The Unburdening of Lack of Evidence: A Review of Jagdish Bhagwati and Arvind Panagariya, India’s Tryst with Destiny

Arnab Acharya

Abstract
Professors Bhagwati and Panagariya in their recent book have sought to debunk what they perceive to be common mistaken perceptions about the Indian economic performance. They argue reforms centering on a more open economy of early 1990s is the primary spurt behind economic growth. India’s economic growth has been equitable in reducing income poverty at a dramatic rate; Indians enjoy human development indicators that far surpass what would be expected given the average income level. However, much of the arguments made in the book fail to properly engage with the debates that centre on evaluating Indian economic progress since the 1990s and the decade before. The arguments often use selective data and ignore the nuanced debate that would place India’s performance in much less favorable terms requiring solutions that would affect many Indians who have not seen significant improvements in their lives over the past two or three decades.

Keywords
India’s economic reform, income equality, health indicators

The book by Professor Jagdish Bhagwati and Professor Arvind Panagariya, India’s Tryst with Destiny, henceforth ITD, is very well written and addresses a host of complicated and important issues concerning the economic changes that a large mass of the world’s population has been experiencing for the last 30 years—the start of the current growth spurt. ITD begins, however, with a short discussion on the historical background of development since independence.

ITD deserves close examination from a variety of angles as Bhagwati and Panagariya (B & P), judging from their well-deserved public and academic stature,
will have considerable sway across the globe. The first impression of the book is one of admiration: the authors should be commended for their refreshingly unpretentious, direct, often clever and erudite style. The book is written with conviction through use of concise language of persuasion. A review needs to ensure that the topics addressed receive significant, nuanced and detailed considerations.

The general message of the book is that growth in income is of primary importance for all relevant measures that can be used for ascertaining human well-being. The topics covered are extensive. I limit myself to examining how the main messages of the book have been presented by examining a few issues. The book asserts that it debunks myths that B & P believe are strongly held by some group or the other. These myths precipitate from the view that growth that followed since the liberalization in 1991 has not contributed to improvement in well-being in the general population and has not been sufficiently pro-poor. Further, B & P assert that it is liberalization alone that has sustained the growth rate for such a long period. I begin by examining the general tenor of these arguments.

The substantive parts of the myths reported and debunked in ITD are based on the poor well-being indicators within India that one sees today after nearly 30 years of high growth. B & P hold that these indicators should not be seen as poor performance. I examine the basis of this view as presented by B & P by examining health issues in India; the methodology around supporting the view that health improvements over the persistent growth period have not lagged behind in India is representative of B & P’s arguments that seek to establish that human development nearly will always proceed from high growth rate income. As an example of how growth fosters well-being, B & P argue that Gujarat offers, in contrast to Kerala, a better approach to improve well-being. To examine this stance, I present a short review of the literature on the developmental path of Kerala. As way of presenting conclusions, I examine the arguments underlying B & P’s approach in contrasting Kerala and Gujarat. This characterizes the general methodology through which B & P present their arguments. I believe that the general tone and approach is to dismiss rather than engage with alternative arguments.

At the cost of more nuance, the authors seek to debunk myths to provide a succinct and readable book. In the process of debunking myths, much of the arguments take the form of last words by B & P, as if there are no debates concerning the issues addressed in the description of the myths. Who holds these views? What could be the motivation or reasons for adhering to them? These questions are not really answered. Instead, the myths are stated and then ‘proven’ wrong by ITD.

For many issues addressed, failing to recognize our lack of knowledge or the need to qualify recommendations is to enter into dangerous territories where, if the alternatives to recommendations/suggestions hold true, the consequences can be enormous. If one were to be rigorous, a clear identification of type I and type II errors might be a start. Perhaps sophisticated analyses of the risk of making the wrong recommendation might be necessary. Two examples, the main thesis of the book, illustrate the complexities of the underlying issues: debates on whether
the current growth turnaround occurred before 1991; and whether or not inequalities have increased post-1991. To dismiss the alternative arguments, as done in ITD, is to not understand the possible viable growth paths fully or to not recognize that growth may leave some people behind. The present article follows up these two arguments in the following section.

Close to the two above-mentioned arguments is the view underlying the general discussion as to whether Indian growth has been poverty reducing. The argument offered in B & P may not be contested in most circles but is worth presenting to suggest that the authors present mainstream views in their awareness of the acute problems that India faces. This makes up the section, ‘Growth and Redistribution’. The section that follows examines health issues. In the penultimate section, I examine B & P’s comparisons of Kerala and Gujarat. The last section concludes with further remarks about the methodology to establish that growth nearly will always lead to improvement in human development.

**The General Thesis**

The fundamental thesis of the book is that India’s growth between 1991 and 2010 has contributed to better health and education, and to poverty reduction, with a minimal worsening of economic inequality. Growth has been fundamentally welfare enhancing and the noted period has propelled India not only towards higher income but significant improvement in human development, for example, through reduction in poverty rates and improvement in health at rates commensurate with economic growth (myth 5.1). Without this high growth rate, these remarkable achievements would not have been possible (counter myth 3.2: There has been no reduction in poverty as a result of post-1991 reforms). A further argument is that there were fundamental policy changes in 1991 through economic liberalization (counter myth 3.1: Reforms do not explain the faster growth since 1991); without these changes, growth would not have occurred.

This section first examines myth 3.1 and then examines myth 3.2.

