CHAPTER 6

Universal Provision of Social Services

Social services – in areas such as health, education, care, water and sanitation – can enhance individual well-being, raise productivity and contribute to overall quality of life. Such services enable families to care for and sustain their members and reduce both the costs and time involved in work and other daily activities. They increase the chances that individuals and their families can lift themselves out of poverty and live dignified and productive lives. The kinds, quantity and quality of services individuals enjoy provide a good measure of their well-being: indeed, poverty can be perceived as a failure to achieve certain basic capabilities arising in part from the absence of social services.[1]

The instrumental value of services, particularly education and health care, in promoting growth and alleviating poverty and inequality is now widely acknowledged in policy circles. Evidence clearly demonstrates the complementarities among different services (health, education, water, sanitation and nutrition, for example), as well as between social service provision and other economic policy goals. Moreover, access to certain social services, specifically education and health care, is considered a right enshrined in numerous United Nations declarations. It is a key goal of rights-based approaches to development and an essential element in the achievement of most Millennium Development Goals (MDGs).

This chapter argues that a universal approach to the provision of social services is essential to realizing their full potential as a component of transformative social policy. Achieving broad-based and inclusive coverage can contribute not only to improved well-being, but also to enhanced productivity and earnings.

In addition, it can reduce inequalities across income, class, gender, ethnicity and location. The challenge of extending effective provision to populations often marginalized or excluded as a result of these inequalities lies at the heart of efforts to reduce poverty and reach the MDG targets. As argued throughout this report, narrowly targeted interventions may make inroads into particular aspects of poverty among specific population groups. However, without broad-based coverage that aims to redress inequalities and generate solidarity around development goals, these gains may not be sustainable.

> *Narrowly targeted interventions may make inroads into aspects of poverty among specific groups; however these gains may not be sustainable*

Drawing on evidence principally from the health and education sectors, this chapter highlights the following key points.

- Integrated systems of social service provision that are grounded in universal principles can be redistributive, act as powerful drivers of solidarity and social inclusion, and improve the capabilities of the poor.
- By contrast, systems that are fragmented – with multiple providers, programmes and financing mechanisms aimed at different population groups – have limited potential for redistribution, and generally result in high costs, poor quality and limited access for the poor.
- Dominant policy trends since the 1980s, in a context of crisis, liberalization and public sector retrenchment, have moved towards the commercialization of social services, undermining previous progress towards universal access in many countries, raising out-of-pocket costs, particularly for the poor, and intensifying inequality and exclusion.

This chapter draws on the experiences of countries that have pursued different paths in the provision of social services at varying levels of income. The evidence shows that it is possible to institute social service regimes that lean towards universalism at relatively low income levels. It demonstrates the importance of substantial public involvement, whether in direct provision or in the financing or effective regulation of services. Public interventions are essential to ensure that services reach rural and remote areas, urban slums and marginalized groups, and thus that their productivity-enhancing and distributional benefits are obtained.

> *A number of countries show that it is possible to institute social service regimes that lean towards universalism at relatively low income levels*

Section 1 of the chapter discusses the case for a universal approach to the provision of social services, how this can be achieved and the barriers to extension.

Section 2 provides an overview of trends in service provision in developing countries.

Section 3 elaborates on these points with a discussion of the effects of commercialization on provision and outcomes.

Section 4 analyses patterns of social service provision in a select number of countries classified as leaning towards universalism, leaning towards universalism in the context of dualistic economies, and fragmented and exclusionary systems.

Section 5 draws conclusions that have implications for policy makers.

1. The Case for Universal and Public Provision

Social services improve the quality of life by creating, protecting and sustaining human capabilities. Despite a lack of consensus in defining the range of basic capabilities, good health, adequate education and nutrition feature prominently on most lists.[2] The centrality of basic services to improvements in people's lives has driven various international initiatives, including the Universal Declaration of Human Rights and the MDGs, to promote the goal of universal coverage. As chapter 5 has shown, universalism is grounded in the principles of solidarity and citizenship; it can foster social cohesion and build coalitions across classes, groups and generations.[3] If the poor are provided with access to the same kinds of services enjoyed by the rich, universalism may also act as an instrument for redistribution and social mobility.

Universal access to social services promotes growth and social development

The widely acknowledged instrumental value of education and health for economic growth and development[4] further underscores the importance of universal provision. This is particularly true in poor countries where the quality of human capital necessary for development is limited. An educated and healthy workforce contributes to economic growth and poverty reduction through improved skills and labour productivity, and thus improved incomes and life chances. The economy as a whole benefits from the expansion of human capital and the acquisition and upgrading of skills through education.[5] Health care likewise contributes to better learning and productivity over the long term; conversely, poor health or nutrition undermines learning at school, impairs cognitive development and reduces future productivity and earnings.

Important complementarities or multiplier effects exist among different social services.[6] Universal access to health care, for example, enhances investment in education by

ensuring that school enrolment and outcomes are not constrained by illness. Similarly, universal access to education enhances investment in health by increasing access to information about health practices, hygiene, nutrition and sanitation. The use of reproductive health care facilities, for example, tends to increase with education.

Health and education provision interact positively with other social policy interventions, with particular implications for women (see chapter 7). Improved health and education services may reduce the burden of caring for children and the sick. Early childhood care programmes can improve child health and education outcomes. Such provisions may reduce the need for social protection or assistance if episodes of illness, and thus loss of employment and income, are reduced. Social protection mechanisms such as cash transfers may in turn relax financial constraints that impede access to social services (see chapter 5). Finally, investments in basic infrastructure such as water, sanitation and transportation can improve health outcomes, reduce the time (often of women and children) spent collecting water or travelling, and facilitate access to other services.

The state plays a critical role in social provision

While the justification for universalizing service provision is clear both on equity and efficiency grounds, how, by whom, and under what circumstances barriers to extension can be overcome remain critical questions. A variety of actors and institutions, including states, markets, households, communities, non-governmental organizations (NGOs) and external donors provide or finance social services. As discussed in section 4 below, the precise mix of actors and institutions depends on a country's development strategy and policy choices, and its historical and institutional legacy. However, the potential benefits of integrated systems of provision may not be realized when market providers and other non-state actors are dominant. Given that many services require significant investments in infrastructure, they will tend to be underprovided by market actors. This is exacerbated where populations are remote or scattered, and thus unit costs are high. Active state involvement is therefore essential – whether in direct provision or financing; in coordinating among different providers and services; or in regulating and providing incentives to non-state service providers to ensure coverage of neglected locations or population groups, in order to maintain quality and to ensure affordability.[7] Countries that have achieved widespread access to basic social services have done so through substantial public sector involvement.[8] In all such cases, the belief that the benefits from income growth trickle down to the poor was rejected. Instead, deliberate actions were taken to provide social services, recognizing the links between economic and social policy objectives.

> *Countries that have achieved widespread access to basic social services have done so through substantial public sector involvement*

Achieving universal provision, however, requires overcoming a number of barriers. Structural inequalities based on individual or collective characteristics (such as gender, disability or ethnicity) may prevent individuals or groups from accessing or paying for services. As chapter 5 has argued, some degree of affirmative action or targeted initiatives may be necessary to resolve this problem. Investments in infrastructure in poor areas (rural and urban) or improvements in transportation can reduce physical distance and the cost of access. School feeding and subsidized medicine and transport programmes, along with free textbooks, can increase attendance at schools or clinics. India's school enrolment rate, for example, rose substantially with the introduction of a mid-day meal programme aimed at increasing enrolment and retention and improving nutrition among primary school children. Since 2002, the programme has been universal in all government and government-aided schools.

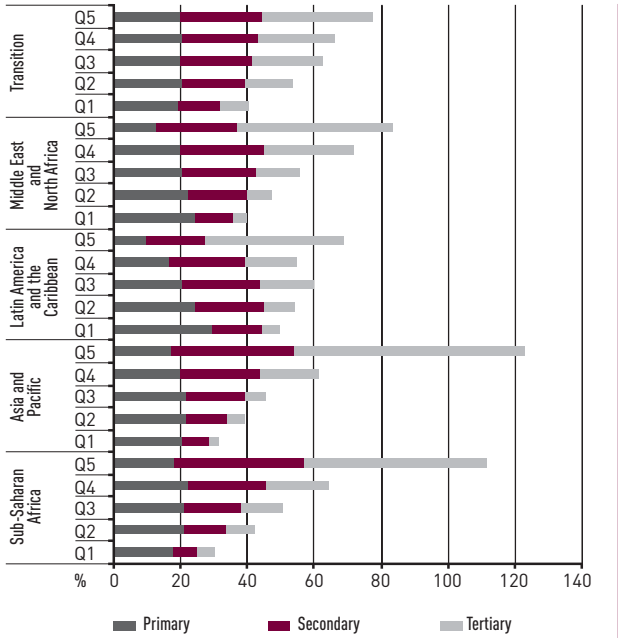
Other barriers include the nature and quality of services. In education, the content of the curriculum and language of instruction, teacher-pupil ratios, and the quality of teachers and facilities, for example, affect attendance, learning

outcomes and subsequent employment opportunities. The school curriculum is often irrelevant to the needs of poor and marginalized sections of society,[9] while gender stereotyping in content often denies girls access to the same subject choices as boys.[10] In multi-ethnic or multi-linguistic environments, the designation of a national language on grounds of creating ethnic or linguistic unity or shared cultural values often provokes resistance and places minority groups at an even greater disadvantage in accessing education.[11]

