and 472 staff for Lagos.

governments were indicated by a trivial number of respondents as principal decision-makers for any area of decision-making. This evidence for the health sector is a striking contrast to available evidence for service delivery in other sectors — such as primary education, water and sanitation — that are characterised by considerable overlap and confusion with regard to the sharing of responsibilities between the three tiers of government, often at the expense of undermining LGA responsibility and accountability (Olowu and Erero, 1995; Khemani 2001).

However, in Kogi, community involvement and facility-level leadership or discretion in various aspects of service delivery frequently overshadowed the importance of the LGA. While in Lagos 95% or more of facility-level respondents indicated the LGA as principal decision-maker for most aspects of service delivery at the facility level, in Kogi, only between 50 and 70% indicated the LGA as the principal decision-maker. Respondents in Kogi indicated communities and facility staff as particularly responsible in the areas of facility maintenance and in making drugs available, the latter being consistent with the supposed existence of drug revolving funds in Nigeria a community-managed & financed system envisaged under the Bamako Initiative (see WHO, 1987), (Adeniyi *et al.*, 2001). However, managing and disciplining staff was overwhelmingly indicated as the responsibility of local governments.

Payment of staff salaries thus emerged as a particular aspect of service delivery for which LGAs are assigned and assume almost

exclusive responsibility in both states. This is a critical input for basic health service delivery, particularly as envisaged in the Nigerian primary health care system. Type 1 and 2 facilities are designed to be managed by community health workers, that is individuals selected from communities that are trained in the very basic preventive and curative care for the specific purpose of providing a public service to their communities. While the state government is responsible for training these community health workers, the local government is responsible for paying their salaries and managing their day-to-day functioning in service delivery (Adeniyi *et al.*, 2001; Ransome-Kuti *et al.*, 1990).

The survey collected data on actual revenues received by LGAs, and health expenditures actually undertaken by them for 1999 and 2000, by scrutinising available actual financial documents. It was not possible to collect actual revenue and spending data beyond 2000 because of the general non-availability of actual accounting data for more recent budgets.[6] Table 2 shows summary statistics on per-capita revenues in the two states. Average per-capita revenues in both states doubled in 2000, owing to the country-wide increase in oil revenues which led to greater allocations to LGAs from the Federation Account. The facility survey has therefore been undertaken at a time when LGA revenues have been substantial and rising. Although the levels of per-capita revenues are not significantly different across the two states, there is greater variation across LGAs in Lagos state, with the richest LGA (Ibeju-Lekki) having more than 10 times the per-capita revenues of the poorer LGAs. In terms of US dollars, using an exchange rate of 102 Naira for 1 USD (The World Bank, 2003), the average for the sampled LGAs in the two states is over 20 USD per capita.

Figures 1a and 1b show the composition of LGA revenues on average for each of the two states. Local governments in Kogi are overwhelmingly dependent on statutory allocations from the Federation Account and VAT, which together constitute 99% of LGA revenues. Revenue sources of local governments in Lagos are more diversified — the bulk of their revenues comes from the Federation Account and VAT, but a substantial amount (8%) is

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[6] All that was available beyond 2000 were budget *estimates*, not actuals. Instead, the analysis undertaken here focuses on actual, accounted, revenues and expenditures in the years 1999 and 2000 for which data were available from LGA records.

Table 2: *Per Capita LGA Revenues (In Nigerian Naira)*

	Mean	SD	Minimum	Maximum
KOGI				
1999 Per capita revenues	1018.6	599.6	443.4	2391.8
2000 Per capita revenues	2191.2	1218.2	1190.6	5634.8
LAGOS				
1999 Per capita revenues	1266.4	1623.1	465.1	6753.7
2000 Per capita revenues	2352.3	3428.1	582.8	14412.1

Source: Survey Data. 2000 data is for 15 LGAs in each state; 1999 data is for 13 LGAs in Kogi (missing values for 2 LGAs) and 14 LGAs in Lagos (missing values for 1 LGA).

internally generated from local tax bases. This is as one would expect given that Lagos state is the urban centre of Nigeria, while Kogi is a largely rural state. Thus, the survey evidence confirms that the declaration of 'zero allocations' by LGAs is more of a political slogan than an actual reflection of reality.[7]

