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Social Services in High-Growth Developing Countries

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ABSTRACT

Social services are an important component of a growing society. A high level of social services is a reflection of a developed society. The ability of a society to provide social services is in large part contingent on both economics, political and institutional settings of an economy. Policies to enable effective social service provision include universal coverage, high and efficient spending and (re-)distribution of income and wealth through spending, transfers and progressive taxation. The higher the economic growth rate, the more social services, at least theoretically, it can afford to provide and vice-versa. The objective of this paper is to provide an overview of social services in high growth developing economies and examine whether they have achieved such social outcomes. More specifically, this paper reviews the development of the social sector through an analysis of the key social indicators for selected high growth developing countries. A second aim of this paper is to review social development policies adopted by some of these high growth developing economies. The main motivation for undertaking this review of policies and strategy is twofold: (1) to investigate the existence of any commonalities in social development policies; and (2) to provide a set of policies, as varied as they may be, that could be used by other developing countries to stimulate the growth of their social sector.

1. INTRODUCTION

The availability of a set of basic social services, such as education, health, access to water and sanitation, employment, among others, is central to the accumulation of social capital and economic growth. Empirical evidence has revealed that those countries with a high level of social development enjoy high rates of economic growth.

Mehrotra (1997) argues that unless countries maintain economic growth their capacity to sustain quality improvements in health and education services will be limited. He points out that countries which do not achieve economic growth may not experience a decline in their social indicators; they will, however, not achieve any improvements in social indicators.

Similarly, Duncan et al. (1997) argue that economic growth will eventually give rise to the expansion of privately provided services, offering an alternative to public social services, and removing some of the burden from universal public service provision. They point out that government's role may gradually shift from universal provider to regulator and provider of last resort for basic services.

There are three specific aims of this paper. First: to examine the trends in social development indicators and gauge the level of social sector development in developing countries. To achieve this aim, the chapter relies on social indicators data published by the World Bank, entitled *World Development Indicators*.

Second: to identify 15 high growth developing countries and analyse in detail the evolution of their social sectors over time (1970-2005). The high growth economies are selected based on their economic growth performance. We consider a select group of 15 countries with annual average growth rate of at least 2 per cent over the period 1970-2005

The third aim of this paper is to review the social policies and strategies for countries identified as "high growth" countries. To achieve this, the paper draws on published country specific documents.

The rest of this paper is organised as follows. In the next section, we provide an overview of selected studies that have examined the relationship between social indicators (such as health, education, etc) and economic growth and development. In section 3, a general overview of social development in developing countries is provided. In section 4, a more specific and detailed analysis of social development in 15 high growth developing countries is undertaken. In section 5, a review of some of the influential social policies relating to health and education are discussed. In the final section, the paper provides some concluding remarks.

2. AN OVERVIEW OF THE LITERATURE

2.1. The overall literature

Most countries tend to emphasize the need to increase well-being of their citizens. Should countries put more emphasis on generating economic growth and leave the social development to take care of itself? We know that development policies generally have a mixture of social and economic strategies. According to Newman and Thomson (1989), there are different hypothesis on the relationship between social and economic development:

- a. social and economic growth are unrelated;
- b. social development is a by-product of economic growth;
- c. social development does not result from but precedes economic growth; and
- d. neither of them cause each other, but they are related.

It is generally accepted that social development is a product of economic growth. This argument was first alluded to by Rostow who argued that economic growth will create various stages of development from primitive to a fully modern economy (Rostow 1960). This approach became the mainstream view since the 1970s where countries were urged to put more emphasis on generating growth. Improving social conditions through economic growth was propelled by the World Bank and its institutions in the 1950s and 1960s. In the 1970s, alternative concepts were proposed that included employment, distribution of income and quality of life. Although the trickle down often has been ineffective in meeting basic needs, this approach is still predominant in development circles.

On the other extreme, many scholars such as Streeten have argued that economic growth results from social development (Streeten 1981). In other words, the basic needs can be satisfied through public services including education, health and water supply. The emphasis is placed on building the human capital a priori or the “trickle-up” effect. Hicks also demonstrated that development of a critical minimum level of basic human capital is a prerequisite for improving economic growth. A better educated and healthier work force is likely to be more productive and therefore can contribute better to the economic growth process. This trickle-up approach is also demonstrated by the Newman and Thomson (1989). Basic needs precede rather than follow economic growth. In other words, earlier economic growth does not predict social development.

2.1. Health and economic growth

An important contributor to human capital accumulation, and ultimately to productivity gains, is health, leading many (Mushkin, 1962; Becker, 1964) to claim health as one form of human capital.

There are several channels through which good health can contribute to economic growth. First, a healthy workforce is associated with higher productivity because workers are more energetic and mentally more robust. Moreover, absenteeism at work is low since both the workers and their family members enjoy good health. Low absenteeism raises production. This argument is embedded in the theoretical models of nutrition-based efficiency wages. Leibenstein (1957), for instance, argued that those who consumed more calories relative to the poorly nourished workers are more productive, and that better nutrition is associated with increasingly higher productivity. Healthier workers with higher productivity earn higher wages (Strauss and Thomas, 1998). Higher wages in turn contribute to higher consumption and savings which by virtue of improving the well-being and happiness of people contribute to economic growth.

Second, improvements in health raise the incentive to acquire schooling, since investments in schooling can be amortised over a longer working life (Kalemli-Ozcan et al., 2000). Also, healthier students tend to be associated with lower absenteeism and higher cognitive functioning, and thus receive a better education for a given level of schooling (Weil, 2001). It follows that better health contributes to increased schooling and knowledge accumulation, which improves the quality of a country’s human capital; thus, contributing positively to economic growth.¹

In the literature that uses cross sectional data to examine the relationship between health expenditure and economic growth, there is a consensus that health stimulates economic growth (see, *inter alia*, Arora, 2001; Barro, 1991; Barro and Lee, 1994; Barro and Sala-i-Martin, 1995; Chang and Ying, 2008; Bhargava *et al.* 2001; Chakraborty and Das, 2005; Gupta and Mitra, 2004; Sachs and Warner, 1995; 1997; Berntsson *et al.*, 2006). There is a related strand of literature (see, for instance, Basta *et al.*, 1979, Spurr, 1983; Bhargava, 1997; Strauss and Thomas, 1998; Mwabu, 2001) that investigates the nexus between health and productivity using time series data and find that better health contributes to improvements in productivity.

There are a number of studies that have examined the impact of economic growth on health. One of the recent studies is Tapia and Ionides (2008) who examine health progress, as measured by the decline in mortality rates and the increase in life expectancy, and economic growth for Sweden. They find that economic growth is positively associated with health progress in Sweden throughout the 19th century. However, the relation becomes weaker as time passes and is completely reversed in the second half of the 20th century, when economic growth negatively affects health progress.

Earlier studies have also found mixed results on the impact of economic growth on health. One set of studies find that periods of economic slowdown has led to a rise in mortality rates in 20th century industrial economies (Brenner, 1971, 1983; Bunn, 1979) while others have found the opposite result (Chay and Greenstone, 2003; Dehejia and Lleras-Muney, 2004; Gerdtham and Ruhm, 2006; Laporte, 2004).

2.2. *Education and Economic Growth*

Theoretically education, through boosting the quality of human capital, is posited to contribute to growth. Higher or greater education leads to accumulation of knowledge. A high knowledge base ensures high quality human capital, able to participate in a wide range of activities including policy making and entrepreneurship. At a conceptual level, increases in a person's stock of knowledge or human capital are assumed to raise productivity (Grossman, 1972). Productivity gains through human capital accumulation can be achieved through investing in formal schooling or on-the-job training.

The education and economic growth relationship is one that has received a large empirical investigation. Empirical studies are not conclusive. In other words, the literature has found mixed results on the impact of education on economic growth. There are some studies (see, *inter alia*, Temple, 1999) that find a positive impact of education on economic growth, while other studies (see, *inter alia*, Benhabib and Spiegel, 1994; Pritchett, 1997) find the opposite.

There are several studies on China that examine the role of education on economic growth. These studies also find mixed results, although the more recent studies using a large time span of data and more advanced estimation techniques generally find a positive effect of education on Chinese economic growth. For instance, the work of Chen and Fleisher (1996) and Wei *et al.* (2001) reveal that while education has a positive effect on growth, the relationship is statistically insignificant. On the other hand, studies by Song *et al.* (2000), Yao and Zhang (2001), Arayama and Miyoshi (2004), Kawakami (2004), and Chi (2008) find that human capital has a statistically significant impact on Chinese economic growth. Self and Grabowski (2004) finds a positive relationship between human capital and economic growth for India.

It should be noted that health and education policies are interrelated, in the sense that policies in one sector have positive externalities on the other sector. For example, policies to boost education, such as free primary level education, by virtue of producing educated citizens, ensure that people have better health. This is possible because education allows people to earn a living and hence look after themselves and their families better. Education also allows people to interpret and understand information regarding better health measures much better. Similarly, health policies, such as those that reduce malnutrition, will allow children to engage more productively in acquiring education.

2.1. Social development surveys

In a survey of social development in Botswana, Duncan et al. (1997) reveal that while overall social development indicators have improved, certain groups of people and certain geographical regions of Botswana remain socially underdeveloped. They recommend: (1) a review of Botswana's social welfare policy to make it more efficient, equitable and affordable; and (2) government's role in encouraging more NGO participation in the delivery of social services.

Dommen and Dommen (1997) survey the status of social development in Mauritius and find that Mauritius has achieved great success in social development, and is one of the more social developed countries amongst developing countries. They attribute the success of Mauritius to a combination of factors, including democracy and political stability due to the fact that the country has no military force, implementation of a liberal dynamic and comprehensive economic strategy for growth and development, and media freedom.

The work of Loewenson and Chisvo (1997) reveal that in the 1980s Zimbabwe achieved progress in social development. They argue that this was achieved because of (1) clear policy support for social development, (2) allocation of substantial public-sector resources towards social services, (3) targeting of international funds to key areas of social development, and (4) using social sector inputs to offset poverty.

