

India Governance Report 2012



INDIAN INSTITUTE OF
PUBLIC ADMINISTRATION



India Governance Report 2012

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Towards Negotiating Paradoxes and Diversities



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PART-III: Reinterpreting Governance

N.C. Saxena, T. K. Oommen, Jagdeep S. Chhokar

FOREWORD

Over the past six decades the Indian Institute of Public administration (IIPA) has advocated the essence of good governance through its research, skill development and support services, covering most aspects of public administration. The IIPA journals and other publications have made important contributions to the existing storehouse of knowledge and experience, in exploring the frontiers of this multi-layered subject of public administration. The efforts made in preparing and presenting the India Governance Report 2012 can be seen in that light.

It is well known that between mal-administered democracy and well governed authoritarian regimes, there are various alternatives. Ethically grounded, subjecting itself to democratic accountability, placing transparency as a central principle in decision making and encouraging participation of all stakeholders are some of the noted attributes of governance adopted by IIPA. In our opinion, the dividing line between ‘Government’ and ‘Governance’ is drawn with these defining features. The difference becomes clearer once the state in all humility recognizes its limitations and agrees to share its responsibilities with non-state actors – Civil Society, Media and the market – creating respective space for each to function in a mature partnership, keeping the good of the citizen as the main focus.

The term ‘Good Governance’ otherwise has been described variously from the very beginning when the World Bank coined it nearly a quarter to century ago. Subsequently, several international donor agencies followed suit with their respective configurations and interpretations. Not surprisingly, scholars have remained divided on its definition, purpose and goal. It is seen as a means for performing clearly defined roles and functions of governmental organizations and making sure that the citizens receive value for their money paid in the form of both direct and indirect taxes. It is also understood as an honest and rigorous attempt towards reinventing government by taking informed, transparent decisions and managing risks while responding to citizens’ requirements. It also means developing the capacity of the numerous governmental bodies to be efficient and discharge their functions effectively. It is a measure to strike a balance not only between various arms of the government but also amongst all stakeholders and governmental organizations. The thrust remains on improving service delivery in open, transparent manner through multilevel consultations and participation. In sum, what was traditionally known as the governmental function and responsibility is no longer its monopoly. There are others, aptly termed as non-state actors, to take charge of some of those responsibilities.

How do we measure good governance? Are there success indicators? Ranking states on the basis of good governance indicators becomes problematic in a diverse society and polity such as India. Uniform indicators may not suit cultural, social, religious and political mores. Reflecting the vast diversity of Indian society and culture, differences are noticeable even in the functioning of the Union Ministries and State Ministries and among various Ministries of the Government of India (GoI). The performance level could even be varying among the departments placed in the same Union Ministry. Even the functioning of field offices of the same department

could be different from one state to another. Likewise, performance of bureaucracy cannot be measured with a single yardstick. Performance appraisal of individual officials within a chain of command, say, from a Delhi based Mantralaya to the remotest village, is again not easy. One official's indiscretion or incompetence can affect service delivery to the citizens adversely and good performance of a majority of officials can get hidden by the failures of one. This is true of government sectors, departments, Ministries and administrative units, all set up to service the citizen.

Acknowledging these issues, this report has tried to examine the applicability of the good governance theme by looking at the performance of several ministries of Government of India as well as state governments with special reference to the health sector.

Dr. Girish Kumar and his team deserve credit for bringing out this volume. I remain grateful for the contributions of Dr. N.C. Saxena, Prof. T.K. Oommen and Prof. Jagdeep S. Chhokar in the writing of this report. I hope, the recommendations will encourage questions, answers and discussions towards continuing reforms.

Dr. Tishya Chatterjee
Director
Indian Institute of Public Administration

PREFACE AND ACKNOWLEDGEMENTS

The idea of bringing out India Governance Report started germinating when the Institute was celebrating Golden Jubilee of its physical existence. Several programmes befitting the occasion it conducted and special publications it brought out, including an occasional paper on the Good Governance would testify to this fact. By then the very term Governance had already acquired a respectable place for itself in the domain of academic discourse as well as in administrative parlance. It was quite logical then to think of designing an Annual Report on Governance. The aim was modest but what was holding it back was the dearth of required financial resources. That the IIPA is the creation of the Department of Personnel and Training (DOPT) is well known and the bonding between the two, over the decades, has by and large remained intact. Yet in the post-reform era, the DOPT had gradually reduced its grant to the institute. In order to meet the shortfall, the IIPA faculty had already begun augmenting resources by running additional training programmes and consultancy services. Notwithstanding this fact, the proposal for financial support to work on this report was not only accepted rather generously supported by the DOPT. Treating it as a major marker after half a century of this institute, the DOPT extended open-handed support so that IIPA could reinvent itself by launching new products, in the form of training programmes and publications, including this report.

Once it was agreed upon, the thinking began on its contour and design. A brief outline of the contents of the proposed work had already been submitted to the DOPT when it had finally agreed to sponsor it. That in itself was enough but being suggestive in nature it was not focussed rather it was vast. Thus, enough time was spent on choosing the theme that would be the focus of the report. A service sector was to be picked up; after all, improving the service delivery is the stated objective of the governance frame. But which service sector? Eventually, we zeroed down to health sector. The National Rural Health Mission (NRHM) was alluring as an appropriate backdrop since major components of the Governance – accountability, transparency, participation, role of (non-state actors) NGOs, market – were all embedded in this an on-going flagship programme of the Union Government.

True, it was agreed upon that the data would be culled from secondary sources, that is, from already published sources. Implicit in this understanding was that information was already available in the public domain therefore what was required was just to collect, collate and rearrange them in a suitable format. It seemed easy; at least that is what the progenitors of the project had thought of, but when the work began it turned out to be no less than a proverbial herculean task.

One can never be sure to get data on a set of indicators for all the states and UTs of a given year. This is precisely what, as coordinator and the principal author of the report, I had to endure for months together. Initially, when the data collection was under progress and also when I was immersed in making sense of those collected facts and figures and trying to give shape to this report. The task had become all the more harrowing when search for comparable dataset of two reference years, somewhat akin to two decennial censuses, was

on. Anybody who has handled large dataset would surely testify the rigour and accompanying ache one had to undergo to meet the ideals.

Taken all these constraints together, it took too much time, much more than what was anticipated. We had drawn sustenance out of the old axiom: while engaged in making a new product, have patience; a new venture inevitably takes time. This is precisely what has happened with this latest product of the IIPA.

Apparently, the project as a whole has passed through various phases and it has benefited, directly or indirectly, from the support and wisdom of many faculty colleagues, senior administrative and support staff. It was conceptualised with the active support of Sri B. S. Baswan, former Director of IIPA, who was singlehandedly instrumental in raising resources from the DOPT. As a thorough liberal administrator and facilitator of enabling environment for creative work, he gave the undersigned a free hand to design the report and its contents. With his deep academic persuasion and engagement, his successor late Dr. Rakesh Hooja remained thoroughly involved when the report writing was in progress. It was indeed on his suggestion that a three part report structure was finalised with the last part, as he envisaged, carrying three papers that could stimulate fresh thinking on the subject. Dr. Hooja's administrative expertise was also a great help in clearing roadblocks on the way. Sadly, he passed away before the report could take its final shape.

Eventually, the report has seen the light of the day when IIPA has found a new Director. Indeed, when Dr. T. Chatterjee took over as the new incumbent, the final draft was at the last lap of revision. With astute blending of his academic interest and administrative deftness, he quickly grasped the configuration and scope of the project at hand and expressed his eagerness to take this to its logical conclusion. As the principal author and coordinator of this huge enterprise, I am deeply indebted to all the three successive Directors and Shri T.N. Chaturvedi, Chairman IIPA for their guidance and affable support.

I am equally grateful to Prof Pranab Banerji and Prof Nand Dhameja, both old hands at the IIPA who along with Sri Baswan had done the spadework for the proposed new vision of IIPA and had ably negotiated support from the DOPT. They had visualised that by virtue of its prolonged engagements with data collection for innumerable research programmes undertaken over the last several decades, IIPA was 'in a position to provide a warehousing facility in a researched, catalogued and indexed manner serving as a one stop source for the large number of data spread across various departments/ organizations.' In continuation, they had proposed a data base on various aspects of governance for the entire country could be developed and an annual report could be brought out.

Thus credit goes to them for laying the design of the Governance Resource Centre, as an anchor for the annual report, within the folds of the IIPA. It had begun with the four faculty / staff of the IIPA: Professor Rakesh Gupta, Professor Suresh Misra, Shri Sunil Dutt, Assistant Editor of the Indian Journal of Public Administration (IJPA) and the undersigned as its coordinator. I am earnestly beholden to them for their unflinching support as also for reposing faith in me in handling this task, both academically and administratively; to Shri Dutt and Shri Anil Gupta all the more, for providing an attractive (page) making and colourful printing of the report.

The report in its present form is the outcome of collective endeavour of a team comprising Shri Saikat Banerji, Dr. Md Gaffar, Ms. Swati Das and Ms. Parma Devi Adhikari. All these young scholars worked full time (except Shri Saikat Banerji who formally worked on part time basis, but his continued association with this project was immensely helpful) and ably assisted me in drafting and redrafting the report. In addition to them a large number of research scholars largely from the Jawaharlal Nehru University (JNU) and the Delhi School of Economics (DSE) were involved in collecting data on a plethora of Governance indicators. They are: Shri Tapabrata Parakshi, Shri Chitrasen Gautam, Ms. Suravi Kar Roy, Shri Neeraj Kumar, Shri Sumit Hawladar, Shri Joy Chakravarty, Shri Shamindra Nath Roy, Shri Pilu Chandra Das, Shri Jaydeep Saha and Shri Arijit Das. Shri

Protap Mukherjee deserves special mentioning for rigorously constructing a new index for measuring state-wise corruption and explaining them. My sincere thanks are due to each one of them for their diligent assistance.

Part- III of the report contains three papers, authored by Dr. N.C. Saxena (formerly Secretary, Planning Commission, Government of India and Director, LBS National Academy of Administration, Mussoorie), Prof T.K. Oommen (Emeritus Professor of Sociology, JNU, New Delhi) and Prof Jagdeep S. Chhokar (Formerly Dean and Acting Director, IIM, Ahmedabad). I am enormously indebted to each one of them for gracefully honouring my request and making scholarly contribution to this volume.

Several scholars were involved in many ways in making of the report. Some of them were involved at the initial stage of conceptualization, whereas many extended help in discussing the initial configuration of index and the report design. Yet another group, though a small one, was always by side in overcoming crisis like situation. The draft report, in parts, some chapters and even sections were read and commented upon by a very large number of academia, including friends, colleagues and well wishers. Naming each one of them who somehow or the other contributed in making of the report, would not be possible but a few names deserve special mentioning: Prof. Kuldeep Mathur (founder Chairperson, Centre for Law and Governance, JNU), and his remote successor, Prof. Amita Singh (JNU), Dr. Ajay Mehra (Director, Centre for Public Affairs, New Delhi), Shri S.S. Meenakshisundaram (Retd. IAS), Shri B.D. Ghosh (ISS, Kolkata) Prof. P.K. Chaube (IIPA) and Prof Biswajit Das (Centre for Media Studies, JMI, New Delhi). Some of these scholars had earlier significantly contributed towards a better grasp of the theme through their deliberations in a national workshop organised for the stated purpose. I pay my sincere gratitude to all of them. Above all, I am especially most grateful to three of my colleagues: Professor(s) Aasha Kapur Mehta, Dolly Arora and Pranab Banerji who went through the draft report which I presented before the entire faculty of the institute. Their incisive comments were exceedingly valuable in finalising the report. I also wish to put on record the remarkable support we received from the documentation section and library, most notably from our librarian Dr. Usha Mujoo Munshi. My sincere thanks to her and her team. Last but not the least, I am most thankful to the administrative and accounts section of the IIPA for their support.

December 12, 2012

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1. HDI Calculation
2. Corruption Index

THE IDEA OF GOVERNANCE

Ideas are not only important for themselves but also for explaining and interpreting social behaviour. Ruling ideas are those by which people and governments are guided. What men believe about the power of the market or the danger of the state has a bearing on the laws they enact or do not – enact – on what they ask of the government or entrust to market forces.

*Galbraith, J. K.
(On Age of Uncertainty: 1979)*

As a new term ‘Governance’ descended on the Indian political landscape a little over two decades ago, though it was initially confined to the precincts of hallowed academia and editorial musings of periodicals. Slowly but steadily, it began moving out of the cosseted walls of elites to the seminars, conferences frequented also by the ordinary, lesser mortals, eventually, becoming part of the general discourse in the country. Like other encumbered terms, such as civil society, empowerment, participation, etc., governance had also originated in the West but precisely against the African backdrop. The progenitor of course was the World Bank (WB) which is given credit for devising it, and rightly so, but also for presenting it as a model that could provide cure to all the entrenched politico-economic maladies of developing countries as a whole. Not to

be left behind, the other international lending and development agencies not only followed the WB’s trail but also prescribed their own models, slightly modified versions of the original prescription.

Broadly speaking, the concept of governance essentially illustrates the changes that occurred in the role and nature of the State in the era of post public sector reforms of 1980s / 1990s witnessed primarily during Margret Thatcher led Britain and in the USA under Ronald Reagan. In fact, “this development like parallel events in the world of work was neither unplanned nor unintended. It was a product of two strands of thinking... of Thatcherism and Reaganism.... One strand of argument had to do with efficiency and accountability.... The second argument... had to do with the reestablishment of

the notion that market is an institution that makes use of resources and skills with some degree of proficiency” (Chandhoke, 2003: 2961). These reforms heralded a shift from ‘hierarchical bureaucracy towards a greater use of markets, quasi-markets and networks, especially in the delivery of public services. The reforms themselves were triggered by a spurt in ‘transnational economic activity’ and the rise of supranational institution like the European Union that emphatically underlined the dependence of hitherto all powerful State on other organisations. In fact, following the growth of neoliberal ideology in the west which placed premium to non-State actors in delivery of goods and services, the State was made to create networks with other stakeholders, forge partnership with non-elected institutions in policy formulation and also to find ways and means to hold these new actors accountable. In any case, in neoliberal scheme of things, State doesn’t have a paramount role rather some of them prefer to rechristen State by any other entrepreneurial pattern of rule they favour. Governance offers them such a concept’ (Bevir, 2009: 4).

Taken together, the very idea of ‘governance’, prefixed with a qualifying adjective ‘good’, twisted the confusion created after the fall of the Berlin wall, along with the coming of a dozen independent republics following the collapse of the then Soviet Union. Innocuously implying, ‘efficient management of the collective resources of the State to optimise the common good’, it seemed like a clarion call for the retreat, if not the total withdrawal of the State *per se*. By mid-1990s however, it had already given birth to voluminous literature on this subject. Having examined this idea both at the macro and micro level, using both the telescope and microscope, the over enthusiasts interpreted it as the only or perhaps the last remedy to take the poor, underdeveloped and developing countries of the South out of the morass they had slipped into their post-independence journey towards progress.

It was coined for the first time by the World Bank in its report on Sub-Saharan Africa way back in 1989, as the W.B argued, ‘Underlying the litany of Africa’s development problems is a crisis of governance. By governance is meant the exercise of political power to

manage a nation’s affairs.’¹ The context was ineffective role of the State institutions in implementations of structural adjustments programmes, which the Bank attributed to a ‘crisis of governance’. This in turn was largely due to, as the Bank observed, pervasive effect of thoroughly incompetent government institutions embroiled in massive corruption. The Bank’s initial prescription was geared towards improving the administrative and managerial capabilities of the State which was perceived largely as a technical solution. From offering a mere technical solution to cure the governmental maladies to redefining the role of the State, the Bank took a big stride in 1992 with its World Development Report. The message was clear that the State should restrict itself to the task of investing and managing basic physical and social infrastructure. For the rest, it should ‘encourage the free and fair play of the market forces in an impartial, open and accountable manner’ (Mathur 2008: 2-3).

The new role of the State indeed heralded switching over from government to governance. This shift however was rooted in the neo-liberal ideology at work in the realms of public policy prevailing in the Western countries in 1970s. Then many of the Western countries themselves had also slipped into crisis mode following the imbalances created on account of welfare programmes and cost of bureaucracy to implement them. A search for alternative strategy to overcome the crisis dictated them to cut in social spending on the one hand and encourage dependency on the market to provide public goods and services on the other. Thus, what was in effect akin to privatization and liberalization, was touted as new apparel of effective government. In this process of churning, however, it emerged that even such policies to work a strong, capable State is required to regulate them. With this realisation, it was also felt that a strong State cannot function without bureaucracy but in different incarnation- the one which is not only competent or effective but also accountable and transparent, which could also encourage supervision of the people in discharge of its functions. The Governance thus acquired the sanctity of mantra to be chanted without examining what it did entail or what were its implications.

¹As quoted by Leftwich in *Sates of Development*; see, chapter five, p 104 also World Bank, 1989:60.

The Concept

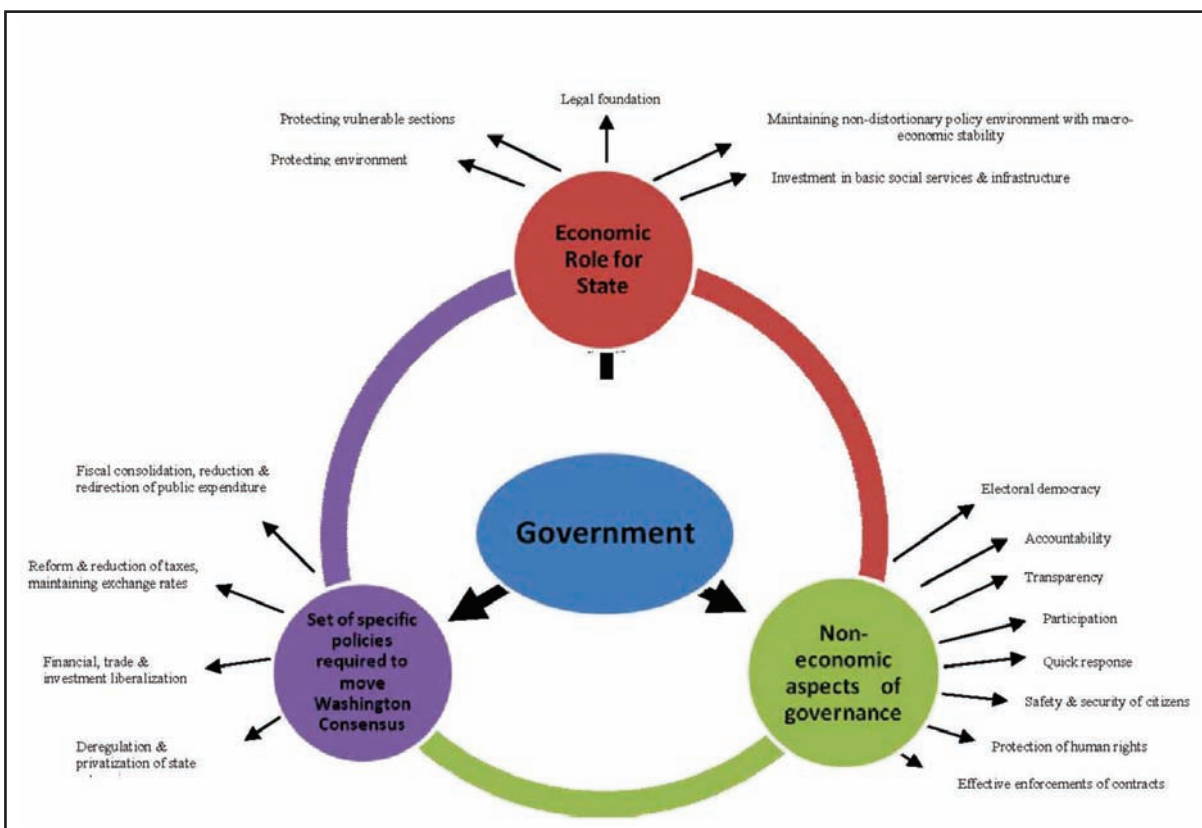
Sounding almost similar to the most familiar ‘government’, the governance as a concept is all encompassing covering practically the entire scope of the government and society. This includes, besides known arms of the government – executive, legislature & judiciary – private sector, NGOs & cooperatives, registered trusts & foundations, media, trade unions, user groups, people’s collectives etc. (see Fig. 1.1). Not only its canvas is bigger than the traditional government but it also has ‘ethical grounding’. It is also an attempt to delve deep into the functioning of any of the stated components/ segments of society from the vantage point of all concerned, including ‘acknowledged stakeholders, beneficiaries and customers’ (Godbole 2001: 2).

In the World Bank prescribed model ‘governance’ had figured out distinct from ‘government’ which is driven by the three factors, namely: (a) the form of political regime; (b) the process by which authority is exercised; and (c) the capacity of the government to design, formulate, implement policies and discharge functions.

Needless to say, these two nearly similar sounding terms - government and governance - are not synonymous; rather the latter has come into vogue following the failure of the former in areas of its core functions, i.e. delivering goods and services to the people. In fact, the very use of the term ‘governance’ recognizes the existence of two non-governmental actors in the realm of service delivery. They are: (a) private sector, (b) NGOs and civil society. What is implied here is not the replacement of the (old) government (*sarkar*), the familiar, somewhat ubiquitous, though not seen when required, institution by governance (a relatively new concept, the implications of which have not yet been fully grasped), nor the withdrawal of the government either. In plain terms, it simply means the sharing of functional responsibilities between the above mentioned stakeholders, including the government. Indeed the government remains at the centre of the governance model.

The notion of ‘good governance’ has been an essential part of millennium development goal of

Fig 1.1 : World Bank concept of Governance



UNDP. Governance is good when state is efficiently providing all necessary public goods with desired quality. Therefore, states should be assessed on both the quality and the quantity of public goods provided to citizens” (Rotberg, 2004-05).² The Human Development Report issued in 2002 insists on “good” governance as a democratic exigency, in order to “[rid] societies of corruption, [give] people the rights, the means and the capacity to participate in the decisions that affect their life and holds their government accountable for what they do” (Nzongola-Ntalaja, 2002).³ In practice it should fulfill “the need of the most vulnerable people” (Cheema, 2005)

The UNDP views ‘good governance’ as participatory, transparent, accountable which includes state institutions with private sectors and civil society organization (See Box 1.1). UNDP Human Development Report (2002) elaborated the concept of ‘democratic governance’ with the central objective of promoting political freedom, ensuring human rights and removal of discrimination, which would ultimately promote human development. Good governance with democracy or ‘democratic good governance’ refers generally to political regime

with liberal democratic polity which protects human and civil rights with non-corrupt and accountable public administration (Chalker,1991).⁴

For Rhodes, “Implicit in the idea of governance is efficient and effective management of the collective resources of any given country for its common good. The term ‘Governance’ is popular but imprecise. It has at the least six use, referring to: the minimal state; corporate governance; the new public management; ‘good governance’; socio-cybernetic systems; and self-organising networks. I stipulate that governance refers to ‘self-organising, international networks” (Rhodes, 1996). In the empirical fronts the pioneering attempt of cross-country comparisons of almost 178 countries on various aspects of governance was made by Kaufman, Kraay and Zoido (KKZ, 1999). The study selected six aspects of governance, namely, voice and accountability, political instability and violence, government effectiveness, regulatory burden, a cluster of rule of law and graft. In another attempt Huther and Shah (2005) constructed governance quality index of 80 countries composed of four dimensions: ensure political transparency and voice for all citizens, provide efficient and effective

Box 1.1 : Principles of Good Governance under UNDP framework

Legitimacy & Voice	Participation : all men and women should have a voice in decision-making
	Consensus Orientation : to reach a broad consensus on what is in the best interest of the group
Direction	Strategic Vision : to have a long-term perspective on good governance and human development, along with understanding of the perspective grounded in historical, cultural and social complexities.
Performance	Responsiveness : institutions and processes try to serve all stakeholders.
	Effectiveness and Efficiency : processes and institutions produce results that meet needs while making the best use of resources.
Accountability	Accountability : decision makers are accountable to the public, as well as to institutional stakeholders.
	Transparency : built on the free flow of information.
Fairness	Equity : all men and women have opportunities to improve or maintain their wellbeing.
	Rule of Law : legal frameworks should be fair and enforced impartially, particularly the laws on human rights.

²As cited in Public Governance Indicators, See, Literature Review, DESA, UN (2007:4)

³Ibid.

⁴As cited in Leftwich, Adrian (1993)

public services, promote the health and well-being of its citizens, create favourable climate for stable economic growth.

The problem however persists, as noted above, due to the lack of conceptual clarity of the new term. Although promoted varyingly by its progenitors

(international development & lending agencies such as UNDP, World Bank etc.), broadly speaking there are certain common elements which are defined from the perspectives of sets of values, norms and processes with emphasis on management and sustainable use of resources (See Box 1.2). Put simply, by switching over to governance, usually a system of delivery and

Box 1.2 : International Organisations' views on Governance

World Bank : Governance is defined as the manner in which power is exercised in the management of a country's economic and social resources. The World bank has identified three distinct aspects of governance: (1) the form of political regime; (2) the process by which authority is exercised in the management of a country's economic and social resources for development; and (3) the capacity of governments to design, formulate, and implement policies and discharge functions.

UNDP : Governance is viewed as the exercise of economic, political, and administrative authority to manage a country's affairs at all levels. It comprises mechanisms, processes, and institutions through which citizens and groups articulate their interests, exercise their legal rights, meet their obligations, and mediate their differences.

OECD : The concept of governance denotes the use of political authority and exercise of control in a society in relation to the management of its resources for social and economic development. This broad definition encompasses the role of public authorities in establishing the environment in which economic operators function and in determining the distribution of benefits as well as the nature of the relationship between the ruler and the ruled.

DFID : The Department for International Development adopts the same approach to governance as that provided by the OECD's Development Assistance Committee (DAC), which identifies four key elements in governance: (1) legitimacy of government (political systems), (2) accountability of political and official elements of government (public administration and financial systems), (3) competence of governments to formulate policies and deliver services (public administration and economic systems, and organizational strengthening). The DFID believes that the DAC conceptualization is seen to reflect the broad degree of convergence in bilateral donor thinking on good governance. Since the good governance agenda has a strong normative content, it has led to calls for an approach more sensitive to the particular historical contextual realities within recipient countries. An additional point is the issue of donor governance, highlighted by many host countries.

ADB : The definition of governance that is adopted by the ADB is that provided by the World Bank. Accordingly, the Bank regards good governance as synonymous with sound development management. It involves both the public and the private sectors. It is related to the effectiveness with which development assistance is used, the impact of development programs and projects (including those financed by the Bank). Thus, irrespective of the precise set of economic policies that find favor with a government, good governance is required to ensure that those policies have their desired effect. In essence, it concerns norms of behavior that help ensure that governments actually deliver to their citizens what they say they will deliver

USAID: Governance encompasses the capacity of the state, the commitment to the public good, the rule of law, the degree of transparency and accountability, the level of popular participation, and the stock of social capital. Without good governance, it is impossible to foster development. No amount of resources transferred or infrastructure built can compensate for-or survive-bad governance

CGC (Commission on Global Governance) : Governance is the sum of the many ways individuals and institutions, public and private, manage their common affairs. It is a continuing process through which conflicting or diverse interests may be accommodated and cooperative action may be taken. It includes formal institutions and regimes empowered to enforce compliance, as well as informal arrangements that people and institutions either have agreed to or perceive to be in their interest.

Institute of Governance, Ottawa : Governance comprises the institutions, processes and conventions in a society, which determine how power is exercised, how important decisions affecting society are made and how various interests are accorded a place in such decisions. (Institute of governance, 2002); Commission on Global Governance: Governance is the sum of the many ways individuals and institutions, public and private

Source: Commission on Global governance 1995; OECD 1995; UNDP 1997b; and World Bank 1994a; <http://www.adb.org/Documents/Manuals/Operations/om54.asp?p=aadb>; USAID, Promoting Democratic Governance, http://www.usaid.gov/fani/overview/overview_governance.htm

regulation is referred to that operates in the ambit of the rule of law with certain desirable attributes. This envisages a system of public governance and delivery mechanism that would be responsive, more efficient and effective, equitable and inclusive, transparent and accountable. The governance system as a whole, it is assumed, would be decentralized and participatory in nature. With these new attributes, it was expected that the old government would be metamorphosed into a worthy one, and by virtue of its centrally located position even in its new incarnation, it would help usher in new era of governance by taking the lead role. Notwithstanding its all professed virtues, the turn and twist ensconced with the concept of governance, embedded with its accompanying jargons, added to the confusion, since some of its attributes had already surfaced with or without the garb of new public management.

Indian Response

The confusion was found further deepening in India. For, the Republic of India had, though perforce, already embarked upon the road to reforms in 1991. Although visioned by Rajiv Gandhi during 80s, it was Narasimha Rao who turned the promises in to policies by introducing decentralization and economic reforms as move towards changing governance scenario. True, initially reform measures were largely confined to the areas of trade, commerce and finance, they had triggered a chain of actions also in other areas. That too led by a government which was not even in majority in the Parliament. Yet, almost in continuation, it had followed the economic reforms with political reforms through the instruments of major amendments to the Constitution (a la 73rd & 74th Amendments) towards the end of 1992. That was a decisive historic step which not only had in-built mechanisms for ensuring accountability, participation at the grassroots level but had also ensured the electoral representation for women as well as *Dalits* and *Tribals* in the decentralised institutions at the third-tier of government.

Against this backdrop, it was hardly surprising therefore that some of the alert Indian scholars (Bandyopadhyay, Guhan Arora, *et al.*) challenged the notion of governance as a panacea. By highlighting the virtuous amendments and their underlying/

embedded components which to them were home grown, Bandyopadhyay (1996) dismissed the idea of Governance⁵ as the one germinated on the foreign soil, not suitable or not required. He was critical of all the components of governance: government both elected leaders and its bureaucratic arm, particularly the Indian bureaucracy, the corporate sector, including transnational corporations as well as NGOs, including the international ones. To him, the idea of good governance calls for “bringing about goodness in all the three sectors: government, civil society and corporate sector including transnational corporation”. But “is it possible?” he raises doubts. And in continuation observes: it is perhaps possible with the government that would entail setting our house in order. Even, if it was achieved, “there is a remote possibility of influencing the activities of the other two sectors.” According to him the problem lies with the over centralization at the top. He further notes “there is far too much power at the centre; a great deal more than necessary in the states and virtually none at the local level where the people are. This disjunction between power and the people is the root of the many ills of this polity” (Bandyopadhyay, 1996:3111). He had felt that we had a sound format of good governance with an “active parliament, independent judiciary and free media... constitutionally guaranteed decentralisation and devolution of power to the third tier of governance... district level and below... but the values which are at the foundation of our republic are under attack through the process of liberalisation”, which was pursued at the behest of the same international lending agencies that had resurrected the idea of governance (Ibid).

Guhan (1998) took on the conceptual frame of this idea by pointing out its inherent weaknesses. Indicting WB for its intransigence, even questioning its credentials in no uncertain words, “in its very essence, governance is a political issue while the WB is not an academy of political philosophers”, Guhan felt that the concept of governance was ‘narrowly

⁵Expressing his strong objection to this term “as is being touted in the recent years by multilateral and bilateral agencies as a part of precondition of aid or as a process of reform as conditions of aid”, he bluntly criticized the Indian elected leaders for “plundering and swindling public funds for private gains.” (see, Bandyopadhyay 1996: 3109).

techno-economic...its paradigmatic state is that whose government is one which not only governs the least but regardless of its character, also one which is administered the best...it was framed around 'state-versus-market' issues in the realm of economic administration"... also that despite its love for 'politics free' or neutral state, its prescriptions are 'as much of politics as economics.'⁶ Guhan was emphatic that even at the ideological level the very thinking of replacing the State with market was fraught with dangers, notwithstanding the failures of the State. He seems to have gone closer to the interpretations of Stoker, a votary of governance but the one who had forcefully defended the centrality of the State in the scheme of Governance. Arora (1998) also found the concept of governance enormously faulty on many counts, including its embedded "insensitivity to diversity of needs, experiences and possibilities." Most importantly, the very scheme of attaching priority to 'good governance' over everything, she found revolting as it was akin to "making a final statement on what societies and States must or must not attempt, which has drastic implications, for it closes the door to all flexibility as well as the new understanding about things" (1998:4).

Notwithstanding initial skepticism based on the line of above arguments, a Government of India convened conference (GOI, November 1996) of the Chief Secretaries made the following recommendations. First of all, it honestly admitted of existing crisis in administration, necessitating administrative reforms, they emphasized, in order 'to make it people-sensitive, efficient and cost effective' and finally, they dittoed the WB proposition by accepting the distinctness of 'governance' from 'government'. In the governance mode, it noted, the government would forge partnership with market and civil society of various hues including media, users group, citizen collectives, local bodies. Six months later (May 1997), all these points were endorsed by the Conference of Chief Ministers, convened again at the GoI behest.

⁶To substantiate his point, Guhan quoted from Charles Lindblom that "aside from the differences between one government and another is degree to which the market replaces government or government replaces market" (Guhan 1998:187).

The first published document on governance, (clubbed with human development) 'Governance for Human Development' was included as a chapter in the Planning Commission published first ever Human Development Report (2001). Stuffed with huge data bank, it gave a long overview of the state-wise quality of life, assessed amidst the backdrop of the state-wise economic development. A recent score card of India's governance covering its economic, political and civil dimensions were also included in this chapter. Above all, the document provided an 'alternative framework' for conceptualising governance. It *inter alia* viewed the governance system as the 'process of intermediation as involving a continuous interplay of (a) institutions⁷ (b) the delivery mechanisms⁸ and (c) the supportive and subordinate framework of rules, procedures and legislation. In short, the alternative frame premises that "efficient governance requires efficient institutions which in turn depend on its adopted delivery mechanism and the supportive frame of rules and procedures, each of which has to work in harmony with the other to discharge the functions and roles for which the institutions have been created." Having put some passing remarks on crisis of civic governance, including delayed justice system on account of hundreds and thousands of pending court cases, along with a pot shot on centrally sponsored schemes etc., the governance chapter is concluded with the agenda ahead (see Box 1.3). Which underscores devolution of power in decentralised frame, followed by an inventory of functions, funds and functionaries devolved to both rural and urban local bodies along with the status of decentralized planning etc. Select governance indicators are also appended with this chapter referred above including sectoral expenditure and performance of state-wise local bodies.

⁷This refers to both formal and informal arrangements either adopted or created for managing any type of transactions in the society.

⁸This includes executive apparatus adopted by the institutions for implementing the agenda.

Box 1.3 : Agenda for National Human Development Report, 2002

➤	Devolution of power to manage local affairs and decentralisation of decision making
➤	Civil service reform aimed at improving transparency, accountability efficiency and sensitivity in public administration at all level
➤	Enforcing incentive/disincentive structures that truly reflect social values and norms
➤	Procedural reforms covering all aspects of government's interface with public; and
➤	Empowerment, particularly of women, the marginal and excluded

Prior to that, at the behest of the BJP driven NDA government, a committee led by a retired Chief of the country's highest court, had also submitted a report proposing comprehensive Constitutional reforms that was more or less akin to rewriting the Constitution itself after half a century of its working. Before making any serious foray in the recommendations of the Constitution review committee, the NDA government was voted out of power. Its successor, the Congress led UPA-I government didn't waste time as soon after coming to power following 2004 general elections, it constituted the Second Administrative Reforms

Commission (ARC, 2005) – nearly four decades after the first ARC report, discussed later in this report. It needs mentioning, however, that in its series of reports, as many as 15 – the second ARC brought out – covering many issues that had also figured as prominent features of governance frame of the World Bank. In continuation, the third published official GOI document on the subject came as a chapter (named just Governance) in the Eleventh five year plan (2007-2012) document (Vol. I: Inclusive Growth, 2007). It begins with a chronology of steps taken during the Tenth plan period (2002-2007, also see Fig. 1.2), given below, 'aimed at improving the quality of governance.' As tenth plan documents express that in India development outcomes of the states do not match with their resource potential. This can be related to the failure of one or more aspects of governance. Thus, the tenth plan vision, "good governance is one of the most crucial factors required if the targets of the tenth to be achieved (Box 1.4)." While, conceptualizing governance, tenth plan document put forward an alternative framework of governance encompassing three factors, namely, institutions, delivery mechanism, supportive and subordinate framework of legislation, rules and procedures. It emphasized that role of government, "can neither completely minimised nor an entirely proactive one."

Fig. 1.2 : Issues and Strategies for Improving Governance



Box 1.4 : Improving Governance Quality (2002-2007)

➤	Made RTI effective in 2005, applicable to governments at all the three levels and non-governmental bodies receiving public funds
➤	Amended All-India service rules by making tenure fixed for certain specified posts.
➤	Introduced value added tax (VAT) regime aimed at simplifying tax structure
➤	Electoral funding reforms introduced, offering tax incentives to donors funding contestants for public offices/ posts
➤	Adopted e-governance plan in order to improve service delivery in 27 major areas
➤	Embedded instruments of participatory governance under entitlement / right based employment (NREGA) and health service delivery (NRHM) flagship programmes
➤	Declared its policy for VOs/ NGOs, reiterating its aim to develop partnership with one of the non-state actors recognised in governance frame
➤	Established a new body - NDMA (National Disaster Management Authority) focussed at better preparation to offer quick & effective response to disasters

Above all the essential features of good governance code prepared by the Department of Administrative Reforms & Public Grievances is illustrated in Figure 1.3.

From the GOI standpoint this is what all has been done following the unfolding of governance mode during the last two decades. Are they different than what the previous governments both at the centre and provincial levels have been doing? Will a simple narrative on details of follow up measures on all these counts be enough to differentiate the functioning of Indian State before and after switching over to governance mode? The answer would be a resounding No. In any case, the purpose of this report is not simply to endorse the stated views of GOI on the subject nor is just to highlight its shortcomings either. This would necessitate underlining the stated objectives of the report and of course its conceptual frame.

Context and the Conceptual frame of the Report

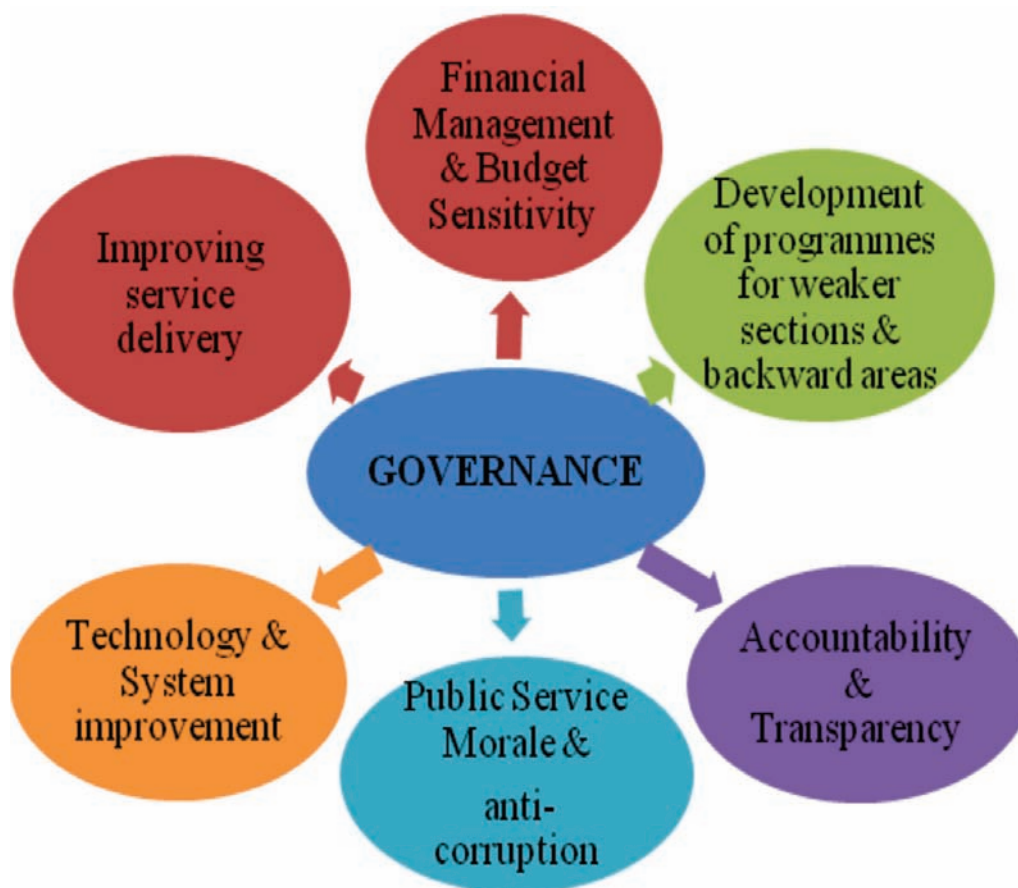
The emergence of governance as a concept is not so old but the amount of debate, laced with controversy it has generated is enormous. But this happens whenever a new idea starts germinating. The general tendency is to reject off hand, the popular refrain would be: what is wrong with the existing one, there is nothing new in what is being proposed; later comes opposition on parts, if not on the whole,

followed by nuanced debates, though sceptics would go on challenging the very utility of any new concept. The tragedy of this new idea is its backdrop and also its neo-liberal ideological moorings. Situated against this milieu, the report is also aimed at addressing the definitional dilemma pertaining to the term 'governance', and its meaning and implications for service delivery.

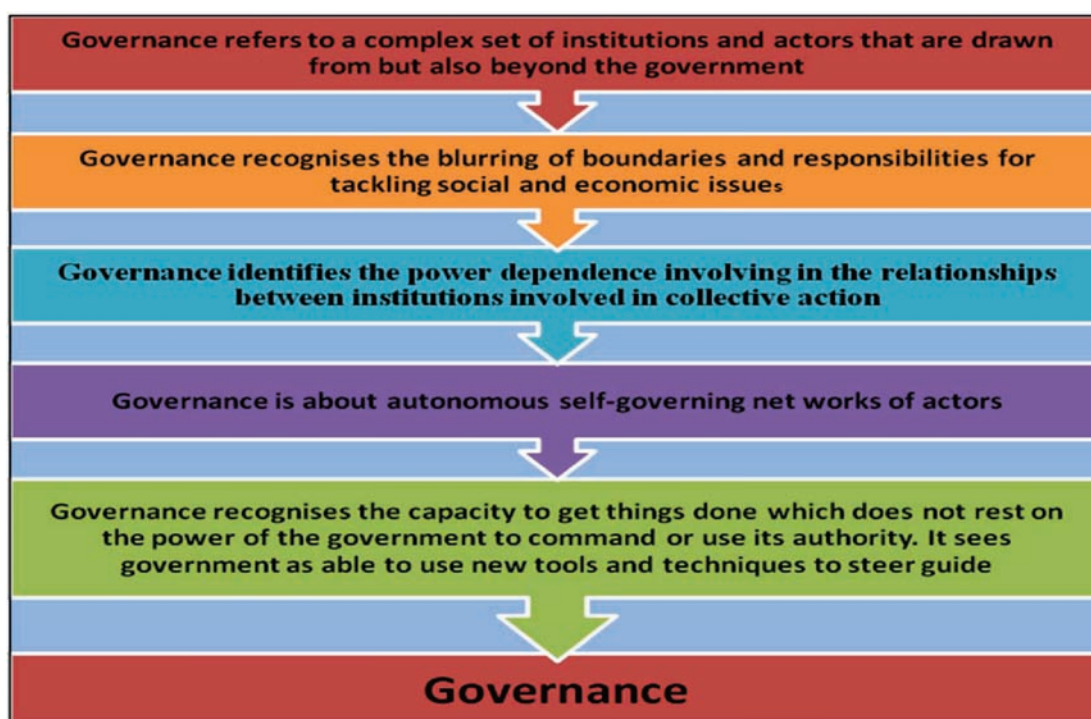
From the above narratives, it is apparent that Governance has been defined differently by international donor/ development agencies and scholars. There are certain common threads running across all proposed models, yet they vary from each other in more ways than one. For its own conceptual frame, the present IIPA governance report has drawn from the propositions of Stoker (1998). Put simply, the state *per se* is accorded central place in governance frame outlined by Stoker (See Box 1.5) but he also recognizes the role of non-state actors along with state actors in handling both social and economic matters.

This also affirms overlapping boundaries between the functional domains of both these actors. This would necessitate, in the first place, mapping out the activities related to a particular function devolved to non-governmental actors and that which is retained for the governmental department/agency itself. This would also include the regulatory function of the

Fig. 1.3 : Essential features of good governance



Box 1.5 : Five Proposition of Governance (Stoker)



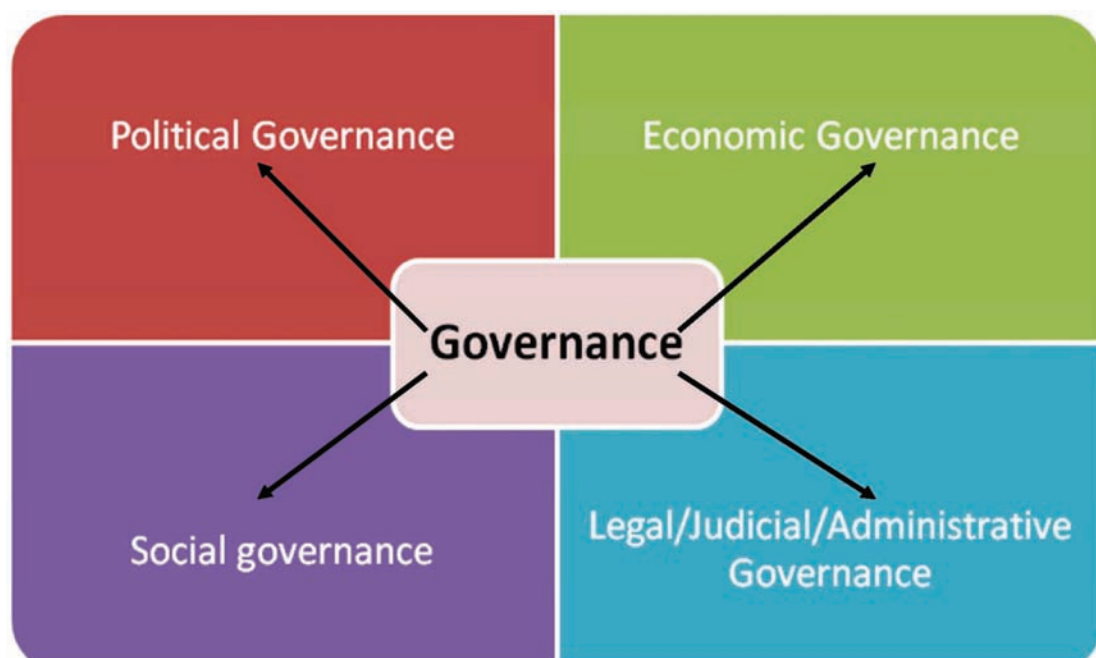
government. Our endeavour would be to develop indicators to measure the governance performance with reference to its above attributes. And these would be examined both in terms of service delivered directly by the government and discharge of its regulatory functions as well as the monitoring mechanism where non-governmental entities have partly taken over some of the governmental responsibilities.

This requires mentioning here that way back in early 1980s itself, onset of the sixth plan period to be precise, for the first time the GOI recognized NGOs as partners in implementing rural development plans. In fact, the decision was not an act of magnanimity rather driven by the failure of the governmental

report therefore proceeds along the conceptual frame of Stoker blended with the reforms enunciated in the country before and after political and economic reforms which started unfolding since early 1990s.

With this broad definition of governance, the study report proceeds towards constructing governance index at sub-national level for Indian states / provinces. The task was challenging, perhaps all the more that a very large number of governance indices were available but there was none at the sub-country level. Here again, the UNDP human development index served as a model; indeed, what eventually has come up is somewhat akin to its modified version. The governance index thus constructed has four dimensions⁹ (See Fig. 1.4).

Fig. 1.4 : Dimensions of Governance



machinery in reaching out the people for whom the development and welfare schemes were meant. In other words, NGOs as non-state actors had already been recognized and accorded due importance to them much before 'governance' acquired a name for itself. Not long after, India also witnessed policy reforms, another component of governance, broadening people's participation in the decision making at the local level at least along with instruments of accountability, transparency embedded into it. The

Grappling with Methodological Tools

For a report of this nature with a very wide canvas, it was obvious that a mix of methodological tools will be opted for collecting required kind of data. It was equally apparent that the report would primarily rely on secondary data, already available in the public domain, both in-print and web-based. Put simply, the

⁹A note on the essential differences between the dimensions and indicators developed for this study and an earlier study on the subject which incidentally was sponsored by DOPT is appended in the end.

report doesn't claim to have generated primary data for the stated purpose. A bulk of data were accessed from secondary sources, that is, published but highly scattered. In fact, our endeavour was to bring all these data published by multiple organizations, including government/quasi-government/autonomous bodies as well as individuals under one roof. It was easier said than done. For, tracing the location of a particular set

of data in itself was an uphill task. After spending a lot of time, this issue (identification of sources) was sorted out. But that was not the end of our predicament. We soon discovered that there was a greater mismatch between the indicators developed for the report (See Box 1.6) and the format of data published by numerous government departments / ministries.

Box 1.6 : Dimensions and Indicators of Governance

Dimension	Objective	Indicators
Political Governance	Government Stability and Democratic Accountability	Electoral data relating to voter turnout
		Criminal & financial background of elected representatives
		Number of bills passed by Parliament
		Women elected representatives in Parliament
		Time lost due to interruption and adjournment in Parliament
		Devolution on (three) 3Fs
Administrative	Rule of law	Strength of police force, charge sheet rate, disposal of crime, conviction rate, under trail prisoner etc.
		Expenditure on police
		Proportion of police force deployed in non core activity
		Crime statistics including those related to SC, ST & women
		Jail statistics including infrastructure
Legal/Judicial/ Governance	Access to Justice and Judicial accountability	Numerical strength of judiciary at all level, vacancies, disposal of cases, pendency etc
	Administrative	Information related to Civil Services, Central administrative tribunal, RTI.
		Recommendations of committees & commissions, 2nd ARC and Best Administrative Practices
Social governance	Access to Information	Access to information through print and electronic media
		Connectivity-roads, phone, internet etc.
	Socio-economic conditions	Rate of unemployment
		% people below poverty line
		Income distribution
	Governments commitment to the Social Welfare Programme	Welfare scheme, social security, rural & urban development programmes
	Quality of Life	Proportion of HHs having access to housing , safe drinking water, sanitation & electricity.
Economic Governance	Economic Management	Growth rate, fiscal health, expenditure pattern, deregulation, capital inflow etc.
	Institutions	CII, FICCI, ASSOCHAM, PM's Council

Besides, how to collect data, in plain terms, was not an issue at all; the report was confronted with another question: data collection on what. For, there are many components, sub-components of governance which are hardly quantifiable. Developing indicators for measuring those facts was the key question. Consider the Constitutional (73rd Amendment) Acts, 1992 which *inter alia* had provided a recognised forum, read *gram sabha* for seeking accountability, transparency and facilitating people's participation in decision making at the local level. During the last two decades, enough data have been generated to prove / disprove the much touted official claim, yet it is difficult to argue whether the forum is serving its intended purpose. For instance, could data collected on mere attendance in the *gram sabha* meetings be enough to qualify 'participation'? In continuation, could mention of certain issues (or, say told about some welfare scheme) alone confirm quality of deliberations the forum is supposed to be encouraging? Likewise, could the number of ASHA (accredited social health activists) recruited and Village Health & Sanitation Committee set up in a state be counted as proof of successful implementation of community participation under broad rubric of National Rural Health Mission (NRHM)? In order to avoid such oversimplification, the report has taken recourse to proxy indicators and used innovative methods to capture institutional performance. In case of NRHM particularly, the field observations¹⁰ were revealing, giving insights into functioning of institutions which cannot be ascertained through lifeless statistics.

Towards measuring the legislative performance and reforms in that sector, another case in point, data have been accessed from three distinct sources and by employing different methodological tools. First of all, quality of the elected representatives have been reconstructed on the basis of data provided by some prominent election watch dogs, including a Delhi based Association of Democratic Rights and its associates operating from provinces; from the websites of the Central Election Commission. This would also indicate, apart from their social and educational attributes, their tryst with unlawful

¹⁰It was akin to quick visits of health centres across a few districts in Tamil Nadu, Rajasthan, Andhra Pradesh and Gujarat but these short trips turned out to be highly rewarding.

activities and their wealth profile, their responsible handling of local area development fund (MPLADS), the way they cultivate their electorates. The second set of data are based on their performance in the national legislative body, i.e. the Parliament, in terms of their physical presence, participation in debate along with number of questions they raise on (what) issues. This is now available on the websites of the Parliament, PRS legislative and on various periodicals and newspapers. Yet another set of data reflects on seriousness attached by them to the Parliamentary Standing Committees they belong to. This has been examined by perusal of the committee report on health, interpreted along with other components of health governance (presented in Part-II of the Report).

The report has gone much beyond the boundaries of conventional methodological approaches. For, it has to capture facts and facets emerging out of definitional dilemma¹¹ blended with liberal interpretation of its conceptual frame. It necessitated innovative ways of data collection. This can be best illustrated from the collection of data and their application to interpret state-wise corruption. Likewise, for calculating state-wise HDI (presented in chapter-4), we reconstructed to a modified version of commonly accepted indicators. It was out and out proxy, based on the data pertaining to the standard of life. Above all, a major dilemma the study had to face was how to contextualize the central place of the State in governing the (day-to-day) life of the people. What people expects from the government? If it is enforcing law and order that would require applying its coercive instruments then how it draws legitimacy from the people at large? If so, then how law and order enforcement would be quantified? The study has taken recourse to innovative ways to overcome dilemmas and underlying quantification problems.

Data Sources: Apart from decennial Census, data have been collected from NSS various rounds, Economic Survey of Ministry of Finance, RBI Annual Reports & Bulletins, data available with the CSSO and other survey reports such as that of NFHS etc. In respect of the health sector, various outcome indicators as well as indicators on the availability of

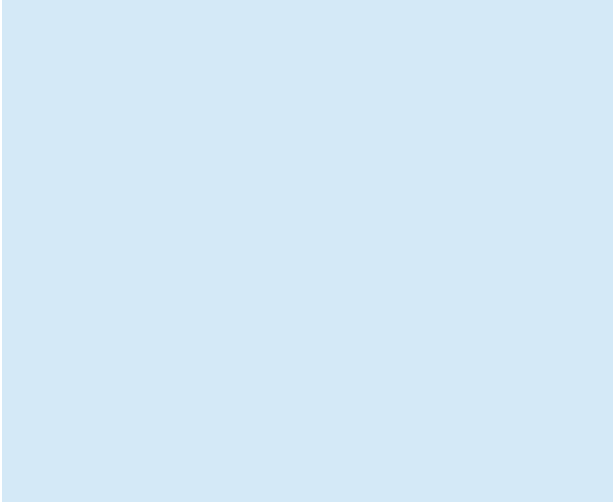
¹¹Highlighting this fact, Arora has also argued that these 'are not only dilemmas of 'how' to arrive at it but also of 'what' constitutes it (1998:7).

services are available. State-wise data on outcomes, health infrastructure and diverse services, ranging from immunization to ambulatory services, are also available from NHFS, Census, NSSO, CSO and other secondary sources. On the other hand, for assessing the perception of the stake-holders about performance, survey is a desirable method which is both expensive and time consuming. We have therefore resorted to alternative methods - recent published reports and studies appearing in journals such as the *Economic and Political weekly*, *Lancet*, to name a few, and some other periodicals.

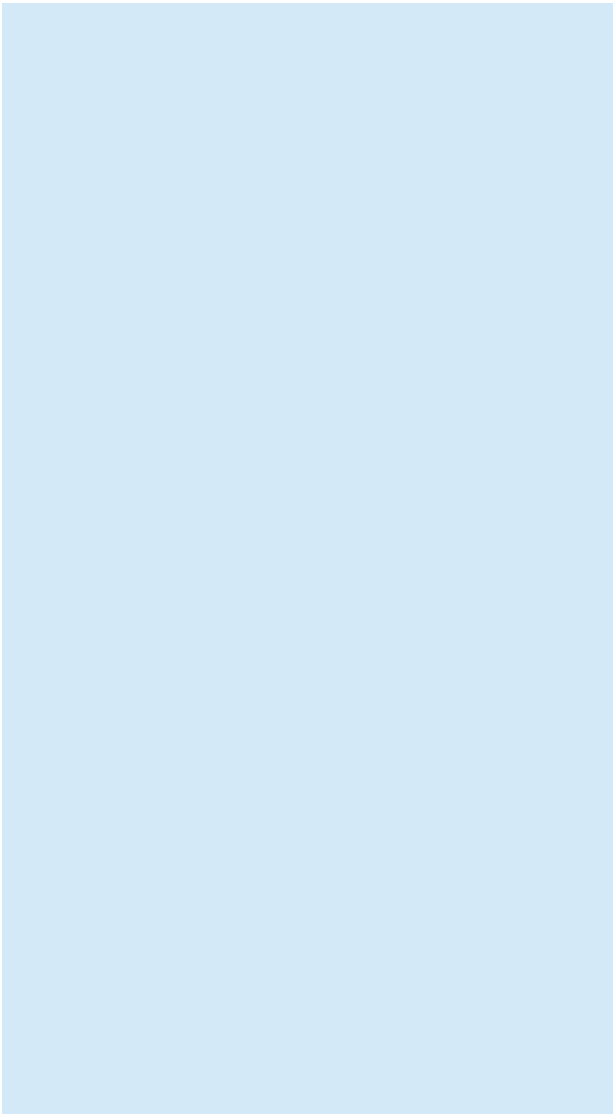
Report Configuration: The report is composed of three parts; first devoted to *state of governance in general*, covering various aspects of political / electoral, economic, social as well as legal/judicial governance, details provided at appropriate sections.

Based on a large number of indicators, the data collected on these components, their quantification, analysis and accompanying text are woven around the emerging drivers of governance frame: legitimacy and voice, accountability, transparency and participation. The entire second part is committed to *health system governance* that essentially happens to be the focus of the 2012 report. The third part contains three stimulating, thought provoking papers interpreting some of the pertinent governance issues. These are:

- Governance and Programme Delivery in India
- Towards Good Governance: Equipoise between State, Market and Civil Society
- Intertwining of the Administrative and the Political in the Executive.■



PART I



MEASURING LEGITIMACY, VOICE & RESPONSIVENESS

Introduction

The conceptual outline of the report, following Stoker (1998), lays emphasis on the centrality of the State in the governance frame. In the first place, therefore, this chapter would take note of the role and responsibilities of the State under the new dispensation. This would necessitate a close look at the functioning of its vital components: legislative, executive and judiciary. Needless to say, all these three arms of the State have been discharging their respective assigned responsibilities for quite long amidst their defined boundaries and constitutionally imposed checks and balances. The crux of the study therefore would be to capture and interpret the nuances and subtleties of changes which have occurred in their functional domain on account of governance induced conditions. This could be done in two ways: (a) by capturing impact of measures the State (read government) had resorted to make its functioning accountable, transparent and participatory; and (b) by underlining those functional responsibilities of the State which have been offloaded to NGOs and the market—two recognized non-state entities under the governance frame, working either separately or in partnership with the state. This, in turn, would also call for a broad mapping of the state regulatory institutions and their efficacies.

The governance performance as measured and quantified has been divided in four broad areas: political, judicial, social and economic. The political and social components also referred to as non-economic aspects of governance, would be measured by interpreting data on electoral democracy, extent of participation, transparency and accountability, rule of law etc. Likewise, social governance is measured with reference to the government's commitment to welfare of different social groups including women.

All taken together, the state is entrusted with multiple tasks: as the enforcer of law and order, as service provider, as regulator, as the one that also makes its people avail a minimum standard of life. In common parlance, the personification of the State is Government. For a government to impose its will, both in terms of tax realisation to provide for essential services and maintaining law & order within its territory, it must be seen as a legitimate holder of power and authority. Put simply, this means a government elected by the people at their free will. A government therefore would be perceived legitimate as long as it allows a free and fair election as per the electoral laws monitored by an independent body of observers. That is the procedural part of legitimacy that requires periodic lease renewed after every five years. But legitimacy also has a moral component that could be measured by assessing quality of life

of the people at large. Although the state is legally not responsible for providing job to everybody, it is expected to create an environment conducive for people to earn their livelihood to lead a decent life. In other words, if a large numbers of people remain disgruntled due to unfulfilled basic needs, the government would run the risk of losing its moral authority to rule.

Electoral Governance

With 714 million eligible voters, India concluded its fifteenth general election on May 17, 2009 which turned out to be the largest democratic exercise in the annals of contemporary world history. Nearly three fifths (59%) of the eligible electorate chose to exercise their right of adult franchise.

The following figures (see Table A 2.1–A 2.2 in Appendix & Fig. 2.1 and 2.2) reveal that in the last twenty years the proportion of people exercising their voting rights has increased marginally from 55 % (10th Lok Sabha) to 58.9 % in the 15th lower house. The data also show that the proportion of women casting their vote has gone up from half to two-thirds of the total women electorate. If nothing else, this confirms increasing participation of women in periodic election exercises. The figure (2) shows that the percentage of women elected in periodic general elections varied between 7 to 9 % till 14th Lok Sabha (2009) but went up to 11% in the 15th Lok Sabha (2009) which is still far below the one-third of the seats proposed under women reservation bill. Yet another noticeable fact is the increasing participation

of poorer section of the society, as the 2004 National election studies (CSDS, 2004) reveal that the category of the very poor, peasant, schedule caste and schedule tribes had greater faith in the integrity of electoral process in India than the average voter.

Notwithstanding increasing participation of poor, women and marginalized sections of the society including SC & ST, a diametrically opposed feeling is increasingly gaining ground that our elected representative system has been manipulated, subverted from within. In fact, this perception in itself is in circulation for over two decades. That both the national and state legislators are anything but the people's representatives in true sense of the term, they have denigrated the political system itself. Is it true? If so, what is the proof? After all, they win elections following due process of electoral laws, the apologists would argue. Also that India is bestowed with an efficient, independent Election Commission, a Constitutional body that zealously safeguards its autonomy. So also does the judiciary. There is also a watchful media. Notwithstanding the alert presence of all these vigilant institutions, the reputation of the Parliament has vastly declined over the last two decades.

The decline could be seen at two levels. At one level, it is related to twin sets of issues: First, (election) campaign finance and the criminalization of politics and the second involves conduct of the MPs outside and (within) on the floor of both houses, including the reduced number of sittings (see Table:

Fig. 2.1 : % of Total Voter and Women Voter Turn out in Lok Sabha Elections (1991-2009)

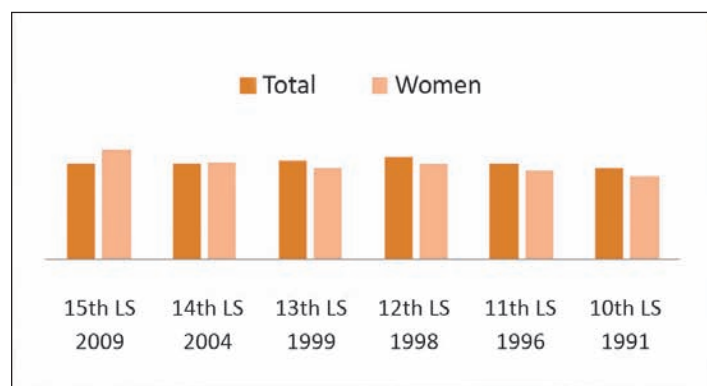


Fig. 2.2 : % of Woman Elected in Lok Sabha Election (1991-2009)



Source: Election Commission of India

A 2.3 in Appendix), disruptions of proceedings as well as the quality of debates. The roots of the first are embedded into 'the structure of campaign finance laws and the imperatives of mobilization of funds' which in fact deters politically active citizen, worthy of becoming people's representative from entering into electoral arena. On the other hand, 'the imperatives of raising electoral financing makes parliamentary beholden of special interests and in some cases corrupt them... the unrealistic nature of (Indian) campaign finance laws, which set impossibly low limits on campaign contributions, makes politics an activity that is implicated in illegality right from the start. This illegality is also manifest in the second major source of concern about electoral practices: the criminalization of politics. This phenomenon involves not just charge-sheeted criminals entering legislative assemblies but also the fact that a significant number of MPs beholden to criminal elements' (Kapur & Mehta, 2006:17).

Both these issues are indeed indicative of far deeper maladies. People of criminal bent or broadly speaking, those who have nothing to do with the politics as such have entered political domain because of the very de-politicisation of electoral process itself. The nomination of state and district leaders as well as those of different wings of the political parties from above over the years has destroyed the functioning of political parties, forcing the political worker to queue up to the party headquarters than remaining engaged in the field. This is something which was initiated in early 1970s has now been identified as one of the greatest paradoxes of the Indian politics: 'democratization of traditional authority, especially in the rural social structure, has paved the way of centralization of power at the top' (Kohli, 2009, Prabhash, 2010). This has another implication: political parties being no longer serious about 'ideological positions, policy preferences and public opinion' and thus 'governance automatically get delinked' from democratic politics. Most importantly, practically for all political parties now 'development' has become a buzz word; they more or less use the same idioms and vocabulary of public choices, politics cease to matter of choice' (Ibid). This is apparent from the fact that there are a large number of political formations but hardly any one

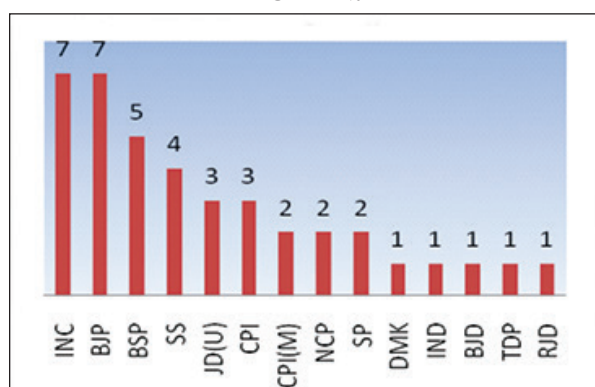
has any alternative programmes. India has already entered into era of de-politicisation, when the scope for 'open politics' getting fast reduced (Kothari, 1992). Its impact on elections is amply summed up by a political analyst, 'they (elections) have ceased to be a contest of ideas and public policies. And when elections are drained of their political content, parties have to look for alternative means to gain popular votes. All these prepare the fertile ground for electoral malpractices of which influences of money is important one' (Prabhash, 2010). Thus the people's representative system has lost its shine. In fact, it is hardly 'authentic' anymore. In the final analysis, it makes one wonder whether this rot can be checked or cleared through administrative/ managerial means.

Criminal Background of MPs

Let us begin with the Rajya Sabha (upper house of the Parliament) whose members are indirectly elected. One fifth of its total 250 members in 2010 had pending criminal cases (see Table A 2.4 in Appendix) against them. This is based on the self declared affidavits submitted by them at the time of filing nominations. Of them, one-third had serious criminal charges pending against. Largest of such stained MPs had come from UP (9 out of total 30), followed by Maharashtra (8 of total 19) but the corresponding figure was the lowest from Tamil Nadu (1 out total 18). They belong to practically all the political parties (see Table A 2.5 in Appendix).

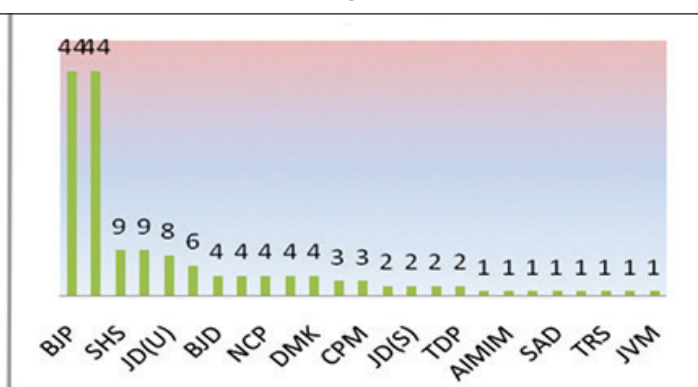
The pattern was by and large similar in the Lok Sabha (Table A 2.6 in Appendix). But in the Lower House, Tamil Nadu also had fairly large number (10 out of 39) of MPs with criminal background. The lowest number had come from Rajasthan (2 out of 25). Among the members elected in 2004 general election, there were nearly a quarter (23.2%) had "criminal cases registered against them. Over half of these had cases that could result in penalties amounting to imprisonment for five or more years. There is good reason to believe that criminals are entering politics in order to use political power to stymie investigations against them" (ibid). For party wise break up of number of MPs with pending criminal cases in 15th Lok Sabha (see Table A 2.7 in Appendix).

Fig. 2.3 : Party wise Break up of MPs with Criminal Cases Pending in Rajya Sabha 2010



Source: ADRIndia.org

Fig. 2.4 : Party wise Break up of MPs with Criminal Cases Pending in 15th Lok Sabha 2010



Wealthy Representatives of Poor Electorates

Although the poverty figures provided by the different arms of the government are quite varying, it is estimated that a little over one-third (37%) of population is below poverty line. Paradoxically, their higher level representatives, Member of the Parliament (MPs) are rich and fabulous (Table 2.1 and also Fig. 2.5). Rather their wealth is disproportionately increasing by leaps and bounds.

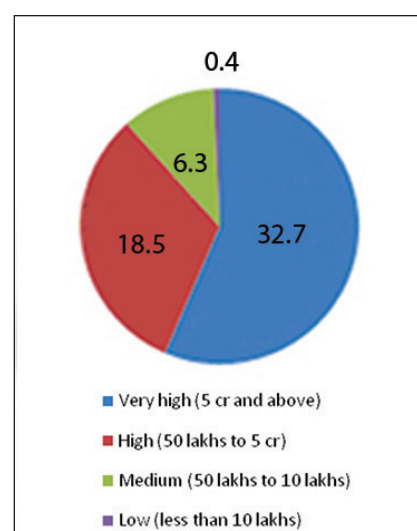
Table 2.1 : Increase in Assets of MPs between 2004 and 2009

No of MPs from Lok Sabha 2004 who re-contested and their details available for both 2004 and 2009	304
The average assets for these re contesting MPs as declared in 2004	Rs 1.92Cr
The average asset for these re contesting MPs as declared in 2009	Rs 4.8 Cr
Average asset growth for these re contesting MPs	Rs 2.9 Cr
Percentage growth in assets for these re contesting MPs	289%

Source: ADRIndia.org

They belong to both national and regional parties. The assets of the average BJP MPs, for instance, went 28.8% up (Prabhash 2010), from 96. 91 lakh rupees in 2004 (14th Lok Sabha) to 3.07 crore rupees in 2009 (15th Lok Sabha). This is equally true of the parliamentarians belonging to the BSP. Terming this wealth making method as ‘bizarre enrichment’, a political commentator writes that average assets of

Fig. 2.5 : Chances of Winning based on Assets of Candidates



Source: ADRIndia.org

the oldest Congress party MPs just doubled, ‘from a high base of Rs. 3.10 crore to Rs. 6.28 crore during the five years tenure of the UPA-1.

This is based on the assets declared by sitting MPs who also won 2009 elections (Mitra, 2011). Incredibly, one of the cabinet Ministers turned out to be so ingenious that he ‘added , on average, over half a million rupees every day to his assets in 28 months between may 2009 and August 2011 (from Rs. 79 Crore to Rs. 122 Crore i.e. Rs. 5 Lakh a day)... The number of multimillionaire elected representatives adorning both the state and national Assemblies is indeed increasing with coming of fresh entrants to these August houses. For instance, in Maharashtra

alone, there number 'went up from 108 in 2004 to 186 in 2009. Over three-fourths of the union cabinet is *crorepatis*. Much of their wealth was acquired while in office (Sainath, 2011).

Hereditary Political Leaders

HMP: With increasing pervasive influence of family being accepted as the safest and the surest entry point to politics, the political parties becoming more dynastic with every passing election. A recent study on the political roots of the parliamentarians entering 15th Lok Sabha following 2009 general elections is a testimony to this sordid truth. Renaming them as hereditary members of parliament (HMP) (see Table 2.2), the study (Patrich French, 2011: 111-123) shows that the nearly two-fifths (78 out of total 208) members of the single largest party which is on the driver's seat of the UPA-II coalition government, that is, the Congress happen to be HMPs, who are in the Lok Sabha by virtue of their political lineage, as children of political family. The corresponding share of the BJP - the party which is not so old and claims itself to be different- is about one fifth (22 out of 116) of their total number in the Lok Sabha.

Table 2.2 : % of Hereditary MPs

Pol. Parties	% of Hereditary MPs
RLD	5/5 (100)
NCP	7/9 (77.8)
BJD	6/14 (42.9)
INC	78/208 (37.5)
BSP	7/21 (33.3)
DMK	6/18 (33.3)
SP	6/22 (27.3)
CPI(M)	4/16 (25.0)
JD(U)	4/20 (20)
BJP	22/116 (19)
AITC	3/19 (15.8)
Shiv Sena	1/11 (9.1)
AIADMK	0/9 (0)
TDP	0/6 (0)

Source: French, 2011

Parliamentary Shortcomings: The changes triggered by economic reforms necessitated 'a large body of new legislation and laws to underpin these changes. However, delay rather than debate seems to be the principal role being played by the Parliament. The delays are due to ineptness in the executive ranging from deficient floor management skills... also by the numerous standing committees (SC) in each ministry', including those headed by opposition MPs. The committees by convention expected to give unanimous recommendations which can clash with the partisan interests of many of their members. This either results in delays or the dilution of the original bill. But the executive also uses the SC to defer decisions when it is convenient.

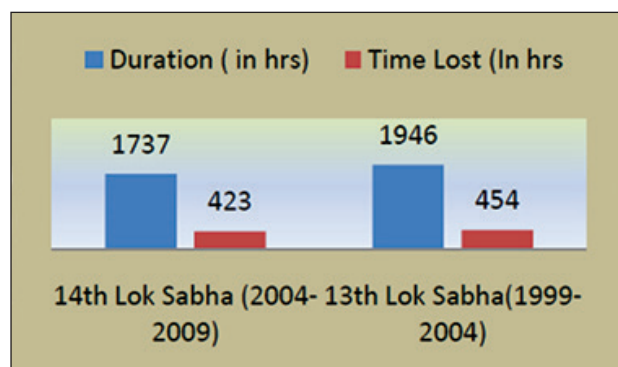
The parliament passed budgets of 1999, 2001, 2002 and 2004 without any scrutiny or debate, notwithstanding alarming levels of fiscal deficits. On fiscal issues... parliament has neither the incentives nor the competence to act in a responsible fashion. Most MPs lack a rudimentary knowledge of basic economics and as a result focus on visible issues, such as subsidies that favour their constituents, while ignoring the much larger effects of policies on their constituents...In 2002, the Lok Sabha first passed the appropriation bill, and the governments revenue proposals were approved only a few days later, thereby abdicating its basic constitutional responsibility that the government cannot spend without Parliament's consent. In 2004, the roles were reversed and the former ruling coalition, now in opposition, repeated what the erstwhile opposition had done. The practice is even worse in state governments (Kapur & Mehta, 2006: 23-24). MPs consider themselves as trouble shooters not as lawmakers. Their electorates do not care for the issues raised by their MP in the house or the recommendations of the standing committees to which s/he belongs, in no way on their contribution in policy making. They are seen as 'dispenser of patronage' rather than a policy maker. (Ibid; p. 20).

Time Spent : Parliamentary democracy system is at work for nearly five decades in India but regrettably its practices are yet not settled. Even on issues of national importance, there is hardly any

agreement between national parties. Thus political debates remain fractured. But more than the party in power, if one goes by the conduct of parties in the parliament, it is the opposition which is often at fault. In fact, with the change of their status from ruling to opposition or vice versa their vocabulary is changed. On issues like reforms, including deregulation, privatization, telecommunication health etc (all major concerns of governance see Table A 2.8 in appendix) the party in power would speak in favour and the opposition, just for the sake of opposition, will oppose it. But as soon as their status is reversed with the change of the government, their stated positions also go under hundred eighty degree changes, irrespective of the ideology they seem to profess. Even the same party speaks in two tongues simultaneously: against in the parliament despite being part of the coalition whereas it will support in the state assembly where it is a ruling party. Thus, more than the party in power, it is opposition that behaves in irresponsible manner.

Two coalition governments with different partners and led by the BJP and the Congress respectively had been in power during 1999 - 2009. If a comparison is made on time lost, (on simple interruption and adjournment following repeated interruptions) during the respective coalition governments, the differences would seem fading (see Table A 2.9 & A 2.10 in appendix and also Fig. 2.6) away. Taken together all the sessions of 13th and 14th Lok Sabha respectively, the hours lost was staggering 454 hours roughly equivalent to 27 working days

Fig. 2.6 : Total Duration and Time Loss in Lok Sabha



Source: ADRIndia.org

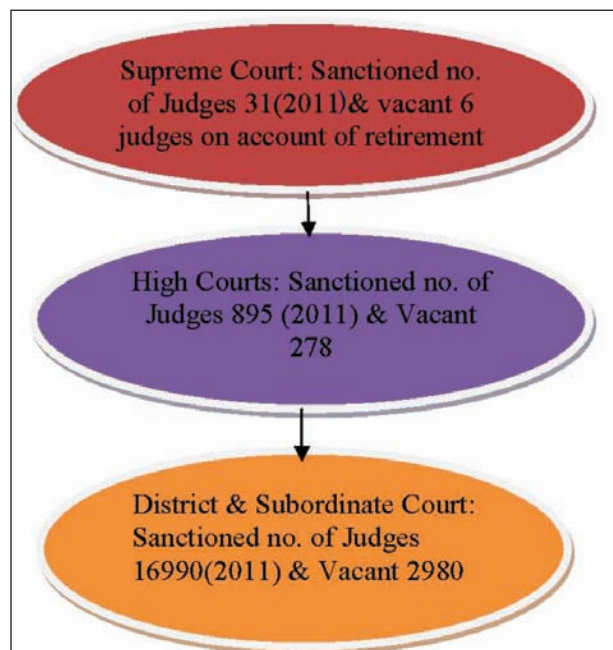
hours) and 480 hours respectively¹². (“Out of 1,738 hours and 45 minutes, put simply, the fourteenth Lok Sabha wasted 423 hours because of disruptions and adjournments due to disorderly scenes” (Chatterjee 2010: 160).

Judicial / Legal Governance

Along with civil administration, railways, postal services and defence services, India also inherited a three tiered judicial system. Leave aside smaller states created in early 1970s late 1960s, practically each of the major states has a high court located at their capital (with exception of MP and UP). Likewise, all subordinate judiciaries are located at the district headquarters.

The district courts are headed by a District Judge who is assisted by judicial magistrate designated as first or second class. Then, there is a chief judicial magistrate. The district collector also dispenses justice in his/her capacity as district magistrate and so does sub divisional officers as sub divisional magistrate.

Fig. 2.7 : Vacant Judicial Pozitions



¹²Early this year, nearly entire session of the Parliament was wasted because an united opposition wanted a Joint parliamentary committee to examine corruption charges involving telecom ministry where as the government was in favour of putting this matter to Public accounts committee. (see Beteelle, 2011: 80)

Against this backdrop of judicial infrastructure, two indicators are chosen to look into the functioning of judiciary. First is the vacancy against the sanctioned strength (see Fig. 2.7); second, disposal and pendency of cases at all the three level. The data given in table A 2.11 (see Table A 2.11 in appendix) show that during the last one decade starting from 1998, the number of pending cases has almost doubled up.

This is true of the Supreme Court of India where also number of disposed cases has doubled up during referred time period (1998-2009), number of pending cases has increased around 2.7 times (see Table 2.3).

Table 2.3 : No. of Cases Disposed and Pending in Supreme Court

Years	2009	1998
No. of cases disposed	71179	35233
No. of cases pending	54864*	20358

*This figure is of 2010

Source: Supreme Court of India website

Altogether 2.74 crore cases are pending. At the level of Suprem Court, it stands at 56,383 and 42.92 lakh cases in high courts. (*Times of India*, 30-11-2011)

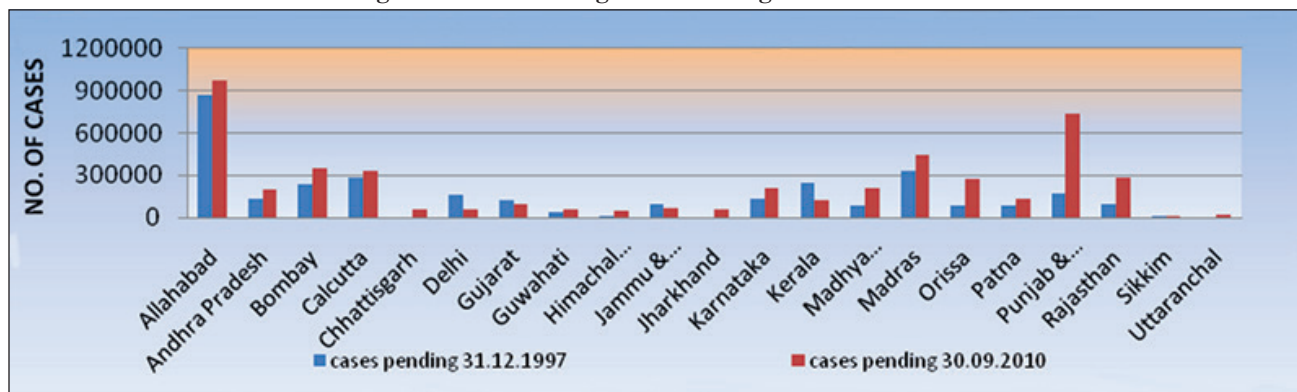
At the level of High Courts, the number of pending cases has increased around 32% over the referred time period. As a matter of fact, all the High Courts, except Delhi and Gujarat, are burdened with increasing number of cases pending over the years. This is especially true in case of Bombay, Allahabad, Punjab & Haryana, Rajasthan and Madhya Pradesh High Court (See Fig. 2.8).

Judiciary Infrastructure

During the last fifteen years beginning from 1996, shortfall in number of judges has ncreased from 501 to 617 (Fig. 2.9). This is common to all High Courts in India, excepting Rajasthan and Andhra Pradesh High Courts.

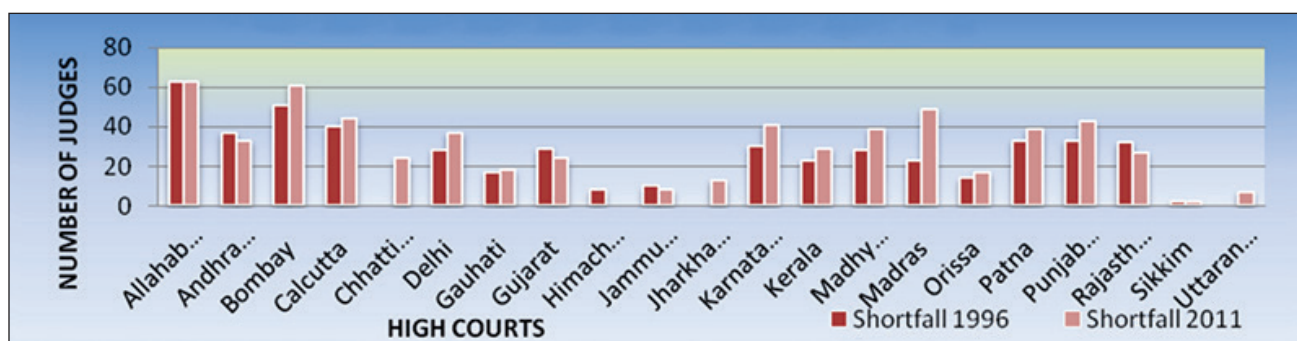
Likewise, number of pending criminal and civil cases in India has increased 30 times (Fig. 2.10) and Table A 2.13, A 2.14 in appendix) over the

Fig. 2.8 : Cases Pending in Various High Courts of India



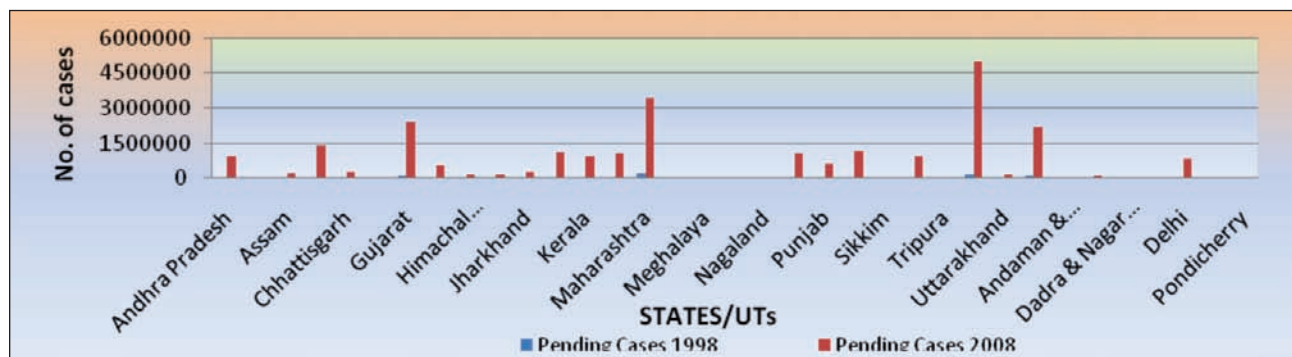
Source: Website of Supreme Court of India

Fig. 2.9 : Judges' shortfall in Various High Courts of India



Source: Website of Supreme Court of India

Fig. 2.10 : Pending Civil and Criminal Cases in District/Subordinate Courts in States of India



Source: Website of Supreme Court of India

years. The backlog is acute in case of Maharashtra, Gujarat, West Bengal, Bihar and Karnataka etc.

Over the time period, shortfall of employees has increased from 11242 to 14010 (Fig. 2.11) in India. This problem is prominent mainly in Bihar, Madhya Pradesh, Uttar Pradesh, Maharashtra etc.

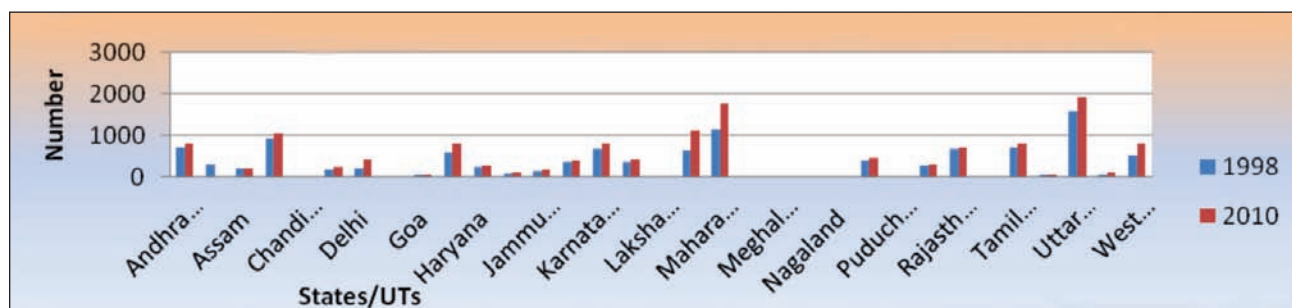
Lower Courts: A supreme court, howsoever alive and empathetic is not enough. To a large extent, this is true of the high courts, though hierarchically and otherwise the latter is not considered as esteemed as the former. The trouble lies at the lower level of the judiciary where it comes face to face with the Indian society. As a matter of fact, it is the evils of Indian society, heavily influenced by social hierarchy and economic inequality reinforced by its traditional social structure and prejudiced mindset that directly or indirectly taints the justice system. The infection moves onwards and upwards and eventually makes the entire system malignant. In fact, “the district level courts remain the foundation of the system, without a comprehensive understanding of what they do and why they do it, reforms have been left

to operate based upon little more than anecdotes and stereotypes”(Moog, 2008: 132-136).

Thus, without clear understanding of the functioning of the district level courts, the justice system cannot be reformed. A naive belief in the functional justice system, open and approachable by any one prevents us from asking fundamental questions: Who uses the courts and for what purpose and, alternating, are there people who fail to knock the doors of justice? All these call for systematic data collection at the lower levels which is virtually absent or records are not properly maintained. If record - keeping at the lower levels itself is haphazard, it is virtually impossible to quantify the cases by the nature of litigation. Indeed, the state-wise annual reports, earlier regularly published, are difficult to find. Based on his research on the subject nearly two decades ago, an erudite western scholar had observed that except Kerala, all other states had stopped circulating or printing annual reports (Ibid; 134).

During the last two-three decades, alternative dispute resolution mechanisms have evolved. This

Fig. 2.11 : Shortfall in District/Subordinate Courts in Various States of India



Source: Website of Supreme Court of India

includes *Nyaya Panchayats* (before 73rd Amendment, this institution would cease to exist in the absence of regular elections), consumer courts, administrative tribunals, fast track courts and a variety of *Lok Adalats*. Notwithstanding the existence of all these quasi-judicial bodies, the formal justice system is still overloaded, hence time consuming and expensive. This not only undermines the effectiveness of the system but ‘damages their legitimacy’ (Moog: 1993).

Rule of Law

A basic function of government is to provide security to its citizens. In fact, as a legitimate holder of power and authority, it is supposed to protect life, liberty and property of the people at large. Is the government alive to its basic responsibility and if so, is it discharging its functions effectively? There are two ways of measuring effectiveness of the government to this end. One is assessing people’s perception which can be captured through a large scale survey. This can be clubbed with a mapping exercise of individual states and UTs in terms of smooth or disturbed law and order situation. That is, differentiating states where emergency like situation exists, causing restrictions on people’s freedom. Second, effectiveness of law and order machinery can also be measured by using proxy indicators. This would include infrastructure, human resources for law enforcing agencies (police) and their conduct (time taken in filing charge sheet, incidence of police firing, status of prison, partisan/ communal conduct of police force etc.) break down of order and police reform (e.g. *Bihar Police Act, 2007*); state-wide variation in cognizable crime rates related statistics etc. This report has taken recourse to the second available option of using proxy indicators.

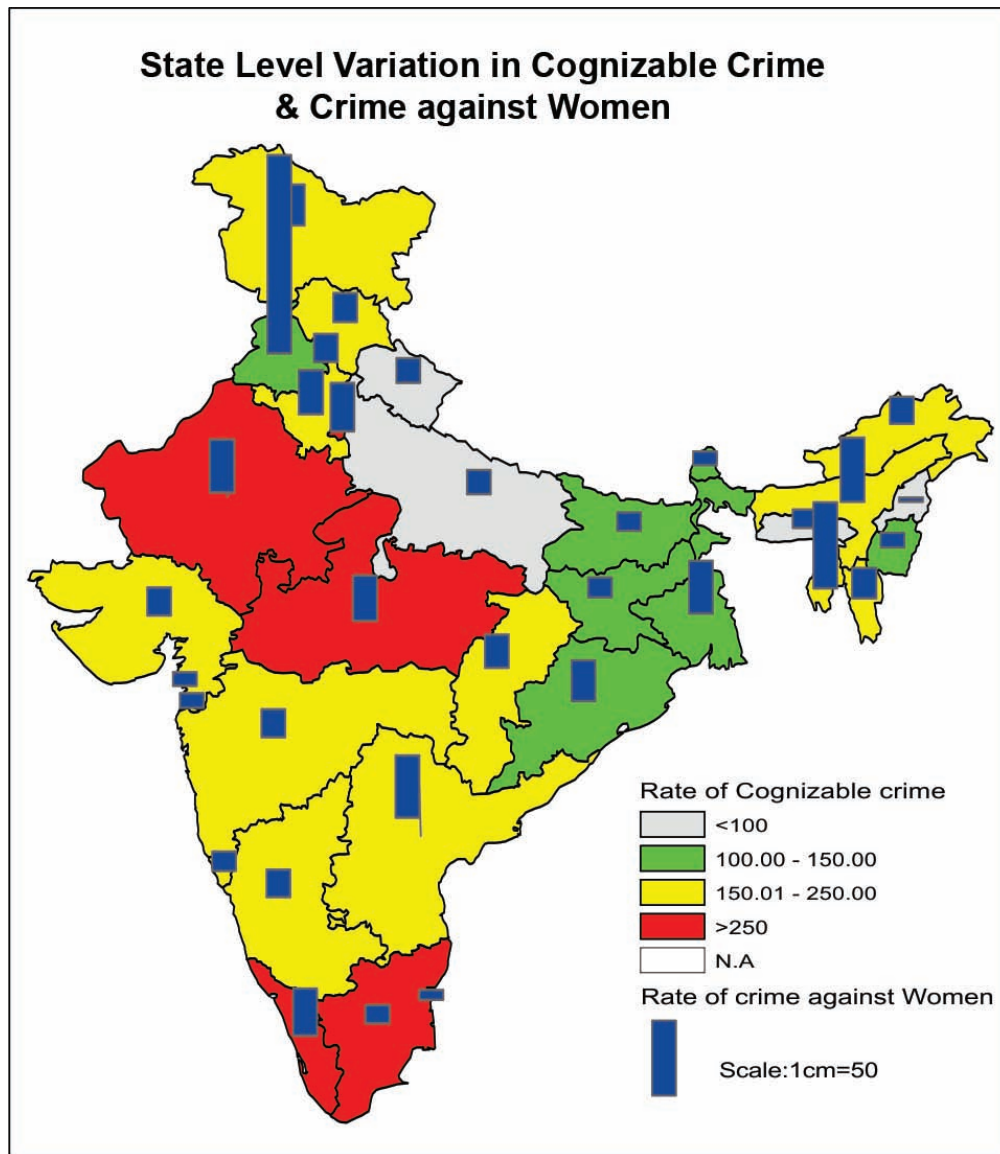
Size of Police Forces: If the availability of policemen per 100 sq km area is considered a benchmark, there are adequate deployments of policemen in Punjab, Kerala, West Bengal, Haryana and Assam (Table A 2.15 in Appendix). On the other end of scale is placed Karnataka, Orissa and Madhya Pradesh. Among the north eastern states, Nagaland has the dense deployment. In contrast, it is the thinner in Arunachal Pradesh and Mizoram. Number of policemen per 1,000 populations is another criterion to measure adequate deployment of police.

Accordingly, north eastern states and smaller states as well as UTs seem to be better provisioned than bigger states. That apart, proportion of state civil police force to their respective armed/ military police and extent of women’s representation among state police force happen to be two more criteria to assess their presence as deterrence to crime. The maiden figure is anywhere between 70 to 80 per cent among major states, but unusually as high as over 90 per cent in case of two southern states, namely Kerala and Tamil Nadu.

Handling Crime: The figures provided in the Table A 2.16 (in appendix) are based on three indicators, namely, charge sheeting, pendency and conviction in the year 2000. In terms of charge-sheeting rates, Kerala scores the highest, followed by Tamil Nadu and Andhra Pradesh. Orissa and Gujarat show higher than the national average. On the other hand, in case of pendency, performance of Orissa is better (above national average) but in case of Kerala, it is on the lower side. And performance record of Gujarat is far below, less than half of the national average. In fact, a dismal picture emerges with very low conviction rates in major states like Maharashtra and Tripura, whereas states like Tamil Nadu seem to be doing much better on this count (see, Table A 2.17 in appendix)

Cognizable Crimes: Data collected on these matters are arranged in the following manner: one set of data show crime rates recorded in terms of four broad sub-heads, namely, murder, dacoity, theft, riots etc; second covers crime committed against women, including abduction/ kidnapping, molestation, rape, dowry deaths, cruelty committed by husbands etc; and the third set of data reveal crime recorded against Scheduled Castes and Tribe (see Map 2.1 Tables A 2.18 & A 2.19 in appendix). Taking all the cognizable crimes together, Kerala is at the top among bigger states, followed by Rajasthan and Madhya Pradesh. Amongst smaller ones, Delhi seems to be leading, rather it shows highest incidence of crimes in the country as a whole, followed by Chandigarh. Among the major states, murder cases were reported (year 2000) highest from Assam, followed by Madhya Pradesh. Among minor states, it was highest in Manipur, followed by Tripura and Jammu & Kashmir, almost double than the national average.

Map : 2.1



If rate of crime committed against women is measured in terms of rape, it was reported lowest from Gujarat and Tamil Nadu, much lower than the national average. On the other end of scale, showing highest incidence, it was Mizoram, followed by Madhya Pradesh. With highest number of dowry deaths but lowest incidence of molestation, as well as very low incidence of kidnapping/ abduction of women (high of national average), Bihar presents a very unusual trend. In this regard, women seem to most unsafe in Delhi, Chandigarh, Jammu & Kashmir, Rajasthan and Assam – all recording three times more than the national average of abduction cases.

It needs emphasizing that Bihar had gained notoriety for deteriorating law and order situation for more than a decade, starting from early 1990s, where nobody was safe. Even cinema halls had stopped showing night shows. There used to be curfew like situation in most of the provincial towns but also in some parts of the Capital city. Sadly, the leaders of the party in power were allegedly found operating hand in glove with criminals and police had stopped taking note of crime due to continuous political inference. Kidnapping particularly had become rampant. It was only after the defeat of the old regime in the 2005 assembly election that light at the end of the tunnel became visible. The

new Chief Minister took bold strides but only after doing enough ground work which greatly improved the law and order situation (see Box 2.1). This once again proved that if there was enough political will, the same rusted machinery could be resurrected to deliver goods.

Crime against SCs, STs : The state of Rajasthan tops the list of all states arranged in order of all the cognizable crimes committed against Scheduled Castes (SCs) under the IPC taken together (2000) showing downward trend nearly a decade later in 2009. This is followed by Andhra Pradesh, Madhya Pradesh and Orissa- all these showing prevalence of much higher rate than the national average. In case of Scheduled Tribes (STs), as against 0.5 national averages, it was reported highest 2.3 both in case of Madhya Pradesh and Sikkim in the referred year (See Table A 2.19 in Appendix and Map 2.2).

Despite expansion of police forces, up gradation of their facilities (availability of wireless communication mode, their own transport vehicle) including computerization in the 21st century; the crime seems to be growing, notable exception apart. Arguably, crime control or management is not only the function of effective policing rather it is a by-product of other factor like socio- cultural setting, greed and behavioural disorder etc.

Jail Infrastructure: Whether crimes were committed inadvertently or deliberately, in cold blood or impulsive reaction caused by immediate provocation, convicts of all sorts, including under trials are kept in jail. The numerical strength of prisoners, usually measured in terms of a thousand population, also reveal the extent of harmony or disquiet in the society. That is larger the number of prison inmates, more iniquitous or violent the society is. Be that as it may the philosophical premises of

Box: 2.1 Bihar Police Act, 2007

- Provided for minimum two years fixed tenure for IPS officers, starting from the Director General Police (DGP – state police chief) to the Superintendent Police (SP – district police chief), and further below to the level of the Station House Officer (SHO – police station in-charge).
- Established State Police Board, comprising the Chief Secretary, Home Secretary and the DGP to review the police performance and implement changes aimed at improving its functioning.
- Created District Accountability Authorities with three key functionaries: the District Magistrate (DM), the additional DM and SP for ‘monitoring the progress of complaints filed against police officers within the district.’
- Separated the investigation and law enforcing wings so that officers engaged in investigation could carry on their task without any distraction.

All these provisions were made to ‘reduce interference in the working of police force as well as hiring of some 70,000 ex-servicemen on a contractual basis to enforce law and order in particularly difficult areas’ (Chand, 2010:5). The SPs were forcefully instructed that they should ‘focus on getting a conviction, not just filing a charge sheet with a court. This , in turn, compelled the police to prioritize cases, focusing on those affording the highest prospect of obtaining a conviction, and also on improvement of investigative techniques and handling of expert witness’(p. 39).

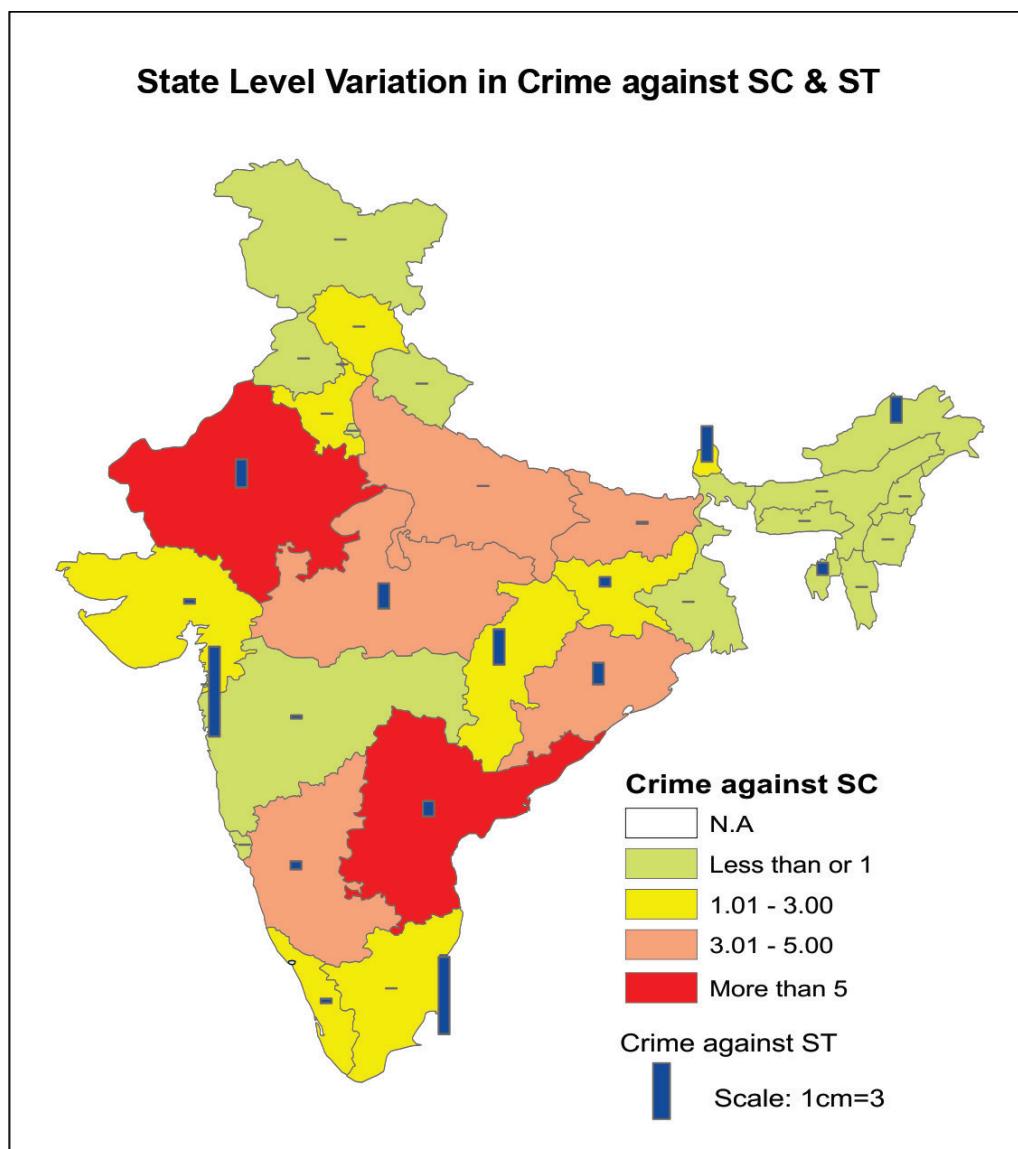
- Significant pay rise of judges, filled up standing vacancies by hiring 300 new civil judges and provided generously for computerization.
- High court began monitoring pendency rates in criminal proceedings; also set up mobile court, moving from one district to another to dispense justice

Cognizable crimes and Conviction

‘Prior to 2005, neither crime nor conviction figures were reliable; the government simply did not focus on the collection of these numbers as an input into police formulation....since 2005, the total number of cognizable crimes committed has shown a small, but steady, upward trend from 104,778 in 2005 to 130,693 in 2008 and 135,525 in 2009. This largely reflects greater willingness on the part of the Bihar police to register crimes in the first place, along with more accurate data collection relating to crime in all its forms rather than an increase in crime rates per se’(p40- 41). This also needs mentioning that there was perceptible decline in major crimes such as kidnapping for ransom, road hold-ups and bank robberies. Altogether 6,839 criminals were convicted in 2006, the number went up to 9,853 in 2007, to 12,007 in 2008 and 13, 146 in 2009.

Source: Chand, 2010

Map : 2.2

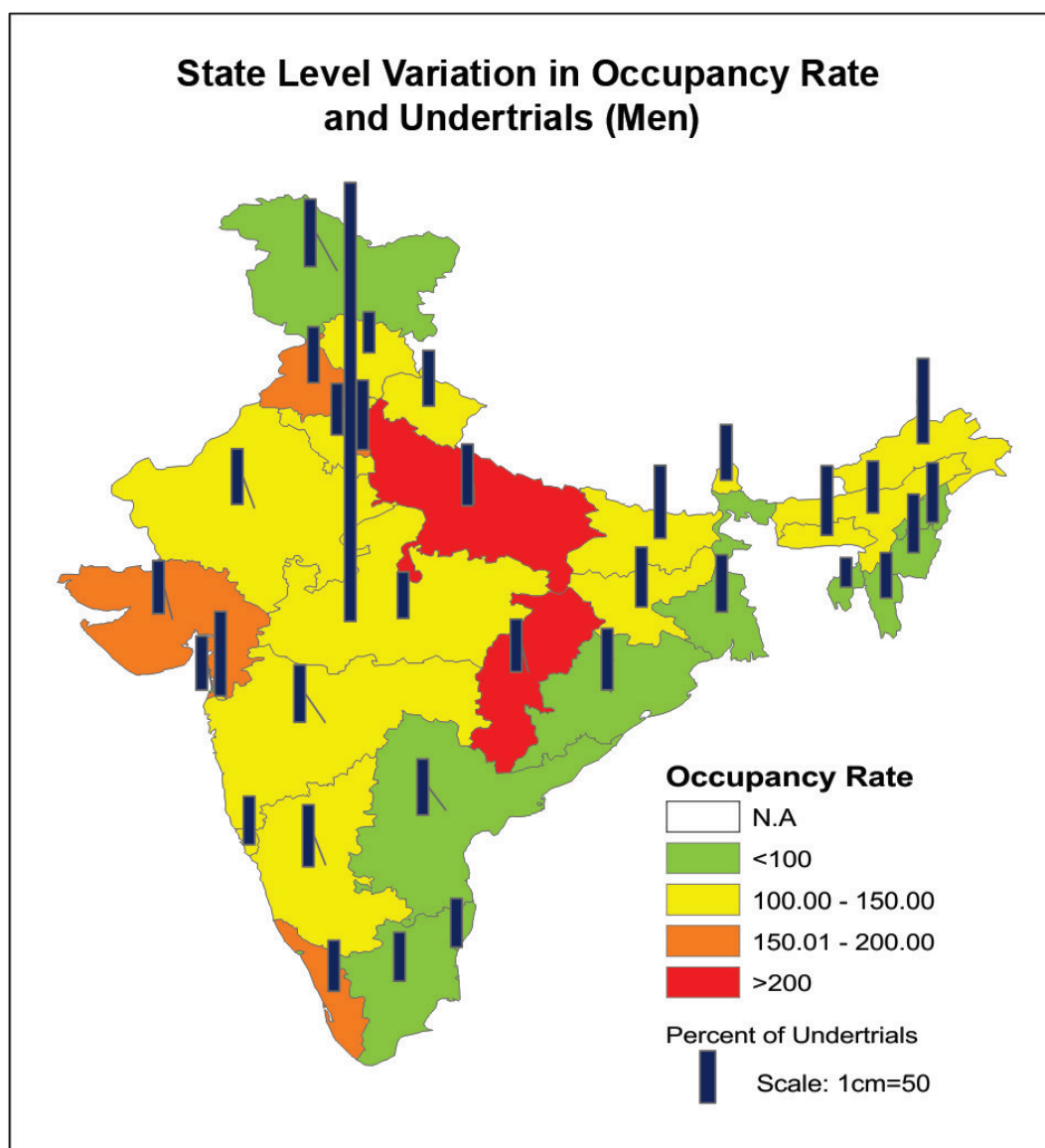


maintaining jails are two pronged: one, to keep criminals in isolation, away from open society so that they could not endanger the life and liberty of others; two, while serving the prison sentence they would get enough time and opportunity to repent and eventually reform themselves. Not surprisingly, prison inmates are provided with basic amenities, they work inside prisons and also earn. For all these activities, a well laid out infrastructural arrangements are required. In the absence of which, jails could not be administered properly and the result would be anarchy.

Three sets of prison related data are presented in this section. Table no (A 2.20 in appendix) even

gives state-wide details on (a) occupancy rate, that is, number of jail inmates, men and women separately, (b) no of jail staff per 100 inmates and its opposite gender counterpart, that is female staff separately for female inmates, and (c) shortfall in jail staff. In terms of occupancy rates, the most crowded jails are in Haryana,(See Map: 2.3 & 2.4; also Table A 2.20 in appendix) showing figures more than twice the corresponding national average number. This is followed by Orissa and Bihar. Surprisingly, extraordinarily high occupancy rate is observed in smaller states and Union territories. Dadar and Nagar Haveli, for instance, have the highest number of prison inmates, followed by Delhi. Likewise, against

Map : 2.3



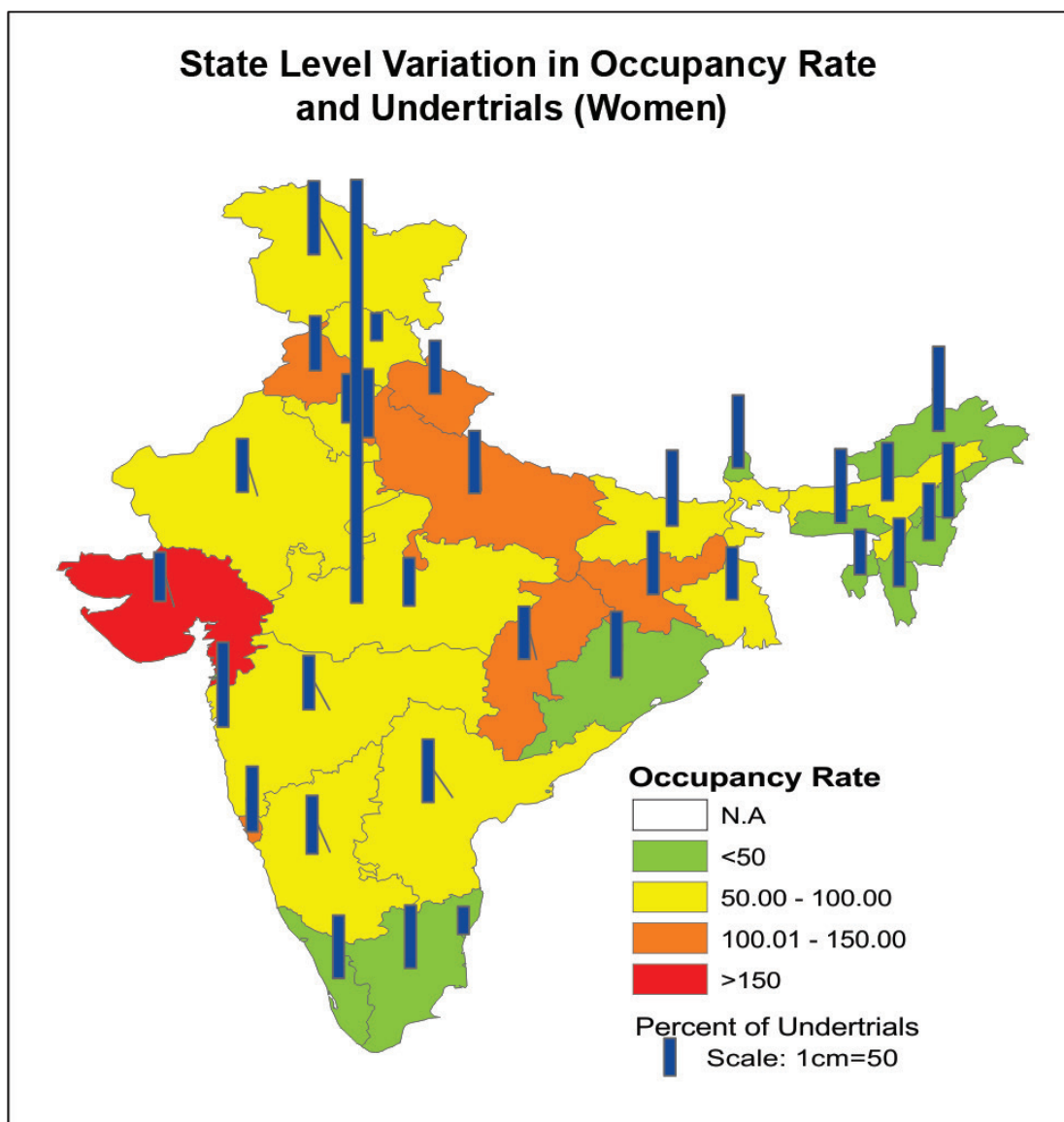
the national average of 15 staff for 100 jail inmates, the lowest was reported from Haryana (5) and Bihar (6) in the year 2000. Nearly a decade later, Haryana witnessed a three hundred per cent increase (15 per 100 inmates) but the corresponding increase was almost negligible in Bihar.

Under trial prisoners: Lack of judicial official, police force or combined effects of both, our jails are inundated with under trial prisoners, estimated to be two-thirds of the total in jails across the states. They are forced to languish sometimes years together; even in such cases where in they would have been released much earlier had they been sentenced after trail and

served the pronounced jail term. A large number of under trial prisoners languishing in jail came in public knowledge in late 1970s itself. Subsequently, this was confirmed in the police commission's report and in writings of a celebrated police officer (K F Rustamji). Recently, following a PIL, the Supreme Court ordered the release of all those under trials (See, Box : 2.2) who have certain years behind bars.

The data available on this count would show that amongst the under trials, the biggest proportion happen to be of those who were in jail for less than six months. In Andhra Pradesh, their proportion was counted for as high as 83 per cent in 2000, but less

Map : 2.4



than one per cent in case of those who had already spent more than three years in jail (Table A 2.21 in appendix and Map 2.4). The corresponding figures for the same state in the year 2009 were 90 and 0.3 per cent respectively.

Quality of Life

To define life in measurable terms, certainly not in its philosophical connotation, is a difficult proposition. It is all the more complex, if it is clubbed with a qualifying adjective. In fact, there could hardly be a precise or standard definition of what is called life. This is equally true of quantifying determinants of the quality of life. For, it is influenced by multiple

variables, interwoven with social, economical and cultural aspects. What is 'highly comfortable' for one set of people could be 'useless' or 'waste' for another set of populace. Therefore, taking a cue from the formula of lowest denominator, it can be safely argued that there are certain basic things whose presence or absence make or mar the day to day life. These are: house, running water, toilet, electricity and connectivity with the rest of the world. To maintain all these, one need to have certain amount of regular income. Barring the last point, that is, quantifying proportion of people on the basis of their income and also measuring people labelled as poor, data pertaining to the rest are presenting below:

Box 2.2 : Release of Under Trial Prisoner

The Indian government's decision to release 92,000 under trial prisoners mostly charged with petty offence was initiated on January 26, 2010, as a part of the "mission –mode programme" and began implementation in April 2010. According to the law ministry, there are 300,000 under trial prisoners in Indian Jails which comes out to 70% of total jail population. The release of prisoner is seen as a major step to decongest Indian Jail. The following table gives the number of under trial prisoners released in a few states.

State	No. of Under-trial Prisoner released
Uttar Pradesh	29009
Andhra Pradesh	9116
Delhi	8701
Orissa	8566
Maharashtra	7252
Punjab	3219
Gujarat	3101
Haryana	2169
Keralav	2334
Karnataka	1081

Source : <http://www.lawisgreek.com/9200-undertrial-prisoner-released/21-2-2012>

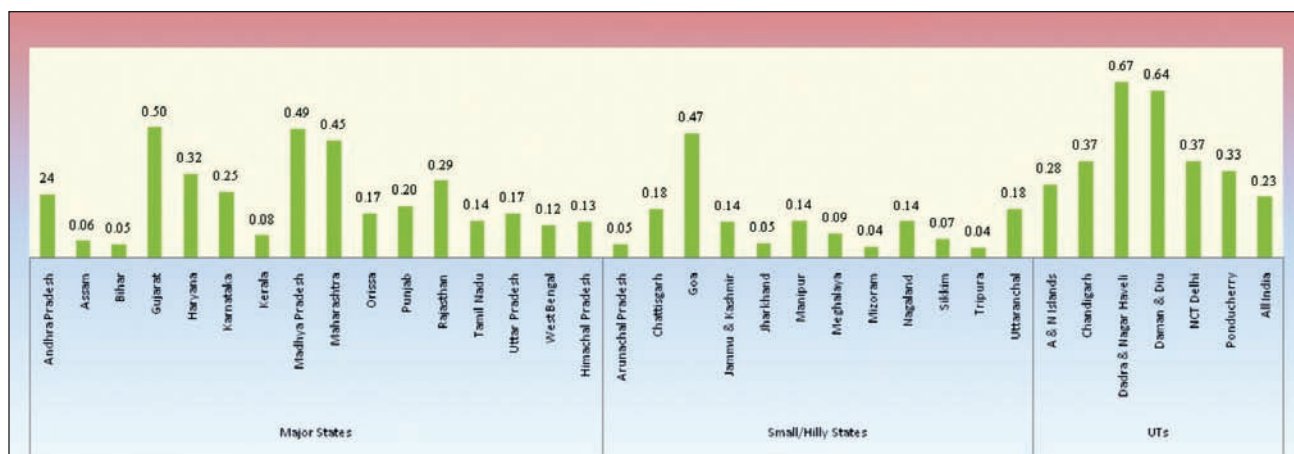
Housing and Homeless Households: What is the extent of homeless population in the country? There was hardly any reliable data on this count till 2001 Census figures went public, though a massive housing scheme the *Indira Awas Yojna* (IAY) started unfolding since 1985. As a part of centrally sponsored schemes (CSS), this was designed to provide house to BPL families¹³. There was nothing wrong with this scheme. Rather it was driven by altruistic approach that by owning house a poor, hapless family can save itself from all sorts of indignities. After all, 'housing is a basic physical need to sustain life; for the homeless possessing a house provides a sense of identity, security and safety' (UNDP: HDR, 2010).

The over enthusiastic political and bureaucratic executives combine could not visualise that in first place IAY would necessitate a policy frame. Also, that in the absence of hard data it would not be possible to work out the details of implementation either. Thus instead of designing a housing policy for the rural poor, the ministry of rural development (MoRD) launched this scheme out of blue, as political expediency. Year after year, the MoRD annual reports would provide the following sets of

information: budgetary allocations and utilization, targets and achievements, all state-wise break ups. The MoRD could never ponder how many homeless families had already been provided roof over their head, how many are still left out and by which year there would not be a single homeless family. Of the total 194 lakh (19.4 million) household in the country (2001 Census), 4.5 lakhs (approximately) were homeless, that is, only around 0.23% of the total households. Proportionately, the figure was very small but in absolute term it meant, around 20 lakhs people were houseless. This figure is for the entire country without any segregation of rural-urban divide. That every year a few lakhs of housing units would be constructed under this programme, this has already been noted. Yet a decade later, under the financial year 2009-2010, the target fixed up for IAY housing scheme was 371,982. Against this 434, 733 housing units were constructed. In plain words more than 60 thousands above the target. Regrettably, this does not match with the statistical figure of 2001 census. Either of two sets of data is wrong. Both are provided by the different agencies of Government of India. This shows nothing but the working of public undertakings working individually, separately without any cross checking. Details are provided in Table A 2.22 and A 2.23 (See appendix), respectively.

¹³ Within this quota there were sub-quotas for families belonging to SC and ST categories as well as for women headed families.

Fig. 2.12 : % of Homeless Households to Total Households



Source: Census of India, 2001.

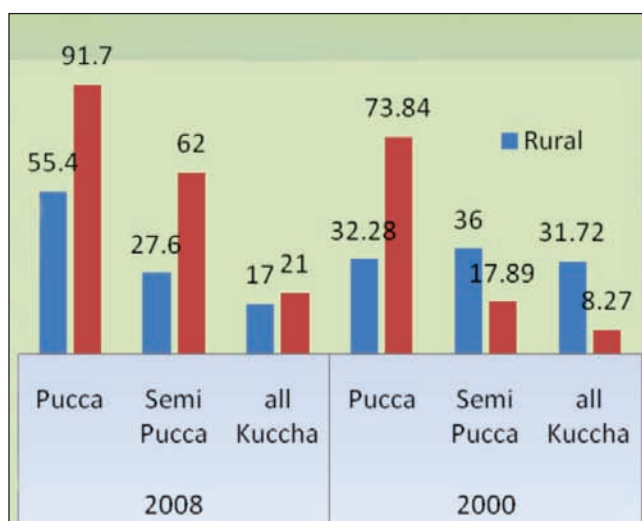
The following figure 2.12 gives state wise distribution of percentage of homeless household as per census 2001. If the housing figures are true there are very few unfortunate poor who do not have a roof over their head. In fact, homelessness to a large extent is an urban phenomenon. The bigger is the city the larger is the homeless population. In the villages one may come across people not having homestead land, particularly, those belonging to SC and MBC categories whose dwelling are erected on the land not belonging to them.

Apparently there is a great deal of variation in the houses (see Fig 2.13 Maps 2.5 to 2.8) available to

the people at large. Yet there is consensus on what is referred to as basic facilities inside house including provision of drinking water, sanitation and electricity (See Table A 2.24 and A 2.25 in appendix).

