
UNIT 24 EDUCATION AND HEALTH

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24.0 OBJECTIVES

After reading this unit you will be able to:

- 1 explain the meaning and importance of the concept of human capital;
- 1 discuss the present state of the education sector in India;
- 1 identify the strengths and weaknesses of the education sector;
- 1 discuss the outlined future education policy for India;
- 1 appraise the present state of the health sector in India;
- 1 outline the recent initiatives of the government in the health sector of India;
- 1 explain the linkage between health and poverty;
- 1 compare the differential health status between groups (i.e. male-female, rural-urban, different states) in terms of major health indicators; and
- 1 identify the causes of poor health vis-à-vis the existing health care system and policy initiatives.

24.1 INTRODUCTION

Education and health contribute to build up what has come to be known as 'human capital'. Human capital is distinct from 'physical capital' but is complementary to the latter. Physical capital facilitates economic growth which, in turn, creates conditions which demand better education and health facilities. This results in human capital formation in the economy. Human capital formation, in turn, spurs economic growth. Thus, these social aspects of development invariably attract the attention of both policy-planners and political leaders albeit with differing motivations for each. In this context, the present unit discusses the issues relating to the two specific sub-sectors of social sector development viz. education and health in the Indian economy.

24.2 CONCEPT AND SIGNIFICANCE OF HUMAN CAPITAL

Human capital can be defined as the body of knowledge possessed by the population and the capacity of the population to use the knowledge effectively.

Till the late 1950s, economists and other social scientists did not pay much attention to the role of investment in human capital as an important determinant of economic development. The birth of this idea can be

traced to the presidential address of Prof. Theodore W. Schultz to the American Economic Association in December, 1960. Following this, the concept of human capital formation came to occupy the center stage as the economists and other social scientists began to look more closely at the functions that human capital can perform in the process of economic development.

24.2.1 Significance of Human Capital

In the present day emerging economies like India the significance of human capital arises from the following:

1. 21st century will promote people who respond to technology (@ speed of thought as Bill Gates has said in his recent book). It will reject those who refuse to move fast enough.
2. There is a technological shift to knowledge-based, brainpower industries. Brain power industries do not have a natural home and can be located anywhere. Smart countries are those who attempt to make themselves attractive to the brainpower industry by educating their people and creating the required brainpower through education and training.
3. In the knowledge economy, the value of intangible assets is increasing and that of tangible assets decreasing. In order to have a cutting edge in this scenario, having only the right kind of technology is not enough – rather a proper organisational climate with the right people competencies is critical.
4. Modern physical technology, which is becoming more and more complex, requires the back up of an advanced social technology. Social technology covers all advances in skills acquired by people individually and collectively.
5. All the well-known breakthroughs in physical technology would not have been possible if they were not preceded by relevant social innovations. Social innovations fosters the birth of more advanced physical technologies, taking them to further matured levels.
6. Higher education is believed to promote independence and initiative, both of which are valuable intellectual resources for the generation and dissemination of knowledge in society.
7. Available evidence in almost all the countries, including India, establish significant —
 - 1 positive association between proportion of people below the poverty line and the proportion of illiterate persons;
 - 1 negative correlation between female literacy and birth rate;
 - 1 positive correlation between years of schooling and net increase in farm production.

8. Poverty is both a cause and consequence of deficiencies in human development. With poverty alleviation at the top of the development agenda, a serious assault on poverty will no doubt bring human beings into focus as the major beneficiaries of development. Increased public spending on aspects of human development is more likely to have a greater impact on poverty reduction and, at the same time, in improving human development.

In short, human resource development is an important condition for improving productivity which hold the key to economic development. Indeed, the available empirical evidence testifies that poverty ceases to be a handicap when a poor country builds up human capital and then uses the low cost skilled labour with global capital to produce a competitive skilled work force. The developing economies have already over-taken the developed economies in many fields particularly in the sector of labour-intensive production.

24.3 EDUCATION SECTOR IN INDIA

The role of education in facilitating social and economic progress is well recognised. It opens up opportunities leading to enhancement of both individual and group potentials. Education, in its broadest sense, is the most crucial input for empowering people with skills and knowledge, giving them access to productive employment opportunities. Improvements in education are not only expected to enhance efficiency but also augment the overall quality of life. The current growth strategy being pursued in India places the highest priority on education as a central instrument for achieving rapid and inclusive growth. It encompasses programmes designed to strengthen the education sector covering all segments of the education pyramid viz. (i) elementary education, (ii) secondary education, and (iii) higher education.

