



The Status Of Health & Education In India

Critical Questions in the Nation's Development

WHERE DO WE STAND IN 2007?


The year 2007 marks a mid-way to the Millennium Development Goals (2000-2015) and the fourth year of a Government brought to power on its promise to meet and exceed the Millennium Development Goals through the full implementation of the National Common Minimum Programme. The year 2007 also marks the sixtieth anniversary of India's independence. Yet despite the celebrations of 9% growth, in the "Other India" millions of poorer Indians remain excluded from the most basic rights and subject to the tyranny of mass hunger, illiteracy, and ill-health.

Poverty in India – Key Indicators

- 836 million Indians are poor and vulnerable
- India is placed 126th out of 177 countries on the United Nations Human Development Index, which ranks countries on how well they ensure health, education and decent living standards.
- Maternal Mortality and Infant Mortality rates in India's poorest districts are worse than sub-Saharan Africa
- India has the largest number of people in any country in the world without access to education
- Poverty in India cannot be overcome without dramatically expanding and improving access to and quality of public education, health, water and sanitation.

The Promise of Universal Access to Health & Education

The promise to ensure universal health and education is common to the Millennium Development Goals (MDGs) and the National Common Minimum Program (NCMP). Further, the government has committed itself to make elementary education a Fundamental Right of every single child in the 6–14 years age group through the introduction of the 83rd Constitutional Amendment (GOI, 2002).





Education in India – Key Indicators

- Only 66% per cent of the Indian people are literate (76% of men and 54% of women).
- While close to 90 per cent children in the 6-11 age group are formally enrolled in primary schools, nearly 40 per cent drop out at the primary stage. The enrolment ratios of Scheduled Caste (SC), Scheduled Tribe (ST) and Muslim children (especially girls) still remain far lower than the national average.
- 1.36 crore (40 *per cent*) children in the age group of 6-14 years remained out of school as on March 2005, four years after the launch of the Sarva Shiksha Abhiyan.
- Half of India's schools have a leaking roof or no water supply, 35% have no blackboard or furniture, and close to 90 per cent have no functioning toilets.
- The official teacher-student norm is 1:40, yet in some states classes average is one teacher per 80 children. The prescribed norm of a school being available within the radius of one kilometre is still not being fulfilled.
- Malnutrition, hunger and poor health remain core problems, which comprehensively affect attendance and performance in classes. The added burden of home chores and child labour influence a large number of children, especially girls, to drop out of school.

Health In India – Key Indicators

- India accounts for more than 20% of global maternal and child deaths, and the highest maternal death toll in the world estimated at 138,000.¹
- United Nations calculations show that India's spending on public health provision, as a share of GDP is the 18th lowest in the world.
- Nearly 67% of the population in India do not have access to essential medicines.
- Infant Mortality Rate (IMR) in India was 67.6 in 1998-99 and has come down to 57 in 2005-06. Kerala heads the progress made so far with an IMR of 15/1000 births. Uttar Pradesh has the worst IMR in the country of 73/1000 births.
- Maternal Mortality Rate (MMR) is currently 4 deaths per 1000 births. India accounts for the largest number of maternal deaths in the world.
- 79% of the children between the age of 6-35 months, and more than 50% of women, are anaemic, and 40% of the maternal deaths during pregnancy and child-birth relate to anaemia and under-nutrition.
- There are 585 rural hospitals compared to 985 urban hospitals in the country. Out of the 6,39,729 doctors registered in India, only 67,576 are in the public sector.

1. WHO, UNICEF & UNFPA, Maternal Mortality in 2000



- The ratio of hospital beds to population in rural areas is almost fifteen times lower than that for urban areas

CALL TO ACTION

‘Nine Is Mine’ is the rallying call to the government that was given up by more than 200,000 children when they petitioned the Prime Minister Dr. Manmohan Singh in February 2007 to fulfil the promise made in the National Common Minimum Programme to increase public expenditure in Health and Education to 9% of India’s GDP.

This Status Report on Health & Education has been published in support of the efforts of the ‘Nine Is Mine’ campaign by presenting an overview of the challenges that face the country backed by data and outlining some important recommendations from experts and activists to meet the challenge of ensuring Universal Access to Health & Education.

The key conclusions that emerge from this Report are:

1. Right, not Charity

Both health and education are rights under the Constitution of India, the latter being a fundamental right. It is therefore the duty of the Indian government to deliver these services to the citizens. Health, education and water and sanitation are neither commercial services to be delivered nor charity to be given to citizens; citizens are neither customers nor alms seekers when it comes to basic human rights.

2. Public not Private


The responsibility to ensure that each citizen receives good education and health care lies squarely with the government. Given the scope and scale of delivery that is required, the state cannot abandon its role as the primary deliverer of services. For instance, in order to achieve the coverage of services envisaged through the National Rural Health Mission, about 21,983 new Sub-centres and 200,000 ANMs are required in keeping with the population norm of the 2001 census². No private or voluntary agency can meet this requirement. Utilize the private and non-government sectors for innovation and monitoring, not as a substitute provider.

3. Education & Health Are Social Investments, Not Just Public Expenditure

The NCMP aims to increase public expenditure on Education to 6% of the GDP, and public expenditure on Health to 2-3% of the GDP as one of the strategies to meet this promise. However to date, the total investment on Health and Education in India remains dismally low. Less than 1% of India’s GDP is spent on public health, which is even lower than the

2. Bulletin of the WHO, South East Asia Regional Forum (Volume 10, released on 11.7.2006) – quoted by the Minister for Health and Family Welfare, Mr. Anbumani Ramadoss in response to LS-SQ No. 54 dated 26.07.2006.





public health expenditures of countries like Sri Lanka and Sierra Leone. Public Expenditure on Education in India is a little over 3% of the GDP.

4. Free not User Fee

Even poorest families spend as much as Rs.350 per child per year (which amounts to more than 10% of the monthly income of a family that is able to earn Rs. 100 per day) for uniforms, stationery, transport, and more if tuition is added. The introduction of User Fees further adds to the burden of the 'invisible' costs that are borne by families who struggle to access health and education, and also negates the 'costs' that are already paid by the poor by way of their recognized economic contribution to the overall GDP of the country.


5. Planning Around The Poorest

The government must prioritize the needs of traditionally marginalized groups in planning its investments and outreach. The poorest districts of the country and most vulnerable groups—including Women, Children, People with Disabilities, and communities like the Dalits, Adivasis, Denotified Tribes and Muslim Minorities – must be the focus while planning for infrastructure and allocating resources.

6. Uniform Quality of Service

The quality of health and education is a crucial factor in ensuring the achievement of the human development outcomes intended through these services. In states that have more teachers (where teacher-pupil ratio is low), where funds are received and utilised, and where there are more classrooms and fewer single-teacher schools - the overall educational achievements have been recorded to be much better.

The quality of services even in the poorest areas of the country should be commensurate with the standards and norms envisaged by the National Development Goals at the very least, and encourage further improvisation and enhancement through active local participation, information sharing and accountability.





Status of Basic Education in India: An Overview

Vimala Ramachandran¹

I. THE CONTEXT: WHERE DO WE STAND?

Travelling around the country to do research on elementary education, women's education and empowerment is both an exhilarating as well as a deeply disturbing experience. Wherever one travels one cannot but notice that even the poorest families are eager to access education and want their children to break out of the cycle of poverty and low educational achievement. Yet, miles and miles of barren land, impoverished rural areas, dysfunctional health centres and elementary schools, as well as poor roads are a grim reminder of the hard fact that India is a county of immense diversity and sharp inequalities.

At the time of India's independence, less than a fifth of the population was literate. After independence, efforts were made to expand access. But the fact that access to education was a moral obligation enshrined in the Directive Principles of State Policy (Article 45) kept it beyond the purview of an enforceable right.


In 1993, the Supreme Court in *Unnikrishman vs the State of Andhra Pradesh*, recognised primary education as an important aspect of one's personal life and liberty and located it within Article 21, a Fundamental Right. In 2002, both Houses of Parliament passed a legislation to amend the Constitution to recognise basic education as a Fundamental Right (86th Amendment).

The Census of India 2001 reveals that despite a host of schemes and programmes, only 65.38 per cent of the Indian people are literate (75.85 per cent men and 54.16 per cent women). A staggering number of children, close to 38.41 per cent of boys and 51.88 per cent of girls in the age group 6-14, are not attending school.

While the statistics of the education department (Selected Education Statistics, Government of India, 2006) claim that 99 per cent boys and 82 per cent girls, aged 6-10, are enrolled in schools, the National Sample Survey (NSS), Government of India (61st Round, 2004-05) reported the enrolment rate to be 80 per cent among boys and 73 per cent among girls in rural areas and 88 per cent boys and 85 per cent girls in urban areas attend school.

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This data hides major disparities across region, caste, class, tribe and ethnicity, as well as the rural-urban and gender divide. For example, there is convincing evidence to show that the contiguous regions of Rajasthan, Bihar, West Bengal, Jharkhand, Orissa, Uttar Pradesh and parts of Madhya Pradesh need special attention. Similarly, some of the North Eastern states like Arunachal Pradesh, Meghalaya, Nagaland and Assam have long been neglected.

II. EDUCATION FOR ALL: POLICY FRAMEWORK

From 1950 onwards the Government of India (GOI) has created policy instruments to promote Universal Elementary Education (UEE) in an attempt to eliminate all forms of discrimination based on caste, community and gender. Some of these are:²

- Policy-level recognition of the importance of providing child care facilities/crèche within school premises. The Integrated Child Development Programme (ICDS) was initiated in 1975-76 in 33 Blocks and now covers 5671 Blocks (Projects) with 7.44 lakh Anganwadi Centres. Slated to be universalised, an additional 467 Blocks (1,88,168 Anganwadi Centres) will be operational by the end of the Tenth Five Year Plan;³
- Provide schools within walking distance, and satellite schools for remote hamlets, stepped after the adoption of the National Policy of Education and Programme of Action, 1986. Enrolment at the primary level went up from 19.2 million (5.4 million girls) in 1950 to 130.8 million (61.1 m girls) in 2004-05⁴. In the 1990s the number of schools increased by 14.8 per cent at the primary level, 50.65 per cent at the upper primary level, 38.43 per cent at the secondary level and 85.74 per cent at the higher secondary level⁵. However, these impressive achievements need to be tempered in the light of the high drop-out rates which stand at 29.0 per cent (24.42 per cent girls) at the primary level, 50.84 per cent (51.28 per cent girls) at the elementary level and 61.92 per cent (63.88 per cent girls) at the secondary level;⁶
- Provide alternative education programmes to reach out to out-of-school children (never enrolled and drop-outs) — through bridge courses, residential schools and focussed initiatives for minorities and special focus groups (migrant groups, etc);
- Appoint more women teachers in rural areas and provide them with secure residential accommodation. Expand the pool of women teachers by lowering qualifications, provide intensive training (near the place of dwelling), among others;
- Improve the quality of education and motivate teachers to make learning a joyful exercise;


2. This has been adapted from Vimala Ramachandran, 1997

3. Annual Report DWCD, MHRD, GOI, 2005

4. GOI, SES, 2006

5. NCERT 6th and 7th Educational Survey

6. GOI, SES, 2006



- Provide incentives like mid-day meals, uniforms, textbooks, exercise books, attendance scholarship and free bus passes;
- Involve the community in managing the school through mobilisation and formation of village education committees with at least 50 per cent women members;
- Decentralise educational planning and administration, bring it closer to the people so that it reflects the special needs and aspirations of the community;
- Mobilise public opinion for primary education and universal literacy in general and women's education in particular. Advocate for greater political will and administrative commitment;
- Adopt a holistic and convergent framework for synergy between different strategies/ projects to revitalise primary education – the main thrust of the District Primary Education Programme (DPEP) launched by the GOI in 1993-94 ;
- Evolve context-specific strategies to respond to educational needs, especially of girls and other special focus groups (Sarva Shiksha Abhiyan 2002);
- Make elementary education a Fundamental Right of every single child in the 6–14 years age group (83rd Constitutional Amendment, GOI, 2002);
- National Programme for Education of Girls at the Elementary Level (NPEGEL) introduced to augment resources in educationally backward blocks of the country;
- Kasturba Gandhi Balika Vidhyala (KGBV) to reach out to out-of-school girls and provide residential education for students from socially disadvantaged groups. This programme was initiated in 2004 in the educationally backward blocks of India.

Table 1: Education Policy in India 1951 to 2005

Period	Policy Framework	Programmes and Approaches of the Central Government
1951-68	Constitution of India	Expansion of the formal schooling system. State governments shoulder the responsibility for primary education.
1968-86	National Policy on Education, 1968	1976: Education shifted to the 'Concurrent list' thereby giving the GOI and state governments equal responsibility for promoting and managing education. 1980s: Non-Formal Education introduced to supplement formal schooling, thereby increasing Central investment in primary schooling.
1986-92	National Policy on Education, 1986 Jomtien Conference for Education for All followed by EFA	Andhra Pradesh Primary Education Project, early 1980 (British ODA) Environmental Education, 1986 (Domestic Resources) Rajasthan Shiksha Karmi Project, 1987 (Sida) Total Literacy Campaign, 1988 (Domestic resources) Mahila Samakhya in Karnataka,



	projects – most of them with foreign aid	UP and Gujarat, 1989 (Dutch Government) Bihar Education Project, 1991 (UNICEF) Rajasthan Lok Jumbish, 1992 (Sida) UP Basic Education Project, 1992 (World Bank)
1992 to 2002	Revised National Policy on Education, Policy Mid-day Meal, 1995 Supreme Court Order on Mid-day meal in 2001	District Primary Education Programme (DPEP), 1993 with consortium funding from DFID India, World Bank, Delegation of the European Union, UNICEF and Royal Netherlands Government) National Programme of Nutritional Support to Primary Education (commonly known as the Mid-day Meal Scheme) was launched as a Centrally-sponsored Scheme on August 15, 1995. Its objective was to boost “universalisation of primary education by increasing enrolment, retention and attendance and simultaneously impacting on nutrition of students in primary classes”. Sarva Shiksha Abhiyan 2001 – an umbrella programme for elementary education in India. November 2001: the Supreme Court of India directed all state governments to provide cooked mid-day meals in all primary schools (order dated November 28, 2001); follow-up order April 20, 2004 – when it was reported that few states were giving a hot cooked meal and many were distributing dry rations.
2002 onwards	Free and compulsory education bill, 2004 Revised Mid-day meal programme in 2004	Free and compulsory education made a Fundamental Right for all children between 6-14 years and included in Part III (Fundamental Rights) of the Constitution of India; Universal mid-day meal for primary schools across the country. Central Government has approved a revised scheme, entitled National Programme of Nutritional Support to Primary Education, 2004 (NP-NSPE, 2004) Objectives of the revised Scheme are: <ul style="list-style-type: none"> ❖ To boost universalisation of primary education (classes I-V) by improving enrolment, attendance, retention, and learning levels of children, especially those belonging to disadvantaged sections, ❖ Improve nutritional status of students of primary stage, and ❖ Provide nutritional support to students of primary stage in drought-affected areas during summer vacation also.



III. CHALLENGES IN EDUCATION

Access and retention: Highs and lows

The decade from 1991 to 2001 saw the country's literacy rate record an increase of 13.17 per cent, the highest increase in any decade after independence.

- As many as 1,52,304 new primary schools and 1,10,830 new upper primary schools have been opened since 1990 (Select Educational Statistics, GOI, 2006). Physical access to formal primary schools improved considerably;
- The growth rate of literacy was higher among females than among males;
- The growth rate of literacy was higher in the rural areas (14.75 per cent), as compared to urban areas (7.2 per cent). Though, despite these improvements literacy in urban areas was 80.3 per cent and that in rural areas 59.4 per cent;
- Female literacy went up from 32.17 per cent in 1991 to 45.84 per cent in 2001 – a 13.67 per cent jump (the increase in previous decades being 7.35 per cent in 1981-91, 6.13 per cent in 1971-81 and 5.74 per cent in 1961-71);
- The decadal increase in female literacy was an impressive 24.87 per cent in Chhattisgarh, 20.93 per cent in Madhya Pradesh and 23.90 per cent in Rajasthan.

There has been a sharp increase in enrolment rates across the country and the percentage of never enrolled children has been steadily decreasing.

Contrary Trend: Muslim Girl Child most Vulnerable⁷

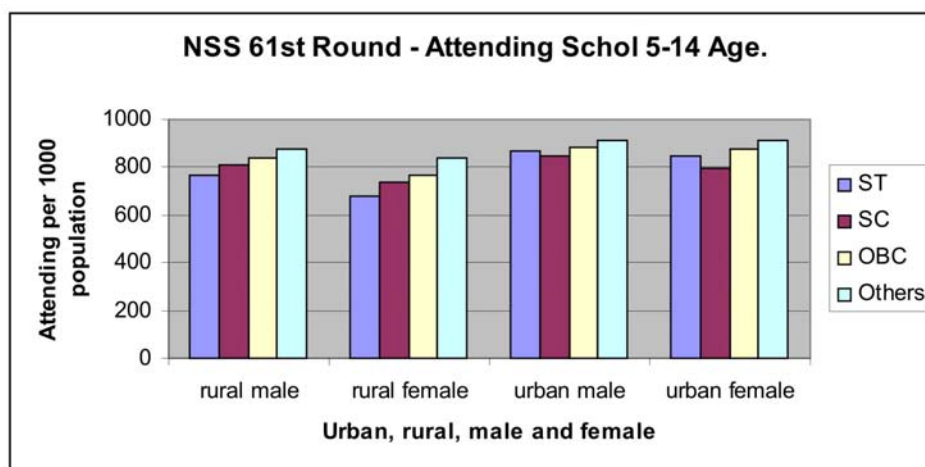
An important exception to this trend is found among scheduled caste (SC) and scheduled tribe (ST) children and Muslim girls. A GOI-commissioned study by the Social and Research Institute (SRI) says the estimate of out-of-school children is highest among Muslims (9.97 per cent). The states and Union Territories that are worse than the national average are Bihar (28.34 per cent), Daman Diu (28 per cent), Uttar Pradesh (14.37 per cent), and West Bengal (11.33 per cent). The estimate of out-of-school Muslim children in rural areas (12.03 per cent) was the highest among all social groups. (SRI report on assessing the number of out of school children in the 6-13 years age group, submitted to MHRD, GOI; New Delhi 2005, page 26-27.)

7. The most exhaustive analysis of the situation of Muslims in India is a GOI, 2006. Social, Economic and Educational Status of Muslim Committee in India – A Report. Cabinet Secretariat, GOI, New Delhi November 2006



An analysis of the trends between the 1991 Census and that of 2001 reveals a disturbing pattern:

- The Muslim girl child is amongst the most vulnerable group for future education policy planners;⁸
- The enrolment rates of Muslim girls have steeply fallen relative to the all-India average, especially during and after the decades of the 1990s (Shariff and Razzack in Council for Social Development Report, India Social Development Report, OUP, New Delhi, 2006);
- Shariff and Razzack point out that the difference in literacy rates amongst Muslim men and women and their non-Muslim counterparts was greater in urban areas. Also, while literacy levels were more even amongst Muslim and Hindu women in the 1950s, 1960s, 1970s and even the 1980s, the differences have widened substantially among the younger age women around the year 2001. (As per Census 2001, 55 per cent Muslim men are literate compared to 64.5 per cent non-Muslim men, and 41 per cent Muslim women are literate compared to 46 per cent non-Muslim women);
- Similarly, the most recent NSSO report (61st Round 2004-05) highlights rural-urban differences and the situation of children from SC and ST communities.



8. The 2002 household survey by Jha and Jhingran illustrates that Muslim children are much worse off than even those from SC/ST categories. The comparison becomes yet more skewed and unfavourable in case of Muslim girls, particularly those from lower castes. Whereas the aggregate figure for enrolment of Muslim children is 50.7 per cent as compared to 67.3 per cent for SC and 59.8 per cent for ST, the enrolment for lower caste Muslim children falls to as low as 36 per cent. The lower caste Muslim children also record the highest percentage (32.6 per cent) in the “never enrolled category”. (Jha and Jhingran, Manohar Publications, New Delhi, 2005)



Table 2: Percentage increase in schools, enrolment and teachers, India

Percentage increase in # of schools	1986-93	1993-2003
Primary	7.89	14.18
Upper Primary	17.11	50.65
Secondary	24.74	38.43
Higher Secondary	53.00	85.74
Percentage increase in enrolment	1986-93	1993-2003
Classes 1-5	12.94	26.15
Classes 6-8	24.93	37.49
Classes 9-10	32.11	43.21
Classes 11-12	55.72	28.73
Percentage increase in # of teachers	1986-93	1993-2003
Primary	8.75	17.83
Upper Primary	12.73	40.01
Secondary	14.62	20.09
Higher Secondary	44.30	68.68

Source: 6th All India Educational Survey, 1998 and 7th All India Educational Survey, NCERT, 2004

Upper Primary Schools: West Bengal Worst Laggard

Ensuring access to upper primary schools (Classes V/VI to Class VII) is one of the most formidable challenges faced by governments in India. The most recent compilation of school specific data reveals that the ratio of primary to upper primary schools and upper primary classes in high schools remains 2.57 in the country as a whole.

Again there are wide regional differences. Perhaps the worst ratio is seen in West Bengal (5.28) – only one in every five children who enrol in primary school can hope to find a school beyond Class IV.

Table 3: Enrolment (in millions) from 1950 to 2004

Year	Primary				Upper Primary				Secondary			
	Boys	Girls	Total	% Girls	Boys	Girls	Total	% Girls	Boys	Girls	Total	% Girls
1950-51	13.8	5.4	19.2	28.13	2.6	0.5	3.1	16.13	1.3	0.2	1.5	13.33
1960-61	23.6	11.4	35	32.57	5.1	1.6	6.7	23.88	2.7	0.7	3.4	20.59
1990-91	57	40.4	97.4	41.48	21.5	12.5	34	36.76	12.8	6.3	19.1	32.98
2000-01	64	49.8	113.8	43.76	25.3	17.5	42.8	40.89	16.9	10.7	27.6	38.77
2001-02	63.6	50.3	113.9	44.1	26.1	18.7	44.8	41.8	18.4	12.1	30.5	39.5
2002-03	65.1	57.3	122.4	46.8	26.3	20.6	46.9	43.9	19.5	13.7	33.2	41.3
2003-04	68.4	59.9	128.3	46.69	27.2	21.5	48.7	44.15	20.6	14.4	35.0	41.14

Source: Select Education Statistics, Department of Education, MHRD, GOI, 2003-04, New Delhi 2006

Dropping Out: Reality Check

Elementary education in India is characterised by high drop-out and low completion rates, persistent inequities and poor quality. While close to 90 per cent children in the 6-11 age group are formally enrolled in primary schools (formal, Education Guarantee Scheme (EGS)/ Alternative Schools (AS) and private schools), nearly 40 per cent drop out at the primary stage (Select Educational Statistics, GOI, 2006).

Drop-outs More Among Poor, Socially Disadvantaged

As is evident in Table 3 above, the number of children enrolled in upper primary drops sharply, and comes down further at the secondary level. The situation is worse for the rural and urban poor and socially disadvantaged groups, such as SCs and STs. The drop-out rates among SC children are higher than the average drop-out rate.

In 2003-04 there were 23.12 million SC children (10.36 girls) in primary and only 8.07 million children (3.34 million girls) in middle schools. But interestingly, girls' enrolment at all stages has increased quite sharply with almost 45 per cent of students at the primary level being girls. A similar trend is visible among ST children.

But the ratios of SC and ST children still remain far lower than the national average. Only 48.6 per cent of SC girls and 40.6 per cent of ST girls are enrolled at the elementary level as compared to the national average of 56.22 per cent of all girls. The sharp drop from primary to elementary is yet another clear indication of high drop-out rates, especially among the most deprived children who access government schools in rural and tribal areas.

Table 4: Enrolment (in thousands) of Scheduled Castes from 1980 to 2004

Year	Primary				Upper Primary				Secondary			
	Boys	Girls	Total	% Girls	Boys	Girls	Total	% Girls	Boys	Girls	Total	% Girls
1980-81	7213	3768	10981	34.31	1621	602	2223	27.08	906	246	1152	21.35
1985-86	8727	5194	13921	37.31	2537	1082	3619	29.90	1378	432	1810	23.87
1990-91	9737	6057	15794	38.35	2747	1413	4160	33.97	1713	635	2338	27.16
1995-96	11284	7892	19176	41.16	3453	1992	5445	36.58	1854	887	2741	32.36
2000-01	12059	9136	21195	43.10	4066	2628	6694	39.26	2418	1394	3812	36.57
2003-04	12764	10365	23129	44.81	4733	3343	8077	41.39	1978	1251	3229	38.74

Source: Select Education Statistics, Department of Education, MHRD, GOI, 2005



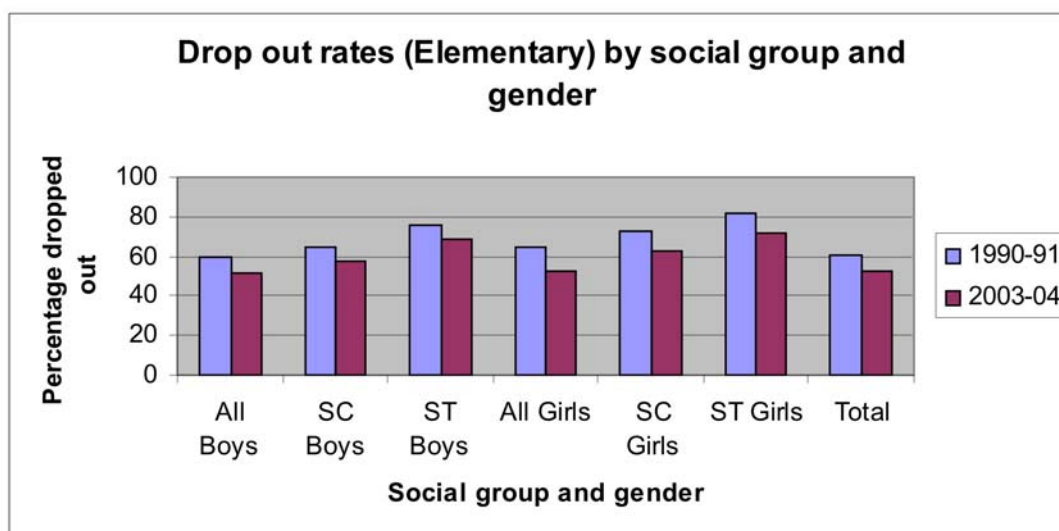
Table 5: Enrolment (in thousands) of Scheduled Tribe from 1980 to 2003

Year	Primary				Upper Primary				Secondary			
	Boys	Girls	Total	% Girls	Boys	Girls	Total	% Girls	Boys	Girls	Total	% Girls
1980-81	3133	1527	4660	32.77	537	205	742	27.63	246	83	329	25.23
1985-86	4174	2406	6580	36.57	893	390	1283	30.40	420	165	585	28.21
1990-91	4958	2911	7869	36.99	1131	576	1707	33.74	567	238	805	29.57
1995-96	5589	3826	9415	40.64	1448	837	2285	36.63	763	359	1122	32.00
2000-01	6330	4665	10995	42.43	1879	1205	3084	39.07	955	535	1490	35.91
2003-04	6776	5741	12517	45.87	2135	1525	3661	41.66	833	517	1350	38.30

Source: Select Education Statistics, Department of Education, MHRD, GOI, 2005

Marginal Change In Drop-out Rates


What is worrying is that there has been a marginal change in drop-out rates. The drop-out rates of SC and ST boys (elementary level – Classes I to VIII) seem to have increased in the last two to three years. Within each category the situation of girls is worse than that of boys (with the exception of the forward castes / economically better off where the drop-out rates of girls have fallen more sharply than that of boys).



