Improving Child Wellbeing in Developing Countries

What Do We Know? What Can Be Done?

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Preface

This paper is one of a series of working papers, reports and policy briefings on different aspects of childhood poverty published by the Childhood Poverty Research and Policy Centre (CHIP). CHIP is a collaborative research and policy initiative involving academic institutions and Save the Children in China, India, Kyrgyzstan, Mongolia and the UK. It aims to:

- Deepen understanding of the main causes of childhood poverty and poverty cycles, and increase knowledge of effective strategies to tackle it in different contexts;
- Inform effective policy to end childhood poverty, ensuring that research findings are widely communicated to policy-makers, practitioners and advocates;
- Raise the profile of childhood poverty issues and increase the urgency of tackling them through anti-poverty policy and action;
- Work globally to tackle chronic and childhood poverty in developing and transition countries.

Financial support from the Chronic Poverty Research Centre, the UK Department for International Development - DFID - (grant no. R8005), Save the Children (UK) and International Save the Children Alliance have made this publication possible and are gratefully acknowledged.

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Executive Summary

This paper examines the successes of ten 'high-achievers'– countries with social indicators far higher than might be expected given their national wealth – in improving child welfare, pulling together the lessons learned for social policy in the developing world. The paper shows how, in the space of fifty years, these countries have made advances in health and education that took nearly 200 years in the industrialised world. Indeed, many of their social indicators are now comparable to those found in industrialised countries.

Relationship between economic growth and social development

These countries did not give priority to achieving economic growth or macro-economic stability first, while postponing social development - indeed regardless of their success in reducing income poverty, these countries tackled the worst manifestations of poverty – preventable child deaths, the powerlessness of illiteracy and debilitation of ill-health – for almost the entire population. Furthermore, there are many historical examples where economic growth has not translated into improvements in health and education status. Although economic growth is a necessary condition of sustained improvement in health and education indicators and in the quality of social services, it is neither a necessary nor a sufficient condition for the 'take-off' in social development.

Without integrating macro-economic and social policy, synergies between economic growth, income poverty reduction and advances in health and education are unlikely - investment in these services has underpinned economic growth in many instances. This implies that social policy must be given equal status with macro-economic policy - if economic growth is the dominant objective, with macro-economic policy determined first (with the Ministry of Finance in the lead), and with social policy trailing behind, this synergy cannot take place.

Key principles underlying success

Although the social and political contexts in which the public investments discussed in this paper are not replicable, the policy choices and investments made by these countries could be replicated elsewhere. Six key principles are common to social policy in all these countries:

- **Maximising synergies between interventions in social services is critical to trigger virtuous cycles.**
- **Sequencing social investment can increase its efficacy: for example, educational achievement preceded, or took place at the same as, the introduction of health interventions.**

- **The pre-eminent role of public action is key, regardless of whether an economy is centrally-planned or market oriented.**
- **While the level of social spending is important for health and education outcomes, the equity of the intra-sectoral spending pattern matters even more.**
- **Efficiency in the use of human and financial resources is important to prevent social spending creating fiscal burdens.**
- **Women were active agents of change, and not mere beneficiaries of a welfare state.**

Underlying each of these principles were sector-specific good practices, such as an emphasis on primary health care, bilingual education.

Some additional principles emerge from more recent experiences, which draw upon the historical experience of countries and regions in the 1990s:

- **Benefits of effective decentralisation.** Effective decentralisation can help deliver good quality health and education services. This requires: a functional central state; local authorities to which functions, functionaries and finance in respect of basic services have been 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 and the adverse effects may 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.

In future, states will need to take notice of not only the six principles summarising the experience of the high-achievers, but also these three lessons of more recent history.

1. Introduction

Within the last 50 years, most developing countries have made health and educational advances that took nearly two centuries in the industrialised countries (Corsini and Viazzo, 1997). Child mortality has declined and life expectancy and the percentage of children going to school has risen dramatically (UNDP, 1998). However, these significant achievements may not be immediately obvious given the number of children's lives that continue to be blighted in the world.

Nearly 12 million children die every year from easily preventable diseases – two-thirds of them in sub-Saharan Africa. Half-a-million mothers in developing countries still die every year during child birth. Some 183 million children still suffer from moderate and severe malnutrition – 80 million of them in South Asia.[1] Shockingly, half of all children born in South Asia suffer from moderate or severe malnutrition. Two in every five children in the developing world are undernourished.

Nearly one billion people in the world are illiterate. Despite the goal of universal primary education adopted in 1990, some 115 million school-age children (57 per cent of them girls), do not attend school. Most of them are in South Asia and sub-Saharan Africa. The majority are working children, many of whom are below the age of ten. A staggering one-third of all children in developing countries fail to complete four years of primary education, the minimum time period required for basic literacy and numeracy.

Clean water, basic sanitation and a standard of living that allows families to meet their basic needs are still beyond the reach of billions of people in all parts of the world. Some 1.7 billion people are without safe water, of whom 600 million are in East Asia and the Pacific and almost another 300 million in sub-Saharan Africa. Well over half of humanity is without access to adequate sanitation – 3.3 billion people – of whom 1.2 billion are in East Asia and the Pacific, and 850 million in South Asia. Moreover, these global averages barely begin to describe the real dimensions of deprivation and inequity in many countries.

Clearly, while progress has been made, much remains to be achieved in the majority of developing countries. What combinations of basic services are essential for any one service to be effective? What have we learned from the combination of different basic services as an effective package to tackle childhood poverty? Are there key organisational and delivery factors? To what extent are these dependent upon local context or are they transferable across countries? Are there particular combinations of public/non-public delivery mechanisms that work, and how important a factor is centralisation/decentralisation of service delivery in their effectiveness and efficiency? Further, financing is an issue: can services be delivered effectively on relatively low

1 The data in this paragraph, and the following two paragraphs, on page 1 is drawn from UNICEF (2001).

financing if other conditions are right? If not, what effective actions have resulted in adequate financing? Finally, what key policy instruments or frameworks (eg Poverty Reduction Strategy Papers, debt cancellation, and so on) are critical for ensuring effective service provision? This paper addresses all of these questions – where the range of questions is broad, the analysis will be cross-national.

This paper concentrates on ten developing countries that managed to exceed the pace and scope of social progress of most other developing countries. In fact, many of their social indicators are now comparable to those prevailing in industrialised countries. In order to understand why and how this social achievement was made possible, UNICEF supported the study of these ten countries: Costa Rica, Cuba and Barbados from Latin America and the Caribbean; Botswana, Zimbabwe and Mauritius in Africa; Kerala state (India) and Sri Lanka in South Asia; and the Republic of Korea and Malaysia in East Asia (Mehrotra and Jolly, 1997).[2]

This paper attempts to pull together the lessons for developing countries from the experience of these high-achievers. The good practices discussed in this paper clearly relate to health and education interventions. In other words, the paper is concerned with the health and education status of the population or the social dimensions of poverty – not income poverty – and the latter issue is not analysed here. Studies were carried out in each country by national teams – with high-achieving states selected in each region. The selection of countries was determined by the output or outcome indicators relating to health status, nutritional level, educational status, and access to services. The selection process looked for countries which were high-achievers relative to their level of income – the selection was, in that sense, purposive. These were longitudinal studies – examining historical data on the evolution of social indicators, and their determinants (social policy and public expenditure patterns). They covered, in each country, a 30-40-year time period, spanning mostly the post-colonial epoch and the immediate pre-colonial period.[3]

The health transition and educational advances that took nearly 200 years to accomplish in the now industrialised countries were achieved within a generation or so in the selected developing countries. Many of their social indicators are now comparable with those of industrialised countries (see Table 1).

2 These country cases are discussed in detail in Mehrotra and Jolly, 1997 (also paperback, Oxford University Press, 2000; see also *Le Développement à visage humain*, Economica, Paris, forthcoming).

3 African and Asian countries became independent after the Second World War. Costa Rica and Cuba had become independent of Spanish rule in the first quarter of the nineteenth century, though in Cuba the influence of the USA was dominant until 1959. Barbados ceased to be a colony in 1938.

Table 1: Social indicators in selected high-achieving countries

	IMR[2] (1998)	Life expectancy	Primary Enrolment Ratio (gross) (1990-97)		Secondary Enrolment Ratio (gross) (1990-96)		Literacy rate		HDI***[3] (1997)
			Male	Female	Male	Female	Male	Female	
Costa Rica	14	76	108	107	48	52	95	95	0.801
Cuba	7	76	108	104	73	82	96	96	0.765
Barbados	13	76	90	91	90	80	98	97	0.857
Botswana[1]	38	61*	111	112	63	69	70	75	0.609
Zimbabwe[1]	59	56*	115	111	52	44	90	80	0.560
Mauritius	19	72	107	106	63	66	86	78	0.763
Kerala**	17	70	109.1	107.0	98.0	95.7	94.5	86.9	0.775*
Sri Lanka	17	73	110	108	71	78	98	96	0.721
Rep. of Korea	5	73	94	94	102	102	99	95	0.852
Malaysia	9	72	90	92	58	66	89	79	0.768
Industrialised countries	6	78	104	103	105	107	98**	96**	0.919
Low income countries 1996[3]	80	60	n.a.	n.a.	n.a.	n.a.	65	41	n.a.
Lower mid-income countries[3]	37	71	n.a.	n.a.	n.a.	n.a.	88	73	n.a.
Upper mid-income countries[3]	31	73	n.a.	n.a.	n.a.	n.a.	88	83	n.a.

Source: UNICEF, State of the World's Children 2000, except for *(Mehrotra and Jolly, 1997), **(UNICEF, State of the World's Children, 1999) and ***(UNDP, Human Development Report, 1999).

Notes:

1 Life expectancy in Botswana fell to 47 years and in Zimbabwe to 47 years in 1998 (UNICEF, State of the World's Children, 2000) as a result of the impact of the AIDS panemic; they were much higher in the early 1990s.

2. IMR= Infant Mortality Rate (probability of dying between birth and one year of age per 1000 live births.) HDI= Human Development Index.

3. The Low Income Countries are: Sri Lanka, Kerala, Zimbabwe. The Lower-Middle Income Countries are: Costa Rica, Cuba, Barbados. The Upper-Middle Countries are: Botswana, Mauritius, Republic of Korea, Malaysia.

Drawn from three continents, this is a highly diverse group of countries – geographically, socially, politically and economically. They include small and large countries, island states and states that are land-locked. Among these states there are ethnically homogenous nations, as well as diverse ones. There is a one-party state and many liberal democracies. One has a centrally-planned economy but most are market economies. In other words, on the basis of their experiences one could argue that there are many routes to social development, low mortality rates and relatively high educational status – but the study found that in many respects their social and economic policies were common. These policies are the subject of this paper.

All ten countries were low-income economies in the mid-twentieth century. Half of them have combined rapid economic growth with social achievement, and are now considered to have high-performing economies. Significantly, the high-growth economies achieved social progress very early in their development process, when national incomes were still low. Others grew more slowly and experienced interrupted growth. They demonstrate that it is possible to achieve a high level of social development (and mitigate the worst manifestations of poverty) even without a thriving economy, if the government sets the right priorities. Nevertheless, for that to be achieved, macro-economic policy cannot be divorced from social policy, since the former has an impact on social outcomes.

Section 2 presents the conceptual basis for the success of these countries, by examining the feedback loops between a core set of basic services that are essential to transform children's lives. Sections 3 and 4 offer the policy lessons that emerge from an examination of these ten countries. Section 3 presents the characteristics of the macro-economic and social policy, organisational conditions and financing that can be derived from the experience of these ten developing countries. Section 4 examines their good practices within the health and education sectors. It also examines issues related to 'hard-to-reach' ethnic minority populations. Section 5 asks the question: 'in which context do the good practices work, or in what kind of context are they not likely to function'. The last section briefly assesses the potential for replication of these good practices in social policy to other countries.

2. The synergy among social services[4]

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.

