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## Meeting basic needs in Asia, Part I: government capacity and performance

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### SUMMARY

Questions concerning the distribution of income and wealth, and access to services have attracted increased attention during the 1970s to complement the earlier emphasis on the promotion of macro-economic development. This article provides a comparative review of service needs in Asia. It presents an inventory of the types of services provided by, or through, government, and assesses their adequacy for rural development. It explores problems with mobilizing resources and delivering services, and it identifies arrangements that appear most effective. The article emphasizes the problem of extending the coverage, and increasing the quality, of social and productive support services for vast rural populations and it stresses that more appropriate ways must be found of delivering services that are needed. A second article, to appear in the next number of *Public Administration and Development*, reviews ways of improving the capacity of governments and local communities to provide services needed by rural populations.

Experience with development over the past quarter of a century suggests that the success of developing nations in stimulating and sustaining economic and social progress and in transforming themselves from subsistence to productive societies depends on two crucial factors. One is government's ability to design and carry out strategies for macro-economic growth. The other, and equally as important, is its capacity to provide those services needed to increase the productivity and fulfil the basic needs of a majority of its population in an equitable fashion. The two factors are closely related. Attempts to distribute income and wealth more equitably, increase participation in economic activities and expand the coverage of social and productive support services are often futile in stagnant economies. But macro-economic growth policies that ignore distributive issues or that fail to build local capacity to provide services often result in highly concentrated and inequitable patterns of development.

A great deal of experience with alternative development policies for achieving growth-with-equity has been gained in East and Southeast Asia over the past

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three decades. Socialist governments in Burma, Sri Lanka and the People's Republic of China emphasized distribution over growth and found that equity was achieved primarily by reducing the entire population to a standard of living just above the subsistence level. Moreover, policies primarily concerned with distribution have led to relatively low levels of productivity in the agricultural and industrial sectors and to severe problems of sustaining the economy over long periods of time (USAID, 1979a; USAID, 1979b). Other countries such as India, Pakistan, Indonesia, the Philippines and Thailand sought macro-economic growth without considering distribution and found that large numbers of people remain in dire poverty despite overall economic progress. Some Asian countries such as Bangladesh and Nepal have neither been able to promote macro-economic growth nor to mobilize resources for local service delivery (USAID, 1979c, USAID, 1980a). Only a few nations such as South Korea, Taiwan and Malaysia have been relatively successful at both (Rao, 1978; Ranis, 1978; Lee, 1977).

Although most countries have given highest priority to promoting macro-economic development, international assistance agencies and some governments in developing nations are now paying greater attention to issues of distribution. They are seeking ways of generating resources within local communities to provide services that fulfill basic needs, increase employment and output and distribute the benefits of development more equitably. The approaches to development that emerged during the 1970s attempted to refocus attention on factors largely ignored during the 1950s and 1960s. 'While these strategies have in common a rejection of economic growth alone as a sufficient means of achieving broad-based development and alleviating poverty in the developing countries, they recognize that rapid growth is an essential element of any development strategy for poor countries', one analyst correctly observes. Concisely stated the issue is not 'between advocates of growth and advocates of no growth or slow growth; it is between advocates of maximum growth in GNP regardless of how it is achieved and advocates of a growth path which puts to productive use the now underutilized labor of the poor' (Paolillo, 1976). In Asia, poverty is most severe in rural areas, and given its magnitude and extent and the paucity of national resources, the only realistic approach to alleviating massive rural poverty is through building the capacity of local governments, and of non-governmental organizations, to mobilize community resources for social and productive-support services (Rondinelli and Ruddle, 1977b). In its initial stages however, a local resource mobilization policy requires substantial support and commitment from the national government and a willingness on the part of policymakers to invest national resources in local capacity-building programmes.

Relatively little effort has been made, thus far, to survey service needs in Asia, compare experiences with trying to fulfil them and assess government capacity to mobilize resources for service delivery. Nor have the reasons for successes and failures been examined, the implications for increasing the capacity of local governments to mobilize resources for community services been explored or successful programmes and projects that could be replicated elsewhere been identified. Thus, this paper will inventory the types of services provided by or through national and local governments in Asia, assess their adequacy for rural development, explore problems with resource mobilization and service delivery and identify the arrangements that seem to be most effective.

## **THE ROLE OF SOCIAL AND PRODUCTIVE SERVICES IN RURAL DEVELOPMENT**

Many development theorists argue that the poor remain indigent in large part because they lack access to social services, public facilities and productive resources required to meet basic human needs and to increase their income. The provision of services has, therefore, become an important component of rural development policies. Increasing the access of the rural poor to social and productive-support services is seen as a means of increasing their overall standard of living, as a way of increasing the participation of those people who had previously been excluded from productive activities, as a means of stemming the tide of migration out of rural areas and at the same time relieving population pressures on large cities, and as a way of increasing the productivity and output of rural labour.