3. SOCIAL DEVELOPMENT IN SELECTED HIGH GROWTH ECONOMIES

3.1. Overview of the economic growth rate

In Table 1, some basic descriptive statistics for the economic growth rate are reported for the 10 developing countries. The countries included in the table are those identified as "high growth" countries in that they achieved growth that was over 2% on average over the period 1970-2005. The second column reports the mean growth rate over this period. For China, India, Malaysia, Singapore, South Korea, Indonesia, Mauritius, Botswana, and Thailand, economic growth rate has been over 5 per cent per annum over the 1970-2005 period. Botswana's growth rate has been most impressive at 10.2 per cent followed by China (9.1 per cent), Singapore (7.6 per cent) and South Korea (7 per cent)

The standard deviation of the growth rate, reported in column 6, suggests that Mauritius, Sri Lanka, and South Africa have the lowest volatility.

Table 1: Descriptive statistics for economic growth rate, 1970-2005

	Mean	Median	Maximum	Minimum	Std. Dev.	Skewness	Kurtosis
China	9.108	9.100	19.400	-1.600	3.896	-0.139	4.130
Ghana	2.943	4.453	9.723	-12.432	4.598	-1.490	5.162
India	5.113	5.451	9.860	-5.242	3.030	-1.184	5.172
Malaysia	6.664	7.383	11.714	-7.359	3.871	-1.677	6.300
Portugal	3.404	3.930	11.201	-4.347	3.316	-0.026	2.938
South Africa	2.567	2.855	6.621	-2.137	2.323	-0.367	2.224
Singapore	7.599	8.338	13.709	-2.399	3.922	-0.976	3.605
South Korea	7.042	7.253	12.035	-6.854	3.619	-1.830	7.693
Thailand	6.415	5.827	13.288	-10.510	4.183	-1.756	8.789
Turkey	4.348	5.581	10.461	-7.494	4.322	-1.088	3.621
Sri Lanka	4.506	4.907	7.057	-1.545	1.943	-1.351	4.699
Indonesia	6.079	7.132	9.776	-13.126	3.943	-3.372	16.809
Mauritius	5.276	5.556	9.316	2.541	1.631	0.484	3.392
Botswana	10.211	8.867	26.361	1.916	5.867	1.199	4.145
Chile	4.392	5.711	12.278	-11.362	5.307	-1.405	4.851

3.2. *An overview of health conditions*

In this section we review the health performance of the 15 high growth developing economies through examining a wide range of health indicators. We begin by examining the infant mortality rates. In tables 2 and 3, we report some data on infant mortality rate for those under the age of 5 (per 1000) and infant mortality rate per 1000 live births, respectively.

The data covers the period 1970-2005. Over this period, we notice that for all the 15 countries infant mortality rates and under-five infant mortality rates have declined. The final column of Tables 2 and 3 present the percentage decline in mortality rates. The following observations are in order. First, significant declines in infant mortality rates have been noticed in countries such as Singapore, Malaysia, China, Mauritius, Indonesia, Sri Lanka, Thailand, and South Korea. This to some extent reflects the success of social policies relating to health in these countries. Second, for some countries, such as Ghana and India where infant mortality rates (under 5 per 1000) respectively, infant mortality rates are still high: 112 in the case of Ghana and 72 in the case of India.

Table 2: Infant mortality rate (under 5 per 1000)

Countries	1970	1980	1990	2000	2005	% decline (1970- 2005)
China	120	64	49	41	27	344.4
Ghana	186	157	112	110	112	66.1
India	202	173	123	94	74	172.9
Malaysia	70	42	22	14	12	483.3
Portugal	61.5	30.9	14.3	7.7	5	1130
South Africa	110 (1975)	91	60	63	68	61.8

Singapore	27	13	8	6	3	2100
South Korea	52	18	9	5.4	5	940
Thailand	102	58	37	22	21	385.7
Turkey	201	133	82	44	29	593.1
Sri Lanka	100	48	32.3	19.4	14	614.3
Indonesia	172	125	91	48	36	388.0
Mauritius	86	42	28.5	18	14.9	477.2
Botswana	142	84	58	101	120	18.3
Chile	98	45	21	10.7	9.5	196.7

Table 3: Infant mortality rate (per 1000 live births)

Countries	1970	1980	1990	2000	2005	% decline (1970-2005)
China	85	49	38	33	23	269.6
Ghana	111	96	75	67	68	63.2
India	127	113	80	68	56	126.8
Malaysia	46	31	16	11	10	360.0
Portugal	52.6	25.3	11	5.5	4	1215
South Africa	75 (1975)	64	45	50	55	36.4
Singapore	19.7	11.7	6.7	3.6	3	556.7
South Korea	43	16	8	5	5	760
Thailand	74	45	31	19	18	311.1
Turkey	150	103	67	37.5	26	476.9
Sri Lanka	65	36	25.6	16.1	12	441.7
Indonesia	104	79	60	36	28	271.4
Mauritius	64	32.9	25.1	22.2	13.1	388.5
Botswana	99	62	45	74	87	13.8
Chile	78	35	17.6	9.7	8.4	828.6

Table 4: HIV/AIDS

Countries	Female adults with HIV (% of population ages 15+ with HIV)		Prevalence of HIV, total (% of population ages 15-49)	
	2003	2005	2003	2005
China	24.5	27.7	0.07	0.08
Ghana	60.7	60.0	2.2	2.3
India	28.8	28.6	0.89	0.92
Malaysia	25.0	25.4	0.41	0.47
Portugal	3.9	4.1	0.4	0.4
South Africa	56.9	58.5	18.6	18.8
Singapore	25.5	27.3	0.26	0.30
South Korea	59.1	56.9	0.1	0.1
Thailand	38.6	39.3	1.3	1.4
Turkey	-	-	0.2	0.2
Sri Lanka	-	-	0.1	0.1
Indonesia	13.64	17.05	0.09	0.134
Mauritius	-	-	0.219	0.55
Botswana	56.0	53.8	24.0	24.1
Chile	26.4	27.14	0.262	0.285

Some statistics, for 2003 and 2005, on HIV/AIDS are reported in Table 4. The data relates to two cases: Female adults with HIV as a percentage of population ages 15-plus with HIV and prevalence of HIV as a percentage of population aged 15-49. Beginning with female adults with HIV, only South Korea and Botswana has experienced a large decline (relative to the rest of the countries), from 59.1 per cent in 2003 to 56.9 per cent in 2005.

India and Ghana have also seen a fall, albeit slightly, from 28.8 per cent in 2003 to 28.6 per cent in 2005 in the case of India and from 60.7 per cent in 2003 to 60 per cent in 2005 for Ghana. The rest of the eight countries have experienced an increase in female adults with HIV.

In terms of prevalence of HIV, except for Portugal, South Korea and Turkey, where there were no changes in prevalence of HIV in the two years, there has been slight increases in HIV prevalence for all other countries. The biggest percentage increase has been in Singapore – from 0.26 per cent of population to 0.30 per cent of population.

In Table 5, we report data on the number of hospital beds per 1000 period in 1970 and in the most recent period for which data is available. We notice that in Malaysia, Singapore, Portugal, Indonesia, Mauritius and Chile the number of hospital beds per 1000 people have fallen.

Table 5: Hospital beds per 1000 people

Countries	1970	Year in parenthesis
China	1.54	2.45 (2005)
Ghana	1.32	1.46 (1990)
India	0.60	0.90 (2003)
Malaysia	3.47	1.90 (2001)
Portugal	4.00 (1985)	3.60 (2002)
South Africa	-	-
Singapore	3.70	2.90 (2001)
South Korea	1.7 (1980)	7.10 (2003)
Thailand	1.14	2.20 (2001)
Turkey	2.00	2.60 (2005)
Sri Lanka	3.02	3.10 (2002)
Indonesia	0.65	0.60 (1998)
Mauritius	3.95	3.00 (2005)
Botswana	2.12 (1960)	2.20 (2003)
Chile	3.78	2.40 (2004)

Some data on the prevalence of undernourishment as a percentage of population is reported in Table 6. We notice that all the 15 countries have done well in terms reducing undernourishment over the period 1971 to 2004. The most successful countries in this respect were China, Portugal, Indonesia, Malaysia, and Ghana, where undernourishment fell by over 100 per cent (see last column of Table 6).

Table 6: Prevalence of undernourishment (% of population)

Countries	1971	2004	% decline
China	46	12	283.3
Ghana	24	11	118.2
India	39	20	95
Malaysia	5	3	66.7
Portugal	46	12	283.3
South Africa	2.5	2.5	0
Singapore	-	-	-
South Korea	3	2.5	20
Thailand	29	22	31.8
Turkey	5	3	66.7
Sri Lanka	22	22	0
Indonesia	47	6	683.3
Mauritius	20	5	300
Botswana	36	32	12.5
Chile	6	4	50.0

We also examine the incidence of tuberculosis for the 15 countries. The trends in the incidence of tuberculosis per 100,000 people are plotted in Figures 1a/b. Except for South Africa and Botswana, where the incidence of tuberculosis has increased over the period 1990-2005, for the rest of the countries there is evidence of a mild decline. In Botswana, however, over the last few years the incidence of tuberculosis has started to decline. The tuberculosis treatment rate as a percentage of registered cases in China has been around 94 per cent. In India, it has been around 86 per cent in 2004, increasing from around 83 per cent in 1994. In Malaysia, the treatment success rate has been much lower: in 2004, it was 56.3 per cent, declining from around 90 per cent in 1999. Singapore has also experienced a decline, from around 95 per cent in 1999 to 81 per cent in 2004.

