

IMPROVING CHILD WELLBEING – LESSONS IN SOCIAL POLICY FROM THE ‘HIGH-ACHIEVERS’

WE ARE FAILING OUR CHILDREN

Nearly 10 million children die every year from easily preventable diseases – two thirds of them in Sub-Saharan Africaⁱ. Two in every five children in the developing world are undernourishedⁱⁱ. 121 million primary school age children (54 percent of them girls) do not attend schoolⁱⁱⁱ. An astounding one third of all children in developing countries fail to complete four years of primary education^{iv} – the minimum required for basic numeracy and literacy. Nearly one billion people in the world are illiterate^v. 1.7 billion people are without safe water^{vi}, and well over half of humanity (3.3 billion) is without access to adequate sanitation^{vii}. These global averages barely begin to describe the real dimensions of deprivation and inequity in many countries. **We are clearly witnessing a social development crisis of staggering proportions – and children are more vulnerable than most to suffering its worst manifestations.**

Why, though, is this the case when the solutions to this crisis – as outlined in this policy briefing – are known? The situation could be dramatically improved if only the global community would heed the lessons learnt from the experience of those developing countries that have, over the past 30 years, successfully boosted their children’s quality of life.

THE ‘HIGH-ACHIEVERS’

Costa Rica, Cuba, Barbados, Kerala state (India), Sri Lanka, Republic of Korea, Malaysia, Mauritius, Botswana, Zimbabweⁱ: these ten developing countries succeeded in the early stages of their development in improving child welfare to a much higher level than might be expected given their national wealth. They are the ‘high-achievers’ in social policy, who in just 50 years have attained the kind of advances in health and education that took nearly 200 years in the industrialised world. For most of them, their social indicators are now nearly comparable to those of industrialised countries, for their **social investment has successfully tackled the worst manifestations of poverty: preventable child deaths, the powerlessness of illiteracy and the debilitation of ill-health. These achievements were made despite the fact that incomes were not necessarily growing rapidly when the ground for future gains was being laid.**

UPGRADING SOCIAL POLICY VIS-A-VIS ECONOMIC POLICY

The poor should not have to wait for the benefits of economic growth to trickle down to them – and, indeed, the high-achievers did not put faith in the trickle-down effect as a method of providing the poor with the benefits of growth. These countries did not prioritise achieving economic growth or macro-economic stability over social development. All ten countries managed to pro-actively relieve the non-income dimensions of poverty early in their development process for almost the entire population regardless of the level of income – leading to the logical conclusion that, if they could do it, other developing, low-income countries should be able to follow suit.

In the high-achieving countries, the state’s commitment to social services was translated into financial resources for investment into those services during the first few decades of their development process. The social investment made by the high-achievers was then sustained at relatively high levels – even during periods of economic crisis in the early 1980s and the resulting periods of structural adjustment. In contrast to most developing countries that experienced these periods of economic crisis and structural adjustment, the high-achievers maintained government expenditure on health and education as a proportion of GDP. When crisis forced macro-economic stabilisation and adjustment, the high-achieving countries went through a relatively unorthodox adjustment process – this is particularly true of Korea, Malaysia, Mauritius and Costa Rica^{viii} which helped to protect government expenditure in the social service sectors. It is also notable that defence expenditures in the high-achieving countries was lower than the average for developing countries between 1978 and 1993, thus freeing up more government resources for social investment.

A critical factor of success for the high-achievers was state ownership of the adjustment processes and the content of macro-economic policy. It is questionable whether low-income countries have a similar level of ownership with regard to their Poverty Reduction Strategy Papers (PRSPs) – the current form for policy related lending – which tends to be dominated by orthodox macro-economic policy as advised by the IMF and World Bank. Not only are there low levels of government ownership of PRSPs, but there is very little stakeholder participation of civil society groups in the process of formulating PRSPs. Moreover, there is little scope for alternative policies to be discussed in the specific context of those countries that have a PRSP. Orthodox macro-economic policies prescribed by the IMF and World Bank have failed to deliver growth over the last two decades for the majority of African and Latin American countries. The fact that such orthodox policy still holds sway over PRSPs raises legitimate questions about the consistency of these macro-economic policies – which demote government spending in social services – and the prospects for achieving the Millennium Development Goals (MDGs) at both national and international level.



