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Santosh Mehrotra, Jan Vandemoortele
and Enrique Delamonica

United Nations Children's Fund
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PUBLIC SPENDING AND THE SOCIAL DIMENSIONS OF POVERTY

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THE UNICEF INNOCENTI RESEARCH CENTRE

The UNICEF Innocenti Research Centre, is based in Florence and is the main research arm of UNICEF, the United Nations Children's Fund, helping to shape the organization's human rights agenda for children. Since its creation in 1988, the Centre has provided solid data on the changing needs of children in both developing and industrialized countries. Its strong focus on children's rights has helped UNICEF and its partners promote a new global ethic for children based on their fundamental human rights. One of the Centre's main aims is to encourage the effective implementation of the 1989 United Nations Convention on the Rights of the Child (CRC) in every country – rich or poor. The Centre gives particular priority to problems of equity, economic affordability and the financing of social programmes to benefit children.

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PREFACE
BASIC SERVICES FOR ALL?

There is a general consensus that basic social services are the building blocks for human development. Indeed, they are now accepted as fundamental human rights. But there is a widening gap between this consensus and the reality of public spending on basic services in the developing world – a gap documented in *Basic Services for All?*[1] The report highlights the shortfall of up to $80 billion per year between what is spent and what should be spent to ensure universal access to these essential services.

Governments often make proud claims about how much they spend on health and education services, when in fact not *all* such services benefit the poor, as the report demonstrates. By denying citizens access to the *basic* social services – primary health care, clean water and proper sanitation and basic education – governments are violating the human rights of their citizens.

The report begins by outlining the human cost: the lives lost, children out of school, the millions undernourished, and the billions without safe water and sanitation because they lack basic social services. It goes on to describe the current facts and figures about public spending on basic services, with around $206 billion to $216 billion (in 1995 prices) needed to provide universal services each year, and only $136 billion currently being spent. The shortfall is twice as high as the estimate of up to $40 billion at the time of the World Summit for Social Development in March 1995.

The report then lays out the moral, instrumental and legal arguments for state provision of basic social services. Looking at the historical perspective, the report describes the transformation that began in industrialized countries 150 years ago as they took their first steps towards state provision of health and education. It goes on to explain the synergies between the different basic services, and between human development, income-poverty reduction and economic growth. The industrializing nations of the 1800s tapped into these synergies, as have the 'high-achieving' developing countries that have improved their social indicators in the last half century. It outlines the successes of these high achievers – developing countries with far better social indicators than might be expected given their national wealth. After examining the role of donors in the provision of basic social services, the report concludes with a Ten Point Agenda for Action.

In 1994, with funding from the Governments of the Netherlands and Norway, UNDP and UNICEF launched detailed studies in more than 30 countries across Africa, Asia and Latin America to gain a detailed picture of investment in basic social services. These studies asked how much governments were spending on these services, who was really benefiting from this spending (the poor or the non-poor), and how efficiently the spending was being carried out.

1. This report is a summary of a forthcoming book "Basic Services for All? Public Spending and the Social Dimensions of Poverty" by Santosh Mehrotra, Jan Vandemoortele and Enrique Delamonica. For information, please contact Santosh Mehrotra at the UNICEF Innocenti Research Centre, Florence (smehrotra@unicef-icdc.it).

Basic Services for All? uses data gathered in these countries to show how much, or how little, governments are spending on basic social services. While building up a picture of public expenditure and establishing a dialogue with government officials and other experts in the process, the studies confirmed an alarming fact - most governments do not know how much they are spending on basic services. It argues that lack of data is a major barrier to the provision of basic services for children, and calls on governments to create more effective systems to gather, monitor and analyze such vital information.

The report urges developing country governments, donors and international financial institutions to provide greater and more targeted resources for basic social services. One option explored is the 20/20 initiative whereby developing countries would commit 20 per cent of their budgets to basic social services, while donor countries would match that commitment by allocating 20 per cent of their official development assistance to such services.

Basic Services for All? calls for a wider recognition of the fact that economic growth, if not properly handled, can increase the gap between rich and poor. Noting that income distribution has been worsening in a large number of developing countries, it urges policy-makers to recognize and exploit the synergies between basic social services, and between income-poverty reduction, social development and economic growth. And it explores ways in which governments can mobilize resources for basic services, using methods that they already have at their disposal. Instead of reducing public expenditure, policies could, for example, place more emphasis on revenue mobilization via taxation to cut budget deficits.

The report maintains, however, that the effective and efficient use of resources is every bit as important as the actual amount of money spent. And it stresses the need for more partnership between governments, donors and communities, recognizing that aid can be more effective if the recipients are in the driver's seat.

Basic Services for All? urges donors to eliminate the inconsistency between aid policies and their international policies on trade. It calls for measures to address the heavy burden of debt repayment which exceeds spending on basic social services in many developing countries, suggesting that no more than 20 per cent of the revenue of the most highly-indebted poor countries should be spent on debt servicing.

Addressing the international financial institutions, the report recommends that social policy should be seen as complementary to macro-economic policy. Where macro-economic stabilization policies are determined by international financial institutions or by national Ministries of Finance, leaving the social consequences of these policies to other agencies, the synergies between social policies and macro-economic policies cannot be triggered.

Meanwhile, says *Basic Services for All?,* the continuing neglect of basic social services in developing countries is part of a pattern of economic development that undervalues the social sector, democratic participation and the equitable distribution of resources.

1 INTRODUCTION: TOLERATING THE INTOLERABLE

In the early 1990s, world summits and global conferences set specific social development targets in the hope that these would lead to a new commitment to human development in economic and social policies. The targets outlined at the World Summit for Children in 1990, for example, pledged to halve maternal mortality and child malnutrition by the year 2000. The World Summit for Social Development in 1995 and the Development Assistance Committee (DAC) of the Organization for Economic Cooperation and Development in 1996 reaffirmed commitment to such achievable social goals. All of these conferences confirmed an international commitment to the universalization of basic social services.[2]

It is true to say that significant headway has been made since 1990. One million fewer children under the age of five die each year and polio is on the verge of eradication. But access to basic services is far from universal and the results of poor quality services are there for all to see. Most developing countries have not made acceptable progress on child mortality, maternal mortality and malnutrition, or on basic education, sanitation and the supply of safe water.

Easily preventable diseases account for the deaths of nearly nine million children in Sub-Saharan Africa and South Asia each year. In these two regions alone, almost 500,000 mothers lose their lives each year as a result of pregnancy and childbirth. While the under-five mortality rate stands at an average of seven deaths for every 1,000 live births in industrialized countries, it is roughly 25 times higher in sub-Saharan Africa.

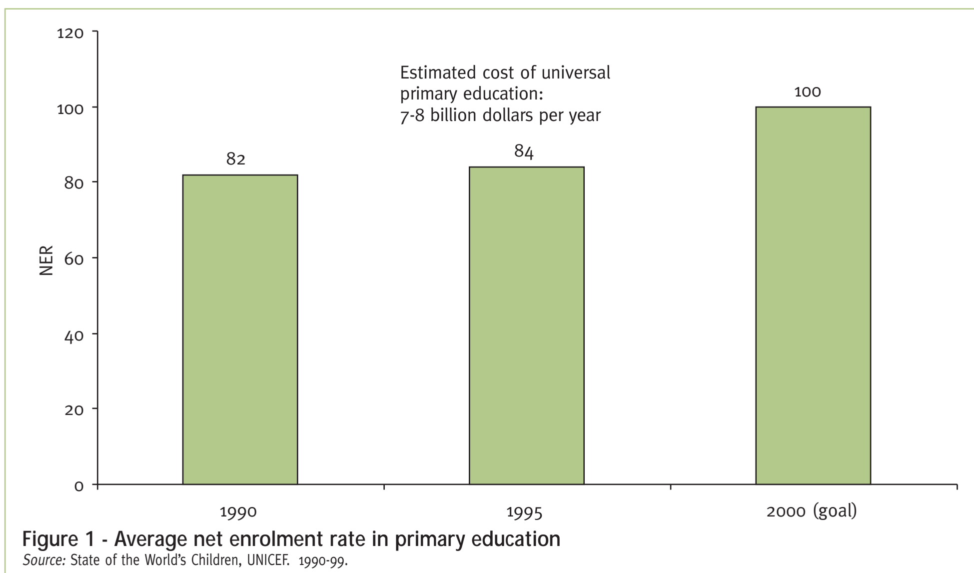

Figure 1 - Average net enrolment rate in primary education
Source: State of the World's Children, UNICEF. 1990-99.

2. If basic social services were universal, every individual would have access to preventive and basic curative health services, reproductive health and family planning services, HIV/AIDS education and prevention programmes, drinking water and sanitation, basic education, including pre-primary, primary and junior secondary education and adult literacy programmes.

Nearly one billion people in the world are illiterate and around 130 million children of school age, about 60 per cent of them girls, are not in school (Figure 1). One-third of all children in developing countries fail to complete four years of primary education.

One third of all children in developing countries are undernourished, rising to half of all the children in South Asia – some 80 million children across the region. Around 1.7 billion people lack safe water, and over half the world's people, 3.3 billion people, are without access to adequate sanitation.

The numbers are so immense that it is difficult to grasp the magnitude of the individual tragedies facing the poorest households each day. What is worse, there was minimal progress on these tragedies in the 1990s.

The goals set at the World Summit for Children in 1990 promised universal access to primary education by the year 2000. But the average net enrolment rate in developing countries in 1995 was estimated at 84 per cent. The average under-five mortality rate in developing countries was supposed to be halved, from 104 deaths to every 1,000 live births to 54 per 1,000 by the end of the century. In 1995, it was still as high as 97 (Figure 2). While the figures for the end of the century are not yet available, it is unlikely that they will show the dramatic progress required to reach the hoped-for goals.

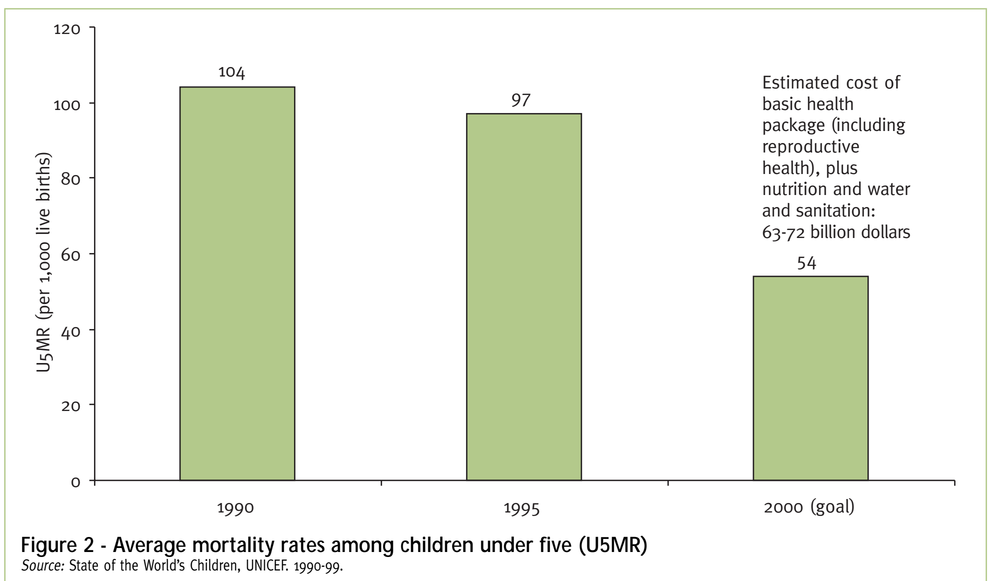

Figure 2 - Average mortality rates among children under five (U5MR)
Source: State of the World's Children, UNICEF. 1990-99.

The disparities between the health of the developing world's poor and non-poor are vast. Males aged 15 to 59 who are poor are more than twice as likely to die than males of the same age among the non-poor. And poor females are more than four times more likely to die. Studies from 35 developing countries have found that children from the poorest 40 per cent of households account for up to 80 per cent of those who fail to finish five years of formal schooling.

