RIGHT TO HEALTH AND EDUCATION

Status and Way Forward

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RIGHT TO HEALTH AND EDUCATION: STATUS AND WAY FORWARD

Abstract

This paper explores the overall status of the health and education sector in India, with focus on Maharashtra. The paper also discusses the Sustainable Development Goals and the importance of contextualizing it to achieve its vision of ***leaving no one behind****. The impact of COVID-19 pandemic on these sectors is also addressed in this paper. Finally, the paper concludes with a set of concrete recommendations for both the sectors to ensure the achievement of the SDGs.*

Introduction

Health and Education are intrinsic to a high quality and dignified life, and progress in these sectors indicate the development index of a country. Hence, prioritizing health and education and ensuring adequate investment in these sectors are crucial to the progress of the nation.

The 86th constitutional amendment made education a fundamental right in India and the RTE Act, enacted in 2009 made it a reality. This was a milestone leap towards universalization of school education in India. The RTE Act is the highest stage reached in the evolution of education policy in India (Rai 2020). The Act committed to several progressive reforms and mandated minimum infrastructure, requirement of teachers, age-appropriate learning, special training for out-of-school children, comprehensive and continuous evaluation (CCE) and banned corporal punishment in schools. The Act also mandated schools to be located within the neighbourhood of the child's habitation, in a radius of one kilometre for primary schools and three kms for upper primary schools (RTE Act 2009). It must be taken into account that the RTE Act has had a significant impact on the education of children:

- The enrolment rates at the primary level witnessed an increase to 135.41 million in 2010-11 from 133.41 million in 2009-10 (NUEPA 2011)
- After the RTE Act came into effect, the central government doubled public spending on education to Rs. 26,000 crores in 2013-14 from Rs. 12,825 crores in 2009-10.
- Approximately, 3.5 lakh schools were opened during the last decade.
- 99 per cent of the country's rural population got access to a primary school within one km radius (PIB 2016)

However, despite this progress, the Act has faced several hurdles in implementation. Poor implementation of the Act is evident from official figures: Data from Unified District Information System for Education (UDISE) for 2016-17 points out that only 12.7 per cent schools are complying with the provisions of the Act nationally. The Act had also laid down timelines for ensuring compliance with infrastructural norms (2013) and also for the training of teachers (2015). Both the deadlines have passed and the goal remains to be achieved. The allocation of resources on education has seen a steady decrease since the Union Budget of 2015-16 and at present, the expenditure on education remains low, with less than 3 percent of GDP being spent on education (ESI), as opposed to the national commitment of 6 per cent, laid down by the Kothari Commission back in 1966 and reaffirmed in the National Education Policy 2020. The low investment in education remains one of the key hurdles in the achievement of universal elementary education in India. The Union Budget of 2021-22 witnessed major budget cuts of nearly 20% against the previous year's allocation, in key flagship programme Samagra Shiksha Abhiyan.

Unlike education, the right to health is yet to be articulated as a fundamental right in the Constitution of India. However, the Constitution makes several references to public health and the role of the state to provide quality healthcare to its citizens (Sirohi 2020):

- Right to Health is part of the Directive Principles of State Policy in Part IV of the constitution
- Article 47 states that it is the duty of the State to raise the nutrition levels and standard of living of people and to improve public health.

The Supreme Court has also upheld the right to health in its judgements, *Bandhua Mukti Morcha v Union of India & Ors*, where right to health was equated with right to life under article 21 of the constitution and again in *State of Punjab & Ors v Mohinder Singh Chawla*, and in September 2019, the Report of the High Level Group on the Health Sector submitted to 15th Finance Commission of India recommended that right to health be made a fundamental right as it would strengthen people's access to quality public healthcare (Sirohi 2020).

