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Third Status Report

The Commission has made explicit its perspective on interaction between the Government and the citizens and provided practical inputs for improvements in various areas of governance including access to health, drug control, food safety and reforms in revenue-related services. The key focus area for recommendations in this report is restructuring the public sector health system and regulatory framework for the private sector health providers.

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Preface

The First Status Report was largely on 'as is, where is' reporting of the administrative affairs as observed by the Commission. The Second Status Report took stock of the status and possible future developments in various areas of governance including fiscal management, citizen services, social security schemes, police station reforms, institutional framework for delivery of services. The key focus area for recommendations in this report was combating the female foeticide.

The Third Status Report of the Commission has attempted to provide a framework for the citizens' interaction with the government. It has also prioritised the interventions for improvements in governance. The Commission has made explicit its perspective on interaction between the Government and the citizens and provided practical inputs for improvements in various areas of governance including access to health, drug control, food safety and reforms in revenue-related services. The key focus area for recommendations in this report is restructuring the public sector health system and regulatory framework for the private sector health providers.

The Commission proposes to submit reports on Social Development, Physical Security, Safety and Justice, Social Security, and Welfare Schemes and Livelihood and Employment. To prepare these reports, four task groups have been setup.

The Commission has received number of suggestions from the common people, political leaders, senior civil servants and other stakeholders. We shall continue to interact with them. The Action Taken Report on the First and Second Status Reports sent to the Commission by the Chief Secretary's Empowerment Committee duly approved by the Chief Minister and the Deputy Chief Minister showed the commitment of the Government to bring about governance reforms.

Pramod Kumar
Chairman, PGRC

Introduction

Governance! For whom and for what? This legitimate question normally gets lost in the processes, procedures and application of technology. To illustrate, the application of unique ID numbers, no doubt, shall provide efficiency, but only to the existing process of undignified and exploitative exchange between the citizens and the government. These rules of exchange in many spheres do not protect the rights and the entitlements of the people on the margins besides treating a fairly large section of the citizenry in an undignified manner.

Rules of governance have become so overtly violative that the system has been rendered non-functional. Earlier, an easy explanation used to be the prevalence of corruption, high transaction costs and lack of transparency.[1] An interesting outcome is that even corruption has ceased to perform one of its foremost functions i.e. facilitation and efficiency. This has been exemplified in the preparation for the Commonwealth Games, wherein even large scale corruption could not induce efficiency. A clear message emerges that the system has ceased to be functional. And consequently, army (as reported in the media), had to be assigned the task of killing mosquitoes to facilitate Dengue-free hosting of the Commonwealth Games.

A near collapse of governance is the dominant feature of the contemporary reality. There are evidences, a section of justice delivery system becoming compromised, politics opportunistic, economy less productive and more accumulative, culture consumerist and utilitarian, and the society directionless and normless. Society, by and large, has become conformist, cynicism is taking over and the revivalist tendencies are becoming all pervasive. There is a belief that political stability (read stagnation) is a necessary condition for growth and, hence, the need for formation of coalition governments. Stability at any cost is the new catchphrase. As such, the argument goes that any dissent that questions the existing order of things must be curtailed. Dissent is treated as a cardinal sin. The spirit of enquiry is welcome, but only to question the individual acts of indiscretion or events.

As a corollary, individuals are projected as either villains or heroes. Not only this, today's villains become tomorrow's heroes by triggering a greater evil. Since the lesser evil is the norm, these villains become heroes.

Any attempt to question the process or the system is held up as a threat to "stability". The threat to stability is synonymous with the threat to the control which a few individuals exercise over the levers of power. It is like disturbing the stability of stagnant water which is full of dirt, stink and germs. Anyone disturbing this "stability" is accused of being anti-social and anti-national because he stirs up the stink which is unbearable and makes the system unstable.

Today's maxim, then, is to prevent the process behind these acts or events from coming to the surface. Isolate an individual or event from its social setting, hang the individual and insulate the process. Stability must not be disturbed and dissent must not question the system.

[1] The corruption induced convenience is under tension. But there is self-corrective factor which is becoming operative. Paradoxically, efforts are being made to reduce corruption at the cutting-edge level (much to the relief of the common person) and maximised in 'big deals'.

The lesson is that there is an urgent need to make the system functional and governance pro-people.

Historically, governance has been a prisoner of the colonial non-faith citizen-government exchange. And, the relationship between the state and the nation has acquired meaning in the background of national freedom movement and post-colonial context. The interaction of the state and the nation (Awam) continued to remain divergent, even antagonistic, in terms of realisation of the claims, entitlements and rights. The dominant discourse is largely shaped by disenchantment of 'nation' with the state. And, it is reflected in more than one ways. Most of the times, the expression of frustration is directed at the symbols of the state. This divergence is more structural than behavioural. The institutions, norms and procedures continued to function as colonial constructs, causing a visible disconnect between the nation and the state. The political and constitutional changes could not transform the activised nation into a participating civil society. And, at the same time, the state conferred citizenship on the colonial subjects in a formal sense, but its substance in many ways provided continuity to some of the retrograde colonial practices.

In other words, the substance of citizenship is related to the evolution of the state. The post-colonial state continued to rely on the processes and procedures treating citizens as colonial subjects. The perpetuation of these practices made the whole conception of citizenship as 'deficient'. As has been established in the literature, boundaries of citizenship are dynamic in nature and evolve historically. At the same time, it is not to overlook the fact that it is inherent in the nature of state to interact with the citizens as subjects. But, a crucial distinction to be noted is that freedom and autonomy conferred on the citizens varies from the colonial subjects to the subjects in democratic and egalitarian societies.

> It is important, moreover, to explore these various strands in their specific historical contexts keeping in mind, however, that at each historical moment, the earlier strands co-exist, keeping alive the tensions and uncertainties over the form and context of citizenship.[2]

For realisation of full citizenship, 'activised nation' is yet to be fully transformed into a civil society. The transformation of the civil society is constrained by the colonial legacy in which sovereignty continues to be located in territorial nationalism and free market and not with the citizens. Therefore, the legal rights conferred on the citizens could not be fully realised in actual practice and the state failed to respond to the needs of the individual citizens.

The meaning of citizenship in post-colonial societies remains ambivalent or extremely vague. However, there are certain 'practical values' which have come to be associated with the idea of citizenship. In this sense, there are two sets of values through which the people connect as citizens with the State, i.e. value of welfare as reflected in the dole-giver and dole-receiver interaction and, second is the value of political power and material wealth. The value of power position and possession of material wealth enable them to realise their claims. The value of hierarchical power position and material wealth builds a collaborative arrangement between those who govern and those who are governed which has been rightly phrased by Korten, as 'coalition of indifference'.[3]

[2] Roy Anupama (2010), *Mapping Citizenship in India*, Oxford University Press, New Delhi, pg. 13.
[3] David Korten (1983), *Bureaucracy and the Poor: Closing the Gaps*, Kumarian London, pg. 32.

> For example, in many developing countries, where the predominant need in the health sector is for preventive public health measures (this is what the poor, especially the rural poor need), quite frequently, the bulk of the resources are allocated to curative health measures (this is what the rich and the advantaged who also constitute the ruling elite, need). In other words, the government responds to the most politically-able segments of its 'market'.[4]

And, these privileged sections become custodians of the state and, not only appropriate their claims and even rights as citizens (which are denied to others), but misappropriate privileges and power. But, intense explorations with cross sections of people has uncovered certain commonalities in their experience of interactions with the State. These commonalities may not constitute the organisation of their collective life, but it reflects the way people connect with the State. Broadly, irrespective of their social positioning – these are values of identity, dignity and productivity. The narratives uncover how the people associate themselves with the State through these values. But non-realisation of values like identity, dignity and productivity for a large section of population results into an experience exclusion. In this sense, they remain 'deficient citizens'. There is a denial of 'personhood' across board to the citizens, as colonial construct reinforces the demand for what Hannah Arendt (1986) termed as 'the right to have rights'. The prerequisite right is based on the realisation of values like identity, dignity and productivity which, in turn, create a conducive environment for availment of other political, economic and social rights.

Identity

First and foremost initiative is to be taken to restore the identity of the citizens. Even after sixty years of Independence, citizens have to prove their identity. The post-colonial State has failed to change 'restrictive citizenship' to full citizenship. Hence, a major ingredient of the 'restrictive citizenship' is mistrust. This mistrust has been institutionalised to the extent that, even to prove their name, they have to seek affirmation from a gazetted officer of the government. For declarations relating to their profession, income, caste, residence proof, etc., affidavits are to be given on legal papers sworn before a Magistrate or public notary. Even to procure ration cards, electricity, sewerage and water connection, birth and death certificates, applications for admission to the educational institutions, affidavits attested by the gazetted officer or third party or public notary, or Magistrate have to be produced[5]. The govern-mentality continues to treat citizens as colonial subjects. It is, however, interesting to note that most of these affidavits are local inventions and are not required by law. On the contrary, there are legal provisions for imposing punishment on the citizens for making wrong declarations. For instance, Section 199 of the I.P.C. stipulates that;

> Whoever, in any declaration made or subscribed by him, which declaration any Court of Justice, or any public servant or other person, is bound or authorized by law to receive as evidence of any fact, makes any statement which is false, and which he either knows or believes to be false or does not believe to be true, touching any

[4] Khan Adil, M. (2005), *Engaged Governance: A Strategy for Mainstreaming of Citizens into the Public Policy Process*, Economic and Social Affairs, United Nations, pg. 7.

[5] Punjab Government by its order discontinued the practice of submission of affidavits unless it is required by law. A list of affidavits eliminated (submitted by Deputy Commission, Sangrur) is being reproduced. (See Annexure I to Introduction). Other districts are in the process of eliminating this practice.

point material to the object for which the declaration is made or used, shall be punished in the same manner as if he gave false evidence.

And, Section 200. states that;

> Whoever corruptly uses or attempts to use as true any such declaration, knowing the same to be false in any material point, shall be punished in the same manner as if he gave false evidence.

But 'govern-mentality' of mistrust has resisted any attempt to repose trust in its own citizens by accepting self-declarations as reliable and authentic. It is, therefore, urgent to discontinue the practice of attestations by third parties and replace the same with self-declarations as a step towards bridging the dichotomy between the state and the nation.

Further, the administrative fragmentation of population on the basis of caste and religion, within 'restrictive citizenship' has multiplied social cleavages and led to the denial of full citizenship. The decision to conduct caste-based Census is a sign of diversity insensitivity that shall only produce fractured identity as a citizen. And, the Government's oft-proclaimed inclusive growth will become prisoner to the exclusive social categories.

The power dynamics has also created a class in possession of the red beacons and security guards as a status symbol with exclusive identity. To illustrate, as the threat of terrorism in Punjab is decreasing in the case of individuals and, is on the increase in so far as people and Public spaces are concerned, the number of individual protectees is multiplying. This clearly shows that security cover has become a status symbol for power holders and denial of this to the large public depicts a built-in contempt and indifference for the common citizens security.

Dignity

Absence of citizenship status is reflected in everyday interactions of the people with the government, and is characterised by lack of respect and dignity. 'The understanding of citizenship, therefore, needs to be conceptually grounded keeping in mind the principles of universalisation and those of the dignity of the individual'.[6] A prerequisite condition to claim rights and entitlements as a citizen is to be treated with dignity as human being. The narrative of people irrespective of their caste, religion, social status uncovers a strong feeling of loss dignity in their interactions with government, particularly the police, revenue collection agencies, and district administration. In addition to this, the accentuated perception of the loss of dignity is narrated by the marginalised groups like dalits, women, minorities etc., in the context of structural need for recognition and respect for their difference.

However, there are forms of indignities which are experienced by people in their everyday interaction with the government. These forms are rooted in the cultural domains in which various institutions have been evolved and nurtured. These indignities range from the denial of 'personhood' to coercive extraction of material wealth.

The spatial disconnect experienced by the citizens in the police stations, in particular and District Collectorates in general, is more pronounced. The visit to these spaces gives a

[6] Gupta, Dipankar (August 1999), "Survivors or Survivals: Reconciling Citizenship and Cultural Particularisms", *Economic and Political Weekly*, pg. 2313.

feeling of alien space and a sense of loss of dignity and identity. And, interactions with the police and consequent loss of dignity has been described succinctly in the Fifth Report of the National Police Commission (November 1980). The Commission expressed anguish that the 1902 Fraser Commission's observation that 'people' now may not dread the police, but they certainly dread getting involved with it in any capacity, continues to be valid. It is, therefore, not surprising that the quote of Sir Phillip Chetwode is displayed in some of the police stations stating that;

> The safety, honour and welfare of your country comes first, always and every time;
>
> The honour, welfare and comfort of the men you command, comes next;
>
> Your own ease, comfort and safety comes last, always and every time.

In this pronouncement, citizen's safety, security and dignity has not been even mentioned. This converged with the current disposition of a majority of the police personnel who regarded the authoritarian to be the only appropriate mode to deal with the citizens. And, people also dread getting messed up with the police. Their (People) general strategy of survival perfected over generations of experience, is to stay away from entanglement with government and its procedures.[7] Ram Gopal, a dalit in rural Meerut was sad that his wife had been raped by a Member of Legislative Assembly (MLA) in Uttar Pradesh. A group of researchers including myself reached the village and two young activists narrated to us the story of Ram Gopal in his presence. We were concerned and suggested that the matter should be brought to the notice of the police and also reported in the media. As we were proceeding to lodge the complaint with the police, Ram Gopal retorted that he does not need our help and told us to leave him alone and mind our own business. He murmured that reporting to the police shall further rob his family of their dignity and add to their torture and even risk their survival. The language of power is different from the language of justice. The institutions of justice delivery understand with clarity the language of power and material rather than listening to the feeble voices of the dispossessed.

Productivity

A third set of prerequisites relates to the productivity, i.e. to engage people with the system in a productive manner and provide conducive conditions to nurture people's capacity to be productive and their ability to exercise some degree of control over their lives. In the post-colonial state, the Ria-Mai-Bap political culture has been institutionalised to engage people with the state.

In this political culture, rights are given as doles to the poor and doles are presented as rights to the privileged. For instance, subsidies to enhance productivity of the poor are given as doles. These doles are packaged as spoils to be shared between the dole-giver and the dole-receiver. In this process, the purpose to build productive capacity and enhance productivity of the poor gets defeated. Instead of productive engagement of the citizen, a culture of sharing of the spoils is reinforced. And, it also results into denial of the conditions to avail opportunities. The story of a dalit in a village clearly depicts the need for productive engagement of the people without means. A dalit in a village, in response to a question about his wishlist, replied that his first wish was to have a school, second, to have a health centre and, lastly, brick lanes for the village. In reply to the related question, will send his

[7] Chattergee, Partha, *The Politics of the Governed*, Permanent Black, New Delhi, pg. 6.

child to school? He replied in the negative. And, explained that he needs extra income for survival and, hence, he will send his child to earn a living. In reply to another question, will he go to the village dispensary for medical treatment, he again replied in the negative. He clarified that he would prefer to get treatment from a village quack as he will be able to get to work in a short span of time. Does he have a bicycle? He said no. Why, then, he needs brick lanes in the village. Because everyone else is asking for these. He has mind of his own, but ideas of somebody else. His foremost need is to be productively engaged to earn a livelihood and, thereafter, he and his family will be able to have access to education, health, physical infrastructure etc. The main agenda of the State should be to build productive capacity by making provisions for structured subsidies.

Why are subsides taken as synonymous with populism? Why are the welfare schemes directed at the poor branded as populist? Why are the political leaders who formulate pro-poor policies accused of being reckless with the State exchequer? Why subsidies, if directed at the poor, are termed as dole-outs? On the contrary, if subsidies are directed to protect the profits, these are described as 'rescue' packages.

Doles are feudal response to the crisis of capitalism. Subsidies are capitalist answer to the crisis of capitalism. And, elimination of subsidies for the poor is market fundamentalist response to the crisis of capitalism. The Government should try to overcome abdication of the pro-poor agenda. Otherwise, the market shall govern.

> Most importantly, the market only responds to the needs of those who have the capacity (or economic/political clout) to pay and not those who do not possess this capacity but need these services desperately. Furthermore, resources generated through sales of public assets were not always used for development activities but, instead, were utilized either for servicing accumulated debts (around programs from which the poor rarely benefited) or poured into state activities that were of little or marginal relevance to the socio-economic needs of the broader population.[8]

The task of the State is to moderate the callousness of the market and create conditions for the people to be productive. The need, therefore, is to subsidise the people without means so that as human beings they become productive, their survival competitive and social existence equitable.

These prerequisites have not been directly addressed in the discourse on citizens' interaction with the State. It is precisely because of this that the restrictive citizenship has resulted into non-realisation of the entitlements as rights particularly for the excluded groups.

This has directly impinged upon the citizens' availment of the following rights:

(a) Right to Social Development (e.g. Education, Public Health, Housing).

(b) Right to Social Security and Safety Nets.

(c) Right to Physical Security, Safety and Justice.

(d) Right to Livelihood and Employment

[8] Khan Adil M. (2005), op.cit. p. 7.

Having recognised the need to transform the status of colonial subjects to subjects, the relevance of across-the-board notion of full citizenship has to be made integral to governance. Further, this notion of full citizenship has to be mediated by overcoming constraints based on gender, caste, ethnicity and religious identities.

These values and rights can be realised only if the actions reflect the political will and ensure opportunities along with provisions of conditions to avail these and institutionalisation of the processes and procedures for the citizens' engagement.

The pursuit of 'engaged governance' has to be based on democratic principles with attributes like participation, representation, distributive justice, accountability and fairness. Engaged governance has been aptly described as,

> an institutional arrangement that links citizens more directly into the decision-making processes of a state so as to enable them to influence the public policies and programmes in a manner that impacts more positively on their social and economic life.[9]

The values and rights can be implemented if the structural constraints emanating from the post-colonial nature of state and society, a priori, to the socio-economic conditions and legal impediments are recognised and moderated. These structural constraints of identity, dignity and productivity have a bearing on the realisation of the principle of equity which is a core concept for the Commission. For a limited purpose of this Commission, equity of access is defined from the supply side consideration. In other words, equal services are to be made available to the citizens in equal need. It also implies to have a critical look at the functioning of the supply side institution of the delivery of services to ensure full citizenship and guarantee rights of the marginalised sections. The distinction between variations in the services made available and services availed have to be captured to locate these into systemic inequities suffered by the identifiable groups of citizens.

The concept of need is ideological as also the capacity to avail these services. For the purpose of the Commission, in the first stage, the needs should be assessed in the context of social environment in which the individual lives. And, thereafter comes the task to formulate the policies relating to availability, quality, costs, information etc.

- Availability: certain services may not be available to some population groups, or delivery personnel may have different propensities to offer services to individuals with identical needs from different population groups.
- Quality: the quality of certain services offered to identical needs may vary between the population groups.
- Costs: the delivery system may impose costs (financial or otherwise) which vary between the population groups.
- Information: the delivery services may fail to ensure that the availability of certain services is known with equal clarity by all the population groups.

Along with availability, it is utilisation which reflects the process through which 'potential access' is converted into 'realised access'. The 'realised access' shall largely depend upon

[9] Khan, Adil M. (2005), ibid. p. 20

the linkages of delivery policy with delivery system and its resource structure and strata-wise nature and level of the utilisation of services.

For example, utilisation of health services is based on the nature of mobidity patterns, health-seeking behaviour and their experience with the private and public health service-providers. In the present report, a critical analysis of all these, has shown that health inequities reflect the unequal distribution of power, prestige and resources among the various groups in the society.

On infrastructure, the study found that the availability of health infrastructure for primary care is both highly inadequate and sub-standard in the State and is much below the national standards. The situation for the secondary and tertiary care appears to be a bit better. However, once we move beyond the numbers, the condition of the secondary and tertiary health care is also very disturbing. The range of the challenges is very wide: poor hygiene and sanitation conditions, absence of medicines and poor diagnostic facilities, poor working conditions for the staff, un-thoughtful application of the privatisation principle, scarcity of specialists, non-transparency and adhocism in staff postings, inadequacy of resources for maintenance, in particular, for ambulance, washing, minor repairs, petrol for generators, X-ray films, water, sanitation, cleanliness, patient infrastructure and medicines.

Overall, the performance of the government in spending the allocated resources for the health sector has not been very impressive and is definitely not enough to overcome the historical neglect of the social and, in particular, health sector in Punjab. Bulk of the health expenditure burden falls on the households (76 percent of health expenditure is made by the households and only 18 percent by the government). The public expenditure is characterized by low levels of per capita public expenditure in health, neglect of social sector in general and medical, public health, water and sanitation in particular; neglect of asset-creating expenditure and non-salary components in the health sector and for providing water and sanitation facilities; low expenditure on nutrition; high dependence on central transfers for deciding expenditure priorities and expenditure in health; urban bias in health expenditure; diversion of funds from the health sector to the other sectors in the 11th Plan; low utilisation rates of meagre allocations in the health sector during the 10th Plan period and the early years of 11th Plan and, in recent years, the financial performance of the Centrally Sponsored and Sharing Schemes have been better than the State-Funded Schemes in Punjab.

On access to health services, the report finds that the social gap in access to health services across gender, income and social groups is large in the State and has even increased in the recent years. Recent policy initiatives appear to be silent on the inequalities in access of the existing health services. The morbidity patterns suggest that the diseases related with conditions of life and living and conditions of work are very significant in Punjab. Significantly, disease patterns within the State show that still a large portion of the diseases are communicable in nature. The paper opines that it is erroneous to assume that Punjab has gone through the epidemiological transition and that only the lifestyle diseases are now the cause of worry. While it is true that the burden of life style diseases is increasing, Punjab's major disease burden is still formed by the diseases that are dependent very much on basic water and sanitation and directly related with the levels of income at the household level. The national programs to address specific morbidities might not be enough to meet the State-specific needs.

The trend in health-seeking behaviour in Punjab suggests that the already low utilisation of public facilities has gone through a serious decline between 1995 and 2004. The decline is much faster in the rural areas compared to the urban. The reasons for this decline are revealed in the perceptions about health care and reasons for non-treatment. People are being compelled to seek expensive private care, knowing well that it is not a sustainable alternative in the long run, given the unregulated, exploitative and sub-standard health care that the public sector provides on an average to the vast majority of the citizens in the State. The share of the people citing financial reason as cause of non-treatment is fairly high in the State, there is a gradient along the monthly per capita consumption quintiles and SCs have the highest share of untreated morbidity compared to other social groups in the State. Untreated morbidity in the rural areas of Punjab is higher than in the urban areas, thereby, clearly indicating the lack of access to health services in the rural areas.

The challenges in secondary and tertiary health care identified in the surveys reported are: cleanliness; recruitment of doctors, specialists and paramedical staff; provision of basic facilities such as water supply, toilet, regular electricity supply, generator, water tank, timely repair of accessories and machines; overhauling the process and structure of the supply of essential medicines to the hospitals and the availability of subsidized medicines for the BPL families. 10.3% of the respondents expressed satisfaction with the availability of medicines in OPD and 13.4% were satisfied with it in the hospitals. Respondents found the facilities unsatisfactory in the OPDs of CHCs, although they found it to be good in the indoor wards of CHC. Interestingly, the civil servants, elected representatives and health administrators, when interviewed, focussed more on solutions rather than on identifying the challenges. They suggested need for more contractual employees; need to introduce public private partnership model; fill up vacant staff positions; improve emergency services and increase the supply of essential drugs as priority areas for the policy on health.

Evaluation of the existing policy framework suggests, either an attempt to continue to do more of what has been done over the years or bring in the private sector to address the challenges. The initiatives suggest government's belief in continuing with the existing multiple agency management of the health structure; continued faith in Punjab Health System Corporation in implementation of the national health programmes under NRHM and NUHM; strong belief in public – private partnerships in health to supplement the government's effort in utilization of health services, conservation of scarce public resources, revenue generation for private and public sector, regular supply of medicines, meet the shortage of staff, meet the training needs of health workers, improve infrastructure and facilities and provide emergency care; orientation to redefine the role of the state from being a provider to a financier of health services; introduce health insurance for protecting poor from the impoverishing effect of illness rather than treating health as a matter of right for all citizens; not being sensitive to the reality of inequalities in access to basic health services but being more focussed on efficiency issues by applying benefit incidence norm to health expenditure, giving greater control to top administrators for punitive action and monitoring absentees and so on; and finally, greater dependence on Central Government for leadership in the health sector.

As a way out to meet these challenges, the report suggests the following core areas for policy - the inadequacy of public provisioning of health facilities and basic sanitation facilities; inequities in social infrastructure - mainly access and utilization issues; absence of effective public health programs; high cost of health care, even in public institutions; health

initiatives for addressing State-specific morbidity challenges; and increasing financial allocations for the health sector.

The State of Punjab needs to have its own health policy based on its own specificities. At the moment, the State is completely dependent on the Central Government for social sector programs. Furthermore, there is a need to correct the mismatch between the morbidities in the State and the disease control programs and medicines supplied in the State; improve the availability of essential drugs; recognise the usefulness of clean water and gains from basic sanitation. The State-specific policy must recognise the significance of safety at work in choosing health priorities and making health expenditure; build environment and social conditions that contribute positively to health and development; promote studies to identify determinants of health at the local level; identify mechanisms to improve access of public health services in urban Punjab by the urban poor and reduce the cost of public health in the rural areas for the rural poor.

The report strongly argues for the existing institutions to be reclassified into three categories - Primary Care Centre's (where basic clinical services will be provided), First Referral Units (FRUs), and Hospitals or Multi-Specialty Hospitals. It is also suggested to consolidate sub-centres and increase the capacity of ANMs, MHWs and Supervisors to provide basic emergency services at the sub-centre level and FRUs to have a full-fledged diagnostic centres where range of specialties will be made available. The recommendation is to convert current PHCs and/or CHC's into FRUs and also create additional FRUs.

The report also makes recommendation for the third tier of health care namely hospitals and multi-specialty hospitals. The first challenge here is to have adequate doctors, particularly specialists. Public-funded medical education is one important way to meet this challenge. Inadequate seats in the existing institutions for super specialty training is another dimension that needs to be addressed. The strategy of creating medical professionals through private institutions is very flawed. There is a need to make the market responsive to the needs of public health. Government has to become a key guarantor of affordable health care. The Government must regulate 'out of pocket expenditure' in private health care.

It is proposed to introduce Punjab State Private Health Regulation Bill to provide quality and affordable health services (see Annexure II to Introduction). In addition, a State-level Authority should be set up to check the adulteration of food.

It is also felt that to introduce accountability in Public sector, the delivery of Public services may be brought under the ambit of law (as has been done by the Government of Madhya Pradesh). This has become urgent.

Pramod Kumar
Chairperson, PGRC

Chapter 1
Post-Reform Economic Development in Punjab: An Introductory Note*

The economic development experience of the economy of the State of Punjab since the advent of green revolution remained quite dynamic. The prosperity ushered in Punjab in the late sixties allowed its economy to occupy first rank in terms of per capita income among the major States of the Indian Union. The dynamic economy of Punjab not only continued its leading position in terms of per capita income for more than three decades, but dramatically reduced the population living below poverty line[10] along with ensuring food security of the country as a whole. Legitimately, the development experience of the Punjab economy has been presented as a successful capitalist model of economic development worth emulating in other States of India in particular and the less developed countries in general. However, the policies of liberalization, privatization and globalisation, on the one hand, and political turmoil in early nineteen nineties. Fed to the neglect of the structural problems faced by the Punjab model of economic development, which persisted over the decades. Consequently, the economic development process slowed down and turned the Punjab economy from the most dynamic and leading economy to a laggard one as compared with the overall economic performance of the Indian economy as well as with the fast growing States. An attempt has been made to investigate the derailment of the development process with a view to providing plausible alternative policy suggestions for the rejuvenation of the economy of the Punjab State.

1.1. Post-Reform Deceleration of Economic Growth in Punjab: Evidence

In the post-reform period, Punjab economy grew at a rate much slower than the overall rate of economic growth of the Indian economy[11]. According to per capita income estimates, the rank of Punjab State was number one towards the end of the 20th century, that is, 1999-2000. The per capita income of Punjab State in 1999-2000 was of the order of Rs. 25,631, which was higher than the per capita income of India's economy (Rs. 15881) by Rs. 9,750. This gap of Punjab State's per capita income declined substantially, during the early years of 21st century, which was just Rs. 7,367 in the year 2007-08.

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*A brief abstract of the note prepared by Prof. Lakhwinder Singh of Department of Economics is being reproduced. A separate task group has been set up to prepare a comprehensive policy paper on this subject.

[10] Punjab state has dramatically reduced population below the poverty line. The population living below the poverty line in Punjab, according to consumer expenditure survey conducted by the NSSO during 2004-05 was 8.4 per cent against the 27.5 per cent of all India (Chaudhuri and Gupta 2009). It is important to notice here that during peak period of green revolution (1973-74 to 1977-78), the population below poverty line declined at a rate over 2 percentage points per annum. However, the poverty reduction rate has slowed down during the period 1993-94 to 2004-05 and the rate of decline was just 0.3 percentage points per annum.

Ahluwalia, I. J. (2010) 'Social Sector Development: A Perspective From Punjab', in Shankar Acharya and Rakesh Mohan (eds.) **India's Economy-Performance and Challenges: Essays in Honour of Montek Singh Ahluwalia**, New Delhi: Oxford University Press: 286-327.

[11] Economic development experience, during the last two decades, in Punjab suffered a setback due partly to the impact of militant moment in the 1980s. But the end of militancy in the early period of 1990s and continued deterioration in the growth process thereafter has pointed out the failure of the government policies to stimulate economic growth in Punjab.

Ahluwalia, I. J. (2009) 'Challenges of Economic Development in Punjab' in Kaushik Basu and Ravi Kanbour (eds.) **Arguments for a Better World-Essays in Honour of Amartya Sen: Vol. II Society, Institutions, and Development**, New York: Oxford University Press: 303-326.

Table 1: Per Capita Income across Major Indian States (1999-2000 and 2007-08)
(Figures at 1999-2000 prices)

State	1999-2000	Rank	2007-2008	Rank	Compound Growth rate 1999-2000 to 2007-08
Andhra Pradesh	15427	10	26195	9	6.06
Bihar	5786	15	8703	15	4.64
Gujarat	18864	7	31780	4	6.00
Haryana	23222	2	39462	1	6.07
Himachal Pradesh	20806	4	30856	6	4.48
Karnataka	17502	8	26418	8	4.68
Kerala	19461	5	32968	3	6.03
Madhya Pradesh	12384	12	13299	13	0.79
Maharashtra	23011	3	33302	2	4.19
Orissa	10567	13	16149	12	4.82
Punjab	25631	1	31662	5	2.37
Rajasthan	13619	11	18095	11	3.21
Tamil Nadu	19432	6	29445	7	4.72
Uttar Pradesh	9749	14	11939	14	2.28
West Bengal	15888	9	23229	10	4.31
All India	15881	-	24295	-	4.84

States shown in Table 1 reveals that four States (Haryana, Andhra Pradesh, Kerala and Gujarat) have grown at a rate of 6 per cent or higher. The per capita income of seven States, that is, Orissa, Tamil Nadu, Karnataka, Bihar, Himachal Pradesh, West Bengal and Maharashtra, have increased at a rate between 4 and 5 per cent per annum. It is pertinent to point out here that the per capita income of Punjab has grown at a rate 2.37 per cent per annum, which is just half the All-India average and can be ranked number 13th among the major States of India according to the compound growth rate of per capita income per annum during the period 1999-2000 to 2007-08. The four States (Haryana, Maharashtra, Kerala and Gujarat), which are having higher per capita income than Punjab State, have shown dynamism in economic development and have substantially increased the gap in per capita income over Punjab State. Himachal Pradesh is another state which has reduced the gap in per capita income at a fast rate and will soon overtake Punjab. This is evidence enough to show that Punjab state has turned from 'a leading to a laggard State' during the post-reform period of economic growth.

There is a strong evidence of deceleration in economic growth of Punjab. In terms of NSDP growth rates recorded during the period 2000-01 to 2007-08 compared with 1990-1991 to 1999-2000, the agriculture sector occupied prime place in the economy of Punjab. The relative share of agriculture sector in the NSDP product was 32.45 percent in 2007-08 which declined from 39 percent in 1999-2000. The growth of agriculture sector, as indicated from the post-reform period, not only remained quite slow (3.33 percent), but decelerated to 2.21 per cent in the second sub-period, that is, 2000-01 to 2007-08.

Table 2: Sectoral Net State Domestic Product Average Annual Growth Rates (1999-2000 to 2007-08) at 1999-2000 prices

Sector/Year	1990-91 to 2007-08	1990-91 to 1999-2000	2000-01 to 2007-08
Agriculture	3.33	4.45	2.21
Manufacturing	4.73	4.43	5.03
Registered Manufacturing	4.59	5.35	3.84
Unregistered Manufacturing	5.68	4.71	6.66
Electricity	11.84	12.46	11.23
Construction	7.61	4.42	10.80
Trade	4.60	4.24	4.96
Transport	11.92	11.14	12.7
Banking	10.33	9.99	10.68
Real Estate	2.42	4.66	1.79
Public Administration	6.74	9.16	4.32
Other services	7.80	13.06	2.54
NSDP	5.26	5.73	4.79
PCI	3.32	3.7	2.9

The foregoing discussion brings out the fact that the deceleration of rate of the growth of agriculture sector has contributed substantially to the slowdown in the growth of per capita income of the economy of Punjab state.

1.2. Agriculture Stagnation: Need for Paradigm Shift

During the period of 1990s, the green revolution technology has shown signs of fatigue. Productivity growth stagnated along with near freeze of the prices, which resulted into the decline of agriculture sector's contribution to the State income.

Growth rate of income generated in the agriculture (crop) proper was less than 1 per cent during the nineties and early years of twenty first century.

This has created an imbalance in the structure of Punjab State's economy, whereas the share of agriculture sector's (crops and dairying) income has sharply declined in the State Domestic Product from 54.27 per cent in 1970-71 to 33.70 per cent in 2005-06. But, the proportion of the workforce engaged in agriculture sector of Punjab continues to be very high, that is, 48 per cent in the year 2004-05. This comes out to be 66.9 per cent of the total rural workforce of Punjab in the year 2004-05.

It needs to be noted here that the agricultural workforce was as high as 82.5 per cent of the total rural workforce of Punjab in the year 1983. The workforce engaged in the agricultural sector of Punjab has declined to 74.6 per cent of the total rural workforce in the year 1993-94 compared with 1983. It further declined to 66.9 per cent in the year 2004-05 (NCEUS, 2007).

Furthermore, the 90.9 per cent of the workforce in Punjab is engaged in the unorganized sector where the wage rate is very low. The workforce in the agriculture sector, especially agricultural labour, small and marginal farmers, are earning below Rs 20.3 per capita per

day[12], which is called vulnerable by the National Commission on Enterprises in the Unorganised Sector.

1.3. Industrialisation: Looking for a Trigger

Industrial sector has been regarded as the most dynamic sector of an economy and provides the desired economic transformation from 'low wage-low productivity' economic activities to 'high wage-high productivity' economic activities. However, in the case of Punjab, the industrial sector of Punjab economy, in terms of its relative contribution to the NSDP, remained quite small.

The manufacturing sector of Punjab State contributed 15.1 per cent of NSDP in 1990-91 and declined to 13.6 per cent in 2007-08. The relative share of the registered manufacturing sector in NSDP was 8.8 per cent in 1990-91, which has declined to 7.4 per cent in 2007-08. The rate of growth of the registered manufacturing sector has decelerated during the period 2000-01 to 2007-08 compared with the 1990-91 to 1999-2000. The registered manufacturing sector has grown at the rate of 5.35 per cent during 1990-91 to 1999-2000, which was much below the 1980s level. However, the growth rate for the period 2000-01 to 2007-08 was 3.84 per cent per annum. Contrary to this, unorganized manufacturing sector has recorded higher growth rate during the 2000-01 to 2007-08 compared with the growth experience of the 1990s (Table 2). That was precisely the reason that the manufacturing sector as a whole has shown marginal acceleration of rate of growth in the later period compared with the 1990s.

The other sectors, which have recorded deceleration of economic growth during the 2000s compared with 1990s, are electricity, real estate, public administration and other services. It is worth mentioning here that the combined share of all the sectors of the Punjab economy, which have observed deceleration in growth during the 2000s, was 68.52 per cent in 1990-91. This share has declined to 57.74 per cent in 2007-08. Obviously, the slow growing sectors have contributed to the slow growth of per capita income and net stated domestic product of the Punjab economy.

Although, the fast growing sector failed to arrest the deceleration of economic growth in Punjab as their relative share in the NSDP was less than 32 per cent in 1990-91, but have triggered the process of structural transformation in terms of changing the relative contribution of the sectors to the State's economy. From the foregoing analysis, it can be safely said that the engine of growth of Punjab economy still continued to be the 'agriculture sector'.

1.4. Constraints on Economic Development in Punjab

Among the macroeconomic policies, fiscal policy has been widely recognized and acclaimed for its impact on economic development process. The impact of fiscal policy on economic growth is mainly dependent on the efficiency with which resource mobilization and

[12] The wheat-paddy predominant cropping pattern gives on an average returns to a farmer owning one hectare of land over and above the variable costs is Rs. 35, 621 per annum. This turns out to be Rs. 19.52 per person per day in a five member farm household in Punjab.
Ghuman, R. S. and G. S. Romana (2010) 'Sustainability of the Existing and Alternative Cropping Systems in South-west Punjab' in Sucha Singh Gill, Lakhwinder Singh and Reena Marwah (eds.) **Economic and Environmental Sustainability of the Asian Region**, New Delhi: Routledge-Taylor and Francis Group: 317-336.

expenditure are incurred. However, the fiscal policy of the Punjab State remained continuously in disarray since the mid-eighties (Rajmal 2009 and Ahluwalia 2009).

The fiscal deficit of the Punjab State remained 5.3 per cent during the period 1985-1990, which was the highest among the 14 major states of India. Whereas the overall fiscal deficit of the 14 major States of India was 3.3 per cent, the fiscal deficit of Haryana and Maharashtra States were 2.7 and 3.1 per cent of gross state domestic product respectively (Rajmal 2009). One fundamental reason for running a high fiscal deficit of Punjab State was due to relatively low revenue receipts as a percentage of the gross state domestic product and was bracketed with the State of West Bengal, Bihar and Uttar Pradesh. State tax to the gross state domestic product (tax effort) was 6.86 per cent in 2007-08 (Government of Punjab 2010).

Therefore, the fiscal deficit over the years has been financed through borrowings from the Union Government and, increasingly during the post-reform period, through commercial borrowings. This has generated huge amount of debt stock over the years and, consequently, the substantial proportion of the tax revenue goes as interest payments. This has led to further deterioration of the fiscal situation of the State and has crippled the capacity of the State Government to involve itself in the developmental economic activities.

It is indicative from the fact that the developmental expenditure in the gross state domestic product has declined from 10.8 per cent during 1990-95 to 8.4 per cent during 2000-2007 (Table 3).

Table 3: Development, Non-Development and Capital Expenditure across Major States

State	Development Expenditure as % of GSDP		Non-Development Expenditure as % of GSDP		Capital Expenditure as % of Total Expenditure	
	1990-1995	2000-2007	1990-1995	2000-2007	1990-1995	2000-2005
Andhra Pradesh	12.8	12.4	4.3	6.1	19.8	24.8
Bihar	11.8	14.9	5.9	8.7	13.0	21.3
Gujarat	12.8	11.9	4.0	5.5	18.5	22.9
Haryana	10.7	9.4	6.4	5.1	15.3	21.3
Karnataka	13.0	12.6	4.5	5.9	15.6	21.3
Kerala	10.9	9.1	5.5	7.4	14.0	14.2
Madhya Pradesh	11.5	13.8	3.9	6.1	13.0	21.4
Maharashtra	10.7	9.6	3.9	5.6	18.3	19.1
Orissa	14.8	11.7	5.8	9.2	18.2	23.0
Punjab	10.8	8.4	5.9	9.8	16.7	18.3
Rajasthan	13.6	12.8	5.4	7.7	22.5	21.9
Tamil Nadu	13.3	9.9	4.0	6.0	12.2	18.9
Uttar Pradesh	11.6	12.2	5.9	8.2	16.6	21.2
West Bengal	8.9	8.2	4.0	7.2	17.2	19.9
All India	11.8	11.1	4.7	6.8	16.7	20.9

Source: Derived from Rajmal (2009) **State Finances and Growth: A Study of Major States of India,** Unpublished Ph. D Thesis, Indian Institute of Technology Bombay, Mumbai

It is perturbable to note that Punjab State, in terms of development expenditure is ranked number 13 among the major States of India. However, the proportion of non-developmental expenditure in gross state domestic product has increased form 5.9 per cent during 1990-95 to 9.8 per cent during 2000-2007 and occupies first rank among the major Indian States (Table 3). Similarly, the capital expenditure in the total expenditure of the State has been very low but marginally improved from 1990-95 to 2000-07 period. But, compared with other major States, the capital expenditure has been one of the low priorities of the State Government. The rising non-developmental expenditure and falling developmental expenditure has a capacity of crowding out investment that adversely affects economic growth. Obviously, the fiscal policy pursued by the State Government during the post-reform period seems to have impacted in slowing down the process of economic growth of the economy of the State.

The operation of the monetary policy, although not under the control of the State Government, has substantial role in the acceleration or derailment of the economic growth process. One of the most important indicators of the functioning of the monetary policy is the credit-deposit ratio, which shows the investment pattern of the State. The analysis of the credit-deposit ratio across the State during the post-reform period presented in Table 4 shows that the credit-deposit ratio remained below the national average. This ratio was 48.04 in 1990 and, accordingly, Punjab among major 14 states was ranked number 14th. This ratio was much below the minimum level prescribed by the Reserve Bank of India. However, the credit-deposit ratio declined to 38.95 in 2000, but improved substantially in 2009 as well as the State rank. It is significant to note that the Southern States, that is, Tamil Nadu, Andhra Pradesh and Karnataka, and Maharashtra observed throughout the period of analysis high credit-deposit ratios (Table 4).

Table 4: Credit-Deposit Ratio Across Indian States (1990-2009).

State	1990	Rank	2000	Rank	2009	Rank
Andhra Pradesh	88.28	3	67.27	3	102.39	2
Bihar	38.61	14	23.35	14	26.38	14
Gujarat	59.58	9	47.56	6	59.75	9
Haryana	57.49	10	39.44	11	72.13	6
Karnataka	89.15	2	62.03	4	77.39	5
Kerala	63.35	7	40.66	9	61.15	8
Madhya Pradesh	66.66	6	49.31	5	59.00	10
Maharashtra	79.40	4	88.72	1	89.67	3
Orissa	76.55	5	39.60	10	51.96	12
Punjab	44.08	13	38.95	12	67.43	7
Rajasthan	61.24	8	46.39	7	84.05	4
Tamil Nadu	101.24	1	83.56	2	108.41	1
Uttar Pradesh	46.96	12	28.41	13	41.23	13
West Bengal	50.05	11	44.55	8	58.59	11
All India	64.35	-	56.37	-	70.24	-

Source: Government of Punjab (1991, 2001 and 2010) **Economic Survey,** New Delhi: Ministry of Finance

That the credit-deposit ratio of Punjab remained quite low clearly brings out the fact that the resources of the State due to operation of the banking sector transferred Punjab State's precious savings to other states of India, which could have been invested in the Punjab State. Punjab State recorded investment-gross state domestic product ratio of 18.7 per cent, which was the lowest among the 14 major States as against 35 per cent of the national average as measured in 1995-96 (Ahluwalia 2002). As such, the centralized monetary and fiscal policies have initiated the process of crowding out investment from Punjab, which has adversely affected the economic growth process of the economy of the Punjab state[13].

1.5. Policy Options and Alternatives

Keeping in view the constraints on Punjab economy, the governance pattern of the State of Punjab needs sweeping changes for rejuvenating the economy and effecting reversal in the deceleration of economic growth. The Government of Punjab has to seek cooperation of the Union Government in dealing with the problems posed by the functioning of the macroeconomic policies, that is, monetary and fiscal policies. The need is also to set its own house in order to introduce the need to realise tax revenue as also suitable reforms in the tax collection machinery of the State. The existing tax structure has the potentialities to raise the proportion of tax in GSDP to the level of dynamic States while wiping out the current level of tax evasion taking place in Punjab. A separate Task Force has been set up to formulate macro-economic policy initiatives and institutional governance reforms.

[13] To attract industrial investment in the states of Himachal Pradesh, Jammu and Kashmir and Uttaranchal-all neighbouring states of Punjab has been given package of fiscal concessions by the Union government in 2003 is one such example of the centralized fiscal policy. This has resulted into investment flight from Punjab. Ahluwalia, I. J. (2009), op.cit. pp. 303-326.

Chapter 2
Status of Health Services and Health Outcomes in Punjab and Recommendations for the Health Sector*

2.1. Introduction

The Commission has analysed the status of health infrastructure and services, records the mortality and morbidity patterns, evaluates the access to health services, measures the public and private expenditure on health, discerns the priorities of policy, comprehends the health seeking behaviour and experience of users before identifying the priorities for policy. The analytical premise is that health inequities reflect the unequal distribution of power, prestige and resources among various groups in society, and that the objective of health policy should be that none should be denied care for want of ability to pay and it is the responsibility of the State to provide health care to its people.

The paper makes a strong case for the government to take leadership of provisioning of health in its own hands and implement the various suggestions made by the Commission.

2.1.1. The evaluation and recommendations are being made with a concern to find pathways to address the impact of the widening social inequalities on health outcomes and access to health care in Punjab.

2.1.2. The analytical premise is that health inequities reflect the unequal distribution of power, prestige and resources among various groups in society. Health services are an important intermediate determinant, as their structure and accessibility or lack of accessibility, can contribute to inequalities.

2.1.3. It is also believed that health constitutes one of the important aspects of the human well-being and the existing conditions of health and health outcomes reflects the 'real' socio-economic conditions in a society.

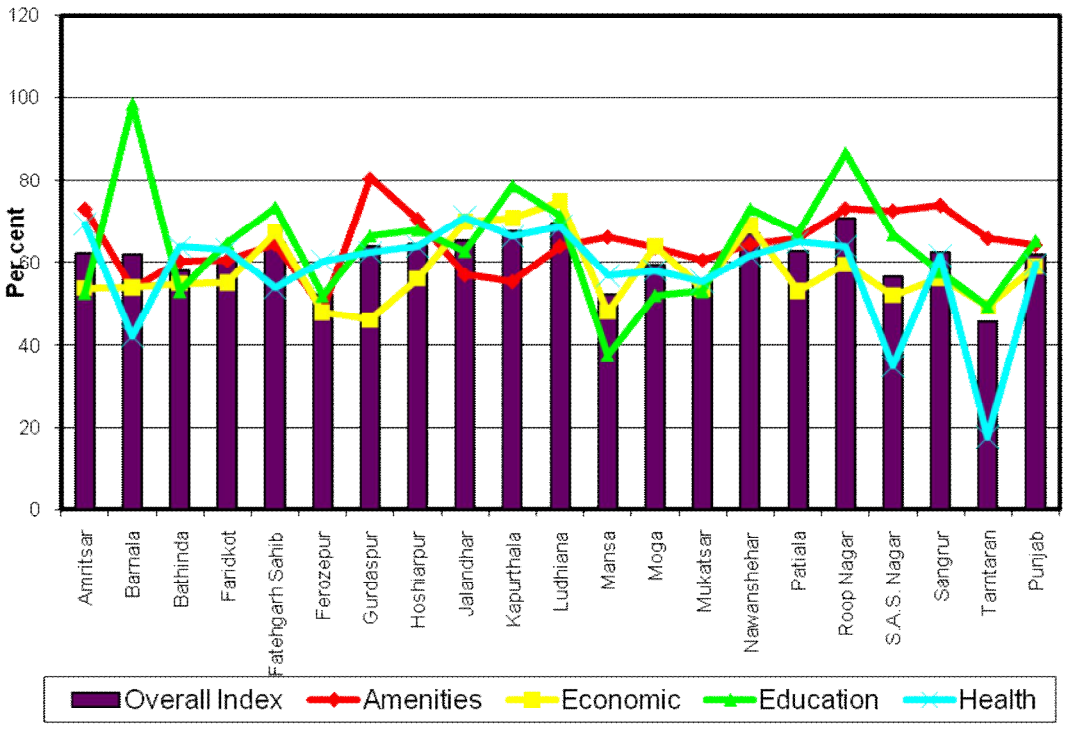
2.1.4. The recommendations are premised on the belief that the objective of health policy should be based on two principles - that none should be denied care for want of ability to pay, and it is the responsibility of the State to provide health care to the people.

2.1.5. The myth about direct association between higher PCY and positive health outcomes is broken by the evidence on interstate health comparisons. Punjab is one of the developed states of the country but its economic achievement has not percolated, as would be expected, in the health sector. The discrepancy between economic infrastructure and health infrastructure is also reflected in the inter-district comparisons within Punjab. This fact suggests that a specific strategy is required to deal with the health sector and the larger development strategy adopted by the

* This paper has been contributed by the Task Force on Social Development chaired by Prof. Atul Sood, Member of the Punjab Governance Reforms Commission.

State will not automatically address the health challenges faced by the people in the state.

Figure1: District Development Index and Health Index in 2007



Source: Data provided by The Directorate of Economics and Statistics, Govt of Punjab.

