ORISSA ECONOMIC JOURNAL

Vol. XXXVI No. 1 & 2

Jan.-June & July-Dec. 2004

ORISSA ECONOMICS ASSOCIATION
BHUBANESWAR

Orissa Economic Journal

Vol. XXXVI No. 1 & 2

Jan.-June & July-Dec. 2004

Editor :

Prof. Baidyanath Misra

17, Saheed Nagar

Bhubaneswar

ORISSA ECONOMICS ASSOCIATION

BHUBANESWAR

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EDITORIAL

GROWTHMANIA

As ye grow,
So shall ye Weep

E.J. MISHAN

Economic growth has now become the universal phenomenon and is cherished objective of each and every country, particularly more so in developing countries. Like a national flag, a national plan for economic growth has become the symbol of each developing country. Gunnar Myrdal calls it 'Asian Drama'. Often it is distinguished from economic development, though the distinction hardly merits any consideration. For example, Williamson and Buttrick in their book 'Economic Development' point out, "Economic development or growth refers to the process, whereby the people of a country or region come to utilise the resources available to bring about a sustained increase in per capita production of goods and services". Even G.M. Maier, in his 'Leading Issues in Economic Development' explains economic development as a process, whereby the real per capita income of a country increases over a long period of time. Maddison in his 'Economic Progress and Policies in Developing Countries' has made a simple distinction between the two concepts. According to him, "The raising of income level is generally called economic growth in rich countries, and in poor ones it is called economic development".

There is no doubt that economic growth or economic development has a significant part to play in reducing poverty. Poverty and underdevelopment are more or less synonymous. A country is poor because its growth of income is low and remains underdeveloped as it has not the necessary resources for promoting growth. Poverty is a curse, but a greater curse is that it is self perpetuating. Economic growth also helps to (a) fully utilize the productive potential of the resources with the aid of improved technical knowledge, (b) increase employment opportunities through an increase in developmental activities, (c) provide adequate subsistence and material comfort to most of the country's population, (d) create economic surplus by increasing the productivity of agriculture, industry which helps in additional capital formation, (e) increase public revenues as higher per capita income enhances the taxable capacity of the people and so on.

Nobody therefore, can question the necessity of economic growth. But we have also to be careful regarding the unfavourable effects of Growthmania. Even though India has not yet attained a take off stage in the process of growth, there is considerable change in social structure which is incompatible with a harmonious development of the country. Now there is greater stress towards acquisitiveness leading to disruption in the social values. The new

stress of materialism has changed the face of India. The number of new rich has increased by leaps and bounds. It is estimated that in the year 2001-02, there were 20 thousand families in India with annual incomes of more than one crore rupees. By 2004, that figure was 53000 families. And economists predict that by 2010, the number would jump to 1,40,000 crorepatis. On the other hand we have colossal poverty, only income poverty as estimated by the Planning Commission comes to about 26% of the population which is more or less equal to the population of Japan.

Inspite of such poverty and inequality, our young men are now impatient to live a life of luxury discarding the comfort zone of their parents along with an increased appetite to acquire wealth. With bulging wallets and easy credit, there is a spending spree increasing urban consumption by 16 per cent in 2004. Can you imagine that the affluence of a 20 year old girl, awash in Armani posing next to her Rs. 5.25 crore Mayback, a birth day gift from a doting father? And Steel king Laxmi Mittal has no hesitation to spend a few billion dollars on his daughter's wedding. The present generation unlike their parents, displays no hesitation in competing with the best in the world. Jean Dreze in Time magazine writes, "The so-called middle class in India (read the upper class) has become rich beyond its members' wildest dreams. They have literally translated themselves to the First World without applying for a Visa". And the global market has created tremendous opportunity to fulfil their outrageous ambition. This shows that the problem of poverty and inequality seems to have taken precedence over the problem of growth. There is so much disenchantment in the growthmania that Mahbubul Haq observes, "We were taught to take care of our GNP as this will take care of poverty. Let us reverse this and take care of poverty as this will take care of the GNP".

No doubt, people often eulogize the blessings of rapid economic growth, which certainly have provided a lot of comfort to many, like a growing assortment of automobiles, television sets, vacuum cleaners, refrigerators, washing machines, computers, antibiotics and so on. But along with such rapid development, we have to consider the concept of external diseconomies, a concept crucial to any appreciation of the mounting spill over effects of modern industrial development and of its products on the amenity of society at large. One example is the fossil fuel based automobile centred, throwaway economy which is pursued leads now to reckless exploitation of earth. Indiscriminate industrialisation has given rise to emission of toxic gasses, depletion of ozone layer, threat of acid rain, pollution of air, water and land surface, in fact, nothing is spared resulting in total population.

The increase in chemical industries causing the depletion of ozone layer which acts as a blanket of earth to filter out the harmful rays of sun is a great danger to the humanity. If the ultra violet rays of the sun reach earth, there will be incidence of skin cancer, increase in the temperature of earth which then could melt polar-ice cap. As a result of this melting all the cities, towns along with seacoast will submerge in water with great devastation to human

civilisation. The recent killer wave of Tsunami is attributed to much of the warming due to accumulation of 'greenhouse gases' in the atmosphere, such as carbon dioxide from fossil fuel burning and it is apprehended by scientists that the warming of the planet would by changing climate would cause further natural calamities as the century wears on.

Another notorious by-product of industrialisation the world has ever known: the appalling traffic congestion in our towns, cities and suburbs. Take the case of Delhi, the capital of India. A Times of India's study shows that Delhi's roads are becoming a living nightmare. Driving in the free-for-all Delhi traffic is more than just a daily headache. It is a stress factor. For those susceptible to hypertension or who have suffered angina trouble, traffic condition can cause blood pressure to increase. In the last few years many men in their 30s are suffering from heart attacks and in this group, driving stress contributes to over all stress. And worse the endless breakings, weaving of cars, cutting in, snarl-ups, honking and lack of discipline on roads hinder the recovery of those who have had heart attacks. Further, people often develop migraine while driving in heavy traffic or stomach ulcers and feel exhausted both emotionally and physically. One lady says she is 'shattered' after a long drive home. And another says, 'it is a miracle you come back home safe'. Mishan in his 'The Costs of Economic Growth' says the pleasures of strolling along the streets of a city are more a memory than a current past time.

Scitovsky in his 'Papers on Welfare and Growth' raises another fundamental question which raises eyebrows among the economists. He says that the optimistic philosophers of the 18th and 19th centuries expected economic progress to accomplish many wonderful things. It was going to bring about 'the greatest possible of abundance of objects suitable to our enjoyment, and the greatest liberty to profit by them; it was expected to free man increasingly from daily toil and thus to provide him with more time to cultivate his mind. In short, they hoped that progress would turn more and more people into philosophers in their own image, engaged in the leisurely and philosophical contemplation of the world and its wonders. In a material sense, and measured in terms of output per man-hour or income per head, economic progress in the west has achieved or surpassed these men's wildest hopes. The consequent rise in our standard of living is a genuine and substantial gain. But strangely economic progress in our society has wrought cultural and social changes that divert time and energy from intellectual pursuits, lower the prestige of learning and diminish the availability of channels of intellectual discussion and the dissemination of new ideas. And T.S. Eliot says, 'Where is wisdom, we have lost in knowledge, where is knowledge, we have lost in information'. These and some related consequences are part of the price we pay for economic progress in our society.

Though economists may allow such a price they cannot neglect the quality of life. Those who are addicted to growthmania presume that (a) sophisticated technological development can increase production and guarantee a good quality of life (b) carrying capacity of the earth is unlimited and (c) such a

society presupposes unlimited resilience in life support systems to keep on absorbing the continued shocks of pollution and ecodegradation. But the experiences of development in different parts of the world show that all these assumptions are wrong.

First, a high-tech society may increase production but may not reduce poverty, unemployment or inequality. It may create a dual society in which a few may have abundance of wealth and a vast majority may suffer from deprivation. If we provide a computer for every household in the 21st century, but wipe out half of the world's plant and animal species, that would hardly be an economic progress. And if we again quadruple the size of the global economy but half of the world's population suffer from starvation, we will not be able to declare the 21st century a success. And it may not improve the quality of life.

Second, it is not correct to say that the carrying capacity of the planet is unlimited. Take the case of energy. It was once conceived that fossil fuels which create instability in climate and increase air pollution can be substituted by nuclear power. But nuclear power has failed to live upto its promise. The nuclear accident at Chernobyl has frustrated all hopes on nuclear power. To a large degree this is also on account of the impossibility of safely storing nuclear wastes over unimaginable stretches of time. According to Einstein, there are only two things which are unlimited, the Universe and human stupidity. This stupidity has to be stopped. Third there is no guarantee that a high-tech society will be able to support the life support system. The major atmospheric problems facing our planet today are global warming and the destruction of protective ozone layer, air pollution, acid rain, and the resultant forest destruction. All these are cumulative effects of increasing industrialisation. It may also be noted that environment degradation involves a loss of capital and incurring of social costs which are not usually taken into account in the process of valuing goods and services.

All these show that while increasing economic growth, we have to protect nature and make efficient use of natural resources. The guiding principle in such a case is to try for a sustainable society which will satisfy the needs and not the greeds of the people, ensure comfort, not luxury and above all bring about equity and social justice. The twin goals of sustainable development are (a) restoration of the ecological damage and (b) insulation of the country from the damage as a consequence of future development. The latter must entail minimum risk to environment. Each type of development entails some risk. To accomplish both restorative and preventive strategies we have to improve the efficiency of energy use, increase the forest area, reduce wants, increase awareness, provide power and authority to the village units so that they can take the responsibility of protecting environment. We can conclude by stating that as India grows economically, it needs to have more social discipline.

Professor Baidyanath Misra

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Secretary's Report

Mr. President Professor Misra, Revered Chief Guest Professor Rakhit, The Doyen of Economists & Guest of Honour Professor D.C. Misra, Economist of Eminence and Felicita Professor Baidyanath Misra, Chairman Reception Committee Professor Padhi, Local Secretary Dr. Swain, Distinguished Guests, Invitees, Members of the Media, Fellow Delegates, Ladies and Gentlemen.

It is a distinct honour for me to be here today, as Secretary of the Orissa Economics Association, to extend you all a hearty and cordial welcome to the 36th Annual Conference. I feel privileged to present before you a resume of the activities of our Association.

The Orissa Economics Association was founded on 26th January, 1968 with late lamented Professor Sadasiv Misra as its President and Prof. Baidyanath Misra as its Secretary with a view to imparting training to teachers in economics in the state in order to improve the standard of teaching in economics in general and stimulating research on current economic issues of the Indian economy and the state economy of Orissa in particular through organizing Annual Conferences and arranging Symposia, Seminars and Workshops. The Association enjoys the distinction of being one of the oldest registered regional academic associations in the country. At present it has 03 institutional life members, 270 individual life members and 19 annual members comprising academic institutions, government organizations, teachers in economics, research scholars, statesmen and policy makers from within the state & outside the state and the country. It has the unique distinction of holding a two-day Annual Conference and publishing its mouthpiece Orissa Economic Journal which contains the papers presented and discussed in the Conference uninterruptedly since inception. The journal finds its place of pride in important libraries in the country and has been a source of information to the researchers.

The Association maintains the healthy convention of discussing two sets of issues in the Annual Conference : one relating to the Indian economy or the Theoretical Developments in Economics and the other in the precincts of regional perspective of the state of Orissa. This year the following two topics have been selected for discussion in the conference: "Economic Reforms in India Since 1991 - its Impact on the Indian Economy" and "Health Service System in Orissa". We are fortunate that Dr. Deba Prasad Rath, Director, Economics Division, Department of Economic Analysis & Policy, RBI, Mumbai

and Sri Rabi Narayan Senapati, I.A.S., Commissioner-cum-Secretary to Government of Orissa, Health and Family Welfare Department have kindly agreed to deliver the keynote addresses on these two issues respectively.

Since 1987, we have been organizing a lecture in a special session in the Conference in the memory of Bhubaneswar Mangaraj, an illustrious teacher of Banki. The topic of this year's Mangaraj Memorial Lecture is "Industrialisation in Orissa with Special Reference to Steel Industry". We are indeed thankful to Sri Braja Kishore Tripathy, Honourable Minister of State for Steel, Government of India for his kind consent to deliver the lecture.

It is my pleasant duty to express our grateful thanks to Professor Mihir Rakhit, our Chief Guest of this function for having accepted our invitation to come over here and inaugurate the Conference. I am extremely indebted to Prof. G.C. Kar, former Director, Prof. Sakti Padhi, the present Director in Charge, Dr. Mamata Swain, the local Secretary, Dr. Shiblal Meher, the Assistant Local Secretary and the staff of Naba Krushna Choudhury Centre for Development Studies for their tireless efforts in organizing this Conference in a befitting manner. My sincere thanks are due to Professor Baidyanath Misra, the Editor of Orissa Economic Journal for his keen interest in all the activities of the Association. Without Prof. G.C. Kar's initiative and Professor Baidyanath Misra's involvement this Conference would not have been possible here. I am proud enough to express my deep sense of gratitude to our Honoured Guest, Prof. D. C. Misra for his kind acceptance of our invitation and presence in the Conference. I really owe a great deal to Professor Bhabani Prasad Dash who is still behind the scene and providing continuous guidance in the functioning of the association. My special thanks are due to the members of the executive body and specially to the President Prof. Misra for their help and cooperation. I am thankful to M/s. Das and Associates, Chartered Accountants, Cuttack for having audited the accounts of the Association for the year 2002-2003 without charging any fee. I am grateful to the invitees, guests, media persons, delegates, paper writers and to you all ladies and gentlemen for having given me a patient hearing.

Thanking you all once again,

Rabi N.Patra
Secretary
Orissa Economics Association

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PRESIDENTIAL ADDRESS

Role of Commercial Banks in the Economic Development of Orissa

An anatomy of mobilisation of deposits and utilisation of resources in the Post-Economic Reform period

Professor S.N. Misra

President,
Orissa Economics Association

Most respected chief guest of the inaugural function, Professor Mihir Rakshit, the doyen of Indian economists, my esteemed teacher, Professor D.C. Misra, Guest of Honour of the Ceremony, my revered teacher, Professor Baidyanath Misra, the honoured guest of the day, Prof. S.P. Padhy, Chairman of the reception committee, Dr. Rabi Narayan Patra, Secretary, Orissa Economics Association, Dr. (Mrs.) Mamata Swain, Local Organising Secretary, Respected all past Presidents, Members of executive committee, Distinguished guests and invitees, Fellow delegates and friends.

Before I start delivering my Presidential Address, let me utilise the opportunity for expressing my gratitude to all the members of Orissa Economics Association for electing me unanimously as the President of the 36th Annual Conference of OEA in Jagatsinghpur College when the 35th Annual Conference of the Association was held sometime in the month of February last year. This is an indication of their trust and confidence reposed on me. I was overwhelmed, academically and psychologically when I was asked to preside over the conference of the Association against the background of eminent economists and personalities who presided over the conferences of the association held in different places of the state in the past. It is for me both an opportunity and a challenge. I accepted the offer with all humility.

The paper I am presenting before the august audience broadly relates to the area of institution finance, especially in the field of Commercial Banking. I preferred to select this topic on account of my long association with the subject since 1983 when I obtained my doctorate degree for the work on Commercial

Banking and Economic Development of Orissa. From 1983 till the present day I have travelled a long route both by teaching and research to understand the role the commercial banks could play in promoting economic development of Orissa. This inquisitiveness compelled me to choose this topic for the interest of distinguished delegates.

INTRODUCTION

Commercial banks are the catalytic agents of economic development. They perform two important functions in the economy. They mobilise the savings from those who have surpluses to spare and channelise these for purpose of productive investment in favour of those who are in dire need of the same. Capital formation has three important states; Savings, Financing and Investment. Commercial banks are more concerned with the 'Financing' stage of economic development. This refers to an act of deposit mobilisation and its channelling for productive investment in the economy. The growth of real sector ultimately depends upon the expansion of the financial sector. In fact financial sector development must ultimately precede real sector development (Narsimham: 1992). Proper development of the financial system is no longer regarded as an 'ancillary' or an adjunct to the development of real sector, but as a necessary precondition for growth (Jalan :2000). In the financial sector the commercial banks occupy a pivotal position by undertaking the twin functions of deposit mobilisation and deployment of credit. This paper makes an attempt to analyse these twin functions undertaken by commercial banks in the context of economic development of Orissa.

The study is pursued with the following objectives :

1. To investigate the extent of deposit mobilisation and deployment of credit by commercial banks in the context of economic development in the state.
2. To enquire against the background of economic liberalisation and financial and banking sector reforms, as to what extent banks have utilised funds for the development of the state and problems associated with it.
3. To suggest policy measures for improving investment by commercial banks in the state.

For the study, greater reliance is placed on the data published by Reserve Bank of India and Regional Offices of Nationalised Banks located in the state. The study covers the period from 1990-91 to 2000-2001 covering the period of first and second generation of economic reforms. The central theme of the study is to examine as to what extent commercial banks, one of the constituents of financial intermediaries, have utilised the mobilised resources for the development of the state's economy.

Deposit Growth

Deposits are the raw materials for the commercial banks. Higher is the amount of deposits mobilised by banks greater is the scope for deployment of such deposits for purpose of development of the economy. An analysis of deposit mobilisation by commercial banks reveals that in the year 1991 they had mobilised a sum of Rs. 2735 crores which increased to Rs. 15072 crores in 2001, i.e. an increase of 5.5 times over the period (Table - 1). It is further seen from the available data that average annual growth rate of deposit was 17.0 per cent between 1990-91 and 2000-2001. Furthermore the per capita deposit which stood at Rs. 912 in 1990-91 increased to Rs.4106 in 2000-2001 showing a rise in the saving habit of the people in the state. The average percapita deposit during the period was Rs.2163. commercial banks thus become the largest repositories of community's saving in the post reform period. Deposit mobilisation by commercial banks in Orissa has revealed certain characteristics which are explained below.

Deposit mobilisation : Relevant Characteristics

- With regard to the type of deposits, the share of term deposits to the total whereas stood at 50.4 per cent in 1990-91, the same was 60.4 per cent in 2000-2001, indicating an increase by 10 percentage point over the period During this period saving bank deposits stood at 29.4 and 28.5 per cent of the total deposits in 1990-91 and 2000-2001 respectively. Over the period saving bank deposits declined by 0.9 percentage point. Most important point to consider is that the share of current account deposits in the aggregate deposits decline from 20.2 per cent in 1990-91 to 11.0 per cent in 2000-2001. The decline over the period was 9.2 percentage point.
- It is further seen that during the period from 1990-91 to 2000-2001 the average percentage share of term deposits to the total whereas stood at 57.0, that of savings and current deposits were 27.6 and 15.4 respectively. Similar trend is also noticed at the all-India level. There is thus a shift of preference from current account and saving bank deposits to term deposits in the post economic reform period covering both first and second generation of economic reforms. In other words, there is a distinct shift from short-term deposits to long term deposits. Relatively higher rate of interest on term deposits and increased inclination for more safe and secured type of deposits are the major causes for a shift of preference towards term deposits.
- The maturity pattern of term deposits for the period 1990-91 to 2000-2001, reveals that the savers have in general a strong preference for holding deposits of shorter maturities than longer maturities. In 1990-91, the proportion of term deposits maturing within 2 to 5 years and above constituted 75.2 per cent of total term deposits. However, this

declined to 60.4 per cent of the total in 2000-2001. On the other hand, term deposits with a maturity period of 90 days to 2 years whereas stood at 24.6 per cent of the total term deposits in 1990-91, the same increased to 39.6 per cent in 2000-2001. This development has two implications; firstly, the larger preference for depositors who desire to yield quick gain within the short period. Secondly, the margin of rate of interest between deposits of short and long periods is so narrow that the depositors preferred to put their savings in the form of deposits of shorter maturities than longer periods.

- Another aspect of deposit mobilisation refers to ownership pattern of deposits. It is revealed that bulk of the deposits of commercial banks have come from household sector. Data available for March 1998 reveal that household sector alone accounts for 76.3 per cent of total deposits. This is in contrast to the experience by banks at the all India level where household sector accounted for 66.5 per cent of the total deposits. In the year 2000 and 2001, the share of household sector to the total deposits in Orissa were 67.6 and 67.2 percents respectively. It is revealed that between 1997-98 and 2000-2001 the share of household sector in the total deposits has declined by 9.1 percentage point. This indicates that the household sector has shifted to other forms of deposits assuring better rate of returns. Inspite of this, household sector still accounts for the bulk of the deposits. Safety and security of deposits, backed by the guarantee coverage under Deposits in lieu of others (Onkarnath, 1997). On the other hand, the share of state government in total deposits of banks was about 17.2 per cent which declined to 10.0 per cent in 2000-2001. One of the dismal pictures is that the share of private sector in the total deposit was only 1.2 per cent in 1997-98. However in 2000-2001 the share of private sector in the total deposit was 4.6 per cent. Similarly the share of financial sector in the total deposits mobilised by bank is only 7.7 per cent in 2000-2001 as against 3.3 per cent in 1997-98. The nonresident Oriyas accounted for 2.3 per cent of the total deposits by banks as against 11 per cent by NRI's at the national level in 2000-2001. There is therefore, greater scope for mobilising deposits by banks in Orissa from private corporate sector and from non-resident Oriyas living in foreign countries. The development of Kerala economy is partly due to the investment made by non-resident Keralites.
- Bulk of the deposits although come from household sector, yet such deposits showed excessive gender bias with males dominating over females and others in ownership of deposits. It is observed that in the household sector commercial banks have mainly collected deposits from the male population accounting for 65.7 percent of the total

deposits in 2000-2001. The female population has occupied a minor position in saving their surpluses in the form of bank deposits although they constitute 49.3 per cent of the total population as per 1991 census. The share of female population in the total outstanding deposit of the banks was only 13.3 per cent in 2000-2001. In the 'other' category the government and government associated institutions had mainly contributed towards the deposit growth by banks. There is thus the scope for empowering women to put their savings in the form of bank deposits which the banks had not done so far through tailor made schemes to tap women folk especially.

Population group wise distribution of deposits by commercial banks during the post-economic reform period (1990-91 to 2090-2001) reveals that commercial banks had succeeded in mobilising deposits from rural areas. The share of rural deposits to the total whereas stood at 27.1 per cent in 1990-91, the same was 33.6 per cent in 2000-2001. However, when compared with semi-urban and urban centres, the average percentage share of deposits to the total in rural centres was only 30.7, as against average percentage share of deposits to the total in semi-urban and urban centres taken together that stood at 69.2 during the period under observation . The average percentage share of rural deposits to the total was thus far below the combined average of semi-urban and urban centres during the post-economic reform period. This calls for greater attention to be paid by commercial banks for mobilising further deposits from rural centres through appropriate rural oriented deposit mobilisation schemes and encouragement by way of suitable incentives to rural clientele, in view of the rising income among the rural clientele due to massive public investment undertaken in rural areas during the post-reform period.

The low average percentage share of rural deposits to the total was due to the fact that there was heavy concentration of rural population below the poverty line in the rural centres. Available data reveal that in Orissa percentage share of rural population living below the poverty line was 49.4 in 1993-94. Within the BPL families, there was a sizeable section of poor families, designated as very very poor and destitute who lacked saving capacity. It is for this reason that rural centres have exhibited low average share of deposits to the total compared to urban centres. The urban-rural income inequality is becoming wider, particularly in the post- reform period (Rath: 2000).

Bank group wise distribution of deposits reveals that the public sector banks like SBI and its group and Nationalised Banks had the privilege of mobilising bulk of the deposits from Orissa compared to other banks. It is seen that the average share of deposits to the total by SBI and its group was 38.0 percent between 1990-91. and 2000-01. During the said period the average share of deposits to the total by Nationalised banks was 51.0 percent. It is noticed that these two groups of public sector banks alone on an average had

accounted for 90.0 percent of the total deposits per annum during the period under observation.

Credit Deployment: Some Indications

Deposit once mobilised, if not utilised timely becomes an idle asset for the banks and no commercial banks will have the luxury of keeping idle deposits for long. The loans and advances of banks have, certain characteristics, which need explanation. The loan and advances by commercial banks during the post economic period exhibit phenomenal expansion in Orissa.

- It is seen that the amount of bank credit, which stood Rs 2093, Crores in 1990-91 increased to Rs 6065 Crores in 2000-2001, an increase of 2.9 times over the period. The average annual growth rate of credit during the period was 10.4 percent. Percapita bank credit whereas stood at Rs 698 in 1990-91, increased to Rs.1706 in 2000-2001. The average percapita credit during the period was Rs. 1125 which is much lower than the average percapita deposit (Rs.2163) mobilised during the period (Table-2).
- Sectoral distribution of credit shows that banks had supplied more credit in favour of industries compared to other sectors in the post economic reform period. The average percentage share of industrial advance to the total was 32.1 between 1990-1991 and 2000-2001. Average percentage share of agricultural advance to the total during this period was 19.6. Trade sector on an average accounted for 16.1 per cent of the total advance during post economic reform period. Sector-wise, the commercial banks had thus concentrated more of their advances in industrial sector followed by agriculture and trade. This schematic pattern of bank finance was also there during the pre-reform period. However looking at the individual sectors, it is pertinent to observe that almost all the important sectors of the economy had experienced a declining percentage share of bank advance to the total in 2000-2001 compared to 1990-91 except personal loans and professional services. The only sector where commercial banks had deployed increased amount of advance was personal and professional service sectors. In 1990-91 these sectors accounted for 12.2 per cent of total advances but in 2000-01 they accounted for 28.0 per cent of the total advances. Between 1990-91 and 2000-01 average percentage share of bank advance to the total was 18.0 percent for personal and professional service sector. There has taken place a shift of preference for providing loans towards personal and professional loans during post economic reform period, a phenomenon of increased 'consumerism' backed by the support of banks.
- Due to economic liberalisation and globalisation of economy, now many companies have started producing commodities, which were once

produced by indigenous manufactures. The increased consumerism and demand for new products like computer software, automobiles and electronic gadgets have resulted in greater reliance for bank loans by customers. The top 3 per cent of the urban households possibly accounted for more than 20 per cent of the total urban income. There is reason to presume that the percentage has risen since then. This is the rich in India on which the new consumer goods industry is putting all its hopes (Jalan: 2000).

- Between 1990-91 and 1998-99 the percentage variation in bank advance whereas stood at 128.7 that of borrowal account showed a negative decline of -30.2. Furthermore, average amount of credit per account which stood at Rs. 64.0 lakhs in 1990-91, increased to Rs. 210.0 lakhs in 1998-99. The borrowers now constitute a highly professionalised class and richer sections of the community. The poor and lower middle class persons who once depended on banks for loans are now finding it difficult to deal with the banks.
- Population group wise distribution of credit by commercial banks reveals that in post economic reform period, the average share of rural sector in the total bank credit was 35.3 percent per annum. As against the rural centres of Orissa still remained at credit deployed by banks in semi-urban and urban centres of Orissa still remained at a very high level i.e., 64.6 percent of total credit per annum during the period under observation. Poor repayment of bank loans by rural customers and higher transaction cost of handling rural loans mainly compelled banks to concentrate on semi-urban and urban centres. It is seen that during the post economic reform period the average share bank credit to the total was higher in semi urban and urban centres combined together than in rural sector.
- Bank group-wise distribution of credit reveals that it was the SBI and its subsidiaries and Nationalised banks on an average which accounted for 87.5 percent of total bank credit in Orissa. It is observed that compared to the public sector banks, private sector banks and Regional Rural Banks had lagged considerably behind in the deployment of credit. They accounted on an average 0.3 per cent and 11.0 per cent of total advances per annum respectively between 1990-91 and 2000-01.
- Banks, under the direction of the central government, are required to deploy fund in favour of the designated priority sectors. In 1969 commercial banks deployed only 11.2 per cent of aggregate credit in favour of the designated priority sectors. The percentage share of priority to 57.1 per cent in 2000-01. This is in contrast to the share of priority sector to the total at the all-India level which stood at 43.7 per

cent in the year 2002-2001. Furthermore, out of the priority sector advance in Orissa the banks had channelised 70.0 per cent of credit in favour of IRDP beneficiaries alone. Within IRDP, bulk of the credit had gone in favour of SC/ST beneficiaries. This accounted for 63.0 per cent of total IRDP credit out of priority sector advance deployed in Orissa. This Directed Credit Programme has certain qualifications. First, the loans were given to priority sector borrowers at low rate of interest of 9 to 10 percent. For weaker sections living below the poverty line, advances were given at a Differential Rate of Interest of 4 per cent annum but loan to these borrowers mostly remained unpaid adversely affecting the income generation by banks. Besides when most of the loans could not be recovered, the percentage share of NPA to total bank credit increased considerably. In Orissa it was as high as 32.0 percent of total bank advance in 1991-92 but declined to 22 per cent of total advance by banks in 1998-99. The higher proportion of NPAs in priority sector advance was attributed to the directed and pre approved nature of loans sanctioned under sponsored programmes, absence of any security, lack of effective follow-up due to larger number of accounts, legal recovery measures being considered not cost effective, vitiation of repayment culture consequent to loan waiver schemes, etc. (Siddiqi & Rao 1999).

Utilisation of loans: Credit-Deposit Ratio

The ultimate test of strength of financial institutions in general and commercial banks in particular depends on how effectively they have utilised the funds for the purpose of development of the economy. The accepted parameters gauging utilisation of loans by banks are; Credit-Deposit ratio and Investment-Deposit ratio. Though the parameters are themselves not full proof yet in the absence of any other acceptable parameters, they are considered to be the only alternatives (Rangarajan : 1982).

- The decline in Credit-Deposit ratio was found to be more sharp in the post economic reform period covering 1990-91 to 2000-01 (Table-3). In 1990-91 the Credit-Deposit ratio of commercial banks in Orissa stood at 76.5 per cent but this declined to 40.2 per cent in 2000-01, a decline by 36.3 percentage point over the period. This pertains to Credit-Deposit ratio as per sanction. Credit-Deposit ratio as per utilisation also showed the same declining trend. Credit-Deposit ratio as per utilisation was 72.3 per cent in 1990-91 but declined to 41.6 per cent in 2000-01, showing a percentage point decline of 30.7 over the period (Table - 3). The fall in Credit-Deposit ratio as per sanction and utilisation thus appeared to be more sharp in the post economic reform period. This is an example of the slackening effort on the part of the banks in

respect of utilisation of loans in spite of the wave of economic liberalisation and structural reforms passing through the state.

Bank group-wise distribution of Credit-Deposit ratio also exhibited a declining trend. In 1990-91, the Credit-Deposit ratio of nationalised banks was 67.7 percent but this decreased to 41.4 per cent in 2000-01. Over the year the decline was by 28.3 percentage point. The same is true in the case of State bank of India and its associates 'and Regional Rural Banks: The Credit-Deposit ratio of both these types of banks declined between 1990-91 and 2000-01. Even Other Scheduled banks', more particularly the private sector banks also manifested a declining Credit Deposit ratio in the above mentioned period.

Population group wise distribution of Credit-Deposit ratio further reveals the same declining trend. Between 1990-91 and 2000-01 Credit-Deposit ratio in rural centres declined by 40.9 percentage point. The same declining trend was also noticed in semi-urban and urban centres. The decline in these two centres was 29.1 and 31.2 percentage point respectively. There is therefore need for improving the Credit Deposit ratio further in rural centres.

District-wise Credit-Deposit ratio also reveals an uneven trend. The available data for 2001 show poor Credit-Deposit ratio in all old and new districts of Orissa except Baragarh district where it was 101.5 per cent. (Table - 4).

=+=Investment - Deposit Ratio

Commercial banks have also utilised a portion of their deposits as investment in state and quasi-government organisations under Directed Investment Programme (DIP). This takes the form of investing funds in bonds, equities and debentures of state government and quasi-government bodies.

Available data reveal that in 1990-91, the Investment-Deposit ratio was 34.8 per cent, which declined to 25.6 per cent in 2000-2001. The average Investment-Deposit ratio during the post economic period was 32.4 percent (Table-5).

