

C H E R
The Coalition for Health and Education Rights

User fees: the right to education and health denied

**A policy brief for the UN Special Session on Children
New York, May 2002**

New research demonstrates that user fees continue to deny children's rights to basic education and health care, despite international commitments to make these services free and universal. Southern governments, the donor countries and the World Bank must now deliver on their obligations, by developing clear strategies for free education and healthcare, and mobilising the resources necessary to implement them.

About CHER

The Coalition for Health and Education Rights was formed in 2001 by four organisations (RESULTS USA, ActionAid (USA and UK), Globalization Challenge Initiative and the Elimu Education Coalition) for the purpose of conducting a multi-country survey of user fees in basic education and healthcare. The study was commissioned in response to a policy shift on user fees in the Bretton Woods Institutions, which was pushed in part by US Congressional legislation prohibiting the United States from supporting future lending programmes that included the introduction of fees as a loan condition.

This paper was written by Patrick Watt (ActionAid UK) and Rick Rowden (RESULTS USA). The authors acknowledge the contribution of the following partner organisations, which produced the national studies:

Tanzania Education Network (TEN/MET), Tanzania
PRODESSA, Guatemala
ActionAid Nepal
ActionAid Uganda
Africa Educational Trust, Somaliland

For further information, email:

rowden@action.org or pwatt@actionaid.org.uk

Executive Summary

In 1948, the Universal Declaration of Human Rights enshrined the rights to education and healthcare. Yet more than half a century on, these rights are violated daily on a massive scale. 113 million children are out of primary school, and 35,000 children in low-income countries die every day from easily preventable conditions. In an era of unprecedented prosperity, this is a moral scandal: the knowledge and means exist to realise the right to basic education and health care for every child. The immediate and urgent challenge is to marshal these resources in support of children's rights.

There is no shortage of commitments to free and universal education and healthcare. In 2001, the international community adopted the Millennium Development Goals in education and health, at the centre of an over-arching strategy to halve global poverty by 2015. But there has been a resounding failure to translate these words into action. On current trends, 75 million children – more than three quarters of them Africans – will remain out of school in 2015. Only one African country – The Gambia - is on track to reduce 1990 child mortality by two thirds by the target date. It is clear that these goals can only be realised if basic services are made genuinely free and accessible.

Non-Governmental Organisations in the North and South have responded to this challenge by campaigning for an end to fees. In particular, NGOs have focused on the International Monetary Fund and World Bank, whose loan conditions and policy advice have often resulted in fees for basic services. In 2000, NGOs in the United States achieved a breakthrough in the US Foreign Aid Bill. This legislation prohibits the US government from supporting future IMF and World Bank programmes that include the introduction of fees as a loan condition. The Foreign Aid bill helped push the World Bank into a reversal of its position on user fees in education in 2001, and has sparked a major debate on fees for health care.

Yet progress in implementing these policy changes remains slow and uneven. There are success stories. Tanzania eliminated fees for primary education in January 2002 with the support of the World Bank, and enrolments have surged – perhaps by as much as 1.5 million children. But Tanzania remains an exception – an example of what can be achieved where donors provide coherent support to a national strategy. In most poor countries, the World Bank and other donors are failing to provide the decisive support that is needed to end fees. Households continue to face spiralling costs for sending their children to school, and for obtaining health services. Insufficient public investment - often a result of ongoing economic conditionalities imposed by the IMF and World Bank – transfers costs onto households. These are manifested in a wide range of formal and informal fees, levies and other charges in education and health, which are beyond the means of poor households with low and unpredictable incomes.

New research by the Coalition for Health and Education Rights (CHER), produced by partners in Guatemala, Nepal, Somaliland, Tanzania and Uganda, demonstrates the continuing impact of charges on access to basic services. In rural Uganda, 43% of people falling sick do not seek health care due to a lack of money, while resistance to drugs is expanding as patients have insufficient funds to complete the full course of treatment. In Tanzania, despite the success of fee-free schooling, exemption schemes for the 'extreme poor' in health and education are failing those in greatest need. The result is high drop-out rates in education, and increasing use of traditional healers for healthcare. In rural Guatemala, cash and in-kind contributions to pay for a child's primary education can amount to as much as 400 quetzals, equivalent to 20 days agricultural wage labour.