Figure 1: Education and health feedback effects

Social services inputs/processes	Human development outcomes/outputs				
	Knowledge	Family Size	Health Status	Nutritional Status	Healthy Living Conditions
Education		↩	↩	↩	↩
Family Planning	↩				
Health	↩	↩		↩	↩
Nutrition	↩	↩	↩		
Water and Sanitiation					

Figure 1 represents this notion of synergy. On the horizontal rows, the various social services are represented as inputs or interventions – education, family planning, health, nutrition and water and sanitation. The vertical columns represent the human development outcomes or outputs – knowledge, family size, health status, nutrition status, and healthy living conditions. The shaded cells are the ones where there is a relationship between a certain intervention, and an outcome. For example, the use of contraception, by helping with the spacing of children, benefits the health status of the mother as well as the children. The arrows represent feedback effects from human development outcomes to the inputs/processes. For example, the improved health status of a child improves his/her ability to learn, just as improved nutritional status does. Similarly reduced family size improves the chances that a poor family will be able to afford education for all the children rather than merely the boy(s) in the family, and so on.

None of these relationships is based on evidence discovered in the last few years. However, probably in part due to over-specialisation, they are all too often presented separately. By integrating them, it becomes clear that their separate effects, the ones often reported, are only partial. Interventions in health, nutrition, water and sanitation, fertility control, and education, not only affect a child's wellbeing but also complement and reinforce each other. Thus the

4 This section draws heavily upon Mehrotra and Delamonica (forthcoming).

impact of any one kind of investment is increased in the presence of the others, proving the advantages of integrated approaches.

The positive effects of *education* are intuitive and well known. Educational inputs have an impact on all types of human development outcomes.[5] First, parents, especially mothers, make better use of information and reproductive healthcare facilities if they are more educated. Thus, more widespread education is associated with lower fertility. Better nutrition and healthcare is provided by educated parents for themselves and their children. Various routes ensure this result. The general knowledge acquired at school increases understanding of modern health practices and scientific beliefs, which make mothers (and fathers) more likely to use healthcare centres. In addition, the capacity to acquire new knowledge and change behaviour accordingly is higher among those who attended school, as evidenced by the differential diffusion of HIV/AIDS among educated and uneducated women. As a result, health investments are more efficient in the presence of a more literate population. In countries where parents have been exposed during their school years to nutrition information, they combine different foods to obtain better nutritional outcomes. Also, mothers take better care of their nutritional needs during pregnancy, avoiding low birth weight. Basic education also facilitates the rapid adoption of improved hygienic behaviour. This not only improves health outcomes but also enhances the impact of investments in water and sanitation systems (Schultz, 1995).

In summary, education, and in particular girls' education, enhances the impact of other sectoral interventions. All of these, in turn, result in good nutritional and health outcomes, increasing the likelihood that children will attend school and become better students (Colclough, 1993). For instance, with lower fertility, parents can devote more attention to their children's studies and afford more food and school supplies which improve learning. In addition, when girls need to give less time to help with household chores like fetching water, they have more opportunities to attend school. Also, they have more time and energy to study, avoiding repetition or dropping out.

Family planning, by providing easy access to contraceptive means, enables the mother to space births, thus lowering the health risk to herself and the child, reducing infant and maternal mortality and improving the healthy development of the child. Thus, lower fertility has positive implication for health and life expectancy. At the societal level, effective family planning and access to basic services has the effect of hastening the demographic transition. As children survive, families voluntarily curtail the number of children. This is not the place to enter the debate on the relative impact of supply of contraceptives versus desired family size in family planning. However, it is clear that lower infant and child mortality plays a major role in reducing

5 There are at least four other benefits of schooling, which extend beyond the conceptual framework outlined in the text. First, it raises the prospect for gainful employment outside the home. Second, it enables people to invoke their legal rights. Third, illiteracy can limit the political voice of people. Fourth, education, especially of women, helps to enhance the autonomy women have in household decision-making.

fertility rates (Caldwell, 1986), as does education, the availability of information on reproductive healthcare, and its accessibility.

As population growth slows down, school systems find it easier to absorb all children. Teacher-pupil ratios can be reduced, increasing quality without unduly burdening budgets, and construction costs can also be reduced, releasing resources for other quality-enhancing measures.

As in the case of the health and nutrition sectors, the availability of information on, and access to, reproductive healthcare will not, on their own, reduce fertility as much as it might be needed or desired. They are more effective when couples are more educated and child survival rates are higher.

It is also very well established that lack of good *nutrition* critically interacts with *health status.* For instance, control of diarrhoea and measles is very important not only for health outcomes but also in reducing malnutrition (by improving the capacity to absorb and retain caloric intake). By the same token, an insufficient intake of total calories, vitamins, and proteins weakens children's immune systems. This would make them vastly more vulnerable to the onset and consequences of infectious disease. Interventions in health promote good nutrition and interventions in nutrition promote good health.

Moreover, micronutrient deficiencies and illness can have devastating consequences for the cognitive development of a child. For instance, iron deficiency anaemia reduces cognitive functions; iodine deficiency causes irreversible intellectual impairment and vitamin A deficiency is the primary cause of blindness among children. Girls are unfairly disadvantaged in many of these cases. They are more likely to suffer from iodine or iron deficiency. In addition, there are many contexts in which girls' education is valued less than that of boys; consequently, girls miss school when they have to stay home to look after sick relatives. Also, boys are usually better fed and more likely to be taken to a health facility when ill.

It is clear that good health and nutrition have benefits which reinforce each other. But it is also clear that good health, the protection against disease, and proper nourishment cannot be produced by the health or food sectors alone (Behrman and Deolalikar, 1995).

Safe water and adequate sanitation also play a fundamental role in determining health outcomes. Access to safe water and sanitation dramatically reduces the incidence of diarrhoea and many other diseases that kill millions of children and adults each year. Another effect of better access to water is the reduced effort in carrying water, which is usually unduly borne by women and girls.

Given their traditional roles, when women and girls have more time, they can apply it to better infant and child care. This leads to positive health results. Finally, especially for women, more time is available for pecuniary productive activities. This direct impact of water and sanitation improvements on income poverty reduction is less well publicised than the effect of higher education and better health on productivity.

Backed by proper hygienic behaviour, such as hand washing and the use of soap, access to safe water and adequate sanitation reduces morbidity from infectious diseases and increases the nutritional status of children, which furthers their learning abilities.

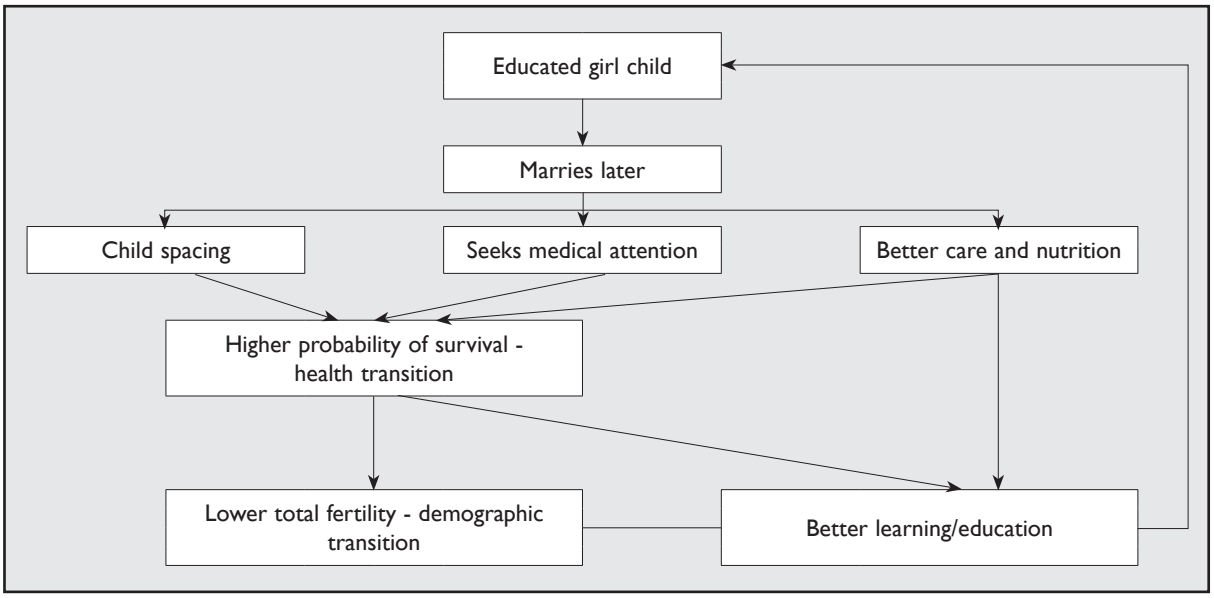
Figure 2 also illustrates this synergy between interventions within the social sectors by presenting the impact in the form of a life cycle of an educated girl. An educated girl is likely to marry later than a girl who remains without any education. This is especially true if the girl's education extends to at least a junior secondary-level and she engages in economic activity outside the home. Also, an educated girl will have fewer children, will seek medical attention sooner for herself and her children, and is likely to provide better care and nutrition for herself and her children. This would reduce the probability of morbidity through disease and hence the survival of her children beyond the age of five. Over time, the survival of her children will change the behavioural pattern of the family in respect to fertility and contraception – thus, lowering the overall fertility rate. Smaller household size improves the care of children, and lower fertility reduces the size of the school-age population. These benefits of girls' education accrue from generation to generation. In other words, in order to maximise the complementarities among basic social services, it is crucial to focus on universal primary education early on, particularly for girls – but it also assumes that health/family planning/water and sanitation services are available (Mehrotra and Delamonica, forthcoming).

In summary, each intervention has ramifications which lie outside its 'sector' and adds up to a virtuous circle of social and economic development. Moreover, they do not just affect another sector, they all impinge on each other, resulting in a mesh of interactions. In other words, it is a multi-dimensional synergetic system. No wonder it results in a complex system, at which most developing countries have not yet succeeded.

From an instrumental point of view, the benefits do not automatically accrue without solving the co-ordination problem in a complex system. Markets alone would not ensure universal access – hence the need for the public sector to step in and finance these services. Moreover, the case for government financing in these sectors also derives from equity considerations. It is the poor who usually lack these services, or if they have to pay for them they will under-consume them.

Hence they find it difficult to pull themselves out of the vicious cycle of a poverty trap, as the basic functionings of ability to read and write and lead a healthy life are essential to widening choices in life.

Figure 2: Lifecycle of an educated girl



Source: Mehrotra (1997a)

While the above arguments form the case for government financing of these services, the case for government provision rests on other grounds. The first is economies of scale. For example, water supply is, in many ways, a natural monopoly. While in a large metropolis there may be a case for provision by two separate bodies (public or private), duplication, and hence higher unit costs per volume of water supplied, would result if several companies were operating in the same locality. The second is improved coverage of services. Private physicians/nurses tend to concentrate in cities, while most of the population in low/middle-income countries lives in rural areas. Similarly, private schools are more plentiful in urban as opposed to rural areas, partly in response to the higher incomes/demand in the cities and towns. If reducing inter-regional inequalities were a goal of government, the state would have to supply these services in rural areas. Third, in social services, the practical contracting problems are particularly severe. Even if private providers were willing and able to finance these services, asymmetric information between the government (which currently owns these services) and the private party interesting in purchasing the public provider can lead to contracting problems.[6] A fourth reason is that the synergies between

6 While this is true for privatisation of publicly owned services, the state also has a role to play in the regulation of the profusion of private education and health services that exist in most countries, especially in South Asia.

interventions in outcomes will not be realised without simultaneous interventions in the different sectors. The risk of co-ordination failure is much greater if the state is merely financing these services, rather than providing them itself.

A final reason for ultimate state responsibility for provision of these basic services is that access to them is a fundamental human right, enshrined in the UN Convention on Social and Economic Rights (1948), as well as the UN Convention on the Rights of the Child (1989), ratified by all but two governments of the world. While citizens have rights, it implies a corresponding obligation on the part of the state to provide these services.