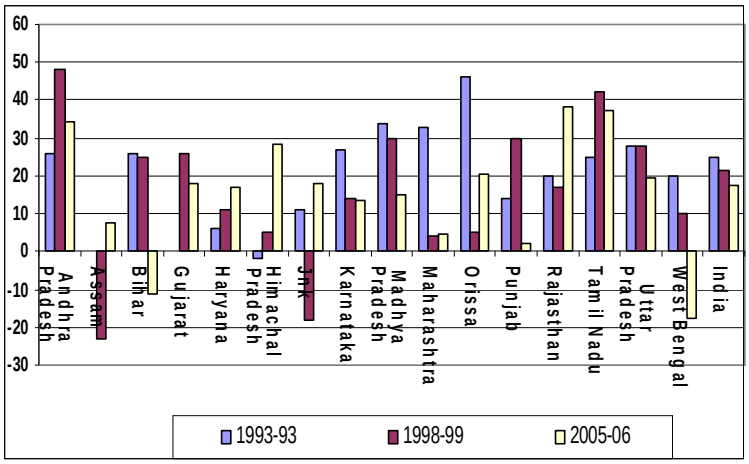
2.2. Access to Health Services and Health Outcomes

2.2.1. Our analysis of information on access to health and health outcomes suggests that any evaluation of them in Punjab has to recognise the specificity of caste, income and gender. Following observations support this understanding.

- Punjab is ranked 5th in case of IMR amongst the Indian States. As per SRS estimates, in 2007, Infant mortality rate in Punjab was 43, compared to 55 at the national level. IMR in Punjab has come down to a great extent, from 102 in 1971 to 43 in 2007. There was a slight increase between 1975 and 1978, but after that there has been a decline, which was more or less smooth till 1991. After 1991 period, till 2001, the decline has been insignificant. IMR has come down from 53 to 51 during this decade. After 2001, we again see that there is decline, but the rate of decline is not as drastic as was witnessed in the 80s. If we compare the movement in IMR in Punjab with other states, what is

noticeable is that Punjab had a relatively lower IMR in the beginning of 90s, it was ranked second after Kerala, but since then, Punjab has moved down in the ranking. States like Maharashtra, West Bengal and Tamil Nadu have done exceptionally well in reducing the IMR. The IMR in Punjab has remained lower than the national average, but if we compare it with the best performing State like Kerala, there is still a lot of catching up to do. The relatively lacklustre performance in reducing IMR in the 90s and early 2000 could be the result of decline in public expenditure in health and associated sectors. Even though in aggregate mortality rates, Punjab has not done too well, the social gap (the difference between outcomes across social and economic groups, for example, between Scheduled Castes and others) in IMR has substantially improved between 1998-99 and 2005-06 (see Figure 2)

Figure 2: Social Gap in IMR



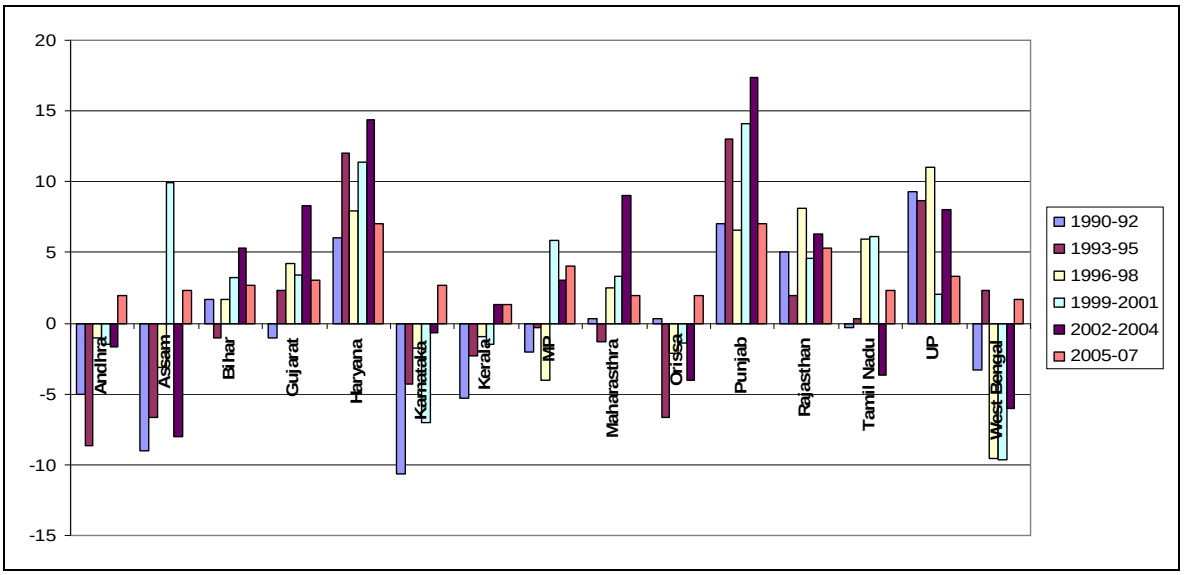
Source: 1. International Institute of Population Science and Macro International, 2007. National Family Health Survey (NFHS 3), 2005-06: India Volume 1; 2. http://www.nfhsindia.org/report.html accessed on March 19th 2009 and 3. Kulkarni, P.M and Baraik, V.K (2006), Health Status and Access to Health Services- Disparities Across Social Groups in India, Indian Institute of Dalit Studies, Working Paper, vol. (1)-4

- It is important to analyse the reasons for the mismatch between IMR status of the State and its status in growth ranking. Reduction in IMR requires better health infrastructure, better access, as well as improved socio-economic conditions at the household level, such as improved sanitation, safe housing, clean drinking water etc.. As we have shown above, Punjab has not done too well on both counts, creating health infrastructure and ensuring good sanitation facilities and clean drinking water. This may explain the relatively inadequate performance of the State to catch up with the best standards in mortality rates. The issue of health access will be analysed in the subsequent sections.

- Gender differences in mortality further add to the challenges that the State faces in the years ahead. The difference in mortality rates of boys and girls in Punjab is higher compared to other major States of India. This becomes evident, if we look at the difference in IMR between boys

and girls between 1990-92 to 2005-07 (see Figure 3). Apart from Punjab, the other two States that show a similar picture are UP and Haryana. The difference in mortality rates between boys and girls is not only high in Punjab but the gap has increased between the years 1990-92 to 2002-2004. Although the difference has come down in 2005-07, but still in comparison to other States the difference is the highest in Punjab, along with its neighbouring State of Haryana.

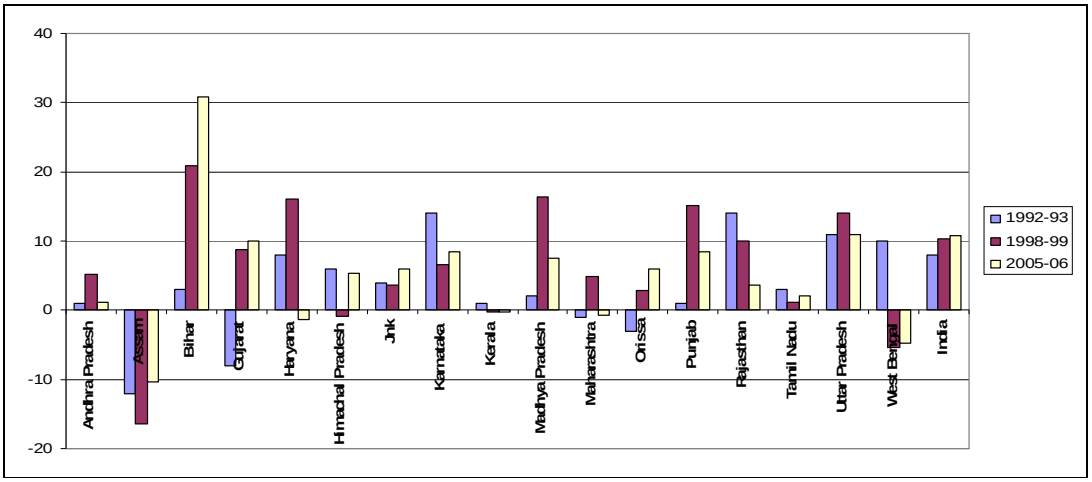
Figure 3: Male-Female Differences in IMR



Source: 1. SRS Bulletin various years , Registrar General of India 2.Compendium of Fertility and Mortality, Registrar General of India

- In case of ante-natal coverage, for the women, Punjab's position has deteriorated between 1992-93 to 1998-99. The gap between SCs and others has increased. After 98-99, the gap got reduced, but even in 2005-06, Punjab had the fifth highest social difference in ante-natal coverage after Bihar, UP, Gujarat and Karnataka (See Figure 4).

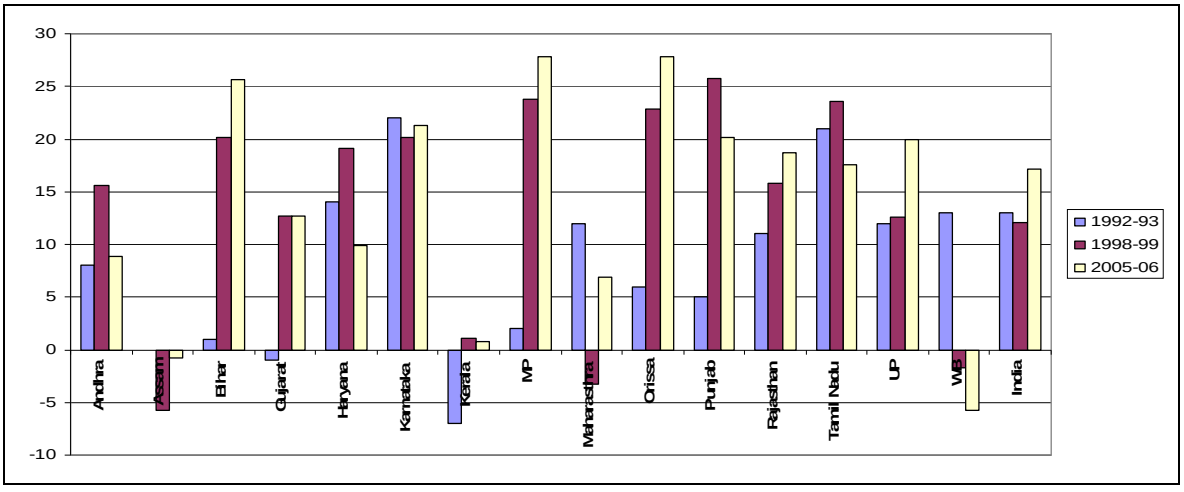
Figure 4: Social Gap in Ante-Natal Coverage



Source: 1.International Institute of Population Science and Macro International .2007. National Family Health Survey (NFHS 3), 2005-06: India Volume 1
2. http://www.nfhsindia.org/report.html accessed on March 19th 2009
3. Kulkarni, P.M and Baraik, V.K (2006), Health Status and Access to Health Services- Disparities Across Social Groups in India, Indian Institute of Dalit Studies, working paper,vol(1)-4

- In terms of medical assistance received at the time of birth, Punjab had a relatively narrow gap between SCs and others in 1992-93, but that gap shot up in 1998-99. Although the gap declined in the period 2005-06 compared to 98-99, it is still higher than the national average and the State is placed 5th after MP, Orissa, Bihar and Karnataka (See Figure 5).

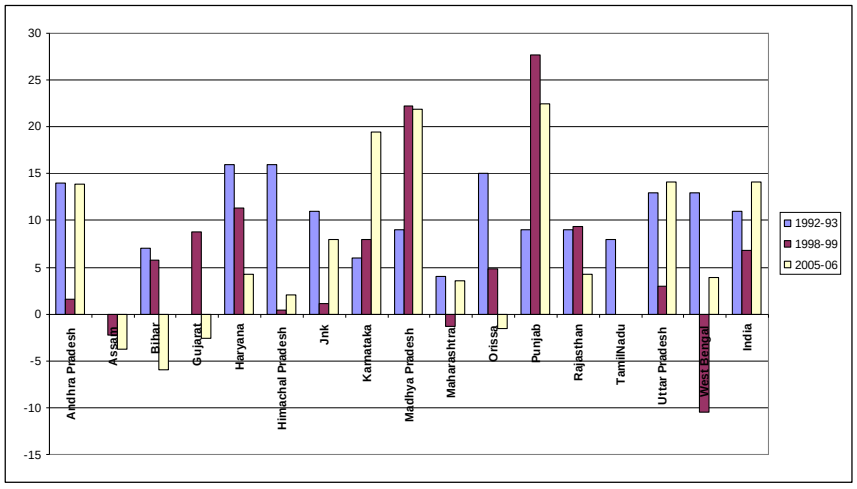
Figure 5: Difference in Medical Assistance at Delivery between SC and Others Households



Source: 1.International Institute of Population Science and Macro International .2007. National Family Health Survey (NFHS 3), 2005-06: India Volume 1
2. http://www.nfhsindia.org/report.html accessed on March 19th 2009
3. Kulkarni, P.M and Baraik, V.K (2006), Health Status and Access to Health Services- Disparities Across Social Groups in India, Indian Institute of Dalit Studies, working paper, vol(1)-4

- In the case of vaccination, the gap between SCs and others has increased from 1992-93 to 2005-06, even though there is some decline between 1998-99 to 2005-06. For the period 1998-99 and 2005-06, the gap in vaccination between SCs and others is the highest in Punjab compared to other States (see Figure 6).

Figure 6: Difference in Immunization between SCs and Others



Source: 1.International Institute of Population Science and Macro International .2007. National family Health Survey (NFHS 3), 2005-06: India Volume 1
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3. Kulkarni, P.M and Baraik, V.K (2006), Health Status and Access to Health Services- Disparities Across Social Groups in India, Indian Institute of Dalit Studies, working paper, vol(1)-4

2.2.2. What the above patterns of basic health in Punjab (i.e., IMR, Vaccination, Ante-natal care and medical assistance at delivery) suggest is that Punjab government's implementation of basic health programs over the last many years have not been very successful in reducing the gap in access to health services across social, income groups and across gender. Some of these differences in the State are larger than the national average.

2.2.3. In order to identify the specific health needs of Punjab, we need to examine the pattern of morbidity in Punjab. We have used information provided from NSSO, NFHS and Ministry of Health to understand the trends in morbidity in Punjab. It is well established that economic prosperity and disease patterns are correlated. With prosperity, comes a shift away from infectious diseases towards degenerative diseases and, therefore, it is important to see how the economic prosperity of Punjab shaped its morbidity patterns.

- Punjab is one of the more developed States in the country. But it also has a relatively higher prevalence of diseases. According to NSSO 1998 and 2004 estimates, the prevalence of disease (persons ailing per 1000 population) is higher than the national average in both rural and urban areas of Punjab. It was third highest, in both rural and urban areas in 1998, compared to other states. In 2004, it was in second place in rural

areas, whereas in urban areas it was placed fifth (See Table 1 in Annexure). It is often argued that the higher incidence of disease in Punjab is a reflection of greater reporting of illness in Punjab. This argument may be true to some extent, but having higher incidence of illness in comparison to other high income states, like Maharashtra, Haryana, Gujarat, Karnataka, also tells us something about the condition of health in the State. In order to understand this issue in greater detail, disease specific morbidity patterns were analysed for Punjab.

- NSSO gives us rate of morbidity reported in the last 365 days for hospitalization, both for rural and urban areas separately. In 2004, in rural Punjab, we find that the category 'other diagnosed disease' had the highest share in Punjab followed by incidence of accidents-injury-burns-fractures-poisoning; fever of unknown origin; disease of kidney; and diarrhoea/dysentery. Incidence of accidents-injury-burns-fractures-poisoning is highest in Punjab, compared to other high income States and so is the case with bronchial asthma, disorder of joints and bones, disease of kidney and urinary system, locomotor disorders, disease of mouth/teeth/gum and gynaecological disorders. Prevalence of lifestyle diseases such as heart disease and diabetes differs across the States. Diabetes is higher in Tamil Nadu and Punjab compared to other states. Heart diseases are more prevalent in Tamil Nadu and Haryana and it is least in Punjab (Appendix 1).

- In urban areas of Punjab, the residual category 'other diagnosed ailments' had the highest share followed by TB, accidents, heart diseases and diarrhoea. Incidence-wise, across the developed States, Punjab has the highest share in case of tetanus, conjunctivitis, locomotor disorder, cancer and other tumours, gastric and TB. Accidents and other diagnosed ailments are quite high in all the States. In Tamil Nadu, prominent diseases are diarrhoea, fever of unknown origin and heart diseases. In Haryana, it is diarrhoea, diseases of kidney and heart diseases. In case of Gujarat, diarrhoea, fever of unknown origin and heart diseases are prominent, and in Maharashtra, it is diarrhoea, fever of unknown origin and heart diseases. Unlike in rural areas, incidence of lifestyle diseases such as heart diseases is higher in urban areas. Diabetes does not follow a similar pattern (Appendix 2).

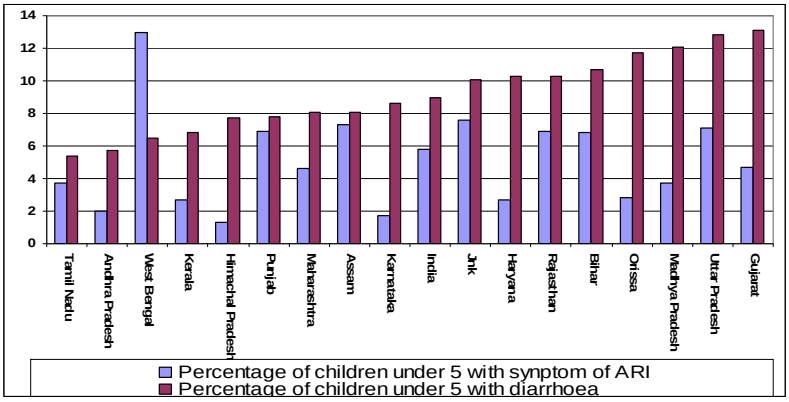
- The NSSO reporting of morbidity with a recall period of 15 days in the rural areas suggests that in Punjab, highest prevalence is of fever of unknown origin, respiratory illness, diarrhoea, other diagnosed ailments and hypertension. It had highest share of diarrhoea compared to other developed States in India in 2004. In urban areas of Punjab, highest prevalence is seen in the case of fever of unknown origin, followed by other respiratory diseases, other diagnosed ailments, diarrhoea and diseases of kidney/urinary system. Punjab has a higher incidence of anaemia, cataract, visual blindness (excluding cataract)

and diseases of kidney/urinary system and fever of unknown origin compared to some of the high income States (Appendix 3 and 4).

- NFHS 3 also gives information on diabetes, which is turning out to be one of the major health hazards in the country and also one of the major non-communicable diseases. In case of Punjab, both for women and men, incidence of diabetes is lower than the national average. Prevalence is higher for women compared to men whereas the trend is opposite at the national level. If we look at the prevalence of TB across the major States in India, Punjab shows least prevalence. It is ranked third after Karnataka and Himachal Pradesh in least prevalence of TB (Table 2 in Annexure).

- The incidence of acute respiratory infection is higher than the national average in Punjab and is comparable to some of the most underdeveloped States in the country (See Figure 7).

Figure 7: Incidence of Diarrhoea and Acute Respiratory Infection, 2005-06.



Source: International Institute of Population Science and Macro International. 2007. National Family Health Survey (NFHS 3), 2005-06: India Volume 1

- The Ministry of Health data, using information from those who visit government facilities, suggests that at the national level, the share of Punjab in different communicable disease is not significant. However, the incidence of viral hepatitis is very high in Punjab. Within the State, the highest cases are that of respiratory system followed by 'abnormal clinical and laboratory finding' and skin and sub- coetaneous tissue. Infectious and parasitic diseases are placed at fourth (9% of total cases) which clearly indicates significant presence of communicable diseases in the State (see Table 3 in Annexure). For in-patient care, complication of pregnancy, childbirth and the puerperium followed by external causes of morbidity, injury and abnormal clinical and laboratory finding are the major cases. But if we look at the incidence of death, parasitic and infectious diseases contribute a major share at 19%, and are placed second following diseases of circulatory system, which are at the top.

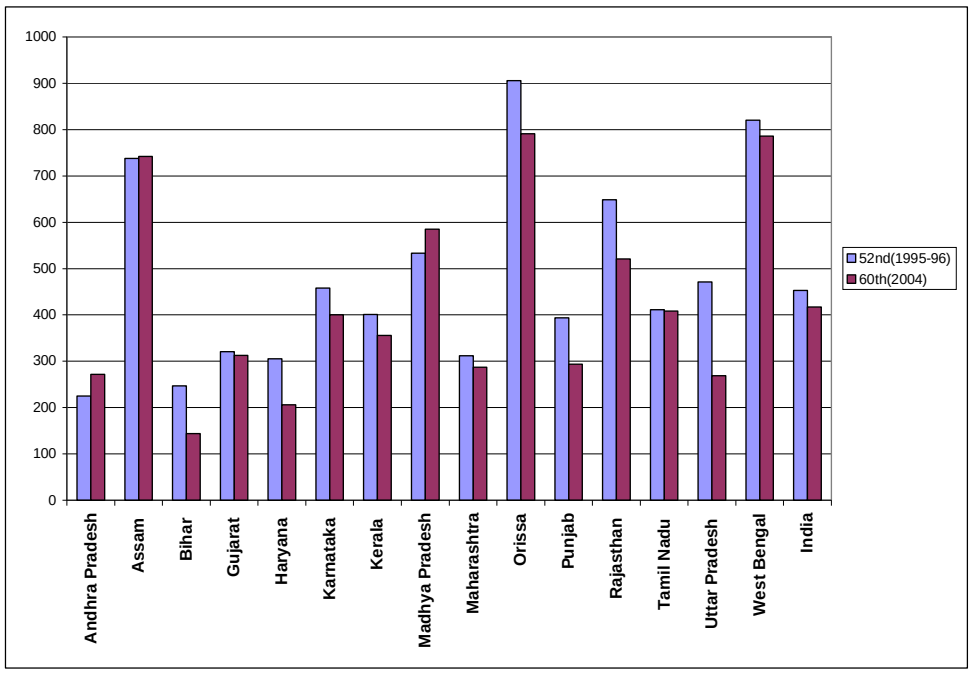
2.2.4. What emerges from the morbidity trends is that prevalence of disease is higher than the national average in both rural and urban areas of Punjab. And, the incidence of illness is higher in comparison to other high income States in the country. Morbidity reported in the last 365 days for hospitalization in the NSSO Survey for both rural and urban areas of Punjab suggests that the incidence of heart disease is not very significant in Punjab. In rural areas, the NSSO Survey suggests that incidence of accident, injury, burns, fractures, poisoning, fever of unknown origin, disease of kidney, diarrhoea and dysentery are quite significant in Punjab. In urban areas, incidence of tuberculosis, accidents, heart diseases and diarrhoea are very significant. When the Survey uses recall period of 15 days, in rural areas, then in Punjab highest prevalence is of fever of unknown origin, respiratory illness, diarrhoea, and hypertension. In 2004, the incidence of diarrhoea was highest in Punjab compared to other high income States in India. Using the recall period of 15 days, the NSSO Survey finds that in urban areas of Punjab highest prevalence is of fever of unknown origin, followed by other respiratory diseases, diarrhoea and diseases of kidney and urinary system. The NFHS Survey reveals that the incidence of diabetes and TB is lower than the national average and the incidence of acute respiratory infection is higher than the national average and is comparable to some of the most underdeveloped States in the country. The incidence of viral hepatitis is also quite high in Punjab as per the NFHS Survey.

2.2.5. What these morbidity patterns suggest is that diseases related with conditions of life and living and conditions of work, are very significant in Punjab. Significantly, disease pattern within the State shows that still a large portion of diseases are communicable in nature. It is erroneous to assume that Punjab has gone through the epidemiological transition and lifestyle diseases are now the cause of worry. While it is true that the burden of life style diseases is increasing, Punjab's major disease burden is still formed by diseases that are dependent very much on basic water and sanitation and directly related with levels of income at the household level. As our later discussion on existing health policy in the State suggests, the health programs currently underway are in many ways oblivious of the reality at the ground level. There is hardly any recognition of the fact that the National programs to address specific morbidities might not be enough to meet the State-specific needs. The specific disease patterns make a compelling case for programs and strategies which are designed keeping in mind the specific reality.

2.3. Health-Seeking Behaviour and Patterns of Utilization of Health Services

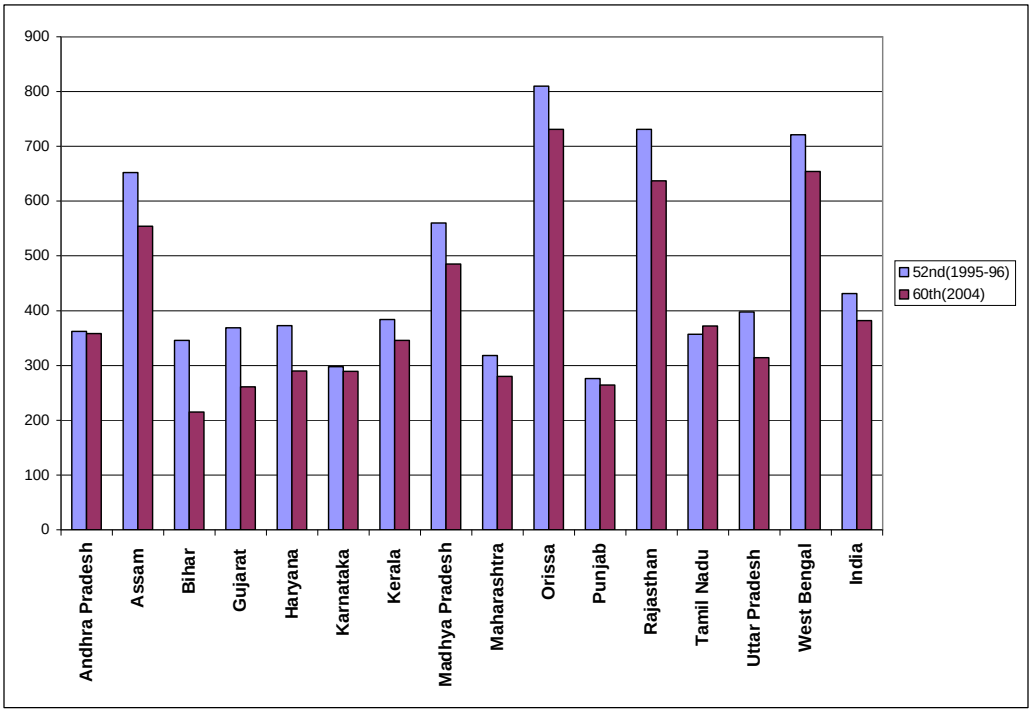
2.3.1. The trend in health seeking behaviour in Punjab suggests that the already low utilisation of public facilities has gone through a serious decline between 1995 and 2004. The decline is much faster in rural areas compared to the urban (Figure 8 and 9). This raises serious questions about the impact of ongoing 'reform' in health sector, the introduction of user charges and a shift towards running public hospitals on the pattern of private facilities. Data suggests that within different income groups, it is the poorest in the rural areas who use the public services for hospitalization. There is decline in use of public hospitals for the second MPCE quintile, but overall, there is decline in use of public hospitals in rural areas as we move up the income ladder. In urban areas, poor people end up using private services much more (Table 4 and 5 in Annexure). In relative terms, the well off in urban areas use more of public services, even though their utilization is also small. There is not much variation seen in the utilization pattern across gender and caste in rural areas. In urban areas, higher numbers of SCs go to private hospitals compared to other castes, which is distinctly different from the national trend. This suggests that already low utilization of public services in urban areas are in fact usurped by the well off in Punjab. Overall, hospitalisation in rural and urban areas of Punjab has been predominantly private. The extent to which the introduction of user charges across the board, in both rural and urban areas, and for all types of services, impacted the pattern of utilization of public services, is something which needs to be evaluated. Clearly, the specificity of utilisation pattern of health services by different categories of people will have to be kept in mind while designing the policies if health equity is any goal.

Figure 8: Hospitalisation in Government Facility in Rural Areas (Per 1000) Across Major States and All India, 2004



Source: Select Health Parameters: A comparative analysis across the National Sample Survey Organisation (NSSO) 42nd, 55th and 60th Round, Ministry for Health and Family Welfare, Government of India in collaboration with World Health Organisation

Figure 9: Hospitalisation in Government Facility (Per 1000) Across Major States and All India (Urban)



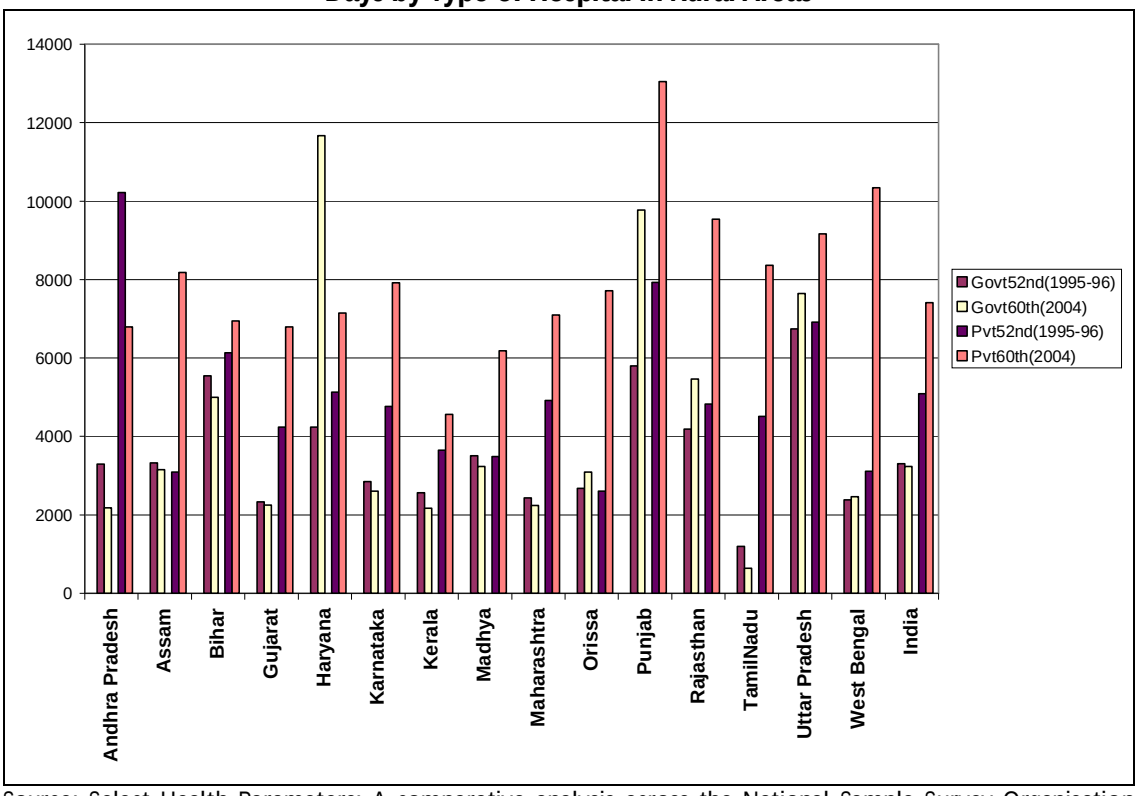
Source: Select Health Parameters: A comparative analysis across the National Sample Survey Organisation (NSSO) 42nd , 55th and 60th Round, Ministry for Health and Family Welfare, Government of India in collaboration with World Health Organisation

2.3.2. Very often, the declining use of public services is cited as an argument for privatization of health care. However, there is a clear trap here. The decline in use of public health facilities may not be a reflection of the changing needs or orientation of the people (see the section on perceptions about health care and reasons for non treatment). It could well be a sad outcome of people's experience of abysmal service standards. As is demonstrated in discussion below, our extensive field visits suggest that people are being compelled to seek expensive private care, knowing fully well that it is not a sustainable alternative in the long run, given the unregulated, exploitative and sub-standard health care that the public sector provides on an average to vast majority of citizens in the State.

2.3.3. If we look at the expenses incurred on hospitalization, a glaring fact is that in rural areas, in comparison to other States, the average health expenditure in Punjab is very high in both public and private hospitals (Figure 10). In urban areas also, there is a trend towards increasing expenses in public hospitals as well as in private health care services as compared to other States (Figure 11). A significant fact for rural Punjab is

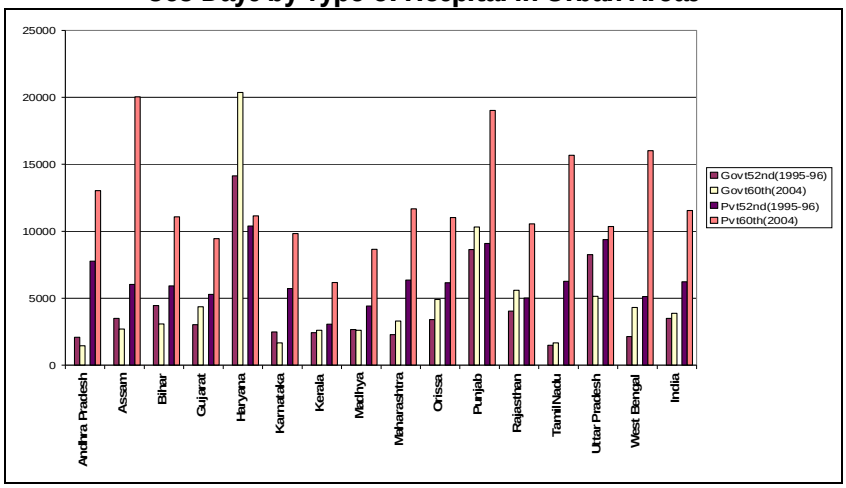
that as far as poor people are concerned, the expenditure on medical services, in absolute terms, is extremely high (Table 6 in Annexure). Cost is higher in the second lowest quintile because they use more of private services (Table 4 in Annexure). Correlating it with the fact that the rural poor use more public services, it is clear that in relative terms, the poor in Punjab spend a very large part of their incomes on health, much more than the national average. The story is not very different in urban areas. In urban areas, the poor and the SC's use public services less, therefore, the burden of health expenditure is very high for them too, because of higher use of private sector (Table 7 in Annexure). Thus, the poor in Punjab, compared to their better off counterparts, are squeezed by both institutions, public hospitals in rural areas and private hospitals in urban areas. The Government of Punjab should take a serious note of the fact that the inadequate access of health services in urban Punjab is causing a major squeeze on the urban poor and the high cost of public health in rural areas is crushing the rural poor.

Figure 10: Comparative Average Total Expenditure Per Hospitalised Case During Last 365 Days by Type of Hospital in Rural Areas



Source: Select Health Parameters: A comparative analysis across the National Sample Survey Organisation (NSSO) 42nd , 55th and 60th Round, Ministry for Health and Family Welfare, Government of India in collaboration with World Health Organisation

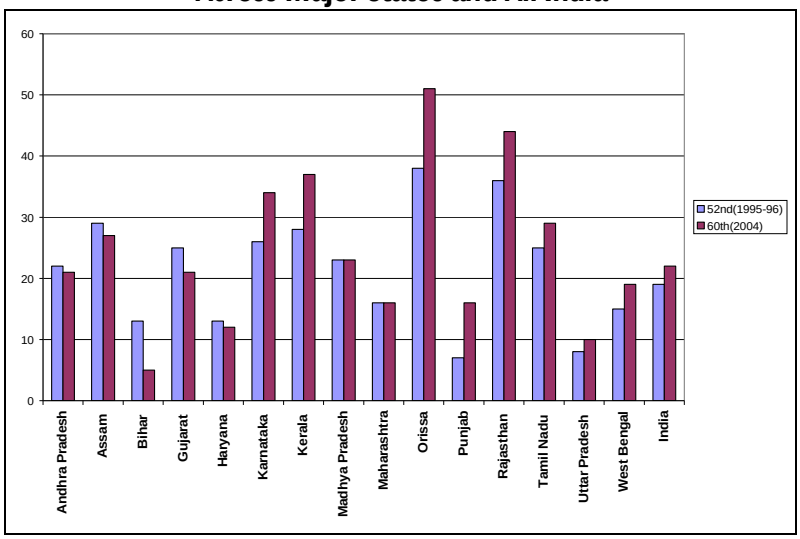
Figure 11: Comparative Average Total Expenditure Per Hospitalised Case During Last 365 Days by Type of Hospital in Urban Areas



Source: Select Health Parameters: A comparative analysis across the National Sample Survey Organisation (NSSO) 42nd , 55th and 60th Round, Ministry for Health and Family Welfare, Government of India in collaboration with World Health Organisation

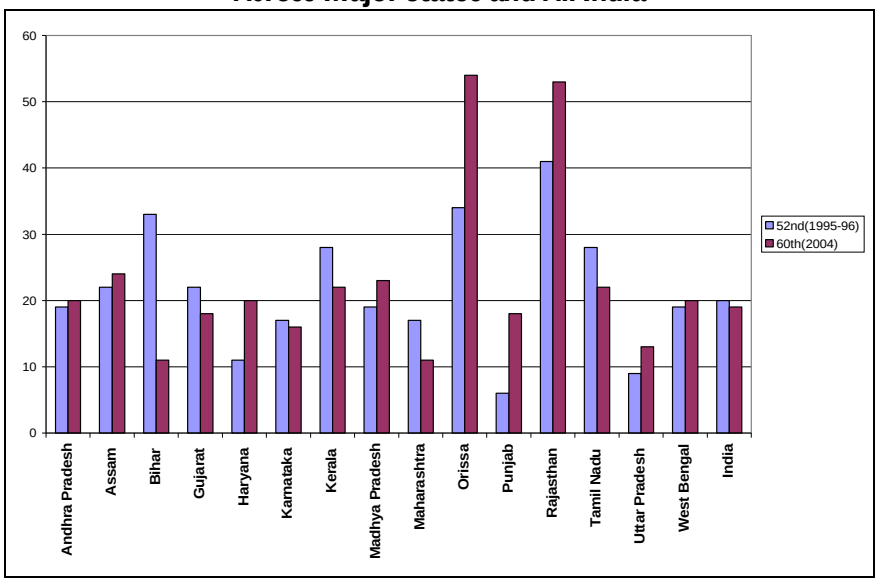
2.3.4. As compared to the other states, in 1995-96, Punjab had the lowest share of OPD in public health sector in rural areas. There has been some increase as evident in 2004, but overall, the percentage of people seeking OPD facilities is still very low (Figure 12). In urban areas, even though there has been increase in utilization of government facility, but at 18%, it is still lower than the national average of 19% and Punjab ranks among the States with low utilization of government services (Figure 13). The reason for such utilization patterns of government facilities are not difficult to understand in view of the pathetic condition of public health facilities presented in our section on availability of health infrastructure.

Figure 12: Non-Hospitalization Treatment in Government Facility in Rural Areas Across Major States and All India



Source: Select Health Parameters: A comparative analysis across the National Sample Survey Organisation (NSSO) 42nd , 55th and 60th Round, Ministry for Health and Family Welfare, Government of India in collaboration with World Health Organisation

Figure 13: Non-Hospitalization Treatment in Government Facility in Urban Areas Across Major States and All India



Source: Select Health Parameters: A comparative analysis across the National Sample Survey Organisation (NSSO) 42nd , 55th and 60th Round, Ministry for Health and Family Welfare, Government of India in collaboration with World Health Organisation

2.3.5. Government's commitment to provide quality health services through public institutions is seriously in question given the trends in utilization of health services, especially by the poor and the deprived, for whom public services remain the only sustainable avenue.

2.3.6. NSSO in its Survey asks for the reasons for non-treatment. The reasons given range from absence of facility, to lack of faith, to long waiting, to financial reason, to ailment not serious etc. Data suggests that there has been an overall shift in the reasons for non-treatment in the country. The ailment was not serious reason has gone down significantly from 511 to 321 per 1000, whereas paucity of funds as a reason for non-treatment has shot up from 242 to 281 per 1000 ailments in rural areas (Table 8 in Annexure). In case of Punjab, we see a reverse trend. Financial reason for non-treatment has come down and ailment not being serious has gone up. This may be a reflection of the better average income status of Punjabi households in comparison to other States. However, Punjab is still one of those States where, in comparison to the national average, the share of people citing financial reason as cause of non-treatment is fairly high. The State was ranked second highest in 1995-96 and sixth in 2004. In urban areas too, a similar trend is visible (Table 9 in Annexure). Even in urban areas, Punjab had the second highest share of financial reason as a factor for non-treatment in 1995-96. In 2004, this factor declined but still it is higher than the national average at 295 per 1000 ailments compared to national average of 204.

2.3.7. This is an extremely significant and discouraging fact from Punjab and corroborates the findings stated above on high cost for the poor of using public services in rural areas and private services in urban areas. The reasons for non-treatment provide us with a clear pointer towards a Government-led quality health care sector in the State. It is a pity that despite the gains made on economic front in the State, the health needs of the people are not being met due to paucity of financial resources. It is paradoxical that the good economic performance is being matched by poor health sector performance, and the State which leads on many economic parameters, its peoples' health needs remain unmet due to financial constraints.

2.3.8. In order to see exclusively the impact of socio-economic status on untreated morbidity, we excluded those who reported ailment as not serious as a reason for non-treatment. The evidence suggests that incidence of untreated morbidity in Punjab is lower compared to all India average (Table 10 and 11 in Annexure). However, there is a gradient along the monthly per capita consumption quintiles both in Punjab, as well at all India level. SCs have the highest share of untreated morbidity compared to other social groups. This is similar to the trends at the national level but the irony is that in spite of its green revolution success, the State has not been able to make a difference on this front.

2.3.9. That untreated morbidity in rural areas of Punjab is higher than that in the urban areas, clearly indicates the lack of access of health services. Untreated morbidity in Punjab is highest at the lowest income quintile and the same declines with the increase in level of income. Incidence of

untreated morbidity across all the monthly per capita consumption quintiles is lower than the national average.

2.3.10. NSSO Survey also asks that those who do not go for medical treatment whether they do anything for recovery. 59% of those who do not go for medical treatment rely on self/other household member/friend for treatment followed by 'others' and medicine at 20% in urban areas. In rural areas, the major chunk (73%) relies on others. NSSO does not specify what the others stand for. Even at the national level share of 'others' is quite high.

2.3.11. Health-seeking behaviour and experience of those who use public health facilities, especially at the secondary and tertiary level, can be discerned in greater detail through a 2007 Survey that was conducted for the Bajaj Committee Report. A total of 580 respondents in this survey were interviewed in the out-patient departments and 224 respondents from inpatient departments in various health institutions like CHCs, Sub-divisional hospitals, District Hospitals and two Special hospitals of the Punjab Health System Corporation. The survey finds that -

- Out of those who were utilizing PHSC, 56.3% were females and 43.7% male. Mostly, these female patients were having poor education, low income and were in the age group 15-30.

- Only half of the respondents were aware of the rules and regulation of these health facilities. More than 3/4th of the respondents were paying user charge for obtaining an OPD card and investigation at the hospitals. 77% of the respondents were not satisfied with the admission procedures and 86.2% of respondents at CHC and 81% at the sub-divisional hospital rated it poor.

- 66.5% rated general cleanliness of wards and bed as good whereas 44.2% rated it as average. 74.1% of the respondents perceived the level of comfort in the ward as good whereas 30% perceived it to be average. Facilities like fan and light were found to be good according to 75.7% of the respondents in the OPDs and 79.5% found these facilities satisfactory as in-door patients. The respondents found these facilities unsatisfactory in the OPDs of CHCs, although they found it to be good in the indoor wards of CHC.

- Among the OPD patients 81% felt that they got adequate information about their disease and their treatment is good. 69.2% of the inpatient respondents felt that adequacy of information was good. Only 10.3% of the respondents stated all the medicines are available in the OPD and 26.4% reported that no medicine was available in the OPDs. Availability of medicines were reported more in sub-divisional hospitals and the least in district hospitals. In case of inpatient respondents, only 13.4% reported medicines were available and 29% reported that no medicines were available.

- 50.7% of the OPD respondents stated that laboratory and radiological facilities were good. In the case of indoor patients, 65.6% said that laboratory and radiological facilities were good.

- 91.4% of the OPD respondents and 93.3% from indoor patients reported that doctor behaviour was good. Overall availability of doctors as stated by respondents at the health institution was 94.8%. Although availability was seen lower in case of CHC and district hospitals among all the institutions. Availability of nurses was found to be 79% and good behaviour in OPD was reported by 64.5% respondents. In case of indoor patients, 80.4% reported nurse behaviour was good. Overall, 56.9% perceived staff behaviour as good in the OPDs and 74% in case of indoor patients. Only 46.4% felt that security in the health facilities was good. 17% of the respondents perceived it as poor.

- Overall, 75.9% of OPD patients and 79% indoor respondents rated the quality of treatment in hospital as good. CHCs and Sub-divisional hospitals were rated lower compared to other facilities. 77.9% of the OPD respondents were satisfied with the service whereas 94.2% of the indoor patient respondents were satisfied with service. 70% of respondents rated their OPD as good but facility-wise, this response was low in CHC at 57%.

- Discerning the views of the community, the Survey listed following challenges in secondary and tertiary care: cleanliness; recruitment of doctors, specialists and paramedical staff; provision of basic facility such as water supply, toilet, regular electricity supply, generator, water tank, timely repair of accessories and machines; greater availability of medicines at the hospital and availability of subsidized medicines for BPL families.

- Finally, the views of stakeholders like civil servants, elected representatives of the area and health/hospital administrators revealed completely different dimensions for policy. They suggested improvement in infrastructure in hospitals; need for more contractual employees; need to introduce public private partnership model; fill up vacant staff positions; improve emergency services and increase the supply of essential drugs as priority areas for policy.

2.3.12. Another field based study in Punjab reveals that for short term morbidities, there is a large dependence on RMPs. A survey of 1000 households in Punjab in 207 showed that 42% of patients for short term morbidity resort to the RMPs. But for long-term illness, only 15% go to the RMPs. Also, people are going to the RMP because they are available in the village itself (64%) or in the neighbouring village. So, the easy availability of the services provided by RMP, and the lack of availability of formal medical care (see section on infrastructure), do have a bearing on the utilization of RMPs in large numbers. The RMP's are difficult to define. In reality, those who are MBBS, are the ones who are registered medical practitioners. In

Punjab, the reference to RMPs is for those who are not MBBS. They may or may not be 'registered' medical practitioners' as the name suggests. The Government does not have any policy or regulation for such medical practitioners. Our frequent interaction with health functionaries did not give us any evidence of any clear thinking to address this challenge in a systematic manner.

2.4. Facts about Availability of Health Infrastructure and Services in Punjab

2.4.1. At the outset, it is pertinent to mention that the Government of Punjab itself recognizes the deep challenges in health infrastructure that the State faces. The 11th Plan document and Annual Plan (2007-08) clearly recognized that 'nearly 50 percent of sub-centres, 74 percent of the SHCs, 51 percent of the PHCs and 11 percent of the CHCs in the State were without proper building at the time of formulation of the 11th FYP (page 219). The district-wise availability of health institutions is provided in Table 12 in Annexure. Health statistics of Punjab published by the government and statistical abstract of Punjab also recognize the fact that the population served per sub-centre (5632) and per PHC (33257) is higher than the national average and, at the CHC level, the population served per centre (138763) is less than the national average suggesting greater scarcity at the level of primary care in Punjab.

2.4.2. The recognition of scarcity in health infrastructure by the Government of Punjab has led to recent initiatives or proposals to improve the physical health infrastructure in Punjab, in particular in primary health care. The midterm review of the 11th Plan provides a list of some of such initiatives that include construction of new sub centre and the renovation of existing ones under NHRM; creation of delivery rooms and minor OT in PHC and creation of new born care centre; upgradation of PHCs to 24x7 under NRHM; and upgradation of CHCs and district hospitals under Punjab Health Systems Corporation and increasing the availability of essential drugs under NRHM at sub-centre, PHC and CHC level and providing drug kits for *ASHA* worker. These initiatives may impact some of the numbers discussed below from DLHS but our understanding is that the overall challenges of health infrastructure listed below remain relevant even today and DLHS remains a valid source of information for making interstate comparisons in health infrastructure.

2.4.3. DLHS survey for the year 2007-08 reveals that at the level of Sub-Centres, Punjab is one of the worst performing States in India, in terms of availability of essential drugs. Only 8.4 percent of the sub-centres had 60% of essential drugs available at the time of the Survey, higher than Bihar's 6% (See Table 13 in Annexure). At all India level, 65% of sub-centres had 60% essential drugs at the time of Survey. In terms of adequacy of equipment, sub-centres in Punjab are better than national average, with

96 percent of the sub-centres being adequately equipped. ANM or Family Health Worker was available in 80 percent of the sub-centres, which is lower than the national average and second worst in the country.

2.4.4. Availability of health services at primary health centre level are highly inadequate and much below the national standards. Only 26 percent of PHCs had a residential quarter for medical officers in Punjab, while 55 percent of PHCs at the national level have these facilities for medical officers. Assam, Maharashtra and West Bengal are far ahead than the national average. Only 17 percent of PHCs in Punjab are functioning for 24 hours while the national average is 53 percent (Table 14 in Annexure). This number would have changed as a result of the initiatives under NRHM in the last two years. In terms of bed availability in Punjab, 75 percent of PHCs had at least four beds, which is above the national average and comparable to other high income States. In terms of regular power supply in PHCs, only 7.5 percent PHCs have regular supply which is a shockingly low number compared to the national average of 36 percent and is the worst in the country. The situation is as bad in terms of availability of a functional vehicle at the PHC level, with Punjab being marginally above the worst performing State in the Country. In terms of availability of essential drugs in PHCs, Punjab is highly lacking and only 36 percent of the PHCs had 60 percent of essential drugs available at the time of the Survey. This number may have improved in the last two years as a result of recent initiatives by the Government of Punjab to improve the availability of drugs at the level of PHCs but, as of now, no alternative source of information is available for inter-state comparisons.

