



IMPACT OF GLOBALIZATION ON 'TWIN PILLARS' OF THE KERALA MODEL: READINGS FROM THE POST GLOBALIZATION STUDIES

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Abstract: *A number of experts in the field of international development regard Kerala as a unique model of development because it has been able to achieve outstanding social development in such areas as health, education, and even the demographic transition, despite low economic development and low per capita income. Much of the uniqueness of the Kerala model of Development is contributed by the pre-eminent achievements of Kerala in the education and health sectors. But all the evidence we have, shows that neo-liberal policies have adversely affected them. Public spending on health and education came down after the reform era. Poor quality of education and health care has been the net outcome of this. The state, which traditionally regarded human development based on social welfare and equity as the major goals of the governance is now placed in a predicament due to ill planned public policies, uneven distribution of wealth and resources and the shift towards the market model of growth. This paper evaluates the twin pillars of Kerala Model – health and education - in the context of the neoliberal economic reforms implemented in India since mid-1991.*

Keywords: *Kerala Model, Health, Education, Globalization, Development*

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INTRODUCTION

Kerala has received world wide acclaim for presenting a non-traditional development model that the State has been successful in implementing development policy for increasing growth rates with reduced income gap. The trust of social welfare in Kerala started in the state long before the United Nations launched its development decades, and long before India decided on planned economic development. Development pattern of Kerala has been evolved through a long drawn process of social intervention, both by governments and social movements. The salient development features of Kerala include educational development, health care development, demographic transition, land reform, public distribution system and other social welfare measures such as mid day meal, old age and unemployment pensions etc. The implementation of liberalized globalization policy targeting economic growth ignoring distributive aspects along with improper implementation of certain earlier reforms raises challenges to the development of Kerala. The methodology used in this study is historical and analytical in nature. The data were collected mostly from secondary sources. Available primary sources were also consulted.

EVOLUTION OF KERALA MODEL

Kerala is one of the smallest states in the Indian union. It occupies 1 per cent of the total land area of India with a population of 3.33 Crore, which is 3 % of the total population of India as per the 2011 census. Modern Kerala came into existence on 1st November 1956, by amalgamating the states of Travancore-Cochin and Malabar on the basis of the State Re-organization Act. The population distribution of Kerala according to religion is about 56.20 % Hindu, 24.7 % , Muslim and 19 % Christian. At present, the state is administratively divided into 14 districts, which in turn are divided into 63 Taluks, 152 Blocks, 1532 Villages, 978 Grama (Village) Panchayats, 53 Municipalities and 5 Corporations.

Since the late 1970's a number of international scholars have held up the South Indian State of Kerala as a "Model of Development" (Frank and Chasin). Kerala model gets its credit because of the state's high standard of living (comparable to US or Europe) at very low per capita income which is only 1/80th of an US citizen's per capita income. According to Frank and Chasin (1994) this model is a set of economic practices developed in the state of Kerala, which resulted in attaining a high level of standards in human development, despite having a very low industrial development. The basic characteristic of the Kerala Model is the high



level of social development and physical social quality of life disproportionate to its level of economic development.

Modern economic theory says that this combination of under development and high standard of living is impossible. How has Kerala done it? There were a large number of factors helping the evolution of the 'model' from the demand side. The activities of the Christian missionaries, various social reform movements, well organized peasants' and workers' movements and left wing political movements increased the desire of people for education and better health care (Kannan 2012). Social equality is one of the hallmarks of Kerala Model. Over the past sixty years or more, Kerala has been transforming itself from an extremely poor state, ridden with caste and class conflicts and burdened by high birth, infant mortality and population growth rates, into a social democratic state with low birth, infant mortality and low population growth rates and a high level of literacy (Parayil 2000). Robin Jeffrey, a noted scholar on Kerala, holds the view that a set of ingredients that evolved over a period of time actually produced the conditions for the Kerala model. The major ingredients are politicization, maritime and commercial connections, presence of a plural society, social reform groups and their leaders, Christianity and Christian missionaries, Communism and communist activists, reform-minded Indian princess and the position of women (Jeffrey 1976, Eapen 1985).

