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Understanding Drivers of Government Initiatives in Primary Health and Elementary Education

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Executive Summary

India has made significant strides in reducing poverty over the past two decades. Yet, its health and education indicators have fallen behind global standards, hindering labour productivity, GDP growth, and overall well-being. This policy brief examines the key drivers influencing government initiatives in health care and education, highlighting the need for prioritisation amid competing fiscal demands. The brief identifies systemic gaps, such as inadequate funding, poor service quality, and weak demand from marginalised populations. It argues that while economic liberalisation since the 1990s has spurred GDP growth and welfare measures, achievements in basic health and education remain suboptimal. Budget allocations tend to be overwhelmed by salaries over items that would enable quality of delivery, contributing to high enrolment but dismal learning outcomes. Urban areas face particular neglect, with a 39.7% shortfall in Urban Primary Health Centres (UPHCs) and only 30.1% government school enrolment in cities versus 66% in rural areas (National Sample Survey [NSS], 2025). Rapid urbanisation, projected to double India's urban population by 2050 and drive 70% of GDP growth, underscores the urgency for affordable, high-quality services for poor migrant households.

The question of why initiatives in these sectors remain limited despite strong economic rationales for greater investment deserves greater attention. At the central level, infrastructure, defence, subsidies, and rural development compete for funds,

overshadowing health and education. State-level efforts focus on operational efficiency rather than budget expansion, often driven by electoral appeal rather than addressing core challenges. Financial stress constrains ambitious outlays, but this does not fully explain the neglect. A critical factor is the weak demand side: poor households, preoccupied with daily survival, exhibit behaviour driven by managing scarcity and a focus on immediate priorities. The poor, therefore, rarely mobilise for better services, while non-poor households have largely abandoned public systems, opting for private alternatives. This exodus reduces political pressure for improvements, unlike in sectors like roads or electricity, where non-poor stakeholders drive demand.

Moreover, policies emphasise access over quality, with new schools and PHCs offering visibility in electoral manifestos but failing to ensure high-quality services. Urban governance exacerbates issues, as municipal corporations lack fiscal power under the 74th Constitutional Amendment, leaving health and education functions underdeveloped compared to rural Zilla Panchayats.

The brief places special emphasis on recommended drivers for meaningful policy actions, advocating a multifaceted approach to catalyse change. Central to this is re-engaging non-poor households in public systems to create vocal constituencies for quality improvements. Highlighting successful government facilities and the link between quality of delivery and outcomes, through the dissemination of relevant findings, can position them as viable alternatives to private ones, fostering demand-side pressure similar to other public services.

Policy advocates and civil society must package initiatives with electoral appeal. Examples include Rajasthan's well-functioning UPHCs with quality certifications, which outperform private counterparts but remain under-promoted. Initiatives should respect budget constraints, prioritising low-cost, high-impact measures in the short term while pushing for increased central allocations.

Addressing ground-level gaps requires targeted, understandable proposals with popular resonance. In primary health care, recommendations include: (i) mandating 24/7 operations for all urban PHCs to handle emergencies and deliveries; (ii) introducing evening OPDs staffed by private doctors for accessibility; (iii) adding branded medicines for non-communicable diseases (NCDs); and (iv) refurbishing select community hospitals to match private standards. For elementary education: (i) hiring qualified English teachers to meet aspirations; (ii) upgrading infrastructure to private-school levels; (iii) integrating nursery classes in primary schools; and (iv) awarding schools that achieve foundational literacy and numeracy.

To amplify impact, it is important to link expenditure and investments to outcomes through extensive studies on lifestyle and economic benefits, emphasising both wealth creation and aspirations. This evidence can inform political messaging on how improving the quality of health and education services contributes to better lifestyles and higher income gains. A novel "Diversity Index" proposed by Singh (2025a) in a recent CSEP working paper titled "Drivers of Primary Healthcare and Elementary Education Initiatives in Karnataka (2014–2024))" is further recommended for measuring economic diversity in facility uptake (e.g., poor vs non-poor) alongside inputs and outcomes. For schools, this could include learning levels and infrastructure; for PHCs, utilisation, 24/7 operations, deliveries, and immunisation rates. Such an index would guide resource allocation, empower civil society advocacy, and provide politicians with metrics for messaging, akin to successful rankings like the Swachh Survekshan or the Annual Status of Education Report (ASER) state comparisons.

