CHAPTER 2

# Human development since 1960

The developing countries have made significant progress towards human development in the last three decades. They increased life expectancy at birth from 46 years in 1960 to 62 years in 1987. They halved the mortality rates for children under five and immunised two-thirds of all one-year-olds against major childhood diseases. The developing countries also made primary health care accessible to 61% of their people and safe water to 55% (80% in urban areas). In addition, they increased the per capita calorie supply by about 20% between 1965 and 1985.

Their progress in education was equally impressive. Adult literacy rates rose from 43% in 1970 to 60% in 1985 — male literacy from 53% to 71% and female literacy from 33% to 50%. The South's primary educational output in 1985 was almost six times greater than that in 1950, its secondary educational output more than 18 times greater. The results were 1.4 billion literate people in the South in 1985, compared with nearly a billion in the North.

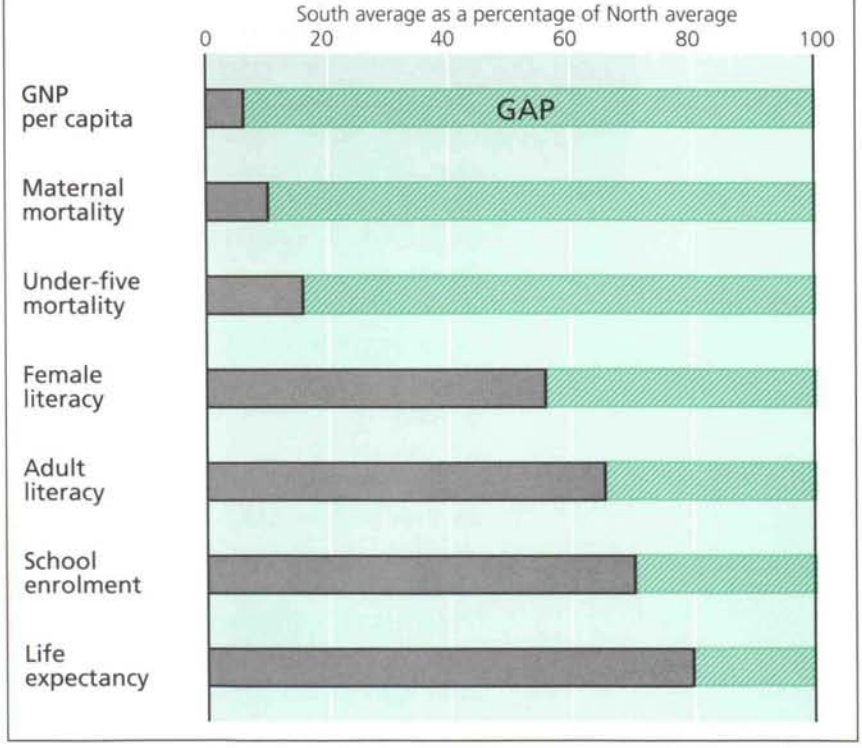
North-South gaps in human development narrowed considerably during this period even while income gaps tended to widen. The South's average per capita income in 1987 was still only 6% of the North's, but its average life expectancy was 80% and its average literacy rate 66% of the North's. The North-South gap in life expectancy narrowed from 23 years in 1960 to 12 years in 1987, and the literacy gap from 54 percentage points in 1970 to less than 40 percentage points in 1985. The developing countries also reduced their average infant mortality from 200 deaths per 1,000 live births to 79 between 1950 and 1985, a feat that took nearly a century in the industrial countries.

This progress must be put in perspective, however.

First, tremendous human deprivation remains. There still are nearly 900 million adults in the developing world who cannot read or write, 1.5 billion people without access to primary health care, 1.75 billion people without safe water, around 100 million completely homeless, some 800 million people who still go hungry every day and more than a billion who survive in absolute poverty.

Children and women suffer the most. Some 40 million newborns still are not properly immunised. Fourteen million children under the age of five die each year and 150 million are malnourished. The mater-

FIGURE 2.1
**Disparities between developing and industrial countries**



*Significant human progress co-exists with tremendous human deprivation*

nal mortality rate in the South is 12 times higher than that in the North, and the female illiteracy rate is at least 15 times higher. Obviously, the backlog of human deprivation presents a challenging agenda for the next decade.

Second, the recent progress in narrowing human development gaps between North and South raises hope — and a question mark. The hope is that the developing world can be taken to a basic level of human development in a fairly short period — if national development efforts and international assistance are properly directed. The question mark relates to the fact that four-fifths of the people in the Third World are leading longer, better educated lives, but they lack opportunities to tap their full potential. Unless economic opportunities are created in the South, more human talent will be wasted, and pressures for international migration are likely to increase dramatically. Moreover, while gaps in basic survival have narrowed, the widening gaps in science and technology threaten the South's future development.

Third, the average figures for human development hide considerable disparities among countries in the South. Life expectancy exceeds 70 years in 13 developing countries but is still less than 50 years in another 20 countries. Similarly, seven countries have literacy rates over 90%, but another seven have rates less than 25%. In general, the least developed countries, many in Africa, suffer the most human deprivation. Of all the developing regions, Africa has the lowest life expectancy figures, the highest infant mortality rates and the lowest literacy rates.

This trend towards the concentration of poverty in Africa is growing: more than half the people in Africa live in absolute poverty. The number of Africans below the poverty line rose by two-thirds in the first half of the 1980s — compared with an increase of about a fifth for the developing world as a whole — and is projected to rise rapidly in the next decade. Any international effort to improve human development in the Third World must thus give priority attention to Africa and the other least developed countries.

Fourth, the gaps in human development within countries are also great — between urban and rural areas, between men and women and between rich and poor. For developing countries as a whole, urban areas have twice the access to health services and safe water as rural areas and four times the access to sanitation services. Female literacy rates are only two-thirds those of men. And the rich often appropriate a major share of social subsidies. These wide disparities show the considerable room for improvement in distributing social expenditures.

Fifth, human progress over the last three decades has been neither uniform nor smooth. Many countries recorded major reverses in the 1980s — with rising rates of child malnutrition and infant mortality, particularly in Sub-Saharan Africa and Latin America. Budget cuts greatly squeezed social spending. Some countries avoided reductions in social programmes through better economic management, but most countries in Africa and Latin America paid a heavy social price during the adjustment period of the 1980s.

The 1990s present the challenge of rectifying the damage to human development in many developing countries and then building up momentum to achieve essential human goals by the year 2000. The responses to this challenge will require more resources, mobilised both domestically and internationally, and in many instances they will also require major shifts in budget priorities. Needed most are cuts in spending on the military, on inefficient public enterprises and on mistargeted social subsidies. To create the enabling framework for more broadly based development, macroeconomic policy formulation and management must improve, and popular participation and private initiatives must increase.

The remainder of this chapter documents the record of human development in the developing world since 1960. The last section also takes up some of the human problems now confronting both developed and developing countries. The discussion throughout reinforces this Report's basic thesis: income alone is not the answer to human development.

## Expanding human capabilities

The key components of the human development index — life expectancy, literacy and basic income — are the starting point for this review of the formation of human capabilities. Basic income is used here as a proxy for access to resources for a decent living standard. The review also examines some major contributing factors, especially people's access to food and such social services as water, education and primary health care.

*Life expectancy*

Life expectancy in the developing countries has risen on the average by nearly a third since 1960, from 46 years to 62 years. But this average masks important interregional and intercountry differences. Africa's average life expectancy is only 51 years, ranging from 42 years in Ethiopia and Sierra Leone to 69 years in Mauritius. Asia's average life expectancy is 64 years, reflecting the rise in China's life expectancy from 47 years to 70 years in three decades. Latin America's average life expectancy is 67 years, fairly close to the industrial nations' average of 69 years in 1960. Nine Latin American and Caribbean countries fall into the group of 18 developing countries that already have a life expectancy of 70 years.

Life expectancy generally is well correlated with a country's income, but important exceptions show that significant gains in life expectancy can be made even at modest incomes. Sri Lanka ($400 per capita) enjoys a life expectancy of 70 years, as high as that in the Republic of Korea ($2,690), Venezuela ($3,230) and the United Arab Emirates ($15,830). Rapid advances in health and nutrition made these exceptional gains possible.

Until the mid-1970s the average life expectancy in low-income countries was increasing three times faster than that in the middle- and high-income countries, but since then the increase has been only slightly faster. As a result, the life expectancy gap between least developed countries and the developing countries as a whole has widened from seven years to 12 years.

FIGURE 2.2
**Life expectancy trends**

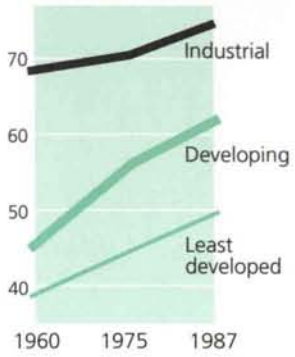



TABLE 2.1
**Life expectancy, 1960-87**

| | Annual rate of reduction in shortfall (%) 1960-87 | | Life expectancy (years) 1987 |
|---|---|---|---|
| *Fastest progress* | | *Highest life expectancy* | |
| Hong Kong | 4.99 | Hong Kong | 76 |
| Costa Rica | 4.55 | Costa Rica | 75 |
| China | 4.33 | Jamaica | 74 |
| United Arab Emirates | 4.06 | Singapore | 73 |
| Jamaica | 4.00 | Kuwait | 73 |
| Kuwait | 3.93 | Panama | 72 |
| Chile | 3.70 | Chile | 72 |
| Malaysia | 3.48 | Uruguay | 71 |
| Korea, Rep. | 3.43 | United Arab Emirates | 71 |
| Panama | 3.38 | Sri Lanka | 71 |
| *Slowest progress, among countries with a life expectancy of less than 60 years* | | *Lowest life expectancy* | |
| | | Sierra Leone | 42 |
| Ethiopia | 0.52 | Ethiopia | 42 |
| Paraguay | 0.78 | Afghanistan | 42 |
| Rwanda | 0.79 | Guinea | 43 |
| Kampuchea, Dem. | 0.80 | Mali | 45 |
| Afghanistan | 0.81 | Angola | 45 |
| Sierra Leone | 0.84 | Niger | 45 |
| Burundi | 0.85 | Somalia | 46 |
| Guinea | 0.88 | Central African Rep. | 46 |
| Central African Rep. | 0.90 | Chad | 46 |
| Mali | 0.91 | | |

| | | 1960 | 1987 |
|---|---|---|---|
| South | 2.33 | South | 46 | 62 |
| North | 2.22 | North | 69 | 74 |
| | | South as % of North | 67 | 84 |

