Financing Human Development in India: Strategies and Options

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Introduction

India's approach to human development can be viewed from the focus on it as human capital formation or as human development itself. Whereas former could be the means and latter the end as the idea that grew and gathered strength over the years is that human development should be an important indicator of economic development. In the first four decades of economic planning India's approach towards financing education and health as investment in human capital formation. It is only since early 1990s that human development became the focus.

Present paper examines the pattern of financing human development and the reasons why desired results could not be obtained as is evident from India's poor progress in human development index (HDI). Study deals with only health and education sectors. Data used to support arguments are secondary. They are taken from the official reports, Non Governmental Organizations, World Bank documents, as well as from the published work of other authors. To analyze government's efforts for the expansion and improvement of education and health, only Planning Commission's allocation are taken as the budgeted expenditures only reflect the maintenance of already created service. Plan of the study is as follows; it begins by tracing the strategy followed by India in financing health and education in independent India, proceeds on to analyze it's shifts per period of time especially the renewed enthusiasm in the current century for human development, and then evaluating it on the basis of it' success in realizing the objectives. Finally concluding remarks have been presented which call for a relook at the design / implementation of public policy towards human development.

Financing Health and Education

Health and education though not public goods have always been accorded fairly high priority in India as far as public expenditure on these items are concerned as these are treated to be the merit goods and therefore required states' intervention as market determined allocation of these goods, considering India's per capita income would be inefficient. Since states have been entrusted, in the constitution, with the task of providing wide array public services basic responsibility of providing health and education too fell on them despite the fact that former is on the concurrent list in our federal constitution while education has been brought on concurrent list through

constitutional amendment in 1976. Central government has also played proactive role in the expansion and improvisation in these sectors. But viewing such activities from the angle of human development is the phenomenon surfaced only in the 1980s when the concept of composite HDI came into existence with literacy and life expectancy being its prominent components along with income per capita.

The economy inherited by independent India in 1947 was one of very low per capita income, inadequate amount of physical and human capital stock, widespread poverty (though the estimates on poverty were not available then), very low level of literacy, awfully poor social and economic infrastructure etc. Thus the challenge before the country was to expand education sector from a very low benchmark with abysmally low level of financial and human resources. So the need was to keep the priorities right as the limited resources were to be allocated to various competing sectors. India did well to go in for economic planning which resulted in allocation of finite resources in accordance with the priorities as determined by the demands of economic development. The requirement was the capital formation - both physical and human. Thus expenditure on education and health is human capital formation intended at increasing its stock as well as maintenance.

Pressure on the economy's resources was on account of the increase in population also as it grew in excess of two percent annually in the first four decades since 1951. Increase in population put additional pressure on the economy's resources as the task was not only to cater to the needs of rapidly rising population but resources had also to be devoted to various programs meant to control its alarming growth. Thus sizable amount of public resources were allocated to family planning and welfare to contain alarmingly rising population on the one hand and at the same time ensuring it better health and hygiene. The twin objectives of providing some credible service in the area of education and health were pursued in right earnest but midway through the course policy confusions did arise.

Let us look at as to how India began in these matters. Taking the case of education first. Table-1 shows that allocation for education and scientific research not only remained stagnant till third five year plan it declined thereafter and continued to decline till seventh plan. Basically

it was in the 1970s that some other social sector expenditures were undertaken especially to directly attack poverty.

Table-1

Sectoral Allocation of Resources under the First Six Five Year Plans

(Rs Crore)

Head of development	**First Plan (1951-56)**	**Second Plan (1956-61)**	**Third Plan (1961-66)**	**Annual Plans (1966-69)**	**Fourth Plan (1969-74)**	**Fifth Plan (1974-79)**	**Sixth Plan (1980-85)**
Education and Scientific Research	149 (7.6)	273 (5.8)	660 (7.7)	354 (5.3)	905 (5.7)	1710 (4.4)	3997 (3.6)
Health & Family Planning	98 (5.0)	216 (4.6)	251 (2.9)	210 (3.2)	613 (3.9)	1253 (3.2)	3442 (3.1)

Source: Government of India, Ministry of Finance, Economic Survey, various years.

Thus policy dilemma was very much in evidence as there was pursuit for simultaneously achieving various goals. Additional demand was put on scarce resources on account of population which grew rapidly after independence and its growth rate peaked during 1960s with decadal growth of 22.2 percent and declined only marginally during 1970s. This was despite the fact that considerable amount of efforts were made to arrest it during 70s which include adoption of National Population Policy in 1976. Public spending on education could not keep pace with the demands of rapidly increasing population. It was around this time that major policy decision was taken. On the recommendation of Secondary Education Commission 1972 private sector was encouraged in the secondary education through fiscal incentives. This has relieved public sector to devote more resources to higher education.

