

# Exclusion and Regional Disparity in 'Kerala Model' of Development: A Threat to the Sustainable Development

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## Introduction

Kerala is known for its high to very high social development indicators and is ranked at the top among states and Union Territories of India. The state has achieved an advanced stage of social development despite relatively low economic growth rate. However, the development issues and concerns are almost the same as those faced by other backward regions of the country. Disparities between the northern and the southern regions of the state have emerged long-back and they continue to persist till to date. Based on the geographic and demographic demands, availability of public institutions across the regions is not at the adequate level. As a result, social inequality appears to have widened among different classes based on their vulnerability.

In the present paper, we analyse regional disparity between north and south Kerala and its concomitant consequences in the development of the state. The paper also discusses implications of widening regional disparity for the development policy of the state.

All the indicators related to education and health in Kerala are the best in the country. Because of the very advanced level of health and education in the state even at low levels of economic development, the 'Kerala model' of development has widely been accepted even at the international level and is considered as a replicable model. The 'Kerala model' of development is referred to as high level of social development at low level of economic development or low industrial growth. In almost all indicators of social developments such as literacy rate, infant, child and maternal mortality rate, expectation of life at birth and female to male ratio, Kerala ranks first amongst all Indian states and Union Territories (Government of Kerala, 2006). It is argued that the very advanced level of social development in the state despite low levels of economic development is the result of the universal availability and utilisation of public services, high political awareness, democratisation of the public administration system and very high female literacy (Government of Kerala, 2006).

The state of Kerala, as it exists today, came into existence for the first time in 1956. Before 1956, there were three major regions - Malabar, Kochi and Travancore - each with different monarchy. The level of social and economic development in the three regions was essentially different because of a number of geographic and administrative reasons. Travancore and Cochin regions were ruled by respective Maharajas and the Malabar was under the Samoothiri Kings (Zamorins). Foreign invasions started in Kerala in the late 15<sup>th</sup> century. Travancore-Cochin was submitted to the foreigners and continued as princely states under a treaty. The Malabar region, on the other hand, was under Tipu Sultan of Mysore until he was defeated by the British and then the region came under the control of the Madras Presidency. However, the region continuously witnessed struggles between the British and the people of the region. Due to the nature of the popular resistance, the British imposed many oppressive acts on the people of the region. The British presence and the political unrest had resulted in the neglect of the development of the region.

On the other hand, the uninterrupted rule of the Maharajas of Travancore under the aegis of the British contributed to infrastructure development of the region. The first school, the first medical college and many other public institutions were opened by the Maharajas. However, the vulnerable population was denied entry into these institutions by the dominant castes in the name of pollution. In the early decades of the 20<sup>th</sup> century, the Travancore region was engulfed by mass movements that demanded the rights of vulnerable populations and equal representation in the public institutions.

The southern Kerala was comparatively more advanced in terms of infrastructure development relative to the northern region (Kabir and Krisnan, 1991; Jacob, 2014) because of the two reasons. The people of Travancore organised and protested for their right for education and political representation. Hence the rulers of the region or the administrators were compelled to open educational and health care institutions. Second, the rulers of the region were native Maharajas. They had the authority and the respect in their regions while the British in the Malabar region captured the power by force and the people revolted against the foreign invasion instead of concentrating on education or other social development activities.

### North-South Disparity

There is ample evidence to suggest significant north-south disparity in the state in almost all dimensions of social and economic development. District level estimates of per capita income at current prices for the year 2015-16 prepared by the state government clearly reveals this disparity (Figure 1). District Malappuram of the state has the lowest per-capita income among all districts of the state. In addition, Wayanad, Kasaragod and Palakkad districts rank the lowest in the state in terms of per capita income. All these districts are located in the northern part of the state. On the other hand, district Kollam ranks second; district Allappuzha ranks third; and district Idukki ranks fourth in terms of per capita income at current prices. All these three districts are located in the southern part of the state. The per-capita income is, however, the highest in the Ernakulam district.

The northern part of the state is facing the deficit of public institutions and, within this region, the Malappuram district has the poorest infrastructure and the lowest level of social and economic development (Government of Kerala, 2006). The Malappuram district of the state is unique in the sense that Muslims constituted more than 67 per cent of total population of the district according to the 2011 Census.

