*IOSR Journal Of Economics and Finance (IOSR-JEF)*
*e-ISSN: 2321-5933, p-ISSN: 2321-5925.Volume 17, Issue 4 Ser. 3 (July. – August. 2026), PP 53-64*
*www.Iosrjournals.Org*

# Social Development In Post-Reform India: An Empirical Analysis Of Health And Education Outcomes

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***Abstract***
*The 1991 economic reforms represent a pivotal event in Indian economic history, fundamentally altering the nation's economic policy approach to its economic and social development. Although the Indian economy has transformed significantly since the reforms, with accelerating growth making India one of the world's largest and fastest-growing economies, this period has also raised pertinent concerns about the country's underachievement in social development. This study addresses these concerns by providing an empirical analysis of India's social development in the post-reform period. It employs descriptive and trend-based analyses of secondary data and relevant indicators to evaluate social development in areas such as health and education. Additionally, it offers a brief descriptive overview of other major dimensions of social development, including gender equality and women's empowerment, social inclusion, and the elimination of discrimination, followed by an examination of welfare expenditure and social protection in the country during the post-reform period. The study finds that although education and health, two major dimensions of social development, have advanced considerably in the post-reform period, substantial improvements remain necessary in these areas. The study underscores the need for sustained policy attention to social development and recommends progressive taxation, legislative interventions, and increased public expenditure on education and health (in alignment with international standards), while emphasising the importance of prioritising the qualitative aspects of social development alongside quantitative coverage.*

***Keywords:*** *Indian economy, Economic Reforms, Social Development, Health, Education, India*

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Date of Submission: 04-08-2026 Date of Acceptance: 14-08-2026

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## I. Introduction

Social development is a fundamental component of inclusive and holistic development in any country. Social development is the improvement of human welfare, social justice, and the institutions through which people organise their collective lives (United Nations, 1995). Social development constitutes a planned process of social change aimed at enhancing the overall well-being of the population, in tandem with dynamic economic development (Midgley, 1999). Social development is a crucial element of inclusive and holistic development in any country. Social development acts not only as an end of the development process but also as a means to further the development and progress of the economy by expanding substantive freedoms or capabilities across the population (Sen, 1999). Social development includes various aspects, such as education, health and nutrition, gender equality and women's empowerment, social inclusion and the elimination of discrimination, social protection and welfare, housing and sanitation, and democratic participation and social cohesion.

The 1991 economic reforms represent a pivotal event in Indian economic history, fundamentally altering the nation's economic policy approach to its economic and social development. The reforms heralded a paradigm shift in the country's economic policy, intending to let the country adopt a plethora of structural reforms that would replace the economic philosophy rooted in self-sufficiency, protection, and public sector dominance that had guided the country until then (Ahluwalia, 2018; Subbarao, 2018). The economic reforms facilitated significant improvements in the country's economic growth, positioning it as one of the largest economies in the world (International Monetary Fund, 2025). Despite this, the effectiveness of economic reforms and subsequent economic growth in facilitating comprehensive economic and social development in the country has been extensively debated. It has been pointed out that the country's remarkable economic growth during this period has not been accompanied by corresponding improvements in its social and human development indicators, with the country also lagging in social and welfare expenditure, which is a very small fraction of the country's overall budget (Drèze and Sen, 2013).

The equitable distribution of economic growth benefits, along with continuous advancements in social and human development outcomes, establishes a sustainable foundation. This foundation is essential not only for enhancing immediate welfare and well-being but also as a prerequisite for the long-term sustainability of a

country's economic growth (Vishnu et al., 2026). Sen (1999) substantiated this through his capability approach, which states that development is to be understood as the expansion of human capabilities and freedoms, wherein economic growth functions as a means rather than the end of economic development, with the value of economic growth being assessed by its contribution to improving the quality of life and agency of the population. The framework advanced by Stiglitz et al. (2009) also reinforces this perspective by cautioning against relying only on aggregate output metrics and advocating for a broader, multi-dimensional assessment of economic performance that incorporates social progress and distributional equity.

Although social development encompasses multiple dimensions, this study specifically examines the primary dimensions of education and health to evaluate the impact of recent economic reforms. Furthermore, a brief overview of other dimensions of social development in the country during this period is provided.

This is particularly salient in the Indian context, where inadequacies persist in social development despite decades of robust economic expansion. This puts the long-run sustainability of the country's growth trajectory in peril because of the continued underdevelopment of human capabilities. This necessitates substantive and sustained policy attention to the structural dimensions of social underdevelopment to ensure that the advantages of economic growth are distributed effectively and that human capabilities and living standards are improved across all population segments. In this context, the present study seeks to understand the overall performance of social development in the Indian economy in the post-reform period. This study is organised around three major research objectives.

1. To analyse the trends and trajectories of India's social development performance concerning education during the post-reform period.
2. To analyse the trends and trajectories of India's social development performance concerning health during the post-reform period.
3. To present an overview of the major dimensions of social development, welfare Expenditure and Social Protection in India in the post-reform period.

## II. Methodology

The present study provides an empirical analysis and descriptive overview of the various aspects of social development in India during the post-economic reform period. It examines the outcomes in education and health, which are two critical dimensions of social development in any country. This study analyses the trends and trajectories of health and education outcomes in India before and after the economic reforms of 1991. In the Education dimension, the analysis focuses on Adult Literacy (1981-2023) and Primary School Gross Enrolment (1971-2025), utilising data from the World Bank Open Data (World Bank, 2026a; World Bank, 2026b). In the Health dimension, the study examines Life Expectancy at Birth (1960-2024), Infant Mortality Rate (1960-2024), and Maternal Mortality Ratio (1985-2024), with data sourced from the World Bank Open Data (World Bank, 2026c; World Bank, 2026d; World Bank, 2026e). The study also provides a brief descriptive overview of other major dimensions of social development, such as gender equality and women's empowerment, social inclusion, and the elimination of discrimination in the workplace. This is followed by an overview of welfare expenditure and social protection in the country during the post-reform period based on a survey of various previous studies and government reports.

