CHAPTER I

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A country's economic development and poverty have been traditionally assessed with the help of income components. Nowadays it is being changed. Apart from income, human needs, capabilities are taken into consideration for analysing these concepts. The present study analyse human deprivation with the help of poverty, health and educational deprivation. It studies the relationship between poverty, health, education, consumption expenditure and human deprivation of Indian States. A study about human development and its index have also been carried out.

1.1. POVERTY

Poverty is defined as the lack of what is necessary for material well-being - especially, food, health, education, shelter, land and other assets. According to the Concise Oxford Dictionary, the adjective 'Poor' means, "Lacking adequate money or means to live comfortably". The noun 'Poverty' is defined as the state of being poor and as "want of necessities of life". In Webster's Dictionary, 'Poverty' means, "The state of one who lacks a usual or socially acceptable amount of money or material possessions".

Poverty is a state of deprivation. In absolute terms it reflects the inability of an individual to satisfy certain basic minimum needs for a
sustained healthy and a reasonably productive living. The proportion of population not able to attain the specified level of expenditure is then segregated as poor (GoI NHDR 2001). Poverty is deprivation of essential assets and opportunities to which every human being is entitled. It is also associated with insufficient outcomes with respect to health, nutrition and literacy, to deficient social relations, to insecurity and to low self-confidence and powerlessness.

Poverty is defined as the lack of what is necessary for material well being – especially, food, health, education, shelter, land and other assets. It is the lack of multiple resources leading to physical deprivation of essential assets and opportunities to which every human being is entitled.

According to World Bank, “poverty is hunger, poverty is lack of shelter. Poverty is being sick and not being able to see a doctor. Poverty is not being able to go to school, not knowing how to read, and not being able to speak properly. Poverty is not having a job, it is fear for the future, and it is living from hand to mouth. Poverty is losing a child to illness brought about by unclean water. Poverty is powerlessness, lack of freedom”.

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Poverty is the state of being deprived of the essentials of well-being such as adequate housing, food, sufficient income, employment, health and education. It is lack of goods and services necessary to maintain a minimal adequate standard of living which is mainly depends on income or expenditure, education and health conditions. Poverty can also be defined as the situation where standard of living below the minimum needed for the maintenance of adequate diet, health, education and shelter.

Human poverty is multidimensional in that it severely constrains human choices and results in vulnerability and perpetuations of inequalities. UN Economic and Social Council (1998) described poverty as a denial of choices and opportunities, a violation of human dignity. It means lack of basic capacity to participate effectively in society. It means not having enough to feed and cloth a family, not having a school or clinic to go to; not having the land on which to grow one’s food or a job to earn one’s living, not having access to credit. It means insecurity, powerlessness and exclusion of individuals, households and communities. It means susceptibility to violence, and it often implies living on marginal or fragile environments, without access to clean water or sanitation”.

“Peter Townsend argued that individuals can be said to be in poverty when they lack the resources to obtain the types of diet,
participate in the activities and have the living conditions and amenities which are customary, or at least widely encouraged or approved in the societies in which they belong" (Jane Falkingham & Ceema Namazie 2002).

People are poor because lack of income, food, clothing and shelter. Poverty by any means is devastating. The worst aspects of poverty are hunger, poor health, illiteracy, malnutrition, poor housing conditions etc. Poverty makes a person vulnerable and a helpless victim deprived of social, cultural and political freedoms.

Poverty is a complex, multidimensional social phenomenon in which a section of the people is unable to fulfill even their necessities of life. Poverty is a condition of severe deprivation in basic human needs. It is a state in which a family’s income is too low to be unable to buy the quantities of food, shelter, clothing, and avail education and health facilities that are deemed necessary.

"Poverty is not just ‘low income’ and ‘low consumption’ but a multiple deprivation causing premature death, chronic undernourishment, illiteracy, illness and social exclusion” (John M. Alexander 2005). It is the situation in that not having enough today in some dimensions of well being. “What is typically referred to as poverty, that is, whether
households or individuals possess enough resources or abilities to meet their current needs" (PRSP Source Book 2002).

The poor often do not have much choice over many things that affect them; ranging from food, shelter, health and safety to the more complex needs that require them to be active participations in the economic system and members of civil society (e.g. employment, purchasing power, civil right, etc). This is what equates poverty to subsistence and a powerless existence.

“In the eighteenth century Adam Smith commented that ‘by necessities’ I understand not only commodities which are indispensably necessary for the support of life, but whatever the custom of the country renders it indecent for creditable people, even the lowest order, to be without” (Jane Falkingham & Ceema Namazie 2002).

1.2. POOR

People are said to be living in poverty if their income and resources are so inadequate to live a decent standard of living. For poor families, meeting their daily basic needs for food, water, shelter is a life struggle; this becomes very severe when there is unemployment and underemployment or lack of land or other income-earning assets.
Poor are defined as those who lack command over basic consumption needs, including food and non-food components. They are hungry, hungry all the time, because they are too poor to buy the food the body needs. Chronic hunger, insufficient meal, nutritionally inadequate food and spending most of the income for food are the routine day to day living condition of the poor.

Due to lack of poverty, poor people’s standard of living is very low. They are struggling even to get the basic necessities of life such as food, dress and shelter. And also, they can access health and education facilities which they want. “To be poor is to be hungry, to lack shelter and clothing, to be sick and not cared for, to be illiterate and not schooled. But for poor people, living in poverty is more than this. Poor people are particularly vulnerable to adverse events outside their control. They are often treated badly by the institutions of state and society excluded from voice and power in these institutions” (WDR 2000/2001). “People who lack adequate food and shelter, who lack education and health, people, who face extreme vulnerability to ill health, economic dislocation and natural disasters, are all categorized as poor people” (Usha Devi M.D 2001).
1.3. POVERTY LINE

To eradicate poverty measuring poverty is important. Identifying the poor is very important to help policy makers to design programmes and policies to fight poverty. The best option to identify the poor from non-poor would be fixing the poverty line, that is, household which consume less than a fixed bundle of goods. “A key building block in developing income and consumption measures of poverty is the poverty line, the critical cut-off in income or consumption below which an individual or household is determined to be poor” (WDR 2000/2001).

The poverty line is conceptualized as a minimum standard required by an individual to fulfill his or her basic food and non-food needs. It has come to serve as a reference income or expenditure level. To quantify the extent of poverty and measure the number of ‘poor’ in the country, the concept ‘poverty line’ is being used. Poverty line is used to identify the poor as a group so that they can be focused on in greater detail.

Poverty line is the cut-off point separating the poor from non-poor. It is defined in terms of either income or consumption expenditure as an indicator of welfare. The poverty line refers to a minimum level of living necessary for physical and social development of a person. A minimum
level of living defined in monetary terms comprises both food and non-food components of consumption.

Poverty line may be defined as "an income level that is just sufficient to meet the defined calorie norm. However households having a per capital income less than the poverty line are identified as poor. It is expressed in terms of an income level which is deemed to be necessary for enabling a person to sustain a minimum level of consumption" "Poverty line" is the lowest amount of money sufficient to purchase the amount of food necessary for a minimally adequate diet (with enough left over to buy other essentials)" (Dwatkin D.R. 2000).

1.4. APPROACHES OF SETTING POVERTY LINES

"There are two main approaches to setting poverty lines, the first being cost-of basic needs method, which estimates the cost of a bundle of essential commodities. In developing an absolute poverty line, welfare is assumed to be linked to the consumption of goods (and services). The basic idea in setting an absolute poverty line is to identify a basket of essentials consumption items. Those who do not have sufficient resources to obtain the basket are considered as poor" (Benu Bidani, et.al., 2001) . The first step in establishing an over-all poverty line is to draw a "food poverty line". Because calories are conveniently expressed in cardinal numeric form, they are used as an abstract quantitative measure of
essential food requirements. A food poverty line assumes as an "average" minimum requirement level needed to live.

The basic need concept defines poverty as the deprivation of requirements, mainly material for meeting basic human needs which also includes access to such necessities as food, shelter, schooling, health services, potable water and sanitation facilities, employment opportunities and even touches on opportunities for community participation. "Cost of basic needs method starts with the specification of a basket of goods considered as the basic consumption needs of life. It then quantifies the needs of an average person and estimates the cost of the basic needs basket at prices prevailing in various localities or in different time periods" (ADB 2004).

Another method is food energy intake method, it sets the poverty line by identifying the level of income or expenditure needed to obtain sufficient food to provide enough calories to meet the minimum energy requirement of an individual. Food energy intake method attempts to provide a normative basis to the derivation of poverty lines and relies on the relationship between income or consumption expenditure and nutritional intakes. "One major difference between the energy intake method and energy needs while the later could potentially consider all major nutrition's, such as energy protein fat, vitamins, and minerals, that
are considered essential for a healthy and active life” (ADB 2004). Food energy intake method considers only energy need. Cost basic need method considers all major nutrients, such as energy, protein, fat, vitamins and minerals that are considered essential for a healthy and active life. “The food energy intake method which finds the expenditure level at which the household’s food energy intake is just enough to meet the predetermined requirements” (Benu Bidani et al. 2001).

1.5. ABSOLUTE LINE AND RELATIVE LINE

There is another two types in analysing poverty line. They are Absolute Poverty Line and Relative Poverty Line.

1.5.1. ABSOLUTE POVERTY LINE

The absolute poverty line is based on the expenditure required to purchase a subsistence bundle of items by the individual. It is defined as the value of consumption needed to satisfy minimum subsistence needs. “The absolute poverty lien is often defined as the threshold that allows minimum calorie requirements plus a small allowance for non-food items” (ADB 2004).

Absolute poverty line refers to subsistence level below minimum socially acceptable living conditions usually established based on nutritional requirements and other essential goods. “Absolute poverty
also implies poor health and a low physical standard depriving a person of the ability to work or lowering it to such an extent that he finds it impossible to maintain the pace of the modern production. It also implies lack of medical care resulting in death due to diseases that could have been readily cured had modern medical instruments and techniques been used. It implies the lack of dwellings, compelling people to sleep under the open sky or live in shacks and dilapidated slums which defy all standards of decency. It implies no opportunity for an education and to bring up one’s children as full participants in society’s affairs” (May Volkov et.al. 1990).

