स्वस्थ भारत शिक्षित भारत

Group IV

Report on

“EDUCATION AND HEALTH- UNIVERSAL ACCESS AND QUALITY”

09/02/2016
New Delhi

“Good Health is not absence of disease; it is presence of well-being”

-WHO-

“People are the real wealth of nations, and human development is about enlarging human choices-focusing on the richness of human lives”

-HDR 2015-

ACKNOWLEDGEMENT

First of all, we are grateful to Hon'ble Prime Minister for giving us this opportunity of making a valuable contribution to the nation-building in form of preparing a report on what needs to be done for universal access and quality of education and health. The group was touched by the fact that Hon'ble Prime Minister himself made a Power Point Presentation to all of us for his expectations from the groups in so many words.

We take this opportunity to place on record our deepest appreciation to the eminent personalities who provided valuable inputs on the subject. Their contribution, by way of stimulating suggestions, was of immense help in identifying some core problem areas and formulating the Action Plan. We would like to thank the two groups of Joint Secretaries led by rapporteur Sh Arun Kumar Mehta and Sh Shashi Prakash Goyal for their inputs.

Our sincere gratitude to the Cabinet Secretary for his guidance in fine-tuning the presentation to make it focussed and concise.

Last but not least, we the group members would like to thank Secretary, Health and Secretary, School Education for their contribution in making this exercise effective and productive.

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ANM	Auxiliary Nurse Mid-wife
APL	Above Poverty Line
ASHA	Accredited Social Health Activist
AYUSH	Ayurveda, Yoga & Naturopathy, Unani, Siddha, Homeopathy
BRC	Block Resource Coordinator
CRC	Cluster Resource Coordinator
DLHS	District Level Household and Facility Survey
GDP	Gross Domestic Product
HDI	Human Development Index
HDR	Human Development Report
MDMS	Mid-Day Meal Scheme
MMR	Maternal Mortality Rate
NCERT	National Council of Educational Research and Training
PHC	Primary Health Centre
PDS	Public Distribution System
PMJJBY	Pradhan Mantri Jeevan Jyoti Bima Yojana
RMSA	Rashtriya Madhyamik Shiksha Abhiyan
RSOC	Rapid Survey on Children
U5	Under Five
U5MR	Under Five Mortality Rate
UN	United Nations Organisation
WHO	World Health Organisation

Chapter 1

Introduction and Process Followed

1. Group of Secretaries (GoS) was formed in compliance with the directions of the Prime Minister on 31.12.2015 to deliberate on some select important subjects impacting the socio- economic development of the country. Every GoS has also been mandated to formulate a pragmatic roadmap for achieving specific outcomes within a specified timeframe. A rapporteur was designated for each Group to organize meetings and prepare the Report/Presentation. A GoS was formed to deliberate on the subject of Education and Health- Universal Access and Quality with Secretary, Revenue as the Rapporteur. The list of group members is placed at Appendix A.

2. Simultaneously, two Groups of Joint Secretaries (GoJS) were formed on each subject who would work independently and present their Report to the GoS. The list of GoJS is placed at Appendix B.

3. The Group met on 9 occasions to brainstorm on the issues. The presentation by the GoJS was also considered in these discussions. Suggestions were invited from eminent personalities having domain expertise on the subject of education and health like Dr. Abhay Bang (Community Health), Dr Devi Shetty (Chairman and Founder, Narayana Health), Dr. P. Namperumalsamy (Chairman–Emeritus, Arvind Eye Care System), Prof Marmar Mukhopadhyay (Former Director of NIEPA) and Mr. Sridhar Rajagopalan (Educational entrepreneur).

4. After extensive discussions, given the multidimensionality of the subject, the Group decided to focus on some select problems and identify doable action plan within a specific timeframe. Focus has been on the issues that have a wide outreach. While proposing suggestions, intent has been to develop a roadmap comprising feasible policy actions. Given the time constraint, the group decided to focus only on School Education and not cover higher and technical education.

Chapter 2

Where Do We Stand?

1. Health and Education are key drivers of economic development of a country. In fact, these can be viewed as means as well as indicators for economic development. A healthy population lives longer and contributes more to nation's productivity. Education further enhances the productivity of people. Good health and quality education figure as two of the United Nations' Sustainable Development Goals. The role of these cannot be over-emphasized.

2. However, India's performance on both these parameters has not been up to the mark. In the health segment, India's position *vis a vis* select countries is as below:

	HDI Rank Value 2015	**Life Expectancy at Birth 2014 (in Years)**	**Public Exp on Health 2013 (% of GDP)**	**U5MR***	**MMR***
Germany	06	80.9	8.7	4	7
Brazil	75	74.5	4.7	14	69
China	90	75.8	3.1	14	32
S. Africa	116	57.4	4.3	45	140
India	130	68.0	1.2	49	167

* The UN's sustainable development goals for these two items for India is to achieve U5MR of less than 25 and MMR of less than 70 by the year 2030.

2.1. Some other facts on India's health scenario are as follows:-

- The **percentage of institutional delivery** has gone up from 47% in 2007-08 (DLHS 3) to 78.7% in 2013-14 (RSOC). There are 12.7 lakh deaths of under-5 children. Among those, 7.3 lakhs are new born deaths.
- The percentage of **stunted children** below the age of 5 years is 38.7% in 2013 Survey.
- The major **causes of child mortality** in India (as per WHO, 2012) are: Neonatal causes (53%), Pneumonia (15%), Diarrheal diseases (12%), Measles (3%), and others.