Policy predicament can also be observed if we go for the disaggregation of expenditure on various levels of education. Table-2 below presents the allocations in various five year plans on different levels of education.

Table --2

Sector	First Plan 1951-56	Second Plan 1956-61	Third Plan 1961-66	Fourth Plan 1969-74	Fifth Plan 1974-79	Sixth Plan 1980-85	Seventh Plan 1985-90	Eighth Plan 1992-97	Ninth Plan 1997-2002	Tenth Plan 2002-2007
Elementary Education	870 (58)	950 (35)	2010 (34)	3743 (50)	5913 (52)	8414 (32)	28494 (37)	103940 (48)	163696 (66)	287500 (65.6)
Secondary Education	83 (5)	510 (19)	1030 (18)			5344 (20)	18315 (24)	52311 (24)	26035 (10)	43250 (9.9)
Adult Education	--	--	--	126 (2)	248 (2)	1533 (6)	4696 (6)	11421 (5)	6304 (3)	12500 (2.9)
Higher Education	117 (8)	480 (18)	870 (15)	1883 (25)	3188 (28)	5604 (21)	12011 (16)	20944 (10)	25000 (10)	41765 (9.5)
Others	227 (15)	300 (10)	730 (21)	936 (13)	1071 (9)	2729 (11)	1980 (3)	7398 (3)	4314 (2)	6235 (1.4)
Technical Education	215 (14)	490 (18)	1250 (21)	786 (10)	1015 (9)	2563 (10)	10833 (14)	21987 (10)	23735 (9)	47000 (10.7)
Total	1512 (100)	2730 (100)	5890 (100)	7474 (100)	11435 (100)	26187 (100)	76329 (100)	218001 (100)	249084 (100)	438250 (100)

Source: Government Of India, Ministry Of Information And Broadcasting: India, 2005, P.200 And Ministry Of Human Development Resources.

It is obvious from above table that whereas plan allocation for school education which grew rapidly till fourth plan, became stagnant thereafter and for higher and technical education they kept on increasing during 70s. Withdrawal of public sector from school education harmed the sector in two ways; one, existing government school rapidly declined in quality as private schools expanded fast, and two, reckless expansion of higher education seriously compromised its quality. This together with lack of correspondence between manpower requirement and its output had produced huge army of educated (degree holders and not necessarily the competent) unemployed people.

Public spending in health care too has been meager as can be observed in tabl-1. It began in first plan with 5 percent allocation of total expenditure to health and then had declined steadily till fourth plan raised it a bit and remained stagnant at little over 3 percent. If this allocation is taken as a proxy for expansion of health care and viewed against the rapidly rising population together with the poor population it can be concluded that government's efforts in this sector were

thoroughly unsatisfactory. If taking into consideration rural-urban divide in health care provision the scenario would appear more bleak.

Financial crises of early 90s forced government to initiate economic reforms and development philosophy and strategy underwent a change. As a result social sector with human development as its major component came into focus in every successive five year plan beginning with 8th plan (1992-97) which states “The objectives of fulfilling the social and human aspirations of the people, meeting the essential requirements of living, raising income levels and improving their quality of life are at the centre of our developmental efforts”. Same can be found in more explicit manner in the 9th plan (1997-2002); "... This will require not only higher rates of growth of output and employment, but also a special emphasis on all-round human development, with stress on social sectors and a thrust on eradication of poverty”. Further impetus to human development was provided by 10th (2002-07) plan wherein it defined development objectives not only in terms of GDP or per capita income but also in terms of enhancement of human well being. This was the first plan which, apart from broadly following human development approach to development, has also introduced specific quantifiable targets for a few key indicators of human development. Eleventh plan accelerated the momentum further by making "inclusive growth" as its theme. A large part of strategy for achieving inclusive growth was to accelerate investment ... education, health, ... and other social sectors.

It can therefore be inferred that the India spent on education and health initially to create human capital which met only partial success but lately human development began to be focused. It will be examined later in the paper as to what extent the strategy worked in realizing the goals.