Recent policy trends have weakened universalist principles

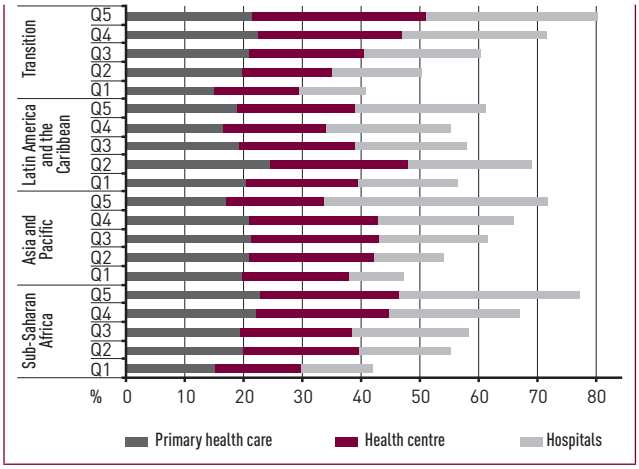
As the rest of this chapter shows, the policy trends affecting mechanisms of delivery and financing of social services in recent decades have generally weakened universalist principles and outcomes. Even where policy objectives are pro-poor and aimed at broadening coverage and reducing exclusions, the strategies may still be at odds with the principles of universalism. Benefit incidence analyses, for example, highlight the skewed distribution of the benefits of public expenditures on education and health towards higher income groups (see figures 6.1 and 6.2). The poor benefit relatively more from investments in primary health and education, while investments in basic services also demonstrate higher rates of return. Such findings have been used to justify the concentration of public spending in these sectors. However, without complementary investments in post-primary education or curative care the quality of primary services and the availability of qualified personnel declines, or does not keep up with the expansion in demand. A study in India shows how a policy prioritizing primary schooling, driven by an analysis of the rate of return, resulted in the neglect of the secondary sector, the rise of for-profit schooling at all levels of education and a fragmented formal primary education system.[12] Similarly, neglect of curative health care has the greatest impact on the poor who are also susceptible to non-infectious diseases but are unlikely to have access to private sector treatment. In addition, the separation between the public and private sectors that results from an orientation towards public spending on primary services undermines the redistributive benefits that a unified system can provide.

FIGURE 6.1: Benefit incidence of public spending on education in the 1990s as a percentage of total spending, by income quintiles (unweighted average)



Note: The quintiles may not add up to 100. Some countries have missing observations for the middle quintiles. Q1 refers to the poorest quintile while Q5 refers to the richest quintile. Source: Davoodi et al. 2003.

FIGURE 6.2: Benefit incidence of public spending on health in the 1990s as a percentage of total spending, by income quintiles (unweighted average)



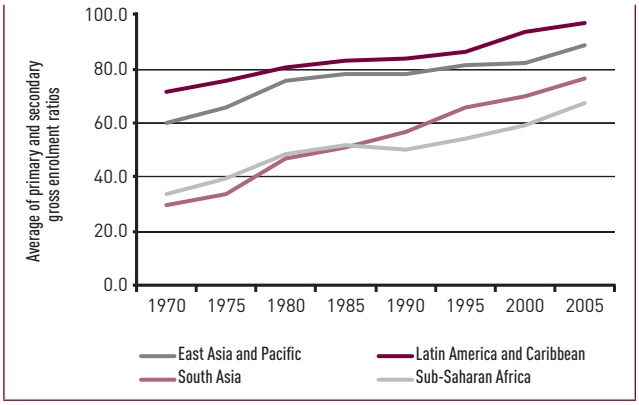
Note: The quintiles may not add up to 100. Some countries have missing observations for the middle quintiles. Q1 refers to the poorest quintile while Q5 refers to the richest quintile. Primary health care refers to one of the following categories: clinics, child health and preventive care. Source: Davoodi et al. 2003.

2. Social Services in Developing Countries: Trends and Outcomes

Social service policies have shifted dramatically over the last half century

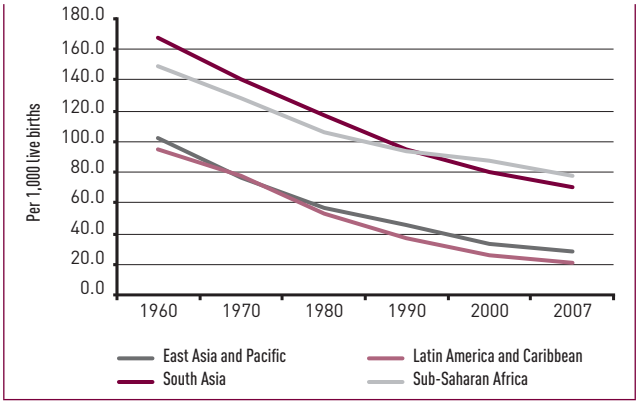
During the 1960s and 1970s, public expenditure on social services grew rapidly in many developing countries, with social policies treated as integral to development objectives of creating a modern economy, national identity and social cohesion.[13] Looking at the long-term trends, progress is visible: overall health and education outcomes have improved considerably over the last 50 years, as illustrated by increased primary and secondary school enrolment and a decline in infant mortality across all regions (see figures 6.3 and 6.4). The most significant expansion in provision took place prior to the 1980s. During this period, in Latin America, public schools, universities and health care networks expanded rapidly although coverage remained low and, until the 1980s, was concentrated in urban areas.[14] Sub-Saharan Africa also expanded public provision of education and primary health care services.[15]

FIGURE 6.3: Combined primary and secondary enrolment by region, 1970–2005



Source: UNESCO 2009b.

FIGURE 6.4: Infant mortality rate by region, 1960–2007



Source: World Development Indicators 2009.

For many countries, the crises and trends towards market liberalization from the 1980s led to severe cuts in social sector spending, with varying effects on social policies and outcomes. The international financial institutions (IFIs), notably the World Bank and the International Monetary Fund (IMF), played a major role in determining the nature of policy change during this period. Stabilization and structural adjustment programmes (SAPs) created substantial pressure for neoliberal reforms particularly in crisis-hit countries that were heavily aid dependent or indebted. In Latin America as a whole, an already moderate share of public expenditure on social services decreased further after 1982.[16] In sub-Saharan Africa, stabilization and adjustment programmes led to the "utter neglect" of public services, largely shifting the financing burden to consumers through user fees.[17] While experiences within each region varied significantly, in many countries in both sub-Saharan Africa and Latin America progress in health and education stagnated or reversed during the lost decade.

Growing evidence of the high social costs of adjustment policies[18] eventually led to their modification, with increased investment in the neglected social sectors alongside support for country-led development strategies.[19] An explicit focus on poverty reduction returned to the development

agenda of the IFIs, and was implemented through Poverty Reduction Strategy Papers (PRSPs), which had at least an implicit social policy emphasis and paid more attention to basic services.[20] By 2000, for example, the World Bank had adopted a "no blanket" policy on user fees,[21] while under the Highly Indebted Poor Countries (HIPC) initiative countries were expected to use the resources gained from debt relief for health and education purposes.

With the mobilization of the international community around the MDGs in 2000, the poverty focus of development assistance has strengthened

With the mobilization of the international community around the MDGs in 2000, the poverty focus of development assistance has strengthened and, with it, the emphasis on basic services. The MDGs contain a number of commitments in the areas of health and education and others that rely on the availability and accessibility of quality services for their achievement. They have mobilized resources and efforts around certain goals, and progress – particularly in basic education and infant mortality – has been significant, at least prior to the global economic crisis.[22] Net primary school enrolment in developing regions reached 89 per cent in 2008, with major advances in sub-Saharan Africa and South Asia, the regions that lag farthest behind; gender parity in primary education has been achieved in 60 countries. In health, deaths of children under five have declined steadily worldwide, although with slower progress in sub-Saharan Africa and South Asia. Since 1990, the percentage of births attended by skilled personnel has improved overall, from 53 per cent in 1990 to 63 per cent in 2008, although in South Asia and sub-Saharan Africa over half of all births are still unattended. The least progress was achieved in reducing infant mortality, which only declined marginally. Increased access to antiretroviral drugs and improved knowledge about preventing the spread of HIV has meant that, worldwide, the numbers of new HIV infections and AIDS deaths have peaked; there has also been a dramatic increase in the use of bed nets to protect people from malaria.