TWIN PILLARS OF THE KERALA MODEL

Education and health and their wider accessibility have been the *twin pillars* of the Kerala Model. A recent study by the UNDP (2013) highlights the comparative lead of Kerala among Indian states with respect to income, education, health and generally on human development index. Better education and better health are important goals in themselves. Each can improve an individual's quality of life and his or her impact on others. There is an extensive literature on the importance of education and health as indicators and as instruments of human development (Sen 1999). Educated people are in a much better position to appreciate the value of health and the cost of sickness to take proper actions to maintain good health and chalk out their own action programmes. In Kerala, the health sector has done well partly because the education sector has done pretty well.



a) Health Status

Health is considered as a fundamental human right and a worldwide social goal. WHO observes health as a complete state of physical, mental and social well-being and not merely the absence of illness or disease. Kerala model of health is the legacy of the erstwhile princely states in Kerala. The health care paradigm followed by the rulers of the princely states of Travancore, Cochin and Malabar have been adopted more or less in the same way by the state after its formation. Kerala's much acclaimed outcomes in health care were to a large extent based on its vast network of public health institutions with the sub-centre and Primary Health Centres, Community Health Centres, Taluk / District Hospitals and Medical College Hospitals at the primary, secondary and tertiary levels, the hallmark of which was universal accessibility and availability of medical care to the poor sections of society. Apart from Modern Medicine, Ayurveda, Homeopathy, and other alternative systems are also very popular in Kerala. Census 2011 put Kerala's population at 3,33,87,677 persons, with a sex-ratio (females per 1000 males) of 1084, and Kerala is the only state in India with a positive figure. In the human development and related indices Kerala occupies prime position among Indian states in lower level of birth rate, death rate and infant mortality rate and highest life expectancy (Table 1). Per capita spending on health care and education in Kerala is the highest among all the states, which translates into high indicators of social development. According to National Family Health Survey of 2007, the incidence of anemia among women is the least in Kerala among the states in the country. Apart from the remarkable improvements in basic health indicators, it is also marked by the absence of any sharp bias against the girl child and women (Kannan 2012). There are many socio-economic conditions unique to Kerala, which have been postulated to make this health model possible. One of the reasons for the better health status of Kerala is its better living conditions. The sustained efforts of the government, both before and after independence, along with high literacy rate, especially female literacy rate, were the major correlates of this achievement (George and Kumar 1997). Notwithstanding, the widely celebrated Kerala Model of Health has started showing a number of disturbing trends recently.



Table 1

Vital health statistics of Kerala and India: 1951-2011

Year	Birth Rate		Death Rate		Infant mortality		Sex Ratio	
	Kerala	India	Kerala	India	Kerala	India	Kerala	India
1951	44	40	18	22.8	128	146	1028	946
1961	39	41	16.11	17.6	94	129	1022	941
1971	32	37	11	15.4	61	114	1016	930
1981	26	34	6.6	13	34	110	1034	935
1991	18	30	6.0	10	16.5	92	1040	928
2001	17.3	26	6.6	9	11	70	1058	933
2011	14.8	20.9	7	6.6	13	48	1084	940