### **The arguments for expanding services in rural areas**

In nearly every society standards of living are measured in part by access to services that fulfil basic human needs. Although definitions vary among cultures, the International Labor Office contends that 'basic needs' usually consist of two components: minimum requirements for private consumption such as adequate food, shelter, clothing, and household equipment; and essential community services such as safe drinking water, sanitation, health and educational facilities, and public transport (ILO, 1976). Economic systems that do not extend access to these services to a large majority of the population are considered underdeveloped and inequitable.

Others contend that access to these, and to commercial and productive resources such as land and credit, is not only a basic human right but is indispensable for increasing productivity and alleviating poverty in the developing world. The staff of the World Bank, for instance, contends that the rural poor not only suffer 'because they have little access to technology and services' but also because 'the institutions that would sustain a higher level of productivity are lacking,' (World Bank, 1975a, p. 21). Providing services in rural areas of Asia is important because most poor countries in that region are, and will remain for the foreseeable future, agricultural societies. Their best hope for economic progress is in developing agriculture and agriculturally related industries. This depends, however, on increasing the productivity of agricultural labour, which in turn requires the extension of those social and productive support services that will increase the output of rural people. The U.S. Agency for International Development's Working Group on the Rural Poor insists that access to appropriate social services is essential for increasing productivity in rural areas. 'Emphasis should be placed on environmental sanitation, preventive medicine, eradication of endemic diseases, improved nutrition and family planning based on rural health clinics, para-professionals and traditional health practitioners', USAID analysts suggest. 'Transport investment should focus on the development of low-cost rural transportation networks with the objective of providing farm to market access . . . (USAID, 1973, p. 30). These services, they argue, are not only private consumption goods for individual households, but

they have social 'spillover' effects that create an environment conducive to increasing productivity and making economic development more equitable.

Another argument often made for expanding services in rural areas is that they are needed to reduce the high rates of rural-to-urban migration that both drain rural areas of their best human resources and create additional pressures on the limited supply of services, facilities and employment opportunities in cities. Recent World Bank studies of migration note that economic factors and potential job opportunities are the primary forces pulling people from rural areas to the cities but that 'other attractions such as better living conditions, better educational opportunities, or a wider variety of shopping, social and recreational activities may also be important' (Yap, 1975, p. 19). The lack of social and productive services in rural villages encourages outmigration and swelling populations in Asian cities create severe pressures on already inadequate urban services. In a recent study for the Asian Development Bank, Prakash notes that services in most Asian cities have been deteriorating during the past decade and that the costs of providing even minimum levels of water, sewerage, housing, health and education services for the increasing numbers of urban dwellers over the next two decades would cost between \$147 and \$210 billion in 1976 dollars. He argues that 'the scale and rapid growth of urban population translates into enormous capital investment requirements resulting in long-run recurring costs', and predicts that even if total savings could be mobilized to provide housing and infrastructure for the additional urban population, the amounts would be insufficient. 'But these resources', he points out, 'are also urgently needed elsewhere' (Prakash, 1977, p. 6). Service needs have increased in Asia because both urban and rural populations have been growing rapidly over the past two decades and the expected pressures on rural land over the next two decades will keep migration to the cities at high levels unless employment, income and service needs can be met in rural regions.

### **The integrated approach to rural service delivery**

Development theorists and analysts within international assistance agencies contend, however, that social and productive support services must be combined and integrated at the local level in order to have an impact on the rural poor. Single services or limited development programmes simply cannot meet the massive needs in rural areas. USAID's Working Group on the Rural Poor has argued that the extreme complexity of rural systems and the diversity of problems in rural areas demands an integrated approach to development. 'Social, cultural, economic, political and historical forces have all combined to create and perpetuate the current adverse conditions in rural areas and therefore 'the interactions and dependencies of these complex elements make it highly unlikely that any single intervention such as increasing small farmer credit or introduction of a new technology will be effective in isolation'. To the contrary, the Working Group insisted, 'it is the capacity of the system as a whole rather than isolated parts which must be the focus of attention in planning' (USAID, 1973, p. 8).

Experience has consistently shown, however, that provision of adequate services in rural areas depends on the existence of—or the ability to create—a

broad range of supporting political and administrative conditions.<sup>1</sup> These include national political commitment to a growth-with-equity policy, domestic and foreign trade policies that are favourable to agriculture, a strong willingness and capacity within national bureaucracies to deliver social services effectively in rural areas, adequate budgetary support for rural services and facilities, and effective administrative arrangements at the field level for implementing local service delivery programmes. Moreover, there must also be political commitment at the local level and ways to overcome the frequent opposition from elites to increasing the participation of the poor in economic activities. An equitable distribution of land ownership is a crucial factor in raising income levels to pay for services and providing an adequate tax base to finance recurrent costs. Local government's financial and administrative capabilities must be improved in most countries and local project management units created to oversee the daily operations of service delivery projects. Private and cooperative organizations have been found to play a crucial role in supporting government efforts. These factors, taken together, form an environment conducive to providing an integrated set of social and support services in local communities that can increase the productivity of the rural poor and raise their standards of living (Rondinelli and Ruddle, 1977a; Rondinelli and Ruddle, 1978b). Where local resource mobilization and service delivery have been successful in Asia—specifically in Korea, Taiwan, Malaysia and the People's Republic of China—all or most of these conditions supported a strong self-help effort at the local level (Asian Productivity Organization, 1978).

