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Drivers of Primary Healthcare and Elementary Education Initiatives in Karnataka (2014–2024)

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Designed by Umesh Kumar

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I would like to thank Sandhya Venkateswaran for providing the time, resources, and immense patience for this study. The study was initiated before the national elections, and field research, which involved detailed interviews with the state-level bureaucracy, became complicated and unpredictable. Her support and space were critical to the completion of this report.

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Table of Contents

Abbreviations	5
Project Overview	7
Executive Summary	8
1. The Problem	11
2. The Questions	14
3. The Methods	16
4. The Insights	18
4.1 Limited State-Level Initiatives in Primary Healthcare and Elementary Education	18
4.2 Exploring the Lack of Focus on Primary Health	20
4.3 Examining the Policy Challenges Prioritised by the Initiatives	24
4.4 Drivers of New Initiatives in Health and Education: Central Government Policy Push and the Local “Policy” Context	28
5. The Implications	33
References	37
Appendix 1: Summary of Health and School Education-Related Initiatives	39
Appendix 2: Detailed Methods Framework	47

List of Tables

Table 1: Comparative Performance Karnataka on Key Health and Elementary Education Indicators Most Recent Data (2020–2024)	11
Table 2: Comparative Performance of Karnataka on Key Health and Elementary Education Indicators (2015–2018) ...	12
Table 3: Uptake of Health Facilities in Karnataka Across NFHS-4 and NFHS-5	14
Table 4: Uptake of Health Facilities in India Across NFHS-4 and NFHS-5	14
Table 5: Categorisation of Key Informants According to Their Role in State-Level Initiatives	17
Table 6: % Share of Health in Total Budget in Karnataka	19
Table 7: No. of UPHC, MO, and ANM Deficit in Bangalore, Belagavi, and Shivamogga	20
Table 8: Comparative Listing of MCH-Related Indicators	23
Table 9: Enrolments and Number of Private Unaided (Recognised Schools) in Elementary Classes in Karnataka 2012–2019	25
Table 10: State-Wise Numbers of Recognised Private Un-Aided Schools Having Elementary Classes I-VIII (2021–2022)	25
Table A1: Summary of Key Health and Education Related Initiatives in Karnataka 2014–2024 as per the Economic Survey Reports	39
Table A2: Key Health Focused State-Level Initiatives in Karnataka 2014–2024	45
Table A3: Key Education Focused State-Level Initiatives in Karnataka (2014–2024)	46
Table A4: Research Questions, Probe Areas and Data Sources	47

Abbreviations

AB-ARK	Ayushman Bharat-Arogya Karnataka
AB-HWC	Ayushman Bharat-Health and Wellness Centre
AB PM-JAY	Ayushman Bharat Pradhan Mantri Jan Arogya Yojana
ANM	Auxiliary Nurse Midwife
APF	Azim Premji Foundation
ASHA	Accredited Social Health Worker
BAS	Basline Assessment Survey
BPL	Below Poverty Line
CAG	Comptroller and Auditor General
CBGA	Centre for Budget and Governance Accountability
CBSE	Central Board of Secondary Education
CHC	Community Health Centre
CWSN	Children with Special Needs
DBT	Direct Benefit Transfer
DIETS	District Institutes of Education Training
DIKSHA	Digital Infrastructure for Knowledge Sharing
DPEP	District Primary Education Programme
DSERT	Department of State Educational Research and Training
ECO	Education Coordinator
FICCI	Federation of Indian Chambers of Commerce and Industry
FRU	First Response Unit
GoK	Government of Karnataka
GoI	Government of India
GSDP	Gross State Domestic Product
HPCRRRI	High Powered Committee for the Redressal of Regional Imbalances
HWC	Health and Wellness Centre
HMIS	Health Management Information Systems
HLEG	High Level Expert Group
ICSE	Indian Certificate of Secondary Education
ICT	Information and Communication Technology
IHIP	Integrated Health Information Platform
IIPS	International Institute for Population Sciences
IMR	Infant Mortality Rate
JSS	Jyothi Sanjeevini Scheme
JSV	Janani Suraksha Vahini
JSY	Janani Suraksha Yojane
KEA	Karnataka Evaluation Authority
KGBV	Kasturba Gandhi Balika Vidyalaya
KKRDB	Kalyan Karnataka Region Development Board
KLES	Karnataka Lingayat Education Society
KPS	Karnataka Public School
KQAAC	Karnataka State Quality Assessment and Accreditation Council
MCH	Maternal and Child Health
MLA	Member of Legislative Assembly
MMR	Maternal Mortality Rate
MO	Medical Officer

MoE	Ministry of Education
MoHFW	Ministry of Health and Family Welfare
MP	Member of Parliament
NAS	National Achievement Survey
NCD	Non-Communicable Disease
NEP	National Education Policy
NFHS	National Family Health Survey
NHM	National Health Mission
NHP	National Health Policy
NIMHANS	National Institute of Mental Health and Neuro-Sciences
NMR	Neonatal Mortality Rate
NRHM	National Rural Health Mission
NTCP	National Tuberculosis Control Programme
NUHM	National Urban Health Mission
NVBDCP	National Vector Borne Disease Control Programme
OOSC	Out-of-School Children
PCI	Per Capita Income
PHC	Primary Health Centre
PM-ABHIM	Pradhan Mantri Ayushman Bharat-Health Infrastructure Mission
RBSK	Rashtriya Bal Swasthya Karyakram
RCH	Reproductive and Child Health
REMS	Research, Evaluation, Monitoring, and Supervision
RNTCP	Revised National Tuberculosis Control Programme
ROI	Return on Investment
RTE	Right to Education
SAST	Suvarna Arogya Suraksha Trust
SCI	Supreme Court of India
SDMC	School Development and Monitoring Committee
SDG	Sustainable Development Goal
SEPC	State Education Policy Commission
SPV	Special Purpose Vehicle
SRS	Sample Registration System
SSA	Sarva Shiksha Abhiyan
STEP	Sikshana Technology in Education Programme
STS	Student Tracking System
TALP	Technology Assisted Learning Programme
TB	Tuberculosis
U5MR	Under 5 Mortality Rate
UDID	Unique Disability Identity
UPHC	Urban Primary Health Centre
VHSC	Village Health Sanitation Committee
WHO	World Health Organization

Project Overview

This paper is part of a three-state study on the drivers of state-level initiatives in primary healthcare and elementary education in urban areas during the last decade, from 2014 to 2024. The selected states are Karnataka, Rajasthan, and Odisha. Effective social welfare, whether in the areas of education, health, sanitation, water, or nutrition, is not only dependent on how well existing programmes are implemented and governance systems function but also on the extent to which social welfare is prioritised by state and national governments. Prioritisation is reflected in forms such as increased budget allocation, mission-mode implementation of existing programmes, or the development of new initiatives that solve specific challenges. Prioritisation of social welfare, whichever form it takes, shapes the commitment of actors such as political leaders, bureaucrats, civil society actors, and professional associations in addressing the challenge. It is widely understood among the community of practitioners as well as researchers that whenever an initiative is implemented in mission mode, through the support of national and state-level executives, the highest levels of political and bureaucratic commitment are given to achieve the project goals.

The overarching question that the study examines is why and when a state undertakes new initiatives in the areas of primary healthcare and elementary education in urban areas. This question will be examined in each of the study states and discussed in stand-alone state-level reports. This will be followed by an overarching synthesis paper in which we will analyse the common drivers of the initiatives across all three states. We will also examine whether the nature of the initiatives differs across the synthesis papers due to differences in the drivers. Lastly, we will examine if the initiatives will solve the key challenges facing elementary education and primary health, or even the challenges they expressly choose to focus on.

Two of the three selected states are Karnataka and Rajasthan; the third state is yet to be finalised. The selected states represent three types of contexts with regard to the emergence of new State-level initiatives. The first is a well-resourced state (indicated by per capita income [PCI]) with health and education indicators above the national average. The second is a poorly resourced state with indicators below the national average. Lastly, there is a state where the political leadership is taking an active interest in

health and education and has undertaken important state-level initiatives.

Karnataka is often regarded as a progressive state with strong social indicators and high PCI. However, gaps exist in both the performance and provision of elementary schools and primary health facilities. Yet, neither of these two areas has been a policy priority in Karnataka. Rajasthan is a large state with low PCI and poor performance on critical indicators such as maternal mortality and infant mortality. It has strong civil-society-led movements advocating for progressive legislation in health and education, the most recent of which is the Right to Health Act. It is important to note that these states face some of the key public health-related challenges present across India, such as a shortage of healthcare personnel and primary care infrastructure, bypassing of the public primary care system, and poor nutritional status among children. These states have not been selected because they have unparalleled public health and education challenges but because they present an insightful puzzle regarding the drivers of state-level initiatives.

The findings will highlight what drives policymaking in diverse settings. This study will shed light on the key stakeholders in state-level policymaking and examine whether there is something inherent in the nature and process of state-level policymaking that leads some states to adopt active and engaged roles in making social welfare policies aligned with grassroots-level realities, while others do not. Broadly, across the three states, the project will employ the following methods:

- a) Analysis of key government policy documents and knowledge reports, such as the state's economic survey reports and Finance Commission reports;
- b) Key Informant Interviews (KIIs) with bureaucrats at the state, district, and facility levels (schools and Primary Health Centres [PHCs]), civil society leaders, researchers, academics, journalists, and engaged citizens; and
- c) Analysis of health and education datasets, which include the Unified District Information System for Education (U-DISE), National Achievement Survey (NAS), Sample Registration System (SRS), and National Family Health Survey (NFHS).

Executive Summary

This study examines the drivers of state-level initiatives in primary healthcare and elementary education in Karnataka, focusing on urban areas over the decade from 2014 to 2024.

Karnataka is often praised in nationally prominent indices as a progressive state with strong fiscal, health, and education indicators. However, our analysis questions this categorisation, suggesting that Karnataka's good performance is limited to certain indicators, where it is only marginally better than the national average. In many other health and education indicators, such as out-of-pocket expenditure and learning levels, Karnataka's performance is sluggish. The state exhibits stark intra-state disparities, and the uptake of public health and education facilities compared to private ones is poor. Despite historically undertaking prominent initiatives, Karnataka is not a national leader in health and education. It possesses a strong financial resource base, with one of the highest Per Capita Income (PCIs) in India, and an active, skilled civil society. We analyse the drivers of state-level initiatives to understand why Karnataka has not become a national leader with high uptake and quality of primary health and elementary education in urban areas. Our focus is on initiatives funded or ideated by the state during 2014–2024, specifically those addressing elementary education and primary care as a whole.

Our study addresses the following questions: (a) What have been the key initiatives in primary health and elementary education? (b) What policy challenges do they focus on, and how do these challenges relate to the everyday functioning of elementary schools and Primary Health Centres (PHCs)? (c) What drivers led to these initiatives? Understanding the current policy initiatives and their drivers will highlight the nature of the government's focus on health and education and the types of challenges that have been prioritised.

We also argue that, while the policy focus on strengthening both elementary education and primary healthcare systems in Karnataka has been weak, primary health has comparatively received less attention. Our study found that new initiatives in elementary education include the Karnataka Public School (KPS) and the State Education Policy Commission (SEPC), both

of which are either funded and/or ideated by the state. In primary health, the initiatives are Namma clinics and Ayushmati clinics, funded by central funds from the 15th Finance Commission.

These initiatives focus on the challenge of declining uptake of facilities in health and education. We describe these as the “big” challenges, as they define the rationale of state-level policy initiatives. Another set of challenges, such as infrastructural weaknesses and unequal distribution of staff, which are critical for enhancing the uptake of facilities, are also present. We refer to these as “small” challenges, as they are not the focus of state-level initiatives.

We argue that there is a mismatch between (a) the types of problems on which the initiatives focus and those that are central to the issue of low uptake, and (b) the solutions proposed to address the challenges and those that will be effective.

State-level initiatives in both primary health and elementary education are led by state-level bureaucracy and political leadership. These initiatives result from a policy push from the central government and the Local Policy Context. We find that all new state-level policy initiatives respond to a “Local Policy Context.” This differs from the local context, which is defined by caste, community, political affiliation, economic, and epidemiological factors. The Local Policy Context refers to those attributes that must be considered for new initiatives to emerge. For example, one of the local contexts of Belgaum city in Karnataka is its high migrant population in urban areas due to a strong presence of local industries. However, this alone is insufficient to drive state-level policy initiatives. The policy initiatives are driven by the conditions present in the Local Policy Context. We identified four such conditions, and all the initiatives we investigated and discuss in this report meet these conditions. We also argue that new initiatives must fulfil the conditions of the Local Policy Context.

State initiatives primarily address challenges that are widely recognised by stakeholders within the school system, although these may not be the most critical issues affecting low uptake. Stakeholders include school users, administrators, and engaged citizens. An example of such a challenge is the absence of English

as the medium of instruction in government schools, as opposed to focusing on teacher training. Secondly, initiatives must offer solutions that are visible and comprehensible to ordinary residents. For instance, initiatives that establish new neighbourhood clinics are more likely to materialise than those involving the mapping of vulnerable populations to better locate new health facilities. Thirdly, new initiatives should be beneficial to local politicians. Lastly, these initiatives should not entail additional financial implications. Other pathways and stakeholders in Karnataka have been less prominent in driving state-level initiatives over the past decade. These include internal bureaucratic processes, advocacy by civil society and professional bodies, expert bodies, commissions, legal rulings, and social movements.

We argue that Karnataka requires new types of state-level initiatives. To this end, we propose three recommendations to transform the local policy context and one for introducing additional pathways from which new initiatives can emerge.

Firstly, PHCs and schools must be valuable to the tax-paying middle classes, who can demand better services, not just the poor. We suggest that the state government should create a “diversity index.” This index would measure the uptake of PHCs and schools among both the poorest and the well-to-do within the facility’s catchment area. To enhance uptake among the middle classes, the administration will need to implement quality improvement measures in health and education facilities. Diversity rankings would be utilised by civil society bodies and engaged citizens to demand better public services.

Second, another aspect of the local policy context that requires transformation is the inability to increase funding for health and education. This necessitates strengthening the economic rationale for increased public investment. In the current policy context, the role of health and education acknowledged in the growth narrative is limited to enhancing productivity through a skilled and healthy population. However, this does not convincingly argue why public facilities should undertake this role. To address this, a government-commissioned study should quantify the cost implications when households privately fund health and education and demonstrate how reduced income for consumption and savings, along with increased inequality, impedes

the creation of a high-growth state. The study must be commissioned by a high-level government body to lend it greater legitimacy and enhance its value for public mobilisation. The findings should be actively disseminated through national and local media, as well as through the activities of engaged civil society organisations.

Third, the local policy context should ensure political ownership of the quality of health and education facilities. This requires the emergence of constituencies that demand quality health and education, which can, in turn, benefit political leaders during and outside elections. One approach is for state departments to create constituency-wise profiles of the state of health and education facilities, along with detailed plans for improving performance. Civil society organisations, academic institutions, writers, and local party workers can assist the state government in developing this index and in fostering political mobilisation around the constituencies.

Lastly, policy initiatives need to strengthen non-bureaucratic channels for developing new initiatives. We make two recommendations. First, instead of ad hoc committees and expert commissions, we recommend the establishment of state-level advisory bodies in education and health, which have the authority to conduct independent examinations and prioritise issues affecting primary health and education, proposing new initiatives. Second, recommendations for strengthening health and education made by various expert bodies, consultations, and commissions in Karnataka need to be publicly endorsed by political leaders. It is important that political campaigns acknowledge and respond to these recommendations, even if they disagree. Doing so would create support groups around solutions to key primary health and education problems and ensure that political leadership takes ownership of them.

We employed qualitative methods in this study, conducting key informant interviews and reviewing government reports (Economic Survey, PAB minutes, National Health Mission [NHM] ROP) and policy documents (state-level task force reports, Comptroller and Auditor General (CAG) Reports, Finance Commission Reports). Our analysis was conducted at three levels: state, selected districts, and sub-district, i.e., taluka and school/PHC. The study districts included one district in North Karnataka

and another in South Karnataka, each with a prominent urban centre under a municipal corporation. Key informants included state, district, and front-line-level health and education bureaucrats, civil society leaders, academics, policy researchers, journalists, engaged citizens, and ordinary users of health and education facilities.

This report is divided into four sections. In Section 1, we discuss Karnataka’s social and economic indicators and its underperformance in health and educa-

tion. In Section 2, we outline the questions this study addresses and argue for a focus on primary health and elementary education in urban areas. Section 3, “The Methods,” details the key methods used in this study, the study sites, and the analytical framework. In Section 4, “The Insights,” we present the main findings of this study. In the last Section, “The Implications,” we synthesise the arguments and discuss their implications for policymaking in health and education in Karnataka, offering policy recommendations.

1. The Problem

At the start of this study, we selected Karnataka as a case of a rich state with strong health and education indicators, which had shown steady improvement over the last decade. We concluded that Karnataka was possibly channelling its financial prosperity towards the social welfare of its people and improving health and education, and we were curious to examine the new initiatives the state had developed, the problems it had solved, and the drivers of these initiatives. However, the course of our study challenged our state selection itself. Karnataka’s performance appeared less impressive. We start by laying out the state of health and education in Karnataka.