3. Policy lessons from high-achieving states

3.1 The role of public action and economic growth

Not inconsistent with the preceding conceptual discussion, the first common theme that emerged from the diverse group of countries termed high-achievers was the pre-eminent role of the state in ensuring that the vast majority of the population had access to basic social services. This was the case regardless of whether the state in question was socialist Cuba or one that has been regarded as the doyen of market-orientation – the Republic of Korea.[7] In other words, there was no reliance on a growth-alone strategy, nor faith in the trickle-down to the poor of the benefits of income growth. In principle, such trickle-down could indeed enable the poor to buy educational and health services – but that was not the assumption made by these countries – regardless of whether income per capita grew rapidly or not.

This is hardly surprising for anyone who takes an historical approach to the rise of social indicators in the now industrialised countries. Each of the European countries passed through a period of free trade and *laissez faire*, followed by a period of 'anti-liberal' or social legislation or measures in regard to public health, education, public utilities, municipal trading, social insurance, and factory conditions. This was as true of Victorian England as of Bismarck's Prussia, of France of the Third Republic or the Empire of the Habsburgs. As Karl Polanyi puts it, 'while laissez faire economy was the product of deliberate state action, subsequent restrictions on laissez faire started in a spontaneous way. Laissez faire was planned; planning was not' (Polanyi, 1944).

Specifically in the field of education, in the early nineteenth century learning became equated with formal, systematic schooling, and 'schooling became a fundamental feature of the state' (Green, 1990). The classic form of the public education system, with state-financed and regulated schools, with free tuition, and an administrative bureaucracy, occurred first in Europe in the German states, in France, Holland, Switzerland and the American North. All these countries had established the basic form of their public systems by the 1830s. Britain, the southern European states, and the American South, were much further behind. But in each case the state was critical to the expansion of the system and the universalisation of elementary education. As a consequence, most European countries saw a consistent rise in the literacy rate during much of the nineteenth century.[8]

Similarly, in respect of health, before the late nineteenth century both governments and parents regarded serious illness and the ensuing mortality of infants and young children as inevitable. The first great successes of medical science contributed to creating a widespread awareness that many deaths were preventable, and public health programmes to address infant mortality were eventually started in earnest (Corsini and Viazzo, 1997). Such measures had a major impact on

7 The Republic of Korea's success may have been touted by some (see World Bank, 1993a) as the result of market-oriented policies. This has been strongly disputed by others (eg see Amsden, 1992; Wade, 1990).

8 For a more detailed discussion, see Mehrotra and Delamonica (forthcoming).

the infant mortality rate in the industrialised countries from the late 1800s, and the decline in these rates has been dramatic ever since. The sharp drop in the twentieth century was linked, in particular, to expanding maternal and child medical care, including pioneering efforts to establish local child health clinics, increase the number of babies born in hospital, and organise antenatal clinics and neonatal units.

There is an interesting question on how much general improvements in the standard of living helped to reduce infant mortality in industrialised countries. This historical question is still relevant to the present day problem of childhood mortality in developing countries (but also industrialised ones) and is posed by Preston and Haines (1991), in their groundbreaking book *Fatal Year: Child Mortality in Late Nineteenth Century America,*

> *'In 1900, the United States was the richest country in the world… On the scale of per capita income, literacy, and food consumption, it would rank in the top quarter of countries were it somehow transplanted to the present. Yet 18 per cent of its children were dying before age 5, a figure that would rank in the bottom quarter of contemporary countries. Why couldn't the United States translate its economic and social advantage into better levels of child survival?'*

Preston and Haines took the co-existence of high levels of child mortality alongside relative affluence as proof of the inadequacy of the thesis – which became very influential – proposed by the British physician and historical demographer Thomas McKeown. This emphasised improvements in material resources as a causal factor in the reduction of mortality.[9] The inability of the USA to translate economic growth into improvements in health status seems to imply that it was advances in medical sciences that did the job.

The question asked for the USA could equally be asked for some developing countries. Why does Brazil, with many times the income per head of China and Sri Lanka, still have a lower life expectancy than the latter countries? The contrasts between some African economies, which experienced rapid economic growth are also telling. Between 1960 and 1993 Botswana managed to increase life expectancy for its population from 48 years to 67 years and Mauritius from 60 to 73 years. But why did Africa's most populous country, Nigeria – whose economy had grown at 9.7 per cent per annum over the period 1965-73, and thereafter experienced the windfall gains of the oil price increases – only manage to reduce its under-five mortality rate by less than ten per cent (212 to 188) over three decades?

9 McKeown (1976) argued that historically both therapeutic and preventive medicine had been ineffective, and that the reduction of infant mortality was primarily an economic issue. Thus, instead of investing money in sophisticated medical technology, perhaps even in public health measures, it seemed preferable to promote programmes capable of increasing the nutritional level of the whole population and enhancing the resistance of its younger members to the aggression of germs and parasites. Preston and Haines (1991), however, suggested, on the basis of the lack of social-class differentials in child mortality in the USA around 1900, that 'lack of know-how rather than lack of resources was principally responsible for foreshortening life'.

The answer lies in the role of public action. As Sen (1999) says, 'the "support-led" process does not wait for dramatic increases in per capita levels of real income. It works through priority being given to providing social services (particularly health care and basic education) that reduce mortality and enhance the quality of life'. The contrast between the high-achievers and other developing countries is instructive in respect of the role of the state in education. For instance, primary education was the responsibility of the state in all the high-achievers from an early stage. On the other hand, there is evidence that the percentage of students enrolled in private schools in other (non-high achieving) developing countries was not insignificant, especially in East and West Africa and in Latin America (Mehrotra, 1998).

3.2 Organisational conditions

Despite this overwhelming evidence about the state's role in high-achieving countries, in recent decades there has been a push to privatise water and hospital services in many developing countries, and the private sector's role has grown. This push has been driven by three factors: lack of government resources; the low quality of public provision; and pressure to liberalise the economy as a whole, including basic services.

The high-achievers made most of their social advances at a time when the role of the state in development was not questioned as much as it has been since 1980. However, by the early 1980s, many low-income countries had faced serious external shocks, especially the quadrupling of oil prices in 1973 and then their doubling again in 1979. Partly as a result of these external shocks, and partly due to poor macro-economic management capacity, many countries, especially in sub-Saharan Africa and Latin America, faced large fiscal deficits (and current account deficits). Public expenditure on basic services was cut as a result (Jayarajah *et al*, 1996) (often at the insistence of the International Monetary Fund). Under the circumstances, the private sector grew to fill the gap. At the same time, the many public enterprises were run inefficiently and lost money; hence the biggest returns to government came from eliminating subsidies to loss-making water utilities in the public sector or privatising hospitals (UNDP, 2003).

The low quality of public provision has also driven users to private providers. In India and Pakistan poor households give teacher absenteeism in public schools as their main reason for choosing private ones. In primary health centres in many developing countries, drugs are often not available, and poorly paid public sector doctors supplement their incomes by selling drugs intended for free distribution. In urban slums, to access water poor people must pay exorbitant prices from private tankers run by small vendors, as the government-owned utility is unable to

supply enough water *(ibid)*. Most residents of South Asian cities receive water for only a couple of hours a day. Clearly organisational conditions have to change if basic service delivery by the state is to improve.

The push for private provision has also come from international financial institutions, The World Bank's *Private Sector Development Strategy Paper* (World Bank, 2000) explicitly promoted private provision in social services, and the International Finance Corporation's Strategy Papers (IFC, 2001a and 2001b) called health and education new 'frontier areas' for future lending by the Corporation. The World Trade Organisation's *General Agreement on Trade in Services* also encourages private entry in social services (WTO, 2003; Save the Children, 2001; Mehrotra and Delamonica, forthcoming).

Where complementarity between the private and public sectors can expand services to the poor without leading to further inequity in service provision, careful policy-making is required. Regulatory capacity is weak in most developing countries, and institutional development is required before privatisation will be effective in promoting equity and efficiency.[10]

The high-achiever states however, did not rely much on the private sector, as noted above. Nor were state failure or the inefficiency of state provision of basic services major issues when they were making their advances. Nevertheless, state failure in social service provision has been so widespread over the last two decades that the international financial institutions have offered decentralisation of public service provision as a way forward to improve the efficiency and effectiveness of services delivery. There was an initial euphoria about decentralisation, and its potential for service delivery on the following grounds:
(UNDP, 2003)

- faster response to local needs
- more accountability and transparency and less corruption
- better information flows
- higher prospect for sustainability of projects due to involvement of local people in design, execution and monitoring of projects
- expanded opportunities for political representation.

However, not all forms of decentralisation have worked. The policy advice to decentralise social service provision has been available from the beginning of the 1990s, with variable outcomes where it has been implemented.

10 See UNDP *Human Development Report* 2003, chapter 5, and Mehrotra and Delamonica (forthcoming), chapter 7, for a discussion of the risks and potential ways in which such complementarity could be encouraged.

Meanwhile, evidence has accumulated over the 1990s on what forms of decentralisation of social service delivery do work and do offer a way forward, if state provision of social service delivery is to provide a credible alternative to the push for private provision and privatisation of services (Crook and Manor, 2000; Mehrotra, 2002). The success of participatory budgeting in Porto Allegre city in Brazil (and its subsequent spread to other Brazilian and Latin American cities), the remarkable success of Madhya Pradesh and Rajasthan in increasing access to schooling in the 1990s and increasing literacy rates,[11] the amazing improvements in child health and social provisioning in one of Brazil's poorest states, Ceara – all these examples have demonstrated that one has to be very careful about what functions can and should be decentralised.

These examples have also demonstrated that there are certain common elements in these successful cases of decentralisation – a model of deep democratic decentralisation. There are three such elements:

- Strong state capacity to decentralise is important. A weak state with limited capacity is in no position to carry out an effective decentralisation. At the other extreme, a military state is unlikely to permit genuine democratic decentralisation, despite maintaining the façade of devolving power to local authorities. A democratic, functioning state is best capable of effective decentralisation.
- The local authority to which social service provision is decentralised should have full control over functions, functionaries and finance in respect of the activities decentralised. Decentralisation of powers and responsibility over one of these without the other two, or over two without the third, would be a dysfunctional arrangement.
- Institutional mechanisms have to be put in place to enable the peoples' voice to be heard in the delivery of services, making the functionaries and finance accountable and responsible to the citizenry.

Where these three elements are present, state failure in the provision of services is minimised, and outcomes for children have improved dramatically (Tendler, 1997; Mehrotra, 2002). However, as we noted earlier, the so-called high-achievers managed to achieve these results without necessarily facing the massive problems of state failure that have been common to many states since the 1980s. What is implied, in other words, is that in the changed circumstances of the twenty-first century, the recent experience of the specific model of deep democratic decentralisation is becoming an essential ingredient of successful social delivery. A functioning central state authority is still common to the high-achievers and new model. The difference in

11 Madhya Pradesh and Rajasthan are among the poorest states in India, and despite these improvements many tribal, and low caste children and girls are still left behind with very limited access to education.

the organisational conditions required now are the latter two elements: a local authority that controls functions, finance and functionaries; and voice for the people.

3.3 Financing

In each of the high-achieving countries, the state's commitment to social services was translated into financial resources. Education expenditure as a proportion of GDP (1978-93) for each of our countries was higher for the high-achievers relative to the region to which they belong, without exception. For health too, the expenditures were higher than the regional average, except in the case of Korea.[12] In other words, the evidence suggests that the high-achievers gave higher macro-economic priority to health and education than the so-called low-achievers (Mehrotra, 1997a).

While the ratios of expenditure give an idea of the macro-economic or fiscal priority accorded the population's health and education by governments, what matters at the receiving end is the absolute size of the expenditure in per capita terms. Relative to other countries in their region, the high-achievers were spending much more per capita than other countries (though some of this may be due to differences in per capita income). This is particularly so in education, and to a lesser extent in health. Thus, in 1992 the median expenditure in education was $49 in East Asia, but $174 in Korea and $123 in Malaysia. The sub-Saharan median was $11, but even a low-income country like Zimbabwe spent $26, while Botswana and Mauritius spent several times as much. Even though Costa Rica is not one of the countries with the highest per capita income in Latin America, it spent nearly three times as much per capita on education than the regional median ($43).[13]

It may appear obvious to argue that the state's commitment in the form of resources translated into high achievement. However, there were many other attributes or associated conditions of that commitment, quite apart from the quality and timing of the social investment. These are discussed later in this and the next sections.

