

# Catalysing Government Action on Health and Education



**Civic  
Policy  
Forum**

**POLICY BRIEF**

**Connect us at [www.civicpolicyforum.in](http://www.civicpolicyforum.in)**

## Executive Summary

India's trajectory of poverty reduction over the past twenty years remains noteworthy, yet substantial gaps persist in basic health and education indicators. These gaps undermine labour productivity, economic growth, and population well-being. This brief investigates the institutional and political-economic factors that constrain government initiatives in primary healthcare and elementary education, offering actionable recommendations for policy advocates and civil society.

The central argument is that inadequate public health and education outcomes stem from a two-sided market failure: weak supply (inadequate infrastructure, poor service quality) coupled with weak demand. Poor households, constrained by immediate survival needs, cannot effectively advocate for service improvements. Simultaneously, non-poor populations have largely exited public systems for private alternatives, eliminating the political pressure that typically drives policy reform in other sectors.

Urban areas face disproportionate neglect, Urban Primary Health Centres (UPHCs) operate at 39.7% shortfall nationally, while government school enrollment falls to 30.1% in cities compared to 66% in rural areas. As urbanisation projects to double India's urban population by 2050 and generate 70% of GDP growth, this deficit becomes increasingly critical.

Meaningful policy change requires reintegrating non-poor users into public systems to create constituencies demanding quality improvements. Successful initiatives share three characteristics: electoral resonance, budget realism, and direct responsiveness to ground-level deficits. Institutional innovations including expanded operating hours for PHCs, qualified English-language instruction, and measurable quality frameworks offer politically viable pathways forward.

## **Why Health and Education are Being Neglected?**

Decades of economic liberalisation have generated sustained GDP growth and poverty reduction, creating a perception that current policy approaches are sufficient. However, this assessment obscures alarming performance gaps. India ranks 130th of 193 countries on the UN Human Development Index, with public health services widely regarded as substandard even against comparable middle-income economies. Out-of-pocket health expenditure as a proportion of total health spending exceeds that of Indonesia, Ghana, Brazil, and the Philippines.

In education, enrollment statistics mask profound learning deficits. The most recent Annual Status of Education Report (ASER) documents that 28.9% of grade 8 students cannot read a grade 2-level text. Rural-urban disparities are stark: 67.5% of government school students in rural areas achieve foundational reading competency versus 80% in private schools, suggesting that government facilities systematically underperform competitors.

When households privately finance health and education, consumption capacity and investment savings decline, amplifying inequality and constraining aggregate demand. Yet government allocations remain inadequate and poorly structured: budget resources concentrate on salaries rather than service delivery quality or infrastructure, producing high enrolment numbers alongside dismal learning outcomes.

## **Competing Fiscal Pressures and Political Economy**

At the union level, infrastructure, defence, subsidies, and rural development compete fiercely for resources, consistently overshadowing health and education. State governments prioritise operational efficiency adjustments over budget expansion changes often motivated by electoral appeal rather than gap closure. Financial stress is real but incomplete as an explanation, prioritisation failures reflect deeper political-economic dynamics.

## The Demand-Side Challenge: Why the Poor Cannot Drive Reform

Economic theory predicts that publicly provided services improve when beneficiary populations mobilise for better outcomes. Yet this mechanism fails systematically in health and education. Research by behavioural economists (Banerjee & Duflo, 2011; Mullainathan & Shafir, 2013) demonstrates that scarcity and bandwidth constraints shape decision-making among low-income households. Preoccupied with daily survival, nutritional security, and employment uncertainty, poor families exhibit behaviour driven by immediate necessity rather than long-term planning. They rarely mobilise collectively for service improvements, even when fundamental gaps are evident.

Critically, the non-poor have virtually abandoned public health and education systems. National Family Health Survey (NFHS-5) data shows 51.8% of all households use private healthcare, with even the lowest-wealth category accessing private facilities at 43.4% nationally. In education, private school enrollments have grown from 84.16 million (2022-23) to 90.04 million (2023-24) across all regions. This exodus fundamentally reshapes political incentives, elected officials face minimal pressure to strengthen public systems when influential constituencies have opted out.

This contrasts sharply with sectors like roads, water, and electricity, where non-poor stakeholders remain active users and therefore constitute persistent demand-side constituencies. Health and education lack such constituencies, leaving governments facing limited electoral costs for neglect.

