



Briefing Paper

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CAN WE ATTAIN THE MILLENNIUM DEVELOPMENT GOALS IN EDUCATION AND HEALTH THROUGH PUBLIC EXPENDITURE AND AID?

Two MDG targets in Education and Health

The UN and the 'development community' of developing countries and their donor partners are committed to the Millennium Development Goals (MDGs). Donors are adding a commitment to managing aid for results to their existing commitments to poverty reduction and good aid practice.

This paper asks how good the record of public expenditure in developing countries has been in delivering two MDG targets, one each in education and health, viz. primary school completion for all (or universal primary education) and a two-thirds reduction in child mortality (Box 1). These reflect longstanding development objectives – formulated in the education case 40 years ago – and abundant data has long been collected on results achieved. The paper finds that public expenditure often has low efficiency and is biased against the poor. This has implications for the management of aid provided in support of poverty reduction strategies.

The emerging consensus among donors (Box 2) is that good aid practice, subject to financial management caveats, should involve the use of flexible instruments, such as budget- or pooled sector-support for public expenditure programmes. The effectiveness of aid is therefore in good part determined by the effectiveness of developing countries' public expenditure programmes.

Progress and issues in primary education

There has been an upsurge of purposeful activity in the international donor community since the Dakar Education for All Forum in 2000 directed at hastening progress towards the education MDG target. The World Bank has been encouraged by its Development Committee to 'fast-track' support for primary education in countries with sound Education for All programmes. The statistical apparatus maintained by UNESCO and the World Bank for monitoring progress has been significantly upgraded, with fuller and more timely reporting by developing countries. The nature of the task ahead in reaching the MDG target in different groups of countries has been re-assessed, and policy priorities have been redefined.

Enrolment rates are rising, but internal efficiency remains low in many school systems

There has been growing regional differentiation in progress towards universal primary education. Gross enrolment rates increased steadily in all low and middle income countries from a weighted average of 82% of school age children in 1970 to 104% in 1999, and for low income countries from 66% in 1970 to 98% in 1999. In sub-Saharan Africa, however, gross enrolment rates have remained stuck at a weighted average of below 80% since 1980.

Gross enrolment rates are heavily inflated by the presence in primary schools of many over-age children. This occurs

Box 1: Education and Health MDGs

Goal 2: Achieve Universal Primary Education

Target 3

Ensure that, by 2015, children, everywhere, boys and girls alike, will be able to complete a full course of primary education

Indicators

- 6. Net enrolment rate in primary education
- 7. Proportion of pupils starting grade 1 who reach grade 5
- 8. Literacy rate of 15-24 year olds

Goal 4: Reduce Child Mortality

Target 5

Reduce by two-thirds between 1990 and 2015 under-five mortality

Indicators

- 13. Under-five mortality rate
- 14. Infant mortality rate
- 15. Proportion of 1-year old children immunised against measles

particularly where there have been recent efforts to widen access to education. Net enrolment and primary completion rates are thus much lower than gross enrolment rates in developing countries (Table 1).

Table 1: 1999 Gross and Net Enrolment, Primary Completion and Repetition Rates

Region	GER	NER	PCR	Repetition ¹
Low & middle income	103.7	82.0	73.0	9.4
East Asia & Pacific	105.7	92.4	81.0	4.9
Europe & Central Asia	94.1	92.0	93.0	1.5
Middle East & North Africa	95.4	83.1	74.0	8.8
Latin America & Caribbean	131.5	97.0	83.0	7.1
South Asia	100.8	79.0	56.0	5.0
Sub-Saharan Africa	79.3	54.4	55.0	17.0

Source: EdStats; NERs for LMICs & S. Asia: UNESCO

¹ Unweighted average of repeaters as a percentage of primary enrolment

In most developing countries, except those in parts of sub-Saharan Africa, the great majority of children attend the first year of primary school. But many drop out thereafter, which is the main reason why 113 million children (18% of the school age cohort) were out of school in 1998. Low completion rates reflect high abandonment rates, particularly among the children of poor households, and where education quality is poor. The major challenge in attaining the MDG target lies in eliminating abandonment, particularly by the children of poor parents.

