COMPARATIVE ANALYSIS OF SOCIAL SERVICE DELIVERY SYSTEM IN DEVELOPED AND DEVELOPING NATIONS

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INTRODUCTION

Service Delivery is conceptualized as the relationship between policy makers, service providers, and poor people. It encompasses services and their supporting systems that are typically regarded as a state responsibility. These include social services (primary education and basic health services), infrastructure (water and sanitation, roads and bridges) and services that promote personal security. DFID (2004)

Providing basic economic and social security to citizens has long been acknowledged as a fundamental responsibility of government. Today, across a broad portfolio – from child welfare and income security to disability services and youth development – the need to adopt a business-like, results-oriented approach to the delivery of human and social services is quickly moving up the public sector agenda.

However, the delivery of services has become increasingly complex for governments in recent years. In many nations with longstanding program structures, the recent financial crisis has stressed existing systems and introduced new challenges. Other governments are struggling to address these financial challenges while simultaneously creating new delivery structures for providing basic services to their citizens, often for the first time.

The delivery of basic services is a central task of poverty reduction. Poor people say that water, education, healthcare and personal security are among their highest priorities Narayan et al (2000)**,** and expanding inclusive service delivery is critical to achieving the Millennium Development Goals.

Strategies to improve service delivery typically emphasize the central role of the state in financing, providing, and regulating services Moreno and Anderson.(2004) The state bears the legal responsibility to ensure that the fundamental human rights to security, education, and healthcare are realized. The state is also well placed to respond to the challenges of scale and market failure in ensuring access for services to all groups. For these reasons, many development analysts have emphasized the central role that governments play in regulating, overseeing and monitoring the delivery of services.

But how should services be delivered where the state is unable or unwilling to take up its responsibilities?

State weakness or fragility can occur in many ways. Moreno and Anderson , (2004). Where the state lacks effective territorial jurisdiction, or is preoccupied by conflict, or where its administrative capacity has effectively collapsed, the challenge of service delivery takes on a different shape. Sophisticated strategies to improve the relationship between state regulators and private providers have little relevance where the government is repressive or lacking commitment to poverty reduction goals.

According to Tshidi Mokgabudi, Head of Infrastructure, Government & Health, KPMG South Africa.

“South Africa, and in most developing countries around the world, there is massive pressure on those delivering human and social services as a result of a number of distinct – but inextricably interlinked – forces, One is the economic crisis which has limited government’s ability to spend on social programs; we are seeing rapid rates of migration and urbanization which is not only changing the demand for services, but also creating a growing wealth and education discrepancy between urban and rural areas; and then you have rapid population growth in many areas which is stretching the capability of governments and NGOs to deliver even basic human and social services”

All around the world, there had been a rising trend of rural urban migration and the migrants seeking new opportunities and services. According to a United Nations Report, In 1950, 30 per cent of the world’s population was urban, and by 2050, 66 per cent of the world’s population is projected to be urban. World Urbanization Prospects (WUP, 2014)

In the developing world, for example, many of these new urban dwellers lack sufficient housing, employment or social safety nets, placing an increased burden onto the shoulders of government. Indeed, in parts of the developing world urbanization has resulted in the growth of slums which – lacking functioning government services – creates new complexities for governments.

In the Democratic Republic of Congo one out of every 5 children dies before their fifth birthday and the statistics is even worse for Sierra Leone, Angola and Somalia Black, RE et al (2003). It will not be possible to reduce the stark inequities within and between countries, or to eliminate poverty and vulnerability, without improving our engagement with service delivery.

Against this backdrop, a growing number of public sector leaders are seeking new approaches and models for service delivery. in part, this is due to a growing realization of the interconnectedness of social services and economic growth. but other external forces are also being keenly felt: technological innovation, shifting demographics, urbanization, and aging populations are all creating new pressures as well as opportunities for public sector service delivery.

As a result, governments will need to quickly reconsider their approach to service delivery and develop new models of care to meet the growing demands of their urban populations.

Human and Social Services

This is a broad term that encompasses all of the government services related to citizen's economic and social welfare. The series of services tends to include a wide range of activities such as: early childhood and youth development; child welfare; income security; nutritional support; employment training/welfare to work; seniors support; disability services; and social housing and other services

aimed at preventing homelessness. And while the term ‘human and social services’ is certainly not universally used; all functioning governments around the world provide a level of these services to at least part of their population. Human and social services agencies tend to occupy a unique place in the government service provision world.