24.3.1 Elementary Education

The 86th Constitutional Amendment of 2002 led to inclusion of a new article 21-A in Part III of the Constitution providing for free and compulsory education to all children of 6 to 14 years of age as a Fundamental Right. Pending enactment of a suitable follow-up legislation (till end of 2008), the amendment has not yet been enforced. However, it is recognised as imperative to ensure good quality elementary education to all children in the age group of 6 to 14 years. Elementary Education, that is, Class I-VIII consisting of primary (I-V) and upper primary (VI-VIII) levels is the foundation of the educational system pyramid and has been emphasised in all our programmes of development. The goal of universalisation of elementary education (UEE) got a big push with the adoption of the *Sarva Shiksha Abhiyan* (SSA) programme in 1999. The scheme has been guided by the following five principles:

- 1 Universal access
- 1 Universal enrolment
- 1 Universal retention
- 1 Universal achievement
- 1 Equity

The specific aims of the SSA are :

- i) All children to be enrolled in regular school by 2005;
- ii) All gender and social category gaps at primary stage to be bridged by 2007 and at elementary education level by 2010;
- iii) Universal retention by 2010; and
- iv) Focus on elementary education of satisfactory quality with emphasis on education for life.

SSA has brought primary education to the doorstep of millions of children, including first generation learners, through successive fast track initiatives in hitherto underserved habitations.

24.3.2 Secondary Education

Secondary education serves as a bridge between elementary and higher education. Since universalisation of elementary education has become an accepted goal, it has become essential to push this vision forward to move towards universalisation of secondary education, something which has already been achieved in a large number of developed countries and the newly industrialised East Asian economies.

Till now, the thrust of secondary education has been on improving access and reducing disparities by emphasising on the Common School System in which it is mandatory for schools in a particular area to take students from low-income families in the neighbourhood. The thrust has also been on revision of curricula with an emphasis on vocationalisation of education. In essence, vocationalisation means focusing on providing employment-oriented courses. Other areas of thrust are: expansion and diversification of the open learning system, reorganisation of teacher training, etc. These objectives till now (2009) have, however, been achieved only partly.

24.3.3 Higher Education

The investment made in higher education in the 1950s and 1960s has given India a strong knowledge base in many fields and contributed significantly to economic development, social progress, and political

democracy in Independent India. At the time of independence, the number of universities was no more than 20 and colleges around 500. The total enrolment was less than 1 lakh. By the end of the Tenth Five Year Plan, the Indian higher education system has grown into one of the largest in the world with 378 universities, 18,064 colleges, a faculty strength of 4.92 lakhs, and enrolment of 140 lakh students.

Despite the expansion that has occurred, the system is under stress to supply the required numbers of skilled human power, equipped with the required knowledge and technical skills helpful in catering to the demands of the economy. The accelerated growth of the economy has already created shortages of high-quality technical manpower. Unlike the developed countries, where the young working age population is fast shrinking with higher dependency ratio, India is in a stage of demographic transition (recall what you have read in Unit-7) with about 70% of the population below the age of 35 years. But this advantage can be realised to economic advantage only if opportunities for youth are expanded on a scale and diversity spread over different fields of basic sciences, engineering and technology, health care, architecture, management, etc. This is possible only if rapid expansion is initiated along with long overdue reforms in the higher, technical and professional educational sectors.

24.4 ACHIEVEMENTS OF THE EDUCATION SECTOR

Since independence, there has been a significant expansion of the education sector in India. Some of the positive achievements in the sector can be summarised as follows:

1. It has thrown open the doors of education at the point of admission at every level – elementary, secondary and higher levels – to all sections of population. Education is no more ‘elitist’; but somewhat ‘democratised’ with a larger proportion of socio-economically weaker section participating in education at all levels, including higher education.
2. There has been an explosion of educational facilities in the country. Indian educational system is now colossal, with almost 100 million students and three million teachers, and costing billions of rupees each year. This is the result of a consciously pursued public policy, with two basic features viz.: (i) Access-based strategy, and (ii) Incentive-based strategy. The principal focus of the education policy has been to increase access to education at all levels. Now, almost everyone (in rural areas over 93%) lives within 1 km. distance of a primary school. Similarly, over 92% of the people in rural areas have a middle school within about 5 km. distance and 82% of the rural population lives within

8 km. distance of a high school. A district headquarter town without an arts college is now unheard of. Colleges have thus proliferated at an even faster rate than schools.