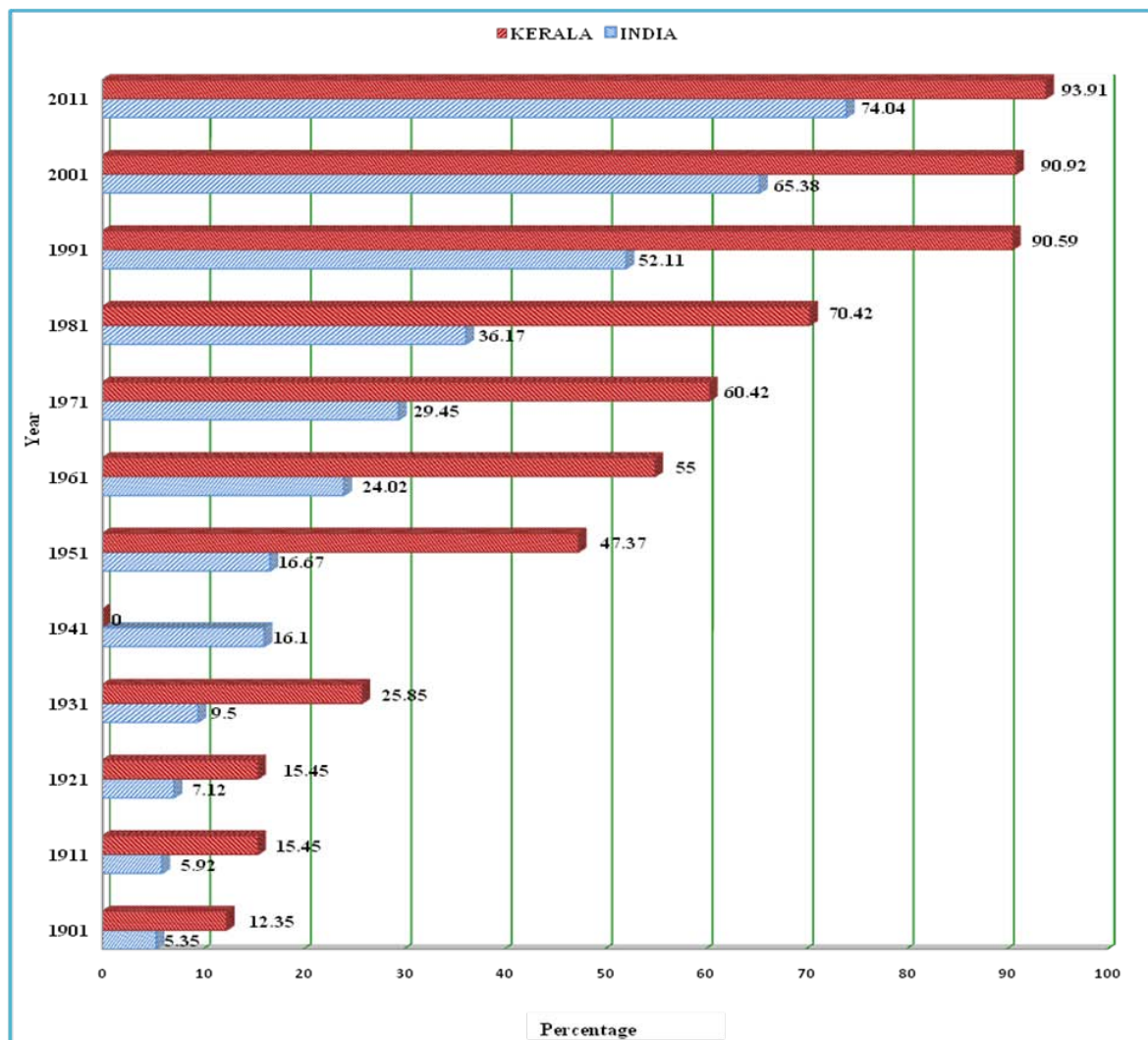
Source: Census of India, Various Years

b) Education

Education¹ is an important instrument of social change. It stimulates economic growth and improves peoples' lives by increasing the efficiency of labour force, improving health, enhancing equality and fostering democracy and thus creating better conditions for good governance. According to Dreze and Sen (1995), literacy is a basic tool of self-defense in a society where social interaction often involves the written media. Kerala is the first state in India, which has achieved universal literacy. Kerala stands miles ahead among the other states in social indicators like literacy rate, higher enrolment of students, higher percentage of girls², SC and ST students in schools. The percentage of SC students in government schools, private aided schools and private unaided schools are 14%, 10.8% and 3.9% respectively (2011). The corresponding shares for ST students were 0.3 per cent, 1.3 per cent and 3.1 per cent respectively (2011). Schools and colleges, even in remotest regions have low dropout rate among students. The drop-out ratio in lower primary section, upper primary section and high school section were 0.38%, 0.32% and 0.85% respectively. Kerala's literacy rate, which was only 47.18% in 1951, has almost doubled to 93.91% in 2011 (Figure 1). The male, female literacy gap, which was 21.92% in 1951, has narrowed down to 4.04 % in 2011.



Figure 1
Trends in Literacy - Kerala and all India- 1901-2011



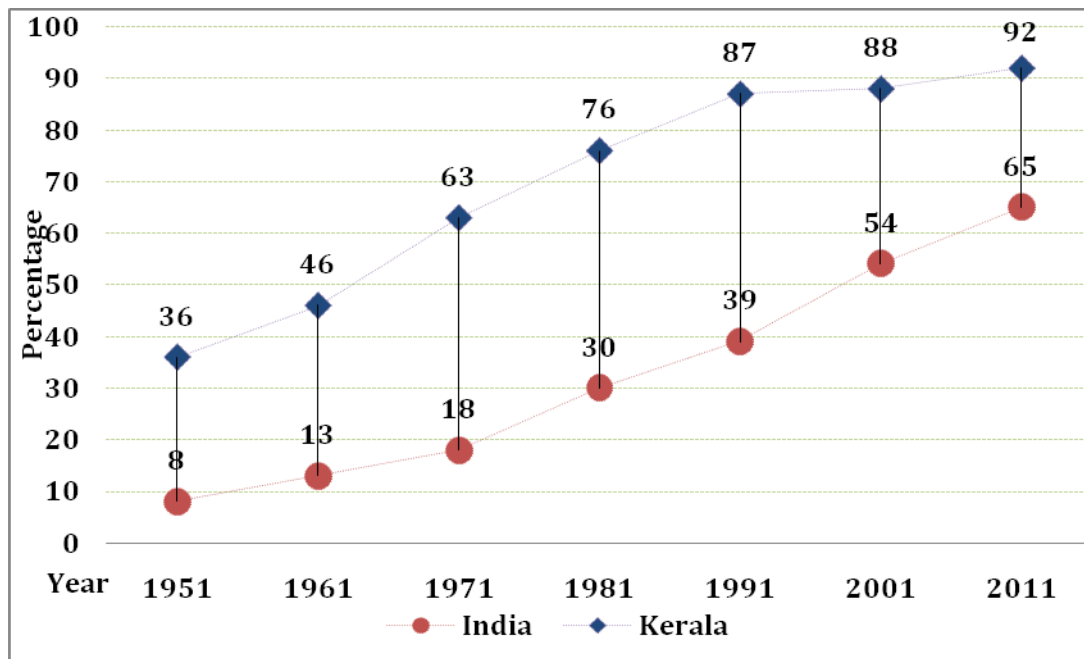
Source: Census of India, Various years.