Figure 1a: Incidence of tuberculosis (per 100,000 people)

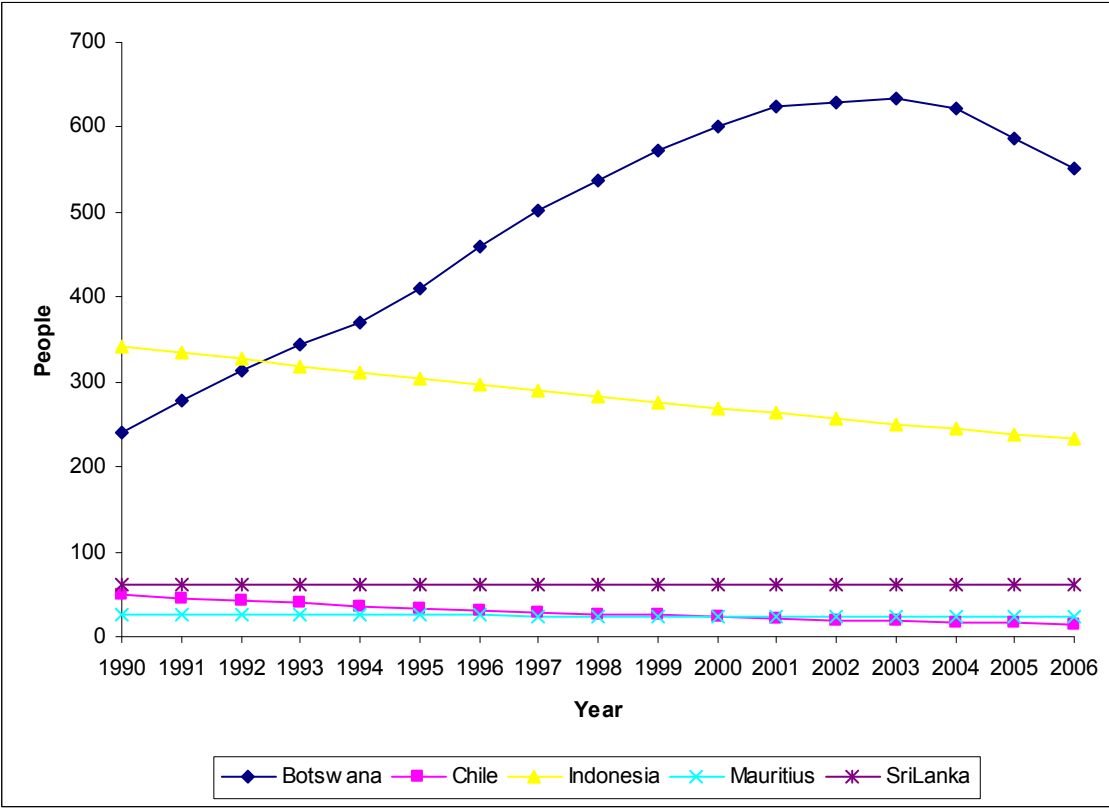
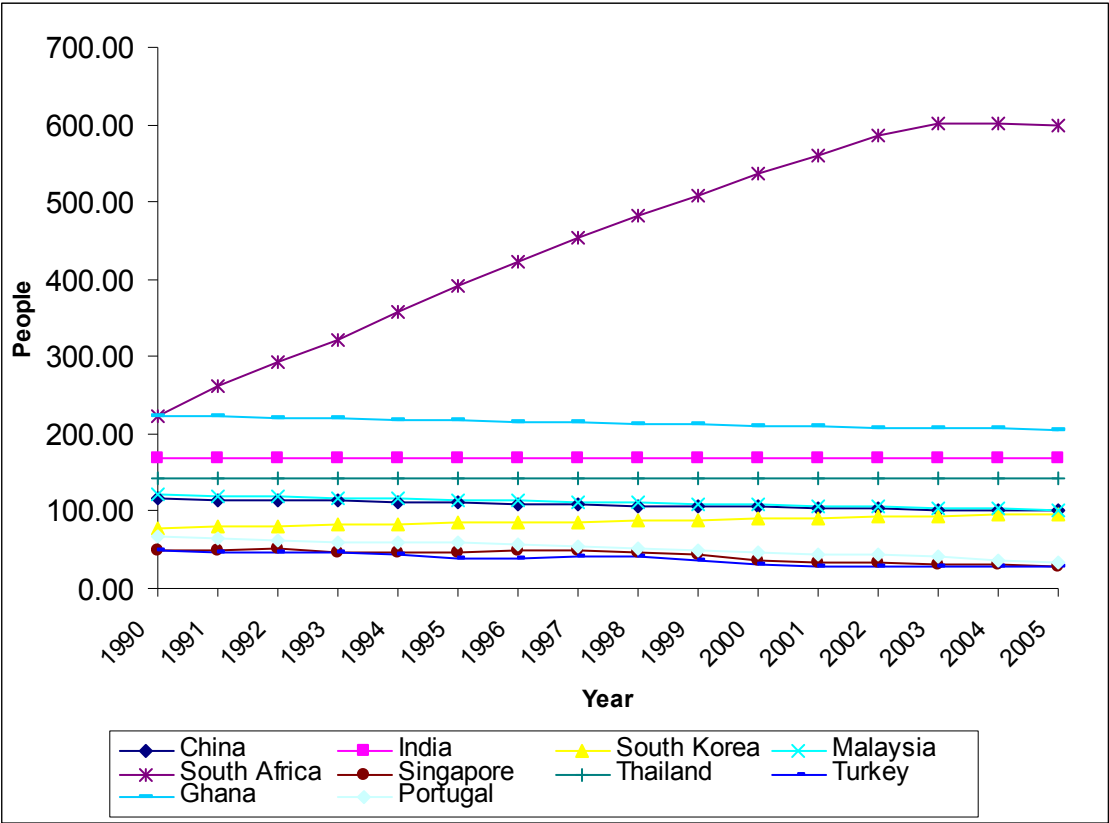
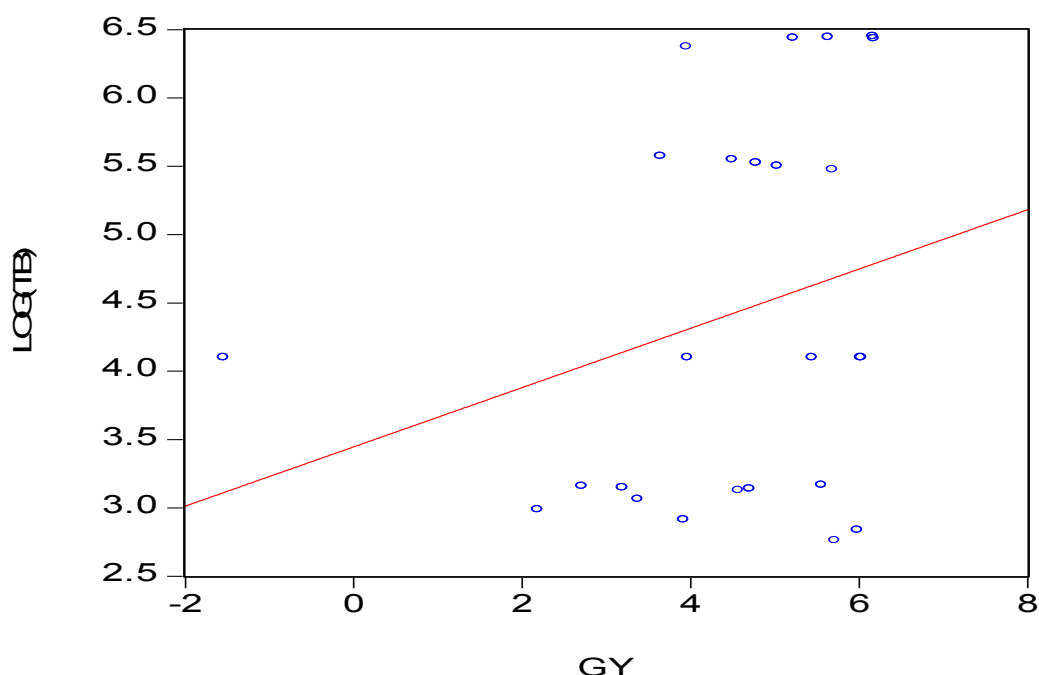


Figure 2: Scatter plot of economic growth and incidence of TB



Over the period 1994-2004, the tuberculosis treatment success rate has been fairly stagnant at around 70 per cent for South Africa, at around 77 per cent for Thailand, and at around 80 per cent for South Korea.

The treatment success rate has been the highest in Turkey at around 90 per cent, while the success rate has increased most in Ghana and Portugal. In Portugal, for instance, the success rate increased from 48 per cent in 1994 to over 84 per cent in 2004, while in Ghana, the success rate over the corresponding period increased from 53 per cent to 72 per cent.

In terms of health facilities, the number of physicians per 1000 people in all the 15 countries have increased over the 1970 to the most recent period for which data is available (see Table 7). The biggest rises have been in Botswana, Thailand, and Mauritius. The least increase has been in Ghana (15 per cent) and South Africa (60 per cent).

