PANCHAYATI RAJ: A REVIEW OF EMERGING TRENDS AND THEIR IMPLICATIONS FOR HEALTH

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CERTIFICATE

Certified that the dissertation entitled **PANCHAYATI RAJ: A REVIEW OF EMERGING TRENDS AND THEIR IMPLICATIONS FOR HEALTH** submitted by **Sanjeev Kumar Singh** is in partial fulfilment of the requirement for the award of the degree of **Master of Philosophy** of this University. The dissertation has not been submitted for any other degree of this university and is his own work.

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Dedicated to
My Parents

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ABBREVIATION

CDP	-	Community Development Programme
CHC	-	Community Health Centre
CHWs	-	Community Health Workers
FRCH	-	The Foundation for Research in Community Health
ICDS	-	Integrated Child Development Scheme
ICMR	-	Indian Council of Medical Research
ICSSR	-	Indian Council of Social Science Research
NES	-	National Extension Service
NGO	-	Non-Governmental Organisation
NHP	-	National Health Policy
NICD	-	National Institute of Community Development
PHC	-	Primary Health Centre
PRIs	-	Panchayati Raj Institutions
SCs	-	Scheduled Castes
STs	-	Scheduled Tribes
WHO	-	World Health Organisation.

CHAPTER ONE
INTRODUCTION

CHAPTER I

INTRODUCTION

Still after many years of modernisation and urbanisation, India is predominantly a country of villages and these villages constitute the backbone of our country. The progress of the country is, therefore, interlinked with the progress of our villages and later can be achieved only with the democratic performance of the village panchayats and active involvement of the villagers in the developmental process. It calls for democratic decentralisation with focus on villages as the basic units of administration that will facilitate each villager, as Indira Gandhi puts it, "to have a means of real swaraj in his own village."[1]

In a democracy, decentralisation of economic, political, administrative and financial power is essential, because a few centres of powers cannot realise or fulfil the needs of the vast multitude of people. In fact, concentration of decision-making powers in a few hands at the centre disrupts the growth of harmonious political system, debilitates the economy, and accentuates disparities. It renders the principal constituents, namely, the states, weak, not to speak of the erosion of such institutions as the panchayats, municipalities, cooperatives and voluntary organisations which form the core of representative people's institutions within each state. It is being realised that so long as this obstruction is not removed, the country will not be able to meet the challenges of mounting inequality, poverty and unemployment nor will it succeed in mobilizing the requisite human and material resources for achieving a higher and sustained standard of

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1 Indira Gandhi, *Royal Institute of International Relations*, London, 29th October 1971.

living.[2] The process of development, being multi-dimensional as well as multi-directional, calls for cooperation that crystallises into sharing of the power by the people. Gandhiji, therefore, had stressed that democracy must begin at the bottom. The decision of development should be made by the village people as also the priorities and implementation of the programmes.

Decentralisation of working at the grassroots level is the crux of development and it should not only restrict to decentralise power, planning process and development activities, but also cover all related activities below the district level. The democratic process should start from village upward to mandal, district, state and the centre. The Ashok Mehta Committee aptly observes, "A vibrant faith in democracy should naturally demand greater opportunities for direct involvement of the people in the management of local affairs. The urge for democratic control over administration at the local level... is also an offshoot of the ongoing democratic process. If the edifice of democratic polity is to become secure in the country, the strengthening of democracy at the grass-roots is inevitable."[3]

The issue of decentralisation is more complex in concept and practice than is generally acknowledged. It has been conceived as an aspect of intra-organisational differentiation, as territorial dispersion of units of organisation and delegation of authority, or simply delegation of power. Decentralisation, in fact, is a process whereby the government divests itself completely of certain duties and responsibilities and devolves them upon some other authority at the local level, along with devolution of

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2 L.C. Jain, "Democratic Decentralisation", *Seminar*, 360, August 1989, p.38.

3 Report of the Committee on Panchayati Raj Institutions, Government of India, 1978, p.32.

powers to them. According to Rajni Kothari, "Decentralisation, like democracy, has to be conceived as providing a total model of social, economic, political and cultural arrangement, as a conception of organizing civic life and as a philosophy that informs the functioning of the institutions, policies and programmes that impinge upon the lives of the people."[4]

As such, democratic decentralisation demand existence of local bodies and a healthy atmosphere where 'participative democracy' among all members of local self-government can thrive. These small units of government gives people a chance to practise democracy at the 'grassroots' level where the issues are easily understood. Essentially, government in small units is personal government, wherein the individual can identify himself more easily. At the same time, it also offers a unique opportunity to participate in developmental work.

The Balwantray Mehta Committee emphasised the importance of local bodies from the development point of view. It observes that, "Development cannot progress without responsibility and power. Community development can be real only when the community understands its problems, realises its responsibilities, exercises the necessary powers through its chosen representatives and maintains a constant and intelligent vigilance on local administration.[5]

In Indian context, where about eighty percent of our people live in villages, democratic decentralisation is being realised through the institution of Panchayati Raj. It is a complex system of rural local self-government with the twin objectives of

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4 Rajni Kothari, "Decentralisation - the Real Issue", *Seminar*, 360, August 1989, p.19.

5 Report of the Team for the Study of the Community Development Projects and National Extension Service, Government of India, 1957, p.26.

democratic decentralisation and the local participation in planned programmes. It was introduced in 1959 on the recommendation of Balwantray Mehta Committee after the failure of community Development Programme (CDP, 1952) and National Extension Services (NES, 1953). The Panchayati Raj Institutions (PRIs) are statutory elected bodies at the village, block and district level, namely, Gram Panchayat, Panchayat Samiti and Zilla Parishad respectively, with powers of local government. These institutions are to guide the villagers and enable them to achieve intense and continuous development in the interests of entire population. By 31 March 1987, Panchayati system almost covered 95 percent of rural population in our country, offering new avenues of service and new programmes to the people.

But over the years, due to various problems like resource crunch, politicisation of local bodies, power structure of society which allowed rural elite to control PRIs and structural inadequacies, Panchayati Raj failed to fulfil the aspirations of self-government. Various committees, then, conducted inquiry into the working of its institutions and suggested measures to bring about an effective decentralised system of democratic self-government. Finally, the Constitution (73rd Amendment) Act have been brought to help Panchayati Raj to operate more effectively.

The seventy-third Amendment Act, 1992 has tried to regularise Panchayati Raj system by providing uniform system throughout country, panchayat accountable to villagers, all members of village panchayats being elected, five year term and compulsory elections within six months of dissolution under supervision of State Election Commission, financial accounting by State Finance Commission, one-third reservation for women in Panchayat seats, reservation for Scheduled Castes (SCs) and Scheduled Tribes (STs), etc. Thus, there is renewed emphasis on local planning and

implementation of development policy and also on participation of underprivileged and weaker sections like women and SCs and STs.

While there is a movement towards people's participation in developmental process, the question of availability and accessibility to primary health care assumes importance as health status is one of standard index of development. Primary health care has become synonymous with basic needs of human being which must be fulfilled with developmental process. In this context, from the very beginning together with movement towards Panchayati Raj, efforts have been made to provide people's health in people's hands., viz., Report of National Health Sub-Committee of National Planning Committee, 1938, Bhore Committee Report, 1946 and later in Community Health Volunteers' Scheme (CHVs 1977). The Alma Ata Declaration on Primary Health Care, 1978 supported the move towards strengthening community self-reliance in health and National Health Policy (NHP), 1982 contained policy decisions to build up individual self-reliance and effective community participation.

But even after five decades of independence, freedom from hunger, disease and deprivation did not come for the majority of people. The eight five-year plans, while marginally affecting a few areas, left a number of major unfinished agenda for health and the people's health status unchanged, while health care costs spiralled and skyrocketed. While Committees and Government documents always show the concern for the poor, the health services were grossly inadequate, priorities misplaced and implementation inappropriate. Despite attention to 'soft' issues such as the orientation of personnel, right from the inception of health policy-making, the emphasis over the decades has been on the 'hardware' - the construction of health facilities, their equipment

and staffing, and research and development for technology- based medicine.[6] Banerji has often pointed out that while the 'existing model' of health services is frequently decried and 'alternatives' sought to improve rural health in particular. there has been a failure to date to modify health plans and allocations.[7]

The curative approach based on western model have been proved to be quite irrelevant to real needs of our people and this enhanced dependency, rather than self-reliance. People's involvement in the identification of their health needs and priorities as well as in the implementation and management of various health and related programmes, were ignored. This fact seriously affected the level of primary health care to the people as while disease are 'invented' to ensure use of high technology like scanners and coronary surgery, large masses suffered from diseases which could be done away with only simple technology and effective policy.[8] There has been virtual breakdown of public health services which has led to a malignant growth of private sector where profit and profiteering are main objectives. Further, whatever health services are provided, the power structure enables elites to control it and enjoy the benefits. With active connivance of the political leadership, the control of health services has been taken over by generalist administrators who neither possess the public health competence, nor can they be held accountable. Moreover, the economic crisis has incurred imposition of conditionalities in the form of structural adjustment with savage budget cuts, pre-fabricated policy prescriptions, including cost recovery from hospitals

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6 Meera Chatterjee, *Implementing Health Policy*, Manohar, New Delhi, 1988, p.9.

7 D. Banerji, "The National Health Policy and Its Implementation", *Economic and Political Weekly*, vol.18, no.4, 1983, pp.105-8.

8 D. Banerji, "Contours of a Health Policy in Panchayati Raj," *Seminar on Punchayati Raj and Health*, FRCH, Bombay, April 9-10, 1994.

and expansion of the 'market' for the private sector.[9] This will certainly make the goal of Health for All more difficult.

It has been proved, both within the country by various NGO experiences, by the experience of Kerala and Karnataka, and by international experiences such as China that good health care at low cost is possible. What is needed is redistribution of available resources and re-arrangement of priorities in expenditure as well as appropriate use of vast infrastructure in accordance with policy commitment. It must be emphasised and forcefully demonstrated that appropriate health care is accessible only with decentralisation of health care. The people have the capacity to demand and control such decentralized health care, if found effective by them. Such a demand can come only when there is first knowledge, backed by widespread demonstration of the effectivity of the decentralization strategy. Accessibility to appropriate health care is possible only when it includes not just physical access to health centres and personnel (although this is important), but also access to knowledge of health and control over the formulation and implementation of health programmes according to local requirement. There must be much higher emphasis on, and similar knowledge and control in health related sectors like water supply, sanitation and literacy at the very least, to begin with, ultimately touching all aspects of development including the political and the economic.[10]

The ICSSR/ICMR in its report "Health for All: An Alternative Strategy" (1981) has pointed out that about 95 to 98 percent of all preventive, promotive as well as

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9 D. Banerji, "Simplistic Approach to the Health Policy Analysis: World Bank Team on Indian Health Sector", *Economic and Political Weekly*, vol.28, no.24, June 12, 1993.

10 Kavita Bhatia, "The Development of Public Health Services in India", in N.H. Antia and Kavita Bhatia (eds.), *People's Health in People's Hands*, FRCH Publication, Bombay, 1993, p.12.

curative health care can be undertaken within the 100,000 population (taluka or block) level in a decentralised, people-based health system. While community-based health workers can deliver curative services and impart some health education, many preventive health activities call for concerted community action. Only an intimate understanding of, and communication with 'the people' can make formal health system responsive to the needs of consumers. This necessarily calls for the involvement of people in the design, implementation and management of health care.

In the Eighth Five Year Plan, it has been reiterated that mechanism need to be developed to make the rural health services responsive to the needs of the rural masses and accountable to the community. It is envisaged that the Panchayati Raj system would become an effective instrument for eliciting community participation in the health programme and for providing supervision and support to primary health care infrastructure. Further, since decentralised health care cannot operate in isolation, this, in effect, means decentralisation of all sectors of development, which is the essence of Panchayati Raj. In this context, the renewed movement towards Panchayati Raj has also posed serious questions that whether and to what extent, this would be effective in promoting primary health care.

Health as well as illness care is primarily a function of the people themselves, except for a few problems where they need the support of professionals with higher training skills and facilities. The 73rd Constitutional Amendment for Panchayati Raj now offers people an opportunity to play a crucial role in improving their health through overall development involving the 29 subjects covered by this Amendment. Through PRIs, people can exercise control over public health care services and can utilize those services more meaningfully. It will also ensure accountability of the officials to the

people as Karnataka experience shows. Above all, most of the diseases which can be avoided by cheap and simple technology and with the help of people only like malaria, tuberculosis, leprosy, can be controlled in a better way by community and its health workers, rather than any centralized system.

Prevention, health education and early diagnosis, the key to health and illness care, lend themselves best to the community's own effort. Even family planning, an intensely personal activity, can be best carried out by the community health workers with professional support when the individual voluntary desires contraception. The felt need of the people for curative services can be fulfilled only when the rural hospitals are paid for by the people making them accountable to the people.

People can, and must play a major role in the decentralized system of Panchayati Raj which affects most aspects of health and its care. The empowerment of weaker and underprivileged sections like women and SCs and STs through their reservation as envisaged in Panchayati Raj wold certainly improve the health status of the population, as they were the people most affected by diseases. Further, women empowerment would create awareness among them and through them to other people, and having control over the resources and services would certainly improve their position as well as health status.

However, the people will have to ensure that adequate resources are handed over to them, which they can surely achieve through the vote. The fear that this will lead to misuse of funds by local leaders is exaggerated. The crucial input for all activities and prevention of misuse is openness, which can be ensured by detailed public information on all programmes and the funds allocated at each level. This cannot be left to the bureaucracy or politicians but must be manifested through various channels not controlled

by those whose interest lies in preserving the present status quo by withholding such information.[11]

It is up to the people themselves to fully utilize the power of their vote. Banerji points out that the fact that despite their own class interests and the strong pressure from the World Bank and the IMF, the political rulers of the country were impelled to bring about constitutional changes to 'guarantee' the ushering in of the Panchayati Raj, gives an indication of the counter-pressure from the democratic forces of the country. The task now is to safeguard this gain by making full use of the concessions so reluctantly made by the ruling class. A health policy in Panchayati Raj may be used by the masses to wrest more powers from the ruling classes to have greater self-determination.[12]

The first step towards decentralisation of health care has been taken with the creation of the rural infrastructure. However, its failure to meet the health needs of the people is not because the strategy was wrong, but because it was incomplete. Now, it is up to Panchayati Raj system to return health and illness care to the people to whom it rightly belongs. We all share the responsibility for building a new social order based on greater equity and human dignity, in which 'Health for All' will be no more dream but a fact of life.

The objectives of this study are as follows:

(1) to examine the issue of decentralisation that has been attempted through Panchayati Raj system,

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11 N.H. Antia, "Health and Panchayati Raj", *Seminar*, 438, February, 1996, p.35.

12 D. Banerji, "Contours of a Health Policy in Panchayati Raj", *Seminar on Panchayati Raj and Health*, FRCH, Bombay, April 19-10, 1994.

(2) to evaluate the changes brought in Panchayati Raj system through seventy-third Amendment Act and their effectiveness;

(3) to examine the issue of decentralisation in health care services under Panchayati Raj;

(4) to analyse the implications of Panchayati Raj for health i.e., to what extent, it would help in promoting health status of the people;

(5) finally, to evaluate the question of supervision by PRIs over health services, i.e., to what extent it is feasible and how it will extend the reach of health services.

Within the paradigm of these broad objectives, the problems and challenges have also been discussed. It is hoped, finally, that by focusing attention on decentralisation in health, the study will also stimulate similar thinking in other areas of development, particularly the social sector, which should essentially be the people's own domain.

The study is primarily a review of existing literature and secondary sources, though wherever necessary, primary sources have also been used. The Government's documents and reports like Bhore Committee Report (1946), Balwantray Mehta Committee report (1957), Ashok Mehta Committee Report (1978), National health Policy (1983) statement, etc. have been used. Further, various NGOs experiences like comprehensive Rural Health Project at Jankhed (1971), Alibag (1973) and Pachod (1976), Mandwa experiment (1972-83), SEWA-Rural in Jhagadia (1980), SEARCH experiences at Gadehiroli (1985) etc. have been taken into account.

This dissertation is divided into four different chapters. First chapter deals with the concept of Panchayati Raj and its evolution from early times to till 73rd Amendment Act. The historical review would give better view and understanding of the Panchayati Raj system.

The Second chapter deals with the 73rd Amendment Act itself, where both its merits and demerits have been examined. Briefly, the promises that it holds and difficulties coming in its implementation based on the experience of states have also been discussed.

The third chapter discusses about the importance of decentralisation in health care and the possibilities of Panchayati Raj system to be helpful in promoting health. Briefly, the public health service development and duality in policy as well as gap between policy pronouncements and implementation have been discussed out. The experiences of NGO's have also been pointed out to express the need of decentralisation. And finally, the usefulness of PRIs in promoting implementing of health policy and utilization of health service has been discussed.

The Fourth chapter summarises and concludes the arguments explicated in the preceding chapters. Various measures have also been pointed out that would be helpful in promoting health. It must be pointed that the goal of people's health in people's hands will be realized under the new Panchayati Raj system only, which, in turn, help realize the objective of 'Health for All'.

CHAPTER II
PANCHAYATI RAJ: CONCEPT AND HISTORICAL REVIEW

CHAPTER II

PANCHAYATI RAJ: CONCEPT AND HISTORICAL REVIEW

I. CONCEPT

Panchayati Raj is often believed to be the most important political innovation of Independent India. The term 'Panchayati Raj' came into usage only after the acceptance of Balwantray Mehta Committee recommendations on Democratic Decentralisation, while earlier terms like 'village panchayat,' 'direct board' etc. were used. Etymologically, the term is derived from Urdu and it is distinct from the term 'Panchayat' which connotes a local body limited to a geographical area. Panchayati Raj is a process of governance: it implies creation of local government institutions at village, block and district level based on decentralisation, democratisation and devolution of powers with responsibility. These bodies play a vital role in rural administration and are indication of democratic functioning of a state.

There can be two approaches to the study and formulation of the concept of Panchayati Raj - normative and empirical - former constructing an ideal conceptual model, while the latter studying it in terms of its operation as per se. But an operationally useful concept must be rooted in a sort of empirical-cum-normative approach. In developing a syncretic conceptual image, Panchayati Raj emerge to be at one and the same time, a system of local government, a mechanism for rural development and also an agency of state government for specific activities. Moreover, each of these dimensions not merely supplement each other, but also forms a part of an integrated system maintaining and strengthening the integrity of the whole.

