

INDIANOMICS

Is Spending Enough? Examining State Development Strategies in India

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Summary: *Low share of social sector spending and investments in human capital formation in overall GDP are believed to be the key factors responsible for inequalities within Indian states. This essay addresses the question of whether higher expenditure shares alone can help India's underperforming states overcome these challenges, by studying the methods India's best performing states adopted. It shows that beyond the actual volume of funds utilised, it is the nature of public institutions and incentives these states created, implemented and maintained which have enabled them to leverage existing bureaucracies towards their objectives. Simply, it isn't how much these states have spent, but how they've spent it.*

Inequality within India's states exists along a multitude of socio-economic dimensions, posing severe challenges for domestic socio-political stability¹. It is often alleged that low shares of social sector spending and investments in human capital formation in overall GDP are the key factors responsible for such inequalities (Drèze & Sen, 2013). In this essay, I address the question of whether higher expenditure shares alone can help India's underperforming states overcome these challenges, by studying the methods India's best performing states adopted. I try to show that beyond the actual volume of funds utilised, it is the nature of public institutions and incentives these states created, implemented and maintained which have enabled them to leverage existing bureaucracies towards their objectives. Simply, it isn't how much these states have spent, but how they've spent it.

Much criticism of the Indian State focuses on *underinvestment* in essential public services, without

adequate recognition of the dysfunctionality of India's bureaucracy (for instance, see (Chandra, 2010))². Comparisons with the BRICS nations, particularly China, and the OECD nations on the levels of Public Investment in Health and Education are often evoked to justify such claims (Drèze & Sen, 2013). These critiques are not baseless. India's investments in human capital formation as a fraction of its GDP are indeed low³, and the reallocation of public expenditures to education and health⁴ from relatively more wasteful subsidies, including those on non-merit goods such as cooking gas, is an important component of any policy recommendation targeting sustained growth in the economy.

However, the examples of Kerala, Himachal Pradesh and Tamil Nadu, states recording rapid growth from a low base, appear to contradict the idea that the *magnitude* of expenditure, or even expenditures as a fraction of income, has been a factor in translating policy into outcome. Bihar has among the highest fractions of GSDP allocated to healthcare – and yet, Bihar's progress on health indices has been limited at best⁵. Public Expenditure per capita in Education has been steadily *rising*; the SarvaShikshaAbhiyan (SSA)'s allocations have risen by 360% between 2005-06 and 2011-12, even as India's education budget has more than doubled between 2007-8 and 2012-13, with an average allocation of INR 11,509 per student⁶(Aiyar, 2014). Minimal progress in human capital formation must then be tied to other factors, and the political economy of modern India must feature in the evidently misplaced priorities of the state. Policymakers are failing to focus on *Outcome* and *Access* indicators of actual progress: the absence of a close relationship, noted above, indicates that in India, allocations at the

national level, even at the State level, are delinked from *local* outcomes⁷, thus indicating the adverse nature of a centralised, essentially “top-down” approach to development policy. Worryingly, policymaking is increasingly being driven by *intent*: showcasing achievements in terms of high allocations to signal commitment, paying little attention to the translation of these allocations to on-ground results⁸.