3. India has the second largest (next only to China) pool of educated and skilled men and women (together referred to as manpower) in the field.
4. There has been development of institutions of excellence at every level. India is thus beginning to measure up to the demands being made on it in areas which attract international attention.

24.4.1 Weaknesses of the Education Sector

The education sector has, however, demonstrated a number of weaknesses, among which the more important are as follows :

1. **Narrow coverage:** It has a very narrow coverage with only 2.5 % of the Indian population in the relevant age group attending colleges and universities, compared with 64% in the US and Canada, 47% in the OECD countries, 37.7% in South Korea and 20% in countries such as Cuba, Costa Rica and Venezuela. Moreover, it has a very low retention rate: of the 100 children entering class I, only 60 make it to the end of the primary school (Class V). In contrast, 68% of the world's children complete primary education. Further, less than 3 children complete class XII. The extremely poor retention rate at the primary level has been traced to the general neglect of the sector. Nevertheless, there has been a significant improvement during the last few years following the implementation of the SSA programme. The dropout rate in primary schools has fallen sharply from 70 per cent in 1950s to 40 per cent presently.
2. **Iniquitous:** The educational system in India is highly iniquitous in respect of access to facilities, utilisation of these facilities and finally realisation of the benefits from education. A recent World Bank study on the subject has established that 10% of the best educated Indians received 61% of the total resources as against 36% across Asia, reflecting higher degree of inequality in the system. The Gini coefficient for India (on a scale of 0 to 100 representing a progressive inequality) is 60, against a regional average of 43. In comparison only Bangladesh does worse than this in this respect.
3. **High cost of Education :** The cost of higher education in particular, has been relatively high. Though it is obvious that higher education would have much larger unit costs (defined as the percentage of per capita GDP spent on each pupil), cross-country comparison shows that India's outlays on higher education are much above the level in many countries (Table 24.1).

Table 24.1: Public Expenditure Per Student - 2005

(% of GDP Per capita)

	Primary	Secondary	Higher
Australia	16.4	14.4	22.5
Brazil	10.8	11.2	48.9
France	17.6	29.6	33.9
Japan	22.6	22.3	19.6
South Korea	18.6	25.1	9.3
Mexico	15.5	16.8	44.1
South Africa	14.2	17.6	49.6
Thailand	13.9	13.1	23.0
UK	18.4	28.4	28.1
USA	21.5	25.8	26.7
India	11.1	19.8	68.6

Spending on higher education is thus 1.55 times the Asian average, where as, it is only 0.61 times for primary education. This means that given the overall allocation of funds invested in the education sector, expenditure on higher education has crowded out the allocation for primary education.

- 4. Low Quality:** Notwithstanding the fact that we have 13 regulatory bodies of higher education, the quality of education is fairly low and content less relevant to the 'needs of the individual and the society'. Only 3 Indian universities appear in a group of top 200 universities in the world. The educational system suffers from what has been called 'diploma disease' i.e. it does not aim at conveying knowledge and skills but is more concerned with certification and credentialing. As such, its contribution to the growth of human capital is minimal; it is unable to meet the emerging demands of skilled professionals.

Another related aspect is that we have one of the most rigid educational systems in the world. At every stage of one's educational career, doors are being shut, rather than opened. The prospectus of the Cambridge University tells the potential applicants for admission: 'you can arrive in Cambridge expecting to become a physicist or Zoologist, and emerge after three years as a metallurgist or a psychologist.' Unfortunately, this cannot happen even in the best universities or institutes in India.

- 5. Gender Bias:** Spread of education has been more biased towards boys than girls. This is brought out clearly by the data relating to gross enrolment ratio at different levels of education (Table 24.2).

Table 24.2: Gross Enrolment Ratio and Dropout Rate– 2004-05

	Boys	Girls
Primary (I-V)	110.7	104.7
Upper Primary (VI-VIII)	74.3	65.1
Elementary (I-VIII)	96.9	89.9
Secondary (IX-X)	57.4	45.3
Hr. Secondary (XI-XII)	30.8	24.5
Dropout Rate (I-X)	0.4	63.9

The gross enrolment rates for girls are lower at all levels of education, whereas drop out rates are steeply higher. These facts are further supported by the data relating to the number of female teachers in relation to the number of male teachers, in some selected states in India, as shown in Table 24.3 below.

