Social Sector Development in Rural Maharashtra: A Case Study of Kolhapur District

Prof. Dr. Dipak Dayanand Shinde
Asst. Prof., Deptt. Of Economics,
Arts and Commerce College, Warje-Malwadi,
Pune 58, Maharashtra

Introduction

Social sector is one of the important sector in the economy because it improves quality of human life as well as help to stimulate the economic development. It is not only improve quality but also make strong, healthy and give power to produce knowledge. Social sector includes such as primary education, public health, housing, drinking water and sanitation etc. Each its own importance and are related with each other. The study of social sector has assumed special significance in recent year and there has been a felt need for comprehensive, analytical and scholarly study on social sector. Generally, economy is classified into various sectors such as primary sector, secondary sector, tertiary sector and social sector. First three sectors are said to be productive sector and social sector is said to be unproductive sector. Primary and secondary sector viz. agriculture sector and industrial sector are directly productive and involve themselves in the direct production of goods adding directly to the gross domestic product. Tertiary sector, which consists of banking, insurance, trade, transport, communication etc., is an indirectly productive sector. As regard social sector, it is mainly related to human resource development and all such activities such as education, health, housing, drinking water, sanitation which are helpful for human capital development. Thus, this sector does not include directly in the production activity but it helps in promoting the human capital, the population quality and efficiency, the productivity which in turn help to enhance economic growth. Thus, social infrastructure development is essential for promoting economic growth and human capital growth in the economy and Society.

Human resources and its contribution to growth is therefore necessary at every stage of development. It is therefore, apparent that it is the quality of the people in the terms of their health and education that constitutes the very important sub-sectors of a modern economy popularly termed as the social infrastructure. Economists, such as Marchall, Schultz and Mrydal
have emphasized the role of man in the process of development. Development efforts according to them should, therefore, first be to raise in raising the quality of this man in form of his health, education, housing, water etc. Since it is this man who forms the basic engine of growth. However, this sector has captured the attention of the policy makers only recently. This occurred particularly when the policy makers often faced with the inability to attain the goals of development and were confronted with the numerous obstacles and constraints in the path of development. As a result, attention has gradually started shifting from a capital dominated investment policy to the neglected social sector. Education, health, housing, water and sanitation constitute the sub-sectors of the social sector. Thus, the development of these sub-sectors is essential for the overall development of a country.

Infrastructure can be broadly divided into two types. 1) Physical, 2) Social. The former consists of transport, communication, energy, banking and insurance. The positive contribution of physical infrastructure comes through increase investment, employment, output and income in a chain of cumulative causation. On the other hand, social infrastructure broadly includes education, health, housing, water, sanitation, and childcare. The contribution to productive activity although indirect is some occasions is no less important.

The economic prosperity, increase in per capita income alone, does not always ensure enrichment in quality of life. Against the backdrop of the increasing importance being attached to human development both at national and international levels, therefore, an attempt should be made to examine the development of social sector and to examine the effectiveness of public spending on social sector viz. education, health, housing, water supply in terms of select human development indicators. As social sector expenditure is supposed to have a bearing on quality of life of human capital.

When the question of funding social infrastructure development arises, the burden falls squarely on the government. Since these sectors don’t enjoy the glamour associated with the construction of flyovers and international airports, they perhaps get low priority. As Dr. Amartya Sen is emphasized, the development of education especially private education and health especially public health is an improvement in the quality of life. According to experts, at least 6 percent of the union budget outlay should be set apart for human resource development.

Various activities under social sector are quite required for the improvement in the quality of human being and thereby raising the efficiency of working labour force in the country.
In fact, social infrastructural development should be viewed as pre condition for stimulating the economic growth.

Maharashtra state has made relatively good progress with respect to social sector, due to having made budgetary provision. Government had spent Rs. 3500.98 crores on social sector development in 1960-61, which increased to Rs. 15003.58 lakh in 1970-71 and Rs. 55786.9 crores in 1980-81 and Rs. 16433.18 crores in 2006-07. It is important to note that this expenditure, beside social sector expenditure, includes urban development, information and publicity, labour and employment, social security and welfare and welfare of SC/ST/OBC.

