

CHALLENGES IN HUMAN DEVELOPMENT IN INDIA THE CASE OF EDUCATION AND HEALTH

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By all evidences available, the public funded part of India's social sector is in a crisis. Over crowded and dirty hospitals, non-functioning primary health services, absent staff, lack of dignity and privacy for clients, wasted investments, in fructuous expenditures, corruption are all found in the Public Health System. In the area of higher education, one fourth of the universities in the country, including deemed universities were private universities. About 80 to 90% of the professional colleges in some of the southern states were completely self financing colleges. They were still rapidly increasing in numbers, while the relative size of the public sector was dwindling. For proper human development along with economic development, social sectors must be linked with economic growth. Social services are the tools of human resource development and all development in the ultimate sense should culminate in human resources and thereby human development. We need to fill the gaps in the health and education sectors in India to meet the challenges in human development and also to meet the millennium development goals as the improvement of education and health have a lasting effect on the quality of life of the people of the country.

Key words : Human development, Public health, Education, Public Private Partnership.

INTRODUCTION

Human capital formation plays a vital role in economic development. The knowledge and skills that individuals acquire and the institutional framework in which these gets deployed together determine an economy's capacity to prosper. This is all the more relevant in the knowledge economy, in which the prime determinant of value is the knowledge wielded by workers (Dash, 2007). The classical economist Adam Smith considered the high potential, abilities and ambience on the part of individuals as a sort of capital. Irving Fisher moves a step ahead and treats capital as all-inclusive. Schultz considered human beings as a part and parcel of the wealth of nations. Investment in people can enlarge the range of choices available to them. Unless societies recognize that their real wealth is their people, an excessive obsession with the creation of material wealth can obscure the ultimate objective of enriching human lives (Human Development Report, 1994).

Economic growth without improving the quality of life of the people is meaningless. The very presence of pure drinking water, provision of education, provision of sanitation and housing provision and accessibility for health care service etc. are the very basis on which the quality of life and progress of human development of a country depends. It is also proved that many advanced countries experienced that investment in health and education accelerate growth in terms of Gross Domestic Product. Though this is the case, the investment pattern that has been followed in India since the inception of the planning era reveals that education and health has not received much attention and is neglected though the economists and social scientists argue for heavy investment in these social sectors.

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HEALTH

As affirmed by the World Health Organization, health can be conceptualized as a state of complete physical, mental and social well-being. Thus, the concept of health includes the physiological as well as psychological dimensions of human life. Public health is a type of public good, or more precisely merit good, which is very critical for general social welfare. Body capital (the physical human body) is a part and parcel of the human capital that determines the rate of growth of labour productivity and economic progress of a country. These days, in many developing countries, health planning, therefore, is made an integral part of the general economic planning. Public health services are the services that are rendered by government institutions for the prevention and cure of diseases and also for the maintenance of the good health of the nation. Public health services are concerned mainly with dissatisfaction, discomfort, disease, disability and death (Cullis et al. 1979; Sifford, 1977 :12-13). Conventional wisdom, however, does not make any valid distinction between the health care systems and health care services in making theoretical and empirical analyses, although the two do not mean the same thing. Health care services are more concerned with all types of services that are needed for good health and the drug sector is generally excluded. The health care system is the totality of the health care protocol that includes all types of institutions, inputs and outputs that the system is dealing with. It is the health care services which has an important bearing in the improvement and sustenance of human development.

Table 1, Differentials in Health Status Among Major States

Different States	IMR	Under five Mortality	Percentage of under Weight Children*	Percentage of stunted Children	Diabetic Asthma		Diabetic Asthma	
					(Per one lakh women)		(Per one lakh men)	
India	57	74.3	42.5	48	881	1696	1051	162
Punjab	41.5	52.0	24.9	36.7	849	945	802	802
Rajasthan	65.3	85.4	39.9	43.7	282	1565	362	173
M.P.	69.5	94.2	60.0	50.0	558	1283	555	110
Uttarpradesh	72.7	96.4	42.4	56.8	383	1089	456	122
Bihar	61.7	84.8	55.9	55.6	1024	1696	940	981
Orissa	64.7	90.6	40.7	45.0	556	2533	1179	159
West Bengal	48.9	59.6	38.7	44.6	1641	3304	2323	436
Meghalaya	44.6	70.5	48.8	55.1	910	1618	641	746
Assam	66.1	85.0	36.4	46.5	402	1411	601	110
Tripura	51.5	59.2	39.6	35.7	1656	5924	2392	508
Maharashtra	37.5	46.7	37.0	46.3	479	1714	906	185
Gujarath	49.7	60.9	44.6	51.7	968	1530	524	184
Andhra	53.5	63.2	32.5	42.7	838	2125	2116	218
Karnataka	43.2	54.7	37.6	43.7	681	1259	973	691
Kerala	15.3	16.3	22.9	24.5	2549	4037	3078	298
Tamil Nadu	30.4	35.5	29.8	30.9	2188	1126	1351	687