In conclusion, the brief urges policy advocates, civil society, and the bureaucracy to prioritise visible, electorally attractive initiatives that bridge supply-demand gaps and reiterate the importance of quality. By re-integrating non-poor users, leveraging budget-realistic proposals, and using tools like the Diversity Index, governments can drive sustainable improvements in health and education, ultimately fostering inclusive growth and well-being.

1. The Context

While poverty levels have dropped appreciably in the last two decades, health and education indicators remain poor. It is in this context that this brief seeks to identify the main policy drivers in the vital health and education sectors. Prioritisation of efforts in health and education is needed to improve labour productivity and boost gross domestic product (GDP) growth as well as general well-being (Kaul,

2023). When households privately fund health and education, their reduced income for consumption and savings, along with increased inequality, impedes the creation of a high-growth State (Singh, 2025a). And yet, there is minimal literature on the drivers of initiatives on education and health. There is limited literature on the dynamics of decision-making at the government level, a gap that this brief attempts to fill.

The extent and areas where prioritisation of health care and education in India are lacking are open questions. However, there is an emerging consensus that much more needs to be done. Several years of relatively satisfactory GDP growth rates in the wake of economic liberalisation since the 1990s may have perpetuated the notion that the present policy approach, backed by a slew of welfare measures, is adequate to serve the country in the years ahead. While there have been impressive achievements, it is also true that on most global scales, India's achievements in basic health and education are found wanting. India ranks a low 130th out of 193 countries in the latest UN Human Development Index (United Nations Development Programme [UNDP], 2024). It is well known that India's public health services are substandard and grossly inadequate, even compared to those of other countries at a similar development stage (Kandi, 2023). For instance, India's out-of-pocket expenditure (OOPE) as a percentage of current health expenditure among LMICs, as per the World Health Organization (WHO)'s Global Health Expenditure database (WHO, n.d.), was higher than that of countries like Indonesia, Ghana, Brazil, and the Philippines. What is not well analysed is why this persists.

Fund allocation may be one reason. For instance, while school education receives a significant chunk of the budgets in most states, the bulk of the education budget is spent on salaries and allowances for teachers and other staff, leaving little for quality of delivery or improvement. Therefore, while school enrolment has improved significantly, learning outcomes remain dismal (ASER, 2024). Children of low-income households who mostly access government schools and public health facilities are particularly disadvantaged, as these are mostly inferior to private facilities.

Within the health and education sectors, there has been a relative neglect of urban facilities. At an all-India level, there is a 39.7% shortfall of Urban Primary Health Centres (UPHCs) as per Rural Health Statistics [RHS], 2021–2022. While states like Andhra Pradesh, Himachal Pradesh, and Meghalaya report no shortfalls, states like Chhattisgarh, Goa, Gujarat, Haryana, Jharkhand, Kerala, Nagaland, Punjab, Sikkim, and Tripura report more than a 50% shortfall of UPHCs. In education, the recently released Comprehensive Modular Survey (CMS): Education (part of the 80th round of NSS) found a significant variation in government school enrolments in rural and urban areas (NSS, 2025). The report finds 66% students enrolled in government schools in rural areas, as opposed to 30.1% in urban areas. This lower participation in public schooling in urban areas is unfortunate, as we are witnessing rapid urbanisation.

Urban areas will also account for 70% of GDP growth (Kouamé, 2024). A recently published study has projected a doubling of India's urban population by 2050 (World Bank, 2025). A large section of this surge to towns and cities will be poor migrant households, who will need access to high-quality, affordable health and education facilities. In this context, two recent studies by Priyadarshini Singh on the policy drivers in education and health in Karnataka (Singh, 2025a) and Rajasthan (Singh, 2025b) have provided good insights on the policy drivers at the state level. These studies form the backdrop for the present policy brief and focus on what levers and drivers can get the attention of policymakers and decision-makers.