Table 7: Number of physicians per 1000 people

Countries	1970	Year in parenthesis	% change
China	0.86	1.6 (2002)	+86
Ghana	0.00	0.15 (2004)	+15
India	0.20	0.6 (2004)	+200
Malaysia	0.20	0.7 (2000)	+250
Portugal	0.90	3.3 (2003)	+267
South Africa	0.50	0.80 (2004)	+60
Singapore	0.70	1.4 (2001)	+100
South Korea	0.5 (1981)	1.6 (2003)	+220
Thailand	0.10	0.4 (2001)	+400
Turkey	0.4	1.3 (2005)	+225
Sri Lanka	0.17	0.55 (2003)	+224
Indonesia	0.04	0.13 (2003)	+225

Mauritius	0.24	1.06 (2004)	+342
Botswana	0.006	0.4 (2004)	+6567
Chile	0.46	1.09 (2003)	+137

3.3. Education status

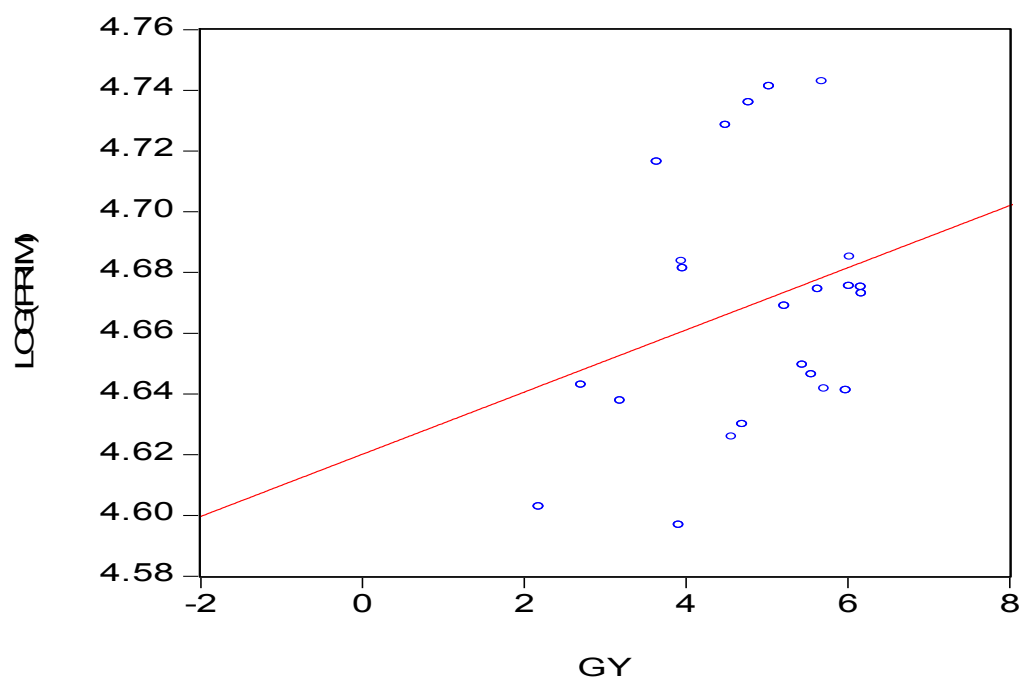
In this section we examine some of indicators for education in these 15 high growth developing countries. In terms of the duration of primary school education, in South Africa and Botswana children spend 7 years in obtaining primary school education, while most countries (Ghana, Malaysia, Portugal, Singapore, South Korea, Thailand, Indonesia, Mauritius, Chile, and Turkey) have a 6-year program for primary school education. In India and China, however, the duration of primary school education is only 5 years (Table 8)

Table 8: Duration of primary education

Countries	1999	2000	2001	2002	2003	2004	2005
China	5	5	5	5	5	5	5
Ghana	6	6	6	6	6	6	6
India	5	5	5	5	5	5	5
Malaysia	6	6	6	6	6	6	6
Portugal	6	6	6	6	6	6	6
South Africa	7	7	7	7	7	7	7
Singapore	6	6	6	6	6	6	6
South Korea	6	6	6	6	6	6	6
Thailand	6	6	6	6	6	6	6
Turkey	6	6	6	6	6	6	6
Sri Lanka	5	5	5	5	5	5	5
Indonesia	6	6	6	6	6	6	6
Mauritius	6	6	6	6	6	6	6
Botswana	7	7	7	7	7	7	7
Chile	6	6	6	6	6	6	6

In Tables 9-11, we report gross enrolment rates in primary, secondary and tertiary education for the 15 countries. We find that gross primary school enrolment rate has been fairly high in all countries. It has increased significantly in Ghana, from 70.66 per cent in 1990 to over 88 per cent in 2005. In 2005, primary school gross enrolment as a percentage was over 100 per cent for China, India, Portugal, South Korea, and South Africa. For most of these countries this represents a remarkable achievement over the period, with initial levels of around 80%. It was a shade under 100 per cent for Thailand and Turkey although again this is an improvement over the period. The scatter plot shows with a positive correlation between the economic growth rate and primary school enrolment rates (see Figure 2).

Figure 2: Scatter plot of primary school enrolment rate and economic growth rate



The secondary school enrolment rate attained has been less impressive than primary school enrolment rates; they, however, show a rise over the period 1999-2004/5. In China, for example, secondary school enrolment increased from 61.7 per cent in 1999 to 74.3 per cent in 2005; in Ghana, it increased from 37.2 per cent in 1999 to 43.6 per cent in 2005; and, in India, it increased from 46.2 per cent in 1999 to 56.6 per cent in 2005. The increase in enrolment rates reflects the general shift of education policies towards making basic education available for all children and education policies that make basic primary education free.

Table 9: Primary school enrolment rate (% gross)

Countries	1980	1990	2001	2002	2003	2004	2005
China	80.98	96.23	117.728	116.006	115.018	117.624	112.777
Ghana	-	70.66	77.065	79.726	77.073	81.391	88.366
India	-	83.3	98.303	98.947	107.429	116.200	119.246
Malaysia	80.9	88.80	95.460	93.188	93.482	95.778	..
Portugal	101.1	110.6	124.020	119.247	118.476	116.205	114.388
South Africa	72.2	85.4	105.668	105.686	105.020	104.067	
Singapore	-	-	-	-	-	-	-
South Korea	89.97	97.22	100.235	102.130	103.583	105.071	104.787
Thailand			94.31433	95.7327	95.73269	97.57667	97.1304
Turkey	77.5	80.89	97.724	99.333	94.686	93.314	93.303
Sri Lanka		60.22	..	..	107.9112	107.2877	104.5411
Indonesia			109.3369	111.7628	113.1298	113.9743	114.5863
Mauritius	89.21	98.88	105.3292	105.2379	104.2052	103.8528	103.3167
Botswana	76.43	80.33	104.2502	104.8381	106.5864	107.1808	107.2548
Chile	90.91	97.77	100.5611	100.3091	..	99.77609	99.17324

Table 10: Secondary school enrolment rate (% gross)

Countries	1999	2000	2001	2002	2003	2004	2005
China	61.747	62.863	65.098	67.198	70.265	72.530	74.343
Ghana	37.223	37.399	35.578	37.483	38.913	41.763	43.573
India	46.172	47.938	48.016	49.799	52.285	53.514	56.559
Malaysia	69.289	69.277	69.613	70.271	75.783	76.381	..
Portugal	106.456	108.227	109.467	110.544	109.036	96.677	98.835
South Africa	87.782	84.902	86.629	88.571	90.473	93.410	
Singapore	-	-	-	-	-	-	-
South Korea	99.922	97.560	94.240	91.272	90.108	90.894	92.903
Thailand	..	..	61.77717	63.45383	63.46427	65.66071	70.28789
Turkey	..	..	77.844	81.517	85.300	79.233	75.293
Sri Lanka	..	..	..	86.02722	85.86592	87.18018	..
Indonesia	54.53338	56.68337	58.00683	61.06831	63.26608	62.22135	54.53338
Mauritius	75.54881	77.59885	79.37674	81.3305	84.48303	85.96017	88.42144
Botswana	73.96855	75.25643	74.83896	75.57994	75.74513	76.91893	74.94449
Chile	79.49732	82.70026	..	85.57231	87.80298	89.14678	90.78883

Table 11: Tertiary school enrolment rate (% gross)

Countries	1999	2000	2001	2002	2003	2004	2005
China	6.387	7.598	9.816	12.605	15.417	19.095	20.307
Ghana	..	2.807	3.186	3.286	3.264	3.144	5.213
India	..	10.228	10.495	11.038	11.498	11.761	11.410
Malaysia	23.278	26.331	26.043	28.829	32.355	32.009	..
Portugal	44.822	47.818	50.719	53.278	55.531	56.603	56.475
South Africa	14.316	14.390	14.479	14.608	15.291	15.649	15.296
Singapore	-	-	-	-	-	-	-
South Korea	65.951	72.581	78.437	83.274	86.827	88.521	89.939
Thailand	32.49804	34.22123	37.90362	39.1037	40.09079	40.97748	43.00563
Turkey	21.51536	23.14979	23.3417	24.3866	28.01402	29.0077	31.19469
Sri Lanka	-	-	-	-	--	-	-
Indonesia	..	..	14.39741	15.02724	16.16194	16.57353	17.01352
Mauritius	6.932064	7.46906	11.26296	11.53037	15.73508	17.24436	16.85605
Botswana	3.036741	3.355662	3.927457	4.176561	..	4.853103	5.119454
Chile	37.64572	37.29086	..	41.00877	43.24394	42.98153	47.82594

Tertiary school enrolment rate has seen the most impressive rise for all countries: from 6.3 per cent in 1999 to 20.3 per cent in 2005 for China; from 23.3 per cent in 1999 to 32 per cent in 2004 for Malaysia; for Portugal, from 44.8 per cent in 1999 to 56.5 per cent in 2005; for Thailand, from 32.5 per cent in 1999 to 43 per cent in 2005; for South Korea from 66 per cent in 1999 to 90 per cent in 2005; and, for Turkey, from 21.5 per cent in 1999 to 31.2 per cent in 2005.

The repetition rates for primary school education by total, males and females are provided in tables 12-14. Examining the total repetition rates in primary schools, we notice that in India, South Africa and Turkey, repetition rates have declined while in China and Ghana, repetition rates have increased albeit slightly. A somewhat similar trend is observable for male and female repetition rates. In general, however, the repetition rates are low in these countries.