2.4.5. Thus, we can see that in terms of all the parameters that capture the availability of facilities at the sub-centre and PHC level in DLHS survey, Punjab is much below the national average except in availability of equipment at sub-centre level and beds at the PHC level. Basic pre-requisites at the PHC and sub-centre level, like drugs, power supply and functional vehicle are far below the national average in Punjab, in spite of the fact that the State has remained as one of the high income States of the country for the last many decades. These aggregate numbers reflect a historical legacy of complete lack of priority in policy over the last many years to provide basic facilities at the first tier of health care in Punjab, and the recent limited policy initiatives will need many years to show up in aggregate numbers.

2.4.6. When it comes to facilities at the Community Health Centre level, Punjab has not fared too badly. The State is at least around or marginally above the national average in terms of availability of specialists, except anaesthetists and health managers (Table 15 in Annexure). However, the State is nowhere near the high income States. The 24-hour availability of normal delivery facilities is available in 85 percent of CHCs in Punjab, but in large number of States, this is true for 90 or more than 90 percent CHCs.

2.4.7. Field visit by the Task Force revealed that in the prevalent health infrastructure, their exist large number of institutions (like SHC's), meant for clinical work, but without any basic diagnostic facilities, making the task of qualified to do clinical work very difficult.

2.4.8. It was also noticed that at the SHC/mini-PHC level, single Medical Officer has to perform clinical as well as preventive job of National programs. Both these services (clinical and community) are in contrast with each other. One demands full duty hours at the institution and the other demands more time to manage and supervise work of preventive teams in the field. Furthermore, at SHC/mini PHC level, two types of paramedical staff is posted, one comprising clinical team and other health workers team. Both these teams are led by the same Medical Officer making the task of supervision and command responsibility difficult. The two tasks need to be disentangled.

2.4.9. In the existing structure, evening clinical OPD is nearly missing at the SHC/mini PHC level. During the morning time also, Medical Officer posted at SHC/mini-PHC has to perform clinical as well as preventive job of national programs reducing the time for clinical work. In these circumstances, doctor posted at SHC/mini-PHC, is unable to provide duty for the evening OPD. Although all mini-PHC's are supposedly having Laboratory facility, X-ray and nursing staff for in-door, but, the doctor posted there is unable to manage expected clinical work and proper use of health infrastructure. Hence, these facilities cannot be properly utilized.

2.4.10. It was found that at the moment there is only one centre of 'secondary and emergency' services i.e. at CHC (PHC) headquarter, with vacuum of services in the remaining population residing at long distance of whole block ranging from 30 to 45 kilometres distance.

2.4.11. It was observed that there is only one administrative head, SMO, at the block level PHC, servicing a population of 1, 25,000 to 1, 50,000, spread in an area of 50 to 70 villages. This causes lot of service delivery, co-ordination and management problems. The block PHC head, who is overloaded with responsibilities for the block, is also the head of another administrative unit namely the CHC, resulting in supervision challenges at the secondary health institution.

2.4.12. During the field visits, promotional opportunities for doctors and para-medical staff was also noted as a challenge. We understand that in a huge cadre of more than four thousand PCMS doctors, there are only a limited number of promotional posts.

2.4.13. According to National Commission on Macroeconomics and Health (NCMH), Punjab's human resource in terms of registered doctors, nurses and ANMs is above the national norm. The national norm for human resources is 2.5 per 1000 whereas for Punjab it is 2.93 per 1000. In case of Medical Colleges, Punjab falls under the category of States having

adequate number. However, Punjab is lacking in primary health care. Availability of sub-centres in Punjab is less than the national average. In case of primary health centres, it is same as all India average and community health centre is higher. Punjab has a better reach in terms of government hospitals. The average population served by the government hospital in Punjab is 114247 whereas the national average is 97958. These numbers, of course, do not evaluate the issues of differential access or the quality of care delivered in public hospitals, which will be discussed separately later in this paper.

2.4.14. At the aggregate level, the situation appears to be much better in Punjab compared to other States for secondary and tertiary care. Punjab is better situated than most of the States, including high income States, on almost all parameters including availability of specialists, ultra-sound facilities, water and ambulance (Table 16 in Annexure). Only in case of the availability of radiologist, some inadequacy was found in the State. However, once we move beyond numbers, the story of the secondary and tertiary health care is very disturbing. We discuss this issue in detail below.

2.4.15. For assessing the infrastructure conditions at the secondary and tertiary level in Punjab, we have used a facility survey by NIHFW. This survey was done for the review committee of the Government of Punjab for reviewing Punjab Health Systems Corporation. The survey was done in Punjab in early 2008 covering 10 district Hospitals, 10 sub divisional hospitals and 10 CHCs. Selection was done using population proportionate sampling technique. The study found location of health facilities to be accessible from bus stops, railway station and also by a motorable road. The building and general infrastructure for all the health care facilities were found to be reasonably well constructed. However, on basic cleanliness, the survey found the surroundings of health facilities, specifically the toilets and general landscape, to be extremely poor.

2.4.16. The survey found that almost all the hospitals had vacant posts including doctor as well as support staff. It found that there was no separate cadre of specialists as a result of which, particularly in CHC and sub divisional hospital, the specialists were doing routine night and emergency duties and, hence, were not available for regular OPDs. The survey also found that lot of time was wasted of doctors, including specialist, to perform other duties like VIP duties, attend court cases and do basic health care duties like health *melas*. The study found that there was acute shortage of radiologist, paediatrician and gynaecologist in almost all the hospitals, particularly in Sub-divisional Hospital and CHCs. It also found acute shortage of support staff, particularly technical staff in sub-divisional Hospitals and CHCs. The study also found frequent transfer of doctors, without any laid down policy guideline, as a factor that disrupted health services. Emergency and maternity services were found to be worst affected mainly in sub divisional Hospitals and CHCs. The main reason for

this was non-availability of doctors round the clock for emergency and maternity services.

2.4.17. The survey also came up with a disturbing finding that nurses were not willing to work night hours, due to security reasons. The absence of nurses, due to their sense of insecurity contributed, as per the study, to general dissatisfaction of the community towards the health service.

2.4.18. In case of equipment, the survey found at some places equipment was either not in use and was out of order. Though laboratory and diagnostic services were available in all the hospitals, however, its functioning was not satisfactory. Most of the times, the patients were forced to go outside to get the test or X-ray done. X-Ray units were found to be non-functional due to erratic electric supply and non-availability of X-Ray films.

2.4.19. None of the hospitals including district hospital were found to be properly prepared to deal with disaster situation in terms of medicine or disaster action plan.

2.4.20. On emergency care, the institutions face major challenges. Five district hospitals out of ten were reported to have ICUs, while none of the specialized hospital studied were having ICUs. It was only available in sub divisional hospital with the bed strength ranging from 2 to 6 beds. None of the ICUs were air-conditioned and also didn't have any backup generator support. None of the CHC's had ICUs.

2.4.21. All the ten district hospitals and two special hospitals under study were having dental services. Two sub-divisional hospitals and four CHC didn't have any dental services. The survey found that dental services have received less attention compared to the meagre attention to health services in Punjab.

2.4.22. The study found that seven district hospitals and one special hospital were having medical record room, with enough number of racks. But none was properly planned and organized. Most of the records were maintained manually and were in chaotic condition.

2.4.23. None of the hospitals was providing regular diet to their inpatients, except in one sub-divisional hospital. It was also found that the relatives of the patient coming from long distances, were not having any proper place to stay and they didn't have access to other facility like toilets, kitchen etc. As a result, they were found loitering in and around the hospital.

2.4.24. Although the much publicised Rogi Kalyan Samities were formed in all the hospitals, the study says that 'due to internal administrative problems and non-fulfilment of other pre requisites', these Samities were found to be non-functional.

2.4.25. Though, on paper, all these hospitals have well laid down referral systems, in practice it is not followed.

2.4.26. Regarding availability of medicines, it was observed in all the hospitals, and reported by almost everybody, that medicines were not available. Although there is a provision for supply from the State and the district level in practice, however, most of these centres were told to buy medicines from the user charges fund. Buying medicines from the user charges has become a practice in all the hospitals and health centres bringing about great degree of variability in availability of medicines between the institutions often at the cost of neglecting essential and life-saving drugs. The medical store management was not found to be well-organized in keeping with the modern techniques of store management.

2.4.27. Looking at the aggregate condition of water supply and sanitation, we find that at the aggregate level, the situation in Punjab is satisfactory. However, household level survey reveals the precarious and iniquitous nature of basic sanitation and health in the State.

2.4.28. Across the States, Punjab has done fairly well in terms of aggregate numbers on water supply and sanitation facility. Even though all the households in Punjab use an improved source of drinking water, only 44 percent have piped water in their dwelling, yard, or plot. Eleven percent of the households treat their drinking water to make it potable: 4 percent boil the water, 2 percent use ceramic, sand, or other filters, 1 percent strain the water through a cloth, and 5 percent treat the water in some other way (Punjab report NFHS3). Also, there is large rural urban disparity as only 26.4% of the rural households have piped water into dwelling, whereas, in urban areas, it is 71.1 %. Again, in treating water to make it potable, it is 19% in urban households, whereas, it is just 6% in rural areas (see Table 17 in Annexure).

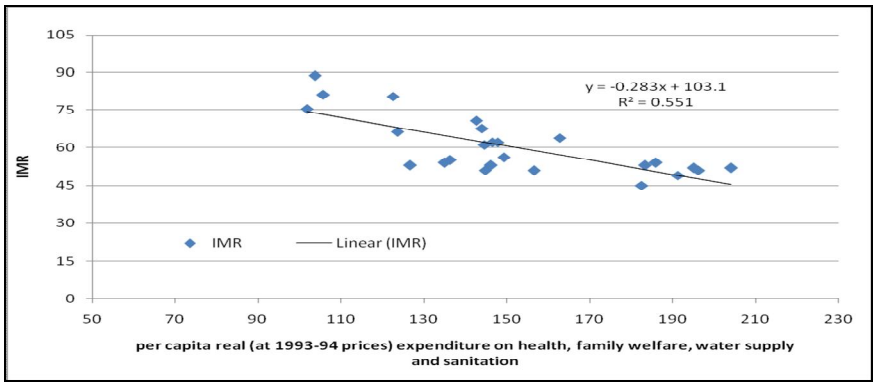
2.4.29. 70.8% of the households in Punjab have toilet facility, but if we break it up, only 50.5 % have improved toilet facility. In urban areas, it is 62.5% and in rural areas it is 42.8%. 29% of the households under category 'not improved toilet facility' go to open fields. In the rural areas, it is as high as 57.1% and in urban areas it is 6.3% (see Table 18 in Annexure).

2.4.30. A survey of 1000 households in Punjab in 2007, further revealed that piped water is available to less than 20% households. Hand pump is still the source of drinking water. Only 41 % percent in Punjab said that they had safe drinking water. Less than 30 percent SC households have toilets in their homes. Amongst those who had no access to toilets, nearly three fourth or more were SC households. Amongst those not having toilets at home, the access to shared toilets was much lower for SC households. Two thirds of household that have toilets were with annual income of more than 25000. The story of covered drainage was no different. 89 % households in Punjab did not have covered drainage in their *mohalla*. Not much difference between SC and other settlements was found around drainage.

2.4.31. It is pertinent to enquire about the trends of expenditure in health, especially public expenditure in health and for improving the quality and coverage for clean drinking water. The strong influence of public

expenditure in reducing IMR (see Figure 14) further reinforces the need for examining the quantum and trends in public expenditure in Punjab.

Figure 14: Relationship Between Real Per Capita Expenditure on Health and IMR in Punjab from 1980 to 2005



Source:1. SRS Bulletin various years and Compendium of fertility and Mortality, both published by The Registrar General of India and Public Finance Statistics, Various years, Reserve Bank of India.

2.5. Inter-State Comparisons of Expenditure on Health - Public and Private

In the following analysis, inter-state comparison of expenditure trends in the social sector has been done from mid 1980s up to2004-05. For the more recent years, we have examined the trends in health sector expenditure for only the state of Punjab.

2.5.1. Punjab ranks 9th in the country in terms of per capita expenditure on health (Table 19 in Annexure). In other words, there are 17 states in the country that spend less on health in per capita terms. Most of the high and middle level per capita income States, like Gujarat, Maharashtra, Karnataka, Tamil Nadu, spend less on health, reflecting perhaps more efficient health services or better health status in these states. However, bulk of this expenditure burden falls on households in all the States. In Punjab, 76 percent of health expenditure is made by households and only 18 percent is made by the government (Table 20 in Annexure). Public expenditure in Punjab is below the national average and share of household expenditure in health expenditure is marginally above. Expenditure by private firms, NGOs and foreign agencies in Punjab for health is 1.5 percentage points more than the national average. Even though public expenditure is a small component of the overall health expenditure (national average of 22 percent), it is still significant expenditure that contributes to the creation of health infrastructure and impacts public health (this is reinforced by results shown in Figure 2 above). In what follows, we shall analyze public health expenditure in greater detail.

2.5.2. Share of plan expenditure in Punjab in the aggregate budget expenditure of the State has drastically fallen, compared to other developed States, in the last decade (Table 21 in Annexure). Plan expenditure is now just 13 percent of the budget expenditure in Punjab compared to 20 to 23 percent

for the high, middle and low income states. Within plan expenditure, the share of central plan schemes and centrally sponsored schemes has also come down over the years, from around 4 percent to 2 percent. This decline is once again larger than what has happened in high income States during this period (Table 21 in Annexure). Within the social sector, the share of plan expenditure is less in Punjab compared to similar income States in India (18 compared to 23), but fortunately, the fall in plan expenditure for the social sector over the years has not been as sharp as in the case of overall plan expenditure (Table 22 in Annexure). Within the social sector, plan expenditure is around 16 percent, out of which the share of centrally planned and centrally sponsored schemes is 4.6 percent, which is marginally more than what has happened in all the high income States. These facts raise serious doubts about the argument, often made in Punjab that the Centre discriminates against the State or that the centrally sponsored schemes have little relevance for the social realities of the State. The State is absorbing marginally more expenditure from the centrally plan and sponsored schemes than other developed States in the social sector up to 2004-05.

2.5.3. The distribution of public expenditure on medical, public health, family welfare and water, sanitation and nutrition into plan and non-plan components suggests that in Punjab the share of non-plan expenditure is much higher than comparable States and this share has increased over the years (Table 23, 24, and 25). The very low share of plan component in health expenditure in Punjab (23.5) compared to other high income states (41%) from the mid 90s onwards suggests that the State has neglected expenditure in areas like creation of primary health centres, hospitals, dispensaries, medical training and research, prevention and control of diseases and programs of water supply and sanitation (these are the major heads under which plan expenditure has been made in the health sector over the years). The contribution of central plan schemes and sponsored schemes to strengthen plan expenditure in the State has reduced over the years, but it is not very different when compared to other high income States. In case of water, sanitation and nutrition, the share of centrally sponsored and plan schemes in Punjab are much larger in comparison to other high income states.

2.5.4. The priority of Punjab Government towards health in its overall expenditure plans and within its social sector priorities can be discerned by looking at the trends of share of health expenditure (both direct and indirect) in total public expenditure (Table 26 in Annexure) as well as in social sector expenditure (Table 27 in Annexure). The share of social sector expenditure in total expenditure has sharply fallen in Punjab in the last decade, from 35 percent to 23 percent and is much below comparable income States. In fact, the share of social sector expenditure in public expenditure is less when compared to even low income States. This is also

true for the share of public health, family welfare and water, sanitation and nutrition expenditure in total State Government expenditure. It has come down more sharply in Punjab in the last decade, compared to other States, and is today less than even the low income States. If we see this separately for medical, public health and family welfare, even then the story is not very different (Table 26). However, in expenditure on medical, public health and family welfare, the share of public expenditure in Punjab is not very different when compared with other high income States.

2.5.5. The share of health expenditure in social sector expenditure reveals a very interesting story for Punjab. The State has done relatively better than other States when we look at the share of medical, public health and family welfare in social sector expenditure. However, the State has done dismally when we look at the share of expenditure on water supply, sanitation, and nutrition compared to not only developed States but even the low income States (Table 27 in Annexure). Over the last decade, there is a small increase in expenditure on sanitation but even today it is much less than other States. The consequence of this neglect becomes very apparent when we link these low level expenditure with morbidity patterns in the State, where we find a high share of infectious and water borne diseases in overall morbidities in the State.

2.5.6. The share of central transfers for social sector expenditure as a share of public expenditure and share of central transfers on direct and indirect health expenditure of States in total public expenditure are shown in table 28 (Annexure). The numbers suggest that the relatively large share of transfers to the social sector in total expenditure up till mid 90s have declined and the transfers from the Centre as a share of total public expenditure have fallen substantially in the last decade when compared with other high income States. If we look at these transfers as a share of total social sector expenditure, then Punjab is at least as well located as other high income States, if not better (Table 29 in Annexure). Interestingly, when it comes to expenditure on water, sanitation and nutrition, then the transfers from the Centre have not been at par with transfers to other States.

2.5.7. Per capita public expenditure on medical, public health and family welfare in Punjab (this expenditure does not include expenditure made by local governments and PSUs but only expenditure made by Central and State Governments) at 93-94 price was Rs. 126 in 2004-05 and was higher than the average for all high income States in India (Table 30 in Annexure). Within this, per capita expenditure on public health is shockingly low in Punjab (around Rs. 8.5 in 2004-05 compared to Rs. 26.3 for high income States at 93-94 prices) compared to high income states. Per capita expenditure under medical and family welfare is at par with high income States or better. Per capita public expenditure on water, sanitation, and

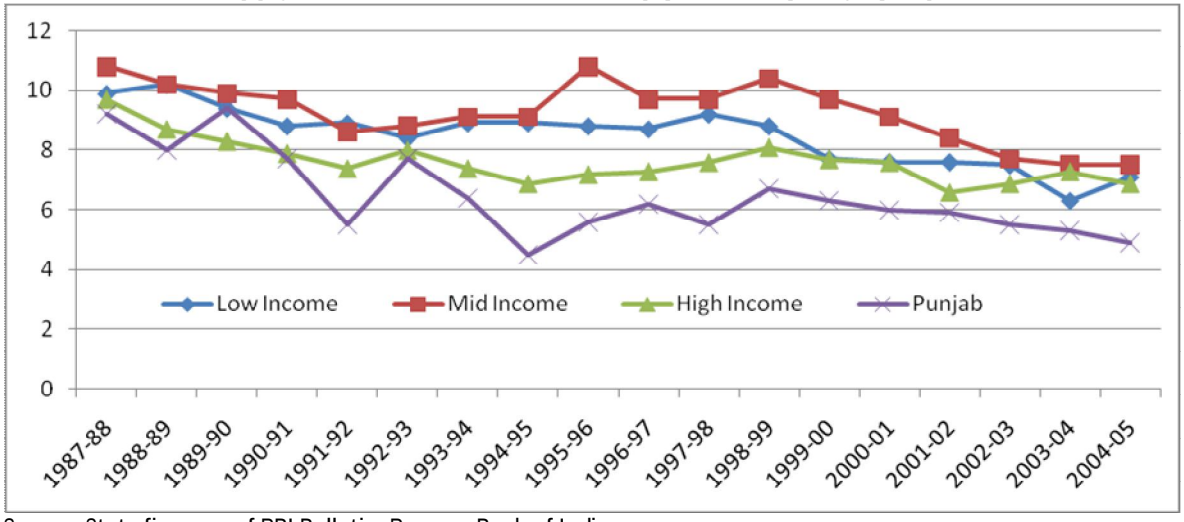
nutrition in Punjab in 2004-05 is Rs. 56 and is much lower compared to both middle income and high income States. The source of low expenditure on public health and water, sanitation and nutrition is lower capital expenditure as well as low plan expenditure in Punjab. Non-plan per capita expenditure on health is much higher than high income States in Punjab (Table 30 in Annexure). If we look at per capita public expenditure, we find that expenditure under medical and public health is nearly equal in rural and urban areas and, in a way, better than public expenditure in other high income States.

2.5.8. When we look at the expenditure on Medical and Public Health, we see that there is a bias towards the urban areas, as major chunk of expenditure goes there. This is true across almost all States. In case of expenditure on family welfare, it is other way round, wherein rural areas get more emphasis. Overall, for medical, public health, family welfare, water supply and sanitation, rural areas get slightly more allocation in Punjab (Table 31 in Annexure).

2.5.9. Health care composition in terms of economic classification in Punjab clearly shows the importance given to salary component, whereas non-salary component like maintenance of motor vehicle, machinery and drugs are totally neglected (Table 32 in Annexure). It is true for other States also but the share in Punjab is abysmally low. In 2005-06, only 0.8% of the total budget was allocated to machinery equipment and drugs.

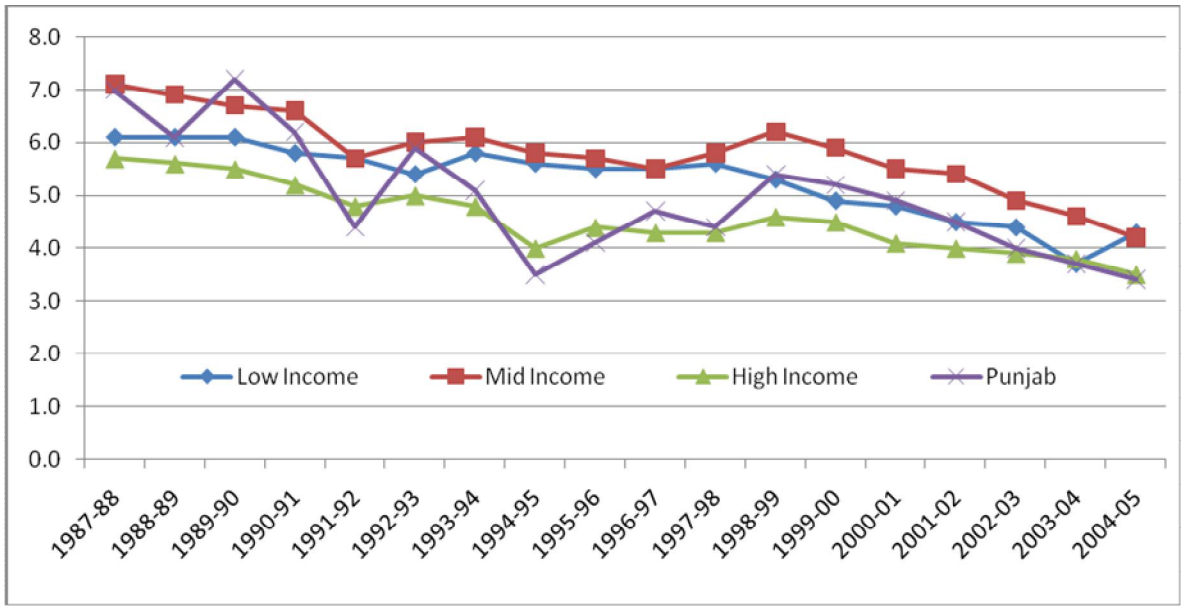
2.5.10. The lack of priority to health expenditure in overall public expenditure is clearly discernible from figure 3 and 4. Share of health expenditure comprising medical and public health, family welfare, water supply and sanitation and nutrition as a share of total government expenditure in Punjab is very low compared to both high income States as well as the low income States. There has been decline in its share from 1985-86 to 1993-94, and there has been some increase till 1998-99, but again from 1999-2000, we see a smooth decline. In case of medical and public health and family welfare, Punjab's share is higher than the high income States, but it also shows decline from1987-88 to 2004-05. Although in mid 90's, there is some increase, but there is a smooth decline from 1998-99 to 2004-05 (Figure 15).

Figure 15: Share of health expenditure (including medical, public Health, family welfare and water supply, sanitation and nutrition exp.) in Total (budget) expenditure



Source: State finances of RBI Bulletin, Reserve Bank of India

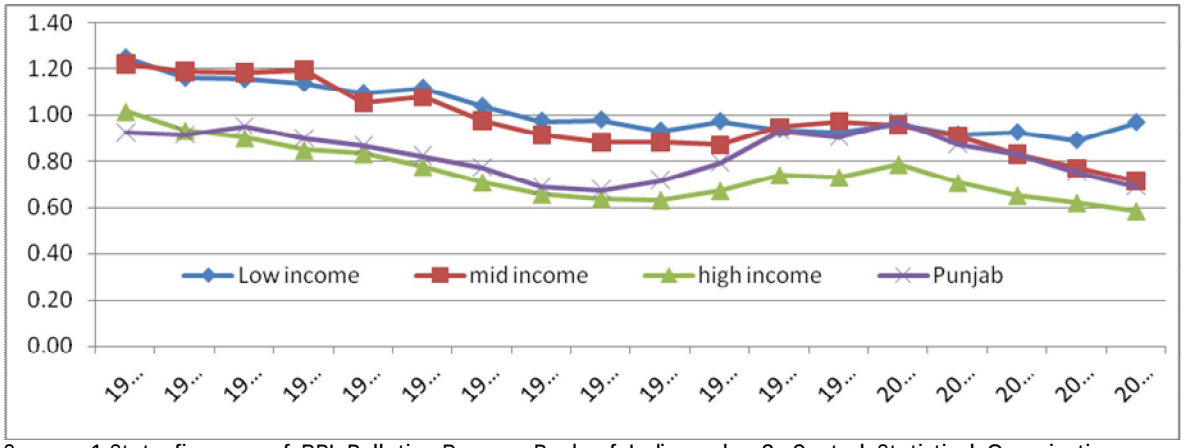
Figure 16: Share of expenditure on medical, public Health, family welfare in Total (budget) expenditure



Source: State finances of RBI Bulletin, Reserve Bank of India

2.5.11. The share of health expenditure as a percentage of GSDP in Punjab declined between 1986-87 and 2004-05, although this decline has not been uniform as we see some increase from 1995-96 to 1998-99 followed by decline in the succeeding period (Figure 17).

Figure 17: Share of expenditure on medical, public health, family welfare as percentage of GSDP



Source: 1.State finances of RBI Bulletin, Reserve Bank of India and 2. Central Statistical Organisation, Government of India

2.5.12. What emerges from the expenditure patterns discussed above is that Punjab spends more money on health in per capita terms, compared to most of the Indian States. Most of this expenditure is made by the households and the share of public expenditure on health in Punjab is less compared to other high income States of India. Within public expenditure, plan expenditure in Punjab is less in comparison with other States, particularly in the social sector. Bulk of the expenditure in social sector is non-plan and is larger than States at comparable levels of per capita income. The very low share of plan component in the health expenditure in Punjab, compared to other high income States, from the mid 90s onwards suggests that the State has neglected expenditure in areas like creation of primary health centres, hospitals, dispensaries, medical training and research, prevention and control of diseases and programs of water supply and sanitation. The support to social sector in Punjab through central plan schemes and sponsored schemes is better than the other high income States, though this support is dwindling.

2.5.13. Moreover, social sector expenditure in Punjab has been neglected over the years and is at par with some of the low income states in the country. Same is true for expenditure related with medical, public health, family welfare, water, sanitation and nutrition. Within these expenditure items, the allocation patterns and time trends in Punjab reflect utter neglect of basic facilities like clean water, improving sanitation and supporting nutrition. Such expenditure is even less than some of the most poor States of the country and this neglect has increased over the years. This neglect is further reinforced by the transfers from the Centre, wherein in relative terms, less resources have been put in for such activities. In per capita terms, per capita expenditure in public health is dismally low, though expenditure on medical and family welfare is at par with other high income states. Furthermore, per capita public expenditure on water, sanitation, and nutrition in Punjab is much lower in comparison to both middle income and high income States. When we look at the expenditure

on medical and public health, we see that there is a bias towards urban areas, as major chunk of expenditure goes there. Health care composition in terms of economic classification in Punjab clearly shows the importance given to salary component, whereas non salary component like maintenance of motor vehicle, machinery and drugs are totally neglected. This trend is true for other States as well, but the allocation to machinery equipment and drugs in Punjab is abysmally low.

2.5.14. The midterm review of the 11th Plan makes the following observations about the public expenditure in Punjab for the recent years.

- The performance (actual expenditure to approved outlay) in health sector (medical and public health) in the State of Punjab during the 10th Five Year Plan (FYP) was only 30.9 percent as compared to 68.2 percent for overall social services and 79.4 percent for the plan as a whole. On the other hand, the approved outlay was 26.0 percent and the actual expenditure was 22.3 percent for the social services sector as a whole. While the total outlay for the social services increased from 26.0 percent during the 10th FYP to 34.2 percent during the 11th FYP, the share of medical and public health in the total plan outlay for 11th FYP substantially reduced to 1.4 percent from 2.85 percent in the 10th FYP. Even within the social sector, the percentage share of medical and public health has been reduced from 10.9 percent during 10th FYP to 4.1 percent during the 11th FYP. This shows that a lesser priority was accorded to medical and public health sector in the 11th FYP within the total as well as within the social sector (for details see page 56 of the midterm review).

- The midterm review further states that the revised outlay on medical and public health during the initial year (2007-08) of 11th FYP in Punjab was reduced from Rs. 10,321.5 lakhs to Rs. 4,042.7 lakhs (which was 39.2 percent of the approved outlay). The main reason for this reduction, as seen by the midterm review, seems to be non-implementation of newly proposed schemes amounting to Rs. 4,762.1 lakhs. Furthermore, the performance (actual expenditure/revised outlay) was only 8.0 percent for the medical and public health, whereas it was 84.1 percent for the social services and 99.5 percent for the overall plan. It appears that there is diversion of funds from health sector to some other sector of the economy. The performance during the 2nd year (2008-09) for the medical and public health sector improved from 8.0 percent in 2007-08 to 46.01 percent. However, it was still much lower than the performance of social services as a whole (87.5%) and 93.5 percent for the overall plan of the State. The State again did not keep any provision for new schemes in the revised outlay of 2008-09, and only continuing schemes were carried forward.

- On specific schemes, the midterm appraisal says that out of the total outlay of Rs. 11261 lakhs during the 11th plan for establishment and

up-gradation of infrastructure in the two annual plans (2007-09), only five percent of the allocation has been spent; the performance of 100 percent Centrally Sponsored Schemes and the Centrally Sponsored Sharing Schemes have been better than the State Funded Schemes during the initial two annual plans of the 11th FYP; among all the 100 percent Centrally Sponsored Schemes, the schemes under family welfare performed much better by utilizing 92.2 percent of the outlay during the financial year 2007-08 and 96.3 percent of the revised allocations during the financial year 2008-09; under NRHM, an increasing trend is observed both in allocations and receipts of funds under the programme since 2005-06. However, the receipts are invariably less than the allocations except during 2008-09; and the performance of the health corporation with respect to centrally sponsored schemes (sharing) was 100 percent during the financial year 2008-09, which is up from 17.9 percent in 2007-08.

- On Centre and State expenditure on health, the appraisal says that the share of the State Government in the actual expenditure during the first annual plan period (2007-08) was only 1.5 percent of the total expenditure on medical and public health which increased to 17.4 percent during the second annual plan period (2008-09).
- Thus, overall, the performance of the Government in spending the allocated resources has not been very impressive and is definitely not enough to overcome the historical neglect of the social and, in particular, health sector in Punjab.

2.5.15. The limited availability of health infrastructure and the inadequacy of public expenditure on public health, water, sanitation and nutrition (components that impact the social determinants of health the most) does suggest that health outcomes in Punjab are not expected to be at par with the general perception about the success of Punjab's economic growth. The following sections evaluate the facts about health outcomes and access to health services in Punjab, so as to discern specific policy lessons for Punjab.

2.6. Challenges for Health Policy and Existing Policy Framework

2.6.1. The above discussion on health infrastructure, health expenditure, mortality and morbidity patterns, utilisation of health facilities, health seeking behaviour and the differential access and cost of seeking health in Punjab open up large areas for policy. The core areas for policy that come to the fore are - the inadequacy of public provisioning of health facilities and basic sanitation facilities; inequities in social infrastructure - mainly access and utilization issues; absence of effective public health programs; the high cost of health care, even in public institutions; need for health initiatives for addressing State-specific morbidity challenges; and increasing financial allocations for the health sector. Before we come to specific policy recommendations, let us identify what are the core

concerns of the existing policy framework and to what extent they address the contemporary supply and demand side challenges.

2.6.2. If we look at the existing strategy in the health sector, following thrust areas of the Government of Punjab can be discerned -

- Addressing the human resource challenges in the health sector (for instance recruitment of *ASHA*, recruitment of medical personnel at the PHC level, appointment of one female medical officer and 3 staff nurses on contractual basis as part of up gradation of PHC into 24x 7 PHC, recruitment of specialist for upgraded CHC mostly on contractual basis and few on regular basis, and integrate all vertical health and family welfare programs in the State for more efficient utilization of staff; provide referral transport through public private partnership under *Janani Suraksha Yojana*);

- Participative health management (for example, setting up of Village health and sanitation committee, more than 50 percent of the released funds have been spent on VHSC; preparing district health plan as an amalgamation of village health plans; initiating the total sanitation campaign through communication campaign with the rural communities on sanitation and toilet use; conduct periodic meetings, inter-sectoral coordination with department of local bodies, bring about greater convergence in water supply, sanitation, and sewerage board through dialogue; joint campaigns by health and public health engineering departments; create guidelines for public private partnership in health sector, identify areas of partnership which are need based, thematic and geographic.; highlight the formulation of management plans for PPP initiative at district, state and national level; use NGOs/CBOs/FBOs and other philanthropic organizations in community awareness programme and other grass root activities);

- Provisioning of medicines (14500 ASHAs were provided with drug Kit; provisioning of essential drugs at the sub-centre level; Department of Pharmaceuticals is establishing *Jan Aushadi* stores in each district for sale of cheaper generic medicines manufactured mostly by CPSUs; drugs worth Rs 37.33 lakhs procured under the head 'up gradation of CHC' in the year 2008-09; dependence on collection of user charges to supply medicines at CHCs);

- Incentive-based motivation for health workers (for instance for the year 2008-09, Rs. 402.17 lakhs was paid as incentive to *ASHA*);

- Improving the health infrastructure (for example, 954 SCs in the State having more than 6000 population upgraded with sanction of a second ANM; initiatives to provide essential equipment at CHC level; construction of new building approved for 50 SCs and renovation of 77 SCs during 2008-09; 10 CHC approved for repair and renovation during 2009-10; attempt to consolidate, up-grade and expand existing medical

institutions in the State by removing the existing deficiencies in the building, infrastructure, medicines, machinery and equipment; up-gradation of 116 CHCs and 20 District Hospitals to IPHS standards; construction of delivery rooms and minor OTs in 50 PHCs; setting up of 25 new born care centres; strengthening of 26 PHCs for 24x7 hours deliveries; district health societies to empanel private health institutions for institutional deliveries among BPL/SC families under the *Surakhit Janepa Yojana* and *Janani Surasha Yojna;* bring in the private sector in creation of multi specialty & cancer hospital in *Mohali* and *Bathinda* in PPP mode in collaboration with M/S. Max Health Care India);

- Introduce alternative medicinal care (for example, homeopathic dispensaries located in 99 out of 112 sanctioned CHCs in addition to one already sanctioned under NRHM);

- Introduce better health management through use of technology (for example, plan to link all the DHs, SDHs, and CHCs with the PGIMER, Chandigarh, and with the Government Medical Colleges in Punjab through Telemedicine; plan to connect three Government Medical Colleges and 15 district hospitals with PGIMER, Chandigarh) and

- Address neglected areas (like establish "drug de-addiction centres" in the existing hospitals and "State Level Drug Dependence Treatment Centre" on the lines of National Drug Dependence Treatment Centre to combat the problem of drug abuse in the State; to establish four new faculties for - health system management and research, health economics; environmental sciences; and bio-informatics and Information Technology; and plan to establish four study centres on educational technology, distant learning and tele-medicines, Public Health, and bio-informatics and information technology in Baba Farid University of Health Sciences; weekly surveillance from CHC, PHC, Civil Hospital level for communicable diseases, where the investigative reports and data pertaining to diseases will be communicated electronically to the district surveillance unit; setting up of a drug testing laboratory at Patiala and Panchkarma unit at Mohali);

- Provide efficient emergency care by provisioning of ambulance services (for example, plan to deploy 90 Ambulances which will cover all the major roads and urban areas under the Emergency Medical Response System through PPP mode; mobile units comprising of medical officer (one male and one female), one staff nurse, one radiographer, one laboratory technician, one driver and one helper; and to develop public- private partnership for availability of safe blood to strengthen institutional deliveries and emergency facilities)

2.6.3. The road map for the secondary and tertiary sector is reflected in recommendations of the Bajaj Committee, suggesting

- focus on recruitment, training, regular in-service training, timely promotion and transparent transfer policy
- Using IPHS norm for doctors as well, recruit specialists at all the levels of health facility
- Participation of the entire health centre should prepare a list of medicines for procurement
- Provision of generic drugs at reasonable price
- Proper installation of equipments at the health centre and systematic maintenance of them
- Improve the general upkeep, cleanliness and landscaping of health institutions. Basic infrastructure like fans, light, drinking water facility etc. be in place. Also, well maintained residential accommodation be provided at all levels of health centres
- Emergency services should be in place with the required health personnel. Emergency obstetric services need to be available at every level of health care.

2.6.4. If we examine the details listed above and discern the current strategy of improving basic health outcomes in interviews with officials, the thrust of government's approach can be summed up as follows -

- The Government seems to be using two main instruments in the health sector - continue to do more of what has been done over the years or bring in the private sector. This is reflected in various initiatives of the Government of Punjab listed above.
- The initiatives suggest Government's belief in continuing with the existing structure of health management, which includes multiple agencies operating in the health sector like DHS, PSHC, NRHM, Zila Parishad etc. The Government does seek, in some of its initiatives, proper coordination between all the levels of health care
- Government believes that PHSC, which has been created to deliver health on the practices followed by the private sector, can be instrumental in implementation of national health programmes under NRHM and NUHM.
- There is a strong belief in the government policies that public – private partnerships in health can supplement the government's effort in utilization of health services, conservation of scarce public resources, revenue generation for private and public sector, regular supply of medicines, meet the shortage of staff, meet the training needs of health workers, improve infrastructure and facilities and provide

emergency care. Public private participation model has been adopted in maternity care for strengthening maternity services.

- Large number of initiatives of the Government of Punjab in the last ten years or so are based on the desire and need to utilize private sector resources for addressing public health goals; and redefining the role of the State from being a provider to a financier of health services as well. This is a shift from the earlier orientation of health policy, which were more focussed on State-led provisioning of equal access to health to one and all. In more specific terms, the current strategy involves handing over management of public facilities to the private sector; contracting private specialist services and outsourcing ancillary services like information, education and communication; transfer of budgets to and involvement of local bodies; contracting professionals for service delivery - ANMs, doctors, surveillance, auditing; multi-skilling, pre internship training, mandatory rural service; introducing user fees and financial autonomy to hospitals; direct transfer of funds from GOI to districts under NHPs; financial delegation of powers to PHCs, CHCs and district CMOs; delegation of powers to district level officials; rationalizing responsibility for better accountability; performance-based monitoring and community mobilisation (for full details of these initiatives see Government of Punjab, Department of Health Web site, accessed on July 30, 2010).

- Instead of treating health as a matter of right for all citizens, there is an attempt to introduce some form of health insurance as a mechanism for protecting poor from impoverishing effect of illness.

- The ongoing strategy appears not to be sensitive to the reality of inequalities in access to basic health services discussed above but is more focussed on the efficiency issues. The policy prescriptions are often intended to achieve efficient utilisation of staff, applying benefit incidence norm to health expenditure, giving greater control to top administrators for punitive action and monitoring absentees and so on.

- The initiatives on health that 'supposedly' respond to social inequities in health in Punjab often depend on; a) financial incentives (Bal Rakshak Yojna; Balri Rakshak Yojna, Reproductive Health Programs through MSS); b) on initiatives led by the Central Government (Janani Suraksha Yojna and numerous initiatives under NRHM); or c) on implementation of vertical disease control programs that address malaria, waterborne diseases (mostly involves testing of water samples), mental health, leprosy, blindness and Iodine deficiency. The focus of each of these disease control programs is rooted in financial incentives, surveillance, punishment and also motivation and mobilization.

- In addition, there is some talk of regulation and standard setting of blood transfusion standards; ISO Certification; ensuring essential drugs

under special schemes; centralised drug procurement and finally liberalization of the insurance sector to provide new avenues for health financing. All of this reflects a general lack of faith in the public sector and public providers of health care and greater dependence on the private sector and community organizations.

2.6.5. It is pertinent to ask why all the specificities of health inequalities in Punjab, listed earlier, are not reflected in the health policy? Why is that the health policy in Punjab is no different from strategy of health in almost all the States of this country? In the overarching strategy of health care in Punjab, particularly in the last decade or so, public health approach to basic health care is missing. As we discuss below, the major failure in achieving the desired outcomes may not lie only in inefficiencies of implementation of the public sector but in inadequacy in understanding the determinants of health care, lack of belief in right-based health care and absence of systematic and focused effort on overcoming the challenges posed by non-transparent functioning of bureaucracies, rent seeking and private sector interests in health care.

2.7. Policy Recommendations

2.7.1. The first major challenge for the State is its need to have its own health policy based on its own specificities. At the moment, the State is completely dependent on the Central Government for social sector programs. Consequently, the priorities of expenditure in health are also determined by the Central Government. This is clearly reflected in our discussion on priorities of health expenditure and in our evaluation of Government's policy framework. A small example of this reality is the mismatch between morbidities in the State and the disease control programs in operation here.

2.7.2. Therefore, on the structure of health delivery there is an urgent need to rethink. The Commission has some initial suggestions in this direction. It is felt that there is a need to bring the first referral unit at the CHC level and lower level health institutions should be available for daily OPD and as centres for implementation of national programs. To improve the utilization of the existing health infrastructure, health providing institutions, should be divided into three basic categories - Primary Care Centres (where basic clinical services will be provided), First Referral Units (FRUs) and Hospitals or Multi-Specialty Hospitals. The existing nomenclature of PHCs, Sub Centre, Mini PHC, SHCs, District hospital and so on should be all merged at different levels into these three categories. A separate exercise needs to be undertaken to decide the location of Primary Care Centres and FRUs. A scientific exercise using the available technology like GIS, evaluation of the available road and transport network and mapping of the existing facilities should be done to make optimal design for locating the health institutions.

2.7.3. With the advancement of transport infrastructure in the State, the people can move easily to other nearby villages to access quality health services. Hence, it is suggested that centralized, manageable clinical services be created at Sub-Block (mini-PHC) level. SHCs be continued to maintain preventive services only. SHC should continue only as centre for preventive multi-purpose health worker teams which can be monitored by the medical officers from the primary care centre. This will improve the utilization of skilled human resources, improve quality of clinical services and provide better access to primary level care.

2.7.4. There is a need to consolidate sub-centres. There is need to increase the capacity of ANMs/MHW/Supervisor to provide basic emergency services at the sub-centre level. There orientation should go beyond reproductive health and capacity needs to be created amongst them for documentation. It is possible to think of existing PHC or mini PHC as apex institutions for national programs (public health) and documentation. It may be worthwhile posting an administrative officer at PHC, as a documentation head, who reports directly to the head of mini PHC or PHC. Current documentation systems have to be reworked and every attempt should be made to reduce doctors' time in these processes. Currently, there is immense amount of daily reporting whose burden falls on the doctors. The DHS needs to get rid of multiple agencies and become the nodal agency for initiating such a restructuring. A special task force should be formed with a clear mandate and time bound program to initiate such changes.

2.7.5. Primary Care Centre (at the mini PHC level) can provide clinical services, emergency support 24 by 7 and basic reproductive services. Elementary diagnostic facility, basic emergency care infrastructure and medicines needed for regular use should be available at the Primary Care Centre. Elementary indoor facility may be provided at these Primary Care Centres. Emergency transportation vehicles, fitted with modern life-saving equipment, will be stationed at these Primary Care Centres to transport patients to FRUs in case of emergency. The primary care centre should meet adequate standards of providing working teams dignified working space. Existing furniture, hygiene and room space for paramedics and doctors at the SHCs, mini PHCs or Sub Centres is in shambles and needs to be immediately attended. As reported in field survey results above, we often found broken chairs, crooked tables, potholed floors as working space of the medical staff. No provision is found for running a basic kitchen so that the staff can arrange for tea/snacks during their duty hours nor any respectable space is made available where the staff can rest during their night shifts. During the visits, we found staff sleeping on tables and converting their working space into makeshift kitchens. Facilities for patients and their attendants need to be substantially improved.

2.7.6. Clinical services at the sub-block level (mini PHC) means serving a population of 40,000 to 50,000 people in the radius of 10 to 15 Km. For

meeting the human resources needs, lot can be achieved by mere pooling of working hours of human resources from the SHCs of the covering areas. This pooled human resources can also be engaged for evening duties and emergency duties. Working hours of whole clinical team should be pooled at the mini-PHC and should be organized in shifts for 24hrs to run evening OPD. All mini-PHC's, which will now be primary care centre, should have diagnostic facility, X-ray and elementary in-door facilities. In this way, clinical services can be provided at these centres, at ¼ distance from the present distance of specialized secondary services (CHC). Each mini PHCs should be led by a senior administrative official like an SMO.

2.7.7. The block PHC serving a population 1,25,000 to 1,50,000 will now supervise three sub-block primary care centres, where mostly clinical service will be provided, and also serve as FRUs for the primary care centre. The administrative head of block PHC could be a doctor senior to SMO, like Deputy Civil Surgeon. This head of the block PHC should supervise all the three sub-blocks and will also be the head of the FRU but the in-charge for day to day functioning of FRU can be SMO.

2.7.8. FRUs should have a full-fledged diagnostic centre where range of specialties will be made available. Current PHCs and/or CHC's can be converted into FRUs and there is also a need to create additional FRUs. Hence, in present system, CHC, a full-fledged health institution would get a new head with more time for management responsibilities. The FRUs should have extensive residential facilities for doctors and paramedics, developed indoor facilities, adequate supply of medicines, sophisticated emergency care provisions etc. Specialists will be posted at the FRU level. Detailed infrastructure needs of an FRU need to worked out, especially to utilize the services of specialists and also upgrade indoor facilities.

2.7.9. Time bound plan needs to be initiated for creating a functioning infrastructure in the existing institutions that deal with first tier of care. The focus here has to be on regular power supply; functional vehicle; hygiene and cleanliness in and around first tier institution; regular maintenance of buildings and residential quarters and physical access to users and timely and regular availability of providers. A mechanism has to be set in place for regular feedback between those who do maintenance, supply equipment and design infrastructure with the health providers so as to utilise scarce resources in the most essential manner. The process of making request and mechanism of taking decision on issues of maintenance, supply and infrastructure needs to be simplified and made much more effective.

2.7.10. To create norms and facilities at FRU, IPHS code should be followed, doctor availability should be ensured, norms for residences be clearly laid out, clear transfer and posting policy be framed, and diagnostics capacity be strengthened in a major way. Most OPD's should be run by MOs. Specialists can be asked to do half of the MO duties. Emergency duty at the CHC level could be given more to MOs. There is a need to prepare a list

of programs and initiatives in which doctors are sent on duty and ensure that MOs are utilised for most of these assignments.

2.7.11. There is a need to enhance the capacity of health workers. Doctors who hold administrative position need to be trained in management and administrative skills. There ought to be constant in house training programs to train and upgrade the skills of paramedics, nurses and other medical staff. Trauma training and counselling services should be given priority at the moment in the area of training because of high incidence of accidents in the state. The training component should be strengthened in conjunction with the changes proposed by the Task Force in institutional arrangements for medical education.

2.7.12. The third tier of health care is at the level of hospitals and multi-specialty hospitals. At this level, much needs to be done to improve the standards of health care and build corresponding infrastructure. The first challenge here is to have adequate doctors, in particular, specialists. There is acute shortage of specialists in Punjab. The existing model of bringing private doctors on contract is no solution for the woes of the State. Publically-funded medical education is one area that is closely related with this challenge. In the absence of publically-funded medical education, the supply of well trained doctors in the public health system has become very difficult. Inadequate seats in the existing institutions for super-specialty training is an added problem. The current approach of either getting on contract specialists or creating multi-speciality hospitals with private sector will not be able to meet the demand side features of the State's health sector.

2.7.13. To ensure the appropriate list of medicines to be supplied, there are lots of process issues that need to be addressed. What the morbidity patterns suggest is that diseases related with conditions of life and living and conditions of work, are very significant in Punjab. Significantly, disease pattern within the State shows that still a large portion of diseases are communicable in nature. It is erroneous to assume that Punjab has gone through the epidemiological transition and lifestyle diseases are now the cause of worry. While it is true that the burden of life style diseases is increasing, Punjab's major disease burden is still formed by diseases that are dependent very much on basic water and sanitation and directly related with levels of income at the household level. The National Programs to address specific morbidities might not be enough to meet the State-specific needs. The specific disease patterns make a compelling case for programs and strategies which are designed keeping in mind the specific reality. Which disease control programs should be launched by the State need to be identified and details of the program and mechanism to reduce these morbidities need to be worked out.

2.7.14. Evidence suggests that Punjab is one of the worst performing states in India, in terms of availability of essential drugs. The issue is availability of drug, timely availability of drug, availability of drugs that are related with

morbidity patterns of the State and availability that meets the seasonal patterns of morbidities in the State. There is a need to prepare a list of essential drugs, injections and other related consumables that should be available at the Primary Care Level; identify the process through which an institution responsible for primary care can acquire these medicines for its usage from the government agency responsible for purchase of these medicines - this will include identifying the delivery chain, and also mechanism to fix responsibility in case of non-availability of essential medicines; and finally, the mechanism through which the essential list will be regularly updated. The process of updating can include a mechanism for regularly creating benchmark information on patterns of morbidity in the State. For improving supply of appropriate medicines, the Task Force felt the need to study more closely diverse experiences across Indian States and restructure the process of supply of medicines along with allocating additional funds.

