

# **Eliminating Human Poverty: Macro-economic and Social Policies for Equitable Growth**

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# Overview: Barriers to Equitable Growth/MDGs and How Policy-Makers Can Respond

- Hierarchy between economic policy and social policy
- Orthodox, not home-grown paradigm, of macro-econ policy
- Low level, inequity and inefficiency of pub. exp.
- Organizational failure in state delivery of pub services – inappropriate decentralization
- Recent over-emphasis on privatization/PPP in BSS
- Inconsistencies in donor policies

# Barrier 1: Hierarchy between econ and social policy

- Leader-follower model of policy-making for developing countries
  - National govts: macro-econ policy determined first, social policy left to address the social effects
    - Ministry of Finance – its aggregated view of outcomes dominates soc mins/civil socy views. MinFin focuses growth, latter more concerned with disaggregated outcomes of econ policy on regions, income-grps, gender
    - MinFin has strong belief in power of econ growth to reduce poverty; latter less convinced; MinFin belief in market power to reduce poverty
  - International arena: macro-econ policies driven by BWIs, with other agencies left to take care of social consequences
- How to address the barrier?
  - Nationally: an intellectual failure – in rich, welfare states this leader-follower abandoned during Great Depression and post WWII (Atkinson)
  - Internationally: good news - IMF's global role declining, except in LICs - donor role!

## **Barrier 2: Orthodox macro-econ paradigm, even though in decline**

- If paradigm was supposed to deliver ECO GR, since 1980 (first SAP), econ growth lower than over 1950-80
  - E.g. in LAC index of IMF-consistent structural reform shows sharp rise from 70s to 90s, but little rise in growth, worsening inc dist, little fall in pov
- IMF IEO (2004): Macro-econ policy options shd be ‘home-grown’ – but still little evidence of such home-grown options being negotiated with IMF (UK White Paper 2006 still speaks of ‘ownership’)
- High-performing economies of China and India did not follow IMF prescriptions; nor did East Asians did 1997 – so Asia now driving global growth

Enlightened donors have a role in pushing BWIs on macro paradigm– until gov structure of BWIs changes

- Japan attacked WB's *East Asian Miracle* (1993)
- UK White Paper (2006): 'pressure WB, IMF to avoid econ policy conditionality in areas such as privatization and trade liberalization'
  - But PRGFs still follow the same macro-eco paradigm – criticized by IEO
  - PRSPs preceded PRGF progr – IEO's criticisms ignored or have evoked defensive response by IMF

## Pro-poor Growth (synergies): 3 equally important components

- Growth that benefits poor disproportionately, i.e. not just proportionately, or even less than proportionately (not all 'growth is good for poor')
  - Employment elasticity of growth shd be higher
    - E.g. India's much faster gr since 1980, but 320mn still poor (not 'growth at all costs')
  - Industrial policy (including one for MSMEs due to growing significance of informal employment – E. Asians did not have it)
- Social policy that delivers h, ed, nutr outcomes – BSS pub exp (incl min soc ins for informal sector, as state's fiscal capacity grows)
- Directly targeted pov red progr will induce gr – redistribution before AND with growth (e.g. landless and marginal farmers are ½ of 1 bn \$1 a day poor – found in s'ern/east Africa, South Asia, parts of LAC)

Synergies: Feedback loops between 3 equally  
imp components – not growth fixation

Human development outcomes =  $f_1$  (gr pci) +  
 $f_2$  (soc pol) +  $f_3$  (pov red)

## Economic growth (1990-2000) by initial level of inc- pov and health status (1990) – 50 countries

<i>Income Poverty</i>	<b>Under Five</b> High	<b>Mortality</b> Medium	<b>Rate</b> Low
<i>High</i>	<b>-1.6</b>	<b>-0.5</b>	0.5
<i>Medium</i>	<b>-2.6</b>	0.9	1.9
<i>Low</i>		0.6	2.7

