5

The distribution of benefits
of health and education spending

The regional averages for social indicators discussed in the previous chapter hide huge intra-country disparities. These disparities would tend to vary not only by gender but also by ethnic groups, regions and different households according to their level of income and wealth.[1] Although this is well known, and some data describing these inequalities are available, this chapter briefly recapitulates data and information on some of these inequalities in outcomes.[2] More importantly, it examines the distribution of benefits of health and education spending for a selection of developing countries in every region.

The source of information for this chapter is mainly the country studies designed and commissioned by UNICEF/UNDP, which provide new information on the incidence of health and education spending by income groups. Section 5.1 provides a sketch of the kinds of disparities in health and education outcomes that are relatively common in developing countries. Section 5.2 examines the evidence on the distribution of benefits of public spending on education as a whole and by level; section 5.3 presents the evidence on the distribution of benefits of public health spending, again overall and by level; both present the implications for education and health outcomes of the inequity in public spending. Section 5.4 attempts to explain the incidence of health and education spending. The final section concludes.

5.1   Disparities in health and education outcomes

The evidence on disparities of outcomes by income available for some of the selected countries is worrisome. For instance, in Nepal almost 60 per cent of the population in the bottom quintile never attended school, while

Table 5.1 Urban and rural enrolment by income group

	Urban	Rural
Benin (GER)		
Poor	45	37
Vulnerable	81	44
Non-poor	114	51
Weighted average	81	44
Côte d'Ivoire (% enrolled)		
Bottom quartile	39	32
Second quartile	40	34
Third quartile	49	36
Top quartile	44	35
Total	44	34

Source: UNICEF country studies.

that share is only 13 per cent in the top quintile (Institute for Sustainable Development, 1998). In Brazil[3] all children in the top three deciles attend school (the vast majority of them private). However, in the second decile 10 per cent of the children never attended school, with the percentage rate increasing to 20 per cent in the bottom decile (Neri et al., 1998).

These disparities, however, give only a partial picture of inequities in a country. There are many other dimensions, often more important, as people do not live in quintiles or deciles. Thus, geographic area or ethnic differences should also be explored. Other social characteristics would be useful too; Pyatt (1999) persuasively argues for a 'social/structural' classification based on source of income or kind of employment.[4] For Honduras, data from the National Demographic Survey for 1983 show that urban-based workers were able to reduce mortality much faster than farmers and agricultural workers.

The location of households impacts on their well-being. This is partly related to the environmental conditions as well as the different types of work done in different regions (e.g. some illnesses are transmitted by animals that live in certain areas; mining towns have their own epidemiological profile). However, one of the main determinants across countries is the insufficient provision of basic social services for rural populations. Thus, for example, in Benin the gross enrolment ratio (GER) at primary level in urban areas is twice as high as in rural ones (Tabélé–Omichessan et

al., 1998). A significant, if less dramatic, difference occurs in Côte d'Ivoire (Gbayoro et al., 1997). Interestingly, in both countries, when the geographic classification is combined with income levels, the rural areas seem more equitable (Table 5.1).

Another relevant breakdown for the analysis of inequalities is gender. Gender discrimination is pervasive throughout the world, and especially so in many developing countries. Moreover, many of the most serious aspects of gender discrimination cannot be captured in figures. Nevertheless, just two examples will be presented here to indicate the relevance of gender in accessing education. In Niger, for instance, the male literacy rate is 21 per cent, but for women it is 7 per cent – only a third of men's (Chafani et al., 1997). Similarly, in Nepal 41 per cent of men can read and write, but the literacy rate among women is only 14 per cent. These data can be further disaggregated by income level too. For the bottom quintile, the proportion of women and girls aged 6–24 who never attended school is as high as 85 per cent, against 54 per cent in the top quintile.

Another important classification is the ethnic background of different groups of people. The ethnic background of certain groups has often been used to divide and oppress them; the social indicators for such groups often lag behind. In South Africa life expectancy at birth in 1990 for whites was close to the industrialized country average, while for Africans it was ten years lower. Although this could be partly the result of income differentials between the two groups, there is little doubt that the inequitable distribution of education and health services played a role too.

Given the differences in health and education outcomes within a given country, it is crucial to assess whether different groups in society receive equitable shares of public spending on social services.[5] Although most of the analysis below concentrates on the incidence of public spending by income group, other ways to identify groups within the country are at least as important, as can be seen from the above discussion of disaggregated outcome indicators. In particular, the gender, ethnic and geographic distribution of benefits is analysed too. Both the gender and the geographic distribution of benefits are intrinsically linked to efficiency issues. Gender balance in benefit distribution is efficient because of the important structural role of women in the 'first synergy', which enhances the impact of spending in one sector when good outcomes are present in the other ones (see Chapter 4). Geographic balance in benefit distribution is efficient because of the greater relative impact on outcomes of expenditure where lack of access is most acute. In general, since rural areas are underserved, additional spending in these areas has more impact than in urban ones.