## III. Analysis Of Data

### Education

Education is a fundamental component and crucial driver of social development in any nation. According to Drèze and Sen (2013), education, particularly universal primary education, female education, and early adulthood development, holds the potential to serve as the most influential catalyst for social development in India, affecting economic opportunities, employment prospects, fertility decisions, public health outcomes, child health outcomes, political participation, enhancement of human rights, reduction of caste- and class-related inequalities, and intergenerational mobility.

Education has been a fundamental and enduring structural challenge and policy concern in India since independence, largely due to the enduring legacies of colonial educational policies and the country's large population size. During the colonial era, both the infrastructural and qualitative dimensions of India's education sector experienced persistent impediments, while many other nations were making substantial advancements in the education sector (Chaudhary et al., 2012). Therefore, the education sector and education levels in the country were in a precarious state when the country became independent from colonial rule in 1947, with the national adult literacy rate of the country being approximately 18% (Waghmare, 2025). Sen (1999) contextualises educational backwardness within the broader framework of capability deprivation. He posited that the deprivation of literacy and schooling faced by a large section of the country's population imposed fundamental constraints on individual agency and developmental freedom, resulting in enduring structural consequences for independent India.

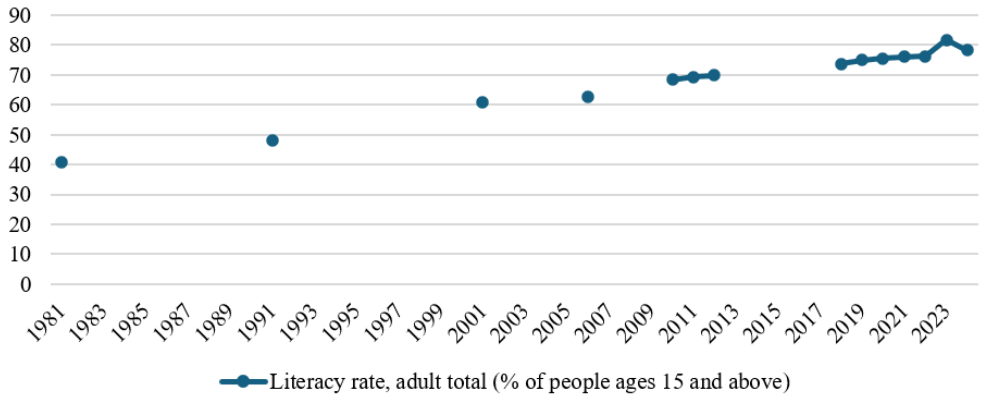
Despite significant progress in higher education through the establishment of new institutions and universities, India continues to encounter challenges in primary education, struggling to achieve universal primary education for its large population and enhance the quality of school education in the country (Drèze & Sen, 2013). In recent years, particularly during the post-reform period, the country has accorded sustained and substantive policy attention to primary education, primarily through two landmark interventions, the Sarva Shiksha Abhiyan (SSA) and Right of Children to Free and Compulsory Education Act, 2009.

The Sarva Shiksha Abhiyan (SSA), launched in 2001-02 as India's flagship programme for the achievement of Universal Elementary Education for children aged 6-14, was the largest initiative for the expansion of educational access in the country's history. The programme sought to achieve its objectives by improving school infrastructure, teacher recruitment and training, gender parity, and the reduction of out-of-school children, with particular emphasis on historically marginalised communities (Ministry of Human Resource Development, 2007). Since its inception, the programme has significantly contributed to the improvement of primary enrolment, adult literacy, and health outcomes in the country (Nasrin et al., 2023).

The advancements achieved by the SSA in the education sector were furthered and constitutionalised by the Right of Children to Free and Compulsory Education Act, 2009, codifying the right to education as a legally enforceable fundamental right, making free and compulsory education mandatory for all children in the country between the ages of 6 and 14 years (Government of India, 2009). The government has enhanced the SSA and the Right to Education Act by launching the National Education Policy, 2020 which aims to fulfil its educational objectives with a renewed emphasis on quality along with the access aspect emphasised in the two earlier initiatives (Ministry of Education,2020).

In this context, the present study evaluates two major educational indicators pertaining to access to education to determine their performance during the post-reform period, thereby assessing the country's progress towards achieving Universal Elementary Education.