Increase Expenditure on Human Development

Thus human development was attempted in its right earnest from 10th plan and 11th plan gave it a further boost by substantially enhancing the allocations for it which is evident from table-3. It was during these plans that a comprehensive programme like National Rural Health Mission (NRHM) were launched. The programme is significant as it aimed at providing and strengthening health care infrastructure which so poor to call it as nonexistent. The Plan also set seven measurable targets, reflecting the health status to be achieved by the end of the Plan period. These targets related to (i) Infant Mortality Rate (IMR), (ii) Maternal Mortality Ratio (MMR), (iii) Total Fertility Rate (TFR), (iv) under-nutrition among children, (v) anaemia among

women and girls, (vi) provision of clean drinking water for all and (vii) improving child sex ratio for age group 0-6 years.

Table-3

Sectoral Allocation in 10th & 11th Five Year Plan

In percent to total plan outlay

Sector	10th Plan (2002-07)	11th Plan(2007-12)
Education	7.68	19.29
Rural development & panchayati Raj	10.70	13.39
Health & Family Welfare	5.62	8.71
Agriculture & Irrigation	6.22	8.55
Social Justice	4.47	6.35
Physical Infrastructure	10.94	9.01
Scientific Development	3.66	4.68
Energy	5.81	4.04
Others	44.90	25.97
Total	100.00	100.00

Source: 11th Five Year Plan Document.

Education especially the school education started receiving attention it deserved during these plans as it has been recognized as the important instrument for achieving inclusive growth. Hence, both the union and state governments increased educational expenditure. Sarva Shiksha Abhiyan (SSA), aimed at universalizing elementary education, since its inception in 2001-02 as the main vehicle for providing elementary education to all children in the 6-14 years age-group has made considerable progress in universalization of elementary education (UEE). Further progress in the matter was made with the enactment of Right to Education (RTE) Act 2009 that came into effect from April 2010, making it fundamental right of all children to demand eight years of quality elementary education. The requirement of realizing the goal of UEE in a planned and time bound manner will be higher level of funding, better targeting of uncovered and under-covered population. Isolated habitations, educationally backward blocks and districts shall require special attention.

Central Government expenditure on social services and rural development have gone up consistently over the years . From Table-2, it can be observed that share of Central Government expenditure (plan and non-plan) on social services, including rural development has increased

from 11 per cent in 2001-02 to 13.75 per cent in 2005-06 to 19.27 per cent in 2010-11. Central support for social programmes has continued to expand in various forms in spite of the fact that most of the items in social sector fall within the purview of the States. Significant amount of programme specific funding is available to the States through the Centrally Sponsored Schemes. The pattern of funding for these schemes varies depending upon the priority laid on the sector. At the same time, the objective is to make States more and more self-reliant in supporting these scheme as is borne out by the funding pattern proposed for Sarva Shiksha Abhiyan.

Table-4

Central Government expenditure (Plan and non-Plan) on social services and rural development

As a percentage of total expenditure

Item	**2001-02**	**2002-03**	**2003-04**	**2004-05**	**2005-06**	**2006-07**	**2007-08**	**2008-09**	**2009-10**	**2010-11**
1.Social Services										
a- Education Sports , youth Affairs	2.93	2.39	2.32	2.81	3.71	4.28	4.02	4.04	3.96	4.46
b-Health & family welfare	1.65	1.58	1.53	1.64	1.89	1.87	2.05	1.91	1.90	2.03
c- Water supply, housing etc.	1.65	1.65	1.67	1.81	2.08	1.72	2.02	2.31	2.20	2.27
d-Information and broadcasting	0.35	0.34	0.28	0.26	0.30	0.25	0.22	0.22	0.20	0.22
e-Welfare of SC/ST and OBC	0.30	0.28	0.24	0.27	0.33	0.34	0.36	0.35	0.41	0.63
f-Labour and employment	0.23	0.19	0.18	0.20	0.25	0.32	0.27	0.27	0.22	0.25
g-Social welfare & nutrition	0.72	0.57	0.50	0.52	0.84	0.85	0.82	0.72	0.79	1.06
h- North-eastern areas	0.00	0.00	0.00	0.00	0.00	0.00	0.00	1.56	1.50	1.75
i- Other-social services	0.55	0.11	0.15	0.34	0.40	-0.17	1.29	1.55	1.87	1.34
Total	7.86	7.10	6.86	7.85	9.79	9.47	11.06	12.94	13.06	14.02
2-Rular development	1.72	2.89	2.59	1.91	3.12	2.84	2.80	4.50	4.27	4.17
3-Pradhan Mantri Gram Sadak Yojana	0.69	0.60	0.49	0.49	0.85	1.08	0.91	0.88	1.11	1.08
4-Social service, rular development	10.97	11.23	10.46	10.81	13.75	13.38	14.77	18.32	18.44	19.27
5-Total central government expenditure	100.0	100.0	100.0	100.0	100.0	100.0	100.00.	100.0	100.0	100.0