3. Similarly, in the field of education some of the vital statistics are as below:

	Govt	**Aided**	**Private**	**Total**
Schools in India (Lakhs)	**11.79**	**1.07**	**2.33**	**15.2**
Teachers in India (Lakhs)	47.78	6.94	22.48	77.2
Enrolment in India (Cr)	13.49	2.3	9.33	25.2
Children per School	114	215	400	166
Student- Teacher Ratio	28:1	33:1	42:1	33:1
Per Child Cost (Rs)-(Elementary)-2014	11,217	NA	NA	NA

- Out of every **100 students in Class-I**, only **64 reach Class-IX** and **54 reach Class IX-XI.**
- There is huge **regional disparity** among the States and also within each State in availability of school infrastructure.
- **Small size of schools** creates problems of not achieving the ideal ratio of one class, one classroom and one teacher.
- **Learning levels** of students in public school are **quite low**, as per the national survey conducted by NCERT as well findings of Annual Survey of Education Reports (ASER) conducted by "Pratham", an NGO working in the field of education.

4. These two areas of Health & Education combined present variety of problems. In this backdrop, and given the terms of reference, the Group has restricted itself to identification of a few select problems and attempted to chalk out some transformational yet doable ideas.

Chapter 3

Health- Issues Identified

1. The Group identified following major issues in the Health sector:

- Persisting public health challenges of anaemia, malnutrition, pneumonia, diarrhea, communicable diseases, etc; and challenges of new life-style non-communicable diseases pose a double burden.
- National Health Profile ("NHP") 2015 shows that despite the declining prevalence, morbidity and mortality of **communicable diseases like diarrohea, respiratory infection, pulmonary tuberculosis** etc., remain a cause of concern.
- Changing lifestyles have contributed to the disease burden in the form of non-communicable diseases like cardiovascular disease, diabetes, cancer etc. **More than 60%** of deaths now are reported due to **non-communicable diseases**.
- NHP 2015 shows that based on available evidence, cardiovascular diseases (24%), chronic respiratory diseases (11%), cancer (6%) and diabetes (2%) are the leading cause of mortality in India.
- About **6.50 crore people** in India have got **Type-II Diabetes**.
- About 10 lakh major deaths have happened due to diabetic complications.
- More than **30% children** up to age six suffer from **mal-nutrition**.
- **70% of the children** below six and 55% of women are **anaemic**.
- **25% of deaths below five year** of age are due to **Diarrhoea and Pneumonia**.
- In respect of out of pocket expenditure on health, **total expenditure (private as well as public) on health** is approximately 3.8 % of GDP in the country. Only **1.2% is by the Government** and the remaining 2.6% i.e. nearly **70% of total health expenditure is by the private sector**. In other words, about 58 % of health expenditure in the country is by way of out of pocket expenditure by the people. **This is really pinching the people now**.

2. In this backdrop, the Group identified following four dimensions of public health challenge in India. These are Doctors, Drugs, Diagnostics and Delivery Mechanism.

2.1 Doctors

(a) As per NHP 2015, ratio of doctor and average population served is as follows:-

Allopathic Doctor	1:1681
AYUSH Doctor	1:1682
Both Allopathic and AYUSH Doctor	1:893
Dental Surgeon	1:8022

(b) Some other facts in this matter are as follows:-

- As against a total of **57,138 medical seats for MBBS**, only **14,500 seats** are available for **Post-Graduation in clinical branches**.
- As per available reports, the current vacancies in Govt. health facilities across India is as follows:
  - ✓ 11.9% of doctors in PHCs (with absenteeism over 50%)
  - ✓ 81.2% of specialists in CHCs
  - ✓ 83.4% Surgeons
  - ✓ 76.3% Obstetrician and Gynaecologists
  - ✓ 83.0% Physicians
  - ✓ 82.1% Pediatricians

(c) As per the existing norms of Medical Council of India (MCI) for 3 PG seats in clinical branches, 30 bed hospital and a Unit of 1- Professor, 1- Associate Professor and 1-Assistant Professor is required. This makes it **one of the most elitist norms** in the world, thereby making the **PG education extremely prohibitive and restrictive**. Further, availability of health personnel, especially in rural areas is a major challenge.

2.2 Drugs

Affordability of drugs and its distribution channel is another aspect in public health care system, particularly in rural areas. As per 71st round of NSSO (2014), **71% of out of pocket expenditure on medical care in case of out-patient care is on drugs alone**. In the absence of quality checks for generic drugs, people prefer to spend more on the branded drugs.

2.3 Diagnostics

Diagnostics, along with drugs, constitute a major part of health expenditure. The present arrangement in Government hospitals for diagnostics suffer from various malaise such as (a) **non-operational machines** (b) **non-availability of technicians** and (c) **non-availability of consumables**. The absence of even preliminary diagnostics facilities of blood and urine testing at the Primary Health Unit level compels people to go to cities for normal requirements also.