Despite positive trends, major challenges remain and have been further exacerbated by the global economic crisis. Underpinning the constraints to further progress in many cases is the lack of an integrated and universal approach to social service provision. As the discussion on commercialization below illustrates, approaches to address the needs of the poor through targeted measures in a context of inadequate public funding, supply and regulation lead to fragmented systems where certain groups are likely to be excluded or receive poor quality services. These exclusions exacerbate existing inequalities, based, for example, on gender, ethnicity, wealth or disability, and present major obstacles to universal access.

Public policies designed to reach the poorest and most disadvantaged groups, such as abolishing fees, constructing facilities in underserved areas and boosting the recruitment of teachers, can be effective.[23] But these need to be part of a broader approach. Narrowly focusing on primary education and health care in order to meet specific time-bound targets risks neglecting investment at the tertiary levels; the result is a lack of qualified personnel that, in turn, constrains quality as quantity expands. In South Asia and sub-Saharan Africa, expanded coverage without commensurate investment means overcrowded classrooms with untrained teachers.[24] Similarly, overburdened public health facilities and the poor quality of services may worsen inequality as higher income groups opt for private services, hiring tutors or buying the necessary materials or medicines that are not provided through the public systems. The poor either lack this option or face severe trade-offs over expenditure choices.[25] Effective delivery of the MDGs thus requires a holistic, sector-wide and integrated approach to the provision and financing of social services.[26]

Neoliberal shifts since the 1980s have produced a trend towards commercialization

One of the most significant trends emerging as a consequence of neoliberal policy shifts since the 1980s, which persists despite increased public investment over the past decade, has been the commercialization of social service provision. Driven by inadequate public funding and pressures to liberalize markets, commercialization processes took various forms (see box 6.1). These have included direct private-sector involvement in the financing and provision of services, the contracting-out of social service management to private providers, and the introduction of cost-recovery measures such as user fees for public services – thus increasing reliance on private insurance or out-of-pocket payments.[27] These trends compound existing problems of access to reliable and quality services by the poor, while also contributing to the fragmentation of provision.

Increasing evidence, including research undertaken by UNRISD,[28] points to ways in which commercialization can undermine effective social service provision. In many cases, accessibility, affordability and the quality of services – particularly those available to low-income or marginalized groups – has fallen, while systems of provision and financing have become fragmented among multiple providers. Often, commercialization has eroded public commitment to service provision for all, in the interests of private actors and profit. Public and community systems that charge fees in conditions of widespread poverty, for example, tend to lose their public service vocation and become semi-commercial facilities, changing the incentives and behaviours of providers. In this process, both the effectiveness and redistributive potential of the system are constrained. Where commercialization involves a mix of private services for those who can pay and public provision for the poor, the redistributive mechanisms – rather than being integral to the system – are separated out and made visible through the targeting of particular services to specific groups. This, in turn, may further fragment and weaken the system of provision.[29] These trends and consequences of privatization are illustrated by experience in the water sector (see box 6.2).

BOX 6.1: Commercializing health and education services: Four paths

There are four widely observed paths of commercialization in health and education services. First, in predominantly middle-income countries, the trend is towards privatization of public services or public-private arrangements to promote choice and competition and therefore improve efficiency. This is carried out through the corporatization of hospitals, the introduction of voucher schemes or by contracting management to private organizations that receive public subsidies. The second trend is towards commercial behaviour and cost-recovery in public services, for example, through user fees. The third trend, in low-income countries such as those in sub-Saharan Africa and South Asia, is a growing tendency towards small-scale private and largely unregulated provision. This tends to occur by default and in response to the underperformance or failure of public provision.[a] Such services are used of necessity by the poor and payments are largely out-of-pocket. Finally, commercialization (particularly in the health sector) is also driven by the globalization in input and labour markets, due to a combination of the operations of multinational companies and trade and industrial policies. Multinational companies operate in increasingly integrated markets and have played a key role in norm setting on trade in goods and intellectual property rights. In addition, international agreements, such as the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS), introduce product patents, increase the power of transnational firms and restrict access to generic drugs in poor countries.[b]

Notes: [a] UNESCO 2009a. [b] Mackintosh and Koivusalo 2005.

BOX 6.2: Policy challenges in the provision of clean drinking water

The provision of safe drinking water can yield dramatic improvements in health and well-being. When combined with other interventions, the benefits are multiplied. Water is a basic necessity, and ready access to it can save household members several hours a day – time that could be used for education or income-generating activities. Yet in spite of these enormous benefits, 1.1 billion people worldwide still lack access to safe sources of water. One result is that 3,900 children die each day from water-related diseases.[a] The MDGs aim to halve, by 2015, the proportion of the population without sustainable access to safe drinking water. The world is on track to meet the target, although many countries still face steep challenges. Of people who lack access to clean water, 84 per cent live in rural areas.[b]

Since the 1990s, private sector participation in the water sector has increased, albeit erratically, in response to rising public sector deficits and problems of infrastructure maintenance as coverage expanded. A key message of the World Bank's *World Development Report 1994* was that the private sector should be involved in the management, financing and ownership of infrastructure. Reforms were intended to reduce deficits, improve coverage, increase efficiency and reduce political influence. Consequently, between 1990 and 2005, 55 countries introduced some form of private sector participation in the water sector.

In analysing this trend, research conducted by UNRISD[c] and others reveals a number of problems, particularly in terms of access and affordability. The private sector has not necessarily invested more than the public sector, and improved efficiency (where it exists) has not resulted in lower tariffs (as shown in studies from countries including Burkina Faso, Colombia and France). In addition, the poor have been disproportionately affected by private sector provision, as they tend to have less access to services and to spend a larger share of their income on water. The pace of privatization has been slow and, since 2002, multinational companies have begun to withdraw from developing countries. Consequently, the World Bank has recognized the difficulty of getting "the private sector to focus on the alleviation of poverty and to design tariffs in a way that does not discriminate against the poor".[d] It has acknowledged that public funding will continue to be important and shifted its policy stance from reliance on the private sector to encouragement of public-private partnerships.

The UNRISD research suggests that social policies and public sector investment have been instrumental in ensuring access to the majority. The policies employed include income support linked to welfare systems; tariff adjustment; a fund for rural supply; and policies to ensure that households are not disconnected due to non-payment. For example, increasing block tariffs, where water rates adjust according to usage, are popular in many developing countries. Subsidy schemes to the poorest households are used in many Latin American countries and even France has provided subsidies to rural areas. The state's role in mobilizing investments has also been significant. Although initial construction is often largely initiated by the private sector, public investment is necessary to secure improved supplies, particularly to the poor.

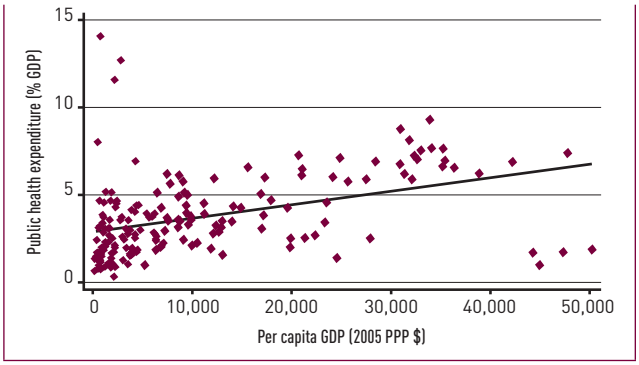
Notes: [a] WHO and UNICEF 2004; WHO 2007. [b] United Nations 2009. [c] Prasad 2008. [d] Prasad (2008:16), citing *Implementing the World Bank Group Infrastructure Action Plan*, 13 September 2003:25.

Underfunding and commercialization can have negative consequences for health and education

Consequences for health

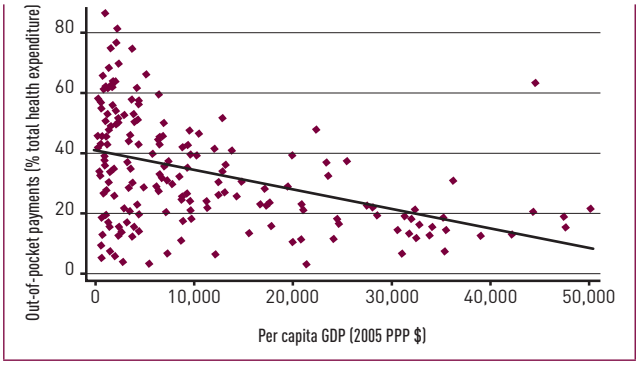
The commercialization of health services has been more prevalent in lower than higher income countries, where it is clearly associated with worse access and inferior outcomes.[30] Overall, public spending on health as a percentage of both total health expenditure and gross domestic product (GDP) are positively correlated with per capita income. Socialized medicine, that is, health care that is free at the point of use and financed by general taxation or social insurance, is more commonly found in wealthier countries (see figure 6.5). Conversely, private spending, as a percentage of total health expenditure, is higher in low-income countries and among lower income groups. Low-income populations are most likely to face the most poverty-inducing form of health financing: out-of-pocket payments (see figure 6.6). For 5.6 billion people in low- and middle-income countries, over half of health care spending is through out-of-pocket payments, and over 100 million people are pushed into poverty each year because of catastrophic health expenditures.[31]

FIGURE 6.5: Public expenditure on health as a percentage of GDP and per capita GDP, 2005–2006



Source: World Development Indicators 2009.