These fees are a not only a barrier to access for the poorest households, they also compound other problems. Fees can entrench and widen gender inequalities where high private costs

force households to choose between a son and daughter for schooling or healthcare, and have a strongly disequalizing effect on society at large. The failure to provide free basic education and healthcare in many low-income countries means that the economic opportunities associated with good health and literacy are confined to a privileged few. This is bad both for development, and for social and political stability. In short, the question is no longer whether fees should be eliminated, but how.

Formally scrapping fees without a major increase in public financing can have a disastrous impact on quality, and is unsustainable. Where fees are removed, revenues are lost and demand increases. In many cases, difficult revenue and budget reforms are needed so that large numbers of teachers and health workers can be recruited and trained, and new classrooms, clinics and dispensaries can be built. The poorest countries cannot be expected to undertake these reforms single-handedly. They need more and better external assistance from donors and international organisations. Having paid lip-service to the principle of free basic education and health care, it is time for the donors to become an active part of the solution to user fees. There are reasons for guarded optimism. The Financing for Development Summit has reversed the decade-long fall in aid volumes, and brought Southern and Northern governments together around a common commitment to the MDGs. The UNGASS presents an unprecedented opportunity to build on this momentum, by governments and international organisations taking the following steps:

- Many Southern governments need to formally commit themselves to free and universal basic education and healthcare, as a matter of principle. Clear, timebound plans for free basic education and healthcare need to be developed and implemented in participation with civil society, as part of broad strategies to reduce poverty. Too many governments can and must spend more to deliver on this commitment, raising their allocations to at least 3% of GNP both for basic education, and for healthcare. Many countries could also spend far more efficiently, ensuring that scarce public resources reach poor, rural households as well as wealthier, urban households.
- The world's richest countries must do much more to ensure that the rights to education and health are realized, by providing massive increases in aid, and improvements in donor coordination. Their recent record is woeful. Only two cents in every dollar of aid - or \$1 billion a year – goes to basic education, less than one tenth of the total needed to achieve universal, free schooling. The picture for health is not much better, with an average of \$2.1 billion in recent years. Better quality aid, as well as more aid, is needed. Too much donor support is fragmented, and unpredictable, and the majority continues to be spent on goods and services in donor countries.
- Deeper and faster debt relief is needed to deliver on the right to education and health, which continues to be obstructed by high debt repayments – exposing the Heavily Indebted Poor Countries (HIPC) initiative as too little, too late. In 2001, of the 22 countries receiving debt relief under HIPC, two thirds were spending more on servicing their debts than on health or education. Ten countries were spending more on debt than on health and education combined.
- The World Bank must move swiftly and decisively to implement its new policy on user fees. Despite the Bank having moved to a position of active opposition to user fees in basic education, more progress is needed at the operational level, where this policy shift is not always reflected in Bank education programmes. Meanwhile, unduly rigid budget constraints imposed through IMF and Bank adjustment loans (PRGFs and PRSCs) often constrain governments' ability to fund free education – highlighting the need for greater coherence and consistency in the Bank's macroeconomic and social development approaches. On health, the Bank must move immediately to a clear position against health user fees, and actively push policies that make health free at the point of use.

Findings

Everyone has the right to education. Education shall be free, at least in the elementary and fundamental stages.

Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including...medical care and necessary social services.... Motherhood, and childhood are entitled to special care and assistance.

Universal Declaration of Human Rights

These days you have to pay for medical care and drugs. Many die in the villages because they cannot afford to pay the user charges. Those who have some money pay, but payment does not guarantee you sufficient treatment

Villager, Apac, Okwir, Uganda

Education and healthcare are fundamental human rights, which states have a legal and moral responsibility to protect. And yet for millions of children, they are an unaffordable luxury for which they and their parents must pay. The result is a human rights violation of massive proportions, which undermines efforts at poverty reduction and equitable economic growth.

Fees for health and education fall within the broader phenomenon of ‘cost-sharing’, which is the practice of parents contributing towards the total cost of a public service. Cost sharing takes a wide variety of forms. In education, these range from official fees and levies for activities such as registration, examinations and sports, to indirect charges for uniforms, books and pencils, and compulsory in-kind contributions such as for school construction and repairs. In health care, fees at the point of use can include the cash cost of a consultation, payment for medicines, and rental of a hospital bed. These various charges can be one-off, or levied on a regular basis, retained at the service delivery level or submitted to government, and used to support both capital and recurrent costs.

