Chapter 11: Social issues, nutrition and expenditure on health and education

The previous chapters have pointed to a number of factors that have reduced the viability of cultivation and pushed farmers into a debt trap. However, rural distress and the material problems of farmers also have social counterparts, in that many farmers have become indebted because of the increased expenditure on health and education. There is also the effect of increased expenditure on marriages, including meeting dowry demands. The decline in the quality of public provision has pushed even poor farmers to private health care and education. This has added to farmers' problems because, given the precarious economic situation especially of small and marginal farmers, even small debts contracted to pay the health expenses for a member of the family can push a farmer into a downward spiral of greater indebtedness. In a context in which the health-seeking behaviour as well as the educational aspirations of farmers have changed, and the public systems cannot cater to this new situation, there are skyrocketing health and education expenditures driving the farmers into deeper debt traps. Therefore the creation of proper public systems in both these areas is a crucial requirement.

I. Health

Andhra Pradesh's performance with respect to health indicators such as life expectancy and infant mortality is worse than in the other southern states, and the extent of malnutrition is also higher. These affect the rural poor the most, since manual work is important for the livelihood of the poor, and so poor health is a major livelihood risk. Poor nutrition also creates greater chances of morbidity and susceptibility to disease. When this happens, even poor farmers choose to go to private health clinics, because public health clinics are not easily available, are poorly staffed and have inadequate facilities because of poor budget

allocations. The excessive focus on family planning in the health system has diverted official attention from other necessary interventions for public health.

To a significant extent, this situation is the result of state government policies. The state government's expenditure on health was around 0.9 per cent of SDP but declined to 0.74 per cent in recent years. Only 0.11 per cent of SDP is spent on primary health. The share of primary health in the total budget of Andhra Pradesh has been only 0.8 per cent in recent years. Even within this, there has been a bias in favour of hospitals located in the urban areas. Expenditure on rural health services, excluding family welfare programmes, constituted less than 20 per cent of the total government health expenditure during 1994-95 to 2001-2002. Even the health manpower policy has been heavily biased in favour of the urban services. Only 22 per cent of the doctors in the state were in place in rural areas to serve 73 per cent of the total population in 1999-2000. The health policy of the state government was not organically linked to the determinants of health such as water, food (nutrition) and sanitation. The vertical disease control programmes were not integrated with the primary health care and referral system.

Lack of adequate public resources has created stagnation in the number and degeneration in the quality of care at the public hospitals. Despite overcrowding, there is still widespread unmet demand for medical care among the poor. Thus public hospitals at present are self-targeted, i.e., used mostly by the poor. The growth of private sector has also weakened the position of public hospitals in resource mobilisation because the state patronage is shifted to the corporate hospitals, which are increasingly used by the policy makers.

The strategy of increasing user charges in public health clinics and hospitals is unlikely to be a successful means of improving conditions and should not be attempted. Since a great majority of the patients in the government hospitals are desperately poor and not in a position to bear even the minimal

indirect expenditure on travel, medicines etc., the feasibility of user charges is very doubtful and may lead to exclusion of poor patients even from the public health system..

The rural primary health care system suffers from a range of problems such as a large number of doctor vacancies, inadequate supply of drugs and pharmaceuticals, doctor absenteeism, doctors not residing in their place of work, apathy and indifference of doctors and medical staff, lack of adequate referral facilities and poor follow up of the patients covered under the referral card system, the reluctance of the doctors to take up risky patients for treatment, and the fact that family planning programmes have taken precedence over health care.

With the large-scale expansion of private health care in 1980s and 1990s, the rich and middle classes no longer go to the government hospitals, which are used mostly by the poor. As a consequence, the public hospitals face unfair competition in mobilising resources, since politicians and bureaucrats are more interested in extending facilities to the private, mainly corporate, hospitals through various financial and other incentives. This explains the predominance of the private sector in health care and its rapid growth. In the 1990s, the private sector accounted for 78 per cent of in-patient health care in rural areas, and even more in the developed districts. Further, the absence of any control on the quality as well as pricing has made medical care a very attractive source of investment for the private capital.

Because of growing criticism against the misuse of incentives by corporate hospitals, tax exemptions on imported medical equipment were withdrawn recently. However, the corporate hospitals still siphon of huge amounts of public resources through inflated bills for the treatment of employees in the government and public sector undertakings, medical insurance claims from public sector insurance companies and through income tax concessions by registering

themselves as trusts and research centres. The past experience shows that the poor did not benefit from the huge amounts of public resources doled out to the private hospitals.

Any attempts at partnership with the private sector are bound to be detrimental to the public sector. The private sector in medical care forms a very strong bureaucratic and political lobby and is likely to manipulate the state and further weaken the public health care system by draining out the resources. The immediate attention of the government should be on enforcing the provision of free care to the poor by the private hospitals, which have benefited from financial incentives, land grants etc. Otherwise, the public policy towards the private sector should be confined to the regulation of quality and the pricing of medical care.

II. Nutrition

Nutrition remains a significant problem in the state. As can be seen from Table 11.1, even in 1999-2000, levels of per capita calorie intake among most of the rural population were far below what are described as the usual subsistence norms. Malnutrition is high in the state among children. Also, there have been reports of hunger deaths in some parts of the state.