Developing and transition countries can roughly be classified as follows in terms of factors affecting their primary completion performance:

	High drop-out	Low drop-out
<95% net 1st year enrolment	Sub-Saharan Africa	Middle East (excl Turkey, Iran)
>95% net 1st year enrolment	South Asia North Africa Latin America South-East Asia	East & Central Europe Transition countries East Asia

Schooling systems where children are steadily promoted through the grades and complete the course in the prescribed number of years are said to be *internally efficient*. Continuing high drop out rates in poor countries are one manifestation of persistent internal inefficiency.

Another symptom is a high rate of repetition – over 30% in some sub-Saharan Africa countries. Where rates of repetition are high, educational facilities are being devoted to pupils who fail to make the grade instead of being used to expand enrolments. Comparisons can be misleading, because some countries promote their pupils automatically while in others, only pupils that pass tests are promoted. Subject to this, it is clear from Table 1 that Sub-Saharan African primary schools are significantly less efficient on average than those of other regions.

Dropping out and repetition are often symptoms of a poor learning environment – with low quality teaching by untrained teachers, inadequate textbook supply and dilapidated premises.

Public expenditure: unit costs vary enormously within and between countries, and there is anti-poor bias

Some 80-90% of expenditure in developing countries on primary education is public. Private, fee-paying, education is for the most part the privilege of the rich.

International comparisons of expenditure on education are usually made in terms of shares of gross national income or GDP, because inputs into education are largely non-traded and cost less in low income countries than in higher income ones. Income shares are therefore a better – but still imperfect – overall measure of the volume of inputs devoted to the sector than undeflated dollar expenditures.

A striking characteristic of public expenditure on primary education is that it varies greatly from country to country in amount (relative to GNP or GDP), in efficiency (unit costs), and in quality. There are also major unevennesses within countries in efficiency and effectiveness.

Low and middle income countries spent in 1998 on average 4.1% of their GDP on education. Low income countries and the least developed spent respectively 3.4% and 2.9%. However, low spending does not necessarily spell low enrolments. Table 2 shows that median expenditure as a share of GDP was higher in sub-Saharan Africa (SSA) where enrolment rates are low, than East Asia and the Pacific (EAP) where enrolments are high. It also shows the high dispersion between countries of shares of GDP spent on education.

Public expenditures on primary education vary greatly as a share of national income and as a share of the education budget. On average, developing countries devote about half their education budget to primary education, but the share varies from as low as 30% to as high as 70%.

These expenditure differences between countries signify major differences in unit costs, i.e. in the efficiency of education expenditure. Relative to the *efficiency frontier* most countries schooling systems are inefficient. Chart 1 illustrates relative unit costs of achieving primary completion in a sample of 66 countries. Their mean efficiency is only 68% of countries

Table 2: Public expenditure on education as a share of GDP 1996–8

	Sub-Saharan Africa	Latin America, Caribbean	East Asia, Pacific	Middle East, N Africa	South Asia
Median	3.7	3.6	3.2	4.6	3.0
Minimum	1.0	1.6	1.3	2.7	2.4
Maximum	10.8	6.7	6.2	8.2	3.4

Source: WDI

on the efficiency frontier, implying that the average cost of primary completion is 47% above this benchmark.

Unit costs may be high because of:

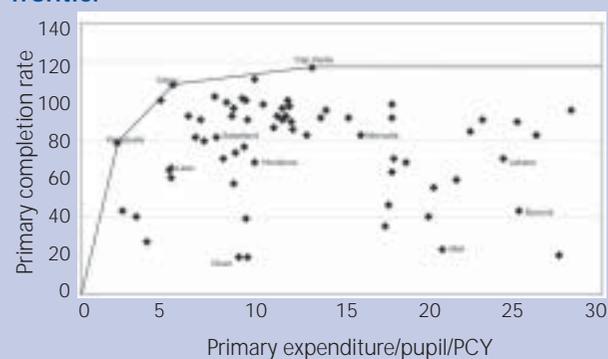
- high teachers' salaries, as formerly in Francophone Africa,
- mismanagement and waste of resources
- low internal efficiency – high rates of abandonment and repetition.