Source: Select Education Statistics, Department of Education, MHRD, GOI, 2005

More SC and ST children drop out than those of forward castes/ communities. If rural/ urban rates disaggregated by caste/ community and gender were available, the combination





of gender, social and location disadvantage could be demonstrated far more convincingly. It is distressing that 71 out of 100 tribal girls drop out before completing elementary education.

Official statistics often generate scepticism. An independent survey, the National Family Health Survey (1998-99) reports a significant increase in school attendance among children 6-14 years of age (73.7 per cent girls, 83.1 per cent boys). But it also reveals that *only* 34.2 per cent girls and 53.3 per cent boys (of all those who responded to the survey) complete primary education.

Beyond The Macro View: Critical Inter-state Differences

These trends also hide important inter-state differences. While the overall completion rate of the full primary education cycle (completing Class V in some states and completing Class IV in others) is 78 per cent in Karnataka, 62 per cent in Maharashtra and 55 per cent in Tamil Nadu, the figure dips to under 40 per cent in Uttar Pradesh, Bihar, Orissa and Madhya Pradesh.


Several studies (Yash Agarwal 2000, 2001, Gopinathan Nair et al 2001, Jha and Jhingran 2002, Vimala Ramachandran 2003) have found that while the proportion of never enrolled children has been going down steadily, it is poor quality education in almost dysfunctional schools that effectively push children out. It is the poorest children in most rural areas who go to the lesser endowed schools – a significant proportion of single teacher and classroom schools, EGS centres and Rajiv Gandhi Pathashalas cater to SC and SC children.

Quest for Equity: Closing Gender and Social Gaps

If the literacy rate variation across the spectrum and between gender and caste groups is correlated then it becomes evident that higher overall literacy goes with lower disparities. *The more educationally backward a region, the greater are the social and gender inequalities.*

- It was estimated that there were 4.4 crore out-of-school children between 6-14 years in 2001 – about 28.5 per cent of the total child population in this age group. According to the government the situation has improved greatly in the past 16 years. A national sample survey conducted by SRI-IMRB in 2005 estimated about 1.34 crore out-of-school children between 6-14 years;
- This was more or less confirmed in the ASER 2005 report by Pratham India Educational Initiatives. But the absolute numbers are still worrying -- Bihar (31.76 lakh), Uttar Pradesh (29.95 lakh), West Bengal (12.13 lakh), Madhya Pradesh (10.85 lakh) and Rajasthan (7.95 lakh) have the highest number of out-of-school children.

Disaggregated data on out-of-school children who have never enrolled in schools reveal a disproportionate presence of special groups like working children, those in urban slums, residents of far flung habitations, SCs/STs and nomadic groups. Within all these categories the proportion of girls is high.





EGS and as Schools: A New Hierarchy of Access

A new trend, less recognised, is the coexistence of a multiplicity of schools – government primary schools, Education Guarantee Scheme (EGS), alternative and private (recognised and unrecognised). Recent research reveals the emergence of a new hierarchy of access. The less well off, usually girls and the socially marginalised, are clustered in specific types of schools — often EGS, alternative and government primary schools — with the better-off, upper caste boys steadily shifting to private schools.

The rapid growth of EGS schools (through the government) has revived the old debate of dualism in education, a process exacerbated by the proliferation of private schools. At one level, financial constraints impede the expansion of formal government schools and hiring of teachers. The new ‘*para-schools*’ at least provide some schooling. But simultaneously, this democratisation of education seems to be relegating precisely those sections that require the maximum attention and resources to a ‘second tier of education’, more deeply inscribing negative social markers on children.

Social Barriers To Education: A Cruel Reality

Children of communities engaged in scavenging, disposal of dead animals and such like “impure” occupations are shunned by other children in the school. The teachers are also not very sympathetic to their predicament. Such issues cannot be captured in macro-data or in large-scale studies. Recent qualitative micro studies done in six states have captured a range of discriminatory practices practised in schools and its impact on the schooling of children from specific social groups (Vimala Ramachandran, Ed., 2004).

Malnutrition and hunger: no food for thought


The recent State of the World’s Children report (2007) has highlighted the nutritional status of children in the country as a whole. The NFHS-3 data reveals that 38 per cent of children under 3 are stunted (too short for their age), 19 per cent are wasted (too thin for their height) and 46 per cent are underweight (too thin for their age). Notwithstanding the ICDS programme and the mid-day meal scheme, recent evidence has highlighted the alarming nutritional status of Indian children. Given prevailing gender relations and attitudes and practises towards girl children, the chances are that girls account for a larger proportion of malnourished children⁹.

Long Shadows of Ill-health and Domestic Chores

Micro-studies in the past seven years have shown that in four to five years of severe drought in many parts of the country, short term and persistent hunger among children was flagged as an important issue (Vimala Ramachandran Ed., 2003 – *Hierarchies of Access*, Sage

9. (Source: <http://www.nfhsindia.org/summary.html> , March 2007)





Publication). Poor health and frequent illness impedes regular attendance in school. The link between health and education is yet to be addressed, especially in the case of children from the poorest quartile of the population. It is not tough to imagine how far a child can advance, especially a first generation learner, burdened with a combination of ill health and domestic chores before and after school.¹⁰

In the Poorest States, Mid-day Meals are a Farce

Responding to the grim nutritional status of children, the Supreme Court of India ordered (dated November 28, 2001) a universal cooked mid-day meal programme. Following the Supreme Court's directive, 23 of the 35 states and UTs switched over to cooked meals. An estimated 58 million children (around 55 per cent of all children in the 6-11 age group) are currently receiving cooked meals spread over 29 states and UTs. According to the Annual Report of the MHRD, around 106 million children were covered under the scheme in 2003-04 (R. Govinda and K. Biswal, 2006). The irony is that the areas which have some of the worst nutritional status are among the states where the mid-day meal programme is not being implemented in letter and spirit.

Quality of education: when learning takes wing

For a long time, poor performance on the basic schooling front was attributed to a lack of schools and teachers on the supply side, and poverty, parental attitudes, social barriers and prevalent social customs on the demand side. As noted earlier, significant progress has been made on both fronts.

Recent research indicates that an important factor explaining both the high drop-out rates and also the persistence of out-of-school children is the stark fact that many of our schools are unattractive - physically and pedagogically. Giving adequate attention to the software of education and issues of quality is a must.

What a Primary School Should be, What It Is

The official policy is that a primary school must have at the minimum two rooms, two teachers and a pupil: teacher ratio of 40:1. It must be located within a kilometre's walking distance for a child. The ground reality is very different:

- Despite an increase in primary and upper primary schools, the annual growth rate of school buildings is around 1 per cent per annum, much lower than the population growth rate;
- To ensure UEE, the Tapas Mazumdar Committee set up by the GOI (1999) calculated that an additional 4,00,000 schools are needed;

10. Vimala Ramachandran et al, 2004. Snakes and Ladders



- Owing to a major shortage of teachers, teacher-pupil ratios are as high as 1:80 in some states, placing an undue burden on teachers and affecting the quality of their teaching.

Table 7: Teacher-Pupil Ratio

Year	Primary	Upper Primary	High/Hr. Secondary
1950-51	01:24	01:20	01:21
1970-71	01:39	01:32	01:25
1980-81	01:38	01:33	01:27
1990-91	01:43	01:37	01:31
1999-00*	01:43	01:38	01:32
2000-01*	01:43	01:38	01:32
2003-04	01:45	01:35	01:33

* *Provisional*

The perennial problem of single teacher schools, multi-grade classrooms, poor quality teaching-learning material and inadequate state of teacher training has to be seen against the wider backdrop of not involving the community in managing the school environment.

No Significant Gender Gap In Learning Outcomes

The most recent District Information System on Education (DISE) statistics reveal that 47.83 per cent boys and 48.50 per cent girls passed Class IV/V with 60 per cent and more marks. An NCERT-sponsored study on learning outcomes also does not reveal any significant gender differences in learning outcomes,¹¹ a key quality indicator of the government. However, this kind of data is not available for the full elementary cycle (classes VII/VIII)

Learning Levels Abysmal

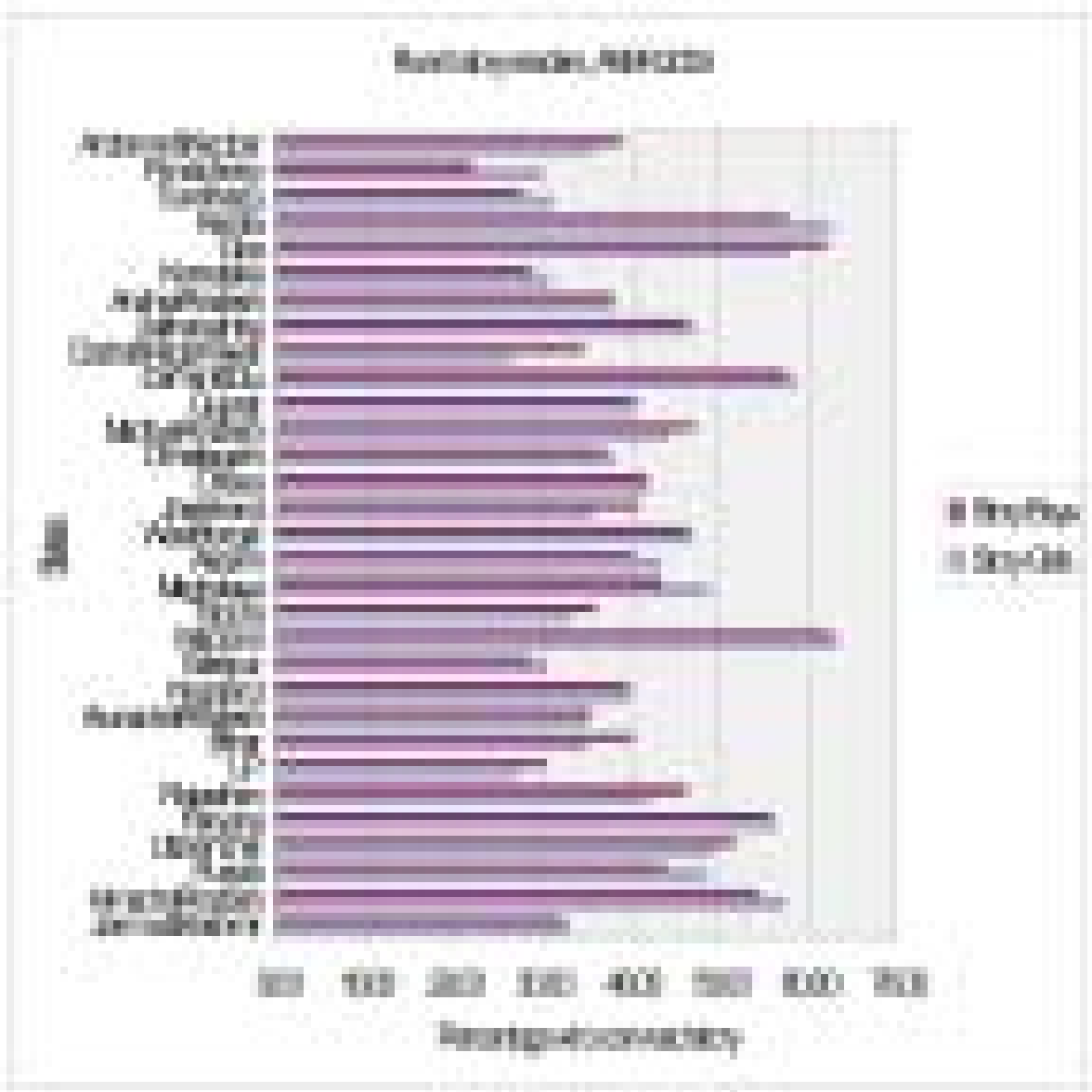
The real issue is not of a gender gap in learning outcomes but of extremely low learning levels across the country – 35 per cent of all children in the 7-14 age group cannot read a Class I text and close to 52 per cent cannot read a short story; 44 per cent children in Class II to V in government schools cannot read an easy Class I paragraph. As the saying goes, when a person is drowning it really does not matter if it is 35 feet of water or 50 feet of water.

The recent Annual Status of Education Report (ASER 2006) prepared by Pratham to assess the learning levels of children across schools reveals a rather dismal picture – the inability of children in Class III to read a story at Class II level shows that the reading ability in private schools is far better than in government schools, and there is no significant gender difference

11. NCERT administered a written test on 88,271 Grade V students in 4787 schools in 105 districts of 27 states and 3 UTs (excluding Jharkhand and Meghalaya) in 2002 and the results were comparable to that of ASER 2005 and did not find any significant gender differences.



across different states in India (see chart below). With respect to gender and education it is important to recognise that once girls are able to enrol and attend school regularly, there is little difference in the learning outcomes.





Forward linkages: thinking many steps ahead and laterally

Many factors determine whether children will continue or drop out, whether, and how much, they learn, and whether they acquire the skill/interest to pursue further education. If and when children do drop out due to poverty, migration, other economic factors and rigid gender roles, the presence or absence of programmes that enable them to get back into the formal system determines whether they can re-enrol in the school system.

Negative Impact of Drop-outs on Family/ Community

Experience shows that the presence of demoralised youngsters, who may have completed primary school or dropped out, acts as a disincentive for younger children in the family/ community. Particularly so if the education imparted does not lead to any material gain (employment/self-employment), or even the unquantifiable value addition in terms of social capital. Increasing adolescent crime and social unrest among 'literate' youth further reinforces negative attitudes towards both the youth and education (Planning Commission Working Group on Adolescents, GOI, 2001).

It is now universally recognised that in order to revitalise basic education, it is essential that we need to focus on the following:

- Move from 'access only' to 'access to good quality education';
- Move from primary to upper primary, middle and high school and forward linkages to higher and technical (including vocational) education;
- Create multiple exit points after class VIII through vocational education, skill and livelihood training alongside opportunities for out-of-school children to improve their educational level through accelerated learning programmes.

Even if most children are able to avail of 10 or 12 years of schooling, the presence or absence of institutions of higher education (including vocational training) determines access. While government subsidy for technical and higher education has significantly decreased in the last five years, the number of good quality institutions is few and far between.

Special Focus Groups: The Outsiders

Specific groups that constitute the majority of out-of-school children pose a huge challenge – notable among them are child workers, special needs children and adolescent girls.

Link Between Child Labour And Non Attendance

It is often argued that children remain out of school because their families need the income from their labour, that their presence at home, especially of girls, frees parents and older siblings for jobs.



But recent studies of the time utilisation of children reveal that a large majority of out-of-school children are not engaged in full-time work. Many are neither in school nor active members of the workforce. (Vimala Ramachandran et al. 2004. *Snakes and Ladders*. World Bank, New Delhi)

A recent GOI report on Child abuse (WCD, GOI, 2007) reveals that the picture on the ground is quite complex. Most working children are in the 12+ age group. While a majority of child workers in the informal sector (tea kiosks, workshops, restaurants) are boys, a majority of the invisible workforce like domestic workers are girls. Bidi rolling is another area where 83 percent are girls.

Importantly, even when they do work, the causation need not be from child labour to non-attendance. Often, it is those children who are excluded from school who take up work as a default occupation. Moreover, even when the child's income is essential for the family, the time spent in these activities is small and flexible. Finally, many school-going children work both before and after school hours. Drawing a one-to-one causality between work and non-enrolment in school could hide context specific nuances of this very serious issue.

Table 10: Work children (6 to 11 age group) before and after school

Boys			<i>What children do</i>	Girls		
◆ Always ● Sometimes * Rarely ▲ Almost Never						
UP	Karnataka	AP		UP	Karnataka	AP
Before going to school						
*	●	▲	Sweeping, cleaning the house	◆	◆	◆
*	*	▲	Washing utensils and clothes	◆	◆	◆
*	*	*	Lighting the fire, cooking	◆	◆	◆
●	◆	●	Fetching Water	◆	◆	◆
●	◆	●	Collecting fodder, feeding animals	◆	◆	◆
After School						
●	●	●	Collecting fodder/ fuel wood	◆	●	◆
●	●	◆	Domestic labour (urban slums)	●	●	●
▲	▲	●	Collecting cow dung	◆	◆	◆
●	●	●	Fetching water	◆	◆	◆
●	◆	▲	Feeding the cattle	●	◆	◆
◆	◆	◆	Grazing cattle and goats	*	◆	◆
◆	◆	◆	Doing odd jobs in the fields	*	◆	◆
◆	◆	◆	Running errands	●	*	*
▲	*	▲	Cooking	◆	◆	◆
*	●	*	Sibling care	◆	◆	◆
*	*	▲	Washing utensils	◆	◆	◆
◆	◆	◆	Working during holidays / vacations	◆	◆	◆



●	●	●	Short-term bondage to pay off loans	▲	▲	▲
●	●	◆	Leisure time spent playing,			
			watching TV (urban area)	*	*	*
*	*	●	Free time used for weaving baskets / Beedi rolling / other jobs	◆	●	●

Source: Vimala Ramachandran et al, 2004

Unfortunately, data on special needs children – physically and mentally challenged – remains scanty, notwithstanding some pioneering work done in select DPEP districts in the past three years where an effort was made to set up special schools and integrate these children in general schools. An educational environment remiss at handling ‘normal’ children has a long way to go before it can be expected to respond satisfactorily to the needs of special needs children with deprivations.

Less Than one-third Adolescents In School

Less than one-third of adolescents (11-17 years) are in school (NFHS-3 2004). The situation has not changed much since NFHS-2 (1998). Of the drop-outs — for girls marriage is usually the reason — less than half have minimum literacy skills. Yet this group continues to receive inadequate attention.

More disturbing is the conventional media portrayal of adolescent boys as violent, troublemakers, sexually active, vulnerable to drugs and infected with HIV/AIDS! While the Planning Commission acknowledges the need to focus on the education and development needs of adolescent boys and girls, calling them “*a tremendous force for change and reconstruction, yearning to be involved in work and development,*” the grim reality is that there are no programmes addressing issues of health, education, sexuality, livelihood, skill and leadership development in a holistic manner within the broad frame of human rights and democracy (Planning Commission Working Group on Adolescents, GOI, 2001).

The poverty of learning: no free education anywhere

Why do certain children not go to school? Several studies have cited teacher inertia, absenteeism, poor infrastructure, irrelevant curricula and a demotivating environment as factors responsible for children being out of schools (Dreze and Gazdar 1996, PROBE 1999). They have shown a close linkage between low family income/poverty and schooling arguing that the economic dimension cannot be ignored.

There is a cost incurred in sending children to school and, despite claims to the contrary, even in government run primary schools, education is not free. Families spend as much as Rs 350-per child per year for uniforms, stationery, transport, and more if tuition is added, not a small amount for poor families. (PROBE, 1999 and NCAER 1994, Deepa Shankar 2003) as depicted in Table 9.



Table 9: Total Mean Household Expenditure per child per year on Education

	Primary	Middle	Secondary	Higher secondary	Tertiary
Government	328	709	1156	1978	2672
Local bodies	447	796	1216	2198	3404
Private aided	1330	1449	1654	2623	3463
Private Unaided	1642	2193	2766	3591	4024
ALL	622	978	1395	2328	3078

Source: NSS, 52nd Round (cited in Deepa Sankar et al, 2003)

Uncertainty of Existence, Schooling More So

Several recent studies (World Bank 1996, Vimala Ramachandran 2003 and 2004) show that children are more likely to drop out and their aspirations about life are likely to remain low due to the uncertainty they face about their ability to continue with schooling. Often drop-outs are engaged in some work, within the household or outside, and this work is rarely conducive to schooling.

While incentives such as free textbooks, bags and uniforms make a big difference, recent evidence has shown that provision of a hot mid-day meal exerts a positive influence (Jean Dreze, personal communication 2004). It is not that poor parents do not want to educate their children; just that below certain threshold income levels they find it difficult to do so.

Violence, Abuse and Corporal Punishment

The recent Government of India, Ministry of Women and Child Development report on Child Abuse in India (WCD, GOI, 2007) based on interviews with 3,163 school-going children released startling figures:

- Two out of every three children were physically abused
- Out of 69 per cent physically abused in 13 sample states, 54.68 per cent were boys;
- Out of those children physically abused in family situations, 88.6 per cent were physically abused by parents;
- Two out of three school-going children reported facing corporal punishment;
- 62 per cent of the corporal punishment was in government and municipal schools;
- Most children did not report the matter to anyone;
- 50.2 per cent children worked seven days a week;
- The ratio of girls physically abused was higher in Kerala (55.61 per cent) and Gujarat (54.61 per cent);
- The highest percentage of abuse among boys was reported from Delhi (62.2 per cent) followed by Madhya Pradesh (59.75 per cent) and Maharashtra (55.75 per cent).



Expenditure on Education¹²

Until the 1990s it was commonly believed that shortage of financial resources was one of the major reasons for India's poor educational achievements. No more. India's economic trajectory in the last 15 years has made advocates of education raise the issue of allocation of existing resources as a problem area.

It is all to do with political will. When the Eighth Five Year Plan was announced, it was announced that 4.9 per cent of the GDP would be invested in education. Ironically, the percentage share of education to GDP has declined (see table below). It perhaps requires greater political commitment to achieve the 6 per cent of GDP target in the Eleventh Plan.

Public expenditure on education in India

Year	Expenditure on education (all, centre and state) Crores	Government expenditure on all sectors Crores	GDP at current prices (at factor cost) base year 1993-94 Crores	% expenditure on education to expenditure on all sectors	% education expenditure to GDP
1999-2000	74816.09	512519.33	1761838	14.60	4.25
2000-2001	82486.88	572160.14	1902998	14.42	4.33
2001-2002*	79865.70	619713.14	2081474	12.89	3.84
2002-2003*	85507.34	678548.31	2254888	12.60	3.79
2003-2004*	89079.25	743668.96	2543396	11.98	3.50
2004-2005*(RE)	104566.00	819231.00	2843897	12.76	3.68

*: Provisional, Source: GOI, SES, 2006

Following the 1990 Jomtien conference there was a palpable shift in favour of elementary education (see table below). As Dr Govinda and K. Biswal point out, from 1999-2002, the share of expenditure on elementary education increased by a little more than four per cent, taking the Centre and the States/UTs together. Several Centrally Sponsored Schemes (CSS) were launched as a follow-up of the NPE in the area of elementary education throughout the country. But the initiative for utilising the resources was with the state governments.

This trend somewhat changed with the DPEP. Funds from the Government of India were channelised through a State Implementation Society created in every state. The state governments were required to bear 15 per cent of the total expenditure for implementation of the DPEP activities.

12. This section of the paper draws upon R Govinda and K Biswal 2006. The author would like to gratefully acknowledge the source of both the arguments and the data cited.



Govinda and Biswal point out that the Central government's flagship elementary education programme – Sarva Shiksha Abhiyan (SSA) — continued with this pattern in the Ninth Five Year Plan. However, under the Tenth Plan, the Central government provides 75 per cent of the additional expenditure under the SSA to each state as compared to 85 per cent earlier. Thus, “what was essentially a supportive role in the Eighth Five Year Plan has got gradually transformed into a major partnership in elementary education development between the Centre and the State.”

Year	Expenditure on Elementary Crores	% to GDP on Elementary	% to GDP on Secondary/Higher Secondary	% to GDP on Adult	% to GDP on University and Higher
1999-2000	34068.78	1.93	1.44	0.01	0.86
2000-2001	39274.60	2.06	1.37	0.01	0.89
2001-2002*	40019.36	1.91	1.20	0.02	0.69
2002-2003*	41747.26	1.86	1.22	0.02	0.70
2003-2004*	44349.47	1.74	1.12	0.02	0.62
2004-2005*(RE)	53796.74	1.89	1.11	0.02	0.66

Increase of State Share In SSA may not be Very Effective

The Central government now seeks to increase the share of state governments to SSA from 15 per cent to 50 per cent by the end of the Eleventh Plan. Given the existing unevenness in the financial health of different states and also given that not all states accord priority to basic education – this move may actually reduce the quantum of resources spent on basic education in the coming years.

Transparency is a Big Issue

For the last four years the Government of India has been levying an education cess of 2 per cent on income tax, corporation tax, excise duties and service tax. This is expected to fetch almost Rs. 4,000-5,000 crore a year. Yet, there is little transparency on how this has been allocated.

IV. STRATEGIES TO MEET CHALLENGES OF MEANINGFUL ACCESS – BEST PRACTICE MODELS

Access and quality are two sides of the same coin. It may, therefore, be more appropriate to use the term ‘meaningful access’ – encompassing the continuum from enrolment, regular attendance of children and teachers, availability of books and other learning materials, a learning environment in a functioning school and finally a place where children learn.





What Best Practice Models can Teach about Core Principles

A look at promising interventions from across the country reveals certain principles at work:¹³


- A realistic assessment of ground reality regarding enrolment, attendance and learning outcome;
- Addressing inequity through differential financial allocation and with empathy. Identifying the most deprived is a good starting point – in order to make sure that the system is able to reach out to the last child first – and working one’s way upwards to cover the less deprived.
- Forging closer community, school and system linkages through real devolution of powers (not just responsibility) and enabling *empowered local action*. There is a wealth of experience in the country, especially in the NGO sector, to empower communities to demand their entitlement and monitor programmes meant for them;
- Creating open communication channels between education administrators/implementers and local officials, teachers, parents and children. The strongest lesson internalised from the Right to Information debate in the country was that creating a free flow of information becomes a powerful tool in the hands of people to access all levels in the government as well as civil society;
- Energising the school system through improved classroom practice and assessment processes; strengthening science education through labs, centres and related activities and use of communication technology like the radio to reach out. The schools do not stand alone – creating a vibrant learning environment in and around the school, using local as well as modern technology to make learning a creative and exploratory exercise, can indeed turn the tide and energise the school;
- Providing academic resource support to teachers and teacher educators in a manner that fosters creativity and respects teacher experience, skills and knowledge.


Discard Linear Process in Favour of Spiral of Change

The overarching message from this exercise is that interlocking elements formulate the education system and sustainability hinges on the ability of the pioneers to systematically weave in practises and processes into the fabric of the system. Teacher training alone cannot improve teaching and learning processes. Addressing administrative, personnel and other issues alongside accountability systems could help us turn the corner. A systemic, not a piecemeal approach, is needed even though we may start from one point.

A virtuous process needs to be set in motion where an innovation – even if limited – demonstrates tangible outcomes resulting in improvement in the input processes in the next

13. This section draws upon the Educational Resource Unit documentation of 17 good practices commissioned by ILO and Department of School Education and Literacy, GOI in 2006 and Vimala Ramachandran (ed) Getting Children Back to School – Case studies in Primary Education, Sage Publications, New Delhi, 2003.





round and the initiative gathers greater support within the system. The second round could take the practice to a higher level, further improving outcomes and gaining more champions in the system. This could – if managed right – set in motion a virtuous spiral of change.

Do Incentives Make a Difference?

A popular argument in policy and development aid circles the world over is that incentives can help turn a difficult situation around. Across India, where vulnerable, poor children lack access to a regularly functioning and a child-friendly school, and remain outside, drop out or are pushed out of the school system, where do incentives come in?

Up to the mid-1990s it was believed that monetary and other benefits to poor children/families through targeted incentives (uniforms, school supplies and mid-day meals) could turn the situation around. Poverty was seen as the main barrier. The unspoken belief was that the problem was with the ‘people’ and not the system.

A recent study by the Educational Resource Unit in the states of Andhra Pradesh, Karnataka, Rajasthan, Orissa and Maharashtra, have revealed that this is not the case.¹⁴

Incentives alone not enough for Quality Education

Perhaps the most important insight that we gained from this study is that incentives – be it individual or to the school – may be necessary and useful in some situations (especially for first generation learners) *but are not sufficient in themselves to enhance children’s access to quality education*. Sponsored children and some of their siblings do benefit and even complete high school. But the children left behind in the village continue to struggle with a dysfunctional school system.