Health Care Service Delivery System

Healthcare can be considered the provision of all services that prevents illness and maintains health. It includes the provision of illness treatment and management and extends to the maintenance of the mental and physical well-being of the person. Healthcare encompasses more than the availability or affordability of medical services. Conceptually, healthcare is multifaceted involving medical care, public health care and social services. Social services as primary promoter of health encompass poverty reduction, housing adequacy, and environmental sanitation including the provision of safe and sanitary water, adequate nutrition, employment and education.

By necessity therefore healthcare embraces the factors that empower development: economics, politics, social services, utility infrastructure, agriculture/food, education and individual responsibility. It draws upon all the goods and services available in a country to provide health, including “preventive, curative and palliative interventions, whether directed to individuals or to populations.” (WHO, 2000).

United States Department for International Development (DFID) considers continued involvement in service delivery of vital importance for four reasons 7:

i. The Millennium Development Goal (MDG) targets represent a global commitment to realizing the rights of the poor to services and livelihood opportunities. They will not be met without increased access to services for the teeming populace and migrants.

ii. There is a 'humanitarian imperative' to respond to an emergency situation where people's access to services has been severely reduced or has completely diminished.

iii. Service delivery may offer an entry point for triggering longer-term pro-poor social, political and economic change.

iv. Service delivery may help to prevent some states from sliding into conflict by addressing its structural causes.

CASE STUDY ON HEALTH CARE SERVICE DELIVERY

Healthcare Systems in General

Health systems comprise all the institutions, organizations and resources that are dedicated to generating health action (WHO, 53rd World Health Assembly, 2000. Report by the secretariat. "Strengthening Health Systems in developing Countries"). Health action can be considered an attempt, whether in individual health care, population or community health services with a mission to improve health. Operationally, healthcare systems are the organization and method by

which healthcare is provided. Ideally this system comprises dedicated services for health and social services.

As with many other systems, healthcare systems are characterized by interrelated components of input (human, technology, financing and equipment resources), structure (organization of public health infrastructure, hospitals, clinics and extended care facilities), processes (operations, services to patients in all settings by providers including Managed Care Organizations) and outputs (outcomes, quality, access and costs) (Busse and Wismar, 2002).

All healthcare systems share certain common features including **components of financing, service delivery and insurer/payer features**. Health systems can also be narrowly distinguished in part by their method of financing (government, individuals, employers, etc), payment for services methods (by doctors, hospitals, extended care facilities), or management processes including that of Managed Care Organizations.

In a National Health Insurance System like Canada's, there is one insurer and financing is done through general taxation revenues (Canada Health Act, 1984). The insurer makes payments to providers who are privately contracted either through a fee for service arrangement or some form of capitation. Both provincial and federal governments in their own areas of jurisdiction and through inter-governmental liaisons, coordinate the processes.

In a National Health Service system such as the UK's, the government raises 80% of the financing needed through tax revenues and 15% from National Insurance

contributions (HM Treasury, Budget 2004). It also directly or indirectly pays providers (physicians and hospitals). The government also coordinates all functions (National Health Service Act, 1946). This system shares some similarity to that of Trinidad and Tobago but additionally in the UK there is a National Health Service (NHS) system in which primary and community health care is emphasized. Hospital based providers are salaried and work in facilities that are state owned. Private or general practitioners are a central cog in the system of primary care groups that function with other health care professionals in geographically defined umbrella units under a local NHS administrative authority. Under the revised National Health Service (Private Finance) Act, 1997, the authority was granted to negotiate and contract for private services. With the institution of primary care trusts, consumer led boards supplanted the government health authorities.

In the socialized health insurance model as occurs in Germany, insurance contributions are made by employees/employers (WHO. *Health Care Systems in Transition, Germany.*). Delivery of services is carried out by private providers and payments to these providers are facilitated through non-profit agencies with the government coordinating interrelated functions and processes. Public health systems are also coordinated with medical care and other health system functions.