*Includes children who are below -3 standard deviation from the International Reference Population Median. Source :NFHS 3

Good health is not only an outcome of increase in income but is also a determinant of the latter. Apart from governing the core of human well being, health itself promotes development via increase in productivity and hence income, which is known as health income linkages. The improvement in the health status of people is essential to sustain economic and social development as the majority of the people living in India have yet to reach the Utopian ideal of the health for all, despite many decades of planning and implementation programmes. Successive governments in India have over the past five decades, proposed and implemented many schemes for the provision of safe water, sanitation, and nutrition and vaccination coverage. Yet millions do not have access to these basic needs. The recent NFHS data (NFHS III 2005-06) reveals that 48% of Indian children are anaemic and 40% of children are under weight. Vaccination coverage is inadequate and only 43.5% children below five years have been ministered all the basic vaccinations. Table 1.1 clearly reveals the differentials in health status across the country, and it reveals that the conditions of health is very deplorable in poor performing states like; Orissa, Bihar, Rajasthan, Uttar Pradesh and Madhya Pradesh and also West Bengal and many North Eastern States, including Assam and Tripura. Even after 6 decades of planned development, the health status of these states is very poor in terms of the basic indicators of health.

Demand and Supply of Health Services

Despite substantial improvement in key health indicators since independence, the burden of disease in India attributable to preventable, communicable diseases remains extremely high. Recent estimates shows that India comprises 19% of the disease burden globally, measured using Disability Adjusted Life year's¹ (WHO, 1999). It is generally agreed that in order to continue the downward trend in mortality and morbidity indicators, in particular for women and children, rapid improvements in access to good quality essential health services such as immunization and emergency obstetric care is required particularly in the BIMARU² states.

Ensuring that sick individuals receive the care they need depends on two broad factors : first, the availability of health services (i.e. supply) and secondly, the health seeking behavior (i.e. demand). The extent and way in which supply and demand interact or do not, will determine to a significant degree the extent to which the burden of disease reduces.

Table 2, Supply of health professionals - India International Comparisons

Country	Doctors per 1,00,000 population	Nurses per 1,00,000 population
India	45	112
Pakistan	57	34
Bosnia Herzegovina	143	452
Zimbabwe	14	129
Tonga	44	315

Source : WHO, The World Health Report (Geneva, WHO, 2002)

The amount of health service supplied in a country is influenced partly by its level of wealth, but also by the priority given to it. Compared with countries of broadly equivalent income levels³, India has similar number of doctors (both in the public and private sectors) but a relatively lower number of nursing staff (Table - 2)

Table 3, Total Government Allopathic Hospitals Including CHCS and Bed Ratio to Population

Sl. No	States and UTs	Total No. of Govt. Hospital	Total No. of Govt. Hospital Bed	Population served per Govt. Hospitals	Population served per Govt. Hospital Bed
1.	Andhra Pradesh	521	35021	154376	2297
2.	Arunachal Pradesh	66	2053	17500	562
3.	Assam	100	3000	280500	9350
4.	Bihar	101	3030	869406	28980
5.	Chattigarh	138	5565	159500	3955
6.	Goa	20	2639	74650	566
7.	Gujarat	503	35056	108974	1564
8.	Haryana	133	7118	170444	3185
9.	Himachal Pradesh	141	7786	45106	817
10.	Jammu division	36	1700		
11.	Kashmir division	40	1595		
12.	Jharkand	47	1410	602191	20073
13.	Karnataka	723	413.4	76744	1343
14.	Kerala	189	25839	177614	1299
15.	Madhya Pradesh	324	17702	186373	3411
16.	Maharashtra	1170	76447	86560	1325
17.	Manipur	28	670	91464	3822
18.	Meghalaya	30	2157	80367	1118
19.	Mizoram	20	1169	47150	807
20.	Nagaland	48	2060	43938	1024
21.	Orissa	406	13146	96190	2971
22.	Punjab	160	8773	158350	2824
23.	Rajasthan	510	32080	120176	1910
24.	Sikkim	7	730	82714	793
25.	TamilNadu	424	43567	153917	1498
26.	Tripura	26	2231	129808	1513
27.	U.P	294	8820	601241	20041
28.	Uttaranchal	36	1080	247917	8264
29.	W.Bengal	642	58516	131924	1447
30.	A.N. Island	8	897	48125	424
31.	Chandighra	7	2200	138428	
32.	Dadra & Nagar Haveli	2	105	121000	23.5
33.	Daman & Diu	4	192	42500	585
34.	Delhi	165	20368	144076	743
35.	Lakshadeep	5	160	1300	406
36.	Pondi cherry	15	3173	68467	2336
	Total	7029	469559	156088	2336

Source : Govt. of India (2005) Health Information. India, Ministry of Health and Family Welfare, New Delhi.