The survey attempted to collect data on actual health expenditures of local governments, which was a difficult exercise because financial documents and categories across local governments, both within and across states, are not uniform. During the field testing of the survey instruments it was observed that numbers on total health expenditures were either not easy to find or simply not available in LGA budget documents. However, three categories of expenditure that appeared to show-up more consistently across LGAs were expenditure on health personnel, overheads and capital projects. These also appeared to be exhaustive categories for the budgeting of health expenditures.[8] Hence, data were collected on these three categories of health expenditure, which we sum here to estimate total health expenditures by local governments. There are several missing values for this estimate of

[7] The survey did not attempt to collect data on other health-specific resources that might be made available to LGAs by the higher tiers of government, for drugs and vaccines for example, because no formal records existed for such resource flows.
[8] Spending on drugs appeared under 'overheads' in the sampled LGAs.

A
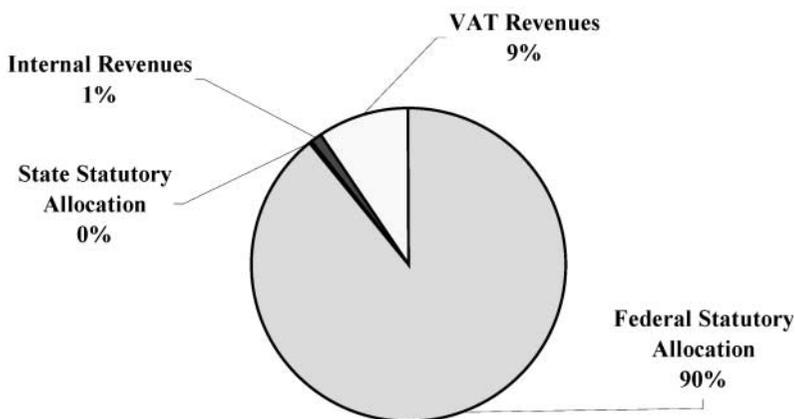
B
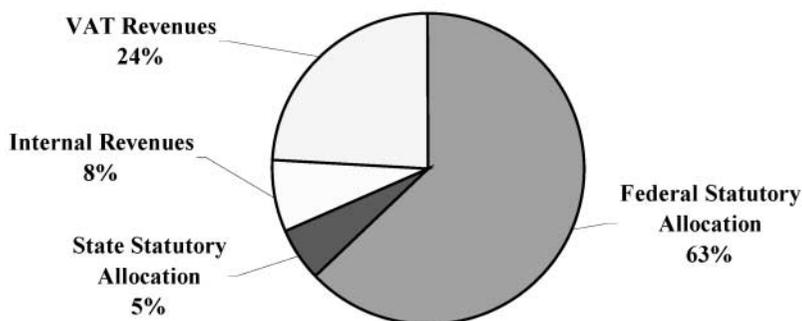
Figure 1: *Composition of 2000 revenues in* A: *Kogi, and* B: *Lagos*

total health expenditures, arising whenever any one of the three categories — personnel, overheads and capital — are missing. In total, we have missing values for total health expenditures for seven LGAs in Kogi and one LGA in Lagos for the 1999 budget, and for four LGAs in Kogi and three in Lagos for the 2000 budget.

Table 3 shows summary statistics for per-capita total health expenditures in the two states, and the proportion of total local government revenues spent on health. For the sample for which data is available, Kogi LGAs spend more per capita and as a proportion of total revenues on health than do Lagos LGAs. However, this comparison is to be interpreted with caution because of potential bias

Table 3: *Local Government Health Expenditure (In Nigerian Naira)*

	Mean	SD	Min	Max
KOGI				
Total health expenditure per capita, 1999	240.7	235.5	92.4	800.2
Total health expenditure per capita, 2000	379.5	261.6	191.8	1121
Proportion of revenues spent on health, 1999, %	26	16	13	62
Proportion of revenues spent on health, 2000, %	22	15	6	61
LAGOS				
Total health expenditure per capita, 1999	154.2	152.1	48.5	624.8
Total health expenditure per capita, 2000	251.2	304	60.2	1162.7
Proportion of revenues spent on health, 1999, %	14	7	8	37
Proportion of revenues spent on health, 2000, %	12	9	5	41

Source: Survey Data. 2000 data is for 11 LGAs in Kogi and 12 in Lagos; 1999 data is for 8 LGAs in Kogi and 14 in Lagos.

introduced by several missing observations. Lower public expenditures on health in Lagos LGAs may be because of greater availability of private health care in the substantially more urban state.