Home to the “Silicon Valley of India” with ambitions of becoming a USD 1 trillion economy, Karnataka is hailed as a progressive state (Planning, Program Monitoring and Statistics Department, Government of Karnataka [GoK], 2022) in important government reports and documents. The state from which the maximum number of Jnanpith awardees have

emerged, Karnataka is a high-growth state and has strong social indicators. It has the third-highest PCI in India (GoK, 2023) and among the highest PCI growth from 2014–2023¹ (Deloitte, 2024; GoK, 2015, 2023). The 15th Finance Commission² (Government of India [GoI], 2020) praises Karnataka for good performance in health, nutrition, education, and gender equality.³ The Finance Commission’s only concern for Karnataka is its prominent intra-state social welfare disparities. Other reports, such as the NITI Aayog SDG India Index 2023–2024, also argue that Karnataka is not a state one should worry about. Health and education indicators commonly discussed in these indices are under 5 mortality rate (U5MR), infant mortality rate (IMR), neonatal mortality rate (NMR), maternal mortality ratio (MMR), and learning levels. Karnataka appears to have performed well when compared with national averages in recent data during 2020–2024 (Table 1) and has shown improvements over previous rounds of data collection (2015–2018) (Table 2).

Table 1: Comparative Performance Karnataka on Key Health and Elementary Education Indicators Most Recent Data (2020–2024)

Indicator	Karnataka	India	Data Sources
Under 5 Mortality Rate (U5MR)	21	32	(Office of the Registrar General Census Commissioner, 2022) SRS 2020 (p.159).
Infant Mortality Rate (IMR)	19	28	(Office of the Registrar General Census Commissioner, 2022) SRS 2020 (p.133).
Neonatal Mortality Rate (NMR)	14	20	(Office of the Registrar General Census Commissioner, 2022) SRS 2020 (p.142).
Maternal Mortality Ratio (MMR)	69	97	(NITI Aayog, 2024) (p.94).
NAS-Mathematics Score in Government Schools (Class 5)*	48%	45%	(Ministry of Education [MoE] GoI, 2021) NAS Report, 2021 (p.18).
NAS-Performance of Students in Different Languages in Government Schools (Class 5)*	61%	55%	(Department of Education and Literacy, 2022) NAS Report Karnataka, 2021 (p.18).

*Percentage of children who give correct responses.

¹ It went from Rs 1,00,594 in 2014 to Rs 3,01,673 2023 (Deloitte, 2024; Government of Karnataka, 2015, 2023).

² The President of India established the 15th Finance Commission under the Chairmanship of NK Singh. The Commission tabled its first report in Parliament in 2020 for the FY 2020–2021 and a second report in February 2021 for the FY 2021–2026. The second report considered the COVID-19 crisis in its recommendations.

³ It uses data from Niti Aayog’s 2019 SDG Index (Niti Aayog, 2019).

Table 2: Comparative Performance of Karnataka on Key Health and Elementary Education Indicators (2015–2018)

Indicator	Karnataka	India	Data Sources
U5MR	28	36	(Office of the Registrar General Census Commissioner, 2022) SRS 2020 (p.164).
IMR	23	32	(Office of the Registrar General Census Commissioner, 2022) SRS 2020 (p.137).
NMR	16	23	(Office of the Registrar General Census Commissioner, 2022) SRS 2020 (p.147).
MMR	97	122	(Sample Registration System Office of the Registrar General of India, 2020).
NAS Mathematics Score in Government Schools (Class 5)*	68%	54%	(National Council for Educational Research and Training, 2020) NAS Karnataka Class 3, 5 and 8 2017 (p.5).
NAS Language Score in Government Schools (Class 5)*	73%	58%	(National Council for Educational Research and Training, 2020) NAS Karnataka Class 3, 5 and 8 2017 (p.5).

*Percentage of children who give correct responses.

The story seemed almost too good to be true when we started this study. On closer examination, we discovered deeper structural challenges in the social welfare situation in Karnataka, which essentially lies between two truths. On the one hand, Karnataka is indeed a rich, fiscally secure state, and compared with national averages, it has performed better on many health and education indicators. On the other hand, a closer disaggregation of the data highlights that its performance has been sluggish. We explain the reasons for our argument in the following discussion.

First, according to recent data, Karnataka’s performance on many important indicators is only marginally above the national average. For example, according to the fifth round of the National Family Health Survey (NFHS-5), institutional births at public facilities in Karnataka are at 65%, while the national average is 62% (International Institute for Popula-

tion Sciences [IIPS] and ICF, 2021). These indicators have been the focus of policy attention for decades, yet Karnataka does not perform significantly better than the national average.⁴ According to NAS (2021), Karnataka’s performance in mathematics for Class 8 is 35%, compared with the national average of 36% (MoE, GoI, 2021).

Second, there are several other critical indicators where Karnataka, as a whole, does not perform better than the national average.⁵ The NITI Aayog Health Index report highlights that Karnataka is among the six states where the sex ratio at birth has declined (Ministry of Health and Family Welfare [MoHFW] & NITI Aayog, 2021, p. 29).⁶ Another important indicator is the out-of-pocket expense per delivery in a public facility. In Karnataka, it is a high Rs 4,954 (NFHS-5), and it has increased by 3% from Rs 4,824 (NFHS-4). The national average for the same

⁴ Other states in South India such as Kerala, Tamil Nadu, Telangana, and Andhra Pradesh—which are also large states—perform much better in critical health outcomes such as NMR, MMR, U5MR, and SBR. For example, Kerala and Tamil Nadu have already achieved the SDG Health Goal of 12 neonatal deaths per 1,000 live births (MoHFW Niti Aayog, 2021, p.28). For Karnataka, this is 14 according to SRS 2020 and 15.8 according to NFHS-5. Kerala, Maharashtra, Tamil Nadu, Telangana, and Andhra Pradesh have achieved the SDG target of less than 70 maternal deaths per 100,000 live births (MoHFW Niti Aayog, 2021, p.28). Karnataka is at a borderline data point of 69 maternal deaths per 100,000 live births. It’s a similar story for learning levels for class 8 in maths.

⁵ While it can be argued that Karnataka’s performance is particularly stark because it is economically doing well. A direct link between economic affluence and health status has been questioned. Better economic status does not mean improved health status. In more recent accounts, Niti Aayog report (MoHFW Niti Aayog, 2021) states that “This suggests that with improved management and governance, the state/UT performance can improve irrespective of the economic or poverty level of the state/UT” (p.22).

⁶ SRS 2020, shows that Karnataka SRB is 916 while this is higher than the national average of 907 it has declined from 924 in 2016–2018 (Office of the Registrar General Census Commissioner, 2022 p.304).

is Rs 2,916 (NFHS-5), and it has decreased from Rs 3,197, a decline of 10%.⁷ In elementary education, Karnataka has among the highest number of single-teacher schools in India (Economic Survey Karnataka, 2023). Learning levels in Karnataka fell from the 2017 NAS round to the 2021 NAS. Although this trend was observed across India, Karnataka did not stand out as a well-performing exception.

Third, within Karnataka, there are disparities across the districts in (a) the availability, (b) the uptake of health and education facilities, and (c) health and education outcomes. Starting with the availability of government health facilities, there are shortages across the three levels of care: primary, secondary, and tertiary.⁸ According to a recent report by the Federation of Indian Chambers of Commerce and Industry (FICCI) State Council Karnataka (2023), there is a deficit of Primary Health Centres (PHCs) both in rural and urban areas. Districts such as Bangalore have the highest deficit of urban PHCs⁹ (UPHCs). At the state level, 54% of Karnataka's PHC deficit is in urban areas (State Council FICCI Karnataka, 2023, p. 220)¹⁰ Rural Health Statistics states that Karnataka's total UPHC deficit is 36% (Ministry of Health and Family Welfare Statistics Division, 2022, p. 165). Many interviewees argued that removing Bangalore, Mangalore, and Udupi from Karnataka would leave a poor state struggling with crumbling health and education infrastructure and a weak economy. North Karnataka (also known as Kalyan Karnataka), consisting of nine districts (out of a total of 31 districts in Karnataka),¹¹ has lagged behind the rest of Karnataka in most health and education indicators for decades.¹² This is despite the establishment of the Kalyan Karnataka Region Development Board (KKRDB) in 2013, which has been channelling additional funds and providing dedicated bureaucratic attention¹³

to North Karnataka to improve social welfare. Not only the backward districts of North Karnataka but even well-to-do districts in South Karnataka, such as Bangalore, perform poorly on important indicators. Karnataka state's average rate of immunisation is 84% (NFHS-5), reflecting a strong improvement from 63% (NFHS-4). But, Bangalore is at 78% (NFHS-5). According to the NAS (2021), learning levels in many districts remain below the national and state averages. In two prominent categories of the health cadres, Karnataka has significant vacancies—for specialists, this is at 38%, and for auxiliary nurse midwives (ANMs), it is at 30% (National Health Systems Resource Centre, 2021). Teacher vacancies are rampant. In response to a starred question raised in the Rajya Sabha, in 2022–2023 Karnataka had an elementary school teacher vacancy of 23,881—the ninth-highest level in India (GoI, 2023).

Fourthly, the uptake of public health facilities is weak in Karnataka. According to the most recent NFHS-5 data (Table 4), only 7% of urban residents in Karnataka access PHCs, and overall, only 45% utilise public health services in urban areas (Table 4), which is lower than the national average of 47% (Table 5). While the uptake of UPHCs data point in the NFHS survey is not a conclusive indicator that UPHCs are not being used at all in urban areas. It highlights that UPHCs are not the first point of care. This could be for many reasons, including the non-availability of facilities nearby. The available UPHCs may even be so constrained due to staff vacancies and the non-availability of medicines and supplies that they cannot cater to patients in their areas, and therefore people themselves do not go there. Private clinics located closer may be preferred because doctors are easily available. The health needs in specific locations may still be so high that UPHCs are dealing with patients

⁷ NSSO 75th round also reports that the OOP expense per child delivery in public institutions in urban areas for Karnataka is higher than the national average though the figures are different from the NFHS-5 ones (Karnataka Health dossier, 2021). OPD care in public facilities in urban areas in Karnataka is marginally lower than the national average in Karnataka. But most importantly, private OPD in urban areas in Karnataka (Rs 815) is notably lower than the national average (Rs 915).

⁸ The Department of Planning, program monitoring and statistics and FICCI took the initiative to prepare an action-oriented report to prepare a roadmap for the state and attain the desired level of growth.

⁹ Based on this FICCI report, Karnataka High Court took *suo moto cognisance of the shortages of medical professionals highlighted by the report and gave directives to the registrar general to file a public interest litigation.*

¹⁰ There is of course a discrepancy in the data points reported on the PHC deficit in the FCCI report vs the Rural Health Statistics (2021) as detailed in the Karnataka Health dossier (p. 7). In the health dossier, rural areas have an excess of PHC in Karnataka while FICCI report states that rural areas also have a PHC deficit.

¹¹ Districts of North Karnataka are: Belgavi, Koppal, Bagalkot, Bidar, Haveri, Yadgir, Raichur, Gulbarga, and Ballari.

¹² Of these nine districts, there are seven districts which were part of the erstwhile Hyderabad state which remain the most backward. These districts are Bellary, Bidar, Raichur, Yadgir, Kalburgai, Vigayanagara, and Koppal.

¹³ Karnataka has a Special Development Plan (SDP) to improve 114 backward talukas. Forty per cent of the SDP is allocated to Kalyan Karnataka Region based on the recommendations of the Nanjuanandappa committee which had highlighted in 2000 that there are severe intra-state disparities in Karnataka (Economic Survey 2022–2023).

Table 3: Uptake of Health Facilities in Karnataka Across NFHS-4 and NFHS-5

	NFHS 4-KAR (%) (p.134)			NFHS 5-KAR (%) (p.158)		
	Urban	Rural	Total	Urban	Rural	Total
Public Health Sector	40	60	51	45	61	55
PHC/Additional PHC	2.4	14	9	7	21	15
Private Sector	59	40	48	53	37	44
Private Doctor	20	12	16	12	10	11

Table 4: Uptake of Health Facilities in India Across NFHS-4 and NFHS-5

	NFHS 4-India (%) (p.376)			NFHS 5-India (%) (p.447)		
	Urban	Rural	Total	Urban	Rural	Total
Public Health Sector	42	46	45	47	52	50
PHC/Additional PHC	3	12	9	5	13	10
Private Sector	56	49	51	52	46	48
Private Doctor	29	29	29	27	29	28

to their highest capacity and yet are only able to cater to a small segment of the population. Highlighting the UPHC uptake data from the NFHS survey only underscores the point that Karnataka has many improvements to make in healthcare, particularly primary healthcare.

According to Karnataka’s Economic Survey 2023 (p. 81), Karnataka lags behind the best-performing states in its cohort on important indicators such as stunting, underweight, and anaemia.

Not only does Karnataka lag in outcomes, but it also lags behind the national average in overall policy attention given to these areas. An important indicator of this is budgetary allocation. In 2023–2024, Karnataka allocated 4.9% of its total expenditure towards health, which is less than the average allocation for health by states (6.3%). It also allocated 11% of its expenditure on education, which is lower than the average allocation for education by states in 2022–2023 (14.8%) (PRS Legislative Research, 2023).

Why is a prosperous, ambitious state such as Karnataka, endowed with talent and technology, unable to provide high-quality health and education outcomes, achieve 100% immunisation, attain high learning levels, and ensure well-functioning schools and PHCs with high uptake across social strata? We examine Karnataka’s health and education sectors from this changed perspective. Although it is a rich state, it is not entirely socially progressive; in fact, it is a wealthy state with sluggish social indicators.

Investigating the state’s initiatives will reveal how Karnataka has focused on health and education, and what has driven these efforts, if any exist. What pathways exist for the emergence of state initiatives?

Karnataka’s story calls for a nuanced approach when drawing insights from raw quantitative data points on human welfare, disparities, and inequalities, and when extrapolating these to make national-level comparisons. This has severe implications for setting the health and education policy agenda in Karnataka.

2. The Questions

Within the broad health and education sectors, this study has restricted its focus to four areas:

1. Primary health and elementary education
2. State provision versus private provision in these two sectors
3. Urban areas
4. Initiatives undertaken by the state, i.e., state-level initiatives

While good-quality public provision of health and education at all levels—primary, secondary, and tertiary/higher—is foundational for human development, primary health and elementary education are particularly essential. Key health and education indicators, such as IMR/MMR and foundational literacy and numeracy, are typically addressed by PHCs and elementary schools. However, due to the poor quality

of these facilities, users bypass them and turn to higher-level institutions—such as district hospitals in the case of health—or rely on private tuition for school education, resulting in poor functional literacy even at higher class levels.

We have focused on urban areas for two reasons. First is the increasing rate of urbanisation in India. Second, focusing on urban areas presents the toughest test of a government's role in prioritising primary health and elementary education. Private providers are dominant, and historically, government action has been limited because the urban poor have largely been invisible in policy discourse, with the assumption that urban areas offer a better quality of life. In rural areas, the government tends to be the sole provider, and competition from the private sector is not as severe. Improving the standard of living in rural areas has also been a focus within policy discourse for a longer period compared to urban areas. Therefore, if a state has managed to focus on urban areas in recent years, it indicates a high level of interest and commitment to ensuring good health and education for its people, including those who have remained in the policy shadows—that is, urban residents.

We have also chosen to focus on state provision. In Karnataka, the majority of elementary schools (GoK, 2023) and almost all primary healthcare facilities (i.e., those facilities that include curative, promotive, and preventive services, not just medical clinics) are provided by the state. Although the private sector has a high uptake across all health and education levels, at the primary level, government facilities continue to be prominent, particularly in underserved areas and marginalised communities. Karnataka also has a history of undertaking nationally recognised state-led initiatives for strengthening public provision of education and health. For example, the Nalli Kalli activity-based learning programme, which was developed and scaled up in Kannada-medium public schools in Karnataka, has been widely noted for enhancing the reach of foundational learning among first-generation learners in public schools. Similarly, Karnataka has a long tradition of state health insurance programmes. For example, the Yashasvini Health Insurance Scheme in Karnataka, launched in 2003 to provide health insurance to members of

cooperative societies in rural areas, has been widely regarded as a successful scheme.

We have limited our examination to Karnataka's state-level initiatives that are funded, ideated, or designed at the state level. These include any policy, programme, scheme, regulatory mechanism, or budget allocation. The initiatives we are covering are not restricted to those involving budgetary allocation or new implementation structures. Budgetary allocation is assumed to demonstrate the highest form of government commitment to meet stated objectives. An exploration of why and when budget allocations are increased to improve health and education reveals the material terms by which the state prioritises social welfare. This tends to receive significant attention in policy discourse and academic writings (Centre for Budget and Governance Accountability [CBGA], 2019; Kundu & Rastogi, 2020; Yadav, 2020). However, we argue that budgets only provide a partial understanding of the policy focus on social welfare. This is primarily because new initiatives may introduce new ways of addressing health and education challenges without involving additional budgetary commitments. Many government initiatives involve improved administrative efficiency (for example, utilising test scores in teacher recruitment), or they are part of partnerships with non-governmental actors such as NGOs or philanthropists. Other approaches taken in research studies to understand why certain sectors have not been the policy focus include a stakeholder analysis of the interest groups involved in policymaking (Ansell, 2010; Corrales, 1999; Lofreda et al., 2021; Singh, 2023) and deep dives into specific successful or failed policies, programmes, and schemes (Lahariya, 2020). We argue that these approaches provide only a partial insight into why and when social welfare receives policy attention.