The composition of investment reveals that commercial banks had deployed a major portion of their investment in buying state government securities. The data for the year 2000 and 200 I show that the banks had deployed more than 80 per cent of the total investment in holding state government securities. It is further revealing that bulk of the investment by banks was directed in meeting outstanding interest bearing State loans which stood at 65.9 per cent and 66.9 per cent respectively in 2000 and 2001.

Credit plus Investment - Deposit Ratio

An analysis of Credit plus Investment-Deposit ratio as per sanction and as per utilisation covering the period 1990-91 to 2000-01 reveals that banks capacity for utilisation of fund has shown a declining trend. It is observed that

Credit plus Investment-Deposit ratio as per sanction and as per utilisation was as high as 104.0 and 107.2 per cent respectively in the year 1990-91. This high proportion of Credit plus Investment-Deposit ratio was an indication of the fact that banks had deployed more of resources than what they mobilised as deposits. According to banking circle, the additional amount of credit deployed in Orissa was siphoned off from other states for purpose of use in Orissa.

During the economic reform period the Credit plus Investment-Deposit ratio showed a significant decline. In 2000-01 it stood at 65.8 and 67.2 per cent as per sanction and utilisation respectively. The average Credit plus Investment-Deposit ratio during the economic reform period as per sanction and utilisation was 67.0 percent and 74.9 percent respectively. (Table - 6) It shows clearly that Commercial banks had been left with some surplus funds, which for lack of suitable avenues of investment in Orissa had been siphoned off to other states for purpose of use. It is quite possible that credit granted in a particular state, may migrate to some other state for being utilised there (Rangarajan 1982). This shift had taken place through trade and commercial channels as most of the trading and commercial houses are operating in Orissa through the branches of head offices located in far-flung states. It is through these branches that credit raised by banks in Orissa had been siphoned off to other states for purpose of utilisation there. It is a common belief among the outside banks operating in Orissa that there are no 'Takers' of bank credit in the state. For them entrepreneurship in the state is at nascent stage. With the advent of it sector and its use by the banking organisations, the head offices of commercial banks quickly know from daily and weekly returns furnished by the concerned Zonal and Regional offices about the surplus funds available in a region. By all intent and purpose, Orissa is considered as a 'soft state' having less prospect for the use of funds. Since 'Takers' are readily available in other states, the surplus funds of Orissa get channelised to other states for purpose of use. The decision is mainly undertaken at the head offices and put into practice by managers acting as the agent of head offices for smooth operation of the flow of funds.

Of late, the Reserve Bank of India, on account of public criticism about the utilisation of fund by Commercial banks has furnished state-wise data relating to credit sanctioned in a state but, utilised in other states. Similarly the bank has also prepared data relating to credit sanctioned in other states but utilised in the recipient state.

The Reserve bank of India for the first time officially acknowledged that there is outflow of funds from Orissa to the extent of 16.0 crores in 1996 and Rs 16.6 Crores in 2001. The data further reveal that there is inflow of funds from outside the state to the extent of Rs 140.5 Crores in 1996 and Rs 213.6 Crores in 2001. The inflow of funds however, explains certain vital features. First, all the bank credit flowed into the state from the other states were not utilised for the

development of the real sectors of the economy. In other words, these funds were rarely used for the development of agriculture, industries, and other productive sectors of the economy. Secondly, most of the funds were utilised for meeting establishment and other overhead expenses of the satellite offices installed by outside organisations. Thirdly, these funds also formed a part of trade expenses by the outsider manufacturers. Finally, whatever funds have come to Orissa by way of investment was much less than the amount that had gone to the other states like; Haryana, Andhra Pradesh, Madhya Pradesh Gujarat and Uttar Pradesh etc. (Table - 7) These are the states where amount sanctioned for utilisation in other states was less, but they utili sed more credit being siphoned off from other states. This is the characteristic of unequal development. The share of the credit coming for utilisation from outside to Orissa forms only an insignificant proportion (0.02 percent) of total credit utilised at the national level. On the other hand, Gujurat and Uttar Pradesh claimed a high proportion (0.6 percent) out of the total credit utilised at the all-India level. It is seen that bulk of the credit is utilised in southern and central regions, although the amount was sanctioned in eastern and Northeastern Regions where banking development is not so pronounced. The utilisation of credit in eastern region including Orissa state is much lower. Credit sanctioned in eastern region but utilised else where in 2001 was Rs. 1769 crores as against credit utilised in eastern region being sanctioned in other regions like south region and western region was only Rs. 1631 crores. As a result of this, the development of the state's economy was affected to a large extent. Liberalisation of financial sector promotes financial deepening by encouraging savings in financial assets, which leads to an improvement in the efficacy by financial intermediation and an increase in the volume of credit flow in the economy (Rangarajan: 1998). However, this has not taken place in Orissa economy.

Promoting Investment climate: The immediate task

The policy prescriptions that follow from the foregoing observation regarding poor investment of funds in Orissa are discussed below.

1. The state has to increase the growth rate of the economy by 6 per cent or more. In order to achieve this, the state needs high dose of investment, both public and private with greater emphasis on the latter, Private Sector investment depends primarily on factors like; skilled labour force with a good work culture, good infrastructure especially power, transport and communications and good administration. In Orissa these factors are not mostly available. As a result the overall investment cli ate in the state remained discouraging for investors. Hence improvement in above spheres is of urgent importance in the state.

2. Infrastructure is a key factor for development. Industrial growth of a state depends on the availability of rail and road transport, electricity and telecommunication etc. Similarly agricultural growth depends upon rural infrastructure such as the spread and quality of irrigation, land development, supply of inputs like fertilizer, pesticides, credit etc. rural electrification and spread 'of rural roads. 'Good infrastructure not only increases the productivity of existing resources going into production and therefore helps growth, it also helps to attract more investment which can be expected to increase growth further' (Ahuluwalia: 2000). Private sector is shy of undertaking investment in infrastructure in the state; Hence the onus of responsibility must rest on public sector, to undertake investment for capacity building of the economy through infrastructural development. 'The proposal here is to make public sector investment project specific, time bound and cost effective' (Misra: 1997).

3. There is dichotomy in the growth pattern as observed in coastal areas and inland districts of the state. Whatever investment in infrastructure has taken place, a major share of such investment has been pocketed by coastal areas like; Puri, Cuttack, Balasore and Ganjam. The inland districts like; Koraput, Kalahandi, Phulbani and Bolangir etc. have lagged behind the coastal areas in infrastructural spread. The prevailing backwardness of KBK districts is due to lack of this facility. It is suggested that central public sector investment needs be undertaken in hinterland districts in order to attract private sector investment in these areas. Besides, there are some critical areas where the State government alone is competent to undertake investment. These critical areas include; education, health, power generation and supply, rural electrification, irrigation and water-management system, State highways and rural roads etc. Once these infrastructural provisions are created in the inland district by the State government, there will be large scale inflow of private entrepreneurs to start and promote industries in those regions.

4. There is no such direct correlation between growth of literacy and economic development of a region. But it is observed that states where literacy growth rate is maximum there, the degree of development is higher. Backwardness of poor States arises on account of the lack of this growth index. The literacy growth rate of Orissa was 34.2 per cent in] 98], which increased to 63.6 per cent in 100 l. This indicates that there are yet 37.0 per cent of population in Orissa who are i II iterates. Compared to the all-India average of 65.4 per cent, the literacy rate of Orissa appears to be low. Education is necessary for the efficient use of available resources. The spread of education as shown by literacy

rate is again more visible in coastal areas than in hinterland where there is concentration of more Scheduled Caste and Scheduled Tribe population. It is therefore, suggested that the State government need to take measures for the growth of literacy in the State through spread of primary and middle schools with emphasis of opening more of such schools in inland districts where the spread of education is still at a lower level. Apart form establishing schools, more attention need be paid for improving enrolment, attendance and retention of children in schools by reducing dropout which is around 47.0 per cent at the primary level in Orissa. For attracting students to primary and middle schools, the state government can draw some lessons from the experiences of Tamil Nadu. In Tamil Nadu, the enrolment of students in primary and middle schools is high on account of the 'Education Package' in the form of free books, free boarding and lodging and free meals supplied by the government to the school going children. In Orissa, the education package also exists but it is not strictly adhered and implemented properly. Besides, budgetary allocation for primary and middle school education in Orissa lags behind Tamil Nadu. This and other problems standing on the way of primary and middle school education need be removed in Orissa with a view to improve the rate of literacy in the state in general and hinterland districts in particular (Misra & Behera: 2000)

5. Skill formation and development of work culture amongst the work-force require utmost attention. In the absence of data it is difficult to find out the ratio of skilled and unskilled workers to total work force in the state. By any guess estimate one can come to the conclusion that the percentage share of unskilled workers is more than skilled workers. In agriculture nearly 70 per cent of the workers depend for their livelihood and employment and a majority of those who are working in agriculture are found to be unskilled as the art of cultivation has remained unchanged or marginally changed over a long period of time. Moreover, those workers who work in organised sector, their work culture is highly discouraging. More time is wasted by them in strikes, lockouts and cease work than contributing to the productivity of the firms. Thus larger concentration of unskilled workers and frustrating 'work culture' prevailing amongst the skilled and unskilled workers mainly discourage private investors to undertake investment in the economy. Dearth of proper and competent entrepreneurs is some of the factors responsible for low investment climate in the state.

6. For investment to take place, the *most* important requirement is good governance and administration. The State needs improvement in these areas. The bureaucracy is not committed. The officials in charge of the implementation of governmental programmes are indifferent, less

committed and slow in delivering the programmes to ultimate beneficiaries. There is also an element of political interference. Each political leader competes with the other for adopting a programme in his own locality. On account of this certain districts get the benefit of having a number of programmes while the other districts have very limited schemes. The discrepancy between coastal and hinterland areas mainly arises on account of this. Because of the apathy and interference on the part of the bureaucrats and politicians, the funds received from the Centre for the implementation of beneficiary oriented programmes are not utilised fully. They are often returned back to the centre. Even funds allotted to parliament and legislative members are not utilised fully in the State. These are some of the problems affecting private investment in the State. Time has come to realise that the economy is moving away from a controlled economy to a market oriented economy. The administration need to exhibit utmost transparency by abolishing controls, regulations, licences and checks and balances. The rules and regulations need be crystal clear with a motive to clear the project proposals at a single point as is witnessed in Rajasthan and Haryana:

7. Once the measures envisaged towards improving the overall investment climate in the state are pursued, there will be large scale growth of private enterprises both in industrial and farm sectors. Banks in such a situation need to adopt more definitive and purpose oriented policy guiding the entrepreneurs in investing the funds. Once a chain of entrepreneurial activities takes place in the state, the scope of resource use will be larger preventing its outflow. Banks are required to reduce their priority sector lending in a phased manner. It is however, not suggested for the complete elimination of priority sector lending as it has some usefulness in the state. But the priority sector lending be more qualitative with the intention of helping the real poor in the state. The redefined priority sector as suggested by Narasimham Committee needs be given a fair trial. Besides, more attention be paid for empowering the poor through Self-Help Groups under the scheme of Micro-finance, the success of which has been witnessed in several parts of the State.

8. There is also the need for reducing State government's dependence on banks for loans. In order to raise resources, the state government has to depend upon the market. This will make the government accountable to the individuals who would be shareholder of the banks. The individuals will have the opportunity to keep a close watch on the government regarding the investment made by them

9. The administered rate of interest as given to borrowers be withdrawn in a phased manner. Concessions in the form of lower rate of interest

has discouraged capacity building of the borrowers. This' is also true when the loan is subsidised. Time has come to teach the borrowers to live and conduct their activities with market based system. Borrowers need be encouraged to borrow at a market related rate of interest for the promotion of their activities. This would encourage their accountability and efficiency in the use of funds. Same logic holds true when subsidised loans come to an end.

10. Private sector banks by all India financial institutions have come up in the state. This has certainly helped to improve the qualitative performance of public sector banks. Banks which were shy of improving their functioning style are now found to be computerising their entire operation and adopting new methods for attracting the customers. But these private sector banks, in the absence of any definite policy, have concentrated only on deposit mobilisation. The Credit-Deposit ratio of some of these banks in the year 2003 is palpably low. As for instance the C-D ratio of Centurian bank is 44.8 and that of ICICI Bank is 2.09, similarly the C-D ratio of IDBI Bank is 3.31, Karnataka Bank is 26.67, Vyasa bank is 15.09 and UTI bank is 3.56. Even the major players in the group of nationalised banks like UCO Bank has CA- CD ratio of 36.6 percent, United Bank of India 31.5 percent, Andhra bank 33.1 per cent Canara Bank 44.7 percent Central Bank of India 46.5 percent and Corporation' Bank 35.7 percent.

All these clearly suggest the need for having a bank of our OWN. The Bank will not only have the unique privilege of garnering the deposits from the state but also will help to tap the deposits from other regions through branch net work. Besides the Bank will contribute substantially for the development of the economy with the active participation of the government and the people. The customers will have a sense of belongingness while dealing with the bank of their own.

CONCLUSION

The foregoing analysis reveals that the utilisation of funds by banks by all intent and purpose is low in the state. This is particularly visible in the state against the background of financial and banking sector reforms. The way' out of this dilemma lies in undertaking massive investment in the economy. Financial and Banking Sector reforms need not be viewed as an antithesis of government role in development. The final objective of a successful development strategy remains what it has always been a sustained and rising income for all the people and removal of poverty, deprivation and illiteracy within a reasonable period of time. Government, both central and state will continue to have an important and crucial role in creating the necessary conditions for growth through investment in areas, such as education, health,

infrastructure, power generation, irrigation, and water management. Successful financial reforms must result in strengthening the ability of the government by creating right and appropriate atmosphere for generating higher growth, larger quantum of resources and higher productivity. *In a backward state like Orissa*, the main challenge is to raise the level of potential output, in stead of just maintaining the output potential, by removing the bottlenecks existing in the' economy at the earliest opportunity (Jalan:2000). The government and financial institutions comprising the banks need to be complementary and supportive rather than competitive in realising the developmental goals as observed above.

Acknowledgments:

I express my deep and sincere gratitude to Professor Bidyadhar Misra, former vice-chancellor of Utkal University and my revered teacher for inducting me to the area of Institutional finance for research and guiding me over the years in the art of Commercial banking in the context of economic development of Orissa.

I also owe my sincere gratitude to Professor Baidyanath Misra, former vice-chancellor of OUAT, former Chairman cum Director, NKC Centre for Development Studies and my esteemed teacher for taking all the pains in correcting the draft and offering valuable suggestions for its improvement.

I sincerely thank to all my Ph. D. Scholars, Dr. P. C. Dhal, Dr (Mrs.) S. R. Mohanty, Dr B. K. Sahu, Dr B. N. Barik, Dr S. K. Hati, Dr Amiya Ch. Panda, Dr (Mrs.) S. Patnaik, Dr (Mrs.) S. R. Sahoo who have substantially contributed in upgrading my knowledge on the theory and practice of banking through their research output.

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TABLE-1

Deposit mobilisation by Scheduled Commercial Banks in Orissa during Post-Reform

Periods : 1990-91-2000-01

Year	Amount of Deposits (in Crores)	Percentage increase or decrease over the previous year	Percapita Deposit* (in Rs.)
1990-91	2735	--	912
1991-92	3161	15.6	1054
1992-93	3608	14.1	1203
1993-94	4144	14.6	1380
1994-95	5275	27.4	1758
1995-96	6056	14.8	2019
1996-97	7296	20.5	2432
1997-98	8709	19.4	2903
1998-99	10,359	18.9	2453
1999-2000	12,744	23.0	3576
2000-2001	15,072	18.2	4106
Average Annual growth rate		17.0	2163

Source : RBI, Banking Statistics, Basic Statistical Returns (1991-2001), Mumbai, relevant issues

** Percapita deposit is calculated on the basis of 1991 population data*

TABLE-2

Deployment of Credit Scheduled Commercial Banks in the Post Economic reform period : 1990-91-2000-01

Year	Amount of Credit (in Crores)	Percentage increase or decrease over the previous year	Percapita credit (in Rs.)
1990-91	2093	--	698
1991-92	2180	4.1	727
1992-93	2417	10.9	806
1993-94	2490	3	830
1994-95	2876	15.5	959
1995-96	3387	–17.8	1129
1996-97	3350	1.2	1117
1997-98	4144	23.7	1380
1998-99	4487	8.3	1496
1999-00	5293	18	1530
2000-01	6065	14.6	1706
Average Annual Growth rate		10.4	1125

Source : RBI, Banking Statistics, Basic Statistical Returns, Mumbai (1990-91 to 2000-01), relevant issues.

TABLE-3

Credit-Deposit Ratio by Commercial Banks in Orissa during Post-Reform period : 1991-2001

	Credit Deposit Ratio	(In percent)
Year	As per Sanction	As per utilisation
1991	76.5	72.3
1992	69	71.1
1993	67	69.5
1994	60.1	62.1
1995	54.5	55.9
1996	55.9	56.6
1997	45.9	53.1
1998	47.6	49.4
1999	43.3	44.2
2000	41.5	42.8

2001	40.2	41.6
Average C-D Ratio	54.7	56.2

Source : R.B.I., Banking Statistics, Basic Statistical Returns (1991-2001), relevant issues.

TABLE - 5

Investment- Deposit Ratio of Commercial Banks in Orissa during Post-Reform Period : 1990-91 to 2000-01

Year	Ratio of Investment to Deposit (in percent)
1990-91	34.8
1991-92	38.7
1992-93	36.3
1993-94	35.3
1994-95	35.9
1995-96	33.8
1996-97	31.3
1997-98	30.1
1998-99	28.6
1999-00	26.3
2000-01	25.6
Average (I-D Ration)	32.4

Source : RBI, Statistical Tables Relating to Banks in India (1990-91 to 2000-01), relevant issues

TABLE - 4

Distribution of Credit-Deposit ratio in Old and New Districts of Orissa : 2001

(In Crore)

Districts	Deposits	Advances	C-D Ratio
1. Anugul	499	148	29.7
2. Bolangir	229	88	38.4
3. Baleswar	580	341	58.8
4. Baragarh	197	200	101.5
5. Bhadrak	292	101	34.6
6. Boudh	52	27	51.9
7. Cuttack	1543	454	35.3

8. Deogarh	45	12	26.7
9. Dhenkanal	358	153	42.7
10. Gajpati	104	36	34.6
11. Ganjam	1429	413	28.9
12. Jagatsinghpur	889	145	16.3
13. Jajpur	461	152	33.0
14. Jharsuguda	251	73	29.0
15. Kendarpara	358	83	23.1
16. Khurda	3289	1664	50.6
17. Kalahandi	205	124	60.5
18. Keonjhar	423	177	41.8
19. Koraput	317	154	48.6
20. Mayurbhanj	580	223	38.4
21. Malkangiri	57	25	43.8
22. Nawapara	77	33	42.9
23. Nayagarh	164	75	45.7
24. Nawarangapur	76	59	77.6
25. Phulbani	102	42	41.2
26. Puri	561	220	39.2
27. Raygada	187	72	38.5
28. Sambalpur	542	207	38.2
29. Sonepur	70	30	42.9
30. Sundargarh	1140	441	38.7
Orissa	15072	6066	40.2

Source : R.B.I, Banking statistics, Basic Statistical Returns (2001), Mumbai.

TABLE -6

Credit Plus Investment-Deposit Ratio of Commercial Banks in Orissa during Post-Reform period-1990-91 and 2000-01

(in per cent)

Year	As per sanction	As per utilisation
1990-91	104	107.2
1991-92	69.0	71.0
1992-93	67.0	69.5

1993-94	60.0	62.1
1994-95	54.5	55.9
1995-96	89.3	91.4
1996-97	76.7	78.8
1997-98	77.8	79.7
1998-99	72.3	71.4
1999-00	67.8	69.1
2000-01	65.8	67.2
Average	**67**	**74.9**

Source : R.B.I., Banking Statistics, Basic Statistical Returns (1989-99 and 1996-97), relevant issues.

TABLE - 7

Classification of Outstanding Credit of Scheduled Commercial Banks according to place of Sanction and Utilisation : March - 1996 and 2001

Selected states	Credit Sanctioned in the state but utilised in the other states		Credit utilised in the state but sanctioned in the other states	
	1996	2001	1996	2001
Orissa	16.0	16.6	140.5	213.6
Bihar	55.5	214	232.5	218.8
M.P	48.0	88.1	739.7	1505.6
A.P	130.6	681.3	518.9	902.4
Karnataka	179.8	972.7	418.5	1459.8
Gujrat	199.3	309.7	1206.1	3090.8
Haryana	219.4	125.0	1049.3	2717.7
Punjab	115.3	228.0	577.6	761.5
U.P	919.4	125.0	1402.4	3197.2

Source : R.B.I., Banking Statistics, Basic Statistical Returns (1996-99), relevant issues.

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MANGARAJ MEMORIAL LECTURE

Industrialisation Of Orissa With Special Reference To Steel Industry

Sri Braja Kishore Tripathy
Union Steel Minister

Prof. S.N. Mishra, President, Orissa Economic Association.

Prof. B.N. Mishra, Distinguished Economist,

Other Esteemed Delegates, Friends from the Media, Ladies and Gentlemen !

I deem it a great privilege to have been invited lo inaugurate this Seminar. The topic" Industrialisation of Orissa with special reference to Steel Industry" is quite relevant today.

Industrialization is a phenomena which started from what is termed by Arnold Toynbee the "Industrial Revolution" in late 18th Century in England. By Industrialisation we mean change in methods of production from hand driven tools to power driven machines producing huge quantities of standardized products. With industrialization comes fundamental changes in the social organisation; there is a shift from rural-agricultural system to urban-industrial system. The most attractive feature of industrialization is high rate of growth of economy resulting in higher per capita income for the people.

Before independence there was no systematic effort at industrialization because the policy of the British was to convert India into a huge market for selling the products of British Industry and use India only as a source of basic raw-materials. No wonder, therefore, that at the time of independence India inherited a very weak economy with no industrial base worth the name. It was the Industrial Policy Resolution of 1948 which set the tone for industrialization in the country. Then came the 2nd Five Year Plan which carried forward the mission by laying emphasis on core industries.

INDUSTRIALIZATION IN ORISSA

According to Annual Survey of Industries: (Factory Sector) 1997 -98, Orissa continues to be one of the least industrialized states with only 20/0 share in the national industrial output, employment and manufacturing value addition. Inspite of 4% of the national population, the state has failed to create a, sustainable industrial base. The state's per capita value addition in manufacturing is the lowest among the major states.

Statistics reveal that about two-thirds of total industrial employment and three fourths of industrial value addition in Orissa come from only four major industry groups namely, Electricity, Basic Metal and Alloys, Nonmetallic minerals and Food Products. States Industrial structure mainly hinges on natural resource based mineral and metal industries. Manufacturing sector such as engineering goods is almost insignificant. Certain inbuilt structural constraints coupled with faulty planning in the past have thwarted the chances of diversification of industrial base in Orissa.

It should have been realised by the planners and policy makers in the past that agriculture constituted about 60% of the Net SDP of the state engaging about three-fourths of the total work force directly or indirectly. Thus agriculture was the most important sector which held the key to increasing the per capita income leading to increased purchasing power of the people. In turn it would have set off a chain reaction in spurring demand for consumer durables and nondurables and ultimately to industrialization. In India the developed states like Punjab and Haryana and recently Andhra Pradesh have high percapita income owing to developed agriculture. It *is* this success in Green Revolution which has accelerated industrialization in those states. But in Orissa unfortunately we are caught in the dilemma of whether Agriculture or Industry. The result is that neither agriculture nor industry has grown in the state. It is time we take agriculture route to industrialization.

Lack of proper infrastructure has been another major hindrance in the way of Industrialization in the state. Since independence the state has suffered gross neglect at the hands of the Centre in building adequate railway network, highways, ports and importantly the power sector which are key to industrialization of any region. This in itself further weakened the financial condition of the state to even avail of Central Plan Assistance which are always required matching share by the state. Thus, the state was crippled in a vicious circle of underdevelopment.

Starting with Industrial Policy of 1968 the state had adopted several Industrial Policy Resolutions to trigger up industrialization in the state; but to no avail. For example the slogan of 1980's Industrial Policy "one thousand industries in one thousand days with an investment of one thousand crore of rupees" remained a mere populist slogan. In 1986 the same was reiterated in a new garb. In effect all these policies failed to address the basic problems of the economy.

The Steel Industry

Orissa is endowed with varieties of mineral resources such as Chromite, Nickel, Bauxite, Iron-ore, Limestone, Dolomite and Coal. According to Orissa Economic Survey 2001-02 Orissa has a total Iron-ore reserve of 3567 Million Tonnes which constitutes 27.99% of the total national reserves. Besides abundant availability of other raw materials like Dolomite, Limestone and Coal makes Orissa an ideal place for Iron and Steel Industries.

World over Iron and Steel Industries are located either near the sources of raw materials or near coast lines with easy access to ports. While Mon Valley in the USA and Ruhr Valley in Germany are examples of the former, Japan and South Korea are examples of the latter. But Orissa is probably the only place in the world which has both the advantages. It has abundant reserves of iron ore, and other steel making minerals like limestone, Dolomite, Nickel, Manganese and Chrome. At the same time it has 480 kms of coast line with all weather ports like Paradeep and a new ones coming up at Dhamra and Gopalpur. All this makes Orissa an ideal place for steel industry.

Although there are many routes to iron making like Blast Furnace-BOF, Scrap-Electric Arc Furnace, DRI, Corex and Romelt etc., in India the most favoured practice is use of iron ore as the basic raw material. This is mainly due to abundance of Iron-ore. With over 30% of the red hematite deposits of the country being in Orissa it makes for the best choice.

Historically, Orissa has had a long tradition of steel making. The iron beams used in Konark and Jagannath Temples stand testimony to this fact. However the first modern steel plant in Orissa came up in mid fifties when the Government of India set up an integrated steel plant at Rourkela. The first steel plant in Asia to implement the LD process it has the unique distinction of having the best product mix and value added items such as electric steel sheets, electrolytic steel plates besides usual flat products. After modernization of RSP with a huge investment of Rs. 5015 Cr, the plant is slated to reach a capacity of 2.0 Million Tonnes of liquid steel per annum. Modernization of its 75,000 tonnes per annum capacity ERW pipe plant has been taken up recently with an investment of Rs. 89 crore. Besides investment of Rs. 115 crore for Coke Oven Battery and Rs.32 crore for Casting Electric Plant have also been approved and Rs.18 crore for Granulation plant, Rs.120 crore for 4th Blast Furnace and Rs.100 crore for CRM repair is on the anvil.

In the first ten months of 2003-2004 the plant has registered an all time high 1.47 million tonnes of hot, metal and crude steel of 1.32 Million Tonnes. Besides Rourkela, Kalinga Iron Works at Barbil was the second venture started by Late Biju Pattanaik which is operating under IDCO.

After liberalization of the economy in 1991 many private entrepreneurs have come up to set up steel plants in the country. Financial Institutions have invested about Rs. 30,000 crores in about 19 new steel plants out of which 9 plants have already started production. Neelachal Ispat at Duburi another dream project of Late Biju Pattanaik has also been commissioned. My ministry had played a catalytic role in persuading the Financial Institutions to organize critical investment for Neelachal Ispat to enable it to come to production stage. As you all know the plant has now started producing Pig Iron.

Kudremukh Iron Ore Company, an undertaking of my ministry is all set to establish a value-added iron ore processing and pelletization plant in Orissa. The company has already applied for mining lease and the State Govt. have

also identified a mine in Barsuan area of Sundergarh District. Once set up, the company will make a total investment of above Rs.700 crore in the project.

Similarly National Mineral Development Corporation, another undertaking of my Ministry is also tying up with the Govt. of Orissa for development of a mine with 10 Million Tonnes iron ore production capacity. There is an investment proposal for Rs. 10,000 crore which will also include investments for development of basic infrastructure like ports, railways and roads etc.

NMDC have also agreed to buy equity worth Rs. 49 crore in Konark Met Coke Limited, a subsidiary of Neelachal Ispat. This will facilitate investment of another Rs. 500 crore by various financial institutions in the KMC Ltd. Besides NMDC is also prospecting the coastal belts of Ganjam & Puri Districts for precious sands.

Steel Authority of India, Kudermukh Iron Ore Company and RINL, the three Public Sector Undertakings in my ministry have come together to develop the Chiria Iron Ore Mine of IISCO Burnpur. The iron ore produced from this mine will be exported through Gopalpur Port necessitating development of road and railway linkages between Western and Coastal Orissa.

With Orissa Government agreeing to provide a mine lease at Thakurani to Steel Authority of India, Rourkela Steel Plant will have assured supply of good quality iron ore. The project is slated to see an investment of about Rs. 400 crore by SAIL.

A global upswing in the steel industry world over driven by phenomenal Chinese demand has had its positive impact on Indian Steel Industry too. With our exports to China and other countries increasing substantially many private steel entrepreneurs have shown keen interest to set up new capacities in the state. There were at least 19 major parties who had submitted their proposals for setting up of steel plants including sponge iron plants in the state. Noteworthy among them are M/s. Bhusan Ltd., M/s. Aarti Steel Ltd., M/s. SMC Power Generation Ltd., M/s. Neepaz Metalics (P) Ltd., M/s. Jindal Steel & Power Ltd., M/s. Jindal Strips Ltd., M/s. Bhusan Steel Strips Ltd., etc. Four companies namely, M/s. Neepaz Metalics (P) Ltd., M/s. Aarti Steel, M/s. SCAN Industries (P) Ltd., and M/s. Deo Mines and Minerals have already signed MOUs with Orissa Government for a total investment proposal of Rs. 2416 crore.

Sponge iron is gradually gaining importance all over the world. India stands at the top in production of sponge Iron in the world. There is a mushrooming growth of sponge iron industries in the state of Orissa recently. These are basically low cost small and medium scale industries in addition to the major one's told earlier.

As it stands today, the future of Indian Steel Industry is very bright with Orissa enjoying the pride of place. I have particular satisfaction in mentioning that my ministry had set up Biju Pattanaik National Steel Institute at Puri to cater to the needs of steel industries in the country and especially in Orissa.

Union Cabinet have on 20th of this month accorded approval to this institute. I am sure this national steel institute will play a crucial role in ushering in a new era of industrialization in the state.

It is important that there is also a healthy growth of downstream and ancillary industries in the state producing more and more value added products. The State Government may inquire into the causes for failure of downstream industries in the state in general around Rourkela & Duburi in particular.

No doubt there exists a very heady and conducive climate for industrialization in the metals and mineral sector in Orissa. More and more entrepreneurs are eyeing towards Orissa for getting mining lease to set up their plants. But the State Government should be watchful of their sincerity and assess their investment plans before granting any mine lease. It may be appropriate to give a fresh look at the State's Mining Policy in consultation with the experts and economists to leverage the current conducive climate.

Time has come now to put our acts together for a brighter tomorrow. As somebody has rightly said Orissa is not poor but her inhabitants are. The state is endowed with the bounties of nature– fertile land, well spread rivers, dense forest, rich mines and large coastline. We only need to know how to make use of all these to make the state rich and prosperous. The future belongs to Orissa. Let us all join hands to fashion our own future.

Thank you.