Panchayati Raj has taken precedence over such terms as 'decentralised democracy', 'delegated democracy', 'local self-government', and even 'democratic

decentralisation'. It means a system which is horizontally a network of village panchayats and vertically an organic growth which may link Gram Sabha to Lok Sabha.[1] At present, it is up to the district level and its decisions are by mutual consultation, consent and consensus.

Panchayati Raj philosophy is based on the conviction that the paramount need of the rural people is real power devolution, when the elected representatives of the people, not the bureaucrats, administer at the grassroots level i.e. the district level and below. The way to develop them is through Panchayati Raj by releasing their potential powers for personal, economic, social and civic growth and ensure social justice. Towards this end, all aspects of administration, including law and order, should be entrusted to panchayats, the real elected representatives.

The primary objective of Panchayati Raj is to strengthen the democratic base at the grassroots level. It also aims to give power with responsibilities to local populace so as to allow them to manage their affairs in the best possible manner. The Panchayati Raj basically, different from all other facets of government, is a process that involves the government as a whole. It is not an administrative arm of the government, but a part of the whole government. Its great potentialities lie in the fact that under the guidance and supervision of the State Governments, the final responsibility for carrying out rural development will fall more and more on the people themselves through their elected local representatives. First Five Year Plan emphasised, "The Concept of Panchayati Raj is not limited to the non-official and democratic organisations associated with it. Representing as it does a district level of responsibility and functions within the general

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1 Iqbal Narain and M.V. Mathur, *Panchayati Raj, Planning and Democracy*, Asia Publishing House, Bombay, 1969, p.18.

scheme of administration, Panchayati Raj comprehends both democratic institutions and extension services through which development programmes are executed."[2]

The primary role that has been assigned to PRIs is planning and implementation: welfare activities are added to it so as to create a participatory psychi among the people. The idea was to create rural local self-government agencies responsible for discharging certain selected functions pertaining to development in which people's involvement is a necessary ingredient. In other words, the philosophy behind establishment of PRIs was socio-economic and political development at grassroots levels.

The Panchayati Raj like democracy at the national and state level, is both an end and a means. As an end, it is an inevitable extension of democracy; as a means, it would continue to be responsible for discharging obligations entrusted to it by the people. As an edifice of democracy, it makes the base of the democratic pyramid in the country. Altogether, both as an end and a means, Panchayati Raj contributes to the philosophy as well as practice of a rich rewarding life in rural India. Nehru emphasised that Panchayats would help in building 'swaraj right from the village up.' S.K. Dey, Minister for Community Development in Nehru's Cabinet and the architect of Panchayati Raj after independence, elevated the whole idea to a philosophical level and viewed it as an instrument which linked the individual with the universe. Within the sphere of national democracy, he visualised an organic and intimate relationship between the gram sabha and Lok Sabha.[3]

The Panchayati Raj is both a living and an interactive part of a democratic continuum and also a unit of democratic self-management at the grassroots level. It is

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2 First Five Year Plan, *Government of India*, 1951, p.140.

3 See S.K. Dey, *Panchayati Raj - A Synthesis*, Asia Publishing House, Bombay 1961.

a sub-system in relation to the democratic polity in the country and will also develop the potential of becoming a political system at the rural level. It will also continue to remain a means for discharging obligations entrusted to it.[4]

L.M. Singhvi Committee prepared a concept paper on Panchayati Raj in 1986. It believes that the concept of Panchayati Raj must draw its inspiration from the quintessential concept of Gram Swaraj. The PRIs must have to be viewed as units of self-government which would naturally facilitate the participation of the people in the process of planning and development, flowing from and as a part of the concept of self-government. The village panchayats are cradles of civic culture, social ethos, public education and constructive work and their functioning will bring optimisation to economic growth and social justice. So the PRIs must not act as an administrative unit to carry out work and they must have closer links with planning machinery and implementation of rural development programmes at lower levels.

However, the operational image of Panchayati Raj is different from its conceptual image. The Panchayati Raj system has to uphold a three-fold image - firstly, to top bureaucracy, it is an instrument for implementation of community development programme and should be used as an adhesive fool. Secondly, to others, Panchayati Raj is essentially a political system of civic administration - an agency of local self-government. To third category of people like Sarvodya School, the institutions being qualitatively made of a different mettle, should open the way to Gram Swaraj. Again, to rural elites, Panchayati Raj offers opportunity for their increasing association with village government and a distinct method for attaining position of political stability for their own parties and factions, while to many who have very limited association with it,

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4 See Report of the Committee on PRIs Government of India, 1978.

panchayati raj is a superficial political device. Thus, the compendium of multi-dimensional attitude of three concerned parties namely, officials, the village elites and the subjects of the two attaches different colour and shades to the concept of Panchayati Raj.

Overall, Panchayati Raj refers to representative institutions in each district capable of evoking local participation and initiative in rural development work. The basic units are village panchayat at village level, Panchayat Samiti at the block level, and Zila Parishad at the district level which are organically linked to each other. With the aim to ensure all round development of men and women, and to provide basic human needs such as food, clothes, shelter, education and health, it also creates a sense of participation among rural people through institutional structure.

II. HISTORICAL BACKGROUND

The village panchayat system has been an age-old institution of the rural India. From the very beginning, 'the little village republics', as called by Sir Charles Metcalfe, were governed by their panchayats. The system was first introduced by King Prithu while colonising the Doab between the Ganges and the Jamuna. In the Manusmriti, the Shanti Parva of the Mahabharata, and the Arthshastra of Kautilya, there are many references to the existences of the gram sabhas or rural communities. In the Ramayana of Valmiki, we read about Ganapada which was perhaps a kind of federation of village republics. Shukracharya's Neetisara also gives an account of the village commonwealth.[5] In fact, the village in India has been looked upon as the basic unit of administration since the earliest vedic times.

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5 J.C.Johari, *Indian Government and Politics*, Vishal Publications, Delhi, 1974, pp.810-11.

Besides being mentioned in ancient writings, there is also definite evidence available of village 'sabhas' (councils) and 'gramins' (senior persons of the village) until about 600 B.C.[6] These village bodies were the lines of contact with higher authorities on matters affecting the villages. In course of time, these village bodies took the form of Panchayats (as assembly of five persons) which looked after the affairs of the village. They had both police and judicial powers, while custom and religion elevated them to a sacred position of authority. R.Venkataraman, former President of India, observed that "ancient India combined the principle of direct democracy with the authority of the king and fostered panchayats in each village to look after their affairs."[7] This panchayat system continued for centuries to govern, guide and direct the daily lives of the people. Indeed, these village bodies had been the pivot of administration, the centre of social life, and above all, a focus of social solidarity.

Even during the medieval and Mughal periods, the panchayat system remained unchanged. Although under the Mughals, their judicial power were curtailed, local affairs remained unregulated from above and village officers and servants were answerable primarily to the panchayats. But due to disturbed political conditions leading up to establishment of British rule, local government was scarcely present except for collection of revenues to sovereign. Moreover, the immediate impact of British rule on local government was its total neglect and uprooting the local community entirely.

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6 G. Mathew and others (eds.), *Status of Panchayati Raj in the States of India 1994*, ISS, Concept Publishing, New Delhi, 1995, p.1.

7 R. Venkataraman, "Decentralisation is the Key", *Mainstream*, August 12, 1995, p.5.

Jayaprakash Narayan had once perceptively commented that the old village communities had survived in nothing else except their physical existence.[8]

However, it is a historical fact that local self-government in India, in the sense of an accountable representative institution, was the creation of the British. As early as 1687, a municipal corporation came to be formed in Madras, on the British model of a town council and it was empowered to levy taxes for building hall and schools. With the passage of time, the sphere of activities of this corporation and similar bodies set up in other major towns widened. Although symbolising local government of a sort, the bodies continued to comprise nominated members with no elective element whatsoever.

The process of involving the people were started when administrative pattern were changed after rebellion of 1857. It began with the establishment of district and taluka local fund committee in 1869. Later, Lord Mayo through a resolution in 1870, conceived a broader setting of decentralisation of power to bring about administrative efficiency. In the wake of this resolution, the first significant step to revive the traditional village panchayat system was taken in Bengal in 1870 through the Bengali Chowkidari Act. This act empowered district magistrates to set up panchayats of nominated members in the villages with power to levy and collect taxes to pay for the chowkidars or watchmen engaged by them.

Lord Ripon's resolution on local self-government of 18 May, 1882 was passed that proved to be a watershed in the structural evolution of local government in the country. Considered to be the Magna Carta of local democracy in India, this resolution provided for the establishment of local rural boards consisting of a large majority of elected non-official members and presided over by a non-official chairperson. This led

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8 G. Mathew and Others (eds.), op.cit., p.1.

to passing of a series of Provincial Acts and local self-bodies were set up at district level. But it was not much successful due to apathy of officers as well as local ignorance and suspicion.

Despite the tardy progress of local self-government, the term 'self-government' had begun to gain currency. In 1906, the Indian National Congress accepted 'self-government' as the political goal for the country. In 1909, Royal Commission on Decentralisation in its report recognised the importance of panchayats in the Indian context. Along with retention of local self-body at the district level, it recommended for the formation of sub-district boards in each taluka and tehsil and village panchayat at village level. But, like the Ripon resolution, the recommendations of the Commission (1909) also remained largely on paper.

The Montagu-Chelmsford Reforms of 1919, under the proposed scheme of dyarchy, made local self-government a 'transferred subject', bringing the same under the domain of Indian ministers in the provinces. Further, the reforms suggested that 'there should be, as far as possible, complete popular control in local bodies and the largest possible independence for them of outside control."[9] Subsequently, the village panchayat Acts were passed in various provinces as well as native states to revive village panchayats, but the panchayats, thus formed, were not democratic bodies as their members were mostly nominated by Government. Also, they had limited number of functions, limited financial resources and covered only a limited number of villages.

The 1935 Government of India Act, and the inauguration of provincial autonomy provided opportunity to the elected governments of provinces to enact legislations for further democratisation of local self-government institutions. But soon, these provincial

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9 R.L. Khanna, *Panchayati Raj in India*, English Book Depot, Ambala Cantt., 1972, p.36.

governments vacated office in 1939 and the position as regards local self-government institutions remained unchanged till August 1947 when the country attained independence. Thus, though the origin of local self-government institutions can be traced in efforts made by Britishers, they could hardly provide any real scope for training in the art of self-government.

III. GANDHI AND CONSTITUTION

Indian historical tradition and democratic theory have both united to make grassroots democracy or local political participation an instantly popular strategy in the struggle for national independence. It was the so-called Moderate and Extremist leaders of the Indian national Congress that first tried to mobilize mass support in favour of greater Indian participation in British administration in India through vague statements of swarajya. In Lahore Session (1909) Congress adopted a resolution urging the government to take early steps "to make all local bodies from village panchayats upwards elective with elected non-official chairmen" and "to support them with adequate financial aid."[10] After First World War, Gandhi and Nehru and other leaders took the message of nationalism to the masses in urban and rural demographic nucleates. To Gandhiji, "Panchayat was an instrument of mass politics; for him, a network of such rural organisations functioning in villages without any connection with government will be true foundation of civil revolt."[11]

Gandhiji observed that if the villages perishes, India will perish too. And accordingly, he stated his vision of village panchayat in following words: "My idea of

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10 H.D. Malaviya, *Village Panchayats in India*, Economic and Political Research Department, All India Congress Committee, New Delhi, 1956, pp.215-16.

11 M. Shivaih, *Panchayati Raj: An Analytical Survey*, Hyderabad, NICD, 1976, p.35.

village swaraj is that it is a complete republic independent of its neighbours for its own vital wants and yet interdependent for many others in which dependence is a necessity. The government of village will be conducted by panchayat of five persons annually elected by adult villagers, male and female, with prescribed qualifications. These will have authority and jurisdiction required. Since there will be no system of punishment in accepted sense, the panchayat will be legislative, judiciary and executive combined to operate for its year of office.... Here there is perfect democracy based upon individual freedom. The individual is the architect of his own government."[12]

Gandhiji envisaged a five-tier system of village panchayats, taluka panchayats, district panchayats, provincial panchayats and all-india panchayats. The administrative system was that of a pyramid whose broad base was composed of numerous village communities of the country. The higher panchayats shall tender sound advice, give expert guidance and information, supervise and coordinate the activities of the village panchayats for increasing the efficiency of the administration and public service. But it would be basic units that would dictate to the centre and not vice-versa. In fact, the whole system would turn upside down, the village shall become the real and moving unit of administration. Gandhiji enunciated: "In this structure, composed of innumerable villages, there will be ever widening, never ascending circles. Life will not be a pyramid with apex sustained at the bottom. But it will be an oceanic circle whose centre will be the individual never aggressive in his or her arrogance, but ever humble sharing the majesty of the oceanic circles of which they are an integral part."[13]

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12 M.K. Gandhi, "My Idea of Village Swaraj", *Harijan*, 26 July 1942.

13 M.K. Gandhi, "Independence", *Harijan*, 1 July 1947.

This romantic picturisation of panchayats and perception of village community was debated in constituent Assembly where Ambedkar and Nehru were strident critics. Ambedkar went to the extreme of condemning village 'as a sink of localism, a den of ignorance, narrow mindedness and communalism; and also responsible for the ruination of the country.'[14] But it must be pointed out that he was speaking from his experience of caste ridden village society and as such he was not against democratic decentralisation or to the concept of giving power to the people.

When Constitution was finally adopted, a mid-way was followed. There was only the formal acceptance of the idea of local autonomy i.e. incorporation of village panchayat in the Directive Principles of State Policy of the Constitution Article 40 says that the state shall take steps to organise village panchayats and endow them with such powers and authority as may be necessary to enable them to function as units of self-government. But being non-justiciable in nature, village panchayat is not a formidable institution from constitutional point of view. Also, the whole subject of local government is a state subject and there is no direct reference to village panchayat, but only to village administration.

There is another place in the Constitution where 'local government' is mentioned. Schedule seven, List II (State list) Item 5 reads; "Local government, that is to say, the constitution and powers of municipal corporations, improvement trusts, district boards, mining settlement authorities and other local authorities for the purpose of local self-government or village administration." Obviously, this is a curious way of defining local government without giving due place to panchayats.

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14 H.D. Malviya, op.cit., p.258.

The question of democracy at grassroots level in state became hot topic during first Plan. The First Five Year Plan pointed out that "the Constitution has provided for democratic institutions at the Centre and in the states, but so long as local self-governing institutions are not conceived as parts of same organic institutional and administrative framework, the structure of democratic government will remain incomplete. Local self-governing bodies have to play a vital role in the field of development. It will also be necessary to work out suitable arrangement for linking local self-government bodies at different levels with one another, for instance village panchayats with sub-division local bodies.[15]

Gradually, the importance of Gandhian ideal of village swaraj was realised. The Committee on Plan Projects emphasised the need of people's participation in every efforts of government for constructive development through co-operation and self-help and recommended the democratic institutions at the grassroots level. This view gained strength day-by-day.

IV. POST-INDEPENDENT DEVELOPMENTS

Since independence, one can delineate three major phases in the tardy growth of participatory institutions at the local level in rural India. The first step in this direction was taken in the early 1950s under the leadership of Nehru and S.K.Dey with the inauguration of the Community Development Programme (CDP) under the aegis of the central and state governments. It aimed "for the transformation of outlook of the people, inculcation of spirit of self-reliance, generation of habit of cooperative action through

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15 First five year plan, *Government of India*, p.139.

popular bodies and these three to lead to enlightenment, strength and hope."[16] The basic feature was self-help i.e., the people themselves provide help and other assistance or contribute towards development at the local level, while government would provide technical and financial assistance. A multiple administrative machinery began at district, block and village level under National Extension Service to facilitate transfer of knowledge to local people.

But the whole programme, built upon individual support, failed because of lack of participation by villagers (people), inadequacy of governmental machinery and lack of essential spirit among civil servants. Too much reliance on government had also not helped. The way the programme was projected resulted in the creation of hierarchical centralised ministry, which turned people's programme into administrative programme based on target-oriented approach. Professor Iqbal Narain states that difference between official expectation and people's response and lack of leadership at grassroots level were the apparent causes for failure of CDP.[17] Finally, Planning Commission appointed a committee under the chairmanship of Balwant Ray Mehta to study and suggest measures towards local self-government.

The Balwantray Mehta Committee found that the reason behind the failure of CDP was that people were not given prime importance in the scheme. It observed that development cannot progress without responsibility and power. Community development can be real only when community understands its problems, realises its responsibilities, exercises the necessary powers through its chosen representatives, and maintains a

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16 L.C. Jain, *Grass Without Roots: Rural Development Under Government Auspicious*, Sage Publications, new Delhi, 1985, p.220.

17 Iqbal Narain and M.V. Mathur, op.cit, p.86.

constant and intelligent vigilance on local administration.[18] With this objective, the Committee recommended establishment of statutory elective local bodies and devolution to them of necessary resources, power and authority.

The Committee gave the blue-print of a 'three-tier system' of Panchayati Raj i.e., Gram Panchayat at the village level, the Panchayat Samiti at the block level, and the Zila Parishad at the district level, and all of them were to be organically linked. This organic link was to be secured through the device of indirect elections. Under this framework, thus, direct participation could only be achieved at the village level, while the other two bodies would consists of members elected by subordinate bodies as well as nominated members like M.P.s, M.L.A.s and others. Among the three bodies, Gram Panchayat would be representative in character, while Panchayat Samiti would be preparing development plan and implementing them, and zila parishad has only supervisory and recommendatory function. There should be genuine transfer of power and responsibility and also adequate resources should be transferred to these bodies to enable them to discharge their responsibilities. The Committee has emphasised on economic development in the priorities of functions allotted to PRIs, which are termed development functions. They have a wide field of agriculture, animal husbandry, social education, industries and public works.

The recommendations of the Committee came into effect on April 1, 1958 and was first introduced in Rajasthan on October 2, 1959 on which Nehru declared, "We are going to lay the foundation of democracy or Panchayati Raj in India".[19] He considered

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18 See Report of the Study Team for Community Development Project and National Extension Service, vol.I, Government of India, 1957.