As the CHER surveys show, households often face a bewildering combination of these costs. Because fees are charged at every level of health and education systems, from central government to health workers and teachers, and many are unofficial, the ‘total cost’ of the same basic service can vary widely between households. Decentralisation has often contributed to these problems, weakening the ability of government to regulate the charges facing households: in Tanzania, 5% of recurrent public health expenditure is collected in fees at the point of use. In practice, fee levels and exemptions are set by Hospital Management teams, and by primary health care facilities, where drug fees are rising to reflect actual cost. Although exemption schemes officially exist, for the disabled, orphans and the very poor, definitions are open to dispute and service providers have a strong disincentive to publicise exemptions that reduce their income.

Although most cost-sharing involves contributions to school and health facility resources, there is a growing trend – especially in education – to call on more ‘qualitative’ support, which is aimed at improving accountability of service providers, and ‘ownership’ at the local level. This includes participation in management, administration, planning, budgeting and oversight of services, often mobilised through

community level associations and committees. One of the key premises behind this approach is the idea that households are more willing to pay for services where they have some control over how resources are used. While traditions of voluntary community self-initiative can make a positive contribution to improved health and education outcomes, non-monetary support carries its own very real costs for households, and can threaten equity objectives – especially where contributions are substituting for the core responsibilities of the state, and are factored into the cost structure of a service.

Fees have usually been introduced with mixed motives of ideology and necessity. In many countries, fees have been an *ad hoc* response to expenditure cuts – either imposed by IMF and World Bank loans, or by falling revenues. This phenomenon has been particularly marked in Africa, where per student public spending on primary education actually fell between 1985 and 1995, at a time that it increased almost threefold for every other developing region.ⁱ In the most extreme cases, as with Somaliland, government services have collapsed, and schools and clinics are entirely dependent on fees for their operation.

In other instances, fees have been pushed by international organisations with the explicit aim of improving the efficiency, equity and quality of health and education. Throughout the 1980s and much of the 1990s, the World Bank especially pushed user fees on the grounds that low demand for poor quality services, rather than cost, was the principal barrier to expanding access. These theoretical arguments in favour of cost sharing were easiest to advance in countries where there was an obvious need to expand the resource envelope for health and education, and where at the same time the state was weak. Therefore in Malawi in education, and in Ghana in health care, the World Bank successfully pressed government to introduce fees.

The ideological arguments in favour of fees have not been borne out by experience, and show that cost sharing has failed to improve efficiency, equity and quality. In the two years after fees were introduced in Malawi's schools in the 1980's, enrolment rates fell by over 5%.ⁱⁱ In Ghana, revenues from health fees were not sustained, after the cost of a visit to a hospital specialist was raised to ten times the daily minimum wage.ⁱⁱⁱ Conversely, the experience of countries where fees have been eliminated demonstrates the impact of cost on access. In Uganda in 1997, the government ended fees in primary education for four children in each household. The response was immediate and dramatic: enrolment doubled overnight, by almost 3 million children.

Regardless of the rationale underlying their introduction, fees have a common effect in restricting access according to ability to pay. And whatever the preferred terminology, user fees and other compulsory charges are also *de facto* taxes, differing from centrally gathered direct taxes only insofar as the direct beneficiaries of a service are expected to bear more of the cost. While high private household costs for health and education have a range of causes, many specific to each country, insufficient public finance is almost invariably an underlying factor. In many low-income developing countries, public per capita spending on health and education is simply too low to cover the full cost of the core expenditures which are needed to achieve effective learning and good healthcare. Whether they are introduced by design or default, fees are an inadequate and inefficient attempt to plug the financing gap. Thus in Nepal, public per capita health expenditure is \$3, less than 10% of the cost of a

minimum package of quality health services for a low-income country.^{iv} The result is a system in a state of near-collapse, lacking key personnel and basic equipment. In rural areas, the health posts charge consultation fees of up to 100 rupees, and prescribe medicines from private dispensaries that are beyond the means of most people. Villagers respond by going instead to traditional healers.