Table 12: Repetition rate (% of primary TOTAL enrolment)

Countries	1999	2000	2001	2002	2003	2004	2005
China				0.298	0.322	0.303	0.313
Ghana	4.203	4.994	5.211	..	5.895	6.667	5.829
India	4.0122	4.1693	3.6860	3.6493	3.5924	3.1909	3.3974
Malaysia	-	-	-	-	-	-	-
Portugal	-	-	-	-	-	-	10.912
South Africa	10.390	8.792	9.364	7.401	5.217	7.960	
Singapore	-	-	-	-	-	-	-
South Korea	0	0	0	0	0	0	0
Thailand	3.483	-	-	-	-	-	-
Turkey	-	-	-	-	-	3.216	2.989
Sri Lanka	..	..	..	..	..	0.804497	..
Indonesia	..	..	6.166483	5.314305	3.771902	2.888132	4.578551
Mauritius	4.20595	4.318902	4.651444	4.821936	4.822303	4.827536	4.424691
Botswana	3.308474	3.396108	3.241757	3.189203	4.679819	4.767381	4.767474
Chile	2.444958	2.008991	..	2.258956	1.952335	2.440494	2.224003

Table 13: Repetition rate (% of primary FEMALE enrolment)

Countries	1999	2000	2001	2002	2003	2004	2005
China				0.239	0.279	0.260	0.270
Ghana	4.105	4.845	5.044	..	5.637	6.119	5.676
India	4.0748	4.0799	3.7090	3.6645	3.6095	3.0930	3.3510
Malaysia	-	-	-	-	-	-	-
Portugal	-	-	-	-	-	-	7.000
South Africa	9.157	7.348	12.705	6.289	4.356	7.508	9.157
Singapore	-	-	-	-	-	-	-
South Korea	0	0	0	0	0	0	0
Thailand	3.532	-	-	-	-	-	-
Turkey	-	-	-	-	-	3.767	3.194
Sri Lanka	..	..	..	..	..	0.742327	..
Indonesia	..	..	6.157785	5.114101	3.768431	2.890042	3.581276
Mauritius	3.759432	3.682402	4.002874	4.020815	4.020448	4.203311	3.609715
Botswana	2.732755	2.646951	2.507354	2.431093	3.534819	3.636689	4.307008
Chile	1.927041	1.567126	..	1.72719	1.467279	1.851911	1.685847

Table 14: Repetition rate (% of primary MALE enrolment)

Countries	1999	2000	2001	2002	2003	2004	2005
China	-	-	-	0.351	0.361	0.341	0.351
Ghana	4.289	5.127	5.362	-	6.138	7.161	5.971
India	3.9640	4.2384	3.6680	3.6373	3.5774	3.2770	3.4386
Malaysia	-	-	-	-	-	-	-
Portugal	-	-	-	-	-	-	13.083
South Africa	11.579	10.156	6.169	8.467	6.039	8.391	11.579
Singapore	-	-	-	-	-	-	-
South Korea	0	0	0	0	0	0	0
Thailand	3.437	-	-	-	-	-	-
Turkey	-	-	-	-	-	2.716	2.802
Sri Lanka	..	..	..	..	..	0.8644	..
Indonesia	..	..	6.174714	5.503764	3.775195	2.886317	5.50875
Mauritius	4.638268	4.937219	5.28428	5.603133	5.601462	5.432894	5.213416
Botswana	3.877896	4.135619	3.96548	3.930737	5.800339	5.865351	5.213228
Chile	2.931069	2.42525	..	2.759836	2.408622	2.982306	2.720004

In sum, we notice that all countries have improved both in terms of the education and health indicators used in this section. The main feature of the data is as follows. While all countries have seen an improvement in their social and economic indicators, the rate of progress is different. In other words, some countries, such as Singapore, Malaysia, Mauritius, and China, have progressed rapidly, others, such as India and Ghana, have progressed at a much slower pace. There are two reasons for this. First, different countries implemented education and health sector reforms at different time since 1970. Second, there are a number of economic, political, and institutional factors that impact on social development progress. This can also be seen from the human development index (HDI) of the countries. The best rated countries according to the 2007/8 rankings are Singapore (ranked 25th), South Korea (ranked 26th), Portugal (ranked 29th), Chile (ranked 40th), Malaysia (ranked 63rd), Mauritius (ranked 65th), while the lowest ranked countries in our sample are Ghana (ranked 135th), India (ranked 128th), Botswana (ranked 124th), and South Africa (ranked 121st).

4. AN OVERVIEW OF SOCIAL POLICIES

In the previous sections, we discussed the trends in health and education indicators for the 15 high income developing countries. Our discussions reveal that generally health and education indicators have improved in these 15 high income developing countries. From this exercise, we confirmed that health and education indicators have had a statistically significant effect on economic growth in the 15 high growth developing countries.

The aim of this section is to provide an overview of the key social policies relating to health and education for each of these 15 countries.

4.1. China

China suffered severe health problems including endemics of the plague, cholera, leprosy, and tuberculosis in the 1950s and 1960s. However, to its credit, China has managed to control and address these health issues as shown by the impressive progress in health indicators discussed in the previous section. Over the period 1950-1965, a three-level health care system was established covering both urban and rural areas.

Government invested heavily in proving primary health care through the construction of village clinics, township health centres and county hospitals in rural areas, while in urban areas, construction of community and street health centre and clinics and district hospitals were given priority. The urban tertiary hospitals were responsible for the provision of medical services for referral patients from both rural and urban areas (Meng, 2007).

The rural health system underwent structural changes in the period 1965 to 1979. In 1978, there were around 5 million barefoot doctors working in rural village clinics and 90 per cent of the rural inhabitants were covered by the cooperative medical scheme (Fu, 1999). Over this time period, prices of drugs were also reduced significantly which improved affordability of medical care (Liu et al., 1996).

The post-1978 period has been one of several innovations in health including a national reform of the basic medical insurance system for urban employees. By the end of 2003, around 109 million people (approximately 10 per cent of the population) in China participated in the basic medical insurance program (Government of China, 2004).

China over the years, and particularly from the time of the onset of economic reforms, has emphasised social security. China's old age insurance scheme has been an important initiative, particularly in light of the country's ageing population. The issue of an ageing population has resulted from China's one child policy implemented in the lasted 1970s. In 1997, the Chinese government unified the basic old-age insurance system for enterprise employees in urban areas across the country by implementing a social-pool-plus-personal-accounts scheme, and by 2003, the monthly basic pension for enterprise retirees covered by the basic old-age insurance scheme was 621 yuan on average (Government of China, 2004). The pension scheme worked as follows. The monthly sum of the basic pension was 20 per cent of the employee's average monthly wage. A second component of pension was income from personal accounts which was calculated at 1/120 of the total accumulated sum in the personal account. The personal account was made up of 11 per cent of the employee's monthly wage.

In 2000, the Chinese government established a national social security fund. The aim of this fund was to provide a financial reserve for the implementation of old-age insurance and other social security programs. By the end of 2003, the fund has accumulated over 130 billion yuan (Government of China, 2004).

Moreover from 2003, a medical insurance fund system (MAF) has been implemented in both rural and urban areas (Ministry of Affairs, 2003). The MAF is funded by the central and local governments and beneficiaries are families and individuals whose income are below the poverty line. In rural areas, the MAF is managed by rural township government who assesses applications for the use of MAF whereby residents are supported for care of catastrophic diseases. The scheme is similar in urban areas. In 2005, a total of 300 million yuan was allocated by the central bank for the continuation of the MAF scheme (Chen, 2006).

China amended its "Infectious Disease Control Law" in 2004, gives financial responsibility to government including control of outbreak of infectious diseases and subsidies for treating poor patients suffering from infectious diseases (PRC, 2004). A number of other specific medical care is provided free of charge. For example, from 2003, hepatitis B vaccines for children were made freely available. Moreover, Zhang

(2005) argues that many disadvantaged populations in urban areas have benefited from the provision of convenient and less costly health care.

In terms of China's education policy, it is in large part driven by the failures of the Cultural Revolution period (1966-1969), when the education system suffered a shutdown leading to loss of human capital. China's human resources suffered as there was lack of trained and qualified individuals. The 1980s, following economic reforms and human resource crisis of previous decades, saw an education policy that promoted expanded enrolments. The aim of education policy was to achieve universal primary and secondary education. This was formalised in 1985 through plans for a nine-year compulsory education (primary plus lower-secondary education) and for providing good quality education. The structure of education finance has moved away from a centralised system with a narrow resource base to a decentralised system with a diversified revenue base (Tsang, 1996).

In China, the role of the state and provincial governments has been high compared with the private sector and the NGOs.

4.2. South Korea

In the 1970s, South Korea established the health insurance law, signalling its priority for health as part of government's broader social policies. By 1989 South Korea had managed to extend social health insurance to the entire population. A national health insurance corporation was formed in 2000 by merging social insurers. The regulation and supervision of the national health insurance scheme is a prerogative of the government.

Social insurance currently pays about 44 per cent of outpatient and hospital care, the government contributes around 11 per cent through public health services and medicare schemes, which are available for those unable to afford insurance premiums. Around 45 per cent of health care funding comes from private sources (Gauld et al., 2006).

South Korea has an education system based on a mixing and sorting framework. In a mixed system, teaching and learning takes place within an heterogeneous group of students, and schools are very much homogenous. In contrast, under a sorting system the composition of schools and systems are reversed, in that students are very much homogenous, while schools are heterogeneous since they are stratified based on student quality (Kim et al., 2008)

South Korea has vigorously implemented an education policy based on mixing. Their equalisation policy introduced a lottery based enrolment system. Under this equalisation policy framework there are a set of centralised education policies, such as same curriculum and teachers' qualifications in both public and private schools, uniform salary schedules, and other benefits for both public and private schools (an excellent discussion on this is provided in Kim et al., 2008 and Kim and Lee, 2002). It follows that the equalisation policy has made South Korean schools very homogenous.

4.3. Portugal

The last three decades have seen a major socio-economic transformation of the Portuguese economy. The 1976 constitution saw the establishment of the National Health Service scheme, which was in large part motivated by the British model. The

scheme ensured that health protection was available to all citizens. The scheme allowed universal and free access to health care to citizens.

Santana (2000), however, argued that while health is guaranteed to all citizens by law, the limits that are imposed by financial, human and technical resources reduce the real impact of the legislation. Moreover, access to health care has been affected by a number of factors, such as the urban concentration of population along the coast, the ageing population, the growth of functional dependence, and the diversifying health care needs (Santana, 2006).