Within countries there can be big inter-regional variations in educational expenditure and in physical coverage. Urban areas are typically better provided with primary schools than rural areas, and poorer areas are often less well provided with accessible schools than more prosperous areas.

There is serious inequity in the distribution of public subsidies for primary education. Beneficiary incidence surveys show that the poor, whose needs are greater, receive less expenditure per pupil than do the better off.

Raising enrolments, therefore, involves not only – and often not principally – raising expenditure, but also raising standards of efficiency and the quality of the learning environment, and eliminating the geographical disadvantage of under-served areas and population groups. The features which make school systems efficient and effective are well known. The reforms needed to achieve them combine resource re-allocation – more to primary schools and to deprived areas – with better resource management for better performance (see below).

Chart 1: Primary completion rate efficiency frontier



Note: The Primary Completion Rates is the ratio of pupils completing the primary cycle to the number of children in the final year of primary schooling age cohort. It can exceed 100% if some completers are over-age.

Source: EdStats data for recent years

Public expenditure has not been the main determinant of educational performance

Many authors (e.g. Mingat & Tan, 1992; Filmer & Pritchett, 1999) have tested cross-country, econometric models relating education performance to public expenditure and other supply-side and demand-side variables. They have all found that factors other than expenditure have significant coefficients and explain a high proportion of the variance in performance,

but that public expenditure (as a share of GNP or of public expenditure) has little explanatory power.

CAPE research using recent EdStats data from the late 1990s confirms these results. Demand side factors (income, and especially adult literacy) exert a powerful influence on enrolment and completion rates; low unit costs significantly favour enrolment (but not completion); but expenditure at best only weakly contributes to these outcomes.

These results do not mean that primary education could achieve the same outcomes without public expenditure, nor that more public expenditure could not improve educational outcomes. The correct interpretation is that (i) expenditure (deflated by GDP) is a poor measure of effective inputs into schooling because its quality and efficiency is so variable, and (ii) the children of poor households will not complete their schooling unless their parents' demand for education for their children is raised – *inter alia* by policy action.

[The demographic transition makes the MDG target more accessible, but some regions have to cope with a 'bulge' of over-age children](#)

The school age populations of many developing countries are stagnating and, in some cases, falling. The age 6-11 cohort will be smaller in 2015 than in 2000 in most countries in South-East and East Asia and in many European and Central Asian transition countries. The size of the cohort will be roughly stable in South Asia and in Latin America. Only in sub-Saharan Africa and in parts of the Middle East and North Africa is it projected to go on growing.

However, improved educational opportunities in countries where many children have not been to school is creating a 'bulge' in enrolments which will last several years. Achieving the MDG target will mean not only offering school places to school age children but also catering to the demand for school places from over-age children. Uganda illustrates this phenomenon. Its gross enrolment rate rose from 87% to approaching 150% after primary school fees were abolished in 1997. Gross enrolments in Grade 1 reached nearly 200% of the Grade 1 age group.

[Raising the demand for education is crucial for meeting the MDG target in poor countries](#)

Rates of schooling are lowest among the children of poor households. The main factors that determine parents' willingness and/or ability to send their children to school, on the evidence of cross-country regressions, are:

- adult literacy
- parents' education
- household income
- children's health
- parents' health and household characteristics
- cost, including opportunity cost, borne by parents
- parents' perception of economic opportunities for children, and
- parents' perception of quality of education.

Household and parental characteristics are particularly important. Poor parents without education or literacy are less likely to send their children to school, especially if they are sick and require children to perform household tasks, and/or if they need to rely on the cash income of child labour.

Among the poor, the demand for education is highly price elastic – as witnessed by the 50% increase in enrolments in the late 1990s in Malawi and Uganda, following the abolition of school fees. Demand is also sensitive to opportunity cost of children's time and to other out-of-pocket costs borne by parents.