FIGURE 2.3
**Infant mortality trends**

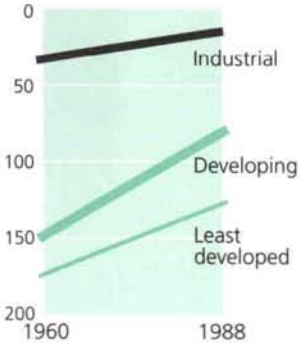


TABLE 2.2
**Infant mortality rate, 1960-88**

| | Annual rate of reduction in shortfall (%) 1960-88 | | Infant mortality rate (per 1,000 live births) 1988 |
|---|---|---|---|
| *Fastest progress* | | *Lowest infant mortality rate* | |
| Chile | 6.20 | Hong Kong | 8 |
| United Arab Emirates | 6.09 | Singapore | 9 |
| Hong Kong | 5.91 | Costa Rica | 18 |
| Oman | 5.81 | Jamaica | 18 |
| China | 5.48 | Kuwait | 19 |
| Kuwait | 5.37 | Chile | 19 |
| Costa Rica | 5.35 | Trinidad and Tobago | 20 |
| Singapore | 4.83 | Mauritius | 22 |
| Korea, Rep. | 4.42 | Panama | 23 |
| Jamaica | 4.32 | Malaysia | 24 |
| *Slowest progress* | | *Highest infant mortality rate* | |
| Mozambique | 0.35 | Mozambique | 172 |
| Ethiopia | 0.48 | Angola | 172 |
| Kampuchea, Dem. | 0.50 | Afghanistan | 171 |
| Rwanda | 0.67 | Mali | 168 |
| Angola | 0.68 | Sierra Leone | 153 |
| Mali | 0.79 | Ethiopia | 153 |
| Afghanistan | 0.81 | Malawi | 149 |
| Uganda | 0.94 | Guinea | 146 |
| Bangladesh | 0.99 | Burkina Faso | 137 |
| Somalia | 1.03 | Niger | 134 |
| South | 2.18 | | 1960 1988 |
| North | 3.08 | South | 150 81 |
| | | North | 36 15 |
| | | South as % of North (Survival) | 88 93 |

TABLE 2.3
**Adult literacy rate, 1970-85**

| | Annual rate of reduction in shortfall (%) 1970-85 | | Adult literacy rate (%) 1985 |
|---|---|---|---|
| *Fastest progress* | | *Highest literacy rate* | |
| Iraq | 11.26 | Chile | 98 |
| Chile | 10.74 | Trinidad and Tobago | 96 |
| Mexico | 6.29 | Argentina | 96 |
| Thailand | 5.48 | Uruguay | 95 |
| Jordan | 4.86 | Costa Rica | 93 |
| Botswana | 4.70 | Korea, Rep. | 93 |
| Trinidad and Tobago | 4.52 | Thailand | 91 |
| Zambia | 4.48 | Mexico | 90 |
| Peru | 4.41 | Panama | 89 |
| Venezuela | 4.27 | Iraq | 89 |
| *Slowest progress, among countries with an adult literacy rate of less than 50%* | | *Lowest literacy rate* | |
| | | Somalia | 12 |
| Burkina Faso | 0.42 | Burkina Faso | 14 |
| Sudan | 0.54 | Niger | 14 |
| Somalia | 0.67 | Mali | 17 |
| Mali | 0.73 | Mauritania | 17 |
| Niger | 0.73 | Sudan | 23 |
| Bangladesh | 0.84 | Afghanistan | 24 |
| Pakistan | 0.84 | Yemen Arab Rep. | 25 |
| Benin | 0.94 | Bhutan | 25 |
| India | 0.97 | Nepal | 26 |
| Nepal | 1.07 | | |
| | | | 1970 1985 |
| South | 2.33 | South | 43 60 |
| North | .. | North | .. .. |
| | | South as % of North | .. .. |

Progress in reducing the deaths of children under five, especially infants, has contributed greatly to higher life expectancy. Developing countries reduced their infant (under age one) mortality rate from nearly 200 deaths per 1,000 births in 1960 to 79 in 1988 — and their child (under five) mortality rate from 243 deaths per thousand to 121.

Some countries have done particularly well, often despite modest incomes. Jamaica's child mortality rate was 22 in 1988, compared with 85 in Brazil, a country with more than twice the per capita income of Jamaica. Similarly, Mauritius has the lowest infant and child mortality rates in Africa — having reduced the deaths of children under five from 104 per thousand to 29 since 1960, a performance much better than that of countries at considerably higher per capita incomes, such as Gabon and South Africa. Some developing countries with the lowest infant mortality rates in 1988 — Hong Kong, Singapore, Costa Rica, Kuwait and Chile — are also among the countries that reduced their infant mortality rates fastest between 1960 and 1988.

*Literacy*

Rapid improvements in education have sharply increased the ability of people in developing countries to read and write. The literacy rate for men rose from 53% in 1970 to 71% in the first half of the 1980s. Although the female literacy rate was still only 50% in 1985, enrolment rates for girls have been increasing far more rapidly than those for boys, an encouraging sign.

Several developing countries already have adult literacy rates above 90%, comparable to the rates in many industrial nations. Despite such successes, some of the most populous countries, such as India, Bangladesh, and Pakistan, have been extremely slow in reducing widespread illiteracy.

Sub-Saharan Africa has witnessed especially fast progress in adult literacy, but since it started from a very low point, its average literacy rate of 48% in 1985 was still far below the average of 60% for the developing world. Low-income Kenya made spectacular progress in extending universal primary education and raised its literacy rate from 32% in 1970 to 60% in 1985.

Literacy rates in Latin America continue to be well ahead of those for all other developing countries, having risen from 72% in 1970 to 83% in 1985. Asia's literacy rates closely follow the developing country average. They have moved from 41% to 59%. Holding down the region's average are four South Asian countries: Bangladesh (33%), Pakistan (30%), Nepal (26%) and Afghanistan (24%). South Asia's literacy rate was only 41% in 1985 — the lowest of all the regional rates.

The least developed countries have an average literacy rate of only 37%. As with other human development indicators, the disparity is growing between their performance and that of the developing countries as a whole. Their literacy gap widened from 18 percentage points in 1970 to 23 percentage points in 1985.

The number of illiterate people in the developing world, just under 900 million in 1985, may well reach a billion by the end of the century. Three-quarters of them live in the five most populous Asian countries: India, China, Pakistan, Bangladesh and Indonesia. Any attack on global illiteracy will thus need to concentrate on these countries.

*Income*

The growth of per capita income, one of the critical elements in improving human development, was 2.9% a year on average for all developing regions between 1965 and 1980. This trend broke sharply in the 1980s. Sub-Saharan Africa's per capita income grew by only 1.6% a year between 1965 and 1980, but it has since been declining by 2.4% a year. Latin America, because of persistent debt problems, moved sharply from 3.8% annual growth in per capita income in 1965-80 to an annual decline of 0.7% in the 1980s.

For human development, the distribution of GNP is as important as the growth of GNP. One measure of the distribution of income is the Gini coefficient, which cap-

FIGURE 2.4
**Adult literacy trends**

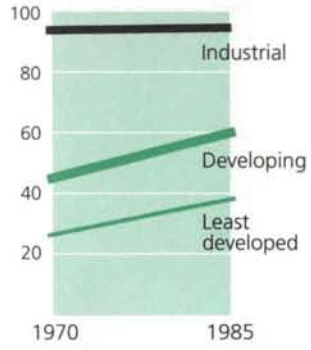



FIGURE 2.5
**GNP per capita trends**

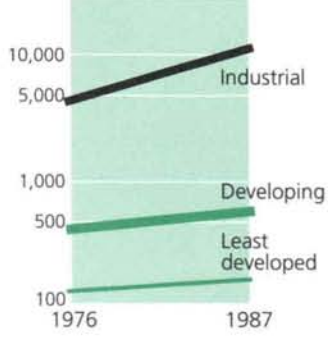
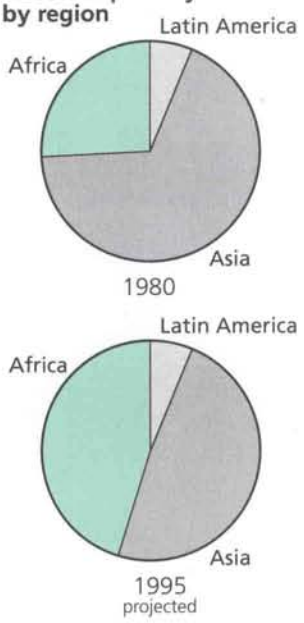


FIGURE 2.6
**Absolute poverty by region**




tures disparities in the percentages of income that each 1% (percentile) of the population receives. If each percentile receives 1% of the income, there is no disparity, and the Gini coefficient is zero. If one percentile receives all the income, there is maximum disparity, and the Gini coefficient is 1. In nine of the 28 developing countries for which the Gini coefficient is available, it is 0.50 or higher, showing that a small part of the population in these countries is getting a very large part of the income.

Another indicator of inequality is the per capita income of the richest 20% of the population compared with that of the poorest 20%. In 12 of the 23 developing countries where such a comparison is available, the income of the richest group was 15 times or more that of the poorest group.

Yet another distributional indicator in predominantly agricultural economies is the concentration of land, which is highly skewed in Latin America. Of 17 countries surveyed, 10 show land concentration indices (Gini coefficients) above 0.8, and five between 0.7 and 0.8. The FAO estimates that about 30 million agricultural households have no land and about 138 million are almost landless, two-thirds of them in Asia.

Most poverty estimates for developing countries use the income needed to meet minimum food needs and thus measure absolute poverty (see technical note 2). Country data are sparse, however, and not always comparable. The available data reveal an overall reduction in the *percentage* of people living in absolute poverty between 1970 and 1985. But owing to population growth, the *absolute number* of poor increased by about a fifth. In 1985 more than a billion people in the Third World were trapped in absolute poverty (box 2.1).

In Latin America more than 110 million people, about 40% of the population, lived in poverty in 1970, a quarter of them in extreme poverty. Fifteen years later, nearly 150 million people, more than a third of the population, were still poor, largely as a result of the economic stagnation in the 1980s. Poverty is so widespread in Latin America, despite its high average income, because of inadequate distribution of income in many countries. Brazil's GNP per capita was $2,020 in 1987, but the poorest 40% of Brazilians received only 7% of the household income. The top 2% of landowners control 60% of the arable land, while the bottom 70% of rural households are landless or nearly landless.

For Africa the ILO estimates that the number of absolute poor rose in the five years between 1980 and 1985 to more than 270 million, about half the total population. If nothing is done to reverse this ominous trend, nearly 400 million people will be living in extreme poverty in Africa by 1995.

In Asia the percentage of poor people is decreasing, but the greatest number of the world's poor, three-quarters of a billion people, still live there. Poverty is extensive in Bangladesh (where more than 80% of the people are poor), Nepal, India and the Lao People's Democratic Republic. The 1980s have been especially harsh for some countries: in Sri Lanka and Bangladesh, the poorest income groups had their shares of household income fall. Some East and Southeast Asian economies have nevertheless made tremendous progress in alleviating poverty.

BOX 2.1

### Who the poor are

The renewed concern about human deprivation in recent years has generated a growing body of research on poverty. Here is a summary of some of the salient facts.

First, the poor are not a homogeneous group. The *chronic poor* are at the margin of society and constantly suffering from extreme deprivation. The *borderline poor* are occasionally poor, such as the seasonally unemployed. The *newly poor* are direct victims of structural adjustment of the 1980s, such as retrenched civil servants and industrial workers.

Second, over 1 billion people live in absolute poverty in the Third World. Asia has 64% of the developing countries' people in absolute poverty, Africa 24% and Latin America and the Caribbean 12%. Poverty is growing fastest in Africa, with the number of absolute poor having increased by about two-thirds between 1970 and 1985.

Third, three-quarters of the developing countries' poor people live in rural areas. There is, however, a recent trend towards the urbanisation of poverty, owing to the rapid increase in urban slums and squatter settlements, expanding by about 7% a year.