## **Barrier 3: Level, inequity and ineff of p.e.**

### **3a:Level of pub exp on BSS**

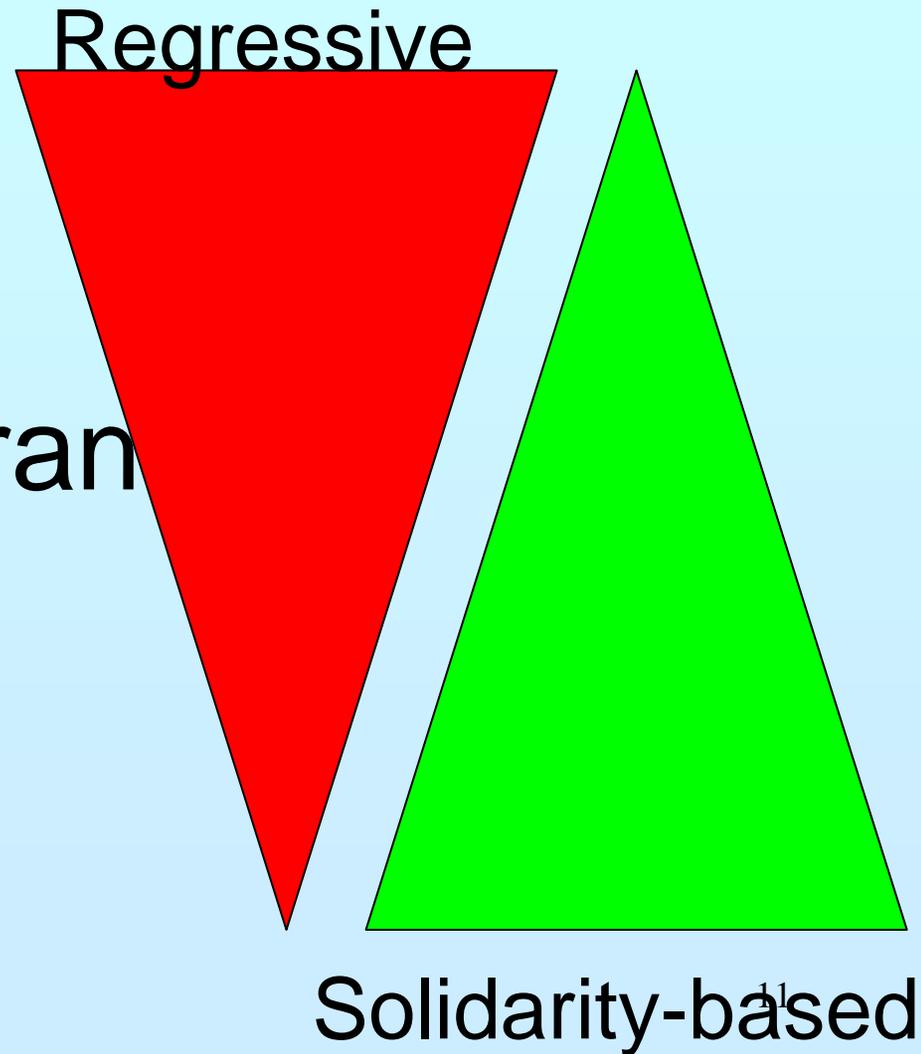
- Rich co. hist p.e. trajectory 100 yr rise 1880-1980: 11% of GDP (1880) to 40-45% post-WWII – driven by social spending (Lindert, 2005)
- LDCs: Fiscal adjustment since 1980 emphasised cutting pub exp (not rev raising)
- WB study (1996) for 1980-1993 showed that p.e., ex debt service, fell as share of GDP; per cap soc spend fell in real terms in 2/3<sup>rd</sup> of countries; composition of health and educ spending between basic/non-basic improved in only a few countries, worsening in many.
- IMF IEO study of 146 countries over 1985-2000 – using pooled cross-section time series data – p.e. in he and ed improved during progr, but +ive effect does not last beyond IMF progr; no info on basic/non-basic component