We cannot go on tolerating such an intolerable situation. The scale of the unmet needs of the poor and the marginalized in developing countries may be enormous, but the resources required to meet these needs can be mobilized. Moreover, value for money can be boosted by reducing wastage, by providing adequate and appropriate materials and by spending equitably. Under the terms of the Convention on the Rights

of the Child, the Convention on the Elimination of all forms of Discrimination Against Women, and a whole host of other international human rights treaties, governments have an absolute obligation to end this waste.

The level of financing of basic social services should be judged by the extent to which it helps ensure universal and equitable access to services of high quality. How much are governments and donors spending on basic social services? Who benefits from the spending: the rich or the poor? Men or women? Is the spending effective and efficient? These are the issues on which we focus in this report.

2 THE ARGUMENTS FOR STATE PROVISION

There are four main arguments for the state provision of universal basic social services: moral, instrumental, consensual and historical.

The moral argument:

The strong moral argument for universal access says that basic social services have intrinsic value because they generate such benefits as learning and good health, and that they should, therefore, be available to all. This argument sees basic social services as "merit goods" – goods that have an inherent worth and that should be supplied whatever the circumstances, even if there appears to be no express demand. The state cannot depend upon private suppliers to provide such services – it must step in to ensure their provision.

The instrumental argument:

The instrumental argument for basic social services is based on the fact that their provision supports the achievement of other human development goals. Education, for example, contributes to greater productivity, better health, more equitable income distribution, and less poverty.

The consensual argument:

There is a general consensus that access to basic social services should be universal. This consensus is implicit in the Convention on the Elimination of all Forms of Discrimination against Women (1979), and explicit in the Covenant on Economic, Social and Cultural Rights (1966), the Declaration on the Right to Development (1986) and

The Example of Immunization

Immunization is an excellent example of how the moral, instrumental and consensual arguments intertwine. First, immunization goes beyond the individual to benefit society as a whole by preventing the spread of disease – even to those who have not been immunized – and it is more cost-effective to prevent disease than to treat it. Immunization has an instrumental effect on other areas, such as education, by contributing to the improved health of children. And, of course, there is a general consensus that it is desirable. For all these reasons, immunization ought to be encouraged and made available even if there is no market demand, like any other "merit good". The children that need immunization are too small to demand it, so it must be provided to them as part of a state's social obligation – as a right, not an option.

the Convention on the Rights of the Child (1989). It was reiterated in the Plan of Action from the World Summit for Children (1990) and in the Copenhagen Declaration from the World Summit for Social Development (1995).

The historical argument

The historical argument for State provision of basic social services originates in the 1800s. Governments in the industrializing countries realized that industrial growth required national communities that were both economically and socially viable. Literate and healthy populations would be needed to fuel the changes taking place.

There were several factors behind the drive to mass literacy, for example. First, there was a realization that people who could read could more easily acquire other skills and play a more active role in the shift to industrialization.

Second, the social unrest that began with the French Revolution and continued through the 1840s created anxieties about order and control. While there were many who argued for repressive measures, education seemed one positive way to reassert the authority of the state and reinforce discipline.

Third, the experience of the American Civil War (1861-65) and the Franco-Prussian War (1870-71) suggested that education contributed to military efficiency, as the victors possessed well-established school systems, while the vanquished did not.

Fourth, with the expansion of suffrage, education was seen as one method of opening the doors to greater political discourse. Of course, this was precisely why some people were opposed to the whole notion of greater literacy – they did not want workers who were more receptive to radical and subversive theories.

Nevertheless, rising government expenditure pumped life into school systems and boosted literacy rates. School attendance was made compulsory and resistance was eased by the reduction or elimination of fees, with the costs covered by taxation.

Progress was rapid. At the beginning of the 1800s Prussia was the only industrializing country with an emerging school system. By mid-century there was some kind of formal, systematic schooling in most industrializing countries. By 1900 the vast majority had state-financed and regulated elementary school systems to provide nationwide, universal and compulsory education. It had become widely accepted that education was a fundamental responsibility of the state, that the state had both the right and the authority to use taxation to support schools and that every child should have access to a free, non-sectarian school system.

Transformations in health care followed similar lines as expanding economies required a healthy workforce. The growing emphasis on public health care meant the construction of hospitals and clinics, the appearance of government health bureaucracies, public water supply and sewerage systems, and the creation of a formidable system of controls on food production, health insurance schemes, and workplace, housing and school health ordinances.

Such measures had a major impact on the infant mortality rate in industrialized countries from the late 1800s, and the decline has been dramatic ever since (Figure 3). The sharp drop in the 20th 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 organize ante-natal clinics and neo-natal units.

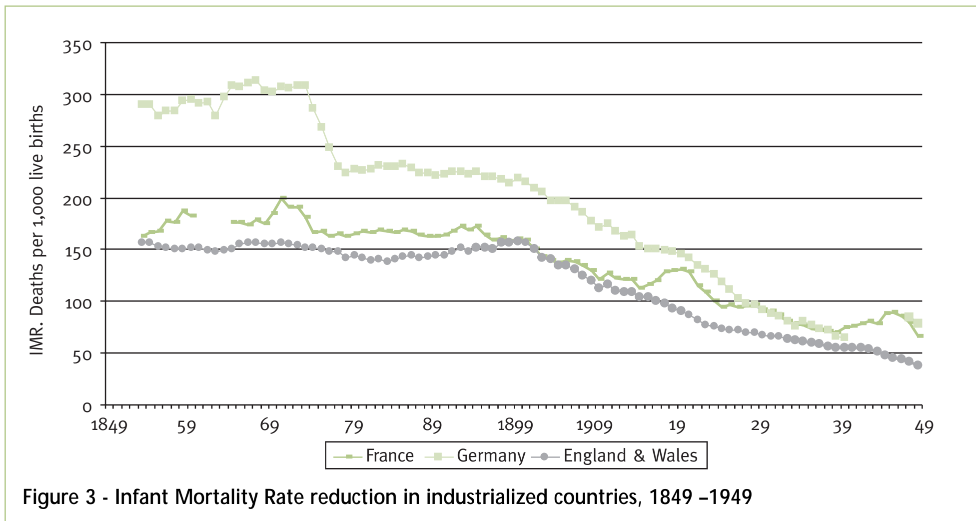

Figure 3 - Infant Mortality Rate reduction in industrialized countries, 1849 –1949

3 HUMAN DEVELOPMENT AND ECONOMIC GROWTH

Economic growth does not, of itself, guarantee human development. While some countries have achieved progress in social development in spite of low economic growth, other countries have seen increases in per capita income without any corresponding dent in the poverty or ill health of their children. Poverty can decline with growth but it is also true that growth can increase the gap between rich and poor. It is equally true that social development alone (specifically health and education development) may not be enough to reduce income poverty or promote economic growth.

It is evident, however, that progress in one area supports progress in the others. This interaction and overlap between different factors can be called "synergy". Governments must tap into two such "synergies" if economic growth is to go hand in hand with human development. They must exploit the spill-over effect between basic social services; and the links between income poverty reduction, social development and economic growth.

The two synergies

There is a synergy between social interventions in basic health care, reproductive health care, education, nutrition, and water and sanitation. Interventions in any one of these will have an impact on all the others. Basic education, for example, facilitates the rapid adoption of good hygiene. Safe water and sanitation improve the nutritional status and the learning abilities of children by reducing infectious disease, especially diarrhoea.

The synergy among social interventions is illustrated by the effects of greater access to education on the life-cycles of women. Educated women are likely to marry later, have fewer children, and to provide better physical care for their children than women without any education (Figure 4). As more women become educated there is a cumulative effect on more households with respect to fertility. As more households become smaller, the provision of care improves for more children. Taken together, the benefits of greater education among women adds up to a virtuous circle of social development.

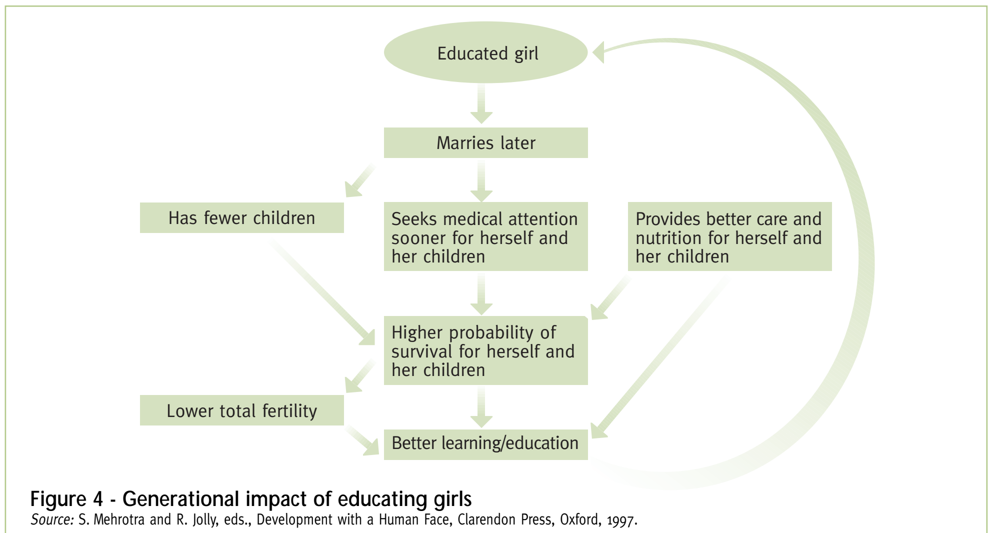

Figure 4 - Generational impact of educating girls
Source: S. Mehrotra and R. Jolly, eds., Development with a Human Face, Clarendon Press, Oxford, 1997.

Then there is the synergy between income poverty reduction, social development and economic growth. It is often said that economic growth promotes poverty reduction and social development, but it is rarely argued that this conditional relationship applies in reverse. In fact, the synergy is so marked that direct action to reduce income poverty and improve health and education may be every bit as fruitful as economic growth in terms of total outcomes. Without efforts to thin out disparities in the distribution of incomes and assets, economic growth cannot guarantee an overall improvement in the quality of life. It may not enrich all citizens. It may, indeed, impoverish many.

The significance of economic growth should not be belittled, however. Continuous improvement in health and education indicators and service quality may not be achievable without income expansion. Equally, economic growth should not become such a dominant goal of development strategy that social policies are left on the back burner. Sustained economic growth may be impossible without adequate education and health care and without improving the distribution of income. Even if it were possible, such economic growth would be detrimental to social cohesion.

Economic Growth and Equity: Nigeria

Experiences in Nigeria show that economic expansion may not have an equitable effect on income distribution. Average real per capita expenditure in Nigeria climbed by one-third between 1985 and 1992, and the share of the population below the poverty line fell from 43 per cent to 34 per cent. But not everyone benefited. Consumption by the wealthiest 10 per cent of the population rose by almost half, while the poverty of the poorest 20 per cent only intensified. The number of people in extreme poverty jumped by around four million.

The historical perspective

The advances in health care and education in industrialized countries that began in the 1800s reached most of their people in the course of two or three generations. Child mortality rates fell, life expectancy increased, education became accessible to all, fertil-

ity rates declined and families became smaller. This demographic transition was accompanied by rising incomes, more and better housing, expanding services, and technological innovations, particularly in agriculture and, therefore, in food supply.

By investing in health care and education early on in their push for industrialization, the Soviet Union and the countries of Eastern Europe were able to establish universal primary education, reduce child mortality and enhance life expectancy within a few decades. They even took a global lead in some areas, particularly in access to education for girls and women.

Some developing countries were also early investors in social services, such as China, Cuba and Vietnam. The results can still be seen today, with under-five mortality rates in Cuba similar to those in Portugal, a country where per capita income is ten times higher. Vietnam and Haiti have similar income levels, but while Vietnam's under-five mortality rate is 43 deaths for every 1,000 live births, it is more than three times higher in Haiti, at 132 per 1,000.

Governments in other developing countries have, at some point, focused their industrial strategies on intense drives for local production to reduce imports of expensive manufactured goods. Wherever this strategy was combined with investment in capital goods and broad-based human resource development, as in Japan, Korea and Taiwan, it yielded sustained economic growth, poverty reduction, improvements in health and education indicators and a spur to export manufacturing.

