India and China: Health Care, Female Empowerment and Capabilities Approach to Development

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ABSTRACT

The Capabilities Approach asserts that development without consideration for human rights is misguided and unsustainable, and that governments and development organizations must focus on expanding individual freedoms by meeting basic needs, or expanding capabilities. In other words, development itself can be understood as the expansion of freedoms, and freedom is the ultimate goal of development. This article compares India's and China's social policy approaches and their impact on development as a whole, specifically focusing on health care and women's empowerment as variables of interest. While India can learn many lessons in social policy from pre-reform China, the importance of expanding women's access to democracy and strengthening democracy overall cannot be underestimated. Though there are segments of the Indian populace that believe successful development necessitates wholesale adoption of China's policies, India must endeavor toward strengthening democracy through greater involvement of women in the political process, rather than mimicking China by cutting back the democratic process as a whole.

THE CAPABILITIES APPROACH

The Capabilities Approach asserts that development without consideration for human rights is misguided and unsustainable, and that governments and development organizations must focus on expanding individual freedoms by meeting basic needs or expanding capabilities. The most prominent spokesperson for this approach is its creator, Amartya Sen, an Indian economist-philosopher who elaborates on the Capabilities Approach thesis in *Development as Freedom*. In his book, Sen contends that expansion of individual freedoms composes both the means and the ends to development. In other words, development itself can be understood as the expansion of freedoms, and freedom is the ultimate goal of development.

Citizens with individual freedoms are equipped to grow the economy while citizens who lack basic capabilities cannot. Sen places the responsibility for expanding capabilities with the state:

> A human rights approach brings to development the notion that people are entitled to have their basic needs met, and that those in power have a duty and a moral obligation to facilitate this process. By attributing culpability to those who fail to duly deliver these benefits, a rights-based approach thus introduces an element of accountability that can be a powerful tool…reducing poverty and inequality, providing basic services, combating exclusion and strengthening people's livelihoods can only be achieved within a political environment that simultaneously seeks to address the issue of human rights for all citizens.[1]

It follows that many of these basic capabilities stem from proper health; access to health care affects an individual's ability to participate in the economy and democracy. A family possessing the agency, productivity, and dignity that health facilitates will be more likely to spend money on children's education, a vital investment for a developing economy.[2]

Amartya Sen's ideas have "significantly influenced feminist development economics."[3] Development initiatives have excluded women in the past, as they often neglect women's potential for participation in the labor force and the political process. However, Sen's ideas can

be used to specifically evaluate development initiatives on the basis of their ability to expand women's capabilities. The Capabilities Approach thesis can make program evaluation much simpler. One simply has to ask, does this expand the capabilities of women or not? This essay will compare India's and China's social policy approaches and their impact on development as a whole, specifically focusing on health care and women's empowerment as variables of interest. While some argue that female empowerment is achieved via access to family planning services, the intention of family planning programs in India and China has historically not focused on the expansion of female capabilities. The importance of intention in the Capabilities Approach toward development for women will also be explored.

THE UTILITY OF THE INDIA-CHINA COMPARISON

When considering the development process of India and weighing potential development solutions for India's future, the trajectory of China's growth since the 1950s is a natural source of inspiration and caution. In *India: Development and Participation*, economists Jean Dreze and Amartya Sen discuss the importance of the Chinese growth narrative in informing Indian development. They claim that "it is natural to judge Indian successes and failures in comparative terms with China."[4] Dreze and Sen argue that this comparative tendency manifests itself in the in the formation of Maoist political parties in India that seek to replicate China's "successful liberalization programs and massive entry into international trade." This urge to take cues from China stems from the fact that only 60 years ago China and India began their development initiatives under relatively similar circumstances, but have since diverged in nearly every metric of development. To understand China's successes and failures is to gain relevant knowledge applicable to Indian development initiatives.