As in the case of literacy, there is only marginal rural-urban and gender difference. Kerala has often been referred to as the 'land of women' (52%). The Kerala model of development owes its attributed success to the achievements in the areas of health and education where the contribution of women is predominantly significant. These early achievements in literacy and education have positively influenced the status of women in the state. Kerala's strength is the high levels of female literacy. Because when you educate a woman, you educate a family. The literacy level of females in Kerala was 36.43 per cent in 1951 while that of the national level was 8.86 per cent. It increased to 91.99% and 65.46% in 2011(Figure 2).



Figure 2

Growth Trends in Female Literacy-Kerala and India



Source: Census of India, Various years.

School education in Kerala, in terms of quantity and physical facilities has been consistently much higher than in any other state. In fact, the girls outnumber boys from the secondary school level onwards due to their lower dropout rates. The number of girls entering higher education except technical/professional education is much higher than that of the boys (Pillai 2004). The remarkable achievement of Kerala over the past century in education was a result of various social and economic struggles, which constitute a unique experience. The contribution of rulers in pre modern Kerala was also unique compared to other regions of the country. The evolution of education in general, and higher education in particular, were greatly due to the influence of western education introduced by the missionaries and the progressive rulers of the native states – Travancore and Cochin. The contribution of Christian Missionaries is worth mentioning (Eapen 1985). Their influence was twofold: firstly, they popularized modern education and provided free education, and secondly, they provided education to the lower caste people breaking the monopoly of the upper castes over education.

IMPACT OF GLOBALIZATION ON EDUCATION AND HEALTH SECTORS

Globalization³ involves economic integration; the transfer of policies across borders; the transmission of knowledge; cultural stability; the reproduction, relations, and discourses of



power; it is a global process, a concept, a revolution, and an establishment of the global market, free from socio-political control. Education and health and their wider accessibility, along with social safety net provisioning to most vulnerable sections of society, have been the hallmark of the egalitarian capabilities of Kerala's development. But all the evidence we have, shows that neo-liberal policies have adversely affected them. Public expenditure on health and education has been consistently coming down since the initiation of the economic reforms. The expenditure on medical and public health as a percent of total government expenditure was 5.01% in 1990's then steadily declined year after year (Table 2) (Pillai 1994). Along with the reduced budget allocations for education and health, the growing commercialization of these sectors under the reform regime materially weakened the Kerala model (George and Ajith 2009).

Table 2: Expenditure on Medical Education and Public Health

Year	Percentage of government expenditure
1990	5.01
1995	4.02
2000	1.2
2005	1.37

Source: Economic Review, Various Years,

Kerala State Planning Board, Government of Kerala

Education is undergoing constant changes under the effects of globalization. The educational system, particularly post-secondary education, is similarly entrapped in a web of institutional, political, and cultural constraints. Mass education has been one of Kerala's greatest success stories and at the foundation of its major achievements. But post-secondary education in Kerala today is stagnant and an unsustainable burden that does not and cannot meet the economic and social needs of society (Tharamangalam 2006). Kerala has the worst record of educated unemployment⁴ in the country. Kerala shows an inverse relationship between growth in education and economic development. With the introduction of the new educational policy by the state government, which enabled private colleges on self-financing basis, a number of colleges offering professional education commenced throughout the state (Table 3). The higher education sector witnessed substantial expansion in professional educational institutions as a result of the government's policy decision in 2000 to allow private agencies to start unaided professional



colleges. The inauguration of self-financing colleges in the higher educational sector of Kerala has opened up new debates-academic, political, questions of access, quality, social equity and justice legal and constitutional (Mathew 1991)