Fourth, there is a close link between poverty and the environment. About three-quarters of the developing countries' poor people are clustered in ecologically fragile areas, with low agricultural potential. Owing to a lack of employment and income-earning opportunities outside agriculture, environmental degradation and poverty continuously reinforce each other.

Fifth, poverty has a decided gender bias. A large proportion of poor households are headed by women, especially in rural Africa and in the urban slums of Latin America. Female members of a poor household are often worse off than male members because of gender-based differences in the distribution of food and other entitlements within the family. In Africa women produce 75% of the food — yet they suffer greater deprivation than men.

Poverty is by no means a problem of the developing countries alone, nor can consistent rates of economic growth guarantee its alleviation. In the United States, after 200 years of economic progress, nearly 32 million people, about 13% of the population, are still below the official poverty line.

*Access to basic goods and services*

The extent to which people can improve their capabilities depends largely on the access that they have to basic goods and services.

*Food*. There has been a general global improvement in food production and calorie supplies. The daily supply of calories in the developing world improved from 90% of total requirements in 1965 to 107% in 1985. Confirming this evidence, food production data show a roughly 20% increase in average calorie supplies per person between 1965 and 1985.

Countries having the most urgent need for food show the slowest progress. For the poorest countries, the daily per capita calorie supply increased only from 87% of the total requirements to 89% between 1965 and 1985.

Regional disparities in daily calorie supplies are stark. Sixteen African countries, of the 34 having data, recorded declines in their supply of calories per capita, while Gabon, Niger and Mauritius had theirs increase by 15% or more. In Latin America, the disparities are similar. The best progress was in the Middle East and in Asia where the per capita calorie supplies went up by 30% and 23%, respectively.

Estimates of world hunger vary. According to the World Food Council, more than half a billion people were hungry in the mid-1980s. The World Bank, in a study of 87 developing countries with 2.1 billion people, put the number of undernourished people — whose diet does not provide them with enough calories for an active working life — at 730 million in 1980. The figure is growing constantly, with as many as eight million people said to have joined the ranks of the hungry each year during the first half of the 1980s. Hunger today may be stunting the lives of as many as 800 million people in the Third World.

FIGURE 2.7
**Nutrition trends**

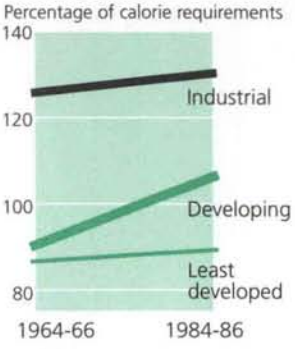



TABLE 2.4
**Access to safe water, 1975-86**

| | Annual rate of reduction in shortfall (%) 1975-86 | | Percentage with access to safe water 1986 |
|---|---|---|---|
| *Fastest progress* | | *Most access* | |
| Saudi Arabia | 20.22 | Mauritius | 100 |
| Chile | 13.61 | Singapore | 100 |
| Colombia | 12.78 | Trinidad and Tobago | 98 |
| Malaysia | 12.09 | Saudi Arabia | 97 |
| Jamaica | 10.76 | Jamaica | 96 |
| Trinidad and Tobago | 10.76 | Jordan | 96 |
| Costa Rica | 9.80 | Chile | 94 |
| Iraq | 8.37 | Lebanon | 93 |
| Burkina Faso | 7.19 | Colombia | 92 |
| Thailand | 6.45 | Costa Rica | 91 |
| *Slowest progress* | | *Least access* | |
| Rwanda | -4.14 | Kampuchea, Dem. | 3 |
| Algeria | -3.05 | Ethiopia | 16 |
| Argentina | -2.37 | Mozambique | 16 |
| Congo | -2.23 | Mali | 17 |
| Uganda | -1.91 | Guinea | 19 |
| Bangladesh | -1.88 | Côte d'Ivoire | 19 |
| Somalia | -0.57 | Uganda | 20 |
| El Salvador | -0.19 | Afghanistan | 21 |
| Guatemala | -0.15 | Sudan | 21 |
| Nicaragua | 0.52 | Congo | 21 |

| | | 1975 | 1986 |
|---|---|---|---|
| South | 3.29 | South | 35 | 55 |
| North | .. | North | .. | .. |
| | | South as % of North | .. | .. |

FIGURE 2.8
**Access to health services, 1986**

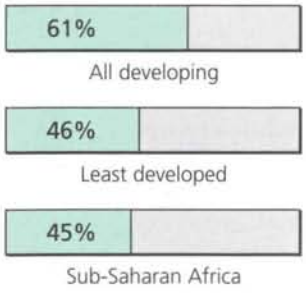



FIGURE 2.9
**Access to safe water trends**

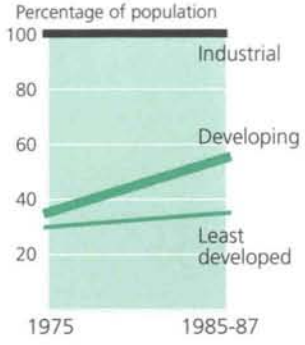
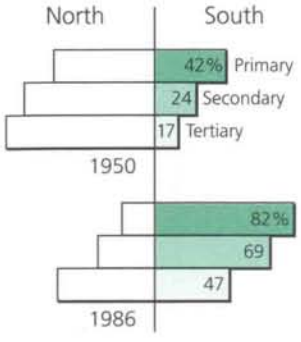



FIGURE 2.10
**North-South distribution of school enrolment**




Two-thirds of those hungry in the developing countries live in Asia, and a quarter in Africa. Mirroring this distribution is the number of low-birth-weight infants in different regions, with Asian countries having some of the highest figures.

A major challenge for the 1990s is thus to ensure that food production increases rapidly, particularly in Africa, and that food is well distributed — supplemented where necessary by targetted nutritional programmes for the poorest and most vulnerable groups.

*Health services*. Ready and affordable access to health services is vital for human development. Most countries collect data on the percentage of people with easy access to health services and on the number of doctors and nurses. But these data do not mean that health services are actually available to people. Doctors may be concentrated in urban areas, possibly specialising in expensive tertiary medicine. People may be close to health services but unable to afford them. Despite the current limitations of available data, some broad conclusions are possible.

Several developing countries came close to the objective of primary health care for all during the 1980s. Many of them also stand out in life expectancy — for example, the Republic of Korea, Costa Rica, Jamaica, Tunisia and Jordan. On the average, however, only 61% of the people in developing countries have access to primary health care services today. For the least developed countries and Sub-Saharan Africa, the corresponding figures are 46% and 45%, respectively.

Access to health care, according to every available measure, is worst in Africa. In Latin America, which has the most doctors and nurses per person in the developing world, only 61% of the people have access to health services, well below the averages for Asia, North Africa and the Middle East.

Exemplifying the considerable progress in the Middle East and North Africa, Kuwait now has more doctors per person than Switzerland. But Kuwait's infant mortality rate is still four times that in Switzerland, reinforcing the argument that the availability of doctors is no guarantee of good health.

*Water and sanitation*. Progress in water and sanitation has generally been much slower than that in health, and it has been slower in sanitation than in water. More than half the people in developing countries had access to safe water in 1986, up from 35% in 1975. In the best-performing countries, practically every person has access to safe water. For the least developed countries, however, the rise was a mere four percentage points: only a third of their people have a source of potable water within reach.

Latin America has made good general progress, with nearly three-quarters of the people there having access to safe water in 1980-87. Chile and Trinidad have reached developed country standards.

Progress in access to safe water has also been impressive in the Middle East and North Africa. Several countries there report that more than 90% of their people have access to safe water, and only in Sudan and the Yemen Arab Republic do fewer than half the people have access.

Asia made good progress between 1975 and 1985, increasing the access to safe water to more than half from less than a third of the population. But in Bangladesh the access has declined by 10 percentage points since 1975.

Africa shows the least progress. In a third of the countries having current data, the access to safe water declined, and in eight African countries fewer than a fifth of the people have access to safe water.

For sanitation, about a third of the South's population had access to proper facilities in the second half of the 1980s.

*Education*. The enrolment gains have been impressive in most developing countries, despite their rapid population growth. Well over 80% of the children of primary school age were enrolled in primary schools in 1987, and several developing countries are close to the goal of universal primary enrolment.

The progress has been considerable in every region. Despite stagnant economies and rapid population growth, half the children of primary and secondary school age in Africa now attend school. Asia, the Middle East and North Africa also show steadily

rising trends, with net primary school enrolment ratios of well over 80% for males. Further progress has been held back by low enrolments of females, an imbalance that future education programmes must redress. In Latin America and the Caribbean, the net primary school enrolment ratio reached 75% in 1985, with equal participation by boys and girls.

The experience of developing countries with secondary and tertiary education has been varied. In East and Southeast Asia, secondary enrolment ratios in the newly industrialising countries rose to 90% for both females and males. Tertiary enrolments also increased considerably. Some Latin American countries surpass even the Asian newly industrialising countries — and even some of the old industrial countries — in tertiary enrolment. By contrast, tertiary enrolment in the least developed countries is 1% for females and 4% for males, showing how much they have to catch up during the next few decades.

The global distribution of basic education has changed radically since 1960. The South now has more than four times as many students in primary education as the North (480 million compared with 105 million) and about twice as many secondary-level students (190 million compared with 87 million). But the South still has to catch up in tertiary education — and in science and technology. It also has to improve the quality and relevance of students' knowledge, for which part of the groundwork has been laid in the past three decades.

*More people sharing scarce resources*

Life has become more liveable for most of the world's people, with millions finding access to improved goods and services. Disappointing, however, is the equally staggering number of people suffering severe deprivation (box 2.2 on p. 27). This does not mean, however, that development has failed. It means that population growth has outpaced part of development's success.

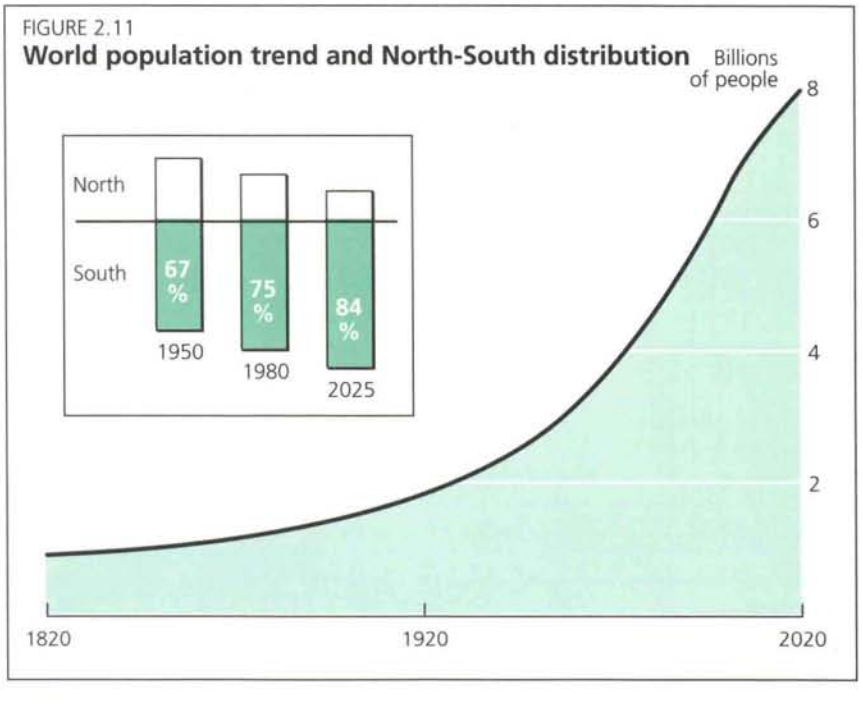
Two billion people have joined the world's population since 1960, bringing the total to more than 5 billion people today. Most of the population growth has occurred in developing countries, where the population has doubled, and this trend is likely to continue for decades.

