

Erosion of rights and marketisation of development

JOHN SAMUEL BOBBY KUNHU ¹



The national development paradigm is a paradox. On the one hand, there is a professed commitment to meeting the Millennium Development Goals by respecting, protecting and fulfilling economic, social and cultural rights. On the other hand, there is clear policy prioritisation towards privatisation of services that affect the basic rights of the most marginalised, such as education, health, water and food distribution. In contrast with the «the language of rights», policy prescriptions push basic services away from the responsibilities and obligations of the State.

Evidence of this trend is the glaring gap between policy pronouncements and budgetary allocation. During the period of economic liberalisation from 1992 onwards, the budgetary commitment in real terms has decreased. The State's presence in health, education and water—which historically has been overwhelming—has slowly started to disappear, with the space being filled by private, for-profit investment. This is most obvious from an analysis of budget expenditure in these core sectors over the last decade as a percentage of GDP. Withdrawal of subsidies and state investment in these sectors is another definitive indicator.²

The basic rights of marginalised groups such as Dalits (commonly called Untouchables), Adivasis (indigenous communities that make up about 25% of the population), landless labourers, women and poor children are significantly eroded amidst policy declarations that mask inadequate financial allocation.

The cost of the State's withdrawal from education

India has a literacy rate of 65% but only 54% of women are literate.³ School dropout rates have increased over the last five years, and are higher for girls. Only 43.6% of girls are enrolled in primary school, and of these, only 40.1% go on to middle school. Disparities between girls in rural and urban areas and between Dalits, Adivasis and other minorities are also sharp.⁴ Delinquent children and children of prisoners and sex workers are deprived of elementary education by the precincts.⁵

Overall public expenditure on education has dropped from a peak of 4.4% of the GDP in 1989 to 2.75% in 1998-1999.⁶ Primary education is still not free or compulsory despite the Constitution's 93rd Amendment and a 1993 Supreme Court decision, which makes education a fundamental right for children between six and fourteen years old.⁷ With current expenditure on primary education around 1.5% of GDP, it is estimated that an increase to 2.8% of the GDP can help fulfil constitutional obligations.⁸

The last decade has witnessed the increasing withdrawal of the State from education, especially higher education, which was historically under state control. The State has left the universities to fend for themselves, and in quite a few cases made them dependent on private funding. The resultant increase in costs makes higher education almost wholly inaccessible to marginalised groups despite various legislative provisions aimed at improving their access.

Health: the major risk is poverty

India is characterised by serious health risks. More than 100,000 women die of anaemia every year. In 1991, 87.5% of all pregnant women were found to be anaemic. Nearly 600,000 children die every year because of diarrhoea, while 56% of children under five years of age have iron deficiency anaemia. It is estimated that 200 million people are exposed to the risk of iodine deficiency disorders and that 63 million suffer from goitre. About two million cases of malaria are reported yearly, despite the National Malaria Eradication Programme. India has 3.86 million HIV/AIDS patients, second after South Africa, despite the National AIDS Control Programme.

The greatest risk factor for poor health is poverty. The worst health indicators are found among the most marginalised groups. For instance, the Adivasis have the highest incidence of infant mortality at 84.2 per 1,000 live births, followed by the Dalits with 83 and the other less privileged castes with 76 compared to the national average of 70.⁹

There is no law enacted for establishing health services and regulation and planning of private health care is lacking. While there has always been a large presence of private stakeholders in health services, the new National Health Policy 2001 furthers state withdrawal from the health sector, as it focuses on involving non-state actors in the primary healthcare sector. However, the policy is a central government policy and since health is a state matter under the Constitution, it technically has only a persuasive effect on the state governments.

The Indian healthcare system is becoming increasingly commercialised. Nearly 70% of the healthcare infrastructure, and over 80% of doctors, are in the private sector. People directly finance, through user fees and purchase of healthcare goods, nearly 80% of the total healthcare expenditure.¹⁰ The result is that healthcare spending is the first cause of indebtedness among poor households. Aggregate healthcare expenditure is 5.2% of the GDP, of which only 14% is from public resources.¹¹ The trend in India shows a decline in the public financing of health care from 1.25% of GDP in 1993-1994 to 0.9% in 1999-2000 (against the World Health Organisation's recommendation of 5%).¹²

¹ John Samuel is the Executive Director of the National Centre for Advocacy Studies (NCAS), Pune, and a visiting fellow at IDS Sussex. Bobby Kunhu is a human rights lawyer working with the NCAS.

² We do not have exact figures for the withdrawal of state subsidies. Since these sectors are controlled by individual states, there are no national figures currently available. But we have evidence that the State has withdrawn subsidies in education for specific educational institutions. The budget for the University Grants Commission (the umbrella organisation for Indian Universities which provides the grants and funds required for the universities and government fellowships for students) has also been decreasing continuously. There has been similar withdrawal of public funding from primary health care.

³ Government of India. *Provisional Census Report*. New Delhi: Department of Census, 2001.

⁴ R. Govinda Ed., *Indian Education Report*. New Delhi: Oxford University Press, 2002.

⁵ *Ibid.*

⁶ Jean Dreze and Amartya Sen. *Indian Development and Participation*. New Delhi: Oxford University Press, 2002.

⁷ *Unnikrishnan v. Union of India*, 1993.