Many developing countries, however, used their meagre revenues in the early decades of development to build up the modern sector without devoting sufficient effort to overall improvements in human capability. Much of this industrialization involved capital-intensive, technologically advanced manufacturing and demand rose for trained scientists, engineers and managers. Resources were channelled to technical, vocational and higher education rather than primary education, and to hospitals near industrial centres rather than primary health care facilities. Medical schools churned out doctors and specialists, while the training of nurses and paramedical staff was neglected. Water and sewerage systems were laid down around manufacturing plants and in residential areas for skilled workers and managers, but not in the countryside.

The relative neglect of basic health care and education, as well as the urban-industrial bias, left many people in the developing world uneducated, unhealthy and poor. These economically weak economies were ill-prepared to face the external shocks (including oil price rises and the debt crisis) of the late 1970s and early 1980s.

International financial institutions began questioning the import-substitution strategy early in the 1980s and, as part of their structural adjustment loans, encouraged governments to liberalize, reduce the size of the state and generally adopt export and market-oriented policies. The 'lost decade' of the 1980s and early 1990s – especially in Sub-Saharan Africa and Latin America – is evidence that these policies did not have the expected results. By the 1990s, there was a growing realization that there was little or no prospect of the market delivering sustainable economic growth and social development without the integration of social concerns into macro-economic policy making. Sadly, this view has not yet been translated into macro-economic policy design in the international financial institutions, the public expenditure policies of developing countries or the overseas development assistance (ODA) policies of donor countries.

The 'high-achievers'

The interchange between basic social interventions, poverty reduction, social development and economic growth can be seen in the findings of UNICEF studies carried out in Barbados, Botswana, Costa Rica, Cuba, Kerala in India, the Democratic Republic of Korea, Malaysia, Mauritius, Sri Lanka, and Zimbabwe.[3]

These countries have achieved unusually good results in social development early in their development process relative to their level of income. They should be viewed as 'high-achievers', demonstrating that it is possible to address the non-income dimensions of poverty and improve social indicators regardless of the level of economic growth.

The studies reveal five principles of good practice in social policy:

1. Most importantly, the state plays an impressive role in the provision of basic social services.
2. A relatively high priority is assigned to equitable, efficient resource use in basic health care and education. Primary health care is emphasized in the organization of the health care system, and efforts are made to offset the urban bias. There is an equitable distribution of resources across educational levels, with primary education receiving over 50 per cent of public education expenditure.
3. More is spent on basic social services during good times, and this expenditure is protected during economic stagnation and recession, an acknowledgement that social sector investments must be sustained if they are to effect growth and equity. Macroeconomic policy in times of crisis did not follow neo-liberal principles. These were elements of the policies recommended by UNICEF in the late 1980s to give structural adjustment a 'human face'.
4. The synergies among social sector investment are considered to be as critical as the size of the investment. When investments in health care infrastructure are preceded by high levels of literacy there will be a growing demand for health services and more effective use of health resources by the population.
5. There are moves away from welfarist approaches to approaches that involve people – particularly women – as active agents of change. In high-achieving countries the education enrolment ratio among women is very high and has been on a par with that of men for a long time. The participation of women in the non-agricultural workforce is also high in these countries.

More generally, government policies would incorporate a social dimension by promoting health care and education, while aiming at economic growth which is broad-based and reduces poverty.

The Washington Consensus

Such policies differ in important respects from the so-called 'Washington Consensus', the set of policy proposals for economic stabilization and growth in developing countries first put forward by influential financial organizations in the early 1980s.

The Washington Consensus assumes that societies consist of people with a fair chance of participating in the labour market and finding sustainable livelihoods. It assumes that people are educated, enjoy good health, are already relatively well off and can, therefore, contribute to economic growth and benefit from it.

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

The development pattern of the last 30 or 40 years shows two problems that undermine such an approach: income inequalities have not improved and gender inequalities remain huge. While leading advocates of the Consensus recognize the need to invest in health care and education, they maintain that there is no general tendency for income distribution to deteriorate with growth, and that distribution in developing countries has improved as often as it has worsened during periods of economic growth. Yet World Bank data show that the number of poor in the developing world, expected to decline in the 1990s, actually grew. Slow growth in Africa is one reason, but worsening income distribution is a major factor in most developing and transitional countries.

Market-oriented policy changes during the 1980s and 1990s have played a crucial role in worsening income distribution. The experience of the industrialized countries during the 20th century shows that the size of both the government itself and the state's regulatory function tend to expand as economies become more complex. Even though this regulatory function has yet to evolve in many developing countries, the Washington Consensus maintains that government sizes must be reduced. If a state lacks the institutions and capacity required for the provision of basic social services, there is a strong argument for their expansion, rather than the dismantling of structures that are already overstretched.

Tapping the synergies

Governments today have a wealth of instruments available to tap the synergies that can generate economic growth, social development and poverty reduction. They can and should, for example, address the unequal distribution of assets, particularly land, which contributes to disparities in income distribution in a context of economic growth. The provision of health care and basic education is another path to more equitable and long-term income and asset distribution.

The gender issue is of particular importance. In many countries, most new employment in recent years has come from the informal sector, especially during economic downturns. The participation of women in the labour force has risen and now dominates labour force growth in many countries. Governments should, therefore, adopt gender-aware policies to support informal sector activities. This requires more access to education for women so that they are well equipped to participate in the labour market, the removal of the gender gap in wages, and better access to training, credit and extension services.

Measures to address such underlying issues as gender by tapping into the synergies between social services, and between economic growth and human development, are feasible and practicable. The desire to promote social development and reduce poverty must cease to be considered impractical or idealistic. Above all, it is a grave error to regard policies aiming solely at economic growth as the only pragmatic solutions.

4 THE FACTS AND FIGURES ON PUBLIC SPENDING

It seems reasonable to expect governments to know how much they are spending on basic services. This vital information is not, however, readily available from most existing budget data. In order to fill this data gap, and to examine the adequacy, equity and efficiency of public expenditures on basic services, UNDP and UNICEF began detailed studies in developing countries in 1994.

Table 1 presents data gathered during these studies on expenditure on basic social

services in 29 developing countries in Asia, Sub-Saharan Africa, Latin American and the Caribbean and the Middle-East. These expenditures are shown as a percentage of total government expenditure to demonstrate the fiscal priority given to basic social services (BSS). The figures vary among these countries and across time, but the expenditure on basic social services is, in general, between 12 and 14 per cent.

There is a clear link between human development indicators, such as infant mortality and primary school enrolment, and the fiscal priority given by governments to basic social services. Despite its fairly low income levels, Sri Lanka has very high levels of literacy, enjoys universal primary school enrolment and has achieved infant mortality rates comparable to those found in some industrialized countries. It has allocated about 13 per

Table 1: Basic social service spending as share of national budget

Country	Year	Total BSS	Basic Education	Basic Health	Water & Sanitation	Nutrition
South and East Asia						
Bangladesh	93-94	9.1	7.5	1.6		
Nepal	1997	13.6	8.3	3.1	2.3	
Philippines	1992	7.7	6.8	0.6	0.3	
Sri Lanka	1996	12.7	3.5	4.5	1.0	3.6
Thailand	1997	14.6	10.2	4.4		
Sub-Saharan Africa						
Benin	1997	9.5	7.0	2.2	0.3	
Burkina Faso	1997	19.5	10.6	8.3	0.6	
Cameroon	96-97	4.0	2.9	1.0	0.1	
Côte d'Ivoire	94-96	11.4	9.0	1.8	0.6	
Mali	1996	15.9	12.2	3.4	0.3	
Kenya	1995	12.6	10.6	1.5	0.4	
Namibia	96-97	19.1	11.5	5.7	1.7	0.2
Niger	1992	20.4	14.7	4.3	1.4	
South Africa	96-97	14.0	10.0	3.5	0.5	
Uganda	94-95	21.0	16.0	5.0		
Zambia	1997	6.7				
Middle East and North Africa						
Morocco	97-98	16.6	15.2	1.4		
Latin America and Caribbean						
Belize	1996	20.3	11.7	8.0	0.7	
Bolivia	1997	16.7	9.8	4.5	2.3	
Brazil	1995	8.9	6.0	1.9	0.6	0.4
Chile	1996	10.6	9.0	1.0	0.1	0.5
Colombia	1997	16.8	7.8	7.6	1.1	0.4
Costa Rica	1996	13.1	8.0	3.6	0.1	1.3
Dominican Republic	1997	8.7	5.9	2.7		
El Salvador	1996	13.0	8.9	4.1		
Honduras	1992	12.5	8.0	4.5		
Jamaica	1996	10.2	7.3	1.1	1.4	0.5
Nicaragua	1996	9.2	4.8	4.1	0.1	0.2
Peru†	1997	19.3	4.8	5.6	1.4	7.4

† budgeted figures

Source: Country Studies in Annex

cent of public spending to basic social services. Elsewhere in South Asia, however, countries such as Bangladesh have poorer human development indicators and have given less fiscal priority to basic services. Thailand, with relatively high social indicators, appears to have allocated a higher share of government spending than other Asian governments.

While some countries may have comparable levels of fiscal priority and marked differences in their human indicators, this phenomenon occurs only over a short period of time – one or two years at most. There is evidence that relative high-achievers, such as Sri Lanka and Thailand, have prioritized basic social services for a longer period of time.

In the 11 Sub-Saharan African countries studied, government spending on basic social services averages around 14 per cent, falling as low as 4 per cent in Cameroon and rising as high as 21 per cent in Uganda. Much of this gap is due to differences in the level of spending on basic education, with Cameroon spending only one third of its education budget on basic primary education. Uganda, in contrast, increased the share of the national budget spent on education from 11 per cent in 1990 to 21 per cent in 1994. The proportion for basic education rose to 60 per cent of overall education spending and enrolments rose sharply. Malawi is another Sub-Saharan African success story, increasing its education spending from 11 per cent to 18 per cent of the national budget between 1990 and 1994, while the share for primary education rose from 42 per cent to nearly 60 per cent of education spending. This, coupled with the government's decision to eliminate school fees and uniforms, led to the doubling of school enrolment over the same period.

In Latin America, the share of public spending allocated to basic services ranges from 9 to 20 per cent. Costa Rica, a high-achiever with lower infant mortality rates and higher literacy rates than its level of income would have suggested two decades ago, continues to give high priority to basic services – over 13 per cent of total public expenditure.

Where the money goes

While countries seem to spend a considerable share of their health and education budgets on the most basic services, these services still account for less than half of all spending on these sectors. More is spent on highly specialized hospital care than on basic health care, even though substantial numbers of people have no access to the most basic health clinic. The same applies to the continuing emphasis on secondary and university spending in countries where most children do not complete even five years of formal schooling (Figure 5).

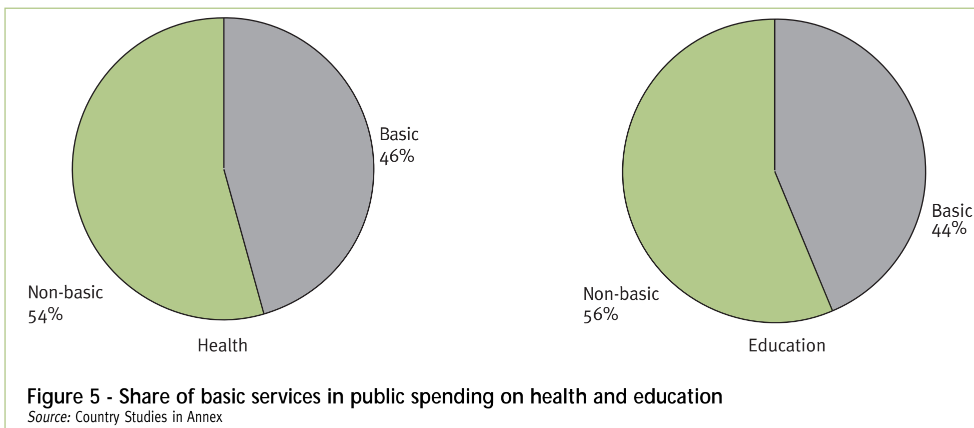

Figure 5 - Share of basic services in public spending on health and education
Source: Country Studies in Annex

Figure 6 shows a clear relationship between expenditures and the mortality rates of children under five in over 50 countries, after taking into account the level of GNP per capita, female literacy, health spending and the Least Developed Country status of over 50 countries. Most countries are in the low-expenditure/high-mortality or in the high-expenditure/low-mortality quadrants.

