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Part 1

Growth, Employment and Inclusion

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Capability-centred Approach to Inclusive Growth

Theoretical Framework and Empirical Reality¹

A basic premise of the capability approach is that focusing development analysis and policy mainly on increasing income and material wealth is misguided. Although almost every person would want to enjoy a higher income, one's state of well-being is determined also by policies that expand one's capabilities, which in turn affect one's income and functioning. There is an interactive relationship (synergy) between income growth and the expansion of capabilities. Our model of synergy leads to a set of recommendations which explicitly integrate economic and social policies, and which are associated in the economics literature with different heterodox approaches (Post-Keynesian, Evolutionary, Structuralism and Transformational Growth).²

Mainstream economics is insufficient as a heuristic device to allow us to understand the main intricacies and complexities concerning the outcomes of development strategy. Mainstream economics, with its theoretical foundations in utilitarianism (see Sen, 1985; Nussbaum, 2001) and its limited success so far in unbundling the family or examining and interrogating intra-household allocation of resources, has been the basis for both macro-economic and social policies. Moreover, mainstream economics has been at the core of much of public policies since the 1980s, with extremely mixed results, as the experience of Latin American and Sub-Saharan developing economies demonstrates. Most

- 1 This chapter's theoretical framework is essentially based upon the theoretical framework (which in turn is based on the work of Amartya Sen) developed for the author's earlier book, *Eliminating Human Poverty: Macro-economic and Social Policies for Equitable Growth* ([2007] 2008) with the Argentinian American economist Enrique Delamonica. The empirical analysis of India is drawn partly upon the chapter on poverty reduction in the 11th Plan (the work for which the author led in the Planning Commission, as head of the Rural Development Division in the Commission), and partly upon the India Human Development Report, 2011 that the author led (IAMR, 2011).
- 2 See Taylor (1983); Nelson and Winter (1983); Nell (1992).

Asian economies performed very differently over this same period, as they adopted policies not consistent with mainstream economics, or prescriptions emanating from their adherents (Rodrik, 2002). Therefore, there is a need for an alternative framework for development, one founded on human development and the capability approach.

The work of Amartya Sen, Martha Nussbaum and others on human capability (Sen, [1985] 1995; Nussbaum, 2001) resulted in the gradual emergence of a human development paradigm – partly manifested in the Human Development Reports. In fact, ‘human development’ became an overly popular term after 1990 – popular even with the international financial institutions, which reorganised departments and then named some of them Human Development networks. However, the consensus within which the term ‘human development’ was used remained founded in neo-classical economics, and the macro-economic policies that emerged remained bound within it.³

An alternative framework for policies is necessary, as the theoretical basis of the consensus (i.e., neo-classical economics) was weak (Sen, 1982; Amsden, 1989; Nell, 1998), and as the philosophical foundation of the theory on which it is based was even weaker (see Sen, 1985). The rest of this chapter is devoted to spelling out that alternative framework. In terms of this alternative theoretical framework, it also examines the dimensions on which India’s development strategy has been failing on the count of inclusiveness.⁴

In this alternative framework, we posit that two kinds of synergies exist. One exists between interventions in health, nutrition, family planning, water and sanitation, and basic education. The other is between interventions that are the basis of income growth, the reduction of income-poverty, and improved health and educational status. The first synergy is actually a sub-set of the second. With these two synergies as foundations, we propose an alternative approach to integrate economic and social policies. As a theoretical construct, the notion of dual synergies is a conceptual framework for understanding a given situation in

3 Such policies became known as the Washington Consensus (Williamson, 1990). The post-Washington Consensus that emerged in the wake of Stiglitz’s critique of IMF–World Bank policies is, we believe, only a partial alternative framework for development policy. For a discussion, see Standing (2001), Fine et al., (2001) and Mehrotra and Delamonica (2007) for a critique of the post-Washington Consensus.