2.4 Delivery mechanism

Delivery mechanism of health care in India is predominantly private. The Govt. system – delivery mechanism in most of the States lacks quality and is characterised by hospitals being flooded with patients, while primary health care facilities remain underutilised. According to NSSO 71st Round – 33% of PHCs have OPDs of less than 20 patients per day. **The PHCs have got adequate physical infrastructure, but absence of Doctors and unavailability of drugs are areas which need immediate attention**. The secondary and tertiary public **hospitals in bigger cities, on the other hand, are packed with patients**. In view of this, justice cannot be done to them in terms of quality of treatment. There are also cases of long waiting period for getting diagnostics and surgeries done in such big hospitals.

3. The Group feels that any suggestion for improving public health system in India should take into account the above four factors and measures to make them accessible and affordable to all citizens with special focus on the poor people. The vision should be that universal life and health assurance be provided **to all citizens with defined standards of services and at affordable rates.**

Chapter 3

Health- Proposals

ULHAS

Solving the problem of health sector requires multiple interventions all of which are not possible to be covered in this report. We, therefore, propose in the report, a new scheme called **ULHAS - Universal Life and Health Assurance Scheme (ULHAS)**, a comprehensive public healthcare system encompassing preventive, primary and secondary healthcare. The salient features of ULHAS are as below:

a) It should provide universal coverage to all citizens. For 10 crore deprived families (as per SECC), this scheme should be provided free of cost; for other citizens, it should be open on payment basis;

b) Coverage comprises **life insurance** of Rs 2 Lakhs under PMJJBY and **health coverage of Rs 50,000/- per family**. In addition we suggest **additional insurance of Rs. 30,000 per senior citizen** in the family. PMJJBY contribution in respect of deprived families to be put in their bank accounts directly;

c) Quality standards of services to be provided should be defined and widely publicized;

d) The scheme should be implemented through empanelled private and public health service providers;

e) State level Health Society/Trust to implement directly. In case State Govt does not want to do it through State Level Health Society, it will have an option to implement it through insurance companies;

f) There should be online record of beneficiaries who would be given **cashless service**. There would be facility for **biometric authentication** of beneficiaries with all listed health providers and with State Health Society.

1.1 The finance part of the scheme is as below:

(i) Cost of PMJJBY comes to **around Rs 330** and for **health insurance Rs 670**

per family. For **additional insurance of senior citizen**, **extra Rs.150 per member**;

(ii) Centre-State share would be in ratio of **60:40** ;

(iii) Estimated total cost would be Rs. 10,000 crore (plus about Rs 1000 crore extra for senior citizens) out of which Central share would be Rs. 6,600 crore.

1.2 Steps to be followed for ULHAS:-

- First step is that SECC data of 10 crore families who will be selected for the scheme should be made available on the server which can be accessed by all health providers and State Health Societies.

- Deprived category people who are in this list can get a small Cashless Card from multiple points to be decided by State Health Society. Others who are willing to pay premium of Rs 670 per family, with the option of senior citizen getting extra cover at Rs 150 per person, can pay this amount and get a cashless card. In order to minimize adverse selection, the APL households should be enrolled in groups.

- Health Ministry should **list out various types of secondary treatments and diagnostics facilities** which will be available under ULHAS and also suggest the maximum rate which will be charged for each of the listed items by the health providers.

- Health Ministry should also decide the minimum norms of qualification for **empanelment of private and public hospitals** under the scheme of ULHAS.

- The State Health Societies to invite applications from private and public hospitals who are willing to be empanelled for giving treatment of listed procedures at rates prescribed by State Health Society.

- Persons covered under the Scheme can go in any of the empanelled public or private sector hospital to get his treatment by presenting the Cashless Card, **after being referred by Primary Health Centre unit**.

Prevention

2. An ideal healthcare system should begin with preventive care which should aim at providing clean air, potable drinking water, sanitation and minimum standard of nutrition. Apart from these, the Group has identified following measures which must be taken, and which are achievable in the timelines mentioned below:

- **Fortification** of staple food like rice, wheat, edible oil and milk with Iron, Folic acid and Vitamin A - 3 years
- Vaccination against Diarrhoea and Pneumonia - 75% coverage in 3 years
- Strengthening School Health Programme - 90% in 3 years

2.1 **Fortification** is already being undertaken for wheat flour in some states. It can be extended to other states and other food items also. In the first year, fortification in MDM Scheme can be started with, while extending it to PDS in second year and covering entire population by third year.

2.2 50% reported deaths of diarrhoea are due to **Rota Virus infection** which can be controlled by new **vaccination**, which is now available. Similarly, **Pneumococcal vaccine** could be extremely useful in reducing the number of deaths due to Pneumonia in U5 children category. The two vaccines should be introduced under the Universal Immunization Programme at the earliest.

2.3 About 10 crore children including students out of 25 crores are now being covered for health screening under **Rashtriya Bal Swasthya Karyakram (RBSK)**. **The target of 90% coverage can be achieved in 3 years**. Looking at the large number of children, teachers need to be given special training to identify children who require more detailed screening under RBSK. We may also include in this, screening of all women above 30 years of age and men above 40 years of age. This can be useful in early detection of diseases. Besides, age appropriate health messages/information should be incorporated in the school curricula.