1.5.2. RELATIVE POVERTY LINE

A relative poverty line, is determined from a percentage cut-off point of welfare distribution, such as income or consumption level which rises with the level of expenditure or income, hence richer regions have higher poverty lines. Relative poverty defines the poor people by comparing with other people.

“The relative approach defines poverty in relation to a generally accepted standard of living in a specific society at a specific time and goes beyond basic physiological needs”(Jane Falkingham & Ceema Namazie 2002). Relative poverty compares the lowest segments of a
population with upper segments, usually measured in income quantiles or deciles.

1.6. CONSTRUCTION OF POVERTY LINE

The first step in the construction of poverty line in general, is to determine the calorie requirements of people of different age and sex. The next step is to drawing a basket of goods which are satisfying minimum needs i.e., food and non-food for an individual on an objective basis.

After that the next step is to compute the cost of the minimum food needs basket at prices prevailing in the market. The computed cost represents the amount of money needed to buy the food basket by the people and then is to compute per capita monthly income needed to buy the minimum needed food. The computed monthly per capita income is the poverty line. It is observed that the poverty line is derived from the expenditure required for food.
Figure No: 1

Construction of Poverty Line

Determining the people's calorie requirements

Specifying basket of minimum needed food

Computing the cost of the food basket

Computing monthly per capita income needed to buy the food basket based on consumption expenditure

Poverty line
Conventionally at international level, poverty has been defined by the levels of income. Those living on less than $1 US per day are considered as poor. “The most common international definition of people in ‘extreme poverty’ – those who live on less than $1 a day and ‘generous poverty’ – those who live on less than $2 a day” (ADB 2004). Actually $1-a-day poverty line is the threshold stands as an internationally accepted level of private consumption at $1.08 US per person per day consumption level in 1993 purchasing power parity prices.

1.7. MEASURING POVERTY – HEAD COUNT INDEX

Once the poverty line is determined, the poor can be aggregated into a summary measure or index in order to estimate the seriousness of poverty. “The most straight forward way to measure poverty is to calculate the percentage of the population with income or consumption levels below the poverty line. This “head count” measure is by far the most commonly calculated measure of poverty” (WDR 2000/2001).

Head count index which is based on the poverty line and most widely utilized income poverty indicator. It is the share of population whose income or consumption is below the poverty line that is the share of population that cannot afford to buy a basic basket of goods.
The most common measure of poverty is to count the number of persons below the poverty line and it as a percentage of total population in the country or region. This is known as the head count measure of poverty. “One of the simplest and most commonly used measures of the extent of monetary poverty is the proportion of poor in a given population. Poverty incidence is the proportion of individuals whose income or expenditure falls below the poverty threshold, among the total population. Poverty incidence is also often referred as the head count ratio or even the poverty ratio or poverty rate” (ADB 2004).

Head Count Index

$$Po = \frac{N_p}{N} \times 100$$

Where as $Po$ is head count index

$N_p$ is the total number of the poor

$N$ is the total population

Simple percentage of $Po$ is used as “the percentage of population below the poverty line”.

1.8. CAUSES OF POVERTY

Poverty is not caused by a single factor, various factors involved in it. At household and individual level, age structure of the household member, education, gender of the household head, employment, income,
debts and assets, health conditions of the family members and the extent of participation in the labour force are important in determining poverty. At community level, infrastructure like markets, roads, electricity, availability of schools and health facilities are the major determinants of poverty. Human resources, equal access to employment, social mobility and representation and land distribution are the key areas in determining the poverty.

At regional level, geographical backwardness, a low resource base, low rainfall and adverse climate conditions are the major causes of poverty. Bad governance, political, economical and market instability, insecurity, terrorism are also causing poverty.

Overall socio-economic under development of a country also determine poverty.

1.9. GLOBAL POVERTY

According to the World Bank’s poverty estimation, the proportion of people below $1/day was already halved, falling from 40.1% to 18.1% between 1981 and 2004. The number of poor people fell by 500 million, from 1.5 billion to less than one billion. In 2001, 2.7 billion people were living on less than $2 a day.

Poverty rates have fallen consistently only in East and South Asia. The number of poor people have fallen in East Asia but risen in Latin
America and Africa. China has made very significant contribution to the decline of global poverty aggregates. In 1981, one-ninth of the world's poor lived in Africa. In 2004 it had reached almost one-third. Sub-Saharan Africa stands out its $1 a day poverty rate has risen until recently, the number of poor has nearly doubled over 1981-2004, from 167 million to 298 million.

“South and East Asia contain the largest number of people in income poverty, though both regions have recently made impressive gains. As noted, in the 1990s China lifted 150 million people – 12% of the population - out of poverty, halving its incidence. But in Latin America and the Caribbean, the Arab States, Central and Eastern Europe and Sub-Saharan Africa the number of people surviving on less than $1.08 a day increased” (UNDP HDR 2003).

“Income poverty has fallen in all regions since 1990, except in Sub-Saharan Africa. The share of the world’s people living on less than $1 a day has fallen from 28% to 21%, leaving just 1 billion people below the threshold. High economic growth in China and India has been the most powerful motor for reducing income poverty. Sub-Saharan Africa is the only region that has witnessed an increase both in the incidence of poverty and in the absolute number of poor. Some 300 million people
there-almost half of the region’s population-live on less than $1 a day” (UNDP HDR 2006).

Table No: 1.1

Regionwise (world) Percentage of population living below $1 at 1993 PPP

<table>
<thead>
<tr>
<th>Sl.NO</th>
<th>Region</th>
<th>1981</th>
<th>1990</th>
<th>2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>East Asia</td>
<td>57.7</td>
<td>29.8</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td>China</td>
<td>63.8</td>
<td>33</td>
<td>9.9</td>
</tr>
<tr>
<td>2</td>
<td>Europe and Central Asia</td>
<td>0.7</td>
<td>0.5</td>
<td>0.9</td>
</tr>
<tr>
<td>3</td>
<td>Latin America and Caribbean</td>
<td>10.8</td>
<td>10.2</td>
<td>8.6</td>
</tr>
<tr>
<td>4</td>
<td>Middle East and North Africa</td>
<td>5.1</td>
<td>2.3</td>
<td>1.5</td>
</tr>
<tr>
<td>5</td>
<td>South Asia</td>
<td>49.6</td>
<td>43</td>
<td>30.8</td>
</tr>
<tr>
<td></td>
<td>India</td>
<td>51.8</td>
<td>44.3</td>
<td>34.3</td>
</tr>
<tr>
<td>6</td>
<td>Sub-Saharan Africa</td>
<td>42.3</td>
<td>46.7</td>
<td>41.1</td>
</tr>
<tr>
<td></td>
<td>World</td>
<td>40.1</td>
<td>28.7</td>
<td>18.1</td>
</tr>
</tbody>
</table>

Source: 2006 World Development Indicators, World Bank.

From the above table it is clear that percentage of people living below $1 a day has fallen between 1981 and 2004. In 1981, there was 40.1% of population living below $1 a day poverty line, whereas in 2004 it was 18.1% only. It is really remarkable reduction though it is
insufficient to eradicate poverty. While analyzing that reduction at regionwise it gives different picture. In 1981 57.7% people lived in $1 a day poverty where as in 2004 it was 9.0% only in East Asia. Especially in China during 1981 the percentage of population living below $1 a day was 63.8% but it was only 9.9% in 2004. It is really a magnificent achievement. Asian region have uplift a sizeable number of people from poverty during the last two decades.

Europe and Central Asia has least number of poor people. During 1981, it was only 0.7% and in 2004 it was 0.9%. There is a increase in 0.2% but that region still has only below 1% of people who are living below poverty. Latin America and Caribbean region had only 10.8% of population living below poverty in 1981; it was further reduced to 8.6% in 2004. Even though it is minimum level, the reduction percentage is very low. During the last two decades it has reduced only 2.2% of poverty. Middle East and North Africa region reduced the poverty from 5.1% in 1981 to 1.5% in 2004.

1.10. POVERTY IN INDIA

The Planning Commission of India defines the national poverty line as the monthly per capita income level that is sufficient for an individual to meet the minimum calorie needs.
The calorie requirement of a person depends upon age, sex, height and weight, activity level of the person, rural and urban and climate. Rural households can obtain food more cheaply, both because food is typically less expensive in rural areas and also because they are more willing to consume food stuffs that are cheaper per calorie, urban consumers are more likely to buy higher quality food stuffs, which raises the cost per calorie. It follows that the calorie income function for rural households will typically higher than that of urban households.

The official poverty line in India is based on the recommendation of the Task Force on Projections of "Minimum needs and effective consumption demand 1979" of the Planning Commission in India. It used the energy intake method for the base year 1973/74 and estimated the poverty line as the monthly per capita total consumption expenditure level that meets the calorie norm of 2,400 and 2,100 per capita per day for rural and urban areas respectively.

To quantify the extent of poverty and measure the number of ‘poor’ in the country, the concept of ‘poverty line’ is being used. Poverty line represents the level of income or consumption necessary to meet the minimum needs which are necessary to live a decent standard of living. Since minimum acceptable consumption levels vary across countries, and over time, poverty line also tends to vary across countries and over time.
“Every society has its own views on what constitutes a minimum standard of living. Such normative thresholds are commonly expressed by means of a poverty line, which specifies minimum living standards to which everybody in a society should be entitled”. (Nanak Kakawani 2004)

Even though, international poverty line is US $ 1 day, setting poverty line at national level is indispensable because national income and standard of living are different for each country. “National poverty lines are a vital part of the fight against poverty, helping to maintain poverty as a focus of public attention. An official poverty line provides a public bench mark for the level of living standards that are considered adequate in a country, and thus constitutes a key device for monitoring the progress of poverty reduction policies, whether by government or other parts of civil society. If the number of people that are poor in a country according to an official national poverty line rises from one year to the next, then whatever else may be happening in that country, one key aspect of national well – being has deteriorated” (Jane Falkingham and Ceena Namazie 2002).