The developing countries' overall population growth is expected to decline from 2.3% a year between 1960 and 1988 to 2.0% a year between 1988 and 2000. But some parts of the world will not achieve even this modest slowdown in growth — Africa's population is projected to continue growth by 3.1% a year between now and 2000, and the least developed countries' population, by 2.8% a year. The developing countries' share of world population, now 77%, is projected to rise to 80% by 2000 and 84% by 2025.

For most developing countries, human development thus poses a triple challenge. They have *to expand the development opportunities for a growing number of people.* They have *to upgrade living standards.* And they often have *to achieve more with less* — to meet the first two challenges with stagnating or even declining resources.

Between 1980 and 1987 the developing countries' share in world GDP fell almost two percentage points (from 18.6% to 16.8%), while their share in world population moved up one percentage point (from 74.5% to 75.6%). The combined impact of these changes proved difficult for them to accommodate.

FIGURE 2.11
**World population trend and North-South distribution**



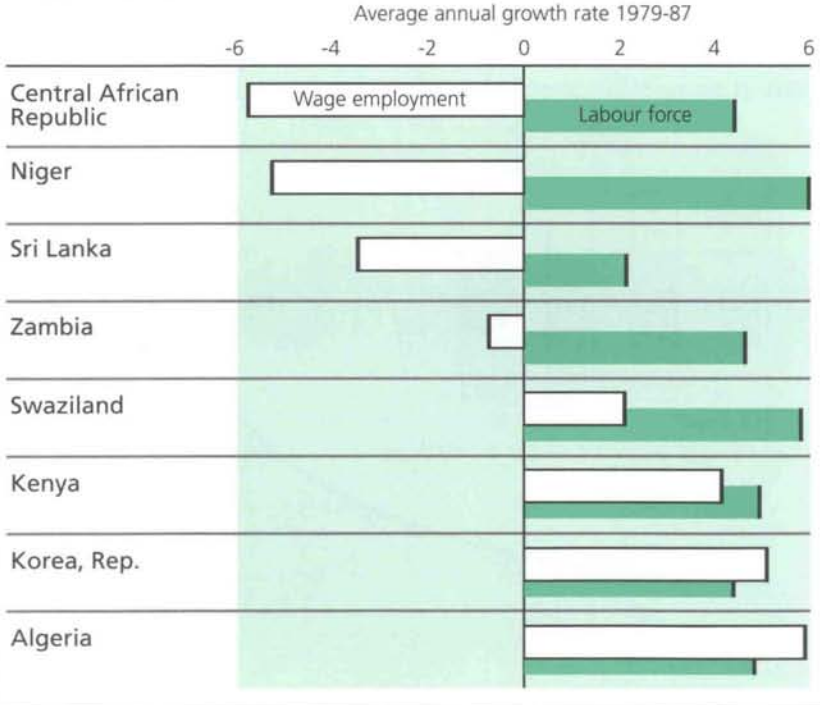
The developing countries' decline in income must be halted to avoid the growing risk of sharp reversals in human development. Early solution of the debt crisis and better opportunities for trade will be as necessary as stronger efforts by the developing countries to improve their economic performance with scarce resources.

## Using human capabilities

Skilled, healthy and well-educated people are in a better position than others to take their lives into their own hands. They are generally more likely to find employment and earn better wages. They have better access to information, such as that gained through agricultural or business training, and are thus more likely to succeed as farmers or entrepreneurs. The educated can also contribute more to the advancement of culture, politics, science and technology. They are more valuable to society and better equipped to help themselves.

The use of human capabilities, as conceptualized here, encompasses the use people decide to make of their abilities as well as their usefulness to society.

FIGURE 2.12
**Wage employment and labour force outside agriculture**




*Employment*

More than 900 million people have joined the developing countries' labour force in the past three decades. High population growth was not the only reason. The ranks of the labour force were increased by women seeking jobs and by poorer families trying to increase the number of income earners in the family. During the 1990s another 400 million are likely to join the labour force.

Economic growth has failed to provide enough employment opportunities for the job-seekers of the last three decades. Reliable data on open unemployment do not exist, but it is common knowledge that unemployment and underemployment are extensive in many developing countries.

The 1980s saw rapid rises in informal sector employment. In Africa the informal sector accommodated about 75% of the new entrants into the labour force between 1980 and 1985, and the formal sector only 6%. In Latin America between 1980 and 1987, the informal sector absorbed 56% of the new workers.

Governments have long ignored the informal sector, but that is beginning to change. It is increasingly being realised that the informal sector needs active political and economic support. It is, after all, absorbing the bulk of new workers, particularly women, youth and the poor.

The fuller use of human capabilities requires sustained economic growth and considerable investment in human beings. The returns from such investment are extremely high. A World Bank study showed private returns to primary education as high as 43% in Africa, 31% in Asia and 32% in Latin America. For developing countries as a whole, average social returns for every level of education exceed 10% to 15%. Differences in technical and general education accounted for about a third of the differences in agricultural productivity in the 1960s in the United States and a sample of developing countries. The special returns to female education are even higher, in terms of reduced fertility, lower population growth, reduced child mortality, reduced school dropout rates and improved family nutrition.

BOX 2.2

## Balance sheet of human development

| HUMAN PROGRESS | HUMAN DEPRIVATION |
|---|---|
| **Life expectancy** | |
| • Average life expectancy in the South increased by a third during 1960-87 and is now 80% of the North's average. | • Average life expectancy in the South is still 12 years shorter than that in the North. |
| **Education** | |
| • The South now has more than five times as many students in primary education as the North, 480 million compared with 105 million.<br>• The South has 1.4 billion literate people, compared with nearly one billion in the North.<br>• Literacy rates in the South increased from 43% in 1970 to 60% in 1985. | • There still are about 100 million children of primary-school age in the South not attending school.<br>• Nearly 900 million adults in the South are illiterate.<br>• Literacy rates are still only 41% in South Asia and 48% in Sub-Saharan Africa. |
| **Income** | |
| • Average per capita income in developing countries increased by nearly 3% a year between 1965 and 1980. | • More than a billion people still live in absolute poverty.<br>• Per capita income in the 1980s declined by 2.4% a year in Sub-Saharan Africa and 0.7% a year in Latin America. |
| **Health** | |
| • More than 60% of the population of the developing countries has access to health services today.<br>• More than 2 billion people now have access to safe, potable water. | • 1.5 billion people are still deprived of primary health care.<br>• 1.75 billion people still have no access to a safe source of water. |
| **Children's health** | |
| • Child (under five) mortality rates were halved between 1960 and 1988.<br>• The coverage of child immunisation increased sharply during the 1980s, from 30% to 70%, saving an estimated 1.5 million lives annually. | • 14 million children still die each year before reaching their fifth birthday.<br>• Nearly 3 million children die each year from immunisable diseases. |
| **Food and nutrition** | |
| • The per capita average calorie supply increased by 20% between 1965 and 1985.<br>• Average calorie supplies improved from 90% of total requirements in 1965 to 107% in 1985. | • A sixth of the people in the South still go hungry every day.<br>• 150 million children under five (one in every three) suffer from serious malnutrition. |
| **Sanitation** | |
| • 1.3 billion people have access to adequate sanitary facilities. | • Nearly 3 billion people still live without adequate sanitation. |
| **Women** | |
| • School enrolment rates for girls have been increased more than twice as fast as those for boys. | • The female literacy rate in the developing countries is still only two-thirds that of males.<br>• The South's maternal mortality rate is 12 times that of the North's. |

*In greater numbers than ever before, people are moving across boundaries and continents*

Skill formation, in addition to general education, promotes more productive uses of human capabilities. Cultivators in the Republic of Korea, Malaysia and Thailand — using modern technology — produced 3% more output for every additional year of schooling they had received. And the higher level of education of farmers in the Indian Punjab explains in part why their productivity is higher than that of farmers in the Pakistani Punjab. Investment in human capital thus increases people's productivity and enhances the chances of their employment — by raising the *potential* for future economic growth. Of course, if education does not create the skills demanded by society, it can lead to educated unemployment and considerable waste of human potential.

*Migration*

In greater numbers than ever before, people are moving across boundaries and continents in search of new opportunities — both economic and political. Expanded transport systems and communications networks have encouraged more and more people to leave their countries and settle elsewhere. They are more aware than previously of their deprivation — more aware of how their lives differ from those of people in other countries. And this drives them to search for the seemingly better life and greater opportunities across the border. If they had seen better opportunities at home, they might have preferred to stay. For many migrants the economic decision to leave is voluntary. For political and environmental refugees, however, there seldom is a choice.

Often well qualified, some migrants are highly trained specialists. They often leave for higher salaries and more job satisfaction. Some governments even see advantages in people leaving. Their remittances can be an important source of foreign exchange, helping to improve the balance of payments.

The brain drain hit Africa particularly hard in the 1980s. With a thin layer of qualified personnel to start with, the loss of even a few key specialists has had dramatic consequences. The brain drain from the more populous countries of Asia and from most Latin American countries is generally less dramatic.

In the early 1980s the number of economic migrants stood at around 20 million — and that of illegal migrants, generally less qualified than the officially registered ones, must be at least as high. So, perhaps 40 to 50 million people have moved in hope of a bigger share of the world's development benefits.

The traditional recipients of migrants from developing countries — Canada, Australia, New Zealand, the United States and the European countries — have adopted measures to limit the influx of migrants. The United States granted some 3 million people permanent immigration status in the first half of the 1980s, compared with 2.5 million in the five preceding years. Europe's foreign population has, for about two decades now, been around 10 million. And even in the Middle East region, immigration is stabilising.

South-South migration is growing because of the increasing restrictions on migration to the North and the increasing poverty in developing countries. The main recipients in Africa have been Côte d'Ivoire, Senegal, Ghana and Cameroon. The main countries of origin include such least developed countries as Burkina Faso, Mali, Guinea and Togo. Lesotho and Mozambique continue to be major suppliers of labour to South Africa.

Argentina, Venezuela and Brazil are about the only major recipient countries for economic migrants in Latin America, with the United States continuing to be the main destination by far. The main countries that export labour in the region are Mexico and Colombia.

In Asia the main releasing countries are Bangladesh, India, Pakistan, the Philippines, Thailand and the Republic of Korea — largely to the Arab states and the United States.

*Popular participation and the NGO movement*

Economic migration is one way for people to seek greater involvement in development. Popular participation in community

affairs — economic, social and political — is another way, and in recent years it has gained in importance. Many community and other self-help organisations now assist people in exploiting their collective strength to resolve some of the challenges they face — their need for a road, a health centre, or an irrigation system, for education for their children, or for access to assets and credit.

Added to these community self-help organisations are a large and still growing number of nongovernmental organisations (NGOs) that typically work as intermediaries between people and governments.