19 J.L. Nehru, *The Hindustan Times* (New Delhi), 3 October 1959.

it "the most revolutionary and historical step in the context of new India."[20] Then it was followed by A.P., U.P., Maharashtra, Bihar and other state and most of them (about 15) adopted three-tier system. Some states like Maharashtra and Gujarat went for two-tier system.

By the mid-1960s, panchayats had reached all parts of the country. More than 217,300 village panchayats, covering over 96 percent of the 579,000 inhabited villages and 92 percent of the rural population had been established. On an average, a panchayat covered a population of about 2,400 in two to three villages. There was enthusiasm in rural India and the people felt that they had a say in the affairs affecting their daily lives. The report of the Ministry of Community Development had stated in 1964-65 that younger and better leadership was emerging through the panchayati raj institutions and there was a fairly high degree of satisfaction among the people with their working. A study team appointed by the A.V.A.R.D. in 1962 to evaluate panchayati raj in Rajasthan, observed that "the people felt that they had sufficient power to enable them to mould their future."[21] It also pointed out that the conferring of power on people's representatives had improved the attendance of teachers in primary schools, while block administration had become more responsive: people were voicing their grievances before the pradhans and obtaining relief through then, and above all, petty corruption, both among the subordinate staff as well as among the newly elected leaders, had declined: the former because the block staff had come under the Panchayat Samiti and the latter because the public reputation of the pradhans was crucial for them to get re-elected. In

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20 ibid.

21 Report of a study team on Panchayati Raj on Rajasthan, Association of Voluntary Agencies for Rural Development (A.V.A.R.D.), New Delhi, 1962.

other words, PRIs fulfilled all the functions of a local government and acted as the nurseries or even the primary schools of democracy.

But this bold experiment in democratization and modernization of rural India failed to realise the dream of its architect. In particular, since the mid-sixties, it came to have a low profile and looked like falling out of favour everywhere. In Abhijit Datta's view, PRIs had become only a 'living caricature of local government'.[22] Ashok Mehta Committee (1978) in its report, regretted that the activities of PRI's were meagre, their resource base was weak, and the overall attention given to them was scanty.

While commitment to Panchayati Raj system was missing, certain other developments in government policies also worked against it. Deep in food crisis, government yielded to recommendations of Ford Foundation and initiated an intensive programme for increase of agriculture production and whole district machinery was geared up for this purpose. Subsequently, PRI's were bypassed in this framework known as IADP. This led to fading away of enthusiasm that had been generated on establishment of PRI's. Summing up the situation, Thomas Matthai had despaired that Village Panchayats had been reduced to a "focus of frustration. The Gram Sabha is something of a joke."[23]

When PRI's were not involved in implementation of IADP, they began to face financial crisis as funds were taken away from CDP to other areas. The inadequate financial resources prevented the PRI's to operate properly and made them dependent on

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22 Abhijit Datta, "Decentralisation and Local Government Reform in India', *Indian Journal of Public Administration*, 1976, p.562.

23 L.C. Jain, op.cit., p.44.

government grants which, ultimately, affects its autonomy. In 1961-62, the per capita expenditure was Rs.1.50 varying from 7 paisa to 7.30 rupees. The break-up was as follows:

	Civic Services - 0.25
	Social Services- 0.05
	Construction- 0.39
	Maintenance- 0.29
	Administration- 0.43
	Miscellaneous- 0.09
Total	1.50 Rs. average per capita

Source: 'Panchayati Raj at a Glance' Government of India, New Delhi, March 1969.

The Ministry of Community Development was reduced to a department in 1966-67 and appended to Ministry of Food and Agriculture in 1971. In 1971, the very programme 'Community Development' was replaced by 'rural development'. "This was not just a cosmetic change. It marked the end of both 'community' and 'panchayats' as agencies of change and agencies of development", observed L.C.Jain.[24] In the words of Ashok Mehta Committee (1978), "The essential idea that all developmental activities should flow only through the block-level organisation lost ground, though the Panchayat Samiti as a key unit of decentralisation was in most cases, coterminous with the block."[25]

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24 ibid, p.44.

25 Report of the Committee on PRIs, Government of India, 1978, p.64.

The bureaucracy had probably its own role in dissociating PRI's from the development process. The officers felt that they were primarily accountable for results and were financial proprieties to the state government. On the other side, they could not get adjusted to working under the supervision of elected representatives. Further, the bureaucracy gained the upper hand in a grand alliance with the state and central level political elites, who would not like to see the erosion of their power by a breed of new local leadership. Thus, it is said that a combination of the bureaucracy, commercial interests, the professional middle class, the police and the political elite 'ganged up' against democratic decentralisation.[26] A thesis was developed and popularised that a centralised bureaucracy can benefit the rural poor better than local elected 'vested interests'. As a result, 'we have ended up creating an impregnable alliance of urban officialdom and the rural rich, and have excluded the rural poor from it." Says Rajni Kothari.[27]

Also there are instances of friction between officials and elected leaders. The Panchayat leaders maintain pulls and pressure to maximise benefit for their groups. Officials on their part resented this kind of leadership and perceived it as a threat to their power. This situation led to moribund state of affairs.[28]

Anther major factor hindering efficiency of PRI's was confusion in determining the administrative boundaries among various sub-divisions in a district. The officials were placed under a dual role that often led to friction. They also felt insecure due to

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26 G.Mathew and Others (eds), op. cit., p.8.

27 L.C. Jain, op.cit., p.57.

28 See Iqbal Narain, "Administrative Challenge in Panchayati Raj", *Indian Journal or Political Science*, March 12, 1961.

political highhandedness. The operation of the system, therefore, depended to a great extent on the interactional skills of the Panchayat.[29]

PRI's were seen as political bodies especially in implementing national plans and there was very little of planning at the grassroots. While guidance was needed by senior officers from the state, a lot of detailed work had to be done by technical officers at the district level as they will be aware of and associated with local understanding, responses and aspirations. But nowhere the stress on community development methods in the working of PRI's has been laid, specifically with regard to people's initiative born out of people's needs. It appears that needs are determined before hand and programme is prepared from above, while People's Participation is confined to a few among the elected representative.[30]

The socio-economic structure of rural society also allowed rural elites to control PRI's and serve their vested interests. Even the franchise enjoyed by deprived sections could not change the character of leadership. Thus, elections did not loosen the hold of traditions and associations of institutional factors such as caste and property. Politics instead of pulling out the ills of society, has been pulled in by caste/class structure.

No doubt, such domination by economically and socially privileged classes and dominant castes (as coined by M.N.Srinivas), being essentially a socio-political problem, could have been tackled to a great extent by holding elections at regular intervals. The resulting political education of communities, oppressed for ages, and emergence of issue-oriented groupings would have replaced traditional rivalries. But elections to PRI's were

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29 See S.N. Dubey, "Organisational Analysis of Panchayat Raj in India", *IJPA*, April, 1972.

30 See, report of the working of Panchayati Raj in Jaipur District, Panchayati Raj Research Project, Department of Economic and Public Administration, University of Rajasthan, Jaipur, 1963.

not held, sometimes for 14-15 years, due to nexus between bureaucracy and local vested interests. The term of existing bodies have been extended or bodies have been superseeded. Panchayat elections were deferred to ward off any threat to ruling leadership and to permit 'continuance of entrenched elite.'[31] PRI's became the instrument of vote banks, of mobilising the people through different kinds of patronage.

There were contrasting views on whether to introduce politics in PRIs or not. Gandhian exponents oppose any party politics at the grassroots. Jai Prakash Narayan opines that Panchayat Raj arena should be kept off political differences and political parties should find other ways of serving people's interests than by exploiting PRIs for party ends. According to him, "Self-powerment through faction-fighting will not be self-government but self-ruination."[32] On the other hand, people like Namboodripad argue that in the name of non-partisanship at any cost, it "disarms common people in their fight against local gentry who would transfer the Panchayati Raj into their instruments."[33]

The official attitude both at the centre and the states has always been against injection of political strife into panchayati raj. Even in some states such as Andhra Pradesh, Punjab and Rajasthan, substantial cash prizes are offered to panchayats whose members are elected without any contest. But, still cases of political friction and factional troubles have not been infrequent. The Committee on the Methods of elections to Panchayati Raj Bodies, though thought it desirable to keep panchayati raj out of party

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31 R.K. Roy, "Decentralized Planning", *The Times of India*, March 1990.

32 J.P. Narayan, *Swaraj for the People*, Akhil Bharat Seva Sangh, Varanasi, 1961. p.14.

33 J.P. Narayan, "Role of Political Parties in Panchayati Raj", *Indian Journal of Public Administration*, 1962, p.246.

politics, ruled out any idea of putting any kind of legal ban on political parties against trying to influence the panchayati raj elections.

It must be pointed out that panchayati raj cannot operate in isolation from the overall framework of parliamentary democracy which operates through the media of political parties. Moreover, the involvement of political parties in PRIs is likely to awaken rural masses, groom local leadership, resolve local affairs, break the old factions, shift the focus towards national issues and strengthen the roots of Indian democracy. No doubt, there are evils of party politics, but remedy does not lie in abolishing it but in improving the tone of party politics. If they do not participate, the gap will be filled in by the opportunist alliances, parochial grouping and caste factions. Taking these issues into considerations, Ashok Mehta Committee (1978) maintained that participation of political parties in elections to PRIs is not only feasible but desirable as they will contribute to the process of democratic seed drilling in the Indian soil. Subsequently, West Bengal was the first state to introduce political partieis in panchayat elections (1998) at the official level.

Finally, the PRIs in India grew out of the Planning Commission's concern for land reforms and reorganisation of land tenure system. The Panchayats were conceived as instrument of development and not regulatory agencies of district administration. The desirability of entrusting regulatory functions to panchayats has always been expressed e.g., Balwantray Mehta Committee (1957) had recommended only those powers to state government which Panchayat Samiti is not in a position to undertake. Such proposals were overruled and regulatory functions were retained by the state government with the collector acting as its agent in the district. The lack of regulatory powers with

the PRI's has discouraged initiative at the grassroots level and has reduced it to the status of a subordinate department of central administration.

Thus, as a result of these shortcomings, the first generation Panchayats could not strike root in our country. There are scholars who opine that 'Panchayats were killed before they were truly born'.[34] The inertness and inertia afflicting them became so pervasive that the grassroots institutions came to be known as 'grass without a root'.

The concern for revival and revamping of the panchayat bodies was noticed when the Indian political scenario witnessed a change in 1977. A Committee under the chairmanship of Ashok Mehta was appointed to report on the status of Panchayat institutions and to suggest measures for revitalisation. The Committee found that 'these institutions have suffered a serious set-back in the absence of regular elections and due to perfunctory audit. What is more, there has been allergy to sharing authority with these nascent institutions both at official and political levels."[35] Therefore, it suggested that the PRI's should be reconstructed, reinforced and revitalised as an organic integral part of our democratic progress and that they should be accorded appropriate constitutional status and recognition. The Committee also said that the dynamics of development require that a high level of technical expertise be made available at the district level, where planning of a more comprehensive and sophisticated kind can be undertaken, and concomitant administrative functions can be discharged more fruitfully.

The recommendations of the Committee initiated the rise of second generation Panchayats in India with emphasis on regular elections on the basis of open participation of political parties, devolution of more powers to them etc. Unlike the existing three-

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34 L.C. Jain, op.cit., p.88.

35 Report of the Committee on PRIs, Government of India, 1978.

tiered structure, it stood for two-tiered Panchayati Raj system to make Panchayat bodies effective and efficient instruments of rural development. It drew the attention of Panchayats to institutional finances rather on budgetary resources and recommended that they should become capable of planning for themselves, with the resources available to them. Several state governments reflected upon these recommendations and set up Mandals and Zila Parishads and started providing the divisive outlays to PRI's from their state budgets.

In 1980s, due to expansion of anti-poverty programmes at lower levels, it was required to integrate Panchayati Raj system with development programmes. Thus, from its narrow span, Panchayati Raj has expanded to cover areas of rural development and economic planning. This led to renewed interests towards revitalizing institutions and as a result various committees were set up to study and suggest measure for this.

A working group on district planning headed by C.H.Hanumanta Rao, set up in 1984, stressed the need for decentralised Plan and recommended that district should be an important point of decentralisation as here all the competent technical staff is available for better planning formulations. The institutional framework for district planning should be a social instrument of decision-making which should be a happy blend of local autonomy, administrative capability, and planning expertise.

G.V.K.Rao Committee set up in 1985 to review the existing administrative arrangement for rural development and poverty alleviation, recommended for strengthening of zila parishad and district level planning as well as better integration of block and lower level planning with lower level PRI's. In fact, the block development

be assigned to PRIs and they must be given all the needed support so that they become effective organisations for handling people's problems.

Dr. L.M.Singhvi Committee, formed in 1987, reviewed the functioning of PRIs in order to suggest measures for their revitalisation. The Committee recommended reorganisation of villages to make village Panchayats more viable. It suggested that they should have more financial resources and that there should be judicial instruments in each state to adjudicate controversies about elections to these local bodies, their dissolution etc. including other matters relating to their functioning. The Committee wanted to look at the system as "a vehicle for homogenisation, secularisation and socialisation of national goals". The operational dynamics of Panchayati Raj should be directed to achieve community and social mobilisation, transcending the barriers of caste, religion, sex and disparities of wealth. This has to be a conscious process through specific programmes and by an effective utilisation of the media of mass communication. The Committee favouring integrated administrative structure for planning and development recommends that every official in the administration should be made to work in Panchayati Raj and rural development setting to as to sensitize our public administration to the problems of rural India. And if needed, substantial training, research and public education should be provided to strengthen PRIs and the performance capabilities of voters, representatives, officials and voluntary workers.

Sarkaria Commission (1988), though mainly concerned with the centre-state relations, outlined the importance of decentralization of power. It observed that decentralisation of real power to the local self governing bodies would 'help defuse the threat of centrifugal force; increase popular involvement all along the line, broaden the base of our democratic politiy, promote administrative efficiency and improve the health

and stability of inter-governmental relations. It viewed that the objectives of decentralised planning cannot be achieved unless the Panchayati Raj and other local bodies are allowed full scope to play their role. The elections must be held regularly and adequate finances are devolved on these institutions.

The government approached Parliament in 1989 for amending the Constitution to constitutionalise panchayats, and make then more powerful and broadbased. But the Constitution (64th Amendment) Bill evoked sharp public protest and could not be passed in Rajya Sabha.

Finally, it was Narsimha Rao government, which enacted Constitution (73rd Amendment) Act, 1992 which meant, inter-alia, for constitutionalisation of panchayats. This has given rise to what might be called the third generation Panchayats. We will discuss this Act's provision and their consequences for health in following chapters.

CHAPTER III
NEW PANCHAYATI RAJ SYSTEM: AN ANALYSIS

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NEW PANCHAYATI RAJ SYSTEM: AN ANALYSIS

The Panchayati Raj System has come to stay - at least physically. The constitution (73rd Amendment) Act has constituionalised this third stratum of government at and below the district level. Hitherto the country had lived with a two-layered governmental system, the Union and the States. The terrain below the States were left unprovided for, except only for a Directive Principle for setting up self-governing village panchayats. For four decades and a half, the Directive Principle remained unacted upon. Now, the omission has been rectified with this Amendment Act. The result has been overwhelming in the sense that India's over 600 million village populace gets the right to rule itself. Indeed, if ever there is to be revolution by rule of law, this may be it.

The idea of empowering people through constitutional amendment was emerging from later 1970's. During the preparation of Ashok Mehta Committee Report (1978), nearly 63 percent of the respondents who reacted to existing conditions, favoured the idea of giving PRIs a constitutional mandate. The Committee made the first official recommendation for including Panchayati Raj in the constitution in keeping with its approach that panchayats should be regarded as political rather than mere developmental institutions.

It was evident that the non-functioning PRIs brought disrepute to the entire concept and its practice. There was a growing realisation that it was lack of constitutional support that had led to the sad state of affairs. For instance, Malcolm Adiseshiah, while commenting on Tamil Nadu not holding panchayat elections for fifteen

years, questions; "why is it that we cannot have a constitutional amendment which will make it obligatory for local elections to be held on time?"[1]

In the mid-1980's the idea of 'district government' conceptually introduced by Nirmal Mukarji[2] came into vogue. It was deeply felt that power should be devolved to grassroots organisations to tackle the crises in rural areas and to cope with the present day requirements. Also, the relative success of Zilla Parishads in West Bengal and Karnataka gave the much needed boost to the district government approach.

By the end of 1988, a sub-committee of the consultative committee of parliament under the chairmanship of P.K. Thungon made recommendations for strengthening the panchayati raj system by providing it constitutional recognition. It was against this backdrop that on 15 May 1989, the Constitution (64th Amendment) Bill was drafted and introduced in Parliament. But opposed on the grounds of overlooking the states in centre's dealing with PRI's and imposing uniform pattern throughout country, the bill could not pass through Rajya Sabha. Again, the National Front government introduced the 74th Amendment Bill, but it was never taken up for discussion. Finally, in September 1991, the Congress government under Narismha Rao introduced the 72nd (Panchayats) and 73rd (Nagarpalikas) constitutional amendment bills. They were referred to a Joint Select Committee of Parliament. The bill was passed in December 1992 and following its ratification by more than half the state assemblies, the President gave his assent on 20th April 1993. And the Act was brought into force by a government notification on 24th April 1993 as the 1992 Constitution (73rd Amendment) Act.

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1 Malcolm S. Adisehiah, "The Need for Constitutional Safeguards" in George Mathew (ed.), *Panchayati Raj in Karnataka Today: Its National Dimension*, Concept Publishing Co., New Delhi, 1986, p.25.

2 Nirmal Mukarji, "The Alternative District Government", in M.L. Dantwala (ed.), *Rural Development, The Indian Experience*, Oxford, IBH, New Delhi 1986.

I. SEVENTY-THIRD CONSTITUTIONAL AMENDMENT ACT

The Amendment Act introduces Part IX (consisting Article 243) in the Constitution regarding the structure, composition, election to and scope of the powers of the panchayats at the district, intermediate and village levels. The Eleventh Schedule, added to the constitution, lists the subjects under which powers and functions could be given to panchayats at district, intermediate and village levels. Now, the legislative and executive action of the State Legislature and Governments as regards panchayats will have to be in accordance with the provision of Part IX of the Constitution.

