

## Optimising Lessons of Efficient Social Service Delivery

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### Abstract

The importance of access to healthcare and education cannot be overemphasised, more so in the contemporary world where these are a *sine qua non* for economic advancement. Several studies confirm the gains from education and health care in alleviating poverty. The paper focuses on issues of governance and delivery of publicly provided services in the education and health sectors, also keeping in view the Millennium Development Goals.

Increasing fiscal pressures on states' finances have resulted in development and social sector expenditures declining substantially, with those on education and health suffering considerable erosion. Variations across states in the allocations for these sectors are quite marked. Besides, allocations for non-salary component of expenditures on these sectors have suffered, which inevitably dilute the quality of service delivery.

Most reviews observe that problems of access based on gender and socio-economic factors, pronounced regional disparities, abysmal lack of basic amenities and infrastructure facilities continue to bedevil the education sector. In this context, innovative initiatives of some states to mitigate service delivery failures are worthy of note and emulation.

Water quality and sanitation constitute an important element in preventive health care. The inefficiencies of the health-care system are characterised by lack of access, growing presence of unqualified practitioners, inefficient Public Health Centres, absenteeism among doctors and paramedical staff, and rising costs of healthcare. The preference for private health care by even some of the poor is a damning indictment of publicly delivered health services.

Health outcomes appear to be significantly associated with health sector interventions. A few initiatives like decentralisation, community involvement, adoption of contractual appointments, and contracting out of some services have been tried by some states with a view to improving delivery of health services.

Privatisation in the form of public-private partnership could be used as a tool to improve government functioning, as a pragmatic measure to offer greater choice to consumers or users of public services. Ideological opposition to the private sector should not overshadow possibilities of cost-effectiveness, value for money, and efficiency gains that may come from

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shared responsibilities in the delivery of services. Issues of affordability by the poor and equity in regard to services available through the private sector can be tackled through appropriate state interventions, vouchers, and the like.

Appropriate capabilities, including designing and negotiating contracts, would need to be inculcated in the bureaucracy if an effective regulatory and enforcement framework is to be put in place.

Participation of users of services, as indeed of all stakeholders, should extend to the full gamut of service delivery, ranging from preparation, design, implementation, and evaluation. 'Voice' or public pressures exerted through feedback on the usefulness, effectiveness and efficiency of public services can make up to some extent the absence of choice and competition in the delivery of public services, apart from providing a lever for accountability. Participatory social audit demonstrates the use of 'collective voice' to demand attention and responsiveness to citizens' needs.

Advances in information and communications technology can be harnessed for spread of information, public consultation, and public private partnership – both singly, and in combination with traditional approaches – given a basic commitment to public involvement in the delivery of services.

Improvement in service delivery, including quality of service, is a continuous process that demands long-term commitment with shared vision and goals, clear strategies and co-operation from different sectors of society.

While there have been significant achievements both in education and health, problems of access, equity, inter- and intra- state disparities, urban-rural divide, and poor quality of service delivery are disquietingly persistent. The preference for private sector services by even some of the poor is equally a judgement on and indictment of the delivery of public services. Examples of local and community involvement and initiatives for better service delivery are both encouraging and inspirational.

Given their fiscal stress and the limited fiscal space available to them, states face a daunting and challenging task in raising public spending on essential social sectors. It can, therefore, come about mainly through: (a) critical review of existing programmes with a view to eliminating those that have outlived their relevance or utility; (b) revamping and coalescing programmes and schemes with identical or similar objectives; and (c) re-orienting of priorities to reflect changing and current needs.

Increased spending should be accompanied by simultaneous efforts at (i) achieving productivity gains through efficiency in the use of resources and better value for money; (ii) improved targeting; (iii) association of the private sector to supplement state efforts and to generate a competitive environment; and (iv) bringing about greater and purposeful accountability by involving the community and users of services.

The paper refers to many innovative initiatives, both within and outside the country, which provide useful pointers and lessons to improve service delivery in terms of enlarging access, improving quality, increasing accountability, and harnessing information and communication technology in furtherance of these.

In this background, the paper makes some specific recommendations for policy initiatives, some of which are financial in nature while others relate to service delivery.

## **Executive Summary**

This paper is one of four research papers being prepared under the thematic cluster "State Government Budget Constraints and Social Services", as part of a project entrusted to Administrative Staff College of India by the Asian Development Bank.

Under the broad rubric of social services, this paper is to focus on issues of governance and delivery of publicly provided services in the education and health sectors. The adequacy and

quality of education and health services in different states are also to be looked into, keeping in view the Millennium Development Goals.

While one may provide legal or constitutional rights to education and health, enforcing them could be fraught with administrative complications and interpretational conflicts. However, the importance of access to healthcare and education cannot be overemphasised, more so in the contemporary world where these are a *sine qua non* for economic advancement.

### **States' Budgetary Constraints**

States are trapped in a vicious cycle of deficits and debt, each reinforcing the other. Rising interest burden on their spiralling debt, mounting salary and pension expenditures, compounded by the financial drain of state public enterprises and inadequate recovery of user charges, constrict their fiscal space for investment in social and economic development.

Increasing fiscal pressures on states' finances have resulted in development and social sector expenditures declining substantially, with those on education and health suffering considerable erosion. Variations across states in the allocations for these sectors are quite marked. Besides, allocations for non-salary component of expenditures on these sectors have suffered, which inevitably dilute the quality of service delivery. This is further compounded by the adoption of the Fifth Pay Commission's recommendations by most states, and consequently salary related expenditures claiming a larger chunk of financial resources.

Given the fragile fiscal situation of states, a significant step up in the allocations for social service sectors is a very challenging task. Better service delivery should therefore be aimed at through re-orienting of priorities, improved targeting, enhanced efficiency, productivity gains, and by enforcing accountability.

### **Education**

Education finds a prominent place in the Millennium Development Goals, in terms of universal primary education to be achieved through full enrolment, retention in schooling, and gender equality. Even if achieving the target of 100% net primary enrolment does not seem unpromising, the likelihood of achieving the MDGs relating to completion rate and gender equality does not seem encouraging in India. Besides, there is wide variation in performance across states, within states and over time.

Education for All Assessment 2000 and a subsequent report by the Asian Development Bank point out that though significant achievements have been made and the goal of elementary education for all children of 6-14 years by 2010 may be achieved, there exist substantial regional disparities in access to education based on gender, social and economic disadvantage, and geography. Achieving gender and social parity in education is likely to pose a formidable challenge. A later ADB report too echoes the point that with the resource constraints faced by states, significant increases in education expenditures are unlikely, and that it is only through efficiency gains and reorientation of allocation of resources across sectors that improvements in access and quality can be brought about.

The recurrent theme of most reviews is that though there is substantial improvement in education, problems of access based on gender and socio-economic factors, pronounced regional disparities, abysmal lack of basic amenities and infrastructure facilities continue to bedevil the sector.

Studies, surveys and empirical evidence discount the commonly held view that it is poverty that prevents the poor from sending their children to school. Likewise, the popularly held impression that poor parents prefer to send their children to work rather than to school is questioned. Studies demonstrate that parents often use the labour of their children after they have dropped out of school for reasons unconnected to poverty. It is failure of service delivery rather than parental disinterest that pushes children out of school and to work.

Significant initiatives have been taken over the last ten years, through government and non-governmental efforts, to re-induct out-of-school children into the education system.

Many factors lead to an intrinsic bias against education of girl children; they look at only the private gains from educating girls and ignore the larger gains to society. State intervention and community involvement is called for to combat this.

The Midday Meal Schemes introduced by many states with the twin objectives of boosting enrolment and retention of children in schools, and improving their nutritional standards are by and large successful. Providing cooked meals in schools is, however, not without potential drawbacks and hazards.

Innovative initiatives of some states to mitigate service delivery failures are worthy of note and emulation, like the Shiksha Karmi and Lok Jumbish projects in Rajasthan, the notable example in Baranbaria village of Ranaghat Block in West Bengal, the MVF project in Andhra Pradesh, the 'Education Guarantee Scheme' in Madhya Pradesh, and so on.

The PROBE survey brings out that even among poor families and disadvantaged communities, parents make great sacrifices to send some or all of their children to private schools because of their disillusionment with government schools. One-fifth of the children enrolled in private schools, it discovered, came from families where casual labour was the main occupation, and half of them belonged to scheduled castes or other backward castes — another example to refute the popularly held view of parental disinterest in education, among the poor.

Trying to reform the totally inadequate, cumbersome and unaccountable government system may not be the best way to serve the needs of the poor in India. A better way may be to reform the regulatory environment to make it suitable for private schools for the poor to flourish, and to encourage public voucher schemes so that parents can use their allowance in schools that are performing well rather than wasting them in unresponsive state schools.

The Tenth Five-year Plan document recognises that in a country as diverse as India, the task of providing basic education is so stupendous that it is difficult to expect the government sector alone to do this effectively. It therefore speaks of forging a 'synergetic partnership' with the private sector to achieve the objective of universal elementary education and to improve the quality and reach of education.

### ***Health***

Though the Constitution places public health within the domain of states, the centre too plays a significant role in the health sector.

The Asian Development Bank observes that in spite of significant improvements in the extent and reach of healthcare, India ranks low among countries with medium human development, and that the health status of the population remains poor. There are wide differentials in the availability and quality of healthcare between urban and rural areas. ADB bemoans the disproportionate emphasis on curative rather than preventive aspects of health care. The private healthcare network, it adds, caters largely to the urban and better off population.

There are indications of heavy concentration of infant deaths in a few districts of the country. Infant mortality could be brought down considerably by first identifying and then targeting mortality-reducing interventions to those districts and villages with the largest number of infant deaths.

Significant inverse association is seen between infant mortality and government health expenditure across states, as also a stronger inverse association for the very poor states than for the non-poor states. Besides, significant associations between infant mortality on the one hand and female literacy and per capita GSDP on the other hand are also observed. However, merely raising spending levels would not suffice; quality and effectiveness of expenditure cannot be ignored.

The MDG relating to maternal mortality rate does not seem likely to be achieved. The performance in regard to the Millennium Development Goals is not particularly edifying. The Asian Development Bank cautions that a major crisis is looming in the form of HIV / AIDs and that the government faces a daunting task in battling AIDs.

The importance of water quality and sanitation to health outcomes cannot be over-emphasised, and would constitute an important element in preventive health care.

There is no denying that health services are failing the poor. The India Health Report (2003) recommends revamping organisational structures, both at the level of the centre and states, streamlining of financial management systems and reorientation of priorities to improve 'allocative' and technical efficiency as essential elements of health-care reform.

Sankar and Kathuria affirm that the efficiency of health systems depends on the extent of education in the state. They attribute the wide variations in levels of health outcomes in different states and efficiencies of the health system to differences in literary levels.

The inefficiencies of the health-care system are characterised by lack of access, growing presence of unqualified practitioners, inefficient Public Health Centres, absenteeism among doctors and paramedical staff, and rising costs of healthcare. A study conducted for the India Health Report 2003 in 14 major states found that health outcomes appear to be significantly associated with health sector interventions.

A few initiatives like decentralisation, community involvement, adoption of contractual appointments, and contracting out of some services have been tried by some states with a view to improving delivery of health services.

The private sector has existed alongside the public sector in health since long. However, it is only since the 1980s that there has been substantial growth in private hospitals. Though the growth of the private sector in health has benefited from concessions like reduced import duties, subsidized allotment of land, and so on, government has done little to enforce conditions such as access and free services to the poor, in spite of stipulations to that effect. The urban bias in public sector healthcare is evident in private sector health care too.

It is desirable that some regulations are put in place to ensure minimum standards and quality of care in private hospitals. However, given the fiscal stress of states and the administrative complications involved, it may be better to set up appropriate autonomous authorities rather than the government itself undertake this responsibility.

A large number of NGOs and voluntary organisations, estimated to be over 7000, also provide healthcare services to the community, which supplement public and private health services. State governments have been trying with mixed results to involve NGOs.

The preference for private health care by even some of the poor for whom the financial burden would be disproportionately higher in relation to their income is a damning indictment of publicly delivered health services.

Several studies confirm the gains from education and health care in **alleviating poverty**. **Corruption** impinges on access to and quality of service. It has both a fiscal as well as direct impact on the delivery of services and exacts a higher toll on the poor than on the rich. It erodes authority and undermines accountability.

Privatisation in the form of **public-private partnership** could be used as a tool to improve government functioning, as a pragmatic measure to offer greater choice to consumers or users of public services. Ideological opposition to the private sector should not overshadow possibilities of cost-effectiveness, value for money, and efficiency gains that may come from shared responsibilities in the delivery of services.

**Contracting out** (of services) does not amount to abdication of governmental responsibility since it implies public financing but private provisioning; there is only a shifting of service delivery with the objective of cutting costs and improving efficiency; a shrinking of government without diminution of government functions. Any concerns about public

accountability being impaired or diluted can be taken care of through appropriate conditions in the contract or through regulation.

Appropriate capabilities, including designing and negotiating contracts, would need to be inculcated in the bureaucracy if an effective regulatory and enforcement framework is to be put in place.

Every situation must be scrutinised to determine what is best for the public, not what is best for the public agency. Initiatives to involve the private sector could include contracting out certain services for under-served or targeted population groups.

Poor **quality of publicly provided services** drives the poor to seek services from the private sector even if it imposes an insupportable financial burden on them. This places a moral responsibility on governments to raise standards and quality of publicly delivered services.

A two-pronged approach of strengthening existing (institutional) macro level mechanisms for **accountability** and devising effective tools for accountability at the micro level is needed.

**Participation** of users of services, as indeed **of all stakeholders**, should extend to the full gamut of service delivery, ranging from preparation (including demand assessment), design, implementation, and evaluation. Unless demand for services is properly assessed and programmes properly designed to meet the needs of users, the services may go abegging; user-feedback on the efficacy and efficiency of service delivery would provide useful inputs for improving delivery as also give a lever for accountability.

'**Voice**' or public pressures exerted through feedback on the usefulness, effectiveness and efficiency of public services can make up to some extent the absence of choice and competition in the delivery of public services. 'Voice' should move beyond consultative process to more direct forms of influence over policy and spending decisions.

Participatory **social audit** demonstrates the use of 'collective voice' to demand attention and responsiveness to citizens' needs.

**Decentralisation** to lower tiers of government, which is the rationale for the 73<sup>rd</sup> and 74<sup>th</sup> Amendments to the Constitution, could lead to improved delivery of services, if properly and sincerely implemented.

Advances in **information and communications technology** can be harnessed for spread of information, public consultation, and public private partnership – both singly, and in combination with traditional approaches – given a basic commitment to public involvement in the delivery of services.

**Improvement in service delivery, including the quality of service, is a continuous process** that demands long-term commitment with shared vision and goals, clear strategies and co-operation from different sectors of society. Integrated effort, shared responsibility and strong partnership between society and various stakeholders are key and central elements.

### **Conclusion**

While there have been significant achievements both in education and health, problems of access, equity, inter- and intra- state disparities, urban-rural divide, and poor quality of service delivery are disquietingly persistent. Examples of local and community involvement and initiatives for better service delivery are both encouraging and inspirational.

The presence of the private sector is growing in both education and health, partly due to inadequacies of public sector delivery of services. The preference for private sector services by even some of the poor, at prodigious financial sacrifice considering their low income levels, is equally a judgement on and indictment of the delivery of public services.

Access to services can be expanded along with improvements in quality of service delivery through public-private partnerships and by also involving the voluntary sector, including NGOs. Issues of affordability by the poor and equity in regard to services available through

the private sector can be tackled through appropriate state interventions, vouchers, and the like.

Greater accountability of the public, private and voluntary sectors in the delivery of services can be enforced by liberal access to information, allowing freer expression to and heeding the 'voice' of users of services, and involving local communities and civic society in the design and delivery of services and monitoring their performance.

Given their fiscal stress and the limited fiscal space available to them, states face a daunting and challenging task in raising public spending on essential social sectors. It can, therefore, come about mainly through: (a) critical review of existing programmes with a view to eliminating those that have outlived their relevance or utility; (b) revamping and coalescing programmes and schemes with identical or similar objectives; and (c) re-orienting of priorities to reflect changing and current needs.

Increased spending should be accompanied by simultaneous efforts at (i) achieving productivity gains through efficiency in the use of resources and better value for money; (ii) improved targeting; (iii) association of the private sector to supplement state efforts and to generate a competitive environment; and (iv) bringing about greater and purposeful accountability by involving the community and users of services.

The paper refers to many innovative initiatives, both within and outside the country, which provide useful pointers and lessons to improve service delivery in terms of enlarging access, improving quality, increasing accountability, and harnessing information and communication technology in furtherance of these.

In this background, some specific recommendations for policy initiatives are made, some of which are financial in nature while others relate to service delivery.

## Optimising Lessons of Efficient Social Service Delivery

### Introduction

The Asian Development Bank (ADB) has selected the Administrative Staff College of India (ASCI) as one of the hub institutions to implement ADB's technical assistance project, "Policy Research Networking to Strengthen Policy Reforms". ASCI is one of two implementing agencies to carry out specific activities under the thematic cluster "State Government Budget Constraints and Social Services". Within this thematic cluster, four research papers are to be prepared, one of which is "Optimising Lessons of Efficient Social Delivery".

Under the broad rubric of social services, the paper is to focus on issues of governance and delivery of publicly provided services, specifically health and education. The adequacy and quality of education and health services in different states is to be looked into, in relation to the Millennium Development Goals (MDGs), as also innovations, if any, by individual states, and the feasibility of their replication.

Five of the eight Millennium Development Goals (adopted at the Millennium Summit of the United Nations in September 2000) relate to education and health (Annex 1), and one of the two prongs of the development strategy of the World Bank relates to health and education<sup>4</sup>. Hence, the focus of this paper is essentially on education and health, though there is peripheral reference to water supply and sanitation because of its impact on health.

Education and health figure prominently in the Directive Principles of the Constitution of India<sup>5</sup>. Education is in the concurrent list of the Constitution<sup>6</sup> (barring some special institutions which fall within the purview of the Centre), whereas public health is in the State List<sup>7</sup>. The constitutions of many countries mention the right to education and health; besides, there are many international covenants enshrining the right to education. (Box 1: Right to Health and Education).

The Tenth Plan document speaks of <sup>8</sup> amendment of the Constitution to make elementary education a fundamental right as one of the measures to achieve the goal of education for all (EFA). The Supreme Court of India in its judgement in Unnikrishnan's case (1993) held that all citizens had a fundamental right to education up to the age of 14 years. The Constitution was amended (Eighty-sixth Amendment Act 2002) to insert a new article 21A, which lays down that "the State shall provide free and compulsory education to all children of the age of six to 14 years in such manner as the states may, by law, determine".

The Indian Constitution does not list health as a fundamental right. The recommendatory Directive Principles of State Policy enjoin states to raise the level of nutrition and standard of living, and improve public health (Article 47). But many court rulings have interpreted the fundamental right of protection of life and liberty (Article 21) as inclusive of the right to health, implying state obligation to protect citizens from medical negligence. (India Health Report, 2003)

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<sup>4</sup> World Development Report 2004, Overview

<sup>5</sup> Articles 41, 45 and 47 of the Constitution of India.

Fundamental Rights are to be distinguished from Directive Principles of State Policy. As opposed to Fundamental Rights, which can be legally enforced and take precedence over any other law of the land, Directive Principles are guidelines for creating a social order characterized by social, economic, and political justice, liberty, equality, and fraternity as enunciated in the Constitution's preamble.