Underpinning the NGO movement's growth are private initiatives by concerned citizens and the sponsorship of government. The NGOs' success in shifting the focus of development to people has in many countries moved them into a fully collaborative relationship with the state. Governments are beginning to realise that NGOs — small, flexible and with good local roots and contacts — often are much better suited to carry out the work of development than is a large bureaucratic machine.

One of the NGOs' big successes is in arranging credit for the poor. The poor traditionally stay poor because they have no assets and are seen as unworthy of even the smallest amount of credit. NGOs have changed this by showing that a joint-liability approach — with close contact and communication between debtor and creditor — can help boost repayment rates and open more credit opportunities for the poor within the official credit system. The NGOs have closely supervised, and provided advice to, borrowers — taking on the often very time-consuming functions that banks typically shy away from.

In Peru the Institute for the Development of the Informal Sector has established programmes to help small entrepreneurs and community groups gain access to credit. It provides bank guarantees for participants and arranges the technical and managerial advice and training they need to set up viable businesses.

Another NGO in Bangladesh, the Grameen Bank, provides innovative links between the government, commercial banks and outside donors on the one side, and landless entrepreneurs interested in borrowing but lacking collateral on the other. The Grameen Bank helps the landless organise into groups to secure loans, and most of its clients are women.

Other NGOs mobilising rural savings and making credit available to the rural poor include Rwanda's Banques-populaires, Zimbabwe's Savings Development Foundation, Ghana's Rural Banks and the Philippines' Money Shops (see boxes 4.2 and 4.3 in chapter 4).

The momentum of people's participation during the second half of the 1980s has done far more than prove that people can help themselves. It has contributed to a fundamental rethinking of the relationship between the state and the private sector. Policymakers now recognise that development can benefit from people's initiatives, and that these initiatives must be encouraged rather than stifled.

There is a growing consensus that the state must be strong and effective in creating an enabling framework for people to make their full contribution to development — to expand their capabilities and to put them to use — but that it should not undertake developmental functions that NGOs, entrepreneurs and people at large can carry out better.

*Average improvements conceal considerable inequality between rural and urban areas, between males and females, and between rich and poor*

### Disparities and deprivation within nations

Every country has shared to a varying degree in the human progress over the past 30 years. But average improvements conceal considerable inequality within countries and mask the continuing severe deprivation of many people. The prevailing disparities also show the great potential for improving human development by distributing income better and by aggressively restructuring budget priorities.

This section focusses on the disparities between rural and urban areas, between males and females, and between rich and poor. Again, the lack of appropriate data hinders a systematic review. Use is thus made of special case studies to supplement the available cross-country data.

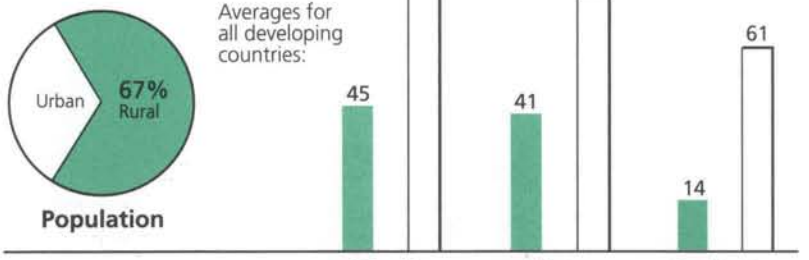
*Rural-urban disparities*

Two-thirds of the people in the developing countries live in rural areas, but in many countries, they receive less than a quarter of the social services for education, health, water and sanitation. For developing countries as a whole, people in urban areas have twice the access to health services and safe water and four times the sanitation services that people have in rural areas.

In many countries, rural-urban disparities reflect the distribution of income and the locus of power. These disparities, often high at lower levels of human development and per capita income, tend to narrow over time. But there are several exceptions to such a generalisation. Argentina has very high rural-urban disparities, despite its relatively high per capita income and human development. Tanzania, by contrast, has a fairly good geographical distribution of social services, even with its low income.

The following examples show how rural areas systematically lag behind urban areas in human development.

FIGURE 2.13
**Rural-urban disparities**
Percentage of population with access to social services




| HIGH DISPARITY | Rural population | Health | | Water | | Sanitation | |
|---|---|---|---|---|---|---|---|
| | | Rural | Urban | Rural | Urban | Rural | Urban |
| Argentina | 14 | 21 | 80 | 17 | 63 | 35 | 75 |
| Bolivia | 50 | 36 | 90 | 13 | 75 | 10 | 33 |
| Mozambique | 76 | 30 | 100 | 9 | 38 | 12 | 53 |
| Pakistan | 69 | 35 | 99 | 27 | 83 | 6 | 51 |
| Somalia | 65 | 15 | 50 | 22 | 58 | 5 | 44 |
| LOW DISPARITY | | | | | | | |
| Algeria | 56 | 80 | 100 | 55 | 85 | 40 | 80 |
| Costa Rica | 48 | 63 | 100 | 83 | 100 | 89 | 99 |
| Honduras | 58 | 65 | 85 | 45 | 56 | 34 | 24 |
| Korea, Rep. | 31 | 86 | 97 | 48 | 90 | 100 | 100 |
| Tanzania | 70 | 72 | 99 | 42 | 90 | 58 | 93 |

- *Infant mortality*. For several Central American countries, infant mortality is generally 30% to 50% higher in rural than in urban areas. Costa Rica, Guatemala and Nicaragua narrowed some of the gap in the 1970s, but other countries have not been able to match urban progress in rural areas.
- *Life expectancy*. Rural Mexicans have a shorter life expectancy (59 years) than their urban counterparts (73 years).
- *Nutrition*. Data on the nutritional status of children in 31 countries show, without exception, higher rates of malnutrition in rural areas, 50% higher on average.
- *Literacy*. For selected countries in Africa and Asia, rural illiteracy rates generally are twice the urban rates — and for women in Latin America the rural rates are three times higher than the urban rates, and for men, four times higher.
- *Health facilities*. Access to health care is better in urban areas than in rural areas in every developing country. In some 20 developing countries the percentage of the population covered by health facilities in urban areas is more than twice that covered in rural areas. Even these figures understate the disparities since rural health facilities usually are simple clinics while urban facilities include hospitals with sophisticated equipment.
- *Water and sanitation facilities.* The rural-urban differences in the provision of water and sanitation are even greater. The coverage of the rural population is on the average less than half that of the urban population. In seven countries the proportion of rural dwellers with access to water was less than a fifth of that in urban areas. In Nepal access to sanitation facilities in urban areas was 17 times that in rural areas, and in Brazil the urban figure was as much as 86 times higher than the rural figure.
- *Income*. In most countries, urban incomes per person run 50% to 100% higher than rural incomes. The differences are particularly large in Africa. In Nigeria the average urban family income in 1978-79 was 4.6 times the rural. In Sierra Leone the average urban income was 4.1 times the agricultural income. And in Mexico urban per capita income was 2.6 times the rural. Rural-urban income differences remain

wide, even after taking into account the differences in the cost of living between rural and urban areas.

To sum up, national data conceal large rural-urban differences, with rural areas performing systematically worse on the basic indicators of human development. Part of the reason is less access to social services, and part is lower income. Moreover, the rural and urban figures hide large dispar- ities within each area. These gaping disparities have major policy implications for restructuring the social spending of governments.

*Female-male disparities*

In most societies, women fare less well than men. As children they have less access to education and sometimes to food and health care. As adults they receive less education and training, work longer hours for lower incomes and have few property rights or none.

Both women and men shared the progress in improving the human condition from 1960 to 1980. In some fields women did even better than men, but substantial inequality remains. During the economic crisis of the 1980s, women had to bear a much greater cost of structural adjustment, and gender disparities tended to widen once again. Moreover, national data usually conceal the true extent of inequality between women and men (box 2.3).

Discrimination against females starts early. In many developing countries more girls than boys die between the ages of one and four, a stark contrast with the industrial countries, where deaths of boys are more than 20% higher than those of girls. And in 30 developing countries the death rates for girls were higher than or equal to death rates for boys, indicating the sociocultural patterns that discriminate against women.

The discrimination takes several forms. Young girls may not get the same health care and nutrition as young boys. In Bangladesh malnutrition was found among 14% of the young girls, compared with 5% of the boys. Families in India's rural Punjab spend more than twice as much on the medical care of male infants as on that of female infants.

The same neglect is evident in exceedingly high maternal mortality rates, mainly because health staff are in attendance for fewer than half the births. Maternal mortality rates were 1,000 or more (per 100,000 live births) in a few countries, and 400 to 1,000 in another 14 countries during 1980-84. In developed countries, maternal mortality rates rarely exceed 20 and are usually less than 10. No other North-South gap in human development is wider than that between maternal mortality rates, a symbol of the neglect of women's health in the Third World.

Gender inequality is reinforced in education. There still are 16 developing countries where female primary school enrolment is less than two-thirds that of males. And 17 developing countries have female secondary enrolments less than half those of males. For the developing world as a whole, the female literacy rate is now three-quarters that of the male. The gap has narrowed slightly in the last three decades, but much progress remains to be made.

The social dividend from female literacy tends to be very high. Higher female literacy is associated with lower infant mortality, better family nutrition, reduced fertility and

FIGURE 2.14
**Female literacy and population growth**

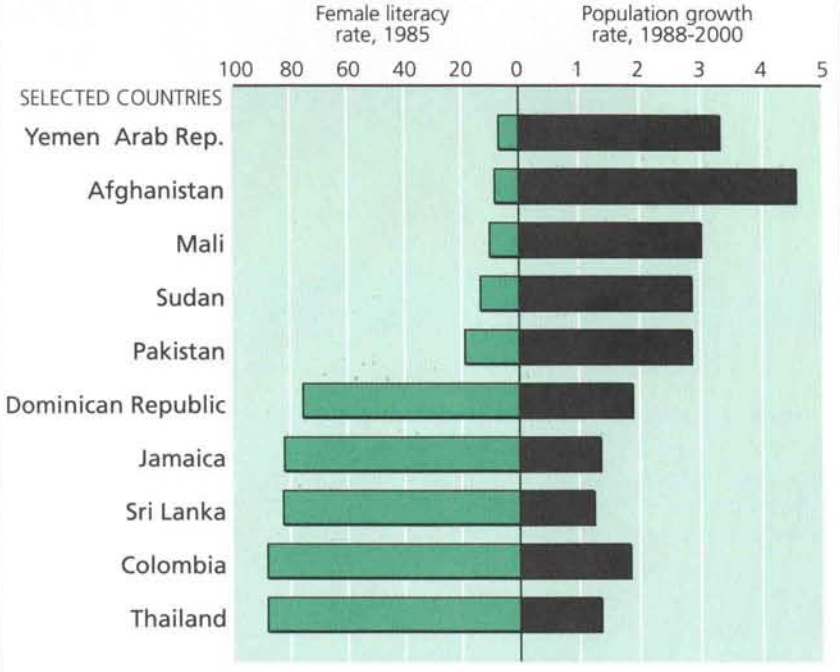
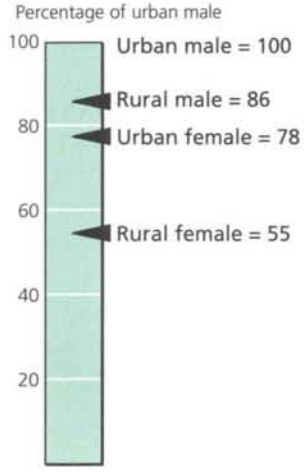


FIGURE 2.15
**Female-male literacy disparities**




lower population growth rates. In Bangladesh child mortality was five times higher for children of mothers with no education than for those with seven or more years of schooling.