In India, headcount index is being a key measure for analysis, that is, the percentage of the population living in households where per capita consumption is below the poverty line. India’s Planning Commission defines poverty line based on the per capita monthly expenditure which is
officially linked to a nutritional baseline measured in calories. A daily intake of 2400 calories per person in rural areas and 2100 in urban areas marked as a cut-off point for poverty line. Who do not meet these calorie norms falls below poverty line. The ‘poverty line’ in India is defined as the aggregate per capita monthly expenditure of that group whose per capita, per diem ‘calorie’ intake (obtained from the expenditure on food items) conforms to certain specified norms. The calorie norms were fixed at 2435 kcal per capita per diem for rural areas and 2095 kcal for urban areas (rounded off to 2400 and 2100 kcal respectively) by the Task Force on Projections of Minimum Needs and Effective Consumption Demand of Planning Commission of India in 1979.

Rural households can obtain food more cheaply, because food is typically less expensive in rural areas and also because they are more willing to consumes food stuffs that are cheaper per calorie, urban consumers are more likely to buy higher quality food stuffs, which raises the cost per calorie. It follows that the calorie income function for rural households will typically be higher than that of urban households. In India, the official poverty line is based on the minimum energy requirements. The official poverty line is based on the recommendation of a Task Force report published in 1979. It used the energy intake method for the base year 1973/74 and estimated the poverty line as the...
monthly per capita total consumption expenditure level that meets the calorie norm of 2,400 and 2,100 per capita per day for rural and urban areas respectively.

“The per capita expenditure class, which satisfied the minimum calorie requirements on nutritional consideration, would provide the cut-off point delineating the poverty line. The per capita consumption of various goods and services pertaining to this expenditure class would constitute normative demand. One variant of the consumption model would be based on the assumption that the population below the poverty line will have the normative consumption and that above it the behaviorist one, separately for the rural and urban areas”.

Applying inverse linear interpolation method to the data on average per capita monthly expenditure and the associated calorie content of food items in the class separately for the rural and urban areas, it is estimated that, on the average, Rs.49.09 per capita per month satisfies a calorie requirements of 2435 per capita per day in rural areas and Rs.56.64 per capita per month satisfies a calorie requirements of 2095 per capita per day in the urban areas respectively, both at 1973-74 prices. These poverty line work out to Rs.61.8 per capita per month in the rural areas and Rs.71.3 per capita per month in the urban areas at 1976-77 prices” (Planning Commission 1979). The Planning Commission of India
estimated the poverty line for 1983-84 at Rs.101.80, for 1993-94 at Rs.205.84 and for 1999-2000 at Rs.327.56 for rural areas. For urban areas it was for 1983-84 at Rs.117.50, for 1993-94 at Rs.281.35 and for 1999-2000 at Rs.454.11.

Table No: 1.2.

Percentage of population living below poverty line (BPL)

<table>
<thead>
<tr>
<th>Sl.NO</th>
<th>States</th>
<th>1993-94</th>
<th>1999-2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Andhra Pradesh</td>
<td>22.19</td>
<td>15.77</td>
</tr>
<tr>
<td>2</td>
<td>Assam</td>
<td>40.86</td>
<td>36.09</td>
</tr>
<tr>
<td>3</td>
<td>Bihar</td>
<td>54.96</td>
<td>42.60</td>
</tr>
<tr>
<td>4</td>
<td>Gujrath</td>
<td>24.21</td>
<td>14.07</td>
</tr>
<tr>
<td>5</td>
<td>Haryana</td>
<td>25.05</td>
<td>8.74</td>
</tr>
<tr>
<td>6</td>
<td>Karnataka</td>
<td>33.16</td>
<td>20.04</td>
</tr>
<tr>
<td>7</td>
<td>Kerala</td>
<td>25.43</td>
<td>12.72</td>
</tr>
<tr>
<td>8</td>
<td>Madhya Pradesh</td>
<td>42.52</td>
<td>37.43</td>
</tr>
<tr>
<td>9</td>
<td>Maharastra</td>
<td>36.86</td>
<td>25.02</td>
</tr>
<tr>
<td>10</td>
<td>Orissa</td>
<td>48.56</td>
<td>47.15</td>
</tr>
<tr>
<td>11</td>
<td>Punjab</td>
<td>11.77</td>
<td>6.16</td>
</tr>
<tr>
<td>12</td>
<td>Rajasthan</td>
<td>27.41</td>
<td>15.28</td>
</tr>
<tr>
<td>13</td>
<td>Tamil Nadu</td>
<td>35.03</td>
<td>21.12</td>
</tr>
<tr>
<td>14</td>
<td>Uttar Pradesh</td>
<td>40.85</td>
<td>31.15</td>
</tr>
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<td>15</td>
<td>West Bengal</td>
<td>35.66</td>
<td>27.02</td>
</tr>
<tr>
<td></td>
<td>INDIA</td>
<td>35.97</td>
<td>26.10</td>
</tr>
</tbody>
</table>

Source: Planning Commission 2001, Govt of India.

The percentage of population living below the poverty line is the best known measure of poverty. The State having higher percentage of poor can be said as least developed State. In 1999-2000, the States like
Orissa (47.15), Bihar (42.60), Madhya Pradesh (37.15), Assam (36.09) and Uttar Pradesh (31.15) had higher level of poverty. In 1993-94 also, these five States had high percentage of people living in poverty i.e. 48.56, 54.96, 42.52, 40.86 and 40.85 respectively. In 1999-2000, Punjab (6.16), Haryana (8.74), Kerala (12.72) and Gujrat (14.07) had least percentage of poor people living among Indian States. In 1993-94 also, those were the States which had the low percentage of poor people i.e. 11.77, 25.05, 25.43, and 24.21 percent respectively.

1.11. HEALTH

Health is considered as an important asset and it is also one of the resources needed for human well-being.

The concept of health is a broad one, embracing health status, nutritional status, morbidity, fertility management, disability and mortality. It embraces not just the health of young children but also the health of older children and adults. It also embraces reproductive health the health of woman during and after pregnancy, and unwanted pregnancies. (PRSP Source Book 2002)

The importance of health in measuring poverty is growing in importance. This is because of the crucial role that plays in the economic development and poverty reduction aspects. How does health relate to
development? The first point to note is that the enhancement of health is a
constitute part of development. Second, given other things, good health
and economic prosperity tend to support each other (Amarty K. Sen
1999).

Poverty and ill health are linked in a vicious cycle, in which
poverty leads to ill health and ill health further contributes to poverty.
This is a two way relationship; ill health prevents people from working,
or affects their productivity by thus lowering their income. The loss of
earnings associated with ill health rapidly impoverished households.

It is widely accepted that socio-economic factors, including
poverty, are key in determining health status. Poor people become sick
more often and die younger than those who are better off. Since poverty
is one of the major determinants of poor health status, poor health is
mostly the cause of the poverty and it is also a good indicator to measure
poverty. Poverty has an obvious impact on health. Income provides
means of obtaining the prerequisites for health, such as shelter, food, and
access to health services. Low income leads to poverty which ultimately
results in poor nutrition, over crowding, inadequate housing, increased
risk of infections and inability to maintain standards of health and
hygiene conditions.
A complex set of biological, socio-economic, demographic and cultural factors underlie infant mortality. "Infant mortality rate is a sensitive index of socio-economic condition of a population. It is an excellent indicator of the level and quality of health care and other social infrastructure available to a population" (ChAndhramouli.S 2002). Regional estimates of under-five mortality in 2002 vary from a low of 8 per 1000 line births for developed countries to a high of 174 per 1,000 live births in sub-Saharan Africa. Even within countries, spatial variation in mortality rates can be large. In India, for example, the 1998-99 national family health survey found that mortality rates for children younger than 5 years varied from 18.8 per 1000 births in Kerala to 137.6 per 1000 births in Madhya Pradesh (UN 2004).

In Indian, infant mortality rate has declined considerably. It was 115 per 1000 live births in 1961 and declined to 71 per 1000 live births in 2001. But this declined has stagnated during the last decade.

Improving health of people is one of the major objectives in today’s development agenda. Health and development of a country is interlinked. Like all other asset health is also an asset. It is a basic prerequisite for human resource development and overall economic growth. The importance of health in measuring poverty is growing in
importance. This is because of the crucial role that health plays in the
economic development and poverty reduction aspects.

WHO defines health as a state of complete physical, mental and
social well being and not merely the absence of disease or infirmity.
Later, economic and political well being is also included in this well­
being definition. In 1986, an addition to this definition has been made i.e.,
health is a resource for everyday life, not the objective of life. Health is a
positive concept emphasising social and physical resources as well as
physical and mental capacity.

"Health is more than the well-being of an individual. The health of
an individual or group affects the well-being of communities and nations
through economic productivity, school attendance and performance by
children and long-term prospects for the development of a country’s
human resources" (WHO 2003).

Health is an asset for people. It has intrinsic value as well as
instrumental value. It is not only the absence of disease or infirmity, it is
also the ability of people to develop to their potential during their entire
lives. Health has always been a valued possession and health is wealth
and it is still considered as the most valuable thing in human life.
1.12. HEALTH AND DEVELOPMENT

Health is an important ingredient of development. Health supports development process. It spurs economic growth and it is a good measure of human well-being. Enhancement of health of the people is one of the major objectives of the process of development. Health improves the productivity and skill of the people and reduces absenteeism from work. By thus it increases income of poor people. Health directly improves the socio-economic conditions of people in many ways. Improving health status of people is one of the basic goals of development. Health is not only an end product but it is also a major contributor for economic development.