<sup>6</sup> Entry 25 of List III of the Seventh Schedule to the Constitution

<sup>7</sup> Entry 6 of List II of the Seventh Schedule to the Constitution

<sup>8</sup> Tenth Plan document Vol.2, Chapter 2: Human and Social Development, paragraph 2.2.13

**Box 1: Right to Health and Education**

“Human rights are increasingly important in international development discourse, particularly in the areas of health and education. The legal foundations for those rights are the Universal Declaration of Human Rights, 1948, and the International Covenant on Economic, Social and Cultural Rights, 1966. In addition, references to the right to education and health care are found in the European Social Charter, 1961, the African Charter on Human and Peoples’ Rights, 1981, and the Convention of the Rights of the Child, 1989. A number of international and bilateral development agencies have endorsed a human rights orientation in the provision of health care and education in developing countries. Social rights are also important at the national level. One analyst found that 110 national constitutions make reference to a right to health care (Kinney 2001). A review conducted for this paper assessed constitutional rights to education and health care in 187 countries. Of the 165 countries with available written constitutions, 116 made reference to a right to education and 73 to a right to health care. In addition, 95 stipulated free education and 29 free health care for at least some population sub-groups and services.”

Source: Gauri, Varun, “Social Rights and Economics Claims to Health Care and Education in Developing Countries” *World Bank Policy Research Working Paper 3006, March 2003*

While one may provide legal or constitutional rights to health and education, enforcing them could be fraught with administrative complications and interpretational conflicts. However, the importance of access to health care and education cannot be over-emphasised, more so in the modern world. Enjoying a healthy, vigorous life and being well educated are not only desirable in contemporary societies worldwide but also a *sine qua non* for advancement.

**Outline of Report**

The budgetary constraints confronting state governments and the fiscal pressures constricting their manoeuvrability in allocating resources for social services, particularly for education and health, are discussed in the first section. The next two sections deal respectively with education and health. Since health is closely linked to (clean) water supply and sanitation, the latter is briefly touched upon in the section on health, though it is not the focus of this paper being outside its remit. Each of these sections presents an overview of the sector, including the status in relation to the Millennium Development Goals; issues of concern; innovative initiatives in states; and the presence, role and involvement of the private sector in the delivery of services. The subsequent two sections attempt to draw some lessons for more effective and efficient delivery of services and make specific recommendations that could form the basis for policy initiatives.

However, before proceeding with the paper a brief reference is made to the human development indices of major Indian states to place their relative levels of development in perspective as they have an impact on the delivery of services.

The table above (Table 1) shows that the states of Kerala and Punjab have consistently

Table 1: HDI of Major Indian States

Trends in the Human Development Index for Selected Major Indian States (1981-2001)						
States	1981		1991		2001	
	Value	Rank	Value	Rank	Value	Rank
Andhra Pradesh	0.298	9	0.377	9	0.416	10
Assam	0.272	10	0.348	10	0.386	14
Bihar	0.237	15	0.308	15	0.367	15
Gujarat	0.36	4	0.431	6	0.479	6
Haryana	0.36	5	0.443	5	0.509	5
Karnataka	0.346	6	0.412	7	0.478	7
Kerala	0.5	1	0.591	1	0.638	1
Madhya Pradesh	0.245	14	0.328	13	0.394	12
Maharashtra	0.363	3	0.452	4	0.523	4
Orissa	0.267	11	0.345	12	0.404	11
Punjab	0.411	2	0.475	2	0.537	2
Rajasthan	0.256	12	0.347	11	0.424	9
Tamil Nadu	0.343	7	0.466	3	0.531	3
Uttar Pradesh	0.255	13	0.314	14	0.388	13
West Bengal	0.305	8	0.404	8	0.472	8
<b>All-India</b>	<b>0.302</b>		<b>0.381</b>		<b>0.472</b>	

Source: Planning Commission (2002) National Human Development Report 2001, Government of India,

Table 2: Grouping of States by HDI and Index of Infrastructure

States Grouped According to Selected Indicators	
Human Development	Infrastructure Index
<i>High</i>	
Goa, Kerala, Maharashtra, Mizoram	Goa, Maharashtra, Punjab
<i>High Middle</i>	
Gujarat, Manipur, Nagaland, Punjab, Sikkim, Tamil Nadu	Gujarat, Haryana, Kerala, Tamil Nadu
<i>Middle</i>	
Andhra Pradesh, Arunachal Pradesh, Haryana, Himachal Pradesh, Meghalaya, Karnataka, Tripura, West Bengal, Uttaranchal	Andhra Pradesh, Karnataka
<i>Lower Middle</i>	
Assam, Chhattisgarh, J & K, Jharkhand, Rajasthan	Himachal Pradesh, Madhya Pradesh, Orissa, U.P., Uttaranchal, West Bengal
<i>Low</i>	
Bihar, Madhya Pradesh, Orissa, Uttar Pradesh	Arunachal Pradesh, Manipur, Meghalaya, Jharkhand, Mizoram, Nagaland, Assam, Chhattisgarh, Sikkim, Tripura, J&K, Bihar, Rajasthan

Source: Table 4.7 Twelfth Finance Commission Report

maintained their pre-eminent position between 1981 and 2001, while Maharashtra has slipped from 3<sup>rd</sup> position to 4<sup>th</sup> and Tamil Nadu has improved its ranking from 7<sup>th</sup> in 1981 to 3<sup>rd</sup> in 1991 and 2001. Gujarat too has slipped from 4<sup>th</sup> position in 1981 to 6<sup>th</sup> in 1991 and 2001, while Haryana and West Bengal have consistently maintained their 5<sup>th</sup> and 8<sup>th</sup> positions respectively. Karnataka has slipped by one place to 7<sup>th</sup> in 2001, while Rajasthan has displaced Andhra Pradesh from 9<sup>th</sup> place by one notch.

Drawing upon estimates made for it by UNDP, the Twelfth Finance Commission notes that there is a clear positive relationship, as expected, between per capita GSDP and HDI. The Finance Commission has grouped states into four categories based on their relative ranking in an index of infrastructure as in Table 2. While HDI reflects access to social services, the infrastructure index reflects access to physical infrastructure. Together, these capture two different dimensions of disparities<sup>9</sup>.

<sup>9</sup> Report of the Twelfth Finance Commission

## Budgetary Constraints

States are trapped in a vicious cycle of deficits and debt, each reinforcing the other. By and large, most states are faced with intractably stubborn revenue deficits; and, with a high proportion of their fiscal deficits being driven by revenue deficits, a major portion of borrowings is used for current expenditures, thus further feeding their growing debt. Rising interest burden on their spiralling debt, mounting salary and pension expenditures, compounded by the financial drain of state public enterprises and inadequate recovery of user charges, constrict the fiscal space for investment in social and economic development. The persistent fiscal pressure on states seriously restricts their ability to discharge their responsibility of developing social and economic infrastructure. Development expenditure of states shows a persistent declining trend from an average of 10.8 % during 1990-95 to 9.6 % during 1995-00, and to 9.2 % in 2002-03. Social sector expenditures too exhibit a similar trend, with education and health suffering considerable erosion. Provisions for education and health as ratios of GDP have declined steadily and are placed as low as 2.4 per cent and 0.7 per cent respectively, in 2004-05<sup>10</sup>. It is imperative that states not only increase spending on education and health but also improve the efficiency and quality of their expenditures.

Further, it needs to be recognised that the bulk of revenue expenditure on education and health is by way of salaries, which in a sense is 'committed expenditure'<sup>11</sup>; the squeeze would, therefore, be particularly acute in the non-salary component of expenditure in these sectors. The adoption of the Fifth Pay Commission recommendations by most states has compounded an already difficult fiscal position further compressing non-salary expenditure, whose effect would be more pronounced in the health sector.

The Economic Survey 2003-04 (presented by the Ministry of Finance, Govt. of India) points out that as against the goal of 6 % of GDP, the total expenditure on education by both central and state governments in India was only 3 % of GDP (2002-03, revised estimates<sup>12</sup>). However, only 38.4 % of the public expenditure on education is on pre-primary and primary education while secondary and tertiary education claim 40.1 % and 20.3 % respectively<sup>13</sup>.

The Economic Survey 2003-04 speaks of the National Health Policy 2002 envisaging increasing the public investment on health from the current level of 0.9% of GDP to 2% of GDP by 2010<sup>14</sup>. Only four countries in the world spend less than this on health - Nigeria, Sudan, Indonesia and Myanmar<sup>15</sup>. In this context, it would be pertinent to recall a recommendation made by the Commission on Macroeconomics and Health chaired by Prof. Jeffrey Sachs that developing countries should aim to raise domestic budgetary spending on health by an additional 1% of their GNP by 2007, rising to 2% in 2015, and use resources more efficiently. The Commission observed that the minimum financing needs should be US \$30-40 per person per year, (even) in the low-income countries, if they are to address the health challenges and cover essential interventions, including those needed to fight the AIDS pandemic. As against that, the total expenditure (revenue and capital) of the Centre and the States is placed at Rs.20066 crore<sup>16</sup> according to the budget estimates for 2004-05<sup>17</sup>, which works out to a per capita expenditure of Rs.195 (based on 2001 census figures) or a per capita expenditure of about US \$ 4.50 (at current rate of exchange). Even within this low national per capita spending the variation across states is quite marked (Table 3). This is very much less than even the US \$13, which the Commission notes is the current actual spending on health in the least-developed countries. The Commission states that the level of health spending in low-income countries is insufficient to address the health challenges they face, which would be true of India as well.

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<sup>10</sup> Budget estimates. The accounts figures as when they become available may be even lower.

<sup>11</sup> At least in the short to medium terms since initiatives to contain or reduce the salary bill though reduction in numbers will take time to produce results.

<sup>12</sup> para 10.26, page 213

<sup>13</sup> 1999-2001, Human Development Report 2004 –Table 10 Commitment to Education: public spending

<sup>14</sup> para 10.38, page 216

<sup>15</sup> Shiva Kumar (2005)

<sup>16</sup> 1 crore = 10 million

<sup>17</sup> Centre for Monitoring Indian Economy, Public Finance, November 2004, page 40

The Common Minimum Programme (CMP) of the United Front Alliance (UFA) that has formed the government after the elections in India (April – May 2004) pledges to raise public spending on education to at least 6 % of the GDP, in a phased manner, with at least half this amount being spent on primary and secondary schools. This is to be financed by levying a cess on all central taxes. Accordingly, the union budget for 2004-05 introduced an education cess to enhance allocations for education. Further, the union budget for 2005-06 stepped up the allocation towards the non-lapsable fund under the *Sarva Shiksha Abhiyan*, in furtherance of government's commitment to enlarge education spending.

It is noteworthy that no timetable has been set for the phased increase of public spending on education to at least 6% of GDP. The assertion that at least half this amount would be spent on primary and secondary education is inconsistent with the Human Development Report 2004 figures cited (in paragraph 0) above, unless it was intended that at least half the public spending would be on pre-primary and primary education.

In a critique of this statement of the CMP, Swaminathan S Anklesaria Aiyar (2004) says the new government promises to increase public spending on education from 4.1 % (sic) of GDP to 6 %, but that "many developing countries have achieved better results with far little spends". India spends 4.1 % of its GDP on education but boasts of just 65 % literacy; China on the other hand spends only 2.2 % of GDP on education, and yet has 91 % literacy. Sri Lanka and Indonesia spend only 1.3 % of GDP on education, yet have literacy rates of 92.5 % and 88 % respectively. The problem is not lack of money but lack of quality (Aiyar, 2004).

Of course, the point made by Ayyar is equally valid for other areas of government expenditure as well. It is the quality and efficiency of expenditure that determines outcomes, not just the magnitude of expenditure. Jayaprakash Narayan (2002) makes a similar point in regard to health expenditures when he points out that higher expenditures on health do not necessarily translate into better health or health care. Though India spends more on health (both as a percentage of GDP and in per capita terms) than China, Sri Lanka and Indonesia, those countries rank higher than India in health indices. (Jayaprakash Narayan, 2002<sup>18</sup>).

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<sup>18</sup> page 8

It is a truism that higher expenditures do not necessarily lead to better outcomes, since ultimately it is the quality and efficiency of expenditure that produces results. However, expenditure is an essential input for execution of programmes and delivery of services, and hence remains an important indicator, though not the sole criterion for comparative assessments.

There are significant variations in the expenditures of states on education and health. The Twelfth Finance Commission has brought out the variations in expenditures of major states on education and health (Table 3). The per capita expenditure on education ranges from a low of Rs.311 in Bihar to a high of Rs.731 in Maharashtra, and that on health from a low of Rs.51 in Bihar to Rs.221 in Punjab.

The India Health Report 2003 notes that the Centre's fiscal commitment to the health sector is declining as reflected in the decreasing share of health expenditures in total expenditures. It adds that state governments, which fund around 75 percent of total public expenditure, have also not made good the gap in decreased central funding. Its analysis of 11 major states indicates that the share of health budgets declined sharply from 7.19 % of total revenue budgets in 1985-86 to 5.76 % in 1991-92, and continues at more or less the same level. Though some improvement was seen in certain states in 1998-99, this is attributed largely to revisions in pay scales. The report laments that with the rising share of salaries, non-salary grants have been reduced drastically, affecting the quality of services delivered through public health institutions. In a damning observation, it remarks that governments spend largely on manpower by way of salaries while households are expected to spend on drugs, diagnostics, and other treatment facilities.

As already highlighted, a substantial portion of state governments' budgets goes towards wage bills, servicing of burgeoning debts, and poorly targeted subsidies. It is the poor, who are in greater need of better access to equitable service, that suffer most when social service sectors are starved of funds, either owing to paucity of funds or their misallocation. A question that arises is why policy-makers who depend on political support from the poor do not effectively deliver basic services to them. Keefer and Khemani (2003) seek to explain this as the impact of political market imperfections. They classify political market failures into three broad categories: (a) lack of information amongst voters about political performance; (b) social and ideological fragmentation amongst voters that leads to identity based voting and low weight placed on the quality of public services; and (c) lack of credibility of political promises to citizens. The most adverse effects of political market imperfections are felt in the area of broad social services, namely health and education, they aver. They assert that there is substantial evidence to show that governments prefer to spend on job programmes or infrastructure rather than on improvements in broad social services, more so in many developing countries. This point will be revisited later in the paper in the context of corruption leading to reduced spending on social services.

**Table 3: Per Capita Expenditures of Major States on Education and Health**

Per Capita Expenditure of Major States on Education and Health - 1998-99 to 2000-01

Amount in Rupees		
States	Education	Health
Andhra Pradesh	411.7	118.2
Assam	615.2	92.2
Bihar	311.1	50.9
Gujarat	664.4	154.3
Haryana	587.6	122.1
Karnataka	558.3	135.7
Kerala	713.3	172.3
Madhya Pradesh	344.5	86.2
Maharashtra	730.9	131.7
Orissa	463.1	94.7
Punjab	716.3	221.1
Rajasthan	545.3	128.3
Tamil Nadu	651.5	154.4
Uttar Pradesh	340.4	63.4
West Bengal	512.3	136.8
coeff of variation	26.3	34.93
Min/Max	0.43	0.23
Min/Mean	0.57	0.41

Source: Twelfth Finance Commission - Extract from Table 4.6

Given the resources constraint and limited scope for states to raise substantial revenues, significantly stepping up allocations for social service sectors is an extremely challenging task. Better service delivery should therefore be aimed at through re-orienting of priorities, improved targeting, enhanced efficiency, productivity gains, and by enforcing accountability.

## **Education**

*“All agree that the single most important key to development and to poverty alleviation is education,” — James D. Wolfensohn, World Bank President, 1999.*

*“Education can be the difference between a life of grinding poverty and the potential for a full and secure one” — Nelson Mandela and Graca Machel, Washington Post, May 1, 2002*

The Constitution of India says: “The State shall endeavour to provide, within a period of ten years from the commencement of this Constitution, for free and compulsory education for all children until they complete the age of fourteen years.” (Article 45) More than 50 years down the road, the goal is still to be achieved. Currently, the date set for achieving universal education is 2010.

As already mentioned earlier, the Constitution was amended (Eighty-sixth Amendment Act 2002) to make right to education a fundamental right by inserting a new Article 21A, which says that “the State shall provide free and compulsory education to all children of the age of six to 14 years in such manner as the states may, by law, determine”. However, giving effect to such a right is another matter, as there are a number of players in the act.

## **Overview**

The importance of education is universally acknowledged. Governments around the world deem it their responsibility to provide education. Generally, the private sector, which is also active in this field, supplements state efforts to provide education, but mainly caters to the well-off sections. Public spending on primary education in India is only about 38 to 39 % of the total expenditure on education, with secondary and tertiary education claiming as much as 41 % and 20 % respectively. The Common Minimum Programme of the newly formed coalition government in India promises to raise public spending on education to 6 % of GDP (from the current level of about 3 % of GDP). Though India has still much ground to cover for achieving the long-stated goals in universal primary education, less than 40% of the public spending is on primary education.

Education finds a prominent place in the Millennium Development Goals, with two of the eight enunciated goals relating to it.

## **Millennium Development Goals**

The Millennium Development Goals relating to education (Goals 2 & 3) are to:

Achieve universal primary education, by ensuring that by 2015 children everywhere, boys and girls alike, will be able to complete a full course of primary schooling; and

Promote gender equality and empower women, by eliminating gender disparity in primary and secondary education preferably by 2005 and to all levels of education no later than 2015 (See Annex 1)

**Table 4: Millennium Development Goals – Progress – Education**

	1990	1995	2001	2002
<b>Goal No. 2: Achieve universal primary education</b>	<b>2015 target = net enrollment to 100</b>			
Net primary enrollment ratio (% of relevant age group)	..	..	83.3	..
Percentage of cohort reaching grade 5 (%)	..	58.6	59.0	..
Youth literacy rate (% ages 15-24)	64.3	68.5	72.6	..
<b>Goal No. 3: Promote gender equality</b>	<b>2005 target = education ratio to 100</b>			
Ratio of girls to boys in primary and secondary education (%)	70.0	75.0	78.6	..
Ratio of young literate females to males (% ages 15-24)	73.9	77.7	81.3	..
Share of women employed in the nonagricultural sector (%)	12.7	14.4	17.1	..
Proportion of seats held by women in national parliament (%)	..	8.0	..	..

Source: Millennium Development Goals India Country Profile-

<http://devdata.worldbank.org/idg/IDGProfile.asp?CCODE=IND&CNAME=India&SelectedCountry=IND>

Even if one were to suspend judgment about whether the net primary enrolment ratio would reach 100 by the year 2015, it seems highly unlikely from the present trend (Table 4) that the percentage of cohorts reaching grade 5 by the terminal year would be achieved. The ratio of girls to boys in primary and secondary education reaching the target of 100 by the year 2005 also seems unlikely.

Citing data from the 55th round of the NSS, the World Bank (2004) observes that the gross primary enrolment rate is 61% with a net rate of only 52.5% in 1999-2000. Further, the data also show that, even at the peak attendance ages of 9-11 years, nearly 15% of the population does not attend school, which is indicative of the large number of children who never attend school. Besides, there are large variations across states in the primary attendance rate. Attendance rates for the age group 6-11 exceed 90% in 9 states - Kerala, Tamil Nadu, Maharashtra, Goa, Himachal Pradesh, and the states of the Northeast. At the other end, the primary attendance rates are only 75% or lower in Bihar, Orissa, Rajasthan, Uttar Pradesh, and Madhya Pradesh. With only 53% of children aged 6-11 attending school, Bihar ranks as the poorest-performing state on school attendance in the country. Not only are there wide variations across states in net primary attendance rates but there are considerable sub-state variations as well.

Enrolment of children is only one aspect of the millennium development goals; retention of students till grade 5 is another. The primary completion rate<sup>19</sup> for the country was 61.4% in 1999- 2000 - only slightly up from 58.7% in 1993-99 - with large interstate variations. For instance, Kerala had the highest rate (92.1%), followed by Goa, Maharashtra, Karnataka and Tamil Nadu. The North-eastern states and Bihar, Madhya Pradesh, Uttar Pradesh and Rajasthan rank at the bottom, with primary completion rates of 50% or lower. Intra-state variations in the primary completion rate are also very large.