Despite this, India ranks the lowest in its spending on public health by investing only 1.28 per cent of its GDP on public health. The Union Budget of 2014-15 witnessed a massive reduction of the health budget by 15 per cent (EPW engage, n.d). This has resulted in poor

healthcare facilities and increased out of pocket expenditure of citizens, severely affecting the most marginalised. While the Union Budget 2021-22 focused on undoing the impact of the COVID-19 pandemic and an increase of 137% was made to the budget, however, it again failed to increase allocations for major public health schemes.

However, there has been certain progress in the health sector:

- Reduction of maternal mortality rate by 77 %
- Improved immunisation coverage from 44 % in 2005-06 to 62% in 2015-16 (Panda 2020)

Unfortunately, in the health sector, the achievements are few and the challenges are plenty. The key challenges of the healthcare sector can be summarised as follows:

1. **Lack of access to health services**: Especially in rural India, health care services are very inferior. A paper in 2012 suggests that people from rural areas are more susceptible to diseases, malnourishment and premature death (Krishna 2018). The same is applicable even today. Primary Health Centres (PHCs) are lacking more than 30000 doctors and the shortage is up by 200 % over the last 12 years ("Doctors' Shortage", 2017).
2. **Poor infrastructure**: There is a huge dearth of adequate rooms, beds, medicines, ambulances and also basic utilities like water, electricity in public hospitals.
3. **Increased out of pocket infrastructure:** The private sector is the dominant player in the health sector in India and the citizens have to bear the cost of their health expenses. Estimates show that 70% of healthcare expenses are borne by individuals and as a result nearly 7% of the population is pushed below the poverty line every year (Rao 2018).

In this background, it is important to discuss the Sustainable Development Goals laid down by the United Nations and understand how we can improve the health and education sector to achieve these goals.

Sustainable Development Goals in India

The United Nations in 2015, under its Sustainable Development Goals (SDGs) has called for Zero Hunger (SDG 2), Good Health and Well-being (SDG 3) and free primary and secondary education for all (SDG 4). A total of 17 goals have been laid down through the SDGs to be achieved by the year 2030. The SDGs replaced the Millennium Development Goals (MDGs)

that was initiated in 2000 to fight against poverty at a global level. To an extent, the MDGs were successful in bringing people out of extreme poverty, reducing child mortality rate by more than half, reducing the number of out of school children and also in reducing HIV/ AIDs infections(UNDP, n.d). However, one key critique for MDGs has been that the success was not uniform across the globe. While some parts of the world successfully reduced poverty, others still had a long way to go, for example, South East Asia surpassed the goal by 16 per cent, whereas Sub Saharan Africa was 12.5 per cent away from reaching the goal. The MDGs were not successful in reducing maternal mortality rates, the percentage of out of school children increased from 30 per cent to 36 per cent between 1999 and 2012 (MDG Failures, n.d). Hence, it was felt that a more sustainable path needs to be adopted to end hunger, achieve gender equality, improve health services and ensure every child continues schooling beyond primary levels. With this vision, the United Nations adopted 17 interlinked goals known as the Sustainable Development Goals .

For the realization of these global goals, it becomes pertinent to adopt these at the national level and have relevant policies to support the targets set by these goals. At the same time, to achieve the vision of "leave no one behind", it is very important to also localize SGDs, in a way that local governments can help in the achievement of these goals, through a bottoms-up approach, to complement and support the implementation of the national policies. A participatory approach by engaging members of the community can help in the achievement of the SDGs (Machingura 2018).

In India, the NITI Aayog has been vested with the task of overseeing the implementation of the SDGs and they have come up with a 3-year Action Agenda (2017-2020) for recommending policy changes. The Ministry of Statistics and Programme Implementation (MoSPI) developed the National Monitoring Framework for SDGs, with a total of 306 national indicators, of which 42 are health indicators and there are 19 indicators for education (NCE 2019).