5.2   The distribution of benefits of public spending on education

Data on the usage of education services by different groups have been obtained for nineteen countries. The first observation one can make (see Table 5.2) is that the distribution of total public spending on education is not equally shared. In most countries, the bottom quintile enjoys less than 20 per cent of the benefits of public spending on education (i.e. total subsidy); in some of them, a lot less. On the other hand, the top quintile seems to be able to capture considerably more than 20 per cent of the benefits of these expenditures. This is particularly true in Bangladesh, Guinea and Madagascar. The situation seems to be different in Colombia, in Costa Rica and, particularly, in Chile, which are relative high achievers in primary-school enrolment.

The evidence in Table 5.2 indicates that the benefit incidence of primary-school expenditure is far more equally distributed than the higher level services (secondary schools and, more prominently, universities).[6] In all countries the subsidy to the primary level of education is more equitably shared, except in South Africa (for obvious reasons) and in Guinea. Countries like Chile and Colombia – which have made significant efforts to universalize primary schooling – have a particularly high share of the subsidy at the primary level going to the poorest share of the population. By and large, countries that have been much less successful in universalizing primary schooling also have a higher proportion of the subsidy being absorbed by the richest quintile of the population.

Nevertheless, the high share of benefits from primary education spending that accrue to the bottom quintile in most countries does not take into account the fact that poorer groups tend to have more children. Survey after survey confirms that poor households have more children than non-poor households.[7] Consequently, they *should* receive a larger share of the benefits than their population share because their share in the school population exceeds their share in the total population.

Table 5.3 uses data from Costa Rica, Côte d'Ivoire and Ghana to corroborate this result. In all three countries, the bottom 20 per cent income quintile has more than 20 per cent of primary-school-aged children, while the top 20 per cent income earners have less than 20 per cent of all school-aged children. Yet, the share of benefits of primary-school spending is less than the share of school-aged children for the bottom quintile, except in Costa Rica.

This means that even a progressive distribution of benefits may mask inequities in the education system. Attempts to encourage private education in order to ease the burden of the state, and thus release funds to educate

Table 5.2   Benefit incidence of public spending on education in selected countries

	Total		Primary		Secondary		Tertiary	
	Bottom	Top	Bottom	Top	Bottom	Top	Bottom	Top
Bangladesh (1994)†	14	39	20	21	6	35	2	48
Bolivia (1990)			37	6			12	23
Brazil (1996)†			23	14				
Chile (1996)	34	7	38	5	31	7	6	19
Colombia (1992)*	23	14	39	4	21	10	5	34
Costa Rica (1992)	18	20	34	7	16	16	2	38
Côte d'Ivoire (1995)	13	35	19	14	7	37	12	71
Ghana (1992)	16	21	22	14	15	19	6	45
Guinea (1994)	5	44	11	21	4	39	1	65
Indonesia (1989)	15	29	22	14	5	42	0	92
Jamaica (1993)			31	6	10	20		
Kenya (1992)†	17	21	22	15	7	30	2	44
Madagascar (1993)	8	41	17	14	2	41	0	89
Malawi (1994)	16	25	20	16	9	40	1	59
Peru (1995)	11	24						
South Africa (1994)	14	35	19	28	11	39	6	47
Tanzania (1993/4)	14	37	20	19	8	34	0	100
Uganda (1992)	13	32	19	18	4	49	6	47
Vietnam (1992/3)	11	38	22	18	9	37	0	66

Header above sub-columns: *Quintile share of subsidy*

Notes: † Rural only for Bangladesh and Kenya and rural north-east for Brazil.   * Household quintiles.

Sources: UNICEF country studies; Castro-Leal et al., 1998.

only the children of the disadvantaged groups, suffer from problems.[8] This theory generates inequalities, as the children of the wealthier class attend better schools – as observed in Brazil and Chile.[9]

The equity of spending, particularly on primary education, strongly relates to overall outcomes. Figure 5.1 shows the distribution of public spending on education at the primary level in the nineteen countries studied. In each case, countries have been classified in terms of primary net enrolment, a measure of the success of their education policies. Where primary net enrolment rate (NER) is less than 70, it can be observed that the poorest 20 per cent of the population receive less than 20 per cent of the benefits of public spend–

Table 5.3   Benefit incidence and primary education needs
(Ghana, Côte d'Ivoire and Costa Rica)

	Ghana (1992)		Côte d'Ivoire (1995)		Costa Rica (1992)	
	% of subsidy	% of age group	% of subsidy	% of age group	% of subsidy	% of age group
Poorest quintile	22	24	19	24	34	27
Richest quintile	14	14	14	14	7	12

Sources: UNICEF country studies; Castro-Leal et al., 1998.

ing on education. In contrast, countries with enrolment above 70 devote a much larger share of public money to the bottom quintile. Families from the richest quintile can and do send their children to private schools, which is why their 'share' of public spending on education is less than 20 per cent. Nevertheless, the equity of primary spending is more apparent in countries where primary NERs are higher.