Public expenditure devoted to reducing the cost and opportunity cost for the poor of sending children to school can therefore produce dramatic increases in enrolment, at least in Grade 1. Appropriate measures may include:

- abolishing fees
- abolishing uniforms
- providing free meals
- paying attendance grants to parents, and
- offering school timetables that allow the children of poor households to work as well as attend school.

Poor parents may also withdraw their children from school if they think that the quality of schooling is so low that their children derive no benefit from it, given their expectations about future employment and income earning opportunities. Primary school completion for all will require sufficient expenditure on the learning environment to convince parents of the merit of leaving their children in school.

[Required reforms are well known, but not carefully enough planned, nor widely enough applied](#)

To accelerate their progress towards the primary education MDG, countries still remote from the target should, according to their circumstances:

- devote more of their budgets to education and more of their education budgets to primary education – generally at the expense of higher education,¹
- use additional resources to raise schooling quality and internal efficiency,
- deploy scarce trained teachers more efficiently, using auxiliaries for non-professional tasks,
- use additional resources to raise poor households' demand for education,
- use results-based budgeting and performance management techniques to raise standards,
- base strategy for primary education on a careful assessment of the factors restraining enrolment and completion.

Careful diagnosis of local factors inhibiting progress, and careful planning, targeting and monitoring of public interventions, are essential for consistent and purposeful progress towards the target. The inhibiting factors may be technical, administrative, socio-economic and political, and they occur on the demand side as well as on the supply side. Without reforms to take account of poverty, adult literacy, and health, and to promote efficient, effective resource management and quality, higher outlays may be absorbed by higher unit input costs and falling levels of efficiency. Even with these precautions the impact of higher expenditure on outcomes may be slow to materialise.

[Progress and issues in reducing child mortality](#)
Child mortality is in secular decline, but the rate of progress fell in the 1990s

The past forty years have seen a tremendous improvement in

¹ On average some 40-50% only of public expenditure on education goes on primary schools, and as much as 15-20% is spent on tertiary education where unit costs are 5-10 times higher and which, for the most part, benefits the élite. Unit costs of education in secondary schools are somewhat higher than in primary, and social rates of return to secondary schooling in poor countries are often, but not always, lower. However, the cognitive skills acquired in secondary schools are vital to developing countries as they adapt to respond better to the challenges of the global economy. It is therefore usually inappropriate to diminish the budget for secondary education in order to pay for more primary education.

child mortality. In the period 1960-1999 child mortality fell in low income countries by 50%, from 24.2 % to 11.6% of live births, and in lower middle income countries by 75%, from 20% of live births to 4%. All regions in the developing world have seen big reductions in mortality rates, particularly in the 1970s and 1980s. The rate of decline fell in the 1990s, and in sub-Saharan Africa it stopped falling altogether.

The income-poor have distinctly worse health than the rich. Child mortality rates in developing countries overall remain twice as high for the bottom income quintile as for the top – in Latin America three times as high. Equity is thus a serious issue.

Public expenditure has been less important than income, education and conditions of life and work in determining health and child survival; but it can benefit the poor

The econometric evidence of the impact of public expenditure on health outcomes is weak. Filmer and Pritchett (1997) find in cross-country regressions that, after controlling for demand-side variables, viz per capita income, income inequality, female education and access to safe water, public expenditure on health added very little to the power of their equations to explain child mortality (only 0.15% of the variance). Other authors find, on the other hand, that public expenditure improves health indicators, specifically among the poor (Bidani & Ravallion, 1997) and the rural population (Wang, 2002).

Public expenditure has a vital role in supplying public goods and services with externalities

One very important reason for public subsidy of health facilities is that there are strong positive externalities from environmental health and communicable disease control interventions. Reduced levels of infection and of the vectors of disease are a pure public good – being non-rival and non-excludable. Public health and public provision of care may be of critical importance if correctly targeted, especially where, as in sub-Saharan Africa, infectious disease is still a major cause of mortality and morbidity, and for groups, such as children, which are particularly at risk. This should be, but often is not, the focus of public expenditure.