**Starting Period of Growth**

It is widely recognized that India started experiencing faster growth in the early 1980s. While many economists have suggested that public investment and shift in political focus towards growth promotion, initiated by Indira Gandhi in the 1980s, were responsible for India’s growth spurt, they also acknowledge the current account deficit and fiscal problems of that period (see Basu & Maertens, 2007 and Kohli, 2012, for reviews of this debate). These problems were both the political catalyst and, most likely, the reasons behind sound policymaking in adopting the liberalization policies implemented in 1991. Debates have centred on: whether or
not external forces played a big role in creating balance-of-payments problem; and whether growth in the 1980s was sporadic. ITD seeks to assert that the growth pattern of the 1980s was not sustainable without the reforms (myth 3.1). B & P also question whether the growth in this period was robust. It is true that the rate was uneven; but depending on how one clusters the years, one gets different pictures. There are at least three years of consistently high growth rate from 1988–1991. Given the dispute around even the trend, one cannot simply claim that the debate is a myth. Scholars do not debate myths. And one or two papers cannot be singled out as having put the matter to rest. Much evidence suggests the debate regarding the importance of growth in the 1980s should continue and not be dismissed as having been settled, which is contrary to what B & P assert.

Start from the fact that the patterns for growth in the two periods do not differ much: there is, for instance, little evidence that industrial production, on average, grew at different rates in the 1980s when compared the period 1991–2010 (see Kohli, 2012). Growth patterns in the agricultural and industrial sectors have experienced little change since 1991. The agricultural growth rate fell by 0.07 per cent when the 1980s are compared to 1990–2008; and the industrial sector grew only at a 0.03 per cent higher rate. The rate of growth in the service sector rose from 6.6 per cent to 8.0 per cent. The level of investment as a percentage of gross domestic product (GDP) rose in the early 1980s; this level remained constant more or less until 2005 when it started to rise at a faster rate. One may thus be led to believe that the growth pattern has not changed much from the 1980s, and even the 1980s growth pattern was not uniform.

It may well be that in the absence of the 1990s reforms, what took place in the 1990s and the growth period of the 1980s would have come to a halt. Positive developments can easily be attributed to the 1991 reforms. However, this does not firmly counter the fact that there may be alternative growth paths for a country at different times. Ghate and Wright (2012), quoted in ITD, suggest that the evidence for a growth turnaround is consistent with the liberalization hypothesis with a single turnaround point in the later part of 1980s–1987 to be exact; their approach is to examine growth patterns in 16 key sectors in the economy from 1970 to the 1980s. Examining these sectors, they look for shifts in the patterns of growth rates in output per capita. Ghate and Wright note that there was a shift in the common factors explaining the growth rate of the 16 sectors that occurred around the time of a decline in the effective tariff rate.

Ghate and Wright’s (2012) work is interpreted as conclusive and definitive evidence by ITD. True, Ghate and Wright (2011) contradict the larger role of public investment reported by previous authors (mainly, Rodrik & Subramanian, 2005). Yet, even the paper by Ghate and Wright notes that in explaining state differences in growth rate, education and transportation link have a key positive role, while having a larger agricultural sector reduces growth. As Rodrik (2010) notes, in discussing the development process in East Asia, research results are not clear-cut; it is possible to construct alternative ‘narratives’ of East Asia’s growth using the same data. To discredit the growth path in the 1980s, and the diagnostic and
prescriptions that led to that achievement, is to dismiss much of what may have been pragmatic and a success for that time in India. For example, a lot would be missed, especially in terms of gaining a better understanding of the role of public investment during this particular period, since this was at a higher level than in the subsequent reform period (Basu & Maertens, 2007; Kohli, 2012). Ghate and Wright (2012) do not explain why the 1980s growth rate was high.

**Fall in Poverty**

One important ‘myth’ (myth 2.5) that ITD seeks to debunk is that by itself, growth makes the ‘rich richer and the poor poorer. To reduce poverty, redistribution is necessary.’ I do not think the authors actually attempt to debunk that the rich got richer, and there is no addressing of this issue in statistical terms. Further, few assert that there has been no reduction in poverty in India since 1992 (myth 3.2). Banerjee and Picketty (2005), using 2002 data, contend that the richest 1 per cent of Indians command 9 per cent of the economy; the follow-up to that study was not found, although global accounts suggest top income earners have gained considerably in absolute and relative terms in the last decade (Facundo, Atkinson, Picketty & Saez, 2013). The second part of the myth is also not debunked by the authors as they suggest a variety of redistributive measures and point out that the job growth has not been sufficient to allow for rise in employment of higher-skill worker at manufacturing wages. The prevalent argument that the Indian labour laws are an impediment to expanding formal sector employment cannot be dismissed; however, it has to be admitted, as B & P do in the book, that growth by itself has not contributed to a significantly larger percentage of formal sector employment.

The more relevant argument around myth 2.5 should perhaps centre on a variation of myth 3.2, that poverty decline has not been sufficient. Further, the pace of improvement in reduction in poverty has not kept up with the growth rate of the economy.

The population making a living through agricultural sector amounts to 66 per cent, yet, it commands only 18.22 per cent of economy (Central Statistical Organization, 2013). Examining growth over the past years, we find that this sector has grown at less than 3 per cent, whereas the manufacturing sector, on average, has grown 7 per cent and the service sector has grown at 8.3 per cent between 1991–2010 (Central Statistical Organization). The trend in the new millennium period indicates that disparities have increased. Thus, more than 60 per cent of the population have, in growth terms, been involved in the worst-performing sector of the economy. Turning to rich and poor states, the evidence is similar: five major poor states grew at a rate of 4.7 per cent, while other major state grew at 6.7–6.8 per cent during the 1991–2008 period. From the available data for 1980–2008, the numbers are closer with poorer states growing faster in 1980–1991 and richer states growing more slowly during that period (Kohli, 2012). Without passing moral
judgements about the increase in wealth of people who are nearly all at low levels of well-being, one must point out that the proposition that growth in 1991–2008 may have increased inequality should not be readily dismissed. ITD, citing two papers, with Panagariya’s sole or co-authorship, notes that growth rate from 2003–2004 to 2010–2011 shows that nearly all states grew faster than they did in any prior period without offering any numbers (pp. 61–62). This does not dispel the fact that the richer states have grown faster on average since 1991; and the poorer states have grown more slowly.