Table 3: Growth Trends in Professional Colleges in Kerala

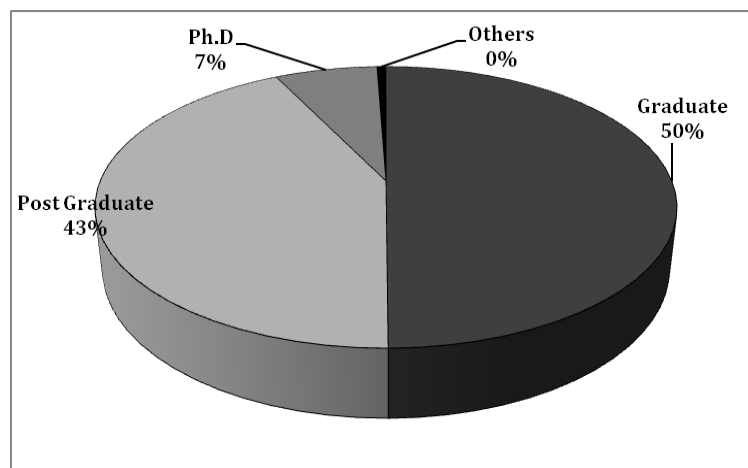
Sl. No	Type of Institution	1991-2000				2000-2012			
		Govt.	Aided	Unaided	Total	Govt. and aided	Govt. Self financing	Unaided	Total
1	Engineering Colleges	5	2	0	7	12	25	116	154
2	Medical Colleges	5	0	1	6	5	2	16	23
3	Nursing Colleges	5	9	0	14	9	10	62	86
4	Dental Colleges	3	0	0	3	3	0	22	25
5	Pharmacy Colleges	3	0	0	3	3	1	26	30
6	Ayurveda Colleges	3	2	1	6	3	2	13	18
7	Homeo Colleges	2	0	0	2	2	3	0	5
8	B-Ed Colleges	4	17	40	61	4	17	147	168

Note: Compiled by the Researcher

Kerala's development experience, therefore, used to be described in the past as the paradox of high degree of social development despite low rates of economic growth. But when the economy started growing, the state shifted its priorities away from education. As a result, the state reduced the share of education in its total expenditure (revenue and capital) (Panicker and Soman 1994). The share of education came down from 27.4% during the Fifth Plan period to 18.6% during the five-year period which ended in 2006-07 (Kumar and George 2009). This vacuum was filled initially by the self-financing institutions in other states to which there was a massive exodus of students from Kerala. Later on, the newly established self-financing institutions within the state met this demand. The government considered the starting of a large number of such institutions as a softer option. Nowadays, education has become a widely used device for social differentiation and exclusion. Education creates a divide between the educated and the uneducated or the semiliterate. This divide makes a society unequal.

There is no question that the unbridled expansion in the field of self-financing professional education has affected its quality greatly. The faulty selection procedure of students in self-financing colleges is the first reason for the decline of quality. In addition to this, in the *Inamdar* case⁵ the managements were given the right to conduct separate entrance tests. The admission procedure based on self-conducting entrance examination leads to corruption and low quality of students getting admission fully upon their ability to pay huge fees. There are several instances for this malpractice, where the corrupt managements misused their power to conduct examination and admission⁶. In several self-financing colleges, there is a dearth of qualified and experienced faculties. The *Annual Technical Education Review 2009* report reveals that most of the existing teachers in engineering colleges have only a graduate degree themselves (Figure 3) and it is not clear about their experience, although discussions have revealed that most of these graduate teachers are fresh hands with very little experience (Mani and Arun 2012).

Figure 3: Distribution of teacher qualification in engineering colleges in Kerala



Source: NTMIS nodal centre for Kerala (2010)

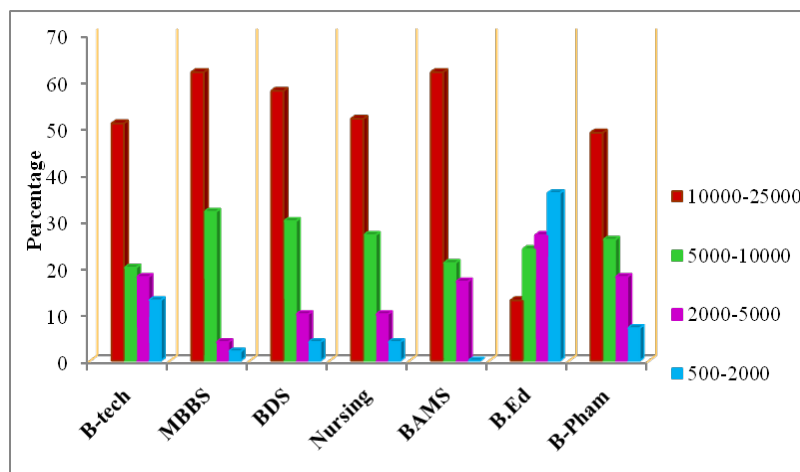
On analyzing the equity aspect, educational opportunities in the state are not evenly distributed among the population. The social and economic inequalities, which are the legacy of the past, get reflected in educational opportunities (Salim & Nair 1999). The self-financing colleges deny right to education to poor students. The students may have better academic quality, but they are unable to pay the fees. The state seems to be totally withdrawing from providing any financial aid to them. Are the students of the self-financing professional colleges eligible and able to compete in national and international markets? The self-financing professional colleges are not producing much of quality students. It is well



