CHAPTER II

REVIEW OF LITERATURE
CHAPTER II

REVIEW OF LITERATURE

There have been numerous studies on poverty, health, education, per capita expenditure, human development and human deprivation. These researches are essential for the analysis of poverty and its various aspects and effects on life. This section illustrates some review of them. This literature review section is divided into two sections, the first looks at the international studies on poverty, health, education, consumption expenditure, human development and human deprivation and the second section particularly deals with India.

2.1: INTERNATIONAL STUDIES ON POVERTY, HEALTH, EDUCATION, CONSUMPTION EXPENDITURE, HUMAN DEVELOPMENT AND HUMAN DEPRIVATION

Masood Ahmad (1993) from his study observed that parent’s education, sound economic status, and their personal involvement with the education of their children significantly influences the academic achievement of their children.

Nasim Shah Shirazi (1994) study finds that majority of the heads of the poor households are illiterate. The percentage of female head of the poor households is as high as 90 per cent, while this proportion is 70 per cent
in case of male heads. The proportion of poor household decreases as the educational level of the head of the households increases. The occupational classifications of the heads of the poor households shows that the majority of the (male) heads of the poor households are found in the occupational category of ‘agricultural, animal husbandry and forestry’, followed by production and related workers, transport equipment operators and labourers categories.

Enrica Chiappero Martinetti (2000) says that the basic assumption of any multidimensional approach to well-being and poverty analysis is that there are relevant dimensions of well-being that the economic resources are not able to capture. Income and consumptions are only rough measures of the quality of life because they are not able to fully describe what people can really achieve with these resources, because they can hide string differences and inequalities among people and finally because the quality of life is something more than simply a given amount of resources. Health, longevity, knowledge and education, social relations, subjective feelings are constitutive elements of human life that should not be ignored if we are interested in assessing of the people’s standard of living.
Gustav Ranis & Frances Stewart (2000) indicated that for a given GNP, a more equal distribution of incomes received by households will lead to lower PIP, which is likely to result in better performance on HD, since poor households are more deficient in HD elements and are likely to spend more of their disposable income on items that contribute directly to improvement in HD, e.g. food, education and health. As we would expect, empirical evidence shows that expenditure on HD-related items is strongly affected by the rate of poverty reduction. For example, if poor households receive extra income, they increase their food expenditure and calorie consumption significantly.

Gustav Ranis et.al., (2000) observed that households' propensity to spend their after tax income on items which contribute most directly to the promotion of HD in poor countries, e.g., food, potable water, education and health, varies, depending on such factors as the level and distribution of income across households as well as on who controls the allocation of expenditure within households.

South Africa HDR (2000) found that there is a new understanding that the well-being of society depends not on the level of income but on the uses to which it is put. The experience of several countries shows that a high level of human development can be attained at relatively low levels of per capita income by means of well structured social expenditure, as in the
case of Botswana, Costa Rica, Malaysia, Sri Lanka and South Korea. At the other end of the spectrum, countries such as Brazil, Nigeria, Saudi Arabia and Namibia demonstrate that, even with a high level of per capita income or a rapidly growing economy, the discrepancy between economic and social performance can be vast.

Moez Doraid (2000) observed that countries differ in how well they translate income into human development—their “human development efficiency.” At each general level of income are countries that are on or close to the “human development efficiency frontier.” They convert income into capabilities more effectively than others do. Countries that constitute the “human development frontier” of efficiency include Canada, China, Costa Rica and Sri Lanka. These countries, together with others that lie very close to the frontier, such as Chile and Jamaica, have the highest efficiency. By comparison, Arab countries lie significantly below this frontier. They have not effectively translated wealth and income growth into human development.

Qamar Jehan (2000) noted that education is the root of all development, no matter which aspect is considered. Education is a critical measure of improved conditions of life. Good health is another requisite of human resource development. Continuing malnutrition is a constant threat to the health of millions living in the developing world. Only when people are
free from malnutrition and crippling diseases can they realize their full human potential.

David E. Bloom et.al., (2001) indicated that healthier workers are physically and mentally more energetic and robust. They are more productive and earn higher wages. They are also less likely to be absent from work because of illness (or illness in their family). Illness and disability reduce hourly wages substantially, with the effect especially strong in developing countries, where a higher proportion of the work force is engaged in manual labor than in industrial countries.

Erich Gundlach et.al, (2001) confirms that education seems to improve the income distribution and thus may allow the poor to benefit from growth to a greater extent. Accordingly, a focus of economic policies on education in order to reduce poverty and to speed up development appears to be justified. Their empirical findings indicate that improving the quality of education rather than merely expanding access to education should play a crucial role in development strategies.

Jennifer Cassar and Gordon Cordina (2001) indicated that the composition of household consumption is an important indicator of the state of development of an economy. Since households tend to satisfy
first and foremost their basic needs, a lower share of expenditure dedicated to necessities could indicate higher living standards.

Okojie Christiana E.E. (2002) finds that important determinants of household welfare in female-headed households were education, household size, rural residence and main occupation. Thus, the higher the education of the head, the greater household welfare and the lower the probability of the household being poor, while the larger the household size, the lower family welfare, the greater the likelihood of poverty.

Finn Trap et.al (2002) said that in economics, the analysis of absolute poverty has four basic steps. First the analyst chooses a welfare measures; this is usually household expenditure or income, adjusted for the size and/or composition of the household. Second, a poverty line is set at a level of welfare corresponding to some minimum acceptable standard of living. The poverty line acts as a threshold, with households falling below the poverty line considered poor and those above the poverty line considered non poor. Third, once the poor have been identified, poverty measures such as headcount ratio, poverty gap, and squared poverty gap are estimated. Fourth, poverty profiles can be constructed, showing how poverty varies over population subgroups (for example, across region), or
by characteristics of the household (for example, landowners and landless).