There is evidence to suggest that the Malabar region of the state lags behind other regions in terms of health care centres and educational institutions (Sajid, 2016). For instance, the availability of the primary health centre (PHC) and the community health centre (CHC) is crucial for the delivery of essential primary health care services to the rural population. However, the population served by one primary/community health care centre in the southern part of the state is lower than the

population served by one primary/community health centre in the northern region of the state (Figure 2). The northern region of the state is more hilly and rural than the southern region, hence this disparity is more crucial in the context of meeting the primary health care needs of the people. Similarly, there is marked difference in the population served by one health sub-centre in the northern as compared to the southern part of the state (Figure 3). As a result, the disparity in the availability of hospital beds and human resources necessary for the delivery of health care is also quite marked between the north and the south regions of the state.

The availability of the health manpower also differs in the southern and northern parts of the state. For example, in most of the districts in the southern part of the state, there is one ASHA worker for every 1000 population approximately. By contrast, in the northern districts, there is one ASHA worker for 1532 persons on average in district Wayanad; for every 1514 persons in district Kozhikode; and for every 1374 persons in district Kasaragode. Similarly, there is one female health worker (ANM) for every 7681 population in district Ernakulam; for every 7384 population in district Kozhikode; and for every 6980 population in district Malappuram against the norm of one female health worker for every 5000

Figure 1  
Per capita income at current prices, 2015-16

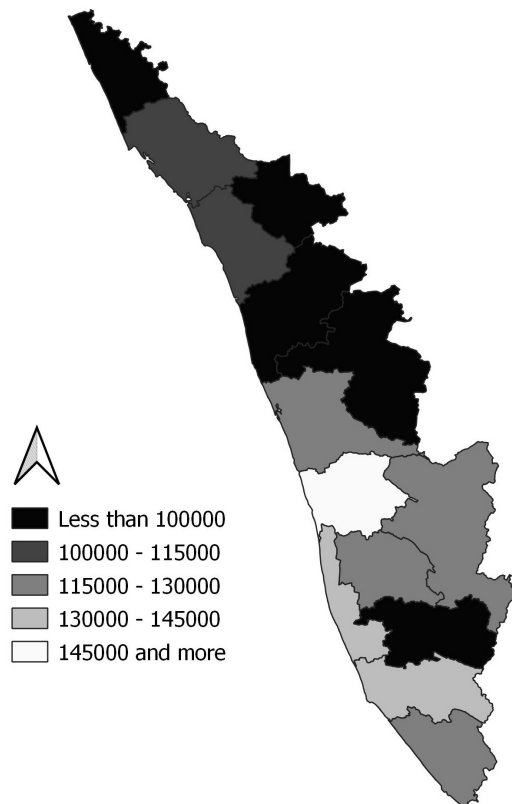
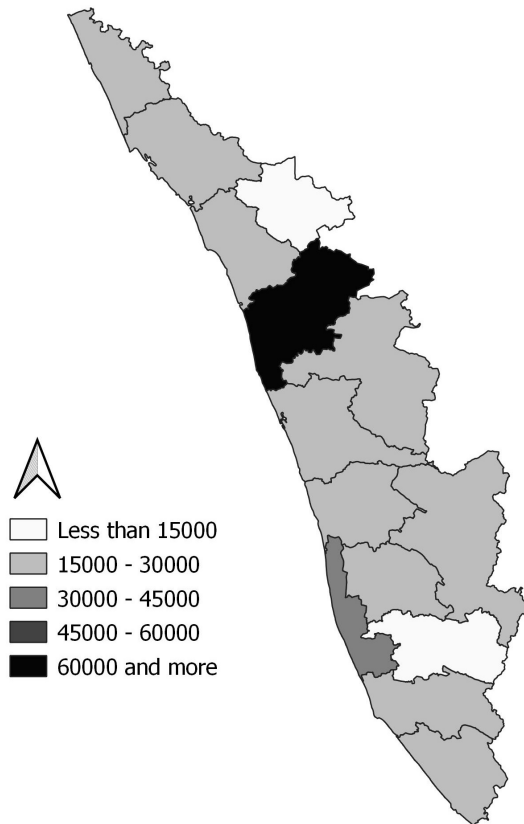


Figure 2  
Population served by one CHC/PHC



population (3000 population in hilly and Scheduled Tribes areas). Obviously, the Malabar region of the state faces severe crunch in terms of the availability of health care services providers in the rural areas.