Table 24.3: Number of Female Teachers Per 100 Male Teachers

States	Female Teachers Per 100 Male Teachers
Bihar	24
Jharkhand	26
MP	36
Rajasthan	38
UP	40

Given the emphasis on improving girls' enrolment which is critically dependent upon the presence of female teachers, there is a need to increase the recruitment of female teachers in educationally fragile states in India.

In view of the above weaknesses, India's record in the field of education is held to be abysmal.

Check Your Progress 1

1. What do you understand by human capital?

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2. Write a brief note on growth in (i) elementary education, (ii) secondary education, and (iii) higher education in India.

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3. Identify the major weaknesses of the education sector in India.

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24.5 ASSESSMENT OF GOVERNMENT POLICY

Since independence, a number of measures have been taken to reform the educational system. These measures can be grouped into three heads, viz. (i) equality reforms, (ii) quality reforms, and (iii) reforms for administrative ease. Studies on the effectiveness of these reforms, further classifying each of these into two categories: as (i) class-oriented reforms, and (ii) mass-oriented reforms, have arrived at the following conclusions.

- (a) Equality reforms meant for the masses have turned out to be, by and large, less successful than equality reforms meant for the classes. Thus, equality reforms of higher levels of education (pursuants of which are from the relatively better-off sections) have been found to be more successful than at lower levels of education.
- (b) In the case of quality reforms also, the mass-oriented reforms are less successful as compared to the class-oriented reforms.
- (c) In advanced environments, the educational reforms seem to have achieved a degree of success but in less-developed and socio-economically weaker environments, educational reforms have been less successful.
- (d) It thus follows that reforms meant for the classes seem to succeed in a shorter time period.
- (e) In the case of a majority of the educational reforms, the primary initiative was taken by the Government with the mass involvement very much limited. The stake holders, both the target group and others, simply followed this initiative or the leadership on the part of the government. This contributes to reduced impact of measures.

(f) The global approach to educational change have received greater attention by the policy-makers than the specific measures meant for specific target groups. The global measures carry an implicit bias towards the socio-economically better-off sections of society, as major benefits from such measures, owing to greater political influence, could be cornered by them.

In short, educational reforms have not been successful in overcoming the weakness of smaller coverage, lower quality and higher inequality. In some cases, the problems have been aggravated with widening inter-regional disparities, inter-community disparities and still larger inequalities on the gender-based fronts.

24.5.1 Future Education Policy

With increased demand for education from across the class, caste and community divides, the four most important elements in future education policy may be identified as follows:

1. Make primary education not only available but also accessed by and availed of by all children, so that at least in the next generation, we have a more educated, live and alert population.
2. Focus on the education of women, and particularly female children, by especially reaching out to them.
3. Make education worthwhile relating it to the actual needs of the population, in terms of suitability of the education imparted for employment, acquisition of better skills, better understanding of health, education, environmental and other relevant issues.
4. Make use of the opportunities offered by the latest advances in information technology to make teaching/learning far-reaching, broad-based and effective.

Primary education to be meaningful has to be imparted in the mother tongue of all children, at least in the 16 major languages (and scripts) which are in use across the country. To this may be added that school curricula have to be made less rigid with innovative initiatives adopted. Substantial increase in the proportion of funding of primary education is also necessary, just as increasing the community involvement to make the education system work more effectively. This calls for decentralisation and de-bureaucratisation of the education system by giving the initiative to the community at large to run the educational system. Also, in order to give effect to the principle of equal opportunity for all through education, primacy has to be given to:

- 1 education for women and, in particular, girls of school-going age,
- 1 education for other backward sections of the population like scheduled castes and tribes.

24.6 RECENT INITIATIVES

Since universalisation of elementary education has become an important goal, it is essential to push this vision forward to move towards universalisation of secondary education. Not only universal enrolment, but universal retention and satisfactory quality of learning should be of a priority. The major challenge before secondary education is that of meeting the surge in demand due to success of Sarva Shiksha Abhiyan whose target is to ensure that all children of elementary school going age are enrolled 100% by 2010. The government has, therefore, embarked upon launching a centrally-sponsored scheme, viz. Scheme for Universalisation of Access to Secondary Education (SUCCESS).

24.6.1 Scheme for Universalisation of Access to Secondary Education (SUCCESS)

The main objective of the SUCCESS is to make secondary education of good quality available at affordable levels to all young students in the age group of 15-16 (classes IX and X). The targets before the scheme are, therefore, two-fold:

1. Universal access of Secondary level education to all students in the age-group 15-16 years by 2015; and
2. Universal retention by 2020.