Table 3, shows the supply of health services in terms of the density of government hospitals including primary health centers across the Indian states. Table 4 presents the percentage of births/deliveries attended by health personnel. Among the major states; Himachal Pradesh, Rajasthan, West Bengal, etc. have the largest density of govt hospitals (Table 3) but it reveals that they have a relatively low level of births attended by a health professional (Table 4) which is one of the most important strategies needed for the reduction of maternal and infant mortality. The available data revealed that in West Bengal only 47.6%, in Rajasthan 41.6% and in H.P only 47.8% of births were attended by health professionals.

Table 4, Percentage Deliveries Attended by a Health Personnel

State	Deliveries Attended by a Health personnel
India	46.6
Delhi	64.1
Haryana	48.9
Himachal pradesh	47.8
Jammu & Kashmir	56.5
Punjab	68.2
Rajasthan	41.0
Uttanchal	38.5
Chattisgarh	41.6
M.P	32.7
Uttarpradesh	27.2
Bihar	29.3
Jharkhad	27.8
Orissa	44.0
West Bengal	47.6
Arunachal Pradesh	30.2
Assam	31.0
Manipur	59.0
Meghalaya	31.1
Mizoram	65.4
Nagaland	24.7
Sikkim	53.7
Tripura	48.8
Goa	94.0
Gujarath	63.0
Maharashtra	68.7
A.P	74.9
Karnataka	69.7
Kerala	99.1
Tamil Nadu	90.6

Source : NFHS-3, 2005-06

Demand for Health Service in India

The data revealed by table 3 and Table 4 suggests that simply establishing a health facility in a particular location does not guarantee that the service provided will be used. Distance to a facility, the cost of consultation with a doctor, availability and cost of alternative providers and perceptions of service quality are just some of the other factors that will influence the way in which demand (patients) and supply (health professionals) do or do not interact (Government of India, 2005). The most reliable quantitative analysis of the usage of health services at the all India level is available from the National Sample Survey (NSS) as well as from the National Council of Applied Economic Research. The usage of private health facilities increased significantly from an already high level as observed between the 42nd and 52nd round (1995-96) of the NSSO. The evaluation of the India's Xth Five Year Plan (2002-2007) and the ongoing consultation in the preparation of reproductive and child health programme for the 1st phase of XIth Five year Plan provides a unique opportunity to assess the health and population outcome achieved and the failures and loopholes associated with the programme.

Table 5, Pattern of Investment in Health (including family welfare) in Different Five Year Plans in India

Sl. No.	Period and Plan	Percentage on health out of total plan investment outlay	Percentage on family welfare out of Total Plan Investment outlay	Total for Health & Family Welfare
1	First Five Year Plan (1951-56)	3.3	0.1	3.4
2	Second Five Year Plan (1956-61)	3.0	0.1	3.1
3	Third Five Year Plan (1961-66)	2.6	0.3	2.9
4	Annual Plan (1966-1969)	2.1	1.1	3.2
5	Fourth Five Year Plan (1969-1974)	2.1	1.8	3.9
6	Fifth Plan (1974-79)	1.9	1.2	3.1
7	Annual Plan (1979-80)	1.8	1.0	2.8
8	Sixth Plan (1980-85)	1.8	1.3	3.1
9	Seventh Plan (1985-90)	1.7	1.4	3.1
10	Annual Plan (1990-91)	1.6	1.3	2.9
11	Annual Plan (1991-92)	1.7	1.5	3.2
12	Eight Plan (1992-97)	2.3	1.7	4.0
13	Ninth Plan (1997-2002)	2.09	1.83	3.97
14	Tenth Plan (outlays) (2002-2007)	1.6	1.3	2.9

Source : Health Information of India, Ministry of Health & Family Welfare.