In one village two families that did not send any of their children to school said the school did not function and anyway they were too poor. In sharp contrast, in another village, the government primary school functioned regularly and almost all the children were enrolled. This village had an active village education committee monitoring the school.

Creating an Environment of Learning Essential

Our travels in Maharashtra and Karnataka revealed that creating a conducive environment for children’s education through active village level committees and children’s clubs, Bal Panchayats and other village level forums for collective action gives teeth to the right to education of every child and promotes child participation. We found that almost all the children up to 14 years were attending school, the mid-day meals were regular, the teachers more responsive and perhaps more regular because of a strong community involvement.

14. Vimala Ramachandran, Nishi Mehrotra and Kameshwari Jandhyala: Incentives in Education – Do they make a difference? Unpublished Mimeo based on a research study commissioned by Plan International India on Incentives and the hidden cost of education, ERU and Plan International India, New Delhi 2006.





One of the disturbing findings of this study was that individual incentives increased disparities. We met siblings of children studying in hostels or residential schools who had dropped out from school. One family had persuaded the NGO to shift the sponsorship from their daughter to their son. Sponsorship – either as scholarships or study in a residential camp — may benefit the concerned child. But it increases the distance between the child and her siblings in some cases and between the sponsored family and other poor households in the village, creating a divide in the community.

The Poorest Need Benefits but have Least Access to Them

A related issue almost everywhere was the selection of beneficiaries. Extremely poor/marginalised households were left out in most of the villages visited. Families with clout or leadership positions in community-based organisations have greater representation among the sponsored children.

No Alternative to Working with Mainstream Schools


Many NGOs run supplementary education centres/tuition classes, short-term accelerated learning programmes/camps or provide additional teachers to local primary schools. Most of them found it difficult to work with mainstream schools. Funds from international donor agencies were utilised to create parallel systems.

Bypassing the formal school system is an attractive option, especially for NGOs with alternative sources of funding. But evidence from across India demonstrates that there is no alternative to working with mainstream schools.

We met NGOs in Maharashtra, Karnataka and Andhra Pradesh who withdrew individual incentives and turned their focus on the formal school system. Their mantra: sustained community level activities; teacher support; working closely with local education department officials and teachers to ensure the proper functioning of the school and regular provision of the mid-day meal; supporting children's learning through remedial education classes, village libraries, pre-school education and children's clubs/Bal Panchayats.

It has been seen that public activities like science fairs, reading and writing contests, excursions and children's clubs help create a positive environment for education. Coupled with sports and cultural activities, such periodic events could enable children to explore their creativity and also hone their managerial/organisational skills.

They focus on all the children in the village at the elementary level. These NGOs supplement the inputs provided by the government and do not duplicate them. Their work has proved that the key is to turn the system around and make the school vibrant and responsive.





Building a Strong People's Movement for Education

Individual or school-based incentives are only as effective as the level of awareness about them. There is a popular saying that if we throw money only the strongest will pick it up! In all the villages we came across extremely poor families in the sample villages who were not aware of individual or school-level incentives; they rarely participated in village level meetings. Building a strong people's organisation/women's organisation, ensuring participation of the poorest of the poor in the village and disseminating information to all social groups is essential for the effective utilisation of either individual or group incentives.

Further, community mobilisation has to be followed up with strengthening Panchayats and making them active agents in universal quality education, as well as creating village-level forums for regular participation of children and the parents in the decision making processes.

Three-way Channel between Community, School and Children a Must

A structured relationship between the three – community, school and children – can enable the community to both access government services/incentives (textbooks, uniforms for SC and ST children, girls; scholarships/stipends, monitor quality (of the mid-day meal) and the functioning of the school with the children playing a key role in their education and empowerment. In the educationally backward regions, NGOs must make sure that children get their entitlements and that statutory bodies like VEC or PTA (as the case may be) are not just paper committees.


Ultimately, quality is about being accountable to children and parents. Accountability and transparency go together. Village and child-wise data need to be placed in the public domain like the Gram Sabha (general body of the community at the village level). A display board outside the school with basic information about the institution, the children, the teachers and availability of government incentives and mid-day meals, would make a big difference. If measurement of learning outcomes is accepted as a key determinant of quality then the measured results must be shared with children and parents, the outcomes analysed by teachers and the entire experience fed into the planning process at the local level.

Right to education and its implementation

Following the 86th Constitutional Amendment Act of 2002, the new Article 21A reads thus: "Right to Education – The State shall provide free and compulsory education to all children of the age of six to fourteen years in such manner as the State may, by law, determine."

This was a result of many years of concerted advocacy by NGOs and social action groups. The ministry of HRD drafted a corresponding Free and Compulsory Education Bill, 2004 for






consideration by the Parliament. and it underwent several modifications – right up to 2005. But a legislation to give the Right to Education legal teeth was never enacted. The Central government circulated this draft to all the states asking them to introduce appropriate bills/ordinances for effective implementation of the 86th Constitutional amendment.


While the draft provides safeguards to ensure that formal schools cater to all children and that the transitional arrangements are strictly short-term, the situation on the ground tells a different story. Given the financial situation of most state governments, transitional strategies – meaning EGS and AS – are becoming the preferred option. The EGS model of MP is here to stay (even though many EGS centres have been accorded the status of a formal primary school) and the previous Congress Party-led government took a decision that in future “Gurujis” would be appointed in place of formal school teachers.

West Bengal and Rajasthan have also opted for contract teachers to meet the demands of an expanding elementary education system. Evidently, EGS and AS are becoming attractive models – especially when state governments are hard pressed for funds. Considering that during the Eleventh Plan the state governments are expected to provide 50 per cent of the funds required for the implementation of SSA, this is a worrisome trend. How effective can the right to education be in the absence of legal instruments to enforce it?

Way Forward

From whichever angle we approach the issue of educational access, quality and relevance – we come back to three basic elements of a functioning and responsive education system:

- The government needs to shoulder the primary responsibility for providing basic education to all children in the 6-14 age group;
 - Civil society organisations/people’s organisations need to be vigilant and ensure that the formal school system functions optimally and, wherever possible, strengthen structures created by the government to forge close community-school relationships. Eternal vigilance is indeed the price we all have to pay to sustain the democratic fabric of our society;
 - The elementary school system does not stand alone. Availability and effective functioning of backward linkages in the form of pre-school education, good nutrition and care in early childhood need focussed and sustained attention. Equally, children and their parents view elementary education as a stepping stone to greater knowledge or opportunities for further training / education and most importantly developing the confidence to negotiate the world. Community-level initiatives that give young people a hope for the future and confidence in their ability to carve a better future for themselves acts as the single most powerful suction pump that that can pull generations of young children through the school system. We cannot depend only on the government to create the forward linkages – the larger development community needs to sit up and think about how we can give hope to children and their parents.
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Donors, funding partners (including Indian NGOs) and the government need to come to a shared understanding on what could work and what is non-negotiable. Perpetuating essentially unequal models (like non-formal education, night schools and so on) and creating parallel and part-time educational opportunities effectively robs children of their fundamental right to education, and is a mere escape route.

There are no shortcuts. If we are serious about achieving the goal of UEE and making sure that the government system functions, then the INGO and donor community needs to seriously reflect on the strategies that they may have promoted which negate the right to education. Public action, advocacy and hands-on work at the ground level are essential to turn the system around and make it accountable to the children of India.

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Status of Health Services in India: An Overview

Imrana Qadeer¹

I. THE CONTEXT: WHERE DO WE STAND?

Health evokes different images for different people. One person might think of well equipped hospitals, primly dressed nurses and a smiling staff. You might think of a fitness-conscious individual, the jogging sort who is careful about his diet, rest, and exercise. Some others might simply dream of shelter, food, safe drinking water and a secure job that ensures all of the above!

It all depends on where we stand in society. The pressures we face make us think of health as something to do with the individual or society. In other words, it is the perspective that one uses to examine issues around health that matters.

Is health purely a function of human biology or available technology — one that stresses disease, diagnosis, cure or management of symptoms — known as the biomedical perspective? Is it a function of our social reality as stressed by the social perspective of health, or is it a combination of both as is stressed in a holistic perspective of health?

Holistic view of health


The holistic perspective not only takes into account existing technologies and their organisation, it also underlines the importance of social determinants that contribute to people's well being — such as food availability and nutritional status of populations, drinking water supply, housing, transport, education, employment and, last but not least, the status of women.


People's health can then be defined as an outcome of the interplay of socio-economic, cultural, political, and technological forces. This outcome varies, depending on gender and caste, class stratification, regional and ethnic factors.

Talking of health services then touches upon only one aspect of the determinants of health. This is something that we don't often fully appreciate, but we must if we have to make headway in achieving health for all.

Does this mean that health services are not important? It does not mean that at all. The provision of health services is one of the most important welfare responsibilities of the Indian

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State enshrined in the guiding principles of its Constitution. What it does mean, however, is that providers and planners of health must, above all, demand the other inputs necessary for health instead of simply building their empires as specialists.

Dimensions of Public Health = Vital Weave of Services + Welfare Inputs

Health services by themselves are a highly complex entity. They operate either as *clinical* or as *public* health services. Clinical health services are individualised services to those who seek medical attention, where the provider offers the best technology available or within the means of the patient.

Public health services are, in fact, organisationally more complex. They have several dimensions:

- (a) They provide a mix of promotive, preventive, curative, and rehabilitative services. Health education and spread of information promotes certain protective health behaviours, through immunisation, sanitation, and nutritional services. It also attempts to prevent occurrence of disease. Through clinical intervention the public health system cures as well as protects those in society who are exposed to communicable diseases. Through rehabilitation it helps people cope with disability;
 - (b) Clinical interventions by public health services to arrest the spread of communicable diseases remain the most potent means of control, prevention, or elimination of these major killer diseases as compared to non-communicable diseases in India. Clinical medicine, to become an instrument of public health, has to be modified such that instead of focussing on the individual, it attempts to optimise effect in order to enhance coverage. It thus reduces the pool of infection to an extent that the spread of disease is arrested and the vulnerable population is protected. In doing so it changes the course and history of disease in populations. Clinical medicine is thus transformed into a *medical care system* in public health where even clinical services have an objective that goes beyond focussing on individuals;
 - (c) Apart from integrating the promotive, preventive, curative and rehabilitative aspects of a disease control programme, public health services demand integration at yet another level: between different programmes with common strategies. These programmes could be concerned with condoms for family planning and protection from AIDS, or immunisation for lowering the Infant Mortality Rate (IMR) and Maternal Mortality Rate (MMR). Public health services have to then respond to the need for personnel, shared monitoring, transport and training, among others. In other words public health services are conceived of as integrated programmes, both vertically as well as horizontally;
 - (d) These different strands of services are provided through a hierarchical network. A network that offers the simplest, basic services at the primary level; and above it supportive, secondary and tertiary level care. These tiers are integrally bound by a two-way referral link that is crucial for the success of health services.
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However, the fact remains that even the most efficient of public health systems cannot achieve the best possible results unless they are supported by the welfare inputs we started with: food availability and nutritional status of populations, drinking water supply, housing, transport, education, employment and gender equality. In Third World countries these are the most critical inputs without which health systems play a very minor role in preventing diseases.

Environmental Conditions And Mortality

This realisation is reflected in the setting up of the Commission on Social Determinants of Health by the World Health Organisation (WHO). Its report on the environmental causes of diseases² shows that 24 per cent of the mortality in developing countries is due to environmental conditions such as diarrhoea, pneumonias, malaria, tuberculosis and malnutrition.

This supports our contention that services need to be evaluated and assessed within a holistic perspective where health planning is constantly linked to larger welfare inputs. This is necessary not only because health is dependent upon them but also because access to services and the nature of service itself is determined by socio-economic and political realities.

II. PUBLIC HEALTH SERVICES TODAY: SKEWED AND CRUMBLING

India has a mixed system of services which includes modern as well as traditional systems. The health providers range from modern-day medical professionals to practitioners of traditional medicine and those with short training — the registered medical practitioners (RMPs) — or no formal training and some work experience. Then there are the paramedical personnel and traditional providers — the ‘dais’ or birth attendants.

Modern medical services are offered by the State as well as by the NGO and private sectors. The traditional systems are said to have acquired a significant space since the mid-1970s at all levels of services. Many of these personnel are being integrated into public health services, such as the AYUSH component (Ayurvedic, Unani, Siddhi, and Homeopathy) of the National Rural Health Mission (NRHM).

Though there are more medical care institutions in the private sector, the public sector continues to have a greater number of beds, despite its slow growth. By the end of the 20th century there were a total of 15,501 hospitals. Of these, 10,848 were private institutions, an overwhelming majority. But the private hospitals had only 2,53,437 beds out of a total of 6,81,643 beds.³ This shows that the larger institutions still remained with the public sector.

2. Pruss-Ustun A. and Corvalan C., 2006: Preventing Disease Through Health Environments: Towards an Estimate of Environmental Burden of Disease, Geneva, WHO, pp. 11-12.

3. Government of India, 2002: Health Information of India 1999, CBHI, DGHS, Ministry of Health and Family Welfare, New Delhi, pp. 138



Or look at it from the rural-urban angle. According to the Health Information of India 2004 report, there are 585 rural hospitals as compared to 985 urban hospitals in the country. The urban bias is very clear, with only the Community Health Centres (CHC) trying to make up for the gap in rural areas. If we include CHCs among hospitals, the total number of rural and urban hospitals comes to 5,479 (Table 1).

Table 1: Number of Govt. allopathic hospitals and beds in Rural and Urban areas (including CHCs)

State/ UT/ division	Rural hospitals						Urban hospitals		Total (Rural+urban) hospitals	
	Community health center		Other rural hospital		Total rural hospital					
	No.	beds	No.	beds	No.	beds	No.	beds	No.	beds
Andhra Pradesh	169	5114	75	2100	244	7214	122	25248	366	32462
Arunachal Pradesh	21	168	0	0	21	168	14	1236	35	1404
Assam	100	[c]3000	NR	NR	100	3000	NR	NR	100	3000
Bihar	@148	[c]4440	NR	NR	148	4440	NR	NR	148	4440
Chattisgarh	116	3514	0	0	116	3514	22	2051	138	5565
Goa	5	222	3	390	8	612	11	207	19	2619
Gujarat	242	[c]7260	NR	NR	242	7260	NR	NR	242	7260
Haryana	64	1920	7	223	71	2143	54	4845	125	6988
Himachal Pradesh	66	1202	31	1566	97	2768	44	5003	141	7771
Jammu division	25	[c]750	3	80	28	830	8	870	36	1700
Kashmir division	33	990	0	0	33	990	[a] 7	605	40	1595
Jharkhand	@		NR	NR			NR	NR		
Karnataka	*259	12130	0	0	259	12130	66	22357	325	34487
Kerala	106	3485	60	7308	166	10793	27	14829	193	25622
Madhya Pradesh	229	6884	0	0	229	6884	95	10818	324	17702
Maharashtra	348	10628			348	10628			[d]1136	[d]75615
Manipur	16	320	10	50	26	370	2	300	28	670
Meghalaya	22	660	3	300	25	960	4	1167	29	2127
Mizoram	12	376	4	120	16	496	5	673	21	1169
Nagaland	21	600	7	240	28	840	8	850	36	1690
Orissa	202	3044	104	1091	306	4135	97	8767	403	12872
Punjab	117	3852	22	738	139	4590	21	4383	160	8973
Rajasthan	287	10175	57	2749	344	12924	**28	5382	372	18306
Sikkim	4	350	2	80	6	430	1	300	7	730
Tamil nadu	128	3840	172	NR	300	3840	42	20141	342	23981
Tripura	9	250	6	325	15	575	***12	1656	27	2231
Uttar Pradesh	@310	[c]9300	NR	NR	310	9300	NR	NR	310	9300
Uttaranchal	@		NR	NR			NR	NR		
West Bengal	95	3418	15	3056	110	6475	119	36682	229	43156



State/ UT/ division	Rural hospitals								Total	
	Community health center		Other rural hospital		Total rural hospital		Urban hospitals		(Rural+urban) hospitals	
	No.	beds	No.	beds	No.	beds	No.	beds	No.	beds
A&N island	4	201	2	154	6	355	4	1114	10	1469
Chandigarh	1	35	1	15	2	50	5	2150	7	2200
D&N haveli	1	30	0	0	1	30	1	75	2	105
Daman & Diu	1	42	1	10	2	52	2	140	4	192
Delhi	0	0					[b]105	20368	[b]105	20368
Lakshadweep	3	[c]90	0	0	3	90	2	70	5	160
Pondicherry	4	120	0	0	4	120	10	2944	14	3064
Total	3168	98410	585	20595	3753	119005	938	197001	5479	380993

Source: Health information of India 2004 pp- 151

Notes: PHC, MCH/RCH centers, PPC, FWC, Municipal Corporation centers etc. are not included in hospitals though these facilities may have few beds attached to them. Government includes central government, state government and local govt. bodies.

[a] Leprosy hospital – bed strength not given; [b] in Delhi there no concept of rural / urban hospitals.

[c] estimated @30 beds per one CHC ; [d] includes CHCs (348) & other rural as well as urban hospitals (788 with 64987 beds) for which rural urban break up is not furnished.

* includes 149 Taluk hospitals which also function as CHC; ** tertiary & super speciality hospital information not included; ***one super speciality hospital (now outdoor for cardiology only); @ Prior to re-organization of states; NR: Not Reported.

The same table also shows the state-wise distribution of these institutions: at first glance the weak position of states like Uttar Pradesh, Bihar, Madhya Pradesh, Rajasthan and Chhattisgarh becomes clear. According to the Planning Commission,⁴ the status of rural infrastructure in 2006 is as follows: 3,344 CHCs; 23,236 Primary Health Centres (PHC); and 1, 46,026 sub-centres.

Missing Personnel: Critical Gaps in Health Services

The statistics hit you in the face. According to the Health Information of India 2004 report, out of the 6,39,729 doctors registered in India, only 67,576 are in the public sector; as many as 5,72,253 doctors are either in the private sector or abroad. This creates a tremendous shortfall in the states where a large number of posts remain vacant (Table 2).

It is a similar story with general nurses and midwives and Auxiliary Nurse Midwives (ANM). There are 8,39,862 general nurses and midwives, 5,02,503 ANMs and 40,536 health visitors and supervisors. Their availability in the rural areas (Table 2) reveals the critical shortages of each of these personnel. To fill in this gap the government is trying to integrate manpower from available alternative systems that constitute a significant number (Table 3). Unfortunately, however, they are replacing doctors from the PHC rather than complementing their work.

4. Planning Commission, 2006: Report of the Working Group on Public Health Services For the 11th Five Year Plan (2007-2012). New Delhi, Planning Commission.



Table 2: Health human power working in rural areas (govt.)

Type of functionary	Required (R)	In position (P)	Shortfall (R-P)	Sanctioned (S)	Vacant (S-P)
PHC doctor	22842	25724	2310	29689	3965
Total specialists	12172	4124	7459	6617	2493
Pediatrics	3043	440	2030	1019	578
Physician	3043	704	1799	1305	601
Obstetrician /gynecologist	3043	780	1699	1498	718
Surgeon	3043	781	1698	1518	737
Block extension educator		5708		6743	1053
HA (male)	22842	19927	5452	23569	3642
HA/LHV (female)	22842	19855	3889	23032	3257
MPW (male)	137311	71053	66902	84750	13697
Pharmacist	25885	21118	6678	22972	2469
Lab Technician	25885	13262	12661	15544	2368
ANM / MPW (female)	160153	137407	24382	148151	10765
Nurse Midwife	44143	27336	20842	32723	5495

Source: Health information of India 2005

Table 3: Number of registered practitioners under alternative system of medicine

Year	Ayurvedic	Unani	Sidha	Naturopathy	Homeopathy	Total
1999	367528	41221	12915	388	189361	
2003	432625	42833	17550		201148	695024

Source: Health information of India 2005

Health Sector: Caught between Population Control and Cutbacks

To see where this poverty of the public sector comes from, we need to examine the pattern of allocation of resources to the health sector:

- Through the 1980s and beyond, the allocation on health and family welfare has not gone beyond 3.97 per cent of the total allocation. Within this, health has never received more than 1.8 per cent of total Plan investment except in the Ninth and Tenth Plans when it got slightly more than the family welfare programme (Table 4). The government's approach to health has always been a single programme of population control against all other programmes related to health;
- When seen as a percentage of the Gross Domestic Product (GDP), the current investment in health declined from 1.3 per cent through the 1990s to 0.9 per cent in 1999⁵ and has stayed there despite promises of an increase in annual budget speeches;

5. Government of India, 2002: 'National Health Policy', Ministry of Health and Family Welfare, New Delhi.



- The expenditure on national disease control programmes within the health sector (Figure 1) reveals a trend of increasing emphasis on AIDS control as against all national vector-borne disease control (NVBDC) programmes such as those to do with leprosy and tuberculosis;⁶

Table 4 : Patterns of allocation of resources

Period	Total plan investment Outlay (all heads of Dept.)	Health	Family welfare	ISM&H / AYUSH	Sub-total
Sixth Plan (1980-85)	109291.7 (100.0)	2025.2 (1.8)	1387.0 (1.3)		3412.2 (3.1)
Seventh Plan (1985-90)	218729.6 (100.0)	3688.6 (1.7)	3120.8 (1.4)		6809.4 (3.1)
Annual Plan (1990-91)	61518.1 (100.0)	960.9 (1.6)	784.9 (1.3)		1745.8 (2.9)
Annual Plan (1991-92)	65855.8 (100.0)	1042.2 (1.6)	856.6 (1.3)		1898.8 (2.9)
Eighth Plan (1992-97)	434100.0 (100.0)	7494.2 (1.7)	6500.0 (1.5)	108.0 (0.02)	14102.2 (3.2)
Ninth Plan (1997-02)	859200.0 (100.0)	19818.4 (2.31)	15120.2 (1.76)	266.35 (0.03)	35204.95 (4.09)
Tenth Plan (2002-07)	148431.3 (100.0)	31020.3 (2.09)	27125.0 (1.83)	775.0 (0.05)	58920.3 (3.97)

Source: Health information of India 2005 pp-79

- The Central budget has been starkly biased against health. In the Tenth Plan it allocated Rs. 2,908 crore to health as against Rs. 6,424 crore for family welfare. This distribution is consistent with the Eighth and Ninth Five Year Plans where Rs.1,712 crore and Rs.5,118.69 crore were allocated for health as against Rs. 6,500 crore and Rs. 15,120.20 crore for family welfare.⁷ These data indicate the marginalisation of the health sector as it is not only almost one third of the allocation to family welfare in the planning of the Indian State⁸ but also compares poorly with the first 20 countries in the HDI index that allocate 5.4- 8.1 per cent of their GDP to health.⁹

6. Sagar A., 2006: 'Health', Alternative Economic Survey of India 2005-2006: Disempowering Masses, New Delhi, Daanish Books, pp. 251-259

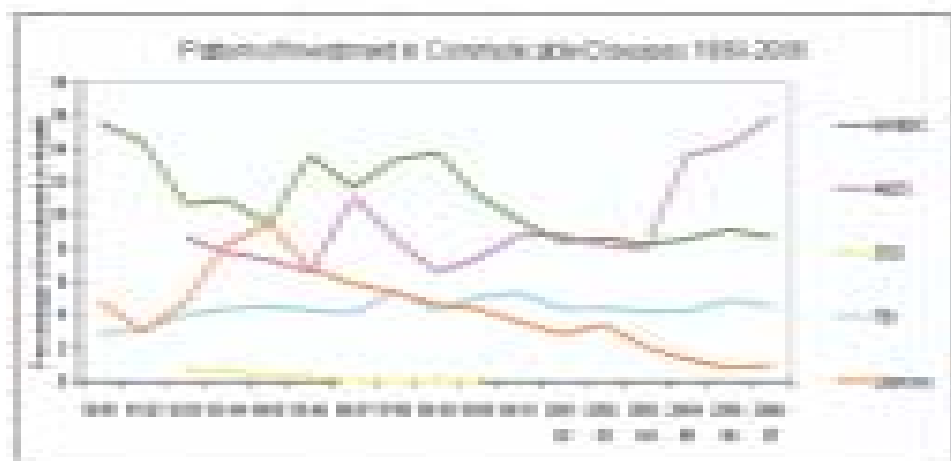
7. Government of India, 2005: 'Health Information of India 2004' CBHI, DGHS, Ministry of Health & Family welfare, New Delhi, pp.80.

8. Government of India, 2005: 'Health Information of India 2004' CBHI, DGHS, Ministry of Health & Family Welfare, New Delhi, pp.370.



The explanation offered for expenditure cutbacks on welfare is that the public sector is inefficient as compared to the private sector. Hence, a shift in subsidies is rational. But evidence from countries like the United States and Britain do not support this logic. These two countries invest 12 per cent and 6 per cent of their respective budgets in health. While the US runs its services primarily through the private market and insurances, the latter still depends on State infrastructure to achieve universal coverage. However, indicators like infant mortality rate and mortality under five years of age are much higher in the US.¹⁰

Figure-1: Expenditure on national disease control programmes



Health Indicators: Unable to Reach out to the Poor

When we compare the morbidity and mortality profiles in India against the infrastructure and investments in health, the picture is not very impressive. Marginal declines in morbidity and mortality or stagnation seem to be the only achievement. In fact it seems to be an achievement fraught with poor recording and misreporting.

Take the data on leprosy published by the government. It shows that the estimate of the number of people suffering from leprosy were much lower as compared to the actual detections all through. The reason is simple: the programme puts a stop to the treatment of individuals after two years of medication. In official records that person is cured. So the estimated targets go down. But this two-year treatment simply reduces the severity of the disease; it does not necessarily lower its prevalence. The incorrect targets were based on the assumption that India has succeeded in eliminating the disease when the truth lies somewhere else.

9. UNDP, 2004: 'Human Development Report 2004', Oxford University Press, new Delhi pp. 156-158

10. Athreya, V.B. and Rao, M., 2006: 'Education and Health in The Draft 11th Plan Approach Paper', Social Scientist vol. 400-401, no.9-10 pp. 21-33.



Similarly, vaccine preventable infections of childhood flourish. Dengue, pneumonia, enteric fever, viral hepatitis and other infections have not subsided either (Tables 5a, 5b, 5c), along with other communicable diseases. If we look at the overall mortality, fertility and life expectancy indicators (Table 6) it becomes clear that an IMR of under-60 per 1,000 live births is seen only in five of the 16 states that were studied and, in the absence of accurate data, maternal mortality remains high and continues to be indirectly assessed through estimates or through samples of population. Similarly, only in four states is the fertility rate 2.5 per cent. And, except for Kerala and Punjab, 35-55 per cent of the children below three years of age in all other states are underweight.

Table 5a: Reported morbidity and mortality due to Vaccine preventable diseases
Vaccine preventable diseases

		1999	2004
Diphtheria	Cases	4216	8465
	Deaths	85	126
Acute polio	Cases	899	218
	Deaths	11	4
Tetanus neonatal	Cases	2792	1087
	Deaths	385	141
Tetanus others	Cases	1309	3743
	Deaths	1014	474
Pertusis	Cases	32939	32786
	Deaths	22	19
Measles	Cases	51001	51456
	Deaths	261	140
A.R.I.	Cases	16730509	25571757
	Deaths	3686	5223

Source: Health information of India 1999 & 2004.