Although measurement of inequality through expenditure data may underreport inequality, monthly per capita expenditure (MPCE) from various National Sample Survey rounds are routinely used to measure poverty. Thorat and Dubey (2012) show that absolute achievement in terms of climbing out of poverty increased at a higher rate of 4.4 percentage point annually within the period 2004–2010 as compared to 2.2 percentage point from 1993 to 2003 in rural areas; in urban areas, the corresponding figures are at 3.9 per cent annual rate and 1.9 per cent annual rate, respectively. Since 1993, all socio-economic groups, especially some of the more discriminated groups (for example, Scheduled Castes and Muslims), recorded a significantly higher rate of decline in poverty and more so in the rural areas. Thus, we can confirm B & P’s view that poverty has decreased; and may have even decreased among those that are likely to be discriminated. Note, the rate of decline is low, however. As the growth rate is substantially higher than the fall in the poverty rate, we must ask how well has the growth rate affected inequality.

Measuring through MPCE, we find that while the rural Gini coefficient changed very little over 1993–2010 from 0.3, the urban Gini coefficient has increased by 0.06 since 2004, from 0.34 to 0.4. Thus, the picture regarding inequality is mixed. While there has been substantial decline in poverty since 2004, the decline is modest given the size of poverty that still remains in the country; the claim that growth has not been inclusive has strong merit. Inclusive growth requires that: (a) growth process continues; and (b) there is substantial absorption of the population into higher-paying employment or there is considerable redistribution through taxes and transfers.

Growth and Redistribution

Redistribution helps to achieve a more egalitarian society; yet, even for advocates of egalitarianism, redistribution is never straightforward. As B & P rightly reiterate, redistributive potential is limited when overall resources are at a low level. Nagel (1991) and Scanlon (1975) have separately argued that redistribution to meet urgent needs would be the responsibility of everyone not near a subsistence level, while addressing the question in the venerable tradition in political theory since Thomas Hobbes as to how much can be asked of the better-off. Given that
one major channel of redistribution is through taxation, it is worth examining the urgent needs of many Indian citizens and the scope for redistribution through this particular channel.

Given the recent developmental achievements, it is reasonable to believe that a threshold level of well-being should be achieved by all Indians. Perhaps, the most urgent needs in most circumstances can be eliminated at the current level of India’s economy. We use expenditure data that report poverty rate and national GDP per capita with purchasing power parity (PPP) adjustment of 2.5 to carry out a simple exercise. The poverty line should be set, at least, at a purchasing power price parity of $1.25 a day, which in 2012 would be around 70 INR a day. The World Bank estimates a poverty rate of about 30 per cent. If everyone with an income below $1.25 PPP per day had exactly that much, the annual equivalent would be $180.00. Another 30 per cent make an income below $2.50. Adjusting for PPP, this is equivalent to $365.00 per annum, which is about 25 per cent of the per capita income in 2012. Assuming that everyone within the next 30 per cent earns at least this much, together the bottom 60 per cent can earn as little as 11 per cent of GDP. The actual figure of 11 per cent is likely to be less as we have assumed that everyone is at the margin. The two benchmark figures from the World Bank, $1.25 and $2.50, define urgency as Scanlon had imagined. With 60 per cent of people in the urgent need for improvement and occupying only less than 11 per cent of the income, there is a moral argument in favour of and practical scope for distribution.

If 60 per cent of the population were to have at least $2.50 per day, this would entail that this portion of the population would command about 15 per cent of the total income in economy. One would imagine that India would need to redistribute about 4–7 per cent of its GDP towards the poor to get off the barrier of $2.50 a day; given that this estimation is slightly inaccurate, a range should be considered. Since India collects only 16.5 per cent of GDP in tax, to redistribute 7 per cent of its GDP may well be a high fiscal burden. A recent report (Meyer & Birdsall, 2012) indicated that Indians earning between $8–$50 per day (PPP), defined as the world middle class, were only about 8 per cent of the population in 2009. This report also indicates that economists have argued for higher level of income as the definition of world middle class. Given the dismal level of earnings of most Indians and a fairly low level of GDP per capita, Indian economy must continue to grow at the level of the first 10 years of the millennium if there is to be a sizable middle class in the next decade. ITD is on firm ground in expounding high growth. The question regarding the poor as to whether it is redistribution that can lift people out of poverty depends on how inclusive growth is generating higher wages, particularly for those at the bottom of the labour market.

The Economic Survey of India notes that although India has been as open to trade as China was 20 years after its take-off period, workers have been added to India’s industry at a 7 per cent level since 1991 (Economic Survey, 2013). That is, the industrial workforce has risen only by 7 per cent of the total labour force. Even this low level of employment absorption is made up of low-paying sectors like...
construction and by non-formal employment agreements within the formal sector (Economic Survey, 2013). These low-paying jobs may well bring some people out of poverty; and B & P further add that growth contributed to opening up of alternative employment avenues for poverty reduction (p. 30). It is far below the expectation of an economy composed mostly of middle class; it is also an economy composed of many people below $2.50. The relationship between growth and poverty reduction is studied next by turning to state-level data.

