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SOME LESSONS FROM SUCCESSFUL EXPERIENCES

by Dharam Ghai

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◆ Preface

This paper is based on findings of the UNRISD research project on **Social Development and Public Policy**. The project was designed to improve our understanding of the reasons behind the superior social performance of some developing countries, and to reveal conditions under which social progress can occur independently of economic advance. The experiences of several countries (and one state within a federated country) whose achievements have aroused much interest and debate were examined: Chile, China, Costa Rica, Cuba, Kerala, Sri Lanka and Viet Nam. The project focused on their impressive performance in health and education, although other dimensions of social development such as social security, unemployment, incidence of poverty and gender disparities also received some attention in the case studies.

This Discussion Paper considers these experiences using a common framework comprising historical, cultural and political economy dimensions. It gives particular attention to the political determinants of social policy, the amount and composition of expenditure devoted to social programmes and the institutional arrangements for financing, organizing and delivering social services. The paper first discusses the nature and extent of the educational and health attainments of these countries, contrasting them with the performance of other groups of countries. This is followed by a brief discussion of their historical and cultural legacies, as well as political processes, institutions and resource allocation. The paper then provides more detail on social policy, with illustrations drawn from the fields of primary health care and literacy. The subsequent sections deal with their experiences with poverty reduction and the social impact of stabilization and adjustment policies pursued during the past two decades.

Costa Rica, Chile, Cuba, Kerala and Sri Lanka enjoyed a historical head-start in health and educational achievements. A political commitment to spreading the benefits of education and health to the entire population was crucial everywhere. The political forces contributing to wide provision of social services were diverse, including enlightened monarchy, a modernizing élite, social movements, political parties, trade unions, professional associations and emerging middle classes. Within this overall political context, cultural factors provided a favourable environment for social progress. In some cases, they took the form of a religion or a tradition placing high value on education and care for the less fortunate members of society. The status and autonomy of women were decisive in equitable access to health and educational facilities. In some countries, ethnic homogeneity made a contribution by preventing discrimination against and exploitation of some social groups.

China and Viet Nam suffered from a historical disadvantage in the domain of health and education. Although Cuba had above average social indicators and relatively high per capita income prior to the revolution, it suffered from massive inequalities between ethnic groups, and rural and urban areas. The impressive social achievements of these countries can be directly attributed to the policies pursued by the communist revolutionary régimes, which, in all cases, were committed to reduction or elimination of economic and social inequalities and to the achievement of universal literacy, basic schooling and elementary health care.

Politics is also central in the other four cases. A long tradition of liberal democracy, electoral competition among different parties for political power, the emergence of

strong social movements and other institutions of civil society made significant contributions to the priority given to universal and free provision of key social services. Although Chile had a long interregnum of a repressive military régime, the military junta felt compelled to give priority to the disadvantaged groups in public nutrition, health and education programmes.

The case studies also bring out the central importance of strong action by the public sector in the provision of certain health and education services. There was a great deal of diversity in the institutional frameworks for planning, organizing, financing and delivering social services. But in all cases, the state assumed responsibility for the provision of certain services critical to social development. It is interesting to note in this context that the amount of resources allocated to social programmes does not appear to have been decisive in explaining their social performance.

A major conclusion to be drawn from the case studies is that the overall social policy and pattern of public social expenditure are responsible for superior social performance. A social policy that accords priority to maternal and child care, prevention of insect-borne and infectious diseases, improvement of health education, adult literacy, universal basic education and sanitary and hygienic conditions can have a quick and powerful impact on social indicators.

To what extent are these lessons relevant and applicable to other countries? The fact that the sample incorporates enormous diversity in terms of political régimes, ethnic groups, social structures, cultural traditions, levels of development and rates of economic advance holds out hope that high educational and health standards can be achieved by countries under widely divergent conditions. The single most important common feature of their experience is the pursuit of social policies according priority to primary health care, adult literacy, basic education and sanitary and environmental improvements. These programmes are not too costly in terms of finance and skills. But they do require an effective public sector that can reach the entire population with services.

At a deeper level, the pursuit of such policies is only possible where political circumstances generate strong pressures on the ruling groups to allocate resources for broad-based social programmes. This can happen under liberal democratic systems with a vibrant civil society, revolutionary régimes committed to social and economic equality and even authoritarian régimes seeking popular legitimacy or facing threats from opposition forces within or outside the country. The recent political changes in a large number of countries across the world conducive to the establishment of democratic systems, the growth of civil society institutions and the recognition of human rights provide a highly favourable environment for the pursuit of the kind of social policies and programmes discussed in this paper.

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◆ Contents

◆ Acknowledgements

Many institutions and individuals have contributed to **Social Development and Public Policy**, the research project launched jointly by UNRISD and the Canadian International Development Agency (CIDA) upon which this paper is based. I am especially grateful to Rémy Beaulieu of CIDA for his initiative and enthusiasm. The International Development Research Centre (IDRC) joined the above two organizations in convening a workshop in May 1996 to discuss the initial drafts of some of the case studies carried out under the project. The studies were prepared by Solon Barraclough (Cuba), Godfrey Gunatilleke (Sri Lanka), Carmelo Mesa-Lago (Costa Rica), Valentine M. Moghadam (Viet Nam), V.K. Ramachandran (Kerala), Carl Riskin (China) and Jaime Ruiz-Tagle (Chile). I am indebted to these contributors to the forthcoming volume, upon which this paper draws, and to the late T.N. Krishnan for their work and for comments on drafts of the case studies.

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1. INTRODUCTION

It is commonly observed that levels of economic development tend to be roughly correlated with levels of social development in countries throughout the world. This observable cross-country correlation, however, does not necessarily indicate a direct causal relationship between economic and social development in any particular case. The existence of numerous outliers — countries in which social indicators are either lower or higher than expected based on their economic indicators — suggests that social development is a complex process influenced by a variety of factors. In particular, the ability of some countries to reach a distinctly superior level of social development than would be expected on the basis of their level of per capita income suggests that social development need not wait for economic development, but can — and indeed should — be specifically and deliberately pursued by countries at every level of economic development.

The research project on which this paper reports was designed to improve our understanding of the reasons behind the superior social performance of some developing countries, and to reveal conditions under which social progress can occur independently of economic progress. The experiences of several countries (and one state within a federated country) whose social achievements have aroused much interest and debate were examined, namely Chile, China, Costa Rica, Cuba, Kerala, Sri Lanka and Viet Nam.[1] The cases indicate that, although economic conditions and social development are linked, they can be disentangled to some extent, and conclusions can be drawn about specific circumstances and policy actions that promote social development.

The literature on the countries included in this study has, for the most part, been concerned with specific aspects of the social policies of individual countries. Some comparative studies have utilized cross-country data to explain the superior social performance of some of these countries using such variables as public social expenditure, average consumption and poverty incidence (Bhalla and Glewwe, 1986; Anand and Kanbur, 1995). Efforts have also been made to undertake a broader examination of the factors that have contributed to some aspects of successful social performance among a larger sample of countries (Ahmad et al., 1991; Dasgupta, 1993; Lindenberg, 1993; Mehrota and Jolly, 1997). Relatively few efforts have been made either at the individual country or the comparative level to understand their experience using a common and integrated framework. The distinguishing feature of the present study is an attempt to analyse the experience of the selected countries using a common framework comprising historical, cultural and political economy dimensions. Among the latter, this study gives particular attention to the political determinants of social policy, the amount and composition of expenditure devoted to social programmes and the institutional arrangements for the financing, organization and delivery of social services.

[1] Unlike other cases included here, Kerala is a state in India, a federal country. It shares remarkable social achievements with other countries included in the research project. The states in India carry primary responsibility for social programmes and policies. The inclusion of Kerala in the project was considered particularly significant as the indicators for social development in India as a whole are among the worst in the developing world (Drèze and Sen, 1995). To avoid repetition, the case studies will be referred to as countries.

The primary focus of this study is on health and educational attainments, although other dimensions of social development such as social security, unemployment, incidence of poverty and gender disparities also receive some attention in the case studies. Of course, social development must be understood as a broad phenomenon — one which includes social and welfare services; progress in tackling problems such as unemployment, poverty, crime, violence, drugs and child labour; relations among different groups; development of institutions and promotion of human rights, gender equality and participation — and countries performing well in the domains of health and education cannot be assumed to have similar achievements in other dimensions of social development. However, while superior performance in health and education does not imply the elimination of poverty and social conflicts or the achievement of gender equality or respect for human rights, good health, long life, adult literacy and basic education are universally recognized as central to human welfare. These conditions are also vital elements of human capabilities and thus play a key role in facilitating the realization of human potential and individual goals. Further, there is growing recognition of their contribution to economic growth, and political and social stability. Thus the ability of some countries to achieve satisfactory health and educational goals at relatively low incomes has profoundly important implications for the welfare of hundreds of millions of people living in poor countries.

The countries studied here have enjoyed consistent and outstanding health and educational indicators over several decades. (There are also some other countries which have been noted for superior educational and health indicators, such as Jamaica, Argentina and Uruguay, which would have qualified for inclusion in the research project.) Their distinguishing feature is that their levels of achievement are much higher than warranted by their per capita income. They should be distinguished from another group of countries remarkable for the rapidity of progress in health and education attainments. It is possible for countries to take rapid strides in social indicators but still have average or below average indices for countries with comparable per capita incomes. This is the case, for example, for countries as diverse as Saudi Arabia, Botswana, South Korea, Kuwait and Malaysia. It should also be remembered that the basis of comparison used here — health and educational performance — is different from the Human Development Index (HDI) of the UNDP Human Development Report, which is based on health, education and per capita income.[2]

[2] The HDI is based on three indicators: longevity, as measured by life expectancy at birth; educational attainment, as measured by a combination of adult literacy (two-thirds weight) and combined primary, secondary and tertiary enrolment ratios (one-third weight); and standard of living, as measured by real GDP per capita (purchasing power parity dollars). For further elaboration of the methodology see the UNDP **Human Development Report** for various years.

Table 1
Socio-Economic Characteristics

	Population (millions)	Population Growth (% p.a.)	Urban Population (%)	GDP per capita $		GDP Growth (% p.a.)		Economic Structure 1994 (% share of each sector)		
	1993	1980-1993	1994	1993 pp[1]	1995	1970-1980	1980-1993	Agricul-ture	Industry	Service
Chile	13.8	1.7	86	8,400	3,170	1.8	5.1	5	40	55
China	1,178.8	1.4	29	2,330	490	5.5	9.6	21	47	32
Costa Rica	3.3	2.8	49	5,520	2,150	5.7	3.6	15	24	61
Cuba	10.9	1.0	75[4]	3,412[4]	1,170[5]			12[2]	25[2]	56[2]
Kerala	29.1[2]	1.4[3]		1,082[4]	248[4]	3.9[6]	2.1[8]			
Sri Lanka	17.9	1.5	22	2,990	600	4.1	4.0	24	25	51
Viet Nam	71.3	2.2	21	1,010[4]	170[5]	0.2[7]	8.0[9]	28	30	42

Notes: [1] Purchasing power parity; [2] 1991; [3] 1989-1990; [4] 1992; [5] 1993; [6] 1960/61-1974/75; [7] 1976-1980; [8] 1974/75-1989/90; [9] 1987-1993
Sources: UNDP, **Human Development Report**; World Bank, **World Development Report** (both various years); Kerala: Krishnan (1997); Ramachandran (1997); Drèze and Sen (1995); Viet Nam GDP: Ronnäs and Sjöberg (1995).

The countries studied here display enormous diversity in terms of historical background, political régimes, cultural patterns, population size, economic structure and growth, and development levels and policies (see table 1). Yet despite this diversity, they have all succeeded in attaining outstanding health and educational performance. Three common factors have been crucial to their success. First, all these countries were characterized for most of the time under consideration by a political leadership that was strongly committed to the provision of health and educational services to the entire population. Secondly, in all cases the state played a central role in extending a minimum core of services throughout the country. Thus the administrative capacity of the state and the infrastructure necessary to reach all parts of the country and the major segments of the population were vital to their success. Thirdly, the composition of public social expenditure — emphasizing literacy, basic education and primary health care — rather than its relative size, accounts for their social achievements.

The following pages examine in more detail these and other elements of the experience of the selected countries. By way of background information, the next section presents data on some educational and health indicators, contrasting the performance of the selected countries with that of other groups of countries. This is followed, in section 3, by an a brief discussion of relevant aspects of the selected countries' historical and cultural legacies, as well as their political processes, institutions and resource allocation. The next two sections provide more detail on social policies, with illustrations drawn from the field of primary health care and literacy, while section 6 analyses poverty reduction efforts. Section 7 examines the impact on social conditions of stabilization and adjustment policies undertaken in these countries in the past two decades.