The three-year Action Agenda of NITI Aayog sets forth three major goals for education:

1. Focus on learning outcomes: The first action point towards improving school education is the focus on improving learning outcomes by moving from an input-oriented system to an output driven system. It completely underscores the relevance of inputs for achieving better learning outcomes. Trained and qualified teachers,

pupil-teacher ratio are key to improvement in learning outcomes and cannot be undermined in any way. In line with the NITI Aayog agenda, the National Education Policy (NEP) 2020 states

"the requirements for schools will be made less restrictive". "The focus will be to have less emphasis on inputs and greater emphasis on output" and "regulations on inputs will be limited to certain areas".

This argument completely negates the idea that inputs and outcomes are intertwined.

2. Tools for teachers and students for effective learning: Under this, the Action Agenda recommends technology-aided aids to improve learning efficacy of students. However, only 57% schools in India have access to electricity (NUEPA 2016). This focus on technology driven solutions was also witnessed during the COVID-19 pandemic and the period of school closures. But this dependence and focus on technology undermines the intrinsic value of education and leads the way for private players to enter the education sector.
3. Improved governance: The Action Agenda proposed exploring the role of private players and public-private partnerships (PPP), which implies that the government is unwilling to spend its resources to improve public education.

The recent policies on Education and Health reflect the NITI Aayog agenda and are discussed below.

Recent Policies in Education and Health:

The National Education Policy 2020 was approved by the Cabinet on 29th July 2020. While the policy reiterates that 6 per cent of GDP will be allocated for education, it fails to give a financial roadmap of achieving the same. The draft NEP 2019 that was released in 2019 had recommended the extension of the RTE Act 2009 to include children from 3-18 years. Presently, the Act covers children up to 14 years and hence this recommendation was viewed as a major milestone towards the achievement of universalisation of school education. However, the final policy document eliminates this recommendation (Rai 2020). The document emphasises digital learning, which will further exacerbate the existing segregation in society as only half of urban households and 14.9% of rural households have internet access (NSS 2017-18). The news of suicides of school-going children, unable to join online classes due to lack of smart-phones, in the states of Kerala, Madhya Pradesh, Assam, Maharashtra, Tamil Nadu and West Bengal, who couldn't face the pressure of online learning, have been doing rounds. The NEP endorses philanthropic schools and Public

Private Partnerships (PPP), which will lead to the entrenchment of private players in education. This will further commercialise education, exacerbating existing inequalities (RTE Forum 2019). This policy is also silent on the Common School System, which was first recommended by the Kothari Commission (1964-66) and reaffirmed in the National Education Policies in 1968 and 1986. One way to remove the discrimination in the school education system is to introduce a Common School System (CSS) in the country which ensures a uniform quality of education to all the children (RTE Forum 2019).

The National Health Policy (NHP) was released in the year 2017. It lays the road for universal access to healthcare services through greater investment, reforms, and expansion of primary healthcare which is free for every citizen. The objective of the NHP 2017 is to *"Improve health status through concerted policy action in all sectors and expand preventive, promotive, curative, palliative and rehabilitative services provided through the public health sector with focus on quality"*. The policy also talks about greater investment in health to 2.5 per of GDP in a time bound manner.

On the other hand, the policy paves the way for the involvement of private players in the healthcare system by reducing the role of the state (Bajpai 2018). It endorses the private sector's role in service delivery of secondary and tertiary care, for training and skill development as also in disaster management (Rai 2020).

Impact of COVID-19 on Health and Education

The recent COVID -19 pandemic and associated national lockdown has minimized the progress of all developmental activities in India. This is a health-related pandemic and it has severely impacted the progress of SDG-3, but SDGs being inter-linked, this has impacted both SDG 2 and SGD 4, as well.

The Global Health Security Index, which measures the preparedness of a country to tackle a pandemic, had ranked India at 57 in the year 2019 ("India's Health System", 2020). The low investment in the health sector could be one of the key reasons why the pandemic affected the country so brutally. Hospitals in India tried to grapple with the novel virus with less workforce and poor infrastructural readiness. The huge scarcity of PPE kits and the dearth of testing kits, caused many doctors and other frontline workers to get infected with the virus (Ghosh 2020). India also witnessed a disruption in healthcare services, as hospitals focused only on COVID-

19 care. Outpatient treatment for all non-communicable diseases (diabetes, heart disease, oncology etc.) declined, inpatient treatment for communicable diseases fell significantly as well. The most severely impacted were maternal health care services and child immunization (Rukmini 2020). The impact of this was most severe in the rural parts of India.