2. Why Have Initiatives in Health and Education Remained Limited?

Despite the strong economic arguments in favour of enhancing investments and introducing meaningful initiatives in health and education at the ground level, policy actions have remained limited. One set of factors at the central level is that competing investments in infrastructure hog a significant chunk of the outlays, as highways, roads, and railways are easily visible to the people. Similarly, outlays on defence have risen due to concerns about national security. Major expenditures towards subsidies also account for a significant portion of the outlays. Similarly, rural development and agriculture justifiably command a large share (Kaul, 2023).

At the state level, limited initiatives have focused on improving operational efficiency rather than on

enhancing budgets. There have also been several initiatives taken more on account of their perceived popular appeal rather than because they address ground-level challenges or fill gaps in existing programmes. It is well recognised that state budgets have witnessed financial stress that has limited the scope to take up initiatives that require sizeable outlays.

However, this does not fully explain why the health and education sectors have not received the prioritisation they deserve, given their vital importance to the economy and the well-being of the people. Not only is the provision of public health and school education services below standard, but arguably, there is limited demand from the masses, especially the underprivileged, who do not or are unable to adequately voice the demand for improvement in the services.

Therefore, not only is the quality of services substandard on the supply side, but the demand side is equally weak. Even if the poor are made aware of a programme's benefits, they do not always access it or demand improvement. Deficiency of service or lack of knowledge does not fully explain behaviour.

Banerjee and Duflo (2011) find that the poor do not display what is considered rational behaviour. Mullainathan and Shafir (2013) attribute this behaviour to scarcity and bandwidth. Struggling with hunger, debt, and work uncertainties, they have no time for anything else. Poor households still struggle daily to meet their basic needs and cannot be expected to become the demand drivers for better services. It is unrealistic to expect that poor households themselves will mobilise or can be easily mobilised by civil society to demand health and education of satisfactory quality, even when these services are fundamental.

This absence of articulated demand for services that are accessed by the poor explains why the policy and budget focus on strengthening both elementary education and primary healthcare systems has remained weak.

Meanwhile, the non-poor have virtually abandoned public health services and government schools, resulting in declining uptake of facilities in health and education. There is, therefore, a strong rationale to believe that service improvement and backing of sound initiatives will take place if the non-poor begin accessing public health care, as well as become active participants in the school system (Singh, 2025a). The important point to note is that the demand-side drivers will have to be non-poor households. This also explains why several other services, such as roads, water supply, and electricity, do see a demand-side impetus, as the non-poor are active stakeholders for such services.

Education and health policies have largely focused on access rather than on a standardised quality of services. The opening of new schools and Primary Health Centres (PHCs) is more easily articulated and garners greater visibility in the electoral arena and the manifestos of political parties than improvement in the quality of services. There is, therefore, no dearth of government elementary schools or PHCs (except in urban areas).

The neglect of urban facilities remains a major governance challenge. The health and education departments at the district level are part of the Zilla Panchayat in most states, and their jurisdiction is limited to rural areas. The municipal corporations that are the counterparts of the Zilla Panchayats in urban areas have negligible health or education functionaries and minimal facilities that they manage. Urban municipal corporations are financially extremely weak and are themselves not able to expand education and health facilities within their jurisdiction. The 74th Constitutional Amendment devolved many responsibilities to urban bodies, but with little fiscal support.

3. Ground-Level Challenges in Primary Health Care

While the country has a vast and extensive network of over 25,000 PHCs, the quality of infrastructure and services remains extremely poor. Over 2,000 PHCs do not have even a single doctor, and a third of the sanctioned posts of staff at the PHC level are vacant. As an illustrative example, while doctor shortfalls at the national level are 3.1% in rural areas and 5% in urban areas as per RHS 2021–2022, this figure hides massive variations at the state level (see Tables 1 and 2). While Chhattisgarh and Odisha report the highest doctor shortfall in PHCs in rural areas, Jharkhand and Uttar Pradesh have a higher percentage of doctor shortfall in urban PHCs.