Inequalities between urban and rural locations are sharp. In Benin, GER in primary schools in urban areas is almost twice as high as in rural ones. In rural areas the richest groups seem to enjoy a GER of 50 while the poor have a GER of 36. The corresponding ratios in urban centres are 114 and 45. These stark differences are a reflection of the inequities in budget allocations among groups. First, rural areas, where 60 per cent of the population live, receive less than half of the basic education budget.[10] Second, benefit incidence is very dissimilar in urban and rural areas. In rural areas poor families, which constitute around a third of all households, benefit from around a third of the public expenditure on basic education. In urban areas 53 per cent is appropriated by the non-poor, who represent 44 per cent of the urban population.

In sub-Saharan Africa, the benefit incidence of education spending seems to suffer more from gender inequalities than health spending. For the population as a whole, girls received only 37 per cent of the education subsidy in Côte d'Ivoire and 41 per cent in Ghana (Castro-Leal et al., 1998). This applies even at the primary level. In Côte d'Ivoire, girls in the poorest quintile received less than a quarter of the overall education subsidy accruing to the quintile. In contrast, girls in the top quintile fared much better. The gender bias is also observed over time between the poor and non-poor. In Côte d'Ivoire, a series of integrated household surveys revealed that between 1985 and 1988 the gender gap in primary enrolment

Figure 5.1   Distribution of primary education spending and enrolment
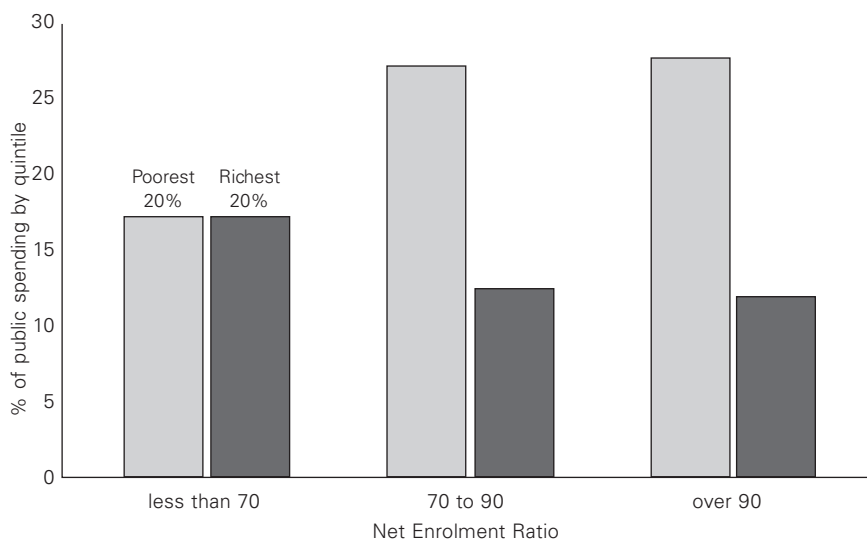
Source: Table 5.2; UNICEF, 2000.

widened by a third for the non-poor and by more than half among the poor, although the overall enrolment ratio remained unchanged through this period (Figure 5.2). The primary enrolment ratio actually decreased for girls from poor households (from 22 in 1985 to 17 in 1988), whereas it continued to increase for their non-poor counterparts (from 54 to 58 respectively).[11]

Overall, education systems in most developing countries need to improve the quality of education. What is less well documented is how much the quality of service varies within countries, and the extent to which the poor are disadvantaged in this respect. Unit spending in South Africa was much lower in poor communities, which made a significant difference to the benefit incidence estimates (Castro-Leal et al., 1998). These variations in unit subsidies have a massive impact on school quality. For instance, in Peru the unit cost for primary education was nearly four times higher for the richest quintile than for the poorest. There is evidence from El Salvador and Uganda that the unit subsidy actually reaching rural schools is much less than aggregate data would suggest, pointing to lower education quality in such areas (Ablo and Reinikka, 1998). There is strong evidence that school quality has a significant impact on school enrolment decisions of

Figure 5.2   Côte d'Ivoire: primary enrolment by income level and gender (%)
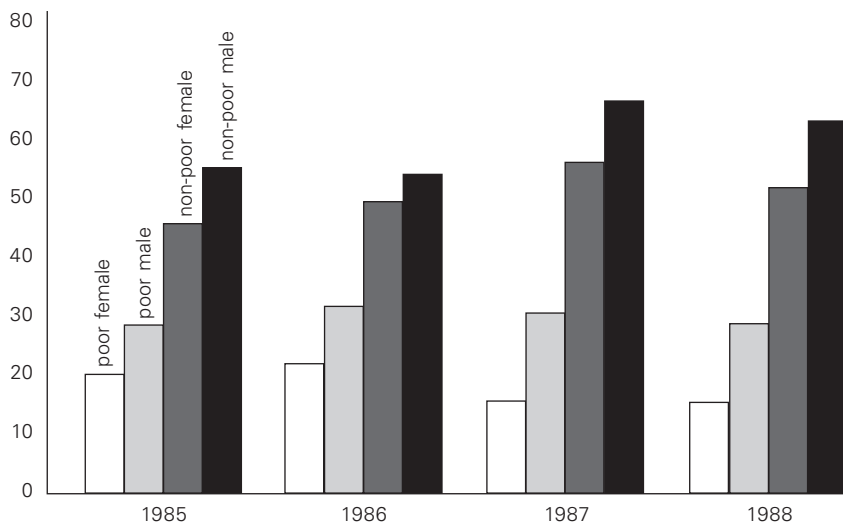
Source: World Bank, Living Standards Measurement Survey.

parents. Leaking and unusable classrooms, inadequate sanitation facilities and the absence of electricity in the school have significant negative effects on decisions to enrol in primary schools. Quality variables (for example, 'no desks') were also found to influence delays in primary enrolment in Ghana (Glewwe and Jacoby, 1992).