Gustav Ranis and Frances Stewart (2002) observed that economic growth is likely to advance human development as the resource base expands, while higher human development generates greater economic growth as healthier and more educated people contribute to improved economic performance.

Kristopher Jerome Kaase (2002) found that for most groups, the community family structure and/or the family poverty rate were significant or the only significant positive effects on equality in educational achievement.

Alia Ahmad (2003) found that the relationship between education and poverty is a circular one: the lack of secondary-level education may force poor households to engage in low-productivity activities, and results in poverty. On the other hand, poverty leads to low investment in education.

Christopher Barrett & Brent M. Swallow (2003) observed that primary education is positively correlated with income in all countries except those in which average primary education is very low (e.g., Mozambique and Ethiopia).
Faye. J. Wilson (2003) study finds that crime, unemployment, teenage pregnancy and illiteracy do have a profound impact on the depravity of a community's overall health and well being.

Imran Sharif Chaudhry (2003) from his analysis concluded that rural poverty is strongly correlated to the absence of basic human and physical assets such as education and landholding, participation rates and household size. The households have large size of members and as a result, they have higher dependency ratio.

Nick Bailey, et al., (2003) in their interim report indicated that in many accounts of deprivation are very explicit about the relationship between poverty and (multiple) deprivation. They argued that the relationship between poverty and deprivation is so strong that it is possible to identify those living in deprivation either through direct measures of standards of living (deprivation measures) or through indirect measures of incomes or resources (poverty measures).

Nick Bailey, et al., (2003) in their final report said that deprivation is a multi-dimensional concept, concerned not merely with material goods but also with the ability to participate in social life. It is a relative concept where standards are defined in relation to social norms or expectations. Poverty and deprivation are seen as interlinked as cause and outcome.
Both financial resources and outcomes should be captured in measures of multiple deprivation.

Neil MacGillivray (2003) suggested that the impact of nutritional deficiency on a population’s susceptibility to infections disease cannot easily be separated from the effects of social deprivation.

UNDP (2003) says that poverty a complex and multidimensional concept, poverty is no longer though of exclusively as having a material component expressed in monetary value. Instead, it also consists of non-material components such as social indicators, environmental and gender issues, accountability and vulnerability. All such facets are inextricably linked to one another. Poverty is a deprivation of not only essential assets but also denial of opportunities to which every human being is entitled so as to attain a minimal standard of well-being.

ADB (2004) defines poverty is the deprivation of essential goods, services, and opportunities to which every human being is entitled. Underlying this deprivation is lack of income and the inability to take advantage of opportunities for advancement. Poor people in general lack daily sustenance, suffer from poor health and inadequate education, and do not have the ability to participate meaningfully in making decisions that affect their lives. Poverty is thus measured in terms of food and
nutrition, basic education, health care, water and sanitation, political participation, and income and wages.

Andrew Sumner (2004) indicated that the comparative advantage of measuring well-being in non-economic terms is non-economic measures of well-being are more useful than economic measures when a medium or longer run assessment is required, because they address more directly the ends or outcomes of policy (being educated and healthy) rather than the inputs or means (greater income).

Faika A. K. Zanjani (2004) found that health status affect health behaviour change and significantly affects change in food consumption, food preparation, and medical care.

Mark McGillivray & Farhad Noorbakhsh (2004) argued that one way of addressing this issue is to retain a universal set of components, chosen on the basis of universal elementary capabilities, but with variables on which these components are based and their weights varying across countries. Thus the variables and weights may well vary across countries and over time. Theory tells us that well-being components or dimensions will assume different priorities in different countries, depending on their levels of achieved wellbeing, different cultural priorities and so on.
Subramaniam Chandrasekhar (2004) observed that while financial factors like cost of education and the economic status of the household play an important role in schooling decisions made in scheduled caste households, human capital as measured by the presence of literate household head is the single most important factor for scheduled tribe households.

WHO (2004) observed that there is now a firm recognition that human capital development – including improved health outcomes – is central to poverty reduction and economic growth. Moreover, better health is important to the achievement of other human capital objectives (e.g. improved health is crucial to primary education goals).

Erik Angner (2005) claims that subjective measures of well-being cannot be shown to be inferior to economic measures quite as easily as some have suggested, but that they nevertheless are associated with serious problems, and that questions about the relative advantage of subjective and economic measures for purposes of public policy will depend on some fundamentally philosophical judgments, e.g. about the nature of well-being and the legitimate goals for public policy.

Erik Thorbecke, (2005) observed that clearly in addition to income, such tangible basic needs as nutrition, health, education, shelter, clothing and
access to information would be high on the list of crucial attributes used to judge whether a person was or was not poor. There are other possible dimensions of poverty that are not as clear-cut and for which a minimum threshold is almost impossible to determine such as different kinds of freedoms (of oppression, of religion, of expression), security, and the degree of discrimination and social exclusion below which an individual is thought to be deprived.

James Heintz (2005) indicated that an income poverty measurement was used because of the report's focus on income-generating employment. However, this measurement might not provide the most accurate assessment of deprivation of basic needs within households. This is because, in living standards surveys, households tend to underreport total income from all sources. Therefore, expenditures on consumption, not income, often provide a more accurate assessment of household-level living standards. If the goal of a study is to provide an accurate picture of how many families fall below a basic needs threshold of consumption, then a consumption poverty measurement, not an income poverty measurement, would be most appropriate.

Jesus Perez-Mayo (2005) found that expenditure is also proposed as an indirect indicator of the standard of living because of the lower underestimation and, furthermore, the distortions derived from the current
feature of the income. This last advantage is related to the consumption theory. According to the classical consumption theory, current expenditure is a better approximation of the permanent income than current income.

