Oxfam Briefing Paper

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Paying for People

Financing the skilled workers needed to deliver health and education services for all

Millions of people are dying, sick, or out of school because there are not enough teachers, nurses, and doctors in poor countries. Some poor-country governments have doubled expenditure on health and education since 2000 but still cannot afford to pay for these workers, so aid must plug the gap. But current aid is failing poor people – only 8 cents in the aid dollar are channelled into government plans that include the training and salaries of teachers and health workers. Two million teachers and 4.25 million health workers must be recruited to make health and education for all a reality. Aid donors must change the way they provide money, making long-term commitments and supporting national plans.

Oxfam International

Summary

This is the first in a series of three papers that examines the financing of services in developing countries. This paper focuses on external assistance in the form of aid and debt cancellation. The other papers in the series will focus on internal revenues; first, receipts from taxation and then receipts from extractive industries.

Without health and education, poor women and men are denied the opportunity and ability to escape poverty. Health and education are basic rights, to which all citizens are entitled. But after decades of under-funding and ill-conceived reforms, these rights remain a distant dream for millions of people in the twenty-first century. Today, eighty million children are out of school. One thousand four hundred women will die in pregnancy or child-birth, with no access to professional care. In particular it is women and girls, poor people in rural areas, people with disabilities, and indigenous communities who are denied access to services, as well as the opportunity to be employed within them. Women and girls also pick up the burden of caring for sick relatives when health services fail.

Health and education systems are built of people. They cannot be fixed with technology alone. Even where there is no classroom, children can still be taught by a teacher. But where there is no teacher, then no amount of classrooms will ensure that children receive an education. Two million trained primary-school teachers are needed this year – and another two million each year until 2015. Today, over four million health professionals and support staff are needed, one-quarter of them in Africa. If things carry on as they are now, these gaps are not going to be filled. Meanwhile, a handful of workers struggle heroically to do their jobs on poverty wages and in appalling conditions. A government school teacher in Cameroon summed it up when talking to Oxfam staff in April 2006: 'Becoming a teacher', she said, 'is like signing a contract with poverty'.

Only public investment has managed to achieve mass recruitment of teachers and health workers in the past, whether in industrial or developing nations. Even countries with low incomes have managed dramatic improvements in training and recruitment, with corresponding dramatic improvements in health and education results. The responsibility for delivering health and education rights through such mass scale-up rests squarely with governments. But in developing nations, international aid is needed to supplement shockingly low national income.

Some suitable support is arriving in the shape of debt cancellation and core funding for national government budgets or health and education sector budgets. Countries receiving highly indebted poor countries (HIPC) debt cancellations more than doubled their expenditure on poverty-reduction plans between 1999 and 2005. But too little aid is supporting national health and education plans in this way. Only 8 cents in the aid dollar goes towards helping governments to pay people to do the work that is needed. And the aid is too short-term to enable governments to make sensible investment plans, training

their workers in the knowledge that aid money will be available to pay salaries when they qualify.

Donors should increase budget-support aid to 25 per cent of bilateral aid funding. They should increase core funding to the health and education sectors in countries where budget support is inappropriate. They should make commitments of at least six years and take steps to minimise the risks associated with budget aid. Full debt cancellations are still needed in 20 countries which are burdened with debts so great that they have no hope of achieving the Millennium Development Goals.

Poor-country governments have made huge progress in the last decade, increasing investment in health and education and employing thousands more workers. But they have also made promises to their citizens which are not being kept. They must aim for education expenditure of at least 20 per cent of national budgets and health expenditure of at least 15 per cent. More than ever, there is a need to ensure citizen representation and oversight to monitor public services and participate in local and national planning and budget processes.

The difficulty of assessing the progress of donors and governments is compounded by the lack of clear information. The World Health Organization has made good progress in analysing the approximate cost of recruiting and retaining health workers. UNESCO should now complete the same analysis for the teaching profession, so that there can be no doubt and no excuses.

These decisions require courage and commitment and cannot be delayed. Millions of lives are blighted and even extinguished by terrible poverty. World leaders have promised a radical change to the way that aid is used but so far their actions have fallen far short of the promises.

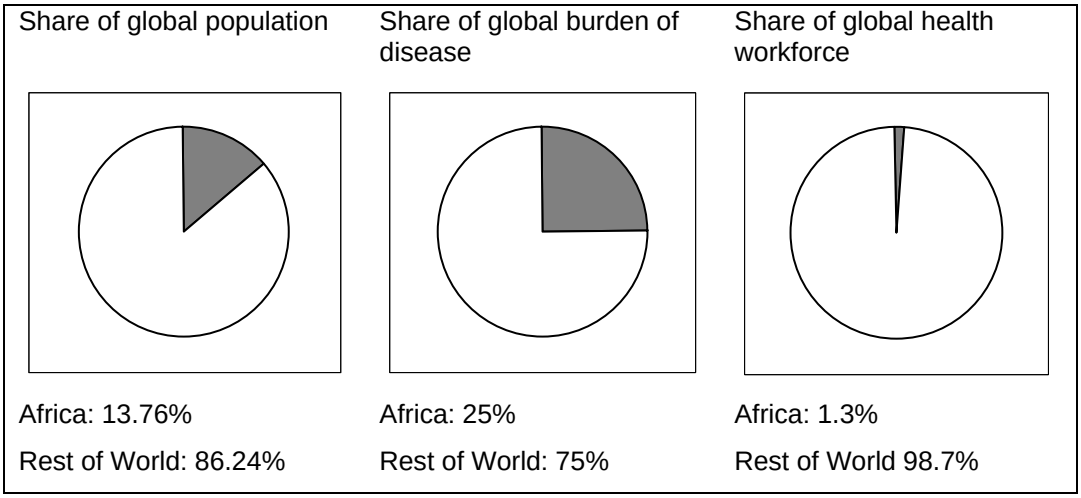
1 Missing millions: no results without workers

Health and education systems are built of human beings; in poor countries millions of teachers and health workers work tirelessly for minimal reward. Today, in poor countries around the world, two million teachers and over four million health workers are simply not in place, and scant plans have been made to train and recruit them. These staff shortages affect poor people disproportionately, particularly poor people in rural areas in low- and middle-income countries. They are denied their rights to health and education after decades of under-investment. Women and girls face the greatest obstacles to accessing services and to gaining valued employment in the health and education sectors.

Every day 1,400 women die during pregnancy or child-birth. Some countries have slashed maternal and infant mortality rates by ensuring universal access to skilled health professionals. Ninety-six per cent of mothers in Sri Lanka now have access to birth attendants and their chances of surviving child-birth complications have more than doubled since 1990.[1]

The World Health Organization's 2006 'World Health Report' calculates a shortage of 4.25 million physicians, nurses, and support workers in 57 countries. Sub-Saharan Africa is the worst affected region, with only 600,000 health workers today (see Figure 1). One million more are needed. Tanzania currently produces some 640 doctors, nurses, and midwives each year. To reach the WHO-recommended staffing levels in ten years it would need 3,500 each year, even assuming there is no attrition due to retirements, deaths, and migration.

Figure 1: Global imbalance in health-worker shortages: Africa's share



Source: Commission for Africa (2005) 'Our Common Interest', p 193

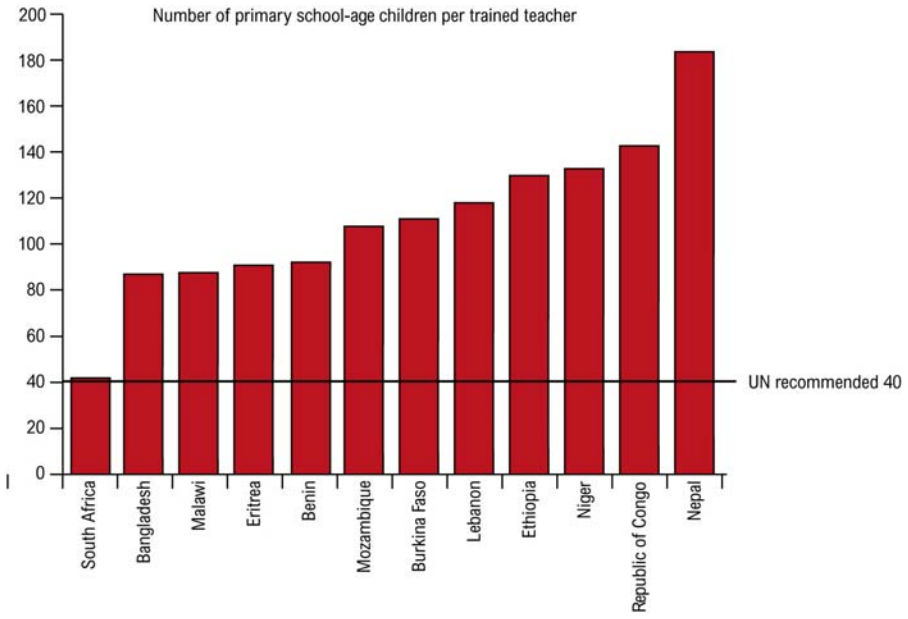
The major constraint to training and recruiting these health professionals is the lack of funding for strong public systems. Overall, WHO's 2001 Commission for Macroeconomics and Health proposed a $34 per capita expenditure on health systems to provide basic, universal health services, compared to existing levels of between $13 and $21. This $34 would include the training and recruitment costs for health workers to provide basic maternal and perinatal services and to attend to the major communicable diseases; a bare minimum package. Those who join Oxfam in advocating a stronger package based on citizens' rights to health and well-being put the cost higher, as will be shown below.