2.7.15. Patterns of morbidity, trends in mortality and some of the challenges of life styles in Punjab (drug and alcohol usage) reinforce the understanding that health outcomes are socially determined. The social determinants of health have been completely ignored in Punjab. The usefulness of clean water, the gains from basic sanitation, the significance of safety at work, have all been forgotten in choosing health priorities and making health expenditure in the State. Health is determined not just by medical understanding but other factors have a much greater role. This understanding has to be the foundation for formulating health policy in Punjab.

2.7.16. Implement processes to make access to public health services in Punjab more fair and unrestricted. Two things need to be achieved here - to identify mechanism to improve access of public health services in urban Punjab by the urban poor and reduce the cost of public health in rural areas for the rural poor. If we look at the expenses incurred on hospitalization, a glaring fact is that in rural areas, in comparison to other States, the average health expenditure in Punjab is very high, in both public and private hospitals. In urban areas also, there is a trend towards increasing expenses in public hospitals and in private health care services as compared to other States. A significant fact for rural Punjab is that, as far as poor people are concerned, the expenditure on medical services in absolute terms is extremely high and they spend a very large part of their incomes on health, much more than the national average. The story is not very different in urban areas. In urban areas, the poor and the SC's use public services less, therefore, the burden of health expenditure is very high for them too. This time because of higher use of private sector. Thus, the poor in Punjab, compared to their better off counterparts, are squeezed by both institutions, public hospitals in rural areas and private hospitals in the urban areas.

2.7.17. At the level of organisation of Public Health, Punjab faces a very peculiar situation today. There is compartmentalization of health sector. The administrative structure is complex and unwieldy and there are too many competing and overlapping layers. There is urgent need for realigning. Existing agencies that are in operation are PRI, PHSC, DHS, NRHM, and various special initiatives under national disease control programs. The impression one gets is that their importance and dynamism depends on central funding. The State only follows where the money is available, rather than have their plan of action. Very often, these agencies work at cross purposes, cause confusion amongst employees, leading to absence of control, accountability and a lot of inefficiencies. The inefficiencies need to be addressed at the level of structures. Addressing these inefficiencies is very different from what is currently being remedied through PPP.

2.7.18. Fragmentation of responsibilities across departments and constitutional entities is a major problem that the administrative structure faces. There is a structural mismatch in the institutional arrangement of Central and State Ministries: into departments of Health, Family Welfare and Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy (AYUSH). Such fragmentation makes inter-programme integration problematic, diluting the technical capacity to think holistically and duplicating resource use. For example, the Reproductive and Child Health (RCH) Programme rarely addresses HIV/AIDS, Malaria or Tuberculosis (TB) programmes. Likewise, the Malaria Control Programme has no indicator focusing on pregnant women, or nutritional deficiencies in the child health programmes.

2.7.19. On Medical Education, the State needs to change the thrust of public education in health in Punjab. The strategy of creating medical professionals through private institutions is very flawed. It has resulted in fall in standards and has compromised the quality of health care in the State in a very significant way. There is a need to act both on creating more public institutions and also addressing the content of public education. There is a need to explore strategies to reorient public health curricula and pedagogy, so that students gain a better understanding of the inter-relationship between social determinants and health. This will involve realignment, of course, in social and preventive medicine departments of Medical Colleges. The purpose is to positively influence the culture of medical practice and produce socially sensitive physicians, who focus on applying their understanding of the social context of health and ill health rather than focusing exclusively on behavioural modifications at the individual level.

2.7.20. What emerges from the DLHS Survey is that Punjab is far behind in provisioning and availability of health care at the basic and primary level. The status of available health facilities improves once we move beyond Community Health Centres. However, the perception of users of secondary and tertiary care reflects deep dissatisfaction with the quality of services provided at these institutions. There is also rural urban divide in

Punjab. The provisioning of health care is very inadequate in the rural areas and there is marked improvement at the district level. The implication of this (non) availability of health facilities in Punjab becomes very clear once we associate with it the morbidity patterns and cost of health care in Punjab. The high prevalence of waterborne and communicable diseases, low outcomes for vaccination and other basic women and child health programs and high cost of health care for vast majority of rural and urban poor all seem to be strongly associated with inadequate public expenditure in basic provisioning of water and sanitation facilities and public health programs.

2.7.21. The current focus of health strategy is to cut the cost of supply and address efficiency issues on the supply side. The demand side (meeting people's needs) is hardly taken into consideration. Health has to be treated as an essential service and mere application of commercial principles will not serve much purpose. Policies ought to be carried out with concern for the views of those who are affected and policies that do not put profits for some over the well-being of the majority. If the yesteryear's health policies did not work, even the recent health reforms have not stopped the decline in the quality of health institutions, over burdening of health workers, and building health institutions that lack basic infrastructure like clean toilets. The recent health reforms have generally demeaned the value, spirit and ambition of the public health. An urgent re-thinking is required on this front. There is a need for increased expenditure in creating quality public health institutions that put greater faith in public health delivery.

2.7.22. Furthermore, the approach of policy should be such that there is constant willingness to learn and there should be built-in feedback mechanisms. The stakeholders are never consulted (employees are seen as a problem and not part of a solution); unions are never taken into confidence and the ground realities are often missed in designing policy. The current belief that keeping the government staff under constant threat of suspension or transfer is the only mechanism to ensure their presence is simplistic, outdated and ineffective way of looking at a very complex issue. A special Task Force should be formed to address this. Evaluation has emerged as a special field in the recent years and expertise in this area must be tapped to get systematic evaluation of the government programs.

2.7.23. The picture of drug and alcohol abuse in Punjab is disturbing. There is high incidence of casualties, accidents and social strife from excessive use of alcohol and drug abuse. This brings into the picture the role of ambulance services, emergency care and establishment of a separate initiative for rehabilitation, counselling and social support.

2.7.24. Initiate steps to improve health status of Punjabi society - increased taxation on products (drugs, alcohol) to bring down their consumption, stringent regulation on food to reduce salt, fat intake; ensuring universal immunization; rehabilitation of patients who leave hospitals; availability of

drugs; and availability of nutritional support. Role of livelihoods and markets cannot be ignored by health policy. There is a need to make the market responsive to the needs of public health. Government has to become a key guarantor of affordable health care. The Government must regulate 'out of pocket expenditure' in private health care. It cannot be the sole provider but the Government should guarantee that no one incurred catastrophic 'out of pocket' expense on health. Quality health services at an affordable price should be a basic entitlement of every Punjabi.

2.7.25. There are also major regulation concerns in Punjab. RMPs, Diagnostic Tests, food industry, medical education and private health care are completely unregulated in Punjab. We need to ensure, through regulation, that diagnostic services do not work towards misusing the technology. The State can think of using Punjab's NRI capacity to establish norms on advice of tests, medication etc, rather than to privatize health care through NRI investments.

2.7.26. On the regulation of food, the Central Act may not serve the purpose since it suffers from many lacunae and Punjab needs to create its own legal provisions learning from the short sightedness of the Central Act. The Central Food Safety Bill suffers from fatal provisions regarding governance and administrative design. It is premised on a centralized and a closed structure and is accountable to none. The Bill emphasizes science-based standards, when most international food safety related legislation emphasize the need for health-based standards.

2.7.27. The State Government must take upon itself the task of enacting laws and framing policies to ensure availability and accessibility of safe drinking water, sanitation, conduction of health impact assessment of all development initiatives, tackle life style related diseases like use of tobacco and alcoholism and other substance abuse, and ensure road and transport safety. Large areas for legislation and rules lie unattended for the State of Punjab, such as, rights related with information and medical records, issue of prior voluntary informed consent, confidentiality, information disclosure, privacy and also the rights of health care providers. Sooner they come on the agenda of policy makers, the better it will be.

2.7.28. The mantra of Public Private Partnership is invoked to symbolise better access, efficient financing, fulfilment of the needs of the people, assuring good returns to private capital, and in doing all of this, it is assumed that it will simultaneously contribute to the ongoing dynamics of growth. Is this possible? The experience of privatisation of health sector in Punjab through the formation of Health Corporation has in fact accentuated the opposition towards privatisation. In the absence of competition, when regulation is absent or weak, the pitfalls of privatisation could easily outweigh the inefficiencies of the public sector. It appears that after the wholesome privatisation project failed, the PPP is the next best option of privatisation that is being sold to the people. The key concern with PPP is whether the efficiency gains in a PPP more go to offset the higher private

sector borrowing costs. PPP cannot be viewed as substitute for good governance. Rather, good governance is a pre-requisite for the success of PPPs.

2.7.29. The field visits of the Task Force members and the results of the field survey reported in this paper clearly outline the limitations of many of the recent initiatives like the introduction of user charges - average of Rs 150 per day for indoor and Rs. 100 for outdoor; the challenges and limitation of hiring contractual workers; un-thoughtful application of privatisation principle, for example, anaesthetist or surgeon are being empanelled for government hospitals rather than hiring specialists, private specialists get paid Rs. 1000 per hour sometimes amounting to more than 50 percent salary of a regular doctor but only quarter of availability of a regular doctor; ad hoc norms for staff with no clear terms of reference for the lab technicians; specialists, cleaners, and drivers; absence of resources for maintenance at almost all institutions for - ambulance running, washing, minor repairs, petrol for generators, X ray films, water, sanitation, cleanliness, patient infrastructure and medicines. Medicinal availability at many places was completely at the mercy of the local philanthropists or was managed through user charges.

2.7.30. Finally, the Task Force strongly urges the Government to take leadership of provisioning of health in its own hands and implement the various suggestions made above. It does not see private health insurance or private health care as an option for the vast number of people. In addition, it urges the Government to immediately form the various Task Forces or Working Groups suggested above for a time bound implementation of the recommendations.

Chapter 3
Regulatory and Civic Services
HEALTH DEPARTMENT – DRUG CONTROL, FOOD SAFETY AND INFORMATION SYSTEMS

3.1. Introduction

This report deals with three areas concerning Health Department – drug control, food safety and information systems in the Department. The overarching perspective conform relates to public policy objectives, such as;

- Rational ignorance or disinterest on the part of the public. There is no self-interest or pressure from citizens. It is not worthwhile for individuals to incur the cost of making efforts to achieve the objectives or to prevent others from appropriating public goods.
- Principal agent problem due to perverse incentives from (lack of) enforcement.

The two public services dealt with are of a regulatory nature. There is no direct demand and the traders will be happy to be allowed to sell drugs without license! So far as citizens are concerned, these areas face the free rider problem, leaving it to the Government and the NGOs to implement the regulations for ensuring quality drugs and quality food. The third area taken up is information systems in the Department covering the NRHM, the traditional areas of curative and preventive health and the regulatory services. As mentioned, the information systems are important to enable assessment of performance in effective delivery of services, based on whatever indicators of outcomes etc. are considered suitable.

3.2. Drug Control

The main function of the Drugs Control Department is "to protect and take care of the health of the consumers by exercising strict control and vigilance on the drugs which are being manufactured and marketed in the State so that drugs of standard quality are made available to the ailing humanity" (as reported on the website). Drugs Control Department of the State of Punjab discharges statutory functions involved in the enforcement of the following Drugs and allied Legislations:

- The Drugs and Cosmetics Act, 1940 and Rules made thereunder.
- The Drugs (Price Control) Order 1995.
- The Drugs and Magic Remedies (Objectionable-Advertisement) Act, 1954 and Rules thereunder.
- The Poisons Act, 1919 (Act 12 of 1919).
- The Tobacco & Tobacco Containing Products Act, 2004.

3.2.1. Staff

At the State Headquarters, the State Drugs Controlling Authority is assisted by two Assistant Drug Controllers for the enforcement of Drugs & Cosmetics Act & Rules thereunder and all the above said Act/Rules. There is no post of Drug Controller or of Joint/Deputy Director and one of the three Assistant Directors is notified as Drug Controller. Administrative control remains with the Director Health Services. There is, as probably required, no separate officer incharge of sampling and testing.

Against 19 posts, 16 officials are in position but only 5 of the staff fulfill the conditions. The staff is also inadequate. Hathi Committee recommended one Drug Inspector for 250 shops/25 manufacturing units.

3.2.2. Budget

So far as the budget is concerned apart from the usual problems and availability of funds for routine office expenses – telephones, vehicles etc. and the non-availability even of vehicles and telephones- the main problem is that the budget for payment for samples taken by staff is very inadequate. Exact figures were not available but funds available may not be more than $1/10^{th}$ of the requirements, based on the targets fixed. It is reported that at present, in most of the cases, payments are not being made and only credit notes are issued. An amount of approximately Rs.15-20 lacs annually may be required.

3.2.3. Communication Infrastructure

The Department does not have any dedicated website and the Punjab Government site only contains a brief description of the functioning of the Department. The site carries information only upto the year 2006 and carries a remark that the Health Department is responsible for the information given! The Department has no internet connectivity and is using computers but only for typing letters.

3.2.4. Drug Testing Laboratory

There is one drug lab at Chandigarh which is located in a building having the food and forensic labs also. The post of Drug Analyst is vacant, the space is inadequate and facilities even for some important tests (sterility testing, biological testing) are not available.

3.2.5. Objectives & Activities

As indicated, the Department has been set up for regulation of drugs under the Drug Control Act and Rules. These are very detailed and apparently do not leave many loopholes. The objectives of ensuring quality require specific activities which are also prescribed under statutes. These are (a) licencing/renewal thereof -for manufacturers and for wholesale and retail distributors; (b) approval of drugs to be manufactured, initially or by way of addition subsequently; (c) annual inspection of manufacturer's premises; (d) surprise inspection of

manufacturers and others; (d) taking samples and follow-up. The first two are client-specific whereas, the other activities are needed to ensure public interest objectives.

3.2.6. Main Problems

Discussions with the trade and the Department indicated the main problems to be;

- Lack of transparency in procedures of licencing, check lists and standards of services to be provided to the clients;
- Delay in approval of additional drugs applied for by the manufacturers;
- Lack of basic data in an electronic form with the result that MIS and analysis is difficult;
- Tracking and monitoring the consumption and use of narcotic drugs.

These aspects are being examined below.

(a) Licencing Procedures and Service Standards

Licences are given:

(i) For Sale Premises i.e. wholesale and retail sale etc.

(ii) For Manufacturing Premises:-

- Allopathic manufacturing units
- Homoeopathic manufacturing units
- Cosmetics manufacturing units etc.

The number of licensed establishments both for manufacturing and sales in the State of Punjab from the year 2002-03 to 2004-05 are as under:-

Manufacturing Establishments

Sr. No.	Item	2002-03	2003-04	2004-05
1.	Allopathic Drugs	246	269	289
2.	Cosmetics	70	74	77
	Total	**316**	**343**	**366**

Source: Health Department, Punjab

The following tables indicate the licences issued and action taken for 2002-2005 and 2005-2008.

Sr. No.	Item	2002-03	2003-04	2004-05
1.	Granted	2434	2587	2624
2.	Suspended	122	160	192
3.	Cancelled	152	367	389
	Total	**2708**	**3114**	**3205**

Source: Health Department, Punjab

Sr. No.	Number of licenses	2005	2006	2007	2008
1.	Suspended	263	364	213	294
2.	Cancelled	219	231	199	110
	Total	**482**	**595**	**412**	**404**

Source: Health Department, Punjab

For retail and wholesale licenses, the Department is presently receiving approximately 100 applications/month. The total number of retail and wholesale licences is 28000. An Advisory Committee at the State level has been set-up sometime back. The Department has prepared some guidelines for licencees (Annexure-I) but these are not available to the applicants or on the website.

The Department has recently framed a policy for regulating wholesale and retail licences which is under discussion in connection with a case in the High Court. It is reportedly proposed that retail licences should be according to population of village (one licence for 2500 population, 2 for upto 10000 populations, 3 for PHC villages and 5-10 for a place having a CHC). The objective is to make the issue of licences a more restrictive process. The Department, however, does not even have a complete list of licences in Punjab nor their rural – urban spread and no data is available for analysis/MIS purposes. *Moreover, it is unlikely, considering past experience of the licence permit raj, that such restrictions will enable the Department to have better control; rather, it is only likely to add to the licence premium and rents.*

(b) Facilitation of Licence-related Services

The rules for licencing are restrictive by nature and unlike citizen-centric services, it is not in the interest of the clients but of the public at large which is to be kept in view while carrying out these activities and tasks. This does not, however, mean that the Department and the

officials have no responsibility for facilitating client services and streamlining of the processes. Punjab is somewhat lacking in these areas as would be clear from a comparison of the practices in other States, especially in regard to information given to clients and the public, standards of services in terms of client charters etc. Andhra Pradesh and Kerala, for example, have provided on their websites forms for applications under the Act, checklists for convenience of the applicants and the response time (time frame within which the licence would be renewed or issued). In Punjab, even the basic checklist (Annexure-I) is not openly available.

It may be desirable to provide for the convenience of clients/applicants, different forms and checklists as well as standards of response to application made, on a website of the Department. The forms then can be downloaded and applications made to the designated authority. The website/sub-site should provide for (a) forms/eligibility/checklist; (b) procedures – who is competent, where the application is to be submitted etc.; (c) the standard of services/timelines; (d) complaints recording and redressal system – online/offline as feasible.

Not much work and expense would be required for this purpose and the site can be updated by a Programmer in the Department or by the common information systems cell as proposed later. Depending on resources, information can be transcribed in the booklet form copies of which can be kept also with the Drug Inspectors (this is being done in Delhi). *What is necessary by way of facilitation, even while enforcing the law strictly is: a) providing clear information on procedures/checklists; (b) citizen charters; (c) complaints and redressal systems? A model on the lines of Andhra Pradesh (Annexure-II) may be appropriate.*

(c) Approval of additional drugs

The SDC (State Drug Controller) cannot grant permission to manufacture any new drug which is within the purview of the Drugs Controller General India (DCGI), a list of which is available on the latter's website. If a manufacturer desires to manufacture additional Items, he has to pay a fee per item as defined in the Act. Each item is granted approval by the SDC only if the manufacturer submits labels/packings of similar items manufactured by some other manufacturer, not necessarily of Punjab, which the former has to procure from the market. The SDC checks the labels/packing of the parallel drug submitted, checks if the manufacturer has a valid license and equipment to manufacture it before permission is granted. Industry feels that this process can be streamlined and approvals given within a day or two instead of 15 days or even more as is the case at present. The manufacturer should be able to go online, pay

the fee online and get the permission in a matter of minutes instead of the process being replicated and precious time wasted.

The List of Items approved by the State Drugs Controller can be codified & put on the site. The New Drugs approved by the DCGI can be added to the Codified List when they go out of the mandatory period.

It is recommended that (a) the department should have a ready list of formulations which are under manufacture/approved and preferably put up the list on the web site; (b) any manufacturer wanting approval for an approved formulation should get approval within 3 days; (d) no information that is not required to be given under law should be asked for or it should be codified and made known to manufacturers, on the lines indicated in AP model, to ensure fair treatment of all applicants.

(d) Drug sampling, testing and follow up

In order to check and detect the manufacture and sale of drugs which are not of standard quality/misbranded/adulterated, the drugs Inspectors are required to take samples as per set targets every month. Joint raids are also conducted under the supervision of State Drugs Controller/Assistant Drugs Controller/Senior Drugs Inspectors. The samples are analysed in the State Drugs Laboratory located at Chandigarh under the charge of the Government Analyst who is authorised to do analysis of both biological and non-biological drugs.

The results of samples from the years 2002-03 to 2004-05 and 2005-2008 are given as under:

Item	2002-03	2003-04	2004-05
Number of samples taken	1956	1853	1997
Number of samples found not of standard quality	188	107	128
Number of samples found misbranded	19	31	83
Number of samples found spurious	13	7	7
Number of prosecutions launched	8	34	34

Source- Health Department, Punjab

Item	2005	2006	2007	2008
Number of samples taken	2068	2332	1254	2099
Number of samples found not of standard quality	149	174	54	71
Number of samples found misbranded	121	111	53	20
Number of samples found spurious	9	7	9	2
Number of prosecutions launched	54	57	71	62

Source: Health Department, Punjab

Information about the latest figures is available at Annexure-III.

(e) Major Sampling Issues

Each field official is required to take about 30-50 samples per year depending upon the jurisdiction. Generally, the issue of licencees from whom drug samples are to be taken, is left to the discretion of field officers and no guidelines or operational parameters are worked out, keeping in view the distinctive purpose, nature and objectives of the process or even of the critical problem areas which sampling should address. Moreover, there are no clear procedures for routine and for intelligence-based inspections & sampling.

It is generally agreed that unlike food items where adulterated food is more common than misbranding etc., in the case of drugs, the quantum of spurious drugs is negligible. Generally, spurious drugs tend to come into the market to substitute for expensive drugs and, thus, may be limited to expensive brands. Moreover, manufactures owning the genuine brands are quite alert in this regard. Over charging is reportedly not an issue now. Discussions indicate that the main issues to be kept in view for the sampling process are; (a) misuse of drugs covered under the NDPS Act; (b) sale of scheduled drugs without prescription; (c) sale of expired drugs. There may be certain other areas. *The guidelines to be developed should focus on these aspects rather than leave it to the absolute discretion of the staff to carry out inspections and take samples. Of course, once the guidelines are finalized in consultation with the staff and the trade as indicated later, autonomy must be given to the staff to take samples.*

(f) Proposals for Inspection and Sampling Systems

(i) Intelligence-based Inspections/Sampling

One important issue is the need to structure the processes for sampling based on intelligence/information as distinct from routine sampling. Generally, spurious drugs are short gestation items- either 'off the books' transactions or in case of traded drugs, unloaded and disposed of quickly and with short expiry dates (spurious drugs would not be allowed to mature in casks like Scotch!) and, therefore, it is very difficult to detect them through random sampling. *Spurious drug control strategy needs to be primarily driven by information and intelligence.*

Field staff needs to be given autonomy as is the case at present but even without the need for prior permission from seniors. The drill should provide that they inform the headquarters in advance regarding locality/place they intend to raid/visit for this purpose, without necessarily indicating the details of specific premises. This information can then be linked with their subsequent report. *This structure of autonomy in intelligence-based surprise inspections will probably take care of the agency problems, whether on the part of the field staff or of the seniors.*

(ii) Routine Inspection/Sampling

Routine sampling, if it is to be useful, needs to be on random basis and not based on personal bias or information. Considering the agency problems (clientelism, monetary incentives, favouritism), a judicious mix of autonomy and control is required to be worked out for guidance of the field staff. The drug manufacturers are aggrieved that the staff tends to take a disproportionate number of samples from manufacturers in Punjab, e.g. if percentage of consumption of State-manufactured drugs is 10%, their proportion in respect of samples may be 50%! Similarly, there are no guidelines regarding proportion of samples from rural and urban areas or types of drugs of which samples may be taken on priority.

Taking note of the various views, it is felt that random sampling guidelines should provide for sample selection to be based on (a) share of State and out of State manufacturers in consumption; (b) the share of different category of drugs in consumption; (c) share of consumption in urban and rural areas; (d) control monitoring of other aspects such as misbranded (or other categories of) drugs as defined under law as may be considered important by the Department. One important area in Punjab is abuse of NDPS drugs and this needs to be the main focus of the inspection of the sale licencee premises.

It may also be desirable to make the process of random sampling a team-based process by suitably coordinating timetable of the field staff every month/quarter. One week in a month could be earmarked for team-oriented inspections. This may lead to more objective and productive results as compared to the jurisdiction-based sampling by the officials.

(iii) Annual Inspection of Manufacturer's Premises

All manufacturing premises are required to be inspected annually. There are, however, no guidelines or protocols in the Department to ensure that the focus of the inspection is not dissipated by undue attention to trivial details in preference to substantive provisions of the law. Similarly, in regard to surprise inspections, which may or not lead to samples being taken, the Department has not issued any guidelines regarding the major problems and violations to be kept in view, which of course, may change from time to time.

(iv) Abuse of Narcotic Drugs

A number of drugs covered under the Narcotic Drugs and Psychotropic Substances Act are grouped under schedule H of the Drugs Act. Abuse of these pharmaceutical drugs has become common in certain parts of the country. The lack of proper procedures in the treatment of drug abuse has created a situation where the addicts buy prescription drugs over the counter for self-medication without proper guidance. Abuse of pharmaceutical drugs is more common than the use of substances such as heroin and cannabis products, chiefly because pharmaceutical drugs can be purchased from legitimate sources and are relatively inexpensive. One study estimates that over 31% of the regular drug users in Punjab are dependent on pharma drugs. The problem of misuse is also likely to become worse as the elite illegal drugs are generally expensive and becoming more and more difficult to procure for obvious reasons.

The law provides for various controls through processes of medical prescription and detailed record keeping. The Drug Control Organisation has issued instructions to the Drug Inspectors to make surprise checks/raids, especially, in order to detect the abuse of intoxicating drugs in the State. For this purpose, Joint raiding parties each consisting of three Drug Inspectors, have been formed which inspect jointly under the supervision of the team leaders. At least four joint raids are to be conducted every month. The State Drugs Controller/Assistant Drugs Controllers also lead joint raiding parties. The Department also proposes to restrict issue of new licences to exclude drugs under the NDPS Act

(Codeine, Proxyvon, Lamotil, Buprenorphine, etc.). This, they feel, will help control supply and availability of these drugs. Old licencees are not subject to the new policy. For reasons indicated in connection with the proposals to restrict the issue of licences, this is not likely to work.

It is generally agreed by the Department and the trade that these controls are not effective due to various reasons:

- Requirements regarding medical prescription and maintenance of records are bypassed as a substantial percentage of the trade in these pharma drugs is off the record and such drugs may be supplied through informal trade channels to the ultimate consumers. In the case of some of the drugs, it is estimated that off the book volumes may be equal to or more than the drugs accounted for;
- Medical prescription for drugs may also not be a difficult condition to satisfy. Some professionals feel that they may only raise the costs of compliance without controlling supply in view of the demand for these drugs;
- The procedures for control as in force or proposed are based on assumptions and guesswork in regard to their effectiveness. No worthwhile data is available with the drug authorities or the Narcotics Bureau regarding the flow of these drugs in the trade, the quantum of drugs received from various sources outside and inside the State or even the total consumption of different categories of these drugs in the State. There is little coordination in this regard between the State drug authorities and the National Narcotics Bureau.
- There is no owner responsible for monitoring and control in the case of NDPS drugs. Unlike illegal drugs and substances, where police is the authority concerned, in case of pharma drugs, responsibility is divided among the State authorities and the officials and the Narcotics Control Bureau. The latter is apparently more concerned about the hardcore illegal drugs and substances (synthetics, opium and its derivatives etc.). The State drug departments, on the other hand, are barely able to manage the rudiments of enforcement, given the staff position and resources available to them.
- Till recently, Drug Controllers used to get information on manufacture of these drugs and supply it to the Bureau, but now, all the data is supplied directly to the Bureau at its Gwalior office by the manufacturers. The States are not informed about drugs manufactured, imported in the State and, consequently, they cannot track their trade &

movement. It is to be noted that these drugs are manufactured under licence with raw material quota etc. being given by the Central Government. Unlike the illegal drug trade, therefore, where trade and consumption are at best informed estimates, monitoring and tracking is possible in case of pharma drugs, but only if basic data is made available to the State authorities concerned with the control over consumption and prevention of misuse i.e. State drug departments.

(v) Recommendations for Control of Abuse of NDPS Drugs

It would appear that the prerequisite for an effective strategy to control use of NDPS pharma drugs is to ensure acquisition and management of the relevant data. There is need to:

- If possible, sub-classify these pharma drugs – opium based/depressants etc.;
- Compile State-level data regarding manufacture and trade of these drugs manufactured under license- the Bureau/Central Government provides the quota for manufacture of drugs & can provide the same to the State;
- Narcotics Bureau to make available/Punjab SDC to get information from the Bureau, regarding quantities received in the State whether from out of State manufacturers or distributors or within the State manufacturers of these drugs;
- The State Government to maintain data about & monitor total stock available for consumption, and subsequent sales/consumption within the State. If necessary, secondary sales from one State to another could be similarly monitored to enable clear acquisition of data and to avoid situations experienced in case of VAT transactions where such a large number of transactions are undertaken for a particular commodity – from trader A to B to C back to B to D etc. It is impossible to keep proper track.
- The SDC Punjab can prescribe for this purpose periodical returns to be filed by the distributors in the State indicating sales to wholesalers and, similarly, for sale from the wholesalers to the retailers. This system will enable SDC to keep track of traded drugs, to analyse data about consumption and devise control strategies based on pattern of use and consumption of these drugs through both regulatory {controlling supply) and promotional (managing demand) means.
- Similarly, the retailers may be required to maintain a separate monthly abstract of total sales etc. along with the

detailed prescription records as already provided under law for easy access and inspection of the records and cross-checking of the transactions.

- Apart from these measures which would empower the State authorities through information (an example of the need, not generally appreciated, to empower officials and not only the public), the SDC needs to give priority while making random inspections to the misuse of NDPS drugs as indicated above.
- It may be difficult to restrict the issue of licences under law and/or hope that simply restricting the number of licences will result in the prevention of abuse, unless measures specified above are taken. One additional step can be that the application form for a licence should provide in the checklist a specific clause about the stringent record keeping requirements for NDPS drugs and a specific undertaking by the applicant to meet those requirements.
- Licencees may also be asked to prominently display a resolution (to be passed) by the Associations not to permit or indulge in misuse of these drugs and to maintain proper and accurate records.
- Demand management measures through media regarding the problems caused by these drugs need to be taken up on an aggressive footing, in addition to the control and management of the supplies.

3.2.7. Grievance & Complaint Systems

The Department does not have any system of receiving problems and grievances or for obtaining intelligence relevant for their functioning – whether telephonically or on the net and is not equipped to deal properly with its clients and fulfill the objectives for which it is set up. It is in the Department's interest to set up a proper system for getting intelligence feedback from the public and clients. Today, let alone a system of rewarding informers, there is not even a nodal official or contact point in the Department for this purpose.

The Department needs to have a web site with online complaint/information system, supplemented by telephonic/IVRS facilities. Till such a system is in place, possibly the District Suwidha Centres (SCs) can be the nodal points for information/grievances which can be transmitted to the SDC for further action. It has already been suggested in the 2nd Report of the PGRC that district SCs should function as residual complaint centres for all Departments and this is especially necessary for the drug organization.

There is need to encourage whistle-blowers through appropriate rewards systems and, in any case, by providing easy internet and telephonic

access. The solution suggested would be helpful for this purpose till internal resources are strengthened for independent feedback.

3.2.8. Information and Communication

One of the major areas of weaknesses is the pitiable dependence of the Department on the traditional modes of interaction, information and communication. In fact, even the somewhat outdated telephonic communication facility is not available with the drug control unit. It is dependent on PBX and the drug inspectors do not have any direct connectivity. Instead of seeking to make up this shortfall through additional telephonic facilities, as proposed by the SDC, it may be appropriate to leapfrog to internet communication for voice as well as for data.

There are two options. One is to use the District Data Centres and the State Data Centre established by the E-governance department. Data Centres are functional at all the district headquarters. The State Data Centre can provide connectivity to the Health Department in respect of all the units, including drug control. The Department has to make some payment only for one-time connectivity. This had also been mentioned in detail in the Second Report of the PGRC. Drug Inspectors can be provided interest-free loans for laptops/notebooks etc. making it unnecessary to have a separate data and information communication infrastructure for their needs.

The second option is for the drug control unit to be allowed to make use of extensive computing facilities already available under the rural health programme in the Civil Surgeon's office at the district level and the statistical cell at the State level. All data relating to NRHM is already online. The only action required is to declare these units as Information and Communication Centres responsible for servicing all wings of the Department including drug control, food safety etc.

In any case, it is essential that the Department gets connectivity through the state PAWAN network to take care of the problems of data storage and security as well as seamless communication. At present, the districts are adopting various modes – BSNL, RELIANCE etc. for this purpose. This will eliminate the problems of erratic and unreliable information flow, security and storage capacity as the Department is not equipped at present in this regard.

(a) Information - A Tool For Enforcement

One powerful weapon in the strategy for enforcement is the use of information for controlling violations. The US Government regulations provided that the companies emitting hazardous substances should simply display on the Department website the quantity of pollutants emitted. Simple display of information on pollution by different industries and companies itself had a salutary effect in reducing emissions without any penalty etc. having to be imposed. A similar

strategy may be appropriate - to put on the web, a list of the licencees from whose premises, samples are taken and to place the results and action taken on the website. For encouraging information & intelligence, the Department may consider some incentives and encourage whistleblowers and, in any case, start a helpline/IVRS system for information, complaints etc.

(b) Performance Measurement and Assessment

This appeared to be a major problem. As indicated in the Second Report of the PGRC, very few departments have satisfactory systems for measurement or assessment of the results and performance of the Department. Similar problems exist in the case of Drug Control Department. Generally, officials agree that it is difficult to assess the outcome of the efforts made – through sampling, prosecutions etc., in terms of quality of drugs over a short time. It was, however, felt that a somewhat relativistic measure of performance could be the rate of failure of the samples in case of different districts/State. Comparative assessment of the districts can be made annually for the change monitored over time. Where necessary, the failure rate for specific areas of concern (e.g. spurious drug samples) could be analyzed.

(c) Infrastructure

There are critical gaps in staffing and equipment in the drug laboratory and at the State headquarters. The posts of SDC and Deputy/Joint director responsible for sampling and testing need to be created and the post of Drug Analyst filled up. Government also needs to assess requirements for additional equipment for the drug laboratory and provide the same. It may be considered whether a PPP (Public Private Partnership) model can be adopted – a private party to be selected through competitive process to take on the job with payment being made on the basis of agreed norms. Of course, the existing infrastructure and staff will need to be put at their disposal.

3.2.9. Main Recommendations – Drug Control

3.2.9.1. Licensing and Related Activities

(a) Information and facilitation

(i) Develop immediately a separate website/sub-website/dedicated pages linked to State Government/Health Department site for the drug control unit.

(ii) Provide

- Display of rules, checklists, forms on the drug controller website.
- Facility for downloading the forms.

- Client charter/standards of response, timelines and clear access systems.

(iii) Maintaining electronic data base of all the licensees in a form convenient for MIS/analysis. This can easily be done by outsourcing, if required, and updating done periodically. In due course, in-house systems could be developed for online receipt and handling of the licence applications.

(b) Approval of additional drugs

(i) Display all drugs already approved for manufacture on the State Drug Department website along with checklist for new additions and service standards. Online acceptance of the applications could follow in due course.

(ii) Timeline of 3-7 days for drugs under manufacture.

(c) Inspection and sampling

(i) Guidelines to be issued for inspection and sampling:

- Separating intelligence-based and routine inspections – the latter should be on a purely random basis.
- Based on ABC analysis, develop guidelines for inspection and random sampling of the manufacturers/other licencees and review annually in consultation with the State Advisory Committee.
- **Intelligence-based inspection and sampling:** should be restricted to mostly spurious drugs and to be left to the local initiative.
- **Team-based sampling and inspection system**: for routine random inspections and sampling.

Contents of Suggested Guidelines

Random sampling:

(i) Should broadly be in the ratio of:

- consumption of drugs in Punjab of State and out of State manufactured drugs;
- consumption in rural and urban areas.

(ii) Priority to sampling of expensive drugs which provide much higher incentives for violation (these can be suitably classified).

(iii) Define percentage of sampling for misbranded drugs/other categories (in case felt necessary).

Feedback on and Review of Guidelines

(i) Get operational feedback by setting up district level committees to be convened by the drug inspectors. Nominees of the state level associations apart from NGOs could be members of the district committees.

(ii) Feedback from the State Level Committee for annual review.

(d) Information and Data Systems

(i) The District and State Health Statistical Units should be reorganized to function as information systems division of the Health Department including drug control wing.

(ii) The Department should make use of the District Data Centres and the State Data Centre facility for connectivity, storage and security of data and even for multimodal communication (video conference etc.).

(iii) Drug Control and similar units should be allowed and encouraged to make use of the district and state information systems/units of the Health Department for this purpose.

(iv) Laptops/notebooks should be provided to the drug inspectors through interest-free loans.

(e) Enforcement – Using Information as a Tool

(i) Place on the website, a list of the licencees from whose premises samples are taken, along with the results and action taken.

(f) Control of NDPS Drug Abuse

(i) Maintain data for different classes of drugs manufactured/imported in the State and available for trade/consumption in the state.

(ii) Track the sale, trade and consumption by:

- prescribing **monthly returns** to be filed with the Department by the distributors/wholesellers regarding; (a) receipt of NDPS drugs; (b) sale within the State, with details of the licencees to whom sold;
- requiring retailers to maintain a monthly abstract of NDPS drugs/received/sold/in stock, in addition to the records already provided under law.

(iii) Compile the data, analyse and incorporate **findings in** the annual guidelines for the Drug Inspectors for inspection of the licensee premises.

(iv) Based on this analysis, prepare strategy for demand management.

(g) Resources

(i) Two posts of SDC/Joint Controller testing to be created and post of drug analyst to be filled up.

(ii) Adequate budget for payment for the sample costs.

(iii) Adopting PPP model for providing lab testing services.

(h) Performance Assessment/Indicators

(i) Rate of failure of samples – overall/specific issues of concern such as spurious drugs.

(ii) Maintenance of data on narcotic drugs – consumption/sale.

(iii) Annual inter-district comparison.

(iv) Ratings to be given (above average, average, below average).

(v) Annual change in the failure rate – for the State and the Districts.

3.3. Food Safety

The Food Adulteration Act, 1954, amended a number of times, provides for the licensing of establishments etc. A comprehensive food safety act enacted in 2006 seeks to empower consumers and society and proposes innovative arbitration mechanisms, but is yet to come into force. In the State of Punjab, the programme is implemented under the supervision of Director, Health and Family Welfare, Punjab, who stands notified as State Food (Health) Authority. At district level, all the Civil Surgeons have been notified as Local (Health) Authorities and are responsible for the implementation of Prevention of Food Adulteration Act in their respective districts. In the field, Prevention of Food Adulteration Programme is executed by Food Inspectors under the supervision of respective local (Health) Authorities. Following Table indicates the performance of the Department under the Prevention of Food Adulteration Act.

Punjab – Sampling and Follow-up

Year	2005	2006	2007	2008
Number of sample seized	**4291**	**3075**	**2377**	**3520**
Number of samples found adulterated	**440**	**282**	**413**	**611**
Number of prosecutions launched	**218**	**41**	**255**	**-**
Number of cases decided by the Courts	**17**	**12**	**116**	**-**
Number of cases resulting in conviction	**-**	**-**	**47**	**12**

Source: Health Department, Punjab

Information for the year 2010 is at Annexure-IV.

3.3.1. Problems and Constraints

Government of India has generally been concerned with problems of; (a) shortage of staff; (b) deficiency in testing laboratories especially trained

manpower, testing facilities and equipment, budget and reference standard materials. Punjab Government has 23 posts of Food Inspectors. For the laboratory, 31 posts are sanctioned and the staff is in position. Not much problem is reported in regard to the infrastructure though the functioning of the food laboratory can be improved through provision of facilities for testing of the pesticide residue in the food items.

It appeared that the main problems faced are:

- duplication/confusion in respect of the jurisdiction of the civil surgeons and the municipal committees in regard to the licencing and jurisdiction;
- lack of clarity regarding the role of professionals- Food Inspectors- and Medical Officers;
- availability of adequate budget for payment for the cost of samples and incidental expenses;
- lack of interaction with the clients;
- performance assessment.

The structure and regulatory perspective of this unit is similar to that of the Drug Control Unit, the analysis and logic of the approach is on similar lines and, accordingly, the following gives a brief account of the major problem areas, and how these may be addressed. Section-I can be referred where necessary.

(a) Licences

Situation in this regard is in a flux. Earlier, the local bodies used to be the licensing authorities, but in 2004, the Health Department functionaries were declared to be the exclusive authorities for this purpose. The matter, however, has been pending for various reasons and the position at present is that the local bodies and the local health authorities are having parallel jurisdiction. Comprehensive data on the number and nature of licences is not available and there is no interaction with the trade except through the enforcement route of raids, sampling and follow-up. A large number of food manufacturers are not even licensed. The Departmental estimate is that only 1% are licenced. Many are registered under different regulations such as the FPO. The food safety unit does not even have a data base. It is understood that the enforcement of the new Act is likely to become with effective soon and the clients would have to take a licence only under the new Act. There is need, however, for the wing to prepare for this change, and to define ownership at various levels for establishing interaction with and feedback from the food trade, apart from providing facilitation services to the clients.

(b) Control of Food Adulteration – Inspection/Sampling

69 Medical Officers have already been notified as Food Inspectors to add to manpower. Instructions have been given regarding sampling (ratio of packaged articles and loose sales and focus on milk and milk products for which a minimum percentage is prescribed). The main problems reported are non availability of budget for payment for samples and miscellaneous expenses involved (sealing the samples etc.) and, surprisingly, *divesting the Food Inspectors of powers to inspect and take samples- they need the prior permission of the district medical officers!* The monitoring systems are, however, in place and district-wise performance is monitored- the samples taken, percentage of failure for the State and the districts in respect of specified categories. The problem of budget is acute and a minimum of Rs.50 to 60 lakhs per year is required for this purpose.

It appeared that there are certain areas of concern apart from milk and milk products- polished pulses, use of prohibited colours for sweets, spurious cold drinks etc. which may also need attention. One issue is that the sanitation at the licencee premises is not within the purview of the functionaries even though at the State level, Health Department is also responsible for public health- hygienic conditions for preparation, proper storage, proper disposal of waste etc. At present, these issues are dealt with under the Epidemics Control Act through annual notifications issued in the summer months but, possibly, these conditions need to be integrated into the licensing conditions of food safety. One problem is that while the district-level data is monitored, no indicators of performance have been developed for this purpose.

3.3.2. Main Recommendations – Food Safety

The following recommendations are made:

3.3.2.1. Licences

(a) The process needs to be streamlined as per law and confusion regarding jurisdiction should be removed – (Civil Surgeons vs local Municipal Committees) immediately and implementation ensured of whatever decision is taken.

(b) A sub-site/website to be developed for food safety giving procedures for issue of licences, the application forms, fees and service standards etc. on the lines suggested for the Drug Control Wing.

(c) Promotional publicity and interaction with the trade highlighting the legal obligations of the dealers to get a licence and penalties for violation to ensure 100% coverage of food trade as per law.

(d) Digitizing the licencee records, if necessary, by outsourcing and updating periodically. **Make a start by borrowing the client data base from the Sales Tax Department**

3.3.2.2. Inspection & Sampling

(a) Guidelines to be issued for inspection and sampling.

(b) Separating intelligence-based and routine inspection – the latter should be on a purely random basis.

(c) Based on ABC analysis, develop guidelines for inspection and random sampling of manufacturers/other licencees and review periodically in consultation with the State Advisory Committee.

(d) Focus on manufacturers and wholesalers rather than retailers (the share of the latter is reportedly 60% at present).

(e) **Intelligence-based inspection and sampling:** Mostly for adulterated food to be left to the local initiative.

(f) **Team-based sampling and inspection system**: For routine random inspections and sampling.

3.3.2.3. Contents and Review of Guidelines

(a) The Department should issue annual guidelines after discussion with the field officers and a State Level Advisory Committee (to be set up) regarding inspection and sampling of food items on the lines being done already.

(b) The focus at present could be on; (a) milk and milk products; (b) use of toxic colours for food items especially sweets; (c) cold drinks; (d) pulses and (e) loose sale of spices etc.

(c) District Level Advisory Committees should be set up and their feedback should be taken note of while issuing/renewing annual guidelines.

3.3.2.4. Integration of Public Health and Sanitation Functions

(a) Sanitation- hygiene and public health at the licencee premises - should also be the responsibility of the Food Inspectors and they need to be empowered under the appropriate law, till the time Food Safety Act comes into force.

(b) Licensing should incorporate conditions regarding licencee' liability for food hygiene at the premises, especially regarding storage and disposal of waste.

3.3.2.5. Enforcement Staff

(a) Single-line professional authority and control, at all levels, without waiting for the new Act to be enforced- for the present, senior staff can be given district in-charge duties in addition to their field duties.

3.3.2.6. Information and Data Systems

(a) District and State Health Statistical units should be reorganized to function as Information Systems Division of the Health Department.

(b) The Department should make use of the district data centres and the State Data Centre facility for connectivity, storage and security of data and even for multimodal communication (video conference etc.).

(c) Food safety and similar units should be allowed and encouraged to make use of the District and State Information Systems units for this purpose.

(d) Laptops should be provided to the Food Inspectors through interest-free loans.

(e) Online/IVRS/ SMS systems to encourage whistleblowers and flow of information with some built-in reward systems.

3.3.2.7. Enforcement Through Information

(a) Place on the web, a list of food licencees from whose premises samples are taken, along with the results and action taken.

3.3.2.8. Assessment of Performance

(a) Rate of failure of samples – overall and for vital areas such as toxic colors, milk products etc.

(b) Annual comparison (inter-district).

(c) Ratings to be given (above average, average, below average).

(d) Annual change in the failure rate – for the State and the Districts.

3.4. Data and Information Systems

This section deals with issues of information systems in the Health Department. Section I has referred in detail to the need to restructure the system in regard to connectivity and service universality for all wings of the department, including drug control and this aspect is not being discussed again in detail though covered in the summary recommendations.

3.4.1. Staffing & Infrastructure

The Department has traditionally been giving focus on data and information systems for assessing efficacy of various programmes. The focus earlier was on information regarding communicable diseases. It is

now on family planning and MCH issues. It is probably the only Department to have 'computers' (a term used earlier) or statistical assistants at the sub-district level for the last over 50 years. At present, the Department has a statistical cell at the headquarters and similar units in the districts and the PHCs. Generally, adequate staff and equipment has been provided. The data has become more and more extensive, the latest addition being under the NRHM programme which has added over 200 'bytes' of information to the over 300 items for which the field institutions used to send information compiled at the district and State levels.

3.4.2. Data & Information Modules

The statistical cell compiles information regarding:

- NRHM – in the proforma prescribed by the Government of India.
- Communicable diseases- in the proforma prescribed by the Government of India.
- Non-communicable diseases- in the proforma prescribed by the Government of India.
- Morbidity and Mortality – covering a large category of diseases – proforma by the State Government.
- Birth and death registration statistics.
- Miscellaneous – disability certificates issued.

Major wings such as drugs and food safety are not covered as also specific programmes such as TB, Leprosy etc. which may be compiling information separately from the districts.

Detailed recommendations have been given in the 2nd report of PGRC in regard to simplification of the system of registration of births and related information. Data regarding deaths is equally important and needs attention especially as it is a 'public good' and is not demand-driven (except where a death certificate is required for inheritance of property etc.) unlike birth certificates.

3.4.3. Problems & Constraints

There are some problems with the current systems. One is structural and organizational. The units, having been funded mostly by the Centre, tend to concentrate on the priorities of and prescriptions by the Central Government, and are not orientated to organize data as per the needs of the State Government. For example, adverse sex ratio is a problem for Punjab but does not get any priority. It is understood that based on birth data, sex ratio is being computed (at birth) but only at the State level and not for the districts.

The second problem is the quality of data and its use for assessment of the performance and monitoring. There is no analytical interpretation of data except for the State as a whole, partly for the reason that the Central

Government is interested only in the State-wise picture. There is little attention to the quality of data as indicated below.

The third issue is that the information systems are focused on core services – MCH, primary health care and exclude major wings of the department such as drug control, food safety etc. which remain 'poor cousins' of the NRHM.

Four, most of the factual data is not reliable as it is not even available with the reporting units; the proforma on mortality/morbidity requires details regarding patients which most of the rural institutions are not equipped to provide. For example, eight sub-categories of intestinal diseases – (cholera, typhoid, food poisoning etc.) are required to be listed separately. The institutions may not have the investigative and diagnostic facilities for providing information in such detail. In regard to the deliveries at home, (an item in the NRHM Proforma) – information regarding untrained, skilled birth attendant etc. is mostly not available and the figures tend to be fudged/invented and for no purpose, as the main issue is institutional versus home delivery.

Five, information is duplicated mainly due to incremental instructions piled on top of the past practices without any attempt at integration. The same information may be covered in more than one proforma. For example, the monthly report on communicable diseases requires information which may also be covered in the mortality report. Similar is the case with monthly report on non-communicable diseases.

Six, the information collected is too voluminous and adhoc to be capable of yielding meaningful data for assessing performance and results. The information is in terms of absolute numbers without any reference to the past performance or other benchmarks.

Seven, the proforma on hospitals is for performance indicators but containing - as it does descriptive data - number of surgeries, number of indoor patients etc. - can hardly be used for this purpose. Similarly, information on the number of children immunised in a particular age group is without any scale or point of reference – physical or temporal – and may not be relevant to the performance.

Eight, data base is not specified- information only for the public facilities in some cases and public and private in others (this has been rectified recently).

3.4.4. Registration of Births and Related Data

This is an important area but tends to be neglected for reasons mentioned. Form-2 of the relevant rules has a detailed format for information regarding deaths, especially, cause of death and specific information related to infant and maternal mortality etc. The abstract of

the data is required to be maintained at the village level. It also provides for information regarding cause of death to be given but this is not properly structured.

The problems are that unlike births, death reporting is not universal, especially, in the case of infant deaths. Second, the information regarding the cause of death is not properly coded/classified and, thus, is not useable for analysis. The result is a pitiable dependence of the health authorities on scattered information gathered through periodical SRS and other surveys even for these vital statistics and indicators.

3.4.5. Recommendations

It would be obvious that the data and information in the present form, whatever its possible use by the Central Government, is not of much help to the State Government. The resources of staff and time are mostly exhausted in complying with the deadlines and the Government is not able to make use of data for State purposes. It is proposed that the following steps should be taken in this regard.