The objectives of the programme are the following:

- a) provision of necessary infrastructure and resources in the secondary education sector to create higher capacity in secondary schools in the country and improve quality of learning in the school;
- b) provision for filling the missing gaps in the existing secondary school system;
- c) provision of extra support for education of girls, rural children and students belonging to SC/ST, minority and other weaker sections of the society; and
- d) adoption of a holistic convergent framework for implementation of various schemes in secondary education.

24.6.2 National Knowledge Commission

In early 2005, the Government constituted the National Knowledge Commission under the Chairmanship of Sam Pitroda with the aim of making India not only a knowledge-producing society but also a knowledge-sharing and knowledge-consuming society.

The Commission submitted its report on higher education in early 2007.

The report advocated expansion to attain gross enrolment ratio of at least 15 per cent by 2015 and increase in government support of higher education to at least 1.5 per cent of GDP. It provides a direction for systematic overhaul of the entire education system without diluting academic standards. The Commission has recommended: (i) transition to course credit system to bring in more flexibility in course structures, (ii) decentralised examination system with focus on internal assessment, (iii) periodic revision and restructuring of curricula and (iv) criteria based resource allocation to ensure maintenance of standards with strategic preference to promote excellence.

Check Your Progress 2

1. Make a brief assessment of the government policy in the education sector.

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2. Outline the important features that should be included in the current/future education policy for India.

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3. Write a brief note on the Scheme for Universalisation of Access to Secondary Education.

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24.7 HEALTH SECTOR IN INDIA

The health of a nation is an essential component of development, vital to the nation’s economic growth and internal stability. Assuring a minimum level of health care to the population is a critical constituent of the development process. Since Independence, India has built up a vast health infrastructure and health personnel at primary, secondary, and tertiary care in public, voluntary and private sectors. Considerable achievements have been made over the period in our efforts to improve health standards, such as life expectancy, child mortality, infant mortality,

and maternal mortality. Nevertheless, problems abound. Malnutrition affects a large proportion of children. An unacceptably high proportion of the population continues to suffer and die from new diseases that are emerging; apart from continuing and new threats posed by the existing ones.

24.7.1 Health and Poverty

Improvement in the health status of a population is recognised as instrumental for increasing productivity and economic growth, as well as an end in itself. Here, it is important to understand the link between poverty and ill-health. The onset of a long and expensive illness can drive the non-poor into poverty. Ill health creates immense stress even among those who are financially secure. High health care costs can lead to entry into or exacerbation of poverty. The importance of public provisioning of quality health care to enable access to affordable and reliable health services cannot, therefore, be underestimated. This is especially so, in the context of preventing the non poor from entering into poverty or in terms of reducing the suffering of those who are already below poverty line.

24.8 HEALTH INDICATORS IN INDIA

The important indicators of health in a country are; (i) the infant mortality rate (IMR), (ii) life expectancy (LE) at birth, and (iii) the maternal mortality rate (MMR).

- (i) The IMR is defined as the number of children dying before age 1 divided by number of live births during that year. It is expressed as the number of infant deaths per 1000 live births. LE at birth is defined as the number of years a newborn would live if the prevailing patterns of age-specific mortality rates at the time of birth were to continue throughout the child's life. The MMR is defined as the number of maternal deaths per 1,00,000 live births. Finally, the under-5 mortality rate (per 1000 live births) is defined as the probability of dying between birth and upto 5 years of age, expressed per 1000 live births.

24.8.1 Trends in Health Indicators

Table 24.4 provides the value of four health indicators for India for selected years over three decades. Its analysis reveals the following :

Table 24.4: Trends in Selected Health Indicators in India

Indicators	1982	1992	2003
LE	55.5	60.3	63
IMR	105	79	63
Under -5 Mortality rate	152	94	87
MMR	-	-	540

- i) The LE at birth was 30 years at the time of independence. Since then, India has made rapid progress. In recent years, the LE increased significantly between 1982 and 1992, but slowed down since then. The current LE in India is much lower than what many other countries have achieved: the figures are 78 and 67.2 respectively for high and medium human development countries, and 74 for Sri Lanka for the same year. Japan and Sweden are on top in this respect with LE of over 80.

Gender difference in LE is a very important marker for inequities that may exist between males and females in health and other related social well-being indicators. In the countries with the highest LE, women tend to outlive men by 5 to 8 years; this difference is 0 to 3 years in countries where the LE is low. In case of India, the female and male LE are 65 and 61.5 respectively. In Sri Lanka, the figures are 76.8 and 71.5 for females and males respectively.