Education services are similarly affected. Every day, 80 million primary-school-age children are out of school.[2] Most of them are girls. The Millennium Development Goal of correcting the gender imbalance in primary schools by 2005 has been missed, even though progress towards universal primary education has been significantly boosted in recent years. Yet a single year's schooling increases a woman's wages by 10 to 20 per cent; a child born to a literate mother is 50 per cent more likely to survive beyond the age of five; and seven million cases of HIV and AIDS could be prevented in the next decade if every child received an education.[3] Primary education is not a gift to be delivered to a select few. It is a basic right that is nominally guaranteed by governments worldwide. But governments are failing to realise this right and the

prospect is dim for millions of poor people who are missing school now, and for those who are yet to become poor due to their illiteracy. Lack of education will further harm economic growth, the growth of good governance, and the security of global relations.

Oxfam calculates that there are 1.9 million missing primary-school teachers globally today – the number needed to ensure that every school-age child can be taught by a qualified teacher in a class of no more than 40 children, which is the maximum recommended by institutions such as the World Bank and UNESCO. Figure 2 shows that in some parts of sub-Saharan Africa and southern Asia, there are only a third to a quarter of the required number of properly trained teachers. Sub-Saharan Africa will need to raise its current stock of 2.4 million teachers by 68 per cent in ten years in order to reach the UNESCO target. And many of the current teachers are poorly trained; 43 per cent of teachers in the Congo fail to meet minimum teaching quality standards.[4] UNESCO estimates that 18 million more trained primary-school teachers will be required between now and 2015, taking attrition and population growth into account. For millions of children, the lack of teachers means low-quality education in crowded classrooms, or no education at all.

Figure 2: Number of primary-school-age children per trained teacher



Source: Oxfam (2006) 'In the Public Interest: Health, Education, and Water and Sanitation for All', Oxford: Oxfam International

The absolute shortages due to under-investment are exacerbated by a number of factors:

- *Migration*. Skilled workers favour working in urban areas, leaving even greater shortages in rural regions. From those urban areas, workers with globally transferable skills migrate overseas in large numbers. The direct cost to Africa of health-worker migration is $500m each year, as workers who have been trained at public expense leave their home countries.[5] Indirect costs such as the increased burden of disease are far greater.
- *Fragmented systems*. Recent research in Ethiopia showed that expert medical specialists could earn three times as much working for an American donor agency, as they could when working for the Ministry of Health.[6] Particularly in the health sector, public systems lose personnel to private providers and donor-funded disease-based programmes. Although these personnel are still performing health-related work, they are not being integrated into universal, equitable systems that cater for all citizens in a given country. The incentives are mainly, but not exclusively, financial.
- *Gender imbalance*. Women face particular challenges in gaining valued employment as teachers and health workers. Already facing discrimination at school age, they have less chance to gain the qualifications necessary to enter highly valued positions in public services. When employed in low-valued positions in hospitals for example, the working environment places women at added risk of contracting HIV in under-supplied and over-crowded wards. Gender-based violent abuse is a particular problem for female personnel in rural areas, where the lack of safe housing and transport exposes them to greater risk.
- *HIV and AIDS*. Recent advances in making anti-retroviral treatments (ARVs) available in low-income countries has given cause for hope that AIDS-related deaths among essential public workers may be on the decline. Each year 170,000 health workers are exposed to HIV infection following unsafe disposal of needles and other biomedical waste.[7] Botswana lost 17 per cent of its health workforce to HIV and AIDS between 1999 and 2005. It does appear that the mortality rate, though still serious, is on the decline. The mortality rate for primary-school teachers in Botswana and Zambia, where government teachers receive free ARVs, peaked around 2001 to 2002 and has declined significantly since then.[8] But AIDS and TB are still affecting health

and education in insidious ways. Girls are taken out of school to care for sick relatives and take on household responsibilities. Health services are stretched to breaking point, coping with the huge numbers of patients. Staff are further demotivated by the risk of becoming infected when basic supplies such as gloves and safe syringe-disposal boxes are unavailable.

- *Education.* This paper focuses on primary education. But without good quality secondary and tertiary education, there will be a short supply of qualified people who may even consider a professional career in health or education. The proportion of girls to boys in secondary and tertiary education is even lower than it is in primary education. This means that fewer women have the opportunity to pursue careers in health and education, which has a negative impact on women's access to the same services.

Box 1: What impact do International Monetary Fund reforms have on human resources for health and education?

The IMF's focus in highly aid-dependent countries should be on reconciling macro-economic stability with broader economic and social objectives, including progress towards the MDGs. This means advising on the appropriate paths for the fiscal deficit and its financing. The IMF has not yet done enough to explore alternative policy options for such fiscal space, but these are undoubtedly areas in which the IMF does have considerable expertise and mandate.

Wage-bill ceilings are a different matter and involve restrictions on choices about expenditure composition that go beyond the IMF's normal area of expertise and can have unintended adverse consequences for health and education, where wages are a large share of spending. Even if the IMF tries to protect such sectors when deriving such ceilings – as statements in its programmes indicate it does – there is usually no practical way in which such 'protection' can be enforced. Moreover, as forthcoming case studies of Mozambique and Zambia by the Center for Global Development (CGD) suggest, such wage ceilings do not fit well with budgetary mechanisms that are designed to give priority to some poverty-reducing categories of government spending such as health and education. It is impossible to ensure a proper fit between wage-bill ceilings and such priorities without undertaking a comprehensive analysis of how human-resource costs for health and education would evolve over the medium term. This is beyond the expertise of the IMF and they have not tried to conduct such an analysis; so they are not in a position to say what the appropriate share of government spending on wages should be for the medium term.

Of course, not all government spending is well-used, and countries have to make hard choices on priorities. But these choices are for the domestic political process to decide. The IMF argues that wage-bill ceilings are used in cases where the wage bill is a source of serious macro-economic pressures. But this is hard to reconcile with a situation where most African countries have largely succeeded in restoring macro-economic stability. Yet about half of IMF programmes in Africa have some form of ceiling and in only one country (Mozambique) has such a ceiling been lifted once introduced. The forthcoming CGD case study of Zambia argues that, although the ceiling was justified when first introduced in 2003 as a short-term device to offset a breakdown in basic budgetary controls over payrolls, it has now outlived its usefulness.

David Goldsbrough, Center for Global Development, Washington DC, Correspondence with the author, January 2007.

2 Successful mass-recruitment drives

The experience of a number of countries shows that mass-recruitment drives are possible over short periods of time. This section highlights three examples of health personnel scale-up, and three examples of teacher scale-up, before drawing conclusions about some common approaches.

Health personnel scale-up

Pakistan: Lady Health Workers

In 1994 Pakistan established a programme to expand family planning and primary-care services. There are now some 80,000 'Lady Health Workers' who provide basic health services and perform data monitoring for nearly 70 per cent of the population.[9] This has extended public-health services and some maternal health services to many thousands of people in rural areas who otherwise would have none. The presence of female health workers encourages more women to use the services they provide, and the impact on maternal mortality is starting to show. The approach has been cost-effective and has improved the flow of information back to planning offices so that they know where and what the needs are.

Thailand: recruitment for rural populations

In 1979 the Thai government launched a rural health development plan to combat the inequitable distribution of health personnel across the

country.[10] By 1985, the number of rural doctors had increased from 300 to 1162, and the difference in the doctor:population ratio between the poorest north-eastern region and Bangkok, the capital, dropped from 21 times in 1979 to 8.6 times in 1986. The expansion of urban hospitals was completely halted between 1982 and 1986. Good logistic support, housing, and other incentives helped to shift the workforce in this way. The result was that outpatient visits to rural public-health facilities shifted from urban provincial hospitals to rural health centres almost entirely. This astounding result was unfortunately undermined by subsequent reforms supporting private hospital investment. This led to a significant brain drain from the public sector to private hospitals in urban areas. The net loss of doctors from the Ministry of Public Health compared to new entrants increased from 8 per cent in 1994 to 30 per cent in 1997. The 1997 economic crisis led to reverse drain as demand for private services fell, so that the number of district hospital doctors rose from 1,653 in 1997 to 2,725 in 2001. Since 2000, economic recovery has yet again reversed the flow, this time back into the private urban sector. This is a clear illustration of the role of governments in tackling geographical distribution of health personnel.

Iran: comprehensive training and health-system development

In 1985 Iran established a national ministry to develop human resources to match the health needs and health-education needs of the population. Rural health workers – *behvarzes* – are selected from local populations and trained locally. However, their work is integrated into referral systems that are backed up by integrated education systems. The result is that access has rapidly expanded in all areas, key health indicators have improved significantly, and reliance on foreign medical workers has disappeared entirely after the number of locally trained physicians increased by a factor of five.[11] The system has achieved almost universal vaccination coverage and reduced the under-five mortality rate from 70 to 33 (deaths per 1000 individuals) in the space of 15 years.