The role of public health systems in many countries is under appreciated. Despite the dominant popular perception of medical care as equivalent to healthcare, public health care is a distinct but essential component of healthcare provision in any

population. Its essential role in developing countries cannot be overstated. It is mandated to lead education, training and research efforts in public health and actively advance people's participation in and promotion of quality health. Governments should be able to depend on public health institutions to develop appropriate policies, planning, and management strategies.

Social and economic developments are the engines that drive the provision of healthcare. Healthcare systems can be funded privately, publicly or both. Most systems in both developed and developing countries are mainly publicly funded and organized. For the most part medical care can be funded through individual out of pocket, individual, group or government insurance or state (public) funding especially through taxation.

The World Health Organization (WHO, 2000) has set as one of its strategic directions, the establishment of health systems that impartially improve health outcomes (good health) for people, act on peoples' legitimate needs (responsiveness), and be monetarily fair. The WHO has concluded that success in carrying out these goals depends on their ability to provide services, generate resources, finance and become good stewards of the system (WHO, 2000).

The Role of Health Insurance

Insurance is a pledge of service or compensation for specific potential or future losses by illness or otherwise in exchange for a periodic payment. It follows that insurers also can act as payers, claims processors, or managers of disbursed funds. Insurers can be private indemnity entities, statutory authorities, or managed care

organizations. The state can be a participant as the insurer of all (universal) as in Canada or of some (Medicare and Medicaid in the USA). The contributions may be collected as taxes from citizens (specific ear marks or from general revenues) or from individuals, workers, or businesses.

In Canada, the policies that brought their health system into focus began with the landmark Lalonde Report of 1973-74 (Lalonde, 1974). In their model, the Canadian Federal government still serves as the administrator of the system receiving tax contributions and paying providers for services.

In Canada individuals, providers and provincial governments can opt out of the single payer system, and seek and provide health services from the private sector but generally not from both. Provincial governments, providers and individuals can opt out of the federal government's mandated rules by simply refusing to accept funding from the (federal) government and paying for health services themselves. So Canada has a *de facto* two-tiered system based on "opting out" provisions; however in practice few individuals and no province have yet chosen these options.

The US Healthcare System

The US system is complex and for the most part fragmented, loosely related or unrelated parts of a whole. There is little overall planning, direction or coordination. As a consequence, there is often overlap, inadequacies, inconsistencies, waste, complexity and inefficiency in service delivery. It consists of multiple players many of who are motivated above all by the pursuit of excessive profit.

In the US, consumption of health services represents a greater proportion of total economic output than most other countries (Barton PL. 1999). Private entities or governments (state or federal), insurers/payers are involved in financing and delivery. Some providers can even be government employees (US Public Health Service, Veterans Administration, and Indian Health Service). In the Mecca of private healthcare provision, the US government is a major provider of healthcare for the military, prisoners, veterans, elderly, disabled, children, extremely poor and indigenous natives.

Secretary Joseph Califano's statement can be modified to: "quality of healthcare *for those who can afford it* is unsurpassed in the US" or "the US has the best *emergency* care system in the world, but not necessarily the best healthcare system."

Despite its abundant resources, the US healthcare system faces many challenges the least of which is its inability to pro-actively respond to changes in cost, access, and quality while eliminating system inequity and inefficiency.

Infrastructure and Social Service Delivery in Nigeria

Existence of basic infrastructure is crucial to the provision and sustenance of public welfare, as well as the enhancement of growth and development of any society. Although this responsibility has in recent times, become a diffused one with the increasing involvement of the private sector, overall delivery capacity of public oriented infrastructure constitutes one of the major criterion for the

assessment of governments performance across the globe. In Nigeria, capacity building has been a major challenge, remaining at a declining state since the 1980s, and therefore complicating the nation's problems.

The availability of adequate and functional infrastructure encourages productive enterprise, employment generation and the capacity of the economy to be self-sustained, attract and retain foreign direct investment (FDI). In the same assessment McNeil submits that:

Adequate infrastructure reduces the costs of production, which affects profitability, levels of output, and employment. When infrastructure works, productivity and labour increases. when it does not work, citizens suffer, particularly the poor. Thus, economic renewal and societal welfare become postponed or halted (Mcneil, 1993).