Such an analysis shows a clear relationship between higher public expenditure and lower child mortality, but this relationship may not be linear. Many other factors play their part, particularly levels of income and female literacy.

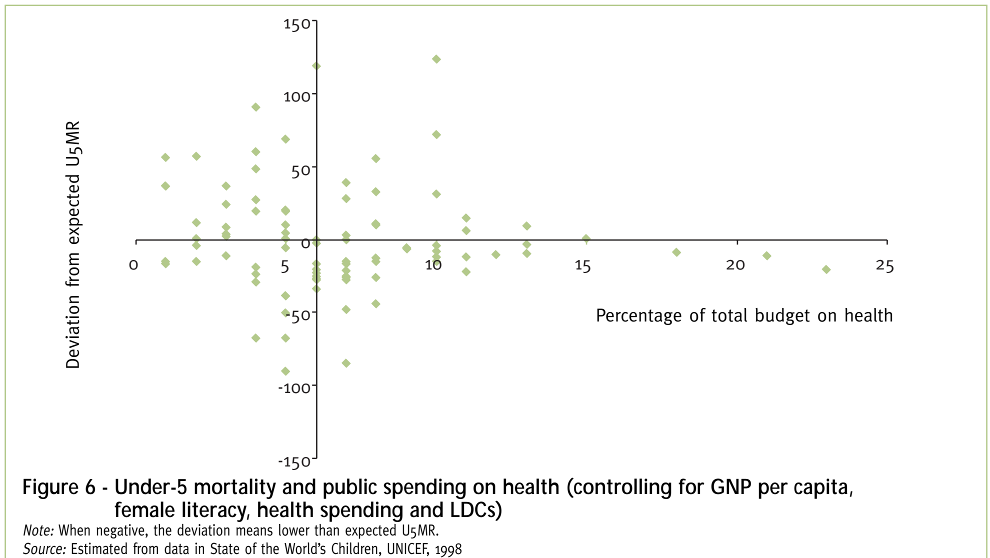

Figure 6 - Under-5 mortality and public spending on health (controlling for GNP per capita, female literacy, health spending and LDCs)

Note: When negative, the deviation means lower than expected U5MR.
Source: Estimated from data in State of the World's Children, UNICEF, 1998

Aggregate public health expenditure was used as the explanatory health variable in this analysis, rather than expenditure on basic health remain. The analysis indicates a degree of inefficient allocation in the health sector. Technical inefficiency also presents problems, suggesting that there is scope for better results with the same level of resources. Finally, the impact of basic social services as a package would also have an impact on the relationship between outcomes and expenditure on all social services. This only reinforces the need for strong and continuous public finance.

Disparities in public expenditure

Unless government expenditures on social services are equitably shared, the gaps between access to basic social services and social indicators will remain. The regional averages for unmet needs hide huge disparities between and within countries. These disparities affect ethnic groups, regions, and different households, as well as individual children, women and men, according to their level of income and wealth. Even the location of households is important, with rural areas often lacking the basic social services enjoyed by urban populations.

The evidence on disparities according to income is alarming. In Nepal, for example, almost 60 per cent of the poorest one fifth of the population never attend school, compared to 13 per cent of the people in the top quintile. In Brazil, all the children from families in the wealthiest 30 per cent of the population attend school, falling to 80 per cent of children in the poorest 10 per cent.

These disparities, however, give only a partial picture of inequity. Gender is another major issue. While many aspects of gender discrimination cannot be captured in figures, its impact can be seen in the figures on education. In Niger the male literacy rate of 21 per cent contrasts with a female literacy rate of only 7 per cent – one third of that for men. Similarly, in Nepal, the literacy rate of 41 per cent for men contrasts with a rate of only 14 per cent for women. This data can be further disaggregated by income level. The proportion of Nepalese women and girls aged 6 to 24 in the bottom quintile who have never attended schools is 85 per cent, against 54 per cent in the top quintile.

Ethnicity is another consideration, with the social indicators of many ethnic groups lagging behind those of the rest of the population. This has been clearly seen in South Africa, where life expectancy at birth in 1990 for whites was close to the industrialized country average, while it was ten years lower for Africans. Income differentials played some part in this, but there is no doubt that the inequitable distribution of education and health services played a major role too.

It is crucial to assess whether different groups in society receive an equitable share of public spending on social services. While most analysis concentrates on the incidence of the benefits of public spending by income groups, other information is at least as important, as can be seen from disaggregated outcome indicators. Analysis of the gender-based and geographic aspects of the distribution of benefits is valuable and both are linked to efficiency issues. Women play an important structural role in the 'first synergy' – enhancing the impact of spending in one sector by improvements in others, and the impact of basic services is likely to be greater in areas that have been traditionally under-served – rural areas in particular.

Distributing the benefits of public spending on education

Data on the use of education services by different groups from 19 countries shows inequities in the distribution of total public spending on education. In most countries, the poorest 20 per cent of the population enjoys less than 20 per cent of the benefits of public spending on education and in some countries the figures are even lower. In contrast, the wealthiest 20 per cent seem to capture considerably more than 20 per cent of the benefits of these expenditures.

Evidence suggests that the benefits of primary-school expenditure are more equally distributed than those of higher level education between the poorest and richest sections of the population. However, the high share of benefits from primary education spending that go to the bottom quintile does not take into account the fact that they tend to have more children. Consequently, they *should* receive a larger share of the benefits. They account for a greater share in the school population than in the total population.

This means that even a progressive distribution of benefits may mask inequities in the education system. Attempts to encourage private education in order to release funds for the education of poorer children may simply exacerbate inequality as the children of the better-off attend better schools.

The equity of spending, particularly on primary education, is strongly related to overall outcomes. Figure 7 shows the distribution of public spending on education at the primary level in the 19 countries studied. In each case, countries have been classified in terms of primary net enrolment, a measure of the success of their education poli-

cies. Where net enrolment at primary level is less than 70 per cent, it can be observed that the poorest 20 per cent of the population receive less than 20 per cent of the benefits of public spending on education. In contrast, countries with enrolment above 70 per cent devote a much larger share of public money to the bottom quintile. Families from the richest quintile can and do send their children to private schools, which is why their 'share' of public spending on education is less than 20 per cent. Nevertheless, the equity of primary spending is more apparent in countries where primary net enrolments are higher.

There are major educational inequalities between urban and rural locations. In

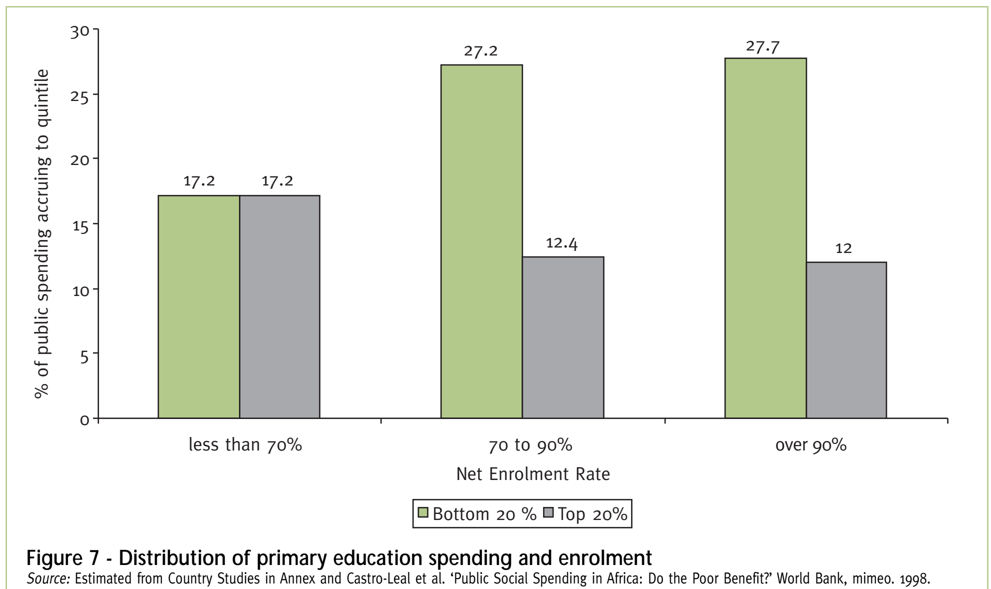

Figure 7 - Distribution of primary education spending and enrolment
Source: Estimated from Country Studies in Annex and Castro-Leal et al. 'Public Social Spending in Africa: Do the Poor Benefit?' World Bank, mimeo. 1998.

Benin, for example, the gross enrolment rate in urban primary schools is almost twice as high as in rural schools. Even so, the better-off get a greater share of the available school places, with the richest groups in rural areas achieving a gross enrolment rate of 50 per cent while the poor only manage 36 per cent. The corresponding ratios in urban centres are 114[4] and 45. Rural areas, where 60 per cent of the population live, receive less than half of the basic education budget.

Some of the problems facing education in Sub-Saharan Africa illustrate the widespread impact of gender discrimination. In Côte d'Ivoire girls receive only 37 per cent of the education subsidy and in Ghana only 41 per cent, even at the primary level. In Côte d'Ivoire, girls in the poorest quintile received less than a quarter of the overall education subsidy accruing to that quintile.

There is no doubt that education systems in many developing countries need improvement. What is less well documented is how much the quality of service varies within countries, and the extent to which the poor are disadvantaged in this respect. The studies found that in Peru, for example, the unit cost for primary education was nearly four times higher for the richest quintile than for the poorest one. Evidence from

4. Gross enrolment rate (GER) includes children older or younger than the standard school-age. GER can, therefore, be higher than 100 per cent.

El Salvador and Uganda shows that the expenditure per student reaching rural schools is lower than aggregate data suggests, pointing to lower education quality in such areas. And there is strong evidence that school quality has a significant impact on parents when deciding whether or not to enrol their children. Crumbling classrooms with inadequate sanitation, lacking light and heating, are unlikely to win new pupils.

Distributing the benefits of public spending on health

Evidence on public health expenditure from 17 countries finds that, as with education, the benefits are not equitably distributed. In every case, the poorest quintile receives significantly less than 20 per cent of the benefits of overall health expenditure. These countries do not achieve even the minimum definition of equity: that each group receive benefits in proportion to their population size.

Spending on basic health services is, however, more equitably shared than total health spending and the poor make disproportionate use of primary health facilities in some countries. In Kenya, for example, the poorest quintile gained 22 per cent of the government subsidy on primary health, compared with only 14 per cent of the total health subsidy. In Chile, the poorest quintile receives 30 per cent of the subsidy on primary health care and in Costa Rica, 43 per cent. The richest groups in both countries can, and do, buy private health care services.

In many other countries, however, and especially in Sub-Saharan Africa, basic spending is not fairly shared. In Ghana and Guinea, for example, the poorest quintile account for only 10 per cent of the total visits to primary health facilities.

The impact of egalitarian spending is strongly reflected in the results. The surveyed countries were divided according to the level of child mortality: very high (above 140 deaths per 1,000 live births), high (between 70 and 140 deaths per 1,000 live births), and medium (less than 70 deaths per 1,000 live births). The share of primary health care benefits was calculated for the poorest 20 per cent and the richest 20 per cent of the population in each group of countries. The results are striking.

In countries with under five mortality rates below 70, the poorest 20 per cent of the population received more than 25 per cent of the benefits of public spending on primary health care. The same group received less than 15 per cent in countries with child mortality rates above 140 (Figure 8). When looking at public spending on hospital care, the results are similar (Figure 9). Richer families make more use of hospitals than poor families in countries with medium levels of mortality, but the differences are relatively small – roughly 20 per cent and 15 per cent respectively. In countries with very high mortality rates, however, the poorest 20 per cent of the population account for less than 10 per cent of the health service usage, while the richest 20 per cent account for around 40 per cent of usage. This is a far larger proportion than their share of the population would justify, giving them a higher 'share' of the government's spending on hospitals.