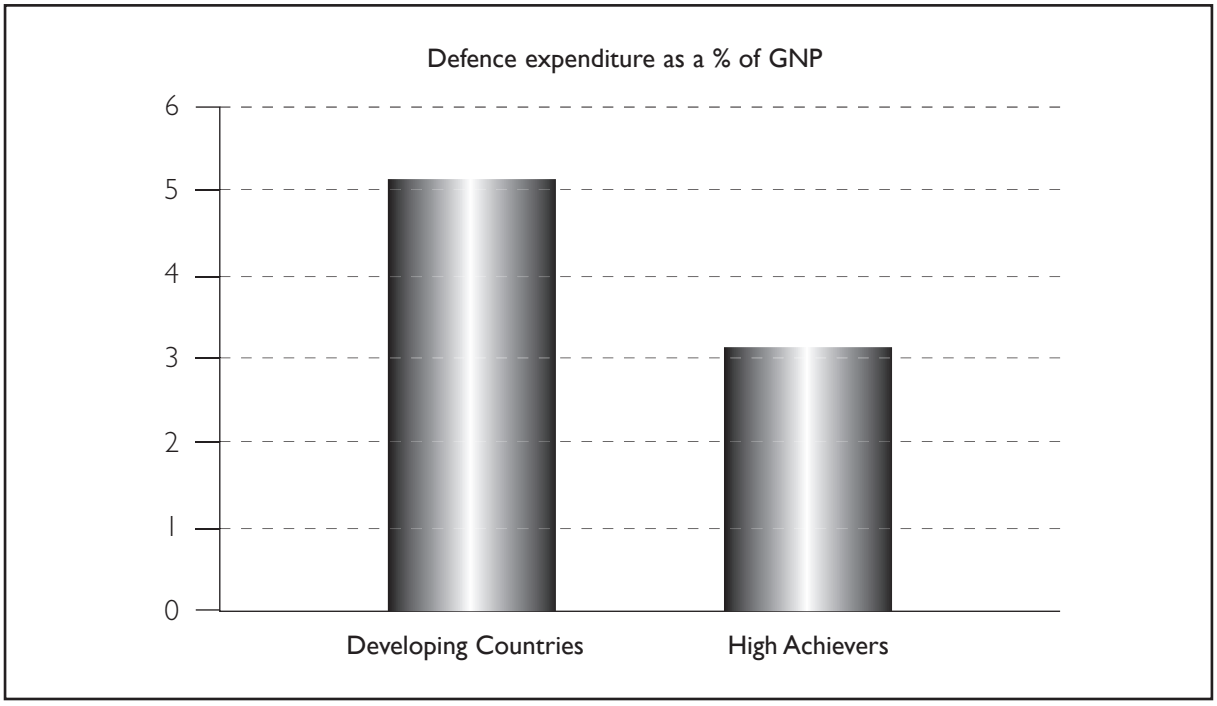
The contrast between the high-achievers and the rest of the developing world (or 'low-achievers') in respect to defence expenditures is instructive. On average the defence expenditure in the high-achievers was lower than for developing countries (the average for the latter was five per cent) for the period for which we have information (1978-93). Defence expenditure was not very significant in most of the high-achieving countries, except Korea (four to six per cent of GDP)

12 Republic of Korea did not have a public health system worth the name until 1976, and even then spending was relatively low. For a detailed analysis of the Korea case, see Mehrotra, et al, (1997).

13 Since exchange rates influence the dollar value of these per capita expenditures, one should be careful in interpreting these numbers, especially for purposes of cross-country comparisons. However, the order of magnitudes seem to suggest that the differences noted in the text are real, especially when taken together with the differences in macro-economic and fiscal priority.

and Zimbabwe (six to eight per cent of GDP). In the case of Korea the potentially negative effects of the relatively high defence expenditure appears to have been offset by high economic growth rates. In Zimbabwe this was not the case; but high defence expenditure was necessitated by its geographical location as a frontline state against the former apartheid regime in South Africa, which destabilised the sub-region through the 1980s.[14] Like Zimbabwe, Botswana too was burdened by the destabilisation of the sub-region by South Africa, and had a relatively high defence expenditure-to-GDP ratio (two to four per cent), though this was somewhat eased by the state's rents from the mineral sector. In Sri Lanka, defence expenditure was very low until the mid-1980s, by which time significant social gains had already been made. From 1984 to 1986, it grew from 0.8 to 2.4 per cent of GDP because of the civil war conditions prevailing in the north and north-east of the country. However, in the remaining countries, defence was hardly any burden at all *(see Figure 3)*. Mauritius and Costa Rica do not have armies, while in Kerala there is almost no defence expenditure, given that defence is the responsibility of the central government in India's constitution.

Figure 3: Defence expenditure: selected high achievers versus developing countries, 1978-92



Source: Mehrotra, (1997a)

14 In Zimbabwe, the tension resulting from unproductive defence expenditure and the commitment to provide social services to the poorest through the 1980s finally resulted in a decline in the capacity to sustain social services in the context of structural adjustment.

3.4 Adjustment with a human face

Once made, the social investment was sustained by the high-achievers, in bad times as well as good.[15] The reaction of most developing countries, mainly in Africa and Latin America, to the economic crisis starting the early 1980s and the structural adjustment that resulted, was to cut health and education expenditures (Cornia *et al*, 1987). However, government expenditure as a proportion of GDP was maintained in all the high-achievers through the 1980s. In sub-Saharan Africa as a whole, health and education expenditure definitely declined in per capita terms and as a ratio of GDP in the vast majority of countries during adjustment between 1980 and 1993 (World Bank, 1994; Jayarajah *et al*, 1996), but it held steady in Botswana, Zimbabwe and Mauritius. In Latin America also, health and education expenditure's share in GDP and in per capita terms was lower during adjustment than it was before adjustment, but in the high-achievers it remained stable. It appears, therefore, that the higher-than-average (relative to other countries in their region) macro-economic priority given to health and education expenditures by most of the high-achievers was sustained throughout the crisis years of the 1980s.

It is not just that most high-achievers protected social investment during times of economic crisis. When crisis forced a macro-economic stabilisation and adjustment, the adjustment process was a relatively unorthodox one. This is particularly true of Korea, Malaysia, Mauritius and Costa Rica in the 1980s. In Korea, for example, inflationary pressures built up in the late 1970s as nominal wages rose faster than productivity. The state launched a phase of stabilisation: it restrained its own budgetary expansion through 'zero-based budgeting', wage earners were urged to accept smaller wage increases, farmers were to accept fewer subsidies, businesses were to refrain from price increases, and households were to spend less and save more. One reason why the government was able to make both capital and labour share the costs of adjustment was that income distribution was relatively equal in the country.[16]

Similarly, Costa Rica was a pioneer among Latin American countries in the sense that it was the first to show concern for the social cost of adjustment. Between 1980 and 1982, output declined, wages fell 40 per cent, and unemployment doubled. However, in 1982 a new government began to implement an unconventional stabilisation process, maintaining public employment (through an employment subsidy), indexing wages, initiating a business rescue plan to protect jobs – all part of a social compensation plan. The stabilisation reduced the fiscal deficit, not only by reducing spending (as in most other countries) but also by increasing revenues (Garnier *et al,* 1997). This enabled the government to provide financial support for its social institutions. Thus, it was able to implement far-reaching adjustment measures without provoking the popular backlashes seen in other countries, such as Argentina, Brazil, the Dominican Republic and

15 UNICEF has often called this the principle of 'First Call for Children'.

16 It has been argued that 'the more equal the distribution of income economy-wide, the higher the quality of government intervention and, hence, the faster the rate of growth of manufacturing output and productivity' (Amsden, 1992)

Venezuela. This was because the cost had been evenly distributed among the country's main social groups.

On the other hand, in Zimbabwe, where the adjustment process in the 1990s has been much more orthodox, in keeping with the 'Washington Consensus', the social costs have seen a reversal in the 1990s of some of the social achievements of the 1980s (Loewenson and Chisvo, 1997).[17]

What is the continuing significance of 'adjustment with a human face' in the twenty-first century? The language of Poverty Reduction Strategy Papers (PRSPs) has now been adopted by the international financial institutions; what were earlier called Policy Framework Papers are now termed PRSPs with some changes in emphasis. The macro-economic policy content of the two documents has not changed much. The erstwhile Extended Structural Adjustment Facility of the International Monetary Fund is now called the Poverty Reduction and Growth Facility. However, the Nordic evaluation of the PRSP process and outcome (Nordics, 2003) has noted clearly that while there is plenty of emphasis in PRSP documents on social services and poverty reduction, a number of major problems still remain, which have also been noted by others and by the Internal Evaluation Office of the International Monetary Fund (2003).

.First, as in the formulation process of past adjustment programmes in the 1980s and 1990s, there is very little real stakeholder participation of civil society groups. In addition, ownership of the programmes by the low-income country governments remains questionable. Second, the Country Policy and Institutional Assessment by the World Bank of government policies – which has to be favourable if governments are to receive loans or debt relief under the Heavily Indebted Poor Countries scheme – still have roughly similar criteria, which guided Washington Consensus policies in the 1990s. There is very little scope for alternative policies to be discussed in the specific context of the country.

Under the circumstances, there are legitimate questions about the consistency of these macro-economic policies with the prospects for achieving the Millennium Development Goals. The orthodox policies have failed to deliver growth over the last two decades for the majority of African and Latin American countries. One of the important differences between the period in which the high-achievers made most of their advances and the twenty-first century is that, until 1980, most developing countries experienced much more rapid economic growth than developing countries experienced over the last decades of the twentieth century. While rapid economic growth is not a pre-condition for human development, there is little doubt that in the absence of sustained income growth, the quality of social services cannot increase (as will be argued later).

17 Throughout this paper, when Zimbabwe is referred to as a high-achiever, the reference is in fact mainly to the period up to 1990, and is not attempting to assess the current situation, or even the situation through a large part of the 1990s.

3.5 Allocative efficiency and equity in public spending

It is both equitable and efficient in the health and education sectors to allocate public resources to the lower or primary levels of service. Prevention is cheaper than cure – hence it is cost-effective to allocate sufficient resources within the health sector to primary levels of care in order to prevent potential cases reaching hospitals. Such cases are dealt with more cheaply – for both the patient and the provider – at the primary health centre. The human cost is also lower, as care can be delivered easily due to the physical proximity of the primary health centre. It is equitable because a larger proportion of the population is likely to use a primary health centre, than a hospital – assuming the primary health centre is effective – since it is more likely to be physically accessible than most hospitals. Similarly, the social return to primary education is known to be higher than that for secondary/higher education (Psacharopoulos, 1985); besides, in most developing countries, rarely do the poor manage to graduate beyond primary school. Hence, it would be both allocatively efficient and equitable to meet the resource needs of primary education from the government budget on a priority basis, followed by lower secondary education.

A significant common feature about the expenditure pattern on education in the high-achieving countries was the efficiency and equity of allocation by level of education, compared to other countries in their regions. Equity may be a prerequisite to ensuring essential inputs for schools. A comparison between the high-achievers (where primary enrolment is universal) and other countries (where education for all has not yet been achieved), shows some interesting contrasts (Mehrotra, 1998).

First, there is a difference in the share of education expenditure allocated to higher education. With the exception of two of the Latin American countries, the high-achievers have tended to spend less than other countries in the region. This is particularly true for the earlier year for which we have data (1980), and was still the case in 1990. Second, there is a sharp difference in primary education expenditure as a proportion of per capita income, with the high achievers normally spending more than the regional average.