Although economic growth is a necessary condition of *sustained* improvement in health and education status and in the quality of social services, it is neither a necessary or sufficient condition for the ‘take-off’ in social development. There are many historical examples where economic growth has not translated into improvements in health and education status, particularly where commitments to social development had not been put in place by the state. For instance, Brazil, whose per capita income is much higher than China’s or Sri Lanka’s, still has a much lower life expectancy than either of those countries. Similarly, despite being the world’s richest country in 1900, the USA had an abysmal child mortality rate, with 18 per cent of its children dying before the age of five. Macro-economic policy cannot be determined first, with social policy intended to take care of its human consequences. A model of policy-making where finance ministries lead, and social ministries follow, has failed the poor, including poor children.

Furthermore, there is strong evidence to indicate that investment in social services has been shown to underpin economic growth in many instances – and that broad-based poverty-reducing growth has rarely occurred on a sustained basis in the absence of the universal availability of basic social services. Therefore, **social policy must be given equal status with macro-economic policy if synergies between economic growth, income poverty reduction and advances in health and education are to materialise.**

THE 6 KEY PRINCIPLES OF GOOD SOCIAL POLICY

Having far exceeded the pace and scope of social progress in most other developing countries, these high-achievers offer valuable policy lessons for addressing childhood poverty through investment in health and education. While these ten countries are undoubtedly diverse in economic, political, social, cultural and geographical terms, research into their experiences highlights six key principles that were common to their human development successes:

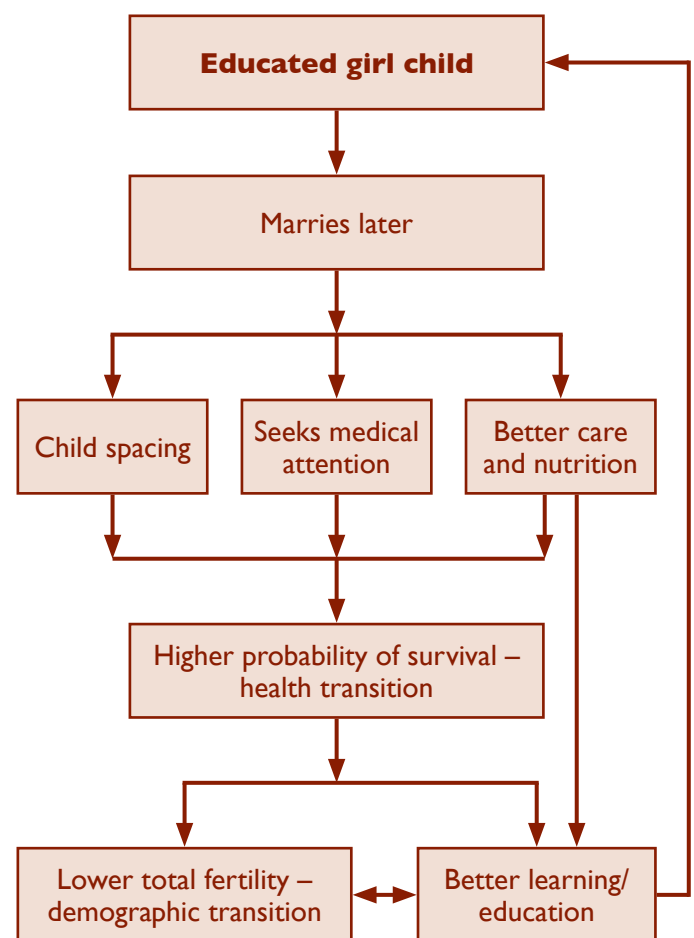
1. Maximise synergies between social service interventions to trigger virtuous cycles

Interventions in health, nutrition, water and sanitation, fertility control and education complement each other, and thus increase the impact of any one from investments in any other, **proving the advantages of integrated approaches in forming a virtuous circle of social and economic development.**