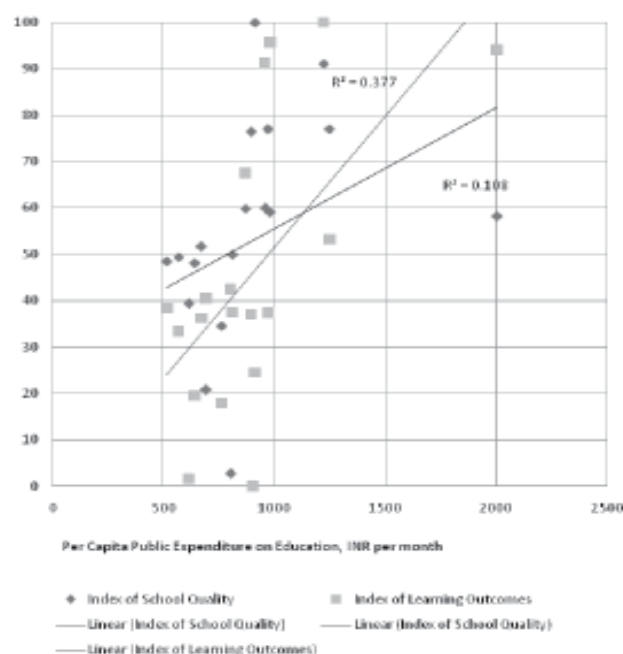
An analysis of the institutional regime surrounding education and healthcare programmes in India, along with the direction and allocation of expenditures is revealing. Massive shares of the budget spent on education are spent on “improving infrastructure”, when successive ASER reports indicate clearly that India has built enough schools, achieved near universal enrolment and appointed a sufficiently large teaching and administrative support staff. Minimal efforts have been undertaken to improve teaching quality and skills, despite successive ASER reports indicating stagnant, if not falling, learning outcomes⁹. 43% of the SarvaShikshaAbhiyan (SSA) budget is allocated as compensation for teachers, while improvements in teaching quality receive 2%. Measures of School Infrastructure Quality¹⁰ and learning outcomes¹¹ are only poorly correlated¹² with per capita public expenditure on education¹³.

If anything, the correlations are worse in the dimension of health, although they remain positive¹⁴. In states scoring poorly relative to their GSDP levels on healthcare, the Urban Allopathic Health Service expenditure is nearly twice that of the Rural Allopathic Health Service Expenditure, reflecting a clear urban bias in public service provision in India¹⁵. Unlike in Education, health infrastructure is indeed lacking across India, and yet, health expenditure on Capital account (broadly reflecting expenditure on health infrastructure) has *declined* as a fraction of total health expenditure (although the data indicate that the ratio is somewhat higher in the poorest states, including Uttar Pradesh¹⁶) (Bhat & Jain, 2004).

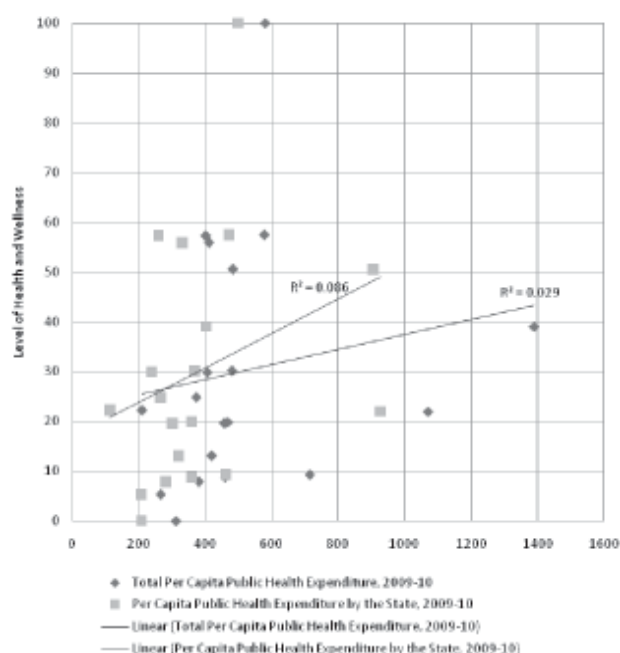
Evidently, for Socio-Economic Development, high levels of per-capita fund allocation are neither necessary, nor sufficient¹⁷. On the Education front, Kerala and Tamil Nadu actually have among India’s lowest per-student public expenditures on education – despite their exemplary performance on provisioning of education¹⁸. What is necessary is the existence of a

set of established institutions, which can generate and enforce accountability in governance, translate allocations into outcomes, and which are able to tackle established socio-economic barriers to the success of these programmes. It is useful to digress and review the stories of some of India’s States that have succeeded in doing this.