Table 5b: Morbidity and mortality due to important communicable diseases

Disease		1999	2000	2001	2002	2003	2004
Malaria	Cases	2284713	2031790	2085484	1842019	1647378	911293
	Deaths	1048	932	1005	973	943	399
Diarrhea	Cases	8215296	8870507	9289558	9441456	10510476	9575112
	Deaths	3594	2918	2787	3475	4709	2855
Kala azar	Cases	12886	14753	12239	12140	18214	19911
	Deaths	297	150	213	168	210	131
J. E.	Cases	3428	2593	2061	1765	2568	1529
	Deaths	680	556	479	466	707	344
Dengue	Cases	944	650	3306	1926	12754	2807
	Deaths	17	7	53	33	215	28
Leprosy	Cases	Targets		183345	183345	420925	
	Cases	Achievements		559938	617993	476000	367143
	Deaths						
Filaria	M.F. carriers				0.35	0.54	0.66
	Diseased persons				0.77	1.22	1.17

Source: Health information of India, 2004

Table 5c: Reported morbidity and mortality due to other Communicable diseases.

		1999	2004
Enteric fever	Cases	379304	658301
	Deaths	382	805
Viral hepatitis	Cases	131798	203939
	Deaths	1322	1122
syphilis	Cases	31684	56473
	Deaths	7	26
Gonococcal infections	Cases	95278	162946
	Deaths	11	210
Meningococcal Meningitis	Cases	7444	8999
	Deaths	868	541
AIDS	Cases	16722	96978

Source: Health information of India 1999 & 2004



Table 6: Selected health status outcomes in India and major Indian states

Area	Life expectancy at Birth, average for 1992-96 years	MMR (1998)	IMR	Under 5 mortality Rates, 98-99 (per 1000 live births)	Total fertility rates, 1997 (percent)	Under weight Children, 98-99 (percent)
Andhra Pradesh	62	159	66	86	2.5	38
Assam	56	409	78	90	3.2	36
Bihar	59	452	67	105	4.4	54
Gujarat	61	28	64	85	3.0	45
Haryana	64	103	69	77	3.4	35
Karnataka	63	195	58	70	2.5	44
Kerala	73	198	16	19	1.8	27
Madhya Pradesh	55	498	98	138	4.0	55
Maharashtra	65	135	49	58	2.7	50
Orissa	57	367	98	104	3.0	54
Punjab	67	199	54	72	2.7	29
Rajasthan	60	670	83	115	4.3	51
Tamil nadu	64	79	53	63	2.0	37
Uttar Pradesh	57	707	85	123	4.8	52
West Bengal	62	266	53	68	2.6	49
India	61	407	72	95	3.3	47

Source: *Better health systems for India's poor, World Bank 2002*
NCMH background papers- burden of diseases in India pp-88


Dismal Performance

This brief overview shows that achievements in health indicators have been far less promising than expected, both in terms of the present status of health and reaching out to the poor as well as in terms of building health infrastructure. Also, whatever has been achieved is due to the overall socio-economic development over time that has no doubt touched the lives of the people. To understand the inability of the health services to effectively deal with health problems, we need to understand the historical trends in the planning process.

III. TRENDS IN HEALTH PLANNING FOR ALL: POLICY FRAMEWORK

The initial hope and commitment to provide health services was reflected in the first comprehensive report prepared by the Bhole Committee in 1946. It promised healthcare to all, irrespective of an individual's paying capacity. The report also recognised that poverty and environmental conditions hamper public health systems from achieving the best possible results. It conceptualised a three-tier pyramidal structure for each district to run an integrated health service.¹¹ This structure was to be further strengthened through medical colleges and

11. Government of India, 1946: 'Report of The Health Survey and Development Committee', (Bhole Committee Report), Vol. II, Ministry of Health, manager of Publications, New Delhi, pp. 17.



speciality hospitals in the cities. National disease control programmes were initiated along with family planning and nutritional programmes, and manpower training became an important part of building the health services.

A Weak Start: Financial Crunch, Urban bias, Coercion

A review after 10 years pointed out the problems of financing programmes in the health sector. It suggested building a health cess or a system of differential payments or a national insurance system, but these were not heeded.¹² On the contrary, the investment in the health sector over the Five Year Plans declined and an urban focus emerged with the neglect of the rural sector.

The emphasis on the family planning programme and other vertical programmes like malaria, leprosy and filaria led to the neglect of general health services. The failure of these programmes to sustain their initial impact by the 1970s forced the system to reorganise. However, that only led to partial integration, domination of the family planning programme, and neglect of supportive programmes for improving nutrition, sanitation, and availability of drinking water. All this weakened rather than improved the public sector.

There were many other factors at work too. The 1970s witnessed economic turmoil due to the worldwide oil crisis and the subsequent hike in oil prices. Added to these was the onslaught of the National Emergency that further cut into welfare investments, the health sector in particular. The result was a total disillusionment among the people who began to identify health services with coercion and forced sterilisations.

This forced the new government formed in 1977 in the post-Emergency phase to talk about revitalisation of the health system. In the late 1970s it made an effort to put the health sector back on track by containing sterilisations, initiating the Community Health Worker Programme, the Integrated Child Development Scheme (ICDS), and by signing the Alma Ata declaration in which the government reaffirmed the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world.


The urban, hi-tech orientation of the services, however, reinforced itself and Primary Health Care was transformed into Selective Health Care, focusing on programmes for which medical interventions were available.

Family Planning by Any Other Name...

The problems of infrastructure and of identification of epidemiologically correct priorities in public health continued in the 1980s. (Epidemiology concerns population-based studies to assess field level problems.) The Sixth Plan initiated a major expansion of health infrastructure. It introduced the concept of one CHC for every 1,00,000 population, reducing the coverage

12. Government of India, 1962: 'Report of The Health Survey and Planning Committee', (Mudaliar Committee Report), Vol. II, Ministry of Health and Family Welfare, Manager of Publications, pp. 78-80.





of Primary Health Centres (PHCs) to 30,000 population from the earlier coverage of 1,00,000. The Sixth Plan also opened up medical care to NGO and private sector providers.¹³ The much talked of maternal and child health services that had become a carrot for the achievement of family planning targets were now converted into a 'child survival and safe motherhood strategy', a synonym for the same. In the 1990s these were rechristened as Reproductive and Child Health (RCH) services, a new strategy for the same old family welfare programme!

Middle Class Push for Privatisation of Healthcare

The rising aspirations of an expanding middle class and professionals belonging to it increasingly put pressure on the State to demand the entry of the private sector in the provision of care and tertiary care hospitals in the name of international standards. The middle class already had at its disposal all the urban health services that are a part of basic public health services. It was the poor and the lower middle class that lacked the basic amenities of life so crucial for health. Having had little experience of an efficient, working basic service, they did not protest against the privatisation trend.

Unopposed, the social pressure exerted by the middle class gave a push to the forces demanding privatisation and penetration of the market into the health sector. The political and economic compulsions of the State led to a shift in its economic policies, from accepting relatively smaller international aid to large loans in the name of development from the International Monetary Fund and the World Bank, among others, accepting in the process the conditionalities imposed by them.

Health Sector 'Reforms': Taking People out of Health Care

For the international agencies acting on behalf of multi-national corporations (MNCs), the twin forces of middle class aspirations and the compulsions of the State became a convenient means to push their agenda of trade in vaccines, drugs and equipment in the healthcare markets. India opened itself to the entire gamut of health sector reforms (HSR) as part of the Structural Adjustment Policies (SAP), first informally and then formally in the 1990s. The health sector reforms consisted of cuts in health sector investment, opening up of medical care to the private sector, opening up the public sector healthcare institutions to private investment; introduction of user fees in public institutions (the fee keeps expanding into admission fee, pathological tests and diets, among others, and the patterns are very different across states); casualisation of health personnel (personnel are taken on an ad-hoc basis rather than as permanent staff with all attendant benefits); and a techno-centric focus in health services.¹⁴

13. Government of India, 1981: 'The Sixth Five Year Plan 1980-85', Planning Commission, New Delhi, pp. 366-387.

14. Qadeer I., 2000: 'Health care Systems in Transition III. India Part I. The Indian experience', *Journal of Public Health Medicine*, Vol.22.no.1, pp. 25-32.



Impact of Reforms: Making the Poor Expendable


These so-called reforms had long-ranging implications for basic health services. These implications stemmed not only from the direct cuts in investment, but also because the structural changes that were introduced, undermined the other key welfare inputs necessary for health, the most serious being:

- (a) Weakening of the food security system, unemployment and loss of subsistence undermined the inter-sectoral approach to health planning;
- (b) Primary health care was reduced to primary level care thus excluding the supportive responsibility of secondary and tertiary care institutions;
- (c) Primary level care got further narrowed down to essential clinical and essential public health care. Its components were defined by the World Bank which had little to do with assessing the epidemiological needs of the people¹⁵;
- (d) A focus on reproductive health made women the agency for population control. Thus, reproductive technologies of fertility control and infertility cure got a boost;
- (e) Medical care got into the hands of the private sector, which had no obligation to follow prescribed procedures for monitoring, data pooling and standardised treatment. It disrupted national disease control programmes;
- (f) Access to services due to rising costs as well as quality of care remained variable in the absence of any formal mechanism to monitor the expanding private sector – either laid down by the private sector itself or by the State;
- (g) Family welfare and AIDS control programmes acquired a major position in health planning that was now guided by the priorities of donors;
- (h) The leprosy, tuberculosis, and filaria control programmes were verticalised instead of being integrated. In each programme medication became the main focus and socio-economic considerations were ignored. In the tuberculosis control programme, to get good results, only those who had permanent addresses and could come regularly, were registered. This excluded those who needed help the most — migrants and daily wagers! Only 50 per cent of those diagnosed were given treatment;¹⁶
- (i) Decentralisation of services was imposed and interpreted as provisioning by several independent providers and not a delegation of responsibility and answerability to a central authority;
- (j) National institutes lost their autonomy and became dependent on those very donors who distorted their priorities;

15. World Bank, 1993: 'World Development Report 1993: Investing in Health', Washington DC, Oxford University Press, pp. 1-17.

16. Department of International Development, India, 1999: 'An Informed Approach: applying research to RNTCP: Main Findings, Unpublished Monograph, New Delhi.



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- (k) Public-private partnerships were seen as the answer to the inefficiency of the public sector and the lack of social responsibility within the private sector, and promoted across the country.

The effects of the so-called reforms were compounded on the one hand by the inclusion of ill equipped, paid consultants to chart out the project mode of planning and, on the other hand, by the multiplicity of planners and providers. The reforms that were supposed to have brought in efficiency and equity in health services, have failed to do either.

National Rural Health Mission: The Answer to Health Sector Ills?

The State too has been conscious of these trends. In 2005 it launched the National Rural Health Mission (NRHM) to target the poor and provide relief. The main components of NRHM are:

- Train accredited social health activists (ASHA) to provide essential healthcare at the village level and work under the ANM and Anganwadi worker (a functionary of the ICDS);
- Provide a fund of Rs. 10,000 to the ANM to use as and when necessary;
- Strengthen the sub-centres;
- Strengthen all CHCs and convert them into first referral hospitals;
- Post additional public health and health management personnel to bring about efficiency in work;
- Develop national public health standards for each level of services.


To complete the required numbers of specialists, doctors from the PHC are to be mobilised for the CHCs. At the PHC, doctors from alternative systems would be posted to provide services¹⁷. In the urban areas the entry of the private sector has been encouraged at all levels to ensure that services are made available. However, there is no regulation of its price for the users.

The Crucial PHC is Not Important to Planners

What implications does this have for the functioning of the all-important PHC? Annual budget allocations give an indication of the official mindset:

- Since 2005, revised annual allocations of Rs. 6075.17 crore and Rs. 7190.37 crore and budgeted allocation of Rs. 9839.00 crore have been made. Yet, resources at the PHC — the key peripheral institution for delivery and monitoring of public health services —

17. Dasgupta, R, and Qadeer, I. 2006: 'The National Rural Health Mission'(NRHM): A critical Overview', *Indian Journal of Public Health*, Vol. 49,no. 3, pp. 138-40.





remain inadequate even though they constitute the crucial link between the CHC and the sub-centres;

- A reduced number of doctors at this level means less professional support for the work of ASHA and ANMs and reduced services for simple diseases that are manageable at the primary level;
- Transportation of serious cases, nutritional services and control of anaemia at the community level remain a serious problem. The burden on CHCs thus increases and its focus on reproductive and child health may leave out general health needs of the population;
- The emphasis on public-private partnerships for secondary and tertiary level care further undermines primary health services for the poor who are in no position to pay the State's private partners, whose charges are completely unregulated;
- The use of AYUSH practitioners at PHCs for running some of its basic programmes also raises basic questions about their training backgrounds, the appropriate use of their professional skills, and expanding choices for people rather than substituting for unavailable allopathic practitioners.


The issue then is, is NRHM the answer to the problems of India's health system? Should the trends initiated by the reforms be permitted to continue privatisation of healthcare along with a further retreat of the public sector? Can public-private partnerships resolve the dilemma? To explore these questions we must examine some critical aspects of services to highlight the importance of the State and its responsibility towards health, not only as an agency that finances and facilitates but as one that provides, sets standards, regulates, and ensures that contradictions within the overall system are minimised.


IV. CHALLENGES IN HEALTH SERVICES: REFORMING 'REFORMS'/ MAKING THE POOR A PRIORITY

Aspects such as access and universality, subsidies, efficiency and quality, and gender justice determine the extent of equity in health services. Investments in health without these may strengthen the business of health (by pushing the states to accept aid and purchase drugs and equipments for national essential services) but not necessarily the health of the poor people. The real reforms would be when the State frees the larger system from its urban bias, structural inefficiencies, techno-centricity, an ill-developed manpower policy and poor management.

It is within the holistic framework for understanding health, mentioned earlier, that we do so and not the narrow frame offered by the Commission on Macroeconomics¹⁸ where health

18. World Health Organisation (2001): Macroeconomics and Health: Investing in Health for Economic Development: Report of the Commission on Macroeconomics and Health, WHO, Geneva, pp. 11-21.





inputs are raised but within the frame of SAP. This means investing in health of the poor without making them a part of the productive forces and thereby not enhancing their self-reliance, welfare, and productivity.

Investments in health without these may strengthen the business of health (by pushing states to accept aid and purchase drugs and equipments for national essential services) but not necessarily the health of the poor people. Privatisation of services and the retreat of the State are presented as 'reforms' by the Commission when these are actually adjustments to accommodate harsh and anti-poor economic policies. The real reforms needed by the larger system to free it from its urban bias, managerial and structural inefficiencies, techno centrality and an ill developed manpower policy are sidelined.

Even the Millennium Development Goals (MDG) for health, whose relevance for the poor has already been questioned,¹⁹ serve more as an instrument of expanding the business of health for international corporations within the SAP perspective.

MDGs reflect an approach to development that curtails the notion of welfare to that which is possible in the techno-centric frame of structural adjustment. It emphasises the responsibility of the individual as against that of the State and holds them responsible for their ills. Correctives are thus fashioned less in terms of the social and collective arena and more in terms of individual action. This pushes for privatisation, deregulation, dismantling State provisioning of welfare services and investment in health for profits through expanded markets rather than for the well-being of all.

The poor are thus targeted and the State at best used as a purchaser of technology to provide for the poor or as one who makes the third party payment for the poor in private insurances. In other words, MDG uses the poor for the expansion of medical business and very often the technologies it promotes are not in their best interests.

Access to Services: Priced out by Privatisation

Three rounds of National Sample Survey (NSS) data from 1986-87 onwards show that the utilisation of private sector services has been increasing over time. According to the 2004 NSS,²⁰ for ailments not needing hospitalisation, 22 persons per 1,000 use government facilities against 78 per 1,000 who frequent the private sector. In the urban areas the corresponding figures are 19 and 81 per cent.


The instant conclusion one draws from this is that:

- People prefer the private sector
- The private sector is more efficient.

19. Gwatkin, R. Davidson (2005) 'How Much Would the Poor People Gain From the Faster Progress Towards the Millennium Development Goal for Health?', *The Lancet* Vol. 365, pp. 813-817.

20. NSSO, 2006: 'Morbidity, Health Care and the Conditions of the Aged, NSS 60th Round, Jan- June 2004', Ministry of Statistics and Programme Implementation, New Delhi.





However, a deeper analysis throws up a different picture. Given the very high levels of marginalised populations and sharp differentials between monthly per capita income groups (mpce), overall and average figures almost always hide the truth. So, instead of looking at the total illnesses for which people seek help, when we look only at serious illnesses needing hospitalisation, a larger proportion of the population is seen using the services of government hospitals — 42 and 38 per 1,000 in rural and urban areas.

This very distribution, when seen through the mpce categories, throws up a very different picture:

- In the lowest mpce groups — up to Rs. 300-340 that constitute 20 per cent of the rural sample — 55.6 per cent use public hospitals where the use of paid beds is negligible (5 per cent) (Table 7a);
- The users of private hospitals in this class depend largely on free beds or paid general wards;
- In contrast, in the highest mpce groups — over Rs. 775-950 — that constitute 16 per cent of the sample, 70.8 per cent use private hospitals;
- The urban population is not very different in the use of public services by corresponding lower mpce groups, but the use of private hospitals increases to 81 per cent here in the higher mpce groups (Table +7b);
- For the poor, utilisation of government hospitals was 60 per cent in earlier rounds. For services such as immunisation, ante-natal and delivery care, 69-94 per cent of those below the poverty line used public facilities.²¹

It is also well known that illness is an important cause of indebtedness in the rural areas where the burden of treatment pushes people into marginalisation. The 52nd round of NSSO data²² shows that there is a major difference in the proportion of untreated cases in the lowest and highest rural mpce deciles:

- In the lowest decile 26 per cent of the episodes are not treated
- In the highest decile there are only 9 per cent of such cases.

21. Peters, David H., Yasbek, A., Sharma, R.R., Ramana, G.N.V., Pritchett, L.H., and Wagstaff, A. (2002): *Better Health Systems for India's Poor: Finding Analysis and Options*, World Bank, Washington D.C.' pp. 133-149.

22. Government of India, ministry of Statistics and Programme Implementation, 2000: 'Note on Morbidity and Treatment of Ailments: NSS 52nd Round (July-June 1996)', *Sarvekshana*, Vol. XXIII, No.3, Jan- March, pp. 43-78.




Table 7a: Public, private distribution of hospitalized cases (per 1000) with type of ward for different mpc classes in rural areas.

m.p.c.e. class	Rural persons										Cases of hospitalization of the total sample
	Public hospital + public dispensary					Private hospital					
	Type of ward					Type of ward					
	Free Ward	Paying General ward	Paying Special ward	All (incl. n.r. cases)	Free ward	Paying General ward	Paying Special ward	All (incl.n.r. cases)	Sample		
0- 225	560	49	1	635	43	281	28	350	758	3.69	
225- 255	510	52	0	563	15	388	35	437	571	2.78	
255 -300	456	79	2	537	31	393	36	461	139	6.80	
300- 340	439	51	0	491	41	408	54	503	1425	6.94	
340- 380	409	71	6	485	52	428	35	514	1571	7.65	
380- 420	460	52	3	515	18	404	63	485	1886	9.18	
420- 470	349	84	5	438	23	464	75	561	1977	9.63	
470- 525	371	57	4	443	31	437	89	557	2329	11.34	
525- 615	345	46	3	395	25	484	93	602	2483	12.09	
615- 775	264	64	4	332	17	532	119	668	2785	13.56	
775- 950	275	48	16	339	27	493	140	660	1466	7.14	
950+	173	55	15	244	9	467	281	756	1887	9.19	
All	350	60	6	417	26	453	104	532	20534	100	

Source:NSSO(2006): NSS 60th Round (Jan ~June 2004)

n.r.: non reporting

Table 7b: Public, private distribution of hospitalized cases (per 1000) with type of ward for different mpce classes in urban areas.

Urban persons

m.p.c.e. class	Type of hospital											Cases of hospitalization	
	Public hospital + public dispensary						Private hospital					Sample	Percentage of the total sample
	Type of ward						Type of ward						
	Free Ward	Paying General ward	Paying Special ward	All (incl. n.r. cases)	Free ward	Paying General ward	Paying Special ward	All (incl.n.r. cases)	Free ward	Paying General ward	Paying Special ward	All (incl.n.r. cases)	
0 - 300	483	70	26	579	22	532	67	421	310			310	2.56
300 - 350	365	32	0	597	12	372	20	403	214			214	1.76
350 - 425	487	68	9	564	26	359	49	435	620			620	5.11
425 - 500	456	87	1	544	14	393	45	455	1156			1156	9.53
500 - 575	440	67	19	526	21	347	106	474	600			600	4.95
575 - 665	317	59	10	386	15	510	89	614	1059			1059	8.73
665 - 775	342	75	5	422	10	451	98	578	1443			1443	11.90
775 - 915	301	79	11	391	9	448	151	609	1433			1433	11.81
915-1120	288	59	14	361	20	492	127	639	1672			1672	13.78
1120-1500	203	66	12	281	14	447	257	719	1923			1923	15.85
1500-1925	133	55	15	203	12	413	371	797	606			606	5.00
1925+	100	50	20	170	14	366	450	830	1095			1095	9.03
All	304	67	11	382	16	433	169	617	12131			12131	100

Source:NSSO(2006): NSS 60th Round (Jan ~June 2004)

n.r.: non reporting



Non Treatment on the Rise

In the 60th round of NSSO data however, there is an increase in these proportions across mpce classes. The main cause for non-treatment remains economic, as people do not have the resources to afford treatment, and lack of finances as a reason for non-treatment increases from 10 per cent of the respondents to 26 per cent across deciles.²³

Non-availability of services is another key reason for not seeking services. The 60th round of NSS confirms the qualitative insights that the poor try their best to save their families and often resort to private treatment, but their use of it is largely restricted to general wards and free beds that are very limited.

Other than health services, access to RCH services of various mpce groups in rural and urban areas (Tables 8 & 9), also show patterns similar to that in health services:

- In the lowest mpce groups of up to Rs. 300-340 in the rural areas that constitute 27 per cent of the sample, about 75 per cent of pregnant women gave birth during the survey – of them 61 per cent gave birth at home, 10 per cent in government and 5 per cent in private hospitals;
- For the richest mpce groups (Rs. 615 and above constituting 22 per cent of the sample) government hospital deliveries came down to 11 per cent and home deliveries to 18 per cent while private hospital deliveries went up to 32 per cent out of the 60 per cent deliveries during the survey of all the pregnancies identified.

This is also true of the social classes where the Scheduled Caste and Schedule Tribe populations have much lower access to services. Their use of private services is even more limited, both for the economically and the socially deprived.

Similarly, the average expenditure per delivery in private and public hospitals is markedly different with the former charging three or four times more. In urban areas the deliveries at home have been seen to decline, the use of government hospitals is almost three times more than rural lower mpce groups, while in the higher mpce groups, private hospital services are used more frequently.

23. Athreya, V.B and Rao M., 2006: 'Education and Health in the Draft 11th Plan Approach Paper' *Social Scientist*, Vol.34 No. 9-10, pp.21-34.



Table 8: Place of delivery and average expenditure per birth for rural women of 15-49 age group for different mpc classes and social groups

m.p.c.e. class/ Social group	No. per 1000 of women who were pregnant at some time during last 365 days	Status of pregnancy of ever married women on the date of survey (and place of childbirth)				Average expenditure on Childbirth (Rs.)				Ever married women (15-19 yrs.) who were pregnant at some time during last 365 days			
		Childbirth not take place	Child birth taken place			Total hospital	Govt. hospital	Private home	At All	sample	percentage of the total		
			In govt. hospital	In private hospital	At home								
0 - 225	154	171	77	51	664	37	1000	765	2232	328	494	340	5.20
225 - 255	142	215	76	52	642	16	1000	652	2886	418	606	261	3.99
255 - 300	146	163	115	81	605	37	1000	990	1951	352	605	593	9.07
300 - 340	133	247	139	64	532	18	1000	609	2801	444	679	583	8.92
340 - 380	145	235	182	51	516	17	1000	607	3003	351	593	620	9.48
380 - 420	119	241	125	117	509	9	1000	1234	2790	461	952	631	9.65
420 - 470	126	241	165	109	480	5	1000	1231	3630	383	1037	664	10.16
470 - 525	129	323	118	147	404	9	1000	1506	2825	462	1165	728	11.14
525 - 615	115	320	146	153	367	14	1000	1432	4163	550	1573	718	10.98
615 - 775	114	350	139	197	307	8	1000	1479	5505	433	2216	711	10.88
775 - 950	118	373	119	237	257	13	1000	2343	7611	522	3616	381	5.83
950+	88	473	79	327	111	10	1000	2628	6087	570	4371	307	4.70
All	127	267	131	119	467	10	1000	1183	4137	414	116	6537	
Social Group													
ST	131	234	113	45	599	8	1000	675	3082	264	498	946	14.47
SC	141	239	151	84	518	8	1000	935	3212	408	825	1303	19.93
OBC	125	273	124	134	453	13	1000	1236	3673	446	1189	2605	39.85
Others	119	297	130	158	382	32	1000	1485	5385	456	1819	1683	25.75
All	127	267	131	119	467	16	1000	1183	4137	414	116	6537	100

Source:NSSO(2006): NSS 60th Round (Jan -June 2004)

Table 9: Place of delivery and average expenditure per birth for rural women of 15-49 age group for different mpc classes and social groups

m.p.c.e. class/ Social group	No. per 1000 of women who were pregnant at some time during last 365 days	Status of pregnancy of ever married women on the date of survey (and place of childbirth)					Average expenditure on Childbirth (Rs.)					Ever married women (15-49 yrs.) who were pregnant at some time during last 365 days	
		Childbirth not take place	Child birth taken place			Total hospital	Govt. hospital	Private home	At	All	sample	percentage of the total	
			In govt. hospital	In private hospital	At home								
0 - 300	187	170	309	53	429	39	1000	671	4845	466	841	112	3.58
300 - 350	153	197	321	192	290	0	1000	628	1799	614	903	95	3.04
350 - 425	115	200	268	233	297	2	1000	724	3633	447	1469	206	6.59
425 - 500	137	294	228	201	270	6	1000	790	3790	512	1543	428	13.69
500 - 575	145	291	186	235	279	10	1000	928	3058	591	1508	202	6.46
575 - 665	110	239	343	190	224	4	1000	781	3837	488	1462	306	9.79
665 - 775	112	298	265	247	188	1	1000	1021	7280	614	3119	388	12.41
775 - 915	103	274	251	392	129	14	1000	949	4754	666	2673	351	11.22
915 - 1120	99	357	130	413	75	25	1000	2653	4926	530	3913	413	13.21
1120-1500	82	328	112	330	25	5	1000	989	6095	1566	3070	362	11.58
1500-1925	88	415	99	483	2	1	1000	1208	7976	1222	6807	127	4.06
1925+	57	486	51	439	16	8	1000	1470	10471	79	9239	137	4.38
All	107	296	215	298	181	10	1000	994	5480	552	2806	3127	100
Social Group													
ST	143	218	357	162	252	11	1000	813	5458	388	1650	215	6.88
SC	124	288	273	176	263	9	1000	737	5070	506	1741	499	15.96
OBC	116	299	188	297	209	7	1000	852	5299	637	2691	1136	36.33
Others	92	305	204	367	113	12	1000	1312	5719	472	3539	1277	40.84
All	107	296	215	298	181	10	1000	994	5480	552	2806	3127	100

Source:NSSO(2006); NSS 60th Round (Jan ~June 2004)

The Politics of User Fees: Serves the Rich, keeps Poor Out

Other than privatisation, the single largest cause of pushing away the poor from public hospitals is user fees. User fees were introduced with the idea that middle class users would rather shift to private hospitals if they had to pay a user fee at entrance to public hospitals. This would leave public services more for the poor.