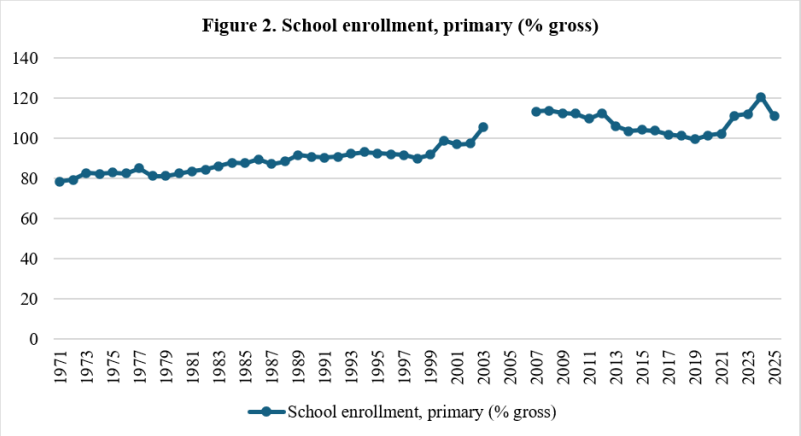
**Figure 1. Literacy rate, adult total (% of people ages 15 and above)**




Source: World Bank Open Data (World Bank, 2026a)

Figure 1 depicts the trend in the adult literacy rate in India, defined as the percentage of the population aged 15 years and above that is literate from 1981 to 2023. The data, sourced from the World Bank (World Bank, 2026a), were derived from census and large-scale survey data. The figure demonstrates a consistent upward trajectory during this period. The adult literacy rate which increased modestly from 40.75% in 1981 to 48.22% in 1991, increased further to 61% in 2001, showing a substantial increase of approximately 13 percentage points in the first decade of the post-reform period. This acceleration in the literacy rate in the post-reform period broadly coincides with increased public investment in elementary education infrastructure, expanded access to schooling, and the initiation of several programmes such as the District Primary Education Programme (DPEP) launched in 1994 (Kingdon, 2007). The upward trend in the adult literacy rate in the country continued throughout the remainder of the post-reform period, reaching 69.3% by 2011 and further improving to 81.69% by 2023.

The marked increase in the adult literacy rate in the country during the post-reform period indicates substantial progress, which can be attributed to the cumulative effects of various policy interventions, including the Sarva Shiksha Abhiyan (2001-02) and the Right to Education Act, 2009. However, despite this progress, the adult literacy rate reaching only 81.69% by 2023 highlights a considerable educational deficit and deprivation in the country, as nearly one-fifth of the country's adult population, representing millions of individuals, remains illiterate.




Source: World Bank Open Data (World Bank, 2026b)

igure 2 depicts the trend in India's primary school Gross Enrolment Ratio (GER), defined as the total enrolment in primary education, regardless of age, expressed as a percentage of the population of official primary school age from 1971 to 2025, as reported by the World Bank (World Bank, 2026b). The UNESCO Institute for Statistics (2012) and World Bank (2026b) have specified that, unlike the Net Enrolment Rate (NER), the Gross Enrolment Ratio (GER) includes all enrolled students in the country, regardless of age, including over-age pupils (repeaters and late entrants) and under-age early entrants. This implies that the GER can exceed 100%, which does not mean the achievement of universal enrolment of all official-age children. Instead, it indicates that the total number of enrolled pupils surpasses the population of the official school-age group, potentially reflecting grade repetition or delayed entry into the schooling system (UNESCO Institute for Statistics (2012). Therefore, it is important to note that GER values substantially above 100% may result from high system capacity or substantial internal inefficiencies and should not be construed as evidence of universal access to education without also considering the Net Enrolment Rate (NER). The analysis presented in this paper is limited to Gross Enrolment Ratio (GER) data due to the unavailability of the Net Enrolment Ratio (NER) data, necessitating interpretations regarding access to education in the country based on literacy and the GER data.

Despite this significant limitation, Figure 2 illustrates several noteworthy trends in school enrolment in the country. The primary Gross Enrolment Ratio (GER) in the country experienced a gradual increase during the pre-reform period, rising from 78.37% in 1971 to 90.39% in 1991. This upward trend continued at an accelerated pace in the post-reform era, with the GER in the country exceeding 100% for the first time in 2001-02, coinciding with the nationwide implementation of the Sarva Shiksha Abhiyan (Ministry of Human Resource Development, 2007). The GER in the country peaked at approximately 112% in 2009-2010, coinciding with the enactment and enforcement of the Right of Children to Free and Compulsory Education Act, 2009 was enacted and enforced (Government of India, 2009). Subsequently, the GER fluctuated between 2010 and 2019, declining to approximately 99.5% in 2019, before increasing to approximately 120.5% by 2024. These fluctuations indicate that both the Sarva Shiksha Abhiyan and the Right to Education Act were effective and instrumental in enhancing enrolment levels in primary education within the country. However, concerns remain regarding over-age pupils, such as repeaters and late entrants, as well as under-age early entrants, as they are factors suggesting the presence of grade repetition or delayed entry into the schooling system, resulting in the aggregate number of enrolled pupils exceeding the population of the official school-age group. Nonetheless, the increase in enrolment in the post-reform period is a positive indicator of the pursuit of universal elementary education and enrolment in the country. The District Information System for Education Report 2017-18 (National Institute of Educational Planning and Administration, 2020) reveals that the Net Enrolment Rate (NER) at the primary level rose from approximately 82% in 2000 to over 97% by 2018. This finding underscores the substantial improvements in school enrolment during the post-reform period and corroborates the analysis of the current study regarding enrolment levels during this timeframe.

The social equity dimension of access to education, as indicated by school enrolment ratios, has improved during this period. This is evidenced by the PROBE study, which examined certain randomly selected villages across various states of the country through surveys conducted in 1996 and 2006. The study found that school enrolment ratios for children aged 6 to 12 increased from 80% to 95% between 1996 and 2006. Notably, the school enrolment ratios of children from disadvantaged communities, such as Dalits, Muslims, and Adivasis, rose significantly during this period, nearly reaching the overall sample population average of 95% (Drèze & Sen, 2013). The progress in enrolment ratios, coupled with enhanced social equity, is a positive development for India, a country with various entrenched and hierarchical social inequities, such as the caste system, as ensuring social justice is a mandatory requirement for the country's social and human development.