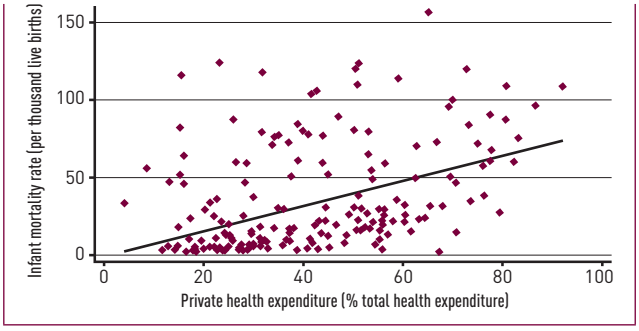
FIGURE 6.6: Out-of-pocket health expenditure as a percentage of total health expenditure and per capita GDP, 2005–2006



Source: World Development Indicators 2009.

Countries with lower levels of commercialization and higher public expenditures or social insurance demonstrate better health outcomes. Infant mortality rates tend to be lower and life expectancy higher in countries with lower ratios of private to public health expenditure (see figure 6.7). Similarly, countries that spend more of their GDP on health through public expenditures or social insurance have significantly better health outcomes and better care at birth (as measured by life expectancy, infant mortality and births attended by skilled personnel).

FIGURE 6.7: Infant mortality rate and private expenditure on health as a percentage of total health spending, 2005–2006



Source: World Development Indicators 2009.

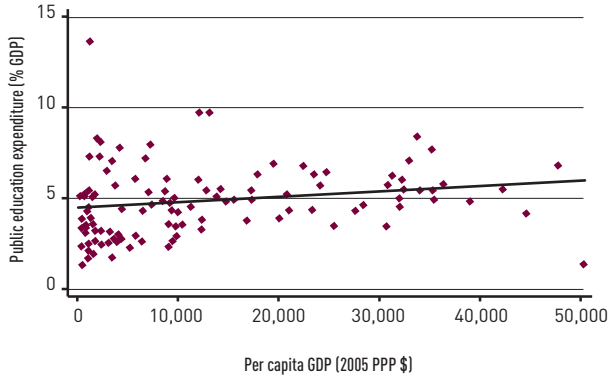
The proportion of hospital beds and use of ambulatory care in the public and private sectors in developing countries suggest that primary care provision (even if nominally public) is highly commercialized, while hospital and in-patient care is not.[32] As a result, the poor are in fact more likely than the better-off to depend on private (that is, often informal, small-scale and low quality) providers that charge modest fees and lack government support and regulation.[33] In terms of insurance, however, UNRISD research[34] shows that higher levels of commercialization of primary health care and private insurers are associated with greater inequality in treatment among income quintiles and greater exclusion of children from treatment when ill. In almost all 44 developing countries with data analysed, more than half of children treated for acute respiratory infection or diarrhoea were treated privately.

The motivations behind the introduction of fees and charges, and thus the push towards commercialization of services, included cost-recovery, revenue raising, greater efficiency through competition among providers, and instilling in recipients a greater sense of value for services obtained. In general there has been a failure to achieve these aims due to flawed assumptions about how markets work. Nor have complementary targeted forms of assistance or exemption mechanisms, designed to improve the access of marginalized groups to services in a context of commercialized provision, been effective in increasing coverage due to supply constraints, inadequate resources, high administrative costs, leakages and stigma (see chapter 5). Overall, in the health sector, the commercialization of services can thus be viewed as "an affliction of the poor".[35]

Consequences for education

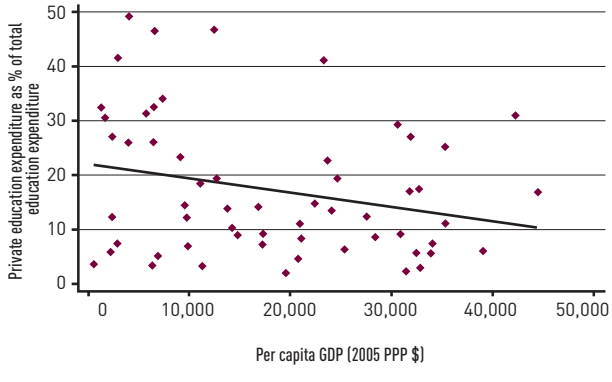
In terms of education, there is greater consensus that the government has a responsibility to provide all children with quality education free of charge, at least at the primary level.[36] In most countries, public expenditures continue to dominate educational provision and financing, although many instances exist of public-private partnerships. However, user fees and other charges also persist, affecting the accessibility and affordability of education. The correlation between per capita income and public spending on education as a percentage of GDP is positive but weak (see figure 6.8). However, as in health, commercialization of education afflicts the poor, with a higher share of private expenditure in countries with lower incomes (see figure 6.9). The average share of private financing in education is much lower than in health: 18 per cent in education versus 42 per cent in health. In the majority of countries, private financing in education is less than 15 per cent of the total, and only five countries (Chile, the Dominican Republic, Guatemala, the Philippines and the Republic of Korea) have levels above 40 per cent.[37]

FIGURE 6.8: Public expenditure on education as a percentage of GDP and per capita GDP, 2005–2006



Source: World Development Indicators 2009.

FIGURE 6.9: Private expenditure on education as a percentage of total education spending and per capita GDP, 2005–2006



Source: World Development Indicators 2009.

As in health, commercialization of education afflicts the poor, with a higher share of private expenditure in countries with lower incomes

The provision of private education, measured by the percentage of the population enrolled in private institutions, displays a large variation among countries, though it is not related to income level. As an average of primary and secondary enrolment, almost half of all countries have a percentage of private enrolment of less than 10 per cent. However, this figure is over 50 per cent in 13 countries, including Chile, Fiji and Zimbabwe. On average, private financing, as a percentage of GDP, is slightly higher in secondary than in primary education, and private provision is more extensive in secondary education.[38] Combined gross enrolment is slightly higher in countries with less private education financing and with higher levels of public spending. However, the relationship between public spending and student performance is, at best, weak, since poor learning outcomes and high levels of inequality are possible at low, medium and high levels of public spending.[39]

As in health, mixed public-private provision and financing often results in high-cost social service systems that are socially polarizing. Although mixed approaches can improve educational quality through choice and competition under certain conditions, they also have the potential to reinforce inequality. Choice is often constrained by a lack of purchasing power, limited access to information and, in many instances, by a lack of provision. Where schools are able to select students based on ability, disadvantages arising from characteristics such as income or ethnicity may be magnified. In Chile, which operates a voucher programme, student composition differs between public and private sectors with voucher schools outperforming public schools.[40] In other words, the system channels public resources to private schools that are able to select the most competent and well-off students. Comparably, in the health sector, private insurers are able to cherry-pick, insuring only the lowest risks and leaving higher cost patients to the public sector.

Commercial activity by public education institutions, such as cost-recovery and user fees, remains prevalent in many developing countries, driven by underfunding and poor regulation. Charges may include fees for uniforms, books, materials, medicines and parental contributions, as well as compulsory in-kind contributions, including for school construction and repairs. As in health, such fees were introduced under erroneous assumptions about the nature of the market for such services: that cost-recovery would limit "frivolous use",[41] raise revenues and improve equity, efficiency and quality. Evidence from sub-Saharan Africa illustrates, on the contrary, that pre-existing barriers to access resulted in serious underuse of services, with user fees only adding to these barriers.[42]

These trends arising from commercialization and underfunding in both the education and health sectors serve to worsen pre-existing disparities in quality as public services are further overburdened. Trained personnel, who are attracted by better pay and working conditions, tend to move from the public to the private sector, thereby reinforcing the trends towards commercialization and further reducing the quality of public sector provision.