But the utilisation pattern shows just the opposite trend. A study of the utilisation of free beds based on NSS data of the 52nd round shows that most of the user fees collected by public hospitals are from the rich, who also usurp their facilities:

- The top 20 per cent mpce groups use 49 per cent of all in-patient days and 46.5 per cent of the free ward days;
- The lowest 20 per cent mpce category use 26.6 per cent of all in-patient days and 27.8 per cent of the free ward days.²⁴

User fees are actually preventing the poor from accessing the only facilities that are somewhat within their reach.

Many benefits of user fees are trotted out officially, one being that they contribute to resource mobilisation. The fact is that they barely do so (Table 10). No state has managed to mobilise more than three per cent of the total costs of a hospital except Karnataka and Punjab where the figures went up to 6.6 and 5.4 per cent of the total cost.


Table 10: Cost recovery in medical and public health services (Non-ESIS) (in percent).

Name of the state	1975- 76	1980- 81	1984-85	1988-89	Average
15 major states	6.4	4.1	3.04	1.6	3.8
Andhra Pradesh	2.9	3.4	3.8	0.8	2.7
Assam	3.9	3.5	-	1.6	2.2
Bihar	17.0	8.5	3.3	-	7.2
Gujarat	3.7	5.0	1.9	2.6	3.3
Haryana	6.4	3.9	7.7	1.5	4.9
Karnataka	11.0	3.2	2.7	6.6	5.9
Kerala	3.8	4.1	3.7	1.6	3.3
Madhya Pradesh	4.9	2.4	6.4	2.4	4.0
Maharashtra	12.9	3.5	1.7	1.7	5.0
Orissa	2.6	3.0	4.3	1.1	2.8
Punjab	15.6	5.6	4.3	5.4	7.7
Rajasthan	4.0	3.9	2.5	0.8	2.8
Tamil Nadu	4.0	3.9	2.5	0.8	2.8
Uttar Pradesh	5.3	1.9	1.3	0.5	2.3
West Bengal	2.2	2.1	2.1	0.8	1.4

Source: Tulsidhar 1992, pp. 85. Cited in World Bank 1997 from Baru Rama "Private Health Care in India", Sage 1998

24. Mahal, A., Singh, J., Lamba, V., Gumber, A. and Selvaraja, V. 2002: 'Who benefits from Public Health Spending in India: Results of a Benefit Incidence Analysis for India', SEO 2005, New Delhi, NCAER.





This simply shows that subsidies to public hospitals are largely utilised by the rich. Therefore, the State not only has to bear the cost, it also has to realise that, in the absence of strict monitoring, user fees distort rather than help the objective of reaching the poor.

First and foremost, there are no established norms about the utilisation of the amount collected as user fees. In some states the amount goes to the state treasury fully or partially, in others it is the Chief Medical officer who decides what is to be done with it.

In some others it may be a wider group of the hospital committee that decides. Nowhere do representatives of different sections of the hospital staff contribute to this decision-making process. The competing needs of patient care, diagnostics, emergency requirements, facilities for attendants, and hospital sanitation are often overlooked by the need to beautify the hospital or its offices. Hospitals that manage to collect substantial amounts are those that are in a position to offer good services. If at all they can reinvest, they further improve their services.

This process completely bypasses those institutions that are resource starved, have poor finances, and are therefore not chosen by people who can pay. Thus, unless a system of sharing resources comes into being, institutions that function poorly shall continue to do so as their user fees collection would remain negligible.


Hospitals Shift to Paying Services

Yet another major issue is the tendency of hospitals to shift priorities to providing more paying services. Thus obstetric care, orthopaedics, and cardiac care units are emerging as the key components of services at the cost of basic care units.

The attempt at introducing differential user fees system has also failed given the size of the country and the difficulties in identifying economic status. Most states that attempted to introduce identification card systems ended up giving higher privileges to the elite who bribe and use their social network.

The introduction of user fees and relief to the middle class in income tax, when put together, amounts to shifting the burden of health care on to the poor. Earlier, based on the system of taxation according to economic ability, services were provided to the collective according to their need so that the poor were subsidised. Now, they fall sick more and are expected to pay more often and the rest of society is absolved significantly of its social responsibility.

In short, privatisation, either by making services inaccessible to the poor or through user fee and cut backs in investments in the public sector, pushes the poor from accessing services and thereby increases inequity rather than reducing it. Thus rising costs, user fees in public institutions, and poor growth of public sector are the key factors in denying the poor access to healthcare facilities.





Quality of Services: Bogey of Super Hi-Tech Speciality

As pointed out earlier there are two uses of medical care — one for individuals and the other for community level interventions for disease control. The nature and definition of quality for both differs. The ‘quality’ of clinical service is a complex concept, as it does not depend only upon diagnostic and curative potentials of the service even though these are the two basic ingredients of quality. It is also dependent upon patient satisfaction, social skills of the physician, and the necessary support available at the individual practitioner’s level and team work in hospitals. Therefore, it brings in issues of referral facility, the right mix of manpower, and creating conditions where each performs her/his best.

While public sector services run through a range of institutions with a provision of referral linkages, the majority of private practitioners and small private institutions operate as isolated units without any regular support. The system of informal linkages that operate become too expensive and force patients to finally land up in the public sector at a late stage when complications develop.

Quality Assessment

The debates on quality are mostly restricted to the performance of hospitals and their clinical outcomes. Yet, the tools available for quality assessment are inadequate and inappropriate. For example, bed turnover as an indicator of efficiency depends upon how quickly a patient is cured and discharged. In most private hospitals opting for high-tech surgical interventions, very high bed turnover rates are maintained to actually get more cases and profits which are not necessarily in the interest of the patients.

This then leads to another advantage for the private institutions — their post-operative death rates may be lower as compared to public hospitals of the same calibre where more extended post-operative care is provided. The probable higher deaths occurring in the public hospital then have more to do with the post intervention time spent rather than quality of care! The World Bank assumes higher efficiency levels of private sector but offers no evidence for the same.²⁵

In the qualitative assessment of the other role of medical care — its preventive role — the issue of coverage of population has to be added to the list above. It is basic to the notion of efficiency of programmes and institutions of basic health services, such as the national health programmes, CHCs, and PHCs.

The case of tuberculosis is a good example to illustrate the importance of coverage. Unless the pool of infection is reduced in the population to an extent that the disease does not easily spread in the community, the prevalence rates cannot be lowered. Thus, if a few institutions provide very good clinical care, it would benefit a few individuals but will have no effect on disease trends and the status of tuberculosis in the population.

25. World Bank, 1993: World Development Report: Investing in Health, NY, Oxford University Press, 1993.



Private Hospitals: Don't Care for Population Coverage

According to experts a case finding rate of at least 75 per cent and a cure rate of at least 85 per cent is necessary. Any programme, even the Revised Strategy for National Tuberculosis Control Programme (RNTCP), is not able to achieve this coverage and therefore cannot be called efficient.²⁶ Even the best institutions in the private sector take no responsibility for coverage of population as profits are their primary concern.

A report on private hospitals written by Justice Qureshi for the government of Delhi (2001) notes that they did not meet their agreement with the government to provide free treatment to poor patients through 25 per cent of total beds in exchange for the subsidies provided.

A serious problem with corporate and hi-tech institutions is over investigation and intervention as the share holders — the doctors — compromise the need for ethical practice with the need for profit. The Qureshi Committee Report in fact calls the corporate hospitals “money minting machines”,²⁷ a sector that is certainly not interested in responding to the epidemiological needs of the population.

Thus effective clinical care, by a mutually supportive team that generates patient satisfaction and provides maximum possible coverage, is the key to the quality of services. The private sector, given its variation, may at best provide clinical services of mixed quality but it does not have the capacity to provide referral support or comprehensive coverage to the majority.

This is illustrated by the fact that, although highly interested in the Rs. 1,030 billion medical market of India, including the primary care market, the Confederation of Indian Industry (CII) insists on huge subsidies from the government to “stimulate private investment” and refuses to enter primary care without this and public-private partnerships.²⁸

The other aspect of quality therefore, is reasonable costs for the patient. These have increased consistently, particularly so in the private sector. The stark difference between the sectors in terms of average amounts paid by all classes as well as the specific amounts paid by different income groups to public and private hospitals forces the lower expenditure groups to stay largely with the public sector (Table 11a, 11b). The costs are increasing even in the rural government hospitals, especially for the poor.

26. Banerji, D. 1997: 'Serious Implications of the World Bank's Revised National Tuberculosis Control Programme for India', Nucleus for Health Policies and Programmes, New Delhi.

27. Qureshi A.S., 2001: 'High Level Committee for Hospitals in Delhi' Unpublished Report of the Government of Delhi. New Delhi.

28. Confederation of Indian Industries (CII) and Mc Kinsey and Company, 2002: Medical Care in India, Report New Delhi, pp. 6-7.



Thus in terms of effectiveness (cure rates), efficiency (higher level of population coverage at lower costs and optimum effectiveness), and efficacy (relative impact on health provided by non-medical welfare inputs as compared to medical inputs), there is little evidence to show the supremacy of private sector as its high-tech super speciality component is not more than 2 per cent of the total private sector and covers a relatively smaller section of the population. Its outreach is limited mainly to out-patient care for the poor and unlike the public sector it does not integrate services with its welfare policies.

Table 11a: Average total medical expenditure (Rs.) for treatment per hospitalization case by type of hospital and mpce class in urban areas.

m.p.c.e class	Rural			Persons	
	Type of hospital			No. of cases of hospitalization	
	Government hospital	Private hospital	All hospitals (incl. n.r. cases)	Sample total no.	Sample %
0 - 225	2530	5431	3598	702	3.60
225 - 255	3173	4886	3931	553	2.83
255 - 300	2087	5542	3686	1348	6.91
300 - 340	2850	5777	4173	1367	7.00
340 - 380	2586	5245	3945	1512	7.75
380 - 420	2094	6895	4430	1806	9.25
420 - 470	2884	6028	4674	1876	9.61
470 - 525	3017	6781	5149	2216	11.35
525 - 615	3508	6813	5532	2339	11.98
615 - 775	4049	7327	5262	2641	13.53
775 - 950	4192	9843	8001	1377	7.05
950+	6374	10349	9718	1785	9.14
All	3238	7408	3695	19522	100

Source: NSSO(2006): NSS 60th Round (Jan -June 2004)



Table 11b: Average total medical expenditure (Rs.) for treatment per hospitalization case by type of hospital and mpce class in urban areas.

m.p.c.e class	Ural			Persons	
	Type of hospital			No. of cases of hospitalization	
	Government hospital	Private hospital	All hospitals (incl. n.r. cases)	Sample total no.	Sample %
0 - 300	1746	9576	5144	287	2.64
300 - 350	1840	5357	2325	204	1.88
350 - 425	2594	4852	3567	597	5.50
425 - 500	2690	8258	5311	1078	9.93
500 - 575	2365	6158	4171	550	5.07
575 - 665	2984	5442	4528	975	8.98
665 - 775	3011	10823	7883	1291	11.89
775 - 915	4304	8074	6733	1275	11.74
915 - 1120	5226	10149	8522	1461	13.46
1120 -1500	5402	13758	11830	1668	15.36
1500 -1925	8231	16433	15275	536	4.94
1925+	15132	22918	21976	935	8.61
All	3877	11553	8851	10857	100

Source:NSSO(2006): NSS 60th Round (Jan -June 2004)

Role of the State: Abdicating Responsibility

It is a given that the medical market primarily reflects the demands of the rich in a situation characterised by persistent poverty levels and high costs of treatment and disease prevention. In such a situation the Indian State was expected to adopt policies that would bring relief to the majority through universal basic healthcare. Instead it has chosen to opt for the 'human capital' approach that promotes individual initiative on the part of providers as well as the users of healthcare while direct State investment is rolled back.



Decline in Health Expenditures

This has led to a decline in expenditures on health since the 1980s. How, is very clear:

- The real per capita spending on health at state levels shows an impressive increase since 1998, but the share of health in the budget allocation has continued to decline. This simply means a neglect of the health sector by the State;²⁹
- At the same time, the Centre, despite its annual promises to increase the health budget to 3 per cent of GDP, has failed to do so. The public expenditure on health and family welfare has moved from 1.264 per cent to 1.347 per cent of the GDP between 2002-03 and 2007- 08 (in the case of total national expenditure the percentage moved from 1.27 to 1.38 per cent between 2002-3 and 2006-07);
- Over the Tenth Plan, though the Central allocation has slightly increased, state allocations actually declined;³⁰
- The current level of increase does not auger well for achieving the 3 per cent level in the near future. The WHO calls for an allocation of 7.5 per cent of the GDP for health. India today allocates less to health than Bangladesh, Nepal and Thailand. Brazil and South Africa have already reached levels over 3 per cent of the GDP, while western countries allocate 6 per cent and above to their health sectors.

Caution: Health Tourism Contributes to Ill-Health

The Tenth Five Year Plan³¹ and the Draft Approach Paper to the Eleventh Five Year Plan³² emphasised the need for promoting health tourism to earn foreign exchange and to facilitate public- private partnerships.

This distorted priority led to subsidy shifts from the public to the private sector through land subsidies for the construction of hospitals, cuts in import duties on drugs and equipments, inclusion of private institutions on government health panels, offering them space and profits in public hospitals by permitting private contracts of non clinical services and investigations, and outsourcing services.

In addition, public-private partnerships were promoted for providing services as well as for research and education and, apart from providing subsidised medical graduates to the private sector, medical education itself is now open to private investment. Some


29. Seeta Prabhu, 2006: 'Public Financing for Health Security in India: Issues and trends', in *Securing Health for All: Dimensions and Challenges*, New Deli, Institute for Human Development, pp. 401-413

30. Centre For Budget and Governance, 2007: *Budget 2007-08: Dream or Despair?* New Delhi, pp. 14-16.

31. Government of India, 2002: 'The Tenth Five Year Plan- 2002-2007', New Delhi, Planning Commission, pp. 81-163.

32. Government of India, 2006: *Draft Approach Paper for the 11th Five Year Plan*, Planning Commission, New Delhi.





idea of the extent of expected subsidies can be had from the Report of the CII on Medical Care in India that puts forward its expectation of State investment into the private sector for every step in its evolution. The Qureshi Committee Report gives a concrete example:

- Apollo Hospital got 15 acres of prime land in 1988 for a token rent of one rupee per annum on condition that it would provide free treatment to one third of its patients;
- It also got Rs. 42 crore from the Delhi Government when the hospital was commissioned in 1996.

This privatisation of services on the one hand gave a handle to the World Trade Organisation to demand that the health sector be treated like any other trade or business and not be given any privileges due to social services and, on the other hand, rationalised the emphasis on medical tourism even by public sector hospitals. Secondly, it promoted the practice of public sector doctors increasingly doing private practice. Thirdly, it promoted the expansion of tertiary care institutions within the public sector despite falling overall investments in the health sector.

As if this was not enough, the district health sector reform projects taken up by the World Bank further distorted the picture. While the Bank invested heavily, the resources were selectively allocated to areas that could promote trade and medical care business. Thus civil works, medicines, transport, equipments, and research were the main focus. Interestingly, these were also the items with high foreign exchange value in all the states where projects were initiated — West Bengal, Karnataka and Punjab³³.


Casualisation of Manpower: Prescription for Disaster

Reforms needed at the systemic level were again ignored and casualisation of manpower in the name of cutting costs further undermined the services. The argument that 70-80 per cent of the expenditure goes on salaries of persons who do not work is totally distorted. The same manpower performs when it shifts to the private sector, so there can be nothing wrong with their ability.

The problem is at the level of structure, management, and resources. A public health service cannot be effective without well-trained permanent manpower that not only provides but also monitors and can therefore prevent epidemics. Their salaries are therefore the baseline over which resources for other components of the service (drugs, equipment, building etc.) are to be added. Without that the institutions provide only clinical care and not public health.

33. Baru Rama, 2001: 'Health Sector Reforms and Structural Adjustment: A State Level Analysis', in *Public Health and the Poverty of Reforms: The South Asia Predicament*, New Delhi. Sage, pp 211- 234





An important fallout of this significant but ill-understood shift is that now a set of diseases remains uncontrolled, and services for them have become permanent commodities. This transformation from service to commodity is perpetuated so that those who run the medical market can benefit from it.

The State, by encouraging these tendencies, has accepted the role of a steward who, within the framework of SAP, in the name of good governance, social responsibility of the private sector, partnerships and stakeholders, smoothens the way for the operations of an expanding medical market at the cost of public health services.

At the same time, since targeting of the poor becomes a part of the strategy, the State also acts as a client for MNC products that have been produced for trade with the Third World in the name of fighting disease at the global level. Since India has accepted the MDG it is bound to take loans for the control of malaria, tuberculosis, and AIDS and follow the prescriptions that come with it.

Distortions Created by MDG Vertical Programmes

For AIDS alone a \$2.2 billion package from the World Bank and its development partners (more than half of which is for targeted interventions) is coming, with India investing an additional \$1 billion of its own to mobilise further International Development Agency credits and donor packets from the Department of International Development, UK and Bill Gates and Clinton Foundations³⁴. This is to be invested in the vertical programme and not in the basic services whose weaknesses are at the core of the problem of AIDS control, especially among the vulnerable populations.

Not only are the diseases included for control in the MDGs, such as malaria, tuberculosis and AIDS, dealt with vertically, but also those that were covered by the NVBDC such as filaria and kala azar.

NRHM: No Bridge between Primary, Secondary and Tertiary Services

Other than aid-dependent vertical programmes, the National Rural Health Mission (NRHM) targets the rural population with the assumption that strengthening the medical care component — the CHC, and the RCH services — through ASHA, ANM and Anganwadi workers will do the trick for the rural areas. The morbidity and mortality data presented in Table 5 and 6 do not show any significant impact on diseases or mortality. The institutionalisation of deliveries has no direct relation with IMR declines between National

34. Chhabra Rami, 2007: 'National AIDS Control Programme: A Critique'. *Economic and Political weekly*, Vol. XLII, no. 2, pp 103- 108.



Family health Survey NFHS I and II. Also at least four states showed similar declines between first and second NFHS surveys (Table 12), when institutionalised deliveries were not being pushed.

Table 12 : Comparative statement on state wise information on the institutional deliveries and IMR as per the N.F.H.S.III (2005-06),N.F.H.S. II (98-99), N.F.H.S.I (92-93)


Name of the state	N.F.H.S. III (2005-06)		N.F.H.S. II (1998-99)		N.F.H.S. I (1992-93)
	Institutional Delivery rate	I.M.R. (prov.)	Institutional Delivery rate	I.M.R.	I.M.R.
Uttar Pradesh	22.0	73	15.2	88.7	99.9
Chhattisgarh	15.7	71	13.8	NA	NA
Gujarat	54.6	50	46.3	62.6	68.7
Maharashtra	66.1	38	52.6	43.7	50.5
Punjab	52.5	42	37.5	57.1	53.7
Orissa	38.7	65	22.6	81	112.1
Andhra Pradesh	68.6	53	49.8	65.8	70.4
Assam	22.7	66	17.6	69.5	88.7
Delhi	60.7	40	59.1	46.8	65.4
Rajasthan	32.2	65	21.5	80.4	72.6
Meghalaya	29.7	45	17.3	89	64.2
West Bengal	43.1	48	40.1	48.7	75.3
India		57		67.6	78.5

Source:NSSO, NFHS I, II and III

The neglect of the PHCs as the basic institution of public health and of the need to integrate vertical programmes emasculates NRHM. ASHA is denied the support of an efficient PHC as an umbrella organisation and diseases that could have been tackled at this level are now left to the CHC where the load increases and also the proportion of complicated cases. At the same time, the increasing distances of the CHC from villages prevent the poor from accessing their services.

The other problem with this mission is that it does not create an effective bridge between primary, secondary, and tertiary level public institutions, inevitably making secondary and tertiary care less accessible to the poor. Identification of private institutions for first referral as well as user charges has further added to their deprivation.





Thus, while much is talked about social security and protection for the poor, by targeting them the State actually focuses more on a RCH strategy for population control and on building its foreign exchange balance through aid and soft loans. For this it has adopted the vertical strategies of technological intervention for control in the three diseases identified by the global donors and their partner MNCs.³⁵ These are malaria, tuberculosis and AIDS.

Achievements of States: Different Strokes

The control of the Centre over resources through centralised schemes has the power to influence state level planning as most states suffer from financial constraints. There are also differences in state allocations to health and welfare sector inputs, critical to health. The result is sharp differences in the overall achievement of states.

K. Seeta Prabhu uses a modified human poverty index that includes achievement indicators such as probability of dying, illiteracy rates, children not immunised, non-institutional deliveries, no access to health services, undernourished children under four years of age, and develops a scoring system where the lowest scorer gets the first rank.

According to her then, the best performing states score the least. These are Karnataka, Haryana, Tamil Nadu, Punjab and Gujarat. The second list includes Maharashtra, Assam, Kerala, West Bengal, Orissa and Andhra Pradesh and the poorest achievements are in Rajasthan, Madhya Pradesh, Uttar Pradesh and Bihar. The unexpected positioning of Kerala here is largely an outcome of its poverty and very poor achievements in supplying drinking water. It needs to be stated though that the data Prabhu uses is of the early 1990s.³⁶ Any reconsideration of planning for health will have to pay attention to the differential needs of the states where the North-east needs a special consideration as it is often left out of most analysis. The states may be small but have very special problems that must be addressed.


Gender Justice

In assessing the status of health and health services, the health status of women and their access to health services requires special attention. Given the patriarchal structure of society and gender differentials in education, work opportunities, participation in labour and decision making powers, it is inevitable that when it comes to getting a share of scarce family resources, women are invariably left out at critical junctures.

35. Buse Kent and Gill Walt, 2002: "Globalisation and Multilateral Public Private Health Partnerships: Issues for Health Policy" in *Health Policy in a Globalising World*, editors Kelley Lee, Kent Buse and Suzanne Fustukian, Cambridge University Press, pp. 41-62, Cambridge.

36. Prabhu K. Seeta and Kamdar Sangeeta, 2002: "Human Poverty and Income Poverty: Linkages and Implications" in *Reforming India's Social Sector*, editors, K Seeta Prabhu and R Sudarshan, Social Science Press, New Delhi, pp. 102- 128.





The low sex ratio of the girl child, high maternal mortality (4-5/1,000 live births) and poor share of women in health expenditure of the family as they mostly go to the traditional healer or local practitioner and less often to the doctor,³⁷ makes it clear that special attention needs to be paid by the health services to ensure their coverage.

Health Services Perpetuate Inequity

The health services, however, primarily focus on maternity services, given their obsession with population control. The data showing causes of mortality from the Sample Registration Scheme shows that the focus needs to be wider. The data shows that:

- Maternal mortality constitutes only about 2 per cent of the total female mortality (15- 45 years of age), while girl children under 15 years of age contribute 30 per cent of the deaths;³⁸
- Even in maternal mortality, if the causes are examined, 20 per cent of this mortality is due to complications with systemic diseases that require services other than maternity;³⁹
- When we look at the prevalence of under-nutrition and anaemia, women again are the most vulnerable given their social roles and self-perception. Irrespective of these, the services focus only on maternal health, not realising that the young carry their burden of under-nutrition and ill health into their childbearing age.

It is also a matter of concern that the focus on improved antenatal care has been replaced by the present emphasis on obstetric emergencies. In other words, restricted services to ward off death rather than extensive outreach to prevent complications, detect potential dangers, and teach mother care seem to be the current strategy.


Last but not least, women are seen as the agency for population growth and therefore, become the victim of population control strategies. The use of invasive and unsafe contraceptives and sterilisations and abortions are being pushed in Third World countries and, as if that was not enough, they are also the targets of global research that must be conducted to test new methods of population control.

37. Gopal Meena, 1997: 'Labour Process and its Impact on the Lives of Women Workers; A study of the Bidi Industry in Tirunelveli District', Thesis submitted to the Centre of Social Medicine & Community Health, Jawaharlal Nehru University, New Delhi. Pp. 360- 361

38. Qadeer, I., 1998: Reproductive Health: A Public Health Perspective' *Economic and Political Weekly*, Vol. 33, No. 41, pp.2675-2684.

39. World Health Organisation 1999: 'Reduction of Maternal Mortality: A joint WHO/UNFPA/World Bank Statement', Geneva, WHO.





In this whole genre the latest is the New Reproductive Technologies (NRT) for creating designer babies, sex selection, and infertility treatment. In the name of 'choice' it promotes women to allow the ultimate medical control of their bodies.⁴⁰

Middle Class Agendas Dominate Health Strategies

In the absence of basic health services to address issues of ill health of women and children and for the care of pregnancy, the introduction of NRT is yet again an example of the domination of middle class needs over the needs of the majority, as sterility among the poor is most often secondary and calls for better delivery services, treatment of obstetric complications and reproductive tract infections and not necessarily expensive NRTs.

The data on place of delivery (Table 9) shows that even though hospital deliveries have increased across states, the number of home deliveries is still three times more in the rural areas. This calls for a strategy to recognise the importance of birth attendants and integrate them into the health service delivery system.

Gender Budgeting: Mere Lip Service

With a view to supporting the objective of strengthening women's social and economic status, women centred planning (the 7th Plan) and gender budgeting (the 9th Plan) was introduced. This effort was seen as investing in programmes pertinent for empowering women and the total share it received for 2007-08 was 4.8 per cent of the GDP over 3.8 per cent in the previous year.


Unfortunately, the approach is limited to a programmatic input irrespective of the nature of programmes and their importance for women. The importance of work, wages, welfare remains unrecognised and gender budgeting is dependent upon the overall perspective of a growth oriented economy where women are being pushed into the unorganised sector or as carers of the family or agency for population control.


At times even unrelated programmes are accounted for in gender budgeting as allocations for AIIMS and Safdar Jung hospitals⁴¹ are shown under it. It also suffers from that very patriarchal perspective in that it attempts to correct — so all inputs on contraception, population control, and child-care are seen as exclusive to women.

The poor impact of this strategy is visible in the continued lower position of India in the gender-based human development index:

40. SAMA Team, 'Assisted Reproductive Technologies, ARTS and Women: Assistance in Reproduction or Subjugation?' SAMA Resource Group for Women and Health, pp. 5-16

41. People's Budget Initiative, 2006: Back Ground Note: National Convention on Union Budget 2007- 2008, Centre for Budget and governance Accountability, New Delhi, pp. 46- 56.






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- India stands 98th among 140 countries;
 - According to the Human Development Report 2005, women's economic activity was 50 per cent of the activity of men even though they worked for 457 minutes per day as compared to 391 minutes of work by men over a day. The earned income of women was less than half of men and their literacy rate remains as low as 47.8 per cent.

Gender justice then demands that women should not only get an equal share of all services including national programmes but that a perspective of equality, justice and fair distribution needs to be adopted. For women's health particularly, RCH services need to be integrated into a comprehensive primary healthcare system as conceived by the Alma Ata declaration.