ascertained that it may also lead to educated unemployment. NASSCOM has revealed that more than 75 per cent of engineering graduates in the country have poor knowledge and skill.

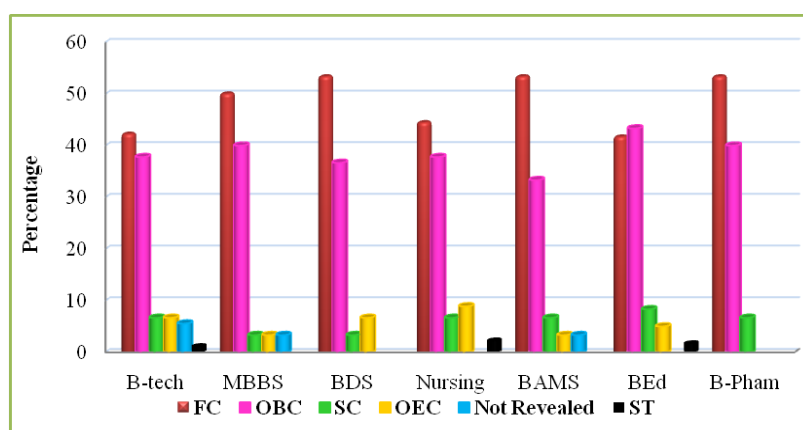
Admission to medical courses in Kerala is largely restricted to the elite group in terms of financial as well as social background. A study conducted by the author in 2007-2008 found that majority of the students who were studying in self-financing colleges belonged to high socio-economic background (Figure 4 and 5). These entry barriers lead to exclusion of the low socio-economic groups from the benefits of higher education, relegating them to the status of social outsiders. A study conducted by George and Kumar (1997) on entry barriers to medical education in Kerala shows that professional education, especially medical education has a predominant urban bias. Urban residents have a better chance of getting admission to these courses (Panicker and Soman 1984).

Figure 3: Income Wise Classification of Students in Self-financing colleges



Source: The Survey, 2007-2008.

Figure 4: Caste Wise Classification of Students



Source: The Survey, 2007-2008.



Proliferation of medical colleges contributes to the unlimited growth in the number of doctors. In 2005, the doctor – people ratio in Kerala was 1:960. As a result of the increase in number of colleges and seats the ratio in 2025 will be 1:430. Further it will become 1:283 if the doctors in Ayurveda and Homeo streams are taken for consideration. The supply of doctors further increases, if the statistics include those who complete medical courses outside Kerala⁷ (Ekbal 2006). Disproportionate increase in the number of doctors irrespective of the social demand creates many problems. The privatization of medical care is leading to over medicalization and escalation of the health care cost⁸. The establishments of large number of self-financing medical colleges are worsening the situation further. Because of private sector boom and also the tendency towards specialization, doctors are refusing to join the government hospitals and hence there is a severe dearth of doctors in the rural and even some urban centers and medical colleges. The net result is the marginalization of the poor and it is roughly estimated that at least 30% of the people in the state are denied health care or find it extremely difficult to meet the growing health expenditure (Ibid.). There has been a serious decline in professional ethics in the health sector.

Commodifying healthcare - increasingly driven by profit, will demolish all that the state had achieved in the health sector during the last decades of the 20th century. Kerala has the country's highest caesarian rate of 30.5 per cent which is not just three times the national average but also higher than the World Health Organization's recommended rate (15 per cent). The greed of doctors, eyeing higher fees and the lure of commission from hospitals for prescribing caesarians play a major role in this⁹. Recent statistics show that, in Kerala, the per capita health expenditure and the ratio between family expenditure and health expenditure are increasing very rapidly. The low expenditure for quality health protection, which is an important feature of Kerala Model of Development, has almost diminished (Asokan 2009). Needless to say, it would have negative consequences for the marginalized people and low-income groups.