## Our finding

- P.E. on h and ed does impact outcomes
- Exp on BSS in selected countries hovers around 12-14% of govt exp – not impressive when overall pub exp were being cut
- BSS share in pub exp and BSS per capita exp in real terms were highly correlated
- Int'l policy advice needs to focus on tax revenue raising – not just p.e. pruning

How will revenues be raised? Assessing  
progressivity of financing of BSS

Self provision  
User fees  
Generalized insurance  
Earmarked taxes  
Indirect taxes  
Direct taxes



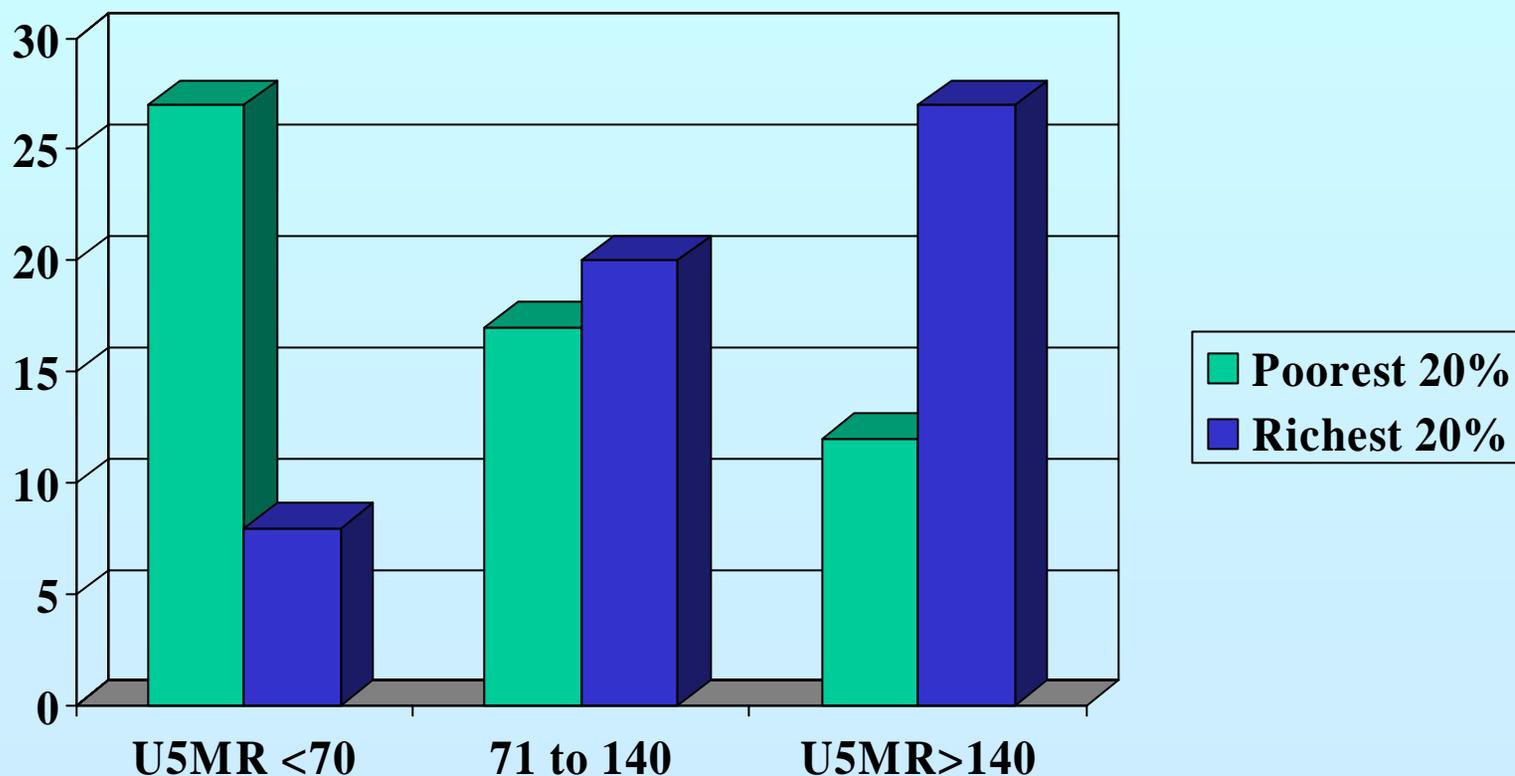
## In low-achievers (e.g. India) high self-provision and hi out of pocket expenses – Response?