2.4 The National **Health Portal** should become the vehicle for dissemination of knowledge and creating awareness among the people.

2.5 It is imperative that we harness our rich heritage of alternative medicines for well-being and preventive healthcare. It is proposed that **AYUSH be part of all PHCs** and mandated to hold campaigns for healthy lifestyle by promoting Yoga etc. This is likely to have more visible impact on the society.

2.6 **Auto-disable syringes** have been introduced for vaccination. However, for therapeutic use, normal syringes are still being used. The group recommends that safe syringes should be introduced over a period of time.

Solving the problems of shortage of Doctors

3. The main stakeholders who can help us in solving the problem of shortage of Doctors is Medical Council of India. The regulations of MCI have been extremely restrictive in nature. MCI can specifically take the following actions:-

(i) If **one extra PG medical seat** is made available over and above the existing 3/4 seats for one unit of PG staff (Professors), it would immediately make available 5,000 more seats in clinical branches of PG in 2016 alone.

(ii) We have about 7 lakh AYUSH Doctors available in the country. With a six month **Bridge Course for these AYUSH doctors** to enable them to dispense common allopathic medicines, several PHCs can be benefited by the presence of these AYUSH doctors who are in any case at present attached to the PHCs.

(iii) To remove the anomaly of admission to MBBS & PG level, a **Common Entrance Test** should be made compulsory.

(iv) If 30 to 50% **reservation in PG seats** for those doctors who have worked in **rural areas** for minimum period of two years is mandated, it will immediately make available more number of Doctors joining the Govt. in order to get the benefit of these

reservations in PG seats.

(v) Services of nurse practitioners and **AYUSH doctors can be utilized to bridge the gap** in the healthcare providers in remote and difficult-to-reach areas.

(vi) Suitable **skill upgradation** courses may also be designed **for ASHA workers** to be trained to diagnose and dispense allopathic medicines for illnesses of common nature. This will augment the human resource deficit in in far-flung areas.

(vii) For other **Allied Health Workers**, there is a scope for **skilling** a large number of them, which will not only improve patient care but also generate employment.

3.1 Some **additional suggestions** for improving access to health care are:

(i) To leverage the advancements in technology and overcome the shortage/ absence of doctors in far flung/ rural areas, it is proposed that **call centres manned by few doctors/ paramedics** may be established in each state. These **tele-doctors** will augment the existing capabilities of the local health personnel like ANMs and ASHAs by providing guidance to them over phone in respect of routine health conditions.

(ii) Ordinary citizen can also call up such call centres and seek advice of immediate relief for their health conditions. This will be a big relief to the people in the far-flung area who have got mobile phones but no family doctor to attend.

(iii) Ministry of Health may roll out **Decision Support System (DSS) which could be called e-Doctor** to assist doctors in arriving at correct diagnosis. The DSS would be algorithm based protocol wherein inputs based on patients' symptoms would be fed by the health professional and the DSS would come up with range of probable diagnoses as output.

Drugs

4. The Group proposes following steps to ensure affordability and availability of drugs:

(i) There is huge difference between in price of generic and branded

medicine. The Govt. should endeavour to **procure generic medicines in bulk** and make available at least **300 such medicines free of charge** in all public hospitals and PHCs for the poor people.

(ii) However, there are two precautions to be taken in this. First is the **quality check of generic medicine** procured. Second, procurement and distribution should be IT-enabled to prevent any pilferage or wastage and for proper inventory management.

(iii) In addition Department of Pharmaceutical should roll out in multiple towns and cities, **public stores called "Jan Ausadhi"** wherein such quality tested, reliable generic medicines are available for people at a very cheap cost. The Pharmaceutical Department should create a PPP Model for such medical stores to be set up over the country to **begin with 1000 such shops should be opened in the year 2016**. The AMRIT (Affordable Medicines and Reliable Implants for Treatment) initiative of Department of Health & Family Welfare needs to be replicated.

Diagnostics

5. The Group is of the view that in order to improve diagnostic facility the following model may be adopted:

(i) Wherever machines are lying idle without proper maintenance or technicians, the same can be made available to the private sector i.e. **diagnostic laboratory under PPP model**. Where there is no facility available, the Government can decide the type of tests and the rates for each one which can be done by the private sector whenever possible in Government facilities. The private sector can engage their own equipment for the same.

(ii) The Govt. could think of a **Hub & Spoke Model for pathology tests** in which the tests are done at decentralized centres but the results are evaluated at central place e.g. Tele-Radiology.

(iii) The Govt. may also at the same time try to reduce the cost of indigenization of manufactured diagnostic tools by giving effective protection to the diagnostic industry, diagnostic tools manufactured within the country, through reduction of input cost for their manufacturing and restricting the import of final diagnostic products.

Delivery Mechanism

6. Some of the suggestions for delivery mechanism are included in the above paras. However, in order to have effective health delivery system, the following more suggestions are made by the Group:-

a) **National eHealth Authority (NeHA)** – NeHA should be immediately set up to create a national wide data base of all healthcare providers as well as to set up health repository of all electronic health record of every citizen. A statutory mechanism for this needs to be put in place.

b) The **Govt hospitals** should have certain minimum standards and **Standard Operating Procedures** defined clearly. A separate agency should keep monitoring these standards. All **health facilities should be rated annually** vis-a-vis these standards.

c) A **part funding** of health budget can be done through **Cess imposed on tobacco**.