Teacher scale-up[12]

Brazil: addressing teacher distribution between poor and wealthy districts

In 1995 a constitutional amendment was passed to establish the 'Fund for the Development of Fundamental Education and Teacher Valorization' (FUNDEF).[13] This aimed to reduce inequalities within and between states by guaranteeing a minimum annual spend of R$315 per pupil[14] from

federal revenues, wherever states and municipalities were unable to reach the minimum themselves. Sixty per cent of FUNDEF resources are earmarked for teacher salaries, and can be legitimately spent on training and certification for teachers lacking the minimum requirement of eight years of education. During its first year, FUNDEF redistributed R$13.3bn from wealthier to poorer states and municipalities. Teachers' pay rose by a national average of 13 per cent (and by nearly 50 per cent in municipal schools in the north-east). This also had an important impact on student enrolments as the money followed the pupils, so many school districts set up school transport systems for the first time. While FUNDEF virtually solved the access problem, there are still huge challenges to address in quality of education, as repetition is still unacceptably high and standardised test scores unacceptably low.

Indonesia: universal, quality primary education

Indonesia launched the first presidential programme (INPRES) in 1973 to improve education equity across its far-flung islands. Starting with a gross enrolment rate in primary schools of about 60 per cent, Indonesia gave priority to basic education and began one of the world's fastest programmes of teacher recruitment and school construction. The government focused on maintaining quality by aiming to train and recruit enough teachers to achieve a ratio of one teacher to 40 pupils – as recommended by UNESCO. Classes were built to accommodate the same ratio. Between 1973–74 and 1978–79, 61,807 primary schools were built at a cost of over $500m (in 1990 US dollars); 1.5 per cent of Indonesia's 1973 gross national product (GNP). In 1978 the government also cut primary-school fees. Today Indonesia's net enrolment rates for both boys and girls approach 100 per cent.

Uganda: commitment to primary education

Uganda announced a new policy of universal primary education (UPE) in 1997 and led a campaign to promote education for girls as well as boys. To reach UPE, the government introduced free schooling for up to four children per household, teachers were given improved training, and their salaries were increased dramatically, from about $8 to $72 per month. The curriculum was changed, for example to teach about HIV and AIDS; the textbook monopoly was replaced by liberalised procurement; and the government earmarked 3 per cent of the recurrent budget for books and materials. To finance the UPE effort, the government increased education budgets sharply, raising education's share of the national budget from 22 per cent to 31 per cent in 1999 while reducing the defence budget in the process – thus demonstrating its

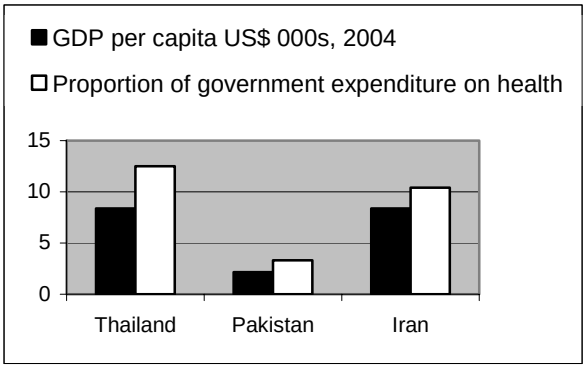
political commitment towards achievement of the universal education goals. The education budget grew from 1.6 per cent of GNP to over 4 per cent. In the late 1990s, research showed that primary-school enrolments doubled, and by 2000 the net enrolment rate rose from 54 per cent to over 90 per cent. Challenges certainly remain to improve quality and teacher:pupil ratios, but this is nevertheless a major accomplishment for a low-income country emerging from civil war.

Common approaches

Sustained increase in government expenditure

All of the countries in these six case studies have increased and maintained public expenditure on health and education over a period of ten years or more. Many have done so during periods of sustained economic growth, but the case of Uganda shows that large economic growth is not the only factor in decisions on public investment in these sectors. Uganda invests some 40 per cent of government spending in health and education, much of which is provided by donors. The government also took the decision that empowering women was critical – both from a human-rights perspective and from the perspective of national development. Thailand, Pakistan, and Iran all took the strategic decision to increase expenditure on health beyond per capita GDP (see Figure 3).

Figure 3: Investing in health



Source: WHO National Health Accounts. http://www.who.int/nha/country/en/

Mix of workers and their training and performance addressed

Most successful mass scale-ups, particularly in the health sector, are not just recruiting more of the same type of workers. Skills and training are

addressed to match population needs. Reforms that are negotiated with existing labour unions tend to have more success in aligning systems more closely to population needs, and increases in salaries are directly linked to an increase in performance expectations.[15] It is important that women workers are not just recruited into lower-paid jobs that require less training, as is often the case. While having women at the front line undoubtedly improves uptake of the services by women and girls, women are also needed in senior managerial positions – both on the grounds of inherent justice, and because this results in decisions at senior levels which reflect the interests of women and girls. It is also important that non-professional workers are not seen as a long-term solution to worker shortages (see Box 2).

Box 2: Professional teachers to achieve Education for All (EFA)

The spread of non-professional teachers is happening at an alarming rate, being seen as a low-cost and permanent solution – yet this is having a devastating impact on quality and equity in education. Education International and ActionAid International's 2006 background paper 'Building a Strategic Partnership on the Need for Quality Teachers to Achieve EFA' recommends that, in situations of rapid expansion, governments should first bring into the workforce any unemployed trained teachers or retired professional teachers – and seek to attract back into frontline teaching any trained teachers who are otherwise employed. If there is a remaining gap then, in consultation with teacher unions, emergency measures may be taken to bring in a temporary new cadre – who should be given accelerated opportunities for full professionalisation within a maximum of five years. Emergency measures may also be needed in situations of conflict but there should be explicit plans for time-bound transition agreed from the start.

Source: Education International and ActionAid International (2006) 'The Parktonian Recommendations'.

Public institutions reformed to improve planning and management

The successful scale-ups have all come with increased efforts to reform planning, training, management, and infrastructure investment. In many cases, not-for-profit providers such as non-government organisations (NGOs) and faith-based groups have been integrated into the public systems, where it is important that they share the commitment of states to provide universal services to all, regardless of their identity. Salary levels are not the only motivation for people to apply for and remain in health and education jobs. Professional and managerial standards, the working environment, and opportunities to pursue a learning career are

all important aspects – when combined, they are more important than salary levels alone.

The common theme: massive expansion of public provision

There is no escaping the conclusion that these three approaches all rely on massive increases in public provision. This has been as true in developed countries that provide universal health and education coverage, as it has in developing countries. A 'simple' increase in the number of teachers and health workers is necessary, but not sufficient to provide services for all. All three components must be addressed.

3 Developing-country governments: current levels of investment

Duty, political will, and lack of resources

Countries with lower incomes have as much duty to their citizens to provide health and education services as do wealthy nations. They have signed up to the same declarations on human rights, and more specifically to targets such as the Millennium Development Goals. Oxfam's 2006 report 'In the Public Interest' highlights the duty of poor-country governments to deliver universal services in an equitable manner – based on need, rather than ability to pay. This means abolishing user fees; increasing the supply of public and publicly managed services to marginalised populations, including women, poor people in rural areas, and ethnic minorities; and making sure that the services offered are appropriate to the needs and interests of these groups. These targets require the recruitment of millions more teachers and health workers. In the words of Zambia's International Monetary Fund (IMF) representative, 'If you're putting money into education but not providing teachers, it won't work'.[16] Poor-country governments still fall short of this duty as great words drift away into pitiful deeds.

In 2002, for example, African Union heads of state met in Abuja, Nigeria, and pledged to increase government investment in health, working towards a target of 15 per cent of the total government budget. Admittedly this is a tall order; only seven of the 74 countries with health-worker shortages invest 15 per cent or more of government budgets in health.[17] If, however, the 38 African countries with health-worker shortages realised their Abuja promise to increase current levels of

government investment in health to 15 per cent, then a further $8bn would be available each year for investment in national health systems (Table 1).

Table 1: Abuja targets in African countries with health-worker shortages

Missing health workers	Govt expenditure on health $ million	Abuja target $ million	Extra available if target met $million
1,073,360	5,929	13,828	7,898

Sources: Harvard Joint Learning Initiative, 2004; WHO National Health Accounts, 2004 data.

WHO estimates that the average country with a severe health-worker shortage would need to increase its level of spending by about $1.60 per capita to meet the costs of training new health workers. To pay the salaries of the scaled-up workforce as they finish training, a further increase of $8.30 per capita would be required. This is based on existing salary levels. This implies extra investment of a minimum $7bn each year.

On their own, sub-Saharan African countries simply do not have adequate resources to train, recruit, and pay health workers to work in well-managed and well-supplied clinics. Donor assistance is critical to break the mould and scale up health investments.