For example, the improved health status of a child improves her/his ability to learn, as does improved nutritional status. Similarly, reduced family size improves the chances that a poor family will be able to afford education for all their children, rather than merely the boy(s) or oldest child. It has also been proven that simultaneous interventions in health and education make a significantly greater impact than isolated interventions in either of those sectors. For example, analysis of data collected in a Nigerian village found that there was a 20 per cent gain in life expectancy when the sole intervention was easy access to health facilities for illiterate mothers; a 33 per cent gain when the intervention was education without health facilities – but when there were both health and education interventions, there was a much higher gain of 87 per cent.^{ix}

The figure below represents the life cycle of an educated girl, illustrating the synergy between interventions within the social sectors – and highlighting the importance of education interventions, in particular, in facilitating social development. Health interventions are known to be more efficient in a population with (at the least) a basic education. For instance, parents who have been exposed to nutrition information at school will pursue a healthy, balanced diet for themselves and their children, leading to better nutritional outcomes, which can prevent, for example, low birth weight in babies. Basic education is also likely to lead to improved hygienic behaviour, which in turn significantly enhances returns to investments in water and sanitation systems.

The life cycle of an educated girl^x



2. Sequencing social investment can increase its efficacy

In the experience of the high-achievers, educational achievement preceded or took place at the same time as the introduction of health interventions – and investment in basic education by the state preceded, or was simultaneous with, the breakthrough in infant mortality reduction or public health expansion. This demonstrates that just as the synergies between interventions in health and education greatly enhance the efficiency and positive impact of each, so the sequence too is crucial. The existence of high (basic) education levels among the population ensures that, when the investments in health infrastructure are made, there is a strong demand for health services and that they are effectively and widely used.

The Republic of Korea provides a good example of investment in education acting as a building block for improvements in health status. Before 1976, healthcare in Korea was largely in the hands of private professionals and there was no publicly supported health system to speak of, whereas its literacy rate already stood at 90% in 1970. Its infant mortality rate was 53 in 1970 and 41 in 1975; with the investment in public health after 1976, it dropped to 17 by 1980. Similarly, Sri Lanka had achieved 60% literacy by 1948 and, once health services expanded post-1948, the country’s population gained 12 years of life expectancy in a matter of seven years.

3. The pre-eminent role of public action is key, regardless of whether an economy is centrally planned or market-oriented

The experience of both the high-achievers and the industrialised countries strongly indicates that the pre-eminent role of the state in social sector interventions ensured access to basic social services for the vast majority of the population. Regardless of whether income per capita grew rapidly or not, these states did not assume that the trickle-down effect would enable the poor to buy basic social services – instead, they pursued pro-active social policy to ensure that basic services were widely available. The state’s commitment to social services was translated into financial resources, with per capita education and health expenditure being higher in the high-achieving countries relative to other countries in their respective regions.

As noted above, each social service intervention has ramifications outside its sector and adds up to a virtuous circle of social and economic development – it is a complex, multi-dimensional synergetic system, which poses a significant co-ordination challenge. Markets alone would not ensure universal access to basic social services and it is usually the poor who do not have these services or, if they are charged for using them, they tend to under-consume them – and without literacy and decent health status to widen their life choices, they are unlikely to pull themselves out of the vicious cycle of poverty. The state would also need to intervene to ensure adequate coverage of services, particularly in rural areas, because private providers and professionals tend to be concentrated in urban areas.

Therefore, the role of the state is hugely important – both for equity reasons and also in order to minimise the risk of co-ordination failure and thus ensure that synergies between interventions materialise. Given the enormity of the task and the need to get it right, it can be legitimately argued that the state should not only finance these services, but also provide them.

The state must take ultimate responsibility for the provision of basic services because access to them is a fundamental human right – as laid out in both the UN Convention on Social and Economic Rights and the UN Convention on the Rights of the Child, both of which have been ratified by nearly all countries in the world. In order for these citizens’ rights to be fully met, the state is obliged to provide these services.