- Higher the level of pci, higher the tax revenue to GDP ratio – hence eco gr essential
  - Dramatic rise in tax revs in India in 2000s, creating fiscal space for making growth ‘inclusive’ (invest in agr, health, educ, infra)
- Focus on Tax revenue generation in IMF policy advice
  - Introducing VAT increases revs – e.g. China (1994); India (2004)
  - but make sure that exemptions protect consumption of poor
- Use ear-marked taxes to secure allocation to high priority BSS – IMF resistance shd be countered
  - Int’l experience with earmarked taxes good (e.g. India imposed in 2004 surcharge on inc tax earmarked for elem ed)
  - With benchmarking to initial year of spending level (to avoid fungibility problems)

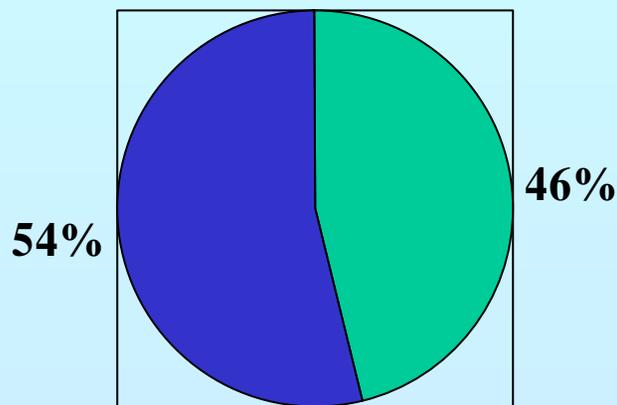
## 3b Barrier: inequity in distr of benefits of p.e.

- We collected new data on benefit incidence of p.e. on h and ed (across Asia, Afr, LAC)
  - Richest quintile of pop receives twice as much benefit from ed and h subsidies than bottom quintile
  - But benefits of basic health exp and basic ed exp are much less regressive than that of non-basic services
  - V. imp: there is a real difference in health and ed outcomes between countries when allocations favour basic services
    - E.g. in countries with U5MR <70, poorest 20% of pop recd over 25% of benefits of p.e., but in co with U5MR >140, poorest recd less 15% of benefits

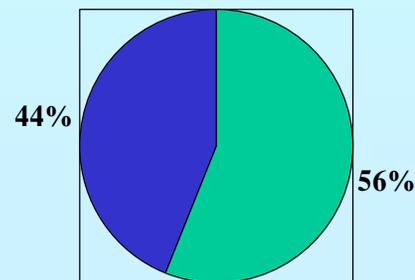
# Inequity of p.e. - distrib of primary health benefits and ch mort (% of p.e. by quintile)



# Despite its benefits, Fiscal priority to basic serv low in HEALTH and EDUCATION



■ Basic health ■ Non-basic



■ Basic ed ■ Non-basic

## Barrier 3c: Inefficiency and inequity go hand in hand in p.e. on Health, Educ, Watsan

- Hi-achievers in h/ed outcomes (DWHF, Mehrotra and Jolly, 1997) – have p.e. patterns v different than low-achievers
- Hi-achievers in EDUCATIONAL outcomes – **Alloc of P.E. on educ** :
  - Share of higher ed in 1980 and 1990 lower than in other cos in region (Korea vs India)
  - Prim ed exp/pci higher in hi-achievers than other countries
  - Per pupil exp on higher educ as multiple of per-pupil prim ed exp is lower
- **Private costs** per pupil/pci lower in high achievers in primary schools
  - Policy implication: p.e./GDP on pri ed must rise which will
    - Reduce costs to parents of sending children to school, retaining them
    - Raise share of non-teacher salary share of pub exp, currently over 90%