⁸ Kirit S. Parikh and R. Radhakrishna Eds., *India Development Report 2002*. New Delhi: Oxford University Press, p. 107.

⁹ Voluntary Health Association of India (VHAI), report on the Draft National Health Policy 2001.

¹⁰ Prakasam Gnana et al., *Advocacy Update. Campaign for Peoples Right to Health*, Pune: NCAS, October-December 2001.

¹¹ *Ibid.*

¹² Centre for Monitoring Indian Economy (CMIE), Public Finance.

The State has historically played a major role in terms of pharmaceutical subsidies, as well as direct and indirect investment in research and development. However, as a direct consequence of the World Trade Organisation's intellectual property rights agreements (TRIPS), state drug subsidies have drastically decreased, raising prices. The complete withdrawal of state subsidies and enforcement of a new patent regime, which will prevent reverse engineering—and therefore affordable production of generic drugs—may be completed as early as 2005. This would result in bringing drug prices up to US levels, while wages remain at Indian levels.

The state trend of withdrawing from public health spending can be seen in Table 1.

TABLE 1

Expenditure of central and state governments on health	
YEARS	PERCENTAGE OF GDP AT CURRENT MARKET PRICES
1993-1994	1.25
1994-1995	1.22
1995-1996	1.02
1996-1997	0.95
1997-1998	1.00
1998-1999	1.11
1999-2000	0.90
Source: CMIE, Public Finance	

This policy steers the healthcare system towards urban specialist-based health care, thereby alienating the most marginalised citizens. The current achievements in the primary health sector pursuant to the National Health Policy of 1983 were possible only because of direct state investment. Kerala, which has the best health indicators in the whole country, has the best state-supported health infrastructure. But in this state also, the government has announced the privatisation of the primary health centres and is planning to introduce a fee for using the state health services.

Rural areas and those regions that already have poor health infrastructure, will suffer directly because of state withdrawal from the health sector. Traditionally, it has been the state role in the health sector that provided health services for women from the marginalised communities, ranging from contraception to hysterectomies.

Plundering the most contested natural resource: water

One third of India is drought prone. Water is the country's most contested natural resource, having significant impact on rights to livelihood of people in general, and the marginalised in particular. There is increasing disparity in access to water and inter- and intra-regional conflict over water is increasing.¹³ In many cases, water is being brought from Adivasi and rural areas to feed the growing water needs in urban areas. For example, drinking water for Bombay is obtained from the Adivasi areas in Thane. Coca Cola has started a plant in an Adivasi area in the Palakkad district of Kerala and their tube wells have resulted in a sharp decline in the water table there.

The State has shifted its stand from the National Water Policy of 1982, with its emphasis on community-owned water resources, to the New Water Policy, declared in 2002, which focuses on encouraging private sector participation in water:

«Private sector participation should be encouraged in planning, development and management of water resources projects for diverse uses, wherever feasible... Depending upon the specific situations, various combinations of private sector participation in building, owning, operating, leasing and transferring water resource facilities, may be considered.»¹⁴

This policy has also been adopted by many of the state governments, and water privatisation has begun in several states. The government of Chattisgarh has leased out the River Sheonath in the Durg region for a period of 22 years on a Build Own Operate Transfer (BOOT) scheme to the private corporation Radius Water Limited, despite protests from civil society and local communities. For centuries this river has provided water for the villagers living by its banks for irrigation, fishing, drinking, washing and bathing. Now the corporation regulates these activities, banning fishing and the diverting of water for irrigation within the 18-kilometre radius it controls. The contract also covers ground water and meters have been installed on tube wells supplying water to local industries. The corporation sells water at USD 0.26 per cubic metre. At a supply rate of four million litres of water per day it is thus expected to generate revenues of USD 127 million in 20 years. There are other water privatisation schemes in the offing including a USD 340 million project in Tirupur, Tamil Nadu, Bargaon, Madhya Pradesh and Vishakapatnam in Andhra Pradesh.¹⁵

Water in India has traditionally been community owned property. Dependence on water is quite high, given that many people depend on small agricultural holdings and fisheries for their livelihood. The privatisation of water, by giving private interests control over these important sectors, is paving the way for large agriculture multinationals to take over these sectors completely.

Conclusion

The most significant effect of a decade of moving toward privatisation is the erosion of human capability caused by a lack of access to basic services, which are becoming increasingly unavailable or unaffordable. The privatisation of basic services essentially excludes a large number of marginalised peoples from making a living and attaining empowerment. Limited access to water, the stagnation of agriculture¹⁶ and layoffs from enterprises once in the public sector, have led to reduction in jobs. This has contributed to an increased migration to the urban areas, where the unemployed and alienated provide a fertile breeding ground for extremist interests.

Depriving people of water and basic services leads to poverty and social exclusion, which can in turn lead to social conflicts. When this trend is coupled with a crisis in governance, there is accelerated erosion of civil and political rights and shrinking tolerance of dissent. ■

National Centre for Advocacy Studies (NCAS)
Centre for Youth and Social Development (CYSD)
<cysdbbsr@sancharnet.in>

¹³ The ongoing stalemate between Karnataka and Tamil Nadu over the sharing of Cauvery waters is a good example.

¹⁴ National Water Policy, 2002, para. 13.

¹⁵ *Outlook*, 23 September 2002.

¹⁶ Also because of the fall in prices of agricultural products due to the lifting of tariff barriers on imports.