The Malabar region of the state accounts for more than 50 per cent of the total deliveries in Kerala but there are only 3 public women and children's hospitals in the region which cater to the needs of around 26,000 pregnant mothers every year. The lack of public facilities forces the people of the region to opt for private health care facilities. Around 70-80 per cent of the deliveries in the Malabar region takes place in private hospitals which are costly and beyond the reach of the common people and highly expensive for the poor and the marginalised ones.

Kerala had only five medical colleges till 2011. There was only one medical college in the Malabar region which served for 14 million people whereas there were four

medical colleges in the Travancore region which served for 18 million people. Recently, the district hospital Malappuram, the most populous district of Kerala, has been upgraded to a medical college in 2013. In 2014, one tribal hospital, located in the Palakkad district, was also upgraded to a medical college. Interestingly, the upgrading of two hospitals into medical colleges resulted in political disputes in Kerala due to the lack of infrastructure and human resource in these hospitals (The Hindu, 2015; Nijeesh, 2014). The inequality in the provision of public health infrastructure and human resources denies the needed equal opportunity for the people of the region and derail the development processes in the northern region of the state.

The public distribution system (PDS) is one of the important interventions to ensure food security in India. It ensures provision of food grains at low cost on a monthly basis to the poor population. The rural poor are benefited most from the PDS. However, the PDS in Kerala is largely concentrated in the urban areas and is largely beyond the reach of the rural poor (Sajid, 2016). In south Kerala, there is one PDS shop for every 1,900 population on average while there is one PDS shop for every 3,200 population in north Kerala. Districts with heavy concentration of the

Scheduled Tribes population like Wayanad and Palakkad are in the northern region of the state. The Palakkad district was recently in the news for very high prevalence of under nutrition among Scheduled Tribes children and for hunger deaths which is largely attributed to inadequate public distribution facilities in these districts. In district Malappuram, extreme marginalisation of the people is very clearly visible. A very large proportion of the population of the district is devoid of even the basic minimum facilities which gets reflected in the very low level of human development in the district. According to the Human Development Report of Kerala, the district is ranked the lowest in terms of the human development index among the 14 districts of the state.

In mid 90's, the social sector spending in Kerala, measured in terms of the state budget was the highest among all states and Union Territories of the country (Chakraborty, 2009). The situation appears to have changed by now and the social sector spending in the state is now at par with many states/Union Territories of the country over the last decade. It is argued that the decrease in the social sector spending in the state has been the result of the decentralisation of the public administration system in the state. In any case, the stagnation in the public spending in the social sector will have implications for the development of the state particularly when the local self governments in the urban areas and Panchayats in the rural areas are not able to generate additional resources to be spent in the social sector.

### Development of Private Sector and Philanthro-capitalism

One of the concomitant consequences of the persistent disparity between the north and the south regions of the state is the growth of private and philanthro-capitalist institutions in health and education sectors (Sajid, 2016). In the recent past, there has been a very rapid expansion of the philanthropic institutions in the backward Malabar region primarily because of gulf remittances (Azeez et al, 2009; Osella and Osella, 2009). Charity has traditionally been one of the many

Figure 3  
Population served by one HSC

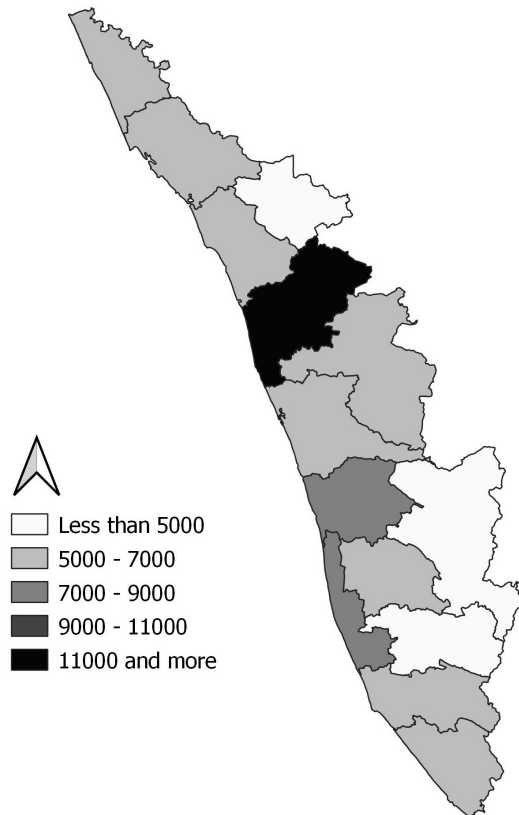
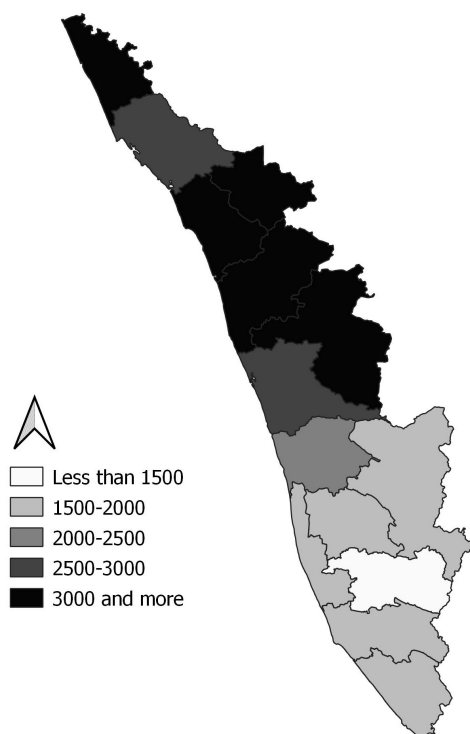