The lockdown resulted in schools and other educational institutions remaining closed for an extended period, affecting the lives of the marginalized. School closures for over eight months resulted in the loss of learning days for most children from marginalized backgrounds. The push for online education by the Ministry of Human Resource Development (now Ministry of Education), through its #BharatPadheOnline didn't take into cognizance the reality that only only 10.7% households have access to laptop (NSS 2014-15), computer. At the same time, almost 70 percent of the internet users in the country were noted to be men, compared to just 30 percent of female internet users(Statista 2020). The prolonged disruption in studies, will lead to children, especially girls to drop out of schools. Malala Fund estimates that 20 million more secondary school-aged girls may be out of school after the pandemic (Malala Fund, 2020). Another estimate by the Global Citizen states that nearly 10 million secondary school girls in India could drop out of school due to the pandemic, putting them at risk of early marriage, early pregnancy, poverty, trafficking and violence' (Rodriguez 2020). The closure of schools affects children in numerous ways: learning is interrupted; closure of school means no mid-day meal. For girls, it leads to increased household chores and sibling care responsibilities. Thus, children are put at risk of early marriages and child labour (RTE Forum 2021).

Status of Public Education and Health in the state of Maharashtra

Maharashtra, the third largest state of India, is located in the western sea coastline of India. The overall literacy rate of the state is higher than the national average at 82.3% (Census 2011). Maharashtra also ranks third in the Health Index of 2017-18 (Economic Survey 2019).

The state has the biggest economy and has the highest contribution to the country's GDP at 15% (Stanley 2018). The financial capital of India, Mumbai, is also located in Maharashtra. Despite this, Maharashtra ranks 9th among the states in the SDG India Index 2019 and is listed under "performer" states. Though the index score of Maharashtra is 64, which is better than the national average of 60.

Though the index score remained the same for two consecutive years of 2018 and 2019, the score for SDG 3 improved from 60 to 76 in the same period. Presently, NITI Aayog is working on only select indicators for achieving SDGs. The Global Target (3.1) seeks to reduce the global maternal mortality ratio to less than 70 per 100,000 live births by 2030. The selected indicators for this were maternal mortality ratio, for which the national target value was set at 70. Maharashtra has been successful in achieving this already at 55. However, Maharashtra is lagging behind in the second proportion of institutional deliveries. The national target is 100 and Maharashtra is presently at 66.5. However, since these are aggregate figures at the state level, one needs to also look into the data at the district level to find out which states are lagging behind.

In Maharashtra, health financing is very low, only 0.5% of GDP and Maharashtra's per-capita health expenditure in 2019-20 was Rs. 1266/-. The state also witnesses high malnourishment, surge in leprosy cases, deaths resulting from swine flu, all of which could be tackled by investing more in public healthcare. This is also acting as a major barrier to the achievement of SDG 2 and 3 that aims to remove malnourishment and provide access to universal healthcare. Low investment in health and multiple positions lying vacant are some of the key reasons why the State was so severely impacted by the COVID-19 pandemic.

During the COVID-19 pandemic, Maharashtra, one of the most severely affected states in India, struggled to make ends meet owing to the multiple vacancies in the health workforce of the state, 66% crucial public health posts and 41% positions for medical teachers lying vacant (Marapakwar 2020). In Mumbai, out of the 18 medical colleges, eight are without deans. In the Public Health Department, out of the total sanctioned post of 1653, only 550 posts are filled, the rest remaining vacant. Other key vacancies in the department:

- 2 posts of additional director
- 3 posts of joint director
- 11 posts of deputy director
- 23 of 31 posts of additional district health officer
- 25 of 28 posts of assistant district health officer
- All 26 posts of dental surgeons
- 25 of 43 posts of assistant civil surgeon

Source: Times of India 2020

However, a positive initiative by the government in Maharashtra was its decision to enforce strong regulatory mechanisms on the private sector by capping the prices of medical procedures in all private and charitable hospitals. This is an important step by the government to reclaim the role of the state in the health sector. The rampant growth of private players in the health sector had led to a massive increase in the out-of-pocket expenditure of citizens and also led to unchecked unethical medical practises, hence this step by the government brings much relief.