PRE-REFORM AND POST-REFORM CHINA

China's "take off" occurred in two stages, the first of which occurred from 1978 to 1993.[5] The initial reform was incrementally carried out by increasing the scope of the markets and utilizing government control of the market as a transitional institution. Though economists agree that "government ownership and control of firms does not have obvious advantage over private ownership," and that there are disadvantages to this system, during development there may be exceptions.[6] In early stages of economic development government control can be seen as a second-best response, and economic arguments for delaying the privatization of existing state firms point to the gaps in the social safety net, the lack of a legal framework for corporate governance, and the lack of regulatory institutions.[7] After this phase of development, China's government loosened the control of firms and allowed the progression of the market economy. The crucial difference between India and China that laid the groundwork for this transition was the social policy from the pre-reform period.

Dreze and Sen explore China before and after the economic reforms of 1979 because the pre-reform "accomplishments relating to education, health care, land reforms and social change" set the stage for China's takeoff in the post-reform period.[8] In 1949, China's condition (in terms of poverty, illiteracy, and undernutrition) was comparable to India's. Since then, China's population has achieved higher literacy rates and improved health care due to a combination of beneficial social policy from the pre-reform period and the unprecedented growth rate of the post-reform period. India has not been as successful in developing these areas, and can find inspiration in certain aspects of China's pre-reform social policy.

PUBLIC HEALTH AND DEVELOPMENT IN CHINA AND INDIA

Accomplishments in public health are an important component of pre-reform China's success, and are impressive considering the low economic growth of the period. Dreze and Sen claim that "China's real achievement…lies in what it managed to do despite poor economic growth."[9] Sen's capability approach explains the significance of health in development, of which China's success is an excellent example. Individual capabilities are expanded by public

health protections, and development can be understood as the expansion of these individual capabilities. An important indicator of public health infrastructure effectiveness is the under-5 mortality rate. China has progressed in this metric due to its combination of policy and rapid economic growth: "The reduction of under-5 mortality rates in China at the country, provincial, and county level is an extraordinary success story. Reductions of under-5 mortality rates faster than 8.8% (twice MDG 4 pace) are possible. Extremely rapid declines seem to be related to public policy in addition to socioeconomic progress."[10]

Public health campaigns in pre-reform China were effective and thorough, specifically in the realm of preventative measures. The Chinese bureaucracy was comprised of an expansive network of health workers charged with the maintenance, improvement, and expansion of medical infrastructure in rural areas. Public health infrastructure was particularly effective in the realm of preventative and vector-borne diseases. Local doctors were directly involved with what Dreze and Sen describe as "social mobilization for public health," which was comprised of directing and organizing the locale with urgency and precision.[11] By tackling preventative disease all over China and targeting vector-borne diseases aggressively, and by employing a network of public health officials, China achieved success in overall health care. The rural population of China benefitted from public health infrastructure in ways their Indian counterparts did not.

After reform, however, public health took a backseat to economic growth. The post-reform period is thus a less desirable model for India's development. While the burst of economic growth did help with the continued success of health programs, growth was primarily concentrated in urban areas, and the special focus given to rural China ceased in the post-reform period:

> A decentralized and fragmented health system, such as the one found in China, is not well-suited to making a rapid and coordinated response to public health emergencies…For the past 25 years, the Chinese Government has kept economic development at the top of the policy agenda at the expense of public health, especially in terms of access to health care for the 800 million people living in rural areas.[12]

For this reason, in the case of India, it is best to seek inspiration in China's pre-reform policy and recognize the limits of the post-reform period. Considering that China's post-reform growth has not been enough to sustain the admirable public health infrastructure of the pre-reform period, India's economic growth, which is much less than China's, is unlikely to carry the health of the citizens. Public and community health in India must be addressed through policy measures—pre-reform China proved that health reform can be successful in the absence of growth and an falter in the presence of rapid growth.