Just as the state’s commitment and delivery role was critical to the success of the high-achievers, so the public ‘voice’ in governance was also a key element of success in all these states except Korea. For instance, even in one-party Cuba, social mobilisation – particularly by women’s groups – was key to the country’s social progress. So, while democracy (in the sense of regular multi-party, free and fair elections) is not a necessary condition for social progress, it would obviously help. The critical point, though, is that there has to be a mechanism for the expression of the voice of the people. In today’s world, where state failure is much more of an issue than it was during the period when the high-achievers made most of their social progress, deep democratic decentralisation is becoming an essential ingredient of successful social delivery.

4. While the level of social spending is important for health and education outcomes, the equity of the intra-sectoral spending pattern matters even more

One of the good practices of the high-achieving countries was to spread resources relatively equitably throughout the pyramid of the health structure. This included allocating sufficient resources to primary level health services, which are largely of a preventive nature, and are actually used by the majority of the population when they function well because primary health centres are more likely to be physically accessible than most hospitals. These countries also made primary health services more widely available in rural areas than they had previously been. By investing in primary levels of care, the state reduces the human cost of illness as care can be delivered easily and quickly given the physical proximity of the primary health centre to the patient. The high-achievers' spending pattern on health is in strong contrast to the pattern of intra-sectoral spending in most developing countries, where the primary healthcare system is typically deprived of the necessary resources, which are instead diverted to one or two referral or teaching hospitals. This is despite the fact that, given the existence of a health service infrastructure, the primary health clinic could be, but often is not, the first point of contact with the health system for the majority of the population.

Similarly, the high-achievers placed emphasis on the lowest level of the education pyramid: primary education. They tended to spend less on higher education and more on primary education than their regional neighbours. As demonstrated by the experience of these high-achievers and others, the social return to primary education is well known to be higher than that for secondary/higher education. Hence, from a state investment perspective, it is equitable and efficient to meet the resource needs of primary education from the government budget on a priority basis, followed by lower secondary education. However, there is also important evidence that “12 years of education (i.e. completing secondary school), protects 80 per cent of young people against poverty”^{xi}, indicating that investment beyond primary level is important to mitigate the post-schooling effects of unemployment and resulting poverty. In light of this, although allocating resources to primary schooling is clearly very important, more analysis is needed on how best governments can allocate their education budget to ensure that children and young people are better equipped to escape/avoid poverty.

5. Efficiency in the use of human and financial resources is important to prevent social spending creating fiscal burdens

A number of good practices^{xii} ensures both allocative (as indicated above) and technical efficiency in resource use at the primary levels of state investment in education and health. The evidence from the high-achieving countries indicates that unit costs per pupil in primary education needs to be kept low for the system to expand without declining in quality. Several methods were employed to keep costs low in these countries – for example, Zimbabwe tackled its shortage of teachers by ensuring that trainee teachers spent most of their four-year training course actually teaching in schools (as opposed to in training college). This considerably reduced the cost of training them and in the process provided schools with teachers as enrolment expanded. Other good practices included double-shifts in schools, low private costs, mother-tongue instruction, bilingual education and a good proportion of female teachers, all of which could be usefully adopted by other developing countries where Education for All is a distant goal.

To give examples of good practice in the health sector, high achievers emphasised a comprehensive approach to primary healthcare, focusing on mother and child health. They implemented this approach with a heavy and cost-effective reliance on community-based, primary health care workers^{xiii}. These community-based health professionals gain local support much more easily, making health interventions much more effective and accessible for community members. To combat the problem of inadequate numbers of health professionals in rural areas, some of these countries made it compulsory for newly trained doctors to spend a minimum amount of time working in rural areas.

6. Women are active agents of change, and not mere beneficiaries of a welfare state

The pivotal role of women's agency cannot be emphasised enough. Women greatly affect the health and education outcomes of children – this includes women's freedom to work outside the home, to earn an independent income, to have ownership rights, and to receive education. Relative to other countries, women in the high-achieving countries had much greater access to education and there were fewer cultural taboos on them working outside the home. Amongst other positive effects, this led to more female health workers and teachers, which facilitated an increase in women and girls accessing health and education services.