Better educated women also have smaller families. Colombian women with the highest education had four fewer children than women who had completed only their primary education. The continuing disparity in male and female education thus inflicts extremely high social and economic costs in the developing world.

Women typically work about 25% longer hours than men: up to 15 hours more a week in rural India and 12 hours more in rural Nepal. But their total remuneration is less because of their lower wage rate and their preponderance in agriculture and the urban informal sector, where pay tends to be less than in the rest of the economy. In urban Tanzania 50% of the women working are in the informal sector, in urban Indonesia 33% and in Peru 33%.

The persistence of female-male gaps in human development offers a challenge and an opportunity to the developing countries — to accelerate their economic and social progress in the 1990s by investing more in women.

In order to monitor progress towards the elimination of existing within-country disparities in human development, it would be desirable to have group and region-specific HDIs. How telling such indices could be is illustrated in technical note 4, which discusses the construction of a gender-specific HDI. Similar indices could be developed to monitor other disparities of special interest in a particular country, whether it be those between various ethnic groups, different geographical areas, rural and urban or rich and poor.

*Disparities between rich and poor*

Income gaps and human development gaps are closely related in most developing countries, which is only natural since income is an important determinant of people's access to social services. In some cases, however, governments have changed this pattern through very active interventions with their social sector budgets. They did this by targetting their social spending and subsidies specifically on the poorer sections of society — and by reducing the appropriation of subsidies by higher income groups and vested power structures.

Two questions are of particular interest here. First, how do different income groups differ in terms of their human development? Second, who benefits from government social expenditures, which in many countries are said to aim at correcting the socioeconomic inequities resulting from the inequalities in the primary distribution of income.

Several studies show that the poor have very unequal access to social services and basic human development. For instance:

- In Brazil life expectancy in 1970 was barely 50 years for the bottom income group and 62 years for those with an income above $400. To put this in perspective, the expected life span of the poor in Brazil was no higher than the average in India, even though Brazil's average per capita income was about eight times that of India.
- In Mexico a person's life expectancy in

BOX 2.3

**Women count — but are not counted**

Much of the work that women do is "invisible" in national accounting and censuses, despite its obvious productive and social worth. The reason is that women are heavily involved in small-scale agriculture, the informal sector and household activities — areas where data are notoriously deficient.

But there is another aspect. Women's work, especially their household work, often is unpaid and therefore unaccounted for — processing food, carrying water, collecting fuel, growing subsistence crops and providing child care. For example, women in Nepalese villages contribute 22% to household money incomes, but when nonmarketed subsistence production is included, their contribution rises to 53%. It is estimated that unpaid household work by women, if properly evaluated, would add a third to global production.

Even when women are remunerated for their work, their contribution is often undervalued. In formal employment, women earn significantly less than men in every country having data. In the informal sector, where most women work, their earnings at times reach only a third (Malaysia) to a half (Latin America) of those of men.

Do women remain invisible in statistics because little value is attached to what they do? Apparently, yes.

Women have shouldered a large part of the adjustment burden of developing countries in the 1980s. To make up for lost family income, they have increased production for home consumption, worked longer hours, slept less and often eaten less — substantial costs of structural adjustment that have gone largely unrecorded.

The low value attached to women's work requires a fundamental remedy: if women's work were more fully accounted for, it would become clear how much women count in development. To do that requires much better gender-specific data on development. There is a need to redesign national censuses, particularly agricultural surveys.

the lowest income decile was 53 years in the early 1980s, 20 years less than the average life expectancy in the top income decile.

- In Colombia infants in poor families are twice as likely to die as infants in the top income decile.
- In rural Punjab child mortality among the landless is 36% higher than among the land-owning classes.
- In a South Indian village the literacy rate in 1989 was 90% for Brahmins and 10% for people at the lower end of the caste hierarchy.
- In Zimbabwe child malnutrition was severe when the average family income was $51, mild at $168, and nonexistent at $230 and above.

Such evidence emphasises the need for careful monitoring of the beneficiaries of government spending to ensure that it reduces rather than perpetuates inequalities.

If the state provides the goods and services essential for human development free or at low cost — as in Sri Lanka in the 1960s and 1970s — it can reduce the handicaps the poor face. But the free or subsidised services may not reach many of the poor. That can happen — as it did in Egypt — where only urban food is subsidised or urban health services are provided. Information about social services may also be more accessible to the wealthier or better educated, who then manage to preempt the major benefit from such services.

Moreover, even free services have a cost. To gain access to health services or to attend school, people have to pay transport costs, and the time taken to use the services has an opportunity cost. That is why very poor families often keep their children out of school, especially at harvest time when farm labour is needed most.

Not enough research has been done on the distribution of social benefits by income group in developing countries, but scattered evidence shows that much social spending often goes for projects and programmes that subsidise the rich more than the poor.

- Hospital spending in Latin America, primarily benefitting the urban nonpoor, ranged from 64% of total central government expenditure on health in Guyana to 100% in El Salvador.
- In the Philippines in the early 1980s, annual subsidies to private hospitals catering to upper-income families exceeded the resources allocated to mass programmes (including malaria eradication and schistosomiasis) and to primary health care.
- In developing countries as a whole, tertiary education covered about 8% of the population but absorbed 73% of the education budget in 1973. The cost per student in tertiary education was 24 times that in primary education.

A major conclusion from all this evidence is that not all government spending works in the interest of the poor and that great care must be taken in structuring social spending to ensure that benefits also flow to them. The very rationale for government intervention crumbles if social expenditures, far from improving the existing income distribution, aggravate it further — an issue that is taken up at length in chapters 3 and 4.

*For more than half a billion poor rural women, there has been little progress over the past 30 years*

Looking at all three types of deprivation, another major conclusion is that *poor rural women* in developing countries suffer the gravest deprivation. Many of them are still illiterate. Their real incomes have not increased and in some parts of the world have even fallen. Their births are still unattended by health personnel, and they face a high risk of death during childbirth. They and their children have almost no access to health care.

There are between 500 million and one billion poor rural women. For them, there has been little progress over the past 30 years.

**Reversibility of human development**

Human progress during the 1960s and 1970s differed greatly from that in the 1980s.

In the late 1970s and early 1980s, very large imbalances had developed in the current account of the balance of payments in many developing countries. The non-oil developing countries had a combined deficit of $74 billion in 1980. Unlike the situation in much of the 1970s, there was no voluntary bank lending to finance the deficits. Voluntary lending dried up because

*It is short-sighted to balance budgets by unbalancing the lives of the people*

the crisis was so widespread, affecting more than two-thirds of the countries of Latin America and Sub-Saharan Africa as well as several Asian countries.

The economies of most developing countries slowed down in the 1980s, except in Asia. Acutely affected by the crisis, they experienced a nearly continuous economic decline, and despite rigorous adjustment efforts, they were still showing severe imbalances at the end of the 1980s.

In 17 Latin American and Caribbean countries, per capita income fell in the 1980s. Average income per person in the region declined 7% between 1980 and 1988, and about 16% if account is taken of the deteriorating terms of trade and the resource outflow. Net investment per capita fell 50% between 1980 and 1985.

In Africa income per person declined more than 25% for the region as a whole, 30% taking into account the deterioration in the terms of trade. GDP did grow faster in 1985-87 than during 1980-84, but that growth was still slower than the growth in population, and incomes per person fell at roughly the same rate in countries with strong reform programmes as in countries with weak or no reform programmes. Investment fell more than 9% a year, and per capita consumption 1% to 2% a year.

Much of Asia, by contrast, was not very seriously affected. Between 1980 and 1986 GDP per capita rose 20% in South Asia and 50% in Southeast and East Asia, though some countries were badly hit, including the Philippines.

Evidence of the effect of these economic changes on social conditions is piecemeal because social data usually are not collected regularly at short intervals, or reported on systematically. Moreover, some social data — such as life expectancy — are generated by extrapolating past trends, until new empirical data, such as that from a population census, establishes a new trend. Few official statistics have thus begun to capture the effects of the 1980s' economic crisis on human development.

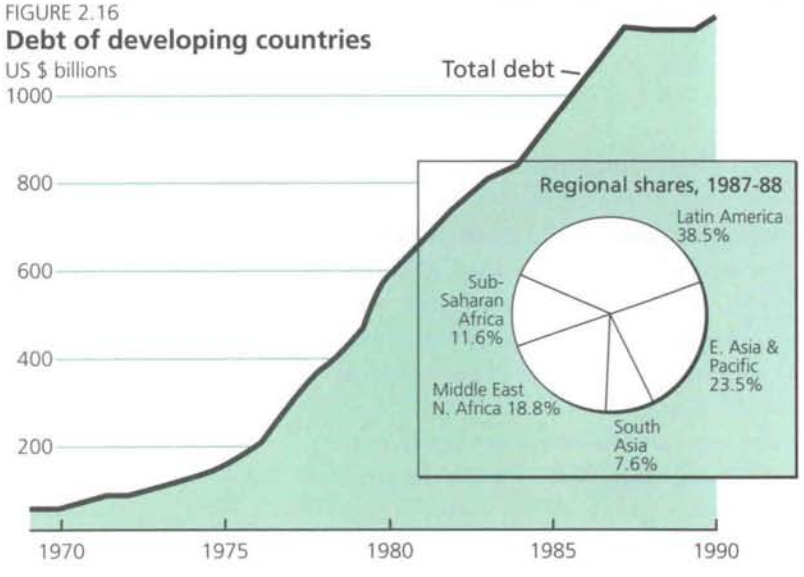
Judging from the piecemeal data that exist, many developing countries have had sharp breaks in their human development trends, and sometimes even reversals. Countries in Africa and Latin America suffered the most adversity.

In seven Latin American countries and six African countries, child malnutrition rose at some time in the 1980s. In two-thirds of the Latin American countries for which data are available, the progress in reducing infant mortality rates slowed or reversed — as it did in 12 of 17 African countries. Many households lost purchasing power and were left with incomes grossly inadequate to meet minimum food needs.

- In Ghana in 1984 even upper-level civil servants could only afford two-thirds of the least-cost diet to meet nutritional needs. A two-wage-earner household receiving the minimum wage could afford less than 10% of such a diet.
- In Uganda in 1984 an average-size urban family needed 4.5 times the minimum wage to meet its minimum food requirements.
- In Dar es Salaam in the mid-1980s, 58% of the women surveyed in low-income households reported that they had been forced to cut down from three meals a day to two, and 61% had reduced their consumption of protein-rich foods.
- In Jamaica in 1986 a family of four needed two to three times the minimum wage to have access to the minimum acceptable nutrition.

In many instances, high inflation, rising food prices, stagnant formal employment

FIGURE 2.16
**Debt of developing countries**



and curtailed government subsidies converged to push household incomes down. Latin America is estimated to have had 4 million fewer new jobs in 1980-85 than it would have had under previous trends — and its unemployment grew more than 6% a year. Africa had an annual increase in unemployment of 10% during the same period.