Proliferation of self-financing colleges is also justified on another reason that it would help the backward regions and states to get the service of doctors. But, there is no ground to imagine that after spending huge money from their pockets in the self-financing colleges, these doctors would be willing to work for the services of the backward regions for lower



financial returns (Ekbal 2006). Such arguments, in fact, would help to shift critical focus from the real issues faced by the health sector in Kerala. The decline of quality in medical field has dreadful impact on the whole society. The self-financing colleges are producing more number of doctors without sufficient quality, which further causes the degradation the moral standards of medical profession. The social milieu of the state is changing and features of a consumer society are visible in all occupations. This has led to the commercialization and the commodification of health care. Health is no more seen as a right, but as a commodity to be purchased by money. The huge remittance of foreign exchange from gulf countries even to the low and middle-income group houses further reinforced this attitude. All these tendencies are leading to a virtual uncontrolled growth of the private medical care facilities in the state (Kutty 2006). Commodifying healthcare - increasingly driven by profit, will demolish all that the state had achieved in the health sector during the last decades of the 20th century.

KERALA MODEL AND THE MARGINALIZED SECTIONS

The process of globalization has made unprecedented change in the lives of indigenous people across the world, though the degree of exploitation and marginalization vary from state to state and tribal group to group. If one compare the tribals¹⁰ on the socio-economic or quality of life indicators, it is true that the tribal groups from Kerala will appear to be far better than many other states. The celebrated Kerala model of development has not made much change for the socio-economic life of the marginalized sections of Kerala. Tribals have been largely left out of the gains of the vaunted Kerala model of development (Govinda 2006). Systematic marginalization of the subaltern sections has been a blot on the Kerala model (Kunhaman 2002). In the implementation of land reforms, the fundamental programme for which Kerala is well known, the legitimate claim of the dalits, the traditional tillers of the soil, to cultivable land was never recognized. In postcolonial Kerala, the Adivasis were characterized by poverty, malnutrition, land alienation, illiteracy, socio-economic and sexual exploitation by settlers and the depletion of their traditional resource base

Health is one of the serious problems among all tribal communities. Many tribals die due to malnutrition, excessive consumption of alcohol, tobacco, ganja and superstitious beliefs. A large number of tribal women face extreme forms of social exclusion and discrimination in the public sphere of life. Most of them are victims of direct sexual exploitation or false



promise of marriage from outsiders - mainly the settlers, owners of tea and coffee estates, fellow workers, and police personnel deployed to check the radical political movement. All these resulted in growing number of unwed mothers among the tribals. The problem of malnutrition deaths is plaguing the tribal belts of Attappady in Palakkad district in the State. Over the past few months there have been recurring deaths of scores of children in Attapaddy. As many as thirty infants reportedly died in Attapadi in last five months (July – November, 2013) due to malnutrition.

Among the few states that have achieved land reforms in India, Kerala has been rated very high. However, it is equally true that Kerala did not achieve complete success in land reforms. In the recent past, Kerala witnessed the rise of land struggles from landless agricultural workers and Scheduled Tribes. The tribals led the Muthanga agitation in Wayanad in 2005. Similarly, the landless set, mostly Scheduled Castes and Scheduled Tribes, conducted the Chengara land struggle between 2001 and 2010. In this context, the need for another land reform is being widely debated. Both these sections have been considered only as eligible for charity and welfare. They have never been recognized as active players in development. Their contributions to the development of the state are seldom recognized. The post globalised developmental projects and developmental dreams of the state have again made by the deprivation of the tribals of Kerala and the developmental divide has increased between the tribal and non-tribal in the state. The invisibility of the scheduled categories at the higher professional levels of learning and research is a matter of serious concern. Thus, social discrimination and intellectual untouchability are very strong, perhaps stronger than in many other states in India (Kunhaman 2000). Amartya Sen is absolutely correct in holding that such groups should mobilize themselves on the basis of the problems specific to them. After all, in the absence of a revolution, such group-specific actions are the only means of improving their conditions. Sen's thesis on group-specific mobilization based on basic issues stands vindicated (Sen 1999).

The forces of globalization and fascism are jamming Dalits from coming together to identify and acknowledge the commonality. All sorts of development and planning have been done in the name of Dalits by non-Dalits. It is never planned with the Dalits or by the Dalits. Therefore the basic problems of Dalits as a social problem are yet to be dealt. As far as a politician is concerned, the marginalized sections are vote-banks only. These groups have



very limited capability to act as strong pressure groups in Kerala politics, because of the poor organizational strength; and bargaining power (Parayil and Sreekumar 2003). Consequent to this, the political bodies seldom take care of their concerns. It is also a fact that pre-independent and post independent governments in our state could not and did not do much for the education of the marginalized groups.