Today, there is general agreement that health is an essential constituent of the human resource which plays such a crucial role in development”. Health is normally viewed as an end product of growth process. People with higher incomes have a greater command over the goods and services that promote health, such as better nutrition, access to safe water, sanitation and good quality health services”.(David E. Bloom 1999.)

Health gives capability and brings the capacity for personal development, with economic well-being; health is a critical input for poverty reduction and economic development. It is a component of
capability and human resource. Improving health conditions not only improves well-being but also increases income earning capacity. Health acts as a means to enhance one’s capability to work and earn more. Income, health, and education acts together and improves individual capability and induces overall development of a country. Health and well-being are interrelated. Healthy people can learn more and can go to work regularly. By thus, the income of the individual increases. The increase amount can improve the standard of living and well-being. Better health is central to human happiness and well-being. It also makes an importance contribution to economic progress, as healthy people live longer, are more productive and save more.

Good health status one of the means to prevent poverty as well as a means to overcome poverty and to achieve development. The nations of the world agreed that health is a prerequisite for development and so putting it on the main agenda. Investment in health is also increasingly recognized as an important means of economic development. Health improves productivity, increases output and income. It creates better incentives for investment. Health improves growth in the human capital. Healthy people have more resources to save and these savings in turn provide investments. Health education and healthy behaviour lower fertility, mortality and morbidity it shows population growth and reduce
dependency ratio by thus per capita income and national income increase.

"Good health and prosperity tend to support each other. Healthy people can more easily earn an income, and people with a higher income can more easily seek medical care, have better nutrition, and have the freedom to lead healthier lives" (Sen.A. 1999). Health gain increases life expectancy and quality of life, reduces morbidity, mortality and fertility. These are signs of development of nation. "Improvements in health are important in their own right, but better health is also prerequisite and a major contributor to economic growth and social cohesion. Conversely, an improvement in people's access to health technology is a good indicator of the success of other development processes" (WHO Report 2003).

With its instrument value, health induces development in a number of ways, it increases the production and productivity as a result of better health and nutritional status, it helps the individual to use their potential well as the natural resources. It lowers the absenteeism rates and improves school attendance. Health reduces economic burden of illness. So, the expenses for the medical expenses reduce and the real income of individual will increase. When a family is in healthy condition, bread winner can earn more and can feed more and the children can learn more.
Healthy children can improve knowledge which positively impacts their future well-being.

"Healthier workers are physically and mentally more energetic and robust, more productive and earn higher wages. A healthy work force is important when attracting foreign direct investment. Healthier workers are also less likely to be absent from work due to illness or illness in their family. Illness and disability reduce hourly wages substantially, with the effect especially strong in developing countries where a higher proposition of the workforce is engaged in manual labour" (WHO 2001).

To lift a country from poverty and to induce economic development of a country, health is a needy important factor. Health condition of the people of a nation is a good parameter to assess country’s development path. In the 1960’s, all Asian least developed countries and South Asian developing countries had a life expectancy at birth below 45 years. During the same period, the East Asian developing countries had a life expectancy at birth well over 50 years. In the late 1990’s, although the Asian least developed countries and South Asian developing countries enhanced their life expectancy to a level of over 60 years. While measuring the GNP aspects of these countries, in the 1960’s all these countries except Malaysia, were below the $ 200 GNP mark. But in 1999 for both Asian least developed countries and South Asian developing
countries, including India and Pakistan, are still below $500 GNP, whereas East Asian developing countries ranging from over $2000 GNP to $8,500 GNP. This difference is mainly because of the health and education factors. "Through mass literacy, better prepared healthy workers and conducive investments friendly government policies, East Asian developing countries seen to have been able to furnish those essential elements of rapid growth at the very early stages of their development" (Aynul Hasan. M 2001).

Health and education are both components and factors of human development. Good health swifts the growth rate. The benefits of good health spread beyond a single generation. With good health, children are more likely to escape from the childhood diseases and have better chance to invest in education with high attendance and learning capacity. Healthy people have more resources to devote to save; these savings in turn provide funds for investment. In turn, investment induces development. So, health is an important factor and means of economic development.

"Good health is a crucial component of overall well-being. However, improvements in health status may be justified on purely economic grounds. Good health raises level of human capital and this has a positive effect on individual productivity and on economic growth rates. Better health increases workforce productivity by reducing incapacity,
debility and the number of days lost to sick leave and increase the opportunities an individual has to obtaining better paid work. Further, good health helps to forge improved levels of education by increasing levels of schooling and scholastic performance" (WHO 2003).

Growth and health are correlated and the effect of health on economic growth is well known. Good health raises per-capita income which leads to increasing expenditures on health care.

**1.13. HEALTH AND POVERTY**

Poor health and poverty are interlinked and mutually reinforcing and can generate a vicious cycle of deterioration, suffering and poverty. There is a two way relationship between poverty and ill health. Ill health prevents people from working and or affects their productivity. By thus ill health lowers the poor people income. When health of the bread winner of a poor family affects, it has severe implications for economically dependent family members, especially children. The loss of earnings of the head of the family associated with ill health rapidly impoverishes households severely.

"The poor suffer worse health and die younger. They have higher than average child and maternal mortality, higher level of disease, more limited access to health care and social protection and gender inequality
disadvantages further the health of poor women and girls. For poor people especially, health is also a crucially important economic asset. Their livelihood depends on it. When a poor or socially vulnerable person become ill or injured, the entire household can become trapped in a downward spiral of lost income and high health care costs. The escanding effects may include diverting time from generating and income or from schooling to care for the sick, they may also force the sale of assets required for livelihoods” (OECD/ WHO 2003).

Poor are more vulnerable to disease and have more limited access to health care. The economic cost of disease for poor people affects their livelihood. Ill health makes unable to work. That reduces the income of the poor which makes hunger and impoverishment which induces the selling of their assets of they have any and pushed them towards debts. Poor health and low income suffers the health and education of young children very much. That makes the children out of school and hence they can’t acquire knowledge and skill. “It is clear that poverty and ill health are casually related, and improved health will result from improvement and changes in sector other then health. Poor nutrition, ill health and the inability to afford healthcare are perpetuated by low and declining real incomes, poor female education and status, unhealthy environments
(housing, water and sanitation) and inadequate access to quality health services” (CHIP 2005).

1.14. ECONOMIC COST OF ILL HEALTH

The loss of income associated with low productivity because of ill health, cost of the medical care to treat the illness, selling of assets if they have for medical treatment, if don’t have any assets or saving, they borrow from money lenders for the treatment which leads to debt are primary economic costs of ill health.

“The human, economic and social costs of ill health are immense. Millions of people die prematurely from diseases that are preventable or curable. At relatively little expense, many of these people could lead, longer, healthier and more productive lives” (Dara Carr 2004).

Poverty has an obvious impact on health. Poverty itself leads to poor health. Poverty and ill health both are cause and effect for themselves. Income provides means of obtaining the pre-requisites for health, such as shelter, food and access to health services. Low income leads to poverty which ultimately results in poor nutrition, over crowding,
inadequate housing, increased risk of infections and inability to maintain standards of health and hygiene conditions.

“Ill health not only affects the poor disproportionately, it also causes poverty. A family struggling to get by day by day cannot afford to be ill; not only because it cannot afford medicine and health care, but because of the loss of earning power that illness causes” (WHO 2002).

Figure No: 2

**Vicious Cycle of Poverty and Health**

Poverty and ill health are linked in a vicious cycle, in which poverty leads to ill health and ill health further contributes to poverty. Illness plunges people into poverty and prolongs it. Ill health reduces the productivity of the poor people which results in low income like that poor
people are more likely to be unemployed and for underemployment which results in loss of employment.

Access of health care for the poor people is another bigger problem related with poverty and ill health. Poor people cannot avail the medical facilities easily, which they need in time because of high cost. Those who are living in poverty cannot access the health care, safe drinking water, sanitation and decent housing facilities easily. For a decent and healthy standard of living conditions these facilities are indispensable. “There are many reasons for the increased burden of disease on the poor. First, the poor are much more susceptible to disease because of lack of access to clean water and sanitation, safe housing, medical care, information about preventive behaviours and adequate nutrition. Second the poor are much less likely to seek medical care even when it is urgently needed, because of their greater distance from health providers, their lack of out-of-pocket resources needed to cover health outlays, and their lack of knowledge of how best to respond to an episode of illness. Third as mentioned, out-of-pocket outlays for serious illness can push them into debt or into the sale or mortgaging of productive assets (such as land). A serious illness may plunge a household into prolonged impoverishment, extending even to the next generation as children are forced from school and into the workforce” (WHO 2003).
1.15. FACTORS DETERMINING HEALTH

A variety of socio, economical, political factors are influencing health status. Income, education especially female education, inequality, nutrition, behaviour, environment, geographical factor, rural and remoteness, safe housing, water and sanitation facilities, transportation facilities, community norms, values and ethics, age, family size, gender, availability of health services, public spending on health and Govt policies are the main determinants of health status. If these factors work together in a positive way then the community will have better healthy people. If these factors act ironically, people may suffer very much and the morbidity and mortality will increase.

According to the World Bank’s PRSP Analysis, health outcomes and impoverishment are determined by various factors. They are

At the household level

Behaviour and Risk factors (ex. food consumption, sanitary and sexual practice, the use of curative and preventive services) and

1. Availability of resources
   (Human, physical and financial)

At the community level,

1. Influence of values and norms
2. Use and availability of services
3. Community involvement and
4. Quality and accountability of health services

At the health services level,

1. access to services
2. The cost, availability, and quality (of drugs, vaccines and other key inputs)
3. Other parts of the health sector
4. Other sectors involvement
   (Ex. education, water and sanitation, transportation energy and other infrastructure) and
5. Govt. Politics and Actions
   (In financing and regulating health services and other sectors).