School Quality and Per Capita Public Expenditure



Health Outcomes and Per Capita Public Expenditures at current prices (INR)



In Kerala, very high literacy rates are partly the legacy of efforts by the British State and Christian Missionaries; however, the key thrust came after the election of a Communist Government in the 1960s, among whose key aims was the achievement of “total literacy.” The Leftist People’s Science Movement recruited volunteers whose goal was to spread education; the movement mobilised 20,000 people, sending them out to teach through methods involving the “concrete problems of their lives.” The poor were provided scholarships, as were traditionally backwards communities and the lower castes. Perhaps most significantly, violent Caste Reform movements and a militant new communist cadre helped in dismantling the hegemonic caste system in the State.

The Experiment, first attempted in Ernakulam, worked: by 1990, Ernakulam was declared India’s first Totally Literate District, with a literacy rate above 96%. In 1991, Kerala was declared as a Totally Literate State¹⁹(Chugh, 2009). It is telling that the total cost of the education provided was about \$26 per capita (McKibben, 1996). The expansion of literacy led directly to an increase in political participation; public pressure on the state, made possible by literacy, ensures the provision of high quality public infrastructure and healthcare, contributing to the high life expectancy and excellent indices of access and outcomes in health²⁰(Drèze & Sen, 2013).

Himachal Pradesh’s experience is perhaps even more significant in terms of a learning experience for currently underdeveloped States. A State commitment to Universal Education deserves credit: the state spends significant amounts on ensuring that students even in remote villages are able to access formal schooling, reflected in an unusually high per-student public expenditure. Planned interventions have led to an expansion of school facilities to bridge intra-regional disparities; this has ensured that despite adverse terrain and scattered settlement patterns, education is available to almost *all* students in the State. Himachal Pradesh’s level of women empowerment in terms of female labour force participation and in family-level decision making²¹ and the prevalence of an egalitarian society, have contributed in this development. The State’s tradition of cooperative action and local democracy, with community participation in education has contributed positively as well (Chugh, 2009)(Infochange, 2000). While Himachal Pradesh’s

accomplishments²² are often overlooked owing to the awe the Kerala model inspires, the state’s rapid growth and emergence as an economic power in North India, the region with the highest concentration of poverty in India makes the institutional underpinnings of its development model worth studying in more detail.

The model of Tamil Nadu also deserves consideration, again owing to very rapid progress since the 1990s on all fronts of human development, particularly health. More importantly, Tamil Nadu’s experience illustrates the power of institutions *existing today* in India’s States. An interesting facet of the development of Tamil Nadu’s health and education infrastructure is the use of traditional public institutions: Public Schools, Hospitals and Primary Health Centres, which differ from those across India only in the fact that they “work²³” (Gupta, 2010). The Maternal Mortality Rate in Tamil Nadu fell by 70% between 1993 and 2008. The importance of an effective and timely public service delivery mechanism is seen as a key factor in this reduction in MMR: the introduction of dedicated one-stop emergency clinics for deliveries, staffed 24x7 by trained health officials, was the main contributor. Regular checks by the Public Health Department ensure accountability.

Impressive results have ensued: the proportion of institutional deliveries (as of 2011-12) has risen to 99.8%. The introduction of functional institutions was accompanied by a commitment to women’s education and literacy, as well as a cooperative family planning programme. The State provides incentives in the form of complete security of employment and high wages for its workers, especially at the ICDS level (Gupta, 2010). Underscoring the fact that there is no need for an additional set of schemes for healthcare, Tamil Nadu has shown that a functioning network of existing Primary Health Centres can do wonders for health indices. The state’s achievements in providing school infrastructure are commendable, however Tamil Nadu still has a long way to go on improving learning outcomes.

Social evils may prove to be severe roadblocks in the implementation of welfare programmes in many of India’s poorest states; unfortunately, the experiences of Kerala and Tamil Nadu do not provide clear guidance on how to rectify failures arising out of caste and class dominance in villages. In Kerala, the caste system was brought down largely through the forceful

redistribution of property and elimination of privilege, brought about often through violence aided by the cadres of the Communist Party. In Tamil Nadu, it is unclear how broad-based growth has been brought about, although the impact of Social Reformers including Periyar must also be accounted for. Despite such efforts, accounts by contemporary Dalit entrepreneurs and authors in Tamil Nadu's heavily stratified society reveal significant barriers in human capital acquisition and deficits in social capital faced by these classes, reminiscent of discrimination in the North Indian heartland as well (Bros, 2010).