Table 1: Doctor Shortfall at Rural PHCs—RHS 2021–2022

State	Shortfall	Required	% Shortfall
Chhattisgarh	279	770	36.2
Odisha	298	1,288	23.1
Himachal Pradesh	52	553	9.4
Uttarakhand	48	531	9.0
Karnataka	60	2,138	2.8
Jharkhand	6	291	2.1
Uttar Pradesh	29	2,919	1.0
Punjab	4	422	0.9
All India	**776**	**24,935**	**3.1**

Source: RHS (2021–2022).

Table 2: Doctor Shortfall at Urban PHCs—RHS 2021–2022

State	Shortfall	Required	% Shortfall
Jharkhand	38	70	54.3
Uttar Pradesh	132	594	22.2
Manipur	4	21	19.0
Andhra Pradesh	63	547	11.5
Madhya Pradesh	35	306	11.4
Gujarat	28	330	8.5
Uttarakhand	6	76	7.9
Meghalaya	1	25	4.0
Haryana	1	103	1.0
All India	**308**	**6,118**	**5.0**

Source: RHS (2021–2022).

Even where staff are present, absenteeism is high, and motivation is low. PHCs in many states often remain closed even during the limited working hours. To provide primary care and perform deliveries, PHCs need to function around the clock, but only a third do so, even on paper. In many States, particularly in urban areas, PHCs are not equipped to perform deliveries. As a result, most deliveries take place in private institutions. Each PHC has five to six sub-centres (SCs), with a female health worker, termed an auxiliary nurse midwife (ANM); however, many SCs are dysfunctional, poorly supervised, and unable to ensure essential services, such as antenatal care (ANC). In this failed state of PHC, the Accredited Social Health Activist (ASHA) workers have been providing the community and public health system interface. Therefore, there should be little surprise that the levels of utilisation of PHCs remain low. There is evidence that there are, on average, two local health providers in every village, and often they are the first point of contact, rather than the ASHA workers or ANMs, though this is changing (Kaul, 2023).

The poor levels of utilisation at the PHCs are a result of a fundamental flaw in their design in most states and their sub-systems, the SCs. States like Rajasthan, UPHCs only have a day shift. If PHCs shut down at 4:30 p.m., the PHC is not available to the household for two-thirds of the day. Therefore, they are not equipped, even in theory, to handle normal deliveries. Consequently, while PHCs have a maternity ward with four beds, very few deliveries take place at the PHC level.

The problem of inadequate and poor service quality is even more acute at the next higher level above the PHCs, that is, at the level of the Community Health Centres and Taluka hospitals. These hospitals face

acute shortages of specialists, support staff and technicians, and lack both diagnostic equipment and medicines. The reality is that even poor households do not fully rely on the public health system, and their OOPE on health is extremely high. As a percentage of total health expenditure, OOPE at an all-India level is 39.4%. This ranges from 25.4% in Karnataka to 58.3% in West Bengal and 59.1% in Kerala (National Health Authority [NHA], 2021–2022). National Family Health Survey (NFHS)-5 data corroborates a preference for private healthcare in urban areas, with a higher proportion of households availing private health facilities (51.8%) as opposed to public health facilities (46.9%). Even among the lowest wealth category, 43.4% of households availed private health sector facilities at an all-India level (NFHS-5, Table-11.6: Source of Care).

At the central level, there appears to be relatively greater political support for revamping curative services at the higher levels—for example, the All India Institutes of Medical Sciences (AIIMSs). However, there is little understanding and support at the grassroots level for preventive and promotive health. It is noteworthy that most of the preventive and promotive health services are the responsibility of the PHCs. Similarly, there is little support for other important determinants of health, such as the environment, maternal and child health, water and sanitation, or the urgent need to tackle new, emerging trends such as non-communicable diseases (NCDs).