Source : Budget Documents and Ministry of Rural Development

Expenditure on social services (which include education, medical and public health, family welfare, water supply and sanitation, welfare of Scheduled Castes (SCs), Scheduled Tribes (STs) and Other Backward Classes (OBCs), labour and labour welfare, social security, nutrition, and relief for natural calamities, etc.) by the General Government (Centre and States combined) has also increased in recent years reflecting the higher priority given to this sector.

Table-5

Trends in Social Services Expenditure by General Government

(Central and State Governments combined)

Rs crore

Central & State (Rs crore)	**2002-03**	**2003-04**	**2004-05**	**2005-06**	**2006-07**	**2007-08**	**2008-09**	**2009-10 R.E**	**2010-11B.E**
Total Expenditure	6,95,203	786212	859545	959855	1109174	1316246	1595110	1909380	20711147
Expenditure on social services, of which	141740	153454	172812	203995	239340	294584	380269	476351	522492
a-Education	71298	75607	84111	96365	114744	129366	161360	204986	235035
b-Health	30184	33504	37535	45428	52126	63226	73898	90700	99738
c-Other	40258	44343	51166	62202	72470	101992	145011	180665	187719
As percentage of GDP									
Total Expenditure	28.32	28.54	27.29	26.81	25.83	26.40	28.57	29.15	26.29
Expenditure on social services	5.77	5.57	5.49	5.70	5.57	5.91	6.81	7.27	6.67
a-Education	2.9	2.74	2.67	2.69	2.67	2.59	2.89	3.13	2.98
b-Health	1.23	1.22	1.19	1.27	1.21	1.27	1.32	1.38	1.27
c-Other	1.64	1.61	1.62	1.74	1.69	2.05	2.60	2.76	2.38
As percentage of total expenditure									
Expenditure on social sector	20.4	19.5	20.1	21.3	21.6	22.4	23.8	24.9	25.2
a-Education	10.3	9.6	9.8	10.0	10.3	9.8	10.1	10.7	11.3
b-Health	4.3	4.3	4.4	4.7	4.7	4.8	4.6	4.8	4.8
c-Others	5.8	5.6	6.0	6.5	6.5	7.7	9.1	9.5	9.1
As percent of social sector expenditure									
a-Education	50.3	49.3	48.7	47.2	47.9	43.9	42.4	43.0	45.0
b-Health	21.3	21.8	21.7	22.3	21.8	21.5	19.4	19.0	19.1
c-Others	28.4	28.9	29.66	30.5	30.3	34.6	38.1	37.9	35.9

Source : RBI as obtained from Budget Documents of Union and State Governments.

BE: budget estimates; RE: revised estimates.

As given in the table-5 expenditure on social services as a proportion of total expenditure increased from 21.1 per cent in 2005-06 to 23.8 per cent in 2008-09 and further to 25.2 per cent in 2010-11 (BE). As a proportion of GDP, its share increased from 5.49 per cent in 2005-06 to 6.63 per cent in 2010-11 (BE). Expenditure on education as a proportion of total expenditure has increased marginally from 10 per cent in 2005-06 to 11.3 per cent in 2010-11 (BE). While the expenditure on health as a proportion of the GDP has increased from 1.23 per cent in 2005-06 to 1.27 per cent in 2010-11 (BE), its share in total expenditure has increased marginally from 4.7 per cent in 2005-06 to 4.8 per cent in 2010-11 (BE).

Gain from increase in expenditure on human development

It is clear from above discussion that the expenditure on human development in India increased after the seventh five year plan. But this increase was basically on Education, health and family welfare. The expenditure incurred on education has been growing because of the commitment under RTE. The goals of the SSA inter-alia include enrolment of all children of the qualifying age in the schools, education guarantee centres (EGCs), alternate schools, 'back-to-school' camp, retention of all children till the upper primary stage by 2010, bridging of gender and social category gaps in enrolment and ensuring that there is significant enhancement in the learning achievement levels of children at the primary and upper primary stages. The achievements under the SSA till September 2010 include opening of 309,727 new schools, construction of 254,935 school buildings, construction of 1,166,868 additional classrooms, 190,961 drinking water facilities, construction of 347,857 toilets, supply of free textbooks to 8.70 crore children, and appointment of 11.13 lakh teachers. Moreover, around 14.02 lakh teachers have received in-service training under this programme. There has been significant reduction in the number of out-of- school children on account of SSA. At the same time there has been an increase in expenditure on National Programme of Midday Meal (MDM) which covers in schools, cooked mid-day meal is provided to all the children attending Classes I-VIII, besides government schools, Government aided, National Child Labour Project schools, EGCs/alternate and innovative education centres including madarsas/maqtabs supported under the SSA across the country. At present cooked midday meal is supposed to provides an energy content of 450 calories and protein content of 12 grams at primary stage and an energy content of 700 calories