CONCLUSION

The state of Kerala, which has high traditional values and social development with a culturally vibrant and politically vigilant society, is now encountering numerous challenging problems. Kerala experience reveals that the development achievement at the level of developed economy is possible without concomitant economic growth. This non-traditional pattern of development in Kerala has been evolved as a result of a long development process, which was initiated right from the reign of the native kings in the pre-colonial period and culminated with the post-independent government of united Kerala. Although Kerala has been acclaimed for presenting an alternative development model to the world by which people can lead a better life with low income, causing less damage to the earth, currently Kerala focuses on neo-liberal economic policies for making high economic growth, ignoring the distribution aspect. This new policy is marked by rampant inequalities that grossly violate the difference principle of justice. Contemporary Kerala is facing an unusual paradox. On the one hand, the setting up and pace of the neo-liberal agenda is challenging the state-centric development pattern, with the result, an unusual development crisis exists in social sphere. The health care, education and the public distribution system etc., are virtually avoided from the accessibility of the common man. In order to overcome the current development crisis in an ever changing world scenario, Kerala has to sketch out an alternative development path of its own without losing earlier emphasis on social welfare. This has become a great dilemma and development puzzle. The conventional model of development had lost its charm and glory and in the competing neo-liberal age, Kerala has to find out a strategy for suitable development.

NOTES

1. Etymologically, the word education is derived from *educare* (Latin) 'bring up', which is related to *educere* 'bring out', 'bring forth what is within', 'bring out potential' and *ducere*, 'to lead'.



2. Girls constitute 52% at the plus two level, 76% at the graduate level and 74% at the post graduate level.
3. Three key institutions helped shape the current era of globalization: the International Monetary Fund (IMF), the World Bank, and the World Trade Organization (WTO).
4. According to live register of employment exchanges in Kerala, the total number of work seekers as on 30th September 2012 was 45.0 lakh; of which 27.4 lakh (60.9 per cent) are female. Unemployment rates for the educated in Kerala are the highest for both rural and urban areas among the major states. Not surprisingly, large numbers of Kerala's unemployed are the educated; many are graduates and post-graduates.
5. The seven-judge bench of the Supreme Court delivered its verdict in *PA Inamdar Vs State of Maharashtra* case on 12 August 2005. In Inamdar case, the Court had struck down existing reservation by state governments in private, unaided medical and engineering institutions. The court declared that the State can't impose its reservation policy on minority and non-minority unaided private colleges, including professional colleges.
6. In the first case, 42 students out of 96 from Thiruvalla Pushpagiri Medical college (Syro Malankara Catholic Church), who attended the first year examination in 2003 failed. Ironically, the students having 32680th and 33728th rank in the state medical entrance examination got admission in that batch. In 2004, the High Court of Kerala banned admission to management seats of Pariyaram (CPI (M) controlled college) and Cochin Co-operative Medical Colleges. Supreme Court also agreed with the High Court verdict and criticized the admission procedure of those institutions. Surprisingly, a student, who got only 10 marks out of 960 in the common entrance test having 40012th rank was able to secure admission in Pariyaram Medical College. Another example is Dr. Somervell Memorial Medical College, run by the Church of South India, at Karakonam near Trivandrum has admitted at least 45 students in the MBBS course for 2011 academic year after collecting between Rs 20 lakh and Rs 50 lakh as capitation fee. None of these students would have qualified for admission in any college in the normal course. What is even more shocking is the fact that the college management had filled these seats even before the entrance examination to be held for finding eligible candidates to be admitted in the management



quota. The college had filled the management quota seats with students who were ranked as low as 47,000 in the Common Entrance Test conducted by the Government in April.

7. According to World Health organization (WHO) doctor-people ratio of 1:3000 is more than sufficient. It shows that there is a big difference between the existing ratio and the actual need of the society.

8. The Kerala Sasthra Sahithya Parishad's (KSSP 2006) studies revealed that at least 15 percent families spend over 30 percent of their income on healthcare alone.

9. A mass caesarian (21 in two days) has been reported from a Government Taluk Hospital at Cherthala on April 2011. Such a large number of operations were performed without taking into account basic factors like bed-strength in the state-run hospital, where mostly less privileged sections come for treatment. Doctors are to be bribed and they have no qualms in demanding their pound of flesh from poor man and woman, who are hailing from the lowest strata of society, mostly labourers and poverty, malnourishment and unemployment are their lot and their plight continues to be the same under different governments.

10. In Kerala, adivasis constitute 1.1 percent to total population. The 2011 Census report records the overall tribal population in the state as 4, 84,839, against 3, 64,189 in 2001, putting the decadal growth rate at 0.36 per cent

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