Figure 4  
Population served by one PDS shop



contributing factors in the development of the Malabar region of the state. However, the nature of the charity has changed significantly over time.

### Industrial Revolution and Charity

Philanthropy may be defined as an organised effort to eliminate worries of the human life. It ensures individual well-being through a systematic way of action. After industrialisation, the term philanthropy has replaced the term charity. In India, more than three million voluntary organisations are working at different levels of the development administration system. Almost 60 per cent of these organisations work in the rural areas in the fields of education, health, research, environment, etc.

Religious charity was prominent in the industrialised countries till the 16<sup>th</sup> century. The industrial revolution had brought important shifts in the philanthropic activity in these countries. The church-based philanthropic activities were replaced by market-driven industrial groups and companies (Leeuwen, 1994). After the World War II, there were significant changes in the international relations and international cooperation. As a result, newly emerged transnational organisations started entering poor income countries regardless of their geographical border (Jenkins, 2011). The economic recession during the 1970s and the 1980s forced many countries to reduce their social sector expenditure. Western countries like Britain and United States searched for new management methods to reduce the social sector expenditure which was steeply increasing since the 1930s (Jahiel, 1998). India also adopted the public-private partnership model for the delivery of social services (Sajid, 2016).

### Development of Philanthropic Sector in Kerala

The charity organisations in Kerala have contributed in the evolution of the Kerala model of development. In the history of Kerala, almost half of its population was denied entry into schools, health centres, temples and even public places because of their social class (Jeffrey, 1976; Kabir and Krisnan, 1996; Osella and Osella, 2001). The charity organisations promoted education and extended health care services to the so-called 'untouchables' which contributed significantly to their

social upliftment, although, a substantial proportion of the vulnerable population in the state still lives at the fringes of development (Thresia, 2014; Devika, 2010). During the period when the development of the public health infrastructure was almost stagnant in the state, private and philanthropic sectors grew steeply in the health sector (Dilip, 2008; Sajid, 2016).

Remittances from the Gulf migrants have also contributed to the entrepreneurship in Kerala during the last fifty years especially in the Malabar region (Osella and Osella, 2009; Prakash, 1998). These remittances were invested primarily in the education sector and in other social services (Azeez et al, 2009). Businessmen and educated middle-class migrants were the key investors behind this investment (Osella and Osella, 2009).

A random analysis of the philanthropic initiatives in the state during 1950 through 2010 reveals that there has been virtually a boom in the philanthropic initiatives in the state during this period of sixty years. As a result of this boom, there has been a rapid expansion and associated consolidation of the education and health infrastructure in the state which has resulted in significant improvement in both education and health status of the people of the state. The philanthropic initiatives working in the field of either health or education or in both are now consolidated. During the 1980s, there was a vigorous expansion of philanthropic initiatives, particularly, in the health sector. The trend continued during the post 1990 period also which was the period of globalisation, privatisation and liberalisation. During this period, the public sector has limited role in terms of investment in education and health sectors.