As we mentioned above, some of the incidence results depend crucially on the assumption that state expenditure on services used by the relatively poorer groups is the same as the expenditures on the same services for the better off. However, in fact, there is strong evidence that the unit cost – that is, the expenditure per child, of the services received by the bottom quintile is considerably lower than for the top quintile. In South Africa the benefit incidence would seem much more egalitarian when a common unit cost across quintiles is used than when the actual unit costs are used. For instance, when actual unit costs are used, the bottom quintile's share in the benefits of public spending on primary education falls from 26 to 19 per cent. At the same time, the share of the top quintile increases from 13 to 28 per cent. For education as a whole, the results are as dramatic. The share of the bottom quintile drops from 20 to 14 per cent, while the share of the top quintile rises from 20 to 35 per cent.

5.3 Distribution of the benefits of public spending on health

Evidence for seventeen countries on the benefit incidence (by income group) of public expenditure on health is presented in Table 5.4. Although Latin America and sub-Saharan Africa are overrepresented, the pattern in the other regions does not seem to be very different. In order not to overload the table, only the shares for the top and bottom quintiles are reported.

The first observation to be made from this table is that total health spending is not equitably distributed to the poorest groups in society. The bottom quintile (which in many countries does not capture all of the poor) receives significantly less than 20 per cent of the benefits from public spending on health. That is, they do not satisfy the weakest version of equity (that each group receive benefits in proportion to their population size). The poorest 20 per cent of the population get less than 20 per cent of the benefits from public spending on health in all countries surveyed, with the exception of Bangladesh and Costa Rica. Also, and partly as a result of this, they receive less than the richest quintile (which in many countries includes not only the rich but also a great portion of the middle class). The inequality is particularly striking in Côte d'Ivoire, Ghana, Indonesia, Madagascar, Vietnam and, particularly, in Guinea.[12]

A second observation is that there are only two countries where the richest quintiles have appropriated shares lower than 20 per cent. These are South Africa and Costa Rica. It is unlikely that the implication is that in these two countries the benefit incidence of public spending on health is progressive. Rather, it is likely that the richest quintiles do not use the public health service very much in these two countries – relying more on private providers.

The third observation is that spending on basic health services is more equitably shared than total health spending. In some countries, the poor make disproportionate use of primary health facilities. In Kenya, for example, the poorest quintile gained 22 per cent of the government subsidy on primary health, compared with only 14 per cent of the total health subsidy. In Chile – which, as we have seen before, is a high-achiever – the poorest quintile receives 30 per cent of the subsidy on primary health care. In Costa Rica – another high achiever – the bottom quintile receives 43 per cent of that subsidy. For Costa Rica, measurements are available for 1986 as well as for 1992. In both years the bottom quintile received around 30 per cent of public spending in health services. They received 30 per cent of the hospital care expenditures, which shows that the whole of the health-care system in Costa Rica was progressive. Also, it means that the richest group could

Table 5.4   Distribution of public health spending benefits, selected countries (%)

|	All health		Quintile shares of Primary facilities		Hospital outpatient	
	Bottom	Top	Bottom	Top	Bottom	Top
Bangladesh (1994)	22	21				
Bolivia (1990)	15	21				
Brazil (1996)	11	23				
Chile (1996)			30	7		
Colombia (1997)	18	27	24	19		
Costa Rica (1992)	30	13	43	7	25	13
Côte d'Ivoire (1995)	11	32	14	22	8	39
Dominican Rep. (1996)			24	12		
Ghana (1992)	12	33	10	31	13	35
Guinea (1994)	4	48	10	36	1	55
Indonesia (1990)	12	29	18	16	7	41
Kenya (1992)	14	24	22	14	13	26
Madagascar (1993)	12	30	10	29	14	30
Peru (1995)	10	27				
South Africa (1994)	16	17	18	10	15	17
Tanzania (1992/3)	17	29	18	21	11	37
Vietnam (1993)	12	29	20	10	9	39

Note: Rural only for Bangladesh and Kenya and rural north-east only for Brazil.

Sources: UNICEF country studies; Castro-Leal et al., 1998.

afford to buy private health-care services, which are seen as being of better quality. The same happened in Chile.