4 For a recognition of this failing, see Ahluwalia (2011) and the Approach Paper to the 12th Plan (www.planningcommission.nic.in).

terms of human development outcomes (as we shall see below for India);⁵ it is, at the same time, a framework for drawing policy implications.⁶

In any economic analysis, it is important to distinguish the means from the ends. We suggest that the state has a critical role to play in ensuring all three desirable *ends* or outcomes for its citizens: economic growth, income-poverty reduction, and improved health and education outcomes. The *means* for achieving these ends – the policies – have not been discussed in this chapter for reasons of space, but the rest of the book is very much devoted to this very subject in the context of India.

Section 1.1 spells out the conceptual framework. Its two sub-sections develop each of the two synergies mentioned above. Section 1.2 deals with the failures of government policy in the case of India, which contributed to the dual synergies not being realised. Section 1.3 then spells out the theoretical contribution of this dual synergy framework.

1.1 The Conceptual Framework of Dual Synergies in the Development Process

The mainstream view of development posits that if economic growth is maximised, poverty will be reduced and increases in welfare will ensue (in a more or less automatic fashion). Thus, much policymaking globally (including in India) occurs under a leader/follower hierarchy model, where macro-economic policy is determined first, while social policy is derivative and left to address the social consequences (Atkinson, 1999). This separation of the ‘economic’ from the ‘social’ discourse is inherent to even the post-Washington consensus, and certainly to the neo-classical theory which underpinned its predecessor.

In this section, we sketch a different theoretical perspective while we take an explicitly normative stance.⁷ The capabilities approach has placed human

5 For instance, see Taylor et al. (1997) and Mehrotra and Delamonica (2007) for applications of the framework to developing countries in general.

6 Women’s well-being and their agency is one of the cornerstones of our alternative framework and hence of policy. They are central to both synergies that constitute this alternative theoretical framework. However, we do not develop this aspect very explicitly here, although we will do so in Chapter 8. In addition, see Mehrotra (2013) in Comim and Nussbaum (2013).

7 See Myrdal (1959) and Sen (1988), *inter alia*, for the case that economics cannot be value-free.

beings and their well-being at the centre of its concerns – not only their well-being, but their freedom to choose a life one has reason to value. Thus, Sen has argued that for many evaluative purposes, the appropriate ‘space’ is not that of utilities (as claimed by welfare economists,⁸) but that of substantive freedoms and capabilities.

At the theoretical level, there have been many other critiques of the simplistic neo-classical view of human behaviour. At the normative level, it has resulted in over-reliance on the principle of Pareto optimality, which severely hinders any redistributive attempt. Sen, in various writings (for example, Sen, 1985), has shown some of the contradictions of this approach. For instance, a rich person may obtain very little utility from having several houses and many cars, while a poor person (without either) may be content with a small hut and a bicycle, leading to the conclusion that redistribution from the former to the latter would increase aggregate utility. The attempt to solve these paradoxes by stressing that fairness should be analysed at the level of commodities, however, also leads to some dead ends.⁹ Actually, people need different goods and services, and more or less of them, for example, if they are sick or they live in different climates. Thus, Sen argues for a ‘middle space’ between commodities and utilities, which he calls ‘capabilities’.

As income or commodities are not enough for human satisfaction (an increase in capabilities), different lenses are needed to understand the interaction of economic and social objectives. Consequently, a different strategy from the one consciously or unconsciously followed by most developing countries is needed.¹⁰ The starting point is the well-known synergy, or feedback loop, among social interventions in basic healthcare, reproductive healthcare, education, nutrition

8 As Nussbaum (2001, 122) says: ‘We have to grapple with the sad fact that contemporary economics has not yet put itself onto the map of conceptually respectable theories of human action.’

9 For elaborations and criticisms of this view, see Sen (1985), and the sources cited therein. Taylor (1983) and Uvin (2002) also present interesting criticisms and limitations of Sen’s approach.