Figures 2a and 2b shows the average composition of health expenditures in terms of capital, overheads and personnel expenditure in 2000 for each of the states. Bulk of LGA health expenditures are allocated to staff salaries — in Kogi in 2000, LGAs on average spent 78% of health expenditures on salaries, while in Lagos, LGAs spent 65% on average on staff salaries.

To summarise the above discussion from the perspective of accountability: (1) the survey data demonstrate that although the extent of local government responsibility for various aspects of service delivery in primary health care facilities varies across the two states, decisions related to health staff management and payment of salaries, a critical input for service delivery at this level of primary health care, is exclusively assigned to them; and (2) LGAs in the two states on average receive general purpose revenues to the tune of more than 20 USD per capita, and allocate a significant portion of this to the payment of health worker salaries; in Kogi in 2000 17% of these revenues, close to 4 USD per capita, was allocated to health personnel. From the perspective of health facility

A

Capital
penditure
7%

Overheads
Expenditure
15%

Personnel
Expenditure
78%

B

Capital Expenditure
16%

Overheads
Expenditure
19%

Personnel
Expenditure
65%
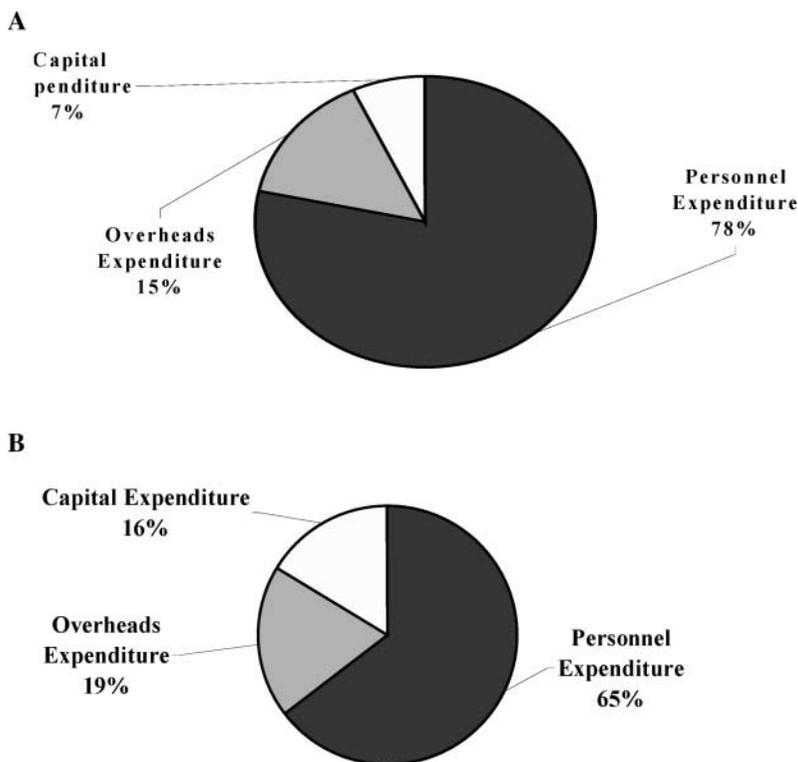
Figure 2: *Composition of Health Expenditures in* A*: Kogi, and* B*: Lagos*

managers in Kogi, salaries for staff are the main input for which they depend exclusively on LGAs, given community-level involvement and facility-level discretion in the supply of other essential inputs.