In many countries inadequate public financing exacerbates other problems, such as low quality, with education and health systems grappling with a legacy of under-investment. Despite Uganda's success in expanding school enrolments, the quality of education remains dismal: children are frequently taught in classes of 100, by poorly paid teachers, often in buildings without roofs or sanitation. Many lack the learning materials needed to acquire literacy and numeracy. Although formal fees have been abolished in Uganda, parents continue to face charges for building materials, school watchmen, sports, stationery and uniforms. Where the quality of education is low, and generates few benefits, parents have few incentives to commit scarce resources to their children's schooling, and sixty per cent of primary school students drop out in the first four grades.

The impact of fees

The impact of fees is greatest on the poor. The precise impact is often difficult to gauge because of a lack of data on household expenditures, enrolment, attendance and sickness, and because poverty is dynamic. However, it is clear that a large share of total spending on education and healthcare is now being met out of households' pockets. In Tanzania, the World Bank has estimated that one half of all health costs and one third of all education costs are met by households. It is also clear that this accounts for a high proportion of poor households' incomes. In Guatemala, the CHER study revealed rural households routinely spending between one-fifth and one-quarter of their income on health care. In Uganda prior to the abolition of school fees, the cost of educating a child for one year at the primary level was equivalent to 20% of per capita income. More recent data from Tanzania shows that direct education costs alone account for 5% of household non-food expenditure.^v

Poor households face the greatest difficulties in meeting these costs, given the unpredictability and seasonal nature of income, their large numbers of dependents, and vulnerability to ill health – which makes heavy demands on out-of-pocket payments. Thus in Côte d'Ivoire, girls from households above the poverty line are twice as likely to be enrolled in primary school as boys from households below the poverty line. And in Ghana, enrolments are 20 percentage points higher for non-poor children than for children in extreme poverty. Similarly, after the introduction of health user fees in Zimbabwe in the early 1990s, the decline in antenatal attendance was twenty-four percentage points higher than the national average in areas of intense poverty.^{vi}

Fees also reinforce and widen inequalities. The children of poor households are more likely to be withdrawn from school, to drop out early, or to fail to enrol altogether. In healthcare, the poor are not only more likely than higher income groups to fall sick: they are also less likely to start a course of medicine, and having started it, to complete it, and are more likely to rely on traditional healers for treatment. In the long run, fees can alter the make up of school populations, for example where parents favour boys' education over girls'.^{vii} Fees, especially in health, can also increase

household vulnerability over the long term, where they lead to distress sales of income earning assets to pay for medicines and hospital treatment. A large research literature has established that health and education are mutually reinforcing, yet user fees can destroy this synergy, by forcing households into invidious choices between the two, and other, non-discretionary basic needs. Indeed, in recent community level interviews in Kilimanjaro Region in Tanzania, the ability to choose between health and education was seen as a sign of privilege, since for the poorest households both services were unaffordable.^{viii}

Recognising that cost sharing widens disparities in education and health, some policy makers have advocated exemption schemes, or differential pricing, to protect access for the poor. In practice, however, these rarely work. They are difficult to design and implement, not least because up-to-date poverty data is expensive to gather and apply where the cash economy is small and people move in and out of poverty. Self-assessment by communities poses its own problems. The CHER studies revealed that the poorest people are typically unaware of exemption schemes, that entitlements are frequently siphoned off in favour of the non-poor, and that the humiliation of applying for exemptions is itself a major deterrent. Ruetieli Anaeli, a single mother of four children interviewed in the Tanzania study, explains, ‘it was very difficult to get (education) exemption because I had to kneel down before the ten cell leader, village council, teachers, guardians in the family, and everybody I felt would sympathise with my problems...it cost me my dignity as a mother’.^{ix}

Fees are usually designed to shift or reduce costs, rather than improve outcomes at a given unit cost, and often lower quality, despite the claims of proponents. School construction is a case in point. The advantages of community-built classrooms are a common justification for shifting capital costs onto households. Yet there is no firm evidence that community construction is more efficient than publicly funded infrastructure, once in-kind contributions, recurrent cost implications and the life-span of the building is factored in to cost estimates. Similarly, in health care the introduction of fees has often encouraged inefficiency through supply-led demand and the prescription of unnecessary medicines and treatment. This is a particular risk where fees are retained by the collecting health facility.^x

In general, fees in both education and health are ‘residual’, in that they are designed to meet shortfalls in income, after public funding is taken into account. In other words, the level of fee tends to be dependent on the efficiency of public spending, not vice versa. Generally, households have little influence over the cost structure of the services they support: unless health and education fees are introduced in the context of a fundamental review of costs, they can actually promote inefficiency, by relieving budgetary pressures and enabling governments to defer difficult spending decisions.