Kevin M. Murphy & Robert H. Topel (2005) analysed and found that of the values of health improvements is founded on individuals’ maximization of lifetime expected utility. They distinguished two types of health improvements – those that extend life by reducing mortality and those that raise the quality of life. Life extension is valued because utility from goods and leisure accrues over a longer period, and improvements in the quality of life raise utility from given amounts of goods and leisure.

Tesfayi Gebreselassie (2005) study reveals that child age, child illness, parental education, household income, distance to primary school and population density are strong predictors of child nutritional status in Ethiopia and income is a strong and significant determinant of child height – for – age, immunization and treatment seeking behaviour of households in Ethiopia.

Chronic Poverty Report (2004–05) observed that the UK People who are chronically poor are likely to be multi-dimensionally deprived; they experience income and/or health and/or education deprivations at the
same time. It is the combination of capability deprivation, low levels of material assets, and social or political marginality that keeps people poor over long periods.

Whelan, Christopher, & T., Maitre, Bertrand (2005) indicated that even where we are in a position to observe both income poverty and life-style deprivation over a reasonable period of time the evidence points to the conclusion that, while there is a substantial correlation between these dimensions, they are to a significant extent tapping different phenomena. Thus, if poverty continues to be defined in terms of “exclusion from a minimally acceptable standard of living through a lack of resources” it is necessary to conclude that even longitudinal measures of income poverty cannot be taken on their own as providing valid measures of the underlying construct and it remains necessary to take into account direct measures of deprivation.

Aloysius Ajab (2006) study found that there have been various conceptual approaches to poverty and the measuring of poverty – ranging from income through basic needs, human development, and human capabilities to a combination of some of them with factors relating to the type of environment good for the reduction of poverty. Countries, like the East Asian countries, that have performed well have used international trade, competition and market mechanism to promote their development.
Angus Deaton (2006) noted that income and health are not the only components of wellbeing that are positively correlated across countries. Education, political and civil rights, and democracy are other components of freedom which, with many exceptions, are positively correlated with income and longevity. People in poor countries live shorter lives than people in rich countries so that, if we scale income by some index of health, there is more inequality in the world than if we consider income alone. Such international inequalities in life expectancy decreased for many years after 1945, and the strong correlation between income and life-expectancy might lead us to hope that economic growth will improve people's health as well as their material living conditions.

Christopher Kuonqui (2006) analysed that the basic characteristics of human development can be fleshed out from the opening paragraph of Amartya Sen's seminal Development as Freedom. Development, he argues, should be seen as a process of expanding the real freedoms people enjoy rather than the narrow focus of other views identifying development with economic growth or social modernization. These other factors such as GNP and personal incomes are crucial means to expanding freedoms but not the only ones. Factors such as education, health and political and civil rights give form to the substance of human freedom.
Daron Acemoglu & Simon Johnson (2006) study results indicate that the increase in life expectancy led to a significant increase in population; birth rates did not decline sufficiently to compensate for the increase in life expectancy. And they find a small initial positive effect of life expectancy on total GDP, and this effect grows somewhat over the next 40 years, but not enough to compensate for the increase in population.

The Global Hunger Index (2006) is based on three equally weighted indicators:

• the proportion of undernourished as a percentage of the population (reflecting the share of the population with insufficient dietary energy intake);

• the prevalence of underweight in children under the age of five (indicating the proportion of children suffering from weight loss and/or reduced growth);

• the under-five mortality rate (partially reflecting the fatal synergy between inadequate dietary intake and unhealthy environments).

UNDP HDR (2006) observed that there is no more powerful – or disturbing – indicator of capability deprivation than child mortality. For every child who dies, millions more will fall sick or miss school, trapped in a vicious cycle that links poor health in childhood to poverty in
adulthood. Child survival is one of the most sensitive indicators of human welfare, the comparative health of nations and the effectiveness of public policy.

Izete Pengo Bagolin and Flavio Comim (2006) conceived that the conceptual core of the (Capability Approach) CA is the idea that good life will be reached when human beings are free to choose and able to get what they have reasons to consider important to do or to be. In this sense, human development means human flourishing. Moreover, poverty means lack of basic freedoms to reach what is considered essential ‘doings’ or ‘beings’.

Mark McGillivary (2006) observed that the use of non-monetary measures gathered momentum in the mid- to late 1970s a number of prominent international agencies compiled various sets of what have been described, rather loosely, as social indicators. Often interpreted as measures of basic human needs fulfillment, these indicators sought to capture achievements in such areas as health, education, the environment, culture, and politics. Specific indicators therefore include life expectancy, child mortality, access to health services, access to water, access to sanitation, infant mortality, calorie intake, literacy, years of schooling, and school enrolment ratios. While some of these indicators reflect the progress countries are making towards attaining fundamental well-being.
or developmental goals, others act primarily as intermediate indicators of progress.

Mozaffar Qizilbash, (2006) observed that the notion of human development has significantly altered and influenced the landscape of contemporary development thought. With its roots in the philosophical writings of Aristotle, Marx and Kant, the idea has led to a significant conceptual shift away from a focus on material progress in development thinking towards one on human beings, seen as ends in themselves and not merely as means.

Nora Lustig (2006) suggested that health as human capital affects growth directly through, for example, its impact on labour productivity and the economic burden of illness. It also has an indirect effect since child health affects the future income of people through the impact that health has on education such as enrollment, attendance and cognitive abilities. In Mexico, as in other countries, health as human capital is an important determinant of economic growth and poverty. Low health levels are linked to the so-called poverty traps. Health indicators and their progress in the past fifteen years are below what is expected in a country with its level of development and the specific goals set within the framework of the MDGs. They are also very unequal with poorer socioeconomic groups and municipalities showing health levels similar to those found in some
sub-Saharan African and South Asian countries. There is a clear imperative to focus on improving the health status of the population to unleash higher economic growth and lower poverty rates.