10 We say ‘most’ and not ‘all’ developing countries because some – the positive deviants – of them (those called ‘high-achievers’) have succeeded in developing education and health standards comparable to those of industrialised countries, despite having a fraction (sometimes just a tenth) of their level of income (Mehrotra and Jolly, 1997). Needless to say, they implemented policies and strategies without reference to the synergies we described ex-post, and they represent an interesting case of what Lindblom (1959) calls ‘muddle-through’.

and water and sanitation. This synergy (which we call synergy 1) takes place at a micro-economic level – at the level of an individual.¹¹

1.1.1 The synergy among social services

Interventions in health, nutrition, water and sanitation, fertility control, education and income complement each other and positively affect the life of an individual. This increases the impact of any one from investments in any other (see Figure 1.1).

Figure 1.1: The first synergy between social service inputs and outputs

| Social services inputs/ processes | Human development outcomes/outputs | | | | |
|-----------------------------------|------------------------------------|-------------|---------------|--------------------|---------------------------|
| | Knowledge | Family size | Health status | Nutritional status | Healthy living conditions |
| Education | ↙ | ↙ | ↙ | ↙ | ↙ |
| Family planning | ↙ | ↘ | | | |
| Health | ↙ | ↙ | ↘ | ↙ | ↙ |
| Nutrition | ↙ | ↙ | ↙ | ↘ | |
| Water and sanitation | | | | | ↘ |

Figure 1.1 represents this notion of synergy (although only of synergy 1). Along the horizontal rows, the various social services are represented as inputs or interventions – education, family planning, health, nutrition, and water and sanitation. The vertical columns represent the human development outcomes or outputs – knowledge, family size, health status, nutrition status, and healthy living conditions. The dark-shaded cells show the direct and obvious relationship between inputs and outputs. The light-shaded cells are the ones where there is a relationship – but an indirect one – between a certain intervention and an outcome; for example, the use of contraception (i.e., family planning), by helping the spacing of birth of children, indirectly benefits the health status of both the mother and the child.

11 See Mehrotra and Delamonica (2007) for details on this synergy and earlier precedents in the literature.

The arrows represent feedback effects from human development outcomes to the inputs/processes. For example, the improved health status of a child improves her ability to learn, just as improved nutritional status does. Similarly, a reduced family size improves the chances of a poor family being able to afford education for all the children rather than merely the boy(s) in the family, and so on.

Since the connections presented here are central to our arguments about synergies, a more in-depth review of these connections is needed. First of all, it has to be recognised that all of these relationships are based on evidence discovered several years ago. However, probably in part due to over-specialisation within the disciplines represented on the matrix, they are all too often presented separately. By integrating them, it becomes clear that their separate effects, the ones often reported, are only partial. In fact, the impact of any one form of investment is increased in the presence of the others, proving the advantages of integrated approaches.

Notice that *educational inputs* have an impact on all types of human development outcomes. The positive effects of education are intuitive and well known. First, parents, especially mothers, make better use of information and reproductive healthcare facilities if they are more educated. Thus, more widespread education is associated with lower fertility. Better nutritional and healthcare is provided by educated parents for themselves and their children. Various routes ensure this result. The general knowledge acquired at school increases the understanding of modern health practices and scientific beliefs, which make mothers (and fathers) more open to using healthcare centres. Households with educated mothers spend a higher proportion of their income on food and health services.

In addition, the capacity to acquire new knowledge and change behaviour accordingly is higher among those who attended school, as evidenced by the differential diffusion of HIV/AIDS among educated and uneducated women (Vandemoortele and Delamonica, 2000). As a result, health investments are more efficient in the presence of a more literate population (Caldwell, 1986). In countries where parents have been exposed during their school years to nutrition information, they combine different foods to obtain better nutritional outcomes. Also, such mothers take better care of their nutritional needs during pregnancy, avoiding low birth weight (ACC/SCN, 2000). Basic education also facilitates the rapid adoption of improved hygienic behaviour. This not only improves health outcomes, but also enhances the impact of investments in water and sanitation systems.