V. STRATEGIES TO MEET THE CHALLENGES: THE WAY FORWARD

If the objective is for India to move towards deepening democracy and increasing equity and justice in the health sector, then the public sector must retain its power to shape services and not become a steward for the private sector. This means:

- Facing squarely the task of building infrastructure for public health in a way that comprehensive primary healthcare becomes a reality. This would mean developing an integrated health system that strengthens the primary, secondary and tertiary level care and emphasises inter-sectoral linkages such as food availability (public distribution systems), drinking water supply, sanitation, public transport, housing etc. Tertiary level public services are critical not only to provide referral services to the deserving but also to set up basic minimum standards of tertiary care that are effective and efficient within the epidemiological requirements of the country. Without this monitoring or regulation of the private sector by the State is not possible;
 - Given the experience with user charges, it is clear that they harm the marginalised sections and do not improve the overall efficiency of state institutions given their very low proportion in the total resource requirement. User charges therefore must be removed;
 - The only way out is to increase the overall investment levels and not delay this already accepted principle. Instead of shifting subsidies to the private sector the same could be used to strengthen the public sector. For additional resources, possibilities of health cess or a national insurance system need to be debated;
 - The epidemiological basis of many of the vertical programmes in existence need a thorough re-examination as evaluation studies bring out their strategic weakness both in terms of their technological choices and their structural coherence. In other words priorities need to be re-set;
 - The commitment to integration must be fulfilled, especially in the case of vector-borne disease control programmes. Organisation and management according to the epidemiological need should be the guiding principle;
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- Referral services need to be strengthened between different levels of services and this does need good public transport systems to support patient movement. Innovative schemes could be tested in this sphere;
 - Making adequate quantities of essential drugs available should be yet another priority;
 - Given a vast private sector, its regulation and monitoring is critical. Standardisation of treatment, its price, and compulsory pooling of data for national monitoring systems must be the minimum requirement;
 - Public-private partnerships should be in response to epidemiological priorities of the region and its people. Inclusion of primary providers of care in the referral and supervisory umbrella of State institutions will provide an impetus to scientific practice and also reduce the burden of primary care on secondary and tertiary level public institutions. Partnerships with corporate hospitals that focus on profits need to be curtailed;
 - Training and referral support to traditional dais and registered medical and untrained practitioners is yet another means of expanding primary care for the poor;
 - The NRHM must work towards building an integrated service as accepted by the Alma Ata declaration. That is possible only with strengthening of the PHC, referral systems, and linking up secondary hospitals with tertiary institutions. The over-emphasis on tertiary sector with hi-tech services for diseases of the rich must not be allowed to hijack the system;
 - Gender sensitive policies are a must and gender budgeting must come with a perspective wherein the patriarchal values and their penetration into programme strategies has to be consciously eliminated;
 - For the implementation of the above it is important to group states according to their achievements in improving health indicators and social sector development and the Human Poverty Index Measure (HPIM) seems to be a good tool to assess differential needs of these states.
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Education in the Union Budget

Centre for Budget & Governance Accountability (CBGA)¹

INTRODUCTION

Education holds the key to progress for any inclusive society and the government, acting as an instrument in providing education, bears an important responsibility. Through the National Policy on Education and several measures subsequently taken by the Government especially through the 83rd and 86th amendments of the constitution, now education has been declared as a fundamental right. The primary objective of the National Policy is to obtain universalisation of elementary education through programmes like District Primary Education Programme (DPEP)² 1997, Sarva Shiksha Abhiyan (SSA) launched in 2001 and several others as will be presently discussed in the note.

Timeless Goals in Education

In the Education Policy of 1968, it was envisaged that public expenditure on education as a proportion of GDP would increase to 6% over a period of time. However, public expenditure on education has declined from above 4% in 1990-91 to about 3.66% in 2005-06. Thus, raising public expenditure on education to a level of 6% of GDP has remained a national commitment for nearly forty years now! A brief overview of the major policies and programmes in education in the country highlight the crucial issues and concerns in the sector since the past few years.

MAJOR POLICY ANNOUNCEMENTS ON EDUCATION IN INDIA

The following is a chronological overview of the most crucial policies and initiatives in the field of education in the country:

The National Policy of Education (NPE) 1986, as revised in 1992, indicated three thrust areas in elementary education:

- i. Universal access enrolment;
- ii. Universal retention of children up to 14 years of age; and

1. Written by Pooja Parvati for the background note on 'National Convention on the Union Budget 2008-09'

2. DPEP, initiated in November 1994 in 7 states (42 districts), moved to its second phase (DPEP II) in May 1996 covering 6 additional states and a total of 80 districts. Currently it is being implemented in just 2 states.



iii. A substantial improvement in the quality of education to enable all children to achieve essential levels of learning.

Launched in 1987, Operation Blackboard was aimed at improving the school environment and enhancing retention and learning achievement of children by providing minimum essential facilities in all primary schools. In all, 523,000 primary schools were covered as originally envisaged.

The 10th Five Year Plan (2002-07) looked at the issues pertaining to elementary education mainly through the SSA. It also recognized that vocational education and skill development is a crucial sector of education and decided to give it importance at all levels. Further, the 86th Constitutional Amendment Act 2002 made education a Fundamental Right for children in the age group of 6-14 years by providing that “*the State shall provide free and compulsory education to all children of the age of six to fourteen years in such manner as the State may, by law, determine*”. Although several states have also put in place the legal provisions required for ensuring free and compulsory education, (Table 2) it is still a matter of legalese vs. actual implementation and monitoring of the service delivery.

Education and The National Common Minimum Programme

The National Common Minimum Programme (NCMP) of the United Progressive Alliance (UPA) government, pronounced in May 2004 also reiterated this commitment. To fulfill this commitment, in addition to augmenting budgetary support, the Government imposed an education cess of 2% on direct and indirect taxes in the Finance Act 2004-05 (No.2). The Union Budget 2006-07 has since increased the contribution towards the education cess by 1%.

Table 1: State Level Legislations on Education in India

State	Title of Act and Year Enacted
Andaman & Nicobar Islands	-
Andhra Pradesh	The Andhra Pradesh Education Act, 1982
Assam	The Assam Elementary Education Act, 1974
Chandigarh	
Delhi	Delhi Primary Education Act, 1960
Himachal Pradesh	The Himachal Pradesh Compulsory Primary Education Act, 1997
Jammu and Kashmir	The Jammu and Kashmir School Education Act, 2002
Karnataka	The Karnataka Education Act, 1983
Kerala	Kerala Education Act, 1958
Madhya Pradesh	Madhya Pradesh Jan Shiksha Adhinyam, 2002
Maharashtra	Bombay Primary Education Act, 1947
Meghalaya	Meghalaya School Education Act, 1981



State	Title of Act and Year Enacted
Pondicherry	Pondicherry School Education Act, 1987
Punjab	Punjab Primary Education Act, 1960
Rajasthan	The Rajasthan Primary Education Act, 1964
Sikkim	Sikkim Primary Education Act, 2000
Tamil Nadu	The Tamil Nadu Compulsory Primary Education Act, 1994
West Bengal	The West Bengal Primary Education Act, 1973

Note: States' Education Acts in shaded boxes represent states that do not guarantee compulsory education to children but merely permit states to develop mechanisms to enforce compulsory Right to Education. These require immediate amendments to bring them in line with the provisions of Free and Compulsory Education, although with 'explicit' and 'implicit' bottlenecks as there is no record of convictions made under these laws.

The rest of the states mentioned, through the legal provisions, make primary education compulsory.

Source: 1. Niranjana Radhya & Aruna Kashyap, The 'Fundamentals' of the Fundamental Right to Education in India, Centre for Child and the Law, National Law School of India University, ActionAid India, 2006, p.17-18

2. <http://education.nic.in/cd50years/x/7C/HA/7CHA0601.htm>

3. <http://megassembly.gov.in/business/1991/01-04-1991.htm>

4. cag.nic.in/cag_reports/pondicherry/rep_2003/OVERVIEW.pdf


Sarva Shiksha Abhiyan (SSA)

Sarva Shiksha Abhiyan (SSA) which has been a major flagship programme of the present UPA Government addresses the needs of 195 million children in the age group of 6-14 years. Another recent development is the proposal to tag on early childhood education to the SSA programme (The Economic Times, 3 September 2007). Given that the SSA is focusing on quality now rather than quantity, the Planning Commission's proposal to attach "at least one year" of the early childhood care and education (ECCE) or the pre-school component to the programme could mean that the SSA loses its focus. The proposal initiated by the Planning Commission suggests that, in principle, the Integrated Child Development Scheme (ICDS), a programme administered by the ministry for women and child development, be bifurcated and the early child education or pre-school component be attached to the SSA. The move will spell the death knell for the ICDS as well as impact the SSA that is currently changing tack from a quantity focus to quality focus. Pre-primary care and education, that is, for children in the age group of three to six years, is provided by the anganwadi component of the ICDS.

Integrated Child Development Scheme (ICDS)

The ICDS, which has traditionally included the pre-school component, is being revamped and universalised. Part of this effort to revamp is to make the anganwadis co-terminus with schools. Besides this, both ministries have worked out a convergent strategy, where anganwadis are located either within the school premises or close to the school. This helps a smoother





transition as well as placing the child, depending on the age, in the right institution. At present, the argument against such a move could be that the pre-primary schooling is not part of the formal schooling; hence lumping two programmes may impact the end result of both. A fact that the joint training programmes for anganwadi workers and primary teachers has revealed. The two segments have separate needs and combining them will have disastrous effects.

The National Council for Teacher Education (NCTE) was established by an Act of Parliament in August, 1995. This scheme stands merged with Sarva Shiksha Abhiyan from 2007-08.

Sharing of Resources between the Centre and the State Government

With regard to the controversial resource sharing for SSA, the Centre has worked out a new funding pattern for SSA in the XIth Five Year Plan in view of the stiff opposition from State Governments to footing half the bill incurred on universalising elementary education, pending approval by the Union Cabinet. As per the new pattern, the Centre will take up 65 per cent of the cost incurred on SSA for the two fiscals beginning 2007 – the first two years of the 11th Five Year Plan. States will have to chip in the remaining 35 per cent. In 2009-2010, the Centre will scale its contribution down to 60 per cent with the States footing 40 per cent of the bill.

The fourth year of the Plan will see a further reduction in the Centre's contribution to 55 per cent. States will have to provide the rest and in the last year of the Plan, the funding pattern will be 50:50 as had been envisaged for the entire duration of the XIth Plan when SSA was launched in 2001. As per the initial programme, the funding pattern had switched to 50:50 from the start of this fiscal despite protests from all State Governments. In view of the opposition from State Governments, the HRD Ministry had prepared a Cabinet note proposing that funding for SSA in the 11th Plan continue as per the ratio followed in the 10th Plan period. Nevertheless, it continues to be a contentious issue. The MHRD contends that lower level of funding for SSA would delay the programme, while the Ministry of Finance and Planning Commission argue that states have ample funds and need no further assistance. (The Hindu, 8 August, 2007)

Mid-Day Meal Programme

About 12 crore children studying at the primary stage in over 9.50 lakh Government and government-aided schools including EGS and AIE Centres are being covered under the Mid-Day Meal Programme³. The norms under the scheme have been revised in September, 2006 to upgrade the nutrition norms. In the year 2007-08, provision has been made in the Union

3. The MDM Scheme is officially known as The National Programme of Nutritional Support to Primary Education



Budget to extend the scheme to the upper primary level in educationally backward blocks in the country (Department of Elementary Education and Literacy). Table 2 presents an overview of the MDM scheme.

Table 2
MDM: An Overview

Coverage of schools	Rs. 9.53 lakh primary schools/sections and EGS/AIE Centres
Coverage of children	Rs. 11.94 crore
Foodgrains allocated and percentage lifted	Rs. 22.50 lakh MTs (64%) up to 3.3.2006
Central assistance provided towards –	
(i) Cooking costs	Rs. 1781 crore
(ii) Management, Monitoring and Evaluation	Rs. 21.30 crore
Total expenditure incurred against BE of Rs. 3010.76 crore	Rs. 3077.59 crore (as on 3.3.2006)

Source: Department of Elementary Education and Literacy, Annual Report 2005-06

The MDM scheme was last revised in June, 2006 with modifications made in the norms governing the scheme. However, evaluation studies conducted point to issues of management, administration and fund utilization as the problem areas.

All States/UTs are implementing the programme and are also contributing their resources to add value and variety to the mid-day meal. In addition to the recurring assistance, funds for construction of 94,500 kitchen sheds and kitchen devices for 2.60 lakh schools have been sanctioned in 2006-07. It is proposed to extend the programme to upper primary stage in 3247 Educationally Backward Blocks (EBB) from 2007-08.

Prarambhik Shiksha Kosh:

Following the imposition of the education cess @ 2% on all major Central Taxes through the Finance (No.2) Act, 2004, Prarambhik Shiksha Kosh (PSK) was established with effect from 14.11.2005 as a dedicated non-lapsable fund to receive the proceeds of the Education Cess. An amount of Rs.10,393 crore is to be transferred to the Kosh during 2007-08. The amount will be used mainly to fund SSA/MDM.



District Primary Education Programme

The following table (Table 3) highlights the status of DPEP in March 2007:

Table 3: Status of DPEP – March 2007

State/UT	GoI Releases	State Releases	Total Funds Available	Expenditure till 31 st March 2007		Unspent Balance	
				Amount	Percentage	Amount	Percentage
Orissa	6601.14	1447.35	8934.49	6487.81	72.62%	2446.68	27.38%
Rajasthan	3189.86	431.00	5208.04	5295.16	101.67%	-87.12	-1.67%
Total	9791.00	1878.35	14142.53	11782.97	83.32%	2359.56	16.68%

Source: <http://ssa.nic.in/finmanagement/13JRM/Annex%20J-DPEP.pdf>

The schemes *Information and Communication Technology in Schools* (ICT in Schools) and *Integrated Education for Disabled Children* (IEDC) are presently under revision. Access and Equity, a scheme launched in the year 1993-94, under which financial assistance is provided to the societies and NGOs to provide boarding and hostel facilities to the girls pursuing education at Secondary and Higher Secondary stage predominantly belonging to the rural, desert and hilly areas, particularly those belonging to scheduled castes, scheduled tribes and educationally backward minorities. The scheme is proposed to be merged in the scheme for Universal Access and Quality at the Secondary Stage (SUCCESS) which is under formulation.

Scheme for Universal Access and Quality at Secondary Stage (SUCCESS)

As a follow-up to the implementation of the SSA, a new programme is proposed to be launched in the 11th Plan leading to a massive increase in the number of students completing upper primary level, it has been felt necessary to meet the increased demand for access to Secondary Education. A provision of Rs. 1305 crore (inclusive of allocation for North-Eastern Region) has been made for 2007-08.

National Scheme for Incentive to the Girl child for Secondary Education (SUCCESS)

Pursuant to the announcement made by the Finance Minister while presenting the budget for 2006-07, a scheme is under formulation for providing incentives to girls for secondary education. Accordingly, a token provision of Rs. 1.00 crore inclusive of allocation for NER has been made for the year 2007-08.

Adult Education & Skill Development Scheme

The existing schemes of Literacy Campaigns & Operation Restoration and Continuing Education for Neo-Literates have been merged into one single scheme of Adult Education & Skill Development that will cover both the existing schemes with an outlay of Rs. 322 crore inclusive of allocation for NER.





HRD Ministry Keen on Analysing NKC Advice on Educational Reforms

AS THE government plans a massive expansion of the university system, the ministry of human resource development has decided to go in for wide-ranging consultations to examine the feasibility of introducing systemic reforms in the higher education system as suggested by the National Knowledge Commission (NKC).

The consultations, which are being spearheaded by the University Grants Commission, will comprise a series of regional conferences with all stake holders. This would be followed by a meeting of the vice-chancellors of all universities, which is likely to be held in October. The issue of university reforms will also be put before the Central Advisory Board of Education (CABE).

These consultations are in keeping with the prime minister's directive that a nation-wide debate be held on the recommendations made by the NKC before any view is taken on adopting them.

Interestingly, the "systemic reforms" that the Planning Commission has suggested for implementing in the 11th-Plan period mirror NKC's recommendations. In its agenda note for the full commission meeting on education to be held on Tuesday, the Planning Commission has suggested that while semester system would be instituted right from the beginning in the 16 new central universities, it would eventually be extended to all central universities.

Other "systemic reforms" envisaged by the Planning Commission includes a common admission system for all central universities, continuous internal evaluation and assessment as against annual examinations. A credit system that would provide students the opportunity to move from one university to another as well as make a break in their studies without losing out has also been suggested.

Source: The Economic Times, 3 September, 2007

However, much remains to be done. The Right to Education is yet to become justiciable. Financial allocation to all tiers of education continues to be woefully inadequate to meet the requirements. Goals that were relevant in 1968 continue to prevail even in 2007; a matter grave in itself! At this juncture, it is instructive to understand the trends in public spending in education in the country

TRENDS IN SPENDING ON EDUCATION SECTOR IN INDIA

Ever since the commencement of economic planning in 1951-52, the education sector has remained the priority sector of the central as well as the state governments. The inter-se priorities on and off have been changed as reflected in the expenditure pattern of the last fifty years. The following table (Table 4) highlights the trend within education in the Five Year Plans.




Table 4: Plan-wise Priorities within Education Sector

Plan Period	Priority within Education Sector
First Plan (1951-56)	Elementary
Second Plan (1956-61)	Higher and Technical
Third Plan (1961-66)	Higher and Technical
Fourth Plan (1969-74)	Higher and Technical
Fifth Plan (1974-78)	Higher and Technical
Sixth Plan (1980-85)	Higher and Technical
Seventh Plan (1985-90)	Higher and Technical
Eighth Plan (1992-97)	Elementary
Ninth Plan (1997-2002)	Elementary
Tenth Plan (2002-07)	Vocational Education and Skill Development

**Table 5: Total Outlays on Education by the Central Government
Ministry of Human Resource Development**

(in crores of Rupees)

Ministry / Department	Actuals 2005-06			Revised 2006-07			Budget 2007-08		
	Plan	Non-Plan	Total	Plan	Non-Plan	Total	Plan	Non-Plan	Total
School Education and Literacy	11979.55	4.56	11984.11	17128.00	5.00	17133.00	22191.00	951.22	23142.22
Revenue	11979.55	4.56	11984.11	17128.00	5.00	17133.00	22191.00	951.22	23142.22
Capital	-	-	-	-	-	-	-	-	-
Higher Education	2558.68	3266.78	5825.46	3616.00	3500.00	7116.00	6480.50	2729.00	9209.50
Revenue	2558.68	3266.78	5825.46	3615.99	3500.00	7115.99	6479.50	2729.00	9208.50
Capital	-	-	-	0.01	-	0.01	1.00	-	1.00

Source: Union Budget 2007-08, Government of India

<http://www.indiabudget.nic.in/ub2007-08/eb/stat02.pdf>**Table 6: Total Outlays on Education, Sports, Art & Culture by the Central Government**

(in crores of Rupees)


Revenue Expenditure	Major Head	Actuals 2005-06	Budget 2006-07	Revised 2006-07	Budget 2007-08
General Education	2202	13882.82	18670.26	18795.49	21047.79
Technical Education	2203	1508.49	1681.39	1703.42	3858.44
Sports & Youth Services	2204	396.57	551.02	479.56	625.70
Art and Culture	2205	632.67	712.08	681.22	811.50
Capital Outlay					
Education, Sports, Art and Culture	4202	28.48	55.54	30.58	54.54
Loans & Advances					
Education, Sports, Art and Culture	6202	-	-	-	25.00

Source: Union Budget 2007-08, Government of India; <http://www.indiabudget.nic.in/ub2007-08/afs/afs2.pdf>,
<http://www.indiabudget.nic.in/ub2007-08/afs/afs4.pdf>

Table 7: **Total Outlays on Education, Sports, Art & Culture from the Budgets of all States & UTs**
(1990-91 to 2006-07)

Items	1990-91	1995-96	2000-01	2001-02	2002-03	2003-04	2004-05	2005-06 (RE)	2006-07 (BE)
Revenue Expenditure	32,826	61,016	1,15,491	1,18,643	1,24,324	1,34,719	1,49,022	1,85,477	2,03,390
Education, Sports, Art and Culture	15,528	28,911	59,826	60,177	62,407	65,438	70,937	84,776	93,767
Capital Outlay	1,566	2,622	8,929	9,862	9,412	11,472	15,981	21,437	23,794
Education, Sports, Art and Culture	284	454	442	616	576	761	1,100	2,015	2,355
Loans and Advances by State Govts	741	1,702	3,500	3,737	3,404	3,439	3,340	5,112	6,032
Education, Sports, Art and Culture	-	21	0.2	3	34	49	128	45	20
Total Social Sector Expenditure	35,132	65,341	1,27,920	1,32,242	1,37,140	1,49,629	1,68,344	2,12,026	2,33,217

Source: Budget Documents of State Governments
<http://rbidocs.rbi.org.in/rdocs/Publications/PDFs/74898.pdf>



With regard to the budgeted public spending by the Central government Education Department (MHRD), the figures reveal that (Table 5) compared to 2005-06 (actuals), the allocation made in 2007-08 has increased two fold. However, it is almost entirely composed of revenue expenditure – a feature that has remained unchanged!

Spending by the other departments of the Central government also comprise mainly of revenue expenditure (Table 6). Further, looking at the combined picture presented by the states and UTs on education outlays (Table 7), it becomes clear that consistent to the increase in the overall social sector spending in the states and UTs, there has been a rise in the spending on education since 1990-91 of about 16%. However, as has been the case at the Central level, apportioning for education has focused primarily on revenue expenditure with scant attention being paid to capital outlays – a matter of concern when seen in terms of physical infrastructural indicators.


Shifting the Burden to the People?

The government had introduced education cess in 2004-05 to mop up resources for funding education programmes. The cess was increased from 2 per cent to 3 per cent in the 2007-08 annual financial statement presented by Finance Minister P Chidambaram. While this is expected to step up public investment not only in elementary, but also secondary and higher education as well, it also conveniently shifts the burden of increased expenditure on to the taxpayers: an undesirable and discomfoting feature! The one per cent hike in education cess is expected to yield the government additional revenue of Rs 5,300 crore in 2007-08. The proceeds from the two per cent education cess being levied since 2004-05 is to be injected into the other key programme Mid-Day Meal (MDM) aimed at drawing children to school.

Did You Know?⁴

- Per capita public expenditure on elementary education from all sources accounted for around Rs.7255 in 2004-05.
- Of this, a large chunk goes towards salaries of the teachers and other services.
- 36.1% children's (32.7% males and 39% females) response to reason for non-enrolment was 'cannot afford school'. (The other responses included 'do not like going to school' – 16.9%; 'too young to go to school' – 14.1%; 'have to work' – 2.9% and 'other reasons' – 30%). Thus, contrary to popular belief, maximum number of children were not enrolled owing to the school education seemingly 'too expensive' and not due to being out for work – clearly shattering the myth propagated by the government on school education being 'free!' (CAG Report No.15, 2006)

4. Mohanty, Siba Sankar et al, A Training Manual on *Monitoring Right to Education* in India with a focus on Budget Analysis and Advocacy, (unpublished), Centre for Budget and Governance Accountability, 2007



- Similarly, leaving aside 'other reasons', the second-most highest rated reason for children not attending school was again non-affordability of the school education! (CAG Report No.15, 2006)
- In a year, an average Indian parent spends Rs.701 for primary education and Rs.1281 for upper primary education of their children out of his pocket in 2005-06 (NSS 52nd Round Data).
- The total cost of availing elementary education in India in 2005-06 was Rs.126318 crore, of which, government paid around 89 per cent and the parents paid around 11 per cent.
- Since 1986, there has been observed, a steady growth in private schools in the country (from 7.9% of private schools to total in 1979, it suddenly shot to 13.8% in 1986, growing steadily to 15.2% private schools in 2005) – a throwback to the early 20th century (1903), revealing influence of the policies adopted by the government (withdrawal of the State from provisioning for basic social services).

Snippets of Educational Outcomes and Infrastructure

Physical attainments can be gauged in terms of three principles of educational development consistent with the objectives of educational policy and planning: **access, equity and quality**. The following set of four tables (Table 7a to 7d) mirror the reality with regard to elementary education:

Table 7 (a)

Indicators of Access Improvement: Supply side Interventions

Items	2003	2005
1.1 Class rooms:		
(a) Ratio of Primary to Upper Primary School	3.70 (1990-91)	2.68
(b) Average No. of Class rooms per school	T 3.50 R 3.20 U 6.50	3.70 3.30 6.60
(c) Conditions of Classrooms		
(i) Good Condition	55.50	63.36
(ii) Need Major Repair	27.30	12.18
1.2. Enrolments:		
(a) Gross Enrolment Ratio	89.4	97.82
(b) Drop-out Rate: Cohort 2003-04	31.5	20.64
(c) Promotion Ratio: Cohort 2003-04	82 84	
(d) Repetition Rate: Cohort 2003-04	5	4
(e) Retention Rate at the Primary level (Average Of 16 major states considered)	53.43 (2003-04)	58.11 (2004-05)

Items		2003	2005
1.3. Teachers:			
(a) Average No. of Teachers per School	T	3.71	4.02
	R	3.41	3.61
	U	6.61	7.25
(b) Percentage of Schools having Female Teacher	T	36.60	39.78
	R	30.53	33.12
	U	63.18	64.75
(c) Percentage of Schools without Female Teacher	T	37.52	26.08
	R	40.93	30.46
	U	14.57	12.83
1.4. Infrastructure:			
(a) Percentage of Schools having Drinking water facility	T	73.28	80.60
(b) Percentage of Schools having Electricity connection in School	T	21.64	28.37
(c) Percentage of Schools having Book-Bank	T	41.04	43.54
(d) Percentage of Schools having Computer	T	7.02	8.99
(e) Percentage of Schools without Black board	T	9.94	7.86
(f) Percentage of Schools without Building	T	—	3.96

- Notes:**
- The indicators presented above are representative of All Management (Govt. & Private) and All Schools (Primary, Upper Primary, Secondary/Hr. Secondary) unless otherwise specified.
 - T = Total, R = Rural and U = Urban.

- Source:**
- Mehta, A.C. (July 2006), Elementary Education in India, (Analytical Report 2004-05), National University of Education Planning and Administration, New Delhi.
 - Sinha, Shabnam (2004), Elementary Education in India, in J. S. Rajput (Ed.) Encyclopedia of Indian Education, Vol-I (A-K), National Council of Educational Research and Training, New Delhi for Sl. No. 1.1(a) and 1.2(a); last but one column.
 - MHRD (1994), Selected Educational Statistics, 1993-94, Department of Education, Govt. of India, New Delhi for Sl. No. 1.2. (b); last but one column.



Table 7 (b)**Indicators of Access Improvement: Demand side Interventions**

Items		2002	2004
01. Percentage of Schools visited/ Inspected			
(a) Visited by C.R.C. (Cluster Resource Centre)	T	53.31	63.01
	R	56.30	66.39
	U	36.45	43.25
(b) Inspected	T	58.44	56.71
	R	59.60	57.87
	U	57.43	52.47
02. Percentage of Schools having Regular Head Master	T	64.64	47.18
	R	49.95	46.68
	U	58.56	53.79

Source: Mehta (July 2006).

Table 7 (c)**Indicators of Equity in School Education**

Items		2003	2005
01. Percentage of Girls Enrolment to Total Enrolment (Elementary Class I –VIII)	T	46.56	46.99
	R	46.15	46.79
	U	48.28	47.84
02. Percentage of ST/SC Enrolment to Total Enrolment (Elementary Class I – VIII)	ST	19.22	20.58
	SC	11.04	10.18
03. Enrolment of Children with Dsability (Elementary Class I – VIII)	Girls	386579	569460
	Total	981164	1399343
	GPI	0.65	0.69

Note : GPI = Gender Parity Index.


Source: Mehta (July 2006).

Table 7 (d)**Indicators of Quality in School Education**

Items		2003	2005
01. Percentage of Teachers provided in-service Training	T	32.19	37.37
	R	35.48	42.07
	U	16.93	21.12
02. Percentage of Schools that received and utilized Teaching Learning Material (TLM) grant	T	33.70	61.81
	R	36.50	65.11
	U	16.44	42.50

Source: Mehta (July 2006).





According to official estimates, the proportion of out-of-school children in 2006 is 17.9%⁵. The HRD ministry is claiming that 3 crore out of the nearly 5 crore out-of-school children have been brought back to school after spending Rs 16,000 crore under the SSA. However, such claims need to be reviewed carefully. Before presenting the Demands to the Government for 2007-08, let us evaluate the progress made of Charter of Demands 2006-07.