Pinar uyan Semeri (2006) said that Amartya Sen introduced us to the concept of “capability” within the specific context of evaluating inequality. Unlike the previous approaches for the measurement of development, mainly utilitarian and resource-based approaches; the capability approach, as Sen suggests, focuses on what people are actually able to do or to be. Sen draws our attention to the fact that people differ in their abilities to convert the resources onto capabilities, due to persona and social factors. The basic claim of the capability approach is to measure how well a person is by looking at what the person is succeeding in ‘doings’ and ‘beings’.

Rio Group, (2006) observed that an approach frequently used in many countries is based on the use of deprivation indicators. This method identifies poor units —mainly households— as those facing severe deprivation of basic human needs. Specifically, it considers as poor those units that do not meet the minima standards established for a set of deprivation indicators related to the satisfaction of basic needs. The indicators describe either result (such as caloric status) or the consumption of, or access to, certain goods and services that satisfy those
necessities. In contrast to monetary poverty lines, in which income or expenditure acts as the welfare indicator, this approach is considered to be multidimensional in that it employs different indicators to represent particular dimensions of welfare.

UN MDG Report (2006) indicated that educating all children presents a significant challenge due to the large number of children, who live in remote, rural areas of developing countries. High rates of poverty in rural areas limit educational opportunities because of demands for children’s labour, low levels of parental education and lack of access to good quality schooling. Based on household surveys in 80 developing countries, 30 per cent of rural children of primary-school age do not attend school, compared to 18 per cent in urban areas. And because rural areas have larger populations of children, they account for 82 per cent of children who are not in school in developing countries. Disparities in child deaths are pronounced both within and among countries. Survival rates for children of mothers with at least a secondary education are twice as high as those for children with less educated mothers. Similarly, children living in the wealthiest 20 per cent of households are twice as likely to survive as those in the poorest 20 per cent of households.
WHO (2006) observed that the concept of poverty lines allows comparisons between population groups and between countries. The poverty line is an income level that allows households to provide themselves with a minimum of goods and services, usually defined in terms of basic nutritional needs. Families with incomes below this threshold are more likely to suffer from chronic malnutrition, inferior housing and inability to send children to school. They also would be subject to the other disadvantages linked to low income.

WDR (2006) said that the large inequalities in health care use and health outcomes in many developing countries do not just reflect different preferences or needs—they arise from constraints on the ability of individuals to achieve good health. Income is one important constraint, especially given incomplete financial markets. Low-income people around the world have worse health and use fewer health services.

Angus Deaton (2007) founded that income poverty and health poverty are positively correlated, and those who suffer from material deprivations are also those who suffer from health deprivations. Those with high living standards generally live longer and better than those with low living standards.
Arthur MacEwan (2007) stated that a combination of relative and absolute consideration – income distribution (and wealth distribution) cannot be excluded from consideration. Just as absolute poverty is abhorrent in terms of basic human values and as an issue of social justice, so too is great inequality in the distribution of income – inequality as it exists in much of the world today.

David Clark & Mark McGillivray (2007) observed that more generally there has been increasing and now widespread recognition that income cannot adequately capture the breadth or complexity of human well-being. In consequence, since the 1970s policymakers and practitioners have increasingly relied on a broad range of social indicators covering health, education, employment, housing, the environment, and basic human rights. An early attempt to produce a multidimensional measure of well-being by combining three social indicators (infant mortality, adult literacy, and life expectancy) was the Physical Quality of Life Index (PQLI). The most successful and widely used composite measure, however, is the United Nations Human Development Index (HDI).

David E. Sahn & Stephen Younger (2007) explored that the extents to which countries in sub-Saharan Africa have been successful in alleviating poverty over the past couple of decades. Their analysis suggested that
Africa was poor compared to the rest of the world and that poverty was not declining consistently or significantly in most African countries. They arrived at this conclusion by considering not only deprivation in the material standard of living (i.e., income or expenditure poverty), but also other dimensions of well-being, especially education and health. In the case of the former, poverty should be understood as more than economic deprivation and includes such capabilities as good health, adequate nutrition, literacy, and political freedoms.

Elizabeth Anne Stanton (2007) found that HDI has played two key roles in the field of applied development economics: 1) as a tool to popularize human development as a new understanding of well-being, and 2) as an alternative to GDP per capita as a way to measure levels of development for comparison across both countries and time. The importance of these dual roles cannot be over emphasized. HDI, as reported in the HDRs along with its companion indicators, makes it possible for policy-makers and development professionals world-wide to gauge both moments and trends in the progress of human development and to tailor public action to suit current and future social and economic conditions.

Felistus Kinuna Kinyanjui (2007) observed that poverty is closely tied to the incidence of ill health in Thika. A myriad of preventable diseases are
endemic to Thika making it an epidemiological zone. Owing to lack of proper sanitation and drinking water the residents of Thika are perennially exposed to waterborne diseases today as they were early in the 20th century.

Frédéric Gonand (2007) argued that, in most cases, efficiency gains will have larger effects on GDP in the long run if they are used to increase educational outputs rather than to reduce inputs. A 10% increase on educational output from 2005 onwards -- roughly equivalent to increasing the average number of schooling years by 1 year at unchanged inputs -- raises GDP by, on average, 3% to 6% in the long run. Using efficiency gains to transfer resources to the business sector has an impact of less than 1% on GDP. However, some trade-off can appear in the short run because input-decreasing efficiency gains materialize more rapidly on growth than improvements in output-increasing efficiency.

UNDP (2007) indicated that the capability approach, a conceptual framework developed by Amartya Sen, emphasizes human achievements and freedoms. It challenges the common view that poverty is purely a deprivation of income, and underscores that human beings are both agents and beneficiaries of development, without downplaying their role as the primary means of economic productivity. The capability approach
evaluates the various "functionings" in human life (what people want to do and what they aspire to be) and their capabilities to achieve these "functionings". These include but are not limited to the ability to be well-nourished, escape avoidable death, be knowledgeable and be equipped to participate in the life of one's community.