Within this political and administrative context, the services considered essential for increasing productivity and income are: marketing and credit, irrigation, agricultural extension, roads and utilities. In addition, health, family planning and social services, elementary and vocational education, and basic commercial and financial services—especially those that support small-scale industrial development—are usually components of integrated rural development projects.<sup>2</sup> The poor in towns and smaller cities require housing, sanitation, water and utility services, and they share with rural people the need for better access to public transportation (Rondinelli and Ruddle 1978c, Chapters 5, 7; Rondinelli, 1979–80).

### **THE PERFORMANCE OF ASIAN GOVERNMENTS IN PROVIDING SOCIAL AND PRODUCTIVE-SUPPORT SERVICES**

Although the ability of governments to provide this combination of services varies widely among developing countries in Asia, a comparative review of needs indicates that in all Asian LDCs services for rural development and resources for local service delivery are inadequate. Three generalizations can be made about services provided by Asian governments.

First, the quantity of services provided in nearly all countries is substantially smaller and coverage is less extensive than in more economically advanced

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<sup>1</sup>For a more detailed discussion see Rondinelli (1979) and Rondinelli and Ruddle (1978b).

<sup>2</sup>A more detailed discussion is found in Rondinelli and Ruddle (1978c) Chapter 4.

societies. Governments in all Asian countries recognize the inadequacy of services, measured by either international standards or indigenous norms. Coverage is more extensive in those countries that have had higher rates of economic growth over the past decade, but in the poorer and slower growing economies a large percentage of the population does not have effective access to most services.

Second, the services that are provided are often inappropriate to the needs of the vast majority of the population. In health, for instance, too much emphasis is placed on high-cost curative medicine. The most pressing health problems in developing countries involve infectious and parasitic diseases resulting from inadequate supplies of drinkable water, poor sanitation facilities and lack of vector control (World Bank, 1975b, Abel-Smith and Leiserson, 1978). Widespread malnutrition is not only a leading cause of death among children, but contributes to the general prevalence of diseases by impairing normal body responses to infection (World Bank, 1975b, Abel-Smith and Leiserson, 1978). These problems, in turn, contribute to the health risks attending high fertility rates in rural areas, and, in combination, lower overall standards of living and individual productivity. Curative medical services are either ineffective or extremely inefficient in combating these problems. Yet a large amount of the limited resources available for health are allocated to services provided by trained physicians and hospitals using sophisticated and costly equipment. Only recently has attention been given to more appropriate alternatives such as preventive health programmes, maternal and child care services, extension of piped water supplies and sanitation facilities, and the creation of vector control programmes. Health and nutrition training programmes could reach a vastly larger number of people than the curative services required to deal with diseases caused or exacerbated by poor health and nutritional practices (WHO, 1978a).

Third, in all of the developing countries of Asia services are inequitably distributed. Substantial disparities in access to social and productive-support services exist between people living in urban and rural areas. Indeed, many of the rural poor have virtually no access. In Korea, less than 50 per cent of the population lives in urban centres, yet over 80 per cent of the physicians and medical facilities are concentrated in the larger cities. In India, four-fifths of the physicians also live in urban centres, but the 80 per cent of the population living in rural villages has little or no access to them (WHO, 1978b). Large disparities can also be found among geographical regions within nearly every country, and people in different income groups differ significantly in their access to services.

An assessment of the performance of Asian governments in providing services must therefore consider a number of crucial factors: the *quantity* and *coverage* of services that are available, their *quality* and *appropriateness* in meeting the needs of various groups within the population, and the degree of *equity* in the distribution of services. Quantity, coverage and distributional equity can generally be assessed more easily than quality and appropriateness, both because of the paucity of general information on quality and because of the variation in standards that are acceptable and feasible in countries at different levels of social and economic development.

Indeed, the developing nations of Asia differ markedly in their levels of economic development, pace of economic growth, political ideology, government

structure and cultural traditions. These factors explain much about differences in the capacity and willingness of governments to mobilize and invest resources in social and productive-support services and to build local capacity to deliver and maintain them. Thus, in this assessment Asian nations are divided into three categories of development to compare records of performance in providing services. Comparisons are made among newly industrializing countries, transitional developing economies and poor countries.