Eliminating gender disparities in schooling is another of the MDGs, with a view to raising the ratio of girls to boys to 100%, at all school levels but more so at the primary and secondary levels. According to the World Bank report, school-based administrative data suggest that India has made impressive gains in reducing the male-female gap in the gross primary enrolment rate in the last fifty years, with the ratio of the female to male gross primary enrolment rate nearly doubling from 41% in 1950-51 to 81% in 1993-94, where it has stayed since. Here too, large interstate variations exist in the extent of gender disparity in schooling. The gender gap is the largest in Bihar, Uttar Pradesh and Rajasthan, where the gross primary enrolment rate for females is about two-thirds or less than that for males. It is the least in Punjab, Haryana, Sikkim and Kerala, where there is parity or near-parity in the gross primary enrolment rates for boys and girls. The data also indicate wide variation in the

<sup>19</sup> The report uses the primary completion rate, as measured by the proportion of 12-year old children who do not report themselves as never having attended school and also report currently being in middle school, as a proxy for retention.

performance of states over time. Between 1980-81 and 1999- 2000, for instance, the largest relative gains for girls occurred in Haryana, where the ratio of females to males enrolled in primary school nearly doubled. At the other extreme, Orissa, Uttar Pradesh, and Kerala experienced small relative declines in the female-male ratio although it is important to note that the female-male ratio of primary school students was already over 95% in Kerala in 1980-81. (World Bank 2004).

That there has not been significant improvement in recent years would be evident by reference to earlier assessments. Education For All Assessment 2000<sup>20</sup> reported that ten years after the Jomtien Education for All (EFA) Summit, notwithstanding significant achievements, problems of gender, regional, sectional and caste disparities continued to plague India's progress in the goal of Universalization of Elementary Education (UEE). Socio-economic and cultural factors, shortage of teachers, unsatisfactory quality of education, and lack of adequate infrastructure led a significant proportion of students to continue to drop out.

Education for All 2000 Assessment (Statistical Document) highlights<sup>21</sup> wide variations in enrolments by state and gender in India in 1997:

enrolment ratios among girls differ vastly by state, from as low as 36 per cent in Uttar Pradesh to as high as 94 per cent in Assam;

the difference in net enrolment ratios by gender at the national level is fairly wide - 78 per cent for boys compared to 64 per cent for girls, with substantial variations among the thirty-two states;

the gap between boys and girls declines with higher net enrolment ratios, but not always; and

two regions among the ten with the highest net enrolment ratios, Madhya Pradesh and Tripura, show lower levels of gender parity than other states with lower net enrolment ratios

Some of these observations are substantially echoed in a later report of the Asian Development Bank. The ADB (2003) observes that judging from the increase in the number of institutions and enrolments, India has made considerable progress in improving access to education. It expects that given the government's acceleration of programmes aimed at achieving universalization of education, the goal of elementary education for all children of 6-14 years by 2010 is likely to be achieved. However, it points to substantial regional disparities in access to education and adds that within regions the disparities are based on gender, social and economic disadvantage, and geography. Achieving gender and social parity in education, it opines, would present a formidable challenge. The report underscores that though per capita expenditures have increased in all states and union territories, there is a decline in real terms in the total central and state government expenditures per year per student, with over 90% of these expenditures going towards teachers' salaries. Thus, hardly any money is available for school improvement, educational material, drinking water and toilet facilities (especially for girl students—which is one of the major deterrents for girls attending schools). It emphasises that with the resource constraints faced by states significant increases in education expenditures are unlikely; hence, only efficiency gains and reorientation of allocation of resources across sectors can bring about improvements in access and quality.

*Plus ça change, plus c'est la même chose* (the more things change, the more they stay the same) about sums it up. The recurrent conclusion of most reviews is that though there is substantial improvement, problems of access based on gender and socio-economic factors, pronounced regional disparities, abysmal lack of basic amenities and infrastructure facilities continue to bedevil the sector. The former set of problems is to do with socio-cultural mores, while the latter reflects inadequate funding, inefficient deployment and use of resources, and ineffective supervision.

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<sup>20</sup> <http://www.undp.org.in/UNDPNEWS/jul2k/pg08.htm> - accessed on June 7, 2004

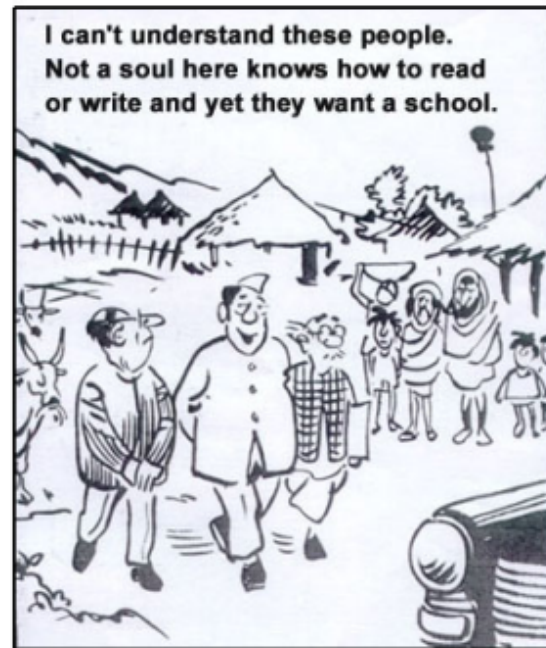
<sup>21</sup> Page 35, <http://www2.unesco.org/wef/en-docs/findings/efastatdoc.pdf> (accessed June 7, 2004)

## Education Scenario

Although, post-1991 there is significant progress in literacy, even today, over 50 million children of school-going age do not receive any sort of education, and more than one out of every three Indian citizens is illiterate. Sadly, one out of every three out-of-school children in the world is Indian<sup>22</sup>. A commonly held view is that child labour (estimated at 10 million children) - is one of the biggest barriers to universalization of education. However, the PROBE Survey (1999; page 14) – see Box 2 – says that it is a myth that most out-of-school children are unable to study because they have to work. The survey debunks another widely held belief that parents are not interested in their children's education. It asserts there is a massive popular demand for schooling, but that the demand is not quite universal though widespread and rapidly growing. The astonishingly widespread belief of parental indifference, particularly in official circles, it says, serves as a convenient rationalisation for India's low schooling levels (PROBE Survey, 1999; page 14). However, the report points out that motivation for education need not be the same as motivation for schooling as many other factors come into play including economic factors<sup>23</sup>, gender bias, quality of education, a conducive environment, and adequate physical infrastructure facilities, teacher resources and social discrimination.

In assessing availability of schools, it is not just the physical distance that one has to look at but also 'social distance' that may prevent a willing child from reaching the local school. The survey points out that in many areas villages are divided into separate hamlets, and children from one hamlet may be reluctant or unable to go to school in another hamlet because of caste tensions. For girls, restricted freedom of movement is an added problem. Besides, even if school facilities are available at a convenient distance they may be inadequate in terms of quality and quantity.

The Millennium Development Goals accord priority to gender equality in education. In India, as in many South Asian countries, the strong preference for male children leads to patent discrimination against girls in many areas, and education is one such. Referring to the PROBE survey, Asha for Education (an action group for basic education in India) observes that girls, particularly in rural areas and from relatively weaker economic sections, face a profound gender bias. They are expected to take care of siblings, or help with household chores, or are married off early. The PROBE team found that in the BIMARU region, the proportion of parents who found that the education of their daughters is not important was as high as 10%-compared to 1% in case of boys. Though governments' claims about free education or at a very nominal fee may, in principle, be correct, in practice there are associated expenditures that have to be incurred for books and other supplies, uniforms, etc. Where money for education is limited, sons are given priority over daughters. It is not



"You Said It" Cartoon by R.K. Laxman

<sup>22</sup> Indian NGOs: <http://www.indianngos.com/und/overview.htm> (accessed on April 24, 2004)

<sup>23</sup> While education may apparently be free in the sense that admission fees in government schools are negligible, it does not mean that it involves no expenditure for the parents. Surveys indicate that the cash costs of education play a major role in discouraging poor families from sending children to school, especially when the quality of schooling is low. (PROBE)

surprising therefore that in a state like Rajasthan, only about 5% of women in rural areas are literate.<sup>24</sup> Lahiri and Self (2004) highlight another reason for gender bias against girls, namely that 'whereas educated boys earn a higher income for the family, educated girls do so for their in-laws' families'.

#### **Box 2: Public Report on Basic Education (PROBE)**

The Public Report of Basic Education investigates the schooling system in India in all its aspects. It is chiefly concerned with the reasons why so many children are deprived of the fundamental right to learn. The report examines the economic, social and political causes of the crisis, and argues that change is possible.

It is based on extensive field surveys carried out from September to December 1996 covering all school facilities and a sample of 1376 households in 234 randomly selected villages of Bihar, Madhya Pradesh, Rajasthan, Uttar Pradesh and Himachal Pradesh. The report attempts to present an authentic picture of the school system as parents, children and teachers experience it. In that sense, therefore, it is not just a public report but also a "people's report". It is written from the standpoint of the underprivileged, especially the millions of children who are excluded from the schooling system, and their parents. The report is based on the premise that elementary education is a fundamental right of every child. Guaranteeing this right is not just a matter of welfare or development, but one of basic social justice.

The five states covered by the survey account for 40 percent of India's population, and more than half of all out-of-school children. The report does not claim to be representative of the country as a whole; in fact, except for Himachal Pradesh, these states are the worst performing in terms of elementary education. Insofar as the problems identified in the selected states often exist in varying degrees elsewhere, the findings in the report have relevance for India as a whole. However, in order to give the report an all-India focus, it also draws on other field-based studies.

The term 'elementary education' usually refers to the first eight years of schooling, which in most states, are divided into two stages: 'primary' (classes 1 to 5) and 'upper primary' (classes 6 to 8). The main focus of the PROBE survey is primary schooling.

It is not a public report made to the government but a people's report made to India's citizens. The concern for social justice – and that education of all children is an imperative – informs the entire fabric of the report.

(Public Report on Basic Education in India, Oxford University Press, 1999 – in association with Centre for Development Economics)

'The expectation of two reasonably large, weather-safe rooms for primary schools is far from ambitious, yet it remains unrealised in the majority of schools in India. Most schools are held outside, in rented rooms, or in crumbling structures with leaking roofs, bad lighting, few resources, poor teachers, and conditions of social discrimination<sup>25</sup>. Many schools are deficient in basic amenities like drinking water and toilets (particularly for girls students), apart from inadequate teaching and library facilities, and absence of playgrounds. High pupil-teacher ratios, physical absence of teachers, and unqualified and disinterested teachers with resultant poor quality of education are other factors that inhibit poor parents from sending children to school.

*"Our constitution fathers did not intend that we just set up hovels, put students there, give untrained teachers, give them bad textbooks, no playgrounds and say, we have complied with Article 45 and primary education is expanding... They meant that real education should be given to our children between the ages of 6 and 14."*  
*Shri M.C. Chagla, Education Minister, 1964<sup>25</sup>.*

#### **Some Issues**

Elementary education runs from grades 1 to 8 for the age group of 6-14 years: consisting of primary education from grades 1-5 (6-11 age group) and upper primary from grades 6-8 (11-14 age group). The elementary education system has 156 million children, 3.3 million teachers and about 1 million schools as against 190 million children in the age group of 6-

<sup>24</sup> <http://www.ashanet.org/colorado/resources/whithereducation.html> - accessed 6 December 2004

<sup>25</sup> World Literacy of Canada: <http://www.worldlit.ca/probe.html> (accessed 24 April 2004)

14<sup>26</sup>. The Committee on the Rights of the Child (CRC), after analysing reports on the implementation of CRC, highlighted some major reasons for low enrolment, and high drop-out or repetition rates in schools. (World Economic Forum, 2003) - Box 3.

### **Box 3: Reasons for Poor School Enrolment and Retention**

Major reasons for low school enrolment and retention are:

- parental attitudes;
- high direct costs;
- indirect or opportunity costs;
- lack of flexible timings to suit working children;
- discrimination against minorities, backward classes, orphans, children with disabilities, AIDS, children of sex workers, etc.;
- long distances to school; inadequate school buildings, lack of basic necessities in schools, lack of a proper teaching and learning environment;
- corporal punishment or other abuse by fellow students or adults;
- highly competitive exam driven systems;
- irrelevant, stereotyped, mundane teaching methods;
- inappropriate curricula and materials;
- conflicts or crises that prevent refugees or displaced people from access to educational opportunities in emergency situations;
- absenteeism of teachers;
- poor management of the education system as a whole

Source: World Economic Forum, India Economic Summit 2003 -India Education Blueprint (<http://www.weforum.org/pdf/India/edu.pdf>)

### **Poverty Preventing Schooling**

A commonly held view is that it is predominantly poverty that prevents the poor from sending their children to school. However, studies, surveys and empirical evidence suggest otherwise.

According to Oonk (1998), a comparison between the states of Kerala and Uttar Pradesh puts paid to this averment. In both states the proportion of people living below the poverty line is around 45 %. Nevertheless Kerala has an average literacy rate of 90 % whereas in Uttar Pradesh this figure is around 40 %. In terms of average income per capita, Kerala is in the middle range of Indian states, but it spends relatively much more on primary education than other states. (A somewhat similar observation appears later in the report in the section on health. Though Kerala and Uttar Pradesh have similar economies, levels of per capita income and poverty, human development indices in Kerala are comparable to those in some of the richest nations of the world while those in Uttar Pradesh are similar to those of the poorest.)

Refuting the view that it is poverty that prevents parents from sending children to school, the position paper of UNICEF India states: 'There is a keen interest among the poorest to send their children to school; nearly 100 % enrol, but they drop out in massive numbers in the first year. The opportunity to keep them in school is best when the children are 4-6 year old. Parents are willing or can be convinced to make the sacrifice of losing the relatively small contribution of those children to family income if they get access to good quality relevant education'.

These observations also concord with the findings of the PROBE survey referred to earlier.

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<sup>26</sup> World Economic Forum, India Economic Summit 2003 -India Education Blueprint (<http://www.weforum.org/pdf/India/edu.pdf>)

Later in this paper there is a mention that many poor parents make great sacrifices and incur expenditure they can ill afford to send their children to private schools to ensure them quality education: another rebuttal of alleged parental disinterest in education among the poor.

### **Child Labour**

Issues of child labour and child rights have come to the fore in the wake of the UN Convention on the Rights of the Child (CRC). The Campaign against Child Labour (CACL), initiated in 1992, is a nationwide effort seeking eradication of child labour, which is seen as a violation of basic human rights. The major focus of the CACL is on mobilisation of public opinion for the eradication of child labour; establishing linkages with other issues, movements and struggles; and intervening in specific cases of child abuse and violation of child rights. (Jain et al, 2002)

The general assumption is that children who are out of school are working a major part of the day. However, surveys and empirical evidence do not bear this out, says Oonk (1998). According to him, the fact that children work rather than go to school does not necessarily mean that poverty or parental apathy is the reason. He claims the evidence is antipodal: children work or remain idle because schooling is not possible or is very unattractive. Parents often use the labour of their children after they have dropped out of school for reasons unconnected to poverty. Bhatt<sup>28</sup> calls it 'child labour as a default activity' and concludes that 'parents are keen to educate their children provided they are assured of basic quality'. (Oonk, 1998)

This view is also echoed by Jain et al (2002) who assert that children are out of school for other reasons like: dysfunctional schools; physical abuse in schools; mismatch between time, pattern, and requirements of school with family and lifestyles; belonging to migratory (labour) groups; and gender roles for girls.

Significant initiatives have been taken over the last ten years, through government and non-governmental efforts, to re-induct out-of-school children into the education system. These comprise four major streams of initiatives: (i) those that focus on rejection of child labour and take a stand on child rights to education; (ii) groups engaged actively in Early in Childhood Care and Education (ECCE); (iii) improving the availability of educational centres- schools or non-formal education (NFE), namely, addressing the 'access' issue; and, finally, (iv) upgrading the image of the school by focusing on the quality of education, improved curricula, and pedagogy. (Jain et al, 2002)

The Mamidipudi Venkatarangaiya Foundation (MVF) in Andhra Pradesh has had remarkable success in weaning children away from work and integrating them into regular government schools. (See Box 4). Active involvement of the community in the management of the programme is seen as the primary reason for its success. The efforts of MVF have had a multiplier effect because of: (a) adoption of the basic philosophy of the programme; (b) its ownership by the local community, including local volunteers; and (c) their initiatives to root out child labour by convincing parents to send their children to school. 'This process is beginning to have a spill-over effect as the community gets empowered to widen its engagement with other social issues.' In large parts of Ranga Reddy district, the focus has now shifted to improving the quality of education and school infrastructure; rejection of child labour and acceptance of the need for children to attend school is taken as almost axiomatic.<sup>29</sup> This approach is in contrast with the philosophy and functioning of the Indian



Girl working in stone quarry near Delhi –Photo Ben Buxton / Oxfam<sup>27</sup>

<sup>27</sup> <http://www.oxfam.org.uk/coolplanet/kidsweb/world/india/indioxf3.htm> - accessed 5 Dec. 2004

<sup>28</sup> Kiran Bhatt of the PROBE team.

<sup>29</sup> [http://hdrc.undp.org.in/childrenandpoverty/referenc/BROCHURE/mvf/08\\_01.htm](http://hdrc.undp.org.in/childrenandpoverty/referenc/BROCHURE/mvf/08_01.htm) - accessed 5 December 2004

Institute of Education (IIE), which believes that NFE is a good substitute for formal school education for working children who find it difficult to attend school during their regular working hours.

There are other examples as well of non-government efforts targeted at out-of-school

#### **Box 4: Mamidipudi Venkatarangaiya Foundation**

Mamipuddi Venkatarangaiya Foundation or MV Foundation, which has its base in the Ranga Reddy district of the state of Andhra Pradesh in south India, has developed a unique and powerful approach to deal with the twin problems of child labour and illiteracy. It started its activities in 1991 when it was successful in releasing thirty children from bonded labour. From these small beginnings, it has grown into a complex organization employing a wide range of strategies. The programme has expanded to over 500 villages and in 400 of these every child in the age group of 5-11 is in school. MV Foundation can count on the support of 8,000 youth volunteers, 1,600 education activists, 1,500 government schoolteachers, 500 women's groups, and countless elected representatives and members of school education committees who are actively involved in its activities. Nearly 150,000 children have been enrolled and retained in schools, more than 4000 bonded labourers have been released, and 168 villages are now child-labour free.

(Source: [http://hdr.undp.org.in/childrenandpoverty/referenc/BROCHURE/mvf/01\\_01.htm](http://hdr.undp.org.in/childrenandpoverty/referenc/BROCHURE/mvf/01_01.htm)- accessed on 5 December 2004)

children. The NGO Forum, established in 13 cities between 1987 and 1992, has more than 60 organisations working with street children. The primary objectives of this group 'are to promote networking and coordination among NGOs, groups, and individuals concerned with street children and to initiate and promote a common programme of action in the areas of healthcare, education, awareness-building, etc.' Sharing of experiences of member organisations through regular meetings is an important element of its functioning. (Jain et al , 2002)

There is no conclusive evidence that it is poverty that makes parents send their children to work rather than to school. On the contrary, researchers have found that once children stay away from school for whatever reasons, they are sent to work. It points therefore to failure of service delivery rather than parental disinterest in education. Even if some children do not attend school because they are working, adopting flexible school timings could be one way of addressing this issue.

#### **Gender Disparity**

The issue of discrimination against girl children in education has already been referred to above. An Oxford University study examined whether the economic incentive in India for girls to acquire schooling was less than for boys. It noted that people do not pursue education for its intrinsic value alone but for its earning potential and job prospects. If the labour market rewards women's education less than it does men's it would lead to an intrinsic bias against educating girl children. An added disadvantage that girls face are societal norms like early marriage and the dowry system, particularly in developing countries where social security is absent and male children are perceived to provide support in old age, whereas the benefits of educating girls will accrue to their in-laws<sup>30</sup>. These considerations look at only the private gains from educating girls and ignore the larger gains to society, which calls for state intervention and community involvement through public awareness campaigns.