Nevertheless, in many other countries, especially in sub-Saharan Africa (e.g. Côte d'Ivoire, Ghana, Guinea and Madagascar) even spending on primary facilities was not fairly shared. In Ghana and Guinea, for example, of the total visits to a primary health facility, only 10 per cent came from the poorest quintile. Given the costs and benefits involved, household decisions about using publicly subsidized health-care services in these countries result in far fewer visits to primary facilities from poor households than from the wealthier segment of the population. The result is that spending even on

Figure 5.3 Distribution of primary health-care benefits and child mortality (% of public spending by quintile)
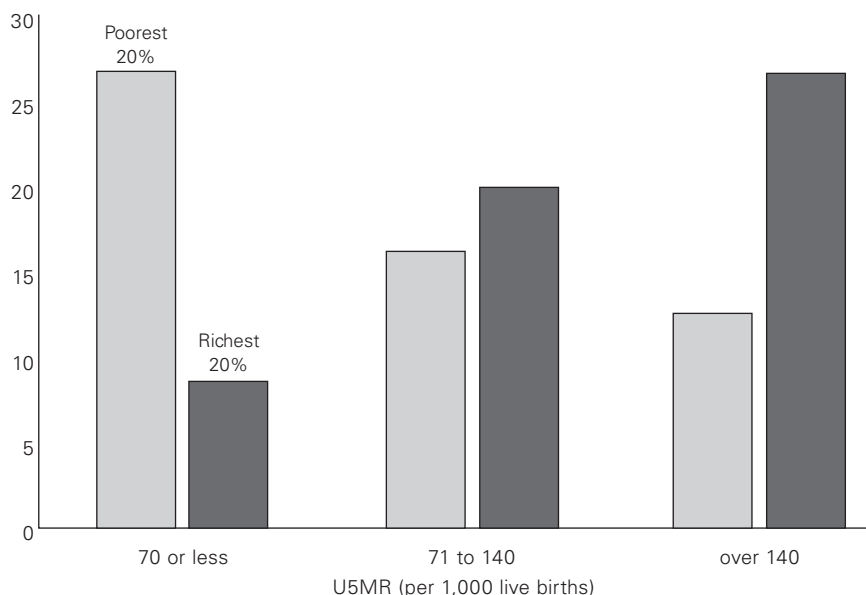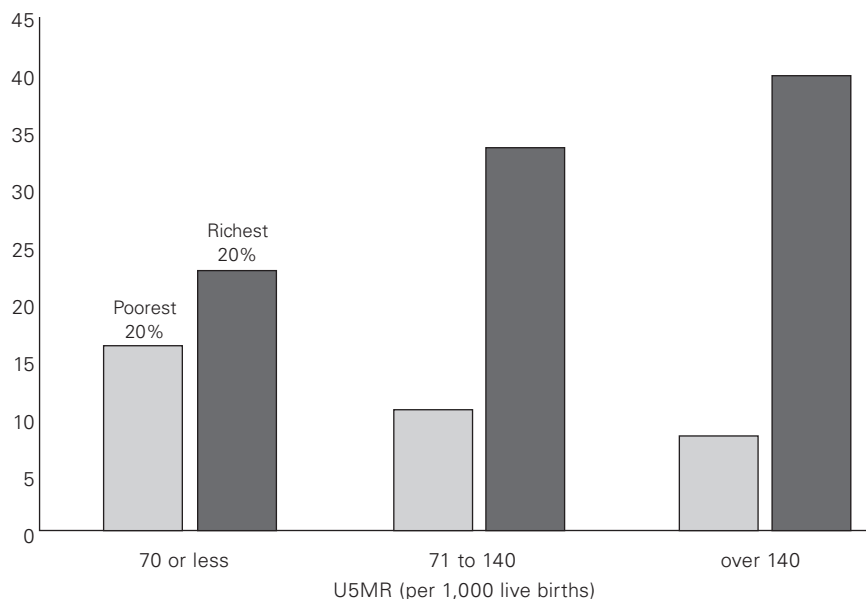

Source: Table 5.4; UNICEF, 2000.

basic health services could be better geared towards providing services to the poor.

However, by and large, the impact of egalitarian spending is strongly reflected in the results. The surveyed countries were divided according to the level of child mortality: very high (above 140 deaths per 1,000 live births), high (between 70 and 140 deaths), and medium (fewer than 70 deaths). The share of primary health-care benefits was calculated for the poorest 20 per cent and the richest 20 per cent of the population in each group of countries. The results are striking (see Figures 5.3 and 5.4).

In countries with under-5 mortality rates below 70, the poorest 20 per cent of the population received more than 25 per cent of the benefits of public spending on primary health care. The same group received less than 15 per cent in countries with child mortality rates above 140 (Figure 5.3). When looking at public spending on hospital care, the results are similar (Fig 5.4). Richer families made more use of hospitals than poor families in countries with medium levels of mortality, but the differences were relatively small – roughly 20 per cent and 15 per cent, respectively. In countries with very high mortality rates, however, the poorest 20 per cent of the population

Figure 5.4   Distribution of public spending on hospitals and child mortality (% of public spending by quintile)

Source: Table 5.4; UNICEF, 2000.

accounted for less than 10 per cent of hospital usage, while the richest 20 per cent accounted for around 40 per cent of usage. This is a far larger proportion than their share of the population would justify, giving them a higher 'share' of the government's spending on hospitals.