### Outcomes of the Transformation

Medical education in Kerala was opened to the private sector after 2000 (Dilip, 2008) which resulted in establishing philanthropic medical institutions by different religious communities. However, in the context of their survival and funding, these institutions adopted business techniques that focussed on the profit from the delivery of education and health services. Because of this orientation, these institutions now have owned vast assets and accumulated wealth. Even small clinics and primary care centres have transformed into bigger institutions and multi speciality hospitals over time. In the process, primary health care has been missed out. This profit orientation of the philanthropic institutions has also blurred the difference between philanthropic and private investment in the social sector. The cost of the care in a philanthropic institution of the state, today, is now almost the same as that in the private sector. The cost escalation is the most steep in the health sector which reflects the nexus between the pharmaceutical companies and the philanthropic institutions. As a result, the philanthropic institutions are now beyond the reach of the poor and the vulnerable group of the population which is a very serious concern. The access to philanthropic health institutions is now limited to the middle and the upper class of the society because of the high cost of care in these institutions. In the past, the social class was the key obstacle in accessing the health care institutions in the state. Today, it is the high cost that inhibits the poor and the vulnerable ones to access the facilities available in these institutions. The orientation of the philanthropic institutions towards profit earning has resulted in an increase in social

inequity in accessing health care services. The privatisation of health care in Kerala is now a big threat to social equity (Ramankutty, 2000; Levesque et.al, 2006; Dilip, 2008). A study carried out by Kerala Shastra Sahitya Parishad (KSSP) in 2011 has found that one has to spend, on an average, Rs 6000 per annum on health care and the out of pocket (OOP) expenditure on health care is six times higher for those who are suffering from chronic illness. This very high cost of health care is a double burden for those who live in poor social and economic conditions. If they chose private health care service providers, then the cost involved smashes their economic background. Obviously, if the philanthropic institutions work like the private sector - to earn profit - then it is the vulnerable population that will be affected the most.

### Policy Suggestions

The regional disparity in the public health care infrastructure appears to have created inequality across social groups and has contributed to the booming of the private sector which is costly and beyond the reach of the poor. Unfortunately, the philanthropic sector is also turning into a private sector in the state. It is therefore imperative that the government must adopt standards to distinguish the philanthropic sector from the private sector. There is, unfortunately, very little initiative in this direction. The information pertaining to the delivery of social services by the philanthropic institutions of the state is largely missing. There is a need of a continuous appraisal of the free ward utilisation and standardisation of the fee in philanthropic institutions. Such an initiative will help in ensuring the accessibility of all sections of the community to quality health care even in the absence of public health care institutions. The government should identify financial frauds in the name of philanthropic care and take coercive actions to curb such frauds. At the same time, there must be a fair allocation of funds for the development of the public health care infrastructure across the regions of the state to reduce regional disparity and associated social inequality. The public sector is without parallel in providing services to all people regardless of their social and economic status. Strengthening of the public sector, therefore, should and must be the ultimate goal of any egalitarian government.

### Conclusions

The regional disparity in Kerala appears to have resulted in the growth of private and philanthro-capitalist institutions in education and health sectors. This trend has adversely affected the process of development in the state and a large section of the weaker and vulnerable people appears to be the victims of this unwarranted trend. In order to address these challenges, local self governments - local bodies in urban and Panchayats in rural areas - must bear the responsibility of providing universal access to education and health care in the state. In order to do so, it is necessary that the state government provides the necessary back up support to local governments. In the absence of such a support, the regional disparity in almost all dimensions of development that is so pervasive in the state, will continue to have a deteriorating effect on the development processes of the state.

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Table 1  
Selected indicators of regional development in Kerala.

District	Population served by one PDS shop	Per capita income at current prices	Population served by one CHC/PHC	Population served by one HSC
Kasaragod	3349	93180	22853	5274
Kannur	2944	104246	23386	6115
Wayanad	3586	86202	8876	2031
Kozhikode	3162	105873	24916	5345
Malappuram	3350	85575	100267	20152
Palakkad	3029	94623	24657	5577
Thrissur	2581	123341	26359	6590
Ernakulam	2451	146518	28521	8000
Idukki	1589	119908	17304	3607
Kottayam	1997	120122	23564	5839
Alappuzha	1703	130172	33155	8161
Pathanamthitta	1437	92130	13284	3266
Kollam	1851	130341	29547	6291
Tiruvananthapuram	1758	118740	28028	6847

Source: Estimated by the author from different sources.

Remarks: PDS: Public distribution system  
CHC: Community health centre  
PHC: Primary health centre  
HSC: Health sub-centre