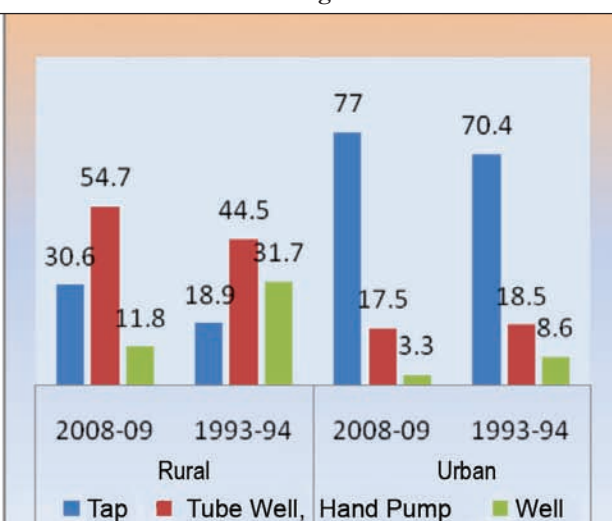
Drinking Water: In India, proportion of households facilitated by improved water sources have decreased over time period. The data available on this point simply indicate proportion of households with access to drinking water by source. That could be roughly distributed into piped water supply and water accessed through other sources, including well, hand pump, tube well etc. Undoubtedly, pipes supplied water would be relatively safer than the water drawn

Fig. 2.13 : Types of Housing in Rural and Urban India

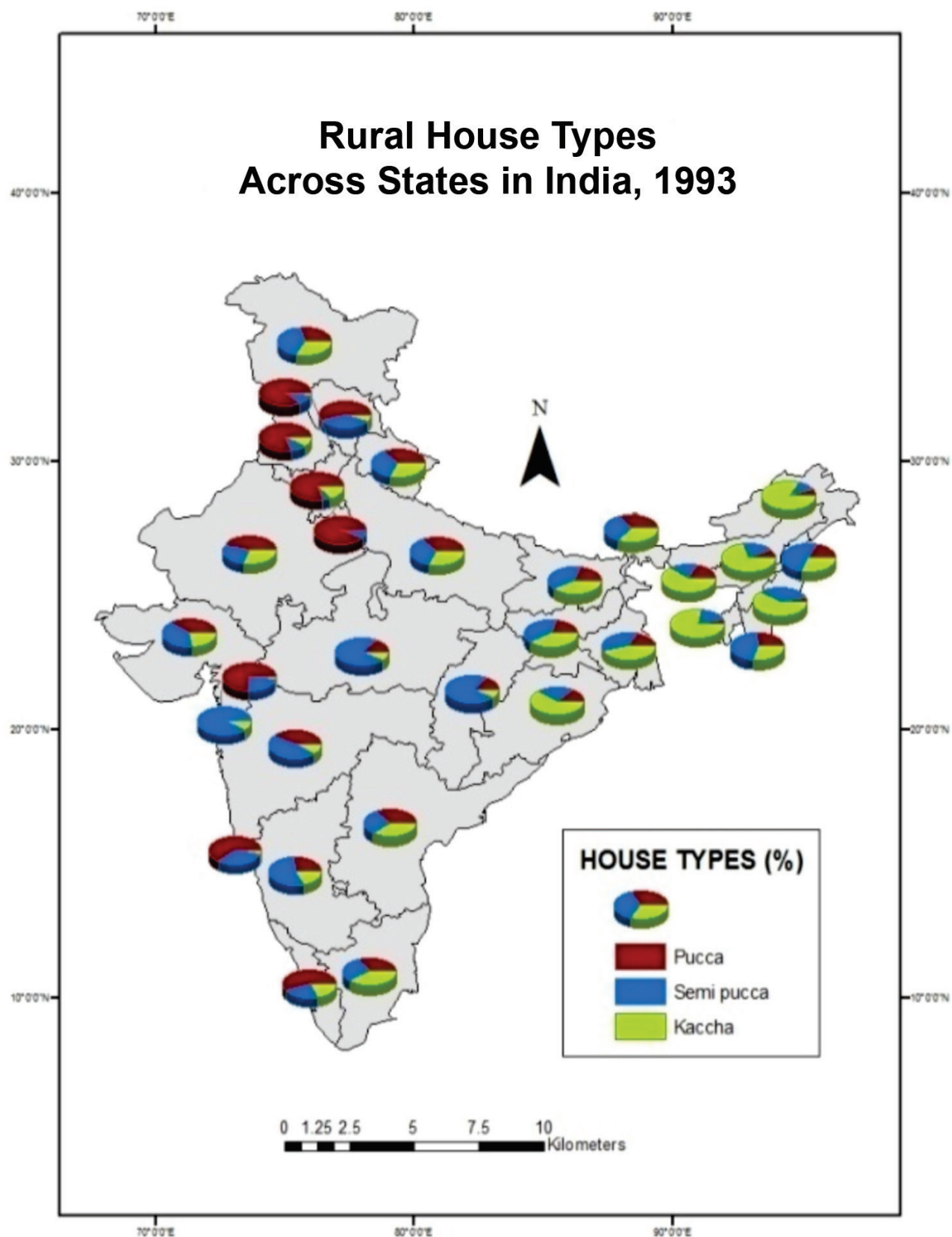


Source: NSS Report no. 429 and 535

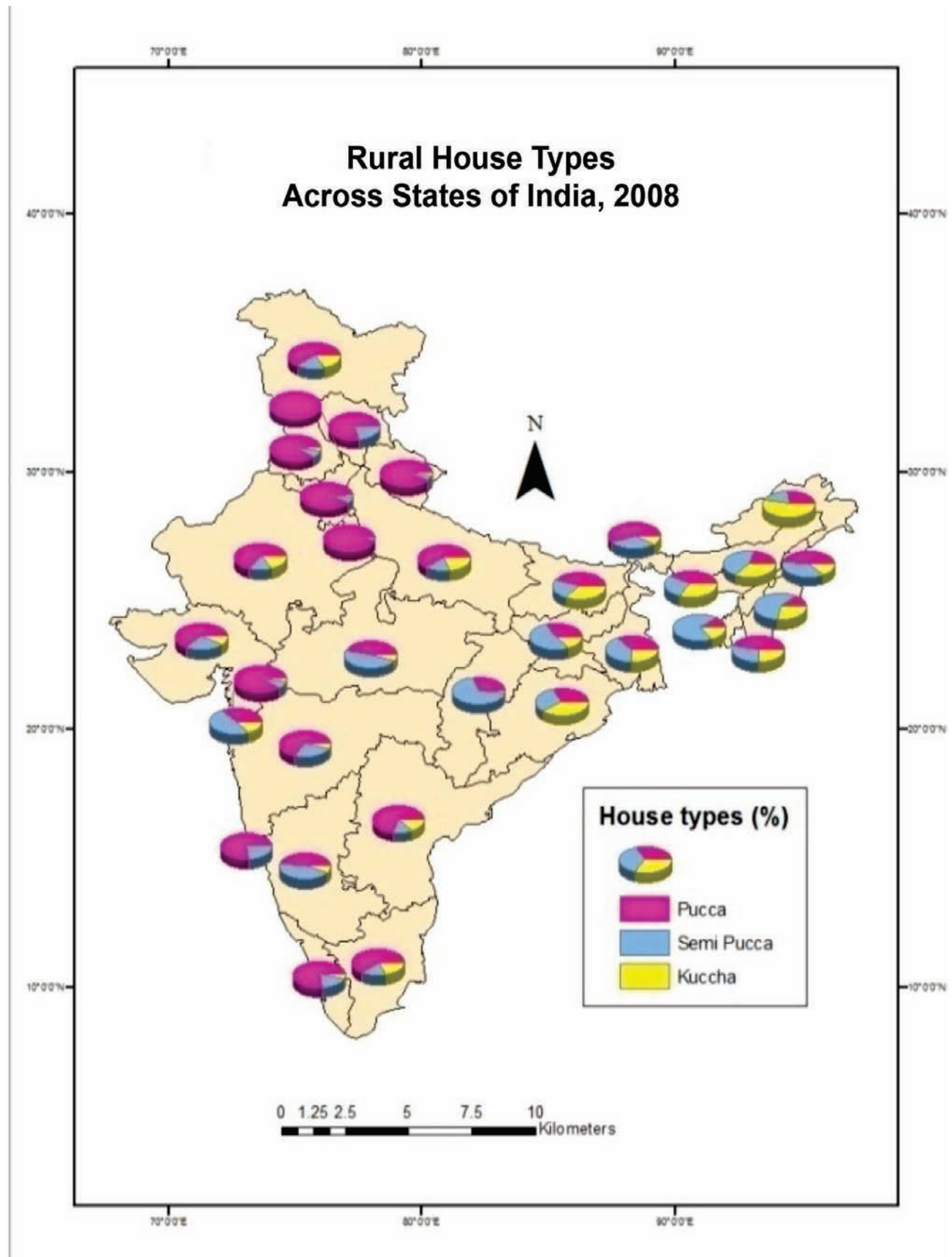
Fig. 2.14 : % of Household with Different Sources of Drinking Water



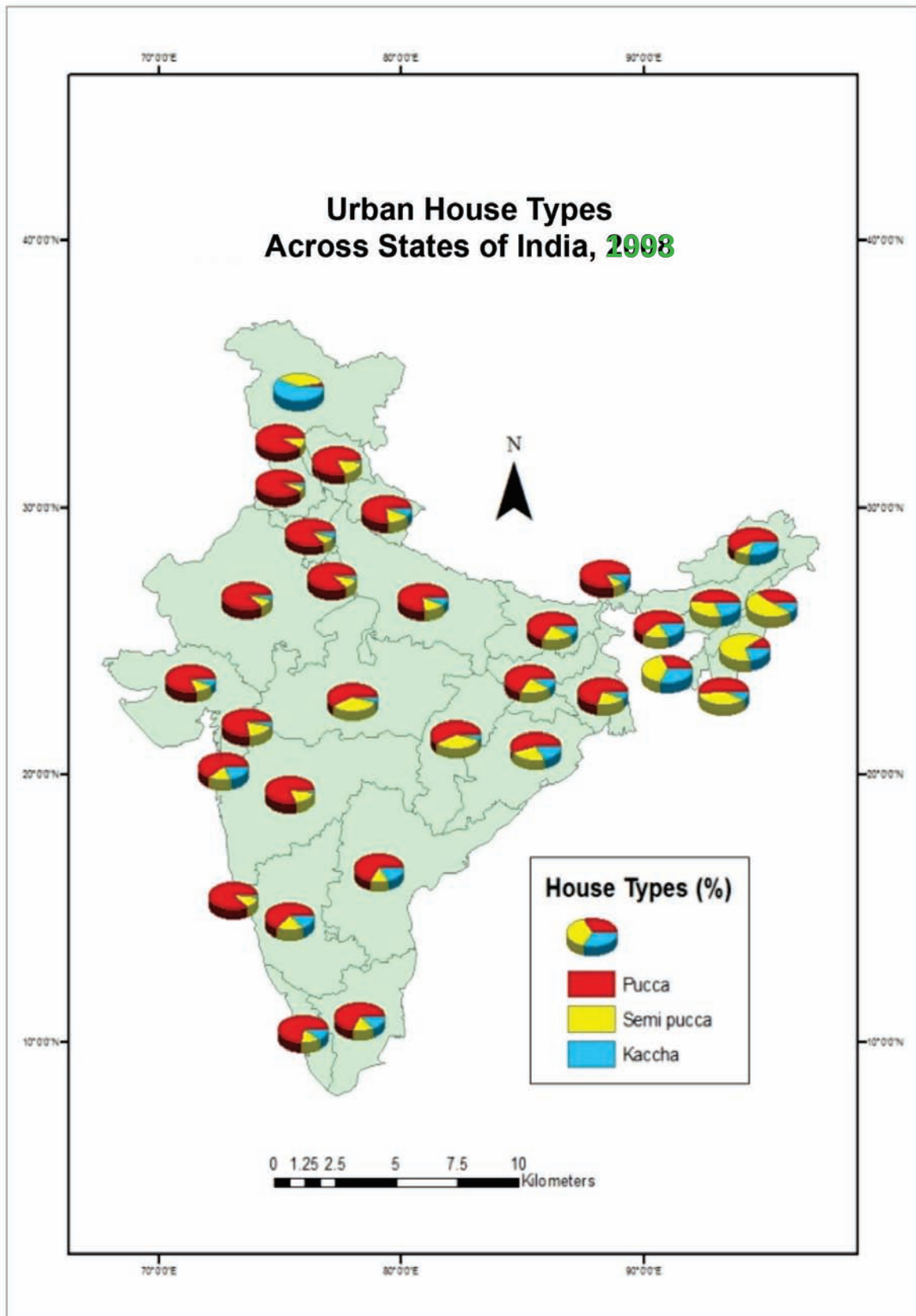
Map : 2.5



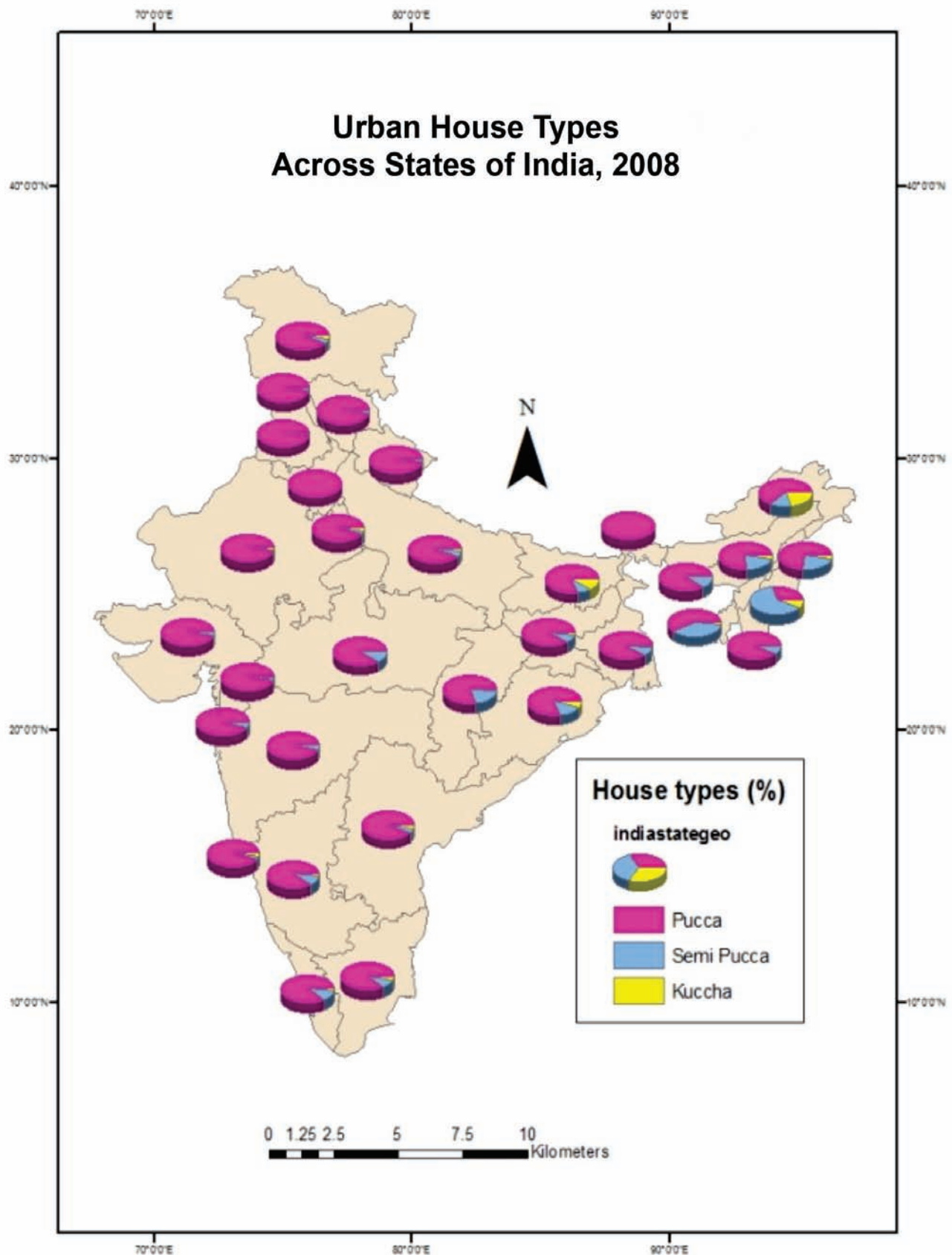
Map : 2.6



Map : 2.7



Map : 8



from the other sources like a well or a pond where possibilities of any type of contamination is highly likely. In (See Fig. 2.14 and Table A 2.26 and A 2.27 in Appendix) distribution (per 1000) of households by the major sources of drinking water at the all-India level is presented for NSS 49th round (January – June 1993), and NSS 65th round (July 2009- June 2009) and the corresponding distribution for each State/UTs.

During 2008-09, for instance the major source of drinking water in rural areas (See Map 2.9 & 2.10) was ‘tube well/hand pump’ in respect of little more than half (55%), as compared to 45% in 1993 of households followed by ‘tap’ for around one third (30%) of households. It was less than one-fifth (19%) in 1993. In urban areas, on the other hand, ‘tap’ was the major sources of drinking water for three forth (74%) of the households (See Map 2.11 & 2.12) and ‘tube well/hand pump’ served another 18% households. ‘Protected well’ was used as a major source of drinking water by nearly 2% of the urban households while nearly 1% of the urban households had used ‘unprotected well’ as the major source of drinking water. One noticeable feature of urban households was the use of ‘bottled water’ as a major source, which served nearly 3% of the urban households. Thus, the patterns in the use of sources of drinking water show the predominance of the sources ‘tap’, ‘tube well/hand pump’ and ‘well’ which were taken together used by nearly 97% of rural households and 95% of urban households.

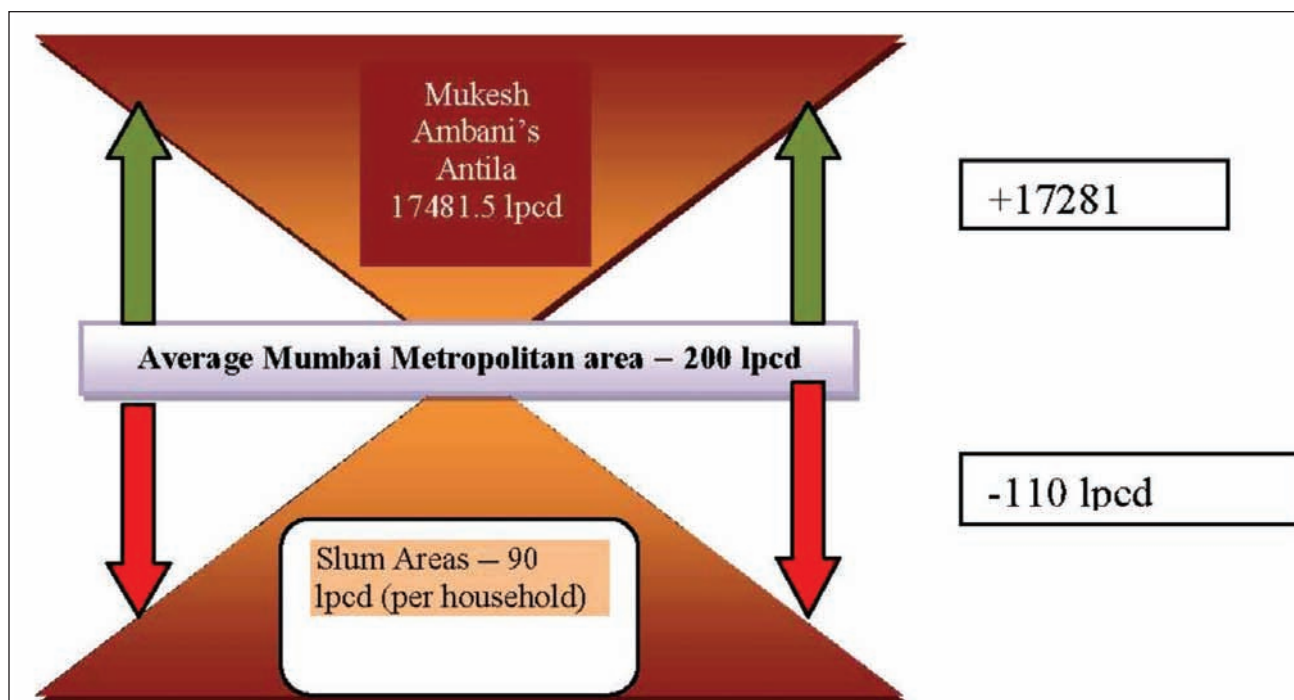
What has been progress to this end during the last two decades, starting from early 1990s? The figures shown in (Table A 2.27 in Appendix) are self explanatory, indicating the status of drinking water supply in pre-reform period, a decade after and of the recent years. It is instructive however to note that among 15 major states in India it was only in Gujarat (52%) and Maharashtra (48%) where around half of the villages had already been covered under piped water supply in early 1990s. With less than one per cent villages served with piped water, Bihar and Orissa occupied the bottom position. Fifteen years down the line, Tamil Nadu is seen as taking a quantum jump by providing piped water to over four-fifth (85%) of the rural habitations, followed by over two-thirds (70%) in Karnataka. Gujarat and

Maharashtra both stuck at less than 60%, showing very marginal improvement. Both Bihar and Orissa are still placed at the lowest ladder on this count with less than 10% coverage. But dramatic change has been noticed in case of Uttar Pradesh, witnessing decline from already pathetic 6 to less than 3 per cent. This is most unusual. On the other hand, located at the other extreme of the scale, there are only a handful of states that could claim coverage around 90 % of households. They are: Karnataka, Maharashtra, Tamil Nadu and Gujarat among major states. In case of smaller states, such as Sikkim (98%), Himachal Pradesh (96%), and Jammu & Kashmir (94%), the coverage is slightly more improved. Even performance of Orissa (64%) is far better as compared to Bihar (30%) and Assam (37%).

With a number of rural habitations cursed to drink water contaminated with fluoride, arsenic etc. even the small proportion of villages enjoying regular supply of piped water is a great relief. This is in any case better than all the open sources of drinking water like, pond, well or stream. Yet that even this (piped supplied water) would be safe, potable, cannot be guaranteed. A proxy data like proportion of households using water filter could give some idea to this end. This could also be seen from the burden of water borne diseases. Therefore, an estimate of access to safe drinking water is nothing but a hazardous guess. Second, the available data is distributed on urban rural pattern. Usually, it is also assumed that accessing of potable water is a problem associated with rural areas only; all the more in case of inhabitations dotted around deserts in Rajasthan or those nestled on hills. This is normally measured in terms of distance covered from a village to a given source of water. On this count, however, the problem faced by the people has a large urban base as well.

This is measured in terms of per capita litre of water available for per person per day (lpcd). In fact, the bigger is the city, the highest is the inequality in accessing water. The contrast is best illustrated in the figure 2.15 showing volume of water supplied to Ambani’s home and slums etc. in Mumbai by the municipal corporation of greater Mumbai (still popular with its old acronym, BMC). The richest person of India has every right to afford water as much

Fig. 2.15 : Paradoxical Water Supply



Source: Mumbai's Water Supply (www.bcpt.org.in) & The Hindu, 24/04/201

as he can; it is no body's business to grumble over. The problem starts when a public service provider, that is BMC, takes recourse to all sorts of constraints while failing in its duty to ensure minimum amount of water to millions of people but for the richest person's house the same BMC becomes too generous to hide its preference. Can this be explained by any other model than attributing it to sheer governance (also, see Box no. 2.3) failure?

Sanitation:

Status of sanitation particularly in rural areas is equally deplorable. The NSS provided data showing 'no latrine' (read, absence of any kind of attached

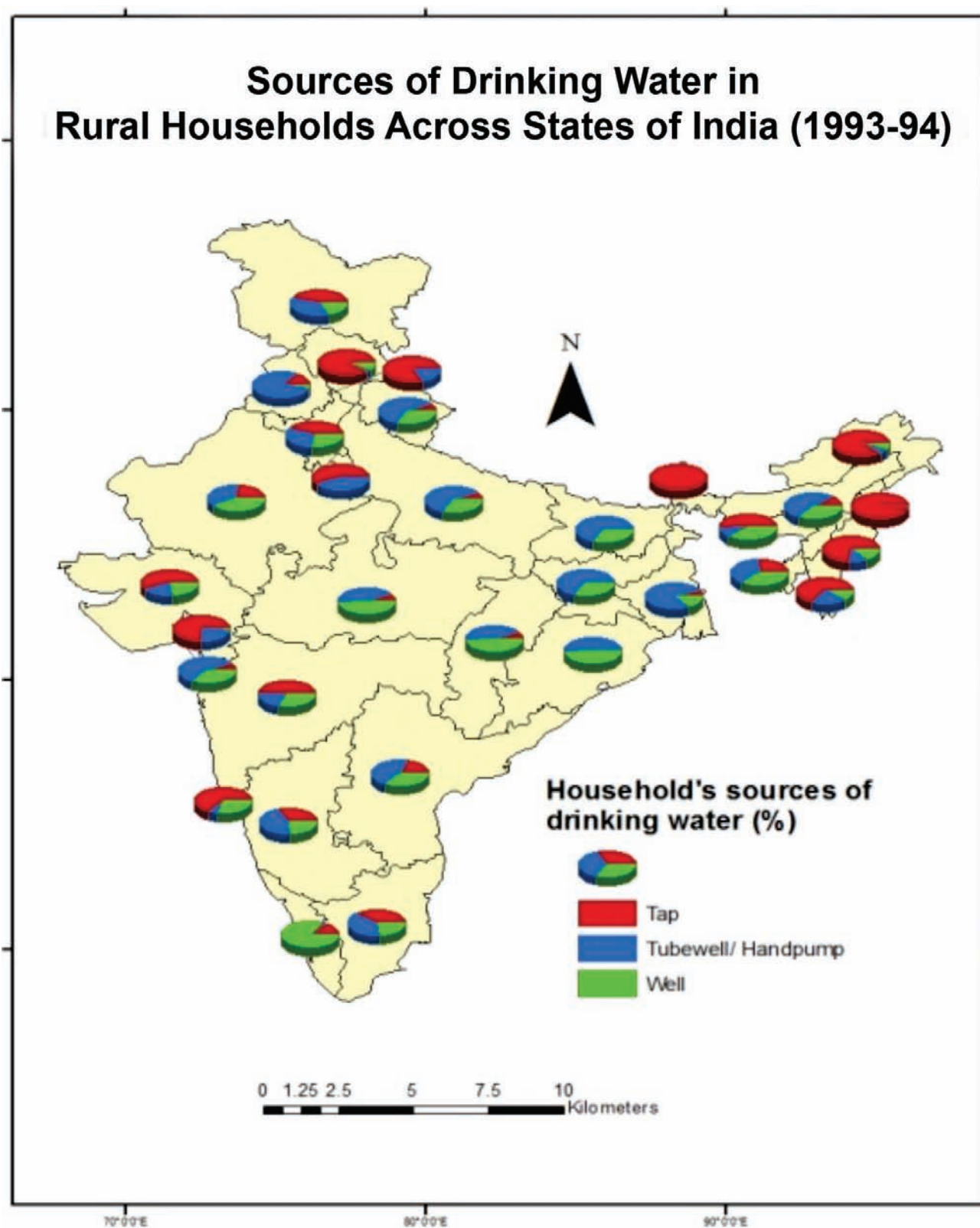
toilet) scores maximum, in the range of 60 to 80 % (Table A 2.28 in appendix), practically in all major states. This stands more than four-fifths households in rural Orissa (88%), Madhya Pradesh (85%) and Rajasthan (82%). It is staggering in Tamil Nadu (79%) where public health concerns paradoxically are so high. The state of Kerala stands apart with less than 6 % corresponding figure of households reporting absence of toilet. Highest rate of literacy in combination with political mobilisation including decades old social reforms, particularly women's education and their health care seem to have boosted the records in this God's own land. It is equally impressive in case of all the north eastern states as well

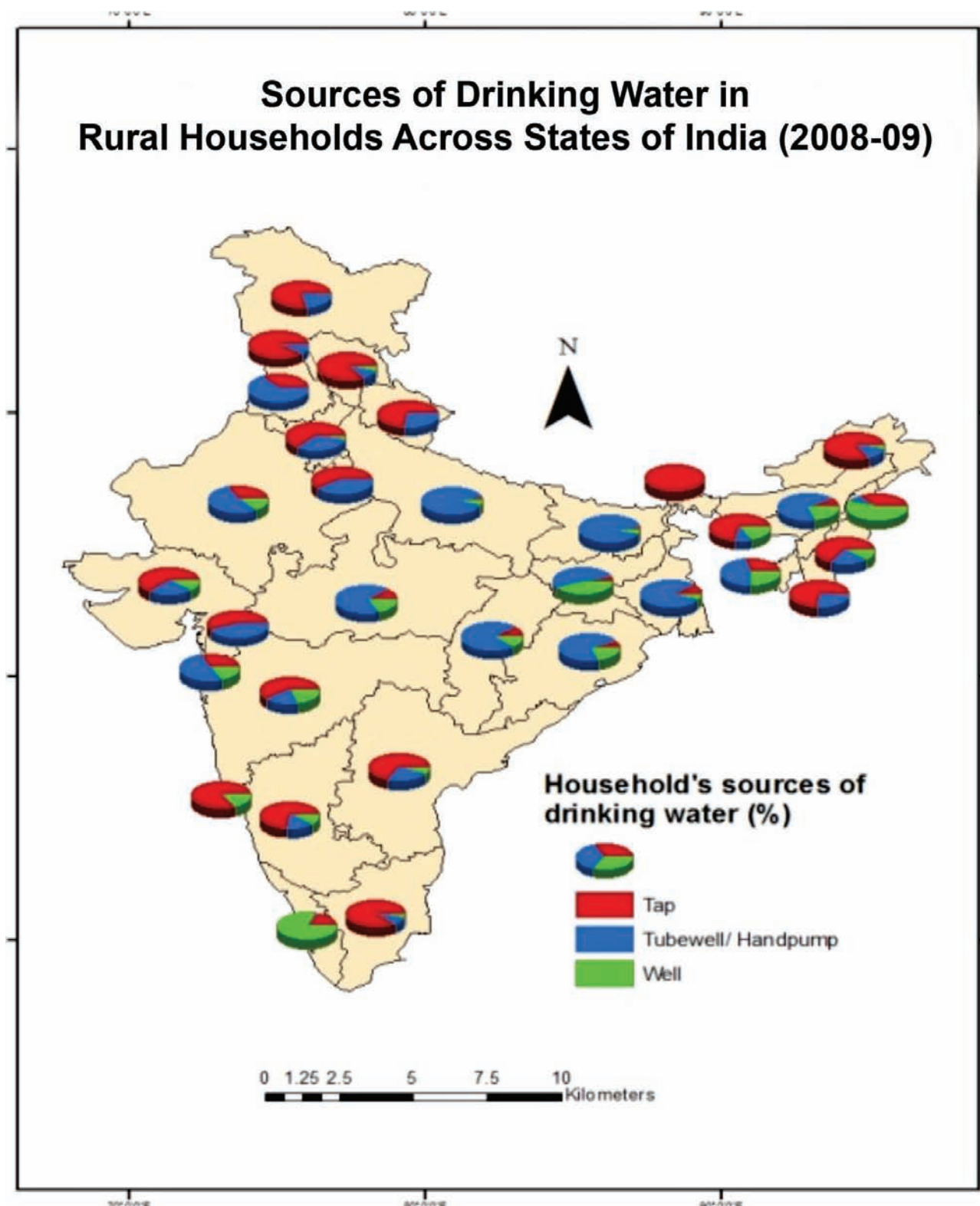
Box 2.3 : Overlapping Functions

A host of multiple departments and ministries are involved in ensuring adequate water supply for different purposes. For instance, water supply for agricultural use is the responsibilities of as many as three organizations. Water for irrigation (major, medium and minor) is managed by the Ministry of Water Resources (MoWR), watershed management is entrusted to the Department of Land Resources whereas MGNREGA related water conservation issues are handled by the Ministry of Rural Development (MoRD) and the Department of Agriculture is arbiter of efficient use of water for agricultural purposes. Above all, the drinking water supply in rural areas is looked after the Department of Drinking Water Supply (DDWS). In small towns, it is the municipal bodies shouldering the same responsibility but in megacities like Delhi there is a separate body like Delhi Jal Nigam which is beyond the confines of the municipal corporation of Delhi.

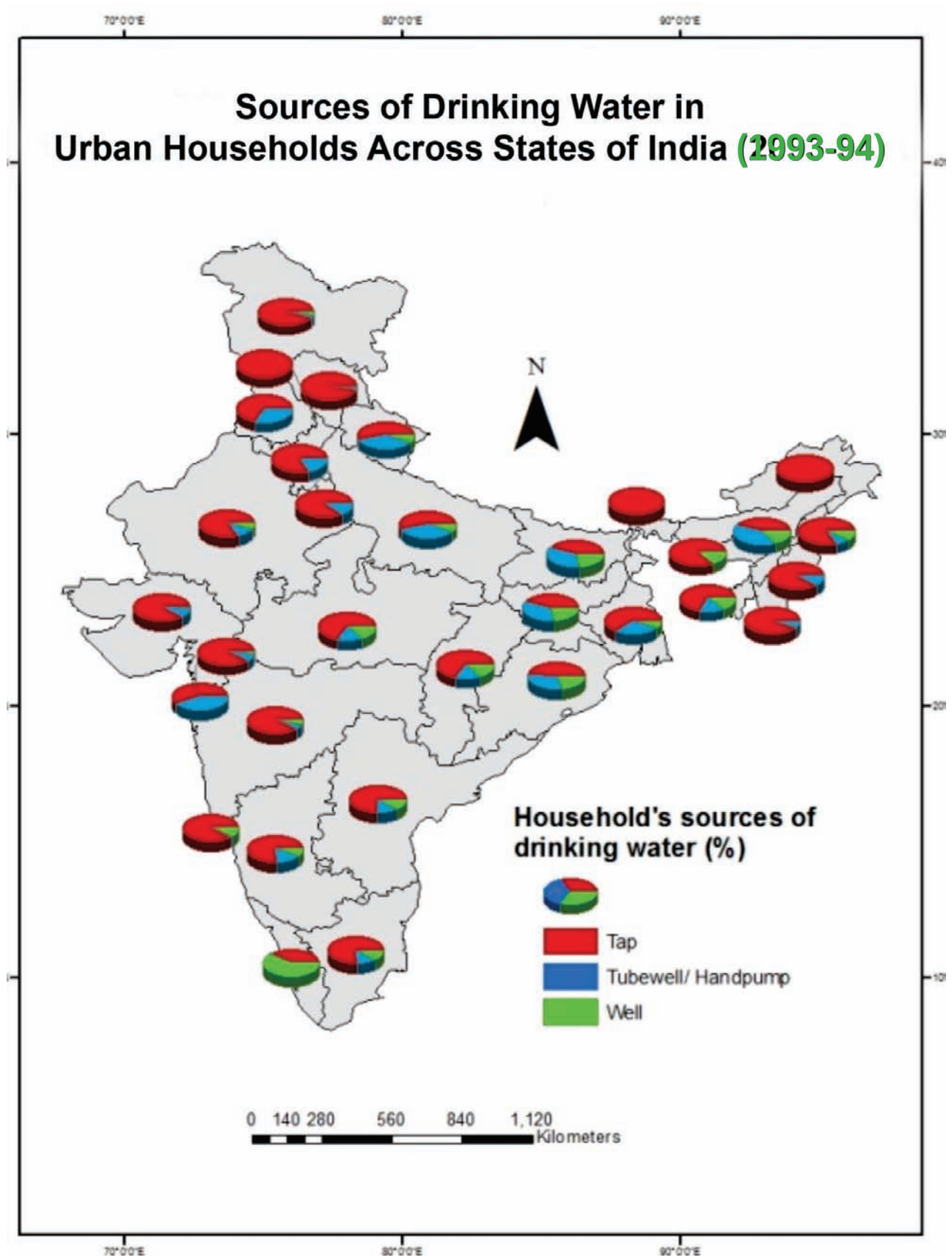
Mid-term Appraisal of the 11th five Year Plan, Planning Commission, 2010-11

Map : 2.9

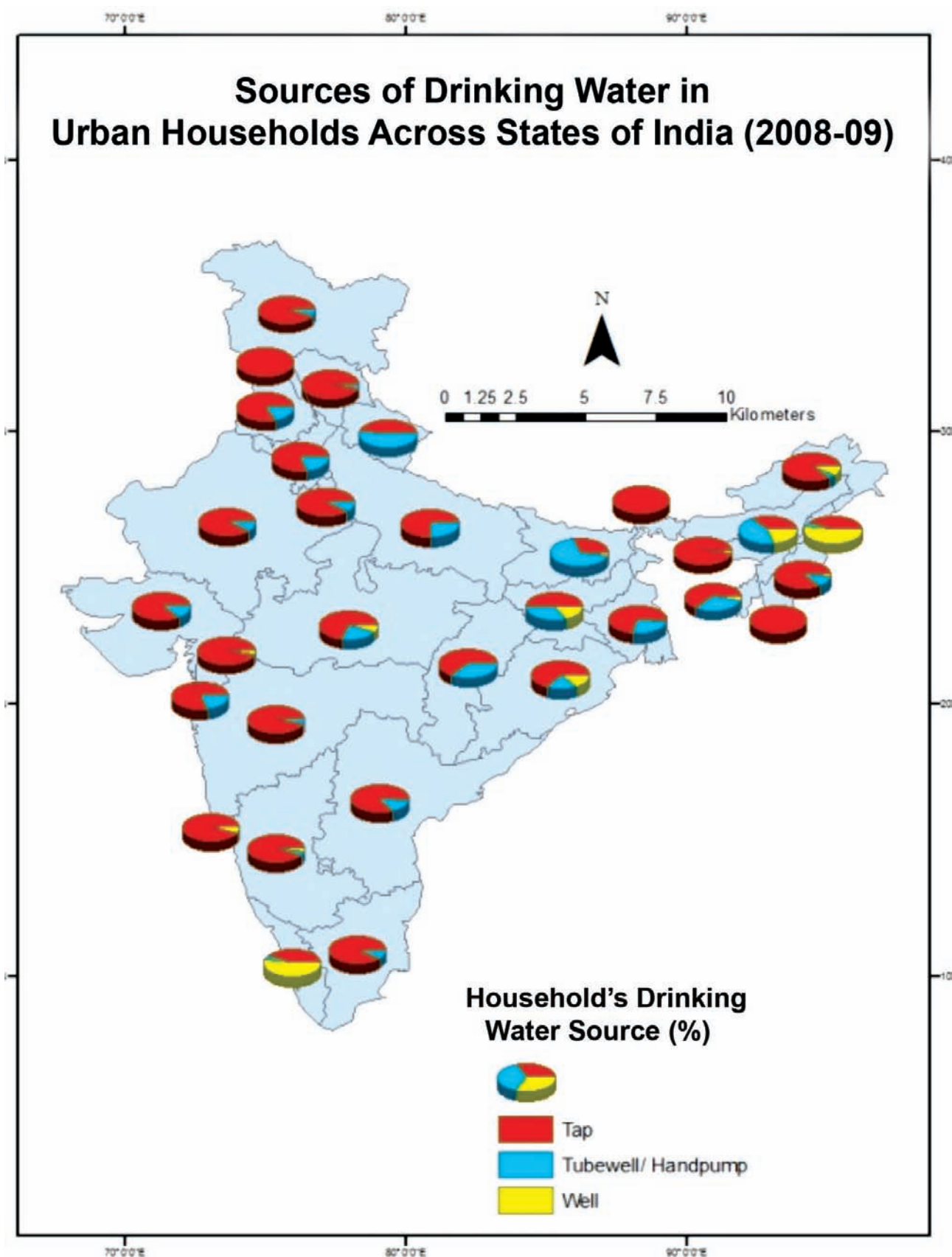




Map : 2.11



Map : 2.12



as Sikkim. In contrast there is marked improvement in urban areas. It is apparent from the fact that there are only five states where still 25 to 30% households (Ssee Table A 2.28 and 2.29 in appendix)) are marked without any type of toilet what so ever. They are Chhattisgarh (31%), Orissa (29%), Bihar (27%), Jharkhand (24%), Madhya Pradesh and Karnataka (24%) as against 11 % national average.

In 2008-09, at the all-India level, nearly half (49%) of the households had no latrine facility with considerable rural-urban divergences: nearly one third (65%) of rural households had no latrine facility whereas only 11% of urban households did not have any latrine. Septic tank/flush, which is considered hygienically better type of latrine was more common in urban areas than in rural areas: nearly three fourth (77%) of urban households used septic tank/flush latrine whereas it was mere 18% in case of rural households.

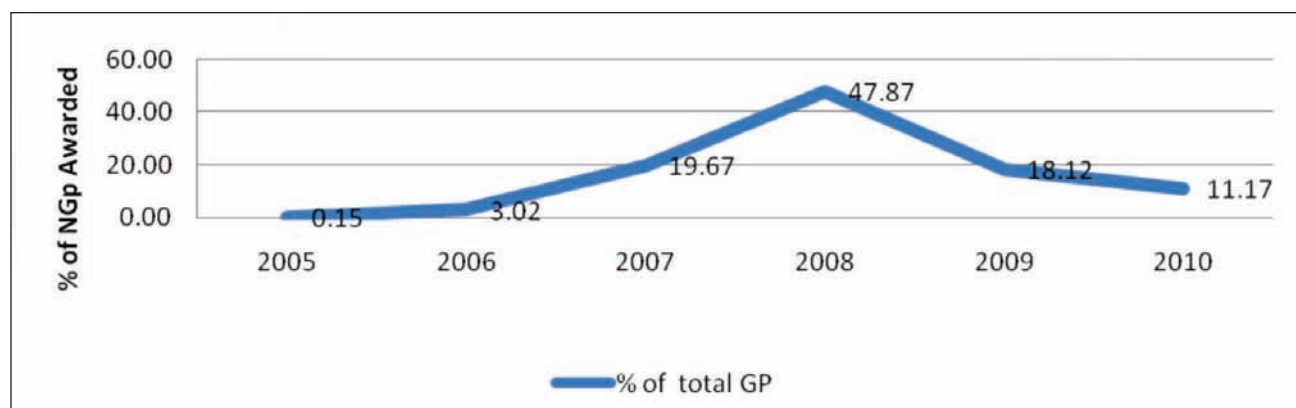
In the rural areas the proportion of households was found declining by nearly 21% points during 1993

and 2008-09 as 86% households had no latrine facility in 1993 which decreased to 65% in 2008-09. In urban areas, on the other hand, while 31% households had no latrine facility in 1993, only 11% households were deprived of this facility in 2008-09.

Nirmal Gram Puraskar (NGP): It was initiated in 2005 to award Gram Panchayats (GPs) for achieving total sanitation. In the first lot 40 GPs (out of 478 applications) from six states, were awarded. Next year, the corresponding number of awarded GPs went up to 769 spread in as many as 14 states (See Fig. 2.16 and Box 2.4). Thereafter, it rose to 4959 and further up to 12,382 in 2007 and 2008 respectively. It may be mentioned that nearly one-third of the total awarded GPs (37%) were from Maharashtra alone.

Access to Electricity: Electricity has multiple uses: for domestic consumption, for industries and business, for irrigation and other farming practices, and of course for public services. Mapping details of electricity consumption, like that of water, therefore entails varying data source. The figures in (Table 2.3

Fig. 2.16 : Distribution % of Nirmal Gram Puraskar Awarded to Gram Panchayat



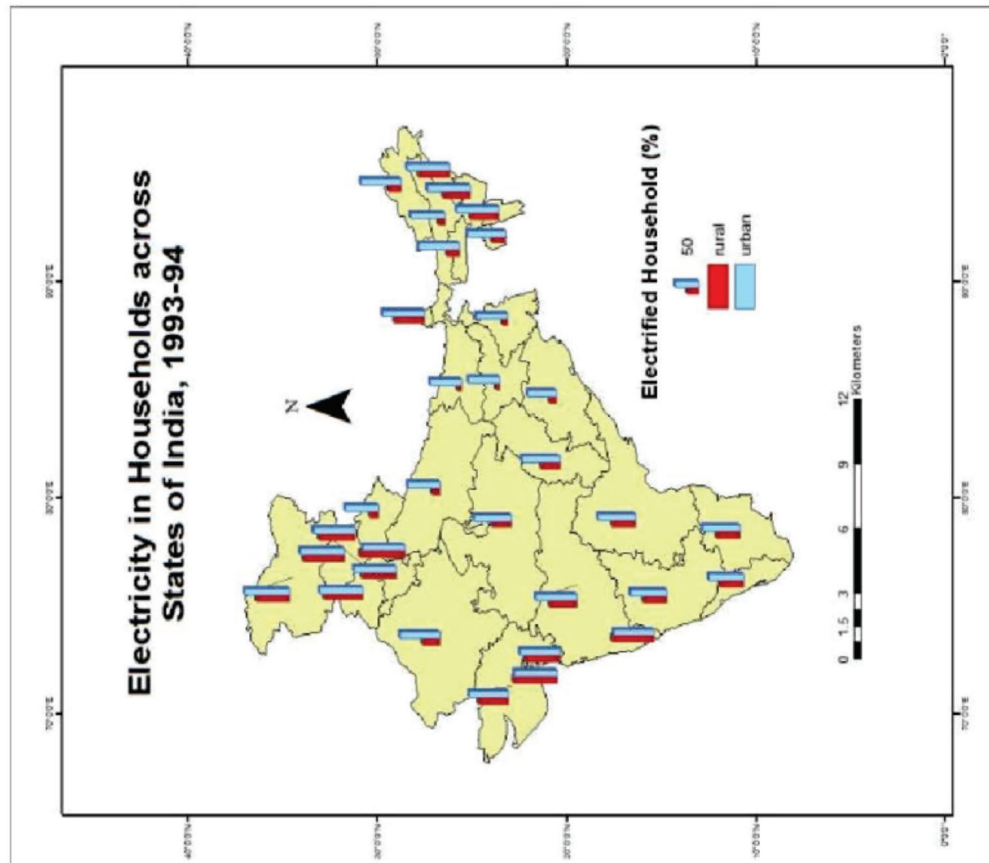
Source: Official website of Union Ministry of Rural Development

Box 2.4 : Scanty Sanitation

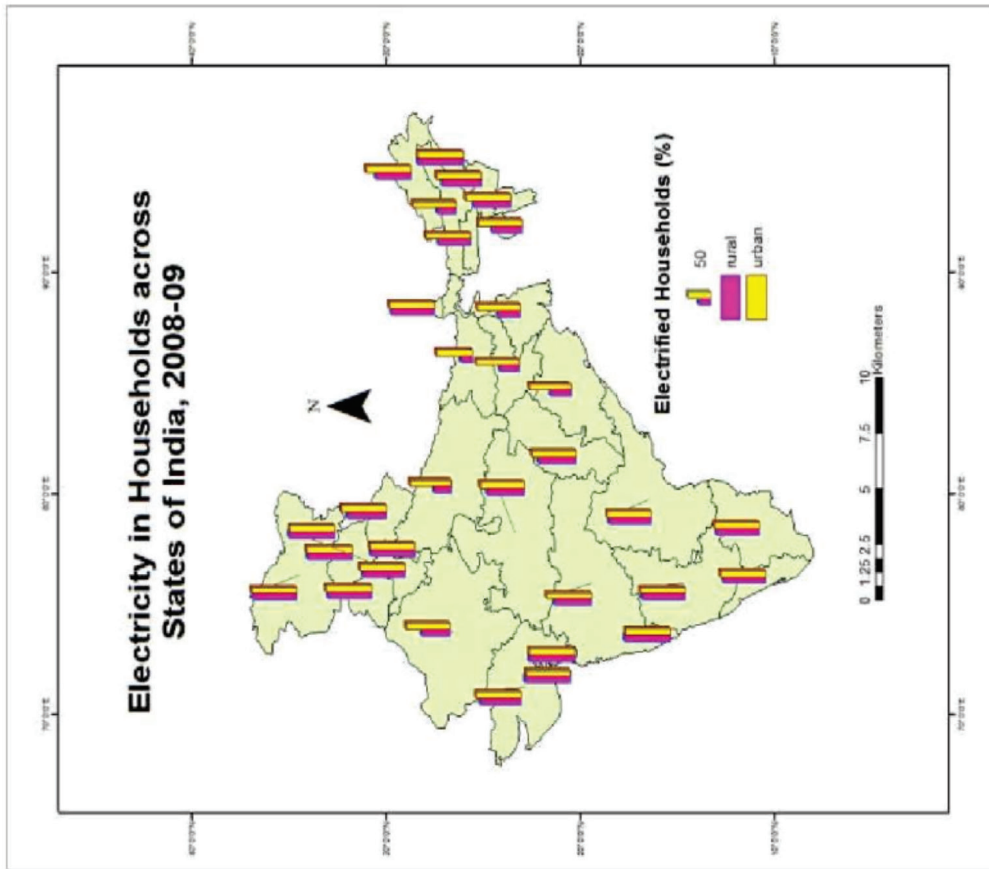
A little over half of the total Indian population, that is, close to 600 million are constrained to open defecation since they didn't have access to any kind of toilet. (Bonu & Kim 2009). Considering their scarce cash inflow in rural areas, construction of a room for toilet within the house or nearby may not seem feasible; and the existing facilities are not adequate. Not surprisingly, 'the sanitation landscape in India is still littered with 13 million unsanitary bucket latrines, which require scavengers to conduct house-to-house excreta collection. Over 700,000 Indians still make their living this way' (Duenas, 2008)

Source : India's Sanitation for All: How to make It Happen, ADB (2009)

Map : 2.13



Map : 2.14



in appendix) provide details of state wide households' consumption, measured separately for rural and urban areas. The all-India average was just one-third of total households (36%) in rural areas but state-wide variation was enormous. Starting from the highest figure for Punjab with its 85% of rural households having electricity connection, it was lowest, (7%) in case of Bihar. Interestingly, rural electrification had begun in Tamil Nadu during the first five-year plan itself, but it had reached to only half of the total rural households by early 1990. Fifteen years down the line, it went up to 92% of households in Tamil Villages. This is by and large true (90% households electrified) of a large number of major states, including the rest of three southern states, Punjab, Maharashtra, Gujarat, to quote NSS survey (2008-09) report (see Table A 2.30 in appendix). The states which are on the lower side of national average are located in the eastern part of country; the lowest is reported from Bihar, just one-fourth of the total rural houses.

The availability of electricity facility to the households during 2008-09 as well as its temporal changes over the period from 1993 to 2008-09 are presented (see Maps 2.13 & 2.14 here. In state wise comparison, Bihar reported lowest proportion (per 1000) of households having electricity for domestic use, followed by Uttar Pradesh, Assam, Jharkhand and Orissa. On the other hand, Delhi, Nagaland, Goa, Himachal Pradesh and most of the Union Territory had more than 95 percent households with electricity as domestic use.

How is the scenario in urban areas? Undoubtedly, it is far better in urban households, with a very large number of states touching 96% national average coverage. In fact, states like Assam, Orissa, and Rajasthan, where domestic use of electricity is not wide spread in their villages, have done better in their urban areas. There are two notable exceptions, namely Uttar Pradesh and Bihar (see Table A 2.30 in appendix). These aggregate data do not reflect on quality of services, read consistency in supply without frequent fluctuations and also interruptions caused by power failure. All these are rampant across the states, even in better performing states like Tamil Nadu, though in the later case hours of power failure are demarcated, pre announced. Except

sporadic mentioning in newspaper columns, it is hardly recorded elsewhere; the worst is in UP and Bihar. Electricity is otherwise a state subject but to install a power plant, thermal or hydro based, states are dependent upon the federal government (see Box 2.5 and its agencies like National Thermal Power Corporation (NTPC) or Hydro Power Corporation (NHPC) for seeking technical and financial assistance. This offers enough scope for blame gaming. The present Bihar government has openly accused the Union government for its partisan role to this end.

Box 2.5 : Centrally Powered Electricity

Consider the following publicity material on Rajiv Gandhi Grameen Vidyutikaran Yojana appearing recently in newspapers:

- Budget provision of Rs 33,000 Crores
- 90% of project cost extended as grant
- Electrification work completed in 98, 612 unelectrified villages (of total 6 lac plus villages)
- Besides intensive electrification works completed in 210, 506 villages
- Free electricity connections extended to 1.7 Crore BPL families

Courtesy: (Hindustan Times, Delhi, August 20, 2011)

Source: NSS Report No.429 and 535 (2008-09): Housing condition in India.

Access to Connectivity: In view of the territorial spread of this huge, sub-continent size country, connectivity is all the more important from the standpoint of its national integration. There are following ways of remaining connected with one-another: roads with provision of adequate public transport, telephone, newspaper and internet. Apparently, multiple organizations are involved in providing connectivity to the people settled in over six lakh villages and nearly eight thousand towns and cities, including megacities like Delhi, Mumbai, Kolkata and Chennai.

Like many other public utilities, the road also finds mentioning in both the state and concurrent lists. In the first place, there is a Federal Ministry of Road and Highways Transport. Within this is located a national highway authority vested with the powers of construction and maintenance of national highways network, providing inter/ intra-

state connectivity throughout the entire length and breadth of the country (see Fig. 2.17 and Map 2.15). This is followed by state highways which, as the nomenclature suggests, falls under the domain of the state governments and it is restricted to intra-state connectivity. The third ring of roads is usually known as district roads layered usually by the public works department. Within the district but beyond the territorial limits of cities and towns, there is yet another level of roads meant for connecting villages. These rural roads were initially looked after by the rural engineering organisation (REO) and now funded under *Pradhan Mantri Grameen Sadak Yojana* (PMGSY) a centrally sponsored scheme. In several states there is a complementary *Mukhya Mantri Grameen Sadak Yojana* (MMGSY). In addition to all that there is the Border Roads Organization that takes care of roads along the international boundaries.

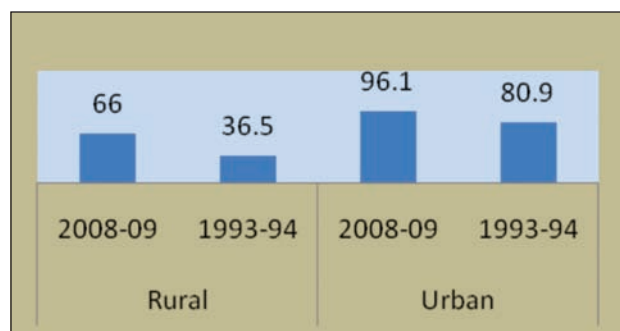
PMGSY: Aimed at providing connectivity to all rural habitations by all weather roads, the *Pradhan Mantri Grameen Sadak Yojna* (PMGSY) was launched in 2000. It was wholly funded by the federal government. There was a rider here that all the villages with 1000 and above population would be linked under this ambitious rural roads project by 2003 and below thousand but 500 and above population would be covered by 2007. What would happen to habitations with less than 500 population? The PMGSY says nothing on this. The state governments were expected to: (a) prepare a detailed project report based on field survey with inputs from MPs and MLAs of the area as also from panchayats; (b) identify / create an agency for execution. Initially, 166,938 habitations were

identified under this project but later only 135,436 habitations were targeted for the stated purpose. What happened to the remaining 31,502 habitations? They were excluded since those were found ‘already connected under other schemes or not feasible’ (see Annual Report 2009-2010, MoRD, p. XIII).

Now let us look at the status of implementation of this ambitious project. It was supposed to be over by 2007 but by the end of 2009, only 33, 812 habitations (around one-fourth of the target), as recorded in the same annual report, had been provided connectivity with all-weather roads. With this rate how long this will take to cover all the rural habitations? It is doubtful that even MoRD can answer this question. For the sake of record, the state-wise performance of PMGSY is provided in the table 34 in Appendix.

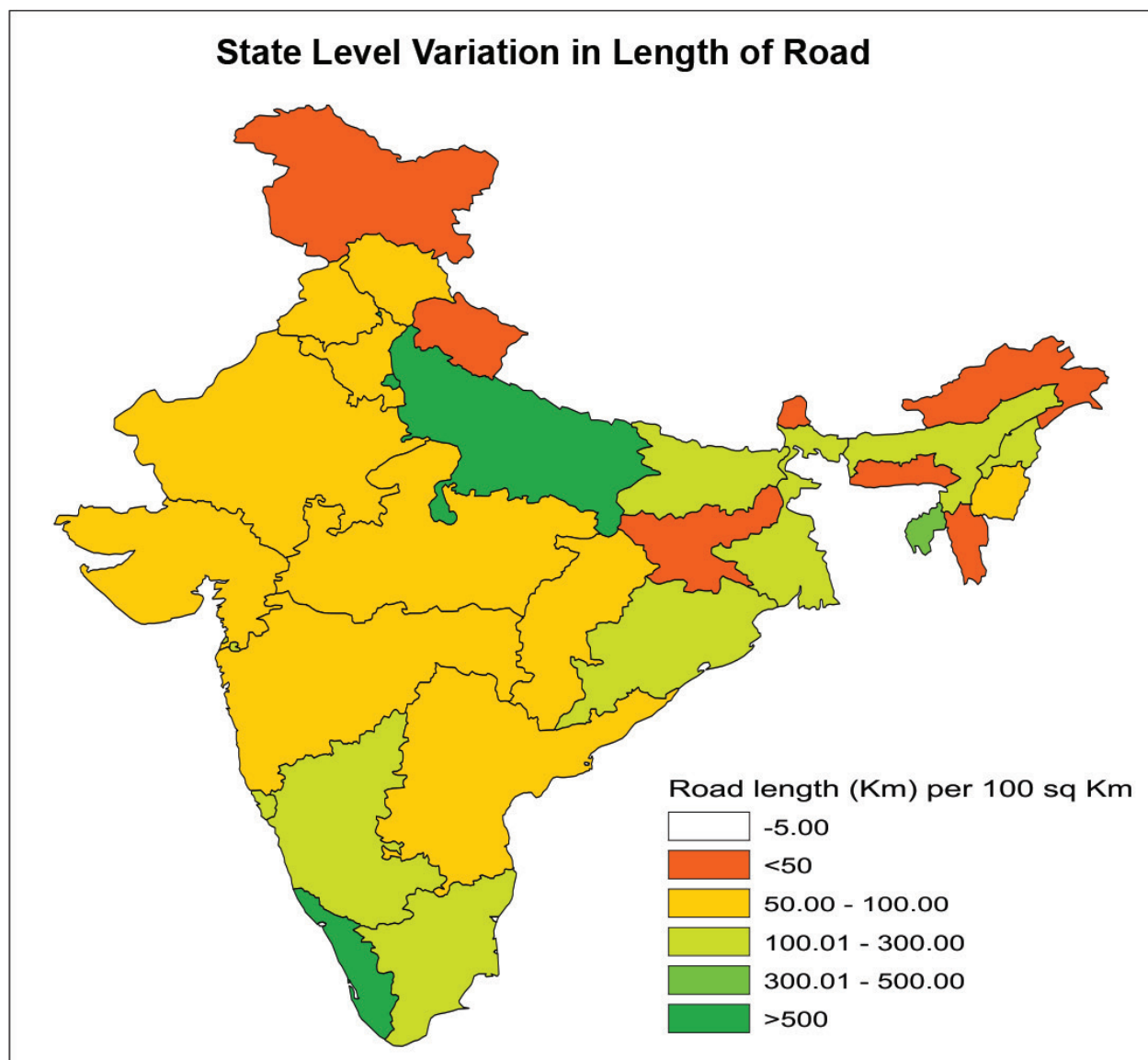
It is apparent from available figures in the table that they do not match with the stated objectives of the scheme. Measuring the performance of this scheme would necessitate, in the first place, getting details of the total number of unconnected villages with specific population strengths before the initiation of the scheme. A quick survey of the remaining villages five - seven years later would have confirmed the success rate, state-wise, of this scheme. Instead, what the concerned ministry has doled out is rural roads constructed per 100 kms. Interestingly, the table showing official data generated on rural roads has a qualifying note explaining that the data available prior to 2000 also take into account of roads constructed under JRY (*Jawahar Rojgar Yojna*). All these data are important in their own way but they are confusing in more than one way. Firstly, by not providing scheme specific data, the MoRD fails to justify the very crafting of the new schemes. If some of the ongoing schemes had the same or overlapping objective then what was the need of another scheme. Secondly, with overlapping profile of schemes, the MoRD can always absolve itself from any failure on the part of any new scheme. In plain words, it helps obfuscate any accountability measure. And finally, all this confirms that top MoRD officials, as usual, have gone on pleasing their political masters by announcing (so called) new schemes which quite often amounts to repackaging of old schemes with little modification here and there.

Fig. 2.17 : % of Household with Access to Electricity



Source: NSS Report No.429 and 535 (2008-09): Housing Condition in India.

Map : 2.15



Consider the fact that PMGSY was launched in 2000 when the Vajpayee led NDA government had assumed power in Delhi. The government was seen attaching priority to expanding the network of highways, leading to conceptualisation of the golden quadrangle project, aimed at linking north-south and east-west corridors in the country and their implementation. Logically, the next step would have been to provide connectivity to rural habitations. But there was already a scheme for this purpose, though as a component of an omnibus JRY scheme. It was easier to dovetail the budgetary allocations for rural road construction with a new scheme under the new dispensation. Thus, instead of rural road construction,

providing connectivity to rural habitation became the stated objective of this new scheme. When it came to reporting the target and achievements, a standard official frame for measuring success in quantitative terms, it was realised that accounting for habitations connected would be difficult (See Box 2.6). Moreover, it would not show the extent of the work done, that is, the length of the road constructed to connect the habitations from all sides. This was all the more important for financial accounting. Hence, the achievements are seen measured in terms of the length of the new road constructed or the old ones improved (means repaired).

Box 2.6 : PMGSY in Bihar

When this scheme was launched, Rabri Devi government was in power in Bihar which had earned dubious distinction of being too slow to follow any time schedule. Therefore, beyond meeting minimum formalities, it practically did nothing, despite pressures from the NDA government from Delhi. Not surprisingly, the PMGSY failed to provide connectivity to not a single unconnected inhabitation till 2003-04. Once the UPA replaced the NDA in Delhi with the RJD becoming an important coalition partner under the new dispensation, the MORD came under its charge. The new MORD minister, owing allegiance to his party RJD than to the federal government, along with his party boss, the then Railway minister, influenced as many as five central agencies to shoulder the task of rural road construction in Bihar. Included among these central establishments were National Hydel Power Corporation (NHPC), Indian Railways Construction International (IRCON) and Central Public Works Department (CPWD). This was against the rule but was allowed as exception. These organisations started working on this scheme in August 2004, but as it was not a priority project for them, in the next four years they could construct mere 27% of the total 18, 900 km allotted to them. Meanwhile, the the JD(U) leader Nitish Kumar (a coalition partner of NDA) replaced the RJD government in Bihar. Known for his methodical approach to work, he took back this project from the central undertakings; the latter were saddled with the escalating cost of inputs while, as the 'guidelines framed for PMGSY provided for no revision in estimates and adjustment of rise in prices of inputs. This had adverse consequences on PMGSY in Bihar'. Subsequently, the rates were revised; special allocations were made as also a complementary *Mukhya Mantri Gram Sadak Yojna* (MMGSY) scheme was launched. Notwithstanding all these, the PMGSY achievements remained terribly slow. Interestingly, under the same leadership, Bihar witnessed nothing less than miracle in resurrecting its national and state highways. Explaining these contrasting performances, miserable in construction of rural roads but spectacular in highways, a perceptive observer noted: "It proved that a chief Minister, no matter how zealous and passionate about development, can not do much in an area being looked after by officers who do not share his fervour. Managerial ability and integrity in key bureaucrats are the two other crucial factors that determine the pace of development (Sinha: 2011).

With the coming of another new coalition UPA government in power in 2004 which put premium on serving *Aam Admi* (common man), the MoRD rose to the occasion, heralding another ambitious *Bharat Nirman Yojna* (BNY). The BNY has six components, including projects on rural roads, rural electrification, drinking water etc. According the annual report referred above, only 54,648 habitations are to be (see Table A 2.31 in appendix) connected under the

auspices of rural roads component of BNY. Where from this number has come? The report does not give any clue. And if this is true, what about the rest 50 thousand plus habitations left uncovered, as sincerely recorded in the same report under the PMGSY?

Huge budgetary allocations for omnibus rural development but thinly spread over a plethora of CSS schemes with rigid central guidelines that quite often do not match with the felt needs of the states and lately the compulsions of running coalition governments, all this result into less than success stories (also see, an incisive paper on this theme in part-III of the report).

Access to Information

Telephone: For long the ubiquitous telephone department of the federal government used to be the only agency to provide telephone services. Since the concerned department had monopoly over the services, it was inefficient and restricted, too. Following the economic reforms, private players were also allowed in this sector leading to expansion of services. The 2009 figure for tele-density, (number

Fig. 2.18 : Roadways per 100 km in India

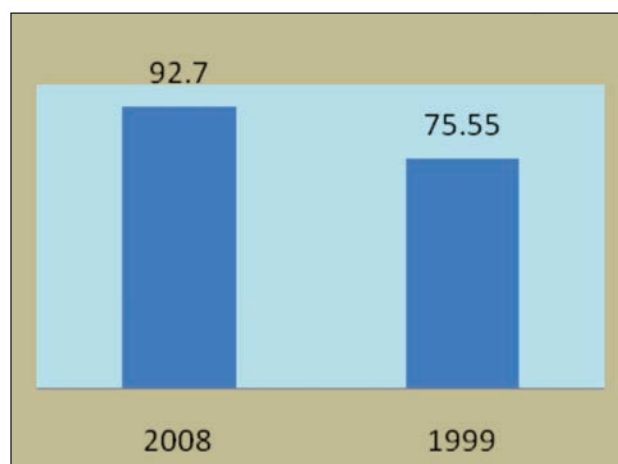
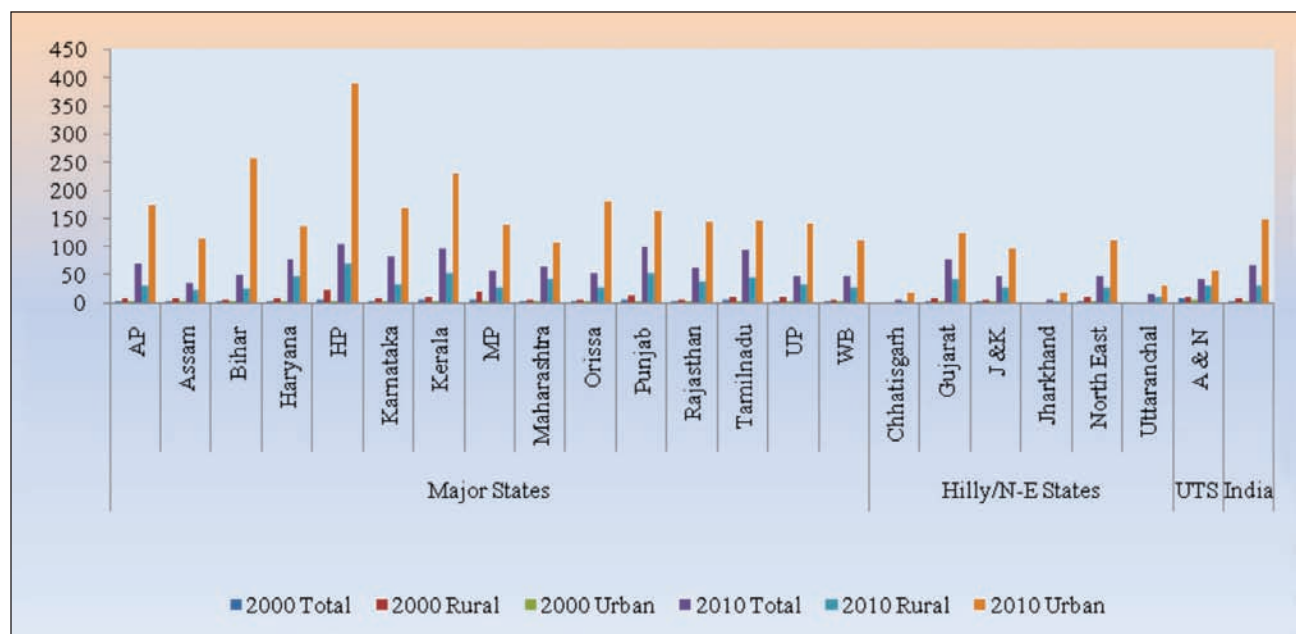


Fig. 2.19 : State Level Variation in Tele Density (Total/Rural/Urban)



Source: Annual Report, Department of Telecommunication, 2000 & 2010-11

of telephone connection per 100 population) was around 8 (in rural areas 4 and urban 19, see Table A 2.33 in Appendix). If it is compared with data for early 1990s, this could be seen as increasing, that is, more households opting for telephone connection. But the corresponding five years old (2004-05) figure, would show a reverse trend that is, thinner density (See Fig. 2.19). This means number of landline users have gone down in urban areas whereas it has registered growth in rural areas. It is not surprising, though. For, during the intervening period the mobile phone subscription has gone increasingly up, bringing down the use of landline. This is apparent from the fact that over all mobile tele-density (separate figures for rural and urban areas not available) is 40 percentage points. The corresponding figure for four metros is much higher in Delhi (140 %) and Chennai (126 %), followed by Mumbai (110%) and Kolkata (90%). This confirms a growing upsurge in mobile users in urban areas with metros taking lead. It also needs mentioning that the state averages for Maharashtra, Bengal and Tamil Nadu excluding their respective metros are far below, indicating the expanding opportunities for business and other occupations fuelling the accelerated growth in number of mobile phone users. The lowest mobile tele-density is seen in Chhattisgarh followed by Jharkhand

Internet: Nearly the same pattern emerges from the figures for internet users. It is highest in Maharashtra, including Mumbai, followed by Delhi, Tamil Nadu (including Puducherry) and Andhra Pradesh not Bengal (see Table A 2.34).

Summing up

With periodic elections being held on time under the careful gaze of a constitutionally recognised independent election commission whose verdicts are invariably honoured by both the concerned parties, leave aside exceptional cases, there is every reason to believe that parliamentary democratic system is alive and kicking. After all, the regular political churning has also propelled elected leaders from hitherto unrepresented, disadvantageous sections of the society. This in itself is no mean achievement, if compared with the countries located in the south and south-east Asian countries that gained independence in the post war period. Beyond these periodical niceties concerning the hardware of political democracy, however, the software driven economic, social and legal democracy are marred with glitches, causing convulsions quite often in the functioning of the system.

The overlapping boundaries of crime and politics, shrinking space for political debates within

the precincts of national and state assemblies and outside, and above all, the functioning of political parties as a dynasty or family run feudal enterprise, devoid of internal democracy speak volumes of systemic defects without any cure in sight. Taken together, the parliamentary system seems to be working against its own ideals, creating disconnects between the electorates and the elected leaders. Against this backdrop, the arena of legal governance gives us a hope as the last resort against the failings of representative democracy and highhandedness of both the State and the market. The general opinion about judiciary, however, is based mainly on the merits of the Supreme Court and some of the High Courts. Notwithstanding the volumes of pending cases at their level, they are doing relatively well; rather on many occasions, they seem to be only available organ of the State that can serve any public good (see Table A 2.35 in appendix). Indeed, their verdicts have led to new policy makings, which otherwise and in the constitutional scheme of things, lie beyond their functional domain. But when one goes down to the level of lower judiciary – the first point where ordinary people come in direct touch with the legal system – one comes across the malignant face of the judicial system at large.

Assessing law and order is all the more baffling. If one goes by media reports on a day-to-day incidence of crime, it would seem as we were living in uncivilized, barbaric world, dragging us back to medieval times by treading human lives as the cheapest commodity to do away with. The data compiled by the bureau of police research corroborates these sordid facts. There is a long list of cognizable crimes (rape, molestation, robbery etc.), unequally committed

particularly against those living on the lowest socio-economic ladder. This does not include the daily humiliation and injustice people suffer at the hands of bullies in villages and small towns and cities, including congested, poorer neighbourhoods in metropolises. Again, it is these hapless people for whom availability of basics – drinking water, sanitation, electricity etc – are all in short supply. It is still not alarming, if seen and compared with the global crime statics. After all, people go on doing their routine work without any fear, leave aside insurgency infested territories. In any case, there would have been less crime, had police been allowed to perform independently and spared from mindboggling obsession with the VIP security to which heaviest deployment is made from scanty police forces.

Beyond all these, the causes of greater concern are the repeated failure of the ruling elites to take note of reforms initiated in the past. Consider the following instances. First, steps taken to hold fair and free election (in phases, forcing state governments to issue voter's identity card, exercising control over district administration during election time and taking action against errant bureaucrat or politicians etc) was practically opposed by all the states and political parties of all ideologies and colours. Second, by accepting PIL, a former Supreme Court Chief Justice heralded judicial reforms but it was dismissed by the elites as a deviant steps taken by a benevolent judge. Both these instances however demonstrated that independence bestowed on constitutional bodies created by our founding fathers are resilient and they are capable of reforming the system from within (irrespective of callousness shown), by the political and executive elites.■

GOVERNANCE REFORMS: PROMISE AND PERFORMANCE

Of the three major governing institutions, the legislative and judiciary have already been discussed earlier; therefore, this chapter is focused on the role and performance measurement of the executive arm of the government: the civil services. The civil services, like the army, as a permanent organ of the government, India inherited from the British. Whether the basic nature and form of the civil services, particularly the elite administrative services that provide the leadership and manned by the IAS officers have changed during the last sixty years or not is debatable but people's perception of civil administration have certainly changed a lot. Measuring the effectiveness of the civil servant with a single yardstick, therefore, would amount to doing injustice to them. For, the people's perception of civil servant is dependent on their expectations from the latter and the degree of their fulfillment. This in itself varies a lot. The poor, the lower middle class households (roughly comprising more than half of the population)¹⁴ expect direct help from agencies

¹⁴What is the percentage of poor people in the country? There is no straight answer to this simple question, though in the name of the poor a lot of things are done by the governments in this country. For instance, ranging between 34 to 72 %, there are three data sets for the BPL population, a euphemism for the poor. In view of this anomaly, this estimation is based on computation from the monthly expenditure (both per head and total) of both

of the State, as beneficiaries of some welfare or development schemes.

On the other hand, expectations of nearly a third of the population, composed largely of rising middle class are entirely different. They appreciate the rule of law to prevail in the country; they attach importance to policies aimed at promoting sustainable development and, in continuation, (they) happen to be votaries of decentralization, people's participation in local decision making bodies and also strongly believe in clean technology. Being concentrated mostly in towns and cities, including metropolises, this largely professional middle class appreciates efficient provisioning of public infrastructure (roads, electricity, drinking water, clean environment etc.) and it does not hesitate in taking recourse to governmental agencies for individual trouble shooting. They are tax payers; therefore, they abhor corruption and resolutely oppose any kind of highhandedness at the hands of the executive. Simultaneously, they are the ones who would appreciate curtailment of the role of the State in certain sectors (e.g tourism, hotel management etc) and demand penalty to civil servants for dereliction of duty besides calling for

rural and urban population as per NSSO 66th round.

strong regulatory frame and impartial enforcement mechanism to curb unbridled profit seeking nature of the market.

The remaining, nearly 10 per cent of the population (excluding 5 % super rich or affluent households), belonging to the gated society do not depend upon the elusive government for their basic needs (education, health, drinking water etc). They remain unconcerned of larger issues affecting the society at large, or say, would turn vocal only when there was any infringement on their wealth, privileges and anything pertaining to their private domain. But, if the middle class happen to be on the forefront of crafting opinion, the tiny upper class drives the forces of globalization.

From the stratification narrated above, it is apparent that a general survey method to measure people's perception would have been difficult, if not impossible. Besides, it is equally important to note, objectivity becomes the first casualty in a huge country like India. For, people are generally guided by subjective factors, based on their personal experiences, varying too much on the face of all sorts of inequalities/ diversities even within the states, not to speak of inter-state variations.

Arguably, highly stratified societies like India which is divided in terms of wealth, status, social ranking and mental makeup resulting into wide variations in their aspirations either for demand or for improving public services, cannot be governed with one-size fits all policies and programmes based there upon. Clearly, it cannot be measured with a single, straight yardstick either. Faced against these odds, the effectiveness of the executive component of the government has been measured in more than one way. It begins with a critical analysis of their role in designing policies and programme implementation with special reference to the flagship programmes, including those bordering on the realm of social welfare.

This chapter also examines the effectiveness of governance induced reform, as proclaimed by the union government, to ensure accountability, transparency, and participation through measures

taken up following the enactment of right to transparency (RTI) act, and those pertaining to decentralization etc. That apart, this section takes note of the effectiveness of the administrative reforms, including brief note on measures proposed in the second administrative reforms commission and the fifth & sixth pay commission recommendations regarding the size of bureaucracy. Although debatably, it also tries to quantify the contribution of public administration to NSDP as well as how much the civil services spend on it for delivering a plethora of services, measured in terms of their share as proportion of revenue expenditure. Last but not the least, it also highlights its failures (measured by number of writs in central/ state administrative tribunal, also number of strictures received from higher judiciary on mishandling of some crises or not being able to prevent others from holding people to ransom – Air India strike, attack on migrant labour in Maharashtra, Haryana, Assam etc.) as well as the achievements of civil services appended as an inventory of awarded innovative administrative practices.

Policy Making: As mentioned earlier, the elite civil servants holding commanding positions both in the federal ministries and the state secretariats are responsible for drafting public policies. The required inputs or feedbacks gathered from the field offices, if so desired, are also controlled by them. True, vetting of political implications of a proposed policy takes time; rather it has become cumbersome under the successive coalition governments. Yet designing public policy afresh or improving upon the existing ones is an area where the performance of the civil services has not been commensurate to their intelligence. One possible reason seems to be restructuring of the federal ministries and departments carried out many times over the last couple of decades in total disregard of their functional compatibility. Besides, when multiple agencies, departments and their administrative ministries are involved without clearly demarcated functional boundaries, it becomes a herculean task to get anything quickly done. For instance, 'matters concerning the food processing industry normally have to go through nine ministries – agriculture, food and consumer affairs, health, commerce, food processing, rural development and others' (Jalan: 2007: 106).

Likewise, under the Delhi based Federal Ministry of Human Resources Development there are four departments: (1) Education (2) culture, (3) Women & Child Development (WCD) and (4) Youth Affairs & Sports (YAS). There are several divisions under each department. Under the Department of education, for instance, there are separate units for primary, secondary, higher, technical & teachers' education, 'book promotion, copyright, planning, languages and Sanskrit, district or distance and international relations, among others. Again, both WCD and YAS have several departments. Further down, under each department there are 'several commissions and subsidiary organizations... reporting to different divisions and authorities with cross cutting functions. While there is multiplicity of specialized departments, divisions and organizations, none of them has adequate authority to take any decision concerning even the most non-controversial items' (Ibid.).

During the last couple of years several empowered group of Ministers (EGM) were set up by the UPA II government, to collectively redress the problems emanating from various fronts. Irrespective of their endless meetings, there has been drift in their public policy approach, aptly designated as policy paralysis. Whether it is pertaining to farmer's suicide, land reforms, investment flow, infrastructure, banking, insurance, even education, health subsidy, airlines etc, the governmental inaction is pervasive (See Box 3.1). If anything at all happens, it does in fits and jerk, confirming a lack of informed thought and action. This is not to say that nothing positive has happened

Box 3.1 : Eternal Inaction

"Nearly 25,000 landless labours coming from several states staged *dharna* (sit-in) in October 2007 in Delhi demanding land reforms measures be taken up by the Union government. The then ruling UPA-I government announced setting up of a council for land reforms (CLR), which would be headed by Prime Minister Manmohan Singh. Frustrated with the long hibernation of CLR which never met during the last four years, the Ekta Parishad- an NGO spearheading land reforms movement – has announced to undertake year long padyatra from Kanyakumari to Delhi from October 2, 2011". (*Hindustan Times*, September 29, 2011)

during the last two decades. The UPA-I particularly is given due credit for adopting 'rights based approach' in policy frame as reflected in clubbing social security with employment (e.g. MGNREGA), health insurance (RSBY), nutrition and education, to name a few. But because of the flaws in their implementations, the present regime has been robbed of the due credit it deserves. This dichotomy / contradictions of policies and policy based programme implementations are given below with reference to some of the notable initiatives.

Devolution of Functions Funds, and Functionaries: With the Seventy-third (Constitutional Amendment) Act 1992 coming into vogue, the continuation of the three-tiered panchayati raj institutions (PRIs) was ensured across the states in the country. Through this step which was hailed as historic, and rightly so, the federal government completed a task which had remained unfinished since late 1950s when the first attempt towards decentralization was made in the country. Two decades have rolled by since then but the issues pertaining to three Fs – functions, funds and functionaries – are yet to be finally resolved. One does not know whether this was done consciously in apprehension of backlash from the federated units or deliberately to delay the onward march of decentralization, this has remained a sore point.

After all, the 73rd amendment *inter alia* had also ensured (a) setting up of State election Commission to conduct regular panchayat elections, (b) State finance Commission to decide allocation of resources from state budgets to PRIs and above all (c) representation of weaker sections, including women in panchayats. Through the 74th Amendment, setting up of district planning body was also mandated so that ideals of social justice could be made inclusive to the plans for economic development at the local level. In continuation, the progenitors of this project could have inserted a 'district list' on the lines of central and state list, drawing functional boundaries of the third-tier of governing structure. Instead, a list of 29 subjects was appended with the seventy- third amendment, now placed as eleventh schedule of the Constitution on which state governments had to work. Practically all of them bungled, including

Maharashtra, Gujarat and West Bengal where PRIs have been in existence for quite long.

Consequently, states could not think of transferring beyond peripheral tasks to PRIs such as planning, monitoring, and supervision. In essence, panchayats continued working as agencies, that is, rendering assistance to the line departments in implementing programmes designed at the higher level of governments. The first serious attempt to reverse this trend was made under the UPA- I government which created a separate ministry of Panchayati Raj (MoPR). The MoPR impressed upon the state governments to engage in ‘activity mapping’. The idea was that every conceivable function under each subject listed in the eleventh schedule will be broken into as many activities as possible. Thereafter, the activities, read precise functions will be allocated to PRIs following the principle of subsidiary. This too was rendered mostly inoperative. For, leave aside noble exceptions, most of the state governments proceeded with a wrong check list, largely due to lack of understanding or without internalising what the activity mapping really meant.

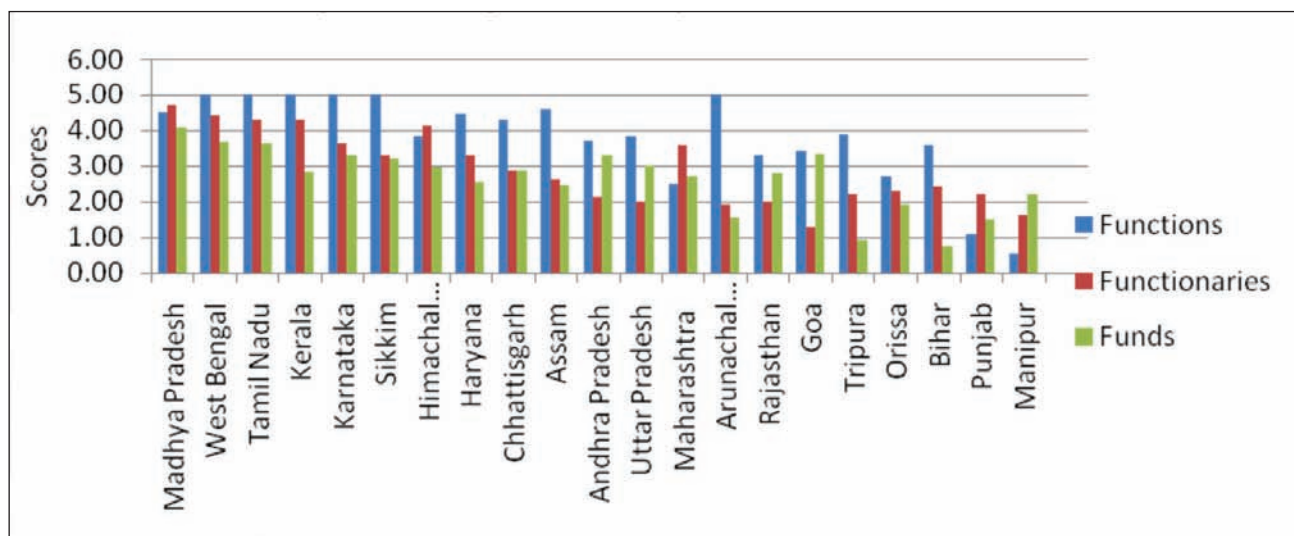
The sole consideration of adopting decentralization route is to improve the service delivery. The reference point therefore, should be a particular service not the department which might be handling a part of multiple delivery system of that particular service. Let us take instance of health

care services which are handled by a large number of departments. The health department, to begin with, is responsible for managing primary and sub health centres the later financed by the federal government. The nutrition component of health is taken care by the *Anganwadis* which are managed and controlled by the women and child department. Sanitation is the responsibility of the Ministry of Rural Development and there is yet another department for providing drinking water. Immunization, vector control also fall into the realm of the health sector but managed by other departments (Ghosh 2007, Kumar 2009). All these call for multi-level, multi-departmental coordination which for obvious reasons do not materialize, instead these matters are dumped on local *Anganwadi*, ANM and gram panchayat functionaries to sort out among themselves. The end result is too obvious to repeat. The latest developments on this count have been captured through state wise devolution of 3Fs in the figure 3.1.

Persistent Poverty and Welfare Programmes

In pursuance of the promises made under the directive principles of the Constitution, welfare programmes came into existence since the first plan period itself. For long, these welfare measures, including free education, hostel facilities, positive discrimination in employment etc., were meant for scheduled castes and tribal population only. Poor people belonging to general category didn’t receive focused attention at that time, though the policy

Fig. 3.1 : Ranking of States by Devolution of the 3Fs



makers tried to address the problems associated with basic needs of people at large through the community development programmes, which began unfolding at the same time at least on pilot basis. Initially government of the day had believed that through the trickle down approach concerns of poor people can be addressed. Programmes aimed at poverty amelioration or directly confronting poverty in a structured way started in early 1970s. This was the result of two epoch making events in Indian political history. First, the then overarching presence of ruling party – the Congress – across the states had already received serious jolts following 1967 elections, in the parliament majority was reduced and in as many as nine states where it had lost power and the second was the vertical division in the Congress party. Added to it were subsequent steps like the nationalization of private banks and abolition of privy purses (given to erstwhile princes who had merged with India in the wake of independence). All these were indicative of the change in the directions of wind blowing but perhaps the biggest was the slogan – eradicate poverty – that caught the attention of the nation during 1971 general elections.

A couple of years later, a number of welfare schemes were launched. Additional welfare programmes were introduced in 1980 which also witnessed a quantum jump in budgetary allocations for rural development programmes.

Thus, it was with the sixth five-year plan, coinciding with the return of the Congress party to power, a number of Centrally Sponsored Schemes (CSS) were launched¹⁵. Every successive government since 1984 onwards has contributed towards this end by way of introducing either a new programme or by deleting another or getting yet another on-going scheme modified. Rather CSS had become the mainstay of three-tiered panchayati raj institutions (PRI) following the passage of Constitutional (Seventy-third Amendment) Act, 1992. Over the years, the number of CSS has increased many folds,

¹⁵Prior to that a 20-point programme, focussed largely on the welfare of SCs, STs and (poor) women in general, had already come into vogue in 1975 during the emergency days. This is not to deny that the first community development programmes and national extension services of early 1950s were by and large akin to the CSS.

up to 185. In fact, for CSS under the 11th five-year-plan, the Union government had allocated over Rs. Ten lakh crore (One hundred million rupees). Of this, around two-thirds of total (Rs 6.91lakh crore) is spent on 13 ‘popular programmes’ alone. Further, consider the total budgetary allocation for entire rural development programmes sponsored by the Government of India in 2009-2010: a whopping Rs. 74, 270 crore, accounting for nearly one-third (31% precisely) of the total ‘Central Budget plan provision (Mid-Term appraisal of 11th Plan, 2010: 251).

Nearly the entire gamut of CSS also falls into the category of omnibus rural development programmes. Again, most of the programmes are routed through the Union Ministry of Rural Development, no matter whether the funds earmarked originate from some other ministry/ department of the Union government. Within this broad rubric of rural development programme, there are another two major categories under which several programmes are clubbed together. These are known as flagship programmes and millennium development goals (MDG) such as mid-day-meal scheme (MDMS), national rural health mission (NRHM), *sarva shiksha abhiyan* (SSA) etc. That apart, there are at least two more important programmes that needs mentioning: Mahatma Gandhi National Rural Employment Programme Schemes (MGNREGS) and *Swaran Jayanti Grameen Rojgar Yojna* (SJGY). Both these programmes happen to be modified versions of earlier programmes of identical nature. For instance, MGNREGS has its origins in Employment Assurance Scheme (EAS) which was initially launched in Maharashtra nearly four decades ago when the state was facing severe drought situation, foreclosing any option for agricultural labours to find daily wage employment in their own villages. But EAS itself was modeled after Food for Work Programme created in the wake of drought or near famine like situation in northern Indian states in the late 1960s. Likewise, SJGY has subsumed *Jawahar Rojgar Yojna* (JRY) and integrated rural development programmes (IRDP), two popular programmes of 1980s and 1990s.

What is the purpose of Rural Development (RD)? A cursory look at a huge basket of RD programmes would reveal that these omnibus programmes are

aimed at (a) reducing, if not eliminating, rural poverty¹⁶; (b) stimulating rural economic growth; and (c) ensuring sustainable development. The country has witnessed several versions of RD programmes during the last three decades and so. All these programmes, including those which have been discarded or subsumed under another on-going programme, placed into three categories. One, providing employment either through wage employment programmes (JRY in early 1980s) or by extending financial support (i.e. subsidised credit and training) aimed at promoting entrepreneurship among rural poor to self employment programme (IRDP, same period). Both these programmes were targeted at poor individuals. Programmes meant for creating infrastructure or public goods for the rural people at large could be placed into second category. And the third category of programmes were essentially welfare oriented, providing succor to old, disabled, poor pregnant women in form of financial assistance for housing, child delivery or pension. Incidentally, the local level rural institutions – panchayats, that are responsible for implementing these programmes – are supposed to select beneficiaries (sites for public goods such as school or health centre and individuals for maternity benefit or old-age pension) through people's participation in decision making.

Ironically, a great majority of RD programmes happen to be centrally sponsored with or without complementary contribution of state governments to be implemented by institutions of local government. Thus governments at all the three level seem to be competing with each other to impress upon the same constituency causing a lot of jurisdictional and functional overlaps, leading to role reversal of institutions and in the process, eroding accountability of all the concerned.

Over the years, the number of welfare schemes has gone up. Some of the federal welfare schemes had in fact originated in states. 'Mid-day meal' (MDM),

¹⁶It may also be mentioned that till the fifth five year plan the assumption was the trickledown effect of economic growth will take care of rural poor; hence there was hardly any programme directly attacking rural poverty. In the past, many provincial governments, largely non-Congress, have raised their concern against the rigid guidelines for programme implementation and instead demanded introducing 'flexi-funds' that would give them leeway in taking up programmes as per the local felt need.

for instance, was introduced as centrally sponsored scheme in 1995, though it had begun long back in Tamil Nadu. This is almost true of *Anganwadi* which started as crèche for working mothers (read poor women labourers) along with provisions for nutritive food for children below 6 years. Later, this also became a CSS where pregnant and lactating mothers would be served nutritional supplement. Tamil Nadu had gone one step further by providing food to poor old men, women, destitute too, at these centres. It is estimated that nearly 80 lakh (8 million) poor including toddlers and old alike are getting cooked food through these centres everyday in just one state alone, Tamil Nadu. The total number of children covered under MDM in the country has gone up by more than 300 per cent, 3.34 crore in 1995 to 12 crore in 2006-07, to quote the 11th plan document, planning commission. The figures inserted in Table A 3.1 and A 3.2 (appendix) gives the total number of beneficiaries across the states. In fact if individual beneficiaries under half a dozen welfare programmes from all the states and union territories are taken together, the figure would run into several hundred millions, more than the total population of relatively bigger and developed West European countries like France or Britain.

What flow out of these welfare programmes? Under national old age pension programme, fifteen hundred rupees are provided on monthly basis to individual beneficiaries¹⁷. This is nearly half of the minimum amount required to keep the soul and body intact, as per the Planning Commission's calculations. This is more or less true of practically most, if not all, of such welfare programmes. The Union government spends Rs. 9 lakh crore (90,000 million rupees) that is less than one-tenth (9 %) of the current one lac crore rupees rural development budget for 2010-11.

It is apparent from the above that the conduct of the Indian State is almost akin to a benevolent monarchy. If so, is it appropriate? There is a counter argument that millions of helpless people also happen

¹⁷That is s/he should be in BPL list, must be above 60 years old and with no known source of income or support. According to the latest estimate of the Planning Commission a person whose earning is Rs. 32 per day or at least Rs. 960 a month is considered poor. This is a highly conservative estimate, devoid of market realities.

to be citizens (or subjects?) of this huge country who needed helping hand. We donot intend to take side with either of the narratives since this was not our brief. Therefore, the report has looked into another question, how are programmes implemented across the states? Like most of such schemes which are distributed as state largesse, there are holes in the distribution network; even at the very high level in the government this is acknowledged.

True, it does not reach all the intended beneficiaries. Rather it also goes in the hands of those whose name, in the first place, should not have figured in the BPL list. Yet, the votaries of such altruistic approach would vouch in favour of these steps, arguing to stop pilferage, root out corruption from implementation at the ground level. But given the magnitude of poverty and attenuated hopelessness of those millions of uncared people these schemes should not be scrapped, they would add.

Interestingly, there is a great amount of discrepancies in number of beneficiaries reported by states to MORD and actual number of beneficiaries, in whose bank account the monthly pension is electronically transferred with Bihar topping the list, followed by west Bengal and Madhya Pradesh. Likewise, an evaluation study of mid-day meal (MDM)

covering 17 states (Table A 3.3 in appendix) and done by the planning commission is equally revealing. The MDM scheme, for instance, was found operating in only 365 out of total 2734 government aided schools in Birbhum district of West Bengal. This is more or less true of several schools in Hissar and Jhajhar districts in Haryana. Appreciating the positive aspects of the MDM – boosting school enrolment and retention, ending class room hunger, learning to share and eliminating social barriers, foster gender equality etc. – perceptive observers have commented, “It is hard to think of a better use of public funds today than the provision of nutritious mid-day meals in primary schools” (Dreze and Goyal, 2003). Yet another persuasive argument is worth considering. This notes that present high economic growth, duly acknowledged by the developed world, is powered by high tech service sector along with a handful of manufacturing sector which employ a very small proportion of huge labour force. The rest, around 90 per cent, is engaged in informal sector which is driven by human capital that requires improvement. Otherwise, contrary to the conventional wisdom, these young people cannot provide demographic dividend since they are malnourished. It is a widely recognised fact that underdeveloped young population can contribute little to economic growth.

Box 3.2 : Whose Welfare?

Prevalence of severe malnutrition is reported among 90, 000 strong Saharia tribes population in Rajasthan. A Delhi based Centre for Equity Studies survey (2004) conducted in five Saharia dominated villages in Barn district had established prevalence of chronic malnutrition virtually among all boys and 93 per cent of girls. Moved by the plight of these tribal children the federal government set up a 72 crore Saharia Welfare Fund under the eleventh plan (2007-12). In 2009, a local NGO reported hunger driven death of more than 100 tribals, including children. Findings of a case study of *Brahmpura* village done in 2010 by *Doosra Dashak* (a voluntary organisation) are equally startling: children in 1-5yrs age group: 42.59 % malnourished 25.93 % severely mal-nourished: 1.85 % acute malnourishment with little hope for survival. Notwithstanding all these frightening statistics, the amount set aside for Saharia welfare fund could not be properly utilised: “over the years the funds were either not released in time by the union government or not used in time by the state government, the report read. A sum of 23 crore was released to the state government of which it submitted utilisation certificate for Rs. 11 crore only. From the remaining 12 crore the state had planned to construct 1,500 houses for this tribal group @ 80, 000 rupees each. But only 52 were constructed. Out of this welfare fund, the state government has generously spent nearly 28 crore rupees on construction of 16 houses for government employees, to be used as “incentives to government employees willing to take a posting to tribal areas”, to quote Rajasthan tribal affairs minister. The unspent amount is parked in public deposit account which is believed to be non-lapsable fund. There is nothing surprising since large amounts of funds are surrendered every year by Indian states. It is apparent from the fact that out of 3205.5 crore budgetary estimates for tribal welfare during 2009-10 only 1996.79 crore rupees could be utilised the states across the length and breadth of the country.

Source: Hindustan Times, 04/11/2011

MGNREGA: Billed as the largest ever launched employment generation scheme for rural poor, this is unprecedented demand driven which is also touted as the biggest social security net for rural populace belonging to the BPL category. Through this scheme the state undertakes the responsibility of providing assured 100 days employment in a year to each poorer household demanding work. It started with 200 most backward districts (nearly one-third of the total) in February 2006. Coverage was extended to additional 130 districts after a year and then to all the districts across the country. A job seeker is expected to go the village panchayat, get a job card with his/ her photograph affixed after applying for the job. The State must provide job (basically unskilled job) to the applicant within fifteen days, failing to do so, give them subsistence allowance. The work under this scheme includes water harvesting, drought proofing, flood protection etc essentially earth/ soil based. The wage is also not paid in cash but transferred into their savings account either with a bank or post office branch (See Fig. 3.2 and also see Table A 3.6 in appendix). It invoked mixed response as it received appreciation from the left and liberal alike but harsh criticism from the right for squandering public money on poorly design and implement schemes, apprehending bad performance, as in case of other schemes and fuelling corruption on a very large scale.

The performance of this scheme can be assessed on three counts: first, state-wise number of days of work demanded and provided; two, quick payment as assured; and three, quality of assets created. The details are provided from the official records (mid-term appraisal of the 11th plan) of the Planning Commission (see Table A 3.4 in Appendix)

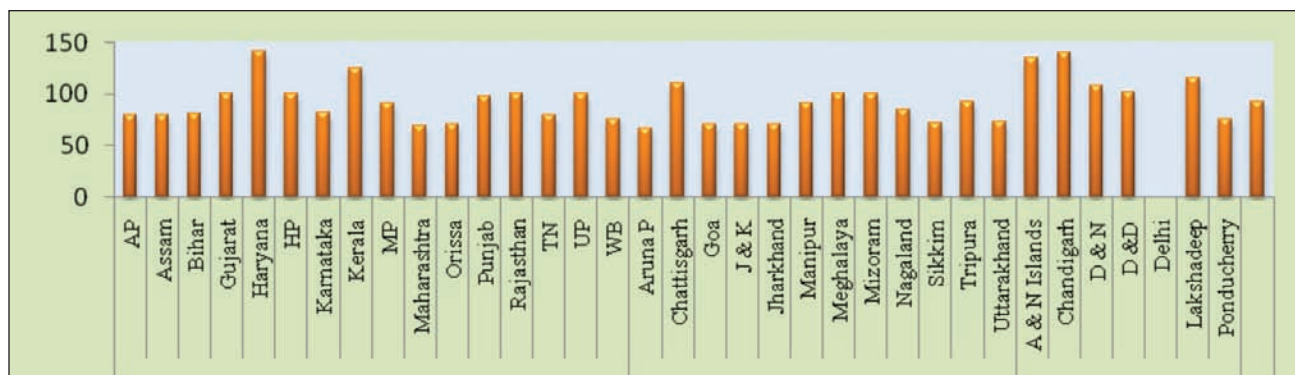
- Largest number of days of work has been provided in states of Andhra Pradesh, Rajasthan, followed by north eastern states like Mizoram, Nagaland and Manipur. But nowhere people could get 100 days employment.
- If the number of man days employment created under MGNREGA is compared with the proportion of BPL, the worst performer

would be Bihar, UP, followed by West Bengal, Orissa, MP (all northern states), Gujarat (west) and Karnataka (south)

- Among the beneficiaries (who applied and got job), two-thirds were women (far more than the stipulated one-third) in states like Kerala, Tamil Nadu and Rajasthan (Table A 3.5 in appendix). On the other hand, as many as nine states failed to provide the minimum, the lowest was recorded in UP (18 %), followed by Jammu & Kashmir (6 %).
- The Planning Commission document underlines the unproductive, poor quality of assets created under MGNREGA led work. Explaining the reasons, the document noted: “work priorities in many states tend to follow orders from the state or district level rather than reflecting the needs and aspirations of the community. The required technical input is also inadequate”, including lack of technical staff (p. 254).
- Except perhaps in Andhra Pradesh where data at all level is computerised and linked, nowhere else payment could be made before minimum two-weeks; quite often not before a month. This is one of the reasons which have discouraged job demand. There is no doubt that MGNREGA has strengthened bargaining strength of daily wage earners leading to very high market rate which is much higher than the official rate.
- As far as the lack of technical and managerial staff is concerned, this has been taken care of (See Fig. 3.2), yet it has not spurred greater demand for employment. Rather there is hardly any demand for MGNREGA linked job in relatively developed states like Punjab, Haryana and Gujarat, yet the GoI has not thought of revising the coverage area of this scheme.

SGSY: Moving away from IRDP driven subsidized credit extended to, the *Swarnajayanti Grameen swarojgar Yojna* (SGSY) was launched in 1999 with emphasis on promoting micro financing schemes/

Fig. 3.2 : State-wise Prevailing Minimum Wage Rate under MGNREGA (as on 1/1/2009)



Source: Standing Committee on Rural Development, Lok Sabha (2009-10)

enterprises by extending the institutional credit and subsidy to groups, aptly called self-help groups (SHGs) (Table 3.1). Run largely by women who are considered to be thrifty by nature and believer in group dynamics and happily, subject themselves to financial and social discipline. They save, periodically (largely monthly but also weekly where the group is noticeably active) meet to distribute loan and invest in profitable ventures, the votaries of micro finance make the world believe in. The fact is that they contribute their monthly subscription from their meager saving in the beginning till the loan with subsidy is sanctioned. Noble exceptions apart, mostly SHGs are engaged in distributing loans which quite often used for personal consumption (there is nothing wrong but it is contrary to what its advocates stand for), including financing education and wedding of their children, particularly daughters. The highlights of the programme are given below:

- Having learnt to deal with the banking system, handle cash, learn procedures, conduct meetings, the women SHG members have

imbibed the values of governance. This is the spin-off effect of this scheme.

- Powered by large federations at the state level, the SHGs are reportedly doing well in states like Tamil Nadu and Andhra Pradesh. In fact, the highest concentration of SHGs (one third of the total in the country) have been seen in southern states whose share of BPL is just 11 per cent where as it is reverse (69 % BPL but only 39% of SHGs) in eastern and north eastern states.
- A large number of SHG groups have remained on papers, as happens with any target oriented programme or even where there is slow demand but made it to work faster instead of allowing it to evolve in natural progression. “Groups have dissolved at a rapid rate, often disappearing with the loans that they had been provided by banks”, to quote the official document cited above (p. 262)

Table 3.1 : Region-wise Performance of SGSY Programme 2007–08 (% of all-India)

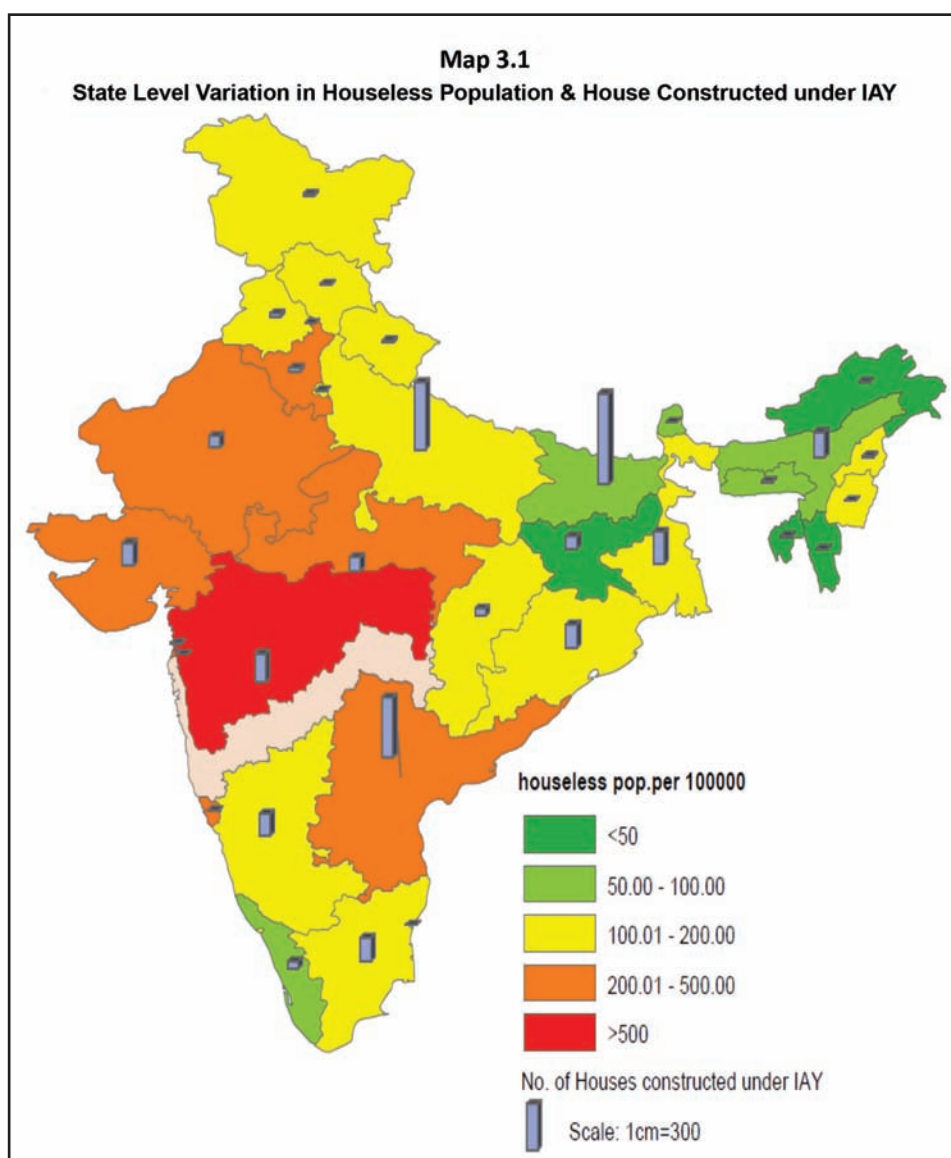
Region	Population	Poor Persons	Swarozgaris Assisted	Total Credit	Total Subsidy	Total Credit + Subsidy	Investment Swarozgari (Rs)
North	11.9	6.1	6.2	9.5	6.3	8.5	39354
Central	27.3	33.8	29.8	34.6	38.5	35.8	34518
West	11.8	10.7	11.1	10.2	11.2	10.5	27222
South	19.5	11.3	21.3	23.4	16.3	21.2	26810
East	25.1	34.6	21.1	16.8	20.2	17.9	24165
North-East	4.4	2.5	9.11	5.5	7.5	6.1	19658
All-India	100	100	100	100	100	100	28722

SOURCE: Radhakrishna Committee on Credit Related Issues under SGSY (2009)

In the light of the above shortcomings, SGSY was restructured and renamed as National Rural Livelihood Mission (NRLM). In fact, by way of restructuring, the MORD has incorporated the key elements of successful models of NRLM already in vogue such as *Indira Kranti Pratham* (Andhra Pradesh), *Jeevika* (Bihar) and *Kudumbashree* (Kerala). What is common in all these three notable livelihood programmes is that they are ‘demand driven’ and based on skilled wage employment fostered by people’s owned institutions which offers flexibility in designing and laying action plans.

IAY: There has been constant improvement in achieving the *Indira Awas Yojna* (IAY) target over the given time period. Initially, there were a few states

which had shown better performance in achieving the target of house construction under the scheme during 1998-99. They were: Tamil Nadu, Gujarat, Karnataka Madhya Pradesh, Kerala and Rajasthan (Table A 3.7 appendix). By 2009-10, some more states like Andhra Pradesh, Punjab, Uttar Pradesh, Haryana, and Orissa joined the group of achievers. On the other hand, states like Assam, Himachal Pradesh and West Bengal could not perform well during the same period. Among small hilly/N-E States, Goa did exceptionally well in 1998-99. In that year, Arunachal Pradesh, Manipur and Meghalaya were found lagging behind. Again, by 2009-10, Mizoram, Nagaland from the north east and new states like Chhattisgarh, Uttaranchal and Jharkhand emerged as better performer. The map (3.1) shows



houseless population is relatively fewer in most of the N-E states, Bihar, Jharkhand and Kerala. In contrast, proportion of homeless is bigger in states like Punjab, Rajasthan, Gujarat, Madhya Pradesh and Maharashtra.

Urban Growth & Reforms

Historically, cities had been absorbing the uprooted rural migrants into their folds, recording unnatural population growth. This is all the more true in case of mega Indian cities like Chennai, Delhi, Kolkata, and Mumbai. To a lesser extent, this is also true of tier-II cities such as Hyderabad, Bangalore, Ahmadabad, Surat, Pune, Indore etc. In the wake of reforms driven economic growth, there has been tremendous growth in urban population. India's urban population in 2001 was about 28 crore, little over one-fourth (28%) of the total, then living in towns and cities. It has gone up to 37.7 crore as per the latest (2011) Census. Although the total urban population is still less than one-third (31%) of the total, Census figures reveal 'for the first time since Independence, the absolute increase in population is more in urban areas than in rural areas'. What this little abnormal increase accounts for? Is it caused by distressed migration? Or is it driven by the rising aspirations of the people at large? Not in equal proportion but both factors seem to have contributed to this end

To cope with growing urbanization, the Federal Ministry of Urban Development launched an ambitious programme, named (after India's first Prime Minister) Jawaharlal Nehru Urban Renewal Mission (JNURM) in March 2005. In terms of programme contents, budgetary allocations as well as their expected reach and impact, this was placed into category of flagship programmes initiated by the UPA-I government. It has the following four components:

- **Urban Infrastructure and Governance (UIG):** This component was intended to improve urban infrastructure by providing projects in the areas of water supply, sewerage, solid-waste management and roads in 65 major cities identified under the mission.
- **Basic Services to the Urban Poor (BSUP):**

Aimed at providing new projects pertaining to housing and slum development to the urban poor located in the same 65 cities indicated above.

- **Urban Infrastructure and Development Scheme for Small and Medium Towns (UIDSSMT):** This comprises the same infrastructure projects, as indicated under UIG, but this component is focussed on small and medium towns.
- **Integrated Housing and Slum Development Programme (IHSDP):** Under this component housing and slum development projects were to be provided to those urban poor who are based in non-mission cities and towns.

The federal government allocated Rs. 66, 043 crore (1crore =10 million) rupees, for this ambitious programme to improve the living conditions of 28 crore 60 lac people (27.8 % of total population in 2001) belonging to all categories – rich, middle class and poor settled in its 6000 odd cities (including mega & metros) and towns. Through this massive federal funding aimed at rejuvenating towns and cities dotted throughout the country, which otherwise happen to be responsibility of the state governments, the Union government attached certain conditionality. Which are essentially reform oriented but for a variety of reasons the state governments were not carrying forward. However, in view of limitations of state governments as well as bottlenecks they would face, the union government did not put all conditions as mandatory rather certain conditions were ticked as optional (See Table 3.2), left to the sweet will of the state governments. It was somewhat akin to replaying proverbial carrot and stick policy by the union government, not to speak of playing safe, considering inherent federal tensions in the concerned subject domain.

The outcome of these massive funding and reforms undertaken were captured by the Planning commission and presented as mid-term appraisal is given under.

- Nearly four-fifths of funds placed under UIG and a little over 90% under UIDSSMT

Table 3.2: Mandatory Reforms both at State & Local Body Level and Optional Reforms

Mandatory Reforms		Optional Reforms
State-Level Reforms	Urban Local Body Level Reforms	
• Implementation of decentralization measures as envisaged in the 74th Constitutional Amendment Act, transfer of functions, constitution of Metropolitan Planning Committees (MPCs), and District Planning Committees (DPCs) • Adoption of modern, accrual-based double entry system of accounting in ULBs • Reforming rent control • Introducing e-governance systems like GIS and MIS in ULBs • Levying reasonable user charges by ULBs • Earmarking budget for basic services to the urban poor • Rationalization of stamp duty, not more than 5 per cent • Enactment of Community Participation Law and Public Disclosure Law	• E-Governance set-up • Shift to double entry accounting • Property tax—85% coverage • Property tax—90% collection efficiency • 100% cost recovery—O&M for water supply • 100% cost recovery—Solid Waste Management • Internal earmarking of funds for services to urban poor	• Repeal of Urban Land Ceiling and Regulation Act • Bye-laws for water harvesting and reuse and recycled water • Introducing Property Title Certification System in ULBs • Earmarking 20–25 per cent of developed land for Lower Income Group (LIG)/ Economically Weaker Section (EWS) category • Computerized registration of land and property • Encouraging PPP

Source: Mid-term Appraisal, 11th Plan Document. Planning Commission

were found used towards improving the services in water supply, sewerage, drainage, and solid-waste management. Likewise, two-thirds of BSUP have been utilized for ‘slum redevelopment’ and the rest on creating infrastructure support for slum housing. There are backlogs, the report notes but it doesn’t say a word about the qualitative improvement in the services on account of JNURM induced funding.

- Likewise, it also notes that two-thirds of BSUP funds spent on ‘slum redevelopment projects’ and the remaining 34% on creating infrastructure support for slum housing. This again is akin to making a general expenditure statement without any reflection on the qualitative utilization of funds.

Not surprising therefore, if the Planning Commission is indicted for creating documents without any substance.

Bane of Urban Governance: Created during British colonial period, the urban local bodies for quite long suffered from multiple maladies. This included lack of clearly demarcated functional domain, persistence government control through parallel para-statal bodies, a fragile financial condition

on account of inappropriate tax base and their realization etc. That apart, it remained unclear whether municipal bodies would work as political nurseries grooming budding politicians for higher level representative institutions or would be responsible for providing basic services to urban population. Caught into this quagmire, the very purpose of the municipal bodies had remained quite confused. Through a major intervention, referred to as 74th (Constitutional Amendment) Act 1992, the federal government ensured continuity of the urban bodies by making their periodic elections mandatory. Further, by ensuring one-third of the total elected seats reserved for women in general and Scheduled Castes and Tribes proportionate to their population, the representation part of the municipal bodies was firmly established. The amendment had also provided for transfer of functions related to twelve subjects listed under the twelfth schedule and also for funds from the finance commissions. The issues pertaining to 3Fs – funds, functions and functionaries – were partially resolved as the state governments were reluctant on all these three counts. The Centre was equally guilty since by then it had also floated MPLADS under which Members of the Parliament, later Assemblies also, were allotted funds to get by and large similar functions and services delivered at their behest to their constituents. This also made the decentralized planning an exercise in

futility, though even without that it was unlikely to make a head start on account of this being clubbed with that of rural local bodies. Frustrated with the defeat of the intended purposes of the constitutional amendment, the UPA government made another decisive intervention in 2005 by launching a massive urban renewal programme in mission mode. Named after the first Prime Minister, the Jawaharlal Nehru Urban Renewal Mission (JNURM), started as usual, with a big bang offering both carrot and showing stick at the same time to the state governments to tame the rot set in impoverished towns and cities.

The end results of both these interventions have been mixed. The rationale for 74th Amendment was that by according constitutional status and demarcation of functional boundaries along with flow of commensurate funds as well as deployment of functionaries, municipal bodies could be metamorphosed into dynamic urban local bodies. Its success was partial for the very simple reason that the state governments were not willing to share power with their local bodies. Indeed, it was in no way different than the Centre's attitude to treat states as its subordinate bodies. The second assumption was equally floppy that participation would be automatic if an appropriate forum is created at the ward level. That participation essentially entails mobilisation of people having shared common interest and destiny-this perspective was just ignored. Therefore participation was misconstrued as counting the number of shoddy attendance of people (Kumar, 2006).

The Union government did not take note of these inherent contradictions, if not underlying dangers, in infusing dynamism in local bodies. Likewise, it unveiled yet another ambitious programme, JNURM, a decade later which again started with mistaken belief that renewal of towns and cities could occur

if huge amount of money is pumped into them. Interestingly, the canvas was much bigger this time as it went beyond the confines of local bodies. Huge funding was made available for improving the urban transport across the country. Swanky Volvo buses are now found plying through even those cities which do not have even wide roads. If nothing else, they are seen as live testimony of misplaced enthusiasm.

This is not to deny however that there are improvements on some fronts but hardly any on many others (See Table 3.3 and Table A 3.8 (i) - A 3.8 (ii) in Appendix). For instance, 11 out of 28 states have transferred subjects pertaining to 12 departments (of total 18 designated) to ULBs though the activities are not highlighted that could confirm whether functioning devolved are peripheral or core. Likewise, 22 out of 28 have reportedly set up their District Planning Committees. Practically, there have been some improvements in every sector whether it is regarding rent control reforms, repeal of ULCRA or for that matter stamp duty rationalization, too. Yet one remains a mute spectator to the functioning of multiple organizations either unaware of the existence of other or even working for the cross purposes.

The lessons drawn from these outcomes are too apparent to be brushed aside. That urban governance is not the exclusive function of the urban local bodies, it also entails professionally qualified managers to handle complex task of managing a plethora of services including transport, drinking water, waste disposal and sanitation (see Box 3.3), roads, housing, land etc. Also that there would be varying models of urban governance, depending upon the population size, spread and topography of the area etc and this will be akin to one size does not fit all. The people's participation could certainly add to the quality of services and in preventing waste of resources, saving

Box 3.3 : Unclean Cities

423 cities conducted by Indicus Analytics, a consultancy firm in 2009 are worth quoting: "No Indian city qualified as healthy and clean. Only four cities – Chandigarh, Mysore, Surat and New Delhi – were rated as 'recovering but still diseased' while 230 were rated as needing considerable improvement, and 189 fell in the lowest category requiring immediate remedial action". The official data (GOI) also shows that little over one-third (35%) of the total urban households (30 million) have inadequate access to sanitation facilities.

Source : *Hindustan Times*, 12/11/2011

Table 3.3 : JNNURM: State Level Reforms

		Achievements till December, 2010
1	74th CAA (Transfer of 12 Sch. functions)	Bihar, Chhattisgarh, Gujarat, Kerala, MP, Maharashtra, Tripura, West Bengal, Andhra Pradesh, Tamil Nadu, Karnataka
2	74th CAA (Constitution of DPC)	Assam, Bihar, Chhattisgarh, Goa, H P, Kerala, MP, Maharashtra, Tripura, West Bengal, Gujarat, Haryana, Manipur, Punjab, Tamil Nadu, Uttar Pradesh, Arunachal Pradesh, Karnataka, Meghalaya, Sikkim, Tripura, Uttarakhand
3	74th CAA (Constitution of MPC)	Andhra Pradesh, Maharashtra, Tamil Nadu, West Bengal, (Not Applicable States: Arunachal Pradesh, Assam, Bihar, Chhattisgarh, Goa, H. P., J&K, Kerala, Manipur, Meghalaya, Mizoram, Nagaland, Pondicherry, Sikkim, Uttarakhand, Orissa, Sikkim, Tripura.) Karnataka
4	Transfer of City Planning Functions	Andhra Pradesh, Tripura, Assam, Chhattisgarh, Gujarat, Goa, H P, MP, Maharashtra, Tamil Nadu, West Bengal, Karnataka, Orissa, Haryana, Kerala, Rajasthan
5	Transfer of water supply & sanitation	Andhra Pradesh, Assam, Bihar, Chandigarh, Gujarat, Haryana, Chhattisgarh, H P, Kerala, MP, Maharashtra, Punjab, Tamil Nadu, West Bengal, Tripura, Uttar Pradesh, Kerala, Orissa
6	Reform in Rent Control	Karnataka, Mizoram, Manipur, Nagaland, Orissa, Rajasthan, West Bengal, MP, Uttar Pradesh, Gujarat, Sikkim
7	Stamp duty rationalization to 5 %	Arunachal Pradesh, Goa, Jharkhand, Puducherry, Sikkim, Maharashtra, Tripura, Gujarat, Meghalaya, Andhra Pradesh, Mizoram, Nagaland, Rajasthan, Uttar Pradesh, HP, Orissa, Chandigarh.
8	Repeal of ULCRA	Arunachal Pradesh, Assam, Bihar, Chandigarh, Chhattisgarh, Delhi, Goa, Gujarat, Haryana, J&K, Chhattisgarh, H P, Kerala, Karnataka, MP, Manipur, Meghalaya, Mizoram, Nagaland, Pondicherry, Orissa, Rajasthan, Punjab, Sikkim, Tamil Nadu, Tripura, Uttarakhand, Uttar Pradesh, Jharkhand, Maharashtra
9	Enactment of Community Participation Law	Andhra Pradesh, Gujarat, Haryana HP, MP, Maharashtra, Manipur, Rajasthan Tripura, Uttar Pradesh, Kerala, Assam, Karnataka, Nagaland, Tamil Nadu, West Bengal, Chhattisgarh.
10	Enactment of Public Disclosure Law	Delhi, Gujarat, Andhra Pradesh, Bihar, Haryana, HP, MP, Maharashtra, Manipur, Meghalaya, Orissa, Rajasthan, Tripura, Uttar Pradesh, Arunachal Pradesh, Assam, Kerala, Karnataka, Nagaland, Sikkim, Uttarakhand, West Bengal

Source: www.jnnurm.nic.in

time and energy but this will remain elusive as long as a sizable middle class comes to the fore. The relative success of *Bhagidari* scheme only in those colonies dominated largely by middle class households would testify to this fact. Or, it would call for the presence of a bunch of active citizenry in every ward of the municipal bodies which alas cannot be created by an executive fiat.

To run a plethora of such programmes and deliverance of other public goods, an efficient civil services is required. True, India is bestowed with hierarchically organized services since pre-independence days. The question remains however: are

they sufficient in the terms of their size, skills and levels of placement?

Reducing Size of Civil Services

An overwhelming proportion (around 93%) of the total strength of civil servants employed with the Government of India is composed of clerks, peons, messengers etc, referred to as class III and IV employees¹⁸ in administrative parlance. The fifth

¹⁸Following 6th pay commission recommendation class IV employees are being upgraded. For instance UP State government accepted the recommendation of 6th pay commission and decided to give grade pay of Rs 1800 to Class IV employee. Simultaneously, it also banned further recruitment and declared as dying cadre. In future, duties discharged by Class IV employee will be outsourced (Source: www.indianexpress.com, 05/09/ 2010)

and sixth pay commission reports had inter alia recommended that the size of bloated bureaucracy should be reduced. This was also in tune of thinking at the onset of 1991 reforms. Did it happen? This can be assessed in two ways: (1) by looking into the public administration contribution¹⁹ to the national state domestic product (NSDP). This was 4.07 per cent in 2008-09 (see the graph 21). (2) by comparing the absolute number of Central Government employees before and a decade after reforms. It was 38.13 lakhs in 1991 which went up to 38.76 lakhs in 2001 by adding 63 thousand employees on its pay roll. The decreasing trend became visible five years later, in 2006 when the absolute number came down to 31.16 lakh and further down to 31.12 lakh in 2008. (See Table A 3.9 in appendix)

Contribution of Public Administration in NSDP

At the level of states, the corresponding figures (public administration contribution to SDP in 1999-00) were higher in smaller north eastern states (Table A 3.10 in Appendix); indeed, highest in Sikkim (18.2%), almost the same in Manipur (18%). The

¹⁹It is the 'income of salaries and wages paid to the employees working in the Central, State, Local Self and Quasi Government bodies' measured as contribution of public administration to the NSDP.