In contrast, hospitals and curative services are more visible and easier to get political support for. In this context, we need to understand the electorally popular political commitment to Universal Health Coverage through the Ayushman Bharat insurance component. However, the Government of India foots the bill for only 40% of households, and coverage is limited to Rs 5 lakh, whereas in several states, the coverage is well above this. Hence, the state has to foot a large portion of the expenditure. Consequently, the budgetary outlay towards the scheme has begun eating into even the limited budgets for primary health care. The bureaucratic response has been to reserve several treatments for public hospitals, as in Tamil Nadu or require patients to get a referral before they can access private hospitals, as mandated in Karnataka. Initiatives here are also in response to an emerging challenge. This scheme has further driven the non-poor away from public health facilities.

4. Quality and Infrastructure Gaps in School Education

While enrolments at the school level have shown vast improvement, there are several worrying signs. The poorest households send their children to government schools, where the quality of learning is extremely poor, while children of relatively better-off households attend private schools. The reduced uptake of government schools (both state and government-aided) in urban areas as opposed to rural areas is stark, as per UDISE 2023–2024 data. In rural areas, there is a high uptake of State Government schools (42.4%), compared to urban areas (8.3%) (see Table 3). In parallel, private school enrolments have increased overall in urban and rural areas from 84.16 million in 2022–2023 to 90.04 million in 2023–2024 (UDISE, 2023–2024).

Secondly, a central issue in school education at the primary and elementary levels is the low level of learning. Despite the recent focus on learning outcomes, learning continues to show only marginal improvement at best. The latest ASER report shows that 28.9% of children in grade 8 are unable to read a grade 2-level text (ASER, 2024). Further, there is a significant difference between students in government and private schools in rural areas. While 67.5% of grade 8 students in government schools are able to read a grade 2-level text, this figure is 80% in private schools (ASER, 2025). Thus, children, even after eight years of schooling, have not significantly improved in their ability to face the world as adults compared to those less educated.

Table 3: Enrolments by School Category and Location

School Management (Broad)	Urban/Rural	Overall	As a % of Total Enrolments
State Government	**Rural**	**10,51,72,009**	**42.4**
Government Aided	**Rural**	**1,35,50,233**	**5.5**
Private Unaided	Rural	4,27,51,741	17.2
Others	Rural	36,24,201	1.5
Central Government	Rural	6,48,218	0.3
State Government	**Urban**	**2,05,29,906**	**8.3**
Government Aided	**Urban**	**1,19,97,608**	**4.8**
Private Unaided	Urban	4,72,85,198	19.1
Others	Urban	13,46,648	0.5
Central Government	Urban	11,40,066	0.5
Total	**–**	**24,80,45,828**	**100.0**

Source: Unified District Information System for Education (UDISE) (2023–2024).

On the other hand are the teachers, where the situation is also highly unsatisfactory. Teachers are required to complete the prescribed text rather than focus on ascertaining what their students have learned. Most government schoolteachers lack the training to address the challenge of educating first-generation learners and lack the skills to deal with multi-grade situations, present in most government schools. Significant shortcomings in teacher training programmes are also substantial factors that adversely affect teacher performance. Governments seem satisfied with monitoring numbers—students enrolled, textbooks distributed, mid-day meals provided, and buildings built. There is little motivation for doing anything else (Kaul, 2023). At the ground level, many states have fragmented school education, with stand-alone primary, elementary, and high schools that have created challenges for governance and academic supervision. There is no surprise, therefore, that poor households that go above the minimum income threshold quickly abandon government schools and shift their children to private schools.

Besides the perception of superior quality of schooling, a primary reason for the growth in the number of private schools is that many parents seek "English" education for their children. English has emerged as an aspirational language and is seen as a passport to a lucrative job.

The starting point for improving the quality of government schools is to focus on learning outcomes, which must begin by transforming preschool education. Alongside, there is a need to change the widely held perception that private schools offer better quality education. This would require a slew of measures. The first step would be to work closely with teachers to improve their pedagogic practices and move them away from a rigid curriculum and rote-learning methods. The second focus should be to ensure each child learns the basics at the primary school level; the curriculum gaps can be bridged at higher levels. A third step would be to progressively reduce multi-grade classrooms through consolidation where feasible. Another important step to arrest the shift to private schools and get the non-poor back to government schools would be to prioritise the quality of English-language teaching. The physical environment, good school infrastructure, and addressing the aspiration of parents to school their children in English impact demand. All this will require good teacher training systems and regular academic support and supervision.