and protein content of 20 grams at upper primary stage. Adequate quantity of micro-nutrients like iron, folic acid and vitamin A are also recommended in coordination with NRHM. During 2009- 10, the budget allocation under this program was ` 7359.15 crore against which actual expenditure incurred was ` 6937.79 crore. A total number of 11.04 crore children (7.85 crore in primary and 3.19 crore in upper primary stages) have been benefitted under the programme during 2009-10.

Success or otherwise of such human development efforts could judged from some quantifiable health indicators which are provided below.

Table-6 Selected Health Indicator-India

Parameter	**1981**	**1991**	**Current level**
1. Crude Birth Rate (CBR) (per 1000 population)	33.9	29.5	22.5 j(2009*)
2. Crude Death Rate (CDR)(per 1000 population)	12.5	9.8	7.3 (2009*)
3. Total Fertility Rate (TFR)(per woman)	4.5	3.6	2.6 (2008*)
4. Maternal Mortality Rate (MMR) (per 100,000 live births) NA		NA	254 (2004-06*)
5. Infant Mortality Rate (IMR)(per 1000 live births): Male Female	110	80	50 (2009*) 49 52
6. Child (0-4 years) Mortality Rate (per 1000 children) 41.2	41.2	26.5	15.2 (2008*)
7. Life Expectancy at Birth:	**(1981-85)**	**(1989-93)**	**(2002-06)****
Total	55.4	59.4	63.5
Male	55.4	59.0	62.6
Female	55.7	59.7	64.2

Source: **Ministry of Health and Family Welfare.**
***Sample Registration Survey (SRS).**
**** Abridged Life Table 2002-06, RGI India.**

What is observed from the table-6 is that almost the same pattern of improvement that was recorded over the period 1981-91 continued to be followed in the next 15 years. That means, there was a poor correspondence between expenditure and the target realization.

National Rural Health Mission (NRHM): The NRHM was launched in 2005 to provide accessible, affordable, and accountable quality health services to rural areas with emphasis on poor persons and remote areas. It is being operationalized throughout the country, with special focus on 18 states, which include 8 empowered action group States (Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Uttar Pradesh, Uttarakhand, Orissa, and Rajasthan), 8 north-eastern States, Himachal Pradesh, and Jammu and Kashmir. The NRHM aims to provide an overarching umbrella to the existing programmes of Health and Family Welfare including the Reproductive Child Health Project (RCH-II) and Malaria, Blindness, Iodine Deficiency, Filaria, Kala Azar, T.B., Leprosy and Integrated Disease Surveillance programmes by strengthening the public health delivery system at all levels. The Sub-centres, PHCs, and CHCs are being revitalized through better human resource management, including provision of additional manpower, clear quality standards, revamping of existing medical infrastructure, better community support, and through untied funds to facilitate local planning and action. Flexible, decentralized planning is the pivot on which the Mission rotates.

Addition of Human Resources made available under the NRHM include 1572 specialists, 8284 MBBS doctors, 26,734 staff nurses, 53,552 auxiliary nurse midwives (ANMs), 18,272 paramedics who have been employed on contract. A total of 16,338 additional primary health centres (APHCs), PHCs, CHCs, and other sub-district facilities have been created to make the availability of service 24 x 7 basis. Over 3.4 crore women have so far been covered under the reproductive health service known as Janani Suraksha Yojna. Around 599 district hospitals (DHs), 4210 CHCs, 1136 other than CHC hospitals, and 17,097 PHCs have their own RKSs with untied funds for improving quality of health services through the scheme Rogi Kalyan Samiti. So far, 4.98 lakh villages (78 per cent) have their own Village Health and Sanitation Committees and each of them has been provided Rs.10,000 as untied grant per year. Another important development in the Indian health-care sector has been the growing use of telemedicine. In 2001, the Indian Space Research Organization (ISRO) launched a pilot project that connects 78 hospitals in remote areas to super specialty hospitals in the cities. Telemedicine has opened up

possibilities of professionals providing expert healthcare service in remote rural areas from their locations in cities. It has also opened up the possibility of patients in India availing of professional advice from physicians in the developed countries.