### Newly Industrializing Countries

Three nations—Taiwan (Republic of China), South Korea and Malaysia—have achieved substantial success in promoting economic growth and extending basic services to a majority of their people. All three are relatively small in population size and land area and they have all placed strong emphasis on macro-economic development through export production. Taiwan and Korea specialized in export manufacturing and Malaysia invested heavily in agriculture and agro-industrial development. Yet, all three countries have also pursued deliberate policies to increase participation in economic activities, create parity between the agricultural and industrial sectors and spread the benefits of development among rural as well as urban populations. As a result, they have created a relatively equitable pattern of economic development. Annual growth rates in industrial production averaged 17 per cent in Korea from 1970 to 1977, a little over 12 per cent in Taiwan and more than 9 per cent in Malaysia. Average growth rates in GNP during the same period were about 5 per cent in Malaysia and Taiwan and more than 7 per cent in Korea. By 1978, *per capita* GNP exceeded \$1000 in all three countries and approached \$1500 in Taiwan. Secondary and tertiary sectors contributed about 75 per cent of Gross Domestic Product (GDP) in 1977, and more than half of the labour force was employed in non-agricultural work (see Table 1). About half of the populations of Taiwan and Korea and one-third of Malaysians were urban dwellers in 1975.

Although significant differences in income and wealth remain between urban and rural populations generally and among occupational groups in all three countries, standards of living tend to be relatively high and, compared to other countries in Asia, income is equitably distributed. Basic needs have been met for the vast majority of the population and access to social and productive-support services is improving. Both Taiwan and Korea have nearly universal adult literacy. Population growth rates were reduced to 2 per cent a year between 1970 and 1977 in Korea and Taiwan and total fertility rates in 1977 were below 3.0. These achievements are attributable in large part to highly successful family planning programmes in both countries. The average annual population growth rate in Malaysia during the 1970s was about 2.7 and the total fertility rate in 1977 was 3.8. Life expectancy in 1977 was 63 years in Korea, 67 in Malaysia and 72 in Taiwan (see Table 2).

Infrastructure and support services have been widely distributed in Korea, and Rao (1976) points out that

Korea's villages enjoy an unusually high level of basic services . . . All villages have easy access to primary schools and most villages to middle

schools as well. Family planning material is widely disseminated—as evidenced by the fact that rural fertility rates have declined about as fast as urban rates. About 91% of all households have access to electricity. More than half of the legal villages have community telephones. Almost all villages are connected by roads, although there is still much room for improvement in the quality of rural access roads.

Table 1. Basic economic indicators for selected developing countries of East and South-east Asia

	Population 1978 (millions) *	GNP per capita 1978 (\$) *	Growth rate of GNP 1970– 1977 (%) *	Average annual growth rate of production† 1970–1977		
				Agriculture	Industry	Services
<b>New industrializing countries</b>						
Korea	36.6	1160	7.6	5.0	17.0	8.5
Malaysia	13.3	1090	4.9	5.4	9.3	8.6
Taiwan	17.1	1400	5.5	1.5	12.2	4.5
<b>Transitional developing countries</b>						
Philippines	45.6	510	3.7	4.8	8.7	5.6
Thailand	44.3	490	4.1	4.4	10.3	6.8
<b>Poor countries</b>						
Bangladesh	83.6	90	-0.2	1.0	4.2	4.5
Burma	32.2	150	1.3	3.0	3.7	4.3
India	643.9	180	1.1	4.1	2.6	—
Indonesia	135.9	360	5.7	4.2	12.9	4.5
Nepal	13.6	120	2.4	—	—	—
Pakistan	77.3	230	0.8	1.8	3.6	5.1
Sri Lanka	14.3	190	1.3	1.6	2.8	4.3
Distribution of gross domestic product† 1977 (per cent)				Sectoral distribution of labour force† 1977 (per cent)		
	Agriculture	Industry	Services	Agriculture	Industry	Services
<b>Newly industrializing countries</b>						
Korea	27	35	38	45	33	22
Malaysia	26	29	45	44	20	36
Taiwan	12	46	42	34	27	39
<b>Transitional developing countries</b>						
Philippines	29	35	32	51	15	34
Thailand	27	29	44	77	8	15
<b>Poor countries</b>						
Bangladesh	55	13	32	78	7	15
Burma	47	11	42	55	19	26
India	37	25	38	73	11	16
Indonesia	31	34	35	60	12	28
Nepal	68	9	23	93	2	5
Pakistan	33	23	44	58	20	22
Sri Lanka	39	21	40	54	15	31

\*World Bank (1979a).

†World Bank (1979b).

Table 2. Basic social indicators for selected developing countries of East and Southeast Asia

	Percentage rural population, 1975	Life expectancy at birth (years), 1977	Adult literacy rate, 1975	Percentage of population in dependent age groups, 1977	Total fertility rate, 1977	Percentage population with access to safe water, 1975	Population per physician, 1976	Child death rate (ages 1-4), 1977
<b>Newly industrializing countries</b>								
Korea	51	63	91	40	2.8	62	1680	5
Malaysia	70	67	60	46	3.8	62	4350	3
Taiwan	49	72	82	37	2.5	—	1590	1
<b>Transitional developing economies</b>								
Philippines	66	60	87	49	5.0	38	3150	7
Thailand	86	61	82	48	4.5	22	8460	6
<b>Poor countries</b>								
Bangladesh	91	47	22	49	6.5	53	11350	23
Burma	75	52	67	45	5.5	17	5410	15
India	79	51	36	45	5.0	33	3140	18
Indonesia	82	48	62	44	4.9	12	16430	19
Nepal	96	45	19	45	6.5	9	38650	23
Pakistan	74	51	21	50	6.7	29	3780	17
Sri Lanka	76	69	—	42	3.6	29	6230	2

Source: World Bank (1979b).