1.16. MEASURING HEALTH

To monitor the health status of a country, a region or an area, various mortality, morbidity, life expectancy, death rate, birth rate fertility rate, nutritional, availability of and access to health services and medical and paramedical professional, water and sanitation facility indicators are being used.
Among them, the prominent are,

a. infant mortality rate
b. under–five mortality rate
c. maternal mortality rate
d. life expectance at birth
e. HIV/AIDS prevalence
f. TB prevalence
g. Malaria prevalence
h. Diarrhea prevalence
i. Acute respiratory infection rate
j. Availability of doctors and nurses
k. births attended by medical personnel
l. immunization coverage
m. Adoption of contraceptive methods
n. Anemia among children, adolescent girls and mothers
o. Body mass Index
p. death rate and
q. fertility rate

Among these life expectancy at birth, under-five mortality, infant mortality rate are being mostly used by international agencies to assess the health and ill health conditions of the people. The data of these are the more sensitive, reliable and easily available.

1.17. HEALTH STATUS OF INDIAN PEOPLE

India is well known for its drought and disease. During pre-independence era diseases like plague, small pox, cholera, malaria
claimed millions of lives of Indian people. Poor knowledge about health and sanitation, unhealthy behaviour increases prevalence rate of diseases. Unavailability of potable water and health services, poor living conditions, high population and high fertility were the common features of rural and urban slum areas. These increased and induced the diseases and deaths. Those were the reasons for low level life expectancy at birth before independence. Low income and illiteracy are the key factors for ill health status of Indian people. Community norms, values, tradition are also playing important role in people’s health behaviour. Gender discrimination is one of the worst form practices that lead to female infanticide.

After Independence the scenario is changing. With the help of various Plans and Committees especially the Bhore Committee and International Development agencies like WHO, UNICEF, the health status of the people of India have been improving remarkably. Various vaccination and immunisation programmes, disease control and eradication programmes, Family planning / welfare programme, water and sanitation programmes are being implemented by State and Central Governments. This improves health status of the people as well as reduces mortality and morbidity rates. Diseases like plaque, small pox, cholera eradicated from India. Leprosy, Malaria, Polio are almost
eradicated from various states in India. Among six killer diseases, polio, diphtheria, tetanus, pertussis, measles are rare to see in India.

Through nutritional schemes, nutritional statuses of children are improving. Life expectancy at birth increased to above 60 years. Infant and under five mortality rates are declining sharply. To avoid material deaths various schemes are being implemented by the Govt.

Even these improvements, TB and HIV are threatening India very seriously. World's most of the TB, HIV and AIDS patients are living in India. Poor living conditions, water and sanitation problem still prevails among rural, urban poor people. Anemia among adolescent girls and mothers are still threatening the Indian society. Hence, India has to take much effort to overcome these problems and to improve the health status of people.
### Regionwise (world) Infant Mortality Rate, 1990-2002

<table>
<thead>
<tr>
<th>Sl.No</th>
<th>Region</th>
<th>1990</th>
<th>2002</th>
<th>Average annual rate of change in 1990-2002 (in percent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>World</td>
<td>64</td>
<td>55</td>
<td>-1.3</td>
</tr>
<tr>
<td>2</td>
<td>Developed Regions</td>
<td>10</td>
<td>6</td>
<td>-4.3</td>
</tr>
<tr>
<td>3</td>
<td>Developing Regions</td>
<td>71</td>
<td>61</td>
<td>-1.3</td>
</tr>
<tr>
<td>4</td>
<td>Northern Africa</td>
<td>66</td>
<td>34</td>
<td>-5.5</td>
</tr>
<tr>
<td>5</td>
<td>Sub-Saharan Africa</td>
<td>109</td>
<td>104</td>
<td>-0.4</td>
</tr>
<tr>
<td>6</td>
<td>Latin America and the Caribbean</td>
<td>43</td>
<td>28</td>
<td>-3.6</td>
</tr>
<tr>
<td>7</td>
<td>Eastern Asia</td>
<td>37</td>
<td>30</td>
<td>-1.7</td>
</tr>
<tr>
<td>8</td>
<td>Southern Asia</td>
<td>87</td>
<td>67</td>
<td>-2.2</td>
</tr>
<tr>
<td>9</td>
<td>South-East Asia</td>
<td>54</td>
<td>36</td>
<td>-3.4</td>
</tr>
<tr>
<td>10</td>
<td>Western Asia</td>
<td>53</td>
<td>49</td>
<td>-0.7</td>
</tr>
<tr>
<td>11</td>
<td>Oceania</td>
<td>63</td>
<td>59</td>
<td>-0.5</td>
</tr>
</tbody>
</table>

Source: Human Development Report 2003, UNDP

From the above table it is clear that Sub-Saharan African region had the high infant mortality deaths in the world, i.e. during 1990 it was 109 and during 2002 it was 104 and the reduction percentage was also very low in that region. After that South Asia had more number of infant deaths, i.e. during 1990 it was 87 and during 2002 it was 67. Oceania region also had more number of infant deaths. Eastern Asia, South East Asia and Northern Africa region had minimum number of infant deaths during that period when comparing with other developing regions.
### Table No: 1.4

Statewise Infant Mortality Rate of India for 1991 and 2001

<table>
<thead>
<tr>
<th>Sl.NO</th>
<th>States</th>
<th>Year</th>
<th>1991</th>
<th>2001</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Andhra Pradesh</td>
<td></td>
<td>55</td>
<td>66</td>
</tr>
<tr>
<td>2</td>
<td>Assam</td>
<td></td>
<td>92</td>
<td>78</td>
</tr>
<tr>
<td>3</td>
<td>Bihar</td>
<td></td>
<td>75</td>
<td>67</td>
</tr>
<tr>
<td>4</td>
<td>Gujrat</td>
<td></td>
<td>78</td>
<td>64</td>
</tr>
<tr>
<td>5</td>
<td>Haryana</td>
<td></td>
<td>52</td>
<td>69</td>
</tr>
<tr>
<td>6</td>
<td>Karnataka</td>
<td></td>
<td>74</td>
<td>58</td>
</tr>
<tr>
<td>7</td>
<td>Haryana</td>
<td></td>
<td>42</td>
<td>16</td>
</tr>
<tr>
<td>8</td>
<td>Madhya Pradesh</td>
<td></td>
<td>133</td>
<td>97</td>
</tr>
<tr>
<td>9</td>
<td>Maharasra</td>
<td></td>
<td>74</td>
<td>49</td>
</tr>
<tr>
<td>10</td>
<td>Orissa</td>
<td></td>
<td>125</td>
<td>98</td>
</tr>
<tr>
<td>11</td>
<td>Punjab</td>
<td></td>
<td>74</td>
<td>54</td>
</tr>
<tr>
<td>12</td>
<td>Rajahstan</td>
<td></td>
<td>87</td>
<td>83</td>
</tr>
<tr>
<td>13</td>
<td>Tamil Nadu</td>
<td></td>
<td>54</td>
<td>53</td>
</tr>
<tr>
<td>14</td>
<td>Uttar Pradesh</td>
<td></td>
<td>99</td>
<td>85</td>
</tr>
<tr>
<td>15</td>
<td>West Bengal</td>
<td></td>
<td>62</td>
<td>53</td>
</tr>
<tr>
<td>INDIA</td>
<td></td>
<td></td>
<td>77</td>
<td>71</td>
</tr>
</tbody>
</table>

Source: Census of India 1997 and Economic Survey, GoI, 2002-03.

Infant mortality rate is the most sensitive health indicator which is used widely for the assessment of a country’s development in health and human development aspects. The above table indicates that Orissa (98) followed by Madhya Pradesh (97), Uttar Pradesh (85), Rajasthan (83) and Assam (78) had very high infant mortality rate in 2001. These States average was above the national average. While comparatively States like Kerala (16), Maharasra (49), Tamil Nadu (53), West Bengal (54) and Punjab (54) had relatively low infant mortality in 2001. At national level infant mortality rate was 71 in 2001.
In 1991 also, the above top 5 States i.e. Orissa, Madhya Pradesh, Uttar Pradesh, Rajasthan and Assam were with high infant mortality i.e. 125, 133, 99, 87 and 92 respectively. At national level it was 77 in 1991. In 1991, there was low infant mortality in the States like Kerala (42), Tamil Nadu (54), Haryana(52) and Andhra Pradesh(55). In this period Kerala’s achievement in infant mortality reduction was quite remarkable from 42 to 16. Where as infant mortality reduction was almost stagnated in Tamil Nadu i.e. 54 in 1991, 53 in 2001. Contrarily, infant mortality rate was increased in the States like Andhra Pradesh from 55 in 1991 to 66 in 2001 and Haryana from 52 in 1991 to 63 in 2001. This is very deplorable.

1.18. EDUCATION

Education is a light for life especially for poor. Education improves knowledge and skill and helps poor people to pull them out of poverty. For poor, education is the very much needed asset than other assets. Educational attainment is an important indicator to monitor the development of a nation. Improving education, literacy, and knowledge not only improves well-being but it also leads to better health outcomes and to higher incomes.

The relationship between education and poverty reduction is thus quite straight and linear as education is empowering, it enables the person to participate in the development process, it inculcates the knowledge and
skills needed to improve the income earning potential and in turn the quality of life. Moreover, education of girls and women helps in improving the number of other indicators of human development (Venkatasubramanian 2001). Like other assets health and education are also assets, which increase the productive capacity and help to earn more income. Health and Education are important and very much needed human for fostering economic growth and to reduce the poverty (WHO 2002). Ironically, deprivation in health and education leads human deprivation. So, a poverty study must include these assets and their deprivation for the assessment of poverty.