What is more, wherever evidence exists on the distribution of health spending there is a strong bias in favour of urban services. In Kenya, where 70 per cent of the population live in rural areas, only 13 per cent of the health budget goes to rural health services. A similar situation is found in Namibia where, at independence in 1990, the health system was characterized by gross racial inequities, a focus on tertiary and specialized care, and geographical imbalances. While the situation is gradually improving,

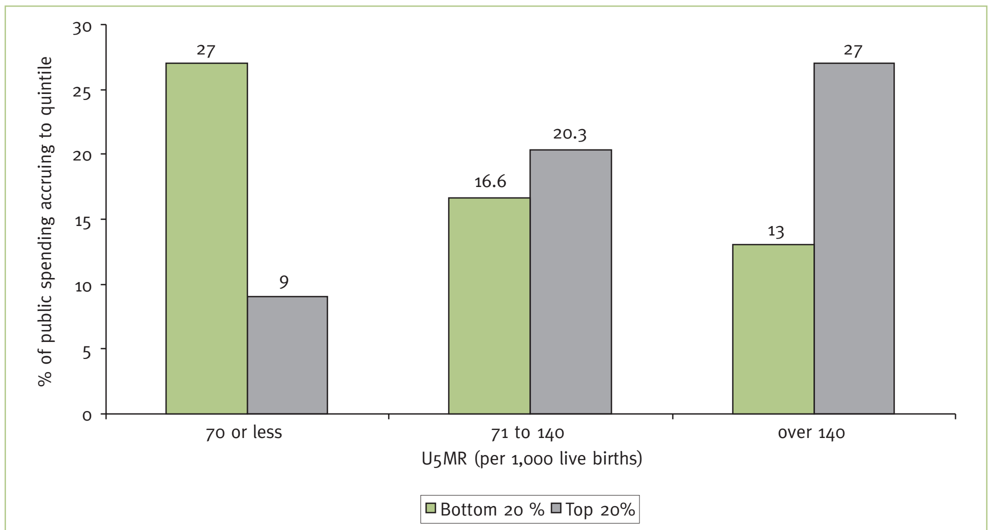

Figure 8 - Distribution of primary health care benefits and child mortality
Source: As in Figure 7

inequities remain and the state hospital in the capital city still employs one third of the Ministry of Health's personnel.

The studies show that the benefits of basic mother and child health services are more equitably distributed than overall expenditures for the health sector. In the Dominican Republic and in Colombia such services are also more progressive and cumulative in their impact than other services, even though they represent a very small proportion of total health expenditure.

In both countries, however, and particularly in the Dominican Republic, users from

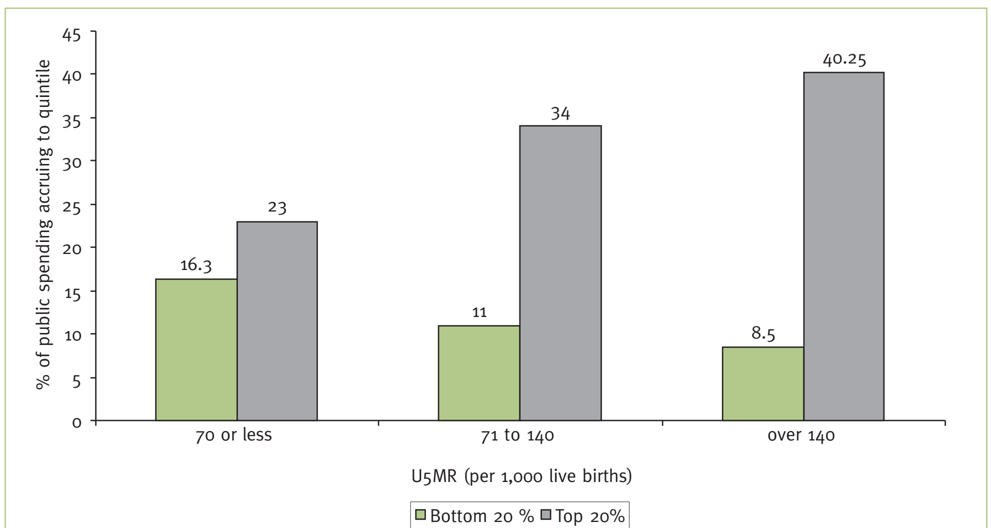

Figure 9 - Distribution of public spending on hospitals and child mortality
Source: As in Figure 7

higher income groups 'opt out' of public facilities and rural dwellers prefer to travel to the towns and cities to use urban facilities if possible. This is due to the perceived lower quality of the public services in rural areas, a perception partly based on the lack of adequate financing for those facilities.

Unit cost data, whether by income, location or ethnic group, suggest large quality differentials in health facilities serving poor and non-poor households. In Peru, for example, the unit cost for health services for the top income quintile is 50 per cent higher than it is for the bottom quintile. And unit cost data from apartheid-era South Africa highlighted major differences in infant mortality rates between different 'races', as well as enormous inequities in the resources allocated per health intervention.

What the studies show

Four main conclusions regarding the distribution of health and education spending emerge from the evidence gathered during our studies:

1. The distribution of the benefits of public spending (both in education and health) are biased in favour of the richer groups.
2. Expenditure per beneficiary increases with the income of the recipient. Not only do the better-off groups usually receive a higher share of the benefits of public spending, they receive better quality services.
3. The distribution of benefits at the basic level of services is more egalitarian than at the secondary and tertiary levels.
4. A more detailed probing of the information on unit costs often finds that the poorest receive lower quality services despite their greater needs.

5 MOBILIZING RESOURCES

What resources are needed?

Approximately $206 to $216 billion (in 1995 prices) is needed to provide basic social services to all, but only $136 billion is currently being spent. In other words, expenditure falls short by about $70 to $80 billion per year. Of this required sum, $7-8 billion would be needed for primary education, $8-10 billion for reproductive health and family planning, $15-17 billion for low-cost water and sanitation, $14 billion for a basic public health package, and as much as $26-31 billion for the essential clinical services.

The shortfall is roughly twice as high as the earlier estimate of between $30 billion and $40 billion at the time of the World Summit for Social Development in March 1995, based on available data from the early 1990s. The approximate doubling of the estimated additional resources required for universal access to basic social services indicates too little progress in achieving many of the social development goals of the 1990s. It also reflects an increase in population and prices, as well as better estimates of costs.

How can these resources be found?

The $70 to $80 billion shortfall could be eliminated. The 20/20 initiative is one guideline for greater resources, calling for developing countries to commit 20 per cent of their budget and donor countries 20 per cent of their ODA to guarantee universal access to these services. But there is some debate on how developing countries can

best achieve such shifts in resource allocation. There are four possible approaches:

1. Increasing the share for basic services in health, education or water/sanitation expenditures, while leaving all other expenditures the same;
2. Increasing the share of sectoral allocation for health or education as a whole in total public spending, while leaving the intra-sectoral allocation for basic services the same;
3. Increasing the public spending share in the GDP, while leaving the inter-sectoral allocation across sectors of the national budget and intra-sectoral allocation within the health and education budgets the same. This would mean enhancing the revenue base of the state through improving tax collection, expanding the tax base, or increasing taxation levels, to increase the revenue to GDP ratio;
4. Increasing public expenditure across the board (as revenues increase with growing GDP), without altering the inter- or intra-sectoral allocation or the public spending to GDP ratio.

Within the education sector much more is spent per pupil in higher education than at the primary level. Part of this difference is due to the higher costs of infrastructure for higher education worldwide. Even in OECD countries, the ratio of per pupil expenditure for higher education is three times higher than per pupil expenditure at the primary level. But in most developing countries the ratios are far worse. The ratio of per pupil expenditure for higher education compared to primary education tends to be highest in regions where the primary school enrolment rates are lowest. In fact, the lower the enrolment rates the greater the difference (Figure 10). In Latin America, where the Gross Enrolment Rate (GER) in 1995 was 106, the multiple is just 3. In South Asia, with a GER of 94, the ratio is 1 to 8, and in Sub-Saharan Africa, with a GER lower than 80, it is 1 to 25.

Those who are able to graduate from primary, secondary and then higher education, usually belong to the non-poor. Clearly, there may be scope for increasing primary education expenditures, while holding higher education expenditures constant. As the funding situation of universities in most developing countries is often weak, alternative

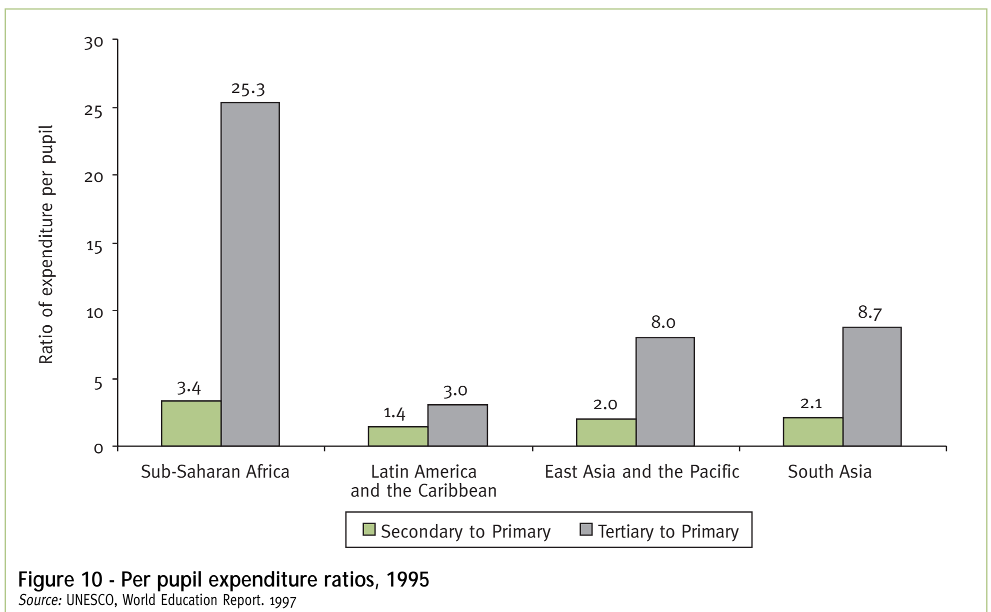

Figure 10 - Per pupil expenditure ratios, 1995
Source: UNESCO, World Education Report. 1997

sources of revenues have to be found in order to maintain and improve quality at the tertiary level. Similar conclusions would apply to other sub-sectors to ensure basic service provision for the majority.

However, intra-sectoral restructuring of expenditures is likely to be resisted by the better-off. Such political considerations are of paramount importance to governments. While they may test the patience of the poor, they are generally more wary of the wrath of the rich. Intra-sectoral reallocation in favour of basic services is much easier if carried out at a time when the funding envelope for the sector as a whole may be increasing. In other words, if governments can shift resources in favour of health or education from other uses, such as economic services, defence or debt payments, the politically difficult task of reallocating resources becomes that much easier.

In addition to this 'political' rationale for creating the right conditions for intra-sectoral reallocation, our studies suggest sound technical reasons for maintaining overall health or education expenditures while increasing basic level service provision. Urban areas are particularly vulnerable to cholera, for example, which spreads easily in overcrowded locations. Hence the importance of safe water and proper sanitation in towns and cities. University libraries that lack relevant textbooks do need adequate funding. Within the health sector, hospital and clinical services may be stretched to breaking point by HIV/AIDS patients, making it difficult for them to cope. In Zambia, for example, health systems are being overwhelmed by cases of secondary infections such as tuberculosis, pneumonia and measles to which those living with HIV/AIDS are vulnerable. And HIV/AIDS claims the lives of over 600 teachers a year – equivalent to half of the graduates from teaching colleges. There can be little argument about the need to maintain overall health, water and education budgets in the face of such challenges.

What then, is the scope for increasing resources for basic services through inter-sectoral resource shifting? It is not possible to pre-judge what shares should go to different government services such as administration, justice, defence, or economic services. Nevertheless, the studies suggest that, predictably, there are three factors that are unduly burdening many budgets: defence spending, debt payments and untargeted subsidies.

The total military expenditure of governments across the world has fallen in the 1990s compared to the 1980s. However, the absolute burden of defence expenditure remains high in many countries. Contrary to the global trend, defence expenditure in South Asia has risen. In many countries examined, including Benin, Cameroon, Chile, the Philippines, and Sri Lanka, defence spending absorbs more resources than basic social services.

In many cases, debt service alone surpasses, often by a wide margin, the allocation to these services. This was true in Brazil, Cameroon, Côte d'Ivoire, El Salvador, Jamaica, Kenya, Nepal, Niger, Peru, the Philippines, Sri Lanka, Tanzania, and Zambia (Figure 11).