Until the mid-1970s, the Portuguese education system was fairly underdeveloped and was characterised by low enrolment rates. However, the post-1974 democratic revolution instigated an expansion of the public education system. While the 1933 Portuguese constitution did not guarantee the rights to education for Portuguese citizens, the 1976 constitution reversed this, and ensured a major reform of the education system. The 1976 constitution ensured education to all citizens and guaranteed the right to establish private and co-operative institutions, while maintaining the role of the state in recognising and supervising private co-operative education (see Amaral and Teixeira, 2000 for an excellent discussion of the Portuguese education system). By the mid-1980s, the private sector was also heavily involved in the provision of education services.

Thus education system in Portugal is predominantly funded by the state but fee-paying private institutions are available for service at all levels of education. In Portugal, regardless of whether the institution is state or private owned, the duration of compulsory education is nine years. Compulsory education graduates have open access to secondary education, which has duration of three years. This is followed by a national exam, success in which confers graduates with a diploma. This is a pre-requisite for higher education studies in Portugal (Botelho *et al.*, 2001).

4.4. India

India established its National Health Policy in 1983. The goal of the policy was to achieve “health for all” by 2000. In the pre-1983 period, India has invested heavily in health infrastructure. Thus, it was perceived that the goal of the NHP was achievable given health infrastructural investments. Moreover, the success of the NHP was to be based on the provision of comprehensive primary health care services. The emphasis was on the creating of adequate infrastructure for primary health care; close coordination with health related services and activities, including nutrition, drinking water supply and sanitation); active involvement and participation of voluntary organisations; the provision of essential drugs and vaccines; qualitative improvement in health and family planning services; the provision of adequate training; and medical research aimed at the common health problems of the people.

India launched its National Education Policy in 1986, aimed at universal elementary education access; universal retention of children upto 14 years of age; and improvement in the quality of education to enable all children to achieve essential levels of learning. Moreover, the 86th Constitutional Amendment Act 2002 made education a fundamental right for children in the age group of 6-14 years. This policy has ensured a reduction in the number of out of school children, a decline in gender and social gaps, and a reduction in school dropout rates (Government of India, 2003).

4.5. *Malaysia*

The Ministry of Health in Malaysia has traditionally (since the 1970s) been responsible for providing health care services to its citizens. Over the last decade, however, emphasis has been to open the health care market to private service providers. The Malaysian government policy, under the free enterprise system, allows private providers to set up anywhere in the country. A national health and morbidity study revealed that around 30 per cent of preventive care for the population in terms of immunisation against childhood diseases, care of antenatal mothers and routine medical examinations... (Ministry of Health, 2005).

To boost health development, the Ministry of Health in 1997 produced a document entitled "Policies in Health". The main thrust of this document was to improve collaboration and integration among all health and health-related agencies to achieve desired national objectives of improvement in health status and quality of life of Malaysians (Ministry of Health, 2005).

As part of initiatives to speed up health development and improvement, the Ministry of Health in 1998 introduced another document entitled "The Strategic Plan for Quality in Health". The main thrust of this document was to stimulate quality improvements in health.

A National Philosophy of Education (NPE) was established in Malaysia in 1988. The NPE aimed to develop the potential of individuals in a holistic and integrated manner. The goal is to produce human capital who are intellectually, spiritually, emotionally and physically balanced (UNESCO, 2008). The government's commitment to education is contained in the Federal Constitution and the Education Act of 1996. This is to be achieved through the provision of free education to every child of school-going age for a period of 11 years.

4.6. *South Africa*

Since the 1970s, South Africa's policies regarding health were weak in the sense that there were no health policy documents targeted at improving the health status of the people. In cases where policies were put in place, there was an absence of implementation and success of such policies. South Africa, however, established a national policy in health in 2001 entitled "Policy on Quality in Health Care for South Africa". The goal of this policy was to achieve quality health care through: (1) addressing access to health care; (2) increasing patients' participation and the dignity afforded to them; (3) recuing underlying causes of illness, injury, and disability through preventive and health promotion activities; (4) expanding research into effectiveness; (5) ensuring the appropriate use of health care services; and (6) reducing health care errors (adverse events) (National Department of Health, 2007).

In the most recent initiative on health, the South African Ministry of Health established a 10-point plan to be implemented over the 2004-2009 period. The main elements of the strategic framework were: (1) improve governance and management of the National Health System; (2) promote healthy lifestyles; improving quality health care; (3) improve management of communicable diseases and non-communicable illnesses; (4) strengthen primary health care and hospital service delivery systems; (5) strengthen support services; (6) human resource planning development and management; and (7) strengthening international relations (National Department of Health, 2005).

The South African Schools Act came into effect in 1996, and it provides for: (1) compulsory education for those in the age bracket of seven to 15 years; (2) two categories of schools (public and independent schools), and the establishment and maintenance of public schools on private property; (3) governance and management of public schools; and (4) funding of public schools.

In 2001, the South African government came up with a national plan for higher education. South Africa also plans to increase the number of tertiary institutions to achieve its goal of ensuring that 20 per cent of people aged between 18 and 25 are enrolled in the higher education system by 2015.

4.7. Thailand

Prior to the 1990s, there was no social security system in Thailand. Thailand's social security system was formalised by the Social Security Act introduced in 1990. Under this Act, social security health insurance started providing medical benefit to workers in companies with more than 20 workers from 1991. In 1996, this Act was modified to cover for medical insurances in companies employing at least 10 workers, and by 2005 the Act was modified to include medical insurance for all workers.

Over the period 1970 to 2001, Thailand had in place various health schemes. These included initiatives such as free medical care for low-income groups, and the Voluntary Health Card Scheme, which was in place from 1987-2001. Thailand's ten national development plans to-date have all placed heavy emphasis on health infrastructure development and health insurance to its citizens (see Ministry of Public Health, 2007).

Over the 1970-1998 period, Thailand's education policy was varied with lack of clear strategies and policies on driving national education. A key feature of the education policy over this period, however, has been to make basic primary education available to all children. Since then, Thailand's education policy is driven in large part by the 1999 National Education Act, which recognises education as a continuous lifelong process. Some of the key policies and strategies contained in the education Act can be summarised as follows:

1. Launching a campaign to create understanding of lifelong learning among all stakeholders, both the providers and the target population as well as the public at large;
2. improving the provision of all types of education so as to be conducive to lifelong learning;
3. Developing learning sources in the communities and building learning networks;
4. Constructing a media and information technology system to facilitate lifelong learning; and
5. Provision, mobilization and allocation of funding for the promotion of lifelong learning

Department of Vocational Education (2003).

4.8. Turkey

Health care reform in Turkey took place against the backdrop of economic liberalisation beginning in the early 1980s. The advent of the Basic Law on Health Services adopted by the Grand National Assembly in 1987 set the tone for health care reform. The law

declared the establishment of a universal health insurance scheme and decentralisation of state hospitals. The speed of reform picked up in the period 1990 to 1993 when a special project unit was setup within the Ministry of Health. This led to the following key policy objectives:

1. to increase the effectiveness of the health care system and improve the health of the country;
2. to reduce inequalities among geographical regions and between rural and urban areas;
3. to increase efficiency and to use resources to ensure effective health services; and
4. to improve quality to increase patients' satisfaction and improve health outcomes

Savas *et al.* (2007).

Moreover, in 1993 as part of Turkey's health reform drive, a Green Card scheme was established for low income earners. Currently, 11.3 million people benefit under this Green Card scheme (Savas *et al.*, 2007).

The Turkish education system, as well developed as it is, is governed by the Constitution of the Turkish Republic, the laws regulating education and instruction, government programs, development plans, and national education councils. These bodies and laws recognise that: (1) education shall be national; (2) education shall be republican; (3) education shall be secular; (4) education shall have a scientific foundation; (5) education has incorporate generality and equality; and (6) education shall be functional and modern. It follows that Turkish education policies are geared towards achieving these.

The overall objectives of the education policies are:

1. to equalise education level for males and females living in rural and urban areas;
 2. to provide equality of opportunity in all kinds and at all levels of education;
 3. to increase student success at all levels of education;
 4. to develop course books and to give them functionality in all education institutions;
 5. to increase efficiency or resource utilisation in investments and current expenditures; and
 6. to make room for specialisation services at all levels of the education system
- Ministry of National Education (2008).

4.9. Ghana

Among the developing countries considered in this study, Ghana has been one of those countries that launched a National Health Insurance Scheme much later. Over the 1970-2002 period there was lack of government focus and commitment to a nation-wide health strategy and policy.

Ghana's National Health Insurance Scheme was set up under Act 650 in 2003. The objective was to reduce financial barriers and increase access to health care for all citizens, especially the poor and the vulnerable (WHO, 2006).

A major constraint to health in Ghana has been lack of human resources, as is common in many low-income developing countries. Four factors have been identified by the

health industry as constraining health development is Ghana. These are: (1) lack of training opportunities and openings for development; (2) poor remuneration and delays in getting salaries paid; (3) delays and lack of promotion for certain key staff; and (4) lack of decent accommodation (WHO, 2006).

To remedy this, as part of its health policy, the government's focus has been on increasing the number of health professionals trained through the existing training institutions and the establishment of new schools. The idea behind this infrastructural development is to produce more health professionals. In order to attract health professionals, health policy has given prominence to the provision of residential accommodation for recruited health staff. A much broader set of health policies targeted at addressing human resources problems also include provision for car loans, enhanced salaries, housing schemes, loans for pressing personal needs, and extended housemaidship for doctors (WHO, 2006).

In Ghana, education policy has been rooted in the Education Act of 1961, which provides for a policy of free and compulsory primary education for all children of school-going age. Despite this education policy, Ghana has failed to achieve high levels of literacy rates. The sole reason has been the lack of skilled teachers. Thus, education reform was instigated in 1987. The aim of this reform was to diversify and make the delivery of education to the population more efficient and productive. Moreover, the 1992 constitution specifically states that the state shall provide educational facilities at all levels in all the regions of Ghana.