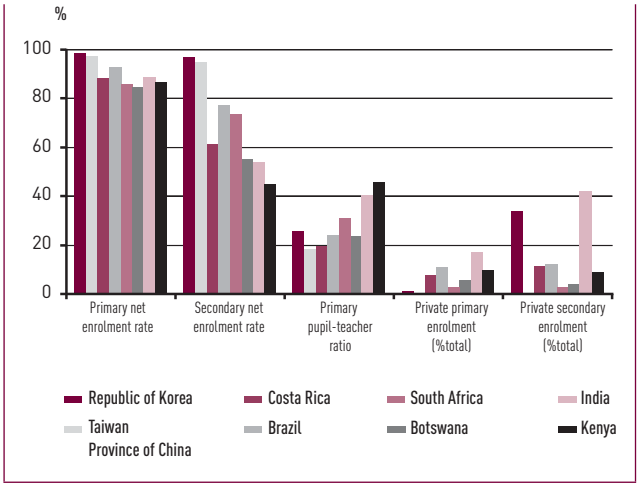
In both health and education, commercialization and underfunding worsen pre-existing disparities in quality as public services are further overburdened

3. Social Service Provision in Different Development Contexts

Countries vary widely in their systems of social service provision

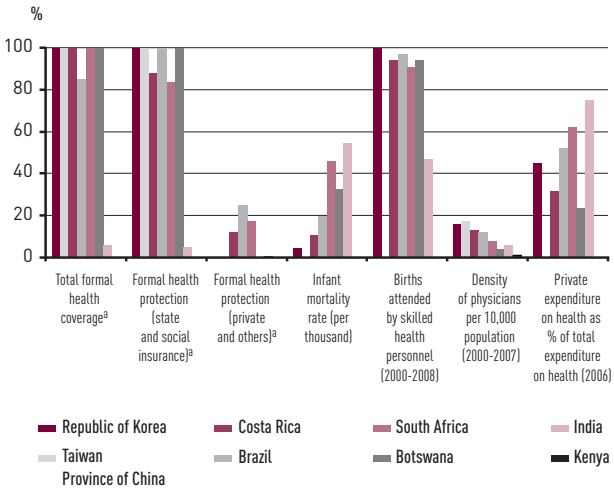
As argued above, underfunding and commercialization are serious obstacles to the universalization of social services. Nonetheless, countries and areas exhibit considerable variation in their systems of provision. This section highlights three broad approaches based on case studies commissioned for this report. Countries and areas are grouped in terms of health coverage, educational enrolment, educational quality and the roles of different actors in provision (see figures 6.10 and 6.11). Along these dimensions, Costa Rica, the Republic of Korea and Taiwan Province of China lean strongly towards universalism; Botswana, Brazil and South Africa are also oriented towards universalism, but entrenched economic dualism produces what can be described as fragmented universalism; and Kenya and India display high levels of fragmentation and exclusion, despite some commitment towards universalism.

FIGURE 6.10: Educational system and outcomes in eight case study countries/areas



Note: Latest year (since 2000); Costa Rica (net attendance ratio between 2000 and 2007). Source: UNESCO 2009b; Directorate General of Budget, Accounting and Statistics, Executive Yuan, Taiwan Province of China 2007.

FIGURE 6.11: Health systems and outcomes in eight case study countries



Note: Formal health coverage includes state, social, private and mutual health insurance schemes; Taiwan Province of China data from 2006. [a] From 2000 to 2007. Source: Directorate General of Budget, Accounting and Statistics, Executive Yuan, Taiwan Province of China 2007; ILO 2008c; WHO 2009b.

Leaning towards universalism

The Republic of Korea, Taiwan Province of China and Costa Rica show significant variation in terms of the public-private mix in financing and providing social services. However, in all three cases, the state plays a significant role in ensuring universal provision. Notably, social policies are well supported by other economic policies that reinforce social investments. These countries and areas progressively expanded coverage alongside the introduction of complementary policies to ensure that marginalized groups were able to benefit from a universal approach.

Republic of Korea and Taiwan Province of China. The provision of education and health care in the Republic of Korea and Taiwan Province of China is based on a strong state regulatory role and bureaucratic capacity, under a mixed public-private system of financing and provision. Interventions in health and education are enhanced by complementary policies: for example, in the Republic of Korea, relatively low levels of income inequality have reduced income constraints among the poor, thereby contributing to equal access to primary and secondary education.

In addition, the early establishment of sectoral occupational welfare programmes, such as health insurance and pensions for personnel in both public and private schools, reduced the incentive for skilled staff to move to the private sector and thus maintained quality in public education.

Education has been a particular priority in both these cases, receiving significant public investment as a contribution to economic growth. In the early stage of industrialization, investments to improve productivity in labour-intensive sectors pushed up enrolment and completion rates in both primary and secondary education; with the shift to higher value added sectors in the 1970s and 1980s, these gains were also secured in tertiary education. The high enrolment ratios for the Republic of Korea can be seen in figure 6.10, with levels well above 90 per cent in primary and secondary education. Primary education is almost exclusively provided by the public sector (only 1.3 per cent of students are enrolled privately); secondary and tertiary levels are characterized by a higher share of private provision (33.5 per cent in secondary education). Since the 1970s, the Korean government has subsidized private schools.[43] Private financing is, however, substantial, accounting for 40 per cent of total expenditures on education.[44] The strong quest for education among the country's population, along with government subsides, has allowed a profitable private education business to flourish and tended to equalize the quality of education in both public and private institutions. In Taiwan Province of China, public schools dominate both primary and secondary education. Although private institutions account for about half of the total senior high schools and universities, the government's tight control on tuition fees has contributed to keeping education affordable.

The delivery of health care in the Republic of Korea and Taiwan Province of China is highly commercialized.[45] In 2007, the private sector accounted for more than 93 per cent and 97 per cent of medical facilities in the Republic of Korea and Taiwan Province of China, respectively,[46] with hospitals and clinics largely privately owned. Significant government involvement and bureaucratic capacity resulted in the introduction of health insurance schemes in both places in the late 1980s and early 1990s, coinciding with democratization and increased concerns with equity. In the Republic of Korea, health insurance schemes were established in 1977. Initially they included only formal sector employees, but coverage was progressively expanded. In 1987, the new democratic government announced its intention to establish universal national health insurance, and within two years coverage had increased from less than 51 per cent of the population to over 94 per cent.[47] Separate health insurance schemes were integrated and coverage increased, thereby enabling cross-subsidization and redistribution. However, in spite of universal social health insurance coverage, out-of-pocket payments remain substantial, accounting for around 50 per cent of total health expenditures (see chapter 5), with implications for equity. Similarly, Taiwan Province of China established a universal national health insurance programme in 1995, just a few years after the democratic government declared its intention to do so.[48]

Costa Rica. Costa Rica has achieved impressive outcomes in health and education, particularly primary education. The state took responsibility for financing and delivering social services, achieving increased coverage and a significant distributional impact. This was complemented by programmes to improve income distribution, including increasing real wages and providing universal social protection (see chapter 5).

> *In Costa Rica, the state took responsibility for financing and delivering social services, and it has achieved impressive outcomes in health and education*

The process of universalizing education in Costa Rica started early. Beginning in the 1940s, public education was conceived as an integrated system from preschool to university with free primary and secondary education. Coverage, especially of secondary education, was progressively expanded

with particular efforts focused on rural areas and marginalized groups in order to reduce disparities. Economic crisis in the 1980s halted and even reversed the gains, especially in rural areas, as public spending on education was cut by 44 per cent between 1980 and 1985.[49] Educational quality also diminished, since wages and investment in infrastructure were cut and school duration reduced. Subsequently, spending levels were restored and efficiency improved, leading to a revival of coverage gains. Disparities in education among various income groups persist, however, and are more significant than gender disparities or those between rural and urban areas. A number of policies have been introduced to address this: a programme targeting urban schools aims to improve educational quality for low-income families, and a universal school lunch programme was introduced to encourage school attendance. Due to limited resources, geographic targeting of the school lunch programme was introduced in the 1980s; data on coverage show that it is successfully reaching poor children.[50]

In the health sector, the Costa Rican Social Security Fund (CCSS) was established in 1941 to provide health insurance (with tripartite funding from employees, employers and the state), initially for employees in urban centres. It gradually expanded to cover family members, independent workers and lower income groups. In 1961 the constitution was amended to achieve universal health care within 10 years. The range of services provided by the CCSS and contribution ceilings were expanded, and private providers were replaced by services provided directly by the CCSS through professional staff graduating from the School of Medicine at the University of Costa Rica, founded in 1960. Primary health care programmes, such as malaria eradication and rural health care, achieved an impressive level of coverage, leading to dramatic improvements in health. By the 1970s, health indicators were similar to those of developed countries, demonstrating the success of public health policies and of low-cost, efficient technologies. The improvements in health indicators were most pronounced among low-income populations.[51]

The crisis of the 1980s led to decreased resources, but halted rather than reversed achievements in health in Costa Rica. The state maintained a dominant role: in 1986, the private sector accounted for only 2 per cent of hospital beds and 3 per cent of discharges.[52] From the 1990s, the Ministry of Health took on more of a supervisory role, with delivery increasingly the responsibility of the CCSS. Increasing labour market informality (though lower than in other Latin American countries, as discussed in chapter 5) led to decreases in health care coverage. However, the government introduced voluntary insurance that, in 2006, became mandatory for the self-employed. Partly as a result of these policies, the level of health care coverage reached 89 per cent in 2008.[53]

Fragmented universalism

Countries that exhibit fragmented universalism are typically characterized by a dualist economic structure, with a large share of the population excluded from the formal labour market and thus formal social provisions. In states such as Brazil and South Africa, government policies aimed at expanding access to social services, particularly in rural areas, have often been successful in achieving near universal coverage with impressive gains in basic health and education. However, trends towards commercialization in the context of high income inequalities and a large informal sector have resulted in polarized service provision segmented between a high-cost private sector and lower quality public services. With the policy shift of the 1980s and 1990s towards privatization, public funding shifted to targeted subsidies or social assistance to the poor, further contributing to the underfunding of public facilities.