2. THE NATURE AND EXTENT OF SOCIAL ACHIEVEMENTS

There are many measures of health and educational attainments, each of them with strengths and weaknesses. The health status of a population may be captured roughly by such measures as life expectancy, infant mortality, maternal deaths, malnutrition and incidence of diseases. This paper uses life expectancy and infant mortality — the most widely used and available measures of health status. People's educational attainment may be approximated by adult literacy, enrolments at primary, secondary and tertiary levels, and quality of education. Again, following current practice and data availability, the major focus here will be on adult literacy and enrolment ratios at primary and secondary levels. A common weakness of all these measures is that they are averages. While higher indices generally imply improvement in the health and education status of the more disadvantaged sections of the population, a disaggregation of such indices by social groups, gender and region would undoubtedly reveal considerable disparities in social achievements. The various case studies attempt, within the limits of data availability, to identify such categories of socially deprived groups. In addition, information on some social indicators in different countries may not be equally reliable or fully comparable. [3]

[3] UNRISD has devoted considerable attention to assessment of the quality of data on social indicators and low cost methods of obtaining social data. See, in particular, McGranahan et al., 1972 and 1985; Westendorff and Ghai, 1993.

The project was not designed to collect new social data but rather to distil some key elements of the social development experience in these countries in order to derive the lessons they may hold for other countries interested in improving their health and educational performance and in reducing poverty. This paper thus relies principally on the data on education and health published by national and international organizations. For the analysis of social progress over time in individual countries, the published data are likely to give a reasonably accurate picture. Even in this respect, however, the further back one goes in time, the greater the chances of changes in definitions and coverage. For some countries, including Cuba, China and Viet Nam, the data for the earlier post-war decades are generally recognized to be deficient in many respects. There are greater problems with inter-country comparisons, but the international sources attempt, within the limits of the available information, to standardize data on health and education indicators used in this paper.[4]

◆ Impressive Indicators for Health and Education

Table 2 presents data for five indicators: life expectancy, infant mortality, adult literacy, secondary school enrolment and total fertility. Chile, Costa Rica and Cuba have life expectancy figures of 74 or more years. Sri Lanka, with a much lower per capita income, has a life expectancy of 72 years, while Kerala, with even lower per capita income, has a life expectancy of 73 years. These figures are very close to the average of 76 years for industrial countries. Figures for China and Viet Nam are lower, at 69 and 66 years, but far superior to the 56 years average for low income countries (excluding China and India). In terms of the progress made in increasing life expectancy, the higher the initial figure, the more difficult it becomes to raise it further. Life expectancy was already relatively high in Cuba, Costa Rica, Sri Lanka and to a lesser extent Chile in 1960. The rate of increase in life expectancy is thus higher for China, Viet Nam and Kerala than for other countries, because of their lower initial values. The ratio of life expectancy of females as a proportion of males varied between 105 and 107 for all countries, with Chile being an exception at 110.

[4] Even so, there continue to be differences in data for some countries for some years in the publications of international organizations.

Table 2
Health and Education Indicators

	Infant Mortality			Life Expectancy			Total Fertility		Adult Literacy			Secondary School Gross enrolment	
	1960	**1980**	**1993**	**1960**	**1975**	**1993**	**1970**	**1993**	**1960**	**1980**	**1992**	**1970**	**1992**
Chile [(a)]	114	47	16	57	65	74.0	4.6	2.5	84	91	95	39	72
China[(a)]	150	42	30	47	65	69.0	5.8	2.0	54	68[3]	79	24	51
Costa Rica[(a)]	85	30	14	62	69	76.0	4.9	3.1	84	93[4]	94	28	43
Cuba[(a)]	65	22	12[1]	63	72	75.3		1.7	79	96[4]	95	80	90[5]
Kerala	120	40	17[1]	45	63	73.0	4.1	1.8[2]	49	70	90		
Sri Lanka[(a)]	71	44	17	62	66	72.0	4.3	2.4	61	87	89	47	74
Viet Nam[(a)]	147	82	41	44	53	65.2	5.9	2.8		84	92		33
Low income, excluding China and India (<$695) [(b)]			89			56		5.5			51[6]		26
Lower Middle Income ($ 696-2,785) [(b)]			40			67		3.0			81[6]		60[6]
Upper Middle Income ($2,786-8,625) [(b)]			36			69		3.0			86[6]		54
High Income (>$ 8,626) [(b)]			7			77					>95[6]		98[6]

Notes: [1]1992; [2] 1992-93; [3] 1982; [4] 1985; [5] 1990; [6] 1993
Sources: (a) UNDP, **Human Development Report**, various years; Kerala: see table 1. (b) World Bank, **World Development Report**, 1995 and 1996.

There is greater dispersion over time and by country in infant mortality rates (IMRs). As with life expectancy, Cuba, Costa Rica, Kerala, Chile and Sri Lanka show a distinctly superior performance, with IMRs between 14 and 17 per thousand live births (compared with an average IMR of 7 in high income countries). This is to be expected, as IMRs have a significant impact on life expectancy at birth. IMRs in China and Viet Nam, at 30 and 44, compare favourably with the low-income countries' average (excluding China and India) of 89. This gap is quite considerable, suggesting that infant mortality is an especially sensitive indicator of the state of health services within a country. The regional differences in life expectancy are quite marked in these two countries, particularly in China. Concerning the rate of progress in reducing infant mortality, the same remarks apply as for life expectancy. It is, however, surprising to find the relatively high IMRs for Costa Rica and even more so for Chile in 1960 — 85 and 114 respectively — as compared, for instance, with 65 for Cuba. The progress made by China, Kerala and Viet Nam in reducing IMRs is quite remarkable, as is that by Chile and Costa Rica.

We have also assembled data on total fertility rate. Although this is not a direct indicator of health, it is an index of the spread of family planning and a measure of the rate of population growth. It also has some social significance as an index of female autonomy, with the important proviso that lower fertility rates are not achieved through coercive measures. The extraordinarily low figure of 1.8 for Kerala is especially remarkable and reflects well the major strides made in the state towards gender equality, in marked contrast to the situation in the rest of the country. The low figure of 2 for China is to some extent due to its strict one-child policy. The Costa Rica figure of 3.1 is relatively high in relation to its other social indicators and in comparison with an average of 3.0 for lower middle-income countries. All the countries have made substantial progress in reducing their total fertility rates but the performance of China, Cuba and Kerala is especially striking.

Moving now to education, Chile, Cuba and Costa Rica have adult literacy rates in the region of 95 per cent, very similar to those in high-income countries. In Kerala, Viet Nam and Sri Lanka nearly 90 per cent of the adults are literate, as are about 80 per cent in China. These figures should be compared with the average adult literacy rates of 51 per cent for low-income countries (excluding China and India) and of 86 and 81 for upper and low middle-income countries respectively.[5] The rate of 92 per cent for Viet Nam, a country with such a low per capita income, is truly impressive. Around 1990, there was practically no difference in male and female adult literacy rates in Chile, Costa Rica and Cuba. In Kerala, Sri Lanka and Viet Nam, the female literacy rates were between 88-91 per cent of the male, with a distinctly lower rate for China at 78.

As for primary education, it is not surprising to find that all the countries included in the study have reached complete coverage of the relevant age group. In this respect at least, their performance is not all that exceptional — since the average gross enrolment rates for countries in lower and upper middle income countries are similar, while in low income countries (excluding China and India) it is around 75

[5] The categorization of countries into low income, lower middle income, upper middle income and high income follows the World Bank practice. The criterion for classifying the countries is US $ per capita income and not purchasing power parity dollars. The income brackets for different categories may change over time. Table 2 shows the brackets for 1992.

per cent.[6] As might be expected, there is near parity in primary school between male and female children

There is more dispersion in gross secondary school enrolments. The Cuban enrolment rate, at 90 per cent, is quite remarkable, exceeding the rates in several high-income countries. Likewise, the Sri Lankan rate of 74 per cent is unique for a country with such low per capita income — the average for low-income countries being only 26 per cent. On the other hand, the Costa Rican figure of 43 per cent is surprisingly low, being below the Latin American average of 47 and the lowest in the countries included here with the exception of Viet Nam. The rate of progress in increasing secondary school enrolments has been especially outstanding in China and Sri Lanka. It is interesting to remark that female rates are higher than male in all countries except for China.

◆ Political, Cultural and Economic Diversity

Despite their common characteristic of superior social performance, the countries studied here display remarkable diversity in many areas (see table 1). In terms of size, the range is between China's population of 1.178 billion and Costa Rica's 3.3 million. Except for Viet Nam, with 71.3 million, other countries have populations between 10 and 18 million people. For the four Asian countries, the great majority of the population lives in rural areas, with the rate of urbanization varying between 20 and 30 per cent. Cuba and Chile are largely urban societies, with the share of population at 75 and 86 per cent respectively. On the other hand, Costa Rica is remarkable in its region and for its per capita income in having only half the population living in urban areas.

There is also very considerable diversity with regard to political régimes. Three countries are ruled by communist régimes under one party, while the other four are multi-party democracies. In the former group, communist rule was established at different times in the post-war period after violent conflict with domestic and foreign opponents. This was followed by a transformation of the social and economic system along socialist lines. The countries in the latter group have for the most part enjoyed liberal democratic systems but have experienced periods of suspension of democratic régimes and/or episodes of violent conflicts. Chile went through a brief period of socialist régime followed by harsh repression under a prolonged military dictatorship. Costa Rica's democratic tradition was also interrupted by a short period of electoral fraud and a popular rebellion. Kerala shared in the suspension of civil and political rights brought about by the declaration of emergency in India. Furthermore, it has had the unusual experience of being governed by a Communist Party, mostly in a coalition government that won power through multi-party elections. Sri Lanka has maintained a liberal, multi-party political system since independence but on several occasions the country has been shaken to its foundations by revolts and rebellions, the bloodiest and most prolonged being the civil war with the Tamil Tigers.

The countries also show considerable cultural and religious diversity. China has been influenced by millennial traditions of Confucianism and Buddhism within a largely homogenous culture, though several ethnic groups and Islam constituted

[6] Gross enrolment rates refer to the total number of students divided by the number in the relevant age group. They may exceed 100 per cent because of the inclusion of students of higher age.

small but significant minority populations. Viet Nam has been influenced heavily by Chinese culture and Buddhism while retaining its distinctive cultural patterns, with ethnic minorities in the highlands and a limited spread of Christianity. Sri Lanka has experienced similar cultural influence from India but is characterized by the dominance of Buddhism with a significant Hindu population and smaller minorities of Christians and Moslems. Kerala has a predominantly Hindu population but important Moslem and Christian minorities. Some sections of the population have social and cultural traditions, especially in regard to the position of women, that separate them from the predominant patterns among Hindus.

The three Latin American countries share a Catholic heritage, although its influence has varied over time. With the growth of a strong professional and middle class and of social democratic traditions, secular influence has grown in Chile and Costa Rica. However, in both countries strong political parties have continued to seek inspiration from Catholic social and economic doctrines. The two countries also have in common a largely homogenous population of European origin, although in Chile there is a small indigenous minority. The influence of the Catholic religion has been drastically curtailed by the atheistic philosophy of communism in Cuba, though it continues to be important in covert ways. Cuba is also distinct from the other two Latin American countries in having a mixed population of whites, mulattos and blacks. In fact, the latter two groups may constitute a majority of the population.

The countries included in the study also display considerable diversity in terms of level of economic development and growth and structure of the economy. Chile is currently classified by the World Bank under the upper middle-income category (per capita income between $2,785 and $8,625). Costa Rica and Cuba[7] fall in the lower middle-income category (per capita income between $696 and $2,785), while all other countries are included in the low income category (per capita income less than $695). The per capita GDP in Chile, at $3,170, was nearly 20 times the level in Viet Nam, 13 times that of Kerala, six and a half times that of China, five times that of Sri Lanka, two and half times the level of Cuba and 50 per cent more than in Costa Rica. These disparities are much reduced if income per capita is measured in purchasing power terms. The gap between Chile and Viet Nam becomes eight times, with China four times and Sri Lanka three times. But it remains roughly the same with Costa Rica and Cuba.

The economic structure reflects the overall level of development. In the low-income countries, the share of agriculture varies between 20 and 30 per cent and that of industry between 30 and 45 per cent. In Cuba, Costa Rica and Chile, agriculture accounts for less than 15 per cent, but the share of services lies between 50 and 60 per cent. Viet Nam, China, Sri Lanka and Kerala are largely peasant economies, with a relatively even distribution of land, especially in the communist countries. Plantations are important in Sri Lanka. Most of the large and medium scale industry in China and Viet Nam is in the hands of the state and townships, while in Kerala and Sri Lanka private ownership predominates. In Cuba, agriculture is dominated by large scale enterprises owned by the state and co-operatives, while most of the industry is in the hands of the state. This is in contrast to Chile and Costa Rica, where enterprises in all sectors are in private hands. As in

[7] The World Bank does not publish data on Cuba. The figures for Cuba are drawn from the UNDP **Human Development Report**.

other countries in Latin America, the disparities in income and asset ownership are very great in Chile, but they are significantly less in Costa Rica.

There are also major differences in rates of economic growth over time and by country. Kerala, Cuba and Viet Nam have experienced relatively low growth since 1970, though Cuba grew rapidly between the mid-1970s and mid-1980s, as has Viet Nam since the late 1980s. China grew slowly until the early 1970s but extremely rapidly subsequently. The growth in Sri Lanka also accelerated over the past decade and a half. Chile and Costa Rica experienced the fastest growth over the period as a whole (since 1950s), though there was a sharp reduction in Chile between the 1970s and early 1980s and in Costa Rica in the 1980s. Kerala has experienced sluggish growth over the entire period, especially since 1974-75.