The failure of Ghana's education policy to deliver high literacy rates is also due to other problems, such as lack of textbooks and stationary, deterioration of school buildings, lack of furniture and weak school management, lack of government funding, among others (Ministry of Education, Republic of Ghana, 1996). Thus, the 1987 education sector reforms and policies were designed to achieve the following:

1. to expand and make access more equitable to all levels of education;
2. to change the structure of the school system, reducing the length of pre-university education from 17 to 12 years;
3. to improve pedagogic efficiency and effectiveness;
4. to make education more relevant by increasing the attention paid to problem-solving environment concerns, pre-vocational training, manual dexterity and general skills training;
5. to contain and partially recover costs; and
6. to enhance sector management and budgeting procedures.

4.10. Singapore

Singapore's health care system comprises a dual system: the public system and the private system. Under the public health care system, health care is managed by the government, while under the private health care system, health care is provided by private hospitals and general practitioners. Approximately 80 per cent of primary health care services are provided by the private practitioners, while government polyclinics provide the rest (WHO, 2008).

Public health care has two arms: the National Healthcare Group and the Singapore Health Services. They provide quality health care services through cooperation and

collaboration between public health care establishments. People are free to choose one of the two health care providers.

Government has restructured all its 13 hospitals and speciality institutes into private wholly owned by the government and managed as not-for-profit organisations. This has allowed efficiency in health care delivery. The government has also introduced low-cost community hospitals for intermediate health care for the convalescent sick and aged who do not require the more expensive care provided by the acute general hospitals (WHO, 2008).

Successive government health policies and strategies have been designed to achieve good health and reduce illnesses, ensure access to good and affordable health care, and pursue and achieve medical excellence.

4.11. Sri Lanka

Sri Lankan health system is enriched with a widely spread network of health institutions providing primary, secondary and tertiary health care services. These institutions are dispersed all over the country. However lack of uniformed facilities across make their utilization by patients uneven.

The enormous variation of facilities in terms of infrastructure, equipment, human resources make the level of care they provide vary, attracting patients towards tertiary care services at the expense of underutilization of the primary care services.

The goals of Sri Lankan health policy are:

- (1) to further increase life expectancy by reducing preventable deaths due to both communicable and non-communicable diseases; and
- (2) Improve the quality of life by reducing preventable disease, health problems and disability; and also emphasizing the positive aspects of health through health promotion.

Source: Ministry of Health Care and Nutrition, 2008.

The education sector has three cardinal policy objectives. First, to provide universal access to primary and secondary education. Second to attaining high levels of education quality, measured in terms of cognitive achievement, subject content mastery, and broader outcomes such as good team work, a disciplined work ethic, a positive, solution oriented approach to problems, ability to take initiative and display dynamism, able leadership, effective communication, and respect for diversity in the context of a multi-ethnic, multi-religious society. Third, to produce high quality human capital capable of contributing to economic growth. The Sri Lankan education system is built around public financing and provision of primary and basic education to its population. The public sector dominates primary and secondary education. It accounts for 93 per cent of schools and 95 per cent of student enrolment (World Bank, 2005). The central government is responsible for national education policy at all levels – pre-school, primary and basic education, secondary education, university education, vocational training and technical education.

A second feature of the Sri Lankan education system is that the establishment of private schools from grades 1-9 was legally banned in the early 1960s, and this policy exists today.

4.12. Indonesia

Indonesia's health policy over the 1970-1991 period has been ad hoc and implementation of health policies significantly weak mainly due to lack of funding. The Health law No. 23 enacted in 1992 provides a legal basis for the health sector activities. This law includes the goals of the health programmes and centres around increasing awareness and the willingness and ability of everyone to live a healthy life. The law emphasized the decentralization of operational responsibility and authority to the local level as a prerequisite for successful and sustainable development.

In the second 25-year development plan (1994-2019), economic and human development is identified as the key to national development and self-reliance.

Following the National Guidelines on state policy issued in 1993, strategy was adopted to improve the health and nutritional status of the population by improving the quality of health services to all, and to promote a healthy life style with adequate housing and environmental sanitation.

The government of Indonesia places great emphasis on intersectoral coordination, joint responsibility of local government and the community, region-specific programmes, targeting of vulnerable groups, and building strong information and communication programme.

The goal of Indonesia's education policy is to achieve universal access to high quality basic education to its people. The education system is characterised by public-private partnerships at all levels of education. Public educational services are monitored and implemented by the Ministry of National Education at the provincial, district and sub-district levels. The private provision of education is dominated by Islamic institutions. The main responsibility for delivery of public primary and secondary education is shared between centre, province, district and sub-district, with district governments playing a central role in this delivery process.

4.13. Mauritius

Since the 1970s, Mauritius health policy has broadly focused on ensuring a health population and health policies have been formulated to achieve this objective. The Ministry of Health and Quality of Life (MoH) is responsible for the formulation of national health policy in Mauritius. Recently, the MoH (2004) has outlined four principles that govern Mauritius health policy:

1. Enhancing the overall health status of the population;
2. Uplifting the quality of health care delivery;
3. Enhancing social equity through provision of a wider range of health services across the population; and
4. Consolidating the health sector whilst ensuring accessibility of health services for all citizens.

The delivery of health care services in Mauritius is a combination of both the public and private sectors. The levels of health care services provided by the public sector are available at all levels --- district level, regional level, and national level. Meanwhile, private health care service delivery takes two forms, namely private practice of medical and dental care practitioners and private clinics with inpatient beds and facilities for examination, consultation and diagnostic procedures (WHO, 2004).

The goal of education policy in Mauritius is to achieve universal access to education for all citizens and produce high quality graduates at all levels of education. In Mauritius the education sector while dominated by the public sector has seen an increasing role for the private sector over the last decade or so. In sum, the Mauritius education system is based on a dual system – that is, state sponsored and private sector sponsored. Under the education policy, secondary education is free for all; this policy came into effect in 1977.

4.14. Botswana

Since the 1970s, there has been lack of policy direction regarding the development of the health sector in Botswana. This changed in 1994 when Botswana introduced a revised national policy on education, and implemented the following policies:

1. re-introduce the three years Junior Certificate Programme;
2. achieve universal access to 10 years basic education;
3. review of basic education curriculum and development of core instructional support material;
4. introduce the three year Diploma in Primary Education Programme;
5. localisation of senior secondary education;
6. diversification of the vocational education and training curriculum;
7. increase access to senior secondary education beyond 50%;
8. establish the tertiary education council to co-ordinate the development of tertiary education; and
9. raise HIV/AIDS awareness.

Source: BFTU (2007).

Specific policies have also been developed to provide education for the people with disabilities. However, education in Botswana is neither free nor compulsory, and it is dominated by the public sector.

4.15 Chile

Chile's health objectives are well placed in two laws: Law No. 19,966, known as the General System of Health Care Guarantees, which established the Universal Access Plan with Explicit Guarantees, or "AUGE" Plan, and Law No. 19,937 on Health Authority and Network of Autonomous Hospitals, which strengthens the health authority and establishes conditions for greater flexibility in managing hospitals

Beginning the 1980s, health care policy in Chile focused on involving the private sector in the provision of health care services. Private health insurance funds, the *Institutos de Salud Previsional*, which came into operation in 1981, offered individually negotiated health care plans (Barrientos, 2002). The heavy emphasis on private sector driven health care services meant that only the sufficiently high income group of individuals were able to afford health care. There was an increase in the consumption of health care services. To remedy this, the new government in 1990 began with a plan for the

involvement of health care based on public sector provision of such services. As part of this strategy of public sector involvement, the government focussed on decentralising health care provision and restructuring the internal mechanism for resource allocation.

The Chilean education system features a high degree of private sector participation. Out of a total 10,600 schools (1998), parents have the option of placing their children in (a) public schools managed since 1980 by the municipalities (55.1 percent of 1998 enrollment); (b) private schools subsidized by the government on the basis of enrollment (34.1 percent); (c) fully private schools (9.2percent); and (d) private technical-vocational schools run by private businesses or corporations (1.5 percent) (Ministry of Education 1998: cited in Delannoy, 2000: 2).

The government's approach to developing the education sector was based on the following (Delannoy, 2000):

1. Decentralisation of education services;
2. Government financing of the school system based on average monthly student attendance
3. Encouragement of competition between private and public schools for student enrolments;
4. Labour market reform, whereby public sector teachers were administered under the same labour laws governing the private sector teachers in terms of wage determination;
5. A student assessment scheme aimed at ensuring quality students.

5. DISCUSSION

What is clear from our analysis is that in the provision of both health care services and education services, the public-private mix has been central. In the 15 countries reviewed here, the trend in service provision has been as follows. Initially, the provision of education and health services have been public sector dominated. However, with the introduction of new innovations in both health care and higher education, and the emphasis on the quality of education and health services, there has been a need for private sector service providers. The country studies reveal a tendency, particularly from the early 1990s, to engage the private sector more in the provision of health and education services. The motivation behind this strategy is fairly obvious: to boost efficiency in the delivery of these social services. Hence, over the last decade or so the role of private sector has increased in the 15 countries examined in this paper. The public-private mix in social service provision has already been recognised in the literature.¹ The public sector service provisions, which existed from the outset, ensure that the key social service provision infrastructure is in place. Thus, the presence of the public sector in social service provision should be seen as complementary to the private sector service providers. The preference for public-private partnership is rooted in optimal distribution of services.