The People's Budget Initiative⁶ – Demand for Education in the Union Budget

With this background, it is in order to assess the progress made on the previous charter of demands that was presented on education by the People's Budget Initiative. Five specific demands had been made:

1. NCMP promise of 6 per cent allocation of GDP to education – a key bottleneck coming in the way of achieving this goal being adherence to FRBM. **Scrapping FRBM or keeping education out of its purview.**

There has been no change in the stance of the government on this critical area of concern. Not only is the Finance Minister insisting on stringently adhering to achieving targets set by the FRBM Act but also continues to have education within its purview.

2. **Existing CSS overlook institutional autonomy. Maintain a formal structure for educational administration and resource flow through single institutional framework.**

In fact, most recent developments point to the contrary. The Report of the Sub-Group for the XI Plan for SSA 2007 reveals that greater centralization of institutional autonomy is imminent with a focus towards making norms more stringent and having multiple frameworks for resource flow.

3. **Adhere to the budget calendar and timely flow of funds**

Again something that has not happened and several independent studies point to a total lack of maintenance of budget calendar, even absence of budget making at the sub state levels, with concomitant delay in fund flow.

4. **Plan separately for achieving targets in enrolment, universalisation of basic education**

Another recent development points to the converse. With the Planning Commission proposing to integrate ECCE (a component of ICDS) with SSA, the scope for dilution of the goal of UEE is increased. Also, with newer schemes being announced in almost every budget (SUCCESS focusing on secondary education), we can only be skeptical about the clarity and focus that the government may have regarding the matter.

5. http://nceus.gov.in/Draft_Conditions_%20of_%20Work%20_NCEUS_April_2007.pdf

6. People's Budget Initiative is a National coalition of Civil Society Organisations to influence the budget making process in India. For more information please www.cbgaindia.org



5. Elementary education funding not at the cost of higher education

Although the Union Budget 2007-08 outlays for elementary and higher education reveal considerable increments, it is worth noting that increases made in elementary education have been via additional outlay on MDM – an increase still very little in comparison to what is needed. On the other hand, criticism from several quarters point to a pervading sense of crisis in the higher education sector since long. There has been stagnant, in fact, diminishing infrastructure with increasingly greater pressure on it. For decades, library and laboratory grants have not been increased although there has been a manifold rise in the cost of books, laboratory equipment and other materials essential for scientific experiments. Maintenance and development grants have been inadequate; Universities and Colleges are being forced to raise funds privately. On the one hand, all this has meant increasingly greater burden on students through Colleges levying fees under multiple heads and on the other hand, it has adversely affected the quality of education that is being imparted. Instead of addressing themselves to the crisis of higher education in the larger social interest, successive governments have been advocating the Universities and Colleges should raise funds through private sources and by raising fees. Both these proposals are fraught with serious consequences for the nature of higher education as also its availability to different sections of society.

Charter of Demands 2008-09

1. Fundamental Right to Education – Having provided the Constitutional tool for providing free and compulsory education to children, it is now imminent to make the Right justiciable as well. While several states have made legal arrangements to ensure that education is made free and compulsory, there is still no component of ‘enforceability’ attached to the law in any state, making it merely another legal proviso without any teeth. Having a Central legislation followed by strong (‘rights’- based) and enforceable provisions at the state level is a minimum requirement now.
2. 6% of GDP for Education: a demand that has been made for over forty years now remains and the government must come up with a specific road map and fixed plan of action for delivering this promise.
3. To reiterate the recommendation made by the National Advisory Committee (2006), performance measurement in education (in terms of measurable quantitative and qualitative goals) must be seen in terms of per-child expenditure in schools and expenditure on various academic support and administrative structures. Related to this is the issue of facilitating easier access to information on expenditure break-up in education, something that needs to be collated using several official documents.



4. Decentralization and delegation of powers of autonomous management through school management committees (comprising parents, PRI representatives, and other stakeholders) including finance and accounting at the school level based on per child grants.
5. Although the government has recently announced new schemes looking at higher education, it must not be a case of side-stepping one to focus on the other aspect. Also, shifting parts of one scheme into another must also be examined closely before implementation to ensure focus is not lost. (A case in point being the proposal mooted to bring in the ECCE part of ICDS under SSA).
6. There is also the challenge of quality in Indian education, which has many dimensions, such as providing adequate physical facilities and infrastructure, making available adequate teachers of requisite quality, effectiveness of teaching-learning processes, attainment levels of students, etc.



Health in the Union Budget

Centre for Budget & Governance Accountability¹

Health scenario in India is full of contrasts. Majority of Indians are burdened with diseases which are easily curable, yet the threats of incurable diseases get more attention. A huge section of the society is succumbing to deaths which could be avoided to a great extent with safe drinking water, proper sanitation, may be some very elementary medicines. Yet the policymakers are more interested in bringing sophisticated technologies; funds are pouring in to areas like promotion of health tourism, subsidizing import of sophisticated equipments and development of private health care. Rural health services which form the backbone of public health system have almost collapsed; they lack basic infrastructure, staffs and essential medicines. Instead of strengthening them, subsidies are being given to the private players establish super specialty hospitals to attract tourist from abroad. Health system in India still remains the most privatized in the world, digging peoples' pocket heavily; yet strategies are being devised to bring more private investment. All these clearly mean that it is the interests of the certain section of the society are being taken care off, where as the vast majority remain neglected.

Some FACTS on the Health Scenario in India:

Child Health

- ❖ IMR is as high as 58 per 1000 live births (SRS- 2005)
- ❖ About 35% of the districts registered child sex ratios below the national average of 927 females per 1000 males
- ❖ Three completely avoidable child deaths occur every minute; 18 lakh deaths of under-five children could be avoided every year (Planning Commission Tenth plan Document). 60% of deaths under five years of age are entirely preventable
- ❖ Every third malnourished child in the world lives in India (MWDCD Report, 2007)
- ❖ Every second Indian child is underweight (MWCD Report, 2007)
- ❖ Children born with low birth weight are 46% (NFHS-III)
- ❖ Four out of every five children are anemic (NFHS-III)

1. Written by Indranil Mukhopdhyay and Bhumika Jhamb for the background note on 'National Convention for The Union Budget 2008-09'



Maternal Health

- ❖ MMR is equally high at 301 per 100,000 live births (SRS, 2001-03)
- ❖ Delivery of mother from the poorest quintile is over less six times likely to be attended by a medically trained person than her well of counterpart. (NFHS II)

Diseases

- ❖ Communicable, maternal and perinatal, nutritional deficiencies contribute to the largest number of deaths in India (30%) (MoHFW Annual Report 2006-07)
- ❖ Resurgence of various communicable diseases. Outbreak of Dengue during the year 2005, claimed 215 and 157 deaths of 12754 and 11985 cases respectively
- ❖ 8.5 million people are suffering from TB in India, every year 1.8million new cases are found and almost 0.37 million die out of TB (MoHFW Annual Report 2006-07)
- ❖ A total of 0.8 million malaria cases and 0.3 million pf cases with 819 deaths were reported till 17.11.2006

THE NATIONAL COMMON MINIMUM PROGRAMME

Given the bleak health scenario, it is very important to understand the broad policy direction of the government on health. As it is the case with other sectors, health policies are also subject to political changes, and depend very much on the class character of the ruling combination. After the outright rejection of the neo-liberal policies of the NDA government in the general elections in 2004, when UPA came to power, it started with a cautious note. The Common Minimum Program of the UPA, which lays out the broad policy direction of the government, recognized the urgency of health crisis and committed to increase public expenditure to 2-3 % of GDP from current level of less than one percent. This is the minimum that the government needs to spend in order to provide basic minimum health care to the entire population but in actual terms this means huge increase in expenditure and if this is realized it can bring radical changes in the health of the entire population. In this context it is crucial that the UPA fulfills its commitment and also it spends on areas which cater to the largest section of the population. How much of it is really done depends on how well the government mobilizes and spends its resources and also how much pressure the people of India put on the government to fulfill its commitments.

Health Infrastructure

- ❖ There is a shortage of 21983 Sub-Centre, 4436 PHCs and 3332 CHCs as per 2001 population norm. 50% of health infrastructure is in rented buildings.
- ❖ Ratio of hospital beds to population in rural areas is almost fifteen times lower than that for urban areas.
- ❖ Ratio of doctors to population in rural areas is almost six times lower than the availability of doctors for urban population (Health Information of India, 2000-01).



Policy Issues: Some Reflections

In the last few years certain very important policy decisions have been taken which have severe bearing on the development of health sector in India. In 2002 National Health Policy has been formulated; in 2005 the 3rd Patent Amendment Act has been passed; the National Drug Policy has been drafted in 2006; the National Rural Health Mission has been launched in 2005; the negotiations on services has started in the WTO to formalise the General Agreements in Trade in Services. In this note we would like to discuss these policies to understand the basic direction of health policy making in India and try to link it with the commitments of the UPA government.

National Health Policy 2002ⁱ

- ❖ 'Attempt to maximize the broad-based availability of health services to the citizens of the country on the basis of realistic considerations of capacity' instead of 'universal and comprehensive primary health'.
- ❖ No concrete direction towards augmenting public investment in health rather dismantling of public services; emphasis on user charges.
- ❖ Dependence on Private health care with greater 'regulation'.
- ❖ Dismantling of population control programme.
- ❖ Silent on drug prices and manufacturing.
- ❖ High priority on the creation of super speciality health facilities to attract foreign exchange and promotion of health tourism.

National Pharmaceuticals Policy, 2002ⁱⁱ

- ❖ NPP 2002 proposed gradual dismantling of Drug Price Control Order.
- ❖ Only 25 drugs under control.
- ❖ 100% FDI in drug manufacturing.
- ❖ Withdrawal of all licensing regulations .
- ❖ Changed criteria for control: more emphasis on monopolization rather than its essentiality.

National Pharmaceutical Policy in 2006

- ❖ Introduction of control over all 354 essential medicines and 74 life saving drugs.

The Patents (Amendment) Act, 2005ⁱⁱⁱ

- ❖ Third amendments to 1970 Patent Act.
- ❖ Replacement of Process Patent regime with Product Patents .
- ❖ Strengthen the monopolistic powers of the big pharmaceutical companies and heavily curtail Indian government's ability to regulate them.
- ❖ Changes in the initial act: software patenting denied; restoration of pre-grant oppositions to patents; options of export open to countries without manufacturing abilities.

National Rural Health Mission 2005

- ❖ Improve the availability of and access to quality health care by people, especially those residing in rural areas, the poor, women and children.
- ❖ Mainly focuses on 18 states only.
- ❖ Omnibus of the existing programs like RCH II, Integrated Disease Surveillance Project and AYUSH.
- ❖ Introduction of ASHA scheme.

General Agreement on Trade in Services^{iv}

- ❖ Framework for progressive liberalisation of services.
- ❖ Treating foreign companies at par with domestic companies.
- ❖ Restrictions in state interventions in essential social services once agreed to open up.


National Health Policy 2002

At a time when influence of neo-liberal policies can be seen in every aspect of our life, it is quite unlikely that health as a social sector will remain insulated from the consequences of rampant liberalization. Let us discuss some aspect of recent policy developments to get a sense what these actually mean for the marginalized sections of our country. The most significant development is the introduction of National Health Policy in 2002, which came up after two decades. The central goal of the first National Health Policy 1983 was 'universal and comprehensive primary health', unfortunately the 2002 NHP dropped this idea introduced the concept of 'maximizing the broad-based availability of health services'. Further this policy has some apparent contradictions. On one hand it does not hesitate to acknowledge the unacceptably high prevalence of many curable diseases; it expresses dissatisfaction over the morbid state of public health system; it also recognises the insufficiency of public government resources in health. On the other hand it does not lay down concrete plans to generate resources for public provisioning and emphasises on greater role of private health care as the panacea of all these problems. Though there is the mention of greater regulation of private health system it hardly recognises the problems of regulation per se, especially in the context of India, where the private health care is among the least regulated in the world. Access to essential medicines is also neglected in the NHP 2002. Thus the NHP 2002 remains a testimony of empty rhetoric and misplaced priorities.

National Pharmaceutical Policy

In India about 80 percent of the population do not have access to essential medicines and purchase of drugs constitutes a major portion of out of pocket expenditure. It is important in this context that access of essential medicines be given enormous priority. But the National Drug Policy drafted in 2002 came as a major setback for the people as it proposed






to dismantle all control over prices of essential drugs, and 100% FDI in drug manufacturing. The draft was opposed by various sections of the society; later on the UPA government proposed re-drafted National Pharmaceutical Policy in 2006, which proposed control over all 354 essential drugs and 74 life saving drugs. Though there were some problems with the new draft, it was undoubtedly a progressive initiative. But the industry, especially the MNCs, came up with venomous criticism against this Policy and ultimately the UPA had to succumb to the pressure and shelved the bill. This clearly shows that the UPA government, is more interested in keeping the interest of the domestic industry and the MNCs and least interested in establishing an effective price control mechanism which benefits the entire nation on a whole.


Third Patents (Amendment) Act, 2005

Another very important policy change that will entirely transform the ways drugs are being produced in India is the Third Patents (Amendment) Act, 2005. India was already committed to the WTO that it will gradually shift to a product patent regime and withdraw process patents. The bill was introduced as a form of referendum, precisely to bypass the parliament. It did not even try to explore the special safeguards offered under WTO. The bill was vehemently criticized by left parties and other progressive sections of the society. Ultimately some safeguards like provision of parallel import and compulsory licensing were introduced in to the bill. Though these changes are welcome, we have to understand that the product patent regime itself is very harmful for the small domestic manufacturers not to talk of the millions Indians. The Indian MNCs who capitalized the benefit of process patents most are now in a position to do well under product patent. Since they are the ones who determine the direction of pharmaceutical policy in India they are voicing in favour of product patent. But the small and medium producers who are majority going to suffer in the long run. It is extremely important in this context that the Amendments are thrown out in its entirety, but this is not possible unless India, along with other developing countries do not take the fight to the WTO.

General Agreement on Trade in Services

Another significant policy initiative which can have enormous consequences for all the services including health is the General Agreement on Trade in Services. Reading the mood of Ministry of Health and Ministry of Commerce and Industries suggest that they are delighted over the prospect of its introduction. Unfortunately their enthusiasm is greatly misplaced because of following reasons. GATS essentially means progressive liberalization of services and treatment of domestic companies with those of their foreign counterparts at par; more over it will leave restricted opportunity for the state to intervene once agreed to open up the sector. As it is well-documented, limited opportunity for state intervention can leave millions of poor without any health care and virtually at the mercy of crony private





care providers. Progressive sections of the world, along with overwhelming majority of developing countries have expressed reservations on the agreement on services; strong voice have been raised against inclusion of essential services like health, education, water out of GATS. Shamefully instead of joining the war against GATS Indian delegates at the Cancun round in WTO played instrumental role in weakening the resistance of the developing countries².

National Rural Health Mission


The flagship program of the UPA on health is the National Rural Health Mission, launched in 2005. Its goal is to 'improve the availability of and access to quality health care by people, especially those residing in rural areas, the poor, women and children. Though it talks about comprehensive care, NRHM is merely a conglomeration of some existing schemes and programs, apart from ASHA there is hardly any new initiative. Further the success of this program can be ensured only through sustained monitoring of the Mission. Some independent reviews of NRHM show that though there are slight improvements in the functioning a lot more needs to done³. There are problems of monitoring of the schemes and benefits are not reaching adequately to the people. In principle the NRHM talks about devolving power to the PRIs and at the district level, but little has been done in this regard. The policy makers, influenced by the logic lack of absorption capacity of the rural sector, do nothing to devolve power to the villages. Fact of the matter is a lot of innovations can be seen in setting up of rural health care delivery system if the local level governments are empowered to plan and given autonomy to allocate fund in accordance to the needs of the locality. It can be safely said that NRHM

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2. In the latest round of WTO Ministerial, held in Hong Kong during December 13-18, 2005 significant developments have taken place. The Draft Text that went to Hong Kong had the entire Annex C, which basically argued for accelerated liberalisation of Services, as bracketed, signifying lack of any agreement on the entire text. In the final Declaration the bracket has been removed and the whole of Annex C has been accepted. The current form of the deal seeks to subvert the basic structure of the GATS. Initially GATS was conceptualized as framework agreement where countries were allowed to make voluntary commitments to liberalise their services sectors in accordance with the level of their economic development and national requirements. Para 7 of Annex C emphasises request-offer negotiations on a 'plurilateral basis', which would undermine that flexibility. A large number of countries under G-90 were opposed the Draft on Services in the Ministerial Text (Annex C) and the G90 had also submitted an alternative draft. Unfortunately, the Indian delegation headed by the union commerce minister, Kamal Nath, took cudgels on behalf of the developed countries, and forced the developing countries to abandon the G90 proposal and accept Annex C.

Shamelessly, the Kamal Nath & Co. started their propaganda on supposed gains in Mode 1 & Mode 4, which essentially mean concessions for BPOs and more H1B visas. However they maintain complete silence on the agreed objectives to Mode 3, where by FDIs have to be allowed to services like health, higher education. The deadline for finalizing the agreement, October 2006, is over and there is almost a deadlock in WTO on the issue of agricultural subsidy. But there is hardly any room for complacency, and once the negotiations starts India might have to face severe consequences. Especially after the proven eagerness of the Government to trade-off opening up of social sectors like health and education and sensitive financial sectors like insurance and banking, which would adversely affect millions of common people, against the benefits accruing to only a few thousand skilled professionals and the BPO sector.

3. Case studies done by SAHAYOG and partners on Janani Surakshya Yojana in UP shows that though families know about their entitlements and they decide to take women for institutional deliveries, even the ASHA workers are present in some areas, the maternal health services have not improved significantly.





is going to remain only a half hearted effort towards provision of basic health services to the country side.

The above review suggests that the recent policy initiatives are full of empty rhetoric and lack concrete policy directions to develop a working well functioning public health system in place. It is also clear that the over all direction of these policies is to promote a private based health care system, knowing well the fallacies of the private health care and their inability to cater to the needs of the vulnerable sections. It is also unfortunate that the multinational have enormous influence on the domestic policies and the government is totally unwilling to do anything which can be detrimental to their business. Unless there is major shift in the attitude of the government towards the needs of the majority of the population universal access to public health services and essential medicines will remain a far cry.


Issues of Finance:

Recognizing the dire state of public health services in the country and sorry state of health of the underprivileged sections of the India, the National Common Minimum Programme (NCMP) of the present United Progressive Alliance (UPA) Government at the Centre seeks to increase public spending on health to at least 2-3% of GDP over the five years, with focus on primary healthcare. This was a major promise which helped it mobilize support from different progress groups. Unfortunately at the fourth year of the UPA this commitment is far from being realized. Though in absolute terms there is some increase in expenditure of the Central Government, in real terms the increase is meager, given high growth rate of GDP and inflation. According to National Health Accounts in 2003-04 public expenditure in health as a proportion of GDP was only 0.9% of GDP. To augment this level to 2-3% of GDP means stepping up not only central expenditure but a greater support to states to increase their own spending.

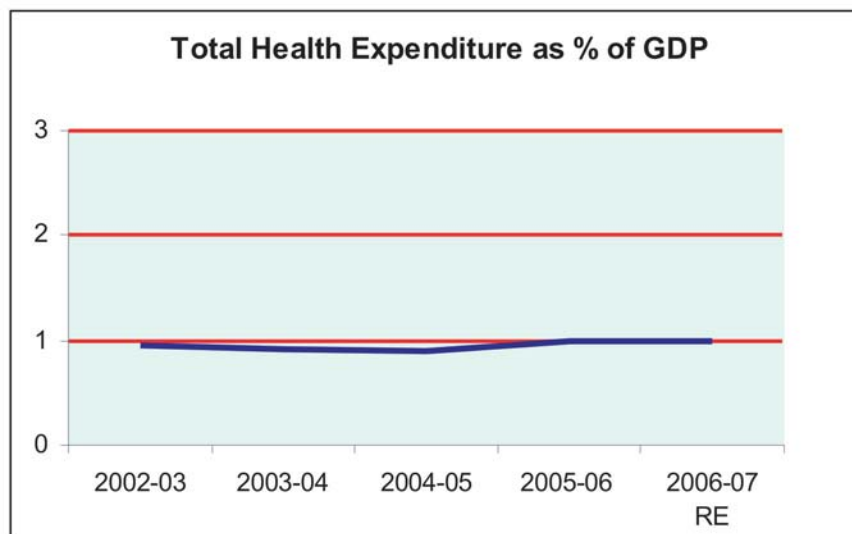
Expenditure on Health

- ❖ India spends only 0.9% of GDP on public health, merely one-third of the less developed countries' average (WHO Report, 2003).
- ❖ 84 per cent of healthcare is out-of-pocket expense.
- ❖ 40% of hospitalized people are forced to borrow money or sell assets to cover health expenses (NSS 42nd and 52nd).
- ❖ Only 20% of population has access to essential drugs (Jan Swasthya Abhiyan, 2004)

Though there is some increase budget allocations since 2004-05, this is far from being adequate. The Total Expenditure of the Union Government on Health and Family Welfare went up from Rs. 9649.24 Crore in 2005-06 to Rs. 11757.74 Crore in 2006-07 RE, which has further been increased to Rs. 15854.88 Crore in 2007-08 BE (Table 1). However, it still



hovered around 1 % of GDP in 2006-07 at the national level. Allocations by the Central Government in 2007-08 register significant increase over the previous years, which may provide some respite to the common people of this country. Now, with only one more budget (for 2008-09) to go before the set deadline in NCMP, meeting this noble goal would definitely remain elusive.

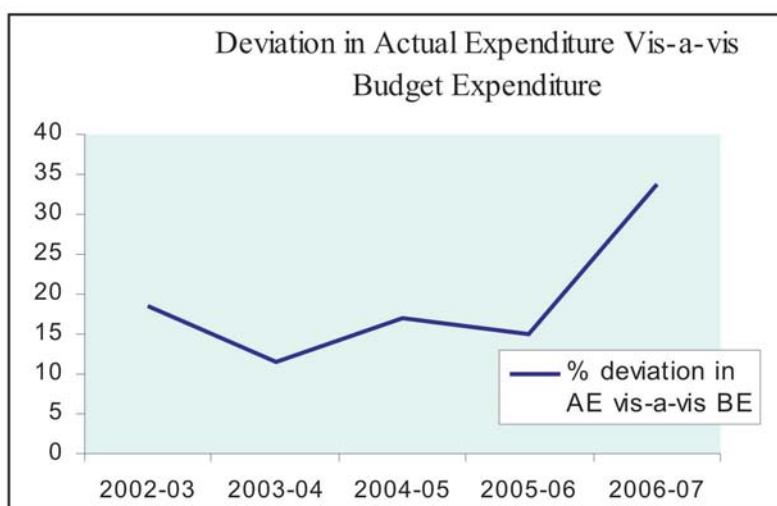


The Parliamentary Standing Committee of Department of Health and Family Welfare on its report acknowledge that the trend in allocation and expenditure shows a steady increase over the 9th and the 10th plan periods. But it also expresses dissatisfaction over the fact that every year for plan expenditure the actual expenditure reduces substantially from the Budget Estimate. The report notes that in 2005-06, Plan allocation of Rs. 9332.00 crore was brought down by almost Rs.1000.00 crores (Rs.8500.00 crores) at the Revised Estimates stage and the actual expenditure reported was only Rs. 8076.76 crores. Whereas, every year utilisation of non-plan fund is more than the BE allocation. This clearly depicts that plan funds under health schemes are being diverted to non-plan expenditures; as a result there remains a dearth of plan fund in Central government institutions and schemes on health⁴. More over

4. It is to be noted that for the health sector plan and non-plan division is little misleading. Because plan expenditures, which should actually be new investments, in the health sector do not necessarily mean that since a large part of plan budgets, for example the entire RCH and Family Welfare budget, include routine line item expenditures like salaries, transport, office expenses etc.. and very little new investments. At the same time if we consider capital and revenue expenditures divisions, at least at the union level there remain gross under estimations. This is because the grant in aid to states from the centre is a revenue expenditure for the centre but it may be a capital if the state spends it to create new facilities and it will be shown at state's budget as capital expenditure. Thus analysis of Union Budget for capital expenditure will lead to underestimations.



the capital expenditure of the centre and state taken together on health has remained alarmingly low over the last two decades. It is also to be noted that over all the actual expenditure of Ministry of Health and Family Welfare is much less than that of the BE and over time the gap is widening.



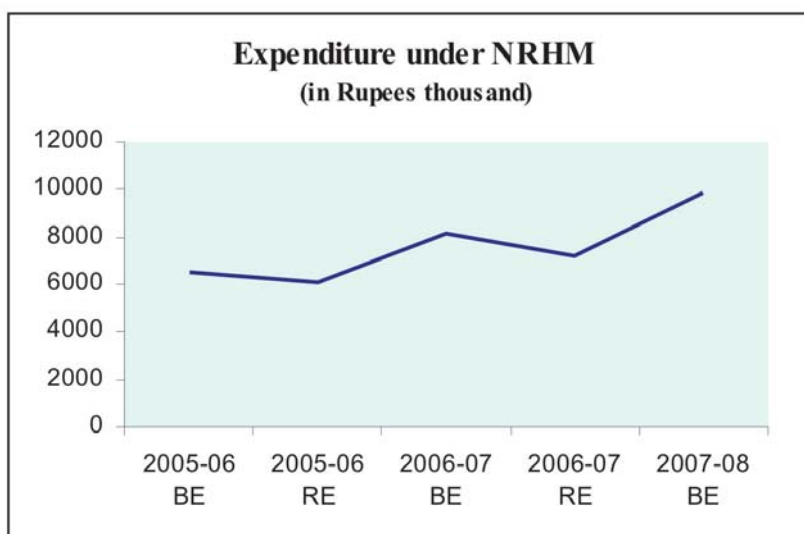
The Standing committee further registered its strong objection over the practice of including external assistance in the gross Budget of the Department. It notes that the domestic Budget for the year 2006-07, an external aid component of Rs.1299.07 crores has been included. The Committee observed that if the practice of including external aid in domestic Budget continues, then the commitment of the Govt. to raise the allocation in the health sector to 2-3% of GDP will remain only on paper and not be realized in actual practice. Moreover, the Committee also felt that financing the non-plan expenditure by external aid is not a healthy practice.

Expenditure under NRHM

The financing of NRHM so far reveals that it is focused more on selective interventions and the aspect of universalisation is neglected. According to the mission document the initial allocation for NRHM for the 2005-06 would be Rs.6700crores, and in subsequent years 30% increase will take place. But for 2005-06 no separate head for NRHM was created and funds for the existing programmes were used. For 2005-06 Plan outlay on NRHM was Rs.6075.17 crores. It received an increased outlay of Rs.7155.97crores (RE) as Plan funds in 2006-07. This has further been increased to Rs.9801crores (BE) in 2007-08. The non-plan outlays for these years remained almost stagnant at Rs.32.29crores (2005-06 RE), Rs.34.40crores (2006-



07 RE) and Rs.38crores (2007-08 BE). The following table clearly shows that for the two years the revised estimates (RE) are substantially less than the budget estimates (BE). Even the commitment of increasing allocations by 30% every year has been violated, the increase has been 18-20 % in nominal terms where as the real increase is much lesser. Further around 80% of the increase in allocations took place in four components: HIV/AIDS program, RCH, medical education and AYUSH; where as strengthening of the PHC infrastructure remains grossly neglected.



The Union Government took some positive steps in 2007-08 Budgets to bring down the prices of 10 anti-AIDS and 14 anti cancer drugs by slashing the customs duty to 5 percent. Duty on certain life saving drugs, kits and equipment were also brought down to 5 percent from the level of 15 percent in the Budget proposals for 2006-07. These drugs were also exempted from excise duty and countervailing duty (CVD).

