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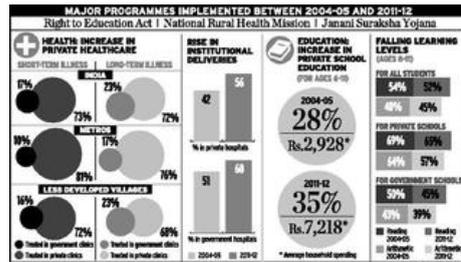
Poorly performing public services

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Implementation of the Right to Education Act and the National Rural Health Mission should lead to better outcomes but we see the reverse



There is something ironic about politicians making announcements about the Right to Education or the Right to Health when the only thing they can ensure is allocation of funds. Their control over the usage of these funds is somewhat weak; the overall quality of services is even weaker; their control over actual health or educational outcomes is the weakest.

Looking at education and health behaviours and outcomes using data from the India Human Development Survey (IHDS) of 2004-05 and 2011-12 paints a picture of striking dissonance between government programmes and experiences at the ground level. The period between 2004-05 and 2011-12 saw initiation of several new programmes. The Right to Education Act (RTE) was implemented in 2010; the National Rural Health Mission (NRHM) began in 2005; the Janani Suraksha Yojana (JSY) began in 2005, to be implemented alongside the NRHM. Substantial expenditure was incurred in each of these centrally-sponsored programmes. Below we look at changes in education and health to see how these programmes line up with outcomes.

Privatisation

The implementation of the RTE should, in theory, lead to higher enrolment in government schools and better educational outcomes. Ironically we see the reverse. Private school enrolment increased from 28 to 35 per cent between 2005 and 2012 for children of 6-14 years, even before poor students in private schools were reimbursed. At the same time, in keeping with the findings of various Annual Status of Education Report surveys, the IHDS also found a small decline in reading and writing skills among children of 8-11 years. While 54 per cent of children could read a simple paragraph in 2005, there was a modest decline to 52 per cent in 2012. A similar decline was observed for basic arithmetic skills like two digit subtraction, from 48 per cent to 45 per cent. For government schools the decline was higher — nearly 5 percentage points for both outcomes, but a shift from government to slightly better performing private schools limits the overall decline in skill levels.

This growing privatisation of education was matched by continued and slightly increased privatisation of health care. The NRHM is supposed to strengthen preventive and curative care, particularly in rural areas and in States with poor health infrastructure such as Uttar Pradesh, Bihar, Rajasthan, Madhya Pradesh. However, a very small proportion of the Indian population relies on public facilities. About 70 per cent of patients visit private providers — either as their first choice or once they are frustrated with public services.

Between 2005 and 2012, years when the NRHM was implemented, instead of increased usage of government services, we see a modest growth in the use of private services for minor illnesses such as cough, cold and fever (from 69 per cent to 73 per cent) as well as for treatment of major illnesses like diabetes, cancer and heart problems (from 67 per cent to 72 per cent). Ironically the greatest increase in the use of private services is in high-focus large States like U.P., Bihar, Rajasthan, M.P. and Orissa. Here the proportion of patients going to private providers increased by nearly 5 percentage points.

The disenchantment of parents and patients with government services is widespread. When asked in 2012 about their confidence in government and private schools and medical facilities, 53 per cent of the respondents expressed confidence in government schools compared to 72 per cent for private schools. Similar differences are observed for confidence in government doctors vis-à-vis private doctors. What explains this? There is no reason to believe that

private doctors and teachers are more qualified than government doctors and teachers. Typically government recruitment standards are more stringent about training and qualifications while there is little control over the private sector. It is hard to imagine that anyone would prefer a self-styled private “doctor” in a distant village to an MBBS doctor in a Primary Health Centre (PHC). Yet, this is exactly what we see around us.

The reasons for these preferences are myriad. Parents and patients feel disrespected by government service providers and may find they get better service if they pay. For example, about 6 per cent of the patients see a government doctor or nurse in their private practice rather than in the government dispensary where the same services could be practically free. Government facilities are often irregular in their opening times and teacher and doctor absenteeism adds to the disenchantment. The classroom environment is often not friendly and supportive. The IHDS finds that children are scolded and physically punished in both government and private schools. Indeed, our qualitative interviews suggest that parents consider this to be a sign that the teachers care about students. But this scolding is not balanced by positive reinforcement in government schools. Only about 33 per cent parents of 8-11-year-olds in government schools claim that their children received any praise in the school in the prior month; this proportion is about 55 per cent for private schools.

These observations reflect our pessimism about the potential for improving government health and educational services, regardless of the “rights” that get enshrined in the Constitution. Any service delivery system that insists that a doctor live in a remote village is doomed to failure since doctors must also think of their children’s education. But instead of focussing mainly on village-based sub centres — which patients rarely seem to use — enhancing PHCs which are located in slightly larger and perhaps better connected towns may have a greater potential for improving the quality of services. Thoughtful organisation of services has a far greater potential for enhancing health and educational outcomes than ideologically influenced discussions of rights.

Some good news

The success of the JSY in increasing hospital deliveries is heartening. The years following the initiation of the JSY document a striking increase in hospital deliveries. This increase is greatest in large focus States. Here the hospital delivery rate has jumped from 25 per cent to 56 per cent between 2005 and 2012. Most of this improvement is in government hospitals — from 14 per cent to 40 per cent. This success may be due to the efforts made by medical personnel in response to cash incentives they receive, and the fact that hurdles to hospital delivery like transportation have received consideration in programme design. Although the quality of maternity care remains a concern, increasing utilisation certainly points to the success of the programme. This suggests that focussing on smarter organisation of public services that aligns with provider incentives, and enhances efficiency, offers potential.

(The authors are with the NCAER and the University of Maryland. This is part 4 of a five-part series. The views expressed are personal.)

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