While existing Indian public health infrastructure is notoriously corrupt and criticism of the Indian bureaucracy is fair, it is unfortunate that negativity towards Indian public health infrastructure dominates public opinion. Preventative measures, such as the targeting of disease vectors, were an efficient use of China's resources and could potentially make a large impact on India considering vector-transmitted diseases are observed in India and only 0.8% of the Indian GDP goes towards health expenditures.[13] This is remarkably little relative to the health expenditures of other countries; it follows that the public health infrastructure is weak and limited. Frustration with the Indian public health bureaucracy is understandable but unhelpful -- if anything, there is an argument to expand public health infrastructure. The dismal state of public health services has increased the burden of Indian primary care providers because it allows the spread of infectious disease. While some physicians are particularly driven and have made an effort to work on public health issues, private practitioners simply do not have the time or resources to effectively work on public health initiatives. The Chinese model of pre-reform public health was carried out by an expansive bureaucracy and was effective in that it did not burden individual, specialized physicians with largely structural public health issues.

In health economies that depend on private care providers, information asymmetries between providers and patients hinder efficient competition. Normally,

competing private entities push one another to provide the best product, but in this case, consumers (patients) may or may not be aware of the quality of care they are receiving. While other countries implement regulatory bodies to manage the lack of efficient competition caused by information asymmetries, in India, these bodies are rife with corruption. Thus, the health care system is divided among highly specialized, technologically advanced care for the elite, and an unregulated informal sector for others. Greater equity can be achieved through a system like that of pre-reform China, one which includes widespread access to basic preventative measures for all. This system reduces pressure on private practitioners, and boosts the quality of care for low-income citizens who suffer disproportionately from preventable disease without access to private practice physicians.

This said, there have been significant successes in specific Indian public health campaigns which concentrate government efforts on a single goal. The Universal Immunization Program was launched in 1985 "with the objective of immunising 85 per cent of newborns and 100 per cent of expectant mothers by 1990" and protecting Indians from the most prevalent preventable infectious diseases in India.[14] The program was motivated by social development goals, and the belief that improving quality of life will by extension encourage growth in social and economic development sectors, which will in turn perpetuate further health care industry improvements. The program was able to surpass its initial goal of 85 per cent (the minimum required for herd immunity protection) and reach nearly 100 per cent immunization rates in all states for all vaccines with the exception of measles.[15]

> The Universal Immunisation Programme (UIP) in India has made an effort to make at least one vital service to the mother and child accessible and affordable. Universalisation of immunisation is the first step towards health for all. Unlike small-pox [sic], which was eradicated once for all, immunisation is a continuous and ongoing process. Anyone concerned with public health must now think of the various issues of the sustainability of UIP.[16]

Effective infrastructure was created to accomplish this feat, though there are concerns about sustainability; the initiative was well-planned at the central level but district immunization officers were unable to draw sufficient funds for longer-term protection.

The Universal Salt Iodization initiative also took a similar form. Iodization of salt is a vital component of preventative health care, and prevents neonatal hypothyroidism, poor mental health, and poor physical development.[17] In Uttar Pradesh, a state that does not manufacture salt, implementation consisted of three phases spanning four years that combined work with salt manufacturers, salt wholesalers, media organizations, and children's schools. An evaluation of the implementation found that "institutionalizing regular salt testing through the school network could be used as an effective method for rapid assessment of the salt situation in a geographical area and as a proxy for assessing progress towards reaching the USI goal."[18]

These instances show a capacity for social mobilization for health care campaigns, but also highlight a lack of sustainable and comprehensive public health initiatives. Though some states have demonstrated progress, there has not been a widespread, unified improvement in Indian public health, and the fact remains that a minuscule portion of the GDP is spent on public health. The unity and functionality of pre-reform China's public health network is a necessary source of inspiration for India. China's post-reform growth is the result of momentum set by pre-reform policy. To rely on economic growth to improve citizen capabilities and to assume that good health will follow the lead of economic growth is to disregard one of the most important components of Chinese development.

MALTHUSIAN FEAR AND WOMEN'S AGENCY NEEDS

A striking example of capabilities expansion through public health campaigns is the expansion of capabilities for women through access to family planning resources. While access to these resources is an important component of women's empowerment in developing areas, they must

be implemented in a manner that considers agency needs of women.