By all evidences available, the public funded part of India's Health and Family Welfare Sector is in a crisis. Over crowded and dirty hospitals, non-functioning primary health services, absent staff, lack of dignity and privacy for clients, wasted investments, in fructuous expenditures,

corruption are all found in the system. It is estimated that over 80% of the recurring expenditure goes for salaries (especially in states like Kerala) and a very meager percentage has been allocated to medicines and supplies which itself makes public health centers as scarecrow (Gangadharan, 2005). The basic issues of the health centers is that there are equipments but no experienced professionals to operate it and even if equipments are available they are not properly maintained. Routine services are in disarray and the contract or adhoc mode of implementation which now prevails is adversely affecting the routine functioning still further. In the population (Family Welfare) sub sector, rates of population growth are not dropping fast enough in the most populous states. In states where reductions have taken place, the drop has been fuelled mostly by government drives for female sterilization. Vertical disease center's programmes are showing limited results at best and killer diseases like tuberculosis is resurgent. The spread of AIDS/HIV is a major threat. The declining female to male ratio is a potential disruption to social order. The management systems, namely the secretaries and directorates, are fragmented, over whelmed with routine personnel and procurement matters and lack both the capacity and the will to think and act strategically (Govt. of India, 2005)

Financial Constraints and Limited Funding

An important issue faced by the health sector in India, especially by the family welfare segment, is the acute shortage of funds. The allocation of funds for health and family welfare from the First Plan to the Xth plan (Table 5) reveals the negligible proportion earmarked for the health sector and even after 6 decades of planned development there was not much improvement in the allocation to this sector and actually it declined from 3.3% in the First Plan to 2.09% in the Tenth Five Year Plan.

The major constraint in family welfare programmes has been the accumulation of arrears payable to the state overtime. The National Family Welfare Programme, which is a centrally sponsored programme is usually financed for both plan and non-plan activities by the central govt. Since state governments have responsibilities for the implementation of the programme, shortfalls in the central funding has resulted in the accumulation of substantial arrears payable to the states. These large arrears are bound to have an adverse impact on programme delivery.

Thus, the shortfall in public spending provides an opportunity for the private sector to occupy its space and later begins to control the entire expenditure in the sector.

The share of private expenditure in total health expenditure increased steadily and the recent estimate (National Accounts Statistics 2004,⁴ WHO 2002 shows that it reached a record level of around 83%. This reveals the domination of private sector in the health care environment of India and the vanishing role of the government in the overall health care expenditure of the country. (Table 6). When compared to other developing and developed countries the position of India is very bleak with regard to the govt. expenditure on health as a percentage of total expenditure. The figure 83% represents the out of pocket expenses incurred by household and includes expenditures incurred while seeking services from both public and private sectors⁵.

Thus, to revamp and revitalize public health care delivery system as the top item on the agenda would require restoring credibility to the public sector primary health service operating at the urban, rural, tribal and remote areas. For ensuring credibility of the system; enough funds along with the supply, properly trained manpower and very committed monitoring and follow up action at the national level must be ensured to wake the system work meaningfully to cater to the health needs of the deprived, marginalized and vulnerable millions.

Table 6, Public and Private Expenditure on Health in Selected Countries

Sl. No.	Countries	Total Expenditure on Health as percentage of GDP	Pvt. Expenditure on Health as % of total expenditure of Health	Govt. expenditure on health as % of total expenditure of health
1	Australia	8.3	27.6	72.4
2	Bangladesh	3.8	63.6	36.4
3	Brazil	8.3	59.2	40.8
4	Canada	9.1	28.0	72.0
5	China	5.3	63.4	36.6
6	France	9.5	24.0	76.0
7	Germany	10.6	24.9	75.1
8	India	4.9	82.2	17.8
9	Iran	5.5	53.7	46.3
10	Italy	8.1	26.3	73.7
11	Jappan	7.8	23.3	76.7
12	Mexico	5.4	53.6	46.4
13	Nigeria	2.2	79.2	20.8
14	Pakisthan	4.1	77.1	22.9
15	Philipines	3.4	54.3	45.7
16	Russia	5.3	27.5	72.5
17	South Africa	8.8	57.8	42.2
18	Thailand	3.7	42.6	57.4
19	U.K	7.3	19	81
20	USA	13	55.7	44.3
21	Uganda	3.9	62	38.0
22	Tanzania	5.9	53	47.0
23	Zambia	5.6	37.9	62.1

Source : WHO, The World Health Report (Geneva, WHO, 2002)

EDUCATION

Like health, education is also an important segment of social development and investment in education is essential for better human development. Alfred Marshal treated investment in education as a national investment (John Vaizey, 1968) and its benefits should percolate to all sections and all communities. Educational advancement has been considered as the pre-condition for agricultural and industrial development. The study made by Schultz, 1961; Harbison and Myres, 1964; Kendrick, Simon Kuznets and others reveals that investment in education is more productive than investment in physical capital. The success story of all advanced countries lies in the utmost significance given to educational planning and development and this has been well proven in the case of countries

like the U.S., Japan, the Soviet Union etc. and the East Asian economic miracle was the outcome of successive and sustained public investment in education.