Instead of exploring what factors lead to an increase in budget priorities, which programmes were well implemented and resulted in improvements in health and education, or which interest groups have been excluded from the policymaking space, we examine if and when Karnataka has undertaken state-level initiatives, why it did so, and what the underlying drivers were.

3. The Methods

This qualitative study employs the following methods:

- Mapping of state-level initiatives through a review of Karnataka's Economic Survey report from 2014 to 2024, web-based searches of government websites, cross-checked through qualitative interviews with bureaucrats in the health and education departments at the state and district levels, as well as researchers and journalists;
- Review of official policy, programme, and scheme documents to understand their objectives, scope, and design;
- Key informant interviews conducted with members of the bureaucracy at the state, district, and sub-district levels; civil society leaders; journalists; academics; experts; heads of professional organisations; and others who are either centrally involved in policymaking or influence the process and its reception at the ground level. The aim was to identify the key factors that led to the initiatives and important challenges in health and education.

Policy-related initiatives need to be studied over long periods because the capacities and resources required to develop new initiatives take time to mature. This consideration applies more to landmark initiatives that reform or reorient the system than to routine, regular-level initiatives that emerge in the course of government operations. Furthermore, the status of an initiative as a landmark one emerges over time. This study focuses on identifying what factors propel a state to introduce new initiatives, rather than on what led to the emergence of a specific initiative that eventually becomes iconic. Therefore, the scope of this study has been limited to the last 10 years, from 2014–2024. It will include only those initiatives that focus on the overall elementary education or primary health system. Initiatives that focus on small and specific aspects, such as curriculum reform or free diagnostic services, will not be included in the analysis. From an operational perspective, access to documents and stakeholders involved in the making of the initiatives is critical for this kind of study, and a more recent time frame enables this more easily.

The number, design, and scope of new initiatives need to be studied at the state level, but their origins need

to be traced from the grassroots upwards. This will allow an exploration of grassroots-level challenges that are best articulated by actual users of schools and PHCs, frontline state officials, district- and sub-district-level bureaucracy, and civil society leaders. The study operates at three levels:

- At the state level, the focus will be on mapping reform initiatives, the officially stated reasons for their implementation, and the key issues in health and education that the bureaucracy considers challenging.
- At the district level, the focus will be on how the district-level bureaucracy, civil society, interest groups, and political leadership engage with initiatives, particularly their role in shaping state-level initiatives and their understanding of challenges in health and education.
- At the grassroots and non-elite levels, civil society organisations, NGOs, and concerned citizens focus on understanding the ideas surrounding the uptake of health and education among non-elites and the actors who shape and influence policymaking. The sites and pathways through which non-elites engage with local political leadership and wider political arenas will also be examined.

A detailed summary of the methods, including sub-research questions, probe areas, data sources, and analysis framework, is available in Appendix 2.

Two urban municipal corporations, one with strong and one with weak performance on health and education indicators, were selected. Each of these corporations corresponds to one or two assembly constituencies. We selected one corporation in North Karnataka and one in South Karnataka. The study sites did not include the very best-performing or worst-performing ones, as such extremes often result from a long history of successful or failed state action, an enabling or restrictive social context, and local-level political mobilisation and leadership, which can give a skewed understanding of the realities of policy.

Eleven categories of stakeholders were focused upon in this study; they are categorised according to the roles they play in state-level initiatives, as shown in Table 5.

Table 5: Categorisation of Key Informants According to Their Role in State-Level Initiatives

Type of informant	Category	Rationale
Minister: Health, Education, Finance, Planning	State level political decision makers	They determine which policy to implement, allocate budgets, decide on the location of facilities, and establish timelines for project implementation.
Secretary: Health, Education, Planning, Finance, Statistics	State level bureaucracy decision-makers	They determine which policy to implement, offer technical input on the design and implementation structure, budgets, locations, timelines, and manage the education and health systems on a day-to-day basis.
Commissioner: Education, Health, SCERT	State level bureaucracy decision-makers	Provide technical input in policymaking, make final decisions on which policy ideas to pursue, participate in policymaking commissions, and handle budget requests.
District level officers in Health, Education, Local governance, collector	District level implementers	Implement the programme at the district level, raise budget requests, and provide technical inputs on areas of policy gaps and strengths.
Taluka level officers in Health and Education	District level implementers	Implement the programme at the taluka level, raise budget requests, and provide technical inputs on areas of gaps and strengths in policy.
School Principals, teachers, MO of PHCs, Accredited Social Health Workers (ASHAs), and ANMs	Frontline level bureaucracy	Implement the programme at the facility level, as they are closest to the hard realities of running PHCs and schools, and have the best understanding of the programme's functioning.
NGO leader	Civil Society partners	Works with the state government and district level, providing ideas, technical inputs, and occasionally funding for schools and PHCs.
Researchers, University professors	Academic experts	Members of state-appointed government commissions provide technical insights on health and education and shape popular perceptions through public writings.
Journalists: Health, Education, Politics	Policy influencers	Influence policy by tracking and observing the implementation of health and education initiatives.
Local journalists	Engaged citizens	May not be working on Health and education but know the locality enough to have a sharp understanding of the functioning of local schools and PHCs.
Users of schools and PHCs	Ordinary residents	They have no role in policymaking or in implementation but both should be oriented towards these processes.

Source: Author's compilation.

4. The Insights

4.1 Limited State-Level Initiatives in Primary Healthcare and Elementary Education

Over the last decade, primary healthcare, particularly urban primary care, has not been a policy focus in Karnataka. The state government launched 11 new health and nutrition initiatives, of which only two focus on urban primary healthcare—Namma Clinics (2022–2023) and Women Wellness Clinics–Ayushmati Clinics (see Appendix 1 for a listing of all health-related initiatives since 2014).¹⁴ Both schemes are funded by the Central government and designed by the state government to implement the Central government’s Prime Minister Ayushman Bharat Health Infrastructure Mission (PM-ABHIM),¹⁵ using funds from the 15th Finance Commission.¹⁶

Overall, policy action in urban primary care in Karnataka¹⁷ during this decade has been led by the Central government under the Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB PM-JAY).¹⁸ As part of this scheme, existing PHCs have been upgraded¹⁹ to Health and Wellness Centres (HWCs), and additional services—such as provisions for non-communicable diseases (NCDs), mental health,

Namma Clinics

A state-level initiative set up under the PM-AHIM and XV FC budget for providing comprehensive primary healthcare clinical services for the urban poor. Namma Clinics are established in areas where the population is not covered by a UPHC. They cater to a population of 15,000–20,000 and provide a package of 12 services (GoK, 2022).

Women Wellness Clinic – Ayushmati Clinic

Set up in response to the recommendation of the 15th Finance Commission and NHM fund, these clinics are established in select urban primary health centres. The clinics aim to provide specialist services, counselling services, laboratory investigations, free drugs, and wellness interventions such as yoga. Fifty-seven Ayushmati Clinics were set up within the BBMP ambit and 71 in other districts as of 2023–2024 (Department of Health annual report).

and elderly and palliative care²⁰—have been introduced at these centres. Interviewees, particularly state-level bureaucratic decision-makers, widely recognised that UPHCs have emerged as a policy focus in Karnataka primarily due to the HWC²¹ programme.

¹⁴ Gruha Arogya (2023) scheme which would be funded under the NHM has also been designed by the state government and is awaiting Cabinet approval.

¹⁵ PM-ABHIM was launched in 2021 to strengthen the country’s health infrastructure, disease surveillance, and health research. It is a centrally sponsored scheme (i.e. the overall funding will be shared between centre and state in 60:40 proportion) with the central sector components (where centre funds 100% amount).

¹⁶ The 15th Finance Commission report has specific recommendations for school education and healthcare including increasing the state’s expenditure on health by 8% and increasing private investment in school education. For health, the recommendations also state that primary healthcare should be the fundamental commitment of every state and that primary healthcare expenditure should be at least two-thirds of the total health expenditure.

¹⁷ As also highlighted by many interviewees particularly state-level bureaucracy decision-makers and district-level implementers.

¹⁸ This scheme emerged from the recommendation of the 2017 NHP and aims to achieve Universal health Coverage and the SDG goals.

¹⁹ The states are also urged to ensure adequate infrastructure for the HWCs and suggested modes of funding new construction include funds disbursed under NHM and through MPLADS and MLALADS.

²⁰ HWC is a part of the PM-JAY scheme initiated in 2018, where the government announced that 1,50,000 HWCs would be created by converting existing sub-centres in the districts. These were first recommended by the Primary Health Task Force in 2015 and conceptualised in the NHP of 2017. PHC is managed under the Minimum Needs Program/Basic Minimum Services Program. HWC have an expanded list of services more than those provided by PHCs. PHCs provide general out-patient care for acute simple illnesses and minor ailments, family planning, and other reproductive health service, neonatal and infant healthcare services, care in pregnancy and childbirth, childhood and adolescent healthcare services, and services for communicable diseases under the national health programs. Under HWCs program, NCDs, mental health, geriatric care, ophthalmic and ENT, dental services, geriatric and palliative, basic trauma care, and emergency services are provided (Lahariya, 2020).

²¹ The Health and Wellness centers are not the only national program which have prioritised urban health. The NUHM was launched in 2013 and created for the first time a “country wide program to establish a structured primary healthcare system in urban areas, like the one in rural” (MoHFW, 2016 p.18). Prior to NUHM, there were a varied types of primary care facilities in different urban areas in India offering limited primary care facilities (See NHSRC planners training module p. 17-18 for an overview of the state of urban primary healthcare before NUHM). However, the NUHM program was not implemented in a uniform manner and large gaps remained in addressing health needs of the population (see our discussion of the implementation of NUHM on p. 14). Hence, the argument that HWC has shown light on the state of Urban primary care has much merit.

Elementary education has received more policy attention than primary healthcare. Karnataka has 14 new State-level initiatives specifically for elementary classes (see Appendix 1 for a full listing of the initiatives).²² Of these, two are focused on the school system as a whole. These are the KPS Programme (from 2017 onwards) and the SEPC (from 2023 onwards). Other programmes, such as the Sikshana Technology in Education Programme (STEP, from 2015 onwards) and the Viveka Scheme, focus on specific aspects of the school system, such as the construction of school classrooms, teacher training, and school curriculum. It must be noted that none of the initiatives focus exclusively on urban elementary schooling.

Karnataka Public School Programme (KPS):

Established in 2018 in 176 talukas in Karnataka for standards 1 to 12, the programme aims to improve learning outcomes. The primary objective of these public schools is to enable 75% of the students to achieve 75% of the learning abilities outlined in the prescribed syllabus, while ensuring that the remaining students attain at least 50% of the learning abilities. In subsequent years, pre-primary classes were also added to KPS, and schools with fewer than 10 enrolments were instructed to transfer their students to the nearest KPS. As of now, 285 KPS schools have been established in Karnataka, and 50 selected KPS will receive a grant of Rs 2 crore each under innovative programmes. In the coming years, 1,000 new KPS schools will be established (Samagra Shikshana Karnataka, 2023).

SEPC: In 2023, the GoK decided to constitute a 15-member state-level commission to review the status of school education as well as higher education, under the chairmanship of Sukhdev Thorat. The commission will draft a state education policy with the objective of increasing student enrolments in government schools and higher education institutions, while enhancing quality, equity, and inclusiveness (Go. No. ED/166/UNE/2023).

Before proceeding to the next section of this report, we must caution against overemphasising the central government’s focus on urban primary care. It should not be concluded that:

- a) the HWC programme is the sole instance of policy focus on urban primary care and that Karnataka has not recognised the importance of primary healthcare on its own merit;
- b) Karnataka state has neglected the condition of its urban health; or
- c) the HWC programme has addressed or is seeking to address some of Karnataka’s most fundamental urban challenges.

We argue that Karnataka acknowledges the significance of primary healthcare and is aware of the weaknesses within state-bureaucratic decision-makers, even though this awareness has not translated into actual initiatives during the study period. Furthermore, the HWC has not led to Karnataka concentrating on primary health in terms of addressing the state’s specific primary health problems. Our argument is based on the following rationale.

Firstly, historically, Karnataka has taken a lead in policy thinking around primary healthcare. It is among the few states that developed a state health policy²³ in response to the National Health Policy (NHP, 2002). The health task force constituted to develop the state health policy specifically examined the state of primary healthcare in Karnataka and recommended that the revival of the health system in Karnataka should be led by the primary care approach (GoK, 2001).

Table 6: % Share of Health in Total Budget in Karnataka

Year	% Share
2014	4.51
2015	4.52
2016	4.25
2017	3.60
2018	4.3
2019	4.4
2020	4.6
2021	5.3
2022	5.8
2023	4.9

Source: Analysis undertaken by Prajakta Shukla, Project Research Team, based on PRS Budget Briefs, 2014–2023.

²² In school education, the nature of centre-state relationship is opposite to that in health. For flagship programs such as the KPS while the funding is provided by the state government, the design and innovation is covered by the centrally sponsored SSA. While in health, for example in initiatives such as Namma clinics, the design is provided by the state government while the predominant funding is provided by the Central government under the PM-AHIM and 15th Finance Commission.

²³ The policy was developed in response to the NHP 2002. Karnataka did not have a state health policy prior to this. Other states which have developed a State health policy after the 2002 NHP are include Tamil Nadu, Odisha, and Uttarakhand. Odisha is the only state which has a health policy since 2001.

Secondly, in the contemporary period, the need to strengthen UPHCs and the challenges they face was widely recognised in our conversations with our interviewees, particularly state-level bureaucracy decision-makers. Senior bureaucrats are well aware of the roadblocks in strengthening primary care. These include low budgetary allocation to health, particularly to urban health, and the lack of focused programming to strengthen systems in UPHCs (see Table 7 for trends in budgetary allocations). Notable gaps in human resources at the UPHC level in Karnataka were frequently stated across all levels of the state health bureaucracy, civil society leaders, and engaged citizens (for data, see Table 8). This is also corroborated by government data and other important government reports. According to the FICCI report (State Council FICCI Karnataka, 2023), “both urban and rural areas lack PHCs, with UPHCs accounting for 54% of the deficit. The deficit of PHCs was concentrated in five districts: Bengaluru Urban,²⁴ Belagavi, Dharwad, Mysuru, and Vijayapura” (p. 220). According to the Karnataka Health Dossier (NHSRC NHM, 2021), the state has a 30% shortage of ANMs, a 10% shortage of Medical Officers (MOs), and a 38% shortage of specialists (p. 11).

Table 7: No. of UPHC, MO, and ANM Deficit in Bangalore, Belagavi, and Shivamogga

Name of District	UPHC Deficit	MO Deficit	ANM Deficit
Bengaluru Urban	72	166	649
Belagavi	20	54	451
Shivamogga	6	17	314

Source: State Council FICCI Karnataka, 2023, p.232.

Lastly, while the HWC programme has enhanced the usefulness of existing PHCs by providing a wider range of services,²⁵ it has not increased the overall

reach of the primary care network. It is the existing UPHCs that are upgraded to HWCs; new ones have not been created. The latter is critical given the 38% UPHC deficit in Karnataka (MoHFW Statistics Division, 2022) (also see Table 7 for illustrative district-wise UPHC and staff deficit). Economic Survey documents that highlight the creation of new health facilities further underscore this point. Karnataka’s Economic Survey 2022–23 provides a status of the upgradation of PHCs, and there is no mention of the creation of new ones. As of 2022, 8,637 PHCs have been upgraded, of which 365 are UPHCs.²⁶

4.2 Exploring the Lack of Focus on Primary Health

Many factors can explain the lack of policy focus on primary healthcare. First, there are historical factors at both the State and Centre levels. Karnataka has a long history of successful insurance programmes, which have possibly created an impetus for insurance-centred health services. Second, across India and within national policy frameworks, the primary care approach for urban areas has remained weak despite the acknowledgement of its importance for achieving universal health coverage and the presence of impressive national policy frameworks on the primary care system. Third, historically, elementary education had a higher number of policy initiatives at both the national and State levels, laying the foundation for new initiatives created during the decade of 2014, which we have analysed in this study. Fourth, the absence of an explicitly stated demand for primary care facilities, despite human resources and infrastructure gaps, may have also condoned policy neglect. Fifth, at the current level, elementary education is more deeply embedded in the daily lives of people than primary healthcare, creating a greater incentive for policy action. We discuss this in detail in the remaining section.

²⁴ This is the richest district in the state.

²⁵ In the service offering for PHCs before the HWC programme, the focus was on RCH and communicable diseases. A useful comparison is provided in the Ayushman Bharat–Health and Wellness Centre (AB-HWC) status update booklet for April 2022 (MoHFW, 2022, p.16). Previously, six sub-groups of services were being provided by a PHC which under AB-HWC was upgraded to 12 sub-groups (Lahariya, 2020).

²⁶ The HFW department annual report also does not give any information on newly constructed UPHCs. The reference is only to those which have been upgraded. The guidelines for AB-HWC state that “existing sub-centres, PHCs, and CHCs are converted in HWC” (MoHFW, 2021, p.5).