Similarly, there has been rampant privatization in the education sector as well in Maharashtra. In 2017, the State Assembly passed the Maharashtra self-financed schools (Establishment and Regulation) (Amendment) Act, 2017, which allows any registered company to open private schools in the state under Section 8 of the Companies Act 2013. This step has been viewed as a step towards commercialisation of education and has been critiqued by activists and academicians across the state. The more recent Strengthening Teaching-Learning and Results for States (STARS) project will further privatise education, one of the major thrust areas of the programme being, partnerships of public-funded government institutions with "non-state actors" i.e., private actors. The possibility of public funds being channelled into the private also persists (Oxfam India 2020). This goes against the entire ethos of the RTE Act which strives to strengthen public education in India. The state has also witnessed an increase in the enrolment of private schools by 27 % whereas, the enrolment in government schools has decreased by 25%. Mirroring the rest of the country, the condition of public education worsens at the secondary levels, with only 18% government schools offering secondary education.

The implementation of the RTE Act 2009 has been better in Maharashtra with 34.3% schools in the state complying with its provisions, as compared to the national figure of 12.7 per cent (UDISE 2016-17). However owing to lack of investment in education aligned with growing privatisation of education, the public education system in Maharashtra is in need of an overhaul especially at the secondary level. The state has witnessed a steep increase in the number of children dropping out of schools at the secondary level. The gross enrolment at primary level is 99.7 per cent which drops to 67.8 per cent at the secondary level (Kundu 2018).

School closures have also been widespread in the state of Maharashtra, when the School Education Department in 2017 decided to close down over 4000 schools having enrollment of less students. The school closures began in early 2018, when the state closed down 1300 Zilla

Parishad schools. This move was criticized by activists as well as Members of Parliament from the state, who raised the issue that this move will affect the marginalized children and they will be pushed out of the education system.

At the time of the COVID-19 pandemic, when all educational institutes including schools remained closed for months, the state education department in Maharashtra introduced digital learning content in government and government aided schools. However, a survey conducted by MSCERT revealed that only 30% students are using the Diksha app (online platform for educational content). The survey also found that only 59% students have access to smartphones and 57% have internet connectivity. Access to desktop or laptops was at a mere 0.8% (MSCERT 2020).

Given the overall status of education and health, concrete steps need to be taken by the government to ensure progress in each sector to enable the achievement of the SDGs.

RECOMMENDATIONS

Keeping in mind the COVID-19 pandemic, the following are some of the key recommendations to ensure a robust and resilient public health and education system and lead the way for reaching the targets set by the SDGs.

Health[1]

1. **Right to Health should be a justiciable right:** Public health experts and activists argue that right to healthcare should be a fundamental right in the Indian constitution. This would ensure universal access to good quality and comprehensive health for all citizens.
2. **More public resources for the health sector:** Public investment on Health care needs to be increased substantially, to 3.5% of GDP in the short term, and 5% of GDP in the medium term.
3. **Expand and strengthen the public healthcare system**: This will ensure availability of health care appropriate to primary, secondary and tertiary level, entirely free of user fees, and provide universal access to the entire range of essential drugs and diagnostics at the public facility.

