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Aims and Scope

The Journal provides a forum for in-depth analysis of the problems of social, economic, political, institutional, cultural and environmental transformation taking place in the world today, particularly in developing countries. It welcomes articles with rigorous reasoning, supported by proper documentation. Articles, including field-based ones, are expected to have a theoretical and/or historical perspective. The Journal encourages inter-disciplinary articles that are accessible to a wider group of social scientists and policy makers, in addition to articles specific to particular social sciences. The Journal also gives scope to Research Notes, Comments, Book Reviews and Review Articles.

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Articles

Review Articles

Book Reviews

Pareto's Revenge

Ravi Kanbur

Introduction: PI, PE, PO

Consider a project or a policy reform. In general, this change will create winners and losers. Some people will be better off, others will be worse off. Making an overall judgment on social welfare depends on weighing up the gains and losses across individuals.[1] How can we make these comparisons? In the 1930s, a strong school of economic thought led by Lionel Robbins (1932, 1938) held that economists *qua* economists have no business making such judgments. They only have a basis for declaring an improvement when no such interpersonal comparisons of gains and losses are involved. Only a change which makes nobody worse off and at least one person better off, can be declared an improvement.

Such a change is called a Pareto Improvement (PI). If no such changes are possible, the state of affairs is described as being Pareto Efficient (PE), a Pareto Optimum, or Pareto Optimal (PO). Named after Vilfredo Pareto (1906), PI and PE are central to post 1945 high economic theory. After all, PE makes an appearance in the two fundamental theorems of Welfare Economics. These are that every competitive equilibrium (CE) is PE, and every PE allocation can be achieved as a CE, under certain conditions. Through these theorems, the post second world war economic theory of Kenneth Arrow and Gerard Debreu links back to Lionel Robbins and Vilfredo Pareto, and thence to Adam Smith's Invisible Hand of competitive markets (Arrow 1951; Debreu 1959). From there the links come full circle back to stances taken in current policy debates on the role of markets and government.

Dr. Ravi Kanbur is T.H. Lee Professor of World Affairs, International Professor of Applied Economics and Management, and Professor of Economics, Cornell University. A paper prepared for the Workshop on Ethics, Globalisation and Hunger. New York: Cornell University, November 17-19, 2004.

Socio-Economic Dimensions of Old Age Security in India: With Special Reference to Karnataka

T. V. Sekher

Abstract

Estimates indicate that the elderly population (60+ years) of India will increase to 100 million by 2013 and 198 million by 2030. A majority of the elderly are in the rural areas and nearly 30 per cent of them are below the poverty line, making the provision of old age support highly justifiable but equally challenging. Among the elderly population, the share of female and status of widowhood are increasing with age. In this context, the paper broadly reviews the socio-economic dimensions of aged and the social security measures required to safeguard the interests of the growing elderly population in India and in Karnataka, using the available data from Census, NSSO and other secondary sources. Taking the Karnataka situation as an illustration, the need for evolving various policy interventions to strengthen the well-being of the aged is emphasised here.

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Gender, Poverty and Employment in India

V. Gayathri

Abstract

Development theories recognise that employment is central to the alleviation of poverty and the enhancement of well-being. This means that at the practical level, it is understood that labour-intensive growth and greater labour-force participation by women are necessary elements for poverty reduction. At the level of discursive practice, the gender and poverty debates treat labour as an abstract category. In recognition of this lacuna, this paper attempts to address two principal questions: a) Does poverty have a woman's face in India? and b) What are the linkages between women's situation in the labour market, education levels and their poverty? The paper attempts to answer these issues by reviewing the changes that have occurred in the reported level of women's economic activity, women's status in the labour market, gender differentials in poverty and the impact that gender mainstreaming in employment and poverty have had on women's lives. Drawing inferences from national level surveys, policy statements and legislative framework, the paper argues that poverty needs to be understood more holistically - in terms of lack of access to services, lack of personal security, low social status and lack of control over labour and employment. The paper concludes by advocating for policies that directly affect the quantum and quality of women's participation in the labour market such as those concerned specifically with regulating gender relations in employment and those concerned with balancing work and familial responsibilities.