Brazil. In Brazil, education and health systems have different historical trajectories. The education system, which owes its origin to the first Republican Constitution of 1891, is nationally regulated and highly decentralized in terms of funding and provision. A national education policy of eight years of free basic education became institutionalized after the revolution of 1930 that centralized state power and propelled the country towards rapid modernization and industrialization. However, the health system remained fragmented and unregulated until the late 1980s, when a national health system was created. Overall, the democratic constitutional reforms of the 1980s

pushed the country towards more universal provision of health and education services.

For much of the post-war period, Brazil's health sector was characterized by a dualist structure that largely benefited formal sector urban employees. The institutional structure for health provision was segmented, with a limited public health system, some medical assistance for formal sector employees, and extensive private provision. Medical assistance coverage was extended to rural workers, domestic workers and those in the formal sector in the 1970s, paving the way for a universal health service in the 1980s.

A unified health system that is highly decentralized was introduced following democratization in 1985. The universal health policy was driven by a national coalition of expert activists with roots in social movements. Under the new system, the public sector can contract private health care providers for certain services, and individuals and enterprises can have their own private health insurance plans.[54] The publicly financed system pays for public health services, as well as reimbursing services provided privately in cases where no public services are available.[55] The target population totals approximately 140 million, with 40 million of those covered by the private sector. A second wave of reforms in the 1990s sought to improve the financial base and redistributive impact of the public system as well as strengthen regulation of private provision. Observers note improvements in health indicators, such as in infant and maternal health.[56] The number of births attended by skilled personnel is approaching 100 per cent and the infant mortality rate is fairly low at 20 per 1,000 live births in 2007 (figure 6.11). Surveys comparing São Paolo (one of the richest regions) and the northeast (the poorest) suggest that although the number of people claiming to have regular health services has improved for all income quintiles in both São Paolo and the northeast, the two regions are still very unequal.[57]

Despite the provision of free public education for the first eight years of schooling before the transition to democracy, more than 50 per cent of those enrolled in the first grade were obliged to repeat and many dropped out of school after the second grade. Almost 50 per cent dropped out before completing all eight grades. Since democratic reforms, Brazil's education sector has also expanded coverage. Near-universal access to primary education was achieved in the second half of the 1990s, largely as a result of successful reforms of primary education funding.[58] Tertiary enrolment was promoted by substantial subsidies in the 1980s (the highest in the world) that largely benefited the rich. In spite of considerable progress, educational opportunities were concentrated in industrialized regions of the country, while the northern and northeastern regions faced a lack of schools and resources. Education reforms in the last two decades have focused on reducing inefficiencies, resulting in impressive improvements in public education.[59] Net primary enrolment is approaching 100 per cent and net secondary education is nearing 80 per cent (figure 6.10).

> *In Brazil, education reforms over the last two decades have focused on reducing inefficiencies, resulting in impressive improvements in public education*

Public financing for education in Brazil comes from two sources – general taxation and an education salary fund raised through contributions by businesses as a percentage of wages. Educational provision is mostly public at the pre-school, primary and secondary levels (accounting for 73 per cent, 91 per cent and 86 per cent, respectively, of schools), while higher education is largely private (67 per cent).[60] The Fund for the Development of Primary Education and Teacher Development (FUNDEF) was created in 1996 to reduce large regional inequalities in per student funding by redistributing resources from richer to poorer areas. Despite considerable improvements, inequalities remain a challenge. The average number of years spent in school for 25-year-old Brazilians varies significantly by income group – from 4.3 years in the poorest income quintile to 10.3 years for the richest quintile. Inequality becomes more significant beyond basic education. The relatively poor region

of Alagoas had a gross enrolment rate of 95.9 per cent for the 7–14 year age group, and 76 per cent for the 15–17 year age group, whereas São Paulo had rates of 98 per cent and 87 per cent, respectively, in 2008.[61]

The social policy innovations in Brazil have been impressive in both their number and coverage, and include Bolsa Familia, as well as the National Fund for the Maintenance and the Development of Basic Education (FUNDEB) and the Family Health Programme. In particular, the increasing centrality of conditional cash transfers has received international acclaim. However, research suggests that there is not much difference in school attendance between beneficiaries and non-beneficiaries of Bolsa Familia.[62] Bolsa Familia is more successful in improving incomes than in expanding educational enrolment.

South Africa. In South Africa, the 1994 post-apartheid state inherited an education system that was characterized by significant inequalities in quality and attainment – the result of the highly unequal allocation of resources. Education was one of the major concerns of the African National Congress, and it immediately sought to tackle inequalities by integrating regionally segregated education departments into one national system. It also made education compulsory until grade nine and reallocated funding from formerly white schools to formerly African schools. The result was an equalization of funding: the share of funding for African pupils increased from 58 per cent in 1993 to 79 per cent in 1997.

South Africa is characterized by fairly high levels of public spending on education, with over 5 per cent of the country's GDP allocated to that sector, financed from general taxation. Net enrolment exceeds 80 per cent at the primary level and 70 per cent at the secondary level (see figure 6.10). Differences in attendance among groups are marginal, but large inequalities in educational quality and outcomes persist, leading to the continued correlation between ethnicity and attainment.

These inequalities can be attributed to a legacy of skewed resource allocation during the apartheid era, in combination with cost-recovery arrangements, which enable schools in richer neighbourhoods to charge fees, which are not regulated, and use the funds to appoint additional teachers and improve facilities. The government has made efforts to target the poor, for example through fee-free schools, which account for 40 per cent of all schools, and the National Schools Nutrition Programme, which fed 1.6 million primary school children in 2007. However, such schemes have not been able to resolve imbalances in the quality of education. Deeply entrenched social and economic inequalities lock many children from black, poor and rural households, who attend badly equipped public schools in poor neighbourhoods, into an underclass in post-apartheid South Africa.[63]

> *In post-apartheid South Africa, deeply entrenched social and economic inequalities lock many children from black, poor and rural households into an underclass*

Health care reform in the late 1980s led to a shift from a regionally and racially segregated system to a public-private dual system, with access dependent on ability to pay. South Africa has an impressive public health system. The majority of the population has access to basic health care through public facilities that charge user fees varying by region.[64] The minority (17 per cent) are covered by high-quality, expensive, private insurance funded through various medical schemes for mainly formal sector workers. Levels of immunization and births attended by skilled personnel are high (see figure 6.11).

While access to health care is not significantly affected by income, the quality of provision is, with the poor overwhelmingly using underresourced public services, whereas the rich opt for private ones. Regional inequalities also exist, since provincial legislatures determine health budgets: public health expenditures per capita have declined in some regions.[65] Despite the fact that the high burden of

disease in South Africa – particularly of AIDS – requires more inputs than in countries with a similar income, the initial neglect of the problem by the government exacerbated the health crisis, leading to severe criticism and protest from civil society and affected communities. This policy neglect is now being addressed and important steps are being taken to combat the disease. In addition, a new national health insurance programme, funded by general taxation and a dedicated payroll tax for the formal sector, is expected to be operational by 2010. It is estimated that the programme will increase the total health budget by 40 per cent and address the lack of funds for the public sector.

Botswana. Botswana has achieved impressive outcomes in health and education. Not surprisingly, the country has one of the most developed social service systems in Africa, largely as a result of successful resource mobilization from mineral rents. The government spends slightly more than 9 per cent of its GDP on education and more than 40 per cent of its total current government spending on social services. Since independence, the government has been the main provider of education and health services, with only limited community or private sector involvement. Botswana has also introduced a social pension, which directly benefits education, since a strikingly high percentage of household income is spent on schooling expenses.[66] However, since the 1980s, there has been a shift towards privatization and decentralization, with the government playing the role of facilitating community and private sector efforts to provide social services and the introduction of cost-recovery measures in health.

In education, substantial government investment and policies to remove barriers to access have dramatically improved outcomes. In the 1980s, primary and secondary school fees were abolished, with subsequent improvements in enrolment. Other schemes, such as school feeding and rural development programmes, were introduced to improve access by marginalized groups. Consequently, net primary and secondary enrolment have reached about 80 per cent and 60 per cent, respectively, and literacy is around 80 per cent (see figure 6.10). However, inequalities based on geographic location persist, partly as a result of a lack of trained teachers in rural areas. User fees, which were reintroduced in 2006, and a growing tendency towards private education are likely to further disadvantage poorer groups. Schools where the language of instruction is the native Tswana tend to be of poor quality compared to schools with English as the medium of instruction, which target higher income groups.[67]

> *Botswana has one of the most developed social service systems in Africa, largely as a result of successful resource mobilization from mineral rents*

In the health sector, a state-led and -financed policy from the 1960s succeeded in achieving virtually universal access to primary health care. The percentage of births attended by skilled personnel is over 90 per cent, and substantial improvements have been made in the infant mortality rate, which stood at around 30 per 1,000 live births in 2007 (see figure 6.11). A network of health facilities was established and run by the government with significant public investment. The initial emphasis was on creating a clinic or health post in every village. Consequently, by the mid-1980s, more than 85 per cent of the population were within 15 kilometres of a health facility.