We find that the 15 developing countries (China, India, Malaysia, Thailand, Portugal, South Korea, Singapore, South Africa, Ghana, Turkey, Sri Lanka, Indonesia, Botswana, Chile, and Mauritius) in our case study for social policies review, had all reformed their health and education sectors, through encouraging private sector participation in the provision of health and education services. It seems, at least from the case studies, that

¹ Sen (1999), for instance, argues that the focus should be on people's capabilities; that is, their ability to function and participate in the development of a society. The efficiency in social service provision and the higher quality of service provision brought about by the private sector helps build "capabilities" of people, hence ensuring a high quality participation in the activities of a society.

private sector involvement preceded social sector development in these countries. The main aim has been to achieve universal access to health care and education services for citizens. The strategy of achieving this aim was to build public-private partnerships in ensuring better resource allocation, management and governance of programs, and ensuring efficiency in the delivery of these services. The difference among policies is that they were implemented at different times, hence to-date the magnitude of the impact of reforms are different. This is reflected in their level of social development: some countries are socially more developed than others. This means that some developing countries have seen fast growth of social development indicators while other countries have experienced slow growth.

Under the broad scheme of public-private partnership in the provision of health and education services, the countries surveyed in this study had at different times, undertaken one of a combination of the following specific strategies:

1. decentralisation of education and health services to the various districts, states, municipalities, village, etc, in order to ensure more efficiency and effectiveness in the delivery of services;
2. the creation of basic education and health related infrastructure, such as building of schools and health centres at the various levels (state, district, village, etc), ensuring greater accessibility of services, particularly for the rural and remote populations; and
3. the creation of incentives for greater government funding based on achievement of certain targets such as high enrolment rates (compared with the past).

There are two other modes of social service provision that developing countries have experienced. First is the increasing role for non-government organisations (NGOs) in the delivery of health care and education services. Of the countries surveyed on this study all countries have experienced the presence of NGOs in social service provision, although the role of NGOs has been greater in India, Sri Lanka, Indonesia, Botswana, Ghana and South Africa; Mehrotra and Delamonica (2007) discuss the role of NGOs in social service provision, albeit briefly, and interested readers may find this source useful. In general, the role of NGOs has increased over the last couple of decades in countries like India, Ghana, Botswana, Indonesia, China, Sri Lanka, and South Africa through aid programs. An increasing share of aid in these countries has been channelled to NGOs, who have undertaken more participatory role, particularly at the village/rural and remote areas. So, the role of NGOs in the delivery of social services has not been a traditional one, rather their role has become increasingly important as aid flows directed at improving the social sector in developing countries has increased.

Second is the role of aid in social development. A strategy adopted by aid donors, in light of the criticisms labelled at the failure of aid, is to target aid (both in money and kind) at specific sectors, such as education and health. Aid donors have assisted many of the developing countries considered here by building hospitals and medical centres and by building schools and providing training to better equip health and education specialist in developing countries.

Implementing reforms is one thing, and the success of reforms is another. Success, in large part, depends on a number of internal and external factors. For instance, the countries considered for the case study have experienced different challenges: from disease outbreaks in Ghana and Botswana to extreme poverty in China and India. These not only have an impact on the success of reforms but also on the speed of reforms, thus

impacting social outcomes. It follows that the social development path for each country is different. Different countries face different socio-economic challenges, so to adopt a particular country's success model (in terms of social development) is not always going to produce success in other countries. Mehrotra and Delamonica (2007) discuss a range of different challenges that developing countries face in developing their social sector. These include both social and economic issues, ranging from the outbreak of diseases, such as HIV/AIDs, Malaria, etc, to lack of well developed institutions. The latter has been an impediment to facilitating social progress in developing countries. They also suggest several strategies for social development in developing countries.

In the case studies we presented there is clear evidence of some improvement in health and education indicators. Apart from the mechanisms highlighted above, the role of the state, as indicated earlier, has been crucial. This can be seen from health and education expenditure. In what follows, we provide a brief overview of the expenditure patterns.

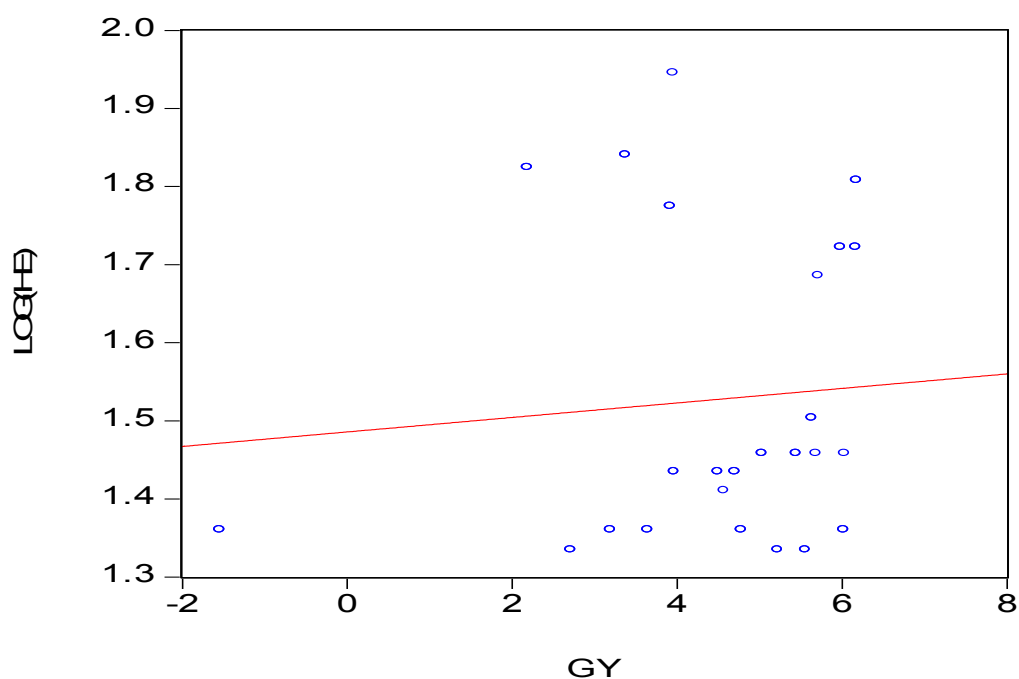
Data on health expenditures as a percentage of GDP is reported in Table 15 over the period 1975-2004/5. For all countries, health expenditures as a percentage of GDP has increased over the period 1975-2004/5.

Table 15: Health expenditures as a % of GDP

Countries	1975	1990	2000	2003	2004	2005
China	0.3	0.9	1.8	1.7	1.8	-
Ghana	0.7	1.1	2.8	2.8	2.8	-
India	0.1	0.1	0.90	0.8	0.9	-
Malaysia	0.5	0.9	1.7	2.6	2.2	-
Portugal	3.2	4.3	6.4	7.2	7.0	-
South Africa	1.1	2.1	3.4	3.4	3.5	-
Singapore	0.2	0.8	1.3	1.6	1.3	-
South Korea	-	-	2.2	2.8	2.9	-
Thailand	-	0.8	1.9	2.2	2.3	-
Turkey	1.3	2.4	4.2	5.4	5.6	5.2
Sri Lanka	0.7	1.1	3.8	3.9	4.2	4.1
Indonesia	-	-	1.8	2.2	2.1	2.1
Mauritius	0.9	1.7	3.9	3.9	4.3	4.3
Botswana	-	-	3.8	5.6	6.1	7.0
Chile	1.6	3.4	6.3	5.9	5.6	5.4

Health expenditures have been the highest for Portugal and Botswana (over 7 per cent of GDP) followed by Turkey and Chile (5.2 per cent of GDP). In sum, health expenditures as a percentage of GDP are significantly less in these developing countries compared with the developed countries. For example, the average expenditure on health in the OECD countries is around 10 per cent of GDP. The scatter plot of health expenditures and economic growth in Figure 3 reveals the positive association between higher economic growth and higher health expenditures.

Figure 3: Scatter plot of economic growth and health expenditures for 15 developing countries



In terms of public expenditures on education, for all countries there has been a rise in expenditures over the period 1975/85 to 2005. Education expenditure as a percentage of GDP has been the highest in Botswana, where it rose from around 3 per cent in 1975 to slightly less than 10 per cent in 2005. This is followed by Malaysia, Portugal, and South Africa (see Table 16).

Table 16: Public expenditure on education as % of GDP

Countries	1975	1985	1999	2000	2001	2002	2003	2004	2005
China	0.54	1.11	1.91	-	-	-	-	-	-
Ghana	-	2.01	4.11	-	-	-	-	-	5.45
India	1.21	2.22	3.99	4.39	-	-	3.68	3.76	-
Malaysia	3.27	4.76	5.69	6.20	7.89	8.10	7.95	6.25	-
Portugal	2.89	3.88	5.59	5.74	5.91	5.84	5.91	5.69	-
South Africa	3.00	4.12	6.03	5.58	5.29	5.20	5.07	5.35	5.39
Singapore	-	-	-	-	-	-	-	-	-
South Korea	1.01	2.27	3.76	-	4.31	4.22	4.62	4.63	-
Thailand	1.29	2.22	4.99	5.41	5.01	-	-	4.23	4.22
Turkey	1.42	2.66	3.99	3.46	3.65	3.56	3.74	4.00	4.00
Sri Lanka	1.90	3.19	3.05	-	-	-	-	-	-
Indonesia	0.24	0.99	-	1.36	1.17	1.08	0.96	-	-
Mauritius	2.11	3.78	4.21	3.90	3.34	3.29	4.67	4.67	4.44
Botswana	2.99	6.20	-	-	-	-	-	-	9.74
Chile	-	2.42	3.84	3.91	-	4.23	4.05	3.66	3.37

6. CONCLUDING REMARKS

In this paper, an analysis of the social sector development for developing countries has been undertaken. The aim was to examine how economic growth has simulated social sector development. A clear correlation was observed over the last 3-4 decades between economic growth and social indicators. For developing countries, for instance, as their economy has grown over the last few decades, social indicators, such as those relating to health and education, have also improved. We identified the various policies and strategies the respective countries adopted in order to facilitate the development of their social sector.

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ⁱ Lucas (1988) argues that improving the standard of living can stimulate economic growth.