Fig 3.3 : Trend in Central Govt. Regular Employment

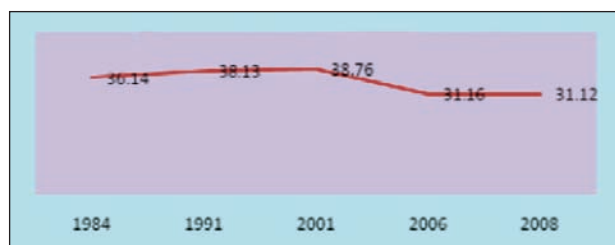
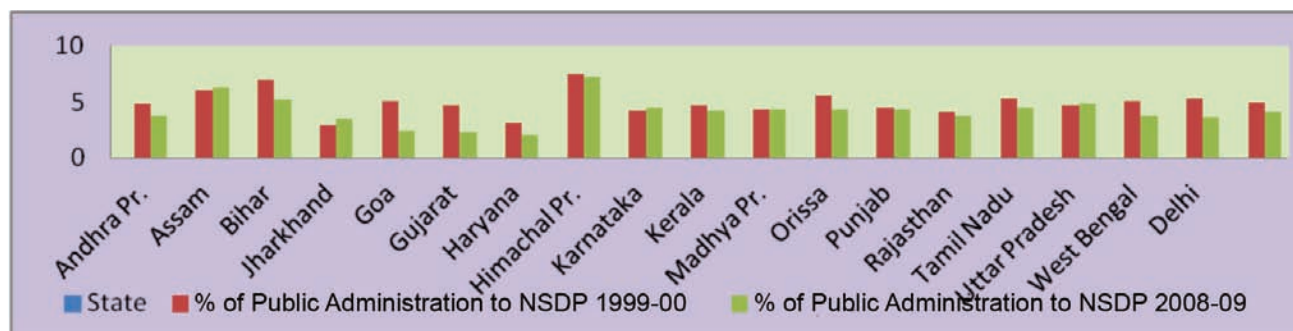


Fig 3.4 : Public Administration Contribution to Net State Domestic Product (Constant prices)



Source: CSO

lowest in this range was Tripura (12). Among major states, it was on in the range of 4 to 6%, higher in Bihar (6.6 %) and lower in Karnataka (4.1 %). It also needs mentioning that the biggest contingent of Central government employees happen to be on the pay rolls of the Ministry of Railways (comprising 16.55 % in 1991, down to 13.94 % in 2008), followed by communications and IT, and defense, as is evident from the Table A 3.11(appendix). And how is the central government employees distributed among states? The figures given in (see Table A 3.12 in Appendix) show their very thin presence, less than one per cent in north eastern and hilly states but among major states they are heavily deployed. Their concentration was highest in Maharashtra (14.27%) in 1995, followed by UP (13.86) and Bengal (12.97%). The corresponding statistics for 2008 reveal substantial decline as only 8.97 % in case of Maharashtra and UP with 9.82 per cent. But in case of Bengal, it has remained high 10.50 per cent.

It is difficult to discern a pattern in deployment of Central government officials in states as it certainly defies any logic or a normative approach. Neither merit nor performance but seniority combined with political contacts that propel civil servants to higher positions. Mercifully, the bloated numerical strength, pointed out by the 5th & 6th pay commission, has gone down, though it is still problematic (see Box 3.4, 3.5 & 3.6). For, a disproportionately very high proportion of them are devoid of any productive skill.

Then, notice the sector-wise distribution of central government employees in the social sector. In terms of absolute number, it is the highest (2008 figures) in urban development, followed by health and family welfare (Table 3.4).

Table 3.4 : Distribution of Regular Central Government (Civilian) Employees

	Ministry/ Department	No of Regular Employees (as on 31 march 2008)		Total
		Gazetted	Non Gazetted	
1	Health and Family Welfare	3717	19941	23658
2	Panchayati Raj	36	47	83
3	Rural Development	146	438	584
4	Urban Development	4402	24553	28955

Source: Census of Central Government Employment, 2011, DGEST, Ministry of Labour

Central Administrative Tribunal (CAT)

Considering the expensive and time consuming cumbersome judicial procedure, the CAT was setup to speedily dispose of the grievances of Central government employees. The growing number of cases and resultant pendency, as shown below (Fig. 3.5), are testimony to growing maladies afflicting the civil services at large. If the civil service cadre management system is becoming increasingly insensitive, forcing

its employees to knock the CAT doors, the later is unable to bear the load. In fact, the very purpose of CAT appears to have been defeated but there is hardly any murmuring about it in the corridors of power. Both the PMO and Cabinet Secretariat seem to be overwhelmed with the handling of routine matters afflicting the functioning of the government that they hardly have time to look into the systemic failures. (See Table A 3.13 in Appendix)

Box 3.4 : Inversed Staffing

The Public Works Department (PWD) in the state of Uttar Pradesh (UP) has on its rolls 77,000 employees. Put simply, this means ‘fifty-one full time workers for every 100 kilometers of road... one of the highest manual staffing ratios in India’. The wages of road workers are nearly three times higher than the prevailing market wage rate but ‘the roads in the state are among the worst in India- thanks to an alarmingly high rate of absenteeism, lethargy, negligence and lack of monitoring, ‘supervision and equipment’.

Source: Jalan (2007:107-08)

Box 3.5 : Misplaced Priorities

It is estimated that 70 to 80 % of total budgetary expenditure is spent on the salaries of government employees engaged in implementation of these programmes at all levels – from concerned union ministries to the village level functionaries. This is equally true of subsidized credit routed through the ‘refinancing agencies and banks’ located at all the three levels – ‘state, district and village level primary cooperative societies - sponsored by the federal government. ‘Thus, subsidized credit provided at 6 percent per annum by the central refinancing agency’ is delivered more than double the initial rates, at 14% ‘or higher’ to the farmers.

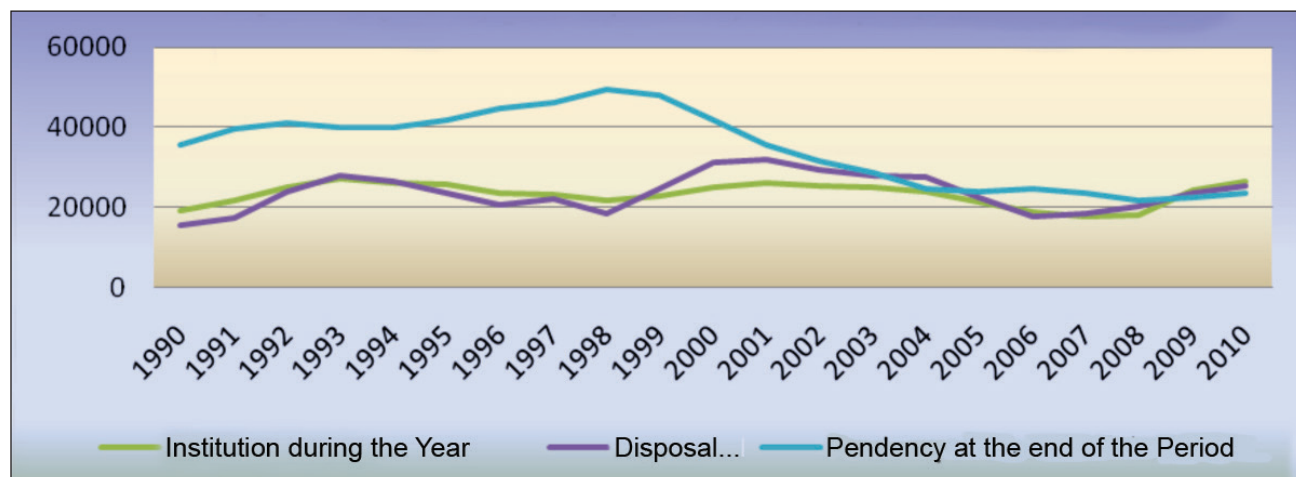
Source: Jalan (2007:107-08)

Box 3.6 : Awful Actions

Either due cumbersome funding pattern or negligence on the part of state and district level agencies, funds quite often remains unspent in several states. For instance, Maharashtra, once used to be a better governed state, could not use around four-fifths (78%) of total allocation meant for serving nutritious food to children under a centrally sponsored scheme. ‘Instead, it demanded funds from of a large number of parents of poor children to fulfill the state’s obligations’. Fund utilization pattern was found worst in many other states including Jharkhand, where ‘the government had failed to avail of entire budget allocations because financial sanction could not be issued on time’

Source: Jalan (2007: 94)

Fig 3.5 : Disposal & Pendency of Cases under CAT



Committees & Commissions

To say that the successive governments have remained oblivious of their shortcomings would amount to ignoring the laborious efforts of the former. A long list of the commissions and committees set up in the past on a large number of issues would testify to the fact (Table A 3.14 appendix). Among all, issues pertaining to administrative reforms have been treated with deep concern by many regimes during the last fifty years. There is no denying to the fact that there was a gap of over four decades between the first and second administrative reforms commission (ARC) reports (submitted in 1967 and 2009 respectively) that examined practically all the aspects pertaining to a vast subject like administration. But during the intervening period several committees also looked into varying issues concerning public sector administration and submitted their recommendations. This includes mode of recruitment of civil servants, their age limit, syllabi for written examination, their tenure, and promotion and so on. Thus, on administrative reforms alone there are more than half a dozen reports. This is not to say that recommendations of none of the committees have not been followed up. But the actions taken up have largely been bordering on mundane issues like age limit at the entry point or certain cosmetic changes in examination pattern on so on.

The fact remains, however, is that the major issues pertaining to accountability²⁰ or negligence shown at the higher level or tenure of key positions have been ignored. Indeed, even directive of the highest court of the land following public interest litigation on tenure of the key executive positions have been overlooked. The political expediencies always take precedence on such issues, disrobing whatever little honest efforts made by the executive arm of the state. The most important issue of 'reward and punishment' has either been twisted or obliquely referred by the governments of the day over the years. By doing so, the state discourages the honest, sincere executive officers on the one hand, but on the other it encourages the wrong doers by not punishing them. The end result is the growing cynicism among all the right thinking people both within the establishment and outside. By all means, the act of omissions and commissions prompts people to think that administration to a large extent is self serving; it does not serve the people for whom this was created in the first place. It is hardly surprising therefore if the very setting up such committees are mocked with contempt and consider as wastage of precious public resources.

²⁰Apart from what occasionally appears on these issues in newspapers, there are well documented studies available on lack of accountability, negligence, and corruption among civil servants as well as wastage of energy and time of highest level of bureaucracy. For instance, see, Ray (2001), Shourie (2005), Jalan (2007)

Recommendation of Administrative Reforms_ (ATR)

That the second administrative reforms commission report is voluminous since there was nearly four decades gap between the two commissions. Secondly, the second ARC has to grapple with a large number of issues, including those reformative steps taken in post-1991 period. Due to space constraints, only a few recommendations are considered here which are highly significant for this report.

The status of the second administrative commission report (ARC) is appended with the report. Table (A 3.15 in appendix) reveals the following facts. Altogether, there are 15 reports on second ARC, giving a total of 1319 recommendations on various issues of which ATR has been furnished with reference to 1030 (83%) recommendations. The largest number of recommendation was given in its sixth-report which is on local governance, forwarding a total 256 recommendations on this subject alone. Of this 231 (around 90 %) are accepted. Although recommendations like 'audit be done by Local fund audit or CAG in discharge of their responsibilities', 'transfer of funds to *panchayats* or those pertaining to activity mapping' etc. need appreciation, some of them are also stated earlier many times (like issue of planning commission guideline on decentralized planning). Likewise, too much has already been said and done on 'research be encouraged on functioning of local bodies'. What has happened with the findings of voluminous studies done on the subject? Had little more time been spent on this issue, the country would have been better informed and perhaps better governed as well.

Regrettably, included among the all accepted recommendations are some which are too obvious to make any impact, like holistic training, change of words in certain sectors, such as education and health service delivery be transferred to PRIs etc. Some of them seem to be repeated many times earlier, such as local bodies audit issues and positions on parastatals. Interestingly, regarding outsourcing of specific functions to public or private agencies a question arises: which public agency is available at the local level? Apart from village panchayat itself, other agencies are: Anganwadi, may be SHG, or primary

school, cooperative society but all are loaded with assigned functions. Similarly, some of the important recommendations fall on the non accepted category like enabling panchayat to perform better at the local level and empowering urban local bodies, though one fails to understand what these recommendations are all about. Indeed, it is too vague to make any sense out of it. Around 98% of the recommendation on e-governance which is given in the 11th report been accepted. Least acceptance can be observed for social capital in 9th report (48%), where 32 recommendations were accepted out of total sixty six.

On RTI (Report number 1) 39 recommendations out of 62 were accepted which comes around 62%. An important recommendation like single window at district level however is not accepted by governments expressing their inability. Frankness of this sort must be appreciated. In the 15th report on State and District Administration out of 158 recommendations 135 accepted which comes around 85%.

Best Administrative Practices

From the above narratives one can easily draw the conclusion that the civil servants do not take up their job seriously. That they remain concerned about their pelf and power, ignoring the masses who they are supposed to serve. This image of administrators has stuck to our mind because it is largely their wrong doings and failures that are highlighted by the media. Rarely does one come across the wonders created by the sensitive souls among them who go out of way to help the needy ones or who take cudgels with the powers that be while fighting for restoring dignity to the persona of an ordinary person. Whether it is related to the communal situation or providing drinking water to villagers or even resorting to creative bending of rules to ensure timely help to an individual or community at large, there are enough documentary evidences to prove their credentials as upright officers. Apparently, such bold, courageous and righteous officers are in thin minority but they are there.

Mercifully, the government has woken up at last to recognize the best efforts made by a handful of executive officers, by rewarding them on the civil

services day (April 24). The incidents recorded in brief in the table (see appendix, Table A 3.16) are based on the compilation of the available data on the innovations introduced by the concerned officers who were duly rewarded.

Right to Information (RTI)

The RTI Act 2005 is perhaps the most innovative among the acts enacted by the Government of India. It empowers the ordinary people to gain required information from the public authorities. Indeed, through this piece of legislation, the government has opened itself bare before the common people. This also amounts to taking a sincere step towards fulfilling one of the governance induced conditions – transparency. This is equally true that it is perhaps the first major victory of the civil society at large that forced the government to open itself, bringing its decisions to public domain. Indeed, the very coming of the act reveals that through tenacious efforts of people's collectives some of the governmental maladies could be remedied.

It needs mentioning that first of all it was the state of Rajasthan where the RTI Act came into being which also did not enact it on its own volition. It was rather forced to do so following a protracted mass movement organized at the level of villages, district town and the state capital. The hallmark of this movement was nearly six month long *dharna* (sit-in) at Bewar, a sleepy, sub-provincial, mufousil town in Rajasthan during 1996-1997. Interestingly, it had started with the demand for public scrutiny of gram panchayt (village council) records (read muster rolls) showing name and address of wage labourers, date on which the work was carried out and payment made to them with their signature or thumb impression appended.

Following a lot of protest, led by a high profile activist (a former IAS officer who had resigned from the services to work with the masses) the government buckled under the pressure. The scrutiny of records confirmed fudging of records. Undeterred, however, the then state government refused to show the muster roll of another panchayat and related documents at the level of block panchayats. This led to another round of protest, involving a large number of people,

duly highlighted by the media, though largely by the vernacular press. Eventually, the government of the day was forced to admit that it could not hide misdeeds of its machinery under the veil of secrecy; that the people have right to know what the government was doing. So what initially had started as scrutiny of documents on how the tax payer's money was being utilized at the village panchayat level eventually ended with the enactment of RTI in Rajasthan.

By and large, similar was the background that led to the coming of RTI in Maharashtra and later in Delhi. Finally, the government of India was forced to toe the line of action of state governments, heralding the victory of federal principles in a reverse manner. Hailed by the media as people's victory, praised by activists for its lethal power and also upheld by the honest, upright officers, the use of RTI has unlocked the official secrecy. All this deserves appreciation but given the obstacles coming its way raise questions about the intentions of the government machinery. In fact, a huge backlog of pending cases before the Central information commission is an indicative of distortions creeping in its implementation (Table 3.5).

Table 3.5 : RTI Cases before Central Information Commission

Years	Cases Pending	Cases Disposed (Cumulative)
2006	638	312
2011	18,668	70,486

Source: The Hindu, 11/9/2011

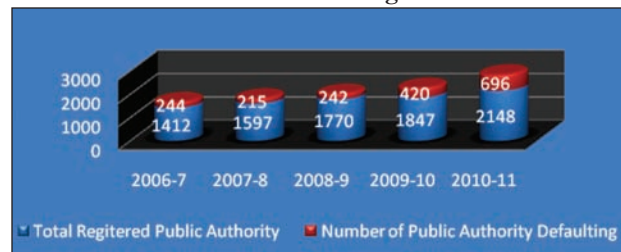
Consider Section 4 of this Act, referred to as its 'cornerstone' that reads: 'it shall be the endeavour of every public authority to provide as much information *suo motu* to the public at regular intervals through means of communication, including internet so that the public have minimum resort to the use of this Act to obtain information. What flows from this Act is that specific information pertaining to certain areas, as identified in the Act, has to be brought into public domain, either on official websites or published within 120 days of the enactment. That this vital aspect has been ignored is apparent from the fact that information commissions both at the level of states and centre are burdened with a very large

number of unfurnished applications. If the uploading information system is not improved, it would take years to collect and collate the required information, rendering the whole system dysfunctional.

This is not to say that the computerization of government records has gone out of order. It is being done but not in the right direction. For, computerization of records is, as observed by an insider having hands on experience in the matter, “not merely a process of conversion of manual records. The challenge lies in re-engineering the business processes and the records in such a manner that it simultaneously leads to improvement in the efficiency of the organization and maximizing the availability of information in the public domain in formats which are useful to the general public or the stakeholders” (Hindu, 11\9\2011). In continuation, the author of the referred newspaper article, a serving IPS officer, has shown a model to handle this problem, but given the increasing number of pending cases, it appears that no heed has been paid to this wise counseling (see Table 3.17)

This is not the end of story. The murder of a large number of RTI activists also confirms the lethal connivance between the vested interest both within the establishment and their contractual partners. There are a number of instances from a large number of states where RTI activists have been harassed in order to silence them. Something most peculiar

Fig. 3.6 : Total Number of Registered Public Authority and Defaulting

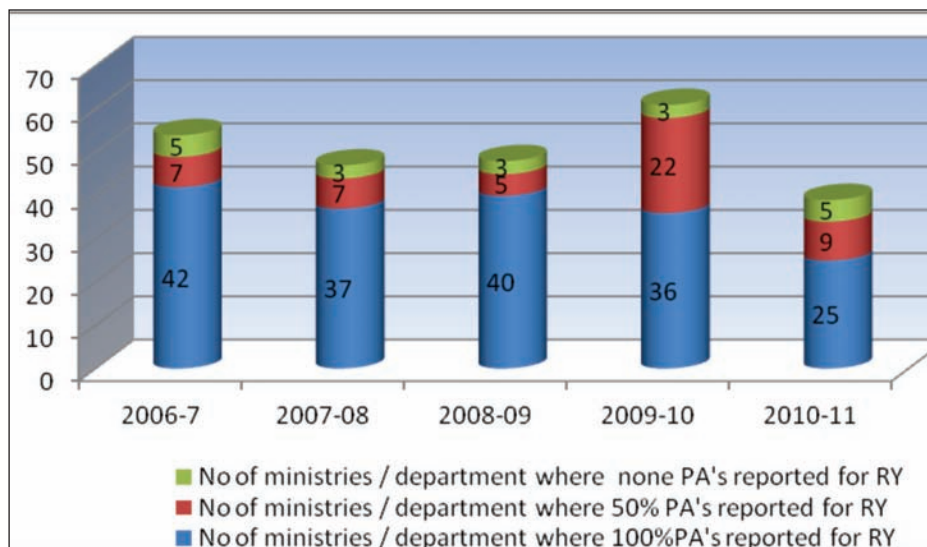


Source : Annual Report CIC 20-10-11

happened in Tamil Nadu in September 2010 where three young RTI activists were illegally detained when they protested against the appointment of a retired chief secretary as chief information commissioner of the state without calling application for the same by the selection committee. Also, the same favoured officer was the one who had earlier ‘blatantly opposed the implementation of RTI act in the state’(Tehelka, October 9, 2010).

The data received from the Annual report (2010-11) of the central information commission reveals that the only 67.5% public authorities submitted the annual return for all four quarters (Fig. 3.6). The number of the ministries and departments where all the public authorities reported the status of implementation of the RTI Act is gradually decreasing. For, it was 40 departments\ ministries reported in 2008-09 but it came down to 36 in 2009-10 and further only to 25 in 2010-11. Significantly, it was only from five ministry and departments in 2008-09 where earlier

Fig. 3.7 : Comparative Status of RTI Act Implementation by Ministries/Departments

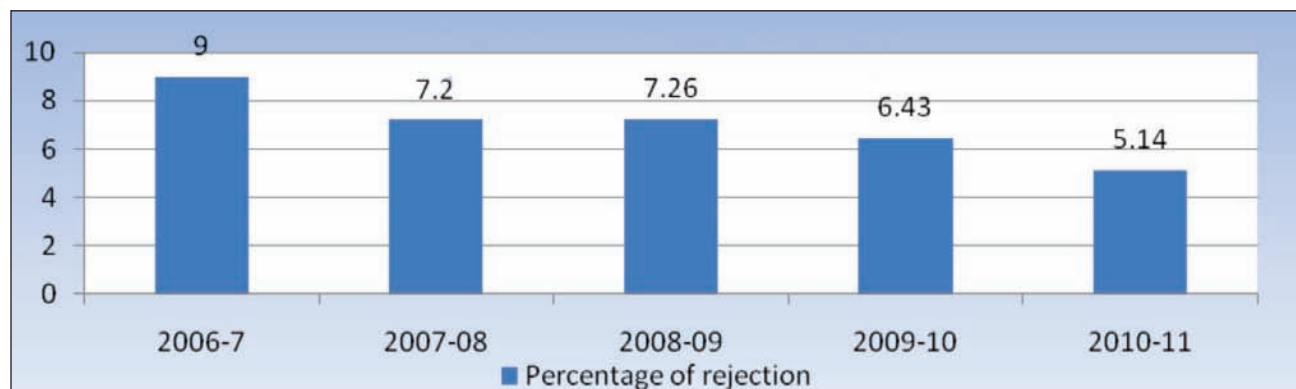


less than half of the public authorities had reported their status, their corresponding number went up to 22 in 2009-10 but again fell down to 9 in 2010-11 (Fig. 3.7). Treating the declining trend as ‘disheartening’, the ARC report has also expressed its apprehensions that this would hamper ‘effective monitoring of the implementation of the Act both qualitatively as well as quantitatively.

It may also be noted that proportion of application seeking information rejected was very less. It was only 6.43 % and 5.14 % in 2009-10 and 2010-11 respectively. If nothing else, it is testimony to the professionalism injected by the public authorities. .

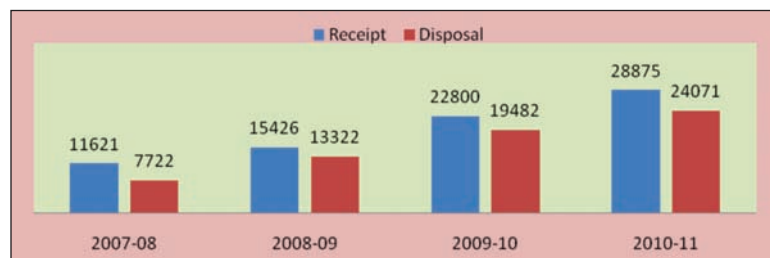
Percentage of disposal of RTI applications initially increased then showing a decreasing trend

Fig. 3.8 : Percentage of Rejection



Source: Annual Report CIC 2010-11

Fig. 3.9 : No of Complaint Received and Disposed



Source: Computed from data given in the Annual Report CIC (2010-11)

Fig. 3.10 : Percentage Change in Receipt and Disposal over Last Year

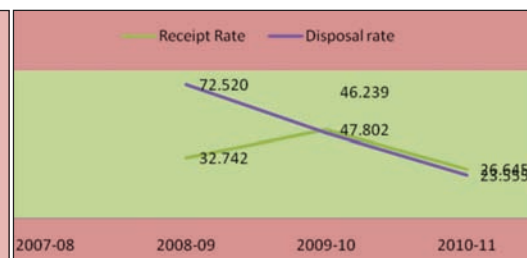
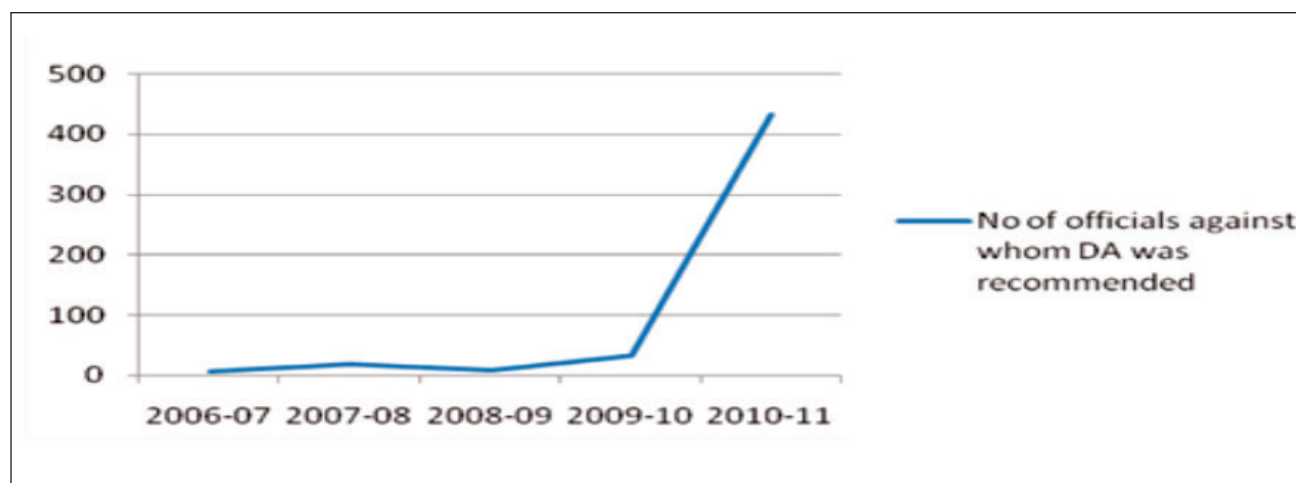


Fig. 3.11 : No of Official against whom Disciplinary Action was Recommended



Summing up

The role performance of the civil servants is the hold of this chapter but by extension, it also traverses through the governance reforms initiated by the Government of India. The chapter unfolds with the policy making and administering of welfare programmes largely for BPL category populace. Apparently, the policy making is essentially handled by the elite administrative officers but in implementation, more particularly at the cutting edge, junior civil servants are also involved. As a matter of fact, civil servants of various cadres and levels, starting from those holding Secretary (to Government of India) level position in the corridors of Union Ministries to a junior/ lower level functionaries of any service delivery or revenue department of state governments are involved in the implementation of the centrally sponsored schemes. Thus a quick appraisal of these twin issues will give clear insight into the performance of the civil servants.

The assessment record, as it would emerge from leafing through the preceding pages, is that of a less than success, notable exceptions apart. But it would be unfair to put entire blame at their door step since policy making at least, has a strong political bearing, which logically is beyond their control. This partly absolves them from facing flack, but not fully. In the eyes of the people, they remain as guilty as politicians. For, in view of the very permanent nature of their position along with powers and privileges they are bestowed with, their being treated as hapless by their political masters do not cut ice with any perceptive observer of the governmental functioning. This is equally true of another argument that if the entire society is degenerated, with hardly any visible sign of moral rectitude on the horizon, how the elite all-India service officers would be different. If they are

perpetually forced to choose between lure of dangling prize postings and threat of remote dumping, how could they be expected to choose eternal indictment? Yet, to be fair to them, it must be acknowledged, there are fearless, bold civil servants who stand up against the might of powerful politicians, though they are in very, very thin minority.

All these apart, there are two significant issues which point to messy affairs of civil services. One is the increasing number of cases against bureaucratic highhandedness being referred to administrative tribunals that speak volumes of cadre mismanagement. Another is the refusal of accepting any wrong doing or failure on the part of bureaucracy; indeed higher is the level, the greater is the propensity of shielding wrongdoers. Several commission reports have pointed out to these facts. Yet the very attitude of negation that they can do no wrong prevents any improvement on this count. There is another perspective on this issue. It rather reminds us that despite voluminous recommendations on professed administrative reforms, the guilty, the brazen, the shirker among them are rewarded with better postings, again notable exceptions apart, while the best and the bright are sidelined, if not punished. Giving false impression is another bane of bureaucracy. When they claim to have designed new programme or scheme, in effect it would be a new packaging of an older programme with little changes here and there. The less than success stories of planned rural development, including welfare schemes or for that matter invigorating health care system despite instruments of locally devolved planning and programmes supposedly powered by 73rd amendment and pouring of thousands of crores under some of the flagship programmes are testimony to these facts. ■

PROMOTING PARTNERSHIP WITH PRIVATE SECTOR & CIVIL SOCIETY

As stated in earlier chapters, the modern notion of governance has evolved for the better use of aid given by the western world to the developing countries. It is claimed that external aid for development could be used efficiently if the recipient countries adopted market friendly pro liberal policy. Over the years, several studies (Leftwich 1993, Bardhan 1997 etc.) have also established the fact that better governance structure lead to sound economic development. It has also been argued that a sustainable economic growth can be promoted by creating conducive environment for investment and its efficient use. These twin pre-conditions could be met by promoting accountability and transparency, as well as controlling graft through a fair political system that allows free and uninterrupted movements of resources. In sum, it is assumed that better governance would propel better economic progress which, in turn, if translated properly would improve the quality of life.

These arguments are equally applicable in the context of India, a country of more than one billion population experiencing rapid transition, being recognised as one of the fastest growing economies of the decade. From the vicious circle of 'Hindu rate of growth', it has come a long way amidst skepticism about its

survival in a globally competitive environment. A quick look into the past reveals that India started its post independence journey by adopting a policy of massive state control over economic recourses in order to fulfill its commitments towards promoting equity and ensuring social justice. Later, the '*Garibi Hatao*' political slogan confirmed that the expected 'trickle down' had not materialised. Yet it was not until the oil shock of '70s that Indian policy makers gave a serious thought towards export promotion as a viable alternative for economic growth. Eventually, India underwent massive structural and economic changes, following major policy changes undertaken to overcome the fiscal and BOP crisis in 1991 under the leadership of P.V. Narshimha Rao. Not surprisingly, India was considered as a late comer to economic reform '...although India took some steps in 1980s with limited deregulation and changing some aspects of control regime but reform in 1990s was much wider and desperate.'"(Ahluwalia, 1992)

Clearly, the economic crisis of 1991 was a consequence of unfavorable macroeconomic situations prevailing in the preceding few years. The growth rate of real GDP was around 4-5% with an inflation as high as 10 3% in 1989 and a fiscal

deficit around 8% consolidated for both the centre and states. Although the general election was not fought on economic issues, the first challenge of the new government was to restore economic health of the country. After all, the minority government had assumed office barely a month ago, inheriting crisis ridden economy. The growing fiscal deficit was covered by borrowing, causing huge internal public debt of the Central Government to the tune of about 55 % of its GDP during 1991. In fact, 20% of the total government expenditure was on account of paying as interest rate alone. Not wonder, the Finance minister proclaimed in his budget speech (See Box 4.1): “Without decisive action now, the situation will

move beyond the possibility of corrective action.... in sum, the crisis in the economy is both acute and deep.... we have not experienced anything similar in the history of independent India” (Budget Speech, 1991-92).

Having witnessed a massive change in the last two decades, it would be interesting to observe how the economy is performing after such reform. The impact of the reform can be measured by looking at the changes in ‘per capita NSDP’ for it is considered as a simple tool measuring standard of living. The following diagram (see, Fig. 4.1) captures the changes in per capita NDP that has taken place over the last two decades. The figure shows an upward trend indicating that per capita NDP is gradually increasing at a rapid rate.

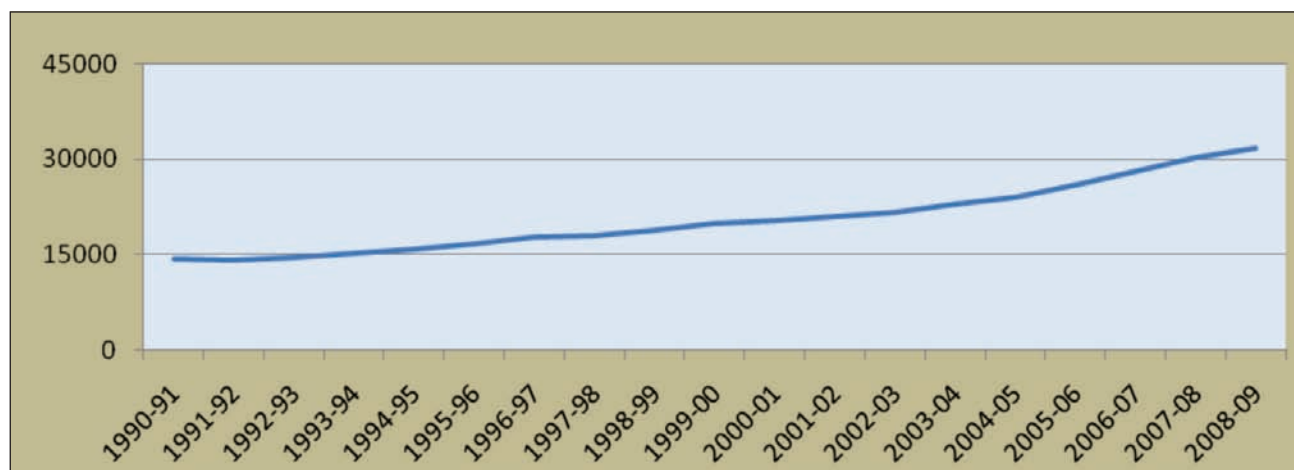
Box 4.1 : Highlighting Speedy Reform

“Macro-economic stabilization and fiscal adjustment.... must be supported by essential reforms in economic policy and economic management.....that an intense debate rages throughout the country as to the path we should adopt... The most important thing that comes out clearly is that we cannot realise our goal of establishing a just society, if we abandon the planning process. But India’s future development depends crucially on how well the planning process is adapted to the needs of a fast changing situation...our planning processes must be sensitive to the needs of a dynamic economy. Over centralization and excessive bureaucratisation of economic processes have proved to be counterproductive So a speedy reform is called for in the different sectors of the economy”-

Source : Budget Speech:1991-92

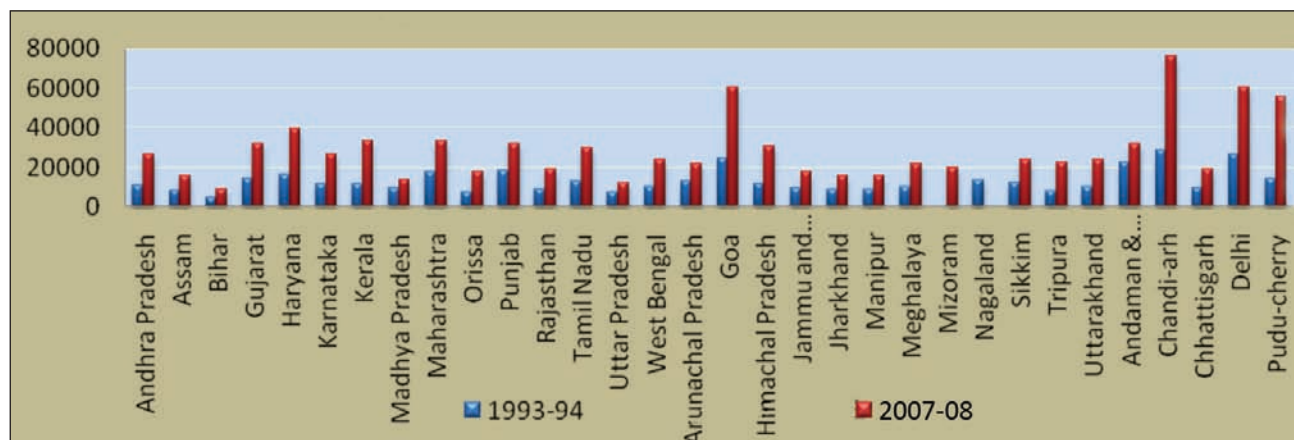
The state level measure of NDP is called net state domestic product (NSDP).The following graph reveals the per capita NSDP (at constant prices 1999-00) between 1990-91, and 2007-08 across states during two time period. This shows Goa (see Fig. 4.2) as one of India’s richest states with the highest per capita NSDP throughout the two reference years: Rs.24,059 in 1993-94, and Rs.60,232 in 2007-08 respectively, whereas Bihar depicts the lowest per capita NSDP in all the referred years among all the states and union territories. Several other states like UP, MP, Jharkhand, Chhattisgarh, Orissa and Rajasthan also did not even cross Rs. 20,000 barrier in 2007-08. On the other hand, Gujarat, Maharashtra, Punjab,

Fig. 4.1 : All India Per Capita NDP (2004-05 Prices)



Source: CSO

Fig. 4.2 : Per capita NSDP at 1999-2000 (Constant Prices)



Source: CSO

Haryana and Kerala are those states that registered higher per capita NSDP. For instance, Tamil Nadu's NSDP is the second largest in South India and is the fifth largest in India.

Among the north eastern/hilly states and union territory, Chandigarh is seen as the India's richest union territory with the highest per capita NSDP during the two reference years: Rs. 28,713 in 1993-94, and Rs. 75,674 in 2007-08. It also shows least variation in the per capita NSDP of states/ UTs belonging to this category. The states of Assam and Manipur, for instance, depict lowest per capita NSDP among special category states, while Himachal Pradesh shows highest per capita NSDP in 2007-08.

There is no doubt that all the Indian states witnessed growth in their respective per capita income. But it may be noted that per capita income is a very crude measure of standard of living as it hides the fact whether the benefit of this growth has actually accrued to all section of the society. Indeed, how far this growth is being able to transform peoples well being is discussed in the last section of this chapter.

The impact of reform can also be observed by identifying a few crucial sectors of the economy and measuring the impact of economic reforms on their performance during the last two decades. The sectors identified here are: industrial, fiscal and external. Changes in the industrial sector including public sector is analyzed by reviewing the industrial

policy. This is true for budgetary position of the Central and State Governments. Likewise, the impact of economic reform on external sector is captured by the quantum of FDI inflow.

Industrial Sector

The industrial policy of the first three decades in the post independent era was characterized by excessive regulation, through licensing, high tariff barrier etc. The presence of monopoly restrictive trade practices (MRTP) Act also discouraged the growth of domestic private sector. All this was designed to minimize the misuse of resources. The main thrust of the economy was on import substitution rather than export promotion. The policy was questioned as by mid-1980s, it became clear that drastic shift in policy was needed to speed up the rate of growth.

It was felt that this can be achieved through deregulation and de-licensing of industry including, removal of barriers for new entrants and expansion of existing ones. It may be noted that the tilt towards liberalisation had begun in 1985 following the New Economic Policy, under the Seventh Five Year Plan (1985-90). But the major shift occurred in 1991 only when Narsimha Rao led government announced a new industrial policy in the Indian Parliament on July 24, 1991. This called for radical changes "to unshackle the Indian industrial economy from the cobwebs of unnecessary bureaucratic controls." The policy shift can be traced as following:

- Industrial licenses for all projects abolished,

except for few under reserved category.

- Foreign equity holding limit was raised from 40 to 51 percent.
- New (public sector) disinvestment policy announced

The thrust of the industrial policy (1991) was on removing bureaucratic controls that had hindered the growth of private sector. It aimed at making industrial sector more competitive both domestically and internationally. Since 1991 the successive federal governments have carried forward the reforms and so have done many state governments. In fact, some of them have been vying with each other for attracting both domestic and foreign investors.

Public Sector Reforms and Disinvestments

Public sectors were built to promote more equity and social justice. Initially, these fulfilled most of the tasks assigned to them. But, gradually, it became an absorber of national savings. While there were only 5 Central Public Sector Enterprises (CPSEs) with a total investment of Rs.29 crore on the eve of the first five year plan, they grew up almost 50 times in next the six decades as their number rose to 249 CPSEs as on 31st March, 2010 (excluding 7 Insurance Companies) with a total investment of Rs.58 lakh

crore (DPE Survey, 2009-10). Arguably, PSUs were not created just for the sake of earning profits but gradually they were identified as a major factor for the growing fiscal imbalance (see Box 4.2).

Not surprisingly, the Eighth Plan asserted that ‘one major step in economic reform was to restructure public sectors of the economy where the private sector can move in and step up our investment in the social sector’. Beset with the problems of public sector enterprises, mainly low productivity and lack of technological up gradation, the government was forced to adopt a new approach towards the public sector. Accordingly, a new policy was framed that inter alia read:

- Referring chronically sick PSUs to the Board for Industrial and Financial Reconstruction (BIFR)
- Raising resources and make public sector self-reliant by selling a part of the government share to organizations and individuals.
- Providing greater autonomy to the public sector management.

The process of reform and restructure continued, in fact, disinvesting in public sector was considered

Box 4.2 : Internal Public Debt

“The Central government alone has established 246 commercial enterprises, not counting the public financial institutions, insurance companies and railways.... The total capital employed in these enterprises is Rs. 160,000 crores (at historical cost)....most of this capital has, in effect, been borrowed by the government at market-related rate of interests...” in tune of 12-14%. Thus total internal public debt of the Central government in 1994-95 was “close to 500,000 cores, and nearly one third of it was accounted for by assets held in the public sector .The interest payments on public debt currently amount to Rs.50,000 crore which is financed by new net borrowing, and represent nearly 90 percent of the Center’s fiscal deficit.”

Source: Jalan (1996: 19-20)

Box 4.3 : Reducing Fiscal Deficit

Headed by a cabinet minister, a separate ministry of disinvestment was set up in 1999 under the Vajpayee government. The minister Arun Shourie, an ardent supporter of reforms, was answerable to the cabinet committee on Disinvestment, presided over by the prime minister himself. His main brief was to negotiate the sale of public enterprises. It may be noted that “except in defense, atomic energy and railways, the government unveiled a new policy to reduce its equity to 26 percent in 210 enterprises as the most expeditious way to reduce the fiscal deficit and raise recourses for investment in infrastructure and social services. By July 2001, 27 firms had been cleared for disinvestment including Videsh Sanchar Nigam Ltd (VSNL), the government monopoly over international telecommunications. Within less than a year, most of these had either been privatized or were at an advanced stage, and had yielded \$2.3 billion (Rs112.15 billion).”

Source : Frankel : 2006

as an alternative to save them. In continuation, in 1999 the NDA government set up the Public Sector Disinvestment Commission (See Box 4.3) as part of their Common Minimum Programme. Included in the Commission's task was to draw up a comprehensive long-term disinvestment programme and determine the extent of disinvestment and supervise the sales process. Accordingly, the Commission recommended that PSUs should be restructured before disinvestment. On the proceeds from the disinvestment process, it was also agreed, that apart from investing in PSUs, it would be utilized for strengthening social sector, viz. health and education particularly in the poorer and backward districts of the country. The NDA governments had created the Department of Disinvestment in 1999 which was subsequently renamed as Ministry of Disinvestment on 2001 in order to expedite the process; later in 2004 (May) it was merged with the Ministry of Finance.

The Fig. 4.3 shows that the receipt from disinvestment varied considerably over the last two decades. The highest receipt was obtained during 2008-09 and the second highest in 2003-04 (Rs. 15,547.41 crore). During 1994-95, 1999-00, and in 2001-02, the disinvestment was at their peak levels. Subsequently, as recommended by the Disinvestment Commission, the National Investment Fund (NIF) was set up in 2007 in which the proceeds from disinvestment in Central Public Sector Enterprises (CPSEs) were deposited. Nearly three-fourths of the annual proceeds of this fund were used to finance select social sector schemes, promoting education,

health and employment. The residual was used to meet the capital investment requirements of profitable and revivable CPSEs. Till the end of year 2008, the corpus of the NIF was about \$ 1,815 crore.

What was the impact of restructuring of public sector? While the number of operating CPSE has gone down from 237 to 213, the number of profit making PSUs has also gone up from 134 to 158. During the same period the number of loss making PSUs has declined to almost half. Although the deficit of sick PSUs that were already in loss increased almost five times, the (profits) earnings of the profit making PSU has increased by fifteen times in the last two decades. The turnover as a percentage of GDP has shown a slight improvement from 20.9 % to 23.9% (see Fig. 4.4).

Coming to the federated state level, it is observed that total profit making units were two-fifths (39.9 %) of the total State Level Public Enterprises (SLPEs) in 2003-04 but in case of total loss making units was three-fifths (60.1%). By 2006-07, the proportion of total profit making units went up to 51.4 %, whereas the size of total loss making units came down (48.6%). The state wise position with respect to loss making units and those identified for disinvestment are given in the Table A 4.1 in Appendix and also Fig. 4.5 & 4.6. The highest number of SLPEs identified for disinvestment was located in Andhra Pradesh, Kerala, Karnataka, Orissa and Tamil Nadu. Likewise, Andhra Pradesh, Uttar Pradesh, Karnataka, Orissa and Kerala are states where a large number of SLPEs were closed down.

Fig. 4.3 : Proceeds from Disinvestment

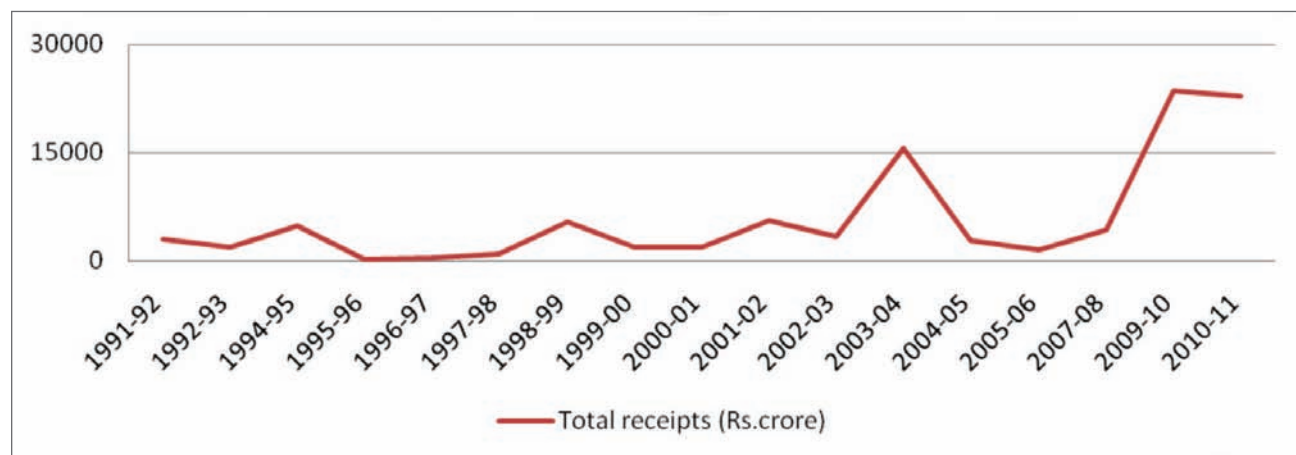


Fig. 4.4 : Performance of CPSEs during 1991-2008

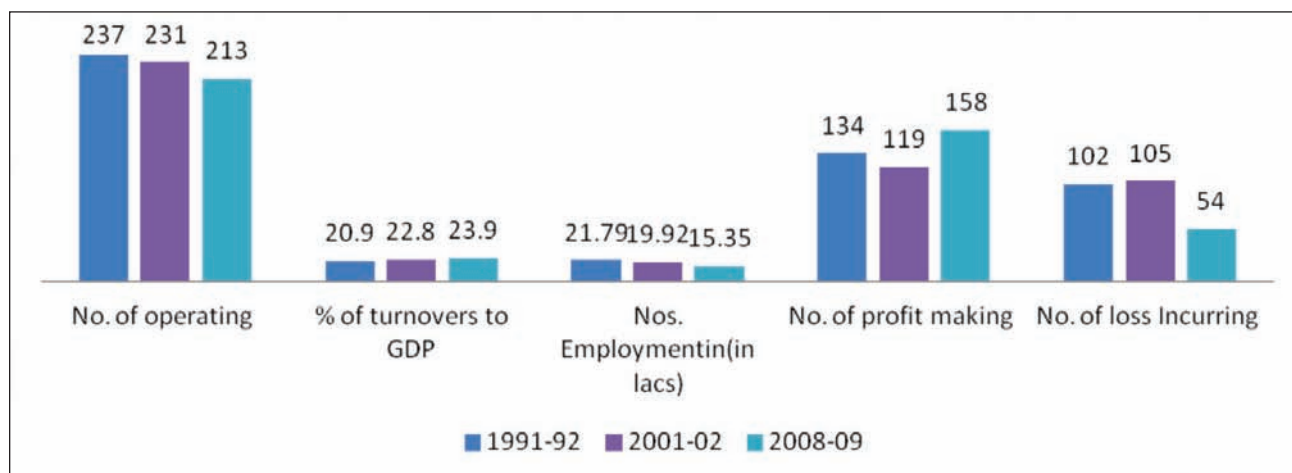
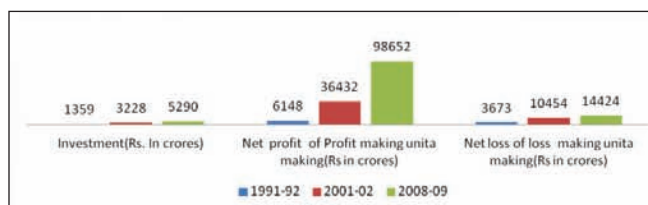
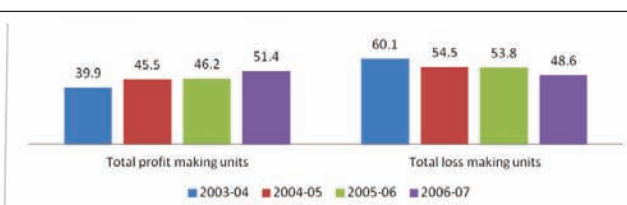


Fig. 4.5 : Financial Performance of CPSEs



Source: Department of Public Enterprises (DoPE)

Fig. 4.6 : Financial Performance of CPSEs



Source: DoPE

Fiscal Sector

As already mentioned, controlling growing fiscal deficits was one of the primary tasks of the economic reform. This had necessitated two fold actions: (a) controlling the government expenditure; and (b) raising the tax revenues. The earlier component was addressed by enacting Fiscal Responsibility and Budget Management Act (FRBMA) and the latter was done by rationalizing tax structure as recommended by the Chelliah committee.

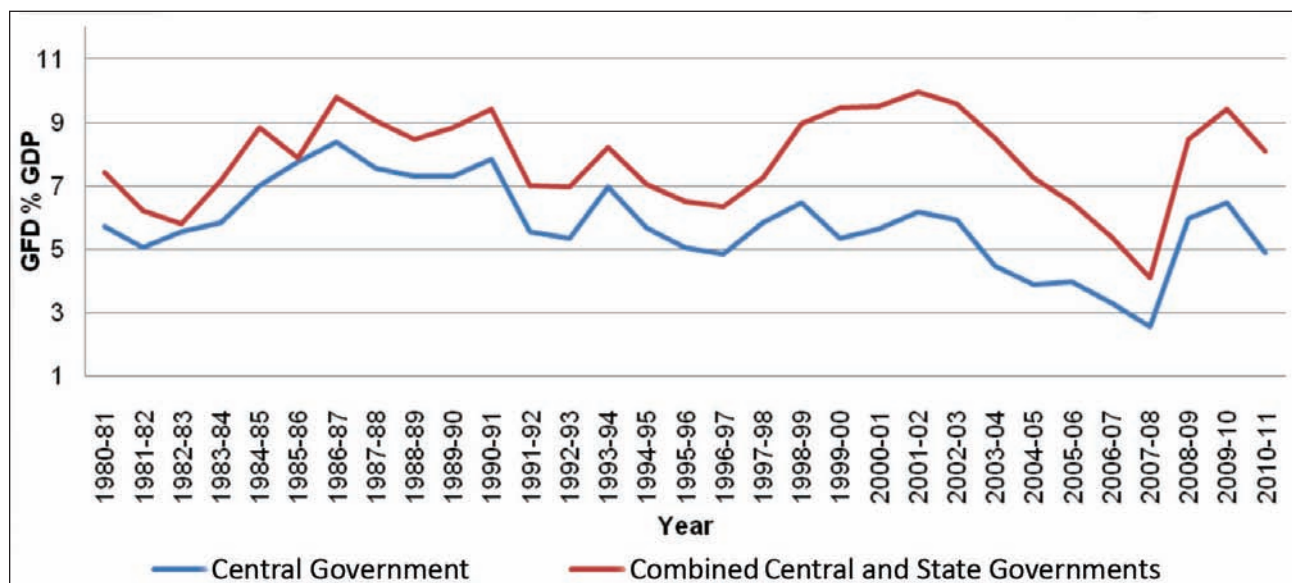
The FRBMA enacted by the Parliament in 2003, has the following objectives: (a) institutionalize financial discipline, (b) reduce India's fiscal deficit, (c) improve macroeconomic management, and finally, (d) overall management of the public funds by restructuring a balanced budget. The ultimate purpose was to eliminate revenue deficit of the country and bring down the fiscal deficit to a manageable 3% of the GDP by March 2008. The tenth plan document (Planning Commission) went further as it highlighted the need for fiscal discipline even at the level of the states. This was intended to reduce the debt-

to-GDP ratio of India. By 2007, several states such as Karnataka, Kerala, Maharashtra, Punjab, Tamil Nadu, and Uttar Pradesh etc. had already enacted their FRBM Act with Karnataka taking the lead.

Although the gross fiscal deficit (GFD) for both Centre and States fluctuated in the last two decades, a decreasing trend was observed during 2001-02. The GFD as a percentage of GDP for combined Centre and State was 9.9% and 6.2% for Centre alone in 2000-01, before the enactment of FRBMA, which came down 4.1% and 2.5% respectively by 2007-08. The Fig. 4.7 shows the combined gross fiscal deficits (GFD) as percentage of GDP for Centre and combined Centre and State taken together.

It also needs mentioning that budgetary reforms were separately suggested by the Committee on Capital Account Convertibility (Chairman: S.S. Tarapore, 2006). That apart, a Task Force on Indirect taxes (Chairman: Vijay Kelkar, 2002) had already recommended for revamping of indirect tax structure while unanimously acknowledging that value added tax

Fig. 4.7 : Gross Fiscal Deficit as % of GDP for Centre and Combined Central and State Governments



SOURCE: RBI

(VAT) was a major reform in the indirect tax system of India. Prior to tax reforms initiated in early 1990s, the prevailing sales tax was plagued with many ills including a 'multiplicity of tax rate and exemptions, lack of uniformity across States, large number of exemptions and concessions, and conflicting procedures for tax collection. In mid-1990s, most states had agreed to phase out the incentive related exemptions and implement floor rates of sales tax. As a part of nationwide efforts to redesign commodity taxation and the implementation of CENVAT at the level of the Centre, many States have modified their sales tax regimes to launch a state level VAT under the scheme prepared by the Empowered Committee set up for this purpose. Further, in order to avoid the unhealthy competition regarding offering tax concessions to lure trade and industry to their respective regions, the states agreed to adopt the minimum floor level rates as recommended by the Committee of Sales Tax Commissioners. Later, they decided to move over to the simple, transparent and efficient regime of VAT with effect from April 1, 2001. In fact, State Finance Ministers in a meeting, 2002 decided that all States and Union Territories would introduce VAT from April 2003.

Three years later the then Finance Minister proposed that India should move towards a national

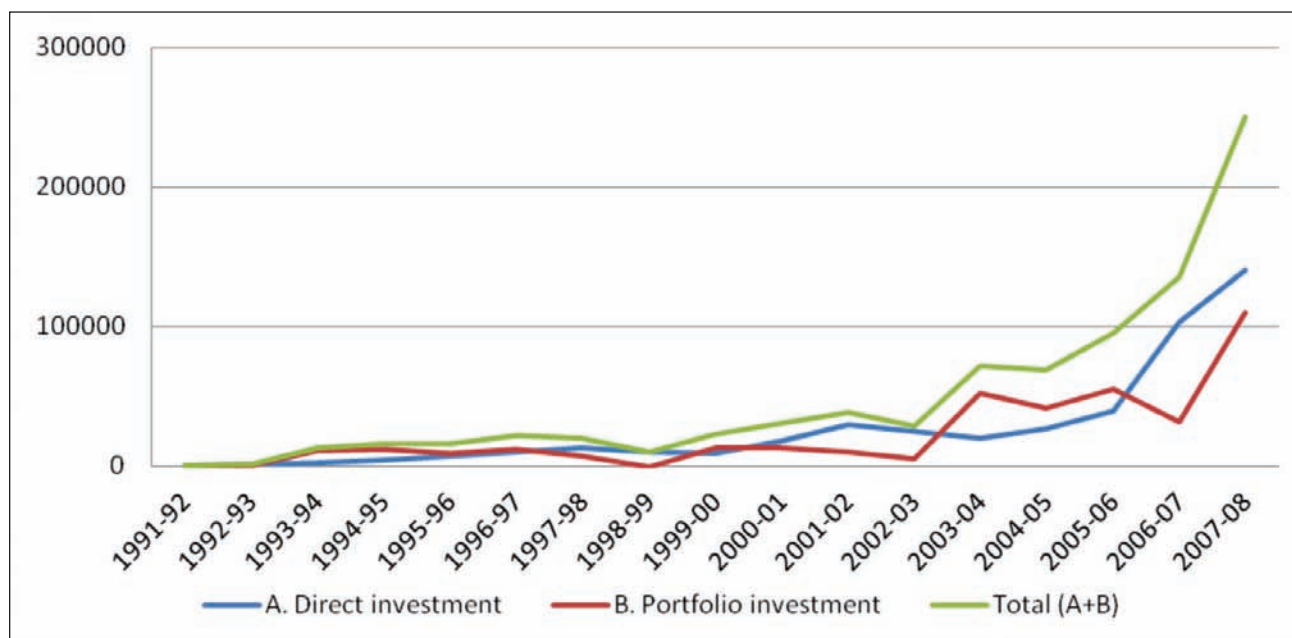
level Goods and Services Tax (GST) that should be shared between the Centre and the States with effect from April 1, 2010 (Budget Speech 2006-07). In the 2009-10 Budget, the importance of continuing the process of structural changes in direct taxes was reiterated. A Discussion Paper along with a draft Direct Taxes Code (DTC) was put in the public domain on August 12, 2009 seeking to increase in the tax-GDP ratio. A couple of years thereafter, till mid 2012, both GST and DTC failed to materialize.

External Sector

The impact of reform in the external sector is captured through a simple indicator inflow of FDI. The Fig. 4.8 shows the inflow of FDI both direct and through portfolio investment during the last two decades. Before going further a distinction between FDI and portfolio investment needs to be mentioned.

FDI is a measure of foreign ownership of productive assets, whereas portfolio investment refers to purchase of financial instruments. So portfolio investments are relatively more volatile than FDI. An increase in the foreign investment can be interpreted as existence of improved economic institutions. It also reflects the initiatives of the governments at both the level of centre and state

Fig. 4.8 : Net Foreign Investment Inflow (in Crores)



Source: Handbook of Statistics on Indian Economy, RBI

to create a favorable investment environment. The Table A 4.2 (Appendix) shows a gradual increase in the net foreign inflow with time. It reveals that in 1990s direct as well as portfolio investment was very low; it picked up only after 2000. It may also be noted that portfolio investment was more than direct investment between 2003 and 2006, it has gone other way round in recent years. The state specific data would show Maharashtra, Karnataka and Delhi throughout occupying highest spot among all the states with Rajasthan, Bihar, M.P and Punjab being overlooked. Table A 4.2 (appendix) shows the state wise FDI approved by GOI.

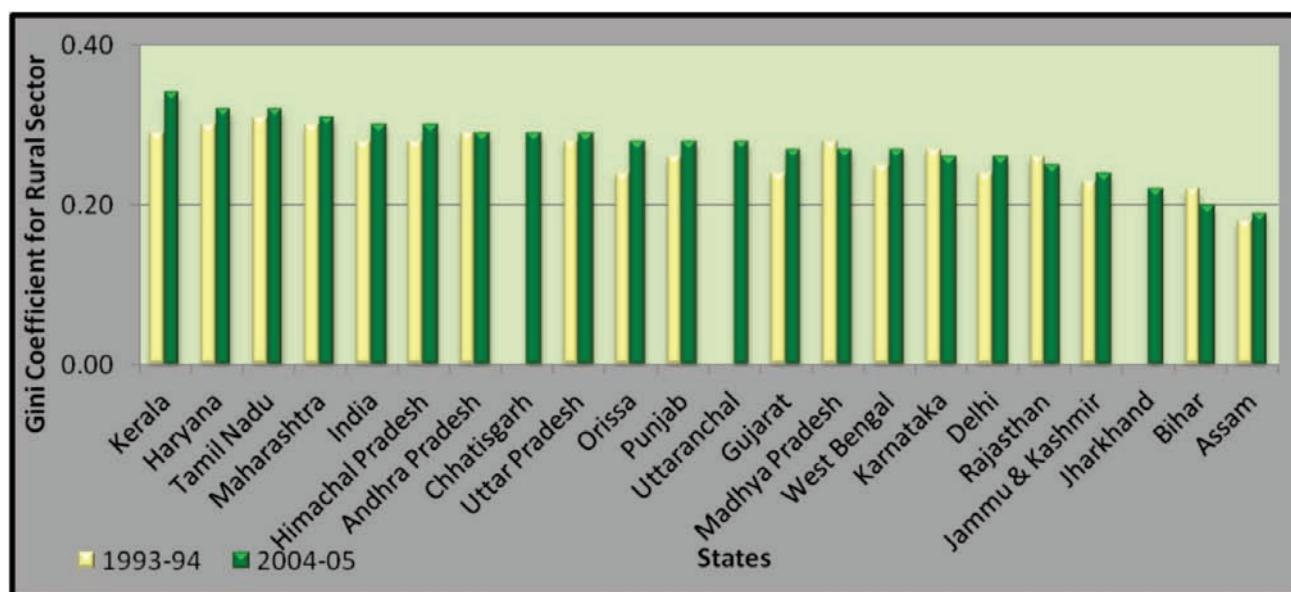
As noted earlier, there was an enormous increase in per capita NSDP in all the states after the initiation of economic reform but to answer how much of this growth has been translated in improving the quality of life a little deeper insight is required. The present section addresses this issue by considering the changes of inequality, level of poverty and a composite measure of wellbeing.

The following (Fig. 4.9 & 4.10 and Table A 4.3) show the level of inequality has gone up in both rural and urban sectors over the last two decades as measured by Gini Coefficient.

In India the level of poverty is measured by Head Count Ratio on the basis of monthly consumption expenditure as provided by the National Sample Survey Organization (NSSO). The Planning Commission has its own estimates of percentage of people below poverty line. The present study sticks to the poverty estimate provided by the Planning Commission prior to the Tendulkar Committee.

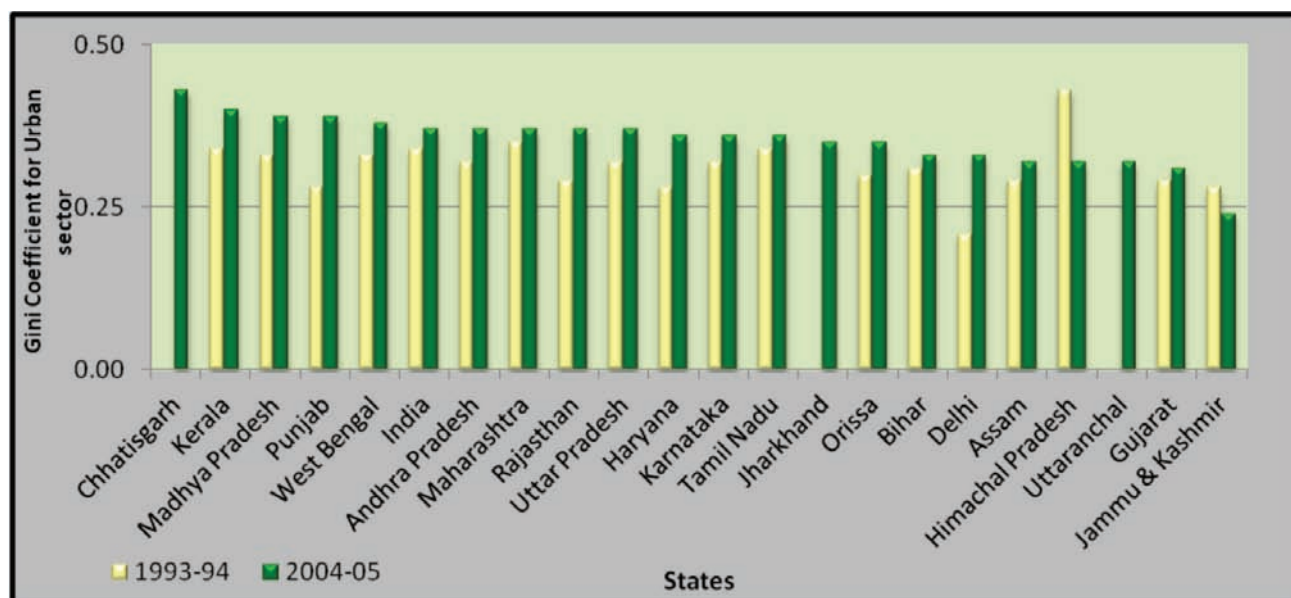
A state-wise comparison in percentage of people below poverty line is as follows (See Fig. 4.11 & also table A 4.4). A number of programmes were taken to reduce number of people below poverty line, some of them succeeded and some did not. As a result, percentage of people below poverty line was found reduced in recent years as compared to early 90s (44.5% in 1983 and 35.9% to 21.8 % in 2004-05). Some states historically had higher proportion of people below poverty line (Bihar 54%, Orissa 48%, M.P 42%, U.P and Assam 40% in 1993-94). Similarly, some states had succeeded largely at reducing percentage of people below poverty, while others had just managed to reduce this by a few percentage points. Likewise, some states (Haryana, Himachal and Jammu & Kashmir) had reduced percentage of people below poverty between 1993-94 and 1999-00, while some after 2000 (Assam, Sikkim, Tripura

Fig. 4.9 : Gini Coefficient of Rural Areas



Source: Planning Commission & NSSO Data, 61st Round

Fig. 4.10 : Gini Coefficient of Urban Areas



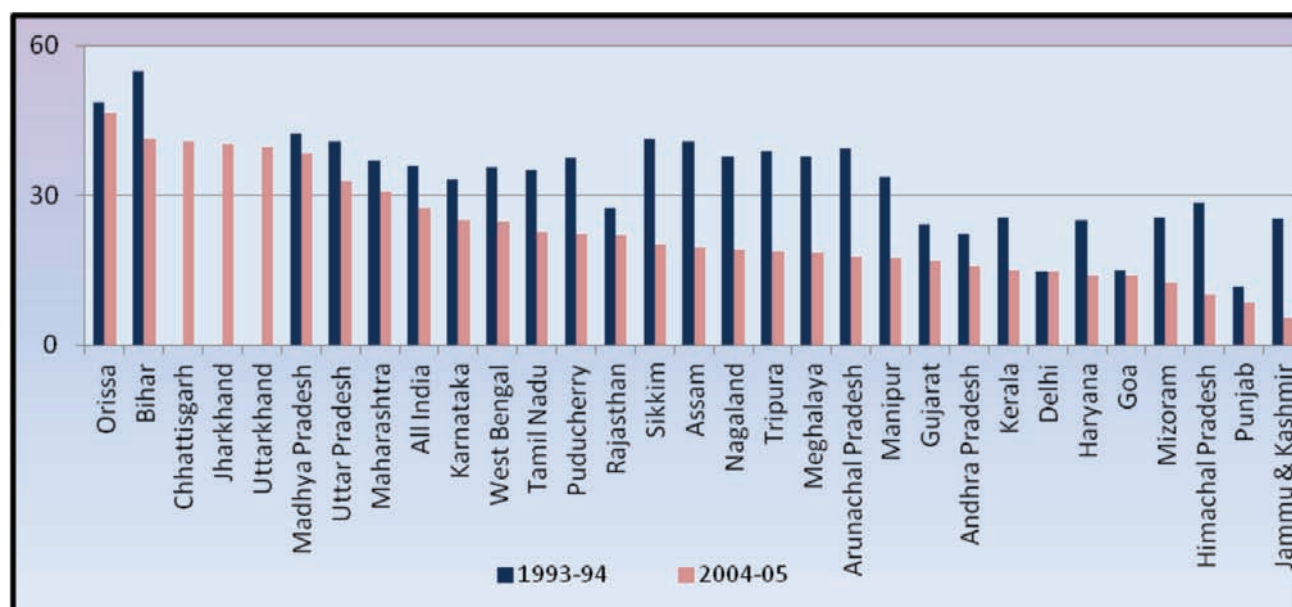
Source: Planning Commission & NSSO Data, 61st Round

and Arunachal Pradesh). Bihar and West Bengal are among the very few, that reduced it during all the referred time period. Delhi, Punjab, Chandigarh and Goa are among such states (historically had lower percentage of population below poverty line), which just lowered it by few percentage points.

After considering inequality and poverty the study computes a composite measure of wellbeing, termed as Human Development Index (HDI). HDI

is a multi-dimensional deprivation index which tried to capture the quality of life. Theoretically, it is rooted on the capability approach, but in simple terms it tries to enlarge people's choice by ensuring achievement of different aspects of life. UNDP started calculating such an index and accordingly, giving rank to countries across the world since 1990. This was based on three indicators of life, long and healthy life, knowledge, and standard of living. Since

Fig. 4.11 : % of Population Below Poverty Line



SOURCE: Planning Commission & NSSO Data, 61st Round

then several attempts have been made to calculate the human development at the sub national level. In India also, human development index is calculated from time to time by the Planning commission. The following table shows the comparison between different measures of HDI provided by different organizations.

Moving away from the commonly referred HDI indicators, the present study has calculated a human development index on the basis of three different but basic indicators: infant survival rate, 7+ literacy rate and NSDP per capita at 2004-05 prices and accordingly, ranked the performance of different states over two time periods 2000 and 2010. The details of the methodology are given in the appendix. While developing the idea of human development

index, its progenitors had emphasised that it should be simple, based on all the countries/ states and include the very basic/elementary indicators of people's life which would enable them to improve their quality of life. Likewise, the present human development index tries to capture the state level achievements in three fundamental aspects of life: A high HDI value i.e the presence of this indicator in a particular state may not mean anything, but their absence i.e a low HDI value, is certainly a state's failure to provide the basic environment for a life. This failure needs to be addressed urgently. The following Table 4.2 shows the HDI values and ranks of the different states calculated at two different point of time.

The table 4.1 reveals that there has been an improvement in HDI values during this period for

Table 4.1 : HDI Dimensions

Organization	Long And Healthy Life	Knowledge	Discent Standard of Living
India Development Report -2011, Planning Commission	Life Expectancy at Birth	Literacy 7+ ,Adjusted Mean Years of Schooling	Per capita real consumption expenditure adjusted for inequality
UNDP(2009)	Life Expectancy at Birth	Adult Literacy Rate with Combined Gross Enrolment Ration	Real GDP per capita in PPP\$
UNDP(2010)	Life Expectancy at Birth	Mean years of schooling , Expected years of schooling	Real GDP per capita in PPP \$
Governance Report-IIPA (2012)	Infant Survival Rate	Literacy 7+	NSDP per capita(at 2004-05 Prices)

India as a whole and for all States. But it needs to be mentioned that the states which were below the national average Table 4.2, a decade ago are still below the present national average.

In the next section, the role of NGOs and Civil Society is discussed. This is followed by a brief note on business associations in promoting globalization. It needs mentioning that both the former and the latter (such as FICCI-Federation of Chambers of Commerce and industries, CII-Confederation of Indian Industries) on behalf of the market, have been accorded adequate space and recognised as non-state actors under the broad rubric of governance frame.

NGOs & Civil Society

The voluntary organizations (VOs) have existed for quite long in the country. The private organizations with altruistic motive and devoid of any pursuit for profit making later came to be known as the non-governmental organizations (NGOs). This transformation in their nomenclature took place around 1970s. During the next three decades, this sector expanded enormously in the country, with huge inter-state variations. For long this term was referred to as “a collective noun to cover an enormous variety of institutions of widely different sizes, pursuing widely different activities and preaching widely divergent objectives” (Srivastava & Tandon, 2005).

Table 4.2 : HDI Ranking of States

State	HDI 00	HDI 10	Rank 2000	Rank 2010	Rank Diff (R 00 -R 10)
Goa	0.837	0.935	2	1	1
Kerala	0.837	0.895	1	2	-1
Delhi	0.816	0.879	3	3	0
Maharashtra	0.722	0.841	4	4	0
Tamil Nadu	0.699	0.826	7	5	2
Himachal Pradesh	0.694	0.792	8	6	2
NE	0.706	0.787	5	7	-2
Punjab	0.702	0.787	6	8	-2
Gujarat	0.648	0.782	12	9	3
Haryana	0.658	0.772	10	10	0
West Bengal	0.667	0.769	9	11	-2
Andhra Pradesh	0.610	0.743	14	12	2
Karnataka	0.651	0.737	11	13	-2
J & K	0.614	0.705	13	14	-1
Chhattisgarh	0.562	0.692	16	15	1
Jharkhand	0.539	0.692	19	16	3
Orissa	0.517	0.673	21	17	4
Assam	0.576	0.666	15	18	-3
Rajasthan	0.560	0.664	17	19	-2
Madhya Pradesh	0.543	0.647	18	20	-2
Uttar Pradesh	0.517	0.632	20	21	-1
Bihar	0.504	0.617	22	22	0
All India	0.616	0.724			

These organizations of varying objectives and sizes are usually registered under any of the available vast number of acts on the subject, of which many were enacted during the British colonial rule itself²¹.

What is the numerical size of NGOs in the country? There were 33 lakh (3.3 million) NGOs operating in India, to quote a recent GOI commissioned study report (2010) which roughly means: “one NGO for less than 400 Indians, and many times the number of primary schools and primary health centres in India” (cited in Indian Express July 7, 2010). They are dotted across the states but are hugely present in the following ten states: Maharashtra (4.8 lakh), AP (4.6 lakh), UP (4.3 lakh), Kerala (3.3 lakh), Karnataka 1.9), Gujarat (1.7), West Bengal (1.7 lakh), Tamil Nadu (1.4 lakh), Orissa (1.3 lakh) and Rajasthan (1 lakh). All these 10 states account for four fifths (80%) of NGOs registered in the country.

Their number was just 1.44 lakh till 1970. In the next decade it went up to 1.79 lakh, and in the following decades, it rose to 5.52 lakh and by 2000 it had taken a quantum jump, going beyond a million, 11.22 lakh (Indian Express, July 7, 2010). Their estimated number in 2005 was 1.2 million.

How many people are employed in this sector? Although the available data is more than a decade old, it does confirm the clout it enjoys as an alternative employment sector, beyond the government and private sector. For instance, altogether nearly 6 million people were engaged in this sector, of them 2.7 million were full time personnel in 1999-2000 and another 3.7 million were ‘full time volunteers’ (Srivastava & Tandon 2005). Whereas 10.7 million was the total strength of the employees of both central and state governments taken together; the share of central government employees was 3.3 million. If only the paid employees (excluding full time volunteers) of the NGOs are compared, their strength was about four-fifths of the central government personnel.

²¹This includes, Society’s Act (1860), Religious Endowment Act (1863), Indian Trust Act (1882), The Charitable and Trust Act (1920) The Muslim Wakf Act (1923), Public Trust Act (1950), The Wakf Act (1954), Indian Companies Act (1956, section 25), and Public Wakfs (Extension and Limitation) Act, 1959 etc.

It was precisely in tune of their employees strength, ability to raise funds to serve, their self sustaining nature as well as their multiple roles, activities and concerns, from advocacy, community services, awareness building implementing action projects, monitoring, evaluation, documentation etc. That NGOs clubbed with the civil society organizations were recognised as non-state actors in the governance frame.

Although from the first five year plan period itself, the GOI had been supporting voluntary activities by extending little financial support to them, they were officially recognised as partners in implementation of development schemes only under sixth plan. In fact, the decision was not an act of magnanimity, but was rather driven by the failure of the governmental machinery in reaching out to the people for whom the development and welfare schemes were meant. In other words, NGOs as non-state actors had already been recognized and accorded due importance much before ‘governance’ acquired a name for itself. The role of NGOs and budgetary allocations made to them by various union ministries and departments under successive five year plans are summarised in the Table 4.3.

Role of ASSOCHAM, FICCI, CII

Indian business has been collectively organised in a large number of industry associations and a smaller number of nation-wide central chambers of commerce since the 1920s. The then most prominent apex organization for Indian business was Federation of Indian Chambers of Industry & Commerce (FICCI-established in 1927), while most foreign business enterprises were organised under Associated Chambers of Commerce & Industry (ASSOCHAM) set up in 1920. With the strengthening of the Indian-controlled industry after Independence and the gradual erosion of the antagonisms between the Indian and remaining foreign business interests, FICCI became the most influential representatives of private industry. On the other hand, ASSOCHAM experienced a decline, though the organisation continued representing selected, often older, foreign enterprises. FICCI was, however, still dominated by traditional Indian industrial interests, originating mainly from the eastern part of the country

Table 4.3 : Supporting NGOs under Five Year Plans

Plan No.	Financial allocation (RS. in Crore)	Schemes introduced	Achievements	New Rules Implemented
6 th	300 for (Central & Centrally Sponsored Scheme) & 12197 (State & UTs)	EDP, TRISEM, IRDP, ITDP, LAMS & Health for All by 2000 AD (WHO- program)	Extending hostel facilities for working women, CSWB provides Grant in Aid(GIA) to 6000 NGOs, 40,000 children is under protection	Simplification of grant giving procedures & timely release of funds introduced/ Business Houses given an added incentive of exemption from IT under Sec. 35cc & 35cc A of the IT Act
7 th	1599.94 (Central & Centrally Sponsored Scheme) & 21239.10(State & UTs)	PADI, DWCRA, SLBP, SLPP, voluntary action bureau, information & mass education cell, national policy on child labour, FLAW	NGOs participation throughout the country for the upliftment of SCs, STs & OBCs. Development of Watershed Management. Nearly 551 ICDS projects evaluated through NGOs. CSWB assisted about 12000 NGOs	Trade Unions, Co-Operatives & Panchayati Raj strictly defined as VO. Code of Conduct applicable to those receiving government funds. Special cells created at the Centre & State level to co-ordinate NGOs. New NGOs based in rural areas should be a legal entity & need to have worked for 3 years.
8 th	7.51 (for 338 projects) & 13.75 (for 234 projects), 35.14 (for RMK)	RMK, awareness generation camps, central rural sanitation program, nationwide network of NGOs created, Gendersensitisation program & UN Campaign to combat atrocities against women, Advocacy & social activism program for gender equality; AIDS control program launched.	RMK extended credit through 170 NGOs which benefited about 1.91 Lakh women. Massive participation of NGOs in spreading adult education with the help of 30 Lakh volunteers, 10,000 Production Units (Work & Wage to poor women) by CSWB, CSWB 6,000 awareness generation camps organized.	Decentralised local level planning & people's participation recognized. Began providing 'One-Window Service' to NGOs working in the area of integrated development
9 th	1208.63 (Social Welfare Sector-Centre), 3348.12 (Social Welfare Sector - State), 102.94 (Empowering Women), 36 (SHGs & NGOs), 109.73 (Sanction of Credit-RMK) & 9(Sishu Griha- NGOs)	Research & development program in Science & Tech Sector, NSAP, CBR, NMEW, Sishu Griha, People's Movement for afforestation, Appropriate Technology Packages.	NIFE Centres achieved more meaningful results when they are run under NGOs. Secondary Health Care Services successfully implemented through collaboration between governments, private & NGOs. Established 246 Old-Age Homes, 346 Day-Care Centres & 142 Mobile Medicare Units. Around 10,000 disabled children benefited. RMK benefiting 4.2 Lakh women through 1,992 NGOs.	Exemption from import duty for import of diagnostic equipments given to NGOs, provide diagnostic to poor patients free of cost, effective enforcement of the Juvenile Justice Act, 1986.
10 th	2,004 (Social Welfare Sector), 1400 (NGOs Health Sector), 300 (NGOs Education Sector), 92.09 (for PTGs)	PTGs, KVIC, SHGs Pilot Project, UEE, SSA, VEP, KSY, CBDM, community drug rehabilitation & workplace prevention program, watershed projects, solid waste management projects	Funded by dept. of family welfare (DFW). 893 development projects undertaken; 1, 21,744 SHGs linked with Banks.	Need to be actively involved in economic & social development especially with the cutting edge, develop core competencies & professionalism, and review the working of Mother NGOs with greater transparency & accountability. Disaster Management grants with community based approach, set up low power FM Community Radio Stations
11 th	9181 (Maulana Education Foundation), 241.61 (NGOs PPP), 265.99 (NACO), 190330 (Rural Development), 2, 7 4, 2 2 8 (Education), 1,23,900 (H&FW-Ayush)	MAEF, IEDC, Government-NGO Partnership Program, Pilot Project on E-health, Janani, Leadership development of minority women	Under MAEF 72 NGOs located in 20 States & Uts. IEDC provided 100% financial assistance to NGOs & Governments - about 2.84 Lakh children were benefitted. According to NRHM up to 2002 country had 11,345 NGO run hospitals with a capacity of 2,62,256 beds. Promoting successfully the NGO-Government partnership. Janani creates a successful network of more than 21,000 Titli Centres & more than 500 Surya Clinics in the states of Bihar, Jharkhand & M.P.	A National Policy on VOs/NGOs notified by the Central Government on July, 2007 : (a) stimulate their effectiveness & safeguard their autonomy, (b) mobilize necessary financial resources from India & Abroad, (c) Government may work together with NGOs on the basis of the principle of mutual trust to greater responsibility, (d) encourage NGOs to adopt transparent and accountable system of governance & management, (e) all NGO schemes will be sanctioned to accredited institutions only (as stated by MHRD), (f) for safeguarding the interest of artisans Government will partner with the NGOs.

Source: Official Website, Planning Commission

Note: With every successive five year plan NGOs involvement in the implementation of css schemes has consistently increased and new rules were framed, to be used under the current plan period. Financial allocation has further gone up.

belonging largely to the influential 'Marwari' business community. The strains became especially visible within FICCI during the 1980s when it failed to accommodate the new up-coming industrialists, controlling engineering industry.

An Association of Indian Engineering Industry (AIEI) was already in existence, possessing many of the features that were in demand among the new type of Indian industrialists. The AIEI in fact had emerged in 1974 as a fusion between two organizations representing foreign and Indian engineering companies, the AIEI was also reputed for its strong professional orientation and, unlike FICCI, its internal organization seemed free from the sectional interests. Besides, it had a strong regional network. In 1986, the AIEI changed its name to Confederation of Engineering Industry (CEI), and in 1992, the organization was again rechristened by which it is now known: Confederation of Indian Industry (CII).

Since early 1990s, CII has been dominant organisation representing Indian industry. Significantly, the idea of establishing itself as an industry organisation goes back to the late 1970s but it could be realised following encouraging nod from Prime Minister Rajiv Gandhi in mid-1980s only. It was thus a stated objective of the CII to work towards globalization of Indian industry. Accordingly, it stands for deregulation, de-control and de-licensing in all areas; it also purports a strong professionalism in its work and believes in 'partnership approach' in its working with the Indian government a fact, that explains its close collaboration with many government agencies.

The CII membership had expanded to nearly 4000 companies by the late 1990s and more than 7800 under its fold by 2006. Its membership profile reflects its foundation in a broad cross-section of Indian industrial enterprises, with a bias towards the modern, high-technology industrial sectors, including electronics and software. Its members are most of the large companies in India, but the majority are of course smaller companies with the largest number being based in south.

In contrast, FICCI remained associated with traditional industrial sectors, even its membership had stagnated throughout the 1990s. Both FICCI and CII had foreign companies as members, but the majority of them were with CII because of its influence in those modern sectors where foreign investments were concentrated. With the rise of the CII, informal but regular links were established between the business organisations and the concerned centralized bureaucracy. Such linkages were partly formalized in 1998 following the formation of the Prime Minister's Council on Trade & Industry. In the same year 'IT Task Force' was also set up on the same line which was also placed directly under the PMO. The reconstitution of a 'Council on Trade and Industry' in 2001 was yet another example of the growing clout of the big business in the changed environment for which the presidents of business federations (CII, FICCI, and ASSOCHAM) were nominated as new members. Not surprisingly, the Indian delegation to the WTO negotiations in Seattle 1999 and Doha 2003 had sizeable representation from Indian business that had bearings on the Indian negotiating position. Prior to that, in 1996, the then general secretary of the CII, had issued a statement criticising the 'cowboy' behaviour of certain MNCs for trying to take undue advantage of the liberalized environment to 'bully' local companies.

From the above, it is apparent that these business organisations, more particularly the CII had been driving liberalization policies throughout the 1990s. Interestingly, liberalisation can be also credited for ushering a friendly relation between the Indian industry & the Indian state that had gone sour by 1960s. The sharp U turn in the business government relationship became all the more visible with the coming of 1993-94 budget referred to as the 'Tarun Das budget'. Montek Singh Ahluwalia went on advocating in favour of "Public-Private Partnership" in industry & inviting the private sector to be part of the decision-making.

Interestingly, in contrast to the CII's stated support to the economic, liberalization, FICCI and ASSOCHAM were in favour of only internal deregulation all along during 1980s but externally also they wanted to go slow. In fact, Indian big business was

Table 4.4 : Overall Indian Scenario

Year	Pending investigation from previous year	Cases registered during the year	Value of Property recovered/seized (in Rs. '000)	Percentage of cases convicted to trials completed	Cases in which final report submitted
2000	4,877	2,943	62,987	610	447
2005	5,090	3,008	84,080	890	659
2009	5,899	3,683	6,09,036	2,094	692
2000-2009	52,583	31,633	19,03,987	9,711	5,999

Source : PRS Legislative Agency

apprehending that India's rapid liberalisation might destroy the capital goods industry. Most importantly, on the lines of the Korea model, they were even lobbying for government help which, they believed, would be helpful in integration with the global economy. Already, more than 90% of CII's members had entered into joint venture collaborations, largely with foreign firms. Their involvement gradually expanded in other sector, including social sector development, security dialogue, electoral participation awareness campaign etc. For instance, on behalf of CII, cellular service providers sent 35 million (SMS) messages to as many voters to vote on polling day in (2004) the general elections.

Earlier, the CII had co-sponsored the India Summit at the World Economic Forum in the 1990. Above all, at the calling of the then Prime Minister Vajpayee in 2001, the CII had invited Pakistan's former premier Benazir Bhutto to India when politically it was not possible for the government to do so. Additionally, the CII had set up a WTO Cell in Geneva in 2003 so that WTO proceeding could be closely monitored. Later, Chidambaram had also sought help to convince the left coalition partners in UPA-I to support an increase in the FDI cap in social sector. Moreover, following the Indian federal frame, the CII had established its regional and state offices too. In fact, way back in 1995 the CII had organised a "Partnership Summit" to highlight the policy of liberalisation.

Notwithstanding all these positive aspects, there is a downside of the State-market partnership, as seen in the rising trend of corruption. An attempt has been made here to assess the impact of state-wise

corruption, measured through a composite index prepared for the purpose.

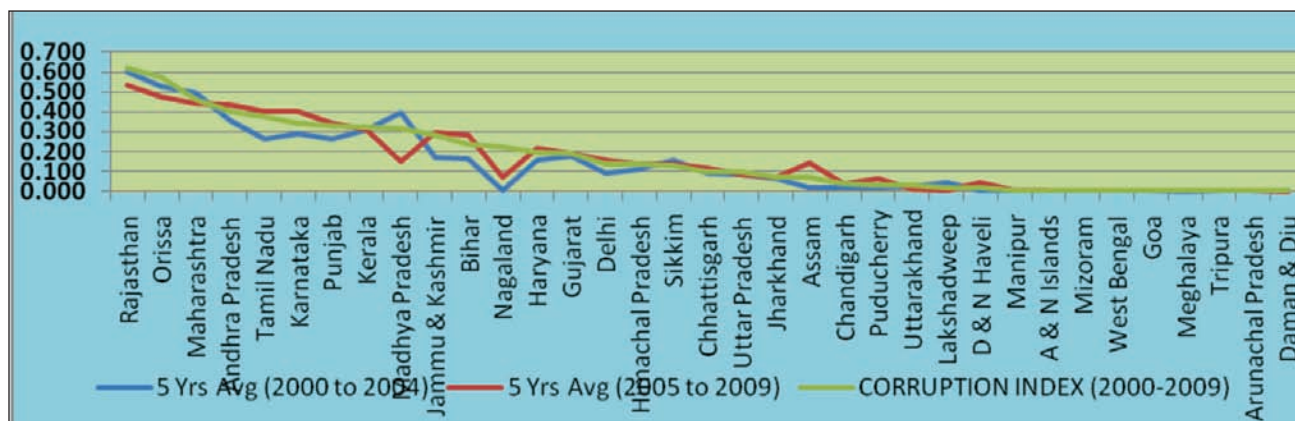
Measuring Corruption Index

Apparently, Corruption is an old phenomenon in India as elsewhere in the world. There have been several studies on the subject as also are the reports of the official commission, including the Santhanam Committee report on Corruption. With the unprecedented economic growth during the last two decades, it appears, the incidence of corruption has also taken a quantum jump. Some of the high profile cases of corruption involving 2G spectrum, Commonwealth Games and the latest coalgate, there has been a series of scams involving hundreds of thousands crores of rupees and plunder of natural wealth, including forest and mineral and metals. The Transparency International has been highlighting the extent of corruption and accordingly ranking of countries at the global level. Going beyond that the present study has attempted to compute a separate national corruption index which is based on a few indicators pertaining to corruption (Fig. 4.12), available for the last ten years, ending 2009. Likewise, a final composite index for states has also been prepared.

Findings:

The data inserted in the table 4.5 reveal the corruption scenario in Indian states from 2001 to 2009. Findings show that Rajasthan in 2001, 2003 and 2007; Andhra Pradesh in 2005 and Tamil Nadu in 2009 as the most tainted states in the country. The ranking of states is done on the basis of final corruption index computed from all the ten years

Fig. 4.12 : Trend in Corruption in Different States of India



data on corruption data (2000-2009). Accordingly, Rajasthan has emerged as the most corrupt states in the country, followed by Orissa, Maharashtra, Andhra Pradesh and Tamil Nadu (Table 4.5). On the other hand, Arunachal Pradesh has appeared as the least corrupt state, followed by Tripura, Meghalaya, Goa and West Bengal Fig. 4.13 and Table 4.6.

Two states identified as highly corrupt states in almost all the referred years happened to be Rajasthan and Orissa. Karnataka was the second most corrupt state in 2001. Andhra Pradesh which was the 4th most corrupt state in 2003 perhaps pushed hard to become the most corrupt state in 2005. Likewise Tamil Nadu joined the group of top 5 corrupt states in the year 2007 and eventually reached the top, becoming the

most corrupt states in 2009. On the other hand, the North-Eastern states have been found as the least corrupted states in India, though it is contrary to the commonly held perception. Although in the final index, Goa and West Bengal have been placed as among the bottom 5 corrupt states in India.

Corruption in Relation to Other Indicators

A correlation matrix was worked out to examine the association between corruption index and other governance indicators. It shows (See, Table 4.7) only conviction rate being correlated with our corruption index. The rest other indicators such as FDI, departmental punishments and % of women representing in Gram Panchayats have shown very weak non-significant correlation.

Table 4.5 : States with High Corruption Index Value

2001	2003	2005	2007	2009	2000-2009
1) Rajasthan 2) Karnataka 3) Orissa 4) Maharashtra 5) Madhya Pradesh	1) Rajasthan 2) Orissa 3) Maharashtra 4) Andhra Pradesh 5) Madhya Pradesh	1) Andhra Pradesh 2) Rajasthan 3) Punjab 4) Orissa 5) J & K	1) Rajasthan 2) Orissa 3) Maharashtra 4) Andhra Pradesh 5) Tamil Nadu	1) Tamil Nadu 2) Orissa 3) Karnataka 4) Maharashtra 5) Rajasthan	1) Rajasthan 2) Orissa 3) Maharashtra 4) Andhra Pradesh 5) Tamil Nadu

Table 4.6 : Bottom 5 Corrupt States

2001	2003	2005	2007	2009	2000-2009
1) Meghalaya 2) Mizoram 3) Tripura 4) Manipur 5) Goa	1) Nagaland 2) Tripura 3) Arunachal Pradesh 4) Manipur 5) Uttarakhand	1) Arunachal Pradesh 2) Manipur 3) Meghalaya 4) Goa 5) Tripura	1) Tripura 2) Meghalaya 3) West Bengal 4) Mizoram 5) Manipur	1) Tripura 2) Meghalaya 3) Goa 4) Manipur 5) Arunachal Pradesh	1) Arunachal Pradesh 2) Tripura 3) Meghalaya 4) Goa 5) West Bengal

Table 4.7 : Correlation with other Indicators

Conviction Rate (% of cases where conviction order is given to total cases put on trial)	Total no of departmental punishments by Police	Foreign Direct Investment (FDI)	% of Women in Gram Panchayats	NSDP (2009-10) at current prices	Deposit per Office (in Lakh Rs) (2010)	Per Capita Credit (in Rs) (2010)	Credit per Office (in Lakh Rs) (2010)
0.008	0.242	0.327	0.281	-0.135	0.020	0.106	0.216

Fig. 4.13 : Corruption Index (2000-2009)

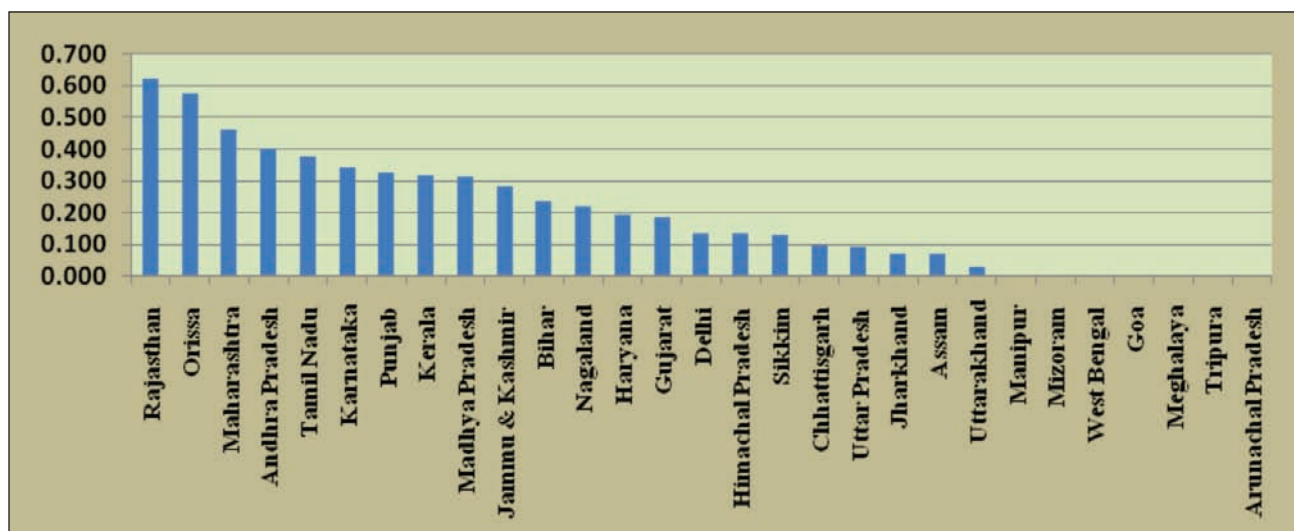


Fig. 4.14 : Corruption in Relation to NSDP

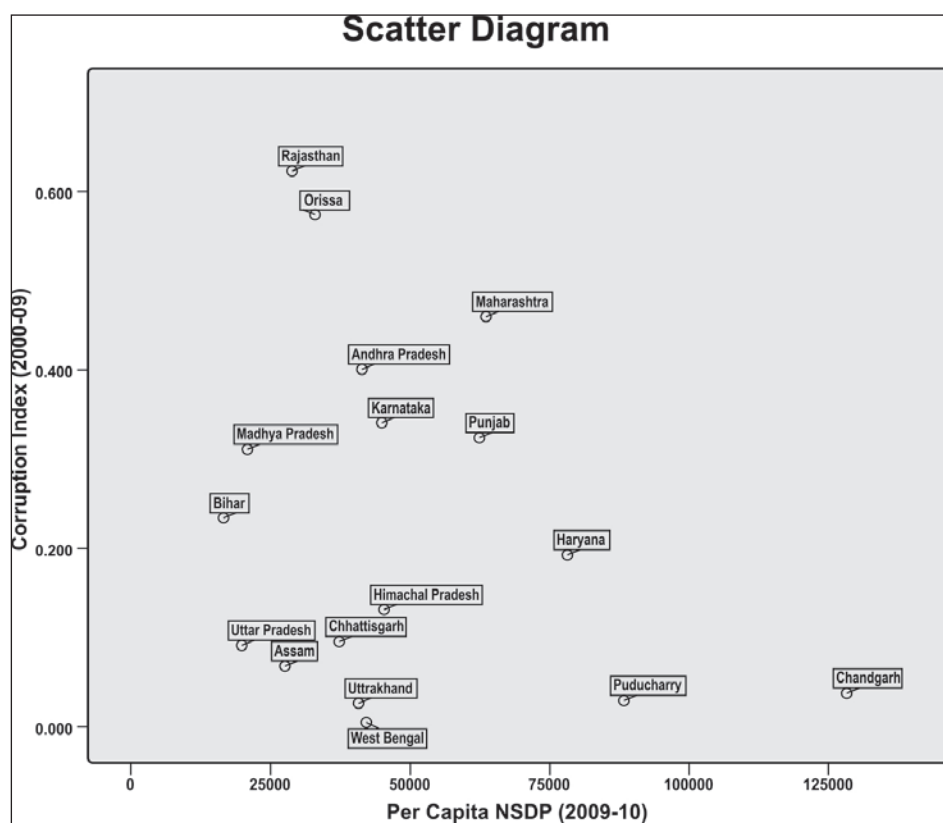


Table 4.8 : Corruption Index for Indian States

The India Corruption Study 2005 was taken up by Transparency International India in alliance with CMS was to sensitize the people of India against all-pervasive corruption faced on day-to-day basis by the common masses in the eleven public services in twenty major states. It was the largest corruption survey ever undertaken in the country with a sample of 14,405 respondents spread across 20 states. From each state, between 525-950 respondents were interviewed. Altogether, 151 cities and 306 villages were covered under the survey. Users of various public services across the interviewed for country in this study named the following seven key factors responsible for wide spread corruption in the system: 1. Lack of transparency and accountability in the system, 2. Lack of an effective corruption reporting mechanisms, 3. Lack of honesty in officials in the Government, 4. Acceptance of Bribe as a way of life, custom and culture, 5. Ineffective Judiciary 6. Poor economic policies , 7. Inadequate training and orientation of Government officials. As per composite ranking of states by Transparency International petty corruption, involving common citizens and in the context of eleven public services, Kerala stood out as the least corrupt State (Table 4.8) in India while Bihar emerged as the most corrupt State. Note : High Score = more corrupt	State	Composite Index	Rank
	Kerala	240	1
	H. P.	301	2
	Gujarat	417	3
	A. P.	421	4
	Maharashtra	433	5
	Chhattisgarh	445	6
	Punjab	459	7
	West Bengal	461	8
	Orissa	475	9
	U. P.	491	10
	Delhi	496	11
	Tamil	509	12
	Haryana	516	13
	Jharkhand	520	14
	Assam	542	15
	Rajasthan	543	16
	Karnataka	576	17
	M. P.	584	18
	J & K	655	19
Bihar	695	20	

Source : Calculated by Transparency International 2005

The scatter diagram (Fig. 4.14) depicts an interesting picture, revealing there is a correlation between corruption index and NSDP. It shows, for instance, high level of corruption in state like Orissa and Rajasthan which are also burdened with low level of economic growth. Conversely, Chandigarh and Puducherry show significant correlation, where level of economic growth is higher, hence, lower corruption Level. On the other hand, state like Punjab and Karnataka seem to be holding the middle ground both in terms of level of growth rate and corruption.

Summing up

This chapter takes note of three crucial aspects of economic reforms which are intrinsically linked with the features of governance. First of all, it underlines the essential features of liberalization and deregulation which not only unshackled the private sector, rather gave fillip to the market forces, resulting

into tremendous economic growth. At another level, it provides details of disinvestment of public sector units, both owned by the Central and State governments that helped partially reducing the budget deficit, to some extent, also on account of FRBM act that started unfolding after a decade of reforms. This, in turn, enhanced public spending in the arena of social sector, particularly, education and health. The reformative steps taken to attract investments, both FDI and through portfolio management are also taken into account, showing progress under the UPA-I but subsequent to global financial meltdown in 2008, the FDI base shrank fast. Likewise, both the proposed DTC and GST failed to make any headway. Indeed, there has hardly been any progress on second generation reforms pertaining to FDI in multi branding retail business, insurance, banking etc. Not surprisingly, practically all the perceptive observers of the economic scene have accused the Centre for this impasse, pointing out its inability to

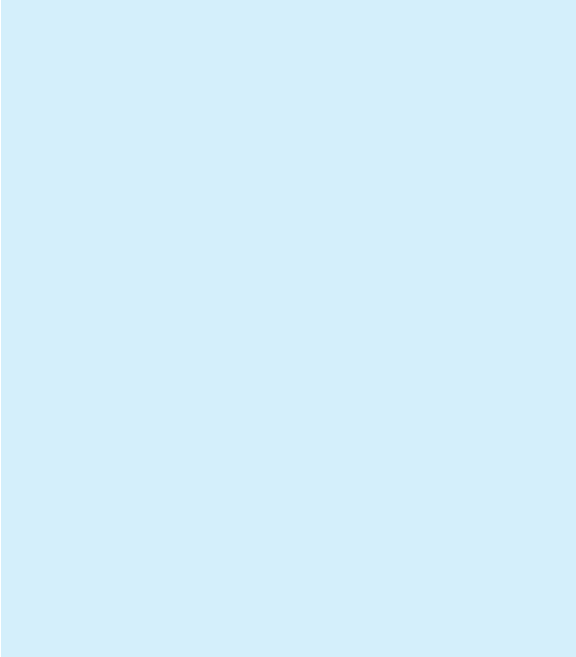
take in to confidence its coalition partners as well as Chief Ministers of opposition controlled states.

The second crucial aspect this chapter has examined is the growing role of NGOs and civil society organizations. It provides details of budgetary support given to the latter under successive five year plans, starting from the sixth plan, considered to be a bench mark in the given context. Yet in the absence of precise data, it is impossible to quantify how much the state managed to offload on these non-state actors and what was its impact on the deliverance of welfare programmes. This has sharply brought into light the working of the bureaucracy which is still in tune of the old saying : the more it changes, the more it remains the same. By merely providing the number of NGOs supported by various ministries / departments, no purpose is served. This fact is yet to be internalized by the bureaucracy.

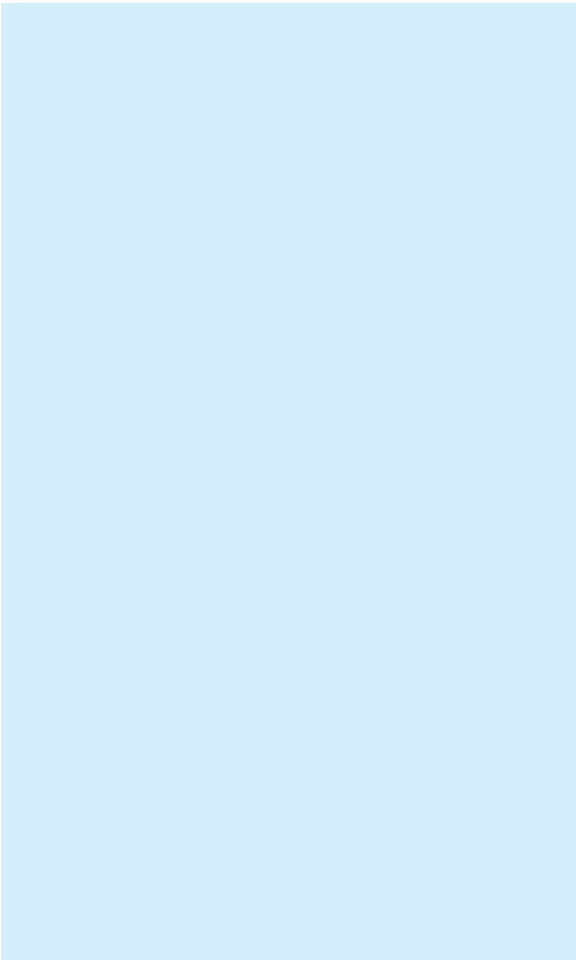
Growing partnership between the government and business associations, forming the third component of governance, and economic reforms are all intertwined. Combined together, in the first place, this had entailed a big change in the perception at the higher echelons of the government. From an era of distrust between the market and the state to creating an honourable space for the private sector, it was nothing less than u-turn in the thinking of the government. This is something which had started showing signs since late 1980s when Rajiv Gandhi was at the helm of affairs in the country.

He was instrumental, it must be acknowledged, in the setting up of the CII, an association of modern, outward looking entrepreneurs who were willing to take the plunge in a highly competitive global economic environment. While substantiating the expanding influence of private sector in general and the CII in particular, this chapter also highlights largely unknown facts, such as the utilisation of their network to reap benefits of globalisation as well as furthering the cause of democracy (read, promotion of electoral participation through CII driven cellular short message services). In association with globalisation, it need to be acknowledged, that governance has been instrumental in giving birth to several power centres, competing with each other to influence decision making at the highest level. This is equally true of the business association. On the surface the voice emanating from private sector seem to be fragmented, this however also confirms democratisation of market concerns.

On all these counts, nothing seems straight, as quid-pro-quo between the government and the private sector or between the government and the NGOs for the lack of furnishing data and their collation in the required format. It also reinforces the doubts that the functionaries of the State are yet not prepared to imbibe the spirit of reforms and governance as well. Finally, this chapter has also followed an alternative route to construct a national corruption index and has accordingly, ranked the major 20 states, excluding north-eastern states and Sikkim.■



PART II



HEALTH SECTOR GOVERNANCE

Health sector governance can be broadly defined as an outcome of interaction among three sets of actors: citizens (individuals and communities), providers (public and private facilities, pharmaceutical firms, insurance agencies), and state actors (political leaders, policymakers, ministerial staff and other government officials). Well coordinated functioning of these actors alongwith paramedics and health volunteers, it is assumed, would lead to good health sector governance. This is not to say that health sector governance is autonomous, independent of governance of any other sector rather the performance of the health system is dependent on overall governance of a country.

Literature on measurement of health governance is however limited. An inventory of global health indicators for measuring commitment to health prepared by the *Centre for Global Development (CGD)* appeared only in 2006. On its footsteps soon came, *Health System Governance* (WHO 2008) that draws upon two types of indicators- **rules based** and **outcome based**-for measuring health sector governance.

The rules-based indicators are designed to measure whether countries have appropriate policies, strategies, and codified approaches for governance of the health sector, such as existence of a national strategic plan for TB/ malaria, HIV etc. The first set of indicators is measured by computing a policy

index which, in turn provides a summary measure of the quality of governance from a rules-based perspective. The outcome-based indicators, such as availability of drugs in health facilities, or shortfall of health workers in public health facilities etc, are used to measure to what extent rules and procedures are being effectively implemented or enforced.

The health sector governance index on the whole is an integral part of the World Bank's annual Country Policy and Institutional Assessment (CPIA). The CPIA index rates the quality of a country's policy and institutional framework in fostering sustainable, poverty-reducing growth, and the effective use of development assistance. This index is based on a set of criteria which are captured in 16 sub components broadly grouped into four clusters viz. i) economic management ii) structural policies iii) social inclusion and equity policies and iv) public sector management and institutions. One of the sub-components addresses governance in health and education. The ratings of each criterion are based on judicious analysis, which are subsequently aggregated into the overall CPIA index.

The WHO (2008) **Toolkit on Monitoring Health Systems Strengthening** uses a simple framework but is comprehensive in so far as the indicators used are concerned. A summary of the indicators proposed by the WHO for calculating health sector

Summary of Proposed WHO Indicators for Measuring Health Sector Governance

Components Sources	Indicators measured in terms of existence of individual items listed below
Policy Index	➤ Existence of up-to-date national health strategy linked to national needs and priorities ➤ Existence of an essential medicines list updated within the last five years and disseminated annually: ➤ Drug procurement policies which specify: (i) procurement of the most cost- effective drugs in the right quantities; and (ii) open, competitive bidding of suppliers of quality products. ➤ TB: A national strategic plan for TB which reflects the six principal components of the Stop TB Strategy as outlined in the Global Plan to Stop TB 2006–2015 ➤ Malaria: National malaria strategy/policy which includes drug efficacy monitoring, vector control, and insecticide resistance Monitoring. ➤ HIV/AIDS: Completion of the UNGASS National Composite Policy Index Questionnaire for HIV/AIDS ➤ Maternal Health: A comprehensive reproductive health policy consistent with the ICPD action plan ➤ Child Health: An updated comprehensive, multi-year plan for childhood immunization ➤ Key health sector documents (budget documents, annual performance reviews, health indicators) which are published and disseminated annually ➤ Feedback mechanisms, such as surveys for obtaining timely client input on appropriate, timely and effective access to health services.
Outcome Indicators	➤ Human Resources: health worker absenteeism in public health facilities ➤ Health Financing: proportion of government funds reaching district-level facilities ➤ Health Service Delivery: (a) stock-out rates (absence) of essential drugs in health facilities; (b) proportion of informal payments within the public health care system. ➤ Pharmaceutical Regulation: proportion of pharmaceutical sales, consisting of counterfeit drugs ➤ Voice & Accountability: Role of effective civil society organizations in countries with mechanisms in place for citizens to express views to government bodies.
Overall Measure of Health Governance	➤ Overall CPIA ➤ Health-specific CPIA

governance is given below. It covers ten rule-based indicators on which a composite governance index is defined. Following this, six outcome based indicators are presented which show if rules at the policy level are being implemented and enforced. A CPIA index, as mentioned before, is finally presented to provide an overall measure of governance in health.

This method of measurement of health sector governance is however, achievable only at the national level. It cannot be applied to cover the state level health governance. In the absence of individual health policies/strategies at the state level, a major determinant of health governance, policy index cannot be computed for specific states. Yet the achievements of the National Rural Health Mission (NRHM) in different states and Union Territories can be measured by applying the tools of this method. In any case, a multi-level assessment of the functioning of all the three sets of actors (citizens, providers, and state actors) remains the best instrument to quantify health governance. It also needs emphasizing, as indicated above, health governance of any country is inherently dependent on its all encompassing governance of the country. Hence, the framework

adopted for quantifying governance for this study – covering political, legal/ administrative, social and economic aspects - is also applied here. What follows hereafter is essentially a reinterpretation of governance frame which is modified with the imperatives of health sector.

Political Dimension: For any country, the policies relating to health, or for that matter any other issue, are a reflection of the political will and intent as well as their effective implementation. While a clear assessment of the political will and intent may be difficult to arrive at, the seriousness with which issues/ policies are debated and discussed in the parliament, or legislative assemblies, the kind of policies that are being implemented, government spending on health sector etc are indicative of the political aspect of health governance. Hence, an attempt has been made to examine and discuss national health policies including those pertaining to population control, recommendations of Parliamentary Standing Committees on Health, other commissions and committees.

Judicial/Administrative Dimension: This is a major component of health governance, as the actual implementation of policies and working of schemes and facilities boils down to effective administrative governance. Even the best policies well in place would fail to take off without good administrative machinery in place. Administrative machinery in the health sector would include the infrastructure and facilities as well as the human resources employed for providing these services.

Social Dimension : The aspects covered under social governance include socio-economic conditions, government's commitment to social welfare programmes, and most importantly, those programmes having bearings on quality of life. For measuring health governance, by and large the same indicators have been used. For instance, incidences of diseases are influenced by socio economic conditions, quality of life spent, as well as government's commitment to welfare programmes.

Economic Dimension : Government expenditure on health as share of the GDP as well as financing of health services and availability of public health facilities may be seen as part of economic components of health governance. In this regard, the section on health expenditure as well as introduction of steps towards financing of health services like user fees, insurance and establishment of Rogi Kalyan Samiti (RKS) under NRHM are discussed.

Thus, the indicators developed to measure state wise health governance are based on a basket of health system indicators (USAID, 2009) carefully developed by various organisations most prominently the WHO including its building block (BB) model as depicted in the following diagram and Box.

Accordingly, health governance is calculated on the basis of five major dimensions of health governance: public policy on health, human resources, infrastructure & facilities for health services delivery, achievements of NRHM, and accountability, transparency and participation.

- Public policy on health includes all policies related to the health care services system including financing of health services (as well



as expenditure on health by households).

- Human resources capture the work force in public health facilities.
- Infrastructure and facilities for health service delivery measures the physical infrastructure and facilities provided by the government.
- A mission achievement captures the achievements of NRHM, so far in different Indian states and UTs.
- Accountability measures the registered cases.

A comparison with the WHO drafted toolkit for health governance and indicators used in the health governance framework in this report is illustrated in the table below.

Within the broad rubric of Policy Index (as defined by the *Toolkit.....* WHO, 2008) an analysis of health policies in India is discussed in the next two chapters (Chapters-5 and 6). The indicators discussed within this component include whether a national level policy on health exists and arrived at through a discussion of various documents like national health policy, national population policy, committees and commissions on health, existence of national health programmes to combat diseases based on national needs and priorities. A discussion on state specific reforms in the health sector, and initiatives taken for financing health services starting from the late 1990s much before the launch of the NRHM, is undertaken

WHO proposed indicators	India Governance Report indicators
Policy Index	
➤ Existence of up-to-date national health strategy linked to national needs and priorities ➤ Existence of an essential medicines list updated within the last five years and disseminated annually ➤ Drug procurement policies specifying: (i) procurement of the most cost-effective drugs in the right quantities; and (ii) open, competitive bidding of suppliers of quality products. ➤ TB: A national strategic plan for TB reflecting the six principal components of the Global Plan to Stop TB 2006–2015 ➤ Malaria: National malaria strategy/policy including drug efficacy monitoring, vector control, and insecticide resistance ➤ HIV/AIDS: Completion of the UNGASS National Composite Policy Index Questionnaire for HIV/AIDS ➤ Maternal Health: A comprehensive reproductive health policy consistent with the ICPD action plan ➤ Child Health: An updated comprehensive, multi-year plan for childhood immunization ➤ Key health sector documents, published and disseminated annually (e.g. budget documents, annual performance reviews, health indicators). ➤ Feedback mechanisms, such as surveys for obtaining timely client input on appropriate, timely and effective access to health services.	➤ Public Policy on Health
Out-come based Indicators	
➤ Human Resources: Health worker absenteeism in public health facilities ➤ Health Financing: proportion of government funds reaching district-level facilities ➤ Health Service Delivery: Stock-out rates (absence) of essential drugs in health facilities ➤ Health Service Delivery: Proportion of informal payments within the public health care system ➤ Pharmaceutical Regulation: Proportion of pharmaceutical sales that consist of counterfeit drugs ➤ Voice & Accountability: Role of effective civil society organizations in countries with mechanisms in place for citizens to express views to government bodies	➤ Human Resources ➤ Infrastructure & Facilities for Health Service Delivery ➤ Achievements of NRHM ➤ Accountability, Transparency & Participation

in Chapter 6. As mentioned earlier, this is possible only at the national level. To evaluate health governance at state level, we have used other indicators akin to the WHO proposed outcome based indicators.

Once it is ascertained that policy is in place, it is important to measure how well it is being implemented. One way of doing so is to analyse the resources, both human and physical, that is available for policies to be implemented. The next set of indicators, thus comprise of human resources as well as infrastructure and facilities for health services delivery. As far as human resources is concerned, it has two components. One component is the number of various types of health workers/personnel in position/available as compared to the required number and where they are distributed (rural-urban disparity, regional imbalance all these are covered under Chapter-8..

How qualified and trained health personnel and what are the opportunities available for their skill enhancement is covered under its second component. An important factor here is the availability of

educational and training facilities for different categories of health professionals. The Chapter-9 examines “Health education, research & regulation” as well as distribution of functional responsibilities between Union, State and local governments.

With regards to infrastructure and facilities available for delivery of health services, the report takes into account the number of health centres at different levels in place as compared to the required numbers and also the types of hospitals. Availability of adequate facilities at these centres/ hospitals would determine to what extent they are being used by the people. This is assumed, though it doesn’t ensure the quality of accessibility of services rendered to the end-users. In the absence of data on quality of services or their efficacies, Chapter- 8 is devoted to the physical infrastructure part only.

Along with these indicators, achievements of the NRHM with reference to indicators such as accountability, transparency & participation are interpreted (Chapter-7) in this report to measure health governance.■

PUBLIC POLICY ON HEALTH

Introduction

Public policy making is widely recognised as an essential and integral part of governance. The very formulation of public policy on any subject entails inputs on its several components. This includes, the needs of the people at large, resources it would necessitate, the existing socio-economic conditions, balancing conflicting interests and demands of various stakeholders, national and international actors, global events etc.

Public policy on health, simply stated, would therefore mean a framework adopted by the state towards the promotion of healthcare, including preventive, promotive and curative care of its people. The need for an all encompassing public policy on health is felt because of the very nature of health as a public good. Conceptually, health is a right of every individual, but in reality, access (to that right) is governed by its costs and affordability. The fact remains however that health is a public good where demand and supply cannot simply be regulated by invisible hands of the market.

Most of the early legislations in the realm of public policies on health were passed by the British Parliament in the wake of the industrial revolution. For, public health problems became evident in the process of industrialisation giving rise to nascent

urban centres with low standards of living, nutrition and congested housing, overcrowding. All this had necessitated disease prevention measures. In fact, the political pressures from the side of elites were all the more strong who were apprehensive that even if diseases first struck the poor, it would reach epidemic proportions and also affect the rich if not contained, resulted in many legislative enactments¹.

Very few would recall today that what served as the basis for Britain's welfare state was an innocuous report on *Social Insurance and Allied Themes*, 1942 [popularly known as the Beveridge (Sir William) Report] which pointed out that "social security cannot be fully provided unless health needs are cared for along comprehensive lines."²

¹George Rosen notes that the Public Health Act of 1848 was as much a response to the cholera epidemic as it was to the "revelations and exhortations of crusading reformers". Other legislations like the Act of 1855 were also a response to the Cholera epidemic of 1853. In 1905, the Royal Commission was appointed to examine the problem of the Poor Law in all its aspects and provide suggestions for the future. The Commissioners issued a Majority and Minority report. The Minority Report was largely the work of Beatrice Webb and called for a unified state medical service to combine the Poor Law medical services with those provided by public health authorities.

²ibid. This followed the creation of the National Health Services (NHS) in 1948 providing health services to the people of Britain. Both, the (Beveridge) Report and the creation of the NHS, are considered important landmarks in provision of social security in Britain.

Public Health Policy in India

India did not have a formal public health policy statement until 1982-83, when the first National Health Policy was adopted. Prior to this, health services and activities were formulated through five-year-plans and recommendations of various committees that examined different aspects of health and health services. Indeed, the evolution of public policy on health in India can be seen in three broad periods pre-Independence³ or the period of Colonial Rule, b) Post Independence, c) Post Economic Reforms—Health Sector Reforms.

The process of health policy making and planning for Independent India began almost towards the end of colonial rule when the then Government of India (Union Government of British India Provinces) set up a Health Survey and Development Committee under the chairmanship of Sir Joseph Bhore in 1943⁴. Considered to be ‘a watershed in

³ Till around the beginning of the twentieth century, when large scale epidemics forced British rulers to take necessary steps, the colonial regime was responsible only for the health of the Army, especially for the large European contingent and other white officials and residents. Seemingly indifferent to major developments in public health taking place in their own country, the British rulers had restricted the same kind of provisions (as being provided under British Municipal Acts) only for the Indian cantonment and adjacent *bazars*. This was true of the other colonies where the relation between military and medicine was an ‘intimate and long-standing one’, as Arnold notes, and was the basis of developing health services. He further notes that the first responsibility of the Indian Medical Services (IMS, formed successively for Bengal, Madras and Bombay presidencies during the autumn of 18th century) to provide medical assistance to the army of the East India Company. And soon after the takeover of the Company by the Crown, the IMS was entrusted with the health of the Indian Army, while the British Army was with the Army Medical Department. Even certain seemingly public health measures like the Contagious Diseases Act of 1866, authorising setting-up of lock hospitals (created especially for the treatment of venereal diseases in Britain and its colonies that operated for nearly two centuries ending by the middle of the twentieth century, and inspecting and treating Indian prostitutes infected with venereal diseases were implemented to protect the British soldiers. Thus, the focus and direction of health services was diseases that soldiers of the Army were seen to be suffering from, for instance cholera, typhoid, and syphilis, and not necessarily those that plagued the civilian population at large. And also, the Army was essentially an adult-male composition and so diseases of women and children and the aged did not receive any attention. See Arnold, D, cited in Dorothy Porter, 1994.

⁴Prior to that the Indian National Congress had already established a National Planning Committee (NPC) in 1938 under Jawaharlal Nehru and formed a sub-committee on National Health with Col.

health policy and health planning in India (Duggal, 2005: 23), the report of the Bhore Committee, as it is popularly known, is seen to be the blue-print for health services development in India. Hailed as an authoritative document not merely because of the way it envisioned provision of health services in a country like India (Banerji, 1985), it also emphasised the integration of curative and preventive medicines at all levels. Among its major recommendations was the development of Primary Health Centres (PHCs) in two stages, discussed in a later section.