Chapter 4

Education- Issues Identified

1. For a country where only 50% children were enrolled in schools in rural areas in 1986, as per the National Sample Survey, 42nd round, it is no mean achievement to have got nearly all the children to schools and a very large percentage attending regularly. Having expanded the infrastructure for access significantly, the challenge now is to transform the classroom transaction process in a fundamental way to make a positive impact on quality. The Annual Status of Education Report-2014 by the non-governmental organization 'Pratham' has highlighted the poor learning levels of the students in India. According to the report, 96.7% of rural children in age group 6-14 are enrolled in school, but **only 48% of children of standard V can read a standard II level text**, **only 25 per cent of children enrolled in Class-V could read simple English sentences** and only **25% of Class-III students could do a two-digit subtraction**. The study brought to light several other deficiencies in the education system.

2. Another issue of concern is the quality of teachers which is evident from the poor learning levels of the students. **Diversion of teachers for non-teaching tasks** during school hours is an important governance issue in the school system. Further, training and development of teachers is a neglected area today.

3. Regional disparity and **small size of schools are also a problem area**. Under the centrally sponsored scheme of Sarva Shiksha Abhiyan (SSA), physical infrastructure has been created at most places. However, this has also led to setting up of many small size schools including multiple schools in the same habitation. Besides, there are **gaps in access to secondary and senior secondary schools** at many places.

4. In this backdrop, the Group feels that the impetus of **Government for elementary education should shift from quantity to quality** by focusing on the quality of class room transaction. As far as **secondary and senior secondary schools are concerned, both quality and access should be given equal impetus.**

Chapter 5

Education- Proposals

UNIQUE

1. The Group proposes a new umbrella programme **UNIQUE (Unique National Initiative for Quality and Universal Education)** which is expected to be an **Outcome based funding** to States, subject to States adopting a **Reform Roadmap** as dealt with in the succeeding paras, and with focus on quality.

2. The salient features of UNIQUE would be as follows:

a) This is an initiative for improvement of quality and **covering Classes I to XII**.

b) The programme entails a planned and phased exit from **all existing schemes over a period of time.**

c) All new funding should only be through the scheme of UNIQUE wherein 80% allocation of funding is based on needs of a recipient State and remaining 20% should be based on the performance of the State on the objectively defined parameters. These parameters would reflect the reform roadmap suggested in this Report. The funding of State projects would be contingent upon State agreeing to a Reform Roadmap as outlined in para 4 of this Chapter.

3. Under this new Initiative, the role of the Central Government would be restricted to following areas:

3.1. Centre should take care of improvement of quality of teachers by way of:

a) Rolling out and encouraging **integrated 4-year B.A./B.Sc. B.Ed. course**. This would prepare a dedicated cadre of teachers.

b) Revamping **teachers' pre-service syllabus**. This would impact the quality and content of teachers' education which should be more contemporaneous.

Establishment of functional laboratories for experimentation, computer rooms for literacy and aided learning, sports and meditation facilities, and linkages with Universities for teacher development and school is necessary. In the current scenario of no-detention policy, teachers should be equipped for handling children in Classes III to V who cannot read or write. To reduce the likelihood of children reaching Class III – V without basic language and arithmetic skills, we need to **earmark the best teachers for Class- I and II** and **train these teachers differently** and provide support in bridging the language learning needs by using local dialects to bridge the gap with formal language.

c) All India led/State level Admission test for B.Ed. courses to capture bright students in teacher's pre-service courses.

d) Achieving expected learning levels at the early foundational stage is important for children to enable effective learning at later stages. Therefore the quality of primary teachers needs improvement. It is suggested to **increase the minimum qualification to become primary teacher from +2 to bachelor degree level**. Already States of UP and Uttarakhand prescribe this educational qualification.

e) Teacher development institutions must be equipped with the finest team of trainers from among teachers and teacher educators. We should also set up a National Centre for Research in Learning. Good teachers who demonstrate learning improvement through innovative practices must be harnessed for these institutions. This will go a long way in creating a pool of the finest teacher development personnel. Exposure to good practices in communication, subject matter, pedagogy and learning facilitation, which help in transforming classrooms should be the core of in-service teacher training. Team building in institutions and direct trainer skills training among faculty will ensure that the thrust for excellence is internalised in the school system. **Navodaya and Kendriya Vidyalayas should be organically linked to State Government schools** of the region and play a pace setting role in teacher development, student interaction, innovation, scientific experimentation, etc.

f) Diversion of teachers for non-teaching tasks during school hours is another important governance issue in the school system. A teacher is not a para worker for

all other tasks from socio-economic surveys to booth level officer. **A teacher must be available during working hours for classroom teaching.** All such tasks must be outside school hours.

3.2. Standards for assessment of each school, teacher & student at each stage should be laid down and an **electronic database should be created to track change and improvement**.

3.3. Digital teaching- learning resources may be developed to augment the existing capabilities, especially in remote areas which are not well-connected, for both teachers and students.

3.4. Efforts should be made for **talent spotting** among the children and so as to motivate and encourage them. For example, external testing may be done for different classes and those performing well may be issued proficiency certificates. Top few students of a school in village may be sent on short trips to adjoining cities to incentivise students to perform well.