Aid-supported 'vertical' programmes have been very successful, but 'horizontal' programmes less so (though there are complementarities)

One reason for the progress made in the 1970s and 1980s in reducing child mortality was the Expanded Programme of Immunisation (EPI), which was promoted by UNICEF and WHO, though implemented by national health authorities. This raised the rate of vaccination coverage against the main childhood diseases, measles, polio, diphtheria, whooping cough, and TB and tetanus, from 4% in the 1970s to 75% in 1990 – though it has stagnated in the last ten years.

The EPI was a 'vertical' programme – one which is supply driven, targeting a defined range of causes of ill-health. It stands in contrast to horizontal approaches to health sector intervention.

A major horizontal initiative has been the extension of primary health care (PHC) that followed the Alma Ata Health-for-All conference of UNICEF and WHO in 1978. The PHC initiative, however well-intentioned, is now regarded as in some respects ill-conceived and often poorly implemented. Primary care centres in the public sector, when well run, have tended to attract customers away from the private sector, especially in urban areas. When badly run, as often in rural

areas, they are poorly frequented. In neither case do they contribute much to improving health outcomes, nor to overcoming the health deficit of the poor.

The World Development Report of 1993 and the WHO's Commission on Macroeconomics and Health (CMH) of 2002 have both recommended a 'basic package' approach to achieving a high impact on health outcomes from limited expenditure. The approach consists of using local epidemiological data to identify the most important causes of, for example, child mortality, and of allocating public resources to cost effective preventive and curative interventions to deal with them. These interventions produce high positive externalities, and an important public good, viz. lower infectivity.

The CMH authors recommended a focus on measures to combat TB, malaria, HIV (including opportunistic infections), hepatitis B, Hib, maternity-related infections and childhood diarrhoea and respiratory infections, and also DPT immunisation for children and perhaps action against smoking. The cost of this in low income countries, once fully implemented, would be \$38 per capita per annum (in 2002 prices). Where implemented it would *per se* go a long way to reaching the child mortality MDG target, but would not guarantee 100% attainment.

Horizontal and vertical programmes should be integrated: PHCs are needed to deliver 'basic package' type services, and should make it their priority objective to do so.

The poor pay for private health care if it is better or more accessible than public care; but they need assistance for catastrophic ill health

A notable characteristic of health care is the significant role of the private sector as a supplier of care, and the high share – approximately 50% – of total health expenditure that goes to private sector providers. Though the poor are more apt overall to use public facilities than the rich, they, too, are major users of the services of private providers (modern and traditional). There is high cross-price elasticity of demand between alternative providers, such that new public sector supply of health care may attract custom away from private providers, without adding greatly to total utilisation. Patients are also very sensitive to the quality of the treatment and care they receive. They will desert public sector providers who treat them badly, keep them waiting, and lack drugs and medical supplies. This accounts for the under-utilisation of public health facilities found in some poor countries.

Health insurance is usually only available to the rich and to those in formal sector employment. The norm is for patients to pay out-of-pocket for the treatment they receive. This means that accidents or serious ill-health requiring expensive treatment may seriously undermine household livelihood. In some societies there are informal provident funds to assist households afflicted by bereavement or other catastrophic collapse of the bases of livelihood. In Sri Lanka, the poor pay for much routine treatment, but have free access to public hospitals in case of catastrophic illness.

Public expenditure is often misallocated relative to need and its potential for high impact; reforms are resisted by vested interests

Unfortunately, the trend in developing countries in public expenditure on health is not towards public expenditure focused on public goods, high impact interventions and the needs of the seriously-ill poor. On the contrary, the greater part of health sector budgets in poor countries goes on low impact services such as the curative care of non-catastrophic

conditions. Benefit incidence surveys detect persistent anti-poor bias in the distribution of public subsidy in sub-Saharan Africa – even in primary health facilities. In Asia the same applies overall, though in some countries such as Indonesia and Malaysia the poor receive more subsidy than the rich. Some 40% of budgets are still typically earmarked for state hospitals which – with some notable exceptions like Sri Lanka – are inefficient (with low patient turnover) and cost-ineffective in relation to child mortality reduction and other MDG targets. Attempts, as in Malawi, to pursue health sector strategies that reallocate resources to high impact services remain unimplemented, often because of the resistance of political and professional vested interests.