International action is vital on debt relief. Bilateral and multilaterial donors, particularly the IMF and the World Bank (which together account for most of the multilateral debt) launched an initiative in 1996 to address the debt crisis of the poorest countries. The Highly Indebted Poor Countries (HIPC) Initiative identifies two thresholds to determine whether a low-income country can repay its debt on a sustainable basis. The debt-to-exports ratio must be below the 200-to-250 per cent range, and the debt-service-to-exports ratio must be below the 20-to-25-per cent range. For countries that

exceed these thresholds, a programme involving strict macro-economic management for several years can eventually lead to some form of debt relief. There are currently 41 HIPC-eligible countries.

However, debt-sustainability should also be considered from the perspective of fis-

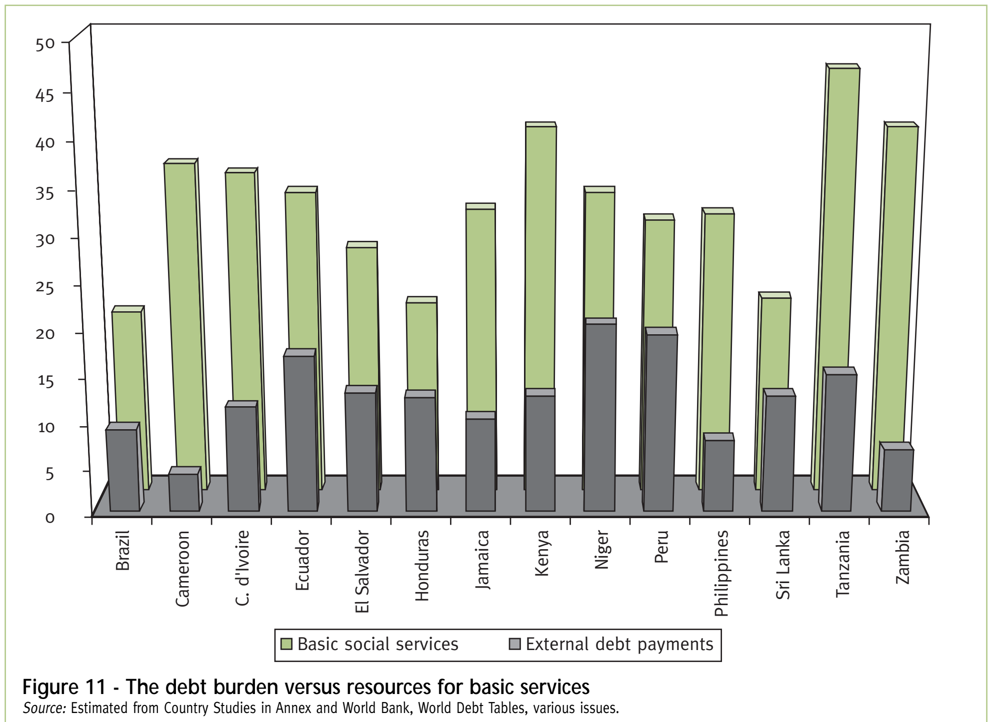

Figure 11 - The debt burden versus resources for basic services
Source: Estimated from Country Studies in Annex and World Bank, World Debt Tables, various issues.

cal balance and the capacity of governments to carry out their core responsibilities. Take one example: Zambia. About 40 per cent of government revenues have been allocated to servicing external debt. This is actually more than the budgets of the entire health and education ministries combined. At the same time, child mortality rates are rising, and only about one third of children are fully vaccinated. The number of children out of school is actually increasing.

In other words, a fundamental problem with debt relief initiatives, including the HIPC initiative, is their definition of debt sustainability on the basis of debt-to-export ratios. It is governments, however, that must service debts - not exporters. Most HIPCs have liberalized their trade policies and capital-account regulations, with the private sector now accounting for 80-100 per cent of export earnings. But governments have only limited access to this revenue through taxation. The fiscal burden on governments, using budget revenue as the denominator, would be a more accurate indicator of a country's ability to repay its debts and would also highlight the true cost of debt servicing in terms of human development.

We propose, therefore, that no more than 20 per cent of the revenue of HIPCs should be spent on debt servicing. Countries spending more than 20 per cent of their revenue on debt service cannot be expected to meet poverty-related expenditure requirements. This should be one measure for determining eligibility for HIPC debt relief.

Other than defence and external debt, untargeted subsidies to agriculture and industry and private consumption are a third major drain on public resources. Unrecovered costs on public utilities such as electricity and irrigation water, not only lead to overuse of these scarce resources in many countries, but contribute to budget deficits. This forces governments to borrow, causing a rise in interest rates, which adversely affects investments, completing a vicious circle.

This brings us to the third method available to governments wishing to increase the resources for basic social services: revenue generation, and thereby an increase in total public spending to GDP across the board, while leaving the inter-sectoral and intra-sectoral allocation untouched. The existence of large budget deficits, however, has forced governments to undertake macro-economic stabilization and adjustment aiming at cuts in budget deficits and public expenditure. Since the early 1980s these adjustment policies have been characterized by an almost exclusive emphasis on public expenditure reduction in the quest for budget deficit reduction. In a recent external review of Extended Structural Adjustment Facility (ESAF) programmes, a group of independent experts noted that public spending limits have often been set too tight, with detrimental effects on human capital and growth. This was again the case in the policy conditions laid down in the IMF's response to the Asian economic crisis. Our studies show that, for all cases, real per capita expenditure on basic social services only declined when the public expenditure share in total output declined.

There is an urgent need to reverse this trend through a greater focus on revenue generation as a means of increasing social spending. Low revenue collection is the combined outcome of institutional weaknesses, dependence on trade taxes for many developing countries, and low incomes. Much more could be done to strengthen tax collection and to prevent tax evasion. And much more could be done to enhance the tax base, by enlarging the tax net to catch those who are currently escaping it. The international financial institutions (IFI) need to take much more seriously the technical support requirements of most developing countries, but especially those in Sub-Saharan Africa and Latin America, in the area of tax administration and collection.

Sadly, little can be done in the short-term about the dependence on trade taxes for commodity producing countries. Government revenues are, therefore, vulnerable to climatic factors that influence production and volatile prices for commodity exports. Countries that are overly dependent on the production and export of commodities should diversify into other products and undertake more domestic processing – cocoa into chocolate, for example – before export. That would require greater willingness on the part of industrialized countries to accept these 'value added' products – an important priority for activities under the auspices of the World Trade Organization.

The final means of increasing public spending on basic social services is economic growth. Incomes, and thus tax revenues, rise with growth in output, thus enabling public spending to grow in per capita terms. This would apply even if public spending to GDP ratio, the share of health and education in government spending, and the shares of basic health and basic education within their respective ministries, all remain the same. Demand-deflationary macro-economic policies, based on the Washington Consensus have failed to yield increases in growth or poverty reduction and should be re-examined.

Specifically, in the context of the HIPC countries' growth would be contingent upon integrating poverty reduction into macro-economic reforms. The IMF-World Bank perspective would make compliance with ESAF programmes the main indicator of a government's commitment to poverty reduction. A link with ESAF programmes should be maintained, since a stable macro-economic environment is essential to growth and poverty-reduction, but economic stability needs to be part of development strategy which marries social and economic objectives.[5]

At least two methods – intra- and inter-sectoral reallocation of expenditures – can show results in the short-term, i.e. in the lifetime of one government (working on the basis of a life of four to five years for governments in most democratic systems). For reasons of political economy and technical issues, intra-sectoral restructuring is easier during periods of increasing resources for the health and education sector as a whole. In addition, more resources can be generated for basic services through inter-sectoral restructuring than merely through intra-sectoral reallocation. Intra-sectoral reallocation would be a more feasible option for increasing resources for basic services in the short-term. In recent years, Uganda and Malawi have shown that it is possible to undertake intra-sectoral reallocations under conditions of increasing overall resources for the education sector – with remarkable results for primary education. In fact, one could argue that newly elected governments, in the initial years of rule, are in a better position, politically, to undertake such reallocation of expenditures, than in later years just before an election.

In the long-term, however, the emphasis must be on enhanced resource generation and new ways of financing social services. The emphasis of the last two decades on expenditure reduction as a means of budget deficit reduction has to change. In the long run, international financial institutions must provide more technical support for improving tax collection and new sources of revenue generation. Gradual increments in the revenue base will also ease the pain of inter- and intra-sectoral restructuring and are feasible in the lifetime of one government. In the longer term, economic growth can enhance the revenue base - though for the government of the day, that is only of theoretical significance. If governments wish to gamble on political survival, investing in the health and education of their children seems a surer bet than any.

6 EFFICIENCY AND EFFECTIVENESS

A new emphasis on mobilizing additional public resources for basic social services should not overlook the importance of efficiency and effectiveness. Indeed, sufficiency, equity and efficiency are intertwined.

The reallocation of resources from urban hospitals to more accessible primary preventive health care, for example, or from universities to primary schools, are actions that would improve 'allocative efficiency' – the better use of existing funds within the health and education sectors as a whole. Such actions would also improve equity by

5. However, a recent paper to their Executive Boards still speaks of a division of labour, not an integration of social and economic dimensions in policy-making: "The Fund would take the lead in defining and monitoring macro-economic policies in the context of ESAF-supported programmes, while the Bank would take the lead in defining and monitoring social policies and poverty-reduction programmes".

supplying adequate services for more people, including people who are currently unreached. Given that urban populations are already, in general, better served, and that health care tends to be weaker in rural areas, these actions would have a noticeable impact on human indicators.

Additional resources for basic services could remove one major barrier to the delivery of good quality services: the lack of basic supplies. Teachers without teaching materials, and nurses without drugs are simply unable to do their jobs. Insufficiency results in inefficiency. However, within the current envelope of resources for basic education or basic health, better outcomes may be possible through *better policies*. In other words, technical efficiency may be improved by reducing the inefficiencies that stem from policy failures.

Education

Enhancing the efficiency of primary education expenditure is an important issue for two reasons. First, as education is often one of the largest items in the government's total budget, cost containment in its largest component – primary education – is essential to prevent excessive strain on the national exchequer. Second, the child population in high-fertility developing countries is still growing. The unit costs for educating each of these additional children must be kept down if they are to be absorbed into educational systems.

One answer is to improve the allocative efficiency of public spending on education. The high-achieving developing countries have concentrated their energies on primary education. This contrasts with, for example, India, where the states with the poorest education indicators failed to allocate even 50 per cent of their education budgets to elementary education in the 1990s. The Republic of Korea, on the other hand, was allocating three-quarters of its education budget to primary education in the 1950s, and even in 1990 as much as 50 per cent was going to the primary level. This approach could be followed elsewhere. The state should ensure that primary education and, if possible, junior secondary education, are universal before spending a large proportion of its education budget on universities. Such early investment should produce a larger cohort of students with the skills to make good use of state-funded universities.

To accomplish this transformation, reasonable fees for higher education would have to be instituted. Fees are currently low as a share of costs per student for higher education in most developing countries, especially in South Asia and sub-Saharan Africa. They seldom cover more than 10 per cent of the recurrent expenditure of public higher education. It is important that the resources generated by fees are ploughed into higher education so that services for students and teachers improve.

Operational efficiency could also be improved by addressing the balance between capital and recurrent expenditures, and more importantly, between salaries and other costs in recurrent expenditure. Several countries have huge backlogs in classroom construction because of growing demand for school places and can only respond if the cost of school construction is moderate. One method is to work with local communities, using locally available construction materials. Community-provided housing for teachers in rural areas can help cut costs, while bringing teachers and communities closer together. Costs can also be reduced by producing school supplies locally. In Burkina

Faso, the local production of schoolbooks since 1987 has made course content more relevant to the needs of the pupils and has cut the cost of books by two-thirds.

The most frustrating challenge in many countries is the wage bill. Salaries take precedence in any education budget, squeezing out capital expenditures and non-salary inputs such as teaching materials. Wage bills for teachers and administrative staff in developing countries often account for 90 per cent or more of recurrent expenditure at the primary level, 80 per cent at secondary level and 60 per cent in higher education. This imbalance becomes a real problem in countries where allocations for primary education are especially low. Salaries represented 95 per cent of primary recurrent expenditure in Côte d'Ivoire in 1994, 97 per cent in Morocco in 1991, 98 per cent in Honduras in 1994, and 97 per cent in a number of Indian states in 1995.