Ranjan Shrestha (2007) study implied that the introduction of family planning programs during the early stages of economic development contributed to the improvements in child survival rates in these societies.

2.2: STUDIES ON POVERTY, HEALTH, EDUCATION, CONSUMPTION EXPENDITURE, HUMAN DEVELOPMENT AND HUMAN DEPRIVATION IN INDIA

Indrani Chakraborty (1997) found that while analyzing the data for 88 developing countries we note that per capita income has positive significant effect on the life expectancy at birth. However, her study had not observed any relationship between the improvement in life-expectancy and change in income as well as the level of income, unlike some earlier studies.

Pradeep Kumar Panda (1997) suggested that the evidence of lower welfare outcomes of children in female-headed households is consistent with the findings that (i) female-headed households are burdened by tighter income and time constraints, (ii) that their children are
disadvantaged in terms of access to social services and finally, (iii) that
female-headship and poverty are strongly linked regardless of the welfare
measure used, and the poverty measure used.

Arvind Pandey (2003) indicated that infant mortality declined 23 percent
in India between 1981 and 1990, and child mortality declined 34 percent
during the same period. Nevertheless, mortality rates are still high.
Among children born during the 12 years before the survey, 88 out of
1,000 are estimated to die during the first year of life, and 121 are
estimated to die before reaching age five. In recent years, infant and child
mortality have declined in every state. These declines have been
consistently largest for child mortality and smallest for neonatal
mortality. Apart from these consistent trends, however, there are
substantial variations among individual states. For example, infant
mortality is less than 40 per 1,000 in Kerala and Goa but more than 120
per 1,000 in Orissa and Uttar Pradesh. Among socioeconomic
background characteristics, urban/rural residence, mother’s exposure to
mass media, and use of clean cooking fuel are found to have substantial
unadjusted effects on infant and child mortality, but these effects are
much smaller when the effects of other socioeconomic variables and
basic demographic factors are controlled. Mother’s literacy, access to a
flush or pit toilet, household head’s religion and caste/tribe membership,
and economic level of the household (indicated by ownership of consumer goods) have substantial and often statistically significant adjusted effects on infant and child mortality. Both unadjusted and adjusted effects of most of these background characteristics are largest for child mortality and smallest for neonatal mortality.

Kannan.K.P (1999) identified that Kerala's health transition has been made possible by the spread of education among all sections of its population. Women played a significant role in this transition because the care of the child and of the pregnant mother required awareness among women in the family. When the life expectancy as well as child survival rates improved, it became feasible to limit the size of the family. The spread of immunisation of children, the popularity of medical personnel attending childbirth, and better nourishment of children, among other factors, are related to the spread of education among women. The remarkable progress made by women in catching up with men in the matter of literacy and schooling and the complete enrolment of children should be viewed as factors facilitating the improvement in the health status of the population at large.

Mariam Claeson et.al., (1999) observed that non-income factors play an even more significant role than income in lowering the IMR. The Effect of technological progress (including access to preventive and curative
health services) on lowering IMR was found to have been the strongest between 1985 and 1990. Technological change caused IMR to decline 20 percent between 1975 and 1990. However, public health expenditures did not have a significant influence on lowering the IMR. They noted that although the poorest states performed worst in terms of IMR and TFR, the richest states did not perform best. The best state performers in the country had relatively low per capita income levels, but achieved relatively good results for those levels. The percent difference between the expected IMR for a given level of income and time period and the actual IMR gives the “relative performance rate.” According to these estimates, Kerala, Tamil Nadu, and Karnataka are the best performers in the country and, significantly, Kerala and Karnataka are also among the poorest in economic terms. The worst performers are the poorest states: Uttar Pradesh and Orissa. However, Andra Pradesh, Punjab, Bihar, and Gujarat have higher-than-expected IMRs for their income levels. Notably, some of the weak performers are the relatively rich states of Haryana, Gujarat, and Maharashtra.

Aasha Kapur Mehta and Amita Shah (2001) indicated that several of the high income poverty states such as Uttar Pradesh, Madhya Pradesh, Bihar, Orissa, and Assam also have the worst record on multidimensionality indicators such as HDI, GDI, GEM and HPI. Data
pertaining to Infant Mortality Rates reinforces this further with extremely high state averages of infant mortality for Orissa and Madhya Pradesh as also for a large number of districts in Uttar Pradesh and Rajasthan. However, some states have managed to achieve more in reducing infant mortality than in reducing the incidence of poverty. High literacy seemed to play an important role in decreasing IMRs in most states.

Duraisamy.P (2001) study found that the household income emerged as a key determinant of the health status. As income increases, the chances of being ill and functional limitation due to illness (measured by number of bedridden days and days of work/normal activity being affected) reduce. Income may enable nutrition and better health care.

Jeemol Unni (2001) indicated that households whose major source of income came from salaried jobs had on average the highest average household incomes in all ethnic groups. They were the least likely to be below the poverty line and had the highest educational attainments among men and women. Agricultural households and households self-employed in non-agriculture were also more likely to be above poverty. Across ethnic groups, the Scheduled Castes, Tribes and Muslims were more likely to be poor. The Scheduled Caste households had the lowest average household incomes among salaried and self-employed households. Mean years of education were the highest in salaried households followed by
households self-employed in non-agriculture. Men and women in Christian households had the highest mean years of education with the least gender difference. Even among Christians, salaried and self-employed households in non-agriculture had the highest mean years of education. Mean years of schooling were the lowest among Scheduled Castes in salaried and self-employed households. Muslim men and women had higher mean years of schooling than the Scheduled Castes in salaried and self-employed households, but well below that of Christians and Hindus. Overall, educational investments were maximum in salaried and self-employed households in all ethnic groups. Among them, Christians and Hindu households invested the most in education.

