Public Spending on Health of Young Children in India

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Abstract—*India has largest number of children among all countries across the world. They constitute the heterogeneous group of different regions and of different age group. Childhood especially early childhood is the most vulnerable stage, as these years lay the foundation for their life long development. There is strong evidence that young children need multipronged care and development support and hence special attention in public policies too. The overall magnitude of public resources available to the government in India has been inadequate in comparison to several other countries, mainly owing to the low magnitude of tax revenue collected in the country. The total quantum of government spending, as compared to the size of the country's economy, has been much higher in most of the developed countries as well as in some of the developing countries like Brazil and South Africa. Public investments in young children in the country are not the responsibility of the Union Government alone; the State Governments too are expected to make adequate budgetary investments in this crucial section of the population. At the national level, it has been stated that fulfilment of children's right need to be treated as a crucial indication of national plan and strategies.*

This paper will tries to present an assessment of current situation in India with regard to public investment. The paper will also discuss briefly different child focussed programme in the country and the problem of fund allocation and utilization. This will threw light on various government schemes and programme covered under different Five Year Plans. Apart from this, paper will also present the analysis of government efforts on different aspect of children well being like their health, nutrition, safe drinking water, proper sanitation, immunization etc. At the end, paper also covers some concluding recommendation on the issue that require greater attention of policymakers.

1. INTRODUCTION:

Every child is born with the same inalienable right to a healthy start in life, an education and a safe, secure childhood – all the basic opportunities that translate into a productive and prosperous adulthood. But around the world, millions of children are denied their basic rights and deprived of everything they need to grow up healthy and strong. An infant deprived of post-natal care may not survive her first days. A child deprived of immunization or safe water may not live to see his fifth birthday, or may live a life of diminished health. A child deprived of adequate nutrition may never reach his full physical or cognitive potential, limiting his ability to learn and earn. The 2030 MDG have set a high bar for progress on maternal, newborn and child survival and health. Among the targets for Goal 3 is the aim to reduce neonatal mortality to at least as low as 12 deaths per 1,000 live births and under-five mortality to at least as low as 25 deaths per 1,000 live births in every country. Universal health coverage, another 2030 target, is one of the conditions for reaching the above outcomes. Availability, timely access and affordability of health care services are the fundamentals of better health and reduced financial risks to the majority of population (WHO, 2010). Studies document that poor health is concentrated among poor households in the poorer states or countries (Wagstaff, 2000; Bhalotra, 2007). For example, under-five deaths (deaths in age-group 0-4) in poor countries constitute 30% of the total death, which is less than 1% in rich countries (Cutler et al., 2006). Furthermore, of the total under-five deaths, 10 million children die due to preventable diseases which are rare in the developed world (Jones et al., 2003). Not only is the poor health concentrated among the poor, but poor in most of the countries also have restricted access to health care. Preker et al. (2002) showed that a majority of 1.3 billion poor people around the globe have restricted access to health services due to their inability to pay for the services. Studies also show that poor are more likely to utilize public health facilities than the rich (Gwatkin, 2000; Wagstaff, 2000), and Bidani and Ravallion (1997) research shows that public spending on health matters more to the poor than to the rich Increased public spending on health improves the availability, accessibility and affordability of health care services, which reduce the chances of negative health outcomes in a population.

There is strong evidence to suggest that young children need multi-pronged care and development support and hence special attention in public policies too. What has also been long established and accepted is that the interventions for this age group are closely linked to those for the mothers. Prioritizing resources towards Early Childhood Care and Development (ECCD) is a long-term and judicious investment, which can bring multiple benefits to the child, his/her family and the entire society.

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2. PRESENT HEALTH INDICATOR OF CHILDREN IN INDIA

The development of a child starts in the mothers' womb. The average Indian child gets a rather poor start in life as many a time, before birth, he/she is heading for disaster due to poor ante-natal care and maternal undernutrition. About 60 percent mothers in India are anaemic, only 25 percent of the pregnant mothers get full ante-natal checkup, and only around 50 percent women get post-natal care within two weeks of delivery. The anaemic mother is likely to result in low birth-weight of the child, a major cause of child undernutrition. (UNICEF, 2016)

More than half of the children in 10 out of 15 states are still anaemic shows National Family Health Survey (NFHS-4) for 2015-16. It also showed that more than half of women were anaemic in eleven states.