The management of the wage bill is of particular importance in many Sub-Saharan and South Asian countries where the large numbers of pupils per teacher demonstrate the clear need for more teaching staff. For countries trying to balance their meagre national budgets, the effect on recurrent expenditures of an increase in the number of teachers or of a rise in the average teacher salary can be devastating. Costs can be reduced by changing the salary structure without changing salary levels, by adjusting the ratio between the top and the bottom in teacher payscales, for example, or the number of years required to reach the highest level. Another method is to adjust the entry-level salaries paid out to teachers with more than the minimum qualifications.

Studies from South Africa show the importance of dialogue with teachers. Between 1991-2 and 1995-6 teacher salaries in South Africa grew from 75 to 83 per cent of recurrent expenditures, and began to drain the resources available for capital expenditures and other running costs. The government and teaching unions began a dialogue in 1998, and the unions accepted a 1 per cent real decrease in teaching salaries over five years, swayed by the government's promise that any savings would be diverted into the education system for non-personnel expenditure.

The efficiency of the primary system can be improved by reducing repetition and drop-outs. Obviously, when a student needs twice the prescribed number of years to finish primary school, the cost per graduate doubles. In Honduras, for instance, it has been estimated that repetition and dropout costs absorb 20 per cent of the primary education budget. Years of investment are wasted when children drop out of school and, unless they have completed a minimum four years of schooling, they are unlikely to retain the little they have learned.

The 'high-achiever' countries such as Costa Rica, Sri Lanka and Vietnam offer several policy lessons for reducing repetition and drop-out. In Costa Rica, repetition was halved by the introduction of automatic promotion through the grades in the 1960s. El Salvador, Malaysia and Zimbabwe have also adopted approaches to ease a child's progression through the necessary years of schooling. But automatic promotion is unlikely to succeed without improvements in training for teachers and better instructional materials.

Schooling in the child's mother tongue is essential and is the norm in most high-achieving countries. Contrast this with the situation in most Lusophone and Francophone African countries where instruction in the earliest grades is not in the mother tongue; these are the very countries with the lowest enrolment rates in the world.

Parents often allow their children to drop out because of the costs of schooling. UNICEF studies in Bhutan, Burkina Faso, Myanmar, Uganda, and Vietnam confirm that the direct and indirect costs of education, ranging between 10 and 20 per cent of per capita income, undermine school attendance. Fees for primary education should certainly be reduced, prior to their gradual abolition. Here again, the high-achievers offer policy lessons. Tuition fees were eliminated in Sri Lanka in 1945 and the country achieved high enrolment rates in its first decade of independence. Enrolment in Botswana received a boost from the decision to halve fees in 1973 and abolish them entirely in 1980.

Costs are a key factor when parents are deciding whether or not to send their daughters to school. Low cost or free education is a spur to the enrolment of girls, as is the employment of a high proportion of female teachers.

Health care

In the high-achieving countries that managed to improve health indicators relatively early in the development process, access to basic health services is virtually universal, with services paid for through government revenues. Experience in these countries shows that certain basic health services should be supplied by the state at little or no direct charge to users: reproductive health care, pre-natal, peri-natal and post-natal care backed by adequate referral services, and nutritional care to prevent child malnutrition.

It is vital to address the widespread imbalance between rural and urban health infrastructure. This imbalance is compounded by the lack of financial and human resources in rural health centres while urban health centres are overstaffed. In the Dominican Republic, for example, overstaffing in urban centres means that 40 per cent of urban doctors perform some administrative duties while many rural areas have no doctors at all.

Many high-achieving countries have tackled this issue. Malaysia requires all doctors trained at public expense to serve the public health system for at least three years. This allows the government to post doctors and para-medical staff to rural areas. Sri Lanka has achieved the same result by requiring all doctors to serve in rural areas for a minimum period as a condition for their registration with the general medical council of the country.

In many countries with shrinking overall health sector budgets, it is the non-wage expenditure that is cut first. With the share of non-wage recurrent expenditure contracting, shortages of essential drugs and other necessities are only to be expected. In Sri Lanka, however, where medicines and supplies account for around one-third of recurrent expenditure on basic health, the government generates savings by procuring generic drugs at low cost. Meanwhile in Nepal, where no such policies exist, health centres lack basic supplies.

In attempts to reverse this trend, Benin, Côte d'Ivoire and Niger have adopted

generic drugs policies that have improved the delivery of medicines. In Benin, the introduction of generic drugs has been accompanied by the inclusion of vaccination in primary health care services and a rise in immunization coverage from 25 per cent in 1987 to 81 per cent in 1996. In Côte d'Ivoire the realization that the private sector could not supply drugs to the population at affordable prices has resulted in greater reliance on generic drugs. In Niger the cost of generic drugs is one-quarter that of brand drugs.

The experience of countries that have made rapid progress in the overall health of their populations shows that many outreach and preventive care activities require more para-medical staff than physicians. In countries with higher life expectancy the nurse per doctor ratio is quite high. Examples are Zimbabwe (9.5 nurses per doctor in 1990), Thailand (4 in 1990) and Sri Lanka (3.2 in 1996). This contrasts with India (1.5 in the late 1980s), Bangladesh (1 in 1990) and Peru (less than 1 in the mid-1990s).

Demand for reproductive health services is undermined by the poor quality of the services on offer and by religious or gender issues. With many service delivery points idle, the costs per user are disproportionately high. Such reproductive health care is often provided through stand-alone programmes – an approach that is inherently inefficient and was discarded by South Africa in the late 1980s in favour of integrated reproductive health programmes alongside efforts to train primary health care nurses in family planning. As a result, South Africa enjoys a high contraceptive prevalence of over 70 per cent. Similarly, in the late 1990s in India, primary health care services have begun to integrate family planning services.

Poor parents in developing countries do not need to be told that child mortality rates are a problem. But the answer lies in a combination of education and good quality health care. Only when mothers are more literate and more trusting of organized health care systems - when they believe that their children will survive into adulthood – will reproductive health services start to have a real impact.

Another continuing health issue is nutrition. In South Asia, the proportion of infants with low birthweight is 34 per cent, more than twice as high as in Sub-Saharan Africa (16 per cent) and more than three times higher than in South East Asia or Latin America and the Caribbean (11 per cent). This disaster cannot be attributed to income differentials or the amount of food production, for the levels of income-poverty and food availability are similar in sub-Saharan Africa, where low birthweights are far less common. The roots of the problem lie in the health status of women, especially pregnant women. The much higher incidence of anaemia among women in South Asia – 60 per cent against 40 per cent in sub-Saharan Africa – is one alarming symptom of gender discrimination.

It is clear that one very efficient way to reduce child malnutrition is to address the nutritional needs of pregnant women. The universal provision of regular antenatal care is one way to carry out such an approach. And improved education and health care systems foster nutritional benefits among mothers and children by boosting parental understanding of appropriate nourishment, proper sanitation, the need for timely health care, breastfeeding, and child growth monitoring without necessarily adding to the costs of public health care. School meal programmes, targeted food subsidies, regular dietary diversification, food fortification, and food supplementation programmes could be established to reach the vulnerable, particularly children.

Water and sanitation

Lack of clean water and proper sanitation seriously undermines the positive effects of other basic social interventions. Throughout the world dirty water and lack of sanitation are among the leading causes of child illness, disease and death.

At the beginning of the 1990s, around 1.6 billion people in developing countries lacked access to safe water, and 2.6 billion had no access to sanitation. Today's figures are actually worse. The number of people without clean water is nearer 1.7 billion, and over half the world's population, 3.3 billion people, lack proper sanitation. Even though 80 per cent of those without safe water or sanitation live in rural areas, WHO estimates that only one quarter of all spending on water and sanitation went to those areas in the 1980s. It is vital that allocations shift dramatically in favour of rural areas and governments should encourage the sustained provision of water and sanitation services by empowering local communities and agents (public and private) to take the necessary action. They should also encourage close links between providers and rural users and the application of appropriate technologies. Handpumps, gravity-fed systems, narrow pipes, the ventilated pit latrine, protected springs and wells, the collection of rainwater, and the upgrading of traditional water sources are ideal low-cost solutions for rural areas.

Most governments, however, still allocate a much larger share of spending to urban water projects. While 70 per cent of the population of Namibia is rural, the share of spending on water and sanitation that went to rural areas in 1996-97 was only 35 per cent, and there is evidence that water is supplied to towns and cities at subsidized rates.

Poor cost recovery in the past for urban services for the better-off is one reason why there have been calls for privatization and the commercialization of urban public water utilities. Private sector involvement is growing in the design and manufacture of hardware, project implementation, service delivery, operations and maintenance within communities. Private funding is being raised to meet service costs. While this may bring many benefits in terms of incentives for efficient service delivery, it is not necessarily a comprehensive solution. There are few incentives for private utilities to reach out to informal and marginalized settlements in remote or difficult areas. Privatization, particularly in monopoly services, has highlighted the need for price regulation and quality control, particularly for the urban poor and for rural residents. Capital cost sharing fosters ownership, and recurrent cost recovery promotes sustainability, but cost recovery from the poor without regard to their ability to pay is unjust.

7 DONORS

The shortfall of $70-80 billion per year between what is being spent and what should be spent to ensure basic services for all is unlikely to be filled by developing countries without external help. While the bulk of these additional resources will have to come from the national budgets of these countries, this task will be difficult, if not impossible, without more official development assistance (ODA) than the $5 billion presently going to basic social services each year.

Under the obligations laid down in the Convention on the Rights of the Child, the governments of all countries, rich or poor, are obliged to provide adequate resources for basic social services. The 20/20 initiative is one guideline, whereby donor countries

would match a similar commitment by developing countries, allocating 20 per cent of their ODA to support these services.

In the past, a large part of ODA was directed towards the provision of external technical expertise and capital goods. The rationale behind the low priority given to basic social services was their labour-intensive nature and their substantial local costs. Members of the OECD's Development Assistance Committee (DAC), which includes all industrialized countries, have been more eager to allocate resources for the alleviation of poverty in recent years, and there is a consensus that accessible basic social services should be the key target of any allocation strategy.

The DAC committed itself in 1996 to the global development goals identified in earlier UN conferences, including the elimination of gender disparities in primary and secondary education by 2005, the establishment of universal primary education by 2015, the reduction of the 1990 under-five mortality rate by two-thirds by 2015, the reduction of the maternal mortality rate by three-quarters during the same period, and the establishment of reproductive health care services within primary health care systems by 2015. The DAC added another goal – halving the proportion of people living in extreme poverty by 2015.

But concerns about ODA and about developing country public spending on basic social services are much as they were in 1996 – too little support for social services overall, too small a share for basic level services, and too much inefficiency in allocation and utilization, with aid often going to projects that are not linked to the budgets or the priorities of the countries concerned.

ODA has been declining as a proportion of the output of industrialized countries, since the early 1980s. In 1997 it fell below 0.25 per cent of donor GNP, the lowest level since the 1950s. The absolute amount of assistance has been declining in real terms, by nearly 5 per cent each year since 1992. A small upswing in 1998 was mainly driven by the exceptional and short-term response to the East Asian financial crisis. In the majority of DAC countries, the allocation of ODA is nowhere near the agreed UN target of 0.7 per cent of GNP.

It also seems that the goal of greater resources for basic services is being overlooked. On average, the DAC bilateral donors allocated 11 per cent of their assistance to basic social services between 1995 and 1996. No DAC country's allocation for basic education, basic health care, reproductive health care, water and sanitation systems exceeded 16.5 per cent of ODA. What is notable is that ODA from DAC countries for basic social services declined between 1995-6 and 1997-8 (Table 2).

Table 2: ODA from DAC Countries

	1995-1996 (US$ million)	1997-1998 (US$ million)
● Basic education:	644	484
● Basic health:	989	605
● Reproductive health:	726	644
● Water supply:	3148	2618

The total ODA for basic social services over 1995-6 was US$5.5 billion. By 1997-8 it was over 20 per cent lower, at US$4.35 billion. Interestingly, basic services as a percentage of overall ODA remained static, at roughly 11 per cent over both time periods. Water

and sanitation accounted for far more than half of all ODA for basic services, followed by reproductive health care. Basic health care and education were almost crowded out by these two other services. On average, in 1995-6, ODA to basic education stood at just 17 per cent of education allocations, while ODA to basic health services amounted to 39 per cent of all health allocations (Figure 12).