Besley, Burgess and Esteve-Volart (2007) ask how well growth in India has been related to alleviation of poverty, measured at nearly $1.25 a day, using data from 1958–2000, which would include nine years of reform. They find that India’s 1 per cent of growth reduces poverty by 0.65 per cent. Variations across states are large and not always correlated with growth; thus Gujarat, a state with high rate of growth, achieves an elasticity of –0.66, equalling that of Orissa, a state with very low rate of growth. Maharashtra, a high-growth state, has an elasticity of –0.40. Given the state differences and that some of the larger and poorer states have lower elasticity, assume an elasticity of roughly –0.5. Then, a 5 per cent growth rate from 2012 would reduce $1.25 poverty to 15 per cent in 14 years, by the year 2026. Kerala, a higher-performing state, has the highest elasticity in reducing poverty at –1.23; it has also been associated with adopting anti-poverty measures and having a per capita income level higher than the Indian average. The equivalent of Kerala’s elasticity level would wipe out $1.25 poverty in India a few years before 2026. Besley et al. (2007) indicate six factors that policies have emphasized to reduce poverty: voice and accountability, including political contestation; access to finance; concerns regarding gender; human capital formation; property rights; and a pro-investment climate. Although the data for this study are a bit dated, this study is not mentioned in ITD; instead, without any statistical data, B & P write: ‘There is a strong negative correlation between per-capita incomes of states and their poverty ratios’ (p. 30).

Thus, growth likely needs be accompanied by certain factors in order to be effective in poverty reduction. The method here is independent of the actual growth rate. The method calculates how growth side by side has reduced poverty; that path to poverty reduction could be through high rates of absorption of labour into the productive sectors or may be through redistributive measures. If poverty reduction occurs through mostly employment absorption and higher wages, we may say the growth process in the economy has been inclusive. It could well be that both redistribution measures as well as high absorption of labour into the most productive sectors are needed. Evidence from East Asia implies that improved health and higher achievement in education and transition of labour were the primary factors in achieving equitable and significant growth (Young, 1995). Kerala’s achievement from 1958 to 2000 may or may not have followed this path; but it is important that Kerala’s achievement is more fully examined, as done later.

Given the unpopularity of redistributive measures in societies where diversity is as large as that of India (see Alesina, Baqir & Easterly, 1999), a growth process that lifted people out of poverty without redistribution may well be highly desirable.
In ITD, the claim seems to be that the growth has been inclusive already. On page 30, B & P write without any statistics: ‘rising incomes in the fast-growing sectors have led to expenditures that lead to gainful employment in the non-traded service sectors’. To what extent this sector has lifted people out of poverty and towards a near $2.50 per day income is not given. It is clear that 60 per cent of the population lives below $2.50 and a large sector of the economy occupies a very small portion of the economy. The claim by B & P does not seem convincing even with a cursory glance at the data; growth in the agricultural sector is a clear indication that growth has not been sufficiently inclusive.

As Alesina and Rodrik (1994) and Hirschman and Rothschild (1973) have pointed out, inequalities may affect future growth. Whatever may have happened in India in terms of economic inequality, over half of India’s population is likely to lead a life that is far from being above the absolute poverty level. If growth is unbalanced to the point of creating a large group of people being left behind, there may be extreme pressures to redistribute. Demands for redistribution would retard future growth through imposing distortionary and confiscatory taxes or even violence. Thus, it is important to examine the inclusiveness of India’s growth patterns thoroughly; ITD does not address the complexity of this issue.

**Health and Health System**

It is within the mainstream economics debate as to whether health contributes to income; thus, chapter 16 in ITD is devoted to health care. Although macroeconomic evidence seems to be mixed (see Aghion, Howitt & Murtin, 2010; Bhargava, Jamison, Lau & Murray, 2001), evidence on health contributing to personal income is established (see Behrman and Rosenzweig, 2004, on returns to birthweight; and Conti, Heckman & Urzua, 2010, on pre-school health and later education) and well accepted by economists (see Conti et al., 2010; Currie, 2009; Cutler & Lleras-Muney, 2010). Even if one sees health purely in instrumental terms, it should be a priority for a government in the presence of widespread nutritional deprivation or of high infant or child mortality rates since health and nutritional deprivation during childhood affects human capital later on. Currently, the Indian government spends about 1 per cent of GDP on health (World Health Organization [WHO], 2012a). This figure and the total health expenditure of 4.16 per cent in 2012 are rather low by any standard (WHO, 2012a), except when compared to other South Asian countries. Thus, calling for higher expenditure on health through higher government spending can well be a policy directive; yet, this may not be necessary given the level of health achieved in Sri Lanka. On the other hand, it is also true that the absolute level of expenditure should play a role. Thus, given that Sri Lanka has a GDP per capita twice the size of India, perhaps India needs to raise its health spending as percentage of its GDP to raise per capita spending in real terms, and some of it can be achieved through greater government
spending targeted for the poor. In this section, we examine ITD’s views on health and health systems.

Health

In debunking myth 5.1, B & P endorse the view that India’s health achievements do not show any sign of lagging behind in comparison to other poor countries. The diagrams on page 72, of course, include many African countries which have been afflicted by HIV/AIDS and have greater income inequalities than India; for example, take South Africa, which is afflicted by both. Botswana is affected by HIV/AIDS and had a life expectancy of 52 years, while having an income of $8,500 in 2010. Many other African countries are much poor than India. Leaving aside all African countries, it is clear from international data that India has one of the poorest health records for countries with a per capita GDP of around $1,000.00 and even some with lower levels of income per capita: Nicaragua ($1,754; 74 years), Bangladesh ($747; 69 years) and Vietnam ($1,576; 74 years) outperform India ($1,489; 65 years). For the last few years, India outperformed Vietnam in terms of PPP per capita income and was slightly below that of Nicaraguan income (World Bank, 2013).