- ii) The IMR for India, although has come down over the years is still high. With an IMR of 63, India is way behind when compared to high and medium human development countries for whom the corresponding values of IMR are 9 and 46 respectively. Bangladesh currently has a lower IMR (46) than India. If one looks at the last thirty years, Sri Lanka, Bangladesh, and China have all achieved a more rapid decline in IMR than India.
- iii) The under-5 mortality rates that stood at 242 in 1960, with a decline to a figure of 87 over 40 years, is indeed significant. However, here too, there remains huge scope for improvement: for example, high and medium human development countries have figures in this respect of 11 and 61 respectively. Sri Lanka and China have values of 15 and 69 respectively, again bettering India's figure of 87.
- iv) The MMR is a difficult parameter to estimate correctly. It is, therefore, indicated only for the latest available year in Table 24.4. The adjusted MMR for India has been calculated by the UNDP as 540, whereas the unadjusted figure is significantly lower at 400. Even this lower value is much higher than the levels existing in developed as well as some developing countries: for example, USA and Sri Lanka have adjusted MMRs of 17 and 92 respectively. Bangladesh has done much better than India with an MMR of 380, not to mention China which is way ahead at 56. Interestingly, Pakistan also has an adjusted MMR of 500, which is lower than India's.

24.8.2 Rural-Urban and Male-Female Differentials

Table 24.5 presents the values of major health indicators, area-wise and gender-wise.

Table 24.5 Area-wise and Gender-wise Health Indicators

	Rural			Urban			Total		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
IMR	67	72	69	40	39	40	62	65	63
Crude Mortality Rate	9	8.4	8.7	6.5	5.6	6.1	8.4	7.7	8.1
LE at Birth	58.9	59.8	59.4	64.9	67.7	66.3	60.1	61.4	60.7

The following inferences flow from the data:

- i) There is a large difference between IMR in rural (69) and urban (40) India;
- ii) The crude mortality rates are also higher for rural India, though females have a slightly better rate in both rural and urban areas; and
- iii) The LE at birth is significantly lower in rural India than that in urban India.

24.8.3 State-wise Variations

Since inter-state variations are critical to such analysis, some state-level analysis is presented in table 24.6. For ease of analysis, the states have been divided into four groups: (i) major states, (ii) the newly defined Empowered Action Group (EAG) states, (iii) north-eastern states, and (iv) union territories. The EAG states broadly correspond to the BIMARU states – a term that was coined to describe the states of Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh. The new list of EAG states additionally included Chhattisgarh, Uttaranchal, Jharkhand and Orissa.

Table 24.6 Health Indicators Across States in India

State/Group	IMR		MMR	LE	
	M	F		M	F
All India	63.0	62.0	407.0	60.4	61.8
Union Territories	27.7	26.5	NA	NA	NA
NE States	34.3	35.7	NA	NA	NA
EAG States	66.3	63.0	538.8	58.1	57.5
Major States	46.8	46.0	151.3	58.1	60.1

The values of IMR and MMR in Table 24.6 indicates that both these indicators for the EAG states are close to that of 'All India' rates. Among these EAG states, the highest IMR is in Orissa, followed by Madhya Pradesh, Uttar Pradesh and Rajasthan. The NE states and the UTs are ahead in their progress, both for males and females in respect of IMR.

The dominance of the EAG states in respect of LE in lowering the national average is also seen from Table 24.6.

To conclude, therefore, there is immense scope for improvement in the health status of the people in India to be focused particularly on the EAG states.

24.9 CAUSES OF POOR HEALTH

The important causes of poor health in India are as follows:

a) High birth rate and fast growth of population

A number of health risks derive from high fertility rates in India. When large number of people live in poor households located in crowded, unsanitary surroundings, communicable diseases spread easily. High mortality results therefrom, especially among the children.

High mortality rates, in turn, induce families to have many children so that they can assure themselves of a few surviving children. This circular pattern adversely affects the health standards.

Similarly, population growth makes it more difficult to provide safe or sufficient water supply, garbage disposal and sanitation for the community. It increases the cost of providing adequately trained health manpower and medical facilities.

b) Malnutrition

Widespread malnutrition contributes to the incidence and severity of health problems. It poses a major threat to the children and, in extreme cases, threatens their lives.

In addition, malnutrition creates serious health problems by contributing to premature births and to abnormally low weight at birth.