3.5. Re-orientation of **educational administrators** is the key to transforming schools. There is a need to engage with School Head Masters, Block and District level Education Officers, and organize meaningful and focused training programmes for them that clearly places the vision for change i.e., focus on quality aspects in school administration and its concrete action plan. Management institutions can play an important role in team building and in making public systems more effective. Supportive supervision by the teacher training institutions and inspection by educational administrators is both required for a more effective transformation of schools.

3.6. In the 21st century work place there would be need for higher level of education and skill. Hence, elementary education is not enough, and **secondary and higher secondary education needs to be universalized**. Further access to secondary education and higher secondary education and availability of infrastructure including science lab, library etc. are a priority.

4. Similarly, the role of the State Governments would be the following **Reform Roadmap**:

4.1. There should be a regular **learning achievement survey**. Assessment of children regarding their learning levels may be done systematically for each class. We need to **understand the learning challenges of every child** and for doing so we need to make continuous and comprehensive evaluation a more demystified task that average teachers understand. Parents need to be involved in tracking of children's performance. School based assessments of learning similar to the NCERT managed Achievement Survey will go a long way in determining where the nature of the problem lies and their solutions. Not assessing learning progress of children as a consequence of a no detention policy is surely a wrong interpretation of a child friendly learning environment.

4.2. Regular **rating of schools by Gunotsav (Gujarat)-like programme** should be institutionalised. This will incentivise schools to perform well. Benchmarking of schools and colleges require robust systems of accreditation and standard setting. This needs the involvement of third party institutions or specially crafted public institutions in partnership with non-governmental organizations in management in a transparent manner. **Accreditation and standard setting is today the biggest need for public and private institutions in India** and we will have to evolve simple systems of assessment that set a time bound compliance agenda for every institution. It is only through a robust accreditation system that grant in aid support for States and UTs can be gradually evolved, based on school standards and performance.

4.3. Wherever feasible, many **small schools should be consolidated into one big school with better resources and facilities and competent teachers**. Primary and Upper primary schools should be brought within a network, as feeder schools to the local secondary or senior secondary schools, whose Principal should be developed into a supervisor and support system for these branch/ feeder schools. While upgradation of schools to the next level is the way forward, transport arrangement where needed can also be considered for students from distant habitations.

4.4. Cluster and Block Resource Coordinators should be selected in a transparent manner on the basis of well-defined guidelines. The best teacher in the cluster ought to be the Coordinator as peer group supervision is most difficult. The **role of the CRC Coordinator needs to be redefined** so that he/she does sharing of good practices and hand holds the teachers at the school level rather than sitting conducting meetings with teachers at the Cluster level. The role of block & cluster Coordinators as school supervisors for quality and teachers support must be made performance orientated & with suitable changes in service rules of teachers.

4.5. Teachers' attendance in schools, and if possible students' also, may be monitored through **biometrics so as to improve teacher's accountability**.

4.6. Lack of transparency and objectivity in appointment and postings of teachers has had a debilitating impact on the system which has given rise to governance deficit. States should make rules under RTE Act for teachers' recruitment and their transfers and postings to ensure objectivity and merit. The process should incentivise good performers.

4.7. With change in content of education, the **examination process should be reformed in conformity with changing needs** by a **shift from rote learning** and knowledge regurgitation to using information/ knowledge for applicability in situations and problem solving. A shift in examination systems and types of questions asked will have a salutary effect on type of teaching by teachers. This will also ensure learning of concepts and higher order thinking skills.

4.8. Sports/ **yoga should be made compulsory** part of the school curriculum to promote healthy lifestyle from a very young age.

5. Vocational Education

5.1 Developing requisite skills and competencies along with essential life skills are indeed our biggest challenge, given the large youth population that is unemployed, under-employed, or employed with lower order skills and competence. This requires a societal effort to provide opportunities as flexibly as possible, in the

private or the public system, to acquire skills that can be tested and certified and that industry or the service sector recognizes for purposes of employability. The Group feels that the quality of education can be enhanced by improving the employability index of the educated. Higher secondary completion is equally important in reaping the demographic dividend. Education of girls at this level in particular, has relevance in delaying the age of marriage, women's empowerment, better adolescent health and hygiene, increased women's participation in skilled workforce, and in bringing down fertility rates.

5.2 Universal **higher secondary education with a wider set of vocational and skill development options** will facilitate promotion of education for life and relevant education. Vocational and skill development will have to be thought through innovatively as these will have to be accessed through partnerships with professional organizations, industry and non-governmental sector. Forward linkages with universities for enhanced skilling programmes or inter-mobility into academic streams, should be worked out.

5.3 A framework of well-crafted autonomous institutions on the same principles as outlined above will need to be **set up for accreditation of vocational training providers**, **setting up of curriculum**, **testing acquisition of skills and competencies**, **interface with industry and trade**, **engaging in manpower planning** and forecasting, multi-skilling, etc.