Karnataka's Long History in Insurance

In Karnataka, the policy focus has been on assurance-mode health insurance²⁷ for the last three decades. Karnataka's extensive experience in implementing health insurance programmes dates back to 2003 when the Yashaswini scheme²⁸ was launched for rural Karnataka. It covered farmers and peasants who are members of cooperative societies. The scheme became the "largest health insurance scheme in the world for the rural poor in the first year of its operation" (Kuruville, 2006). Karnataka also launched its own health assurance programme, Arogya Karnataka, in 2018, before Ayushman Bharat was launched²⁹ the same year. While primary care was usually not covered in these older insurance schemes, recent insurance programmes such as Arogya Karnataka (from 2018 onwards) include some primary care procedures³⁰ (GoK, 2018). Study respondents, including bureaucrats, civil society leaders, health experts, and journalists, stated that health insurance is an effective path towards achieving universal health coverage and highlighted that Ayushman Bharat has been beneficial to people (Sancheti et al., 2023). It is possible that strengthening insurance has become a policy priority over primary care, even though, as we have argued above, the state has a history of policy thinking on primary health and recognises the weaknesses of its primary care facilities. Additionally, a lack of policy demand for primary care may impact the prioritisation of insurance. We examine this in the final discussion section on "lack of policy demand."

Historically Poor Strengthening of Urban Primary Care

Neglect of urban health is evident not only in Karnataka but across India at all levels of government—national, state, and local.³¹ Rural health received higher policy attention due to the creation of new primary care facilities and the hiring of PHC staff under the National Rural Health Mission (NRHM) and other donor-funded projects, such as the World Bank's Health System Development Project, from the late 1990s onwards. For UPHCs, a limited focus emerged under the Minimum Needs Programme (1974), under which some were established across India with a restricted set of services. Later, under the National Urban Health Mission (NUHM) programme (2015), there was an attempt to develop a comprehensive framework for addressing urban health issues. However, many key aspects of the NUHM programme remain incomplete. For example, building new UPHCs or establishing a coherent governance mechanism for urban health under urban local bodies did not occur in many places. In Shivamogga, for example, urban health is still governed by Zilla Panchayats, an elected body for rural governance. The municipal corporation has no role in the implementation or oversight of UPHCs. Out of 12 UPHCs in Shivamogga city, data on the date of establishment were available for nine, and all were set up before the NUHM. One UPHC was established as far back as 1983. Particularly missing have been interventions to improve the "quality" of care, which go beyond providing PHC facilities with

²⁷ In insurance, a third-party agency is hired to implement health schemes, whereas in an assurance-based model, all procedures related to insurance claims are handled by a government agency without the involvement of insurers or implementation support agencies.

²⁸ Yeshaswini is the first of many health insurance schemes in Karnataka with a wider ambit. The first was the Arogya Bhagya scheme, launched in 2002 for police personnel and their families (Karnataka State Police, 2021). In 2009–2010, the GoK introduced the Vajpayee Arogyashree scheme, which covered tertiary care for serious and life-threatening illnesses for the Below Poverty Line (BPL) population (World Bank, 2012). In 2015, the Rajiv Arogya Bhagya scheme was launched, covering Above Poverty Line families for tertiary care. The Yeshaswini scheme was withdrawn in 2017–2018 and reintroduced in the budget of 2022–2023 (Yeshaswini Co-Operative Members Healthcare Trust, 2024a). In its 2003 version, it only covered rural areas. It provided coverage of Rs 5 lakh per annum for a family of five for all major surgeries and outpatient services at a network of private hospitals. Members paid a premium of Rs 60 per annum. In its new version, post-2023, it now extends to members of cooperative societies in both rural and urban areas and has a higher per annum contribution of Rs 500 for a family of four (Yeshaswini Co-Operative Members Healthcare Trust, 2024). The Department of Cooperatives has always administered this scheme. After the introduction of the Arogya Karnataka scheme in 2018, all insurance schemes were subsumed under it (GoK, 2018).

²⁹ Arogya Karnataka has now been merged with Ayushman Bharat and is referred to as Arogya Karnataka–Ayushman Bharat.

³⁰ Multiple members of the district level bureaucracy implementers stated that some primary care procedures are also covered under the Ayushman Bharat- Arogya Karnataka (AB-ARK) scheme. The scheme website also states that primary care is included (GoK, 2018). However, government documents related to the scheme state that "simple secondary procedures, complex secondary procedures, and tertiary care" are covered under the programme (Department of Health and Family Welfare Government of Karnataka, 2022).

³¹ The NRHM and World Bank-led Karnataka Structural Reforms have played an important role in reshaping the health sector in Karnataka (Sarkar, 2018).

adequate human resources.³² Urban PHCs have a long way to go in aligning themselves with the needs of the populations they serve on very basic issues, such as extending the opening hours of PHCs beyond 4:30 pm and providing adequate frontline staff, such as ANMs to conduct outreach activities. Comprehensive policy focus to enhance the utilisation of UPHCs and expand the scope of service programmes has been integrated under HWCs along with funding from the 15th Finance Commission. However, as previously stated, these measures do not enhance the reach of the urban primary care network, as no new UPHCs are being built under this initiative, at least in Karnataka.

Lack of a Long History of Policy Action from Central and State Governments

Elementary education in Karnataka benefits from more state-level initiatives partly because it can build on a longer history of intense national-level policy and programme efforts. Since the 1990s, the Central government and international donors have strongly focused on enhancing access to primary schooling under the District Primary Education Programme (DPEP) 1994 and later the Sarva Shiksha Abhiyan (SSA, 2000). Under these programmes, primary schools were constructed within one kilometre of every habitation. Additionally, the quality of education became prominent in national-level debates, and Karnataka was among the states that pioneered its own school learning programme called Nalli Kalli. It was aimed at strengthening the quality of learning in Kannada medium government schools. Due to this strong policy attention, a substantial elementary education-focused infrastructure was created, including a large number of elementary schools, district-level training centres for school staff (District Institutes of Educational Training, DIETs), and a school governance administrative architecture. Many recent initiatives are responding to this framework established for school education several decades ago. The KPS Programme is designed to tackle the problem of very low enrolments in government schools, resulting in reduced teacher allocation by the state government

and the emergence of multi-grade teaching and single-teacher schools in large numbers. Karnataka has the ninth-highest number of vacancies in elementary classes (GoI, 2023). School education also employs one of the largest workforces in the state government and occupies the largest component of the state budget, which can explain the larger share of policy focus. An ethos of “Education for All” has been created among citizens as well as state officials, which does not have a parallel with “Health for All.” While there is a Right to Education (RTE), implemented in a flawed and limited manner, there is no similar Right to Health in Karnataka. One of its main implications has been the establishment of a mandate for the provision of a certain level of publicly provided schooling. For primary health, this mandate has not been realised.

Lack of Policy Demand

Across our interviewees, there was a shared understanding that a strong network of government and private hospitals effectively addresses primary health needs in urban areas. Additionally, the prevailing argument, particularly shared with us by senior members of state-level bureaucracy, was that Karnataka performs well in comparison with national averages,³³ particularly in traditional primary healthcare services such as maternal and child health (MCH), immunisation, and tuberculosis (TB). Table 8 lists some key MCH indicators where Karnataka excels, highlighting why primary care-related health challenges are less problematic in the state.

Among the respondents, there was a lack of an explicitly stated demand for primary care facilities. This is despite the widely shared consensus among interviewees in different categories on the importance of strengthening primary-level healthcare, particularly in urban Karnataka. It was understood that PHCs are critical to improving health outcomes and need to be strengthened with additional funds and dedicated programming. However, a glaring anxiety or articulated demand was not dominant. It was not emphasised as an urgent policy priority (see the snapshots of responses from the interviewees).

³² “In the Bhole Committee Report of 1946, and more recently as a comprehensive service guarantee to people under the National Rural Health Mission. The High-Level Expert Group (HLEG), constituted by the Planning Commission in 2010, provided a definitive framework to operationalise the UHC across India (Planning Commission, 2011). Drawing from this, the 12th Five Year Plan (Planning Commission, 2012) urged all the state governments to pilot and test out approaches for achieving UHC” (Padvetnaya et al., 2017) despite this, PHC was never the focus of policymaking.

³³ To recall, in the introductory discussion, I established that Karnataka is not necessarily a high performer but a middling state.

Table 8: Comparative Listing of MCH-Related Indicators

Indicator	Karnataka	India	Rationale
MMR	69	97	A key maternal health indicator, which is globally discussed and tracked, highlights the extent to which core elements of the health system—such as frontline workers within the state—are functioning effectively.
IMR	25	35	A key infant health indicator is globally discussed and tracked. This indicator highlights the extent to which core elements of the health system are functioning, such as frontline workers in the state.
Immunisation	84%	84%	Important indicators, because immunisation has been a policy priority since the early decades of Indian independence, and it is one of the main functions of the primary care system at the frontline level.
Institutional Births at Public Facilities	65%	62%	Institutional births are a significant indicator, as they have been a policy focus. A low level of institutional births suggests that either the public facilities are not being accessed or are unavailable to the population, or both.
Contraception Prevalence	69%	68%	This indicator has also been a policy focus, highlighting the strengths of frontline health workers who are tasked with specific responsibilities.

Source: NFHS-5 (International Institute for Population Sciences, 2021). (Niti Aayog, 2024).

Interviewee Category	Interviewee Snippets
Engaged citizens and district level implementers	<p>“Private healthcare is dominant in urban areas, and this trend will take time to change. In locations where we have made progress, such as KC General and CV Ramana Hospitals, the urban middle class still depends on these institutions because a variety of basic services would become unaffordable otherwise. In cities like Bangalore, private healthcare expenses are three times higher than those in tier 1 or tier 2 cities and large metropolises. There is a continued dependence on government facilities, with good medical colleges established at the taluk level.</p> <p>Healthcare in a private setup has become very expensive. Current policies favour the private sector; however, increasing government setups would provide more benefits and a higher return on investment (ROI). Perhaps because disposable and average incomes are higher, there is significant competition among private actors, leading to monopolies in many areas.”</p>
State-level bureaucracy decision-makers	<p>“The issue of an excess number of PHCs pertains to rural areas. In contrast, urban areas face a shortfall in PHCs, and primary services remain in demand. Both private and government PHCs are necessary, as there are specific requirements that need to be addressed.”</p>
Policy influencers	<p>“To my knowledge, everything is in order apart from minor issues. However, this does not mean that all PHCs are the same. In North Karnataka, the situation is similar to that in Rajasthan, with the government focusing on improving medical infrastructure there as well.”</p>
District level implementers	<p>“The issue is the increasing population; my PHC has a large migrant population.”</p>

Location of Elementary Education and Primary Health in Everyday Lives

These different policy trajectories intersect with the unique position that elementary education and primary health hold in the lives of citizens and societies. The way a school intersects with an individual's life differs from that of a health facility. One engages with the school daily, whereas interaction with a health facility typically occurs only during illness.

There is a certain similarity in the school experience across social strata. Everyone studies more or less the same subjects at similar age groups. School is also a symbol of community identity, particularly concerning the medium of instruction. This sets expectations for ordinary users to hold authorities accountable and can create a political or bureaucratic incentive to develop more programmes. Schooling, with its standardised basic structure despite the diversity of curricula, is a part of every individual's life. Health, particularly primary health services focusing on Reproductive and Child Health (RCH) (MoHFW,2013), has not occupied this position. The availability of government hospitals, private providers, and non-medical care providers in urban areas has also provided a rationale for decision-makers to prioritise other segments of healthcare over the urban primary care system. These factors have created a trajectory, rationale, and context for limited state action in urban primary healthcare in Karnataka.

4.3 Examining the Policy Challenges Prioritised by the Initiatives

We examine the key challenges facing urban primary care and elementary education to determine whether they define the state-level initiatives, identifying which challenges do so and why. Different stakeholders (for example, parents, frontline bureaucracy, political leaders) and various levels within the health and school systems (for example, facility, block, district, or state levels) focus on different types of challenges to enhance uptake. To differentiate between challenges that attract policy attention and those that

do not, we use the concept of “big” and “small” challenges. “Big” challenges are those being addressed at scale because state-level initiatives are focusing on them. “Small” challenges are those highlighted by interviewees or that have emerged through the analysis of policy documents, data, or literature. They do not inform the goals of the state-level initiatives. The term “big” does not denote the most critical challenges to the health or school systems.

We highlight in the following discussion that the state-level initiatives, as well as the overall policy approaches that define them, do not appear to be aligned with either solving the challenges identified by the interviewees as most critical or enhancing the uptake of health and education facilities. There seems to be a disconnect between the critical challenges and those focused on by the initiatives on the one hand, and the solutions proposed by the initiatives compared to those that will solve the problems they focus on, on the other hand. The rationale for why certain challenges are the focus of the state-level initiatives, which challenges are critical, and how the initiatives address these critical challenges is less clear in our analysis of the state-level initiatives.

We will first detail the case for the core challenges facing urban primary care and elementary education in Karnataka. We will then highlight the “big” and “small” challenges and discuss them in light of the state-level initiatives we have analysed so far. Next, we examine the initiatives and what they intend to solve.

The state of urban primary care and elementary education

Broadly speaking, primary care and elementary education in urban areas face similar challenges. In health, the uptake of primary healthcare facilities is low, and individuals seek care in private facilities or secondary health facilities, such as district-level hospitals. In education, enrolments in government schools are declining, while there is a surge in the number and enrolment in private schools (Table 9).

Table 9: Enrolments and Number of Private Unaided (Recognised Schools) in Elementary Classes in Karnataka 2012–2019³⁴

Indicator	Karnataka (2012)	Karnataka (2019)
Percentage share of enrolments in private unaided recognised schools in class I in urban areas	64	83
% share of private unaided schools with class I–VIII	20	24

Source: UDISE data analysis undertaken by the research team (Department of School Education & Literacy Ministry of Education Government of India, 2023).

Uptake of government primary care facilities in Karnataka can be gauged from NFHS-4 and NFHS-5 data, which was also presented in Table 3 in the previous sections. Karnataka’s PHC uptake increased from NFHS-4 to NFHS-5, rising from 2.4% to 7% in urban areas. For India, this figure rose from 3% to 5%. While the uptake has increased, the actual number remains low—just 7%. Engaged citizens, civil society leaders, academics, and ordinary citizens among the respondents highlighted that in the study sites, for primary care level health services, the urban poor either bypass the PHC system and go to government hospitals or visit private clinics and hospitals.

In both health and education, private sector players have a strong presence in Karnataka. Nationally, it has the fourth-highest number of private schools with elementary grades (I–VIII standard) (Table 10) and the highest number of private medical colleges—46 (National Medical Commission, 2020). The uptake of private hospitals between NFHS-4 and NFHS-5 increased in Karnataka from 37% to 40%, while at the national level this fell from 25% to 15%.

Table 10: State-Wise Numbers of Recognised Private Un-Aided Schools Having Elementary Classes I–VIII (2021–2022)

State	No. of Private Unaided Schools	Rank
Uttar Pradesh	74471	1
Madhya Pradesh	21977	2
Rajasthan	19131	3
Karnataka	9514	4
Maharashtra	9329	5

Source: *Indiastat.com*, 2024.

The “Big” and the “Small” Policy Challenges

The declining uptake of government education and health facilities is identified as the “big” policy challenge within the bureaucracy, shaping the rationale for state-level initiatives. Subsumed under this overarching challenge are other “smaller” issues, as listed by district and frontline bureaucrats. They argued that addressing these challenges would transform government health and education facilities and increase uptake. Although state-level bureaucracy decision-makers acknowledge the “small” challenges, these are not the focus of state-level initiatives.

In primary health, key factors reducing the uptake of PHCs in urban areas include staff shortages—particularly frontline staff such as ANMs and lab technicians—low numbers of sanctioned posts in the context of rapidly expanding slum areas in urban centres with large migrant populations, challenges in securing specialist visits to PHCs, and the non-availability of PHCs after 4:30 pm. According to district-level functionaries, the sanctioned number of PHCs for urban areas does not align with the geographic distribution of the population. Certain areas require additional PHCs. For example, Belgaum has two Namma clinics, both located in the industrial areas of Macche and Piranwadi. Frontline bureaucrats argue that the location of these Namma clinics is

³⁴ Due to COVID, there was an abnormal surge in government enrolments because many in low-cost private schools moved their children to government schools as they lost their livelihoods. This trend reversed from 2023–2024 onwards. To include a sufficient number of years for a trend to emerge (which is not possible from 2023 to 2025), the years in this range are 2012–2019.

not ideal as functional PHCs are situated nearby and numerous private medical facilities are also available in abundance. The clinic timings conflict with the working routines of the local population, with clinics closing at 4:30 pm and during the noon hours. Since these are the working hours for the migrant population and slum dwellers, the relevance of Namma clinics for their intended population has diminished. District and frontline functionaries told us that merely increasing the working hours of the PHCs would significantly enhance the uptake of primary care facilities. Additionally, increasing staff for frontline activities, such as NCD camps, maternal health check-ups, and mental health camps, would further reduce the need for individuals to visit private facilities or government hospitals.

In elementary education, the small challenges include deteriorating infrastructure within schools—particularly the construction and maintenance of toilets, boundary walls, and classrooms. Regarding teachers, challenges include a large number of single-teacher schools, multi-grade teaching, irregular teacher appointments, poor teacher training—especially in English—and inadequate teacher accountability. Additionally, the splitting of exam boards has created a hierarchy in which elite boards such as Central Board of Secondary Education (CBSE) and Indian Certificate of Secondary Education (ICSE) outrank state boards, and there is poor regulation of private sector school licensing. Members of the frontline bureaucracy and engaged citizens identified these as key challenges driving students to private institutions. The frontline bureaucracy argued that, with the infusion of funds and focused programmes, enrolments in all urban government schools could be easily increased. For example, enrolments in KPS schools in both study sites increased when each school received KPS school-level funds, facilities, teacher training, and standards of a modern school, such as English as a medium of instruction and pre-primary education.