The main features of Part IX of the constitution are:

1. Panchayats will be institutions of self-government.
2. There will be a gram sabha for each village or group of villages comprising all the adult members registered as voters in panchayat area.
3. There shall be a three-tier system of panchayats at village, intermediate block/taluk/mandal and district levels. Smaller states with population below 20 lakhs will have the option not to have an intermediate level panchayat.
4. Seats in panchayats at all the three levels shall be filled by direct election. In addition, chairpersons of village panchayats can be made members of the panchayats at the intermediate level and chairpersons of panchayats at intermediate level can be members of panchayats at the district level.
5. Members of Parliament, M.L.As and M.L.Cs could also be members of panchayats at the intermediate or the district level.
6. In all the panchayats, seats would be reserved for Scheduled Castes (SCs) and Scheduled Tribes (STs) in proportion to their population. Offices of the

chairpersons of the panchayats at all levels shall be reserved in favour of SCs and STs in proportion to their population in the state.

7. One third of number of seats will be reserved for women. One third of the seats reserved for SCs and STs will also be reserved for women. One-third offices of chairpersons of panchayats at all levels shall also be reserved for women.

8. State legislature have the liberty to provide reservation of seats and offices of chairpersons in panchayats in favour of backward classes.

9. Every panchayat shall have a uniform five year term and elections to constitute new bodies shall be completed before the expiry of the term. In the event of dissolution, elections will be compulsorily held within six months. The reconstituted panchayat will serve for the remaining period of the five year term.

10. It will not be possible to dissolve the existing panchayats by amending any act before the expiry of its duration.

11. A person who is disqualified under any law for election to the legislature of the state or under any law of the state will not be entitled to become a member of panchayat.

12. There shall be a State Election Commission, which will be responsible for preparation of electoral rolls and holding of elections to Panchayats.

13. Specific responsibilities will be entrusted to the Panchayats to prepare and implement plans for economic development and social justice in respects of 29 subjects listed in XI schedule. Also, there shall be a District Planning Committee to consolidate the plans prepared by the panchayats and municipalities.

14. The panchayats will receive adequate funds for carrying out their functions. Grants from state governments will constitute an important source of funding but

state governments are also expected to assign the revenue of certain taxes to the panchayat. In some cases, the panchayat will also be permitted to collect and retain the revenue it raises.

15. In each state, a Finance Commission will be established to determine the principles on the basis of which adequate financial resources would be ensured for Panchayats.

II. PROSPERITY MOVEMENT

Of the changes effected, the Panchayati Raj Bill is a landmark in the constitutional history of India. Because this is a beginning in the exercise of changing option from scientific state management of development to people's management of development. It is not only a change of instrument merely altering the existing structure. It is a new institution with a different strength. It has to act vibrantly to share the burden of federal government and state government. More particularly, it is going to create a feeling among the people that the government is not far away from the people and it is always with the people and by the people.

Prime Minister P.V.Narasimha Rao declared, "The main objective of enacting this Constitution Amendment Act is to improve the participation of the people in the process of their development. It was felt that involvement of the people was lacking and they were not having opportunity to decide the matter which directly affects their life. Once the provisions of the Constitution Amendment Act are incorporated in the Acts of the States and institutions are established at different levels, the quality of implementation of programmes will be substantially improved. State governments will devolve adequate functions, finances and powers to ensure better implementation of various developmental programmes." (September 1991).

Thus, with the Panchayati Raj Act coming into force, each of India's roughly five lakh villages have both right and duty to elect their panchayat representatives. These panchayats will have clearly defined responsibilities in 29 constitutionally delineated areas and with enough resources, they won't be beggared nobodies as before. It means, a trinity of power, programmes and paisa is expected to hold up the weighty business of village self-governance. But can it really enshrine Mahatma Gandhi's cherished ideal of Sarvodya or even Lohia's relatively less idealised Hankhamba Raj concept?

"In 50 years perhaps" writes L.C.Jain, former Planning Commission member and panchayati raj ideologue, "With this Constitutional amendment, a beginning has been made. Of course, the Constitution is only a mute document, we now have to amend our own (personal) constitution. But at least the people will have accountability from their representatives."[3] There is bound to be tremendous change with this critical mass of modern coming into the system by right, and not as a favour.

Of course, the dynamics of each self-contained village community planning from below, for itself, is the most important aspect of the new era that looms ahead. Whittled down to basics, it means that the village can ensure that the profligate of the last decade - with two-thirds of the Rs.75,000 crore spent on primary education and health going down the drain - will not be repeated. It means that each region can, for instance, decide how much to pay its anganwadi workers to keep them motivated. Rs.245 per worker may be riches in a poor state like Orissa,but grossly inadequate for rich Punjab.[4] It will

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3 Quoted in R.Z.Ahmed's "Implications of Panchayati Raj Act 1993", *Indian Express*, (New Delhi) June 1993.

4 R.Z. Ahmed, "Implications of Panchayati Raj Act, 1993", *Indian Express*, June 1993.

also mean that pilfering of resources raised or allocated may be instantly apprehended as little can be kept secret in a closely-knit village set-up.

L.C.Jain cites the sterling example of a gram panchayat in Karnataka which was able to check its corrupt Pradhan who had auctioned the fish tank for Rs.80,000 but rendered accounts for only a quarter of the sum. The gram sabha asked him to pay back the money - he could not lie because his dishonesty was common knowledge anyway - and then debarred him from holding office for five years for breach of trust.[5] Thus, the energised panchayats are not just, wistful visions from Plato's ideal, but much more than that. Indeed, the Amendment Act is the process of total transformation of people in rural areas. It wakes up the mass from a deep slumber and gives options to them to think of their future. It is almost 'a conscientization process of India'.[6]

New Panchayati Raj system has been introduced with an unconquerable hope. It is going to be government by itself and thereby reduce the gap between people and government. That will help in solving two major problems, namely, the heavy pressure on the Centre and the states, and the socio-economic problems of the rural poor. The rural mass is to be given power and resources to tackle crisis without any outside interference. People's aspirations would be faithfully implemented as they are the planners.

Villagers are equally equipped to plan for their future. What is needed is external support for their action, not external action for their development. The villagers know their problems, priorities, solutions, strategies, resources and what they need is non-interference and an independent power structure. The centralised planning and

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5 ibid.

6 Palanithurai, G., *Empowering People for Prosperity: A Study in New Panchayati Raj System*, Kanishka Publishers, 1994, p.108.

implementation for rural development alienate the people and make them passive spectators. The new Panchayati Raj system, though does not give powers to the people directly, creates an opportunity to the people to take up the mantle of deciding their destiny. All programmes have to be executed and implemented by local people with the supervision of implementation committee of village. Through new Panchayati Raj Act. the individual energy would be transformed into a social energy as M.K.Gandhi converted the unutilized individual energy into a social energy to fight against the British. In this context, the Panchayati Raj Institutions are not merely a civic body but more than that. It is almost a development outfit. Intellectuals call the new Panchayati Raj system as a prosperity movement.[7]

III. CRITICAL APPRAISAL

While the constitutional amendment have provided the opportunity to create vibrant PRIs in the country, the Act is not without its dark areas, that needs to be highlighted. The major flaw of the new Act is that it has adopted a uniform three-tier system below the state level. This means thrusting a uniform prescription on states which are widely disparate in administrative culture, in historical background and in demographic size. It may be disastrous for some states where the already existing two-tier system have been more or less successful. Even in bigger states like Karnataka, Assam and Tamil Nadu having three-tiers, there were structural differences in the system of panchayats. So, it would have been better to leave the states to decide the number of tiers they required in line with their specific socio-historical melieu. It appears artificial to create a fixed number of tiers, irrespective of a state's history and tradition.

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7 Ibid, p.110.

A major lacuna is the contradictory and inconsistent approach to the idea that panchayats are institutions of self-government. On the one hand, Article 243 defines panchayat as an institution of self-government, but later in defining the functions of this institution, the Act has narrowed them down to developmental functions, in Article 243 G(a) and (b). Here, State legislature have been given power to devolve powers and responsibilities upon panchayats with respect to preparation of plans for economic development and social justice and the implementation of schemes for economic development and social justice. While planning cannot really be objected to, implementing entrusted schemes in this field might because that could reduce panchayats to mere executors of handed down programmes. Further, without policing (law and order) as a function at each level, no institution of self-government is worth the name. In the words of Nirmal Mukarji, this dilution of the concept of institutions of self-government is 'flawed thinking and drafting'.[8]

The fact of the matter is that it is entirely within the competence of the state legislatures to decide what powers and authority the panchayats should have in order that they function as credible institutions of self-government. The introduction of the development motif in the Amendment perhaps, limits the competence of the legislatures only in the sense of indicating the minimum that each state legislature should transfer to the panchayats. There is, in other words, a floor but no ceiling.[9]

What has made for further confusion is the simultaneous enactment of the 74th Amendment for municipalities. For, although self-government for these bodies is surely to be welcomed, the legislation of two separate Amendments divides the governing space

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8 Nirmal Mukarji, "The Politics of Self-Government", *The Hindustan Times*, 23rd June, 1993.

9 Ibid.

below the state level into two parts, rural and urban, and gives the partition constitutional legitimation. The idea of a single third stratum, therefore becomes difficult to grasp.

While an artificial dichotomy between rural and urban self government has been constitutionalized, there is growing evidence of the transition from rural to urban in the shape of a large number of urbanized villages. In this context, notwithstanding their 'rural only' origin, the Panchayats must squarely shoulder this rapidly growing urban reality in their respective rural areas. So, the municipalities and the panchayats in the districts should become component units of self-government within an overall set up of district self-governance.

Another major criticism concerns the compulsory membership and voting rights to M.P.s and M.L.A.s in Panchayat bodies which is illogical from the point of view of power to the people. Moreover, it has been observed that the M.P.s and M.L.A.s have not been too friendly to these institutions. At times, they have also been hostile to these bodies. No one likes to see another centre of power emerging as a challenge, nor does one like to see one's existing powers being diluted. The M.P.s, M.L.A.s and ministers are reluctant to surrender power and authority, thereby, influencing the effective implementation of the Panchayati Raj. For instance, the MPs' Local Area Development Scheme; parcelling of JRY funds from the Centre; the administrative structure which continues to be of 19th century etc. So the grant of membership and voting rights to them will undermine the panchayats which we are now aiming to strengthen. The idea of co-opted members, E.M.S. Namboodripad believes, was a hangover of the idea that

PRI's are concerned with development alone and are not the elected organs of administration at the appropriate level.[10]

A crucial question is regarding the devolution process itself, both in terms of powers and funds. With the states being asked to give more powers and departments to panchayats, what about the centre devolving more powers to the states? It has been widely felt that for the PRIs to succeed, devolution of functions and powers from the Centre to the states and from the states to the PRIs is essential. According to Rajni Kothari, merely holding elections of panchayats does not mean decentralization. They need to have significant power and resources to work with and they need to be organized vertically through functional inter-relationships along various tiers, reaching out to the state level. This is not possible without first (or simultaneously) endowing the state themselves with significant power and resources.[11] Mukarji (1991) insists that since reforming the system of governance is the objective, initiate the process by first decentralizing powers from the Centre to states. He went to advocate that the state governments should first wait for this decentralisation through a coherent and concrete set of proposals.[12] However, given the Indian diversity, it is suggested that the Bill can only provide a broad overall framework and within that framework the devolution exercise has to be conducted by the State Authorities.

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10 Quoted in George Mathew and Others (eds.), *Status of Panchayati Raj in the States of India, 1994*, Institute of Social Science, Concept Publishing Company, New Delhi, 1995, p.13.

11 Rajni Kothari, "Perspective on Decentralisation" in N.H.Antia (ed), *People's Health in People's Hands*, FRCH Publication, Bombay, 1993, p.266.

12 N. Mukarji, *The Panchayats Report of a Panel Discussion on the Constitution (72 Amendment) Bill 1991*, Institute of Social Sciences, New Delhi, 1991.

There is no bone of contention over the powers granted to PRIs. Opposition emanate from the point that power has not flown from the centre to local bodies through provincial authorities (states). Dr. Malcolm Adisheshiah has pointed out that "in agriculture which is wholly a state subject, the Union Plan share is 39 percent of total plan resources in 1987-88, in rural development, the Union share is 54.02 percent, in social and women's welfare 79.2 percent, and in family welfare 100 percent."[13] No doubt, state have acted irresponsibly earlier and have been reluctant to give up powers, yet it is illogical on the part of central government to have direct control over PRIs, without the role of the state. The power should flow only through the state.[14]

The main functions of the Panchayats, as provided under Article 243 G of the Constitution, will be the planning and implementation of economic development programmes with inbuilt concern for social justice. Ideally, as units of self-government, the panchayats should have full autonomy in deciding the priorities and determining the allocations to different programmes. But in reality, the system of centralised planning severely constrains local autonomy. When such constraints operate at the state level, it is not surprising that they should also be visible at sub-state levels. Besides, the 'earmarking' of a large proportion of plan provisions restricts the extent to which sectoral allocations can be altered. The situation has been aggravated by the enlargement of centrally sponsored schemes with tied funds and national guidelines. Such limited availability of free funds and restrictions tend to make the PRIs the agencies of the state government rather than units of local government. No doubt, there is need for national

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13 Quoted in L.C.Jain, "Democratic Decentralisation", *Seminar*, 360, August 1989, p.39.

14 Rajni Kothari, "Perspective on Decentralisation", in *Journal of Rural Development*, September 1991, p.499.

priorities in key areas, but the scope of 'earmarking' and centrally sponsored schemes should be minimum so that the states can enable the PRIs to have a modicum of united funds and some say in prioritisation which can make local planning more meaningful.[15]

Unless the power from the centre is decentralised, cabinet ministers at the state level will not allow power and patronage to be given away to the people. For instance, the U.P. Panchayati Raj Act attempted to circumscribe the authority of the Panchayats (which was struck down by Allahabad High Court) by providing for the participation of MPs, MLAs and MLCs; by placing the panchayats at the mercy of the administrators who could dismiss members; by allowing administrators to prohibit the execution of a Panchayat's order; by allowing state governments strict control over the power to levy taxes, etc.

Under XI schedule, only developmental authority and powers (i.e. preparation of plans and implementation of socio-economic schemes) has been given to panchayats, but it seeks to create an impression that legislative and executive powers are being extended to sub-state levels along the lives of Seventh Schedule.[16]

Indeed, the position under Article 243G is not different from what had prevailed since 1959 when developmental activities were entrusted to the Panchayats. Jhunjhunwala points out that it appears that the Act pits the panchayats against the state governments in a zero sum game, while attempting to carve out a third tier from the ambit of state government without devolving central powers and functions.[17]

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15 Nirmal Mukarji, 1991, op.cit.

16 Nirmal Mukarji, 1991, op.cit.

17 B. Jhunjhunwala, "Panchayats vs. The State Government", *Pioneer*, December 27, 1994.

However, instead of finding fault with Article 243 G, it has been pointed out that at the present stage when institutions of self-government have yet to take firm root, it is important that they win acceptability and confidence of the people through efficient implementation of development programmes and exclusively devoting itself to the task of development. "What is important is that in the areas assigned to them, the PRIs should enjoy as large a measure of autonomy as possible" T.R. Satish Chandra continues. "They should be able to provide responsive administration which implies a degree of freedom to adjust programmes according to local needs, without being hamstrung by detailed government directives. To the extent possible, they should mobilise local resources and augument the scale of development effort. Through better accountability the implementation of programmes should become more effective. It is from these angles that one should approach the question of allocation of functions among the tiers of the government."[18]

The problem is further compounded by the fact that funds for developmental projects are not locally generated; they come from either New Delhi or the state capitals. Financial arrangement is the oxygen of all self-government, at every level i.e. there is need to transfer much of the allocation decisions from the Planning Commission, the central government and the state governments to the market, the local authorities, to the public and semi-public institutions. Realising the fact that poor 'panchayat finance' was the major reason attributing to the failure of the PRI system during the 60s and 70s, the new Act has provided for the provision of setting up of State Finance Commission and allowing panchayats to generate its own resources. Simultaneous reading of Articles 243

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18 T.R. Satish Chandran, "Inter-tier Allocation of Functions, in Amitabh Mukherjee's (eds) *Decentralisation: Panchayats in the Nineties,* Vikas Publishing, 1994, p.25.

H, 243 I and 280(bb) make it clear that apart from current recoveries and receipts by way of taxation within the state, non-plan financial resources can also be made available. Since the PRIs would also be implementing agency, it would mostly be executing the plan schemes for which money would come from the plan funds. Simultaneously, other expenditures which the PRIs would be duty-bound to undertake,would be financed from non-plan funds.

Panchayat finances impinge upon the local resources of the Panchayats, grants and scheme funds and additional resource mobilization,which have to be institutionalised on prudent financial lines. Under the new Act, logically, the centre should devolve all the resources to the Panchayats through states to ensure efficiency and equity in their use. As long as funds flow from the higher echelons of government to panchayats, they may not be consistent with felt needs and local requirements. At the moment, only one half of one percent of panchayat's resources flow from their own taxes, 92.6 percent being funds received from departmental schemes and 6.8 percent being institutional finance.[19]

The limitations in generating its own resources is result of both poor taxation and poor realization of whatever tax has been imposed. It,in turn, increase PRI's dependence on state government for grants in various forms and these programme funds in effect are controlled by state government themselves.

The new Panchayati Raj Act has increased the representation of women in panchayats to not less than one third of the total members. These women in turn are to be elected by direct elections. Further more, the Act provides for reservations for SCs and STs. Of these, one-third is to be reserved for women and these reserved seats will be rotated among different constituencies in a panchayat. Also, one-third of the offices

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19 A.K. Pande, "Flow of Funds to Panchayats during Seventh Five Year Plan", *Kurukshetra*, January 1994, pp.24-28.

of chairpersons in the panchayats at each level shall be reserved for women. Significantly, with this provision, nearly 7.95 lakh women will be representing in the panchayats. A third of chairpersons- about 76200 - have to be women. This would certainly led to a silent revolution and a social transformation aimed at upliftment of women.

Thus with this Act, it is claimed that social dimensions like equity and egalitarianism have been injected into the political governance of the country. While a welcome provision, it has been under constant public debate and scrutiny, regarding its implementation given the violent culture, corruption and rigging during elections.

The elections to panchayat bodies and the various findings of the studies points out the fact that the system of reservation for women has set the ball rolling. Orissa was the first state to implement 33 percent reservation for women in Panchayats. The state has now about 25000 women representatives in 5263 Gram Panchayats and 314 Panchayat Samitis.