5.4 Vocational education will not only help redress the drop-out problem, as more parents/ students would feel the inherent benefit of pursuing education if it results in employability of the student, it will also help reduce the skill deficit in the labour market. **At present, 3,654 out of 36,217 composite (classes IX to XII) schools have this option, for 7.3 lakhs students**. However, there is a need to bring it to mainstream and expand the scope. Hence it is proposed that:

- The curriculum of school education be revised to include
  - ✓ Vocational Education
  - ✓ Soft Skills
- Vocational Education may be made part of regular curriculum after Class

VIII in composite schools having class IX to XII.

- **Mobility from Vocational Stream to the traditional educational system** and vice versa should be allowed through well-defined pathways so that vocational education gets similar footing as traditional education.
- School Boards must link with industry/trade to bring in locally, nationally and globally relevant courses, syllabli and testing systems. Teachers can be contractual with industry based orientation & training.
- **Schooling systems must work with industry** for the on-site training & final placement of students seeking jobs after class 12th
- **Coverage of composite schools** to offer vocational education may be increased from the **present 10% to 25% in the next 3 years**, while ensuring introduction of appropriate vocations and curriculum to improve employability.

6. Quality of Teachers

In the preceding paras, the Group has suggested the Centre should take a leading role in encouraging States to focus on improving the quality of teachers. In this direction, the Group recommends following specific measures:

6.1 Testing the competence of a teacher, to see whether he/she has the basic capability to continue as a teacher, is important. This can be achieved by having regular assessment programs of the teachers.. There is a need for **developing learning facilitation materials to accompany every textbook**, to give teachers a collection of activities that can help in explaining the content to the children in a more effective manner. Teacher development and learning has to be activity based. Every lesson needs to be practiced in sessions with the cluster coordinators.

Progress cards for children, teachers and schools with a clear self-development agenda, will further facilitate this development process. A teacher must know what competence children have to achieve and for doing so what qualities the teachers and what facilitation the school needs to provide.

6.2 Teacher development requires sound institutional back up. There have to be a series of institutions for teacher development with the finest team of trainers from among teachers and teacher educators. The Teacher training institutions have to be re-crafted with a focus on quality of faculty and activity based learning. The adoption of schools by teacher training institutions, creating a progression opportunity of CRCs, BRCs to become faculty in the District Institutes of Education and Training and even the SCERT, will go a long way in creating a pool of the finest teacher development personnel. **Exposure to the teacher development personnel of the finest practices in communication, subject matter, pedagogy and learning facilitation,** will help in transforming classrooms. Team building in institutions and direct trainer skills training among faculty will ensure that the thrust for excellence is internalized by the school system.

6.3 There should be no compromise with quality, excellence, transparency and fairness in the recruitment of teachers. **Recruitment of teachers must be fully based on objective criteria so that the best candidates** are available. Presently, the States conduct recruitments off and on without any periodicity or regularity. States should project the requirement of teachers of each category for the next 10-13 years in advance and **conduct recruitment on an annual basis** so that the best candidates available every year are retained by the system.

7. Community Participation

The **role of the community needs to be further emphasized** through institutional arrangements for their participation. Holding regular **community meetings** through enhanced cultural activities, sports events, progress report sharing should be encouraged. **Parents need to take interest** and the challenge is to having representation of articulate women in the School Management Committees needs to be promoted.

Chapter 6

Summary and Conclusions

This Report has tried to place the key challenges in education and health and developed ways to make the best use of limited public resources. It has focused on reforming on-going programmes with a clear thrust on linking expenditure with equity, inclusiveness and quality. The main recommendations along with the expected expenditure and timelines are re-capitulated in the following paras.

1. Health

Suggestion	**Expected Expenditure and Source of Fund**	**Implementation Schedule**
Introducing ULHAS - Universal Life and Health Assurance Scheme (ULHAS), a comprehensive public healthcare system encompassing preventive, primary and secondary healthcare.	Rs 6,600/- Crore Health Cess on Demerit goods	PMJJBY is already operational. ULHAS has to be integrated with PMJBBY
Fortification of staple food like rice, wheat, edible oil and milk with Iron, Folic acid and Vitamin A		First year, fortification in MDMS can be started with while extending it to PDS in second year and covering entire population by third year
Vaccination against Diarrhoea and Pneumonia		75% coverage in 3 years
Strengthening School Health Programme		90% in 3 years
Campaign for healthy lifestyle by promoting Yoga etc.		
Increasing the ratio of PG students to Professors from existing 2:1 to 3:1		Within next 1 year
6-month Bridge Course for AYUSH doctors		Within next 1 year
Common Entrance Test for MBBS and PG		Within next 1 year
30 to 50% reservation in PG seats for doctors with rural experience		Within next 1 year
skill up gradation courses for ASHA		Within next 1 year

At least 1 tele-doctor (call centre) facility in each State		Within next 1 year
Roll Out of e-doctor software		Within next 1 year
IT enabled procurement of generic medicines in bulk and make available at least 300 such medicines free of charge in all public hospitals and PHCs for the poor people		Within next 1 year
At least 1000 Jan Ausadhi stores in towns and cities		Within next 1 year
PPP model for diagnostic facilities		Within next 1 year
Hub & Spoke Model for pathology tests		Within next 1 year
Effective protection to the indigenous diagnostic industry		Within next 1 year
NeHA to be immediately set-up		Within next 1 year
Govt hospitals should have certain bare minimum standards and Standard Operating Procedures defined clearly		Within next 1 year
Part funding through Health Cess		In Budget 2016