[1] Recommendations for the health segment has been taken from the press release of Janta Parliament session on Health. http://phmindia.org/wp-content/uploads/2020/08/Press-release-Janta-Parliament-demands-%E2%80%9CRight-to-Health-Care%E2%80%9D.pdf

4. **Regulation of the private sector:** Ensuring effective, generalized implementation of the Clinical Establishment Act (2010) immediately, with focus on regulation of rates in the private health sector.
5. Universal implementation of the **Patient Rights Charter** while making it legally mandatory, accompanied by the establishment of an effective Patient Grievance Redressal mechanism ·
6. **Universalise Community based planning** and monitoring of health services at village, block and district levels
7. Effective, prompt and just **grievance redressal system** needs to be operationalised to handle all complaints and disputes arising from citizens for health care rights, at all levels, starting from the community level.

Education[2]

1. **Ensure universalisation of school education** through implementation of the RTE Act 2009 and an extension of the Act up to secondary standards (Standard XII)
2. **Continue essential care services during school closures** — such as Mid-Day Meals, Iron Folic Acid supplements and sanitary pad provision in order to ensure good health and adequate nutrition for children especially girls.
3. **Enhance Budget for Education:** Ensure education's share of national and state budgets reaches 6% of GDP as mandated by the NEP. The Ministry of Human Resource Development has deprioritised education to a Category C expenditure (the lowest classification), which will restrict expenditure to within 15% of that budgeted for at least Q1 and Q2 2020-21. Central government must treat school education as a priority sector and not relegate it to Category C.

   For immediate Covid-19 Response Strategy adequate allocations are necessary to

   (a) ensure safe school operations and re-opening of schools;

   (b) support measures for recovering all marginalized students' learning loss and socio-emotional impact during educational disruption;

[2] Recommendations for the education section has been taken from RTE Forum's submission to the Ministry of Finance, http://rteforumindia.org/wp-content/uploads/2021/01/Ministry-of-Finance.pdf and the Factsheet on Girls' Education, http://rteforumindia.org/wp-content/uploads/2020/10/RTE-National-Factsheet-Advocacy-for-Girls-Education.pdf

(c) ensure (re)enrolment and targeted support for learners who are at risk of not returning to school, especially, Dalits, Adivasis, girls, those living in poverty and persons with disabilities;

(d) In view of evidence of the existence of a digital divide, it would be critical to ensure that low and no-technology options are prioritized over the introduction of digital modes of instruction.

4. **Develop alternatives to online education:** Develop diverse distance learning material — using radio, TV, SMS, printed material, peer-to-peer and parent resources to ensure that the fundamental right of education isn't violated for children who do not have access to digital technology.
5. **Ensure functional WASH facilities** in all schools as per the norms laid out in the RTE Act, incorporating specific guidance to prevent further outbreaks of coronavirus.
6. **Stop merger** and closure of schools under the pretext of rationalisation. In the context of the COVID-19 pandemic and the reverse migration into villages, it becomes pertinent to also re-open the schools that were previously closed as part of the rationalisation policy, to accommodate the children who have returned back to the villages.
7. Take steps to **stop commercialisation of school** and regulate non- state actors in education.
8. **Address specific barriers** to education faced by Dalit, Adivasi, minority children, children with disabilities, girls and other vulnerable groups. This is the only way to ensure that no one is left out from their fundamental right to education.
9. Ensure **Community Participation** in education by strengthening local bodies like the School Management Committees (SMCs).

Conclusion

Accessible and affordable quality healthcare and education is crucial to the achievement of SDG 2, 3 and 4. In both the sectors, it is vital to reduce the role of private actors and strengthen the public system to ensure reduction in the out-of-pocket expenses. Alongside this, investing more public resources for both the sectors is vital since it has been established that without resources, one cannot implement schemes and policies effectively. With the COVID-19 pandemic undoing the progress made in these sectors in the last few years, it becomes all the more important for the government to focus on reviving these sectors on an urgent basis. Without the strengthening of the public systems and making the government accountable, the most vulnerable communities will be left out and deprived of their right to

health and education, thereby failing to reach the last mile. Lastly, community participation is key to localising SDGs and can be instrumental for the progress of these sectors.

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