A survey conducted in 2002 by Vacha, a Mumbai-based women's and girl's resource centre, found that though in theory government provides for universal education up to the age of 14 it is difficult for many girls to complete the last years of schooling as they enter the marriage and child labour markets at the age of 13. The period between the ages of 9 and 13 is a particularly difficult time for girls in India, discrimination against whom starts from birth, in matters of investment in education, rest and recreation, and food intake.<sup>31</sup>

<sup>30</sup> Gender gap in India's schools - Is the labour market a factor? <http://www.id21.org/insights/insights29/insights-iss29-art06.html> - accessed on 12 Dec. 04

<sup>31</sup> Providing for pre-adolescent girls in India - <http://www.id21.org/insights/insights-ed03/insights-issued03-art02.html> - accessed on 12 Dec. 04

Nayar (2002) notes that there is a noticeable shift over the last decade, in the approach to female education: education of girls is being seen as a basic human right and a crucial input for national development, raising it was from a question of pure ethics to sound economics. She points out that over the period 1960-61 to 1997-98 both enrolment and retention have registered improvement. The dropout rate for primary stage (classes I –V) is said to have gone down from 62 to 38 percent for boys and from 71 to 41 percent for girls. At the middle school stage, the dropout rate has reportedly come down from 75 to 51 percent for boys and from 85 to 59 percent for girls. These figures, however, mask wide regional variations and differences across social groups. Notwithstanding these impressive gains in female education, an area of concern, she points out, is the formulation of action programmes focusing on the education of out-of-school girls at elementary and secondary levels. The estimated number of out-of-school children in the age group 6-14 was more than 40 million in 1997-98, of whom 67 percent were girls: in the age group of 6-11 (classes I-V), there were more than 12 million children out of school of whom 89 percent were girls; and an estimated 28 million children in the age group 11-14 were out-of-school, of whom 58 per cent were girls. She observes that in the age group 10-18 years, a major proportion of girls are out-of-school.

Among the different interventions suggested by her for improving girls' access to education are: (i) the need to create part or alternative schooling in small 'unserved' habitations, since a large number of girls from remote and small rural habitations continue to be excluded from primary education; (ii) the need to upgrade all primary schools to middle schools as girls do not ordinarily cross village boundaries; and (iii) making all-weather motorable roads to all villages as a first charge and providing free school bus service to all elementary school children and to girls up to higher secondary level.

A recent initiative in the union government budget for 2005-06 of introducing 'gender budgeting' is a step in the direction of reducing gender disparity.

### **Mid- day Meal Scheme - Enrolment and Retention**

Many states have introduced mid-day meal programmes with the twin objectives of boosting enrolment and retention of children in schools, and improving their nutritional standards.

An evaluation of the Food For Education programme in Bangladesh found that the programme was successful with 20 to 30 percent higher school participation rates (compared to those outside the programme). Participants also stayed at schools for 0.5 to 2 years longer. Further, it estimated that this would represent an increase in lifetime earnings of between 7 and 16 % if the participant went to work in the rural sector and 25 % if in the urban sector. The paper concludes that these increases would pull large numbers of households above the poverty line. (Meng 2003)

A study<sup>32</sup> conducted by the Centre for Equity Studies of the Delhi School of Economics establishes a clear link between improved student enrolment and retention, and the free mid-day meal scheme. Jean Dreze (Professor, Centre for Development Economics) believes that apart from boosting school attendance and child nutrition, mid-day meals have an important socialisation value and foster gender equity: "as children learn to sit together and share a common meal, one can expect some erosion of caste prejudices and class inequality. They also reduce the gender gap in education, since they boost female school attendance more than male attendance"<sup>33</sup>

Ayyar (2004), however, scoffs that while school meals may attract more students, they can't impart educational skills. Kerala and Sri Lanka achieved near-full literacy without any resort to food, he adds. But this line of argument misses the point that for educational skills to be

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<sup>32</sup> The study / survey, which covered the three states of Chhattisgarh, Rajasthan and Karnataka, was conducted between January and April 2003. Twenty-seven villages were randomly selected in each sample state. Field surveys, that involved detailed interviews with teachers, parents and cooks in the 81 villages, focused on several qualitative and quantitative issues.

<sup>33</sup> "Groundswell for mid-day meal scheme", [indiatogether.org, http://www.indiatogether.org/2004/jan/pov-midmeal.htm](http://www.indiatogether.org/2004/jan/pov-midmeal.htm) (accessed on 15 May 2004)

imparted children first have to attend school, and the mid-day meal programme is one way of drawing children to school and retaining them.

Many states have yet to introduce the Mid-day Meal Scheme in spite of a Supreme Court ruling of November 2001. In November 2004, the Supreme Court asked the central government to ensure efficient functioning of the scheme in all states and union territories by 1 January 2005. However, providing cooked meals in schools is not without drawbacks and hazards, as the tragic fire in a Tamil Nadu school in July 2004 when scores of children perished poignantly illustrated.

### ***Innovative Initiatives***

Some innovative steps have been taken by a few states to mitigate service delivery failures. A few examples of successful initiatives in the education sector by non-governmental organisations are worthy of recall.

Two striking examples in Rajasthan with external (Swedish) assistance are the Shiksha Karmi Project (Box 5) and the Lok Jumbish project (Box 6). The efforts of a local

NGO called the Sree Ma Mahila Samity in Baranbaria village, in Ranaghat Block of West Bengal are also noteworthy.

The Shiksha Karmi Project is cited as a phenomenal success of a voluntary organization working with the government, in a state like Rajasthan, which has one of the lowest literacy rates in India. Under the project, a large number of efficient primary schools have been established educating students from various villages. By creating an appropriate management framework, the project envisages symbiotic working together of the state government, panchayati raj institutions, NGOs, and private research institutions.

The Lok Jumbish project (Box 6) has been able to set up innovative management structures incorporating the principles of decentralisation and delegation of authority, and building partnerships with local communities and the voluntary sector. The project has also made a positive contribution to raise quality through the development of improved minimum level of learning (MLL)-based textbooks for Classes I-IV, which are also being used in all schools in Rajasthan<sup>34</sup>.

#### **Box 5: Shiksha Karmi Project**

The Shiksha Karmi Project is being implemented since 1987 in Rajasthan with assistance from the Swedish International Development Authority (SIDA). Its aim is UPE in selected remote and socio-economically backward villages of the State. The project identifies teacher absenteeism as a major obstacle in achieving the objective of universalization. It accordingly, envisages substitution of the primary school teacher in single teacher schools by a team of two locally resident educational workers called "Shiksha Karmis". To ensure appointment of local persons, educational qualifications prescribed for teachers are not insisted upon in the selection of Shiksha Karmis.

(<http://www.indianngos.com/und/centralgovt.htm> - accessed on April 24, 2004)

For an appraisal of the project see: <http://www.sida.se/content/1/c6/01/76/80/Edd7%5B1%5D.pdf>

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<sup>34</sup> Tenth Five Year Plan- Volume II, Chapter 2.2, paragraph 2.2.22

#### **Box 6: Lok Jumbish: Democratising Educational Management**

Lok Jumbish (LJ) was initiated in 1992, with SIDA, the Government of India and the Government of Rajasthan, funding it in the ratio of 3:2:1 respectively. It began with a bold vision to transform the educational scenario in Rajasthan. One of the main challenges of LJ was to bring the village community, especially women, into the educational orbit. Another significant challenge was to devise a sound educational management system that would avoid rigidities and inefficiencies.

The technique of 'school mapping' is LJ's special contribution to the task of mobilising people for education. School mapping depicts every household in the village visually on a simple map, with small symbols indicating the schooling status of every household member in the 5-14 age group. The whole exercise is an occasion for interacting with the community. When the map is ready it is possible to see which households need special help, and to discuss the schooling facilities required in the village. Proposals based on a mapping exercise, mainly relating to need for new schools, non-formal centres and the improvement of existing ones, are sent to a block-level committee, which is the sanctioning authority.

Along with school mapping, careful micro planning at village level makes it possible to monitor the participation of every child in primary education. The LJ culture emphasises a high degree of autonomy and freedom at the block level.

LJ also stresses the empowerment of women. Suitable women are identified who can lead the mahila samooch (women's group) in the village and these women become part of all LJ deliberations. There are special facilities for women and girls who want to educate themselves but missed the chance.

Though enrolment and retention have gone up, pupil achievements in LJ schools have been modest. The goal of empowering women has also met with only partial success.

On the whole, the pace of LJ work has been slower than envisaged, but this does not detract from the value of what has been achieved.

(PROBE- pages 107-109)

Another notable example is Baranbaria village, in Ranaghat Block in West Bengal where a local NGO called the Sree Ma Mahila Samity provided the impetus for the community to establish efficient schools, particularly in a state where the socialist government has until recently held the view that the state alone should be responsible for social change. (Naik 2002)

'Education Guarantee Scheme' was initiated by the Government of Madhya Pradesh in January 1997 under which the government guarantees the provision of educational facilities in habitations where there is no school within a radius of 1 km, within 90 days of receiving a demand from the local rural community. However, the number of prospective students in the 6 to 14 years age group should be at least 40, which in tribal areas is relaxed to at least 25.

The EGS teacher, a local person selected and appointed by the community, is paid an honorarium (Rs 500 per month) by the gram panchayat, with one teacher being provided for a group of 40 children (25 children in tribal areas). The EGS is an initiative of the state government to universalise access to schooling facility in hitherto 'unserved' areas, in as little time as possible. Local accountability and community involvement in school management with a sense of local ownership are vital elements of this initiative.

In a case study on the EGS, the World Bank states that the programme had significantly reduced the absolute numbers of out-of-school children, and increased female literacy. One of the key messages to emerge from the EGS experience, it points out, is that structural reform in one sector cannot be sustained unless reforms in governance follow. In its words: 'the EGS program demonstrates that when poor people are confident that their voice will be heard, and that they can exert a positive influence, their enthusiasm to participate in local governance increases. By the same token, the programs shows that decentralization cannot be sustained without appropriate institutional mechanisms and legal instruments.'

On the other hand, presenting the results of a field study of public schools conducted in Betul and Dewas districts (of Madhya Pradesh) in 2002, Leclercq (2003) observes that though substantial progress has been made in enrolling underprivileged children, the quality of education now deserves more emphasis. 'Education guarantee' is incomplete, he finds, because of low quantity and poor quality of teaching. 'The potential for better school

management created by decentralization does not actually translate into adequate incentives for the local residents recently appointed as teachers to work effectively'.

The PROBE survey highlights the remarkable achievement of Himachal Pradesh in substantially raising literacy rates between 1961 (21 percent for males and 9 percent for females, as per the 1961 census) and 1991 when the literacy rates in the 10-14 age group were as high as 94 % for males and 86 % for females. The survey attributes this noteworthy accomplishment to:

high parental motivation for education in Himachal Pradesh for *all* children (including female children);

supportive attitude of parents towards their children's schooling;

self-confidence and high spirits of the children;

orderly premises and better management of available facilities, in spite of minimal facilities in small hamlets and physical infrastructure not being better than elsewhere;

better staffing;

maintenance of accurate records, including enrolment attendance etc;

higher academic activity; and

more 'exemplary' schools.

The investigators of the survey also observed better work culture among teachers and a concern for children that went beyond minimal standards of responsibility.

### **Private Sector**

The presence of private sector schools cannot be wholly attributed to the failure or shortcomings of the public education system. They have long existed alongside, and private schools exist even in developed countries, which have well-developed public education systems. The PROBE survey identifies two conditions favourable for the emergence of private schools: the breakdown of government schools and parents' ability to pay.

The PROBE survey brings out an interesting point that even among poor families and disadvantaged communities, parents make great sacrifices to send some or all of their children to private schools because of their disillusionment with government schools. One-fifth of the children enrolled in private schools it discovered came from families where casual labour was the main occupation, and half of them belonged to scheduled castes or other backward castes. That parents in poor families often make great sacrifices to send their children to private schools is testimony to their high motivation for education, and their desire to give quality education to their children. This again refutes the popularly held view of parental disinterest in education, among the poor.

James Tooley who conducted fieldwork for the International Finance Corporation says that the existence of a large number of private schools for the poor came as a surprise to him. He refers to the Federation of Private Schools' Management based in Hyderabad, which runs 500 private schools (from kindergarten to grade ten) serving poor communities in slums and villages. The schools are run on non-commercial principles, and are not dependent on handouts from state or on philanthropy. The great majority of the schools offer a sizeable number of places — free for the poorest students, based on informal needs-check in the community. (Tooley 2000) He adds:

*All of this suggests that if one is interested in serving the needs of the poor in India, then trying to reform the totally inadequate, cumbersome and unaccountable government system is unlikely to be the best way. Instead, reform the regulatory environment to make it suitable for the flourishing of private schools for the poor, help build private financing schemes using overseas and indigenous philanthropy, and encourage public voucher schemes, so that*

*parents can use their allowance of funding where they see the schools are performing well, rather than wasting them in unresponsive state schools.*

The Tenth Five Year Plan document recognises that in a country as diverse as India, the task of providing basic education is so stupendous that it is difficult to expect the government sector alone to do this effectively. It therefore speaks of forging a 'synergetic partnership' with the private sector to achieve the objective of UEE and to improve the quality and reach of education.

SIDA (2001) lists a number of valuable lessons gleaned from stocktaking reviews and comparative studies. It says that the most important and consistent factor determining more successful experiences is the presence of strong political commitment to education for all. Among the other critical issues for improving access and quality, it cites community involvement and the need for government to assume the main responsibility, recognising however that it cannot deliver alone but must develop partnerships and networks at all levels. It further emphasises that gender equality in education requires proactive and systematic approaches. Understanding demand increases the effectiveness of EFA strategies, it adds, and that inclusion of all children requires flexible responses.

## **Health**

Though the Constitution places 'public health and sanitation, hospitals, and dispensaries' within the domain of states, the Centre too plays a significant role in the health sector. Some areas like medical education, drugs, family planning, etc. are in the Concurrent List of the Constitution; besides, the Centre provides full or partial funding for many programmes through numerous centrally sponsored schemes.

DFID (1999) pithily summarises the health sector in India as follows:

*The medical system in India is based on publicly provided services, which are free at the point of delivery. Infrastructure and medical staffing levels are based on population-based norms with the intention of providing equitable access. In practice, however, financial constraints have restricted expansion of the infrastructure and staff tend to be concentrated in urban areas. Policy is still largely based on a norms approach although there is greater recognition of late of the potential of the private sector.*

## **Overview**

*"The approach to health sector development in the country has not been sufficiently integrated with the overall process of development."*

National Human Development Report 2001  
Planning Commission, Government of India

*"The national level health attainments hide the large inter and intra-State differences, as well as persisting vulnerabilities of some segments of the population. For some States, indicators on health attainments are comparable with the middle income countries, and in parts of others mortality levels are as high as in poorest regions of sub-Saharan Africa. The differences across the rural — urban areas and the gender divide, as well as across population segments on caste and class lines are quite striking."*

National Human Development Report 2001  
Planning Commission, Government of India

In a presentation at the Ministerial Summit on Health Research, in Mexico City in November 2004, Sujatha Rao, Secretary of the National Commission on Macroeconomics and Health in India observed that primary health care in India is a state subject, with a limited role for the central government. The public sector provides about 44% inpatient care and 18% out patient care, with wide disparities between regions and states. The government spends only 17% of total health spending in the country; 83% being paid for out of the pockets of people. Insurance hardly covers 10 million people. Estimates show that 2.2 million people get pushed below the poverty line owing to medical costs. Hospitalisation is a major cause for rural

indebtedness (Rao, 2004). Krishna (2003) identifies high-interest private loans taken by households to pay for healthcare and medical expenses as one of the reasons for descent into poverty.

ADB (2003) observes that in spite of significant improvements in the extent and reach of health care, India ranks low among countries with medium human development and the health status of the population remains poor. There are wide differentials in the availability and quality of health care between urban and rural areas, it points out. Further, it draws attention to the disproportionate emphasis on curative rather than preventive aspects of health care. The expansion of private healthcare network, it adds, caters largely to the urban and better off population. Health expenditures as a percentage of GDP have declined from 1.52 % in 1985 to 0.90 % in 1999-2000. The National Health Policy (2002) recommends increasing (public) expenditure on health from 0.9 % of GDP to 2.0 % by 2010. (ADB, 2003)

The common minimum programme of the present government of the United Front Alliance states:

*The UPA Government will raise public spending on health to at least 2-3% of the GDP over the next five years, with focus on primary healthcare. A national scheme for health insurance for poor families will be introduced. The UPA will step up public investment in programmes to control all communicable disease and also provide leadership to national AIDS control effort.*

The Economic Survey 2003-04, presented subsequent to the CMP, refers to the National Health Policy 2002, which talks of raising public spending on health from the current level of 0.9% of GDP to 2% of GDP by 2010. (See paragraph 0 above). The Economic Survey 2004-05 too refers to the CMP raising public spending on health to at least 2-3 per cent of GDP with focus on primary health care.

### **Millennium Development Goals**

Health sector issues receive prominence in the Millennium Development Goals; as many as three out of the eight goals relate to health. The millennium development goals relating to health (Goals 4, 5 & 6) are to:

Reduce child mortality, the under-five mortality rate by two-thirds between 1990 and 2015;

Improve maternal health, by reducing the maternal mortality ratio by three-quarters between 1990 and 2015; and

Combat HIV / AIDs, malaria and other diseases, by (a) halting and reversing the spread of HIV / AIDs, and (b) halting and reversing the incidence of malaria and other major diseases (See Annex 1)

The World Bank (2004) recalls that the millennium development goal to reduce infant and child mortality by two-thirds between 1990 and 2015 would in the case of India translate into reduction of the infant mortality rate (IMR) to 27 and of the under-five mortality rate (U5MR) to 32 by 2015.

In spite of impressive decline in infant mortality in India - from 130-140 infant deaths per 1,000 live births in the early 1970s to 68 in 2000 - the absolute levels of infant and child mortality are still too high (about 68 infant and 95 child deaths per 1,000 live births in 1998-99), according to the World Bank (2004). Nearly 1¾ million children die each year in the country before reaching the age of one. Moreover, India compares poorly with several other countries in South and Southeast Asia, including Bangladesh, on the pace of IMR reduction too. (World Bank 2004).

According to the Human Development Report 2004, Bangladesh reported a lower infant mortality rate of 51 deaths per 1,000 in 2002 than India (64 deaths per 1,000 live births). India's IMR was much higher than that of Malaysia (8), Sri Lanka (17), China (20) and Thailand (24).

Further, there are large inter-state and intra-state variations in IMR across the country, ranging from 14 in Kerala to as high as 96 in Orissa. The rate of progress also varies significantly across states. Bihar and U.P., which had among the highest IMRs in the country in 1981, were among the top performers in IMR reduction over the period 1980-99. On the other hand, Andhra Pradesh and Karnataka had the slowest rate of IMR decline over the two decades. In general, however, some convergence is seen, narrowing the inter-state disparity in infant mortality between 1981 and 2000. (World Bank 2004)

An interesting feature of infant deaths in India is that they are concentrated in just a few states. The NFHS-2 data indicate heavy concentration of infant deaths in a relatively small number of districts and villages in the country. For instance, during 1994-99, a fifth of the country's districts and villages accounted for one-half of all infant deaths in the country. While these numbers are not precise (owing to the difficulty of measuring infant mortality for small samples), they suggest that infant mortality could be brought down considerably by first identifying and then targeting mortality-reducing interventions to those districts and villages with the largest number of infant deaths in the country. (World Bank 2004)

The World Bank report hints at significant inverse association between infant mortality and government health expenditure across states, as also a stronger inverse association for the very poor states than for the non-poor states. Significant associations between infant mortality on the one hand and female literacy and per capita GSDP on the other hand are also observed. However, merely increasing health spending may not suffice: the composition, quality and effectiveness of spending are no less important.