2. Education

Suggestion	**Expected Expenditure and Source of Fund**	**Implementation Schedule**
Introducing UNIQUE	Same as available now	May be initiated from 2016 onwards
Introduction of 4-year integrated B.Ed	-	200 institutions in 2016-17
Entrance exam for teachers training institutions		2017-18
Plan for talent spotting		2017-18
Deepening National Achievement Survey from State level to District level		2017-18
Universalization of Secondary Education	Existing programme to be continued	3 years
Extending the scope of RMSA to higher secondary	Rs 1000 cr in 2016-17 Rs 2000 cr per year in subsequent years	2016-17
Including vocational education in more composite schools		15% schools to be covered in 2016-17 25% in 3 years

School rating		10% schools in 2016-17 50% in 3 years

The Group feels that it is time to focus on crafting and strengthening credible public delivery systems in health as well as education sector. The potential of a public education and public health system can be harnessed with appropriate professional leadership which will enhance the existing capacities in these sectors by way of teacher development and for skilled health workers, especially at the PHC level. This will be the cornerstone for realizing the vision of equity, inclusiveness and quality in access of healthcare and education.

The Group also feels that unless the State expenditure on education and health is stepped up substantially, the real impact on these two sectors will not be visible. There is a need for increasing budget provision for health and education at the rate of **25% annually** in order to reach the target of **2.5% of GDP on health and 6% of GDP on education**.

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Appendix-A

Group-IV-Education and Health – Universal Access and Quality

1.	Revenue - Rapporteur	Shri Hasmukh Adhia	IAS (GJ:81)
2.	Health	Shri Bhanu Pratap Sharma	IAS (BH:81)
3.	School Education	Shri Subash C.Khuntia	IAS (KN:81)
4.	Food & PD	Ms. Vrinda Sarup	IAS (UP:81)
5.	Women & Child Dev.	Shri V. Somasundaran	IAS (KL:79)
6.	Inter State Council Secretariat	Ms. Naini Jayaseelan	IAS(AGMUT:80)
7.	MEA	Shri Navtej Singh* Sarna	IFS (1980)
8.	Sports	Shri Rajiv Yadav	IAS (AM:81)
9.	Health Research	Ms. Soumya Swaminathan	Scientist
10.	AYUSH	Shri Ajit M. Sharan	IAS (HY:79)
11.	Social Justice & Emp.	Ms. Anita Agnihotri	IAS (OR:80)
12.	National Commission for STs	Sh. Shyam S. Agarwal	IAS (RJ:80)

*Ms.Mukta Tomar, Additional Secretary, MEA (IFS-1984) participated in most of the meetings, since Mr. Navtej Singh Sarna was in transit to go to London as Indian High Commissioner.

Appendix-B

Education and Health – Universal Access and Quality

Grp 1

1.	Shashi Prakash Goyal-Rapporteur	IAS (UP:89)	Higher Education
2.	B. S. Bhalla	IAS (UT:90)	Commerce
3.	Anshu Prakash	IAS (UT:86)	Health & FW
4.	Satbir Bedi	IAS (UT:86)	School Edu. & Lit.
5.	Avinash Awasthi	IAS (UP:87)	EP Disabilities
6.	Kalpana Awasthi	IAS (UP:90)	DIPP
7.	Amit Yadav	IAS (UT:91)	Telecom
8.	Uday Singh Kumawat	IAS (BH:93)	Revenue
9.	Sreya Guha	IAS (RJ:94)	Culture
10.	I Rani Kumudini	IAS (TG:88)	Ag. Coop. & FW
11.	Rajesh Aggarwal	IAS (MH:89)	DFS
12.	Ram Prasad Meena	IPS (AM:93)	Health Research
13.	Sanjiv Mittal	IDAS (XX:84)	Culture
14.	Dammu Ravi	IFgS (XX:89)	Commerce
15.	Santosh Jha	JS(PP&R,GCI)	MEA

Appendix-B

Education and Health – Universal Access and Quality

Grp 2

1.	Arun Kumar Mehta - Rapporteur	IAS (JK:88)	Env. Forest & CC
2.	Utpal Kumar Singh	IAS (UD:86)	Agri. Coop. & FW
3.	Lalit Kumar Gupta	IAS (TR:87)	Youth Affairs
4.	Ali Raza Rizvi	IAS (HP:88)	Health & FW
5.	Iqbal Singh Chahal	IAS (MH:89)	Panchayati Raj
6.	V. Venu	IAS (KL:90)	Sports
7.	Vandana Gurnani	IAS (KN:91)	Health & FW
8.	Rajesh Kumar Sinha	IAS (KL:94)	Coal
9.	Manoj Kumar Dwivedi	IAS (JK:97)	Commerce
10.	Rakesh Bhushan Sinha	IFS (MP:86)	Agri. Coop & FW
11.	Aditya Kumar Joshi	IFS (MT:89)	Animal Husbanday
12.	Deepak Anurag	IA&AS (XX:88)	Defence
13.	AP Singh	IPoS (XX:86)	Disinvestment
14.	Sumita Mukherjee	IRAS (XX:87)	DSIR
15.	Munu Mahawar	JS(AMS)	MEA