Table 7 , Dropout Rates in class (I-X), Number of Schools Per Thousand Population and Accessibility to Schools within Premises Among Major States in India

States	Dropout rates in classes I-X in 1998-99			Population with U.P Schools *			Number of Schools per 1000 population in 1997-98	
	Boys	Girls	Child ren	Within Habitation	Up to 1.0km	Total up to 10km	Prim ary	Upper Primary
Andhrapradesh	76.52	78.65	77.44	42.99	13.70	56.69	5.34	1.56
Arunachal Pradesh	76.09	78.67	77.20	33.13	6.80	39.93	8.21	4.64
Assam	76.55	75.32	76.00	22.40	26.69	49.09	8.62	3.58
Bihar	81.44	87.26	83.47	27.13	29.39	56.52	3.97	1.92
Gujarath	70.12	74.96	72.29	76.79	6.70	83.49	2.86	6.12
Haryana	45.24	55.98	50.04	64.70	10.24	74.94	4.06	1.24
Himachal Pradesh	42.21	43.20	42.67	17.33	19.82	37.15	10.03	2.19
Jammu& Kashmir	61.47	70.24	65.10	38.41	20.16	58.57	7.89	4.93
Karnataka	67.21	68.91	68.02	60.86	10.45	71.31	3.82	6.61
Kerala	30.02	19.16	24.70	50.54	16.97	67.51	2.20	1.54
Madhyapradesh	60.37	75.22	66.73	31.36	11.45	42.18	8.18	3.76
Maharashtra	55.02	64.22	59.33	61.08	7.82	68.90	3.97	3.68
Manipal	76.35	76.74	76.54	37.25	25.60	62.85	8.69	4.02
Meghalaya	62.12	63.74	62.89	25.57	21.21	46.78	13.38	6.05
Mizoram	73.85	71.10	72.56	77.58	3.0	80.58	11.17	11.11
Nagaland	63.84	60.98	62.59	47.76	15.32	63.08	6.80	4.56
Orissa	52.42	62.05	52.27	34.21	18.25	52.46	9.66	4.99
Punjab	39.99	44.35	42.02	45.41	17.67	63.08	4.84	1.65
Rajasthan	77.63	82.74	79.29	46.96	8.74	55.70	4.88	3.88
Sikkim	89.38	89.00	89.21	26.38	16.88	43.26	6.72	3.05
Tamil Nadu	57.22	58.35	58.01	35.36	32.44	67.80	4.91	1.43
Uttarpradesh	79.94	83.95	81.78	24.92	28.38	53.30	4.14	1.77
West Bangal	55.13	72.68	61.25	21.69	22.16	43.85	4.21	1.71
All India	65.44	70.22	67.44	37.02	19.89	56.91	5.04	2.75

*Figures as on 1993/ Source: National Human Development Report 2001

In 1960, Pakistan and Korea had a similar level of income, whereas by 1985 Korea's GDP percapita was nearly three times that of Pakistan. Investment in education has a important egalitarian effect on equity and alleviation of poverty (Dash, 2007) Education has important links with other

aspects of human resource development such as health and fertility (Cochrane, 1979). The strong link between education and life expectancy, disease and nutrition has been reinforced by Cochrane, O Hara and Leslie (Cochrane et al, 1980). Studies held in India revealed that education plays a significant role in bringing about a socio-economic change. A study of 14 most populated states in India during the period 1961-81 has shown that one additional year of education of the workforce was associated with a 15 percent increase in income output (Loh Jacqueline, 1995). Spending on education, therefore, is not simply a consumption activity, but it is an investment in human capital.

The investment in education and the development of the education sector in India is a matter of concern even after 6 decades of planned development of this country. Though the average literary rate was estimated at 65% in 2001 census, there are wide sex, regional and community differences in the literary rates in India. Similarly, the educational attainment, accessibility, dropout rates etc. are also very high among the backward states and the backward communities in India. Table 7, reveals the dropout rates in classes 1-X, the accessibility of schools within the premises for children in the upper primary level and number of schools per thousand population etc in different states in India and it reveals the severity of inequality and differentials that exists among different states and also the deteriorated profile of education in these states which directly affects the quality of human development.