The Ministry of Health and Family Welfare released the results from the first phase of the National Family Health Survey (NFHS-4), 2015-16. Findings for the 13 States of Andhra Pradesh, Bihar, Goa, Haryana, Karnataka, Madhya Pradesh, Meghalaya, Sikkim, Tamil Nadu, Telangana, Tripura, Uttarakhand, West Bengal and two Union Territories of Andaman and Nicobar Islands and Puducherry show promising improvements in maternal and child health and nutrition. The results from NFHS-4 in 15 States/Union Territories indicate that fewer children are dying in infancy and early childhood. After the last round of National Family Health Survey in 2005-06, infant mortality has declined in all first phase States/Union Territories for which trend data are available. All 15 States/Union Territories have rates below 51 deaths per 1,000 live births, although there is considerable variation among the States/Union Territories. Infant mortality rates range from a low of 10 in Andaman and Nicobar Islands to a high of 51 deaths per 1000 live births in Madhya Pradesh.(NFHS, 2016)

3. DIFFERENT INDIAN GOVERNMENT HEALTH POLICIES AND PROGRAMMES FOR CHILDREN UNDER DIFFERENT FIVE YEAR PLAN

For the smooth functioning of any economy, planning plays an important role. The Planning Commission has been entrusted with the responsibility of the creation, development and execution of India's five year plans. India's five year plans are also supervised by the Planning commission. From a highly centralised planning system, the Indian economy is gradually moving towards indicative planning where the Planning Commission concerns itself with the building of a long-term strategic vision of the future and decide on priorities of nation. It works out sectorial targets and provides promotional stimulus to the economy to grow in the desired direction. In the social sector, schemes that require coordination and synthesis like rural health, drinking water, rural energy needs, literacy and environment protection have yet to be subjected to coordinated policy formulation.

In first five year plan (1951-56), The First Five Year Plan recognized the importance of promoting social services for maintaining and consolidating the gains of economic development, attaining adequate living standards and social justice. The World Health Organization, with the Indian government, addressed children's health and reduced infant mortality, indirectly contributing to population growth.

In the **Second Five Year Plan (1956-61)**, social welfare activities were extended to different sectors. The plan particularly focused in the development of the public sector. About 2,100 maternity and child health centres were set up. These centres were integrated with the primary health unit services. These centres arranged for the regular training of maternal and child health personnel and also give periodic refresher courses.

In the Third Five Year Plan (1961-66), many primary schools were started in rural areas. States were made responsible for secondary and higher education. The achieved growth rate was 2.84 percent. Holiday homes for children were promised and much social concern was shown towards children. Problem of child beggary was to be isolated and taken care of.

In the **Fourth Five Year Plan (1969-74),** all attempts were made to consolidate the initiatives taken in the previous plans. It was the tenure of Mrs. Indira Gandhi and all the activities of Central Social Welfare Board were further strengthened. In the health care area the main objective was to control and eradicate communicable diseases, to provide curative and preventive health services in rural areas through the establishment of a primary health centre in each community development block. Among children those who are destitute should receive higher priority.

The **Fifth Five Year Plan (1974-78)** proved to be the landmark in the field of child development through the adoption of a National Policy for Children (1974), and launching of the Integrated Child Development Services (ICDS) with a shift from welfare to development in the approach towards development of children. The programme of ICDS, launched in 33 experimental blocks in 1975, aimed to reach a package of 6 basic services, viz., health check-up, immunization, referral services, supplementary feeding, non-formal pre-school education and health and nutrition education for children below 6 years and expectant and nursing mothers living in the most backward areas through a single window delivery agency called 'Anganwadi Centre'. The Central and State Governments provided scholarships to the physically disabled.