## Primary Healthcare Crisis

India operates an extensive network of 25,000+ Primary Health Centres, yet over 2,000 lack permanent doctors and one-third of sanctioned positions remain vacant. Doctor shortfalls exceed 30% in states like Chhattisgarh (36.2% in rural PHCs) and Jharkhand (54.3% in urban PHCs). Where staff exist, absenteeism rates remain high and motivation low.

Structural design failures compound staffing deficits. Many PHCs operate only day shifts, making them unavailable for two-thirds of the day. This renders them incapable of handling routine deliveries or emergency care, the core functions of primary health systems. Consequently, most institutional deliveries occur in private facilities. Sub-centres often remain dysfunctional, unable to ensure essential antenatal care and maternal health services.

The higher-order system deteriorates further, Community Health Centres and Taluka hospitals face acute specialist shortages, lack diagnostic equipment, and cannot stock essential medicines. Poor households respond rationally by seeking private care despite financial hardship. Out-of-pocket expenditure on health ranges from 25.4% (Karnataka) to 59.1% (Kerala) as a proportion of total health spending unsustainable for vulnerable populations.

Paradoxically, government enthusiasm concentrates on curative services at tertiary levels (AIIMSs expansion) while neglecting preventive and promotive health at grassroots levels the domain where PHCs can generate maximum impact. The political visibility and electoral appeal of hospital-level interventions outweighs fiscal arguments for primary care investment.

## Education Quality Collapse

Government schools educate predominantly low-income populations whose parents cannot access private alternatives. Learning outcomes are catastrophic. Rural government school students trail private school peers substantially, 67.5% of grade 8 students in government facilities achieve grade 2-level reading competency versus 80% in private schools.

Teacher capacity and pedagogy remain sub-standard. Educators are incentivised to complete prescribed curricula rather than assess learning, lack training for first-generation learner cohorts, and remain ill-equipped for multi-grade classroom management, a common scenario in government schools. Teacher training programmes exhibit systematic shortcomings. Government monitoring focuses exclusively on enrolment numbers, textbook distribution, and infrastructure rather than learning processes or outcomes.

Urban governance structure exacerbates these gaps. District-level health and education departments operate under Zilla Panchayats with rural jurisdiction. Urban municipal corporations supposed counterparts maintain negligible health and education capacity and receive minimal budget allocations under the 74th Constitutional Amendment. This institutional gap leaves cities systematically under-served.

Enrolment growth masks infrastructure and learning quality deterioration. Government schools concentrate on numerical targets while infrastructure and learning environments lag private schools substantially. Multi-grade classroom configurations, common in rural government schools, create administrative and academic supervision challenges.

## RECOMMENDATIONS

### Measuring Progress Through the "Diversity Index"

A novel measurement framework, the "Diversity Index" offers a valuable tool for guiding resource allocation and enabling political communication. This index measures facility uptake across income groups (poor vs. non-poor) alongside traditional outcome and input metrics.

For Schools, Include:

- Learning levels (foundational literacy and numeracy percentages)
- Infrastructure quality scores
- Teacher qualification profiles
- Diversity of student wealth representation

For PHCs, Include:

- Utilisation rates by economic demographic
- 24/7 operational status and actual implementation
- Institutional delivery rates
- Full childhood immunisation completion rates

Such indices would:

- Guide resource allocation toward facilities serving diverse economic populations
- Empower civil society advocacy with standardised metrics
- Provide politicians with communication tools for electoral messaging
- Enable comparison rankings across states and districts similar to ASER or Swachh Survekshan.

## **Linking Investment to Economic Outcomes**

Policy advocates must strengthen the evidence base linking health and education improvements to household economic benefits. Research should document:

- Wealth creation pathways through improved health status
- Income enhancement through quality education attainment
- Lifestyle aspiration fulfilment and social mobility effects
- Long-term household productivity gains

Such evidence when packaged for political messaging and disseminated through media campaigns shifts debates from technical input metrics toward outcome narratives that resonate electorally. Political leaders require evidence of how service improvements translate to voter benefits.

## **Institutional Coordination and Implementation**

Success requires alignment across multiple stakeholder groups:

**Policy Advocates and Civil Society:** Frame initiatives with electoral appeal; disseminate evidence of government facility success; propose budget-realistic solutions; support political communications.

**Elected Leadership:** Provide direction ensuring initiatives address voter aspirations; allocate fiscal resources; champion reforms through media and direct communication.

**Bureaucratic Systems:** Execute initiatives according to specification; maintain quality standards; ensure transparent monitoring; adapt implementation based on ground feedback.

**Research and Academic Institutions:** Generate rigorous evidence on intervention effectiveness; develop measurement frameworks; communicate findings for policy uptake.