Jai Hind

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Economic Reforms in India Since 1991:

Its Impact on the Indian Economy

Irrigation Sector Reforms in India : A Critical Review

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INTRODUCTION:

Irrigation is a critical and vital input required for agricultural production. Availability of irrigation water triggers the use of other yield stimulating inputs like high yielding varieties of seeds, chemical fertilizer, farmyard manure and also induces farmers to adopt advanced agricultural techniques and improved agronomic practices. Irrigation increases agricultural production and farm income by enhancing crop yield, diversifying the cropping pattern in favor of remunerative cash crops and increasing the cropping intensity (Bharadwaj; 1974, 1990; Dhawan; 1987, 1988). Therefore, in India for accelerating agricultural growth, from the very inception of planning and in subsequent five-year plans a major chunk of plan outlay has been meant for irrigation development (Vaidyanathan, 1999). Contribution of irrigation in ushering in green revolution and making India self-sufficient in food production is of course noteworthy and recognised. Nevertheless the overall performance of irrigation sector is viewed suboptimal, inefficient and inequitable and therefore not sustainable in the long-run. Estimated benefit-cost ratio of irrigation projects at the pre-sanction and project appraisal stage is rarely achieved after completion and operation of the project. The actual achieved yield from irrigation commands by and large remains far below the estimated/projected yield. As a result, irrigation projects have become economically unviable.

Moreover, poor financial performance of irrigation projects is a cause of concern for irrigation planners and policy makers. Water rates are highly subsidised and quite arbitrarily fixed without any economic rationale. Revenue receipts from sale of water hardly covers the Operation and Maintenance or recurrent expenses of irrigation projects (Svendsen and Gulati, 1995; Gulati et al, 1994; Swain, 1998). Because of resource crunch and paucity of finance government is not in a position to operate and maintain the existing irrigation structures properly. As a result, the conditions of canal networks and irrigation structures have deteriorated over time. On the other hand, farmers are reluctant to pay higher water charges unless there is improvement in quality of irrigation service. Thus, irrigation sector is confronted with a vicious circle and a deadlock

situation (Jairath, 2001; Swain; 2002). As an escape from this impasse and to make the vicious circle a virtuous one, during the last decade most of the state governments in India have undertaken profound institutional and financial reform measures in irrigation sector.

REFORM MEASURES

In India during the last two decades the following reform measures have been undertaken to improve the irrigation system's performance (Das, 2000).

1. Shift in strategy from expansion of irrigation network to consolidation and improving irrigation system efficiency and performance by renovation, rehabilitation and modernization of existing projects
2. More emphasis on socio-economic aspects of water management: equitable distribution, efficient utilisation in the field and sustainability of the irrigation system
3. Multi-disciplinary approach in water resources management
4. Interdepartmental linkage and coordination: agriculture, irrigation, rural development, revenue department, NGOs
5. Participatory Irrigation Management: Turning over O&M of tertiary canals, water distribution and water rate collection to Water Users' Associations or Pani Panchayats
6. Restructuring water tariff system: Economic pricing of water, revenue generation for financing O&M and financial autonomy to irrigation sector
7. Legal support and amendment of irrigation laws
8. Irrigation department restructuring for better objective management focus and farmer need satisfaction
9. Personnel management, training and human resource development
10. Irrigation management style and culture: Introduction of accountability and transparency of irrigation decision-making and developing computer-based management information system

In this paper we are concentrating on Participatory Irrigation Management (PIM) or Irrigation Management Transfer to farmers as implemented in India as a part of overall economic restructuring programme.

IRRIGATION MANAGEMENT TRANSFER TO FARMERS

A critical review of the path of irrigation development in India unfolds that irrigation has been considered mainly as a technical enterprise and major emphasis has been laid on hardware part of irrigation system i.e. creation of physical infrastructures like dams, barrages, reservoirs, canal networks without adequate attention to the software or the socio-economic and institutional aspects of irrigation management (Chambers, 1988: Coward, 1980). Due to high

costs of creating irrigation potential and little scope to recover the costs of irrigation from water users, in India major and medium irrigation projects have remained state owned, state funded and are bureaucratically managed in a hierarchical top-down approach. The role of the water user who is indeed the main protagonist in irrigation has not been pondered in their real dimensions and potential. New trends advocate much more active participation of the water user in irrigation water management. In a bureaucratically managed canal irrigation system it is extremely difficult on the part of irrigation technocrats to provide satisfactory irrigation service catering to the need of numerous marginal and small farmers having fragmented land holdings scattered over extensive irrigation commands. Due to rigid procedures followed in a bureaucratically managed system, the irrigation engineers are not in a position to take immediate decisions on the basis of observation of field conditions. Also, they lack knowledge and information on local resources and socio-economic conditions. Furthermore, having ample administrative power in fund management they fall prey to rent seeking behavior to usurp unearned income.

In the era of liberalization, privatization, delicensing and decontrol, which has started in India since 1991, its impact on irrigation sector is obvious. Now there is a worldwide consensus based on experience, experimentation and research studies that for long-term sustainability of irrigation infrastructure, crafting appropriate institutional arrangement is as important a job as is good engineering. It is now widely recognized that the farmers who are the end-users of irrigation water should participate in the planning, development and management of irrigation infrastructure (Wade, 1987; Ostrom et al. 1993, Meinzen-Dick et al. 1997, Balland and Platteau, 1996 ; Vaidyanathan, 1994 and others). Many countries all over the world are in fact broad basing their PIM programme. Pioneers in PIM are the Philippines, Mexico, China, Japan, Egypt, Turkey, Sri Lanka, Chile, Columbia, Morocco (Meinzen-Dick et al, 1997; Johnson et al., 2002).

In recent years, in India under the economic restructuring programme far-reaching reform measures have been undertaken in irrigation sector by bringing about profound institutional and organizational changes by implementing Participatory Irrigation Management (PIM) through formation of Water Users Association (WUA) or Pani Panchayats and transferring them the responsibilities of operation, maintenance of irrigation system, distribution of water among water users and collection of water rates. In the reform process of irrigation sector, PIM has been highly eulogized as a befitting strategy to bring about efficient utilization, equitable distribution and sustainable use of irrigation water (Brewer et al, 1999; Hooja et al., 2002). The concept of PIM is based on laudable ideologies like democratization, decentralization and debureaucratization. It is expected that this attempt to democratize and decentralize irrigation management and empowerment of water users will undoubtedly bring about improvement in irrigation service by substantially reducing transaction costs of getting accurate information, negotiation and

enforcement of contract cost (Baland and Platteau, 1996). The irrigation executives can devote their time for effective management of main canal system and other technical matters in which they have competence and comparative advantage.

There is a growing realization that the unnecessary bureaucratic control in management of irrigation system at tertiary levels should be reduced to improve irrigation efficiency and to check corruption and rent seeking behavior (Mitra,1996: Vaidyanathan, 1994, 1999). As the farmers have better knowledge of their eco-environment and field conditions, they can manage the irrigation system more efficiently and effectively, which is truly a common pool resource. Usually the farmers believe that the canals belong to the government and they are the beneficiaries of the system. They do not have any role and responsibility in upkeep of the physical structures. In the changed institutional context irrigation will be considered as a common pool resource and will be managed by the farmers community (Sengupta, 1991; Singh, 1994).

As a matter of fact, in agriculture cooperative efforts are necessary, as there are several externality effects. If farmers at head ranch use excess water, tail-enders face water scarcity; if there is pest attack in one's field, the neighboring field is affected. Therefore, a rational economic response is to internalize such externalities by making coalition or forming an association. As irrigation is a common pool resource characterized by non-excludability and rivalry in its consumption (Meinzen-Dick et al. 1997), rational action on the part of each water user in isolation will give rise to free rider problem and will result in Hardin's (1968) 'tragedy of the commons'. Therefore, there is a need for forming Water Users' Association for efficient, equitable and sustainable use of water.

Irrigation comes under state list of Indian constitution. In most of the sates of India.(Andhra Pradesh, Gujarat, Maharashtra, Madhya Pradesh and others) steps are now being taken in a mission mode to increase farmers' participation in irrigation management starting from planning, design, construction, operation, maintenance, rehabilitation, modernization, monitoring, evaluation, water distribution and water rate collection through formation of Water Users' Association (WUA). Successful implementation of PIM requires involvement, cooperation and commitment of various stakeholders like Department of Water Resources, Department of Revenue, Department of Agriculture, Non-Governmental Organizations and the beneficiary farmers and implementing NGOs.

In India the concept of PIM has evolved gradually through three distinct phases (Maloney and Raju; 1994:16). In 1980s the concept was in its nascent stage limiting to farmers' participation through their representatives. It was felt then that in the decision making process of irrigation development, the views of farmers should be taken into account and they should be consulted in planning, design, construction, operation and maintenance of the system. However, mere farmers' representation in scheme level committees could not

yield much result. In the latter part of 1980s, it was realized that farmers cannot have much stake in irrigation management without a formal structure/forum to express their views. Therefore, the catchword became farmers' organization.

In various states like Andhra Pradesh, Tamil Nadu and Maharashtra thousands of outlet associations/chak committees had been formed only in pen and paper but actually most of them became dysfunctional after a short period. By 1990s it became apparent that the concept of farmers' organization is not sufficient. Therefore, a radical concept of farmers' organization and system turnover has evolved in which it is envisaged to entrust the WUAs with the responsibility of operation and maintenance of minor/ distributary, allocation of water among farmers and collection of water charges from water users.

Of late, most of the state governments in India have taken policy decision and enacted/amended irrigation laws to implement Participatory Irrigation Management (PIM) and turning over the management of tertiary segment of the canals like minor/sub-minors/ distributaries to Water Users' Associations (Maloney and Raju, 1994; Jairath, 2001.; Hooja et al. 2002, Brewer et al, 1999). It is contemplated that WUAs will be entrusted with the responsibilities of operation and maintenance of the tertiary units, distribution of water among water users and collection of water rates. The irrigation agency will make bulk sale of water volumetrically to WUA at minor/sub-minor level and retailing of water to farmers will be the responsibility of WUA. Andhra Pradesh has legislated Farmers' Management of Irrigation Systems Act in 1997. Government of Orissa has enacted Orissa Pani Panchayat Act in 2002. Madhya Pradesh and Rajasthan have promulgated laws based on Andhra Pradesh model. In Uttar Pradesh and Maharashtra membership of WUA is mandatory for water users. In Andhra Pradesh and Orissa more than ten thousand Pani Panchayats have been formed. The target is to cover the entire irrigated command area under Pani Panchayat scheme within a couple of years.

National Water Policy of India adopted in 1987 clearly envisages that 'Farmers should be involved progressively in various aspects of management of irrigation system, particularly in water distribution and collection of water rates.' Recently, National Water Policy 2002 emphasizes that 'Management of water resources for diverse uses should incorporate a participatory approach by involving not only the various governmental agencies but also the users and other stake holders, in an effective and decisive manner, in various aspects of planning, design, development and management of the water resources schemes. —Water Users Associations and the local bodies such as municipalities and gram panchayats should particularly be involved in the operation, maintenance and management of water infrastructures/facilities at appropriate levels progressively, with a view to eventually transfer the management of such facilities to the user groups/local bodies.

BENEFITS OF PIM

Several benefits that will accrue to farmers and irrigation agency due to farmers' participation in irrigation management have been recognised by many authors (Singh, 1991; Maloney and Raju, 1994, Hooja et al., 2002), which are as follows:

Benefits to Farmers

Better water management at the tertiary level, Farmers' flexibility in use of water, choice of crops and land use, More crop production and more income, Optimal use of water in agriculture, Ensuring equity in water allocation, Helping resolve disputes on water distribution, Encouraging community responsibility for the management of assets, Forum for facilitating effective communication between farmers and government departments, Better collection of irrigation fees, More economic use of water, less wastage, Better maintenance - reduction in the cost of irrigation, Encouraging collective management of agricultural input supply and marketing of agricultural produce, Less waterlogging because of careful use of water, Less opportunity for corruption, Better mutual trust and understanding between farmers and officers

Benefits to Irrigation Agency

Improved relations with client farmers; less mistrust, Reduced complaints on inequitable distribution of water between head reach and tail end, Increase in irrigation efficiency, job satisfaction, More time to attend to technical matters and using their expertise, Less bothering about unauthorized outlets, obstructions and maintenance problems, Improvement of credibility of the irrigation agency and irrigation officers, Better collection of water rates and saving on maintenance cost

Thus, it seems PIM is a win-win strategy for both the farmers as well as the irrigation agency. Many negative impacts of PIM on different stake holders have also been pointed out by several authors (Groenfeldt and Sun, 2004). In many turned over projects second generation problems like insecure water rights, financial shortfalls, lack of financial and administrative experience of office bearers of WUAs and lack of downward accountability of irrigation officials to water users have cropped up.

CONDITIONS FOR SUCCESS OF PIM

Though several state governments in India have taken policy decision to encourage farmers' participation in irrigation management and attempts are under way to motivate farmers to form WUAs, the farmers' response in this regard is not up to the satisfaction. Many economists hold the view that the success of PIM crucially depends on several fundamental factors as mentioned below (Wade, 1987; Shah, 1995, 1996; Singh and Viswa Ballabh, 1996; Swain; 2002,2003):

(i) Felt needs, (ii) Common interest, (iii) Collective effort, (iv) Effective leadership, (v) Bureaucratic commitment of the agency involved, (vi) Political will of the party in power, (vii) Financial viability, (viii) Legal support

It is often argued that state sponsored programs meet with failure due to its top down approach to solve localized grass root problems. The local problems in natural resource management like water and land should be resolved through local initiatives and peoples' participation. In case of irrigation management the farmers should themselves feel the necessity of forming an organization or association to improve the situation. There should not be any imposition from above. The change should be spontaneous and demand driven based on bottom-up approach.

Moreover, the farming community should perceive that the WUA would serve their common interest. There should not be disproportionate distribution of benefits among farmer groups. It is not mere felt needs and common interest that will foster WUAs, more importantly majority of water users should strive collectively to set up WUAs. For motivating and organizing the farmers there should be effective leadership. Capable, efficient, honest, trustworthy farmers should be elected as office bearers of Pani Panchayats.

The irrigation bureaucrats should be committed to the cause of organizing farmers to form WUA and to decentralize and delegate power to them. The political party in power should provide all out support for implementing the program successfully. Furthermore, the WUA should be financially viable by raising its own resources from different sources. There should be necessary amendment of irrigation rules and acts to incorporate the role of WUAs in irrigation management. The WUAs need to have reliable sources of income; otherwise they can hardly be sustainable.

CONCLUSION

The approach for institutional restructuring of irrigation sector should be bottom-up, demand driven and flexible. However, it is observed that only restructuring the organisational set-up has not yielded desired results. The functional efficiency of the sector should improve. Capacity building, training, skill development, transparency, accountability, appropriate reward system should be introduced. The physical condition of the irrigation system should be improved and a fully operational project in good condition should be turned over to the farmers for its upkeep.

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Export-Growth Causality : An Empirical Investigation during Pre and Post Liberalization Period in India

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1. INTRODUCTION

The export-led growth hypothesis propounded by neoclassical economists suggests that exports make major contributions to economic growth. Studies carried out by several scholars which are based on cross country experiences have revealed that openness in trade promotes growth. Furthermore, it has been argued that exports assume a special significance in the LDCs owing to its multiplier effects on the economy in terms of generating employment, income and foreign exchange reserves. The theory of export-led growth evolved into a 'new conventional wisdom'. It had also shaped the development policies of the World Bank in some countries with objectives of enabling them to attain high economic growth and to develop their industrial potentials in the mid 1980s.

The export -led growth has been considered as the rational and efficient alternative to import substitution industrialization strategy. The outward orientated export-led growth is said to lead higher total factor productivity (TFP) growth through fostering greater horizontal specialization, by offering greater economies of scale due to the enlargement of the effective market size, by affording greater capacity utilization and also by increasing the rate of capital formation and technological changes. Further, the pressure of competition in the world market may lead to the better product quality and force domestic producers to reduce their inefficiencies. To add to it, foreign exchange liberalization that reduces the allocative inefficiencies in exchange control can provide boost to export-led growth.

Although the benefits of free trade and export promotion trade policy are well endorsed by mainstream economists and exports are seen as the engine of

economic growth, a bulk of empirical literature regarding the impacts of trade policies on economic performance has produced mixed results over the last few decades. While the empirical work of some authors had supported the export-led development hypothesis, otlier studies had contested these findings. In spite of the criticisms, the export-led growth strategy has been supported by many scholars not only empirically but by using different econometric models over the last couple of decades.

To start with, Jung and Marshall by using the Granger concept of causality had found that the thesis of export-led growth was established in four out of the thirty-seven countries. In a similar kind of study, Chow (1987), on the other hand, had adopted the Sims test to investigate the issue of causality between export growth and manufactured output growth. He found that there was a two-way causality in the case of Brazil, Hong Kong, Israel, Korea, Singapore and Taiwan, and one-way causality in case of Mexico; and no causality for Argentina.

Dodaro (1993) had investigated the issue of causality by employing Granger's approach to a larger set of countries and found very weak support for the contention that export growth promotes GDP growth. On the contrary, he developed the contention that GDP growth promotes export.

Bahman-Oskooe and Alse (1993) pointed out that there are three major shortcomings of the above time series studies. First, none of these studies have checked the co-integrating properties of time series variables involved (such as, GDP and Export). Standard Granger or Sims tests are only valid if the original time series are not co-integrated. If the time series are co-integrated, then inferences based on the traditional time series modeling techniques will be invalid.

The studies from India report mixed results pertaining to export led-growth thesis. The earlier studies on India had suggested insignificant causality in either direction. Jung and Marshall had reported that there was no casual relation between export and GDP, using traditional Granger causality test for the period 1960-1979. Similarly, Dorado had reported an insignificant F-statistics in both the cases but the sign of the second relationship was reported to be negative for the period 1967 -1986. These two studies had examined the pre liberalization time period and that too somewhat short periods. Therefore, there is a need to investigate causality by using data over longer period of time. But few recent works on the direction of causality in India do not agree with the 'no causality result' of the above studies. Mallik (1996), by using the annual data for the period 1950-92 and employing the Engel-Granger co-integration cum error-correction procedure had found that there was a strong co-integration between income and exports and the direction of causality runs from income growth to export growth (i.e., growth-led exports).

In another study, Dhawan and Biswal (1999) had investigated the direction of causality for the period 1961-93 in a multivariate framework by specifying

terms of trade as an additional variable. The causality from exports to GDP was found to be a short-run phenomenon. Thus, their results had supported a bidirectional causality. Similarly, Subasat (2002) had empirically tried to find out the link between export and economic growth by using cross country analysis. He had suggested that middle-income countries those are more export oriented generally grow faster than relatively less export-oriented economies. Interestingly, the study had noted that export promotion does not have any significant impact on economic growth for low and high-income countries.

2. OBJECTIVES OF THE STUDY

In tune with the export promotion growth policy and its related literature, the objective of the study has been set to investigate the causality between the export and economic growth by using Granger causality method and by using real exports and real GDP data. Thereby, the hypothesis of the present study is set as "higher export leads higher economic growth". The above-mentioned reviewed studies had not taken trade policy while determining the time period. The selected time period for the study is based on shift in the trade paradigm (i.e., from Import Substitution to Export Promotion). The bi-direction causality test has been arrived at between export and GDP for the period 1951-1985 (IS trade regime) and 1985-2003 (EP trade regime).

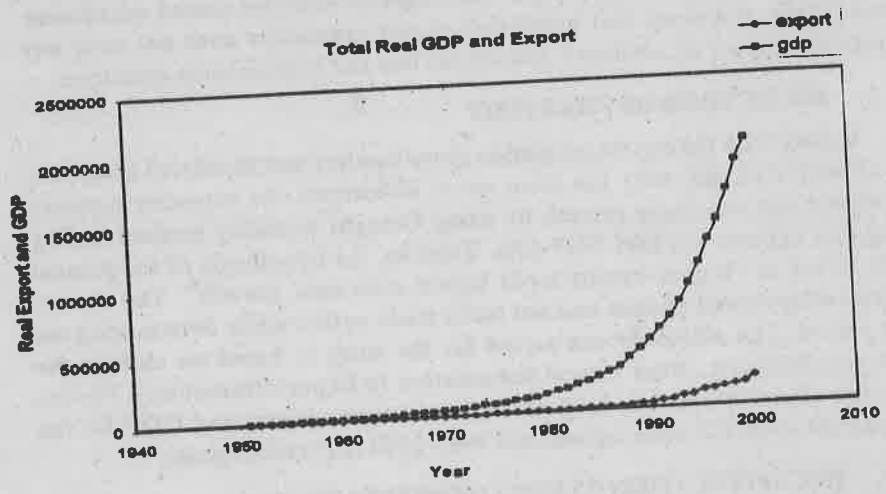
3. RECAPITULATION OF INDIAN FOREIGN TRADE

Broadly, the trade policy regime of India can be classified into different phases after taking into account the paradigm shift in the trade policy. There are four phases: import substitution phase (1950-1965), import substitution and export promotion phase (1966-1984), partial liberalization (1984-91), and post liberalization phase (1991 onwards). The inward looking policy regime of the 1950s was followed by the export subsidization regime of (1962-66), and the same was followed by an abortive attempt of liberalization (1966-1968). Between 1968-1975, there was a more restrictive trade regime. Though the next decade saw a selective relaxation of controls (1975-1985), a systematic approach towards liberalization was commenced during 1985-1991. Eventually there was a paradigm shift in our trade policy. With the adoption of a comprehensive structural adjustment policy (SAP) there was a more liberalized trade regime since July, 1991.

In 1984, with Mr. Rajiv Gandhi as Prime Minister, the Government of India adopted a partial liberalization policy. In 1985, the export promotion policy was announced with priority deviating from the inward looking policy of encouraging import substitution by the then government. Though the blueprint for complete liberalization of trade was prepared during his regime, it was fully implemented in 1991 in the name of Narasimaha Rao – Manmohan Singh policy of privatization of the Indian economy.

The impact of these policy changes on the growth of real GDP and export are shown in figure-1. The graph indicates that owing to import substitution

policy, the growth of real export was sluggish until 1985. However, the total export and gross domestic product have increased substantially in the period between 1985-2000. The trend shows that liberalization of trade policy regime promotes both GDP and export earnings.



Source: RBI Bulletins and CMIE

4. Empirical Analysis of Export and Growth

Recent studies on export-led growth hypothesis as reviewed in the introduction section have adopted the following growth equation for their empirical estimation.

$RY = bO + a\ I/Y + b2RL + b3RX$

Where R/Y = Growth rate of GNP,

I/Y = investment-income ratio, proxy for the growth of the capital stock,

RL = Growth rate of labour force

RX= Growth rate of exports,

a = is the marginal physical product of capital, and

b2 and b3 are output elasticities with respect to labour and exports

The above growth equation has been used in a number of cross country and time series analyses of trade policy and economic growth (e.g., Balassa, Williamson, Tyler, Feder, and Ram).

On the other hand, Yaghmaian had adopted somewhat different models. In order to investigate the export led growth hypothesis, he had adopted the following equations to estimate the results.

RY = aO+ alI/Y+a2RL (1.)

RY = aO+ alI/Y+a2RL+a3+RX (2)

RY = aO+alI/Y+a2RL+a3RYm x Ym/Y (3)

RY = aO+alI/Y+a2RYm x Ym/Y +RLm xLm/L (4)

RX = aO+a1 RYm x Ym/Y +a2RLm x Lm/L (5)

RX = aO+alI/Y+a2RYm xYm/Y +a3RLm x Lm/L (6)

where Y = GNP in constant prices, RY = Average annual rate of growth of industrial output, Ym= output of the industrial sector in constant prices, RYm= average annual rate of growth of industrial output, Lm= urban population, RLm= average annual growth of urban population, L= total population, I= Gross domestic investment, RL =average annual rate of growth of total employment, X= Exports in constant prices, RX= average annual rate of growth of exports, Rym x Ym/Y= growth of industrial output weighted by the share of industry in total output, RLm x Lm/L= growth of urban population weighted by the share of urban in total population.

Equation (1) is the typical neoclassical growth equation. While equation (2) includes exports as an additional determinant of growth to test the statistical soundness of the export-led growth thesis, equations (3) and (4) are used to test the impacts of structural transformation and the process of development on the growth of output. Equations (5) and (6) are applied to test the hypothesis that export growth is preceded by prior economic development and structural change.

In a similar kind of study, Subasat has made an attempt to reexamine the neoclassical theory of trade by taking into account the cross-country evidence. The model adopted in his study is as follows:

GDP gr = f (EPPI + Xgr+ Igr+ GNP pc 1983+ Government+ Unrest+ Population+ Illiteracy)

Where: GDP gr = annual average growth rate of GDP; EPPI= Export promotion policy Index; Xgr= annual average growth rate of exports; and Igr = annual average growth rate of investments.

But in the present study, we have used Granger causality model to test the export-led growth hypothesis propounded by the neoclassical. The following model has been adopted in our study to empirically examine the above-mentioned hypothesis. Let's start by defining Granger's concept of causality. X is said to be Granger cause Y if Y can be predicted with greater accuracy by using the past values of X. Consider the following equation:

$$Y_t = \alpha_0 + \alpha_1 Y_t\text{-}1 + \alpha_2 Y_{t-2} + \beta_1 X_{t-1} + \beta_2 X_{t-2} + u_t$$

If $\beta_1=\beta_2=0$, X does not Granger cause Y. On the other hand, if any of the β coefficients is non-zero, the X does Granger cause Y. The null hypothesis that $\beta_1=\beta_2=0$ can be tested by using the standard F -test of joint significance.

Note that it has been taken two period lags in the above equation. In practice, the choice of the lag is arbitrary but varying the lag length would lead to different results.

To estimate Granger causality, we have made stationary test of the variables concerned by using Augmented Dickey-Fuller test. If the variables don't have unit root problem then Granger can be estimated. If the calculated Augmented Dickey-Fuller (ADF) statistics is less than its critical value, then X is said to be stationary or integrated to order zero, i.e., I (0). If this is not the case, then the ADF test is performed on the first difference of X (i.e., *X). If *X is found to stationary then X is integrated order one i.e., I (1.). If two variables X and Y are both integrated to order one I (1.), then the next step is to find out whether they are co-integrated. This can be done by using Johansen's co-integration approach. If the two variables are not co-integrated then the best approach is to find out the causality between variables by using standard Granger test, which only establishes short run relationship. In practice, however, a number of econometrics packages can be used to perform these tests which also give the critical values of the ADF statistic. But we have used E-views package for our estimation.

5. RESULTS OF OUR STUDY

With the help of the above-specified model, the empirical estimation has been done through E -Views Package. First, the variables are stationary at all levels. The estimated ADF values are greater than the critical values at the 5% level of significance, as shown below. The next step is to find out the causal relationship between two variables by using Granger causality test. The estimated values are provided in the following tables 1 and 2.

TABLE-1: ADF TEST (FOR PERIOD 1951-1985 & 1985-2003)

Variable (at level)	1951-1985		1985-2003	
	t value	Critical t value at 5%	t value	Critical t value at 5%
In GDP	5.33*(1)	2.949	3.89*(2)	3.122
In Export	3.12*(2)	2.955	3.12* (3)	3.148

Notes: (1.) Figures in the parentheses are number of lags. Lngdp and lnexport denote log GDP growth and log Export growth respectively.

(2) * Significant at 5% level

As shown above the estimated ADF value is greater than the critical value at 5 % level of significance. The GDP and Export series are stationary series without any unit root problem. These series are stationary at all levels and there is no serial co-relation problem.

TABLE - 2

Granger Causality Test (For Period 1951-1985 & 1985-2003)

Direction of Causality	1951-1985		1985-2003	
	Estimated F	Critical Value F at 5%	Estimated F	Critical Value F at 5%
lnExport→ lnGDP	0.1.7 (3)	1.84	5.21* (3)	2.4
lnGDP→ lnExport	0.36 (3)	1.84	0.397 (3)	2.4

Figures in the parentheses are number of lags.

* Significant at 5% level

It is established from the above table -2 estimates that the estimated F value is less than the critical value in both directions indicating that there is no short run bidirectional causality between real export growth and GDP growth during the period 1951-1985.

Furthermore, the estimated results shown in the table - 2 (first row) reveal that the real export growth has caused the GDP growth during the period 1985-2003 because the estimated F value is greater than the critical F value at 5 %. The results of the second row (Table -2) indicate that the GDP growth doesn't cause real export growth during the period of discussion since the estimated F value is less than the critical F value.

6. CONCLUDING OBSERVATIONS

The empirical results provide strong evidence that the export promotes higher economic growth which in India during the period 1985-2003, which is termed as an era of export promotion trade. This result is well established in the many seminal papers by eminent scholars pertaining the neoclassical trade hypothesis i.e., export-led growth hypothesis. But on the other hand, the estimates have shown that the export-led growth did not hold good during the period 1951-1985. The inward looking trade policy in this period did not allow the export to rise and so also our economic growth significantly. The findings of the study clearly reveal that had India pursued the outward looking trade policy like South Asian countries (latter known as South Asian tigers) then it would have achieved higher economic growth and economic development in mid 1980s and the balance of payment crisis occurrence could have easily been ruled out. Thus, it is concluded that the trade policy for the forthcoming days should be more export promotion oriented rather than export pessimism kind of trade policy to accomplish higher economic growth. It is revealed that real export has an important bearing on our real GDP growth and, hence, it can be used as a stimulant to enhance growth of the Indian economy.

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Economic Reforms and Inter-State Disparities in Income Growth

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I. INTRODUCTION

Studies relating to interstate disparities in income growth has dominated the literature particularly after India embarked upon economic reforms in the year 1991. In fact, these studies can be broadly placed under two opposing camps. One set of studies that support the 'Accordion effect' hypothesis (propounded by Hanna, 1959 and found empirically valid by Hanna, 1959, and Perloff et al 1960; Gupta, 1973) subscribes to the view that inter-state disparities converge in the course of national economic growth. Included in this category are the studies made by Dholakia (1994) Cashin and Sahay (1996), Sarkar (1996) and Alhuwalia (2001) those who have noticed a marked reduction in income differentials. The other set of studies holds the opposite view contained in what may be termed as 'self perpetuation' hypothesis (propounded by Hughes, 1961, and found empirically valid by Booth, 1964; Nair, 1971; Choudhury, 1974; Majumdar and Kapoor, 1980) that inter-state disparities diverge in the growth process. Studies of Bajpai and Sachs (1996), Marjit and Mitra (1996), Rao et al (1999), Dasgupta et al (2000), Sachs et al (2002), Kawadia (2002) and Setty (2003) that have discerned tendencies of divergence belong to this category.

However, another set of studies which depart somewhat from these clear-cut strands support the 'concentration cycle hypothesis' (developed by Myrdal, 1958, Hirschman, 1961.; Williamson, 1965 and Alonso, 1968 and found empirically valid by Williamson, 1965 and Korpeckyz, 1972) maintains that interstate disparities diverge initially only to converge later. The study of Dasgupta et al (2000) finds a clear tendency for the Indian states to have diverged as far as per capita SDP goes but in terms of sector-wise composition of SDP, they find a tendency for overall convergence towards the national average.

The present study does not try to resolve the aforesaid controversies rather makes a modest attempt to make a comparative analysis of inter-state disparities in income growth before and after economic reforms in India.

II. DATA BASE AND METHODOLOGY

The present study makes use of the secondary data relating to Gross State Domestic Product (GSDP) and per Capita State Domestic Product (PCGSDP) compiled by the EPW Research Foundation. The comparable data

(1980-81 series) of fifteen major states for the period 1980-81 to 1997-98 is used for the purpose. 1980-81 to 1990-91 is taken as the pre-reform period and 1991-92 to 1997-98 as the post reform period. The present study could not be extended further due to non-availability of comparable data. Simple statistical tools like percentages, linear growth rate and Gini coefficient are used to analyse the results.

III. RESULTS AND DISCUSSION

(A) Share of the states as seen through GSDP data

Gross state domestic products and shares of the states are shown in Table-1. It is evident that all the states have gained in terms of GSDP during the study period. But looking to their shares it is found that these states taken together have lost in the same period. There is a continuous fall in the share from 88.83 per cent in the year 1980-81 to 86.23 per cent in the year 1990-91 and further to 84.14 per cent in the year 1997-98. However, the rate of fall in the post reform period is less compared to that in the pre-reform period.