Table 11.1: Estimates of calorie intake in rural Andhra Pradesh, 1999-2000

Monthly per capita expenditure in Rs.	Average per capita expenditure in Rs.	Calorie intake per head (Kcal)	Per cent of all persons	Cumulative per cent of all persons
Less than 225	186	1232	4.8	4.8
225-255	241	1488	4.4	9.2
255-300	279	1662	10.3	19.5
300-340	321	1780	11.7	31.2
340-380	359	1871	12.5	43.7
380-420	400	1990	12.2	55.9
420-470	445	2096	10.8	66.7
470-525	495	2212	9.5	76.2
525-615	565	2381	9.7	85.9
615-775	684	2458	7.0	92.9
775-950	852	2754	3.4	93.3
950 and above	1299	2954	3.7	100
All	**454**	**2020**	**100**	**100**

Source: Utsa Patnaik (2004) based on NSS 55th Round, 1999-2000

There are many programmes in the state to reduce hunger and malnutrition. The poor rate institutions that provide food security very highly – these include the PDS, Antyodaya, ICDS and the Food for Work programme. The implementation of food security programme through a network of PDS outlets has certainly promoted the physical and economic access of the poor and the vulnerable sections to food grains. The relevance of the PDS for food security will depend on its playing an integrative role for household level food security, wage employment and nutrition programmes including the ICDS and Mid-Day Meals scheme.

However, there do remain errors of inclusion and exclusion; in particular there are some cases of very poor households not getting cards. The interactions during field visits of the Commission in several districts indicated that the coverage of PDS could be expanded to include edible oils, pulses, and other important food items in tune with the changing consumption basket of the poor, without any additional cost to the exchequer. That is, the additional commodities can be supplied at prices lower than the market, thus protecting the poor and

vulnerable from the exploitation of traders in the market. Also, the Commission has already recommended that jowar, bajra ragi and similar grains and also dry land pulses should also be supplied in the PDS at subsidised prices.

It may be noted that nutrition status depends not only on calorie intake but also proper drinking water facilities and sanitation. Many villages in the state do not have these facilities.

III. Social issues including education

Among other causes of rural indebtedness, it is important to mention the expenditure on marriages (including on dowry) and on education. The first is a reflection of social pressures which still remain strong, and around which social mobilisation is required to reduce such spending. However, private expenditure on education reflects the combination of changing aspirations of the rural population as well as the inadequacy of the public education system and the lack of access of the rural poor to the better public educational institutions. Literacy rates in Andhra Pradesh are still low and show high disparities across regions, social groups and gender. Public expenditure on education has declined from the mid-1980s. Despite some recent improvement, public expenditure on education is still much below the advocated norm of 6 per cent of GSDP. There are numerous complaints regarding the quality of public education at all levels.

IV. Recommendations

On health:

1. Public expenditure on health (which is currently less than 1 per cent of the GDSP) sector must be substantially increased..

2. A major weakness in the public health care system is the poor performance of the primary health centres and health sub-centres. Adequate incentives should be provided to motivate the staff to stay in rural areas, and community participation should be encouraged.

3. The strengthening of the public sector hospitals is also essential. Apart from additional resources, there is need for professional management and accountability to the local community.

4. Private sector involvement in health care provision should be strictly regulated.

5. **There is a need to promote comprehensive health insurance schemes for farmers and other rural dwellers**.

6. The state government should take all measures to ensure access to safe drinking water for all the rural population, especially in tribal pockets and fluoride affected areas. .

For nutrition:

1. At present the BPL allocation of rice per person is too low and the total entitlement is fixed at 20 kg per family. The Commission was informed during the field visits that poor people are forced to purchase a substantial amount of their food grain from the private system. **The allocation of food grain should be on a per capita basis and the per capita entitlement needs to be doubled to meet the basic food requirements of the family.**

2. The Fair Price Shops must remain open for the all days in the month and card holders must be allowed to access their entitlements in instalments as they prefer. In order to make this viable, the following are required:

- It is necessary to ensure that fair price shop dealers receive a line of credit similar to that provided by the RBI to the Civil Supplies Corporation, since the dealers currently take on costly private debt to lift the food supplies and therefore try to sell the supplies quickly.
- The shop dealers' margin may be enhanced to make to make the Fair Pirce Shops viable.
- The range of commodities that are sold under the PDS may be increased to include items such as Janta cloth.

3. **There must be a major drive to provide nutritious cereals such as jowar, bajra, and ragi at especially subsidised and very low prices to all card holders**. The prices must be sufficiently low to attract consumers; in case it is not, it should be further lowered through a subsidy from the state government.

4. The state government should request the Government of India to provide coverage under the Antyodaya and Annapurna schemes to all BPL card holders in drought-prone areas.

5. All poor households should be provided with BPL cards.

6. The various food-based welfare schemes should be integrated with the PDS.

7. The ICDS should be made universally accessible within a specified time-frame. The existing anganwadis should be converted into creches which include children in the 0-3 age group and provide all the six services provided under the ICDS. The timings of these crèches should be daylong.

On education and social issues:

1. More resources have to be allocated to education, particularly to primary education, from the budget. Government should enhance budget allocations for

upgrading primary schools into upper primary schools and setting up residential schools for girls in all the districts.

2. The quality of education in terms of curriculum, better infrastructure and teaching has to be improved.

3. Our field surveys show that farming households want scholarships or credit for the higher education of their children. Therefore, government should increase scholarships and hostel seats to provide greater access to children from rural areas. Also, residential schools for children (especially girls) from the rural areas should be increased.

4. There are inter-regional and social disparities in education. More expenditure for education should be made in backwards districts. Similarly, focus also should be made on Scheduled Castes and Scheduled Tribes as their education levels are lower than other castes.

5. Since expenditures on marriages have been on the rise, mass marriages should be encouraged to reduce private spending on ceremonies.