Modern gender and development approaches utilize the capabilities approach, and take into account both physical needs and "agency needs."[19] Amartya Sen dedicates a chapter of *Development as Freedom* to the topic of women's agency and social change. Women's agency includes several factors including, but not limited to, earning power, economic role outside the family, literacy, and property rights.[20] Sen explains that "the concentration [in the past] was mainly on women's wellbeing—and it was a much needed corrective. The objectives have now, however, gradually evolved and broadened from this 'welfarist' focus to incorporate and emphasize the active role of women's agency." He maintains that an "'agent' is fundamentally distinct from (though not independent of) a patient."[21] According to Sen, experiencing wellbeing is only one dimension of personhood—acknowledging agency is the other. Furthermore, focusing on agency may "remove the inequities that depress the wellbeing."[22]

By this logic, simply providing access to family planning resources or creating policy that encourages a low fertility rate is not sufficient for promoting women's agency. While access to family planning provides resources that may empower women, it fails to comprehensively improve women's empowerment because its emphasis is not directed towards actively improving women's agency. In the case of China and India, the focus of family planning programs is on curbing population growth, not on the improvement of women's agency.

Family planning is an area of interest in both China and India, and the policies that relate to family planning in these nations are driven by a fear of rapid population growth, not by a desire to work towards women's empowerment. During development, populations tend to grow as birth rates remain high and death rates decrease because of medical advancements, sanitation, and economic growth.[23] Fertility rates stay constant, in a phenomena known as birth rate inertia, caused by the large proportion of young people; even if some have few children, there are sufficient couples that the birth rate remains high. In addition, "societal norms regarding children and other socioeconomic factors" play an important role in birth rate inertia.[25] Malthusian fears drive government interests in fertility, and these interests have significant impacts on the freedoms of women.

China responded to this birth rate inertia with its famous One Child Policy. By incentivizing parents to have just one child, China's government indirectly created an aggregate disadvantage for young girls. In any environment with failing markets of insurance (social security or pension), parents must have children until the marginal benefit of having an additional child equals the marginal cost, and the utility of children is old-age support.[25] Furthermore, if it is a cultural view that only sons will be responsible for old-age support, this ideal number of children for old-age support doubles. The policy "jeopardizes old-age security" and may result in discrimination against daughters in the form of sex-selective abortion or female infanticide.[26] In the instance that mothers are pressured to have just one child, they are more likely to adhere to the rule if they have a son first than if they first have a daughter. In the case that most daughters are born to multiple-child families, and sons are more likely to be only children, sons will systematically benefit from the only child incentives more frequently than daughters.[27] This will result in a long-term gender disparity, emerging from disparate access to financial support, quality education, and even parental attention.

There are arguments that the One Child Policy actually benefits women: it decreases the burden of childrearing and may even encourage female participation in the workforce. The One Child Policy may have "indirect benefits for some Chinese women" but it is vital to note that it "is not explicitly designed for the benefit of women."[28] Even if it contains indirect benefits for women, it is fundamentally "in conflict with the right of women to make decisions concerning their own reproductive choices" when "women should be able to attain full equality without first being required to undergo the supreme sacrifice."[29] Sen and Dreze describe this sacrifice as a loss of freedom, as a "social loss in itself," and maintain that the same end result can be achieved through other means, means that expand freedom through education and opportunity rather than reducing

freedom through coercion.[30] For example, the Indian state of Kerala has achieved a fertility rate of 1.8 (lower than China's) without state coercion. This progress is attributed to the education of women and the involvement of women in gainful employment.[31]

In India, public health campaigns have emphasized the importance of contraception out of Malthusian fear. In fact, "after the World War II era, Western experts…warned [of] population explosion and its terrifying consequences: famines, riots, political instability, expansion of Communism, wars. A heterogeneous coalition of demographers, public health experts, and politicians was urgently looking for an effective means to curb population growth."[32] Even decades before, "concerns about population growth in India began to be expressed late in the nineteenth century, ironically when there was little or no data to establish the fact of population growth."[33] The very first Indian Five Year Plan (1950-1955) included slowing the birth rate among the country's most urgent tasks.[34] Access to family planning resources was lauded as a solution to the population problem. However, the women's right to family planning in India did not result from protracted protests of feminists as it did in the West. It was a recommendation of the government, a recommendation that was not seeking to expand the rights of women.[35] While explicitly, justifications included women's health and wellbeing, politicians were focusing on women's roles as mothers, and the ways in which women can impact economic and population growth—family planning was about reproduction, not about the expansion of liberties for women.[36]