It is also found that Maharastra is the only state to have increased its share continuously while the shares of the states like Goa, Punjab, Karnataka, M.P., Orissa, U.P. and Bihar have continuously declined. The shares of the states like Haryana, Andhra Pradesh, Karnataka and Rajasthan which were increasing in the pre-reform period are found to have declined in the post-reform period while the reverse has happened for the rest of the states like Gujrat, West Bengal. Karnataka and Tamilnadu.

Thus it is manifest that the performance of the states is not uniform. Some states have fared well so as to increase their shares while some have performed less efficiently to have declining shares during the period under reference. While Gujrat , West Bengal and Tamilnadu are found to have been favoured by the Economic Reforms, Haryana, Andhra Pradesh, Karnataka and Rajsthan are adversely placed.

B. Growth Performance as seen through GSDP and per capita GSDP growth.

Table-2 presents the estimated growth rates of GSDP and per capita GSDP in the 15 major states in the pre-reform and in the post reform period. A cursory glance at the table reveals that

i) The growth rate of 15 major states taken together has increased from 5.25 percent in the pre-reform period to 5.96 per cent in the post reform period. This acceleration corresponds to a similar acceleration in all India GDP growth that has grown from 5.55 per cent in the pre-reform period to 6.89 per cent in the post reform period.

ii) There is considerable variation in the performance of the states with some states growing faster than the average and others slower. Post reform GSDP growth rate found to be more in Goa, Maharastra, Gujrat,

Kerala, West Bengal. Tamilnadu and Madhya Pradesh while compared to their pre-reform growth rate. This growth rate is seen to have marginally declined for Andhra Pradesh and Rajasthan but has sharply declined in Punjab, Haryana, Uttar Pradesh, Orissa and Bihar after reforms. Karnataka is the only state to have maintained the growth rate throughout.

iii) The differences in performance across states become more distinct when we evaluate the performance in terms of growth rates of per capita GSDP. The variation in growth rates in the pre-reform period ranged from 2.08 per cent for Madhya Pradesh to a high of 3.96 per cent for Rajasthan. But in the post reform period it ranged from a low of 1.12 percent in Bihar to a high of 7.57 percent in Gujrat.

Looking to the growth performance it is very difficult to identify the reasons for success or failure of the states. It necessitates further investigation at the state level.

C) Inter-state Disparity:

There has always been an unquestioned assumption that inter-state disparities would narrow with development. This is possible if poorer states grow faster than the richer ones. But the pattern of growth after reforms is quite different. Table-3 presents the estimates of inter-state Gini-coefficient. It is seen that the Gini-coefficient which was 15.2 per cent in the year 1980-81 has increased to 17.2 per cent in the year 1990-91. Further it has increased to 22.6 per cent in the year 1997-98. It is important to note that inequality has continuously increased but has become more prominent after economic reforms.

TABLE-3

GINI-CO-EFFICIENT MEASURING INTER-STATE DISPARITY

1980-81	0.152
1990-91	0.172
1997-98	0.226

IV. HOW GOOD IS OUR GROWTH ?

The question of whether economic growth guarantees poverty reduction is not new. But recently it has become the subject of intense debate among economists. One model emphasises growth and efficiency under the idea that they eventually, if not immediately improve the standard of living of the population at large including the poor. The alternative model stresses that the state must play an active role in determining where the benefits of development end up, since it is not clear that the poor will benefit automatically. Under the first paradigm Governments concentrate in growth promoting activities as it is done in India after reforms while the second, they devote considerable effort to redistributive activities that is neglected in India after reforms.

The consequence of such a pattern of growth in India, no doubt resulted in poverty reduction. But looking to the performance of the low income category states, the situation does not appear to be that rosy as seen at the macro level. This shows that output effect of the liberalisation process seems to be going in a different direction than the welfare effect particularly for the low income states. Thus post-reform policy initiatives taken by the government have failed to improve the condition of the poor states and poor people sheltered in them.

V. CONCLUSION

In conclusion, it may be said that the policy of liberalisation after reforms has put the Indian economy on a higher growth trajectory but what is alarming is that it has perpetuated disparity across the states and thereby throwing up more uncertainties in the growth process. Market oriented economic policies that have failed to equitably distribute gains of growth may not be sustainable and prove to be detrimental to the interest of the poor states. Therefore the Government must intervene in the growth process such that the benefits trickle down to the backward states.

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TABLE - II

Gross State Domestic Product & Share of the State

(1980-81 series) (Rs.in Crore)

States	1980-81	1991-92	1997-98
Goa	398	678	989
	(0.33)	(0.32)	(0.31)
Punjab	5025	8795	11494
	(4.07)	(4.13)	(3.70)
Maharastra	16631	29889	47403
	(13.47)	(14.04)	(15.27)
Haryana	3368	6459	8381
	(2.74)	(3.04)	(2.70)
Gujrat	7427	11663	21154
	(6.20)	(5.48)	(6.81)
West Bengal	10345	15837	15002
	(8.38)	(7.44)	(8.05)
Karnataka	6210	11494	15611
	(5.03)	(5.40)	(5.04)
Kerala	4286	6251	8869
	(3.47)	(2.94)	(2.85)
Tamilnadu	8081	13960	20626
	(6.58)	(6.56)	(6.64)
Andhra Pradesh	8191	15897	200215
	(6.63)	(7.47)	(6.51)
Madhya Pradesh	7788	12072	17236
	(6.31)	(5.67)	(5.55)
Orissa	3708	4884	6774
	(3.00)	(2.30)	(2.18)
Uttar Pradesh	15554	25349	31419
	(12.60)	(11.94)	(10.12)

Rajasthan	4637 (3.76)	8895 (4.28)	13043 (4.20)
Bihar	7363 (5.96)	11295 (5.30)	12980 (4.18)
Major States	109030 (88.83)	183463 (86.23)	261196 (84.14)
All India	122427 (100)	212253 (100)	310430 (100)

Figures inside the parentheses indicate percentage of all India.

Source : Domestic product of States of India 1960-61 to 2000-01, EPW Research Foundation, Mumbai.

TABLE - III

Annual Rates of Growth of GSDP & PCGSDP

States	1980-81 to 1991-92		1991-92 to 1997-98	
	GSDP	PCGSDP	GSDP	PCGSDP
Goa	6.01	3.25	6.08	3.50
Punjab	5.32	3.33	4.71	2.80
Maharastra	6.02	3.58	8.01	6.13
Haryana	6.43	3.86	5.02	2.66
Gujrat	5.08	3.08	9.57	7.57
West Bengal	4.71	2.39	6.91	5.04
Karnataka	5.29	3.28	5.29	3.45
Kerala	3.57	2.19	5.81	4.52
Tamilnadu	5.38	3.87	6.22	4.95
Andhra Pradesh	5.65	3.34	5.03	3.45
Madhya Pradesh	4.56	2.08	6.17	3.87
Orissa	4.29	2.38	3.25	1.64
Uttar Pradesh	4.95	2.60	3.58	1.24
Rajasthan	6.60	3.96	6.54	3.96
Bihar	4.66	2.45	2.69	1.12
Major States	5.25	3.03	5.96	4.02
All India	5.55	3.32	6.89	4.07

Source : Domestic product of States of India 1960-61 to 2000-01, EPW Research Foundation, Mumbai.

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A Decade of Economic Reforms : Assessing Development Outcomes A Distant Dream Vs. Dreams Unlimited

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India continued to make good progress in increasing incomes and improving living standards over the past decade. After the setback associated with the 1991 balance of payments crisis, economic growth picked up, income poverty continued to decline, and many social indicators, in particular literacy continued to improve. These developments were supported by the wide ranging reforms launched in 1991 to open and deregulate the economy. Even though the pace of reforms has slowed down since mid 1990s, the cumulative changes have been substantial, improving the investment climate. More sectors have been opened to private activity. Trade policy and the exchange rate regime have been further liberalized. And capital markets have been reformed.

MACROECONOMIC PERFORMANCE

Overall, India's economy performed well in the 1980s and even better after reforms of the early 1990s (Table 1). Inflation remained low, and external balances improved. GDP growth accelerated, from only 3.5% a year in the 1960s and 1970s, to nearly 7% a year between 1992-93 and 1996-97. Growth was led by industry and services in the 80s and by services in the 90s (Table 2). Agriculture and allied sectors expanded slowly through out the two decades. The structure of the Indian economy changed considerably as a result, with the share of agriculture declining to one fourth of total output and the share of services increasing to nearly half. But recent trends give cause for concern. First, fiscal aggregates of the general government deteriorated after 1997-98 with the overall fiscal deficit expanding from 7% of GDP to more than 10% by 2002-03. A decline in revenue mobilization and a significant increase in government consumption, driven by wages and pension of civil servants, food subsidies, and debt service.

The effects of nuclear tests, tight monetary policy to keep inflation low, and higher interest rates worldwide, contributed to higher interest costs. As a result, resources available for public investment were constrained, with adverse consequences for infrastructure development and, to less extent, social programs. Interest rates have declined since, primarily because of low investment demand in India and the current low interest rates world- wide for government and prime

borrowers. But the public debt burden remains high, and small medium scale enterprises continue to face high interest costs. Except in the 1991 crisis, when fiscal policy clearly encouraged macroeconomic stability and growth, it can be argued that fiscal policy has kept growth below potential. Second, economic growth decelerated, to 5.5% on average between 1997-98 and 2001-02, and to 4.4% in 2002-03 (see Table 1). Output from agriculture, which performed poorly throughout the 1990s, contracted by 3.1.% in 2002-03. Industrial growth slowed down markedly between 1997-98 and 2001-02, and expanded at average rates below those of the 1980s. The exception is services, which continued to expand rapidly.

SECTORAL OUTPUT PERFORMANCE

Agricultural output expanded slowly in the 1980s and 1990s. Growth slowed further after 1997, partly a result of extensive droughts in many states and flooding in others. Two other factors contributed to the slowdown. First was the dwindling impetus from the green revolution that increased productivity increases in Punjab, Haryana, Andhra Pradesh and western Uttar Pradesh. Second was the limited public investment in agricultural infrastructure. Instead, an increasing share of public resources for agriculture was spent on the minimum support price for food grains. This programme has given farmers little incentive to diversify. It has filled government storage facilities with huge food grain stock while keeping the market price for food grains artificially high. Slow agricultural growth is a concern not so much because of its contribution to India's overall output of food security but because of the sector's importance in the country's economic, social and political fabric. Agriculture still provides employment to a large share of India's population and an even larger share of the poor.

Industrial growth slowed sharply after the mid-90s. Following liberalization in the early 1990s, investment and industrial output expanded rapidly. But because demand failed to expand as rapidly as expected, and with greater competition from imports, industry was left with excess capacity. Simultaneously, the domestic policy environment did not support productivity increases. Infrastructure bottlenecks and distortions in product and factor markets, combined with lower external demand and rising interest rates, led to a slowdown in industrial investment and growth after 1997-98. Industry has only recently begun to see signs of recovery with the index of industrial production suggesting a recovery, particularly in capital goods.

Growth of the services sector has been strong and broadly based. One of the reasons is the rapid expansion of information technology, which has turned India into one of the world's leading providers of software. But other services have also expanded, such as transport, trade, and financial services. The national accounts also reflect an increase in the value added by public administration. But if GDP estimates are corrected for the spurious addition to growth caused by the use of wage bill to estimate the value added of government services, annual GDP growth between 1997-98 and 1999-2000 would have been lower by about half a percentage point (Acharya 2002).

INVESTMENT CLIMATE

Previously enabling phases of acceleration and stability in periods of slow down, investment declined markedly after 1997-98, raising concerns about future growth. Public investment was clearly crowded out by expanding public consumption and debt service. Several economists agree that the slowdown of public investment in the 1990s contributed to the slowing of private investment, as there appears to be a crowding-in phenomenon between public and private investments.

Private investment slowed for several reasons. Following the higher growth rates in the early 1990s, firms invested and borrowed heavily in the mid- 90s, building capacity for a continuing expansion in domestic demand. Businesses invested on the expectation that the pace of regulatory and infrastructure reform and investment would remain rapid and thus may contribute to higher productivity investment. Meanwhile, trade reform left some sectors more open to competition, while they still faced across the border constraints to improving productivity specifically from Chinese dumping. As the pace of reform slowed, interest rates rose, and the expected demand from high overall growth rates failed to materialize, many firms found themselves saddled with excess capacity and debt.

EXTERNAL SECTOR

India's integration with the world market increased in the 1990s. The real depreciation of the rupee after the 1991 crisis promoted exports, and the reduction of import barriers allowed more foreign goods into the country. Exports of goods and non-factor services rose from 7.5% of GDP in 1990-91 to 10.5% in 2001-02. The balance of payments has strengthened considerably in recent years. The performance of merchandise exports has been somewhat erratic as the stimulus from the steep real depreciation of the rupee in early 90s faded, replaced by upward pressure. Sluggish domestic demand growth, however, has more than offset the impact of gradual relaxation of import barriers, and import growth have been modest in recent years. The trade deficit has thus roughly halved since 1999-2000 from around $1.2 billion to around $6 billion in 2002-03. Exports of IT services have increased sharply, and remittances have edged up. The current balance, which swung into deficit of 3.4% of GDP in 1990-91, has shifted to a small surplus.

Capital inflows picked up strongly in response to the reforms of the early 1990s but have since been more modest. Foreign direct investment and equity inflows have eased from their peaks, and borrowing from both official and private creditors has typically been more moderate. The external debt has risen only modestly, falling from almost 40% of GDP in the early 1990s to around 23%. The combination of an improving current balance and even modest capital inflows has been enough to allow a substantial build up of reserves, from $17 billion in 1995-96 to more than $90 billion today- equivalent to almost 14 months of imports.

The external sector continues to play a modest role, and India remains much more closed than other large Asian economies, where exports account for much larger shares of GDP- 29% in China, 34% in Indonesia, and 41% in South Korea. India's share of world exports edged up from 0.5% in 1990 to 0.7% in 2001, but

remains relatively modest as compared to the size of the economy. Fiscal imbalances are reemerging. And domestic vested interests, concerned about their ability to compete against foreign companies, resist further trade liberalization.

UNEMPLOYMENT

Jobless rates in India are not high by international standards, but recent trends have raised concern, as reflected in the Tenth Plan (Table 3). Unemployment rates based on National Sample Survey data have been traditionally low in India. But all measures show an increase in unemployment between 1993-94 and 1999-2000, explained almost entirely by an increase in unemployment in rural areas (World Bank, 2003). Disaggregated unemployment figures in the rural sector suggest that this deceleration in rural employment in agriculture and the low capacity of rural industry and services to absorb the labor released from agriculture. The share of employment in the organised sector remains low, and unemployment rates are high among certain population groups, such as urban educated youth, and in certain states such as Kerla, Tamil Nadu and West Bengal.

SOCIAL OUTCOMES

Social progress in India has been uneven. Education indicators have improved markedly, but progress in health has been mixed. For the first time since independence, the absolute number of illiterates in India declined between 1991-2001. Literacy rates rose, particularly for women. Enrollment rates of primary age children rose, and the gap in the enrollment ratios of boys and girls narrowed.

Health indicators in the 1990s improved slowly or in some case not at all. Between 1992-93 and 1998-99, the infant mortality rate fell from 79 to 68. But there has been little progress in reducing India's high maternal and under-five mortality rates and in addressing malnutrition. Many of these outcomes have to do not only with health policy, but with slow progress in improving access to social infrastructure like safe drinking water and sanitation. An estimated four million people in India are now infected by HI+54V/AIDS, and the rate is increasing. The declining sex ratio in some of the developed states like Gujarat, Maharastra and Punjab is disturbing. And although polio has disappeared from most countries, India is one of seven where polio is endemic, accounting for 85% of all confirmed polio cases in the world in 2002.

These worrisome trends are somewhat surprising. Worrisome, because they suggest that increased public expenditure alone will be insufficient to improve the outcomes. Public expenditures on health and education increased over the 1990s. Surprising, because the 1990s witnessed a large increase in compensation to all including health and educational professionals, which could have contributed to improvements in the delivery of basic education and health services. There is no evidence that it did. To the contrary, households particularly poor households are increasingly resorting to the private sector for education and health services.

REGIONAL DISPARITIES

India's good aggregate performance masks divergence in per capita incomes, poverty, and other indicators of well being between richer and poorer states.

Poverty declined in both poorer and richer states, but the progress in richer states has been greater. An important part of the explanation is that economic growth has been slower in the states that were poorer to start with (Deaton and Dreze 2002). Faster population growth in states with initially higher incidence of poverty has concentrated poverty in India's Northern and Eastern States. Indeed, 54% of the poor now live in four states alone: Uttar Pradesh, Bihar, Madhy Pradesh and Orissa (World Bank, 2003). So making progress in poverty reduction in India requires faster growth in these lagging states. These are also states with weaker state institutions, and where government finances are most severely stressed. Recent research by the World Bank and CII suggests that a weaker investment climate in these lagging states may also be behind this slower growth. These diverging trends have translated into large disparities of incomes and other indicators of living standards. Average per capita incomes in 1997-2000 varied from more than Rs. 15000 in Maharastra, Punjab, Haryana and Gujarat to below Rs. 7500 in Orissa and Uttar Pradesh, and below Rs.5000 in Bihar. Obviously, disparities in per capita income between states are mirrored in indicators of poverty, health, education, safe drinking water and of course on regional unemployment. This in certain states has lead to violence. Recent clash between Assamese-Bihari is a case in point.

GOALS AND POLICY AGENDA

Increasing growth to 8% and accelerating progress in a wide range of living standards indicators are the goals set out in the Government's Tenth Plan. But macroeconomic vulnerabilities and structural impediments limit India's ability to accelerate development, as the Plan and this year Economic Survey recognize. Meeting these goals will require a radical departure from current policies. Some of the structural weaknesses may already help explain the growth slowdown of the past five years, suggesting that the high growth rates of mid-1990s were an outlier, not a shift to a higher growth path. They also help explain the mixed performance in improving living standards and the persistence of regional disparities. The key now is to implement the policy and institutional changes as started in 1991 in a more vigorous way with appropriate legal reforms. Sustained progress will no doubt be difficult, especially in the politically charged areas of labor, power and agricultural reform.

THE DREAM: INDIA 2050

A recent Goldman Sachs (October, 2003) study indicates that India's economy could be larger than all but the US and China in 30 years. India's GDP will outstrip that of Japan by 2032. With only population out of BRIC (Brazil, China, Russia, India) and countries that would continue to grow throughout the next 50 years, India has the potential to rise its US dollar per capita in 2050 to 35 times that of current levels. Of course not a distant dream! But dreams unlimited!

TABLE-1

Macroeconomic Trends Over The Past Two Decades

ITEMS	1980s	1990s	1992-93/ 1996-97	1997-98 /2001-02	2002-03
GDP Growth (% a year)	5.6	5.8	6.7	5.5	4.4
Agriculture and Allied	3.4	3.0	4.7	1.8	–3.1
Industry	7.0	5.8	7.6	4.5	6.1
Services	6.9	7.6	7.5	8.1	7.1
Investment Rate (% of GDP)	22.0	23.3	22.5	22.1	
Private	10.0	7.8	8.0	6.6	6.3
Public	12.1	15.2	15.3	15.9	15.7
Inflation (WPI, % a year)	8.0	8.1	8.7	4.9	2.5
Fiscal Deficit (% of GDP)	8.1	7.8	7.2	9.3	10.4
Current Account Balance (% of GDP)	–2.1	–1.4	–1.2	–0.7	1.0
External Reserves (months of imports)	3.3	5.6	5.9	7.0	11.0

Sources : NAS various issues

TABLE-2

Sectoral Shares Of GDP Factor Cost, 1980/81 And 2001/02

Sectors	1980-81	2001-02
Agriculture and Allied	38	25
Industry	26	26
Services	36	49
Total	100	100

Source : As of Table-1

TABLE-3

Unemployment Rates, India And Comparator Countries, Selected Years (%)

Country	Year	Unemployment Rate
India	1999-00	4.4
China	1996	3.0
Indonesia	1998	5.5
Brazil	1998	9.0
Pakistan	2000	5.9

Source : ILO, 2001

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Globalisation and Foreign Direct Investment

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Globalisation refers to a process of increasing economic integration and growing economic interdependence between countries in the world economy. There are three dimensions of globalisation: International Trade, International Investment and International Finance. In Indian context, globalisation implies opening up the economy to foreign direct investment (FDI) in different fields of economic activities so as to encourage competition and to enhance the productivity and efficiency of the system. In this context, the present paper is an attempt to analyse the impact of FDI on Indian economy in the post reform period.

Foreign Direct Investment plays an important role in the development process. The strategy followed during the first 43 years made Indian economy a closed one. A high degree of protection was provided to the domestic industry through restriction of trade and imposition of tariff and quotas. There was no inducement for Indian industry to be efficient since it was protected from foreign competition. Consequently foreign investment shied away and the total FDI remained rather negligible. However, after the announcement of New Economic Policy in 1991, a strategic shift in economic policy has occurred in order to attract foreign direct investment. The Government has realised the importance of FDI in practically at areas of economic activity. This marked a major deviation from the post-independence strategy to attract more FDI to the country.

NEED FOR FDI

India is a labour surplus economy. It has abundant natural resources. With the use of appropriate technology the resources can be better utilized. To set the process of increased production in motion, more funds are required. Opening up the Indian economy facilities the flow of foreign investment into the country, which will help to meet the shortage of internal finance.

FDI has the attraction of bringing in new technologies and products that local companies are unable to evolve, given their low technical base. It also helps in industrial development by providing technology transfers, management expertise, industrial training and an incentive for the development of related infrastructure and services. Given the compelling need to increase investment and to improve technology, most developing countries have opted for a liberal policy and regard FDI as something to be promoted rather than permitted. FDI is needed primarily for the reason that it goes directly to increase the capital formation of the recipient country. India has a strong entrepreneurial class that can collaborate with the foreign investors. Foreign investment as a supplier of technology and expertise in critical areas is expected to raise productivity and India's competitive strength and thereby to give exports a boost.

FDI POLICY – A POST REFORM SCENARIO

Policies in the post reform period have emphasised upon grater encouragement to welcome FDI into the country. These steps include reduction in administrative and regulatory barriers to FDI by providing various fiscal incentives and other measures. The several changes in FDI policy that the government since July 1991 can be broadly classified into four categories:

1. Choice of Product : The number of products in which foreign investment was not permitted under the previous policy regime has been significantly reduced.
2. Choice of Market : In a large number of newly permitted products, foreign investors are free to compete in the domestic market.
3. Choice of Ownership Structure : In most cases foreign investors are free to own majority share of firms equity if he so chooses.
4. Simplification of Procedures : Most procedures relating to application and approvals of foreign investment based ventures has been greatly simplified. India has signed Multilateral Investment Guarantee Agency (MIGA) protocol for protection of foreign investment.

A part of ongoing process of liberalising FDI policies the Planning Commission had set up a steering committee on FDI, in August 2001 for suggesting measures for enhancing FDI inflows to the country. The committee has made a number of recommendations for facilitating foreign direct investment.

TRENDS AND COMPOSITIONS OF FDI

Progressively liberal policy adopted during post reform period led to increased inflow of foreign investment in the country both in terms of direct investment (FDI) as well as portfolio investment. A disaggregated time series foreign investment inflows shows.

That the annual aggregate foreign investment inflows varied between US $ 4 to 6 billion during the period 1993-94 to 2001-02 (Except for 1998-99). The average volume of foreign investment inflows during the period is estimated to be US $ 4.9 billion. Inflows during the year 2002 have been around 53 per cent of inflows during the corresponding previous period.

In respect of receipts of 709 in the developing world; it is found that China occupies first position followed by Hong Kong and India. The gap between China and India may be exaggerated owing to technical issues in measurement. RBI is presently evaluating some modifications in the way that Indian FDI is measured, which could yield somewhat higher estimates for India. India faces Keen Competition in seeking to attract FDI. Other countries are also trying to improve policies and institutions so as to attract further increase FDI inflows.

There is also a close link between FDI and exports. Exports from developing countries are often associated with international firms choosing to use a country as a target for FDI and then for production destined for global markets.

In terms of country-wise break-up FDI inflows the most important countries are Mauritius (38.7 per cent) followed by USA (17.1 per cent) and Japan (6.8 per cent). The special role of Mauritius here is likely to be the consequence of special tax treatment accorded in India to investment routed through Mauritius.

The sectors attracting highest 709 approvals with inflows during August 1991 to October 2002 shows that the most important sectors are telecom, computer software, energy and transportation. These four sectors accounted for roughly 50 per cent of FDI inflows.

IMPACT OF FDI ON INDIAN ECONOMY

FDI has direct impact on output growth by augmenting the available investible capital. However, a far more impact of FDI is through externalities leading to higher efficiency and productivity. FDI typically serves to increase competition in markets, bring new technology and foster skill acquisition amongst domestic labour.

- So far the induction of new technology is concerned, no study has quantified how much technology has spilled over to Indian industry. However, the extent of spill overs absorbed can easily found out as this depends on absorptive capacity of Indian industry, captured through investment in R & D and human capital. FDI in the energy, oil and telecommunication sector is adding no new technology. In fact, after liberalisation the giant companies like Kelvinator and Godrej have been taken over by Whirpool and LG.

- As per the impact of FDI on competitiveness is concerned, a recent study by Ganeshan Wignaraj and Ashley Taylor benchmarks industrial competitiveness in 80 developing countries using the concept of manufactured export competitiveness index (MECI). The study placed India in the 37th position with a score of 0.38, which is much below the score obtained by East Asian countries, Mexico, Brazil, South Africa and China with which India is often compared. This implies that despite increase in FDI competitiveness of Indian industry has not improved (with few exceptions), which proves the low absorptive capacity of the country and its firms. Table–1 shows that even though after 1991 FDI inflow has increased, the R & D intensity is declining continuously. Similarly, human capital expenditure intensity fell continuously till 1997-98. Only investment on physical capital has increased over the years.

TABLE–1

Trend in FDI and Broad Capital Indicators

Year	FDI Approvals (Rs. Crores)	FDI inflow (Rs. Crores)	GFCG/ GDP	R & D/ GDP	EE/ GDP
1990-91	534	351	21.3	0.84	3.84
1991-92	3,888	657	20.3	0.83	3.80
1992-93	8,859	1,787	20.6	0.81	3.72
1993-94	14,187	3,289	20.7	0.84	3.62
1994-95	32,072	6,820	22.1	0.79	3.56
1995-96	36,147	10,389	24.7	0.69	3.56
1996-97	54,891	16,425	23.4	0.66	3.53
1997-98	30,814	13,340	22.9	0.67	3.49
1998-99	28,367	16,870	23.4	NA	3.81

Source : Economic Survey and Other Sources

MAJOR INITIATIVES TAKEN TO ATTRACT MORE FDI

In order to attract more FDI to the country, the government has taken major initiatives during the year 2002-03, which are as follows :

- FDI up to 100 per cent permitted under the automatic route in advertising and film sectors.
- FDI up to 100 per cent is allowed in tea sector.
- FDI up to 100 per cent permitted with prior approval of the government for development of integrated township including housing, commercial premises, hotels, resorts, urban infrastructure, etc.

- Automatic route of FDI up to 100 per cent allowed in all manufacturing activities in Special Economic Zones except defence, alcoholic drinks and cigars.
- FDI in print media sector up to 26 per cent of paid up equity capital of Indian entities publishing periodicals and newspapers dealing with news and current affairs.

Apart from the above, FDI inflow can be augmented if we take into consideration the following factors.

- Law and order conditions, rules and regulations and the labour policy become investor friendly.
- There should be transparency, stability and adequacy to achieve the objectives of the FDI policy.
- A liberal exit policy, financial sector reforms and investor friendliness of states along with desirable political actions are some of the other factors which can be helpful in augmenting FDI inflows to the country.

CONCLUSION

Foreign Direct Investment should be permitted and encouraged only in those sectors which would significantly contribute to income generation, employment creation and net export earnings. The stipulation that the right to invest by the multinationals should become a legal right without intervention of the states which is envisaged in the proposed Multilateral Agreement on Investment (MAI) should not be acceded to, under any circumstances. On the contrary India along with other like-minded countries should mount pressure in the WTO and other fora to include code of conduct and the obligation of multinationals for transferring technology, sharing information and promoting employment in any multilateral agreement. The time is now ripe for the government to plug the loopholes and lacunae in the policy. FDI can be helpful only if it is well coordinated, monitored and tailored so as to fit into an investment process that lends to economic growth of the country.

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Disinvestment in PSUs and Sustainable Development: The Indian Scenario

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SECTION - I

INTRODUCTION

On the eve of Independence, India had to face the challenges especially from socio-economic fronts: such as economic stagnation, low per capita income, high rate of inequality, large regional imbalance, unemployment, low productivity, low capital formation, high rate of population growth, greater degree of poverty and so on. All sorts of socio-economic disadvantages were highly inherited from the bygone British colonial-rule in India. Since independence, the country has been persistently persuading itself to a better governance through the process of trial and error with policies, in order to overcome the above problems. The long-term objectives of economic planning in India have been spelt out in various plan documents. Broadly, the main objectives are: (1.) economic growth (approximately at an annual rate of 5% per annum), (2) self-reliance, (3) employment, (4) reduction in inequalities, and (5) elimination of poverty. Initially, following economic doctrine of Prof. P.C. Mahalanobis, the country had to adopt the approach of unbalanced growth. But, later on, the nation followed the path of balanced growth model. The economic structure is characterized as 'mixed economy'. Public Sector and private sector coexist in the economy. The role of state in industrialisation has been important even in advanced countries like Japan, Germany and USA. These advanced countries had also the features of mixed economy. But, ideological approaches towards the mixed economy between these countries and India were quite different. While in the advanced countries, the concept of mixed economy envisaged an ultimate takeover by the private sector, in Indian type of mixed economies, the objective was defined as ultimate takeover by the private sector (Sachs: 1964). The public sector in India was designed to control the 'commanding heights'. Since the beginning of 1990s, India's

objective of mixed economy was changed. India envisaged an ultimate takeover by the private sector. Since then, under the canopy of new economic reforms, disinvestment in public sector enterprises has been undertaken as a major step towards a complete privatisation of the economy.

In this paper, an attempt is made to investigate into the contentious issues of disinvestment in PSUs. We also critically examine how can such structural change in the economy ensure the conditions of equality and efficiency for sustainable development? Will it go in favour of compliance with socio-economic objectives and maximum social welfare? This paper consists of four sections including introduction.

SECTION - II

RETROSPECT AND PROSPECT OF PSUS IN INDIAN ECONOMY

There has been a phenomenal growth of the central government enterprises since the commencement of the planning in India. The public sector was then assigned a very important role to play in the industrialisation and economic development. The industrial policy resolution of 1948 made it very clear that the areas such as, manufacture of arms and ammunition, the production and control of atomic energy, the ownership and management of railway transport, would be the exclusive monopoly of the Central Government. Later on, six more industries; such as, coal, iron & steel, aircraft manufacturing, manufacture of telephone, telegraph & wireless apparatus and mineral oils, were brought under the monopoly of the Central Government.

Industrial Policy Resolution of 1956 further pronounced the role of public sector. In order to fully comply with national objectives of adopting a socialist pattern of society and planned and balanced development, the nation felt the necessity of all industries of basic and strategic importance or in the nature of public utility services, to put under the public sector (Bureau of Public Enterprise: 1983-84). In this policy, there were two Schedules: Schedule-A enumerated 17 industries for the future development which would lie within the exclusive right of the state, and Schedule B contained a list of 12 industries which would be progressively state owned. The Central Government investment in enterprises increased from Rs.29 crore (1951.) to Rs.1, 35,445 crore (1992), and the number of PSUs increased from 5 (1951.) to 246 (1992). Between 1992 and 2002, the number of PSUs declined to 230 from 246, whereas the capital investment in them increased to 3, 24,632 crore. The decrease in number of PSEs was due to privatisation. But the privatisation did not have any decreasing impact on capital investment.

The performance of the public sector units in many countries have, by and large, been far from satisfactory. They have often put large burden on public budget and debts (World Bank: 1987).