4. Using Evidence on Staff Salary Payment to Assess Accountability of Local Governments

The approach taken by this paper to assess LGA accountability is to identify an area where LGAs are supposed to be primarily and exclusively responsible, by their own admission and by assignment, and then evaluate their performance in this area. We therefore focus our analysis on the payment of staff salaries, in the interest of focusing on a particular outcome that can be directly linked to LGA responsibility and management, and that has substantial

implications for service delivery outcomes, and enormous policy relevance in the Nigerian context.

In fact, by far the most striking phenomenon uncovered by this survey is the extensive non-payment of salaries of public health personnel in the state of Kogi — 42% of staff respondents report not receiving any salary for 6 months or more in the past year at the time of the survey.[9] Figure 3 shows the distribution of staff against the months in the past year for which their salary has not been paid for each state — the distribution of Kogi staff, in contrast to that of Lagos, clearly shows that non-payment of salaries is a pervasive problem in Kogi state.

Consistent with this picture of salary non-payment being a problem in Kogi relative to Lagos, regression analysis, reported in Table 4, shows that variation across local governments in the extent of non-payment of salaries (as measured by LGA-level average number of months that staff report salary not being paid) is largely explained by an indicator variable for Kogi (Column 1). If non-payment of staff salaries is due to lack of resources available to local governments then much of the rest of variation should be explained by local government revenues. In particular, we should see a negative correlation between the average number of months of non-payment of salaries reported by staff sampled in an LGA and the amount of LGA revenues — an LGA which is constrained by lack of revenues is likely to have staff that have not been paid for a greater number of months in the year. However, Column 2 of Table 4 shows that per-capita local government revenues are an insignificant predictor of non-payment of salaries.[10]

It might be that demands on limited local government resources are so overwhelming and urgent that even essential expenditures such as salary payments get neglected. This would account for

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[9] While the other evidence on provision of services, availability of drugs and equipment, was not inconsistent with comparable facility survey evidence on health services delivery in other countries (Lindelow *et al.*, 2003, 2004), the non-payment of staff salaries seems particularly relevant for service delivery in Nigeria and begs explanation.

[10] The time frames for the salary payment data (reported by respondents for the year preceding June–August 2002) and the budgetary data (actual revenues and expenditures for fiscal year 2000 from budget documents) are not identical. Yet, given that local government revenues have been increasing since 2000 because of a global oil price boom, revenue data for 2000 is likely to be either a close approximation for 2001–2002 numbers or an underestimate.
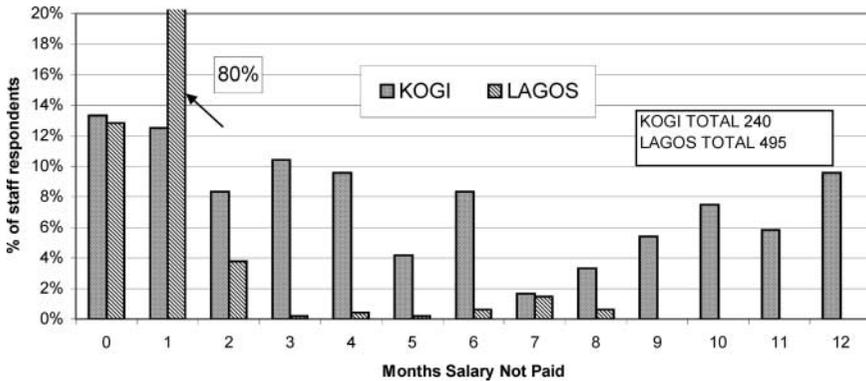
Figure 3: *Non-payment of staff salaries in Kogi and Lagos. Source: Survey data*

the lack of significant negative correlation between revenues and non-payment of salaries, and yet explain non-payment of salaries by appealing to insufficiency of local resources. A variable that might capture demand for LGA resources, and why resources might be thinly spread, and therefore account for non-payment of salaries, is the number of health facilities owned by an LGA. In the largely urban and densely populated environment of Lagos there is a significant private market even for primary health services, whereas in mostly rural Kogi, with dispersed settlements, health services appear to be largely provided in public facilities.[11] In Lagos, the majority of all health facilities are privately owned (61%) whereas in Kogi only 7% belong to the private sector. Column 3 of Table 4 shows that the greater the number of facilities, the greater is the extent of non-payment of salaries. Yet, even after controlling for this measure of demands on local resources, there is no significant correlation between local revenues and non-payment of salaries.