5. Recommended Drivers for Meaningful Policy Actions and Initiatives

We have noted that the poor are unable to provide articulated demand for improvement in health and school education services. Hence, the important recommendation is that there needs to be a concerted push to get the non-poor back into the government school system and get a significant section to access public health facilities. For this, existing government schools that are doing well need to be highlighted as better options compared to private schools. The success of these schools in terms of learning outcomes, teacher qualifications, and infrastructure needs to be disseminated both by the schools themselves and by the school education administration at the block level. Secondly, policy advocates and civil society will have to be imaginative and put themselves in the shoes of the elected representatives. The bottom line is that if you need to get the political leadership to respond, the packaging of the initiatives has to be electorally attractive, and where required, backed by catchy rhetoric. There are several valuable initiatives in the government health and education system which put the government facilities in a better position than private ones, but remain under-recognised. For example, in Rajasthan, well-functioning UPHCs have excellent infrastructure and staff, have received several quality certifications, and provide markedly better services than their private counterparts.

Third, there is a need to be cognisant of the budget realities at the state level and identify initiatives that do not require, at least in the short run, large outlays from the states and yet give improved results. The financial situation at the national level is different, and budget allocations to the states can and should be improved.

Finally, initiatives must address identified gaps and critical ground challenges. We examine these four recommendations against the most important initiatives taken in Karnataka and Rajasthan.

In Karnataka, the Karnataka Public School (KPS) system has been imagined as an attempt to place government schools on a par with private schools, which would get the non-poor back into the government school system. The KPS schools are integrated schools with improved infrastructure and mono-grade teaching that commences from the pre-primary stage and goes up to high school. The KPS schools offer English-medium education from the foundational level. There is a complete alignment between the political leadership and the bureaucracy that the way forward is the introduction of English-medium education in government schools. Though the introduction of English medium from grade 1 is not pedagogically sound, it does meet the aspiration of most poor households who wish their children to obtain an English education. There is now a state cabinet nod to establish as many as 5,000 KPS integrated schools that would be from nursery to at least grade 8.

Regarding the health sector, the notable state initiative has been the expanded health insurance scheme, termed Ayushman Bharat Arogya Karnataka (AB-Ark). Karnataka launched its health insurance scheme even before the central government's Ayushman Bharat programme. This, like the KPS scheme, provides non-poor households and the urban population access to an affordable health system, albeit through the inclusion of private health facilities. The AB-Ark scheme covers 75% of the population, though the Government of India's funding is limited to only 40% of households. As a result, as the scheme becomes popular, a lot of the health sector budget will get diverted into purchasing facilities from the private sector. The risk is that this would come at the cost of primary health care (Vahab & Dreze, 2025). As in Karnataka, Rajasthan has also taken the initiative in health insurance to expand the coverage from Rs 5 lakh as in the central government programme to Rs 10 lakh. Perhaps the more notable and meaningful initiative in the health sector in Rajasthan has been the scheme to widen the quantum and number of free medicines provided at PHCs. However, Rajasthan has not taken any initiative in elementary education. It is also worth noting that neither Karnataka nor Rajasthan has taken any initiative specifically targeted at the urban population.

The initiatives taken in Rajasthan and Karnataka have three common features. First, they were easily understandable. Second, they were perceived by the political establishment to have popular electoral appeal. Third, they did not have a sizeable financial outlay. Proposals that do not have political resonance remain confined to academic discourse, while those that require high spending languish due to a funding shortage.