Although literacy and enrolment data indicate substantial improvements in the education sector's trajectory during the post-reform period, concerns regarding the quality of education and learning outcomes remain significant. The Annual Status of Education Report (Rural) 2024 (ASER Centre, 2024), a nationwide household survey capturing the status of children's enrolment and learning outcomes in rural India, reveals that the proportion of Standard V children in government schools who read a Standard II level text decreased from 42 44.2% in 2018 to 38.5% in 2022 and then recovered to 44.8% in 2024. According to the same report, only 30.7% of the Standard V students could perform a numerical division problem. These findings highlight the abysmal quality of the learning imparted to students by the Indian education system and its systemic issues, such as high teacher absenteeism, inadequate infrastructure, and poor infrastructure quality, as demonstrated by Kingdon (2007).

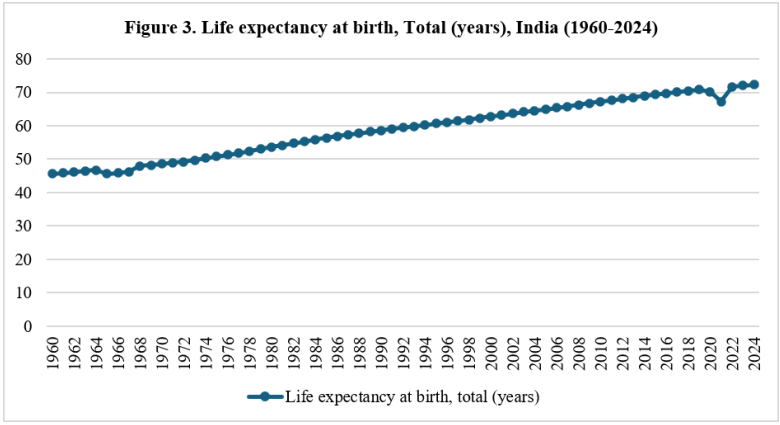
The above analysis of the enrolment data, in conjunction with findings from various studies on school enrolment, highlights that significant progress has been made in expanding access to schooling in the country during the post-reform period, as illustrated by Figures 1 and 2. However, when these findings are compared with studies on the quality of school education in the country, it becomes evident that improvements in enrolment must be accompanied by corresponding improvements in educational quality. This is essential for the education sector to fully realise its potential to contribute to the country's social and economic development.

**Health**

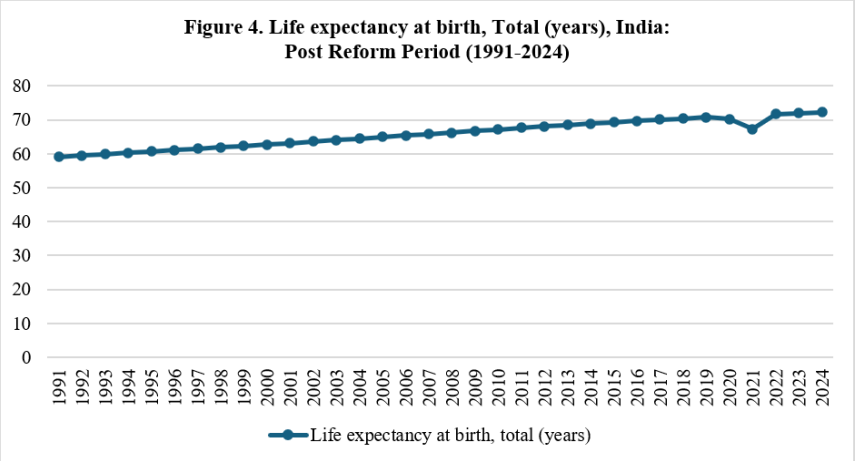
Health constitutes a fundamental aspect of social development, serving both as an intrinsic capability (Sen,1999) and as a prerequisite for effective economic participation (Drèze & Sen, 2013). Substantial progress in the health sector is essential for economic development, as a nation's health conditions directly influence the overall well-being of its populace. Similar to education, health has posed a significant challenge for various central and state governments, particularly because of the country's large population and high population density. During colonial rule, health was one of the most neglected domains, with epidemic outbreaks being neglected and health infrastructure remaining underdeveloped. Consequently, health became a significant element of the country's policy agenda. Although some progress was made in the health sector of the country post-independence, these improvements were generally slow and inadequate to meet the demands of a densely populated country such as India.

In the post-reform period, India has faced considerable challenges in the health domain, with its performance falling short of the potential improvements in healthcare quality, equity, and public health expenditure despite significant economic gains during this period. Although India has surpassed many countries in terms of economic growth indicators, it lags behind comparable developing countries in terms of many health indicators (Drèze and Sen, 2013). The country has implemented several initiatives in the health sector, including the National Rural Health Mission (later expanded to the National Health Mission), immunisation campaigns, and efforts related to nutrition, child health, maternal health, childbirth, and health infrastructure development. Nevertheless, health outcomes in the country exhibit severe inequities in morbidity, mortality, and nutritional status, influenced by factors such as caste, class, gender, and geography (Kumar, 2018). Therefore, it is crucial to analyse the health dimension of social development to comprehend the development scenario in the post-reform period.

The present study examines the health situation in the country by evaluating overall life expectancy, as well as child and maternal health, during the post-reform period. Figures 3,4,5,6 and 7 illustrate the data on three primary outcome-based population health indicators in India, the Life expectancy at birth, Infant Mortality Rate (IMR), and Maternal Mortality Rate (MMR), utilising data from the World Bank (World Bank, 2026c; World Bank, 2026d; World Bank, 2026 e).