In West Bengal, the elections to Panchayat bodies held in 1993 resulted in elections of 24,799 women to different tiers of Panchayat, amounting to 36 percent of the total members. In Karnataka elections to the grass roots tier held in 1994 increases women's representation up to 43.77 percent in 5640 Gram Panchayats. In Kerala, a large number of women had fought non-reserved constituencies against men and won (34%) far above the thirty percent reservation provided for women.[20] However, it must be pointed out that reservation of seats for women is not end in itself, it is a means to an end, the end being women's development and empowerment.

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20 Prabhat Datta, "Village Self-covernment in Post-colonial India", *Khurukshtra*, April, 1995, p.55.

The implementation of reservation of seats for women in states like Karnataka, Andhra Pradesh and kerala much earlier than the new Act coming into force, points out difficulties faced by women. The most important factor that has throughout hampered their functioning as elected members was their traditional status in society vis-a-vis men.[21] Their domestic commitments also proved to be obstacle in attending meeting regularly. Above all, women in all the states except Kerala came from the upper income bracket families. Kerala set a different kind of record because of land reforms, higher literacy rate for women and active women movements.

In fact, initially the participation and role performance of women in panchayat bodies had not been encouraging, but it registered improvement at a later stage. In Karnataka, the study conducted by ISS points out that there have been qualitatively improved participation at a later stage and there have been no nonsense approach in dealing with education, health, hygiene and such matters which come under the purview of Panchayats.[22] In Orissa, a study has revealed that women's entry into the rural political system would ensure change in the political system of village, the perceptions of the role of women and develop grass roots leadership among women. The study extended over two stages, found that in later stage, women's representatives were more enthusiastic and happy with their performances, as they could get the work done which were pending for several years.[23] Again Sharma (1995) reported the plight of ten women Panches and Sarpanches of Punjab. They had to fight through mockery,

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21 G. Mathew, *Panchayat in India: From Legislation to Movement*, Concept Publishing, New Delhi, 1994., p.89.

22 Ibid, p.98

23 Snehlata Panda, "Women in Rural Local Government, *Kurukshetra*, April 1995, p.103.

intimidation, apathy, bureaucracy, illiteracy about their constitutional rights, powers and duties, while managing the daily problems of their villages. Though initially many of the elected Sarpanches were rubber stamps, through sheer courage and common sense, they outsmarted their male counterparts and earned the respect of their colleagues and constituencies.[24] It shows that, contrary to myth, the women folk in the rural areas are ready to come forward and to take up the leadership to work for the betterment of the ruralities.

In this context, implementation of provisions of reservations will help balance the often conflicting political and economic interests of men, women, the SC and ST. The rotation system will ensure that even in the upper caste dominated Panchayats, the SC/ST candidates would come to acquire the posts of chairpersons. But the Act has left to the states to decide the question of reserving seats for backward classes. In the light of the social tension that got triggered off with Mandal Commission report, this could not but be considered only too desirable.

Reservations have a positive role to play in promoting the accelerated uplift of disadvantaged groups such as SCs, STs and women. Non should grudge this. But the key to progress for these groups lies less in ever-widening and deepening preference than allowing normal process of democracy to function to elect chairpersons at various levels in Panchayati Raj System. It is, therefore, advisable to let the logic of the electoral process determine who is to hold these vital offices.

However, it must be pointed out that in the given rural power structure, the Panchayat bodies may be captured by the power elites. It is hard truth that socio-economic conditions determine who will wield political power. So far this has favoured

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24 R. Sharma, "Women at the Grass Roots", *The Tribune*, January 8, 1995,

the privileged few and consequently, it is largely their writ that runs in the districts through the official machinery. No doubt, the reservation for SCs, STs and women would lessen their control over official machinery. But again, studies have shown that women representative mostly belong to dominant castes and upper classes of the area, while SCs, STs elected to seats and posts are more often than not, agents of local power groups. In this context, as West Bengal experience shows, restructuring of society through land reforms can only be helpful in implementing panchayati raj scheme effectively. Further, the mobilisation of the underprivileged, which has already started, would be effective in changing political power. This will have a better chance of crossing critical thresholds in panchayat governments than across entire states. Thus, panchayat governments would present new opportunities to such movements and in this way could turn out to be an effective intervention even without land reform.[25]

The Act has provided for direct elections to the posts of chairpersons only at the village level. It has been pointed out that indirect election to the Samitis and Zila Parishad robs the lower bodies of legitimate and healthy control over the higher tiers. However, indirect elections at intermediary and district levels are more in consonance with the cabinet system of government adopted in India.

Another serious drawback is that the Act contains only the minimum possible mandatory provisions, while in large areas, the expression 'may' is deliberately used in place of 'shall', thereby leaving the discretion to enact to the state legislatures. For instance, 'Gram Sabha' is only defined but its establishment is not made compulsory. It is only mentioned that the state legislature may prescribe its powers and functions.

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25 N. Mukerji, "Panchayat Governments", *Seminar*, 360, August 1989, p.32.

Thus, even the functioning of Gram Sabha depends upon discretion of state legislature and this lacuna deprives soul to the Panchayat at the village level.

Absence of a clear functional jurisdiction for the Panchayats is also an important drawback. There is utter confusion over the division of work among the three tiers. For instance, there has been overlapping of functions among the three tiers in sectors like education. There is confusion over who should district school teachers be answerable to.

Further, Panchayat legislation adopted in different states contains innumerable provisions relating to control of panchayats. These control extends to regulation of local decisions, actions, finances and even over the elected functionaries. No doubt, today supersession of a local body or local bodies should be followed by fresh elections within six months. But the mere threat of supersession which entails re-election of the directly elected members, who have to undergo the ordeal at considerable cost and effort, is enough to bring them around to the government view point.

Also, bureaucratic control has not been withdrawn. Instead, in Panchayat legislation, they are being conferred wide powers through statutory rules that provides them upperhand in the whole scheme of democratic decentralisation. The district level officials are not made accountable through subordination to the Panchayats for the activities of their respective departments e.g. Harayana Panchati Raj Act provides that the government can cancel any resolution of panchayat under the pretext of it being against public interest and the term 'public interest' goes without explanation; In Kerala, government can take away with a mere notification any function of Panchayats and the controlling power is vested in Panchayat Commissioner at the state level and deputy commissioner at district level; the Punjab Panchayati Raj Act empowers the Director,

Panchayat to remove or reinstate any Sarpanch. In several cases, the order of the Director, Panchayat is not only final but also cannot be questioned in any court of law. The constitutional backing to panchayats, thus, becomes a hollow device of democratic decentralisation. Real decentralisation can take place only where each tier is assured of its autonomy. The government gives power by the right hand and takes it back by the left hand.

It is clear now that while the Act has both merits and demerits in its fold, the healthy growth of village self-government in India today cannot be ensured simply by giving it a constitutional sanction. In the ultimate analysis, it is the political will of the state governments which determines the future of village self-government in India. So. much depends on how the various States are responding and at what speed they are implementing the Panchayati Raj as envisaged by the Constitutional Amendment.

All the states passed their acts before 24 April 1994, in conformity with the new Act. They have also appointed state election commissions and finance commissions. But it is widely felt that in many cases, the states have not lived up to the expectations of the people in giving powers to the three tiers of the Panchayats. In other words, they have tried to follow the letter of the amendment Act and not its spirit. The observation made by S.N.Singita still holds true, "In recent years, the Panchayati Raj reforms have been politicised in an unprecedented manner. There is no rational consensus on such a vital issue of institutional building at grass roots. All political parties are viewing these reforms from their short term electoral gains."[26]

The representatives of PRIs complain that the system exists 'only on paper' because of the lackadaisical response from the central and state governments (Conference

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26 N.Rajgopal Rao, *Panchayati Raj - A Study of Rural Local Government in India*, New Delhi, 1992, p.88.

of PRIs representatives, May, 1994). The lack of enthusiasm and reluctant approach on the part of the state governments is evident from the casual manner in which many states passed their respective Panchayati Raj Acts within the stipulated one year period under the 73rd Amendment Act. As many as 11 states enacted their Panchayat Acts in April 1994, including six on April 23, 1994, the last day for such enactments as per the 73rd Amendment. In fact, Bihar assembly passed the Act in just 20 minutes, even though the 80-page Act was not distributed to all the MLAs. This only proves the non-seriousness of the law makers towards the PRIs and the concept of decentralisation of power.

Further, the basic ideology behind the 73rd Amendment to the Constitution of making Panchayats institutions of self-government had been largely ignored in the recent legislation by states. After analysing the provisions of eleven of the state laws relating to Panchayati Raj, the Rajiv Gandhi Foundation Task Force on Panchayati Raj has come to the same conclusion. Still, the high handedness of bureaucracy over the local autonomy prevails and PRIs are seen as agency for implementing developmental activities of the State. In addition, the principles of local self-government have not really percolated into the minds of the rural people which is evident from their lack of reaction when panchayat elections are not held in time.

Elections are considered to be the red-blood cells of a democratic body or to used Tocqueville's words, 'institutionalised revolutions'. This fact has been taken into account and the new Panchayati Raj system has put a statutory requirement to conduct elections to Panchayats within six months of dissolution. As in June 1994, out of 25 states and 7 union territories, only four had elected Panchayats at all levels. Now, about a dozen state have since completed elections to PRIs, and the participation of the people in the elections was overwhelming, at times going up to 75 to 80 percent voting. Thus, it is

observed that when democracy comes nearer to the people, their participation and enthusiasm increases, making democracy genuine and meaningful.

Holding of elections at regular intervals will not only supply political blood into Panchayats, but also help increase political awareness of the people and the general image of institutions before them. However, the statutory requirement of holding elections have been ignored by some states under some pretext or the other. The union government directed the erring states to conduct elections latest by February 1995. Warnings were issued to nine of the states under Article 257 of the constitution with a threat of withholding of grants, and central assistance for rural development. States like Gujarat, Bihar, Andhra Pradesh and Karnataka have indicated Assembly elections as an excuse, while Kerala and Tamil Nadu have ignored the warning. But, again, such warnings were not enforced and today even after two years of enactment of state legislation, states like Bihar and Tamil Nadu are still without elected Panchayats. This could happen because the 73rd Amendment did not set a deadline for holding the first election.

It can be said that the PRIs in India have since its inception, "remained 'down to earth' without ever taking roots."[27] But they have survived without any regularity in elections. This shows their inbuilt strength and perhaps, makes them the only institution that lives on despite the appalling conditions, justifying their departure. So what is required is the 'will' to make the PRIs viable democratic institutions on which the real democracy will thrive.

Since the states are acting well within the ambit of their legal and constitutional powers in restricting the role of Panchayats, political and social pressures alone may

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27 K.K. Mohanty, "More Noise, Meagre Substance", *Financial Express* (New Delhi), 21 July 1993.

bring the desired results. Educating the rural masses about the efficacy of Panchayati Raj in providing solutions to their problems is essential so as to develop clientele pressure groups of citizens whose demands the democratically elected state government cannot ignore. Only then the silent revolution can be realised, but certainly it will take time.

There is no substitute for healthy conventions and traditions in democratic politics and we must recognise them as the backbone of our society and polity. The county and city local government institutions below the state level in the USA have had a satisfactory existence for many decades and one of the reasons have been the preservation of tradition of democracy. Unfortunately for India, from independence onwards, violations of conventions have been of a very high magnitude. In such a context, question is raised against the efficacy and sanctity of constitutional amendments or legislations alone.

Further, it is well established that constitutional support and legislative measures are necessary for bringing about social change, but they are not a sufficient condition to achieve the goal. Political will and people's political awareness are crucial for bringing about democratic decentralisation below the state level. So, a three-dimensional approach - political will, people's awareness, and building healthy conventions and traditions undergirded by constitutional and legislative measures - is a must for any far reaching changes to be brought about in our society, and when one of these is weak, the entire measure may remain in form without content.

Thus, democratisation of our pluralistic society cannot be ensured merely through legislative and administrative actions of the state. These enabling provisions will require massive mobilisational support and non-governmental organisations, academics and professional bodies, political parties and other groups should involve themselves in

exerting pressure to restore power to the place where it belongs. George Mathew suggests a 'powerful intellectual and mass movement' to realise the dream of 'empowering the people'.[28] Certainly, if the policy of the government in giving impetus to the panchayati raj movement is implemented faithfully and effectively with all needed support, the country will witness a full-fledged grassroots level democracy.

The future of India lies in the growth of villages and the rise of the true villager who is fearless and conscious of his rights as well as responsibilities. The participatory democracy brought by new panchayati raj system will enable villagers to become equal partners in shaping their own future and will restore power to the people to whom it belongs. Certainly it would include taking control of their own health care, by supervising over health services and utilising them more effectively. The participation and involvement of the people in health care through PRIs would do away with many negative aspects of our health care services and would help in improving health status. This fact and the implications of new Panchayati Raj system for health would be discussed in detail in next chapter.

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28 G. Mathew, "From Legislation to Movement", *The Hindu*, 9 January 1993.

CHAPTER IV
HEALTH AND PANCHAYATI RAJ: ISSUES AND IMPLICATIONS

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HEALTH AND PANCHAYATI RAJ: ISSUES AND IMPLICATIONS

In the previous two chapters, we have discussed Panchayati Raj and its revival through the 73rd Constitutional Amendment Act and the promises it holds for empowering the people as well as the development in every walks of life. Through PRIs it is felt that, people would come forward to shape their own future. On the other hand, the health status of community is deeply embedded within its ecological, social, economic and political system. These have a profound influence on the size, extent and nature of community health problems and they play an important role in the formulation of policies, plans and programmes for dealing with them. Thus, health services are but one of the many factors that influence the health status of a population. Moreover, health services are a function of its political system as decisions concerning resource allocation, manpower policy, choice of technology and the degree to which health services are made available and accessible to different segments of the society are taken by the political system. The question of availability and accessibility of the people to health services assumes importance in the Indian context, where despite the development of health infrastructure, health status is not improving as desired. The decentralisation of health care becomes a necessity to improve the health status and so the concept of Panchayati Raj holds great promise for millions of the rural poor. In this chapter we will discuss the health service development, the hindrances in the implementation of policy and finally, to what extent, Panchayati Raj would be beneficial for the people's health.

and mortality on account of communicable disease. The infant mortality rate has shown an impressive decline and life expectancy has risen from a mere 32 years in 1947 to 58 years in 1990.

The concern for easy accessibility of the rural population to public health services has led to the creation of an extensive rural health infrastructure consisting of a community health worker and a dai at 1000 level, a subcentre at 5000 level, a Primary Health Centre (PHC) at 30000 or 20000 for hilly/tribal areas and one Community Health Centre (CHC) for 100,000 population with 30 beds and 4 specialist doctors along with other staffs. At the district level is a Civil/ General Hospital. It is no mean achievement for a developing country like India to have this extensive network of health. Yet this vast health infrastructure and staff has been only partially successful in meeting the urgent health needs of the population it was designed to serve.

The demographic and health profile of the country still constitutes a cause of serious concern. Infant mortality rate remains unacceptably high at 91 (1989), as does the population growth, and preventable diseases like tuberculosis, leprosy, malaria and diarrhoeal diseases continue to take their toll. Almost half of the world's TB patients live in India of whom 400,000 die annually. More than 40,000 children in India become blind each year due to lack of vitamin A. About 120,000 women die of maternity related causes every year in India, taking maternal maternity rate to 50 times higher in comparison to western society. Much worse is the danger of accepting at face value the aggregate statistics presented in a country where the upper one or two deciles of the population, who have monopolised most of the gains of development, are clubbed with those of the majority who live in poverty.[1] Even curative services, leave alone the

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1 N.H. Antia, "Comprehensive Health Care", *Seminar*, vol.369, May 1990, p.19.

preventive and promotive services, are not easy to avail at village and block level, leading to overcrowding of district and city hospitals and proliferation of private practice.

Such condition of health services in India was not due to lack of any policy, per se, as from the very beginning, India was fortunate in having one of the most farsighted documents ever produced in the form of Bhore Committee report. In fact, even before that report, National Planning Committee through its sub-committee on Health 1938 called attention to the need to have a state controlled free health system which balanced curative and preventive care. The health of the people was seen as the responsibility of the state. The committee recommended that a ratio of one worker with elementary training in practical community health per 1000 people be achieved within five years and that within 10 years there should be a qualified medical practitioner for every 3000 people, and a hospital bed for every 1,500.[2]

Most significant from the point of our health system was the Report of Health Survey and Development Committee of 1946 (popularly known as the Bhore Committee), which preceded the WHO's Alma Ata Declaration by three decades. The emphasis of this report was on providing preventive, promotive and basic curative health services to all the citizens through a country-wide network of primary health centres and subcentres, manned by a large number of paramedics under the guidance of doctors. Laying out norms for rural health infrastructure, it suggested that health services should be as close to the people as possible in order to ensure the maximum benefit to the community to be served.

It also visualised the importance of involving the people in their own health care and sought their active cooperation in the health programme. For this, it suggested for

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2 K.T.Shah (ed.), *Report of Sub-Committee on National Health* (Sokhey Committee), National Planning Committee, Bombay, 1938.

a system of Statutory Boards at the district level, where the people were to have elected representation and where autonomy to design health services was to be vested. Councils of 'experts' were to be appointed at the state and district levels to advise on technical issues. Further, a village health committees of five to seven volunteers be formed to promote health activities and people's cooperation. But both these recommendations of Bhore Committee aimed at decentralising health decision-making and democratising health care was ignored, at the implementation stage, where the main concern was seen to be expanding infrastructural facilities. While rural health was consistently projected as the most 'urgent need', sophisticated medical facilities were also viewed as necessary. By and large, as Meera Chatterjee points out, 'a top-down approach to building health facilities was ordained'.[3]

Thus, from 1947 to 1972, there was a rapid expansion of health infrastructure under the broad policy of primary health care system. At the same time, two major programmes viz. vertical programmes for control of communicable disease like Malaria, Tuberculosis, Leprosy, Smallpox etc. and family planning were started. Efforts were also initiated to produce enough number of health manpower for manning these services viz. Doctors, Nurses, Auxiliary and Paramedical functionaries. Reviewing the successes in implementation, Health Survey and Planning Committee (Mudaliar Committee) of 1962 pointed out that basic health facilities had not reached at least half the nation, due to gross maldistribution of hospitals and beds in favour of urban areas, inability to attract doctors to rural area, and inadequate training. The emphasis was laid on ensuring proper use of already established infrastructure with a provision of referral support to them at district and taluka levels, with appropriate strengthening of facilities. But, while reasons for the failure were identified, concrete steps were not taken to rectify the situation.