Examining Problem Prioritisation—The “Big” Challenges

Policy analysis focuses on the “big” challenge of declining uptake of school and primary health centres (PHC) facilities. The proposed solution through state-level education initiatives is the development of school complexes via the KPS programme. For primary care, two new initiatives funded by the central government—the Namma clinics and Ayushmati

clinics—have been introduced. No new initiatives are proposed for the existing UPHC network. Regarding the existing PHC system, state-level bureaucratic decision-makers argue that the overall policy approach is to rationalise PHCs. Both approaches aim to consolidate resources and enhance efficiency.

The main initiative in elementary schooling, the KPS programme, involves developing a school complex that accommodates all classes from pre-primary to Year 12 within a nearby complex. A distinctive feature of the KPS programme, highlighted by state-level decision-makers and bureaucrats at the district level and below, is its intention to concentrate funds, teachers, and facilities in the best-performing, high-enrolment school within a neighbourhood. The KPS programme addresses some of the “small challenges” of the school system. These include: a) lack of English as the medium of instruction, b) the absence of pre-primary classes in primary schools, c) the presence of all school grades in nearby areas to prevent student drop-out after completing elementary schooling, d) funding to improve infrastructure, and e) providing transport facilities for students coming from distant areas. However, by consolidating these new features in a select few schools, the focus is on reducing resource inefficiencies caused by schools with low enrolments rather than enhancing the uptake of existing schools.

In primary care, the two key initiatives are the Namma clinics—extension clinics to existing UPHCs—and Ayushmati clinics. Both are funded by the central government, thus posing no cost implications for the state level. These initiatives increase the reach of the primary care network. Namma clinics are new facilities, while Ayushmati clinics are an additional feature of existing UPHCs. However, firstly, both are implemented in select urban areas, and secondly, they do not focus on enhancing the uptake of existing public primary care facilities. Regarding the existing UPHC network, the stated policy approach is rationalisation and consolidation, which also aims at resource efficiency. The rationale, as stated by members of the state-level and district bureaucracy and engaged citizens, is that in certain parts of Karnataka, such as South Karnataka, there is an excess of PHCs. They stated that the PHCs were set up in an ad hoc manner, often in response to popular pressure to increase the provision of health facilities. Whether the facilities were needed and their locations were not decided according to specified norms. Some districts, with Shivamogga as an example, have an excess of PHCs as well as PHC staff members, and the

suggested policy response is to rationalise. Respondents noted that this is not the approach in North Karnataka, particularly its rural areas, because there is a high uptake of government facilities in health and education, and limited private options. Therefore, additional funds are needed to enhance the reach of schools and PHCs³⁵ in these areas.

Examining the problem-solution linkage: Resource consolidation and rationalisation as a solution for the “big challenge” of declining uptake of health and education facilities appears odd. Conclusive data highlighting that poor uptake is due to an excess of facilities or a preference for private options is not available. Some data, in fact, highlight the opposite. For urban primary care, both the data and secondary literature indicate a lack of facilities and medical staff. For urban elementary education, the data highlight infrastructural lacunae, a shortage of teachers, and low learning levels. It is unclear how the new initiatives—KPS, Namma Clinics, Ayushmati Clinics, and the rationalisation of PHCs—would address these problems and therefore solve the declining uptake of public health facilities.

According to the most recent data provided in the Rural Health Survey 2021, there is a 36% shortage of UPHCs in Karnataka (RHS 2021), a 44% shortage of ANMs, and a 25% shortfall of pharmacists.³⁶ What is noteworthy is that the problem-solution mismatch exists even for primary healthcare in rural South Karnataka, which is often cited as an example of excess PHCs. This is highlighted both by data (RHS 2021 shows more rural PHCs than sanctioned) and in our conversations with state-level bureaucratic functionaries and engaged citizens. Rural South Karnataka also faces a shortage of medical staff, according to the Karnataka Evaluation Authority (KEA) (Gururaj and Karnataka Health Vision Group Collaborators, 2021). In rural North Karnataka, such as Belgaum and Gulbarga, the situation is worse, with shortages of both facilities and field-based personnel.

For elementary education, resource consolidation in model schools via the KPS programme does not fully address the low enrolment challenge. Low enrolment is not entirely due to an excess of facilities. In fact, some parts of Karnataka lack primary schools according to the norms laid out in the RTE. The recent Comptroller and Auditor General (CAG) audit report highlights this for rural habitations. It states, “Of the 487,929 habitations in the State, 132,924 habitations did not have lower primary schools within one kilometre and 10,278 habitations did not have an upper primary school within the norm of three kilometres” (CAG of India, 2024, p. viii). This indicates that in 27% of all habitations, primary classes (children aged six years) do not have a school within one kilometre of the children’s residence. Disaggregated data on the number of teachers in urban schools is not available, but datasets such as Indiastat (MoE, 2025) highlight that between 2016 and 2020, teacher vacancies increased from 1% to 15%. Another crude analysis involves matching the number of enrolments per primary school with the number of teachers available in the school. The data is available for government (state government) schools for the year 2021–22 for Karnataka as a whole. This highlights that each school has 1.8 teachers per school with a new enrolment of 126 students in 2021–2022.³⁷ Of course, the concentration of enrolments will vary across schools; however, it does appear necessary to investigate the state of staff availability as a factor in declining enrolments.

The mismatch between the problem and the solution was recognised by multiple categories of interviewees. These include state-level bureaucracy decision-makers, frontline-level bureaucracy, civil society members, and engaged citizens. They argued that initiatives such as the KPS programme, Namma Clinics, and Ayushmati Clinics are beneficial. They recognised that consolidating and augmenting resources, reducing wastage of infrastructure, staff, and management time, and setting up extensions

³⁵ It must be noted that a separate board was set up to propel social development in North Karnataka. The region was given a special status under the constitutional provision called 371-J in 2012. It was implemented in 2013, and a new board was set up called the Kalyan Karnataka Region Development Board (KKRDB) in 2013. Prior to this, a High-Powered Committee was set up by the State government for the Redressal of Regional Imbalances (HPCRR) under the chairmanship of Dr D. M. Nanjundappa. The committee submitted its report in 2002. The report identified 114 backward taluks in the state, of which 59 were in North Karnataka and 55 were in South Karnataka. The improvements in the backward taluks in the KK region remain marginal.

³⁶ We also do not know if the sanctioned numbers themselves align with the health needs of urban areas. District- and facility-level disaggregation for urban areas, particularly with regard to uptake, is not available to determine whether the sanctioned number of health facilities is sufficient to address the health needs.

³⁷ According to the dataset, in 2021–2022, there were 21,405 primary schools in Karnataka, and the total number of teachers in primary schools was 36,703. Enrolments in primary classes in 2021–2022 were 2,670,886. This equates to 1.8 teachers per school and 126 enrolments per school (Indiastat.com, 2024).

to existing PHC facilities will help in the uptake. However, this will occur only for a few select facilities. These measures will not enhance uptake across government elementary education and primary care institutions. To address the ‘big’ challenge of declining uptake, an infusion of funds and new initiatives for all schools and PHCs is needed. However, this is not happening. Among interviewees, the need for an increase in funds was clearly articulated; nevertheless, it was tempered with a resignation that in a government system outcomes must be met with limited resources. This is also reflected in the initiatives themselves. Both in primary health and education, none of the initiatives call for a significant increase in the state government’s resource envelope. The KPS programme is based on pooling and consolidating resources. SEPC will make policy recommendations, and at this stage, it is unclear if this will result in a cost implication. The healthcare initiatives are using central government funds. Namma Clinics and Ayushmati Clinics are based on central government funds, and it was not clear from the interviewees that the consolidation of PHCs is followed by a plan to channel the savings into a revamp and upgradation of the existing PHC system.

4.4 Drivers of New Initiatives in Health and Education: Central Government Policy Push and the Local “Policy” Context

Karnataka’s key initiatives in primary health and education, as discussed so far, were led by state-level bureaucracy and political leadership in response to a policy push from the central government on the one hand and the demands of the local policy context on the other. The policy context differs from the overall local conditions, which are defined by socio-cultural, political, financial, and bureaucratic issues in health and education. The local policy context refers to those aspects of the local conditions that determine the types of state-level policy initiatives undertaken. For example, certain districts, such as Belgaum, have a higher proportion of migrant populations due to the presence of manufacturing units. This has significant consequences for school education and primary care. As migrant children frequently move, their school attendance is affected, and it becomes difficult to track their learning levels. In primary care, tracking the health of young women, pregnant and lactating mothers also becomes challenging. UPHCs catering to migrant populations experience fluctuating numbers in their catchment areas. These are all

part of the local context. However, the presence of these issues does not ensure that state-level initiatives will address them. For policy initiatives, other factors of the local context become important. We argue that the policy context comprises four components. The initiatives discussed thus far meet these four criteria. Moreover, we contend that future initiatives will also emerge within the boundaries of these four components unless the local policy context changes. The four components are:

Commonly Agreed-Upon Challenges: The policy context leads to the selection of challenges that are commonly agreed upon and recognised by school users, administrators, and engaged citizens, although they are not necessarily “critical and urgent” challenges. Challenges that are “critical and urgent” do not always make it into the policy ecosystem. For example, the lack of teacher training, monitoring and supervision, and poor human resources for front-line health functionaries were prominent challenges. Nonetheless, these are not part of the “policy” context. In contrast, the lack of English as a medium of instruction at the elementary level, the lack of linkage between primary and secondary schools, and MCH indicators are part of the policy ecosystem. Many factors influence whether a particular challenge becomes part of the local policy context. Issues that require significant expenditure from the exchequer, organisational restructuring, the establishment of new bodies, new recruitment or transfer rules for personnel, or outcomes linked to system design rarely attain prominence. Teacher training, particularly English language training, is critical to making the elementary school system effective; however, while the change in the medium of instruction has entered the policy ecosystem, training teachers in teaching English and upgrading and streamlining the teacher training ecosystem has not. This does not imply that “urgent and critical issues” do not enter the policy domain. Karnataka is among the leading states that have developed a transparent policy for teacher recruitment and transfers; both were critical and urgent challenges but were not part of the policy ecosystem for several decades until the early 2000s. Under the leadership of then Chief Minister S.M. Krishna, the teacher recruitment system was changed from district-level recruitment, where local political leaders had significant influence (Ramachandran et al., 2018), to one with transparent norms for recruitment and transfers based on merit. However, in the current period, teacher training is not a challenge that is prioritised in the local policy context.

Solutions That Are Visible and Understandable to Ordinary Residents: The policy context places a premium on solutions that are “visible” and “understandable” to ordinary residents, for example, providing a seamless transition to higher secondary classes and neighbourhood clinics in addition to PHCs. Solutions that are structural and hence not visible to school users, engaged citizens, and ordinary residents, and those which are dependent on long-term, incremental system development, are less valued. Examples include teacher training and monitoring, as well as developing systems to ensure the quality of care at the primary care level.

Involvement of Local Politicians: The context is also defined by the imperative that local politicians be involved in the initiative. All the key primary health and elementary education initiatives discussed so far are actively used by local Members of Legislative Assembly (MLA). The KPS Programme was designed to be one school per MLA constituency. Local MLAs demand KPS Programme schools for their constituencies from the education department. MLAs also have a formal role to play in KPS. They recommend which schools can be upgraded to KPS and are heads of the KPS School Development and Monitoring Committees (SDMC). The fact that MLAs demand that a model school like KPS be in their constituency highlights the value of KPS for their political visibility. The State Education Policy Commission (SPEC) is frequently highlighted as a political initiative of the GoK to establish Karnataka’s position vis-à-vis the National Education Policy (NEP). Similarly, the establishment of Namma clinics and new urban PHCs is also actively publicised by the local political leadership.³⁸ It must be highlighted that ownership by local politicians does not translate into “electoral ownership.” While many of these initiatives occasionally appear in electoral campaigns—for example, the presence of new Namma clinics in a neighbourhood or the setting up of KPS—electoral politics itself does not revolve around the extent to which local political leadership provides better education and health. Political leaders are not held accountable for the poor performance of local schools and primary care facilities. Across the stakeholders, including state-level bureaucracy deci-

sion-makers, district- and frontline-level bureaucracy decision implementers, academics and policy influencers, engaged citizens, and ordinary residents, there is an understanding that political ownership does not translate into the electoral influence of the initiatives.

No Additional Financial Implications: The local policy context in Karnataka is such that resource-demanding initiatives for elementary schooling and primary healthcare are not entirely viable. Policy drivers prioritise resource consolidation and efficiency. This is the overall orientation of the elementary education and primary health policy system. In the case of elementary education, one example of resource consolidation is that, in some talukas, KPS schools are also selected as PM Shri schools and therefore benefit from additional funding. This was the case in both study sites. The resource base of elementary education and primary health has not improved in any significant manner, as discussed in the previous sections (see 15th FC and Karnataka Economic Survey 2023 findings on budgetary allocations on page 7 and Table 7 for health and education budget share). It is important to note that, within the bureaucracy, the understanding that financial resources will never be available in adequate numbers is prominent. Some respondents (state-level and frontline bureaucracy implementers) spoke with pride about their capacity to meet education and health objectives by drawing funds from other schemes, raising resources from local philanthropists, and at times even asking local community leaders to support schools and PHCs. An MO at one of the UPHCs said she has a good relationship with the local corporators, who assist her in meeting the objectives of local health and nutrition drives and health camps by rallying treatment seekers. Some local corporators also get additional rooms constructed in a PHC. The approach to the availability of financial resources is possibly the biggest schism between the experts and academics on the one hand, and the decision-makers and implementers on the other. The former category emphasises that a collective focus has to be on increasing the resource envelope of the state towards health and education, if any, while the latter believes that the government system will never have adequate resources.

³⁸ The case of Shivamogga was frequently given in discussions, given that it has an active political leadership and they demand PHCs and quality of health facilities. However, it must be noted that Shivamogga district has an excess of rural PHCs from the sanctioned limit but Shivamogga city does not have an excess of Urban PHCs. Furthermore, the distribution of PHCs is contested in Shivamogga. One of the UPHC in a neighbourhood in Tungnagara had a disproportionately large catchment area under its ambit.

Other Drivers and Pathways to New Initiatives

Many of the other pathways through which new initiatives can emerge appear to be fragmented in the case of Karnataka. Five prominent ones are:

- a) The internal bureaucratic process based on feedback received from the grassroots level;
- b) Expert committees and consultative bodies set up by the government;
- c) Engagement from private and professional bodies such as large civil society organisations, teachers' unions, and doctors' associations;
- d) Inputs from local political leadership or electoral pressures; and
- e) Pressure from social movements.

These pathways already exist in the policy ecosystem in Karnataka, but they are not prominent in driving new state-level policy initiatives. The discussion below highlights the limitations of each of these pathways.

Internal Bureaucratic Process

As part of the regular internal bureaucratic process, annual plans for schools, PHCs, and requests for funds, personnel, and project status updates provide significant inputs on the gaps and challenges at the grassroots level. The internal, planning-focused paperwork is further supported by in-person meetings between district- and sub-district-level bureaucratic implementers and video calls with State-level education bureaucrats, during which many functionaries at the grassroots level highlight their specific challenges. For example, MOs at one of the PHCs and the district collector in one of the districts visited as part of this study stated that specific challenges regarding extending the opening hours of the PHC beyond 4.30 pm and making staff available during evening shifts had been raised to district-level authorities. Demand for an additional maternity hospital in urban Shivamogga to improve access to maternity care has also been raised to state-level authorities.

Internal bureaucratic processes for sharing details of the state of school and healthcare facilities have been undertaken for a long time, particularly since the implementation of national-level programmes such as the Sarva Shiksha Abhiyan (SSA) and the NRHM. However, the process does not have mechanisms for the consolidation of grassroots inputs and consensus generation among various levels of the bureaucracy. The availability of technical inputs

or an accurate assessment of the state of schools and primary healthcare is not sufficient for momentum to emerge for new initiatives. It is the initiative of the Education and Health Secretaries, along with support from the political leadership, including the Chief Minister, that results in new initiatives with additional funding, if required, from the state.

Expert Committees and Consultative Bodies

Karnataka has established several prominent consultative commissions and expert committees on school education and primary healthcare. While they play an important role in knowledge creation, consensus building, provision of technical inputs, and elite socialisation, neither their constitution nor the provision of policy recommendations necessarily leads to state-level initiatives in health and education. Several leading academics, former state-level commission members, state-level bureaucracy decision-makers, district-level implementers, and policy influencers highlighted that commissions do not have policy-making traction in Karnataka.

The inputs from commissions and expert committees, along with legal rulings—whether from the Karnataka High Court or the Supreme Court of India (SCI)—provide a range of policy ideas which the state-level decision-makers may act upon. However, whether this happens through focused initiatives backed by increased funding or smaller interventions nested within existing programmes is driven by the state-level policy and bureaucratic decision-makers. The recent intervention by the Karnataka High Court regarding the FICCI report (State Council FICCI Karnataka, 2023), which studied key sectors including education and healthcare that could accelerate Karnataka's economic growth, is a good example. Based on the report's findings on the poor state of primary care infrastructure in the state, the Karnataka High Court directed the Karnataka government to immediately complete recruitment for vacant positions. The government is still considering ways to address the directive, and it is unclear whether comprehensive measures will be undertaken to enhance the reach and quality of primary care.