The same is true for primary-school teachers. Estimates currently suggest that approximately $10bn in external financing is needed each year to achieve the goal of ensuring that every child completes a quality primary education by 2015.[18] World Bank analysis of the low-income countries that had the hardest task to achieve this goal suggested a 67 per cent ceiling of recurrent spending on salary costs. This does not include the further cost of training the missing teachers, and investing in the training academies to do so. So a minimum of $6.7bn is needed. The Global Campaign for Education recommends that developing countries should aim to allocate 20 per cent of the government budget to education, and seek external assistance for the balance.

Estimates of training and salary costs still too low

Current official estimates of the minimum cost of training and paying both teachers and health workers are around $13.7bn. But would this

sum of money actually achieve the results that are intended? Guaranteeing the right to health and education is in fact a greater task.

Existing salary levels are proving insufficient to retain workers in the health sector, so WHO admits that their salary estimate could easily be doubled. For the 700 million people who live in countries with health-worker shortages, this implies extra investment of $13bn each year, rather than $7bn.[19] With thousands of workers migrating to better-paid jobs overseas, it is clear that salaries must be addressed.

The calculations also assume that these countries already have the training capacity to produce those extra health workers, but a cursory look illustrates a further gap. Africa has only 4 per cent of the world's medical training institutions; 5 per cent of nursing and midwifery training colleges; and 13 per cent of public-health training institutes.[20] Although the capacity of institutions worldwide can vary greatly, these figures are indicative of the severe constraints in Africa.

The case studies of successful scale-ups in Section 2 show that investment is also needed in the public institutions that manage health and education services. Without strong state institutions, staff become less motivated; are poorly and irregularly paid; are poorly managed; and have less incentive to perform well. Most reforms since the 1980s have sought to reduce the role of the state. But Oxfam's research for 'In the Public Interest' (2006) shows that in fact, the real challenge is to make the state a stronger planner and manager of strong incentives for workers.

An analysis of these comprehensive costs of worker scale-up is beyond the scope of this paper. Oxfam believes that it is the responsibility of global institutions to develop more realistic estimates of this challenge as an urgent priority. But knowing that at least $13.7bn is needed, one fact is abundantly clear: even those developing countries that take their duties seriously have insufficient funds to invest in the necessary mass scale-up. This is why aid is essential – but only the right kind of aid.

4 The right kind of aid

Governments need stable, predictable revenues if they are to plan for the training, recruitment, and retention of large numbers of new workers. The case studies of reforms that were highlighted in Section 2 generally comprised three main investment decisions:

- Increased investment in existing worker salaries, in order to halt migration and to give incentives for new recruitment. In rural posts, salary incentives were often combined with other incentives such as housing, transport, and loans.
- Increased investment in training and recruiting new workers for under-served populations.
- Increased investment in public institutions to improve the planning and management of human resources and increase worker motivation.

Domestic resources in low-income countries are too small to achieve these investments. Since 2000, governments in rich and poor countries alike have pledged to work together to achieve a number of goals, called the Millennium Development Goals. These include providing a complete course of primary education for all children by 2015; reducing child-mortality rates; improving maternal health; combating HIV and AIDS, malaria, and other diseases; and promoting gender equality and empowering women. All of these goals require investment in the recruitment of health workers and teachers, and donors have pledged to provide the financial assistance where countries have insufficient domestic revenues. But why has aid to poor countries not worked already?

Why aid has not transformed essential public services in the past

Poor-country governments and donor governments both shoulder blame for squandering aid in the past. In the second and third papers of this series, the focus will be on poor-country governments. In this paper, we focus on the quality and conditions of aid that are determined by donors.

Structural Adjustment Programmes during the 1980s and early 1990s entirely undermined social-service systems by opening up fragile public institutions, some only a decade or two old, to global market forces. Poor-country governments were obliged to cut back on social expenditures and reduce the numbers of publicly employed teachers and health workers. Institutions like the World Bank and IMF tried to reform health and education systems without addressing workers' concerns or providing incentives to work well. These same institutions focused on narrowly defined 'efficiencies' without safeguarding citizens' rights to universal, equitable services. The notion that health and education were

inalienable rights rapidly lost ground to another notion; that health and education were commodities to be paid for like any other. The introduction of user fees appeared to be the nail in the coffin of publicly guaranteed health and education services, but the devastating effects of user fees on poor people is now recognised and the tide is slowly turning back.

Bilateral donors have been accused of using aid not to address poverty, but to further their own geo-political interests. Aid has not necessarily flowed to the poorest countries and aid to health, education, and water and sanitation was so low that donors finally committed to achieving a 20 per cent minimum allocation to basic social services only in 1995.

Donor projects have also proliferated to such an extent that governments in poor countries spend so much time dealing with donors, that attention is diverted from developing public systems for the whole population. According to the UK Secretary of State for International Development, 'over four-fifths of 35,000 aid transactions that take place each year are worth less than $1 million, and require 2,400 quarterly progress reports. In Vietnam 11 different UN agencies account for only 2% of aid. Most are active in HIV/AIDS — all pursuing the same donor money — and each agency has its own overheads. Zanzibar, with a population of only one million people, has 20 different agencies operating in it.'[21] Public workers are attracted out of public systems into these fragmented projects with the promise of better pay and management.

Finally, too much aid is still being spent on expensive foreign consultants. As much as 70 per cent of aid for education is spent on technical assistance.[22] Some of it is clearly necessary and useful, but in some countries 100 days of consultancy bills cost the same as employing 100 teachers for a year, or keeping 5,000 children in school.[23] A study of technical assistance in Mozambique found that rich countries were spending $350m a year on 3,500 technical consultants, while 100,000 Mozambican public-sector workers were paid a total of $74m.[24]

Fewer workers, and poverty wages

Recruitment of workers has not just stalled, it has gone into reverse. The impact of this trend on women has been particularly severe, not only because women workers lost jobs in the teaching and health professions, but also because the reduction in publicly available social services meant that women increasingly became burdened with the task of caring for sick family members in the home, and girls missed education to take on

these extra chores. As the ratio of teachers and health workers to population declined, so did the investment into the tools they needed to do their jobs, so schools and clinics lacked regular supplies. Salaries decreased so badly that many workers were paid below or at the recognised poverty line. Teachers' salaries have halved since 1970, as a proportion of per capita GDP.[25] Performance understandably suffered in these circumstances, but the Washington Consensus solution to under-performing public workers too often ignored the causes of the problem and focused on the effects.[26] Workers who could, drifted into the private sector and into cities where opportunities for employment and moonlighting were greater. As a result, public systems have been left in disarray – a skeleton staff of public-sector workers struggles under immense pressure, being paid less than a living wage when they are paid at all (see Box 3).

Box 3: Signing a contract with poverty – the teacher's lot in 2006

Mr Boureima, a primary-school teacher in Niger, spoke of his worries over low pay and conditions:

'For months I lived a life of torment, anguish, and indecision through many a long day and sleepless night spent turning things over and over in my mind. On the one hand my conscience told me to hold my course, because my class of 67 seven- and eight-year-old boys and girls seemed to view me as a life-saving presence in their midst; and on the other hand, I knew for certain that fortune would never smile on me and that I could never make life better for myself out here, in this remote, enclosed place. On top of all this mental and emotional strife, there were other difficult physical conditions: in particular the lack of supplies and school desks, and the inadequate premises … out here, "school" is the only institution symbolising the State. Yet the State was totally absent from the scene.'

A government school teacher in Cameroon told Oxfam in April 2006: 'Becoming a teacher is like signing a contract with poverty'.

Source: Oxfam (2006) 'In the Public Interest', Oxford: Oxfam International.

Workers are people. They too have families to feed. They too have children to educate and relatives who need health care. They must be paid a dignified wage. In Zambia, the Jesuit College for Theological Reflection calculated in May 2006 that the monthly cost of absolute basic needs for a family of six to survive was 1.4 million Kwacha ($410). An average teacher's salary was 660,000 Kwacha ($191) and an average

nurse's salary was 1.2 million Kwacha ($351).[27] Workers also have a fundamental role in addressing the whole nation's future development. Without access to quality teachers and health workers, poor people become poorer. These workers are a pillar of development. They must be given the training, dignity, and support to achieve their task. Donors have a moral imperative to use their aid to achieve this.

At least $13.7bn must be invested every year in training and salaries. This may seem a depressing figure, but it is the same amount that will be spent on mobile music downloads in 2007. [28] More money is needed to improve public institutions' capacity to manage finances and people, to improve planning, and to build civil society's ability to hold governments to account. With global aid spending now in excess of $100bn, for the first time this is within our reach.

Promising signs that aid is starting to work

Significant progress has been made in providing universal access to education; some 37 million more children have enrolled in school since 2000. The number of teachers has also increased, dramatically in some cases. In just four years, increases of over 30 per cent occurred in Benin, Burkina Faso, Burundi, Ethiopia, Guinea, Guyana, Madagascar, Mali, Mozambique, and Senegal.[29] The Education for All Fast Track Initiative (FTI) is an example of a new agreement between donors and recipients. Poor-country governments promise to draw up realistic long-term education-sector plans and to increase domestic investment in education. Donors promise to work together to fund these government plans so that 'no countries seriously committed to education for all will be thwarted in their achievement of this goal by a lack of resources'.[30] As a result, some 30 developing countries have had their plans endorsed. Public expenditure on education as a proportion of government expenditure has increased in 70 countries.[31] Aid for education has been slower to catch up,[32] but the results are encouraging more donors to join in.