Wherever we were able to obtain evidence on the distribution of health spending between rural and urban areas, a strong bias in favour of urban services was observed. In Kenya, for instance, where 70 per cent of the population lives in rural areas, rural health services only receive 13 per cent of the health budget. A similar situation prevails in Namibia, where, at independence in 1990, the health system was characterized not only by gross racial inequities and by an undue focus on tertiary and specialized care, but also by geographical imbalances. The situation has gradually been modified, within a growing budget which has steadily been focused on immunization, control of diarrhoeal diseases, mother–child care, and rural health centres and clinics. Despite these efforts to increase the supply of basic health-care services in the rural areas of the Northwest (efforts which included almost doubling the allocation of the budgeted staff to the region), regional inequities remain. For instance, the state hospital in the capital city

Table 5.5 Distribution by quintile of subsidies for different health services (%)

	Bottom	II	III	IV	Top
Dominican Republic (1996)					
Immunization	21	22	23	20	14
Pap test	27	22	21	18	12
Child check-up	33	21	20	15	11
Pregnancy control	33	22	20	15	10
Colombia (1997)					
Hospitalization (55%)*	25	17	22	15	21
Surgery (31%)*	12	15	9	35	29
Dental (9%)*	0	2	5	23	70
Maternity (2%)*	29	25	19	24	4

Note: * Share in total public health spending.

Source: UNICEF country studies.

still concentrates a third of the Ministry of Health personnel.[13] Despite the increase in per capita spending on basic social services in both Kenya and Namibia in the 1990s (as discussed in the previous chapter), the HIV/AIDS epidemic contributed to an increase in child mortality between 1990 and 1998. Under such circumstances, the inequity of the spending pattern only worsens the plight of the poorest AIDS sufferers.

In Benin, while 60 per cent of the population live in rural areas, public expenditure on health (assuming the same unit costs) is slightly biased, as only 55 per cent are allocated to rural areas. The inequities, however, seem larger within each area. Thus, the rural non-poor account for 42 per cent of the rural population, but receive 51 per cent of the benefits of public expenditure on health in rural areas.[14] Poor rural households represent 34 per cent of the population, but only receive 23 per cent of the benefits of public spending on health. Similarly, the non-poor urban families, which represent 44 per cent of the population, enjoy 58 per cent of the benefits of public spending on health. The urban poor, on the other hand, only appropriate 21 per cent of these benefits although they represent 33 per cent of the urban population.

Table 5.5 provides an interesting perspective on health services affecting women and children. It shows that the benefits of these services, which are an important component of the basic services, are also better distributed than overall expenditures for the sector. In the Dominican Republic, preventive health services (like pregnancy and childcare) are very progressive; within the

Table 5.6 Health services unit costs by quintile

	Bottom	II	III	IV	Top
Côte d'Ivoire (1988, CFAF)	3,347	5,174	7,738	9,419	14,407
Ghana (1992, Cedis)	2,964	4,524	6,314	8,306	12,452
Madagascar (1993/4, FMG)	1,133	2,528	2,573	2,139	4,581
Peru (1997, constant 1996 US$)	0.8	1.0	1.1	1.1	1.2

Sources: UNICEF country studies; Castro-Leal et al., 1998.

education sector, the same holds true for pre-primary and primary public spending. The different benefit incidence even within the basic level of health care is also observed in Colombia, where maternity services (just like pregnancy control in the Dominican Republic) are more progressive than other services. However, for Colombia we also find out that maternity services represent a very small proportion (2 per cent) of total health expenditure.

However, given the qualitative information available for these two countries, it might be incorrect to take solace in these numbers. In both countries, and in particular in the Dominican Republic, there is 'exit' by users in the higher income groups from public facilities and by rural dwellers to facilities located in the cities. This is due to the perceived lower quality of the public facilities, especially in rural areas. Evidently, this perception is partly based on the lack of adequate financing of those facilities (as discussed below).

Unit cost data (by income, and by location or ethnic group) suggest that there may well be large quality differentials in health facilities serving poor and non-poor households. The evidence in Peru, for instance, shows that the unit cost for health services is 50 per cent higher for the top quintile than for the bottom one (Table 5.6), while in the three African countries the unit costs are four times as high for the top quintile relative to unit costs of health services for the bottom quintile.

Although major progress has been achieved in the last few years in South Africa to redress the unfairness of the apartheid system, and to attempt to eliminate 'race' as a category to classify individuals, the information in Table 5.7 is telling. It has also to be pointed out that the efforts of the new authorities are not reflected in these data, which pertain to the early and mid-1990s. In the table, it can be observed that 'race' is associated not only with major differences in terms of infant mortality rates, but also with enormous inequities in the resources allocated per health intervention.[15]

The regional distribution is also interesting because people were forced during the apartheid years to live in so-called 'homelands'. The difference

Table 5.7 Health services expenditures per person by region and race,
South Africa