ADDITIONAL LESSONS FOR THE MDG GENERATION

The above six principles can be usefully adopted elsewhere in the developing world to dramatically improve child welfare. Furthermore, they could prove to be crucial in assisting the international community to attain the Millennium Development Goals (MDGs), an aspiration that hinges very much upon developing countries making substantial gains in the health and education status of their people, particularly children. In addition to these lessons from the high-achieving countries, there are three other instructive points emerging from social development experiences elsewhere, which are more recent (1990 onwards):

- **Benefits of effective decentralisation**

Effective decentralisation can help deliver good quality health and education services. This requires: a strong central state; local authorities to which functions, functionaries and finance in respect of basic services has been fully decentralised; and citizen voice.

- **Dangers of private provision**

There is a danger in the twenty-first century that the risks of growing private provision and privatisation of services may not be realised until the adverse effects overtake the poor (as with user charges in the 1980s and 1990s). Without a simultaneous improvement in regulatory capacity of the state, private provision may be neither efficient nor equitable.

- **Policy conditionalities may undermine the economic base for investment in basic services**

The policy requirements and conditionalities explicit in PRSPs and World Bank/International Monetary Fund lending instruments with regard to institutional development have compromised economic growth for most of the last two decades in most countries of Latin America and sub-Saharan Africa. This poses a critical challenge to sustained improvements in child wellbeing. As of now, there still seems little scope for alternative macro-economic policies.

THE TIME FOR LEARNING IS NOW

The causes and driving forces behind social successes are historical and specific to the countries in question. These social forces can hardly be replicated. They cannot be conjured up, nor can any amount of social engineering help to create them. Social policies, however, can be replicated and the policy principles identified in this briefing were common to all the high-achieving countries, *despite* their different social and historical conditions. These policy lessons must be taken seriously *now*. They offer us key insights into making positive impacts on relieving the suffering endured by tens of millions of the world’s children. At this, the beginning of the 21st Century, it is imperative that we learn urgently from the lessons of history if we truly are committed to breaking poverty cycles which begin in childhood and, indeed, to meeting the Millennium Development Goals.

Further reading:

Mehrotra, S. and Jolly, R. (eds), 1997, *Development with a Human Face. Experiences in Social Achievement and Economic Growth*, Oxford: Clarendon Press

UNDP, 2003, *Human Development Report 2003 – A Compact Among Nations to End Human Poverty*, New York: Oxford University Press

Andrea Cornia (ed), 2004, *Inequality, Growth and Poverty in an era of Liberalisation and Globalisation*, Oxford: Oxford University Press.

i Source: UNICEF 2002, *The State of the Worlds Children*, New York, Oxford University Press. Botswana and Zimbabwe made rapid progress in child welfare and social indicators during the 1980s before the AIDS pandemic hit them hard during the 1990s.

ii Source: UNICEF 2001, *The State of the Worlds Children*, New York, Oxford University Press.

iii Source: UNICEF 2004, *The State of the Worlds Children*, New York, Oxford University Press.

iv Source: UNICEF 2001, *The State of the Worlds Children*, New York, Oxford University Press.

v *Ibid.*

vi *Ibid.*

vii *Ibid.*

viii For more details of adjustment processes in these countries, see Mehrotra, S., 2004, *Improving Child Wellbeing in Developing Countries: What Do We Know? What Can be Done?*, CHIP Report 9, London: CHIP.

ix Caldwell 1986, *Population and Development Review*, vol. 12

x Source: Mehrotra, S., 1997^a, ‘Social Development in High-Achieving Countries: Common Elements and Diversities’, in Mehrotra, S. and Jolly, R. (eds)

xi Source: CHIP Policy Briefing 6: Promoting Disadvantaged Young People’s Employment – What Can be Done?

xii More detail on good practices in these countries can be found in Mehrotra, S., 2004, *Improving Child Wellbeing in Developing Countries: What Do We Know? What Can be Done?*, CHIP Report 9, London: CHIP.

xiii see CHIP Policy Briefing 7: Child Health and Poverty

This briefing is based on Mehrotra, S., 2004, *Improving Child Wellbeing in Developing Countries: What Do We Know? What Can be Done?*, CHIP Report 9, CHIP: London.

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