Engagement by Large Civil Society Bodies and Professional Organisations such as Teachers' and Doctors' Associations

These organisations provide inputs and insights on health and education, some of which result in new programmes; however, these must align with the

policy priorities already set by the political leadership of the State and the state-level bureaucracy. Their role is limited in fundamentally shaping policy priorities. Many health- and education-focused government programmes are run by civil society organisations, including both small, local ones that work within a district and large ones such as Karuna Trust and Azim Premji Foundation (APF), which operate at the state level. Their ideas and insights strengthen policy initiatives primarily through engagement with the state-level bureaucracy. Civil society organisations propose ideas and programmes to the education or health departments, or the departments approach civil society organisations for support in implementing certain ideas.

For example, APF is working in partnership with the education department to implement the Guruchetana programme for teacher training, and the programme was designed collaboratively between the education department and APF. The state-level decision-makers initiated the programme by prioritising the specific challenge of in-service teacher training and connected with APF. Similarly, the role of professional organisations such as teachers' and doctors' associations involves providing supportive inputs as requested by the state-level decision-makers.

To illustrate, in 2021, the Karnataka government set up the Karnataka Health Vision Group, headed by Prof. G. Gururaj, Former Director and Senior Professor of Epidemiology and Public Health at the National Institute of Mental Health and Neuro-Sciences (NIMHANS). The vision group consulted various doctors' associations, such as the Private Hospitals and Nursing Homes Association, Karnataka, and the Federation of Healthcare, Karnataka. District-level bureaucracy implementers indicated that they welcome proposals from local NGOs for support in education and health activities, but their objectives must align with the health or education department's requirements.

Political Leadership

The role of political leadership is perhaps the most complex and poorly understood. It is important to highlight that political will, political leadership, and political accountability—which are critical in strengthening social welfare—must be differentiated from the role played by “political leaders” and “politics.” The provision of primary health and elementary education is simultaneously deeply political, yet

devoid of political ownership for social welfare. Political leaders implement new initiatives, such as the construction of classrooms and new PHCs in their constituencies and electoral campaigns, but this rarely translates into taking ownership for the provision of high-quality services and being held accountable for them.

Political leaders have an individualistic, transactional, and episodic role both in formal and informal domains in the provision of public education and health. Their formal role—as per the design of the programme and scheme frameworks—is limited in the implementation of primary education and health facilities. Appointment of staff, transfer of funds, and monitoring and supervision occur through bureaucratic systems. Political leaders are represented on district-level committees but are seldom the main actors whose inputs or support lead to the strategic reorientation of district-level health and education systems. For example, while they may support the provision of new classrooms in a particular area within a district, they are not responsible for ensuring regular oversight of whether the addition of new classrooms results in greater uptake of government schools or if other initiatives are needed to achieve this. In certain initiatives, they have a prominent local-level role. For example, they head the SDMC for KPS and are members of Rogi Kalyan Samitis in PHCs and district hospitals (MoHFW, 2015). Few interviewees stated that political leaders in their formal roles were proactive in improving the provision of public health and education, such as providing strategic inputs to improve schools and PHCs, mobilising funds within the bureaucracy and from non-government sources, or enabling better performance of staff through supportive supervision or mobilising community support.

In their informal influence on the delivery of public health and education, politicians are important actors who respond to the demands for schools and PHC facilities made by ordinary residents. One reason why our study site in South Karnataka had a higher number of rural PHCs than the sanctioned number was the active local political leadership. The politicians have historically responded well to local demands for new PHCs. Ordinary residents also approach politicians for admissions to schools and local hospitals and for financial help with medical expenses. The selection of the location of health and education facilities, and support for fundraising done by channelling funds from other sources, are some

key areas in the informal role that local political leaders play. For example, KPS in the study site in North Karnataka were set up on the recommendation of the local MLA. Similarly, in the selection of localities for Namma clinics, local MLAs and Members of Parliament (MPs) have an important say. Ward corporators used available funds to construct extra rooms in PHCs in the study site in South Karnataka. In the North Karnataka study site, local political leaders sanctioned the use of “smart cities” funds for the provision of smart classes in government schools. When new initiatives at the state level are selectively implemented across the state, such as setting up KPS schools, local MPs and MLAs play a critical role in ensuring that their constituencies receive funds on priority. In the North Karnataka study site, local political leaders were well-known for organising school competitions and student socialising activities, declaring prizes for academic excellence and distinctive contributions to teaching and learning. These activities were seen as supporting the cause of health and education, helping local politicians connect with their constituents and shape their image as “good” leaders.

This has resulted in a particular structure of politics where the provision of schools and health facilities appears as an extension of political leaders’ contributions to society, rather than as their responsibility for systemic functionality. Consequently, this perception does not foster the consolidation of the political will necessary to address systemic change through well-funded State-level initiatives. Many political leaders run schools and medical colleges, which reinforces the impression among ordinary citizens that these leaders lack incentives to strengthen public facilities. For example, Prabhakar Kore, a prominent Lingayat political leader in Belagavi and a member of the Rajya Sabha, heads the Karnataka Lingayat Education Society (KLES), which operates schools, hospitals, medical research centres, pharmacies, etc. Ravi Patil, the official BJP candidate from the Belagavi North Constituency, is a trained medical doctor who runs an Ayurvedic medical college, hospital, and research centre in Belagavi.

Elections have not played a significant role in altering the political structure. By their very nature, they are episodic, “popular events” that tend to highlight aspects of a political leader’s role in social welfare delivery that are visible, communicable, and non-controversial. The construction of school and PHC buildings, provision of medical equipment and class-

room materials, and mass recruitment of teachers and ANMs—all within existing regulations, without initiating structural changes to recruitment policies—are more amenable to electoral competition. These activities contrast with the deliberative, laborious, long-term, and structural changes required, which involve mobilising across the bureaucracy, community, local civil society leaders, engaged citizens, and experts.

Social Movements

Social movements focusing on the provision of health and education have been few and far between in Karnataka. For example, the Shivamogga and Belgaum districts in Karnataka have been the epicentres of social and political movements. Shivamogga has witnessed several system-challenging movements, including the socialist, farmer, Dalit, and women’s movements. Belgaum has had a long-standing and ongoing movement for the merger of Belgaum city and neighbouring villages into Maharashtra. In the self-assessment of engaged citizens, ordinary residents, local political leaders, and district-level implementers, Belgaum and Shivamogga are politically “active” districts, though they differ in the nature of their politics. In Shivamogga, the political cultures and history have been part of the mainstream Kannada identity, whereas Belgaum has remained on the periphery of Karnataka due to its focus on Marathi identity and demands to separate from the state. The specific nature of political activism in Shivamogga has been such that its political leaders have succeeded in their demands for more PHCs, schools, and similar facilities, particularly in rural areas. In Belgaum, the nature of political activism has resulted in local leaders succeeding in their demands for Marathi/Kannada medium educational institutions. However, none of the social movements have focused on the provision of quality education, health, or other welfare provisions or on creating public facilities that are accessed across social strata. Hence, the political culture has remained limited to providing access to education and health facilities and the medium of instruction, rather than ensuring quality and effective uptake of schools and health clinics.

Policy Initiatives and Pathways

Each of these pathways can be located vis-à-vis the key initiatives examined in this study. In the case of KPS, the idea of school complexes has been suggested by various civil society leaders for several decades. It was also introduced into the policy ecosystem as

part of various national-level policies, such as SSA, since the early 2000s, and state-level knowledge commissions. One such knowledge commission was the 2008 Karnataka Gyan Ayog Commission, which recommended the development of school complexes. The KPS programme also builds on the broader range of policy ideas of “model schools” that have been implemented in Karnataka over the last two decades. Some of these include the Morarji Desai residential schools, Adarsh schools, and Kendriya Vidyalayas. The most recent addition to model schools in Karnataka is the PM Shri Schools. However, the actual KPS programme emerged only in 2017–18 as a result of decisions by state-level bureaucratic and health and education political decision-makers aiming to concentrate resources in a few good schools due to declining enrolments in government schools.

The Namma Clinic programme and Ayushmati Clinics are the result of policy pushes from the 15th Finance Commission and an engaged state-level bureaucracy and political decision-makers working with feedback received from frontline bureaucracy and engaged citizens regarding the chronic lack of urban health facilities. Other initiatives, such as the School Education Policy Commission, are entirely political initiatives in which state-level bureaucratic decision-makers have played only supportive roles. Across all these initiatives, local political leaders have been active in selecting the locations of these facilities and in publicising their services during election campaigns. However, the initiatives themselves have not originated from bottom-up mobilisation by elected leaders within specific constituencies or across constituencies.

5. The Implications

Karnataka is a pioneer in numerous sectors, including information technology, infrastructure, schooling, and healthcare, particularly in teacher recruitment and transfers, as well as health insurance. The state possesses all the makings of a national leader in the provision of urban primary health and school education. Its health and education systems are oriented towards strong public facilities, rather than being options of last resort for the poorest of the poor. Karnataka boasts a robust fiscal capacity, prominent civil society organisations—some emerging from social movement histories and others from private sector backgrounds—a large cohort of technically grounded academics and experts, a culture

of decentralised governance, and highly valued private sector skills and human resources.

However, the number and nature of state-level initiatives undertaken in Karnataka and their drivers suggest that schooling and health should be prioritised by the state. There is an urgent need to collate the various elements required for establishing sustainable state-level initiatives, including political will, financial resources, technical design, stakeholder buy-in, and clarity of purpose. In their current form, state-level initiatives are primarily focused on channelling funds, conserving resources, and addressing some of the overt demands of the poorest of the poor. These initiatives are driven by the commitment of state-level bureaucratic and political decision-makers responding to external contexts, whether involving national-level policy pressures, local policy contexts, or international development influences. To develop a strong health and education system in Karnataka, prioritisation must emerge from within the state’s political, bureaucratic, for-profit, and civil society sectors, aligning towards the vision of achieving health and education for all, with quality that exceeds merely catering to the poorest of the poor in India.

When and why did Karnataka initiate state-level initiatives in primary healthcare and elementary education? Karnataka’s new state-level initiatives have emerged as state-level bureaucratic and political decision-makers in health and education respond to policy pushes from the Central government on one hand and the demands of the local policy context on the other. The initiatives examined in this study have largely not resulted from directives of state-level political leadership or from entrepreneurial, ambitious, and well-networked bureaucrats heading the health or education departments. They have not been the outcome of social movements or advocacy by civil society or professional organisations. The drivers behind Karnataka’s state-level policy initiatives highlight the limitations of the top-down and bottom-up binary in analysing state-level policy-making. Both the drivers identified in this study and the alternative pathways that are not effective in Karnataka encompass top-down and bottom-up elements. For example, the local policy context is shaped by state-level political leaders as well as ordinary non-elite individuals. Advocacy by civil society organisations can serve as a channel for highlighting grassroots aspirations, but only if the organisations themselves are community-focused; large national-level civil society organisations may not necessarily fulfil this role.

What does this mean for addressing the specific challenges facing elementary education and primary healthcare in Karnataka? How have the existing pathways through which state-level initiatives emerge impacted the provision of high-quality schools and PHCs? What does it mean for uptake even among the poorest of the poor? Why is the overall orientation of the government system such that it is best suited only for the poorest?

For new state-level initiatives that tackle the hard problems, for example, teacher training and quality of care, we argue that: a) a transformation in the local policy context is necessary to allow initiatives to focus on structural challenges, raise more financial resources, and ensure relevance for users and grassroots workers; and b) more formalised pathways are needed through which new policy initiatives can be developed.

Transforming the Local Policy Context—Go Beyond the Poor: Among the components of the current local policy context in Karnataka is that only those policy solutions which are visible to facility users and the frontline bureaucracy are implemented, such as the construction of new classrooms, the creation of extension clinics like Namma Clinics, or the development of school complexes such as the KPS. These visible solutions expand access to newer sections of the community; however, they do not improve the quality of the existing system, which requires a structural approach—for example, upgrading the existing infrastructure of schools.

How can one create a local policy context in which structural challenges are also addressed? One way this can happen is by having users of the facilities demand better quality education and health services. However, the poor, due to their vulnerabilities, are commonly not in a position to do so. To effect this change, both short-run and long-run approaches are necessary.

In the short run, it is important to create an incentive for the state and district-level bureaucracy to improve the quality of services by enhancing infrastructure and staffing facilities and by creating internal efficiency in facility functioning and governance. In the long run, the user base of the facilities will include the non-poor, particularly the middle classes, who have the financial resources, as well as the social and political voice, to demand better quality services.

We propose that the state government should create a Diversity Index to achieve both short- and long-run goals. The Diversity Index would rank schools and PHC facilities, and the results can be aggregated at the taluka (block), district, and regional levels. The purpose of the index is to measure the extent to which facilities are used by both the poorest and the better-off sections in the catchment area of the facility. This could include indicators such as parental education, nature of employment, and income bracket.

To achieve the targets set in the index, the state-level bureaucracy will need to find ways to make the facilities attractive to the non-poor and provide quality that is superior to private options. In the long run, as more sections of the middle classes and the affluent use public facilities, a more empowered community of users will emerge, towards which both the political and bureaucratic strata are likely to be more responsive.

Creating the Diversity Index does not necessarily require additional resources. The Karnataka government has existing databases in education (Student Tracking System (STS)) and health (Health Management Information Systems [HMIS]), which track the backgrounds of the users of the facilities. Using this data, existing indices on SDGs and Human Development can be updated to include diversity indicators.

Creating a Political Case for Increasing Funding: Another inhibiting feature of the local policy context is that new initiatives should not have any financial implications. Consequently, only those initiatives that do not involve deeper structural changes and additional cost burdens in terms of infrastructure and training tend to gain prominence. It appears that the ROI for investing in health and education from a growth perspective is not clearly understood. While the contribution of a healthy, well-educated, and skilled population to growth is acknowledged, it is also clear that this is a long, drawn-out and elliptical path. However, the more immediate implications of public provisions of health and education are less recognised. Public facilities reduce the cost burden of health and education on households, which are currently funding these privately at a higher cost. This, in turn, increases the amount of disposable income available to people and contributes to economic growth.

It is critical that the Karnataka state commissions studies that highlight, in numerical terms, the cost to the economy from the private provision of health and education. These studies must specifically highlight how this would hinder the achievement of a 1-trillion economy for Karnataka. The studies must also detail the costs borne by households in numeric terms. Reduced income for consumption and savings, as well as higher inequality, are not conducive to the creation of a high-growth state.

The studies must be widely discussed in local and regional language media, emphasising the household-level costs associated with the use of private facilities instead of quality public ones. The active role of the state in anchoring this dissemination is important, as it provides the studies with legitimacy and political impartiality. Civil society organisations working with state departments could also be involved in disseminating the studies. Parts of the work that civil society organisations do, which link to improving funding levels by the state government for health and education, can be discussed in their dissemination activities. For example, organisations working in teacher training for English language teaching can highlight areas where an increase in government funding will improve the quality and frequency of teacher training.

This study will play an important role in developing a state-level public agenda on why strong state-funded health and education facilities benefit all social strata. Presently, the state-level agenda prioritises large infrastructural and livelihood projects such as roads and IT parks. While these are important contributors, it is also necessary to highlight the critical role of public health and education systems, which impact all strata.

Creating Political Ownership: Political ownership in providing quality health and education, rather than merely political visibility, is another aspect of the local policy context that requires change. This necessitates the emergence of constituencies that demand quality health and education, which can, in turn, benefit political leaders both during and outside elections. To facilitate the emergence of these constituencies, one approach is for state departments to develop constituency-wise profiles of school and health facility performance, along with plans to improve performance. Potential actors in this process include civil society organisations, academic institutions, writers, and local party workers.

Add Pathways Through which New Initiatives can Emerge

Non-bureaucratic channels for developing policy initiatives must be strengthened. Although commissions, committees, and expert inputs have been prominent in Karnataka's policy history, they have not served as effective pillars in the dynamics of decision-making during our study period. We suggest two aspects that need reinforcement.

Government Commissions and Their Impact

FICCI Report (2023): The Department of Planning, Programme Monitoring and Statistics, GoK, in partnership with FICCI, prepared a report focusing on 14 sectors that will help Karnataka's economy grow to USD 1 trillion. One of the findings of the report was the poor state of urban primary care facilities. Taking suo motu cognisance of the findings, the Karnataka High Court directed the State Government to fill chronic health staff vacancies.

Nanjundappa Committee (2002): In April 2000, the Karnataka Government set up a high-power committee under Dr D. M. Nanjundappa (Nanjundappa Committee) to study the regional disparities in the State. The committee report highlighted the high prevalence of backwardness in several districts in North Karnataka. Based on the report, the State Government granted a special status to the KKRDB and also initiated a Special Development Plan (SDP) to address the backwardness of the taluks (Centre for Budget and Policy Studies, Bangalore, 2018).

First, there is a need for increased politicised awareness of the findings, recommendations, and solutions proposed by these bodies. It is not that commission and committee reports are never actioned (see text-box). (For a detailed account of the role prominent education commissions have played in setting up the structure of the school education system in India, see Singh, 2023). However, these reports are actioned only when adopted by bureaucratic and political leadership, which may not occur or may be significantly delayed. While the acceptance of a commission's recommendations cannot be enforced, the findings can certainly be made more impactful in shaping bottom-up demands and support for policy interventions.

Any health or education policy commission, for example, the Primary Care Task Force Commission in 2000, discusses basic and easily understandable aspects such as the number of facilities, staff, and training. However, users of government schools and health facilities, as well as the frontline bureaucracy, are rarely aware of these recommendations. Increased knowledge about them will shape public opinions regarding both the nature of the problems and the solutions these commissions propose. To achieve this, whenever challenges related to health and education are raised by political leaders and new measures are proposed, particularly by these leaders, relevant recommendations from these commissions should be promoted.