### Social Sector Expenditure in Maharashtra

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<tbody>
<tr>
<td>1</td>
<td>Education</td>
<td>2241.16</td>
<td>9810.89</td>
<td>37732.98</td>
<td>168200.75</td>
<td>935753.11</td>
<td>1221546.03</td>
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<td>2</td>
<td>Public Health, Medical</td>
<td>1145.24</td>
<td>4023.59</td>
<td>7398.84</td>
<td>41295.29</td>
<td>141784.54</td>
<td>197531.85</td>
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<tr>
<td>3</td>
<td>Family Welfare</td>
<td>NA</td>
<td>NA</td>
<td>1284.74</td>
<td>6447.13</td>
<td>17749.71</td>
<td>27823.20</td>
</tr>
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<td>4</td>
<td>Water Supply &amp; Sanitation</td>
<td>0.89</td>
<td>1159.48</td>
<td>7471.71</td>
<td>20687.81</td>
<td>83007.73</td>
<td>146463.77</td>
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<tr>
<td>5</td>
<td>Housing</td>
<td>113.69</td>
<td>9.62</td>
<td>1898.63</td>
<td>9675.21</td>
<td>30618.02</td>
<td>49953.30</td>
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<tr>
<td></td>
<td>Total</td>
<td>3500.98</td>
<td>15003.58</td>
<td>55786.9</td>
<td>246306.19</td>
<td>1208913.11</td>
<td>1643318.15</td>
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Moreover, sub sector wise break-up of social sector shows that, in case of primary education, the enrolment of students in primary school has improved over the period of time. In 1960-61, there were 34594 primary schools, which increased to 69330 in 2007-08, students enrolment was 11571 thousand in 2007-08 and 341 thousand teachers were recruited in 2007-08. However, there has been increasing trend in drop out rates of students in rural areas which has been serious concerned. Therefore, empirical investigation is required to look into the causes of these problems associated with the primary education and also to examine magnitude of shortage of educational facilities in rural areas. In case of rural health facilities, there were 1054 public and government aided hospitals and 2072 dispensaries and 1812 primary health centres and 177
primary health units and 2520 TB hospitals and clinic and 90 beds available per lakh population in 2007-08. With respect rural housing facilities, Indira Aawas Yojana has been implementing by the state which is central government sponsored scheme. The aim IAY is to provide houses at free of cost to BPL families in rural area. Moreover, the drinking water is serious problem in rural area of the state, 22780 villages/wadies having has the problem of drinking water in the state.

Objectives of the Study

Kolhapur district has been selected for examining the progress of social sector infrastructural facilities made available in the rural areas. Accordingly, following objectives are set to examine.

1. To examine the temporal progress of social sector viz. primary education, public health, housing etc. Maharashtra state.
2. To study the social sector development viz. primary education, public health, housing etc. in Kolhapur district and its talukas viz. Karveer and Radhanagari.
3. To examine the availability of infrastructural facilities such as primary education, public health, housing, drinking water across different sample villages in Kolhapur district.
4. To study the obstacles in realizing the target and to suggest remedial measures to improve the condition of social infrastructural facilities in rural area.

Database and Research Methodology

Temporal Analysis

The required temporal data relating to primary education, primary health services, housing, drinking water etc. has been collected from government reports and private agencies for the period of 1960-61 to 2008-09 for the state and districts. The statistical information on these items would help to know the trends in development of social sector in Maharashtra and Kolhapur district. Moreover, it will also facilitate to understand the magnitude of inter regional disparities in social sector development in the study areas.

Cross Sectional Analysis: Sample Design

Kolhapur district has been selected for micro level analysis for examining existing condition of social sector developmental at grassroot level. For this purpose, two talukas of Kolhapur district have been selected. Among the developed talukas of Kolhapur districts, Karveer taluka has been selected for intensive study. Among backward talukas, Radhanagari
taluka has been selected which is located in hill and mountainous areas. Thus, these two taluka having heterogeneous level of economic backwardness have been selected for this study. Moreover, eight villages out of total villages (125) in Karveer taluka and six villages out of total villages (114) were selected. Moreover, 10 percent families, out of total families across different social strata from each village were selected viz. 134 families from Karveer taluka and 84 families from Radhanagari taluka were selected. Karveer cross sectional data on various indicators of social sector has been collected through field work by using scheduled method.

**Statistical Techniques Used**

Simple growth rates average, percentage change are calculated to know the progress of social sector viz. primary education, health services, housing and other social parameters in rural areas of Maharashtra and its districts during 1960-61 to 2004-05. Moreover, some appropriate diagrammatic devices are also used.

**Important Findings of the Study:**

1. Some findings at cross sectional should that, economic prosperity of Karveer and Radhanagari has created impact on the availability educational facilities in these two talukas. While Karveer taluka, which is developed taluka has good educational facility as compared to Radhanagari taluka, which is backward and hilly taluka. Moreover, of the total households selected under study, Majority of households were belonging to backward communities particularly scheduled caste in both taluka.

2. Out of the total households (218) of both talukas, majority of households had not owning land, the majority of households in both talukas were landless labourers whose main source of income was agriculture wage, and who had owned land they were either sub marginal or marginal farmers. It was observed that, 43 households had less than 10 gunta land (i.e. one fourth of acre) in Karveer taluka and 10 households had less than 10 gunta land in Radhanagari taluka. These households agriculture income was in the range of Rs. 501 to 30,000 in both talukas.

3. Moreover, some households were also engaged in non-farm activities as labourers activities such as construction of road, painting, barber work, carpenter work, leather shop, tailoring etc. in both talukas and some households were engaged in subsidiary occupations.
4. It was observed that nearly 88% and 92% households of Karveer and Radhanagari taluka respectively had income less than Rs. 30,000 and remaining households had annual income more than Rs. 30,000 respectively.