Due to financial limitations, state initiatives may not have the desired impact. There is a need to push for much higher outlays for health and education in the central budget. It is, therefore, critical to influence policymaking at the central level, though initiatives at the state level are equally important because they are more likely to address specific state-level concerns. The additional budgetary outlay required for health and education is within the overall financial capacity of the government. An alternative estimate based on detailing the required interventions is much lower than those made by sectoral experts, who estimate 3% and 6% of GDP for health and education, respectively. A modest increase of 1% of GDP each in the health and education sectors, if properly directed, could transform these sectors and ensure overall quality improvement, including providing for the renovation and refurbishment of existing schools and health institutions (Kaul, 2023).

To identify initiatives that are easily understood by both the people and the politicians, and address ground-level challenges, is not easy, but there have been successful initiatives. The AAP government in Delhi found it electorally popular to focus on improving schools, with many government schools being provided with infrastructure even better than that of several private schools, leading to non-poor households also accessing the schools. The KPS programme, through the introduction of English as the medium of instruction, though not pedagogically sound, has become popular even among the non-poor.

Focusing on learning outcomes may also not require large financial outlays. The challenge for educationists and the bureaucracy would be to plan a slew of measures for improving learning in schools that can appeal to politicians. Further, if policy initiatives can get the non-poor to also access health and education facilities, they will provide an alternative pathway for the emergence of constituencies that demand quality health and education, which can, in turn, benefit political leaders during and outside elections (Singh 2025a & Singh 2025b). Examples of initiatives that could succeed in primary health care are:

i) A programme to make all urban PHCs work around the clock.

ii) Provision of evening OPDs at urban PHCs staffed by private doctors.

iii) An initiative to add branded medicines to tackle identified NCDs.

iv) Refurbishing select government community hospital infrastructure on a par with high-quality private hospitals.

With respect to government schools, the initiatives could be:

i) Provision of qualified and trained English teachers.

ii) Upgrading school infrastructure on a par with private schools.

iii) Introduction of nursery classes in primary schools, avoiding the pitfalls of multi-grade situations.

iv) Awards to schools that achieve foundational literacy and numeracy for their children.

To push for state-level initiatives, apart from greater allocations, two other recommendations are worthy of note.

First, we need to better link investments in education and health to outcomes for the masses. For this, there should be extensive studies showing the economic benefits of public provision of health and education for individual households, particularly from the perspective of creating wealth and meeting new-age aspirations. Greater awareness continues to be an important component of the political-economic process. An economic rationale based on such evidence will need a popular, visible, attractive packaging of sound initiatives that have a strong electoral appeal as well as wide dissemination of the benefits through all forms of media, including social media.

A key element of such evidence involves linking the quality of education and health care delivery with outcomes, with a strong emphasis on quality. As discussed above, research-backed evidence needs to be generated to better inform political messaging on the quality of services and beneficial lifestyle and income outcomes.

Second, state governments need to work with a "Diversity Index," as proposed by (Singh, 2025a), that includes, among other types of diversity, a strong emphasis on economic diversity (e.g., incomes or wealth). 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. The

diversity index would therefore include indicators that reflect uptake for health and education facilities among poor and non-poor, alongside existing outcome and input indicators.

A school-level rating mechanism would also have multiple uses. For instance, it would help in better prioritising efforts and resource allocation at the district and block level. It could be used by civil society to improve the quality of services. It would also create a metric for political messaging to embrace. CSOs and the public can also use this to advocate for improving schools and health facilities so that they are useful to a wider segment of the population, many of whom are taxpayers. For school education, learning levels and school infrastructure could become key indicators, while for PHCs, uptake, the number of PHCs working around the clock, deliveries undertaken, and the percentage of children fully immunised could be proposed indicators.

In addition, states and districts could be ranked on education outcomes that include weightage given to "diversity." An example of an impactful ranking is the Government of India's ranking of towns and cities through the Swachh Survekshan survey, based on their cleanliness. This ranking gets a lot of visibility and triggers attention from policymakers, practitioners, and politicians, as the awards are presented by the President (Swachh Bharat Mission, 2025). ASER's ranking of states based on learning levels is another successful example that receives a lot of attention.

In conclusion, there is a need to reiterate that policy advocates, civil society, and the bureaucracy may have better success if they focus on the identification of sound initiatives in health and education that have high visibility and electoral appeal.

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