Attempts were made to maintain equitable participation in economic activities and distribution of the benefits of economic growth during the 1970s with a vigorous rural development programme, the *Saemaul Undong* (New Community) Movement.

Similar policies in Taiwan contributed to relatively equitable development and widespread access to social and productive services there. A strong emphasis on rural industrialization strengthened the rural economy at the same time that agriculture was being developed, which became a crucial factor in raising rural household incomes. Well-organized agricultural cooperatives provided a vehicle for mobilizing resources in rural areas for self-help projects, supported in large part by the Joint Commission for Rural Reconstruction (JCRR).<sup>3</sup>

Since the mid-1950s, Malaysia's government sector has been large, with central, state and municipal expenditures totalling more than 40 per cent of GNP during the 1970s, a level approximating that of some European welfare states. Malaysia's post-Independence governments have strongly emphasized investment in productive support services in agricultural and industrial sectors, transportation, and social services with developmental or productive impact such as education, health and family planning. In 1973, for example, about 23 per cent of total Federal expenditures went for agricultural, industrial, transportation and rural development, and nearly 30 per cent for education, family planning, health and community services. Private consumption services have been made available through public enterprises at or near cost and have been accessible to a majority of the population (Meerman, 1977).

The problems that remain in all three of these newly industrializing countries are of maintaining existing services under conditions of rapidly rising costs in economies that are experiencing high rates of inflation, of increasing the quality of services provided in societies with rising expectations concerning overall standards of living, and of extending the coverage of appropriate services to lower income groups and economically lagging rural regions in order to maintain equity in the distribution of development benefits.

In all three countries rural populations generally receive lower quality services than those living in cities, especially in health care and education, and have less access than urban dwellers to such services as piped water, sewerage, electricity, housing and transportation. Meerman notes that in Malaysia, rural schools 'have poorer facilities and less qualified teachers. Poverty is associated with lack of parental education and home environment is extremely important in determining success in school. However, village financial resources must also contribute substantially to this outcome—far more than is the case in the developed countries' (Meerman, 1977, p. 14). Moreover, the lowest income groups in all three countries have less access to services, no matter where they live, and the costs of obtaining the services that are available tends to be more burdensome than for higher income groups. In Malaysia, for example, where public education is provided free, the supplementary costs for books, fees, uniforms and supplies were estimated to be about 18 per cent of total family income for the poorer households in the mid-1970s, a substantial burden on the poorest 40 per cent of

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<sup>3</sup>The background of the community development effort in Taiwan is described in Huang (1977).

the population. Meerman concluded that 'this factor is a major reason for the rapid decreases in enrollment rates as incomes fall irrespective of level' (Meerman, 1977, p. 8).

### Transitional developing economies

The Philippines and Thailand are in a transitional stage of development; they have maintained respectable rates of economic growth during the 1970s, averaging 3.7 per cent in the former and 4.1 per cent in the latter from 1970 to 1977. Industrial growth rates during the same period averaged 8.7 per cent a year in the Philippines and 10.3 per cent in Thailand. *Per capita* GNP reached about \$500 in each country in 1978. Industry contributed about 35 per cent to GDP in the Philippines and 24 per cent in Thailand. Both countries still have agricultural economies, with half the labour force of the Philippines and 77 per cent of Thailand employed in the agricultural sector (see Table 1). A large share of industrial capacity and urban population are concentrated in the national capitals—Bangkok and Manila—which dominate the national economies and spatial systems of these countries. Large disparities in income, wealth, productive capacity and quality of services are found between rural regions and the national capitals. High levels of poverty in rural areas offer a strong challenge to policies promoting equitable growth.

Although Thailand has had two decades of relatively stable growth and was at about the same income level during the 1970s that the newly industrializing countries of Asia had reached during the 1960s, nearly 25 per cent of the population in Thailand still lives in absolute poverty. Large segments of the rural population lack access to many of the social and productive services needed to fulfil basic human needs and increase agricultural output. Although 80 per cent of the adult population has completed the fourth grade, only 14 per cent of the workforce has an education beyond that level, and the relatively high literacy rate is based on a limited ability to read and write. The country as a whole still suffers from high morbidity rates, the number of population per physician is relatively high, and the utilization rate for curative facilities is low. Many provinces lack professional health services (USAID, 1980b). About 86 per cent of the population in Thailand lives in rural areas and nearly half of the population is in the dependent age groups of below 14 and over 65 years old. Less than a quarter of the country's population has access to safe water (see Table 2).