Clearly, nonetheless, access to family planning expands some capabilities of women in developing nations. Following Amartya Sen's capabilities approach, which asserts that provision of capabilities is an important means to development, it could be that, regardless of its intention to control women, family planning access in India is beneficial to women. After India's first implementation of population policy, access to family planning measures improved women's health and wellbeing by allowing them to limit the number of children they have, and decreased the financial and bodily strain associated with multiple unplanned births.[37] However, in practice, social pressures led women to only use contraceptives after already having children.[38] This expanded capabilities by allowing women to improve their health status, but if the main utilizers of family planning resources were mothers who had already fulfilled social norms of childbearing, then benefits of contraception for single women were not fully observed. These benefits would include improved access to higher education and greater opportunity for gainful employment which works slowly to develop women's participation in the economy.

The *Family Planning Practices in India Third All India Survey* provides insight into the norms of family planning in the year 1990, almost 50 years after the original push for contraception and population control. The survey, sponsored by the Ministry of Health and Family Welfare, investigated differences in family planning practices by geography, gender, educational level, and several other parameters. The found that 30 years remained the median age at which women begin using family planning services. When compared with the average age of marriage, the survey claims that it seems women begin using family planning techniques only after achieving a desired family size.[39] Further corroboration of this conclusion comes from the data that reflects that 70 percent of total family planning patients choose sterilization.[40] Access to family planning methods has enabled couples to stop having children, allowing for more manageable family financial decisions and for women to better manage their own bodies.

It does not appear that women are empowered in these decision-making processes merely because family planning services are available. The educational status of wives is positively correlated with the age of marriage, the number of children desired, and the general awareness of family planning techniques.[41] Furthermore, in rural settings, large proportions of men "reported that they had 'never' discussed [family planning issues] with their wives" and it was shown that awareness of female sterilization methods was far greater than that of male sterilization methods.[42] Family planning has improved the capabilities of women in some ways, but not in the most efficient way, and has

not affected the lives of women from rural backgrounds or women who have not completed their education. The report concludes that "existing methods of canvassing… need to be reviewed."[43]

CONCLUSIONS

While India has had less success than China in expanding education access to women, there have been some strides in the realm of women's education and democratic participation. Education for women has increased and improved over the last three generations, but education has not translated directly to political participation. While there are greater numbers of women voters, "it does not indicate that political consciousness and level of participation in women in political affairs have been as expected…Politics has remained outside the domain of women. Raising a handful of them to the topmost level in the Parliament, Cabinet or administrative jobs cannot be accepted as the index of general level of consciousness…"[44]

While India is able to learn many lessons in social policy from pre-reform China, the importance of expanding women's access to democracy and overall strengthening of democracy cannot be underestimated. Dreze and Sen explain that "no substantial famine has ever occurred in a democratic country where the government tolerates opposition, accepts the electoral process, and can be publicly criticized."[45] A nation is protected by those that hold the government accountable—voters, vocal protestors, and a well-supported press. The greatest "non-lesson" from China is observed in a comparison of China's poor record with famine and India's performance in famine prevention since independence in 1947.[46] Dreze and Sen place responsibility for famine on China's failing incentive system in agriculture and poor distribution policies. While these were certainly the root cause of famine, the inability of the poor to respond or protest, and the Chinese government's immunity to public pressure ensured that the policies could not be adjusted until the famine was well underway. In fact, by the time the famine was registered in government offices, it had been going on for three years.[47] Though there are segments of the Indian populace that believe successful development necessitates the adoption of all of China's policies, India must endeavor towards strengthening democracy through greater involvement of women in the political process, rather than aiming to cut back the democratic process as a whole, mimicking China.

Using the capabilities approach to examine the successes and failures of China and India allows for future recommendations and prioritizations in future development proposals in Asia.

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