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3 Meera Chatterjee, *Implementing Health Policy*, Manohar, New Delhi, 1988, p.8.

Two major aspects of this phase (1960s) of health policy was that the focus was neither on providing comprehensive and integrated services nor on involvement of the community in the planning. In a true sense, it was delivery of services.[4] The result was the development of wide medical infrastructure with specific achievement like malaria control, but not a significant change in the health status of the population. It was as if the commitment of the public health services towards decentralisation was complete by simply establishing rural health centres, while the real business of the health system went on outside it.[5]

The successive two decades have been characterized by an increase in expenditure, infrastructure and a plethora of health programmes aimed at rural population. Fifth Plan, through the Multi-Purpose Workers Scheme (1972) sought to retrain all the paramedical personnel of various disease control programme into a single cadre and those vertical programmes were integrated with all health programmes offered at village level. A Minimum Needs Programme (1974) sought to increase accessibility of health services through a package of integrated programmes including primary education, drinking water, health infrastructure, roads and electricity, home sites for rural landless and slum improvement.

In 1975, the Study Group on Medical Education and Support Manpower, known as Shrivastava Committee shifted the focus on the need for community involvement. It specifically voiced the view that the health care is not something to be delivered, but acquired by the individual by their own actions. The practical recommendation was to

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4 S.D. Kapoor, "Involving Community in Health Policy Making, Planning and Implementation in India", *Health and Population: Perspective and Issues* 12 (1-4), 1989.

5 Kavita Bhatia, "Development of the Public Health Services in India", in N.H. Antia (ed.), *People's Health in People's Hands*, FRCH Publication, Bombay 1993, p.6.

develop a cadre of personnel with greater awareness of the community and the community acceptance.

On this recommendation, the Community Health Workers (CHWs) Scheme was initiated in 1977, under which a representative of the village community (now called health guide), proposed or selected by the community itself, was to receive three months training and thereafter, to take care of the primary health care needs of a population of about 1000 with full technical support from existing organised health infrastructure. The striking feature was that it expects to have a health functionary from the community itself and thereby to bring about a qualitative change in health care. Though initially the Government was to meet the expenses for the programme, in the long run, it was expected that the community itself would take over this responsibility and would bear the cost of scheme. This CHWs scheme was the first serious attempt by the government on the lines of the broad principle of placing 'people's health in the people's hands. Not being a government employee, the CHWs could not be dismissed by the government Medical Officer and this relationship symbolized the supremacy of the community over the medical bureaucracy. Certainly, the scheme benefitted women, children and weaker sections of the community by providing greater access to curative care, and also made village communities more aware of the need for disease preventive measures, such as environmental sanitation. But the turbulent political scene from 1977 to 1980, drastic changes in funding arrangements, uncooperative and opposite attitude of medical professionals, overlap between the roles of multipurpose workers and CHW's, and scheme having no provision for concurrent evaluation - all worked against the successful implementation of the scheme.

Following the Sixth Five Year Plan, there was a further expansion of rural infrastructure and village level health worker. But there has been a trend or a shift from

health delivery with the community being passive to the community taking the major role. India's signing of the Alma Ata declarations of 1978 led to its commitment to achieve the goal of Health for All by 2000 AD through primary health care approach. The declaration defined primary health care as "essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation at a cost that the community and country can afford. It forms an integral part both of country's health system of which it is the nucleus and of the overall social and economic development of the community."[6]

Echoes of Alma Ata abound in Indian health policy statements, plans and critical analyses. The Report of the Ramalingaswami Committee on 'Health for All' (ICSSR-ICMR, 1981) described an alternative model of health care which is 'strongly rooted in the community.' But again the radical change envisaged was simply built on the existing health system. Further, for the development of a community based integrated health system, Community Health Centre (CHC) was introduced in the health infrastructure, but largely they remained a non-functional mini district hospital short of staff and other facilities. Thus there was little possibility of increasing accessibility when there was only physical expansion, while all other functioning went in a totally different direction from the one envisaged.

Finally, a health policy document was prepared for the first time in 1982. The policy taking stock of the limitations of the 35 years of health planning, came to recognise the need for community involvement and stated that "the ultimate goal of achieving a satisfactory health status for all our people cannot be secured without involving the community in the identification of the health needs and priorities as well

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6 Declaration of the World Health Assembly held at Alma Ata, USSR (WHO-UNICEF) 1978.

as in the implementation and management of the various health and related programmes... the success of the decentralised primary health care system depends vitally on the organised building up of individual self-reliance and effective community participation."[7] It aims to provide an integrated package of services to tackle the entire range of poor health conditions that includes (a) major modifications in the existing system of medical education and para-medical training, (b) reorganisation of the health service infrastructure with focus on decentralisation, and (c) integration of health plans with efforts in health in health-related sectors as well as with socio-economic development processes. But again, the implementation of this health policy could not be satisfactorily enough to attain its desired goals.

The Seventh Plan also is old wine in new bottle, but goes one step further in that it gives special priority to new medical technology. Finally, the Eighth Plan has also emphasised a commitment to provide adequate health services and essential services like drinking water within easy reach of the rural people. 'Human development' being the ultimate goal, the plan accords priority, inter alia, to the building up of people's institutions, control of population growth, provision of safe drinking water and primary health facilities to all. 'Towards Health for the Under-privileged' has been identified as the key strategy in the health sector and to this end, the structural framework for the delivery of health care must undergo a meaningful reorientation so that the underprivileged themselves become the subject of the process and not merely its objects. This can only be done through community based systems, taking into account the ethos and culture of the communities.

Thus, from Bhore Committee to the Eighth Plan, the pattern is the same - a strongly stated commitment to accessibility of the majority of the people to adequate

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7 Statement on National Health Policy (NHP), Government of India, 1982.

health and related services. Yet estimates show only 20-30 percentage of population coverage through public health services. Thus, in spite of the fairly massive expansion of the health infrastructure, the health status of the population remains far from satisfactory. The fault lies not in the inadequacy of human or financial resources or infrastructural facilities or shortage of drugs, (see Appendix III and IV) but in their skewed utilization and distribution. After independence, the decision for determining the developmental direction of our nation has been gradually usurped by small section of our society, the nouveau riche and the new elite. Since the medical profession has from its inception been a part and parcel of this new class, it has, in conjunction with the rest of the elite, ensured that medical services are made to serve their own ends rather than those envisaged in the Bhore and other committee reports.[8] The major emphasis has, therefore, been on expensive hospital- based, urban, curative services in both the private as well as the public sector for the convenience and monetary gain of the medical profession at the cost of basic services for the rural population as described in government's own NHP, 1982. This deliberate distortions by increasingly powerful lobbies has converted health into a major business in illness and human suffering where consumer resistance is at its lowest, and now poses a new threat to the health of our people.

II. OBSTACLES AT IMPLEMENTATION LEVEL

India's assignation of the Alma Ata declarations of 'Health for All', 1978 and its subsequent adoption of primary health care through the framing of the NHP must be considered evidence of intent. However, this aim has not been converted into reality and still a large proportion of the 'needy' 'sick' people are deprived of health services. This lack of access is due in part to the centralised nature of health care facilities and in part

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8 N.H. Antia, "Comprehensive Health Care", *Seminar*, vol.369, May 1990, p.20.

to social and economic constraints to the utilisation of these facilities. It is pointed out that by vesting certain health functions in the community, the reach of health services can be extended and the links established thereby between communities and health service providers can increase awareness of and engender rational and effective use of higher-level services. The slogan 'people's health in people's hands' thus has a dual meaning: "people must assert their right to better health, as well as undertake their responsibility to assist the process of improving the supply of services. Their participation in the planning, implementation and evaluation of health programmes will allow them to exercise both these contemporary roles."[9]

The desired people's participation in health programmes have been unsuccessfully attempted by government twice through CDP, 1952 and CHWs Schemes (1977). In the first, a lack of cooperation between the bureaucracy and people's institutions, reluctance of local leaders to share the benefits, lack of awareness among people and the top-down approach prevented effective implementation. In CHWs Scheme, the worker has to come from within the village and his main role is conceived as one which draws upon indigenous stores of knowledge, labour and resources. Accountable to people, he is to be responsible for motivating the community to identify its specific health problems, organising it to deal with them and generating the participation of the people in health activities. But many problems emerged with its participatory intentions as various studies (Bose and Desai, 1983; NIHFW, 1979, 1984; Bhatt et al, 1981; Qadeer, 1985) reveal. Firstly, selection is carried out by village leaders, instead of community, taking it as an opportunity for nepotism or to hand out political patronage. Secondly, the CHWs are trained by outsiders who attach importance to converting the ways of village people rather than building on indigenous knowledge. Thirdly, being paid a small stipend by

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9 Meera Chatterjee, op.cit., p.101.

government, the CHWs are perceived as government functionaries and they are rarely supervised by the people, and thus, their accountability to the people remains notional. Thus the experiences from the CDP and the CHWs scheme has pointed out fundamental problems in operationalising community participation, such as the heterogenous character of village communities divided by religion, caste, class and clan that prevents them to work together as cohesive units; the low priority accorded to health, based on the curative aspect when disaster strikes in the family, while no value is attached to preventive health; lack of access to knowledge, technology manpower and finances for the maintenance and improvement of health, making self-reliance difficult; and lack of commitment on the part of medical profession.[10]

The concept of Primary Health Care' holds that health is a basic human right and, together with its aim to improve the basis of health, it implies the distribution of resources - financial, manpower and materials like food, water etc. This distributive aspect makes the provision of primary health care a profoundly political issue. In this context, the existing political constraints must be given a serious considerations. Firstly, health is not a basic human right under the Indian Constitution as the subject is dealt with in the Directive Principles of State Policy, which is non-justiciable in character. Under Article 39, the state is directed to make policy to ensure health, while Article 47 provides for improvement of nutrition and health. The fact that there is no recourse to judicial process, if policies are not legislated or implemented, allows to government to delay legislation and implementation.

Secondly, matters pertaining to health are variously listed under 'Union', 'State' and 'Concurrent' categories provided in the Seventh Schedule of the Constitution. This segregation of responsibility in health matters could engender confusion (or diffusion) in

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10 Ibid, pp.115-20.

the process of health policy-making, legislation and implementation of programmes.[11] Further, through concurrent list, the centre has played an active role in the regulation of standards affecting professional training and food and drugs. But no similar initiatives have been undertaken in the vital areas of Maternal and Child Health, Nutrition, Sanitation or Rural Health Services. Also, the vast divergence between States has reduced the Central Governments role to establishing 'least common dominators'. Consequently, although uniform health services have been sought, patterns adopted by different states vary. And finally, budgeting and implementation of the policy being dependent upon State Health departments, has engendered the vastly differing health conditions of different states.

Thirdly, vested interest groups, such as medical professionals and elites have been antagonistic or apathetic to the universalisation of health care. Functional specialisation and high technology perpetuate the 'mystification' of health and professionals wield this 'knowledge power' over the poor and illiterate. This is in sharp contrast with the objective of primary health care to simplify and disseminate basic health knowledge as widely as possible. Elites and government employees consider specialised medicine essential for their health, but not feasible 'for all'. Significantly, the Health Policy has continued to support this double standard of health care: specialist facilities for the urban elite and basic health care for the rural poor.[12] The vested interests of professional and elites are inseparable. Jeffery (1980) has suggested that the 'familiar' critique of the health system, which blames existing inequalities in access to health care on the inappropriate training of medical personnel, misses the essential point that doctors willingness and ability to serve in rural areas is determined by the relationship between

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11 Ibid, p.20.

12 Ibid, p.24.

medicine and other aspects of Indian politics and society. He has argued that proposals to reform the health delivery system will be vitiated by continued 'medical dependency.'[13]

Finally, the health policy has focused on functional rather than structural modifications of the health system, such as 'reorientation', and 'reorganisation', 'decentralisation' and 'integration'. While reorganisation is sought, the rural health system, poor in content and effectiveness, requires considerable strengthening besides reorganisation. As Banaerji has noted, the National Health Policy Statement does not even specify how the government proposes to bring about changes in the system.[14] Though there is explicit call for the involvement of the people in the design, implementation and management of health care, there is little clarity about how it can be brought about and what specific outcomes can be expected.

Due to these political obstacles to the implementation of primary health care, it has become a mockery of the original concept. It is alleged that 'the concept of Primary Health Care has been converted into another techno-managerial ritual and a governmental sop for the rural population. Like most programmes for the poor, it has ended up as a further tool for the subjugation and exploitation, catchy slogans to the contrary notwithstanding.'[15] Against this backdrop, if the Primary Health Care concept is to succeed, there must be a radical change in the present top-down 'delivery' approach. In fact, primary health care incorporates certain 'democratic' principles, such as 'community involvement', individual and collective responsibility for health and 'self-

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13 R. Jeffery, "Medical Policy-making in India in the 1970s - Out of Dependency," *Economic and Political Weekly*, November 1980, pp. 1495-1503.

14 D. Banerji, "National Health Policy and Its Implementation", *Economic and Political Weekly,* February 1983, pp.105-106.

15 N.H. Antia, "Comprehensive Health Care", *Seminar* vol.369, May 1990, p.21.

reliance'.[16] These imply that implementation of the health policy cannot be left entirely to the machinations of the state to formulate programmes. While the level of political commitment will be reflected in resource allocations, in the enactment and enforcement of necessary legislation, and so on, it will mostly be judged by the institution of mechanisms to share 'health power.'[17] Thus, the universalisation of health care requires changes in the health sector to extend its services widely to involve people in them, and to collaborate with other sectors. Change is also called for in both bureaucratic and professional orientations, in their modus operandi, and most-importantly, in the relationship between health providers and 'the people'.

III. RATIONALE FOR DECENTRALISATION

In order to be 'accessible', 'acceptable' and 'affordable', health services must be distributed through an organisational structure that continuously reaches the mass of the population, has cultural 'fit' at all levels and is low or no-cost to the needy. Towards these objectives, people 'self-reliance' and involvement in primary health care delivery are sought.[18] Community involvement is desired in the assessment of need and in the design and planning of services. People are also to be involved in 'mass-actions', such as the improvement of water supplies and drainage. All these can be done only when democratic decentralisation come to play an important role in developmental process.

The case for decentralisation has been well-brought out in the report of the Working Group on District Planning, "Decentralisation enables a better perception of the

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16 Malcolm Segall, "The Politics of Primary Health Care", *IDS Bulletin*, vol.14, 1983, pp.27-37.

17 Meera Chatterjee, op.cit., p.16.

18 Ibid, p.16.

needs of local areas, makes better informed decision making possible, gives people a greater voice in decisions concerning their development and welfare, enables the felt needs of the people to be taken into account, ensure effective participation of the people, serves to build up a measure of self-reliance by mobilizing resources of the community in kind or money, making development self-sustaining, and enables better exploitation of local resources and growth potentials of the local area for improving productivity and increasing production."[19] Decentralisation poses neither a fragmented view of polity, nor a mere proliferation of centrally controlled structures at lower levels. Rather, it is to be conceived 'as a step in the direction of a more integrated polity, a better performing economy and a model of social reconstruction necessary for a properly functioning democracy and a genuinely socialist state.[20]

The case for decentralisation seems to be all the stronger in the specific case of health care, especially in the rural areas. This would result in getting a better perception of the hard core health problems afflicting the majority of the population in each region, ensuring community involvement in decision making with a bearing on priorities in health care and facilitating people's participation in the implementation of health care plans and programmes including financing.[21] The report of the study group constituted by the ICSSR jointly with ICMR has observed: "In fact, the present view is that the goal of Health for All can only be reached through the fully democratic process; it must be programme of health for the people, health of the people and health by the people. This

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19 Report of the Working Group on District Planning, Planning Commission, Government of India, New Delhi, 1984, p. 22.

20 Rajni Kothari, "Perspective on Decentralisation" in N.H. Antia (ed.), *People's Health in People's Hands*, FRCH Publication, Bombay, 1993, p.271.

21 C.R.Soman and P.G.K. Panikar, "Decentralisation in Health Care - The Kerala Experience", in N.H.Antia (ed.), *People's Health in People's Hands*, FRCH Publication, Bombay, 1993, p.297.

new approach of health cannot be implemented in a centralized political system where experts take all the decisions for the people and the bureaucrats implement them. It is, therefore, necessary to abandon the existing centralized and top-down approach to the organisation of health services and create a new system of building from below with community-based health services. This will be possible in a democratic, decentralized and participatory system of government in which the people in a community have the authority, resources and expertise to prepare and implement all plans for their welfare, including health."[22]

The need for decentralisation in health care is more pointed out by the experiences of various Non-Governmental Organisations (NGOs) field projects working in the area of health such as Banwasi Seva Ashram in Sonbhadra district (Uttar Pradesh, 1968-1991), comprehensive Rural Health Project in Jamkhed (Mahrashtra, 1971), Mandwa experiment in Community Health (1972-1983), RUHSA of CMC at K.V. Kuppam (Tamil Nadu, 1977), SEARCH experiences of research in Gadchiroli (Maharashtra, 1985), SEWA-Rural in Jhagadia (Gujarat, 1980). Comprehensive rural health Project in Alibag (Maharashtra, 1973), comprehensive Health and Development Project at Pachod (Maharashtra, 1976) and others. Discussing the experiences of these NGO's, N.H. Antia and Kavita Bhatia has pointed out their implications for health services at the community level.[23] An important lesson from most of these NGO experiences is that contrary to common belief, many of the health problems of the community can be tackled by members of the community, if provided with necessary knowledge, encouragement, training of local workers and support. This includes preventive, promotive as well as

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22 ICSSR and ICMR, *Health for All: An Alternative Strategy*, Indian Institute of Education, Pune, 1981, pp.15-26.