Above all else, what should really explain variation in non-payment of salaries is variation in actual local government spending on health personnel. Local governments which were able to spend less on health personnel, either due to limited revenues or due to competing urgent demands on their scarce resources, should have staff

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

Table 4: *Explaining Variation in Salary Non-Payment Across Local Governments*[a,b]

	1	2	3	4
Indicator for Kogi state	3.84**	3.84**	2.07**	2.03**
	(0.66)	(0.67)	(0.66)	(0.78)
Local Government Revenues		−0.00001	−0.000001	0.00001
(per capita)		(0.0001)	(0.00001)	(0.00004)
Number of health facilities			0.05**	0.04**
owned by Local Government			(0.02)	(0.02)
Local Government Spending				−0.0000001
on Health Personnel				(0.0000001)
(per facility)				
Constant	1.22**	1.23**	0.81**	1.21**
	(0.1)	(0.18)	(0.19)	(0.61)
R^2	0.55	0.55	0.71	0.70
Number of observations	30	30	30	26

[a]Dependent variable: Average number of months of non-payment of salary reported by staff.
[b]OLS regression with robust standard errors reported in parentheses; **significant at 1–5% level.

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

 We consider some additional alternate explanations for the evidence of non-payment of salaries presented above. Can managerial

capacity constraints explain the pattern? We argue that an outcome such as payment of staff salaries is not likely to be so sensitive to management skills as to explain the wide prevalence of non-payment of salaries of 6 months and more. We are not attempting to explain, for example, the 1–2 month delay reported by staff in Lagos, which might indeed be due to administrative constraints. Instead, we focus on the Kogi experience. A capacity-based explanation cannot be reconciled with the evidence that some LGAs in Kogi, where non-payment is particularly rampant, report actually spending substantial enough sums on salary payment to cover their estimated needs. Explanations based on federal action, such as delays in the arrival of federal resources, are also not consistent with the divergent experiences of Kogi and Lagos — there is no reason to believe that federal administrative inefficiencies will be so different across the two states as to explain the scale of non-payment of salaries in Kogi. World Bank documents indicate that in meetings with the Association of Local Government Chairmen, and with individual LGA chairmen, a number of problems with federal resource transfers were raised, with deductions at source for teacher salaries being the most contentious issue, but no mention was made of significant administrative delays in the flow of resources (The World Bank, 2002, 2003).

All of the analysis described above suggests that the problem of non-payment of staff salaries in Kogi may not be lack of budgetary allocations for this purpose but rather leakage in resource flows at the LGA level — resources reported as being allocated to staff salaries do not appear to sufficiently reach their intended destination. Although the evidence provided here cannot inform us about where the resources reportedly allocated to staff salaries might have gone, for in principle they could have gone to other competing demands even within health service delivery, the discrepancy between allocations and outcomes does suggest that accountability for these outcomes is low.

In order to have a sense of the cost of this discrepancy between allocations and outcomes, we estimate the impact of non-payment of salaries in Kogi on service delivery. The survey collected data, from actual facility records, on the number of cases of antenatal care, in-patient deliveries, out-patient consultations, routine immunisations and home visits (that is, seeing patients in their homes) in the last 3 months. Table 5 reports regressions at the facility level in

Table 5: *Impact of Non-Payment of Staff Salaries on Services Provided in Kogi*[a]

	Antenatal Services	Inpatient Deliveries	Outpatient Services	Immunisation	Home Visits
Facility-level average no. of months not paid in past year salary	−0.14 (0.69)	0.18 (0.14)	0.47 (1.02)	0.05 (1.57)	2.27[*] (1.31)
Indicator of Type 2 facility	12.31 (9.12)	0.47 (1.8)	8.37 (12.77)	13.04 (19.23)	−11.24[*] (6.58)
Distance from LGA headquarters	−0.02 (0.13)	−0.003 (0.02)	0.31 (0.18)	0.15 (0.27)	0.04 (0.13)
Number of facilities in the neighbourhood	−0.35 (0.24)	−0.09[*] (0.05)	−0.55 (0.41)	−1.40[*] (0.77)	−0.14 (0.59)
LGA population, 1999	0.0001 (0.0001)	0.00003 (0.00002)	0.0001 (0.0002)	0.0001 (0.0002)	0.000 (0.000)
LGA internally generated revenues per capita, 2000	1.01 (0.83)	0.04 (0.03)	−0.21 (0.23)	−0.44 (0.34)	−0.10 (0.18)
Constant	−14.61 (22.42)	−0.94 (2.33)	21.69 (23.96)	55.13 (35.91)	15.50 (21.69)
No. of observations	95	81	117	88	109
R^2	0.24	0.12	0.09	0.05	0.08