	Unit cost/person (R)	Infant mortality rate
Race		
African	137.8	54.3
Coloured	340.2	36.3
Indian	356.2	9.9
White	597.1	7.3
Region		
Eastern Cape	245.1	44.7
Free State	307.2	45.8
Gauteng	577.1	32.3
KwaZulu-Natal	274.2	44.9
Mpumalanga	158.3	45.1
Northern Cape	265.2	42.9
Northern Province	181.9	52.9
Northwest	203.6	40.1
Western Cape	700.4	24.4

Source: UNICEF country study.

between Western Cape and the rest of the country, in terms of both
outcomes (measured by infant mortality rates) and expenditure per capita,
again confirms that not only do disadvantaged groups receive less benefit
from public spending on health services, but the services they receive are of
lower quality. And even if the system looks progressive, as suggested in Table
5.4, it masks the fact that those who can afford to visit private clinics or
practitioners (in the upper quintile) would tend to do so if the services are
available. It is also worth mentioning that the correlation between expendi-
ture per person and infant mortality when race and province are analysed
are −0.86 and −0.91.

5.4   Explaining the incidence of benefits of
health and education expenditure

Three main conclusions stand out from the available evidence.[16] First, the dis-
tribution of the benefits of public spending (both in education and health[17])
are biased in favour of the richer groups. Evidently, this simple approach

implicitly assumes that members of different groups receive the same unit subsidy. This is clearly not true. In most cases, the unit subsidy increases with the income of the recipient, as in Peru, where the state spends 50 per cent more on the health of the top fifth of the population than on the health of the bottom fifth. This, in effect, confirms the Matthew effect: not only do the wealthier groups usually receive a higher share of the benefits of public spending, they receive better-quality services.[18]

Second, the inequity of public spending is much weaker at the basic level of services than at the secondary and tertiary levels. Thus, in a few countries the distribution of the benefits of public spending on elementary education is progressive.

Third, probing beyond the quantitative data, qualitative assessments and indirect data on unit costs often indicate that what looks like a progressive distribution of benefits actually hides a regressive distribution. This emerges from the low quality of the services received by the poorer strata of society.

There are several factors underpinning the inequality in the distribution of public education and health spending in these countries. The first one is that the political process through which budgets are determined usually favour the groups that are most visible, especially those that have a stronger voice in the capital or other important urban centres. Consequently, fiscal resources are channelled to the districts where these groups live and to the services they prefer. This results in the second element (which is clear from the evidence in this and the previous chapter): governments show a tendency to allocate large shares of their budgets to higher-level services, which are not widely used by the poor. In Ghana, for example, two-thirds of the health budget was allocated to hospital services, with a major portion going to one large teaching hospital in Accra. Around nine-tenths of current health spending in South Africa and Vietnam went to hospitals (de Bruyn et al., 1998). And in most of the other countries, over half of the recurrent health budget was devoted to hospital-based care. In Egypt, universities absorb 25 per cent of the total education budget, although they account for only 5 per cent of the student population. Improving the equity and impact of public spending on social services, therefore, would require a shift away from secondary and tertiary levels in favour of basic social services. This is closely related to issues of allocative efficiency, discussed in the next chapter.

Given the current distribution of benefits, it might be very hard to shift allocations without increasing overall expenditure. That is the way found in Namibia in order to arrive at a better balance between rural and urban expenditure. This anticipates the discussion in Chapter 9, where it is argued

Figure 5.5 Enrolment increase in Malawi after elimination of fees and uniforms (million children)
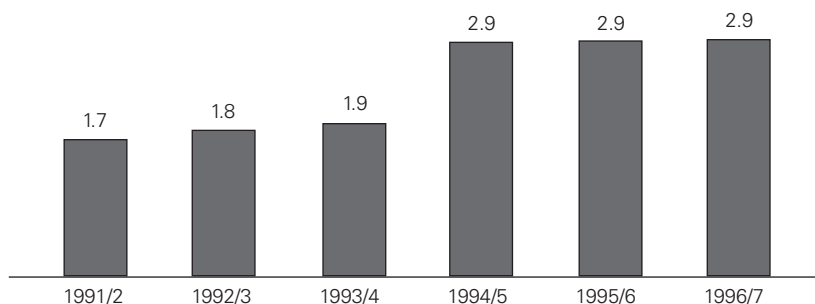
that more resources would be needed to be able to increase the shares allocated to BSS. In this case, not only will additional resources be needed to facilitate the restructuring in favour of less-privileged groups, but also, because of the low per capita or per unit expenditure that they currently receive, the total expenditure will have to increase quite substantially.

The evidence in Tables 5.1 and 5.6 also shows that for too many countries, the distribution of benefits was regressive even at the basic level of services. Thus, it cannot be ruled out that costs (both direct and indirect) are precluding the lower income groups from accessing BSS. These costs can all be eliminated, or at least mitigated, if more resources are available for BSS.