Observation made earlier that huge public expenditure in the last 15 to 20 years failed to bring about corresponding improvement in health indicators which might have been because of the multiplicity of schemes and lack of coordination amongst them.

Functionality Problem

In an overpopulated economy with sizable section of it being poor (on criterion of bare minimum in terms of nutritional intake) government's renewed efforts in the current century to improve human development is undoubtedly the welcome move. But seems to have been achieved is the enrolments in the schemes, number of beneficiaries from various schemes that can be statistically shown but when it comes to improvement in qualitative variables the picture is not that rosy. One thing everyone agrees to is the expenditure on human development is only possible when government plays proactive role as otherwise education as well as health care would remain inaccessible to the neglected and poor population. This increased expenditure on education is necessary so as to make it accessible to every child irrespective of income strata as only through this children can be ensured better place in the world. The problem is not at the level of provision but in delivery mechanism. One of the key element in development process is the proper functioning of the political and administrative institutions responsible for the delivery of service. The Annual Status of Educational Report (ASER) – 2010 point to very poor outcome in terms of quality as far as the primary education is concerned and the Evaluation Study of NRHM 2011 presenting the pathetic state of health care in the state that were covered under the study. The problem is that of leakages. Efficiency requires the optimum mix of key elements which include resources, information, decision-making, delivery mechanisms, and accountability. Following problems could be outlined in this regard. Resources are centralized and canalized. The center collects nearly all resources from general taxes, rents, or aid—there are few user fees or local taxes—and then allocates them into budgets of line ministries. Information, if it exists at all, is tightly controlled and only flows internally and upward (not horizontally). Decision-making is done primarily by government agencies and their agents, with the discretion of local agents, at least on paper, tightly controlled by rules, regulations, and mandates from the

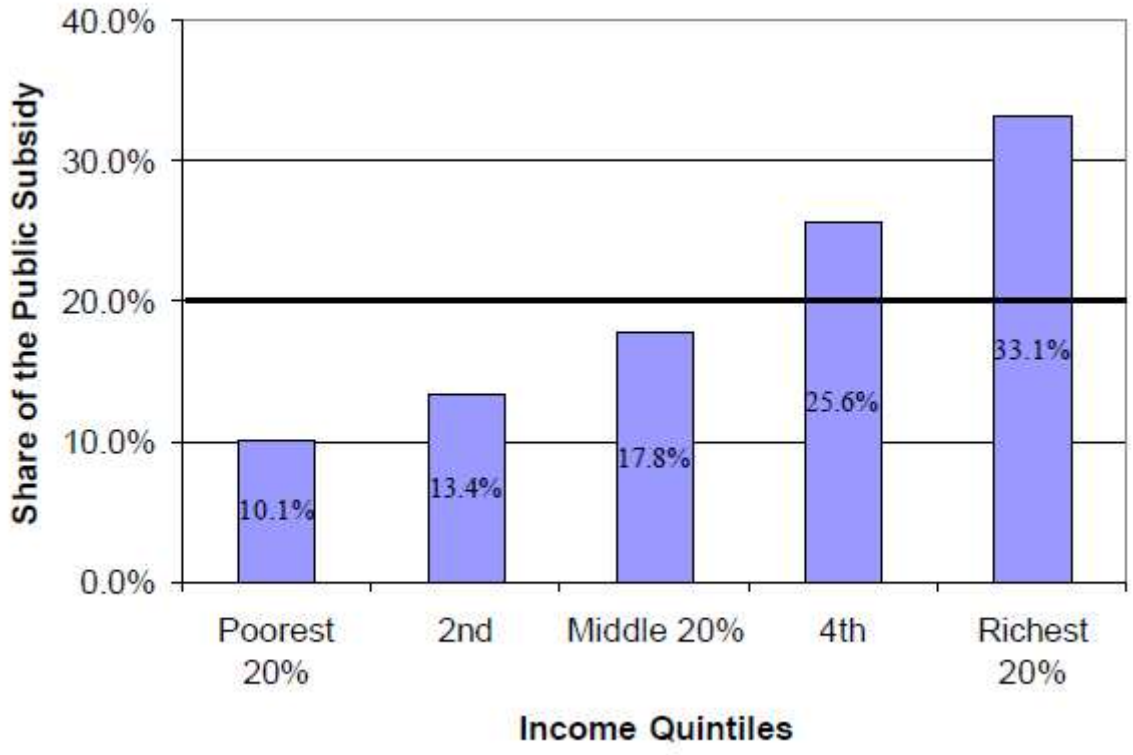
top. Delivery mechanisms is the stage where all the problem spillover. Accountability of the service providers flows internally and upward, with accountability to the citizens occurring only via whatever political mechanisms exist for expressing discontent (which may be tightly limited in autocratic, authoritarian, and totalitarian regimes).