For instance, the idea of school complexes and school consolidation was raised in the recent CAG Audit Report (2024). The report discusses the KPS programme, but it is doubtful that its findings will reach the school facility level. The CAG report also highlights the problem of the lack of primary schools within a 1 km radius of some rural habitations and recommends mapping rural habitations and the number of school-going children in these areas. When ideas from health and education experts are endorsed and disseminated by political leaders, they tend to enter common parlance and shape the viewpoints of facility users and administrators. This is essential for creating constituencies that demand better health and education services. Currently, it is sometimes challenging to locate some of the reports developed by these bodies.

Second, a formal, institutionalised process is needed through which new initiatives can be proposed by non-bureaucratic channels and widely disseminated. Under the current system, civil society leaders and other non-government actors either respond

to requests from senior bureaucracy and political leaders for support on social welfare issues or propose ideas that align with these leaders' agendas. We require a formal, institutionalised process that engages with all stakeholders routinely and proposes new ideas, initiatives, or focuses on addressing key challenges in health and education.

Sector-specific State advisory councils have been proposed in various national-level initiatives such as the DPEP and the RTE Act. However, these councils have three limitations. First, political and bureaucratic members are prominent in number and influence, which effectively means that bureaucratic channels remain very strong in policymaking. Second, the primary role of these councils has been to oversee implementation. Third, they were never fully established with the required powers and resources at the state level. It is time to revisit the design of these bodies.

It is essential to constitute State-level advisory bodies in education and health with the power to propose new initiatives through the examination and prioritisation of challenges and problems. These bodies must include representation from important stakeholders such as civil society, academia, journalism, professional bodies (e.g., teachers' associations) and private school associations. Roles, responsibilities, and key responsibility areas must be delineated vis-à-vis the bureaucracy and political leadership. Allocation of financial resources should be provided.

While state leadership will always reside with political leaders and the heads of health and education departments, it is also essential to establish other channels through which new thinking can drive the state towards true leadership in creating public facilities.

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Appendix 1: Summary of Health and School Education-Related Initiatives

In this study, we highlight the key health- and education-focused initiatives undertaken by the Karnataka government from 2014 to 2024 using two approaches. The first table presents a year-by-year listing of initiatives highlighted in the Economic Survey report. This listing includes ongoing and

some new initiatives at the state and national levels. Secondly, a listing was developed by the research team through a review of government documents and stakeholder interviews at the state level.

Table A1: Summary of Key Health and Education Related Initiatives in Karnataka 2014–2024 as per the Economic Survey Reports

Year	PCI, Gross State Domestic Product (GSDP), and Their Rankings	Primary Healthcare Initiative(s)	Elementary Education Initiative(s)
2014–2015	<p>PCI: Rs 1,00,594</p> <p>PCI Ranking: 9th among all states in India</p> <p>GSDP: Rs 3,44,106</p> <p>GSDP Growth Rate: 7.0%</p> <p>GSDP Ranking: 6th among all states in India</p>	<p>NHM: In each district, programme implementation is carried out through the District Chief Medical Officer’s office, blocks, Community Health Centres (CHCs), PHCs, sub-centres, and Village Health Sanitation Committees (VHSCs).</p> <p>The Integrated Disease Surveillance Project: The project aims to establish a decentralised, state-based system of surveillance for communicable and NCDs, enabling timely and effective public health actions in response to health challenges at the State and national levels. It was launched nationally in 2004.</p> <p>Janani Suraksha Yojane (JSY): The goals of JSY are to reduce MMR and IMR and to increase institutional deliveries among Below Poverty Line (BPL) and SC/ST families. It was launched in 2005.</p> <p>Thayibhagya: To reduce IMR and MMR in the backward districts of Bijapur, Bidar, Gulbarga, Yadgir, Raichur, Koppal, Bagalkot, and Chamarajanagar, empanelled private hospitals receive an incentive of Rs 3,00,000 for every 100 deliveries conducted, including surgeries, with treatment provided free to patients. It was launched in 2009.</p> <p>Arogya Kavacha 108: This programme provides free first aid and referral transport in cases of medical, police, and fire emergencies.</p> <p>Prasooti Arai: Under this scheme, BPL pregnant women (including SC/ST) who undergo deliveries in government hospitals are given an incentive of Rs 2,000 (including JSY) for meeting their nutritional requirements.</p> <p>Arogya Vani-104: This programme enables citizens to ask health-related queries.</p>	<p>Out-of-School Children (OOSC) Annual Work Strategies: Providing elementary education to children aged between six and 14 is the duty of the government according to Article 45 of the Indian Constitution. In this regard, the State GoK has made serious attempts to provide elementary education to this age group by offering basic and academic facilities.</p> <p>Pancha Saulabhya and Other Basic Facilities under SSA: Under the national flagship programme of SSA for universalising elementary education, the state has accorded special significance to the provision of infrastructure facilities such as school buildings, additional classrooms, and the maintenance and repair of school buildings.</p> <p>Nali-Kali (Joyful Learning): All 45,476 schools in the state have adopted the Nali-Kali method of learning and teaching.</p> <p>Kasturba Gandhi Balika Vidyalayas (KGBV): Seventy-one KGBVs have been set up in backward blocks of the state for the benefit of drop-out, disadvantaged, and nearly destitute girls.</p> <p>Student Learning Achievement Study (Baseline Assessment Survey (BAS): The state has initiated a study on students’ learning assessment. The major findings of the study are being disseminated to all senior officers and section officers.</p>

Year	PCI, Gross State Domestic Product (GSDP), and Their Rankings	Primary Healthcare Initiative(s)	Elementary Education Initiative(s)
2015–2016	<p>PCI: Rs 1,45,799</p> <p>PCI Ranking: 9th among all states in India</p> <p>GSDP: Rs 7,80,805</p> <p>Growth Rate: 6.2%</p> <p>GSDP Ranking: 6th among all states in India</p>	<p>National Vector Borne Disease Control Programme (NVBDCP): In each of the districts, programme implementation is carried out through District Health Officers, Taluka Health Officers, and Administrative Medical Officers at CHCs and PHCs.</p> <p>Janani Suraksha Vahini (JSV): Initiated under the NHM to ensure 24/7, round-the-clock free referral transport between facilities for pregnant women and sick neonates/infants.</p> <p>Bike Ambulances (First Response Unit): The Bike Ambulances/ First Response Unit (FRU) was inaugurated on April 15, 2015, by the GoK. It is the “Platinum Ten Minutes” trauma care initiative aimed at reducing deaths due to road accidents.</p> <p>Rashtriya Bal Swasthya Karyakram (RBSK): This unique programme is being implemented for the first time in the country. Approximately one crore schoolchildren (both private and government sectors) are medically screened, and children requiring surgeries are provided surgical treatment free of cost in empanelled hospitals.</p> <p>Madilu: This scheme, launched by the state government in 2007, provides postnatal care for mothers and children.</p> <p>Vatsalya Vani: For the first time in India, a three-way call conferencing structure for a mother–child tracking system called “Vatsalya Vani” was launched in Karnataka by the Honourable Chief Minister.</p>	<p>OOSC: To prevent absenteeism and ensure regular school attendance, an Education Coordinator (ECO) is appointed as the Attendance Authority. In cases where absenteeism exceeds seven days, the ECO is required to visit the students’ families to persuade parents to enrol their children in schools. This method is currently being implemented.</p> <p>Sarva Shikshana Abhiyan: Under the Universalisation of Primary Education Scheme, the State is undertaking efforts to provide school buildings, additional rooms, and aid for the repair and maintenance of schools.</p> <p>Residential Schools for Specific Categories of Children: Five residential schools for specific categories of children— one each in Bengaluru Urban, Dakshina Kannada, Dharwad, Mysuru, and Shivamogga—sanctioned under the RTE, have been established.</p> <p>KGBV: The Central and State Governments have undertaken efforts to educate girl children.</p>
2016–2017	<p>PCI: Rs 1,59,893</p> <p>PCI Ranking: 9th among all states in India</p> <p>GSDP: Rs 8,71,995 crore</p> <p>Growth Rate: 6.9%</p> <p>GSDP Ranking: 6th among all states in India</p>	<p>Nagu-Magu: Provides a drop-back facility for postnatal mothers and newborns from government health facilities to their residences using 200 drop-back vehicles. It was launched in 2015.</p> <p>Suvarna Arogya Suraksha Trust (SAST): A Special Purpose Vehicle (SPV) within the Department of Health and Family Welfare, GoK. It is registered under the Indian Trusts Act of 1882 for the implementation of various health assurance and insurance schemes.</p>	<p>Children with Special Needs (CWSN): In the State, there are 82,364 children identified as part of the special needs group. Of these, 63,582 children are enrolled in schools, and 18,782 require the highest level of special needs care and are provided with home-based education.</p> <p>Learning Ability of Students in Second, Fourth, and Eighth Standards: To assess the learning ability of students, a study is being conducted by the Karnataka State Quality Assessment and Accreditation Council (KQAAC).</p>
2017–2018	<p>PCI: Rs 1,74,551</p> <p>PCI Rank: 10th among all states in India</p> <p>GSDP: Rs 9,49,111 crore</p> <p>Growth Rate: 8.5%</p> <p>GSDP Rank: 6th Among all states in India</p>		

Year	PCI, Gross State Domestic Product (GSDP), and Their Rankings	Primary Healthcare Initiative(s)	Elementary Education Initiative(s)
2018–2019	<p>PCI: Rs 2,07,062</p> <p>PCI Ranking: 9th among all states in India</p> <p>GSDP: Rs 10,82,534 crore</p> <p>Growth Rate: 9.6%</p> <p>GSDP Ranking: 6th among all states in India</p>	<p>NHM: The NHM integrates primary healthcare services for both urban and rural populations. The NHM seeks to provide accessible, affordable, and quality healthcare to the rural population, particularly targeting vulnerable sections.</p> <p>NVBDCP: In each district, programme implementation is carried out by the District Vector Borne Disease Control Officer, Taluka Health Officers, and Administrative Medical Officers at CHCs and PHCs. The State implements activities for the prevention and control of vector-borne diseases such as malaria, filaria, dengue, chikungunya, and Japanese encephalitis in accordance with the guidelines of the GoI and the Directorate of NVBDCP, Delhi.</p> <p>National Tuberculosis Control Programme (NTCP): The Revised National Tuberculosis Control Programme (RNTCP) Karnataka aims to achieve universal access and zero TB deaths as part of the End TB Strategy.</p>	<p>OOSC: In this context, the updated census was conducted in December 2018, identifying 6,704 children between the ages of seven and 14 as school dropouts. Additionally, 6,803 children from the previous year were prevented from dropping out of school.</p> <p>School Buildings and Classrooms: During 2018–2019, there were 372,385 classrooms in elementary schools, indicating an increase of 10,169 classrooms over approximately 10 years.</p> <p>Research, Evaluation, Monitoring, and Supervision (REMS): REMS is a major intervention focusing on the quality dimension of education under the SSA Mission. The approved activities within REMS emphasise research and evaluation, aiding in the assessment of the strengths and weaknesses of educational practices.</p>
2019–2020	<p>PCI: Rs 2,31,246</p> <p>PCI Ranking: 9th among all states in India</p> <p>GSDP: Rs 12,01,031 crore</p> <p>Growth Rate: 6.8%</p> <p>GSDP Ranking: 6th Among all states in India</p>		<p>Basic Facility under Sarva Shikshana Abhiyan: The State, under the universalisation of the Primary Education Scheme, undertakes efforts to provide buildings to schools, additional rooms, and aid for the repair and maintenance of schools.</p> <p>Nali Kali: All Government Kannada- and Urdu-medium primary schools in the State have adopted the Nali Kali mode in the teaching and learning method. All schools are supplied with revised Nali Kali learning cards.</p>

Year	PCI, Gross State Domestic Product (GSDP), and Their Rankings	Primary Healthcare Initiative(s)	Elementary Education Initiative(s)
2020-2021	<p>PCI: Rs 2,26,796</p> <p>PCI Ranking: 11th among Indian states</p> <p>GSDP: 11,13,818</p> <p>GSDP Growth rate: 2.6%</p> <p>GSDP Ranking: 6th among all Indian states</p>	<p>NTCP: The World Health Organization (WHO) TB statistics estimate an incidence of 2.6 million TB cases in India for 2019, as reported in the Global TB Report 2020.</p> <p>Integrated Health Information Platform (IHIP): Launched on November 26, 2018, by the Secretary of Health, MoHFW, GoI, in Karnataka State, the IHIP has been implemented alongside six other states. The reporting rates for “L” and “P” forms under IHIP were 59% and 63%, respectively, in November 2020.</p> <p>Arogya Kavacha 108: From April to November 2020, 583,739 emergency calls were attended. Of these, 467,864 emergencies were addressed, including 127,198 pregnant women who utilised the services, resulting in 34,194 lives saved.</p> <p>JSV: Three drivers (one regular and two outsourced) are allocated to each vehicle to work in eight-hour shifts. The total number of beneficiaries under JSV from April to November 2020 was 12,586.</p> <p>Arogya Vani-104: The Arogya Sahayavani-104 call centres are situated at IT Park Hubli and Sir C. V. Raman Nagar Hospital, each with a capacity of 100 seats. Citizens from any part of the state can avail themselves of the service by calling 104.</p> <p>ASHA Programme: An ASHA worker is a woman selected from and resident within the community who is trained and supported to operate in her village, thereby improving the community’s health status through enhanced access to healthcare services and improved healthcare practices and behaviours. In rural areas, there is one ASHA per 1,000 population, and in urban areas, one ASHA per 2,500 population. She is incentivised for 37 different health activities.</p> <p>Jyothi Sanjeevini Scheme (JSS): This health assurance scheme is specifically for the benefit of all State Government employees and their dependents, with no cap on the financial limit. Treatment under the scheme is entirely cashless.</p> <p>Child Health Programme: The Child Health Programme comprehensively integrates interventions that improve child survival and address factors contributing to infant and under-five mortality.</p>	<p>KGBV: Efforts have been made by the Centre and State Governments to educate girl children. Seventy-one KGBV residential schools in 69 educationally backward blocks have been established for girls in sixth to eighth standards. These schools continue education under the SSA of the Central Resource Development Department, addressing gender disparity, rural areas, weaker sections of society, SC/ST, and economically backward classes.</p> <p>CWSN: There are 85,200 children in the state identified as belonging to the special needs group, of whom 81,014 are enrolled in schools. Additionally, 4,186 children require the most special needs care and are provided with home-based education.</p>

Year	PCI, Gross State Domestic Product (GSDP), and Their Rankings	Primary Healthcare Initiative(s)	Elementary Education Initiative(s)
2021–2022	<p>PCI: Rs 3.05 lakh</p> <p>PCI Ranking: 11th among all Indian states</p> <p>GSDP: 20,50,000</p> <p>GSDP Growth rate: 7.2%</p> <p>GSDP Ranking: 6th among all states</p>	<p>“Ayushman Bharat-Arogya Karnataka” (AB-ARK) provides cashless treatment (in an assurance mode) for specified secondary, tertiary, and emergency healthcare treatments.</p> <p>The State has also been implementing the JSY, which aims to reduce MMR and IMR and increase institutional deliveries for BPL and SC/ST families.</p> <p>The State implements the Organ Transplantation Scheme, Child Health Programme, RBSK, and District/Taluk Mental Health Programme, among others.</p>	<p>Karnataka has made efforts to provide the five basic facilities (Pancha Soulabhya) of drinking water, toilets, playgrounds, compound walls, and school buildings in all schools under the Samagra Shikshana Karnataka programme.</p> <p>Karnataka has also developed “Shikshana Kirana,” the Student Achievement Tracking System, which monitors every child enrolled in school.</p>
2022–2023	<p>PCI: Rs 3,01,673</p> <p>PCI Ranking: 11th among all Indian states</p> <p>GSDP: 22.41 lakh crore</p> <p>GSDP Growth Rate: 14.2%</p> <p>GSDP Ranking: 6th Among all Indian states</p>	<p>Ayushman Bharat Arogya Karnataka: A total of 3,419 hospitals have been empanelled, of which 2,940 are government hospitals and 479 are private hospitals. A total of 1.22 crore AB-ARK cards have been issued, and 9.23 lakh beneficiaries have availed themselves of benefits amounting to Rs 746.69 crore.</p> <p>As of November 2022, the number of upgraded HWCs are 8,637, comprising 6,106 Rural Sub-centres, 2,166 Rural PHCs, and 365 Urban Health Centres.</p> <p>Manochaitanya Programme (Tuesday Clinic): Psychiatrists from the District Mental Health Programme, district hospitals, medical colleges, and private practitioners visit taluk hospitals on selected Tuesdays to identify and treat mentally ill patients. This programme has been implemented in all taluks of the state.</p> <p>The E-Hospital Programme is operational in 123 taluk hospitals, 27 CHCs, 217 PHCs, and 5 MCH Hospitals.</p> <p>COVID-19 Vaccination: Approximately 6,000 vaccination centres are functioning daily in the state. To date, a total of 12.04 crore doses have been administered to eligible individuals, achieving 100% progress.</p> <p>Shuchi–“Nanna Maithri”: During 2022–2023, menstrual cups were distributed to around 15,300 beneficiaries.</p>	<p>Higher Primary Schools are being upgraded to include Year 8 wherever there are no High Schools within three kilometres. A total of 7,817 Higher Primary Schools have been upgraded.</p> <p>The “e-Sarvajanika Granthalaya” app is provided for the public to access digital library services via mobile devices. E-contents are localised, translated, and uploaded to the Digital Infrastructure for Knowledge Sharing (DIKSHA) portal with the assistance of trained teachers. To date, 29,581 e-resources are available.</p> <p>A total of 358,425 Unique Disability Identity Cards (UDID) have been issued to individuals with disabilities, compared to 684,542 previously.</p> <p>A total of 5,090 Braille books have been printed at the Government Braille Printing Press in Mysore and supplied to students with visual impairments.</p>