A review of heavily aid-dependent countries shows that huge progress has been made since 2000 (Table 2). The challenge for donors and governments alike is to build on this progress and take bold steps to ensure that things don't just carry on as they are.

Table 2: Health and education investment in aid-dependent countries

Malawi	
Government	**Donors**
• Education expenditure by government increased from 2.8% of GDP to 5.0% between 2000/01 and 2003/04. • Share of total education expenditure on primary education increased from 25% to 54% over the same period. • Education sector has benefited from Pro-Poor Expenditures (i.e. protected from budget cuts; increased using HIPC debt relief). • Total health expenditure increased from MK 4.7bn in 2000/01 to MK 8bn in 2003/04; equivalent to increase from 5.1% to 7.7% of GDP. • Expenditure on primary care increased from 24% to 34% between 2000/01 and 2003/04; expenditure on secondary care increased from 22% to 42%; expenditure on tertiary care fell from 19% to 16% of total.	• Significant increase in donor disbursements to education – from $25.9m in 2000/01 to $35.4m in 2003/04. • Externally funded share of total health expenditure increased from 64% to 74% over the same period.

Mozambique	
Government	**Donors**
• Total education expenditure has increased by 50% in real terms between 1997 and 2001; equivalent to increase from 3.9% to 5.8% of GDP. • Recent data not available but 'no doubt that the past five years have been characterised by a substantial increase in spending on education' (MoRHEP, p7). • Intra-sectoral allocation stable; primary education consumes 61% of recurrent and 80% of capital expenditure. • Government expenditure on health as a share of total government expenditure has increased from 7.7% to 8.8% between 1997 and 2001. • Governments' share in total health expenditure is 46.4%, with 51% coming from external sources.	• Budget support increased from $30m in 2000 to $239m in 2005. • External support for the health sector is estimated to be approx. $100m per annum, and expected to increase.

Tanzania	
Government	**Donors**
• Total education expenditure increased from TSh 189.2bn in 2000/01 to TSh 464.4bn in 2003/04; equivalent to increase from 3.3 to 5.1% of GDP. • Recurrent spending has increased from 74% to 81% of total spending over the same period. • Primary education share of expenditure has increased from 65% to 71%. • Total health sector expenditure has increased from TSh 118.8bn in 2000/01 to TSh 201.1bn in 2003/2004; equivalent to increase from 2.1% to 2.25% of GDP. • Government share in total health expenditure increased from 68% to 78% over same period.	• Basket funding[33] accounted for 50% of total external funding in 2003/04.

Uganda	
Government	**Donors**
• In constant (1998) prices, real education expenditure increased by 38% between 1998/99 and 2003/04. • Education expenditure increased as a proportion of total discretionary expenditure from 30% to 32% over the same period. • Actual expenditure on primary education increased from 66% to 68% in same period. • In constant (2003) prices, real health expenditure increased by 19% between 2000/01 and 2003/04. • Composition of expenditure changed significantly due to big switch to GBS; government share of resource envelope (incl. GBS) rose from 37% to 48% over same period. • Between 1999/2000 and 2003/04 the share of the government health budget allocated to primary health increased from 33% to 54%.	• Budget support increased from $66m in 1998 to $409m in 2005.

Source: Adapted from DFID (2005) 'Review of health and education progress in selected African countries (RHEP-SAC) Synthesis Report', London: DFID Africa Policy Department.

5 Debt cancellation and aid for workers

Donors have three main choices to support the training, recruitment and retention of teachers and health workers: debt cancellation, sector budget support, and general budget support.

Debt cancellations have increased domestic expenditure on health and education

The Gleneagles 2005 G8 Summit struck a historic deal for highly indebted poor countries when donors cancelled 100 per cent of their debts to the IMF, World Bank, and African Development Bank. This has opened space for greater social spending on a recurrent basis, including on thousands of new teachers and health workers. Debt-service payments by the 29 highly indebted poor countries which have achieved the conditions for this cancellation declined from 3.5 per cent of GDP in 1999 to 1.8 per cent in 2005. With a combined 2004 GDP of $222.3bn,[34] this represents approximately $3.8bn extra money available for domestic budgets (see Box 4).

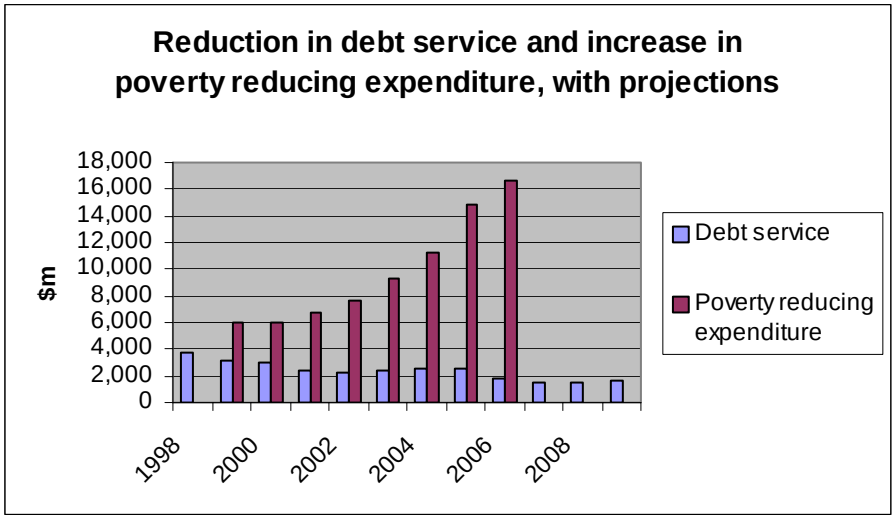
Box 4: Zambia – reaping the benefits of cancelled debts

The impact of debt cancellation in Zambia will reduce the country's debt from $7bn to about $500m, freeing up vital resources for reducing poverty. Zambia's budget for 2006 substantially increased the share of spending on both health and education. It has also removed fees for basic health care in rural areas. Extra spending on education will include funds to recruit more than 4,500 teachers, and for the construction and rehabilitation of schools in rural and urban areas. Additional funds are going to HIV and AIDS control and mitigation programmes, primary and community health care, recruitment of medical personnel, and the purchasing of medical equipment and medicines.

From Oxfam (2006) 'In the Public Interest: Health, Education, and Water and Sanitation for All', Oxford: Oxfam International.

The World Bank's August 2006 report on HIPC and the multilateral debt-relief initiative (MDRI) showed that countries receiving HIPC debt relief more than doubled their expenditure on poverty-reduction plans between 1999 and 2005 (Figure 4). Furthermore, a 2004 World Bank report found that 'expenditures on poverty-reducing expenditures have been *increasing much faster* than total government revenues'.[35]

Figure 4: The effect of debt-service reduction on pro-poor expenditure



Source: http://siteresources.worldbank.org/INTDEBTDEPT/Resources/Table11A.pdf

Poverty-reducing expenditure includes health and education spending, and within that, recurrent spending on workers' salaries. It takes time to recruit essential workers, but already the results in HIPC countries are being felt. Immediate increases have been seen in Benin, Burkina Faso, Madagascar, Malawi, Mozambique, Tanzania, Uganda, and Zambia. Under a separate debt-reduction agreement, Nigeria is also training thousands of new teachers. [36]

But there are still millions of people living in poverty whose governments are obliged to service the debts taken over the past three decades. Oxfam concurs with the Jubilee campaign calculations that 60 countries need all of their debts to be cancelled if they are to have any chance of achieving the Millennium Development Goals. There are yet more countries that require partial cancellations, and a number of countries with odious debts, such as that contracted by South Africa's former Apartheid regime.

More aid is supporting domestic budgets

Donors have essentially found two ways to support worker salaries. Sector-wide approaches (SWAPs) in health and education are the precursor to the sort of contract between donors and governments that led to the Education for All Fast Track Initiative mentioned above. Governments commit to longer-term plans and to increasing domestic

investment. Donors commit to funding these plans in partnership with governments and with other donors, as well as providing technical assistance to build the capacity of public institutions to improve management. Mary Muduuli, Uganda's Deputy Secretary at the Treasury, explains that 'sector wide approaches have provided a very useful vehicle for improving coordination between government and donors, for enhancing donor confidence and support for government's expenditure strategy and for improving capacity in line ministries'.[37]

SWAPs also enable donors to earmark aid money for certain sectors, such as health and education. This is a useful mechanism in instances where government corruption or lack of transparency subverts national debate on the proportion of budget that should be allocated to social spending. SWAPs have a tendency to centralise policy decisions in ministries, leaving local authorities with less space to make decisions relevant to local conditions. There is no doubt that in some countries *without* national and local debate, however, SWAPs can be a valuable tool to improve planning, financing, and delivery of public services, and to open policy decisions to more public scrutiny.