Third, per pupil expenditures are also relatively equitable in the high-achievers. Per pupil expenditure in higher education as a multiple of primary per pupil expenditure is lower in all the high-achievers than in other countries in the region (except in Costa Rica and Malaysia, where it is comparable, not higher) *(ibid).*

While expenditures by level of education are readily available, it is much more difficult to find information on health expenditure by level (primary, secondary and tertiary), or type of service (preventive and curative).[18] There are, however, a few countries where information is available on the allocation of health expenditure to primary versus non-primary activities.[19] It appears that Malaysia allocated one-fifth (in 1986 to 1990) and Barbados one-quarter (in 1990 to 1991) of its health expenditure to primary healthcare activities, while Costa Rica's allocation may have been about ten per cent (Leong and Tan, 1997; Bishop *et al*, 1997; and Garnier *et al*, 1997). What is clear is that primary health services (which are the point of delivery for preventive and basic curative services) are low-cost activities – and ones that do not absorb a very large part of public expenditure. It is the clinical activities, largely provided at the secondary or tertiary level, which are relatively more expensive (Joseph, 1985; World Bank, 1993b).

Qualitative evidence from the selected countries indicates that emphasis was placed on primary healthcare in the organisation of the health system. These countries also reduced the urban bias in health services that had previously existed. All the countries succeeded in providing access to health services – in both physical and cost terms – in both rural and urban areas. Access to health services was nearly 100 per cent in urban areas for all the selected countries by the late 1980s, and in the range of 80 and 100 per cent in rural areas – not the case for other countries in their region. A universally available and affordable system, financed from government revenues (with minimal out-of-pocket costs for users), functional at the lowest level, made effective by allocating resources at the lower end of the health system pyramid – these were the keys to an equitably-structured health system. This is in strong contrast to the pattern of intra-sectoral spending in most developing countries, where a significant proportion of the total health budget is spent on one or two centrally-located referral or teaching hospitals, while starving the primary healthcare system – despite the fact that the latter services the majority of the population.

3.6 Educational achievement preceded high health status

As regards the sequencing of social investment, the investment in basic education by the state preceded, or was simultaneous with, the breakthrough in infant mortality reduction (or public health expansion). It did not post-date the breakthrough period. The synergies between interventions in health and education are critical to the success of each, and increase the return to each investment – and the sequence is important.

18 The primary level is the first level of care, usually a health clinic; the secondary level would usually consist of a district hospital, as a first-level referral centre; while the tertiary level may consist of a teaching or specialist hospital.

19 This gap in information on public spending on basic social services is about to be filled in a forthcoming book, based on country studies

In a comparison of decadal rates of reduction of infant mortality rates we define the 'breakthrough' period as that decade during which the largest percentage decline in infant mortality rates took place. We found that high education indicators preceded the health breakthrough in our selected countries. (See Table 2). These gave the selected countries a tremendous advantage over the others, since high education levels are closely linked to positive health improvements. When the investments in health infrastructure came, high educational levels ensured a strong demand and effective use of health services.

Table 2: Sequence of investment in high-achieving countries: health breakthrough followed or simultaneous with education breakthrough

	Education Breakthrough Date	Health Breakthrough Date	Infant mortality rate % reduction
Republic of Korea	1960-70	1970-80 especially 1975-80	68 58
Malaysia	1947-60	1960-70 1975-85	40 50
Kerala	1956-60	1975-85	40
Sri Lanka	1947-60	1940-50	40
Botswana	1970-80	1980-90	37
Mauritius	Before 1950 (m) 1950-60 (f)	1945/9 – 50/4	40
Zimbabwe	1980-85	1980-90	30
Barbados	Before 1938 1970-80	1950-60 1970-80	50 50
Costa Rica	Before 1960	1970-80 1940-50	68 30
Cuba	1958-60	1970-80 1975-85	40 50

Source: Mehrotra (1997a)

The most interesting example of this synergy between educational health interventions comes from Korea. Before 1976 Korea had no publicly supported health system worth the name, and no form of broad-based medical assistance or medical insurance scheme. Healthcare was predominantly in the hands of private professionals, especially pharmacists. But its literacy

rate was already 90 per cent in 1970. When the investment in public health came after 1976, the infant mortality rate, which was still 53 in 1970 and 41 in 1975 dropped to 17 within a matter of five years (1980). Similarly in Sri Lanka, literacy levels were already 60 per cent before independence in 1948, higher than they are in (much larger and more populous) India and Pakistan today. Not surprisingly, when health services expanded immediately after independence, Sri Lanka experienced a very rapid increase in life expectancy in the first decade of independence.

The point about this sequence of social investment is that the synergy between the interventions is triggered. The health interventions have more impact because they build upon a base of relatively high educational status in the population. The demand for the health services is greater, as is their utilization. For instance, Caldwell (1986) notes in an analysis of data from two Nigerian villages, the equivalent gain in the expectation of life at birth was 20 per cent when the sole intervention was easy access to adequate health facilities for illiterate mothers, 33 per cent when it was education (as measured by mother's schooling) without health facilities, but 87 per cent when it was both, ie neither merely additive, nor multiplicative, but greater than either.

3.7 The role of women's education and women's agency

Underlying all the above characteristics – the quality, timing and sequence of investments in these countries – lies women's 'agency' role (Sen, 1995) ie the freedom women have to work outside the home, the freedom to earn an independent income, the freedom to have ownership rights, and the freedom to receive education.

Health outcomes for children are not only the result of adequate food consumption and the availability of health services, but proper child-caring practices. In this respect the position of women in the household and in society, and the freedoms they enjoy, acquire major significance. Relative to other countries in their region, the selected countries were characterised by much greater access to education by women in the early stages of our period of analysis. In the selected countries, 1960 female enrolment ratios at primary level were above the regional average (except in Malaysia). In 1970, female adult literacy rates were also higher than the regional average for all countries. By 1970, primary enrolment ratios were similar for males and females in all the selected countries, and substantial parity existed between males and females in secondary school enrolment. In other words, any disparity in educational levels in terms of primary/secondary enrolment of men and women was completely eliminated by 1970 – in striking contrast to the

large disparities that continue to exist to date in the vast majority of countries in Asia and Africa (Mehrotra, 1997a).

While education is an important determinant of women's position in society, there are other factors at play as well. Culturally, where there are no taboos attached to girls taking up roles outside the house, the task of setting up an effective health service becomes easier. In Sri Lanka and Kerala, where rural women have become educated, and where parents permit them to engage in work outside the home, it is easier to hire them as nurses or train them as midwives. Because they work in their own areas and in their own language, they are accepted more easily by the community in house-to-house visits (Caldwell, 1986). In many parts of northern India (especially the Hindi-belt), the shortage of local recruits has meant the perennial under-supply of female health workers.

In schools the presence of female teachers has a positive impact on female enrolment. The proportion of female teachers in school is very high in the high-achieving countries. On the other hand, in most South Asian, Middle Eastern, and sub-Saharan societies, there is a considerable male-female differential even in primary school enrolment, which in fact tends to worsen at the secondary level. Not surprisingly, many of these education systems are characterised by a low proportion of female teachers in schools (Mehrotra, 1998).[20]

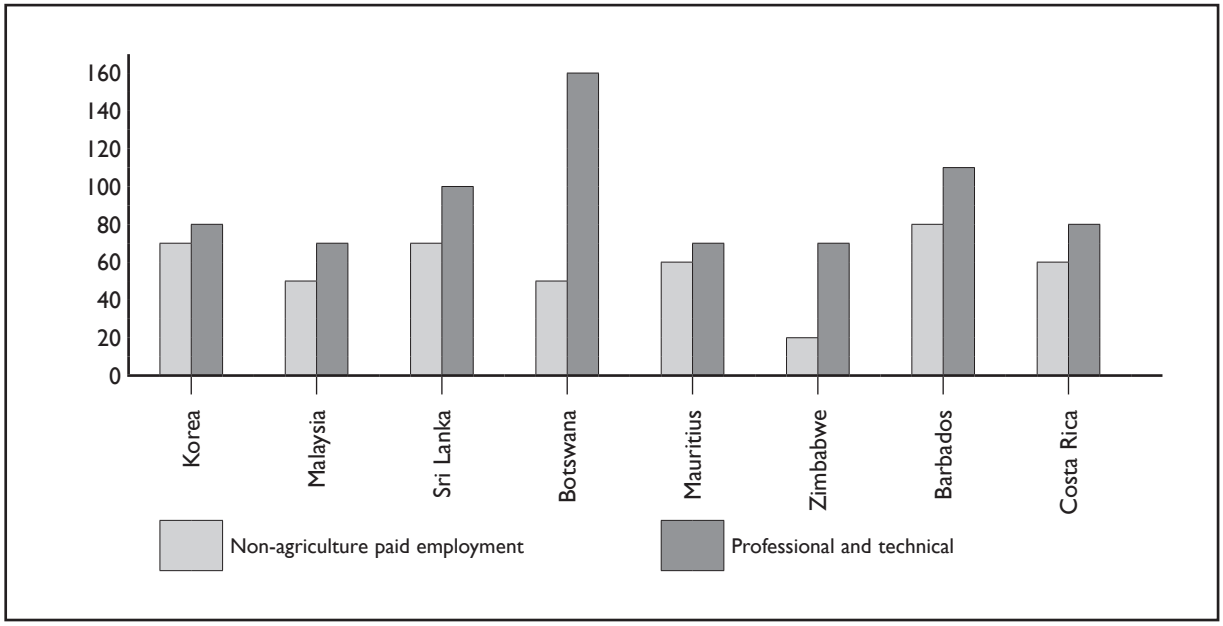
There is an overall difference in the sectoral distribution of women's employment in the high-achievers. In the selected countries, women, as a percentage of men in the workforce, are well represented in non-agricultural sectors of employment.[21] Non-agricultural employment is a better indicator than agricultural employment of the propensities to work outside the home and of an independent source of income.[22] Because of the high educational levels achieved by women in the selected countries, women are nearly as well represented as men in the professional categories of employment. This is not to suggest that parity has been achieved with men even in these societies, but that considerable advances have been made. (See Figure 4).

20 Dreze and Gazdar (1998) find a similar contrast between the educationally backward state of Uttar Pradesh in India and the relatively advanced states of South India, and especially Kerala.

21 If both agricultural as well as non-agricultural employment are included, the regional average in East Asia and Africa and even Latin America for female economic activity rate tends to be higher than in our selected countries, since agricultural work has traditionally been part of female economic activity. Hence, we particularly examined data on the non-agricultural employment of women.

22 Agricultural sector employment will not give women an independent income unless undertaken as wage labour, which is more likely to be undertaken within landless families by the male.

Figure 4: Women's 'agency': employment outside the household, spending as share of national budget, selected countries.



Source: Mehrotra (1997a)

In many of these societies the modern state has helped to strengthen the position of the woman in society. Nowhere is this more obvious than in Cuba. Many sections in Cuba's constitution explicitly refer to gender equality, and its penal code treats the infringement of the right to equal treatment as a criminal offence. In Zimbabwe changes in legislation have conferred majority status on women and now ensure inheritance and maintenance rights. Women no longer need their husband's consent to buy immovable property, and law allows equitable distribution of family property between spouses upon divorce. In many of these respects Zimbabwe is quite unusual in sub-Saharan Africa.

4. Systemic operational efficiency – the essence of good practice in health and education sectors

As we have seen above, in terms of allocative efficiency the fact that resources in the health system are spread relatively equitably throughout the pyramid of the health structure minimises overall costs for a very simple reason – that prevention is cheaper than cure. Primary level services are largely of a preventive nature, and when they function well, they are actually used by the majority of the population, especially those who cannot afford private providers. A large number of hospital cases in developing countries could have been either prevented or treated at much lower cost to the health system (and to the individual) had a primary healthcare system been functional – one that also provided basic curative care.

Similarly, despite the social rate of return to primary education to the society being higher than the return to higher education, governments in many developing countries have invested in higher education at the expense of primary schooling. In terms of allocative efficiency the pattern of state investment should have been the other way round, leaving the investment in higher education to be made by families. As we have seen above, all the selected high-achievers ensured allocative efficiency through a pattern of state spending in the education sector – by placing emphasis on the lowest level of the education pyramid.