The above brief review of the political and economic profiles of the countries leads to a heartening conclusion that high achievements in health and education are compatible with diversity in size, political régimes, religion, culture, ethnicity, per capita incomes and growth rates. The next section seeks to understand the factors that have contributed to these achievements.

3. UNDERSTANDING SOCIAL ACHIEVEMENTS

Social policy is determined by a complex of historical, political, economic and institutional factors. Historical and cultural traditions and colonial experiences often shape in important ways the salient features of contemporary policy. The nature of the political régime and distribution of power among social groups affect in a fundamental manner the scope and content of social policy. Such factors are important determinants of the amount and allocation of public resources for social programmes. Social achievements depend also on the private resources that are mobilized for health and education, as well as the efficiency with which both public and private resources are used to attain given objectives. Institutional arrangements for financing, organizing and delivery of social services are a reflection both of dominant ideologies and concern with efficiency in the use of resources. Understanding the social achievements of the countries studied here thus requires an approach integrating historical, political and economic analysis.

◆ The Importance of Historical and Cultural Legacy

This paper focuses primarily on social performance and policies in recent decades. A full understanding of the social performance of a country cannot, however, be gained without some attention to the salient features of its historical experience. These influence and shape in varying degrees the scope and substance of social policies. Often a major determinant of recent social performance is achievements in the past.[8] Of the seven countries studied here, the high social achievements of four go back to earlier periods. We do not have adequate data for these periods to compare in a rigorous manner their social performance with other countries at comparable levels of income, but the available information indicates that their social lead in several fields dates back often to pre-war years. Chile, Costa Rica, Sri

[8] This is one of the principal conclusions of the study by Lindenberg (1993).

Lanka and Kerala have for long been known for their progressive social policies. Despite very considerable economic and social inequalities, some of the social indicators also placed Cuba among above average performers well before the revolution.

Even at the beginning of the twentieth century, health conditions in Costa Rica were more favourable than the average for Latin America. Although explicit public health measures were rare until the 1920s, the subsequent period saw a rapid expansion of health facilities for a rising proportion of the population in Costa Rica (Rosero-Bixby, 1985). In the field of education, as far back as 1869, the constitution declared education free and compulsory. Already by 1892, 28 per cent of the population over 10 years was literate. The figure had reached 66 per cent by 1927 — an exceptionally high figure by Latin American standards.

In Chile also the foundations of social policy were laid in the 1920s, although some measures in the field of education, health and social security date back to the early years of the century (Raczynski, 1994). In the 1930s there was a considerable expansion of social services. In Cuba, the infant mortality and life expectancy data were better than average for Latin America in the 1950s. In 1953, illiteracy was at 23.6 per cent and primary school enrolment at 58 per cent (Carnoy, 1990).

In Sri Lanka, the foundations of a modern health care system were laid in the late nineteenth century (Caldwell, 1986). The anti-malaria campaign of the 1940s reduced the death rate from 187.3 per 100,000 in 1940 to 66.1 in 1947 and 32.8 in 1949. The educational system, comprised of public, religious and traditional schools, was well established by the turn of the century. Literacy rates rose from 26.4 per cent in 1901 to 39.9 per cent in 1921 and 65.4 per cent in 1953 (Anand and Kanbur, 1995; Gunatilleke, forthcoming).

The primacy accorded to health and education in Kerala goes back at least to the enlightened policies of some of the maharajas and maharanis of the princely states of Travancore and Cochin in the nineteenth century. It was reinforced by the work of the missionaries in establishing schools, orphanages and hospitals, especially for the poor and low caste people (Zachariah and Sooryamoorthy, 1994; Ramachandran, 1997). By the mid-1890s, the Travancore government claimed that 40 per cent of the school age population was attending school (Jeffrey, 1987). The subsequent social movements for the emancipation of lower castes were fundamental in eliminating barriers to health and education services for the most deprived sections of the population.

The situation was different in China and Viet Nam. Although both countries had ancient traditions of education and medicine, the primary beneficiaries were the élite groups. Furthermore, the period of colonial rule in Viet Nam and of warlords and foreign concessions in China, followed by prolonged wars in both countries, had a devastating impact on education and health conditions. The literacy level was low. In Viet Nam, the revolutionary leaders estimated it at between 5 and 10 per cent in 1945 (Woodside, 1983). In both countries, infant mortality was in excess of 200 per 1,000 live births in the pre-revolutionary period.

Thus the countries studied here present a contrasting picture: five of them had relatively good social indicators in the pre-1950 period, while two experienced very poor health and education conditions. The circumstances that contributed to good performance in the earlier period created a favourable political and institutional environment for the further consolidation of progressive social policies

in Chile, Costa Rica, Kerala and Sri Lanka. This should not diminish the credit they deserve, because good practices and policies must be maintained and adapted to ensure that earlier leads in social development are sustained.

The case studies also show that countries are not prisoners of their past. It is possible to break out of a dismal social situation of poor health, low literacy, high child mortality and low life expectancy to chart a new path with impressive and sustained rise in social indicators. China and Viet Nam witnessed a transformation in their ranking in social development, and in Cuba basic social services were brought within reach of the entire population. All three achieved socialist revolutions after the overthrow of the previous régimes. Later we shall examine the strategies and policies that enabled them to make a quantum leap in social indicators. Here it is worth noting that socialist revolutions have historically provided a route to rapid social progress. There are, of course, instances of other countries that have leaped up in the league of social performance. But in almost all such cases the social achievements have resulted from rapid growth — as happened, for instance, in East and South East Asian countries and oil producing countries in the Middle East. There are not many cases of countries with rapid ascent in the ranking of social indicators with average or below average growth rates.

Coming now to the first group of countries with a head start in social achievements, it is important to understand the specifics of the historical experience that contributed to their superior social performance. Different authors have drawn attention to different aspects of their experiences. For instance, it has been argued in the case of Sri Lanka, Kerala and Costa Rica that they are small, isolated from their neighbours, have densely settled rural areas and intensive exchanges with the outside world (Caldwell, 1986). This has made them more receptive to outside influences, especially from the western world, with positive health and educational results. These geographical factors, however, do not appear to have had similar impacts in many other similarly placed countries.

Another category of explanations pertains to the cultural domain. In the case of Costa Rica and Chile, several scholars have cited the relatively homogeneous character of the population (Hojman, 1993; Rosero-Bixby, 1985).[9] The vast majority of their population is of European origin — as indeed is true of Argentina and Uruguay, which are also characterized by high social indicators. The homogeneous character of their populations has resulted in a more egalitarian distribution of public education and health services than in other Latin American countries, where people of indigenous, African and mixed origin have faced systematic discrimination in public social and economic provisioning. Costa Rica and Chile have also been unique in Latin America in having a long tradition of liberal politics with strong organization of different social and economic interest groups.

In Kerala and Sri Lanka, social and cultural factors have also been said to be important in explaining the priority the government and people have given to literacy, education and health. In both countries, education has been revered and considered necessary for enlightenment. In Sri Lanka, the influence of Buddhism and the resurgence of Sinhalese cultural nationalism have been important in the

[9] However, as mentioned earlier, Chile has a small minority of people of indigenous origin.

early acceptance and rapid spread of primary education.[10] These factors were reinforced by the work of the missionaries and the colonial government (Caldwell, 1986; Gunatilleke, forthcoming). In Kerala too the emphasis placed by Christian missions on education was considered important, as was the leadership given by local rulers and various social and political movements. The traditional village schools played an important role in promoting literacy and basic education (Caldwell, 1986; Ramachandran, 1997).

It is interesting that both these societies were marked by a substantial degree of female autonomy. The influence of Buddhism was important in the case of Sri Lanka, while in Kerala the matrilineal system among some sections of the population combined with the missionary influence and the reformist movements of the Nayars and Ezhavas in the late nineteenth and early twentieth centuries gave girls and women a higher status and greater freedom than in other parts of India (Caldwell, 1986; Nayar, 1985; Jeffrey, 1987). The relatively emancipated position of women ensured access to education for girls and was also a key factor in promoting personal hygiene, clean environment, family planning and reduction in infant mortality.

This brief review of the historical experience of good social performers yields a varied and complex picture. Geographical position at a certain historical juncture can endow the region with important benefits. The homogeneous quality of the population has at certain times contributed to a relatively egalitarian distribution of public services through avoidance of discrimination against minorities. Religious and cultural factors were considered to have contributed significantly to good social outcomes in some countries. Finally, the nature of the political system and the growth of reformist movements and social organizations played a crucial role in their achievements, as shown below.

◆ The Politics of Social Development

The countries studied here fall into two broad categories of political systems: socialist one-party régimes govern China, Cuba and Viet Nam, while liberal democratic régimes are established in the other four countries. Chile constitutes somewhat of an exception, as it experienced a military authoritarian régime between 1973 and 1990. The classification of these countries into two broad régime categories conceals important features of the specific historical experiences and social, political and economic structures of individual countries which need to be taken into account in explaining their social achievements. However, the two-fold categorization of political régimes is a useful analytical tool in exploring the politics of social development in different countries.

The communist revolutions in China, Viet Nam and Cuba were followed by suppression of all opposition and autonomous organizations, nationalization of all major forms of property, creation of state enterprises, collective and co-operative farms, establishment of central planning, and of a strong centralized system with power concentrated in the communist party with the mass organizations under its control. The revolutionary parties were committed to the establishment of a new system with public ownership of all means of production and the creation of social and economic equality. Among the central aims of the communist régimes were

[10] However, Buddhism does not seem to have had similar impact in other countries in the Asian region.

eradication of illiteracy, improvement of health and provision of free education and health services on a universal basis. The social services were financed from the surpluses generated by collective agriculture and state enterprises and from assistance from the Soviet bloc, especially in the case of Cuba. They resulted in dramatic improvements in literacy, infant mortality, life expectancy and in primary and secondary schooling. They also went a long way in consolidating popular support for the new régimes.

The liberal democratic régimes also provided, in varying degrees, a favourable setting for the expansion of social services to cover an ever increasing proportion of the population. Although universal suffrage was only attained in the post-war period in Chile and Costa Rica, both countries had a long tradition of competitive party politics, going back to the nineteenth century. The liberty of expression and association in combination with competition for political power in periodic elections led, over time, to an extension of education, health and social security coverage to growing strata of the population (Graham, 1994; Raczynski, 1994; Hojman, 1993; Pearce, 1996; Rosero-Bixby, 1985).

There were, however, significant differences in the political systems in the two countries. In Chile, economic inequalities were greater and political cleavage between the conservative and centre-left parties was wider. This led over time to sharpening social divisions. The competition for power among parties led to a type of client politics under which the more powerful groups sought and obtained a widening range of social benefits. While universal primary education (though with uneven quality for different groups) was attained in the early post-war years, health and social security benefits were extended piecemeal first to the upper ranks of the bureaucracy and the army, gradually filtering down to lower ranks and then to the organized working class. The urban poor, small farmers and other marginal groups were not brought into the health and social security coverage until the 1960s. Furthermore, the system led to a proliferation of health and social security schemes with differential range and quality of benefits. In the meanwhile, the continuing economic disparities and growing radicalization of politics led to political polarization first with the victory of the socialist coalition under Allende and subsequently to the Pinochet military dictatorship.

The Allende régime, with its power base rooted in the working class, small farmers and sections of the middle class, sought to bring about a drastic redistribution of wealth and income through a programme of nationalization, agrarian reform and increases in wages of low-paid workers. In social policy, the régime sought to extend health, pension and unemployment benefits to the unemployed, poorer peasants, and unorganized rural and urban workers. The armed forces, especially the army, constituted the power base of the Pinochet government, but the régime also benefited from explicit or implicit support from owners of large businesses, estates and sections of the middle class. Its political project was to crush the power of popular organizations and roll back the socialist measures initiated by the Allende government.

In its economic policy, Chile's military dictatorship promoted privatization, deregulation and marketization, and it applied the same principles to social policy. It encouraged privatization and decentralization of health, education and social security services. It promoted rationalization and consolidation of these services and sought to target nutrition, child and maternal care and health programmes on the poorest sections of the population (Huber, 1996). The pro-poor bias of some of

its social programmes appears to have been motivated by a desire to win support from the lower classes, enhance régime legitimacy and build up "human capital".

In Costa Rica, greater social and economic equality contributed to a more consensual political system. The major political parties, despite periodic electoral competitions, were able to achieve consensus on the main political, economic and social goals. The consensual political style was facilitated by participatory democracy with a strong role played by trade unions, peasant associations, co-operatives and other segments of the civil society. While universal primary education was achieved before the Second World War, the coverage of health and social security was progressively broadened over the years. It was, however, only in the 1970s that the bulk of the population benefited from unified health, unemployment and old age pensions (Mesa-Lago, 1994b).

The existence of a multi-party liberal political system in Sri Lanka facilitated the emergence of progressive social policies. Universal suffrage was attained in Sri Lanka under the colonial régime in 1936 — well before it was achieved in many western democracies. Electoral competition between the parties of the left and the centre was a constant spur for them during election campaigns to promise the people better coverage and improvements in health and education services. The pressure from rural and urban unions, social movements and the middle classes led to the establishment of free health services and free education from the primary to the tertiary levels (Caldwell, 1986; Gunatilleke, forthcoming).