With the abysmal level of infrastructure in Nigeria, it is not surprising that the country performed woefully over the years in basic economic productivity performance indicators across the globe. In the World Economic Forum Report for Global Competitiveness, between 2002—2003, Nigeria was ranked 76 out of a total of 82 countries on the infrastructure sub-index. (Eboh and Igbokwe 2006).

There is a notable recurrent relationship between access to infrastructure and poverty. It can thus be attributed that the rate of poverty in Nigeria is accentuated by the poor social service delivery to the populace. The poor masses suffer the

problem greatly as they now exploit the environment and such a vicious cycle continues to degrade the environment. According to the UN Development Programme report, inequality has been on the increase in the country, rising from 0.43 to 0.49 on the index between 1985 and 2004. And says "**inequality in access to basic infrastructure and services are key drivers of poverty, vulnerability and inequality in the Nigeria"** (UNDP, 2000).

Table 1: PERCENTAGE DISTRIBUTION OF HOUSEHOLD BY TYPE OF ELECTRICITY SUPPLY, 2008
Percent

Sector	PHCN (NEPA) only	Rural Electrification only	Private Generator only	PHCN (NEPA)/ Generator	Rural Electricity/Generator	Solar Panels	None
Urban	73.2	0.3	2.1	14.9	0.8	-	8.6
Rural	28.7	1.2	3.6	3.2	1.2	0.0	62.0
National	40.4	0.9	3.2	6.3	1.1	0.0	48.0

Source: National Bureau of Statistics 2009

Table 2: PERCENTAGE DISTRIBUTION OF HOUSEHOLDS BY TYPE OF FUEL FOR COOKING, 2008

Sector	Electricity	Gas	Kerosene	Wood	Coal
Urban	0.5	1.8	49.6	44.9	3.1
Rural	0.1	0.1	7.3	92.1	0.4
National	0.2	0.6	18.5	79.6	1.1

Source: National Bureau of Statistics 2009

Table 3: PERCENTAGE DISTRIBUTION OF DWELLING UNITS BY TYPE OF WATERSUPPLY, 2004 - 2008

Percent

Type of Water	2004	2005	2006	2007	2008
Pipe-borne Water	14.5	16.2	15.4	10.4	8.8
Bore-hole Water	17.6	24.0	20.8	26.8	28.4
Well Water	36.0	25.1	30.6	33.3	31.5
Streams/Ponds	31.5	33.5	32.5	24.4	27.6
Tanker/Truck/Van	0.4	1.2	0.8	4.1	3.2
Total	100.0	100.0	100.0	100.0	100.0

Source: National Bureau of Statistics 2009 - General Households Survey

The Nigeria State in Perspective: Examination of State Failure.

The failure of the Nigerian state in addressing the problems of infrastructural deficit in is made manifest as evidence has shown the rate of individuals ability in meeting these needs sporadically. These often cover the provision of utilities such as roads construction and repairs, provision and supply of portable water through drilling of boreholes in the communities, communal funded power supply, among others.

As illustrated in Table 3 above, the number of households having access to pipe-borne water—a facility solely provided and maintained by the state decreased from 14.5% in 2004 to 8.8% in 2008, Bore-hole and Tanker/Truck normally used by individual households and community efforts increased from 17.6% to 28.4% and 0.4% to 3.2% respectively. The tables above shows the poor output of state-operated welfare infrastructural facilities on the one hand, and an exponential increases in individual/community-operated social infrastructural amenities on the other hand.

Bad leadership, poor maintenance culture and increased private sectors that are profit driven are contributing factors to the declines in social service in Nigeria have persisted in spite of increasing revenues accruing to the government from its natural resources and other sectors of the economy.

(The Punch, May 23, 2012 page 18).

In view of this development, the state has continued to witness a fall in performance of its social responsibilities.

The establishment of agencies for social service delivery such like the Nigerian Railway Corporation, National Electric Power Authority, Nigerian Water board and the now moribund Nigerian Telecommunications Limited among others since the colonial era to the late 80s, there has been a sharp decline in the numbers of these agencies since the 90, leading to increased service burden on the citizenry, therefore compelling them to source for alternative to the expected government social services. This development has made every household that has the resource a government of its own in terms of self-help in provision of security and social services. This is the state of social service delivery in the country.

Recommendations

With respect to Nigerian Government, I recommend as follows:

In terms of building capacity, both state and non-state providers should be considered to strengthen service delivery.