One kind of direct cost is health charges. They represent a greater burden to the poor compared with the wealthier. There is ample evidence to suggest that health care is much more expensive relative to income for the poor compared with the non-poor. The poor are more likely than the non-poor to reduce their use of health services when prices for health care are higher (Gertler and van der Gaag, 1990; Lavy and Germain, 1994; Reddy and Vandemoortele, 1996). Most of the studies are based on cross-section evidence, and are ambiguous about causation. If government pricing/quality decisions are influenced by utilization, the observed relationship would be difficult to interpret, since utilization would determine price/quality, rather than the other way around. But longitudinal studies incorporating carefully controlled experiments[19] confirm that price increases (without compensating improvements in quality) discourage utilization among the poor.

The evidence also suggests that direct costs discourage school enrolment. When Malawi abolished primary-school fees and uniforms in 1994, the number of pupils increased by nearly half (Figure 5.5).

A significant negative effect of fees on enrolment decisions in Ghana has been reported. The discouraging effect of fees on the transition from primary to secondary schooling was found to be much greater for poor Indonesian children than for the non-poor. Price elasticities of demand for secondary schooling in rural Peru were highest for the poorer groups. If the quality of schooling services available to the poor is inferior, there is every expectation that poor households would be more sensitive to changes in direct costs than those enjoying a better quality of service. Evidently, if governments devoted more resources to BSS, there would be no need to charge user fees.

A very important indirect cost is ease of access – for example, in terms of transportation cost and the opportunity cost of time and effort. In South Africa, for example, the poorest quintile reported travel time of almost two hours on average to obtain medical attention. The richest 20 per cent spent only thirty-four minutes on average (Castro Leal et al., 1998). Though less dramatic, the Ghana Living Standards Survey of 1992 also recorded longer travel and treatment time for poorer households. These costs can dominate the decision as to whether to seek care when an illness or injury occurs. The evidence suggests that the demand for health care is particularly sensitive to the distance to a facility. Distance was found to be a critical factor governing health-care decisions in Colombia, Ghana, Kenya, Côte d'Ivoire and Peru (Gertler and van der Gaag, 1990; Mwabu, et al., 1993; Lavy and Germain, 1994). The easiest way to remedy this problem is to spend more in order to have more and better facilities closer to where people live.

5.5   Conclusion

Ensuring universal coverage of basic social services requires that public expenditure benefits all segments of society in an equitable way to equip the poor with the capabilities to escape from poverty. Evidence from nearly twenty developing countries indicates that health and education spending discriminate against the poor, but that spending on basic health and basic education is less regressive. The data show that, on average, the richest quintile of the population receive about twice as many benefits from education and health subsidies than the bottom 20 per cent of the population.

However, the distribution of benefits depends on the composition of expenditure between basic and non-basic social services. The distribution of benefits from basic social services appears less regressive than that from non-basic social services. The Matthew effect seems particularly strong in higher education. At the primary level, by contrast, the bottom quintile

receives more benefits than the top quintile. Caution is counselled when interpreting these results because they critically depend on the measure used. One of the reasons why the poor appear to benefit more from subsidies for primary education is because they tend to have more children than the rich, so that the poorest quintile often account for more than a fifth of the school-age children. Indeed, poor households have more children than non-poor households, so that their relative education needs exceed their population share.

The same point can be made for health, but information on the different health needs between poor and rich is not readily available and quantifiable. Evidence from industrialized countries suggests that factors such as low self-esteem, insecurity and unemployment are associated with higher morbidity and mortality among the poor (Wilkinson, 1994). In short, the evidence above may overstate the progressivity of public spending on primary education and basic heath because of the measure used (i.e. household income quintiles, and not benefits per child or health subsidies per instance of morbidity).

Nevertheless, the above evidence clearly supports the need for broad targeting by increasing the proportion of public spending on basic social services. This will not only lead to a more egalitarian distribution of the benefits, but will also enhance its effectiveness in terms of social outcomes, poverty reduction and future economic growth.

The current education subsidies do not ensure equality of opportunities among socioeconomic groups. Whereas the distribution at the primary level is reasonably equitable, the bias in favour of the wealthier families increases with the level of education. We estimate that over the period of a lifetime, a child from a rich family receives approximately ten times more education subsidies than a child whose family belongs to the bottom quintile, thereby preventing education playing its full potential as the great equalizer in society. The importance of the maldistribution of education subsidies can hardly be overstated because poverty reduction starts, in most cases, with education.

Averages mask important gender gaps in the benefit incidence. For example, it is not uncommon to see females use the publicly funded health and education facilities less, in comparison to males. In Côte d'Ivoire, for instance, the enrolment ratio remained unchanged in the second half of the 1980s, despite a marked decline in the enrolment ratio for poor girls. Figure 5.2 shows that the gender gap in primary enrolment widened by a third for the non-poor and by more than half among the poor between 1985 and 1988. The primary enrolment ratio for girls from poor households actually decreased, whereas it continued to increase for their non-poor counterparts.

The reasons why girls and women in poor households are disadvantaged in public health and education are not totally clear. It may be due to supply-side effects, as facilities available to the poor do not provide relevant or quality services. Or it may arise from demand-side preferences as poor households may decide that females should not use health facilities or attend school because of social values or higher opportunity costs involving time consumption in the daily cycle of a woman's social role. It has been observed that poor households make different health and education choices for males than for females, which may explain, in part, why subsidies are not progressive.