GoI NHDR (2001) analysed and pointed out that at the State level, Chandigarh, Delhi, Kerala, Punjab and Himachal Pradesh were among the States with better HDI at both points of time. States like Bihar, Uttar Pradesh, Madhya Pradesh, Rajasthan and Orissa were at the other end. In fact, in the early eighties, these States had HDI close to half that of Kerala. In general, HDI was better for smaller States and Union Territories. The rural-urban gap in the HDI was the least in case of Kerala and the highest for Madhya Pradesh in the early nineties.

Amitabh Kundu et.al., (2002) observed that human development indices should attempt to evaluate the achievements of growth and development
in terms of improvement in quality of life of masses and overall development of society and environment. The indices can, therefore, be used to assess the level of success of development programs implemented by the national and state governments as well as those proposed by the multilateral and bilateral aid agencies and international civil society organisations.

Angus Deaton & Jean Dreze (2002) indicated that it is important to supplement the evidence reviewed so far, which essentially relates to purchasing power, with other indicators of well-being relating, for instance to educational achievements, life expectancy, nutritional levels, crime rates, and various aspects of social inequality. This broader perspective reveals that social progress in the nineties has followed very diverse patterns, ranging from accelerated progress in some fields to slowdown and even regression in other respects.

Jandhyala B. G. Tilak (2002) in his study found that among the determinants of household expenditures, household characteristics—particularly household income and the educational level of the head of the household—are found to be important. Other important determinants include demographic burden of the household (size of the household), caste and religion. Generally, gender is believed to be a very significant
determinant of household expenditures on education. This is not necessarily true in all cases. School related variables chosen—the incentives such as mid-day meals, uniforms, textbooks and stationery, etc., and the availability of school within the habitation—are also quite important. Coefficients of elasticity clearly show that government expenditures and household expenditures do not substitute each other, instead they complement each other. So if the government wishes to mobilise household finances for education, it is important that the government increases its own allocation to education considerably. Conversely, and more clearly, if government budgets on education are reduced, household expenditures may also decline resulting in severe under investment in education.

Human Development Report Maharashtra (2002) conceived that human Development is the combination of people’s entitlements and actual attainments in the crucial aspects of their lives: education, health and livelihoods. Taken together, these three elements form the everyday experience of—and even an unremitting struggle for—‘development’. It is true for all people as individuals and also members of a community, a State or the nation. It is, then, the sum of outcomes relating to schooling, health services and quality of life chances such as life expectancy and nutrition and importantly, income. This revolves critically around access
and the quality of services available. With respect to incomes, it is a question of a secure and adequate and above all, sustainable livelihood and the quality of consumer choices that flow from it. The share of elementary education in the total education outlay was as high as 56 per cent in the First Plan. This share steadily decreased, and in the Seventh Plan this sector was allotted only 34 per cent of the education budget. In the Eighth Plan, the allocation increased to 42 per cent. The share of expenditure going to higher education and technical education in the period between the Second Plan and the Fifth Plan was in the range of 34 per cent to 49 per cent. Although the share of higher education has dropped considerably, it still remains higher than 20 per cent.

Kulkarni P.M (2002) showed that the social groups in India differ considerably in educational achievement and economic conditions. The Scheduled Castes and Tribes fare poorly compared to non Scheduled Caste/Tribe Hindus. Muslims also do not do as well as non Scheduled Caste/Tribe Hindus. But there are notable regional variations in the disparities. In some states, notably Kerala, Gujarat, Himachal Pradesh, Andhra Pradesh and Tamil Nadu, the gap in literacy between Scheduled Castes and other Hindus has declined recently, either due to government efforts or otherwise. But in many states the gap has been very wide and continues as such even in current enrolment.
Sundaram.K and Suresh D. Tendulkar (2002) viewed that the experience of countries that succeeded in reducing poverty significantly indicates the importance of high rates of economic growth in achieving this. High growth, however, is not a sufficient condition for poverty reduction; the pattern and sources of growth as well as the manner in which its benefits are distributed are equally important from the point of view of achieving the goal of poverty reduction. And employment plays a key role in that context. Indeed, countries which attained high rates of employment growth alongside high rates of economic growth are also the ones who succeeded in reducing poverty significantly.

Suryanarayana M.H. (2002) claimed that it follows that the precise impact of a growth or redistribution strategy on poverty reduction depends upon the mean level of income itself i.e. at what stage of development the country is currently placed. While a growth strategy is uniformly poverty reducing, though the pace of reduction varies at different stages, a redistribution strategy can reduce poverty only when the size of the cake is large enough so that the poverty level is not acute. This finding makes a clear case for strategies for growth in the interest of the poor. However, the Indian Plan exercise did not recognise the limited scope for a redistributive exercise; instead it laid considerable emphasis on it.
Savitha Sharma (2004) observed that the progress in poverty reduction and improvement in the socioeconomic indicators in India has been marked by extreme regional inequalities. The performance in this regard varies widely across the states and evidences suggest a variation of equal if not greater intensity between the regions within particular states. Also, within a state, the performance level of the indicators of level of living and quality of life measured in terms of the indicators of poverty and deprivation and socio-economic indicators varies. There are some states that have performed well in reducing the incidence of poverty but not so well in improving the quality of life in terms of education and health. There is a north-south divide in the performance of poverty reduction. The four southern states, viz., Andhra Pradesh, Karnataka, Kerala, and Tamil Nadu have performed well whereas the performance is poor in some of the central (Uttar Pradesh, Madhya Pradesh) and eastern states (Bihar and Orissa). Unfortunately, in the current century more than 40 percent of the population of India will be residing in Uttar Pradesh, Madhya Pradesh, Bihar, and Orissa. The performance of these states both in respect to poverty alleviation and socioeconomic development needs to be decisively strengthened.