Problem in Health Sector

The major problem facing the health and family welfare is that whatever facility is created for the benefit of poor it is the upper class which somehow manages to take be the major benefits. Two factors contribute to the pro-rich orientation of public spending. Overall utilization of publicly provided services is skewed towards the rich as more individuals from the higher income groups are likely to seek health care services. The second factor is the type and level of services sought by the different income groups. Poor get the benefits only from the primary health center and very small population get the advantage of the better hospital.

Table- 7

Share of public subsidy for curative care according to income group



Source: calculations based on Mahal et. al. 2001 – referred to in MTA para. 2.2.68

. Above figure clearly illustrates the positive correlation between the income level and the flow of benefits from government's subsidies. The richest 20 percent get away with maximum share with 33.1 percent while the poorest 20 percent are content with little over 10 percent. The reasons for such strange correlation can be found in the following table. For the ailments that remain untreated financial problems are accountable for this in good measure.

Table-8

Distribution of Untreated Ailments by Reason of No Treatment

Reason for not seeking Medical treatment	Rural			Urban		
	42nd	52nd	60th	42nd	52nd	60th
No medical facility	3	9	12	0	1	1
Lack of faith	2	4	3	2	5	2
Long waiting	0	1	1	1	1	2
Financial Problem	15	24	28	10	21	20
Ailment not serious	75	52	32	81	60	50
Others	5	10	24	6	12	25

Source: NSSO various publication.

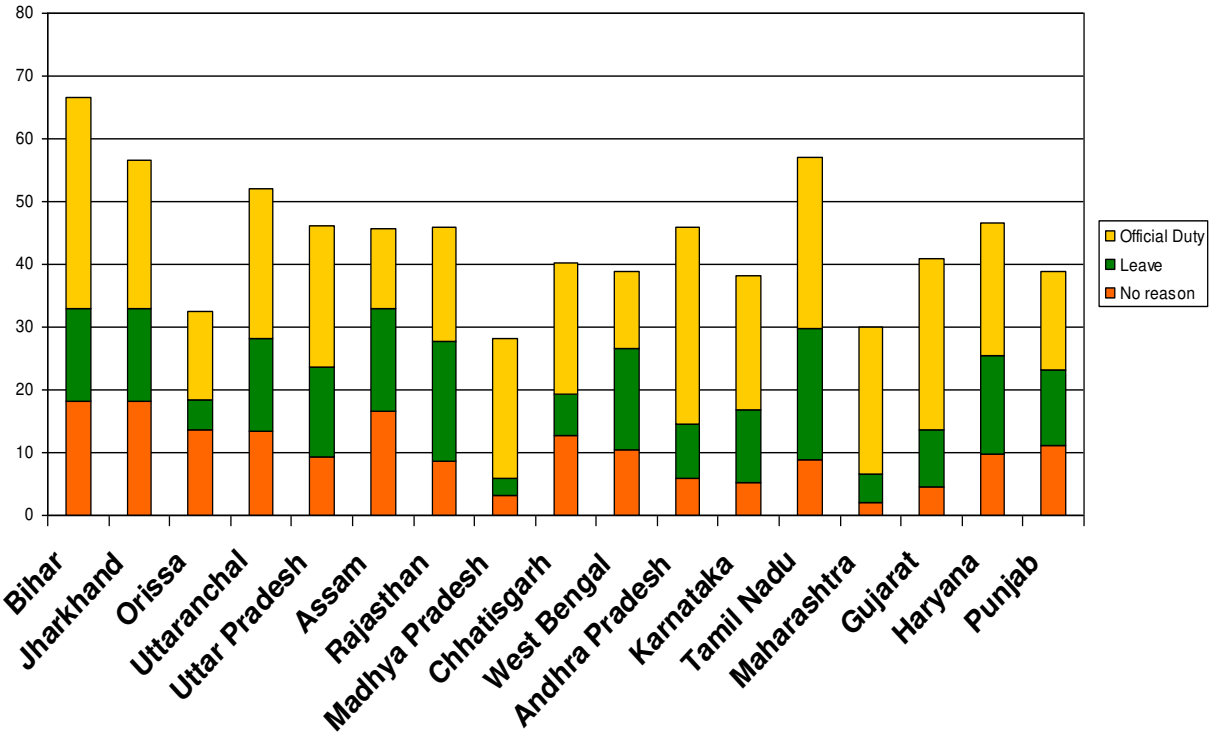
In the table it is clear that there is a change in the pattern of rural and urban sector in the utilization of the health services. In the rural areas it is the the non-availability of medical facility that together with financial problem is responsible for the non-treatment of ailment. While in urban areas the problem of 'no medical facility' is not much significant but still the financial problems are very much there. Other reasons are more common in urban area.