[a]OLS regressions with robust standard errors (in parentheses); *significant at 10% level; **significant at 1–5% level.

Kogi, estimating the impact of average number of months of non-payment of salaries in the facility on services provided on average by each staff. There is no significant impact of non-payment of salaries on the number of patients seen in the last three months before the survey per staff — for antenatal care, in-patient deliveries, out-patient consultations and immunisations. However, the greater the average number of months for which staff salaries are not paid in a facility, the greater are the number of home visits by facility staff. This is suggestive of health staff providing services privately to households, an interpretation supported by other evidence reported in Table 6 — that the greater the average number of months for which staff salaries are not paid in a facility, the lower the likelihood of the facility being clean, and the greater the probability that essential drugs (chloroquine, paracetamol and antibiotics) are privately provided by facility staff rather than being facility owned. The available data and evidence does not allow us to distinguish whether the essential drugs are provided by staff out of their personal funds or if they are expropriated from facility stocks for private sale.[12]

These results suggest that although non-payment of staff salaries does not lead to an obvious decline in health services provided, it is probably causing staff to provide services privately, in exchange for remuneration from their patients. It should, however, be indicated here that this impact of non-payment of staff salaries is being estimated for facilities that are still functioning and therefore responding to the survey questions, and does not capture whatever impact non-payment may have in terms of closing-down of health facilities. Field work for the survey in fact revealed that several facilities in Kogi had been closed down for months due to non-payment of staff salaries (Adeniyi *et al.*, 2003).

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

Table 6: *Impact of Non-Payment of Staff Salaries on Facility Characteristics in Kogi*[a]

	1 = Facility is clean	1 = Chloroquine is privately owned	1 = Paracetamol is privately owned	1 = Antibiotics are privately owned
Facility-level average no. of months in past year salary not paid	−0.02** (0.01)	0.02** (0.01)	0.03** (0.01)	0.03** (0.01)
Indicator of Type 2 facility	0.19** (0.06)	−0.25** (0.09)	−0.17* (0.10)	−0.11 (0.10)
Distance from LGA headquarters	0.000 (0.001)	0.000 (0.002)	0.000 (0.002)	0.001 (0.002)
Number of facilities in the neighbourhood	0.000 (0.006)	−0.001 (0.005)	0.003 (0.005)	−0.001 (0.005)
LGA population, 1999	0.000 (0.000)	0.000 (0.000)	−0.000 (0.000)	−0.000 (0.000)
LGA internally generated revenues per capita, 2000	0.003 (0.002)	−0.001 (0.002)	−0.002 (0.002)	−0.002 (0.002)
Constant	0.74** (0.15)	0.27* (0.16)	0.24 (0.15)	0.24 (0.16)
No. of observations	141	141	141	141
R^2	0.11	0.10	0.12	0.11

[a]OLS regressions with robust standard errors (in parentheses); *significant at 10% level; **significant at 1–5% level.

5. Policy Lessons and Conclusions

This paper argues that the pattern of evidence from the analysis of the survey data indicates that non-payment of salaries cannot be explained by lack of resources available to local governments. First, there is no significant correlation between non-payment of salaries and actual local government revenues or actual spending on staff salaries. Regression analysis shows that per-capita local government revenues and per-facility local government spending on health personnel are not able to explain variation in non-payment of salaries across local governments. Second, a comparison of estimated actual staff costs per facility in each sampled local government in Kogi with what the local government reported as actual spending towards staff salaries per facility within its jurisdiction, shows that even when budget allocations were sufficient to cover estimated actual costs, the staff survey revealed non-payment of salaries for several months in a year. The evidence therefore suggests that there is a general problem of accountability at the local government level in the use of public resources.