23 N.H. Antia and Kavita Bhatia, *People's Health in People's Hands - A Model for Panchayati Raj*, FRCH Publication, Bombay, 1993, pp.250-59.

curative care, not only for minor illness but also for most of the major diseases like malaria, tuberculosis, leprosy and immunisation as well as family planning programme. This is because the knowledge and technology for the prevention, cure and control of these diseases are remarkably simple, effective, cheap as well as safe and hence, can be best utilized by the people themselves. While the skills are simple, teaching and making them available to the community requires a high degree of cultural affinity with the people as well as constant availability and accountability to them. A number of NGO's have successfully implemented both promotive and preventive measures, with involvement of local people as non-medical community health and paramedical workers. These locally selected health workers have been able to spread health awareness, information and education, in a manner in which no outsider could have made the same impact. This cadre of trained workers along with the supportive ANMs have been able to take over much of the curative load including diagnosis, treatment, injections, follow-up etc. and they have also been accepted by the community as useful health personnel over a period of time. Given the opportunity, semi-literate and even illiterate workers have proved to be articulate, practical and efficient health functionaries.

Sensitivity to cultural and social factors seems to be the key to effective health care. Openness and communication with the community is vital. This includes granting due respect to traditional health practices, and attempting to incorporate folk remedies as also the traditional systems. Only a person familiar with members of the community, their language, lifestyles, health beliefs and practices, is able to influence health behaviour. The projects demonstrate that an effective village health worker needs appropriate selection, continuous on the job training, adequate resources, back-up of an effective and supportive referral system, intensive coverage by a small population to health worker ratio, and due respect and faith in the ability of the village health workers.

All these projects demonstrate that decentralisation of health is not only desirable, but possible. It enables empowerment and enhancement of the people's capabilities, leading to a shift from the delivery of health services to self-reliance of people. In the process of decentralisation, technical guidance, support in planning, training inputs and curative referral were the major interventions from outside the community and had been attempted in different ways by these NGOs. The block with about 100,000 population seems to be the most effective unit for health coverage with the majority of the functions being undertaken at the village level itself. Decentralisation includes optimum encouragement of local talents and resources to undertake local health related functions like simple pathology, purchase and dispersion of medicines, cooking supplementary meals from locally available foodstuff manufacture of furniture/artificial limbs or other requirements etc. It is demonstrated that community members have the ability to take up successively complex responsibilities with the passage of time and in fact, they have contributed their unique insights in planning and developing health programmes which are relevant to their needs.

The importance of health education and information is reiterated in every NGO experience - as powerful tool for people to gain control over their own health. Simple knowledge of nutrition, coupled with immunisation and supervised delivery, could save lakhs of maternal and neo-natal deaths. Health education and information can also be a powerful catalyst for people to demand their rights and accountability from the health services and personnel. This education and information is again chiefly a non-medical intervention requiring high social and cultural skills and affinity, hence best designed and imparted by local people, with technical guidance from the professionals.

Finally, the most important lesson is that priorities in health goals must start from the people. The planning, implementing and monitoring must all come from the people

for whom the interventions are meant. The extent of success in intervention will depend directly upon the extent of sensitivity to the local conditions and the involvement of the local people. Therefore, health goals, methodology, implementation, monitoring and any changes in these must involve people. Also, there should be appropriate documentation and accountability - qualitative and measured in terms of actual results. Effective channels of two-way communication and information must be developed to provide ongoing participation.

The cost of comprehensive health care, including all preventive, promotive and curative functions is affordable by a developing country utilizing such a decentralised and practical approach. It is notable that Medical and Welfare Department at Tata Tea Estates, Munnar (Kerala), which offers the latest technology, all speciality services and necessary drugs, catering to a captive population of 100,000 with access to no other government, voluntary or private practitioners, and having full population coverage of comprehensive health care, spends Rs.120/- per capita per annum, excluding the doctor's salaries. Even if each of the 27 doctors of Munnar are paid even Rs.10000/- per month, it adds up to about Rs.32/- per annum per capita. Thus, at about Rs.150/- per capita, this project provides complete coverage of every health need, using one doctor for every 2800, one nurse for every 1040 and 8 beds for every 1000 population and having high-tech equipment.[24] It clearly demonstrates the relatively low cost of high quality appropriate services. On the other hand, while the per capita rural public health expenditure for the PHC is Rs.27/- that for the urban public sector is over Rs.100/- and for a city like Bombay almost Rs.200/-. This demonstrates that finances do not present

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24 T.K. Cherian, "Rural Development Through Total Health Care" in N.H.Antia (eds.) *People's Health in People's Hands*, FRCH Publication Bombay 1993, pp.158-175.

the restraint to the provision of good health care to all our people. It is the distribution and manner of expenditure that is at fault.

Linkages between health and other areas of development like education, environment, economic and political factors have been integral in NGO experiences. The most effective intervention is a package including, at the very least, health, nutrition and education. Witness the merging of conventional ICDS and health services in all field projects. such integration has also been contemplated by policy makers but without any concrete step in that direction. Indeed, the struggle for health must be part of the larger struggle for equitable distribution of the nation's and the earth's resources.

IV. PANCHAYATI RAJ AND HEALTH SERVICES

Thus, it has now become clear from past experiences - both governmental and NGOs - that the major pillars of health such as nutrition, education, water supply, sanitation and environment can only be achieved by the people themselves through their own political and social action. The community must participate in every stage of the health programme viz. initial assessment of the situation, defining the main health problems, setting the priorities for the programme, implementing the activities, and monitoring and evaluating the results. Indeed, health begins at home and at the work place, because it is there, where people live and work, that health is made or broken. And the goals of Primary health Care also "range from that of health as a political and social right to that of health as an expression, or spin-off, of a quietly functioning informed community."[25] And this necessarily requires decentralisation in health services.

Since independence, rural India has experienced considerable infrastructural development including the growth of PRIs and cooperative organisations. These

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25 K.Newell (ed.), "Health by the People", WHO, Geneva, 1975, p.192.

institutions were created to act as links between the people and higher level government departments and many development programmes have been channelled through them. The call for people's participation in health rests with the participation of such institutions in the delivery of health services. However, the experience of the voluntary sector, as well as of other development programmes show that links between such institutions and 'the people' are weak or even missing. The panchayats, mahila mandals and so on represent and cater just to the dominant elites, and not to the mass of the people i.e. the poor and the needy. In this context, channelling health care through them would be pointless because the major reason for people's participation in health is universal access, which remains elusive owing to highly stratified and hierarchical society such as rural India. Even the VHW (Voluntary Health Worker) concept, based largely on the experience of the 'barefoot doctor' in China in the exploitative structures, has often become a cheap, gimmicky means of mobilising community participation in health programmes, planned and implemented in top-down fashion and of little or no benefit to the vast majority of the people.[26]

However, it must be pointed out that though these PRIs were created to provide power to the people, it remained on paper only and in reality, many of these bodies remained defunct throughout the years. And this fact substantially explains the failure. On the other hand, Karnataka where serious considerations have been given to implement Panchayati Raj in 1980s, presents its successful account as far as decentralisation in health care is concerned. Here, 1983 panchayats Act visualize PRIs as units of government enjoying a great deal of autonomy and the executive power is vested at two

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26 Maitrayee Mukhopadhyay, "Human Development - through Primary Health Care - Case Studies from India" in D.Morley and Others (eds.), *Practising Health for All*, Oxford University Press, London, 1983, p.134.

levels - the Zilla Parishad at the district level and the Mandal Panchayat covering a cluster of villages with a population of 8000-12000. The working of Zilla Parishad and Mandal Panchayats was reviewed by an Evaluation Committee 1989 which reported significant progress in the area of medical and public health facilities. The medical personnel show greater accountability and there is greater rationality in their posting. The supply of drugs and medicines became more regular and in accordance with local requirements. Zilla Parishads have been able to secure more of their supplies locally more cheaply and promptly. Thus, there is evidence to indicate improvement in two directions, first, in mobilizing local resources for strengthening the infrastructure for health services and secondly, in greater accountability of the doctors and paramedical workers, along with improvement in the supply of drugs.[27]

Thus, given the proper direction and implementation, Panchayati Raj can do wonder for the health of the rural people by ensuring accountability of the professionals and strengthening the infrastructure for health services. More so with the 73rd Constitutional Amendment which has tried to distribute responsibilities to PRIs to become the true decision-making centres with local power. It has given man back his dignity and heightened sense of responsibility for his actions implying the movement from 'dependent' to 'self-reliant'. The state, on its part recognises that the survival of the group depends on the total involvement and participation of the individual in the global welfare effort. So the state, seen as the provider of services and 'taking care' of welfare

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27 T.R.Satish Chandran, "Panchayati Raj and health Care - The Karnataka Experience" in N.H. Antia (ed.) *People's Health in People's Hands*, FRCH Publication, Bombay, 1993, pp.328, 335.

of people is 'giving up' its role to these PRIs for the management and carrying out of tasks of local interest and welfare.[28]

The new Panchayati Raj as outlined in the Eleventh Schedule, offers people an opportunity to play a crucial role in improving their health through overall development involving the 29 subjects listed therein. The ICSSR/ICMR report of 1981 clearly states that an improvement in health is only possible under Panchayati Raj. With their own specifically trained community health and paramedical workers, they would be able to cater to over 80 percent of the health and illness problems which affect people at the village level. Even most important communicable diseases like malaria, gastroenteritis, tuberculosis and leprosy can be controlled by early detection, treatment and control at the Gram Panchayat level by its health workers and paramedics, if duly supported by the PHCs. For example, malaria can be readily suspected by the village worker when there are many cases of fever with rigors and associated with sudden increase in mosquitoes. The village health worker merely needs to take a finger prick smear for parasite examination and give chloroquine to the patient. If the smear is positive, then a course of primaquine is provided. If there are many positive cases, the community must be alerted to spray the house with a suitable insecticide using the same pesticide spray available for their fields. No malaria technician can undertake this more efficiently than the village itself with its trained health paramedical workers. These workers are not only constantly available and know every member of the community, but also consider this as much a social as a medical function. This leaves only a few cases which when in doubt, can be referred to the PHCs. Similarly, the early suspicion of tuberculosis or leprosy is best handled by the village health functionary who can after confirmation by

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28 K.D. Gangrade, "People's Welfare in Their Own Hands- Role of Panchayats", *Yojana,* January, 1996, p.41.

the PHCs, ensure continuity and regularity of treatment through personal rapport. They are also the most effective health communicators and educators of the people. The community and its health workers have a great deal of self-interest in the control of such diseases, as it can also affect them and their families, rather than a centralized system whose interest and accountability is not to the people but to itself.[29]

New Panchayati Raj also offers control of the public health services from the gram panchayat up to the taluka and even the district level. This would also enable meaningful utilization of the graded referral professional services at the PHC and CHC level, since it would relieve these personnel from the pressure of 'targets' and threats of transfer. It would encourage better rapport between them and their health services. It would also provide the unique job satisfaction that medicine gives to its practitioners and overcome the conflict of interest between the people and their health personnel.[30]

The health personnel of the PHC and CHC is to be paid by the panchayat rather than by the bureaucracy and this would make them accountable to the people they are paid to serve. Such accountability would also fulfil the 'felt-need' of the people for problems like obstetrics care, emergencies and for curative services. The system of administrative and financial control being vested with the people at each level, can function only when adequate financial resources are made available at each level. While there is provision to authorise panchayats to impose collect and appropriate taxes and duties, government can also allocate resources to these institutions. The present individual allocation of Rs.30/- per capita per annum for rural health as compared to Rs.100/- for urban health must be rectified since about 95-98 percent of all preventive, promotive and curative services can be provided within the 100,000 population

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29 N.H.Antia, Health and Panchayati Raj, *Seminar,* 438, February 1996, p.34.

30 Ibid, p.34.

taluka/block level. If over 80 percent of all care can be provided at the village/subcentre level then this level must get its due share of the public sector health allotment of about Rs. 120/- per capita per annum. A country which spends Rs.480 billion on its health and illness care, representing 6 percent of its GDP can easily provide this amount.[31]

Since women and children comprise over 70 percent of our population, and the problems of health chiefly affect this segment of society, it is essential that health workers at all levels must be comprised chiefly of females and not males as at present. The Comprehensive Health and Development project at Jamked (1971) and at Pachod (1976) clearly demonstrates that involving women as village health worker have had a marked impact on the patterns of health practices and knowledge within the community. The reservation of women in Panchayati Raj can have a significant impact in the field of health. It will provide gainful employment to over two million women in rural areas within the villages themselves, if a team of about five women can cater at the village level of 1000 population. They could take over many of the functions of single programme functionaries like anganwadies. Such functionaries selected, paid and accountable to the village gram sabha, would not only be available at much lower salary than the unionized workers of government, but would also avoid the problem of unions in the present system, being the people's own local functionaries.[32]

Thus, Panchayati Raj provides the unique opportunity for good health care for our people at a cost well within what we are expending at present. However, it does not mean that decentralisation in health care will not be confronted with problems. The Karnatka experience as pointed out by T.R. Satish Chandran[33] has shown the reality.

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31 Ibid, pp.32-34.

32 Ibid, p.35.

33 T.R. Satish Chandran, op.cit., pp.328-335.

It has been seen that as in other sectors, there have been transitional difficulties in rural health administration. One of the major problem area is personnel management where recruitment, transfers and disciplinary control have been a source of friction between the State Government and the Zilla Parishads. Inevitably, the initial complement of Panchayati Raj personnel comprises Government officials on deputation, as Zilla Parisads can build up their own cadres only over a period of time. There are legal limitations to the extent to which administrative control over deputed personnel can be passed on to the borrowing authorities. With no working arrangements regarding the role of Government and PRIs, there has been considerable misunderstanding and confusion. Also, the relationship between the officials and the elected representatives at different levels has changed. Certainly, it would take some time for the officials to appreciate the rationale for Panchayati Raj and to adjust themselves to the new working environment. In the interim, for lack of proper understanding of their respective responsibilities on the part of both officials and the elected representatives, strains have developed and programme implementation has suffered. Another sensitive issue has been the nature of relationship between Heads of Departments and regional officers and the counterparts in the districts in regard to technical control and supervision. The administrative autonomy of the Zilla Parishad administration is difficult to be reconciled with need for continuing technical support.

Secondly, even though decentralisation of power is the underlying concept of Panchayati Raj, it does not automatically follow that the power passes into the hands of those who have concern for the poor and the under privileged. Studies on the caste composition and economic background of the elected representatives of the Zilla Parishads and Mandal Panchayats in Karnatka do not evidence a loosening of the hold of the dominant landed sections of the rural community. It will take time before the

power equations shift in favour of those who have traditionally remained out of the mainstream. This is of importance if health services, which have the vast masses of the rural poor as their clientele, are to receive adequate attention.

Lastly, the system of planning followed so far in the country has led to regidities at the national and the state levels, leaving little scope for local initiative and innovation. If Panchayati Raj is to achieve its full impact the planning procedures will themselves require decentralisation, particularly with regard to social and community services.

On the other hand, the experience of decentralisation in health care in Kerala and West Bengal shows that given the political commitment and socio-economic upliftment of the people, their health status can be improved a lot. In Kerala,[34] Power and Planning process remained centralized and implementation was bureaucratized, but equitable distribution of health facilities between urban and rural areas was attempted successfully. The result has been that though being one of the poorest state in the country, Kerala has the highest levels of life-expectancy, literacy and utilization of health services as well as the lowest levels of the infant and child mortality. Thus it demonstrates that equitable socio-economic and health policies are not necessarily incompatible with democratic government and that a high Gross Domestic Product is not essential for health: fair shares for the many are better than large shares for the few.[35] And it could be possible with the creation of a political climate favourable to equitable development and widespread community participation. However, it must be pointed out that the health scene would have been far better and health care more efficient if decentralisation had been implemented in Kerala effectively.

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34 C.R.Soman, and P.G.K. Panikar, op.cit., pp.296-315.

35 D. Morley, and Others (eds.), *Practising health for All*, Oxford University Press. London, 1983, p.324.

In West Bengal,[36] Panchayati Raj has been effectively introduced after 1977 allowing planning and implementation of the programme to be done from the bottom. Through this system of administration, land reforms and distribution was done properly that brought change in socio-economic scenario. The socio-economic upliftment of lowest strata people led to the improvement in their health status as reflected in the vital statistics of health. Birth rate, crude death rate and infant mortality rate have reduced from 36.5, 10.2, 80.9 respectively in 1974 to 28.4, 8.3, 69 respectively in 1988. The position of West Bengal is not optimum but better than many other states because of better social justice enjoyed by the people in recent years. Further, the government even tried to democratize the functioning of the health department and involve three tier Panchayati Raj in the health delivery system. But the success is limited because of the conceptual deficiency of the political and administrative echelons, indoctrination of the political by the ruling class to demand for medicare alone, and wrongly planning strait-jacket central directive without taking people into confidence. It is strongly felt that if the political will which made Panchayati Raj effective in the socio-economic sphere, takes up the health care problem in the proper perspective and panchayat is properly involved in the health delivery system, the health situation of the state will be optimized.

The experiences of these two states - Kerala and West Bengal points out that health status of any community cannot be improved without bringing socio-economic equalities and there must be political commitment to ensure universal coverage by health services as well as the integration of health with other sectors of development. Health covers almost all aspects of human activity as does Panchayati Raj. Therefore, health

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36 G.P.Dutta, "The Effect of Panchayati Raj on the Health Care System in West Bengal", in N.H. Antia (ed.), *People's Health in People's Hands*, FRCH Publication, Bombay, 1993, pp.316-327.

cannot be achieved only through a medical service divorced from all the other aspects of development.

In the context of existing social and economic inequalities and their profound influence on health, the poor health conditions of rural area will persist and 'people's health in people's hands' will become an alibi for the systems continued non-performance. So, there are certain 'preconditions' for meaningful and effective decentralisation in health services as well as in achievement of good health care. Firstly, 'community' identities must be created in population of individuals with widely differing status, aspirations and requirements. The community must see the health of all as inter-related and view health for all as their joint concern. A comprehensive policy for people's participation in development as a whole would be more conducive to participation in health programmes. Secondly, as Banerjee has pointed out, for the health policy to be meaningful to any extent, it is essential to have a certain level of social consciousness to have involvement of the people in decisions that directly concerns them. Besides, a well-reasoned health policy framework can also be used as a lever to promote the process of democratisation among the people.[37]

Third need is to increase public awareness of health problems and possibilities. The psychological dependence on curative services must be lessened and people must realise that individuals, families and communities can prevent illness on their own. Further this health education must be accompanied by appropriate health services to enhance public credibility in the health system and to be effective in improving health.