In the next table it is clear that major hindrance in the non-utilization of health services is the absenteeism of doctors from the primary health centers. This is may not be solely on account of the doctor's absence from work but because these doctor are generally used for other duties by the different government organizations. In this regard al states are equally guilty. Maharashtra

and Madhya Pradesh though are the states where absence without reason and because of leave is relatively small. But in matters of of official duty there is no difference in these states too.

Table-9

India 2003: Doctor absence from PHC's by State and Reason



Source: Shanta Devarajan, Development 3.0: What to do when markets and governments fail poor people World Bank.

Problem in Education Sector

As per findings of ASER-2011 what class IV student hardly manages in villages, students of class 3 manages quite well in towns. Another observance is that private school students fare better than govt. school students

A common chronic problem that has been identified in all the schools is the shortages of teacher especially Hindi teacher. Under RTE norms every classroom should have at least one teacher

which has been found to be seriously lacking. In some school whenever some teachers are appointed they are transferred away with post or remained absent from their place of posting. As all the pleas often goes unheeded by authorities, the village communities in order to mitigate this problem has been trying to make all ends meet sponsoring private tutors and subject teachers to salvage students' career but where no such effort exist, students are condemn to suffer for no fault of theirs. In view of this observation the lack of correspondence between public expenditure and provision of credible public service continued to exist. It appears as if no remedial measures were undertaken after the startling revelations by ASER-2009.

Table-10

All India Teacher Absent

State	**Teacher Absence (%)**
Maharashtra	14.6
Gujarat	17.0
Madhya Pradesh	17.6
Kerala	21.2
Himachal Pradesh	21.2
Tamil Nadu	21.3
Haryana	21.7
Karnataka	21.7
Orissa	23.4
Rajasthan	23.7
West Bengal	24.7
Andhra Pradesh	25.3
Uttar Pradesh	26.3
Chhatisgarh	30.6
Uttaranchal	32.8
Assam	33.8
Punjab	34.4
Bihar	37.8
Jharkhand	41.9
Delhi	-
All India Weighted	**24.8%**

Source: Kremer, Muralidharan, Chaudhury, Hammer, and Rogers. 2004. "Teacher Absence in India."

The need of the hour now is redeployment of teachers from the excess areas to the shortage areas or appoint new one but to let the schools thrive without teachers would not only be unfair but cruel. Those who are unwilling to go to their areas of posting should gracefully retire as there are enough qualified youth to take up the same as this profession is not only to earn livelihood.

Many schools are reeling under pathetic condition with no electricity connection, proper desk & benches, worn out building & located in places not conducive to learning that just at the sight its not hard to comprehend why we are backward.. Schools are the perfect manifestation of what kinds of govt. exist or what community live in that area for no good govt. or community would dare to neglect its school because that is where the future lies.

Conclusion

It follows from the analysis of facts that government's renewed enthusiasm for human development did not bear fruits. The amount of improvement in health parameters might have still been there even as a normal trend factor. The huge public expenditure in the area of education and health made only marginal difference which is evident by the fact that India continued to slide in ranking amongst the countries in terms of human development. Thus for such loss strategy itself could be blamed as huge resources were poured into it without caring for the delivery mechanism and putting in place the system of accountability. Plethora of schemes targeting the same people and without requisite amount of coordination between them might also helped government agencies escape the blame. Better option would have been setting out the monitorable and standards not only in terms of quantity but quality as well and creating a mechanism of social audit. Other problems that have been observed are the financial provision being short of what is actually required, and lack of information on the part of stakeholders. Further research may work out if the same amount of resources had been disbursed in some other ways that might improve people's income which in turn would help them get better access to health care and quality education.

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