"Inadequate education is one of the most powerful determinants of poverty, and unequal access to education opportunity is a strong correlate of income inequality. Basic education or literacy training, of adequate quality, is crucial to equipping disadvantaged individuals with the means to contribute to and benefit from economic growth. Education is one of the most powerful instruments societies have for reducing deprivation and vulnerability: it helps lift earning potential, expands labour mobility, promotes the health of parents and children, reduces fertility and child mortality, and affords the disadvantaged a voice in society and the political system" (PRSP Source Book 2002).
Improvements in educational attainments have invariably been accompanied by improvement in health and longevity of the population and in their economic well-being. Literacy rate, Illiteracy rate and drop, out are important educational indicators for the measurement of human development and deprivation. As per the Economic Survey of India 2002-2003 the literacy rate in India was 18.30 in 1951, 52.20 in 1991 and 65.38 in 2001. So, there is a sharp increase in literacy rate during the past fifty years. But there is a long way to go to achieve "Education for all" in India.

Education is the process of imparting knowledge and skills and it is a crucial ingredient for a person's development. Education is the most important element for growth and prosperity of a nation. Education is the fundamental right of every human being. The process of national development requires educated people. Education has always served as a building block of the society and contributed for nation's development.

Education equips pupils with literacy skills for life and further learning. Literacy is the basic education. Literacy involves a continuum of reading and writing skills, often extending to basic arithmetic skills and life skills. The United Nations Educational, Scientific and Cultural Organization (UNESCO) has defined that the literacy is the ability to identify, understand, interpret, create, communicate, and compute using
printed and written materials associated with varying contexts. Literacy involves a continuum of learning to develop his or her knowledge and potential, and to participate fully in the under society.

1.19. EDUCATION AND DEVELOPMENT

Education is a crucial path that needed to get out of poverty. Education develops personal strength and skills, self-esteem and job-related skills and life skills. It increases people’s ability to access employment, health, and welfare activities. Education is the one of the indispensable means for effective social, economic development and important contributor for human development and poverty reduction. Education is essential for eradicating poverty, reducing child mortality, curbing population growth, achieving gender equality and ensuring sustainable development, peace and democracy.

"It is through education that individuals realize their potential to contribute to production, wealth creation and execution of various roles that make for national development. It is also through education that they are able to benefit from the distribution of wealth in the economy, have a political voice and access social goods and services to enhance their living standard" (UNICEF 2002). Education enables a person to participate in the development process; it improves the knowledge and
skills, and the income earning capacity. Education is an important means of social change. Social change made possible through education, with the expansion of human capabilities through individuals action as well as public activism. Human Development is possible only when people’s capability fully and effectively utilized, that can be possible if the people are educated. Eradicating illiteracy is being one of the primary objectives of development goal. Educating all the persons spurs development process.

World Declaration on Education for All states that every person – child, youth and adult shall be able to benefit from educational opportunities designed to meet their basic learning needs. These needs comprise both essential learning tools (such as, literacy, oral expression, numeracy, and problem solving) and basic learning contact (such as knowledge, skills, values and attitudes) required by human beings to be able to survive, to develop their full capacities, to improve their quality of lives, to make informed decisions and to continue learning.

Education is a fundamental element of human development. It is positively linked to employment, income, health and empowerment of women, “Every individual is born with a collection of abilities and talents. Education, in its many forms, has the potential to help fulfill and apply them” (WDR 1980).
Education develops a country more swiftly. It is the key determinant of nation’s income and growth. It gives more productive work force to the society. Science and Technology requires educated people. Countries, which are having more educated people, are the developed countries, which are well advanced in science and technology. “Basic education or literacy training, of adequate quality is crucial to equipping disadvantaged individuals with the means to contribute to and benefit from economic growth. Education is one of the most powerful instruments societies have for reducing deprivation and vulnerability it helps earning potential, expands labour mobility, promotes the health of parents and children, reduces fertility and child mortality, and affords the disadvantaged a voice in society and the political system” (PRSP 2002 Education).

Education creates skills which facilitate higher levels of productivity. Earning capacity also increases with education. Education is a means of poverty reduction. Education helps an individual to improve her own quality of life as well as to participate meaningfully in community life. Countries having more educated people are tending to achieve more productivity, dynamic and income growth.
1.19. MEASURING LITERACY

Some of the major educational indices are literacy rate, illiteracy, enrolment ratio, drop out, mean years of schooling, attendance, teacher-pupil ratio, number of educational institutions in the area.

Literacy is a person's first step in learning and knowledge building and therefore, literacy is a basic indicator measuring knowledge of a society. And literacy is the important means for people to improve personal endowment building capacities and capabilities and enlarge and use the available opportunities and choices for a sustained improvement in well-being. Where as illiteracy is the condition of not being able to read or write.

Literacy rate is mostly determined by measuring the reading, writing, and memory skills of each person within a social context. Thus, literacy rate reflects literacy skills of the population. Literacy rate is the accumulated achievement of primary education and adult literacy programmes.

Literacy rate is one of the measurements that systematically measure the basic education skills. It is being considered as crucial measure of a regions human capital.
1.20. EDUCATION AND HEALTH

Education is strongly correlated with improved health outcomes. Educated people generally have better health and hygienic practice, having knowledge about disease and prevention method of disease. Education improves the knowledge about health and that leads to better health status. Education alters individual’s characteristics that affect health investments and health. Education creates health awareness and risk factors aversion. With better health, education helps to use knowledge and new scientific and technological techniques more rapidly and more effectively.

Abilities of learning in schools mainly depend on nutrition and health of the schools children. Education facilitates an increase in the consumption of nutrition and health related goods such as adequate nutritional food or medicine.

Health and education are having synergetic effect on skill, productivity capacity of an individuals and both influences income in a positive way. Education and health are positively linked to different dimensions of economic growth. “Researches behave the association between education and health may be due to a number of factors, including the tendency of educated people to obtain safer, better jobs, have greater levels of health literacy take preventive health care
measures, avoid risky behaviors, and experience greater “self efficacy” or level of control in their lives” (WHO 2003).

1.21. FACTORS DETERMINING EDUCATION

Several factors play important role in determining educational status at different level i.e. from household to national level. They are,

1. Family income.
2. Parent's education especially mother's education.
   (a) Employment.
3. Health and nutrition,
   (a) Order of birth
   (b) Size of the family.
4. Parent’s knowledge, attitude and involvement
5. Gender
6. Ability of the student
   (a) Teachers role
7. Geographical area
8. Educational infrastructure development
9. Government policies

1.22. POVERTY AND EDUCATION

Poverty measurement, now a day, includes non-monetary indicators of well-being such as education, health, nutrition, etc. Poverty analyses forces on important dimensions of capability viz., health and
literacy. And there is a close relationship between poverty and education. Educated people can get better employment which leads to income earning capacity which is one of the basic pillars of improvement in the standard of living. And also educated person can easily learn and develop skills by thus their productivity increases which are also leads to income increase. On the other hand, illiterate people either haven’t enough opportunity or they can get employment which gives only a low income. Illiterate people’s skills are at a low level and they are very hard to get modern and technical skills because they required at least basic education. Hence, illiterate people are more prone to catch in the hands of vicious cycle of poverty.

Illiteracy is the key vehicle through which poverty is passed on from one generation to next and education is the most effective means of helping to counteract the damaging effects of poverty.

If a person is illiterate then he cannot acquire the basic skills needed to function as a productive responsible member of the society. Illiteracy leads a person to low income and ill health. Lack of education perpetuates poverty and poverty constrains access to schooling. Higher mortality and morbidly are predominant of among uneducated poor families. Ill health compelled the poor for absenteeism and drop-out. Hence poverty is both a cause and an effect of illiteracy.
Poor people like all others have potential and capabilities and they are contributing much more to the Socio-economic development of a country. Educating poor leads them to use their potential and capabilities. Educating poor helps them to lift them out of poverty. And there is direct relationship between education, employment and poverty eradication.

1.23. FEMALE EDUCATION

Female education is very strongly correlated with improved health care for children, families, and communities. It leads to charge in reproductive behaviors, lower maternal and child mortality, spacing of births, better care for children reduces the fertility rates, improved health care for family member. Female education is associated with better health outcomes. Educated females improve family care and the quality of life of households.

Education of females is a driving force for better health status of a community. Higher literacy rates among women are associated with low fertility and maternal and infant mortality. Education is the basic need to eliminate gender disparities. "Educating girls directly improves family welfare, reducing some of the most precious effects of poverty. With even a few years of formal education, women are more likely to plan their families and have fewer children; to seek pre- and postnatal care, lowering maternal and child mortality, and to provide children with better
nutrition, ensure they are immunized, and procure appropriate medical care, thereby reducing child mortality” (PRSP Source Book 2002).

Table No: 1.5

Region wise Adult Literacy Rate (world) (% ages 15 and above )

<table>
<thead>
<tr>
<th>Sl.NO</th>
<th>Region</th>
<th>1990</th>
<th>2003</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Arab States</td>
<td>50.8</td>
<td>64.1</td>
</tr>
<tr>
<td>2</td>
<td>East Asia and Pacific</td>
<td>79.7</td>
<td>90.4</td>
</tr>
<tr>
<td>3</td>
<td>Latin America and the Caribbean</td>
<td>85.1</td>
<td>89.6</td>
</tr>
<tr>
<td>4</td>
<td>South Asia</td>
<td>47.7</td>
<td>58.9</td>
</tr>
<tr>
<td>5</td>
<td>Sub-Saharan Africa</td>
<td>51.1</td>
<td>61.3</td>
</tr>
<tr>
<td>6</td>
<td>Central and Eastern Europe and the CIS</td>
<td>98.7</td>
<td>99.2</td>
</tr>
</tbody>
</table>

Source: Human Development Report 2005, UNDP

From the above table it is cleared that South Asia region had most illiterate in the world. In 2003, over 41 percentages of people were illiterate in this region. Sub-Saharan Africa and ARAB States followed that with 61.3 and 64.1 per cent literates each. These regions have to take concrete effort to improve the literacy of masses. Central and Eastern Europe and CIS region had achieved almost universalisation of education with 99.2 per cent literacy rate. East Asia and Pacific and Latin America and Caribbean regions are also in good position in the literacy level with 90.4 and 89.6 per cent respectively. In 1990 the scenario was same for
example South Asia had most illiterates (52.3 per cent) and the Central and Eastern Europe and the CIS region's literacy rate was 98.7 per cent.