Post Independence

The immediate aftermath of Independence was devoted to consolidating resources and nation-building. Health policy, during this period, included the implementation of rural health services through PHCs, health planning as a part of the national socio-economic plan, mass campaigns against communicable diseases, social orientation of education and training of health workers of various kinds, population control through a national programme for integrated family planning, promotion of indigenous systems of medicine, provision of adequate protected water supply, environmental sanitation, and nutrition programmes (ibid.) .

The growth of health services in the post independence period in India could be traced in four phases: 1950-65, 1966-1980, the 1980s and since the 1990s. Barring the fourth phase which is discussed in the next section, this section is devoted to the rest three phases.

1950-1965

The first and the second five-year-plans, covering the initial periods of the 1950s till 1961 lay focus on developing basic infrastructure and manpower, including ‘provision of water supply and sanitation, control of malaria, preventive health care of the rural population through health units and mobile units, health services for mothers and children’ (Nundy, 2005) All this was visualised by the Bhore Committee.

S. S. Sokhey of the IMS as its Chairman. It submitted its final report only in 1948. Even though it was the first committee to be formed to assess the health situation and health services in the country and give recommendations for improving the same, its report came after the Bhore Committee Report. See, Duggal et al., 2005.

Along with this, development of health education and training, setting up of advanced research institutions, medical colleges with tertiary hospitals, and primary health centres⁵ took place rapidly (Priya, 2005). However, with sub-centres lagging behind, the situation at the village level remained as it were.

With reference to the health education, it was graduate medical education that grew while nursing and paramedical cadres lagged behind. The licentiate course (see Chapter 7) was abolished following recommendations of the Bhore Committee. Thus, a doctor-centric health system was established. This resulted in the neglect of other health personnel who were required for comprehensive health services to become a reality.

This period also witnessed the initiation of vertical programmes in the form of nationwide disease control programmes (see Table 5.1) and mass campaigns to combat epidemics along with the national family planning programme which has had its share of controversies. Early 1950s, for instance, saw the launch of two national programmes: the Family Planning Programme⁶ in 1951 and the Malaria Eradication Programme in 1953. Programmes for eradicating smallpox and for controlling TB, filariasis, leprosy and venereal diseases were also carried out. Essentially techno centric in nature, these programmes were assisted by international agencies like UNICEF, WHO etc. Dependence on international agencies for economic aid, technological assistance also brought political and ideological influences. With vertical programmes gaining focus, health infrastructure and personnel were diverted to take part in these

⁵Established in October 1952, the first lot of primary health centres (PHCs) were a major landmark in the development of health services in India. The PHC embodied an integrated approach to all encompassing health services development-curative, preventive and promotive. Its major functions included i) medical care, ii) control of communicable diseases, iii) promotion of maternal and child health, iv) collection of vital statistics, v) protection of water supply and promotion of environmental sanitation, vi) conducting school health programmes, and later on, vii) family planning services (Banerji, 1985).

⁶In 1951, India was the first country in the world to launch a family planning programme at the national level. Since then, approaches at reducing population have taken a variety of forms. In the initial phase of the programme, passive clinic based approach was followed. This gave way to a more proactive, extension approach in the early 1960. In the '70s, forced sterilisations as part of the target and camp approach, resulted in much criticism.

programmes, while general health services lagged behind. All this eventually resulted in the creation of “an urban oriented, curative, and biomedical expertise centred professional mindset of the health professional” (ibid: 51).

Thus in the first two five-year-plans (FYP), structural framework remained unchanged. The focus was on urban areas, while rural areas received special attention through the Community Development Programme (CDP), that sought to bring about multifaceted developments in rural areas covering agriculture, rural industry, education, social organisation, transport and so on (Banerji, 1985). All this was to be accomplished through three major components: extension education, community self-help, and government action. Within the purview of the CDP nutrition, sanitation and water supply were also included. As part of the CDP organisation, the PHC put into practice community involvement and inter-sectoral development for health care.

Table: 5.1: Initiation of National Disease Control Programme

National Programme	Year Launched
Family Planning Programme	1951
Leprosy Control Programme (NLCP)	1954-55
Malaria Eradication Programme	1958
Tuberculosis Programme (NTP)	1962
Integrated Child Development Services Scheme	1975
Programme for Control of Blindness	1976
Expanded Programme on Immunisation	1978
Filaria Control Programme	
AIDS Control Programme	1995
Goitre Control Programme (NGCP) renamed as National Iodine Deficiency Disorders Control Programme (NIDDCP)	1962 (NGCP) 1992 (NIDDCP)

1966-1980:

Amidst growing debate over the choice of development model adopted in late 1960s, the global oil crisis of the 1970s resulted in cutting back on public expenditure on social sector. A shift towards rural areas and ‘people’s knowledge’ was stressed again following the global acceptance of the Alma

Ata Declaration of 1978. This inter alia had called for promoting the primary health care approach as the basis of health care services.

However, before that happened, the third plan launched in 1961 highlighted the inadequacy of health care institutions, doctors and other personnel in rural areas as shortcomings of the second five year plan. Eventhough, the third plan spoke of these shortages, there was no mention of concrete, specific steps to address this. Increasing the number of ANMs was recognised and yet establishment of training centres for ANMs were not put on place because of inadequate funds. There was, thus, a contradiction in stated policy objectives and actual allocation of funds.

The need to focus and strengthen the PHC programme was reiterated in the fourth plan (1969-74). Accordingly, construction of PHC buildings, providing them with adequate staff, equipments and other facilities was stressed. A separate allocation to PHC was made for the first time (Duggal, 2005). Sub-divisional and district hospitals were to be developed as referral centres for PHCs so as to strengthen its base. The importance of the PHCs was felt and acknowledged with a sudden increase in malaria cases between 1963-65, it was understood that gains made through disease programmes cannot be maintained unless basic, infrastructure and facilities are in place. Family Planning, however, continued to enjoy greater emphasis.

It was in the fifth-five-year plan (1974-79) that the government acknowledged the neglect of rural areas and failure in adopting an integrated approach in provision of health services. It also realised that health had to be addressed alongwith other development programmes. Thus, the Minimum Needs Programme⁷ launched in the first year of the fifth five- year plan period sought to increase accessibility of health services to rural areas. Referral services were also

⁷The Minimum Needs Programme initially had eight components : elementary education, rural health, rural water supply, rural electrification, rural roads, rural housing, environmental improvement of urban slums and nutrition. While adult education was added to the list of MNP components in the Sixth Plan, rural domestic energy, rural sanitation and public. distribution system were added during the Seventh Plan. See, www.planningcommission.nic.in.

developed. Health programmes were reformulated and health care services were to be provided through a new category of health personnel to be specially trained as multipurpose workers. This followed the recommendations of the Kartar Singh Committee (1973) of converting uni-purpose workers into male and female multi-purpose workers with each pair serving a population of 10,000 to 20,000. Thus, this scheme integrated the various vertical programmes into the primary health care package for rural areas.

The Family Planning Programme got further impetus during the Emergency Years of 1975-77 eventually contributing to the fall of the then government. As is known, the Emergency years were closely identified with forcible male sterilisation conducted with a target oriented approach. Health workers were again sucked into the family planning programme and whatever little integration of services had been achieved by the recommendations of the Kartar Singh Committee was again lost. The much maligned-and yet favoured family planning programme or euphemistically called population control programme, has undergone many changes in the terminologies used since. It was integrated with maternal and child health during the Fourth Five Year Plan, and with health and nutrition in the Fifth Plan, and finally in 1977 came to be known as “Family Welfare Programme”.

Another scheme that was introduced in 1977 following recommendations of the Shrivastava Committee, was the Community Health Workers/ Volunteers Scheme. This entailed the creation of a cadre of village based workers, selected by the village panchayat and trained for three months in simple promotive and curative skills both in allopathic and indigenous systems of medicine. This was essentially done to rectify the dearth of trained manpower in rural areas. The Committee pointed out the over-emphasis on provision of health services through professional staff under state control had proved to be counter-productive. It noted that the new professional services provided under state control was inadequate and in quantity and unsatisfactory in quality.

1980s

In the wake of widespread disillusionment

with vertical programmes and need to provide comprehensive health care, the Alma Ata declaration of 1978 promoting primary health care approach came to be adopted in countries worldwide. The ICCSR report on “Health For All by 2000 AD” noted that to make the Alma Ata Declaration a reality, there was a need for the development of a comprehensive national health policy. It stressed the need to get back to the goal of an integrated and comprehensive health system, which we kept wavering from. It also reiterated that “governments formulate a comprehensive national health policy dealing with all dimensions-environmental, nutritional, educational, socio-economic, preventive and curative” (Nundy, 2005).

India’s first National Health Policy was thus, formulated in 1983, during the Sixth Plan Period (1980-84) with the goal of providing universal, comprehensive primary health services. In contrast to the curative oriented western model of health care, it emphasised a preventive, promotive and rehabilitative primary health care approach. To this end, the government was to utilise the support of private and voluntary agencies in providing integrated health services.

However, soon after the Alma Ata Declaration, questions were raised across the world, on the financial viability of the Primary Health Care approach and alongwith strong lobbying resulted in selective primary health care (SPHC) being adopted. Vertical programmes were reintroduced as “interim arrangement”, even before comprehensive primary health care was realised. Interventions⁸ such as immunization, breast feeding, oral rehydration etc were suggested. The focus, again went back to programme driven health policies.

The sixth plan emphasised the development of a community based health system (Duggal, 2005) providing health services to the rural areas. The need to establish linkages between all interrelated programmes like water supply, environmental sanitation nutrition, education was stressed. This period, along with that of the seventh plan, saw massive expansion of rural health infrastructure. However, there was a mismatch

between infrastructure, adequate and quality facilities, as also adequate and trained personnel. The sixth and the seventh Plans, no longer spoke of “targets” (ibid). They used the keywords of “efficiency” and “quality” making way for privatisation.

The seventh plan (1985-1990) re-emphasised the need to develop rural health programme and health infrastructure at the primary level. It reiterated strengthening of the three-tier system and also called for addressing shortage in personnel, equipments and infrastructure. This, the state, could not do entirely on its own given the financial crisis it was going through. Thus, the eighth plan openly encouraged setting up private hospitals, clinics and medical education by tax incentives, soft loans etc.

Added to this, the country was going through major financial crisis along with the ongoing global oil crisis. Thus what necessitated reforms in the health sector, was “essentially a cumulative effect of the following: a series of unfavourable developments coupled with misguided perception of appropriate use of health infrastructure as well as the inability of the State to confront with the problems emanating from several sources plus fiscal crisis” (Kumar, 2009).

Health Sector Reforms

Health Sector reforms is a feature of the 1980s and 1990s. It is a global phenomenon and rooted in the neo-liberal ideological framework as a response to the oil crisis of the 1970s. India experienced an economic crisis due to balance of payments and with negligible foreign currency reserves. Thus, perforce India adopted Health Sector Reforms (HSR) incorporating more selective and technology centred changes in the programmes for health. Most importantly, by switching over from a ‘service’ to a ‘commodity’ for which everybody has to pay, it brought in a change in the ‘conceptualisation of health care’. It promoted assumptions that expenditure on public systems are wasteful, public systems have thoroughly been inefficient and ineffective; markets need to be given greater prominence and market principles can be introduced in public systems to make them more efficient (Baru, 2009).

⁸Interventions like UNICEF’s GOBI programme

Broadly speaking, health sector reforms were initiated with the basic tenets of improving efficiency, effectiveness and quality of care of the public health services. These reforms included restructuring public health services contracting out ancillary services, scaling down manpower and decentralisation. The World Bank's World Development Report of 1993 was devoted to health, titled *Investing in Health* outlined the bank's perspective for health sector development in developing countries. Following this, countries adopted 'reforms' in the health sector. The various forms of proposed reforms are given below:

- Strengthening management structures
- Contracting Staff
- Strengthening infrastructures
- Public Private Partnership (PPP)
- Introduction of user-fees
- Public-NGO links
- Campaign modes
- Public institution sale to the Private sector

Almost all states in India have adopted reforms in the health sector (see Map : 5.1). Some states took up initiatives without any assistance from the World Bank. Gujarat, Madhya Pradesh, and Tamil Nadu were states which initiated reforms without the bank's assistance. States like Andhra Pradesh, Karnataka, Maharashtra, Orissa, Uttar Pradesh, and West Bengal availed financial assistance of the bank. For the bank assisted states, emphasis was on improving the physical infrastructure of services, particularly those related to national sector programmes which are funded by bilateral and multilateral agencies.

Various Committees on Health

The first Committee to come up with its report on health services was the Health Survey and Development Committee (Bhore Committee) 1946. The report of the committee, influenced by the freedom movement, is considered an authoritative document on health services planning in India and is in fact seen as the blueprint for the development of health services in the country. The committee

comprised of individuals belonging to a different areas and this has probably contributed to the richness of the report.

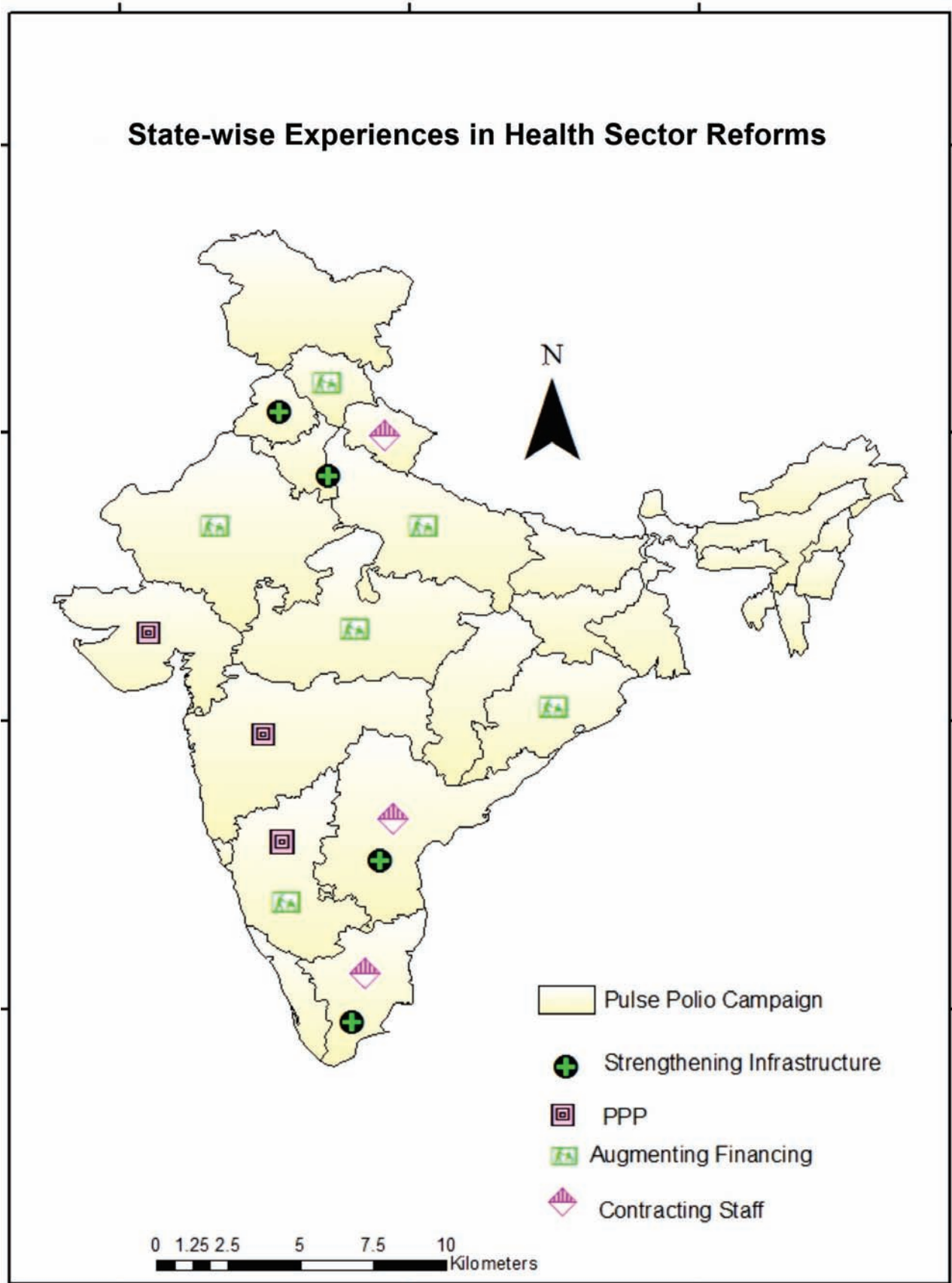
Among the guiding principles adopted we:

- No individual should be denied adequate medical care because of inability to pay for it.
- Health services should provide, When fully developed, all the consultant, laboratory, and institutional facilities necessary for proper diagnosis and treatment.
- Health programme must, from the beginning, lay special emphasis on preventive work.
- Medical relief and preventive health care must be urgently provided as soon as possible to the vast rural population of the country.
- Active cooperation of people in the development of health programme
- Social orientation of medical practice and a high level of public participation

The Committee recognised the importance of primary health centres in the development of health services, and recommended steps for the developing health services in two phases: Long term covering 20-40 years and Short term stretching two five year periods.

The Long term recommendations envisioned the smallest serving unit to be a Primary Health Unit covering a population of 10,000-20,000. A Secondary Health unit would assist and supervise 15-25 such units. These would in turn come under the District health organisation serving a population of 3 million. The Committee also recommended the setting up a Health Centre at each district headquarters with general and special hospitals having total bed strength of about 2500. The secondary health units would have 650 beds and primary health centres would have 75 beds. As regards, the staffing pattern at these units, it recommended that at the primary health unit, there should be 6 medical officers, 6 public health nurses along with nursing staff for the 75 bedded hospital. Above all, it envisaged resources

Map : 5.1



and personnel for the special services for control of diseases like malaria, TB, venereal diseases, leprosy and mental disorders.

As part of the short term plan (the first two five-year plan periods), the committee felt that emphasis should be on setting up of 30 bedded hospitals, one in every two primary health units. District health organisation was to be established in every district initially to cover five primary units and one secondary unit each and gradually increasing up to 25 primary and 2 secondary units through the 10 year period.

The Bhore Committee also saw the importance of involving the community in the provision of health services. For this, it recommended the setting up of Village Health Committees (fructified nearly six decades later in the form of Village Health and Sanitation Committee under the aegis of NRHM, discussed in chapter 9) comprising of five to seven voluntary workers who would be trained in promoting specific lines of health. The Committee believed in giving wider autonomy to the provinces, something that later policies of decentralisation also have advised. It also pressed for the discontinuance of the three year licentiate course for doctors also as it felt that less highly trained doctors would lower the standards of service to the community. It strongly recommended the training of 'the basic doctor'- the most highly trained doctor, and proposed that funds could be used to train ancillary staff to assist the basic doctors.

Thereafter various committees were set up over the years into examining different aspects of health services. An inventory of the various committees and their recommendations is given in Table 5.2. It can be seen that many policies go through a 'to-and-fro' movement, with the government riveting back to earlier policies when certain recommendations were found unsuitable when implemented.

Health Budgeting in India

India spends just about 1% of its GDP on health, compared to the average share of 2.8% in low and middle income countries⁹. It is among the lowest in the world with one of the highest out-

of pocket expenditures (over 80% of total health finance is private out-of-pocket). It is estimated that one-quarter of all Indians fall below the poverty line in the event of hospitalisation and more than 40% of individuals hospitalised in a year borrow money or sell assets to cover health care.¹⁰

The National Common Minimum Programme of the UPA government had stated in 2004 that it would raise public spending on health to at least 2-3% of GDP over the next five years with focus on primary health care¹¹. It had also proposed a national scheme for health insurance for poor families. Increase in public investment in disease control programmes, and examining the feasibility of reviving public sector units for producing bulk critical drugs, so as to bring down drug prices were also stated objectives.

A health insurance scheme for the poor in the form of Rashtriya Swasthya Bima Yojana was introduced in 2008. But even till the end of the 11th Plan, public spending on health has not been increased to the stated 2-3% of GDP. In fact, it has now become part of the 12th Five Year Plan (2012-13 to 2016-17), as recently announced by the Planning Commission.¹² The introduction of a 1% health cess as proposed by the Planning Commission is also on the anvil¹³. However, introducing a new cess, when existing funds are not utilised optimally, is questionable.

Health is essentially a State subject, in India, with part financing from the Centre. Though, states account for 75-90% of public spending on health, almost 80% of it is spent on salaries and wages¹⁴, leaving little funds for essential inputs like drugs, equipment and non-wage items.

National Policy Documents

In addition to the various committees set up to look into issues of planning health services/

¹⁰For details, see Sujata Prasad & C Sathyamala (ed) *Securing Health For All: Dimensions and Challenges*, 2006, IHD

¹¹National Common Minimum Programme, 2004

¹²See, Hindustan Times (Business section) dated 10/09/11

¹³See <http://timesofindia.indiatimes.com> dated 17/08/11

¹⁴Selvaraju 2000 cited in David Peters et al (2003), *Lumping and Splitting: The Health Policy Agenda in India*, Health Planning and Policy.

⁹NCMH, 2005

Table 5.2 : National Committees on Health (1946-1986)

Name of Committee	Major Recommendations
Health Survey and Development Committee (Bhore Committee), 1946	Emphasis on integration of curative and preventive medicines at all levels. Major recommendations included (i) Development of Primary Health Centres in two stages: short term and long term (ii) revision of Medical Education
Chopra Committee on the Indigenous Systems of Medicine, 1946	Recommended mutual learning between allopathy and the indigenous systems of medicine (Ayurveda, Unani and Siddha). Recommended that some practitioners of each system be given education in the other systems evolving into one integrated knowledge system. (**RituPriya,2009)
Report of the National Planning Committee-Sub-Committee on National Health (Sokhey Committee), 1948	Was set up before independence, in 1938 as a sub-committee of the National Planning Committee of the Indian National Congress • integration of curative and preventive facilities in a single state agency urged and stress on state's responsibility in maintenance of health of the people • Large scale training of health workers in practical community and personal hygiene, first aid, simple medical treatment, stress on social aspects and implications of medical and public health work to meet immediate situation • 1 worker per 1000 population aimed to be achieved within 5 years. One hospital bed for every 600 persons • Immediate targets: integrating practitioners of Ayurveda and Unani systems into the state health system after giving scientific training where necessary. • Expansion of medical education and research, nutrition, compilation of Indian pharmacopoeia, production of drugs etc.
Health Survey & Planning, (Mudaliar Committee Report, 1962)	Assess performance of health sector since the Bhore Committee. Recommendations: Existing PHCs need to be strengthened before new PHCs built. Population catered to by PHC not more than 40,000. Creation of All India Health Services in place of Indian Medical Service
Chaddha Committee, 1963	National Malaria Elimination Programme-Vigilance work be carried out by basic health workers (1/10,000) function as MPW and carry out FP activities in addition to collection of vital statistics
Mukherjee Committee, 1965	Chhadha Committee recommendations were found to be unsuitable as MPWs could not fulfil all their duties. Mukherjee Committee recommended that FP staff do only FP work. And basic workers do work other than FP. Also delinking Malaria from FP work so that attention can be given to FP
Mukherjee Committee, 1966	Details of basic health services provided at Block level and some strengthening administrative level.
Junglwalla Committee, 1967	Looked into Integration of Health Services, Abolition of private practice by govt. docs, Service conditions of doctors Integration of health services defined as: Unified approach for all problems instead of segmented approach for different programmes. Medical programmes/health programmes under a single administrator at all levels of hierarchy. Recommendations: i.) Unified Cadre, ii.) Common seniority, iii.) Recognition of extra qualification, iv.) Equal Pay for equal work, v.) Special pay for special work, vi.) Abolition of private practice by govt docs, vii.) Improvement in service conditions.
Kartar Singh Committee, 1973	Multipurpose workers Various peripheral workers converted to single cadre of MPWs-male, female. ANMs becoming MPW(f) and basic worker, malaria surveillance worker etc becoming MPW(m) 3-4 MPWs supervised by Health Supervisor (Male, Female respectively) 1 PHC to cover 50,000 population. divided into 16 Subcentres staffed by 1 male, 1 female health worker
Shrivastava Committee, 1975	Group on Medical Education and Support manpower -Reorientation of Medical Education in accordance to national needs & priorities, -Develop curriculum for health assistants to serve as links between medical officers and MPWs RECCOS: i) Create semi-professional health workers from community itself ii) 3 cadres of health workers- MPWs and Health Assistants between community level workers and doctors at PHC iii) Development of Referral Services Complex iv) Establishment of Medical and Health Education Commission on the lines of UGC, for planning and implementing reforms in med and health education Rural Health Service launched in 1977 as a result of recommendations of Shrivastava Commission
Bajaj Committee, 1986	Expert Committee for Health Manpower Planning, Production and Management Recommended establishment of Educational Commission for Health Sciences on lines of UGC, Health Science Universities in states and UTs, and health manpower cells at centre and states Formulation of National Medical & Health Education Policy and National Health Manpower Policy Vocational education at 10+2 level with health related courses for developing quality paramedics in large numbers Realistic manpower surveys.

health care development, the government formalises its policy on health in the form National Policy Documents like National Health Policy-1983, National Health Policy-2002, National Population Policy etc. Some of these are discussed below.

National Health Policy(NHP)

The National Health Policy has so far been formulated twice; the first in 1983 and two decades after, the second in 2002. The first National Health Policy of the country came into being in 1983 as a response to the need for an integrated and comprehensive approach in the development of health care. It was highly critical of the model of healthcare development adopted till then. Healthcare services till then followed 'curative' approach based on Western models of health care which were largely inappropriate to the real needs and priorities of the people. The emphasis on curative approach led to the neglect of comprehensive primary health care services for the entire population. This resulted in a cultural gap between the people and the personnel providing care. The NHP-83 felt that the planning process failed to involve the community in planning programmes and policies by not acknowledging its role in identifying health needs and priorities.

Against this backup, the NHP-1983 was evolved through an integrated planning framework to provide "universal, comprehensive primary health care services, relevant to the actual needs and priorities of the community at a cost which the people can afford, ensuring that the planning and implementation of the various health programmes is through the organised involvement and participation of the community, adequately utilising the services being rendered by private voluntary organisations active in the Health sector."¹⁵ It is worth recalling that long after the Bhore Committee, the first health policy document underlined the need of providing universal comprehensive health care.

The NHP-83 advocated a health policy based on the Revised 20 Point Programme.¹⁶ The policy was probably the first state document that openly

encouraged establishment of private practice of medical professionals and increased investment in curative facilities by private sector to reduce the burden of the government. It encouraged the private investment in establishing speciality and super speciality service centres for those who could afford so that limited speciality centres in the public sector could be made available for those who were entitled to free care. It recommended offering organised financial and logistical support to voluntary organisations to increase private investment. Thus, it called for organised efforts to fully utilise and assist in enlargement of services provided by private voluntary organisations.

It also recommended establishment of chains of sanitary cum epidemiological stations throughout the country staffed with suitably trained personnel to identify plan and provide preventive, promotive and mental health care services. Yet the focus, the document emphasized, should be on up-gradation of existing facilities at selected locations, and new curative centres to come up only in exceptional cases.

Following the 1983 NHP, rural health care received special focus and a massive expansion of PHC facilities was undertaken in the 6th and the 7th FYPs to achieve the target of one PHC per 30,000 population and one sub centre per 5000 population¹⁷. Many studies on primary health care had indicated that even in areas where the infrastructure was in place, there was still underutilisation due to a number of factors including poor facilities, inadequate supplies, faulty planning of health programmes and lack of proper monitoring and evaluatory mechanisms. Added to this, factors such as inadequate training and skill enhancement opportunities for health personnel, lack of appropriate accommodation for personnel, inadequate transport facilities, etc. were also contributing towards the underutilisation of services. It also needs mentioning that the NHP 1983 had also called for decentralisation and de-professionalization of health services. While some beginning was made, community participation per se hardly took off, largely due to non-acceptability of the model of primary health being implemented by

¹⁵MOHFW, National Health Policy,1983,Govt. of India (1983)

¹⁶Revised 20-point programme Main features: i) Promotion of Family planning as 'people's programme' on voluntary basis, ii) Augmentation of comprehensive primary health care facilities

¹⁷Duggal, op cit.

the people (Duggal, 2005).

On the whole the main objective of the 1983 health policy was providing primary health care to all, especially the under-privileged. It had *inter alia* called for evolving an integrated planning framework, to provide comprehensive primary healthcare relevant to the actual needs of the community. However, there was hardly any concerted move towards achieving the goals. Many factors contributed to this. The '83 policy was formulated in response to the Alma Ata Declaration. Yet, the concept of comprehensive primary health care itself was soon criticised for being too ambitious hence not feasible and thus selective primary health care was proposed as an alternative. Proponents of this approach delinked health from development (Qadeer, 2002), and felt that health could be promoted by providing available technological interventions, not necessarily based on the actual needs of the community.

Reverberations of this line of argument were felt practically all over the world. In India, the period after the 1983 policy saw massive expansion of rural health infrastructure especially PHCs. But, merely increasing the number of health centres, as noted earlier, without improving the quality of services did not yield desired results. Along with this, with focus on population control still intact, workers at the primary level essentially performed family planning tasks. Thus, even though there was more number of PHCs, they were carrying out the same task, that is, population control. The policy document had called for an integrated approach and the sixth plan had stressed the need to establish inter linkages between related programmes like water supply, environmental sanitation, nutrition and education, but all these remained rhetoric and never became a reality.

By the end of the 1980s, the public health system was in a crisis: increased, but inadequate infrastructure, poorly functioning primary level institutions and competitive and expanding private sector coupled with increasing demand for health care doubled with existing socio-economic conditions. The country was going through severe economic crisis of 'balance of payments' with depleting foreign currency reserves. India, as with other developing countries, gave in to

Structural Adjustment Programme and adopted the Health Sector Reforms. This resulted in even more selective and technology centred changes in the vertical programmes. The 1990s thus proved to be a mixed bag in the case of health services with some developments, albeit slow, on some fronts had been made.

- Improving 'quality' of health services became a priority though the debate on defining quality remained inconclusive. Yet, as part of the health sector reforms, this period witnessed an increase in 'state-of-the-art' medical technology meeting international standards. This mainly catered to a particular class of society, suited the "aspirations of a section of medicos and the medical corporate sector" and was "conducive from the perspective of the internationally powerful lobbies of the pharmaceutical and medical equipment industry as well as insurance capital" (Priya 2005). This resulted in a rise in the secondary and tertiary level services, promoted in the private sector, while strengthening primary health care in the public sector was reduced to primary level services.
- The private sector made inroads into the health sector and experienced boom with tax incentives, government subsidies granted to them for investing in health (all under the broad rubric of PPP). Public spending on general health services, however, suffered cut-backs resulting in shortages of drugs, except for the Reproductive and Child Health (RCH) Programme that had been integrated with family planning. Even with regards to personnel, there was a decrease in recruitment of MPW (males) who would have been involved in routine health services, and increase in recruitment of ANMs, clearly indicative of where the focus lay. Expansion of national programmes for the control of certain diseases, like leprosy, polio, HIV AIDs that depended heavily on pharmaceutical products, and drug regimens proved expensive and difficult to sustain. At the primary level, only those services

strengthened that were part of disease control programmes. Once again, general health services deteriorated, as was evident in the poor infrastructure and inputs at the PHC during that time.

- Thus, at the end of decade of the 1990s, health services lay fragmented as isolated primary/secondary/ tertiary levels; vertical programmes/ general health services; surveillance / programme implementation activities; and routine activities/ campaigns (Priya, 2005). Continued emphasis on population control reduced the PHC to ‘family planning centres’, as it were, in the eyes of the community. Though infrastructure has increased or been upgraded, it has mostly meant new buildings but without matching with corresponding increase in trained personnel and available facilities. Likewise decentralisation has not translated into devolution of power, but merely as rearrangement of duties. This was notwithstanding to all claims of the enabling effect of the Constitution (Seventy-third & fourth Amendment) Acts, 1992.

The National Health Policy 2002 came about in these circumstances. While some policy initiatives of the ’83 document had shown results, it was felt that the outcome was not as expected. The NHP-2002 document thus observed that the ’83 policy was ambitious in its promises of providing “Health for All By 2000” given the existing financial resources and public health administration. This document, therefore would like to be more realistic in its recommendations. One of the major criticisms of NHP-2002, has been that there has been a complete break from the past. The ’83 document had stressed the need to strengthen the referral system. NHP-02 seems dismissive of the importance of the referral system. In fact, NHP-02 assumes that private players can take care of services at all levels from the first referral as well as to secondary and tertiary care (Qadeer, 2002). This would amount to inequity when people who require secondary level are not able to afford it (ibid). The document has also been criticised for not ensuring a system of regulation

and surveillance of the private sector in the form of legislative mechanism for monitoring and regulation.

While the ’83 document laid emphasis on strengthening the general health services, integration of services in NHP-02 doesn’t include disease control programmes like that of AIDS etc which require huge amount of resources. Continuation of these as vertical programmes would not improve the health services.

National Health Policy 2002

The second National Health Policy came up after a gap of 18 years, with the Draft National Health Policy 2001 being announced and feedback from the public being welcomed. The NHP-2002 was pitched to a realistic expectation of resources and financial constraints. It talked of integration of vertical programmes, strengthening infrastructure, decentralisation of health care delivery, regulation of private practice, etc. The document has also been criticised for its “break in continuity from the past” by “ignoring the 1983 policy’s objectives of protecting and providing primary health care for all, especially the under-privileged” (Qadeer, 2002). None would fault the government of the day for expressing its good intentions, but without mentioning how these goals would be achieved.

Foremost among the recommendations was an increase in the health sector expenditure on the part of the central and the state governments. While Central Govt expenditure was to increase to 6% of the GDP by 2010, state governments should be at 8 %. An increase in sectoral outlay was also in the offing with allotment to primary health care getting a little over half (55%) of total public health expenditure, followed by secondary care (35%), and remaining for tertiary care (10%). The policy envisaged gradual convergence of all health programmes under a single field administration, with disease control programmes such as TB, Malaria, AIDS, RCH and UIP continuing till moderate levels of prevalence reached. Rural health staff should be available for the whole gamut of public health activities, irrespective of whether they are a part of national programmes or other public health activities. Reiterating the head for training and reorientation of health staff, NHP-

2002 also called for implementation of programmes through autonomous bodies at the State and District levels. As far as the state health departments' role was concerned, it was limited to the overall monitoring of programmes.

As regards the role of private sector, NHP-2002 encouraged the participation of the private health sector at all - primary, secondary and tertiary - levels, though it felt that it could play substantial role in the urban primary and tertiary levels. It nevertheless, recommended the enactment of legislations to monitor and regulate quality and infrastructure at clinical establishments. The NHP-2002 also envisaged multiple partnership – between the public-private and public-NGO partnership - in providing health care.

Above all, it called for the setting up of private insurance facilities to deal with financing at secondary and tertiary levels. The NHP, in fact strongly favoured setting up of a social health insurance scheme funded by the government with service delivery through the private sector. Likewise, along with the private sector, the policy also advocates partnering with civil society in its disease control programme, and is open to “the handing over of public health service outlets at any level for management by NGOs and other institutions of civil society, on an “as is where is basis” (MoHFW 2002).

Thus, the focus of the NHP is enhancing financing of health sector and restructuring of public health services so as to make equitable access possible. The policy statement, in fact, states that equity in the health sector is an independent goal and that, “NHP-2 would like to be measured in terms of this equity norm, rather than any other aggregated financial norm for the health sector.”

Draft National Health Bill, 2009

The Draft National Health Bill, 2009 is the first step towards legally recognising “the right to health” as it intends to “*provide for protection and fulfilment of rights in relation to health and wellbeing, health equity and justice*” and accordingly, it lays down a legal framework on health at the national level. This coverage is much more expandable as it includes practically *all the underlying determinants of health as well as health care; and*

for achieving the goal of health for all; and for matters connected therewith or incidental thereto” (MoH&FW, 2002)

The guiding principle of this bill is people's participation and empowerment in their health issues thereby invoking a sense of ownership among people. The draft bill recognises the right to health as a fundamental right and links it to the exercise of all other human rights. It states that “the right to health is an inclusive right extending not only to timely and appropriate health care but also to the underlying socio-economic, cultural and environmental determinants of health ” (ibid :). The framework of the document comprises of:

- People's rights relating to health and health care
- Concomitant obligations of governments as well as private actors, core principles, norms and standards on health rights and obligations
- Institutional structure for implementation and monitoring
- Justice mechanism for health rights

In sum, this document puts together both the rights of individuals/population and also the obligations of the government (central, state) towards realisation of health and well-being. Included among the obligations of the government is that of providing free and universal access to health care, and ensuring that there is no denial of health care to anyone by any public, private health care provider or for profit or not for profit service providers. It calls for the establishment of monitoring bodies like the *National Public Health Board, State Public Health Board* that would determine decentralized district, block, and village level planning and implementation authorities.

It also impinges upon the Government to establish intensive accountability framework through (a) health information systems (HIS); (b) monitoring by government agency; and (c) community based monitoring. Above all, the bill calls for the state and the central government to resolve disputes related to healthcare by establishing a mechanism of public

dialogues and *Jan Sunwais* (public hearings).

National Population Policy 2000

It is nearly forgotten today that India was the first country in the world to launch a national programme for family planning in 1952. It had realised that reduced birth rates will help stabilise population at a level consistent with the requirements of the economy. Later, the (family planning) programme was widely criticised when it took recourse to targeted approach that entailed forced sterilisations, more particularly during the mid-1970s. Since then, it has undergone many changes in the way the policy is being formulated and administered.

While the NHP 1983 spoke of reducing Total Fertility Rates (TFR) by 2000, an exclusive population policy at the national level was missing until the National Population Policy (NPP 2000) was formulated. The NPP affirmed “the commitment of government towards voluntary and informed choice and consent of citizens while availing of reproductive health care services, and continuation of the target free approach in administering family planning services” (NPP, 2000). Accordingly, the NPP 2000 provided a policy framework for advancing goals and prioritizing strategies during the next decade, to meet the reproductive and child health needs of the people of India, and to achieve net replacement levels (TFR) by 2010.

It also recognised the need to address issues of child survival, maternal health and contraception along with the expanded coverage of a comprehensive package of reproductive and child health services being provided by the government, industry and voluntary non-government sector working in partnership. Thus, it acknowledged the role of the private and voluntary sector in promoting family planning services.

National Policy on Indian Systems of Medicines and Homeopathy (ISMH) 2002

The ISMH policy, under implementation since 2002, emphasised the need for meaningful phased integration of ISM with modern medicines, and also outlined complete integration of all plans for health and human development. The main thrust, the policy

document argued, would be to upgrade education and research in this sector and integrate it into the national health delivery system¹⁸.

73rd and 74th Constitutional Amendment Acts (1992)

The 73rd and 74th Amendments to the Constitution brought a “comprehensive decentralisation package paving the way for community initiatives at the local level. Among the subjects assigned to local bodies (municipals and Panchayats) as part of the decentralisation process, 29 can be seen to be associated with health. These include health and sanitation (covering hospitals, PHCs, and dispensaries), family welfare, drinking water, women and child development, the public distribution system and poverty alleviation programmes¹⁹. After the 73rd and 74th Amendments, Panchayat would oversee the working of the Anganwadi. The Anganwadi worker would be involved in the Pulse Polio campaigns, promoting ante-natal services etc.

Wrapping up

The very designing of public policy on health in India started with a well thought out comprehensive document like the Bhore Committee Report which laid down the blueprint for providing comprehensive primary health care (CPHC) to the people of this vast country. Its recommendations, however, could not be followed optimally in the decades thereafter. Instead of strengthening comprehensive primary care, to begin with, too much effort was laid on vertical disease control and population control programmes. As a matter of fact, the CPHC was attacked as not ‘feasible’ in many countries, including India, just a year after the *Alma Ata* conference, and instead, selective primary health care (SPHC) was offered as an interim alternative. The SPHC, it may be emphasized, only addresses 5 to 8 diseases, almost all of them falling within the realm of paediatrics. Not surprisingly, SPHC is considered to be counterproductive to the *Alma Ata Declaration* and primary health care approach.

Till 1977, the major health activity, apart from the various national disease control programmes in the country, was family planning, later rechristened family

¹⁸MOHFW,2002 and www.hinduonnet.com accessed on 26/07/11

¹⁹www.searo.who.int accessed 26/07/11

welfare programme with the addition of “maternal and child health” component to the family planning programme. Over the years, while some changes kept coming to the existing programme, the basic focus remained on reproductive health. For instance, child survival and safe motherhood programme (CSSM, jointly funded by the World Bank and UNICEF) was started in 1992-93 for implementation till 1997-1988. The objectives of the programme were improving health status of infants, children and reducing maternal morbidity and mortality. This was later combined with the reproductive and child health services in 1997-98, to form the reproductive and child health programme (RCH). This so called new programme was simply aimed at expanding the coverage and improving quality of ‘family welfare’ services.

Thus, notwithstanding certain apparent changes, the focus has remained the same. The NRHM induced recent changes has further confirmed this point. While the concept of ASHA, for instance, of a woman from the community, being part of health services delivery system may seem to be empowering and participatory, in reality, the work she does is no way different than what was expected of a community health worker/ volunteer, as envisaged in earlier official documents, including the Bhore committee report. If the focus of services still remains the same, new posts with fancy names would not make much difference. Over the last few decades, health policy designing in India seems to have been constrained with this convoluted syndrome.■

PRE-NRHM REFORMS & HEALTH FINANCING

Introduction

The initiation of Health Sector Reforms (HSR) has largely been seen as a turning point in the way governments shared or shifted responsibilities for the healthcare of its citizens, not just in India, but globally too. While major changes in health policies, in India, became visible with the formal adoption of the health sector reforms, many of them made their first move much earlier, albeit as experiments in individual states, at the level of community or as immediate and urgent responses to disease outbreaks. Against this backdrop, the commencing of the National Rural Health Mission (NRHM) is considered as a landmark. However, many of the components of the NRHM may actually predate the programme itself. Indeed, some of these had begun as state specific initiatives. Likewise, newer forms of financing health care were introduced. All this has been covered under this chapter.

There are many aspects of the health service delivery system, ranging from infrastructure to personnel to health programmes, to the manufacturing and procurement of essential medicines and equipments etc. In addition, different aspects of the health sector components come under the Union list, the Concurrent list as well as the State list in the Constitution. All this adds up to the complexities of

sharing responsibilities between the Centre and the States as also between the States and the third tier of governing structures. Above all, involvement of multiple ministries separately dealing with varying determinants also give rise to incongruity at many levels. This chapter examines these complexities, while looking at the role of various agencies involved in health care delivery, directly or indirectly.

It is widely believed that the economic upheaval triggered by post-1973 oil crisis eventually laid the foundations of reforms in many areas including the health sector. Globally, it started with the developed western countries that crafted a neo-liberal ideological frame to cope with the resultant recession in the 1970s and 1980s. As a matter of fact, by late 1970s 'the debate on privatization' of health services had also started gaining momentum in the developed western countries primarily but with wider ramifications for developing countries, including India. It needs mentioning that the social sector in India, including the health sector had witnessed substantial investments during 1950s and 1960s but the tempo had lost momentum in the wake of world-wide recession in the following decades. With the unfolding of 1991 reforms, it was envisaged that the gradual withdrawal of the State from the sick public sector would enable it to hike its spending in the health sector. This did not happen due to deteriorating

fiscal problems, though the allocation for centrally sponsored health programmes continued increasing through mid 1990s with immunization and family welfare (read family planning) programmes gaining priority.

The curative health care programme, on the other hand, was unable to make any headway. The country-wide network of PHCs was seen to be largely catering to family planning needs, if they were alive to their responsibilities, otherwise they were plagued with absenteeism of their commander (read doctor), unavailability of medicines or pathological services. The net result was overcrowding of sub-division or district level hospitals where rural poor patients would flock in. In case of seriousness, even the poor would be forced either to sell whatever meagre assets they had to bribe touts for availing the services at higher level public health institutions or simply forced to go without treatment. So the rural population had suffered, in first place, near absence or absence of health care institutions in the rural areas, or was constrained to avail services, largely restricted to consultation in overcrowded hospitals with rusted beds, lacking medicines, equipments and having filthy bathrooms. In towns and cities, the best health care services were available but not at affordable cost. So the urban poor would queue up again in crowded public hospitals, become indebted in case of serious illness or go without health care like their rural counterparts. It was not for nothing that out of pocket expenditure on health care has gone on rising with every passing five year plan period.

A paradigm shift occurred with the eighth five year plan when the Government of India agreed to accept the major recommendations of the World Bank. With this the conceptualization of health care was changed from service to commodity, necessitating payment for the (health) services availed by anybody. Along with this emphasis was put on efficiency, efficacy and quality of health care services. This was soon interpreted as an expanded role for markets. Among the multilateral agencies, the World Bank – the progenitor of the reforms – came forward, offering required financing for the restructuring of intended health sector reforms. This included the budgetary cuts in public spending on

health services, introduction of user fee to augment the meagre resources and privatization of medical care along with hiring contractual staff.

Interestingly, almost all states took up some form of reforms but given their initiatives the states could be bunched into two categories: the ones which assumed reforms without any recourse to the World Bank and the second category comprised those states which availed financial assistance. States like Gujarat, Madhya Pradesh and Tamil Nadu belong to the first category whereas Andhra Pradesh, Karnataka, Maharashtra, Orissa, Uttar Pradesh and West Bengal could be placed in the latter category. It may also be noted that there is an element of commonality among all these Bank-assisted states: emphasis on improving the physical infrastructure of services, particularly those related to national health sector programmes which are funded by bilateral and multilateral agencies (Kumar, 2009; Baru, 2009). On the other hand, the experience of the first category of states reveal the state specific initiatives, confirming state autonomy allowing elbow room for experimentation. The dividing line between these two categories however got blurred in certain states which initially did not take Bank's assistance but later strengthened its physical infrastructure with the Bank's provided financial resources. Tamil Nadu, for instance, that belonged to the first category of states, launched several innovative public health programmes financed by the World Bank in the late 1990s. Likewise, the second category of states also witnessed initiatives triggered by circumstantial reasons but restricted to an individual state only; in any case, not planned under the Bank's auspices.

Above all, it must be emphasized, some of the novel features of the flagship national rural health mission (NRHM) had their origins in certain state-led initiatives in mid-1990s. In view of such variations, this section will take note of some of the state specific initiatives. This will include introduction of user's fee and *rogi kalyan samiti* (RKS) in Madhya Pradesh; community participation in West Bengal with panchayats as one of the stakeholders, innovative changes brought out in the functioning of health centres / hospitals in Orissa; and finally, centralized procurement and supply of drugs in Tamil Nadu.

Notwithstanding all these state specific experiments, several state governments had also taken recourse to varying models of public-private-partnership (PPP) to meet the growing health need of the ever-increasing number of people in 1980s amidst their shrinking health budget. The nature and extent of partnerships were different, but they were premised on three basic assumptions: one, it will reduce the financial burden of the government; two, strengthen the capacity of the private sector to cater to the health need of people; and three, improve the quality of health care through new management structures. The well-known models of PPP (Bhatt, 2000) as then practiced in most of the states (provinces) are given under:

- I. Offering subsidized land and certain exemption on excise duty on import of machinery as well as other fiscal incentives to private sector to set up super-specialized hospitals. This model was adopted by all the major states of the country but they were situated largely in state capitals and in a few important cities²⁰.
- II. Handing over management of primary health centres (PHCs) to NGOs (e.g. Gujarat) but PHCs would continue to be wholly financed by the state government; and

²⁰Again among the states, such hospitals were heavily concentrated in four mega-polis (more in Mumbai, Chennai & Delhi but less in Kolkata) and in Tier-II cities like Bangalore, Hyderabad, Chandigarh, Ahmadabad, Surat, Vadodara, etc. Obviously, these hospitals were situated more in relatively developed southern and western parts of the country. "Those states, where private healthcare is prominent, have experienced either higher growth rates in agricultural incomes, as in Punjab, Haryana and Andhra Pradesh or very high growth in demand for health care, as in Kerala", notes a data-rich study. The reverse is true in case of economically backward, poor states, such as Bihar, Uttar Pradesh, Madhya Pradesh, and Orissa where "high levels of poverty and low incomes presumably restrict the demand for private health care" (Krishnan 1999:210). It may also be noted that during the previous two decades, cities like Patna, Bhubaneswar (the capital city of Bihar and Orissa respectively) have witnessed a mushrooming growth of a large number of small and medium sized private nursing homes, signifying the near defunct status of public health institutions.

III. Involving industries in managing health centres as in Tamil Nadu. Under this scheme an industry will adopt a local primary or sub-health centre (SHC) and would be responsible for building, maintaining and equipping the facility while the state government would continue providing staff and medicine.

Rogi Kalyan Samiti (RKS) in MP

Whether RKS led hospital reforms in Madhya Pradesh too can be placed under the broad rubric of PPP is still debatable, it was based on direct participation and contribution of multiple stakeholders. This entailed the formation of *Rogi Kalyan Samiti* (RKS), loosely translated as Patients Welfare Society. The RKS²¹ sought partnership of all concerned actors at the local level to raise funds for the upkeep of the public hospitals and, in turn, ensured their participation in the management of hospitals. This included local level administration, civil society organizations represented by charitable trusts/ institutions, donors leading citizens of the area, elected representatives as well as hospital staff. The Madhya Pradesh scheme of PPP, if at all it were, was all the more unique in the sense that unlike in other states, where partnership had been sought from

²¹The decision to form 'Rogi Kalyan Samiti' (RKS) was, however, a bureaucratic intervention made when the scare of plague was looming large over the western part of Madhya Pradesh following its outbreak in neighbouring Surat (Gujarat) in 1994. The fear of plague had necessitated a thorough clean-up operation the 750-bed Maharaja Yashwant Rao (popularly known as MY) Hospital, of Indore, the biggest commercial city in Madhya Pradesh. Amidst severe financial crunch, the then district collector made use of an obscure official directive, permitting the collector to set up RKS. Put simply, it meant involving people in running the hospital as also for the welfare of patients. The RKS was formed; an appeal was made to people and charitable organizations for donating money for the purpose. The response was quick as soon the money started flowing. Within a month Rs. 48 lakhs (4.8 million rupees) was collected. That was enough not only to tide over the immediate crisis but also to refurbish the old hospital and put it under a different management system. The district administration, doctors, nurses, para-medicos, donors, people's elected representatives and the press- all the possible local level actors decided to join hands together to keep the momentum on for the upkeep of the hospital and improve upon its existing services. And thus, RKS was given a formal shape and authority (See, Kumar 2004, 2009).

market forces (excepting the areas where NGOs were involved), the RKS looked for direct involvement of the users (people) and service providers (doctors, para-medicos) in running the public hospitals. Thus if the motivational factor in the case of the former was profit, the latter instance was of meeting the social goal and, by extension, raising the social capital.

The effectiveness of RKS-led reforms in MP in terms of ensuring transparency and accountability of the new management structure as well as patient's satisfaction was highlighted in two studies²² (Kumar 2004 & 2009). Yet another study (Shariff & Mandal 2009) also looks into impact of user's fee (but sans RKS) in delivery of health care services, covering a relatively large number of community health centres and district hospitals selected from as many as eight states.

Findings: The RKS driven reforms seem to have injected a new lease of life to the near-defunct government hospitals in Madhya Pradesh. Thanks to the resources generated on account of user fee, new structures were created and additional resources were used to create more facilities to serve patients. In fact, additional (but contractual) staffs (paramedics and support) were recruited to serve them without putting financial burden on the state exchequer. Steps were taken to enforce accountability of the staff, including doctors as also transparency in the use of available resources, though on both these counts there was much to be desired of. The functioning of hospitals in general had improved on account of limited delegation of authority and responsibility sharing, though predictably, not in equal measure everywhere but lack of team spirit was noticeable everywhere either because of appropriation of space by the doctor- in-charge of the hospital or because a very large number of staff including doctors had not imbibed the spirit of reforms, therefore, they were skeptical of small impacts that reforms generated. In any case, the public hospitals were flush with

²²The first was essentially a case study of a hospital while the other was based on data collected (case study method) from ten hospitals, selected from as many as five districts of MP. The sampling was purposive and hospitals were selected following discussions with the concerned officials, including the director, health services and a senior officer belonging to elite Central administrative services (of MP cadre) who happens to be the progenitor of this reform package (Ibid).

resources, thanks to the willingness of patients to share the cost of treatment by paying the user fee. They were paying for all the available services under the same roof. In the pre-reform period, hospital visit was restricted to consultation only. And only the poor patients had been availing barely minimum services rendered to in-ward patients. A very large number of patients and their attendants interviewed expressed satisfaction with the functioning of the hospitals. "The substance of their response, though narrated variously was that the quality of services had gone up and several facilities had been added; the doctors and nurses were more attentive", a study (Kumar 2009) had noted.

Monitoring was limited as it was more geared towards observing procedures than an exercise in ushering dynamism in the functioning of the RKS. "Indeed, the main actors of the RKS, noble souls apart, seem to be complacent, happy, satisfied, even saturated with their performance, as if they have reached the end of the journey; there was nothing beyond. Admittedly, the task was far from being completed. Undoubtedly, less than a decade period is too short to internalize the essence of the reform by all the stake holders, the report had liberally observed, though it had noted disturbing signs. The glaring shortcoming of this entire endeavour was the fact that instead of making RKS a truly broad based body vested with the decision making, its role was restricted to the management of locally used resources (user fee, donations etc.). The hospital administration in general powered by the annual budget received from both the central and state governments was simply kept beyond the purview of the new management structure.

Another study (Shariff & Mandal 2009) had also found that people were willing to pay for better services, including medicines. In Bengal a recommendation letter from a political leader was enough to get exemption²³ from user fee. Quoting hospital staff in general, the report had observed that user fee had been helpful in upkeep of the hospital. Indeed, "direct access and control over

²³In Madhya Pradesh, on the other hand, a phone call or a letter from a journalist or local level politicians would be enough to ensure exemptions. Chief Medical officers of several hospitals had earlier confided this fact to the author.

resources has proved to be beneficial in improving the hospital infrastructure such as repairs of water tanks, electricity generator and incinerator, and to alleviate shortage of disposable items, medicines and surgical equipments.... ambulances etc. (Shariff, 2009: 161) ‘While the financing of operations and maintenance through user charges has offered greater autonomy and flexibility to the health care institutions to improve the efficiency of hospital resources’...it was equally true that “not all possible gains are being exploited...management and utilization of resources taking too much time of doctors which they are not trained for...poor people not even aware of exemption provision bottlenecks in the system producing BPL card etc. couldn’t evaluate impact in terms of patients satisfaction because of data constraints..ibid; 164)

Strengthening Existing Institutions in Orissa

A number of reformative steps were taken in Orissa in mid-1990s. At the core of these initiatives was the recommendation of a House Committee of Legislatures that had examined the following issues: a) raising resources to cure the sick health sector; b) introducing user fee in the district hospitals and associate hospitals of medical colleges; and c) banning private practices of government doctors. This was followed by evaluation report of two projects of DFID on the subject, calling for initiating reforms. Shortly thereafter, the state witnessed unfolding of a World Bank sponsored project – Orissa Health Systems Development Project (OHS DP) – aimed at invigorating secondary and tertiary level health institutions (Kundu, 2009).

Accordingly, user charges were initiated in medical college hospitals in 1997, subsequently, extended to the district hospitals and finally, to the hospitals located at sub-divisional headquarters. Next was the setting up of district cadre²⁴ for paramedics. Multi-tasking of health personnel, particularly lab technicians was yet another ingenious reform measure undertaken in the state. It needs mentioning that earlier there used to be single tasked personnel responsible for examining disease specific slide, say a

²⁴The earlier system of having a state cadre of paramedics was plagued with absenteeism since professional of coastal areas, particularly female staff, were reluctant to take up their postings in relatively backward western part of the state. They had thus become more a liability than a service oriented professional cadre.

lab technician for testing malarial infection only. For testing blood sample for TB, either recruit another technician, adding cost to the system or there would be time lag when taken recourse to higher level hospitals. Either way, the single task technician would sit idle, wasting resources. With just one stroke, government was simultaneously able to reduce cost and make effective use of trained human resources.

Likewise, a *Zila Swasthya Samiti* (District Health Committee) was created by merging a number of identical societies dealing with individual diseases such as Malaria, TB, leprosy etc. In continuation, two pronged strategies were adopted to overcome problem of doctor’s absenteeism from rural/ remote areas. At first, postings of young medical graduates to remote areas PHC were incentivised by reserving seats for them for post graduate courses and secondly, exposing medical graduates to the functioning of health centres at grassroots level by introducing mandatory training for interns in social and preventive medicine at PHCs and CHCs level. That apart, the government also made cost free treatment of five diseases - leprosy, malaria, acute respiratory infections, scabies and diarrhoea - identified as major causes of morbidity (Kundu, 2009).

Taking a cue from Tamil Nadu, Orissa also opted for centralised procurement (through open tendering process) and supply of generic (not the branded ones) drugs based on WHO-prepared list of essential drugs. It also decentralized decision making to PHC in-charge for maintenance of and provided untied fund worth Rs 10, 000 for meeting other petty expenses.

Decentralization & Community Participation in West Bengal

In view of the embedded pitfalls in a centralized health system, there had been demand for introducing decentralized health delivery system. Not only would this make the system relatively efficient and cost effective, the proponents of decentralization argued, but would also make the system transparent and accountable to the people. Acting on this line of thinking, the West Bengal government aligned its sub health centres, PHCs and *Anganwadis* with the three-tiered panchayati raj institutions. This entailed involvement of village and block level panchayats in influencing the functioning

of PHCs and SHCs in planning and implementing promotive and preventive health care services. Taken together, it was believed, this will enrich the quality of health delivery services. This will ensure, if nothing else, accountability of field level health officials to their departmental supervisors but also to the local level panchayats. Above all, “by transferring the very important function of maintaining the physical assets of the local level health institutions from PWD (public works department) to the panchayats, a crucial step was taken toward devolution (Ghosh, 2009). Prior to that the arrangement worked out by the government was partial decentralization, termed as ‘de-concentration’ whereas devolution necessitated transfer of functions along with funds and functionaries to local level elected panchayats. With this, new possibilities were opened up, as illustrated below, for community participation and augmentation of resources both local as well as departmental for delivery of health services.

The Amkopa Experiment: Launched as a pilot project in 2003 in a few selected gram panchayats of West Medinipur district, at the core of Ampoka initiative was *Swasthya Sahayikas* - studied at least up to 8th standard, resident of the same village where she would serve as volunteer and preferably a member of an active self help group.

Around 40 women SHG members were selected in the first lot to serve around 30 villages and neighbourhood. In their first meeting with the officials, they were briefed by the Block Medical Officer and the elected panchayat representatives on their role and functions. They were asked to conduct household health survey on wide ranging aspects such as nature of ailments and expenses incurred on their treatment during the last one year, pregnancy, nutrition, child birth, status of immunization, contraceptives used, drinking water, sanitation and personal hygiene practices etc. By way of demonstration they were also exposed to the functioning of PHC where they also received formal training on their day to day work.

With a medical kit containing essential items²⁵, they returned back on bicycle provided by the government

²⁵Apart from first-aid materials, including thermometer and bleaching powder, the medical kit also contained ORS packets, medicines applicable in case of common diseases, antibiotic ointment etc.

to cover around 60-65 households by each *Sahayika*. “They started advising household members directly on various preventive health care matters. In order to look credible, they themselves started following hygiene practices....got sanitary toilets constructed in their houses before they started advising people on sanitation....their credibility increased when they enabled people to access facilities available at health centres, and by their interaction with staff of SHC or with doctors at PHC was indeed helpful in bridging the gap between the community and the health delivery institutions (Ghosh 2009: 59).

Procurement & Supply of Drugs in Tamil Nadu

In order to strengthen infrastructural support for public health, a number of reformative steps the state government in Tamil Nadu had taken up in the pre-NRHM period. This had included expansion (30-bed capacity with operation theatre, labour ward etc) of selected PHCs, staff (nurses, sanitary workers) recruitment on contract basis etc by making use of untied fund available with PW Society and discretionary local funds of MLAs, ward commissioners, District Collector. In addition to all that and with the World Bank fund driven *Health Systems Project* (HSP), the health department had also initiated round the clock ambulance services. It is a different matter altogether that the ambulance was largely used for ferrying expectant mothers for institutional child delivery. The HSP funding had also helped public health directorate to maintain a network of paramedic field staff including Village Health Nurse²⁶ (VHN), Health Inspector (3-4 at every five thousand population). It needs mentioning here that unlike in other states (barring Kerala), the main (regional) Dravidian parties had kept public health on their agenda for quite long. Again, besides Kerala, this is the only state which had its state Public Health Act in operation since pre-independence period. It is hardly surprising therefore that over the years the state has had witnessed innovative programmes in correspondence with its leadership concern over matters pertaining to public health.

The creation of Tamil Nadu Medical service

²⁶Village Health Nurses are known to have been introduced in Tamil Nadu in the late 1970s itself, around the time of the Alma Ata Declaration.

Corporation (TNMSC), an autonomous body in operation since 1995, for procurement and supply of drugs is yet another instance of political support creating space for innovation. Unlike a plethora of state corporations, the TNMSC is entirely different in terms of its structure, operations and effectiveness. First of all, it was designed in such a way that it would hardly have any permanent staff, excepting its chief accounts officer designated as company secretary. The health secretary is the ex-officio chairman but for all practical purposes it is headed by the managing director, an IAS officer of the state cadre holding this tenured position. The rest are on deputation or the employees belonging to other organizations to which certain services are outsourced. All this has helped minimize its overheads and administrative expenses. Most importantly, it does not have a separate budget as its expenses are covered by all the three separate health directorates, looking after exclusive domains of medical education, public health and medical services respectively. Each directorate for instance, has its separate sub-heads for drug purchase of which '90 per cent of the budget meant for the purchase of drugs' is passed on to the TNMSC, the 'remaining 10 per cent is retained with the directorates to purchase any drug outside the list, but considered essential' (Lalitha, 2009). It has been functioning efficiently largely due to political support extended to it by the successive regimes and greater amount of transparency brought in its entire operations. This includes making inventory of drug list, open tendering and selection of bulk medicine supplier, transport and warehouse arrangements for their efficient distribution to multiple public hospitals and health centres dotted all through the state²⁷. In essence, this also meant reallocation of the budget and its rational use by a corporation meant for this purpose.

Above all, this is the only state which has restructured its health districts beyond the boundaries of revenue districts. Tamil Nadu, for instance, has 30 revenue districts whereas it has 42 health districts, each under the charge of a Deputy Director (Health) level officer. S/he commands a battalion of around 500-600 health department officials including drivers,

cooks, sweepers etc., much more than prevailing staff provision elsewhere in India. The public health directorate, one of the three directorates of health department in the state, commands lion's share of the health budget and the doctors manning the field units including PHCs are kept separate all along their career once they become part of it.

Health Insurance

India is one of the countries with the highest out-of-pocket expenditure (OOP) on health. Additionally, out of pocket expenditure is the dominant form of health care financing in the country. This accompanied by high levels of poverty, makes seeking health care a catastrophe for many. It is apparent from the fact that about 40% of individuals either borrow money or sell assets to pay for health care and almost one-quarter of those hospitalised fall below the poverty line (Peters, 2002). Also, financial hardship, is a major reason cited by almost 40% of low income residents in not seeking health care (Yip and Mahal, 2008). One of the reasons that make it catastrophic is that insurance or any form of pre payment is not well developed in India, thus increasing the burden on out of pocket expenditure. Health insurance is seen as a way in which this burden may be reduced. This section thus looks at the development of health insurance in the country.

The Act that governs insurance in India today was framed in 1938, nearly a decade before India's independence, though the first Insurance Act was passed in India in 1912 (Rao s, 2005). The first major initiative in the history of insurance in India came about only in 1972 when the insurance industry was nationalised; as many as 107 private insurance companies were brought under the General Insurance Corporation (GIC) (Rao, 2005). Another milestone for the industry came about with the Parliament passing the Insurance Regulatory and Development Authority (IRDA) Bill in 1999. In its new form, the Bill opened up of the insurance market to private players and international agencies. It therefore was a defining moment for private corporate insurance firms dealing with health care and health insurance. Many international firms entered into partnership with their Indian counterparts in stepping into the health care market.

²⁷A detailed account of TNMSC is provided in a chapter entitled, 'Access to medicines in public Health Care', see, Lalitha (2009).

Under this Bill, to begin operations, foreign promoters are required to have a capital of Rs.100 crore (1000 million rupees) and are allowed paid up capital of up to 26 % in an Indian company. As part of the Bill, the Insurance Authority and Development Authority (IRDA) was set up as an autonomous body to regulate and promote the insurance industry. The IRDA aims at promoting competition by deepening customer satisfaction through expanding consumer choices and lower premiums.

However, health insurance or health sector has not found any reference in the IRDA. Mahal (2002), while observing that the policy environment in India is such where health insurance continues to be neglected, notes that health is not mentioned in the nearly 175 pages of the Insurance Act of 1938. Even in GOI's report on Insurance reforms (1994), there was precisely one reference to health insurance. Health Insurance can be of the following types: (i) Social health Insurance Schemes, (ii) Private Health Insurance, (iii) Community-based health Insurance, and (iv) Universal Health Insurance Schemes.

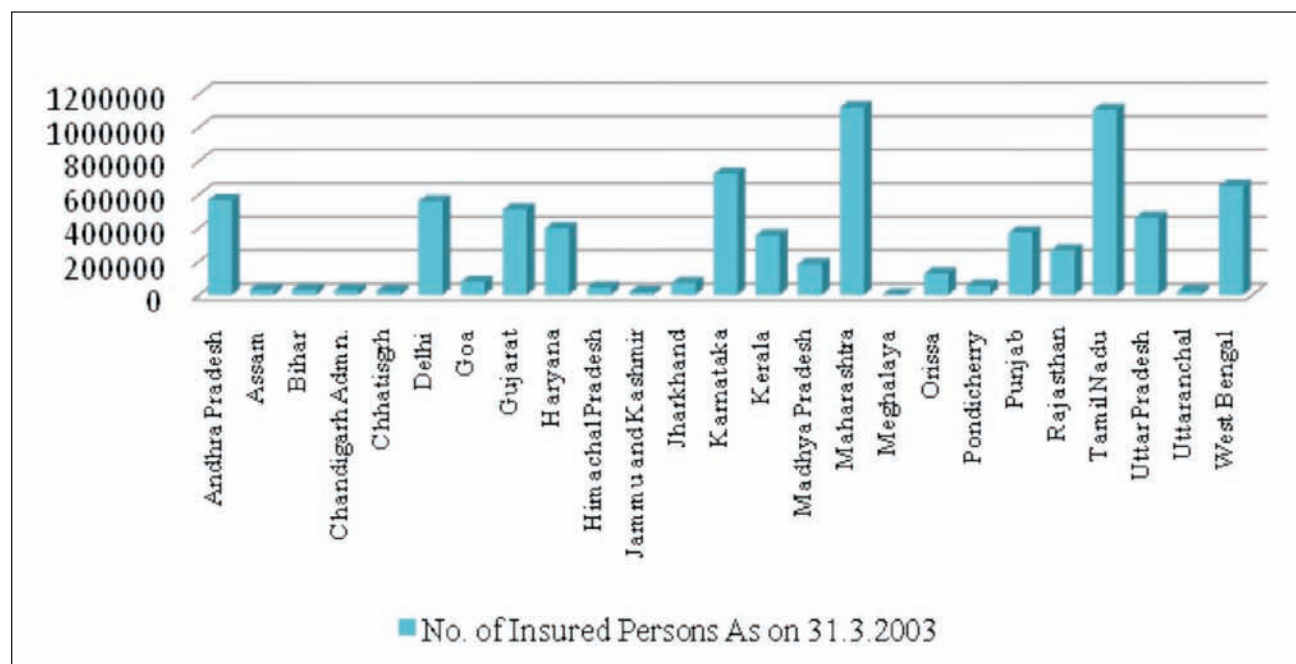
Social Health Insurance (SHI)

In India, two systems of state based health insurance schemes exist that are considered as social health insurance schemes 1.) Employees State

Insurance Scheme (ESIS) and 2.) Central Government Health Scheme (CGHS). However some (Gupta and Trivedi, 2005)) feel that only the ESIS can fit into the classical definition of SHI. The main characteristics of it are: it is mandatory, contributory and there is an Employer State Insurance Corporation (ESIC) that manages the funds. The CGHS on the other hand, though contributory and employment based, is not compulsory and nor does it have a separate fund manager. In any case, these schemes are for the employed / workers in the organised sector accounting for a thin minority of the total population.

The ESIS is applicable to non-seasonal factories using power and employing 10 or more persons and non power using non seasonal establishments such as shops, hotels, restaurants cinemas etc employing 20 or more persons. It does not cover the unorganised sector workers, self employed nor the seasonal workers of factories, mines and plantations. This is an integrated social security scheme providing not only health insurance benefits like medical benefits but also cash benefits in contingency cases like maternity, death or disability due to employment injury or occupational diseases. Table A 6.1, appendix and Fig. 6.1, below show the state wise number of insured persons under the ESIS in 2003.

Fig. 6.1 : State-wise No. of Insured Persons Covered under ESIS in India as on 31-3-2003



Central Government Health Schemes (CGHS)

The CGHS, introduced as contributory plan in 1954, was started in Delhi. It now covers 23 cities across the states (Gupta & Trivedi, 2005). Facilities like outpatient care, emergency/inpatient care, free drugs supply, laboratory and radiological investigations are provided. It is applicable to the following categories of government employees :

- All Central Govt. Servants paid from Civil Estimates (other than those employed in Railway Services and those employed under Delhi Administration except members of Delhi Police Force).
- Pensioners drawing pension from Civil Estimates and their family members –
- (Pensioner residing in non- CGHS areas also may obtain CGHS Card from nearest CGHS covered City)

The Members and ex- Members of Parliament, Judges and former Judges of the Supreme Court and High Courts, Employees & Pensioners of Autonomous Bodies covered under CGHS (Delhi), ex- Governors and ex-Vice Presidents, former Prime Ministers, Freedom Fighters, Accredited journalists etc.

Currently there are nine lakh CGHS beneficiaries in the country of which six lakh are serving officers. A recent decision by the health ministry has expanded

the ambit of the CGHS to include dependent children of widowed/separated daughters of beneficiaries²⁸

It provides its services through dispensaries that are now called ‘wellness centres’ / polyclinics that run under both, allopathic as well AYUSH systems of medicine. Presently, there are:

- 248 allopathic dispensaries, 19 polyclinics. 78 Ayush dispensary/ units
- 3 Yoga Centres 65 Laboratories & 17 Dental Units (<http://msotransparent.nic.in>)

The CGHS is also seen to be wrought with many issues such as inefficiency, problems of coverage, corruption. In fact, the CGHS is considered to be “a high cost enterprise with an inequitable spread of service delivery and no control system for checking market failures as moral hazards” (Rao S 2005) . Rao also observes, while analysing the total expenditure of CGHS as well as on CGHS, that of the total expenditure of CGHS, a third is spent on wages and salaries of the staff. Analysing the expenditure on CGHS from 1999-2004 annually, three important points are observed:

- 18% of the health department’s budget is spent on less than 0.5 % of the population.
- Most of the expenditures are for the Central Governments with only 12% being contributed.

Table 6.1 : Comparison between ESIS and CGHS

Year started	1948	1954
Beneficiaries	Factory sector employees (and dependents) with income less than Rs.7500 per month	Employees and dependents of central govt. employees, current and retired, some autonomous organisations, MPs, judges, freedom fighters, accredited journalists
Financing of scheme	4.75% of employees wages by employers, 1.75 % of their wages by employees ; 12.5 % total expense by the state governments	Varies from Rs.15 to Rs.150 per month based on salaries. Mainly financed by Central govt funds.
Benefits	Medical and other health related benefits through ESIS facilities & partnerships	Medical care through public facilities and restricted private facilities
Coverage	About 353 lakh beneficiaries in 1998	About a lakh beneficiaries in 1996

Source: Rao, S (2005)

²⁸For details, see Hindustan Times, 26/2/2012

- A sharp increase in in-patient expenditure is observed in the period 2001-2004. This coincided with an increase in membership of retired persons(Rao, 2005)

Taken together, the ESIS and the CGHS cover only about 3 per cent of the total population. The following table (Table 6.1) draws comparison between the two schemes-ESIS and CGHS.

There are other schemes under specific ministries that extend health coverage to their employees. Ministries like railways, defence and coal provide health benefits to their employees. Apart from this, there are schemes for artisans, handloom workers etc.

Private Health Insurance

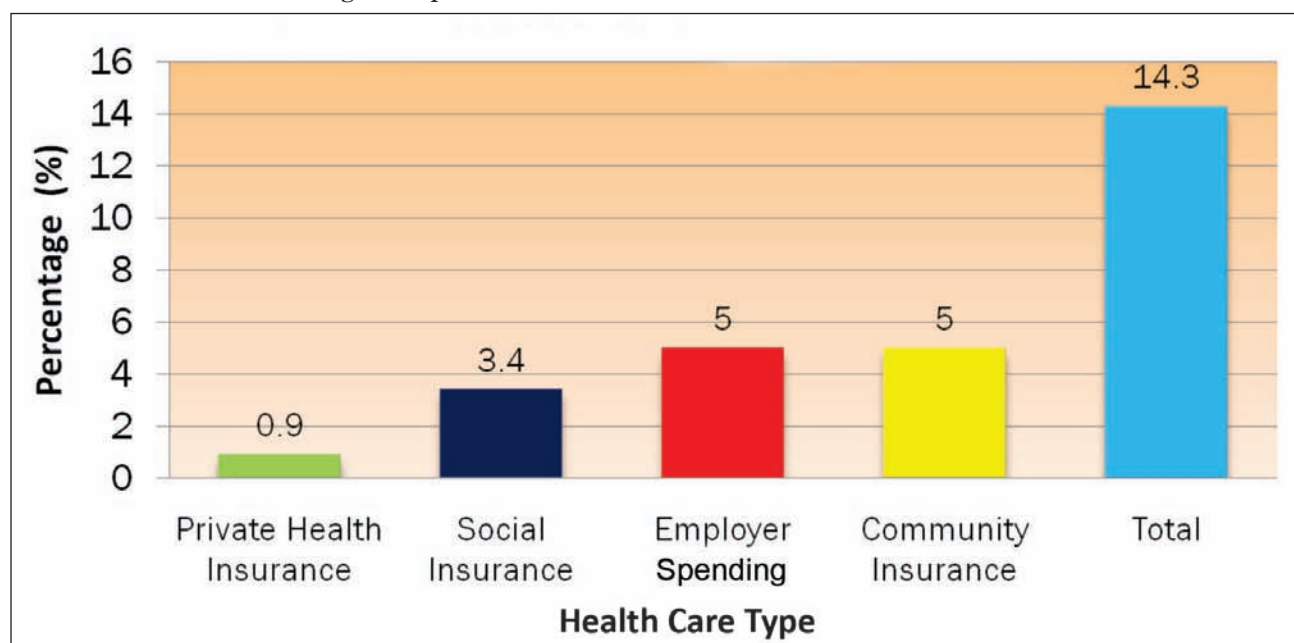
The Insurance Regulatory and Development Act (IRDA) of 1999 enabled the entry of private players into the health insurance sector. With this, a regulatory framework was established to protect the interests of the policy holders. Apart from this, a landmark decision of 2001, that established Third Party Administrators (TPA) led to the growth of the industry by providing an administrative intermediary structure (Rao, 2005.)

There are a total of 24 general insurance companies 29 TPAs²⁹. Among the health insurance companies, there are different kinds catering to different aspects of health insurance namely

- Non-life insurance companies –New India, Oriental, United India in the Public and ICICI Lombard, Reliance, Bajaj Allianz etc in the private.
- Specialised health Insurance Companies- STAR Health and Allied Insurance and Apollo DKV insurance
- Life Insurance Companies- LIC and other private companies

As shown below (Fig. 6.2), private health insurance accounts for a very small proportion of the population: merely 0.9%. Private companies are selective in targeting their potential customers – the young, healthy, rich males, leaving what are considered bad risks – the old, poor, young women in reproductive age group and the ill, to be taken care of by the public sector.

Fig. 6.2 Population covered under Diverse Health Care Provider



Source: www.rsby.nic.in

²⁹IRDA, <http://www.irda.gov.in>

Taken together, both the public as well as private players in the health insurance sector, the New India Insurance is at the top, commanding one-fourth of the total (24%) market share followed by ICICI Lombard (17%) (See, Fig. 6.3). Among the prominent private health insurance provider, it is ICICI Lombard which leads the market followed by Reliance and Bajaj Allianz (See Fig. 6.4).

Community-Based Health Insurance (CHI) in India

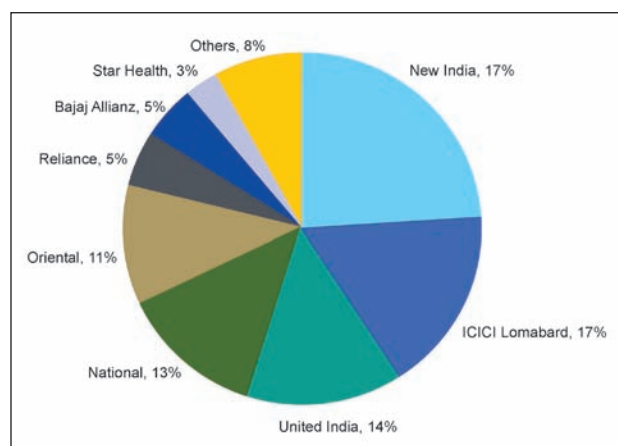
The community health insurance (CHI) is described in various terms, such as ‘micro health insurance’ (Droer et al 1991), ‘local health insurance’ (Criel 2000), ‘mutuelles’ (Atim, 1998) cited in Devadasan et al (2004). Accordingly, CHI is described as “any not for profit insurance scheme that is aimed primarily at the informal sector and formed on the

basis of a collective pooling of health risks and in which the members participate in its management” (ibid).

Under the Bamako Initiative for Africa in 1987, UNICEF initiated community financing as a method of raising finance at the community level. With the basic aim of revitalising public health systems and promoting decentralised decision making, it encouraged community participation through management of services and generating funds locally. The idea of community based health insurance seems to have been borne from this, though instances of this could well have been practised earlier.

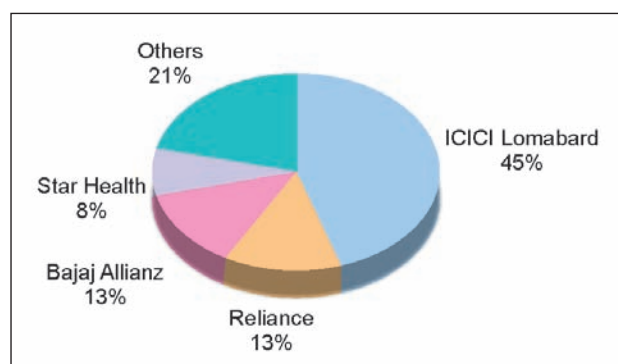
In India, for instance, CHI can be traced back to 1952, when the Student’s Health Home (SHH) started in Kolkata as part of a student’s movement. It caters to the students in schools and universities of West Bengal even today. The health insurance scheme for SEWA members is also another example of CBHI (See Box 6.1).

Fig. 6.3 : Market Share of Key Players in Health Insurance



Source: IRDA

Fig. 6.4 : Market Share of Key Players in Private Health Insurance Sector (2008)



Source: IRDA

Box 6.1 : SEWA Insurance Scheme

Formed in 1972, the Self –Employed Women’s Association or SEWA as it is popularly known is a labour union of more than 6,00,000 women workers working in the informal economy in Gujarat. One of its first initiatives was the SEWA Bank, a microfinance organisation that addressed the key issue of financial services for the women workers.

In 1984, Aarogya SEWA (SEWA Health) a community based primary health care programmes was established. This was followed by Vimo SEWA (or SEWA Insurance) in 1992. This provided a comprehensive insurance package including life, health (hospitalisation) and asset insurance. It covers SEWA members, their spouses and children. Apart from Gujarat, it is also implemented in other states.

Source: Acharya & Ranson, 2005

Three basic designs of CHI are available in India depending on who is the insurer (Devadasan, 2004)

Type I or Health Maintenance Organisation (HMO) Design – Hospital plays the dual role of providing health care as well as running the insurance programme e.g ACCORD, VHS

Type II or Insurer Design- Voluntary organisation is the insurer, while purchasing care from independent providers e.g DHAN Foundation

Type III or Intermediate Design-Voluntary organisation plays the role of an agent, purchasing care from providers and insurance from insurance companies e.g SEWA, Karuna Trust, BAIF.

The Table 6.2 below lists some selected CBHI schemes that are functioning in the country, in partnership with various organisations.

In India, the dominant pattern of healthcare financing for a household is out of pocket expenditure. With escalating costs of hospitalisation, almost 40% of individuals borrow money or sell assets in order to pay for hospitalisation. Spiralling health care costs including hospitalisation costs, has been the cause of people falling below the poverty line in at least 24% cases of those hospitalised (Peter et al 2002 cited in

Devadasan et al 2004).

Publicly funded health insurance schemes attempt to lessen the catastrophic spending of households by reducing hospitalisation expenses and providing financial risk protection. Many such initiatives by the central as well as some state governments have been taken to provide financial risk protection to the poor in times of ill health.

1. The Universal Health Insurance Scheme (UHS) for below poverty line (BPL) population was introduced in 2003 by the union (which)(NDA) government. The government gives a subsidy of Rs.100 per BPL family, and the four public sector insurance companies sponsor this scheme by offering an annual premium of Rs.365 for an individual and Rs.548 for a family of five members. The benefits include reimbursement of medical expenditure up to

Table 6.2 : Selected CBHI Schemes

Name and Location	Year	Population Covered	Benefits Package
ACCORD, Tamil Nadu	1992	Tribals living in Gudalur taluk and are members of the AMS	Hospitalisation cover upto Rs.1500/ person /year
BAIF, Maharashtra	2001	Women members (between 18-58 yrs)	Hospitalisation cover upto Rs.5000/person /year
BULDHANA Urban Cooperative & Credit Society, Maharashtra		Members	Hospitalisation cover upto Rs.5000/ person /year
DHAN Foundation, Tamil Nadu	2000	Women members of micro finance scheme	Hospitalisation cover upto Rs.10000/ person/year
Karuna Trust, Karnataka	2002	BPL families in T Narsipur Block	Hospitalisation cover upto Rs.2500per person per year. Includes ambulance services and wages lost
MGIMS Hospital, Maharashtra	1981	Small farmers and landless labourers living in 40 villages around Kasturba Hospital	Hospitalisation cover upto Rs.1500/ person/year
RAHA, Chhattisgarh	1980	Poor people living in catchment area of the 92 rural health centres and hostel students	Primary and secondary health care
SEWA, Gujarat	1992	SEWA Union women members and their husbands living in 11 districts of Gujarat	Hospitalisation cover upto Rs.2000per person per year
Student's Health Home, WB	1952	Full time student in WB state from class5th to University level	Primary and secondary health care
Voluntary Health Services Centre, Tamil Nadu	1972	Total population of the catchment area of 14 mini health centres	Hospital cover
Yeshasvini Trust, Karnataka	2003	Members of district farmer's cooperative societies and their families	Cover for all surgeries upto Rs. 100000

Source: Universal Health Insurance Scheme Devadasan et al 2004

Table 6.3 : Selected State-wise No of BPL Families Covered under UHIS

States	2004-05	2005-06	% of Change
Andhra Pradesh	18591	12587	-32.3
Gujarat	6775	1379	-79.6
Haryana	656	452	-31.1
Himachal Pradesh	381	58	-84.8
Jammu & Kashmir	168	81	-51.8
Karnataka	2692	2201	-18.2
Kerala	24067	36829	53.0
Maharashtra	3008	447	-85.1
Orissa	71	99	39.4
Punjab	671	250	-62.7
Rajasthan	4227	4272	1.1
Tamil Nadu	696	492	-29.3
Uttar Pradesh	1161	714	-38.5
India	65718	68296	3.9

Source: Lok Sabha Unstarred Question No. 2207 dated 10.03.2006

Rs. 30,000 and illness compensation of Rs. 50 per day for the days of hospitalisation of the earning of the head of the household. However the uptake of this has been slow and in 2005 as only about 2% of the policies had been sold to BPL families (See Table 6.3).

1. Social Security Scheme for the Unorganised Sector

A comprehensive social security package to be implemented for two years on pilot basis was announced by the labour ministry for the workers in the unorganised sector. A single contribution of Rs. 50 per month from the workers joining the scheme in the 18-35 age group and Rs. 100 per month from workers of 36-50 years age group is to be made. The contribution from employers will be Rs.100 per employee and the government will add up 1.16 % of minimum wages of the workers notified from time to time.

2. Rashtriya Swasthya Bima Yojana

RSBY, a Central government insurance scheme for the BPL families in the unorganised sector, was announced by the Prime Minister in 2007. Of its total cost about 75% is provided by the federal government and the remaining by the state governments. Under the scheme, a BPL family (including head of the

household, spouse and three dependants) is entitled to medical expenses up to Rs. 30,000 per annum for a nominal registration fee of RS. 30. Pre-existing medical conditions are covered and there is no age limit. For Ch 6, p. 22 under RSBY

Under this scheme, driven by the Union Ministry of Labour and employment, beneficiaries (read BPL families) can choose from amongst designated 981 public hospitals and 3146 private hospitals. By April, 2010, the executing agency claimed to have issued 14.45 million smart cards to 29.76 million beneficiary families across 172 districts. Distribution of smart cards is still in experimental stage therefore they are not hassle free. The financial cover provided under this scheme and similar other medical insurance schemes offered by the state governments “remains insufficient...Most schemes cover treatment costs of hospital admission or serious illness, and not outpatient care. Also, many of the schemes do not reimburse costs of drugs – a major out-of-pocket expenditure” (Lancet, February 19, 2011).

It needs mentioning that in 1993-94, households in rural areas were spending 5.4 % of the total household consumption on healthcare which a decade later (2004-05) went up to 6.6%. The corresponding figures for urban households were 4.5% and 5.2% respectively. This increase was attributed to the rising

cost of drugs by more than 300% between 1993-94 and 2006-07 (Lancet Feb 19, 2011)

It is apparent from the fact that (in 2005) three-fourths (74%) of expenditure was incurred not for in-patient care but for out-patient treatment. Of this 72% counted for drug alone.

The NFHS (2005-06) revealed that one out of ten households in India had at least one member covered under any medical insurance. This is hardly surprising in view of the fact that an overwhelming proportion, 93% of total work force belong to unorganised sector who are devoid of any permanent regular source of income.

Tables 6.4 : Reasons for Not Accessing Public Hospitals

Reason	Rural	Urban
Not satisfied with doctor or facility	41	45
Distance covered for reaching public facility	21	14
Non-availability of facility & services	30	26

In terms of expanded size of health department personnel and public expenditure on health, Tamil Nadu stands as an exception. Health has been on the political agenda of both the Dravidian parties which is rooted in the Dravidian socio-cultural movement aimed at overcoming social barriers. In continuation, the successive government of this south Indian state has shown a stronger commitment to invest in sectors that are complimentary to health such as nutrition, water and sanitation, education and basic infrastructure. (Lancet, Feb 19, 2011:673) In contrast, particularly the northern states provisioning on health, both on human resources and infrastructure has been poor. Correspondingly, the health outcomes have remained at variance.

Beyond lack of political backing, insufficient public provisioning in the health and allied sector, there were other reasons restricting people from approaching public health centres. Based on several (42nd, 52nd & 60th, as cited in Lancet, Feb. 19, 2011) rounds NSSO survey on health parameters, including patient's satisfaction, a report of MH&FW (2004) has *inter alia* cited the following reasons: not satisfied with

treatment at government hospitals; distance-faraway location of health facility; non-availability of services (both in rural and urban areas but with percentage point differences). Consequently, people approach private providers for consultation (outpatient care) 78% in rural areas and 81% in urban areas). For inpatient care, 58% of Indian people in rural areas and 62% in urban areas accessed private health facilities. (Lancet Feb 19, 2011: 671)

Above all, the prevailing health facility scenario and outcome was aptly summarised by the Planning Commission :

“There are exceptions, but by and large, the quality of care across the rural public health infrastructure is abysmal and marked by high levels of absenteeism, poor availability of skilled medical and para-medical professionals, callous attitudes, unavailable medicines and inadequate supervision and monitoring. The fact is that when people at the grassroots, first seek diagnosis and treatment for illness, an estimated 70-85 per cent among them, visit a private sector provider (PSP) for their health needs. Private providers are fragmented along diverse delivery models, not always present in the most under-served states, largely unregulated, and the mushrooming of sub-standard facilities is dominated by unqualified practitioners. All of this yields enormous variation in the quality of diagnosis and treatment” (Mid-term appraisal, 10th Five year plan, 2005).

According to a recent report (*Economic Times* 19/3/2012), only 11% of the beneficiaries of RSBY are in UPA ruled states. It is states like Bihar, Kerala, Gujarat, and West Bengal that account for the rest. It is also reported that three-fourths of the poor BPL families in four of the 14 UPA states have covered under RSBY.

An inventory of state-wise health insurance scheme cutting across the categories referred above is given in Table 6.5 and 6.6, this includes:

1. Andhra Pradesh- Rajiv Aarogyasri Scheme, 2007
2. Tamil Nadu- Kalaingar's Insurance Scheme, 2009; renamed Tamil Nadu Insurance

Table 6.5 : A Comparative Account of Insurance Scheme under Public-Private-Partnership Mode

Name of the prog	Yeshaswini	Arogyasri	Vajapayee Arogyasri	Rajasthan Swasthya Bima Yojna	Kalaigmar Insurance Scheme for Life Saving Treatments
Type of provider	Public-Private Partnership	Public	Public	Public	Public-Private-Partnership
Location	Karnataka	Andhra Pradesh	Karnataka	Rajasthan	Tamil Nadu
Provider	Govt. of Karnataka & Yeshaswini Trust	Govt Of Andhra Pradesh	Govt. of Karnataka	Govt. of Rajasthan	Govt. of Tamil Nadu
Starting Year	1st May, 2003	1 st April, 2007		8 th Dec. 2007	
Government Entry	Yes	Yes	Yes	Yes	Yes
Insurer Partner	No	Star Health & Allied Insurances			Star Health & Allied Insurances
Target Group	Rural Harmers	All BPL ration card holders	BPL	BPL	BPL Family + Family whose annual income less than Rs. 72,000 + All members of 27 welfare boards
Intervention Area	Rural	Rural-Semi Urban	Rural + Urban		
Premium Paid by	Insurers & Govt.	Govt.	Govt.	Govt.	Govt.
Premium	Rs. 120 per year	None	None	None	None
Co-contribution	Rs. 110	Rs. 300		Rs. 300 NRHM + Remaining by State Share of NRHM	
Total	Rs. 230	Rs. 300		Rs. 480 + 12.36% Service Tax per BPL family	Rs. 469 per Family
No. of persons Cover	3000000	36,700,000	78,000,000	11537 BPL Family	1.43 corer families
Surgical Coverage	Rs 100,000	Rs 150,000	Rs. 1,50,000	Rs. 30,000 + 1.35 Lacs for critical illness	Rs. 1 Lakhs per family for a period of 4 years
OPD & Misc Charges	Free	Rs 50,000			
TPA	No	No			
Risk	Health	Health	Catastrophic Illness (Health)	Health	Health

Compiled from various sources

Table 6.6 : A Comparison Account of Community Based Insurance Scheme

Sl. No.	Name of the prog	Location	Starting Year	Govt Entry	Insurer Partner	Target Group	Premium Paid by	Premium	No. of persons Cover	Coverage	Type of Insurance
1	ACCORD/ ASHWINI Health Insurance Scheme	Tamil Nadu (Gudalur)	1992	Yes	CORRD AID, Sir Ratan Tata Trust, Royal Sundaram Alliance Insurance Company, Govt of Tamil Nadu	Adivasi Families	Sir Ratan Tata Trust	Rs. 45/ person	7356 (1997)	Upto Rs. 2500	Health Insurance (with NIA)
2	Aga Khan Health Services	Gujrat (Sidhpur)							40,000 (1997)		Health Insurance
3	Apollo Hospital Association (AHA)	Tamil Nadu (Madras)			GIC				10,000 (1995)		Health Insurance (with GIC)
4	ASSEFA (Association of Sarva Sewa Farms)	Tamil Nadu (Madurai)	1993		United India Insurance Co. Policy			Rs. 23/ person		Rs. 25000	Cattle Insurance Health Insurance
5	Cooperative Development Federation (CDF)	Andhra Pradesh (Hyderabad)							26,000		Death Relief Fund (Life insurance)
6	Goalpara Cooperative Health Society	West Bengal (Shantiniketan)							1247 (1997)		Health Insurance
7	Kottar Social Service Society (KSSS)	Tamil Nadu (Kanyakumari)							34,000		Health Insurance
8	Mallur Health Cooperative	Karnataka							7 000		Health Insurance
9	Mathadi Hospital Trust	Maharashtra (Mumbai)							150 000		Health Insurance
10	Medinova Health Card Scheme	West Bengal (Calcutta)							35 000		Health Insurance
11	Navsaranjan Trust	Gujarat			NIA				10 000		Health Insurance (with NIA)
12	New Life	Tamil Nadu							N.N.		Health Insurance

13	Organization for Development of People (ODP)	Tamil Nadu (Mysore)																1 137			Health Insurance (with NIC)
14	Pragati Thrift and Credit Society																	410			Death Relief Fund
15	Raigarh Ambikapur Health Association (RAHA) Medical Insurance Scheme	Madhya Pradesh (Raigarh District)	1972															75 000			Health Insurance
16	Saheed Shibsankar Saba Samity (SSSS)	West Bengal (Burdwan)	1978															6800			Health Insurance
17	Seba Cooperative Health Society	West Bengal (Calcutta)																3000 families			Health Insurance (with GIC)
18	Self Employed Women's Association (SEWA)	Gujarat (Ahmedabad)	1992															93000 (2002)	Rs. 2000		Health Insurance
19	Kasturba Hospital Scheme, Sewagram	Maharashtra (Wardha District)	1972															19,457 (1997)			Health Insurance
20	Social Work and Research Centre (SWRC)	Rajasthan (Ajmer)																20000			Health Insurance
21	Society for Promotion of Area Resources Centre (SPARC)	Maharashtra (Mumbai)																			Health Insurance
22	Students Health Home	West Bengal (Calcutta)	1952	Yes														550 000	Rs. 4 per/ student		Health insurance

Compiled from various sources

Scheme for Life Saving Treatment in 2011.

3. Karnataka³⁰ - Yashaswini in 2003 (pre NRHM), Vajpayee Aarogyasri model 2009;
4. Chattisgarh- CM health Insurance Scheme

A recent study has shown a marginal decline in the household's expenditure on health for the first time in 2009-10. This can be contributed to the fall in share of out-patient expenditure. (Selvaraj & Karan, 2012)

However, there is a mixed response to health insurance schemes. Some feel that such schemes appear to be promoting private players in the (health) insurance sector. For, giving private players a legitimate entry into the health care system without mechanism of regular monitoring could prove counterproductive. Schemes like Aarogyasri health care, for instance, have an inherent bias towards corporate hospitals. Yet another study notes that "the overall structure of the programme is such that it is a cash-rich, no risk enterprise for the healthcare industry in Andhra Pradesh" (Shukla et al 2011). A set of interesting data show that while nearly one-third (32%) of the Aarogyasri cases in government hospitals are treated in small towns and district headquarters, whereas nearly half (46%) of Aarogyasri cases in corporate hospitals are treated in small towns and district headquarters.

Drug Procurement

'Drugs' is listed under the Concurrent List of the Indian Constitution and thus it is governed by both the Central and the State government acts, inherited from the pre-independence Drugs and Cosmetics Act, 1940. The procurement of drugs and medicines in India is done at all the three levels - central, state and district (varies from state to state) of governance. At the central level, drugs are procured for the national health programmes. In some states, decentralised procurement takes place at the district level.

That, apart, the procurement and supply of drugs needed for the vertical national health programmes

³⁰As many as three state supported health insurance schemes, viz; Yashaswini, RSBY and Vajpayee Aarogyasri coexist in this southern state.

is done by the Directorate of Procurement, under the Ministry of Health and Family Welfare through its Empowered Procurement Wing (EPW)³¹. It also enhances the capacity of the central and state government on the supply chain management as well as making the process more transparent.

State level procurement of drugs is carried out differently in different states. While in most states procurement is ensured through their respective departments of health and family welfare, Tamil Nadu is one state which set up the Tamil Nadu medical Services Corporation (TNMSC) in 1994, for procuring drugs and equipments (details already provided under Pre-NHRM reforms section). Besides, illustrating the drug procurement process from states like Rajasthan, Assam and Bihar, a recent study (Selvaraj et al, 2010) observes that drug procurement in India can be seen to be a combination of different mechanisms such as "pooled procurement at the central level and decentralised distribution system in the state such as in Tamil Nadu, and decentralised procurement as in the state of Chhattisgarh and a mixture of the two in the state of Bihar (cash and carry model)". They feel that the kind of mechanism followed in TN is the "key to improve and sustain good governance in medicine supply", since there is clear and detailed documentation of the processes involved and it is a transparent process, and procurement is based on the needs and quantified accordingly.

Involving Multiple Ministries

Manufacturing of drugs entails many functions such as licensing, regulation, procurement etc. Accordingly, these matters are handled by a number of ministries. The table (6.7) lists the ministries and the various bodies constituted under them that are involved in the manufacture and procurement of drugs.

It needs mentioning that under the Drugs and Cosmetics Act, 1940, states are responsible for the regulation, manufacture and sale of drugs³², while central government departments are responsible for other issues related to drug regulation and monitoring. The Central Drugs Standard Control Organisation

³¹Selvaraja et al, PHFI 2010

³²<http://cdsco.nic.in>

Table 6.7 : Ministries/Directorates/Depts. involved in Drug Manufacture, Procurement

Ministry of Health & Family welfare	Ministry of Chemicals & Fertilizers	Ministry of Commerce	Ministry of science & Technology	Ministry of Environment
DGHS, CDSCO, DCGI DTAB, Enforcement & GMP audit Div, Quality Control Division-CDTL, Registration Div, New Drugs Div. Pharmacovigilance, Trainings	Department of Pharmaceuticals NPPA	Patent Office Controller General of patents	DBT CSIR Labs	Environmental clearance to the manufacturing sites
CDTL= Central Drug Testing Laboratory CSIR = Council of Scientific and Industrial Research DCGI= Drugs Controller General of India DTAB= Drug Technical Advisory Board NPPA= National Pharmaceutical Pricing Authority CDSCO= Central Drugs Standards Control Organisation DBT = Department of Biotechnology DGHS= Directorate General of Health Services GMP=				

(CDSCO), under the DGHS (Ministry of Health & Family Welfare) is the nodal body for the approval of new drugs, clinical trials in the country, laying down the standards for drugs, control over the quality of imported drugs, coordination of the activities of State Drug Control Organisations.

It also provides expert advice in order to bring about uniformity in the enforcement of the Drugs and Cosmetics Act. The Table 6.8 lays down the

functions of both the CDSCO and the State Licensing Authority.

Conclusion

To say that governments at the state level seldom bother to take initiatives until they are prodded by the federal government is a fallacy. This mistaken belief however had gained grounds over the years, more particularly in the health sector that is listed under both the Concurrent and State lists of the

Table 6.8 : Functions of Central and States Monitoring Bodies

CDSCO (Central Government)	State Licensing Authorities
Statutory Functions	Statutory Functions
- Laying down standards of drugs, cosmetics, diagnostics and devices - Laying down regulatory measures, amendments to acts and rules. - To regulate market authorization of new drugs. - To regulate clinical research in India. - To approve licenses to manufacture certain categories of drugs as Central Licence Approving Authority i.e. for Blood Banks, Large Volume Parenterals and Vaccines & Sera. - To regulate the standards of imported drugs. - Work relating to the Drugs Technical Advisory Board (DTAB) and Drugs Consultative Committee (DCC). - Testing of drugs by Central Drugs Labs - Publication of Indian Pharmacopoeia.	- Licensing of drug manufacturing and sales establishments. - Licensing of drug testing laboratories. - Approval of drug formulations for manufacture. - Monitoring of quality of Drugs & Cosmetics, manufactured by respective state units and those marketed in the state. - Investigation and prosecution in respect of contravention of legal provisions. - Administrative actions. - Pre- and post- licensing inspection. - Recall of sub-standard drugs.
Other Functions - Coordinating the activities of the State Drugs Control Organizations to achieve uniform administration of the Act; and policy guidance - Guidance on technical matters - Participation in the WHO GMP certification scheme. - Monitoring adverse drug reactions (ADR). - Conducting training programmes for regulatory officials & Govt. Analysts. - Distribution of quotas of narcotic drugs for use in medicinal formulations. - Screening of drug formulations available in Indian market - Evaluation/Screening of applications for granting No Objection Certificates for export of unapproved/banned drugs.	

Constitution. Contrary to this contrived notion, reinforced in the era of economic reforms, this chapter has vividly shown the initiatives taken by the state level governments. Launched under peculiar circumstances and accordingly, varying in nature and their reform contents, the pre-NRHM reforms, as they were, could be seen as testimony to the political will of different political regimes, rooted in different ideological persuasions, in concerned states. It was these successful models, customised to meet emergency situation or to honour long standing demands and surely, taken up on pilot basis, and eventually, subsumed under nation-wide reform. Together, their success also paved the way for reforms in other areas as NRHM, explained in the following chapter, turned out to be a comprehensive reform package, covering associated determinants of public health and introducing new institutional structures.

This has also brought out the financial constraints of state governments that prohibits them from taking sustained reform initiatives. The Sahayika model in West Bengal is a case in point which operated in a limited number of panchayats, if allowed to continue with financial support from the federal government,

could have offered experienced examples of strengthening the illusive community participation and might have impacted the functioning of the accredited social health activist (ASHA) under NRHM.

A host of health insurance schemes, more particularly in the public sector and with or without community contribution, gives an impression of unseen helping hand of the state at work, mitigating the painful sufferings of the people. To say all such schemes are flop would be as untrue as to accept without scrutiny that they happen to be grand success. The truth lies somewhere between the two. What else can explain a fairly large proportion of poor still not been able to access the available health care because of their poor purchasing capacity or substantial, if not equal in proportion, population would not have been debt ridden or slipped into BPL category on account of serious health episodes. The failures or less than success stories are attributed to governance failure. It appears to be equally pronounced in the area which is within the reach of the governmental machinery itself that is streamlining the functions of ministries to avoid red tape and unnecessary overlap.■

HEALTH EDUCATION, RESEARCH & REGULATION

Introduction

Starting from the Bhole Committee Report in 1946, to the launching of the National Rural Health Mission in 2005, the idea of providing for universal and affordable health care has been central to planning the country's health system. An increase in the share of the country's GDP for the health sector is well sought, nonetheless, "substantial government efforts and resources have been devoted to the creation of a wide network of public sector health facilities (ie primary health centres and sub centres, community health centres, district hospitals and tertiary hospitals) at which qualified health workers can provide low-cost services" (Rao et al, 2011). However, as is evident from prevailing data on health statistics, such services have not been able to take off. For a majority of the country's population, quality healthcare from qualified providers is still remains out of reach.. In fact, given the high cost of health care, to many mere access to health care itself is *inaccessible*.

A well functioning health services system requires three components- infrastructure, amenities/facilities and (qualified/trained) personnel/human resources to work in tandem. The onus of providing quality health services to the people, lies on the shoulders of the health personnel working at various levels. Together they form the backbone of the health

services system. While infrastructure might be in place and might even be adequate, in the absence of required number of trained and qualified personnel at these facilities, they would not serve the intended purpose. Thus, education and training of the people delivering these services is an essential and integral component of the health services system.

This chapter is therefore focussed on the evolution of health education (research and regulation) in India through the years. It needs emphasizing here, that prior to the advent of modern medicine, healing and cure in India was rooted in the indigenous systems³³ of Ayurveda, Unnnai etc as well as different forms of faith healing practices. These were culturally defined, and depended upon patronage of clients and passed on from one generation to another. Yet as knowledge systems they were not accessible to all as learning was restricted; at least, not open to all.

Medical Education: The first modern medical

³³For long, India had nurtured three major indigenous systems of medicine: Ayurveda- the Hindu medical system, Unnani- the Greek system of medicine brought to India from West Asia by the Muslim rulers of India and the Siddha system- a specialised branch of Ayurveda. Together, along with homeopathy and naturopathy, they are now redesignated as Indian Systems of Medicine (ISM). The term *AYUSH* denoting Ayurveda, Yoga, Unnani, Siddha and Homeopathy is now in use.

Box 7.1 : Resurrecting LMP?

The Licentiate Medical Practitioners (LMP) played an important role in rural health care, particularly during the last 25 years of British rule before they were abolished in 1947. While the exact year of its initiation is not known, it certainly dates back to the early days of the East India Company. They were then called as “Dressers” and later on rechristened “Hospital Assistants”. In 1911, their designation was changed again to **sub-assistant surgeon** and from the next year, the term **Licensed Medical Practitioner (LMP)** came into vogue. The three-year training course was extended by 1 year in 1904 followed by one more year in 1933. The LMP course was abolished in 1947, following the recommendations of the Bhore Committee. It is all set to make a comeback with the government giving the go-ahead for a three year **Bachelor of Rural Health Care** for meeting the needs of the rural poor. This has however met with criticism from many on the grounds that in what ways is it felt that a doctor for rural areas would suffice with three years training.

college was established in Calcutta (Calcutta Medical College) followed by the Madras Medical College in 1835³⁴. Modern medical education in India consists of a basic undergraduate degree (MBBS) for a duration of 5.5 years, after which there is the option of specialisation leading to a post graduate degree (MD/MS). This system of medical education was laid down soon after Independence. Prior to that, there were two kinds of allopathic physicians - doctors who had undertaken 5.5 years medical degree and licentiate medical practitioners (LMP, see Box 7.1) who underwent 3-4 years course. As a matter of fact, nearly two thirds of qualified medical practitioners were essentially licentiate medical practitioners who worked mainly in rural areas. Along with them practitioners of the ISM and untrained medical practitioners also served the health system in addition to this. At the time of Independence, India had only 1.6 doctors per 10,000 populations (Rao et al 2011) and most were in the private sector and located in urban areas.

³⁴Modern medicine was introduced in India by the Portuguese in the 1500s, though its formal practising could begin more than three centuries later, in 1835 precisely when the British established hospitals in Calcutta and Madras. Until then, Surat and Machillipattinam - the first trading posts established by the British - were being served by British surgeons aboard trading ships. Only with the founding of Madras in 1639, did the British think of establishing permanent medical facility in India. Two centuries later, however, the British could set up a medical college in India. In 1664, a rented house functioned as a small hospital, The Madras General hospital with facilities to treat 8-10 sick British soldiers. In 1827, it started giving training to Europeans, Eurasians, and Indians in modern/ allopathic medicine, though a formal school had yet to be established. It was only in 1835 that modern medical colleges were established in Calcutta and Madras.

However, soon after Independence, following the recommendations of the Bhore Committee, the licentiate course was abolished leaving only the 5.5 years medical graduate degree course untouched which continued as it were for MBBS. It comprises of pre-clinical and clinical teaching. Thereafter, it is concluded with a one year compulsory internship in different hospital departments.

Quite often questions have been raised regarding the relevance of this kind of medical education to the existing health problems that plague the country. Studies reveal that the way the undergraduate course is designed; adequate learning/knowledge regarding common infectious diseases or problems of child and maternal health is not imparted. In fact, students are not adequately trained to work in rural settings/primary health care centres.

Nursing : The nursing profession was severely neglected for a very long time. Consequently on the eve of independence, India had just 0.23 nurses per 10,000 population. Most hospitals were functioning without trained nurses. This was mainly because of two reasons: first, there were few nursing colleges since the government was investing very little in such colleges. In fact, it was Christian Missionary institutions³⁵ which were imparting required skill

³⁵The very idea of developing nursing as a service not just for the army but also for civilians was mooted by Florence Nightingale, who had earlier served at the Crimean War. Later, in 1867, missionaries working at St. Stephen's Hospital, Delhi made attempts at training Indian nurses. Systematic professional development on the lines of modern trained nursing in India began from the start of the twentieth century. The first School of Nursing was started in 1871 at the Government General Hospital, Madras with 6 months Diploma Midwives program with four (mid-wife) students. In 1908, the trained nurses association of India was formed with the view to uphold the dignity and honour of the nursing profession.

and training to aspiring nurses. The other reason had cultural roots- as a profession nursing necessitated not just interaction, but bodily contact with people including males from different castes and communities. Thus, it was not an attractive profession for women of higher castes who had also gained access to high school level education.

It also needs mentioning that the pay, status and general working conditions of nurses were not commensurate with their occupation. All these needed much improvement, the Bhore Committee had recommended. The community development programmes introduced in the country triggered a demand for nurses, Auxilliary Nurse Midwives (ANMs), lady health visitors (LHVs), nursing administrators etc. Thus, during the first five year plan period itself, attempts were made to improve the state of nursing in the country through standardising of nursing education and increasing the resources for training of public health nurses and midwives. The Indian Nursing Council, earlier passed through an ordinance in 1947, was formally constituted in 1949. Subsequently, the master's degree course, a two-year post graduate programme was introduced in 1960 at the College of Nursing, Delhi. In 1963, the School of Nursing in Trivandrum, instituted the first two years post certificate bachelor degree programme in nursing.

During the 1960s, many changes to the nature of medical education in the country were witnessed. Following recommendations of the Medical Education Conference in 1955, to give social orientation to medical education, Department of Preventive and Social Medicine (also known as

Slowly training schools started coming up, initially for health visitors and dais. Again, by 1918 two such schools were set up at Delhi and Karachi. Madras became the first province to set up a registration council in 1926, providing basic standards in education and training. Subsequently, the four years basic bachelor's degree programme was introduced in 1946, in the college of nursing at Delhi and Vellore. Thus, nursing was initially introduced to take care of the injured soldiers, but in time efforts were made to expand the realm of these services for the general public. It needs mentioning however, the profession of nursing was not an attractive option for upper caste Hindu women, as it involved cleaning and caring, necessitating contact with patients including men from all communities. Not surprisingly, overwhelming proportions of early nurses were essentially Christians and were trained by missionaries. (For details, see Nair and M Healey, 2006).

Community Medicine) were established in all medical colleges throughout the country, as an essential department hereafter. This department is entrusted with the task of orienting students to the basic tenets of public health³⁶ facilitating deployment of students and interns to preventive and health promoting assignments in urban as well as rural settings. This compulsory rotation still continues with the expectation to cultivate a community orientation among junior physicians.

Subsequently, several institutes were also developed (Box 7.2) in the 1960s, providing support to the education and training and research to the budding health service system of the country.

Along with this, it was also felt that to really tackle issues of health of the people, it was important to give primacy to people. Thus, incorporating sociological dimensions to epidemiological issues and use of operational research approaches in public health

³⁶A new department was established in 1912 to cater to education and health which made public health physicians teach hygiene in medical colleges. At the same time, given the kind of problems that the health care delivery system encountered in the country, the need to constitute a public health workforce was felt. The workforce included both medical and non-medical personnel, auxiliary nurse midwives (ANMs), nurses, midwives, traditional birth attendants, sanitary inspectors, sanitary assistants, health officers and physicians were brought together (Bangdiwala et al. 2011). With this, a need to train these personnel eventually led to the establishment of public health institutes. The School of Tropical Medicine was established in 1922 at Kolkata (then Calcutta) "to cater the need of an Indian School to confer Diploma at par British Universities, second, to generate quality human resource for the recruitment of Indian Medical Service (IMS), and third, to update the knowledge of the British Doctors in India since they were viewed inferior upon their return home" (Gopal et al 2010). Indeed there was a conscious shift from medical to public health school. Along with this, in 1932, the All India Institute of Hygiene and Public Health (AII&PH) was set up, which has maintained its old fame as the oldest school of public health in Southeast Asia. It was established with a generous grant from the Rockefeller Foundation with "an objective to develop health manpower by providing postgraduate (training) facilities of the highest order and to conduct research directed towards the solution of various problems of health and disease in the community" (Bangdiwala, 2011).

BOX 7.2 : Institutes Set Up

- National Institute of Communicable diseases, had its origins in 1909 as the Central Malaria Bureau (Kasauli), was renamed Malaria Survey in India in 1927. After being shifted to Delhi, in 1938, it was called the Malaria Institute of India. With drastic reduction in the incidence of malaria, the government decided to expand the Institutes activities to include other communicable diseases. Thus, in 1938 it was renamed as NICD. It has currently undergone another change in name and is now known as the National Centre for Disease Control.
- Malaria Institute of India, 1956
- National Tuberculosis Institute (NTI), 1959
- National Institute of Health Administration and Education (1971)
- National Institute of Health and Family Welfare (NIHFW) –established in 1977 by merger of National Institute of Health Administration and Education and National Family Planning Institute. Apex technical Institute funded by ministry of Health and Family Welfare.
- All India Institute of Hygiene and Public Health, 1980

became added features of the national tuberculosis programme.

Committees on Medical Education/ Health education

As noted earlier, the Bhore Committee had *inter alia* recommended setting up of Preventive and Social Medicine departments in medical colleges so that medical students could be sensitised with the imperatives of public health. That apart, it had also recommended training for nurses, public health engineers and other cadres of public health. Thereafter, the Mudaliar Committee (1965) recommended schools for public health in every state and imparting one year public health training to medical officers so that they could learn about public health and sanitation. It had also recommended that universities offer degrees in public health for non-medical personnel.

Apparently, there was disconnect with the rural population, since people were essentially living in rural areas but medical colleges were located in urban areas. Medical education in India was predominantly urban oriented and seemed distant from the actual needs of the country. Thus, the Srivastava Committee set up in 1974 as “Group on Medical Education and Support Manpower” to determine steps needed to (i) reorient medical education in accordance with national needs & priorities and (ii) develop a curriculum for health assistants who were to function as a link between medical officers and MPWs. It recommended immediate action for:

- Creation of bands of para-professional and semi-professional health workers from within the community itself.
- Establishment of 3 cadres of health workers namely – multipurpose health workers and health assistants between the community level workers and doctors at PHC.
- Development of a “referral services complex”
- Establishment of a Medical and Health Education Commission for planning and implementing the reforms needed in health and medical education on the lines of University Grants Commission.

The Rural Health Service was launched in 1977, following the recommendations of the Shrivastava Committee. Another committee was set up in 1986 with the realisation that for better management of health services, training and education of manpower and personnel required.

Bajaj Committee, 1986

An “Expert Committee for Health Manpower Planning, Production and Management” was constituted in 1985 under Dr. J.S. Bajaj, then a professor at AIIMS. Major recommendations included (a) Formulation of National Medical & Health Education Policy, (b) National Health Manpower Policy, and (c) Establishment of an Educational Commission for Health Sciences (ECHS) on the lines of the UGC,

Health Sciences Universities in various states and union territories and also of health manpower cells at the centre and in the states. Besides that, the Bajaj Committees also called for vocationalisation of education at 10+2 levels as regards health related fields with appropriate incentives, so that good quality paramedical personnel may be available in adequate numbers. The committee also emphasised the need for carrying out a realistic health manpower survey.

Current Scenario

Educational infrastructure in the country has increased considerably during the last 25 years. According to the Medical Council of India (2011), there are all together 337 medical colleges in the country teaching MBBS course. However mere increase in the number of colleges is not sufficient. One of the major drawbacks related to this, is that they are not evenly distributed. Secondly, continued focus on medical education and neglect of other streams like nursing and paramedics has resulted in skewed doctor-nurse/paramedic ratios. With pro-privatisation (or in the garb of public-private partnership model) a policy coming to vogue in the 1990s, there has been substantial growth in the number of private institutes. Private medical institutes also include those managed by faith-based organisations, and private trusts and societies. Many have been financed by NRIs. Many of these have also been established through political pressures. They are grossly inadequate in facilities, poor level of training and with insufficient faculty. The cost of medical education at private institutions is exorbitantly high and along with this, they demand capitation fees. The Table 7.1 below compares data at the time of independence and at present.

As noted above, there are 337 medical colleges in the country. Against this, there are 319 ANM training schools, 49 Health and Family Welfare Training Schools and only 34 LHV training schools (GOI, 2011). The map (7.1) below shows the number of medical colleges with the type of management across the states. With regards to medical colleges in the country, as shown in the map, there is a higher concentration of medical colleges in the southern and western states of the country, revealing the geographical imbalance in the distribution of medical colleges, across the states. It also shows a higher number of privately managed institutes in these states. States like Andhra Pradesh, Maharashtra, Karnataka, Tamil Nadu show a higher number of medical colleges³⁷. Given the high demand for medical education, it is considered to be a lucrative investment, that explains growth of private institutions managed by specific political and caste groups in most regions.

It is also noticeable that states that have poor health indicators, like Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh comprising 36% of the country's population have only 15% of medical colleges (Rao et. al, 2011). Clearly, there is a major gap between what is required and what is made available. Viewed from the norm of one medical college for a 50 lakh population, states like UP, WB, Chhattisgarh, MP, Orissa, Assam and Rajasthan have a huge shortfall (NCMH 2005). Even where medical colleges and universities exist there is overall shortage of teachers affecting the quality of instruction. In fact, there is a shortage of teachers/ medical professors for teaching basic subjects like anatomy, physiology, biochemistry. These are not considered

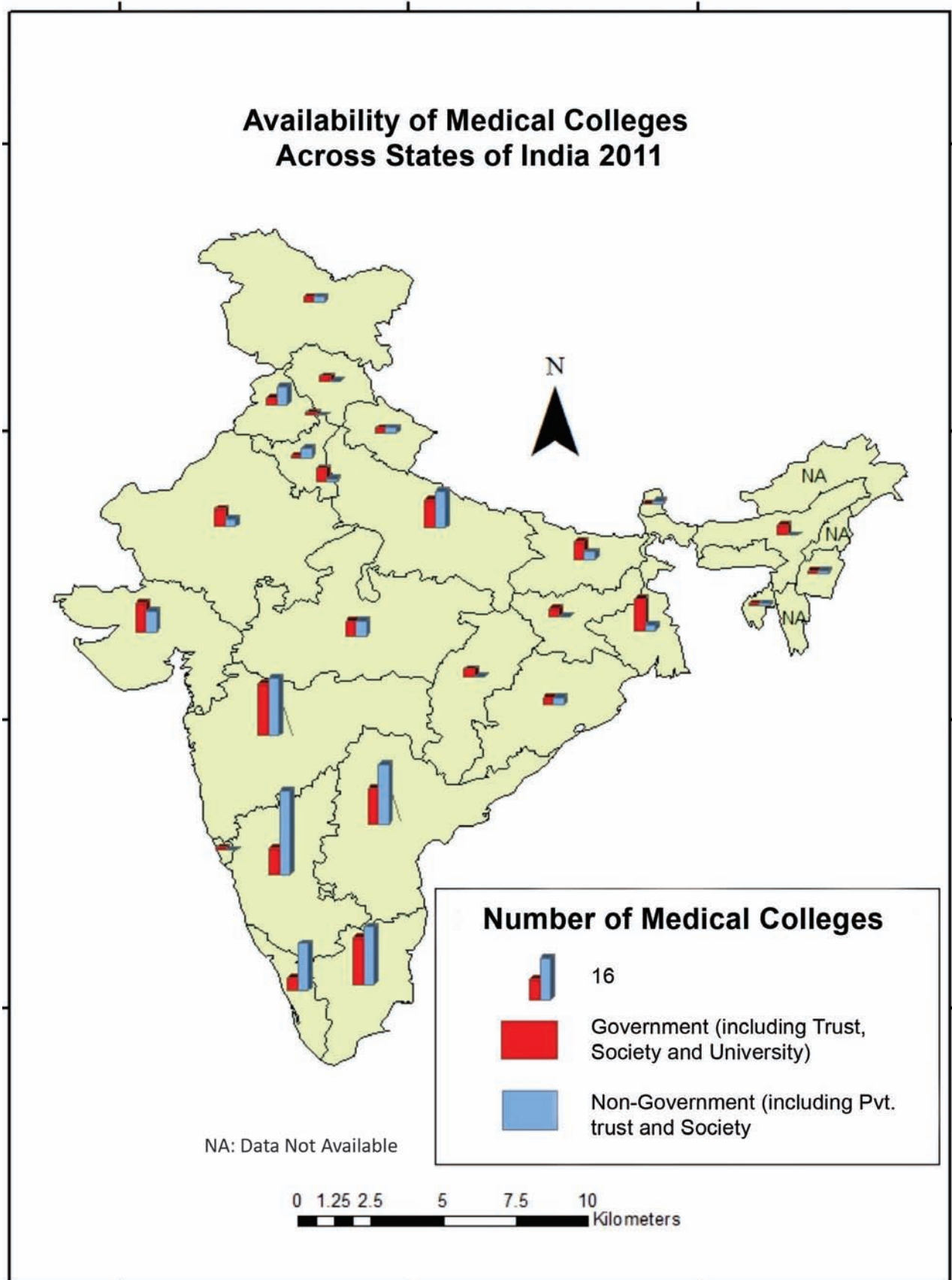
Table 7.1 : Doctors, Medical School: A Comparative Account.

S.N		1947	2011(Current)
1.	Doctors	1.6 (per 10,000 population)	0.6* (per 1000 population)
2.	Nurses	0.23 (per 10,000 population)	1.3* (per 1000 population)
3.	Medical schools	19**	300# (2010)
4.	Doctors graduating annually	1200**	33528# (2010)

Sources: * 12th Plan Approach paper, Plan Commission; ** Rao et al (2011), # Annual Report 2009-2010, MCI .

³⁷ Maharashtra shows the highest number of medical colleges in the public sector followed by Tamil Nadu.

Map : 7.1



attractive subjects by MBBS graduates going in for post graduation/ specialisation. After all, if there is no demand in the market for specialists in these disciplines, why would young medical graduates like to pursue them? It calls for being innovative in designing incentive structure to sustain the interest of young doctors in these subjects which, regrettably, no body at least those who are in position, wants to take up.