No two countries have the same experience with SWAPs, as they depend on continued negotiation between government and donors, between sector ministries and national treasuries, and on very different political environments and events. Ghana, Tanzania, Uganda, and Bangladesh have been experimenting with them for many years and they have evolved in different ways with constant negotiation between donors and ministries, and between ministries and central treasuries. The impact on increased worker recruitment has been seen particularly in Uganda and Tanzania, and Ghana has experimented with rural incentive packages to attract key workers to remote areas. In Malawi, the health SWAP has specifically targeted salaries in an attempt to provide a dignified wage in a country where more than 100 nurses emigrate each year, and only 9 per cent of health facilities have adequate staff to provide the minimum package of health services (Box 5).

Box 5: Donor funding for salaries to retain health workers in Malawi

In October 2004, the Government of Malawi launched a major Sector-wide Approach (SWAp) for the health sector that attempted to revitalise Malawi's health services and support the delivery of the Essential Health Package. The SWAp programme of work saw the pooling of funds from major donors to the sector (UK, Norway and the World Bank) into the Ministry of Health budget to cover delivery of the EHP, strengthening of human resources, and systems strengthening and referral over a seven year period.

The total cost of the SWAp is USD 735.7 million, of which 71 percent is to be provided by external donors. The Government of Malawi also committed itself to raising the share of Government spending allocated to health from 11.2 percent in the 2002/03 budget to 13.5 percent by the end of the programme in 2009/10. 40 percent of the cost of the SWAp is allocated to strengthening human resources, of which a significant proportion is targeted towards raising the salaries of Malawi's public health workers.

Senior physicians have seen the most dramatic increases in salaries and the gross P4 monthly salary has risen from USD 243 to USD 1,600. However, salaries at most grades have risen to the order of 40–60 percent. Mid-level nurse gross monthly salaries have risen from USD 108 to USD 190.

From R. Record and A. Mohiddin (2006), 'An economic perspective on Malawi's medical "brain drain"', *Globalization and Health* 2(12).

General budget support

General budget support (GBS) is 'aid funding to governments that is not earmarked to specific projects or expenditure items. It is disbursed through the government's own financial system. Although the funds are not earmarked, they are part of a package which includes dialogue and conditions, technical assistance and capacity building, and donor efforts to harmonise their aid and align it with government strategies and procedures'.[38]

Budget support is currently a very small proportion of overall aid. Table 3 shows disbursements for general budget support by Organisation for Economic Co-operation and Development (OECD) donors in 2004, when it accounted for 3 per cent of overall aid.

The EC, the UK, and the Netherlands are clearly the major proponents of budget support. The EC was one of the earliest advocates, starting in 1995 and elaborating its commitment under the Cotonou Partnership Agreement from 2000. The current 9th round of European Development

Fund (EDF) funding for African, Caribbean, and Pacific countries started with the intention to disburse 30 per cent of the €13.8bn total in the form of GBS. The large figure listed for Japan is not in fact budget support as defined in this paper, but consists mainly of balance of payment support.[39] Japan intends to start a new aid scheme in April 2007 that will allow for its contribution in the form of GBS along with sector-wide support and common baskets (which means contributing to pooled funds with other donors under a combined financial management system). Sweden, Norway, Ireland, and Denmark are all steadily increasing GBS aid, and Germany is considering significant increases. Canada has already increased GBS significantly, to over 20 per cent of bilateral aid in 2005/6.[40] Italy, the USA, and Spain remain unconvinced and give only very small proportions of aid as budget support.

Table 3: General budget support in US$m, 2004

EC	650
United Kingdom	606
Netherlands	168
Japan	157
Sweden	86
Norway	83
France	55
Germany	55
Ireland	30
Denmark	29
Italy	23
Belgium	21
United States	12
New Zealand	10
Canada	8
Australia	5
Portugal	5
Greece	4
Spain	0
Total	**2,009**

Source: OECD DAC online database

In 2005 a rigorous evaluation was completed of the impact of GBS in seven countries, five of which had been receiving budget support over a period of four years or more: Burkina Faso, Mozambique, Rwanda,

Uganda, and Vietnam. The evaluation found that the initial effects of GBS were indeed to support the expansion of basic public services in health and education, in support of poverty-reduction strategies. Further benefits included the tendency of GBS to enhance the country-level quality of aid as a whole by reducing transaction costs and increasing the coherence of aid flows. Effects on income poverty and empowerment of poor people are as yet less clear, but the evaluation found 'in all cases a capacity to learn from experience which suggests that GBS could become more effective, and have a broader scope, over time'.[41]

Budget support risks need to be addressed

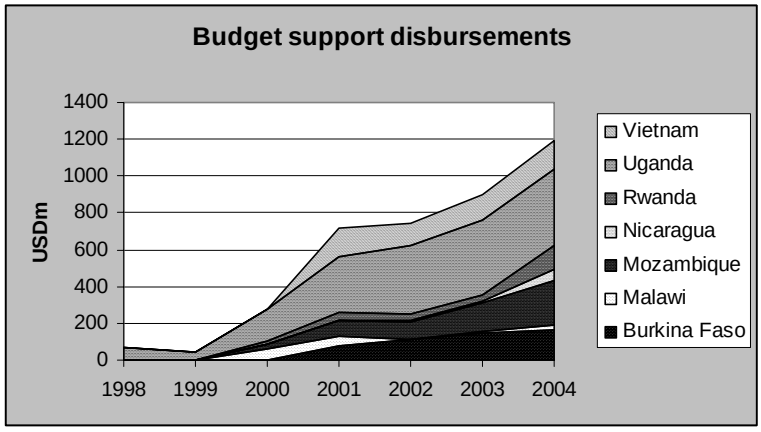
GBS is still a relatively unexplored area and evaluations show that it delivers good results in social spending where donors and governments have built mutual trust and transparency. It is also a contributing factor to that trust and transparency. It delivers results where civil society is better at holding government to account; and it is also a contributing factor to that accountability. It delivers results where there is better management of public finances; and it is a contributing factor to that better management. But evaluations also expose a number of risks, which must be addressed.

Governments need long-term commitments

The main question for recipient countries is whether they can rely on GBS to be maintained in the long term, so giving them the confidence to train and pay workers, knowing that the money will be available. Budget support in its common form is essentially another short-term agreement between donors and governments, with few agreements exceeding three years. Some donors such as the UK and the EC are now beginning to explore ways to increase the term of commitment that they make with GBS. Discussions within the EC on 'MDG Contracts' suggest that six-year commitments may be made, with clear understandings of why, when, and how such support would be suspended.

On the face of it, some existing GBS partnerships suggest that long-term commitment is already occurring, as can be seen by the slow increase of GBS[42] in the OECD evaluation countries (Figure 5).

Figure 5: General budget support receipts in countries evaluated



Source: IDD and Associates (2006) 'Evaluation of General Budget Support: Synthesis Report', Paris: OECD Development Assistance Committee.[43]

But these commitments have come about by default, rather than by design. It is clear that poor countries must meet minimum eligibility criteria to qualify for official long-term arrangements. Such criteria can sensibly focus on the existence of a well-defined development strategy and plans; stability-oriented macro-economic policies; and a credible programme to improve the management of public finances. In such situations, six-year agreements should guarantee a minimum annual disbursement, with remaining funds released against incentives relating to achievement of the Millennium Development Goals. Under the lowest EC eligibility threshold, 15 countries could already be eligible to access longer-term contracts in this way.[44] Once commenced, these contracts should be reviewed in the third year, with an express view to extending the original six-year contract, subject to continued performance.

Many donor governments are prevented by constitutional constraints from committing to long-term aid. Germany would require legislation changes to commit beyond two years. Canada's Treasury Board likewise imposes additional restrictions on commitments above CAN$20m, leading the Canadian International Development Agency to limit each contract to two years (despite which, even with small budget commitments, Canada has increased programme-based funding, a type of sector budget support, from under 2 per cent of total bilateral aid in 2001/2 to over 20 per cent in 2005/6).

Governments need predictable aid flows

The Malawi data in Figure 5 show that GBS was removed entirely in 2002, after Malawi failed to achieve agreed macro-economic targets.

Canada and the UK suspended budget support to Ethiopia in 2006 after the government jailed political opponents. Aid for individual projects continued to flow during these periods; but that aid was of no use for training and paying workers. Measures to address the inherent political and economic risk of GBS are now being formulated, most recently by the European Commission (EC), which proposes increases over and above a stable foundation *tranche* as an incentive for good governance, as opposed to total withdrawal as a punishment for poor governance or failure to meet economic conditions. Other donors in Uganda, Burkina Faso, Mozambique, Zambia, Malawi, and Tanzania are adopting the same approach.[45] Another mechanism has been used in Uganda and replicated in many other countries since. Under the 'Poverty Action Fund' agreement, a minimum set of poverty-reducing activities and expenditures was agreed between government and donors. Regardless of changes in government allocation to health and education spending, donors committed to continuing their support so long as these minimum expenditures were fulfilled. In Malawi, the same idea was used, but this time ensuring that government-agreed Priority Poverty Expenditures could not be reduced without the express agreement of the whole parliament. Where governments are not trusted, there is often the option of reverting to a sector-wide arrangement.