Similar circumstances led to political support for the expansion of social services in Kerala. Although Kerala forms part of a federal country with a strong centre, the responsibility for health and primary and secondary education has been vested in India's constituent states. The nineteenth century tradition of social movements was further consolidated in the struggle for independence and in the post-independence period. Of all the cases considered here, perhaps Kerala has the most powerful and radical social movements. These consist not only of workers' organizations in rural and urban areas but also students, teachers and women's associations of various sorts (Zachariah and Sooryamoorthy, 1994). The emergence of a powerful communist party put further pressure on the government continuously to improve provision of health and education services. The strong grassroots organizations and social movements not only demanded universalization of these services but also ensured that the available facilities were fully utilized. With the coming to power of the communist party, further measures were adopted to improve these services and provide income support for the indigent and extend pensions to the elderly (Osmani, 1991, Kannan, 1995).

◆ Institutions and Resources

The institutional framework for organizing and delivering social services influences efficiency and access as well as participation by the people in the government's social programmes. Social services may be organized through the state — central, provincial or local governments — the commercial sector, popular organizations, voluntary agencies or through a combination of these. The countries included in this study demonstrate a wide variety of institutional arrangements, but they were all characterized by a strong role played by the state in the provisioning of social services. The dominance of the state is obvious in the three communist countries, but it was also decisive in Costa Rica, Sri Lanka and Kerala. Although Chile was celebrated in the 1980s as a model of privatization of social services, it is

worthwhile underlining that its earlier achievements were due largely to the assumption of responsibility by the state for social services. Even under the Pinochet régime, it was the effective targeting of resources on the poor and vulnerable groups by the state which resulted in sharp improvements in infant mortality and child nutrition.

Both China and Viet Nam practised considerable decentralization in the provision of social services. In China, the major responsibility for education and health services devolved upon the provinces and counties. Prior to the reforms of the 1970s, the agricultural co-operatives and communes played an important role in primary health care and basic education. Likewise, mass organizations such as the Communist Party, Women's, Workers', Youth and Peasant Organisations contributed significantly to literacy and health campaigns. In the urban areas, the state enterprises shared responsibility for health care, child care and pensions. In Viet Nam also, in part because of the prolonged period of wars, the main responsibility for basic health and primary and secondary education was vested in the provinces and counties. The producers' co-operatives in rural areas and mass organizations were critical, but state enterprises did not have responsibilities in the domain of health and education. In Cuba, the central government was the most important state organ, though the mass organizations continued to assist in the implementation of social policy.

In Sri Lanka and Costa Rica, the central governments carried the main responsibility for health and education provisioning. It was the state government in Kerala which played a leading role in providing the health and school services. The ruling junta in Chile decentralized and privatized social services, with the municipalities assuming greater responsibility in health and education provision. Furthermore, except for the army, health insurance was privatized for most employees and better off sections of the population. However, the government continued to carry responsibility for free education and health for the poorer sections of the population.

In all cases, the administrative capacity of the state to reach down to major segments of the population was crucial to widespread social provisioning. It would not have been possible to provide mass coverage without the support of abundant professional and sub-professional personnel. The physical infrastructure as well as a good transport system were essential. In fact, it is the remote areas, especially in China and Viet Nam, with poor physical infrastructure that continue to lag behind in social indicators. These human and physical capacities can only be created and maintained by firm state action sustained over long periods.

The voluntary sector, either on its own or with the support of the state, has played an important role in education in Kerala and Sri Lanka. Schools run by religious organizations and charities have been important historically, but increasingly they are supported and regulated by the government. The role of the commercial sector has greatly expanded in recent years in most countries under the impact of stabilization and structural adjustment programmes. The most important developments have been in China and Viet Nam, where a good deal of medical treatment has been privatized or covered by charges in both rural and urban areas. Private practitioners are also important in Kerala and to a lesser extent in Sri Lanka. The commercial sector plays a more limited role in education, although in recent years there has been a strong growth in several countries — Chile, Costa Rica and Sri Lanka — in private universities and technical colleges. Interestingly,

in Cuba and Costa Rica the state has held on to its central role in the provision of education, health and social security.

The level of government spending on health and education is an index of the importance attached by the government to social development. It is generally assumed that better social performance is due to larger amounts allocated to social programmes. But the amount of resources is only one determinant of social performance. How effectively these resources are used is of equal importance. Comparable data on the amount and composition of public social expenditure in different countries are difficult to come by. Table 3 shows one estimate of the share of public expenditure on education and health in GDP for 1960 and 1990. It should be emphasized that these figures exclude private expenditure on these services and thus cannot give a picture of total resources spent on education and health.

Table 3
Public Expenditure on Health and Education (% of GDP)

	Health		Education	
	1960	**1990**	**1960**	**1990**
Chile	1.3	2.5	2.7	3.7
China	1.3	2.1	1.8	2.3
Costa Rica	3.0	5.6	4.1	4.6
Cuba	3.0	3.4	5.0	6.6
Kerala[4]		3.0	3.4	6.4
Sri Lanka	2.0	1.8	3.8	2.7
Viet Nam[1]		0.9		1.1
		(1.2)[2]		(2.8)[2]
Low HDC[3] (excluding India)	0.6	1.6	2.3	3.6
Med. HDC (excluding China)	0.7	2.4	2.5	4.7
High HDC	1.2	2.1	2.2	3.7
All developing countries	0.9	2.2	2.2	3.9

Notes: [1] World Bank (1995); [2] 1993; [3] HDC = Human development category; [4] Krishnan (1997)
Source: UNDP, **Human Development Report**, 1994.

Apart from Cuba and Costa Rica, which stand out for the relatively high share of public expenditure on education and health — around 10 per cent of GDP in 1990 — the share in other countries is relatively low. Indeed in 1990, only Chile and Kerala equalled or slightly exceeded the average public sector share in education and health of the high and medium human development countries.[11] China and Viet Nam have especially low shares. The rest of them were below the averages of all three categories of countries —high, medium and low human development — in education and for the most part in health, although in 1960 their shares were higher. If the data given in the table are reasonable approximations of the true situation, they lead to the important conclusion that the high social achievements of

[11] This categorization of countries by HDI, taken from the UNDP **Human Development Report**, should not be confused with the World Bank classification into high, medium and low income countries. As Kerala forms part of a federal state, its data are not strictly comparable with the other cases.

these countries may have been less due to the relative size of public expenditure and more to the effectiveness with which these resources were spent. The main reason for their outstanding social performance, as shown in the next section, is the emphasis in public social expenditure on universal provision of preventive and primary health and literacy and basic education.

The table also shows that the share of spending on health and education has increased over time in all countries with the significant exception of Sri Lanka. The time series data on individual countries show that, with the exception of Cuba and perhaps Kerala, all the other countries experienced a decline in the shares of public social expenditure in the 1980s. As discussed further below, this was due to policies of structural adjustment. This trend was reversed in all countries with the resumption of growth but it did not reach the high levels attained in some earlier years in Sri Lanka, Costa Rica or Chile.

Foreign assistance accounted for a high proportion of national income in Cuba for much of this period, tapering off only in the 1990s. Thus indirectly it played a vital role in sustaining high levels of government spending on health and education. Development assistance has also been important in Sri Lanka since the late 1970s and thus facilitated the protection of social programmes in the subsequent years of structural adjustment. Costa Rica benefited greatly as well from foreign aid in the crisis years of the 1980s. In recent years, aid flows have come down to modest levels. Development assistance has been relatively insignificant for China, Chile and Kerala. For Viet Nam, foreign aid from the Soviet bloc may have been quite substantial but aid flows have been modest in recent years.

4. PRIORITY TO PRIMARY HEALTH CARE

The key to achieving low levels of infant mortality and high life expectancy is a primary health system that brings certain basic services within the reach of the entire population. Among the most important of these are healthy environment, clean drinking water, proper sanitation, personal hygiene, improved nutrition (in particular breast-feeding), food safety, immunization, and pre- and post-natal maternal and child care. The experience of the countries studied here bears out the validity of this approach to health policy. The poorer the country, the greater the relevance of health policy based on primary health care.

Pre-revolution China suffered from high levels of child mortality, overall morbidity, high incidence of malnutrition and low life expectancy. The health policy adopted after 1949 and evolved in subsequent years was based on eradication of the root causes of mass diseases, health education and the creation of a low-cost, multi-purpose and widely accessible system of primary health care. Major campaigns were organized after 1949 to improve environmental sanitation to eliminate the four pests — rats, flies, mosquitoes and bedbugs. From 1951 on, four to five similar campaigns a year were organized. These were accompanied by a mass programme of vaccination against infectious diseases and measures to control malaria and schistosomiasas. Mobilisation of vast numbers of people through mass organizations played a key role in the success of these campaigns. Personal hygiene, clean water, prevention of food contamination and improved nutrition formed important parts of health education propagated through the party and other mass organizations. Their success depended upon improvement of women's status and education (Taylor, 1988; Jamison, 1984; Kane, 1985; Bhalla, 1992).

These policies were further buttressed through a nation-wide system of commune and brigade health centres that brought treatment against common ailments within easy reach of the great majority of the population. These co-operative health schemes were financed and organized by production units at the commune and brigade levels in rural areas. In townships and cities, medical care and treatment were assured through a combination of facilities run by neighbourhood associations, state enterprises and the health ministry. Apart from treatment against disorders, the health centres also served as bases for immunization, maternal and child care, family planning and assistance with child delivery.

Both in rural and in urban areas, there was a three tiered structure of health care. Most of the health care was provided free or for nominal charges. This system of universal access to health care would not have been possible without the training of a huge number of paramedical staff popularly known as barefoot doctors. Equipped with a rudimentary training in public health and treatment of common ailments, the barefoot doctors spanned the length and breadth of the country and provided the backbone of the health system. Volunteer workers of various sorts provided additional manpower in health campaigns, public education and other tasks.

These were the key features of a health system which proved so successful in sharply reducing epidemics, improving environmental and personal hygiene, curtailing child mortality, enhancing life expectancy and promoting family planning. With the resolution of the most basic health problems, the emphasis shifted to improvements in quality of health care at all levels. The changing nature of diseases and health problems led in the 1980s to changes in some elements of the health system. But it was the economic reforms in the 1970s, with fundamental changes in the system of rural production, which were responsible for far-reaching alterations in the health system. The implications of these changes for public health are analysed subsequently.

The development of the health system in Viet Nam has strong parallels with that in China. The health situation was deplorable after the Second World War. “Few people boiled their drinking water. Bathing areas were little more than stagnant pools, breeding grounds for malaria-carrying mosquitoes. Untreated animal and human wastes were applied to fields as fertilizer, and no septic tanks existed.” (Ladinsky and Levine, 1985). Insufficient health care combined with poor public health practices resulted in high morbidity and mortality rates among the population. The impressive achievements in reduction of child mortality and morbidity and increase in life expectancy witnessed in Viet Nam in the 1950s and subsequent decades owe much to the establishment of a system characterized by emphasis on literacy, especially of women, environmental improvement, health education, wide participation in provisioning of health services and access to basic health services by the great majority of the population.

As in China, great reliance was placed in the early years on health campaigns. A patriotic movement was launched for improvement of environmental conditions under the slogan “clean villages and fertile rice fields”. This movement developed promotional and preventive activities with participation both by the general public and the health workers (Djukanovic, 1978). Educational campaigns were important as they led the struggle against some traditional practices inimical to good health, such as drinking unboiled water, using untreated faeces as a fertilizer and relieving

oneself beside the rice fields. The campaigns were also instrumental in the construction of wells, latrines and sewage disposal facilities.

Until 1986, the core of the health system in Viet Nam consisted of commune health centres at the base, with district, provincial and national hospitals at higher levels. The commune health centres provided basic preventive and curative health services to the entire rural population free of charge. They consisted mostly of paramedical staff, including at least one assistant doctor trained for three years and a nurse-midwife trained for two years. The financing was shared between the central government, the commune authorities and production brigades. Maternal and child care, family planning, health education, traditional medicine and environmental cleanliness were integrated into the system. There was extensive participation of the people in the management and running of the commune health centres. The quality of services varied according to the wealth of the area, but certain criteria were used by the government to ensure a basic minimum throughout the country (Djukanovic, 1978; Ladinsky and Levine, 1985; Allman, 1993).

It was this system which was primarily responsible for the remarkably good infant mortality and life expectancy figures of Viet Nam in relation to its per capita income. Following the introduction of *doi moi* reforms in 1986, a number of changes were introduced to the structure of the health system. Some of the important changes introduced in recent years in both China and Viet Nam, as shown later, include the imposition of user fees, introduction of health insurance schemes, legalization of private practice, expansion of private drug stores and private practice by commune health workers. This has resulted in greater variation in the quality of health services among different regions, a reduction in the intensity of public health centres and a greater reliance on self-medication, traditional medicine and private practitioners. Even though the user charges can be waived for the poor, the less well-off groups and areas have clearly been adversely affected by these changes (Moghadam, forthcoming; World Bank, 1995; Güldner, 1995; Ensor, 1995; Tran Hien, 1995).