(a) Focus on Material Indicators:

The information needs to be structured and limited to major areas of concern (infant mortality, immunisation, MMR, sex ratio, major diseases) which need to be monitored. Information should be available in a form indicative of reporting unit's performance. Even where information required by the Government of India has to be provided, the State Government needs to prescribe for its own assessment similar indicators relevant for assessing results and performance. The Expenditure Reforms Commission, Punjab 2002, had suggested some indicators, though under a PPP model of management of the health institutions - local bodies for rural areas and agency contracts/autonomous committees for urban areas. Some of them, however, need to be redefined for relevance and others (eg ratio of own resources to total expenditure) are not relevant in the present context. The main point is that the indicators need not necessarily be linked to the management change and can be relevant even for the present system. Care has been taken to see that information is easy to collect, compile and assess.

(b) Re-organising Data Formats

The proforma on communicable and non-communicable diseases may need to be discontinued as private sector data is essential for a comprehensive picture. In case this is not possible (as it may be required by the Government of India), duplication with mortality/morbidity proforma should be avoided and information for the morbidity proforma can be limited to the items not covered in the two proformas. Moreover, the morbidity/mortality proforma can be

drastically changed to avoid duplication and be confined to data which may be relevant, considering the use thereof. *There is no point in having information on bone injuries and mental diseases when private sector data is not being taken into account.* In patient - outpatient figures and deaths need not be compiled, as for most of the specific diseases, they are not amenable to any worthwhile analysis. Instead, the total number of patients for major diseases and annual changes (in percentage) may need to be monitored.

(c) Mortality Proforma

This needs to be modified to exclude diseases covered under the monthly report on institutional cases and deaths due to communicable diseases as also non-communicable diseases. The first two already provide information in respect of items like Cholera, Tetanus, Rabies, Syphilis etc. Similarly, non-communicable diseases proforma provides information regarding OPD and IPD cases and deaths due to cardiovascular diseases, neurological disorders, lungs diseases etc. *Considering all aspects, it appears that the morbidity and mortality report should: (a) exclude the items covered under other proformas; (b) exclude various diseases (malignancy, skin, fractures, poisoning etc.) for which a comprehensive picture including cases handled in the private sector is required for worthwhile analysis.* If this is done, only a few items would be left out -e.g. TB, Malnutrition, Leprosy. *It is felt that the proforma could be discontinued as information on TB, Leprosy is being obtained separately under specific programmes.*

(d) Hospitals' Performance Indicators

Performance indicators listed in the Hospital proforma are not relevant for performance. For example, change in the number of deaths may be due to reasons not connected to performance. This needs to be modified to focus on the result indicators.

(e) Re-organisation of Data on Deaths

As indicated above, the morbidity proformas are not of much use, containing as they do, information only on deaths in the public institutions. This data needs to be re-organised on the basis of information gathered through the death registration systems for compiling authentic information regarding morbidity and deaths. Considering the problems mentioned, two sets of interventions would be necessary. One is to ensure that recording is as nearly universal as possible. In case of births, the reporting is almost 100% whereas, in case of deaths, especially in case of infants, the reporting is negligible. Families may not report infant deaths as there are no legal issues involved warranting issue of death certificate. *It has separately been agreed by the State Government that ASHA needs to be given the responsibility for 'notifying' all births and deaths in the area and, once*

it is done, there should be no problem in ensuring almost 100% recording of deaths specially in case of infants, as the information about the core clientele of mothers and infants is very much within the knowledge of ASHA workers.

The second intervention is to have an easily understandable classification of the causes of death to be recorded in the register. The broad categories are natural causes, suicides, accidents and, in case of natural causes, there should be classification of morbidity due to particular diseases. The list needs to be confined to diseases which are a cause of worry in the context of Punjab (e.g. cancer, waterborne diseases) and could be modified from time to time. At present, *the classification of causes of death could be: (i) accidents/crime; (ii) suicides; (iii) death due to specified diseases namely (a) cancer; (b) waterborne diseases; (c) chest infections; (d) diseases other than those listed at (a), (b), (c).* Thus, the total number of classifications will be six. In any case, the list should not exceed ten, so as to be manageable in the field conditions.

The advantage of this approach is that the State Government will have ready information on major parameters for MMR, Infant Mortality, deaths due to diseases which need to be monitored and policy interventions can be devised accordingly without having to depend on periodical surveys which may not be very reliable for this purpose. This information once available in the village abstract as prescribed under rules can be used for getting locational/district/regional picture in regard to IMR, MMR, deaths due to various diseases (e.g. cancer which is believed to be responsible for excessive morbidity in the Malwa region but critical data and relevant incidence is not available).

The data is already being digitized and once this process is complete, micro and macro level status in respect of major indicators (IMR, MMR, morbidity due to particular diseases) can be calculated and situational and local context specific interventions designed.

(f) Unit of MIS Analysis

As most of the field institutions (PHC's) may not be in a position to present information in the form required for assessing results and performance, this exercise can be done at the district level which, in case of Health Department, appears to be appropriate unit for performance assessment.

(g) Organising Data for MIS

The districts need to be provided information to enable them to appreciate the significance of their performance. *For example, information on child population of a particular age group can be derived from Census figures and may be supplied to the districts for assessing percentage of children immunized within a particular age group* and provide the same to the Health Department. In other cases, where districts have the relevant information (number of male and female infants born), the districts must provide the data (sex ratio at birth) to the Government in an easily comparable format.

(h) Comparative Assessment

It is necessary to rank the districts annually on the basis of 'traffic light' system - above average, below average, average.

The main recommendations are indicated below:

3.4.6. Main Recommendations - Data and Information Systems

(a) Reorganization of Statistical Units

(i) The District and State Health Statistical units should be reorganized to function as information systems division of the Health Department and should service all divisions and wings including drugs, food safety etc.

(ii) The Health Department should make use of the District Data Centres and the State Data Centre facility set up by IT Department for connectivity, storage and security of data and even for multimodal communication (video conference etc.).

(b) Nature of data/information to be compiled by the Information Systems Division

(i) **NRHM proforma** – to be continued as required by Government of India.

(ii) **Communicable diseases proforma** – to be continued as required by Government of India.

(iii) **Non-communicable diseases proforma** – to be continued as required by Government of India.

(iv) **Morbidity/Mortality proforma** – to be discontinued for reasons indicated.

(c) Registration of Deaths and Related Data

(i) As already recommended, ASHA to be declared as the notifier under the Act so as to ensure that information, especially

regarding infant and maternal mortality, is provided as prescribed in form-2.

(ii) Form-2 regarding information about deaths to be modified to classify causes of deaths on the following lines:

- Accident/homicide
- Suicide
- Natural causes – *sub-classified- waterborne diseases, cancer, chest infections/all other diseases not specifically indicated.*

(iii) The data to be digitized starting with current entries and analysed at district, regional and State levels, to devise policy and programme interventions in regard to IMR, MMR, cancer, other diseases as per the priorities of the State.

(iv) Information required by Drug control, Food Safety and other wings such as Malaria control, TB etc. to be compiled as required by different wings.

(d) MIS and Data Analysis

(i) Considering that the hospitals and health institutions do not have any defined jurisdiction, the district should be the unit for comparison of results and performance.

(ii) Result/performance indicators should be developed and data compiled and assessed district-wise for the indicators.

(iii) District performance should be assessed under the 'traffic light system' – Green (+ Avg.), Amber (Avg.) and Red (- Avg.). It will be more appropriate than a ranking system, and provide pointers for improvement, without necessarily indulging in a blame game.

(iv) All data needs to be assessed **annually** for performance – a month or a quarter is not a long enough period except for purely quantitative items like family planning measures.

(e) Performance and Outcome Indicators

Suggested performance and outcome indicators, the data and sources thereof and criteria for assessment are indicated below:

Performance and Outcome Indicators

Indicator	**Data and source**	**Assessment criteria**
MMR	Birth and Deaths Registers [as proposed by the PGRC (2nd Report), ASHA and ANM will have direct control of the data]	Annual change District and State level

Indicator	**Data and source**	**Assessment criteria**
Institutional & home delivery percentage	As per present system-ASHA/ANM reports/ Institution data	Annual change District and State level
IMR	Births and Deaths Register - (as above)	Annual change District and State level
Sex Ratio at Birth	Births and Deaths Register - (as above)	Annual change District and State level
Common/ major diseases-Prevalence (e.g. waterborne diseases) Percentage of patients in each category of major diseases; Total number (indoor and outdoor) patients	Information about number of patients and deaths –average in proformas and village death register abstracts	Annual change District and State level
Urban Hospitals-effectiveness/efficiency • Number of outpatients per MO • Inpatients per MO/Nurse • Average number of lab tests per technician • Average number of X-Rays per unit • ECG etc. per unit machine • Average bed occupancy ratio • Costs-maintenance cost, raw material cost per laboratory (optional).	Data collected already	Annual performance Institution level

Chapter 4
Citizen-Centric Services: Revenue[14]

4.1. Introduction

The system of maintaining the record of rights, especially for the agricultural lands in Punjab, is theoretically fairly sophisticated. The model designed by the British is being followed in the North West India including Punjab, Haryana and Himachal Pradesh as also in Pakistan. The main institutions are (a) **survey and settlement** - periodically undertaken for recording the rights. In Punjab, as also in other States which were earlier part of Punjab, the settlement process that was initiated towards the end of 19th century got completed by 1930s. The settlement provided for the rights of the owners and the tenants and made land revenue assessment based on the classes of land etc. There was a re-survey and consolidation of the holdings in the 1950s. No further survey has been taken up since then; (b) **periodical updating of the record of rights – Jamabandi;** (c) **mutations** reflecting the changes in the record of rights; (d) **girdawari** - maintaining record of the produce/possession.

Due to various reasons, especially extensive land transactions, multiple owners, fragmentation of the holdings due to inheritance, abolition of land revenue etc., the system has, in practice, become non-functional and is not responsive even to the primary need of making up to date records available to the public. In recognition of these problems, the Central Government and a number of State Governments have taken some initiatives for modernizing the revenue services, especially in regard to the digitization of the record of rights and the land registration processes. The Central Government has been providing assistance to the States for this purpose. Pivotal institutions of the revenue system and the processes of crop inspection, jamabandi, record of rights and mutations for updating the record of rights – have, however, broadly continued unchanged and the systems have not been redesigned by taking note of the opportunities and challenges of the new technology, changing nature of the transactions and the public expectations. These issues, being substantive, procedural, transactional, have been examined by the Commission in discussions and meetings, during the field visits as well as at the headquarters, with the revenue officials at the cutting edge and the executive levels. The Report deals with the computerization of the record of rights (ROR), maintenance and updating of the land records, including urban areas, crop inspection system and other related issues.

4.2. Digitization of the Record of Rights (RORs)

Under computerisation of the Land Records (CLR), Government of India released 100% funds to the various State Governments in 1990.

[14] This Report has been prepared by Task Group on **Basic Civic Services and Civic Regulatory Services** Chaired by Sh. R.N. Gupta. The report was submitted to the Department for their consideration on March 18, 2010.

A number of States have built on the initial support and have developed good systems of on-line provision of the copies of the record of rights and updating of the same. The Karnataka Project Bhoomi is in operation since 2002 and has provision for on-line updation of the mutations. Gujarat and Haryana have also started giving copies of the ROR's electronically even though provisions for electronic updating of the Jamabandis are not yet fully in place in Haryana. The same position obtains in Himachal Pradesh where all the Jamabandis/mutations etc. have been digitized and it is ensured that the sanctioned mutations are digitized and the text entries are made in the Jamabandis within a week, so that the copies of the Jamabandis, including intimation about the mutation/copies of the mutations where required, can be given immediately on application at the Tehsil office where the digitized records are being maintained.

4.2.1. Status of Computerisation of Land Records in Punjab

Punjab got its share of the Central funds and many Deputy Commissioners started the work of Computerization in the districts. However, due to the non-availability of good software and various other reasons, the project could not be implemented and the efforts made from time to time in the various districts did not result in any tangible outcomes. The funds released by Government of India were also not sufficient for full implementation of the Project.

4.2.2. ILMS Project

In order to overcome the financial difficulties and for successful implementation of the Project, the Punjab Land Records Society was constituted as an executing agency in the year 2004 with the Revenue Minister as its Chairman and Financial Commissioner, Revenue, as its Vice Chairperson. It was decided that the project may be implemented on PPP model with the help of the BOOT Operators/Technology Partner. It was also decided that the State will develop an Integrated Land Records Management System (ILMS) consisting of the following stages:

- Data Entry of Jamabandis, Mutations, Khasra Girdawari, Roznamcha, Fard Badr, Mussavis, Shajra Nasb & Field Book.
- Verification & Validation of the above records.
- Establishment of Fard Kendras at all the 153 Tehsils/Sub-Tehsils of the State. The following services will be provided to the citizens from the Fard Kendras:
    - Issue of 'Nakals' of all kind of land records like Jamabandi, Mutation, Khasra Girdawari, Roznamcha Waquiati, Field Book, Mussavis.
    - Registration of the Property Documents. The Registration module will be integrated with the Land Records, Stamp Duty and Deed-writing module.

An RFP for the selection of a suitable operator through competitive tendering for the implementation of the project of Computerization of

Land Records and Registration of Documents was issued in 2006. The following three vendors were chosen to help the State to implement this ambitious project and three separate agreements were made:

M/s. CMS Limited

For carrying out the project in the whole State (except District Sangrur).

M/s. CMC Limited

For the project of Computerization of Land Records only in Sangrur district.

M/s. Microsoft Inc.

Microsoft was selected as the Technology partner. Their work involves application & database revamp and porting, training to PLRS software professionals, hand-holding and aspects like language components, GIS, data security etc.

The ILMS is being implemented under PPP model in Build-Operate-Own and Transfer basis. The BOOT Operator shall implement the following:

- Data Entry and validation of all revenue records.
- Digitization of Mussavis.
- Operation and Maintenance of Service Centres (Fard Kendras) where copies of the Record of Rights will be generated and given to the Public.
- Back-end operations like Data Entry of Mutations, Khasra Girdwari, Roznamcha etc.
- Registration of Documents.

The main objectives of ILMS are:

- Improving the quality of services to the citizens.
- Infusing transparency in the operations by enabling the stakeholders to have easy access to the records.
- Minimize abuse of the discretionary powers and minimize under-valuation, a step that will increase the Government revenue.

4.2.3. Progress of ILMS

The software of CLR has been developed by M/s. Microsoft and is under implementation. As the software is developed on DOT-NET technology of Microsoft, there will not be any problem to port the data on the web for public viewing if the State so decides. The software is developed on the state of art Microsoft tools and, therefore, many services can be provided like locking of Khewats, urban planning wherein the conversion of Agricultural Land to other Land use can be monitored by locking the Khasra numbers for mutations etc. The software will be highly useful for Land Acquisition purposes also.

The application software will be the property of the State and will be maintained by the State.

The data entry of Jamabandis was started in the State in November 2006 and is almost complete in the entire State. The data entry of Mutations, Roznamcha and Khasra Girdawari has been started in all the twenty districts. The data entry of the mutations is very time-consuming as illogical mutations or any mutation where data does not match with the Jamabandi record is not accepted by the Computer. Software Digitization of the Mussavis has also been started. The Mussavis are being digitized using standard Autocad format and the output is in DFX Format. Further, Mussavis will be automatically updated from the GIS/Mutation module. About 10,000 Mussavis out of total of 80,000 have been digitized and are being validated by the revenue staff. The digitization work is expected to be completed by the end of year 2010.

The latest status of the data entry of the various records is at Annexure I & II. It would be noted that the backlog of the mutations is huge as about 90% of the work is still pending.

The Fard Kendras are also being set up and about 24 Fard Kendras have been made operational so far. Computerized 'Nakals' are being issued from these Fard Kendras. The remaining Fard Kendras in the State are expected to be made live by the end of year 2010. A manual has been prepared for the guidance of the field staff.

4.2.4. Problems of ILMS

There are a number of bottlenecks in the implementation of this Project and the project is running behind schedule.

- One reason appears to be the rather ambitious ILMS plan, attempting to integrate a number of separate transactions. While scanning the web sites for information on Punjab, a couple of web sites of the Punjab Government in Pakistan came to our notice. It was interesting to see that these two States, earlier part of the same province in pre-Independence India, appear to share similar problems though the formal approach adopted for resolving them is different. The Punjab area in Pakistan has taken up a World Bank-Assisted Project for updating and digitization of the record of rights, but they have decided, for the present, to follow the presumptive system of title rather than attempting the shift to conclusive title and have three separate modules for spatial mapping, digitization and registration of property instead of integrating the three modules as being proposed for the State of Punjab.
- The records are not maintained in accordance with the relevant laws and provisions. Annexure-III provided by the Department of Revenue indicates some of the errors. It is a tedious job to rectify the inconsistencies and make data entries. About 10% of the total records need to be corrected.

- The staff is inadequate and may not be positively oriented to the new processes and systems.
- The process of urbanization has led to extensive changes and the Revenue Department has been unable to cope with record keeping in the urban areas.
- The maps are completely out of date and do not reflect the ground realities.

4.2.5. Present Status

It would appear that despite the passage of four years since the award of contracts, the basic objectives of providing copy of the record of rights immediately on demand (let alone providing it on-line) is still a long way. Even in the Fard Kendras, which are operational and where Jamabandis have been digitized, the applicants have to approach the Patwaris for certification due to the lack of proper validation of the digitized record, thus, making the delivery problem much worse than it was earlier. Moreover, even where the Jamabandis are digitized, mutation entries are pending digitization (backlog is 30% in the operational Fard Kendras and 90% in the State of Punjab as a whole) and, even where this process is complete, Jamabandis cannot be updated through incorporation of the Mutation entries due to the software and manual record problems mentioned above. Punjab is lagging behind the neighbouring States of Haryana and Himachal Pradesh, not to speak of the more advanced States (e.g. Gujarat, Karnataka) where the copies are available any time and at any place.

It appears that there is some confusion in balancing the two objectives – (a) providing copies of RORs as these are more efficient – i.e. simply providing digital printouts which, at present, the Patwaris supply on demand, account for substantial transaction costs and harassment to the applicants; and (b) improving reliability and quality of RORs.

The Department, in its anxiety to achieve the second objective, has not given priority to the first issue which is really bothersome for the general public. In their concern for developing a perfect system with automatic updation of the records and on-line access, even the earlier (unsatisfactory) standards of service are probably not being matched.

4.2.6. Recommendations

It appears unlikely that these problems will be resolved in the immediate future. Over three million entries of Khevats and thousands of Mutations that are completed manually are not likely to be rectified so easily even as most of the errors apparent on the face of record have continued to be a part of the ROR's. It may also not be easy to establish the validation standards. Six sigma quality is not easily achievable, even as the problem of the errors and mistakes that are likely to remain, despite all the care, thereby making the task of acceptable validation difficult. Further, in this

important area involving property rights, even a small percentage of errors may not be acceptable at all.

It may, therefore, be appropriate to adopt different approaches for achieving the two objectives and calibrate the processes. The following suggestions may be considered:

- Digitization of the existing manual Jamabandis should be completed and got validated from the Patwaris. This need not be a public validation exercise,
- The digitized Jamabandis must also carry the text entry about the mutations in column 12 of the Jamabandi so that the *digitized Jamabandis reflect the position exactly as is available in the* ***parat patwar*** *of the Jamabandi.* The remarks entry needs to be only brief indicating the number of mutation, nature of transaction etc.
- Sanctioned Mutations should also be digitized for all such Jamabandis as per the software already developed as soon as practicable.
- **The digital format should be used in place of the mutation register for entry and sanction for all future mutations** even in cases where on-line mutation sanction is not feasible. Orders of the competent authority can be digitally entered at the Tehsil, thus making it unnecessary to keep two copies of the mutations in future. This will facilitate incorporation of the future mutations (through module or in text) in the Jamabandi while the problems of the mutations sanctioned already are taken care of as indicated above at (b) & (c).
- The staff and other resources need to be concentrated at the Tehsil level for time bound digitization so that the copies of Jamabandis including column 12 entries can be provided immediately on application at the Tehsil level.
- There may a need for suspending the process of 'Daur' and giving discretion to the Deputy Commissioners for proper scheduling of the digitization process and updating through the mutation module (e.g. Jamabandis which have relatively manageable number of sanctioned mutations could be taken up for digitization of Mutations in the first instance, whereas other Jamabandis could make do with brief text entries in column 12 as indicated above while the urban areas having large number of mutations could be taken up later).
- The software and other technical problems can be resolved at the time of formal updating of the Jamabandis not according to any fixed rotation but as per some revised pragmatic schedule to be fixed by the Deputy Commissioner. The idea is that any upgradation henceforth should be carried out only through the software. That, of course, will be possible only if the software and other problems are first resolved and it may be appropriate to delay the revision by a few years rather than waste resources and prepare updated Jamabandis

as per the old process even as the digitization process is already under way.

4.2.7. Aligning present systems to ILMS

Some related issues need to be considered. One problem related to the fully digitized khevats, running in a number of pages, having to be copied whereas the Patwaris used to give only copy of short relevant extracts with a notation of 'badastoor' (the rest unchanged). This problem seems to have been rectified by the Department. There are some other problems in the manual records which make it difficult to have a trouble-free updating. These could be addressed in the following manner:

- *entry of the new shares in a Khevat. This is creating problems as the shares do not total up exactly. It may be appropriate to record the shares in quantitative terms to overcome this problem.*
- *khasra, rather than khevat, should be the main entry in the record of rights* as the khasra numbers have a physical identity and, as such, maintaining the records khasra number-wise rather than khevat-wise may be more appropriate. As land revenue stands abolished, the aggregation of the village holdings owner-wise has no relevance now.

The Department is conscious of these limitations and may like to take note of these issues while updating the Jamabandis in due course.

4.2.8. Conclusion

The upshot of these proposals is that the search for (mythical) ***conclusive title*** *needs to be abandoned and there is a need to concentrate on:*

- *digitizing the present Jamabandis and mutations and making entries in column 12 of the digitized Jamabandis as per ' parat patwar';*
- *giving copies of the Jamabandi entries along with mutation entries in column 12 in all the Tehsils. This will ensure that the people get a copy of the ROR's on the day of the application at the Tehsil. It should be possible to make the practice universal within a period of six to nine months.*
- *efficient service delivery of the copies of the present record of rights in whatever state they are and replacing the Patwari's role for this purpose;*
- *resolving software and other problems at the stage of revision of the Jamabandis which should be made flexible by suspending the process of 'daur'. As and when the process of on-line incorporation of the mutations is completed in any village area, the Department can start providing copies of the updated Jamabandis (including changes due to mutations) in the substantive columns of Khevat etc. It should be possible to do this by the end of year 2012.*

4.3. Registration of Property

At present, the Registration of Deeds is being done using The Prism software at all the 153 Sub-Registrar Offices of the State. A Pilot Project on Registration is already under way on BOOT model in Sangrur and Barnala districts. There are a few shortcomings in the software. To overcome those shortcomings, the State has decided to get its own software developed from Microsoft. The software so developed will be integrated with Land Records, Deed Writers, Stamp Duty and GIS module. The software has been developed and is under testing. It is expected that the software will be rolled out in the State in a few months. The present process of registration is fairly streamlined even though the ideal process (standard format of the sale deed etc.) has not yet been feasible. Generally, registrations are being executed on the day of presentation.

4.3.1. Problems & Suggestions

There are, however, two main problems – valuation problems and pre-audit that are causing harassment.

4.3.1.1. Pre-audit

The pre-audit needs to be dispensed with as it is nothing but a route to extracting informal commission and other payments. Any shortfall in the duty can be recovered from the buyer at the time of the next sale, if not earlier. A note should be attached in the abstract of the record to this effect. It is understood that pre-audit has already been discontinued in practice.

4.3.1.2. Valuation of Property

The issue of making valuation system transparent and easily understandable needs to be looked into by the Department, especially by avoiding vague description and complex/classifications, which lead to corruption due to the opacity/ambiguity. The system has already been rationalized to a great extent and cent percent khasra numbers are listed under the specific valuation groups for transparency. This is a good initiative. The only problem is that the software does not accept more than a particular number of characters for a specific valuation group and it may not be possible to enter, say, one thousand khasra numbers in one valuation group. The solution to this problem may be to enter the khasra numbers in a series (say 1 to 150) in a specific group and to group the odd khasra numbers, not a part of the group, in a separate miscellaneous group.

The second issue relates to the vague description of the valuation groups, especially in the urban areas, where the localities/grouping for valuations are somewhat vague ('near bus stand', 'near the road' etc.). There is a need to be more specific and concrete in giving the location of the property.

The third issue is regarding the standard format introduced for the sale deed. This may need to be simplified. The ideal solution will lie in the proposed integrated application thereby grouping together the valuation, property number, spatial mapping and registration but the suggestions given are likely to help in the meantime.

The fourth problem is the determination of the ***valuation of the built property****. Recently, a system of certification by the valuers has been introduced. It is generally felt that the Government should announce for the guidance of the public: (a) the present cost of construction for average but acceptable quality construction, (b) indicate the rate of depreciation (similar to the indexing followed by the Income Tax Department for capital gains); (c) accept self-declaration of the owner regarding the year in which the building was constructed and, to then calculate the market value thereof. The Registering authority should have absolutely no discretion in the matter.*

The value of construction is now a major irritant and the suggestions put forth here are likely to be helpful being revenue neutral as the value of the constructed property is a negligible contributor to the leviable stamp duty which is mostly provided by the land valuation.

4.4. Girdawari

The institution of girdawari (crop inspection) had multifarious objectives;

4.4.1. Collection of land revenue/cesses

The land revenue was mainly assessed on the basis of the nature of the agricultural lands and their productivity. Assessing the crops actually cultivated was also necessary for the imposition of cesses and levies on commercial crops such as sugarcane and cotton.

4.4.2. Estimating agricultural production

Physical inspection was probably the only method available earlier for arriving at some estimates of the agricultural production. The estimates may have been relevant for the British primarily in terms of the potential to feed the population and the factories of Britain and, to some extent, the urban population in India. For the rural areas, production had relevance for exemption/suspension of the land revenue. Whatever the reasons, crop inspection was necessary for estimating the yield and the production of the cereals and other crops.

4.4.3. Property Rights of the Tenants

The crop inspection included/assessed the occupation status and the tenurial relationships of the owners and the cultivators. This was necessary as the tenancy and the occupation rights were mostly through 'word of mouth' contracts and were rarely reflected in the formal process

of the mutations. Girdawari, therefore, was an important ingredient for the maintenance and updating of the record of rights of the tenants.

In fact, crop inspection probably was unavoidable as a large part of the jurisdiction of the supervising officers required compulsory camping outside the headquarters making it impossible to have impressionistic estimates by the executive officers. Their job was generally confined to ensuring that the inspections were carried out meticulously and carefully.

4.4.4. Relevance of Girdawari

The relevance of the following factors needs to be re-assessed in the light of some pertinent issues, such as: (a) substantial reduction in the 'fraction of distance', especially in Punjab; (b) abolition of land revenue and commercial crop cess; (c) settlement of the tenurial rights and conferment of the ownership on the tenants; (d) evolution of cash (theka) system of tenancy in Punjab under which the lessees pay annual rent in cash for cultivation to the owner **without any expectation of the tenancy being continued**, let alone, recognized under law and the continued recording of the occupation in such cases as 'self cultivation by the owner' in the girdawari; (e) marginalization of the girdawari system for the purpose of production estimation due to multi-cropping, small holdings, change of land use etc. Remote sensing, satellite imagery and even less sophisticated estimates by the Agriculture Department based on crop cutting experiments have replaced the crop inspection system. In fact, there is such a wide divergence in the estimates that, for all practical purposes, Agricultural Department which is now primarily responsible for providing the production estimates has even discontinued the practice of calling for the estimates of the Revenue Department; (f) the entries of possession, under Government instructions, are not allowed to be changed by the Patwari in the course of crop inspection and the legal evidence is required for this purpose.

On top of these factors is the problem of the availability of the qualified and motivated manpower in adequate numbers. For these reasons, girdawari has become an empty ritual without any substance in the present context.

4.4.5. Recommendations

It would appear, therefore, that **the system of girdawari which consumes precious time of whatever revenue officials are available, needs to be discontinued.** Needless to say, special girdawaris will continue to be taken up for the purpose of relief under certain special circumstances when, in any case, the local manpower is rarely sufficient for the purpose and outside manpower has to be inducted.

4.5. Record of Rights - Jamabandis and Mutations

4.5.1. Present System

The record of rights is maintained in the form of jamabandi in two copies. One copy is maintained by the Patwari and the other by the Tehsil. The jamabandis are updated every five years. The changes approved through the process of sanctions of the mutations are entered by the Patwari in the remarks column (12) of the existing Jamabandi. Only brief details regarding the mutation number, nature of mutation etc. are given in this column. The Tehsil copy is not, however, updated simultaneously and the effect of these mutations is incorporated in the Jamabandi to be revised after 5 years with the assistance of the details provided in the mutation register. The institution of mutation, thus, takes care of the changes in the rights of parties – through sale, inheritance, partition, tenancy agreement, court orders etc. A party wanting a change in the record of rights is required to file an application with the Patwari who enters the mutation in the mutation register. The mutation can only be sanctioned after public hearing by the authorized revenue officer. The contested mutations can only be decided by the SDO (Civil). There is a provision for filing appeals to the Collector/Commissioner/FC(R) (Appeals). The parties can also approach the High Court against these orders and, in any case, if the dispute regarding the title is raised, the civil courts can be approached at any time as it is a well settled law that the revenue authorities cannot decide the issues of title.

After sanction of the mutation, a copy of the mutation order is retained at the Tehsil whereas the mutation register is retained by the Patwari and this register is used at the time of revision of the Jamabandi. 'Parat sarkar' (Tehsil copy) remains in the Tehsil but is not used practically for any purpose or for making entries in the Tehsil copy of the Jamabandi.

4.5.2. Issues and Problems

- The appellate system for the contested mutations is elaborate and tortuous which, as indicated earlier, has no finality anyhow;
- Patwaris are rarely available at their headquarters and even physical delivery of the application for mutation to the Patwari– a prerequisite for sanction - may take months. Patwaris have no fixed place of work and even where the Patwarkhana exists, even well intentioned Patwaris may not find it possible to be available due to the various duties that keep them busy such as elections, census, miscellaneous reports etc.
- Registered sales of land are also subjected to the same procedure even though these can be sanctioned straightaway on the basis of registry, especially when the mutation fee is charged at that time and the rules also seem to permit the same.

4.5.3. Recommendations

- Applications for mutations should only be accepted at the Tehsil where full time staff is available, a proper receipt can be given and the progress in sanctioning of the mutation can be monitored. This will be easier, once the record is digitized and the particulars of the application can be straightaway entered digitally, even though for the present, the mutations may not be decided online.
- Once a mutation is sanctioned, suitable entries can be made in the Jamabandi at the Tehsil itself.
- So far as the registered sales etc. are concerned, these can be straightaway sanctioned as mutations on the day of the registration on the basis of the registry.
- The system of successive appeals needs to be discontinued and, instead, only one appeal to the District Collector should be permitted after which any aggrieved party should be free to approach the Civil Court.
- As indicated above, the format of the mutation module should be adopted for all future mutations and all the sanctioned mutations should be digitized immediately on sanction at the Tehsil level.

4.6. Maintenance and Updating – Urban Land Records

4.6.1. Present System

The record of urban property – earlier within 'lal lakir' of the revenue village or even outside (through development of the urban estate etc.) is in a mess. These areas were not taken up for settlement/re-survey and no record or mutations were made in the case of plots sold by the colonizers/PUDA etc. The Municipal Committees should have maintained these records but their interest, in the absence of clear obligations in this regard, was confined to the imposition of the property tax and, once that was abolished, they stopped taking any interest in maintaining the record except for passively making changes on the application on payment of transfer fee.

The Director, Land Records, Punjab has prepared a note at our request. The same has been put at Annexure-IV and indicates the alarming state of affairs in this regard. The recommendations and suggestions spelt out at length by Director, Land Records in his note on the 'Extent and Genesis of the Problems of Title of the Urban Properties in Punjab' (Annexure-IV) are very comprehensive, reasonable and, hence, merit to be accepted and implemented, especially the one pertaining to the setting up of a Punjab Urban Properties Management Authority (PUPMA) and the introduction of Unique Property Code (UPC) with a view to effectively managing the issues of title for the urban properties in the State of Punjab. The Commission strongly advocates the acceptance of the proposal.

4.6.2. Recommendations

- It is essential that a government agency is made responsible for maintaining and updating the record of lands in the urban areas. It is suggested that the Revenue Department should be the agency for the maintenance, periodic survey and updating. Settlement/survey would involve aerial/satellite imagery supported by detailed physical survey, enlistment of the properties along with the property numbers and dimensions/size.
- Enabling rules may be required for the survey/settlement of the urban properties and for providing a compulsory process similar to that of the mutations for reflecting the changes in the record.
- Approach should be to provide presumptive title as in the case of agricultural lands – the process of confirming the conclusive title is likely to be much more difficult initially.
- Assuming that the girdawari is discontinued and the revenue staff is relocated/headquartered at the Tehsil level, as proposed, it would be possible for the Department to take up this work without any additional staff support. It would, however, be appropriate to have a **separate urban wing** at the Tehsil level for all the urban areas within the Tehsil jurisdiction.
- Further changes would be reflected through compulsory intimation of the changes in the property register that would have to be prescribed by the Department.
- The Revenue Department, Punjab is maintaining the Land Records System which is primarily focused in its intent and purpose for collection of land revenue from the land owners of the State. This approach has led to the utter neglect of creating and maintaining of Public Registers for the Urban Properties. The system of rural land records system is being followed for urban lands/properties. As the pace of urbanization in the State has increased during the past few decades, this development has thrown many challenges for the record keeping. The system of multi-storey housing flats and shops in the malls has completely changed the scenario of record system. Keeping in view the above developments, it is recommended that the urban land record and property system should be separated from the rural and semi-rural land systems.
- The urban land system may be created, managed and controlled by independent authority to be enacted under the law and may be called as Punjab Urban Property Management Authority (PUPMA) under the Department of Revenue. PUPMA may be professionally managed by a Board comprising of members from diverse fields like Information Technology, Geographical Information System (GIS), Survey, Settlement, Revenue, and Banking and Finance. The Authority should be headed by a person of eminence, not necessarily a Minister.

- PUPMA should have its own funding based on user charges.
- The PUPMA should create a database for each property falling in the Municipal Limits of a city with attributes which may be utilized by different Departments like Electricity Board, Municipal Corporation, Town Planning Department, Sewerage Board, Industries Department etc.
- PUPMA should create a database of UPC of 24 digits for each property with attributes to be finalized in consonance with different user departments.
- The UPC should be maintained and may carry with it the history of transactions carried on property like sale, gift, mortgage, inheritance, sub-division, court orders, exchange, change in the land use, change in the built-up area, demolition, increase in the built-up area, change of the land use, increase in the sanctioned load of PSEB etc.
- The UPC should be web-enabled.
- Once the revenue estate falls into the Municipal limits of town or city, the records of rights of the village should be changed into UPC and this process should become a part and parcel of the notification for extending the limits of the Municipal area.
- All properties/plots being carved out of open land after the change in land use whether it is industrial, residential, commercial should have a UPC with attributes before the conveyance deed is sanctioned.
- For all properties and plots which are already in existence, a UPC may be assigned by PUPMA after following the due processes and after certain notice period, it should be mandatory that no Registration Deed be sanctioned on any property in urban areas which does not have UPC.

The Government needs to set up a Working Group to design the detailed proposals for maintaining and updating the records of land in the urban areas including the issues of organization/staffing/legislative changes wherever required/working systems/required computer applications etc.

4.7. Revenue Organisation and Staffing

4.7.1. Present Structure

The Revenue Department is organised in a traditional pyramidal structure. The patwaris are the first point of contact with the public and the rest of the hierarchy is for the primary work and man-management functions – Kanungos, Naib Tehsildar/Tehsildar, DC, Commissioner upto Financial Commissioner (Revenue).

4.7.2. Issues & Problems

It is recognized that there is an acute shortage of the staff – about 25% at the level of Patwaris and Kanungos. In addition, there is substantial

overload imposed by other departments (enquiries, reports in the case of pensions, income, caste certificates etc.) census and elections. Generally, Patwarkhanas have not been constructed and the Patwaris have to operate from their residences. In any case, due to extensive field duties on behalf of other departments as also departmental obligations (Girdawaris, Mutations etc.), they are rarely available at their headquarters. Due to the staff shortage at these levels, the duties have also tended to overlap in practice. There may a need to review the cutting edge staff deployment in view of the substantial changes in the technology, and in the mode of interaction of the public with the Department as also in view of the easy communications available across all areas in the State of Punjab.

4.7.3. Recommendations

4.7.3.1. Single-Window Services

Technologically superior alternatives are also available now for the delivery of the core revenue services to the public through a single window at the Tehsil/Sub-Tehsil Headquarters. The core services are the maintenance of the records of rights, updating mutations, girdawaris and providing copies of the revenue record to the public, apart from handling the need based issues like demarcation, partition etc. The advantage of single window operations for the revenue services is that it is amenable to control and monitoring and has the advantage of scale as compared to the present state of diffusion of the delivery points.

4.7.3.2. Re-deployment of the Staff

The discontinuation of the girdawari is likely to result in 30% saving of the working time of the officials even on conservative estimates. Further, when the records are computerized, there will be a single point of delivery for them (Tehsil Fard Centre) which can, in due course, provide online service also at the doorstep of the applicant (through e-gram centre/common service centre or even in the internet cafes operated by the private parties). The patwaris would, therefore, be no longer required to be posted in the villages for these revenue services. So far as the mutations and other revenue matters are concerned, the competence thereof is mostly of the Naib Tehsildar/Tehsildar and the Patwaris do not have any independent authority for this purpose. Revenue collection and other cesses, another main reason for the deployment of Patwaris, have also been abolished. It has been separately recommended (2nd PGRC Report) that the system of verification of the personal particulars of the applicants, in case of need based services, should be discontinued.

It would appear that, in view of these factors, the optimal deployment of the Patwaris and the Kanungos will be to group them as teams headquartered at Tehsil/Sub-Tehsil. It can be ensured that the public is attended to at all times and the transactions completed, quickly/immediately. The Tehsil will also get the much needed professional support which is now provided by the informal deployment of the Patwaris and the Kanungos at the Tehsil.

There will be, of course, a need to provide suitable infrastructure for accommodating the revenue staff at the Sub-Tehsil headquarter and assistance should be provided, if needed, for this purpose.

4.8. Summary Recommendations

4.8.1. Digitization

Complete digitization of the Jamabandis including column 12 text entry by December 2010; have them validated by the Patwaris so that the copies of ROR's can be given immediately on application in the Tehsils all over Punjab. However, in view of some functional constraints, initially, text entry of Column 12 be taken up only for those villages for which the D.C. concerned feels that he will not be able to get the data entry for all the mutations done by December, 2010.

Digitize already sanctioned mutations as per the software, if necessary, by allowing sub- contracting to the private parties.

All mutations after a particular date - say December 2010 - should only be entered in the standard software format and straightaway digitized.

'Daur' process should be suspended for the next two to three years and Deputy Commissioners empowered to reschedule updating process as per the needs of the different areas/villages in the district.

All Jamabandis should be updated only through ILMS after December 2012.

4.8.2. Registration of Sale Deeds

Pre-audit should be dispensed with.

Valuation: Valuation system should be improved as indicated below:

- to be clear and transparent and avoid ambiguity;
- value of construction should be based on the government - declared present rates of construction for acceptable quality construction, fixed in consultation with the PWD. The variations in the quality of construction should be ignored for this purpose. Any person wanting lower rates should be asked to produce supporting evidence and valuers' certificate etc., which should not be asked for in other cases;

- rate of depreciation should also be announced for the guidance of the public along with the present rate of construction;
- self-declaration of the seller should be accepted regarding the year of construction and calculation of the valuation of the built property on the basis of (i) & (ii) above;
- discretion of the registering authority should, thus, be completely eliminated.

4.8.3. Girdawari

Institution of girdawari should be discontinued. Special girdawari will, of course, be done as and when required. It may also, however, be clarified that discontinuation of girdawari shall not mean that the column of cultivation in the revenue record will be eliminated. The column of cultivation will remain, but for any change therein, an application will have to be made to the Tehsildar/Naib Tehsildar concerned who will make the change in a quasi-judicial manner after hearing all the interested parties.

4.8.4. Mutations/Jamabandis

Only one appeal should be provided in the case of contested mutations.

Powers of revision exercised by the higher authorities should be withdrawn.

Applications for the copies of RORs/Mutations should be entertained only at Tehsil level all over Punjab after December 2010. The copies will be provided only at the Fard Centres at the Tehsil.

Sale of registered deeds/mutations should be automatically sanctioned at the Tehsil on the basis of registry.

4.8.5. Urban Land Records

Responsibility for the maintenance of the records of land in the urban areas should be formally entrusted to the Revenue Department.

A Working Group should be set up to define timelines, strategies, action plans and resources required for the maintenance and upkeep of the record.

The recommendations contained in DLR's note (Annexure-IV) merit to be considered for implementation in right earnest.

4.8.6. Revenue Organization & Staffing

Fard Centre at the Tehsil should be the single point of contact of the public for all revenue matters/services, applications and complaints, for proper monitoring and assessment and ensuring compliance with the delivery standards.

All Patwaris and Kanungos should be stationed at the Tehsil/Sub-Tehsil Headquarters as soon as practicable, latest by December 2010.

Deputy Commissioners to be empowered financially and administratively to ensure compliance with the timelines – December 2010 for providing 'Nakals' of the digitized Jamabandis and December 2012 for electronic updating of all Jamabandis.

For the revenue organization to improve radically in terms of the quality of the key personnel, it is desirable to study afresh the institutions of Tehsildar since it is he who plays a pivotal role in the entire revenue functioning. Surprisingly, Tehsildar does not have any legitimate and attractive promotion channel. Merit based promotion is only to the post of DRO, which no Tehsildar wants to avail. Every Tehsildar aspires to become a PCS Officer, but it would be shocking to note that not a single promotion to PCS is based on seniority-cum-merit or merit-cum-seniority. All the promotions are by way of **nominations**. In the recent nominations, 80% of the nominees were Naib Tehsildars and many Tehsildars were ignored. In this situation, Tehsildars do not have any incentive to work properly and to keep their service record clean. Rather, many of them deliberately get charge sheeted when they are on the verge of promotion to the post of DRO. The State Government may reconsider the present practice and effect promotions from Tehsildars to PCS on the pattern of promotions from PCS to IAS.

Chapter 5
Summary of recommendation

5.1. Administrative Need-Based Services

5.1.1. Affidavit-Common for all Services

- Allow self-declaration in lieu of affidavit.
- Self-declaration to be a part of the application for need-based services.
- Declaration to provide for liability for wrong declaration.

5.1.2. Area/ Residence Certificates

- 2 years stay to be sufficient for issue of certificates.
- Discontinue verification and reports from public officials/government officials.
- Declaration by applicant in lieu of affidavit/field report/ verification.
- In case 3rd party verification considered necessary, accept declarations from citizens.
- Same day delivery.
- Tehsildar /NT/Suvidha Centre in charge- the deciding authority.
- SDM- grievance redressal authority.

5.1.3. Marriage Certificate

- Only formalities as prescribed under rules to be complied with. Obligation of producing affidavits of parents should be dispensed with and affidavits from any two witnesses who are residents of the area and have proof of identity should be considered adequate.

5.1.4. I - Card

- Powers to the in-charge Suvidha Centre to issue I- cards.
- Same day delivery for I- Cards.

5.2. All Departments

5.2.1. Income Certificates

- Standard format Annexure A of Chapter 3.
- Family definition- Head of family/wife/husband/children upto 21 years.
- Criteria of per head family income to be adopted.
- Specifying criteria for self assessment of income by the applicant in regard to income from agricultural land.
- Self declaration in place of affidavit.
- Supporting citizen declaration in place of field reports/ verifications.
- Delivery on the day of application.

5.3. LSG Department

5.3.1. Urban Civic Services

i. Construction/ approvals

- Registered architect/draftsman to be responsible for compliance with rules for residential construction.
- Architect certificates to be accepted for three residential storey buildings up to one kanal (or any other criterion considered suitable) for issue of sanction.
- Only one certificate after completion should be necessary.
- Surprise visits by officials on strictly random basis only for compliance with essential regulations.
- Revised plans to be necessary only for material – e.g. building line - changes.
- Post construction inspection before completion certificate issue to be dispensed with.
- Random post construction visits to check material violations.

ii. Water and Sewerage Connections

- Water and Sewerage connection to be sanctioned for new buildings on the day of application.
- Prior site visits to be discontinued.
- In case of water supply connection, random visits for checking material violations.
- Department to prepare simple pamphlets containing technical and financial information regarding rain water harvesting, earth quake proofing.

5.3.2. Revenue

i. Digitization

- Complete digitization of the Jamabandis including column 12 text entry by December 2010; have them validated by the Patwaris so that the copies of ROR's can be given immediately on application in the Tehsils all over Punjab.
- Digitize already sanctioned mutations as per the software, if necessary, by allowing sub- contracting to the private parties.
- All mutations after a particular date - say October 2010 - should only be entered in the standard software format and straightaway digitized.
- 'Daur' process should be suspended for the next two to three years and Deputy Commissioners empowered to reschedule updating process as per the needs of the different areas/villages in the district.

- All Jamabandis should be updated only through ILMS after December 2012.

ii. Registration of Sale Deeds

Pre-audit should be dispensed with.
Valuation: Valuation system should be improved as indicated below:

- to be clear and transparent and avoid ambiguity;
- value of construction should be based on the government - declared present rates of construction for acceptable quality construction, fixed in consultation with the PWD. The variations in the quality of construction should be ignored for this purpose. Any person wanting lower rates should be asked to produce supporting evidence and valuers' certificate etc., which should not be asked for in other cases;
- rate of depreciation should also be announced for the guidance of the public along with the present rate of construction;
- self-declaration of the seller should be accepted regarding the year of construction and calculation of the valuation of the built property on the basis of (i) & (ii) above;
- discretion of the registering authority should, thus, be completely eliminated.

iii. Girdawari

- Institution of girdawari should be discontinued. Special girdawari will, of course, be done as and when required.

iv. Mutations/Jamabandis

- Only one appeal should be provided in the case of contested mutations.
- Powers of revision exercised by the higher authorities should be withdrawn.
- Applications for the copies of RORs/Mutations should be entertained only at Tehsil level all over Punjab after December 2010. The copies will be provided only at the Fard Centres at the Tehsil.
- Sale of registered deeds/mutations should be automatically sanctioned at the Tehsil on the basis of registry.

v. Urban Land Records

- Responsibility for the maintenance of the records of land in the urban areas should be formally entrusted to the Revenue Department.
- A Working Group should be set up to define timelines, strategies, action plans and resources required for the maintenance and upkeep of the record.

5.3.3. Revenue Organization & Staffing

- Fard Centre at the Tehsil should be the single point of contact of the public for all revenue matters/services, applications and complaints, for proper monitoring and assessment and ensuring compliance with the delivery standards.
- All Patwaris and Kanungos should be stationed at the Tehsil/Sub-Tehsil Headquarter as soon as practicable, latest by December 2010.
- Deputy Commissioners to be empowered financially and administratively to ensure compliance with the timelines – December 2010 for providing 'Nakals' of the digitized Jamabandis and December 2012 for electronic updating of all Jamabandis.

5.4. Transport Department

5.4.1. Motor Vehicles

i. **Residence Proof –** to be asked for issue of permanent driving license.
ii. **Driving Test –**harness volunteers.
Issue guidelines for volunteers.
iii. **RC-** out source to dealers for new vehicles.
Discontinue pre audit.
iv. **Fitness certificate**- authorize major authorized service stations to verify.
Guidelines for empanelment and certification.
v. **Compounding Traffic Offences-** powers to police department.
Online National Permits for Commercial Vehicles to be centralised
vi. **Bus passes for students** – Encourage private transporters to subsidise

5.5. Welfare Department

5.5.1. SC/BC certificates

- Affidavit of the applicant to be substituted by a declaration (see section on affidavits).
- Supportive declarations by two citizens in place of verification by Public officials - Municipal Commissioner/Sarpanch/ Lambardar.
- Discontinue system of field reports from revenue officials in rural area.
- Same day delivery.

A uniform pattern of income eligibility criteria should be adopted and the existing income limits require to be enhanced by 50 percent across the board for all the target group categories.

The quantum of the scholarship to be uniformly fixed for (i) all the classes up to the Middle level; (ii) from 9th to tenth; and (iii) from plus one to plus two classes. Moreover, the stipend amount would require to be enhanced by 10 percent every two/three years.

The stipend amount to be disbursed in the months of January and July during the ongoing academic session.

The payment of stipend/scholarship under these schemes should be made to the concerned student/family through account payee cheques credited into the Saving Fund account to be maintained by the students under the guardianship of mother/father.

i. Shagun

- It has been proposed that the 'Shagun' amount be disbursed in two parts. The first installment of Rs. 10,000/- may be paid to the beneficiary family before the marriage ceremony and the balance amount of Rs. 5,000/- be released through the Suvidha Centre/E-Gram at the time of registration of the marriage. The process to be completed within 60-days of the marriage.