The discussion above has provided certain examples of states which have successfully travelled down a path of human development. Curiously, these states remain economic powerhouses, despite governments spending significant amounts each year – and this growth has aided in poverty alleviation as well. Tamil Nadu is the third largest state by GDP with the 6th highest per capita income, the highest level of urbanisation (49%) and a thriving domestic industry with international linkages, with export turnovers in the billions (Mallaby, 2005). Despite its mountainous terrain, Himachal Pradesh has developed into a Pharmaceuticals hub, and is fast developing capacities in textiles, electronics, and food processing and cosmetics products. The 2013 Draft Industrial Policy indicates clearly the vision of *sustainable growth*. Between 2004-05 and 2009-10, poverty in Himachal Pradesh fell by 13.4%; by 2012, only 8.06% of the population was below the official poverty line. Even by the Multidimensional Poverty Index estimates, 32.7% are vulnerable to Poverty or in Severe Poverty in the State, a figure better than any other state under comparison (Alkire, Roche, Santos, & Seth, 2011).

The experiences of the States above in development present a clear case for *activist policy* which involves *community participation*. In both Kerala and Himachal Pradesh, the State has invested heavily in developing infrastructure; having done so, it has devolved regular management and expansion of education to the community. In Tamil Nadu, making existing institutions functional has been a matter of encouraging their employees through moral measures and economic incentives (Khera, 2012), as well as monitoring mechanisms. While these solutions are innocuous in themselves, their applicability in the context of the BIMARU²⁴ states will depend on how the political

economy and social structure of these states, particularly in rural areas, responds to them. While concerns that North Indian politics may derail any reform attempts abound, it is worth noting that corruption in the PDS and the MGNREGA, two of India's "leakiest" social support schemes, has declined significantly over the period 2004-5 to 2009-10. More encouragingly, the bulk of this decline has occurred in Bihar and Orissa, states notorious for their supposedly dysfunctional politics (Khera, 2011). Whether the rest of India can learn from these experiences, allowing it to converge in living standards to the rest of the nation in the near future is a matter of crucial import for India's ambitions towards alleviating poverty and emerging as a global power.

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The Direct Cash Transfer v/s Subsidies Debate

Arushi Gupta-2nd year

Summary: This article makes use of microeconomic theory to further the case for cash transfers as against subsidies to be used as an instrument for social protection in India. However, at the same time, it also highlights the unrealistic assumptions underlying the microeconomic theory and seeks to establish the practical problems surrounding the implementation of the DCT scheme in India.

Since 2005, the government has indicated a preference for the policy of cash transfers in lieu of the subsidies it provides to the populace under various social welfare schemes (health, education, agriculture, food rations, etc.). The logic behind their preference is that with cash transfers, people are free to 'buy' these services in the open market.

The main approach to social protection in India has been the provision of subsidized food and kerosene via the public distribution system, involving a vast bureaucratic edifice. The initiative behind subsidized

food for 'the poor' presumes that if they are most deficient or lacking in something, then that is food. This may be true on an average. However, for an emerging market economy, the presumption that all poor people suffer from 'food poverty' may not be as reasonable as in the case of a traditional village economy. Other 'lacks' may be as or more important. The PDS is costly and provides low-quality food. Although its supporters claim that the PDS could be improved; inefficiency in the PDS is enormous, not marginal.

Keeping in mind equitable distribution of resources and not just efficient distribution, the government provides the economically weaker sections of the society with transfers in kind, or subsidies. From an economic viewpoint, we know that subsidies in kind constrain the consumer and narrow their choice set, which implies lesser utility or satisfaction. The second theorem of welfare economics states that any Pareto efficient allocation of resources is also the optimal allocation, (point of competitive equilibrium) if lump sum redistribution of income is done and then the