The foundations of an integrated health system in Sri Lanka were laid in the 1940s. The earlier emphasis on prevention of infectious diseases through environmental improvement led to dramatic reductions in mortality. The attack on malaria in the early 1940s was the most important example of this approach. Early attempts were also made to provide health care to the entire population through a network of hospitals and clinics. Already by 1946, a population of 5.75 million was served by a network of 145 general and rural hospitals, 250 central dispensaries and over 600 branch dispensaries. The number of health centres serving expectant mothers and pre-school children rose from 86 in 1935 to 503 in 1945. Nearly half the births took place in hospitals and nursing homes (Gunatilleke, 1985).

Programmes for maternal and child care, including nutritional supplements, were put in place. School children received free milk. Food prices were stabilized and food subsidies were provided to the entire population. The health care system was further consolidated and universalized in the 1950s. Maternal and child health services were strengthened, including services in the vulnerable ante-natal, post-natal and infant stages. Immunisation programmes were launched against smallpox, tuberculoses, polio, diphtheria and whooping cough. By mid-1960s, diseases such as smallpox and cholera had been eliminated and typhoid had almost disappeared. After the success of the campaign against malaria, similar campaigns were initiated to control tuberculosis and leprosy.

From the mid-1960s to 1977, there was little improvement in the infant mortality rate and life expectancy. This was due to severe economic crisis with high unemployment and declining expenditure on health, education and food subsidy. The system also appears to have become excessively centralized. While health services were widely and equitably distributed, one section of the population — the Tamil estate workers — were left out. Prior to independence their social indicators were above the average but they steadily lagged behind in the subsequent period since they were excluded from health, literacy and environmental programmes. The result was that in 1980, while the infant mortality rate for Sri Lanka as a whole was 37, it was around 80 for estate workers (Gunatilleke, 1985).

After 1977, there were further cuts in social expenditure as part of a major reorientation in social and economic policy. The bulk of the fall in welfare expenditure related to food subsidies, while most of the earlier health programmes were maintained. Health services continued to be provided free, as were school meals and nutritional supplements to expectant mothers and to children suffering from malnutrition. The improvements in infant mortality and life expectancy resumed their earlier trend.

The beginnings of the public health system in Kerala go back to the last decade of the nineteenth and the early decades of the twentieth century. Attempts were made in the Travancore-Cochin area to control infectious diseases such as plague, cholera and small pox through such measures as improved sanitation, water supply, health education and personal hygiene (Panikar, 1985). The town improvement committees and rural conservancy establishments were set up in the 1880s to supervise sanitary arrangements, scavenging and waste disposal. In the 1930s, maternity and child care centres were established and health education campaigns initiated. After independence in 1947, the state government built on these traditions and public policies to extend and improve health facilities.

The major planks in the health policy were expansion of immunization, state-wide extension of primary health centres, emphasis on child and maternal care, especially the steady growth of institutionalization and professional attendance at births, widespread use of traditional (ayurvedic) medicine, increase in literacy and basic education, especially for women, and the introduction of nutrition programmes for mothers and infants. For instance, there was a remarkable reduction in infant mortality between 1956 and 1966 due primarily to the rapid expansion of vaccination against small pox and other infectious diseases and the spread of health facilities in the Malabar district, which was incorporated into the newly created state of Kerala in 1956. After a period of slow change, there was a further spurt in reduction in infant mortality after 1976 due to an expanded programme of immunization and rapid institutionalization of child delivery and increased paediatric care. Between 1973 and 1991, the proportion of institutional deliveries in rural areas rose from 26 to about 92 per cent, while the remaining 8 per cent benefited from professional attendance (Krishnan, 1997).

A good transport system combined with a relatively even and dense network of rural health centres and expanding hospital facilities brought health care within reach of the entire population. Already in 1977, the catchment area of primary health centres was 22 square kilometres (Moni Nagi, 1986). The health consciousness of the population contributed to an intensive use of public health services: for instance, in 1965 over 80 per cent of the population visited

government hospitals. The health facilities are relatively evenly distributed between rural and urban areas and between less and more developed districts. Thus there are no sharp differentials either in access to health care or in infant mortality and life expectancy rates among different districts and socio-economic groups.

A remarkable feature of the evolution of health policies is how such differentials have been progressively reduced or eliminated with regard to two categories of disadvantaged groups. Lower castes have substantially inferior social indicators throughout India. This was also true of Kerala. But decades of struggle for removal of caste discrimination, supported by powerful social movements and political parties, have largely eliminated these differences in infant mortality and life expectancy (Ramachandran, 1997; forthcoming). Similarly, at the time of its incorporation into Kerala, the Malabar district had a death rate twice that of the Travancore-Cochin region (United Nations, 1975). There were also substantial differences in the two regions in birth rates and total fertility levels. These differences have been steadily reduced over the past four decades by a systematic policy of heavy public investment in health and education facilities in the former Malabar district.

Costa Rica has long had relatively favourable social indicators. Steady progress has been made in reducing infant mortality and increasing life expectancy since 1940. Infant mortality rates fell from 95 per thousand live births in 1950 to 67 in 1970, but really big improvements occurred in the 1970s, with the figure for 1980 declining to 21. The biggest factor in the transformation of the health situation was the adoption in 1970 of a health strategy based on primary health care (Rosero-Bixby, 1985). Its objective was to bring environmental sanitation and basic health services to the excluded population, mainly in the rural areas. This was achieved in two ways. First, social security (which included health care) coverage was expanded rapidly, increasing from 39 to 78 per cent between 1970 and 1979 and further to 84 per cent by 1992. This was brought about by unification of the social security function in one organization and provision of state subsidies to ensure coverage for the poor and the elderly (Saenz, 1985; Mesa-Lago, 1994b).

Second, sanitation and primary health services were provided by the Ministry of Health, which covered the countryside with a network of health centres and mobile clinics providing a range of services, including vaccination, child and maternal care, nutrition and family planning. Between 1973 and 1979, the proportion of the rural population provided with these services rose from 10 to 60 per cent. The basic health zone covered 3000 inhabitants and no more than 150 square kilometres. The rates of immunization against measles, diphtheria and tetanus rose to 85-90 per cent. At the same time, under the community health programme, rapid progress was made in the provision of clean drinking water, sanitary latrines and nutritional schemes for infants, school children, pregnant women and breast-feeding mothers. Thus by 1981, the entire urban population and 86 per cent of the rural inhabitants had access to clean drinking water. Between 1976 and 1979 the population with access to sanitary latrines expanded from 60 to 96 per cent in urban areas and from 41 to 88 per cent in rural areas (Saenz, 1985).

In Chile, health indicators such as infant mortality, death rates and life expectancy have shown a steady improvement in the post-war period. The country had over the years built up good health services, and after the creation of the National Health Service in 1952 there was a steady extension of free medical services to a growing proportion of the population. In the late 1960s, over 65 per cent of the population,

including workers and their families, the poorest groups and children had the right to free health services. Programmes of child and maternal care and nutrition, first created in the 1930s, had been greatly expanded over the years (Raczynski, 1994). Infant mortality rates declined from 120 per thousand in 1960 to 65 in 1974. But really dramatic reductions in the IMR took place in the subsequent decade, with the figure declining to 20 by 1984. Child malnutrition declined from 15.9 per cent in 1976 to 8.7 per cent in 1985 (Ruiz-Tagle, forthcoming).

It is remarkable that these improvements occurred in a period marked by severe economic crisis, high levels of unemployment, rising poverty and declining public expenditure on social services. While a number of factors contributed to this achievement, the decisive role was played by the policy of targeting limited resources to reach the poorest groups and to ameliorate conditions affecting infant mortality. A study examining the redistributive impact of the health services and the food nutrition programme estimated that the poorest 20 per cent of households received between 34 and 40 per cent of this component of expenditure on health (Raczynski, 1994).

The focus of the health and nutrition policy was maternal and child health and nutrition programmes. Beginning in 1975, a system was set up to identify children under six with nutritional and health problems. Programmes of pre-natal care, child and maternal nutrition and vaccination were redesigned to focus on these groups, and they were able to reach 95 per cent of the relevant population. At the same time, major advances were made in the provision of clean water and sewage facilities. Between 1974 and 1988, the proportion of the urban population with access to clean water rose from 70 to 98 per cent, while in rural areas it rose from 35 to 75 per cent. The coverage of the sewage system expanded from 38 to 81 per cent of the urban population. The impact of these policies on child nutrition and mortality was reinforced by improving education for women and declining fertility (Raczynski, 1994).

5. ACHIEVEMENT OF ADULT LITERACY

This section examines some remarkable efforts made by selected countries to rapidly reduce or eliminate adult illiteracy as an illustration of focusing of social policy on priority needs. Literacy and primary education are intrinsically valuable but they also have beneficial effects in many areas. They are associated with lower mortality and fertility rates, more informed participation in civil society and political activities and more broad-based growth patterns (Drèze and Loh, 1995). All the countries included in the study show impressive educational achievements. By the early 1990s, with the exception of China, they had attained adult literacy rates around or in excess of 90 per cent, with relatively little differential between male and female literacy levels. There was nearly universal access to primary schools in all the countries, although secondary school enrolments showed considerable divergence.

Chile, Costa Rica and Cuba had already attained adult literacy rates above 75 per cent in the early 1950s. By 1970 their rates were in the region of 90 per cent. Similarly they had nearly universal primary education in the late 1950s. In the domain of literacy and primary education, the achievements of the low income countries included in this study are outstanding. In the late 1940s, the adult literacy rate in China was estimated to be 15 per cent, and is likely to have been even lower in Viet Nam. Sri Lanka, where significant social initiatives were taken in the

1930s, had reached a literacy rate of 57 per cent in 1945, with, however, big differences in male and female rates — 70 and 44 per cent, respectively. Kerala also enjoyed a relative lead in education, but by 1951 the adult literacy rate was still at a modest level of 40 per cent, with considerable gender disparity.

There was steady progress in reducing illiteracy in Sri Lanka and Kerala, with the big jumps occurring in the 1960s in the former and in the 1980s in the latter. In both these periods, special programmes were mounted to make a major dent in illiteracy. But the greatest progress was made in China and Viet Nam, where massive campaigns were undertaken to promote adult literacy in the 1950s. Although the Cuban illiteracy rates were quite modest on the eve of the revolution (concentrated among the rural and black population), the 1961 literacy campaign stands out as an extraordinary effort to eradicate illiteracy within the space of nine months.[12] In a world where there is still widespread illiteracy, it is worthwhile reviewing the major achievements and key features of the mass literacy campaigns conducted in these countries.

In terms of sheer numbers of people, the Chinese mass literacy campaign launched after the revolution is without parallel in human history. Between 1949 and 1966, over 100 million illiterates were taught to read and write (Bhola, 1984a). The literacy campaigns were based on the experience gained in the liberated areas in campaigns conducted in 1937, 1940 and 1944. The driving force behind the effort was the ideology of the revolution, which looked upon literacy as essential for consciousness raising, eradication of class differences and improvement of living conditions. The importance attached to literacy by the revolutionary government is illustrated by Mao's statement "The necessary condition for establishing a new China is to sweep away illiteracy from the 80 per cent of China's population." (Bhola, 1984a).

The approach and methods utilized in the Chinese literacy campaigns have been used in varying degrees by other revolutionary régimes. While the leadership was provided by the party and the government, the campaigns drew upon the resources and co-operation of numerous groups and institutions such as the local authorities, unions and peasant, women's and youth associations, factories, community buildings and schools. Given the constraints of infrastructure, finance and organization in such situations, a massive mobilization of community and voluntary resources was indispensable for a speedy and large scale attack on illiteracy. Another notable feature of the literacy campaigns was the importance of flexibility in approach and methods to suit the circumstances of specific groups and areas. The timing, duration and methods for imparting literacy differed between rural and urban areas, between peasants and workers, younger and older people, housewives and working women and more and less advanced regions. There was also enormous diversity in organization of teaching (circuit teaching, reading circles, collective teaching method, little teachers) as well as in systems of incentives (learning contests, honours, attendance charts). Typically the literacy classes were used to promote political aims as well as for imparting knowledge about health, personal hygiene and healthy environment.

China's educational policy has tended to shift directions in accordance with ideological changes associated with factional power struggles (Burris, 1990;

[12] There were, however, problems of sustaining low levels of illiteracy. The subsequent period saw a reversion to illiteracy of 10-12 per cent.

Bhalla, 1992). The great leap forward in the late 1950s put emphasis on proletarian education and equal access at the expense of quality and higher education. This was reversed in the early 1960s with the adoption of the New Economic Policy. The Cultural Revolution in the late 1960s in effect resulted in the suspension of the formal educational system and of the adult literacy effort. The mid-1970s witnessed the resumption of formal education, renewed emphasis on the literacy campaign, upgrading of quality and greater differentiation in access by area and income group.