5.6. Department of Social Security Women and Child Development

5.6.1. Social Security Women & Child Development

- Per head income criteria should be used for all schemes. The family definition should be standardized as indicated in the Second Status Report of PGRC. (CH. 4-4.2.2 (iii), (iv)
- A uniform proforma for the assessment of income based on self-certification supported by two identified citizens rather than public officials, should be used. Verification by the public officials should be discontinued altogether.
- Except for the schemes covered by specific laws, e.g., reservation in employment which is governed by specific income/other conditions, there ought to be only the following criteria for giving all benefits/ concessions/ subsidies as under:-
- BPL – as per Government of India definition since the State Government cannot after the same.
- (ii) Family income to be calculated at Rs. 650/- per head in the rural areas and Rs. 800/-in the urban areas.
- Discontinue verification by the public officials and shift to self-certification with supportive testimony by two identified citizens.
- Department to assess potential beneficiaries and be accountable for any inefficiency and / or wastage of resources.

5.6.2. Old Age Pension:

- Age limit should be 60 years for both men and women. The eligibility criteria require to be streamlined and made simple, less tedious and absolutely transparent.
- Medical Certificate should be dispensed with.
- Evidence of EPIC/ voter list/ ration card should be accepted for determining the age of the applicants.
- District wise lists of the pensioners be maintained in a manner that enables verification with the lists of the voters qua the age of the beneficiaries.

- Income Criteria: Per head family income of Rs. 650 per month for rural areas and Rs.800 per month for urban areas should be accepted and used to compute the eligibility limit.

5.6.3. Combating Female Foeticide

- Regulating the health delivery system: To fix the targets for reducing maternal mortality and provide promotional incentive of Rs. 1000/- to pregnant mothers belonging to BPL families from three months pregnancy to three months post-pregnancy.
- Tracking a girl through her life cycle from birth to death, including sphere of health, education, skills and atrocities against women. The existing schemes may be restructured to cover her life cycle. The Commission is of the view that the Government may deposit Rs. 5000/- per girl child for first three years.
- To check cultural neglect, a girl child family must be given incentive of Rs. 1200/- every year for first five years.
- And thereafter it should be linked with education as per the proposal.
  - On admission in Class – 1 (Age 6 years) – Rs. 2100/-
  - On admission in Class – 6 (Age 11 years to 17th)– Rs. 2400/- p.a.
  - On admission in Class – XII (Age 18 years) – Rs. 11000/-
  - Girl attaining the age of 21 years – Rs. 50000/-
- A package of schemes at the village level ranging from recognition of families – conducting marriages without dowry exchange and imparted technical degrees to daughters belonging to families with only girl children.
- There is a need to formulate strategies inclusive of legal awareness, councelling, incentives and strict enforcement of laws.
- For preventing dowry exchange, a village level scheme to be formulated to honour those who have married without dowry.
- Similarly, a multi-pronged strategy for eve-teasing, molestation and rape should be formed.
- Special training to be imparted to act as a counsellor with a rape victim rather than investigator.
- As a short-term measure, a pension scheme for parents of girl children should be started.
- Similarly, for transferring of property in the name of women, concession in registration fees may be enhanced.

5.7. Police Station Reforms and Institutionalization of Delivery of Police Services

5.7.1. Police station Reforms and Institutionalization of Delivery of Police Services

i. Physical Infrastructure of Police stations

- **Online police service delivery –** It is proposed that online police service delivery system may be introduced in all the CPRCs. The main services include FIR Registration, Copies of FIR, Crime

details, proclaimed offenders, List of Banks/Petrol Pumps/Money Exchangers, List of Hospital/Schools/Hotels, List of Cyber Café/Marriage Palaces, List of NGOs/Press Reporters, E-Complaint, Complaint Status, Foreigner's Registration, PCC Status, Passport Verification Status and Download Forms. The Pilot projects functioning in districts of SBS Nagar and Kapurthala districts can be replicated in other CPRCs.

- **Incentive for pro-people police performance –** To promote community participation, the system of incentives should be organically built into police administration. It is proposed that a State-Level Community Policing Medal/Disc should be instituted. This should be based on the performance of the CPRCs. The performance measure must have built-in mechanism of improvement in the working of the CPRCs rather than merely ranking the units.
- **Grievance Redressal Unit (GRU) –** Commission recommends evolving such GRUs within the CPRCs to listen to the grievances of the public either against police or otherwise in any matter related with the police department. In-charge CPRC should take action in such public complaints within one week. All these complaints should be properly recorded (computerised) and action taken reports are to be submitted in the District Level Steering Committees of CPRCs. As categorised earlier, each district shall start GRUs in their respective centres as per the timeline mentioned corresponding to their respective category.
- **Quota for merit promotion –** A minimum quota of one per cent (within 10 per cent limit) for merit promotion be reserved for excellent performance in the field of community policing from the rank of Constable to Head Constable, Head Constable to ASI, ASI to Sub-Inspector, SI to Inspector.

5.7.2. Police Station Reforms

i. Capacity-building of police stations to perform specialised functions

- Categorisation of police stations such as tourism, sports, religious symbols and strategic locations, national and state highways, old/inner city, NRI population locations, crime specific such as cyber crime, drug-related crimes, human trafficking, economic offences, etc. There may be a need to create intelligence and counter-intelligence units in some of the Police Stations.
- For ensuring traffic enforcement and road safety particularly on the national highways, state highways and district roads, the police stations have to be equipped with trained human resources, specialised equipments such as recovery vans, cranes, speed radars besides ambulances equipped with life-saving gadgets etc. And, in view of the rapid urbanisation and

changing life styles, 24-hour urban police stations may have to be accordingly restructured with manpower, tools and technologies to meet these additional responsibilities.

ii. Liberal DDR entries and registration of crimes

- DDR entry points may not be confined to the police station alone. CPRCs to be upgraded for this purpose so that the complainants are not subjected to any extra burden/ inconvenience. There should be proper monitoring of the entries made in the DDR and the SHOs be made accountable for each and every entry.

5.7.3. Human Resource Management at the Police Station Level

i. Redeployment of staff

- The districts of Amritsar and Gurdaspur have disproportionate police-population ratio and have unsatisfactory performance index. This shows that more police strength may not necessarily lead to better performance. However, the districts of Barnala, Bathinda, Faridkot, Hoshiarpur, Ludhiana, Moga and Mukatsar have poor police-population ratio. This needs to be rationalised.

ii. Appointment of Inspectors for specialised functions

- In police stations, two Inspectors other than the SHO, may be appointed in a police station. One Inspector should be dedicated to the investigation work and another as in-charge of Police Station Outreach Centre (proposed to be set up) for law and order, delivery of police services and community policing work.

iii. Withdrawal of Police station staff from security of individuals

- Deployment of the police station staff for the 'security of individuals' must be discontinued forthwith. For the security of the individuals, an additional force may be sanctioned. A transparent system be put in place, preferably a Security Board to be constituted to scrutinise the genuine security needs of the concerned individual and allow the level of security.

iv. Separate Investigation Cell in police stations

- Dedicated team of 1 SI/ASI, 1 H.C. and 2 constables be deputed for conducting the investigation work in the police station.

v. Specialised District Level Investigation Cell

- A separate district level investigation cell should be set up as per the Police Act 2008.

vi. Performance and Posting of SHO

- SHO's tenure should be fixed for a minimum period of one year. (Section 15 of Punjab Police Act)
- The tenure can be extended as per the specialized requirement of the police stations catering to NRI population and tourists and

the police stations predominantly dealing with cyber crimes and drug-related crimes.

- Regular performance audit of the SHO's work should be conducted.
- A sub-committee consisting of Range DIG and district SSP to take decision on the posting and transfer of SHO after perusal of the performance audit.

vii. Transparency in malkahans

- Malkhanas in police stations are a major source of pilferage, misappropriation and theft of not only costly items deposited as the case property but also for promoting drug abuse through the sale of narcotics confiscated by the police authorities. During this era of terrorism, misappropriation of the weapons and explosives from Malkhanas happens to be quite common. MHC is over-burdened with paper work. A regular custodian of the case properties has to be appointed for each Thana who should be an NGO. This will also improve the conviction rate since the production of the case property is very crucial for the success of the related case.

5.7.4. Efficient Disposal of Cases

i. Constitution of Dedicated Cadre for Investigation

- The disposal rate is a measure to know the percentage of cases investigated to the total cases meant for investigation (including pendency) in a year. As investigation is a specialised activity, a dedicated cadre may be constituted.

ii. Efficiency Management

- A comparative statement of the average time taken by the investigator to complete the investigation (crime category-wise) to be prepared for every police station. Further, there is a need to monitor the chargesheeting rate by calculating the percentage of cases chargesheeted to the cases in which investigation was completed.

iii. Monitoring Mechanism

- An Inspecting Officer to prepare for the police station a monthly report on the number of challans submitted in the court and the number out of these that were submitted within the prescribed time.

5.7.5. Traffic Management

- It is recommended that alongwith Mega Cities Traffic Plans, a State-wide traffic management policy should be formulated.
- Special plan of action should be prepared to check accidents on the routes and locations in the districts that are prone to accidents.
- Public sector transport system to be strengthened.

- Non-motorised transport users should provide training in road safety and they should be challaned in case of violations.
- Procurement of permanent driving licence should be provided after adequate training and strictly on merit.
- Regular medical checkup and verification of documents of commercial vehicles should be periodically undertaken.
- Stray cattle or dogs on the roads should be tackled for preventing fatal accidents.

i. Heavy Penalty for Violations

- Heavy penalty should be imposed for serious violations like **jumping red light, use of mobile phones, non-wearing of helmets or turban, triple riding, driving without valid driving licence, non-observance of speed limits, non-wearing of the seat belt while driving, consumption of liquor while driving**. Therefore, it is recommended that the present quantum of fine be increased on the Chandigarh pattern. Further, repeated violations of this nature should be dealt with more rigorously involving confiscation of the driving licence or disqualification from driving.

ii. Setting up of Traffic Advisory Committee

- A Traffic Advisory Committee be set up in the Community Policing Resource Centres to function as an interface between the traffic police and the commuters. The CPRC Committee can act as a Traffic Advisory Committee to avoid multiplicity of oversights. These Committees may perform the following functions:
    - To redress the complaints relating to the functioning of the traffic police.
    - Plan and advise on parking, regulation of traffic like speed limits etc.
    - To resolve disputes between citizens and contractors/staff of parking lots.
    - To grant permission for using traffic space for public functions.
    - To regulate delivery of driving documents
    - To plan education and awareness to the commuters regarding traffic rules and traffic congestion through FM radio and other available media.
    - To help appoint traffic marshals to assist the police to make their functioning as transparent as possible.
    - A citizen's traffic awareness and information unit may be set up in each CPRC at the district level, CPSC at the sub-divisional level and police station outreach centres in police station level.
- E-Complaint tracking system for registration to FIR to investigation to chargesheeting.

5.8. Business Process Re-Engineering In Government

5.8.1. Department of General Administration

- The department would implement Integrated Work flow and Document Management System (IWDMS) in Main and Mini Secretariat.

5.8.2. Department of Industries and Commerce

- The department would bring transparency and efficiency in the procurement process. Implementation of e-tendering.

5.9. Health, Drug Control, Food Safety and Information Systems

5.9.1. Department of Health

i. Registration of births and deaths

- Notifier – At present Village Chowkidar notifies birth and death to the Local Registrar. ASHA workers should be declared as notifier.
- Local Registrar – ANM may be declared as Local Registrar.
- Delayed registration – ANM (new Local Registrar) should be authorised to make registrations after taking the approval from the Senior Medical Officer of PHC (in place of District Registrar who is Civil Surgeon).
- Delayed registration – after one year – Registration within 10 years, there is little possibility of misuse and therefore for such cases the process adopted for registration within one year should be adopted.
- Entry of names in time barred cases – Entry of names should be permitted without any limitation.
- Digitisation of records – The Commission has suggested three points:
  - Digitisation should be linked from the e-governance project.
  - Suvidha Centres be authorised to digitise the records.
  - To declare the incharge of Suvidha Centres as Additional Registrar for the purpose of maintenance of digitised record and issuance of copies.
- Fees – The Commission has suggested that no fees should be charged upto one year and the notional liability should be carried by the State Government.

ii. Emergency medical response system

- The department should place a network of ambulances and central control facility in place. And upgrade medical emergencies in all FRUs.

iii. Regulatory Mechanism for Private Medical Facilities

- To put in place regulatory mechanism for private nursing homes and hospitals. RMP, Diagnostic tests, private health care is completely unregulated in Punjab.
- Quality of health service in terms of setting up basic minimum service standards. Need to work out a treatment protocol.
- Regulating Cost since health is an essential service and needs to treated as a 'right' of citizens. No monopoly or unreasonable gains be permitted for those who provide this service as 'business'.
- Grievance redress - establish the balance between critical and timely care from the service provider and protecting the rights of the consumers. Address the problems of asymmetric information.
- Establish the framework of 'social responsibility' for the service providers based on the belief that health is a service.

iv. Restructuring of Health Providing Institutions in Pubic Sector

- Health providing institutions, should be divided into three basic categories
  - Primary Care Centre's (where basic clinical services will be provided)
    - Primary care centre (at the mini PHC level) can provide clinical services, emergency support 24 by 7 and basic reproductive services. Elementary diagnostic facility, basic emergency care infrastructure and medicines needed for regular use should be available at the primary care centre.
    - Elementary indoor facility may be provided at these primary care centre. Emergency transportation vehicles, fitted with modern life saving equipment, will be available to transport patients to FRUs in case of emergency.
  - First referral units (FRUs)
    - FRUs should have a full fledged diagnostic centre where range of specialties will be made available. Current PHCs and/or CHC's can be converted into FRUs and there is also a need to create additional FRUs.
    - To create norms and facilities at FRU IPHS code should be followed, doctor availability should be ensured, norms for residences be clearly laid out, clear transfer and posting policy be framed, and diagnostics capacity to be strengthened in a major way. Most OPD's should be run by MOs.
  - Hospitals or multi Specialty hospitals.
    - The third tier of health care is at the level of hospitals and multi specialty hospitals.
    - The first challenge here is to have adequate doctors, in particular specialists.

- The administrative structure is complex and unwieldy and there are too many competing and overlapping layers. There is urgent need for realigning. Existing agencies that are in operation are PRI, PHSC, DHS, NRHM, and various special initiatives under national disease control programs.
- There is a structural mismatch in the institutional arrangement of Central and State Ministries: into departments of Health, Family Welfare and Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy (AYUSH). Such fragmentation makes inter-programme integration problematic, diluting the technical capacity to think holistically and duplicating resource use.
- There is a need to enhance the capacity of health workers. Doctors who hold administrative position need to be trained in management and administrative skills. There ought to be constant in house training programs to train and upgrade the skills of paramedics, nurses and other medical staff. Trauma training and counselling services should be given priority at the moment in the area of training because of high incidence of accidents in the state.

v. Framing Punjab State Health Policy

- The first major challenge for the state is its need to have its own health policy based on its own specificities. A small example of this reality is the mismatch between morbidities in the state and the disease control programs in operation here.

vi. Enhance Resource Allocation of Public Health

- Initiate steps to improve health status of Punjabi society - increased taxation on products (drugs, alcohol) to bring down their consumption, stringent regulation on food to reduce salt, fat intake; ensuring universal immunization; rehabilitation of patient who leave hospitals; availability of drugs; and availability of nutritional support.

vii. Formulation of Food Regulation Act including State Level Advisory Committee

- On the regulation of food, the Central Act may not serve the purpose since it suffers from many lacunae and Punjab needs to create its own legal provisions learning from the short sightedness of the Central Act. The bill emphasizes science-based standards, when most international food safety related legislation emphasize the need for health-based standards.

viii. Health Policy

- Punjab Health Policy to take into consideration morbidity patterns in the State.
- Health policy must address Public health concerns. There is an urgent need of framing policing to ensure availability and accessibility of safe drinking water, sanitation, conduct of health impact assessment of all development initiatives, tackle life style

related diseases like use of tobacco and alcoholism and other substance abuse and ensure road and transport safety.

- To ensure the appropriate list of medicines to be supplied there are lots of process issues that need to be addressed. Punjab's major disease burden is still formed by diseases that are dependent very much on basic water and sanitation and directly related with levels of income at the household level. The National programs to address specific morbidities might not be enough to meet the state specific needs. The specific disease patterns make a compelling case for programs and strategies which are designed keeping in mind the specific reality.

5.9.2. Drug Control

i. Licencing and related activities

- **Information and facilitation**
  - Develop a separate website
    - Display of rules, check lists, forms on the drug controller website.
    - Facility for downloading the forms.
    - Client charter/standards of response, time lines and clear access systems.
  - Maintaining electronic data base of all licensees in a form convenient for MIS/analysis.
- **Information Systems**
- **Approval of additional drugs**
  - Display all drugs already approved for manufacture on the State Drug Department website alongwith check list for new additions and service standards. Online acceptance of applications could follow in due course.
- **Inspection and sampling**
  - Guidelines to be issued for inspection and sampling:
    - Separating intelligence based and routine inspection – the latter should be on a purely random basis.
    - Based on ABC analysis, develop guidelines for inspection and random sampling of manufacturers/other licencees and review annually in consultation with the State Advisory Committee.
    - **Intelligence based inspection and sampling:** mostly for spurious drugs to be left to local initiative.
    - **Team based sampling and inspection system**: for routine random inspections and sampling.

ii. Contents of suggested guidelines

- **Random sampling:**
  - Should broadly be in the ratio of:
    - consumption of drugs in Punjab of State and out of State manufactured drugs;
    - consumption in rural and urban areas.

- Priority to sampling of expensive drugs which provide much higher incentives for violation (these can be suitably classified).
- Define percentage of sampling for misbranded drugs/other categories (in case felt necessary).

- **Feedback on and review of Guidelines**
  - Get operational feedback by setting up district level committees to be convened by the drug inspectors. Nominees of state level associations apart from NGOs could be members of the district committee.
  - Feedback from the state level committee for annual review.
- **Information and data systems**
  - The district and state health statistical units should be reorganized to function as information systems division of the health department including drug control wing.
  - The department should make use of the district data centres and the state data centre facility for connectivity, storage and security of data and even for multimodal communication (video conference etc.).
  - Drug control and similar units should be allowed and encouraged to make use of the district and state information systems units of the health department for this purpose.
  - Laptops/ note books should be provided to the drug inspectors.
- **Enforcement through information**
  - Place on the web site, a list of licencees from whose premises samples are taken, along with the results and action taken.
- **Control of NDPS Drug Abuse**
  - Maintain data for different classes of drugs manufactured/imported in the State and available for trade/consumption in the state.
  - Track the sale, trade and consumption by:
    - prescribing **monthly returns** to be filed with the department by distributors/whole sellers regarding; (a) receipt by of NDPS drugs; (b) sale within the State, with details of the licencees to whom sold;
    - requiring retailers to maintain a monthly abstract of NDPS drugs/received/sold/in stock, in addition to records already provided for under law.
  - Compile the data, analyse and incorporate **findings in** the annual guidelines for the Drug Inspectors for inspection of licensee premises.
  - Based on this analysis, prepare strategy for demand management.

iii. Resources

- Two posts of SDC/Joint Controller testing to be created and post of drug analyst to be filled up.
- Adequate budget for payment for sample costs.
- Adopting PPP model for providing lab testing services.

iv. Performance Indicators

- Rate of failure of samples – overall/specific issues of concern such as spurious drugs.
- Annual comparison inter district.
- Ratings to be given (above average, average, below average).
- Annual change in the failure rate – for the State and the Districts.

5.9.3. Food Safety

i. Licences

- The process needs to be streamlined as per law and confusion regarding jurisdiction should be removed – (Civil Surgeons vs local Municipal Committees) immediately and implementation of whatever decision is taken ensured.
- A sub-site/website to be developed for food safety giving procedure for issue of licences, the application forms, fees and service standards etc. on the lines suggested for the Drug Control Wing.
- Promotional publicity and inter action with the trade highlighting the legal obligations of dealers to get a licence and penalties for violation to ensure 100% coverage of food trade as per law.
- Digitizing the licencee records, if necessary by out sourcing and updating periodically. **Make a start by borrowing the client data base from the sales tax department**
    - **Inspection & Sampling**
        - Guidelines to be issued for inspection and sampling.
        - Separating intelligence based and routine inspection – the latter should be on a purely random basis.
        - Based on ABC analysis, develop guidelines for inspection and random sampling of manufacturers/other licencees and review periodically in consultation with the State Advisory Committee.
        - Focus on manufacturers and wholesalers rather than retailers (the share of the latter is reportedly 60% at present.
        - **Intelligence based inspection and sampling:** mostly for adulterated food to be left to local initiative.
        - **Team based sampling and inspection system**: for routine random inspections and sampling.

ii. Contents and review of guidelines

- The department should issue annual guidelines after discussion with the field officers and a State level advisory committee (to be set up) regarding inspection and sampling of food items on the lines being done already.
- The focus at present could be on; (a) milk and milk products; (b) use of toxic colours for food items especially sweets; (c) cold drinks; (d) pulses and (e) loose sale of spices etc.
- District level advisory committees should be set up and their feedback should be taken note of while issuing/renewing annual guidelines.
    - **Integration of public health and sanitation functions**
        - Sanitation- hygiene and public health at the licencee premises - should also be the responsibility of the food inspectors and they need to be empowered under the appropriate law, till the time Food Safety ACT COMES IN FORCE.
        - Licensing should incorporate conditions regarding licencee' liability for food hygiene at the premises, especially regarding storage and disposal of waste.

iii. Enforcement Staff

- Single line professional authority and control, at all levels, without waiting for the new Act to be enforced- for the present senior staff can be given district in charge duties in addition to their field duties.
    - **Information and data systems**
        - District and state health statistical units should be reorganized to function as information systems division of the health department.
        - The department should make use of the district data centres and the state data centre facility for connectivity, storage and security of data and even for multimodal communication (video conference etc.).
        - Food safety and similar units should be allowed and encouraged to make use of the district and state information systems units for this purpose.
        - Laptops should be provided to the food inspectors through interest free loans.
        - On line/IVRS/ SMS systems to encourage whistle blowers and flow of information with some built in reward systems.
    - **Enforcement through information**
        - Place on the web, a list of food licencees from whose premises samples are taken, along with the results and action taken.

- **Assessment of Performance**
  - Rate of failure of samples – overall and for areas vital areas such as toxic colors, milk products etc.
  - Annual comparison inter district.
  - Ratings to be given (above average, average, below average).
  - Annual change in the failure rate – for the State and the Districts.

5.9.4. Data and Information Systems

i. Reorganization of statistical units

- The district and state health statistical units should be reorganized to function as information systems division of the health department and should service all divisions and wings including drugs, food safety etc.
- The health department should make use of the district data centres and the state data centre facility set up by IT Department for connectivity, storage and security of data and even for multimodal communication (video conference etc.).

ii. Nature of data/information to be compiled by the Information Systems Division

- **NRHM proforma** – to be continued as required by Government of India.
- **Communicable disease proforma** – to be continued as required by Government of India.
- **Non-communicable disease proforma** – to be continued as required by Government of India.
- **Morbidity/Mortality proforma** – to be discontinued for reasons indicated.
- **Registration of deaths and related data**
- As already recommended ASHA to be declared as the notifier under the act so as to ensure that information especially regarding infant and maternal mortality is provided as prescribed in form-2.
- Form-2 regarding information about deaths to be modified to classify causes of deaths on the following lines:
  - Accident/homicide
  - Suicide
  - Natural causes – sub classified- water borne diseases, cancer, chest infections/all other diseases not specifically indicated.
- The data to be digitized starting with current entries and analysed at district, regional and state levels, to devise policy and programme interventions in regard to IMR, MMR, cancer, other diseases as per priorities of the State.

- Information required by Drug control, Food Safety and other wings such as Malaria control, TB etc. to be compiled as required by different wings.

iii. MIS and Data Analysis

- Considering that the hospitals and health institutions do not have any defined jurisdiction, the district should be the unit for comparison of results and performance.
- Result/performance indicators should be developed and data compiled and assessed district wise for the indicators.
- District performance should be assessed under the traffic light system – Green (+ Avg.), Amber (Avg.) and Red (- Avg.). It will be more appropriate than a ranking system, AND provide pointers for improvement, without necessarily indulging in a blame game.
- All data needs to be assessed annually for performance – a month or a quarter is not a long enough period except for purely quantitative items like family planning measures.

iv. Performance and Outcome Indicators

- Suggested performance and outcome indicators, the data and sources thereof and criteria for assessment are indicated below:

Performance and Outcome Indicators

Indicator	**Data and source**	**Assessment criteria**
MMR	Birth and Deaths Registers [as proposed by the PGRC (2nd Report), ASHA and ANM will have direct control of the data]	Annual change District and State level
Institutional & home delivery percentage	As per present system- ASHA/ANM reports/ Institution data	Annual change District and State level
IMR	Births and Deaths Register - (as above)	Annual change District and State level
Sex Ratio at Birth	Births and Deaths Register - (as above)	Annual change District and State level
Common/ major diseases-Prevalence (e.g. water borne diseases)	Percentage of patients in each category of major diseases; Total number (indoor and outdoor) patients	

Information about number of patients and deaths –av. in proformas and village death register abstracts
Annual change
District and State level

v. **Urban Hospitals-effectiveness/efficiency**
   - Number of outpatients per MO
   - Inpatients per MO/Nurse
   - Average number of lab tests per technician
   - Average number of X-Rays per unit
   - ECG etc. per unit machine
   - Average bed occupancy ratio
   - Costs-maintenance cost, raw material cost per laboratory (optional).

Data collected already

Annual performance
Institution level

5.10. Institutional Framework for e-Governance

5.10.1. Urban Civic Service Centres

- There is an urgent need to bring together the services of all the departments under one single umbrella and give citizens a "multi-service" - "single-window" experience in the cities apart from eradicating the undue harassment met by the citizens due to lack of transparency.
- **Master Urban Civic Centres** – Every city would have one master urban civic centre showcasing the delivery of services to the citizens as one stop citizen service centre. The type of centre may depend on the type of urban local body.
- **Other Civic Service Centres (CSCs)-** Apart from the Main Civic Centre in every urban local body, there would mandatorily be number of other civic centres spread across the city.

5.10.2. Optimizing Suvidha Centres

- Optimize service delivery for designated services within 6-months.
- District Suvidha Centre information cum complaint centres-off line/ on line as resources permit- for Inf/assistance/ (residual) grievance recording and monitoring RTI/ other information on sector services-to be setup in six months.
- Develop single window web based inter active information/ complaint systems for the major ULBs; for others outsource to Suvidha Centres.
- Provide RTI / other information on sector services at the district Suvidha Centres.

5.10.3. Networking and Data Management

- District Suvidha Centres be service providers for other departments for data uploading, storage and transmission.
- Data centres be established in each district at the Suvidha Centres/P.O.Ps, to service all departments in respect of sub district level data.
- State departments should be provided connectivity to the state and district data centres.
- MIS systems to be developed for key indicators and performance monitor.
- Information/MIS in the data centres should be accessible to the district departmental heads and H.O.Ds.
- E-Gram Centres - In order to support and simplify governance for the government as well as the rural citizens, the village panchayat, the lowest rung of Panchayati raj system has to be empowered to harness Information and Communication Technology to raise the level of access and quality of services. It is possible only if the village panchayat is equipped with the IT infrastructure and support services by setting up an e-Gram Centre in each panchayat.
- It is accordingly proposed to equip all the tiers of PRI's with state-of-the art ICT facilities and capabilities to deliver the schemes and services to the citizens efficiently and effectively to fulfill the aspirations of the citizens. The e-Gram centres at the village level can truly emerge as one stop service centres for many line departments at the village level. These e-Gram centres would also enable the PRI's to build internal capability by automating most of the routing accounting and reporting functions.

5.11. Institutional Framework for Community Policing and Access to Police Services

5.11.1. Community Policing Resource/Suvidha Centres

i. Revamp Community Policing Resource Centres at the district level

- For fixing some standards for time and quality of services based on the existing capacity and infrastructure of their CPRCs, police districts have been divided into three categories for the time-bound adoption of this proposed citizen charter.
- Category I: CPRCs at Nawan Shehr (SBS Nagar(, Patiala, Sangrur, Bathinda, Ferozepur, Kapurthala, Mansa, Ropar, Ludhiana and Hoshiarpur should straight away adopt this citizen charter after the initial sensitisation of their staff. (Action will be taken within three week).
- Category II: CPRCs at Batala, Barnala, Faridkot, Jalandhar, Khanna and Gurdaspur districts need to create more space and improve infrastructure and facilities to implement proposed charter after staff sensitisation which is prerequisite for effective implementation. These centres should adopt this charter within

one month. Since these districts need to create more space and improve infrastructure, it will take some time. Therefore, this recommendation will be implemented in two months time.

- Category III: CPRCs at Amritsar, Tarn Taran, Moga, Majitha, Jagraon, Mukatsar, Fatehgarh Sahib and Mohali either need to relocate or create more space to run these centres properly. Proper office facilities and specialised staff need to be arranged. As such, these centres should be given two months for the adoption of the charter. (This recommendation will be implemented within 6 months time).

ii. Community Policing Suvidha Centre (Sub-division level)

- To set up 79 Community Police Suvidha Centres at the sub-division level to promote easy access to the police services (see attached list)

5.11.2. Police Station Outreach Centres

To provide space for the citizens to avail these services at the police station level. 300 Police Station Outreach Centres are being set up for this purpose.

Crime Related Services

Copies of FIR

On line/immediate

Copies of untraced reports (As per Time-line suggested in the Report)

i. Passport Services

- **Passport verifications**
- **Emergency/urgent passport verification (time line 20 days)**

ii. Arms License Verification

- **Verification for new Arms license**
- **Verifications for renewal of Arms license and other services**

iii. Registration of vehicles

- **Verification for registration of vehicles**
- **NOC for stolen/recovered vehicles**

Permission for fairs

Permission for fairs/melas/exhibitions/sponsored events etc.

Permission of loudspeakers etc.

Permission for use of loudspeakers/orchestras at social functions etc.

Issuance of NOCs on setting up of petrol pumps, cinema hall etc

NOC with regards to public nuisance, safety

Issuance and renewal of licenses (Arms Dealers etc.)

NOC with regard to public nuisance, safety concerns etc.

iv. Police Clearance Certificate

- Service verification.
- Character verification.
- Stranger Verification.
- Tenants and servants.
- Verifications.
- Other related services.

v. Issuance of copy of Miscellaneous documents

- Issuance of copy of documents
- To promote community participation, the system of incentive should be organically built into police administration. The performance measure must have built-in mechanism of improvement in the working of the CPRC's rather than merely ranking the units.

vi. CPRC Performance Indicators

- Police Public Committees at each level (number of meetings conducted)
- Spatial factors (demarcation of space, public utilities, etc.)
- Service provided by CPRCs (number of beneficiaries)
- Physical resource management (infrastructure like computers, communication facilities)
- Grievance redressal unit (number of complaints against police personnel dispensed)
- Community service cum information unit (number of verification and permission granted).
- Victim assistance unit (Number of people provided with medical systems)
- Child unit (number of calls on the helpline)
- Professional capacities (number of trainings conducted for the staff)
- Community mobilization (number of community awareness camps organized)

5.12. Department of Power

- Release of Electric Connection under domestic/non-residential supply category for load upto 50 kw.
- Release of electric connection under domestic/non-residential/bulk supply category for load above 50 kw.
- Change of name
- Shifting of connection
- Re-connection order
- Meter change order/meter challenge
- Challenged bill

Annexure to Introduction

Annexure I — A list of affidavits that have been eliminated

After the receipt of recommendations of Punjab Governance Reforms Commission, a number of schemes in which self-declaration has been implemented instead of affidavits.

1. Succession certificate
2. Dependence certificate
3. Freedom fighter certificate
4. Counter Sign
5. N.O.C. of marriage palaces
6. N.O.C. of video parlours
7. Title of printing press/Newspaper
8. Regarding character certificate (for Media related)
9. Issue of nambardari certificate
10. Advance of G P fund
11. Final payment of G P fund
12. Medical reimbursement
13. NOC for issue of passport
14. Apply Ex-India leave
15. Inter district transfers
16. Employment on compassionate ground
17. Reimbursement of medical bills
18. Affirments regarding complaint
19. Regarding issue of new ration card
20. Regarding issue of duplicate and replaced ration card
21. Addition of name in ration card
22. Regarding editing of name in ration card
23. Regarding caste certificate
24. Certificate of residence
25. Regarding Schedule Caste certificate
26. Regarding backward class certificate
27. Regarding rural area certificate
28. Certificate of others backward
29. Certificate of agricultural income

30. Regarding late registration of death
31. Regarding late registration of birth
32. Regarding registration of birth certificate
33. Regarding amendments in birth certificate
34. Regarding amendments in death certificate
35. Regarding non-encumbery certificate
36. Registration of marriage under Hindu Marriage Act
37. Regarding of marriage under Special Marriage Act
38. Regarding dependence certificate regarding succession certificate

– Sd
Deputy Commissioner
Sangrur

Annexure II — Framework For Private Health Regulation Bill

Background: Engaging the private sector and controlling health markets will need to have a basis–a framework of rules, regulations and transparency. This is because, in the ultimate analysis, service delivery is based on discretionary judgment of the provider and this can (and does) change from case to case, since no single case is similar to another. Balancing the dual role of protecting the interest of the patient and his own creates a grey area where the provider can abuse his power by getting the patient to undergo unnecessary tests and procedures, stay longer in the hospital, or resort to irrational prescribing, etc. One most effective way of countering such perverse incentives and speeding the restructuring process of provider markets to offer multi-skilled quality care under one roof is through standards and treatment protocols and having a system for enforcing them. Standards-based payment systems do help in enforcing provider accountability, and also check unethical practices and conflict of interest issues.

In some places, there is a clear nexus between the private medical practitioners and pharmacy shops– pharmacy shops are often 'owned' by the doctors; most private doctors depend on referrals from quacks who act as 'procuring' agents for getting patients to their facilities for which a certain commission is paid; fee-splitting between diagnostic centres and referring doctors, AYUSH practitioners practising allopathy; etc. Such practices contribute to increasing the costs on account of over-prescription of drugs, over-diagnosis of tests and over-treatment, or subjecting the patient to unnecessary investigations and procedures. The indiscriminate proliferation of technology is a clear pointer at the back of such tendencies.

Cited above are some of the dimensions related with the delivery of the private health care for which the State needs to develop a regulatory framework. Detailed rationale for providing such a framework is provided in the Report.

Aspects of private health care that need to be regulated are:

1. Quality of health service in terms of setting up basic minimum service standards. Need to work out a treatment protocol.
2. Regulating Cost since health is an essential service and needs to treated as a 'right' of the citizens. No monopoly or unreasonable gains be permitted for those who provide this service as 'business'.
3. Grievance redressal - establish the balance between critical and timely care from the service provider and protecting the rights of the consumers. Address the problems of asymmetric information.
4. Establish the framework of 'social responsibility' for the service providers based on the belief that health is a service

For 1: **Quality of Health Service - Need for Standards and Treatment Protocols**

The question under quality of care is whether the people receive value for their money. No one knows, as there are no norms or yardsticks with which to measure good quality against inferior. All that is known is that while the private sector has expanded access and been responsive to the patient needs, competitive pressures have set off a 'technology race', making quality a concern. While on the one hand, there is the private sector getting known to overtreat, undertake unnecessary and expensive investigations; on the other hand, there

is the rapid mushrooming of substandard facilities indulging in malpractice with impunity. The private sector, particularly at the lower end of the spectrum, is seen to have a poor knowledge base and tends to follow irrational, ineffective and sometimes even harmful practices for treating minor ailments. In the absence of a nationally accepted set of standards and quality assurance mechanisms, there is a disturbing perception that equates the use of sophisticated technology with 'good' quality and good value for money. In the health sector, the patient's perceptions determine health-seeking behaviour, which have important implications in a system where money follows from the patient.

In the long run, quality reduces morbidity and mortality, which entail huge costs to the society and family when a breadwinner dies. However, the motivation to institute quality assurance systems for enhancing patient safety will be a low priority so long as the payments are based on fee for service for, in such a system, every visit and every additional investigation brings revenue to the provider. Therefore, non-development of the standards and non-establishment of the quality assurance systems either by law or professional bodies is a barrier for expanding social insurance.

(a) Nursing Homes and Hospitals

- Setting up minimum decent standards and requirements for each type of unit; general specifications for general hospitals and nursing homes and special requirements for specialist care, example: maternity homes, cardiac units, intensive care units etc. This should include physical standards of space requirements and hygiene, equipment requirements, manpower requirements (adequate nurses, doctors, bed ratios) and their proper qualifications etc.
- Maintenance of proper medical and other records which should be made available statutorily to the patients and, on demand, to the inspecting authorities
- Filing of minimum data returns to the appropriate authorities e.g. data on notifiable diseases, death and birth record, patient and treatment data etc.
- Regular medical and prescription audits which must be reported to the appropriate authority.
- Regular inspection of the facility by the appropriate authority with stringent provisions for flouting norms and requirements.
- Proper geographical distribution to prevent over-concentration in certain areas.
- Periodic renewal of registration after a through audit of the facility
- Doctors to write only generic drug prescriptions and, in special circumstance, provide reasons for not doing the same

(b) Private Practitioners

- Ensuring that only properly qualified persons practise.
- Compulsory maintenance of patient records, including prescription, with regular audit by concerned authorities.
- Regulating a proper geographical distribution and switching over to family practice.
- Filing appropriate data returns about patients and their treatment.
- Provision for continuing medical education on a periodic basis with license renewal dependent on it.

- Doctors to write only generic drug prescriptions and, in special circumstance, provide reasons for not doing the same

(c) Diagnostic Facilities:

- Ensuring quality standards and qualified personnel.
- Audit of tests and procedures to check their unnecessary use.
- Proper geographical distribution to prevent over-concentration in certain areas.

(d) Pharmaceutical industry and Pharmacies:

- Allowing manufacture of only essential and rational drugs.
- Regulation of this industry by the Health Ministry.
- Formulation of a National or State Formulary of generic drugs which must be used for prescription by the doctors and the hospitals.
- Ensuring the pharmacies are run by pharmacists through regular inspection by the authorities.
- Pharmacies should, on a first principle basis, dispense only generic drug prescriptions and must retain a copy of the prescription for audit purposes. In case generic drug is not dispensed, specific reason must be put in the records for the same.

For 2: Equity: Cost of Care - Regulating Cost

Most literature on the private sector has found it to be 'exploitative' and three to four times more expensive when compared to the public sector, making it inaccessible to the poor and the chronically ill. In the private sector (barring some faith-based institutions), pricing is influenced to a large extent by the market prices of inputs–land, building, equipment, provider payments, etc. Based on this understanding, the Government extended subsidy to the private sector–the logic being that in subsidizing the actual cost of inputs by giving land free or excise waivers on import of equipment, it would enable lowering of the prices. Such 'lowered prices' were then seen as a social gain, justifying the public subsidy. Time has shown this logic to be faulty.

It is necessary for the Government to undertake the unit costing of services. This is an important and useful exercise even for itself as it gives the benchmark with which to compare the extent to which the private pricing structures are unreasonable. Such pricing would also help to instil some consciousness of costs and prices, which is very necessary, as there is nothing called 'free health care' since someone does pay for it–directly through user fees or indirectly through taxes. Therefore, when the Government provides 'free care' it reflects the principle of solidarity where the richer sections, through taxes, enable the poor or all sections of society to obtain free or subsidized care depending on the value the society attaches to health. This then makes it unjustifiable to allow wasteful use of these resources which happens as a consequence of not being 'cost conscious'.

- Since costs are context specific, a Working Group needs to be formed (already suggested in the Report) that, on a regular basis, updates/modifies/ and establishes the maximum costs for the delivery of health care. The group could consider different tiers of service and decide the permissible charges. The process of coming to be decision ought to be transparent and open to questioning from consumer groups and other stakeholders.

- Fixing reasonable and standard hospital and professional charges.
- Fixation of standard consultation charges.
- Standard/reasonable charges for various diagnostic tests and procedures.

4. Grievance redressal – establish the balance between critical and timely care from the service provider and protecting the rights of the consumers. Address the problems of asymmetric information. Here the framework already created by the Consumer Courts needs to reviewed and strengthened thereby ensuring proper balance between the supply and demand side.

5. Establish the framework of 'social responsibility' for the service providers based on the belief that health is a service. Establish clear and categorical guidelines for providing free or affordable care by private providers who benefit from the State subsidies of any kind. The norms of delivery of reciprocation have to be clearly laid out; reporting guidelines be made and a monitoring mechanism needs to be put in place.

Annexure to Chapter 2

Table 1: Number of Persons Ailing per 1000 (Population) in Indian States in 1995-96 and 2004				
	Rural 1995-96	Urban 1995-96	Rural 2004	Urban 2004
State	PAP	PAP	PAP	PAP
Andhra Pradesh	64	61	90	114
Assam	80	86	82	83
Bihar	34	41	53	63
Gujarat	46	36	69	78
Haryana	61	63	95	87
Karnataka	45	40	64	57
Kerala	118	88	255	240
Madhya Pradesh	41	38	61	65
Maharashtra	52	48	93	118
Orissa	62	62	77	54
Punjab	76	85	136	107
Rajasthan	28	33	57	72
Tamil Nadu	52	58	95	96
Uttar Pradesh	61	72	100	108
West Bengal	65	65	114	157
India	55	54	88	99

Source: Select Health Parameters: A comparative analysis across the National Sample Survey organisation (NSSO) 42nd, 55th and 60th Round, Ministry for Health and Family Welfare, Government of India in collaboration with World Health Organisation.

Table 2: Number of women and men age 15-49 per 100,000 who reported that they have diabetes, by State, India, 2005-06		
State	Women	Men
Andhra Pradesh	838	2,116
Assam	402	601
Bihar	1,024	940
Gujarat	968	524
Haryana	1,169	608
Himachal Pradesh	1,048	344
Karnataka	681	973
Kerala	2,549	3,078
Madhya Pradesh	558	555
Maharashtra	479	906
Orissa	556	1,179
Punjab	849	802
Rajasthan	282	362
Tamil Nadu	2,188	1,351
Uttar Pradesh	383	456
West Bengal	1,641	2,323
India	881	1,051

Source: International Institute of Population Science and Macro international .2007. National Family Health Survey (NFHS 3), 2005-06: India Volume 1

Table 3: Type of disease treated indoor and outdoor in Punjab, 2005			
	Outdoor Patient share	Indoor Patient share	Death share
Infectious and parasitic diseases	**9.1**	8.5	**19.0**
Neoplasm's	0.2	1.0	2.5
Diseases of blood and blood forming organs	6.8	3.0	2.4
Endocrine, nutritional and metabolic diseases and immunity	2.6	2.4	4.1
Mental disorders	1.2	1.2	0.3
Diseases of the nervous system and sense organs	0.6	0.8	3.2
Eye and Odenexa	7.3	5.3	0.0
Ear and Masoid	3.4	0.7	0.0
Diseases of the circulatory system	4.4	5.9	22.9
Diseases of the respiratory system	**18.6**	5.8	12.3
Diseases of the digestive system	9.9	6.7	5.0
Skin and Sub- coetaneous Tissue	10.0	1.0	0.2
Muscular Skelton system and connective tissue	4.5	1.0	0.1
Diseases of genito-urinary system	2.7	6.7	1.6
Complication of pregnancy, childbirth and the puerperium	2.0	15.1	0.8
Prenatal Period	0.2	2.0	1.3
Congenital anomalies	0.0	0.2	0.4
Abnormal clinical and laboratory finding	11.5	10.6	5.6
Injury and poisoning	3.8	10.6	9.9
External causes of morbidity and mortality	1.1	11.2	8.4
Others unspecified	0.3	0.0	0.0
Total	100.0	100.0	100.0
Source: Statistical Abstract of Punjab , 2007, Government of Punjab			

Table 4: Hospitalisation across MPCE quintiles by caste and gender in rural areas of Punjab (In percentage)

	Punjab			India		
MPCE quintile	Public Hospital	Public Dispensary	Private Hospital	Public Hospital	Public Dispensary	Private Hospital
1	42.90		57.10	52.24	2.86	44.89
2	29.29		70.71	48.36	1.14	50.50
3	35.57		64.43	41.79	1.54	56.67
4	14.91	0.88	84.21	36.03	1.26	62.70
5	21.06	2.37	76.57	27.89	1.54	70.57
caste						
ST	0.00	0.00	0.00	57.10	1.30	41.50
SC	25.00	0.00	75.00	54.20	2.40	43.40
OBC	32.40	1.60	66.00	33.30	1.40	65.30
Others	26.50	1.10	72.40	36.00	1.50	62.50
Sex						
Male	29.00	0.40	70.60	40.10	1.50	58.40
Female	24.20	1.10	74.80	39.30	1.70	59.00
	372084	3757	372084	7478128	293099	10855468

Source: Calculated from the unit level data of NSSO 60th Round (January – June 2004) on Morbidity.

Table 5: Hospitalisation across MPCE quintiles by caste and gender in urban areas of Punjab (In percentage)

	Punjab			India		
MPCE quintile	Public Hospital	Public Dispensary	Private Hospital	Public Hospital	Public Dispensary	Private Hospital
1	25.57	0.00	74.43	51.44	2.95	45.61
2	17.18	0.00	82.82	39.40	4.92	55.68
3	32.33	0.00	67.67	35.45	3.11	61.44
4	31.23	0.00	68.77	27.98	2.48	69.53
5	27.11	0.00	72.89	19.06	1.96	78.97
caste	0.00	0.00	0.00	0.00	0.00	0.00
ST	100.00	0.00	0.00	45.60	7.10	47.30
SC	24.70	0.00	75.30	46.60	2.80	50.50
OBC	45.30	0.00	54.70	35.50	2.80	61.70
Others	22.90	0.00	77.10	28.80	3.20	68.00
Sex	0.00	0.00	0.00	0.00	0.00	0.00
Male	21.60	0.00	78.40	34.90	3.30	61.80
Female	32.20	0.00	67.80	34.00	2.90	63.20
Number	63906		178498	3002789	253664	5258466

Source: Calculated from the unit level data of NSSO 60th Round (January – June 2004) on Morbidity.

Table 6: Average health expenditure and loss of income for Hospitalisation in Rural Punjab and All India across MPCE quintiles by caste and gender

Rural	Punjab				India			
MPCE	Medical	Other	Total	Household	Medical	Other	Total	Household
1	7221	310	7531	618	3840	408	4248	546
2	10931	530	11461	596	4168	468	4636	532
3	9620	402	10022	778	4856	464	5320	648
4	11654	602	12256	700	5335	517	5852	661
5	15449	824	16273	349	8178	667	8845	683
caste								
ST					3523	407	3930	560
SC	8612	523	9135	551	3980	414	4395	559
OBC	10214	381	10595	978	5739	551	6290	652
Others	13386	621	14008	571	6678	569	7247	636
Sex								
Male	10006	563	10569	665	5830	541	6371	753
Female	12837	558	13395	562	5229	498	5726	478
Total	12132	623	12755	589	5695	530	6225	636

Source: Calculated from the unit level data of NSSO 60th Round (January – June 2004) on Morbidity and the health care for aged.

Table 7: Average health expenditure and loss of income for Hospitalisation in Urban Punjab and All India across MPCE quintiles by caste and gender

Rural	Punjab				India			
MPCE	Medical	Other	Total	Household	Medical	Other	Total	Household
1	9579	138	9717	666	4504	314	4819	635
2	21488	834	22322	1134	5265	348	5613	602
3	11419	275	11694	766	7542	357	7899	574
4	14775	388	15164	550	8641	459	9100	702
5	25420	2921	28341	210	18460	955	19415	1273
Caste								
ST	402	100	502	0	5238	420	5658	826
SC	21541	795	22336	1321	6228	329	6558	500
OBC	6941	356	7297	469	7110	397	7507	624
Others	16095	904	16999	472	11233	611	11844	947
Sex								
Male	20185	1200	21385	1165	9494	549	10043	1104
Female	12323	301	12624	187	8064	415	8479	384
Total	16728	807	17535	728	8851	516	9367	745

Source: Calculated from the unit level data of NSSO 60th Round (January – June 2004) on Morbidity and the health care for aged.

Table 8: Cause of non-treatment in rural areas				
	Financial reason		Ailment not serious	
	52nd(1995-	60th(2004)	52nd(1995-	60th(2004)
Andhra Pradesh	262	256	562	371
Assam	92	183	580	366
Bihar	404	223	368	305
Gujarat	28	239	664	410
Haryana	129	107	559	321
Karnataka	227	326	584	280
Kerala	129	208	698	512
Madhya	210	188	454	391
Maharashtra	201	358	637	316
Orissa	230	224	383	253
Punjab	490	308	77	228
Rajasthan	603	351	257	229
Tamil Nadu	233	315	612	508
Uttar Pradesh	234	283	514	289
West Bengal	431	384	346	183
India	242	281	511	321
Source: Select Health Parameters: A comparative analysis across the National Sample Survey organisation (NSSO) 42nd , 55th and 60th Round, Ministry for Health and Family Welfare, Government of India in collaboration with World Health Organisation				

Table 9: Cause of non-treatment in urban areas				
	Financial reason		Ailment not serious	
	52nd(1995-96)	60th(2004)	52nd(1995-96)	60th(2004)
Andhra Pradesh	203	128	548	638
Assam	205	177	580	313
Bihar	249	146	554	676
Gujarat		83	524	489
Haryana	129	0	228	203
Karnataka	116	296	737	332
Kerala	124	96	686	710
Madhya Pradesh	104	185	524	362
Maharashtra	251	170	633	613
Orissa	454	385	356	323
Punjab	490	295	77	299
Rajasthan	603	345	257	334
Tamil Nadu	143	212	609	419
Uttar Pradesh	202	252	586	416
West Bengal	197	253	659	467
India	198	204	594	500
Source: Select Health Parameters: A comparative analysis across the National Sample Survey organisation (NSSO) 42nd , 55th and 60th Round, Ministry for Health and Family Welfare, Government of India in collaboration with World Health Organisation				

Table 10: Percentage of those who have not sought medical care in Rural Areas (excluding ailment not serious) when ill across MPCE quintiles India and Punjab		
MPCE quintile	Punjab	India
1	6.14	18.64
2	5.43	15.22
3	5.83	12.06
4	2.56	11.60
5	3.93	7.08
caste		
ST		19.20
SC	6.20	15.40
OBC	4.42	11.30
Others	3.25	11.30
Sex		
Male	4.30	12.80
Female	4.80	12.60
Number	101513	7949083
Source: Calculated from the unit level data of NSSO 60th Round (January – June 2004) on Morbidity and the health care for aged.		