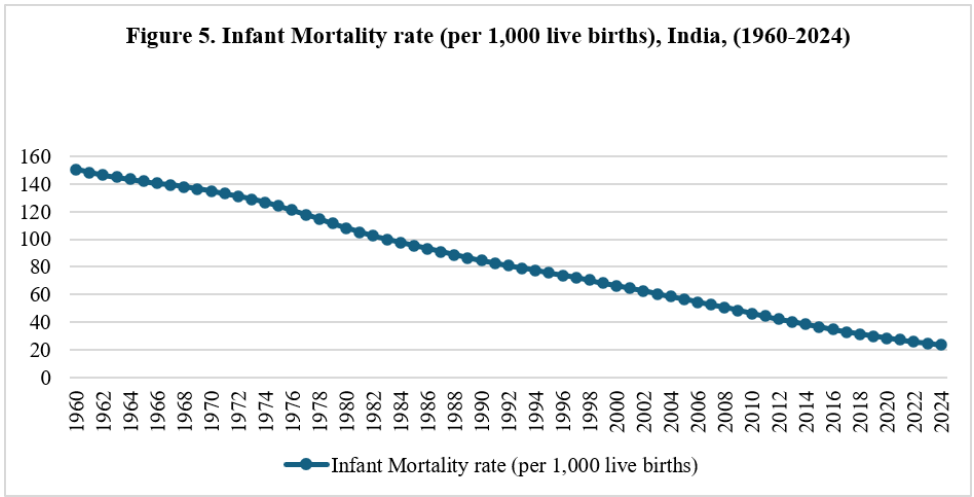

Source: World Bank Open Data (World Bank, 2026c)



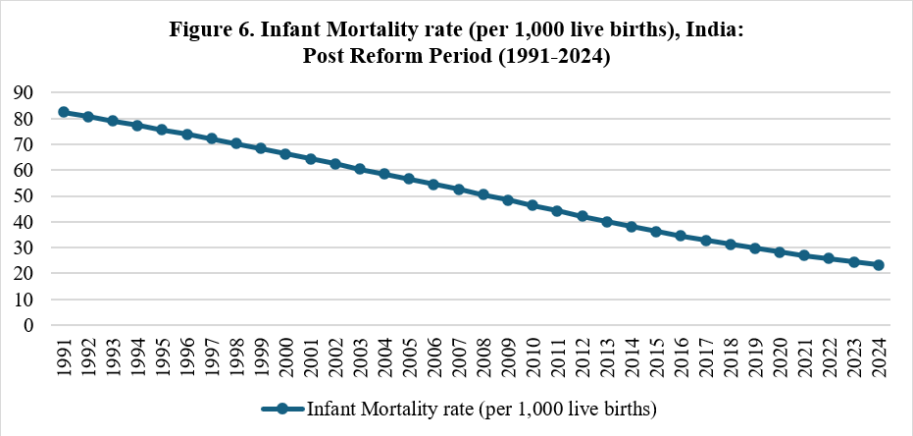

Source: World Bank Open Data (World Bank, 2026c)

Figures 3 and 4 illustrate the life expectancy at birth in India over the long historical period (1960-2024) and the post-reform period (1991-2024), respectively. Life expectancy at birth, defined as the number of years a newborn infant would live if the prevailing patterns of mortality at the time of its birth remained throughout its life (World Bank, 2026c), serves as an important indicator of the health conditions in an economy. This is because life itself holds intrinsic value, and good health and adequate nutrition are closely associated with higher life expectancy (UNDP, 1990). Figure 3 demonstrates that the life expectancy in India has been on a continuous upward trajectory since 1960, with the life expectancy in the country rising from 45.61 years in 1960 to 59.03 years in 1991, the year economic reforms commenced. This consistent and remarkable increase can be attributed to improvements in the public healthcare system, health infrastructure, immunisation, disease control, hunger reduction, nutrition, drinking water provision, and sanitation during the post-independence period, in contrast to the inadequate conditions during the pre-independence colonial era. Figure 4 provides a detailed account of the trend in life expectancy in the country during the post-reform period, showing a continued rise from 59.03 years in 1991 to 72.24 years in 2024. Both figures indicate a decline in life expectancy in the country during 2020-2021, attributable to the COVID-19 pandemic, which temporarily increased mortality levels in the country. This also aligns with the global and South Asian patterns of pandemic-induced excess deaths and maternal mortality among women aged 15-49 years during the COVID-19 pandemic (WHO et al., 2025). The swift recovery of the country's life expectancy by 2022-2024, returning to its original upward trend, further confirms that the dip in 2020-2021 was temporary rather than structural.

The advancements made by the country in life expectancy during both the pre- and post-reform periods, as depicted in Figures 3 and 4, align with cross-country evidence from OECD (2015) regarding the relationship between economic development, public health investment, and longevity outcomes. Despite the positive trend and significant gains in life expectancy, it is important to note that India's life expectancy lags behind that of many comparably less developed nations in South Asia and sub-Saharan Africa. This highlights the persistence of public healthcare deficits and inequities in healthcare access in the country (Drèze and Sen, 2013).