Eradication of illiteracy was listed as one of the 10 major objectives of the communist revolution in Viet Nam. The country sustained a huge literacy effort under extremely difficult and varied conditions during years of resistance, independence and unification (Woodside, 1983). The literacy campaigns were utilized to promote political objectives such as struggle against colonial powers and class enemies, to further agrarian reform and agricultural production and to ameliorate personal hygiene and the physical environment (Phong Nuin, 1985). Four major campaigns were conducted between 1945 and 1976. More than 13 million illiterates learned to read and write between 1945 and 1958, resulting in the virtual elimination of illiteracy in the North except for the remote mountain regions. The government made a special effort to reach minority groups through mobile schools. In April 1975, a literacy campaign was launched in the South and by December 1977, illiteracy among working people below 50 years of age was largely eliminated. In March 1978, Viet Nam celebrated the virtual eradication of illiteracy in the entire country (Bhola, 1984b).

The material conditions under which the literacy effort was carried out, especially during the years of resistance, were much worse than in China. Classes were often held in private homes or in the open. Often they could only be held in the evening or during bombing pauses. Banana leaves substituted for paper and a combination of certain leaves and fruit gathered in the forest provided a liquid that served as replacement for ink. A great deal of flexibility and ingenuity was deployed to meet the special needs of different groups and areas. For instance, in some areas, in order "to revise the lessons, letters of the alphabet are written up on boards, or on the backs of buffaloes, or on the hats of the labourers themselves; blackboards are set up in the shade of a tree, in the yard where normally they thrash the rice, so that workers can revise what they have learnt, without wasting time, even while working" (quoted in Bhola, 1984b:76). The literacy campaigns could not have succeeded without the voluntary contribution of the mass organizations, teachers and students and without co-operation between the central, provincial and local levels. As in China, the existence of cultural homogeneity and especially the use of a common alphabet among the great majority of the population contributed greatly to the success of the literacy campaigns.

Although starting from a much more favourable educational profile and material conditions, the Cuban literacy campaign of 1961 is celebrated for its many innovative features and for the speed with which it virtually eliminated illiteracy in the country. In 1953, 24 per cent of Cubans were illiterate, with rates of 42 per cent in rural areas and much higher among the blacks. After eight months of the 1961 campaign, the rate come down to 3.9 per cent (Bhola, 1984c; Leiner, 1987). Eradication of illiteracy was part of the 10 point programme set out in the manifesto of the Sierra Maestra in 1957. The importance attached to literacy is well brought out in Castro's statement: "Revolution and education are the same thing. . . . Society as a whole becomes a huge school" (quoted in Leiner, 1987:175). As in

other communist revolutions, the literacy campaign had wider political and social objectives, such as the fight against class enemies and racist tendencies, the promotion of agrarian reform and rural-urban solidarity, and the improvement of production and living standards (Carnoy, 1990).

The 1961 literacy campaign was preceded by a careful survey of the numbers and socio-economic characteristics of the illiterate population and pilot programmes to test the literacy material and training modules. Practically all literate people were mobilized to participate in the campaign: 250,000 teachers and students spent up to 9 months in the countryside, and 100,000 additional persons received special training as instructors. Mass organizations of women, youth, peasants and workers played a key role in identifying the illiterate population, providing volunteers and furnishing material support. The media — radio, television, newspapers and billboards — was used intensively to promote the campaign. The literacy campaign was followed by programmes of further education through part-time courses or full time study in the formal educational system.

The high levels of literacy in Kerala and Sri Lanka were the result principally of an early start in education and steadfast expansion of primary education to cover the entire school age population. But efforts were also made to mount intensive literacy campaigns to rapidly reduce adult illiteracy. In Kerala, the experiment at total literacy was launched in the Ernakulam district by voluntary agencies. Its success encouraged the adoption of the Total Literacy Programme in the state. This was a co-operative venture by government, political parties, NGOs and individual leaders. It elicited the voluntary participation of nearly 400,000 persons in the literacy campaign (Ramachandran, 1997; forthcoming). In April 1991, Kerala was declared the first totally literate state in India. The example of Kerala shows that eradication of illiteracy in very low income countries is possible in non-revolutionary situations. The essential elements in Kerala were the political priority attached to this objective and the mobilization and co-operation of government, political parties and civil society organizations.

6. EXPERIENCES WITH POVERTY REDUCTION

Elimination or rapid reduction of poverty is an important aspect of success in social development. This section examines the trends in poverty reduction in the countries included in this study and their relationship with economic growth and social indicators. It pays special attention to strategies and programmes for poverty reduction which have been particularly effective. While creditable in some respects, the performance with regard to poverty reduction of the countries examined here has not been as consistent and outstanding as with health and education. This is partly due to the way poverty is defined conventionally. It is also important to note that data on poverty are of much inferior quality and comparisons over time and across countries are difficult if not impossible to make.

No country has a consistent series of poverty data covering the post-war period. At best there may be observations covering a few periods which are reasonably comparable. Comparisons across countries are virtually impossible to make because of the lack of a common definition and methodology for measuring poverty, although some attempts have been made, particularly by the World Bank,

to measure poverty in different countries on the basis of an absolute figure for a poverty threshold (World Bank; 1990; Lipton, 1996).[13] These points should be borne in mind in the following discussion on poverty levels and trends in different countries

◆ Poverty Levels and Trends

Poverty may be defined in many different ways. It may refer to material deprivation, social exclusion, certain psychological attributes or power relations. It may be measured in some "objective" way or in terms of perceptions of the poor, in absolute or in relative terms. In the development literature, poverty is typically defined in material terms and measured by the number of people or households falling below some level of nutrition, consumption or income (defined, in turn, in terms of meeting some core basic needs). It is important to note that nutritional and consumption measures generally leave out in varying degrees access to education, health, clean water, adequate shelter and basic sanitation.

In the communist countries the collective ownership of property, full employment, free education and health services and a favourable price structure for essential goods and services, resulted in a relatively even distribution of income and consumption and meeting of the most basic needs. The level at which these needs were met depended upon the general level of development and regional disparities in incomes. For instance, after the initial difficult years and the overcoming of the worst production and distribution problems, absolute poverty was reduced in Cuba to insignificant proportions in the late 1970s and most of the 1980s until the onset of the economic crisis. The choice and quality of non-essential goods and services were limited, but most of the population had access to good education and health, and basic foodstuffs, shelter and sanitation. As discussed in the next section, there was a dramatic fall in average living standards from the late 1980s, with big declines in food availability, energy, transport and in the quality of education and health services. However, a determination to safeguard social services and sharing of sacrifices limited the adverse social impact of the economic crisis (Barraclough, forthcoming; Mesa-Lago, 1994b; Pastor and Zimbalist, 1995).

The much lower average income levels in China and even more so in Viet Nam meant that prior to economic reforms, poverty — in terms of meeting food, shelter and sanitation needs — was quite prevalent, although access to basic health care and primary education at fairly modest levels was widespread. Given the size of the country, in China poverty was predominantly a regional problem. Measured in terms of meeting nutrition and other elementary needs, poverty in Viet Nam was estimated at around 70 per cent in the mid-1980s (World Bank, 1995, Allen et al., 1996). In China it was estimated at 28 per cent in 1978, though with very considerable regional variation. In both countries, rapid growth after the initiation of economic reforms led to major gains in poverty reduction. In China it fell to around 10 per cent in 1985, where it remained over the next decade (World Bank, 1992). This has been called the largest and quickest decline in absolute poverty in human history (Riskin, forthcoming). Likewise, poverty in Viet Nam also fell sharply to around 50 per cent by 1992. In China and to a lesser extent in Viet Nam, poverty is no longer largely region specific, but growing inequalities have resulted in pockets of poverty even in affluent areas.

[13] Typically, the World Bank uses a poverty threshold of one dollar per capita per day (in 1986 dollars).

There are many different estimates of poverty in Costa Rica and Chile for different years. But the general picture in Costa Rica appears to be that the incidence of poverty declined significantly in the 1960s and 1970s but rose in the early 1980s. After a decline in the late 1980s, it appeared to have stabilized around 22 per cent, falling further in 1993. In Chile, the proportion of people living below a poverty line also appears to have declined in the 1960s, with, however, a rise in the 1970s with economic crisis and change in economic policies. After fluctuating in the 1980s, it fell sharply from around 44 per cent in 1987 to 20 per cent in 1994 (Ruiz-Tagle, forthcoming). In Sri Lanka, poverty estimates ranged around 25 to 30 per cent over the period 1970-1985, with some decline in the subsequent years (Gunatilleke, forthcoming). The experience in Kerala seems quite remarkable. Rural poverty rose in the early 1960s but declined steadily in the subsequent period, with impressive progress in the 1970s and 1980s. It fell from 69 per cent in 1969/70 to 42 per cent in 1977/78, and further to 21 per cent in 1986/87. Recent years have seen further declines in rural and overall poverty (Kannan, 1995).

◆ Poverty, Growth and Human Development

There does not appear to be a correlation between measures of income or consumption poverty and indicators of health and education (Lipton, 1996; Taylor et al., 1997; UNDP, 1997). This is partly a matter of definition. Absolute poverty is typically defined in terms of a minimum income for meeting food and other essential material needs which do not necessarily include education and health. It is a function of per capita income and patterns of income and consumption distribution. Good social indicators reflect widespread provision of literacy, primary schooling and basic health care. There is no reason why the two should go together.

Recently, an attempt was made to develop a new measure of poverty, integrating social service provisioning with consumption of basic goods (UNDP, 1997). The human poverty index (HPI), as this measure is called, incorporates indicators of deprivation concerning longevity, knowledge and living standards. These are given by the percentage of people expected to die before age 40, the percentage of illiterate adults, the proportion of malnourished children under the age of 5 and of people without access to health services and safe water. It is not surprising that HPI correlates well with other human development indices that seek to incorporate some measures of health and education. On the other hand, it correlates poorly with the income measures of poverty.

Of the cases included in this study, China, Kerala, Chile (since 1988) and to some extent, Cuba and Viet Nam, exemplify a pattern where relatively low poverty or rapid poverty reduction has been accompanied by good performance on human development. In the case of communist countries, relatively even distribution of incomes and consumption explains good poverty performance. In Kerala, it is the coherent application of a set of far-reaching anti-poverty measures, such as land reform, special employment and nutrition programmes and social security schemes, that have contributed to a sharp reduction in poverty. In Chile, rapid growth combined with employment expansion, raising of minimum wages and pensions and social assistance for the needy, was responsible for an impressive reduction of poverty.

In our sample of countries, there does not appear to be any correlation between poverty reduction and rate of economic growth. On the one hand, extremely rapid growth in China over the past two decades and in Viet Nam since 1988 was central to significant poverty reduction. But in China, as seen earlier, most of poverty reduction took place between 1978 and 1985 when growth resulted from a rapid rise in rural production. The extremely high growth in the subsequent period at best held the poverty rate at the same level. Growth played no role in poverty reduction in Cuba and Kerala. Indeed, in Kerala the period of more rapid growth in the 1960s was accompanied by a worsening poverty situation, while lower growth in the succeeding two decades saw a significant reduction in poverty. Cuba experienced only modest growth during the three decades following the revolution, but the massive crisis of recent years has undoubtedly greatly worsened the poverty situation.

It is somewhat surprising that the poverty performance in Costa Rica and Sri Lanka should have been less than impressive, as was the case in Chile prior to 1990. In all these countries the incidence of poverty has fluctuated a good deal, with good periods offset by poor years. In general, the poverty incidence has varied with

growth rates. The relatively uneven distribution of income and consumption in Chile and Costa Rica is the main explanation for weak performance with regard to poverty reduction. The experience of Sri Lanka remains a puzzle. Despite serious and systematic efforts to improve nutrition through food subsidy and special programmes for the vulnerable groups, malnutrition rates have persisted at high levels. Likewise, measures of poverty have hovered around 25 per cent for prolonged periods. Rapid economic growth since 1984 seems to have only marginally improved the incidence of poverty. Deterioration in income distribution and removal or reduction of subsidies on food and other essential goods may have contributed to this outcome.

◆ Anti-Poverty Strategies and Programmes

Apart from the overall rate and pattern of growth, poverty incidence can be affected by specific programmes designed to augment incomes, consumption and assets of the relevant groups. Three of them appear to have been particularly important in the countries studied here: employment policies, food subsidies and social security.

Two types of employment policies have played an important role in poverty alleviation: full employment policies and special employment programmes. The communist countries included in the study have pursued full employment policies for most of the period. Indeed, employment has been regarded both as a right and as an obligation in these countries for much of the period. Such policies are possible under collective or state ownership of property where enterprises do not base their decisions on considerations of profitability. The state and collective units of production no doubt suffer from underemployment and excess labour. But this is considered preferable to open unemployment and cash transfers to the unemployed. The switch to market régimes in China and Viet Nam, and to a much lesser degree in Cuba, has transformed some of the underemployment into open unemployment, but large state enterprises have continued to follow a cautious policy regarding shedding of excess labour. These policies may be contrasted with those pursued in several ex-centrally planned countries in Europe, where an abrupt shift to capitalist régimes has generated massive unemployment.