II. Nursing

In recent years there has been an increase in number of teaching institutions for nursing. However, till 2005, an adverse nurse for doc ratio (1.5 :1) had existed (NCMH, 2005). It is apparent from the fact that only 40% of registered nurses are active because of factors like low recruitment; migration (mainly to UK, Middle East and generally from Kerala), attrition and drop-outs due to poor working conditions.

Even though, number of institutes may have increased substantially, they suffer from many shortcomings- poor training due to non-adherence to teacher: student norms, inadequate infrastructure, insufficient budget, inadequate clinical facilities and insufficient hands-on training for students. In the public sector it is common to find nursing schools as mere appendages to district hospitals.

Listed in the Table 7.2 are the different types of nursing programmes in India, along with the associated duties and the duration of the courses, as well as eligibility requirements for them. The ANM, LHV and General Nursing and Midwifery (GNM) courses are conducted in schools of nursing, while the rest are university level courses. Alongwith these, there are several certificate and diploma courses available.

The next table (Table 7.3) shows the number of recognised ANM schools.

Table 7.2 : Nursing Programmes in India

	Nursing Programs	Eligibility Criteria	Training Duration	Examination	Registration
➤	Auxiliary Nurse & Midwife	10 th Pass	1 and 1/2 years	Nursing Examination Board	R.ANM
➤	General Nursing & Midwifery	10+2th Class pass with aggregate of 40%	3 and 1/2 years	Nursing Examination Board	R.N & R.M
➤	B. Sc (Basic)	10+2th Class Pass with 45% aggregate in PCBE	4 years	University	R.N & R.M
➤	B.Sc (Post Basic)	Regular 10+2th GNM	2 years	University	Additional Qualification
		Distance 10+2th GNM + 2year Exp.	3 years		
➤	M. Sc.	B.Sc. Nursing / B.Sc. Hons. Nursing / Post Basic B.Sc. Nursing with minimum of 55% aggregate marks. one year of experience after Basic B.Sc. or Post Basic B.Sc. Nursing.	2 years	University	Additional Qualification
➤	M. Phil	M. Sc.	1 year (Full time) 2 years (part time)	University	Additional Qualification
➤	Ph D	M. Sc./ M. Phil	3-5 years	University	Additional Qualification
➤	Post Basic Specialty Diploma Courses	R.N & R.M one year of clinical experience	One Year	Board or University	Additional Qualifications

Source: <http://www.indiannursingcouncil.org>

**Table 7.3 : Recognised ANM Schools of Nursing
(Students Enrolled for the Academic Year 2011-12)**

States/Uts	No. of institutions
A & N Island	1
Andhra Pradesh	47
Arunachal Pradesh	2
Assam	9
Bihar	36
Chhattisgarh	63
Chandigarh	
Delhi	4
Goa	1
Gujarat	59
Haryana	50
Himachal Pradesh	6
Jammu & Kashmir	8
Jharkhand	21
Karnataka	43
Kerala	16
Madhya Pradesh	110
Maharashtra	345
Manipur	7
Meghalaya	2
Mizoram	3
Nagaland	1
Orissa	78
Pudducherry	1
Punjab	127
Rajasthan	38
Tamil Nadu	16
Tripura	3
Uttar Pradesh	110
Uttarakhand	14
West Bengal	57
INDIA	1278

Source: RHS Bulletin 2010

With regards to ANM training schools, differences in data from two different sources -Nursing Council of India and Rural Health Statistics are noticeable. Data from the Nursing Council of India (2011), puts the figure of ANM schools at 1278 (Table 7.4), of GNMs at 2731 (Table 7.5). The RHS bulletin (2010), puts the number of ANM (&LHV) schools at 353. The difference in the two may be explained due to methodological issues- Nursing council lists the number of training schools irrespective of whether

**Table 7.4 : ANM, LHV Training Schools and
Average Population Covered (per training school)**

States/UT	No. of Training Schools		Avg. Popn covered (IN LAKHS) (2001)	
	ANM/ W (F)	LHV/ HA (F)	ANM/ HW (F)	LHV / HA (F)
Andhra Pradesh	16	3	34.63	184.67
Arunachal Pradesh	1	0	8.7	*
Assam	18	1	12.9	232.16
Bihar	21	2	35.39	371.58
Chhattisgarh	10	0	16.65	*
Goa	1	0	6.77	*
Gujarat	13	2	24.42	158.7
Haryana	8	1	18.79	150.29
Himachal Pradesh	6	1	9.14	54.82
Jammu & Kashmir	8	0	9.53	*
Jharkhand	10	0	20.95	*
Karnataka	19	4	18.36	87.22
Kerala	13	0	18.13	*
Madhya Pradesh	29	2	15.3	221.9
Maharashtra	23	5	25.25	111.56
Manipur	3	1	5.3	15.91
Meghalaya	2	0	9.32	*
Mizoram	1	0	4.48	*
Nagaland	2	0	8.24	*
Orissa	16	1	19.55	312.87
Punjab	6	0	26.83	*
Rajasthan	27	3	16.03	144.31
Sikkim	1	1	4.81	4.81
Tamil Nadu	5	0	69.84	*
Tripura	2	1	13.27	26.53
Uttarakhand	5	0	12.62	*
Uttar Pradesh	40	4	32.91	329.15
West Bengal	10	1	57.75	577.49
A& N Islands	1	0	2.4	*
Chandigarh	0	0	*	*
D & N Haveli	0	0	*	*
Daman & Diu	0	0	*	*
Delhi	0	1	*	9.45
Lakshadweep	0	0	*	*
Puducherry	0	0	*	*
All India	319	34	23.28	218.38

Source: <http://www.indiannursingcouncil.org/>

Table 7.5 : Schools of Nursing (GNMs) (2011)

States/Uts	No.of Institutions
Andaman & Nicobar	1
Andhra Pradesh	247
Arunachal Pradesh	2
Assam	21
Bihar	10
Chattisgarh	27
Chandigarh	
Dadra & Nagar Haveli	1
Delhi	16
Goa	2
Gujarat	79
Haryana	46
Himachal Pradesh	30
Jammu & Kashmir	10
Jharkhand	20
Karnataka	541
Kerala	224
Madhya Pradesh	181
Maharashtra	117
Manipur	8
Meghalaya	7
Mizoram	5
Nagaland	2
Orissa	50
Puducherry	3
Punjab	117
Rajasthan	182
Sikkim	1
Tamil Nadu	196
Tripura	5
Uttar Pradesh	152
Uttarakhand	14
West Bengal	54
INDIA	2371

Source: <http://www.indiannursingcouncil.org>

in the public sector or in the private sector, both in the rural as well as the urban whereas RHS only lists public infrastructure in rural areas. However, the inconsistency appears to wide to be covered in this way.

The increase in the number of teaching institutions is also a result of the growth of private institutions and initiatives taken by corporate hospitals in training

nurses for employment abroad. As noticed in the case of medical colleges, here too is seen deepening geographical imbalances. Earlier studies (cited in Rao et al)³⁸ have shown southern states of Andhra Pradesh, Karnataka, Kerala and Tamil Nadu having a little over two-thirds (63%) of general nursing colleges in the country. Along with these states, current data shows a high number of institutions in states like Madhya Pradesh, Maharashtra, Uttar Pradesh, Rajasthan and Punjab.

Nursing education has faced neglect for past many decades despite efforts at standardising education and increasing training capacity for nurses and public health workers etc taken after Independence. Yet Indian nurses are much sought after abroad, paradoxically. Even though, there is need to strengthen nursing and paramedical force, the focus on medical education, and influence of the medical community, along with poor health financing by the government has led to the neglect of this profession.

The impact of regional imbalance in educational institutions for nursing has serious consequences when it comes to higher level education. The absence of these institutions in some states results in near collapse of lower levels of nursing with hardly any qualified faculty. In Orissa, for instance, the lone college of nursing in the government sector had less than three qualified faculty even though it offers undergraduate and postgraduate courses³⁹. However, with the launch of the National Rural Health Mission, the role of nursing to strengthen the Mission has been acknowledged. A new scheme, the Development of Nursing Services was started in the XIth Plan period. It remains to be seen how far it is successful in improving the present situation.

III. Lab Technicians and Pharmacists

In India, the training for laboratory technicians is nine month diploma course the eligibility for which is 12th pass with Arts/Humanities background. On the other hand, diploma holder pharmacists are treated equivalent to pharmacy assistants in developed countries. In any case, competency levels

³⁸See, Trained Nurses Association of India, 2006

³⁹For details, see Raha et al (2009)

of both need to be enhanced. Likewise, laboratory technology needs to be upgraded to BSc. level.

Recommendations for strengthening Health Education and Research

The Approach Paper to the 12th Plan recommends strengthening of district hospitals in terms of equipment and staffing, and should, in fact, function as District Knowledge Centres for training a plethora of health workers including nurses, mid-level health workers, paramedics and other public health workers. In order to link actual needs with the infrastructure, it proposes that new medical and nursing colleges be linked to district hospitals in underserved states and districts ensuring that districts with a population of 25 lakhs are prioritised for establishing of medical colleges if they presently lack them.

Regulation

Setting up regulatory bodies to monitor quality and maintain standards is an essential function of the state institution. With this objective the Medical Council of India (MCI) was established in 1934 under the Indian Medical Council Act, 1933, now repealed. Its stated objective was to establish uniform standards of higher qualifications in medicine and recognition of medical qualifications in India and abroad. With the increase in the number of medical colleges after Independence, it was felt that the provisions of Indian Medical Council Act were not adequate to meet with the challenges posed by the very fast development and the progress of medical education in the country. As a result, in 1956, the old Act was repealed and a new one was enacted. This was further modified in 1964 and much later in 1993, 2001 and 2010 respectively.

The objectives of the Council are as follows⁴⁰

- Maintenance of uniform standards of medical education, both undergraduate and postgraduate.
- Recommendation for recognition/de-recognition of medical institutions of India or foreign countries.
- Permanent registration/provisional

registration of doctors with recognised medical qualifications,

- Reciprocity with foreign countries in the matter of mutual recognition of medical qualifications.

As an autonomous organisation, the MCI has the mandate to set and monitor standards for medical education, recognise medical degrees, offered by universities in India and abroad, and register qualified medical doctors.

Recently, however, the role of the MCI has come under severe criticism especially after the 1990s with the rapid increase in private medical education. The National Knowledge Commission has noted that regulation by the MCI is neither adequate nor appropriate⁴¹. Charges of corruption and irregularities have repeatedly been levelled against MCI officials. In 2010, serious charges of corruption were levelled against the then president of the council, Ketan Desai. The MCI was dissolved in May 2010, with the arrest of Desai and three others by Central Bureau of Investigation on charges of accepting bribes for permitting a medical college without adequate infrastructure to function. A new board of governors was constituted in May 2011.

Health Research

A new department to focus on health research in the health sector, under the Ministry of Health & Family Welfare was created on the September 2007.

The Indian Council of Medical Research (ICMR) is the apex body for the formulation, coordination and promotion of biomedical research in the country. It is one of the oldest research bodies in the world which was redesigned in 1949. The ICMR is funded by the Govt of India through the Department of Health Research, Ministry of Health & Family Welfare. The Council's mandate is as follows:

The Council's research priorities coincide with the national health priorities such as management and control of communicable diseases, fertility control, maternal and child health, control of nutritional

⁴⁰For further details see, www.mciindia.org

⁴¹See, Rao et al 2011

disorders, developing alternative strategies for health care delivery, containment within safety limits of environmental and occupational health problems; research on major non-communicable diseases like cancer, cardiovascular diseases, blindness, diabetes and other metabolic and haematological disorders; mental health research and drug research (including traditional remedies). All these efforts are undertaken with a view to reduce the total burden of disease and to promote health and well-being of the population. The Council promotes biomedical research in the country through intramural as well as extramural research. Over the decades, the base of extramural research and also its strategies have been expanded by the Council. (<http://icmr.nic.in/>)

Apart from biomedical research, health research in India also includes interdisciplinary research in public health. With this objective, a number of institutes (as given below) have been set up.

- **National Institute of Health & Family Welfare and State Institutes of Health & Family Welfare :** The National Institute of Health & Family Welfare was established in 1977 with the merger of National Institute of Health Administration and Education (NIHAE) and National Institute of Family Planning (NIFP). It is an apex technical institute, funded by the Ministry of Health and Family Welfare for the promotion of health and family planning programmes through education, training, research and consultancy.
- **Indian Institute of Health Management Research (IIHMR):** IIHMR was established in 1984 in Jaipur, with public health and management as its core. Subsequently, it set up institutes in Delhi and Bangalore with focus on improved health management and research, education and training. The institute collaborates with international organisations such as UNFPA, UNICEF, WHO, World Bank, ODA, DANIDA, KFW & GTZ, NORAD, CARE and USAID as well as with the Government of India for training, research and consultancy in health management and hospital management. It conducts post-graduate courses in hospital and

health management, alongwith diploma courses in pharmaceutical and rural management.

- **The Public Health Foundation of India (PHFI), a PPP initiative,** was launched in 2006. The Indian Institutes of Public Health that are established by the Foundation are engaged in delivery of long term academic programs as well as strengthening health system through short term trainings and programme and policy relevant research. PHFI also has mandate to facilitate the creation of accreditation systems for public health education.

The PHFI has established a network of four Indian Institutes of Public Health (IIPHS) at Gandhinagar, Hyderabad, Delhi and Bhubaneswar.

- **CEHAT:** Centre for Enquiry into Health and Allied Themes (CEHAT) is the research centre of the Anusadhan Trust, Mumbai. With a strong belief in the right to health and the people's health movement, it was established in 1994 with the aim of conducting socially relevant and rigorous health research in order to strengthen the same. The organisation is involved in research, training, service and advocacy on health and other related issues. CEHAT in its work attempts to act as an interface between progressive people's movements and academia. Their research areas include:

- Health services and Financing
- Health Legislation and Patients' rights
- Women's Health
- Investigation and Treatment of Psycho-Social Trauma

CEHAT has compiled database on health sector for all states in India from 1951 to the latest available year. Data has been arranged on five major aspects –Finance, Human resources, Indicators, Infrastructure and Socio-Economic data. Further, data is also found in terms of gender, rural-urban status or other categories.

It runs two courses-i) Health and Human Rights and ii) Violence against Women and Role of Healthcare Providers. From 2011, two more courses have been added: Developing a Comprehensive Healthcare Response to Survivors of Sexual Assault and Responding to Violence against Women through Feminist Counselling.

Among its advocacy work has been the National campaign on safe abortion, Health budget and advocacy. It is currently working on integrating gender in medical education. The centre also provides counselling services through its Dilaasa Crisis Centre in addition to providing legal counselling. It also publishes the Journal of Health Studies in collaboration with eSS. CEHAT has been involved in numerous important programmes in the health sector over the years.

- **VHAI:** The Voluntary Health Association of India (VHAI) is a non-profit registered society comprising of 27 State Voluntary Health Associations that was formed in 1970. These in turn are associated with more than 4500 grassroot level organizations. Known to be one of the largest health and development networks in the world, VHAI work involves development of people centred policies in health planning and programme management. Its work ensures social justice, equity and human rights in the provision of health services. Its primary objective is to promote community health, and justice in the provision of health services.

VHAI's work involves campaigns, policy research, advocacy, need based training, media and parliament interventions, publications and audio visuals, dissemination of information and running of health and development projects in difficult areas.

In continuation, some new initiatives have been taken up. The "Public Health Education & Research Consortium: Network and Partnership (PHERC)" has been developed with the objective of sharing experiences and promoting public health in the country. The consortium includes medical and nursing colleges, State Institute of Health and Family Welfare, Central Training Institutions and

Non-Governmental Organisations. Rapid Appraisal of Health Intervention (RAHI), related to National Rural Health Mission (NRHM) activities was a distinct initiative supported by UNFPA under this. The National Child Health Resource Centre (NCHRC) was established with the Norway - India Partnership Initiative (NIPI). With WHO support, a health financing unit has been established to strengthen research and devise implementation strategies related to health financing and insurance.

Distribution of functional responsibilities between Union, State & Local governments

The constitution of India has demarcated the functional boundaries of the Union and State governments with the instrument of Union list, State list and Concurrent list. Health is essentially a state subject, as it placed under is included in the State List with items such as *Public Health, hospitals, sanitation, dispensaries*, included in it. Health is also listed as part of the Concurrent List where in items that have wider ramifications at the national level are put such as population control and family welfare, medical education, prevention of food adulteration, quality control in manufacture of drugs etc. Apart from this, the Ministry of Health & Family Welfare designs and implements (also see Box 7.3) various programmes on a national scale in the areas of Health & Family Welfare, prevention and control of major communicable diseases and promotion of traditional and indigenous systems of medicines. It assists States in times of disease outbreaks and epidemics through technical assistance. The ministry incurs expenditure either directly under Central Schemes or by way of grants-in-aids to the autonomous/ statutory bodies etc. and NGOs. It implements certain World Bank assisted programmes as also the 100% centrally sponsored family welfare programmes.

Parliamentary Oversight

Standing Committee on Health and Family Welfare

Parliamentary Committees are of two kinds: Ad-hoc Committees and Standing Committees. Ad-hoc committees are set up for specific purposes and after the completion of the assignment such committees cease to exist.

Box 7.3 : Role of Health, Family Welfare and Nutritional Division, Planning Commission

The Division has the following important functions: -

- Evolving policy and strategy guidelines pertaining to:
 - (i) Health & Family Welfare with a special reference to the flagship programme, the National Rural Health Mission (NRHM). ii) HIV/AIDS Control, iii) AYUSH iv) Health Research, v) Nutrition
- Drawing up short-medium-and long-term perspectives and goals for each of the above.
- Monitoring changing trends in the health sector viz., epidemiological, demographic, social and managerial challenges.
- Examining current policies, strategies and programmes in health and family welfare and nutrition sector, both in the States and in the Central sector and suggest appropriate modifications/mid course corrections.
- Suggesting methods for improving access, affordability, accountability, efficiency and quality of services.
- Evolving priorities for basic, clinical and operational research essential for improving health status of the population and achieving rapid population stabilization.
- Looking into inter-sectoral issues and evolving appropriate policies and strategies for convergence of services so that the population benefits optimally from on-going programmes.
- The Division represents the Planning Commission in:
 - (a) Various Committees of Ministry of Health & Family Welfare and Ministry of Women & Child Development.(b) EFC/SFC pertaining to Ministry of Health & Family Welfare and Ministry of Women & Child Development. (c) Scientific Advisory Groups of Indian Council of Medical Research, National Institute of Health & Family Welfare, Public Health Foundation of India, etc.
- Expert Panels set up from time to time to advise the Planning Commission regarding the priorities and targets in the Plans and Programmes relating to Health and Nutrition sector - the resources including human and material required, the training programmes to be initiated, standards of construction and equipment for health facilities and the development of health research etc.

Linked Ministries: Ministry of Health and Family Welfare, Ministry of Women and Child Development.

Broadly speaking, the purpose of these committees are, to quote Shri K.R. Narayanan, the then Vice-President of India, “to ensure the accountability of Government to Parliament through more detailed consideration of measures in these Committees. The intention is not to weaken or criticise the administration but to strengthen it by investing it with more meaningful Parliamentary support” (<http://rajyasabha.nic.in/rsnew/rsweb.asp>)

Standing Committees, on the other hand, are those committees that are either elected by the house or nominated by the presiding officers (Speaker of the Lok Sabha or Chairman of the Rajya Sabha) periodically and are permanent in nature. They perform the task of keeping a check over governmental expenditure and policy formulation thus functioning as “Watch-dogs” over the executive. Currently, the total number of members of a committee is 31 with 10 Rajya Sabha members and 21 Lok Sabha members. A member appointed as a Minister cannot continue

as a member of any committee.

4. These Committees are entrusted with the following functions:
 - a. to consider the Demands for Grants of the related Ministries/Departments and report thereon. The report shall not suggest anything of the nature of cut motions;
 - b. to examine Bills, pertaining to the related Ministries/Departments, referred to the Committee by the Chairman or the Speaker, as the case may be, and report thereon;
 - c. to consider the annual reports of the Ministries/Departments and report thereon; and
 - d. to consider long term national policy documents presented to the Houses, if referred to the Committee by the Chairman

or the Speaker, as the case may be, and report thereon. All these functions exist “provided that the Standing Committees shall not consider matters of day-to-day administration of the related Ministries/ Departments” (<http://rajyasabha.nic.in>).

Till 1989, there were three standing committees to dealing with Agriculture, Science and Technology and Environment and Forests. The number of Department –related Standing Committees (DRSCs) was increased to seventeen in 1993, to bring all the Ministries/departments of the government under its purview. Interestingly, until 2004, the Committee on Health and Family Welfare was the department related standing committee clubbed with the Human Resource Development, and was placed under the Rajya Sabha. The other departments under the Human Resources Development were Culture, Sports & Youth Affairs, Women & Child Development, and Education.

It was only in 2004, when the number of DRSCs was further increased to twenty four, that an independent Committee on Health and Family Welfare came into being under the Rajya Sabha. Currently, there are eight committees under Rajya Sabha and sixteen under the Lok Sabha.

The reports of the Committees are of the following kinds:

- i. Demand for Grants for the current year, of the departments under the Ministry of Health and Family Welfare, that is Health, Family Welfare, and AYUSH; department of Health Research and Department for AIDS Control were added later.)
- ii. Action taken by the Government on the recommendations/ observations given by the Committee on the Demand for Grants.
- iii. Reports on the working of schemes like the Central Government Health Scheme (CGHS), or medical institutes or research centres like the Ayurveda institute, or institute of Homeopathy, or Jawaharlal Institute of Post Graduate Medical Education and Research (JIPMER) etc.

- iv. Amendments to Bills regarding issues pertaining to health and health sector on subjects varying from the transplantation of human organs bills, to drugs and cosmetics bills, to acts relating to institutes etc.

- v. On specific diseases.

Issues pertaining to items no. (iii), (iv) and (v) taken up as and when they come up.

Under the “Demand for Grants”, the committee reviews the budgetary allocations to the department and the working of central government hospitals, research centres, working of disease control programmes, functioning of medical colleges, medical council, rural and urban health infrastructure, family welfare programmes, immunisation programme, promotion and integration of AYUSH services with the health care systems, medical education etc.

The report on “Action taken by the Government on recommendations / observations (R/O) given by the Committee on Demand for Grants”, is divided into the following sections:

- i. Those accepted by the Government
- ii. Those which the Committee does not desire to pursue in view of the Government’s replies
- iii. Those of which replies of the Government have not been accepted by the Committee
- iv. Those of which final replies of the Government are still awaited

The Table 7.6 shows the number of reports corresponding to the respective government at the centre, from 1999-2011.

Table 7.6 : Parliamentary Standing Committee Reports (1999-2011)

	1999-2004 (NDA)	2004-2009 (UPA-I)	2009-present (UPA-II)
Chairman	(Congress)	(SP)	(BSP)
Total No. of Reports	22	33	20 (till 4 th March 2011)
No. of Reports other than Demands for Grants	-----	10	7

Certain key areas identified in analysing role of Committee in different time periods.

A. Budgetary Allocations

Throughout the decade referred above (1999-2009), the committees have been of the opinion of increasing the health sector allocation. The Committee, in fact reiterates that priority areas such as public health be spared from cuts imposed by the Planning Commission / Ministry of Finance.

The Committee feels that before finalising budgetary allocations, the Planning Commission and the Finance Ministry should give careful thought to the WHO recommendation of spending at least 5 % of GDP on public health Care.

It has recommended the Department of Health to approach the Finance Ministry for additional funds over the regular budgetary provisions. The committee shares serious concern over continuance of insufficient outlays in the budget for health over the years. Simultaneously, it is also deeply concerned with non-utilisation or under-utilisation of funds and periodically questions the Department over the same.

It had serious reservations regarding the Department's proposal of introducing 2% cess on the lines of 2% education cess, on the grounds that it involved taxpayers' money and also going by the department's past record of under utilisation of funds. It is more perturbed by declining trends in allocation of non-plan funds. This prompts the Department in diverting funds from plan to non plan heads which reflects the Department's inability in utilizing allocated plan funds to the optimum, due to poor management and incapacity of implementing agencies. The Committee urges the Department to go in for remedial steps at the earliest.

B. Central Government Health Scheme (CGHS)

The Committees have reviewed the working of the CGHS periodically. Among other issues, the committee asked the Department to consider running of CGHS in two shifts so as to make it more convenient to beneficiaries. It is not convinced by the Department's stand that this would require

additional posts, and asks for a review to be done. It also welcomed the CGHS' initiative towards decentralisation of payment of reimbursements to beneficiaries' parent organisations. It wondered however, why this initiative has not been accepted readily by the beneficiaries.

The committee also recommends Department to consider reimbursing total expenditure to beneficiary, rather than reimbursing only approved expenditure. In later years, the Committee has shown deep anguish over the quality of services provided by the CGHS, especially the delay in supply of drugs due to the delay in finalising drug formularies.

The Committee strongly recommends that Government should take immediate steps to ensure that CGHS dispensaries, function in such a manner that instead of being a place for referring patients to specialists and disbursement of medicines recommended by them, should become competent health centres where its beneficiaries actually receive proper treatment.

C. National Health Programmes

The Committee is of the view that the national health programmes need to have local input to it. The Committee feels a definitive preventive scheme to address state wise prevalence of particular diseases is required. The Committee feels that the Department should ensure review of all national programmes in a phased manner.

The Committee is also of the opinion that effective delivery of health care needs active cooperation of other concerned Ministries and / or Departments both at the Union and the State level. Accordingly, a system of coordination between concerned departments needs to be evolved.

D. Rural Centres

Committee have recommended the opening of new centres, be it rural family welfare centres, or rural sub centres on a regular basis. It feels it is the duty of the Department to provide sufficient funds for maintenance of these centres, as these serve primarily the rural poor. Rural family welfare centres and sub-centres are meant for the effective implementation of

the Family Welfare Programme in rural areas where it is needed the most; the committee therefore desires that required funds may be provided at the 'Revised Estimate' stage.

During the VIII Plan period (1992-97), state governments were not being assisted in the opening of new sub-centres as such scheme was not in vogue then and also the outlay was insufficient to maintain even existing centres. The Department informed the Committee that from 1997, state governments would be given freedom to use additional Central assistance transferred to them by the Planning Commission for any item covered under the Basic Minimum Services. The Committee felt that this approach was not correct, and recommended revival of old pattern as it apprehended diversion of funds. The Committee wants the Department to ensure that States open fixed number of centres each year, and set apart some provision in their budgets for the same.

E. Urban Family Welfare Schemes

The Committee has taken seriously the underutilization of funds under urban family welfare services for a number of years in succession and that too on the same ground. It feels that the Department perhaps did not take any remedial steps to improve the situation. It asks Dept to take suitable steps for strengthening and expanding the scheme based on the findings of the evaluation study.

F. Public-Private Partnership (PPP)

- 1.) While commenting on the cleanliness and behaviour of staff of government hospitals in general and Safdarjung Hospital in particular, the Committee reminds the Department of its decision to entrust the work of maintaining cleanliness at least in the emergency wards to private agencies. The Committee fails to understand why the decision has not been implemented.
- 2.) With respect to empanelment in the CGHS list of hospitals, the Committee notes:

“The Committee thinks that provision of recognized private hospitals and diagnostic centres should be logical and essentially treated extension of

the existing system and to hold that it is an additional facility is not in sync with the current buzzword of public-private-partnership. The Committee feels that literally speaking, though the Department cannot force private hospitals / diagnostic centres to be empanelled, it can indirectly compel the quality private hospitals / diagnostic centre to opt out of empanelment, if the rates quoted are very low. The Committee, therefore, recommends that the rates should be fixed realistically, taking into account the market realities so as to encourage quality private hospitals and diagnostic centres to join the system.” (Report No. 22, 2007-08)

G. NRHM

The Committee, when informed about launching of the NRHM, made the following observations while lauding the objectives of the Mission as much required in the present scenario: “The Committee observes that divergent activities not only of the Ministry of Health and Family Welfare, but also number of other Ministries are proposed to be implemented in an integrated manner.

Two Departments of the Ministry-Health and Family Welfare have been integrated for optimum utilization of financial resource and manpower. The Committee, however, wondered that when both the departments as separate entities had quite a few programmes under them, which were not being administered effectively due to a very weak monitoring mechanism forcing them to rely only on state figures. Then whether the convergence of a number of Health and Family Welfare Schemes under NRHM, would be feasible. The Committee would, therefore, emphasize that dilution of services at present available separately under the two Departments must be avoided at all costs.

H. Vacancy Position in Central Govt. Hospitals/ Institutions / Autonomous Organizations

The Committee takes a serious view of this position. The Committee notes that the Department has been repeatedly pleading for exempting technical posts under it from the operation of Department of Personnel and Training orders regarding reduction in staff and abolition of vacancies, but with no success. The Committee is of the view that direct recruitment

at various levels and filling of vacancies in the health institutions is vital in the interest of public health. Department of Personnel instructions should not be made applicable in the case of technical posts. The Committee therefore, strongly recommends that the Department should approach the Department of Personnel, once again, for exemption, if necessary at the highest level so that continuing vacancies in a large number of operational posts of doctors, nurses, para-medical and other supporting staff are filled up without any further delay.

I. Monitoring Mechanism

The Committee time and again calls for establishing of monitoring mechanism for private institutes, blood banks, manufacture of drugs, etc. It also calls for regular monitoring of disease control methods in the national health programmes as also monitoring mechanism for AYUSH doctors practicing in the country. It recommends that immediate action is required to be taken either by the two councils or any other body which is empowered to regulate in such matters

J. Mainstreaming AYUSH

The committee calls for steps to be taken in that direction. It had voiced its concern over the delay in providing AYUSH services at CGHS dispensaries and is not convinced by the Dept's contention that recruitment is to be handled by UPSC. It is not too hopeful of the sanctioned dispensaries when existing facilities are not in place in the first place.

K. Medical Education and Health Research

Committee strongly feels that medical students who go abroad, after completion of studies should be made to come back. In other words, Committee feels that medical students should serve the country in some manner, and in fact calls for one year compulsory stint in rural areas after completing their MBBS course. While the committee seems to be involved in many aspects of the department, it is not evident from these reports, if there is considerable/lively debate amongst the members regarding these issues. As the reports/minutes are processed, we fail to get an insight into how seriously engaged members are with issues under consideration and what, if any, are the varied viewpoints.

Conclusion

Whether it was lack of will or dearth of resources, India perhaps never had the required number of medical colleges and institutions/ schools for nursing and other paramedics. The institutional base for medical education and research was weak in the country and that too was unevenly distributed among provinces. The states which were earlier part of the Bombay and Madras presidencies during British period were relatively better endowed than those under the Calcutta presidency. This pattern almost continued after independence. No wonder, the first private medical institutions came up in southern states, particularly in Karnataka thereafter in Tamil Nadu. Later, Maharashtra, Gujarat and Andhra Pradesh followed the suit. Two decades after the onset of liberalization, the eastern states and Hindi heart land states are yet to catch up with the states located in the western and southern parts of the country. In fact, the largest numbers of medical colleges are still located in Tamil Nadu (along with Puducherry), Andhra Pradesh and Maharashtra. This is equally true of institutions for pharmacy, nursing etc, though lately states like Punjab, Madhya Pradesh and Rajasthan, earlier clubbed with other underprovided states, are catching up fast. This is almost true of nursing schools. And ditto for lab technicians, pharmacists etc.

Paradoxically, many new private medical colleges and allied institutions in the arena of health have been found deficient, showing a clear mismatch between eligibility criteria and actual provisioning. Documented periodically and publicised by the media on their state of affairs but these new shops have gone on thriving in the absence of lax regulatory bodies. That the Indian Medical Association (IMA) was for long believed to be thoroughly inefficient and corrupt but it was confirmed only after the arrest of its head last year. By injecting professionalism, the newly constituted body, hopefully, would be able to clear the rot and strengthen the medical education in the country.

The number of health research and training institutes has also been very few in number; all in the public sector and until recently funded invariably by the federal government, notable exceptions apart.

Following reforms, more particularly since the last decade a chain of institutions have been set up in the area of health management, administration and research. Perhaps the most notable one that gives us hope is: The Public Health Foundation of India. It is trying its best to improve upon the existing health system through quality health research, policy papers as well as short training programmes. By creating a new department of health research (in 2007) within its folds, lately, the union health ministry has also realised the significance of research. These initiatives will be of great assistance in filling the gap in the arena of health education and research.

The Parliamentary Standing Committee has been doing its job independently for over almost decade now. While the committee seems to be involved in many aspects of the department, it is not evident from these reports, if there is considerable and lively debate amongst the members regarding these issues. As the reports are processed, one fails to get an insight into how seriously engaged members are with issues under consideration and what, if any, are the varied viewpoints. Likewise, it is difficult to discern whether their recommendation are followed in letter and spirit.■

HUMAN RESOURCES & PHYSICAL INFRASTRUCTURE

Introduction

Effective functioning of any public goods delivery system is dependent upon its architectural structure put in place and the human resources deployed for providing the same. In fact, recent studies have shown that greater availability of health workers is associated with better service utilisation and health outcomes such as immunization coverage, outreach of primary care and infant, child and maternal survival.”(PHFI, 2009). This chapter is thus focused on both these components – human resources and infrastructure in the context of health service delivery system in India.

Information regarding all this is crucial not only for planning the delivery of health services, but also for bridging their geographical and compositional mal-distribution. This is not to deny, however, that effectiveness of the health workforce is influenced by a mix of other factors: numerical strength, skill mix, geographical distribution, adequate remuneration, a suitable work environment and infrastructure etc. - all taken together enable them to use their skills optimally.

Human Resources for Health

The health workforce or as it is also called human resources for health (HRH) encompasses all

those who work in the health sector. This includes not just physicians, but also paramedics, public health workers, administrative staff, educators, pharmacists etc. Thus, human resources in India include specialists and super specialists trained in bio-medicine/allopathic medicine, the most familiar symbols of health sector, but also psychiatrists, dentists, radiographers, paramedical workers such as nurses, pharmacists, laboratory technicians, health educators, health planners and managers (see Box 8.1). The practitioners of the traditional Indian systems of medicine (Ayurveda, Unanni, Siddha, Homeopathy – are bunched together as they are commonly referred to as AYUSH). Apart from this, there are also informally trained providers such as *dais* (traditional birth attendants), bone setters, faith healers, folk and magico-religious healers and other practitioners of indigenous medicine. Above all, there other self-claimed providers who are neither professionally trained, nor qualified - the quacks. It is unfortunate that a large part of our population is forced to seek their treatment because of their easy accessibility than those well qualified services providers.

The size and composition of the total work force is difficult to assess. It is nearly impossible to get information regarding the number of qualified workers in the private sector; for workers in the public sector whatever data is available in all fragmented and

Box 8.1 : Health Personnel in India

Doctors (Allopathic)
Practitioners of AYUSH
Nurses-General
ANMs/ Paramedics
Dentists
Pharmacists
Health Planners
Technicians & Allied Health Professionals - Lab Techs, Radiographers, Dieticians, Nutritionists
Multi Purpose workers
Community Health Workers-Health Educators, Assistants
ASHAs
RMPs
Managers

Source : Rao, 2011

diverse. The official machinery collects information on the number of health workers in the public sector and reports on doctors, dentists and nurses registered with their specific state professional councils. The data sources for health workforce in India are : Census 2001, NSSO 61st round on Employment and Unemployment, Official statistics from the Government of India, and -professional councils like the Medical Council of India, Nursing Council etc. Yet the problem of reliable and systematic data regarding workers in the health sector in India goes on persisting. For instance, Census of India uses self reported occupation of individuals which may not necessarily be verifiable.

Notwithstanding all these constraints, it would be interesting to observe what available data shows regarding health workforce in India. For this chapter particularly, data available from RHS (2009) and DLHS-3 (2007-08) sources for health facility and amenities have largely been used.

The World Health Report 2006 titled *Working Together for Health*, identified 57 countries that had *critical shortage of health service providers*, falling below the

threshold of 2.24 healthcare providers⁴² (including only doctors, nurses and midwives) per 1000 population and which failed to cover 80% coverage levels for deliveries by skilled birth attendants. Each of these countries has fewer than 2.5 health workers (counting only doctors, nurses, midwives) per 10,000 people - the minimum required to achieve an 80% coverage rate for deliveries by skilled birth attendants or for measles immunization . The ‘threshold’ has been defined on the bases of requirement for achieving the MDGs. It is not a substitute for specific country sufficiency assessment. In any case, it is well acknowledged that the need to increase health workers in specific are determined by countries depends on many factors including levels of income, education and other economic factors. Although, 36 of the 57 countries were from the sub-Saharan Africa, the greatest shortage in absolute terms was noticeable in South East Asia, led by Bangladesh, India and Indonesia.

Additionally, in India, a huge gap exists between rural and urban areas in terms of health care providers. To bridge this gap and also the improve health care services for the rural population, the National Rural Health Mission (NRHM) was launched in 2005 as a flagship programme. . By taking a series of steps including increasing the strength of the human

⁴²The World Health Report, 2006 cites various estimates of the availability of health workers that is required to achieve a package of essential health interventions and the Millennium Development Goals (including the scaling up of interventions for HIV/AIDS). This exercise identified of shortfalls in workforce within and across mostly low income countries. To achieve a global assessment of shortfall, the joint learning initiative (JLI), a network of global health leaders launched by the Rockefeller Foundation, suggested that, on average, countries with fewer than 2.5 health care professionals (counting only doctors, nurses and midwives) per 1000 population would fail to achieve an 80% coverage rate for deliveries by skilled birth attendants or for measles immunization. This method of defining a shortage, whether global or by country, is driven partly by the decision to set the minimum desired level of coverage at 80% and partly by the empirical identification of health method and updated information on the size of the health workforce obtained for this report, the JLI analysis has been repeated for skilled birth attendants. A remarkably similar threshold is found at 2.28 health care professionals per 1000 population, ranging from 2.02 to 2.54 allowing for uncertainty worker density associated with that level of coverage.

resources involved in health services (through contractual appointments), upgrading existing infrastructure the Mission is an attempt to meet the requirements of the rural population.

Improved Human Resources

To serve the health needs of the rural population a three-tiered health infrastructure was created largely under two consecutive five year plans in the 1980s. A sub health centre (SHC), as per the guidelines, at 5000 population excluding hilly and trebal regions and a primary health centre (PHC) for every 30,000 population was set up. Further up, a community health centre (CHC) was organised covering 100,000 population figure. As per their organizational structure, a SHC is the 'peripheral contact point between the primary health care system and the community'. The PHC, in continuation, is considered to be the 'first contact point between the village community and the medical officer' but

it mainly runs out patient care, with only minimum facilities for in-patient care. Indeed, the in-patient care and treatment by specialists are available at the level of CHC only. In plain terms, the SHCs are run not by qualified doctors but by para-medicos known as Auxiliary Nurse Midwife (ANM). One can consult a doctor at a PHC but if a patient's condition demands continuous observation and hence admittance in the public health centre, s/he will have to be taken to a CHC (Kumar 2009, Mishra 2002) .

The norm for staffing patterns at the respective centres is given (see Box 8.2). These are the minimum norms to be fulfilled. Additional staff has been prescribed under Indian Public Health Standards (IPHS) following NRHM Box .

SHC level

A total number of 137, 271 SHCs (two-thirds of which were financed by the federal government)

Box 8.2 : Staffing Norms

Sub-Centre	
Health Worker (Female/ANM)	1
Additional Second ANM (on contract)	1
Health Worker Male	1
Voluntary Worker (Paid at Rs.100/- pm as honorarium)	1
Total.....	3
New Primary Health Centre	Community Health Centre
Medical officer.....1	Medical Officer.....4#
Pharmacist.....1	Nurse Midwife (Staff nurse).....7
Nurse Midwife (Staff Nurse).....1+2	Dresser.....1
Additional Staff Nurses on contract	Pharmacist/Compounder.....1
Health Worker Female/ ANM.....1	Laboratory Technician.....1
Health Educator.....1	Radiographer.....1
Health Assistant (Male).....1	Ward Boys.....2
Health Assistant (Female)/ LHV.....1	Dhobi.....1
Upper Divisional Clerk.....1	Sweepers.....3
Lower Division Clerk.....1	Mali.....1
Laboratory Technician.....1	Chowkidar.....1
Driver(availability of Vehicle).....1	Ayah.....1
Class IV.....4	Peon.....1
Total.....	Total.....
15	25
The PHC is a referral unit for 6 SCs and has a medical officer (MO) and other staff.#The CHCs are supposed to have four medical specialists (surgeon, physician, gynaecologist, paediatrician) with an anaesthetist and eye surgeon, eventually made mandatory. (RHS,2010)	

were in existence in the country towards the close of 1999. In pre-NRHM period, there was better provisioning of sub centres in the southern states, more particularly in Kerala and Tamil Nadu in terms of their functional efficacies. Thus, leave aside a couple of states, the requirement of ANMs across the states was huge. With Uttar Pradesh topping the list where the requirement was the biggest, followed by Andhra Pradesh, Maharashtra and Rajasthan (Table 8.1). The shortfall could be explained by the fact that nearly two-thirds of the cost of running ANMs posts are funded by the union government and the state governments, noble exceptions apart, treat public health as the responsibility of the federal government, hence recruitment of ANMs have not been a priority at the state level. Filling up vacant positions thus started only after release of NRHM funds. What has been the outcome?

In terms of the required number of ANMs, Andhra Pradesh was in dire need as on 2009 (see Table 8.1), followed by Rajasthan and Maharashtra among the major states. Likewise, need was the highest in Chhattisgarh among smaller states. The positions were filled up, thanks to generous NRHM funding. Interestingly enough, nine out of 16 major states including Andhra Pradesh, Maharashtra, Rajasthan, Punjab etc. went on filling the gap in top gear leading to surplus recruitment, much more, than actually required. The available reports do not explain these aberrations; indeed also fail to explain whether by filling up such vacant positions the ground level functions have been improved.

It needs mentioning here that the preventive health outreach services are essentially carried out by the ANMs or multi-purpose health worker at the sub centre level. This includes pre and neo natal care of pregnant women as well as children. They also serve as a bridge between the people and huge health multi-layered bureaucracy through the PHC. Their job profile include visiting villages under their jurisdiction, ensuring multiple checkups of pregnant women, help organise health camps including mobilisation of mothers during the periodic pulse polio campaign, data gathering (collect information) on multiple issues pertaining to public health and maintain registers (as many as 28 in Gujarat) and

Table 8.1: Surplus/Shortfall in Health worker (female)/ANM at Sub Centre as per 2001 population in 2009

States/UT	Required ¹	In Position	Difference
Major States	[R1]	[P]	(R1-P)
Andhra Pradesh	12522	22140	9618
Assam	4592	7270	2678
Bihar	8858	7672	1186
Gujarat	7274	6431	843
Haryana	2465	4513	2048
Himachal Pradesh	2071	1725	346
Karnataka	8143	8028	115
Kerala	4575	4728	153
Madhya Pradesh	8869	11236	2367
Maharashtra	10579	17322	6743
Orissa	6688	4051	2637
Punjab	2950	4466	1516
Rajasthan	10951	14492	3541
Tamil Nadu	8706	8635	71
Uttar Pradesh	20521	18592	1929
West Bengal	10356	12966	2610
Smaller States			
Arunachal Pradesh	592	217	375
Chhattisgarh	4776	4351	425
Goa	171	226	55
J&K	1907	1663	244
Jharkhand	3947	6435	2488
Manipur	420	840	420
Meghalaya	401	404	3
Mizoram	370	426	56
Nagaland	397	621	224
Sikkim	147	209	62
Tripura	579	377	202
Uttarakhand	1765	1664	101
UTs			
A&N Island	114	195	81
Chandigarh	16	30	14
D&N Haveli	38	60	22
Daman & Diu	26	42	16
Delhi	41	31	10
Lakshadweep	14	14	0
Puducherry	53	104	51
All India	145894	172176	8484*

Notes: R1 based on norm of two ANMs per each existing Sub-Centre. *All India shortfalls is total of state shortfall, ignoring surplus in some states. Shaded columns show surplus

SOURCE: RHS Bulletin, 2009

Box 8.3 : Beating Odds in Wilderness

Nearly hundred and fifty kms away from the district town of Jodhpur, we came across a brave soul whose work station cum residence was located on outer periphery of a *dhani* (hamlet). It was late evening but because of its isolated location, devoid of any live human contact or neighbourhood as such it was appearing more like a shadow in pitch dark condition. Compounded with the lack of electricity, it seemed like mid night; the whole ambience was almost frightening. It was hard to imagine how a relatively young lady in her early thirties lived there by her own. Defying all odds, she had come from neighbouring Haryana to take up a contractual job of which she was in dire need. She walks 6 kilometres (one way) four day a week to take a bus for onward 10-15 kms trip to the villages assigned to her. A tough job by all means. “Whenever acute loneliness overwhelms me, I move to the nearest house, located at a distance of at least five hundred metres, to spend night in the company of an elderly couple who live there” she narrated. There are many such sub centres located at isolated spots, amidst the wilderness in desert districts like Jaisalmer, Barmer, Bikaner, Jalor etc. but it would be hard to find them functional, leave aside a couple of brave duty bound ANMs, the accompanying district official confided us. This is also true that because of entrenched feudal moorings, Rajasthani women hesitate in taking up such lower level jobs, leaving the field open for women from other states to beat the odds. (Field notes, February 11, 2011)

reporting at weekly meetings at the PHC level. A sub centre is run single handed by an ANM. Recruited with educational background of 10th standard level, they are imparted with occupational skills before their postings. Thereafter, ANMs are heavily loaded with multiple responsibilities. Until recently, there has hardly been fresh recruitment of ANMs or MPHWs. Most of them, we met during the field visit in Tamil Nadu, Andhra Pradesh, Rajasthan and Gujarat, were in their late forties or in fifties (except those who were newly recruited on contract), no longer young and energetic to meet the demands of their job.

Their salary has improved but not the living conditions and circumstances (See Box 8.3) under which they have to work. Leave aside exceptionally duty bound noble souls, the health department mandarins find it hard to maintain functional sub health centres in remote areas.

Two other states, Kerala and Tamil Nadu stand as exceptions. Rather both these states have adequate provision of permanent field staff, including ANMs. On the other hand, this is not true of another southern state like Andhra Pradesh or economically developed states like Gujarat.

PHC & CHC levels

The expansion of PHCs had begun during the sixth (1982-87) and seventh plan (1987-92) periods. But review reports appearing under the eighth plan had put them in poor condition, ‘grossly underutilized’ largely due to inadequate ‘staff,

medicine, equipment, transport etc. and also because the PHCs were mainly engaged in ‘completing family planning⁴³ targets’ (Duggal, Nandraj and Vadir 1995). In any case, by late 1999 there were 22, 957 PHCs and 2,935 CHCs were operating throughout the country. But many of them had scanty infrastructure and were running without doctors, even without nurses in nights. Or, wherever doctors and nurses were posted, none would be available on Sundays or holidays. To make the PHCs reliable in the eyes of the people at large, the NRHM envisaged up gradation of PHCs on two counts. The first intervention was aimed at increasing the number of PHCs with round the clock services. They were already there but limited in number and only in four out of ten non north-eastern states. Thus there is six fold increase on this count with Bihar taking the lead (starting from zero in pre-mission to 480 by 2010) followed by Rajasthan (Table A 8.1 appendix). On the other hand, Madhya Pradesh has registered minimum progress over its pre-NRHM PHCs operating under 24x7 modes. It may also be noted that Bihar had the largest number of PHCs without doctors till 2008, three years after NRHM, to quote Rural Health Statistics (RHS) 2009. In fact, Bihar alone had accounted for about two-thirds of total PHCs running without doctors in this category of focused states. In this context, the

⁴³In this context, observations of a former union health secretary is worth recording: ‘Even though public health and family planning (FP) services had to be delivered through the common rural health infrastructure, the emphasis on FP targets have virtually transferred the entire rural health portfolio to that department, divorcing it from other health programmes’... Not surprisingly, the ‘PHCs in many states are perceived as FP centres’ (Misra et al, 2003: 9)

efforts of all the three newly created states deserve appreciation where not a single PHC is reported without a doctor. But this is regrettably not true of CHCs in these states.

Three years after the Mission was launched, the official statistics was released showing the staff position. For instance, as many as 54,961 nurses were required across the states. The requirement was staggering in UP followed by Karnataka, Maharashtra, Rajasthan and West Bengal (Map 8.1). All these states managed to recruit nurses in bulk, rather more than their requirement except in UP which has earned dubious reputation for siphoning off funds, even brazen loot of public funds, leading to the murder of two chief medical officers in the state capital and consequent sacking of the health minister of the state. The states like Madhya Pradesh, Bihar, Jharkhand, Orissa are located on the other end of the scale that failed to fill up the standing vacancies. It is worth recalling that the mortality rates like IMR, MMR are very high in these states. It may also be noted that as per the protocol, there should be at least one nurse in each PHC and seven at every CHC.

In case of radiographers (one per CHC) the status was hardly appreciable. A little over 2,550 positions were lying vacant till 2009. Again the shortfall was highest in UP, followed by Karnataka, Orissa, Kerala and Gujarat (Map 8.2). Given its impressive social development records, it is puzzling to find Kerala being clubbed with known laggard states? Likewise, nearly one-third of the total number of required pharmacist was reported from UP (Map 8.3) alone, followed by Madhya Pradesh, Bihar, Assam, Rajasthan⁴⁴, Orissa and Gujarat. This is nearly true

⁴⁴60 kilometres away from the Jaisalmer district town, we came across a PHC, well staffed with recently added facilities (additional labour room, beds, furniture, toilets etc) but without a doctor. How many patients visit a day? Not more than three-four, we were told. Not a single child delivery conducted in months together. If the existing infrastructure and available manpower was of no use then why extra facilities were added or why additional personnel on contract were hired? We were curious to know. Simply because, an official explained, the state government was following the central guidelines which had envisaged that by upgradation of PHCs, problems could be sorted out. In view of its poor health indicators, the state government just could not thought of taking such issues with the MH&FW. We learnt from the staff nurse that the PHC without a doctor is more a norm than an exception in desert areas, though later we also found in Gujarat where a single doctor runs two some time three PHCs by turn. If a doctor is

Box 8.4 : Spending from Pocket

India has one of the highest proportions of out of pocket spending on health care, 75 % of the total, comparable with very poor countries like Burundi, Chad, Congo and Guinea. The corresponding figure is 13% for the USA, 12 % in UK and 33 % in Brazil.

Source: World Social Security Report 2010-11, ILO cited in TOI, 18\12\2011

in case of standing vacancy for lab technicians table (see A 8.2 in appendix).

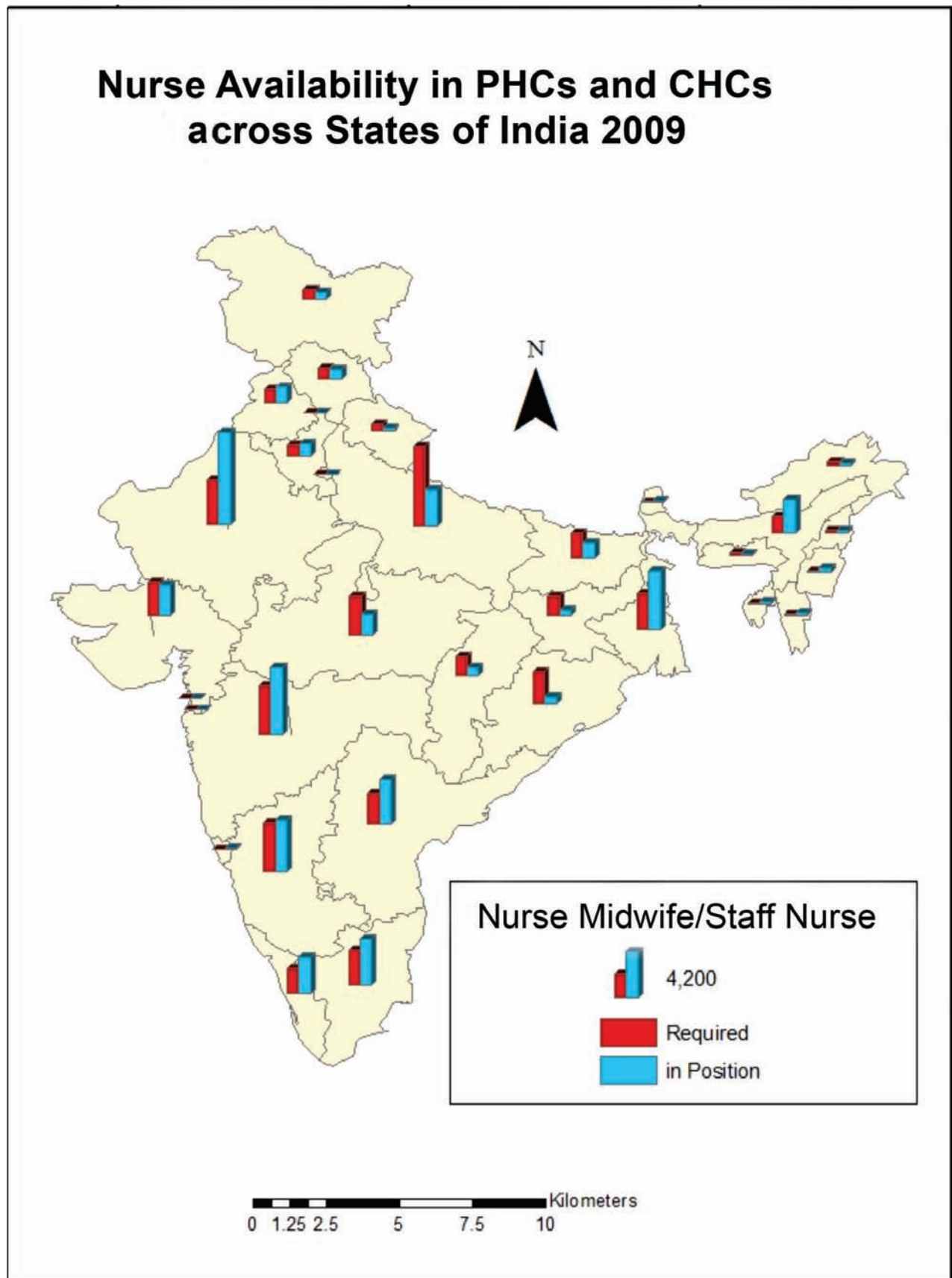
What do figures inserted in all these tables indicate? That states located in all the corners are performing badly. From southern states, Karnataka seems to be joining the league of BIMARU states along with Orissa and worse, even states like Maharashtra and Gujarat, considered until recently to be relatively better governed and also economically developed, are trailing behind on these parameters. Perhaps Tamil Nadu is the only state which seems to have taken the task (filling up standing vacancies) seriously. Be that as it may, the conduct of states in this regard runs contrary to the conventional wisdom that shortage of staff was largely due to prevailing financial crunch at the state level. It is equally difficult to comprehend that filling up required positions was not in tune with the felt need of the states (also see Box 8.5 & 8.6) noble exceptions apart, or at least, it was not a priority item on their agenda.

Physical Infrastructure

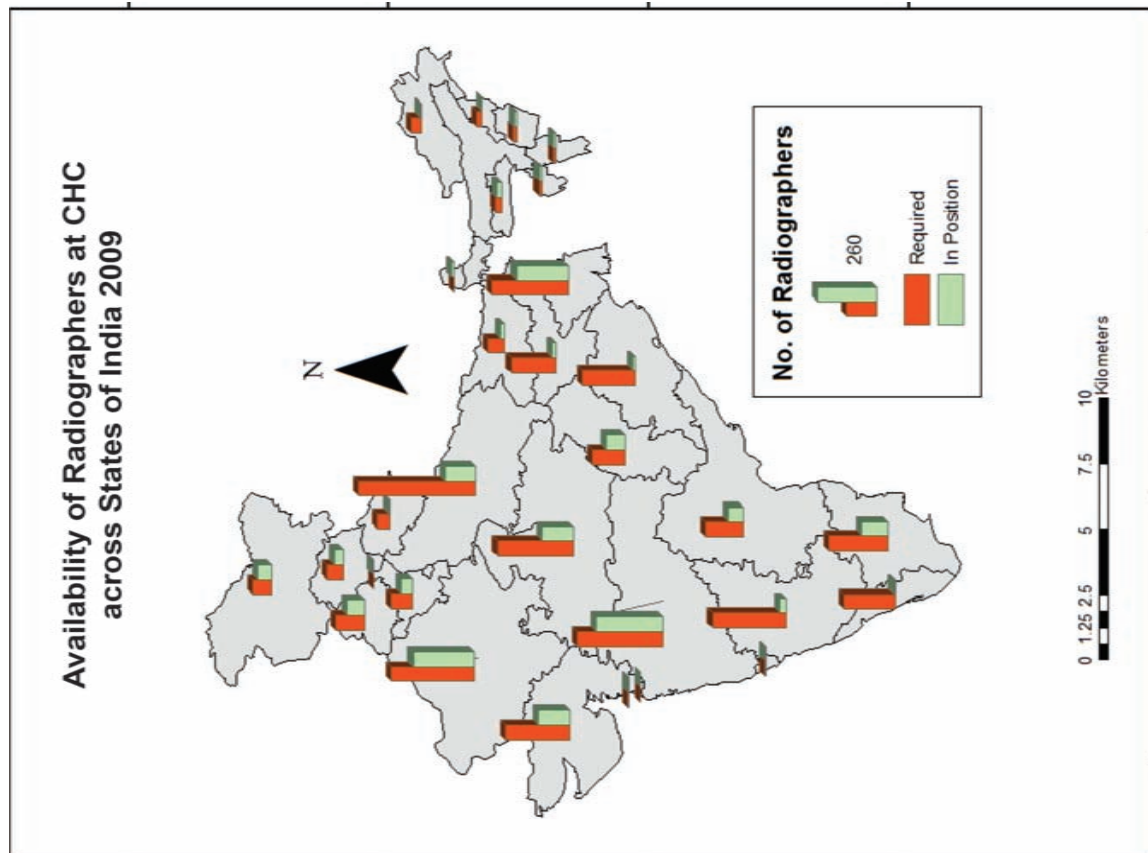
As mentioned earlier, a three-tiered health infrastructure for the rural population was created at certain population levels. The following table shows the number of Sub Centres, PHCs and CHCs that

compelled to join; he goes soon on leave, never to return. Where do people go in case of illness? Or, for that matter, pregnant women for child delivery? To the district hospital, the local lab technician replied. Interactions with individuals in several villages in Jaisalmer, Jodhpur and later also in Barmer district, we learnt every village has at least one-two versicles (Boloros, commanders etc.) that ferry people, including patients to the district town in the morning and drive them back in the evening. To carry an expectant mother usually the same taxi is hired which costs a lot. But people had no choice. Those who can't afford seek help of quacks or traditional dais for child delivery. This also explains why MMR and IMR continue to be higher in Rajasthan than the national average. (Field notes, February 13, 2011)

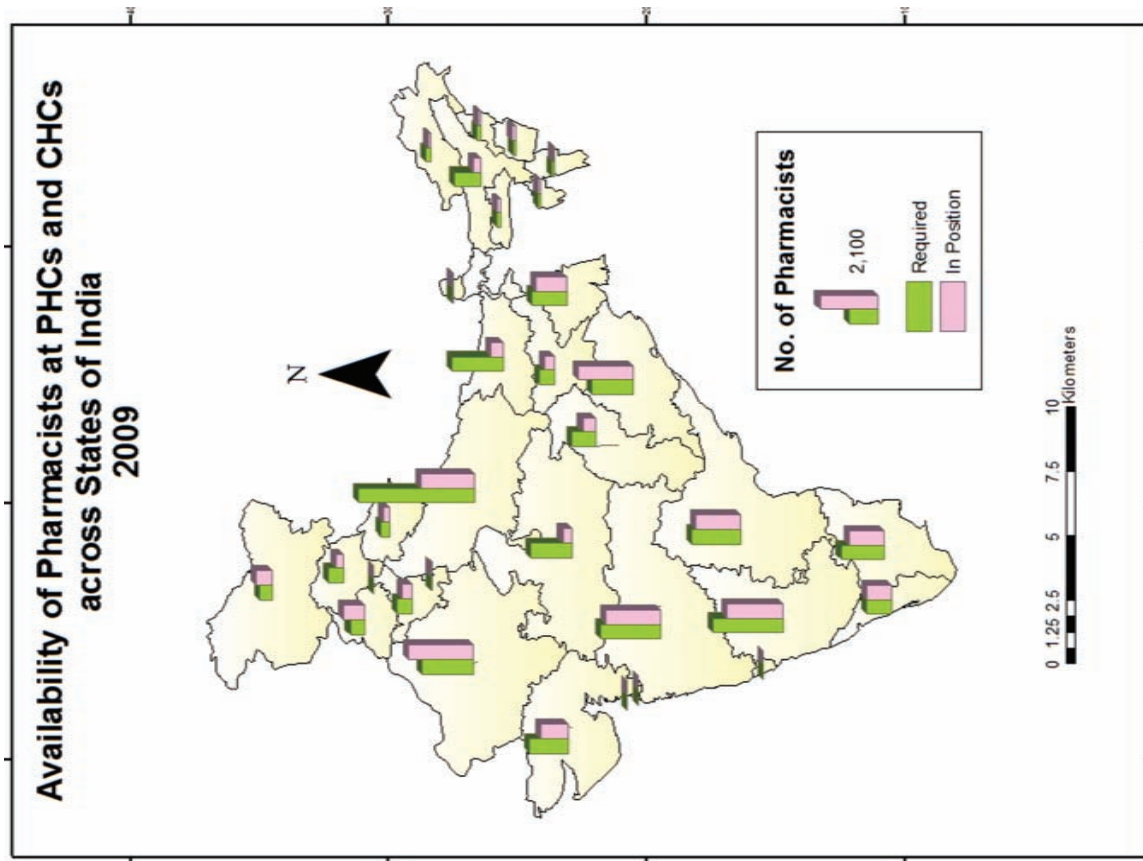
Map : 8.1



Map : 8.2



Map : 8.3



Source: Computed from RHS 2009

Box 8.5 : Handling Emergency?

A resident of Chennai was impressed when his emergency call for an ambulance was responded, just 15 minutes after his father had a stroke. But when he learnt that following the protocol the ambulance can take his father to a government hospital only, he preferred to wait for another vehicle since he didn't want to take his father to a general hospital. Notwithstanding availability of an efficient preventive public health system in Tamil Nadu, its general hospitals are known for 'crowded wards, dingy and smelly corridors, leaking toilet taps, rodents and clogged drains. Even the lower middle class, which avails the state health insurance scheme rolled out in 2009, prefers private hospitals'... In fact, the public hospitals in the state 'accounted for less than 8 % of the total payment made under the state health insurance scheme till May 2011'. But this has not eased the pressure on institutions like Rajiv Gandhi Government General Hospital (RGGGH) attached to the Madras Medical College. The hospital which has 2700 beds gets request for 3,000 admissions, besides 10,000 outpatients. Including attendants and relatives, the hospital gets more than 50,000 visitors a day...The hospital occasionally runs out of vital medicines, x-ray plates; even had to postpone surgery since it ran out of nitrous oxide, the anaesthetic gas.

Source: (Hindustan Times, April, 2012)

Box 8.6 : AIIMS Treating both Common and Rare Diseases

With 453 faculty and 1,200 resident doctors, the Delhi based AIIMS handled 15.28 lakh outpatients, 84,000 admissions and as many as 78,000 surgical cases. That apart, they taught 1,661 students, investigated 381 projects and got 1,424 research papers published. It was conceived as a referral centre, capable of treating complex and rare diseases and handling surgeries. Over the years, it was reduced to the level of 'a medical institution that handles both – basic medical services as well as rare cases', to quote its present director who feels that what is urgently required is setting up of 'comparable institutions created at the regional level'. In Delhi, there are more than 100 cars per 1,000 population but the number of hospital beds available is less than 3 per 1,000 and the bulk of the beds are with the private sector... most of the government hospitals have failed to cope with the demand', to quote a Delhi health department official.

Source: (Hindustan Times, April, 2012)

were in place in 2009 as against the requirement of 2001 population according to the norms.

The Table 8.2 shows the number of health centres in position and required along with their shortfall as on March 2009 as per 2001 population.

Apparently, a very large number of states/UTs such as Bihar, Haryana, Jharkhand, Madhya Pradesh, Maharashtra, Punjab, Uttar Pradesh, West Bengal, D & N Haveli, Delhi are facing shortfalls in terms of infrastructural facilities at all the three (SCs, PHCs and CHCs) levels as on March 2009. On the other hand there are surplus of SCs, PHCs and CHCs in Arunachal Pradesh, Himachal Pradesh, Jammu and Kashmir, Karnataka, Mizoram, Uttarakhand, A & N islands and Lakshadweep during the same period (See Table 8.2).

The highest shortfall of SCs is observed in Bihar, Uttar Pradesh then West Bengal, Maharashtra, Madhya Pradesh and so on.

Likewise, The States of Uttar Pradesh, Bihar, Andhra Pradesh, West Bengal and Maharashtra are among the top five states showing the highest shortfall at the level of CHCs. (see Table 8.2)

The health infrastructure has been created on the basis of population norms, in practice they are seen serving far more population than the intended ones. The state-wise variations are illustrated in the Table A 8.3 (appendix).

The available data show a higher population being served by each type of facility than the national average. In the case of Sub-Centres, for instance, Bihar (24,589), Maharashtra (20,182) and Andhra Pradesh (10,702) are among the states that serve a much higher population than the all-India average (8372). With regards to PHCs, (norm 30,000 for plains and 20,000 in case of hilly or tribal areas), it is again Bihar (158,275) which tops the list of states covering a higher population than the national

Table 8.2 : Health Infrastructure, 2009 (as per 2001 Population))

	Sub Centres			PHCs			CHCs		
Focussed Non NE States	R	P	S	R	P	S	R	P	S
Bihar	14959	8858	6101	2489	1776	713	622	70	552
Chhattisgarh	4164	4776	*	659	715	*	164	144	20
HP	1128	2071	*	186	449	*	46	73	*
J&K	1666	1907	*	271	375	*	67	85	*
Jharkhand	5057	3947	1110	806	321	485	201	194	7
MP	10402	8869	1533	1670	1155	515	417	333	84
Orissa	7283	6688	595	1171	1279	*	292	231	61
Raj	9554	10951	*	1555	1503	52	388	367	21
UP	26344	20521	5823	4390	3690	700	1097	515	582
Uttarakhand	1294	1765	*	214	239	*	53	55	*
NE Focussed States									
Arunachal Pradesh	254	592	*	39	116	*	9	44	*
Assam	5063	4592	471	826	844	*	206	108	98
Manipur	412	420	*	64	72	*	16	16	0
Meghalaya	597	401	196	90	105	*	22	28	*
Mizoram	146	370	*	22	57	*	5	9	*
Nagaland	535	397	138	80	123	*	20	21	*
Sikkim	109	147	*	17	24	*	4	0	4
Tripura	659	579	80	104	76	28	26	11	15
Non-focussed large States									
Andhra Pradesh	11699	12522	*	1924	1570	354	481	167	314
Goa	135	171	*	22	19	3	5	5	0
Gujarat	7263	7274	*	1172	1084	88	293	281	12
Haryana	3005	2465	540	500	437	63	125	93	32
Karnataka	7369	8143	*	1211	2193	*	302	324	*
Kerala	4761	4575	186	791	697	94	197	226	*
Maharashtra	12153	10579	1574	1984	1816	168	496	376	120
Punjab	3219	2950	269	536	394	142	134	129	5
Tamil Nadu	7057	8706	*	1173	1277	*	293	256	37
West Bengal	12101	10356	1745	1993	922	1071	498	334	164
Non-focussed small states & Uts									
A & N Islands	51	114	*	8	19	*	2	4	*
Chandigarh	18	16	2	3	0	3	0	2	*
Dadra & Nagar Haveli	50	38	12	7	6	1	1	1	0
Daman & Diu	21	26	*	3	2	1	0	2	*
Delhi	188	41	147	31	8	23	7	0	7
Lakshadweep	11	14	*	1	4	*	0	3	*
Puducherry	65	53	12	10	24	*	2	3	*
All India²	158792	145894	20534	26022	23391	4504	6491	4510	2135

Source: National Health Profile 2009

average (49,193), followed by Jharkhand (127,298), and Assam (111,408).

Likewise, at the CHC level many states exhibit a higher proportion of population being served by one CHC than the prescribed population norm. In the states like Bihar, West Bengal, Uttar Pradesh, a CHC serves more than 150,000 population. On the other hand, the corresponding figures are well within the prescribed norms in case of Kerala and Tamil Nadu.

Does this corroborate with the available data used to explain shortfall of SC, PHC, CHC? Yes, indeed; clearly most states showing higher population, also exhibit a shortfall in the required number of each centres. That is, the higher proportion of population served by the health Centres is inversely proportional to the shortfall of these Centres.

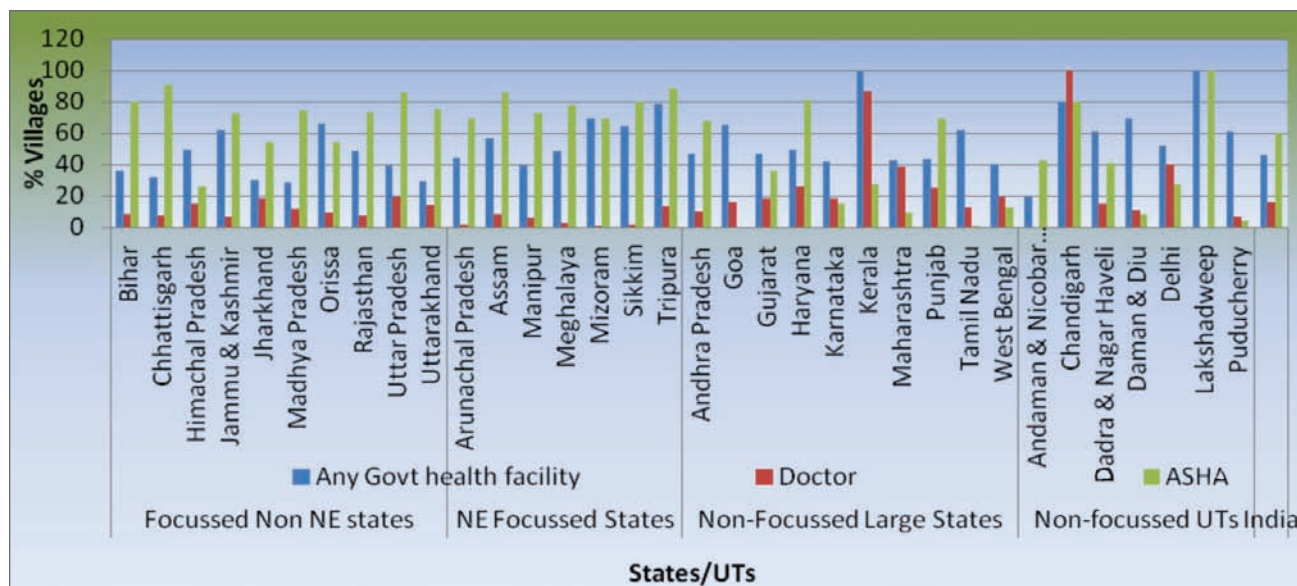
Next, the presence of any government health facility in the village is discussed below. The Fig. 8.1 below is a representation of the percentage of villages having either a doctor, ASHA or any government health facility.

At the all India level (46.2%), not even half of the sampled villages had access to any government health facility, less than one-fifth (16.4%) had access to a doctor and three-fifths (60%) to ASHA. The newly created states of Uttarakhand (29.5%),

Jharkhand (30%), and Chhattisgarh (32.1%) as well as A&N Islands (19.5%) show lowest presence of any government health facility within the village. In Bihar also, little over one-third (36 %) sampled villages have any government facility. The corresponding facilities in Assam (57%) and Orissa at (66.3 %) surprisingly show a higher figure than the national average. As far as doctors in the village are concerned, only 16.4 % of surveyed villages across India have doctors. Apart from the NE states (except Tripura 13.7%) that show low presence of doctors in the villages (0.8%-6.3%), the other states that exhibit the similar pattern are Jammu & Kashmir (6.5%), Rajasthan (7.4%) and Chhattisgarh (7.5%).

ASHA, not surprisingly, given the importance of NRHM is present in good numbers in almost all states. The states showing a low presence of ASHA are mostly those where the scheme has not been implemented or not given prominence for instance Tamil Nadu with merely 1.1 % of villages having ASHAs. It needs mentioning that the villages in Tamil Nadu are well endowed with public health personnel. This includes a three-tiered network of nurses – Village Health Nurse (VHN), Cluster Health Nurse (CHN) and Block Health Nurse (BHN) – covering practically all villages except those located in the tribal pockets of Nilgiris where ASHAs have been recruited. In fact, the job assigned to a VHN

Fig. 8.1 : Village with Health Facilities 2007-08



in Tamil Nadu is the same what ASHA is expected to do in the rest of the country.

Status of Infrastructure, Amenities, Facilities

There are certain basic requirements for any health facility. The fundamental requirement is that it be well staffed with necessary and additional personnel in place, either a government or rented building. Among the other amenities and facilities required are housing facilities available for staff, regular supply of electricity and water, toilet facilities, essential drugs, availability of Ambulance, motorable road etc. In addition, specific facilities are needed at different levels depending on the norms:

- Sub Centre- Labour room in current use
- PHCs-24 hrs, equipments etc
- DHs-lab and investigative facilities

In the following section we analyse this.

Sub-Centre

The data inserted in Table 8.3, have been accessed from the RHS, showing facilities available at the Sub centre. At the all India level, over half (51.8%) of SCs have ANM quarters of which nearly three-fifths (59.8) were occupied, it may be noted however that about one third (30.5 %) of SCs are without regular water supply, little more (32.6 %) at the level of individual states without electricity, and about one one-fifth (21 %) are not connected with 'all weather motorable approach road'.

Adequate Equipments and Essential Drugs at SC⁴⁵

Are the SCs adequately equipped and having essential drugs? Over four-fifth (84%) of 18,068 SCs surveyed were found adequately equipped, and 65. % had at least three-fifth (60%) of available (see Table 8.4) essential drugs. Thus, most states are well endowed in terms of being adequately equipped and

⁴⁵Equipments include: instrument sterilizer, auto disposal syringes, hub cutter, B P instrument, stethoscope, weighing machine (Infant/Adult), haemoglobin meter, foetoscope, SIMS speculum, IUD insertion kit, vaccine carrier. drugs- drug-kit A/B, IFA tablets, Vitamin-A solution, ORS packet.

having essential drugs. Manipur with 46% and Orissa are at the bottom among focussed states with only 47% of SCs being adequately equipped and a little over one-third (36%) were having essential drugs. Likewise, Tripura (39%) and Bihar (50%) are the other states that have less than half of SCs being adequately equipped.

In the case of availability of essential drugs (at least 60%) , Bihar portrays a dismal picture with only 6% of the 1165 Sub centres surveyed having essential drugs, followed by Punjab (8%). This was almost true of around one-third in the case of Orissa (36%) and Uttar Pradesh (35%) showing fewer number of SCs having essential drugs.

The NRHM, has made it mandatory to display and give information regarding some activities at the SC level. These are: 1. Citizen's Charter, 2. Constitution of Village Health Sanitation Committee & 3. Untied Funds received.

As far as the citizen's charter is concerned, it was found displayed at around two-fifth (40%) of SCs at all- India level, on an average has over four-fifths (83 %) of SCs with VHSCs constituted, and little less (81 %) had received untied funds (Table 8.5) Among the major states

Bihar, again shows the least a mere (5%) (barring Goa 3%) centres displaying the citizen's charter. Otherwise, in most of the states, at least 40% of SCs were found displaying the citizen's charter. As regards constitution of VHSC, most states appear to have fared well (around 80% on an average.) with West Bengal and Orissa showing the least, yet around half to two-thirds (49.8% and 59.9 %). Again, around one-third SCs (34%) in Bihar seem to have received the untied fund, in contrast to figures (See Table 8.5) available for Meghalaya (68%), Orissa (70.%), Arunachal Pradesh (70.%) and Uttar Pradesh (73%).

Facilities available at PHCs: The available figures reveal that little less than one-tenth (8.%) of the total PHCs in the country are still without electric supply (see Map 8.4) below. Among the states, two-thirds (61 %) of PHCs in Andhra Pradesh are without electricity, followed by Assam (44%), Chhattisgarh

Table 8.3 : Facilitate at Sub Centre

States/UTs	Number of Sub Centres	Number of Sub Centres with ANM Quarter		No. of Sub Centres with ANM living in Sub Centre Quarter*		Without Regular Water Supply		Without Electric Supply		Without All-Weather Motorable Approach Road	
		Number	%	No.	%	No.	%	No.	%	No.	%
Andhra Pradesh	12522	4221	33.7	4221	100	0	0	0	0	0	0
Arunachal Pradesh	592	74	12.5	0	0	112	18.9	63	10.6	0	0
Assam	4592	899	19.6	716	79.6	1016	22.1	3056	66.6	4209	91.7
Bihar	8858	6375	72	432	6.8	5287	59.7	6348	71.7	1915	21.6
Chhattisgarh	4776	1329	27.8	1295	97.4	2517	52.7	2124	44.5	1140	23.9
Goa	171	0	0	0	0	0	0	0	0	0	0
Gujarat	7274	6413	88.2	6413	100	0	0	0	0	45	0.6
Haryana	2465	669	27.1	480	71.7	938	38.1	932	37.8	305	12.4
Himachal Pradesh	2071	1119	54	230	20.6	432	20.9	362	17.5	645	31.1
Jammu & Kashmir	1907	181	9.5	56	30.9	NA	NA	NA	NA	540	28.3
Jharkhand	3947	596	15.1	434	72.8	2606	66	2654	67.2	1229	31.1
Karnataka	8143	4493	55.2	4493	100	NA	NA	0	0	NA	NA
Kerala	4575	2529	55.3	1674	66.2	830	18.1	142	3.1	351	7.7
Madhya Pradesh	8869	6926	78.1	2007	29	3609	40.7	2385	26.9	1665	18.8
Maharashtra	10579	7452	70.4	NA	NA	2954	27.9	4838	45.7	0	0
Manipur	420	7	1.7	0	0	333	79.3	249	59.3	237	56.4
Meghalaya	401	388	96.8	171	44.1	75	18.7	73	18.2	73	18.2
Mizoram	370	350	94.6	350	100	330	89.2	NA	NA	177	47.8
Nagaland	397	60	15.1	60	100	258	65	281	70.8	20	5
Orissa	6688	3524	52.7	2553	72.4	2277	34	1490	22.3	0	0
Punjab	2950	903	30.6	398	44.1	903	30.6	958	32.5	131	4.4
Rajasthan	10951	9199	84	2056	22.4	3041	27.8	1895	17.3	10951	0
Sikkim	147	94	63.9	55	58.5	1	0.7	1	0.7	43	29.3
Tamil Nadu	8706	6538	75.1	NA	NA	0	0	0	0	0	0
Tripura	579	28	4.8	8	28.6	249	43	305	52.7	79	13.6
Uttar Pradesh	20521	7702	37.5	7702	100	12819	62.5	14359	70	Na	Na
Uttarakhand	1765	879	49.8	879	100	789	44.7	730	41.4	817	46.3
West Bengal	10356	2404	23.2	0	0	0	0	3524	34	0	0
A & N Islands	114	104	91.2	80	76.9	26	22.8	28	24.6	211	9.6
Chandigarh	16	5	31.3	0	0	0	0	0	0	0	0
D & N Haveli	38	38	100	21	55.3	12	31.6	0	0	2	5.3
Daman & Diu	26	20	76.9	6	30	3	11.5	0	0	0	0
Delhi	41	0	0	0	0	0	0	0	0	0	0
Lakshadweep	14	0	0	0	0	0	0	0	0	0	0
Puducherry	53	33	62.3	12	36.4	0	0	0	0	0	0
All India	145894	75552	51.8	36802	59.8	41417	30.5	4679	32.6	24585	21.0

Source: RHS, 2009



Table 8.4 : % of SCs with Adequate Equipments & Essential Drugs

States/UTs	Percentage of Sampled Sub-Centres		
	Adequately equipped ¹ (at least 60%)	Essential Drugs ² (At least 60%)	Total No. of SCs
A & N Islands	100	100	25
Andhra Pradesh	76.3	96.9	885
Arunachal Pradesh	87.5	85.7	112
Assam	90.5	72.4	714
Bihar	49.6	5.9	1165
Chandigarh	100	40	5
Chhattisgarh	97.4	95.6	574
D & N Haveli	100	100	29
Daman & Diu	95.5	100	22
Delhi	97.4	89.5	38
Goa	97.4	74.4	39
Gujarat	98	94.1	714
Haryana	95	29.1	625
Himachal Pradesh	97.8	93.4	409
Jammu & Kashmir	60.6	72.8	368
Jharkhand	83.3	66.4	783
Karnataka	85.2	76.6	880
Kerala	77.6	96.4	532
Lakshadweep	20	60	5
Madhya Pradesh	92.4	93.7	1362
Maharashtra	92.6	86.8	1058
Manipur	45.8	20.3	118
Meghalaya	76.5	80	115
Mizoram	89.5	86.6	172
Orissa	47.3	35.8	1053
Puducherry	100	100	26
Punjab	95.5	8.4	595
Rajasthan	92.6	84.4	1035
Sikkim	97.6	60.7	84
Tamil Nadu	97.9	82.1	861
Tripura	38.7	90.2	163
Uttar Pradesh	83.9	35.3	2403
Uttarakhand	92	46.6	412
West Bengal	98.1	89	688
India	83.5	65.3	18068

Source: DLHS-3 2007-08

Table 8.5 : % of SCs Performing Assigned Tasks 2007-08

Display of certain activities at the health centres as mandated by NRHM guidelines				
States/Uts	Citizen's Charter	VHSC1	Untied Fund received	Total no. of SCs
A & N Islands	24	35.3	84	25
Andhra Pradesh	34.6	88.6	90.4	885
Arunachal Pradesh	23.2	84.6	70.5	112
Assam	39.6	88.2	83.8	714
Bihar	5.3	83.3	34.3	1,165
Chandigarh	100	60	20	5
Chhattisgarh	48.8	86.8	84.7	574
Dadra & Nagar Haveli	41.4	90.9	0	29
Daman & Diu	40.9	93.3	95.5	22
Delhi	50	0	13.2	38
Goa	2.6	12.5	94.9	39
Gujarat	46.1	94.3	84.9	714
Haryana	46.4	91.2	95	625
Himachal Pradesh	60.9	92	86.8	409
Jammu & Kashmir	13.9	76.6	80.4	368
Jharkhand	31.6	81.7	86.7	783
Karnataka	29.2	88.5	90.5	880
Kerala	59.4	94.2	86.3	532
Lakshadweep	0	40	100	5
Madhya Pradesh	40	78.8	86.8	1,362
Maharashtra	40.9	95	84.3	1,058
Manipur	40.7	74.7	80.5	118
Meghalaya	64.4	76	67.8	115
Mizoram	65.1	94.4	90.7	172
Orissa	55.1	59.9	70.4	1,053
Puducherry	42.3	100	23.1	26
Punjab	50.8	82.6	92.3	595
Rajasthan	45.9	87.7	90.7	1,035
Sikkim	39.3	79.5	97.6	84
Tamil Nadu	40.7	94.7	96.1	861
Tripura	58.3	83.3	89.6	163
Uttar Pradesh	31.3	70.5	72.7	2,403
Uttarakhand	74.5	96.5	88.1	412
West Bengal	42	49.8	93.8	688
India	39.6	83.4	81.3	18068
	7152	10,853	14684	

Source:DLHS 3



(30%), Himachal Pradesh(20%), Nagaland (19%), and Orissa (18%).

Likewise, with regards to regular water supply, 12 % of thePHCs in the country do not get regular water supply. At the level of individual states, the figure is astounding in case of Manipur and Mizoram (95% and 100% , respectively) followed by Arunachal Pradesh (61.2%), Chhattisgarh (49.1%), Nagaland (38.2%), Orissa (24.4) Himachal Pradesh (20.5%) (Map 8.4).

Providing a residential quarter to the serving medical officer was among the proposed amenities and facilities to be added at the health centres. As per DLHS-3 data, little over half (54.5%) of PHCs across India have been provided residential quarters for medical officers. Individually, PHCs are well endowed in Kerala and Tamil Nadu, butthese facilities are meagre in case of Andhra Pradesh (25.7%) Himachal Pradesh (21.5%), J&K (26.1%) and Kerala (24.9%) all showing figures lower than the national average (Table A 8.4 appendix).

PHC Functioning on 24 x 7 Mode: Half of the PHCS surveyed across the states found functioning on 24hrs basis (52.8%). In Tamil Nadu however, only block PHCs operate on this mode- the main PHC. Several states however exhibit figures far below the national average. This includes Kerala (10.3%), Punjab (17.2%), Manipur (13.2%), and West Bengal (25.9%) (See Table A 8.4 appendix). The reason Kerala shows a low figure is because of standardisation norms. One the other end of the scale are the states of Jharkhand, Maharashtra, Madhya Pradesh and Uttarakhand where more than two-thirds (70%) of PHCs are found functioning on 24 hrs basis as seen in the map 8.5.

What is the average number of beds available at the PHC level? According to DLHS figure over two-thirds (67 %) of PHCs have at least 4 beds. West Bengal (27.%), Tamil Nadu (28%) and Kerala (27.4%) have the lowest number of PHCs with at least 4 beds in the map given below (Map 8.5).

As far as the availability of functional vehicle to meet exigencies is concerned (Table A 8.4 appendix), little more than one-third (37.2 %) of sampled PHCs

have a vehicle across the states of India. Less than half of this all-India average figure was reported from Kerala (16%), Orissa (17%), and Haryana (14%).

Apart from these facilities, it can be seen that new born care equipment was also available but only in one-fourth (28%) of PHCs, three-fourths (61%) have functional OTs and nearly half of (47%) PHCS were providing referral services for delivery (See Appendix A 8.5) Likewise, cold chain equipment was available in two-thirds (67%), little more 70% had at least 60% of essential drugs. The southern states 90% of PHCs surveyed in Karnataka and Tamil Nadu had at least 60% essential drugs compared to Manipur with 6% and West Bengal 43% of sampled PHCs.

Facilities at CHC

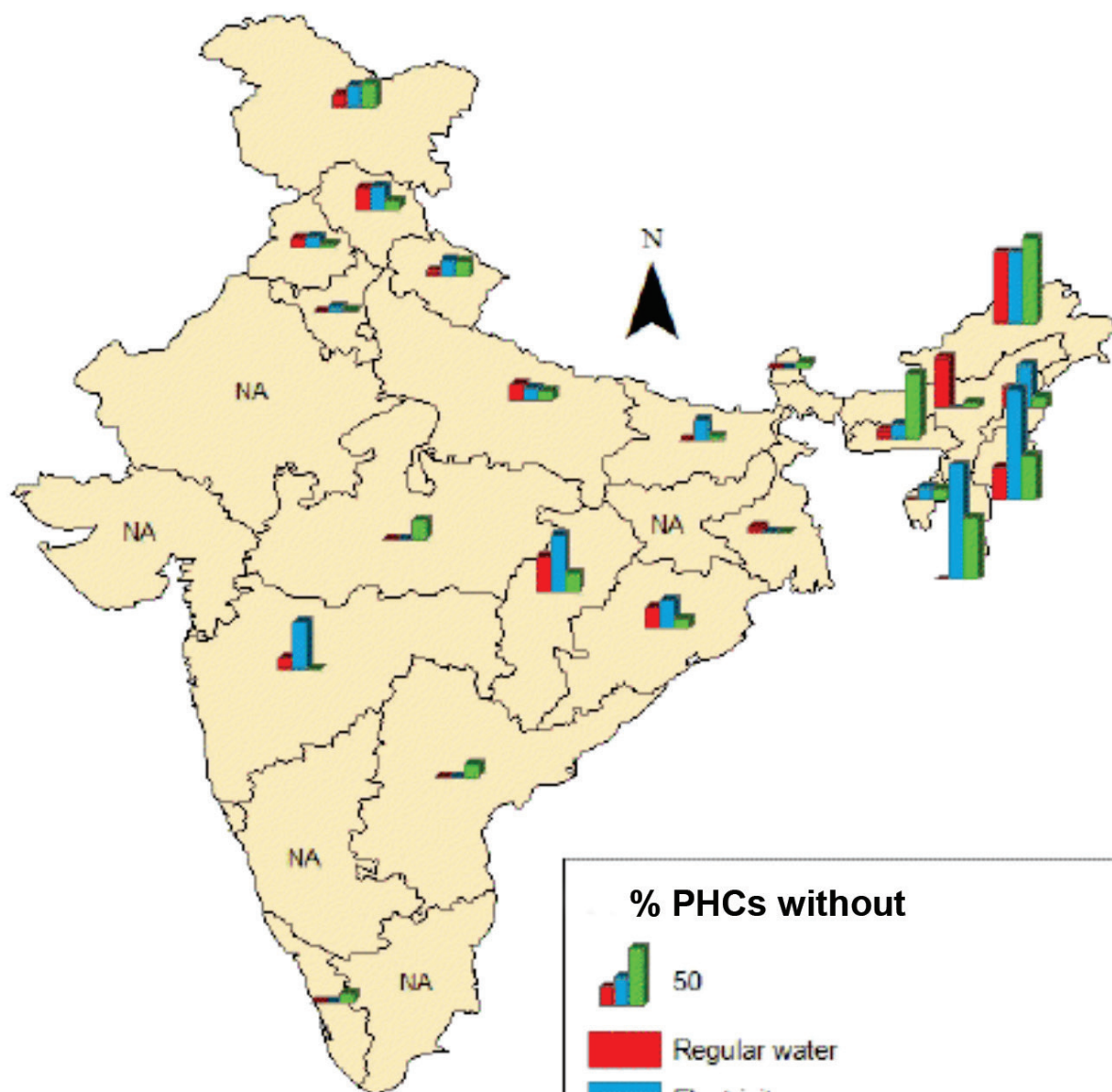
A Community Health Centre (CHC) is a referral centre for at least 4 PHCs and by norm it should have 4 medical specialists (surgeon, physician, gynaecologist and paediatrician), 21 paramedics and other staff. As far as infrastructural facilities are concerned, it should have at least 30 in door beds, one OT, X-ray and labour room(s) and laboratory facility. From the figures inserted in the table (Table 8.6) on the availability of specialists at the CHC, it is apparent that only a quarter (25%) (1047 of the 4162 sampled) CHCs in the country had obst.gynae; one-fifth have a paediatrician, little less (17 %) had an anaesthetist, and less than one tenth (8.5 %) had a health manger.

Gynaecologist: Of the CHCs surveyed in Tripura, Mizoram, none had a gynaecologist in place. Among the other states, Himachal Pradesh shows the lowest with less than 5% of the 92 sampled CHCs having gynaecologists in position. The corresponding figure was slightly higher in case of Tamil Nadu where 7% of the 373 sampled CHCs had a gynaecologist. Gujarat (11.3%), West Bengal (11.6%) and Meghalaya (11.5%) are the other states with fewer CHCs having gynaecologists. The states showing a better picture in terms of presence of gynaecologist (See Table 8.6) at CHCs are Orissa (87.3 % of 229 CHCs surveyed), Jharkhand (62.5% of 8 CHCs surveyed) and J&K (45.2 % of 73 surveyed CHCs)

Paediatrician: In the case of paediatrician, (Table 8.6) Himachal Pradesh again shows the lowest

Map : 8.4

PHCs without Basic Facilities

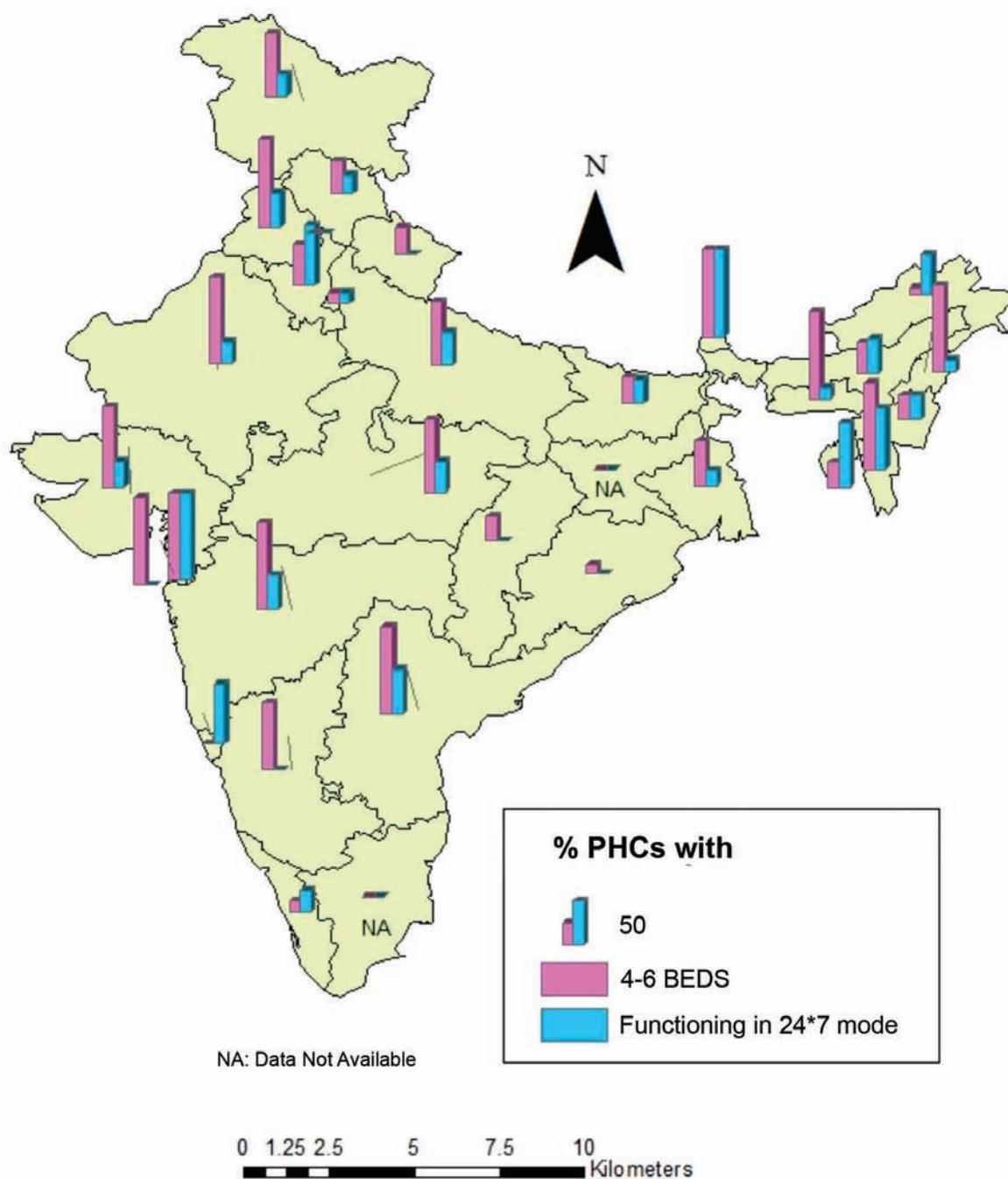


NA. Data Not Available

0 150 300 600 900 1,200 Kilometers

Map : 8.5

Full Time Child Delivery Facilities in PHCs across States of India 2009



(1.1%) of the sampled CHCs having one, followed by Arunachal Pradesh (3%), Gujarat (5%) and West Bengal (6%). With corresponding figure of 69% Orissa again demonstrates a better example followed by Bihar with (43%) and Jharkhand (37%).

Anaesthetist: Kerala (2.3 %), Himachal Pradesh (5.4%) and Punjab (7.7%) show the lowest number of CHCs with an anaesthetist (Table 8.6). On the other hand, J&K (54.8%), Orissa (50.7%) and Maharashtra (27%) and Chhattisgarh (24.1 %) fare better with figures higher than the national average.

Health Manager: With the new IPHS norms in place, the presence of a health manager at the CHC, is mandatory. It takes time for any new idea to percolate time. This is precisely what appears to be happening on this front. Clearly the progress is slow, gradually states have started picking it up. Not surprisingly, so far merely 8.5 % CHCs in the country having a health manager in place. Kerala (0.5%), Gujarat (0.5%), Uttar Pradesh (2.7%), Rajasthan (2.8%) and Tamil Nadu (3%) show lower number of CHCs having health manager. States faring better include Orissa (57.2%), Bihar (34.9%) and Chhattisgarh (22.6%). In addition to all this and as per the IIPHS norms, the CHCs should also be endowed with some other organisational structure aimed at facilitating transparency and accountability. We look at the display of citizen's charter, RKS being constituted and monitored regularly and utilization of untied funds (see, Table 8.6).

Citizen's Charter: More than three-fourths (78.9%) of the CHCs have displayed the citizens charter, nearly nine-tenth (89.6%) have constituted RKS of which 95% are monitored regularly (Table 8.7). Besides 4 out of 5, more than (80%) of CHCs surveyed were found utilising untied funds across India. Likewise, display of citizens charter was reported from most states and even on the lower end, it was at least three-fifth (60%) of CHCs in Orissa, Meghalaya and J&K.

Around two-thirds (60-65%) of CHCs have constituted RKS in Goa, Jharkhand and Andhra Pradesh. Gujarat (210) with 99% tops the states followed by Rajasthan, Maharashtra and Madhya

Pradesh (all showing 96.9%). Most states reported monitoring RKS regularly (around 95% of CHCs) except Goa where only one-third of the RKS is monitored regularly.

Utilisation of untied funds: Only 31.8% of CHCs in Bihar reported utilisation of untied funds (Table 8.7) followed by Uttar Pradesh (63.8%) and Orissa (63.3%).

District Hospitals (DHs)

Of the total 596 district hospitals surveyed, around three-fourths (75%) had at least one medicine specialist, four-fifth (81%) had at least one surgery specialist, almost equal number of hospitals (82%) had an obstetrician gynaecologist. And little over half (54%) had at least one radiologist (Map 8.4, also see, Table 8.7).

Andhra Pradesh (57.1%), Haryana (55%), Mizoram (50%) and Manipur (42.9%) are the states showing fewer DHs with at least one medicine specialist. Rajasthan (96%) and Orissa and West Bengal top the list with almost 94% of DHs with at least one medicine specialist.

If the choice is restricted to at least one surgery specialist at the DHs, Manipur with only 14.3% lies at the bottom along with Sikkim (25%) and Arunachal Pradesh (37.5%). The corresponding figure for Assam, Punjab and Rajasthan is 100%, followed by West Bengal (94%), Kerala (92%) In terms of facilities and amenities at the DHs, almost all DHs (92%) have 24 hrs water facilities, three phase electricity connection a stand-by generator in working condition, and ambulance on the road. Following the norms prescribed in IPHS, NIC terminal has been made available at least in one-fourth of DHs (Table A 8.6 appendix).

It is found that around 90% of the DHs have displayed citizen's charter and also constituted the RKS. More than 95 % of DHs regularly monitor the activities of the RKS. Among the states displaying the citizen's charter, Arunachal Pradesh has the lowest number of DHs displaying it (37.5%). Kerala (61.5%) and Jharkhand (65.2%) show similar picture (Table A 8.7 appendix).

Table 8.6 : Human Resources Available at CHC

States/UTs	Obs. Gyn.	Paediatrician.	Anaesthetist	Health Manager	Total no CHCs
A & N Islands	100	50	100	50	2
Andhra Pradesh	42.6	29	26.5	3.7	162
Arunachal Pradesh	34.2	2.6	7.9	15.8	38
Assam	31.3	10.8	20.5	9.6	83
Bihar	40.9	43.9	19.7	34.9	66
Chandigarh	100	50	0	0	2
Chhattisgarh	19.7	19	24.1	22.6	137
D&N Haveli	0	0	0	0	1
Daman & Diu	100	100	100	100	1
Delhi	NA	NA	NA	NA	NA
Goa	20	0	0	0	5
Gujarat	11.3	4.7	9.4	0.5	212
Haryana	13.1	13.1	10.7	9.5	84
Himachal Pradesh	4.4	1.1	5.4	10.9	92
Jammu & Kashmir	45.2	19.2	54.8	9.6	73
Jharkhand	62.5	37.5	12.5	0	8
Karnataka	28.8	12.7	11	6.8	118
Kerala	14.3	15.7	2.3	0.5	217
Lakshadweep	0	0	0	0	3
Madhya Pradesh	15.8	18.5	10.4	9.3	259
Maharashtra	40.3	23.9	27	4.8	293
Manipur	15.8	21.1	10.5	15.8	19
Meghalaya	11.5	7.7	7.7	19.2	26
Mizoram	0	0	10	0	10
Orissa	87.3	69	50.7	57.2	229
Puducherry	0	25	0	0	4
Punjab	31.6	17.4	7.7	5.8	155
Rajasthan	29.9	23.1	17.8	2.8	355
Sikkim	NA	NA	NA	NA	NA
Tamil Nadu	7.2	6.7	9.4	3	373
Tripura	0	0	8.3	0	12
Uttar Pradesh	19.5	20.8	16	2.7	693
Uttarakhand	16.8	23.2	8.4	3.2	95
West Bengal	11.6	5.7	13.4	4.8	335
India	25.2	19.3	17.1	8.5	4162
	1047	805	710	355	

Source : DLHS-3

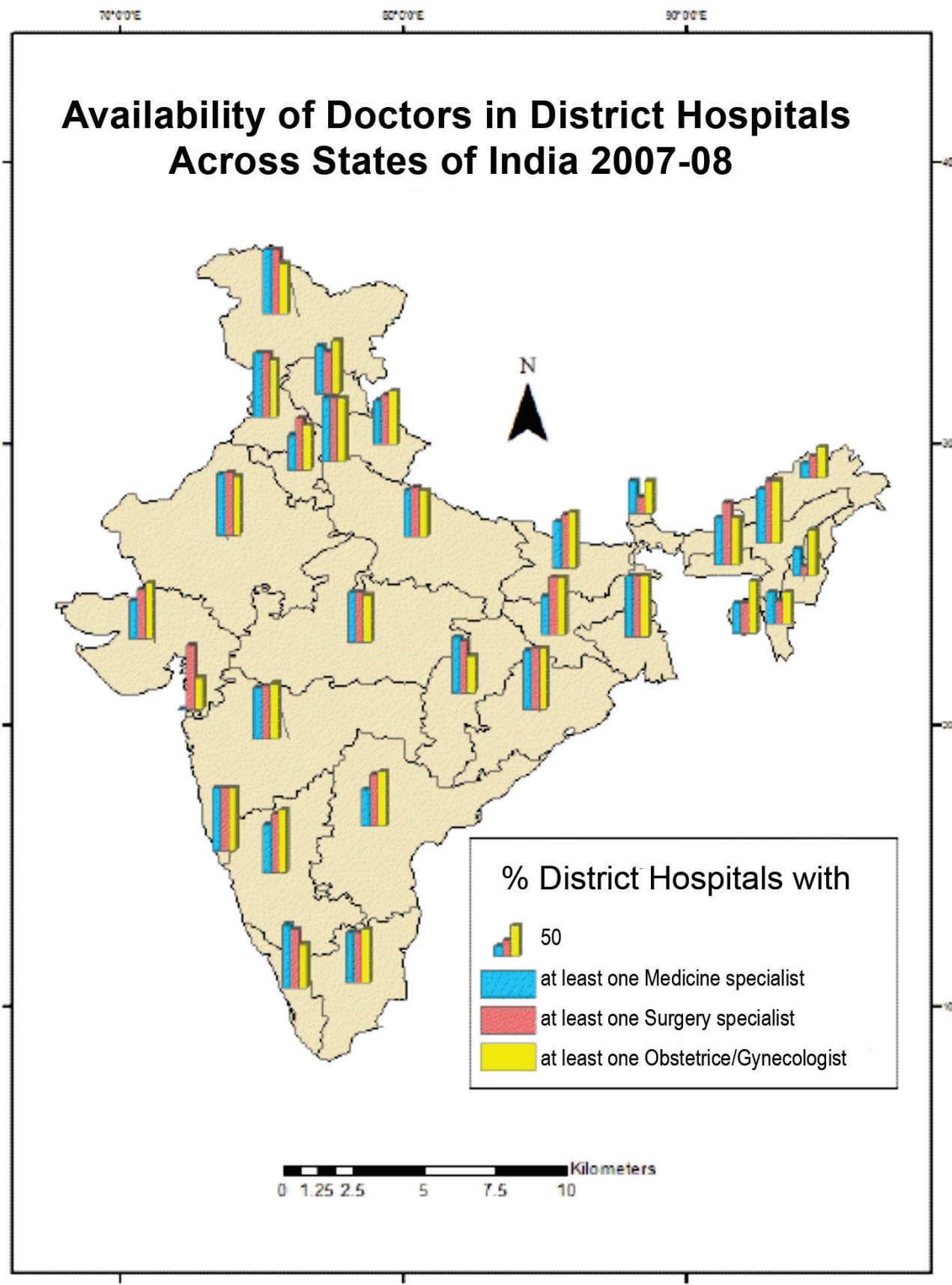
Table 8.7 : % of CHCs Performing Assigned Tasks

States/Uts	Citizen's charter displayed	RKS constd.	RKS monitor regularly	Utilised untied fund	Total number of CHCs
A & N Islands	50	50	100	100	2
Andhra Pradesh	74.7	67.3	92.7	78.4	162
Arunachal Pradesh	71.1	81.6	96.8	89.5	38
Assam	81.9	78.3	95.4	83.1	83
Bihar	65.2	93.9	87.1	31.8	66
Chandigarh	100	50	100	50	2
Chhattisgarh	86.9	95.6	97.7	82.5	137
D& Nr Haveli	100	0	0	0	1
Daman & Diu	100	100	100	100	1
Delhi	nc	nc	nc	nc	nc
Goa	60	60	33.3	60	5
Gujarat	80.2	99.1	99.1	77.4	212
Haryana	82.1	86.9	97.3	94.1	84
Himachal Pradesh	77.2	93.5	100	60.9	92
Jammu & Kashmir	65.8	95.9	94.3	78.1	73
Jharkhand	62.5	62.5	100	75	8
Karnataka	76.3	70.3	85.5	65.3	118
Kerala	81.1	95.4	98.6	84.3	217
Lakshadweep	66.7	66.7	50	100	3
Madhya Pradesh	83.4	96.9	97.6	90.7	259
Maharashtra	77.5	96.9	97.9	80.2	293
Manipur	79	89.5	94.1	94.7	19
Meghalaya	61.5	84.6	95.5	88.5	26
Mizoram	100	100	100	100	10
Orissa	62	78.2	97.2	63.3	229
Puducherry	75	50	100	50	4
Punjab	81.9	89.7	83.5	92.3	155
Rajasthan	95.2	96.9	97.7	97.5	355
Sikkim	nc	nc	nc	nc	nc
Tamil Nadu	85.8	84.7	97.2	97.6	373
Tripura	83.3	91.7	100	100	12
Uttar Pradesh	86.6	87.7	91.8	63.8	693
Uttarakhand	92.6	82.1	100	93.7	95
West Bengal	46.6	97.6	93.6	87.8	335
India	78.9	89.6	95.2	80.6	4162

Source: DLHS-3



Map : 24



Summing up

By any yardstick, the health care system has hardly been satisfactory in the country for quite long. Besides, there has always been a distinct rural-urban divide. Despite provisioning, the rural public health institutions have either been defunct (notice wholly or nearly permanent absenteeism of the doctors) or chronically deficient infrastructure. In the urban areas, in contrast, there have been improved infrastructure with doctors available largely on duty, though because of too much rush it would be crowded. Above all, given the facilities available in the private hospitals/ nursing homes, the choice was always there to buy the private health care services at least by those who could afford it. In rural areas the alternative to near defunct or non-existent public health services was *jholachap* doctors (read quacks) or move to towns and cities at enormous cost and attenuated discomfort. Set against this backdrop, the NRHM was designed to minimize, if not completely eliminate, this unrelenting gap between the rural and urban areas. Lunched with much fanfare with huge budgetary allocations in 2005, the NRHM covers a plethora of programmes within its folds, all aimed at improving the health care system by augmenting both human resources and physical infrastructure in the health sector.

Undoubtedly, there has been over all improvements in deployment of practically all cadres of medical staff – from medical officer to ANM to health assistant etc. – posted at all the three levels of (sub, primary and community) health centres and also at the district hospitals. This is equally true of additional facilities provided to health centres and hospitals. There have been wide ranging variations, as usual, across the states, including Bihar, Rajasthan

and Tamil Nadu. For instance, doctors were recruited in Bihar after the lapse of more than a decade, thanks to NRHM but on contract basis. On the other hand, Tamil Nadu continued with its open recruitment policy – walk-in for doctors – which has remained in vogue for nearly two decades. Rather, the staff provisioning in this southern state has been on higher side. The PHCs were also upgraded in this state, at least one in a block, with additional facilities (including ambulatory services) and minimum three doctors to run these health centres on round the clock basis. In Rajasthan, we also came across PHCs run on the 24 into 7 hour/ day basis but instead of doctors, nurses would be in charge of PHCs in night shift. At some places, even nurse would sleep at her residential quarter within the campus on night shifts, leaving behind an ANM to take care of in-patients, (largely pregnant or women with their newly born child) and alert her in case of emergencies. Paradoxically, even those PHCs which have been lying almost defunct due to perennial absence of doctors in the far flung areas were also provided additional equipments, even newly recruited extra staffs were deployed while the existing one had hardly any work at all. All this confirm a mindboggling obsession for uniform implementation of central guidelines in complete disregard for ground realities. When utilisation of available funds become the prime concern, then who cares for quality or wastage of precious resources. Be that as it may, the status report prepared at the NRHM headquarters would look impressive, showing number of staff recruited, additional labour rooms added, new equipments etc provided. If all these are not in use, the mandarins sitting in Delhi are not at fault (see, Saxena in Part III), at least, this is what they would like us to believe in. Should we?■

NRHM : ATTAINMENTS & CONSTRAINTS

The National Rural Health mission (NRHM) began unfolding since April 2005. Its stated objective was to provide effective health care to rural population, intended to serve even the poorest people located in the remote regions. Initially, the Mission started with 18 states⁴⁶ but subsequently, the entire countryside was brought under its coverage. The mission was, in fact, launched in pursuance of the commitment made out in the common minimum programme of the UPA-I Government (assuming power in May 2004) towards enhanced budgetary allocation for improved public health services. On its operational plank, the NRHM is essentially a strategy for integration of all ongoing vertical health and family welfare programmes with effective determinants of public health utilities such as drinking water, nutrition and sanitation. As a matter of fact, the NRHM has subsumed major national programmes of the union Ministry of Health and Family Welfare (MHFW) such as the Reproductive and Child Health-(RCH II) project, the National Disease Control Programmes (NDCP) and the

Integrated Disease Surveillance Project (IDSP). The NRHM is also believed to be useful in mainstreaming of the *Ayurvedic, Yoga, Unani, Siddha* and Homeopathy Systems of Health (AYUSH).

The key components of the Mission are as follows: (1) locating accredited social health activist (ASHA) in each village; (2) preparing decentralized village health plan by health and sanitation committee of the village panchayat; (3) invigorating rural hospitals for effective services (both curable and preventive) measurable and accountable to community; (4) minimizing inter-state and inter-district disparities; and above all (5) ensuring unmet public health needs by inter-sectoral convergence of line departments handling programmes of safe drinking water, nutrition, sanitation and hygiene. In addition to all these, it also aims at regulating private sector to ensure 'equity and reduce out of pocket expenses' besides promoting PPP to meet 'national public health goals, re-orienting medical education, and introduction of effective risk pooling.'

Report from Focus (Non- NE) States

The NRHM was essentially designed to address the public health concerns of as many as eighteen states, geographically located in north, central and north-eastern parts of the country. A common thread running along these states is measurable

⁴⁶These are: 8 north-eastern states including Sikkim, 7 BIMARU states including three newly created states of Chhattisgarh, Jharkhand, & Uttaranchal and besides Orissa, two hilly states, Himachal Pradesh and Jammu & Kashmir. All these states have weak health indicators, more particularly in respect of infant and maternal mortality rates. These states do not display strong economic development indicators either.

health indicators showing below national average records. Notwithstanding this fact, focussed states are classified in two categories: North-eastern and non-NE states that covers the rest. In fact, even the latter category is composed of three different types of states. In the first category there are four, all located in the Hindi-heartland and known by their acronym-BIMARU states. These are Bihar, Madhya Pradesh, Rajasthan and Uttar Pradesh. Clubbed with them is Orissa because of its equally underdeveloped / backward socio-economic parameters. Second, three states – Chhattisgarh, Jharkhand and Uttarakhand – carved out from three BIMARU states – Bihar, MP and UP – respectively in 2000 on account of their remaining as underdeveloped regions as part(s) of bigger states. Himachal Pradesh and Jammu & Kashmir belong to the third category. In the fourth category falls the entire seven states of north-east and Sikkim. Interestingly, the two hilly and border states (HP, J&K) have some of the features comparable with both the second and the fourth category states.

The progress on implementation of mission programmes and their outcome in focussed states are usually compiled on two axes by separately bunching them as north east and non- north eastern states. Accordingly, what follows now is essentially focussed on non-north-eastern states. It also needs mentioning that among several components; only those issues are covered in this chapter which have bearings on governance driven reforms such as community participation, accountability and monitoring etc.

ASHA & Role for Community

The NRHM envisages the presence of a health volunteer, in effect a social mobiliser in each village. Not only she could keep track of immunization schedules for children, including new born and pregnant women but also persuade and accompany the latter to hospital for safe child delivery. The combined effect of all these, it was assumed, would boost up institutional child delivery, bringing down the infant and maternal mortality rates. The volunteer is designated accredited social health activist (ASHA). ASHA will also be linked with the village health and sanitation committee (VHSC); will coordinate its activities in collaboration with the local level institutions such as the village panchayat, ANM,

women self help group members, *anganwadi* worker. She would essentially be a resident of the village, preferably a young (married/widow/divorced) woman in the 25-45 age groups and studied up to 8th standard. Attempts would also be made, the official guidelines read, to ensure adequate representation from disadvantaged population groups to serve them better.

The stated official norm is ‘one ASHA for 1000 population in plain areas to be relaxed in case of villages located in deserts and on hills, selected by the Village Health & Sanitation Committee (VHSC). Once selected, she would undergo a short training course at the nearest PHC. As a trained, accredited health activist she would be back to her village with a drug kit at her disposal. She would not be a paid employee, basically a volunteer who would be compensated for rendering services under multiple government programmes like *Janani Suraksha Yojana* (promoting institutional delivery), National TB Control Programme (completion of DOTS treatment), Total Sanitation Campaign (promotion of household toilets) etc. She would be accountable to the community through the VHSC/ Gram Panchayat.

This is important to bear in mind that the health being a state subject, the federal government cannot take charge of the implementation of Mission’s programmes. In fact, states also lack effective control over the selection process of ASHA or formation of VHSC either. They are to be identified at the local level where the hold of dominant community/ power takes the centre stage. This becomes all the more important since the institution of *gram sabha* (village assembly) is yet to acquire the moral authority necessary to express the general will through wider consultations. Not surprisingly, it fails to intervene to ensure the common good of masses in overwhelming majority of villages, notable exceptions apart. This is notwithstanding the passage of the Constitution (Seventy-third Amendment) Act, 1992. In fact, it was akin to misplaced enthusiasm that the prevalent caste/ class/ cultural divides/ sub divides in the countryside could be overcome with a legislative stroke. Thus, in the absence of functional people’s collectives, the powers that be in the villages (whether traditional

or otherwise) decide who should take driver's seat (ASHA and the VHSC members in the present case) to facilitate the mission's goal at the ground level. However, the NRHM has inbuilt provision to thwart such attempts by the powerbrokers. That is, instead of paying a fixed honorarium, it provides for case based incentives to ASHA. This incentive, it is assumed, will demand promptness from ASHA, forestalling all the apprehensions regarding appropriation of ASHA by local tuff. But there is hardly any plan or time frame for meeting ambitious goals of preventive health concerns such as nutrition, public hygiene and sanitation etc. Likewise, the Mission's assurance regarding strengthening of PHCs is also vague. At another level, the role of block and district level committee are no less important in making the mission successful. Equally crucial is to address the frictions and contentious issues that would crop up in course of facilitating inter sectoral coordination at all the three levels: from the district to the level of village panchayat.

What is the score on this count? The Union Ministry of Health & Family Welfare (MH&FW) has been compiling data collected on practically every measurable component. Highly impressive at a glance they would seem, sometimes appearing even mind boggling but when examined closely, then occasionally, if not quite often, the available data would give the truncated picture. For instance, the Mission headquarters in Delhi provide year-wise recruitment of ASHA, separately for high focussed

states (Table 9.1) but by giving only absolute number without any indication of percentages of villages covered, it does not serve the intended purpose.

First of all, it should have also collected data on state-wise norm deviations for a village having either more or less than a thousand population. For, a revenue village is not the unit for ASHA's recruitment. Besides, in view of caste/ sub caste (occasionally mixed caste) wise habitation pattern, practically every village in plain areas is composed of several hamlets located around the main village. Therefore, it is quite likely that an upper caste ASHA, noble souls apart, would not keep track of pregnant women belonging to lower castes, particularly that of scheduled castes. Likewise, if ASHA is from SC Category, she cannot dare going interiors of upper caste households. Even a quick round of villages in some of the districts located in Bihar, Western UP and Rajasthan, as the lead writer of the project observed, would testify to this fact. A glance through some of the evaluation reports would also confirm this point.

In Madhya Pradesh, for instance, a majority of ASHAs were recruited who had neither required educational background nor any inclination whatsoever to work for the weaker sections but they became part of the mission since they came from local influential families. Likewise, the community health workers also found it convenient to get their wives recruited for the job which they had been performing for long (Basu, 2004; Husain, 2011).

Table 9.1 : Recruitment of ASHA

	Years	Total	Bihar	Chhattisgarh	HP	J&K	Jhkhnd	MP	Orissa	Raj	UP	Uttkhnd
No. of ASHAs selected during	2005-06	11962	36488	5030	0	2773	1382	16463	12730	20785	19887	4104
	2006-07	252391	21758	55062	0	6727	13043	15227	21522	14681	100186	4185
	2007-08	57805	8455	0	2393		23790	8810		3534	9704	1119
	2008-09	16664	2423	0			2573	25358		3385	5745	
	2009-10	34748	2876	0	14495		8494	6244		1404	660	575
	2010-11	-	-	-	-	-	-	-	-	-	-	-
	Total	481250	72000	60092	16888	9500	49282	49282	34252	43789	136182	9983

SOURCE: NRHM state report as on 3rd June 2010

The earlier evaluation reports have also highlighted the shortcomings of training imparted to ASHAs, kits given to them with drugs close to their expiry, delay in payment of monetary incentives leading to even dropout among ASHAs and unfolding of a tug of war like situation between anganwadi worker and ASHA as the latter is seen as encroaching upon the former's turf (Bajpai et al 2009; Bhat et al 2009; Husain 2011). As a joint custodian of the untied funds (ten thousand rupees annually) meant for health and sanitation work, ASHAs (in many states, it is ANM) have also been at loggerhead with the village council chief vested with equal authority.

Notwithstanding these shortcomings, it would be unfair to depict the entire community mobilisation effort through ASHA as useless. They have performed their task in a society ridden on the face of multiple odds, including caste, religious superstitious believe etc. admirably leading to a spurt in ante-natal care and safe institutional delivery in states like Bihar, Rajasthan etc (Bajpai et al 2009). Perhaps that is the singular laudable achievement that needs to be recorded and appreciated. If they have been found performing less than what was expected of them, they need not be blamed. The onus falls on the Mission's architectural designers who tried to kill so many birds with just one stroke. For instance, her dismal involvement in preparation of the health plan at the (village) panchayat level, its implementation, community based monitoring, and the extent of inter-sectoral convergence in meeting public health needs, such as drinking water, nutrition, sanitation and hygiene. Paradoxically, these hapless workers in tandem with local level institutions are expected to achieve what the higher level bureaucracy and their political executives have not been able to do (striking sectoral convergence) in Delhi based *Mantralayas* and *Sachivalayas* at the state capitals. The centralized guidelines also constrained the deployment of community health mobilizer in certain states.

When we failed to locate ASHAs in far flung villages tucked somewhere in border districts of Barmer, Jaisalmer and Jodhpur (Rajasthan), we were told it was the combined effect of prevailing social and educational backwardness (read *purda* system and lack of educated women in rural areas). Likewise,

position of ASHAs were filled up only in tribal villages (ST population is less than 2% of the total) in Tamil Nadu since in the rest of the state there is a massive deployment of the village health nurses, already engaged in rendering the services what ASHA is supposed to perform. It may be instructive to note that Tamil Nadu holds a huge hierarchically organised nursing structure, starting from staff nurse, community health nurse (CHN), block health nurse (BHN), sector health nurse (SHN) to village health nurse (VHN) at the village level.

The official data on the other hand reveal setting up of the VHSC in three fourths of the total (75%) villages and the release of untied funds to the tune of Rs 970 crore ((9700 million rupees). Another study shows about 95% panchayats reporting bank accounts for untied funds being jointly operated by ANMs and village panchayat chief (Bajpai et al 2009). Likewise, by 2006-07 almost half (48%) of the districts had prepared their health plans, the corresponding figure went up to 85% by 2008-09 and then coming down to 74% in 2009-10 (Hussain, 2011). If all these figures were taken at their face value then this would amount to endorsing huge improvement on the health front. And if these facts are true then how one would explain yearly recurrence of brain fever in Gorakhpur and Gaya districts? How one could explain cold blooded murder of two successive CMOs in identical circumstances in Lucknow and the unnatural death of their deputy in mysterious circumstances inside the jail? How the same old rusted machinery could woke up overnight and neatly performed its role?

All this can be true and false at the same time. But, anybody who is a little familiar with the great saga of decentralised planning in this country that began unfolding since the sixth five year plan would vouch for its protracted failure, leave aside most unusual exceptions. That too remaining on the paper, a document, not workable given the ground realities, lying in labyrinth pile of stored official documents, occasionally fished out as a proof of its existence. Taking a cue from the experiences of the decentralised planning, piloted and induced by the MoRD, it can be safely concluded that they may have got plans documented but nothing beyond that. At least, there is no proof of the decentralised

plan being implemented. An effective decentralized plan would necessitate control over resources, both physical, financial and material as well as functional autonomy, completely independent of all pulls and pressures, lateral and vertical influences, none from any other governmental, semi-governmental agencies, to implement it. Does such an autonomous space exist in this country? To say “No” is not even an intelligent answer, for it is too obvious to ask.