In summary, education and in particular girls' education, contributes to enhance the impact of other sectoral interventions. All of these, in turn, result in good nutrition and health, increasing the likelihood that children will attend school and become better students. For instance, with lower fertility, parents can devote more attention to their children's studies and afford more food and school supplies, which improve learning. In addition, access to clean water and safe sanitation (that is, healthy living conditions) helps girls – when girls need less time for household chores like fetching water, they have more opportunities to attend school. Also, they have more time and energy to study and do well in school, avoiding repetition or dropping out.

Family planning, by providing easy access to contraceptive means, enables the mother to space births, thus lowering the health risk to herself and the child, reducing infant and maternal mortality and improving the healthy development of the child. Thus, lower fertility has a positive implication for improving health and increasing life expectancy. Another important complementary outcome of intervention in health, education, water/sanitation and family planning is the rapid demographic transition. As children survive, families voluntarily curtail the number of children. This is not the place to enter the debate on the relative impact of supply of contraceptives versus desired family size in family planning (Bongaarts, 1994; Pritchett, 1994; Cassen, 1994). However, it is clear that lower infant and child mortality plays a major role in reducing fertility rates (Caldwell, 1986), as does education, the availability of information on reproductive healthcare and its accessibility (Cochrane, 1979).

As population growth slows down, school systems find it easier to absorb all children. Teacher-pupil ratios can be reduced (see the evidence in Chapter 9) without unduly burdening budgets, and construction costs can also be reduced, releasing resources for other measures to enhance school quality.

As in the case of the health and nutrition sectors, the availability of information on and access to family planning services will not, on their own, reduce fertility as much as it might be needed or desired. They are more effective when couples are more educated and child survival rates are higher.

It is also very well established that lack of good **nutrition** critically interacts with **health**. For instance, control of diarrhoea and measles is very important not only for health outcomes, but also in reducing malnutrition (by improving the capacity to absorb and retain caloric intake; see the analysis in Chapter 10). By the same token, an insufficient intake of total calories, vitamins and proteins weakens

children's immune systems. This would make them vastly more vulnerable to the onset and consequences of infectious disease. Interventions in health promote good nutrition, and interventions in nutrition promote good health.

Moreover, micronutrient deficiencies and illness can have devastating consequences for the cognitive development of a child. For instance, iron deficiency anaemia reduces cognitive functions, iodine deficiency causes irreversible mental retardation and vitamin A deficiency is the primary cause of blindness among children. Girls are unfairly disadvantaged in many of these cases. They are more likely to suffer from iodine or iron deficiency.

While it is clear that good health and nutrition have benefits that reinforce each other, the above examples also show that they impact positively on fertility control and education. But it is also clear that good health, protection against disease, and proper nourishment cannot be produced by health services or food alone.

Safe water and adequate sanitation also play a fundamental role in determining health conditions. Access to safe water and sanitation dramatically reduces the incidence of diarrhoea and many other diseases that kill millions of children and adults each year. Another effect of better access to water takes place through the reduced effort in carrying water, which is usually unduly borne by women and girls. Given the traditional roles they play in most societies, when women and girls have more time, they can apply it to better infant and childcare. This leads to positive health results. Finally, especially for women, more time is available for pecuniary productive activities. This direct impact of water and sanitation improvements on income-poverty reduction is less well publicised than the effect of higher levels of education and better health on productivity.

The presence of toilets, safe water and hygienic conditions at school can reduce some constraints on sending children, especially girls, to school. Separate toilets for girls are known to be a consideration for parents (Mehrotra et al., 2005). Backed by proper hygienic behaviour, such as hand washing and the use of soap, access to safe water and adequate sanitation reduces morbidity from infectious diseases and increases the nutritional status of children, which furthers their learning abilities.

In summary, each intervention has ramifications which lie outside its 'sector' and add up to a virtuous circle of social and economic development. This is different from the existence of an externality, although they are of course present. Unlike the traditional treatment of externalities, which are usually exceptions, these interactions are pervasive.