Health achievements in Bangladesh are often compared to those of India because it has made important strides in health despite its low income. For example, the infant mortality rate (IMR) and life expectancy are better than those found in India. B & P assert that, once stillbirths are taken into account, child health, and subsequently health in general, may be worse in Bangladesh when compared to that in India. Indian IMR and stillbirth reported in 2009 by B & P are 50 and 22 per 1,000 respectively; the corresponding numbers for Bangladesh are 41 and 36. Supposing the counterfactual that all stillbirth would be IMR, the IMR would be 72 for India and for Bangladesh, it would be 77. How would Bangladesh’s life expectancy of 70 years, as reported in 2009, change in comparison to that of the corresponding number for India, 65 years? Most likely, the change would be very little. ITD compares the accomplishment of West Bengal with that of Bangladesh. It is likely that Bangladesh, a poorer county with 65 per cent of Indian per capita GDP, should not be compared to West Bengal, a richer state. If the myth that B & P want to eliminate is that income does not matter for health, they should have offered a different state for comparison. The pair-wise comparison between GDP per capita and IMR for Bangladesh and West Bengal, respectively, is the following: $684, 39 and $930, 31 for years around 2010. However, Bangladesh performs quite well in comparison to Odisha ($803, 61) and Madhya Pradesh ($630, 62), even if we cannot dismiss the stillbirth numbers as IMR. West Bengal in India is a better-performing state in terms of income and tackling poverty, with a growth to poverty reduction elasticity of –1.17. One can compare IMR of 44 in Gujarat, a richer state with more than 50 per cent of West Bengal
income and an elasticity of $-0.66$. Thus, within India, income cannot be associated with better health indicators.

B & P write, ‘in comparing Bangladesh and India, we must also take into account history’ (p. 74). This argument appears elsewhere in the book as well, as the focus is on changes rather than levels. They summarily dismiss the fact that Bangladesh suffered greatly from the war in 1971; thus, the fact that, at the time of independence, Bangladesh lacked institutions to serve its population is dismissed as irrelevant.

For many human development indicators, B & P report changes for a fixed duration and not a fixed time period, for example, changes in life expectancy over 30 years with the time period being different for different regions. ITD points out that the difference in Kerala and Gujarat, for example, should be seen from some starting point. Aside from the reference points which are discussed later, simple changes without taking account of the initial value may not be appropriate for two reasons: (a) not many human beings live past 75 years or so of age; and (b) the IMR, a main factor, would be harder to reduce from a low initial level since the gradient flattens out as the IMR declines. Kerala had achieved IMR of about 24 by 1988, a figure achieved only by Tamil Nadu among the other states by 2010 (United Nations Children’s Fund [UNICEF], 2012). In 22 years, Kerala has seen an additional decline in IMR of only 11; and from 2003–2008, it saw a rise in IMR, perhaps due to the presence of poor primary health infrastructure during this period (Powell-Jackson, Acharya & Mills, 2013). Mozambique achieved a reduction of IMR from 82 to 72 in the period from 2006–2011, while Nicaragua moved from 25 to 22 in this period with GDP per capita comparable to that of India. From 1983 to 2008, among those states that had a higher IMR than 100/1,000, the fall in IMR was significant in Gujarat (50), Uttar Pradesh (66), Madhya Pradesh (67), and Odisha (68). The outstanding achiever is Odisha, a state that did not perform well economically during this period. Examining these changes, we cannot substantiate the claim that economic growth induced higher improvement in child health. The IMR can change rapidly most likely due to deliberate policy interventions; this argument is reinforced later in this article.

In ITD, some lengthy remarks are made that stunting (defined as height for age, and then measured against the median of an international reference group to indicate a level of malnutrition in a population) in India is due to genetic factors (p. 82). Coffey, Deaton, Dreze, Spears & Tarozzi (2013) note that environmental factors outside the home may play a strong role in inducing stunting. One of the environmental factors they emphasize on is density of open defecation. Jayachandran and Pande (2013) examine stunting across birth order. They find that stunting rate at first birth is lower for India than it is for Africa. However, for later birth order, this relation reverses; thus, there are variations in stunting within households that relate to a child’s birth order. These authors note that consumption declines for successive pregnancies and are concentrated among women. Further, the consumption input is related to whether or not the

first born was a son; the decline for higher birth order is more significant if the first born is a son.

Within South Asia, India has made less progress in health than nearly all other major countries since 1985; Bangladesh has made the biggest stride among those having a large number of stunted children in 1985, dropping from 70 per cent to 43.2 per cent. Nepal shows a similar drop. India surpasses these countries economically. Would we have to consider that there may be genetic differences across South Asia? Examining the Sri Lankan level for stunting around 2010, we find a figure of 19 compared to that of Thailand at 15; both have been middle-income countries for some time with Thailand having a $1,500.00 higher income. Given Kerala’s income level, it compares well with a figure of 25 with Sri Lanka and Thailand. Vietnam, with a comparable economy to that of India’s, and of course Kerala, has a stunting rate of 30 (WHO, 2012b). That Senegal performs well, as indicated in ITD, may be a puzzle given what we find in Thailand and Sri Lanka; it is this puzzle that should be addressed in the literature.

The puzzle of African and Indian stunting rate is likely to be not that the data are misleading, for India at least—the claim in ITD, but a combination of factors: the stronger children survive in Africa; the command of resources within Indian households does not reside with women who would feed children better or feed themselves better during pregnancies; command of food resources by the entire household may be poor; outright discrimination of female children is highly prevalent; and factors related to the disease environment may lower even the health of the children of the richer income earners. The literature has clearly established that childhood health has enormous consequences in later years (see Conti et al., 2010; Loury, 1981). It is dangerous to dismiss, without much research, that stunting as a problem does not need rectification. Unfortunately, B & P emphatically take this stance.

