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Social Services in High-Growth Developing Countries

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ABSTRACT

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

1. INTRODUCTION

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

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

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

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

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

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

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

2. AN OVERVIEW OF THE LITERATURE

2.1. The overall literature

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

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

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

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

2.1. Health and economic growth

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

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

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

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

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

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

2.2. Education and Economic Growth

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

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

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

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

2.1. Social development surveys

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

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

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

3. SOCIAL DEVELOPMENT IN SELECTED HIGH GROWTH ECONOMIES

3.1. Overview of the economic growth rate

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

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

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

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

3.2. An overview of health conditions

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

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