In practice, the introduction of fees has rarely freed up additional resources for targeted assistance to the poor, or for intra-budget reallocations to basic services. This is because governments don’t usually allocate a fixed share of the budget to one sub-sector, and because the sums raised are small compared with the needs – especially after collection costs are taken into account. These tend to be much higher for fees than for centrally gathered taxes. In the case of Zimbabwe, the administration of health user fees cost 400% more for each dollar raised than through the tax system.^{xi} However, the central problem is that in order for fees to contribute substantial funds

to education and health, they must be set at a level far beyond the reach of the poorest households. Educating two children on a full cost recovery basis costs over 10% of a poor household's income in almost every developing country.^{xii} In sum, experience shows that user fees not only exclude the poor from health care and education, but are an ineffective tool for raising revenues.

Policy options for eliminating fees

There is a broad international consensus in favour of free and universal basic education, and universal health coverage that is free at the point of entry. Yet in practice there have been few examples of donors and governments working together to eliminate fees, and translate these principles into an everyday reality for poor households. In Tanzania, CHER research found that the Ministry of Health, 'is unaware of the new World Bank scepticism towards charging poor people for basic health, and claims that there are no plans to reduce fees in primary health care in the foreseeable future, as fees are necessary to purchase emergency essential drugs.'

In contrast, Tanzania and Uganda have both registered dramatic gains in education, demonstrating the progress that can be made where governments make a firm political and budgetary commitment to free access, and have their efforts supported by donors. Yet at present, few sector plans factor in the cost of transferring household costs to the government budget, and in practice most donors' position on user fees is ambiguous. The challenge is clear: if the 2015 goals are going to be met, donors must work with national governments far more systematically and coherently, to develop financing strategies to achieve the transition to free education and health care.

Eliminating fees has two key implications: first, it reduces the overall revenue, especially at the service delivery level where most fees are collected and retained. Second, where eliminating fees genuinely lowers the cost for households, it raises demand for education and health, and increases the number of service-users. Unless governments find alternative sources of financing for health and education, eliminating user fees will have one of two effects. Either it will reduce expenditure per student and patient, and possibly lower quality, thereby undermining the same goals it set out to achieve. Alternatively, it will simply informalise fees, with health facilities and schools unofficially charging households in an attempt to protect their income. For a country to sustain progress towards universal access, it needs not only to eliminate fees, but to mobilise predictable and additional funds, and use these efficiently to raise quality and improve equity.

If these measures aren't taken, 'free' education and health care become meaningless. This has happened in Uganda's health sector, where in 2002 the government announced a policy reversal on fees as part of a bid to expand access to treatment. Because this announcement was not backed by sufficient additional funding at the district level, fees are continuing to be charged under the table – often to supplement low health workers' salaries - and are still estimated to account for 10% of spending. The experience of Uganda does not, as some governments and donors claim, make a case for delaying the elimination of fees, but it does underline the need for countries to tackle the fiscal stresses that led to the introduction of fees in the first place, through well-defined national plans, and financing strategies for achieving the MDGs.

The starting point for gauging the budget implications of phasing out fees is to agree on a package of inputs that will be provided through public funds. Definitions of what it means for a service to be 'free' vary, but free education and health care are unlikely to expand access unless public money covers the core expenditures needed to ensure that effective learning and good health care are achieved. In basic education, this should include not only the cost of tuition, but also infrastructure, learning materials, inspection and support services. In healthcare, salary costs, medicines and hospital treatment should be free at the point of use, with special attention paid to the needs of mothers and children.