Higher Education : A Mirage

India has a well-developed and comprehensive higher education system. Though it has the second largest system of higher education next only to U.S.A, the total number of students represent only about 10% of the relevant age group aged between 18 and 23 years, which is much below the average of developed countries (47%) and less than that in many developing countries which varies between 20 and 25%. There is an overwhelming need to undertake major expansion measures to increase access to higher education without sacrificing quality. As the 11th Five Year Plan Document states, the triple objectives of expansion, inclusion and excellence will require a substantial increase in resources devoted to this sector by the center and the states.(Government of India,2006)

Secondly, inter-state variations in the development of higher education are glaring in India. Some states have expanded their higher education systems fast, but many are lagging behind. For example, the enrolment ratio was as high as 29 percent in Chandigarh, but less than five per cent in Jammu and Kashmir and Nagaland in 2002-03. In as many as 15 out of 31 states/union territories in which estimates are made, the enrolment ratio is below the national average, less than nine per cent.

The World Development Report for 2004 titled “Making Services Work for Poor People” is in a sense an eye opener. It has shown how services are failing poor people. First, public spending on health and education is typically enjoyed by the non-poor. Second, even reallocation towards the poor does not help the poorest among the poor. Third, there are no incentives for effective delivery of services to the poor. The fourth way services fail the poor people is lack of demand.(World Development Report, 2004)

Demographic Dividend

The quantitative aspect of taking general higher education to the poor is revealed by some recent research studies which indicate that there will be significant changes in national income and per capita income in the next 50 years. The present age structure of the Indian population is such that India has now certain advantages not available to developed countries and even fast developing

countries like China and this is called demographic dividend. The bulge in the population at present is concentrated below the working age (15-60 years) group. In the coming decades, this bulge will move and all these people will be in the working wage bracket contributing to GDP. Even China may experience labour shortage in the next few decades because of the belated effect of the strict one-child norm imposed much earlier. So India may be more favourably placed in terms of its age composition of the population. Our dependency rate is falling whereas in industrialized countries and even in China it is rising. The presence of a skilled young population in an environment where investment is expanding and the industrial world is aging could be a major advantage. It is important to realize that we can only reap this demographic dividend if we invest on human resource development and skill to provide productive employment for our relatively young working population. If we fail to do so, the demographic dividend will be turned into a demographic nightmare. The state has to play an increasingly important role in formulating plans for human resource development, which should benefit the poor.⁶

There are some instances and events in India, which vividly indicate the dangers associated with the withdrawal of state from higher education. The Bombay University is thinking in terms of getting listed on stock exchanges. This sets us on thinking about the objectives of educational institutions, their finances and the purpose of stock exchanges. The first petition to set up Bombay University was sent in 1852 to the British Parliament by the Bombay Association. The petition stated that the purpose of setting up the University was to impart education to the citizens to become knowledgeable and thereby wealth creators. The University was destined to become a facilitator and not necessarily a wealth creator itself. The reason no university has gone public to raise funds is that the institution is regarded a provider of great social service and not as a profit-making avenue. A day may come when the Vice-Chancellor of Bombay University would be seen quarter after quarter defending the profit numbers and not talking about the merits of good education. On the flip side, the courses would be priced to the market. Hence all the “inefficiencies” of the University would be built into the pricing of the courses. There are all possibilities of poverty of money and knowledge. Considering all such possibilities, Deena Mehta writes that a regulator or an authority, a university included cannot and should not be held by a few shareholders seeking profits. Instead it must continue to be held by public at large via structure of the government.⁷

Hurdles in the Development of Higher Education

The faulty assumption about the role of higher education in the socio-economic and political development of the nation and, more importantly the neo liberal policies introduced in the early 1990's had caused serious damage to higher education in the country. The available data reveals that public expenditure on higher education per student had declined in real prices by more than 25% between 1990-1991 and 2004-05. Allocation to scholarship's and research too had suffered significantly. Currently, hardly 0.4% of the GDP is being spent on higher education while it had been suggested by the Central Advisory Committee on Financing of Higher and Technical education constituted by the Central Advisory Board (CAB) on education, that 1% of the GDP should be allocated for higher general education, another 0.5% for the higher technical education and the National Knowledge Commission has also endorsed the same. As a corollary to declining public budgets, the private sector has grown very rapidly in the area of higher education in the form of self financing colleges and private universities. About one-fourth of the universities in the country, including deemed universities were private universities. About 80 to 90% of the professional colleges in some of the southern states were completely self financing colleges. They were still rapidly

increasing in numbers, while the relative size of the public sector was dwindling. The available data reveals that higher education in India is more privatized than in the United States. Student's fee has been raised in most institutions very significantly during the last 10-15 years and as a result more than 50% of the recurring budgets in some universities were being met out of student's fee contribution. Most private institutions were charging a fee that equalled if not exceeded the costs. Increase in student's fees along with cut in scholarships and increasing reliance on educational loans would create serious impediments to improving the access to higher education and cause serious imbalances in the development of higher education.