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37 Banerji, D., "Contours of a Health Policy in Panchayati Raj" - Article presented in Seminar on Panchayati Raj and Health, April 9-10, 1994, FRCH Publication, Bombay.

Talking about the health policy in Panchayati Raj, Banerjee[38] has pointed out that health services will not involve itself with the people unless it has been demonstrated that it can offer an alternative way of alleviating their suffering with the available resources which is perceived by the people to be superior to what they have been practising hitherto. This ensures subordination of medical technology to the people. Banerjee went out to outline the key elements of suggested policy as such - First, using the changes engendered by Panchayati Raj Movement to more substantially implement the CHVs scheme of entrusting people's health in people's hands. This is complemented by promotion of home remedies, locally available indigenous system of medicine and other healing practices to promote greater community self-reliance. Second, ensuring that health service institutions up to the district level provide referral support to people, that health service must be provided in an integrated form, that an efficient management information system monitor the performance of the health services, and that information, communication and active education process must be based on the understanding of local socio-cultural conditions. Thirdly, the PRIs ought to exercise social control over the health services within a district. The district Chief Medical Officer will report directly to the Chairman of the Zilla Parishad and most of the manpower needs for the health services will be met from within the district. Finally, considerable groundwork needs to be done in the form of health systems research and political analysis in drawing up strategies which would suit different conditions.

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38 ibid.

CHAPTER V
CONCLUSION

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Almost five decades of experience shows that health cannot be 'delivered' to the people, even at great costs. For country-wide implementation is the people's own function, with the Health Services, NGO's and the medical professional providing the support they need. In this context, only a system based on the people's sector can achieve both outreach as well as accountability far more effectively and at much lower cost. This is because health like education, lends itself best to people's small scale action which is in their own interest for their own problems. Thus, under the prevailing social and economic conditions and in a democratic set up only decentralized people-based health care is needed as well as desirable and feasible. Even the Expert Committee on the Public Health system headed by J.S.Bajaj, reviewing comprehensively the failure of health system to cope with outbreaks of Plague and Cerebral Malaria in 1994-95, points out that poor surveillance and deteriorating facilities have slowed down the public health system's response to the early signs of an epidemic.[1] This poor surveillance can be improved substantially with decentralised health care as the Karnataka experience shows.

The health, socio-economic and political reality of each region must dictate its health care policies and the nature of its health care. Blue-prints of health programmes made in ivory towers usually lack both vision and spirit as well as the capability to motivate and mobilise people for action.[2] If it is to work, it will have to be rooted in the genuine health needs of the people and not in the 'false wants' created by vested

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1 Kalpana Jain, "Public Health: Alternative Strategies Are Needed", *The Times of India*, July 1, 1996.

2 Mira Shiva, "The Problem", *Seminar*, vol.369, May 1990, p.18.

interests. Thus, it calls for community participation and involvement of the people in planning process and decentralisation in health care will facilitate the same. PRIs as the unit of planning and socio-economic development provides the opportunity to the people to play an important role in the planning as well as implementation process.

The revitalization and rejuvenation of PRIs by 73rd Constitutional Amendment Act will certainly bring people close to development process. These institutions, bridging the gap between the bureaucratic elite and the people, would create a sense of participation, a 'we feeling' in democratic institutions. The local planning through these institutions will help the poor, the underprivileged sections of the society to come up in their lives. The reservation system for the weaker sections like women, SCs and STs will certainly help them to move upwardly. However, it must be pointed out that despite the perfect looking of draft piece of legislation on paper, it is a different game altogether when it comes to implementing such a massive job of social engineering in a society as complex as ours. The enactment should therefore, be seen as starting point of a learning process that can only happen gradually and with experience over a time.

The elections of PRIs in many states show that these institutions are still dominated by rich landed castes, who are not willing to let the others come up and corners all the benefits of developmental process. In this context, decentralisation without restructuring power may mean empowering the local elite rather than the local people. Balance of forces has to be changed in rural areas. Otherwise, inequalities will continue to exist in all sectors, including health.

There is gross maldistribution in health in favour of the urban upper and middle classes, whereas the rural residents and poor people have neither the 'goods' to maintain health nor access to the services. It calls for 'redistributing' health, but political

exigencies dictate that the levels of health of the upper strata cannot be reduced, notwithstanding the goal of 'Health for All' through Primary Health Care approach. Thus, a duality ensues in health policy it talks of providing minimal health care to all while still maintaining and furthering the development of 'five-star' hospitals and sophisticated medicine.[3] This duality can be removed, once the planning is initiated from the below.

The existing health infrastructure reaches down to village level from Primary Health Centres through Multipurpose workers and community based Health Guides. While prescribing the strategies to reach the goal of 'Health for All', the policy stops short of developing the necessary interface between health services and clients. Most health functions are vested in the family or household units, where the role of women is crucial. But in the presence of stratified social structures, while women provide health care inside the home, they have limited access to health services outside. Thus, health workers must be selected, trained and organised to develop a systematic interface with women by visiting homes on a regular basis. The reservations for women in PRIs will certainly bring them forward, make them conscious of their rights, and enable them to take part in improving health condition outside home. The comprehensive Rural Health Project at Jamkhed (1971) and Pachod (1976) have shown that recruitment of women and low-status people as voluntary Health Workers has led to de-elitism in health care and the underprivileged sections utilized health services in a much extensive and better form.[4]

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3 Meera Chatterjee, *Implementing Health Policy*, Manohar, New Delhi, 1988, p.282.

4 Maitrayee Mukhopadhyay, "Human Development Through Primary Health Care: Case Studies from India", in D.Morley's (ed.), *Practising Health for All*, Oxford University Press, London, 1983, p-134

One of major obstacle to the implementation of a primary health care policy is the powerful interest group of medical professionals in both public and private, traditional and modern health sectors, and their related 'ancillary' groups such as the drug industry. For widespread basic health care to become available, the current system in which doctors influence political decision-making, resource allocations and implementation in favour of "high technology" health care, must give way to one in which consumers' needs and concerns are given primary importance.[5] Panchayati Raj System with its objective of 'Power to the People' will provide the opportunity to the community itself to guide the policy in favour of their own needs. However, it entail a real devolution of power and it can be possible only when decentralisation is carried forward to its logical conclusion, at the state and National levels also. Only then, the panchayats will have significant power and resources to work with and will be organised vertically through functional inter-relationship along various tiers, reaching out to the state level.[6]

It is observed that health is a function of political process. Being a state subject, it depends upon each state's willingness and commitment that vary widely, notwithstanding the national goal of 'health for all' espoused at the national level. Therefore, mechanism need to be instituted to ensure that all states must pursue more fully its obligation to legislate and implement actions favouring the principle of 'ensuring health for all'. PRIs through its pressure on state can be helpful, but it must be pointed out that the success of Panchayati Raj system itself depends upon State's willingness to

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5 N.H. Antia, "Panchayati Raj and Health", *Seminar*, vol.438, February 1996, p.33.

6 Rajni Kothari, "Perspective on Decentralisation" in N.H. Antia (ed.), *People's Health in People's Hands*, FRCH Pub., Bombay, 1993.

decentralise power and responsibilities. Under the new Act, the State has been given the responsibility to endow the Panchayats with such powers and authority as it think necessary within the broad paradigm of economic development and social justice. Thus, real power is vested in the state legislatures and devolution of powers depends upon states willingness to share power.

Moreover, the system of planning and financing gives the Central Government some authority over the states, despite the constitutional provision for states autonomy in matters of health. This authority can be used in the crucial area of primary health care to remove wide disparities among states. In addition, there are many ways like using 'residuary' power or through Article 249 or 256, the Centre can play a major role in promoting health at the national level. Thus, while 'decentralisa-tion' is a key element for the implementation of primary health care, the 'Centre' cannot abdicate its responsibility to cooperate with the states, to assist them fully, and to guide then where necessary.[7]

It has been realised that while people's self-reliance and involvement in primary health care is essential, at the same time, the task of improving health cannot be done by the community alone. The assistance of appropriate service agencies is essential. In this way, government health services must cooperate with the community's role in implementing primary health care. However, a fundamental contradiction may be perceived between state provision of services and the concept of 'self-reliance'. But in reality one begins where other ends, as a balance between government health services and community responsibility is the essence of decentralisation in health care. The role

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7 Meera Chatterjee, op.cit., p.281.

of the health system is to assist in organising 'communities' to change the conditions that perpetuate ill-health.

Above all, the people must be made aware that the true cause of their problems related to health and disease is poverty and its associated ills like malnutrition, lack of potable water, and poor sanitation and environment. As the most of problems require low technology but high cultural affinity with the people for its delivery, it is up to the people themselves to take the lead and demand the knowledge and support from the health services rather than the other way round. They must be made to realize that this is their birth right as citizens of a free country. What they need is neither welfare doles nor charity but the right to gainful employment whereby they can purchase their own food and clothing, build their own homes and educate their children.[8] Liberated from ignorance and poverty, they can plan and supervise their health and other services to suit their needs. Panchayati Raj Institutions would be much helpful in eradicating ignorance as well as poverty, thereby facilitating a better, healthier, and a more humanised and just world.

To sum up, the review of the existing work related to Panchayati Raj and health brings out the following concerns and conundrums -

(1) Unless the hierarchical character of our society is changed, maldistribution in resource allocations including health cannot be rectified. It entails restructuring of power relations that cannot be done at one stroke.

(2) The implementation of both Panchayati Raj and health policy is dependent upon State governments' willingness. Can it ignore the upper strata which will have political implications?

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8 N.H. Antia, "Comprehensive Health Care", in *Seminar*, 369, May 1990, p.23.

(3) The objective of 'Power to the people' that would enable them to guide health policy in favour of their own needs, can be achieved only when devolution of powers is completed at national and state levels. Are the Centre and the State ready to share power?

(4) Finally, the creation of awareness among the masses, which is necessary for development and improvement in health status, can be done gradually over a time period. In this context, whether Panchayati Raj system will function effectively?

Some of these issues need to be examined and analysted in the particular rural context of India such as restructuring of power relations, and awareness among the rural people etc. They decide the question of accessibility and availability of health services to the people and so the effect of implementation of Panchayati Raj system on them would be crucial for both health and Panchayati Raj.

However, the fact remains that Panchayati Raj system will take its own time to 'deliver' the effect, as it happens in any democratic transition or to use Karl Popper's phrase, 'social engineering'. Subsequently, the system would enable the people to be active participant in all aspects of development including health and would help realise the goal of 'Health for All'.

APPENDICES

Appendix-I

Administrative Units and Panchayati Raj Bodies (1988-89) All India

S.No.	Item	Unit	All India
1.	Districts	No.	427
2.	Zilla Parishads	No.	350
3.	CD Blocks	No.	5,138
4.	Panchayat Samitis	No.	5,332
5.	Gram Panchayats	No.	2,19,059
6.	Population covered by Gram Panchayats	Million	440
7.	Villages and hamlets covered by Gram Panchayats	No.	5,97,926
8.	Average number of villages per Gram Panchayat	No.	2.7
9.	Average population per Gram Panchayat	No.	2,008
10.	Average number of Panchayat Samitis per Zilla Parishad	No.	15.2
11.	Average number of Gram Panchayats per Zilla Parishad	No.	626
12.	Percentage of rural population covered by Gram Panchayats	%	98.6
13.	Percentage of blocks covered by Panchayat Samitis	%	100.0
14.	Percentage of villages covered by Gram Panchayats	%	100.0
15.	Average number of Gram Panchayats per Panchayat Samiti	No.	41.1
16.	Percentage of districts covered by Zilla Parishads	%	82.5

Source: Panchayati Raj at a Glance, 1988-89.

Appendix II

ELEVENTH SCHEDULE
(Article 243 G)

1. Agriculture, including agricultural extension.
2. Land improvement, implementation of land reforms, land consolidation and soil conservation.
3. Minor irrigation, water management and watershed development.
4. Animal husbandry, dairying and poultry.
5. Fisheries.
6. Social forestry and farm forestry.
7. Minor forest produce
8. Small-scale industries, including food processing industries
9. Khadi, village and cottage industries.
10. Rural housing.
11. **Drinking water.**
12. Fuel and fodder.
13. Roads, culverts, bridges, ferries, waterways and other means of communication.
14. Rural electrification, including distribution of electricity.
15. Non-conventional energy sources.
16. Poverty alleviation programme.
17. Education, including primary and secondary schools.
18. Technical training and vocational education.
19. Adult and non-formal education.
20. Libraries.
21. Cultural Activities
22. Markets and fairs.
23. **Health and sanitation, including hospitals, primary health centres and dispensaries**
24. **Family welfare**
25. **Women and Child Development**
26. Social welfare including welfare of the handicapped and mentally retarded.
27. **Welfare of the weaker sections, and in particular, of the Scheduled Castes and the Scheduled Tribes.**
28. Public distribution system.
29. Maintenance of community assets.

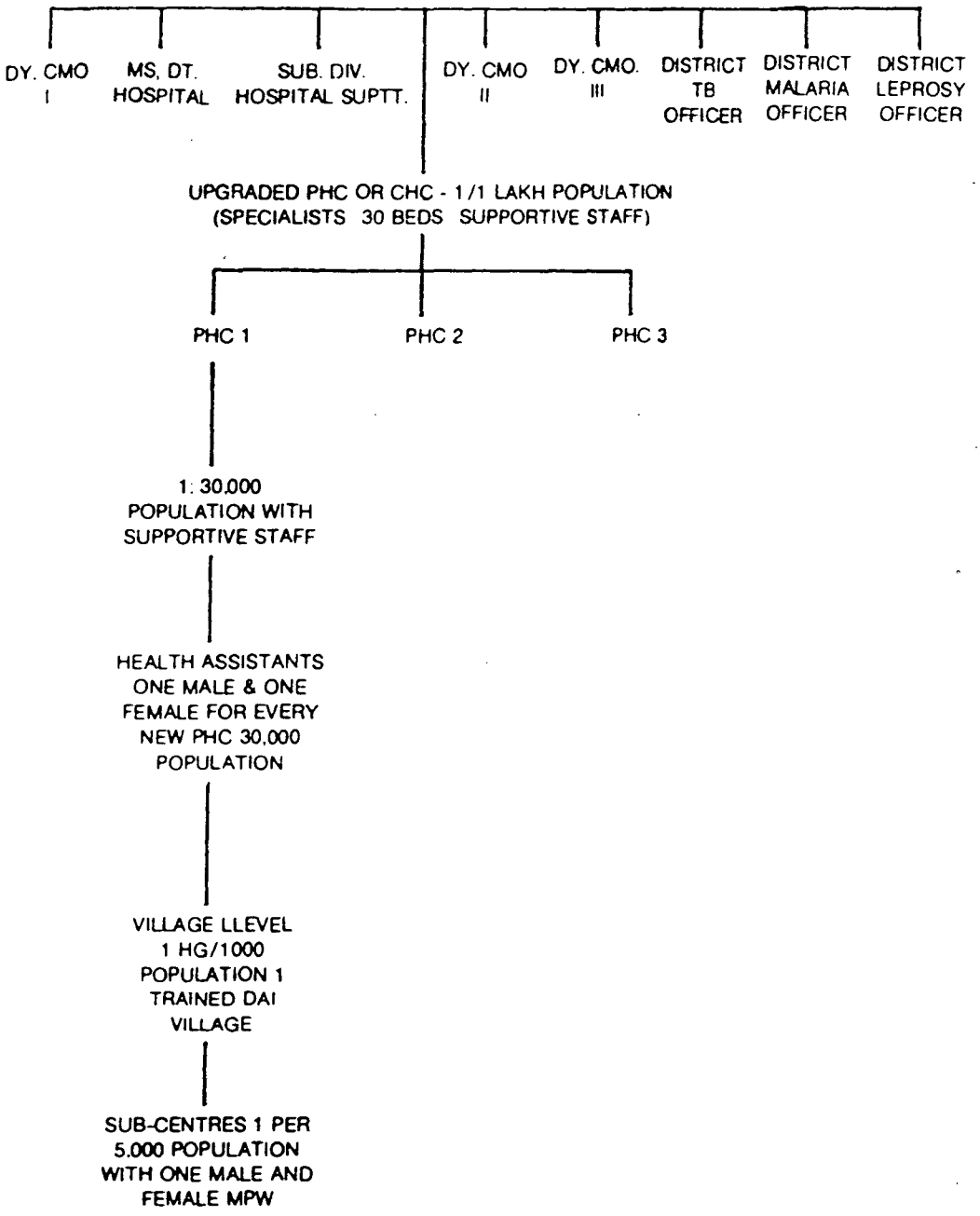
Appendix III
Increase in Infrastructure, Humanpower and Expenditure Since Independence

Indicators	1951	1971	1988
A. INFRASTRUCTURE			
1. Hospitals (a+b)	2,694	3,864	9,831
a. Rural	(1956) 1,315	(1974) 1,011	3,099
b. Urban	(1956) 2,059	(1974) 2,974	6,732
c. Private	(1974) 644	5,497	
2. PHCs	Nil	5,112	16,756
3. Sub-Centres			112,004
4. Beds (Hospitals + Dispensaries) (a+b)	117,000	348,655	609,735
a. Rural	(1956) 35,936	(1974) 38,110	109,192
b. Urban	(1956) 116,952	(1974) 303,170	500,543
c. Private		(1974) 57,550	182,322
B. HUMANPOWER			
1. Medical Colleges	30	98	125
2. Out-turn of Medical Graduates	1,557	10,407	15,000
3. All Doctors	156,440	(1976) 627,575	816,000
a. Allopathic	61,440	151,129	352,000
b. Non-allopathic	95,000	(1976) 417,071	464,000
c. Rural allopathic		59,545	
d. Private allopathic		(1981) 189,711	
4. Nurses	16,550	80,620	219,299
5. Out-turn of General Nurses	1,282	6,257	9,500
C. TOTAL EXPENDITURE			
1. Medical, Public Health and Family Welfare (excld. Water Supply) (Rs. million)	218.55	3,351.18	46,185.98
D. DRUG PRODUCTION (Rs. million)	199	2,998	26,900

Source: Duggal Ravi et al, State Sector Health Expenditures - a Database: all India and States, 1951-1985, FRCH, 1992.

Appendix IV

DISTRICT AND BELOW ORGANISATION OF HEALTH SERVICES



Source : Health and Population : Issues and Perspective, 12(4), 1989.

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