1.24. EDUCATION IN INDIA

While India's independent, the literacy rate was just about 16 per cent. It showed the poor educational scenario of the country. It was understood that if India has to take rapid strides in the socio-economic development human resource development has to given priority and it has the ability to play an anchor role in the development of the country. Hence, concerted efforts have made to wipe off illiteracy in the shortest possible time. With this idea several schemes and projects have been implemented to eradicate illiteracy and promote education among the masses. Education for All, Universilisation of Education, Eradicating illiteracy, Disseminating Technical Education, Strengthening higher education are set as the goals of various primary Indian developmental programmes.

Article 45 of the Indian Constitution reiterated that the State shall endeavor to provide free and compulsory education for all children, until they reach the 14 years of age in India.

The availability of education, health care, housing, water, sanitation, and employment are the basic needs for a civilized living. An
educated and healthy person can contribute more effectively to the growth of the nation. To meet this objective, the government of India formulated the National Policy on Education in 1986, which provides a broad policy framework for total eradication of illiteracy and a commitment to make primary education free and compulsory up to fifth grade. Several schemes were launched by the government to meet the needs of not only the educationally disadvantaged but also for the overall strengthening of the social infrastructure for education.

National Literary Mission, Operation Blackboard and the recently introduced Sarva Shiksha Abhiyan are the some of the schemes being implemented to achieve cent per cent literacy in India. On education, National Policies had been formulated in 1968 and 1986 with the aim of free and compulsory education for children up to age of 14 years.

**Operation Blackboard**

One of the important objectives of educational development is universalisation of primary education. Free and compulsory education to all the children up to the age of 14 years is included in the guiding principles of the Indian Constitution and is also a part of Minimum Needs Programme and 20-Point Programme. Free and compulsory education to all the children up to the age of 14 years by 1995 was the objective in the educational policy declared by Central Government in 1986. In the
different measures to achieve this target the scheme viz. "Operation Blackboard" is included.

1.25. SARVA SHIKSHA ABHIYAN

Sarva Shiksha Abhiyan is an effort to universalise elementary education by community-ownership of the school system. It is a response to the demand for quality basic education all over the country. The SSA programme is also an attempt to provide an opportunity for improving human capabilities to all children, through provision of community-owned quality education in a mission mode. The main aim of this scheme is to provide useful and relevant elementary education for all children in the 6 to 14 age group by 2010.

Objectives of Sarva Shiksha Abhiyan Scheme

1. All children in school, Education Guarantee Centre, Alternate School, 'Back-to-School' camp by 2003,
2. All children complete five years of primary schooling by 2007,
3. All children complete eight years of elementary schooling by 2010,
4. Focus on elementary education of satisfactory quality with emphasis on education for life,
5. Bridge all gender and social category gaps at primary stage by 2007 and at elementary education level by 2010, and

Table No: 1.6
Illiteracy Rate - India for the years 1991 and 2001

<table>
<thead>
<tr>
<th>Sl.NO</th>
<th>States</th>
<th>Illiteracy Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1991</td>
</tr>
<tr>
<td>1</td>
<td>Andhra Pradesh</td>
<td>55.90</td>
</tr>
<tr>
<td>2</td>
<td>Assam</td>
<td>47.10</td>
</tr>
<tr>
<td>3</td>
<td>Bihar</td>
<td>61.50</td>
</tr>
<tr>
<td>4</td>
<td>Gujrat</td>
<td>38.70</td>
</tr>
<tr>
<td>5</td>
<td>Haryana</td>
<td>44.20</td>
</tr>
<tr>
<td>6</td>
<td>Karnataka</td>
<td>44.00</td>
</tr>
<tr>
<td>7</td>
<td>Kerala</td>
<td>10.20</td>
</tr>
<tr>
<td>8</td>
<td>Madhya Pradesh</td>
<td>55.80</td>
</tr>
<tr>
<td>9</td>
<td>Maharasthra</td>
<td>35.10</td>
</tr>
<tr>
<td>10</td>
<td>Orissa</td>
<td>50.90</td>
</tr>
<tr>
<td>11</td>
<td>Punjab</td>
<td>41.50</td>
</tr>
<tr>
<td>12</td>
<td>Rajasthan</td>
<td>61.40</td>
</tr>
<tr>
<td>13</td>
<td>Tamil Nadu</td>
<td>37.30</td>
</tr>
<tr>
<td>14</td>
<td>Uttar Pradesh</td>
<td>58.40</td>
</tr>
<tr>
<td>15</td>
<td>West Bengal</td>
<td>42.30</td>
</tr>
<tr>
<td></td>
<td>INDIA</td>
<td>47.10</td>
</tr>
</tbody>
</table>

Source: Computed by the scholar

Illiteracy rate is an indicator of educational poverty and deprivation. The above table shows that at national level, it declined from 47.10 in 1991 to 34.62 in 2001. That means there was a sharp increase in literacy rate in India. At the State level, among major States, at the one end, in Kerala it was very low in 2001 (9.08) as well as in 1991 (10.20). At
the other end, in Bihar it was very high in 2001 (52.47) as well as in 1991 (61.50). Uttar Pradesh (58.40 in 2001 and 42.64 in 1991), Rajasthan (61.40 in 1991 and 38.97 in 2001), Andhra Pradesh (55.90 in 1991 and 38.89 in 2001) and Orissa (50.90 in 1991 and 36.69 in 2001) had very high illiterates. Punjab (41.50 in 1991 and 30.03 in 2001), Gujrat (38.70 in 1991 and 30.03 in 2001), Tamil Nadu (37.30 in 1991 and 26.53 in 2001), Maharastra (35.10 in 1991 and 22.73 in 2001) and Kerala (10.20 in 1991 and 9.08 in 2001) had least illiterates.

1.25. CONSUMPTION EXPENDITURE

Consumption has been used to measure purchasing power of people. It is widely used to define poverty line. Consumption expenditure is a proxy for measuring the income and the well being status of individual/family.

There is a close relationship between consumption expenditure and decent standard of living. If one can spend more on consumption, his standard of living is a better. Like that, the relationship between the consumption expenditure and poverty is also crucial. Poor people cannot spend more. Their consumption expenditure is very minimal. This is because of low income.
"The usual indicator for identifying the poor is either income or expenditure. Most extensively using indicator is expenditure because, it fluctuates less and is more reliability reported. Consumption is conventionally viewed as the preferred welfare indicator, for practical reasons of reliability and because consumption is thought to better captures long sum welfare levels than current income" (WDR 2000/01).

It is important to identify the poor, who are unable to consume goods which are the basic needs. Consumption expenditure is one of the methods to identify the poor. Consumption data provide information on how much people spend for food, housing, heath care, education and other assets.

In India, per capita consumption expenditure was Rs.125.13 per month in 1983, and it has been marginally improved to Rs.590.98 per month in 1999-2000. This shows the reason for the marginal reduction in poverty in India.

Since poverty line refers to a benchmark level of consumption, a person whose consumption is below this benchmark level could not enjoy a decent standard of living and is thereby defined as poor. In this sense, poverty means either lack of command over commodities in general or a specific type of consumption which are essential to constitute a
reasonable standard of living in a society or lack of “ability” to function in a society.

Using monetary income or consumption to identify and measure poverty has a long tradition. Poverty line is constructed mostly either on the basic of “calorie intake” or the minimum consumption expenditure needed to live a decent standard of life. Hence, consumption expenditure study has a unique place in the poverty analysis.

1.26. INCOME APPROACH AND CONSUMPTION EXPENDITURE

"Poverty measurement has been dominated by the so-called income approach. From a conceptual perspective, the “money metric” is more appropriate since some of the so-called income indicators can, in fact, be based on the expenditure or consumption data. This approach to poverty measurement assures that individuals and household are poor if their income or consumption falls below a certain threshold usually defined as a minimum, socially acceptable level of well-being by a population group. Well-being is a broader concept than economic welfare. There are a number of conceptual approaches to measure the well-being. The most common approach is to measure economic welfare based on household consumption expenditure or household income, which is then assigned
each resident in the household a share of the total amount. This is a per capita measure of consumption expenditure or income.

United Nations Organization defines household consumption expenditure as expenditure incurred by resident households on consumption goods or requires excluding expenditure on fixed assets in the form of dwellings or on valuables. When dwellings are occupied by owners, the imputed value of the housing services enters into both the output and final consumption expenditure of the owners. Wikipedia dictionary defines household final consumption expenditure is a price index which represents consumer spending. It consists of the expenditure including imputed expenditure incurred by resident household on individual consumption goods and services including those sold at prices that are not economically significant.

The usual indicator for identifying the poor is either income or expenditure. Now a day most extensively used indicators is expenditure, because it fluctuates less and is more reliably reported “Economists generally prefer expenditure to income as income tend to fluctuates over the course of a year particularly so in developing countries where income is dependent on the agricultural season. The permanent income hypothesis first proposed by Friedman, supports the view that consumption expenditure is a better proxy and permanent income, since
people tend to smooth out their fluctuation in income, and this is reflected in their expenditure for example, if a person receives a bonus, they do not necessarily spend it, they may same part of it. Similarly, if income falls in a particular year a person may use savings to make up for the temporary short-fall” (Renata lok-Dessallien 1999).

It is important to identify how many people are unable to consume goods which are the basic needs. Consumption expenditure is one of the method to identify the poor spend how much for food, housing, health care, education and other basic needs. Consumption is conventionally viewed as the preferred welfare indicators for practical reasons of reliability and because consumption is thought to better capture long run welfare levels than current income” (WDR 2000/2001).

Consumption expenditure is the better indicator of poverty measurement than income because of the following reasons.

1. Consumption is more closely related to a person’s well-being than the income.
2. In poor agrarian economics, incomes for rural households may fluctuate during the year, according to the harvest cycle. In Urban economies with large informed sectors, income flows also may be erratic.