The Economic Survey 2002-03 states that the maternal mortality rate per 100,000 live births has declined from 437 in 1991 to 407 in 1998<sup>35</sup>. It should come down to 109 by 2015, if the MDG target is to be achieved. However, according to the World Bank development data the maternal mortality rate per 100,000 live births was 540 in 2001<sup>36</sup>. The United Nations Statistics Division also places the maternal mortality rate in 2000 at 540<sup>37</sup>, based on sample surveys or census. Either way, it does not seem likely that this goal would be anywhere near achieved. India's maternal mortality ratio of 540 deaths per 100,000 births is many times higher than the ratio in Malaysia (41), Thailand (44), China (56) or Sri Lanka (92).

ADB (2003) cautions that a major crisis is looming in the form of HIV/AIDS and that India is described as being at the stage of "concentrated epidemic"<sup>38</sup>. It observes that HIV infection is concentrated largely among the poor and marginalized groups, including commercial sex workers, truck drivers, and intravenous-drug users. It warns: "HIV infection could grow to 5% of the adult population—more than 37 million people—by 2005. Even with intervention, the number of HIV-infected people is likely to grow substantially." With inadequate health infrastructure to cope with the magnitude of preventive and curative demands of HIV/AIDSs, the government faces a daunting task in battling AIDS, it adds.

Chances of achieving the MDG targets, therefore, appear slim. But what is disconcerting is the grim picture emerging on HIV/AIDSs.

### **Impact of Water Supply and Sanitation on Health**

'Water and sanitation have been recognized for a long time as being among the most important factors for public health. They are close to the

***Access to safe water is a fundamental human need and therefore a basic human right***  
***Kofi Annan, United Nations Secretary-General***

<sup>35</sup> Economic Survey 2002-03, Box 10.8

<sup>36</sup> <http://devdata.worldbank.org/hnpstats/HnpAtaGlance.asp?sCtry=IND,India> - accessed on June 7, 2004.

<sup>37</sup> [http://unstats.un.org/unsd/mi/mi\\_series\\_results.asp?rowId=553](http://unstats.un.org/unsd/mi/mi_series_results.asp?rowId=553) - accessed on 26 Dec. 04

<sup>38</sup> "Concentrated epidemic" is defined as 5 percent prevalence among people practising high-risk behaviour

top of WHO's list of the components of primary health care. Wherever people achieve reliable access to safe drinking-water and adequate sanitation they have won a major battle against a wide range of diseases.<sup>39</sup>

Diseases could be transmitted through water; hence the quality of water is a universal health concern, more so in developing countries where though safe drinking water may be available to millions of people, improvements may still be called for to prevent outbreak of diseases. Focus on water quality may be sharpened during emergencies when the risk of contaminated water supply and sources is greater. Hence, both during normal times and emergencies a preventive approach is essential. Certain water-related diseases are endemic to parts of India, like fluorosis caused by fluoride-laden water derived from bore wells dug deep into the earth. Excess fluoride in drinking water sources in Anantapur and Nalgonda districts of Andhra Pradesh has made the area's marginalised, rural population vulnerable to fluorosis. Fluorosis is also endemic in parts of Rajasthan, Chattisgarh, Assam, etc.

The importance of water quality and sanitation to health outcomes cannot be over-emphasised, and would constitute an important element in preventive health care. The first Global WASH Forum, managed by the Water Supply and Sanitation Collaborative Council (an organisation under the aegis of WHO in Geneva) and hosted by the Government of Senegal was held in Dakar in December 2004. The Dakar statement issued on 3 December at the conclusion of the forum re-iterated the commitment to water, sanitation and hygiene as human rights, people-centred and gender-focussed approaches to attaining the Millennium Development Goals. (See Targets 10 & 11 under Goal 7 of MDGs - Annex 1)

It is outside the remit of this paper to embark on a detailed discussion on water supply and sanitation. Suffice to say therefore that policy makers in India are alive to the risks to health from poor water supply and sanitation. (See Box 7). The union government budget for 2005-06 seeks to significantly step up the allocation for drinking water and sanitation. This is, however, not to say that enough is being done in the public sector in this area, which probably explains the presence of a large number of NGOs in India in the area of sanitation and health. Spending by states on water supply and sanitation shows wide variations as brought out in the report of the Twelfth Finance Commission, with a low of Rs. 19 in Bihar compared with a high of Rs.112 in Rajasthan (Table 5).

**Table 5: Per Capita Spending on Water Supply and Sanitation**

Per Capita Expenditure on Water Supply and Sanitation- 1998-99 to 2000-01

States	Rupees
Andhra Pradesh	57.7
Assam	59.2
Bihar	19.1
Gujarat	39.0
Haryana	102.1
Karnataka	60.3
Kerala	52.3
Madhya Pradesh	63.4
Maharashtra	79.7
Orissa	56.2
Punjab	55.0
Rajasthan	111.5
Tamil Nadu	38.3
Uttar Pradesh	20.0
West Bengal	42.5
coeff of variation	45.11
Min/Max	0.17
Min/Mean	0.34

Source: Twelfth Finance Commission - Extract from Table 4.6

### Health Scenario

Both in developed and developing countries, it is the poor who are more vulnerable to ill health and shorter life spans than the rich. Though lifestyle and many socio-economic factors influence people's health, the importance of access to quality and affordable healthcare and public health services cannot be minimised. There is no denying that health services are failing the poor; richer and influential groups tend to benefit more from subsidies for health

<sup>39</sup> <http://www.who.int/dg/lee/speeches/2003/washpartnership/en/> - accessed on 19 Dec. 04

care; and hospitals in urban areas generally receive disproportionately larger funds to the neglect of healthcare in rural areas. The incidence of 'out-of-pocket' payments made to both public and private providers falls more heavily on the poor, as they claim a larger proportion of their income. (Eldis, Health Service Delivery)

#### **Box 7 : Water Supply and Health**

Water, which is essential for life, growth and health, can also be a source of spread of disease and cause of ill-health, if contaminated or improperly handled and stored. Safe drinking water and improved sanitation play a major role in the overall well-being of the people, with a significant bearing on the infant mortality rate, death rate, longevity and productivity.

The poor, both in rural and urban areas, bear a disproportionate burden of non-availability of water, as well as of poor quality. They often supplement public sources of water with supplies obtained at high prices from other sources. Women bear the physical burden of fetching water. Women and children are particularly vulnerable to the effects of water contamination.

Water-Borne Diseases: 70-80 per cent of illnesses are related to water contamination and poor sanitation. The national objectives of reducing morbidity and mortality largely depend on the reduction of diarrhoea and jaundice. In fact, no water supply and sanitation programme can be successful if water-related illnesses are not reduced. It is a matter of concern that despite the progress made with water supply, the level of water-related sickness continues to be high.

Causes of contamination of water are indiscriminate use of chemical fertilisers and chemicals, poor hygienic environment of the water sources, improper disposal of sewage and solid waste, pollution from untreated industrial effluents, over-exploitation leading to quality degradation. Thus, the supply of additional quantity of water by itself does not ensure good health; proper handling of water and prevention of contamination are also equally important.

[Source: Tenth Five Year Plan 2002-07, Chapter 5: Rural Water Supply and Sanitation; Box. 5.5.3]

As already mentioned, responsibility for the health sector in India is divided between the centre and the states. The centre finances some activities through centrally sponsored schemes but since about 75 % of the expenditure on health is by the states and implementation is by the states, it is largely their performance that determines the efficiency of health outcomes and delivery of services. Revamping of organisational structures, both at the level of the centre and states, streamlining of financial management systems and re-orientation of priorities to improve 'allocative' and technical efficiency are seen by the India Health Report (2003) as essential elements of health care reform.

A study conducted by Sankar and Kathuria (2004) across 16 major states in India finds a positive relationship between health outcomes in rural areas and the level of health infrastructure in terms of access to facilities and availability of skilled professionals such as doctors. They affirm that the efficiency of health systems depends on the extent of education in the state. They attribute the wide variations in levels of health outcomes in different states and efficiencies of the health system to differences in literacy levels. They point out that the overall expenditure on health services in India is estimated at 4.5 % of GDP, below the average of 5.6% for low and middle-income countries. Of this, public spending on health in India is less than 1 % of GDP, which is among the lowest in the world. Since resources are limited it is important they are used wisely and efficiently. The study concludes that investment in the health sector alone would not result in better health indicators. Efficient management of investment is also required—a point that is repeatedly made in this paper, namely that quality and efficiency of expenditure are what significantly determine positive outcomes.

But as also pointed out earlier in this paper, while quality and efficiency of expenditure are important, expenditure *per se* is a relevant input-indicator too. In this context, a comparison of Kerala and UP is pertinent. Keefer and Khemani note that human development outcomes in Kerala are comparable to those of some of the richest nations of the world, while in UP they are similar to those of the poorest, despite the two states having very similar economies, levels of per capita income, and poverty. They attribute the differences in human development outcomes, at least in part, to the striking differences in real per capita public expenditures on health and education in the two states. Over four decades from the 1960s to the 1990s, average real per capita spending in each decade in Kerala has been more than double that in UP.

The India Health Report (2003) brings out an interesting point relating to expenditure on curative care incurred on different income quintiles of the population. Kerala, Gujarat, Tamil

Nadu and Maharashtra spend almost equal amounts on each of the income quintiles, whereas other states appeared to show a pro-rich bias. Bihar and Rajasthan spend almost five times on the richest quintile than on the poorest. The report proffers a plausible explanation for the pro-rich bias in the relatively poorer states, namely the absence of private sector facilities in these states. Availability of private health services may free up public services for the poor and facilitate better targeting of public subsidies, it suggests. But another, less charitable, explanation is also possible; namely, capture of public health services by the rich and administrative failure in the delivery of public health services to the poor.

### **Issues**

The reasons for the failure or shortcomings of the delivery of public health services are well known and are not far to seek. The inherent systemic and structural weaknesses are characterised by: lack of access to healthcare because of geographic, social or cost barriers; non-availability of medicines and equipment; absence and apathy of medical and paramedical personnel and their lack of responsiveness and accountability. The India Health Report 2003 proposes that reorganising and better management of existing resources can effectively address these problems<sup>40</sup>.

Improving delivery of services to the poor should involve all stakeholders: policy makers, public and private providers, users of the services and the communities themselves. In this context, a reference needs to be made to the recent budget for 2005-06 of the union government announcing the National Rural Health Mission (NRMH), whose focus will be 'strengthening primary health care through grass root level public health interventions based on community ownership.'

The India Health Report (2003) examined why some states have been more successful in achieving better health outcomes; whether the factors contributing to improved health outcomes in certain states can be isolated; and to what extent health sector interventions are responsible. It concluded that the oft-quoted hypothesis that poverty and illiteracy are the main determinants of health outcomes is not borne out by its analysis covering 14 major States and that health outcomes appear to be significantly associated with health sector interventions. (This is somewhat at variance with the findings of Sankar and Kathuria cited above.)

### **Access**

The importance of physical access to health care should not be underestimated. The India Health Report (2003) attributes the superior performance of Kerala to proximity of health care providers. While the average radial distance of a PHC in Kerala is 3.4 km, it is 6.8 km in the rest of the country. Further, a typical PHC in Kerala covers 37 km<sup>2</sup> compared to 143 km<sup>2</sup> in the rest of the country. The percentage of people who did not access health care is higher in the poorly performing states, it states. Thus, while in Madhya Pradesh and Orissa this figure is close to 20 percent, in Uttar Pradesh it is about 11 percent. From a study of eight states, the India Health Report (2003) finds that the better performing states have relatively better public bed strength. The report concludes that a key lesson for states, therefore, is 'the pressing need to remove locational and infrastructural inequities that push up health costs'.

Better access depends on a number of factors. At the policy level, these include strategy and plans that prioritise health needs and allocate resources; at the operational level it would depend on: motivated and properly trained personnel, good supporting infrastructure including communications; and finally, well-informed clients and their representative bodies. (Eldis, Health Service Delivery)

It would be pertinent in this context to recall the remarkable success Iran has achieved in improving access to health care in remote areas through its primary health care system,

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<sup>40</sup> page 121

which has resulted in reduced infant and child mortality, elimination of major infectious diseases, and improved health of mothers. A World Bank case study shows a narrowing gap between urban and rural areas, in terms of basic health interventions, including immunization coverage and infant, child, and maternal health care. The success of the Iranian experience is attributed to political commitment, broader involvement of local communities, and institutional innovation.

### **Unqualified Practitioners**

Another indicator of the failure of health delivery systems, particularly in rural areas, is the disquietingly large presence of unqualified practitioners. It is estimated that one million unqualified rural medical practitioners (RMPs) exist. This is attributed to the urban concentration of qualified practitioners and facilities, and the limited spread of the voluntary sector.

According to Shiva Kumar (2005), with most government operated rural health sub-centres and primary healthcare centres on the verge of collapse, a large private sector in health –to quote Amartya Sen– thrives on ‘quackery and crookery’.

### **Inefficient PHCs**

The Programme Evaluation Organisation (2001) of the Planning Commission carried out an evaluation of the Primary Health Centres covered under the Social Safety Net Programme (SSNP) assisted by the World Bank<sup>41</sup>. It observed that more than 51% expressed dissatisfaction with the functioning of the PHCs. The reasons cited for their dissatisfaction were: (i) non-availability of medical and para-medical staff, (ii) not being examined by doctors, (iii) proper attention not being given, and (iv) non-availability of medicines in PHCs. Similar responses were also obtained at PHCs not assisted under the programme. The study further noted that low-income group households seemed to stay away from the public health care delivery system primarily because of non-availability of medicines, indirect cost on transport, and high opportunity cost in terms of foregone income (due to loss of wage income). They, therefore, depended on cheaper alternatives, such as traditional Indian medicines or unqualified medical practitioners. It is noteworthy, however, that a large majority showed willingness to pay for the services if the quality of delivery improved. The principal finding of the study was that PHCs were not able to deliver the intended health care and medical services in rural areas. One of the suggestions made in the study was that the functioning of PHCs should be monitored and supervised by the panchayats raj institutions (PRIs). Shiva Kumar (2005) says: ‘There is virtually no performance monitoring in public health centres. Absenteeism is reportedly high as are levels of corruption.’

### **Absenteeism**

To combat the problem of absenteeism by doctors at PHCs and in rural areas, Maharashtra, Orissa and Karnataka have legislations requiring obligatory rural service before one can gain admission to post-graduate courses. Some states have opted for contractual services of doctors to fill up chronic vacancies; in Kerala this power has been devolved to panchayats. Special monetary incentives could also be considered, particularly in remote and unattractive locations, to encourage doctors to serve there.

### **Costs of Health Care**

India Health Report 2003 points out that the costs of health care have grown substantially in the country as a whole, the rise being steeper in the case of inpatient care as compared to

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<sup>41</sup> The World Bank assisted Social Safety Net Programme (SSNP) for family welfare was initiated in 1992-93 for a period of five years in 90 poor performing districts characterised by high maternal mortality rate and low levels of institutional deliveries. The programme aimed to reduce the maternal mortality rate by creating essential health infrastructural facilities.

outpatient care. This burden, it says, has fallen more heavily on the poor than on the rich, with 45 percent of the poorest quintile borrowing money or selling assets to meet the costs of hospitalisation compared to just over 30 percent for the richest quintile. High levels of borrowings for meeting hospitalisation costs are evident in the public sector too, possibly because of diagnostic charges, medicines to be purchased, and 'informal' payments to be made within the institutions, it adds. This points to the failure of the public sector to provide insurance against crippling costs of illness. Thus, there is need to focus on improving access to health care and on equity issues, both in terms of service coverage as well as targeting of public subsidies, the report concludes.

The high costs of private sector health care are due to a variety of factors, like 'fee-for-service' payment systems prevalent in private hospitals; and over-prescribing and unnecessary investigations (induced in part by the 'fee-for-service' system). Contrary to normal expectations, technological advancements have contributed to increased costs rather than lowering of costs, because of attempts and pressures to recover investment in high-cost equipment<sup>42</sup>.

Studies conducted by doctors at Harvard reveal that the quality and rate of success of diagnosis have not necessarily improved with advances in technology and use of sophisticated equipment. Apparently, it was not so much the fault of technology as the failure of physicians to order the perfect test or scan though it may have been available. (Gawande, 2002, pages 197-198). This finding fuels the suspicion that many of the diagnostic tests are perhaps unnecessary and dictated more by the desire to recoup the investment in high-cost sophisticated equipment rather than the exigencies of treatment. Doctors may, however, take the plea that it is necessitated by the practice of 'defensive medicine'<sup>43</sup>.

One way to control costs could be to bring about greater transparency in the charging practices of private healthcare bodies. Publishing of prices in the media or elsewhere would lead to greater awareness among consumer-rights activists or other community-based groups, which could put pressure on private providers to contain their prices.

### ***Decentralisation and Other Initiatives***

According to India Health Report (2003), of the eight states<sup>44</sup> studied by it, all except Tamil Nadu have attempted decentralisation in one form or the other. Kerala, Maharashtra, Madhya Pradesh, and Uttar Pradesh have devolved administrative and financial powers at the primary level to local bodies. Rajasthan has devolved certain administrative and supervisory powers to local bodies, but not financial powers. Andhra Pradesh has chosen the mechanism of registered society at the facility level to promote stakeholder participation, and Orissa the route of district health society. The report comments that the latter states and Tamil Nadu have not handed over control of health institutions to panchayats, possibly fearing resistance from staff, and the perception that more inequities could result from control by different political parties or local elite.

The National Rural Health Mission attempts a major shift in the governance of public health by giving leadership to the Panchayati Raj institutions in all matters related to health at the district and sub-district levels. It aims to increase the outreach of the health system to village and even household levels through the provision of a voluntary trained female community health activist called ASHA (Accredited Social Health Activist). The Mission will cover all the States in the country with special focus on 18 States which have weak health infrastructure and demographic indicators. (Shiva Kumar 2005)

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<sup>42</sup> Many hospitals fix the amount of 'business' a doctor has to bring in to ensure that beds are occupied and equipment fully utilized. Hospital managers have also admitted that they are forced to recover the investment on high-technology equipment through 'excessive' referrals. (India Health Report, 2003; page 109)

<sup>43</sup> to combat malpractice suits

<sup>44</sup> The eight major states studied are considered representative of the good, middling and poor performing states, in terms of health outcomes.

## **Community Involvement**

Community involvement can play a major role in improving the performance of health systems, particularly through accountability. The India Health Report (2003) recommends the initiative of Andhra Pradesh to institutionalise community participation through advisory committees at the PHC and sub centre level – involving both local bodies and representatives of women and self-help groups – as worth replicating. Additionally, it says, the Madhya Pradesh experiment with village help communities, having a fair representation of women and disadvantaged communities deserves emulation.

## **Contractual Appointments**

Resort to contractual appointments could bring about greater responsiveness and accountability, but this may call for greater flexibility in the recruitment procedures of government. India Health Report (2003) advocates flexibility of contractual appointments at least in regard to peripheral paramedical staff and adds that Orissa has permitted such contractual appointments through district health committees.

## **Contracting Out**

The private sector (whether for-profit or not-for-profit) has been associated for some time in family planning and other programmes, with payment being made on per case basis. Transferring the management of public health facilities to the private sector (mainly voluntary sector) is a more recent form of contracting to improve access and efficiency. Gujarat has handed over the management of all primary healthcare services in one district to SEWA rural. Orissa and Karnataka have handed over management of PHCs in tribal/remote areas to NGOs. These steps are expected to enlarge the coverage of services in a cost-effective manner in public institutions that have remained under-utilised for various reasons.

Some governments have been considering the transfer of hospital management to private providers. Action was initiated in one case in Mumbai and one in Kolkata. (The Kolkata venture is functional, while the one in Mumbai is yet to take off.) Such contracting efforts have however to be combined with effective regulatory and enforcement framework. At present, most of these contracting initiatives in states are funded through externally aided projects; whether they can be sustained once external funding ceases is to be seen.

## **Private Sector**

The presence of the private sector in India in health is not new; it has existed alongside the public sector since long. However, its role has not been significant until the seventies.