According to ILO estimates, wage earners have borne the brunt of the economic crisis, with real wages having been cut back severely. In Africa and Latin America, wage cuts of a third to a half were not exceptional. Between 1980 and the mid-1980s, real wages fell 50% in Peru and Bolivia, 30% in Mexico and Guatemala, and 25% in Venezuela. The share of labour income in the region's GNP declined by 25% between 1980 and 1987. In Africa, too, real wages fell more rapidly than income per person during the first half of the 1980s.

Rapid rises in food prices compounded the damage from falling real incomes. In many countries food prices rose faster than other prices because of reduced food subsidies, higher producer prices, decontrolled consumer prices and devalued currencies. Food subsidies fell from 1980 to 1985 in each of 10 countries examined in detail. Food price rises exceeded the general cost of living in five of six UNICEF case studies. And more than half the countries receiving World Bank structural adjustment loans had the availability of food per capita decline as a percentage of requirements from 1980 to 1987.

The declines in government spending on social services generally impaired human development in the 1980s. Social spending was not cut disproportionately more than total spending, but real government spending per person declined in around two-thirds of the countries of Africa and Latin America, in some cases considerably. Madagascar's real social spending per person fell 44% (during 1980-84), Senegal's 48% (1980-85) and Somalia's 62% (1980-86). In Zambia the real value of the drug budget in 1986 was a quarter of that in 1983, and only 10% of the budget was spent because of shortages of foreign exchange. In Bolivia central government health expenditure per person in 1984 was less than 30% of that in 1980.

The worsening of social conditions was far from uniform. Some countries protected the most vulnerable groups from the downward pressures. Zimbabwe, Botswana, Costa Rica, Chile and the Republic of Korea managed to adjust and protect the human condition, but these are countries that have done consistently well in human development (box 2.4). Moreover, many of them have well-established capacities for planning and managing national development.

The countries that protected vulnerable groups during the adjustments of the 1980s did so in a variety of ways.

- Some countries avoided excessively deflationary macroeconomic policies and thus managed to maintain incomes and employment. The Republic of Korea and

BOX 2.4

**Adjustment with a human face in Zimbabwe**

When Zimbabwe became independent in 1980, it launched a series of programmes in health, education and the productive sector to correct some of the large inherited racial inequalities and to improve the position of the poor. But imbalances developed, in part because of external shocks, and the government introduced a series of adjustment measures.

Some of the measures were orthodox: restraining the growth of credit, keeping wage increases below the rate of inflation, reducing subsidies, devaluing the currency and raising interest rates. Others were less orthodox: restraining dividend remittances, continuing import controls and adopting a more expansionary general stance than most policy packages approved by the IMF.

For much of the 1980s Zimbabwe failed to reach agreement with the IMF and adjusted on its own. The period of adjustment also coincided with an acute drought.

The government introduced measures to protect the most vulnerable population segments during the adjustment period.

- Credit and marketing reforms shifted resources to low-income farmers, whose share of credit from the Agricultural Finance Corporation rose from 17% in 1983 to 35% in 1986 and whose share of marketed maize and cotton rose from 10% to 38%.
- Expenditures on basic health and primary education increased rapidly. While the share of defence and administration in total government expenditure fell from 44% in 1980 to 28% in 1984, the share of education and health rose from 22% to 27%. Within the education budget, the share of primary education rose from 38% to 58% over the same period, involving a doubling of real per capita expenditure on primary education. A growing proportion of the rising health budget was devoted to preventive health care.
- Special feeding programmes were introduced, with a drought relief programme and a supplementary feeding programme for undernourished children. More than a quarter million children received food supplements at the peak of the drought.

Because of these efforts, the economic costs of adjustment did not become human costs. The infant mortality rate continued to decline, primary school enrolment rose at a rapid rate, and malnutrition did not rise despite the drought.

*Without some end to the debt crisis, the impressive human achievements recorded so far may soon be lost*

Zimbabwe adopted less deflationary adjustment policies than were typical.

- Some launched special employment schemes to maintain the incomes of low-income households. Chile undertook massive public works programmes, which were at one time employing as much as 13% of the work force. Zimbabwe diverted substantial amounts of credit to smallholder farmers.
- Some directed special nutrition support to the neediest. In Botswana and Chile, infants and children were carefully monitored, and food and other support was supplied as necessary.
- Some protected real expenditures on priority services in the social sector. Zimbabwe greatly increased spending on primary education and primary health care, cutting back on defence. Many countries supported low-cost and high-priority measures despite overall cutbacks in expenditure — and made progress in extending immunisation.

A general feature of the successful countries was their careful and systematic monitoring of human and economic variables. Good and up-to-date statistics on what was happening proved essential for appropriate and timely policy action.

Although many countries maintained their human development levels over this difficult period by redirecting resources towards priority areas — and indeed continued their progress in reducing infant and child mortality rates — it was clear that continuing economic decline would make such efforts increasingly difficult. Despite its economic problems, Jamaica maintained support for human development throughout the 1970s, but stabilisation programmes in the 1980s severely cut social spending, and there has been evidence of halts and even reversals in some human indicators.

Resumed economic growth is thus essential to allow the expansion of incomes, employment and government spending needed for human development in the long run. Without some end to the continuing debt and foreign exchange crisis in much of Africa and Latin America, the impressive human achievements recorded so far may soon be lost.

**De-formation of human development**

Human development is fragile. Economic slowdowns and their consequences — falling income, flagging employment, plunging wages and deep cuts in social spending — can quickly reverse progress.

This fragility is not limited to developing countries or to economic recessions. In the United States the number of homeless people has risen tremendously in the past years. And in the United Kingdom the distribution of income — whether original, disposable or final income — worsened during the 1980s, leading to a deepening of poverty.

Losses of human development gains may stem from the development path a country pursues, for development is far from unidirectional. Technological advancement has given a tremendous impetus to production and eased human life in innumerable ways. But it has also brought industrial pollution. The growing density of the transport network enhanced people's geographical mobility and access to developmental opportunities. It has also entailed environmental degradation.

The point is that development has desirable and undesirable effects. And people must be able to make informed choices about the weight they assign to the pros and cons. Is tobacco-smoking worth the risk of lung cancer? Is high speed on highways worth the deaths and disabilities it costs each year? What are chemical fertilizer's tradeoffs between increased agricultural production and polluted water resources? Such questions have no easy answers.

Many countries have seen more and more lives destroyed by rising crime, drug abuse, environmental pollution, family breakup and political turmoil. And now there is a new major threat to human life — the acquired immune deficiency syndrome (AIDS).

*Development and crime*

The relationship between crime and development is complex. Rapid socioeconomic change — often entailing dramatic consequences for people's lifestyles and the crum-

bling of traditional norms and values, but also sharp economic and social inequities — may lead to an increase in crime. Criminal activity, in turn, can further worsen the societal imbalances by destroying human lives and encouraging drug use. Perhaps worse, it makes people feel vulnerable and insecure, depriving them of dignity and optimism.

Property crime increases with higher levels of development. The relationship for other types of crime is less conclusive, but it is known that the developing countries' reported homicide and assault rates exceed those of developed countries, while the reverse is true for thefts and frauds.

For nine Western European countries the frequency of street crimes more than doubled between 1960 and 1980. From 1975 to 1980 the greatest increase was in drug crimes, which increased more than 10-fold globally, with increases for individual countries between 5% and 400% a year.

Crime apparently pays. Criminals are becoming more technically experienced and better organised, often with vast international operations and connections. The proceeds from organised criminal activity amount to billions of dollars, outstripping the GNP of many countries. But crime also imposes costs, for the frequent response to growing crime has been a large increase in police forces, in both developed and developing countries, syphoning off resources that could otherwise be available for development purposes.

*The drug trade*

The use of illicit drugs threatens the health and well-being of many millions of people in both developed and developing countries. Possibly even greater harm comes from production and marketing. The enormous illegal profits in producing and using countries criminalises society, corrupts law enforcers and brings political violence to countries and military conflicts between them.

More than 2 million people are directly employed in drug production and trade, which contributes much to the economies of drug-producing nations. Returns per hectare from growing narcotic crops in Latin America are 10 to 20 times those from legal crops. Yet the producers receive only a fraction of the street price, which is often as much as 120 times the production cost.

Drug abuse and trafficking defy measurement, but they are known to be increasing sharply. The cocaine seized between 1980 and 1985 increased more than fourfold, and the heroin sevenfold. WHO estimates that 48 million people worldwide regularly used illicit drugs in 1987 — among them 30 million cannabis users, 1.6 million coca-leaf chewers, 1.7 million opium addicts and 0.7 million heroin addicts. The value of trade in illegal drugs exceeds that of world trade in oil and is surpassed only by the trade in arms.

*The value of trade in illegal drugs exceeds that of trade in oil and is surpassed only by the trade in arms*

Drug users are a third less productive than nonusers, three times more likely to be involved in accidents on the job and twice as often absent from work. Drug abuse during pregnancy means more miscarriages and infant deaths — and lower birth weights and mental achievements for the children that survive, with the babies of drug abusers often born as addicts. Intravenous drug takers also risk and promote the spread of AIDS.

Drug abuse imposes growing costs on drug users and their families, on governments for prevention, rehabilitation, medical and enforcement programmes, and on society for lost output and heightened violence. The United States alone spent $2.5 billion in 1988 for law enforcement against drug production and trafficking. Falling drug prices suggest, however, that these efforts are far from effective.

Attempts to control drugs have failed because the incentives for producers and traffickers and the demand pressures from consumers are far too strong. So, the battle continues to be lost at very heavy costs.

TABLE 2.5
**Drugs seized worldwide, 1980 and 1985**
(tons)

| Drug | 1980 | 1985 |
|---|---|---|
| Cannabis herb | 5,806 | 6,434 |
| Cannabis resin | 172 | 360 |
| Cannabis liquid | 1 | 1 |
| Cocaine | 12 | 56 |
| Heroin | 2 | 14 |
| Opium | 52 | 41 |

*Industrial pollution is foreclosing many opportunities for humankind*

*Environmental degradation*

People should be able to live in a safe environment with clean water, food and air — and without undue health hazards from industrial wastes and other environmental degradation. The environmental hazards, already large, have been increasing over the past decades. These include health risks from the earth's warming, from the damage to the three-millimeter layer of ozone and from industrial pollution and environmental disasters.

Some of the startling environmental disasters of the 1980s were:

- The leak from a pesticides factory in Bhopal, killing 2,500 people and blinding and injuring more than 200,000.
- The explosion of liquid gas tanks in Mexico City, killing 1,000 and making thousands homeless.
- The breakdown of the Chernobyl nuclear reactor, spreading radioactivity throughout Europe and greatly increasing future cancer risks.
- The warehouse fire in Switzerland that allowed chemicals, solvents and mercury to flow into the Rhine, killing millions of fish and threatening drinking water in Germany and the Netherlands.
- The 75,000 active industrial landfills in the United States, most of them unlined, allowing contaminants to leak into groundwater.

Such industrial pollution is accelerating the extinction of species and perhaps foreclosing many opportunities for humankind, especially in the medical field.

- At least 93% of the original primary forest in Madagascar has been destroyed, and about half the original species (numbering around 200,000) have been eliminated.
- In western Ecuador since 1960 almost all the forests have been destroyed to make way for banana plantations. As many as 25,000 species have been destroyed in the past 25 years.