In the 1980s and 1990s, the private sector played an increasingly important role in broadening the choice of facilities and reducing the burden on government services. User fees were introduced, with exemption mechanisms for low-income groups. In spite of the shift to increased private-sector participation, the share of private health care in total health expenditure is only 23 per cent. Thus, health and education provision in Botswana is less fragmented than in Brazil and South Africa. Formal sector employees are able to access higher quality private care, largely in urban areas, with shorter waiting times than overcrowded government hospitals. The AIDS epidemic poses considerable challenges in Botswana, and in the 1990s and 2000s has

resulted in a reversal of previous gains in health. However, the government provided free treatment to those living with HIV or AIDS, irrespective of social and economic status, ethnicity or gender.

Fragmented and exclusionary systems

In a large number of countries, social service provision is fragmented and exclusionary. This is often the case in low-income agrarian economies, where a large share of the population may lack access to public services. Many of these countries are aid dependent, and consequently have come under donor pressure to reduce social expenditures and shift the burden to consumers, largely through cost-recovery measures. Reduced public spending has tended to diminish availability of services, particularly in rural areas. Insufficient investment in personnel, infrastructure and materials has led to a decline in quality, exacerbated as trained staff move to the private sector or abroad, where working conditions are better. Although the state remains the main provider, social services have been increasingly commercialized, with the emergence of informal, small-scale providers in response to demand from both rich and poor for better availability or quality of public services.[68] A dual system of health and education provision has thus developed, consisting of "an underresourced and neglected public sector, and a private sector"[69] that is unregulated and may also be of poor quality. Payments for health care are largely out of pocket and user fees or other informal charges in education increase barriers to access and raise inequality.

Kenya. In Kenya, SAPs led to the introduction of cost-sharing measures and constrained spending on social services. Real expenditure on basic services as a proportion of government spending fell from 20 per cent in 1980 to 12.4 per cent in 1997.[70] As a result, low-income populations tend to have access only to poor services that they can often ill afford, whether through the public or private sector.

In the early post-independence period, the Kenyan government aimed to improve both coverage and access through free health services. Progress was tremendous, with life expectancy rising from 44 years in 1962 to 60 in 1993, and infant mortality falling by one-third between 1963 and 1987.[71] Although public spending was reduced and user fees introduced between 1989 and 2004, the state has remained the main funder of the health sector, contributing over 50 per cent. However, the government has commercialized the operation of some of its facilities, which has led to disparities of access and problems of affordability for the poor. Trained staff move to the private sector or run private clinics within, or in parallel to, public facilities, sometimes siphoning off public resources for private practice.[72] Health expenditure has largely been skewed against poor rural areas: 80 per cent of the population receives only 20 per cent of health expenditures.[73] Although subsidized health programmes have been introduced, even these are unaffordable for many households.

> *In a large number of countries, often low-income agrarian economies, social service provision is fragmented and exclusionary*

Kenya's PRSP for 2001–2004 prioritized rural and preventive health to address inequalities. However, in addition to poor distribution, the health sector still receives insufficient funding to achieve international commitments, including the MDGs: public health expenditures in 2006 were 2.2 per cent of GDP. This translates into per capita spending of $6.40 – far short of the World Health Organization (WHO) target of $34.

Kenya places a high premium on education, particularly higher education. This need was particularly pronounced in the immediate post-independence years, as the country struggled to fill a large skills gap.[74] School enrolment increased dramatically from 1970: primary gross enrolment increased from 61.7 per cent to 105.9 per cent in 2006; similarly, secondary gross enrolment rose from 9 per cent to 50.3 per cent in this period.[75] Gender equality also improved. Although public spending on education initially

increased substantially, the SAPs of the 1980s reduced funding and brought in cost sharing. The government met the costs of salaries, administration and some financing of infrastructure, while parents were required to pay tuition fees and textbooks, and communities contributed to school infrastructure and maintenance.

Many households were unable to meet education costs, and there was a subsequent decline in primary and secondary enrolment in the early 1990s, as well as very high drop-out rates.[76] In addition, the quality of education declined and facilities proved to be inadequate. The target pupil-teacher ratio of 40:1 is yet to be attained and varies by region, from 35:1 to 70:1. Moreover, less than 50 per cent of pupils enrolled in primary education complete their schooling, although the situation has been improving. Government commitment to full primary education has been a positive development, but there has been no programme for ensuring continuation into high school, which affects the poor most severely. Targeted programmes to improve educational access have been introduced, such as school feeding programmes that focus on poverty-stricken regions as well as the provision of textbooks and scholarship funds. However, these schemes serve less than a quarter of those in need and the poor often cannot afford even subsidized services.[77]

India. India's recent growth acceleration has not translated into substantial improvements in the provision of basic social services.[78] The levels of public expenditure on health (about 1 per cent of GDP) and education (about 3.5 per cent of GDP) are very low for the country's per capita income. Low public funding, preference for higher education and curative medicine over primary education and public health, and an extensive and largely unregulated private sector have produced a highly segmented regime of social service provision.

At independence, the Indian nationalist movement, through the Bhore Committee report, had committed itself to building a welfare state that would provide health services to all citizens irrespective of ability to pay.[79] However, private provision, including private practice by government doctors, was widespread even before independence and proved difficult to control. Studies suggest that private sector provision of health is among the highest in the world.[80] The share of private provision in primary care rose from 74.5 per cent to 78 per cent in rural areas between 1986/1987 and 2004, and from 73 per cent to 81 per cent in urban areas over the same period;[81] private hospital care rose from 40 per cent to 58 per cent in rural areas and from 40 per cent to 62 per cent in urban areas over the same period. Primary health care accounts for less than 0.5 per cent of total public health spending. Out-of-pocket payments account for over 85 per cent of all health expenditures.

The current health system is unable to deliver standard services to the vast majority of citizens, and is characterized by problems of underinvestment, poor maintenance, poor equipment, low-quality personnel and considerable distance to facilities for much of the population.[82] The under-five mortality rate (87 per 1,000 live births) and infant mortality rate (63 per 1,000 live births) are higher than the world average, and the country's percentage of underweight children is also high for its level of per capita income. The proportion of births that are attended by skilled personnel is only 47 per cent, and 35.6 per cent of villages have no health centre within five kilometres.

A National Rural Health Mission (NRHM) scheme was launched in 2005 to reduce the rates of infant and maternal mortality, universalize access to public health services and promote indigenous systems of medicine by the year 2012. The NRHM focused on 18 states with weak public health indicators. Although it is too early to evaluate the impact of the programme, reports from the field and the Ministry of Health's own evaluations show that its most important achievements are the institutionalization of deliveries and the expansion of immunization coverage. The programme seems to have had limited impact on other aspects of care, such as full antenatal care. While institutional deliveries have gone up substantially in all major states in which the programme is operating, full antenatal coverage has not improved in most of them and immunization coverage has improved in only five.

In the field of education, universalization of primary education has been one of the important goals of India's development objectives.[83] Unlike health, education (especially primary education) is still largely publicly provided. Eighty-five per cent of primary schools are managed by central (43 per cent), state and local (42 per cent) governments. However, the private sector accounts for 40 per cent of secondary school enrolment. The National Education Policy Statement of 1968 emphasized free and compulsory education for all at the primary level, better status and emoluments for teachers, equalization of educational opportunities, support for vocational education, and allocation of 6 per cent of GDP to education. This policy of universalism was reinforced in the New Education Policy of 1986, which called for a reduction of inequalities in educational opportunities for women and disadvantaged castes.

However, improvements in educational indicators have been less spectacular than shifts in policy. Public expenditure on education steadily rose from 0.5 per cent of GDP in 1950–1951 to 2 per cent by 1970 and to 3 per cent to 4 per cent at present, which is still well below the 6 per cent target. Net primary enrolment is reported to be over 80 per cent, and net secondary enrolment is around 50 per cent, although studies indicate that national data may be overestimated and regular attendance levels may be lower.[84] Data for 2005 suggest that 29 per cent of pupils in grade one through eight drop out of school.[85]

Health and education expenditures and outcomes vary considerably across Indian states. States in which governmental power rests on a broad political base and that have embraced a redistributive agenda tend to perform well. The state of Kerala, for example, which is well known for high standards in the social sector, spends 40 per cent of its budget on social services, whereas the all-India average is 32 per cent. Kerala has a long history of literacy and education movements. In addition, political and social activism have been employed on occasion to keep health centres open, and elections have been won on the basis of a candidate's support for public social services.[86]

4. Providing Universal Social Services: Implications for Policy

Comprehensive provision of health care and education enhance well-being, improve productivity and income-earning potential, and reduce poverty and inequality. Underfunding, cuts in social sector expenditures and commercialization lead to segmentation, inequality and exclusion in service provision. High-quality private provision for better-off groups may coexist with low-quality services for the poor, undermining the effectiveness and redistributive outcomes of an integrated system. In addition, focusing public spending exclusively on basic social services can exacerbate inequalities: the resulting deterioration in secondary and tertiary education may lead to a decline in the number of trained personnel to staff schools and hospitals. This concluding section highlights the importance of publicly financed provision and public regulation of commercialization to achieve universal, equitable and quality outcomes.