Until the Sixth Five-Year Plan, when the Health Policy Document spoke of the role of voluntary agencies and of encouraging non-governmental agencies to set up curative centres, the plan documents did not mention the role of the private sector. However, government has been offering subsidies to the voluntary sector as part of the family planning programme since the Fourth Five-year Plan. Baru (1998) says the growth of private hospitals that has taken place in India and in other developing countries during the late seventies and early eighties was linked to developments in the international as well as national scene. Until then, the presence of private sector in medical care consisted largely of individual practitioners running clinics and nursing homes. However, since the eighties, Baru (1998) states there has been a change of scene with the entry of regional business groups, with or without the involvement of non-resident Indians (NRIs), in the provision of medical care

Government's encouragement of the private sector in health has been mainly through (a) reduction of import duties on high-tech medical equipment, (b) special concessions (to NRIs), and (c) recognition of medical care as an industry, thus making it eligible for loans from financial institutions. These measures saw the setting up of corporate hospitals and the entry of business groups. The expansion of medical insurance also helped promote the growth of private medical care; for example, major hospital groups like Apollo Hospital tying

up with major insurance companies. Baru (1998) comments that the urban bias of public health services and the urban-rural divide is 'mirrored' in private sector health care too.

Though the growth of private sector in health has benefited from concessions like reduced import duties, subsidized allotment of land, and so on, government has done little to enforce conditions such as access and free services to the poor, in spite of stipulations to that effect. And, the few feeble steps government has taken in this regard have met with resistance from vested interests. Recently, there have been media reports, however, that courts have taken judicial cognisance of such omission following public interest petitions. But these relate to private schools; one is not aware whether similar petitions have been filed regarding private hospitals and have similarly attracted judicial attention.

### **Standards**

Recent years have seen the mushrooming of hospitals, nursing homes, dispensaries/clinics, diagnostic facilities and laboratories. Existing legislation in Delhi and Maharashtra prescribe registration/licensing and inspection by designated authority, but do not lay down any minimum standards for infrastructure, personnel, record keeping, reporting on public health issues, sanitation, and hygiene. Karnataka and Andhra Pradesh have constituted committees chaired by reputed medical professionals, representing the interests of all stakeholders. The committee in Andhra Pradesh has formulated minimum standards of roles for each type of medical establishment. (India Health Report, 2003)

Given the fiscal stress of states and the administrative complications involved, it may be both impractical and inadvisable for governments directly to assume responsibility for enforcing regulations. A better option may be to set up appropriate autonomous authorities chaired by a medical/judge/administrator of repute with representatives of all stakeholders including consumers. (India Health Report, 2003)

Educating the community and users can reinforce regulation of private providers while empowering users to negotiate better information sharing, quality of care, and cost-containment.

### **Absence of Reliable Data**

Reliable data on private health facilities are not available in spite of the increasing presence of the private sector in health care. There are discrepancies in the data on availability of health services in the private sector between information reported by Central Bureau of Health Intelligence (CPHI) and data provided by state medical councils and state governments. At present, private sector health services consist of large corporate hospitals, smaller hospitals/nursing homes, clinics/dispensaries run by qualified practitioners, and services provided by unqualified persons. Most private sector hospitals are small establishments. Tertiary care provided by institutions in the private sector account for only one to two percent of the total number of institutions while corporate hospitals constitute less than 1%. There are wide variations across states in the distribution of private sector hospitals and beds, given the private sector preference to set up facilities in the more prosperous states or districts. The private sector accounts for 82% of all outpatient visits and 52% of hospitalisation at the all-India level, without any significant variations across income groups. The majority of government and private sector hospitals and beds are in urban areas because of lack of social infrastructure and the ability of people to pay. Thus, the population in areas where health care needs are the greatest have very poor access to either government or private health services. (Planning Commission)

### **NGOs and the Voluntary Sector**

NGOs and the voluntary sector also provide healthcare services to the community, which supplement public and private health services. It is estimated that more than 7000 voluntary agencies are engaged in health-related activities. As with public and private health services, wide inter-state differentials exist in their coverage too. Relatively few NGOs provide a variety

of services. Some implement government programmes of family welfare and health, while others run integrated basic health services or provide special care/rehabilitation to people suffering from specific diseases. Agencies like the Red Cross, industrial establishments<sup>45</sup>, Lion's Club, Helpage India, etc are also active in providing health services. (Planning Commission, 2003)

For instance, non-governmental organisations (NGOs) affiliated to Chennai-based AIDS Prevention and Control Project (APAC) have contributed to the remarkable achievements of the APAC project. The project was formulated under a tripartite agreement among the Voluntary Health Services (VHS) in Chennai, the United States Agency for International Development (USAID) and the Government of India with the primary objective of preventing and controlling the spread of HIV/AIDS.<sup>46</sup>

The Government of Tamil Nadu assigned one of its PHCs in the year 2000 (Bagalur PHC that serves 80,000 people) to The George Foundation to "co-manage" its operations. The George Foundation claims that within a year this PHC became a model institution in all of Tamil Nadu, delivering quality healthcare to its population. This it says was accomplished through (a) implementation of a diagnostic and health management system developed by it, (b) improvement of the physical infrastructure, and (c) implementation of superior management procedures.<sup>47</sup>

The National Population Policy 2000 envisages increasing the role of NGOs / voluntary organisations in building up awareness about and advocacy for reproductive and child health (RCH) interventions and also in improving community participation. State governments too have been trying to involve NGOs in providing services or to adopt a PHC, apparently with mixed results. (Planning Commission, 2003)

NGOs are a mixed bag of good, bad, indifferent and have varying degrees of credentials and performance record. Some even receive government funding or carry tacit or formal government recognition. Where NGOs receive government funding or recognition, it is desirable that their performance is periodically independently assessed, and continued funding or recognition made contingent on satisfactory performance. Further, networking between NGOs (including voluntary agencies), the administration and local community including panchayati raj institutions would make for better synergy.

### **Recourse to Private Sector even by the Poor**

Private health services are predominantly in diagnostics and curative care. India Health Report (2003) says that judging by visits to hospitals at the all-India level, the preference for the private sector over the public sector seems quite marked. It found that income levels was not significant in the preference for the private sector, the range being 79% to 85 % from the poorest to the richest quintiles, cutting across urban and rural areas, and gender. The private sector has an edge in outpatient care, hospitalisations, and institutional deliveries, while the public sector is ahead in antenatal care and immunisations, it adds. However, there are wide variations across states in in-patient care as between the public and private sectors; the more advanced states with a better-developed private sector manifest a higher preference for the private sector. The percentage of the poorest quintile using private sector hospitalisation facilities (39%) is almost half that of the richest quintile (77%), though there are dramatic

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<sup>45</sup> A number of industrial concerns and public sector undertakings, for instance Tata Iron and Steel Company (TISCO), Escorts, Steel Authority of India Ltd (SAIL), United Planters Association of South India (UPASI), Larsen & Tubro (L&T) are said to have done excellent work in family welfare, by providing services not only to their own employees and their families but also to neighbouring communities. The Federation of Indian Chambers of Commerce and Industry (FICCI) had developed a scheme for voluntary expenditure by industry on social welfare programmes, according to which a certain amount of the project cost is to be spent on education, health care etc. Profit-making units would have to spend one to two percent of their net profits for social welfare programmes. (Planning Commission, 2003).

<sup>46</sup> The APAC Experience by Asha Krishnakumar; Frontline, Volume 21 - Issue 25, Dec. 04 - 17, 2004; <http://www.flonnet.com/fl2125/stories/20041217005411300.htm> - accessed 11 Dec. 04.

<sup>47</sup> The George Foundation –Health Projects – Overview (<http://www.tgfworld.org/health.html> - accessed on 22 May 2004)

differences across states depending on availability of private services. (India Health Report, 2003).

The unmistakable preference for private health care even by the poor for whom the financial burden would be disproportionately higher in relation to their income is a damning indictment of publicly delivered health services.

### **Lessons For Efficient Social Service Delivery**

There was a reference earlier in the paper to poverty resulting in education and health services bypassing the poor. Further, that rural indebtedness arising from high-interest private loans taken by households to pay for healthcare and medical expenses was pushing them into poverty. On the other hand, access to education and health can also result in escape from poverty.

Morrisson (2002) recalls that as early as 1990, the World Bank's *World Development Report* on poverty cited several studies from the 1970s and 1980s to demonstrate that educational attainment increases both wages and labour productivity in agriculture and the informal sector. These findings are re-affirmed by four of their own studies, says Morriison.

Morrisson points out that the incidence of education spending on wages has always been significant in the formal sector. Their studies in Indonesia, Tanzania and Madagascar reveal appreciable returns for salaried workers, both in the formal and informal sectors. In agriculture, however, the gains related to human capital are less clear. In Indonesia, additional years of education (nine instead of five) increased agricultural output by 10 per cent, but no discernible effect on agricultural productivity was observed in Madagascar. In this case, however, education resulted in some reallocation of the labour force outside of farming, thereby increasing a given family's total income.

Morrisson adds that while the 1990 *World Development Report* addresses the impact of improved nutrition on agricultural labour productivity, it provides no information on the effects of health care. However, several surveys undertaken in Madagascar and Indonesia show that access to health care has a positive effect on income. Morriison , however, cautions that 'certain reciprocal positive externalities' could exaggerate the gains flowing from education and health care. For instance: 'Education has an impact on health and vice versa, making the overall effect on gains greater than the sum of the direct effects of these two factors.'

Three dominant themes about service delivery that stand out from the discussion on education and health are access, quality, and accountability. There are many other factors that are related to or influence service delivery like equity, effectiveness and efficiency, community involvement and participation, privatisation, corruption, and so on. But these are related in one way or other to one or more of the three broad themes and are subsumed under those.

Both the education and health scenarios outlined earlier in the paper reveal that though there have been significant improvements in these sectors problems still persist such as:

physical and socio-economic barriers to access;

inter-state, and inter- and intra- regional disparities in availability of services, cutting across public services, private services, and those provided by NGOs and the voluntary sector;

urban bias in the availability and delivery of services;

lack of basic amenities and infrastructure;

***"... ignoring the issue of quality in the public education system will further aggravate the problem of equity as the poor continue to depend on publicly funded schools. The aim must be to break the insidious link between quality and exclusivity."***

Sir John Daniel, Assistant Director-General for Education, UNESCO in his foreword to India Education Report

poor quality service leading either to abnegation (like poor parents withdrawing their wards from school) or forcing even the poor to seek private services though the financial sacrifice or burden may claim a disproportionately larger share of their income than for the rich;

absence of accountability for publicly delivered services; etc

Availability of services in the private sector mitigates to some extent the shortcomings or gaps in publicly delivered services but brings in its wake attendant issues like affordability, equity, regulation, and so on. What this suggests therefore is a judicious blend of delivery of services through the public, private and voluntary sectors (including NGOs). The inherent competition and choice that results may lead to upgrading of quality of service. In short, a public-private partnership rather than (outright) privatisation as such.

In the backdrop of the discussion so far, some lessons bearing on effective and efficient delivery of services are discussed in what follows.

### **Access**

Physical access to services can only be increased by enlarging their scope and reach, and by allowing the private and voluntary sectors (including NGOs) to supplement publicly delivered services. Public delivery of services would have to be expanded by larger investments in the services themselves and by improving the supporting and enabling infrastructure, with accent on effective and efficient use of resources. Accountability of those entrusted with service delivery would also need to be heightened.

Breaking down of socio-economic barriers would have to be tackled by better targeting, including targeting of subsidies; general improvement in the economic well being of the people; community involvement in the delivery of services; and transformation of social mores.

Participation of the private and voluntary sectors in the delivery of services can expand access to services, apart from affording users greater choice and thereby generating competition too. Issues of affordability by the poor and equity in regard to services available through the private sector can be tackled through appropriate state interventions, vouchers, and the like.

### **Equity**

Incentives like subsidised land, fiscal concessions, etc could be used to influence private providers to locate in underserved areas, and provide services to targeted groups. Recognising that fiscal pressures on central and state governments would constrain investment in capital intensive care, the 1983 National Health Policy recommended the promotion of private investment in tertiary care. Thus, concessions were granted mainly to tertiary-level speciality and super-speciality facilities, but these were generally concentrated in urban areas. Further, though conditions may have been set that they should provide free treatment to a stipulated percentage of the poor, mechanisms for enforcing these conditions are weak, if not non-existent.

Non-monetary incentives could also be offered to encourage large private investment in rural locations. Andhra Pradesh recently permitted medical and dental colleges to be set up only in identified backward areas, a policy that is said to have paid dividends, though no conditions for treatment of the poor were laid down. While incentive mechanisms may have improved access to health care, little attention has been paid to equity issues, mainly because of non-existent or weak and ineffective monitoring mechanisms. This lacuna could perhaps be dealt with by entrusting monitoring of obligated service provisions to decentralised local bodies or non-governmental organisations.

Maharashtra has a landmark legislation that requires doctors to serve for three years in rural areas if they are to be eligible for admission to post-graduate studies. Similar legislation prescribing a compulsory period of rural service exists in Kerala, Orissa and Andhra Pradesh.

Such initiatives may also alleviate to some extent the problem of absentee doctors in rural areas.

### **Corruption**

Corruption is a hydra-headed cancer, which gnaws into access, dilutes quality, and whittles down accountability. Corruption has both a fiscal and direct impact on the delivery of services.

The fiscal impact of corruption can be felt both from the revenue side as well as the expenditure side. Corruption leads to private gain at the expense of public coffers; the reduced revenue flows starve social service sectors of adequate funding. On the expenditure side, opportunities for rent seeking direct spending towards big-ticket items and sectors, again paring allocations for social sector spending.

Corruption also directly affects the delivery of services. The poor often have to pay bribes to gain access to services they are entitled to. The bribes the rich pay are generally for speedier and better service than for access. Corruption exacts a higher toll on the poor than on the rich, as it claims a larger proportion of their income. Corruption in procurement of goods and services has a direct bearing on the quality and delivery of services, like for instance poor quality medicines and equipment for delivery of health services. Corruption erodes authority and undermines accountability.

Hallak and Poisson (2004) argue that the problems posed by corruption in education are neglected. Corruption in the recruitment and promotion of teachers lowers the quality of public school teachers and illegal payments for school entrance and other hidden costs help explain low school enrolment and high dropout rates. They make an interesting point by drawing a distinction between corruption in education and education against corruption, which calls for focussing on institutions, procedures and mechanisms. Greater voice and community involvement is necessary if the potential for political and monetary gains in the sanctioning of educational institutions, appointment of teachers and officials, and admission of students is to be contained.

### **Private Sector Participation**

One of the reasons for low efficiency of the public sector is its weak accountability. A compelling argument for increasing private sector participation is the low efficiency of government, which causes people to seek private institutions to satisfy their needs for goods and services. Inefficiency of the public sector leads to more bureaucracy and government. This is not to suggest that the private sector is the epitome of efficiency. But in a competitive environment inefficient firms go out of business, while such pressures are absent on government.

Privatisation in the form of public-private partnership could be used as a tool to improve government functioning, as a pragmatic measure to offer greater choice to consumers or users of public services. Further, growing affluence enables consumers to afford better services and demand quality services. (Savas, 2001)

Private sector participation in the delivery of services can take many forms: from outright privatisation of services, to competitive provision of service, to contracting out management of government owned assets (like hospitals or schools for instance), to contracting out provisioning of services, and so on.

Ideological opposition to the private sector should not overshadow possibilities of cost-effectiveness, value for money, and efficiency gains that may come from shared responsibilities in the delivery of services.

## **Contracting Out**

Contracting out or outsourcing services is an aspect of privatisation or public-private partnership that needs consideration. Contracting does not amount to abdication of governmental responsibility since it implies public financing but private provisioning; there is only a shifting of service delivery with the objective of cutting costs and improving efficiency, a shrinking of government without diminution of government functions. (Savas, 2001) Any concerns about public accountability being impaired or diluted can be taken care of through appropriate conditions in the contract or through regulation. Contracting out or privatisation of service delivery can, therefore, be a form of forging effective public and private partnership without sacrificing access to services, equity, efficiency and accountability.

An evaluation survey-cum-study in Cambodia reveals that providing health services by contracting them out to non-governmental entities is not only feasible but can enlarge the coverage in a short time. (Bhushan et al, 2002) The study brings out that gains in efficiency in the access and delivery of health services are not achieved at the expense of equity. Bhushan et al conclude that in developing countries where governments face severe fiscal pressures, contracting NGOs or other private entities for the provision of primary health care services presents an attractive alternative, allowing governments to deploy their constrained resources to maximise efficiency of service provision.

Drawing from the experience of two large projects in Bangladesh, one financed by the World Bank and another by the Asian Development Bank, Loevinsohn (2002) says that there is considerable interest in developing countries to contract the delivery of public health services, including nutrition and family planning services, to the private sector. He emphasises, however, the importance of having clear bidding procedures, involving experts from outside the government in the bid evaluation procedures, and of designing contracts to focus on outputs and outcomes.

Many states are contracting out ancillary or paramedical functions, like security, sanitation, laundry and catering. However, there does not appear to be any assessment as yet of the efficacy of these measures. Some states are now contemplating contracting out diagnostic services as well. Contracting and partnering with the private sector could provide wider access to essential and specialist health services and products, at the same time ensuring equity and cost effectiveness. However, appropriate capabilities, including designing and negotiating contracts, would need to be inculcated in the bureaucracy if an effective regulatory and enforcement framework is to be put in place to monitor and ensure that contracting of services functions properly.

The capacities required for contracting out services would depend on the type of service and the nature of the contractor. Contracting ancillary services would pose fewer challenges than contracting out clinical services. The environment within which contracting takes place is also relevant: tardy and rule-bound bureaucracies would face greater constraints to successful implementation. Clear guidelines and definition of responsibilities with periodic evaluations of contractual arrangements are essential for successful contracting. (Bennett 1998)

Every situation must be scrutinised to determine what is best for the public, not what is best for the public agency, as their interests often diverge. (Savas, 2001) Initiatives to involve the private sector could include contracting out certain services for under-served or targeted population groups.

## **Role of NGOs**

Flexibility in implementation is a key element for effective and successful delivery of services, a requirement that the rigidities of government functioning do not always permit but which can be found in voluntary organisations. Non-government agencies interact more closely with the recipients of services and can therefore continually modify or adapt strategies based on the feedback they constantly receive. However, voluntary organisations may not be able to undertake large-scale interventions for they lack the financial and political clout that

governments command. The strengths of the government system lie in its power and network, while its weaknesses are monolithic structure and rule-bound functioning. Much synergy can therefore be achieved by combining the strengths of the government system with the flexibility of voluntary organisations.

### **Quality**

The earlier sections of this paper refer to even the poor seeking services provided by the private sector because of the low quality of publicly delivered education and health care, though it may place a heavy financial drain on their low incomes. But not all can make such sacrifices, which causes them either to endure or submit to whatever is on offer or forgo the service altogether. Besides, choice is not always available for publicly delivered services as they might be operating in a monopolistic or non-competitive environment. This places a moral responsibility on the government to raise the standards and quality of publicly delivered services.

In the United Kingdom (UK), the six principles of public service formulated within the 1991 Citizen's Charter are guided by concern for quality. These principles are: (explicit) standards, (full) information and openness, choice and consultation (for and with users), courtesy and helpfulness (from public servants), putting things right (swiftly), and value for money (efficient and economical services). Despite its name, the charter is more in the nature of a consumers' charter rather than a citizen's charter. It seeks to make services more responsive to the wishes and needs of users by setting, monitoring and publication of explicit standards which individual service users can reasonably expect. (Younis et al, 1996)

### **Accountability**

Accountability in the public sector has two dimensions: at the macro level, where the national or state governments can be held responsible in a general way through elections, legislative answerability, public audit and so on; and, at the micro level, i.e. at the local level, which is the point of delivery of public services (Paul, 1995). Between the two, there are intermediate levels of administration. At all levels, the ability of citizens to hold governments accountable is weak at best, which is further attenuated by the expanding role and increasing complexity of governments. Accountability in the public sector will remain weak as long as the facilities, resources and career prospects of public servants remain insulated from their performance.