Table 11: Percentage of those who have not sought medical care in Urban areas (excluding ailment not serious) when ill across MPCE quintiles India and Punjab		
MPCE	Punjab	India
1	5.64	9.71
2	5.73	7.82
3	1.00	4.74
4	0.72	3.87
5	0.48	2.57
caste		
ST	0.00	8.30
SC	3.40	8.40
OBC	5.20	6.20
Others	1.40	4.50
Sex		
Male	3.40	5.00
Female	1.60	6.20
Number	21484	1404640
Source: Calculated from the unit level data of NSSO 60th Round (January – June 2004) on Morbidity and the health care for aged.		

Table 12: District-wise Availability of Health Institutions, Punjab, 2009								
District/ State	**Sub-Centre**	**Subsidiary Health Centre**	**Primary/ Mini Primary Health Centre**	**Community Health Centre**	**Rural Hospitals**	**Sub-divisional Hospitals**	**District Hospital**	**Other special Hospital**
Amritsar	170	88	26	4	2	2	1	0
Barnala	75	35	8	4	3	0	1	0
Bathinda	136	60	18	9	3	2	1	1
Faridkot	62	17	8	4	0	1	1	0
Fatehgarh Sahib	73	23	13	4	1	1	1	0
Ferozepur	231	79	31	8	3	3	1	0
Gurdaspur	290	114	38	15	2	2	1	0
Hoshiarpur	244	86	29	10	3	3	1	0
Jalandhar	198	93	26	10	3	2	1	0
Kapurthala	88	43	10	4	3	2	1	0
Ludhiana	258	107	27	9	5	4	1	0
Mansa	103	37	12	4	2	1	1	0
Moga	121	52	19	5	2	0	1	0
Muktsar	102	43	14	5	3	2	1	0
Nawan Shahar	95	47	15	3	2	1	1	0
Patiala	191	60	29	11	0	3	0	1
Ropar	83	30	12	2	2	1	1	0
Sangrur	194	68	27	6	4	4	1	0
SAS Nagar	74	43	12	3	0	1	1	0
Tarn Taran	162	62	20	9	2	1	1	0
Punjab	2950	1187	394	129	45	36	19	2
Source: Mid Term Review of the 11th Plan.								

Table 13: Facilities at Sub-Centres,2007-08			
	Adequately equipped (at least 60%)	Essential drugs (at least 60%)	ANM/FHW available at sub centre
Andhra Pradesh	76.3	96.9	84.4
Assam	90.5	72.4	96.1
Bihar	49.6	5.9	91.2
Gujarat	98	94.1	94.7
Haryana	95	29.1	92.3
Karnataka	85.2	76.6	92.7
Kerala	77.6	96.4	97.6
Madhya Pradesh	92.4	93.7	90.2
Maharashtra	92.6	86.8	93
Orissa	47.3	35.8	78.1
Punjab	95.5	8.4	79.7
Rajasthan	92.6	84.4	86.5
Tamil Nadu	97.9	82.1	99.8
Uttar Pradesh	83.9	35.3	99.5
West Bengal	98.1	89	89.7
India	83.5	65.3	90.7

Note:
1. Equipments 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.
2: Drugs includes, Drug kit-A/B, IFA tablets, Vitamin A solution, ORS packet
Source: International Institute for Population Sciences (IIPS), 2010. District Level Household and Facility Survey (DLHS-3), 2007-08: India. Mumbai: IIPS

Table 14: Facilities at Primary Health Centre,2007-08						
	Residential Quarter for MO	24 Hour Functioning	At least 4 bed	Regular power supply	Functional vehicle	Essential drugs (at least 60%)
Andhra Pradesh	25.7	51.1	82.9	45.5	25.9	69.5
Assam	90.8	65.6	64.6	57.4	79.5	73.3
Bihar	62.2	64.5	75.8	9.5	45.8	58.2
Gujarat	56.6	46.9	77.1	72.3	74.9	53.3
Haryana	43	39.2	64.3	41.8	14.1	41.1
Karnataka	58.7	47	85.7	13.4	23.9	67.5
Kerala	24.9	10.3	27.4	96.9	15.8	15.8
Madhya Pradesh	63.5	73.1	66.6	20.4	29	62
Maharashtra	81.3	78.1	89.7	13.6	86.3	51
Orissa	53.4	49.2	31.3	41.5	17.2	32.1
Punjab	26.1	17.2	74.6	7.5	12.7	35.8
Rajasthan	63.3	56.9	89.9	12.1	11.4	28.9
Tamil Nadu	22.2	50.6	28.4	86.5	31	61.7
Uttar Pradesh	52.8	45.5	56.7	11.6	18.1	30.9
West Bengal	82.8	25.9	27	37.2	8.6	41.7
India	54.5	52.7	67.1	35.7	37.2	47.2

Source: International Institute for Population Sciences (IIPS), 2010. District Level Household and Facility Survey (DLHS-3), 2007-08: India. Mumbai: IIPS

Table 15: Facilities at Community Health Centres ,2007-08						
	Obstetric Gynaecologist	Paediatrician	Anaesthetist	Health Manager	Functional OT	24 Hours normal delivery service
Andhra Pradesh	42.6	29	26.5	3.7	80.9	93.8
Assam	31.3	10.8	20.5	9.6	24.1	91.6
Bihar	40.9	43.9	19.7	34.9	86.4	90.9
Gujarat	11.3	4.7	9.4	0.5	65.6	97.6
Haryana	13.1	13.1	10.7	9.5	60.7	88.1
Karnataka	28.8	12.7	11	6.8	72	94.1
Kerala	14.3	15.7	2.3	0.5	26.3	18.4
Madhya Pradesh	15.8	18.5	10.4	9.3	70.7	99.6
Maharashtra	40.3	23.9	27	4.8	84.6	95.9
Orissa	87.3	69	50.7	57.2	59.4	79
Punjab	31.6	17.4	7.7	5.8	69.5	85.2
Rajasthan	29.9	23.1	17.8	2.8	60.3	98.9
Tamil Nadu	7.2	6.7	9.4	3	56.8	100
Uttar Pradesh	19.5	20.8	16	2.7	88.5	92.1
West Bengal	11.6	5.7	13.4	4.8	46.3	96.1
India	25.2	19.3	17.1	8.5	65.2	90
Source: International Institute for Population Sciences (IIPS), 2010. District Level Household and Facility Survey (DLHS-3), 2007-08: India. Mumbai: IIPS						

Table 16: Facilities at District Hospitals,2007-08										
	At least one medical specialist	At least one Surgery specialist	At least one Obstetric/ Gynaecologist	At least one Radiologist	Pap Smear services	ELISA for HIV Test	Ultra Sound	Blood Bank	24 hour water facility	Ambulance on road
A P	57.1	81	85.7	14.3	21.4	85.7	85.7	71.4	95.2	95.2
Assam	87	100	100	52.2	60	65.2	60.9	91.3	87	91.3
Bihar	73.5	82.4	88.2	50	100	73.5	17.6	52.9	91.2	91.2
Gujarat	60	76	88	36	0	76	88	64	96	96
Haryana	55.6	83.3	72.2	66.7	12.5	100	83.3	66.7	100	83.3
Karnataka	76	92	100	64	50	92	96	84	84	88
Kerala	100	92.3	69.2	30.8	34.8	69.2	46.2	69.2	100	100
M P	78.3	78.3	73.9	37	13	60.9	56.5	73.9	93.5	95.7
Maharashtra	81.3	84.4	87.5	71.9	20	87.5	84.4	87.5	90.6	93.8
Orissa	93.3	96.7	96.7	76.7	0	46.7	60	56.7	63.3	96.7
Punjab	100	100	90	50	75	65	85	75	95	100
Rajasthan	96.9	100	93.8	68.8	28.6	78.1	87.5	84.4	100	90.6
Tamil Nadu	79.3	79.3	82.8	51.7	100	69	96.6	93.1	93.1	96.6
U P	72.6	77.4	72.6	75	46.2	69	88.1	58.3	95.2	90.5
West Bengal	94.7	94.7	94.7	89.5	66.7	89.5	94.7	100	100	89.5
India	75.5	81.5	81.8	53.9	28.2	70	74.7	68.8	91.9	91.6
Source: International Institute for Population Sciences (IIPS), 2010. District Level Household and Facility Survey (DLHS-3), 2007-08: India. Mumbai: IIPS										

Table 17: Water Supply in Punjab			
	Total	Urban	Rural
Improved source	99.6	100	99.3
Piped water into dwelling/yard/plot	44.3	71.7	26.4
Public tap/standpipe	10.4	7.7	12.1
Tube well or borehole	44.6	20.2	60.6
Other improved	0.3	0.4	0.2
Non-improved source	0.4	0	0.6
Other source	0.1	0	0.1
Water treatment prior to drinking	Total	Urban	Rural
Boil	3.7	6.1	2.2
Strain through cloth	0.7	0.6	0.7
Use ceramic, sand, or other water filter	2	3.6	1
Other treatment	5.2	9.4	2.4
No treatment	88.8	80.8	94
Note: Total percentages may add to more than 100.0 because multiple answers are allowed. Source: International Institute for Population Sciences (IIPS) and Macro International. 2008. National Family Health Survey (NFHS-3), India, 2005-06: Punjab. Mumbai: IIPS.			

Table 18: Sanitation facilities in Punjab			
	Total	Urban	Rural
Improved, not shared	50.5	62.5	42.8
Flush/pour flush to piped sewer system, septic tank, or pit latrine	46.4	61.4	36.7
Pit latrine with slab	4	1	6
Other	0.1	0.1	0.2
Not improved	49.4	37.5	57.1
Any facility shared with other households	17.7	29.7	9.8
Flush/pour flush not to sewer system, septic tank, or pit latrine	0.6	1.2	0.3
Pit latrine without slab/open pit	1.8	0	3
Other unimproved facility	0.1	0.3	0
No facility/open space/field	29.1	6.3	44
Other	0	0	0.1
Missing	0	0	0.1
Source: International Institute for Population Sciences (IIPS) and Macro International. 2008. National Family Health Survey (NFHS-3), India, 2005-06: Punjab. Mumbai: IIPS			

Table 19: Household, Public and Total Health Expenditure 2004-05								
State	**Per Capita Household Expenditure in Rs**	**Rank**	**Per Capita Government Expenditure in Rs**	**Rank**	**Per Capita Other Exp in Rs**	**Rank**	**Per Capita Health Exp.**	**Rank**
Nagaland	4897	1	404	8	37	16	5338	1
Goa	3613	3	798	2	153	1	4564	2
A.P	3776	2	589	4	0	26	4365	3
H.P.	3377	4	486	5	64	9	3927	4
Kerala	2548	5	319	13	86	4	2952	5
Sikkim	1274	10	965	1	0	24	2240	6
J & K	1609	7	431	7	43	13	2082	7
Manipur	1680	6	356	10	32	19	2068	8
Punjab	**1379**	**9**	**326**	**12**	**108**	**3**	**1813**	**9**
Haryana	1518	8	189	21	79	7	1786	10
Maharashtra	1156	11	348	11	72	8	1576	11
Bihar	1021	13	124	26	23	22	1497	12
Assam	1089	12	239	16	19	23	1347	13
M.P.	746	20	164	24	35	17	1200	14
W.B.	931	14	205	19	52	11	1188	15
Gujarat	920	16	187	22	80	6	1187	16
Delhi	664	22	476	6	37	15	1177	17
U.P.	924	15	150	25	31	20	1152	18
Andhra Pradesh	820	17	216	18	82	5	1118	19
Tripura	760	19	301	14	40	14	1101	20
Mizoram	405	25	623	3	0	25	1027	21
Karnataka	702	21	231	17	64	10	997	22
Orissa	786	18	179	23	29	21	995	23
T.N.	566	23	248	15	119	2	933	24
Rajasthan	565	24	198	20	44	12	808	25
Meghalaya	242	26	388	9	34	18	664	26
All India	1012		304		61		1377	

Note: Govt. Expenditure includes Central, States, Local Govt., and PSUs; data obtained from States Finances (Provisional), RBI, Various issues; Other Expenditure includes foreign agencies, private firms and NGOs; Household expenditure is based on National Health Accounts 2001-02 and extrapolated for 2004-05

Source: Report of the National Commission on Macroeconomics and Health, page 70.

Table 20: Share of Households, Governments and Other in Health Expenditure			
	Household expenditure as % total Health Expenditure	**Public Expenditure as % of total health expenditure**	**Other Expenditure as % of total health expenditure**
Andhra Pradesh	73.38	19.39	7.29
Arunachal Pradesh	86.51	13.49	0
Assam	80.84	17.78	1.38
Bihar	90.17	8.3	1.53
Delhi	56.41	40.48	3.11
Goa	79.17	17.48	3.35
Gujarat	77.51	15.78	6.71
Haryana	85.03	10.56	4.4
H.P.	85.99	12.38	1.63
J & K	77.26	20.69	2.05
Karnataka	70.36	23.18	6.46
Kerala	86.3	10.8	2.9
M.P.	83.41	13.63	2.96
Maharashtra	73.34	22.1	4.55
Manipur	81.24	17.2	1.56
Meghalaya	36.45	58.37	5.18
Mizoram	39.39	60.61	0
Nagaland	91.74	7.57	0.7
Orissa	79.04	18.02	2.93
Punjab	**76.05**	**18**	**5.95**
Rajasthan	70	24.5	5.5
Sikkim	56.89	43.11	0
T.N.	60.67	26.61	12.72
Tripura	68.99	27.35	3.66
U.P.	84.28	13.02	2.7
W.B.	78.38	17.27	4.36
U.Ts.	85.13	8.74	6.12
All India	73.5	22	4.46
Source: Report of the National Commission on Macroeconomics and Health, page 70.			

Table 21: Percentage Distribution of Aggregate (budget) Expenditure of State Governments into Plan and Non-Plan Components (including both revenue and capital account)

	Low Income			Mid Income			High Income			Punjab		
	Total Plan		Total Non plan	Total Plan		Total Non plan	Total Plan		Total Non plan	Total Plan		Total Non plan
	State + CP/ CSS	of which CP/ CSS		State's + CP/ CSS	of which CP/ CSS		State's + CP/ CSS	of which CP/ CSS		State's + CP/ CSS	of which CP/ CSS	
1987-88	38.8	8.2	61.2	27.3	5.1	72.7	29.4	3.8	70.6	29.5	3.7	70.5
1988-89	36.2	9	63.8	25.6	5.7	74.4	26.4	4.5	73.6	26.5	7.7	73.5
1989-90	31.8	6.8	68.2	23.8	4.1	76.2	24.4	3.2	75.6	19.3	3.2	80.7
1990-91	32	11.3	68	22.8	5.3	77.2	23.2	2.2	76.8	22.8	3.7	77.2
1991-92	30.3	10.5	69.7	20.5	5.1	79.5	23.9	2.3	76.1	19	2.9	81
1992-93	27	9.2	73	22.7	6.1	77.3	25.2	2.8	74.8	21.6	4.2	78.4
1993-94	26.3	9.6	73.7	25.3	5.7	74.7	21.8	2.6	78.2	22.3	3.1	77.7
Average	**31.8**	**9.2**	**68.2**	**24.0**	**5.3**	**76.0**	**24.9**	**3.1**	**75.1**	**23.0**	**4.1**	**77.0**
1994-95	25.3	8.2	74.7	25.7	4.6	74.3	24.6	2.2	75.4	16.3	2.2	83.7
1995-96	24.7	6.8	75.3	26.3	3.7	73.7	24.5	2.4	75.5	19.4	3.5	80.6
1996-97	26	6.1	74	21.1	4.2	78.9	23.6	2	76.4	12.2	2.7	87.8
1997-98	25.5	6	74.5	21.9	3.7	78.1	22.8	1.8	77.2	16.2	2.3	83.8
1998-99	23.1	5.1	76.9	23.5	3.9	76.5	21.9	1.5	78.1	15.7	2.9	84.3
1999-00	21.1	4.7	78.9	20.6	3	79.4	20.5	1.4	79.5	13.2	1.8	86.8
2000-01	20.6	4.5	79.4	22.2	3.2	77.8	19	1.7	81	11.6	1.9	88.4
2001-02	21.5	4.7	78.5	22.6	3.3	77.4	14.3	2.1	85.7	13.3	1.1	86.7
2002-03	23.7	5.5	76.3	21.4	3	78.6	15.1	1.9	84.9	10.5	0.9	89.5
2003-04	19.6	4.4	80.4	23.7	2.9	76.3	17.5	5.4	82.5	7.6	0.7	92.4
2004-05	24.8	5	75.2	25.1	2.6	74.9	19.1	4	80.9	6.2	0.7	93.8
Average	**23.3**	**5.5**	**76.7**	**23.1**	**3.5**	**76.9**	**20.3**	**2.4**	**79.7**	**12.9**	**1.9**	**87.1**

Note: 1. The division of low, middle, and high income states is on the basis of real per capita income (at 1993-94 prices) for the year 2004-05 of a state.

2. Low income states – Assam, Bihar-undivided, Madhya Pradesh-undivided, Orissa, Rajasthan and Uttar Pradesh-undivided; Middle Income states- Andhra Pradesh, Karnataka, Kerala, Tamil Nadu and West Bengal; High Income states – Gujarat, Haryana, Himachal Pradesh, Maharashtra, Punjab

Source: Calculations from the ongoing Ph. D dissertation on *The Impact of Decentralization on Health Sector Outcomes*, Shailender Kumar, Centre for the Study of Regional Development, Jawaharlal Nehru University, New Delhi, 2010.

Table 22: Percentage Distribution of Social Sector Expenditure of State Governments into Plan and Non-Plan Components (including both revenue and capital account)

	Low Income			Mid Income			High Income			Punjab		
	Total Plan		Total Non plan	Total Plan		Total Non plan	Total Plan		Total Non plan	Total Plan		Total Non plan
	State + CP/ CSS	of which CP/ CSS		State + CP/ CSS	of which CP/ CSS		State + CP/ CSS	of which CP/ CSS		State + CP/ CSS	of which CP/ CSS	
1987-88	31	8.9	69	26.7	7.1	73.3	23.8	4.4	76.2	18.8	4.1	81.2
1988-89	30.6	10.1	69.4	25.6	6.7	74.4	23.9	6	76.1	22.9	12.6	77.1
1989-90	29.2	8.3	70.8	25.6	6.5	74.4	24.8	4.7	75.2	19.5	5.2	80.5
1990-91	26	8.8	74	19.7	5.5	80.3	18.9	3.3	81.1	14.1	6.6	85.9
1991-92	24.6	10	75.4	20.7	6.3	79.3	20.5	3.4	79.5	17.5	6.2	82.5
1992-93	23.3	8.8	76.7	20.8	6.7	79.2	21.5	4	78.5	17.6	8.6	82.4
1993-94	24.3	9.2	75.7	21.9	7.2	78.1	21.5	3.8	78.5	19.4	6.5	80.6
Average	27.0	9.2	73.0	23.0	6.6	77.0	22.1	4.2	77.9	18.5	7.1	81.5
1994-95	28.3	10.7	71.7	23.8	7.8	76.2	23	3.8	77	19.8	6.2	80.2
1995-96	28.5	9.8	71.5	24	6.8	76	24.5	4.4	75.5	18.4	6.6	81.6
1996-97	29.4	9.4	70.6	25.9	7.5	74.1	27.1	4.4	72.9	17.3	5.8	82.7
1997-98	28.4	11	71.6	25.2	7.5	74.8	25	3.6	75	15.8	4.8	84.2
1998-99	26.2	8.4	73.8	26.5	7.7	73.5	24	2.8	76	18.1	4.4	81.9
1999-00	24.3	7.6	75.7	22.4	6.3	77.6	22.8	2.6	77.2	18.8	4.1	81.2
2000-01	24.4	8.3	75.6	23.2	7.3	76.8	21.5	2.9	78.5	17.7	4.7	82.3
2001-02	27.1	9.3	72.9	25.5	7.9	74.5	19	4.1	81	19.2	3.7	80.8
2002-03	25.9	9.6	74.1	26.3	7.5	73.7	20.2	4.2	79.8	12.3	3.3	87.7
2003-04	27.1	9.9	72.9	30.3	7.1	69.7	23.2	8.4	76.8	9.1	3.4	90.9
2004-05	31.2	10	68.8	32.2	6.2	67.8	25.5	6.5	74.5	10.7	3.2	89.3
Average	27.3	9.5	72.7	25.9	7.2	74.1	23.3	4.3	76.7	16.1	4.6	83.9

Source: Calculations from the ongoing Ph. D dissertation on *The Impact of Decentralization on Health Sector Outcomes*, Shailender Kumar, Centre for the Study of Regional Development, Jawaharlal Nehru University, New Delhi, 2010.

Table 23: Percentage Distribution of Direct and Indirect Expenditure on Health into Plan and Non-Plan Components (including revenue and capital account)

	Low Income			Mid Income			High Income			Punjab		
	Total Plan		Total Non plan	Total Plan		Total Non plan	Total Plan		Total Non plan	Total Plan		Total Non plan
	State + CP/ CSS	of which CP/ CSS		State + CP/ CSS	of which CP/ CSS		State + CP/ CSS	of which CP/ CSS		State + CP/ CSS	of which CP/ CSS	
1987-88	55.7	23.5	44.3	49.2	18.2	50.8	51.7	12.4	48.3	36.7	15.1	63
1988-89	54.5	22.8	45.5	45.5	16.3	54.5	47.5	14.6	52.5	34.6	16.2	65
1989-90	49.5	20.6	50.5	46.7	16.1	53.3	45.9	10.9	54.1	30.5	13.4	70
1990-91	45.5	21.2	54.5	35.5	14.1	64.5	40.4	8.7	59.6	21.4	12.5	79
1991-92	45.3	26.2	54.7	38.4	16	61.6	41.3	10	58.7	26.6	13.2	73
1992-93	42.6	21.1	57.4	39	15.7	61	40.8	10.9	59.2	30.5	19.7	70
1993-94	42.6	22.5	57.4	40.4	17.5	59.6	40	10.8	60	28.3	14.4	72
Average	48.0	22.6	52.0	42.1	16.3	57.9	43.9	11.2	56.1	29.8	14.9	70.2
1994-95	46.1	24.2	53.9	44.4	19.1	55.6	38.3	9.9	61.7	22.4	13	78
1995-96	46.5	22.1	53.5	35	15.2	65	38.9	12.3	61.1	28.8	18.5	71
1996-97	45	22.8	55	39.3	16.4	60.7	44.2	11.9	55.8	25.6	14.2	74
1997-98	44	22.5	56	40.6	17.9	59.4	44.5	8.9	55.5	20.7	11.5	79
1998-99	43.3	21	56.7	40.5	16.7	59.5	42.1	6.2	57.9	18.7	4.3	81
1999-00	39.7	21.1	60.3	38.3	15.4	61.7	42.1	6.7	57.9	22.8	6.4	77
2000-01	41	22.3	59	41.1	16.3	58.9	43.6	7.5	56.4	28.3	7.9	72
2001-02	44.5	21.7	55.5	42.7	16.5	57.3	36.6	12.3	63.4	29.5	6.1	71
2002-03	42.9	21.3	57.1	46.1	15.1	53.9	36.7	11.4	63.3	22.9	5.7	77
2003-04	45.4	20.9	54.6	48	16.1	52	42.6	16.1	57.4	21.9	6.6	78
2004-05	47.5	19.2	52.5	50.3	12.4	49.7	41.6	9.6	58.4	17.3	7.2	83
Average	44.2	21.7	55.8	42.4	16.1	57.6	41.0	10.3	59.0	23.5	9.2	76.5

Note: Direct expenditure on heath includes – medical, public health and family welfare and indirect expenditure on health includes – water supply, sanitation and nutrition.

Source: Calculations from the ongoing Ph. D dissertation on *The Impact of Decentralization on Health Sector Outcomes*, Shailender Kumar, Centre for the Study of Regional Development, Jawaharlal Nehru University, New Delhi, 2010.

Table 24: Percentage Distribution of Direct Expenditure on Health into Plan and Non-Plan Components (including both revenue and capital account)

	Low Income			Mid Income			High Income			Punjab		
	Total Plan		Total Non plan	Total Plan		Total Non plan	Total Plan		Total Non plan	Total Plan		Total Non plan
	State + CP/ CSS	of which CP/ CSS		State + CP/ CSS	of which CP/ CSS		State + CP/ CSS	of which CP/ CSS		State + CP/ CSS	of which CP/ CSS	
1987-88	46.7	25.2	53.3	31.3	20.5	68.7	31.3	11.6	68.7	28.8	13.1	71.2
1988-89	45.6	25.4	54.4	31.7	17.1	68.3	30.1	16.8	69.9	24.9	13.4	75.1
1989-90	41.5	20.6	58.5	33.3	17.2	66.7	30.2	10.2	69.8	23.6	13.5	76.4
1990-91	36.8	24.5	63.2	25	15.5	75	23.9	11.6	76.1	17.8	12.6	82.2
1991-92	37.7	27.7	62.3	27.6	17.8	72.4	25.1	11.1	74.9	21.5	10.3	78.5
1992-93	35.1	22.4	64.9	26.6	18.1	73.4	27.5	12.1	72.5	23.8	14.1	76.2
1993-94	36.2	25.9	63.8	27.6	19.2	72.4	27.4	14	72.6	26.9	15.5	73.1
Average	39.9	24.5	60.1	29.0	17.9	71.0	27.9	12.5	72.1	23.9	13.2	76.1
1994-95	39.5	26.9	60.5	29.7	19.5	70.3	25.1	10.4	74.9	19.6	9.8	80.4
1995-96	38.3	23.5	61.7	30.7	20	69.3	27.1	13.7	72.9	24.5	13.6	75.5
1996-97	36.6	24.1	63.4	32.3	18.7	67.7	30.1	11.2	69.9	22.7	12.7	77.3
1997-98	34.3	23.6	65.7	33.1	18.8	66.9	27.8	8.9	72.2	18.7	11	81.3
1998-99	32.2	21.8	67.8	32.2	17.6	67.8	26.3	7.6	73.7	17.3	5.3	82.7
1999-00	32.2	21.4	67.8	31.4	16.7	68.6	24.1	6.5	75.9	21	4.5	79
2000-01	32.6	21.4	67.4	32.1	16.5	67.9	27.1	7.2	72.9	26	6	74
2001-02	33.8	21.3	66.2	32.1	16.8	67.9	27.9	10.1	72.1	23.5	3.8	76.5
2002-03	30.5	18.9	69.5	28.8	14.2	71.2	25.2	8.9	74.8	13.6	3	86.4
2003-04	33.5	17.7	66.5	29.9	13.8	70.1	27.9	8.6	72.1	16.8	6.1	83.2
2004-05	37.6	17	62.4	27.3	13.4	72.7	28.2	8.8	71.8	10.1	6.3	89.9
Average	34.6	21.6	65.4	30.9	16.9	69.1	27.0	9.3	73.0	19.4	7.5	80.6

Source: Calculations from the ongoing Ph. D dissertation on *The Impact of Decentralization on Health Sector Outcomes*, Shailender Kumar, Centre for the Study of Regional Development, Jawaharlal Nehru University, New Delhi, 2010.

Table 25: Percentage Distribution of Indirect Expenditure on Health into Plan and Non-Plan Components (including both revenue and capital account)

	Low Income			Mid Income			High Income			Punjab		
	Total Plan		Total Non plan	Total Plan		Total Non plan	Total Plan		Total Non plan	Total Plan		Total Non plan
	State + CP/ CSS	of which CP/ CSS		State + CP/ CSS	of which CP/ CSS		State + CP/ CSS	of which CP/ CSS		State + CP/ CSS	of which CP/ CSS	
1987-88	70.2	20.7	29.8	83.3	13.6	16.7	80.9	13.5	19.1	61.2	21.4	38.8
1988-89	68	18.8	32	74.1	14.6	25.9	79.3	10.7	20.7	66.1	25.5	33.9
1989-90	64.2	20.6	35.8	75.1	13.8	24.9	77.1	12.4	22.9	52.6	12.9	47.4
1990-91	62	14.9	38	57.8	11.1	42.2	72.9	2.8	27.1	36.7	12.2	63.3
1991-92	58.7	23.6	41.3	59.5	12.5	40.5	71.7	7.7	28.3	46.5	24.9	53.5
1992-93	56.3	18.6	43.7	65.3	10.5	34.7	63.6	8.8	36.4	51.9	37.3	48.1
1993-94	54.9	16.2	45.1	65.6	14	34.4	63.7	4.7	36.3	34.1	9.8	65.9
Average	62.0	19.1	38.0	68.7	12.9	31.3	72.7	8.7	27.3	49.9	20.6	50.1
1994-95	57.7	19.4	42.3	69.8	18.3	30.2	56.7	9.2	43.3	32.1	24	67.9
1995-96	60.3	19.8	39.7	39.9	9.7	60.1	57.7	10.1	42.3	40.7	32	59.3
1996-97	59.3	20.7	40.7	48.6	13.2	51.4	64.6	12.7	35.4	35.1	19	64.9
1997-98	59.2	20.8	40.8	52	16.5	48	66.5	9	33.5	28	13.5	72
1998-99	60.2	19.8	39.8	52.8	15.3	47.2	63	4.4	37	24.6	0	75.4
1999-00	52.8	20.5	47.2	49.1	13.5	50.9	68.1	6.9	31.9	31.2	15.1	68.8
2000-01	55.2	23.9	44.8	54.9	15.9	45.1	62.6	8	37.4	38.1	16.1	61.9
2001-02	59.6	22.2	40.4	61.8	16	38.2	50.1	15.8	49.9	49.6	13.8	50.4
2002-03	60.5	24.7	39.5	76.3	16.6	23.7	52	14.8	48	48	13.3	52
2003-04	63	25.7	37	77.5	19.8	22.5	58.5	24.2	41.5	33.9	7.5	66.1
2004-05	62.2	22.5	37.8	79.7	11.2	20.3	55.3	10.3	44.7	33.4	9	66.6
Average	59.1	21.8	40.9	60.2	15.1	39.8	59.6	11.4	40.4	35.9	14.8	64.1

Source: Calculations from the ongoing Ph. D dissertation on *The Impact of Decentralization on Health Sector Outcomes*, Shailender Kumar, Centre for the Study of Regional Development, Jawaharlal Nehru University, New Delhi, 2010.

Table 26: Share of Social Sector and Health Expenditure in Total Expenditure (including both revenue and capital account)												
	Social sector exp as a ratio of total exp. of state govt.				Direct & Indirect exp. on Heath as a ratio of total exp. of state govt.				Direct exp. on Heath as a ratio of total exp. of state govt.			
	Low Income	Mid Income	High Income	Punjab	Low Income	Mid Income	High Income	Punjab	Low Income	Mid Income	High Income	Punjab
1987-88	34.2	41.2	35.2	45.3	9.9	10.8	9.7	9.2	6.1	7.1	5.7	7
1988-89	35.4	39.3	35.5	43.3	10.2	10.2	8.7	8	6.1	6.9	5.6	6.1
1989-90	36.5	39.9	34.6	40.1	9.4	9.9	8.3	9.4	6.1	6.7	5.5	7.2
1990-91	35.6	39.6	32.7	33.2	8.8	9.7	7.9	7.7	5.8	6.6	5.2	6.2
1991-92	34.4	35.8	30.9	23.6	8.9	8.6	7.4	5.5	5.7	5.7	4.8	4.4
1992-93	33.5	36.1	31.7	29.9	8.4	8.8	8	7.7	5.4	6	5	5.9
1993-94	33.1	35.9	30.6	26.7	8.9	9.1	7.4	6.4	5.8	6.1	4.8	5.1
Average	34.7	38.3	33.0	34.6	9.2	9.6	8.2	7.7	5.9	6.4	5.2	6.0
1994-95	33.5	35.1	26.8	19.1	8.9	9.1	6.9	4.5	5.6	5.8	4	3.5
1995-96	34.1	36.5	31.7	26.1	8.8	10.8	7.2	5.6	5.5	5.7	4.4	4.1
1996-97	34.8	36	29.5	24.9	8.7	9.7	7.3	6.2	5.5	5.5	4.3	4.7
1997-98	35.3	35.8	30.6	23.9	9.2	9.7	7.6	5.5	5.6	5.8	4.3	4.4
1998-99	36.1	37.8	32.2	28.4	8.8	10.4	8.1	6.7	5.3	6.2	4.6	5.4
1999-00	35.3	37.2	32.7	25.9	7.7	9.7	7.7	6.3	4.9	5.9	4.5	5.2
2000-01	33.9	34.8	32.9	23.2	7.6	9.1	7.6	6	4.8	5.5	4.1	4.9
2001-02	32.1	33.4	32.5	23.1	7.6	8.4	6.6	5.9	4.5	5.4	4	4.5
2002-03	33.1	31.7	30.4	21.3	7.5	7.7	6.9	5.5	4.4	4.9	3.9	4
2003-04	27.2	32	30.6	20.6	6.3	7.5	7.3	5.3	3.7	4.6	3.8	3.7
2004-05	30.5	31.4	29.4	20.2	7.1	7.5	6.9	4.9	4.3	4.2	3.5	3.4
Average	33.3	34.7	30.8	23.3	8.0	9.1	7.3	5.7	4.9	5.4	4.1	4.3

Source: Calculations from the ongoing Ph. D dissertation on *The Impact of Decentralization on Health Sector Outcomes*, Shailender Kumar, Centre for the Study of Regional Development, Jawaharlal Nehru University, New Delhi, 2010.

Table 27: Share of Health Expenditure in Social Sector Expenditure (including both revenue and capital account)												
	Direct & Indirect exp. on Heath as a ratio of total social exp. of state govt.				Direct exp. on Heath as a ratio of total social exp. of state govt.				Indirect exp. on Heath as a ratio of total Social exp. of state govt.			
	Low Income	Mid Income	High Income	Punjab	Low Income	Mid Income	High Income	Punjab	Low Income	Mid Income	High Income	Punjab
1987-88	28.9	26.3	27.5	20.4	17.7	17.3	16.2	15.4	11.2	9.1	11.3	5
1988-89	28.7	25.9	24.4	18.4	17.3	17.5	15.7	14.1	11.3	8.4	8.7	4.3
1989-90	25.6	24.9	24	23.5	16.6	16.9	16	17.9	9	8	8	5.6
1990-91	24.8	24.4	24.2	23.2	16.2	16.6	16.1	18.7	8.5	7.8	8.1	4.5
1991-92	25.8	24.2	23.9	23.4	16.5	16	15.6	18.7	9.3	8.2	8.3	4.8
1992-93	25.2	24.3	25.2	25.8	16.2	16.5	15.9	19.6	8.9	7.8	9.3	6.2
1993-94	26.8	25.4	24.2	23.9	17.6	16.9	15.8	19.3	9.2	8.5	8.4	4.7
Average	26.5	25.1	24.8	22.7	16.9	16.8	15.9	17.7	9.6	8.3	8.9	5.0
1994-95	26.5	26	25.7	23.4	16.9	16.5	15	18.3	9.7	9.5	10.7	5.2
1995-96	25.9	29.6	22.6	21.6	16.2	15.7	13.9	15.8	9.7	13.9	8.7	5.8
1996-97	25	27	24.7	24.8	15.8	15.4	14.6	19	9.2	11.5	10.1	5.8
1997-98	26.1	27	24.9	23.2	16	16.2	14.2	18.3	10.1	10.8	10.7	4.9
1998-99	24.3	27.6	25.1	23.7	14.7	16.5	14.3	19.1	9.6	11.2	10.8	4.5
1999-00	21.8	26.1	23.4	24.2	13.9	15.8	13.9	20	7.9	10.3	9.6	4.2
2000-01	22.4	26.1	23.1	26	14.1	15.9	12.3	21	8.3	10.2	10.8	5
2001-02	23.8	25.1	20.2	25.4	13.9	16.1	12.3	19.5	9.9	9	7.9	5.8
2002-03	22.8	24.3	22.6	25.8	13.4	15.5	12.9	18.8	9.4	8.8	9.8	7
2003-04	23.1	23.3	23.9	25.7	13.8	14.4	12.4	18.1	9.4	8.8	11.5	7.7
2004-05	23.4	24	23.5	24.3	14	13.5	11.9	16.8	9.4	10.5	11.6	7.5
Average	24.1	26.0	23.6	24.4	14.8	15.6	13.4	18.6	9.3	10.4	10.2	5.8

Source: Calculations from the ongoing Ph. D dissertation on *The Impact of Decentralization on Health Sector Outcomes*, Shailender Kumar, Centre for the Study of Regional Development, Jawaharlal Nehru University, New Delhi, 2010.

Table 28: Central Transfer (CSS/CPS) to State in Social and Health Sector (including both revenue and capital account)												
	CSS/CPS transfer in social sector exp as a ratio of total exp. of state govt.				CSS/CPS transfer in direct health exp. as a ratio of total exp. of state govt.				CSS/CPS transfer in Indirect health exp. as a ratio of total exp. of state govt.			
	Low Income	Mid Income	High Income	Punjab	Low Income	Mid Income	High Income	Punjab	Low Income	Mid Income	High Income	Punjab
1987-88	3.05	2.94	1.53	1.85	1.53	1.46	0.66	0.91	0.79	0.51	0.54	0.48
1988-89	3.58	2.64	2.13	5.45	1.56	1.17	0.94	0.82	0.75	0.49	0.33	0.48
1989-90	3.05	2.58	1.61	2.08	1.25	1.16	0.56	0.97	0.68	0.44	0.34	0.29
1990-91	3.13	2.2	1.08	2.19	1.42	1.02	0.61	0.78	0.45	0.34	0.08	0.18
1991-92	3.44	2.26	1.04	1.47	1.58	1.02	0.54	0.45	0.75	0.36	0.2	0.28
1992-93	2.94	2.41	1.27	2.58	1.22	1.08	0.61	0.82	0.56	0.3	0.26	0.69
1993-94	3.06	2.57	1.17	1.74	1.51	1.16	0.68	0.8	0.5	0.43	0.12	0.12
Average	3.2	2.5	1.4	2.5	1.4	1.2	0.7	0.8	0.6	0.4	0.3	0.4
1994-95	3.59	2.73	1.02	1.19	1.52	1.13	0.42	0.34	0.63	0.61	0.26	0.24
1995-96	3.33	2.48	1.4	1.73	1.29	1.15	0.6	0.56	0.65	0.49	0.28	0.48
1996-97	3.29	2.71	1.31	1.45	1.33	1.04	0.48	0.6	0.67	0.55	0.38	0.28
1997-98	3.87	2.68	1.11	1.15	1.33	1.09	0.38	0.48	0.74	0.63	0.3	0.16
1998-99	3.02	2.89	0.9	1.25	1.15	1.1	0.35	0.29	0.69	0.64	0.15	0
1999-00	2.69	2.35	0.84	1.07	1.05	0.98	0.3	0.24	0.57	0.52	0.21	0.17
2000-01	2.82	2.54	0.95	1.09	1.03	0.91	0.29	0.29	0.67	0.57	0.28	0.19
2001-02	2.98	2.63	1.33	0.86	0.95	0.9	0.4	0.17	0.7	0.48	0.41	0.19
2002-03	3.17	2.39	1.27	0.71	0.84	0.7	0.35	0.12	0.77	0.46	0.44	0.2
2003-04	2.69	2.28	2.58	0.7	0.66	0.64	0.33	0.23	0.66	0.56	0.85	0.12
2004-05	3.06	1.96	1.92	0.66	0.73	0.56	0.31	0.21	0.64	0.37	0.35	0.14
Average	3.1	2.5	1.3	1.1	1.1	0.9	0.4	0.3	0.7	0.5	0.4	0.2

Source: Calculations from the ongoing Ph. D dissertation on *The Impact of Decentralization on Health Sector Outcomes*, Shailender Kumar, Centre for the Study of Regional Development, Jawaharlal Nehru University, New Delhi, 2010.

Table 29: Trends in Central Transfer (CSS/CPS) to State in Health Sector (including both revenue and capital account)												
	CSS/CPS transfer in direct & Indirect health exp as a ratio of total social exp. of state govt.				CSS/CPS transfer in direct health exp. as a ratio of total social exp. of state govt.				CSS/CPS transfer in Indirect heath exp. as a ratio of total social exp. of state govt.			
	Low Income	Mid Income	High Income	Punjab	Low Income	Mid Income	High Income	Punjab	Low Income	Mid Income	High Income	Punjab
1987-88	6.78	4.78	3.41	3.08	4.47	3.54	1.88	2.02	2.31	1.23	1.53	1.06
1988-89	6.54	4.23	3.57	2.99	4.41	2.99	2.64	1.89	2.13	1.24	0.92	1.1
1989-90	5.27	4.01	2.62	3.15	3.41	2.91	1.63	2.43	1.86	1.11	0.99	0.72
1990-91	5.26	3.45	2.1	2.9	3.99	2.58	1.87	2.35	1.27	0.87	0.23	0.55
1991-92	6.77	3.88	2.38	3.11	4.58	2.86	1.74	1.91	2.19	1.02	0.64	1.19
1992-93	5.3	3.81	2.75	5.08	3.64	2.99	1.93	2.76	1.66	0.82	0.82	2.32
1993-94	6.05	4.44	2.61	3.44	4.55	3.24	2.22	2.98	1.5	1.2	0.39	0.46
Average	6.0	4.1	2.8	3.4	4.2	3.0	2.0	2.3	1.8	1.1	0.8	1.1
1994-95	6.41	4.97	2.55	3.04	4.54	3.22	1.56	1.8	1.87	1.75	0.99	1.24
1995-96	5.72	4.49	2.78	4	3.8	3.14	1.9	2.15	1.92	1.35	0.88	1.85
1996-97	5.71	4.41	2.92	3.53	3.8	2.88	1.64	2.42	1.91	1.53	1.28	1.11
1997-98	5.87	4.83	2.23	2.67	3.76	3.05	1.26	2.02	2.1	1.77	0.97	0.65
1998-99	5.1	4.61	1.56	1.01	3.19	2.91	1.09	1.01	1.9	1.7	0.47	0
1999-00	4.59	4.02	1.56	1.54	2.97	2.63	0.91	0.91	1.62	1.39	0.65	0.64
2000-01	5	4.24	1.74	2.07	3.03	2.62	0.88	1.26	1.97	1.63	0.86	0.8
2001-02	5.16	4.15	2.49	1.55	2.97	2.71	1.24	0.75	2.19	1.44	1.25	0.8
2002-03	4.85	3.66	2.59	1.48	2.52	2.19	1.14	0.56	2.33	1.47	1.44	0.92
2003-04	4.84	3.74	3.85	1.69	2.43	1.99	1.07	1.11	2.41	1.75	2.79	0.58
2004-05	4.49	2.97	2.25	1.74	2.38	1.8	1.05	1.06	2.11	1.18	1.2	0.68
Average	5.2	4.2	2.4	2.2	3.2	2.6	1.2	1.4	2.0	1.5	1.2	0.8

Source: Calculations from the ongoing Ph. D dissertation on *The Impact of Decentralization on Health Sector Outcomes*, Shailender Kumar, Centre for the Study of Regional Development, Jawaharlal Nehru University, New Delhi, 2010.

Table 30: Per Capita Health Expenditure at 1993-94 prices (in Rs.)													
		Low income			MID income			High Income			Punjab		
		1987-88	1996-97	2004-05	1987-88	1996-97	2004-05	1987-88	1996-97	2004-05	1987-88	1996-97	2004-05
A	Direct Health	65.4	62.1	76.7	83.5	87.6	103	95.6	95	113	112	111	126
B	Indirect Health	41.1	36.3	51.2	43.9	65.5	80.4	66.9	65.6	110	36.3	34	56.6
	Revenue	91.7	87.8	110	121	151	146	149	144	189	142	144	182
A+ B	Capital	14.8	10.6	17.5	6.4	2.4	37.7	13.5	16.7	34.1	6.6	0.8	1.2
	Plan	59.4	44.2	60.7	62.7	60.1	92.1	84.1	71	92.8	54.6	37.1	31.6
A+ B	Non-Plan	47.1	54.2	67.2	64.7	92.9	91.1	78.5	89.6	130	94.1	108	151
	State Own's	81.5	75.9	103	104	128	161	142	142	202	126	124	170
A+ B	CSS/CPS	25	22.5	24.5	23.1	25	22.7	20.1	19	21.3	22.5	20.6	13.1
	a). Medical	40.9	40.7	58.1	58.3	63.1	77.1	53.9	56.4	75.7	81.5	84.5	107
	b). Public Health	10.4	8.4	6.8	9.5	10.9	10.1	27.7	25.5	26.3	15.2	10.3	8.5
A	c). Family Welfare	14.2	13	11.8	15.7	13.6	15.7	14	13.1	10.6	15.7	16.1	10.9
	d). Water Supply & Sanitation	38.2	32.6	43	29.9	30.8	54.8	54	51.9	89	34.1	34	56.6
B	e). Nutrition	3	3.8	8.2	14	34.7	25.6	12.9	13.8	21.4	2.2	0	0
	Rural	14.5	17	23.4	10.2	11	15.6	12.7	14.7	18	32	38.8	45.8
	Urban	19.3	19	26.4	38.2	38.9	43.3	33	32.6	44.2	40.1	36.5	47
	Medical Edu. Tr. & Research	6.3	4.6	7.9	6.1	8.1	11.6	8.1	8.9	13.3	8.8	8.7	13.4
	Public Health	10.4	8.4	6.8	9.5	10.9	10.1	27.7	25.5	26.3	15.2	10.3	8.5
a + b	Others	0.7	0.1	0.4	3.8	5.1	6.5	0.2	0.2	0.2	0.6	0.6	0.4
	Rural	5.1	6.4	7.2	4.8	6.3	7.6	4.6	4.9	4.8	4.8	4.8	7.9
	Urban	0.3	0.4	0.4	0.4	0.7	0.5	0.8	0.6	0.8	0.8	1	1.1
	MCH Care	0.5	1.7	1.2	0.6	1.2	1.6	0.8	2.5	1.5	0.1	2.7	0
c	Others	8.3	4.5	3	9.9	5.4	5.9	7.9	5.2	3.5	10	7.6	2
	Rural	21.2	15.4	21.6	11.3	13.3	30.9	41	26	40.1	18.8	9.7	18.8
	Urban	9	9	11.5	6.8	3.1	5.3	3.2	8.4	6.2	0	0	0
d	Other	7.9	8.1	10	11.8	14.4	18.7	9.8	17.4	42.7	15.3	24.3	37.8
	Rural	40.8	38.9	52.2	26.2	30.6	54.1	58.3	45.6	62.9	55.6	53.2	72.4
a + b +	Urban	28.7	28.4	38.3	45.4	42.8	49.1	36.9	41.6	51.1	40.9	37.5	48.1
c+d	Other	34.1	27.4	29.3	41.7	45.1	54.5	54.4	59.7	87.5	50.1	54.1	62.1

Source: Calculations from the ongoing Ph. D dissertation on *The Impact of Decentralization on Health Sector Outcomes*, Shailender Kumar, Centre for the Study of Regional Development, Jawaharlal Nehru University, New Delhi, 2010.