Publicly financed systems can be affordable

Lessons from countries leaning towards universalism demonstrate the importance of substantial public involvement in ensuring that the majority have access to social services. They also show that public financing of social service provision is affordable. Domestic public financing instruments are best suited to minimize exclusion of certain groups from access, to promote the redistributive role of social service provision through progressive funding arrangements, and to strengthen links that promote democracy and social solidarity. However, as chapter 8 will show, external resources, such as aid and remittances, can complement domestic public financing, especially in low-income countries.

Problems of equity in public spending, highlighted by benefit-incidence analysis, should be dealt with through a wider distribution of social services, encompassing rural and disadvantaged urban areas. In conjunction,

policies should be introduced to alleviate the structural constraints that may impede access to universal provision. Examples of such policies include school meal programmes, subsidized transport and free medicines, either as targeted initiatives to complement universal provision or as universally provided schemes. In addition, in the case of health insurance, initiatives should ensure the coverage of the informal sector through mandatory, voluntary, free or subsidized programmes.

> *Lessons from countries leaning towards universalism demonstrate the importance of substantial public involvement in ensuring that the majority have access to social services*

In countries that have achieved high levels of success in the provision of social services, faith in trickle-down benefits from income growth was rejected and deliberate policies were adopted to support comprehensive coverage. Effective state intervention is required to maximize the synergies and complementarities among services and their links to other parts of the political economy, and to promote equity, improve coverage and avoid coordination failure. The synergies within social policy interventions can be enhanced through comprehensive social protection – grounded in claimable entitlements – covering the majority of the population, along with effective care policies. Social service provision should also be embedded in and support a broader macroeconomic policy, based on productive investment and employment that alleviate inequality and poverty.

In highly unequal societies that are leaning towards universalism, such as Botswana, Brazil and South Africa, there have been impressive levels of coverage, especially of basic health and education. However, the systems tend to be fragmented and have not eliminated inequalities based on geographic location or income level. In Brazil and South Africa, universal provision has largely been achieved due to social service reforms and commitment to ensuring accessibility in education and health in recent years, which should form the basis for further policy reform in the social sector. Additional efforts should aim to incorporate the poor into better quality social services by increasing and improving the distribution of financing and by improving the distribution and quality of social services in rural and disadvantaged urban areas.

Cost-recovery schemes that result in unequal financing of schools and health services and uneven quality should be removed. Financing should be balanced out through public expenditures based on tax revenues or social health insurance. Adequate public funding should minimize private sector involvement, which should also be regulated to ensure that premiums do not restrict access. In terms of health, insurance should be extended to hard-to-reach groups, such as informal and subsistence workers, through voluntary, mandatory or subsidized insurance schemes,[87] as was successfully done in Costa Rica and the Republic of Korea. These efforts should be supported by comprehensive social protection in order to enhance income and access to social services.

In countries with fragmented and exclusionary systems, such as India and Kenya, public spending should be increased and directed to rural and disadvantaged urban areas. Fees, which create barriers to access, should be removed, and complementary policies, such as school feeding programmes, should be introduced or expanded to encourage enrolment and attendance.

Effective commercialization requires regulation

Commercialization of health care and education is both a market-driven process and one that responds to policy decisions. The experience of the Republic of Korea demonstrates that, even with high levels of commercialization, access to health and education can be widened. In the case of health, this has occurred when financing is via social – not individual private – insurance and is

increasingly extended to the whole population. In the case of privatized secondary and tertiary education, access has widened when schools are subsidized and fees are regulated by the state.

Effective commercialization therefore requires effective regulation. However, commercialized health and education systems in developing countries are largely unregulated, and formal regulation is not only hard to achieve in liberalized markets, but also costly, as experiences in developed countries show. A more effective policy framework would focus on defining and enforcing the form and limits of commercialization appropriate to health and education objectives at different levels of development and in diverse political contexts. Key policy tools for this purpose include national financing mechanisms that promote solidarity, along with public provision. Rebuilding public sector provision reshapes the market and competitive framework for the private sector. It also means establishing the rights of the poor to make claims on the public sector that match the rights of the socially and privately insured to health care, and then rebuilding public sector provision to respond to those claims.

In the past, macroeconomic policies focused primarily on containing public debt and inflation, liberalizing markets, privatizing state assets and liberalizing external trade and capital flows. Protecting livelihoods, incomes and social services was not a priority. Instead, poverty reduction was perceived as an outcome of growth, which was expected to occur following stabilization and liberalization. Yet as described in various chapters of this report, growth performance and poverty reduction in many countries have been unsatisfactory. While progress has been made in meeting the MDGs in the areas of health and education, more remains to be done to tackle inequalities in provision, transcend the focus on primary health and education, and improve quality.

Notes

1 Sen 1999; Stewart et al. 2007.
2 Nussbaum 2001; Gough and McGregor 2007; Stewart et al. 2007.
3 Swain 2005.
4 Barro 1991; Mankiw et al. 1992; Sala-I-Martin et al. 2004.
5 Esping-Andersen 2005.
6 Mehrotra and Delamonica 2007.
7 Mehrotra and Delamonica 2007.
8 Mehrotra 2000; Ghai 2000.
9 Mehrotra 2000; Ghai 2000.
10 Jha and Subrahmanian 2006.
11 Swain 2005.
12 Jha and Subrahmanian 2006.
13 UNRISD 2000.
14 Draibe and Riesco 2007.
15 Adésínà 2007.
16 Urrutia 1987.
17 Adésínà 2007:15.
18 Cornia et al. 1987; UNRISD 2000.
19 King 2006.
20 Mkandawire 2001a.
21 World Bank 2004b; see Hutton (2004) for a critical review.
22 United Nations 2009a.
23 United Nations 2009a.
24 Adésínà 2007.
25 UNESCO 2009a.
26 King 2006.
27 UNRISD 2007.
28 Mackintosh and Koivusalo 2005.
29 Mackintosh and Tibandebage 2005.
30 UNRISD 2007.
31 WHO 2009a.
32 Mackintosh and Koivusalo 2005.
33 Mackintosh and Koivusalo 2005.
34 Mackintosh and Koivusalo 2005.
35 Mackintosh and Koivusalo 2005:8.
36 UNESCO Institute of Statistics 2007; Bayliss and Kesler 2006.
37 Hypher 2009.
38 UNESCO Institute of Statistics 2007.
39 UNESCO 2009a.
40 Barrera-Osorio et al. 2009; UNESCO 2009a.
41 Adésínà 2007:25.
42 Adésínà 2007:25.
43 Kim Gwang-Jo 2002.
44 UNESCO 2007.
45 Kwon and Tchoe 2005.
46 Ministry for Health, Welfare and Family Affairs [Republic of Korea] 2008; The Government Information Office 2009.
47 Kwon and Tchoe 2005.
48 Carrin and James 2005.
49 Trejos 2008.
50 Trejos 2008.
51 Trejos 2008.
52 Trejos 2008.
53 Mesa-Lago 2008; MIDEPLAN-SIDES 2009b (see also figure 5.5 in chapter 5).
54 Draibe 2007.
55 Jasso-Aguilar et al. 2005.
56 Medici 2002; Arretche 2004.
57 Silva and Dachs 2008.
58 Draibe 2007.
59 World Bank 2001d.
60 World Bank 2001d.
61 Instituto Brasileiro de Geografia e Estatística 2008.
62 Schwartzman 2009; Draibe 2010.
63 Seekings and Nattrass 2005.
64 ILO 2008c.
65 McIntyre et al. 1998.
66 Devereux 2001.
67 Nthomang 2009.
68 Mackintosh and Koivusalo 2005.
69 Adésínà 2007:35.
70 Mitullah 2008.
71 Mitullah 2008.
72 Mitullah 2008.
73 Atieno and Shem 2007.
74 Chachage 2007.
75 World Bank 2009c.
76 Mitullah 2008.
77 Mitullah 2008.
78 Nagaraj 2008.
79 Baru 2005.
80 Sen et al. 2002; Shankar and Shah 2009.

81 Shanker and Shah 2009.

82 Shankar and Shah 2009.

83 Constitution of India, Article 45. http://lawmin.nic.in/coi/coiason29july08.pdf, accessed on 9 June 2010.

84 Ghosh 2005.

85 Shankar and Shah 2009.

86 Ghosh 2005; Mackintosh and Koivusola 2005.

87 Mesa-Lago 2008.