Institutional mechanisms for accountability exist at the macro level; like elections, audit, legislative reviews, etc. but these are too diffuse and far removed from the cutting edge of administration to be really effective at the ground level. While elections may confer legitimacy, their power to enforce performance is limited, at best. They empower citizens to vote out a non-performing government but have little power to ensure performance by the incoming government except to vote that out too should it fail to deliver. Thus, elections confer a 'negative' power to punish political parties and elected representatives who fail to perform or deliver on their promises, without the 'positive' power of enforcing performance or accountability for non-performance.

The weakness of traditional accountability mechanisms at the macro level, namely audit and legislative reviews, is that they focus more on inputs and internal processes of government rather than on outcomes (Paul, 1995). Besides, though audit reports and legislative reviews are in theory in the public domain, wider dissemination of their findings, including through the media, would make for more public awareness and informed debate, which are pre-requisites for greater accountability.

A two-pronged approach of strengthening existing (institutional) macro level mechanisms for accountability and devising effective tools for accountability at the micro level is therefore needed.

## **Participatory Approach**

Administrative hierarchical controls, the staple of bureaucratic functioning, leave little scope for people's participation in any meaningful form, and are at best internal review processes. They are therefore dysfunctional as an instrument of accountability to citizens for holding officials responsible for service delivery. Involving outsiders or independent agencies in reviews relating to public service delivery programmes could introduce a measure of accountability, for users of public services are more concerned with results rather than with inputs, processes or even outputs. Besides, institutionalised external scrutiny of the functioning of public programmes could by itself induce a sense of responsibility and accountability in the administrative machinery. However, for such reviews to be really effective, involvement of outsiders should be enjoined by legal provisions, lest it be frustrated by bureaucratic apathy. (Paul, 1995)

Participation of users of services, as indeed of all stakeholders, should extend to the full gamut of service delivery, ranging from preparation (including demand assessment), design, implementation, and evaluation. Unless demand for services is properly assessed and programmes properly designed to meet the needs of users, the services may go abegging; user-feedback on the efficacy and efficiency of service delivery would provide useful inputs for improving delivery as also give a lever for accountability. User-surveys, like the PAC initiative of the 'report card' and the millennium survey (Box 8), the PROBE survey on education (Box 2), are potent instruments for: (i) gauging the level of satisfaction with the delivery of public services; (ii) taking corrective action; and, (iii) holding service providers accountable for their performance, more so in the absence of an 'exit' option.

User-surveys need not necessarily be privately sponsored; independent studies and surveys could be commissioned. Some public utilities in the United States (notably power and telecom utilities) have commissioned public surveys to improve their services. The Gore Report<sup>48</sup> on Reinventing Government had recommended a directive to be issued requiring all federal agencies delivering public services to survey customers about their satisfaction with reference to declared standards of service, and for a better understanding of their needs. (Paul, 1995)

Drawing from over 60 case studies of public sector reforms to strengthen client-focus and civil-society initiatives for better service delivery, Goetz and Gaventa (2001) "identify means of amplifying citizen 'voice' such that engagement with the state moves beyond consultative process to more direct forms of influence over policy and spending decisions." They conclude that if citizen engagement with public service providers is to transcend consultation and wield real influence, citizens must enjoy rights to more meaningful form of participation, including formal recognition of citizens' groups, their right to information and redress for poor service delivery. They add that 'public service providers, for their part, would need assurances regarding the mandate and internal accountability of such groups.'

## **Voice Vs. Exit**

Services provided by the public sector as opposed to those of the private sector differ in one major aspect. A customer dissatisfied with the service provided by the private sector can show his or her dissatisfaction by 'voting with their feet' or exercising an 'exit' option, because of availability of choice in a competitive market environment. However, an 'exit' option is not always available for services in the public sector, as in many cases they operate as monopolies or near-monopolies and the scope for introducing a competitive market environment may be limited. Hence, the importance of 'voice': public pressures exerted through feedback on the usefulness, effectiveness and efficiency of public services can make up to some extent the absence of choice and competition.

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<sup>48</sup> Former Vice President Al Gore; 1993

## Social Audit

The 'report card' initiative by the PAC in Bangalore, and the examples of Development Initiatives for Social and Human Action (DISHA) in Gujarat, and of the Mazdoor Kisaan Shakthi Sangathan (MKSS) in Rajasthan are notable instances of participatory social audit. They demonstrate the use of 'collective voice' of the target-citizenry of public services to demand attention and responsiveness to their needs.

The Public Affairs Centre (PAC), Bangalore (2002)'s "Millennial Survey of India's Public Services" (Box 8) finds that the central and state governments seem to focus more on extending access to public services than paying adequate attention to the quality, reliability and effectiveness of the services. This, it concedes, is perhaps due to the compulsions and pressures of a democratic polity, but emphasises nonetheless that ensuring effectiveness and quality in the delivery of services should demand greater attention of states. While extending access to service calls for investment in physical and administrative infrastructure, improving quality and effectiveness demands attention to management systems, and responsiveness to the problems of citizens and communities.

PAC's millennium survey concludes that governance is not 'primarily a function of the income levels of states'. Political leadership, stability of regimes, discipline in the bureaucracy and a more active "local voice" are more likely responsible for better outcomes.

Drawing from the successful examples of such initiatives the government should

itself put in place institutional mechanisms to involve public participation in the design and evaluation of public services. Systems and mechanisms also need to be put in place for public disclosure relating to performance of social service delivery systems, both public and private, and to increase awareness among the public for exerting pressure on the system to perform

### Box 8: Millennium Survey - Public Affairs Committee

The Public Affairs Centre, Bangalore is an independent organisation dedicated to improving the quality of governance in the country. It gained prominence with its 1993 initiative to introduce a "report card" system to create greater public awareness about the performance of public service providers and to make them more responsive to citizens' (customers') needs.

The Millennium Survey by the PAC undertook a nation-wide, independent study of user-feedback focussing on five basic public services: drinking water, health and sanitation, education and child care, public distribution system (fair price shops) and road transport.

Three key objectives of the study were to: (i) provide a well focussed and independent assessment of key public services; (ii) create an independent database and benchmarks to help measure progress and performance of services over time; and (iii) stimulate public debate on critical issues affecting users of public services.

The survey covered 36,542 households in 115 districts spread over 24 states. ORG-MARG assisted in the design of the field research, execution of the survey and analysis of the findings.

The project was financed from the internal resources of the PAC and a grant from the Ford Foundation.

## Transparency and Right to Information

Access to information is essential if service providers and government are to be held accountable. If the Government of India and some states have now legislated on the right to information, it owes not a little to the revolutionary and indefatigable efforts of the Ms. Aruna Roy and the Mazdoor Kisaan Shakthi Sangathan (MKSS) since the early 1990s.

MKSS of Rajasthan was the first to take a lead in holding public hearings (*jan sunvais*) in the early '90s by demanding access to muster rolls, vouchers and records of bill payments of development projects. Evidence of wrongdoings by panchayats and village authorities was sought to be presented to the community at large, through the medium of public hearings. *Jan Sunvais* (public hearings) have been established as a process of social audit of government's performance. It was later attempted in certain areas in Orissa and more are being planned in other parts of the country. (Rana) (Also see Box 9)

### **Box 9: Jan Sunvai (Public Hearing)**

"Ab aaye parivartan ki aandhi"-the slogan rightly captured the mood of the crowd in the Sundernagari area of north-east Delhi on the 14th of December 2002, where people came together for the first of its kind jan sunvai (public hearing) to be held on urban development expenditure.

Never before had any urban area in India experienced such an exercise where government records of completed works were discussed between the people, the government functionaries and local politicians out in the open. Jan Sunvai essentially involves getting official records about development /public works, verifying the actual work done vis-à-vis the work reflected in the records in the presence of members of the community and presenting these findings to the community in the presence of government officials, local politicians, eminent persons etc. The jan sunvai was organised by Parivartan (a Delhi based NGO) together with the Mazdoor Kisan Shakti Sangathan (MKSS) and the National Campaign for Peoples Right to Information (NCPRI), coming just days after the Lok Sabha passed the elusive Freedom of Information Bill 2002.

The crowd was large, with women clearly taking the lead. Eminent persons like Justice P.B. Sawant, Aruna Roy, Prabhash Joshi, along with high-level government officials like Dr. K.B. Rai (Deputy Director, Administrative Reforms) attended the proceedings as panellists.

The issues under discussion were those of construction of lanes, drainage pipes, public toilets etc, seeing a clear clash of interests between the local residents and the public officials.

Source: Jan Sunvai: Right to Information now a reality By Swasti Rana, Commonwealth Human Rights Initiative (<http://www.humanrightsinitiative.org/programs/ai/rti/india/articles/Jan%20Sunvai-%20Right%20to%20Information%20now%20a%20reality.pdf> - accessed on June 27, 2004)

### **Role of Women in Society**

*"Human attainments appear to be better and more sustained in those parts of the country where there is social mobilisation for human development, and where female literacy and empowerment encourages women to have a say in the decision making process at the household level."*

*National Human Development Report 2001  
Planning Commission, Government of India*

The correlation of high levels of female literacy with improved human development indices are fairly well documented. Paul Dreze (2003) attributes the relatively better delivery of services in Tamil Nadu, in education, health and public distribution system, to the role of women in society. As women's votes in Tamil Nadu matter a great deal because they are relatively well informed and vote with their own mind, political leaders are forced to pay attention to women's aspirations, including those relating to health and education, he observes. Women are the prime movers of social services in Tamil Nadu. The only state in North India that is comparable in performance to Tamil Nadu in social development is Himachal Pradesh, which has much in common with Tamil Nadu in regard to the role of women in society, he adds.

### **Decentralisation**

Decentralisation implies transfer of authority and responsibility from the higher (centralised) levels of government to the lower tiers of administration, closer to the grassroots of administration and the points of delivery of public services. There is no gainsaying that decentralisation enhances the effectiveness of service delivery: local needs and demands are better articulated and heeded, and transparency and accountability are heightened.

The 73rd and 74th amendments to the Constitution of India sought to entrust local bodies (panchayat raj institutions and municipalities) with greater responsibilities, and to empower them to discharge these responsibilities. The basic objective underlying these amendments was to decentralise functions to the administrative levels best suited to carry them out. Entry 17 of the Eleventh Schedule of the Constitution (introduced as part of the 73rd amendment) setting out the responsibilities of panchayats relates to education, including primary and secondary schools, while Entries 23 and 24 concern health and sanitation, and family welfare respectively. Likewise, Entry 6 in the Twelfth Schedule outlining the responsibilities of municipal bodies relates to public health, sanitation etc. and Entry 13 concerns promotion of education. Unlike the rigid division of responsibilities and functions in the Constitution between the centre and the states, the 73<sup>rd</sup> and 74<sup>th</sup> Amendments only suggest a list of responsibilities that may be entrusted to local bodies.

Merely transferring authority and responsibilities to local bodies without empowering them financially would serve little purpose. State finance commissions are set up every five years in the states to recommend devolution of resources to local bodies. Analysing budget data

from seven states, Jha (2002) suggests some measures for strengthening fiscal decentralisation to local bodies.

The approach to the Tenth Five Year Plan concedes that merely establishing more schools or hiring more teachers would not necessarily lead to improvement in the quality of education, if teachers remain absent as is common in many parts of the country. It therefore recommends states should transfer control over schools and teachers to local bodies and implement the 73<sup>rd</sup> and 74<sup>th</sup> amendments to facilitate transfer of management of primary and upper primary schools to panchayats / local bodies<sup>49</sup>. The successful initiatives by local communities in Rajasthan and West Bengal referred to earlier are encouraging.

However, decentralisation, people's participation and community involvement are not without potential pitfalls. Adequate statutory or other institutional safeguards may have to be provided to ensure that powerful, local socio-economic groups do not deny disadvantaged sections or communities access to services. (Puri, 2004)

There could be other limitations to participation as well. Goetz and Gaventa (2001) enter two caveats. They point out that though citizen participation in the design, delivery and monitoring would in general result in better information flows about the needs of clients, greater transparency and better accountability, there could be some services where direct citizen engagement is neither desirable nor possible. For, considerations such as privacy and confidentiality can restrict the scope for citizen engagement – though these could be exaggerated to keep citizens out. Secondly, merely because initiatives emanate from civil society they are not necessarily more democratic or better designed or more effective than the efforts and actions of the public sector. Further, there could be inherent limits to citizens' interest in and capacity for participation, owing partly to other commitments and demands on their time. Besides, it is a moot assumption that citizens value direct participation more than 'improved responsibility and trusteeship amongst public service providers-a trusteeship which enables citizens to withdraw from everyday participation and leave the monitoring of service quality to professionals.'

Another point to be borne in mind is that enthusiasm for public and citizen participation should not go overboard so as to undermine established institutions and processes available for articulating opinion and giving voice to political will.

### ***Using IT for Improving Service Delivery***

Recent years have witnessed tremendous advances in information and communication technology (ICT). Citizens and administration alike have powerful tools at their command that enable access to information, public consultation, and engaging citizens in policy making and improving delivery of public services.



The 'Hole in the Wall' project sponsored by the International Finance Corporation, a World Bank affiliate, illustrates how information technology can be employed to spread education among slum children. (See Box 10). In 2002, the Asia-Pacific Programme of Education for All (APPEAL) launched the project "ICT Application for Non-Formal Education Programmes" with the support of the Japanese Funds-in-Trust. Currently in the first phase of the project, five countries (Indonesia, Lao PDR, Sri Lanka, Thailand and Uzbekistan) are implementing programmes and activities to empower communities through the effective use of ICT.<sup>50</sup> UNESCO's APPEAL project has supported member states in: systematizing non-formal education curriculum; training personnel; and developing learning materials. Since the late

<sup>49</sup> Approach to the Tenth Five Year Plan, paragraph 3.59

<sup>50</sup> <http://www.unescobkk.org/education/ict/v2/info.asp?id=15643> - accessed on 17 Dec. 04

1990s, APPEAL has also been promoting the concept of Community Learning Centres (CLCs) for generating grassroots based interest and participation in literacy, basic education and continuing education activities for disadvantaged people. Using the potential of ICT, the project explores more effective use of existing resources, with a view to widening access to and improving the relevance and quality of learning.<sup>51</sup>

#### Box 10: Use of ICT in Education

##### Hole-In-The-Wall



##### Training



##### Systems

The International Finance Corporation, a World Bank subsidiary has invested \$1.6 million in a project called 'Hole in the Wall', where computer kiosks are being placed in urban slums and street children with almost no education are teaching each other on the use of computers. The project encourages underprivileged children in India to learn from a web-based curriculum through Internet kiosks, which will be installed in more than 60 locations over the next three years. The aim is to improve education for poor children, ensuring equal access for girls and boys.

The project began in early 1999, on the initiative of Dr. Mitra, who heads research and development at the National Institute for Information Technology Limited (NIIT), a leading computer software and training company in New Delhi. Just outside his office is a wall that separates his air-conditioned 21st-century office from a slum. Mitra decided to place a high-speed computer in the wall, connect it to the Internet, and watch who, if anyone, might use it. To his delight, curious children were immediately attracted to the strange new machine. Within minutes, the children had figured out how to point and click. By the end of the day they were browsing.

NIIT went on to conduct further studies to determine if illiterate slum children could use the Internet without instruction. The ICT-education firm set up continuous video tape monitoring of the computer that they had set up. The video showed that young boys and girls from the settlement became highly proficient at using various features of the computer regardless of lack of proficiency in English, and without any instruction. Already ubiquitous in New Delhi and Mysore, the Hole-in-the-wall systems are due to be spread throughout the country.

Source: <http://www.unescobkk.org/education/ict/v2/info.asp?id=15339> - accessed on 13 Dec. 04

Recent major advances in information and communications technology (ICT) has made it possible to develop and organize new ways of providing efficient health-care services. Consequently, there is a dramatic increase in the use of ICT applications in health care, which is becoming a reality in developed and developing countries alike. Obviously, PCs may not be available at each primary health care centre in developing countries. An even wider constraint could be connections and networks that make communication between different pieces of equipment and health care personnel possible. But when they become established they hold a tremendous potential for taking specialists to primary health care e.g. through tele-conferences. The question therefore is not whether ICT is an option for developing countries, since it already is. 'The main challenge is [to] make sure that these options are used optimally and in a coordinated manner to ascertain that the desired effects do come through and that resources are indeed not diverted away from basic needs.'<sup>52</sup>

An eloquent example of the use of ICT in healthcare is the work being done by The George Foundation to improve the quality of healthcare services in PHCs and in rural communities. Their strategy is to provide effective early medical intervention and deliver expert health care by using technology to overcome the handicap faced by patients and health-workers because of poor logistics and long travel time. They also view this as an important strategy to tackle the reluctance of doctors to practice in or travel to rural or remote areas, which is unlikely to disappear soon. Health education focussing on family planning, hygiene, sanitation, and prevention of communicable diseases is another important role identified by them for PHCs.

<sup>51</sup> <http://www.unescobkk.org/education/ict/v2/info.asp?id=10957> - accessed on 17 Dec. 04

<sup>52</sup> <http://www.who.int/bct/eHealthHCD/> - accessed on 17 Dec. 04

Another commendable example of 'telemedicine' are the initiatives and endeavours of Dr. Devi Shetty<sup>53</sup> of Bangalore

But information and communications technologies are just instruments; aids to better governance through sharing and dissemination of information, and involving citizens in public policy, decision-making and improved service delivery. Their effective use, however, presupposes (a) a certain level of commitment by government and public agencies to sharing of and giving access to information, (b) acceptance of public consultation as central to policy-making, and (c) genuine conviction that public partnership is a relationship to be nurtured.

Advances in ICT can contribute significantly in all three areas – spread of information, public consultation, and public private partnership – both singly, and in combination with traditional approaches, given a basic commitment to public involvement in the delivery of services.

### ***Key Elements of Service Delivery***

Summing up the key points from presentations at a conference on service delivery<sup>54</sup>, Trevor Holdsworth recalls that people management, financial and asset management, technology and information, and combating corruption are the four main pillars of service delivery. This is graphically represented with these four key points as spokes of a wheel, with the community as the hub and the government as the rim (Box 11). 'The community, who are traditionally perceived as passive recipients or consumers are placed at the centre or hub of the wheel while the government who have also been perceived as 'all-knowing provider' appear as the rim of the wheel. However, the four spokes can be viewed as conduits of communication between the government and the community thus signifying the importance of ongoing consultations between the two. The community thus becomes a consumer and also experts in what they need and the government becomes a service deliverer whose activities are determined by the community.'