When certain stark realities are considered, we may be justified in developing the impression that the fate of higher education is almost doomed. In 'minority institutions' admissions, appointments and expenditures, frequently violates the rules as and where it suits its governing body. With FDI flowing into higher education, foreign colleges are mushrooming in Bangalore. Thousands of degree holders that these colleges turn out are unemployable. A Bangalore based Foreign University charges very high fees but employs only part-time faculty. Deemed Universities, Foreign Universities, autonomous colleges, fully self-financed colleges, fully self-financed courses and minority colleges—all of these have discriminatory standards that nullify our dreams of general higher education. Any form of withdrawal of the states from this field would amount to denying general higher education to the poor. Only the state funded and the state controlled colleges and universities could at least provide avenues of general higher education to the poor.

Table 8, Public Expenditure on Education in India

Year	Percentage of Expenditure on education to Expenditure on all sectors (including Centre and State)	Percentage of Education Expenditure to GDP
1951-52	7.92	0.64
1955-56	10.65	1.15
1960-61	11.99	1.48
1965-66	9.82	1.69
1970-71	10.16	2.11
1980-81	10.67	2.98
1990-91	13.37	3.84
1995-96	13.34	3.56
1999-2000	14.60	4.25
2000-01	14.42	4.33
2001-02	12.89	3.82
2002-03	12.74	3.97

Source: Govt. of India, Ministry of Human Resource Development, selected Educational Statistics 2002-03, New Delhi.

Availability of financial resources is vital for any development programme in the field of education. The central govt., state governments and households are the main sources of finance for education. The ability of the state governments to finance education depends on their revenue raising ability and the transfer of resources through the Finance and Planning Commission as total expenditure on education is low, expenditure by the Central and State Government was only 3.56%

of the GDP in 1995-96 which rose to 4.33% in 2000-01 but again declined. to 3.97% in 2002-03 (Table 8). The recent data reveals that this has again declined to 3.54% in 2004-05.

Table 9, Percentage of Plan Expenditure on Different Segments of Education

Sector	1 st Plan	II nd Plan	III rd Plan	IV th Plan	V th Plan	VI th Plan	VII th Plan	XIII th Plan	IX th Plan	X th Plan
Elementary education.	58	35	34	50	52	32	37	48	65.7	65.6
Secondary education.	5	19	8	-	-	20	24	24	10.5	9.9
Adult education	-	-	2	2	6	6	5	24	2.9	2.9
Higher education	8	18	15	25	28	21	16	10	10.3	9.5
Others	15	10	12	13	9	11	3	3	1.6	1.4
Technical	14	18	21	10	9	10	14	10	9.5	10.7
Total	100	100	100	100	100	100	100	100	100	100

Source : Gopalji and Soman Bhatt, Statistical data on Indian Economy, New Delhi.

The plan expenditure for the last 6 decades reveals that top most priority has been given to elementary education, but the allotment has remained the same for 9th and 10th plan period. The proportion allocated for higher education has shown a steady increase during the 2nd, 3rd, 4th and 5th Plan periods, but thereafter it has declined steadily and the 10th plan allocated only 9.5% for higher education (Table 9). The expenditure pattern of education in India reveals that expenditure composition is skewed towards secondary and tertiary education.

The task of taking higher education to the doorsteps of the poor calls for greater involvement of the state which in turn would necessitate greater financial commitment of the Central and State Government. This financial commitment may have to be periodically monitored and reviewed to ensure the optimum utilization of financial resources as also to guarantee quality of higher education in the interest of the poor in India

As a country moving towards a knowledge economy, allocation of more funds to the education sector is most evitable to develop its human capital base. Since the public sector is starving for funds, for social sector investment the private sector must be encouraged to invest heavily in the higher education segment of the economy but this investment must be within the control of the government and in the form of public private partnership with control of the public sector in the basic academic and administrative spheres.

HUMAN DEVELOPMENT

The need for increasing investment in human capital formation is of crucial importance at the present level of development and the postponement of this will invite severe threat to the knowledge economy of the country.