Mainstreaming Indigenous Healthcare Practices

For long several indigenous healthcare practices have had existed in India, such as *ayurveda*, *unani* and homeopath. Over the years, the allopath, mistakenly equated with modern medicine, overshadowed it to the extent these health care systems were pushed to periphery. On the face of providing ‘quick, even instant’ remedy in certain cases, reinforced with huge publicity in the case of allopath and strict regimen to follow with an inventory of dos and don’ts in the case of latter even people lost faith in the indigenous health care system. Rechristened as alternative

health care, people would resort to these but only under special circumstances, largely when allopathic treatment would fail to provide relief.

Against this backdrop, NRHM sought to reinvigorate the indigenous health systems in two ways. First of all, by reintroducing and popularising indigenous medicines through the kits provided to ASHA. And, second, by inducting doctors of other paths to fill up the standing vacancies of doctors at CHC and PHC levels, more particularly in remote areas. It was also envisaged that single doctor manned PHCs could be upgraded by providing one additional AYUSH practitioners.

It is instructive to note that in almost half (49%) of the district hospitals in the country have now Ayush practitioners, little over one-third (37%) at CHC and little less than one-third (29%) at the PHC level. The figures are not very encouraging at PHC level where the need was greater; even much lower in focussed non- north-eastern states (See Table 9.2). Recent

Table 9.2 : Status of Ayurveda, Yoga, Unani, Siddha and Homeopathy (AYUSH) Components

		Total	Bihar	Chattgrh	HP	J&K	Jhkhnd	MP	Orissa	Raj	UP	Uttkhnd
AYUSH components included in NRHM PIP		9	Y	Y	Y	Y	Y	Y	Y	Y	Y	N
	Health Society	8	N	Y	Y	Y	y	y	y	Y	Y	N
	State Health Mission	6	N	Y	Y	N	y	y	y	Y	N	N
	Rogi Kalyan Samities	6	N	Y	N	Y	y	y	y	Y	N	N
	ASHA Training	6	N	Y	Y	N	Y	N	Y	Y	Y	N
No. where AYUSH facilities is available as on date	DH	124	0	15	0		24		0	67		18
	CHC	645		92	0		97		231	205		20
	other than CHC at or above block level but below district level	488	429	0	0				59	0		
	PHC	3318	0	353	0	375			1116	1036	428	10
	other health facilities above SC but below block level	328	127	0	0		170			31		
	Total	4903	556	460	0	375	291		1406	1339	428	48
No. of Contractual appointment under AYUSH	Doctors	3661	0	325	0	398	50		1286	1034	428	140
	Paramedical Staff	906	0	0	0	331				435	0	140

Source: NRHM State Report as on 3rd June 2010

survey findings reveal presence of Ayush doctors only in one-third of the PHCs covered in Madhya Pradesh, Rajasthan, UP and Uttarakhand whereas the corresponding number was higher in Jammu & Kashmir. But even in Jammu & Kashmir, there was lack of alternative drugs and also of pharmacist who could handle Ayush medicines. Above all, it is the preference of the patients that force Ayush doctors to prescribe allopathic medicines (Bhat et al 2009).

If the increasing expenditure is another indicator then certainly Ayush has acquired a place for itself. It is apparent from the fact that under the Ayush head the expenditure has 'increased fourfold in the span of four-five years, starting from 2005-6. Also, their presence is being increasingly noticed in other NRHM components including state health mission, health societies at both the state and district levels as well as in RKS and ASHA training (Duggal, 2009; Hussain 2011).

Health Management Information System

Given an ambitious healthcare delivery system

with country-wide outreach, it was natural that implementation of multiple components of Mission would necessitate strong managerial and technical support. It therefore envisaged creation of programme management units both at the district and block levels, aptly named district programme management unit (DPMU) and block programme management unit (BPMU). Staffed by both management and accounts graduate, the management units were first set up at the district level. It is hardly surprising therefore that positioning of DPMU was found quite satisfactory, less than that at the block level but unsatisfactory at the PHC level where only an accountant is deployed to handle quantum of fund, not seen earlier (see, Tables 9.3 and 9.4).

Setting up modern management unit is one thing but making them integral part of the Mission, placed mostly at the disposal of hierarchically organised health bureaucracy, is entirely different. The young management graduates are not vested with authority commensurate to their responsibilities. They are supposed to monitor working of ASHA (also see Box

Table 9.3 : Snapshot of Programme Management Units (%) in 2010

Indicators		India	High Focus Non NE States	High Focus NE States
No. of districts where	DPM is in position	90.5	92.6	87.5
	DAM is in position	90.2	84.2	98.9
	DDM is in position	82.7	86.8	98.9
	DPMU established	99.5	102.3	98.9
No. of Blocks where	BM in position	48.5	72.5	64.2
	Actnt is in position	59.2	79.4	54.9
No. of PHCs where accountant is in position		12.5	3	57.3

Source: Hussain, EPW 2010

Legend: DPM – District Programme Manager, DAM – District Accounts Manager, DDM – District Data Manager, BM – Block Manager, Actnt - Accountant

Box 9.1 : Technology Driven Monitoring

Having realised that data obtained from states are 'at times fudged' (e.g. "2,09,444 phone numbers of ANM or ASHA were not valid or not reachable while 7,00,624 SMSes were sent of which 3,35,220 failed"), the union MH&FW has recently taken recourse to specially designed software 'The Mother & Child Tracking System' to communicate directly with ANMs, ASHAs and pregnant women about ante-natal checkups and immunisation (2.5 crore mothers and children across the states will be registered). In order to make the effective use of technology, the MH&FW has ensured registration of the mobile numbers of 2.15 lakhs (93%) ANMs and 8.5 lakh (83%) ASHAs with the centralised call centre. This, in turn, will enable the authorities to communicate directly with the beneficiaries.

Source : The Hindu, 08/01/2012

Table 9.4 : State Programme Management Units, Dist PMUs & Block PMU (High focus Non-NE States)

				Number of Districts where						Number of Blocks where			
	Prog. Mngt Unit (SPMU) at state level	Total Number of Districts	Dist.Prog Mngt Unit (DPMU) estbd	Dist Prog Mngr in position		Dist. Accts Mngr in position		Dist. Data Mngr in position		Blk Mngr in position	Acctnt in position	PHC where Acctntnt in position	
				Nos.	%	Nos.	%	Nos.	%				
Total	10	324	311	288	88.89	257	79.32	271	83.64	2245	1665	862	
Bihar	Y	38	38	35	92.11	36	94.74	37	97.37	433	441	0	
Chhattisgarh	Y	27	18	17	62.96	16	59.26	18	66.67	50	91	100	
Himachal Pradesh	Y	12	12	16	133.33	0	0.00	0	0.00		58		
Jammu & Kashmir	Y	22	22	17	77.27	17	77.27	17	77.27	83			
Jharkhand	Y	24	24	22	91.67	20	83.33	23	95.83	183	187	0	
Madhya Pradesh	Y	50	50	35	70.00	30	60.00	29	58.00	282	257	196	
Orissa	Y	30	30	30	100.00	30	100.00	30	100.00	305	300		
Rajasthan	Y	33	33	32	96.97	32	96.97	33	100.00	212	537	566	
Uttar Pradesh	Y	75	71	71	94.67	63	84.00	71	94.67	615	0	0	
Uttkhnd	Y	13	13	13	100.00	13	100.00	13	100.00	82	94	0	

Source: Computed from NRHM, June 2010

9.1) ANM in the field but they cannot take them to task when the former is found non-performing. The traditional health bureaucracy manned by doctors and even paramedics are permanent staff, well organised and thoroughly intermingled with the traditional machinery take affront when their shortcomings or non- performance is pointed by these outsiders. Even when the District Collector, as ex-officio head of the district health mission, appreciates the businesslike approach of DPM, the traditional health bureaucracy treats it as their criticism. With their rigid mindset, cemented by the prevailing pathetic work culture including job security, they fail to appreciate these young professionals, not to speak of imbibing positive attributes of their young colleagues. The end result is often negative: maintaining distance, going slow on work, in any case not extending cooperation and seeking harmony. This was confirmed during field visits while discussing NRHM activities with the DPMU heads and CMOs in several districts across focussed and non-focussed states, but more in the former category states. A palpable tension was noticeable in their dealings. Also, because the PMUs at all levels are manned by contractual staff who make enthusiastic start but once they encounter road blocks they begin losing steam; some also learn fast the official tricks of evading work.

Accountability, Participation and Monitoring

The *rogi kalyan samiti* (RKS) is the institutional mechanism available for ensuring accountability of vast mission machinery through community participation and monitoring. As a registered body, the RKS is formed at all the level of health centres and hospitals with adequate representation of activists, media, NGOs and civil society at large. It was expected that RKS will function as a body encompassing the multiple role of watchdog, inspector, ombudsman, all rolled into one. The fact remains however that their job is limited to the management of users fee collection and expenses, including the maintenance and upkeep of the hospitals/ health centres. The official data show the existence of RKS practically at all district hospitals and CHCs but little less than one-fourth (29%) PHCs across the states (see Table 9.5) didn't have registered RKS (Husain, 2011).

Convergence

It is a commonly held view that the health of community/ society/ country is influenced by several other factors such as availability of safe drinking water, status of nutrition and hygiene, sanitation, women's literacy and empowerment etc. All these subjects are inter-related but they are handled by separate union ministries and departments in Delhi. The functional variations are much wider at the state level and then further down to the level of districts and blocks. In order to seek their cooperation to meet its stated objectives, the NRHM had planned its convergence with all other concerned departments. As a first step in this direction, a committee for inter-sectoral convergence was set up with the Mission Director as its chairman. This committee had to grapple with planning and monitoring strategies for convergence in its quarterly meetings.

First of all, it could meet just four times, twice in 2005 and then twice again in 2008, to quote a CAG report. Although the Ministry claimed to have held around 18 meetings, including two during 2007-09 on 'smaller scale with individual Ministries', the CAG report has noted but in the same breath also commented: 'The Ministry (MH&FW) had had not prepared any detailed action plan outlining the specific targets and timelines for activities to be undertaken for inter- sectoral convergence by the different departments.' Not surprisingly, most of the States and UTs failed to impress upon the convergence issue in their annual programme implementation plan (PIP). The omission was all the more glaring at the district level. For instance, CAG team did not come across 'any attempt at convergent action' in the district health action plan (DHAP) in all the sampled audited districts in Assam, Manipur, Mizoram, Orissa, Uttar Pradesh, West Bengal (all focussed states), Puducherry, Punjab and in UTs of Chandigarh, Dadar & Nagar Haveli, Daman & Diu, Lakshadweep as well as in two thirds of sampled districts (14 out of 23) selected for performance audit in Andhra Pradesh, Gujarat, Haryana, Karnataka and Sikkim. The same report regrettably notes that 'DHAP had not even prepared in Bihar, Himachal Pradesh, Jammu & Kashmir, Jharkhand, Rajasthan, Tripura and Tamil Nadu. This task was taken up

Table 9.5 : Rogi Kalyan Samitis

High Focussed States											
	Total	Bihar	Chattgrh	HP	J&K	Jhkhnd	MP	Orissa	Raj	UP	Uttkhnd
District Hospitals (DH)	296	29	16	12	14	21	50	32	33	71	18
CHCs	1941	52	138	73	87	170	331	231	368	438	53
Other than CHCs or above block level but below District Level	313	22	26	35		36	56	101	19	0	18
PHCs	5184	420	695	448	375	254	860	117	1503	470	42
Other health facilities above SC but below block level (may include APHC etc.)	3801		57	0	0	0	0	1064	0	2680	0
High Focussed NE states											
	Total	Arunachal Pradesh	Assam	Manipur	Meghalaya	Mizoram	Nagaland	Sikkim	Tripura		
District Hospitals (DH)	76	14	22	7	6	8	11	4	4		
CHCs	227	30	108	16	28	9	21	4	11		
Other than CHC at or above block level but below District Level	27		13	1	0	2			11		
PHCs	1378	79	844	73	99	57	124	24	78		
Other Health facilities above SC but below block level (may include APHC etc.)	13			4	0	5	4				

Table 9.5 Contd...

Non Focussed States (Large)												
	Total	A. Pradesh	Goa	Gujarat	Haryana	Karnataka	Kerala	Maharashtra	Punjab	Tamil Nadu	West Bengal	
No. of Rogi Kalyan Samitis registered	District Hospitals (DH)	16	2	26	21	19	14	23	20	29	15	
	CHCs	168	3	281	93	176	226	361	114	256	348	
	Other than CHC at or above block level but below District Level	58	0	36	25	148	84	85	35	234	80	
	PHCs	1581	9	1105	344	2193	839	1805	396	1165	850	
	Other Health facilities above SC but below block level (may include APHC etc.)	0	0		2465	516		0	0	0	0	
Non Focussed UTs												
No. of Rogi Kalyan Samitis registered				Total	A & N Islands	Chandigarh	Dadra & Nagar Haveli	Daman & Diu	Delhi	Lakshadweep	Puducherry	
	District Hospitals (DH)	13	3			1	1	2	0	2	4	
	CHCs	16	4			2	1	2	0	3	4	
	Other than CHC at or above block level but below District Level	0				0		0	0	0	0	
	PHCs	71	19			0	6	3	0	4	39	
	Other Health facilities above SC but below block level (may include APHC etc.)	0	0			0		0	0	0	0	



with due commitment in only a handful of states, namely, Arunachal Pradesh, Kerala, Madhya Pradesh, Maharashtra and Meghalaya... also that only 19 states/ UTs could incorporate AYUSH components and that of school health programme (SHP) in 21 states in their PIPs. Consequently, Rs. 1.40 crore earmarked for SHP during 2007-08 left untouched. [CAG Report to Union Government (Civil) No. 8, 2009-10: 29-30]. The report has however expressed satisfaction over inclusion of the same inter-sectoral convergence in state PIPs during 2009-10. Had all this impacted the Mission outcome in measurable terms? Let us take Madhya Pradesh where infant mortality rate (IMR) was the highest (76) in 2005 among all the states when the Mission started unfolding but five years down the line, it remained at the same level, the highest (62 in 2010) in Madhya Pradesh (see, Table 9.6) in India .

Partnership with NGOs

Clearly, the Mission's success was dependent upon the role played by other stakeholders, including NGOs. But to get them involved by creating an honourable space for them was the responsibility of the Ministry. It needs mentioning that NGOs had already been involved in implementation of the Reproductive and Child Health (RCH) - the flagship programme of the Ministry in 1990s which was subsumed under the NRHM. Indeed, to this end, the Ministry had unveiled a scheme called Mother NGOs (MNGO) under which the Ministry sanctioned grants to MNGOs and they in turn funded local NGOs, designated as field NGOs, identified and trained by them for the stated purpose.

In order to run this multi-level, multi institutional scheme it was envisaged to create resource centres at both the federal and regional levels that will coordinate NGO-driven activities, provide them technical support and interact with respective state health societies. As many as 11 Regional Resource Centres (RRCs) were set up but the Apex Resource Centre (ARC) ceased functioning since 2007 for the very simple reason that its original sponsor-United Nations Population Fund (UNFPA) - withdrew financial support to it. From the available sources it is not clear as to why the support was withdrawn by the UN body and also why alternative arrangements

were not made by the Ministry. What is known is that altogether 125 MNGOs were active in 178 (out of total 609 districts). The Ministry had no clue as how many field NGOs were working. The over all impact of this half hazard programme, as recorded in the CAG report, referred above, is worth reading: "The Ministry continued to fund MNGO scheme under the RCH and NGO under NDCCPs separately resulting in *disintegrated functioning and weak monitoring of the NGOs* (emphasis ours)...*the possibility also exists of multiple projects being awarded to the same NGO* without coordination and common information sharing as to its capabilities... *The MNGO scheme did not have the desired impact* as the involvement of NGOs in building capacity towards health delivery schemes was in primary stage and due to delay/ non selection of SNGOs in the targeted districts, the *Mission's objectives of building capacity at all levels of the health delivery system and delivering health care services under RCH to the undeserved/ unserved areas remained unfulfilled* (Ibid; 32).

Public-Private Partnership

The Rashtriya Swasthya Bima Yojna (RSBY) Scheme was started mainly to reduce financial hardship faced by the poor households due to high cost of hospitalisation. Based on public private partnership model, this scheme is designed to provide health insurance up to Rs 30,000 for the BPL households. Coverage extends up to five members of the family and the family has to pay Rs.30 only, as the registration fee. The premium is paid by both the state and central government to the insurance companies. Given the assured premium from the government, the insurance companies have incentive to include as many households as possible from the BPL list. The households covered under this scheme are provided with smart card that enables them to access the services rendered by the empanelled hospitals/ nursing homes belonging to both public and private sector. And these health institutions are directly linked with the insurance companies.

As usual, the RSBY scheme seems to have been launched in haste without giving due consideration to complexities involved. First of all, in the absence of any effective regulation of private health providers in the country, there is every possibility of misuse of this kind of arrangement; rather it might lead to faulty

practises in use of health services. The private hospital will have incentive to escalate cost of treatment due to assured return from the government and it might result in unnecessary or improper treatment

RSBY scheme does not have any special incentive for those BPL households living in remote rural areas as most of the empanelled hospitals are located in urban centres. Recent work on RSBY (Rathi et al., 2012) clearly proves this point as empanelled hospitals tend to be placed near district headquarters, raising costs of access for the poor.

Recent irregularities involving the scheme have been reported from Chhattisgarh and Bihar (www.thehindu.com), where the scheme was misused by private doctors to carry out hysterectomies on a large number of women, many of whom were even unmarried and were in their teens and twenties. In just 11 districts of Bihar, 16,765 hysterectomies were carried out in the last two years, a majority of them found to be not required according to preliminary report by district magistrates. A similar racket was reported from Andhra Pradesh in 2010 (www.epw.in). These cases bring to light how PPP schemes such as these can result in huge scams, when proper monitoring and accountability mechanisms are not in place.

Chiranjeevi Yojana, Gujarat

Initiated in 2005 on a pilot basis in five districts of Gujarat, the entire state was brought under Chiranjeevi Yojna in 2008. Under the scheme, BPL category pregnant women can avail the facilities available at empanelled private nursing homes/private doctors for child delivery at the expense of the state health department. Not only that, the state government also pays additional Rs.200

towards transport cost. The person accompanying her gets Rs.50. That apart, there is a provision for ASHA who would also receive Rs.200. This scheme, aimed at encouraging institutional delivery and, by extension, reducing maternal mortality, has received Asian Innovation Award instituted by the wall Street journal.

As part of this scheme, the Empanelled Private Providers (EPPs) including private gynaecologists and obstetricians working with the trusts/ hospitals have to agree to perform free delivery for BPL women. There is a package of for every 100 deliveries, including caesarean section and complicated deliveries, wherein EPPs are paid Rs.1,79,500 @ Rs.1795 per delivery. This payment was enhanced to Rs.2,80,000 (again for the same 100 deliveries) in 2010. Since there is no separate incentive for handling complicated cases, it has been reportedly able to check unnecessary caesarean operations. The Chief District Health Officer (CDHO) is responsible for identification and signing of MOU with the private providers for the stated purpose. .

Initially, the scheme was lauded as a great success. However, a year after, in 2009, the number of EPPs active under this scheme went down in Surat (Acharaya & McNamee, 2009). Many of EPPs started dilly-dallying after pocketing advance money worth Rs 15,000. To many private providers, it remained a charitable activity than a professional commitment as expressed under MOU signed with the health department. Many had shown enthusiasm to build their 'reputation'; to some this provided an opportunity to become licensed providers for abortion as it entitled them to obtain official certificate of Medical Termination of Pregnancy (MTP). On the other hand, the EPPs that continued working under

Box 9.2 : Public Partnership for Private Profit

“The state could not achieve the intended goal of bringing down its MMR and IMR from 3:89:1000 and 57:1000 respectively in 2005-06 to 1:1000 and 30:1000 respectively by March 2010 despite launching the Chiranjeevi Yojna,” states the CAG report, 2011. In fact, the private practitioners from 40 % of talukas (93 out of 231) did not participate in this scheme, the CAG report highlighted. “With no system of crosschecking BPL claims of private doctors, the scheme now runs the risk of processing bogus and fraudulent claims, remarked the report. Ironically, in six tribal-dominated districts of Dahod, Banaskantha, Panchamals, Vadodara, Sabarkantha and Kutch, a fund of Rs 27.93 crore for the scheme remain unutilised.”

Source: Indian Express, March 31, 2011

this scheme preferred to admit 'safe' delivery cases while passing on all complicated deliveries to the same under-staffed public hospitals (See Box 9.2). All this was done in complete violation of the agreement which had budgetary provisions for pregnancy complications. The private providers did argue that the cost of handling complicated pregnancies was much higher than what was provided for under the package. It also needs mentioning that the pregnant BPL women located in remote areas had to bear a high transportation cost since EPPs were situated in cities only. Above all, cases of forging records by registering dummy cases and charging for the services were also reported (<http://articles.timesofindia.indiatimes.com/2009-06-30>).

Some other successful PPPs:

1. Yeshasvini scheme, Narayana Hrudalaya-health insurance for Karnataka Milk Federation members.
2. Managemnet of PHCs (Karnataka- Karuna Trust) Similar initiatives of people like retired Colonel CS Pant (Uttaranchal mobile health clinic), Dr KJR Murthy (Mahavir Trust Hospital, Hyderabad), Mr MA Wohab

(boat-based mobile health services in the Sunderbans, West Bengal), and Dr Haren Joshi (Shamlaji Hospital, Gujarat) have inspired partnership initiatives.

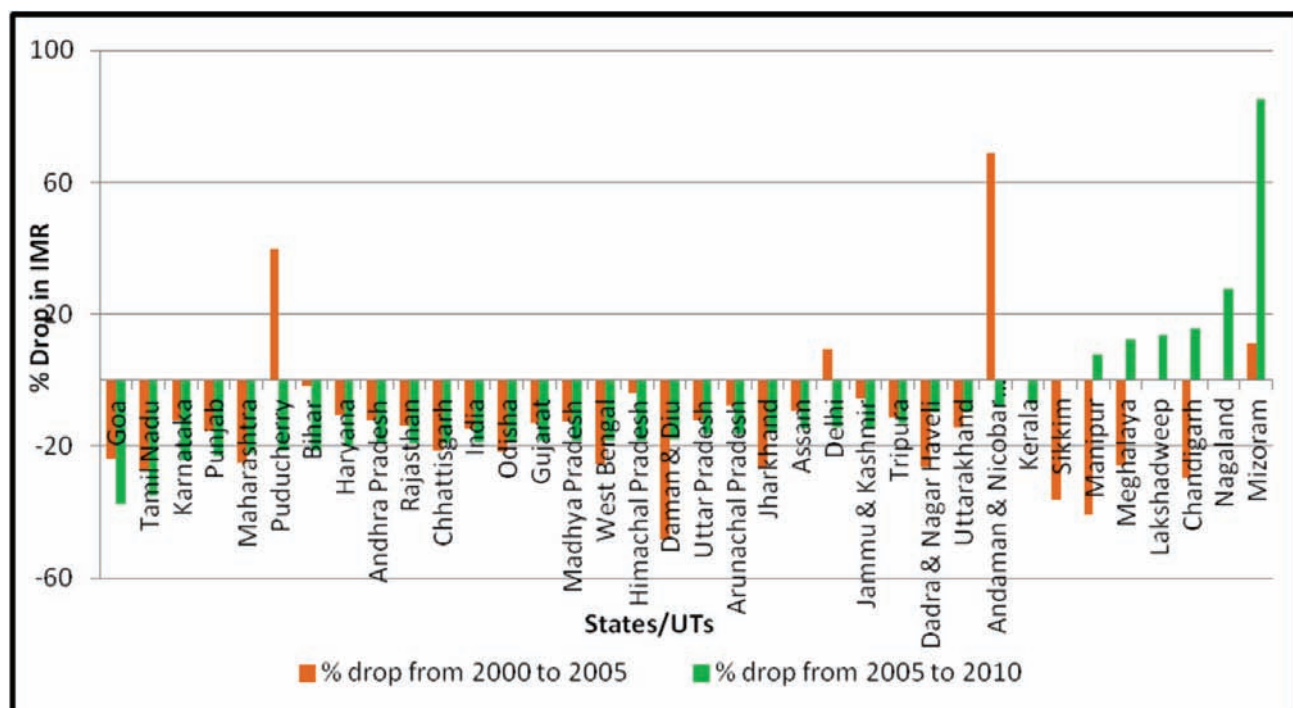
(Source: <http://pppinharyana.gov.in/ppp/sector/health/report-healthcare.pdf>)

While PPPs are being undertaken and have had mixed results, well placed monitoring and accountability mechanisms have to be maintained. Also, while assessing the success of PPPs, it is necessary to analyse whether they are helping in reducing the problem or they are merely shifting problems elsewhere.

Comparing IMR, MMR, NNR

As seen in the preceding sections, the NRHM, had multiple objectives. It has of course, been relatively successful in achieving some of its goals amidst immense constraints. The fact remains, however, that it was designed essentially to reduce the mortality rates which are not only visible, hence shameful, but also to meet the UN Millennium Development goals (MDG). What has been the score on these counts? The success rates are varying, as usual, with

Fig. 9.1 : % Decline in IMR from 2000 to 2005 and from 2005 to 2010



the better performing states like Kerala and Tamil Nadu taking the lead. But several other states have also improved their performance in the post-NRHM period. The data inserted in the Table 9.6 (also see

Fig. 9.1) provide the relevant details.

- The highest IMR in 2010 was reported from Madhya Pradesh (62) and the lowest from

Table 9.6 : Infant Mortality Rate (IMR 2000 and 2005 to 2010)

Sl. No.	State/UT	2000	2005	2010	% drop from 2000 to 2005	% drop from 2005 to 2010	% drop from 2000 to 2010
1	Andhra Pradesh	65	57	46	-12.31	-19.3	-29.23
2	Arunachal Pradesh	40	37	31	-7.5	-16.22	-22.5
3	Assam	75	68	58	-9.33	-14.71	-22.67
4	Bihar	62	61	48	-1.61	-21.31	-22.58
5	Chhattisgarh	80	63	51	-21.25	-19.05	-36.25
6	Goa	21	16	10	-23.81	-37.5	-52.38
7	Gujarat	62	54	44	-12.9	-18.52	-29.03
8	Haryana	67	60	48	-10.45	-20	-28.36
9	Himachal Pradesh	51	49	40	-3.92	-18.37	-21.57
10	Jammu & Kashmir	53	50	43	-5.66	-14	-18.87
11	Jharkhand	68	50	42	-26.47	-16	-38.24
12	Karnataka	57	50	38	-12.28	-24	-33.33
13	Kerala	14	14	13	0	-7.14	-7.14
14	Madhya Pradesh	87	76	62	-12.64	-18.42	-28.74
15	Maharashtra	48	36	28	-25	-22.22	-41.67
16	Manipur	22	13	14	-40.91	7.69	-36.36
17	Meghalaya	66	49	55	-25.76	12.24	-16.67
18	Mizoram	18	20	37	11.11	85	105.56
19	Nagaland	18	18	23	0	27.78	27.78
20	Odisha	96	75	61	-21.88	-18.67	-36.46
21	Punjab	52	44	34	-15.38	-22.73	-34.62
22	Rajasthan	79	68	55	-13.92	-19.12	-30.38
23	Sikkim	47	30	30	-36.17	0	-36.17
24	Tamil Nadu	51	37	24	-27.45	-35.14	-52.94
25	Tripura	35	31	27	-11.43	-12.9	-22.86
26	Uttar Pradesh	83	73	61	-12.05	-16.44	-26.51
27	Uttarakhand	49	42	38	-14.29	-9.52	-22.45
28	West Bengal	51	38	31	-25.49	-18.42	-39.22
29	Andaman & Nicobar Islands	16	27	25	68.75	-7.41	56.25
30	Chandigarh	27	19	22	-29.63	15.79	-18.52
31	Dadra & Nagar Haveli	57	42	38	-26.32	-9.52	-33.33
32	Daman & Diu	54	28	23	-48.15	-17.86	-57.41
33	Delhi	32	35	30	9.38	-14.29	-6.25
34	Lakshadweep	22	22	25	0	13.64	13.64
35	Puducherry	20	28	22	40	-21.43	10
36	India	68	58	47	-14.71	-18.97	-30.88

Legend: IMR is defined as the number of infant deaths in a year per 1,000 live births during the year.

Note: Data for Nagaland is not available for the year 2000. It has been replaced by the value of 2005 to make comparison between the states. (Source: SRS Bulletins, April 2002, Oct. 2006 – Oct. 2009).

Kerala (13), after Goa (10). In 2005 – the year NRHM was launched – it was maximum (76) in the same state, Madhya Pradesh and minimum in Manipur (13), followed by Kerala (14). In 2000, that is the pre-NRHM period, the highest IMR was observed in Odisha (96), Madhya Pradesh was at the second highest position with 87 IMR. Kerala was at the minimum IMR (14). It can thus be safely concluded that in terms of ranking among the states in India there has hardly been any change in Madhya Pradesh and Odisha during all the three reference years: 2000, 2005 and 2010. So has been the trend of states showing minimum IMR with Kerala having the lowest IMR in each year (2000, 2005 and 2010).

- The changes observed in IMR figures indicate downward trend from 2000 to 2005 and further down from 2005 to 2010. Overall it has fallen from 2000 to 2010.
- From the national average point of view IMR has gone down from 68 in 2000 to 47 in 2010. This is true of almost all the states except for Mizoram, Nagaland, A & N Islands, Lakshadweep and Puducherry.

It is apparent from the above figure that the percentage point change in IMR is stagnant for Kerala, Lakshadweep and Nagaland. There is a percentage fall in IMR from 2000 to 2005 for all the states except for Delhi (9.38%) and Puducherry (40.0%). Likewise, in the next quintile, a drop in percentage point change in IMR from 2005 to 2010 is registered for all the states excluding Manipur, Meghalaya, Lakshadweep, Chandigarh, Nagaland and Mizoram whereas it is observed to be stagnant for Sikkim from 2005 to 2010.

IMR is depicting a downward trend from 1995 to 2010 (see Fig. 9.2 Table 9.7). The IMR has fallen for both rural and urban although the IMR is higher for rural sector than urban.

Maternal mortality ratio (MMR) is the annual number of maternal deaths per 100,000 live births. A maternal death is the death of a woman during pregnancy or within 42 days of termination of pregnancy, from any cause related to or aggravated by the pregnancy or its management, but not from accidental or incidental causes. Thus, in order to have robust estimates it requires a very large sample size of data pertaining to the maternal deaths. Accordingly, the results have been derived by following the practice of pooling the three years data (from the SRS sample

Fig. 9.2 : Trend of IMR in India from 1994-2008

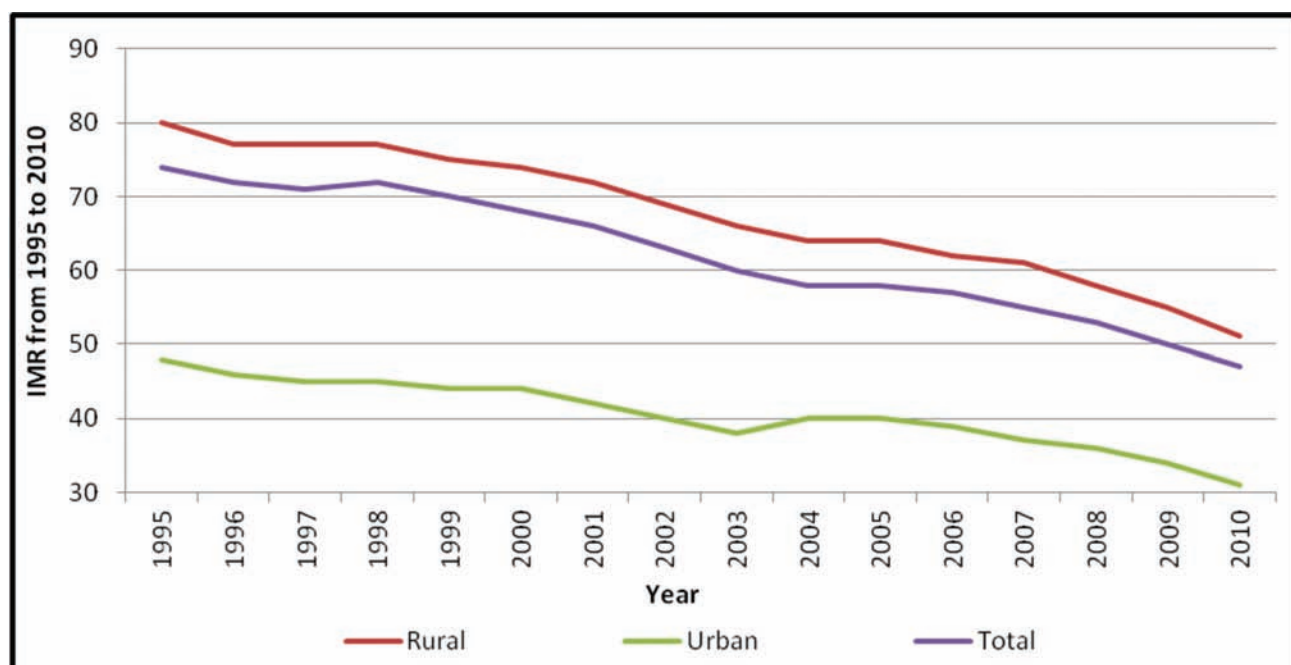


**Table 9.7 : Infant Mortality Rates in India
1995- 2010**

Sl. No.	Period	Rural	Urban	Total
1	1995	80	48	74
2	1996	77	46	72
3	1997	77	45	71
4	1998	77	45	72
5	1999	75	44	70
6	2000	74	44	68
7	2001	72	42	66
8	2002	69	40	63
9	2003	66	38	60
10	2004	64	40	58
11	2005	64	40	58
12	2006	62	39	57
13	2007	61	37	55
14	2008	58	36	53
15	2009	55	34	50
16	2010	51	31	47

Notes: Per 1000 live births, 1997 & 1999: Excludes Jammu & Kashmir, 1995: Excludes Mizoram, 1995 to 2002: Excludes Nagaland (Rural)

SOURCE: SRS Bulletins

size see Table 9.8) to yield reliable estimates of maternal mortality (Special Bulletin on Maternal Mortality in India 2007-09).

The MDG of the United Nations has set the target of achieving 200 maternal deaths per lakh of live births by 2007 and 109 per lakh of live births by 2015. It is worth noting that at least three states have realized MDG target in 2007-2009. Kerala was the only state with the minimum (95) MMR in 2004-2006. In 2007-09 Tamil Nadu and Maharashtra became the new entrants with MMR 97 and 104 respectively along with Kerala (81). Andhra Pradesh, West Bengal, Gujarat and Haryana are in closer proximity to the MDG target. The highest MMR in 2007-09 was reported from Assam (390), followed by Uttar Pradesh (359) and Rajasthan (318) among the focussed group states.

It is inspiring that the MMR for the whole of India has declined from 327 in 1999-2001 to 254 in 2004-2006 to 212 in 2007-2009. The maximum fall in MMR from 1999-01 to 2007-09 was marked in Rajasthan followed by Uttar Pradesh/ Uttarakhand, Orissa and Bihar/Jharkhand. MMR

Table 9.8 : MMR (1999-01, 2004-06 & 2007-09)

Sl. No.	India & Major states	1999-01	2004-06	2007-09	Drop in MMR (1999-01)-(2004-06)	Drop in MMR (2004-06)-(2007-09)
1	Andhra Pradesh	220	154	134	66	20
2	Assam	398	480	390	-82	90
3	Bihar/Jharkhand	400	312	261	88	51
4	Gujarat	202	160	148	42	12
5	Haryana	176	186	153	-10	33
6	Karnataka	266	213	178	53	35
7	Kerala	149	95	81	54	14
8	Madhya Pradesh /Chhattisgarh	407	335	269	72	66
9	Maharashtra	169	130	104	39	26
10	Orissa	424	303	258	121	45
11	Punjab	177	192	172	-15	20
12	Rajasthan	501	388	318	113	70
13	Tamil Nadu	167	111	97	56	14
14	Uttar Pradesh/Uttarakhand	539	440	359	99	81
15	West Bengal	218	141	145	77	-4
16	India Total	327	254	212	73	42

Note: Per100000 Live Birth

Source: <http://nrhm-mis.nic.in>

in Rajasthan and Uttar Pradesh/Uttarakhand has declined remarkably by 183 points and 180 points respectively. The drop in MMR between five years from 1999-01 to 2004-06 and from 2004-06 to 2007-09 can be seen (Fig. 9.3):

Omitting Assam, Haryana and Punjab, it is worth noting that MMR has fallen for all the states from 1999-2001 to 2004-06. In case of Assam, however, the MMR has increased from 398 in 1999-2001 to 480 in 2004-06. MMR of Punjab and Haryana had also gone up by 15 and 10 points respectively for the same time period. Yet these three states have recovered and have shown significant change in their MMR from 2004-06 to 2007-09. All other states have improved their MMR during the same period except for West Bengal. Indeed, in case of West Bengal, it went up from 141 in during 2004-06 to 145 during 2007-09. The decline, on the other hand, has been most significant in Bihar, Jharkhand, Madhya Pradesh, Chhattisgarh, Orissa, Rajasthan, Uttar Pradesh & Uttarakhand and Assam, all focussed states. Andhra Pradesh, West Bengal, Gujarat and Haryana are in relatively closer proximity towards achieving the MDG target.

Based on the availability of data (see Table 9.9) a correlation between institutional deliveries and maternal mortality rate is established to be negative. This indicates more the percentage of institutional deliveries in the states, less the maternal mortality rate and vice versa. Similar relation is established between the IMR and percentage of institutional deliveries.

The institutional delivery in Kerala is observed to be declining throughout the period starting from 2005-06 to 2009-2010. It has increased more or less for all the States and UTs till 2009-10. But when the institutional delivery as a percentage of child birth is observed, an interesting picture is seen for Kerala and other states of India. The data (Tables 9.10 & 9.11) show institutional deliveries as a percentage of child birth for Indian States and India. These table reveal the number of institutional deliveries as compared to 100 numbers of child births in a state/India. For example, there are 8.23% institutional deliveries out of 100 numbers of child births in Andhra Pradesh and likewise for other states.

The top 10 states are coloured in yellow and the bottom 10 states are coloured in red with respect to the ratio of institutional deliveries to child birth. Kerala ranks 1st among all the states during all the referred periods: 2005-06 to 2007-08. It has slipped to 3rd position, replaced by Andhra Pradesh during 2008-09. Goa has shown a spectacular improvement. It moved from bottom 10 states during 2005-06, 2006-07 to top 10 states during 2007-08, 2008-09. Further, it is seen that Goa is doing extremely well and it is in the top most position in terms of improvement in institutional delivery from 2005-06 to 2008-09 as compared to the rest of the states. Bihar occupies the next position in terms of improvement from 2005-06 to 2008-09, though it is still counted among the poor performing states compared to other states starting from 2005-06 to 2008-09. Uttar Pradesh and Nagaland, apart from being among the

Fig. 9.3 : Declining MMR (1999 to 2009)

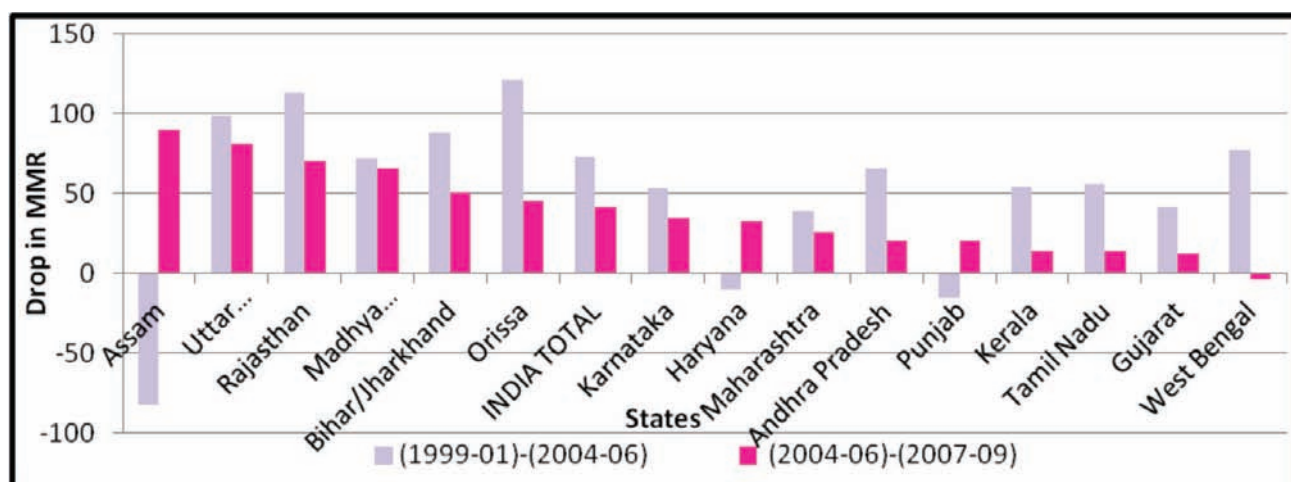


Table 9.9 : Correlation between % Institutional Deliveries as per NFHS-III and MMR (2004-06)

S. No.	States	% of Institutional Deliveries as per NFHS-III (2005-06)	Maternal Mortality Rate 2004-06	IMR 2005-06	Correlation between Institutional Deliveries and Maternal Mortality Rate	Correlation between Institutional Deliveries and IMR
1	Andhra Pradesh	68.60	10.9	56.5	-0.82	-0.83
2	Assam	22.70	34.4	67.5		
3	Bihar	22.00	38.4	60.5		
4	Gujarat	54.60	14.8	53.5		
5	Haryana	39.40	17.4	58.5		
6	Karnataka	66.90	14	49.0		
7	Kerala	99.50	4.9	14.5		
8	Madhya Pradesh	29.70	36.9	75.0		
9	Maharashtra	66.10	9.3	35.5		
10	Orissa	38.70	24.9	74.0		
11	Punjab	52.50	13.7	44.0		
12	Rajasthan	32.20	47.5	67.5		
13	Tamil Nadu	90.40	6.6	37.0		
14	Uttar Pradesh	22.00	53.8	72.0		
15	West Bengal	43.10	10	38.0		

SOURCE: NRHM, State data sheets as on 30th June 2010, Special Bulletin on maternal mortality in India 2004-06 and SRS Bulletin, Oct.2006-07.

poor performing states with respect to institutional delivery, their performance have also deteriorated from 2005-06 to 2008-09. Overall India has shown an increase in institutional delivery per 100 child birth from 2005-06 to 2008-09.

The details of beneficiaries of Janani Surakhsha Yojana (JSY) for different Indian states and UTs are shown in the (Table 9.12) from 2005-06 till 2010-11.

Disease Burden and Epidemiological Transition in India

The natural course of disease burden affecting a country is to move from high mortality due to communicable disease to that which occur due to non-communicable ones as a country develops. Put simply, a shift or transition occurs in the burden of disease with the corresponding degree of development. Contrary to this perceived wisdom, India faces parallel disease burdens along with increasing morbidity and mortality due to new and emerging infectious diseases such as H1N1, avian influenza (bird flu), HIV or SARS (GOI, 2010). Apparently, India has not been able to control morbidity and mortality from

communicable diseases like TB, diarrhoea, etc. For instance, India is known to have one fifth of the global TB cases, meaning nearly 1.9 million cases of the 9.2 million cases in the world. Likewise, Malaria also affects 1.5 million people (see Table 9.13) every year in India (GOI, 2010).

India, however, has also witnessed increase in non communicable diseases like cardiovascular diseases, diabetes, cancers, asthma and Chronic Obstructive Pulmonary Disease (COPD) in the last decade. Known together as lifestyle diseases mostly affecting adult population, this group of diseases was believed to affect mostly urban population. It has, however, increased in rural population, too.

With increasing out of pocket expenditures, and loss of work days due to illness leading to further impoverishment, it was necessary to understand and identify the diseases that cause most mortality and morbidity⁴⁷.

⁴⁷The National Commission on Macroeconomics and Health (NCMH) undertook an exercise in 2005 to identify the major health conditions in terms of their contribution to the disease burden in the country.

Table 9.10 : No of Institutional Deliveries (in Lakhs) from 2005-06 till 2010-11

S.No.	States/UTs	05-06	06-07	07- 08	08- 09	09-10
1	Puducherry	0.26	0.29	0.5	0.47	0.48
2	Arunachal Pradesh	0.09	0.08	0.09	0.1	0.09
3	Assam	1.49	1.92	3.23	3.57	3.98
4	Bihar	2.37	1.24	8.38	11.47	12.46
5	Chhattisgarh	1.03	1.31	1.49	1.79	2.46
6	Goa	0.02	0.02	0.22	0.24	0.19
7	Gujarat	7.53	8.11	9.2	8.43	9.43
8	Haryana	1.68	2.16	2.75	3.18	3.58
9	Himachal Pradesh	0.52	0.54	0.58	0.59	0.55
10	Jammu & Kashmir	0.91	1.31	1.51	1.52	1.52
11	Jharkhand	0.52	0.69	0.82	1.67	2.96
12	Karnataka	5.75	6.16	6.35	6.82	8.49
13	Kerala	5.79	5.43	5.38	4.99	4.88
14	Madhya Pradesh	5.99	9.19	12.9	13.7	13.01
15	Maharashtra	11.03	10.95	13.46	15.53	13.71
16	Manipur	0.12	0.16	0.2	0.2	0.24
17	Meghalaya	0.2	0.21	0.25	0.23	0.28
18	Mizoram	0.13	0.14	0.19	0.15	0.18
19	Nagaland	0.14	0.01	0.1	0.13	0.1
20	Orissa	2.55	3.58	4.4	2.8	5.14
21	Punjab	2.11	2.33	2.24	2.41	2.5
22	Rajasthan	5.37	7.23	10.19	11.36	12.02
23	Sikkim	0.06	0.06	0.06	0.06	0.06
24	Tamil Nadu	10.78	10.85	11.16	11.05	10.5
25	Tripura	0.29	0.31	0.31	0.32	0.37
26	Uttar Pradesh	19.22	21.23	23.25	18.18	25.59
27	Uttarakhand	0.2	0.36	0.6	0.74	0.98
28	West Bengal	7.31	8.33	8.85	9.4	9.8
29	A & N Islands	0.05	0.05	0.05	0.05	0.05
30	Chandigarh	0.15	0.17	0.18	0.19	0.2
31	Dadra & Nagar Haveli	0.03	0.04	0.02	0.03	0.03
32	Daman & Diu	0.04	0.04	0.02	0.03	0.03
33	Delhi	2.14	2.3	1.48	2.65	1.72
34	Lakshadweep	0	0.01	0.01	0	
35	Puducherry	0.26	0.29	0.5	0.47	0.48
	All states and UTs	3.10	119.59	143.71	148.24	162.08

Source: NRHM, State data sheets as on 30th June 2010

Table 9.11 : Institutional Deliveries as % of Child Birth

S.No.	States/UTs	2005-06	2006-07	2007-08	2008-09	R 2005-06	R 2006-07	R 2007-08	R 2008-09	Changes 2005-06 to 2008-09	Rank
1	Andhra Pradesh	8.23	8.38	8.72	9.37	3	4	5	4	1.14	16
2	Arunachal Pradesh	3.21	3.2	3.38	3.89	19	23	25	23	0.68	22
3	Assam	2.11	2.72	4.57	5.07	24	24	22	21	2.96	6
4	Bihar	0.87	0.46	3.09	4.24	27	29	27	22	3.37	4
5	Chhattisgarh	1.7	2.16	2.45	2.95	25	25	29	29	1.25	15
6	Goa	0.87	0.91	9.9	10.85	28	7	6	10	0.72	20
7	Gujarat	5.87	6.28	7.17	6.59	6	20	20	15	2.70	9
8	Haryana	3.02	3.88	4.95	5.72	22	17	18	20	1.01	18
9	Himachal Pradesh	4.08	4.47	5.07	5.09	14	6	7	8	2.71	8
10	Jammu & Kashmir	4.47	6.4	7.17	7.17	13	28	30	30	1.47	14
11	Jharkhand	0.68	0.9	1.06	2.14	29	11	13	13	0.96	19
12	Karnataka	5.02	5.45	5.61	5.99	9	1	1	3	-1.59	30
13	Kerala	11.7	10.96	10.91	10.11	1	15	9	9	3.99	3
14	Madhya Pradesh	3.13	4.76	6.7	7.12	20	8	8	7	2.41	10
15	Maharashtra	5.62	5.65	6.99	8.04	7	13	10	17	1.89	11
16	Manipur	3.58	5.17	5.84	5.47	16	22	24	25	0.33	26
17	Meghalaya	3.28	3.43	4.12	3.61	18	3	2	5	1.47	13
18	Mizoram	7.32	8.56	10.84	8.8	5	30	28	26	-0.63	29
19	Nagaland	3.95	0.4	2.66	3.32	15	18	17	27	0.33	27
20	Orissa	2.97	4.2	5.21	3.3	23	14	21	18	0.68	21
21	Punjab	4.53	5.02	4.82	5.21	12	19	11	11	3.33	5
22	Rajasthan	3.07	4.1	5.76	6.4	21	9	15	19	0.33	25
23	Sikkim	4.88	5.53	5.4	5.21	10	2	3	2	0.34	24
24	Tamil Nadu	10.11	10.28	10.76	10.45	2	10	16	14	0.44	23
25	Tripura	5.43	5.46	5.24	5.87	8	26	26	24	2.81	7
26	Uttar Pradesh	3.52	3.85	4.22	3.28	17	21	23	28	-0.23	28
27	Uttaranchal	1.04	1.84	3.14	3.85	26	12	12	12	1.56	12
28	West Bengal	4.61	5.31	5.74	6.17	11	5	19	6	1.11	17
29	Delhi	7.39	7.8	4.96	8.5	4	27	4	1	9.98	1
	India	0.12	4.58	5.51	5.68	30	16	14	16	5.56	2

Source: NRHM, State data sheets as on 30th June 2010

Table 9.12 : No. of Beneficiaries of JSY (in Lakhs)

S. No.	States/ UTs	2005-06	2006-07	2007-08	2008-09	2009-10	2010-11
1	Andhra Pradesh	0	0	4.35	5.51	2.63	0.22
2	Arunachal Pradesh	0.01	0.01	0.08	0.09	0.1	
3	Assam	0.18	1.9	3.05	3.28	3.66	0.75
4	Bihar	0	1.14	8.38	11.47	12.46	2.55
5	Chhattisgarh	0.25	0.75	1.76	2.25	2.77	0.38
6	Goa	0	0	0.01	0.01	0.01	0
7	Gujarat	0.42	1.21	1.86	2.13	3.5	0.5
8	Haryana	0.03	0.23	0.57	0.48	0.68	
9	Himachal Pradesh	0.02	0.06	0.1	0.13	0.16	0.02
10	Jammu & Kashmir	0.02	0.13	0.11	0.08	0.92	0.21
11	Jharkhand	0	1.23	2.52	6.19	6.55	0.63
12	Karnataka	0.38	2.33	2.83	3.31	3.34	0.14
13	Kerala	0.2	0.59	1.48	1.36	1.34	0.17
14	Madhya Pradesh	1	4	11	10.99	11.18	2.13
15	Maharashtra	2	1.81	2.19	2.24	3.17	0.28
16	Manipur	0	0.08	0.09	0.11	0.17	0.03
17	Meghalaya	0	0.04	0.09	0.14	0.14	0.01
18	Mizoram	0.07	0.13	0.13	0.14	0.51	0.01
19	Nagaland	0	0.01	0.1	0.13	0.08	0
20	Orissa	0.26	2.27	4.9	5.06	5.87	1.58
21	Punjab	0.78	0.17	0.29	0.68	0.97	0.12
22	Rajasthan	0.05	3.88	7.75	9.17	9.78	2.15
23	Sikkim	0.01	0.02	0.03	0.04	0.03	0
24	Tamil Nadu	0.87	2.88	2.3	3.87	3.89	0.83
25	Tripura	0	0.21	0.16	0.18	0.2	0.04
26	Uttar Pradesh	0.12	1.69	8.64	15.64	20.22	3.79
27	Uttarakhand	0.02	0.21	0.59	0.71	0.74	0.11
28	West Bengal	0.31	2.25	5.73	7.48	6.83	
29	A & N Islands	0	0.01	0	0	0	0
30	Chandigarh	0.03	0.03	0	0	0	0
31	Dadra & Nagar Haveli	0	0.01	0	0	0.01	
32	Daman & Diu	0	0	0	0	0	
33	Delhi	0	0	0.07	0.24	0.22	
34	Lakshadweep	0	0	0	0.01		
35	Puducherry	0	0.03	0.05	0.05	0.05	0.01
	All States and UTs	7.04	29.31	71.19	93.16	102.19	16.66

Source: NRHM, State data sheets as on 30th June 2010

Table 9.13 : Health Conditions and Disability Adjusted Life Years (DALY) Lost in India, 1998

Disease/ Health Condition	DALYs Lost (x 1000)	Share in the total burden of disease (%)
Communicable diseases, maternal & peri-natal conditions		
Tuberculosis	7577	2.8
HIV/AIDS	5611	2.1
Diarrhoeal diseases	22005	8.2
Malaria and other vector borne conditions	4200	1.6
Leprosy	208	0.1
Childhood diseases	14463	5.4
Otitis media	475	0.1
Maternal and perinatal conditions	31207	11.6
Others	49517	18.4
Non-communicable conditions		
Cancers	8992	3.4
Diabetes	1981	0.7
Mental Illness	22944	8.5
Blindness	3699	1.4
COPD and Asthma	4061	1.5
Oral diseases	1247	0.5
Others	18801	7.0
Injuries	45032	16.7
All listed conditions	200,634	74.6
Others	68319	25.4

COPD: chronic obstructive pulmonary disease

SOURCE: *Peters et al.* (2001) cited in NCMH Background Papers-Burden of Disease in India

WHO Global Burden of Disease

The Global Burden of Disease classifies the causes of death into three categories (see Table 9.14):

Category I: Communicable Diseases maternal and child health conditions – These are the traditional health threat in poor and developing countries.

Category II: Non Communicable Conditions such as cardiovascular diseases, diabetes, depression, cancer, respiratory conditions such as asthma and COPD, mental health conditions

Category III: Consists of injuries-intentional and unintentional, traffic accidents, suicides, homicides etc.

The same classification is used to measure the share of particular diseases to the total burden of

diseases as well as contributing to the total DALYs lost in India in 1998. NCMH has, accordingly identified the top 17 health conditions as significant conditions.

The Million Death Study (MDS)⁴⁸

The preliminary results of the MDS came out as the Report on Causes of Death in India, 2001-2003 (RGI, 2009). Accordingly, the leading causes of death in India were non communicable diseases (NCDs) constituting 42% of all deaths. Communicable diseases, maternal perinatal and nutritional

⁴⁸The Million Death Study is an attempt to analyse in detail the cause of approximately 1 million deaths in India from 1997 to 2007. The Study was conducted by the Registrar General of India (RGI) in collaboration with the Centre for Global Health Research (CGHR), Canada. After the report on Maternal Mortality Rates in 2006, this is the second report on the causes of death.

conditions constituted 38% and Injuries and other ill-defined causes constitute 10 %, all quantified on the prevalence of diseases in 2004 (see, diagram 9.4 and table 9.14).

As is seen (Table 9.14), in the Empowered Action Group (EAG) states along with Assam, communicable diseases, maternal and peri-natal conditions account for 60 % of all deaths. These constitute Category I conditions, which include what have been considered the ‘traditional health threats’ of poor countries—high infant mortality, deaths due to under nutrition, respiratory infections, peri-natal conditions etc. In the Other states, Category I conditions make up for one third of the disease burden.

In addition, Category II conditions which include

the non communicable diseases like cardiovascular diseases, diabetes, etc contribute rather significantly in both, the Other (non EAG) states as well as the EAG states. While in the other states, this accounts for half of the disease burden (50%), in the EAG states, 31% is attributed to this. Though, it is much lower than the communicable diseases, this is significant as it amounts to a double burden of disease for these states. While non communicable diseases were earlier attributed to affluent lifestyles prevalent largely in urban areas, they are now also affecting rural population (40%).

Communicable Diseases

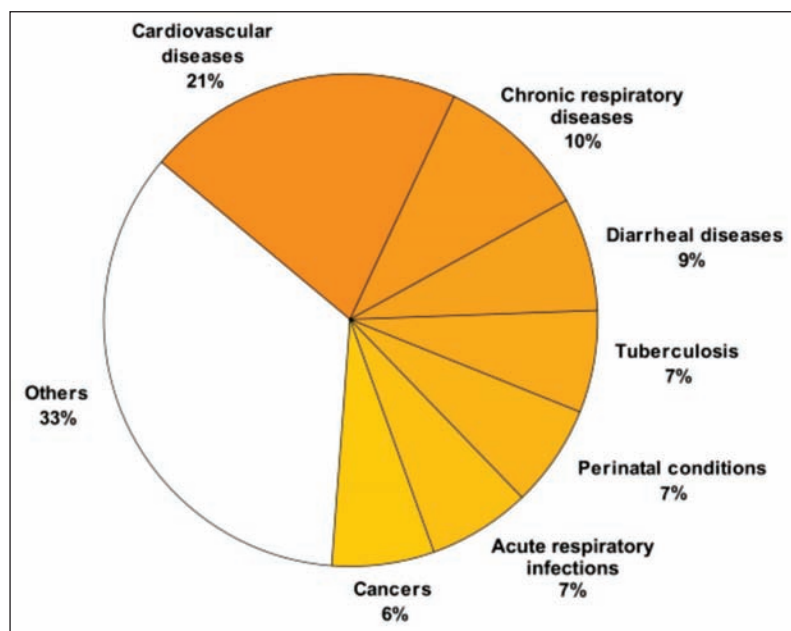
Malaria: Malaria accounts for nearly 1.5 million cases, annually in India. However, this is an under

Table 9.14: Mortality Rates under Different Categories

	Territorial Spread	Communicable Diseases deaths (%)	Non Communicable Diseases deaths (%)	Injuries (%)
1.	EAG ¹ States and Assam	59	31	10
2.	Other States	34	51	15
3.	Rural Areas	41	40	
4.	Urban Areas		56	

Source: Computed from RGI and CGHR 2009

Fig. 9.4 : Leading Causes of Death, All India, All Age, 2004



Source: RGI and CGHR 2009

estimated figure, given, as with other diseases, the under-reporting of incidences as well as non reporting of cases that sought treatment at private facilities. The states which are the most affected are the North-eastern states, Chhattisgarh, Jharkhand, Madhya Pradesh, Orissa, Andhra Pradesh, Maharashtra, Gujarat, Rajasthan, Karnataka, with almost 80% of the malaria cases coming from these states.

The table 9.15 reveals the number of Malaria cases and deaths due to malaria across the country in 2000 and 2009. Some states have shown a decrease in both the number of cases as well as deaths. However, many states have shown an increase in both. Notable among these are the states where malaria is pandemic- Chhattisgarh, Jharkhand, Maharashtra, Meghalaya, Mizoram, Rajasthan etc.

Table 9.15: State wise Cases and Deaths due to Malaria (2000, 2009)

Sr. No.	States/Uts	2000#		2009**	
		Cases	Deaths	Cases	Deaths
1	Andhra Pradesh	80557	6	31,095	20
2	Arunachal Pradesh	46165	0	15,337	0
3	Assam	84915	43	57,969	34
4	Bihar	9509	2	1,149	3
5	Chhattisgarh*	359155	63	1,18,500	32
6	Goa	9164	11	2,186	1
7	Gujarat	36712	2	58,996	9
8	Haryana	1050	0	9,610	0
9	Himachal Pradesh	491	0	197	0
10	Jammu & Kashmir	3045	0	718	0
11	Jharkhand *	133453	16	1,73,891	13
12	Karnataka	109118	14	41,861	11
13	Kerala	2940	9	2,162	4
14	Madhya Pradesh	194689	92	80,094	0
15	Maharashtra	81406	40	1,24,860	162
16	Manipur	1064	0	890	4
17	Meghalaya	13699	11	40,180	82
18	Mizoram	9059	33	15,061	22
19	Nagaland	3443	0	4,736	5
20	Orissa	509497	467	3,28,767	203
21	Punjab	493	1	3,369	0
22	Rajasthan	35973	10	47,054	26
23	Sikkim *	16	0	47	0
24	Tamil Nadu	43053	1	14,102	1
25	Tripura	12245	6	22,926	8
26	Uttar Pradesh	96971	0	59,114	0
27	Uttaranchal *	2008	0	1,599	0
28	West Bengal	145322	103	1,08,180	38
29	A&N Islands	1002	1	2,377	0
30	Chandigarh	256	0	347	0
31	Dadar & Nagar Haveli	2415	0	5,339	0
32	Daman & Diu	132	0	194	0
33	Delhi	2631	0	250	0
34	Lakshadweep	5	0	6	0
35	Pondicherry	137	0	154	0
	All India	2031790	931	13,73,317	678

Source: #National Malaria Control Programme and ** NHP, 2010

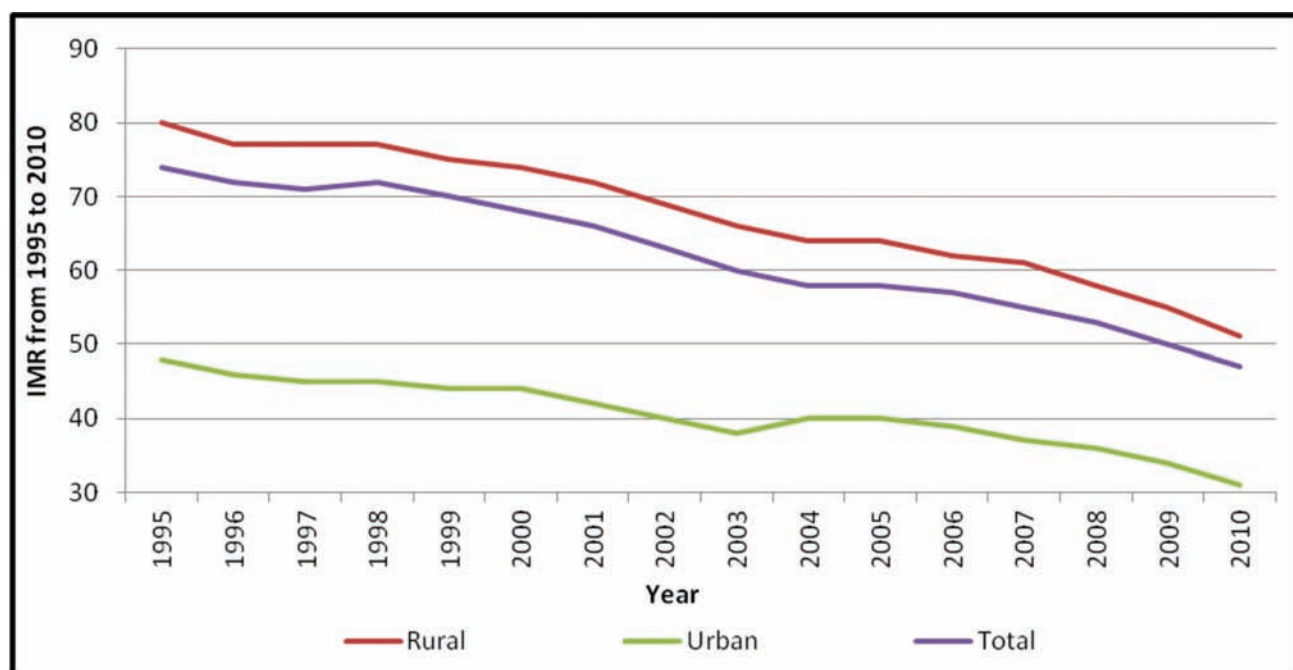
The figure is a representation of the number of Malaria cases (particularly, *P. Falciparum* cases and deaths due to malaria across the country in the last decade (figures for 2000 to 2011 are provisional). The number of deaths peaked in 2006 with 1707. While the figure shows a decrease subsequently, care should be taken to note that a true estimation is not possible given the under reporting of cases and the fact that this kind of data is collected from public health facilities only. It is apparent from the fact that 1.6 million cases of malaria and only 1144 resultant deaths (also see Fig. 9.5) were officially acknowledged in 2009. Based on the ‘analysis of data from verbal autopsies for 2001-03 from the sample registration system suggested that 125,000-277,000 deaths are caused by malaria per year in India’, the highest was reported from Orissa (see Table 9.15), Chhattisgarh, Jharkhand and north-eastern states (Lancet, January 15, 2011). Another study, quoted in the same issue of Lancet, had pointed out that an ‘estimated 98,500 spontaneous abortions and 1000 maternal death per year were due to malaria’. It may be noted that ‘the methods used to arrive at this number are being contested. However, the burden of malaria in India is almost certainly more than that suggested by official data’ (Ibid;).

Tuberculosis (TB): With 2 million new cases of TB recorded in 2009 that is the ‘highest for any country in the world... and 280,000 deaths from tuberculosis. The incidence of 168 per 100, 000 per year has not decreased’ (Lancet, January 15, 2011).

2. Kala Azar : From the table 9.16, it is apparent that Kala Azar is prevalent mainly in the eastern states of West Bengal, Bihar and Jharkhand, though incidence of this disease has been reported from UP and Delhi also but fewer in number. West Bengal reported the highest with 1244 cases in 2000, it was able to bring down the number to 756 in 2009. However, in the case of Bihar, it has gone up from 12,909 (2000) to 20,519 (2010) and Jharkhand, 469 in 2000 to 2875 in 2009.

Japanese Encephalitis (JE): The data pertaining to Japanese Encephalitis (JE), showing both cases and deaths on this count during the last decade is presented (see, Table 9.17). Unlike Kala Azar, it is reported practically from all the corners of the country. Strangely, however, its spread is limited. For instance, it is prevalent in Assam but not in the other north-eastern states, except in Manipur, reporting a few cases. Likewise, it is prevalent in

Fig. 9.5 : Malaria cases and deaths in India (2000-2011)



SOURCE: National Vector Borne Disease Control Programme

Table 9.16 : State wise cases and deaths due to Kala Azar 2000, 2009

Sr.No.	State/ U.Ts.	2000		2009	
		Cases	Deaths	Cases	Deaths
1	Assam	0	0	26	0
2	Bihar	12909	130	20519	80
3	Delhi	84	9	12	0
4	Jharkhand	469	0	2875	12
5	Sikkim	0	0	5	0
6	Uttar Pradesh	47	0	17	1
7	West Bengal	1244	11	756	0
Total		14753	141		

Note : Kala Azar is reported from a few States, as given above, only

Table 9.17 : State wise reported Cases and Deaths due to Japanese Encephalitis (JE), 2000 and 2009

Sr.No.	States/UTs	2000		2009	
		Cases	Deaths	Cases	Deaths
1	Andhra Pradesh	343	72	14	0
2	Assam	158	69	462	92
3	Bihar	77	19	325	95
4	Goa	15	3	66	3
5	Haryana	74	43	12	10
6	Karnataka	438	45	246	8
7	Kerala	164	2	3	0
8	Maharashtra	2	0	1	0
9	Manipur	0	0	6	0
10	Nagaland	0	0	9	0
11	Tamil Nadu	4	0	265	8
12	Uttar Pradesh	1170	253	3073	556
13	West Bengal	148	50		
	India	2593	556	4482	772

Note : Only a few States have reported prevalence of JE

Bihar, West Bengal but not in Orissa. Again, cases of JE have been reported from all the southern states, highest number being reported from Tamil Nadu in 2009 as against very few nearly a decade earlier. In Andhra Pradesh in 2000 its prevalence was the second highest in the country, only next to UP,

has come down substantially in a decade time. The pattern is odd by all means with repeated outbreaks of the disease in certain pockets of the country.

Dengue : The picture regarding dengue has also been similar with increasing trend in the number of cases as well as these leading to death.

Table 9.18 : State wise Dengue cases and deaths, 2000, 2009

Sr.No.	States/Uts	2000		2009	
		Cases	Deaths	Cases	Deaths
1	Andhra Pradesh	5	0	1190	11
2	Bihar			1	0
3	Chhattisgarh			26	7
4	Goa			277	5
5	Gujarat	29	0	2461	2
6	Haryana	2	0	125	1
7	J&K			2	0
8	Karnataka	196	0	1764	8
9	Kerala	0	0	1425	6
10	Madhya Pradesh			1467	5
11	Maharashtra	66	3	2255	20
12	Nagaland			25	0
13	Punjab	91	1	245	1
14	Rajasthan	0	0	1389	18
15	Tamil Nadu	81	1	1072	7
16	Uttar Pradesh	0	0	168	2
17	West Bengal			399	0
18	Chandigarh			25	0
19	Delhi	180	2	1153	3
20	Puducherry			66	0
	Total	650	7	15535	96

Until 2000, it was not present in many states, the picture is clearly different in 2009 with all states showing substantial incidences of the disease, the highest being Gujarat, Maharashtra followed by Karnataka (see, Table 9.18).

Non-Communicable Diseases

After communicable diseases, this category accounts for the second largest share in terms of burden of disease in India. In its components are included cardiovascular diseases, diabetes, cancer, respiratory conditions such as asthma etc. As a share in the burden of disease in India, this category is set to increase significantly, as can be seen in the available data.

Cardiovascular Diseases (CVD)

Amongst individual diseases, cardiovascular disease is the topmost cause of death in India. Data suggests that CVD in rural population is also set to increase in the coming years.

Table 9.19 : Burden of Strokes

S.No.		1998	2004 (latest)
1	No. of cases of stroke	7,92,628	9,30,985
2	No. of deaths	5,93,362	6,39,455
3	No. of YLL	48,18,740	52,89,357
4	No. of DALY	58,02,295	63,68,970

Source: Assessment of Burden of Non-Communicable Diseases, ICMR (2006) cited in NHP, 2010.



Table 9.20 : Burden of Diabetes

Year	1998			2004 (Latest)		
	Urban	Rural	Total	Urban	Rural	Total
No of Cases	16686891	14370120	31257011	21404225	16364177	37768402
No of Deaths	51251	44299	95550	62506	46627	109133
No of YLLS	529959	484983	1014942	646351	510471	1156822
No of DALYs	1016866	971890	1988756	1240195	1022968	2263163

Source: Assessment of Burden of Non-Communicable Diseases, ICMR (2006) cited in NHP, 2010.

The table 9.19 shows substantial increase in the number of cases of stroke, including those leading to death from 1998 to 2004 and as mentioned earlier data suggest that it is going to further increase in future.

Diabetes: Diabetes is fast becoming a serious health challenge in India and is associated with an increased risk for CVD. In 1998, it accounted for 0.7 % of India's disease burden (See Table 9.20), however the number of cases is estimated to reach 4.6 crore by 2015 (NCMH background papers, 2005).

Although the burden of disease in India is going through an epidemiological shift, the share of communicable diseases in it is still very significant to the extent that it is said that India has a parallel disease burden. Loss of lives due to diseases caused by under-nutrition, low birth weight, poor sanitation, unhygienic living conditions, unavailability of clean drinking water is hardly decreasing.

The incidence of diseases in India suffers from non availability of data which in turn is fallout of under reporting. Along with this, available data for most diseases is collected from public health facilities, thus excluding the cases that seek treatment from private facilities. Hence, a clear and exact estimate of diseases is hard to get.

Summing Up

For the last three decades, the Indian health care system has remained, supposedly under the guidance of a structured health policy. Starting from the expansion of the primary health centres (PHCs) to vertical disease control to reproductive child health, a number of programmes and schemes came up during this period. Irrespective of their focus and

contents, most of these programmes were essentially preventive (a la immunization, family planning etc.) in nature, mainly aimed at population control, notable exceptions apart. At least, this had been the public perception.

Set against this backdrop, the coming of NRHM was seen as a huge improvement over all the previous efforts. It was rather all encompassing, intended for striking also at the roots that fuel disease burden in the country, such as lack of potable water and sanitation in rural areas, causing a lot of diseases. By implanting a community health worker, as a link between the community and health care delivery centres and also creating institutional space for involvement of the gram panchayats through the instrument of village health and sanitation committee (VHSC), the NRHM was all set to galvanize the health care system in rural areas. Did it happen?

The reading of the progress report gives a mixed feeling. It has been a success on many counts; the opposite is also true. In the first place, it has bridged the huge gap, to a large extent, that had existed for long between the manpower required and filled in actual position. Most importantly, this has happened at all levels and practically across all the cadres. This is equally true of creating new/upgrading/adding infrastructural facilities: medicines, equipments, furniture, electrical fittings, office space, face lifting of health centres, telephone, ambulances, etc. everything was provided for. Funds were not a constraint. Indeed, there was a mad rush for spending enhanced budgetary allocations but strictly in accordance with the guidelines. The euphoria thus created has propelled them to make additional facilities even at those PHCs where existing ones were not in use. Ditto for new management system created at the district and the

block level. As new entities, the programme managers at both the district and block level, drafted laterally to the traditional hierarchy of health department, were helpful in creating huge data bank pertaining all the components of the NRHM. It is a different matter that vast amount of data set prepared are quite often mind boggling; serving hardly any purpose in the absence of any qualifying data set. The outcome is no way different when multi-phased capacity building programmes for health volunteers are considered. As a matter of fact, data generated by various agencies of the state are not even comparable in the absence of proper sequencing. The state-wise performance has, as usual, remained varied.

Notwithstanding all these, the cumulative effect of NRHM has been a sharp reduction in mortality rates, both infant and maternal. This seems to be the final outcome of a mammoth exercise undertaken during the last seven years at the cost of huge public spending. Paradoxically, the NRHM had promised much beyond that; rather on many counts. This had inter alia included reducing intra and inter-state disparities, a much coordinated effort to ensure provisions of safe drinking water supply and sanitation with greater involvement of local government bodies etc. The progress on all these matters is minimal, to say the least. Likewise, multi level and multi-sector coordination remained peripheral, as were north-south, east-west divide which remained as pronounced

as they were. On the face of all these, one fails to understand why additional administrative structures (state health committees, for instance) were set up in the state capitals if these offices had to work as appendages to the traditional health department.

It was ambitious indeed since it promised to go beyond measurable outputs, focussing on outcomes. It has succeeded on some matters but has fallen flat if its success is measured in terms of its impact on the prevailing disease burden. Consider a few facts: 18 million children die every year due to poor sanitary conditions 60 % of total rural population defecate openly in rural areas. Not to speak of communicable diseases like Malaria, dengue, TB, there has been tremendous increase in incidence of non-communicable diseases and deaths caused by these. Paradoxically, the disease burden has remained unconnected with the NRHM. Seemingly obsessed with their concern for reducing mortality rates, the progenitors of NRHM had overlooked, it appears, the curative part of the resurrected health infrastructure and manpower. Therefore, they cannot be blamed if the efforts, including budgetary allocations made under NRHM had hardly shown any impact on disease burden and its catastrophic effect on *Aam Admi*. But death on account of poor sanitary and unhygienic conditions speak volumes of the 'success' of a mega health programme ran on mission mode.■

IN LIEU OF CONCLUSION

Measuring performance, in the first place, necessitates a benchmark, usually set against identified parameters along with a designated time frame. This is all the more important in case of governance performance appraisal as the term is theorised and interpreted in many ways. Rather, a plethora of governance indicators has been constructed over the years, including a bunch of those which are hard to quantify. To overcome these odds, the present study has followed Stoker's conceptual frame which has re-emphasised the central role of the State, albeit with a rider that this recognition is not accorded to a monstrous State, described famously as 'Leviathan' but the one which is ethically grounded. Put simply, within the broad rubric of the governance frame, this would mean a State which diligently discharges its responsibilities, opens itself to scrutiny by encouraging transparency and accountability as well as participation of other stakeholders in its conduct. All this would be applicable in varying degrees, it assumes, to its all the three arms: legislative, judiciary and executive along with their allied and subordinate institutions. Secondly, it would off-load some of its responsibilities to the non-state actors, such as market and the NGOs, including civil society organisations, media etc. Finally, it would be market friendly. This would also entail a re-assessment of the role of the State in the beam of its legitimacy.

Set against this backdrop, the study revisits the twin issues of legitimacy and responsibility of the

State in the light of what people expect from the government – a much simpler notion of the State in popular parlance. Or, perhaps better still to assess how government performs its basic functions, measured in terms of law and order situation, justice deliverance, people's welfare, particularly of weaker and vulnerable sections, use of resources for creating both social (education, health etc.) and physical infrastructure etc. Based largely on secondary sources, the present study has taken recourse to both published reports and raw data on carefully chosen indicators, including proxy indicators. For the sake of comparison, data set of two time periods are presented – late 1990s and the end of last decade, exception apart wherever data of required time frame was not available. It is only in the second part of the report that one would find flavour of the primary data which the principal author of the report picked up during his field visit across few states in the country.

With periodic elections fairly conducted by an autonomous election commission under the glare of alert media, the legitimacy aspect of the government is never suspected. Over the years, there has been increasing participation of the poor in general, SCs and STs in particular in electoral arena. By introducing the quota system in representative institutions, empowering the electorates with voter's identity card, and above all, by facilitating political mobilisation, the State has been instrumental in expanding the social base of democracy. Rather, it

has instilled feeling among the marginalised sections that they happen to be a part of the system, and thus it has ensured its own resilience and long time survival. Ironically, when the poor, marginalised have made their presence felt in representative institutions (particularly during the last two decades), the strains of de-politicisation had already begun affecting the democratic ideals. Consider the following symptoms: politics bereft of any ideology as all political players speaking the same language of growth and development, notable exceptions apart; devoid of internal democracy and controlled by individuals or families with increasing preference for kith and kin to contest election while putting barriers against public spirited new comers with merit and abiding interest, preventing them from entering politics, the political parties are turning into family enterprise; hijacked by criminals and crooked moneybags, the politics has taken a back seat. It is being increasingly felt that the representative character of the government has taken a huge toll on its performance. It has necessitated major reform which perhaps cannot be realised with the State funding of elections alone, often touted as cure to all governance failures.

Is there any institution that can save the system from the tyranny of the market and the failings of electoral governance? Yes, Judiciary! This is not even an intelligence guess. This optimism however, is based on the merits of the Supreme Court and some of the High Courts. They have their own shortcomings such as tons of unheard cases at their end; yet they are serving public cause, even going beyond their functional domain. This bright picture of (the higher level) judiciary turns pale when it comes down to the lower judiciary. Located at the district and sub-divisional towns, it is here the hapless masses come face to face with the hassles of the legal system with no end of their plight in sight when faced with resourceful adversary who can bend the judicial system at large by sheer use of its loopholes. The legal governance has not been able to touch it, not to speak of offering any cure to this pervasive malady afflicting the judicial system at its roots.

Intimately linked with the subordinate judicial system is the functioning of the law and order machinery in the country. Has the improved

governance system impacted the law and order functions of the State? If one is not convinced with the murky details appearing in daily newspapers, take note of the voluminous statistics compiled by the bureau of police research. This brings to surface the depressing accounts of all sorts of cognizable crimes committed against ordinary people and also against the vulnerable sections of society: SCs, STs, poor and women. Yet these neatly compiled figures arranged in percentage points showing the state of crime across the states and union territories do not tell the trauma borne out of humiliation and injustices that poor, asset-less persons are subjected to, in their everyday life and practically everywhere in the country. For the sake of record, it may be noted that the crime committed against the SCs in Rajasthan is seen coming down in recent past as compared to what was recorded a decade ago. The corresponding figures of Andhra Pradesh, Madhya Pradesh and Orissa are on higher side of national average. Madhya Pradesh is worst in recording crimes against STs in particular. There could be many contributory factors but the fact remains is that if a large number of already scanty police force is deployed for the personal security of VIPs, then police cannot be expected to effectively deal with crime control.

To cap it all, the writ of the State does not seem to run under the command of as many as 400 'disturbed' police stations which are dotted in 90 districts spread across thirteen states. Against this, Bihar has thrown up surprises. By adopting a multipronged strategy, including fixed tenure of police officials, filling up judicial positions and setting up fast courts, Bihar put a halt to kidnapping particularly which had become order of the day for more than a decade and half, starting from early 1990s. The administrative and judicial reforms initiated by the present leadership in Bihar that pulled out this eastern state from morass it had slipped in, gives us hope.

If half of the population (ignoring rural urban divide) is constrained to defecate openly, little less having no direct access to drinking water, and electricity connection, then even to talk of quality of life is an insult to their miseries. It is a huge problem, calling for extraordinary measures to be taken up in partnership with both the state and non-state actors.

The frame is available but what is missing is political will and above all, an inspiring leadership that could put every instrument at its disposal to ensure the provisions of basic needs for every household in a mission mode.

Paradoxically, there is no dearth of such programmes. Rather to achieve the stated goals and that too in mission mode, at least half a dozen centrally sponsored schemes, are in vogue. This includes schemes pertaining to sanitation, drinking water and rural health etc – all treated as flagship programmes and especially monitored by the Prime Minister's Office. Notwithstanding all these, the fact remains is that the governments at all the three levels – federal (union), provincial (state) and the local (panchayats/ municipalities) – seem to be competing with each other to impress upon the same constituents. All these three – water, health and sanitation – essentially happen to be the state subjects but the union government encroaches upon the authority of both the state and local governments by virtue of its control over financial resources and also because these subjects are inserted in the concurrent list. At the ground level that is at the district level and below the functional delivery system is somewhat like a diarchy wherein the line departments exercise control over the resources at its disposal and the manpower to do the same thing what is also devolved to local bodies.

Most importantly, there is a mistaken belief at the higher level in the country that involvement of village panchayats would ensure speedy and appropriate delivery of (any) services. All the more better, if the site and beneficiary has to be selected. This optimism is based on the assumption that the villages are homogenous units without any division or hierarchy at work; all think alike and always willing to help the needy ones and their elected local leaders are insulated from outside influences. That local level election is equally expensive rather the investment level is nearly commensurate to the quantum of funds reaching at the local level. This fact is thrown to winds by both the higher level legislatures and bureaucracy. There are even instances of auctioning of seats by the villagers to the highest bidder. What for? Don't they realise that bidding is an investment

made in expectations of heavy returns. Well known to everybody involved in the game – from powers that be in Delhi to the state capital to the villages – but none would accept it openly.

That decentralization can effectively work only when a group of active citizenry is available that could mobilise people, evolve consensus by minimising, if not eliminating, differences and get things done. Where half of the population is living on subsistence economy, can they be expected to debate, raise questions on finances, rules and regulations for implementation of any scheme? Divorced from these ground realities, the Indian establishment has gone on praising the virtues of non-existent or defunct village assembly, noble exceptions apart, debates where mere attendance is construed as participation.

The report also takes note of reforms initiated by the Government of India and as catalogued under the mid-plan review of the eleventh five year (2007-12) plan. Among the reform oriented initiatives, most prominently displayed is RTI. It is necessary to recall here that the RTI was pioneered by the government of Rajasthan that too not by its own volition but under tremendous pressure exerted by people's movement under the leadership of political activists of high repute. The suit was followed by few more states, only then the Government of India came out of its slumber and enacted its own (central) RTI. The trend was just reverse in case of facilitating decentralisation wherein states had perforce suitably amended their relevant acts, following the enactment of 73rd and 74th Constitutional Amendments. In both the cases, however, ambiguity remained, causing a lot of roadblocks. This was more on account of subordinate rules and regulations but, in the first place, the problem had originated from policy itself.

Conceptually, the policy making is touted as the function of political masters but in reality policies are drafted by the elite civil servants, manning both the higher echelons of bureaucracy and the field office of the district collector, wherefrom inputs are sought. Likewise, implementation and monitoring of the policy based programme is the responsibility of civil servants of varying cadres, particularly at the cutting edge level. But political interference

into implementation of at least centrally sponsored schemes has been an open secret. Over the years, this has resulted into overlapping, if not reversal, of roles of both the politicians and civil servants at the top and ground levels.

In plain words, a drift is noticeable at all the levels. Take RTI again, for instance. It did not appear suddenly. Rather, the bureaucracy got enough time, as it slowly began unfolding at the state level, to grasp the nuances of this potent instrument. Whether the information sought is innocuous matter or a crucial issue (disclosure about the latter might be problematic), they could not visualise that operationalisation of RTI would entail collection of data from diverse sources. This, in turn, would necessitate a change in the format of data gathering, if RTI applications were to be handled swiftly. Consequently, there is a huge backlog of undisclosed RTI triggered information. If the remedial measures are not taken up, this would eventually defeat the very purpose of crafting RTI itself. In plain words that would mean losing the honour the RTI had bestowed on the State for promoting transparency.

Notwithstanding all these, in the eyes of the people, the bureaucrats remain as guilty as politicians. With three Ps – permanent position, power and privilege – bestowed on the elite bureaucrats, they are seen as invincible; therefore, people do not believe that they are equally helpless before their powerful political ministers. The same is true of another dictum: how can the elite administrative officers would be different if the entire society is degenerated? After all, if they learn early in their career that they can get cosy postings only by remaining in the good books of their political masters why, in the first place, they would cross sword with their patrons? This is not to deny that there are fearless civil servants who are guided only by their sense of right or wrong but sadly, their number is dwindling fast.

But what is the explanation for bureaucratic highhandedness? Consider the increasing number of such cases referred to various administrative tribunals that speak volumes of cadre mismanagement. No less injurious is the attitude of civil servants to deny any wrong doing, rooted in their cultivated self-

importance and unparallel wisdom, in continuation, their propensity to shield wrongdoers, the fellow travellers. Included among their abilities is to repackage an old programme with little changes here and there and take credit for designing a new one. Several schemes and programmes of rural and urban development will testify to this fact. These facts, barring perhaps the last one, have been brought out by several committees but all have fallen into deaf ears. This also explains inaction on voluminous recommendations on professed administrative reforms; on the contrary, scheming civil servants are preferred by the crooked politicians. Is it any surprise that the guilty officers are often rewarded with prized postings, thanks to their political networking, at the cost of the best and the bright ones who are sacrificed, if not punished?

Yet the same set of politicians and bureaucrats facilitated liberalisation and deregulation under the broad rubric of economic reforms that gave a boost to the private sector, resulting into tremendous economic growth. They also worked in tandem in disinvestment of public sector units, including both ailing as well as alive and kicking, raising additional resources for enhanced social sector spending. Paradoxically, the second generation reforms pertaining to FDI in multi branding retail business, insurance, banking etc. have stuck in a logjam. Who is responsible for this impasse? The obvious answer is the federal government, the economists would like us to believe and pointing out its inability to take its coalition partners as well as Chief Ministers of opposition controlled states in confidence. But it does not seem to be so simple and straight. No doubt, the Congress government was in minority that heralded reforms but against the backdrop of a serious financial crisis. The NDA governments of course followed the suit easily since its crucial partners were reform oriented. The UPA-I also managed to steer through by balancing economic reforms with carefully crafted employment generation and health reforms that were seen as honest efforts to bridge the widening gap between the poor and the rich.

The current impasse is the result of ongoing battle of ideas and concerns amidst the financial meltdown of 2008. For instance, there is an increasing demand

for checking environmental degradation caused by reckless mining on the one hand, and issues pertaining to land acquisition where the State is seen taking side of the rich and powerful on the other. Closely linked with it is the absence or failure of regulatory bodies leading to numerous financial scandals involving thousands of crores of rupees. Most importantly, it is the financial buccaneer's lust for profit at the cost of everything else that the second generation reform is seen as favouring the capital alone, both indigenous and global. Above all is the internal dynamics of the Congress party that is trying to perform contradictory tasks: perpetuating hereditary politics and aiming at modernising economy. Put simply, all this amounts to attaining a stupendous task that is lost in the maze of negotiating political logic of economic reforms with the economic rationale of political dynasty.

Growing partnership between the business associations and the government forms the third postulate of governance which is intertwined with the economic reforms theme. In the first place, this had entailed a big change in the perception at the higher echelons of the government. From an era of distrust between the market and the State to creating an honourable space for the private sector, it was nothing less than the u-turn in the thinking of the government. This is something which has started showing signs since late 1980s when Rajiv Gandhi was at the helm of affairs in the country. He was instrumental, it must be acknowledged, in the setting up of CII, an association of modern, relatively outward looking entrepreneurs who were willing to take plunge in a highly competitive global economic environment. On all these counts, nothing seems straight, as quid-pro-quo between the government and the private sector or between the government and the NGOs for the lack of furnishing data and their collation in the required format. It also reinforces the doubts that the functionaries of the State are yet not prepared to imbibe the spirit of reforms and governance as well.

Health Governance

The maladies afflicting the functioning of governing institutions can be further substantiated by applying the same tools to measure the efficacy of the health governance, which happens to be

the focus of the report. First of all, it is the lack of clearly demarcated functional boundary for governing institutions at different levels. Likewise, the health system management in India is handled by the governments at all the three levels. It is essentially a state subject but designing health policies, regulatory functions, surveillance and control of disease outbreak happen to be the responsibilities of the Government of India. The curative health care, medical education (excluding recognition of medical colleges and approval of syllabi) and training fall into the domain of the state governments. The responsibilities transferred to the local (third-tier) government (though a distinct 'district list' is yet to be evolved) includes social mobilisation for immunization (including highly publicised anti-polio campaign) and ante-natal care of pregnant women/expectant mothers, construction and upkeep of sub (health) centre etc. Added to it is preparation of village health plan, thanks to NRHM, done by the health and sanitation committee of the village panchayat, not to mention the ubiquitous village assembly which is supposed to approve of the health plan and also give concurrence to selection of ASHA, the social health volunteer.

Now consider the realm of the policy making which over the years has been misconstrued as the sole responsibility of the federal ministry of health and family welfare. In complete disregard of the fact that a plethora of activities pertaining to the three specific areas of health — medical education, curative health infrastructure and personnel as well as public health along its socio-economic determinants — all largely intertwined cannot be handled properly in the absence of a distinct (public) health policy at the state level. Contrary to this perceived wisdom, the states consider public health, if not all the components of health sector, as the responsibility of the Union government and hence, they pay scant attention to the public health requirements. And perhaps they cannot be faulted. After all, the Centre makes huge budgetary allocations under the sub-heads of drinking water, nutrition and sanitation, (all that have strong bearings on the public health) largely as centrally sponsored schemes (CSS) with detailed guidelines for using funds allocated for the same, contrary to the spirit and content of decentralisation. In the absence of well

defined and legally enforceable financial devolution in the country, this has remained an unresolved dilemma. This is not to deny that financial profligacy or inaction of certain regimes in certain states in utilisation of CSS have also contributed to this sorry state of affairs.

Measured against this backdrop, the role performance of the Dravidian parties in Tamil Nadu in providing political support to the cause of public health deserves appreciation. This is the state which has a distinct public health act (Kerala also has an old public health act), a separate directorate for public health controlling a lion's share of health budget and a very large number of personnel, including field staff to handle public health activities. All this have contributed to highly appreciating public health outcome (only next to Kerala), better than that of economically developed states like Maharashtra and Gujarat. It is a mute question as to why other states have not learnt from Tamil Nadu? If the Federal government had devised an incentive structure to reward the better performing states, like Tamil Nadu, the other states might have noticed the signal and the purpose would have been served. Interestingly, the Union government is responsible for preventive health care but 'public health' per se cannot be located in the organizational frame of the Union Ministry of Health & Family Welfare (MH&FW).

Another malady afflicting the health system management is the control of communicable diseases. Amidst the odds mentioned above, the federal government adopts two pronged strategies to handle epidemic or outbreak of infectious diseases. First, it takes recourse to 'selective disease control (vertical) through special programmes' for TB, Aids, leprosy, immunisation etc. To run these special programmes, there are separate health officers operating from their offices at the central, state and the district levels with their field staff. All these are 'too expensive to be replicated for the control of other diseases' besides also being autonomous entities, these 'programmes cannot be integrated with other or with the health care system without which disease control cannot be efficient' (see, Lancet, January 15, 2011). Second, the centre provides ad hoc assistance for controlling and investigating outbreak of diseases.

Usually, a team drawn from the Delhi based National Institute of Communicable Diseases is sent to the field following a request from the state government. In the absence of effective disease surveillance, the outbreak is reported by the media which 'they tend to sensationalise whereas the state's department of health tends to deny or underestimate the magnitude of the outbreak' (Ibid:).

That apart, the curative part of the health sector entails a host of functions. This includes governance of hospitals/ health centres, maintenance of infrastructure, including upkeep of hospital buildings, equipments and machinery etc., and adequate deployment of doctors and para-medics, including nurses, compounders, field level staff etc. Last but not the least, is the regular supply of medicines and other essentials, including chemicals and other ingredients for pathological tests etc. Above all, adequate budgetary allocations and a suitably crafted health act, followed by subordinate rules and regulations. All this is the responsibility of the state governments. From its own resources, it makes allocations for health sector. On an average, Union government's contribution to the state health budget comes around 25-30 per cent. This includes budgetary support required for handling national diseases and immunization etc. Grippingly, of the total health spending in a state, usually 70-80% goes on account of salary, pension and meeting establishment costs, leaving out very little to think beyond the routine function of the provincial health department, again notable exceptions apart.

In the absence of health policy as such, states have been following guidelines and directives issued by the MH&FW, largely in tune with the recommendations of the several committees on the subject as also spelt out in the successive plan documents. There is a chain of organised hospitals / health centres from the provincial capitals to the district level and below, though there always is a rural urban dichotomy. Above all, the State has never categorically answer the dominant question of meeting the cost of the universal health care. On the face of scanty health infrastructure in the public sector, compounded with the lack of medicines and / or absence of doctors and even paramedics in remote/ rural areas, the

villagers would be left with four options. One, rely on quacks; two, move to already crowded sub-divisional or district hospitals; three, sell/ mortgage whatever meagre assets they have or raise loan to avail the private health care services in the nearest town; and four, in case of being asset-less, leave the sick person to the mercy of God and pray. Nothing is less bewildering than the fact that proportion of ailment remaining untreated have gone up less in urban areas, with every passing decade for they could not pay for it. It is equally sad to note that for the poor seeking treatment means getting into indebtedness, quite often this indebtedness and resultant impoverishment being inherited for generations. For the establishment it is cold, lifeless statistics: several million people pushed below the poverty line following serious health episode, every years.

Yet another uncomfortable fact of the health sector in India is its long running obsession with population control. Family planning alternatively known as family welfare or population control has enjoyed overriding priority by the successive governments to the extent that the Union ministry of health stands composed of two parallel halves: one for overall health and another for family planning. So much so that despite their massive expansion during the sixth and seventh plan periods, PHCs remained 'grossly underutilised' because they remained fixated with meeting family planning targets. Later, this was rechristened as family welfare programme with the addition of 'maternal and child health' component to the on-going family planning programme. Some changes were further incorporated to the existing programme thereafter; the focus remained on reproductive health. The child survival and safe motherhood programme (jointly funded by the World Bank and UNICEF), for instance, was initiated in 1992-93 with the avowed objectives of improving health status of infants, children and reducing maternal morbidity and mortality. This was later combined with the reproductive and child health services in 1997-98, to form the reproductive and child health programme (RCH).

This so called new programme, however, was simply aimed at expanding the coverage and improving quality of 'family welfare' services. Thus

a huge network of PHCs dotted across the length and breadth of the country has remained glued to the idea of limiting the family size of the poor and the lower middle class families. The NRHM driven recent changes have further confirmed this point. Irrespective of its outcome in other areas, at its core the NRHM was designed to reduce the number of IMR and MMR in the focussed states. This is true of ASHA. In view of role in health service delivery the idea seems to be empowering and participatory. As a matter of fact, what ASHA does is hardly different than that of a health volunteer, as visualised in earlier official documents. Notwithstanding little changes here and there, if the scope of services remains the same, new posts with eye catching designations would not make much difference. In sum, health policy designing in country, over the last few decades appears to have been affected with this garrulous syndrome .

This is not to belittle the achievements of the on-going national health mission programmes. After all, the coming of NRHM was seen as a huge improvement over all the previous efforts. It was rather all encompassing, aimed at striking at the root causes disease burden such as lack of potable water and sanitation in rural areas. The progress report, as usual, is akin to looking at a half filled glass which also gives the impression of being half empty. It has certainly improved the IMR and MMR records in a very large number of states. What is more, not only the gap between the required manpower and actual positioning has been abridged with generous fund flow from the Federal government, this has also helped states to create additional infrastructure facilities including assured supply of medicines, equipments, furniture, telephone, ambulance etc. Most of the health centres across the states have been given facelift; indeed health mission has injected new lease of life to near defunct/ moribund hospitals. In states like Bihar, vacancies for doctors were filled up after the gap of 17 long years. It is a different matter altogether that in the absence of a well defined absorption policy, the annual lease given to the doctors recruited on contract has remained a nagging issue. On the other hand, this has also resulted into creation of additional facilities in remote areas of Rajasthan and other BIMARU states where the existing ones were lying unused.

This is almost the same with the new management system laid down for receiving feedback (read reporting) from the field management units set up at the block and district headquarters. This is not to say that they are not regularly reporting. On the contrary, computerised feedbacks received on a number of items on structured formats are baffling. All these aggregated data are quantitative in nature which hardly serves any purpose in the absence of qualifying data. Certainly, the field offices run by management graduates and computer professionals are not at fault. The blame, again, goes to the mandarins sitting in Delhi. The same is almost true for the capacity multi-phase(s) building programmes designed for the community health workers particularly. That hapless 10th passed or below health volunteers are bombarded with charts, graphs along with series of lectures, customised in several phases which they were unable to comprehend. But the so called community based civil society organisations are engaged in overkill in their misguided zeal.

Not to mention of the grandiose plans of assuring coordinating efforts at the local level for the improved outcome of services in the field of nutrition, drinking water, sanitation, hygiene etc. which hardly took off; at the most, the multi-sector coordination efforts at the village level and up to the district level remained peripheral. Nearly the same for reducing inter and intra-regional divides. Against these outcomes, it is difficult to comprehend as to why additional administrative structures, (state health committees, for instance) were created in the provincial capitals if these offices were to function as external arms of the traditional health department

Most importantly, the NRHM has just bypassed the disease burden and meeting the cost of treatment. A very high burden of communicable diseases accompanied with a parallel burden of non communicable diseases, coupled with existing socio-economic conditions makes the delivery of health care services to the people, a daunting and challenging task. Apparently, health financing in India is characteristic of a high out of pocket expenditure. This in fact has created infinite business opportunities for multiple health insurance providers.

Located in both the public and private sector, these providers, until recently, were catering to the needs of people in organised sector only, ignoring overwhelming 92% of the people engaged in the unorganised sector. A few innovative communities based insurance schemes piloted by private providers in partnership with the state governments have also come up, mainly taking care of the poorer segment of the population. Several states (Tamil Nadu, AP, Karnataka for instance) also initiated health insurance for BPL households wherein a governmental agency will pick up the bill for their treatment in the specialized private referral hospitals. Above all, the GOI has launched a massive health insurance scheme, RSBY for people engaged in the unorganised sector. The beneficiaries have been issued smart cards, facilitating cash less admittance of poor patients to a very large number of referral hospitals. This is still in experimental stage, therefore it works in fits and starts.

What is most noticeable is the difference in the profile of their clients. The private health insurance providers serve largely to urban young, male with high spending capacity whereas the health departments both in the provinces and at the Centre, not the public sector health insurance agencies, are supposed to take care of the old, poor, with negligible or less purchasing capacity. There are grievances against wastage, siphoning of resources which again, given the lack of ethics and morality in public service delivery, is not surprising. But what is shocking is the fact that a fairly large proportion of poor still remain untreated. The same is true of people who become indebted in order to meet the cost of treatment. The NSSO data would testify to this fact. Be that as it may, it cannot be denied that the accounts of failures or less than success health insurance schemes are attributed to governance failure.

This is almost true in the field of medical infrastructure. During the last two decades a large number of medical, nursing institutions have come up. How awfully short they are in meeting the required norms was in public domain, duly highlighted by the media. That informed people had always suspected the regulatory body, the MCI, was itself in soup but it became a news only after its head

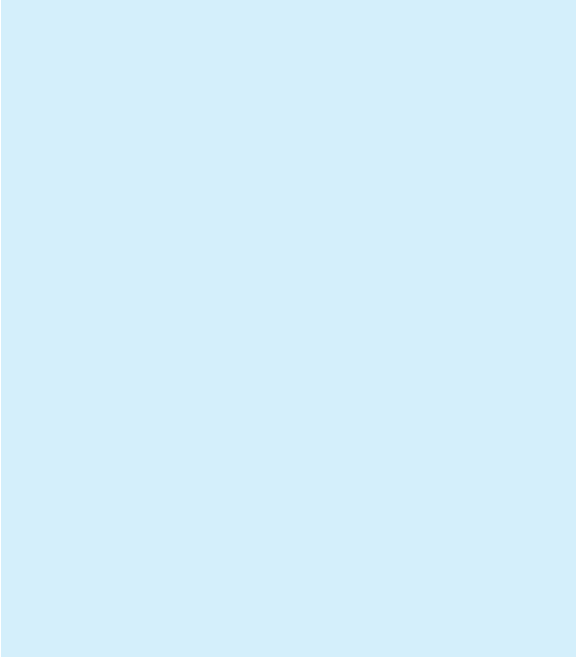
was arrested on charges of misusing his authority in granting recognition to medical colleges shorn of any standard. By injecting professionalism, the newly constituted body, hopefully, would be able to clear the rot and strengthen the medical education in the country.

Call it the lack of foresight or sheer callousness, the higher medical education in the country is in real mess. That the number of seats for post graduate courses is very limited in the public sector is known to the government for quite long. Also, that the young medical graduates perforce have to pay several million rupees for these seats in the private medical colleges which are almost auctioned to the highest bidder. How then government or the society at large would expect them to work in provincial town and that too for pittance?

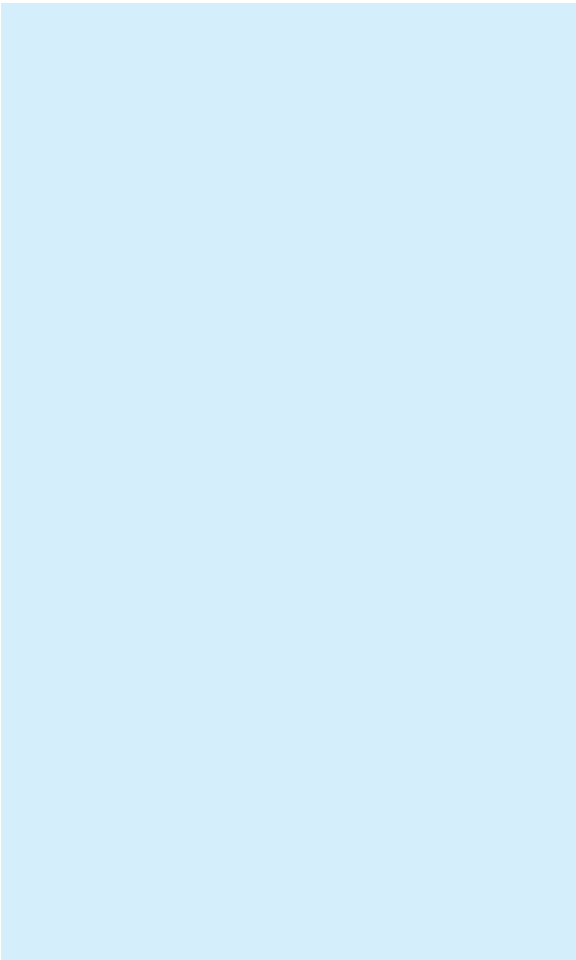
Amidst these congruities one can find explanations for the riddles of the health sector governance in India. Thus, on the one hand, by offering super speciality treatment the concerned agencies are promoting medical tourism in India. On the other we suffer from acute shortages of trained and qualified health professionals (where they are required the most) infrastructure, basic amenities and equipments, making us vulnerable to high rates of mortality and morbidity due to infectious diseases, under nutrition, poor sanitary conditions etc.

All this is not to say that the entire health sector itself is terminally ill but it certainly requires a

thorough check up. A critical review of its various components, in the light of its experiences under the NRHM will be revealing; not only for the MH&FW and provincial health departments alone but also for other ministries and departments. For, the fault lines are by and large common. First of all, the very realisation that government with or without governance frame cannot do everything at a time; sequencing is a must and there should be a real time frame to achieve the intended results. Second, a strong regulatory frame is required for all those sectors where governmental responsibilities, partly or wholly, are off-loaded to the market or even the civil society organisations. This would also entail monitoring and revival of inspection by senior officers whose inspection reports should be made available online. The government should refrain from shielding the guilty persons / culprits; rather punish the alleged than shooting the whistleblowers. Finally, instead of mouthing platitudes for so called radical administrative reforms, a lot can be achieved by sticking to the old *mantra*: reward the honest and diligent civil servants and punish the dishonest and corrupt ones and let it be publicised. It would be naive to believe, however, that with these select steps the rot set in the system for quite long would be cleansed. But writing on the wall is clear: that amidst the prevailing political unrest and disquiet in the country, the very legitimacy of the State is at stake. Indeed, mistrust around all public institutions is growing fast. It certainly calls for introspection, soul searching, even resorting to precise remedial actions.■



PART III



GOVERNANCE AND PROGRAMME DELIVERY IN INDIA

Abstract: There are two prominent but conflicting trends in India: impressive economic growth and wealth creation; and stagnation in key social indicators, particularly among the disadvantaged populations (i.e. by region, caste, gender). The launching of several flagship programmes since the last decade, and the Government of India's (GOI) increased commitment to accelerating social development present a unique opportunity to cover the gap between the desired goals and the present levels of achievement, but unless constraints impeding programme delivery are identified and remedial action taken, reducing poverty and reaching basic services to all is unlikely. This paper offers a few hypotheses for slow progress and suggests how we can improve governance and achieve the desired goals.

N.C. Saxena*

Growth, Outlays and Outcomes

In the last decade and a half that India has successfully embraced economic reforms, a curious problem has haunted the country and vexed its policy makers: India's excellent growth has had insufficient impact on its social indicators, and India is likely to miss achieving the Millennium Development Goals in respect of poverty, health, nutrition, sanitation and gender. What is worse, a large number of marginalised and disadvantaged people have either not gained

from development, or in some cases have actually been harmed from the process, such as tribals in central India.

According to the Planning Commission 26 percent of India's population lived below the poverty line in 1999; this figure has gone up to 32 per cent in 2011. In absolute terms the number of poor has gone up from 27 to 41 crores during 1999-2011. Today the number of the poor is more than our total

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population in 1950, when the Planning Commission was set up. Internationally, India is shown to be suffering from alarming hunger, ranking 67 out of the 81 developing countries studied. What is worse, India is one of the three unfortunate countries where the hunger index in the period 1996-2011 has gone up from 22.9 to 23.7, whereas 78 out of the 81 developing countries studied, including Pakistan, Nepal, Bangladesh, Vietnam, Kenya, Nigeria, Myanmar, Uganda, Zimbabwe, and Malawi have all succeeded in improving their scores (IFPRI 2011).

Despite GDP rising by eight to nine per cent every year, the NFHS 3 data shows that malnutrition in the age group 0 to 3 years has declined only by one percentage point in the last eight years. Immunization rates have remained stagnant. The government's assurance in 2004 of increasing health expenditure to 2 to 3 per cent has remained unfulfilled as this figure is still around one percent. The decline in the juvenile sex ratio over the last decade, visible in the data from Census 2011, is an indication that the Constitutional assurance of freedom and equality for women is still far from being fulfilled. India's maternal mortality ratio (MMR) of 230 deaths per 100,000 live births is unacceptably high. It is significantly higher than the MMR reported by Thailand (36), China (41) and Sri Lanka (43). We seem to be doing badly even when compared to countries poorer than us, such as Vietnam and Bangladesh as shown in Table 1.

India's aspiration to become a middle income country has to come to terms with its poor quality of governance. According to a survey of 12 Asian economies done by the Hong Kong-based Political

and Economic Risk Consultancy last year, India's "suffocating bureaucracy" was ranked the least efficient, and working with the country's civil servants was described as a "slow and painful" process. "They are a power centre in their own right at both the national and state levels, and are extremely resistant to reform that affects them or the way they go about their duties," the report said. The World Bank's 2008 Doing Business survey ranks India 120 of 178 countries in the ease of doing business index; Singapore is ranked 1, Mexico 44 and China 83. The same survey ranks India 134 under the component "Dealing with licenses," with 20 procedures and 224 days required to obtain a business license. So even though the worst of the "licence Raj" has been dismantled since the early 1990s, the "Babu Raj" remains as oppressive as ever.

Problematic as the business environment is, the plight of average Indian citizens is no better. They face enormous challenges in simple matters such as obtaining a ration card, an electricity connection, a required government application form or a driving permit. These tasks can require repeated visits to unresponsive government offices, payment of bribes, connections in the government to unblock obstacles or a combination of all of these. Average Indian citizens have many avenues for recourse in theory, but they know well the futility of trying to use them. The problems are magnified even more for the poor and the weaker sections of the society.

Social exclusion - The second major weakness in the economy is that the growth is not sufficiently inclusive for many groups, especially Scheduled Castes

Table 1: Social Indicators in Selected Countries

		India	Bangladesh	Myanmar	Vietnam	Bhutan
Infant Mortality Rate	1990	84	103	84	39	91
	2009	50	41	55	20	52
Underweight children under 5		43	41	30	20	14
Immunized against measles		71	89	87	97	98
Rural population with adequate sanitation		31	53	81	75	65
Attendance ratio of girls to boys in secondary school (net) (%)		83	116	94	93	107

(SOWC 2010)

(SCs), Scheduled Tribes (STs), urban poor, single women (widowed, divorced, or just abandoned), and minorities. Their economic deprivation derives from lack of productive assets like land and water, and access to credit. These chronically poor tend to remain in poverty for much of their lives, passing on the tragic legacy of deprivation and exclusion to their children. The brutal expulsion of those who most need it, from support and succour, from care and rights - often by their own families (as in the case of women), by local communities, but most importantly by the State - is one of the most profound public crimes of our times. It is important therefore to identify those classes, social categories and local communities, who are destitute and socially expelled.

It is not the size of allocations on pro-poor services alone that matters. Government of India transfers close to 5.5 lakh crore Rupees every year to the states. If even half of it was to be sent to the eight crore poor families directly by money order, they would receive more than 100 Rupees a day! It proves that public expenditure needs to be effectively translated into public goods and services that reach the poor for it to have an impact on poverty and social outcomes. Unfortunately different kinds of distortions can come in the way of resource allocations reaching the intended beneficiaries. There is enough evidence to show that government's capacity to deliver has declined over the years due to rising indiscipline and a growing belief widely shared among the political and bureaucratic elite that state is an arena where public office is to be used for private ends. Weak governance, manifesting itself in poor service delivery, excessive regulation, and uncoordinated and wasteful public expenditure, is one of the key factors impinging on development and social indicators.

Addressing these issues will need a shift in the way India prioritizes for social sector and focus on cross-cutting systemic issues like dilatory budgetary flows, M&E of programmes, personnel and administrative reforms, and accountability. Actions are needed along many critical areas, and first and foremost there must be adequate and specific information regarding the reasons for failure. Therefore there is an urgent need for state-specific studies to focus attention on such bottlenecks.

Factors Responsible for Poor Delivery

Low allocations for social sector

According to the Economic Survey 2009-10, the total social sector expenditure by Centre and the state governments combined as a percentage of GDP has increased from 5.57% in 2003-04 to 6.72% in 2008-09 (BE). This is primarily because of the fact that GOI allocation for education, health and other sectors relevant to MDGs has increased significantly over the past few years. However, part of this increase is illusory because the Pay Commission Award has added to the salary burden. Thus the budget increase may not have resulted in corresponding increase in the number of teachers or doctors. Second, 70 to 80% of the total expenditure on social sector is borne by the states, but they have not been able to arrest the decline in social expenditure as a proportion of total expenditure, as shown below. It is likely that as GOI stepped up its share in social sector expenditure, states decided to cut down on the plan schemes that they were running till the last decade.

Table 2 : Expenditure on education and health from state budgets as a percentage of total state expenditure

Year	Education	Health
2000-01	17.4	4.6
2001-02	16.2	4.4
2002-03	15.1	4
2003-04	12.6	3.4
2004-05	12.7	3.4
2005-06	14.2	3.9
2006-07	14	3.9
2007-08	13.8	3.8
2008-09	14.3	3.9
2009-10 (BE)	15.4	4.2
2010-11 (RE)	16.2	4.3
(RBI 2011)		

Outlays should not be considered as an end in themselves. Delivery of social services requires increasing financial resource, but more important is the quality of public expenditures in these areas. This in turn requires improving the certainty of budgetary

flows, monitoring of outcomes, governance, productivity and accountability of government machinery. In contrast, over the last two decades there has been hardly any improvement in the quality of services being provided by government to its citizens, especially the poor. We suggest some of the factors responsible for poor outcomes.

Budgetary procedures

Despite poor allocations it is ironic that some Ministries such as Health and Family Welfare, Tribal Affairs, and some states such as Bihar, Orissa and Jharkhand are unable to spend even the meagre funds that are allotted to them.

There has been large surrender of funds by the Ministry every year in the last 5 years, especially in 2009-10. Because of the poor expenditure by MOTA in 2009-10, there has been little increase in the BE for the Ministry in 2010-11. Non-receipt of adequate number of complete proposals in accordance with the scheme guidelines from the State Governments, non receipt of Utilization Certificates and lack of physical progress by State Governments, non-filling of vacant posts, austerity measures, non-receipts of bills from the suppliers etc. have been cited by the Ministry as the reasons for the surrender of funds. MOTA should improve its monitoring capabilities over timely expenditure of its budget.

To a Rajya Sabha Unstarred question no 1438, answered on 24.08.2007, the Minister for Health and Family Welfare admitted that 'data on the extent of utilization of funds by states reveals that of the eighteen States having weak public health indicators/ weak infrastructure, identified for special attention under the NRHM, eight states viz., Arunachal

Pradesh, Assam, Chhattisgarh, Himachal Pradesh, Madhya Pradesh, Mizoram, Rajasthan and Sikkim have utilized more than 50% of allocated funds while others have utilized funds of a lower order'. In FY 2008-09, Tamil Nadu and Gujarat spent 94 and 92 percent of total health funds available (centre and state) respectively. West Bengal and Maharashtra on the other hand, were low spenders with expenditures of only 54 and 45 percent respectively in the same period (Accountability Initiative 2011).

Among the states, the record of Bihar is atrocious in using central funds. In the Accelerated Rural Water Supply Programme alone, it lost about Rs.540 crores of Central assistance during 1994-2005. Even salaries are not paid on time in Bihar. An evaluation of ICDS in Bihar in 2007 by Unicef showed that only less than 10% of AWWs receive honorarium regularly, most receive it only twice in a year rather than monthly.

Reasons for poor utilisation of central funds by the states are many. Some of the common ones that need action primarily at GOI level are systemic bottlenecks, such as

- Delay in the flow of funds (at various stages)
- Rigid conditionalities of Centrally Sponsored Schemes preventing the government staff from addressing all local needs leading to poor expenditure
- Insufficient monitoring of delay at the senior level, with the result that remedial action to cut down red tape is not taken promptly
- Delay in the supply of goods such as medicines, food grains, etc.

Table 3 : Plan expenditure against budget provision for the Ministry of Tribal Affairs (In crore Rs.)

Year	Budget Estimates (BE)	Revised Estimates (RE)	Expenditure	% age of expenditure over BE
2006-07	1656.90	1652.68	1647.37	99.42
2007-08	1791.71	1719.71	1524.32	88.63
2008-09	2121.00	1970.00	1805.91	85.17
2009-10	3205.50	2000	1996.79	62.35
2010-11	3206.50			

In addition, many factors leading to delays require reforms at the level of state governments. These are:

- States are not able to contribute counterpart funds because of fiscal constraints
- Long process of identification of potential beneficiaries under various schemes (e.g. beneficiaries only from BPL families, or SC/ST communities, etc.)
- Capital expenditure (such as construction of schools) requires preparation of estimates and floating of tenders, which takes time
- Often estimates need to be sanctioned by a competent authority who is not locally available, and files travel up and down; there is insufficient delegation
- Poor budgetary allocation for support services, such as travel, telephones, which render supervision ineffective
- Government machinery is used to working in a sequential order, whereas quick completion of projects requires undertaking several activities concurrently
- Inadequate delegation of power to District/ Sub-District level government staff with regard to spending money
- Poor coordination between the Line Departments and PRIs
- Difficulty in decision-making in the Elected Local Bodies due to political differences
- Lack of adequate number of staff to implement schemes
- Funds received from GOI for MDG related programmes are diverted by the states to some other sector.

Funds allocated to the departments in the state budgets are not released during the year in an orderly manner and that far too many references have to be made to the finance department (FD) for prior

approval for release of funds on ways and means considerations. The same is found to be true in respect of release of funds to ZPs. Large funds are released at the end of the financial year resulting in many irregularities in booking the expenditure.

Release of budget is neither certain nor timely. The budget cycle is too short for full utilisation of funds for capital works. Expenditure budget should be valid for two years, so that capital expenditure can be completed without surrender of funds. Similarly for centrally sponsored schemes, approval of the state legislature should not be necessary for using central funds that are transferred to the state consolidated fund.

Ineffective M&E systems

At present officials at all levels spend a great deal of time in collecting and submitting information, but these are not used for taking corrective and remedial action or for analysis, but only for forwarding it to a higher level, or for answering Parliament/ Assembly Questions. Often data on performance reaches late, or is not available district-wise, with the result that accountability cannot be enforced. For instance, no figures are available for district-wise changes in poverty even over a five year period. Had this data been available timely and for each district, it would be easy to fix responsibility and help in outcome monitoring.

Equally, state governments do not discourage reporting of inflated figures from the districts, which renders monitoring ineffective. As data is often not verified or collected through independent sources, no action is taken against officers indulging in bogus reporting. Most Secretaries, both at the GoI and State level, are not prepared to accept the reality of poor service delivery in their files, lest they and their Ministers would be taken to task in the Parliament/ Assemblies. Thus vested interest develops from top to bottom in hiding the reality and resorting to bogus reporting. In UP the number of fully immunized children that is being reported by the state government is almost cent percent, but independent surveys put the figure of fully immunized children as less than 30 per cent! President of India gave awards to village panchayats that reported 100 percent use of toilets,

but a recent GOI survey showed only 65 percent of such toilets were functional.

Most states have a computerised ICDS monitoring system, but the available information is not used for taking corrective and remedial action or for analysis. For instance, each AWC reports on the number of malnourished children category wise, but these figures are neither verified independently nor being used for assessing the effectiveness of the programme.

A young Member of Parliament, Sachin Pilot, while trying to understand how ICDS functions in the districts observed (Economic Times 11th Feb, 2008):

‘As a part of a group of MPs working on the issue of malnutrition, we visited several states, especially remote tribal areas, to see how these centres were being run. I was surprised to see that the *anganwadi* worker who manages the centre with almost no help has to keep 18 registers updated! It is another matter that sometimes the number of children at such centres is less than the number of registers.

During another visit, we discovered that all data of children at the centre for the past five months, weight, vaccinations, health records etc, were filled in with pencils. On probing further, I found it was done so that in case of an official inspection, the figures could be erased and “correct” data inserted to make the centre’s performance look good!’

The practice is so widely prevalent in all the states, presumably with the connivance of senior officers, that the overall percentage of malnourished children, in case of 0-3 years according to the data reaching GOI is 8 per cent (with only one per cent children severely malnourished), as against 46 per cent reported by NFHS-3 (with 17 per cent children severely malnourished). The field officials are thus able to escape from any sense of accountability for reducing malnutrition.

The situation can easily be corrected by greater transparency of the district and centre records that should be put on a website, and by frequent field inspections by an independent team of experts,

nutritionists, and grassroots workers. The Ministry of WCD at the Centre should also pull up the states for not recognising and reporting almost 90 percent of the severely malnourished children.

NRHM evaluation 2009

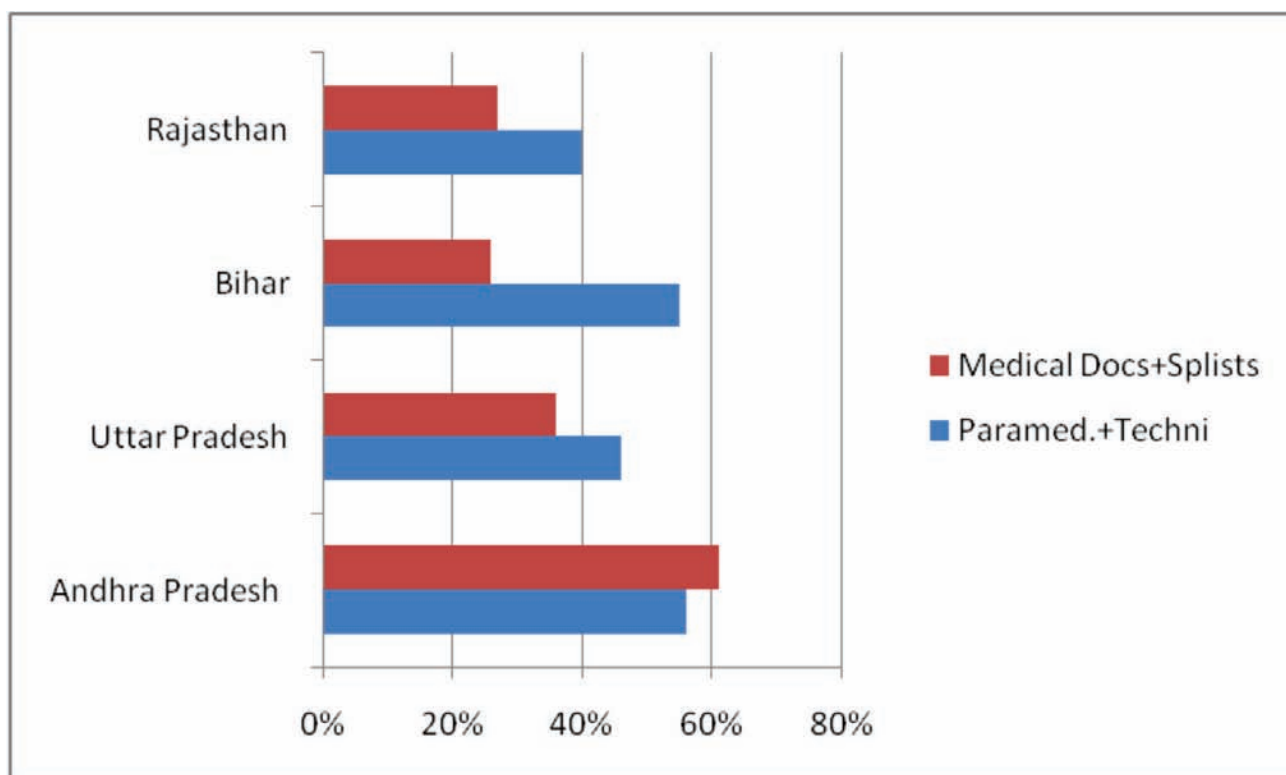
The Planning Commission in 2009 evaluated quantity and quality of service delivery in rural public health facilities under NRHM in four states, UP, Bihar, Rajasthan, and AP. Its finding was that the human resource gap remains the singular most important challenge in strengthening the public health system and meeting the NRHM goals. Medical professionals available in the country, especially specialists, are not joining the public services. Some specialties, such as anaesthesia and psychiatry, have very few professionals being produced in the country. Nursing colleges are far short of requirements, and ANM Training Centres have been non-functional for about a decade in several states, leading to non-availability of staff nurses and ANMs for recruitment. Paramedical personnel such as Laboratory Technicians are again too few, or not trained and registered as per standards. Few of the cadres have an orientation or training in public health planning and management.