Poverty also has outcomes with respect to sexual division of labour, which are affected by the regulation of the wider social environment in which men and women make decisions. For example, personal laws, regulated by cultural institutions, indirectly affect women's access to land and other immovable assets, thereby excluding them from control over their labour and often even skills that can lead to better quality employment.

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Health Financing Reforms in India: Lessons from other Countries

S. Sandhya

Abstract

This paper examines the economic theory behind State's intervention in the provision and financing of health care. The paper is a meta-analysis and a) reviews critically the approach to health policy by various countries and examines the link between public health spending and the allocation of health expenditure in different sectors, on the one hand, and health outcomes and equity, on the other; b) it examines the health status of India and notes that the health needs of the country require more public health measures than ever before and looks into the quality of private health care; c) it examines the causes for mortality transition of developed and developing countries and notes the role of inter-sectoral approach to the success of Sri Lanka, China, Taiwan and South Korea and suggests that India should follow the same, because India is characterised with high malnutrition, high incidence of communicable diseases, and high infant mortality. In India, out of the total health expenditure, only 20 per cent is from the government and the rest is from private sector; it notes that the health outcomes and equity are better in countries where the share of public health expenditure is more. It also notes that out of this public expenditure in India, 65 per cent was spent on medical sector – an inefficient way of spending resulting in poor health outcomes. To achieve better outcomes and equity, the government must intervene in subsidising prevention and treatment of communicable diseases and subsidising rural health; d) it reviews different sources of health financing and their limitations and notes that the major source of health financing in India—out-of-pocket expenditure — is an inflationary and cost escalating method resulting in inequity in spatial distribution of health services in India; and e) finally, it examines the circumstances under which various countries adopted reforms in health

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care. It also examines the experiences of other countries with regard to one financial strategy, i.e., user fee and its impact on cost recovery, utilisation, and equity and shows that user fee as a strategy did not give the expected results. It concludes that user fee in India may not be suitable because here 75 to 80 per cent of the users are from private sector. Also, user fees as a tool to reduce the financial burden may not be applicable in the Indian context with its high poverty levels, malnutrition, inequity in health facilities and low literacy levels.

Introduction

There are two basic theoretical frameworks on which different health systems can be analysed—libertarian and egalitarian (Culyer *et al* 1981). The former values consumer sovereignty and market forces while the latter is committed to the pursuit of community health – equal health as a right to everyone, and inability to pay should not deny access to this fundamental human right. The egalitarian approach favours *equality of opportunity* (physical proximity and lowering of financial barriers), i.e., equal access and opportunity to the poor in the use of health care.

United States of America follows the libertarian approach, with its private insurance-based system and buys health care using public fund insurance for deserving poor and the elderly (Peabody *et al* 1996).

Australia and other OECD countries follow egalitarian approach with social insurance system and the governments of these countries take into account externalities, such as preventing communicable diseases, protection of environment, etc., and provide merit goods. The health outcomes are better in these countries than in the United States[1], which follows libertarian approach. The government's role as an agent to reduce risk and improve welfare has both an economic value to society in terms of maintaining household productivity and humanitarian value of helping the disadvantaged. Even the argument for interventions in health care, so as to reduce poverty, is largely economic. Economic theory suggests that governments may or should intervene in health care system to redress the failure of the market mechanism.

The basic needs approach to development focuses on welfare aspects and explicitly considers inequality in society. For the eradication of mass poverty and attaining equity[2] in society, economic growth alone is not adequate. A comprehensive range of economic and social policies is needed. Equity is associated with social justice and fair distribution of resources. Under basic needs approach, social services are extended to different social groups based on needs. Health, along with education and other human services, forms the social sector. In this approach, the most vulnerable groups are attended first.

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