Subramanian.S (2004) claimed that are poverty and inequality assessed in the space solely of incomes sufficient to convey a picture of how well or...
badly a society is doing? Is an ‘adequate’ level of personal disposable income a sufficient guarantor of achievement in the dimensions of, say, literacy, nutrition, longevity and health? Inter- and intra-country comparisons do not invariably furnish an affirmative answer to these questions. Thus, for example, relatively income-poor countries like China or Ecuador or Costa Rica have relatively impressive records in dimensions of well-being such as literacy, life expectancy and health, while relatively income-rich countries like some of the Arab States display relatively poor performances in extra-income aspects of well-being. Similarly, the Indian state of Kerala is way ahead of a relatively (income-wise) richer state like Haryana when it comes to assessing well-being in dimensions such as fertility, expectation of life at birth, infant mortality, and literacy. These empirical findings suggest strongly the importance of going beyond the metric of income in assessing deprivation, disparity, and well-being.

Sudip Ranjan Basu (2004) explained many of the developing countries have registered an increase in economic growth (of per capita income growth), but failed to progress in terms of social indicators (literacy, infant mortality, etc). Thus the focus is now shifting towards a qualitative nature of this growth and development. According to Sen, the realisation
of human capabilities, which enlarge the range of human choices, is essential for a broader notion and measure of economic well-being.

Agarwal (2005) indicated that India's performance vis-à-vis human development has been mixed in the last decade. Health indicators, while recording improvements over time, point to alarmingly high rates of malnutrition and mortality, especially among women and children. Infant mortality is a good indicator at how well nations are doing in protecting their most vulnerable members. Both infant and child mortality have continued their declining trend, but remain at high levels in India. The country contributes 2.4 million of the global burden of 10.8 million under-five deaths. Nearly 26 million infants are born each year, of whom 1.2 million die before completion of the first four weeks of life and 1.7 million die before reaching the first birthday. The principal causes of infant deaths are neonatal disorders, pneumonia, diarrhoea, and measles. Low birth weight and undernutrition are the most important risk factors of child mortality.

Anup K. Karan and Ajay Mahal (2005) said that increases in the average income are also associated with declines in the poverty ratio, especially when the overall distribution of income does not simultaneously worsen too much. To the extent that commonly used measures of absolute poverty incorporate expenditure required to achieve the consumption of a
‘minimal basket of food items,’ or the purchase of food items required to achieve a ‘minimal level of energy defined in calories’, it is reasonable to argue that increases in the average income, taking account of disparities, will tend to be associated with improvements in the nutrition of the poorest.

Motkuri Venkatanarayana (2005) observed that the levels of schooling in India fall short of the Constitutional dictum of universalisation of elementary education, even after more than half a century of promise; where around one-fourth of the children in the age group 5-14 still remain out-of-school. Across states there exist wide variations in the level of educational deprivation of children. Kerala and Bihar represent the two extremes in the incidence of educational deprivation of children. Our analysis of deprivation levels across mutually exclusive social groups of children indicates that the difference in the levels of deprivation across social groups declined but their relative positions in the ladder are intact. Our decomposition method measuring change with respect to decline in the incidence of deprivation indicates that the reduction in group-inequality claims the major share of the change during the period.

GoI NSSO (2005) estimated that between 1972-1973 and 2004-2005, the share of food in total consumer expenditure has fallen from 73 to 55 per cent in rural areas and from 64 to 42 per cent in urban areas. The decline
in expenditure on food is mainly due to low cost of cereals (especially those provided to the poor under PDS) which are the major source of energy in Indian diets. The share of cereals has fallen from 41 per cent of consumer expenditure to 18 per cent in rural India and from 23 to 10 per cent in urban India.

Sen.P (2005) indicated that India was the first country in the world to define poverty as the total per capita expenditure of the lowest expenditure class, which consumed 2400 K cal /day in rural and 2100 Kcal/day in urban areas and attempted to provide comprehensive package of essential goods and services to people below the poverty line. Initially the poverty line was defined on the basis of National Sample Survey (NSS) Household Consumption Expenditure data for 1973-74.

Shri Deepak Mehra (2005) observed that reduction in poverty and inequality and improvements in the level of living has been the central objectives of Indian planning during the past half a century. The poverty estimates have not only been used for evaluating the development efforts, but in the view of the importance of poverty eradication as a social objective, have found use in the allocation of funds for poverty alleviation programmes among the states. The issue thus relates to the choice of variables that can stand as fair measures of prevalence of poverty. Income
is one of the measures of estimating poverty but in the low developing countries it has rarely been used to measure poverty because a large proportion of the population depend on agriculture for their livelihood and derive a major portion of income in kind. In most of the countries Consumer Expenditure data has been found to be more appropriate for analysis of levels of living and estimating the poverty estimates. Our country is also using Consumer expenditure data for estimating the poverty estimates. In the methodology used by Planning Commission for estimating the poverty line the base year poverty line of 1973-74 has been updated for price rise for the subsequent year

Amlan Majumder (2006) found that both the social factors have significant impact on level of nutrition. Women belonging to Muslim and other religious communities are likely to have better nutritional status than Hindu women. As compared to women belonging to the general caste category, women from the Scheduled Caste and Tribe communities (with Other Backward Class) are significantly less likely to fulfill nutritional requirements.

Bhanumurthy N..Rand Mitra.A (2006) observed that the incidence of poverty in rural India declined from 45.61 per cent in 1983 to 37.27 per cent in 1993/4. Between 1993/4 and 1999-2000, it declined by 10.18 percentage points, the extent of fall being larger than in the previous
period. This trend is similar even in urban India. The decline in poverty has been accompanied by an increase in the average per capita consumption expenditure, which rose by 18.3 and 11.3 per cent (in constant prices) over 1983 through 1993/4 and 1993/4 through 1999-2000 respectively.