Eliminating fees, and providing sufficient public funding for these core expenditures, has recurrent and capital cost implications. The capital costs will depend on the increase in the number of students and patients using schools and health facilities, and on the excess capacity in the system, but they can be very large. Additional classrooms and clinics must be constructed, furnished and equipped to cope with the surge in demand when fees are eliminated. In Tanzania, where free primary education was introduced in January 2002, the government must build 46,000 new classrooms to cope with an additional 3 million children entering the system. Eliminating user fees requires not only major front-end capital investment. These investments have major implications for recurrent costs, since teachers must staff schools, and health workers clinics. In the medium term, expanding access in primary education and basic health care will raise demand for secondary and tertiary education, and for more sophisticated curative health services. Governments will need to gradually expand these services in line with expansion at the basic level, and work progressively to extend free access – especially for the poorest households – in these sub-sectors.

Much of the cost of free education and health care can be met by national governments, which bear the principal responsibility for ensuring that these basic rights are protected. Many governments are in a position to do much more than is currently happening. In Guatemala, the government spends less than 2% of its GNP on education, and on health, much of it skewed in favour of the wealthier urban population. This is less than half of what is committed in countries achieving free universal coverage. For some governments, there is scope to re-allocate within budgets from non-productive expenditures such as the military, towards the social sectors. Costa Rica is one example of a country generating dramatic dividends from the decision to prioritise the learning and health of children over military hardware. For many countries, free universal access can only be sustained over the longer term by increasing taxation as a proportion of national income. Uganda's experience – raising its tax take from 9% to 14% of GDP during the 1990s - shows what is possible in a low-income country.

However, for many countries, strong political and budgetary commitment to free education and health care is not enough. Low-income countries, concentrated in sub-Saharan Africa, are simply unable to finance free universal access without an immediate step change in the volume and quality of donor support. The UN estimates that \$10-15 billion is needed annually in additional aid to provide every child with free, quality basic education, and that approximately \$20 billion is required to provide the universal health coverage necessary to reach the child and maternal mortality targets. Donors rightly press Southern governments to prioritise spending for the social sectors, yet fail to follow this through in their own commitments to education

and health. Aid to basic education stands at about \$1 billion a year, or just 2% of total ODA, while health fares little better, receiving about \$2 billion. Overall aid flows fell steadily through the 1990s, to 0.22% of rich countries' GDP, less than one-third of the UN commitment of 0.7%. Very little of this reaches low-income countries where the need is greatest. In the case of health, between 1997 and 1999 donors collectively spent just \$2.29 on each person living in a low-income country.

Better quality, as well as more aid, is urgently needed to achieve free education and healthcare. Extra-budget support is the norm for most donors, undermining the capacity of governments to make effective sector plans, and effective aid coordination is rare. This forces governments to juggle competing donor demands and priorities, and spend scarce time and resources satisfying multiple donor reporting and procurement conditions. Meanwhile, equity objectives are ill defined for many donors, with free education and health care remaining only a vague aspiration at the operational level. Although the recent announcements of new aid at the UN Financing for Development Conference in Monterrey are promising, it is too early to know whether these will materialise, and under what terms and conditions.

Unsustainable debts continue to undermine the ability of countries to provide free and universal education and health care. Debt squeezes government's discretionary expenditure, reducing the resources available for the social sectors. The Heavily Indebted Poor Country initiative, HIPC, has failed to address this problem. Countries must wait years to receive debt relief while implementing IMF and World Bank reform conditionalities, and when debt relief arrives it is serving principally to close the gap between scheduled repayments – most of which could practically never be paid – and actual repayments. In short, HIPC is more of debt sustainability mechanism than a strategy to release resources for the MDGs. Of the sixteen countries receiving debt relief in 2001 under HIPC, sixteen were continuing to spend more on debt repayments than on education, and fifteen countries were spending more on debt than on health. In the case of Tanzania, which is struggling to implement a plan to provide every child with free basic education, \$434 million in debt servicing must be paid up to 2004, despite HIPC relief. This sum is almost exactly the same as Tanzania's external financing gap over the same period for implementing its primary education plan.

IMF and World Bank conditions in their adjustment lending instruments, PRGFs and PRSCs, continue to inhibit governments' ability to provide free, basic education and health care. Social development policy objectives are poorly integrated into macroeconomic frameworks, despite the establishment of Poverty Reduction Strategy Papers. In practice, PRGFs are designed behind closed doors with minimal involvement even from sector ministries, and take precedence over poverty reduction goals in the PRSPs. Fiscal conditionalities, including cash budgeting systems, continue to be unduly restrictive, and have undermined governments' capacity to commit to and plan for the long-term development goals. The CHER study in Guatemala summarises this problem: 'Fiscal adjustments, austerity programmes, deficit reduction, monetary controls and the push for greater domestic savings are being demanded, with priority attached to macroeconomic conditions that provide for profitability and investment security, and the elimination of state monopolies in social services'.

