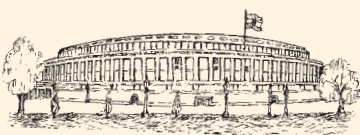


Issues for Parliamentarians

To facilitate informed discussions among Indian Parliamentarians on key economic policy issues

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Parliamentarians' Forum on Economic
Policy Issues (PAR-FORE)

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Social Sector Budgeting: Higher Allocations Mask Poor Utilisation

Social services, such as health and education have often suffered from governmental neglect in India. While most modern nations have expanded provision of health and education through significant public spending, public financing of health and education in India has always been inadequate. To compound this problem, there are various non-financial constraints impeding progress in these sectors. These constraints only serve to widen disparities and impede national efforts to meet development targets.

INTRODUCTION

In the last few years, India has become one of the world's fastest growing economies. The high economic growth of the last few years has provided the government with additional resources for expenditure on social sectors like health and education.

The National Common Minimum Programme (NCMP) of the last United Progressive Alliance (UPA) regime reflected the government's commitment to rapid and more inclusive growth through higher and targeted investments aimed at the poorest of the poor. The NCMP outlined ambitious public expenditure targets on key social services – public spending on education and health at elevated levels of six and two-three percent of gross domestic product (GDP) respectively.

However, there seems to be a gap between plans on paper and actual practice. Though budgetary allocations to the social sector have been rising, outcomes are not encouraging. In the context of the objective of sustained inclusive growth, it is important to analyse various issues relating to budgetary allocations for the social sector and related implementation modalities. To make the discussion more focussed, we limit it to implementation issues in health and education, which are considered to be an input into human capital generation, empowerment and social justice.

SOCIAL SERVICES: THE PROBLEM OF IMPLEMENTATION

The Finance Minister P Chidambaram, in his first budget (2004-05), announced plans to empower the poor through universal access to education and health, and facilitation of gains to them from the growth process through provision of gainful employment. These have not, however, materialised despite enhanced social sector expenditure.

In most democracies one major responsibility of the state is the implementation of social welfare schemes. Broad budgetary provisions indicate that the Central government's expenditure on social services has been steadily rising as a proportion of aggregate government expenditure. The same is manifested in an increase in outlays on major programmes, such as National Rural Health Mission (NRHM), *Sarva Shiksha Abhiyan* (SSA), Integrated Child Development Scheme (ICDS) and Mid Day Meal Scheme (MDMS). However, the share of the Central government in total social sector expenditure, especially in health and education, is still small and the primary responsibility

for provision lies with the states. From all indications such performance has been inadequate.

In India, there are various non-financial constraints impeding progress in all sectors, especially social sectors such as health and education. Removing such constraints entails improving the quality of governance. Experience all over the world suggests that it is not so much the size of the government budget but how it is spent that determines the efficacy of the system.

Education

Education empowers the poor to participate in the growth process. Despite various efforts made by the government to give a boost to education, every third illiterate person in the world is an Indian. Rising budgetary allocations have increased the number of schools but the quality of education offered is still sub-standard mainly because of supply side constraints. The introduction of schemes, such as MDMS and SSA has helped in increasing enrolment but drop-out rates before completion of primary education are still high, implying wastage of public money which often runs into crores.

India lags behind China and Sri Lanka in terms of the adult literacy rate and education index but is doing far better than its other neighbours such as Pakistan, Bangladesh, Nepal and Bhutan. India has an adult literacy rate of 65.2 percent while for China and Sri Lanka literacy rates are 90.8 and 93 percent respectively. According to the Human Development Report, 2009 of the United Nations Development Programme (UNDP), India has an overall education index of 0.620 while in China and Sri Lanka the corresponding figures are 0.837 and 0.814 respectively. However, in terms of the combined gross enrolment ratio for primary, secondary and tertiary education India is doing better than all its neighbours except China.

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BUDGETARY ALLOCATIONS

There has been a declining trend in the Central share in public expenditure on education – in 2004-05 total public expenditure on education was 3.47 percent of GDP with the Centre and states accounting for 0.67 and 2.80 percentage points respectively whereas in 2005-06 the Central share declined to 0.58 percentage points. This declining trend continued in subsequent years. Further, an analysis of central budgets indicates that most of the budgetary expenditure on education (almost 99 percent) is accounted for by revenue expenditure (running expenses such as salaries etc.), thus leaving precious little for capacity augmenting capital expenditure. The UPA government during its tenure did not increase the share of capital expenditure on education in total government expenditure. Thus, education infrastructure remained poor.

Another important issue is the revenue from education cess. The basic objective of imposing a cess on taxpayers is to generate additional resources for the development of a sector. In 2006-07 and 2007-08, the education cess funded 38 and 49 percent of total expenditure on education respectively. This reflects a gradual rise in the revenue from cess and reduced contribution of other budgetary resources to total expenditure on education. Thus, the education cess is being used as a substitute for budgetary allocations and not as an additional source of revenue to boost the existing allocation to education.

OUTCOME

Within the education sector, the priority of the government has been elementary education with almost 50 percent of budgetary allocations for education being targeted towards this sub-sector. But higher allocations do not always mean better outcomes; utilisation matters. The government spends a huge amount of public money on school education but the outcomes have been much below expectations. The government has showcased provision of proximate access to primary schools to more than 90 percent of the population as an achievement. However, the quality of

education related infrastructure is appalling: school buildings consist of one or two rooms; these are located in unhygienic environments and lack sanitation facilities for girls. The student-teacher ratio is high and absenteeism among students and even teachers is common. Finally enrolment is low and dropouts are high. Thus, from all indications, money allocated for education is not being properly utilised.