Equally damaging, though less obvious, are the cancers, respiratory diseases, and diarrhoeal diseases from pollution.

- Only 209 of the more than 3,000 large towns and cities in India have even partial sewage facilities, and only eight have full sewage treatment. More than 100 cities dump untreated sewage, chemicals, and other wastes into the river Ganges. Three of every five people in Calcutta suffer from respiratory diseases related to air pollution.
- Deaths from lung cancer in Chinese cities are four to seven times the national average, with many of the deaths attributable to heavy air pollution from coal furnaces.
- In Malaysia the area around Kuala Lumpur has two to three times the pollution of major cities in the United States.
- In Japan air pollution reduces some wheat and rice crop production by as much as 30%.
- About 10,000 people die each year in developing countries from pesticide poisoning, while 400,000 suffer acutely.
- Diarrhoeal diseases from unsanitary facilities and dirty water kill an estimated 4 million children a year in developing countries.

Along with this deterioration, there has been some progress. Developed countries have tightened their regulations on pollution substantially. Air pollution in most developed cities has been declining. International action has been initiated on chlorofluorocarbons. Awareness of the environment's importance and the market's limitations in protecting it has greatly increased in recent years.

For the Third World, however, such progress has often been offset by pressures of population, poverty and urbanisation. The developing countries now exhibit the greatest increases in world pollutants, because few of them have the capacity to install, use and maintain environmentally benign technologies.

In absolute terms, the industrial pollution in the North is far greater than in the South. For example, 29% of the chlorofluorocarbons escaping into the atmosphere originate in the United States, 41% in Australia, Canada, New Zealand, Japan, and Western Europe, 14% in Eastern Europe and only 16% in developing countries. Acid rain is worst in central Europe, and about half the forest in Western Germany is already damaged.

According to the WHO the cost of measures to remedy environmental degradation and eliminate significant public health hazards is greater than the cost of prevention.

*Refugees and displaced persons*

Much human potential goes to waste because of forced migration — people compelled to abandon their homes and their assets because of political turmoil, military conflicts or ethnic strife. For such reasons, 12 to 14 million people had registered as refugees at the end of the 1980s.

The world has always known massive population movements. The Second World War and its aftermath displaced nearly 15 million people, including Germans, Hungarians, Poles, Czechs and Russians. The partitioning of the Indian subcontinent in 1947 uprooted more than 14 million people. More than a million Palestinians are displaced. Periodic wars and crises in various parts of Africa have also displaced millions — for example, Nigeria expelled a million people in 1983.

The refugee problem grew tremendously during the 1980s. Some 14 million people were displaced in 1988, compared with an estimated 8 million at the start of the decade. The Afghan war displaced about 5 million people, a third of the Afghan population. About 300,000 Somalis have fled to Ethiopia. Other growing groups of refugees include ethnic Turks from Bulgaria and Vietnamese boat people. And in Central America, 160,000 Salvadorans are scattered throughout South America (120,000 in Mexico), many Guatemalans are in Mexico and the United States, and many Nicaraguans are in Honduras, Mexico and the United States.

In addition to international refugees are the millions of people displaced in their own countries: 10 million in Africa in 1988, including 2.7 million in Uganda, 2 million in the Sudan and 1.1 million in Mozambique.

Added to these numbers are the numbers of environmental refugees, who rank today with political refugees: 12 to 14 million people who have abandoned their homes because of natural resource degradation and its sequels — drought, flooding, soil erosion, lost productivity, failed harvests and threats of hunger and death.

*Changing household patterns*

The traditional extended family has in many parts of the world been replaced by the nuclear family — typically two parents and their children. Accompanying the decline of the extended family has been the breakdown of the social security net and the support it provided to its members. In many countries, especially developing countries, the replacement systems — nurseries, health and unemployment insurance, and other social services — have not yet emerged. The uneasy transition has often been marked by considerable hardship, especially for the children, the elderly and the disabled.

Now, the nuclear family is itself breaking up in many countries and being replaced by single-person households and single-parent households. In the United Kingdom nuclear families of two parents with children accounted for only a quarter of the households in 1988. In the United States couples with children dropped from 44% of all households in 1960 to 29% in 1980, while one-person households rose from 13% to 23% and single-parent households from 4% to 8%. If the trend continues, only three of five young American families will be headed by a married couple in 2000. Trends are similar in other developed countries. The incidence of divorce has also been high in the North, and it appears to be on the rise in the South.

Poor women, in both North and South, are hurt most by these trends. Because

FIGURE 2.17
**Refugees by region**
Millions of people

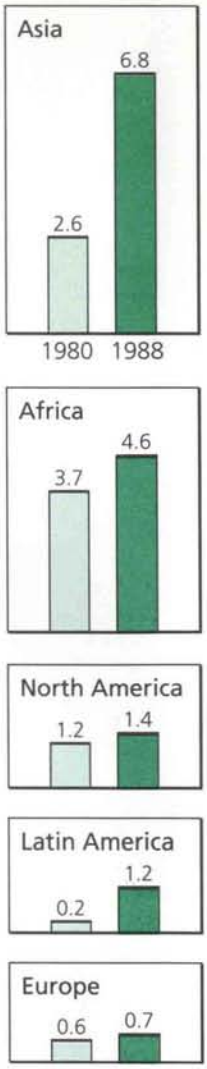



TABLE 2.6
**Changes in the size of households in selected developed countries**
(percentage of total households)

| | One person | | | Couple with children | | | Single parent with children | | |
|---|---|---|---|---|---|---|---|---|---|
| Country | 1960 | 1970 | 1980 | 1960 | 1970 | 1980 | 1960 | 1970 | 1980 |
| Canada | 9 | 13 | 20 | .. | 50 | 37 | .. | 2 | 3 |
| England and Wales | 12 | 18 | 22 | 49 | 44 | 39 | 7 | 7 | 8 |
| France | 20 | 22 | 24 | 45 | 41 | 39 | 4 | 5 | 5 |
| Germany, Federal Rep. | 21 | 26 | 31 | 55 | 47 | 42 | 2 | 2 | 3 |
| Netherlands | 12 | 17 | 22 | 56 | 53 | 43 | 6 | 7 | 6 |
| Sweden | 20 | 25 | 33 | 37 | 30 | 25 | 3 | 3 | 4 |
| Switzerland | 15 | 20 | 27 | 48 | 45 | 41 | 5 | 5 | 4 |
| United States | 13 | 17 | 23 | 44 | 40 | 29 | 4 | 5 | 8 |

women are typically less qualified than men, they tend to go into lower paying jobs and have fewer opportunities to be upwardly mobile, leaving them less able than men to provide a decent living to their families. The increasing number of female-headed households has led to a feminisation of poverty.

*Tropical diseases and the AIDS epidemic*

A vast number of people in the developing world suffer from, or are threatened by, debilitating or fatal tropical diseases.

- Malaria is endemic in 102 countries and threatens more than half the world's population. There are 100 million malarial infections each year and about one million deaths.
- Onchocerciasis has infected nearly 18 million people and about 80 million people are seriously threatened by it. In many affected villages a third to a half of the adults have been blinded. Victims of the disease are concentrated in West Africa and in parts of Latin America and the Middle East.
- Schistosomiasis is endemic in 76 countries, with 600 million people at risk and 200 million people already infected.
- More than 90 million people are infected by filariasis, and an estimated 900 million people are at risk.

For onchocerciasis, the distribution of the drug ivermectin has in recent years been a striking breakthrough. For malaria, however, there has been little improvement in the numbers affected in the past 15 years. The situation may even have become worse, because there is significant underreporting for all tropical diseases.

The social consequences of tropical diseases are severe. In a village affected by guinea worm, for instance, agricultural productivity has dropped by 30%. In many cases, children are the most affected. In Sub-Saharan Africa malaria has caused more than 100,000 deaths of children under the age of one and nearly 600,000 deaths of children between the ages of one and four. Even when children survive, their subsequent growth and learning capabilities are often reduced.

Migrant workers are also at a great risk. Health workers have found a high incidence of malaria in the new settlements of the mobile and diverse population along the Amazon.

A decisive effort is thus required to advance research on the prevention and control of tropical diseases and to make drugs available to all people at risk.

AIDS emerged as a frightening threat to mankind only in the late 1970s. Between 5 and 10 million people apparently are infected worldwide, although only 133,000 cases were reported to the WHO at the end of 1988. Of the reported cases, about 68% were in the Americas, mainly in the North, 14% in Europe, 17% in Africa and 1% in Asia and Oceania. But these figures are gross underestimates because of the lack of diagnosis and reporting. The actual figures must be much higher, especially in developing countries.

Most AIDS cases are 20-40 year olds, the most productive members of the work force. In some cities in Africa, the rate of infection for this age group is thought to be 25%.

AIDS is likely to reverse many of the

BOX 2.5

**The AIDS epidemic**

The AIDS epidemic poses a serious threat to all countries, but it particularly affects developing countries that lack preventive health and social support services and that have a high incidence of infection. It adds burdens to debt, poverty, illiteracy, structural adjustment and other diseases.

The developing countries most affected include those in much of Central, Eastern and Southern Africa and a number of Caribbean countries, including French Guyana, Bermuda, the Bahamas, Haiti and Trinidad and Tobago. Rates of infection are also high for some subgroups in Brazil, Mexico and Thailand.

In its infancy, the epidemic has already induced sharp increases in adult, maternal and child morbidity and mortality rates in affected countries. Associated secondary epidemics of endemic developing country diseases, especially tuberculosis, are also occurring. National health budgets in many of these countries are inadequate, and health care systems are predominantly urban-centred with a curative orientation.

A distinctive feature of the epidemic is that — unlike famine, drought and poverty, which often claim the very young and the very old — AIDS claims those in the productive years and so also threatens the health of the economy.

Dependency ratios are increasing, and with per capita income on the decrease, there will be more dependents to feed with less. One study estimates that in 10 high-incidence African countries, more than 10% of the children have lost at least their mother to AIDS by the end of this decade.

As the epidemic intensifies, the already-limited social services and health insurance provided by governments or the private sector will be withdrawn because of high costs. Key sectors of the economy — including mining, transportation, defence and finance — may lose many of their trained workforce. Remittances from abroad, tourism and foreign investment could all be adversely affected. Infection rates in rural areas are increasing and will eventually reduce food and other agricultural production.

successes in reducing infant and child mortality and in raising life expectancy. It has been estimated that if 5% of the pregnant women in a typical African developing country are infected, the infant mortality rate would rise by about 13 per 1,000, an increase higher than the current rate in most developed countries.

The cost of caring for AIDS patients is imposing tremendous strains on health budgets. Public spending on AIDS research and education in the United States amounted to $900 million in 1988, and the cost of care was $50,000 to $150,000 per patient. Costs like these, if reproduced in developing countries, would soon absorb entire health budgets. Although the cost of care is much less in developing countries, the disease already is putting immense strain on budgets and taking resources away from other priorities. This pattern can only worsen as the disease spreads.

To sum up: the picture of human development needs qualification. Human progress does not take place automatically, and higher income is no guarantee for a better life. The problems of reversed or de-formed human development challenge both developing and developed countries, but they also underscore the centrality of human development as a continuing policy concern and priority. Development, even in countries at higher incomes, cannot afford to lose sight of its primary goal: the betterment of human life.