The **Sixth Five Year Plan (1980-85)**, in the early Eighties witnessed an effective consolidation and expansion of programmes started in the earlier Plans. The National Policy of Health adopted in 1983 set certain specific targets like

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bringing down the high rates of Infant and Child Mortality and take up universalization of immunization etc. by the year 2002 A.D. The National Policy on Education of 1986 emphasised universal enrolment and retention of children in the schools especially the girl children. Non-formal education programmes were also promoted intensively.

The **Seventh Five Year Plan (1985-90)** continued the major strategy of promoting early childhood survival and development through programmes in different sectors, important among these being ICDS, universal immunization, maternal and child care services, nutrition, preschool education, protected drinking water, environmental sanitation and hygiene, and family planning. Under the maternal and child health services of the Ministry of Health and Family Welfare, the universal immunization programme to protect children from six major diseases which affect early childhood mortality and morbidity, viz. diphtheria, whooping cough, tetanus, polio, measles and childhood tuberculosis was strengthened for the development of children as a whole. ICDS continued to be the single nation-wide programme for early childhood survival and development during Seventh Plan.

Human Resources Development being the major focus of the **Eighth Five Year Plan (1992-97)**, policies and programmes relating to 'child survival, protection and development' were accorded high priority with emphasis on family and community based preventive services to combat high infant and under-5 child mortality and morbidity. Following the ratification of the 'Convention on the Rights of the Child', in 1992 the Government of India formulated two National Plans of Action (NPA) - one for children and the other exclusively for the Girl-Child. Children sets out quantifiable goals to be achieved by 2000 AD in the priority areas of health, nutrition, education, water, sanitation and environment, the NPA for the Girl Child (1991-2000)aimed at removal of gender bias and enhances the status of girl child in the society, so as to provide them the equal opportunities for their survival, protection and development. Both the Plans of Action adopted an inter-sectorial approach in achieving sectorial goals laid down in the Action Plans in close uniformity with the major goals of 'Health for All', 'Education For All.'

The **Ninth Five Year Plan (1997-2002)** re-affirmed its priority for the development of early childhood as an investment in the country's human resource development. The strategy aimed at placing the Young Child at the top of the Country's Developmental Agenda with a Special Focus on the Girl Child; instituting a National Charter for Children. Efforts were made to strengthen the on-going approach of converging the basic services of health, nutrition and preschool education towards promoting the holistic development of the young child through Integrated Child Development Scheme (ICDS). Though universalization of ICDS was contemplated by the end of 1995-96 through expanding its services in all the 5652 Blocks all over the country, yet only 4200 could become operational at the beginning of Ninth Plan, before the ban on further operationalization of ICDS projects was imposed by the Ministry of Finance. However, the ban was finally lifted and now the Government has decided to Universalize ICDS all over the country by the end of the Ninth Plan. **The Reproductive and Child Health (RCH)** Programme, being operated by the Ministry of Health and Family Welfare since October 1997 aimed at integration and expansion of family welfare services, up-gradation of their quality and making them easily accessible to the people. Focus was given regarding nutrition by improving the dietary intake and through a change in the feeding practices and intra-family food distribution and preventing the deficiency diseases. **Mid-Day Meals** Programme for school going children implemented by the State Governments.

In Tenth Five Year plan (2002-2007), various programmes were launched especially for adolescent girls such as Kishori Sakti Yojana, Nutrition programme for Adolescence girls, Reproductive Child health and ICDS. Special Nutrition Programme was also launched that focused on improving the nutritional status of children below 6 years, with special priority for children below 24 months.