Delhi Human Development Report (2006) reported that Delhi’s balance sheet of human development highlights many achievements and several shortcomings. Delhi is one of the richest Indian states in terms of per capita incomes. And only 8 per cent of its population lives below the poverty line. Women in particular have experienced an expansion in their job opportunities. The city-state can boast of excellent health and medical institutions. Conditions of health and schooling are better than in many other States. Despite the recent progress, Delhi displays many shortfalls in human development. These are, for instance, in the areas of provisioning of basic services and amenities to people, safety, gender discrimination, and access to good quality health care for the poor. Another striking feature of Delhi is the inequities in the patterns of development. Two such inequities that differentiate the more fortunate from the less are to be found in employment opportunities and in the living conditions enjoyed by people across Delhi. The chapter that follows discusses these inequities.
Gopal Kadekodi and Keerti Kulkarni (2006) observed that as a share of total private consumption expenditure, as well as that of total disposable income (not shown in this table), the private expenditure on health and medical care has been consistently decreasing (both at current prices and in constant prices). In constant prices, the share of private expenditure on health care out of the total private consumption expenditure was 3.03 percent in 1980-81, which slowly declined to 2.03 percent by 1996-97.

HDR Kerala (2006) observed that human development affects per capita income growth via population growth also. The demographic dividend arising out of demographic transition also extends to the supply of labour force, with a shift in the working age population. The huge bulge in the working age population in the second phase of age structural transition has the potential to act as an engine of growth. Moreover, fertility decline apart from raising per capita incomes also presents the possibility of better quality of children, with respect to education and health along with increase in female labour force participation. However, these cumulative effects get manifested only in the long run.

Mita Choudhury (2006) estimated that in a number of low income states of the country, the requirement of resources for providing even the minimum health services is much more than 2 to 3 percent of their GSDP.
In Bihar (including Jharkhand), Orissa, Rajasthan, and Assam the requirement is more than 3 percent of GSDP. In Madhya Pradesh (including Chhattisgarh) and Uttar Pradesh (including Uttaranchal), the requirement of resources is very close to 3 percent. Sixty percent of the total shortfall in expenditure requirements to provide basic services in the health sector in 15 major states has been found to be in the states of Bihar, Uttar Pradesh, and Madhya Pradesh, alone.

Sujata Singh et.al.,(2006) cautioned that the performance of health care services has remained far from satisfactory as indicated by the unacceptably high mortality and morbidity rates. The health related targets and goals outlined by the Millennium Development Goals (MDGs) and the Tenth Plan are unlikely to be achieved. Diseases like diarrhoea, pneumonia, TB, malaria and HIV/AIDS, which can be prevented, continue to take a heavy toll.

Sunila Claire (2006) found that higher expenditure on a child’s healthcare will curtail the couple’s present consumption but increase their future utility by enhancing their children’s chances of survival to adulthood. Given fertility, there is a point at which the discounted future income gain from improved survival chances is offset by the present cost of this extra health expenditure; this trade-off is the same for both parents since the mother’s utility function is just an attenuated version of the father’s.
India Post (2007) noted that once again, India’s ranking in the Human Development Index (HDI) has dropped. Last year, India ranked 126 amongst 177 countries. This year, the ranking has come down to 128, even behind Maldives. To be fair, however, India’s HDI value has grown marginally from 0.611 to 0.619. Yet its lower rating is due to the fact that other developing countries have fared better.

Ninam.T.N (2007) observed that the UNDP categorises 70 countries with an index higher than 0.8 as having high human development, and another 85 countries that score between 0.5 and 0.79 as having medium human development. India crossed 0.5 threshold in the late 1980’s, thus moving out of the low and into the medium developed category. China’s HDI level at the time was where India is today, showing a gap of nearly two decades between the two countries. China’s index now stands at 0.777 at rank 81, and it is probably the years away from moving into the high development category.

Parthapratim Pal and Jayati Ghosh (2007) pointed out that the discussion of health and education related indicators shows that though there has been some progress by India in these areas, this progress has been unsatisfactory, even when compared to other developing countries. Huge
inter-state disparities in health and education related indicators remain across the country.

Ramachandran (2007) indicated that at the time of independence majority of Indians were poor. In spite of spending over 80 per cent of their income on food, they could not get adequate food. Living in areas of poor environmental sanitation they had high morbidity due to infections; nutrition toll due to infections was high because of poor access to health care. As a result, majority of Indians especially children were undernourished. The country initiated programmes to improve economic growth, reduce poverty, and improve household food security and nutritional status of its citizens, especially women and children. India defined poverty on the basis of calorie requirement and focused its attention on providing subsidized food and essential services to people below poverty line.

Ravi Duggal (2007) suggested that poverty and health also have similar linkages. Health outcomes are a function of poverty but more importantly poverty levels are closely associated with public health investment, and hence again public financing of healthcare becomes critical even for poverty
Subha Mani (2007) found that nutritional status at a young age is positively associated with an individual’s total human capital accumulated. Higher levels of human capital are in turn strongly correlated with an individual’s economic and social well-being. Health is one such dimension of human capital and improvements in children’s nutritional status improve an individual’s overall lifetime well-being.

Sukhadeo Thorat (2007) observed that the individual indicators of attainment and composite indices attempt to capture human development from two perspectives - achievement and deprivational. The achievement perspective captures advances made by society as a whole and the deprivational perspective assesses the level of deprivation. This implies that in order to improve the performance of the disadvantaged groups on the human development front, it is imperative that measures are taken to increase ownership and access to income earning capital assets like agricultural land, capital for non agriculture economic business activities; increase employment, and ensure living wages; and also to promote education and skill development so as to increase employability.