Source: World Bank Open Data (World Bank, 2026d)

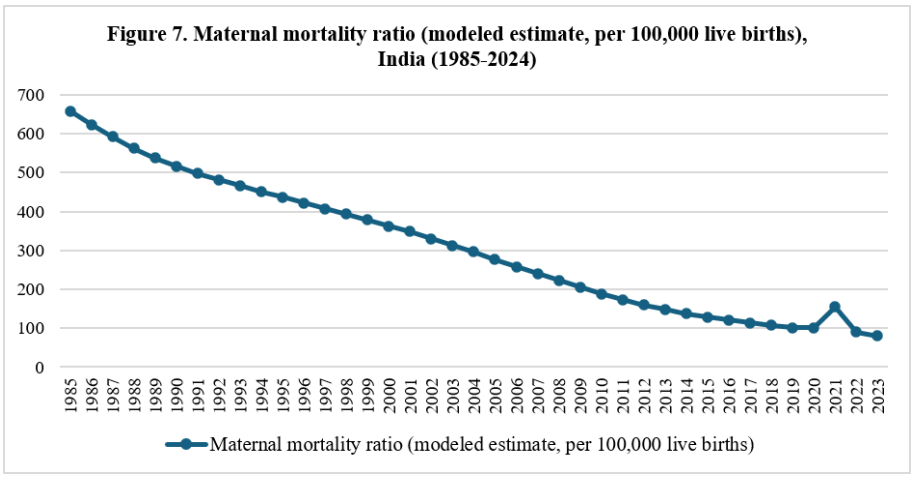



Source: World Bank Open Data (World Bank, 2026d)

Figures 5 and 6 depict the trend in the Infant Mortality Rate (IMR), defined as the number of infants dying before reaching the age of one year per 1000 live births, in every given year in India, over the long historical period (1960-2024) and the post-reform period (1991-2024), respectively (World Bank, 2026d). Both figures demonstrate a consistent decline in the Infant Mortality Rate during both the long historical period and the post-reform period, marking a significant achievement in the health sector of post-independence India.

Figure 5 illustrates a substantial decrease in the IMR in the country from approximately 150.4 per 1000 live births in 1960 to approximately 82.5 per 1000 live births in 1991, reflecting a 45.16% reduction in the IMR during the pre-reform period. Figures 5 and 6 further show a decline in the IMR of the country from approximately 82.5 per 1000 live births in 1991 to 23.3 per 1000 live births in 2024, indicating a dramatic 71.76% reduction in the IMR. The trend analyses in the above figures suggest an accelerated decline in the IMR during the post-reform period compared to the pre-reform period. This observation is consistent with the findings of Prinja et al. (2021), who reported a significant decline in India's IMR between 1991 and 2016, with an accelerated reduction following the implementation of the National Rural Health Mission. According to Prinja et al. (2021), this mission, which was later expanded into the National Health Mission, strengthened primary healthcare delivery and maternal and child healthcare services in rural and previously underserved areas of the country.

Despite the substantial reduction in the country's IMR to 23.3 per 1000 live births by 2024, it remains significantly higher than the averages of upper-middle-income countries and falls short of achieving the Sustainable Development Goal (SDG) 3.2 target of reducing neonatal mortality to less than 12 per 1000 live births and under-five mortality to fewer than 25 per 1000 live births by 2030 (United Nations, 2015). This underscores the necessity for further reductions in the IMR and highlights the importance of adopting and implementing policies to achieve this goal.




Source: World Bank Open Data (World Bank, 2026e)

Figure 7 illustrates the trend in the Maternal Mortality Ratio (MMR) in India, defined as the number of women who die from pregnancy-related causes while pregnant or within 42 days of pregnancy termination per 100,000 live births in every given year over an extended historical period, primarily the post-reform era (1985-2023). The analysis utilises data from the World Bank (2024e), estimated through a regression model

incorporating variables such as the proportion of maternal deaths among non-AIDS deaths in women aged 15-49, fertility rates, the presence of birth attendants, and GDP measured using purchasing power parities (PPPs), using data sourced from the World Health Organization (WHO), United Nations Children's Emergency Fund (UNICEF), UN Population Fund (UNFPA), and the World Bank.

Trend analysis indicates a consistent decline in India's Maternal Mortality Ratio (MMR) during this period, with a notable reduction during the post-reform period. The country's MMR which was initially 658 per 100,000 live births in 1985, decreased to 498 per 100,000 live births in 1991 at the beginning of the post-reform period. This declined sharply to 101 per 100,000 live births by 2020, towards the end of the study period, and further to 80 per 100,000 live births by 2023, the end of the study period. Thus, the MMR of the country witnessed a remarkable reduction of 83.94% in the post-reform period (1991-2023). This decline is attributable to improvements in various facets, such as institutional delivery rates, antenatal care coverage, skilled birth attendance, nutrition, and healthcare infrastructure. The progress in these facets was facilitated by increased investment in healthcare and public health facilities, alongside flagship policy programmes of the government, such as the National Health Mission and Pradhan Mantri Surakshit Matritva Abhiyan. Additionally, there was an enhancement in public awareness regarding maternal health and prenatal and neonatal care. However, similar to the IMR, an upward spike in MMR was observed during the period 2020-2021, attributed to the disruptions in essential maternal health services due to the COVID-19 pandemic. This upward spike diminished soon after the pandemic's containment, with the MMR in the country recovering and improving in subsequent years.