UNDP's global Human Development Report for 2005 ranks India at 127 out of 177 countries of the world in terms of a composite Human Development Index. Compared to 2000 in 2003 the HDI has fallen from 124 to 127 and at the same time gender development index has improved from 105 to 98. During this period some of India's neighbors (Table 10) not only improved their HDI and GDI values but also improved their relative ranks. The progress of social development has varied across states. While Kerala stood apart from the rest and achieved a high level of human

development comparable to the rich developed countries, whereas the so called BIMARU states (viz. Bihar, Madhyapradesh, Rajasthan and Uttar Pradesh) performed very badly (Table 11).

Table 10, India's Global Position on Human and Gender Development

Country	Human Development Index (HDI)		HDI Rank		Gender Development Index		GDI Rank	
	2000	2003	2000	2003	2000	2003	2000	2003
Norway	0.942	0.963	1	9	0.941	0.960	3	1
Australia	0.939	0.955	5	3	0.956	0.954	1	2
Sri Lanka	0.741	0.751	89	93	0.737	0.747	70	66
China	0.726	0.755	96	85	0.724	0.754	77	64
Indonesia	0.684	0.697	110	110	0.678	0.691	91	87
India	0.577	0.602	124	127	0.560	0.586	105	98
Pakistan	0.499	0.527	138	135	0.468	0.508	120	107
Bangladesh	0.478	0.520	145	139	0.468	0.514	121	105
Nepal	0.490	0.526	142	136	0.470	0.511	119	106
Mozambique	0.322	0.379	170	168	0.307	0.365	144	133

Source : UNDP Human Development Report 2002 and 2005

Table 11, Human Development Index for Selected States

States	HDI Value 2001	2001 Rank
Andhrapradesh	0.416	10
Assam	0.386	14
Bihar	0.367	15
Gujarat	0.479	6
Haryana	0.509	5
Karnataka	0.478	7
Kerala	0.638	1
Madhyapradesh	0.394	12
Maharashtra	0.523	4
Orrisa	0.404	11
Panjab	0.537	2
Rajasthan	0.424	9
Tamil Nadu	0.531	3
Utter Pradesh	0.388	13
West Bangal	0.472	8

For proper human development along with economic development, social sectors must be linked with economic growth. Social services provide a better chance of self expression and for community recreation. Myrdal is of the view that a vicious circle of poverty can be turned into a virtuous circle where meeting social needs is cumulatively raising the levels of production (Chopra, 1992). Social services are the tools of human resource development and all development in the ultimate sense should culminate in human resources and thereby human development. We are therefore required to lay emphasis on economic development and social development simultaneously. We need to fill the gaps in the health and education sectors in India to meet the challenges in human development and also to meet the millennium development goals as the improvement in education and health have a lasting effect on the quality of life of the people of the country. The policy makers, planners, administrators and politicians should realize that augmenting the quality of population through better education and better health care will provide a sound edifice for rapid and sustained economic development.

NOTES

1. This includes 23.9% of all DALY, lost due to communicable diseases and 14.9% due to non communicable diseases.
2. BIMARU includes Bihar, Chattisgarh, Jharkhand, Mandhya Pradesh, Orissa, Rajasthan, Uttar Pradesh and Uttaranchal.
3. Based on purchasing power parity dollars, which adjust for price differentials between countries and as reported in the World Fact Book 2001, India at PPP \$2200 percapita has the same level of income as Tonga. Other countries with similar level includes Pakistan (2000) Bosnia & Herzegovina (1700) and Zimbabwe (2500)
4. National Account Statistics 2001, Central Statistical Organization, Ministry of Statistics and Programme Implementation, Govt. of India, July 2001.
5. Out of pocket health expenditure by house holds includes;
 - * Buying services from a purely private allopathic (Western India) practioner (doctor, nurse, pharmacist or Para medical) working in a private clinic or corporate hospital.
 - * User charges at government facilities, buying medicines and or diagnostic services from open market when these are not available at government facility or illegal payments to government doctors in a public health facility.
6. The Demographic Dividend can be a fortuitous Economic Opportunity or a missed chance, depending on how the Government deploys the huge emerging workforce into productive streams of economic activity. For details see his paper "India must leverage the 'demographic dividend', **The Hindu Business Line**, March 28, 2007.
7. S.D.Naik examines the need for improving the quality of Higher Education and expanding the supply of top institutions in his paper "Taking Education to a Higher Plane" published in **The Hindu Business Line** dated 22.12.2006. The Dangers of Universities going to the Market are explained by Deena Mehta in his article "Why a University must not got to the Market" published in **The Hindu Business Line**, dated March 12, 2007.

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