5. It showed that majority of households in Karveer and Radhanagari taluka had monthly expenditure on food less than Rs. 2000 which shows the economic deprivation of the majority households in both talukas.

6. It was observed that, the majority of children in rural area had taken primary education in village itself because facility of primary education was available at village level in Karveer and Radhanagari taluka. For higher-level education children's have to go other places, either of near by big village or taluka place or district place. However, majority children left their education to lack of transport facility and economic problem.

7. In Karveer and Radhanagari taluka the quality of teachers, as it was reported by parents of children that quality of education at primary level was satisfactory and children were satisfied with the teaching of teachers.

8. Moreover, majority of schools has their owned building along with playgrounds and toilet facilities. However, some children in schools preferred to go to open space for toilet particularly in Radhanagari taluka. Moreover, 50% primary schools had garden facility in Karveer and Radhanagari taluka.

9. Moreover, drinking water facility was made available in the premise of schools. However, it was not made available adequately, particularly in hilly areas of the Radhanagari taluka.

10. It was also observed that majority of parents were not aware about facilities for children to be provided by government in the schools (rice, books, food etc) particularly in hilly areas of Radhanagari taluka.

11. It was observed that majority of households (parents) annually spend Rs. 1000 on education of children in both talukas.

12. It was observed that parents belonging to BPL category were not in position to enrol their children in private schools due to high fees. Moreover, they were satisfied with the availability of primary education facilities made available by government.

13. It was observed that majority of beneficiaries who had been allotted houses under IAY were size of 10 by 10 and 10 by 12 square feet. It was responded by sixty-six households in
Karveer taluka and sixteen households in Radhanagari taluka houses constructed under this scheme were not adequate in space keeping size of family of the households.

14. Moreover, 29.9% households in Karveer told that they had not toilet facilities in attached to the houses and 47.6% of households had responded that they had not toilet attached to their houses because they were not aware about sanitation. Moreover they did not feel to have it urgently, because prefer to go in open space for toilet.

15. In Karveer and Radhanagari taluka, some households had spent owned amount ranging from Rs. 10,000 to 30,000 for construction of houses. In fact it size of house exceed s(14 by 16) then beneficiaries have to spend extra amount as per guideline. Moreover, beneficiaries those had append extra money they had borrowed from co-operative bank, commercial bank, and moneylenders against the mortgages of land, gold, some have sold buffalos, cows, land etc for raising extra money for the construction for additional room.

16. Indira Aawas Yojana has been improving housing condition of rural people in Karveer and Radhanagari taluka and however, amount made available per beneficiary per house was not sufficient because prices of raw materials have increased significantly. Moreover, houses allotted under this scheme were not in adequate number keeping in view increasing need of houses of pourers in rural areas.

17. It showed that households who were relatively economically better off were using public services as well as private medical services in Karveer and Radhanagari taluka. Primary Health Centre gives only preventive medical services, therefore if diseases is serious then villagers go to hospital located either at taluka place or district place for medical treatment.

18. Family planning centres set-up in Karveer and Radhanagari taluka have been providing reasonably good and these centres gives advice for medical services to those who require. People in rural areas are aware about the importance of family planning.

19. Public Health Centre has been providing nursing and primary services in Karveer and Radhanagari taluka. In Karveer taluka 74.6% households and 90.5% households of Radhanagari taluka were quite satisfactory to medical treatment provided by Public Health Centre. However sometime due to inadequacy of medical facilities, and increasing demand for medical treatment also resulted into either nonavailability medical facilities in proper time or late treatment. Sometime health personnel remain absent, which create problem for the patients.
20. Sourcewise break up of drinking water scheme that 37.3% households were using public tap, 41.8% households had their owned water connection and remaining households were taking water from the place one kilometre away from their locality in Karveer taluka. While in Radhanagari 35.5% households were using public tap, 40.5% households had their owned water connection and 20.2% households were using bore and hand pumps, it was observed that majority of households drinking water sources was public and private tap.

21. It was also observed that there was not systematic timing of providing drinking water to the villagers through Government schemes. 53% households in Karveer taluka and 89% households in Radhanagari have been facing irregularities in getting drinking water of which was caused due to load shedding of electricity. Moreover, water ever quantity of water was made available was not in time and in adequate quantity. This problem becomes more serious during summer season in both taluka.Moreover increasing water charges is matter of great concern particularly to poorers in rural areas.

22. With regard to sanitation, 47.7% households in Karveer taluka and 64.3% households in Radhanagari taluka were not much aware about the sanitation. Moreover, proper attention has not been to paid to implement sanitation programmes in rural areas. Hence management of solid waste material, garbage and wastewater etc. has became serious issue due to lack of awareness about sanitation among people in rural areas.

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