Countries have also relied upon special employment programmes to generate work and reduce poverty. One of the best known of such programmes is the minimum employment emergency programme (PEM) in Chile initiated in 1975 and supplemented by the occupational programme for the head of the household (POJH) in 1982. These programmes were created to deal with high levels of unemployment, in turn generated by severe stabilization policies designed to cope with sharp declines in incomes and budgetary and balance of payments deficits. They provided employment on public works organized by municipalities and in private firms which received subsidies and other incentives to recruit workers. The remuneration was below minimum wage and declined over time. Unemployment hovered around 18 per cent over the period 1974-82, rising in 1982 to over 30 per cent. At their height in 1983, the two programmes provided jobs to 13 per cent of the labour force. Although the jobs were temporary and poorly paid, they nevertheless made a contribution during periods of acute economic crisis to poverty reduction. With the improvement of the employment situation, the two programmes were phased out in the late 1980s (Raczynski, 1988; Martínez and Díaz, 1996; Stewart and Van der Geest, 1995).

Food subsidies in various forms have been used by all countries to relieve poverty or to cushion the impact of stabilization and adjustment policies (Utting, 1992). Costa Rica and Chile, as well as Viet Nam and China in the post-reform period, have relied upon food subsidies or free distribution of food to specific groups such as pregnant or lactating women, children and poor households, as part of their anti-poverty programmes. But it is in Kerala, Sri Lanka and Cuba that subsidized food has formed a central part of the effort to combat poverty.

In Kerala, the food grain subsidy system was introduced in 1964. The food is supplied to the population through a well spread out network of ration shops. The subsidy is quite substantial: in 1986-87, the price of rice with ration cards was around two thirds of that in the open market. From the outset, more than 90 per cent of the population benefited from the food subsidy schemes, which have been organized far more effectively than in other states in India. In addition, the Supplementary Nutrition Programme has been targeted at special groups such as pregnant women, infants and early primary school children. These food programmes have accounted for around 50 per cent of the benefits to rural households provided under various anti-poverty schemes, and around 10 per cent of the annual income of rural households and presumably a higher proportion of that of the poorer category (Kannan, 1995; United Nations, 1975; Ramachandran, 1997).

In Sri Lanka, a system of food rationing and subsidies, introduced in the Second World War, was universalized in the subsequent years. It provided for subsidies on rice, flour, bread and sugar. In the 1970s, the system was modified to target the subsidies on the poor. Its scope was reduced by the exclusion of flour and sugar from the ration. The real value of the food stamps declined significantly over the years. However, the special nutrition programmes for pregnant women, young mothers, infants and school children were either maintained or reintroduced in subsequent years. At its height in 1975, the food subsidy programme absorbed 4.6 per cent of GDP. It fell steadily in the subsequent years and accounted for a mere 1.7 per cent of GDP in 1994 (Gunatilleke, forthcoming).

There has been a great deal of controversy over the effectiveness of Sri Lanka's social programmes. It has been argued that the universal coverage of food rationing and subsidy was wasteful and diverted a significant proportion of the resources from investment and other desirable programmes. On the other hand, it has been alleged that the targeted approach has not been too successful in reaching the poor and the reduced value and scope of the food subsidy programme led to a significant increase in malnutrition among the poor. But there can be little doubt that food subsidy policies played an important role in poverty reduction in Sri Lanka over much of the post-war period, though they failed to reduce malnutrition to acceptable levels (Gunatilleke; forthcoming; Alailima and Sanderatne, 1997; Anand and Kanbur, 1995; Bhalla and Glewwe, 1986; Isenman, 1980; Osmani, 1991; Sen, 1988; UNICEF, 1985; Gooneratne and Gunawardena, 1984).

A comprehensive system of food rationing and subsidies in Cuba also played a central role in reduction of poverty and malnutrition to impressively low levels. The system, introduced in 1961, has sought to provide food security to the entire population through rationing and subsidies. Every Cuban was entitled to a basic food ration allowing a minimally nutritious diet. Children, expectant mothers, the ill and the elderly received special supplementary rations. The range and extent of benefits have changed over the years depending upon the overall food and

economic situation. But until the crisis of the 1990s, practically everyone had enough to eat to maintain health and an active life (Barraclough, forthcoming; Benjamin et al., 1984).

Social security has been the third major plank of anti-poverty policies in some of these countries (Ahmad et al., 1994; Guhan, 1993). In communist countries, state or enterprise pensions for retired workers constitute an integral part of the welfare system. However, they cover only part of the eligible population. In Cuba, efforts were made to cover all categories of people, including private farmers, under a special scheme. In Viet Nam, state pensions for war veterans, their widows and those disabled in the war account for a substantial proportion of the state welfare budget. But it is above all in Costa Rica and Kerala that innovative social security policies have been devised to reduce poverty.

Costa Rica has achieved the rare distinction among developing countries of nearly universal provision of pensions. Its social security system covers both health and pensions. In 1960, only 25 per cent of the labour force was covered by pensions. In the subsequent two decades, coverage was steadily extended to categories generally left out of pension schemes such as domestic servants, employees of micro-enterprises, the self-employed, seasonal workers and unpaid family workers. While most of the people participate in contributory schemes, there is also provision for non-contributory pensions for the poor. The social security system has been financed through a variety of sources such as contributions by workers, employers and the state. The non-contributory pension component has been financed by a payroll tax paid by employers, as well as a sales tax (Mesa-Lago, 1994a).

The experience of Kerala shows that it is possible even for a very low income state to devise a social security system capable of reaching the most disadvantaged groups. Two types of schemes are relevant in the context of an anti-poverty strategy. The first involves cash payments by the state to various categories of destitute persons, such as the physically and mentally disabled and old persons in agriculture. The second scheme , introduced in 1989-90, extended the monthly pension scheme to cover old workers in non-agricultural occupations as well. The old age pension schemes covered over 20 per cent of those aged 60 and above in 1991. These programmes undoubtedly made an important contribution to poverty reduction among the most disadvantaged groups (Kannan, 1995).

7. STRUCTURAL ADJUSTMENT AND ECONOMIC REFORM

All the cases included in the study, except for Kerala, experienced significant phases of structural adjustment and economic reform over the past 25 years. This section examines the main characteristics and social impact of these reform efforts. In line with world-wide changes in economic policy and organization over this period, the general thrust of changes in these countries was in the direction of an expanded role for market forces and private enterprise. But there was considerable diversity with regard to the circumstances that precipitated the reform process, the scale and speed of policy changes and their social and economic consequences. In contrast, however, with the experience of structural adjustment in most other countries, the cases examined here were characterized by a serious effort to protect their remarkable social achievements and minimize the adverse social consequences of policy changes. Chile and Cuba illustrate two extreme responses to profound economic crisis. The economic reform in China and Viet Nam has been gradual but systemic. In contrast, Costa Rica and Sri Lanka have sought to bring about policy changes within the framework of the existing socio-economic system.

However, in most cases there were some costs. Some social programmes had to be abandoned or seriously curtailed. The universalist and egalitarian provisioning of social services had to be modified in some cases in favour of targeting or privatization of such services (Vivian, 1996). As these countries adapt to the rapidly changing global and macro-economic environment ushered in by the accelerating pace of globalization and liberalization, important questions arise about the sustainability of the social achievements of these countries.

◆ Two Extremes of Adjustment

The Chilean experience with structural adjustment stands out in several respects. Chile was among the very first countries in the world to implement a far-reaching programme of adjustment based on what came to be known as the Chicago model. Indeed, it preceded the Reaganite and Thatcherite reforms. In several respects, countries around the world have adopted changes in economic policy initiated in Chile in the mid-1970s. A notable feature of the reform process was that it was carried out by a military authoritarian régime following the overthrow of the socialist government of Allende.

The programme was designed to overcome an acute economic crisis brought about by heightening political struggles and the first petrol shock. The package of measures brought in to deal with the crisis was administered in a thoroughgoing and draconian fashion. It has been aptly called a “shock therapy”, and could only have been imposed by a military régime. The measures included a sharp reduction in government expenditure, abrupt removal of a range of subsidies, massive lay-offs of workers in the public sector, elimination of quantitative controls on resource allocation, liberalization of trade and capital markets, unification of exchange rates, privatization of public enterprises and changes in agrarian policies. The immediate effect of the stabilization programmes was a huge decline in economic activity and

real wages, escalation of unemployment to unprecedented levels and a sharp increase in poverty (Martínez and Díaz, 1996).

The military régime devised a series of distinctive measures to deal with these problems. The distinguishing feature of these measures was an effort to target them on the most needy and the most vulnerable groups. Thus food subsidies were reorganized to focus on nutrition programmes for infants, school children, pregnant women and young mothers. Likewise an attempt was made to restrict access to free primary education and health services to the low-income groups. Large scale emergency employment schemes were introduced to provide subsistence income and improve infrastructure. The government devised a new instrument — Ficha CAS — for obtaining socio-economic information to target its social programmes to the needy and vulnerable groups. The democratic governments which followed the Pinochet régime have continued to use the Ficha CAS as a key planning instrument for social programmes (de Kadt, 1993).

In addition to targeting, the military régime attempted to improve the effectiveness of social expenditure through consolidation and integration of existing schemes for health and pensions and decentralization and reorganization of delivery systems. All these measures were effective in maintaining — and in most cases, improving — such social indicators as infant and maternal mortality, levels of nutrition, life expectancy, adult literacy and primary school enrolments. That this was possible despite sharp reductions in per capita expenditure on health, education and other social services is a testimony to their effectiveness, although there was a general decline in the quality of public services not captured by these indicators.

Although Cuba has faced several economic crises since the revolution, the gravity of the economic difficulties that have confronted the country since 1989 is unprecedented. Between 1989 and 1993, the output of goods and services was estimated by official sources to have fallen by around 37 per cent; other sources estimate the fall between 29 and 58 per cent. Perhaps a better indication of the seriousness of the situation is given by the decline in import capacity from US$ 8 billion in 1989 to US$ 1.7 billion in 1993, and in food availability from about 3,000 to 2,000 kilocalories per person daily over the same period (Mesa-Lago, 1994b; Pastor and Zimbalist, 1995; Barraclough, forthcoming). This economic catastrophe was caused primarily by the collapse of trade and aid arrangements with the Soviet bloc, but the tightening of the American boycott and the rigidity of the centrally planned system exacerbated the crisis.

The Cuban response to this massive crisis has been shaped by two overriding objectives: the preservation of the social achievements of the revolution and the safeguarding of the socialist character of the economy. Thus in the initial years of the crisis, from 1989 to 1993, adjustment was carried out through reduction in energy use, decline in investment, tightening of the rationing of consumer goods and encouragement of special sectors such as tourism, biotechnology, food production and foreign investment. While these measures helped reduce the severity of the crisis somewhat, they fell short of the scope and scale of structural adjustment required by the magnitude of the problem. Furthermore, they intensified other problems, such as the monetary overhang, the state deficit and the black market.

The adjustment measures taken since 1993 have sought to enhance production and the flexibility of the economy through the transformation of the agricultural state

enterprises into co-operatives, the leasing of land to individual farmers, the authorisation of farmers' markets where agricultural products can be sold at uncontrolled prices, and the legalization of self-employment in a range of activities and of the ownership and use of dollars in the domestic market. These measures have been complemented by reduction in subsidies to state enterprises, new forms of taxation and increases in the prices of some goods and services. The decline in production was halted in 1994, and the economy achieved modest growth in 1995-96.

A crisis of this magnitude cannot but affect the living standards of the people. Indeed, there is evidence of increasing malnutrition, hunger, illness, deprivation of basic consumer goods and decline in the quality of health, education and water services. Some of the deterioration in social conditions is reflected in such indicators as the rise in infant mortality rates from 9.4 in 1993 to 9.9 in 1994, and in maternal mortality from 31.6 in 1990 to 44 in 1994 (declining back to 33 in 1995) and small increases in tuberculosis, diarrhoeal, infectious and parasitic diseases. But what is more remarkable is the success achieved by the government in preserving most of the social gains of the preceding years in the face of a drastic shrinkage of the supply of essential goods and of government revenue. This quite exceptional experience is due to the determination of the leadership to keep intact the country's excellent health and education services and to prevent widespread hunger and poverty. It has been able to do so, first, by maintaining the resources allocated to health and education and increasing those for social security, despite a fall in the state budget of 20 per cent between 1990 and 1995. Secondly, it has ensured, through an extension of the rationing system, that the diminished supply of essential goods such as food has been distributed in an equitable manner.

Despite the extraordinary success achieved in preserving universal access to social services and preventing serious aggravation of poverty and hunger through a period of acute economic crisis, the country is faced with daunting problems and unenviable policy dilemmas. These centre around the problem of sustaining economic recovery and achieving rapid growth to underpin its expensive social programmes. Cuba has thus far made limited institutional and policy changes to enhance economic efficiency and flexibility. It will need to confront difficult choices regarding the appropriate balance between market incentives and central planning, private property and state and co-operative ownership, integration in the global economy and national control over the domestic economy. Cuba thus finds itself at a cross-roads. The paths it will follow will be determined as much by domestic social and political developments as by the evolution of policy in its giant neighbour.