Quantifying the welfare of individuals or households is notoriously difficult. In theory, the best indicator of welfare is the actual consumption
of the individuals, and ideally this consumption would include both consumption of food and other goods as well as consumption of services such as education and health. In practice, income and expenditure date are commonly used to proxy for the level of consumption enjoyed. They are normally easier to measure directly and have the advantage of providing a monetary definition of poverty. Such a definition is readily understood by the wider public.

In simple term consumption refers to combination and use of goods and services to produce satisfaction for the consumer. Expenditure incurred for using these kinds of goods and services is called as consumption expenditure. It includes expenditure on food, cloth, housing, education, and health, social and religious and other miscellaneous expenditure. In many ways consumption expenditure indicator is a better one because it suffers least shocks from seasonal variations of income of an individual/family. "In this way, consumption is thought to provide a better picture of a household’s longer run standard of living than a measure of current income. Further calculating consumption expenditure is often easier than calculating household incomes, particularly for the poor. While poor households are probably purchasing and consuming only a relatively narrow range of goods and services, their total income may derive from a myriad of different activities with strong seasonal
variation and with associated costs that are not always easily assigned. Getting an accurate net income figure for such households can be frustratingly difficult” (Jesko Hentschel & Peter Lanjow 1996).

1.27. DETERMINANTS OF CONSUMPTION EXPENDITURE

There are only three main contributors playing major role in determining the consumption expenditure, they are, income, assets and loans. Income is the prime determinant of consumption expenditure, if it fell short of the needy level, availability of loans and assets determine the consumption. Psychological factors and marketing factors also play roles in that determination but they come after these three important factors.

1.28. CONSUMPTION EXPENDITURE IN INDIA

In India, National Sample Survey Organisation is being carried out sample surveys throughout country regularly and finds the consumption expenditure of the people in Rupees. The data is being collected by the survey experimental questionnaire with three different reporting periods, 7-days recall method, 30-days recall method, and 365- days recall method, which are applied to different classes of goods. The data collected referred to more than 300 items comprising cereals, vegetables, fruits, pulses, milk and milk products, edible oil, meat, egg and fish, sugar, salt, spices, beverages, pan, tobacco, and intoxicants in a very
detailed manner. Data on clothing, fuel and light, footwear, medical expenses, education, entertainment, goods for personal care, sundry articles, durable goods, conveyance, and other miscellaneous goods and services is also collected.


Poverty ratios estimated with the use of poverty lines based on the NSSO data on household consumer expenditures and its distribution across households is provided by the NSSO consumption expenditure surveys. Consumer Expenditure data has been used for the analysis of levels of living and estimating the poverty estimates. Initially the poverty line was defined on the basis of National Sample Survey (NSSO) Household Consumption Expenditure data for 1973-74 and it has been updated for price rise for the subsequent year.
The methodology used by the NSSO is being criticized by the experts severely regarding the selection of the sample items, sample size, sample period and the recall period selected by the NSSO and many experts viewed that more goods which are essential for life should be included in the survey analysis. But even those criticisms, in India, NSSO data are the primary contributor in determining poverty.

The Finance Minister, Govt of India in his 2005-06 budget speech said that besides, definition of below poverty line (BPL) families mainly with reference to the nutrition needs to be expanded to include access to drinking water, primary health care, elementary education and sewage and sanitation for better quality of life.
Table No: 1.7


<table>
<thead>
<tr>
<th>Sl.NO</th>
<th>States</th>
<th>1999-2000 (in Rupees)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Andhra Pradesh</td>
<td>550.53</td>
</tr>
<tr>
<td>2</td>
<td>Assam</td>
<td>473.42</td>
</tr>
<tr>
<td>3</td>
<td>Bihar</td>
<td>417.18</td>
</tr>
<tr>
<td>4</td>
<td>Gujrat</td>
<td>678.27</td>
</tr>
<tr>
<td>5</td>
<td>Haryana</td>
<td>767.89</td>
</tr>
<tr>
<td>6</td>
<td>Karnataka</td>
<td>638.81</td>
</tr>
<tr>
<td>7</td>
<td>Kerala</td>
<td>816.76</td>
</tr>
<tr>
<td>8</td>
<td>Madhya Pradesh</td>
<td>478.92</td>
</tr>
<tr>
<td>9</td>
<td>Maharastra</td>
<td>697.42</td>
</tr>
<tr>
<td>10</td>
<td>Orissa</td>
<td>413.71</td>
</tr>
<tr>
<td>11</td>
<td>Punjab</td>
<td>792.07</td>
</tr>
<tr>
<td>12</td>
<td>Rajasthan</td>
<td>611.19</td>
</tr>
<tr>
<td>13</td>
<td>Tamil Nadu</td>
<td>681.37</td>
</tr>
<tr>
<td>14</td>
<td>Uttar Pradesh</td>
<td>516.99</td>
</tr>
<tr>
<td>15</td>
<td>West Bengal</td>
<td>571.99</td>
</tr>
<tr>
<td></td>
<td><strong>INDIA</strong></td>
<td><strong>590.98</strong></td>
</tr>
</tbody>
</table>


During 1999-2000, Kerala was the first State which’s per capita consumption expenditure was Rs.816.76, which was more than other States of India. Punjab followed that and stood at the second place in the per capita consumption expenditure i.e. Rs. 792.07. Haryana, Maharastra and Tamil Nadu stood at 3\(^{rd}\), 4\(^{th}\) and 5\(^{th}\) position respectively with Rs. 767.89, Rs. 697.42 and Rs. 681.37 per capita consumption expenditure each. Orissa’s per capita expenditure was lowest in India i.e. Rs. 413.71 and Bihar was the second State which’s per capita expenditure was Rs.417.18. Followed them, Assam and Madhya Pradesh were at 3\(^{rd}\) and
4th place respectively with per capita consumption expenditure of Rs.473.42 and Rs.478.92. These States are lagging in developmental aspects and their socio-economic development also very low among the Indian States.

1.29. HUMAN DEVELOPMENT

Economic growth is a means of development and not its ultimate goal. Increased income contributes largely if it improves people's lives. But income growth is not an end by itself. Development should be people-centered and economic growth must be equitable for its benefits to have an impact on people's lives. UNDP defines Human development as "about much more than the rise or fall of national incomes. It is about creating an environment in which people can develop their full potential and lead productive, creative lives in accord with their needs and interests. People are the real wealth of nations. Development is thus about expanding the choices people have to lead lives that they value. And it is thus about much more than economic growth, which is only a means.

Human development is a process of enlarging people's choices. The most critical ones are to lead a long and healthy life, to be educated and to enjoy a decent standard of living (UNDP HDR 1990). Human development concept emphasis the importance of choices and human capabilities. It brings together the production and distribution of
commodities and the expansion and use of human capabilities.

Human development is a concept consisting education and knowledge, health and longevity, material well being and the disposable income. There is, today, a broad-based consensus to view human development in terms of, at least, and three critical dimensions of well-being. These are related to longevity the ability to live long and healthy life, education-the ability to read, write and acquire knowledge, and command over resources -the ability to enjoy a decent standard of living and have a socially meaningful life” (GoI NHDR 2001).

Human development analysis focuses three essential elements of human life-longevity, knowledge and decent living standards. Human development index measures a country's achievement in these three elements. Longevity is measured by life expectancy at birth, knowledge is measured by a combination of the adult literacy rate with two – third and the combined gross primary, secondary and tertiary enrolment ratio and standard of living, as measured by GDP per capita (PPP us $). In the National Human Development Report 2001 of India, Inflation and inequality adjusted per capita consumption expenditure, literacy rate for the age group of 7 years and adjusted intensity of formal education and life expectancy at age one and infant mortality rate indicators have been used to construct the Human Development Index. According to that
report HDI value for India was 0.302 in 1981, 0.381 in 1991 and 0.472 in 2001.

1.30. HUMAN DEPRIVATION

The poor are defined as those who lack command over basic consumption needs, including food and non-food components, such as health, education, shelter, etc. According to the World Bank "Poverty is pronounced deprivation in well-being", where well-being can be measured by an individual's possessions of income, health, nutrition, education, assets, housing, and certain rights in a society such as freedom of speech" (WDR 2000/2001).

Poverty is multidimensional in nature. Poverty is associated not only with insufficient income or consumption but also with insufficient outcomes with respect to health, nutrition, and literacy and deficient social relations, insecurity, and low self-esteem and powerlessness. In some cases it is feasible to apply the tools that have been developed for monetary poverty measurement to nonmonetary indicators for well-being. Applying the tools of poverty measurement to nonmonetary indicator for a "given individual or household to a threshold or "poverty line" under which it can be said that the individual or household is not able to meet basic needs" (PRSP Source Book 2002).

Since poverty is a multidimensional phenomenon, measurement of
poverty must cover many dimensions. So far, the income and/or consumption indicator has received most attention. But, now the focus is shifted towards deprivation in different dimensions for example income, health and education. Poverty is often defined in terms of income. But to describe its multi dimension, different sets of indicators are required. They may include poverty line, unemployment, life expectancy, morality and morbidity, literacy level, availability and access to health services, water and sanitation.

The present study proposes a composite index i.e., human deprivation in income, health and educational aspects. There are lots of indicators available for measuring human deprivation, but among these, very prominent and effective indicators have been taken for the construction of human deprivation index. Human deprivation index includes three equally - weighted indicators, they are poverty line, infant mortality rate, and illiteracy.

In this study, human deprivation index has been constructed for Indian States. After constructing the index, the States are ranked according to their derivational index point. According to the rank, the number one state is first in deprivation and least in human development.

Human deprivation Index = 1/3 (Poverty Line) + 1/3 (Infant Mortality...
India is rapidly growing country. In 2003, India’s population was 1064.4 billion and the population growth rate was 1.6. The percentage of population living below poverty was 29%, the life expectancy at birth was 63 years, infant mortality was 65, and illiteracy for 15 + age was 39. And the GDP was 600.6 US $ billions.