As in Thailand, the macro-economic statistics that show the Philippines better off than most of the poorer countries of Southeast Asia mask the extensiveness of poverty. A large majority of the rural population lacks access to services and productive resources. Difficulties in meeting basic human needs in rural areas are attributable in part to the high population growth rate during the 1950s and 1960s. Although the growth rate dropped by 25 per cent during the past decade, population increased by 2.5 per cent a year at the end of the 1970s. Rural people have less access to family planning services and make less use of those available than urban dwellers. Average rural family size remains at more than 6 members.

A little more than 40 per cent of the families in the Philippines suffer from

some form of undernourishment. Only about 38 per cent of the population has access to safe water, and in rural areas the weaknesses in health and sanitation services and the lack of drinkable water supplies perpetuate high incidences of water and airborne diseases. Gastro-intestinal infection, bronchitis, influenza, tuberculosis and pneumonia are frequent causes of death, and a high percentage of deaths occur without medical treatment. Many rural health clinics lack equipment, supplies and staff and are physically inaccessible to most rural people because of inadequate transportation services and lack of rural roads in many provinces. Although primary and secondary schools are widespread throughout the Philippines, the quality of education in rural areas tends to be low and enrollment increases have created textbook and teacher shortages in many rural provinces (Cheetham and Hawkins, 1976, chapters 10–12). As in the other developing countries of Southeast Asia, the dependency ratio in the Philippines is high. Over 40 per cent of the population is 14 years old or under.

Disparities in access to services remain a serious problem in both countries, and one that government must come to grips with during the 1980s if development is to become more equitable. Large differences in quantity and quality of services are evident between urban and rural areas generally, and among specific geographical areas in the Philippines.<sup>4</sup> In Thailand access to social and productive services within regions is highly correlated with degree of urbanization. The USAID Mission in Thailand notes that the rural poor have 'higher dependency ratios, less schooling, more deaths from communicable disease, housing without water, toilets or electricity, lack radios and private transportation and are more victimized by crime (USAID, 1980b, p. 12). The incidence of absolute poverty in Thailand is highest in the North and Northeast regions where in 1976 more than one-third of the population had incomes below the poverty level compared to 12 per cent in the central region and Bangkok. The Northeast and Northern regions are predominantly rural and have about half of Thailand's total population. *Per capita* income in the Northeast region was only 42 per cent of the national average in 1977 and has been declining in relative terms over the past decade. During the mid-1970s access to telephone and other communications services were much lower for those living in the north and northeastern parts of the country than for those residing in the Central and Southern regions. Only 9 per cent of the villages in the Northeast had electricity and less than 20 per cent of the houses had toilets. Whereas almost 80 per cent of the central region's population had access to piped water, less than 6 per cent of the Northeast region's population were served. Moreover, government expenditure *per capita* in 1976 for all public services was only \$20 in the Northeast compared to \$47 in the Central and Southern regions (USAID, 1980b).

### **Poor developing countries**

Among the remaining non-Communist countries of Asia, Bangladesh, Burma, India, Indonesia, Nepal, Pakistan and Sri Lanka have extensive poverty and relatively low rates of economic growth. Only Indonesia has experienced

<sup>4</sup>A detailed description of inter-regional inequalities in the Philippines is found in Rondinelli (1980).

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significant economic progress during the 1970s, with a 5.7 per cent average annual growth in GNP and a 13 per cent growth in industrial production between 1970 and 1977 (see Table 1). The growth rate in GNP for Bangladesh has been negative, and less than 2 per cent for all of the other countries except Nepal. *Per capita* GNP for all of the countries except Indonesia has been less than \$250.

All of these nations have agricultural economies. The agricultural sector employed over 50 per cent of the labour force, with about 70 per cent or more of the labour in Bangladesh, India and Nepal engaged in agriculture. Industrial workers constitute less than 20 per cent of the labour force in all seven countries. Agricultural contribution to GDP is substantially lower than the sector's share of the labour force, and average annual growth rates in agriculture have been extremely low during the 1970s in all countries except India and Indonesia, where they reached about 4 per cent. More than three-quarters of the population in these countries live in rural areas.

Pakistan, India, Indonesia and Bangladesh have the world's largest concentration of people living in absolute poverty (World Bank, 1975b). The rural poor consist largely of subsistence farmers, landless labourers, tenants and small-scale non-farm entrepreneurs, whose access to social and productive services is minimal. Only Burma and Sri Lanka—two small socialist welfare states—have been able to provide basic social services to a large segment of the rural population, but even in these countries the overall impact on standards of living and levels of productivity have not been great. Distribution of income and wealth, and thus access to social and productive services, tends to be highly inequitable in most of the poor countries of Asia. The poorest 40 per cent of the population receives less than 18 per cent of income in Bangladesh, India, Pakistan and Sri Lanka, with the richest 20 per cent receiving nearly half of the income in these countries (ILO, 1977, pp. 19–25).