Privatisation through the process of disinvestment in PSUs gathered momentum since around 1980 across the world. During 1980-92, more than 8,500 state owned enterprises had been privatised in over 80 countries (Cherunilam; 1998). Privatisation means transfer of ownership or management of an enterprise from the public sector to the private sector.

The main objectives of privatization in India were to enhance efficiency and maintain equality in the economy through the process of modernising and upgrading PSEs, creating new assets, generating employment and retiring public debts. (Annual Report 2002-2003 of Ministry of Disinvestment).

Deficiency in Privatisation Process

(i) Till 2002-2003 around 129 companies' equity shares were sold mainly through auction method and strategic sale amounting to Rs 30,917 crore, out of targeted receipt of amount of Rs 78,300 crore. The actual disinvestment proceeds remained much below 50% of the target receipt. This is largely attributable to the government inefficiency of timely equity selling.

(ii) Most of the profitable units were selected for disinvestment under the clue of high valuation of equity and large amount of disinvestment proceeds to meet reduction of large fiscal deficit. Again, the domestic private units do not have sufficient capital to purchase large volume of PSU stocks. Consequently, the foreign companies and investors were the net purchasers of these stocks.

(iii) Fears of large-scale unemployment prompted trade unions and employees to strike work, whenever large PSUs are divested, which became a strong resistance to privatisation.

(iv) While the government's objective was to create efficient private companies under disinvestment, it fail to achieve this objective because of lack of political will to relinquish control over the acquiring companies. Interference in decisions relating to allocation of resources and price cutting has acted as a deterrent to the privatised companies' business strategies.

SECTION - III

DIVESTMENT AND SUSTAINABLE DEVELOPMENT

Privatisation through Govt.'s disinvestment in PSUs will have certain impact on the sustainability of the economies. Since late 1980s, sustainable development (SD) and protection of environment/ecosystem have been the evocations all over the world. 'Sustainable development' as defined in the high-profile United Nations Conference on Environment and Development

(UNCED, aka The Earth Summit) held at Rio de Janeiro in 1992, is that "the right to development must be fulfilled so as to equitably meet development and environmental needs of present and future generations". The intrageneration and intergeneration equity and efficiency are prerequisites for sustainable development [Hartwick: 1990; Solow: 1992; Daly: 1990; Common and Perrings: 1991 and so on]. In less-developed countries, for achieving the requirements SD, a balanced development approach through a process of managing intra-and-intersectoral resource flows (wherein natural resources are set in a separate sector) has been perceived as a necessary condition. [Mohapatra & Naik : 2004]. Because, a balanced development approach causes conditions for diversification of economic activities and ultimately, this becomes helpful in minimizing poverty, unemployment, inequality, insufficiency, etc. which are largely attributable to less-developed countries. The economic divergence also lessens the intensity of environmental pollution and people's excessive dependence on natural and common property resources.

Collating objectives of privatisation to the above requirements for sustainable development, some plausible contradictory implications are discerned. These are explained as follows.

The important objectives of privatisation are to increase 'efficiency' and maintain equity in the fields of production, distribution and overall management as well as productive potential of the economy as a whole. These are also conditions for sustainable development. This is to critically examine, how could the process of privatisation comply with the above objectives for sustainability ?

(a) This is the established fact that 'economic efficiency' of productive factors can be increased by effectively using them and adopting optimal resource allocation principles. These processes require development of new culture within the organizations, along with structural changes. Switchover to privatisation transforms the structure of ownership only, but it may not ensure a change in culture. Without a change in organization-culture, simple structural change will not be adequate to bring about any apparent change in economic efficiency in the system. An economic system chosen by a nation in a period is not itself defective. The defection lies within the people who legislate, manage, implement and work in the system. Whether we move to privatisation or nationalisation or to a mixed system, unless people's attitude, morality and work-culture are changed, it will not create as such favorable conditions for improvement of 'efficiency'.

(b) Many pro-privatisation economists advocate that privatisation is a process by which state monopoly can be abolished, and diffusion of ownership among mass public is possible. This will create a favourable

environment for free competition among private enterprises. This is quite true that keen competition can enhance efficiency of the economic factors. But, this increase will not ensure sustainable development. It will be short-lived and cannot persist for long to pass to future generations. For self defence in business world, the business community will lose their moral values. Further, high degree of competition will lead the entrepreneurs/suppliers towards excessive commercial motive, short-sighted resource management, misuse of science and technology and so on. [Mohapatra : 2003]. Fulfillment of 'efficiency' and 'equity', which are conditions for sustainable development, will be then a nightmare. Withdrawal of government control, partially or fully through the process of disinvestment, especially over natural-resource based enterprises, and letting the process to the free-hands of the private players, would have very dangerous implications for sustainability.

(c) No doubt, the policy steps to disinvestment in PSUs will be very much helpful in correcting deficit of fiscal balances. But, as regards improvement of efficiency and equity (SD requirements), it depends upon how the state utilising the divestment proceeds in different productive activities. For example, in India, the government commitment is to utilise divestment proceeds for retirement of public debt, generation of employment, modernisation and upgradation of existing public enterprises and strengthening infrastructure base (Annual Report 2002-03, Ministry of Disinvestment). Utilising proceeds for debt redemption is purely unproductive whereas it is productive in other activities. The net social utility from privatisation depends upon (i) the difference between 'productive and unproductive use of the proceeds and (ii) change in the productive potential of the taken over units under private sector. If the net social utility is, after all, substantially positive, it may go in favour of sustainable development, provided that the state did not lose its control over natural resources and natural resource-based industries.

(d) A lot of doubt arises in the context of intra-and-intergeneration 'equity' through a process of privatisation. The economic control of multinational corporations during past years at different areas of business has substantiated the above doubt. As Samuel Paul [1985] stated if the benefits of privatisation were likely to be reaped solely by local elites, expatriate groups, or multinational companies, political resistance to reform was likely to increase. This would lead the system to the state of inequality and unsustainable development.

In sum, a step to privatisation along with a static socio-culture and existing morality of politicians and bureaucrats will be hardly successful in establishing

a balanced development and economic diversification and consequently, sustainable development.

CONCLUSION AND SUGGESTION

Keeping in view of low performances of the PSUs and excessive burden of fiscal deficit due to these, privatisation through the process of divestment would be an alternative measure to correct the economic system. In sum, the process of privatisation has its noble objectives of enhancing 'efficiency' and 'equity' in the economy. But the progress since the inception of divestment, the performance towards the above endeavour is not at all satisfactory. Furthermore, at macro level, while the objectives and performance of privatisation endeavour are collated to requirements for sustainable development, many contradictory points are noticed. If privatisation is not properly tackled and the government allows the entire system to the free hands of the private players, achieving sustainability will be a formidable task for the nation.

Whether nation moves to privatisation or nationalisation or to a mixed system, unless peoples attitude, morality, and work culture are changed, it will not create much sense towards enhancement of efficiency and equity. The change in organization's culture is a necessary condition for the new system to increase their productivity and maintain equity.

A stifled competition among suppliers in private sectors will create unfavourable conditions for sustainable development. Because, it motivates competitors to resort to excessive commercial motive, short sighted resource management, misuse of technology, etc., mostly causing from their defensive attitudes. In this context, it is suggested that the government must not apply its divestment policy to core and natural resource based industries in which social utility is highly sensitive to private exploitation.

By and large, a systematic and controlled divestment measure based on wise decisions may create a congenial business environment for high efficiency and social equity which will be conducive to sustainable development.

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the adverse environmental consequences (in turns of air and water pollution) in the state. As per the examination by Pollution Control Board the existing water quality at various monitoring stations of Orissa particularly after 1990s has been deteriorated compared to the desired level. The critical parameter observed in water at different monitoring stations of rivers is 'Biochemical Oxygen Demand' (BOD). Besides, the approved and proposed bauxite mines will adversely affect the ground water level.

Nandira :

The Nandira river, which is tributary of the Brahmani river and passes through Talcher town, has virtually become the industrial drain for all big and medium industries including NALCO, its captive power plant, MCL, and many other industries in Talcher-Angul region that discharge their untreated waste water and solids into this river. The black water is poisoning and slowly killing people, animals, fish and plants as far away as around 50 miles downstream. Agricultural productivity has dropped for farmers dependent on this polluted water, and fishing communities have been wiped out (Das: 2003).

Chronic Diseases :

The rates of cancer, bronchitis, and other lung and skin diseases in the region around the Talcher-Angul industrial area, where air pollutants are heavy, are rising. These diseases are found high among the tribal population. It is because they are traditionally landless and have little choice but to live on the most undesirable land – the non-productive land closest to the mines; and they have no option to drink the water blackened by coal dust and toxic effluents.

Violating Environmental Standards

It has been found that the multinational companies are not only violating our national environmental standards but also they set lower standards for their activity. In April 1996, the World Bank revised its earlier 1994 guidelines for power plant emissions. The new guidelines double the limit for SO_2 emissions given in the 1994 guidelines, which ignore the standards set by the World Health Organisation. They fail to combat the alarming greenhouse gas emissions. In addition to other adverse conditions, as mentioned earlier, the high concentration of SO_2 and NO_x in Talcher-Angul region has caused acid rain and soil acidification and hence reduced crop yields. They have also strong negative impacts on human health.

CONCLUSION :

Lack of data concerning FDI and environmental and livelihood impact of mining in Orissa requires detailed analysis of the environmental and livelihood linkages to FDI. However, from the above evidences, it can be concluded with two suggestions: (1) as per the latest report of the CAG that the Orissa State Pollution Control Board should strictly enforce the Air and Water (Prevention

and Control of Pollution) Acts, and ensure that the environmental standards are maintained; and (2) the state should not offer huge subsidies, as provided through its Industrial Policy, to investors involved in mineral-based industries because they have no other Indian state to go. No other Indian state can match with the mineral resources of Orissa. By offering these subsidies to new investors, the state government has unnecessarily created a financial resource crunch which it plans to fill through the outright sale of public sector units and privatization of basic services, which directly affects the poor as they do not have purchasing power to afford basic services.

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Fiscal Discipline In Orissa And Reforms Of Development Strategy

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The widespread poverty and depressed standard of living among a large number of people of Orissa have posed serious threat to the socio-economic development. The reason of poverty and misery in the state is not essentially the lack of potentialities or resources, either human or financial but underutilisation and misutilisation of these resources. It is manifested in material deprivation of income and assets, social deprivation and intellectual deprivation of education skill and opportunities and deprivation of health and other basic minimum services.

ISSUES AND OBSERVATIONS

1. The poverty Scenario

Despite the abundance of natural resources such as forest, fisheries, metals, minerals and water, poverty figures show that 47.2% of the people live below the poverty line, much above the All India average of 26.10% as per the latest estimate made by the Planning Commission in 1999-2000. of the total people 86.62% live in villages and the rural poverty ratio (48.01%) is higher than urban poverty (42.83%). The nature of poverty in Orissa is spatial. It is 41.7% in coastal region while 68.5% in the southern region and 65.1% in the northern region. The poverty ratio among the S.T. and S.C. is higher in both rural and urban areas than that of other groups. By 1993-94, in the rural areas it is 63.6% among S.T., 40.5% among S.C. and 32.9% among others compared to urban area, where it is 58.6% for ST, 12.5% for S.C. and 31.6% for others. At 1993-94 prices, the per capita income of Orissa is Rs.5663/-, which is about 50% of the all India figure of Rs.10,254/-. Of the total population of our state, S.T.s constitute 22.12% and S.C.'s 16.2% compared to the all India average of 8.08% and 16.4% respectively. Various causes attributing to the poverty situation in Orissa are; under utilisation of existing natural and human resources, heavy population pressure, low agricultural productivity, inadequate infrastructural development and leakages of poverty alleviation programmes.

2. Fiscal Performance

Taxation, public expenditure and public debt constitute the fiscal triangle in the financial system. Growing non-developmental expenditure, low revenue

yield and mounting public debt have increased the revenue deficit. Orissa being an agrarian economy has low tax base.

A. Revenue Structure

Contrast to the heavy and unbearable salary and pension burden, unsustainable debt burden and rising debt servicing liability, the generation of revenue is quite inadequate. State's own tax and non-tax revenue taken together during 1997-98 was 6.01% of the GSDP, where tax revenue was 4.35% and non-tax revenue was 1.66%, lower than the neighbouring states, Bihar, Andhra Pradesh and Madhya Pradesh. The ratio of revenue to GSDP was, Sales Tax 2.83%, State Excise 0.32%, Tax on Vehicles 0.43%, Stamps and Registration 0.23% and Tax and duties on Electricity 0.39%.

The actual amount of revenue from Central shared taxes was Rs.2638 crores 61 lakhs as against the estimate of 3187 crores causing a deprivation of 548 crores at the end of 2001-2002. Hence emphasis to be laid upon generation of internal resources of tax and non-tax revenue. The return from non-Tax revenues like Royalty from forests, mines, water tariff, licence fee, fees on education, public health is not satisfactory.

B. Analysis Of Public Expenditure

Orissa is facing a major financial crisis of unprecedented nature. Expenditure on salary and pension was 180% of State's own revenue and nearly 80% of State's total revenue and consumes 11.41% of GSDP. Unsustainable salary and pension bill has imposed severe burden on the State Exchequer. The impact of the Fifth Pay Commission on the finances of the state has been very severe. Instability in the price level has added to the burden of paying additional D.A. to the employees. Increase in the committed expenditure and lack of accountability have added to the fiscal crises.

Orissa has been a low-income and high spending state. During the period 1991-92 to 1996-97 our total public expenditure was 23.5% of the GSDP, which is the highest among the 14 major states in the country for which the figure is 18.2%. Lowest internal revenue generation obviously compels the state to be heavily dependent on transfers from the centre including share of devolution in central taxes and the plan and non-plan grants; which were 10.5% of the GSDP during the above period as against our own revenue receipt from all tax and non-tax sources being only 6.14% of the GSDP in 1999-2000. Obviously, it makes Orissa's revenue base extremely fragile and over dependent on Central transfers putting to fiscal stress.

An overview of the fiscal trend shows that due to various reasons, it has not been possible to manage the State Finance strictly in accordance with the norms of prudent fiscal management. There has been concentration of expenditure on non-priority and unproductive sectors. Though Public expenditure itself has risen from the percentage of GSDP at 20.55% in 1980-81 to 26.2% of GSDP in 2001, the structural anatomy of the Govt. expenditure

reveals that there has been a shift towards non-capital and unproductive expenditures. The mounting revenue expenditure on staff, salaries, pension, interest payment and implicit unproductive subsidies has reduced the scope for much needed investment expenditure. The composition of public expenditure has shifted from capital investment to non-essential revenue expenditure. Capital expenditure as a percentage of the total budgetary expenditure has come down from 28.22% in 1980-81 to 11.1% in 1999-2000(RE).

C. Critical Imbalances, Deficit Situation And Public Debt

A serious mismatch between the receipt and expenditure has created a devastating financial condition and deterioration of the State Finances as an issue of serious concern. The widening gap between the revenue receipt and revenue expenditure has forced the Government to resort to higher borrowing. The financial crisis has become acute due to mounting revenue deficit and higher doses of borrowing. More than 3/4ths of the borrowings do not contribute to capital formation but go to salary, pension and debt servicing. Revenue deficit and fiscal deficit as a percentage of GSDP have been estimated to have increased to 6.4% and 11.8% respectively in 2003-04. Growing revenue deficit meets the current running expenditure, not the developmental expenditure. The unsustainable debt burden continues when the ration of debt of GSDP has increased from 28.52% in 1985-86 to 33.83% in 1995-96 and riser to 46% in 1999-2000, the highest among the 14 major states as compared to all states average of 24.33% of GSDP calculated by the Eleventh Finance Commission. Consequently, 35% of the total state revenue and central assistance is spent on meeting debt servicing charges. The total loan burden of the State Govt. as on March, 1991 was Rs.4539 crores, which has risen to Rs.18,000 crores by the end of the year 1999-2000. More than 90% of the State plan outlay is being financed from borrowing and the state have been adding to the debt burden of more than Rs.2000 crores per annum. While the State's GSDP is 2.23% of National GDP and its population constitutes 3.76% of the country's population, Orissa's share in total debt of all states constitutes 4.11%. Increasing debt servicing charges and debt liabilities have put the state in the debt trap. Despite the efforts of the State Govt., total expenditure exceeds revenue by 35.5%.

Following steps need to be taken for fiscal sustainability.

1. Poverty Reduction Strategy

Policy measures are needed on persistent and sustainable basis to reduce the incidence of poverty by generating self employment opportunities, provision of wage good at subsidised prices, wage payment linked to price index and productivity, widening social security measures, emphasis on social sectors like education, health etc. to provide minimum needs for the weaker deprived and underprivileged section, strengthening targeted public distribution system, subsidies on fertilizers for small and marginal farmers, right fixation of procurement prices, fiscal incentives to the entrepreneurs of

small scale and cottage industries, strengthening of Self Help Groups (SHGS), discrimination of price policy for Non-Timber Forest products for tribals and overall monitoring and evaluation of poverty alleviation programmes.

2. Public Sector Reforms

Profits of public enterprises and plough back of profits is an important source of capital formation and development. Of the total 36 Public Sector Enterprises at the operational stage in Orissa only 10 are operating with profit and are economically viable such as Orissa State Cashew Development Corporation, Orissa Hydro-Power Corporation, Orissa Construction Corporation etc. There is need to improve the productivity of others by increasing professional efficiency.

3. Smoothing the Financial Relation Between the Centre & the State

The Eleventh Finance Commission in its report recommended for drawing up the Medium Term Fiscal Reform Programme (MTFRP), which needs to dovetail time bound action with proper monitoring and flexibility.

4. Reforms for fiscal discipline-strategic financial planning and expenditure management reforms

Severe cut on populist programmes, cut down of wasteful and unproductive revenue expenditure on Govt. vehicles, official travels, office equipments, stationary etc. to make them cost-effective and result-efficient. A policy of austerity and best tightening measures need to be adopted and transparency in public expenditure be insisted upon.

5. Reforming Local Govt. Finance

Greater autonomy to the local govt. in staffing pattern spending local development fund within the framework of district plan and appropriate user charges by the Municipalities for providing public utility services.

The Orissa Power Sector Restructuring and Reform is an example of poor performance and ineffective operationalisation which needs a great deal of corrective measures such as rationalised and reasonable tariff structure, satisfactory consumers service by accurate metering and billing, uninterrupted power supply, use by energy efficient equipments, appropriate penalty for energy theft and so on.

If all these measures are taken expeditiously, Orissa may attain certain amount of fiscal discipline which may improve development strategy.

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New Economic Policy And Its Impact On Employment Of The Scheduled Castes In India

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INTRODUCTION

This paper makes an humble attempt to evaluate the impact of New Economic Policy on the employment situation among the Scheduled Caste population in India. It analyses literatures and evidences on the issues along with data over a period of 17 years from 1983 to 2000 and compares the situation of pre-reform period with that of post reform period. The paper is organized into three sections. Section-I deals with the issues and objectives of the analysis; Section-II examines the impact of New Economic Policy on the level of employment of the Scheduled Castes in India and reveals some findings and Section-III brings out conclusion and suggests some policy measures.

I

ISSUES AND OBJECTIVES

One of the major features of the New Economic Policy (NEP) is the move towards privatisation and hence increasing dependence on various markets such as markets for land, labour, capital, credit, output, consumer goods and social services. Under the regime of LPG (Liberalization, Privatization & Globalization) emphasis is put on free competition on a global scale. It is also believed that competition will increase efficiency in resource allocation, production and distribution of income, assets & wealth. However, it is worth mentioning that the poor without having command over resources except their physical labour get lost in the market. Therefore, the impact evaluation must focus on the plight of the poor especially, the Scheduled Castes & the Scheduled Tribes, the most vulnerable sections of the society. With this background the object of this paper is to make an assessment of the employment situation of the scheduled caste population in India by looking at the trend of changes of employment output ratio during pre-reform as well as post reform period.

The introduction of New Economic Policy has manifested in (i) withdrawal of the state from some of the sectors of the economy and (ii) reduction in govt. expenditure as a ratio/percentage to GDP (Gross Domestic Products)

particularly in economic services. The withdrawal of govt. may not affect one section in particular. The fall in govt. expenditure on economic services in general and agricultural and its allied activities in particular is expected to affect that section which is engaged in those services in large number.

As per the Census figure of 1991 Scheduled Caste people constitute 16.33% of the total population of India and 16.20% population of Orissa whereas Scheduled Tribe people constitute 8.01% of India and 22.21% of population of Orissa respectively. Therefore, the combined figures of SC & ST constitute 24.34% and 38.41% of the total population of India and of Orissa respectively. Most of the small farmers, marginal farmers, agricultural labourers and landless persons of the society at the national level as well as state level (Orissa) belong to these two main sub-set of the general poor of the society. Socially, their literacy rate is far below of the National level. As per the estimate of the planning Commission (1993-94) 45.80% of the total S.C. population are living below the poverty line. As such a number of provisions has been made to improve their economic and social condition.

The introduction of NEP has led to the withdrawal of the state from some of the sectors of the economy and permitting private sectors to control the commanding heights of the economy in the name of increasing efficiency and productivity. Unlike the govt. and the public sector, in the private sector there is no protection against discrimination in the various markets. And therefore, the Scheduled Castes will be increasingly exposed to the discriminatory operation of the markets without any protection in the form of Reservation Policy.

II

IMPACT OF NEW ECONOMIC POLICY ON EMPLOYMENT SITUATION OF SCHEDULED CASTES IN INDIA

As a part of the structural adjustment of New Economic Policy, when the general public expenditure is reduced mainly through decline in govt. expenditure, the purchasing power of the people falls leading to a reduction in the aggregate demand. As mentioned before the declining purchasing power could be something like in the range of three times of the original reduction in the govt. deficits. This fall in purchasing power and shrinking market at home for selling goods typically bring a loss of income and employment all around and hence increase poverty. There is evidence that substantial reduction in the govt. deficit reduces the trade deficit very significantly through a reduction in economic activity, i.e. fall in employment and output rather than simply reducing the rate of inflation in the country attempting stabilization. It may reduce the trade deficit only at a great social cost by reducing output and employment drastically.

Trend of changes in Employment of the Scheduled Caste during Pre-Liberalisation (before 1990s) & Post Liberalisation Period (1990s):

About three-fourths of the Scheduled Castes live in rural areas, where the main sources of income are either cultivation of agricultural land, wage labour or some kind of non-farm self-employment. Access to agricultural land for cultivation and capital for undertaking non-farm self-employment is critical. We now look at the trends in employment of the Scheduled Caste (SC) during pre-liberalization and post-liberalization period. Since more than 60% SC workers in rural areas and more than 30% in urban areas depend upon wage employment, their earnings are determined by the level of employment and wage rates. The SC workers seem to suffer from lower employment. Figures in Table 1 shows the employment rate for SC & others (Non-SC & ST). Two things emerge quite clearly from the analysis of this table. First, employment rate based on UPS for SC during 1977-78 and 1983-84 was higher compared with that during 1993-94 & 1999-2000. Subsequently, this employment gap between SC & Non-SC has reduced during 1999-2000. The SCs generally have a high component of marginal workers and so their employment rate is likely to be higher than others. The second point that has emerged is that since 1972-73 there has been a steady decline in the employment rate both for SC & Non-SC.

The figures in Table-2 show the unemployment rate of the SC vis-a-vis the others for 1977-78, 1983-84, 1993-94 & 1999-2000. The unemployment rate of SCs is much higher than that of other workers based on current weekly and current daily in those years. Unemployment rate based on current weekly status and current daily status clearly shows that the unemployment among SC workers is much more higher as compared with others. Here also two things appear clearly. Firstly, higher unemployment rate of SC workers indicates a possible existence of caste based discrimination against SC workers in hiring. Secondly, it is important to note that there has been a continuous decline in the unemployment rate under all status both for SC and others between 1977-78 & 1993-94. After 1993-94 however, there has been an increasing trend in the unemployment rate during the liberalization period. Thus, it is quite clear that during 1990s the employment rate has declined and there has been a corresponding increase in unemployment rate.

Deterioration In Quality Of Employment Of Scheduled Caste

The analysis of figures in Table 3 shows that in 1999-2000 only 16.4 per cent of all SC households cultivated land as (independent) self-employment worker whereas among the other (i.e. non SC/ST) the percentage was more than double 41.1 per cent. Only 28.40 per cent of SC household seem to be engaged in self-employment activities as compared to 55.90 per cent for others, in rural area. The limited access to agricultural land and capital assets is both due to the historical legacy associated with the restrictions of caste system to acquire means of income by the untouchables and ongoing discrimination in land market and capital market and other related economic spheres. The proportion of casual labour, however, was much higher at 26.5 per cent among the Scheduled Castes as compared to only 7.4 per cent among others. Thus, the proportion of casual labour in rural areas among the Scheduled Castes was

about four times higher others. A comparison of situations during 1980s and 1990s brings out the deterioration in the quality of employment particularly of the Scheduled Caste in the later period. There has been a decline in the percentage of household engaged in agriculture as self-employed cultivator accompanied by a corresponding increase in agriculture labour. There has been a noticeable change in the employment pattern in urban areas as well. In the case of SC worker the percentage of regular wage earner salaried has significantly declined and same is the case with respect to the employment in other jobs. Further in case of casual labour in Orissa where SC & ST people constitute about 40% of the total population, the percentage of SC members among casual workers has decreased during the post reform period when the SC casual labour increased by 2.46% during 1983-88 the same increased by only 0.64% during 1994-99.

Findings

(i) It is revealed from the study that there has been a decreasing trend in employment rate both for SC and others. After 1993-94, there has been an increasing trend in the unemployment rate during the liberalisation period but the unemployment rate based on current weekly status and current daily status clearly shows that under-employment and unemployment among SC workers is of much higher order as compared with other non-SC workers. Higher unemployment rate of SC workers, which is twice that of others, indicates a possible existence of caste based discrimination against SC workers in hiring;

(ii) Under the regime of competition, where market forces take economic decisions for increasing efficiency in allocation of resources, production and distribution of wealth and income, the poor especially the Scheduled Caste, without having command over resources except their physical labour get lost in the market;

(iii) Unlike the govt. and public sectors, in the private sector there is no protection against the discrimination in the market for land, labour, capital, credit and social services. And therefore the scheduled caste will be increasingly exposed to the discriminatory operation of the markets without any protection in the form of reservation policy. The study of Deshi & Singh (1995) has brought out the significant presence of caste & untouchability based economic discrimination in urban job market. They also observed that difference in jobs was associated with education and labour market distortion arising out of caste and religious background of persons. Banerjee & Knight (1991) in their study of the Delhi urban job market during 1975-76 observed that "Discrimination appears to operate at least in part through traditional mechanism, with untouchables disproportionately represented paid (low paid), dead end jobs";

(iv) The Karnataka study that nearly 85% of respondents continue with

their traditional occupation and only 15% could make a switch from traditional occupation to other new occupation. In the urban areas, however, 56% express a shift in the traditional occupation. The study in Andhra Pradesh reveals that when untouchables wanted to switch over from their traditional occupation in rural areas to some other occupation they were abused and beaten. In Orissa, it was observed that in the case of OBC like barbers of Brahmagiri area of Puri District when they refused to carry on their professional job of washing down and cleaning the feet of higher castes during marriage ceremony and other occasions they were beaten and abused by the so called higher castes and even they were threatened to leave the village.

(v) After the introduction of the New Economic Policy, there has been a substantial decreasing in govt. expenditure on economic services in general and agriculture and its allied activities in particular which has led to a decline in opportunity or access to job market on the part of SCs.

IV

CONCLUSION

It is concluded from the above analysis that after the introduction of NEP the rate of employment among the scheduled caste population has fallen and it has aggravated the incidence of their poverty. Ultimately it has widened the gap of inequality between the SCs & Non-SCs. As the plight of SC people deteriorates due to decline in employment level arising out of social and economic discrimination the issue of employment which is economic can not be separated from the social issues. Therefore, the policy suggestions include both social and economic aspects of the society for the betterment of down-trodden and oppressed class. The suggestions are:

TABLE-1

All India-Employment Rate (% of employment to total population)-Male

Years	Scheduled Caste				Others (Non-SC & ST)			
	UPS	UPSS	CW	CD	UPS	UPSS	CW	CD
1977-78	63.50	NA	60.81	54.58	60.98	NA	59.46	56.28
1983-84	62.24	64.95	58.80	53.09	60.21	62.56	55.78	55.75
1993-94	54.90	56.70	54.50	52.90	54.40	55.60	54.30	53.30
1999-2000	52.90	53.10	54.50	46.20	52.40	52.60	50.50	47.60

TABLE-2

Unemployment Rate

Years	Scheduled Caste				Others (Non-SC & ST)			
	UPS	UPSS	CW	CD	UPS	UPSS	CW	CD
1977-78	1.23	NA	2.93	6.73	1.57	NA	2.15	3.90
1983-84	1.10	0.76	3.22	7.16	1.30	1.90	2.15	4.03
1993-94	0.90	0.60	1.97	4.30	1.20	0.90	1.60	2.70
1999-2000	1.20	1.00	2.50	5.00	1.60	1.20	2.50	3.50

Sources : National Sample Survey (1977-78, 1983-84, 1993-94 & 1999-2000)

Note : UPS - Usual Principal Status, UPSS-Usual Principal and Subsidiary Status, CW-Current Weekly Status, CD-Current Daily Status.

TABLE-3

Percentage Distribution of Household by Household Type in Rural Areas

Household Type	Scheduled Caste			Others			Ratio (SC to others)		
	1987	1993	1999	1987	1993	1999	1987	1993	1999
Self Employed in Agriculture	18.9	20.1	16.4	43.3	43.32	41.1	0.44	0.46	0.40
Self Employed in Non-Agriculture	11	10.7	12	13.8	14.42	14.8	0.80	0.74	0.81
Agricultural Labour	51.7	49.3	51.4	23.2	23.2	19	2.23	2.13	2.71
Other Labourer	11.4	10.2	10	7.9	6.9	6.3	1.44	1.48	1.59
Others	6.9	9.7	10.2	11.5	12.1	18.7	0.60	0.80	0.55

Sources : National Sample Survey (1987-88, 1993-94, 1999-2000)

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Impact of fiscal reforms in the economy of Orissa

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Economic reform is a curious mixture of short term stabilisation policies and long term structural adjustment programmes started in India in June 1991. The fiscal reform is an important component of economic reforms. Orissa is one of the least developed and poorest state in India where 47.15% people live below the poverty line compared to all India average of 26.10% according to the Planning Commission estimate in 1999-2000. The schedule tribes and schedule castes constitute 22.12% and 16.20% respectively compared to all India average of 8.08% and 16.48%. The poverty is more concentrated in rural area specially among the SC & ST population.

There is a major financial crisis in Orissa where salary and pension together are more than 180% of states own revenue and nearly 80% of total revenue. The economic reforms initiated in 1991 has not recovered the economy of Orissa from the unprecedented fiscal crisis. Approximately 82.62% people of Orissa live in villages which is 4th highest only after Bihar, Assam, Himachal Pradesh. The per capita income of Orissa is the third lowest only above Bihar and Assam. The Orissa economy is growing at 3% per year compared to national growth rate of 6%. The govt. employees are 5.80 lakhs which are the highest in the country. The outstanding loan is Rs. 21073 crore which was 15% of gross state domestic product in 2001.

OBJECTIVES :

The objectives of this research paper is to analyse the impact of fiscal reform on revenue and expenditure profile of Orissa. The specific objectives are follows.

(i) To find and compare the growth rate of salary, pension and total revenue of Orissa before and after reform.

(ii) To estimate the growth rate of tax and non-tax revenue share from central tax and grant in aid.

(iii) To analyse the relative position of different sources of revenue as a proportion of gross state domestic product.

(iv) To investigate the inter-state comparison and position of Orissa in revenue.