If the Medical Officer in Charge (MOIC) is not present to monitor the attendance of those operating under him / her in PHFs (including not just paramedical staff but also technicians and pharmacists etcetera), it is more likely that they will abscond from their duties altogether.

In order to improve monitoring, government could take several possible steps. In addition to revitalizing the traditional inspection system, requiring government officials to travel regularly to the field to personally inspect the performance of programmes and schemes at the cutting edge level, it should outsource evaluation to private professional players, which do not have an interest in misrepresenting data, to get feedback on a real time, continuing basis.

It is not enough that the central government departments and the state governments use professional and academic organisations to undertake impact studies from time to time. Their findings must be publicised and discussed with key stakeholders

Staff at CHCs present at time of visit - The figure below describes the physical availability of staff at the CHCs.



so that improvements in design and delivery can be effected at the earliest. Governments should also put on its website findings of the impact studies, and distribute these in the workshops it organizes. Dissemination of results is critical for use.

The CAG audit focuses mainly on financial irregularities and while systems or performance appraisals are carried out, these fall short of management audits and do not indicate how management can be strengthened. Also, physical inspection is rarely undertaken. CAG should involve social scientists and professional experts in auditing programmes. All Departments and Ministries should publish in their Annual Reports action taken on CAG's findings in the last two years.

Governments should introduce social audit by assessing the experience of the people service providers are intended to serve. With community participation, the evidence should be collected from stakeholders, so as to promote accountability, equity, effectiveness, and value for money. Such an audit will supplement conventional audit and will often provide

leads to it.

Centrally Sponsored Schemes

Centrally Sponsored Schemes (CSS) were originally to be formulated only where an important national objective such as poverty alleviation was to be addressed, or the programme had a regional or inter-State character or was in the nature of pace setter, or for the purpose of survey or research. However, the CSS have proliferated enormously, and in the terminal year of the Tenth plan (2002-07) there were approximately 200 CSS. This results in dilution of monitoring and oversight, and causes confusion at the field level.

As the table below indicates, the major proportion of funds is accounted for by a few flagship schemes such as NREGA, National Rural Health Mission, and the Sarva Shiksha Abhiyan. Together, nine flagship schemes account for over 80% of funds allocated to all CSS.

A possible way out

In many States releases by the State Finance Departments to the districts is highly adhoc,

Table 4 : Budgeted Allocations to Major Centrally Sponsored Schemes (in crore Rs)

	2007-08	2008-09	2009-10
National Rural Employment Guarantee Scheme	12000	16000	39100
National Rural Health Mission (NRHM)	10586	11580	13580
Sarva Shiksha Abhiyan (SSA)	10671	13100	13100
Pradhan Mantri Gram Sadak Yojana (PMGSY)	6500	7530	12000
Rural Housing(IAY)	4040	5400	8800
National Programme Nutritional Support To Primary Education (MDM)	7324	8000	8000
Accelerated Rural Water Supply Scheme	6500	7300	8000
ICDS	5293	6300	6705
Swaranjayanti Gram Swarozgar Yojana (SGSY)	1800	2150	2350
Total of 9 flagship schemes	64714	77360	111635
Total for all CSS	84105	101824	137137
% of flagship schemes in total CSS allocation	77%	76%	81%

Source : adapted from LS Unstarred Question No. 338 answered on 24th February 2010

uncertain, delayed, and subject to personal influences. Faced with the inordinate delays in releasing of money by the Finance Departments in the States, many Central Ministries, such as RD, education, and Health have opted for releases to district or State level societies for receipt of funds directly from the Central government bypassing the state governments. While this may improve the flow of fund position to the field, ignoring State legislatures has long-term implications and is at best a temporary solution. In the long run we must improve the fiscal discipline of the States, so that credibility and integrity of the budget process is preserved.

A practical solution would be to reduce the number of schemes without hitting at the outlay of the Ministries by way of convergence and weeding out. This indeed was attempted in the terminal year of the Ninth plan (2001-02), and of the 360 CSS in operation in the Ninth plan, Planning Commission recommended weeding out of 48 schemes, merger of 161 schemes into 53 schemes, and retaining the remaining 135 schemes, implying a carrying forward of 188 CSS to the Tenth plan. In some of the merged schemes, such as SSA (*Sarva Shiksha Abhiyan* – a scheme for promoting elementary education) and macro management in agriculture Ministries have

adopted a cafeteria approach whereby a cluster of CSS have been clubbed together under one umbrella scheme and the option to select schemes has been left to the States as per their needs and priorities. Time thus saved should be used by the central Ministries in capacity building, inter-sectoral coordination, and detailed monitoring of State sector projects. CSS compare unfavourably with EAPs (externally aided projects) as far as the practice of frequent reviews and evaluations are concerned. Third party reviews should be periodically undertaken, such as in NRHM, which have the desired effect of putting mild pressure on the states for improving implementation.

In future, no Ministry should be allowed to run more than 3 or 4 CSS (this figure could be higher for large Ministries) and the outlay for each scheme should not be less than 100 crores a year. In 2010, less than 20 percent of the total number of CSSs had an outlay of more than 100 crores a year. CSS funds should also be used for enhancing the budgetary allocation of successful development schemes that are being run by state governments on their own, or for meeting the State contribution for donor assisted programs for poverty alleviation and social infrastructure.

Finally, delays in financial sanctions are inherent in the very process of annual budget formation. It would be useful to take Parliament sanction of expenditure once for two to five years, so that continuity in releases is maintained. The annual budget could only be for receipts and taxation, and for new schemes in expenditure. This radical change in procedure will result in timely releases of financial sanctions.

Improving governance

Although the number of CSS must be drastically curtailed, but reducing funds for the flagship programmes and devolving more untied resources to the States for State plans in the spirit of decentralisation will improve efficiency only if it is accompanied with improving governance and accountability, at least in the poorer and badly governed States. As already discussed in previous sections, states must **simplify procedures to reduce delays and improve outcome monitoring**. Some other measures that these states could take are described below.

Accountability

One way to bring in accountability is to start the system of holding public hearings in matters pertaining to the works handled by each office. Prominent social workers and NGOs should be associated with this exercise for more productive results. The teams would undertake surveys of quality of service delivery in key areas; scrutinize policies programs and delivery mechanisms. Civil servant's views on work constraints and reporting fraud and corruption should be elicited. The reviews conducted should also form the basis of time bound changes and improvements which should be monitored.

Needless to say that such comprehensive reforms need for their sustenance strong political and administrative will from the top. In its absence, reforms remain only on paper. Accountability has to be induced; it cannot be decreed by fiat. Accountability is a result of a complex set of incentives, transparency in processes and decision making, and checks and balances at various levels of government. Thus, the seniors in the government departments have to put their weight behind new accountability systems and review it from time to time.

Transparency

The term public interest is most abused today, as it is used to cover hidden and malafide motives knowing fully well that the public is not in a position to challenge the bonafides of decision-makers. Transparency builds external demand for reform and makes administration more responsive and performance oriented. As an experiment, all muster rolls in employment schemes should be put on the internet in at least those blocks of a district where internet facilities exist. The Official Secrets Act should be repealed and replaced with a less restrictive law. Property and tax returns of all senior officers should be available for scrutiny by the public. These could be put on a 'home page' of the government on the internet, so that anyone having access to internet could inform government if the stated facts are contrary to his knowledge.

Many states have tried to computerize land records, but feeding incorrect and out-of-date entries in the computer without field verification has not added to consumer satisfaction, and for most states it is 'garbage in, garbage out'. Only in Karnataka, the 'mutation' process is made online as a result of which the data base of land records is updated as soon as a mutation was approved. Even here its ultimate success would depend whether it is able to reduce the dependence of the landowners on petty bureaucracy, by making records available on-line through a web-site. The farmers still have to come to the taluka for a copy of land records.

Redressal of public grievances

Villagers **today** spend a lot of time and money in sending petitions by registered post, and often they do not get any acknowledgement of their application. One could introduce a system of on-line receipt of such applications for which the petitioner needs to go only to a kiosk, and send his application by email. Even copies of documents can be scanned and sent along with the application. The applicant should immediately within seconds get an acknowledgement with a particular number so that he could trace the movement of his application on the computer itself. In a World Bank funded program on drinking water for poor localities of Hyderabad similar procedure was evolved where people did not send any written

application, but they only had to dial a toll free number and get their complaint registered as well as trace its movement.

One of the prime reasons for the harassment of citizens by government agencies is the need of the people to approach state agencies for various requirements from time to time. It is not uncommon to hear from people complaints regarding harassment, waste of time and money, repeated visits to offices, and institutionalized systems of informal payments which have to be made for getting services. A great deal of corruption and harassment can be reduced if these requirements can be met, without approaching the government departments, through single-window stations such as the TWINS, in Hyderabad, funded in the course of time by private operators. A beginning can be made by permitting payment of all government dues through banks and even post offices.

Creation of individual database through UID

At present, for getting various certificates, a citizen has to apply and furnish various details to support his claims. The village staff do the enquiry and then issue necessary certificates. This consumes a lot of time. There is no comprehensive individual database available in the village office. It is suggested that a village level individual database should be created so as to cover a variety of purposes and certificates. Once the database is created, the same can be used effectively for fast and efficient service to the general public.

One may also mention here that a large number of government departments in the states collect information on the households. These are Social Welfare, Food & Civil Supplies, and Rural Development, to name a few. These are parallel activities which consume a great deal of time, which can be reduced through proper coordination and sharing of information through computers.

Launch a Citizens Service Delivery Mechanism

Some states such as Delhi and Bihar have already taken a lead in assuring services to the citizens in a timebound manner. The aim of this initiative should be to make all government services available in each locality and to ensure efficiency, transparency,

affordability and reliability of such services. However, it should be remembered that mere computerisation of forms and data will not be enough to achieve the objective; it would need redesigning the government processes keeping the citizen at the centre, providing for the enablement of citizens, businesses, producers and consumers, and replacing the old mistrust and control regime of the colonial past.

To illustrate, an applicant for old age pension has to apply in the prescribed form to the Block Development Officer (BDO), enclosing an income certificate and a residence certificate, both issued by the village officer. It does not help the applicant that both these certificates have been computerized as the applicant still has to go to the village office to collect these before he or she can submit the application to the BDO. There is again further verification of the claim by the BDO office before the file is sent to the social security/welfare department. In spite of the application of IT, the applicant has to visit at least three departments – revenue, development and social security.

The process can be simplified if one single agency in any of these departments is made responsible for receiving and sanctioning/ rejecting the application. The agency should collect the clearances from other departments through the IT network without the applicant having to run around. Only such an integration of processes, focused on the delivery of each identified service, can benefit the common people (Ramachandran 2011).

It may be recalled that Singapore, in order to quickly address citizens' grievances, follows a 'No Wrong Door' policy. That is, if an agency receives application on an issue which is not under its charge, it must redirect the application to the right agency and ensure that the latter agency responds to the applicant; and if the application involves more than one agency, the agency receiving the application should coordinate a single consolidated response.

Simplifying procedures

GOI issued instructions in December 2004 for increasing ICDS centres, but the states took almost four years in completing formalities. Nine Chief Secretaries had to personally appear before the

Supreme Court and apologise for the delay. The state governments could expedite the process and cut down on possible delays by doing activities concurrently in a parallel fashion, rather than do them sequentially. For instance, they can complete several steps (creation of posts, recruitment, selection of villages and sites, advance budget provision) simultaneously rather than do one activity at a time, so that much of the delay can be reduced.

Selecting NGOs – Several programmes, such as IEC for sanitation are run by the NGOs. However there is a great deal of wastage, as often the procedure to screen out undesirable NGOs is not in place. A study may assist governments in framing new Guidelines which would help the districts in identifying good NGOs in an objective manner, so that assistance is extended only to those NGOs who have a good track record and proven competence in i) community mobilisation, ii) implementation of development projects through people's participation including expenditure through people's committees, and those iii) who have worked for the empowerment of the socio-economically disadvantaged people. It is of utmost importance that the process of selecting NGOs be completely transparent.

Personnel issues

All states have recruited a large number of teachers, AWWs, ANMs, and other medical staff in the last five years. Procedure for doing so varies from state to state, and some states are able to complete recruitment with minimum complaints or litigation, because they follow a fair and transparent procedure. If appointment is for a particular post (and not to the cadre), postings to remote and difficult places do not pose a problem. There is also a great deal of variation in promotions of para teachers to regular posts. Some states, such as Karnataka, evolved a transparent procedure for annual transfers and placement of teachers. However, these procedures were not followed every year uniformly, and may have been totally dissipated by now.

In the case of transfers, although some criteria are developed from time to time, they are not necessarily followed in all cases. The transfer of IAS officers,

teachers, rural development engineers, and doctors is considered to be one of the most politically sensitive areas. These are powerful groups and transfer is seen as a politician's tool for obliging, reprimanding or exhibiting their influence in the government. For all these reasons, politicians are opposed to having a statutory policy. In Rajasthan, in the late 1990s, a committee under the chairmanship of Mr Bordia had submitted a report recommending a transfer policy based on an objective set of criteria. The then government made a move to make this into an Act but the Assembly did not pass it.

At the same time it must be recognized that some posts would have more attraction for the employees than others. These may be due to better location where good schools or cheap government housing is available, more challenges, the pull of private practice for doctors, or simply more opportunities to make money. Except for the Indian Foreign Service, no other service categorises posts according to its demand so as to ensure that everyone gets a fair chance to serve on both important and difficult (such as in remote and tribal areas) assignments. One should categorise posts in each department according to the nature of duties and geographical location into A, B and C posts, and chart out the kind of mix that should dictate the average officer's span of career. At least for Group A officers, one should be able to know through websites that total transparency is being observed and whether some 'well connected' officials have not been able to get 'plum' postings and avoid difficult areas.

One progressive element introduced by some states relates to the computerised counseling system based on transparent consultation with departments, with decisions on transfer being related to incentives and objective criteria. Based on the recognition that staff transfers in the past have been too frequent, and not sufficiently based on merit criteria, it is important that transparent policies are adopted, which increase employees' morale and faith in professionalism.

Government positions in social sector should have an adequate representation of women. In some states, such as Rajasthan, the cadre of CDPOs is not reserved exclusively for women, with the result

that 88% of the serving CDPOs are male. They are often on deputation from other departments, which reduces their sense of ownership with the ICDS. In most states, avenues for promotion for AWWs and Supervisors are limited, and stagnation sets in their mid-career. It would be better if all Supervisors are selected from eligible AWWs, whereas Supervisors can be promoted as ACDPOs.

It may be mentioned here that countries like Japan and Singapore do not pursue the practice of annual transfers. If an employee is corrupt or inefficient, the traits would get displayed wherever the employee is posted. What is required is effective supervision and the prompt commencement of disciplinary action against such employees instead of shifting them to another place.

Concentrate on the excluded groups

It is well known that economic and social progress has generally bypassed the dalits, Scheduled Tribes, women, and people living in remote areas, who have remained voiceless and ignored. The crux of such a hopeless situation for them lies in their inability to access and retain their rightful entitlements to public goods and services due to institutionalised structures and processes of exploitation. This can be changed through dissemination of studies that analyse discrimination and neglect, and suggest practical steps how the situation can be improved.

Excluded groups are disadvantaged in many ways. They are victims of prejudice, are ignored, and are often treated as less than human beings by the village elite and government officials. They live in remote hamlets and are thus geographically separated from the centres of delivery. Their hamlets are scattered so that the cost of contacting them is higher. Finally it is their extreme poverty that prevents them from taking advantage of government schemes, whether it is free schooling (children are withdrawn because their labour is needed at home or for work), or immunization (they migrate along with their parents and therefore not present in the village when ANM visits).

For instance, despite three BPL¹ surveys (1992, 1997 and 2002) the errors of exclusion and inclusion

¹Below the poverty line

in the list remain above acceptable limits (Himanshu, 2008). Errors of exclusion are those that misclassify the poor in the non-poor category, while errors of inclusion include the non-poor in the poor category. According to the XI Plan (volume 2, chapter 4), there are huge exclusion and inclusion errors in identifying the poor, as seen from the following Table.

Table 5 : Distribution of cardholders among poor and non-poor

	% poor with no ration card	% poor with BPL/AAY cards	% BPL/AAY cards with non-poor
Rajasthan	5.0	23.6	65.2
UP	16.4	22.9	48.7
Bihar	25.5	21.2	45.1
Assam	25.7	23.3	56
Jharkhand	22.1	31.9	42.4
Orissa	29.3	54.8	38.1
Chhattisgarh	24.1	47.9	47
MP	30	41.9	46.2
All India	19.1	36	59.8

Thus more than half of the poor either have no card or have been given APL cards, and are thus excluded from the BPL benefits. These must be presumably the most poor tribal groups, women headed households, and people living in remote hamlets where administration does not reach. Thus the people most deserving of government help are deprived of such assistance. On the other hand, almost 60% of the BPL or Antyodaya cards have been given to households belonging to the non-poor category. This needs to be corrected by launching a drive to weed out errors of exclusion and inclusion.

Fiscal transfers

As already stated, GoI transfers roughly 5.5 trillion Rupees (this amount does not include subsidies, such as on food, kerosene, and fertilizers) annually to the states, but very little of it is linked with performance and good delivery. Often incentives work in the other direction. For instance, Finance Commission (FC) gives gap filling grants so that revenue deficit of the states at the end of the period of five years becomes zero. Thus, if a State has been irresponsible and has ended up with a huge revenue deficit, it is likely to get a larger gap-filling grant. In other words, FC rewards profligacy.

The concept of good governance needs to be translated into a quantifiable annual index on the basis of certain agreed indicators such as infant mortality rate, extent of immunisation, literacy rate for women, sex ratio, feeding programmes for children, availability of safe drinking water supply, electrification of rural households, rural and urban unemployment, percentage of girls married below 18 years, percentage of villages not connected by all weather roads, number of class I government officials prosecuted and convicted for corruption, and so on. Some universally accepted criteria for good budgetary practices may also be included in the index. Once these figures are publicized states may get into a competitive mode towards improving their score. Central transfers should be linked to such an index.

States should be divided in three categories, those whose per capita income is below the national average, those where it is above the national average, and the special category states (such as the north-east and hill states). The advantage of this categorisation, which already exists in the Planning Commission, is that poorer states like Orissa will not be competing with better off states like Tamil Nadu.

Summing up

A good civil service is necessary but not sufficient for good governance; a bad civil service is sufficient but not necessary for bad governance. Thus, a dilapidated civil service has been a key factor in Africa's economic decline. Conversely, a strong civil service is one of several reasons why in several east Asian economies, especially Japan, Singapore, and South Korea, authoritarianism has co-existed with excellent economic performance. It can be argued that the link between authoritarianism and economic decline, so evident in Africa, has been inoperative in these Asian countries largely because of their strong civil service. Greater responsiveness and openness can legitimately be demanded of public administrations in many East Asian countries. Clearly, civil service systems in most East Asian countries cannot be considered a problem; they are, rather, an important part of the solution to these countries' other problems.

The State in India implements massive food, livelihood and social security programmes – some of

the largest in the world - which theoretically support vulnerable people from even before their birth to their survivors after death. These programmes are however plagued by corruption, leakages, errors in selection, delays, poor allocations and little accountability. They also tend to discriminate against and exclude those who most need them, by social barriers of gender, age, caste, ethnicity, faith and disability; and State hostility to urban poor migrants, street and slum residents, and unorganised workers.

Overcoming corruption, theft, leakages, inefficiencies, and constraints of costs, are imperative, but still not sufficient, in a highly unequal society like ours, to overcome the barriers that powerless and expelled dispossessed people face to access food and livelihoods with dignity. They may not be able to find work and food only because they are women, and worse single women, because they are aged or disabled, because they suffer from caste discrimination of millennia, because of the discrimination fostered against ethnic and religious minorities and indigenous people, because of the stigma of dreaded diseases like leprosy or HIV AIDS, and for a host of other social barriers.

The strategy for inclusive growth should not be just a conventional strategy for growth to which some elements aimed at inclusion have been added. On the contrary, it should be a strategy which aims at achieving a particular type of growth process which will meet the objectives of inclusiveness and sustainability. This strategy must be based on sound macroeconomic policies which will ensure that the structure of growth that is generated, and the institutional environment in which it occurs, achieves the objective of inclusiveness in all its many dimensions.

To sum up, despite good achievement on the growth front, India faces significant challenges and needs to revamp its social policies so as to provide more funds for sectors affecting the poor. In addition to resources, India needs pro-poor attitude of bureaucracy, better policies and sound delivery mechanisms. Mere increase in the social sector expenditure would not be enough, unless it is linked with outcomes directed to the socially excluded groups, and effectively monitored.

Governance reforms are intractable under a ‘kleptocracy’ that exploits national wealth for its own benefit and is, by definition, uninterested in transparency and accountability. A pliable and unskilled civil service is actually desirable from its point of view--public employees dependent on the regime’s discretionary largesse are forced to become corrupt, cannot quit their jobs, and reluctantly become the regime’s accomplices. Providing financial assistance from GOI to such states without linking it with performance and reforms would be a waste of resources. In all other cases, reform is manageable, albeit difficult, complex, and slow. Therefore, considering that the states would need external pressure on them to improve outcomes, certain control by GOI over funds and policy domain in social sector is necessary, till such time that the states show signs of improvement in governance.■

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TOWARDS GOOD GOVERNANCE: EQUIPOISE BETWEEN STATE, MARKET AND CIVIL SOCIETY

Governance is not synonymous with government. While government is backed by formal authority of the state and endowed with powers to ensure the implementation of duly constituted policies, governance is a more encompassing phenomenon. It subsumes informal mechanisms in civil society and the functioning of institutions of market. Good Governance can only be achieved when the citizens participate by insisting on their rights and conforming to duties, the consumer through restricted and responsible consumption and the actors in civil society by demonstrating compassion to fellow human beings and nature. I will trace briefly the evolution of governance process in Independent India and will identify the inadequately addressed deficits of development discourse. Finally, an analysis of the pre-requisites of good governance will be attempted and the chapter will conclude with a discussion on the goals good governance should pursue.

T.K Oommen*

From Government to Governance

There were two competing models of society when India attained political freedom. One model was that of the capitalist democracies of the West. These polities had evolved gradually on the principle of separation between the state, market and civil society. The underlying assumptions of this separation were the following: First, the state is an agency of coercion

and is motivated by power. Therefore, the process of acquiring and exercising power should be well-defined and checked through legal mechanisms. Second, economic activity is motivated by material incentives and is to be regulated by the market mechanism in terms of free exchange. Third, civil society is the space for free voluntary activity for the citizens, between the state and the market, the zone

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in which a variety of socio-political actions could be initiated to moderate the potential authoritarianism of the state and the likely rapacity of the market. In the West, state, market and civil society emerged successively and each of these spheres acquired a certain level of autonomy.

In contrast to the separation principle of capitalist democracies, the socialist societies functioned on the institutional principle of fusion of the state, market and civil society. Here, the party-state monopolized all powers and regulated market and civil society. From the command economy of the socialist state the market disappeared and civil society was absorbed by the state. The conjoint activities of the one-party system and its numerous front organizations came to be christened as people's democracy!

In the beginning capitalist democracies were only concerned with creating congenial conditions for citizens to pursue their preferred pattern of life, protecting them from external aggression and providing them with internal security. But the emergence of socialist states which attended to the economic welfare of their citizens posed major challenges to the capitalist democracies. Understandably, 20th century capitalist states tended to become welfare states. Thus, what were considered to be the private worries of individual citizens became public issues to be handled by the state. Most of the colonial states became politically independent by the mid-20th century and took over the agendas of the socialist and the welfare states in different combinations.

Independent India opted for what came to be referred to as the 'third way' that is, combining multi-party democracy, one of the distinctive features of capitalist states, with planned economy, the hallmark of the socialist states. This was indeed a challenging experiment in that efforts were made to fuse the best of both in the two models. However, it was the planned economy and the associated state centrism which assumed saliency in the first quarter century of India's independence. The state intended to promote economic development with an accent on distributive justice and also initiated a number of measures to introduce and institutionalize people's participation in the context of planned development.

The First Five Year Plan (1951-56) formulated and articulated it thus: 'Planning in a democratic state is a social process(in) which ...every citizen should have the opportunity to participate Development ... should embody the input of public opinion and the needs of the community...'. The Second Five Year Plan maintained the same orientation: 'The problem is to create a milieu in which the small man who has so far had little opportunity of perceiving and participating in the immense possibilities of growth is enabled to put his best in the interests of a higher standard of life for himself and increased prosperity for the country'. But intentions were not translated into reality. Thus the Seventh Five Year Plan (1985-90) insisted that the plan '... can be implemented successfully only with the involvement of the people. The plan proposes to do this through effective steps for the decentralization of planning and development administration as well as by increasing the involvement of voluntary agencies (read civil society) in the implementation of plan programmes, particularly in the rural areas'. However two points need to be noted here: one, the participation of the people was visualized mainly in the economic context and two, it was initiated by the state.

It is thus clear that the state in India wanted to retain its centrality not only in initiating planned economic development but also in promoting and sustaining the civil society. Although one-party dominance persisted for long in independent India, it did not become a party-state or usurp the space of civil society. However, by the 1970s one witnessed a proliferation of organizations which started interrogating the state. While some of these organizations are not explicitly anti-state, quite a few are. Further, some are neither anti-state nor pro-state, but objected to the unanticipated consequences of state-initiated development leading to the ravaging of the ecology and the environment. The prominent new collective actors are women, Dalits, Adivasis, religious minorities, rural poor, urban slum dwellers, environmentalists, and so on. They heralded a new beginning and manifested a new stirring--the emerging vibrant civil society.

It is far from my intention to suggest that civil society crystallized in India only recently. Quite

the contrary, India had a long tradition of anti-establishment mobilizations. In fact, the 'national' state and civil society reinforced each other in independent India (although the former was far too strong as compared with the latter), and some agencies in civil society became inimical to the state only during the emergency (1975-77) and since then.

Free India's state was committed not only to usher in and sustain political democracy but also to foster fast economic development. Understandably, a large number of giant high-tech ventures have been sponsored and financed by the state; these were even sacralised. Jawaharlal Nehru's allusion to them as the 'temples' of modern India is an example of this. But gradually the ill-effects of big projects surfaced. Not only did most of them cause environmental degradation, some of them also led to the uprooting of millions of citizens from their habitats. This gave birth to a large number of mobilizations by environmentalists who are invariably unattached to any political party and are against the mode of governance pursued by the state. The state was accused of 'destructive development', that is, reckless development which ignores the human dimension. Some have dubbed this accusation as 'ecological fundamentalism' and argue that environmentalists ignore the ground reality of poverty and underdevelopment in India. According to them, these problems could be successfully tackled only through substantial application of science and technology, which are likely to bring about some negative consequences for the environment. But, the trade-off is worth it according to the 'developmentalists'. The point to be underlined here is that in a democratic polity a wide variety of articulations crystallize which in itself is a testimony to the existence of a vibrant civil society.

While civil society tried to assert its autonomy, in independent India right from the beginning the story of the market is almost the reverse. The Bombay Plan of 1944 conceived by a few Indian industrialists suggested state intervention in planning, financing and managing industrial development. Thus, even before independence, 'economic nationalism' pursued by the big bourgeoisie in India prompted state intervention. However, two points may be noted here. One is that

the all-India big bourgeoisie was seeking protection from its foreign counterpart through the state as the presence of the latter would continue even after the political withdrawal of the colonial power. The other point is that the small bourgeoisie of different linguistic regions also wanted protection from the state against the all-India big bourgeoisie.

The national state, which succeeded the colonial state, invariably started with adequate legitimacy as an agent of economic intervention and development. Understandably, the Indian state had initiated a series of measures to achieve this objective. The two earliest such measures were the instituting of the Planning Commission in March 1950 and the passing of the Industries (Development and Regulation) Act of 1950. The first was an instrument to initiate the process of long-term economic development and the second was intended to curb monopolistic tendencies and to avoid waste of financial resources emanating from undesirable competition between private industrial houses.

The Industrial Policy Resolution of 1956 sectoralized Indian industries into public and private, reserving investments in basic and heavy industries for the public sector, which eventually came to occupy the 'commanding heights' in the economy. But, the real problem was that the public sector in India was perceived more as a social service agency than as an economic venture competing with other agencies and generating at least modest profits. On the other hand, the Companies Act was amended in 1956 to reduce the control of family members over industrial corporations. This was followed by the abolition of the Managing Agency System and the nationalization of commercial banks in 1969. Following close on its heels was the passing of the Monopolies Restrictive Trade Practices Act of 1970 which prescribed that big business houses needed to obtain permission from the government to expand their enterprises. Further, the share of foreign investment in Indian companies was restricted to 49 per cent of the equity capital. Finally, stringent rules for repatriation of profits and on foreign exchange transactions were introduced through the Foreign Exchange Regulation Act of 1973. Truly, India's was a licence permit raj.

The rural economy was moulded by the state basically through land reforms and the 'green revolution'. Land reforms sought to abolish absentee landlordism and intermediaries between the landowner and the actual tiller of the land, the idea being to make those who worked on the land its real owners. The hope was to bring about a land reform which breaks the strangle hold of big farmers and the rural elite, which provide a framework within which public goods and services can be delivered to the target groups with minimum leakage. But due to serious implementation lags and gigantic leakage the objectives could not be achieved. Although the 'green revolution' provided for the subsidization of agricultural inputs and ensured the marketing of agricultural produce at an agreed and often agreeable prices, it mainly benefited the rural rich. The real tillers of land drawn mainly from scheduled Castes (SCs) and Scheduled Tribes (STs) as well as the lower group of Other Backward Classes (OBCs) were untouched by these measures.

The state thus was a decisive factor in the affairs of the Indian economy from 1947 till 1990. The announced aim of this involvement was to bring about economic development and distributive justice. But neither of these goals has been achieved. According the Economic Survey of 1994-95 the rate of return from the public sector enterprises remains a measly three percent. The restrictions imposed on the private companies did not produce the intended results as licensing favoured the big industrial houses. In spite of the emphasis on distributive justice, not only did the disparity between the rich and the poor increase, but even the absolute proportion of the population below the poverty line increased. These developments prompted the liberalisation of the economy, thereby conceding autonomy to the market. That is, while the civil society wrested its autonomy from the state, autonomy was bestowed on the market by the state.

The implications of the progressive reduction in state centrism and autonomization of civil society and market ought to be noted. First, the state is increasingly compelled to share its authority not only with other spheres within the domestic polity

but is also constrained to undergo an erosion of its sovereignty vis-a-vis the Bretton Woods institutions. This is evident from the success with which the World Trade Organization (WTO) and such other agencies can impose their conditionalities on the Indian state. Second, while the market in India has achieved a certain degree of autonomy vis-a-vis the state, the global market substantially erodes the Indian market's autonomy; witness the manner in which even the retail trade is increasingly taken over by multinationals. Third, civil society has to fight its battle at two fronts, the state and the market, both formidable adversaries.

The Defecits of Development Governance

The central tendency is to view governance of development exclusively as an exercise in enhancing wealth and income ignoring the unanticipated consequences. Hence there are a number of absences or cognitive blackouts in development discourse. I shall identify four of them, the four Ds, to illustrate the inadequacy of the development governance. The four Ds are: Displacement, Disparity, Distress and Discrimination.

There seems to be an unquestioned acceptance of the unidirectionality implied in the process of development that hardly draws anyone's attention. Thus, the rural is to be displaced by the urban; low, simple or traditional technology by high, complex or modern technology; the state by the market or the state and market by the civil society as agents of development. This is one of the serious deficits in development thinking. Reckless displacement is no road to development, often quite the contrary.

The state should be displaced by the market under the neo-liberal regime of development; the market should be displaced by the state promoting development under the socialist model. Development radicals want that both state and market should be displaced by civil society, which should be the prime mover of development. But none of these proposals are feasible. What is called for is the cooperation between state, market and civil society to bring about balanced development. Similarly, the central tendency in development thinking is to advocate the displacement of traditional/simple technology; even

the advocates of appropriate technology are inclined to do so. But what we need is co-existence of all these technologies, that is, technological pluralism. Good governance should advocate co-existence and not displacement.

The second inadequately addressed issue in development is disparity. While dependency theory highlighted increasing global disparity, it did not address the issue of disparity within national states. According to neo-liberals, the notion of meritocracy and its motivating engine, namely, 'incentives' legitimises wide disparity between individuals. Both neo-liberals and advocates of human development perspective take the individual as the target of development and hence ignore inter-group disparity. Even those who advocate an alternative paradigm for development do not adequately address rural-urban disparity or disparity between cultural communities--religious and linguistic--and racial groups. Only gender disparity attracted some attention in development discourse. While a society from which disparity in income disappears completely is an utopian dream, a society which limits the range of disparity, is in the realm of possibility. While development analysts do discuss the issues of equality and equity, the focus is on equality of opportunities, on providing a 'level playing ground' so that inequality among individuals can be legitimised.

It needs to be noted here that equality of opportunity cannot be translated into practice except in a very limited sense in so far as deep inequalities on the basis of gender, class, caste, and race exist. To cope with the situation we need to create equality of condition for the disadvantaged so that they can successfully compete with the privileged. That is why policies such as affirmative action, protective discrimination and policy to correct regional imbalances are required. But, the vested interest forces from traditionally privileged categories as well as a section of the neo-elite emanating from the traditionally underprivileged categories will oppose or hamper the proper functioning of the policies. And yet, the policy should be implemented and equality of outcome should be achieved. The real deficit in development discourse is the silence about equality of outcome leading to the widening of disparity, even among the traditionally disadvantaged.

The third cognitive blackout in development discourse is distress. Some of the development toppers, which are certified to have good governance (as well as labelled as successful democracies) have an unacceptably high level of human distress. For example, Sweden is among the highest four countries in the rate of murders and rapes and is also among the highest seven countries for suicide, according to Human Development Report of 1991. The United States of America had the highest rate of murders, rapes and prisoners in the same year. Generally, a developed country is assumed to have a high quality of life. Can a country where rapes, murders, suicides etc., are rampant have a high quality of life? It is necessary to re-cast the present conceptualisation of 'development' taking into account human distress, which prevails in a society. Good governance of development process cannot but take cognisance of the widespread individual and group distress that exist in society.

Finally, the issue of discrimination is rarely discussed in development discourses. Development necessitates movement of population across rural-urban spaces and cultural regions within countries as well as between countries. The tendency on the part of the 'sons of the soil' to look upon the migrants into their ancestral homelands as cultural strangers and usurpers of their economic opportunities is antithetical to the very ethos of development. Racism, religious persecution, caste discrimination and discrimination based on linguistic background surface in the context of development. And yet, development discourse rarely takes cognisance of these socio-cultural discriminations. They seem to be impervious to what happens to human beings even as they are propagating the idea of human development. Good governance should put people first.

One of the widely accepted assumptions is that economic development and modernization which accompanies it are capable of transforming traditional structures and values associated with them. However there is no clinching evidence to confirm this widely shared assumption. On the contrary there is substantial evidence to demonstrate that in spite of modernization some of the traditional structures and values persist depending upon the nature of the

society. Additionally, development and modernization unfold new social pathologies and aggravate some of the old pathologies.

Pre-requisites of Good Governance

We can now turn to the four pre-requisites of good governance with special reference to India. These are (a) informing the process of recruiting the ruling elite with legitimacy; (b) Facilitating proportionate representation for all segments of population in governance process; (c) ensuring respect for the dominated by the dominant, and (d) instituting an appropriate reward-punishment mechanism.

While direct democracy may be desirable, it can only be practised in the context of local self-governments, that is, in city corporations, town municipalities and village panchayats. But even at this level, it is confronted with two limitations. The first is the limited availability of expertise and knowledge with regard to certain sectors within the locality. The second is practical difficulties in involving all adults in the decision-making process on a regular basis. Therefore, both representative democracy and delegation of decision-making authority will come to obtain even at the level of local self-governments. Herein lies the importance of endowing the governing elite with adequate legitimacy.

From its inception, the Indian national state had acknowledged the importance of universal adult franchise. It has also instituted appropriate and adequate machinery that is endowed with constitutional authority and autonomy to conduct periodic elections, the Election Commission. While it cannot be claimed that elections have always been 'free and fair' in independent India, it may be asserted without fear of contradiction that they have become increasingly so over a period of time. The press and the electronic media have played an active role in rendering the election process in India a relatively 'free' enterprise.

The weak spot in Indian elections has been their funding. Contesting candidates are not funded by the state and the tradition of active involvement by citizens in generating election funds is not sufficiently strong. Consequently, Indian elections are funded

mainly by private corporations not as altruistic acts to sustain a transparent democracy but as investment from which ample pay-offs are expected, particularly from the winning candidates and party once they form the government. This, in turn, means that candidates' entry into and sustenance in politics is substantially influenced by their ability to fund elections. Since the source of funding is more often than not from corporations, it necessitates an alliance between the government (party/parties in power) and the market forces. This is the seedbed of much of the corruption in India and civil society can play a crucial role in minimising, if not eliminating, the corruption emanating from this source.

As state funding of elections is not the norm, the relevant institutions of civil society should be actively engaged in the mobilisation of such funds. Further, voluntary donations of corporate houses to political parties should be made transparent so that the possible linkages between them are known to all concerned. In India, as of now, the visibility of sources of election funds is extremely low, if not completely absent. If the recruitment process of the ruling elite, particularly the lawmakers, is not transparent, corruption is bound to seep in. A vigilant civil society should act as a watchdog in this context, thereby contributing to good governance. But, even the civil society is not entirely exempt from corruption.

In a democracy, those who govern should be drawn more or less proportionately from different segments of the population. This does not happen in India. In India's four-tier government structure-panchayats, zilla parishads, state assemblies, parliament--women are 'adequately' represented only at the first two levels and that too because of the 73rd Constitutional Amendment. One-third representation by women is considered 'adequate', even though they constitute half of India's population. At the Assembly and Parliamentary levels, all attempts to pass a legislation providing women with even 33 per cent representation have remained unsuccessful to this day. To complicate matters, most political parties, inspite of their promises, have not fielded the requisite number of women candidates. Although a section of civil society is largely supportive of this

measure towards gender justice, the idea has not yet found legislative compliance.

The problem of representation in legislatures is largely met in regard to SCs and STs through the policy of reservation. As for OBCs, their numerical strength reckoned at 50 to 52 per cent of the national population, ensures their representation in legislative bodies thanks to universal adult franchise, although it took a few decades for this to happen. While the OBCs are gaining a decisive dominance in numerical terms in several State Assemblies and in Parliament, those who occupy top political positions (ministers, governors, etc.) are disproportionately drawn from the twice-born caste groups--Brahmins, Kshatriyas and Vaishyas. The most powerless and underrepresented category in legislatures is the religious minorities, which are either numerically negligible (e.g., Buddhists, Baha'is, Jains, Jews and Zoroastrians) or socioculturally stigmatised (the Christians and Muslims). The fact that although the vast majority of the latter two categories are converts from SCs or OBCs, their being deprived of the benefit of protective discrimination renders their representation grossly inadequate seen in terms of their numerical strength. To conclude, women and religious minorities are not adequately represented in our legislative bodies, which is a serious lacuna in initiating good governance.

This under-representation is not simply a democratic deficit but also an experiential deficit. The legislative process requires taking into account all the relevant experiences of the diverse social categories in a society. The representation in the executive wing of the state, too, is very skewed in terms of the social bases of the Indian population. Once again, while those who are eligible for protective discrimination (SCs and STs) have an increasing presence and those who are traditionally privileged (upper caste men) are over-represented, others are grossly under-represented. For example, women, who comprise about 50 per cent of the population, constitute only 7 percent; Muslims, who comprise 12 per cent, constitute only 2.1 percent; and the OBCs, with over 50 percent share of the population, comprise only 2 percent of the Indian Administrative Service (IAS), in early 1990s. In contrast, Brahmins, who constitute

only 5 to 7 percent of the population, are grossly over-represented in the IAS with 37.7 percent. One cannot speak of good governance when the distribution of those who are responsible for implementing the laws of the land and the rules of government is so unevenly distributed across social categories.

A different situation obtains with regard to the judiciary. Given the absence of systematic protective discrimination, the higher echelons of the judiciary in India are monopolised by the traditionally privileged upper caste males. Women, SCs, STs, OBCs and religious minorities are all under-represented. That the judiciary, instituted for delivering justice, too reflects the same uneven representation of social categories does not augur well for good governance. Although several civil society organizations play a critical role in educating all concerned about the imperative need for the legislature, executive and judiciary to be fairly representative of all sections of national population, the desired goal is yet to be achieved.

It is also necessary to remind ourselves of the importance of the representative character of knowledge producers and communicators. While knowledge can be creatively used to ameliorate or improve the human condition, it can also be deployed to maintain the status quo. To a certain extent, the differing uses of knowledge depend upon those who produce and communicate it. Feminists have often noted the negative role of patriarchy in producing knowledge and perpetuating attitudes and value orientations favourable to male dominance. This also applies to racial dominance.

In the case of India, the traditional hierarchical society had evolved an elaborate division of labour, which assigned production and diffusion of knowledge as the exclusive prerogative of Brahmins. This had enduring consequences as manifested by upper caste monopoly in most of the prestigious professions that required long pre-entry training traditionally imparted through family elders. With the institutionalisation and opening up of modern education about a century ago, the situation is gradually changing. Yet, deep prejudices persist with regard to the unsuitability of women, lower castes, tribes and certain religious minorities to pursue certain

occupations. The participation of individuals drawn from all segments of Indian society in the production and dissemination of knowledge is a pre-requisite for an alert civil society and for institutionalising good governance.

The third pre-requisite for good governance is respect for the dominated by the dominant. This is a requirement in all societies but particularly in those where the ethos of social Darwinism persists in the name of merit. Cut-throat competition, which the maxim 'the survival of the fittest' fosters, is not conducive to developing compassionate attitude towards the dominated when the majority of the population is adjudged to be congenitally inferior. This was the case in traditional hierarchical society of India, vestiges of which continue to persist with a vengeance. Systematic efforts are therefore needed to inculcate respect towards the dominated right from childhood. For this to happen, the curriculum in educational institutions, particularly in schools, will have to be suitably restructured.

No systematic effort has been made to foster respect for the dominated in India, although there is an attempt to accommodate some sections of them in different sectors of society. The policy of reservation initially introduced for SCs and STs, and later extended to the OBCs and women (at the Panchyati Raj level), is a step in this direction. But the introduction of this measure without creating the required value orientation has resulted in an attitudinal lag expressed through pejoratives and contemptuous phrases such as 'Sarkari Brahmins' and 'Mandalisation'. These allude to persons (and processes) who presumably come to occupy positions without possessing the requisite merit and undergoing the required procedures. This is exactly the opposite of 'respect for the dominated'. Consequently, those who come to occupy positions through reservations end up being demoralised. Remedies for social injustice become intimations of intimidation. This creates enormous tension in civil society, often covert but occasionally overt. The manifestations of this tension also surface in the context of governance when persons with handicapped social backgrounds form their own specific associations, such as the Muslim Intellectual Forum, the Scheduled Caste Employees' Association

or the Women's Guild.

The fourth imperative for good governance is instituting a reward punishment mechanism. No society can function efficiently without ensuring rewards for conformity and achievement and punishment for deviance and failure. While material incentives invariably constitute an important item of reward, symbolic rewards can often substitute and reinforce them. In many societies, the occupations and professions that command high respect are not necessarily the highest paid and vice versa. Human beings yearn for recognition but there are different routes through which they seek to achieve this.

The corollary to rewards for conformity is punishment for deviance. Therefore, the system cannot ignore or be indifferent to those who do not conform to prescribed norms. Punishments to the deviant also work as a deterrent to potential deviants. But it may not be always productive to condemn deviants instantly; it is necessary to provide them with opportunities to reform. If some of them do change, it will have a demonstration effect on other deviants. Thus the reward punishment mechanism should be viewed as an enabling device in the construction of civil society and in institutionalising good governance.

It is useful to make a distinction between two types of deviance: one is deviance from the existing normative pattern resulting in social problems; the other manifests as protest which challenges the status quo and results in innovation. The latter type of deviance is also often resisted, condemned or even punished in the beginning but gradually, when its beneficial effects become known, 'the innovator-deviant' is applauded and rewarded. Similarly, conformity to some of the obsolescent norms (e.g., such practices as giving / receiving dowry and honour killing) invites punishment when abolished by law or through reform. This is to say that the normative structure itself is an evolving one and good governance requires that the direction of change be channelled in favour of the deprived and towards social justice. Civil society can and should play a very vital role in facilitating social transformation in the desired direction. Thus, the link between good

governance (read governance that brings about social justice) and civil society (which should facilitate the process) is organic.

It could be argued by some that the four pre-requisites for good governance are not mutually consistent; in fact they are contradictory. For example, both proportionate representation in the legislature, executive and judiciary and respect for the dominated could be seen as undermining merit. But in a society where inequality has been legitimised and institutionalised for centuries, to insist on merit is to promote a perverse elitism legitimising traditional privileges. Therefore, to provide for protective discrimination in societies such as India is but an instrument to correct this traditional imbalance. At the same time, the process of protective discrimination is bound to produce an elite category from the traditionally underprivileged. Those who fall into this category should not be allowed to perpetuate a new elitism that would undermine opportunities for the less privileged in the same category. Fostering vested interest, be it of the traditional or the new elite, is antithetical to developing a civil society that can contribute to good governance. Good governance therefore requires that while the rights of the dominated and minority groups are recognised, they be not allowed to degenerate into vested interests. Herein lies the merit and need to eliminate the 'creamy layer' from the purview of protective discrimination. Once again, civil society can and should articulate this perspective without taking a partisan view. But this does not often happen because most interlocutors are afraid of the unpopularity that taking such a stand would almost certainly bring.

What I am suggesting is that good governance should not pursue the singular and narrow objective of

economic development but enlarge its scope to envelop the goals of delivering equality, nurturing identity, bestowing dignity and providing security to individuals, groups and communities. Equity is already recognized as a goal of development in India through the notion of distributive justice. And yet, economic disparity is incessantly increasing. This needs to be arrested. Nurturing even legitimate identity is not endorsed in several quarters in India but the policy of protective discrimination is an indirect affirmation of accepting it. The confusion arises because those who oppose and condemn 'identity politics', do not distinguish between hegemonic identities and emancipatory identities; the former perpetuates status-quo and domination, the latter aims at social transformation and equity. The earlier notion that citizens should abjure their identity to avail of equality was anchored to the goal of creating mono-cultural nation states. This is not valid in multi-cultural national states. Nurturing of identity should go hand-in-hand with dignity; self chosen identities should not be an invitation to stigmatization. If individuals and groups are denied dignity they will feel insecure. Thus equity and identity as well as dignity and security go hand in hand.

The current bragging about India emerging as a super power is empty verbiage. Even if this label is eventually earned in so far as the majority of Indian citizens do not have access to basic needs--nutritious food, clothing, housing, health facilities, clean drinking water, quality education, dignified co-existence amidst other cultural groups, possibility of nurturing appropriate identities and a sense of security--the label of super power would remain hollow. Therefore, what is needed is invoking good governance as an instrument of pursuing goals which touches the lives of the deprived millions of India.■

INTERTWINING OF THE ADMINISTRATIVE AND THE POLITICAL IN THE EXECUTIVE

The years 2010 and 2011 have seen the term ‘governance’ being talked about, commented upon, and discussed more frequently than in the 60 years since India became free of colonialism. While it may not be possible to find any one single or primary causes for this greater focus, one of the principal reasons, possibly, was the broader—social, economic, and political—impact of the structural changes that the economy went through as it moved from being a command and control type of system towards a market driven system. Considering governance in its holistic perspective, as the functioning of the economic system underwent changes, it became imperative that the entire system of governance also undergoes changes, despite the inherent resistance to change in any system, more so in a bureaucracy. This flux in the governance has given some new insights into the working of the executive.

Jagdeep S. Chhokar*

The Intended Scheme of Governance

The intended scheme of governance is laid down in the Constitution of India, essentially in Part V for the Center, titled The Union, and in Part VI for the states, titled The States. Since both these parts are similar in intent and in essence, the discussion here will be limited to Part V. It can be applied more or

less, in totality, also to Part VI. Chapter I of Part V is about “THE EXECUTIVE”. In it are discussed “The President, and Vice President”, “Council of Ministers”, “The Attorney General of India”, and “Conduct of Government Business”. Chapter II is about the “PARLIAMENT”, Chapter III lays down the “LEGISLATIVE POWERS OF THE

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PRESIDENT”, Chapter IV is about “THE UNION JUDICIARY”, and the last, Chapter V is about the “COMPTROLLER AUDITOR GENERAL OF INDIA”.

The other part of the Constitution that has a bearing on governance is Part XIV, titled “SERVICES UNDER THE UNION AND THE STATES”. Of particular relevance are Articles 311 and 312, which contain provisions about civil servants. Article 311 provides conditions for the “Dismissal, removal or reduction in rank of persons employed in civil capacities under the Union or a State”, and Article 312 provides some general conditions about the “All-India services”.

Intentions of the “intended” scheme

As far as can be surmised from the Constitution, the debates in the Constituent Assembly, and early writings on the issue, the intention was that the functioning of the Executive will combine two elements, one accountable to the Parliament, and thus indirectly to the people. These are the members of the Council of Ministers who, according to Article 74(3) “shall be collectively responsible to the House of the People.” While the mandate of this element was to be renewed periodically, through elections, and therefore it was, in a way, temporary or transitory, the other element was to be somewhat permanent nature, and that was the civil services, commonly referred to as the bureaucracy, and it was provided for in Part XIV of the Constitution. This is what was often referred to as the “steel frame” of the Government of India. The services, particularly the Indian Administrative Service (IAS), the successor to the famed Indian Civil Service (ICS) which served the colonial government of the British with distinction, was thought of as a bulwark against the possible vagaries of the political executive either under what are euphemistically called political compulsions or a myriad of other reasons.

The intentions of the Constitution makers seemed to be that even if the political executive tried to do something for political exigencies, the bureaucracy, or what may be referred to as the administrative executive would, with the safeguards that it was provided with, under the Constitution, ensure that nothing against the letter and spirit of the

Constitution was done. The working model followed for quite a few years after independence was for the bureaucrats to express their views and provide their advice to the political executive, without the risk of fear or expectation of favour, fearlessly or frankly, so to say, in keeping with the Constitutional provisions, precedent, and the overall well-being of the society and the nation. Legendary and anecdotal examples of redoubtable bureaucrats who stood their ground even in the face of tremendous pressure from political quarters and also of upright and understanding members of the political executives, ministers, who overruled the views and suggestions of the bureaucracy, openly on file, recording reasons for their disagreement, but continued to respect the integrity of the bureaucrats, abound.

Working of the “intended” scheme

The well known scholar of the Indian Constitution, Granville Austin, says in the third paragraph of the Introduction to his book *Working of a democratic constitution: A history of the Indian experience* (1999) that, “(C)onstitutions, however ‘living’, are inert. They do not work, they are worked.” The same observation can fully justifiably be extended to schemes or systems of governance. Going by the history of the governance experience in India, the same scheme of governance, which seemed to have worked as intended, during the first couple of decades after independence, seems to have started to falter from the late 1960s to early 1970s. The famed “steel frame” of the bureaucracy, known for its independence, and allegiance and accountability only to the Constitution, started melting, and turning and bending in keeping with the ideological wind that the government of the day seemed to be in favour of.

The irony of the situation lay in the fact that none of the political formations that came into power in different states and even at the center did not have even a semblance of an ideology except to acquire and retain political power. That is why the historian Ramchandra Guha has carefully referred to “a more general view, held by P.N. Haskar more forcefully, that judges as well as civil servants should be ‘committed’ to the *policies and philosophy* of the government in power” (Emphasis added) (Guha, 2007, p.474).

The phrase “the government in power” came to be replaced first by “the political party in power”, and then gradually by “the politician in power”, and the transformation was complete, with the former “steel frame” having become completely unrecognizable. The process was perfected by 1975-77 with the well-known flirtation with authoritarianism.

Current Situation

The process, unintended by the Constitution and initiated and intended during the 1960s and 1970s continued to evolve even after the Emergency and has by now acquired a well-known and familiar form of a nexus among the political, bureaucratic, and business classes. In essence, it consists of exploitation, sometimes over-exploitation of natural and other economic resources of the nation to the mutual benefit of the three classes. The usual initiators of the process are business persons, often big, who on locating opportunities for making money, often in the form of what are called super-normal profits, and approach either bureaucrats or politicians (if the deal is really big, the first point of contact is often a politician), and some kind of mutually profitable arrangements are worked out. The plan is then put into effect with all possible precautions to prevent a paper trail with everyone concerned being co-opted, with appropriate pay-offs. The pay-offs have to be appropriate as not everyone is amenable to financial or monetary pay-offs, and multiple other forms are thought off as appropriate.

The above process, or some variation of it, has been behind the mining, spectrum, and real estate scams that have been unearthed recently. The reason why these have been detected is the onset of some complacency and over confidence with repeated successes. The Right to Information law, and its innovative and persevering use has also made a very significant contribution in the uncovering of the scams.

How do people get away?

The three sections of people involved have different escape routes and protections available under the current constitutional scheme. Let us take the business first. The main law governing the conduct of big business is the Companies Act. Technically, law

making is the function of the legislature, and hence of the politicians. But the basic drafting of the law is done by bureaucrats sitting in the ministry dealing with the subject matter and the ministry of law. Once the legislature has done its job and the President has given the assent, then the bureaucrats take over again, starting with notifying the legislation and making the rules under the Act. Almost the total responsibility for implementation rests with the bureaucracy.

The initiators of the process, the business folks, though technically governed by the Companies Act, framed by a combination of the politicians and bureaucrats, and implemented by the bureaucrats, and hence manipulable, are in reality answerable only to their shareholders. The shareholders are often satisfied by the payment of reasonable dividends or capital appreciation, or are controlled through majority share holding or influencing the majority share holders.

The bureaucrats are governed, in the aggregate, by the provisions of the Constitution and the rules of business of the government, which are, in reality, framed by the bureaucracy itself. They also enjoy special protection provided by Articles 311 and 312 of the Constitution.

The only group answerable to the citizens at large, at least in theory, are the politicians who, in order to get access to exercising state power, have to contest elections. I say, “in theory” simply because “in practice” or at least in the minds of the elected politicians, at least, this does not seem to be the case. While examples of this, what might be called the “arrogance of the elected”, let me cite three of the recent ones.

The first one came up in Parliament on August 17, 2011, the day after Anna Hazare began his fast in New Delhi, after the drama, farce, or tragedy of his arrest and move to the Tihar Jail. While reporting on the proceedings of the Parliament, it was widely reported in the media that the Home Minister, P. Chidambaram, said in Parliament on August 17, 2011, that, “The people have a right to vote us in and vote us out of Parliament but no right to make law. That right has been given to us by the people.” Mr.

Chidambaram is an accomplished lawyer and therefore has the well deserved and well earned reputation of choosing his words very carefully, therefore no one can find any fault with him on the correctness of the letter of what he has said but the spirit of his statement possibly indicates, and is representative of what most politicians, particularly elected ones, seem to be convinced of. And that is a high degree of arrogance and haughtiness. It might do the politicians much good to remember that no right given by one person or group to another is never absolute, and that there always are some basic norms underlying such bestowal of rights or power. The right to make laws is given by the electorate to the members of Parliament under the implicit assumption that the laws will be made in the spirit of the overall good of the nation and the people of the nation. Any violation of that assumption, weakens, violates, and might even destroy the implicit social contract between the citizens and their leaders, which is the bedrock on which a democracy society is founded. A moot question here is who has greater responsibility of weakening the implicit social contract of democracy in India, the politicians or the People.

The second example is also from the Anna Hazare episode. During his many press conferences, another minister and another eminent lawyer, Kapil Sibal, gave a reasonably detailed tutorial on what is a Fundamental Right and what is not a Fundamental Right. While his explanations were undoubtedly correct, as is expected of a lawyer of his eminence, it was his apparent assumption that “the people” who have given the Parliament the right to make laws, do not understand complex issues such as Fundamental Rights. Mr. Sibal’s view must be respected since he is an eminent lawyer, but his assumption that the so-called average citizens and even the Fourth Estate does not understand it, raises serious concerns about the mindset of our elected leaders. Of course, Mr. Sibal might also do better by remembering that the final arbiter of what is a Fundamental Right and what is not, remains the Supreme Court of India.

The third example is from a Chief Minister of a large state, elected with a significant majority in the last elections. Offering gratuitous advice to the so-called Anna Movement, the Chief Minister said,

“My advice to the leaders of the Anna Movement is that they should forget about things like fast, etc. They should form a political party, contest the next parliamentary election, get elected, and form their own government, and then do whatever they like.” The operative phrase here is “do whatever they like”. The refrain, once again, is once elected, one can do whatever one likes, till the next election or till one is “de-throned” by some other means. The fact that there is a document, called the Constitution, which has created the very institutions to which these worthies get elected, and which bestows political and administrative powers on them, and which also lay down the limits for what they can and cannot do, seems to have been almost completely forgotten. And the bureaucracy one of whose jobs it is to keep the political executive aware of the limits, has become a willing accomplice in this forgetfulness.

Lest the above three examples give the impression that it is only the current governments, and the Anna Hazare phenomenon that has evoked such responses from the elected politicians, here is another example from one of the earlier governments and on a very different issue in which the judiciary was also involved.

A civil society organization, the Association for Democratic Reforms filed public interest petition in the Delhi High Court in 1999 asking the court to direct candidates contesting elections to parliament and state assemblies, to disclose details of criminal cases pending against them, and their financial and educational antecedents, at the time of filing their nomination papers for contesting the elections, so that voters could make an informed choice while casting their votes. The High Court upheld the voters’ right to know the antecedents of the candidates and directed, in a judgment on November 02, 2000 (in *Association For Democratic Reforms vs Union of India and Another*, Civil Writ Petition No. 7257 of 1999), the Election Commission to collect that information in an affidavit to filed as an integral part of the nomination paper of the candidates.

The judgment of the High Court was not acceptable to the Government of India, which one assumes, consisted of the political as well as the

administrative executive, and the Union of India went to the Supreme Court in a Special Leave Petition against the Delhi High Court judgment as if disclosure of criminal, financial, and educational background of candidates contesting elections was not in public interest. The Supreme Court rejected the appeal (Civil Appeal No.7178 of 2001, Union of India vs Association For Democratic Reforms & Another) on May 02, 2002, upholding the Delhi High Court judgment. The entire political *establishment* (not the Executive only) of the country got together in the form of twenty-two political parties which held an all-party meeting on July 8, 2002, and decided that the Supreme Court judgment will not be allowed to be implemented, and if necessary, the Representation of the People Act will be amended in that very session of Parliament.

Exactly a week later, on July 15, 2002, a Bill to amend the Representation of the People Act had been prepared to be passed in that Monsoon session itself but it could not be introduced as the Lok Sabha had to be adjourned due the Petrol Pump scam. The government (and here we have the Executive at work) of the day was not deterred and sent an Ordinance to the President. The President returned the Ordinance but the Cabinet sent it to the President a second time. It was reported that it was the Attorney General of India who carried the Ordinance to the President the second time. The Attorney General is also part of the Executive, as his/her appointment and duties, etc. are also part of Chapter I of Part V is about “THE EXECUTIVE”, as mentioned above. Article 76(2) of the Constitution says, “It shall be the duty of the Attorney-General to give advice to the Government of India upon such legal matters, and to perform such other duties of a legal character, as may from time to time be referred or assigned to him by the President, and to discharge the functions conferred on him by or under this Constitution or any other law for the time being in force.” Under the established convention, the President had to sign the Ordinance, and the Representation of the People Act stood amended. The Ordinance was later converted into an Act by the same Parliament that Mr. Chidambaram says has the exclusive right to pass laws, and the People can not do anything once having elected the members of Parliament. It is difficult to

decipher what role did the administrative executive play in the whole process. The quality of the advice given by the highest law officer of the government, and a part of the Executive, becomes clear from the next paragraph.

The Ordinance, and the corresponding Act, were subsequently challenged in the Supreme Court in Writ Petition (Civil) No. 515 of 2002 (Association for Democratic Reforms vs Union of India and another, and in a judgment on March 13, 2003, the Supreme Court struck down the Ordinance, and the corresponding Act, as “unconstitutional, null and void”. The government of the day, and hence the Executive, was led by a different political formation and the decisions and actions could not have been taken without the active involvement of, at least the political executive of the day, but the guidance on constitutionality and the legality of the proposed actions needed to be provided by the administrative executive. The person who apparently piloted the initiative, being the Law Minister who, if not initiated, at least approved, if not directly, at least implicitly, all these actions on the part of the government since he was heading the Law Ministry, was another eminent lawyer, Arun Jetley. It seems to be a curious phenomenon that eminent lawyers, when they become part of the Executive, either of the political or the administrative, seem to start overlooking some basics of constitutional law that they, as lawyers, have argued for effectively and successfully for years and years!

The reason for describing the last example in some detail is to show the complex interplay of the political and administrative executives, in governmental actions. This complex interplay results in a collusive nexus between the two wings of the Executive, the roots of which lie in the lack of clarity in the constitutional formulation, as indicated earlier in this piece.

Whither Bureaucracy?

Just in case the above gives an impression that it is only the political class that is delinquent, let me mention a few examples from the bureaucracy. It needs to be clarified that because (a) incontrovertible proof is hard to come by, (b) several of the instances

mentioned below are still in process, and (c) all of the information below has been taken from media reports; it is not possible to hold that the instances given below are totally accurate and are not beyond question but these do throw some light on how things with the bureaucracy, or at least, some sections of it, are.

Possibly one of the most celebrated, in a perverse way of course, is the case of Akhand Pratap Singh, from the 1967 batch of the IAS. He rose to be the Chief Secretary of UP but also had the dubious distinction of being voted as the “most corrupt” IAS officer in UP by his own fraternity, the IAS Action Group, in a secret ballot conducted by this Group in 1997. Raids by the CBI were reported to have yielded evidence of his owing as many as 84 immovable properties in Delhi, UP, and Uttarakhand. His total wealth was estimated to be around Rs.200 crores.

Another infamous example is of Neera Yadav who belonged to the 1971 batch of IAS. She came into limelight in what was referred to as a “multi-billion rupee land scam” in the allotment of land at NOIDA, near Delhi. She was reported to have allotted prize plots to politicians of all persuasions, to their relatives, and also to several senior bureaucrats, in contravention of existing rules and practices. It seems more than one governor was keen not to permit the CBI to pursue investigations against her. Reports in the media also alleged that she owned properties in Bulandshahar, Ghaziabad and Lucknow, besides Bangalore and Bombay. Somewhat ironically, like Akhand Pratap Singh, she also rose to be the Chief Secretary of UP but resigned the position after a judgment from the Supreme Court. There were also reports of her joining a major political party after quitting the service but then resigning from that too. In December 2010, she was sentenced to four years rigorous imprisonment after being convicted of misusing her official position to fraudulently allot land in NOIDA to Flex Industries, owned by industrialist Ashok Chaturvedi. She thus, possibly, became the first IAS officer of Uttar Pradesh to have been convicted of corruption charges.

The now, well known, 2-G scam is a recent example where the nexus between the political and

bureaucratic classes seems to be evident. Siddhath Behura of the 1973 batch of IAS, was Telecom Secretary with A.Raja, is reported to have approved issuance of 122 licenses under doubtful premises.

Just to show that it is not only the Indian Administrative Service which provides all the examples, the 2-G scam also has a member of the Indian Economic Service (IES). The person concerned is R.K Chandolia of the 1984 IES batch, who was first private secretary to A. Raja, and when he was promoted so he could no longer be designated as a private secretary, he was appointed as an Economic Advisor reporting directly to the Secretary, making him responsible for all policy related work in the Department of Telecommunications. Reports said that he interacted with all the licensees and actually handed over letters of intent to the representatives of various companies.

Possibly the latest in this tragic series is a report in the Indian Express of January 02, 2012, from Bhopal that a “suspended IAS couple, Arvind Joshi and Tinoo Joshi, whose worth was estimated at Rs.350 crore, will have to pay Income Tax and penalties on undisclosed income of more than Rs.150 crore, which would add up to at least Rs.45 crore.” Arvind Joshi belongs to the 1979 batch of the IAS and was reported to have denied receiving any notice or order.

In all of the above instances, it defies imagination that the bureaucrats have amassed such wealth purely through their legitimate earnings. At the same time it seems extremely unlikely that their political executives were either ignorant or innocent when such large scale irregularities were going on.

The actions of the political and administrative executives described above highlight the importance of breaking this nexus by separating the two by making clear provisions in the Constitution.

What can be done?

One solution often proposed is removal of the special protection to the bureaucracy by deleting Articles 311 and 312 from the Constitution. This amounts to throwing out the baby with the bath water and is therefore misplaced. The problem with Articles 311 and 312 is *not* that they exist and

provide protection to the administrative executive. The protection is not misconceived and is actually required to provide strength to the administrative executive to protect the Constitution, the State, and the people at large from the misbehaviour of the political executive under what is euphemistically called “political compulsions”. The problem with Articles 311 and 312 is that they are misinterpreted and misused—to provide protection where protection is neither required nor justified, and not to provide protection where protection is required and justified. Articles 311 and 312 are, in this way, somewhat similar to nuclear energy. It can be used to create power for industrial use or to create bombs to destroy industry or anything one wants to destroy. The solution lies in using nuclear energy in the right spirit and not to ban it completely. Similarly, the way to deal with Articles 311 and 312 is to make sure they are used properly and not to get rid of them.

The real solution can come only if we go to the root of the problem and tackling that. The current situation has arisen out of an ambiguity or lack of

clarity in the formulation of constitutional provisions, which has been “used” or misused for partisan ends. The most appropriate remedy would therefore be to amend the Constitution and provide the much-needed clarity. The functions, roles, duties, facilities, and privileges of the *political* and *administrative* wings of The Executive need to be specified and described separately because their *raison d’êtres*, or reasons for being are very different. But the question is whether the existing incumbents who have grown up on this issue allow a required constitutional amendment to happen. The answer, given the current milieu, seems to be obvious answer which, of course, is sad for the governance of the country. ■

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APPENDICES

Table A 2.1 : State wise %age of Voter Turnout and % of Women Voted in Different Lok Sabha Elections

Sr. No	Names	Percentage of voter Turn out				Percentage of Women Voted			
		1991 (10 th Loksabha)	1999 (13 th Loksabha)	2009 (15 th Loksabha)		1991 (10 th Loksabha)	1999 (13 th Loksabha)	2009 (15 th Loksabha)	
1	Andhra Pradesh	61.42	69.14	72.62		56.87	66.4	71.37	
2	Arunachal Pradesh	51.28	72.16	68.04		47.83	75.39	67.22	
3	Assam	74.93	71.26	69.5		73.27	69.54	66.75	
4	Bihar	60.35	61.48	44.47		49.44	53.33	42.62	
5	Chattisgarh	N.A	N.A.	N.A.		N.A	N.A	52.23	
6	Goa	42.39	45.11	55.28		38.94	40.43	53.8	
7	Gujarat	44.06	47.03	47.89		37.06	40.78	43.36	
8	Haryana	65.84	63.68	67.48		62.34	58.27	65.84	
9	Himachal Pradesh	57.42	56.78	58.4		53.65	54.34	59.09	
10	J&K	N.A.	32.34	39.67		N.A	28.55	33.82	
11	Jharkhand	N.A.	N.A.	N.A.		N.A	N.A	47.39	
12	Karnataka	54.81	67.58	59.17		49.1	64.99	47.37	
13	Kerala	73.32	70.19	73.33		73.17	69.77	72.55	
14	Madhya Pradesh	44.36	54.88	51.16		35.31	46.21	43.86	
15	Maharashtra	48.75	60.94	50.72		43.01	58.02	47.39	
16	Manipur	69.65	65.67	77.16		69.92	64	76.76	
17	Meghalaya	53.75	56.16	64.38		49.65	53.3	64.16	
18	Mizoram	58.64	65.31	51.8		56.89	63.09	48.42	
19	Nagaland	77.07	76.25	89.99		78.18	75.27	89.22	
20	Orissa	53.81	55.63	65.31		46.86	49.75	64.43	
21	Punjab	23.96	56.11	69.75		21.02	54.52	69.44	
22	Rajasthan	47.25	53.86	48.39		39.35	45.93	44.77	
23	Sikkim	58.75	81.71	83.75		47.87	83.29	82.86	
24	Tamil Nadu	63.92	57.98	72.98		61.76	54.96	71.91	
25	Tripura	67.28	68.14	84.45		61.62	65.09	82.52	
26	Uttar Pradesh	49.24	53.53	47.75		44.45	48.26	44.23	
27	Uttarakhand	N.A.	N.A.	81.41		N.A	N.A	50.57	
28	West Bengal	74.67	75.05	55.29		72.78	73.25	80.25	
29	Andaman & Nicobar Islands	64.35	59.46	51.33		64.65	60.29	63.21	
30	Chandigarh	57.84	48.35	64.16		57.5	46.51	64.94	
31	Dadra & Nagar Haveli	66.48	74.72	65.16		64.94	76.7	75.55	
32	Daman & Diu	67	71.74	65.51		68.76	73.65	75.54	
33	Delhi	48.52	43.54	71.57		43.53	40.9	49.59	
34	Lakshadweep	80.37	80.21	71.32		85.39	83.41	87.97	
35	Pondicherry	67.71	63.27	51.84		68.14	63.13	79.77	
	India	55.71	59.99	85.9		50.43	55.64	65.97	

Source : Election commission of India

Table A 2.2 : Percentage of Voter Turn Out in Assembly Election in Last 20 Years

Election year	Last	2nd Last	3rd Last	4th Last	5th last
Andhra Pradesh	(2008)	69.96 (2004)	69.15(1999)	71.02(1994)	70.44(1989)
Arunachal Pradesh	(2009)	64.02 (2004)	72.95 (1999)	81.21(1995)	72.84(1990)
Assam	75.92(2011)	75.77(2006)	75.05(2001)	78.92(1996)	74.6(1991)
Bihar		45.85(2005, Oct)	46.5(2005, Feb)	62.57(2000)	61.79(1995)
Chhattisgarh	(2008)	71.3(2003)			
Delhi	(2004)	(2004)	53.42(1998)	48.99(1993)	61.75(1983)
Goa	70.51(2007)	68.75(2002)	(1999)	71.24(1994)	(1989)
Gujarat	59.77(2007)	61.54(2002)	59.3(1998)	64.39 (1995)	52.2(1990)
Haryana	(2009)	71.96(2005)	69.01(2000)	70.54(1995)	65.86(1990)
Himachal Pradesh	71.61(2007)	74.51(2003)	71.23(1998)	71.5(1993)	67.76(1990)
Jammu & Kashmir	(2002)	(1996)	(1987)		
Jharkhand		57.03			
Karnataka	64.75	65.17(2004)	67.65(1999)	68.59(1994)	67.57(1989)
Kerala	75.22(2011)	72.38(2006)	72.47(2001)	71.16(1996)	73.42(1991)
Madhya Pradesh	69.78	67.25(2003)	60.22(1998)	60.52(1993)	62.26(1990)
Maharashtra	(2009)	63.44(2004)	60.95(1999)	71.69(1995)	62.26(1990)
Manipur	86.73(2007)	90.38(2002)	89.87(2000)	91.4(1993)	85.95(1988)
Meghalaya			70.42(1998)	74.52(1993)	79.52(1989)
Mizoram		78.65(2003)	76.32(1998)	80.75(1993)	81.3(1989)
Nagaland	86.16(2008)	87.85(2003)	91.53(1998)	78.95(1993)	85.65(1989)
Orissa		66.05(2004)	59.1(2000)	73.64(1995)	56.63(1990)
Punjab	75.42(2007)	65.14(2002)	68.73(1997)	23.82(1992)	
Pondicherry	86.09(2011)	(2006)	(2001)	(1996)	(1991)
Rajasthan		67.18(2003)	63.39(1998)	60.59(1993)	57.09(1990)
Sikkim		79.23(2004)	81.83(2009)	87.96(1994)	72.28(1989)
Tamil Nadu	78.19(2011)	70.82(2006)	59.05(2001)	66.95(1996)	63.84(1991)
Tripura	92.49(2008)	78.71(2003)	80.84(1998)	81.18(1993)	
Uttar Pradesh	45.96(2007)	53.8(2002)	55.73(1996)	57.13(1993)	48.51(1991)
Uttarakhand	(2008)	(2008)			

Source : Election Commission of India

Table A 2.3 : Sittings of Parliament, 1952-03

Decade	No. of Sittings of Lok Sabha(annual average)	No. of Sittings of Rajya Sabha(annual average)
1952-61	124.2	90.5
1962-71	116.3	98.5
1972-81	97.9	85.5
1982-91	92.7	79.4
1992-01	81.0	71.3
2002-03	79.0	78.0

Source : Adopted from Kapoor Mehta

Table A 2.4 : State wise Break up of MPs with Pending Criminal Cases, Rajya Sabha 2010

State	Total No. of MPs	MPs with Pending Criminal Cases	% of MPs with Pending Criminal cases	MPs with serious Pending Criminal cases (%)
Major States	Andhra Pradesh	18	3(16.7)	2 (11.1)
	Bihar	15	4 (26.7)	0(0.0)
	Haryana	5	1(20.0)	0(0.0)
	Karnataka	10	1(10.0)	1(10.0)
	Kerala	9	3(33.3)	1(11.1)
	Madhya Pradesh	11	1(9.1)	0(0.0)
	Maharashtra	19	8(42.1)	0(0.0)
	Orissa	10	1(10.0)	1(10.0)
	Rajasthan	10	1(10.0)	0(0.0)
	Tamil Nadu	18	1(5.6)	1(5.6)
	Uttar Pradesh	30	9(30.0)	2(6.7)
	West Bengal	15	2(13.3)	1(6.7)
Hilly/ Others/N-E States	Chhattisgarh	5	3(60.0)	2(40.0)
UTs	Delhi	3	1(33.3)	1(33.3)
	Jharkhand	6	1(16.7)	0(0.0)
Total		184	40(21.7)	12(6.5)

Source: ADRIndia.org

Note: Value in parentheses shows % of MPs with pending criminal cases and % of MPs with serious pending criminal cases.

Table A 2.5 : Party wise Number of MPs with Pending Criminal Cases (Rajya Sabha 2010)

Sl.No	Party	No of Total No. of MPs	MPs with Pending Criminal Cases (% of MPs with Pending Criminal Cases)	MPs with Serious Pending Criminal Cases (% of MPs with Serious Pending Criminal Cases)
1	INC	69	7 (10.1)	2 (2.9)
2	BJP	47	7 (14.9)	3 (6.4)
3	BSP	17	5 (29.4)	1 (5.9)
4	CPI(M)	15	2 (13.3)	1 (6.7)
5	DMK	7	1 (14.3)	1 (14.3)
6	IND	6	1 (16.7)	1 (16.7)
7	BJD	6	1 (16.7)	1 (16.7)
8	JD(U)	6	3 (50.0)	0 (0.0)
9	NCP	6	2 (33.3)	0 (0.0)
10	CPI	5	3 (60.0)	1 (20.0)
11	SP	5	2 (40.0)	0 (0.0)
12	TDP	4	1 (25.0)	1 (25.0)
13	SS	4	4 (100.0)	0 (0.0)
14	RJD	4	1 (25.0)	0 (0.0)
Total		201	40 (19.9)	1 (26.0)

Source : ADRIndia.org

Note: Value in parentheses shows % of MPs with pending criminal cases & % of MPs with serious pending criminal cases

Table A 2.6: State wise Break up of MPs with Pending Criminal Cases (15th Lok Sabha)

State Category	State Name	Total Constituency	% of MPs with Pending Criminal Cases	% of MPs with Serious Pending Criminal Cases
Major States	Andhra Pradesh	42	11 (26.2)	3 (7.1)
	Assam	14	2 (14.3)	0 (0.0)
	Bihar	40	18 (45.0)	6 (15.0)
	Gujarat	26	11 (42.3)	7 (26.9)
	Haryana	10	2 (20.0)	1 (10.0)
	Karnataka	28	9 (32.1)	5 (17.9)
	Kerala	20	7 (35.0)	2 (10.0)
	Madhya Pradesh	29	4 (13.8)	2 (6.9)
	Maharashtra	48	26 (54.2)	10 (20.8)
	Orissa	21	5 (23.8)	2 (9.5)
	Punjab	13	2 (15.4)	1 (7.7)
	Rajasthan	25	2 (8.0)	0 (0.0)
	Tamil Nadu	39	10 (25.6)	6 (15.4)
	Uttar Pradesh	80	31 (38.8)	22 (27.5)
	West Bengal	42	7 (16.7)	7 (16.7)
Hilly/N-E States	Chhattisgarh	11	2 (18.2)	0 (0.0)
	Jammu & Kashmir	6	1 (16.7)	0 (0.0)
	Jharkhand	14	8 (57.1)	2 (14.3)
	Uttarakhand	5	1 (20.0)	0 (0.0)
UTs	A & N Island	1	1 (100.0)	0 (0.0)
	D & N Haveli	1	1 (100.0)	0 (0.0)
	Delhi	7	1 (14.3)	0 (0.0)
Total		522	162(3.1)	76(14.6)

Note: Value in parentheses shows % of figures given in column 2 and 3

Source : ADRIndia.org

Table A 2.7 : Party wise MPs with Pending Criminal Cases ((15th Loksabha)

Sr.No.	Party	Total	MPs with Pending Criminal Cases (% of MPs with Pending Criminal Cases)	MPs with Serious Pending Criminal Cases (% of MPs with Serious Pending Criminal Cases)
1	BJP	116	44 (37.9)	19 (16.4)
2	INC	206	44 (21.4)	13 (6.3)
3	SHS	11	9 (81.8)	3 (27.3)
4	SP	23	9 (39.1)	8 (34.8)
5	JD(U)	20	8 (40.0)	3 (15.0)
6	BSP	21	6 (28.6)	6 (28.6)
7	BJD	14	4 (28.6)	1 (7.1)
8	AITC	19	4 (21.1)	4 (21.1)
9	NCP	9	4 (44.4)	3 (33.3)
10	ADMK	9	4 (44.4)	4 (44.4)
11	DMK	18	4 (22.2)	1 (5.6)
12	RJD	4	3 (75.0)	2 (50.0)
13	CPM	16	3 (18.8)	1 (6.3)
14	RLD	5	2 (40.0)	1 (20.0)
15	JD(S)	3	2 (66.7)	1 (33.3)
16	JMM	2	2 (100.0)	2 (100.0)
17	TDP	6	2 (33.3)	1 (16.7)
18	MDMK	1	1 (100.0)	0 (0.0)
19	AIMIM	1	1(100.0)	1(100.0)
20	VCK	1	1 (100.0)	1 (100.0)
21	SAD	4	1 (25.0)	0 (0.0)
22	IND	9	1 (11.1)	0 (0.0)
23	TRS	2	1 (50.0)	0 (0.0)
24	AIFB	2	1 (50.0)	1 (50.0)
25	JVM	1	1 (100.0)	0 (0.0)
Total		523	162 (30.9)	76 (14.5)

Source : ADRIndia.org

Note: Value in parentheses shows % of MPs with pending criminal cases & (% of MPs with serious pending criminal cases

Table A 2.8 : Time Spent (in hrs) on Debates Taking Place on the Following Issues

Sectors	13 th Lok Sabha	14 th Lok Sabha
Health	106	199
Privatisation	31	10
Telecommunications	20	6

Source: Compiled from the official website of the Parliament of India.

Table A 2.9 : Statement Showing Time Lost due to Interruptions during the 13th Lok Sabha

Session	Duration	Time Spent on Interruption		Time Lost due to Adjournment of the House Following Interruption		Total Time Lost	
		Hours	Minutes	Hours	Minutes	Hours	Minutes
1st	20th October to 29th October, 1999	NA	NA	NA	NA	NA	NA
2nd	29th November to 23rd December, 1999	2	3	12	35	14	38
3rd	23rd February to 17th May, 2000	3	47	59	5	62	52
4th	24th July to 25th August, 2000	0	59	14	29	15	28
5th	20th November to 22nd December, 2000	1	22	59	45	61	7
6th	19th February to 27th April, 2001	0	50	73	28	74	18
7th	23rd July to 31st August, 2001	1	43	27	48	29	31
8th	19th November to 19th December, 2001	0	59	29	33	30	32
9th	25th February to 17th May, 2002	3	11	63	24	66	35
10th	15th July to 12th August, 2002	1	45	34	10	35	55
11th	18th November to 20th December, 2002	2	48	0	27	3	15
12th	17th February to 9th May, 2003	8	9	5	27	13	36
13th	21st July to 22nd August, 2003	2	49	36	20	39	9
14th	2nd to 23rd December, 2003 and 29th January to 5th February, 2004	0	38	6	50	7	28
	Total	31	3	423	21	454	24

Source : Compiled from the official website of the Parliament of India

Table A 2.10 : Statement Showing Time Lost due to Interruptions during the 14th Lok Sabha (2004-09)

Session	Duration	Time Spent on Interruption		Time Lost due to Adjournment of the House Following Interruption		Total Time Lost	
		Hours	Minutes	Hours	Minutes	Hours	Minutes
1st	2nd to 10th June, 2004	0	17	10	15	10	32
2nd	5th July to 26th August, 2004	1	50	45	26	47	16
3rd	1st December to 23rd December, 2004	1	41	5	0	6	41
4th	25th February to 13th May, 2005	2	48	34	51	37	39
5th	25th July to 30th August, 2005	1	51	8	30	10	21
6th	23rd November to 23rd December, 2005	1	39	25	54	27	33
7th	16th February to 23rd May, 2005	2	57	32	45	35	42
8th	24th July to 25th August, 2006	3	46	33	3	36	49
9th	22nd November to 19th December, 2006	1	31	24	3	25	34
10th	23rd February to 17th May, 2007	3	14	66	59	70	13
11th	10th August to 10th September, 2007	0	26	41	41	42	7
12th	15th November to 7th December, 2007	0	59	19	37	20	36
13th	25th February to 5th May, 2008	1	4	27	26	28	30
14th	Part-1: 21st July to 22nd July, Part-2: 2008, 17th October to 24th October, 2008, and 10th December to 23rd December, 2008	0	16	21	16	21	32
15th	12th February to 26th February, 2009	0	36	1	19	1	55
	Total	24	55	398	5	423	0

Source : Compiled from the official website of the Parliament of India

Table A 2.11 : Court wise Number of Cases Pending in High Courts in India (as on 2010)

High Courts	30.09.2010	31.12.1997
Allahabad	973599	865455
Andhra Pradesh	194691	133211
Bombay	347618	237618
Calcutta	333763	282209
Chhattisgarh	56102	-
Delhi	60375	163430
Gujarat	98128	119383
Guwahati	53400	34165
Himachal Pradesh	46698	13352
Jammu & Kashmir	65905	98645
Jharkhand	57218	-
Karnataka	209843	135389
Kerala	120764	250261
Madhya Pradesh	213028	83131
Madras	444979	326619
Orissa	275052	84897
Patna	128293	84666
Punjab & Haryana	737658	170671
Rajasthan	282826	98416
Sikkim	52	95
Uttaranchal	17911	-
Total	4217903	3181613

Source : Supreme Court of India

Note: The question was asked in 1997 and not in 1998 in Rajya Sabha. Interestingly some high court referred by the name of the states while other by the capital

Table A 2.12 : High Court wise Sanctioned Strength and Vacancies of Judges in India

High Court	2011		1996	
	Approved Strength	Vacancies	Approved Strength	Vacancies
Allahabad	160	97	95	32
Andhra Pradesh	49	16	39	2
Bombay	75	14	60	9
Calcutta	58	14	50	10
Chhattisgarh	18	-6		
Delhi	48	11	33	5
Gauhati	24	6	19	2
Gujarat	42	18	42	13
Himachal Pradesh	11	-	8	0
Jammu & Kashmir	14	6	14	4
Jharkhand	20	7		
Karnataka	50	9	40	10
Kerala	38	9	29	6
Madhya Pradesh	43	4	29	1
Madras	60	11	42	19
Orissa	22	5	16	2
Patna	43	4	33	0
Punjab & Haryana	68	25	40	7
Rajasthan	40	13	32	0
Sikkim	3	1	3	1
Uttaranchal	9	2		
India	895	278	647	146

Source : Supreme Court of India

Compiled from the statistics released by: Lok Sabha Unstarred Question No. 5652, dated 02.05.2002

**Table A 2.13 : State wise Number of Civil and Criminal Pendency Cases in District/
Sub-ordinate Courts in India Over 10 Year Old**

States/UTs	2008	1998
Andhra Pradesh	958276	7177
Arunachal Pradesh	6289	0
Assam	239527	32
Bihar	1373423	59449
Chhattisgarh	265440	
Goa	33931	2857
Gujarat	2420052	97822
Haryana	563337	1880
Himachal Pradesh	142910	351
Jammu & Kashmir	167798	3827
Jharkhand	267008	
Karnataka	1137645	28132
Kerala	964342	2825
Madhya Pradesh	1065789	66219
Maharashtra	3445782	217257
Manipur	6442	431
Meghalaya	12044	1658
Mizoram	6138	2
Nagaland	5365	-
Orissa	1033812	10187
Punjab	589621	4142
Rajasthan	1180334	49468
Sikkim	1129	0
Tamil Nadu	945419	5182
Tripura	36703	335
Uttar Pradesh	4988743	158532
Uttarakhand	157270	
West Bengal	2194631	95555
Andaman & Nicobar Islands	47676	3
Chandigarh	96350	79
Dadra & Nagar Haveli	3007	7
Daman & Diu	1612	16
Delhi	860339	15571
Lakshadweep	198	4
Pondicherry	22803	345
Total	25240185	829345

Source : Supreme Court of India

Table A 2.14 : State wise Sanctioned/Working Strength and Vacancies in District and Subordinate Courts in India

States/UTs	2010		1998	
	Sanctioned	Vacant	Sanctioned	Vacant
Andhra Pradesh	930	129	776	63
Arunachal Pradesh#	2	0	293	0
Assam	326	106	259	54
Bihar	1385	323	1137	197
Chandigarh	20	1	19	0
Chhatisgarh	293	38	190	15
Delhi	605	166	407	191
Diu, Daman & Dadra and Nagar Haveli	4	0	5	0
Goa	49	7	44	5
Gujarat	1072	281	636	55
Haryana	409	123	266	33
Himachal Pradesh	126	7	98	5
Jammu and Kashmir	207	41	156	15
Jharkhand	546	149	533	163
Karnataka	914	103	733	57
Kerala	437	8	370	1
Lakshadweep	3	0	3	0
Madhya Pradesh	1288	171	792	138
Maharashtra	2087	324	1285	129
Manipur	33	2	32	4
Meghalaya	10	2	7	1
Mizoram	67	35	35	14
Nagaland	27	1	21	0
Orissa	509	46	483	79
Puducherry	20	6	19	5
Punjab	408	116	301	22
Rajasthan	896	180	790	127
Sikkim	15	6	12	3
Tamil Nadu	827	33	767	68
Tripura	92	31	74	19
Uttar Pradesh	2185	264	2136	544
Uttarakhand	265	136	183	128
West Bengal & Andaman & Nicobar Island	933	145	596	81
India	16990	2980	13458	2216

Source : Supreme Court of India. & Lok Sabha Unstarred Question it has jurisdiction over the state of West Bengal and the Union Territory of the Andaman and Nicobar Islands.

Above: Statement is compiled on the basis of figures received from the High Courts

Table A 2.15 : State wise Distribution of Police Force

States / Uts	No. of Policemen per 100 km ² Area	No. of Policemen per 100 km ² Area	No. of Policemen per 1000 Population	No. of Policemen per 1000 Population	% of Women Police to total Police (Actual)	% of Women Police To total Police (Actual)	% Short Fall In total Police Force between Sanctioned and Actual In 2009	% Short Fall In total Police Force between Sanctioned and Actual In 2000	Per Police Expendi- ture (Crores)	Per Police Expendi- ture (Lakhs)
	2009	2001	2009	2001	2009	2001	2009	2001	2009	2001
Andhra Pradesh	38.9	28.3	1.3	1	1.4	1.8	16.40	6.25	2.35	1.71
Arunachal Pradesh	8.7	6.4	5.9	4.9	11.1	4.4	7.96	2.13	3.75	2.21
Assam	65.9	68	1.7	2	0.7	0.8	7.12	2.17	3.37	2.03
Bihar	62.9	48.2	0.6	0.5	2.3	2.0	30.68	14.79	2.98	1.99
Chattisgarh	29.4	9	1.6	0.6	4.5	3.8	4.34	8.47	2.46	2.21
Delhi	4345.4	3806.5	3.6	4.1	7.7	4.4	19.17	1.20	2.56	1.88
Goa	127.6	98.8	2.8	2.7	8.1	6.3	2.40	4.83	3.19	1.70
Gujarat	30.8	30.8	1.1	1.2	3.4	3.5	22.57	8.05	2.36	1.42
Haryana	93.6	71.9	1.7	1.5	4.8	0.9	27.21	21.20	2.27	1.66
Himachal Pradesh	25.1	21.8	2.1	2	6.3	5.6	8.49	4.13	3.12	1.70
J&K	86.9	58.2	6.8	5.9	2.8	3.6	12.58	0.00	2.23	1.93
Jharkhand	53.1		1.4		4.8		24.14		4.15	
Karnataka	39.3	26.3	1.3	1	7.1	2.4	12.94	11.91	2.02	1.61
Kerala	102.4	112	1.1	1.4	7.4	1.3	6.36	1.04	2.70	1.21
Madhya Pradesh	24.9	31.6	1.1	1.6	3.2	1.5	0.00	1.36	2.26	1.04
Maharashtra	58.5	42.7	1.7	1.4	7.7	0.2	10.89	11.98	1.63	0.97
Manipur	86.2	65.2	7.2	6.1	4.2	1.8	14.13	-0.12	2.46	0.98
Meghalaya	44.9	37.6	3.9	3.7	1.6	2.3	9.04	38.68	3.19	1.67
Mizoram	51.9	30.2	11.0	7.2	0.0	2.0	15.53	-22.27	1.89	1.91
Nagaland	60.3	69.9	4.5	5.8	1.2	10.2	6.25	-0.31	8.83	1.73
Orissa	27.9	22.4	1.1	1	10.8	1.2	11.79	8.16	3.18	1.38
Punjab	133.1	135.5	2.5	2.8	3.7	2.0	6.08	1.00	3.47	1.61
Rajasthan	21	18.5	1.1	1.1	6.2	1.4	8.53	10.33	2.00	1.28
Sikkim	50.8	57.1	6.0	7.5	9.0	3.9	8.99	-26.70	4.49	1.50
Tamilnadu	68.2	61.7	1.3	1.3	8.3	3.3	15.59	15.83	2.55	1.52
Tripura	216.9	142	6.4	4.7	4.2	2.6	21.94	16.85	2.49	2.53
Uttar Pradesh	61.3	64.8	0.8	0.9	2.1	1.5	64.60	7.86	3.69	1.72
Uttarakhand	29.1	22.8	1.6	1.4	9.7	1.8	18.38	1.92	3.85	1.64
West Bengal	93.9	94	0.9	1	3.8	1.7	15.10	7.60	1.91	1.30
A&N Islands	45.2	33.8	8.8	7.8	8.0	4.2	6.31	5.24	4.36	1.60
Chandigarh	4118.4	3510.5	4.3	4.4	9.0	5.8	28.86	-31.26	2.46	1.43
D&N Haveli	45.2	47.3	0.8	1.1	4.1	15.2	6.33	1.43	3.28	1.11
Daman&Diu	196.4	209.8	1.1	1.5	0.0	1.3	10.20	-6.33	1.92	1.14
Lakshadweep	793.8	1012.5	3.6	5.3	6.3	5.2	54.32	6.90	3.64	1.80
Puducherry	436	326	2.0	1.6	5.7	8.6	16.52	43.88	4.70	2.69

Source : National Crime Statistics

Table A 2.16 : State Level Variation in Disposal of IPC Crime by Police, 2000 & 2009

	Charge Sheet Rate		Pendency Percentage		Conviction Rate	
	2000	2009	2000	2009	2000	2009
Andhra Pradesh	88.6	85.4	24.1	23.7	32.6	33.3
Arunachal Pradesh	66.5	60.9	21.4	32.8	50.7	58.2
Assam	53.8	56.6	52.2	58.1	21.1	21.1
Bihar	79.2	72.3	35.9	45.2	19.9	18
Chattishgarh	N.A	80.5	N.A	8.6	N.A	48.4
Goa	53.7	58	24.5	50.6	17.6	26.2
Gujarat	80.5	79.1	8.2	13.9	28.6	41.1
Haryana	76.3	71.7	12.3	19.9	32.4	36.3
Himachal Pradesh	83.6	84.8	19	15.3	29.2	24.5
Jammu & Kashmir	71.8	79.8	27.7	26.5	36.6	46.3
Jharkhand	N.A	70.5	N.A	45.2	N.A	31
Karnataka	79.1	82.8	20.4	33.7	31.9	35.7
Kerala	93.4	91.1	17.5	15.9	47.9	57.1
Madhya Pradesh	81.6	85.8	5.6	5.2	54.2	47.4
Maharashtra	69.9	70.9	20.4	32.5	12.6	9.6
Manipur	4.3	3.4	74.9	86.8	30.8	26.9
Meghalaya	54.2	45.2	60.6	70.1	29.5	38.8
Mizoram	70.4	91.4	11.5	13.3	77.5	91
Nagaland	45.2	61.9	53.5	38.1	76	80.7
Orissa	82.4	89.6	22.9	41.2	16.5	13.2
Punjab	77.7	71.8	31.2	34.8	46.1	35
Rajasthan	82.3	79.7	3.1	4	51.2	60.7
Sikkim	66.5	52.2	14.3	34.4	45.2	46
Tamil Nadu	91.8	89.1	17.2	25.1	64.2	62.1
Tripura	48.3	84	30.5	17.4	15	12.7
Uttar Pradesh	72.6	70.2	12.8	9.3	55	54
Uttarakhand	N.A	73.6	N.A	11.3	N.A	69.3
West Bengal	58	74.9	39.5	41.4	22.6	12.6
A & N Islands	69	77.5	37.3	38.7	27.6	37.6
Chandigarh	55.6	34	12.5	45.3	56.3	48.2
D & N Haveli	75.6	74.7	24.2	50.9	45.6	24.7
Daman & Diu	56	60.3	20.2	46.5	26.7	12.7
Delhi	67.4	54	39.5	46.7	48.7	58.1
Lakshadweep	54.8	52.3	42.6	49.6	0	0
Pondicherry	89.3	90.2	2.9	10.3	91.9	90.2
Total (All-India)	78.4	78.4	20.9	27	41.8	41.7

Source : Crime in India, National Crime Records Bureau, Ministry of Home Affairs, 2000 & 2009

Note: Charge Sheet Rate= (Charge Sheets Submitted/ (Final Report True Submitted+ Charge Sheets Submitted)*100 Convection Rate= (Convicted/ Total Trials Were Completed)*100)

Table A 2.17 : State wise Variation % in Convicted and Undertrial Prisoners

	Convicts						Under trails					
	Men		Women		Total		Men		Women		Total	
	2000	2009	2000	2009	2000	2009	2000	2009	2000	2009	2000	2009
Andhra Pradesh	31.4	36.1	16.5	25.4	68.0	35.4	83.5	63.5	74.4	74.4	64.2	64.2
Arunachal Pradesh	N.A	3.4	N.A	0.0	N.A	3.2	N.A	96.6	100.0	100.0	96.8	96.8
Assam	33.7	41.2	32.4	30.8	65.2	40.8	59.5	58.8	68.6	68.6	59.1	59.1
Bihar	14.6	16.6	10.8	10.5	85.2	16.4	89.2	83.4	89.4	89.4	83.5	83.5
Chattisgarh	N.A	40.1	N.A	37.7	N.A	40.0	N.A	59.7	N.A	62.3	N.A	59.9
Goa	33.2	45.1	30.0	22.6	66.4	43.5	70.0	54.9	77.4	77.4	56.5	56.5
Gujarat	34.7	36.9	28.3	31.5	60.8	36.7	63.5	60.4	58.4	58.4	60.3	60.3
Haryana	28.0	41.8	23.1	42.7	71.9	41.9	76.9	58.2	57.3	57.3	58.1	58.1
Himachal Pradesh	40.6	53.7	36.7	67.3	59.4	54.2	63.3	46.3	32.7	32.7	45.8	45.8
J&K	8.0	15.3	6.8	12.2	58.7	15.2	88.6	76.7	86.7	86.7	77.1	77.1
Jharkhand	N.A	32.3	N.A	25.7	N.A	32.0	N.A	67.7	N.A	74.3	N.A	67.9
Karnataka	17.3	28.0	17.4	28.8	81.6	28.1	81.7	70.5	68.9	68.9	70.4	70.4
Kerala	34.0	40.9	27.9	25.7	65.9	40.5	72.1	58.0	74.3	74.3	58.5	58.5
Madhya Pradesh	43.3	47.0	38.5	43.0	56.4	46.8	60.9	52.6	57.0	57.0	52.8	52.8
Maharashtra	28.6	34.6	28.9	35.7	70.3	34.6	70.6	65.1	64.3	64.3	65.0	65.0
Manipur	6.9	7.0	3.1	0.0	80.5	6.4	87.5	66.7	66.7	66.7	66.7	66.7
Meghalaya	5.9	15.0	0.0	12.5	93.1	14.9	100.0	79.2	87.5	87.5	79.3	79.3
Mizoram	26.5	48.2	22.9	19.6	73.1	46.1	74.3	51.8	80.4	80.4	53.9	53.9
Nagaland	10.0	25.1	5.0	11.8	89.1	24.7	95.0	68.0	88.2	88.2	68.5	68.5
Orissa	21.8	30.0	13.6	21.6	77.6	29.7	86.4	70.0	78.4	78.4	70.3	70.3
Punjab	27.2	36.1	22.0	35.9	7.3	36.1	78.0	63.8	64.1	64.1	63.8	63.8
Rajasthan	30.1	36.5	25.0	37.3	68.6	36.5	73.3	63.1	62.7	62.7	63.1	63.1
Sikkim	41.0	36.6	33.3	14.3	59.0	35.8	66.7	63.4	85.7	85.7	64.2	64.2
Tamilnadu	25.6	38.1	9.3	23.1	12.3	37.3	9.7	55.8	74.7	74.7	56.8	56.8
Tripura	29.5	66.7	42.9	46.7	70.5	66.1	57.1	33.3	53.3	53.3	33.9	33.9
Uttar Pradesh	N.A	29.3	N.A	26.0	N.A	29.2	N.A	70.4	N.A	74.0	N.A	70.5
Uttarakhand	10.2	36.6	10.1	36.7	88.4	36.6	89.9	63.4	63.3	63.3	63.4	63.4
West Bengal	23.3	33.5	21.6	36.3	75.4	33.7	79.0	65.4	62.0	62.0	65.2	65.2
A&N Islands	17.2	21.1	75.0	0.0	82.8	21.1	25.0	78.9	0.0	0.0	78.9	78.9
Chandigarh	22.5	38.3	22.2	31.0	77.5	37.9	77.8	61.7	69.0	69.0	62.1	62.1
D&N Haveli	1.4	3.7	0.0	0.0	98.6	3.6	100.0	96.3	100.0	100.0	96.4	96.4
Daman&Diu	76.9	38.5	0.0	100.0	23.1	40.0	100.0	61.5	0.0	0.0	60.0	60.0
Delhi	18.1	20.5	19.7	18.6	81.5	20.4	79.8	79.3	81.4	81.4	79.4	79.4
Lakshadweep	0.0	2.3	0.0	0.0	0.0	2.3	0.0	97.7	0.0	0.0	97.7	97.7
Puducherry	42.3	44.0	40.0	66.7	57.7	44.2	60.0	56.0	33.3	33.3	55.8	55.8
All India	23.7	33.0	19.2	29.8	71.3	32.9	68.0	66.2	69.4	69.4	66.4	66.4

Source : Crime in India, Prison Statistics, National Crime Records Bureau, Ministry of Home Affairs, 2000 & 2009.

Table A 2.18 : State wise Total Cognizable Crimes under 2000 & 2009

States	Rate of Total Cognizable Crimes (IPC)		Murder Rate		Dacoity		Theft Rate		Riots Rate		Other IPC Crime Rate	
	2000	2009	2000	2009	2000	2009	2000	2009	2000	2009	2000	2009
Andhra Pradesh	159.9	216.6	3.6	2.9	0.3	0.1	21.5	29.6	3.3	2.7	151.9	210.2
Arunachal Pradesh	197.3	193.6	5.7	4.8	3.9	1.6	36.0	31.2	1.7	4.3	177.7	178.4
Assam	133.8	181.2	5.8	4.3	2.7	0.8	21.4	25.0	13.0	5.9	109.5	168
Bihar	123.4	128.4	5.3	3.3	2.1	0.7	14.0	15.9	10.6	8.9	102.5	113.8
Chattishgarh	N.A	212.6	N.A	4.5	N.A	0.6	N.A	24.0	N.A	4.0	N.A	201.2
Goa	150.8	177.7	2.6	3.1	0.2	0.2	41.6	50.7	3.9	3.0	142	169.6
Gujarat	238.9	200.5	2.7	1.8	0.7	0.4	34.1	34.2	4.7	2.7	228.4	193.1
Haryana	198.2	231.9	3.9	3.9	0.5	0.6	32.7	53.3	4.4	4.8	187.3	219.8
Himachal Pradesh	165.1	200.9	1.8	1.9	0.1	0.1	10.2	12.4	9.0	8.9	153.9	189.7
Jammu & Kashmir	175.4	170.2	7.7	1.8	0.4	0.0	18.5	20.4	9.4	11.4	156.5	156.5
Jharkhand	N.A	122.6	N.A	5.4	N.A	1.3	N.A	25.3	N.A	7.6	N.A	105.7
Karnataka	209.2	230.3	3.2	2.9	0.5	0.5	26.1	35.4	14.5	10.8	189.2	213
Kerala	306.1	341.5	1.4	1.0	0.4	0.3	12.4	16.1	22.1	23.3	281	314.5
Madhya Pradesh	269.8	293	4.3	3.4	0.3	0.2	31.8	32.8	5.2	3.4	257.7	282.8
Maharashtra	189.7	183.6	3.1	2.4	0.6	0.7	45.4	46.9	6.2	7.4	177	170.1
Manipur	101.7	106.8	8.6	4.9	0.5	0.0	8.3	14.8	3.7	1.8	87.8	100
Meghalaya	69.4	95.0	5.1	5.0	3.8	2.5	15.5	21.1	0.4	0.7	55	84.2
Mizoram	241.5	205.5	4.2	3.1	0.6	0.2	97.6	76.4	0.2	0.1	234.7	201.7
Nagaland	80.7	47.6	6.5	2.1	2.5	0.4	15.4	15.6	0.6	0.2	63.7	40.8
Orissa	137.4	137.9	3.2	3.1	0.8	0.9	17.9	17.6	4.2	4.2	125.9	144
Punjab	103.2	131.7	3.4	3.2	0.1	0.1	10.6	20.8	0.0	0.0	99.4	127.8
Rajasthan	298.8	252.2	2.8	2.1	0.2	0.1	31.6	33.5	29.1	1.7	264.8	247
Sikkim	76.9	110.8	3.4	3.1	0.4	0.0	10.9	10.3	3.0	6.5	69.7	100.5
Tamil Nadu	244.3	260.3	2.8	2.6	0.3	0.1	27.9	23.4	8.1	3.6	232	252.3
Tripura	88.6	153.8	8.0	3.7	1.0	0.2	7.7	11.6	7.5	5.0	70.2	142.7
Uttar Pradesh	102.4	88.4	4.5	2.3	0.5	0.2	16.0	14.9	4.5	2.2	90.5	82.5
Uttarakhand	N.A	90.9	N.A	2.0	N.A	0.4	N.A	16.5	N.A	4.8	N.A	81.9
West Bengal	83.0	126.7	2.4	2.3	0.4	0.2	19.7	19.2	4.9	7.5	74.3	115.9
A & N Islands	193.8	222.5	4.6	3.5	0.3	0.0	22.9	31.7	7.5	2.6	179.3	213.8
Chandigarh	328.3	324.1	2.1	2.0	0.1	0.4	119.8	157.8	8.4	6.0	316.6	313.2
D & N Haveli	229.2	160.7	5.2	3.6	0.5	3.3	37.5	22.9	14.6	19.3	207.9	133.8
Daman & Diu	178.0	142.3	2.1	2.6	2.1	0.0	28.4	21.1	19.9	14.9	153.2	122.7
Delhi	399.0	282.6	4.2	3.1	0.5	0.2	149.6	122.2	1.5	0.3	387.4	276.1
Lakshadweep	33.3	188.7	0.0	0.0	0.0	4.2	11.1	14.1	0.0	62.0	33.3	122.5
Pondicherry	302.1	418.5	2.3	3.4	0.1	0.6	35.4	64.8	5.5	12.9	293.8	400.8
Total (All-India)	176.7	181.4	3.7	2.8	0.7	0.4	25.8	27.7	8.0	5.4	162.2	170.9

Source: Crime in India, National Crime Records Bureau, Ministry of Home Affairs, 2000 & 2009

Note: Crime Rate= number of crime per one lakhs population, e.g: Murder rate= (Number of incidence of Murder/ Total midyear population)*100000

Other crime includes Rape, Kidnapping and Abduction, Counterfeiting, Arson, Hurt, Molestations

Table A 2.19 : State wise Total Cognizable Crimes under (IPC) against Women and other Deprived Groups, 2000 & 2009

States	Rate of Cognizable Crime against Women and its Different Heads														Rate of Total Cognizable Crime against SCs		Rate of Total Cognizable Crime against STs	
	Total		Dowry Deaths		Rape Rate		Molestation		Sexual Harassment		Kidnapping & Abduction of Women & Girls		Cruelty by Husband and Relatives					
	2000	2009	2000	2009	2000	2009	2000	2009	2000	2009	2000	2009	2000	2009	2000	2009	2000	2009
Andhra Pradesh	17.1	27.9	0.6	0.7	1.2	1.4	4.3	6.2	3.0	4.2	0.9	1.8	7.1	13.6	2.1	5.4	0.3	1.0
Arunachal Pradesh	11.9	26.9	0.0	0.0	3.0	4.8	4.4	4.8	0.2	0.5	3.5	2.3	0.8	1.1	0.0	0.0	1.1	1.7
Assam	14.1	63.4	0.2	0.6	2.9	5.3	3.0	4.4	0.1	0.0	4.2	6.9	3.7	14.4	0.0	0.0	0.0	0.0
Bihar	5.4	17.1	1.1	1.4	1.6	1.0	0.5	0.8	0.1	0.0	0.7	2.1	1.4	2.6	0.7	4.0	0.1	0.1
Chattishgarh	N.A	32.9	N.A	0.5	N.A	4.0	N.A	6.6	N.A	0.6	N.A	0.9	N.A	3.7	N.A	1.9	N.A	2.3
Goa	4.4	18.0	0.1	0.2	1.3	2.8	1.2	2.2	0.6	0.6	0.4	1.3	0.8	1.2	0.1	0.2	0.0	0.0
Gujarat	12.5	27.8	0.2	0.0	0.7	0.8	1.9	1.3	0.2	0.2	1.8	2.0	7.7	9.6	2.7	2.1	0.6	0.3
Haryana	16.5	43.5	1.3	1.2	2.1	2.5	3.0	1.9	2.1	2.5	1.5	2.7	6.5	10.8	0.6	1.2	0.0	0.0
Himachal Pradesh	12.5	28.7	0.1	0.0	1.9	2.8	4.3	4.8	0.2	0.6	1.4	1.8	4.6	4.3	0.8	1.3	0.2	0.0
Jammu & Kashmir	16.3	40.5	0.1	0.1	1.8	1.8	4.8	7.5	3.4	2.9	5.7	6.4	0.5	1.5	0.1	0.0	0.0	0.0
Jharkhand	N.A	18.5	N.A	1.0	N.A	2.4	N.A	0.9	N.A	0.3	N.A	1.7	N.A	2.3	N.A	2.1	N.A	0.6
Karnataka	7.8	25.0	0.4	0.5	0.5	0.9	3.0	3.8	0.1	0.1	0.6	0.7	3.2	5.5	2.5	3.7	0.1	0.5
Kerala	15.0	45.4	0.1	0.1	1.7	1.6	5.2	7.3	0.2	1.1	0.3	0.5	7.5	11.6	1.4	1.3	0.2	0.3
Madhya Pradesh	22.2	44.4	0.9	1.2	4.7	4.2	10.6	8.9	1.0	1.0	1.1	1.2	3.9	5.6	5.8	4.3	2.3	1.6
Maharashtra	14.0	27.4	0.4	0.3	1.4	1.4	3.1	2.9	1.0	1.0	0.7	0.9	7.4	7.1	0.5	1.0	0.2	0.2
Manipur	2.9	14.6	0.0	0.0	0.3	1.2	0.7	1.5	0.0	0.1	1.7	3.6	0.2	0.9	0.0	0.0	0.0	0.0
Meghalaya	2.7	18.2	0.0	0.0	1.4	4.3	0.3	2.8	0.5	0.0	0.5	1.0	0.0	0.9	0.0	0.0	0.1	0.0
Mizoram	13.6	30.0	0.0	0.0	6.0	8.3	7.3	6.1	0.0	0.1	0.3	0.0	0.0	0.4	0.0	0.0	0.1	0.0
Nagaland	1.2	4.0	0.1	0.0	0.8	1.0	0.1	0.5	0.0	0.0	0.2	0.4	0.0	0.0	0.0	0.0	0.0	0.0
Orissa	11.9	37.8	0.8	0.9	2.1	2.5	4.6	6.7	0.4	0.5	1.0	2.0	3.0	5.1	2.2	4.2	0.6	1.4
Punjab	8.9	107.5	0.8	0.5	1.4	1.9	1.4	1.2	0.2	0.1	1.2	1.9	3.9	3.9	0.1	0.4	0.0	0.0
Rajasthan	23.7	52.2	0.8	0.7	2.3	2.3	5.7	3.8	0.1	0.0	4.7	3.5	10.1	15.7	9.6	7.5	2.1	1.8
Sikkim	3.8	13.5	0.0	0.0	1.1	3.0	0.0	1.7	0.0	0.0	0.2	1.0	2.5	1.0	2.7	2.6	1.4	2.3
Tamil Nadu	10.5	16.7	0.3	0.3	0.9	0.9	3.1	1.9	3.5	0.7	1.3	1.7	1.4	2.2	2.1	2.0	0.0	0.0
Tripura	8.7	84.9	0.4	0.8	2.3	5.3	1.5	10.8	0.0	0.1	1.1	2.6	3.4	22.8	0.0	0.2	0.1	0.8
Uttar Pradesh	10.8	23.6	1.3	1.1	1.1	0.9	1.5	1.4	1.8	1.3	1.6	2.6	3.5	4.4	4.3	3.8	0.0	0.0
Uttarakhand	N.A	24.5	N.A	1.0	N.A	1.1	N.A	1.2	N.A	2.6	N.A	2.6	N.A	3.7	N.A	0.6	N.A	0.0
West Bengal	8.8	52.2	0.4	0.6	1.0	2.6	1.3	2.2	0.1	0.1	0.9	2.5	5.1	18.1	0.0	0.0	0.0	0.0
A & N Islands	11.4	43.3	0.0	0.2	1.3	4.3	5.9	7.1	0.3	1.7	0.8	3.3	3.1	5.0	0.0	0.0	0.3	0.5
Chandigarh	17.3	27.0	0.2	0.2	2.6	2.6	3.8	2.4	0.9	0.2	5.8	3.3	4.0	4.6	0.1	0.0	0.0	0.0
D & N Haveli	8.8	14.3	0.0	0.0	1.6	1.5	2.1	0.7	0.5	0.4	3.6	3.3	1.0	1.1	0.0	0.4	1.6	5.8
Daman & Diu	4.2	11.3	0.0	0.0	0.7	0.5	0.0	2.1	0.0	0.5	2.1	0.0	1.4	1.5	0.7	1.0	0.0	0.0
Delhi	16.7	47.6	0.9	0.8	3.1	2.6	3.9	3.1	0.9	0.7	7.1	9.3	0.8	7.2	0.1	0.2	0.0	0.0
Lakshadweep	1.4	2.8	0.0	0.0	1.4	1.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.4	0.0
Pondicherry	7.0	18.2	0.3	0.0	0.4	0.1	2.9	4.8	2.4	1.5	0.7	1.2	0.3	0.9	1.9	2.6	0.0	0.0
Total (All-India)	12.8	34.0	0.7	0.7	1.6	1.8	3.3	3.3	1.1	0.9	1.5	2.2	4.6	7.7	2.5	2.9	0.4	0.5

Source : Crime in India, National Crime Records Bureau, Ministry of Home Affairs, 2000 & 2009

Table A 2.20 : State Level Variations in Infrastructure of Jails

States	Occupancy Rate				No. of Jail Staff per100 Inmates		No. of Female Jail Staff per 100 Female Inmates		Shortfall in Jail Staff	
	Men		Women							
	2000	2009	2000	2009	2000	2009	2000	2009	2000	2009
Andhra Pradesh	124.5	85.3	74.2	53.6	26.9	23.0	19.1	15.9	7.2	29.0
Arunachal Pradesh	N.A	131.8	N.A	33.3	N.A	262.9	N.A	650.0	N.A	11.9
Assam	107.8	122.1	40.0	62.9	16.2	13.5	69.6	44.8	4.1	6.9
Bihar	172.2	105.1	141.3	95.5	6.2	7.7	17.2	16.5	26.8	65.8
Chattisgarh	N.A	242.3	N.A	129.4	N.A	8.7	N.A	19.3	N.A	25.8
Goa	146.4	121.1	40.0	124.0	18.1	47.9	10.0	16.1	25.0	9.2
Gujarat	162.5	167.9	92.4	165.4	12.2	7.2	6.8	4.1	22.0	58.2
Haryana	275.3	120.1	486.4	73.4	5.3	15.2	0.3	16.3	18.9	34.8
Himachal_Pradesh	106.7	125.3	47.6	58.4	24.3	28.0	40.0	51.9	19.3	22.2
J&K	63.7	84.8	30.6	93.3	74.2	46.0	138.6	75.5	5.1	20.5
Jharkhand	N.A	133.4	N.A	119.2	N.A	6.6	N.A	10.8	N.A	51.2
Karnataka	120.8	105.2	55.7	51.8	14.5	11.8	41.7	46.4	27.0	29.5
Kerala	105.1	162.5	44.7	39.9	22.3	15.1	48.2	57.3	0.0	35.6
Madhya Pradesh	177.4	141.6	50.0	58.3	10.3	10.7	11.6	20.5	15.5	19.7
Maharashtra	131.7	104.4	135.8	95.6	15.4	14.9	7.9	8.4	13.7	19.0
Manipur	33.0	56.3	160.0	43.6	88.8	56.6	215.6	135.4	14.1	47.5
Meghalaya	111.0	133.6	22.9	17.8	30.0	32.3	262.5	362.5	0.0	2.8
Mizoram	128.9	71.0	59.7	33.3	26.8	37.3	26.7	75.0	0.0	9.2
Nagaland	58.4	50.3	25	20	42.9	95.2	200.0	741.2	0.0	0.0
Orissa	179.6	94.7	71.5	43.2	16.3	17.8	14.4	13.6	1.3	11.4
Punjab	116.9	150.3	200.6	131.1	22.9	13.6	9.0	10.9	0.0	2.5
Rajasthan	80.0	104.2	39.1	62.8	18.0	12.1	17.2	13.6	25.2	25.7
Sikkim	221.3	116.3	12.0	14.9	20.1	54.9	0.0	242.9	0.0	5.4
Tamilnadu	95.2	71.6	103.8	39.2	20.3	26.8	12.8	50.9	14.8	22.8
Tripura	172.2	76.9	42.0	39.0	74.4	54.8	123.8	120.0	8.1	22.4
Uttar Pradesh	N.A	200.8	N.A	128	N.A	8.8	N.A	15.1	N.A	25.0
Uttarakhand	149.4	121.2	134.4	139.5	12.3	9.0	0.0	15.8	7.8	58.2
West Bengal	54.3	87.2	42.2	70.0	28.1	19.8	16.3	25.8	5.6	14.1
A&N Islands	273.8	84.8	10.0	0.0	18.1	57.9	325.0	0.0	19.1	7.0
Chandigarh	38.0	64.0	45.0	72.5	27.7	17.4	27.8	20.7	0.9	11.1
D&N Haveli	367.5	108.0	40.0	20.0	0.0	0.0	0.0	0.0	0.0	0.0
Daman&Diu	32.5	48.8	2.5	2.5	70.4	35.0	100.0	100.0	5.0	22.2
Delhi	314.0	184.6	115.3	111.8	8.8	11.8	19.3	40.9	23.1	32.0
Lakshadweep	0.0	275	0.0	0.0	0.0	9.1	0.0	0.0	0.0	0.0
Puducherry	85.3	80.4	12.8	7.0	28.9	39.4	80.0	233.3	1.5	18.5
All India	131.1	125.9	82.3	77.3	15.3	13.1	19.2	22.4	12.2	29.3

Source : Crime in India, Prison Statistics, National Crime Records Bureau, Ministry of Home Affairs, 2000 & 2009.