Even more important than the allocative efficiency is the technical efficiency in the use of resources invested at the primary level – ie obtaining the best results (outputs) from the use of given resources (or inputs), both financial and human.

The evidence from these countries in the primary education sub-sector suggests that unit costs per pupil should be kept low if the system is to expand in coverage without precipitous loss of quality. This is because education is, in most developing countries, one of the single largest categories in the budget, and in most countries the primary system accounts for half of that expenditure. In other words, unless costs are kept low it rapidly becomes almost impossible for the public exchequer to bear the burden of the rising recurrent costs as the system expands, particularly if quality is to be maintained.

Several methods were employed to keep costs low in the high-achieving countries in primary education. Zimbabwe offers useful lessons on how to expand the number of teachers – a dire need in most African and South Asian countries where there is a serious shortages of teachers. A four-year teacher-training course was introduced, with only the first and last terms spent in college. The rest of the time was spent teaching in schools (Chung, 1993). The cost of training a teacher under this programme was less than half the cost of conventional training, and schools got the teachers as enrolment expanded. Another mechanism used in Korea, Malaysia and

Zimbabwe to reduce costs was to use existing facilities more fully by having double-shifts in schools.

Other means were also adopted to keep technical efficiency high. High repetition rates are a common feature of most primary schools in developing countries. High repetition often leads to drop-out by the repeaters. Both cause wastage of resources, and repetition places a limit on the number of school places available for new cohorts of children. Reducing this kind of wastage improves what is called 'internal' efficiency within the education sector.[23] One of the means adopted to reduce wastage and maintain internal efficiency was automatic promotion, practised in Korea, Malaysia, Kerala, Barbados, and Zimbabwe. Automatic promotion increases the number of years low-achieving students spend in school, and thus may increase learning. Given that it is known that spending at least four years in school is essential to retain literacy and numeracy skills, this system ensures a minimum level of learning. Second, automatic promotion clears the backlog of repeaters in grades one and two (grades where much of the repetitions is concentrated), creating space for new students. There could be problems, however, with such a system. If automatic promotion is implemented with no attempt to eliminate factors associated with school failure, problems of learning in the early grades may be passed on. There is a strong case for automatic promotion if accompanied by a minimum package of inputs, especially teacher training and materials.

Korea managed to keep costs low by maintaining a very high pupil-teacher ratio (early 1950s: 68 pupils per teacher; 1980: 48). High pupil-teacher ratios (normally high in most developing countries) combined with low teacher motivation and inadequate instructional materials cannot contribute to learning. However, in the selected countries, adequate levels of financing for primary education ensured that teachers were not poorly paid, and funding for materials was available (Mehrotra, 1998). While maintaining low unit costs, minimum standards of quality were maintained in the high-achieving countries. While early on the ratio was relatively high, a situation forced on the country by the expansion of coverage, the pupil-teacher ratio has declined in all the selected countries. The decline in the pupil-teacher ratio would not by itself be an indicator of improving quality, unless repetition rates and drop-out rates were simultaneously low – which they are.

On the demand side, the reduction of costs to parents of sending children to school seems to have been a primary reason for the rapid expansion of primary enrolment in the selected countries. In all countries (except Korea) primary schooling has been entirely free of tuition fees. In many cases, even the indirect costs have been progressively reduced. By contrast, in many developing countries, for poor parents out-of-pocket costs and user charges (and parent-teacher

23 'External' efficiency of the education sector refers to the absorption rates of the graduates in the labour market.

association contributions) remain a barrier to enrolment and an incentive to drop out (Mehrotra and Delamonica, 1998).

Apart from private cost, another family-related factor that should be taken into account is the language of instruction. In the early years the mother tongue was used as the medium of instruction at the primary level in the high-achieving countries. Contrast this to the situation prevailing in most francophone and lusophone (Portuguese-speaking) African countries, where the colonial language is still the medium of instruction even in the earliest years of school.

Expanding girls' enrolment and keeping them in school is the key to universal enrolment in South Asia and sub-Saharan Africa. Reducing the direct financial costs of schooling also reduces the incentive to send the child to work and increases the incentive to enrol and retain the child in school (assuming that quality of schooling is not so bad as to lead to a parental perception that it is not worth investing in education at all). In the selected countries, the expansion of physical facilities and proximity to schools laid the basis for the participation of girls. Moreover, an important underlying factor was the high proportion of female teachers in schools in the selected countries. Female teachers give parents of girl children a sense of security as well as providing a role model for girls in the community. In countries that are farthest from achieving Education for All these good practices – low private costs, mother-tongue instruction, female teachers – adopted by the high-achievers have tended to be overlooked.

What about good practices in the health sector? The high-achievers emphasised health-system building and a comprehensive (not selective) approach to primary healthcare. They achieved major reductions in mortality of mothers and children by focusing their primary healthcare activities on mother and child health – thus applying the principles of the Alma Ata Declaration on Health (1978) long before the principles were written down.[24] Almost all children were born under medical attention, supported by good health referral systems. This was followed by household visits by the first-level health worker. High levels of immunisation of children – provided mainly by primary healthcare centres – ensured that communicable diseases, which dominate the disease burden in any developing country, did not lead to high levels of morbidity or mortality for mother and child. Immunisation coverage, which was high in these countries, is usually an indicator of a relatively effective formal health system that can reach a large proportion of the population. In the majority of the selected countries, immunisation coverage had reached

24 At a major international conference was held in 1978 in Alma Ata, the then capital of Kazakhstan. An important principle, already in practice in many countries, was internationally recognised in a declaration of the organisation of the health system in developing countries based on primary health services. The principle responded to the nature of the disease burden in developing countries.

high levels long before the UNICEF-World Health Organisation campaign for universal immunisation was launched in 1985.[25]

Primary healthcare is supposed to be delivered by first-level health workers acting as a team. Zimbabwe specifically trained a large number of community health workers. Sri Lanka relied heavily on the primary health midwife. In many societies, it is advantageous if these health workers come from the community in which they live, so that they have local support – as was the case in Kerala and Sri Lanka.

The first-level health worker should be able to turn for help to more highly trained staff. A serious problem facing most developing countries is that physicians and other health professionals trained at public expense have not been willing to work in rural hospitals or health centres. Malaysia ensured that all doctors trained at public expense were required to serve the public health system for at least three years. This allowed the government to post doctors to the rural areas. Sri Lanka would not permit the registration of doctors with the General Medical Council without requiring doctors to work for the government health service. This involved being posted to rural areas.

Among the determinants of nutritional status, it is noticeable that most of the selected countries have a calorie supply at 120 per cent of requirements or above, which is a rough rule of thumb to offset for inequality of distribution among households. It is also higher than the calorie availability in other developing countries in the region. Second, as we have seen above, most provide geographical access to health services for a substantial part of their population, including immunisation coverage. Immunisation against measles reduces mortality from poor nutrition; and tetanus immunisation also reduces child mortality. Third, maternal and child health services usually included surveillance of young child growth (weight and growth cards). Fourth, most high-achieving countries have safe water for most of their population – rarely the case in other countries in their region. They are also ahead on the provision of sanitary means of excreta disposal, except in rural areas of Sri Lanka, Kerala, and Zimbabwe. Diarrhoea, largely caused by infection from water and the environment, is a major cause of malnutrition. The typical growth curve dips below that usually found in industrialised countries at four to six months of age when the baby begins to crawl on the ground and to take foods complementary to breast milk (which makes access to safe water crucial).

In addition to the above factors, actions to improve nutritional status in low-income countries (or those that have remained low-income countries because of lower per capita income growth) was found to be an effective mechanism of reducing protein-energy malnutrition. In three of

25 Thus, in 1982, the immunisation rate was (as a percentage of one-year olds): Korea 61, Malaysia 60, Sri Lanka 56, Botswana 63, Mauritius 94, Barbados 62, Costa Rica 81 and Cuba 99. Zimbabwe became independent in 1980 and had 75 per cent immunisation coverage by 1986.

them (Cuba, Sri Lanka, and Kerala) a system of food subsidies has been maintained from the 1960s to date. Fair price food shops (as part of a public distribution system providing essential commodities at below market prices) have existed in other states of India as well since the 1960s, but the point here is that in Kerala they are found in the rural areas, while they are effectively non-existent in the rest of rural India.[26] However, provision of the nutritional floor was one among a number of factors accounting for the low level of malnutrition in these countries, the others being better disease control through health services and women's control over resources.

In the majority of the selected countries, the health transition has been accompanied by a demographic transition. In fact, the country cases strongly suggest that it was non-family planning interventions – mortality decline and rising education, with rising marriage age and increased economic participation by women – that resulted in behaviour change in relation to fertility and ultimate decline of fertility. (Only in Korea is there evidence of a strong family-planning programme.) In other words, the demand for family planning services increased with the behavioural change in regard to fertility, which was in turn determined by factors that had little to do with family planning programmes. However, that does not mean that the supply of the means and instruments of family planning was unimportant – only that without an effective demand for contraceptive means, any conscious government-led family planning programme is unlikely to be effective.[27]

The inter-play between supply and demand for family planning is demonstrated by the fact that although all of the high-achievers have managed to reduce infant mortality rates below 20 per 1000 live births per year (except Botswana and Zimbabwe), those that have not raised contraceptive prevalence rates over 50 per cent (Malaysia, Botswana, Zimbabwe) still have population growth rates that are hardly declining. Hastening the demographic transition will require more than ensuring a health transition in some of these countries. It will require attitudinal change which will happen with falling child mortality plus effective family planning. However, in most of the selected countries the demand for family planning services followed the health/education breakthroughs. In fact, this pattern is consistent with the phenomenon in all industrialised countries, where fertility rates were very low before modern contraception was even around.

26 See Dreze and Grazdar (1998) for the contrast between the state of Uttar Pradesh, with a very high level of child under-nutrition, and the state of Kerala, in this respect. While 97 per cent of Kerala's villages had a fair price shop (part of the system of public distribution of essential commodities) in 1992-93, only 38 per cent of Uttar Pradesh villages did.

27 The contrast between the states of Uttar Pradesh and Kerala in India brings home the point. While the percentage of villages with medical facilities in 1981 in Uttar Pradesh was ten, in Kerala it was 96, with a similar contrast in 1991 between the number of births taking place in medical institutions. In other words, in Kerala, health centres provided family services as part of overall healthcare – and the total fertility rate was 3.9 in 1981 and less than two in the mid-90s. On the other hand, the few health services in rural Uttar Pradesh concentrated on family planning campaigns, especially female sterilisation often using force. The total fertility rate was 5.9 in 1981 and has stagnated since (5.1 in 1991) (Dreze and Gazdar, 1998).

4.1 Reaching the 'hard-to-reach'

The high-achievers offer no particular lessons for the 'hard-to-reach' and inaccessible groups without access to basic services. Nevertheless, there is plenty of other evidence available on good practices in respect of reaching minority ethnic groups and indigenous people, who often tend to live in remote areas. For reasons of space, this section will concentrate on reaching minority ethnic groups and indigenous people, while acknowledging that disabled people, displaced people and refugees and many other groups may be particularly hard to reach.

Low educational attainment continues to be a major source of exclusion for minority ethnic groups and indigenous people. In such cases offering bilingual education not only recognises their cultural traditions but it can also enhance learning and reduce educational disparities –widening people's choices. Children learn best when they are taught in their native language, particularly in the earliest years. Experience in many countries shows that bilingual education, which combines instruction in the native language with teaching in the dominant national language, can open educational and other opportunities (Dutcher, 1982).

In Latin America bilingualism is an established strategy for reducing the educational exclusion of indigenous children, who have the worst education indicators. Studies in Bolivia, Brazil, Guatemala, Mexico, Paraguay and Peru show that providing instruction to minority groups in their own language and using teachers from the same group is highly effective. Bilingual education leads to much less repetition, lower drop-out rates and higher educational attainment among indigenous children. In Guatemala the Q'eqchi' communities, which had fewer bilingual education opportunities than three other indigenous groups surveyed by Cummings and Tamayo (1994), had much higher drop-out and repetition rates.