IMPACT OF FISCAL REFORMS ON REVENUE EXPENDITURE :

The economic reforms emphasized on reducing the fiscal deficit by decreasing the expenditure on govt. employees. The World Bank and International Monetary Fund warned the State Govt. of Orissa for reducing the number of employees. The growth rate of salary, pension & total revenue are compared in table-1 to analyse the impact of fiscal reform on salary of employees.

TABLE-1

Salary, pension and revenue growth rate.

Year	Salary	Growth Rate	Pension	Growth Rate	Total Revenue	Growth Rate
1980-81	221.70	--	7.29	--	266.29	--
1990-91	883.34	29.84	73.97	91.47	869.92	22.67
1995-96	1767.6	20.02	194.35	32.55	1755.42	20.36
1996-97	2064.03	16.77	252.72	30.03	1823.82	3.89
1997-98	2626.36	27.24	316.83	25.37	1962.66	7.61
1998-99	3399.06	29.42	475.3	50.12	2044.62	4.18
1999-2000	3807.11	12.00	688.41	44.84	2421.39	18.43
2000-01	3987.88	4.75	719.7	4.55	3174.6	31.11

The growth rates in table are average annual percentage growth rates.

The average annual growth rate of salary was lowest, 4.7% in 2000-01 and it was highest in 1990-91. However the growth rate of salary expenditure in monetary terms is above 20% upto 1998-99 and thereafter it has declined. Similarly the pension growth rate is higher than salary growth rate. It is lowest 4.55% in 2000-01 but it is 91.47% in 1990-91. The pension growth rate is higher than 30% in 1995-96 compared to 1999-2000. There is no correlation between the salary growth rate and revenue growth rate of the Govt. of Orissa.

Impact Of Reforms On Revenue Structure Of Orissa.

There are four sources of revenue of Govt. of Orissa such as :

(a) Own tax revenue.

(b) Own non-tax revenue.

(c) Share of tax from Central Govt.

(d) Grant in aid (GIA) from centre.

The growth rate of revenue from all above sources are compared below to analyse the impact of reforms on the revenue profile of Orissa. The growth rate of own tax revenue is the highest 36.26% in 2000-01 due to introduction of new professional tax and increase in excise revenue. The growth rate of non

tax revenue is highest in 1999-2000 which is 28.67% but it is negative in 1996-97. The grant in aid from centre has uneven growth which decreased in 1998-99 by -26.27% but it increased by more than 10% after 1999. Similarly the share of the state govt from central tax was negative in 1997-98 and it is highest in 2000-01 (28.79%.) The table clearly implies that the total revenue growth rate has improved after 1999 but it was negative 1998-99. This is due to the political instability and fall in N.D.A. Govt. within one year in 1998-99. There is positive correlation between the town the own tax revenue and tax share from Central Govt. The tax and non-tax revenues are inadequate and they are in contrast to unbearable salary and pension burden, unsustainable debt burden and ever rising debt servicing liability. The own revenue of Orissa Govt. is only 6.01% of GSDP which is one of the lowest when compared to other states. The gap between the revenue receipt and revenue expenditure is growing at an alarming rate forcing state Govt. to higher state of borrowing. There may be total break down of the fiscal situation of the state of Orissa by 2008. For every Rs.100 investment Orissa has to borrow Rs. 424 which is disastrous and a situation of fiscal bankruptcy.

SOURCES OF REVENUE AND GSDP :

The sales tax is the major source of own revenue of Orissa Govt. which is 2.83% of GSDP in 1997-98 and reduced to 2.10% in 2001-02. The motor vehicle tax is second important source of revenue which is 0.41% of GSDP followed by electricity duty (0.34) and state excise duty (0.31).

These sources of revenue must be improved so that total own revenue collection exceeds the salary and pension expenditure.

Inter State Comparison Of Revenue :

The comparative position of revenue of Orissa is also distressing compared to many other states as shown in Table–3

TABLE–3

Percentage of Revenue to GSDP in different States.

State	Own Tax Rev.as % of GSDP	Own Non-Tax Rev. as % of GSDP	States Rev. as % of GSDP
Andhra Pardesh	8.05	2.02	10.07
Madhya Pradesh	6.44	2.85	9.29
Maharashtra	7.53	2.00	9.52
Orissa	4.35	1.66	6.01
Tamil Nadu	9.44	1.28	11.22
Rajasthan	6.88	2.60	9.48
Uttar Pradesh	5.38	0.99	6.38
West Bengal	5.05	0.50	5.55

TABLE -2

Sources of Revenue and their growth rates

Year	Own-tax revenue	Gth Rate	Own-nontax revenue	Gth Rate	Share tax from Centre	Gth Rate	GIA	Gth Rate	Total Revenue	Gth Rate
1980-81	--	--	--	--	--	--	--	--	621.35	--
1990-91	--	--	--	--	--	--	--	--	2170.94	24.94
1995-96	1127.19	--	628.23	--	1284.93	--	850.36	--	3890.71	15.84
1996-97	1342.04	19.06	481.78	-23.31	1565.98	21.87	896.96	5.48	4286.76	10.18
1997-98	1421.73	5.94	540.93	12.28	1563.61	–0.15	1105.76	23.28	4632.03	8.05
1998-99	1487.13	4.60	557.49	3.06	1694.52	8.37	815.26	–26.27	4554.4	–1.68
1999-2000	1704.09	14.59	717.3	28.67	1748.45	3.18	1715.62	10.44	5885.46	29.23
2000-01	2322	36.26	852.61	18.86	2251.84	28.79	1963.76	14.46	7390.2	25.57

Own tax revenue of Orissa percentage of GSDP is only 4.35% compared to highest 9.94% of Tamil Nadu followed by 8.05% in Andhra Pradesh and 7.53% in Maharashtra. The percentage of own non-tax revenue is only 1.66% compared to 2.85% in Madhya Pradesh, 2.60% in Rajasthan and 2.02% in Andhra Pradesh. The states total own revenue as percentage of GSDP of Orissa is only 6.01% which is lower than that of Tamil Nadu, Andhra Pradesh, Maharashtra, Madhya Pradesh, Rajasthan and Uttar Pradesh. Hence Orissa is laying behind in both tax and non-tax revenue collection compared many other states. It is apparent that the revenue departments of Orissa are not effective enough to generate sufficient revenue for the state.

SPECIFIC SUGGESTIONS :

In view of alarming fiscal situation of Orissa it is strongly left that the fiscal reform has been effective in the state till 1999. It is only after 2000 State Govt. has awaken up to restructure its fiscal system. The following suggestions are forwarded to solve the economic crisis of the state.

(i) The fiscal governance reform programme must be seriously implemented to correct the critical imbalances in fiscal situation of the country.

(ii) The size of Govt. employees should be reduced below 41 lakhs by merging different departments and reducing particularly the number of class-III employees by providing voluntary retirements.

(iii) The revenue collection must be increased by checking the leakages in revenue stream and controlling corruption.

(iv) The unproductive expenditure needs to be reduced by contractual appointment at low consolidated salary to employees appointed in case of bare necessity.

(v) The professional tax rates on monthly income above Rs.2000 must be increased to above Rs.1000.

(vi) The grant-in-aid from centre needs to be utilised properly and central assistance to state should increase at higher rate.

(vii) The growth rate of Orissa economy is at 3% per annum which must be accelerated above 5% from 2005.

(viii) The public corporation and Board need to be restructured without any political interference into their management.

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Impact of Economic Reforms on Social Sector of India

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Economic reforms of the current decade is only aiming at instant economic growth. But social investments are required for sustained economic growth. India ranks very low in terms of social indices like HDI, GDI, GEM, OEI, DALY etc. The social obligation of the state is gradually diminishing. Education, literacy, health, women and child development, welfare of backward castes and less privileged groups have recorded uneven progress in the entire country even after 13 years of implementation of Economic Reforms. Social sector called as *Soft Sector* is the most neglected sector in India. It accounts for only 10 to 11.% of the total expenditure of the Government. It is found that whenever the Govt. faces any financial crunch– health, education, housing, welfare of the poor had to bear the brunt. The budgetary allocation for education and health as percentage of GDP remains very meagre at present. Expenditure on health stands at 1.37% of GDP whereas it is 2.1.% in China. Spending on education has increased from 0.8% in 1950 to 3.2% today though it still falls short of the Government target of 6% of GDP but it is only 2.3% in China.

IMPACT ON HEALTH SECTOR

The modern concept of human development depends upon the education and health status of the people. But unfortunately in India, after five decade .of independence, these two are the most neglected and untouched areas found by the Govt. The slogan, "Universalisation of Primary Education" and "Health for All" has become a myth for the majority of poor Indians even after the adoption of Economic Reforms since 1991. Public health services were poor in terms of access and quality even during the pre-reform period. Gender inequality in access and caste continues to be severe. Deregulation of drug prices, deterioration of public hospitals combined with growing subsidies to private hospitals and a range of other privatization measures are at present a source of uncertain effects in the country. Inequality and disparity between rich and poor in terms of untreated illness appears to have worsened and expenditure on health services as well as in the use of both public and private health care institution has grown. The class-based inequality in access to health services have worsened for both men and women and it is of course more pronounced in case of poor women than men. There is predominance of private sector in health care and in its rapid growth. Government hospitals

have their own limitations in terms of inadequate funding, overcrowding, corruption, and lack of cleanliness. On the other hand overcharging, excess medication, and testing or unnecessary treatment made by the private sectors make the patients more harmful physically and financially. The poor suffer more than the rich because of their unethical practices.

Another major weakness in the Public Health care System is poor performance of Primary Health Centres, which have fragile existence in the rural areas. There is dualism in the provisions of health facilities. Often villages are found without having any doctor. Even if some doctors are there, adequate medicines are not available in those hospitals. The IMR among the rural population in India is highest (68 per 1000 live birth), in the world and Orissa ranks first (92 per 1000) in the country.

In order to improve the performance of the health sector the Government needs to increase the public expenditure and to allocate more resources. However along with this the efficiency of public spending has to be improved. More resources should be spent on preventive care to benefit the poor. Primary health care services should be accountable to promote common health insurance scheme in order to provide health services at low cost to the poor.

IMPACT ON EDUCATION

(i) Primary Education

So far as education is concerned, more than 50% of world's illiterates live in India. The design of primary education is not at all conducive to rural and tribal children. It is high time to admit that the problem lies with defective, deficient, and irrelevant rigid educational system. Sometimes in remote rural areas, there is no trace of any school, and even if some schools are established by Govt. agencies, the teachers are reluctant to serve there. Moreover, the targeted pupils lack attitude for studies and there is no motivation from any corner to develop the same. These factors are ultimately reflected in the level of knowledge acquisitions and performance in examinations. Hence the rate of illiteracy is very high in backward areas. In India literacy stands for 65% whereas in China it is 84%. The inadequate institutional facilities and inefficient educational system has not only resulted in high 'dropout' rate but also 'push out' rate in the school. The demand factors are important in influencing the extent of literacy and dropout rates and supply or quality factors influence enrolment rates. Poverty in backward regions and rising demand for labour in developed regions are the most important reasons for dropouts. Indirect cost of education like uniform and transport is substantial; hence dampen the demand for education. There is a need for an integrated approach in order to bring children to school and retain them. Even the introduction of Mid-Day Meal scheme by the state Govt. has become failure as the steps could not retain children in the primary schools in most of the rural areas. The demand and supply factors like low literacy of parents, poverty, lack of access to school and poor infrastructure facilities, lack of attitude of teachers due to irregular

payment of salary are the main causes of low literacy rates. In order to bring universalisations of education to all children in the age group of 6-14 years, the State Govt. should play a pro-active role to improve supply side factors like access to school, increase in the number of teachers and enhance the quality of teaching and by facilitating better infrastructure and moreover regular salary payment.

1. More resources have to be allocated by Govt., particularly, for primary education as fund allocated towards it, is very meagre.
2. The quality of education in terms of curriculum, better infrastructure and teaching has to be improved.
3. Social mobilisation of the community against child labour, intensive institutional and educational management should be made to retain the children in school.

(ii) Higher Education

The reform policy also deeply affects the field of higher education, in terms of both content and access to education. So far as content is concerned, the opening up of the economy has increased the requirement of professionals in the field of economics, banking, law, marketing, management, engineering and information technology etc.– having little interest in theoretical subjects like science and mathematics. As a result of international trade there is pressure upon old universities like Punjab and Delhi to open certain new subjects like Computer Application, Business Economics, Business Administration or Human Resources Development since UGC is reluctant to fund the courses. New courses are started with high tuition fees which act as a constraint for the common students to take admission. On the other hand traditional subjects like philosophy, history, literature, religious studies are losing their values.

The present Globalisation policy has made the whole country a big market and educational institutions are like various Shopping Centres, where the price of teaching and learning is determined by the market forces of demand and supply. Private institutions have started a mushroomed growth in the country. They design their own course, catering to the need of MNCs which make access to such institutions difficult specially for the poor students. The products of IITs, IIMs, and graduates of economics are being lapped up by MNCs with lucrative salaries. Sometimes it is seen that some rotten foreign universities and management institutes are holding educational fairs in their embassies and 5 star hotels in big cities to attract the Indian students from upper income groups to their countries by offering them various lucrative jobs with high salaries, with an objective of making enoromous profit rather than serving the educational needs of the country.

Universities have gradually become deserts due to this policy of commercialization of education. It also leads to the creation of a pool of contract teachers in both colleges and universities which is not at all conducive to the

Indian situation unlike *Body Shopping* which is a common practice in the western countries under which professionals like engineers and doctors are being engaged in attractive terms. They may be in USA today, Canada tomorrow, and Germany after a week .Undoubtedly the practice of contract teaching not only fails to provide value-based education but also helps in deteriorating the quality of teaching.

Besides, large scale recruitment of Indians as teachers for schools in USA and UK is a recent phenomena. This is due to paucity of skilled teachers in those countries because of market forces. It is easier and less expensive to give a six months orientation programme to their guest teachers rather than invest in producing large number of teachers to fill up the teaching vacancies. The irony is that, on the one hand England wants Indian teachers to come and teach school students in their country, on the other hand the rich Indian parents want their children to pass 'O' level in the elite school like DPS etc. to qualify themselves to study in British Universities.

CONCLUSION

Although nearly one-third of the total outlay on education in India is spent on higher education, it reaches hardly 10% of the appropriate group, mostly the children of middle and upper income groups, which perpetuates the gross inequalities and injustice in the income and social status related to the level of higher education. Therefore it becomes the major responsibility of the Government to promote value-based education by making huge investment on the human capital, specially in areas like education and health, and ensure equity and justice by putting a check and balance through proper regulations on the private sector. In order to reap the benefits of economic reforms Indian Govt. has to play a proactive role in bringing reforms both in health and education sector. Social sector reforms is warranted along with economic reforms in India.

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Health Service System in Orissa

An Enquiry into the Public Health Care Delivery System in Orissa

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SECTION - I
INTRODUCTION

1.1 Health–Development Interface

Economic development and human health are interrelated. Development brings persistent increases in per capita income and significant improvements in health status. Health is a major determinant of the quantity and quality of human resources, productivity growth and economic development. By increasing the longevity and improving the strength, stamina and efficiency of the work-force, better health makes significant contributions to accelerated economic development. It is reasoned that children who enjoyed better health and nutrition in their pre-school years and those who are healthy and well-fed in their years of education usually achieve higher success rates both at education and in the future.

1.2 Concern for Health:

However, the concern for health is relatively recent. The goal of improving health conditions was accorded priority only in the 1970s as part of equity oriented development strategies in the less developed countries. It attracted special attention of the policy makers and planners with UNDP's annual series of Human Development Reports initiated in 1990 and its emphasis on Human Development Index as a holistic measure of living levels. Health has large externalities and promotion of health is now seen as social concerns.

Public provision of health care is also an instrument of equity. It can be an effective means of reducing economic disparities between the rich and the poor, urban and rural areas, and accessible regions and less accessible pockets. There is thus a strong case for state provision of health care and for regarding health expenditure as investment in human capital for increasing labour productivity and economic growth, and improving the quality of life and social welfare.

1.3 Unit of Study:

This article focuses on the state of health in Orissa in general and in rural Orissa in particular. We realize that the central government has a considerable

influence on the policies and expenditure in the states in the Indian system. But as per the provisions of the constitution, health is the responsibility of the states. Thus analysis of health care in the states has a merit. Coming to the states we find that Orissa is one of the poorest states in India. The incidence of poverty (47.15% in 1999-2000) and the infant mortality rate (90 in 2001) are very high and life expectancy at birth (61 years in 2001) is low in the state. The nature of development in the state has also been highly uneven during the plan period. To examine different health related issues we have therefore selected Orissa as the unit of our study.

1.4 Objectives:

The broad objectives of the study are:

(i) To highlight the reciprocal nature of health -development relationship,

(ii) To present a picture of the state of health in India vis-a-vis some selected countries of the world and of Orissa vis-a-vis India,

(iii) To measure the extent of disparity in health infrastructure among the districts in Orissa, and

(iv) To examine the effectiveness of public health care facilities in rural Orissa on the basis of a household health survey.

1.5 Data & Methods:

The study is based on both primary and secondary data. Simple statistical tools such as percentages and coefficient of variation are used to interpret data relating to a cross section of households and areas and draw conclusions therefrom.

1.6 Limitations:

The paper draws on the data from different secondary sources and a field survey. Hence the conventional limitations of data sources apply to the study. The responses in the survey are a reflection of the feelings, observations, judgments and memories of the respondents, and were not verifiable from any record(s). Therefore, the results may not have universal applicability.

1.7 Framework of the study:

The study is designed in six sections. Section I being introductory highlights the interconnectedness of health and economic development, introduces the research problem, sets the objectives and pinpoints the limitations of the study. A comparative picture of the state of health in India and Orissa is presented in Section–II. In section–III the health scenario at the district level and the uneven nature of health services in the districts of Orissa are discussed. The user fees issue is examined in Section–IV and the results of household health survey are analysed in Section–V. Section–VI summarises the main conclusions of the study.

SECTION – II

STATE OF HEALTH CARE IN ORISSA–A COMPARATIVE ANALYSIS:

Health services are an important area where public policy and government expenditure play a major role all over the world. International comparisons of government expenditure on health and related performance indicators are presented in Table–1. The table reveals that the ratio of public spending on health to GDP and the share of government expenditure in total health expenditure are the highest in high income countries followed by middle income and low income countries. This represents a paradoxical situation in so far as the high income countries are mostly free market economies. In India, public expenditure on health accounts for a mere 0.9% of GDP. This is lower than the health expenditure – GDP ratio for the low income countries as a whole (1.1%) and is much lower than that of Bangladesh (1.4%), China (5.3%) and Sri Lanka (1.8%). The share of public expenditure on health to total health expenditure in India (17.8%) is one of the lowest in the world. It compares very poorly to those for the group of low income countries (27.1%), for Bangladesh (36.4%), China (36.6%), Pakistan (22.9%) and Sri Lanka (49%). In terms of select performance indicators such as life expectancy at birth and infant mortality rate our achievements are dismal when compared even to those in Sri Lanka.

TABLE - 1

Health Expenditure and Selected Performance Indicators Across Countries

Group of Countries/ Country	Public Expenditure on Health as per cent of GDP in 2000	Percentage share of Public and Private Expenditure in total Health Expenditure in 1997-2000		Life Expectancy at Birth in years in 2001	Infant Mortality Rate per 1000 live births in 2001
		Public	Private		
1.	2	3	4	5	6
High Income Countries	6	62.2	37.8	78	5
Middle Income Countries	3	51.8	48.2	70	31
Low Income Countries	1.1	27.1	72.9	59	80
Bangladesh	1.4	36.4	63.6	62	51
China	5.3	36.6	63.4	70	31
Germany	10.6	75.1	24.9	78	4
India	0.9	17.8	82.2	63	67

Pakistan	0.9	22.9	77.1	63	84
Sri Lanka	1.8	49.0	51.0	73	1.7
U.K.	5.9	81.0	19.0	77	6
U.S.	5.8	44.3	55.7	78	7

Source : World Bank (2003), World Development Indicators.

In India, state governments account for a majority share of the total social sector expenditure in general and health expenditure in particular. But despite all rhetoric on human development, health continues to be a field of low priority and the share of state expenditure on health in both total state expenditure and state domestic product has remained low in most of the states. The gap in per capita state expenditure on health between the highest and lowest spending states has also widened over the years. Performance of different states in terms of select health indicators such as life expectancy at birth, infant mortality rate and number of persons per health centre, per doctor and per bed also reveals large differences.

Orissa compares very poorly with the national scenario in respect of per capita state expenditure on health, life expectancy at birth and infant mortality rate. Relevant data are presented in Table-2. It can be seen from the table that per capita state expenditure on health is lower in Orissa (Rs.144.57) when compared to that for India as a whole (Rs.176.11). The share of per capita public expenditure on health in total per capita state expenditure in Orissa is also lower (4.25%) than the national average (4.55%). Life expectancy at birth is lower and infant mortality rate higher in the state relative to those for the nation. Only in terms of the share of per capita public expenditure on health in per capita domestic product Orissa's figure (1.0%) is slightly above that for the country (0.9%). The numbers of persons served per health centre and per doctor in the state are far greater than those at the all India level.

TABLE - II

State of Health Care – Orissa Vs. India

	Per Capita Public Expenditure on Health			Life Expectancy at Birth in years in 2001	Infant mortality rate per 1000 in 2001
	Rs. In 2001-02	As per cent of Domestic product in 2001-02	As per cent of per capita public expenditure		
India	176.11	0.9	4.55	63	67
Orissa	144.57	1.0	4.25	61	90

Source : Government of India (2004), Economic Survey -- 2003-04.

Government of Orissa (2004), Economic Survey – 2002-03.

SECTION – III

DISTRICT LEVEL SCENARIO

Orissa has an extensive health care delivery system with 03 medical college hospitals, 31 district head quarters hospitals, 21 sub-divisional hospitals, 125 other hospitals, 1508 health centres and 13 mobile health units totaling 1701 as on 31.01.2003. This, however, does not mean that the public health care facilities are well developed in the state. The state has a fairly higher concentration of depressed category (SCs & STs: 38.66%) and rural (85.03%) population, and many less accessible pockets. Economic development in the state has also been highly uneven among different regions. Thus viewed, macro level data are a grossly inadequate measure of the performance of the health care system across space. A study of the system at the district level is, therefore, important in its own right.

Relevant data are presented in Table–3. For purposes of comparison we have constructed composite health development index (CHDI) of health infrastructure for each of the 30 districts of the state on the basis of five indicators viz., number of persons served per health facility, number per doctor and number per bed, and area served per health centre & per doctor. Each of these five indicators is assigned equal weight for the sake of simplicity. We have calculated the coefficient of variation in respect of these indicators and composite index values as a measure of inequality to show the disparity in health services across districts in the state.

The coefficient of variation is found to be very high for the number of population covered per health centre (17.16%), per doctor (36.18%) and per bed (59.38%), and for average area covered per health centre (56.13%) and per doctor (63.92%). It is also very high (37.56%) in the case of the composite index. Looking at the composite index values for different districts we see that out of the 30 districts in the state only 13 have index values of more than 100 & hence may be termed as developed districts so far as the public health care facilities are concerned. They are Cuttack, Sambalpur, Khurda, Ganjam, Kandhamal, Jagatsinghpur, Puri, Balasore, Malkangiri, Nayagarh, Bhadrak, Jajpur, and Kendrapara in the descending order. It is disheartening to note that barring only three i.e., Sambalpur, Kandhamal and Malkangiri, the rest ten are parts of the four erstwhile coastal districts and are also easily accessible to the two medical college hospitals located at Cuttack and Berhampur. Of the three other districts in the medically developed category, Sambalpur has a favourable composite index because it has a small population and a medical college hospital and Kandhamal and Malkangiri are very thinly populated. The remaining 17 districts are less developed with very low composite index values. Boudh, Angul, Nuapada, Deogarh and Nabarangpur are found to be the least medically developed states in that order.

Thus the health service system in the state exhibits large disparities across districts. Worse still, there is a wide gap between the data presented in

TABLE -3

Health Services at the District Level - 2001.

Sl. No.	Name of the District	Population Served Area Per Hlt.Cntr.	Per Doctor	Per Bed	Per Hlt. Cntr.	Served Per Doctor	Score 3	Score 4	Score 5	Score 6	Score 7	CHDI overall score	Rank
1.	2	3	4	5	6	7	8	9	10	11	12	13	14
1.	Angul	26496	9907	3538	148.3	55.4	81.45	74.93	74.70	61.70	56.86	69.93	29
2.	Balasore	23524	10818	4277	44.3	20.4	91.74	68.62	61.80	206.55	154.41	116.62	8
3.	Bargarh	22807	11701	5404	98.9	50.8	94.62	63.44	48.91	92.52	62.01	72.30	28
4.	Bhadrak	22204	13735	4880	41.8	25.8	97.19	54.04	54.16	218.90	122.09	109.28	11
5.	Bolangir	22263	8096	3050	109.6	39.8	96.93	91.69	86.66	83.49	79.15	87.58	19
6.	Boudh	23315	9817	5329	193.6	81.5	92.56	75.61	49.60	47.26	38.65	60.74	30
7.	Cuttack	28897	3888	1205	48.5	6.5	74.68	190.92	219.34	188.66	484.62	231.64	1
8.	Deogarh	22841	8062	2323	245	86.5	94.48	92.07	113.78	37.35	36.42	74.82	26
9.	Dhenkanal	22208	7725	2769	92.8	32.3	97.17	96.09	95.45	98.60	97.52	96.97	15
10.	Gajapati	17282	7624	2605	144.2	63.6	124.87	97.36	101.46	63.45	49.53	87.33	20
11.	Ganjam	25925	5964	2036	67.8	15.6	83.24	124.46	129.81	134.96	201.92	134.88	4
12.	Jagatsinghpur	22969	12006	7139	36.3	19	93.95	61.83	37.02	252.07	165.79	122.13	6
13.	Jajpur	23184	14362	7277	41.4	25.7	93.08	51.69	36.32	221.01	122.57	104.93	12
14.	Jharsuguda	23139	9790	4713	94.6	40.0	93.26	75.82	56.08	96.72	78.75	80.13	24
15.	Kalahandi	21522	7990	2718	127.7	47.4	100.27	92.90	97.24	71.65	66.46	85.70	21

16.	Kandhamal	11570	4319	1596	143.2	53.5	186.52	171.87	165.60	63.90	58.88	129.35	5
17.	Kendrapara	23670	12282	4858	48.1	24.9	91.17	60.44	54.41	190.23	126.51	104.55	13
18.	Keonjhar	18590	7887	3111	98.8	41.9	116.08	94.12	84.96	92.61	75.18	92.59	16
19.	Khurda	23141	8011	2819	34.7	12.0	93.25	92.66	93.76	263.69	262.50	161.17	3
20.	Koraput	18122	7316	3375	135.5	54.7	119.08	101.46	78.31	57.53	57.59	84.79	23
21.	Malkangiri	12314	5650	1679	148.5	68.1	175.25	131.38	157.42	51.62	46.26	114.38	9
22.	Mayurbhanj	19320	7935	2798	90.6	37.2	111.70	93.55	94.46	100.99	84.68	97.08	14
23.	Nabarangpur	20363	10285	4314	105.8	53.4	105.98	72.17	61.27	86.48	58.99	76.98	25
24.	Nayagarh	17279	8307	1777	77.8	37.4	124.89	89.36	148.73	117.61	84.22	112.96	10
25.	Nuapada	23066	8557	3358	167.5	62.1	93.56	86.75	78.71	54.63	50.72	72.87	27
26.	Puri	22440	9028	2398	53.5	21	96.17	82.22	110.22	171.03	150.00	121.93	7
27.	Rayagada	16796	7914	3658	144.3	31.4	128.48	93.80	72.25	63.41	100.32	91.65	17
28.	Sambalpur	20642	2288	816	147.9	16.4	104.54	324.43	323.90	61.87	192.07	201.36	2
29.	Sonepur	20795	8582	3534	89.9	37.1	103.77	86.49	74.79	101.78	84.91	90.35	18
30.	Sundargarh	22310	8241	2994	118.4	43.7	96.73	90.07	88.28	77.28	72.08	84.89	22
St. Dev.		3702.2	2685.7	1569.4	51.36	20.14						37.56	
Orissa		21580	7423	2643	91.5	31.5						100.0	
C.V.		17.16	36.18	59.38	56.13	63.92						37.56	

Hlt. Cntr. - Health Centre

Area in Sq Km

Source : Government of Orissa (2002), Statistical Abstract of Orissa

(2003), Economic Survey - 2002 - 2003.

(2003), Directorate of Health Services, Bhubaneswar.

Table-3 and the ground realities in the rural areas and tribal regions in the state. Like most low income countries of the world, the capital city, the millennium city, and other major and minor urban areas and towns in the state usually have several times as many doctors and public health facilities relative to the rural areas, highland villages and tribal pockets in Orissa.

It has repeatedly come in the mass media that in the remote areas and backward tribal pockets in Orissa public health care units run with skeleton staff, irregular timings, and unwilling staff, and offer slipshod and half hearted treatment. In some cases, the nurse, the pharmacist and the doctor are seen attending the health centre alternately for a very short time twice or thrice a week. Long periods of unauthorized absence are also not uncommon in the less accessible and disadvantageously located places. In many villages consulting a doctor in emergencies in a luxury and people fall preys to quacks, black magic and spirit worships. Thus the public health care delivery system has become dysfunctional in the rural hinterlands and is not working the way it is desired to.

SECTION - IV

HEALTH SERVICES AND THE MARKET:

The economy of Orissa is in a terrible fiscal crisis and health services are severely underfinanced. In this background the possibility of financing health services through the market has been experimented in the state. As a first step the government introduced user fees in the three medical college hospitals in the state in 1997. Improvement in the health service system and development of the big hospitals through partial self-financing were the basic objectives of this policy. The user fee system was later extended to the district headquarters hospitals and others. A further extension of the system to all the public health care facilities in the state and an enhancement of the existing rate structure have been proposed recently. Inadequacy of state revenues is being cited as a justification for such a proposal. But while the need of generating additional revenues to increase health expenditure for expediting economic growth and improving human welfare is important in its own right the constitutional provision of the government responsibility to provide free minimum health service for all cannot be overlooked. Therefore, charging higher user fees and its application to the public health service sector as a whole should be approached with a critical frame of mind.

Serious objections can be raised against charging user fees on equity and adequacy grounds. Nondiscriminatory user fees would discourage the use of public health care facilities. Imposition of substantial user fees would raise the cost of such services. The rich, who find an alternative in the private health care facilities, would drift away and the poor who cannot afford such fees would prefer to exit, accept the health defect and would die. Thus charging user fees would keep away from public facilities the very people the system is supposed to reach. Worse still, it would indirectly promote the private nursing

homes and clinics through the backdoor. Hence the fee charged for the service must be less than its cost and also less than that charged in the private health care facilities. Discriminatory user fees and cross subsidization is more justified in a poor state like Orissa. Secondly, it is reasoned that user fees is not a sure way to garner substantial additional resources. Available data show that the recoveries from the health sector by way of user charges have remained at a miserably low level in Orissa. Such recoveries constituted only 2.83% of revenue expenditure on health in the year 2000-01 in the state.

Further there has never been any attempt in the state to examine the utilization of the amounts collected by way of user fees. There is very little doubt that many costly instruments and equipment are lying in a dysfunctional state for a long time in many hospitals including the state's biggest SCB Medical College & Hospital. Wrong test reports which pose threat to life and treatment of serious patients on the floor are not very uncommon even in the biggest hospital. Besides medical service in Orissa is more a profession and a business proposition than a mission to save valuable lives and improve human welfare. The user fees system is to be seen with these ground realities in mind.