The limited access to social and productive services in these countries is reflected in basic social indicators (see Table 2). Life expectancy in all of the countries except Sri Lanka was about 50 years or less in 1977. No more than a quarter of the adult population was literate in Bangladesh, Nepal and Pakistan and only about one-third of the adult population in India was considered literate in 1975. Fertility rates range from 3.6 in Sri Lanka to 6.7 in Pakistan. Less than a third of the population has access to safe drinking water in any of the countries. In Pakistan, less than half of rural school-age children are enrolled in schools and only a quarter of them complete the fifth grade. Only 22 per cent of Pakistan's population is literate. Population growth rates in Pakistan averaged 3 per cent during the 1970s and fertility rates exceeded 6.7. The Government's *per capita* expenditure on health and education are extremely low at \$1.62 and \$4.04, respectively. About 20 per cent of houses are built of durable construction materials and the government estimates a shortage of more than one million housing units. Only a quarter of the population is served by drinkable water and only 10 per cent by sewerage facilities (USAID, 1979d). Moreover, the government's commitment to providing needed services in rural areas is rather weak. The USAID Mission in Pakistan observes that 'government investment in rural areas for education, electricity, extension, seed production and other input distribution have been ill-planned and minimal. *Status quo*,

subsistence agriculture continues in much of the country and most farmers are unaffected by government programs' (USAID, 1979d, p. 30).

Similar conditions exist in Nepal, where life expectancy is 44 years, infant mortality is 152 per thousand and the fertility rate is more than 6.5. Less than 10 per cent of the population has access to safe drinking water. Foreign assistance analysts point out that 'because of constraints of the terrain and absolute scarcity of facilities, staff and supplies, usually health posts and hospitals are not easily accessible to villagers. In addition to these system delivery problems, the most serious basic health problem probably is the exceedingly low level of sanitation' (USAID, 1979c, p. 4). Population growth rates are high and continue to rise. Only about 5 per cent of the population in the child-producing age group accepted contraceptive methods in 1978. More than 20 of every one thousand children in Nepal die before the age of 5. Less than a third of school-age children are enrolled in primary school and only about 19 per cent of the population—including only 4 per cent of the women—were literate in 1975. Access to markets and market information is extremely limited for Nepalese farmers and their dependence on traditional farming methods has kept agricultural production and rural incomes low.

The relatively high rate of industrial production in Indonesia during the 1970s has done little to overcome the pervasive poverty and extreme inequality in the distribution of income and wealth among regions in that country. Recent studies indicate that 90 million Indonesians, about two-thirds of the total population, live on less than \$200 a year and that many of their basic needs cannot be met on this subsistence income (USAID, 1979e, p. 1). Nearly 70 per cent of the rural population lives on incomes below the poverty line, and rural people continue to have large families (6 or more members). The inadequacy of water and sanitation services promotes diarrhoeal diseases that together with high levels of malnutrition and respiratory diseases account for more than 90 per cent of all deaths of children under 5 years old. Indonesia's child death-rate of 19 per thousand is one of the highest in Asia. Life expectancy remained about 48 years in 1977. Moreover, educational attainment continues to be low, with few rural children advancing beyond the fourth grade. In 1976, less than 1 per cent of the Indonesian population over the age of 10 had completed secondary school.

The situation in Bangladesh is equally grim. More than 90 per cent of the country's population lives in rural areas. Life expectancy is about 47 years, only 22 per cent of the adult population was literate in 1975 and 23 of every thousand children die before they reach the age of five. While basic social and productive services are available to higher income groups the majority of the poor have only minimal access. 'In general, health services available in most villages consist of the village midwife (dai), the local health practitioner and occasional visits by field based health and family planning workers', foreign aid analysts in Bangladesh report. 'Doctors and hospitals are so remote as to be considered only at times of serious need and even then are likely to be out of reach' (USAID, 1980a, p. 16). Only about 15 per cent of the children in Bangladesh advance beyond a fifth grade education and the quality of that education is extremely low.

Only two of the poor and transitional countries in Southeast Asia—Sri Lanka and Burma—have a somewhat better record of providing basic social services.

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Both socialist welfare states have had low rates of economic growth during the past two decades, however, and their economic capacity to extend coverage and increase the quality of service is limited. At least 20 per cent of Sri Lanka's population lives in dire poverty and a majority live in relative poverty. More than 80 per cent of Burma's population has income below the poverty level (USAID, 1979a, pp. 2-6). Little attempt has been made until recently to increase the levels of productivity in these stagnant economies.