Studies in Africa find the same results, with bilingual schools more effective than traditional schools. Studies of bilingual education in Mali, Niger, Nigeria and Zambia find that it ensures continuity among families, communities and schools, strengthening interactions among them. It stimulates the production of school and cultural materials in the second language, broadening the body of knowledge and facilitating learners' integration into social and cultural life. And it encourages a blending of cultures, since it enhances the standing of both languages and the cultures they convey. Monolingual schools, whether in a Western or an African language, perform much less well (Ndoye, 2003). Nor is cost a real issue. An examination of the costs and benefits of bilingual education for indigenous people in Guatemala estimated that there would be a $5 million cost savings thanks to reduced repetitions, savings equal to the cost of providing primary education to about 100,000 students a year (Patrinos and Velez, 1996).

It is true that the unit costs of producing local language materials are often higher than those of producing majority language materials because of the smaller quantities. But sharing by countries with the same local language can help hold unit costs down. Costs include those for modernising and standardising the orthography of the local language and for developing materials, training teachers in their use and distributing them. These financial costs have to be weighed against the social and political costs of inequality and unfairness. And since local language materials are produced in small quantities, they have little effect on the average unit cost of producing materials in all languages. In Senegal the production of materials in Wolof and other local languages does not push up the average unit cost of production of materials in all languages since the number of French books produced is much higher than the number of Wolof or Pulaar language books.

Bilingual education is a long-term investment, but nowhere do the costs appear prohibitive. In Guatemala bilingual education accounted for 0.13 per cent of the primary education recurrent budget, increasing the unit cost of primary education by nine per cent annually (over the traditional Spanish-only instruction system) *(ibid)*. In India producing materials in local languages adds five to ten per cent to total recurrent cost. But as noted earlier, the gains can be massive, because of fewer drop-outs and repetitions.

Most countries in sub-Saharan Africa have local language education in schools in the first three grades, but after that almost all countries use French, English or Portuguese. These countries may find introducing local language education particularly difficult because of the many languages spoken. But most languages are related, and there are only 15 core language groups for the 45 sub-Saharan countries (Prah, 2000). Developing local language education would require greater investment and regional co-operation to standardise and develop these languages. Standardisation would require translating texts into these languages and introducing these texts to education at higher grades.[28]

Bilingual schooling can run up against unfavourable perceptions, problems of transition from the first language to the second, and poor follow-up, evaluation and support systems. But most of these problems are linked to poor planning and a failure to make adjustments in curricula, teaching, training and promotion of the use of the language in official and public spheres (Ndoye, 2003). Once these conditions are met, bilingual strategies improve learning, contribute to a multicultural identity and have a transforming effect on society.

28 However, language diversity in Africa is a complex matter, closely related to issues of ethnic, tribal or community identity. Communities may desire (and they have a right to) maintain the integrity of their own languages, as an integral part of their culture. Such ethical considerations, combined with the fact that languages within the same language group are not always spoken in geographically neighbouring (or politically co-operating) areas, could make standardising and developing local languages for the purpose of mother-tongue education prohibitively problematic. The extent of the cross-regional co-operation and investment needed might exceed the capacities of African ministries of education.

Since knowledge of Western languages is often a means of upward mobility, the goal is not to remove Western languages, which would narrow choices and access to international knowledge. The goal is to give local languages equal or superior status. This reduces the heavy burden of repetitions and drop-outs and thus builds human skills.

Apart from the issue of bilingual education, in many countries public spending in basic social services systematically discriminates against minorities and indigenous people. The low provision of services can be a result of lower financial allocations or of distance and isolation. Indigenous people often receive fewer health care inputs and have worse health outcomes than the average population. The Brazilian government spent $7 per capita on indigenous people's health care, compared with $33 on average for the country (IRC, 2004). Indigenous people may also be underserved because health infrastructure and medical personnel are concentrated in urban areas. In Mexico there are 79 hospital beds and 96 doctors per 100,000 people on a national level, but the number of hospital beds falls to eight and doctors to 14 per 100,000 in areas where indigenous people constitute more than two-fifths of the population *(ibid)*.

In Bolivia and Peru surveys show that indigenous people are more likely to have been sick in the previous month than are non-indigenous people, but are much less likely to consult a physician. Poorer uptake of health services by indigenous people may sometimes reflect their view that the services are culturally inappropriate because they fail to consider the spiritual dimensions of good health or fail to incorporate, their traditional medicine, based on herbs and other plants *(ibid)*. These issues need to be addressed if the health of indigenous people is to improve, and this can be done without additional financial resources.

5. In what context do good practices function?

Methodologically, the approach in this section is quite different from that in Sections 2 and 3. In those sections we looked at the concentration of various characteristics among the high-achievers, and compared them with the concentration of the same characteristics among the low-achievers. In this section we attempt a much more difficult exercise. Here we search for the concentration of underlying reasons for success – 'causes' if you will – among the high-achievers.[29]

The role of ideology and politics cannot be ignored as driving forces behind public action in the selected countries. Thus, in Cuba – as in all other developing centrally-planned economies (eg Vietnam is another good example) – communist ideology was the driving force behind state action in not only reducing poverty, but also providing equitable access to health and education services to all. In Kerala, the process began during colonial times in the independent royal state of Travancore-Cochin, partly as a response by the local king to missionary activity. After independence, however, which is when most of the social development occurred, the process was driven by the competitive electoral politics between the Communist Party and the populist Congress Party (Krishnan, 1997). In Sri Lanka, public action stemmed from the combined influence of socialist ideology, competitive electoral democracy and Buddhism (characterised by the tenets of equality of all human beings and compassion for all living beings) (Alailama and Sanderatne, 1997).

In Costa Rica it was essentially a social-democratic consensus in a democracy that has lasted almost 150 years, with elections every four years, in strong contrast to the rest of Latin America. Similarly, in the island states of Mauritius and Barbados, it was competitive electoral politics that drove the state's interest in health and education services. Both island states have a tradition of electoral democracy based on the parliamentary system.

Likewise, Botswana's political history since independence has been rather exceptional by African standards (Duncan *et al*, 1997). As in other African countries, independence was preceded by a multiparty election and Western-style constitution, but it is unusual in that these were retained after independence. The political process in Botswana has been for the most part democratic, with regular free elections and a range of political parties both within and outside parliament.[30] In Zimbabwe, social development came more as a natural consequence of the liberation struggle; and the country has maintained a democratic framework within a one-party dominant state.

29 An alternative method could be followed – at least in theory. We could, for instance, have looked at the incidence by each characteristic (rather than the concentration of a characteristic among the high-achievers). In other words, we would have looked at the percentage of all countries with certain characteristics that are high-achievers compared to the percentage of high-achievers among all countries. However, there are several methodological problems with such an approach. The search for characteristics across countries is, essentially, a qualitative matter, and estimating percentages (or incidence) in quantitative terms may raise questions about differences of the degree to which a characteristic is present in a given country – questions that are impossible to answer.

30 Botswana politics is indeed dominated by the Botswana Democratic Party, which has won every election since 1964. The domination of this party seems to reflect the popular will, in that it has consistently won an absolute majority of the vote.

During the liberation struggle, new forms of social organisation emerged that encouraged popular participation under the auspices of the liberation movements. After independence, popular participation was mobilised and channelled by party and central-government programmes and structures.[31] While both Botswana has and Zimbabwe had a tradition of regular democratic elections, both have remained one-party dominant states.

Cuba is a one-party state, while Malaysia and Korea (at least during the relevant historical period) have been one-party dominant states. But even in Cuba and Malaysia there has been scope for a public 'voice' in the governance process. Social mobilisation by the cadres of the Communist Party, especially by women's groups, was a key element of social progress in Cuba (Mehrotra, 1997b).

In Malaysia, social development was the outcome of the state's attempt to correct the social and economic disadvantage of the Malay population based on ethnicity. The dominant political party in Malaysia has indeed governed through a coalition of parties, the other parties being essentially representative of the two other major ethnic groups (Chinese and Indian).[32] In Korea, early social development was driven by a military state (supported by the USA) facing a communist 'threat' from the north; once set in motion the process was sustained by an authoritarian state committed to economic growth. In other words, 'voice' in governance was a key element of success in all states except Korea.

It is important to emphasise here the distinction we have tried to draw above between 'democracy' and 'voice'. Democracy has, unfortunately, come to mean many things to many people. In fact, despite the considerable increase in the number of states that became democratic in both Latin America and sub-Saharan Africa during the 1980s and early 1990s, there is no systematic evidence that they are more progressive than the non-democratic states that preceded them.

That suggests that democracy – in the conventional sense of regular multi-party, free and fair elections – is neither a necessary condition, nor a sufficient condition, but it helps. What is critical, however, is that there has to be a mechanism for the expression of the voice of the people.[33]

31 Over the 1980s and 1990s, this increasingly shifted to more bureaucratic forms of participation in response to central government policy.

32 A New Economic Policy was introduced after the race riots of 1969. The Policy was based on a strategy of gradually redistributing wealth from growth rather than outright expropriation of the ethnic minorities. The indigenous Malay population, which lived mainly in rural areas, was targeted to own at least 30 per cent of the corporate wealth (companies with shareholders funds above Malaysian Ringit 2.5 million were to allocate 30 per cent equity to Malays) and a similar proportion of modern-sector employment by 1990. To speed up Bumiputra participation in the commercial sector, the government set up state enterprises that provided employment opportunities at every level. Small and medium non-Bumiputra enterprises were basically unaffected by this law and left to grow (Leong and Tan, 1997). The 20-year time frame, gradual approach, and presence of escape routes for non-Bumiputra businesses helped to limit ethnic animosity towards the policy.

33 On the role of 'voice' in improving the health sector, see Mehrotra and Jarret (2002).

The form of popular representation is one question. Another is whether a particular structure of the organisation of production is a necessary condition of ensuring longevity and knowledge for the majority of the population. It is noticeable that only one high-achiever was a centrally-planned economy – Cuba. Of course, there are other developing countries with centrally-planned economies that have achieved health and education levels far superior to that achieved by developing market economies at the same level of per capita income (eg Vietnam, Mongolia, and the Central Asian states during the Soviet period). In fact, among the small number of developing countries in the post-war, post-colonial period that have been centrally planned, it is remarkable that such a high proportion of them managed to achieve social indicators well above those for other countries in the same income bracket.[34]

In fact, almost all countries with centrally-planned economies achieved social indicators far better than might be expected by their level of per capita income.[35] In that sense, the percentage of all countries with central planning that were high-achievers, compared to the overall percentage of high-achievers among all countries, is much higher. However, with the end of central planning as we knew it – whether mandatory or indicative – and the shift in the dominant policy paradigm, the notion of now introducing centralised planning is a non-starter.

In fact, selected high-achievers were market economies. Given that the vast majority of developing market economies in their region were unable to match their improvements in social indicators, the lessons from the high-achievers are particularly relevant for these market economies. Moreover, while central planning may be unfashionable, we have demonstrated earlier that the role of the state in these market economies in ensuring universal access to basic services was paramount.

Another critical issue is whether economic growth is a necessary condition of social development. We have already discussed above (see Section 3.1) how all the selected countries made substantial improvements in their health and education indicators early in their development process, when incomes were still low. They all started as low-income countries. While some have graduated to become middle-income countries, many of them (Cuba, Zimbabwe, Kerala, Sri Lanka) have remained low-income countries, having experienced limited economic growth.

In these slow-growing economies, while quantitative indicators of health and education status have not been affected adversely, the quality of services does seem to have been affected. Thus relative economic stagnation – in Sri Lanka, Kerala, Zimbabwe, and (in the 1990s) Cuba

34 If countries like Lao PDR and Cambodia did not achieve significant improvements in social indicators, for instance, a large part of the explanation must lie with the long-term effects of the war in Indo-China lasting over two decades – and the continuing internal conflict even after 1975.