Disbursements must match commitments more closely

Bottlenecks in donor bureaucracies or recipient bureaucracies can block timely disbursements. According to the Strategic Partnership for Africa, 81 per cent of 2003 GBS commitments to African nations were disbursed during 2003, with an additional 10 per cent being disbursed in 2004. 'However, large differences across countries were observed with less than 25 percent of resources disbursed on time in Senegal, and 100 percent disbursed on time in Ethiopia and Niger'.[46] A review of disbursement delays by the European Commission in 2005 showed that 40 per cent of delays were due to bottlenecks in EU administrative processes compared to 25 per cent due to administrative problems in recipient countries. The remaining 35 per cent were due to failure of recipient countries to satisfy conditions. [47] Oxfam is proposing a new insurance mechanism to transfer the risk from recipient countries to donor countries. It is unacceptable that recipient countries should suffer delays due to donor administration bottlenecks. Donors should take out insurance on their aid commitments so that funds continue to be disbursed in these circumstances.

More research is needed on the impact of GBS on women and marginalised groups

Most evaluations – including the OECD one cited above – have not focused on the implications of GBS for women's equality and gender relations. Overall increases in financing do not necessarily overcome the unequal access and status of marginalised groups – including women. Governments have generally not upheld their commitments to gender mainstreaming and women's empowerment that were made at the UN conference on women in Beijing 12 years ago.[48] Whether health and education services reach the people who need them depends on the willingness of planners to integrate these commitments into their policies and practices. New procedures should help to make sure that gender-equality work becomes fully-integrated with national policies and strategies – a result that was seen in Uganda's sector-wide education reforms. Future evaluations of GBS must analyse the different impact that budget support has on women, on men, and on marginalised communities.

Government accountability to citizens must be supported

The OECD evaluation noted civil-society concerns about the risk of budget support giving donors more control over government policy than parliamentary representatives have. GBS can also lead to the centralisation of policy decisions into national finance ministries, threatening the ability of the health and education sectors to gain appropriate allocations of the national budget. The capacity of civil society to hold governments to account – both in terms of budget allocation to social sectors as well as ensuring that the money reaches its intended destination – is an increasing concern also for NGOs such as Oxfam. Oxfam's support to civil-society groups and alliances has helped civil society to become much more engaged in policy making and monitoring. Some results include the campaign for free education in Kenya, community monitoring of school budgets in Malawi, legal changes to health policy in Armenia, and district-level retention of teachers in Ghana. In January 2007, civil-society coalitions launched the '9 is Mine' campaign to pressure the Indian government to invest 6 per cent of GDP in education, and 3 per cent in health. Currently, India spends less on social services than Uganda as a proportion of gross national income (GNI) – a scandal in a country that prides itself on strong economic growth and does not even rely heavily on external aid. This is slow work and has to build on what is already being done in very varied political contexts, but there is long-term commitment to

supporting these civil movements and donors have a duty to ensure that they do not undermine it. Donors are increasingly willing to support parliamentary oversight groups to monitor government budget decisions.

Means to alleviate the risk of budget support

These are some mechanisms that could be established to ensure that GBS can be used by governments to pay for workers. In such mechanisms:

- Budget-support commitments would be for a minimum of six years in countries where conditions are favourable.
- Contracts would include clear understandings of why, when, and how budget support would be withdrawn during the contract period. Such conditions should relate only to outcome and governance issues, including human-rights protection.
- GBS could be withdrawn over time, and the funds transferred for a minimum of two years to an escrow fund, and made available to recipient countries the moment agreed conditions are re-established.[49]
- Budget-support donors could insure themselves against disbursement delays caused by donor bottlenecks, in order to maintain 100 per cent disbursement where recipients have the ability to absorb the aid. Recipient countries should not have to hold reserves simply to cover for donor disbursement shortfalls.
- Donor governments with legislative obstacles to providing long-term budget support would set a timetable for parliamentary debate on removing these obstacles.

Due to the risks outlined earlier in this section, it is clear that some countries do not currently have favourable institutions or policies in place for budget support. In such circumstances, it is entirely acceptable that aid should be restricted to sector support where appropriate, or to projects with strictly defined activities and financial management procedures.

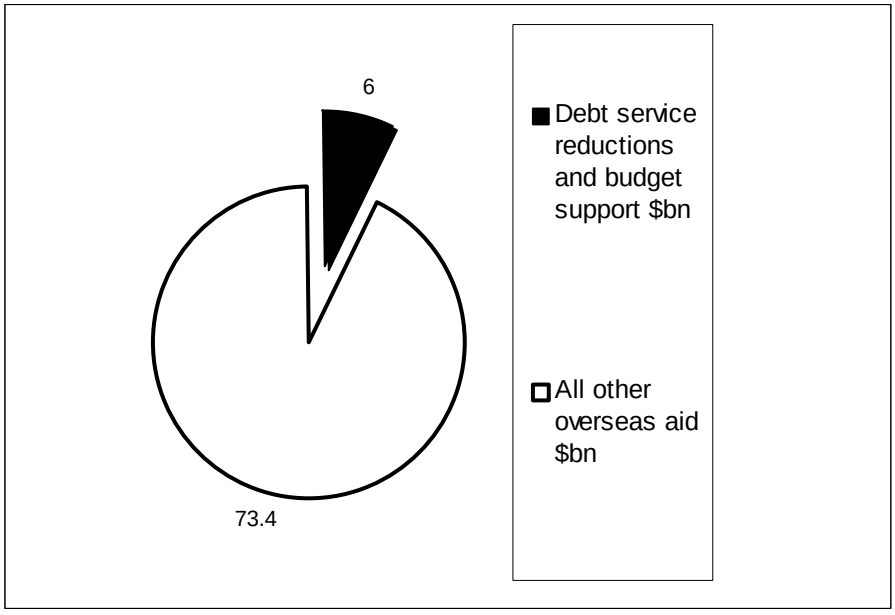
More debt cancellation, budget support, and sector support is needed

From the data presented, it appears that the total amount of annual budget support and new money made available through debt

cancellations is approximately $6bn. As a proportion of the overall overseas development assistance of $79.4bn in 2004, this means that less than 8 per cent of aid was directed into government plans and budgets (Figure 6). All other aid is directed to individual and capital projects, to technical assistance, and to vertical, disease-based initiatives.

All of these endeavours can be important and useful. For example, disease-based initiatives such as the Global Fund to Fight HIV/AIDS, Malaria and Tuberculosis, or the US President's Emergency Plan for AIDS in Africa (PEPFAR), have achieved remarkable results in getting treatment, care, and preventive services to people who need them. But even as the initial results are celebrated, it is becoming ominously clear that without workers, it will be impossible to get medicines to those who need them in all areas. The same goes for long-term care and preventive public-health interventions. These funds also need their own staff, and attract more workers out of public systems as they provide better salaries.

Figure 6: Budget support and reduced debt servicing, as a proportion of overall aid, 2004



Source: OECD DAC online database

Governments need more money to spend on salaries. Budget support, sector budget support, and debt cancellations are the only external means that governments have to increase their spending on these

salaries. But the $6bn of this type of money is less than half the bare minimum $13.7bn that is needed to recruit new workers. Of the $37bn calculated to achieve the Millennium Development Goals in health and education,[50] approximately 67 per cent – $25bn – is likely to be needed for the recurrent salary costs of existing workers, on top of the $13.7bn for new workers. Poor-country governments and donors must therefore invest a total of $38.7bn together.

Oxfam is calling for donors to extend debt cancellations to more countries that will otherwise have no chance of achieving the Millennium Development Goals; to increase budget support to a minimum of 25 per cent of bilateral aid funding – using the mechanisms outlined above to mitigate risk for themselves and for the recipient countries; and to increase investment in health and education SWAPs in countries that are unlikely to benefit from general budget support.

Conclusion

Health and education are essential if poor people are to have the opportunity and ability to escape the bonds of poverty. Health and education systems cannot function without teachers, nurses, and doctors supported by good planning and management institutions. Millions of these essential health and education workers are needed in poor countries. For the few workers who struggle today in systems that have been under-funded for decades, life is a constant battle against their own poverty and lack of support.

Enormous progress has been made in increasing investment in health and education in poor countries. Donors have added their weight to these governments' resolve by promising to increase their aid for countries unable to afford these basic rights, and to improve the quality of their aid to build sound systems, rather than undermining them. But donors' actions are falling short of those promises. Millions of teachers and health workers are still needed. Action is needed now.

Donor governments should:

- Extend debt cancellations to more of the countries that are unable to aim for the Millennium Development Goals under existing debt burdens.
- Increase general budget support to at least 25 per cent of their bilateral aid budgets by 2010.

- Increase the length of budget-support commitments to a minimum of six years.
- Take steps to reduce the risks of this aid for taxpayers in their own countries, and for citizens in poor countries.
- Increase sector budget support where general budget support is inappropriate.
- Ensure that evaluations of budget support contain rigorous gender analysis.
- Ensure that disease-based initiatives are integrated into equitable health systems that guarantee the rights of poor citizens.