Despite significant improvements in MMR during the post-reform period, India recorded the second-highest number of maternal deaths globally, after Nigeria, in 2023. This underscores that, despite a declining MMR, the absolute number of maternal deaths remains substantial in India because of the country's large population (WHO et al., 2025). Furthermore, significant inter-state disparities in MMR also persist in India, with states such as Kerala and Tamil Nadu achieving remarkable MMR levels comparable to even upper-middle-income countries, whereas states such as Uttar Pradesh, Bihar, Assam, and Madhya Pradesh lag behind the well-performing states, reporting MMR values that are multiple times the national MMR average. These disparities highlight the structural inequalities in health infrastructure, public awareness, female literacy, and socioeconomic development across states (Drèze & Sen, 2013; OECD, 2015). Even states like Kerala, that are relatively advanced in terms of health infrastructure within the country experience disparities in health infrastructure at the intra-state level (Anas & Natarajamurthy, 2025). The findings on the substantial absolute number of maternal deaths and significant inter-state disparities emphasise that, although the MMR of the country as a national average may be on a consistent decline, the decline alone is insufficient. It is imperative that policy attention and administrative efforts focus on further reducing the MMR in the country, particularly in states lagging behind the national average.

Despite these improvements, India's health system is marked by persistently low public expenditure, a substantial and largely unregulated private sector, regional disparities, and the ongoing prevalence of various infectious and non-communicable diseases (Mor, 2018). In 2018-19, out-of-pocket (OOP) health expenditure constituted approximately 48% of total health spending, thereby exposing households to catastrophic health expenditures and significantly contributing to impoverishment (National Health Systems Resource Centre, 2019). It is estimated that approximately 7% of Indian households fall below the poverty line every year due to health shocks and the high incidence of out-of-pocket (OOP) health expenditure (Mor, 2018). This indicates that, although considerable progress has been achieved in India's health sector during the post-reform period, numerous aspects of health and healthcare quality in the country still necessitate substantial improvements and the implementation of appropriate policy interventions and initiatives.

**Other Major Dimensions of Social Development**

Social development encompasses various dimensions beyond education and health, including gender equality and women's empowerment, social inclusion, the elimination of discrimination, and social protection and welfare. This section provides a concise review of the country's performance in these dimensions based on the findings of existing research studies.

The dimensions of gender equality and women's empowerment in India's social development during the post-reform era present a complex picture. India ranks low within its income peer group on both the Gender Development Index (GDI) and the Gender Inequality Index (GII) (UNDP, 2022). Despite significant economic growth and expansion during the post-reform period, the Female Labour Force Participation Rate (LFPR) in India did not increase proportionately and even declined for a substantial part of this period. This decline in the LFPR is attributable to factors such as rising household income, which allows withdrawal from low-quality employment, social norms constraining mobility, and structural barriers such as inadequate public transport and childcare (Klasen and Pieters, 2015). The sex ratio at birth and the prevalence of gender-based violence also remains significant challenges (Ghai, 2018).

Challenges pertaining to social inclusion and the elimination of discrimination have persisted in India, particularly in the form of caste-based exclusion, which operates through occupational restrictions, untouchability, educational depreciation and political marginalisation (Bhalla & Lapeyre, 1997). Caste-based social exclusion has continued in the country even during the post-reform period, affecting the educational attainment, occupational outcomes, and asset ownership of Dalits and Adivasis. Caste-mediated exclusion is evident even in the rapidly expanding private sector, which largely remains outside the scope of constitutional reservations (Deshpande 2011). Caste discrimination is also prevalent in urban labour markets (Thorat and Newman, 2010).

Scheduled Castes and Scheduled Tribes consistently achieve lower human development outcomes across nearly all dimensions. National Sample Survey (NSS) data consistently indicate that SC and ST households experience lower per capita consumption, higher poverty rates, lower educational attainment, poorer health outcomes, and more limited access to formal employment than the non-SC/ST population, even after controlling for income (Hnatkovska, 2013).

**Welfare Expenditure and Social Protection in India in the post-reform period**

The 1991 economic reforms marked a significant transformation in the scale, pattern, and composition of India's welfare expenditure. Prior to the 1991 economic reforms, the government's welfare programmes were primarily concentrated on rural development, poverty alleviation, and employment generation schemes, aligning with the prevailing development paradigm of the period and the fiscal constraints of the country (Drèze & Sen, 1995). During the pre-reform period, fiscal space was limited for both the central and state governments due to relatively low tax revenues and the absorption of a significant portion of public expenditure by government operations and loss-making Public Sector Undertakings (PSUs) (Ahluwalia, 2002). Following the 1991 economic reforms, the government's fiscal autonomy increased significantly, driven by higher tax revenues and reduced fiscal burden through disinvestment in PSUs and overall fiscal consolidation (Ahluwalia, 2002; Kotwal et al., 2011). The expansion of the government's fiscal space in the post-reform period was accompanied by the diversification of welfare policy at both the central and state levels. This diversification led to the introduction of various schemes aimed at achieving multidimensional human development goals, in addition to the existing poverty reduction and rural development programmes.

The post-reform period also witnessed a significant increase in both the number of welfare schemes and the overall welfare expenditure at the central and state levels (Drèze and Khera, 2017). Despite this expansion, India's public expenditure on health and education as a proportion of GDP has remained below international standards, even during the post-reform period (Drèze and Sen, 2013). The combined central and state government expenditure on education increased from approximately 3% of GDP in 1991 to a peak of approximately 4.4% in 2014-15, before experiencing a modest decline thereafter (Ministry of Finance, 2022). Consequently, India's public expenditure on education as a percentage of GDP has remained between 3% and 5% during the post-reform period, failing to meet the target of 6% of the country's GDP on education, as initially recommended by the Kothari Commission in 1966 and reiterated in both the National Policy of Education (1968, 1986) and the National Education Policy 2020 (Ministry of Education, 2020; World Bank, 2024). The country's public expenditure has lagged behind international standards. Although the combined central and state government health expenditure was approximately 1.4% of the country's GDP between 2017-18 and 2019-20, it fell significantly short of the public expenditure on health target stipulated to be 2.5% of the country's GDP by the National Health Policy, 2017 (PRS Legislative Research, 2025; Ministry of Health and Family Welfare, 2017). This persistent underinvestment in education and health has been identified as the most significant structural failure in post-reform India's development. Substantial progress in the social, economic, and human development of the country can only be achieved through significantly higher levels of public expenditure on education and health, as the private sector cannot adequately substitute the public sector in providing these services (Drèze & Sen, 2013).