SECTION - V

HEALTH CARE DELIVERY SYSTEM IN RURAL ORISSA:

5.1. Economic Profile:

Comprehensive studies on the health care delivery system in rural India are conspicuous by their very absence. No wonder then that very little is known about the health providers, use of health services and related issues in the countryside. On the basis of a census survey of 45 households in a poor village in Balasore district of Orissa we intend to throw some light on this aspect. The village was selected just for convenience and the household survey was conducted in January, 2004. Of the 45 households in the village 18 or 42.2% are agricultural & other causal labour households and they come on the below poverty line (BPL) category. Among the rest 27 households officially placed in the above poverty line (APL) category, 23 are not really rich. The village has a health sub-centre with one auxiliary nurse midwife (ANM) & one anganwadi worker operating under the intensive child development scheme (ICDS). There is a primary health centre with two doctors and other personnel at a distance of 1.5 kms from the village and is well-connected by an all weather road and a hospital with five specialists and other medical staff at a distance of 09 kms from the village. The village is also well connected with the hospital through both public and private transport service.

5.2 Health Care Delivery System:

The health care delivery system in the study area, as in other parts of rural India, has a two tier structure with the public health care facilities stated above and the private practitioners. While the state run health care system provides promotive, preventive and curative care, the private system provides

only curative care. The private system which operates at a distance of 01 km. and above has a heterogeneous structure. Individual practitioners and chemist shops function at the primary level dealing mainly in minor ailments. At the secondary and tertiary levels there are nursing homes promoted by sin owners or partners who are generally doctors. They provide curative medici and surgery services for some serious ailments to the people as bc outpatients and inpatients.

5.3 Findings:

The findings of the household health survey are presented in Table Per capita monthly total expenditure and health expenditure of the household are given in columns 3 and 4 of the table. Evidently the BPL category households spend less on health (Rs.20.04) than the APL category (Rs. 62.33), but the share of the health expenditure in total expenditure is approximately the same for both the groups. Columns 6, 7 and 8 show the use of health care facilities by the households. It can be read off the table that on an average a person visits a health facility 0.54 times a month of which only 0.16 or 29.6% are to a public facility. For the BPL category the visit to a health provider is 0.47 times a month of which 0.12 visits or 25.5% are to a public provider. In the case of the APL category of households these figures are 0.58 and 0.19 (32.8%) respectively. Paradoxically enough the non-poor visit a public health facility significantly more number of times than the poor even though neither category uses it very much. The note is clear, i.e. the public health care system is not working in the desired lines.

TABLE - 4

Health Expenditure and Health Care Delivery System in Rural Orissa

Household Category	No. of Households	Per Capita Monthly Expenditure (Rs)	Per Capita Monthly Health Expenditure (Rs)	Health expenditure as percent of total expenditure	Percapita No. of visits to a health facility in the last month		
					Public	Private	Total
1	2	3	4	5	6	7	8
Below Poverty Line	18	223	20.04	8.9	0.12 (25.5)	0.35 (74.5)	0.47 (100.0)
Above Poverty Line	27	692.2	62.33	9.0	0.19 (32.8)	0.39 (67.2)	0.58 (100.0)
All	45	498.7	44.89	9.0	0.16 (29.6)	0.38 (70.4)	0.54 (100.0)

Figures in brackets indicate percentages to total.

5.4 Why Do People Prefer Private Health Care?

The results of the household survey are puzzling and beg the question as to why even poor people are moving away from the public health care facilities? These signal that something is wrong with the public health service system. Discussion with the respondents and the medical personnel reveal the following.

Absenteeism:

Public health personnel, especially doctors, do not like to live in the rural areas. They have a strong urban bias and are technology- minded. They are not accessible as they also practice privately in the nearby small town. The pharmacist and the doctors attend the PHC for one or two hours in a day on alternate days. Consulting a doctor in emergencies is a problem.

Waiting Time:

Public health care also involves waiting on account of either absenteeism or unwillingness of medical personnel. "The come tomorrow syndrome" is a common thing in government run health centres. In course of discussion respondents revealed that a delivery patient died while waiting for treatment in the PHC. Sometimes, the illness heals on its own in the waiting process. After a period of waiting, the patient also prefers to accept the illness or exits the public facility and enters the private system. Needless to say high money, welfare and even life costs are associated with waiting for treatment in the public health care facilities. People being poor find it difficult to afford loss of wages and/or production involved in sheer waiting. Such losses are higher if the patient is relatively young and active. The condition of the patient may deteriorate while waiting for treatment compelling new tests and diagnosis and a more costly treatment or a worse post-treatment condition than if immediate treatment is given. The patient also suffers a welfare loss in terms of persistence of pain and discomfort or sheer fear psychosis in the waiting process

Poor Infrastructure:

The public health facilities present a disheartening picture of poor and disfigured buildings, empty clinics, defunct equipment, filthy sanitation and unwilling staff who are in the habit of inducing patients to go to private facilities.

Poor Service:

Over the years the public health care delivery system has earned a bad name for its abysmally low level of patient satisfaction. The quality of service is worse in rural PHCs. It is reported that during delivery the nurses hit the mother and ridicule their attendants for not having brought clean clothes. Most often the treating physician, the nurse(s), the technician and the sub-

staff behave in a very rude manner and even do not care to reply to the patient / attendant's queries.

Unauthorized Fees:

Nowadays the patients have to 'please' the surgeons even in government clinics and the only convenient way of pleasing them is by paying some amount. Sometimes the doctors demand a payment and make the patient / attendant pay the same in advance. They are also to pay the nurse(s), the technician and sub-staff in cash and/or kind in the name of tips.

Respondents were of the view that if allowances were made for the above, the private health care facilities would not be too costlier than the public facilities. It was reasoned that the private facilities are prompt, informal, satisfying and provide one window quality curative care for which they are more popular than the public facilities.

But the fact remains that the private health care facilities provide only curative care and that too under relatively less problematic situations. A respondent revealed that in a life-threatening situation the private nursing home where he was treated almost compelled him to rush to S.C.B. Medical College and Hospital and his life was luckily saved by the emergency treatment offered there. However, people who availed of health service facilities from both public and private systems are divided with regard to the choice between the two systems. Some say that the quality of care offered by the private providers is better while some others hold the opposite view.

The most widely accepted view is that the public health care delivery system is the best. When it comes to promotive and preventive care it has no alternative. In the case of curative care it is also the best in very critical life-threatening situations. What is needed is to reform the public system and to bring the private system under effective regulation.

SECTION - VI

CONCLUSION:

The study clearly reveals the poor state of health care system in India and in Orissa. In GDP terms public expenditure on health in the country is one of the lowest in the world. It has declined from 1.3% in 1990 to 0.9 in 2000. In Orissa it is just 1% of SDP in 2000-1. Since revenue expenditure constitutes more than 98% of total state expenditure on health only skeletal infrastructure survives. The system is rendered incapable of providing health services in any meaningful way. Absenteeism and poor quality of service have become common in the public health care facilities. The implementation of the user fee system has only aggravated the deterioration. As we move on the path of marketisation of health services, the elite and vocal move increasingly to the private health providers while the poor are eliminated. The private alternative has undermined the public system and inequality in access to health care facilities has increased. The situation is worse in the countryside.

It is a good thing that of late the health care delivery system in the state is showing signs of slow improvement. The government of Orissa is implementing some innovative people-friendly health service programmes in recent years. Two such programmes deserve special commendation. The first is the system of health auxiliaries. Under this system, the village health workers, the anganwadi workers of ICDS and the ANMs are operating as "barefoot doctors". They are providing preventive care, giving treatment at home to patients suffering from minor ailments, assisting with mass health and sanitation campaigns, and disseminating information on family welfare and maternal and child health care. The second is the Five Disease Treatment Programme popularly known as "Panchabyadhi Chikitsa Vyabastha." Under this programme, the government is distributing free drugs/reimbursing the costs of drugs purchased by patients for five common diseases such as acute respiratory infection, diarrhoea, leprosy, malaria and scabies. The programme is doing an excellent job in the health care delivery system in the state. But this again has different degrees of effectiveness across population groups and space. A peculiar feature of the state's population is that the people by and large are highly stoic in nature. They hardly lodge any complaint about what they are supposed to get but are not getting. In such view of things the onus of improving the health care delivery system lies with the government. But given the type of political economy and the nature of governance which we have, reforms in the health sector are really a Herculean task.

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Health Status and Health Care Infrastructure in Orissa :

Accessibility, Utilisation and Reform Initiatives

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INTRODUCTION

Health is one of the basic indicators of development. It is necessary that people should be healthy and active in order to participate in different developmental programmes. The importance of the public sector in health needs no belabouring, given the proportion of poverty in the developing countries. The World Bank and DFID have played increasingly significant role in changing the pattern of investments and production in health and associated sectors, depending upon the country's pre-reform status. These organisations are setting priorities regarding where and how the money is to be spent.

The utilitarian perspective carries in-built assumptions regarding issues of efficiency, quality and effectiveness of public and private provisioning. Private and voluntary sectors are viewed as being more efficient, as providing better quality services, and as being more effective than the public sector. However, the former two sectors, specially the private sector, do not invest in a host of preventive services since it is not profitable to do so. Preventive services are indispensable for disease control programmes and therefore the state should assume responsibility for delivery of public goods (Baru, 2001). Hence the World Development Report 1993 emphasises the need for selective state intervention at the primary level and reforms at the secondary and tertiary levels to become self-financing in the long run.

STATUS OF HEALTH

Life expectancy (LE) at birth, infant mortality rate (IMR) and maternal mortality rate (MMR) are the major indicators for the status of health. A higher life expectancy and low level of infant and maternal mortality are the result of better status of health. It is found that life expectancy in Orissa is much below the all India level. It ranks 13 among the 15 major states in India. It has also the lowest ratio among the poor states, except Assam and Madhya Pradesh. However, there is increase in life expectancy between 1970-75 and 1992-96.

One of the important reasons for the increase in LE at birth in Orissa is the decline in the IMR. In Orissa IMR has declined from 135 in 1981 to 96 in 2000. A major factor, which has contributed to the fall in IMR, is the universal immunisation programme. The fall in IMR in Orissa does not, however, mean that the IMR is at very low level. It is highest among the major states in India. Not only the IMR is highest in Orissa, but also the rural-urban difference in IMR is alarmingly high in the state (Hirway *et al,* 2002). While whole complex of biological, social, economic and cultural factors have a bearing on the problem of infant mortality the very important role played by exogenous or environmental factors is also undeniable. In the rural areas, the level of development of infrastructure facilities related to health care, water supply and sanitation is very low, leading to high level of infant mortality. The urban areas on the other hand, represent a situation where the delivery system of these facilities is better developed leading to low level of infant mortality. The high IMR in the state is also linked, both as cause and consequence, to a high birth rate, which is a consequence of high fertility rate.

Maternal mortality is another indicator of status of health. A low maternal mortality indicates better provision of health care for women. In Orissa, MMR shows a dismal picture. It is not only significantly higher compared to the all India level but also occupies fourth rank among the major states in India.

Considering all the three indicators of heath status, we can observe that the index of health status of Orissa is poor among the major states in India. Only Assam and Madhya Pradesh lag behind Orissa. All other states have better health condition compared to Orissa.

HEALTH INFRASTRUCTURE AND ITS ACCESSIBILITY

The supply of health care services or in other words the access to health infrastructure imparts health status through its effect on the ability to treat illness in a timely and effective manner and on the availability of prevention services to support optimal levels of health. Health infrastructure in Orissa is hard pressed with the large population served per institution, large area served per institution, higher population-bed ratio/ area-bed ratio, and high population-doctor/ area-doctor ratio.

Not only the different ratios are unfavourable to the state but also there is uneven supply of health infrastructure to different districts. The coverage of population and area by medical institution, health centre, indoor bed and doctor varies among districts. It is observed that the western districts as well as central districts have less than average access to all kinds of health infrastructure, indicating that the supply of health infrastructure in these districts is poor. On the other hand, the access to health infrastructure differs between the coastal and hilly districts in respect of coverage of population and area. While coverage of population is better in case of the hilly districts, coverage of area is better in case of the coastal districts.

Considering the access to water supply by households in Orissa, it is observed that a majority (56.7 per cent) have access to hand pump water source for drinking purposes. Only 8.6 per cent households do have access to piped water. Comparing between rural and urban areas, it is observed that households in urban areas have more access to piped water than households in rural areas. While around 47 per cent of households in urban areas have access to piped water, only 3.9 per cent in rural areas have access to piped water. On the other hand, a majority of households in rural areas have access to water through hand pump. In both rural and urban areas more than 60 per cent have access to safe drinking water through both piped and hand pump. In other words, about one-fifth in urban areas and one-fourth in rural areas do not have access to safe drinking water.

Access to sanitation in rural areas is worst. Around 92 per cent of the households in rural areas do not have any sanitation facility. At the same time, around 6 per cent have access to flush toilet facility. On the other hand, 45 per cent of households in urban areas do not have any sanitation facility. Hence, poor sanitation facility in rural areas compared to the urban areas is a major threat to the status of health in Orissa.

The poor access to health infrastructure including health institution, health manpower, water supply and sanitation has kept the state in low health status. Besides the poor physical access to health care, the state has also poor economic access to health care due to its severe poverty prevailing in the state (the state has the highest percentage of population below poverty line among all the states in India).

UTILISATION OF HEALTH SERVICES

In Orissa there is higher dependence on public hospitals for health care as there is insignificant presence of private health care institutions. This is true in the case of both rural and urban areas of Orissa. This is in contrast to the low-income states like Bihar and Uttar Pradesh, where utilisation of private hospitals is higher compared to Orissa. Similar is the case for outpatient care. In Orissa medical institutions including public hospital, primary health centre and public dispensary account for more than 50 per cent of outpatient treatment, which is lower in the case of other low-income states like Bihar and Madhya Pradesh. All these show that there is greater dependence on utilisation of public health care facilities, both for inpatient and outpatient care, in rural as well as urban areas of Orissa.

The indicators of utilisation of maternal health care are the percentage of women who receive any Ante Natal Care (ANC), full ANC and institutional delivery. It can be observed from the Reproductive and Child Health (RCH) survey carried out in Orissa during 1998-99 that about 73 per cent of women received ANC during pregnancy. The ANC coverage is highest in Jharsuguda, Sundargarh, Sonepur, and Bargarh with 89 per cent coverage each. The coverage is lowest in Bhadrak (53 per cent), followed by Malkangiri (56 percent), Keonjhar

and Angul (62 percent). Considering the full coverage of ANC (at least three ANC visits + at least one TT injection + IFA tablets), the share varies from 18 per cent in Jajpur to 56 per cent in Jharsuguda. The coverage of full ANC is better in Sambalpur, Sundargarh and Sonepur (49 - 50 per cent) and the coverage of ANC is poor in Nayagarh, Nawarangapur, Malkangiri and Jagatsinghpur (18 - 25 per cent). Considering the utilisation of maternal health care in respect of institutional deliveries in Orissa, it is observed that only 23 per cent of total deliveries in Orissa were conducted in the health institutions as compared to 34 per cent for India as a whole. The extent of institutional delivery is highest in Khurda (57 per cent), followed by Cuttack (41 per cent) and Puri (39 per cent). On the other hand, it is only 7 per cent each in Malkangiri, Nabarangapur and Nuapara and varies between 11-15 per cent in Kalahandi, Koraput, Boudh, Phulbani, Gajapati, Bolangir, Sonepur and Balasore.

The indicator of utilisation of child health care is the percentage of children who receive complete vaccination. The extent of complete vaccination is 58 per cent in Orissa and varies from 28 per cent in Nawarangapur to 80 per cent in Sundargarh. More than 70 per cent of the children received complete immunisation in Sundargarh, Jharsuguda, Sambalpur, Bolangir, Dhenkanal, Cuttack and Angul. On the other hand, between 28-52 per cent of the children received complete immunization in Nawarangapur, Ganjam, Keonjhar, Malkangiri, Boudh, Balasore and Nuapara. The percentage of children who did not get any vaccination is highest in Ganjam (20 per cent), followed by Keonjhar (19 per cent), Jajpur (15 per cent) and Balasore (14 per cent).

Auxiliary Nurse Midwife (ANM) is expected to play a very key role in delivery of RCH services to the community. Therefore an important indicator of utilisation of government health facilities is the percentage of eligible women from rural areas visited by ANM. From the RCH survey it is found that only seven per cent of the rural women were visited by ANM. While 10-13 per cent of the women in Koraput, Nawarangapur, Sundargarh, Kalahandi, Rayagada, Ganjam, Bargarh and Bhadrak reported that ANM had visited them at their residence, only 2-5 per cent of the women in Puri, Boudh, Jajpur, Cuttack, Jagatsinghpur, Nayagarh, Khurda, Kendrapara and Bolangir were visited by ANM.

The above discussion shows that almost all the backward and tribal districts are bad performers in respect of utilisation of health facilities. Within these districts, Malkangiri, Nawarangapur, Kalahandi, Nuapara an Phulbani have performed badly. Hence, in respect of utilisation, these districts lag behind.

HEALTH SECTOR REFORM INITIATIVES

Against the backdrop of the poor health status of the population in Orissa, it is not difficult to see the imperative of health sector reforms in the state. This situation has been made serious by the manner in which health care delivery system has evolved over the years – sharp rural-urban as well as coastal-inland differences in accessibility and effectiveness of service offered.

One factor that has sustained these imbalances is the lopsided nature of the budgetary resource allocation to the three tiers of the health care (Padhi and Mishra, 2000). The tertiary sector absorbs a lion's share of total expenditure on health (59%), where as the primary and secondary tiers each has a share of only 20 per cent. Thus, primary health care and first referral services delivered through primary health centres are seriously under-funded. Further, the priority sector in health care (i.e. preventive health and basic curative care, including public health, family welfare, maternal and child health, and rural health services) has remained almost constant over a decade from 1990-91 to 2000-01 (Meher and Padhi, 2003). At the same time, the proportion of expenditure spent on health in Orissa is below the national average, as against the very poor status of its population. Further the share of expenditure on health in Orissa has been declining.

The state government under the above circumstances has taken initiative in health sector reform, which began in 1996 with the DFID strategy review and impact assessment of project highlighting the gross under-utilisation of health infrastructure, poor asset maintenance and the constraints in primary health care. The major health sector reforms are: introduction of user fee in all medical colleges, district and district level hospitals; privatisation of Hospital Cleaning Services introduced in 1998; mandatory pre-PG rural service; Pancha Vyadhi Chikitsa initiated in July 1999; drug purchase and distribution introduced to make sufficient and good quality drugs available to patients in all public health institutions; enhancing skills of health personnel introduced in 1998; formation of district cadres for paramedics brought out in 1998; amalgamation of multiple district societies in 1999; starting of state health and family welfare society; etc. (Panda, 2002).

CONCLUSION

The health status in Orissa is poor among the major states in India. Only Assam and Madhya Pradesh lag behind Orissa. Life expectancy in Orissa is much below the all India level and has occupied the lowest ratio, except Assam and Madhya Pradesh. The IMR is not only highest among the major states in India but also the rural-urban difference in IMR is alarmingly high. Orissa has also shown a dismal picture in terms of MMR. It is not only higher compared to the all-India average but also Orissa occupies fourth rank among the major states in India.

Health infrastructure in Orissa is hard pressed with the large population served per institution, large area served per institution, lower bed-population ratio and bed-area ratio, and lower doctor-population ratio and doctor-area ratio. Not only the different ratios are unfavourable to the state but also there is uneven supply of health infrastructure to different districts. The western districts as well as central districts have less than average access to all kinds of health infrastructure. On the other hand, while the coverage of population is better in case of hilly districts, coverage of area is better in case of coastal districts.

There is greater dependence on utilisation of public health care facilities, both for inpatient and outpatient care, in rural as well as urban areas of Orissa. Among the different districts, the backward and tribal districts are bad performers in respect of utilisation of health facilities like receiving Ante Natal Care by pregnant women, receiving complete vaccination by children, percentage of women visited by ANM, etc. Among these districts, Malkangiri, Nabarangpur, Kalahandi, Nuapada and Phulbani have lagged much behind.

Against the backdrop of the poor health status, the proportion of expenditure on health in Orissa is not only below the all India average but also has been declining during the period of liberalisation. Besides, not only the primary health care and first referral services are seriously under-funded but also the expenditure on priority sector in health care, viz. preventive health and basic curative care including public health, family welfare, maternal and child health and rural health services has remained almost constant during the 1990s. Even though the state government has taken initiative for health sector reform with the assistance from DFID and World Bank, the health status in the state has remained still below the average of the major states and needs to improve a lot.

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Health Care in Orissa : Initiatives, Success and Challenges

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India as a signatory to the Alma Ata Declaration had committed itself to achieve Health for All by 2000 A.D. A major concern in Medical Science is to find a satisfactory answer to the question when will Health for All be achieved. For a State like Orissa, social development is as important as economic development. Since independence, Orissa has made some progress in economic horizon. But on the social front Orissa has been lagging far behind and therefore has been at the low ebb in terms of human development. This is why the fruits of development have not been reaped by the people. The present paper reviews the health policy and programmes of the Government of Orissa, on the basis of secondary data.

SECTION - I

DEFINITION AND OBJECTIVES OF HEALTH POLICY

During the last decade, issues relating to the concept of health has been the subject of discussion both at home and abroad. The W.H.O. has defined health as "a State of physical, mental and social well-being". Dr. Sanjaya Sanglare (2003) states that, "the health of nation is sum total of the health of its citizens, communities and settlement as well as the overall climate in which the citizens and communities live.

It is well recognised that, good health and defence against illness is fundamental to human beings. If the State exists to safeguard the rights of its citizens for the fundamental prerequisite of survival, it must also own up its responsibility to protect them from illness and premature mortality. (India Health Report: 2003). In a poverty stricken economy like Orissa, where 47.15% of people live below poverty line it seems reasonable to contend that, health services should be provided free of cost and be targeted towards the poor.

There is considerable substance in the contention of the World Development Report, 2000 that improved health reduces production losses caused by worker's illness, it permits the use of natural resources, which have been inaccessible because of diseases, it enhances enrollment of children in schools and enables them to learn better. As Amartya Sen emphasises, good health is an end in itself.

In line with the recommendation of the Bhora Committee, the Government of Orissa has formulated a comprehensive health policy for the people of the State with a focus on thrust areas like infrastructure, water supply and sanitation.

SECTION - II

HEALTH INFRASTRUCTURE AND HEALTH SERVICES

Health service in Orissa is multifaceted consisting of diverse practitioners and institutions, mixed ownership pattern and differing systems of medicine. A three-tier structure comprising the primary, secondary and tertiary health care facilities was visualised by the policy makers of the State to reach every nook and corner of the State with basic health services. The primary health tier has three types of institutions, namely, a sub-centre for a population of 5,000 in plains and 3,000 in hilly and tribal areas, a Primary Health Center for 20,000 - 30,000 population and a community Health Center for every four P.H.Cs. The District Hospital will function as secondary tier for rural health care.

Recent evidence suggests that population served per hospital in Orissa is 21,700 while in advanced countries like U.S.A population per physician is 470. Analysts observe that, the area served per medical Institution is 92 sq.Km. There is shortage of medical and para medical persons in rural area and this has negative impact on the quality of service in public sector. One dark spot in the health system of the economy is the vacancy position of 883 doctors in the prevailing hospitals of the State. To resolve the problem, the State Government is mooting on enhancing seats in medical colleges and directives are promulgated requiring doctors to serve in backward and rural areas to secure entry into P.G. studies.

The process of liberalisation initiated in the nineties has resulted in cut-backs in Government expenditure on health. The State Government's expenditure on health is inadequate for expansion of facilities. The State Government's expenditure on health, as a percentage of total NSDP was 1.45 in 1990-91, 1.11 in 95-96 and 1.32 in 1998-99. The current level of per capita State Government expenditure on medical, public health and family welfare is awfully low i.e. Rs. 136.3 and it had to catch up with Punjab's average of Rs. 254.2, Karnataka's average of Rs. 207.6 and the All India average of Rs. 158.0. The story of bed-population ratio is a dark one i.e. 1: 2680.

The Urban-rural divide in service provisioning is dramatic. The Urban middle class use private facilities more than government facilities, while the rural masses utilise facilities of Government Hospitals. The percentage of Hospital Births (H.B.) is higher in urban areas (27%) than in rural area (7%). However the percentage of lady visitors to public hospitals is more in rural

areas (54%) than in urban areas (47%). It is plausible to believe that, pre-Natal-Registration in hospitals may bring down maternal mortality. Records reveal that, the percentage of pre-Natal Registration (PNR) in public Hospitals in rural areas and urban areas of the State comes to 54% and 76% respectively.

It appears that, privatisation of health care in the iniquitous society of Orissa may jeopardise access to the poor. Interestingly enough, the average amount of payment a patient makes towards public hospitals is higher in rural areas (Rs. 225/-) than in urban areas (Rs. 211/-). With regard to private hospitals, on the other hand, a patient in urban areas makes a payment of Rs. 640, while in rural areas his counterpart pays Rs. 511/- for private hospitals.

SECTION : III

HEALTH PROJECTS :

From 1945 through the 1960s, there was considerable growth of welfare services with a focus on food security and maternal and child health services. The health initiative taken by the State Government has resulted in the creation of several I.C.D.S. and DWCRAS in different parts of the State. Childhood diseases are Diptheria, Whooping cough, Polio, T.B. & Tetanus. In view of the alarming rate of maternal and infant mortality in the State, the I.C.D.S. were directed to enhance the health status of expectant mothers and children by provision of food, medical assistance and vaccination.

A number of health projects has been initiated by the State Government, with the active support of the center. These projects refer to control TB, Filaria, Malaria, Leprosy and so on. Planning efforts have also been directed to equip and enrich the existing medical colleges of the State with super speciality facilities and Health experts in different disciplines.

SUMMARY AND CONCLUSION

The daunting task of planning commission in Orissa in the new millennium is to enhance the outlay for health, ensure its equitable distribution between different classes, narrow the rural and urban gap and remove the lacunae in effective delivery of health care services both in rural and urban areas. Health education may also be imparted to control personal habits like tobacco chewing, smoking and alcohol intake are.

According to WHO Director G.H.Brunndtband, poverty is the main source of ill health. A gigantic problem in rural and urban areas is the absence of environmental sanitation. Provision for waste disposal facility and sanitary latrine are inadequate. Deteriorating environment and poor infrastructure are adversely affecting the quality of life of people. Health staff are detected not to pay much attention to patients. The costly nature of modern medical facilities

is the probable explanation for increase in the percentage of home deliveries and maternal deaths. The overall health seeking behaviour of people is poor. It must be realised that, due to insanitary conditions at indoor and outdoor and practices of not using mosquito nets or repellents, malaria is most prevalent. Because of many common diseases, infant mortality is quite high, life expectancy is exceedingly low, water borne diseases reduce the capability of people to lead a decent and active life and so on.

To improve the delivery system efforts may be made by Government to encourage community participation and community management in health care services. It is important to communicate with the community regularly to get the feedback. As many health problems can be remedied by changing behaviour, information, communication and education are necessary. Making doctors, para medical and non medical staff accountable suitable legislation in an indispensable necessity. Supply of good quality drugs at affordable prices to the consumers needs the attention of planners.

To conclude, the need of the hour is to adopt a holistic approach to health care service, which gives due consideration to indigenous and alternative systems of medicine, like Ayurveda, Siddha, Unani, Yoga, Reki, Psychotherapy, Solar therapy and Acupressure, while not discouraging the present Allopathic approach altogether.

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Health care expenditure in rural and urban areas of Orissa: A comparison

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I. INTRODUCTION

"Health is wealth" goes the adage in India and it is relevant for all countries of the world. Health is a holistic and multidimensional phenomenon. It is an important aspect of human well-being. One should keep body and mind fit and active to enjoy life and contribute to the good for the society. The World Health Organisation (WHO) defines health "as a state of complete physical, mental and social well-being and not merely the absence of diseases and infirmity". Health can be defined in terms of several criteria such as life expectancy, capacity for work, need for medical care, or ability to perform a variety of personal and social functions. It may also be defined in terms of life expectancy at birth (LEB), infant mortality rate (IMR), crude death rate (CDR) or in a self evaluation of health status or simultaneous account of mortality, morbidity or health related limitations or by weighing years of life according to illness and disability or in terms of disability adjusted life years (DALY) or in terms of quality adjusted life years (QALY). Therefore it varies with the purpose on hand and the meaning of health one takes into account.

Expenditure on health is considered as investment expenditure rather than as consumption expenditure. Expenditure on medical and public health is one of several determinants of health. Expenditure on health differs from state to state, and also within a state Disparity is also seen from rural to that of urban areas.

The problem raised here is the disparity in health care expenditure. In this context the paper attempts to examine the importance of health expenditure in rural and urban perspective. Secondly, to probe the disparities in trend of health care expenditure for rural and urban areas over a period of 15 years of

Orissa. The paper is presented in six sections, besides this introductory and conclusions. The material and methods are focused in the section II. Section III is a brief review of literature. Section IV is devoted to the importance of health care expenditure. Rural and urban health care expenditures are articulated in Section V. Section VI describes the inter-state variations in health care expenditure, the conclusion follows in Section VII.

II. MATERIALS AND METHODS

The study is based entirely on secondary information. The data have been collected from various statistical reports published by Government of Orissa and Government of India, journals collected from public libraries and research publications. The health expenditure data on rural and urban areas have been covered for a period of 15 years i.e. from the year 1987-88 to 2001-02 from the Finance Accounts of Government of Orissa.

III. REVIEW OF LITERATURE

Quite a large number of studies are available relating to rural urban differences and inter-state variation in health care expenditure. Srinivasan (1994) critically reviews the various government policies and programmes of rural health care in India. And he also analyses the organizational structure and management of rural health services. The problem of access and reduction in the quality of services is the marked features of health services in rural areas. Some suggestions have been made for improving efficiency and effectiveness of the rural health care services through better understanding of the problems and constraints faced in rural areas. Gill and Ghuman (2000) point out that giving priority to rural health care in the state policy by allocating additional investment for sanitary infrastructure and medical personnel in rural areas is essential for redressing the growing disparity in health care facilities in rural areas.

Prof. N. Narasinhulu (1994), in his study "Economics of health: An analysis of regional variations" used three indicators such as number of thousand persons per doctor, number of thousand persons per bed and percapita state government expenditure on health in order to find out regional imbalances. His study reveals there is no reduction in the disparity inspite of huge government expenditure. He suggests to make proportionately more allocation to health sector in backward states.

Rama V. Baru (1993), points out that economic development, availability of investible surplus and infrastructural facilities are major features for determining the spread of health services in rural areas. The cooperation of public, private and voluntary sector is responsible for reducing variation in the distortions of health services.

IV. IMPORTANCE OF HEALTH CARE EXPENDITURE

Investment on health is in fact investment on human capital. The development of human resources is essential and prerequisite for socio-economic status of the community. A multitude of factors such as population size and growth (age, sex and distribution), per capita income, housing, sanitation, water supply, nutrition, geography, climate, literacy, urbanization, socio-cultural milieu and practices, availability of health services and way of life determine health care expenditure. One of the major challenges in the new millennium is to enhance the outlay for health, to ensure its equitable distribution among the states, to bridge the rural urban gap and remove the lacunae impeding effective deliberate health care at the community level both in rural and urban areas.

V. RURAL VS. URBAN EXPENDITURE ON HEALTH

This section makes a comparison of rural and urban health expenditure. There are two major heads under which health expenditure of government of Orissa is classified such as revenue expenditure and capital expenditure. The present study focused certain selected areas such as (i) medical and public health and (ii) family welfare. Under the medical and public health category the expenditure on Allopathy and other systems of medicine are included for both rural and urban health services.

Expenditure on Allopathy in rural areas is counted under sub-heads like sub centres, subsidiary health centre, primary health centre, community health centre, hospitals and dispensaries, tribal area sub-plan. Whereas in urban areas, the different sub-heads are Direction and Administration, employees' state insurance scheme, medical store depot, school health scheme, hospitals and dispensaries, other health schemes and tribal area sub-plan. The expenditure on other systems of medicine in rural area includes the expenditure on ayurveda, homoeopathy, unani and tribal sub plan. Whereas, in urban area it is counted under sub-heads like direction and administration, ayurveda, homoeopathy and unani. Family welfare is also taken for both the rural and urban areas.