## Structure of recurrent exp is critical: need for balance between wage/non-wage elements

- Hi-achiever: Sri Lanka: meds and supplies are 1/3<sup>rd</sup> of recurrent exp on health; govt procures essential drugs (WHO)
- Hi HDI countries: entire pop has access to essential drugs; medium HDI, e.g. China 80-94% access; India 0-49% access
- Hi-achievers' composition of wage component: nurse-per-doctor ratio much higher than in other countries – many outreach and preventive services don't require doctors
  - Reduce costs plus improve outcomes by training/recruiting more paramedical staff than physicians

## **Barrier 4: Institutional design failures in state delivery of services – Inappropriate decentralization since 1990**

- Centralized governance structures were inherited from colonial state and militarized state in LAC – inappropriate model
- Line ministries still delivering services – reporting lines of teachers, doctors to line mins despite ‘decentralization’ – NOT to local community
- Needed: horizontal accountability to community, not vertically to distant line ministry officials – otherwise teachers/doctors will remain absent, corruption remain undiscovered
- WB-driven Decentralization of 1990s driven by desire to limit the role of central state – not well-conceptualized

# Deep democratic decentralization requires transfer of 3 Fs to local bodies

- Functions
- Finance
- Functionaries
  
- This requires:
  - A capable central government
  - An empowered local govt (with 3 Fs)
  - Mechanisms for community to articulate its VOICE (since EXIT possibilities are ltd)
- Requires a decentralization not driven by merely concern about lack of VOICE (WB – *‘Voices of the Poor’*) and overbearing centr govt

Where redesigned decentralization has radically improved health/ed outcomes

- Will impact efficiency of targeted pov red progr AND basic soc serv: evidence
  - Ceara state, Brazil – health outcomes
  - Participatory budgeting all over LAC – all services
  - Madhya Pradesh/Rajasthan, India – impact on school enrolment literacy

## **Barrier 5: Misconceived faith in Private sector/NGOs in BSS ignores rich co history**

- In Europe, in first half of 19<sup>th</sup> C., pvt providers dominated health, educ, water
- In second half of 19<sup>th</sup> C., public providers became predominant – access to BSS became universal only when govts intervened in last qtr 19<sup>th</sup> C. and first half of 20<sup>th</sup> C.
- Lesson about sequence: Comprehensive prov by state early on; then more targeted interventions to reach unreached; then PPP more recently
- Lesson from high-achiever LDCs in latter half of 20<sup>th</sup> C (DWHF, Mehrotra and Jolly, 1997): very similar

# Experience with Health Pvtion in LAC and Water PPPs

- Health Pvt in LAC and transition economies: Not improved equity in already unequal, or growingly unequal, countries
- PPPs in Water in urban areas: Water TNCs backing off esp in LAC, having burnt fingers

## Barrier 6 : Inconsistency in rich country policies

- Aid: WSC goals agreed in 1990; repeated in WSSD goals 1995 – accepted by OECD countries in 1996 as the *International Development Targets (became MDGs)*; BUT
  - Total ODA fell in absolute terms thru 1990s till 2001, also as % of GNP
  - ODA Composition: Since 1994, possible to monitor share of BSS in ODA
    - stuck at around 10% of falling ODA; agr aid stagnant
  - ODA rose sharply post-2001, but share in it of debt relief and emergency/reconstruction aid high
  - Good news: sharp rise in abs terms of ODA for basic health, basic ed since 2003

# But trade policies undermine the aid effort

- Global summits call for halving food insecure, but agr and natural resource skills are cut in aid agencies
- Mins of Trade promote trade liberalization (excl UK White Paper 2006), but aid agencies unable to build LDC capacity for trade negotiation
- To achieve consistency with equitable growth objective:
  - Market access: Mins of Trade impose M quotas when recently liberalized partner countries try to raise X to rich cos (ave trade def in LDCs in 1990s higher than in 1970s by 2%age points of LDC GDP);
  - agr subsidies of EU-US-Japan undermine LDC agr growth, which support over 60% of LDC pop