There is thus ample scope, within existing health budgets, for a reallocation of public expenditure towards the poor and to high impact programmes. This would be highly effective, if insufficient to meet the MDG target, especially if accompanied by reforms to reduce unit delivery costs.

Donor Good Practice and Public Expenditure Good Practice

'Good practice' by donors and PRSP monitoring may not *per se* be sufficient to achieve results by supporting public expenditure programmes

In both education and health, there are serious problems in poor countries in ensuring that public expenditures deliver the services needed to accelerate progress towards the MDG targets. The problems are ones of accessibility to poor people, inter- and intra-sectoral resource allocation, resource management and service provider incentive. Dealing with these problems calls for persistence with politically sensitive institutional and managerial reforms, without which question marks will remain over programmes' efficiency and effectiveness.

This leaves aid donors in a quandary. They are committed to the MDG targets. Some finance public expenditure through flexible, non-sector-specific instruments such as general budget support. They also support the Comprehensive Development Framework principles of country ownership and leadership, working through countries' own programmes and procedures to implement the poverty reduction strategies and policy priorities that countries articulate (Box 2). Yet they find that, though their partners' goals are consistent with the targets, their resource allocation and management practices and incentives are not.

A currently favoured solution is to rely on PRSP reviews and monitoring, using the targets and indicators proposed in PRSPs. This approach has the great merit of sustaining and institutionalising a dialogue between donors and recipients on national priorities and approaches to poverty reduction. However, the targets and indicators to be monitored relate in the main to trends in final or intermediate outcomes, not to the activities and proximate outputs with which implementing agencies are immediately concerned. Furthermore, the PRSP monitoring and review process is not designed to investigate reform processes and to diagnose the reasons for deviations from outcome targets.

PRSP monitoring should therefore be complemented by other processes, with a stronger focus on sector strategy, activity, output and performance

Donors wishing their support to contribute to progress towards the MDG targets in education and health should remain engaged with the authorities in these sectors on issues of strategy, capacity building and performance management.

Box 2: Good practice by donors

The Task Force on Donor Practices of the Development Assistance Committee (DAC) of the OECD drew up, in late 2002, a reference document on Harmonising Donor Practices for Effective Aid Delivery.

The document elaborated the principles advanced in the DAC's Guidelines on Poverty Reduction of 2001. Donors should:

- support national development policies
- base their programmes and conditionality on national poverty reduction strategies
- build local institutional capacity for policy, implementation and accountability
- be coordinated, preferably under partner government leadership
- adopt flexible aid management practices consistent with sound budget and expenditure management by partner governments and which reduce transaction costs for partners
- use partner government systems - for budgeting, accounting, reporting, monitoring and procurement - where these are conducive to agreed purposes
- in the meanwhile, use simplified and harmonised procedures
- make their assistance predictable - using multi-year framework agreements
- be transparent about their actions - keeping partner governments fully informed of their actions

The Guidelines added an important codicil on the complementary need for public expenditure programmes to be effective:

'In the right political, economic and institutional environment programme aid supporting a sound poverty reduction strategy is likely to have the biggest impact. But, given the fungibility of resources, it is important to ensure that programme aid supports a sound, agreed and monitored reform programme.'

Source: OECD/DAC (2003) *Development Cooperation 2003 Report*, Chapter III

The prototypes for donor involvement at the sector level are sector-wide approaches to sector development – SWAps. The great majority of SWAps are in education, health and in transport infrastructure. These include the valuable features of:

- results-oriented sector development and reform strategies, implemented through action plans, with budgets funded by governments and donors,
- integrated programmes of professional, managerial and institutional capacity building,
- arrangements for monitoring and evaluating results achieved, and for using assessments in performance management.

Early SWAps, though, were often insufficiently locally owned, somewhat naive about political and professional resistance to reform and resource re-allocation, and over-ambitious about the pace of institutional change. They were burdened in their implementation by extra-budgetary financing, and by unharmonised and over-complex donor disbursement procedures and reporting requirements. Performance was sometimes below expectation (eg in Ghana Health and Basic Education). Early SWAps did not raise the development impact of public expenditure programmes.