The Indian government has attempted to address underinvestment at various points during the post-reform period. Initiatives to improve public expenditure on education and health were significantly accelerated by the Indian government with the advent of the 21st century, marked by the launch of the Sarva Shiksha Abhiyan in 2001-02, and the National Rural Health Mission in 2005, and the enactment of the Right of Children to Free and Compulsory Education Act, 2009 (Ministry of Human Resource Development, 2007; Government of India, 2009). Successive governments at the central and state levels have also initiated and expanded various welfare programmes in food security, employment guarantee, and rural livelihoods in the post-2000 period.

Social protection, as defined by the United Nations Research Institute for Social Development, is a fundamental component of social policy concerned with preventing, managing, and overcoming situations that adversely affect people's well-being (Piachaud, 2013). It includes social insurance, social assistance, and labour market programmes, forming the institutional framework through which the Indian government operationalises its welfare and social development commitments. Social Protection programmes are designed to protect the welfare of society's most vulnerable members and address social and economic injustices faced by marginalised individuals, thereby enhancing their resilience to socio-economic shocks (Agarwal, 2023). India's social

protection system is primarily structured as a scheme-based public provisioning system rather than a unified, insurance-based social security structure. It consists of various central and state government schemes implemented within their respective jurisdictions rather than an integrated framework. The post-reform era has seen a significant increase in the number and allocation of central and state social protection schemes, facilitated by rising tax and non-tax revenues (Drèze & Khera, 2017). Nevertheless, India's social protection expenditure (excluding health) remains at approximately 5% of GDP, which is considerably lower than the global average of 13% (International Labour Organization 2025).

## IV. Discussion

The study subsequently investigates social development in post-reform India, with particular emphasis on two dimensions of social development: education and health. Regarding education, the study finds significant improvements in India during the post-reform period, particularly in literacy rate and primary school Gross Enrolment Ratio (GER), analysed in the study. The findings indicate that the country performed better on these indicators during the post-reform period than during the pre-reform period. This improvement is closely linked to government initiatives such as the Sarva Shiksha Abhiyan, launched in 2001-02 (Ministry of Human Resource Development,2007; Nasrin et al.,2023) and the Right of Children to Free and Compulsory Education Act, 2009 (Government of India, 2009). Despite these significant gains, the study acknowledges that significant challenges remain, as nearly one-fifth of the country's adult population, representing millions of individuals, remains illiterate. Additionally, a country's GER indicates either high system capacity or substantial internal inefficiencies, such as grade repetition or delayed entry into the schooling system (UNESCO Institute for Statistics, 2012; World Bank, 2026b). The study also documents findings from existing research that point to quality deficits in learning and pedagogy within the Indian schooling system (Kingdon, 2007; Drèze & Sen, 2013; ASER Centre, 2024). In terms of health, the study identifies substantial, yet insufficient and incomplete, improvements in life expectancy at birth, infant mortality, and maternal mortality during the post-reform period. These improvements are attributed to the combined effects of economic growth and targeted public health programmes, such as the National Rural Health Mission (Ministry of Health and Family Welfare, 2005; Prinja et al., 2021). However, similar to education, the overall gains in health in India during the post-reform period conceal significant regional disparities, shortfalls in public health expenditure relative to international and domestic policy standards, and persistent lags in achievements compared to similar developing economies (Drèze & Sen, 2013; OECD, 2015; World Health Organization et al., 2023).

Finally, this study reviews various existing studies to highlight the welfare expenditure and social protection initiatives undertaken by the central and state governments in the post-reform period. This review finds that the scale, pattern, and composition of welfare expenditure and social protection have expanded significantly in India since the 1991 economic reforms (Drèze and Khera, 2017; International Labour Organisation, 2025).

In summary, the findings of this study suggest that India's economic trajectory since the 1991 economic reforms has been marked by improving, but underperforming, social development. These characteristics of the post-reform Indian economy have significant implications for formulating future social and economic policies in India.

## V. Conclusion

This study provides an empirical analysis of India's economic and social development performance following the economic reforms of 1991. It examines conventional GDP-based indicators of economic performance, trends in economic inequality, and the key dimensions of social development. Additionally, although social development vis-à-vis education and health has progressed considerably during the post-reform period, substantial improvements are still required in these areas. This study highlights the necessity of sustained and focused policy attention on the social development aspects of India's economic growth. The recommended policy measures include progressive taxation, legislative interventions, and increased public expenditure on education and health (aligning with international standards), prioritising qualitative aspects of social development alongside improvements in quantitative coverage. This study has some limitations. First, it is descriptive and trend-based, relying on secondary and aggregated national data. The study could not been able to establish definitive causal links between the 1991 economic reforms and documented trends, as no econometric or causal inference techniques were used. The use of aggregate national data may also cover regional, spatial, and intersectional heterogeneities. Hence, future research should use disaggregated regional data and econometric tools to assess causal relationships.

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