In Sri Lanka, infant mortality and birth rates are relatively low, life expectancy and adult literacy are high for the population as a whole, but these statistics mask regional disparities and the low quality of services provided to many areas of the island. Moreover, in recent years the government has encountered severe problems of maintaining services because of the low levels of economic growth. A high percentage of those people seeking treatment at Sri Lanka's rather widely dispersed health clinics suffer from diseases attributable to the lack of safe water supplies, sewage disposal and vector control. Gastroenteritis is a main cause of infant deaths. One-third of the urban population and almost 95 per cent of rural people lack access to piped water. One study reports that 'although recorded rates of literacy and school enrolment are impressively high in Sri Lanka, deficiencies in facilities, teaching quality and curriculum as well as economic pressures on low income families have caused an increasing drop-out problem. It is estimated that only 58 per cent of entering students complete the fifth grade (USAID, 1979b, p. 14). Housing quality in both Colombo and on the estate sector is recognized by the government as being poor—overcrowding and deterioration are widespread. The emphasis on social welfare during the past two decades clearly has been at the expense of productive investment, and the government's ability to sustain social services has been deteriorating during the late 1970s. Rural areas lack adequate roads, transportation, electrification and marketing services and facilities.

Similar but more serious problems plague Burma's government. The USAID Mission concisely describes the situation when it referred to Burma as 'an impoverished country, of extensive natural resources, whose population lives in shared deprivation without the pervasive, dire, grinding poverty of the subcontinent' (USAID, 1979a, p. 3). Although the government has made a deliberate attempt to provide basic social services to the majority of the population, quality remains low. About two-thirds of the adult population is marginally literate, but children generally receive only a fourth or fifth grade education and there is a tendency for rural people to lose their literacy as they grow older because of a lack of reading material. Health services are available at clinics in most larger towns, but evaluators have discovered that 'such facilities are overcrowded [and] unsanitary . . . medicines from government sources are in short supply and consequently have to be purchased on the black market at prices that tax the family's ability to afford them' (USAID, 1979a, p. 3). Health centres are scattered among rural villages but they are chronically short of supplies and staff. Malnutrition and intestinal and pulmonary diseases are widespread in rural areas. Less than 15 per cent of the rural population has access to drinkable water. The vast majority of rural people also lack access to agricultural extension, credit or marketing services and basic technology and productive support services such as transportation and irrigation equipment that

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could increase their income and agricultural output. Severe financial problems and low levels of capital formation make provision of even basic social and production services increasingly difficult.

As in the newly industrializing and transitional countries, large disparities in the quantity and quality of services available to different geographical regions and income groups are serious problems to be overcome in Asia's poorest societies in the coming decades. In Pakistan, for instance, strong urban-rural disparities exist in service coverage and quality. Recent studies estimate that *per capita* income in urban areas in 1978 was about 90 per cent higher than in rural areas, thus expenditure levels were more than 70 per cent higher in cities, as was total share in consumption. Literacy in rural regions was only 14 per cent compared to 41 per cent in cities. About 14 per cent of the rural population, compared to 61 per cent in cities, had access to drinkable water and less than one per cent of the rural population had access to sanitation facilities. About 8 per cent of the houses in rural villages were built of durable construction materials compared to 54 per cent in urban areas. More than 80 per cent of the hospital beds and 60 per cent of the dispensaries are located in urban centres, and a vast majority of the rural poor cannot make use of them.

The USAID Mission points out that in Indonesia:

Health care services and personnel are both insufficient and extremely maldistributed in favor of urban areas. Only 13% of the rural population has direct access to safe drinking water, and only 20% of Indonesians have sanitary toilets. Less than half the 4,300 public health centres are staffed by a physician; only 20–25% of the population utilizes these facilities. The distribution of the 10,000 physicians in Indonesia ranges from 3.18 per 10,000 population in Jakarta to 0.19 in rural areas. The country's 45,000 nurses, 17,000 midwives and 5,000 sanitarians are also located primarily in urban areas (USAID, 1979e, p. 12).

Other services are also poorly distributed: less than 10 per cent of rural households have access to electricity and piped water and the lack of rural roads limits government's ability to extend services efficiently outside of towns and cities.

Large disparities also appear among different income groups. Those individuals and families that have accumulated wealth or who are in the upper income groups, even in rural areas, have greater access to services than lower income groups. Aid officials in Bangladesh point out that 'with status and economic well-being come regular access to such social resources as education, health care and institutional credit. Similarly, local political offices and local decision-making are primarily in the hands of the influential maliks and the nonagricultural elite who live in the rural towns.' The combination of higher income and greater access to political influence give the elite a stranglehold over the distribution of services to lower income groups. 'Efforts by those occupying the lower portion of the social hierarchy to obtain access to resources and services without the assistance of an influential person are ordinarily met by demands for bribes and concessions' (USAID, 1980a, pp. 12–13).

Thus, the poorest countries in Asia must not only extend the coverage and increase the quality of social and productive-support services for a vast rural population, but also find more appropriate ways of delivering the services that are needed. Means must also be found of reducing the large disparities in coverage and access to services among geographical regions and income groups. The problems of resource mobilization and service delivery will be examined in Part II of this study, which will also explore issues and directions for improving the capacity of governments and local communities to meet basic human needs and provide productive support services.

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