Year	PCI, Gross State Domestic Product (GSDP), and Their Rankings	Primary Healthcare Initiative(s)	Elementary Education Initiative(s)
2023–2024	<p>PCI: Rs 3,32,926</p> <p>PCI Ranking: 6th Among all Indian states</p> <p>GSDP: 25 lakh crore</p> <p>GSDP Growth Rate: 10.2%</p> <p>GSDP Ranking: 6th among all Indian states</p>	<p>353,084 private medical establishments are registered under the Karnataka Private Medical Establishment Act to provide quality care in accordance with medical ethics by prescribing quality service. Of these, 11,907 (33%) are located in the Bangalore district alone, followed by Dakshina Kannada with 2,242 (6%) and Dharwad with 2,221 (6%).</p> <p>Under the “Ayushman Bharat Pradhan Mantri Jan Arogya-Mukhya Mantri Arogya Karnataka Scheme,” as of November 2023, 1.45 crore cards have been registered. During the 2023–2024 period, up to November 2023, 19,72,577 beneficiaries have availed themselves of the benefits.</p> <p>Under Shuchi–“Nanna Maithri,” during the 2023–2024 period (November 2023), 3,428 children have started using menstrual cups.</p> <p>Under Arogya Kavacha, there is currently one ambulance for every 85,000 population, with a total of 711 ambulances.</p> <p>A total of 9,875 HWCs have been upgraded, of which 6,496 are Rural Sub Centres, 2,161 Rural PHCs, 368 Urban PHCs, 376 Ayush centres, and 474 Namma Clinics.</p>	<p>The Department of State Educational Research and Training (DSERT) is committed to offering academic guidance in school education while enhancing the overall quality of primary and secondary education, aimed at achieving universal literacy through comprehensive mass education programmes.</p> <p>The success of the “Digital Libraries Initiative of the State of Karnataka” makes it a model worth emulating by other States and Union Territories.</p> <p>The Karnataka Gazette, a regular publication, is now available both in print every day and electronically on the website www.gazette.kar.nic.in. This dual approach has led to significant savings of 15 tonnes of paper and Rs 90 lakh in printing and supply expenses for government offices.</p>

Source: Economic Survey reports of Karnataka 2014–2015 to 2023–2024. The details provided in this table are the Health and Education programs underway in Karnataka during this period and include a mix of new and ongoing state and national-level initiatives. Developed by research team member Sitara Gupta.

Table A2: Key Health Focused State-Level Initiatives in Karnataka 2014–2024

S.No.	Name	Nature of Initiative	Years Enacted	Aims and Objectives
1	Karnataka State Integrated Health Policy	Policy	Drafted: 2002; Enacted: 2004; Amended: 2017.	“Improve access to healthcare based on the principles of equity, a responsive system, and guided by transparency, accountability, and community participation.”
2	Annabhagya Yojana	Government scheme	First Implemented in 2013, changes made in 2023.	<ul style="list-style-type: none"> ● Provide adequate food provisions to those below the poverty line. ● Increase the ration of food grains from 4 kg to 10 kg. ● Promise cash incentives during rice shortages due to a ban on the state’s purchases from open markets.
3	Indira Canteen	Government-run canteens	First started in 2017; Reignited in 2023.	To offer nutritious and affordable meals to the Urban Poor
4	Arogya Karnataka (Ayushman Bharat-Arogya Karnataka)	Government scheme	March 2018 (Integrated with PM-JAY in September 2018).	<ul style="list-style-type: none"> ● Provide universal healthcare coverage to citizens. ● Provide primary healthcare, as well as specified secondary and tertiary healthcare coverage.
5	CM Mathrushree Scheme	Government scheme	2018	Offers financial assistance of Rs 6,000 through Direct Benefit Transfer (DBT) to pregnant women.
6	Anupalana Gruhas	Institutions	Announced in the 2018 Budget.	Institutions for the Care of Male and Female “Destitute”.
7	Apthamitra helpline	Government initiative	Set-up in 2020.	Helpline and App Set-Up for COVID-19 (App No Longer Available).
8	Namma Clinics	Government institutions	2022	To provide citizens of Karnataka with primary care and access to basic medicines.
9	Gruha Arogya	Government Scheme	Announced in 2023, yet to be implemented.	Provide basic door-to-door medical check-ups, especially in remote areas.
10	Yashswini Scheme	Government Scheme	First introduced in 2004 and stopped in 2017–2018. Reintroduced in 2022–2023.	Health insurance for members of cooperative bodies.
11	Women Wellness Clinics-Ayushmati Clinics	Government Scheme	Under the 15 th finance commission and the NHM programme.	Provide counselling to women and girls on health issues and provide free medicine, check-ups by Gynaecologists. The clinics are set-up in PHCs.
12	National telemedicine service	Government Scheme	Lunched in August 2020.	Teleconsultation with general practioners, specialists and super specialists.

Source: Collated through web-search of education and health department websites in Karnataka, KIIs with members of the bureaucracy, research experts, and annual reports of relevant departments such as SSK- Karnataka and Department of Health and Family Welfare. Developed by research team members Prajakata Shukla and Aishwarya Aggarwal.

Table A3: Key Education Focused State-Level Initiatives in Karnataka (2014–2024)

S. No.	Name	Type	Years of Implementation	Aims and Objectives
1	Ganitha Kalika Andolana	Project (NGO Partnership)	Started in 2015, extended to all districts.	Improve mathematical literacy through the use of mathematical kits and teacher training in primary schools.
2	STEP	Project (NGO Partnership)	Adopted in rural government schools in 2015.	To build basic Information and Communication Technology (ICT) and 21 st century skills in students, and train teachers to leverage technology.
3	Prerana	Project (NGO Partnership)	Pilot in 2016–2017; adopted in all government primary schools in 2017–2018.	Model to motivate students, encourage peer-learning and group work and inculcate structured learning.
4	Odu Karnataka	Project (NGO Partnership)	Pilot in 2016–2017; adopted and scaled up in 2017–2018 and 2019–2020. Adopted throughout the State by 2021.	Enable children (std. 4-5) to read at a basic level and recognise basic numbers.
5	Technology Assisted Learning Programme (TALP-IT @ Schools)	Programme (NGO Partnership)	Implemented from 2016–2017.	Technology supported learning programmes for teachers to enable them to use technology to enhance their teaching.
6	Guruchethana	Government programme	Established in 2017.	Teacher training programme to enable them to voluntarily train for their development and become more autonomous educators.
7	KPS Programme	Government programme	Launched in 2019.	They are specialist schools developed on the idea of clustering of public schools where there are no teachers/students available. They cover from pre-primary to 1 st to 12 th standard classes with English as medium of instruction.
8	Angadwadi centres renamed Balasnehi centres and shifted into the existing pre-primary education infrastructure	Shifting of existing government scheme	Announced in the 2018 Budget.	Previously under the women and child welfare department, these centres were shifted to strengthen them, foreseeing an increase in enrolment in LKG/UKG.
9	Sushravya Digital Book Banks	Government programme	Announced in Budget 2021–2022.	Establishment for the book banks in government braille printing press to enable them to distribute books.
10	Changes in Curriculum based on National Education Policy (NEP) 2020	Policy in work	Announced in budget 2022–2023. Reverted in 2023.	Create a curriculum based on the NEP2020 Guidelines.
11	New State Education Policy to be set up	Policy in work	Announced in 2023, committee to submit a report by the end of February 2024.	To replace the Central NEP with an Educational policy that keeps in mind the cultural and socio-economic contexts of the state.
12	Reverting changes made in school textbooks	Change in existing policy	Announced in the 2023 Budget.	To undo the changes made by the previous state govt in 2022, based on NEP and NCF 2023, which the new state govt has rejected.
13	PARAKH State Education Assessment Survey	New Assessment Survey	Conducted in 2023.	To survey the education landscape in individual states, at the Block level as opposed to the standard district level.
14	Viveka Scheme	Scheme	2022 Onwards.	To provide a better learning environment to the students by providing basic amenities in the Schools and Colleges. Each assembly constituency was awarded 35 Viveka classrooms, with 1-4 classrooms per school depending on the school's requirement and capacity.

Source: Collated through web-search of education and health department websites in Karnataka, KIIs with members of the bureaucracy, research experts, and annual reports of relevant departments such as SSK-Karnataka and Department of Health and Family Welfare. Developed by research team members Prajakata Shukla and Aishwarya Aggarwal.

Appendix 2: Detailed Methods Framework

To understand why and when Karnataka undertook new initiatives, data collection and analysis were undertaken using the framework given below.

Table A4: Research Questions, Probe Areas and Data Sources

Question	Probe Area	Data Source
<p>1. What types of urban health and education initiatives has Karnataka implemented over the past ten years?</p> <p>2. Have they attempted to address any specific urban primary health or education-related challenges? If so, how?</p>	<ul style="list-style-type: none"> ● Mapping the initiatives ● Origin of intent underlying the initiatives ● Objective of the initiative 	<ul style="list-style-type: none"> ● Web search ● Review of Economic survey documents ● Review of policy documents on each of the selected initiatives ● Department annual reports in which details of initiatives are provided ● Key informant interviews (KIIs)
<p>What are the origins of the initiative? Did some groups lead it? Who led it and why?</p>	<ul style="list-style-type: none"> ● Mapping of stakeholders involved in the initiative and their role in it 	<ul style="list-style-type: none"> ● KIIs ● Listing of participants in commissions through review of commission reports
<p>Why was the initiative undertaken?</p>	<ul style="list-style-type: none"> ● Mapping of the process through which the government undertakes new initiatives in general ● Mapping of the process through which the specific initiatives included in this study were undertaken ● Role of each stakeholder in the initiative ● Key factors which led to initiatives such as social movement pressure, instruction from political leadership, routine bureaucracy work, stand-alone bureaucratic interest, civil society/expert committee interest 	<ul style="list-style-type: none"> ● Program and scheme implementation documents ● KIIs

Source: Author's compilation.

Policy Documents Examined as Part of the Study

- **Education:** KPS Guidelines, PM SHRI Guidelines, SEPC documents
- **Health:** Namma Clinic Guidelines, KKC Reports, State Integrated Health Policy, Arogya Karnataka Scheme Document
- **MP/MLA LAD:** Only for Shivamogga

Budget Documents and Annual Economic Survey Documents Examined as Part of the Study

- **Budget documents:** Last three years
- **Karnataka at a Glance:** Last 10 years
- **Annual Reports:** SSK (10 years), Department of Health and Family Welfare Report 2022–2023
- **NHM PIP–Karnataka:** Last five years
- **District Education and Health Budget:** Last five years (only for Shivamogga)

Data Collection

Data collection for this study was undertaken from January to March 2024. A total of 58 interviews were completed during this period. Interviews were conducted with senior bureaucrats in health, education, and planning departments; district-level health and education officers; members of the district commissioner’s office in Belgaum and Shivamogga; headmasters; teachers; MOs of four PHCs; KPS schools; ordinary residents in the areas surrounding the PHCs and KPS schools; academics; researchers; journalists; civil society leaders; and local activists.

Key questions posed across the categories of respondents emerged from the probe areas listed above. Some of these questions included:

- a) Key initiatives focused on PH/EE in recent years
- b) Purpose of the initiative
- c) Origin of the initiative
- d) Key challenges in PH/EE in the respondent’s understanding
- e) Measures to strengthen PH/EE
- f) Most influential leader (politician, bureaucrat, NGO, etc.) in health and education

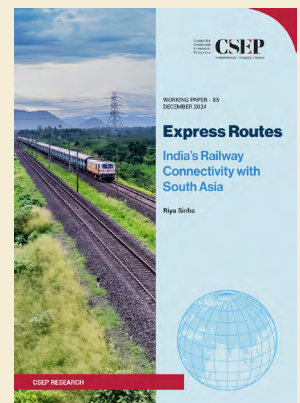
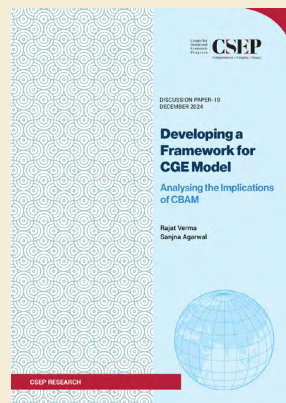
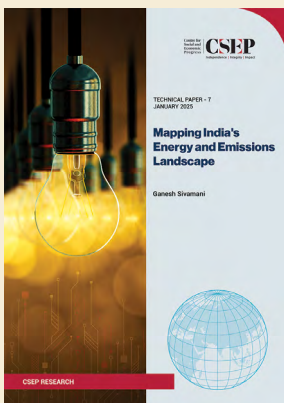
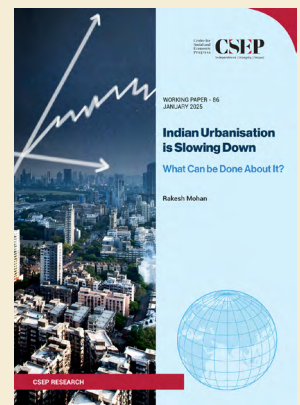
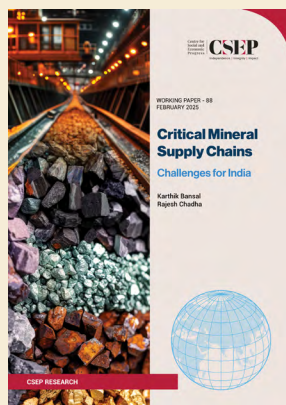
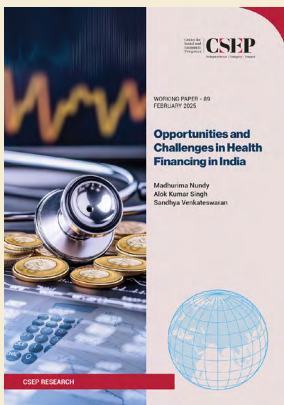
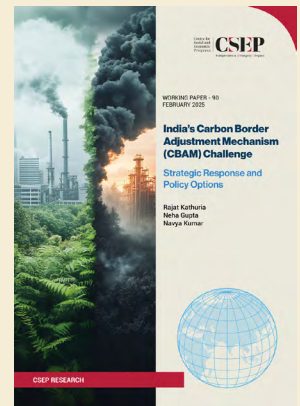
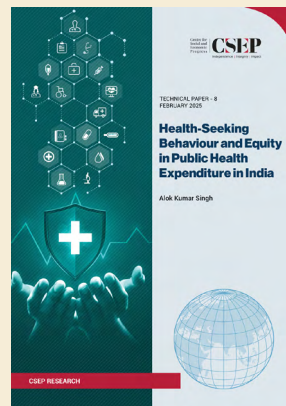
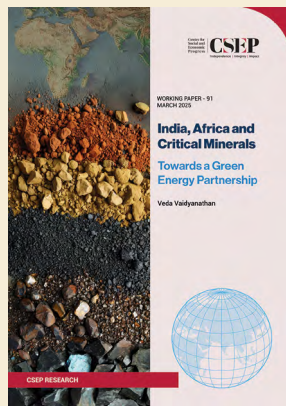
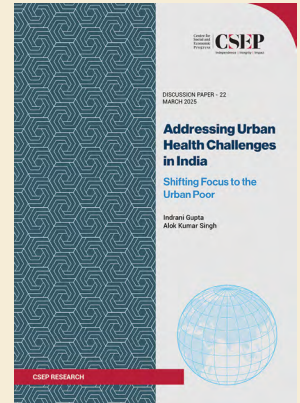
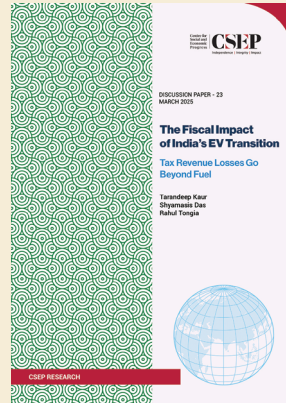
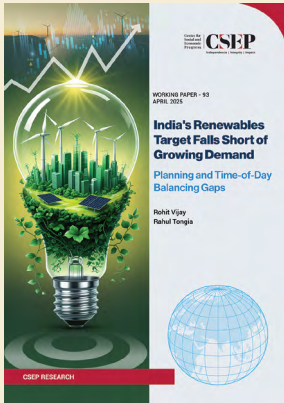
About the author



Priyadarshini Singh is a Fellow with the Human Development research program at CSEP. She has previously worked with the Centre for Policy Research- New Delhi, Ashoka University and PwC-India. She completed a PhD at the Department of Politics and International Relations at SOAS, University of London as a Felix Scholar. Her research work focuses on political economy of policy-making with a focus on education, history of public institutions and grassroots political ideas and politics. Her recent publication is 'Ideas, Policies and Practices: Tracing the evolution of elementary education reform from 1975' (2023 PE05- RISE program at University of Pennsylvania).

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Other publications



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