More recent SWAps feature better donor practice, including pooled financing, harmonised and simplified reporting and monitoring, and use of local procurement systems. Sector authorities' strategic purpose and initiative, and ownership of reforms is now stronger. Results-oriented approaches to management and budgeting have been instituted, with strengthened planning and performance management systems – including data collection, monitoring and diagnostic performance assessment. Officials and service providers are

clearer about their objectives and have stronger incentives to achieve them.

The foundations have thus been laid for higher impact public expenditure – financed by budget support, but with close attention paid to performance and performance management processes in sectors of key importance in poverty reduction. Positive results are being achieved (Box 3). It is important now to sustain the momentum and widen the application of these practices, reinforcing as necessary local capacity in areas of continuing weakness, promoting the cross-fertilisation of successful experiences, and restraining the

Box 3: Partnerships for Performance

Uganda General: Uganda's Poverty Eradication Action Plan (vol. iii) states that: 'all donors who are providing fully flexible budget support ... should be invited to participate in the review of any sectors where they can contribute useful expertise'.

In Uganda, likely external assistance is factored into the setting of sector ceilings in the Medium Term Expenditure Framework. Offers in excess may be declined. Allocations within sector ceilings are decided by Sector Working Groups in which donors, civil society and MPs are represented, as well as officials. Donors have a voice, but not a veto.

Uganda Education: In 1997, the Ugandan government launched its Education Sector Investment Programme, with the aim of achieving universal primary education. It was supported by the bilateral and multilateral donors using the instrument of a SWAp. Most donors' funds pass through the national budget, but on the understanding that education would receive pro tanto additional financing. Quarterly Ministry-donor meetings monitor school construction, enrolments, the recruitment of teachers and the provision of teaching materials. Disbursements of ESIP assistance were made conditional on the fulfilment of actions agreed at these meetings. Since the start of ESIP, gross primary enrolments have risen from 80% to 130% and the reported Primary Completion Rate from 50% to 80%.

Bolivia Education and Health: In Bolivia sector-wide financing by donors of education and health passes through the Ministry of Finance, but with the understanding that the activities of the sectors will receive adequate recurrent financing from the central budget.

The 1994 education sector reform integrated previously scattered donor projects. Focusing mainly on primary education, it strengthened the role of targets and indicators in planning and in the performance agreements of different units in the Ministry of Education. Performance is jointly monitored by the Ministry and donors on the basis of a common assessment plan. Primary school enrolments have not yet shown much improvement, but the reported Primary Completion Rate rose from 71% in 1990 to 97% in 2000.

In health, for a new SWAp starting in 1997, the Ministry of Health formulated output targets on which it based performance contracts for the entire health service. All targets have been met – though there are some doubts about data quality.

Tanzania Assistance Framework: In April 2000, the Tanzanian government and its donors agreed to set up a donor-financed Poverty Reduction Support Facility – a pool of flexible, predictable and coordinated budget support. On its side, the government committed itself to a Performance Assessment Framework covering macroeconomic management, MTEF allocations, PRSP targets for public service outreach, public sector reform, financial accountability reform, and joint performance monitoring. The monitoring covers sector expenditure and performance indicators.

vested interests that oppose pro-poor reforms.

Reaching the MDGs calls for a mixed strategy

Donors should therefore pursue a mixed strategy in countries at risk of not meeting the MDG target, comprising:

- budget support for resource transfer to the national budget, on the basis of long-term, trusting, partnerships,
- policy dialogue in poverty reduction strategy and assistance strategy fora about the priority due to pro-poor social sector programmes in public expenditure allocations, with due recognition of the needs of evolving programmes of action,
- sector-level dialogue on sector strategies and their implementation, and on the coherence of allocations and actions with strategic options and agreed objectives, and
- capacity building support at both national and sector levels for performance assessment and performance management.

The mixed strategy requires that donors should be able to maintain a close relationship with country authorities at the sector level, while using support for the national budget as the main vehicle for financial transfers.

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