Health System

It may well be that spending 4.16 per cent of GDP on health would achieve some much-needed improvement in health. Most likely, Tamil Nadu spends the same amount of public expenditure at the average figure for India and spends less on private care. It has achieved better health than most of India (Das Gupta, Shukla, Somanathan & Datta, 2010). ITD asserts that evidence from Tamil Nadu is not compelling that it provides the right path but does not state why (p. 218). Recent trends show that there is increasing private expenditure in Kerala with somewhat deteriorating outcomes, at least in terms of IMR showing a rise of 2.4/1,000 between 2003–2008 (UNICEF, 2012). Does private service offer better health for the poor? Currently, the evidence clearly shows that poor people do not get proper care no matter from whom they seek care (Das & Hammer, 2007). The private sector for the poor is a mishmash of unqualified quacks, formerly active public medical professionals and non-modern medicine (Kanjilal et al., 2007).
Large-scale private care, as the mix exists today, especially for outpatient care, is most likely to prove too unwieldy for proper regulation.

A standard argument given for involvement of the public sector in health care centres on asymmetry of information which gives rise to the possibility that medical professionals can provide unnecessary and expensive care due to the fact that the patient knows less about health than the provider. ITD dismisses this argument with some equivocation and endorses wholly the view that even if this were true, the Government of India will not be able to offer high-quality routine care (p. 220). The view B & P support is not uncommon in the literature. There is also the common view that, most likely, without a great deal of reform of the private sector, the poor will be served by quacks (practitioners without much qualifications) at best. Patient satisfaction with health service is most likely not an important criterion for good health as it appears in ITD. Yet, this view is endorsed wholeheartedly in ITD. Provider-induced care can be common and quality of care should be detailed through examining whether care met some checklists (see Gawande, 2009, for a concise well-written account). The incentive structure in the private sector, in general, is based on satisfying patients’ expectations, which may not coincide with proper medical care; there is always an incentive to get the patient to come back for more care.

If the private sector is to deliver routine care, then, most likely, regulatory bodies have to be highly skilled and efficient. It is not clear if establishing the proper regulatory framework is possible in India from the outset. The poor will be served mostly by quacks in the absence of a working public system or a well-regulated private system. It is likely that outpatient care will be harder to regulate. Considerable research effort needs to be put in place in order to examine the possibility of learning and duplicating from Sri Lanka, Thailand, Mexico or Brazil, where the poor do not turn to unqualified medical providers. Whether or not the experience of countries such as Malawi, where medical officers trained at a lower level than nurses provide the bulk of routine care, is replicable in India should also be explored. ITD’s suggestion about cash transfers to families to finance routine care would only work in the presence of qualified caregivers in the private sector. It is far from certain that the caregivers that the poor approach with the use of cash transfers would be qualified unless the amount is substantial. Turning to the public sector is unlikely to be a solution when the public sector personnel have parallel private practices. Thus, preponderance of the private sector may severely hinder the poor from accessing proper health care in India. Further, India’s health system at the routine level sometimes reflects India’s deepest prejudices centred on caste and hierarchy, where discrimination against the poor and minorities is extremely strong. In fieldwork in 2007, I noted that high caste medical providers in the public sector in Delhi routinely refused care because the poor were suspected of being lower caste. Such entrenched problems are unlikely to be solved through simple cash transfers.

B & P endorse the insurance scheme known as the Rashtriya Swasthya Bima Yojana (RSBY) which issues a government insurance card to a family identified
as being poor, mainly through below the poverty line (BPL) identification scheme. Insurance schemes can make use of a plurality of caregivers; they are likely to be highly applicable in the Indian formal medical sector as both supposedly public and the private sectors are extremely market oriented. Yet, it is unlikely that given the shortage of human resources in India’s systems of medical care, which the authors recognize perceptively, RSBY will be wholly successful without a proper functioning outpatient system. As long as the outpatient sector will have to be paid for, the poor may seek hospital care unnecessarily or wait until problems get worse. The nature of the public–private partnership on which RSBY is based on is yet to be systematically studied. There have been few rigorous studies of the impact of RSBY; evaluations have been flawed and the results, in general, are mixed regarding the impact of insurance schemes for the poor in developing countries (see Acharya, Vellakkal, Taylor, Masset, Satija, Burke et al., 2013). A recent study (Fan, Karan & Mahal, 2012) provides mixed evidence for a scheme in Andhra Pradesh that is a more intensive version of RSBY. Aarogyasri health insurance scheme has not been instrumental in reducing impoverishment from incurring costs due to ill health, with the Schedule Caste and tribe groups benefitting less. We cannot claim that health insurance does or does not work yet (Fan et al., 2012). A great deal of empirical studies is needed; and the optimism expressed in ITD has no convincing empirical foundation.

B & P may well be correct in implying that health care expenditure does not need to increase in order for India to witness significant gains in health; future research will verify such conclusions. However, currently, India underperforms when health indicators are compared across South Asian countries—excepting, under some circumstances, Pakistan—which all have nearly the same proportions of GDP per capita being spent on health. A dramatic example underscores how the public health system has operated in India during some part of the reform period: in 1995, India had immunized 70 per cent of the eligible children against measles and by 2006, the number fell to 55 per cent, while other South Asian countries made strides by 6–35 per cent, with the absolute level standing above 80 per cent. The National Rural Health Mission was implemented in 2005 to rectify such problems; I am not aware of any rigorous impact evaluation of this programme.

**Kerala Model?**

If one is to comment at all about health policy in India, Kerala’s achievements should not go unmentioned. ITD uses the term ‘Kerala model’ with some agnosticism to state that whatever the Kerala model really is, it is not applicable to any other state. It is hard to believe that there is a Kerala model in the new millennium, whatever there may or may not have been before 2000. As mentioned earlier, Kerala experienced a rise in IMR during the period 2003–2008, the only state in India to have done so, while Tamil Nadu had the largest fall in IMR of all the
states. As noted in ITD, in 2004–2005, private expenditure on health in Kerala was the highest among all Indian states, while the neighbouring state of Tamil Nadu had a lower per capita private expenditure than the Indian average. Among southern states, Kerala had the weakest primary health centre infrastructure as per the data from District Level Household and Facility Survey in 2007–2008 (Powell-Jackson et al., 2013). If there was a Kerala model in health, it had, indeed, disappeared by 2008 with worsening health and rather high levels of private health expenditure.