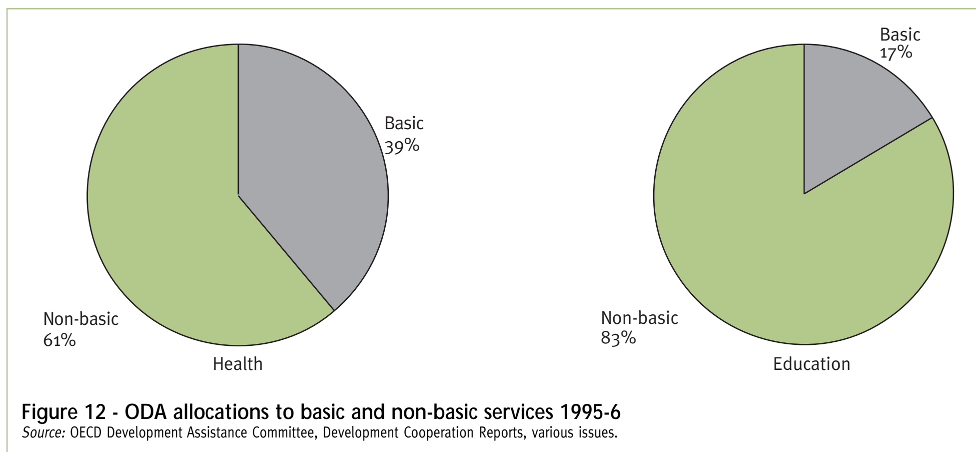

Figure 12 - ODA allocations to basic and non-basic services 1995-6
Source: OECD Development Assistance Committee, Development Cooperation Reports, various issues.

So far, OECD donors do not appear to be allocating more resources towards the achievement of the goals agreed at the World Summit for Children, the World Summit on Social Development or any of the other international conferences of the last decade. The 1998 DAC report revealed that, since the early 1990s, aid to countries with the poorest populations had declined more than aid overall. Between 1991-2 and 1995-6, total bilateral aid fell by 16 per cent in real terms, but the decline was 21 per cent for the countries where the under-five mortality rate was over 100; fell by 23 per cent for countries where access to safe water was less than 60 per cent, and fell by 25 per cent for countries where less than 80 per cent of children were attending primary school.

DAC assistance for water and sanitation grew from $1.8 billion over 1990-1 to $2.6 billion over 1997-8. Such expenditure may be justified by the vast numbers of people without access to safe drinking water and proper sanitation. The resources needed to achieve universal coverage in water and sanitation are probably exceeded only by the requirements for essential clinical services. However, much of this water and sanitation ODA is actually spent on studies and assessments, planning, waste water treatment, water conservation, and many other areas that, while important, do not directly involve the provision of basic services. Furthermore, a UNICEF-funded survey of water and sanitation projects suggests that there is a definite urban bias in the targeting of DAC assistance in the vast majority of countries.

The value of DAC assistance for the overall health sector, including basic services, grew from $2.3 billion in 1990 to nearly $4 billion in 1996. For countries where the basic health share in total health ODA, excluding ODA for reproductive health, is reported in DAC data, the share was 42 per cent over 1995-6. Germany, Japan and the United States accounted for 62 per cent of the basic health ODA over 1997-8.

DAC assistance to education increased from nearly $6 billion to just over $7 billion

between 1990 and 1996. Six donors accounted for 80 per cent of the assistance to basic education in 1997-8: Germany, Japan, the Netherlands, Sweden, the United Kingdom and the United States. Going by the DAC data available, the share for basic education within total education bilateral ODA was 12.4 per cent over 1995-6.

We examined ODA to education based on recipient country data from UNDP's Development Cooperation Report for 1989-91. This found an insignificant share of education assistance going to basic education. However, recipient country data for 1994-6 suggests that the share of basic education in ODA to education had increased – probably as a result of the new commitment to universal primary education. However, basic education accounts for the smallest part of basic service ODA, under 15 per cent, suggesting that donors have not fully grasped the notion of synergy among interventions within these services.

There is scope for improving the effectiveness of aid by putting recipients in the driver's seat. The need for improved co-ordination, increased ownership, and reduced dependence on aid is increasingly recognized by the donor community, and there is a new emphasis on partnership in sectoral approaches. Many developing country governments are, however, unable to get into the driver's seat because large donors – particularly in the areas of health and education – have a tendency to drive the sectoral policy agenda. The pooling of external resources would give more leeway to government policy-making. Pooled resources could be disbursed by the recipient country according to a general development strategy, including a human poverty reduction plan, discussed and agreed in advance, rather than through specific programmes and projects in a particular sector.

We need to move in this direction, with one proviso – more donor resources need to be allocated to basic services in the short-term. At a minimum, 20 per cent of donor assistance should go to the basic services so essential for human development.

Multilateral Assistance

The World Bank and the regional development banks account for most of the multilateral official development assistance. The World Bank estimated its allocations for basic social services at 15 per cent in 1993 and 19 per cent in 1996. The Bank is the largest source of multilateral assistance for education and its funding for basic education doubled from $437 million to $916 million between 1989-90 and 1995-6. Funding for basic education in sub-Saharan Africa doubled over the same period, but then fell back to the levels that existed at the time of the Jomtien Conference on Education for All in 1990. This fall may be explained in part by the competition for resources from South Asia and in part by the fact that other areas, such as public sector reforms, were absorbing more World Bank resources in Africa.

The multilateral agencies within the UN system allocate a varying proportion of their assistance for basic services, depending on their mandates. UNDP's broad mandate accounts for the fact that, according to its own estimates, just under one fifth of its assistance goes to basic social services. UNICEF, with its child-focused mandate, allocates roughly three-quarters of its resources to such services. The UN Population Fund devotes over four-fifths of its assistance to reproductive health care.

If a developing country government has a poverty reduction plan in place, then pooled resources should be able to support such a plan under the direction of the recipient government.

Finally, it is critical that various ministries of donor governments attempt to achieve consistency between aid policies on the one hand, and trade policies on the other. There is a real problem when Ministries of Finance promote investment liberalization that may increase imports into industrialized countries, while Ministries of Trade impose quotas on those same imports.

In an ideal world, aid would no longer be needed. Aid would be replaced by fair trade and by government investment in universally accessible, high quality, basic social services. In the real world – where developing countries face such problems as HIV and AIDS, natural disasters, immense debt, deteriorating terms of trade, and civil conflict – concerted and expanded donor assistance will be essential in the foreseeable future.

AN AGENDA FOR ACTION

There has been only limited progress towards the social goals agreed upon at the World Summit for Children in 1990 or the World Summit for Social Development in 1995. Progress will remain limited in the first decade of the millennium unless social policy is seen as complementary to macro-economic policies – by governments and by international financial institutions. Future progress is dependent on stronger donor policies on social services and measures to address the inadequacy, inequity and inefficiency of public spending in developing countries. It is also dependent on action to ease the burden of debt that sees some countries spending more on debt-servicing than on the health or education of their children.

The new doctrines of 'small' government and extreme fiscal austerity followed in many developing countries flatly contradict the historical experience of the industrialized world. There, the size of the state consistently increased, and with it the revenue base, throughout the 20th century. Public expenditure as a percentage of GDP in OECD countries now stands at an average of about 50 per cent – more than twice that for developing countries. In order for developing countries to grow, their governments will have to grow.

Second, the experience of developing countries over the last 50 years shows that economic growth does not always reduce poverty. Indeed, income distribution has deteriorated in most of these countries. In 1990 the World Bank predicted a decline in the numbers of poor in the world from 1125 million in 1985 to 825 million in 2000. In reality, the number of people living on less on $1 reached 1.2 billion by 1998, including more than 600 million children. In Africa and Latin America the proportion of the poor remained largely constant while their numbers rose by 73 and 15 million respectively, despite a moderate rise in output per capita.

The current pattern of low expenditure and neglect in basic social services in developing countries goes hand-in-hand with a pattern of economic development that undervalues the social sector, democratic participation and the equitable distribution of the benefits of higher income.

Above all, there must be greater and better-targeted resources for basic social services. At present, developing countries and donors place too little emphasis

on the provision of services that are essential for the well-being of children and women, thus denying the human rights of millions to primary health care, basic education, clean water and proper sanitation.

Ten steps are needed to close the gap between the rhetoric about good quality basic social services and their universal availability:

1. **Policy makers should acknowledge that economic growth can increase the gap between rich and poor.** More effort is needed to distribute incomes and assets equitably. Support for basic social services is one possible additional avenue for this redistribution as greater and more efficient investment in basic services could help to trigger the synergy between economic growth, social development and income-poverty reduction. If economic growth is the dominant objective with macro-economic policy determined first – while social policy is expected to address the social consequences – this synergy cannot be triggered.
2. **Donors and developing country governments should exploit the synergies between basic services** – the links between interventions in health, education, nutrition, water and sanitation and reproductive health – backing those policies with adequate institution-building and financing. These synergies have not been grasped by decision-makers or government functionaries at lower levels, except in those countries that are now regarded as high-achievers.
3. **Policy makers should study and absorb the experiences of the 'high-achieving' countries** – countries with better social indicators than expected given their low levels of national wealth. Their experiences offer some principles of good practice: basic education and health care are provided free of charge; schoolchildren learn in their own language and progress automatically through the grades; there are more female teachers, and so on. There are functional health services in rural areas; there are adequate budgets for essential and generic drugs, an emphasis on the training of nurses and there is compulsory rural service for personnel trained at the public expense.
4. **The state must guarantee adequate basic social services through financing, regulation and provision.** Experience in both industrialized and high-achieving countries shows that if higher incomes or open markets led to improved social indicators – as argued by the advocates of globalization – governments could simply concentrate their efforts on trade, finance and economic growth. History, however, shows us that this is not the case. Without state involvement, disparities in well-being between rich and poor, women and men, city dwellers and rural residents are inevitable and tend to undermine growth.
5. **There is an urgent need for better information on public spending on basic social services.** Most governments possess little reliable information on their allocations for basic services and this is a major obstacle to sound investment. Analysis of public spending on basic services – as undertaken in the studies by UNDP and UNICEF – needs to be institutionalized by developing country governments. As well as supplying them with a meaningful policy tool, this information would help them improve the delivery of their services, understand the economic and social outcomes of their spending, and control the efficiency and equity of the service systems.

6. **In the short-term, additional resources can be mobilized by intra-sectoral reallocation within the social sectors.** Long-term progress on basic services requires inter-sectoral reallocation – especially away from defence, external debt, and subsidies to production or consumption that have no positive impact on the well-being of the poor.
7. **Cost sharing at the higher levels of service – universities, specialist hospitals – could release limited public resources for the poor** and would be dependent on a perceived improvement in services. But basic services must always be provided free.
8. **Macro-economic policies must place more emphasis on revenue mobilization.** Measures could include new types of taxation to cut deficits and provide greater resources for social services. International financial institutions could upgrade their technical assistance to developing countries on this issue.
9. **Aid can be more effective if recipients are in the driver's seat**. Governments, donors and the recipients themselves should work in partnership, increasing a sense of ownership and reducing dependence on aid.
10. **There should be a greater effort by donor countries to increase ODA for basic services and end the burden of debt.** Donor countries should aim for consistency between aid policies, international policies on trade and finance, and the debt repayments that drain the budgets of so many developing countries. One step would be an international agreement that no more than 20 per cent of the revenue of Highly-Indebted Poor Countries (HIPCs) should be spent on debt servicing.

ANNEX
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A proposal on monitoring the 20/20 compact on budget and aid restructuring, 1998

BASIC SERVICES FOR ALL?

There is a shortfall of up to $80 billion per year between what is spent and what should be spent to ensure universal access to basic social services such as primary health care, basic education and clean water. Drawing on case studies from over 30 developing countries, Basic Services for All? highlights the human cost of this shortfall in terms of lives lost, children out of school, the millions undernourished, and the billions without safe water and sanitation. The report concludes with a Ten Point Agenda for Action - urgently needed measures to close the $80 billion gap.

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