◆ Adjustment with Systemic Change and Growth

China and Viet Nam have followed remarkably similar policies of structural adjustment and economic reform (Bosworth and Ofer, 1995; Ronnäs and Sjöberg, 1995). The process was initiated in China in 1978, with Viet Nam following suit in 1986. In both the countries, the reform was preceded by a long period of economic stagnation and crisis. In China it came after years of political and economic upheaval associated with the Cultural Revolution. In Viet Nam it followed increasing economic difficulties in the wake of reunification, the occupation of Cambodia, cessation of development assistance from the Western countries and growing inefficiencies in central planning. These problems were subsequently

exacerbated by the termination of assistance from the centrally planned countries in Europe.

The second distinguishing feature of the reform experience in the two countries was its systemic nature. In essence it consisted of the transformation of a system based on central planning and collective ownership of property into one characterized by resource allocation through the market mechanism and mixed patterns of property ownership. The key initial reform in both countries was the replacement of collective agriculture by family-based farming. While the role and importance of the private sector in other areas has greatly expanded under the reform programme, the state enterprises (and also township enterprises in China's case) continue to play a central role in the economy. The other features of their reform effort have been of a more conventional nature. These have included control or reduction of state expenditure, reduction or elimination of subsidies to state enterprises and consumer goods, liberalization of prices, trade, financial and foreign exchange markets, and incentives to foreign investment (Dodsworth, 1997).

The third common element of their reform experience is the extraordinary spurt in economic growth in the post-reform period. In China, the rate of economic growth shot up from 3 per cent per annum in 1960-78 to close to 9 per cent in the subsequent years. Likewise, Viet Nam experienced a spurt in growth from around 2-3 per cent per annum in 1976-86 to nearly 8 per cent since 1988. The rapid growth in the post-reform period has been due to a combination of a stable political and economic environment, increased efficiency in resource allocation, incentives to production and accumulation and integration into the world economy. The restructuring into high sustained growth sets apart the Chinese and Vietnamese experience from that of most transition and developing countries and has clear implications for social performance.

As was seen earlier, rapid economic expansion was central to sharp reduction in poverty both in China and Viet Nam, although in China most of the strides were made in the initial reform period, which generated major gains in rural production. Both countries have continued to experience improvements in other social indicators, such as infant and maternal mortality, life expectancy, adult literacy and primary school enrolments. However, once again there has been a noticeable decline in the rate of improvements in recent years in China. In both countries, gender equity in the educational field has deteriorated, and in Viet Nam there has been a decline in secondary school enrolments.

The provisioning of social services has suffered in two principal ways from the reform process. In the pre-reform period, the responsibility for health and basic education services was vested in producers' co-operatives and communes. With the break-up of co-operatives and their replacement by family-based farming, the co-operative health insurance system has virtually collapsed in many communes. In effect, the health system has been largely privatized in rural areas and increasingly for non-state employees in the urban areas. This has generally been accompanied by improvements in the quality of health care. But in the poorer areas and for poor people in better-off areas, the new system has resulted in reduced or denial of access to basic health services.

The situation has been exacerbated for the poor by the imposition of various kinds of user fees for health and education services. Although in most cases the poor are supposed to be exempted from these charges, in practice they seldom receive free

services. Furthermore, the drastic reduction in child care facilities and the shift to family farming has greatly increased women's work load and has had adverse effects on educational opportunities for women. After an initial reduction in social spending, the increased revenues of the state in Viet Nam have facilitated an expansion of social services but the bias against poorer regions and poorer people continues. In China, fiscal decentralization has reduced the scope for revenue redistribution in favour of the poorer provinces and counties and has increased the gap in social indicators between the prosperous and poorer regions (World Bank, 1992; Allen et al., 1996; Riskin, forthcoming).

◆ Adjustment in a Social Democratic Framework

Costa Rica and Sri Lanka have in common a relatively long uninterrupted tradition of pluralist democracy with power alternating among different parties. The two countries have also developed over time a welfare system with free and universal provision of health and education services, and social protection for vulnerable groups. Although there have been differences of emphasis among the major political parties, there has been a broad consensus on the essentials of the welfare programmes. Adjustment and reform were forced on Sri Lanka by economic difficulties in the 1970s, while Costa Rica faced similar challenges in the wake of the acute crisis of 1980-82. Both countries responded with a series of reform measures which, however, attempted to preserve the social achievements of the previous years.

Sri Lanka encountered growing budgetary and foreign exchange difficulties in the 1970s. Although steps were taken to slash expenditure and reduce outlays on social programmes in the early 1970s, the basic change in development strategy was initiated by the new government in 1977. Over the next few years, the government steadily removed controls on prices and trade, unified the dual exchange rate, liberalized foreign trade and payments, privatized state enterprises, encouraged foreign investment and reduced government expenditure with major cuts in subsidies to food and other consumer goods and services. The share of social expenditure fell from 9.1 per cent of GDP in 1976-80 to 5.5 in 1981-85, rising to 8.0 in 1986-90. The biggest cuts were made in the food subsidy programme, whose share declined from 3.4 per cent of GDP in 1976-80 to 0.2 per cent in 1981-85. Although the share of expenditure going to education and health also declined somewhat, these services continued to be provided freely on a universal basis (Gunatilleke; forthcoming; Alailima and Sanderatne, 1997).

The reform measures contributed to a significant acceleration in growth from around 2-3 per cent per annum in 1970-77 to nearly 6 per cent in 1977-84. This enabled the government, in subsequent years, to increase the share of expenditure going to education and health beyond the levels reached in the pre-reform years, although it did remain below the highs of the 1960s and early 1970s. A sharp increase in development assistance flows was critical in restoring social spending, thus offsetting the diversion of state revenues to greatly increased military expenditure.

Costa Rica experienced a huge economic crisis in 1980-82, when output per capita fell by nearly 14 per cent. The government responded initially by a conventional stabilization programme with deep cuts in public expenditure, employment and real wages. Social expenditure as a share of GDP fell from 15.5 per cent in 1980 (an all-time high) to 10.8 per cent in 1982. However, in the subsequent years it devised

an imaginative and unorthodox programme, which sought to promote recovery and protect universal social services and incomes of the poor through food subsidies, special employment programmes and a progressive wage policy. The share of social expenditure in GDP rose gradually in the later years to reach and surpass the levels attained in the 1970s. The reform programme comprised, as in other countries, liberalization of prices, trade and foreign exchange, privatization of state enterprises, decrease in state subsidies to agriculture and consumer goods, liberalization of the financial system and renegotiation of the foreign debt. As in Sri Lanka, generous foreign assistance was an important factor in sustaining the country's impressive welfare system (Chalker, 1994; Huber, 1996; Mesa-Lago, forthcoming).

8. CONCLUDING REMARKS

This paper has sought to understand the reasons behind the superior educational and health performance of selected countries. Five of the high performing cases (Costa Rica, Chile, Cuba, Kerala and Sri Lanka) enjoyed a historical head start in health and educational achievements. There were a variety of circumstances which accounted for this head start. A political commitment to spreading the benefits of education and health among the mass of the people was crucial everywhere. The political forces contributing to wide provision of social services took different forms at different times in different countries. They included an enlightened monarchy, a modernizing élite, social movements, political parties, trade unions, professional associations and emerging middle classes. Through their efforts and struggles, the coverage and range of social services were progressively widened to reach the bulk of the population.

Within this overall political context, cultural factors in a variety of forms provided a favourable environment for social progress. In some cases, they took the form of a religion or a tradition placing high value on education and care for the less fortunate members of the society. The status and autonomy of women were decisive in equitable access to health and educational facilities. In some countries, ethnic homogeneity made a contribution by preventing discrimination against and exploitation of some social groups. But historical advantage by itself cannot ensure a continuing lead. A number of other factors mentioned below were critical in sustaining social progress.

Two countries (China and Viet Nam) suffered from a historical disadvantage in the domain of health and education. Although Cuba had above average social indicators and a relatively high per capita income prior to the revolution, it suffered from massive inequalities among ethnic groups and between rural and urban areas. The impressive social achievements of these countries were directly due to the policies pursued by the communist revolutionary régimes. In all cases, the new régimes were committed to reduction or elimination of economic and social inequalities and to the achievement of universal literacy, basic schooling and elementary health care.

The importance of politics is also central in the other four cases. A long tradition of liberal democracy, electoral competition among different parties for political power, the emergence of strong social movements and other institutions of civil society — all these made a powerful contribution to the continuing priority given to universal and free provision of key social services. It is true that Chile had a long

interregnum of a repressive military régime. But it is perhaps a tribute to the strong traditions of social provisioning in the country and the need of the ruling groups to win legitimacy that the military junta felt compelled to give priority to the disadvantaged groups in public nutrition, health and education programmes.

The case studies also bring out the central importance of strong action by the public sector in the provision of certain health and education services. There was a great deal of diversity in the institutional framework for planning, organizing, financing and delivery of social services. But in all cases, the state assumed responsibility for the provision of certain services which were critical to the social achievements of these countries. It is interesting to note in this context that the amount of resources allocated to social programmes do not appear to have been decisive in explaining their social performance.

A major conclusion to be drawn from this study is that it is the overall approach to social policy and pattern of public social expenditure that are responsible for superior social performance. Infant mortality, life expectancy, adult literacy and basic education are greatly influenced by the pattern of social expenditure. Factors such as maternal and infant nutrition programmes, vaccination rates, institutional delivery and post-natal health care are decisive in lowering infant mortality rates. Overall life expectancy is influenced by these factors as well as by the state of the physical environment, general cleanliness and personal hygiene. These in turn are related to rates of literacy and schooling, especially among women. It is thus clear that a social policy that accords priority to maternal and child care, prevention of insect-borne and infectious diseases, improvement of health education, overall literacy, basic education and sanitary and hygienic conditions can have a quick and powerful impact on social indicators. All the countries considered here gave high priority to such programmes.

These, then, are some of the main lessons to be drawn from the experiences of a few countries with high social achievements. To what extent are these lessons relevant and applicable to other countries seeking to emulate their achievements? The fact that our sample of countries incorporates enormous diversity in terms of political régimes, ethnic groups, social structures, cultural traditions, levels of development and rates of economic advance holds out hope that high educational and health standards can be achieved by countries under widely divergent conditions. The single most important common feature of their experience is the pursuit of social policies according priority to primary health care, adult literacy, basic education and sanitary and environmental improvements. These programmes are not too costly in terms of finance and skills. But they do require an effective public sector which can reach the entire population with these services.

At a deeper level, the pursuit of such policies is only possible where political circumstances generate strong pressures on the ruling groups to allocate resources for broad-based social programmes. This can happen under liberal democratic systems with a vibrant civil society, revolutionary régimes committed to social and economic equality and even authoritarian régimes seeking popular legitimacy or facing threats from opposition forces within or outside the country. The recent political changes in a large number of countries across the world conducive to the establishment of democratic systems, the growth of civil society institutions and the recognition of human rights provide a highly favourable environment for the pursuit of the kind of social policies and programmes discussed above.

There are two other factors which can be expected to favour the expansion of such programmes. There is growing consensus among specialists and policy makers across a wide spectrum of political beliefs that investments in people's health and education generate an impressive array of social and economic benefits, including favourable impact on growth rates, improved distribution of gains from growth and slowing down of population expansion. The emerging consensus has been reinforced by the declarations and programmes of action adopted at the series of world conferences organized by the United Nations in the 1990s. In evaluating country performance, economic growth and human development are beginning to receive equal attention. The multilateral financial institutions and the bilateral donor community have become converts to the emphasis in development policy on human development and poverty reduction (World Bank, 1990; OECD, 1996). There are thus good reasons to believe that the trail blazed by the countries considered in this study may act as a beacon of light to others desirous of emulating their achievements.

The study also examined the poverty reduction performance of these countries. It found that the performance of some countries in this regard was not as outstanding as in the domains of education and health. This is perhaps partly a matter of definition. The conventional measures of poverty leave out entirely or in part people's access to education and health. If these were incorporated in poverty measures, the performance of this group of countries would be distinctly improved. Of the various programmes put in place to combat poverty, three were particularly effective: employment creation schemes, food subsidies and social security for disadvantaged groups. The experiences of Kerala, Cuba and Costa Rica show that it is possible, with relatively modest resources, to provide social security to vulnerable groups to protect against extreme destitution and hardship.

The overall global and macro-economic context has changed radically over the past two decades. The highly successful programmes and policies that have characterized these countries were for the most part put in place in the three or so decades after the Second World War. The paper examined the social impact of the wide ranging measures of liberalization that were undertaken in most of these countries, as elsewhere in the world, over the past two decades. Unlike the experience of many other countries, most countries included in this study were largely successful in protecting their social achievements while undertaking the necessary adjustment and reform measures.

However, there were some costs. Some countries have been forced to significantly modify if not largely discard the universalist approach to provision of health and educational services and food subsidies. Most have sought to create greater scope for targeting and privatization of some social services. Inevitably there has been some intensification of inequalities in access to health, education and social security, especially with regard to quality. If the trend towards globalization and liberalization continues — with all their implications and consequences for rates and patterns of growth, national and international competition and public revenues — attempts to maintain the relatively egalitarian and universalist thrust of social provisioning in these and other countries will become increasingly difficult. The search for creative responses to the continuing advances in globalization and liberalization constitutes the central challenge to social policy worldwide in the coming years and decades.

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