35 For an analysis of social achievement in three centrally-planned economies (Vietnam, China, Cuba) see Ghai (1997). The paper is based on case studies for UN Research Institute for Social Development on these three countries, plus Sri Lanka, Kerala, Costa Rica and Chile.

– has created problems for the social sectors. In Sri Lanka, food subsidies and free health and education services were made possible by heavy taxation of export plantation crops – tea, rubber and coconut. When international commodity prices dipped in the late 1950s and the 1960s, and the balance of payments deteriorated, it became increasingly difficult to sustain those expenditures. Nevertheless, because of the political difficulty of cutting social expenditures and the food subsidy, the government continued to tax heavily the plantation sector, and jeopardised the plantation industry (Alailama and Sanderatne, 1997). Quite clearly, the economy needs to generate a surplus for social investment (as the plantation sector did), but excessive surplus extraction may lead to lower economic growth, ultimately causing a curtailment of social expenditures.

Kerala offers similar lessons – though for rather different reasons. Kerala ranks ninth among the 25 states of India in terms of per capita income and has had one of the lowest levels of industrialisation. At the same time, trade unionism is common not only among industrial and public sector employees as in other parts of India, but, unlike the rest of India, among agricultural workers. It has even spread to the informal labour sector – all aided by the high levels of literacy. One outcome of unionisation is that Kerala has the third highest wage rate for agricultural workers in the country (after the bread-basket states of Punjab and Haryana), and Kerala is the only state where real wages have nearly doubled between 1960 and 1990. The result has been that the little industry that existed has tended to shift to neighbouring states, and agricultural output has been declining because it is cheaper for the state to import its food from the rest of India (Krishnan, 1997). The overall result is that the economy has been practically stagnant since 1975. The scope for increasing public expenditure in order to improve quality of services has been limited by slow growth; however this has not affected social indicators.

Similarly, Zimbabwe's per capita income growth was slightly negative (0.2 per cent) over the 1980s. Hence the concern in the 1990s has shifted from the social policy, distribution and equity concerns that dominated Zimbabwe in the 1980s to aggregate growth and balance-of-payments concerns. The adoption of a structural-adjustment programme has also limited social expenditures, and there was a rise in infant and maternal mortality as real health expenditures shrank and fees were introduced for health services (Loewenson and Chisvo, 1997).

Clearly then, sustained improvements in the quality of services will require increased per capita expenditures, especially if the population is still growing. Increased per capita social expenditures – whether private or public – may be difficult to sustain in the absence of per capita income growth. In the absence of sustained increase in per capita social expenditures, the quality and quantity of services is likely to be impacted adversely. However, economic growth does not

automatically get translated into improvements in health and education status. The example of oil-rich countries like Cameroon, Venezuela, Gabon and Nigeria demonstrated that windfall gains (from oil-price increases in the 1970s) can be wasted, while Brazil's example shows that the fruits of rapid economic growth (eg in the late 1960s and 1970s) need not be shared equally.

Turning to another possible explanation of the success of social policies in the high-achievers, an argument could be made that one reason for their success was their relatively small size – in terms of territory or population – and hence their manageability in terms of the scale and magnitude of problems facing policy-makers. While this argument may possibly hold for two of the cases that are island states (Barbados and Mauritius), it is hardly valid for the remaining countries. Large populations are not typical for developing countries – there are no more than 15 developing countries with populations larger than 50 million – and the vast majority of these smaller states have social indicators that are worse than those in the high-achievers. The population size of the selected countries exhibits considerable range and is comparable to the population of most other countries in their region. Malaysia has 20 million people, while Korea has 45 million people – only Indonesia in the East Asia region has a population that is significantly larger than Korea. In South Asia, the relevant comparison is not with countries per se, but with states within countries, which usually have similar populations. Kerala (30 million) and Sri Lanka (18 million) have populations comparable to those in a province of India or Pakistan.

Zimbabwe's population (ten million) is larger and Botswana's (1.4 million) smaller than that of the average African country. A small minority of African countries have a population exceeding ten million (Nigeria, Ethiopia and South Africa among them). Among the Latin American cases, Costa Rica has a population similar to those found in Central America; Barbados is not very different from other Caribbean island states, and Cuba's population is that of a median population for countries in Latin America. Clearly then, to the question: is a small population size a necessary condition for rapid improvement in health and education in a developing country, the answer must be no.

A final point: could it be argued that ethnic homogeneity is a necessary condition for the state to potentially follow polices which promote human development? It has been argued, for instance, that one reason why Botswana was able to pursue successfully human development policies was that, more than any other country in Africa, it is dominated by one ethnic group – the Batswana. It could also be argued that ethnic divisions are not an issue in Korea or Cuba. However, most countries among the high-achievers had racially or linguistically mixed populations – Malaysia, Sri Lanka, Kerala (with its caste conflicts), Zimbabwe, Mauritius or

Costa Rica. Clearly, conflict between linguistic or racial groups is a complicating factor, but these countries have demonstrated that there are policy instruments at hand to allow skilful handling of those conflicts.

One can see from the preceding analysis that it is difficult to establish any common characteristics as reasons for success: neither the organisational form of the government, nor organisational form of the economy, nor geographic size, nor social composition. However, in the earlier sections we did establish some commonality or good practices in economic and social policy.

6. Summary and reflections on replicability of good practices

We derived six principles of good social policy, and a number of good practices, based on the experience of the high-achieving developing countries. However, before we summarise them, we need to note the over-arching principle that provided the foundation for the development strategy: these countries did not give priority to achieving economic growth or macro-economic stability first, while postponing social development.[36] The high-achievers demonstrate that it is possible for countries to relieve the non-income dimensions of poverty, and achieve social indicators comparable to those of industrialised countries, regardless of the level of income. The poor should not have to wait for the benefits of growth. We do not downplay economic growth but, for the 'Washington Consensus', per capita income growth is a predominant part of the strategy, since proponents of the Consensus believe 'there is no general tendency for distribution to worsen with growth' and that 'distribution remains stable over long periods of time' (Deininger and Squire, 1996). We have seen, however, that there are plenty of historical cases of episodes of economic growth that have not translated into improvements in health and education status.[37] We have argued elsewhere (Taylor *et al*, 1997) that broad-based poverty reducing growth has rarely occurred on a sustained basis in the absence of the universal availability of basic social services.

The six principles are:

1. **Synergies exist between interventions in social services.** Senior policy-makers should not only be aware of this; co-ordinated policy-making and institutional-building by government in each of the 'sectors' will ensure that the synergies are triggered.
2. **The pre-eminent role of public action is key, regardless of whether it took place in a centrally-planned economy or a market economy.** The experience of the industrialised countries from a comparable period of development offers the same insight.
3. **While the level of social spending is important for health and education outcomes, the equity of the intra-sectoral spending pattern matters even more.**[38]

   The social investment was also protected during times of economic crisis as well as structural adjustment.

36 This is one respect in which our conclusions differ from those of the Washington consensus. Leading researchers in the World Bank suggest that 'economic growth typically promote[s] human development, and a strong positive relationship is evident from the line of best fit (the 'regression')'. It is acknowledged that there are deviations (the 'residuals') around this line; these are cases with unusually low, or unusually high, performance in human development at a given level of income or a given rate of economic growth' (Ravallion, 1997). They argue that the human development approach – espoused in the current paper – devotes 'more attention to residuals' and the 'regression line is ignored'.

37 Cornia (2000) argues that the Deininger and Squire formulation is highly questionable in any case. In an analysis of 77 countries, he demonstrates that income inequality has worsened in 45 countries.

38 The level of social spending is often determined by such unproductive expenditures as defence (which we found is generally low in the high-achievers) and external debt servicing (of particular significance today in the Highly Indebted Poor Countries).

4. **Efficiency in the use of human and financial resources needs to be practised if social spending is not to become a burden on the state exchequer.**

   A number of specific good practices in both health and education sectors ensured both allocative and technical efficiency in resource use.

5. **There seemed to be a sequence of social investment: educational achievement preceded, or took place at the same as, the introduction of health interventions.**

   The separate sectoral interventions had a synergistic impact on health, educational and nutrition status of the population ie the sum of their impact was greater than the effects of the individual interventions.

6. **Women were agents of change, and not mere beneficiaries of a welfare state.**

Underlying each of these principles were specific good practices of social policy. We found that the worst manifestations of poverty – preventable child deaths, the powerlessness of illiteracy and debilitation of ill-health – were relieved in the selected countries for almost the entire population. However, with the exception of Cuba, Mauritius, Korea and Malaysia, income poverty remained more stubborn, although it certainly declined in most of the ten selected countries. Where income poverty has been resistant, the pace of economic growth has been relatively slow. In fact, a principle emerging from the historical experience of the high-achievers is that there is little prospect of the synergy between economic growth, income poverty reduction and health/education advance being realised without integrating macro-economic and social policy. If economic growth is the dominant objective, with macro-economic policy determined first (with the Ministry of Finance in the lead), and with social policy trailing behind, this synergy cannot take place.

Some additional principles emerged from more recent experiences, which draw upon the historical experience of countries and regions in the 1990s.

First, given the poor quality of publicly provided basic services in a large number of countries, the experience with decentralised delivery of services suggests strongly that there is a successful model of decentralisation that has been demonstrated to work. This model has three elements: a functional central state; local authorities to which functions, functionaries and finance in respect of basic services has been decentralised; and voice for the people.

Second, just as the risks of user charges in basic services were not realised well into the 1980s, there is a similar 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.

While the advantages of higher level services being provided by private providers should not be overlooked, the risks of private provision of water and of hospital services are much greater in the absence of cross-subsidies in the water sector and pooling of risk in the case of hospital services. Without a simultaneous improvement in regulatory capacity of the state, private provision may be neither efficient nor equitable.

Third, the greatest risk to the achievement of Millennium Development Goals comes from the fact that the policy requirements and conditionalities in regard to institutional development – explicit in PRSPs and World Bank/International Monetary Fund lending instruments – have compromised economic growth for most of the last two decades in most countries of Latin America and sub-Saharan Africa. As of now, there still seems little scope for alternative macro-economic policies.

In future, states will need to take notice of not only the six principles summarising the experience of the high-achievers, but also these three lessons of more recent history.

What is the potential for replication, and what kind of general insights can be learned about processes taking place? What does it take to transfer the specific good practices to other areas? We suggest that economic growth is a necessary condition of *sustained* improvement in health and education indicators and in the quality of social services, but it is neither a necessary nor a sufficient condition for the 'take-off' in social development.

The harder issue to resolve is what kind of political system (as opposed to political commitment) is most conducive to the replication of these good practices. While 'voice' in the decision-making process is a pre-requisite, the more difficult question is how that voice is articulated. Clearly, a democratic system alone is not sufficient, though we found that it was definitely helpful. [39]

The only general insight that we can safely draw is that the causes and driving forces behind social success were historical, and very specific to the country in question. The social forces that combined to produce the revolutionary changes within a matter of decades in these high-achievers can be understood in a national context, but can hardly be replicated. Social forces cannot be conjured up, nor can any amount of social engineering help to create them. Policies, however, can be replicated. Hence this paper has focused on those public policy principles and

39 That it is not sufficient becomes clear from a contrast in the social indicators between two states in India: West Bengal and Kerala. Both have had regular elections to the state legislature and both have a long tradition of multi-party politics. For over 20 years, West Bengal has had a government of the Left Front, of which the dominant member is the Communist Party of India (Marxist). While this government has done much to secure the tenancy rights of small-holder tenant farmers (which are extremely insecure in other non-Communist ruled states in India), the health and education indicators in the state are not much better than in the poorest states of northern India's Hindi belt (Sengupta and Gazdar, 1998). Kerala, on the other hand, is a high-achiever in terms of social indicators, as we have seen. Perhaps the fact that the Communist Party in West Bengal has hardly faced any serious opposition, and has been continuously in power for over 20 years may explain some of this difference. In contrast, in Kerala, the electoral competition between Left Front governments and the Congress has led to each party internalising the social agenda.

good practices that the state in developing countries would need to adopt to be child-friendly and address key elements of human development.

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