The survey data also enabled an analysis of the impact of non-payment of staff salaries on service provision. Although there is no discernable impact on health services provided, in terms of the number of patients served on average per staff, the greater the extent of non-payment of salaries the higher the likelihood that facility staff in fact behave as private providers, with more services provided outside the facility through home visits, and with essential drugs being privately provided, either funded by staff's own resources or expropriated from facility stocks.

The evidence on local accountability provided here might be construed as running counter to the conventional wisdom in many development policy circles that by 'bringing government closer to the people' decentralisation will have a beneficial effect on the allocation and use of public resources. However, in and of itself, this analysis cannot address the question of whether decentralisation is good or bad — that is, whether more centralised delivery in the hands of the state or federal government would be better — because we are unable to compare outcomes across more or less decentralised systems. But the overall policy lesson that the analysis does provide is that of strengthening local government accountability. Bardhan (2002) points out that institutions of local

accountability in developing countries are often weak, with the attendant risk of 'capture' of public resources by local elite.

What can be done about this problem of local accountability? Non-payment of salaries of health staff by local governments is reminiscent of a similar problem of non-payment of teacher salaries in primary schools in the 1990s, when primary education was decentralised to local governments (Olowu and Erero, 1995). Following nationwide agitations by teacher unions a policy of deducting primary school teacher salaries from the revenue share of local governments in the Federation Account was adopted (termed 'deductions at source'), with the salaries being directly passed on to the teachers.

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

What about an alternate instrument of intergovernmental fiscal transfers — conditional or matching grants? Providing incentives to local governments to improve performance through additional resource transfers (additional to their constitutionally determined share in federal revenues) *conditional* on actual improvements in service delivery, will only have the desired impact if incentives of higher tiers of governments are better aligned to improve services, and if transfers are large enough to persuade local governments to relinquish their capture of existing resources. The literature on con-ditional or matching grants from other parts of the world usually takes as given that local governments are accountable to local citi-zens, and the incentive component of the grants is largely intended to make local communities internalise potential spill-over effects of local investments for the national good.

The evidence presented here, correlating the non-payment of sal-aries with local revenues and spending on salaries, suggests that there is a problem of general accountability of local governments,

which the technical design of intergovernmental transfers is unlikely to solve on its own, and that larger political economy solutions need to be explored to promote better public service delivery by local governments. The conditions under which local governments, or any elected government for that matter, will have the right incentives to improve the delivery of basic services have been explored in a large political economy literature, and one of the 'solutions' to these political constraints suggested by the literature is greater information dissemination about the roles and responsibilities of government, and the outcomes of public resource allocation (see Keefer and Khemani, 2005, for a review of the literature and suggested solutions).

Based on this political economy view of public accountability this paper proposes a specific type of policy intervention to strengthen local accountability, namely, providing citizens with greater information about the resources and responsibilities of their local representatives, so they are empowered to hold them accountable for the delivery of basic services. Fosu and Ryan (2004) reach the same conclusion about the centrality of information dissemination and disclosure in policy interventions to improve accountability, based on their reading of more general principal-agent models of service delivery.

An information dissemination strategy, through newspapers and other media, was adopted in Uganda after survey evidence revealed that district governments were not transferring budgeted resources to schools. A follow-up survey in Uganda showed that this information dissemination had a substantial impact in preventing leakage of public funds away from purposes intended in public budgets (Reinikka and Svensson, 2004). However, there is very little systematic research evidence on whether information dissemination truly has an impact, or what forms of dissemination are likely to have greater impact; yet, theoretically, it seems to be a reasonable way to proceed. Designing a rigorous impact evaluation component to policy experiments with information dissemination would therefore be valuable to enhance our understanding of what works and what doesn't, and how best to design institutional interventions to improve public accountability.