Poor-country governments should:

- Set salaries of existing health workers and teachers at dignified levels in collaboration with their unions.
- Train and recruit the millions of extra health workers and teachers needed, following the example of successful scale-ups in other countries.
- Set a timetable for reaching the target of investing at least 20 per cent of government budgets in education.
- Set a timetable for reaching the target of investing 15 per cent of government budgets in health systems.
- Ensure citizen representation and oversight in monitoring public services and facilitate the participation of civil society in local and national planning and budget processes, including agreements and contracts signed with donors, the World Bank, and the IMF.

UNESCO should:

- Estimate the cost of teacher training and salaries in order to provide reliable data for international funding efforts. This should include gender analysis of the rights of girls and women in countries affected by worker shortages.

Notes

[1] Oxfam (2006) 'In the Public Intrerest: Health, Education and Water and Sanitation for All', Oxford: Oxfam International.

[2] Kailash Satyarthi, President, Global Campaign for Education. High-Level Group on Education for All, Cairo, 22 November 2006.

[3] Global Campaign for Education (2007), Hhttp://www.campaignforeducation.org/news/news.htmlH, accessed 17 January 2007.

[4] UNESCO UIS (2006) 'Teachers and educational quality: monitoring global needs for 2015', Montreal: UNESCO UIS.

[5] The Commission for Africa (2005) 'Our Common Interest', London: The Commission for Africa.

[6] G. Davey, D. Fekade, and E. Parry (2006) 'Must aid hinder attempts to reach the Millennium Development Goals?', *The Lancet* 367: 629–31. The researchers found that an expert medical specialist could earn a base monthly salary of $354–513 in the Ministry of Health, compared to $950–$1200 in US bilateral agencies.

[7] WHO (2006) 'World Health Report', p 107.

[8] P. S. Bennell (2006) 'Anti-Retroviral drugs are driving down teacher mortality in sub Saharan Africa', Brighton: Knowledge & Skills for Development.

Primary-school teacher mortality rates in Botswana:

1999: 0.71 per cent

2002: 0.88 per cent

2005: 0.18 per cent

Primary-school teacher mortality rates in Zambia:

2000: 2.0 per cent

2002: 1.6 per cent

2005: 1.4 per cent

[9] WHO (2006) 'World Health Report', p 59.

[10] S. Wibulpolprasert and P. Pengpaibon (2003) 'Integrated strategies to tackle the inequitable distribution of doctors in Thailand: four decades of experience', *Human Resources for Health* 1(12).

[11] S. Vatankhah (2002) 'Human Resource Development for Health in the Islamic Republic of Iran', paper presented at the 49th Session of the WHO Regional Committee for the Eastern Mediterranean, Cairo, October 2002, quoted in 'Joint Learning Initiative' (2004) *Human Resources for Health*. From 1985 to 2000, Iran

increased the number of local physicians from 14,000 to 20,000. The infant mortality rate fell from 51 to 25 per 1,000 live births, and vaccination coverage increased from 20 per cent to 95 per cent. The number of foreign medical workers fell from 3,153 to zero.

[12] The three examples given (Brazil, Indonesia, Uganda) were identified in M. Nilufar (2005) 'Creating a public service ethos in education: What has worked for improving the conditions of teachers?', background paper on education prepared for Oxfam, 21 August 2005.

[13] F. Delannoy and G. Sedlacek (2000) 'Brazil: Teachers' Development and Incentives: A Strategic Framework', Washington DC: World Bank. Document no. 20408-BR. All data in this paragraph is from this paper.

[14] For 1998 – this rose to R$350 in 1999.

[15] School enrolments in Bogotá, Colombia increased by nearly 40 per cent, while costs increased by only half as much, thanks to a new information system and negotiations with teacher unions that deployed teachers where they were needed and eliminated 'ghost' teachers. (Oxfam and WaterAid 2006, 'In the Public Interest').

[16] GCE (2004) 'Undervaluing Teachers: IMF policies squeeze Zambia's education system', London: Global Campaign for Education.

[17] Joint Learning Initiative (2004). Those countries are Paraguay, Central African Republic, El Salvador, Honduras, Colombia, Costa Rica, and Haiti.

[18] EFA Global Monitoring Report (2007) 'Strong Foundations', Paris: UNESCO; DFID and HM Treasury (2005) 'Education: from commitment to action', London: DFID.

[19] The WHO 2006 'World Health Report' calculated two scenarios. In the first scenario, the cost of training new health workers was calculated at an increase in annual levels of health spending of $1.60 per population capita. The cost of employing these new professionals at existing salary levels was calculated at $8.30 per population capita. In the the second scenario, WHO took a more realistic approach and assumed a doubling of salaries in order to ensure adequate incentives for qualified professionals to enter the health service, which adds a further $8.30 per population capita to their figure. However, this does not account for doubling the salaries also of existing health workers.

[20] H. Mercer and M. R. Dal Poz (2006) 'Global health professional training capacity', background paper for 'The World Health Report' 2006, Geneva: WHO.

[21] H. Benn (2006) ODI meetings. *An international development system fit for the 21st Century*, ODI/APGOOD series 'What's next in international development?'.

[22] World Bank (2005) 'Global Monitoring Report 2005', Washington: International Bank for Reconstruction and Development / World Bank, p 93.

[23] World Bank (2006) 'Global Monitoring Report 2006', Washington: World Bank, p 60.

[24] Personal communication with report author, Richard Jolly, Instuitute of Development Studies, University of Sussex.

[25] Oxfam (2006) 'In the Public Interest: Health, Education and Water and Sanitation for All', Oxford: Oxfam International.

[26] The Washington Consensus is a phrase describing the package of economic policy reforms (and the assumptions behind them) for countries in crisis, which were prescribed by Washington-based institutions such as the World Bank, the International Monetary Fund, and the US Treasury Department during the 1980s and 1990s.

[27] http://www.jctr.org.zm/bnb/may06.html, accessed February 2007.

[28] http://www.gartner.com/it/page.jsp?id=500295, accessed 24 January 2007.

[29] Education for All Fast Track Initiative (2006) Progress Report July 25, 2006. Table B4.

[30] Communiqué from High-level Group on Education for All. First meeting, UNESCO, Paris, October 2001.

[31] EFA Global Monitoring Report (2006) 'Literacy for Life', Paris: UNESCO.

[32] In the year when global military spending topped $1 trillion, the 16 countries endorsed by the Fast Track Initiative faced a shortfall of over $400m – a paltry amount, but a barrier to 16 million children who missed their opportunity for an exit from poverty in 2006. GCE (2006) 'Underachievers: A School Report on rich countries' contribution to universal primary education by 2015', Johannesburg: Global Campaign for Education.

[33] Basket funding means funding that is pooled together with that of other donors and administered under a single financial management system.

[34] World Bank (2006) *World Development Indicators 2006*.

[35] K. Hinchcliffe (2004) 'Notes on the Impact of the HIPC Initiative on Public Expenditures in Education and Health in African Countries', World Bank Human Development Sector Africa Region, Working Paper Series, June.

[36] Currently, donors include in their aid budgets the amounts that they have spent on cancelling debts. OECD figures on aid for 2005 and 2006 will include the full cost of cancelling $18bn of Nigeria's $35bn debt. But the actual saving to Nigeria will be approximately $1bn annually over the next 20 years. Although debt cancellation for poor countries is important, the practice of counting the cost in aid figures does not show the real volume of extra financing that is being made available in the same year.

[37] ODI (2006) 'Learning from Experience'.

[38] IDD and Associates (2006) *Joint Evaluation of General Budget Support 1994–2004*, Birmingham: University of Birmingham.

[39] Balance of payment support relates to aid that is given to redress a deficit in the balance of traded goods or services between countries.

[40] Personal communication, CIDA Policy Branch, January 2006.

[41] IDD and Associates (2006), *op.cit*.

[42] Malawi is the exception. Budget support was suspended in 2002 when government failed to control public expenditure.

[43] The IMF Africa Division has noted in correspondence that the study data for Rwanda does not match with IMF data. IMF data show a higher average of $85m during 2001 to 2003, which increased two-fold in 2004. This data shows an average of $33m in 2001 to 2003, with a four-fold increase in 2004. The trend of increase holds in both cases, but the rate is different. For the sake of comparison with the other countries, we retain the IDD study data in this table.

[44] Benin, Botswana, Burkina Faso, Ghana, Guyana, Jamaica, Madagascar, Mali, Mauritius, Mozambique, Niger, Rwanda, Uganda, Tanzania, Zambia.

[45] S. Ndaruhutse and L. Brannelly (2006) 'The Role of Donors in Creating Aid Volatility and How to Reduce It', London: Save the Children UK.

[46] Strategic Partnership for Africa – Budget Support Working Group (2005) *Survey of the Alignment of Budget Support and Balance of Payments Support with National PRS Processes*, Brussels and London.

[47] European Commission (2005) 'EC Budget Support: An Innovative Approach to Conditionality', Brussels: European Commission, p 44.

[48] Gender and Development Network (forthcoming, 2007) *Gender equality, new aid modalities and civil society organisations*, London: GADN.

[49] An escrow fund is an account administered by a third party. Donors pay into the account according to the agreed timetable. The third party releases those funds to recipients when satisfied that they have met the agreed conditions.

[50] Oxfam (2006), *op.cit*.

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For further information on the issues raised in this paper please e-mail advocacy@oxfaminternational.org.

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