Malnutrition is also a major contributing factor in spreading infectious diseases. By weakening the body response to diseases, malnutrition reduces acquired immunity. The problem of inadequate nutrition is compounded by rapid population growth. Large family size and close spacing of births frequently preclude sufficient food and care for children.

c) Unsanitary conditions and housing

The contamination of food, water or soil with human waste is a cause of a number of diseases. If water is not safe for drinking, or is insufficient for personal hygiene and sewage disposal, diseases spread more easily. This reduces the health status of the country.

In addition to poor sanitation and water supply, very sizeable proportion

of the total population of cities live in substandard dwellings lacking in space, ventilation and sunlight. Such conditions tend to increase the incidence of diseases.

24.10 HEALTH CARE SYSTEM IN INDIA

Over the last six decades, India has built up a vast health care system. The health care system consists of the following:

1. Primary, secondary and tertiary institutions, manned by medical and paramedical personnel.
 - i) The primary health care institutions provide the first level of contact between the population and health care providers. These consist of primary health centres, dispensaries run by various Government departments, medical infrastructure of PSUs and large industries.
 - ii) The secondary health care institutions consist of district hospitals and urban hospitals. They take care of (a) patients referred to them by the primary health care institutions, and (b) primary health care needs of the population in the places in which they are located.
 - iii) The tertiary health care hospitals are attached to medical colleges, both in the public and the private sector.
2. Medical colleges and paraprofessional training institutions to train the needed manpower giving them required academic input especially in terms of practical training.
3. Programme managers managing ongoing programmes at central, state and district levels.
4. Health management information system consisting of a two-way system of data collection, collation, analysis and response.

24.10.1 Deficiencies in Health Care System

In spite of the phenomenal expansion of the health care system at all levels, the system suffers from a number of deficiencies.

One: communicable diseases have become more difficult to combat because of development of insecticides resistant to strains of vectors, antibiotic resistant strains of bacteria and emergence of HIV infection.

Two: longevity and changing lifestyle have resulted in the increasing prevalence of non-communicable diseases.

Three: under-nutrition, micro nutrient deficiencies and associated health problems co-exist with obesity and non-communicable diseases.

Four: the existing health system suffers from inequitable distribution of institutions and manpower.

Five: even though the country produces every year some 20,000 doctors in modern system of medicine and similar number of practitioners and professionals in Indian systems of medicine, there are huge gaps in critical manpower needed in institutions providing primary health care, especially in the remote rural and tribal areas, where the health care needs are the greatest.

24.10.2 Issues in Health Care System

It is becoming clear that India is in the midst of a health care transition across the following four dimensions:

1. **Demographic:** With declining mortality and fertility, we find that in the year 2020, as compared to 2002, the percentage of total population in the age group of 15-64 years will increase from 59 per cent to 67 per cent, and that for above 64 years, from 7 to 9 percent. The percentage of population below 15 years of age will drop from 35 to 28 percent. This window of 'demographic opportunity' in India is expected to last for a quarter century from then i.e. up to 2045. Among the increasing older population, many may be widows, without family support. This demographic shift has implications for the way in which institutional health care is delivered by extending the social-security provisions.
2. **Epidemiological:** We are encountering a 'double burden of disease'. A high proportion of the population continue to die from preventable infections like diarrhoea, pneumonia, under-nutrition, child birth related complications, etc. Simultaneously, the growing incidence of non-communicable chronic conditions of ill-health is stretching the capacity of the health care system, since it must continually attend to the 'unfinished agenda'.
3. **Social:** There is, on the one hand, a rising demand for high quality health care, including a preference for multi-specialist hospital even if these entail higher costs. On the other hand, there is an unwillingness to discard myths and misconceptions, as for instance, practices contributing to adverse sex selection (see unit 26 for more details).
4. **Managerial:** We need to develop health financing systems (inclusive of risk pooling) that will address the shift in disease burden due to increase in health service costs, and minimise inefficiencies across health care management. To respond to these issues and existing deficiencies, a comprehensive national health policy has been formulated and implemented.

24.11 POLICY INITIATIVES

With the aim of achieving inclusive growth, recent policy initiatives in health sector include two programmes viz. (1) National Rural Health Mission, and (2) National Urban Health Mission, the two forming **Sarva Swasthya Abhiyan**, in health sector, parallel to the **Sarva Shiksha Abhiyan** in the education sector.