There is potentially a role for combining conditional transfers with information dissemination. The Nigerian Constitution provides for a commission to be appointed by the President, with members nominated by each state, to advise the President and Parliament upon intergovernmental transfers — the Revenue Mobilisation Allocation

and Fiscal Commission (RMAFC) mentioned earlier. The RMAFC could serve both as an agency for determining conditional transfers based on costs of providing minimum basic services, and an information dissemination agency, widely publicising data on costs and service provision used to determine the transfers. Such a strategy would only be effective if the agency determining transfers, and disseminating the information upon which transfers are based, is reasonably independent from the political process. Khemani (2003) provides evidence from India that constitutional rules can enable an independent agency to determine intergovernmental transfers to promote regional equity and curb political influence.

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

References

Adeniyi, J., C.L. Ejembi, P. Igbinosun, D. Muhammed, F.E. Nwagbo, M.O. Ogundeji and A. Zoakah (2001) 'Report of the National Primary Health Care Needs Assessment Survey', National Primary Health Care Development Agency: Abuja, Nigeria.

Adeniyi, J., O. Oladepo and A. Soyibo (2003) 'Survey of Primary Health Care Service Delivery in Lagos and Kogi: A Field Report.' African Regional Health Education Center, University of Ibadan.

Bardhan, P. (2002) 'Decentralization of Governance and Development', *Journal of Economic Perspectives*, **16**(4): 185–205.

Ekpo, A. and J. Ndebbio (1998) 'Local government fiscal operations in Nigeria', AERC Research Paper No. 73, African Economic Research Consortium: Nairobi, Kenya.

Federal Republic of Nigeria, Constitution of the Federal Republic of Nigeria (1999).

Federal Ministry of Health (1996) 'National Health Policy', Federal Republic of Nigeria: Abuja, Nigeria.

Fosu, A.K. and T.C.I. Ryan (2004) 'Public Sector Delivery: A synthesis', *Journal of African Economies*, **13**(Suppl 1): 137–41.

Keefer, P. and S. Khemani (2005) 'Democracy, Public Expenditures, and the Poor', *World Bank Research Observer*, **20**(1): 1–27.

Khemani, S (2001) 'Fiscal Federalism and Service Delivery in Nigeria: The Role of States and Local Governments', Mimeo, Development Research Group, The World Bank: Washington, DC.

Khemani, S (2003) 'Partisan Politics and Intergovernmental Transfers in India', Policy Research Working Paper No. 3016, The World Bank: Washington, DC.

Lindelöw, M., R. Reinikka and J. Svensson (2003) 'Health Care on the Frontlines: Survey Evidence on Public and Private Providers in Uganda', Africa Region Human Development Working Paper 38, July 2003. The World Bank: Washington, DC.

Lindelöw, M., P. Ward and N. Zorzi (2004) 'Primary Health Care in Mozambique: Service Delivery in a Complex Hierarchy', Africa Region Human Development Working Paper 69, April 2004. The World Bank: Washington, DC.

Olowu, D. and J. Erero (1995) 'Nigeria: Institutional Delivery Mechanisms and the Poor', Background Paper Prepared for the World Bank Poverty Assessment Report, Faculty of Administration, Obafemi Awolowo University: Ife-Ife, Nigeria.

Ransome-Kuti, O., A.O. Sorungbe, K. Oyegbite, and A. Bamisaye (Eds) (1990) '*Strengthening Primary Health Care at Local Government level: The Nigerian Experience*', Academy Press, Ragos, Nigeria.

Reinikka, R. and J. Svensson (2004) 'The Power of Information— Evidence from a Newspaper Campaign to Reduce Capture.' Policy Research Working Paper No. 3239, The World Bank: Washington, DC.

WORLD HEALTH ORGANIZATION (WHO) (1987). Women and children's health through funding and management of essential drugs at community level: the Bamako Initiative. WHO/ AFR/R37/H. Brazzaville: WHO. Proceedings of the 37th session.

The World Bank. 2002. '*State and Local Governance in Nigeria*', Sector Report No. 24477, The World Bank: Washington, DC

The World Bank. 2003. '*Nigeria: State Finances Study*', Sector Report No. 25710, The World Bank: Washington, DC.

The World Bank. 2004. '*World Development Report 2004: Making Services Work for Poor People*', The World Bank: Washington, DC.

Appendix

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

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

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

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