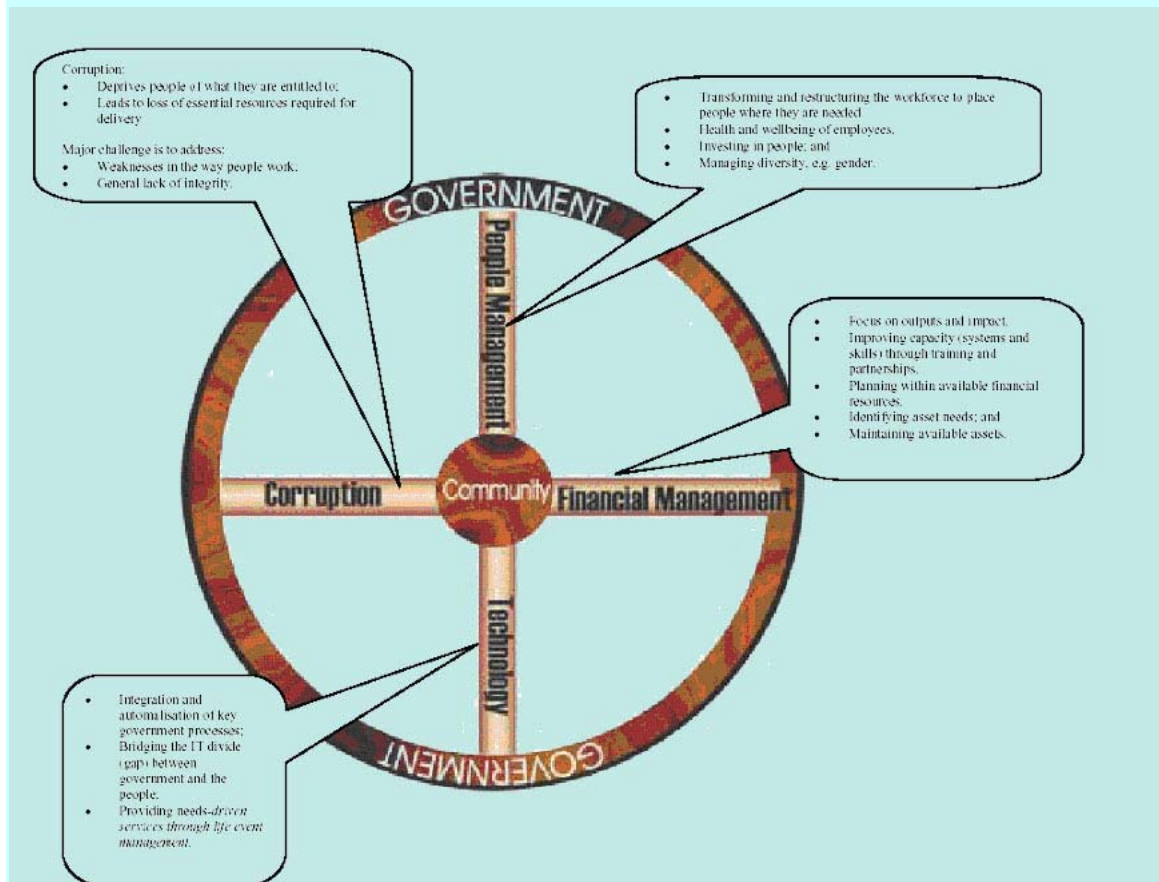
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<sup>53</sup> Dr. Devi Shetty is Director of Narayana Hrudayalaya Heart Hospital in Bangalore

<sup>54</sup> Public Service Learning Academy, Nelspruit, South Africa

He rightly observes that improvement in service delivery, including quality of service, is a continuous process that demands a long-term commitment with shared vision and goals, clear strategies and co-operation from different sectors of society. Integrated effort, shared responsibility and strong partnership between society and various stakeholders, he adds, are key central elements. Communication and consultation are key factors to success, he emphasizes recalling the principles of *batho pele*<sup>55</sup>, which means 'people first'.

### Box 11: Central Elements of Service Delivery



Source: Enabling strategies for effective and innovative service delivery by Trevor Holdsworth-*“Voices from the Trenches”*

### Policy Recommendations

Given their fiscal stress and the limited fiscal space available to them, states face a daunting and challenging task in raising public spending on essential social sectors. It can, therefore, come about mainly through: (a) critical review of existing programmes with a view to eliminating those that have outlived their relevance or utility; (b) revamping and coalescing programmes and schemes with identical or similar objectives; and (c) re-orienting of priorities to reflect changing and current needs.

<sup>55</sup> The South African government had brought out a white paper on „batho pele”, for transforming public service delivery. The eight guiding principles for batho pele are: (i) consultation, (ii) service standards, (iii) courtesy, (iv) access, (v) information, (vi) openness and transparency, (vii) dealing with complaints, and (viii) giving best value. This is quite similar to the 1991 UK Citizens’ Charter referred to above at paragraph 0

Merely increasing budgetary allocations for education, health (and other social service sectors) will not necessarily lead to improved quality and better delivery of services. It is the composition and quality of expenditure, and efficiency in the use of resources that determines outcomes. Even so, one cannot ignore that financial resources are an important and essential input for enlarging access and ensuring equity in the delivery of services. Increased spending should therefore be accompanied by simultaneous efforts at (i) achieving productivity gains through efficiency in the use of resources and better value for money; (ii) improved targeting; (iii) association of the private sector to supplement state efforts and to generate a competitive environment; and (iv) bringing about greater and purposeful accountability by involving the community and users of services.

The discussion in the foregoing sections refers to many innovative initiatives, both within and outside the country, which provide useful pointers and lessons to improve service delivery in terms of enlarging access, improving quality, increasing accountability, and harnessing information and communication technology in furtherance of these.

In this background, some specific recommendations for policy initiatives are made, some of which are financial in nature while others relate to service delivery:

Though the Common Minimum Programme of the United Front Alliance (currently in government at the Centre) speaks of raising spending on education in a phased manner to 6% of GDP from the current level of 3%, it has set no timetable for this. Public spending on education needs to be raised to 6% of GDP from the current level of 3% of GDP, by 2010 at least. Further, currently spending on pre-primary and primary education is a little over 38% of total spending on education, which should be raised to at least 50% by 2010.

In addition to increasing spending on education, the allocations for non-salary expenditures need to be substantially and progressively stepped up in real terms to provide essential basic amenities (like drinking water, toilets –especially for girl students) and at least minimal infrastructure.

Greater efforts should be made, including improving the quality of education, to achieve the MDG targets concerning cohorts reaching grade 5 and achieving gender parity in universalization of primary education. Involvement of the community, NGOs and civil society must be keenly pursued.

State intervention and community involvement through awareness campaigns are called for to overcome the intrinsic bias against education of girl children. One should look beyond the private gains from educating girls to the larger benefits to society.

Public investment in health is very low at less than 1% of GDP. The National Health Policy 2002 target of increasing public investment on health to 2% of GDP by 2010 falls short of the recommendation of the Commission on Macroeconomics and Health. The Commission recommended that developing countries should raise domestic budgetary spending by one percentage point of GNP by 2007 (from current levels) and by an additional percentage point by 2015, and that resources should be used more efficiently.

India should at least aim to meet these targets. Besides, the non-salary component of public investment in health should be substantially and progressively raised in real terms.

Further, the disproportionate emphasis on curative rather than preventive aspects needs to be redressed.

The current per-capita expenditure of the centre and states on health is less than Rs. 200 (about US \$4.5) whereas the Commission on Macroeconomics and Health observes that to address the health challenges the minimum financing needs (even) in low-income countries should be US\$ 30-40 per person per year to cover essential interventions, including those needed to fight the AIDS pandemic.

India should therefore aim to at least double the per-capita domestic budgetary spending by 2007 and to at least quadruple it by 2015, more so in view of the alarming rise in the incidence of HIV/AIDs in the country.

There are indications of heavy concentration of infant deaths in a relatively small number of districts and villages in the country. Infant mortality could be brought down considerably by first identifying and then targeting mortality-reducing interventions to those districts and villages with the largest number of infant deaths.

The ADB warns of an imminent looming crisis on HIV / AIDs. Urgent concerted and concentrated interventions are therefore required in battling it.

To combat the problem of absenteeism by doctors at PHCs and in rural areas, the example of Maharashtra and some other states which passed legislation requiring obligatory rural service before one can gain admission to post-graduate courses could be adopted by others.

Appointment of doctors on contractual basis, devolving supervisory and administrative control to panchayats, and granting special monetary incentives could also be attempted.

The use of ICT in providing healthcare to overcome the reluctance of doctors to serve in or travel to remote and rural areas should be fully exploited.

To bring about greater responsiveness and accountability, recruitment procedures in government need to be reviewed and revised to permit contractual appointments, at least in peripheral activities and functions to start with.

Contracting out some functions, at least non-core functions to begin with, should merit serious consideration. Appropriate capabilities, including designing and negotiating contracts, would need to be inculcated in the bureaucracy, if an effective regulatory and enforcement framework is to be put in place.

Participation of the private and voluntary sectors in the delivery of services can expand access to services, apart from affording users greater choice and thereby generating competition too. Issues of affordability by the poor and equity in regard to services available through the private sector can be tackled through appropriate state interventions, vouchers, and the like.

Suitable regulatory mechanisms and framework should be devised to ensure standards and equity in the provision of services by the private sector.

Further, while incentives to the private sector may have improved access to education and health care, little attention has been paid to equity issues, mainly because of non-existent or weak and ineffective monitoring mechanisms. This lacuna could perhaps be dealt with by entrusting monitoring of obligated service provisions to decentralised local bodies or non-governmental organisations.

Involving outsiders or independent agencies in reviews relating to public service delivery programmes could enhance accountability. However, for such reviews to be really effective, involvement of outsiders should be enjoined by legal provisions.

States that have yet to pass legislations on right to information must do so without delay. Right to information legislation should not be hemmed in by restrictions and procedures that frustrate the underlying intention of transparency, accountability and fighting corruption.

## Annex 1: Millennium Development Goals

<b>Millennium Development Goals (MDGs)</b>	
<b>Goals and Targets (from the Millennium Declaration)</b>	<b>Indicators for monitoring progress</b>
<b>Goal 1: Eradicate extreme poverty and hunger</b>	
<b>Target 1:</b> Halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day	1. Proportion of population below \$1 (PPP) per day <sup>a</sup> 2. Poverty gap ratio [incidence x depth of poverty] 3. Share of poorest quintile in national consumption
<b>Target 2:</b> Halve, between 1990 and 2015, the proportion of people who suffer from hunger	4. Prevalence of underweight children under-five years of age 5. Proportion of population below minimum level of dietary energy consumption
<b>Goal 2: Achieve universal primary education</b>	
<b>Target 3:</b> Ensure that, by 2015, children everywhere, boys and girls alike, will be able to complete a full course of primary schooling	6. Net enrolment ratio in primary education 7. Proportion of pupils starting grade 1 who reach grade 5 8. Literacy rate of 15-24 year-olds
<b>Goal 3: Promote gender equality and empower women</b>	
<b>Target 4:</b> Eliminate gender disparity in primary and secondary education preferably by 2005 and to all levels of education no later than 2015	9. Ratios of girls to boys in primary, secondary and tertiary education 10. Ratio of literate females to males of 15-24 year-olds 11. Share of women in wage employment in the nonagricultural sector 12. Proportion of seats held by women in national parliament
<b>Goal 4: Reduce child mortality</b>	
<b>Target 5:</b> Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate	13. Under-five mortality rate 14. Infant mortality rate 15. Proportion of 1 year-old children immunised against measles
<b>Goal 5: Improve maternal health</b>	
<b>Target 6:</b> Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio	16. Maternal mortality ratio 17. Proportion of births attended by skilled health personnel
<b>Goal 6: Combat HIV/AIDS, malaria and other diseases</b>	
<b>Target 7:</b> Have halted by 2015 and begun to reverse the spread of HIV/AIDS	18. HIV prevalence among 15-24 year old pregnant women 19. Condom use rate of the contraceptive prevalence rate <sup>b</sup> 20. Number of children orphaned by HIV/AIDS <sup>c</sup>
<b>Target 8:</b> Have halted by 2015 and begun to reverse the incidence of malaria and other major diseases	21. Prevalence and death rates associated with malaria 22. Proportion of population in malaria risk areas using effective malaria prevention and treatment measures <sup>d</sup> 23. Prevalence and death rates associated with tuberculosis 24. Proportion of tuberculosis cases detected and cured under directly observed treatment short course (DOTS)
<b>Goal 7: Ensure environmental sustainability</b>	
<b>Target 9:</b> Integrate the principles of sustainable development into country policies and programmes and reverse the loss of environmental resources	25. Proportion of land area covered by forest 26. Ratio of area protected to maintain biological diversity to surface area 27. Energy use (kg oil equivalent) per \$1 GDP (PPP) 28. Carbon dioxide emissions (per capita) and consumption of ozone-depleting CFCs (ODP tons) 29. Proportion of population using solid fuels
<b>Target 10:</b> Halve, by 2015, the proportion of people without sustainable access to safe drinking water	30. Proportion of population with sustainable access to an improved water source, urban and rural
<b>Target 11:</b> By 2020, to have achieved a significant improvement in the lives of at least 100 million slum dwellers	31. Proportion of urban population with access to improved sanitation 32. Proportion of households with access to secure tenure (owned or rented)
<b>Goal 8: Develop a global partnership for development</b>	

<p><b>Target 12:</b> Develop further an open, rule-based, predictable, non-discriminatory trading and financial system Includes a commitment to good governance, development, and poverty reduction – both nationally and internationally</p> <p><b>Target 13:</b> Address the special needs of the least developed countries Includes: tariff and quota free access for least developed countries' exports; enhanced programme of debt relief for HIPC and cancellation of official bilateral debt; and more generous ODA for countries committed to poverty reduction</p> <p><b>Target 14:</b> Address the special needs of landlocked countries and small island developing States (through the Programme of Action for the Sustainable Development of Small Island Developing States and the outcome of the twenty-second special session of the General Assembly)</p> <p><b>Target 15:</b> Deal comprehensively with the debt problems of developing countries through national and international measures in order to make debt sustainable in the long term</p>	<p><i>Some of the indicators listed below are monitored separately for the least developed countries (LDCs), Africa, landlocked countries and small island developing States.</i></p> <p><u>Official development assistance</u></p> <p>33. Net ODA, total and to LDCs, as percentage of OECD/DAC donors' gross national income</p> <p>34. Proportion of total bilateral, sector-allocable ODA of OECD/DAC donors to basic social services (basic education, primary health care, nutrition, safe water and sanitation)</p> <p>35. Proportion of bilateral ODA of OECD/DAC donors that is untied</p> <p>36. ODA received in landlocked countries as proportion of their GNIs</p> <p>37. ODA received in small island developing States as proportion of their GNIs</p> <p><u>Market access</u></p> <p>38. Proportion of total developed country imports (by value and excluding arms) from developing countries and LDCs, admitted free of duties</p> <p>39. Average tariffs imposed by developed countries on agricultural products and textiles and clothing from developing countries</p> <p>40. Agricultural support estimate for OECD countries as percentage of their GDP</p> <p>41. Proportion of ODA provided to help build trade capacity<sup>e</sup></p> <p><u>Debt sustainability</u></p> <p>42. Total number of countries that have reached their HIPC decision points and number that have reached their HIPC completion points (cumulative)</p> <p>43. Debt relief committed under HIPC initiative, US\$</p> <p>44. Debt service as a percentage of exports of goods and services</p>
<p><b>Target 16:</b> In co-operation with developing countries, develop and implement strategies for decent and productive work for youth</p>	<p>45. Unemployment rate of 15-24 year-olds, each sex and total<sup>f</sup></p>
<p><b>Target 17:</b> In co-operation with pharmaceutical companies, provide access to affordable, essential drugs in developing countries</p>	<p>46. Proportion of population with access to affordable essential drugs on a sustainable basis</p>
<p><b>Target 18:</b> In co-operation with the private sector, make available the benefits of new technologies, especially information and communications</p>	<p>47. Telephone lines and cellular subscribers per 100 population</p> <p>48. Personal computers in use per 100 population and Internet users per 100 population</p>

. *The Millennium Development Goals and targets come from the Millennium Declaration signed by 189 countries, including 147 Heads of State, in September 2000 ([www.un.org/documents/ga/res/55/a55r002.pdf](http://www.un.org/documents/ga/res/55/a55r002.pdf) - A/RES/55/2).*

The goals and targets are inter-related and should be seen as a whole. They represent a partnership between the developed countries and the developing countries determined, as the Declaration states, "to create an environment – *at the national and global levels alike – which is conducive to development and the elimination of poverty.*"

a For monitoring country poverty trends, indicators based on national poverty lines should be used, where available.

b Amongst contraceptive methods, only condoms are effective in preventing HIV transmission. The contraceptive prevalence rate is also useful in tracking progress in other health, gender and poverty goals. Because the condom use rate is only measured amongst women

in union, it will be supplemented by an indicator on condom use in high risk situations. These indicators will be augmented with an indicator of knowledge and misconceptions regarding HIV/AIDS by 15-24 year-olds (UNICEF – WHO).

c To be measured by the ratio of proportion of orphans to non-orphans aged 10-14 who are attending school.

d Prevention to be measured by the % of under 5s sleeping under insecticide treated bednets; treatment to be measured by % of under 5s who are appropriately treated.

e OECD and WTO are collecting data that will be available from 2001 onwards.

f An improved measure of the target is under development by ILO for future years.

(Source: <http://www.oecd.org/dataoecd/30/28/2754929.pdf>- accessed on May 29, 2004)

## **Annex 2: Innovative Programmes in Education - Extract from Plan Document**

### **Box 2.2.3**

#### **INNOVATIVE PROGRAMMES IN EDUCATION IN DIFFERENT STATES**

Several state governments have designed innovative programmes to improve the quality of education in schools.

##### **HEAD START**

The Rajiv Gandhi State Mission in Madhya Pradesh has introduced a project on a pilot basis for using computers to improve the quality of teaching in rural elementary schools through indigenous customised educational software. The idea is to integrate the use of computers with classroom activities to improve the child's comprehension of difficult parts of each subject as well as to instill computer literacy. A syllabus mapping the difficult areas of learning has been developed and educational software on this for all subjects is being prepared for use in the academic year 2002-03.

Started in November 2000, 648 Head Start centres were operationalised in middle schools that have a primary section and serve as Jan Shiksha Kendras or school cluster resource centres for primary schools in a radius of eight km. A total of 2,358 teachers have been given training in computer-enabled education.

##### **GYANKALASH**

The District Primary Education Programme in Himachal Pradesh, in collaboration with All India Radio, Shimla, has started a 15-minute bi-weekly programme called Gyankalash to provide academic support to primary teachers. The programme helps in improving the teachers' access to the knowledge, especially those in the remote areas as it is impossible to reach them through conventional means.

In the first phase of Gyankalash, topics were identified and radio scripts developed in workshops organised for the purpose. Resource persons, teacher educators from state and district level, practising teachers in secondary and primary schools participated in the workshops.

In the next phase, teachers and students from government primary schools were involved in the production and broadcast of the spots.

In order to motivate teachers, certificates were given to teachers on the successful completion of the training under different phases of Gyankalash.

##### **NALI KALI**

The Nali Kali programme in Karnataka was introduced in privately managed schools in 1999. Under the programme, learning takes place in an interactive situation in accordance with age-wise competency. Children are divided into groups and they master one level of competency, then move to another group to learn the next level of competency. Children learn at their own pace and the move from one level of competency to another is not dependent on the whole group's learning achievement. All teaching-learning processes involve songs, games, survey, story telling and use of educational toys. This method effectively eliminates the formal system of roll calls, examination, promotions, ranking – all these now deemed unhealthy – at least between the of 5 and 14.

### Annex 3: References

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#### Abbreviations and Acronyms

ADB	Asian Development Bank
AP	Andhra Pradesh
ASCI	Administrative Staff College of India
ASHA	Accredited Social Health Activist
BE	Budget Estimate
BIMARU	Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh
CMP	Common Minimum Programme
CRC	Committee on the Rights of the Child
CSO	Central Statistical Organisation
DFID	Department for International Development, UK
DISHA	Development Initiatives for Social and Human Action

EFA	Education for All
EGS	Education Guarantee Scheme
HDI	Human Development Index
ICT	Information and Communication Technology
MDG	Millennium Development Goal
MKSS	Mazdoor Kisaan Shakthi Sangathan
MLL	Minimum Level of Learning
MVF	Mamidipudi Venkatarangaiya Foundation
NFHS	National Family and Health Survey
NRI	Non-Resident Indian
NRMH	National Rural Health Mission
NSS	National Sample Survey
PAC	Public Affairs Centre, Bangalore
PHC	Primary Health Centre
PRI	Panchayat Raj Institution
RBI	Reserve Bank of India
RE	Revised (Budget) Estimate
SEWA	Self Employed Women's Association (Gujarat)
SIDA	Swedish International Development Authority
SKP	Shiksha Karmi Project
UEE	Universal Elementary Education
UFA	United Front Alliance
UPE	Universal Primary Education
WASH	Water Sanitation and Hygiene
WHO	World Health Organisation