Assertion of an existence of Kerala model may be less mythical before 2000. ITD perhaps is too quick to dismiss such a model. ITD notes that Kerala took longer to accomplish a change in literacy over a designated 30-year period which differs for two different states and that of India. The designated period for Kerala is 30 years before that of Gujarat, one of the states in the comparison and nearly always richer than Kerala and that also has experienced better growth. Thus, what Kerala achieved within 1951–1981 is being compared to what Gujarat achieved within 1981–2011. Nowhere would we find an assertion that income would play no role in achieving better health and education. Setting aside the comparison, ITD notes that Kerala’s achievement is either insignificant in the post-independence period or that income was solely the factor in Kerala’s achievement as Kerala ranked consistently among the top five richest states from the year 1980–1981, the year from which consistent data are available. The debate regarding Kerala’s achievements in human development is of utmost importance. One should caution that this can be resolved in the 11 pages devoted to it in ITD. It is worth examining some of the arguments made in ITD.

Most of Kerala’s achievements took place between 1961–1981, after the Communist Party had came to power in 1957, which may have been achieved by being able to manipulate ‘regional patriotism of all Kerala’ (Harrison, quoted in Singh, 2010). We note the data available from Singh (2010). Kerala did start at higher initial levels for many human development indicators at the time of independence and moved in parallel with changes observed in India from 1951 to 1961. The gradient for this period is flat for many human developmental factors; but the 30-year period from 1961 to 1991 saw significant improvements. ITD, taking 1951 to 1981, shows smaller changes. The levels achieved in Kerala by 1991 are yet to be matched by any other Indian state. Progress, however, slowed down after 1991 (Singh, 2010). From 1971 to 1981, the progress was rather rapid.

In ITD, a claim is made that Kerala was clearly ahead of India during the pre-independence period on all indicators; and this came about due to globalization even dating back to the Roman times and, to a lesser extent, to the interventions of the princely state. However, other writings indicate that the absolute value of well-being indicators was low in 1947, and not much better than that of India; life expectancy was only 2 years higher for Kerala male than for the rest of India (Ramachandran, quoted in Singh, 2010). Most likely, the spread between India and Kerala became much wider after the Communist Party came to power and
much of the gains were achieved by 1991. Although Kerala spent higher proportions of GDP than other states for most of the period from 1991 to 2010, as noted in ITD, this expenditure level may have added little to literacy levels, for example. It is likely to have added only about 5 years more to life expectancy. In fact, the social sector has been neglected in the new millennium in Kerala.

Political science scholars such as Heller (1996) and Singh (2010) endorse the view that the dominant factor in being able to maintain higher social expenditure was due to a cohesive subjective sense of belonging present in Kerala. Although there is a lack of documentation of expenditure before the period beginning in 1991 in much of the political science literature, the argument has been that social programmes were put in place due to contested elections between the Congress and the communist parties, where the latter, along with trade unions and students, first embraced regional-inclusive Malayali sub-nationalism (Heller, 1996). The Congress Party was pushed to accept this sub-nationalism which had as its core that there be a united Kerala state ensuring cultural, democratic and collective economic development of the Malayalis. The sub-nationalism may have had roots in opposition to the caste system where the lower castes, trained by Christian missionaries to read and write, were able to contest Brahmanical hegemony. Motivated by ties of solidarity, the Kerala population has been highly political and tended to act collectively on a range of issues, including monitoring of the functioning of schools and health centres. The evidence up to 1999 suggests that staff in public health facilities were regularly at work and Kerala had one of the lowest rates of teacher absenteeism in the country (Mehrotra, 2006). It would be hard to believe that public expenditure and finance did not play a role in ensuring that these facilities operated properly. As noted earlier, up to late 1990s, the elasticity of reduction in poverty due to growth was the highest for Kerala at −1.23; it is nearly twice the Indian average of −0.65. Of course, Kerala is not among the poorest states. However, as other richer states did not achieve nearly the same level of human development, there may well be a Kerala model that needs examination. Achievements in Punjab, Gujarat and Haryana are clearly worse, although all these states have higher incomes. Perhaps rigorous research into how the elasticity of −1.23 was achieved would serve to establish what the Kerala model is.

Conclusions

In this section, we examine nature of some of the arguments made in ITD. The nature of the arguments, I believe, advocates wrongly simple solutions where facts are complex. None of the issues mentioned in this article can be solved: (a) by claiming that they do not exist; (b) with reference to a panacea of greater private sector involvement or increasing private sector role through abandoning government programmes in favour of transfers made to the targeted poor; or (c) exclusion of the private sector in providing services. It must be emphatically
claimed, as it has been clear in the popular media, that nowhere does ITD claim that redistribution is not necessary. The book is emphatic in endorsing cash transfers that utilize private markets in health, education and nutrition. These may well be the proper solutions for India. However, the focus here is on the methods of the debates made in ITD.

In many instances, the authors seem to endorse the view that India is on the correct path in terms of human development; and the state should focus on growth while withdrawing from direct focus on social programmes and rely on the private sector to enhance health and educational achievements. The correct methodology to assess India’s achievement is shown through changes made in India rather than the levels at which India is at. In ITD, these changes are not observed over a particular fixed time period, even for the same indicator. The problem of selective years has already been highlighted. For example, it is likely that changes from 1961–1991 are relevant for Kerala and not 1951–1981 as the authors use when comparing with the achievements of Gujarat from 1981 to 2011. The periods chosen should be so that each comparator shows the largest change for the corresponding equivalent number of years. It could be that the period chosen is based on some other reason prevalent in the literature. If this is so, it is not apparent in ITD.