In Eleventh Five year (2007-12) clearly states "Development of the child is at the centre of the Eleventh Plan". According to the MWCD working group report the plan outlines its work according to the National Plan of Action for Children (NPAC) 2005. There are four key areas the plan address: ICDS, Early Childhood Education, Girl child and Child Protection. The plan calls for further expansions of the ICDS services and reiteration of major concerns about infrastructure, training of workers, quality of services, etc. Early childhood education needs a boost with regards to access, day care services, infrastructure, training, minimum standards and regulatory mechanisms, and revamping curriculum. With regard to Girl child the plan reiterates the goals set out in NPAC. Age specific and setting specific interventions are needed for girls. The eleventh plan recognizes the need for Child protection programmes and initiatives. It specially addresses the need of those children that have fallen out of the purview of previous interventions and hence fallen on difficult times. According to the MWCD report the eleventh plans idea of child protection is very limited and does not cover all commitments of NPAC.

Following Goals were set for XI Five Year Plan:

- Reducing Maternal Mortality Ratio (MMR) to 1 per 1000 live births. Reducing Infant Mortality Rate (IMR) to 28 per 1000 live births. Reducing Total Fertility Rate (TFR) to 2.1.
- Providing clean drinking water for all by 2009 and ensuring no slip- backs. Reducing malnutrition among children of age group 0-3 years to half its present level.
- Reducing anaemia among women and girls by 50%.

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- Raising the sex ratio for age group 0-6 to 935 by 2011-12 and 950 by 2016-17.

The **12th Five Year Plan (2012-2017)** aims at a 9-9.5% growth rate during plan period (present averages at about 8.2). the main theme of this plan is **Sustainable growth.** In order to achieve this, the Government of India aims at developing on a few major sectors like agriculture, industry, education & disadvantaged groups. The major child relevant health targets areas follows:

- Clean drinking water, sanitation and better nutrition, childcare.
- Focus on women and children; ICDS needs to be revamped.
- Health and Education received less than projected in Eleventh Plan. Allocations for these sectors will have to be increased in 12th Plan
- Health, Education and Skill Development together in the Centre's Plan will have to be increased by at least 1.2 % point of GDP.

4. CONCLUSION

In India, childhood has been defined in the context of legal and constitutional provisioning, mainly for aberrations of childhood. It is thus a variable concept to suit the purpose and rationale of childhood in diverse circumstances. Essentially, the difference lies in defining the upper age-limit of childhood. Since Independence, a number of legislations and policies have been adopted with the purpose of ensuring development of children and upholding their rights. However, the government's approach towards children under six has been and continues to be fragmented. Delegation of responsibilities pertaining to young children to different Ministries without well-defined mechanisms for convergence, limited interventions through the schemes, low magnitudes of budgets for the schemes, and absence of a Rights framework and entitlements have escalated the problems of young children in India. A major drawback in the country's policies and programmes has arisen from the failure to recognize the close interconnectedness of women's needs and rights with those of young children during this important period of their development. The planning for women as workers and that for the health and development of children has been carried out in compartments. This lacuna in conceptualization has led to inadequacy of policy interventions for both. India has 158.8 million children less than six years of age, and some of its States have 0-6 child populations that are higher than even the total populations of some countries. The development deficits and deprivations confronting the country's young children, however, has been a cause for serious concern. The overall magnitude of public resources available to the government in India has been inadequate in comparison to several other countries, mainly owing to the low magnitude of tax revenue collected in the country. The limited fiscal policy space available to the government and the limited priority given to social sectors in the country's overall budgetary spending have resulted in low magnitude of public spending on social sector programmes, which provide the larger resource envelope for targeted public investments in young children.

Taking care of the special needs of the country's young children ought to be an urgent priority for both the Union Government and the States as the future of India's development depends to a large extent on how well the country takes care of its young children now.

The government, along with developing public health infrastructure, must take steps to promote health education in the country. The government must also focus more on building capacity of the health personals, and must also sensitize the health personnel towards the needs of special groups. All these are likely to increase the effectiveness of the public health care system in the country. There is also a greater need for increased spending on preventive measures like improved water and sanitation. Finally, the fruits of public health expenditure on health outcomes will only be realized when the benefits of public health expenditure reach to the needy and the socially marginalized groups. Strong political will, minimal diversion of funds and appropriate selection of beneficiaries for the publically financed schemes is likely to pay immediate and larger dividends in terms of improved health outcomes.

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