There is a need to emphasise quality over quantity, i.e. it is important to have good infrastructure, spacious and hygienic surroundings and regularity in attendance by teachers and students even at the expense of numbers. Enhancement of quality of infrastructure and related facilities would help get over problems like low enrolment and poor attendance and thus ensure better utilisation of public expenditure on education.

One of the important reasons for poor outcomes of public expenditure on education has been the inability of the government to provide targeted assistance to needy students. The government has been financing schools instead of directly financing the education of children. The financing of schools has led to wasteful expenditure with little improvement in either quality of or access to education. On the other hand, financing of students (through vouchers) encourages greater competition among schools in attracting students and, therefore, an improvement in the quality of schooling.

Healthcare

There has been some improvement in the quality of healthcare over time, but wide inter-state, male-female and rural-urban disparities in outcomes continue to persist. Achievements in health indicators have fallen short of expectations, especially as far as the poor are concerned.

India's ranking in terms of health performance indicators continues to be unsatisfactory even in comparison to some of its poorer neighbours. While India has a male life expectancy of 63.3 years, the corresponding figures for Bangladesh and Sri Lanka are 63.4 and 68.8 years respectively. On the other hand, the Chinese enjoy a much higher male life expectancy of 71.4 years. Indian female life expectancy (66.6 years) is higher than that for males but is still far below that of China (74.9 years) and Sri Lanka (76.3 years)¹.

Similarly, while India has an Infant Mortality Rate (IMR) of 54 per 1000 live births, Nepal, Bangladesh, Sri Lanka and Bhutan have lower IMRs of 53, 51, 11 and 44 respectively. China's IMR is only 23, suggesting a huge lead over India in the nutrition and care of infants.

Incidence of early fertility is the highest in India with 62 births per 1000 women in the age group of 15-19 years, far in excess of that in Pakistan, Sri Lanka and Iran with figures of 36, 25 and 20 respectively. China's performance in terms of this indicator is far better than all mentioned countries with eight births per 1000 women in the same age group. In regard to conditions provided for delivery of infants, 47 percent of births in India take place under skilled supervision while Sri Lanka does much better at 97 percent².

A country like India, where the incidence of poverty is very high, needs to have extensive health safety nets. The health network has expanded rapidly but remains widely skewed. The irony is that medical tourism in India is becoming popular with patients coming from overseas, but our own citizens do not have proper access to basic healthcare services.

BUDGETARY ALLOCATIONS

The proportion of GDP allocated to public spending on healthcare in India is among the lowest in the world; China spends around two percent of its GDP, UK six percent while the US spends around 16 percent. Countries like Nepal and Bangladesh spend about 1.5 and 1.6 percent respectively of their GDPs on health while we spend around one percent³. The aggregate public expenditure on health has increased only

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1 State of World Population 2008, Reaching Common Ground: Culture, Gender and Human Rights, UNFPA

2 *Ibid*

3 The Financial Express, March 02, 2006

by 0.1 percent of GDP during the last five years. However, the almost stable trend masks a doubling of the central share in the total health budget of the government at the expense of state governments.

The UPA government has been seemingly committed to helping the rural people but figures tell a different story. As per the budget estimates of 2007-08, the Central and state governments are spending about Rs 42000 crore annually on healthcare. If these resources were distributed on an equitable per capita basis, then rural areas would get Rs 29000 crore at the rate of Rs 420 per capita in contrast to the actual figure of Rs 17500 crore at the rate of Rs 250 per capita. There is a gap of almost Rs 500 between per capita government health expenditure in urban areas and that in rural areas.

OUTCOME

Inadequate and inefficient expenditure on the public health system has led to deterioration of quality and adversely affected the vast majority of the poor who are its main users. This has forced many among the poor to shift to private healthcare which is almost unregulated.

Programmes, such as NRHM and ICDS have been implemented to provide accessible, affordable and quality health service to the rural poor and pre-school children in rural areas and urban slums. However, their implementation leaves a lot to be desired – for instance, these programmes are being implemented through underpaid women workers [Associated Social Health Activists (ASHAs) and *Anganwadis* constitute the backbone of these schemes] receiving less than minimum wages, and lack adequate equipment and infrastructure.

ISSUES FOR DISCUSSION

- ◆ It is important to make growth inclusive. The best way to achieve this is through augmentation of human capabilities for participation in the growth process, and improved delivery of public/social services. How should the composition of government expenditure be changed to facilitate this objective?
- ◆ Most of the government spending on health and education is being allocated to the revenue account. Given the large share of unproductive and distorting subsidies in revenue expenditure, do you think that a shift towards more capital expenditure is viable and desirable? What should be the extent of this shift?
- ◆ The budgetary allocations to social sectors are growing but without any commensurate increase in welfare benefits to the masses. Do you think that a change in the implementation modalities of budgeted schemes is required for better outcomes?
- ◆ Public expenditure on social services hardly benefits the needy because of leakages and wastage. Only well targeted expenditures coupled with sound implementation can benefit the poor. What should be the mechanisms for achieving these objectives?
- ◆ Can the voucher scheme help in improving the outcomes of public expenditure on health and education?
- ◆ Equity in healthcare and education is measured by attributes such as access and universality, efficiency, quality and subsidy. Investments in these sectors without any progress in mentioned attributes would imply a lack of enhancement in benefits for the poor from such services. How can budgetary allocations be used to enhance the values of these parameters?
- ◆ The state has the responsibility of ensuring proper healthcare. Thus, it not only has an important role to play as an agency that finances and facilitates but as one that sets standards, regulates, and ensures that contradictions within the overall system are minimised. How can the state effectively perform its dual roles? Can privatisation of healthcare or public-private partnerships (PPPs) resolve this dilemma?

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