Table A 2.21 : State wise Variation in period of Detention of under Trails Prisoners

States	Percentage of under Trails Prisoners by period of Detention							
	Less than 6 Months		6-12 Months		1-3 Years		More than 3 Years	
Andhra Pradesh	83.1	90.5	6.8	6.8	4.1	2.4	0.7	0.3
Arunachal Pradesh	0	70	21.7	21.7	0	8.3	0	0
Assam	82.1	78.6	10.2	10.2	7.1	9.2	1.8	1.9
Bihar	46.7	45.8	27.7	27.7	22.8	22.3	4.6	4.3
Chattisgarh	N.A	62.6	N.A	25.3	N.A	11.4	N.A	0.8
Goa	51.4	50	33.2	33.2	29.7	15.2	1.6	1.6
Gujarat	55.4	58.1	19.3	19.3	20.1	18.5	3	4.1
Haryana	62.2	56	25	25	14.5	18.2	1	0.8
Himachal Pradesh	82.9	57.8	23	23	0	17.8	0	1.4
J&K	40.1	40.2	13.7	13.7	34.9	34.5	12.1	11.6
Jharkhand	N.A	58.3	N.A	19.5	N.A	19.6	N.A	2.6
Karnataka	65.9	60.6	19.1	19.1	13.6	16.2	1.3	4
Kerala	85.5	88.7	9.3	9.3	4.6	1.7	0.7	0.1
Madhya Pradesh	70.9	70.8	15.4	15.4	11.5	12.6	1.1	1.3
Maharashtra	61	59.7	15.4	15.4	22.2	22.7	0.3	2.2
Manipur	74.1	67	17.5	17.5	8.1	10.4	1.5	5
Meghalaya	59.4	43.5	26.3	26.3	17.8	22.3	3.7	7.9
Mizoram	85.7	84.7	6.6	6.6	2.7	7.5	0	1.2
Nagaland	50.8	71.4	16.9	16.9	23.8	10.3	10.1	1.4
Orissa	61.5	67.6	16.8	16.8	17.7	12.5	2.7	3.2
Punjab	68.1	54.7	14.6	14.6	17.2	18	5.7	12.8
Rajasthan	60	57.2	21.3	21.3	20	19.1	1.4	2.4
Sikkim	55	52.4	12.9	12.9	26	20.9	0	13.7
Tamilnadu	40.4	77.5	14.7	14.7	13.9	6	2.1	1.7
Tripura	78.5	89.2	3	3	12.4	6.3	0	1.5
Uttar Pradesh	59.6	68.2	18.7	13.8	18.2	15	2.8	3
Uttarakhand	N.A	55.1	N.A	18.7	N.A	22.1	N.A	4.1
West Bengal	176	65	15.9	15.9	2.2	14.9	0	4.2
A&N Islands	99.3	82.2	10.6	10.6	0.2	5	0	2.3
Chandigarh	42.4	67.2	14.3	14.3	31	16.8	7.7	1.8
D&N Haveli	24.7	63	37	37	2.7	0	0	0
Daman&Diu	100	29.2	37.5	37.5	0	33.3	0	0
Delhi	56.6	47.7	16.6	16.6	21.8	26.2	5.8	9.5
Lakshadweep	0	97.7	0	0	0	2.3	0	0
Puducherry	99.2	82	13.3	13.3	0	4	0	0.7
All India	61.0	59.9	18.5	18.5	16.6	17.9	2.5	3.7

Source : Crime in India, Prison Statistics, National Crime Records Bureau, Ministry of Home Affairs,

Table A 2.22 : State wise Variation in Homeless Population

State Category	States	Houseless Household	No. of Households
Major States	Andhra Pradesh	40818	17004305
	Assam	3126	4914823
	Bihar	6940	13744130
	Gujarat	48095	9691362
	Haryana	11860	3712319
	Himachal Pradesh	1634	1221589
	Karnataka	26057	10401918
	Kerala	5654	6726356
	Madhya Pradesh	53489	10912025
	Maharashtra	87474	19576736
	Orissa	13044	7738065
	Punjab	8579	4348580
	Rajasthan	27196	9317675
	Tamil Nadu	20532	14665983
	Uttar Pradesh	43033	25757640
	West Bengal	19385	15872083
Small/Hilly States	Arunachal Pradesh	105	215574
	Chattisgarh	7504	4091551
	Goa	1393	294812
	Jammu & Kashmir	2123	1568519
	Jharkhand	2559	4799081
	Manipur	522	375095
	Meghalaya	380	418850
	Mizoram	72	176134
	Nagaland	452	328057
	Sikkim	80	114223
	Tripura	246	664334
	Uttaranchal	2940	1603242
UTs	A & N Islands	217	78242
	Chandigarh	757	206465
	Dadra & Nagar Haveli	305	45586
	Daman & Diu	227	35686
	NCT Delhi	10044	2733383
	Ponducherry	710	215538
	All India	447552	193569961

Source : Census of India, 2001

Table A 2.23 : Status of IAY

State Category	States Name	1998-99			2009-10		
		Target	Houses Constructed	% of Achievement	Target	House Constructed	% of Achievement
Major States	Andhra Pradesh	73645	24113	32.74	371982	434733	116.87
	Assam	28576	4722	16.52	240446	181162	59.49
	Bihar	171378	66929	39.05	1098001	653214	91.41
	Gujarat	19692	11146	56.6	182429	166760	94.25
	Haryana	10690	1676	15.68	25611	24138	110.54
	Himachal Pradesh	4435	393	8.86	8212	9295	64.73
	Karnataka	39505	19460	49.26	143311	158417	84.69
	Kerala	17726	7507	42.35	79695	51590	92.59
	Madhya Pradesh	103652	51116	49.32	114396	96877	79.16
	Maharashtra	78092	16204	20.75	224323	207695	85.58
	Orissa	67684	20404	30.15	215715	170766	94.9
	Punjab	5630	1488	26.43	31674	27108	113.98
	Rajasthan	35599	14995	42.12	91670	86992	98.13
	Tamil Nadu	46258	27862	60.23	148929	169753	77.35
	Uttar Pradesh	188051	61943	32.94	493156	483949	113.19
	West Bengal	74594	15661	20.99	297564	230155	75.34
Hilly States/N-E States	Arunachal Pradesh	1046	56	5.35	10873	6026	55.42
	Chhattisgarh	N.A	N.A	N.A	57520	58449	101.62
	Goa	130	412	316.92	2291	1864	81.36
	Jammu & Kashmir	7699	4200	54.55	25508	18594	72.89
	Jharkhand	N.A	N.A	N.A	97926	87524	89.38
	Manipur	1911	67	3.51	9439	3296	34.92
	Meghalaya	2409	81	3.36	16440	9875	60.07
	Mizoram	472	255	54.03	3504	4851	138.44
	Nagaland	2050	876	42.73	10878	11645	107.05
	Sikkim	784	396	50.51	2080	1819	87.45
	Tripura	4519	2566	56.78	21182	8322	39.29
	Uttaranchal	N.A	N.A	N.A	22476	20373	90.64
UTs	A & N Islands	202	6	2.97	2750	242	8.8
	Chandigarh	N.A	N.A	N.A	N.A	N.A	N.A
	Dadra & Nagar Haveli	309	5	1.62	458	0	0
	Daman & Diu	10	0	0	205	0	0
	Delhi	N.A	N.A	N.A	N.A	N.A	N.A
	Lakshadweep	17	31	182.35	229	0	0
	Pondicherry	257	113	43.97	1370	47	3.43

Source : Annual Report, Rural Development, 1998-99 & 2009-10



Housing Conditions

Table A 2.24 : State Level Variation in Types of House (Urban)

	2008-09			1993-94		
	Pucca	Semi Pucca	All Kuccha	Pucca	Semi pucca	Kaccha
Andhra	92.8	3.4	3.9	68.06	15.33	16.61
Arunachal	62	17.2	20.8	59.06	11.81	29.13
Assam	75.5	22.1	2.4	48.67	30.84	20.48
Bihar	79.4	10	10.3	65.98	25.22	8.8
Chhattisgarh	79.9	18.8	1.1			
Delhi	94.4	2.8	2.8	87.35	10.21	2.44
Goa	94.6	3.1	2.4	86.82	11.33	1.85
Gujarat	96.1	2.9	1	81.22	12.14	6.64
Haryana	98.8	0.7	0.5	86.97	7.41	5.61
Himachal	98	1.7	0.3	82.74	15.14	2.02
Jammu	93.6	3.4	3.1	1.36	13.41	19.57
Jharkhand	90.4	7.7	1.9			
Karnataka	89.3	9.2	1.5	63.55	23.17	13.28
Kerala	88.7	10.1	1.2	73	16.28	10.72
Madhya	88.6	10.4	1	58.65	36.7	4.65
Maharashtra	95.5	4.1	0.4	81.8	15.31	2.89
Manipur	29.1	64.3	6.6	10.16	69.35	20.49
Meghalaya	88.3	11	0.7	62.07	20.75	17.18
Mizoram	92.1	7	0.9	51.63	40.85	7.52
Nagaland	72.7	24.7	2.6	38.78	52.55	8.67
Orissa	79.8	14.8	5.4	55.42	27.8	16.78
Punjab	98.2	1.3	0.5	91.96	4.7	3.34
Rajasthan	96.9	1.8	1.3	87.45	8.3	4.25
Sikkim	99.9	0.1	0	82.95	7.95	9.09
Tamil	87.7	8.6	3.6	69.25	17.22	13.53
Tripura	57.6	40.9	1.5	30.76	37.77	31.47
Uttarakhand	98	1.8	0.2			
Uttar	94	3.8	2.1	77.16	15.68	7.17
West	90.9	7.9	1.1	70.93	22.53	6.54
A	93.4	6.5	0.1	95.15	4.37	0.48
Chandigarh	97.5	2.3	0.2	91.73	7.86	0.41
Dadra	94.4	5.6	0	61.9	19.05	19.05
Daman	97.5	1.4	1.1	77.78	18.52	3.7
Lakshadweep	92.9	4.7	2.3	94.44	0	5.56
Puducherry	88.2	4.6	7.2	69.36	20.24	10.4
All-India	91.7	6.2	2.1	73.84	17.89	8.27

Table A 2.25 : State level Variation in Types of House (Rural)

	Rural 49	2008-09			1993-94		
S.No.	States	Pucca	Semi Pucca	all Kuccha	Pucca	Semi Pucca	Katcha
1	Andhra	70.2	16.2	13.6	37.47	23.33	39.2
2	Arunachal	26.2	19.9	53.7	5.52	11.13	83.45
3	Assam	20.6	42.7	36.6	7.5	21.62	70.88
4	Bihar	44.5	20	35.5	20.76	37.19	42.04
	Jharkhand	34.1	51.5	14.3			
5	Goa	77.4	22.2	0.4	61.57	34.76	3.56
6	Gujarat	62.3	29.2	8.5	39.94	38.37	21.69
7	Haryana	92.9	4.9	2.2	79.42	6.24	14.34
8	Himachal	78.5	20.7	0.8	55.05	38.86	6.09
9	Jammu	61	22.7	16.3	29.33	38.4	32.27
10	Karnataka	48.3	45.1	6.6	26.31	55.79	17.9
11	Kerala	77.3	19.2	3.5	55.3	25.74	18.96
12	Madhya	46.5	47.5	6	13.35	78.3	8.35
	Chhattisgarh	30.1	67.7	2.3			
13	Maharashtra	65.6	29.9	4.5	42.54	47.93	9.53
14	Manipur	12.1	59.7	28.1	3.15	37.89	58.96
15	Meghalaya	42.6	22.9	34.4	18.13	21.68	60.19
16	Mizoram	47	27.8	25.1	25.61	45.12	29.27
17	Nagaland	48.1	39	12.8	17.61	52.27	30.11
18	Orissa	32.8	26.6	40.6	12.06	28.35	59.59
19	Punjab	90.4	6.4	3.2	79.99	11.28	8.73
20	Rajasthan	65.3	19.3	15.4	46.08	23.55	30.37
21	Sikkim	55.9	35.1	9	36.35	27.5	35.95
22	Tamil	61	20.3	18.6	35.16	23.5	41.33
23	Tripura	10.6	74.6	14.8	2.69	19.24	78.09
	Uttarakhand	92.7	4.1	3.1			
24	Uttar	60.5	19.3	20.2	37.19	31.2	31.61
25	West	36.3	38.5	25.3	16.59	37.45	45.97
26	A	56.2	34	9.8	44.24	21.98	33.78
27	Chandigarh	99.7	0.3	0	87.57	9.47	2.96
28	D	37.2	48.1	14.7	1.66	90.04	8.71
29	Daman	90.7	6.5	2.9	74.11	23.21	1.79
30	Delhi	98.2	1.5	0.3	93.54	6.46	0
31	Lakshadweep	94.5	2.7	2.8	85.71	10.71	3.57
32	Pondicherry	56.6	13.4	30	25.15	29.74	45.11
33	All-India	55.4	27.6	17	32.28	36	31.72

Table A 2.26 : %age of Household by Source of Drinking Water for each State & U.T. (Sector:Rural)

S. No.	State/UTs	1993-94			2008-09		
		Tap	Tube Well, Hand Pump	Well	Tap	Tube Well, Hand Pump	Well
1	Andhra Pradesh	17.4	42.7	33.7	65.4	26.6	5.9
2	Arunachal Pradesh	66.3	3.8	3.7	81.1	11.2	3
3	Assam	8.4	46.6	31.6	6.4	65.4	18.2
4	Bihar	0.7	64.7	32.7	2	93.8	4.2
5	Chhattisgarh	0	0	0	8.1	81	10.1
6	Goa	60.3	5.9	27.7	85	0	15
7	Gujarat	52.6	18.5	21.5	58.9	28.4	8.7
8	Haryana	43.5	27.8	25.9	61.2	35.3	2.7
9	Himachal Pradesh	75.6	2.4	6.1	79.3	7.9	4.1
10	Jammu & Kashmir	29.3	23.3	10.7	66.5	16.9	1.1
11	Jharkhand	0	0	0	3.6	50.9	43.7
12	Karnataka	31.3	40.1	22.1	70.5	17.5	8.9
13	Kerala	12.8	2	83.3	15.8	2.6	77.8
14	Madhya Pradesh	5.6	43.8	46.7	9.4	73.9	15.5
15	Maharashtra	48.7	17.6	31.4	57.5	22.7	18.1
16	Manipur	39.2	6.9	6.9	25.7	10.4	3.7
17	Meghalaya	25.1	4.6	19.6	51	9.4	11.3
18	Mizoram	19.9	7.6	3	14.6	4.8	0.4
19	Nagaland	91.7	1.1	0	28.7	5.2	40.7
20	Orissa	0.6	45.6	43.6	5.9	73.3	17.7
21	Punjab	13.1	82.6	3.1	37	62.7	0
22	Rajasthan	22.1	30.9	40.1	29.2	48.3	10.7
23	Sikkim	77	0	0.3	67.4	0	0
24	Tamil	38.7	33.3	20.8	87.5	7.3	3.3
25	Tripura	23.4	33.6	35.1	27.6	43.7	23.6
26	Uttarakhand	0	0	0	61.1	23.3	0
27	Uttar Pradesh	6.6	58.6	33	2.7	92.6	4.6
28	West Bengal	4	79.2	14.3	8	84.8	5.4
29	A & N Is.	60.5	0	20.1	83.7	0.9	10.7
30	Chandigarh	83.7	16.3	0	91.6	8.4	0
31	D & N Haveli	5.7	47	30.8	31.6	51.5	16
32	Daman & Diu	68.8	20.5	2	55.5	44.5	0
33	Delhi	57.7	42.3	0	46.4	34.3	0
34	Lakshadweep	6	3.4	90.6	22.5	0.1	71.8
35	Puducherry	89.2	4.4	6.4	99.1	0.9	0
	All-India	18.9	44.5	31.7	30.6	54.7	11.8

Source : NSS Report No.429, 535 (2008-09): Housing Condition in India.



Table A 2.27 : % of Household by Source of drinking Water for each State & U.T. (Sector: URBAN)

S. No.	State/UTs	1993-94			2008-09		
		Tap	Tube Well, Hand Pump	Well	Tap	Tube Well, Hand Pump	Well
1	Andhra Pradesh	74.4	14.9	10	79.6	13.2	1.1
2	Arunachal Pradesh	100	0	0	88.4	3.8	7.4
3	Assam	43.6	39.8	14	36.9	41.1	19.8
4	Bihar	44.4	34	21.3	29.9	67	2.5
5	Chhattisgarh				61.5	37.3	0.5
6	Goa	89.9	1.8	8.2	87.7	0.3	4.5
7	Gujarat	85.4	7.9	1	87.2	11.6	0.2
8	Haryana	81.8	17.2	0.9	78.8	19.7	0
9	Himachal Pradesh	95.4	1.7	1.6	96.5	3	0.1
10	Jammu & Kashmir	92.5	2.6	2.7	94.3	5.5	0.2
11	Jharkhand				49.8	34.3	15.4
12	Karnataka	74.8	16.4	6.8	92.6	3.7	2.4
13	Kerala	40.3	1.4	56.2	43.2	4.1	52.5
14	Madhya Pradesh	66.2	18.5	13.5	69.9	23.6	5.8
15	Maharashtra	90.9	5.3	3.6	91.1	4.3	0.8
16	Manipur	68.4	7.4	0.5	66.6	7.4	1.4
17	Meghalaya	85.4	0.2	12.7	97.2	0.7	1.4
18	Mizoram	32.8	2.3	0.2	72.2	0.1	0
19	Nagaland	81.4	9.6	7.7	25.9	2.6	31.1
20	Orissa	48	29.4	20	64.7	22.3	12.5
21	Punjab	67.6	31.8	0.3	83.2	16.8	0
22	Rajasthan	83.7	11.1	4.7	87.6	7.9	0.7
23	Sikkim	97.7	0	0	98.7	0	0
24	Tamil	67.1	12.9	8.4	89.1	7.1	0.8
25	Tripura	66.8	18.3	12.3	60.6	33.7	3.3
26	Uttar Pradesh	54.1	39.7	6.1	48.7	50.8	0.4
27	Uttarakhand				75	25	0
28	West Bengal	61	31.4	6.6	71.1	26.2	1.8
29	A & N Is.	99.6	0	0.1	100	0	0
30	Chandigarh	100	0	0	99.1	0.9	0
31	D & N Haveli	56.4	43.7	0	80.2	18.3	0
32	Daman & Diu	81.2	5.3	2.1	95.9	1.4	2.5
33	Delhi	88.7	11.3	0	89.5	8.7	0
34	Lakshadweep	14	9	75.9	9.7	14.9	73.6
35	Puducherry	94.1	0	5.4	97.6	0.3	2
	All-India	70.4	18.5	8.6	77	17.5	3.3

Source : NSS Report No.429, 488(2002) and 535 (2008-09): Housing Condition in India.

Table A 2.28 : %age of Household by type of Sanitation for each state & U.T. (Sector: Rural)

S.No.	state/u.t.	2008-09				1993-94			
		No Latrine	Service Latrine	Flush System/ Septic Tank	Others	No Latrine	Service Latrine	Flush System/ Septic Tank	Others
1	Andhra Pradesh	64.3	1	29.9	4.4	87	2.6	5.7	4.5
2	Arunachal Pradesh	16.2	5.3	23.9	52.7	8.4	15.7	2.2	43.6
3	Assam	13.5	2.2	18.2	65.3	29.6	16	7.1	47.1
4	Bihar	79.8	1	11.8	6.7	92.6	1.1	4.3	1.5
5	Chhattisgarh	82.3	0.2	11.3	4.9				
6	Delhi	7.5	0	84.5	8.1	43.8	0.3	55.9	
7	Goa	36.2	0.1	40.6	23.1	69.6	5.8	16.6	8
8	Gujarat	67.3	0.1	26	6.3	83.1	1	12.4	3.6
9	Haryana	45.3	0.1	29.6	24.7	93.5	0.5	4	1.3
10	Himachal Pradesh	46.5	0.5	47.8	4.9	86.9	0.8	10.4	1.8
11	Jammu & Kashmir	34.9	19.1	17.2	28	96.1	0.4	2.5	0.9
12	Jharkhand	84.1	0.2	7.3	7.8				
13	Karnataka	75.2	0.4	7.4	16.8	88.8	0	7.7	3.1
14	Kerala	5.3	0.3	21.7	71.9	33.1	0.2	27.4	39
15	Madhya Pradesh	85.3	0.3	10.5	3.2	97.3	0.5	1.5	0.2
16	Maharashtra	60.7	0.6	31.6	6.6	92.4	1.9	5.2	0.3
17	Manipur	1.1	9.4	21.8	67.5	15	16.1	2.7	66.2
18	Meghalaya	11.4	4.3	14.8	68.8	55.1	0.4	3.1	40.9
19	Mizoram	1.2	1.1	32.1	65.5	2.1	14.6	3.1	80.3
20	Nagaland	3.1	2.2	32.6	60.6	1.2	29.9	8.1	60.8
21	Orissa	88.2	1.3	7.3	2.9	97.4	0.3	1.4	0.6
22	Punjab	36.2	0.8	32.1	30.8	79.2	1	17.9	1.7
23	Rajasthan	82.1	0.6	8.2	9.1	90.3	1.3	4.4	3.2
24	Sikkim	2.5	0.1	68.9	28.6	38.9	2.5	22.4	36.3
25	Tamil	73.5	0.5	23.7	1.5	91.7	0.9	6.7	0.7
26	Tripura	3.4	0.9	5.2	90.1	6.6	14	3	76.3
27	Uttar Pradesh	79.2	1.5	12.6	6.4	91.1	4.3	3.9	0.4
28	Uttarakhand	53.5	1.3	23.2	21.9				
29	West Bengal	41.7	3.4	14.8	39.5	83.1	3.5	7.1	6.3
30	A & N Is.	39.9	0	47.5	12.6	67.9	2	19.3	10.9
31	Chandigarh	9.6	0	90	0	67.9		32.1	
32	D & N Haveli	53.2	0	32.2	14.4	93.6		6.4	0.1
33	Daman & Diu	31.9	2	8.4	57.9	74		26	
34	Lakshadweep	0	0	21.7	78.3	8.1		17.4	74.4
35	Puducherry	65.4	0	34.6	0	91	2.7	6.3	
	All-India	65.2	1.2	17.9	15.2	85.8	2.4	6.3	5.2

Source : NSS Report No.429, 488(2002) and 535 (2008-09): Housing Condition in India.

Table A 2.29 : % of Household by Type of Sanitation for each State & U.T. (Sector: Urban)

S.No.	States/UTs	1993-94				2008-09			
		No Latrine	Service Latrine	Flush System/ Septic Tank	Others	No Latrine	Service Latrine	Flush System/ Septic Tank	Others
1	Andhra Pradesh	36.8	3.3	56.4	3.5	11.2	0.7	85.3	2.1
2	Arunachal Pradesh	6	8.9	56.9	28.2	0.1	11.6	61.5	25.7
3	Assam	7	14.7	58.3	19.8	0.9	0.2	84.8	13.6
4	Bihar	35.1	7.2	53.4	4	27.7	2.1	61.9	7.5
5	Chhattisgarh					31.5	0.5	64.3	3.1
6	Goa	22.3		70.9	6.9	9.6	0.2	87.6	1.4
7	Gujarat	27.2	0.8	70.7	0.8	7.3	0.7	79.5	12.1
8	Haryana	31.6	7.5	60.1	0.9	8.4	1.9	73.5	16.2
9	Himachal Pradesh	27	5.3	66.4	1.1	8.8	1	87.5	2.7
10	Jammu & Kashmir	32.1	26.7	39	1	11.8	3.2	71.3	13.5
11	Jharkhand					24.5	0.9	70.6	3.5
12	Karnataka	35.2	2.1	58.2	4.5	11.3	1.1	72.8	14
13	Kerala	15.7	0.2	50.6	33.2	1.5	0.1	50.6	46.8
14	Madhya Pradesh	43.3	9.9	46.3	0.4	24.3	1.4	66.2	6.7
15	Maharashtra	23.1	2.9	73.3	0.5	5.9	1.4	89.4	2.8
16	Manipur	5.1	11.1	13.2	70.7	0	9.3	51.6	39.1
17	Meghalaya	1.3	17.9	61	19.9	0.2	5.1	79.1	15.6
18	Mizoram	0.4	0.1	21.1	78.4	0	0.2	82.3	17.6
19	Nagaland	0.9	28.2	44.6	26.3	1.3	1.5	70.1	23.8
20	Orissa	55.4	5.8	36.9	1.9	29.1	3.6	56.2	8.4
21	Punjab	21.1	7.1	69.1	2.7	5	2.3	84.1	8.4
22	Rajasthan	37.2	7.3	50.5	4.6	12.6	0.8	70.3	16.3
23	Sikkim	8.5	28.4	51.4	11.7	0	0	98.9	1.1
24	Tamil	36.1	6.4	56.6	0.9	16	1.3	79.1	1.1
25	Tripura	0.6	7.9	49.9	41.6	0.9	0	48.6	50.5
26	Uttarakhand					3.3	0.9	70.6	24.9
27	Uttar Pradesh	32.5	23.5	43.1	0.8	14.2	4.4	72.8	8.1
28	West Bengal	21.2	5.6	65.5	7.5	5.6	2.2	73.4	17.6
29	A & N Is.	23	5.2	69	2.5	6.1	0	93.9	0
30	Chandigarh	11.3		88.4	0.3	0.6	0	99.4	0
31	D & N Haveli	30.7	4.2	65.1		7.1	0	87.1	6.1
32	Daman & Diu	35.2		64.3	0.6	6.4	6.3	86.7	0.7
33	Delhi	29.4	11.1	57.7	1.6	1.2	1.2	92.8	4.1
34	Lakshadweep	28.9		25.3	45.8	1	0.9	62	33.9
35	Puducherry	19.3	3.6	74.8	2.4	9.1	3.7	84.8	2
	All-India	30.6	7.4	58.1	3.8	11.3	1.6	77.3	9

Source : NSS Report No.429 and 535 (2008-09): Housing Condition in India.

Table A 2.30 : % of Households with Electricity for Domestic use for each State/UTs

	State/UTs	1993-94		2008-09	
		Rural	Urban	Rural	Urban
Major States	Andhra Pradesh	49.9	81.4	93.2	97.5
	Assam	15.6	74	40.2	94.6
	Bihar	6.7	67.8	24.5	79.4
	Gujarat	66.1	86.4	89.7	99
	Haryana	74.4	90.5	93.4	98.3
	Karnataka	50	78	94.1	97.9
	Kerala	53.5	77.3	92.7	97.9
	Madhya Pradesh	42.7	81.5	81.3	96.9
	Maharashtra	60.9	90.5	81.9	98.5
	Orissa	14.6	62.5	44.9	90.1
	Punjab	85	94.1	96.5	99.3
	Rajasthan	37.7	85.9	63.8	97
	Tamil	50.5	81.6	92.6	97.8
	Uttar Pradesh	17.5	72.2	37.6	89.8
	West Bengal	10.3	68.6	49.5	93.3
North East/Hilly/Others	Arunachal Pradesh	27.3	87.3	77.9	98.5
	Chhattisgarh			81.1	96.7
	Goa	92.2	87.8	99.5	97.3
	Himachal Pradesh	89.1	95.7	98.6	99.4
	Jammu & Kashmir	74.1	98.2	95.9	97.5
	Jharkhand			43	93.9
	Manipur	58.1	92.6	86.8	99.5
	Meghalaya	27.2	89.8	69.8	99.3
	Mizoram	61.4	91.3	81.9	99.8
	Nagaland	68.4	94	99	100
	Sikkim	65.3	91.9	95.8	99.4
	Tripura	30.2	83.5	66.1	95.3
	Uttarakhand			85.5	98.6
UTS	A & N Is.	66	96.8	84.5	98.5
	Chandigarh	77.6	90.2	100	98.5
	D & N Haveli	77	87.9	100	100
	Daman & Diu	97.2	95.8	100	97.4
	Delhi	100	93.6	96	98.6
	Lakshadweep	99.9	97	100	100
	Puducherry	62.9	94.3	95.2	99.3
	All-India	36.5	80.9	66	96.1

Source : NSS Report No.429, 488(2002) and 535 (2008-09): Housing Condition in India.

Table A 2.31 : Physical Progress of PMGSY under duration of Bharat Nirman

S. No.	States	Habitations Coverage			New Connectivity length in km		
		Target (2005-09)	Cumulative Achievements	Cumulative Achievements in %	Target (2005-09)	Cumulative Achievements	Cumulative Achievements in %
1	Andhra Pradesh	236	21	9%	0	1043.73	NR
2	Arunachal Pradesh	104	51	49%	2118.75	634.01	30%
3	Assam	4445	3233	73%	13153.22	6522.87	50%
4	Bihar	9956	2424	24%	18946.31	3385.72	18%
5	Chhattisgarh	3831	3074	80%	20574.8	10534.68	51%
6	Goa	2	2	100%	0	1.8	NR
7	Gujarat	1332	1052	79%	1710.03	2277.45	133%
8	Haryana	0	0	0%	0	42.8	NR
9	Himachal Pradesh	922	596	65%	2378.13	4022.27	169%
10	Jammu & Kashmir	1468	458	31%	4416.43	1057.21	24%
11	Jharkhand	2991	897	30%	7777.78	2685.22	35%
12	Karnataka	17	17	100%	0	71.5	NR
13	Kerala	73	61	84%	0	128.16	NR
14	Madhya Pradesh	7055			27561.61	22427.39	81%
15	Maharashtra	295	263	89%	0	1062.55	NR
16	Manipur	249	83	33%	1744.05	892.74	51%
17	Meghalaya	128	34	27%	543.88	163.12	30%
18	Mizoram	130	28	22%	941.95	758.35	81%
19	Nagaland	37	24	65%	421.84	679.6	161%
20	Orissa	5672	3350	59%	9993.35	8090.51	81%
21	Punjab	50	50	100%	0	177.97	NR
22	Rajasthan	3009	2966	99%	11460.85	10376.43	91%
23	Sikkim	154	91	59%	419.17	813.1	194%
24	Tamil Nadu	83	79	95%	0	651	NR
25	Tripura	810	339	42%	1158.88	741.62	64%
26	Uttar Pradesh	3874	3917	101%	7794.96	9458.11	121%
27	Uttarakhand	771	229	30%	2848.56	2063.49	72%
28	West Bengal	6954	3775	54%	10220.81	6819.61	67%
	Total	54648	33812	62%	146185.34	97583	67%

Note Cumulative achievement is the achievement upto Dec., 2009 against the overall target for 2005-09.

Source : Annual Report 2009-10, MoRD

Table A 2.32 : State Level Variation in Length of Road per hundred Sq km

State Category	States	2008	1999
Major States	Andhra Pradesh	79.3	65.18
	Assam	293.7	109.35
	Bihar	127.6	94.98
	Gujarat	74.8	47.62
	Haryana	67.2	65.30
	Himachal	65.2	52.70
	Karnataka	133.2	79.22
	Kerala	526.9	381.70
	Madhya	53.8	66.12
	Maharashtra	72.6	124.06
	Orissa	138.3	168.59
	Punjab	89.7	128.17
	Rajasthan	50.1	41.16
	Tamil	139.3	117.71
	Uttar Pradesh	532.3	532.44
	West Bengal	238.6	89.30
Small/Hilly States	Arunachal Pradesh	19.7	21.82
	Chhattisgarh	55.1	
	Goa	285.5	263.45
	Jammu	10	10.75
	Jharkhand	22	
	Manipur	73.9	51.21
	Meghalaya	43.9	40.69
	Mizoram	29.2	22.99
	Nagaland	134.5	122.67
	Sikkim	26.4	26.09
	Tripura	302.6	148.44
	Uttarakhand	17	100.00
UTs	Andaman & Nicobar	15.8	13.67
	Chandigarh	1857.9	1604.39
	Dadra & Nagar Haveli	128.7	109.16
	Daman & Diu	200	227.68
	Delhi	1993.2	1861.83
	Lakshadweep	537.5	
	Pudducherry	562.8	525.26
India		92.7	75.55

*Includes roads reported as construction under JRY and PMGSY

Source : Government of India, Ministry Of Road Transport and Highways Transport Research Wing, New Delhi, July 2010

Table A 2.33 : State Level Variation in Tele Density

State Category	States Name	2000			2010		
		Total	Rural	Urban	Total	Rural	Urban
Major States	Andhra Pradesh	3.17	9.05	0.98	70.27	31.28	171.99
	Assam	1.06	6.99	0.2	35.88	22.16	114.11
	Bihar	0.8	6.12	0.17	50.07	25.81	256.45
	Haryana	3.21	8.76	0.95	77.49	47.55	136.77
	Himachal Pradesh	4.85	21.93	3.0	104.86	69.7	388.78
	Karnataka	3.77	8.61	1.28	82.25	32.28	166.84
	Kerala	5.77	11.08	3.9	96.67	51.26	228.94
	Madhya Pradesh	5.78	20.26	0.52	57.67	26.61	138.92
	Maharashtra	2.89	5.5	0.96	63.88	41.9	105.78
	Orissa	1.2	5.95	0.36	52.31	26.8	179.24
	Punjab	5.59	12.15	1.91	97.97	53.32	162.14
	Rajasthan	2.03	6.71	0.6	62.37	36.73	144.01
	Tamilnadu	5.9	9.88	0.51	93.89	46.02	145.9
	Uttar Pradesh	2.02	11.05	0.29	47.84	32.6	141.12
	West Bengal	1.8	6.61	0.34	47.635	27.25	111.535
Hilly/N-E States	Chhatisgarh	N.A	N.A	N.A	5.94	2.69	16.83
	Gujarat	4.12	9.22	1.09	76.12	43.69	124.23
	Jammu & Kashmir	1.31	4.96	0.1	46.62	28.02	97.46
	Jharkhand	N.A	N.A	N.A	6.0	2.32	18.12
	North East	3.12	11.04	0.82	47.635	27.25	111.535
	Uttaranchal	N.A	N.A	N.A	15.54	9.37	31.15
UTS	Andaman & Nicobar Islands	6.98	11.65	4.71	41.38	30.64	58.2
India		2.9	8.44	0.66	66.17	31.22	147.52

Source : Annual Report, Department of Telecommunication, 2000 & 2010-11

Table A 2.34 : Number of Internet Subscribers and their % to Total Subscribers

State/Telecom Circle	Internet Subscribers		% to Total Internet Subscribers	
	(As on 31.03.2009)	(As on 31.03.2010)	(As on 31.03.2009)	(As on 31.03.2010)
Andhra Pradesh	975594	1153571	7.15	7.16
Assam	70290	75625	0.52	0.47
Bihar (Including Jharkhand)	179043	213924	1.31	1.33
Gujarat	739167	893258	5.42	5.55
Haryana	254467	303994	1.86	1.89
Himachal Pradesh	59663	78483	0.44	0.49
Jammu and Kashmir	83985	90999	0.62	0.57
Karnataka	1093617	1363872	8.01	8.47
Kerala (Including Lakshadweep)	898009	1155399	6.58	7.18
Madhya Pradesh (Including Chattisgarh)	503708	626406	3.69	3.89
Maharashtra (Including Goa)	2937570	3329934	21.53	20.68
Orissa	152280	198062	1.12	1.23
Punjab	538759	708352	3.95	4.40
Rajasthan	582968	658298	4.27	4.09
Tamil Nadu (Including Puducherry)	1404983	1657218	10.30	10.29
Uttar Pradesh (Including Uttarakhand)	644735	794918	4.72	4.94
West Bengal (Including Sikkim)	860700	929192	6.31	5.77
North East **	84287	99432	0.62	0.62
Andman and Nicobar Islands	6780	8119	0.05	0.05
Delhi*	1576095	1763370	11.55	10.95
India	13646700	16102426	100.00	100.00

Source : Department of Telecommunication

Table A 2.35 : A Brief Quotient of Influential Cases at the Higher Judiciary

The following are a list of, non-exhaustive but important, litigations that have left a mark when judiciary had to directly or otherwise exercise its interventionist judicature:

Case: Title & Nature	Nature of the Case	Judgement and its Importance
Fertilizer Corporation Kamagar Union vs. Union of India [AIR 1981] SC 344 ¹ Supreme Court	Petitioners challenged sale of certain plants of the FCI as being unconstitutional, and infringing their fundamental right to livelihood under provisions of the Art. 19, 21, 14 etc. et al of Constitution. It also impinged upon the issue of access to judicial remedy and that of the Court's Constitutional role of balancing State powers.	Court ruled that such sale was not unconstitutional and that the employees were provided remedial employment in another plant within the premises. However, there were excerpts in the judgement, which have bearing upon public administration. The Court viewed that, ubi jus ibi remedium ² ought to be expanded in the interests of access to justice of the common man. Justice Krishna Iyer said that, PIL is all about 'policing the corridors of power' until some other efficacious monitoring arrangements could be made. (at 359)
Bandhua Mukti Morcha vs. Union of India [AIR 1984] 3 SCC 161, Supreme Court Against exploitation of children working as bonded labour, especially in the Carpet industry in Uttar Pradesh, violative of Art. 243 and Art. 39 (e) and (f)4 of the Constitution		Court asserted that 'vulnerability may preclude the person directly affected from taking any action.' (Justice A.N. Sen). Justice Bhagwati said that if a person was physically or economically unable to approach the Court, he/she may do so 'just by writing a letter', because the legal system would otherwise be inaccessible to some of its citizens.
M.C. Mehta vs Union of India [1986] 2 SCC 176 in Supreme Court Environmental (pollution) litigation, involving public enterprises manufacturing caustic soda and other chemicals and gases. This litigation was treated as 'representative action'.		Exercising its power to interfere under Article 32 of the Constitution, the court heard all the concerned industries along the river Ganges (getting polluted) and then went on to close many of them. It also ordered that effluents in the river Ganga must be treated.
Sheela Barse vs. Union of India [1986] 3 SCC 596 in Supreme Court PIL under Art 32 of Constitution of India for the release of all children below 16 years of age detained in jails in various states of the country.		Court ordered all states that have legislations for (protection of) children to explain in 3 weeks the reason for delay in implementing those statutes; providing information on such children, release of such children along with other various protective measures including setting up of juvenile courts.
Olga Tellis vs. Bombay Municipal Corporation, A.I.R. [1985] 3 SCC 545, Supreme Court PIL under Art 32 in matter relating to the eviction of pavement dwellers from the streets of Bombay as infringing upon their fundamental right to life u/Art 21, thereupon livelihood, the question of 'trespassers' in any public property in a welfare state, etc.		Relying on published empirical data and studies, the Court concluded that the rights to life and livelihood of the pavement dwellers would be affected by their eviction. Considering whether the right to life includes the right to livelihood, the Court commented, 'The sweep of the right to life contained in Article 21 is wide and far-reaching ... and includes the right to a livelihood.' (at 572)

Case: Title & Nature	Nature of the Case	Judgement and its Importance
Vellore Citizens' Welfare Forum Vs. Union of India and Others, (1996) 5 SCC 647, Supreme Court PIL under Art. 32 against the pollution caused by enormous discharge of untreated effluent originating from the tanneries and other industries in the State of Tamil Nadu, damaging agricultural fields, road sides, water ways and open lands.		It was ruled that, the State Government and the statutory authorities must anticipate, prevent and attack the causes of environmental degradation ⁵ . Where there are threats of serious and irreversible damage, lack of scientific certainty should not be used as a reason for postponing measures to prevent environmental degradation. The "onus of proof" is on the actor or the developer to show that his action is environmentally benign.
Narmada Bachao Andolan vs. Union of India (2000) 10 SCC 664, 727.	Writ petition seeking relief and rehabilitation of people affected by acquisition of their land for building Sardar Sarovar Dam. It was contended that they are entitled to rehabilitation packages of the government's agencies. This case was based on 'Precautionary principle' in environmental law.	Besides shifting the burden of proof not only to the governments of States or their authorities but also to the industry, the Court in this case added a controversial and questionable extension in environmental law.
S.C. Writ Pet. (Civil), M.C. Mehta vs. Union of India (July 28, 1998) (No. 13029/1985) Supreme Court Add in text above, activist role of court	Failure of implementing agencies to limit extent of air pollution in Delhi, notwithstanding adequate legislation in place, prompted the Court to act on its own.	Having relied up on Arts. 39A, 47 and 48A of the Constitution, the court reminded the Union government and the Govt. of Delhi that it is incumbent upon the State to secure the health of the people, improve public health and protect and improve the environment, the Court suo motu mandated the conversion of diesel-powered buses operating in Delhi to compressed natural gas (CNG). However, the Court also agreed upon a gradual phasing out of non-CNG buses on time-barred policy.
Mohini Jain vs. State of Karnataka, (1992) 3 SCC 666. Supreme Court What finally happened?	Petition seeking constitutional right to education in the face of capitation fee demand.	Having examined the validity of a State issued notification that 'capitation fees' was charged from non-meritorious students, the Court opined, 'Charging capitation fee in consideration of admission to education institutions is a patent denial of a citizen's right to education under the Constitution.'
Unni Krishnan vs. State of A. P., (1993) 1 SCC 645 Supreme Court	Right to education. It also addressed other issues like whether Article 19(1)(g) of the Constitution guaranteed a right to establish an educational institution	Confirming the right to life under Art 21 of the Constitution also included right to education, yet in view of Art. 45 read with Art. 41 of the Constitution, the Court's ruling were that 'right' to free education is restricted only up to fourteen years of age. Beyond that age, this right is subject to the State's financial constraints.
Consumer Education & Research Centre vs. Union of India, (1995) 3 SCC 42 Supreme Court	Petitioner sought to petitioner seeks to fill in the yearning gaps and remedial measures for the protection of the health of the workers engaged in mines and asbestos industries with adequate mechanism for and diagnosis and control of the silent killer disease "asbestosis".	Court ordered State of Gujarat to pay compensation under Employees' State Insurance Act and the Workmen's Compensation Act for workers in hazardous asbestos industry. Incorporated certain additional rules under International Labour Organization (ILO) and made them binding for 'all industries' in future.
Paschim Banga Khet Mazdoor Samity vs. State of W. B., (1996) 4 SCC 37. Supreme Court	Writ petition on right to obtain treatment under right to health falling within an expanded ambit of right to life under Art. 21 of the Constitution	Court said, "failure on the part of a government hospital to provide timely medical treatment to a person in need of such treatment results in violation of his right to life guaranteed under Article 21." It awarded compensation in excess of spent amount by the petitioner in receiving treatment in private hospital.

Case: Title & Nature	Nature of the Case	Judgement and its Importance
Rakesh Chandra Narayan v. State of Bihar, AIR (1989) SC 348 Supreme Court	Letter to the Chief Justice of India on condition of hospitals for mentally challenged treated as a PIL under Art. 32 of the Constitution	Court ordered Chief Judicial Magistrate, Ranchi to investigate the matter and whose report brought to light under-staffing, acute water shortage and unusable toilets in those hospitals. It directed the Bihar government to take care of things. However, upon failure, it itself constituted committee that would look into all aspects of its functioning, and would report to it on its progress. The fact that the Court itself taking the remedy out of the State's direct control suggests that upon ignorance of its directions, it may further strengthen the remedy, and thereby, its enforcement.
PM. Bhargava vs University Grants Commission AIR 2004 SC 3478 Supreme Court	PIL in Andhra Pradesh High Court against introduction of 'Jyotir Vigyan' as a curriculum of study by the University Grants Commission.	
Indra Sawhney vs. India, A.I.R. 1993 S.C. 477: 1992 Supp (3)SCC 217 Supreme Court	Writ (civil) petition challenging implementation of separate reservation for Other Backward Classes (OBCs) in central government jobs.	Court upheld implementation of separate reservation for other backward classes (OBCs) in government jobs. Important criteria set like exclusion of 'creamy layer' among OBCs in enjoying such reservation, and maximum limit of reservation should not in any way, exceed 50% of the total number of seats. It directed the Union government, and all states except Tamil Nadu, to spell out the criteria for identifying the creamy layer among the OBCs.
Ashok Kumar Thakur vs. Union of India & Ors, I.A. No.13 In Writ Petition (Civil) No. 265 OF 2006 --- (With WP (Civil) Nos. 269/2006, 598/2006, 35/2007 and 29/2007)	PIL against 93 rd Constitutional Amendment sought by the Union government for introduction of 27% reservation for 'other backward classes'	It was held that the Mandal Commission was flawed since its projection of OBCs as high as 52% was contradicted by NSSO, putting it only 32%. It also noted that the reservation discriminates against 'meritorious' candidates, not belonging to socially disadvantaged sections. due to caste, race or ethnicity.
A.S.T. 205 of 2007 Association for Protection of Democratic Rights Vs. The State of West Bengal & Ors Intervening court - High Court of Calcutta	Writ petition acted upon within suo motu jurisdiction, termed as special jurisdiction (contempt)	The court took serious note of gun-firing on people protesting against their land acquisition, causing a lot of deaths in Nandigram, West Bengal. Not only the Chief Justice reprimanded the home department & the Government of W. Bengal for their failure in taking preventive steps, it also directed the CBI to make a comprehensive inquiry into the incident and submit its report to the Court within one month.
OOS No. 1 of 1989 Shri Gopal Singh Visharad Vs. Zahur Ahmad and 8 others, OOS No. 3 of 1989 Nirmohi Aakhada etc. Vs. Baboo Priya Dutt Ram and others, OOS No. 4 of 1989 Sunni Central Board of Waqfs U.P. Lucknow and others Vs. Gopal Singh Visharad and others and O.O.S.No. 5 of 1989 Bhagwan Sri Ram Virajman at Ayodhya and others Vs. Rajendra Singh Allahabad High Court	Consolidated judgement on a series of title suits	Court admitted existence of Ram temple and its demolishing before the Babri mosque was built. Basing its views upon 'faith of millions of Hindus....' it pronounced for the trifurcation of the site into three parts: one part to each of the parties to the title suits, i.e., one for Hindus, another for Muslims and the third for Nirmohi Akhara, a Hindu sect, an original litigant in the case. Is it sub-justice? An appeal currently under process at the Supreme Court.

Table A 3.1 : State Level Variation in Physical Performance of NSAP

State Category	States	No. of Beneficiaries Reported					
		1999-00		2009-10			
		NOAPS	NFBS	IGNOAPS	NFBS	IGNWPS	IGNDPS
Major States	Andhra Pradesh	466000	18323	919230	4576	276314	58723
	Assam	60830	3317	628949	15000	N.A	N.A
	Bihar	691569	12679	2133678	12474	43382	2435
	Gujarat	8860	514	184863	3419	N.A	404
	Haryana	17520	389	130306	N.A	N.A	N.A
	Himachal Pradesh	11370	242	85637	564	N.A	N.A
	Karnataka	172866	3777	833927	2780	N.A	N.A
	Kerala	117042	3949	141956	N.A	N.A	N.A
	Madhya Pradesh	584137	23407	1066051	5819	171935	107199
	Maharashtra	69916	5937	1024364	5000	160400	125364
	Orissa	355832	13003	643400	N.A	10315	5677
	Punjab	0	96	159292	1446	N.A	N.A
	Rajasthan	400648	3521	494179	N.A	N.A	N.A
	Tamil Nadu	3249189	9676	888825	3927	357014	119105
	Uttar Pradesh	857628	18392	3280512	39514	1121500	56300
	West Bengal	337000	5495	1191716	16525	N.A	N.A
Small/Hilly States	Arunachal Pradesh	142	26	14500	N.A	N.A	N.A
	Chhattisgarh	N.A	N.A	497127	3482	N.A	N.A
	Goa	2195	255	2687	131	N.A	N.A
	Jammu & Kashmir	17474	204	97372	N.A	N.A	N.A
	Jharkhand	N.A	N.A	643000	5965	130000	30000
	Manipur	4665	84	72514	N.A	N.A	N.A
	Meghalaya	8761	101	36794	1197	N.A	N.A
	Mizoram	3440	73	23747	614	1192	587
	Nagaland	546	407	28053	600	200	631
	Sikkim	0	0	18779	N.A	N.A	N.A
	Tripura	15499	288	136592	1024	N.A	N.A
	Uttaranchal	N.A	N.A	162141	555	7054	1840
Uts	A & N Islands	0	0	861	N.A	4568	N.A
	Chandigarh	1763	20	4464	106	2915	74
	Dadra & Nagar Haveli	0	0	6956	N.A	N.A	N.A
	Daman & Diu	262	1	95	N.A	5	4
	Delhi	0	0	121974	400	N.A	2011
	Lakshadweep	0	0	36	N.A	N.A	N.A
	Pondicherry	1500	1	20757	N.A	16945	N.A
India		7456654	124177	15695334	125118	2303739	510354

Source : Annual Report, 1999-00 & 2009-10, Ministry of Rural Development, GoI

Table A 3.2 : State-wise Benefited Children under MDM

States Category	States Name	Number of Children Benefited	
		2001-02	2009-10
Major States	Andhra Pradesh	7758454	6107962
	Assam	3057221	4132618
	Bihar	7252547	11241336
	Gujarat	4856615	3820600
	Haryana	1617412	1993615
	Himachal Pradesh	668604	741014
	Karnataka	5585159	5502935
	Kerala	2334680	2902204
	Madhya Pradesh	7482769	9003584
	Maharashtra	10125032	12187761
	Orissa	4423250	5525792
	Punjab	1659750	1855841
	Rajasthan	6221663	5982376
	Tamil Nadu	5800543	5026843
	Uttar Pradesh	15837747	850551
	West Bengal	9581419	9216678
Hilly/Small States	Arunachal Pradesh	143500	174379
	Chhattisgarh	2717758	3027221
	Goa	80284	163208
	Jammu & Kashmir	716592	1056126
	Jharkhand	2085571	4031582
	Manipur	279648	225718
	Meghalaya	419112	471738
	Mizoram	98239	150569
	Nagaland	159664	221368
	Sikkim	80670	89432
	Tripura	474655	468621
	Uttarakhand	763093	12713580
UTS	Andaman & Nicobar Islands	38461	36900
	Chandigarh	18662	61311
	Dadar & Nagar Haveli	25807	35261
	Daman & Diu	15124	15227
	Delhi	1010533	1318353
	Lakshadweep	N.A	10192
	Pondicherry	62349	91298
India		103452587	110453794

Source : www.indiastat.com

Table A 3.3 : School Covered under CDMD in Selected Sample State

States Category	States Name	Total Schools	Enrolment	School Covered under CDMD	No. of Uncovered schools
Major States	Andhra Pradesh	60780	6033039	60780	0
	Bihar	69204	12858653	69204	0
	Haryana	16589	2549331	12744	3845
	Himachal Pradesh	10982	529843	10982	0
	Kerala	10913	2160354	10913	0
	Madhya Pradesh	94905	8891737	94905	0
	Maharashtra	85821	9014434	79918	5903
	Punjab	20494	1767825	0	4506
	Rajasthan	74690	6960000	74690	0
	Tamil	34710	4826835	34710	0
	Uttar Pradesh	107377	18917189	107377	0
Small/Hilly States	West Bengal	74993	10206608	69814	5179
	Arunachal Pradesh	4593	218905	4593	0
	Jammu	26648	1484887	23091	3557
	Jharkhand	38524	5048908	37923	601
	Meghalaya	7640	627596	7640	0

Source : Performance Evaluation of Cooked Mid Day Meals, Planning Commission, May, 2010

Table A 3.4 : State-wise Performance of MGNREGA Performance, 2008-09

State Category	State Name	State Average Days Provided per Households who Got Work	Man-Days of Work	Expenditure (Rs crore)	Households Provided Work with (lakh)
Major States	Andhra Pradesh	48	2,735	2964	57
	Assam	40	749	950	19
	Bihar	26	991	1320	38
	Gujarat	25	213	196	9
	Haryana	43	69	110	2
	Himachal Pradesh	46	204	332	4
	Karnataka	32	289	358	9
	Kerala	22	154	224	7
	Madhya	57	2947	3551	52
	Maharashtra	45	400	338	9
	Orissa	35	381	597	11
	Punjab	31	40	72	1
	Rajasthan	76	4827	6171	63
	Tamil Nadu	38	1199	1004	31
	Uttar Pradesh	54	2341	3582	43
	West Bengal	26	764	911	30

Small/Hilly States	Arunachal Pradesh	54	14	15	0
	Chhattisgarh	55	1244	1434	23
	Jammu & Kashmir	36	61	66	2
	Jharkhand	48	750	1327	16
	Manipur	64	237	300	4
	Meghalaya	38	86	89	2
	Mizoram	73	125	159	2
	Nagaland	68	203	272	3
	Sikkim	49	25	44	1
	Tripura	60	328	452	5
	Uttarakhand	35	104	136	3
All-India		48	21479	26975	445

Source : Mid Term Appraisal, 11th Plan, Planning Commission, GoI

Table A 3.5 : Coverage of Women under MGNREGA, 2008-09

State Category	State Name	Women as Percent of Persons Employed
Major States	Andhra Pradesh	58
	Assam	27
	Bihar	30
	Gujarat	43
	Haryana	31
	Himachal Pradesh	39
	Karnataka	50
	Kerala	85
	Madhya	43
	Maharashtra	46
	Orissa	40
	Punjab	25
	Rajasthan	67
	Tamil Nadu	80
	Uttar Pradesh	18
	West Pradesh	27
Small/Hilly States	Arunachal Pradesh	26
	Chhattisgarh	47
	Jammu & Kashmir	6
	Jharkhand	29
	Manipur	46
	Meghalaya	41
	Mizoram	37
	Nagaland	37
	Sikkim	38
	Tripura	51
	Uttarakhand	37
All-India		48

Source: Mid Term Appraisal, 11th Plan, Planning Commissio

**Table A 3.6 : State-wise Prevailing Minimum Wage rate under MNREGA
as per notified by the Central Govt. on 1.1.2009**

States Category	States	Wage rate (in Rs. Per day)
Major States	Andhra Pradesh	80.0
	Assam	79.6
	Bihar	81.0
	Gujarat	100.0
	Haryana	141.0
	Himachal Pradesh	100.0
	Karnataka	82.0
	Kerala	125.0
	Madhya Pradesh	91.0
	Maharashtra	Rs. 72, RS.70, RS68, & Rs.66 respectively for Zone I,II,III,IV
	Orissa	70.0
	Punjab	Hoshiarpur-Rs. 98.61 Jalandhar Rs. 93, Nawanshar- Rs.94.91, Amritsar Rs.105
	Rajasthan	100.0
	Tamil Nadu	80.0
	Uttar Pradesh	100.0
	West Bengal	75.0
Small/Hilly States	Arunachal Pradesh	Area-i(Rs.65), Area-ii(Rs. 67
	Chattisgarh	110.0
	Goa	70.0
	Jammu & Kashmir	Rs. 81.40 for Hill & Valley
	Jharkhand	70.0
	Manipur	91.0
	Meghalaya	100.0
	Mizoram	100.0
	Nagaland	85.0
	Sikkim	72.2
	Tripura	92.0
	Uttarakhand	73.0
Uts	A & N Islands	Andman Disrict Rs.130, Nicobar District-Rs. 139
	Chandigarh	140.0
	Dadra & Nagar Haveli	108.2
	Daman & Diu	102.0
	Delhi	
	Lakshadeep	115.0
	Ponducherry	Rs. 80 for men for six hours of work & Rs.70 for women for five hours of work
All India Average		92.8

Source : 1st of 15th Loksabha, Standing Committee on Rural Development (2009-10)

Table A 3.7 : Status of IAY

State Category	States Name	1998-99			2009-10		
		Target	Houses Constructed	% of Achievement	Target	House Constructed	% of Achievement
Major States	Andhra Pradesh	73645	24113	32.74	371982	434733	116.87
	Assam	28576	4722	16.52	240446	181162	59.49
	Bihar	171378	66929	39.05	1098001	653214	91.41
	Gujarat	19692	11146	56.60	182429	166760	94.25
	Haryana	10690	1676	15.68	25611	24138	110.54
	Himachal Pradesh	4435	393	8.86	8212	9295	64.73
	Karnataka	39505	19460	49.26	143311	158417	84.69
	Kerala	17726	7507	42.35	79695	51590	92.59
	Madhya Pradesh	103652	51116	49.32	114396	96877	79.16
	Maharashtra	78092	16204	20.75	224323	207695	85.58
	Orissa	67684	20404	30.15	215715	170766	94.90
	Punjab	5630	1488	26.43	31674	27108	113.98
	Rajasthan	35599	14995	42.12	91670	86992	98.13
	Tamil Nadu	46258	27862	60.23	148929	169753	77.35
	Uttar Pradesh	188051	61943	32.94	493156	483949	113.19
	West Bengal	74594	15661	20.99	297564	230155	75.34
Hilly States/N-E States	Arunachal Pradesh	1046	56	5.35	10873	6026	55.42
	Chhattisgarh	N.A	N.A	N.A	57520	58449	101.62
	Goa	130	412	316.92	2291	1864	81.36
	Jammu & Kashmir	7699	4200	54.55	25508	18594	72.89
	Jharkhand	N.A	N.A	N.A	97926	87524	89.38
	Manipur	1911	67	3.51	9439	3296	34.92
	Meghalaya	2409	81	3.36	16440	9875	60.07
	Mizoram	472	255	54.03	3504	4851	138.44
	Nagaland	2050	876	42.73	10878	11645	107.05
	Sikkim	784	396	50.51	2080	1819	87.45
	Tripura	4519	2566	56.78	21182	8322	39.29
	Uttaranchal	N.A	N.A	N.A	22476	20373	90.64
UTs	A & N Islands	202	6	2.97	2750	242	8.80
	Chandigarh	N.A	N.A	N.A	N.A	N.A	N.A
	Dadra & Nagar Haveli	309	5	1.62	458	0	0.00
	Daman & Diu	10	0	0.00	205	0	0.00
	Delhi	N.A	N.A	N.A	N.A	N.A	N.A
	Lakshadweep	17	31	182.35	229	0	0.00
	Pondicherry	257	113	43.97	1370	47	3.43

Source : Annual Report, Rural Development, 1998-99 & 2009

Table A 3.8(i): JNNURM : ULB Level Reforms Achieved, Cities (As on December, 2010)

S.N.		1st Yrs	2nd Yrs	3rd Yrs	4th Yrs	5th Yrs	6th Yrs	7th Yrs	All Ready Achieved
1	e-Governance Setup		Hyderabad, Vishakhapatnam, Rajkot	Ahmedabad, Pune, Greater Mumbai, PCMC(Pune), Jaipur, Ajmer	Surat, Vadodara, Mysore, Thane			Indore	Vijayawada, Nashik, Coimbatore
2	Shift to Accrual based Double Entry Accounting	Nagpur, Thane, Ajmer	Bhubaneswar	Vijayawada, Vishakhapatnam, Raipur, Delhi, Ahmedabad, Rajkot, Surat, Vadodara, Shimla, Kochi, Thiruvananthapuram, Bangalore, Mysore, Jabalpur, Ujjain, Pune, Greater Mumbai, PCMC(Pune), Amritsar, Puri	Hyderabad, Bhopal, Nanded, Nashik, Ludhiana		Guwahati,		Indore, Jaipur, Coimbatore
3	Property Tax(85% Coverage)	Vishakhapatnam, Tirupati, PCMC(Pune), Coimbatore		Rajkot, Vadodara, Bangalore, Thane, Puducherry	Gubati, Raipur, Surat, Mysore, Nanded, Nashik		Thiruvananthapuram,	Hyderabad, Ahmedabad,	Vijayawada
4	Property Tax(90% efficiency)	Coimbatore	Thane	Tirupati, Pune	Rajkot, PCMC(Pune), Shillong	Mysore, Greater Mumbai	Raipur, Surat	Hyderabad, Ahmedabad, Vadodara	Vijayawada, Chandigarh,
5	100% cost recovery(Water Supply)	Vishakhapatnam, Greater Mumbai		Nashik	Nagpur	Bangalore	Vadodara, Pune, PCMC(Pune), Shillong(50%), Aizawl(80%), Patna(80%), Bodhgaya(80%), Surat, Imphal(50%), Gangtok(50%)		
6	100% cost recovery (Solid Waste)	Vishakhapatnam				Pune	PCMC(Pune), Shillong(50%), Aizawl(80%), Patna(80%), Bodhgaya(80%), Surat, Imphal(50%), Bhubaneswar(75%), Gangtok(50%)		
7	Internal Earmarking of Funds for Services to Urban Poor	Delhi, Rajkot	Kochi, Vishakhapatnam, Bangalore, Mysore, Bhopal, Indore, Jabalpur	Faridabad, Shimla, Mysore, Ujjain, PCMC(Pune), Imphal, Bhubaneswar, Puri	Ranchi, Nagpur, Thane, Ludhiana	Tirupati, Itanagar, Guwahati		Patna, Amritsar	Hyderabad, Vijayawada, Vishakhapatnam, Bhubaneswar, Ahmedabad, Surat, Vadodara, Nanded, Nashik, Pune, Greater Mumbai, Kohima, Raipur, Puducherry, Jaipur, Ajmer, Coimbatore

Table A 3.8 (ii) : JNNURM : Optional Reforms Achieved Cities Level as on December, 2010

S.N.		1st Yrs	2nd Yrs	3rd Yrs	4th Yrs	5th Yrs	6th Yrs	7th Yrs	All Ready Achieved
1	Introduction of Property Title Certification System								
2	Revision of Building by laws- streamlining the Approval Process	Rajkot, Surat, Bhopal, Indore, Jabalpur, Ujjain	Pune, Asansol	Hyderabad, Vijaywada, Vishakhapatnam, Tripati, Imager, Raipur, Banskara, Nagpur, Nanded, Imphal, Shillong, Puri, Ajmer	Gurubati, Nashik, Greater Mumbai, Thana, PCMC(Pune), Kamrup, Amritsar, Ludhiana	Bhimavaram, Agartala	Jambhodpur (UA), Mysore	Porbandar, Thiruvananthapuram	Almedabad, Vadodra, Coimbatore, Madurai*, Chennai
3	Revision of Building by laws- Mandatory Rainwater Harvesting	Hyderabad, Vijaywada, Vishakhapatnam, Tripati, Raipur, Bhopal, Indore, Jabal, Ujjain	Nagpur, Nanded, Pune, Thana, PCMC(Pune), Puri, Ajmer, Asansol, Kolkata	Almedabad, Rajkot, Surat, Vadodra, Jamun, Sringer, Puducherry, Bhimavaram	Nashik, Mysore, Ranchi, Dhanbad, Bodhgaya, Amritsar, Ludhiana, Dehradun, Haridwar, Nainital, Jaipur	Agartala	Jambhodpur (UA), Gangtok		Gurubati, Patna, Delhi(MCD), Porbandar, Faridabad, Shimla, Kochi, Thiruvananthapuram, Chennai, Agra, Allahabad, Kamrup, Lucknow, Madhura, Meerut, Varanasi
4	Examining 25% developed land in all housing projects for EWS/LIG		Amadabad, Rajkot, Surat, Jabalpur, Ujjain	Hyderabad, Vijaywada, Vishakhapatnam, Tripati, Vadodra, Jamun, Sringer, Bhopal, Thana	Imager, Raipur, Shillong, Jaipur, Ajmer, Nainital	Faridabad, Pune, Aizawl, Kolkata, Amritsar, Ludhiana, Dehradun, Haridwar, Agra, Allahabad, Kamrup, Lucknow, Madhura, Meerut, Varanasi	Porbandar, Nagpur	Imphal, Gurubati	Indore*, Nanded*, Nashik*, Greater Mumbai*, PCMC(Pune), Gangtok
5	Simplification of legal and Procedural framework for conversion of agricultural land for non-agricultural	Asansol, Kolkata	Hyderabad, Vijaywada, Vishakhapatnam, Tripati, Raipur, Surat, Vadodra, Ajmer, Coimbatore, Madurai, Chennai	Bangalore, Bhopal, Mysore, Nagpur, Ludhiana	Greater Mumbai*, Amritsar, Jaipur, Dehradun, Haridwar, Nainital	Punaji	Imager, Gurubati		Porbandar, Kochi, Thiruvananthapuram, Indore, Jabalpur, Ujjain, Nanded*, Nashik*, Pune*, Thana, PCMC(Pune), Gangtok, Agra*, Allahabad*, Kamrup*, Lucknow*, Madhura*, Meerut*, Varanasi*
6	Introduction of computerised process of Registration land property	Hyderabad, Vijaywada, Vishakhapatnam, Tripati, Greater Mumbai, PCMC(Pune)	Ranchi, Nagpur, Madurai	Amadabad, Rajkot, Surat, Vadodra, Nashik, Mysore	Gurubati, Dhanbad, Bangalore, Amritsar, Ludhiana, Bhimavaram, Puri	Punaji, Puducherry, Agartala, Agra, Allahabad, Kamrup, Lucknow, Madhura, Meerut, Varanasi	Bodhgaya, Faridabad, Jambhodpur (UA), Imphal, Aizawl	Gangtok	Patna, Porbandar, Shimla, Nanded, Pune*, Thana, Jaipur, Ajmer*, Coimbatore*, Chennai
7	Bylaws on Reuse of Recycled Water		Hyderabad, Vijaywada, Vishakhapatnam, Tripati, Chandigarh	Mysore, Thana, Nanded	Coimbatore, Madurai, Chennai, Amritsar, Ludhiana, Shillong, PCMC(Pune), Greater Mumbai, Nashik, Bhopal, Bangalore, Imager	Gurubati, Amadabad, Rajkot, Surat, Vadodra, Asansol, Kolkata, Kochi, Thiruvananthapuram, Shimla	Porbandar, Gangtok	Puducherry	Indore*, Jabalpur*, Ujjain*, Delhi(MCD)
8	Administrative Reforms			Hyderabad, Vijaywada, Vishakhapatnam, Tripati, Coimbatore, Madurai, Chennai, Thana, Bangalore	Nanded, Nashik, Pune, Greater Mumbai, PCMC(Pune)	Amadabad, Rajkot, Surat, Vadodra, Asansol, Kolkata, Kochi, Thiruvananthapuram, Shimla		Nagpur	
9	Structural Reforms		Mysore	Hyderabad, Vijaywada, Vishakhapatnam, Tripati, Coimbatore, Madurai, Chennai, Thana, Bangalore	Kochi, Thiruvananthapuram, Pune, Greater Mumbai, Bhimavaram	Gurubati, Bodhgaya, Shimla, Nanded, Puri	Nashik, PCMC (Pune)	Asansol, Kolkata	Almedabad*, Rajkot*, Surat*, Vadodra*

Table A 3.9 : Trend in Central Government Regular Employment during 1971-2008

As on 31 st march	Central Government Employment(Regular)		
	Number (in Lakhs)	%age Increase over Previous Available Year	Index of Employment (base100 in 1971)
1971	26.99	-	100
1980	33.21	4.73	123.05
1984	36.14	2.03	133.9
1991	38.13	1.03	141.27
2001	38.76	(-)2.66	143.61
2006	31.16	(-)1.52	115.45
2008	31.12	(-)0.13	115.3

Source : Census of Central Government Employment, 2011,DGEST, Ministry of Labor

Table A 3.10 : Public Administration Contribution to Net State Domestic Product Constant prices)

Rs. in crores

Sl. No.	State\UT	Net State Domestic Product		Contribution of Public Administration		% of Public Administration to NSDP	
		1999-00	2008-09	1999-00	2008-09	1999-00	2008-09
1	Andhra Pr.	11636025	22671500	554821	853500	4.77	3.76
2	Arunachal Pr.	149696	271043	21340	36013	14.26	13.29
3	Assam	3201066	4826205	192840	302815	6.02	6.27
4	Bihar	4607078	9642241	322844	493616	7.01	5.12
5	Jharkhand	3022893	4959515	87823	174088	2.91	3.51
6	Goa	557043	1049556	28458	25880	5.11	2.47
7	Gujarat	9254100	20364333	432100	461920	4.67	2.27
8	Haryana	4732937	10233136	146343	215114	3.09	2.10
9	Himachal Pr.	1246700	2245556	93685	161317	7.51	7.18
10	J & K	1353297	2088602	199637	193731	14.75	9.28
11	Karnataka	9053192	15863159	380624	700827	4.20	4.42
12	Kerala	6135933	12040406	285739	508022	4.66	4.22
13	Madhya Pr.	7265536	9537080	315561	418177	4.34	4.38
14	Chhattisgarh	2383965	4704492	84580	181635	3.55	3.86
15	Maharashtra	21719793	38992519	1008302	1365823	4.64	3.50
16	Manipur	295411	440768	53452	52591	18.09	11.93
17	Meghalaya	321130	587810	44300	60907	13.80	10.36
18	Mizoram	140951	220544	22908	37376	16.25	16.95
19	Nagaland	260980	503579	35390	52563	13.56	10.44
20	Orissa	3839889	7288909	212990	317618	5.55	4.36
21	Punjab	6113923	9292171	275955	402454	4.51	4.33
22	Rajasthan	7417385	12849585	307195	485601	4.14	3.78
23	Sikkim	76537	150281	13993	25248	18.28	16.80
24	Tamil Nadu	11970394	20348549	634335	901328	5.30	4.43
25	Tripura	449557	819713	56913	82613	12.66	10.08
26	Uttar Pradesh	15680934	24003869	744563	1148997	4.75	4.79
27	Uttarakhand	1118719	2410224	63936	124510	5.72	5.17
28	West Bengal	12529882	21631598	639594	807004	5.10	3.73
29	A & N islands	83777	149792	12925	35383	15.43	23.62
30	Chandigarh	379157	997415	43931	43377	11.59	4.35
31	Delhi	5117464	11394242	273790	412447	5.35	3.62
32	Puducherry	289252	726211	14385	31648	4.97	4.36
All-India NDP(99-00 base)		152404596	273304603	7605252	11114143	4.99	4.07

Source : CSO



Table A 3.11 : Trend of Employment in Major Ministries during 1990 to 2008

Employment in Major Ministries (no. in lak)h As on 31 st March					
Year	Railway	Communication and IT	Defence (Civilian)	Others	Total
1990	16.49	6.57	5.38	9.3	37.74
	(1.35)	(0.92)	(-0.74)	(0.22)	(0.69)
1991	16.55	6.64	5.26	9.68	38.13
	(0.36)	(1.06)	(-0.02)	(4.08)	(1.03)
1995	16.05	7.03	5.01	11.73	39.82
	(-3.03)	(5.87)	(-4.76)	(21.18)	(4.43)
2001	15.12	6.18	5.9	11.56	38.76
	(-5.73)	(-12.09)	(17.76)	(-1.53)	(-2.66)
2004	14.42	2.65	3.93	10.64	31.64
	(-4.63)	(-57.12)	(-33.39)	(-7.96)	(-18.37)
2006	14.12	2.42	3.54	11.08	31.16
	(-2.08)	(-8.68)	(-9.92)	(4.13)	(-1.52)
2008	13.94	2.25	3.65	11.27	31.12
	(-1.27)	(-7.02)	(3.11)	(1.71)	(-0.13)

Figures in brackets represent percentage increase/decrease over previous Census year.

Source : Census of Central Government Employment, 2011,DGEST, Ministry of Labor

**Table A 3.12 : Estimated Distribution of Central Government Employees in Various States/
UTs (as on 31st march, 1995 and 2008)**

(in thousands)

S.No.	States	1995	%age	2008	% age	% age comparable
1	Andhra	256.05	6.43	185.9	5.97	
2	Assam	106.32	2.67	65.1	2.09	
3	Bihar	228.57	5.74	49.7	1.6	
4	Chhattisgarh*	0		42.5	1.37	
5	Gujarat	148.53	3.73	74.1	2.38	
6	Haryana	40.22	1.01	16.9	0.54	
7	Himachal	21.5	0.54	14.2	0.46	
8	J & K	36.24	0.91	28	0.9	
9	Jharkhand*	0		26.6	0.85	
10	Karnataka	138.18	3.47	78.7	2.53	
11	Kerala	99.55	2.5	60	1.93	
12	Madhya	230.17	5.78	123.1	3.96	
13	Maharashtra	568.25	14.27	279	8.97	
14	Manipur	2.79	0.07	2.8	0.09	
15	Meghalaya	21.11	0.53	8.8	0.28	
16	Nagaland	5.18	0.13	2.9	0.09	
17	Orissa	74.47	1.87	42.6	1.37	
18	Punjab	102.34	2.57	55	1.77	
19	Rajasthan	199.5	5.01	105.9	3.4	
20	Sikkim	0.4	0.01			
21	TamilNadu	293.08	7.36	137.6	4.42	
22	Tripura	11.15	0.28	1.9	0.06	
23	Uttar	551.92	13.86	305.9	9.82	
24	Uttarakhand*	0		20.8	0.67	
25	West Bengal	516.48	12.97	326.6	10.5	
26	Andaman	1.59	0.04	1.8	0.06	
27	Arunachal	1.99	0.05		-	
28	Chandigarh	18.32	0.46	11.7	0.38	
29	Dadar					
30	Daman	0				
31	Delhi	294.68	7.4	203.7	6.55	
32	Goa	6.37	0.16	6.2	0.2	
33	Lakshadeep					
34	Mizoram	0.8	0.02	0.8	0.03	
35	Pondicherry	4.38	0.11	5.3	0.17	
36	Mission Abrod	1.99	0.05	2	0.06	
37	Other Employment **	0		825.5	26.53	
	Total	3982.1	100	3111.6	100	
	Total comparable			2286.1		100

* states were included in their parent state for 2008 for comparable figure .This excludes item 37

** Other employment (including Civilian Para Military Forces and others)

Table A 3.13 : Disposal and Pendencies of Cases under Central Administrative Tribunal

S.No.	Year	Institution during the Year	Disposal During the Year	Pendency at the end of the Period
1	1990	19283	15495	35562
2	1991	21623	17552	39633
3	1992	25184	23782	41035
4	1993	27067	28074	40028
5	1994	26230	26409	39849
6	1995	25789	23668	41970
7	1996	23584	20667	44887
8	1997	23098	21981	46004
9	1998	21911	18394	49521
10	1999	22944	24566	47899
11	2000	25146	31398	41647
12	2001	25977	31953	35671
13	2002	25398	29514	31555
14	2003	25089	28076	28568
15	2004	23825	27735	24658
16	2005	21528	22408	23778
17	2006	18722	17774	24726
18	2007	17725	18674	23777
19	2008	18287	20352	21712
20	2009	24496	23681	22527
21	2010	26,620	25,477	23,670
	Total	5,73,000	5,49,330	23,670

Table A 3.14 : Recommendation and ATR of Different Commission And Committee

Name of the Committee	Main Findings of the report	Major Recommendations	ATR	Remarks
The Rajinder Sachar Committee (March, 2005- Nov.,2006) Preparing a report on the social economic & educational status of the 'Muslim community of India'.	1) The literacy rate among Muslims is very much below than the national average. 2) Access to government schools is limited. 3) Participation of Muslim in the Professional & managerial Cadre is low. 4) The average amount of 'Bank Loan' is half. 5) Muslim concentration villages are not well served with 'Pucca' roads. 6) The Presence of Muslims has been found to be only 3% in the 'IAS', 1.8% in the IFS and 4% in the IPS. 7) Representation of Muslim is very low in the 'Universities' and in 'Banks'. Their share in 'Police Constables is only 6% in health 4.4% and in transport 6.5%. 8) 'Muslim-OBC's are deprived lot in comparison to 'Hindu-OBCs'.	76 recommendations- 22 ministries involved 1) Ensure "equity and equality of opportunity and eliminate discrimination". 2) Creation of a "National Data Bank" (NDB) 3) An equal opportunity commission be constituted 4) process of "evaluating the content of the school textbooks 5) Providing 'hostel facilities' at reasonable costs for students from minorities 6) access to 'Muslims' in priority sector Bank. 7) Provide financial and other support to initiatives built around occupation.	1) The 'P.M.' unfolded a comprehensive '15 POINT PROG' for the welfare & employment of Minorities. 2) The "Sarva Shiksha Abhiyan" (SSA) quality elementary education to all children in the 6-14 years age group. 3) 'Free Textbooks' provided to all minority girls from class I-VIII in Urdu medium Schools – 'Major Focus' is on the states of "Bihar, W.B, U.P & Assam".	The 'Committee is completely silent on the 'failings' of the Community which have contributing at least Partially to its backwardness
Name of the Committee	Major Recommendations			
Madan Mohan PUNCHHI Report (April 2007) To take a fresh look at the relative role and responsibilities of the various levels of government and their inter-relations. (Made more than 200 recommendations)	Major Recommendations A) Over Article 355 & 356 i) Should be an amendment in ART 355 & 356 ii) Localizing emergency provisions under Governor rule -not more than 3 months. iii) Right to give sanction for the prosecution of ministers B) Deployment of Central Force i) Deployment of central forces without the state's consent for a short period. C) Appointment of Chief Ministers i) A Pre-Poll alliance should be treated as 'one Political-Party' ii) Then the single largest party with support of others iv) The 'Post-electoral' coalition with all parties joining the Govt and v) Remaining including independents supporting from outside. D) Appointment and Removal of Governors i) Governors should have the right to sanction 'Prosecution of minister' against the advice of the Council of ministers. ii) Nominee be an eminent person. iii) Criticises 'arbitrary' dismissal of Governors – fixed 5 year tenure – removal only through 'impeachment' iv) A constitutional amendment be brought about to limit the scope of 'Discretionary Powers' – of the Governor under ART 163 (2). E) National Integration Council i) Along the lines of the 'US' Homeland security Dept. ii) Should meet at least once a year F) Internal Security i) Studied new set-ups like the 'NIA' and recommended procedures to ensure smooth co-operation of the states.			

Name of The Committee	Major Recommendations	ATR	Remarks
Raghavan Committee on Ragging (2007) To look into the steps to be taken against the menace of ragging	An act of human rights abuse. Guidelines of the 'Supreme Court; judgment of 2001 not implemented. Requirement of anti-ragging awareness Need "strong and uniform anti-ragging law" . "Proactive monitoring" Now some of its "Key – recommendations" are:- institution must lodge an FIR head of the institution in its 'Prospectus' advised to mention that 'a student found guilty of indulging in ragging be rusticated from the institution' . institution found lacking and checking ragging – denied government aid and grants. Strict action is taken against the inefficient Police officers. Setting up of 'anti-ragging cells' -central, state and college level. Setting up of a 'toll-free helpline' "NCERT, SCERT" include a "chapter" on ragging. "Psychological – counseling necessary Organize interactive sessions between the juniors & seniors. Staggered entry of fresher's & seniors. Ragging' considered an 'important factor' in accrediting the institution by "central regulatory bodies.	Received wide acknowledgement and appreciation of the 'civil society' and the various stakeholders at large. 'Apex court' has already initiated action on the recommendation including compulsory filling of 'FIRs', compulsory setting up of 'anti-ragging committee', directed universities to form 'anti-ragging' squads and 'UGC' has also threatened to block funding.	1) Academicians criticize the 'harsh' approach of the report and decry its 'bureaucratic' approach. 2) They fear in practice it will alienate students from teachers and ruin the very spirit of living and learning together. 3) a new section should be added to the 'IPC' making ragging a punishable offence.

Major Recommendations	
Name of the Committee	Major Recommendations
Committee on panchayati raj institution (Janata Government), 1978 Chairman: Ashok Mehta	132 Recommendations. some are- (a) Three tier system of PR- Zila Parishad at district level, below Mandal panchayat, (b) Zila Parishad responsible for planning at district level, (c) Official participation of political parties at all levels of panchayat election, (d) Should have compulsory powers of taxation, (e) Regulate social audit by a committee of legislators, (e) Nyay Panchayats kept as separate bodies, (f) The Chief Electoral Officer of the state conduct the elections, (g) Voluntary agencies play an important role, (h) A minister for PR be appointed
Committee on Centre-State Relation, 1983-1988 Chairman: R. S. Sarkaria	Final Report Contained 247 Recommendations. some are- (a) Recommended status quo in the Centre-State relations, (b) Suggest changes within the framework of Constitution of India- specially in the areas relating to legislative matters, Role of Governor, and use of Art. 356
Commission on review of administrative laws, 1998 Chairman: P.C. Jain	(a) Recommend repeal of 1382 Central laws of different categories, (b) 700 acts pertain to appropriation acts, 114 central acts for state subjects, 11 pre-nationalization acts, 20 validation acts, 35 reorganization acts, 12 personal laws, etc.
Y.K. Alagh Committee, 2001 To review the Civil Service Examination	(a) Recommend remedial measures for recruitment and induction phases, (b) Refers flaws in the 'Ruler Mindset' of Civil Servants, © Personal weaknesses identified, (d) Criticises their extensive regulatory controls, (e) Easily influenced by the politicians and business class, (f) Tendency to favour colleagues to one's own caste, (g) If they refuse to compromise then sidelined, (h) Recommend a designed scheme to identify younger candidates- lowering the age limit, (i) Preliminary examination made more objective- Environment and law includes in Mains, (j) Cadets exposed to field oriented development activities, (k) Be closely with civil society- aware of the contemporary issues.
Yugandhar Committee, 2003. To review in service training of the IAS officers	(a) Flexible optional training open for IAS officers in IIMs, (b) Phase iii (at the 12th year of career service- 8 weeks), Phase iv (20th year of service- 12 weeks), phase v (28th year of service) programmes introduced.
Surinder Nath Committee, 2003 To review the system of performance, promotion and placement for the All India Services	(a) Develop a system of recording of ACRs (Annual Confidential Report), (b) Review the present system of promotion and placement in the Central Government Group A services, © Better monitoring and scrutiny through computerization, (d) Evolve the system of PAS (Performance Appraisal System), (e) System of numerical grading introduced, (f) Provisions for VRS
P.C. Hota Committee, 2004 To review the Civil Service reforms	(a) Junior officers given training in Customer Service- attending phone calls, (b) The Official Secrets Act be modified, © Officers having a public interface to wear 'name Badges' while on duty, (d) Cadets spend at least two months with an NGO, (e) ISO 9000 introduced for Government offices (f) Annual property return put on website, (g) Art. 311 be amended, (h) Each department develop an inter evaluation mechanism, (i) 'Citizen Centre' be set up.

Table A 3.15 : ARC- A (Fact Sheet)Recommendation of Administrative Reforms_(ATR)*

S. No.	Report Name	Submission Date	No. of Recommendations	No. of Accepted Recommendations	% of Accepted Recommendations
1	Right to Information: Master Key to Good Governance	June, 2006	62	39	62.90
2	Unlocking Human Capital: Entitlements and Governance – a Case Study	July, 2006	114	89	78.07
3	Crisis Management : From Despair to Hope	Sept., 2006	142	136	95.77
4	Ethics in Governance	Jan., 2007	134	101	75.37
5	Public Order : Justice for each ... Peace* for all	June, 2007	51		0
6	Local Governance	Oct., 2007	256	231	90.23
7	Capacity Building for Conflict Resolution – Friction to Fusion	Feb., 2008	126	111	88.10
8	Combating Terrorism-Protecting by Righteousness*	June, 2008	18		
9	Social Capital-A Shared Destiny	August, 2008	66	32	48.48
10	Refurbishing of Personnel Administration-Scaling New Heights*	Nov., 2008	22		
11	Promoting e-Governance: The SMART Way Forward	Dec., 2008	47	46	97.87
12	Citizen Centric Administration- The Heart of Governance	Feb., 2009	50	44	88.00
13	Organizational Structure of Govt. of India	April, 2009	37	32	86.49
14	Strengthening Financial Management Systems	April, 2009	36	34	94.44
15	State and District Administration	April, 2009	158	135	85.44
	Total Recommendations		1319	1030	83.88

*No ATR available on DOPT websise till december2011.

Source : darpn.ic.in

Table A 3.16 : PM s Awards for Excellence in Public Administration 2008-09

Sr.No	Categorie	Name Of the Project	Details of Awardees
1	Individual	Removal of Encroachments of Structures of Different Religions-Maintaining Communal Harmony, Madhya Pradesh	Shri Vijay Singhal, IAS
2	Individual	Involvement of Community Under National Rural Employment Guarantee Scheme in Naxalite Affected Areas, MP	Shri Gulshan Bamra, IAS
3	Individual	Making Medicines Affordable, Rajasthan	Dr. Samit Sharma, IAS,
4	Individual	River Linking Project at Jalgaon, Maharashtra	Shri Vijay Singhal, IAS,
5	Individual	Cervical Cancer Screening Evolving A New methodology-A Life Saving Initiatives of Chennai Corporation , Tamil Nadu	Shri Rajesh Lakhani, IAS
6	Group (3 Members)	Computerisation of decentralized paddy procurement and public distribution system in Chhattisgarh.	1. Dr. Alok Shukla, IAS 2. Shri Gaurav Dwivedi, IAS 3. Shri A.K.Somasekhar
7	Group (5 Members)	Implementation of The Scheduled Tribes and Other Traditional Forest Dwellers (Recognition of Forest Rights) Act,2006 in MP	1. Shri O.P Rawat, 2. Shri Jaideep Govind, 3. Shri Anil Oberoi, 4. Ms. Rashmi Arun Shami, 5.Shri Ashok Kumar Upadhaya
8	Group (3Members)	Integrated Tax Payer Data Management System (ITDMS) A Data Mining Tool, Government of India	1. Shri S.S. Khan, 2. Shri Milap Jain, 3. Shri Venkateswara Rao,
9	Organization	Project Arrow-Transforming India Post, Government of India	D/o Posts, M/o Communications & IT, GO

Source : DoPT Annual Report 2010-11

Table A 3.17 : Committees and Commissions on Police Commissions

Name of the Commission	Major Recommendation
National Police Commission (1977-1981) Police Reforms	Constitution of statutory State Security Commissions to help State Govts in discharge of their superintending responsibility. Selection of DGP from out of a panel prepared by a Committee chaired by Chairman, Union Public Service Commission (UPSC). Police Act itself to specify the authorities competent to issue orders of transfer/suspension of police officers of different ranks. Fixity of tenure of office for DGP & other key functionaries
Ribeiro Committee (1998) Police Reforms	Constitution of non-statutory, advisory & recommendatory State Security Commissions to, <i>inter alia</i>, 'check arbitrary acts of politicians', 'ensure transparency & accountability in policing', & 'protect police officers from unwarranted pressures'. Selection of DGP by a Committee comprising Chairman, UPSC & officials of State & Central Govts. Establishment of Police Establishment Boards to monitor transfers, promotions etc. matters upto the rank of Dy. SP .
Padmanabhaiah Committee on Police Reforms (2000) Police Reforms	Operational autonomy of police to be ensured to check political interference. Selection of DGP from out of a panel of names recommended by a Committee chaired by Chief Justice of concerned High Court. Minimum tenure of 2 years for DGP & other police officers.
Model Police Act drafted by Soli Sorabjee Committee (2005-2006) Superintendence as well as Administration' defined	Constitution of 'State Police Boards' to : Frame policy guidelines for promoting efficient, effective, responsive & accountable policing Prepare panel of police officers for selection of DGP Identify Performance Indicators to evaluate police functioning periodically Role & Functions of State Govt as well as DGP clearly demarcated & elaborated Constitution of Police Establishment Committees to consider & recommend transfers/postings & to examine complaints from police officers about being subjected to illegal orders Empanelment for DGP's selection by State Police Board. Elaborate procedure for empanelment laid down Fixity of tenure for DGP & other key functionaries, with provision for removal only under specified situations.
Supreme Court's Intervention	Implementation of Recommendations/ Supreme Court Directions (ATR)
Directions of the Supreme Court to all State Govts. in a PIL filed by an ex-Police Officer (Prakash Singh v. Union of India – WP No. 310 Of 1996) : Constitute State Security Commissions to lay down broad policies & oversee police functioning Create Police Establishment Boards to decide transfers/postings & other service-related matters Select DGP from amongst 3 senior-most officers empanelled by UPSC Provide fixity of tenure to DGP & other key functionaries.	Strong reservations among State Governments Many also sought revision of orders by the Apex Court, albeit unsuccessfully ➤ 31 March 2007 – Deadline set by Supreme Court ➤ No movement in the direction of reform, however, in evidence so far

Table A 4.1 : Fact Sheet of SLPEs

State	Approximate number of SLPEs	SLPEs identified for disinvestment/ winding up/ restructuring	No. of SLPEs in which process initiated	No. of SLPEs privatised	No. of SLPEs closed down
Andhra Pradesh	128	87	79	13	38
Arunachal Pradesh	7	—	—	—	—
Assam	42	—	—	—	—
Bihar	54	6	6	—	—
Delhi	15	—	1	*1	—
Gujarat	50	24	24	3	6
Haryana	45	8	6	1	4
Himachal Pradesh	21	15	8	3	2
Jammu & Kashmir	20	7	2	—	—
Karnataka	85	39	20	2	12
Kerala	111	55	40	—	10
Madhya Pradesh	26	14	14	1	—
Maharashtra	66	11	4	—	—
Manipur	14	10	—	—	—
Mizoram	5	—	—	—	—
Orissa	72	33	10	9	11
Punjab	53	11	11	1	6
Rajasthan	28	10	6	1	1
Sikkim	12	—	—	—	—
Tamil Nadu	59	29	29	—	7
Total	1036	399	300	36	111
Uttar Pradesh	41	25	25	1	14
West Bengal	82	15	15	—	—

Source : Government of India (2006), Department of Disinvestment, Ministry of Finance.

Table A 4.2 : State-wise Foreign Direct Investment (FDI) Approved by GOI (In Crore)

States/UTs	2006	2001	1996
Andhra Pradesh	6305.98	5142.92	9089.54
Bihar	0	316.69	228.95
Gujarat	667.92	61860.83	8489.07
Haryana	104.79	2126.6	5734.4
Himachal Pradesh	0	14.29	335.7
Karnataka	47463.08	12995.1	34233.89
Kerala	440.92	1885.27	4233
Madhya Pradesh	59.97	206.06	5819.47
Maharashtra	93203.43	57412.41	36222.76
Orissa	1925	2422.1	8109.54
Punjab	17.5	164.57	4869.9
Rajasthan	2	559.01	805.65
Tamil Nadu	4409.14	12032.12	35800.57
Uttar Pradesh	706.8	6242	15066.01
West Bengal	784.25	3122.93	10296.05
Chhatisgarh	16500	160.47	3117.73
Jharkhand	0	0	270.35
Uttaranchal	199.3	0	24.5
Chandigarh	0	38.85	1
Dadra & Nagar Haveli	0	0.35	66.88
Daman & Diu	0	96.26	2.4
Delhi	25520.33	35994.93	14505.09
Goa	1.25	3491.28	1854.66
Pondicherry	50	8461.07	561.05
Other State Not Indicated	31674.48	54000.6	161655.23
India	230036.14	268746.71	361498.5

Source : SIA Newsletter (Annual Issue), Ministry of Commerce & Industry, Govt. of India.

Table A 4.3 : State-wise Gini-coefficient in Rural and Urban Area

State	1993-94		1999-2000		2004-05 (URP)*	
	Rural	Urban	Rural	Urban	Rural	Urban
India	0.28	0.34	0.26	0.34	0.3	0.37
Andhra Pradesh	0.29	0.32	0.24	0.31	0.29	0.37
Assam	0.18	0.29	0.2	0.31	0.19	0.32
Bihar	0.22	0.31	0.21	0.32	0.2	0.33
Jharkhand	*	*	*	*	0.22	0.35
Gujarat	0.24	0.29	0.23	0.29	0.27	0.31
Haryana	0.3	0.28	0.24	0.29	0.32	0.36
Himachal Pradesh	0.28	0.43	0.23	0.3	0.3	0.32
Jammu & Kashmir	0.23	0.28	0.17	0.22	0.24	0.24
Karnataka	0.27	0.32	0.24	0.32	0.26	0.36
Kerala	0.29	0.34	0.27	0.32	0.34	0.4
Madhya Pradesh	0.28	0.33	0.24	0.32	0.27	0.39
Chhatisgarh	*	*	*	*	0.29	0.43
Maharashtra	0.3	0.35	0.26	0.35	0.31	0.37
Orissa	0.24	0.3	0.24	0.29	0.28	0.35
Punjab	0.26	0.28	0.24	0.29	0.28	0.39
Rajasthan	0.26	0.29	0.21	0.28	0.25	0.37
Tamil Nadu	0.31	0.34	0.28	0.38	0.32	0.36
Uttar Pradesh	0.28	0.32	0.25	0.33	0.29	0.37
Uttaranchal	*	*	*	*	0.28	0.32
West Bengal	0.25	0.33	0.22	0.34	0.27	0.38
Delhi	0.24	0.21	0.29	0.34	0.26	0.33

Source : Planning Commission & NSSO Data, 61st Round

Table A 4.4 :Percentage of Population Below Poverty Line

States/U.T.s	1993-94	1999-2000	2004-05 (URP)*
Andhra Pradesh	22.19	15.77	15.8
Arunachal Pradesh	39.35	33.47	17.6
Assam	40.86	36.09	19.7
Bihar	54.96	42.6	41.4
Chhattisgarh	*	*	40.9
Goa	14.92	4.4	13.8
Gujarat	24.21	14.07	16.8
Haryana	25.05	8.74	14
Himachal Pradesh	28.44	7.63	10
Jammu & Kashmir	25.17	3.48	5.4
Jharkhand	*	*	40.3
Karnataka	33.16	20.04	25
Kerala	25.43	12.72	15
Madhya Pradesh	42.52	37.43	38.3
Maharashtra	36.86	25.02	30.7
Manipur	33.78	28.54	17.3
Meghalaya	37.92	33.87	18.5
Mizoram	25.66	19.47	12.6
Nagaland	37.92	32.67	19
Orissa	48.56	47.15	46.4
Punjab	11.77	6.16	8.4
Rajasthan	27.41	15.28	22.1
Sikkim	41.43	36.55	20.1
Tamil Nadu	35.03	21.12	22.5
Tripura	39.01	34.44	18.9
Uttar Pradesh	40.85	31.15	32.8
Uttarkhand	*	*	39.6
West Bengal	35.66	27.02	24.7
A & N Islands	34.47	20.99	22.6
Chandigarh	11.35	5.75	7.1
Dadra & Nagar Haveli	50.84	17.14	33.2
Daman & Diu	15.8	4.44	10.5
Delhi	14.69	8.23	14.7
Lakshadweep	25.04	15.6	16
Puducherry	37.4	21.67	22.4
All India	35.97	26.1	27.5

Source : Planning Commission & NSSO Data, 61st Round

Table A 6.1 : State-wise No of Insured Persons Covered under ES I Scheme in India

States/UTs	No. of Insured Persons as on 31.3.2003	Population & % as per 2001 Census (figs. In lakh)
Andhra Pradesh	567550	76210007 (0.74)
Assam	33300	26655528 (0.12)
Bihar	32900	82998509 (0.04)
Chandigarh Admn.	29500	900635 (3.28)
Chhattisgarh	24100	20833803 (0.12)
Delhi	561100	13850507 (4.05)
Goa	78150	1347668 5.80)
Gujarat	511700	50671017 (1.01)
Haryana	399700	21144564 (1.89)
Himachal Pradesh	43900	6077900 (0.72)
Jammu and Kashmir	17400	10143700 (0.17)
Jharkhand	72100	26945829 (0.27)
Karnataka	724700	52850562 (1.37)
Kerala	356350	31841374 (1.12)
Madhya Pradesh	185950	60348023 (0.31)
Maharashtra	1122250	96878627 (1.16)
Meghalaya	1500	2318822 (0.06)
Orissa	128450	36804660 (0.35)
Pondicherry	57750	974345 (5.93)
Punjab	372800	24358999 (1.53)
Rajasthan	267450	56507188 (0.47)
Tamil Nadu	1104900	62405679 (1.77)
Uttar Pradesh	460950	166197921 (0.28)
Uttaranchal	21700	8489349 (0.26)
West Bengal	652000	80176197 (0.81)
India	7828150	1018726909 (0.74)

Table A 8.1 : Number of PHCs, CHCs in High Focus non NE States at the Start of NRHM (as on June 2010)

	Total	Bihar	Chattgrh	HP	J&K	Jhkhnd	MP	Orissa	Raj	UP	Uttkhnd
Number of PHCs as per 2009 RHS	11502	1776	715	449	375	321	1155	1279	1503	3690	239
Total Number of PHCs functioning on 24x7 basis											
at start of NRHM(2005)	538	0	125	0		0	180		750	225	8
as on June 2010	3068	480	418	95	115	194	210	64		648	94
Number of PHCs											
Without a Doctor(RHS 2009)	1951	1243		50	2	0	211	157	0	197	91
With three SN posted	1460	105	14	0	42	0	249	48	750	252	0
Number of CHCs as per 2009 RHS	2067	70	144	73	85	194	333	231	367	515	55
Number of CHCs functioning as 24x7											
at start of NRHM(2005)	144		117	15						12	
as on June 2010	1694	70	144	73	57	188	237	150	367	372	36
Required (RHS 2009)	8268	280	576	292	340	776	1332	924	1468	2060	220
Total Number of Specialists at CHCs											
Sanctioned (RHS 2009)	4958	280	576	na	381	na	502	563	976	1460	220
In Position (RHS 2009)	2599	104	145	0	138	341	245	371	598	618	39
Appointed on contract under NRHM	740	381	0	21	34	19	53		43	189	0
Required at CHC	2699		544	511		1316	0				328
Sanctioned at CHC	709		544			0	0				165
In Position at CHC at start of NRHM	1222		302	225			0			615	80

Source : NRHM MIS (2010) Nurses, Radiographers, Pharmacists, Lab Technicians



Table A 8.2 : Laboratory Technicians at PHCs & CHCs

States/Uts	Required [R]	In Position [P]	Diff bet R-P (%) %Shortfall
Andhra Pradesh	1737	1363	374 (21.5)
Arunachal Pradesh	160	52	108 (67.5)
Assam	952	557	395 (41.5)
Bihar	1846	135	1711(92.7)
Chhattisgarh	859	370	489 (56.9)
Goa	24	25	*
Gujarat	1365	789	576(42.2)
Haryana	530	195	335(63.2)
Himachal Pradesh	522	155	367(70.3)
Jammu & Kashmir	460	399	61(13.3)
Jharkhand	515	381	134 (26.0)
Karnataka	2517	1312	1205(47.9)
Kerala	923	347	576 (62.4)
Madhya Pradesh	1488	384	1104 (74.2)
Maharashtra	2192	828	1364 (62.2)
Manipur	88	116	*
Meghalaya	133	130	3(2.3)
Mizoram	66	37	29 (43.9)
Nagaland	144	102	42 (29.2)
Orissa	1510	188	1322 (87.6)
Punjab	523	499	24(4.6)
Rajasthan	1870	2065	*
Sikkim	24	32	*
Tamil Nadu	1533	866	667(43.5)
Tripura	87	50	37 (42.5)
Uttarakhand	294	18	276 (93.9)
Uttar Pradesh	4205	1085	3120 (74.2)
West Bengal	1256	334	922 (73.4)
A & N Islands	23	26	*
D & N Haveli	7	7	0
Daman & Diu	4	3	1 (25)
Delhi	8	6	2 (25)
Lakshadweep	7	12	*
Puducherry	27	29	*
All India ²	27901	12904	14997(53.75)

Source : RHS, 2009

*surplus

Table A 8.3 : Average Population Covered by Health Facility (2007-08)

Focussed Non NE States	Sub-Centre	PHC	CHC	DH
Bihar	24589	158275	253523	2478682
Chhattisgarh	4430	25685	133882	801941
Himachal Pradesh	3032	13158	59417	495313
J&K	6011	25802	89659	1605040
Jharkhand	7184	127298	120303	1534943
Madhya Pradesh	5912	43390	149413	871014
Orissa	6086	37978	106948	1108505
Rajasthan	4149	28303	98505	766011
Uttar Pradesh	8032	69037	176720	2027596
Uttarakhand	4801	24410	76344	563417
NE Focussed States				
Arunachal Pradesh	1168	5216	9811	59767
Assam	4864	111408	126456	605622
Manipur	3904	29206	37478	393047
Meghalaya	3484	16311	28346	70373
Mizoram	2254	9154	18299	122356
Nagaland				
Sikkim	2322	11482	NA	98222
Tripura	6307	31985	69842	621696
Non-focussed large States				
Andhra Pradesh	10702	48110	137650	3353437
Goa	5395	46409	56699	4649999
Gujarat	7234	38171	90765	1223827
Haryana	7585	41500	167422	990033
Karnataka	4575	25673	106006	2301128
Kerala	5994	29683	118654	1086155
Maharashtra	20182	45267	123096	1807091
Punjab	6185	29157	127033	921954
Tamil Nadu	8334	32059	76521	1424683
West Bengal	6869	37867	196478	3485144
Non-focussed small states & Uts				
A & N Islands	2465	8430	7598	NA
Chandigarh	20480	NA	152008	900735
Dadra & Nagar Haveli	7591	41602	50000	264814
Daman & Diu	9213	56166	170135	79774
Delhi	16881	75992	NA	NA
Lakshadweep	2628	3996	8363	10000
Puducherry	3968	11633	18407	314919
All India ²	8372	49193	128356	1444633

Source : DLHS-3

Table A 8.4 : Available Infrastructures at PHC (2007-08)

Percentage of PHC						
States/Uts	Resid. quarter for MO	Functioning on 24 hr basis	At least 4 beds	Regular power supply	Having functional vehicle	Total number of PHCs
Major States						
Andhra Pradesh	25.7	51.1	82.9	45.5	25.9	646
Assam	90.8	65.6	64.6	57.4	79.5	195
Bihar	62.2	64.5	75.8	9.5	45.8	524
Gujarat	56.6	46.9	77.1	72.3	74.9	542
Haryana	43	39.2	64.3	41.8	14.1	263
Himachal Pradesh	21.5	52.8	70.8	61.8	37.5	144
Karnataka	58.7	47	85.7	13.4	23.9	673
Kerala	24.9	10.3	27.4	96.9	15.8	361
Madhya Pradesh	63.5	73.1	66.6	20.4	29	476
Maharashtra	81.3	78.1	89.7	13.6	86.3	830
Orissa	53.4	49.2	31.3	41.5	17.2	470
Punjab	26.1	17.2	74.6	7.5	12.7	134
Rajasthan	63.3	56.9	89.9	12.1	11.4	692
Tamil Nadu	22.2	50.6	28.4	86.5	31	423
Uttar Pradesh	52.8	45.5	56.7	11.6	18.1	819
West Bengal	82.2	25.9	27	37.2	8.6	290
Smaller States						
Arunachal Pradesh	52.8	36.1	79.2	58.3	50	72
Chhattisgarh	39	58.6	40.2	67.7	17.1	251
Goa	50	62.5	62.5	100	100	16
J&K	26.1	32.4	47.5	6.3	57.2	222
Jharkhand	84.2	79.4	89.1	44	89.7	184
Manipur	26.4	13.2	49.1	18.9	24.5	53
Meghalaya	94.1	62.7	94.1	48.5	52.9	68
Mizoram	88.7	69.8	92.5	69.8	54.7	53
Nagaland	na	na	na	na	na	na
Sikkim	87	95.7	100	78.3	100	23
Tripura	72.7	70.9	87.3	21.8	69.1	55
Uttarakhand	58.3	72.6	82.1	52.4	20.2	84
UTs						
A&N Island	100	93.3	100	73.3	73.3	15
Chandigarh	nc	nc	nc	nc	nc	nc
D&N Haveli	66.7	100	100	100	100	6
Daman & Diu	0	50	100	100	100	2
Delhi	42.9	42.9	50	71.4	78.6	14
Lakshadweep	50	100	100	100	100	4
Puducherry	46.7	73.3	93.3	100	100	15
ALL INDIA	54.5 (4697)	52.7 (4538)	67.1 (5759)	35.7 (3080)	37.2 (3204)	8619

Source : DLHS-3



Table A 8.5 : Facilities at PHCs (2007-08)

Percentage of PHC having									
States/Uts	New Born Care Equipments	Functional OT	Cold Chain Equipments (At least 60%)	Essential Drugs (at least 60%)	Referral Services for Delivery	Referral Services for Delivery ³	New born Care Services ³	Conducted at least 10 deliveries ³	Total number of PHCs
A & N Islands	73.3	100	86.7	100	46.7	42.9	71.4	14.3	15
Andhra Pradesh	48.9	89	92	94.7	69.5	72.4	95.8	54.2	646
Arunachal Pradesh	11.1	88	51.4	68.1	27.8	34.6	73.1	7.7	72
Assam	43.1	72.3	78	71.3	73.3	84.4	92.2	81.3	195
Bihar	9.9	43.9	59.2	57.3	58.2	71	85.8	84.9	524
Chandigarh	NC	NC	NC	NC	NC	NC	NC	NC	NC
Chhattisgarh	31.1	46.6	25.9	62.6	37.5	43.5	82.3	24.5	251
D & N Haveli	33.3	50	100	100	50	50	100	50	6
Daman & Diu	0	100	50	100	100	0	100	100	2
Delhi	57.1	50	85.7	64.3	70	100	100	83.3	14
Goa	50	62.5	100	100	31.3	50	90	10	16
Gujarat	30.4	74.2	90.6	87.5	53.3	64.2	95.7	62.6	542
Haryana	24.7	60.5	66.2	84.8	41.1	46.6	94.2	38.8	263
Himachal Pradesh	14.6	34.7	67.4	75	37.8	48.7	75	9.2	144
Jammu & Kashmir	14	25.2	39.2	29.3	43.7	51.4	66.7	19.4	222
Jharkhand	31.5	65.8	89.1	79.4	46.2	47.3	86.3	48	184
Karnataka	37	75.5	82	96.1	67.5	72.2	93.4	47.8	673
Kerala	1.1	1.4	97.2	74	15.8	21.6	86.5	0	361
Lakshadweep	50	100	75	100	50	50	75	0	4
Madhya Pradesh	30	78.4	49.4	52.7	62	67.7	88.2	82.1	476
Maharashtra	42.2	81.5	88.8	85.7	51	53.1	90.9	46.8	830
Manipur	15.1	30.2	54.7	5.7	37.7	57.1	57.1	14.3	53
Meghalaya	19.1	60.3	86.8	20.6	25	28.6	57.1	21.4	68
Mizoram	32.1	88.7	56.6	43.4	35.9	29.7	91.9	29.7	53
Orissa	14.5	29.2	34.9	30.6	32.1	39	55.4	26.4	470
Puducherry	73.3	100	93.3	100	53.3	54.6	90.9	9.1	15
Punjab	20.9	50	53	40.3	35.8	43.5	100	39.1	134
Rajasthan	20.7	75.1	81.1	65.2	28.9	31.5	94.2	44.2	692
Sikkim	73.9	100	87	69.6	65.2	63.6	100	18.2	23
Tamil Nadu	63.8	90.1	94.8	97.9	61.7	70.1	93.5	59.4	423
Tripura	25.5	70.9	69.1	58.4	58.2	64.1	74.4	43.6	55
Uttar Pradesh	15	44.6	21.4	54.6	30.9	39.7	81.2	44.5	819
Uttarakhand	17.9	50	46.4	73.8	47.4	42.6	68.9	14.8	84
West Bengal	7.6	25.2	32.4	43.1	41.7	45.3	73.3	33.3	290
India	27.9	61.3	67.2	69.6	47.2	55.2	86.8	49.9	8619
	2404	5284	5792	6001	4068	2505	3937	2263	

Source : DLHS-3 (2007-08) Note: N.C: Not calculated because there are no case

Table No. A8.6: Infrastructure Facility Available at District Hospitals (2007-08)

States/Uts	% of DHs having					
	24 hrs water facility	3 phase electric-ity connection	Gen/inverter avail-able in working condition	NIC1 termi-nal available	Ambulance on Road	Total number of DHs
A & N Islands	100	100	100	50	100	2
Andhra Pradesh	95.2	100	95.2	4.8	95.2	21
Arunachal Pradesh	87.5	50	50	18.8	56.3	16
Assam	87	91.3	100	4.3	91.3	23
Bihar	91.2	85.3	100	8.8	91.2	34
Chandigarh	100	100	100	0	100	1
Chhattisgarh	100	100	100	43.8	93.8	16
D & N Haveli	100	100	100	0	100	1
Daman & Diu	100	100	100	0	100	2
Delhi	NC	NC	NC	NC	NC	NC
Goa	100	100	100	66.7	100	3
Gujarat	96	100	100	44	96	25
Haryana	100	100	100	22.2	83.3	18
Himachal Pradesh	91.7	100	100	33.3	100	12
Jammu & Kashmir	85.7	100	92.9	7.1	78.6	14
Jharkhand	87	78.3	95.7	34.8	91.3	23
Karnataka	84	100	100	44	88	25
Kerala	100	100	92.3	7.7	100	13
Lakshadweep	100	100	100	0	100	1
Madhya Pradesh	93.5	93.5	95.7	54.3	95.7	46
Maharashtra	90.6	100	96.9	46.9	93.8	32
Manipur	85.7	71.4	71.4	14.3	71.4	7
Meghalaya	75	100	100	25	100	4
Mizoram	75	50	75	0	87.5	8
Orissa	63.3	63.3	56.7	30	96.7	30
Puducherry	100	100	100	66.7	100	3
Punjab	95	95	100	15	100	20
Rajasthan	100	100	90.6	15.6	90.6	32
Sikkim	100	100	50	25	100	4
Tamil Nadu	93.1	93.1	96.6	34.5	96.6	29
Tripura	100	100	66.7	13.3	86.7	15
Uttar Pradesh	95.2	95.2	96.4	26.2	90.5	84
Uttarakhand	100	100	92.3	23.1	100	13
West Bengal	100	100	94.7	26.3	89.5	19
India	91.9	92.1	91.6	27.2	91.6	596
	548	549	546	162	546	

Source : DLHs-3(2007-08)

Note: N.C: Not calculated because there are no case, NIC: National Informatics Centre

Table A 8.7 : % of DHs Performing Assigned Tasks

States/Uts	Citizen's Charter Displayed (%)	RKS constituted (%)	RKS monitor regularly ¹ (100%)	Total number of DHs
A & Nr Islands	100	100	50	2
Andhra Pradesh	90.5	100	100	21
Arunachal Pradesh	37.5	81.3	100	16
Assam	91.3	82.6	94.7	23
Bihar	85.3	97.1	93.9	34
Chandigarh	100	100	100	1
Chhattisgarh	93.8	100	100	16
D & N Haveli	100	100	100	1
Daman & Diu	100	100	50	2
Delhi	nc	nc	nc	nc
Goa	100	66.7	100	3
Gujarat	88.8	100	100	25
Haryana	94.4	100	100	18
Himachal Pradesh	91.7	100	100	12
J&K	92.9	100	85.7	14
Jharkhand	65.2	30.4	85.7	23
Karnataka	100	72	100	25
Kerala	61.5	100	100	13
Lakshadweep	0	100	100	1
MadhyaPradesh	100	100	97.8	46
Maharashtra	93.8	90.6	100	32
Manipur	85.7	85.7	100	7
Meghalaya	100	75	100	4
Mizoram	87.5	75	100	8
Orissa	70	70	100	30
Puducherry	66.7	66.7	100	3
Punjab	100	100	85	20
Rajasthan	96.9	96.9	100	32
Sikkim	25	100	25	4
Tamil Nadu	82.8	93.1	85.2	29
Tripura	86.7	93.3	100	15
Uttar Pradesh	89.3	89.3	94.7	84
Uttarakhand	92.3	76.9	100	13
West Bengal	100	100	89.5	19
India	87.4	89.1	95.3	596
	521	531	506	

Source : DLHS-3

(Footnotes)

¹ Here, AIR 1981 SC 344 is the citation of the case. The full form of AIR is All India Reporter. It is the authorized official digest of cases in India. It denotes the details of a particular case like the year, page number, etc. of the particular case in question. Just next to AIR, is the year (1981 here) in which the case was decreed. SC denotes Supreme Court, and SCC (in relevant case citations) denotes Supreme Court Cases, indicating that the case in question was decided in the Supreme Court. Similarly, HC denotes the concerned High Court. In certain other citations the volume of the reporter is mentioned after the year, like if the aforementioned citation was AIR 1981 1 SC 344, the number 1 before SC indicates the volume.

² This is Latin legal maxim meaning ‘where there is a right, there is a remedy’; so as to also give us the corollary that where there is no right arising, the question of having a remedy also does not arise.

³ Art. 24 is a fundamental right which prohibits the employment of children below the age of 14 years in any hazardous employment in any factory, industry or mine.

⁴ Art 39 directs the State to take measures to ensure that no women or children of tender age are subjected to exploitation or forced to take up avocations that are unsuitable to their age and ability.

⁵ This case ushered in the ‘precautionary principle’ in environmental law in India. This case was all the more important due to its dating right after the Rio Declaration on Environment and Sustainable Development of 1992.

⁶ The precautionary principle in environmental law states that if an action or policy has the suspected risk of causing harm to the public or to the environment, in the absence of a scientific consensus that harm would not ensue, the burden of proof falls on those who would advocate taking the action.

METHODOLOGY FOR HDI CALCULATION

	Long And Healthy Life	Knowledge	Decent Standard of Living
HDI(Governance Report)	Infant Survival Rate= 1000-IMR	Literacy 7+	NSDP Per Capita(at 2004 Price)
Maximum Value	150(for IMR)	100	100000Rs
Minimum Value	0 (For IMR)	0	1000Rs
Formula for the Sub Index	$[X_i - \text{MIN}(X)] / [\text{Max}(X) - \text{Min}(X)]$ (A)	$[X_i - \text{MIN}(X)] / [\text{Max}(X) - \text{Min}(X)]$ (B)	$[\text{LOG}(X_i) - \text{MIN}(\text{LOGX})] / [\text{Max}(\text{LOGX}) - \text{Min}(\text{LOGX})]$ (C)

The HDI is calculated by taking simple average of three sub indices.

CORRUPTION INDEX METHODOLOGY DATA

Raw data for corruption index have been obtained from PRS Legislative Research which actually used corruption data from National Crime Records Bureau (NCRB). Data have been used from 2000 to 2009 for this purpose.

METHODOLOGY

Using the above data, a composite index for corruption has been developed on the basis of five different indicators of corruption which are given below:

- 1) Pending investigation on corruption from the previous year,
- 2) Cases on corruption registered during the year,
- 3) Value of property recovered seized (in '000 rupees),
- 4) Percentage of cases convicted to trials completed and

5) Cases in which final report submitted.

A summary statistics has been given for each of these indicators. It is important to note that '0' is not shown here as minimum value in this table even when many states have shown '0' value for last three indicators. The value zero may be due absence of cases or absence of data. Whatever in case of computing index, the zero has been considered as minimum value.

Each above indicator of corruption has been normalized using the following formula:

$$(X_i - X_{\min}) / (X_{\max} - X_{\min})$$

Using this formula, all values will range on a scale from '0' to '1' where the values '0' and '1' indicate the best and worst conditions respectively for an indicator. To build the final 'Corruption Index', normalized scores of all five indicators have been summed up. The exact formula used in the final composite index has been given below.

$$(\text{Sum of all normalized scores for all indicators}) / \text{number of indicators}$$

Summary Statistics	Total Sum of Pending Investigation from previous year	Total Sum of Cases Registered during the year	Total Sum of Value of Property recovered/seized (in Rs. '000)	Total Sum of Percentage of cases convicted to trials completed	Total Sum of Cases in which final report submitted
Minimum	2	1	2	1	1
Maximum	9926	4566	634735.6	759	791
Range	9924	4565	634733.6	758	790
Standard Deviation	2122.38	1232.28	128902.22	229.01	224.13

Source: Calculated from data provided by PRS Legislative Research

Thus, the final index developed is very simple in nature and the values ranges from '0' to '1'. Higher the value, higher the corruption is in a state where

'0' indicates 'least corrupted' state and '1' indicates 'most corrupted state.

One hypothetical example is given below to understand the methodology:

States	Cases on Corruption	(a) Cases on Corruption – normalized score	Value of property recovered in '000 rupee	(b) Value of property recovered in '000 rupee – normalized score	Cases convicted to trials	(c) Cases convicted to trials – normalized score	Corruption Index [(a+b+c) / 3]	RANK
Orissa	43	$= (43-34) / (78-34) = 0.205$	60	$= (60-56) / (86-56) = 0.133$	22	$= (22-17) / (48-17) = 0.161$	0.166	7
UP	46	0.273	76	0.667	34	0.548	0.496	5
WB	64	0.682	56	0.000	40	0.742	0.475	6
Bihar	34	0.000	67	0.367	17	0.000	0.122	8
Maharashtra	78	1.000	86	1.000	44	0.871	0.957	1
Gujarat	76	0.955	80	0.800	43	0.839	0.864	2
Tamil Nadu	68	0.773	71	0.500	48	1.000	0.758	4
Kerala	73	0.886	75	0.633	45	0.903	0.808	3

Maximum value for cases on corruption = 78,
Minimum cases on corruption = 34

Maximum value for property recovered = 86,
Minimum value for property recovered = 56

Maximum value for cases convicted to trials = 48,
Minimum value for cases convicted to trials = 17

Total numbers of indicators = 3 in this illustration

Total number of states = 8 in this illustration

In this current report, corruption Index has been developed for each year from 2000 to 2009 and also a final composite index for states has been prepared on the basis of all the years.

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ABBREVIATIONS

AIEI	Association of Indian Engineering Industry	CCS	Centrally Sponsored Schemes
AIIMS	All India Institute of Medical Science	CDP	Community Development Programme
ANMs	Auxiliary Nurse Midwives	CDSCO	Central Drugs Standards Control Organization
ARC	Administrative Reforms Commission	CDTL	Central Drug Testing Laboratory
ASHA	Associated Social Health Activists	CEHAT	Centre for Enquiry into Health and Allied Themes
ASSOCHAM	Associated Chambers of Commerce & Industry	CEI	Confederation of Engineering Industry
ATR	Action Taken Report	CENVAT	Central Value Added Tax
AYUSH	Ayurvedic, Yoga, Unani, Siddha and Homeopathy Systems of Health	CGD	Centre for Global Development
BHN	Block Health Nurse	CGHR	Centre for Global Health Research
BIFR	Board for Industrial and Financial Reconstruction	CGHS	Central Government Health Scheme
BIMARU	Bihar Madhya Pradesh Assam Rajasthan Uttar Pradesh	CHC	Community Health Centre
BMC	Municipal Corporation Of Greater Mumbai	CHI	Community Health Insurance
BNY	Bharat Nirman Yojna	CHN	Cluster Health Nurse
BPL	Below Poverty Line	CIC	Chief Information Commission
BPMU	Block Programme Management Unit	CII	Confederation of Indian Industry
BSUP	Basic Services to the Urban Poor	COPD	Chronic Obstructive Pulmonary Disease
CAA	Constitutional Amendment Act	CPHS	Comprehensive Primary Health Care
CAG	Comptroller & Accountant General	CPIA	Country Policy and Institutional Assessment
CAT	Central Administrative Tribunal	CPSEs	Central Public Sector Enterprises
CBDM	Certified Business Data Modeler	CPWD	Central Public Works Department
		CSDS	Centre for the Study of Developing Societies

CSIR	Council of Scientific and Industrial Research	ESIS	Employees State Insurance Scheme
CSO	Central Statistical Organization	EWS	Economically Weaker Section
CSS	Centrally Sponsored Schemes	FDI	Foreign Direct Investment
CSSM	Child Survival and Safe Motherhood Programme	FICCI	Federation of Indian Chambers of Industry & Commerce
CSSO	Center for the Study of Social Organization	FRBMA	Fiscal Responsibility and Budget Management Act
CSWB	Central Social Welfare Board	FYPs	Five Year Plans
CVD	Cardiovascular Diseases	GDP	Gross Domestic Product
DAC	Development Assistance Committee	GFD	Gross Fiscal Deficit
DBT	Department of Biotechnology	GIA	Grant in Aid
DCGI	Drugs Controller General of India	GIC	General Insurance Corporation
DDWS	Department of Drinking Water Supply	GNM	General Nursing and Midwifery
DFID	Department for International Development	GoI	Government of India
DGHS	Directorate General of Health Services	GP	Gram Panchayat
DGP	Director General Police	GST	Goods and Services Tax
DHAP	District Health Action Plan	HDI	Human Development Index
DLHS	District Level Health Survey	HDR	Human Development Report
DM	District Magistrate	HIS	Health Information Systems
DoPT	Department of Personnel and Training	HMO	Health Maintenance Organization
DPCs	District Planning Committees	HMP	Hereditary Members of Parliament
DPE	Department of Public Enterprises	HSP	Health Systems Project
DPMU	District Programme Management Unit	HSR	Health Sector Reforms
DRSCs	Department Related Standing Committees	IAS	Indian Administrative Services
DTAB	Drug Technical Advisory Board	IAY	Indira Awas Yojna
DTC	Direct Taxes Code	ICMR	Indian Council of Medical Research
DWCRA	Development of Women and Children in Rural Areas	ICPD	International Conference on Population and Development
EAG	Empowered Action Group	ICSSR	Indian Council of Social Science Research
EAS	Employment Assurance Scheme	IDSP	Integrated Disease Surveillance Project
ECHS	Educational Commission for Health Sciences	IEDC	International Economic Development Council
EDP	Entrepreneurship Development Programme	IHD	Institute for Human Development
EGM	Empowered Group of Ministers	IHSDP	Integrated Housing and Slum Development Programme
EPP	Empanelled Private Provider	IIHMR	Indian Institute of Health Management Research
EPW	Empowered Procurement Wing	IMR	Infant Mortality Rate

IMS	Indian Medical Service	MPCs	Metropolitan Planning Committees
IPC	Indian Penal Code	MPLADS	Member of Parliament Local Area Development Scheme
IPHS	Indian Public Health Standards	MPs	Members of Parliament
IRCON	Indian Railways Construction International	MPWs	Multipurpose workers
IRDA	Insurance Regulatory and Development Authority	MRTTP	Monopoly Restrictive Trade Practices
IRDPA	Integrated Rural Development Program	MTP	Medical Termination of Pregnancy
ISMH	National Policy on Indian Systems of Medicines and Homeopathy	NCDs	Non Communicable Diseases
ITDP	Institute for Transportation and Development Policy	NCHRC	National Child Health Resource Centre
IUD	Intra Uterine Device	NCMH	National Commission on Macroeconomics and Health
JIPMER	Jawaharlal Institute of Post Graduate Medical Education and Research	NDCP	National Disease Control Programmes
JNURM	Jawaharlal Nehru Urban Renewal Mission	NDMA	National Disaster Management Authority
JRY	Jawahar Rojgar Yojna	NFHS	National Family Health Survey
KSY	Kishori Shakti Yojana	NGOs	Non-Governmental Organizations
KVIC	Khadi and Village Industries Commission	NGP	Nirmal Gram Puraskar
LAMS	Learning Activity Management System	NHP	National Health Policy
LBP	Stem-Loop Binding Protein	NHPC	Hydro Power Corporation
LHV	Lady Health Visitor	NIF	National Investment Fund
LIG	Lower Income Group	NIFP	National Institute of Family Planning
MAEF	Maulana Azad Education Foundation	NIHAE	National Institute of Health Administration and Education
MCI	Medical Council of India	NIHFW	National Institute of Health and Family Welfare
MDG	Millennium Development Goals	NIPi	Norway - India Partnership Initiative
MDMS	Mid-Day-Meal Scheme	NMEW	National Mission for Empowerment of Women
MLA	Member of Legislative Assembly	NPC	National Planning Committee
MMGSY	Mukhya Mantri Grameen Sadak Yojana	NPPA	National Pharmaceutical Pricing Authority
MMR	Maternal mortality Ratio	NREGA	National Rural Employment Guarantee Act
MNC	Multi National Corporation	NRHM	National Rural Health Mission
MNGO,	Mother NGOs	NRLM	National Rural Livelihood Mission
MNREGS	Mahatma Gandhi National Rural Employment Programme Schemes	NSAP	National Social Assistance Programme
MoH&FW	Ministry of Health and Family Welfare	NSDP	National State Domestic Product
MoPR	Ministry of Panchayati Raj	NSS	National Sample Survey
MoRD	Ministry of Rural Development	NSSO	National Sample Survey Organization
MoWR	Ministry of Water Resources	NTPC	National Thermal Power Corporation



O&M	Organization and Methods	SMS	Short Message Service
OECD	Organisation for Economic Co-operation and Development	SPHC	Selective Primary Health Care
OHSDP	Orissa Health Systems Development Project	SSA	Sarva Shiksha Abhiyan
OOP	Out-of –Pocket Expenditure	TB	Tuberculosis
PHC	Primary Health Centre	TFR	Total Fertility Rate
PHERC	Public Health Education & Research Consortium	TNMSC	Tamil Nadu medical Services Corporation
PHFI	Public Health Foundation of India	TPA	Third Party Administrators
PIP	Programme Implementation Plan	UEE	Universal Elementary Education
PMGSY	Pradhan Mantri Grameen Sadak Yojana	UGC	University Grant Commission
PPP	Public Private Partnership	UHS	Universal Health Insurance Scheme
PRIs	Panchayati Raj Institution	UIDSSMT	Urban Infrastructure and Development Scheme for Small and Medium Towns
PSP	Private Sector Provider	UIG	Urban Infrastructure and Governance
PSU	Public Sector Undertaking	ULBs	Urban Local Bodies
PWD	Public Works Department	ULCRA	Urban Land Ceiling & Regulation Act
RAHI	Rapid Appraisal of Health Intervention	UNDP	United Nations Development Programme
RBI	Reserve Bank of India	UNGASS	United Nations General Assembly Special Session
RCH	Reproductive and Child Health	UNICEF	United Nations International Children's Emergency Fund
RD	Rural Development	USA	United State of America
REO	Rural Engineering Organisation	USAID	United States Agency for International Development
RGGGH	Rajiv Gandhi Government General Hospital	VAT	Value Added Tax
RKS	Rogi Kalyan Samiti	VEP	Visual Evoked Potential
RMK	Rashtriya Mahila Kosh	VHAI	Voluntary Health Association of India
RSBY	Rashtriya Swasthya Bima Yojna	VHN	Village Health Nurse
RTI	Right to Information	VHSC	Village Health and Sanitation Committee
SC	Standing Committees	VIP	Very Important Person
SEWA	Self –Employed Women's Association	VOs	Voluntary Organizations
SHC	Sub-Health Centre	WB	World Bank
SHGs	Self Help Groups	WCD	Women & Child Development
SHH	Student's Health Home	WHO	World Health Organization
SHI	Social Health Insurance	YAS	Youth Affairs & Sports
SHN	Sector Health Nurse	2G	Second Generation
SHO	Station House Officer		
SJGY	Swaran Jayanti Grameen Rojgar Yojna		
SLPE	State Level Public Enterprises		
SLPP	Simple Loop Prevention Protocol		