24.11.1 National Rural Health Mission (NRHM)

NRHM was launched to address the infirmities and problems prevailing across the primary health care system in the country. It, thus, aims to bring about improvement in the health system and the health status of those who live in rural areas. The mission aims to provide universal access to equitable, affordable, and quality health care that is accountable and at the same time responsive to the needs of the people.

Five Planks of the Mission

1. The Mission is expected to address the gaps in the provision of effective health care to rural population with a special focus on 18 states, which have weak public health indicators and/or weak infrastructure.
2. The mission is a shift away from the vertical health and family welfare programmes to a new architecture of all inclusive health development in which societies under different programmes will be merged and resources pooled at the district level.
3. The mission aims at effective integration of health concerns, with a focus on major determinants of health like drinking water, sanitation, and nutrition, through the drawing up of integrated district plans for Health. There is a provision for flexible funding so that, States can utilise it in the areas they feel are important.
4. The mission provides for appointment of Accredited Social Health Activists (ASHA) in each village and strengthening of the public health infrastructure, including outreach through mobile clinics. It emphasises involvement of the non-profit sector, especially in the underserved areas. It also aims at flexibility at the local level by providing for untied funds.
5. The mission, in its supplementary strategies, aims at fostering public-private partnerships (PPPs) for improving equity concerns, reducing out of pocket expenses, introducing effective risk pooling mechanisms by social health insurance, and taking advantage of social health traditions.

24.11.2 National Urban Health Mission (NUHM)

The NUHM will meet the health needs of the poor, particularly the slum dwellers, by making available to them essential primary health care

services. This will be done by investing in high-calibre health professionals, appropriate technology through PPP and health insurance for urban poor.

The NURM will ensure the following:

1. Resources for addressing the health problems in urban areas, especially among urban poor.
2. Need based city specific urban health care system to meet the diverse health needs of the urban poor and other vulnerable sections.
3. Partnership with community for a more proactive involvement in planning, implementation, and monitoring of health activities.
4. Institutional mechanism and management systems to meet the health-related challenges of a rapidly growing urban population.
5. Framework for partnership with NGOs, charitable hospitals, and other stakeholders.
6. Two-tier system of sick pooling like: (i) women’s Mahila Arogya Samiti to fulfill urgent hard-cash need for treatments; (ii) a Health Insurance Scheme for enabling urban poor to meet medical treatment needs; etc.

Check Your Progress 3

1. Bring out the relation between ill-health and poverty in about 50 words.

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2. State, in brief, the important causes of poor health in India.

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3. State, in brief, the important components of the health care system in India.

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24.12 LET US SUM UP

In the process of economic development, human capital has come to be recognised as an important factor. This factor is recognised to be two edged i.e. it influences growth, and at the same time, is itself influenced by growth. Human capital has been defined as the body of knowledge possessed by the population and the capacity of the population to use the knowledge effectively. Two important determinants of human capital are education and health. Since independence, significant changes have taken place in both these social sectors of the Indian economy. Nevertheless, much still remains to be achieved if India is to catch up with other middle-income countries.

24.13 KEY WORDS

Universalisation of Elementary Education or Sarva Shiksha Abhiyan	: A government initiative to provide elementary education from class I to VIII to all school going aged children in the age group of 6-14.
Dropout Rate	: An indicator expressed in percentage terms conveying the number of children not reaching the next class (or stage of education) from the previous class (or stage of education). In India, it is estimated that out of every 100 children enrolled in Class I, only about 19 reach the stage of higher secondary education. This means that at the secondary school level the drop out rate is 81 percent.
Unit Cost of Education	: Percentage of per capita GDP spent on each pupil.

24.14 SOME USEFUL BOOKS

1. Government of India Economic Survey
2. Planning Commission Mid-Term Appraisal of the Tenth Five Year Plan
3. Planning Commission Eleventh Five Year Plan: 2007-12
5. Kaushik Basu (ed.) The Oxford Companion of Economics in India

24.15 ANSWERS/HINTS TO CHECK YOUR PROGRESS EXERCISES

Check Your Progress 1

1. See section 24.2 and answer.
2. See section 24.3 and answer.
3. See section 24.4.1 and answer.

Check Your Progress 2

1. See section 24.5 and answer.
2. See sub-section 24.5.1 and answer.
3. See sub-section 24.6.1 and answer.

Check Your Progress 3

1. See sub-section 24.7.1 and answer.
2. See sub-section 24.9 and answer.
3. See section 24.10 and answer.



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