Recommendations

The right to education and health can only be realized if there is a major international effort to eliminate user fees, as part of a broader strategy to achieve the Millennium Development Goals. Governments and donors both have a critical role to play in achieving this objective. They must take the following steps:

- **Southern governments** need to formally commit themselves to free and universal basic education and healthcare, as a matter of principle. Too many governments remain wedded to user fees. Clear, timebound plans for free basic education and healthcare must be developed and implemented in participation with civil society. These plans must be embedded in broader strategies for poverty reduction. Many governments also need to spend more to deliver on this commitment, raising their allocations to at least 3% of GNP both for basic education, and for healthcare. Many countries could also spend far more efficiently, ensuring that scarce public resources reach poor, rural households as well as wealthier, urban households.
- **The world's richest countries** must do much more to ensure that the rights to education and health are realized, by providing massive increases in aid, and improvements in donor coordination. Their recent record is woeful. Only two cents in every dollar of aid - or \$1 billion a year – goes to basic education, less than one tenth of the total needed to achieve universal, free schooling. The picture for health is not much better, with an average of \$2.1 billion in recent years. Better quality aid, as well as more aid, is needed. Too much donor support is fragmented, and unpredictable, and the majority continues to be spent on goods and services in donor countries.
- **Deeper and faster debt relief** is needed to deliver on the right to education and health, which continues to be obstructed by high debt repayments – exposing the Heavily Indebted Poor Countries (HIPC) initiative as too little, too late. In 2001, of the 22 countries receiving debt relief under HIPC, two thirds were spending more on servicing their debts than on health or education. Ten countries were spending more on debt than on health and education combined. The donor countries, the World Bank and IMF must come together and reform HIPC, so that it supports rather than undermines progress towards the MDGs.
- **The World Bank** must move swiftly and decisively to implement its new policy on user fees. Despite the Bank having moved to a position of active opposition to user fees in basic education, more progress is needed at the operational level, where this policy shift is not always reflected in Bank education programmes. Meanwhile, unduly rigid budget constraints imposed through IMF and Bank adjustment loans (PRGFs and PRSCs) often constrain governments' ability to fund free education – highlighting the need for greater coherence and consistency in the Bank's macroeconomic and social development approaches. On health, the Bank must move immediately to a clear position against health user fees, and actively push policies that make health free at the point of use.

-
- ⁱ UNESCO, 1998. *World Education Report 1998*. Paris:UNESCO.
- ⁱⁱ Rose, P. 'Willingness and (In)ability to Pay for Education: Cost-Sharing in Malawi'. IDS, December 1998
- ⁱⁱⁱ Arhin-Tenkorang, D. 'Mobilising Resources for Health: the case for user fees revisited'. Center for International Development, Harvard, November 2000.
- ^{iv} Report of the Commission on Macroeconomics and Health. *Macroeconomics and Health: Investing in Health for Economic Development* 20 December 2001
- ^v World Bank, 1999. *Tanzania: Social Sector Review*. Washington, DC: World Bank.
- ^{vi} Watkins, K. 2001. *Cost-Recovery and Equity in the Health Sector: The Case of Zimbabwe* in Mwabu, G, Ugaz, C, and White, G. *Social Provision in Low Income Countries*. Oxford: OUP.
- ^{vii} Gertler and Glewe, 1992. 'The willingness to pay for education for daughters in contrast to sons: evidence from rural Peru'. World Bank Economic Review 6 (1)
- ^{viii} Oxfam. 'Cost Sharing, Access and Equity in Primary Education'. August 2001.
- ^{ix} TEN/MET. 'Tracking fees in primary education and basic health services: Impact on basic rights in Tanzania'. November 2001.
- ^x Arhin-Tenkorang, D.
- ^{xi} Oxfam, 2001.
- ^{xii} Colclough, C. with Lewin, K. 1993. *Educating All the Children*. Oxford: Clarendon Press.