When comparing Bangladesh with India, no clear reference period is given. There is also the issue of selection of states and regions to support the arguments made in ITD. For example, two states are chosen to compare Gujarat’s achievement. It is noted by B & P that Gujarat achieved a fall of 96/1,000 in IMR from 1971 to 2009 (p. 97). Gujarat, of course, leads in this category in comparison to the two other states chosen: Kerala and Maharashtra. If Kerala had achieved the same level of change, then Kerala would have IMR of minus 40/1,000 in 2009. Kerala achieved an IMR of 14/1,000, while Gujarat’s number was 44/1,000 by 2010. Take another change: Nepal, a poor country with IMR of 94/1,000 compared to Gujarat’s 74/1,000 in 1991, reduced its IMR to a level of 39/1,000 by 2011. The fast-growing Gujarat has thus not been able to achieve much in comparison to poor Nepal. It is likely that regarding IMR, changes do not reflect what can be done. Careful comparisons of levels across many countries are likely to help reveal policy priorities. Perhaps the rate of change over the years matters, especially when IMR is not below a level of 15 or so; there India has done dismally. China, since 1990, has reduced IMR by 4 per cent yearly, while India has reduced it by 2.9 per cent per year. India’s performance does not also match that of Nepal’s.

If India indeed is performing poorly in health as most indicators seem to suggest and growth is likely to not have made much of an impact on health, then the future of India’s growth rate that can absorb its vast population into higher wage employment must be in doubt. Healthy and intelligent workers are needed for higher wages. This is and should be a serious concern. Those who have examined educational issues in India may come to the same conclusion regarding India’s educational achievements.3 Centrality of modern growth theory now rests on
technological progress, human capital and equity with a great deal of emphasis on how to break poverty traps for the poor. The issues in development economics have merged both the literature from macroeconomics of returns to labour and investment and microeconomics of programme development serving the poorest population. These types of literature get scant attention in the book, especially on the numerous occasions the authors endorse cash transfers.

Health insurance and cash transfers seem to be the main instruments in ITD to fight poverty. Take school vouchers, for example. They are ruled out in ITD due to gaming between the parents and teacher where the parent may turn in a voucher getting half the value and the remaining half to be collected by a school (p. 187) while no education is provided to the child. We are not given any evidence that this happens. The same argument is used for conditional cash transfer; seeking health care, say, is part of the condition on which a transfer is received. Certification of use of health can be purchased for a minimal price (p. 221). Both cash transfers and conditional cash transfers are ruled out. Instead, simple cash transfers are preferred. If recipients are bent on not spending the money on school through vouchers or receiving a transfer conditioned upon health, then why should any unconditional transfer be spent either on health or education? If transfers are to work through the senior-most female member of the household receiving this amount, then why should conditional payment not work through these women? It may well be easier for other members of the households to take the money from the female member and spend it on tobacco, alcohol or gambling than arranging for illegal activities involving defrauding the government with selling of vouchers or buying certification where other offending parties are also present. Most likely, it is the case that we do not know which or any of these would prevail. In Latin America where public sector in health and education are stronger than they are in India and women may occupy stronger positions in households, conditional cash transfers seem to have worked (Skoufias & McClafferty, 2001). Without experimenting as to which programmes might work at the ground level, pronouncements made in ITD are unwarranted. In Latin America, rigorous impact evaluations have been conducted on these programmes before they were scaled up to the national level.

In ITD, only one study is mentioned as empirical evidence for cash transfers, but macro assessments of the employment programme, National Rural Employment Guarantee Act (NREGA), is offered. The evidence from three states where most programmes often fail is offered; and from Odisha, three of the poorest districts are included as places where NREGA has failed. Rather than presenting selective evidence, it would seem that avenues for collection of better data should be strongly encouraged. The authors seem to make too many conclusions without much reservation even when they cannot cite empirical studies that are conclusive one way or the other. The emerging field of impact evaluation does not get prominence in any of the pages of this book. Yet, it is only through this type of rigorous research that we will know what can work. Policymakers in India will have failed
their constituency if they take this book as the last word on any of the subjects the book covers. Instead, policymakers should initiate fact-finding missions for nearly all the subjects covered as the issues raised in this book are of extreme importance, although there are also important omissions, for example, fuel subsidy, gender policy and India’s current account deficit. The book is extremely valuable; interested readers and policymakers merely need to be sceptical of all the arguments presented in the book and the turn to paths where more information can be discovered.

The discoveries need to be made are many. A great deal of research needs to be carried out as to how most Indians can achieve better health, education and escape the poverty trap. The book’s argument leads one to make a long list of issues that should be studied in detail. India will need great many serious social science studies in years to come in order to solve many of its problems. The burden of lack of evidence weighs heavily; this is the only conclusive remark that can be made towards policy recommendation at this stage.

Notes
1. The myth 5.1 also includes education.
2. The ratio of total wealth of all Indian billionaires to GDP rose from 1 per cent in 1991 to 10 per cent of GDP in 2012 (Gandhi & Walton, 2012). Even without the follow-up study to Banerjee and Picketty, one suspects that the income of top 1 per cent occupies a higher percentage. One should note that B & P deride, somewhat frivolously, the notion that Indian billionaires may occupy large share of country’s wealth or have done so in unproductive ways. Gandhi and Walton note that substantial part of the billionaires wealth may have come from real estate, construction, infrastructure or ports sectors, media, cement and mining.
3. As noted by Panagariya elsewhere, correct investment climate is needed to absorb the educated and able workforce.

References
Arnab Acharya