This year, the Finance Minister has exempted clinical trial of new drugs from any service tax obligation with the stated goal of making India as a preferred destination for drug testing. This step may have adverse implications for the poor people of this country. The obvious vulnerability imposed due to poverty may drive people to become guinea pigs and this may adversely affect the social fabric of our country.

Another important step, that merits mention here, is the reduction of import duty on medical equipment from as high as 12.5 % to 7.5 %. Although, modern medical equipments are necessary for accurate medical aid, this step may further the interests the private sector in the health sector, where it is an established fact that more than 80 % of the health expenditure





by the people of India goes into the hands of private players.

Another significant development in this sector was the proposal for setting up six AIIMS-like institutions in Union Budget 2005-06 to augment medical education in deficient States. In 2005-06 Budget, Rs. 250 Crore (BE) had been provided for this purpose (Expenditure Budget Volume 2). The revised allocations for 2005-06 have been reduced drastically to a meagre Rs. 6 crore. In 2006-07 Budget, the allocations for this purpose has been pegged at Rs. 75 crore only, which has been revised and stood at Rs. 10 Crore only. This means that the Central Government has been going back and forth on this issue, which clearly shows the lack of commitment on the part of the Centre to carry forward its promise in this regard. For the year 2007-08, Rs. 150 crores has been set aside for this purpose.

The Prime Minister has shown enormous enthusiasm in proposing the establishment of Public Health Foundation of India, where in 5-7 institutes for training in Public Health will be set up throughout the country. The Foundation is being envisioned as 'world class' institute for teaching in Public Health built on Public-Private Partnership model where academicians throughout the world will be roped in and around 10000 public health professionals will be created everywhere. Apparently the proposal looks interesting given the dearth of public health manpower in the country. But a deeper scrutiny in to the overall structure of the Foundation suggests that it has problems. Given that it is PPP initiative, there is every chance that exorbitantly high fees will be charged and in that case will cater to the students from the upper strata. This will clearly defeat the very purpose of the initiative. Like it is the case with other private professional courses, graduates from the foundation may not find it lucrative to work in the rural areas. Moreover it may lead to major brain drain at the cost of public resources.


Over it can be argued that the interms of expenditure of the central government there is some increase, but that is far from being adequate to meet up the target. Further given that expenditures at the state level have not increased significantly also, it seems impossible to reach the level of 3% of GDP with in just one year. If there is no effort in improve the debt position of the states and alternative ways of revenue generation are not evolved there is hardly any possibility that the target will be achieved. Countries which have universal access to health care system has tax-GDP ratio of the level of 30-40 Per cent, and in contrast to that currently tax-GDP ratio is hovering around 15 per cent,⁵ and highly inadequate to meet the health care needs of the people.

UNFULFILLED DEMANDS

If we compare Union Budget with our demands in last years charter, we find most of the demands are far from being fulfilled. As we have seen UPA's commitment of spending 2-3% of GDP on health remains a far cry. Though in absolute terms there is some increase in spending, in terms of GDP it has increased marginally in last three years- from 0.89 per cent of GDP in 2004-05, it has gone up to mere 0.99per cent in 2006-07. In 2007-08 increase is

5. In the eighties our tax : GDP ratio was over 20% and public health was doing well grossing 1.4% of GDP by 1987. Subsequently there was a declining tren with SAP expediting this by bringing TAX:GDP ratio down to 10% by mid nineties with so called tax reforms. Today tax:gdp ratio is around 15%







not substantial in real terms, and only one more budget to go, it is not going to reach anywhere near to the target. Further government had committed that under NRHM every year 30% more fund will be allocated. We had observed that mere 30% increase in NRHM fund will not help to fulfill NCMP target. Further analysis suggests that even government has failed to fulfill its own commitment and funding under NRHM has increased only around 18-2%. We had also demanded that matching grant requirement under the CSS be relaxed for the poorer states. Unfortunately Union Budget 2007-08 has not made any commitment to help poorer states to enhance their funding capacity.

Agenda for the Future: Demands from the People's Perspective

As we have seen most of the demands in last year's charter remained unfulfilled. This year charter should re-emphasise on those issues again.

- First of all UPA's commitment to spend 3% of GDP in health is far from being realized. Union Government needs to take serious measures in this regard. Until the financial conditions of the states are not improving, this goal is not going to get realized because major responsibilities are lying with the states. In order to step up states' spending capacity more grant-in-aid should be provided to the states.
 - There is the urgent need to generate additional resources for health sector. Several options can be thought off. To start with a direct health tax in the line of professional tax can be imposed; additional levies can be imposed on consumption of health hazardous substances.
 - Last year we had demanded that the Centre should increase spending under NRHM more than the committed 30%. As we have seen even that 30% is not being increased. A huge increase under NRHM is extremely important.
 - There is marginal increase in capital expenditure. In a situation where rural health services are at the blink of collapse, extra initiative should be given in this regard. Additional resources need to be put in form both the centre and the states to augment rural health services.
 - Communicable diseases like TB are still the major killers. Though these have been given special attention under NRHM, but spending has not increased significantly. There is urgent need to step up spending on communicable diseases.
 - As we have discussed, poorer states find it difficult to provide matching grants, due their limited resource mobilization capacity. This hampers the utilisation of central grants and funds remain unspent. The provision of matching grants centrally sponsored schemes should be abolished with immediate effect.
 - Establishment of AIIMS like institutions or the PFI should not be at the cost of primary health services.
 - The government should take every effort to bring essential services like health, education, water out of the ambit of GATS.
 - All the 354 essential drugs should be brought under price control.
 - Government should not take any initiative to promote clinical trials and should revert back its subsidy from clinical trails.
- 



The above measures are very elementary and may not be adequate for developing comprehensive public health system for all. The need for a radical transformation of entire health care system and the way it is financed today is imminent if we really want to change this regressive system of finance where people have to pay heavily, borrow and sale their assets in order to tide over their health emergencies- to one where every Indian have access to comprehensive health care services. Unfortunately as off now there is hardly any positive step on the desired direction, radical transformation remains a far cry.

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Annexure

Table 1: Public Expenditure on Health and Family Welfare

(in Rs. Crore)

Year	Revenue Account (Centre)	Capital Account (Centre)	Total (Centre) (1+2)	States' Expenditure	Total National Expenditure	GDP at current market price	3 as % of 6	5 as % of 6
	1	2	3	4	5	6		
1997-98	3176.60	14.05	3190.65			1522547	0.21	
1998-99	3990.68	46.94	4037.62			1740985	0.23	
1999-2000	5014.16	44.21	5058.37			1936831	0.26	
2000-01	5289.73	-34.89	5254.84			2089500	0.25	
2001-02	5928.23	8.66	5936.89			2271984	0.26	
2002-03	6493.81	10.00	6503.81	17094	23597.81	2463324	0.26	0.96
2003-04	7180.60	68.54	7249.14	18235	25484.14	2760224	0.26	0.92
2004-05	8065.39	20.56	8085.95	19617	27702.95	3121414	0.26	0.89
2005-06	9578.54	71.70	9649.24	25418 (RE)	35067.24	3529240	0.27	0.99
2006-07 RE	11681.28	76.46	11757.74	29137 (BE)	40894.74	4116972.9	0.29	0.99
2007-08 BE	15499.03	355.85	15854.88			4574181.8	0.35	

Notes: Figures for 1997-98 to 2005-06 are Actuals, those for 2006-07 are Revised Estimates (RE), and those for 2007-08 are Budget Estimates (BE), and for States's Expenditure, 2005-06 data is Revised Estimates and 2006-07 data is Budget Estimates.

Source: Expenditure Budget Volume I for various years and RBI: State Finances – A Study of Budgets for various years. Reproduced from the Response to Union Budget, CBGA, 2007-8

Table 2: Expenditure Incurred vis-à-vis the Budget Estimates during the Tenth Plan, Ministry of Health and Family Welfare

Xth Plan Period	Budget Estimates	Actual Expenditures	% Deviation
2002-03	6480	5276.45	18.6
2003-04	6480	5735.08	11.5
2004-05	7988	6634.45	16.9
2005-06	9332	7926.25	15.1
2006-07	11305	7484.17	33.8

Source: Outcome Budget, Ministry of Health and Family Welfare, 2007-08

Table 3: Budget Allocations under NRHM (in Rs. Crores)

	2005-06 BE	2005-06 RE	2006-07 BE	2006-07 RE	2007-08 BE
Plan	6477.01	6042.88	8108.47	7155.97	9801.00
Non-Plan	131.04	32.29	33.43	34.40	38.00
Total	6508.05	6075.17	8141.90	7190.37	9839.00

Source: *Expenditure Budget Vol. 2, Union Budgets 2006-07, 2007-08, GoI.*


i. National Health Policy 2002:

The National Health Policy adopted in 2002 by the NDA regime exposed the insensitivity of the current ruling class towards the dire need to strengthen and expand the public health system in India. It conveniently abandoned the idea of 'universal and comprehensive primary health', which was the goal of the first National Health Policy adopted in 1983. At the level of rhetoric it is quite impressive- it does not hesitate to acknowledge the unacceptably high level of prevalence of many curable diseases; it expresses dissatisfaction over the morbid state of public health system; it also recognises the insufficiency of public government resources in health. But when it comes to providing concrete direction to address these problems on the ground it ends up creating confusions, with many contradictions. It does not propose any concrete direction towards augmenting public investment in health, but the entire effort seems to be towards legitimising the ongoing privatisation of the health care system of the country. As a positive sign the NHP 2002 has expressed concern for regulating the private health sector through statutory licensing and monitoring of minimum standards by creating a regulatory mechanism, but how far it can be realised is to be seen. While remaining silent on the need to review the ill-conceived population control programme, which has proved to be a massive failure causing a huge drain on primary health care, the NHP 2002 instead argues for the virtual dismantling of the latter. The NHP also remains silent on drug prices and manufacturing with the ministry of industries taking over the decisions about Drug Policy. The NHP is vociferous in arguing for creation of health facilities to attract foreign exchange and promotion of health tourism. NHP proposes the introduction of user charges for public health facilities in order to bring greater financial autonomy. Experiences in some Indian states clearly suggest that user charges can at the maximum contribute to only 1-2% of the total expenditure and the goal of financial autonomy can hardly be achieved. Further it has been seen world wide that user fees are regressive and can drive away a large section of potential beneficiaries. Over all it is an insincere effort towards developing comprehensive health care system which is accessible to every Indian.

ii. Access to Essential Medicines:

According to WHO estimates (The World Medicines Situation (WHO 2004)) 56% of Indians do not have access to modern medicines. In this context it is very important that cheap if not free drugs are made available to the entire population. In 1970 prices of all drugs were brought under control, but gradually over the years number of drugs under control got







reduced. The Drug Price Control Order of 1979 brought 378 drugs under control and in 1994 the number went down to 74. The policy also recommended for total abolition of the Drug Price Control Order (DPCO) in stages. This 2002 policy abolished all licensing restrictions and allowed 100% foreign share on investment. The Govt had doubled the excise duty from 8% to 16% for medicines, which enhanced the prices of domestic production. At the same time it liberalised imports and cut import duties – thus making it more lucrative to import medicines. Thus all control over the medicine sector was virtually withdrawn. Repercussion of such wholesale withdrawal of regulatory control in this sector led to increase of import, spiralling rise of drug prices and flooding of the market by high priced imported medicines.

In July 2006 draft National Pharmaceuticals Policy, 2006, was announced which proposed to include 354 essential drugs under price control along with 74 life saving drugs. The domestic pharmaceutical industry with their MNC counterparts severely opposed this move. Even different ministries including Ministry of Commerce and MoHFW opposed the increase in the width of price control. Union Minister of Health and Family Welfare criticized such a move with the logic that this may affect the supply of these drugs because many of the producers may pull out from production not finding it remunerative to produce. They vouched for adopting non-price control mechanisms to make prices affordable. Fact of the matter is the span of price control will go up only by 8% and 675 drugs which is only two thirds of the drugs available in the market will remain out of control. Ultimately the PMO has asked the chemicals ministry to prepare a separate cabinet note explaining how the issue of price control can be dealt with without increasing the span of control, which essentially means almost withholding this progressive regulation. In this context it is important to note that drug prices are controlled through out the world, in various forms. In a context where India has entered into a stricter patent regime which can lead to great monopolistic practice, it is imperative for a developing country like ours to take stronger price control mechanisms, in order to ensure greater access to essential medicines. Unfortunately, the UPA government, which is more interested in keeping the interest of the domestic industry and the MNCs seems to be least interested in establishing an effective price control mechanism which benefits the entire nation on a whole.

iii The Patents (Amendment) Act, 2005

In March 2005 the Patent (Amendment) Act was passed in the parliament to bring about the third set of amendments to 1970 Patent Act, in order to comply with the Trade Related Aspects of Intellectual Property Rights (TRIPS). From 1970s India had a patent law which was seen as a model for the developing countries. It exempted food, drugs and chemicals from product patent. As a result Indian drug industry grew into one of the strongest and self-reliant industries in the world. In 1986, under Uruguay Round of negotiations, TRIPS was proposed to be included in to General Agreement of Trade and Tariff (GATT). The agreement on TRIPS was one of the most bitterly fought negotiations of WTO which essential required countries to follow a Product Patent Regime. Unfortunately, India agreed to this inclusion in 1989-90, despite some initial opposition. The TRIPS agreement was signed in 1995 (as part of the WTO agreement) and countries like India were provided a transition period of ten years till 2005, to enact laws that were compliant with the provisions of TRIPS. In 1999 and 2003






some transitional amendments were made into the Patent Act. In 2004 December the UPA government promulgated an ordinance to pave the way for the amendments.

There are a whole range of issues connected to TRIPS agreements which are meant for safeguarding of national interests. The Indian ordinance went beyond of TRIPS requirements and ignored safeguards like compulsory licensing and pre-grant oppositions. In a product patent regime, a proper compulsory licensing system is of fundamental importance to ensure competition and competitive prices. The ordinance provides enough opportunities to the powerful patent holders to manipulate the process by litigation to prevent others from producing their patented products. Over this ordinance was meant to strengthen the monopolistic powers of the big pharmaceutical companies and heavily curtail Indian government's ability to regulate them.

The ordinance was met with enormous criticism from left parties, trade unions and progressive movements and intelligentsia around the country. Finally the UPA government tabled the amendments addressing some of the key concerns of the opposition. The new Bill included some restricts on patentability; it denied the option of software patenting; it restored pre-grant oppositions to patents; it kept options of export open to countries without manufacturing abilities; further it allowed Indian companies to produce drugs for which patent applications are pending in the mailbox, even after the patent was allowed, given they pay a royalty. Introduction of these amendments may safeguard the interest of millions of Indian to some extent, but it should be remembered that ultimately the TRIPS agreement itself is very controversial as it is a major sacrifice in interests of developing countries and has met with enormous criticism throughout the world. It is important in this regard to take the fight to the WTO and throw the TRIPS out of it.

iv. General Agreement on Trade in Services:

General Agreement on Trade in Services is one area of WTO which can transform the way services are being provided in the developing world. GATS lays out the framework for progressive liberalisation of services. Though all the services are included in GATS, currently 19 services including health have been identified. Services where there is partial involvement of the government or there is some user charges will fall under GATS purview. There are four modes of service which are identified: mode one includes services those are offered from a remote distance, services like telemedicine are relevant in this context; services which are consumed abroad falls under mode two- health tourism falls under this category; another important form and the most significant one is the presence of foreign commercial entities like super-speciality hospitals set up by multinationals fall under mode three; mode four includes presence of natural persons like doctors and nurses in other lands. Progressive sections of the world, along with overwhelming majority of developing countries have expressed reservations on the agreement on services; strong voice have been raised against inclusion of essential services like health, education, water out of GATS.





Conclusions

India continues to confound conventional wisdom: great wealth and abject poverty; thousands of world-acclaimed scientific, technical and medical manpower and millions of illiterate citizens; a destination for medical tourism, and home to millions of mothers who have no access to medically assisted deliveries.

Health, education and other essential services create the basic grounds of change in developing societies, lifting the people from the mire of poverty and powerlessness, leading to greater democratisation in development and political empowerment. They also, as the experience world over shows, lay the foundations for a sustained and equitable economic growth of any country.

However large swathes of population across India stand out as testimony to the neglect of the State towards the poor and marginalised sections – all citizens. Primary Health Centres (PHCs), the crucial first point of contact for delivery and monitoring of public health services, function without doctors, nurses and medicines. Drab single room and single teacher schools make children's first contact with education a dreaded experience that makes them lag far behind in life. In unending rural landscapes in states that are 'fully' provided with water as per official figures, people go down to the depths of wells with unsafe water, falling prey to diseases. As for toilets connected to a sewerage system – well, that is a dream for vast sections of rural and urban sections in India.

All the evidence points to the fact it is public action alone that can provide these universally accessible services. The state has struggled to ensure that public policies integrate equity, gender justice and universalism, as well as larger welfare inputs like food availability, drinking water, education among others.


The papers in this Status Report on Health & Education highlight the tremendous churning in India today. Neither universal nor accessible; in their current poor state these essential services in no way empower people to rise above the socio-economic context which oppresses them.

EDUCATION – KEY CONCLUSIONS

The Right To Education Is Still To Be Actualized

India has made some progress on education, especially since the introduction of the Government's Sarva Shiksha Abhiyan ("Education for All") programme, and since the Supreme





Court of India's decision to make cooked midday meals compulsory in primary schools¹. From 1991-2001, India recorded the highest increase in its literacy rate in any decade after independence (13.7 per cent). The promise of the Constitution of India however, that "The State shall provide free and compulsory education to all children of the age of six to fourteen years" has still not been fulfilled. Even the proposed Right to Education is still to be actualized.

Investment In Public Education Must Be Increased

The India government spends far less on education than even its own assessments call for. Current spending is between 3 and 4% of GDP. Yet from as far back as the Kothari Commission (established by the Government of India from 1964 to 1966) to as recently as latest Central Advisory Board on Education (reconstituted by the Government of India in 2004), the Government's own assessments have consistently argued that average annual expenditure from the public exchequer has to be in the range of 6% of GDP, at least half of which should be for primary and secondary school.

Recently, the education cess levied by the Government in the past four years is expected to fetch almost Rs. 4,000-5,000 crore a year. However this cess is being used as an excuse to cut down the spending on primary education from government's own budgetary allocations. At the same time there has been a proliferation of fee-charging private institutions, many with government subsidies. Lack of investment in government services, plus government subsidies for private schools have let down the poorest children.

Quality Education Has Not Reached the Most Marginalized


While close to 90 per cent children in the 6-11 age group are formally enrolled in primary schools, nearly 40 per cent drop out at the primary stage. About 38.41 per cent boys and 51.88 per cent girls in the 6-14 age group are not attending school. The enrolment ratios of SC, ST and Muslim children and more so among girls still remain far lower than the national average.

Further, a new class-based education system is officially propagated by the government. The most socially disadvantaged in most rural areas have been allocated single-teacher, single classroom Education Guarantee Scheme (EGS) kind of schools whose dysfunctional education pushes them out. We are giving legitimacy to new markers of inequality on the marginalized by creating these 'para schools' in the name of increasing access.

In addition to this, the official teacher-student norm is 1:40, in some states it is 1:80. A one per cent annual growth rate of schools compared to a much higher population growth rate and teacher shortage are some of the reasons. The prescribed norm of a school being available within the radius of one kilometer is still a distant dream.

1. Providing midday meals in schools increases the incentive for poor parents to send their children to school, and by reducing hunger and malnutrition also enables children to perform more effectively at school.





Further, there is nothing like ‘free’ education even in government schools. Families spend as much as Rs. 350-per child per year for uniforms, stationery, transport, and more if tuition is added. Poor school infrastructure, lack of things like toilets, safe drinking water in the schools, poorly paid teachers burdened with multiple tasks with no stakes in the system merely add to the misery of the children.

Lessons Learnt

Evidence suggests that universal education, driven by a uniform system, delivers higher literacy rates than do systems with different types of schools for different socio-economic groups.

Within India, the state of Himachal Pradesh provides an outstanding example. Himachal Pradesh has any number of excuses not to have achieved high rates of literacy, including: hilly terrain; lack of running water, meaning it has to be fetched from great distances; extreme weather conditions; general poverty. Himachal’s literacy rate was 19% in 1951; by 2001 it had gone up to 77% - with 96% for the 15-19 age group- The gender gap and caste disadvantages appear to be minimal according to Indian academic Kiran Bhitty, who says that “the schooling revolution in Himachal Pradesh has been fundamentally a state initiative. Its common schooling system, which contrasts so sharply with the segmented schooling found elsewhere in India, has played a key role in sustaining the egalitarian features of Himachal society.”²

Where states have more teachers, where teacher-pupil ratio is low, where funds are received and utilised, where there are more classrooms and fewer single-teacher schools, the overall educational achievements are much better.

HEALTH – KEY CONCLUSIONS

The Right to Health is recognized in various international and national level covenants and statutes. Article 25 of the Universal Declaration of Human Rights states: ‘Everyone has the right to a standard of living adequate for the health of himself and of his family, including... medical care...’. In the case of India, Right to Health is part of Right to Life enshrined under Article 21 and has been interpreted in this way in several rulings of the Supreme Court of India. What this means essentially is that it is the states’ primary responsibility to ensure primary health care in a socially just and equitable environment.

Unfortunately there is a clear chasm between the ideal and the reality. Hence, in India there are 585 rural hospitals compared to 985 urban hospitals in the country. Out of the 6,39,729 doctors registered in India, only 67,576 are in the public sector. It is a similar story with





regard to Auxiliary Nurse Midwives (ANM) and nurses.

Adverse Impact of User Fees & Privatization of Health Services

Possibly the single largest cause of putting health services out of the reach of the poor is the introduction of user fees in public hospitals by the Government (user fees keep expanding into admission fee, pathological tests and diets, and follow different patterns across states).


Since the 1990s, pushed by middle class aspirations and the compulsions of the State in the 1990s, 'health reforms' or the privatization and penetration of the market into the health sector have had damaging consequences for the poor. Rising costs are greatly limiting access to health services. The identification of private institutions for first referral is damaging primary health services. We know that almost 82% of the health spend in India comes from the private sources³ and nearly 67% of the population in India do not have access to essential medicines.⁴

Focus on Women is Needed

The patriarchal functioning has ensured that health for women normally means maternity services, excluding basic health services that lie at the root of many a problem. Along with gender budgeting, RCH services need to be integrated into a comprehensive primary health care system as conceived by the Alma Ata declaration. According to the latest National Rural Health Mission III surveys, more than 50 % women of this country are anemic. 40% of the maternal deaths during pregnancy and child-birth occur due to anemia and under-nutrition. This points further towards the vicious cycle of poverty and ill-health following each other in a socially oppressive system.

Public Expenditure on Health Must Increase

The WHO calls for a 7.5 per cent allocation of GDP for health. India today allocates less to health (lower than 1% GDP) than Nepal and Thailand, and reaching its avowed target of even 3 per cent of GDP seems difficult. Western countries allocate 6 per cent and above to their health sectors. United Nations calculations show that India's spending on public health provision as a share of GDP is the 18th lowest in the world.⁵

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2. Kiran Bhatta, The Schooling Revolution in Himachal Pradesh, in FOCUS, Abridged Report, December 2006, Citizens' Initiative for the Rights of Children Under Six. p23
 3. National Health Accounts of India, cited in Centad paper on Barriers to Trade and Access to Medicines, Workshop in Hyderabad, 9-2 October, 2007
 4. World Medicines Situation Report, WHO, 2004, *ibid*.
 5. UN Human Development Report 2006, based on World Health Organisation figures for expenditure in 2002. The Human Development Index ranks 177 countries. The only countries spending less on health as a share of GDP than India are: Myanmar, Burundi, Azerbaijan, Bangladesh, Tajikistan, Guinea, Georgia, Sudan, Yemen, Philippines, Pakistan, Togo, Indonesia, Madagascar, Cameroon, Nigeria and Congo.
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Lessons Learnt

Where the state has taken decisive action, results have been extremely good. Compare the state of Kerala with the rest of India:⁶

Health Indicators	Kerala	India
Infant mortality rate	11 per 1000	60 per 1000
Maternal mortality rate	0.3 per 1000	4.4 per 1000
Safe Delivery	98%	48%

What this shows is that whilst urgent action is needed, ensuring education and health for all is not just a dream, but also an achievable goal. Evidence from different parts of India, and from elsewhere in the world, shows that it can be done.

An Integrated Approach

This Report argues that high educational levels ensure strong demand for and utilisation of health services while critical investments in children's health, nutrition, access to safe water and sanitation help to lower the level of absenteeism and improve educational attainments. It is, therefore, equally important that the lessons drawn from it also translate in an integral approach. Even a small country like Costa Rica, for example, water supply, latrine construction, and public education on hygienic practices went hand-in-hand with extending rural health services.

There is a need to look at the successful public sector delivery models which have produced great results. In the Indian context, therefore, there is a greater need for inter-linkages among the existing national schemes like Total Sanitation Campaign, National Rural Health Mission, National Rural Employment Guarantee Programme and National Urban Renewal Mission as well as Sarva Shiksha Abhiyan.

6. Centre for Socio Economic Studies, Kochi,, presentation made in Oxfam's Consultation Meet on Essential Services, July 20, 2006





Publisher's Note

India has an all-important role to play in the achievement of the Millennium Development Goals (MDGs), and the broader global objectives laid down in the Millennium Declaration. The progress made by India will significantly determine whether the world as a whole will be able to meet some of the most critical targets of the MDGs – such as in relation to the reduction of Infant Mortality Rates (IMR), Maternal Mortality Rates (MMR), increase in School Enrollment & Retention, and assurance of universal access to Water & Sanitation.

India also has an important contribution to make to the future global agenda. Our role as the world's largest democracy, our significant technical, intellectual, financial and cultural resources need to be harnessed towards the ideals of the modern global society. The right to live with human dignity and freedom from the bondages of poverty and social exclusion are an integral part of this global future.

This report therefore serves as a reminder of the challenge that India faces in ensuring the right to Health & Education for all its citizens, and a reinforcement that India has the capacity and the resources to make universal access to these essential services an immediate reality - the only thing we need now is the political will.

This report is also a tribute to the children, ranging from eight to eighteen years, who have taken action to remind the government of its commitment to spend 9% of India's GDP for public expenditure on Health & Education. Brought together by the Nine Is Mine! campaign these children were successful in reaching the Prime Minister Dr. Manmohan Singh with their petition in advance of the Budget Session of Parliament in February 2007, earlier this year. Soon after, the sectors of Health & Education have seen significant increases in allocation within the Union Budget 2007-08 - however the overall investment in terms of GDP still remains a dismal average of 3% for Education and even less than 1% for Health.

This publication is accordingly being released to coincide with the launch of the second phase of the national advocacy effort that will be undertaken by over 300,000 children across the length and breadth of the country to inform and exhort their elected representatives of State Legislature and Parliament to speak up for 9% of the GDP to ensure that every child in India has a Future.

Wada Na Todo Abhiyan
13 November 2007





Ensuring Universal Access To HEALTH & EDUCATION IN INDIA

Wada Na Todo Abhiyan

November 2007





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Wada Na Todo Abhiyan (Keep Your Promise Campaign) is a national initiative to hold the government accountable to its promise to end Poverty, Social Exclusion & Discrimination. We aim to do this by monitoring the promises made by the government to meet the objectives set in the UN Millennium Declaration (2000), the National Development Goals and the National Common Minimum Program (2004-09) - with a special focus on the Right to Livelihood, Health & Education. Wada Na Todo Abhiyan is active through a network of more than 3000 rights action groups across 23 states of India, who have come together to link social groups and engage policy makers on issues of strategic relevance.

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- The People’s Verdict - Outcomes of the National Tribunal on NREGA, December 2006
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- Promises Are Not Enough! A Civil Society Review of Three Years of the National Common Minimum Programme, May 2007
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