Table 31: Composition of Different Components of Health Expenditure (in %)													
		Low income			MID income			High Income			Punjab		
Code	Items	1987-88	1996-97	2004-05	1987-88	1996-97	2004-05	1987-88	1996-97	2004-05	1987-88	1996-97	2004-05
A	Direct Health	61.4	63.1	59.9	65.6	57.2	56.1	58.8	59.2	50.5	75.6	76.6	69
B	Indirect Health	38.6	36.9	40.1	34.4	42.8	43.9	41.2	40.8	49.5	24.4	23.4	31
	Revenue	86.1	89.2	86.3	95	98.5	79.4	91.7	89.6	84.7	95.6	99.4	99.4
A+ B	Capital	13.9	10.8	13.7	5	1.5	20.6	8.3	10.4	15.3	4.4	0.6	0.6
	Plan	55.7	45	47.5	49.2	39.3	50.3	51.7	44.2	41.6	36.7	25.6	17.3
A+ B	Non-Plan	44.3	55	52.5	50.8	60.7	49.7	48.3	55.8	58.4	63.3	74.4	82.7
	State Own's	76.5	77.2	80.8	81.8	83.6	87.6	87.6	88.1	90.4	84.9	85.8	92.8
A+ B	CSS/CPS	23.5	22.8	19.2	18.2	16.4	12.4	12.4	11.9	9.6	15.1	14.2	7.2
	a). Medical	62.5	65.6	75.7	69.8	72	74.9	56.4	59.4	67.2	72.5	76.2	84.5
	b). Public Health	15.8	13.5	8.9	11.4	12.4	9.8	28.9	26.8	23.4	13.5	9.3	6.8
A	c). Family Welfare	21.7	20.9	15.4	18.8	15.5	15.3	14.6	13.8	9.4	14	14.5	8.7
	d). Water Supply & Sanitation	92.7	89.7	84	68.1	47.1	68.2	80.7	79	80.6	93.9	100	100
B	e). Nutrition	7.3	10.3	16	31.9	52.9	31.8	19.3	21	19.4	6.1	0	0
	Rural	28.4	34.6	36.1	15	14.8	17.9	15.6	18	17.7	33.1	40.9	39.8
	Urban	37.7	38.8	40.6	56.3	52.6	49.7	40.4	39.8	43.3	41.5	38.5	40.9
	Medical Edu. Tr. & Research	12.3	9.3	12.3	9	11	13.3	9.9	10.9	13	9.1	9.2	11.6
	Public Health	20.2	17.1	10.5	14	14.7	11.5	33.9	31.1	25.8	15.8	10.8	7.4
a + b	Others	1.4	0.2	0.5	5.6	6.9	7.5	0.2	0.2	0.2	0.6	0.6	0.4
	Rural	35.7	49.3	61.2	30.5	46.3	48.7	32.9	37.3	45.2	30.3	29.6	72.1
	Urban	2.1	2.7	3.5	2.5	5.4	3.3	5.6	4.3	7.7	5.2	6.3	10
	MCH Care	3.7	13	10.2	3.9	8.5	10.4	5.4	19.2	13.9	0.7	16.9	0
c	Others	58.5	35	25.1	63	39.9	37.6	56.1	39.2	33.3	63.8	47.2	17.8
	Rural	55.6	47.4	50.1	37.7	43.2	56.3	75.9	50.2	45.1	55.1	28.6	33.2
	Urban	23.7	27.6	26.7	22.8	10.2	9.6	5.9	16.3	6.9	0	0	0
d	Other	20.7	24.9	23.2	39.5	46.7	34.1	18.2	33.5	48	44.9	71.4	66.8
	Rural	39.4	41.1	43.6	23.2	25.8	34.3	39	31.1	31.2	37.9	36.8	39.7
a + b +	Urban	27.7	30	32	40	36.1	31.1	24.7	28.3	25.4	27.9	25.9	26.4
c+d	Other	32.9	29	24.4	36.8	38.1	34.5	36.4	40.6	43.4	34.2	37.3	34

Source: Calculations from the ongoing Ph. D dissertation on *The Impact of Decentralization on Health Sector Outcomes*, Shailender Kumar, Centre for the Study of Regional Development, Jawaharlal Nehru University, New Delhi, 2010.

Table 32: Composition of health expenditure by economic classification (in %)						
	1992-93			2005-06		
	Wages and Salary, scholarship	Maintenance, and motor vehicle	Machinery and equipment , material supply and drugs	Wages and Salary, scholarship	Maintenance, and motor vehicle	Machinery and equipment , material supply and drugs
Low income	93.5	3.3	3.3	86.2	8.8	5.0
Middle income	88.4	3.6	8.0	74.5	14.2	11.9
High income	90.7	2.6	6.7	90.5	1.3	8.2
All state avg.	89.4	3.7	6.9	83.3	9.7	8.6
PN	92.3	1.4	6.3	99.2	0.1	0.8

Source: Calculations from the ongoing Ph. D dissertation on *The Impact of Decentralization on Health Sector Outcomes*, Shailender Kumar, Centre for the Study of Regional Development, Jawaharlal Nehru University, New Delhi, 2010.

Appendix 1

Morbidity reported in last 365 days for hospitalization in rural areas of top 5 developed States in India					
	Tamil Nadu	Haryana	Punjab	Gujarat	Maharashtra
Diarrhoea/dysentery	8	4.1	6.5	3.7	8.7
Gastritis/gastric or peptic ulcer	7.3	2.8	1.9	2.2	4.2
Worm infestation	0.4	0	0.2	1	0.2
Amoebiasis	0.2	0	0	0.2	0.3
Hepatitis	0.5	1.5	2	1.3	3.1
Heart disease	6.1	5.8	3.7	4.2	3.8
Hypertension	1.2	1.4	2.2	2.4	3.5
Respiratory including nose and throat	6.1	12	3.6	2.4	2.2
TB	1.6	1.6	2.5	7.6	1.8
Bronchial Asthma	2.7	2.9	5.6	3.8	3.6
Disorder of joints and bones	1.5	2	3.6	2	3.3
Disease of Kidney/ urinary system	4.9	5.1	6.6	2.8	4.5
Protastic disorder	0.3	0.5	0.2	0.2	0.1
Gynaecological disorder	3.9	4.4	6.2	5.9	4.3
Neurological disorder	4.2	5.4	3	3.1	3.7
Psychiatric disorder	0.4	1.7	0.9	0.6	0.9
Conjunctivitis	0.3	0.2	0.5	0	0.2
Glaucoma	0.1	0.3	0.1	1.5	0.3
Cataract	6.3	4.2	0.4	2.8	4
Disease of skin	0.8	1.5	0.7	0.5	0.7
Goitre	0	0.1	0.1	0	0.4
Diabetes	2.8	0.3	2.1	1.8	1.5
Undermalnutrition	0.1	0	0	0	0.1
Anaemia	0.2	1.2	1.8	0.8	2.1
Sexually transmitted diseases	0	0.9	0.4	0	0.1
Malaria	0.8	0.2	0.3	8.8	4.4
Eruptive	2.5	0.3	0	0	0
Mumps	0	0	0	0	0.1
Diptheria	0.1	0.4	0.3	0	0.5
Whooping cough	0.4	0	0.2	2.3	1.6
Fever of unknown origin	7	8.3	8.3	8.5	4.9
Tetanus	0.2	0.4	0	0	0
Filariasis/Elephantiasis	0	0	0	0	0.1
Locomotor	1.2	0.4	2.4	0.8	0.5
Visual including blindness(excluding cataract)	0.3	0	0.2	0.7	0.7
Speech	0	0	0	0	0
Hearing	0	0.1	0	0	0.5
Disease of mouth/Teeth/Gum	0.2	0.3	0.8	0.3	0.2
Accidents/Injuries/Burns/Fractures/Poisoning	10.2	9.6	14.3	8.4	8.6
Cancer and other tumours	1.7	1.6	2.2	3.8	1.9
Other diagnosed ailments	15.3	16	14.8	14.6	17.3
Others	0.4	2.7	1.3	0.9	1.1
Total	100	100	100	100	100
Source: Calculated from the unit level data of NSSO 60th Round (January – June 2004) on Morbidity and the Health					

Appendix 2

Morbidity reported in last 365 days for hospitalization in urban areas of top 5 developed States in India					
	Tamil Nadu	Haryana	Punjab	Gujarat	Maharashtra
Diarrhoea/dysentery	6.7	6.9	5.6	8.4	4.4
Gastritis/gastric or peptic ulcer	3.6	2	4.6	3.4	3.8
Worm infestation	0	0.5	0	0.5	0.5
Amoebiasis	0.2	0	0	0.3	0.2
Hepatitis	0.9	1.6	1.6	3	3.3
Heart disease	8.9	8.5	8.7	7.8	8.9
Hypertension	3.1	3.5	1	2.5	4
Respiratory including nose and throat	2.8	5.1	1.9	2.9	2.4
TB	1.5	0.9	11.7	1.9	1.1
Bronchial Asthma	2	3.5	1.5	1.6	2.9
Disorder of joints and bones	2.3	2.9	2.8	2	2.7
Disease of Kidney/ urinary system	4.2	6.7	4.6	5.1	8.3
Protastic disorder	0.2	1	0.1	0.6	0.2
Gynaecological disorder	3.9	4.2	4	4	4
Neurological disorder	3.2	3.4	2.5	4.1	3.6
Psychiatric disorder	0.6	1.4	1.2	0.4	0.3
Conjunctivitis	0.1	0	2	0	0.2
Glaucoma	0.4	0.3	0.1	0.1	0.6
Cataract	3.5	2.8	0.5	2.8	2.4
Disease of skin	0.3	0	0.6	1.1	0.6
Goitre	0.3	0	0	0	0.1
Diabetes	4.2	0.3	1	2	1.5
Undermalnutrition	0.2	0	0	0.1	0
Anaemia	0	2.3	0.7	0.1	2.9
Sexually transmitted diseases	0	0.2	0	0.1	0.1
Malaria	2.9	2.6	1.2	12.6	4.6
Eruptive	0.1	0	0.1	0.2	0.1
Mumps	0	0.2	0	0	0
Diptheria	0.1	0	0.4	0	1.5
Whooping cough	0.5	0.7	0.3	2.4	1
Fever of unknown origin	7.4	4.6	3.2	5.8	5.6
Tetanus	0.1	0	1.9	0	0.2
Filariasis/Elephantiasis	0	0	0	0.3	0.1
Locomotor	0.8	0.1	2.5	0.9	0.4
Visual including blindness(excluding cataract)	0.6	0	0.1	0	0.4
Speech	0	0	0	0.2	0
Hearing	0	0	0	0	0
Disease of mouth/Teeth/Gum	0.3	0	0.3	0.2	0.3
Accidents/Injuries/Burns/Fractures/Poisoning	9.8	12.4	9.7	8.6	8.8
Cancer and other tumours	5	3.2	4.1	2.7	2.4
Other diagnosed ailments	19.1	14.7	18	10.7	14.9
Others	0.3	3.6	1.4	0.6	1
	100	100	100	100	100
Source: Calculated from the unit level data of NSSO 60th Round (January – June 2004) on Morbidity and the Health					

Appendix 3

Morbidity reported in last 15 days in rural areas of top 5 developed States in India					
	Tamil Nadu	Haryana	Punjab	Gujarat	Maharasthra
Diarrhoea/dysentery	7.00	11.70	14.10	7.30	7.30
Gastritis/gastric or peptic ulcer	2.20	2.60	0.40	2.10	0.10
Worm infestation	0.00	1.60	0.60	1.50	1.20
Amoebiasis	0.20	0.00	0.00	0.00	0.00
Hepatitis	0.60	0.00	0.00	0.00	0.00
Heart disease	0.80	0.80	0.00	0.70	0.10
Hypertension	0.40	5.10	4.80	0.00	0.40
Respiratory including nose and throat	9.00	15.70	25.70	4.40	10.70
TB	0.00	0.00	0.00	0.00	0.10
Bronchial Asthma	0.70	0.50	0.20	5.10	1.30
Disorder of joints and bones	2.80	1.90	2.70	2.00	3.90
Disease of Kidney/ urinary system	0.50	1.70	0.00	0.30	0.90
Protastic disorder	0.00	0.40	0.00	0.00	0.00
Gynaecological disorder	0.60	1.30	0.10	0.00	0.50
Neurological disorder	1.20	1.50	0.60	0.20	0.40
Psychiatric disorder	0.00	0.00	0.10	0.00	0.00
Conjunctivitis	0.40	0.80	0.00	0.00	0.70
Glaucoma	0.10	0.00	0.00	0.00	0.00
Cataract	0.10	0.00	0.00	1.00	0.30
Disease of skin	1.30	3.10	0.30	0.20	3.90
Goitre	0.00	0.00	0.30	0.00	0.30
Diabetes	0.60	0.00	0.00	0.00	0.10
Undermalnutrition	0.00	0.00	0.00	0.40	0.00
Anaemia	0.00	2.20	0.00	0.00	0.20
Sexually transmitted diseases	0.00	0.00	0.00	0.00	0.10
Malaria	2.40	1.60	3.50	12.00	8.30
Eruptive	1.50	0.00	0.70	0.20	0.00
Mumps	0.00	0.90	0.00	0.00	0.20
Diptheria	0.30	0.00	0.00	0.00	0.20
Whooping cough	0.20	0.20	1.00	9.70	2.10
Fever of unknown origin	31.90	26.90	25.90	38.00	27.40
Tetanus	0.00	0.00	0.00	0.00	0.20
Filariasis/Elephantiasis	0.00	0.00	0.00	0.00	0.00
Locomotor	0.50	0.00	0.00	0.00	1.70
Visual including blindness(excluding cataract)	0.20	0.00	0.00	0.40	0.60
Speech	0.00	0.00	0.00	0.00	0.00
Hearing	0.00	0.00	0.00	1.00	0.20
Disease of mouth/Teeth/Gum	2.30	3.10	2.20	1.10	1.30
Accidents/Injuries/Burns/Fractures/Poisoning	5.50	4.20	1.60	4.40	2.80
Cancer and other tumours	0.20	0.00	0.40	0.00	0.00
Other diagnosed ailments	20.60	10.90	13.00	7.10	21.10
Others	6.10	1.40	1.80	0.60	1.40
Source: Calculated from the unit level data of NSSO 60th Round (January – June 2004) on Morbidity and the Health					

Appendix 4

Morbidity reported in last 15 days in urban areas of top 5 developed States in India					
	Tamil Nadu	Haryana	Punjab	Gujarat	Maharashtra
Diarrhoea/dysentery	7.50	5.90	7.90	7.90	6.40
Gastritis/gastric or peptic ulcer	1.60	1.00	2.70	4.10	1.10
Worm infestation	0.60	0.10	0.00	0.00	0.40
Amoebiasis	0.10	0.90	0.00	0.00	0.70
Hepatitis	0.10	6.50	0.00	0.00	0.10
Heart disease	1.00	0.60	0.20	1.50	0.20
Hypertension	2.80	1.00	2.20	5.30	0.90
Respiratory including nose and throat	6.80	18.80	11.50	16.50	15.00
TB	0.20	0.00	0.00	0.00	0.10
Bronchial Asthma	0.50	0.40	0.60	5.30	0.70
Disorder of joints and bones	3.50	5.70	1.40	0.20	1.70
Disease of Kidney/ urinary system	0.80	3.30	4.30	0.00	0.60
Protastic disorder	0.00	0.10	0.00	0.00	0.00
Gynaecological disorder	0.60	0.50	0.00	1.00	0.60
Neurological disorder	1.10	1.10	0.00	0.20	0.20
Psychiatric disorder	0.20	0.00	0.00	0.00	0.00
Conjunctivitis	0.20	0.00	0.00	0.00	1.40
Glaucoma	0.00	0.30	0.10	0.20	0.00
Cataract	0.00	0.00	1.10	0.00	0.30
Disease of skin	1.60	1.60	0.50	0.80	1.70
Goitre	0.00	0.00	0.00	0.00	0.00
Diabetes	0.40	0.30	0.40	0.00	0.60
Undermalnutrition	0.80	0.00	0.00	0.00	0.00
Anaemia	0.00	0.70	1.30	0.00	0.50
Malaria	0.70	2.40	0.40	9.10	2.40
Eruptive	0.00	1.70	0.00	0.50	0.60
Mumps	1.30	0.00	0.10	0.00	0.10
Diptheria	1.00	0.00	0.00	0.00	1.10
Whooping cough	2.60	0.90	2.30	23.20	5.20
Fever of unknown origin	33.90	14.30	45.50	14.30	25.60
Filariasis/Elephantiasis	0.00	0.00	0.00	0.00	0.00
Locomotor	0.10	0.00	0.50	0.00	0.30
Visual including blindness(excluding	0.00	0.00	2.00	0.00	0.00
Speech	0.00	0.00	0.00	0.00	0.00
Hearing	1.00	0.00	0.00	0.40	1.00
Disease of mouth/Teeth/Gum	1.30	2.80	0.50	0.00	2.10
Accidents/Injuries/Burns/Fractures/Poisoning	3.70	9.40	2.40	0.40	3.70
Cancer and other tumours	0.00	0.00	0.10	0.00	0.10
Other diagnosed ailments	19.70	17.80	11.20	8.00	22.60
Others	4.00	1.80	0.90	1.10	2.10
	100.00	100.00	100.00	100.00	100.00
Source: Calculated from the unit level data of NSSO 60th Round (January – June 2004) on Morbidity and the Health					

Annexure to Chapter 3

Annexure I — Punjab Drug Department

Checklist of documents required to apply for Retail Sale and Wholesale Drugs Licences:

1. Forwarding letter for obtaining drugs sale licenses, which shall be addressed to Assistant Drugs Controller/Licensing Authority.
2. Application in Form-19 in duplicate shall be signed by Prop./all partners or by authorized partner/GPA holder/Director in case of Private Limited or Limited Companies.
3. Complete affidavit of Prop./Partners/Directors/GPA holder duly attested by Executive magistrate or Notary properly (overwriting & cutting shall be avoided).
4. Complete affidavit of qualified person/competent person whichever is applicable duly attested by Executive Magistrate or Notary.
5. Challan receipt in original being proof of fee deposited in scheduled bank (Rs.3000/- amount).
6. Attested copy of proof of valid and up to date renewed registration of qualified person/ pharmacist.
7. Attested copy of proof of residence of qualified person/competent person residing within 20 kms. from the place of employment.
8. Attested copy of Matriculation Certificate of Prop./Partners/Directors/GPA holder etc.
9. Attested copy of proof of residence of the applicant/applicants.
10. Attested copy of Rent Deed/Rent Agreement/Mortgage Deed/Registry in case of ownership etc. along with copy of rent receipt.
11. Three copies of site cum location plan of proposed premises (one on butter paper and two blue prints) prepared and signed/stamped by approved architect with dimensions, the site plan shall also be signed by the applicant/applicants.
12. Proper experience certificate in original in case of wholesale application (not less than one year experience for graduates and not less than four years for matriculates in sale & purchase of drugs) supported by his own affidavit and affidavit of experience issuing persons.
13. Copy of educational qualification of competent person.
14. Copy of Partnership deed of Article of Memorandum as a proof of constitution of the firm as applicable copy of Form 32A / 7B regarding status of directors.
15. Attested copy of dissolution deed or sale deed etc. in case of change of constitution and legal heir certificate and any other related documents e.g. attested copy of death certificate in case of death of Prop./Partner.

16. Original drugs licences along with copy of validity of licences in case of change on constitution and change of premises.

17. I- Card of Pharmacist/Qualified Person in triplicate.

18. Appointment & joining report of pharmacist/competent person and copy of resignation of qualified person/competent person, if already working with some other firm.

19. NOC from Gram Panchayat containing detail of already existing retail sale shops, population and number of authorized medical practitioner in the village where the licence is to be issued.

20. Attested copy of purchase bill of refrigerator.

Source: Health Department, Punjab

Annexure II — Andhra Pradesh Drug Control Department

Citizen Charter

I. Services offered by this department:

- Information on licensed Blood Banks.
- Information on Banned Drugs.
- Information on prices of Notified Drugs.
- Information on drugs about contra-indications, doses, etc.
- Complaints on services of Chemists and Druggists.
- Complaint on quality and adverse reaction of drugs.

II. Our Service Standards

We have set the following Targets/Standards/Response Time for delivery of services by our department:

Sr. No.	Item of Work	Targeted Response Time
a.	Information on licensed blood banks	One day/visit http://www.apcda.com/
b.	Information on Banned Drugs	Immediate/visit http://www.aidcoc.org/
c.	Information on prices of Notified Drugs	Two days/visit http://www.nppaindia.com/
d.	Information on drugs about contraindications, doses, etc.	Two days/visit http://www.rxforce.com/
e.	Complaints on service of Chemists and Druggists	15 days for local dealer 30 days for outstation dealer
f.	Complaints on quality and Adverse reactions of drugs	Result will be communicated to you after receipt of Quality Report

In respect of the above information, complaints can be lodged at the concerned Drugs Inspector's Office.

In case any further follow-up and for suggestions to improve the services, where you feel necessary, please contact the following officers:

1. Joint Director, Drugs Control Administration, Vengalarao Nagar,

   Hyderabad-500 038; E-mail: apdca@ap.gov.in

2. Director, Drugs Control Administration, Vengalarao Nagar, Hyderabad-500 038; E-mail: apdca@ap.gov.in

3. Inspector General, Drugs and Copy rights, Drugs Control Administration, Vengalarao Nagar, Hyderabad-500 038; E-mail: apdca@ap.gov.in

III. Availability of Forms and Information:

Checklist and Forms, please visit http://www.apcda.com//http://www.pharmabiz.com/ or respective Associations.

IV. Guidance and Help can be obtained from the Concerned Drugs Inspector's Office.

V. In case any further follow-up and for suggestions to improve the services, where you feel necessary, please contact the following officers:

1. Deputy Director-I, Drugs Control Administration, Vengalarao Nagar,

   Hyderabad-500 038; E-mail: apdca@ap.gov.in

2. Joint Director and Director (FAC), Drugs Control Administration, Vengalarao Nagar,

   Hyderabad-500 038; E-mail: apdca@ap.gov.in

3. Additional Director General, Drugs and Copy rights, Drugs Control Administration, Vengalarao Nagar, Hyderabad-500 038; E-mail: apdca@ap.gov.in

VI. HOW YOU CAN HELP US TO HELP YOU BETTER?

i. Follow the Guidelines given under the Drugs and Cosmetics Act 1940 and rules thereunder.

ii. Associate Drugs Control Administration in meetings of professional organization like IPA, BDMA, etc.

iii. Apply for renewal of licences in time.

iv. While dispensing drugs against prescription, consult the doctor in case of doubt.

v. In case of doubt on quality of drugs or complaint from citizens, inform the nearest Drugs Inspector.

HOW YOU CAN HELP US

FOLLOWING GUIDELINES ARE FOR YOUR SAFETY AND HEALTH

1. Consult qualified Doctor and use drugs as per his advice only.
2. Purchase medicines from licensed Medical Shop and insist for bill.
3. In case of non-availability of any drug, please inform nearest officer of Drugs Control Administration for taking further action.
4. Look for the date of expiry and price printed on the label of the drug and, if any discrepancy is found, please report to us for taking necessary action.
5. Inform details of any adverse drug reaction you have come across on the use of any drug to us for investigation immediately.
6. Show the drug purchased by you to your doctor for verification and guidance.
7. Destroy all containers of used medicines along with their labels.
8. Keep medicines out of reach of Children.
9. Store medicines properly as per the directions given on the label.
10. Citizen has right to get drug/cosmetics analysed on cost by Government Analyst as per the Drugs and Cosmetics Act.
11. Aggrieved citizen can institute prosecution against any erring dealer/manufacturer under the Drugs and Cosmetics Act.
12. Don't accept medicines labeled as "Physician's Samples" and "Govt. Supply not for sale" from any Medical Shop.

Clarification:

1. Our operations are restricted to Allopathic Drugs and Cosmetics.
2. No action will be taken on anonymous complaints.

CLIENT'S CHARTER

I. Services offered by this Department:

1. Grant of manufacturing licences
2. Renewal of manufacturing licences
3. Grant/renewal of approval for Approved Laboratories
4. Approval of Additional Products
5. Approval of Technical Staff
6. Recommending Grant/Renewal of Licenses to Central Licensing Authority, Delhi, with respect to Vaccines and Sera; Large Volume Parenterals; Blood Banks
7. Effecting changes in existing licences
8. Issue of WHO GMP Certificate
9. Issue of Free Sale Certificate
10. Issue of Market Standing Certificate
11. Issue of GMP Certificate
12. Issue of Non-Conviction Certificate
13. Issue of Production Capacity Certificate
14. Grant of Sales Licences
15. Renewal of Sales Licences
16. Effecting changes in existing Sales Licenses

II. Our Service Standards

We have set the following Targets/Standards/Response Time for delivery of services:

Sl. No.	Item of Work	Targeted Response Time
1	Grant of Manufacturing Licences	21 Working days
2	Renewal of Manufacturing Licences	60 Working days
3	Grant/Renewal of approval for Approved Laboratories	30 Working days
4	Approval of Additional Products	10 Working days
5	Approval of Technical Staff	10 Working days
6	Recommending Grant/Renewal of Licences to Central Licensing Authority, Delhi with respect to Vaccines and Sera; Large Volume Parenterals; Blood Banks	30 Working days
7	Effecting Change in Existing Licences	10 Working days
8	Issue of Free Sale Certificate	5 Working days
9	Issue of Market Standing Certificate	5 Working days
10	Issue of GMP Certificate	15 Working days
11	Issue of Non-Conviction Certificate	5 Working days
12	Issue of Production Capacity Certificate	5 Working days
13	Issue of WHO GMP Certificate	30 Working days
14	Grant of Sale Licences	30 Working days
15	Renewal of Sale Licences	90 Working days
16	Effecting Change in Existing Sale Licences	15 Working days

Source: Website of Andhra Pradesh Drug Control Department

Annexure III — Punjab Drug Sampling – January to December, 2009

1.	Number of Drugs Samples Taken	2969
2.	Number of Samples Tested	1956
3.	Number of Samples Declared “Spurious”	1
4.	Number of Samples Declared As “ Not of Standard Quality”	121
5.	Number of Samples Declared “Misbranded”	52
6.	Number of Chemists From Where Drugs Seized	553
7.	Total Amount of Seized Drugs	34857001
8.	Number of Licenses Cancelled	203
A)	Cancelled Due to Contravention Relating to Habit Forming Drugs	21
B)	Cancelled Due to General Contravention	3
C)	Cancelled Due to Firm’s Own Request without any Contravention.	179
9.	Number of Licences Suspended	409
A)	Suspended for Contravention Relating to Habit Forming Drugs	106
B)	Suspended Due to General Contravention	303
10.	Number of Court Cases Under Trial	326
11.	Number of Prosecution orders issued against Defaulters	70
12.	Number of Prosecutions Launched	59
13.	Number of Cases Decided	33
14.	Number of Persons Convicted	20
15.	Number of Persons Acquitted	13
16.	Number of Persons Discharged	Nil
17.	Number of Persons Declared P.O.	7
18.	Number of Joint Raids	611
19.	Number of Inspections	5444

Source: Health Department, Punjab

Annexure IV — Prevention of Food Adulteration

Sr. No.	District	Sample Reports			Sample Reports	
		Received from lab during the month	Received from lab from January to till date	Number of samples found adulterated during the month	Number of samples found adulterated from January to till date	Samples pending with lab till date
1.	Amritsar	27	85	7	22	-
2.	Bathinda	25	71	2	15	9
3.	Barnala	10	48	-	13	14
4.	Faridkot	8	33	-	-	5
5.	Ferozpur	17	90	2	10	34
6.	Fatehgarh Sahib	11	33	1	3	11
7.	Gurdaspur	9	77	6	6	28
8.	Hoshiarpur	29	67	-	2	53
9.	Jalandhar	27	91	11	12	38
10.	Kapurthala	4	62	-	3	10
11.	Ludhiana	-	146	-	25	50
12.	Mansa	5	24	1	3	12
13.	Moga	11	30	1	2	11
14.	SAS Nagar	21	50	2	6	10
15.	Mukatsar	17	46	1	5	7
16.	Nawanshahr	11	12	2	12	5
17.	Patiala	14	67	1	3	13
18.	Ropar	-	46	-	3	15
19.	Sangrur	19	58	8	11	20
20.	Tarn Taran	6	53	3	4	31
	Total	**271**	**1189**	**48**	**160**	**376**

Source: Health Department, Punjab

Annexure to Chapter 4

Annexure I — Status of Data Entry of Jamabandis

Sr. No.	District	Total Khewats	Khewats Entered	Pending khewats	%age of Khewats Entered	Number of inconsis-tencies found in the revenue record	Number of inconsis-tencies removed	Number of inconsis-tencies to be removed	%age of inconsis-tencies to be removed
1	Jalandhar	315861	270936	44925	86%	24710	15251	9459	38%
2	Gurdaspur	267119	210015	57104	79%	20161	11945	8216	41%
3	Shahid Bhagat Singh Nagar (Nawanshahr)	147311	121129	26182	82%	14234	10100	4134	29%
4	Amritsar	279345	179495	99850	64%	49283	31399	17884	36%
5	Tarn Taran	133668	116499	17169	87%	21363	7837	13526	63%
6	Kapurthala	146100	142508	3592	98%	23775	18448	5327	22%
7	Hoshiarpur	375296	324192	51104	86%	26099	17736	8363	32%
8	Patiala	187096	182561	4535	98%	22684	11201	11483	51%
9	Ludhiana	428747	375209	53538	88%	31488	10640	20848	66%
10	Sangrur	206710	197431	9279	96%	25920	21125	4795	18%
11	Barnala	103753	100092	3661	96%	6770	5793	977	14%
12	Fatehgarh Sahib	92336	90069	2267	98%	9227	3416	5811	63%
13	Roopnagar	143666	139290	4376	97%	1738	364	1374	79%
14	S A S Nagar	95513	90423	5090	95%	7993	5029	2964	37%
15	Ferozepur	288276	266460	21816	92%	14539	7051	7488	52%
16	Moga	196968	192663	4305	98%	25447	24379	1068	4%
17	Mukatsar	150443	138706	11737	92%	11626	5241	6385	55%
18	Faridkot	59250	58197	1053	98%	1424	1068	356	25%
19	Mansa	99671	99209	462	100%	9589	8591	998	10%
20	Bathinda	155040	145226	9814	94%	11511	11212	299	3%
	Total	3872169	3440310	431859	89%	359581	227826	131755	37%

Annexure II — District-wise Status of Data Entry of Mutations

Sr. No.	District	Number of current mutations to be entered	Total Mutations entered so far	Mutations pending	%age of Mutations completed
1	Jalandhar	117677	11234	106443	10%
2	Gurdaspur	89594	9920	79674	11%
3	Shaheed Bhagat Singh Nagar (Nawanshahr)	51164	14334	36830	28%
4	Amritsar	168415	4267	164148	3%
5	Tarn Taran	72165	4408	67757	6%
6	Kapurthala	43068	5697	37371	13%
7	Hoshiarpur	73359	15759	57600	21%
8	Patiala	198871	14882	183989	7%
9	Ludhiana	191751	12879	178872	7%
10	Sangrur	112304	19397	92907	17%
11	Barnala	33321	7818	25503	23%
12	Fatehgarh Sahib	35720	17033	18687	48%
13	Roopnagar	36870	15654	21216	42%
14	S A S Nagar	56826	11419	45407	20%
15	Ferozepur	147539	11077	136462	8%
16	Moga	76929	14499	62430	19%
17	Mukatsar	62971	8846	54125	14%
18	Faridkot	38536	12343	26193	32%
19	Mansa	54827	9531	45296	17%
20	Bhatinda	70671	11020	59651	16%
	Total	**1732578**	232017	**1500561**	**13%**

Annexure III — Types of Common Errors

The share of owners is not equal to one (1/1) in number of Khewats.

In many cases, the name of the owner does not find mention in the owner column but he/she is selling/mortgaging the land in column no. 5 (Cultivation) of the Jamabandi.

Mundraja Khewat number has not been recorded thereby rendering the record to be incomplete.

Although there are number of owners in a Khewat, only one or two persons are selling the land of all the landowners in that Khewat.

There are duplicate Khewat Numbers, Khatouni Numbers and Khasra Numbers in the Jamabandis.

The total area of a village has not been correctly recorded in the Jamabandi.

In many cases, name of Father/Grandfather is missing in Jamabandis.

In many cases, name of Father/Grandfather differs in Jamabandi and the Mutation register.

In many cases, an owner is selling more than his/her share from the Khewat from all the Khasra Numbers as well as selling specific Khasra Numbers.

Against many Khewats, in the column of ownership, the word “Kamj Marla” has been written instead of defining their share.

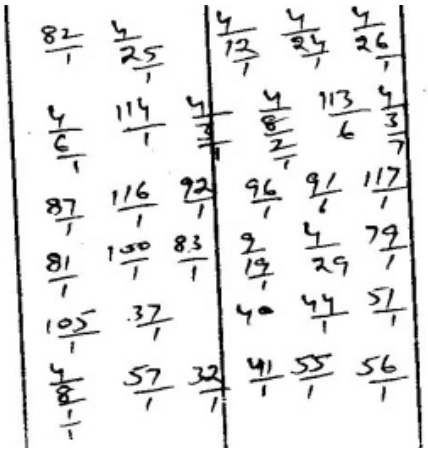
There is variation in the records of “Parat Patwar” and “Parat Sarkar”.

A few cases have been noticed where the sequence numbers of Khewats have been changed in the records.

In many cases, the Owner of the land is Central Government but some third person is selling the land.

There are many cases where a Cultivator (Gair Marusi) is mortgaging the land further to a third person.

There are a few cases where the Khasra number has been mentioned incorrectly as per the illustration given below:



There are a number of cases where the record has been amended with Red ink in various columns of Jamabandi instead of mentioning the same in the Remarks Column.

Land units have been used in the records which are not prescribed in the Land Record Manual e.g. in many villages in Amritsar, Land Unit of Sq. feet has been used.

Annexure IV
Extent and Genesis of the Problems of Title of the Urban Properties in Punjab

The spread of urban settlements and urbanization in Punjab is centered on the 'Lal Lakir' of every village of Punjab. 'Lal Lakir' was created during the settlement process (*Settlement of Records of Rights was done by the British India Government from 1896 onwards and was more or less completed by 1930's*) and no record of rights of the properties within the 'Lal Lakir' is maintained by any of the departments of the State of Punjab.

With the growth of population in the urban areas, plotting and change of land use from agriculture to residential and commercial took place rapidly in the areas falling outside the Lal Lakir. For example, in the villages of Jalandhar, there is a 'Lal Lakir' which is the oldest part of Jalandhar and perhaps with the population of a few thousand persons. The urban development and urban settlements took place around the 'Lal Lakir' as Jalandhar grew up from a Jalandhar village in the later part of 19th Century to a city of more than 10 lacs population as of now.

As per the Land Records Manual of the Revenue Department, the Sub-Division of any Khasra No. should be captured through the process of Tatima Mutation in the Mussavi of the village.
(*A village is a village in the revenue system irrespective of the fact whether it has become a big city or remains a nondescript rural village with very small population*). With the growth of some villages which have become urban cities now, the incorporation of Tatimas in the Mussavis did not take place as was expected because with the plotting of the agriculture land in colonies, mohallas, roads, streets, chowks etc., nor feasible to update the mussavis to capture the miscellaneous plotting. It was neither possible.

This problem was further compounded by the fact that certain development departments acquired land under Land Acquisition Act and carved out residential, commercial and industrial estates. The Revenue Department conveniently entered the name of the Development Department as the owner of the land in the revenue records and did not give any attention to the individual owners in the development scheme. The ownership, mortgage, transfer, inheritance etc. is being carried out vis-à-vis the development department/undertaking, while the work of registration only goes to the revenue department as mandated under the Transfer of the Property Act that any property worth more than Rs. 100 is to be compulsorily registered if the ownership has to change from one person to the other.

The pertinent question is to tackle the lands that are outside the 'Lal Lakir' and outside the development schemes in a reasonable way. Well, the answer is that the ownership and the Records of Rights are theoretically being maintained by the Revenue Department and the quality of such record keeping can be imagined when it is learnt that only five Patwaris are maintaining the record of the city as big as Jalandhar. To put it briefly, the maintenance of the record of rights is chaotic, non-standardized, unspecific and illogical. While the Khasra Nos. from the settlement process remain intact and there is no wilful break of Khasras with the division of the Khasras and, therefore, the Patwaris are normally giving shares of the land to the owners instead of breaking the khasra numbers. For example, a person may own

9/480 share in a khewat, which logically will say that he owns 9th share of the total 480 shares, but no body knows from which Khasra number and which side of a particular Khasra number? There are khasra numbers as large as 20 acres in the city of Bhatinda. This is the bitter reality of the Land Record System of modern Punjab in urban areas. Needless to say, it is a very fertile ground for the land grabbers to dispossess a helpless landowner from one corner of a Khasra Number to another as long as he is given the area equivalent of 9/480 share.

With the advent of PAPRA Act and PUDA Act in the Urban and Housing Department, the private colonizers obtain licence to develop a colony or a shopping mall or a multi-storey building. After the development, the land or the built-up area is sold through a registered deed from the developer to the purchaser of the property of the scheme/project, without 'tatima map' along with the registered deed and, more often than not, it is again in shares and the possession is given as per the ground/site (Mokka). In this way, basically, the person has got a share of the total area of the land in question and not a demarcated piece of land. Of what worth is the 'title' without demarcation! Who will prevent the colonizer from selling the park and the road once his bank guarantee is released by the development agency. After all, he has to sell and execute the registered deed of the leftover shares in the land and there will be willing buyers to buy at half the offering price! Where is the system to address this problem to prevent selling common lands/areas?

The Government lands in the urban areas have been grabbed or have been encroached with impunity. That will keep on happening year after year as the custodians of such properties i.e. the Tehsildars and Naib-Tehsildars are busy in the registration work. To give an example, there was a big village pond at Jalandhar measuring approximately 7 to 10 acres abutting Tanda Road near the Railway Phatak. With not even a square inch of land lying vacant, every nook and corner has been encroached and over a period of time, the registrations effecting transfer of the ownership have also taken place in the name of the encroachers who have now become the rightful owners of the Government land. An instance of colossal loss to the State exchequer!

To sum up this mess in the Urban Land/Property Management System, some discernible conclusions can be drawn as under:

1. No register of the properties is being maintained which ought to reflect the records of rights (ROR) of the owners as per their possessions. As such, no demarcation of the parcel of land is in consonance with ROR.

2. There are multiple agencies like PUDA, GMADA, Municipal Corporations, PSIEC, Improvement Trust', DC Office etc. which are maintaining the records of ownerships and the rights on the Urban Lands.

3. Private colonizers are selling plots to the public without proper title with verifiable/demarcated possession entered in a register of the competent public Authority.

4. No system is in place to address the need to give title backed by a law on built-up areas like a shop in a mall or a office on the 4th floor of a commercial building.

5. Large encroachments on the Government lands to start with and the surreptitious acquisition of the ownership rights on such Government lands by the encroachers with active or passive connivance of the Revenue Officials.

6. Huge scope of selling these lands through a well devised policy on "drawing the curtain approach" which would unlock the Government assets to generate huge amount of funds for the State exchequer, if the land could be identified & measured.

7. There is no demarcated register for the Government lands in the urban areas.

The System of Registration of Deed based on the earlier Registration Deed

The transactions of buying, selling, mortgaging, etc. the properties in the urban areas are continuously taking place despite the aforementioned difficulties. These transactions are now being done on the basis of the previous registered deeds and on the basis of the municipal record, which are placed before the Sub-Registrar as a proof of ownership. In other words, the general public are not coming forward to get the mutations entered and sanctioned after the registration of a deed from the circle revenue officer primarily owing to the absence of any urban record which is maintained to capture the last owner's name. The deed becomes the proof of ownership and the banks are also taking the sale deeds as a lawful title for a particular property. The question arises about these being any difficulty in all this? How can this be allowed to happen as the public seems to have devised its own system for transacting business in the real estate? In fact, it is not possible to find solution to the problems for the following reasons:

1. How does one get the title of the property based on inheritance, whether on the basis of a Will or otherwise, if there is no public register maintaining such record?

2. Despite depositing the original registration deed with the bank for mortgaging the same for raising loan, one can still sell the property on obtaining the attested copy of the registration deed from the Sub-Registrar' Office! Where is the security with the bank? In other words, no collateral security is possible unless there is a public register which enters a mortgage mutation on the title.

3. Without the updated public register, the buyer of a property is always on tenterhooks, whether he is purchasing a property with or without a clear title? There is no register which verifies the credentials of the ownership? What about the hidden 'Patanamas' which are in private domain and the persons get into unnecessary litigation when he finds to his utter shock that the property he had purchased was already encumbered.

4. How does one implement a court decree or order in the absence of a public property register? Impossible! In view of the non-existing public property register, there is no way a court order or decree can be implemented.

Why has this happened?

The reasons why this mess has been created over the years are manifold. To start with, during the process of consolidation of the holdings, which started in the year 1948, the Revenue villages which had been urbanized when the Consolidation Process started, were left out of the process, because the revenue records in these villages were complicated and

the consolidation authorities decided to leave these villages out of the consolidation operations. The cities of Jalandhar, Amritsar, Ludhiana, Patiala, Bathinda, Pathankot etc. are among those urban villages where consolidation could not take place and the basic records of the areas falling under these cities flow out of the Settlement records, which are not accurate and are not referenced to any particular ground pillar or marks. The khasra numbers of these cities have different dimensions unlike (36 Karam x 40 Karam standard acre) and, it is astonishing to know that a particular khasra number in Bathinda is of 40 acres. The Mussavis of these cities were never prepared and, therefore, the only revenue maps of these cities are the Patwaris' Lathas, which are not accurate in the sense that the dimensions of a field number do not match with the area, as given in the Jamabandi.

Even otherwise, the 'tatimas' (supplementary maps) have not been carved out of these khasra numbers as has been mentioned in the earlier parts of this paper.

It is worth mentioning that even though Para 7.45 of the Punjab Land Records Manual prescribes 'Jamabandi Abadi ' with following columns, the guidelines were never implemented by the Revenue Department for unknown reasons:-

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
										Area in Kanals/ marlas or metric units		Description of Land						
Serial No. according to auction of allotment register/private treaty	Khewat Number	Khatauni Number	Name of lambardar with revenue	Name of owner with description	Name of tenant with description	Name of owner of building/material with description	Name of the rent payer with description	Number of block	Field number or site number	Area according to the registered deed or according to the original contract	Present area	Purpose for which the land was originally allotted	Purpose for which it is being used	Rent annually paid by the occupier	Class of ahata	Rate of revenue imposed	Demand with details of revenue and cesses	Remarks

Had the Revenue Department adopted the concenpt of 'Jamabandi Abadi' during or after the consolidation, perhaps the present mess could have been avoided. The fact that the Department persisted with the rural Jamabandi in the urban areas with the accompanying processes of 'tatima mutations' not being carried out for the urban areas. All this has led to a situation where the land records are out of sync with the ground reality and have woefully lagged behind the speed with which the plotting of the agricultural land parcels have taken place while the land records system in the urban areas 'remained' a silent spectator. For

example, even today the land (about twenty five acres) on which a high density population of the famous Bastis of Jalandhar city resides is still in the name of Maharaja of Kapurthala in the ownership column of the Jambandi while average size of the holding in these areas is not more than 5 marlas or so.

To summarize, the following factors have led to the current situation:

1. Consolidation did not take place in most of the cities of Punjab with the result that the Mussavis were not prepared for the cities.

2. The revenue authorities did not follow the abadi Jamabandi system for the urban areas.

3. The rural revenue system of khewat, khatauni, khasra numbers etc. were applied in the urban areas and this system was not designed to cater to the rapid sub-division of the land parcels around the cities.

4. With the acceleration of the development in Punjab in 1980s, the Revenue Department lost its prime position in the Government and, in fact, went into neglect after the Department completed the consolidation work. No new innovative schemes or systems were introduced to keep pace with the commercial transactions, which took place, especially for those lands, which were on the periphery of the original 'lal lakir' of the urban villages.

5. General deterioration in the work culture of the Revenue Department.

Can Computerization of Land Records Help?

The Department of Revenue has undertaken a Project for the Computerization of the Land Records in the State, wherein data entry work is being carried out in all the districts. One of the most noteworthy findings of this Project is that the revenue records in the urban areas are not fit enough to be computerized, because most of the entries are logically incorrect and not in consonance with the Land Records Manual. As a result, most of the records for the urban areas are going to be left out of this Project for obvious reasons.

What should be the approach to clear up the mess?

The approach to clear up these ambiguous records in the urban areas is to create a data base of all the properties, afresh, which have come under urbanization. All vacant lands and the built-up properties in the urban areas need to be given a Unique Property Code (UPC) and data base of UPC needs to be created, maintained and to be updated as and when there is a change in any parameter in the database pertaining to a UPC, owing to any **transaction** or changed **status** of the land/property.

A good amount of work has been done by the Directorate of Land Records in creating the UPC and the suggestive parameters of the UPC are given as below:

The suggested property code will be of 22 digit characters and is defined as follows:

State Code	District Code	City Code	Locality (2)	Street/ Road	Block/ Sector	Type	Building (2)	Floor	Property Number

(2)	(2)	(2)		(2)	(2)	(2)		(2)	(4)

a) First two characters in the UPC are proposed to be State Code that can be either "PB" or "03" and may be fixed as "PB" or "03" and will remain the same for the whole State. As per the Census of 2001, the State code of Punjab was 03. As per the Transport Department, the State code of Punjab is "PB". It is proposed that either of these codes may be used. This would be very relevant if, at any later stage, Government of India decides to have a National Property Information System.

b) Next 2 characters in the UPC are proposed to be District Codes. It is proposed that either district code used by the Census department can be used or new codes can be defined.

c) Next 2 characters will be the code of the city. This will be unique within the district.

d) Next 2 characters will be the code of the locality. This will be unique within a city.

e) Street/Road: Every street and road will be assigned a 2 digit code. This will be unique in the locality.

f) Every Block/Sector will be assigned two digit code.

g) The following types are likely to be covered:

   i. Open Plot

   ii. Commercial

   iii. Residential

   iv. Agriculture

   v. Institutional

   vi. Religious

   vii. Government Office

   viii. Semi-Government Office

   ix. Others

h) Next two characters will indicate the type of building e.g. Single-storey, Multi-storey, Flat, Shopping Mall, Multi-storied commercial building etc.

i) Next two digits will indicate the floor number of the property

j) Last 4 digits will be unique incremental numbers within that locality/building/built-up area.

Creation of Database

The creation of database is likely to be a difficult task. First of all, the existing record that is available with the Urban Jamabandis of the Revenue Department, Urban Development Agency like PUDA, GMADA, Improvement Trusts, Municipal Bodies, PSIEC, D.C. Offices, Punjab State Electricity Board etc. needs to be collected for creating a skeleton data base.

Thereafter, a High Resolution Satellite Imagery (HRSI) has to be obtained and a tentative property code given to each property. Thereafter, a detailed ground survey will have to be carried out to fix the longitude and latitude coordinate of the traverse points of each and every property and then, UPC for each property will be assigned. Many large cities in India have started this work like New Delhi, Kanpur, Pune, and Mumbai.

Against each UPC, the number attributes will have to be assigned, which will create a database for each property for multiple use by the different departments of the Government as well as the private organizations.

The suggestive attributes, not limited to the following, are given as below:

- Property Code
- Ground Survey GPS Coordinates of traverse points
- Ownership Details
- Mortgage Details (If any)
- Tenant Details
- Neighbour details
- Court Orders
- Any pending dues of the State Government Central/Government or any other Government Agency
- Dimensions
- Area
- Built-up Area
- Any Encroachment
- Market Value
- PSEB Account details
- Municipal Account Details (Property Tax, Water Bill, Sewerage Bill etc)
- Photo of the Property
- Photo of the Owners and unique personal identification code (when available)
- Signature of the owners
- Abutment details from the approach road or paths
- Sewerage and sewerage connection details
- Physical characteristics of the built-up area

Settlement of the Title of the UPC

Obviously, this is likely to be the most difficult and cumbersome task, which will decide the success and failure of the concept. The settlement means settling the ownership rights of the urban property, settling the area and dimensions of the property, settling the ownership rights between the co-owners (if they desire to do so), settling the encumbrances on the property, incorporating the decisions of the court orders against the property etc. The idea is to settle the above parameters and to give absolute title to the owners.

The process for the settlement shall be by inviting objections from the general public regarding each and every property and, after scrutinizing the available titles, evidence, claims and counter claims, if any, the Settlement Authority shall give a certificate of the attributes of each UPC.

The work of the settlement can only be carried out through an Act of the State Government, which will have to be promulgated and the settlement authorities created under the Act.

Updating the Attributes of UPC or UPC itself

The Urban Properties are subject to many changes carried out by transactions like sale, gift, mortgage, inheritance, sub-division, court orders, exchange, change in the land use, change in the built-up area, demolition, increase in the built-up area, change of the land use, increase in the sanctioned load of PSEB etc. If the data has to remain meaningful and of value, then all the changes will have to be incorporated in the database. The database may change because of some valid reasons though not limited to the following:

- Registration of Deeds
- Change in the Market Value
- Inheritance
- Court Orders
- Partition
- Banks/Financial transactions like mortgage, deposit of title deeds etc.
- Local Bodies
- Urban Development Authorities (Issue of licenses to develop the colonies)
- Improvement Trusts
- Town Planning Department (For change of Land Use)
- Any other Govt. Department

Implementing Agency

It is proposed that an agency with the name 'Punjab Urban Properties Management Authority' (PUPMA) be created. The agency should be a statutory body under the State Government Act to be headed by a person of national repute and be given status of the Cabinet Minister. The person should have experience in the domain of Urban Development, Land Records and Information Technology including Geographical Information System. The Authority should be autonomous and enjoy all administrative and financial freedom. All decisions taken by the Authority should be appealable in the Hon'ble High Court. Such Authority is already functioning in our neighboring State of Rajasthan, where a 'Board of Revenue' is in place and all the judgments of the Board are appealable only in the Rajasthan High Court.

Methodology

A question may arise about the parameters within which the Authority shall work. The functions, which are not critical and do not require any discretion, can easily be outsourced. It is proposed that the functions that may be outsourced under Public Private Partnership paradigm are survey, preparation of the database, verification, maintenance of the database and may be undertaken through the Built, Own, Operate (BOO) Operator. The software work can also be outsourced. The IT component of networking, maintenance of the data centres and other IT infrastructure can also be outsourced.

The critical function of the settlement of the urban records may have to be done by the officers of the Authority for which recruitment, selection, training will have to be organized by the Authority.

Control

No registration of the Deeds, Power of Attorney, Inheritance or any commercial transaction will be allowed without UPC. Initially, UPC will be made optional for a period of 3-5 years. After that, it will be made mandatory by a public notice to have UPC within some stipulated period of time.

Conclusion

To summarize the concept, it is very similar to the Project conceived and being implemented by the Government of India i.e. Unique Identification Authority of India (UIDAI) which shall have the responsibility to lay down plans and policies to implement Unique Identification (UID) Scheme (for individual persons), and shall own and operate UID database...," ***The PUPMA shall be such an authority for the urban properties of Punjab State*** and will set the trend for the rest of India. By taking such a path-breaking initiative aimed at ameliorating the plight of the genuine urban property owners, Punjab State will be giving litigation free title to the properties they own. The solution, as prescribed, will ensure that the State of Punjab takes the necessary steps to move towards conclusive titling and 'de-matting' of the urban properties, which was completed many years back by the developed countries like USA, UK, Germany and others.