Fig. I reflects the revenue expenditure of government of Orissa on Allopathy and other systems of medicine for both rural and urban health services.

During the period of 15 years i.e. 1987-88 to 2001-02, in case of Allopathy, urban health has claimed larger amount of public money than rural health expenditure. But the graph tells a reverse story in case of other systems of medicine. The claim of the rural areas was more in other system of medicine comparing to urban areas.

The trend picture of public expenditure on Allopathy and other systems of medicine is also evident from Figs.1 & 2. Fig.1 depicts the expenditure on Allopathy for rural and urban areas. The growth of expenditure on Allopathy in rural areas was slow upto I997-98, after which it rises sharply. The slope of the trend for urban health expenditure (Allopathy) is 9.07, whereas for the rural health it is 5.81.

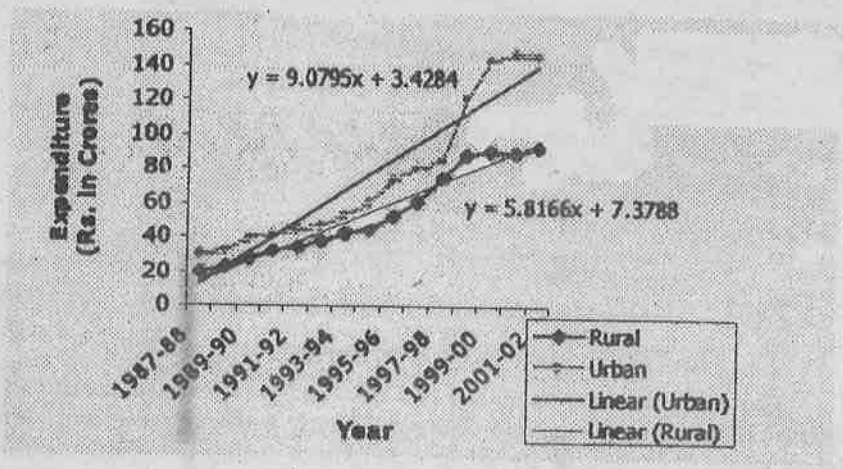

Fig. 1 Expenditure on Allopathy for rural and urban areas.

The claim of other system of medicine in rural areas is more than that of urban areas as is evident from Fig. 2. The slope of the trend line for other system of medicine is 1.20 for rural areas, whereas the same for the urban areas is 0.36. A comparison of these trends indicates that in the total public money for other system of medicine is prioritized in rural areas and neglected in urban areas (Fig. 2).

The split of public money into revenue and capital component under rural and urban category reveals an interesting scenario. It is disheartening that under capital account the growth of spending on urban health services is slower. The story is reverse in case of expenditure in rural areas. The higher amount of capital expenditure is made on rural and urban health services indicating that there will be positive benefit in the long run.

Fig. 3 reflects the capital expenditure on rural and urban health services. The rural expenditure was fluctuating over the time period whereas the same initially was very slow up to 1999-00, afterwards it rises in case of urban services.

Trend lines of expenditure on rural and urban health (Capital Account)

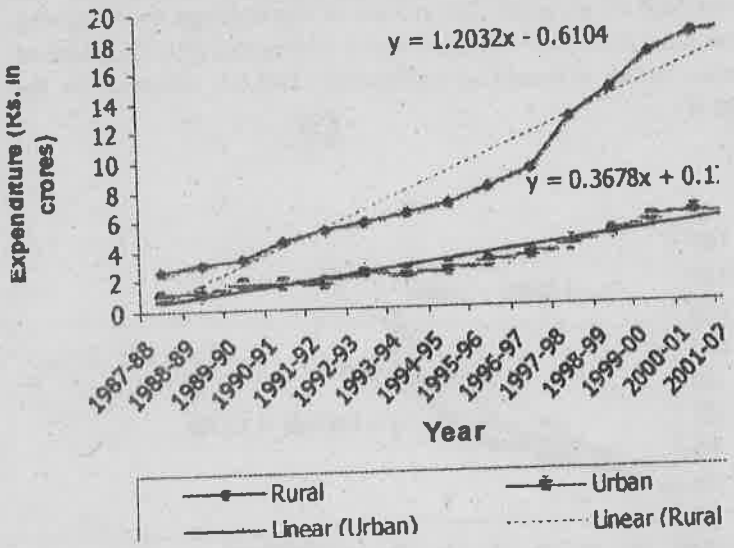

Fig. 2 Expenditure on rural and urban (capital Account)

The division of public money into rural and urban welfare expenditure in Orissa tells an interesting story. The rural family welfare expenditure claims a larger share compared to the urban expenditure during the period. While the rural demand has increased four times, urban claim has increased by only about three times. The revenue expenditure on family welfare increases consistently. The urban welfare expenditure increases marginally over the time period. The slope of the trend line for rural areas is 2.31 and for urban areas it is 0.14.

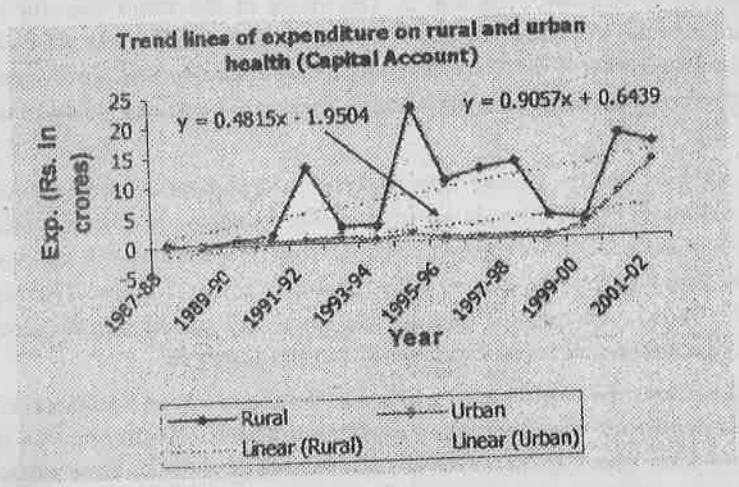

Fig. 3 Expenditure on family welfare (Revenue Account)

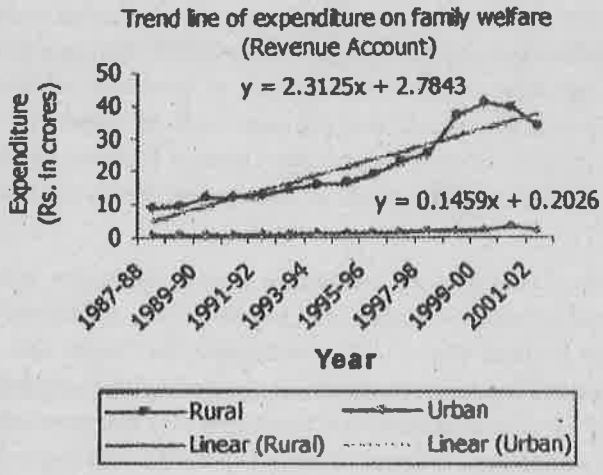

Fig. 4. Expenditure on family welfare (Revenue Acoount)

VI. RURAL AND URBAN HEALTH CARE SERVICES - INTER STATE VARIATIONS

The nature and extent of health problem varies from rural areas to that of urban areas. The dichotomy in cultural, social taboos and practices, fertility pattern, demographic composition, literacy and education, availability and access to medical and health facilities, occupational hazards posed by urbanization and industrialization and environmental pollution, distribution system for essential commodities and income distribution etc. are responsible for providing the health care services in rural vs. urban area. Though some progress has been made but the health problems are severe in rural areas. It is well known that the infant mortality rate (IMR) and the child mortality rate are a sensitive index of the socio-economic development. Kerala is the only state with an IMR below 20 both in rural and urban areas. Orissa continues to have IMR above 100 in rural and urban areas. The IMR is highest in rural Orissa. The data draws the attention to the marked and persistent rural urban differential.

There is much variation in the availability of non-government services across the principal states. Health care services are located mostly in urban areas. The 10 states which had the largest number of health establishments per million persons in urban areas are Haryana, West Bengal, Utar Pradesh, Maharastra, Kerala, Tamil Nadu, Karnataka, Orissa, Bihar and Andhra Pradesh in a ranking order. In rural areas the 10 states are Tamil Nadu, Kerala, West

Bengal, Maharastra, Gujarat, Karnataka, Bihar, Andhra Pradesh, and Punjab. It appears that relatively better developed states have a higher concentration of private and voluntary health services (Rao, 1999). Baring a few developed states, there has been a significant growth of private institutions while in other states it is public sector that provides bulk of in-patient care. This is especially so in the backward states in the country. In short, public sector still continues to be the major provider of health services in the majority of the states.

It is found that among the major states, there are inequalities in expenditures of government on medical, public health, and family welfare. It is lowest in Utar Pradesh (Rs. 34.62) and highest for Punjab (Rs. 83.49). The coefficient of variation is 24.44. In Orissa the percapita expenditure on health care is Rs. 55.77. It is also seen that the disparities between urban and rural areas is quite substantial. In terms of percapita health care expenditure it is Rs. 25.90 in rural sector and Rs. 151.56 in the urban sector i.e. urban sector receives 5.85 times more than the rural sector (Reddy and Selvaraju, 1993)

There is a wide difference in the allocation of resources among the states as between rural and urban sectors. As of 1990-91 taking all governments together 33.04% health care expenditure was allocated to the rural sector and 66.96% to the urban sector. If we consider the central government alone 29% of the health care expenditure was allocated to the rural sector and 71% to the urban sector. Taking all state governments together 33.79% of the total health care expenditure was allocated to the rural sector and 66.21% to the urban sector.

The total cost of the treatment depends to a large extent on the source of the treatment. The costs are lower if the treatment is at a government hospital. A comparison is made for hospital charges for rural and urban patients among 15 major states and it is HPT that government hospital charges are lower for urban patients in Andhra Pradesh, Assam, Bihar, Madhya Pradesh and Punjab.

The 52nd (1995-96) rounds of NSS provide state-wise estimate on the private and public sources of in-patient as well as out-patient treatment. On an average about 45% of patient care was provided by public sector. However the private sector is predominant in AP. It accounted for about 77.5% in rural areas and about 62% in urban areas. In case of Orissa, in rural areas inpatient treatment was 9.4% in private hospitals and 90.6% in government hospitals. Whereas in urban areas the distribution of in-patient cases was 19.0% in private hospitals and 81% in government hospitals.

VII. CONCLUSIONS

The basic objective in the paper is to examine the public health care expenditure in rural and urban areas. Health is a semi public good. Investment on health is investment on human capital. One of the major challenges of today is to enhance the health expenditure, to ensure its equitable distribution among rural and urban areas.

In the state of Orissa, urban expenditure on Allopathy claims larger amount of public money than rural health care expenditure. However the claims of other systems of medicine and family welfare in rural areas are more than in urban areas. A comparison among different states reveals interesting scenarios. The infant mortality rate is highest in Orissa fallowed by Madhya Pradesh and Rajasthan. The child death percentage is above the all India picture. In majority of the states public sector continues to be the major provider of health services. The disparity in health care expenditure among different states is well evident. The percapita expenditure on health care in Orissa is Rs. 55.77, which is not adequate. The government hospital charges lower for urban patients in Andhra Pradesh, Assam, Bihar, Madhya Pradesh, Punjab.

The economy of Orissa is lagging behind in supply of the basic health care facilities. The expenditure seems to be inadequate. The paper makes a plea that the state government of Orissa should emphasize to eliminate the rural urban differences in health care expenditure.

What Determines Health Status ?

A comparative Study of Kerala and Orissa

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The impact of socio-economic condition of a population on its health status, though obvious, has been the topic of discussion for quite a few years now. Of late the role of health in shaping the economic status of a country has come under the scanner and extensive research has been undertaken to unravel the complex linkages that exist between health and economic development. In this paper an attempt has been made to present a comparative study between the socio-economic conditions and health status of two very diverse states in our country - Kerala and Orissa. The focus will be on the loopholes in the policy making machinery in Orissa which has resulted in its abysmally low health standard.

We wish to analyse the disparities that exist between the health status of both these states in terms of five parameters namely, life expectancy, maternal mortality rate, infant mortality rate, crude death rate and morbidity.

Life expectancy at birth is one of the most important parameters by which one can judge the overall health condition of a population. A healthy and wholesome populace definitely has a higher life expectancy which has a direct bearing on the economic development of the particular state/country. In the year 1999, the life expectancy in Kerala was 70.9 years in the rural areas and 72.2 years in the urban areas. On the other hand, life expectancy in rural Orissa was a mere 54.8 years and it was 63.1 years in urban Orissa which were very low as compared to Kerala despite the fact that Orissa had a greater per capita health spending during this period. The reasons for this anomalous behaviour of life expectancy- health expenditure relationship can be many, primarily among which are, lack of health awareness among people, improper mobilisation of funds and rampant corruption on the administrative sector. Kerala on the other hand, famed for its highest literacy rate and cleaner political environment saw government funds being utilised effectively thereby bringing about a greater rise in the life expectancy of people.

Maternal mortality rate, that is the number of maternal deaths per 1,00,000 live births gives us a good idea about nutrition and ante natal and post natal health care facilities available to the womankind in the state. A healthy mother is indispensable if we are to have a healthy and wholesome population. So a higher MMR means that the overall health condition in the state is poor. There exists a large disparity in the MMR of Kerala and Orissa. According to 1992 data Orissa had an alarmingly high MMR of about 738 deaths per 1 lakh live births, compared to Kerala's 87 deaths per lakh live births. This can be accounted for by taking into consideration the number of midwives and rural hospitals in both the states. In Kerala there are about 2027 hospitals in the rural areas as compared to Orissa which has only 100 hospitals. The number of registered midwives in Kerala is 58780 while it is 38455 in Orissa for the year 1999. This clearly shows that rural centric health policies are more effective in bringing about an overall development in the health status of the state. Maternal mortality rate also gives us an idea of the gender inequity prevalent in the particular state. Most maternal deaths result due to multiple pregnancies in desire of a male child, which shows that there is a direct linkage between gender inequality in the society and MMR. Hence the low MMR for Kerala shows that women enjoy greater social status which is again due to higher literacy rate.

The infant mortality rate is widely recognised as a sensitive indicator of the general health status of the population. It is also considered as an indicator of the socio-economic condition of the people in the context of education, nutrition etc. There is a stark difference in the IMR of Kerala and Orissa. In the year 2000 IMR of Kerala was 14 deaths per 1000 births while IMR for Orissa was 96 deaths per thousand. This is a direct repercussion of the small number of rural hospitals, inadequate nutrition, poverty and lack of awareness among people. The health care system in Orissa is largely urban centric, on account of which the rural population are mostly neglected. A closer look into the antenatal care and immunisation received by the mother and the child reveal the main reason for the high MMR and IMR in Orissa. It is seen that in Kerala about 86 per cent of the mothers received ANC and 83 per cent of the children have immunisation. On the flip side in Orissa only 37 per cent mothers receive ANC and 62 per cent of children have immunisation. This disparity exists though there is a greater health expenditure in Orissa as compared to Kerala. These findings only bring to the forefront the fact that government funds are grossly misused in the state.

Death rate is one of the most important indices to judge the performance of health services in a state. Death rate depends upon factors like availability of hospitals, transportation facilities, number of medical personnel and nutrition among other factors. In the year 2000 the death rate in Orissa was 10.5 while it

was 6.4 in case of Kerala which is lowest at the national level. This directly points to the fact that people in Kerala have a greater access to essential health care services. On the other hand, rural population in Orissa are deprived of essential health care facilities like emergency ward in PHCs, life saving medicines etc., which account for its highest annual death rate at the national level. The lower death rate in Kerala is largely due to the large number of hospitals, hospital beds and doctors who function at the grassroot level.

In recent time morbidity as a state of ill health has been increasingly recognised as a reliable indicator of well being. It can be used as an index of social development and personal well being of the people. At a first glance it seems that there is not a profound difference in the morbidity rates of Kerala and Orissa. Figures available for 1993 show that morbidity in the rural area of Kerala was 2196 per 10,000 population while it was 2124 per 10,000 in rural Orissa. However, it is to be noted that a large number of cases in Orissa go unreported owing to the lack of awareness and motivation among people. On the other hand in Kerala, there is a greater awareness among the people on account of which most of the cases are reported to the hospitals. If the state aims to provide better health care facilities to the citizens impetus should be given to the backward rural population in terms of health expenditure and literacy programme.

There is a significant interstate difference in the pattern of morbidity, fertility and mortality, at the same time between urban and rural and between male and female population. The improvement in the health status of the country as a whole is uneven and it has been confined to more advanced states, and even within them, to selected regions only. The health status of Orissa, remains stubbornly in the shadow.

SUGGESTIONS:

One reason why the resources in Orissa are not used effectively is that most of the finances are channelised by way of salary of medical personnel. Moreover lack of motivation in the administrative sector leads to the concentration of finance in the urban areas. Rural areas are by and large neglected. Over the years there has been a persistent and acute shortage of funds allocated to the health sector for the rural population. Another area of concern when it comes to resources, is the rural - urban inequity in health infrastructure. This is clearly evident in the low concentration of health services in rural areas compared to urban areas. With increasing hold of private medical practice in rural areas, this disparity is widening. The government should make a conscious effort to ensure that the rural population get cost effective health care by diverting funds to specific rural pockets for infrastructure and provision of incentive to medical personnel.

Low cost and affordable preventive and curative health care can be provided if importance is given to community participation. People must be involved at all stages of planning, implementation and evaluation of programmes. The imbalance and distortions in the state's health programme can be overcome by harnessing community partnership.

To bring about effective health care at the grassroot level NGOs are the most obvious choice. Steps should be taken to mobilise these NGOs in a proper manner so as to increase the accountability.

Moreover traditional health care givers like Dhais, Quacks, Kabiraj and Hakims in the rural area can be trained in order to provide cheap and safe health service.

Literacy activists also play a pivotal role in bringing about health awareness in an area. By forging partnership with such activists, the government will benefit immensely in the field of health education and mobilisation.

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TABLE-1

Budgetary Allocation under Health Sector from 1994-95 to 1999-2000 in Kerala and Orissa.

(Rs. in lakh)

Year	Kerala	Orissa
1994-95	3100.00	3940.00
1995-96	3900.00	3769.00
1996-97	6126.00	4659.55
1997-98	6096.00	4104.00
1998-99	6200.00	7526.21
1999-2000	6400.00	13208.00

TABLE-II

Real per-capita Public spending

(In Rs.)

Year	Kerala	Orissa
1985-86	25.97	10.95
1991-92	32.15	23.26
1995-96	30.98	30.05
1998-99	19.54	28.28

TABLE-III

Percentage Share of salaries and wages in total Public spending in Health

Year	Kerala	Orissa
1985-86	63.54	65.14
1991-92	70.90	72.08
1995-96	66.57	73.22
1998-99	70.06	83.39

Source : Selvaraju et.al, Background paper, 2001.

TABLE-IV

Health Status in Kerala and Orissa in 1999

Health Indicator	Kerala	Orissa
Live birth rate (per 1000 population)	18.0	24.6
Death rate (per 1000 population)	6.4	10.6
Infant mortality rate	Rural 14 Urban 10 Combined 14	Rural 100 Urban 65 Combined 97
Life expectancy in 1990	Rural 70.9 Urban 72.2	Rural 54.8 Urban 63.1
MMR (1992)	87 deaths per 1 lakh live births	738 per lakh live births

Source : 1) Various issues of Sample Registration System Bulletin

2) FRCH state surveys, 2000, IIPs, Bombay.

TABLE-V

Health Infrastructure in Kerala and Orissa in 1999

Health Infrastructure	Kerala	Orissa
No. of Hospitals	2107	273
No. of Beds	97840	11980
No of Doctors	4404	4873
Population	31982(000)	35534(000)
Population served per doctor	7988	7292
No. of Health visitor	748	110
Health workers	7758	15954
General Nursing Midwives	24914	32122

Source : Directorate of Health Services of states

TABLE-VI

Facilities taken by % of population

	Kerala	Orissa
Reported immunization	83%	62%
Antenatal care	86%	37%

Source : State Government Reports and NFHS-2.

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Health Services in Orissa :
At Cross Raods

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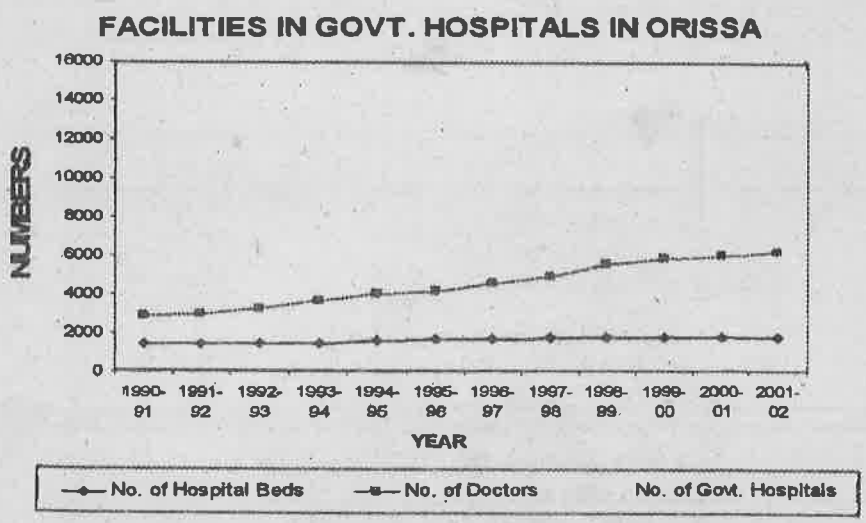
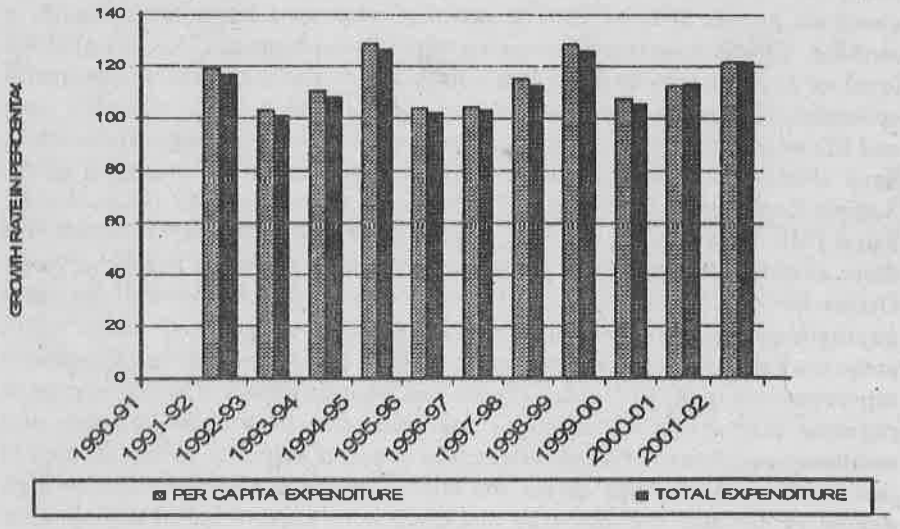
Health is one of the most important objectives of development. Development means more than economic growth alone; it means the realization of human potential and the satisfaction of basic human needs. Good health should not be seen simply as an objective of development but as a positive force driving development. The overall scenario of health care is an admixture of light and shade; of some remarkable achievements and also grave failures.

Over the last fifty years or so a vast network of health care services and personnel has been built up (Figure-1). The average growth rate of population of the state during 1990-2000 was 1.59 per thousand as compared to 2.13 per thousand at the all India level. The crude birth rate 1998 was 25.7 per thousand which declined to 24.1 per thousand, crude Death Rate has been declined from 11.1 per thousand to 10.6 per thousand and Infant Mortality Rate (IMR) from 97 to 81 per thousand. Over the years due to the expansion in the heath care network, there has been a steady decline in the death rate which resulted in the improvement of expectancy of life at birth.



There is a steady increase in total expenditure on health services notwithstanding the low per capita expenditure. The rate of growth has been equipoise. The allocation of funds for health services by the Government is keeping pace with the rate of population growth.



The present morbidity and mortality pattern shows some significant variations from the past. Flood and Famine no longer take the massive toll of life as they used to in the past. Small pox has been eradicated, Immunization Programme from dangerous childhood diseases like whooping cough, diphtheria, tetanus, polio etc. has protected children.

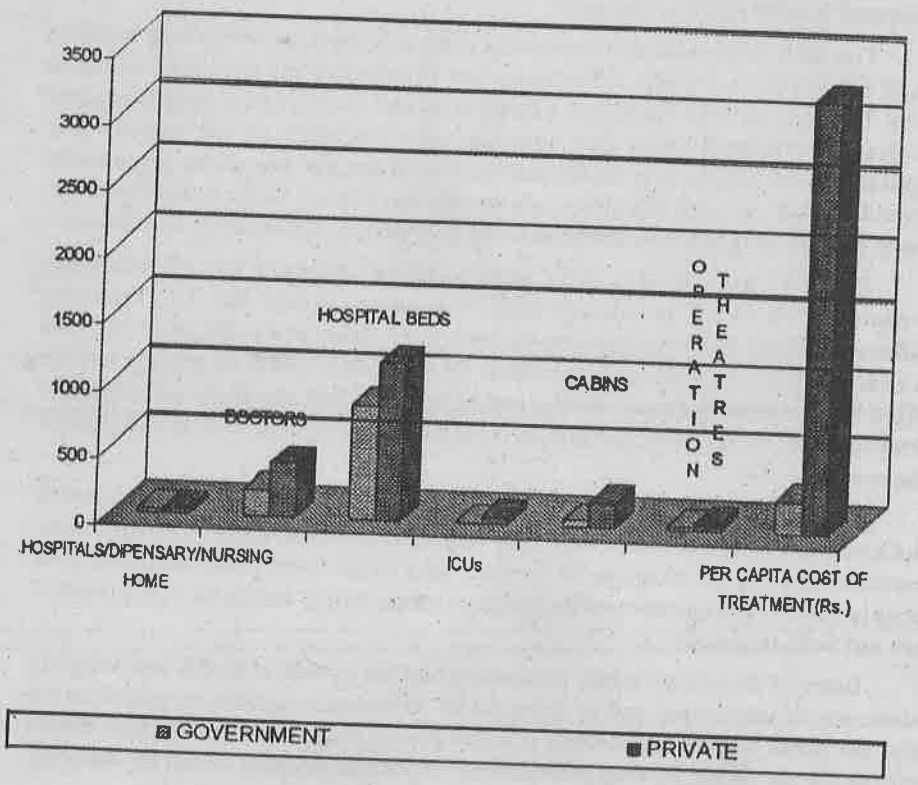
But in other respects, the overall character of morbidity has not changed much. Diseases arising from poverty, ignorance, malnutrition, and under nutrition, bad sanitation, lack of safe drinking water and adequate housing resulting in low levels of immunity still continue. These include tuberculosis, gastroenteritis, malaria, leprosy, measles, tetanus, whooping cough, bronchitis and pneumonia, scabies, worms and fevers especially among children. Communicable diseases and acute illnesses which include diseases like respiratory infection or diarrhoea still account for a high proportion of reported illness in our state. Massive measures have been undertaken for the control of such diseases through the organization of national programmes for all the major scourges like smallpox, tuberculosis, malaria, leprosy, AIDS etc. The performance of these programmes shows that the situation among the communicable diseases continues to be dynamic– some diseases like smallpox are almost eradicated, some are under control and others show varying response. New diseases like AIDS have appeared and necessitate the evolution

of new strategies to combat old diseases such as tuberculosis. Established strategies to combat a disease grow stale and ineffective and hence need change. The fight against communicable diseases is thus a continuous process. There exists not only large inter state variations, even within a state there are wide variations between the urban and rural areas, between the upper and middle classes and the bulk of the poor people. Amongst them gender difference also stand out. Thus health status is closely related with class, area, income and above all gender differences. The extent of inter-state disparities in health is striking. Kerala is an impressive state with life expectancy (74.4 years) at the level of high human development countries. At the other end of the health spectrum, Orissa, Madhya Pradesh and U.P. have high infant mortality rates and life expectancy consistently well below the national average. These states have always recorded the poorest vital statistics since the inception of the Sample Registration System in 1971. Orissa has the highest IMR (96 per 1000). Rural IMR is 100 in Orissa, a significant decline in IMR-UNDP Report. But there exists wide inter-state variation in the availability of health services. Orissa has the lowest number of doctors per capita. Almost half the rural population does not have access to safe drinking water. In all states urban areas are better served than rural areas. Lags in development have had political repercussions in many regions– South and Western Orissa. The persistence of regional disparities within states has given rise to popular agitation and militancy and demand for new states. The extent of disparity within the state is just acute as disparities across the states. Orissa is characterized by high degree of district-level disparity and there is no clear trend of decline over time in the extent of disparity.

Health is a state subject and the concern for health arises out of a moral and practical concern for both the physical and spiritual well being of persons. But the funds required for health care have reduced progressively and to couple this limited funding the money is incorrectly spent in buying irrational drugs. The bureaucracy has most conveniently overlooked the monitoring, the production of essential drugs has resulted in the multiplying of unessential ones. Incidence of Malaria, TB, and Leprosy and blindness are ever increasing and the government does not hesitate to reduce the health budget and increase the allocation for AIDS. A World Bank study of the Indian Health Care Policy throws light on the fact that if the delivery of health services is integrated within the purview of the private sector, the government should have effective policy to regulate these services. Also it can afford to regulate these services. It can not afford to have laissez-faire in health services. The shift of the government expenditure towards primary health care includes a call for NGOs and Community Based Organisations (CBOs) to become more involved in the provision of health care. Striking budgets, mercenary interests, appalling administration and general apathy have reduced public hospitals to cesspools of corruption where people are the worst victims. Concern for public health has waned over the years and captains of the industry have washed their hands off these institutions. They prefer setting up and helping hospitals in

the private sector. Competition among the hospitals promoted by corporate and private individuals is increasing. Already the fragmented segment is showing signs of increasing competition with more and more specialized hospitals being set up to cater to a niche segment. According to industry sources, this will reduce the competition. If any hospital is concentrating on the broad services, then it has to compete with local, private and specialized hospitals. However if it is a specialized hospital, the number of competitors will drastically reduce. They are designing various strategies to capture a big share. While some of them are using the names of eminent personalities, others are wooing them to become their board of trustees. This is believed to increase the inflow of patients as the presence of these people will create a sense of confidence. Others are using innovative means to attract patients; with high quality health care. The entry of insurance companies will boost the sector similar to other countries. In tune with the global trends health care business is booming. According to the World Bank Report the emergence of large scale investors owned hospitals in the country will lead to a dramatic development.

MEDICAL FACILITIES IN BHUBANESWAR MUNICIPAL CORPORATION (GOVERMENT Vrs. PRIVATE) 2003-04



Market failures and a concern for equity call for some government financing of health services. One type of market failure is the under provisioning of services to prevent or treat individual illness that spill over to the general populace. The concern for equity is either a social choice or based on the notion that health is a human right.

Private sector entry into health care business brought about competitio resulting in the creation of more and more super-specialty services, ultimately increasing the cost of medical care. In this context the medical facility portfoli of Bhubaneswar Municipal Corporation may be revisited, wherein th dominance of private entrepreneurs has been well acknowledged at the cost the intellectual capital created by the Government. As a result, the cost o medical care has been skyrocketed beyond the reach of the commoners.

In spite of the foray of the private sector in to health care business, one area that has remained immune to the entire activity is the rural area. The entry of private sector is no doubt going to benefit urban population in terms of cost and infrastructure but their impact in rural areas is yet to be felt.

Introduction of user fees for basic health services in a context of high unemployment, soaring prices and growing poverty will increase the inequalities in access to health services and effectively reduce access to adequate health care for the poor.

The shift of government expenditure towards primary health care includes a call for NGOs and CBOs to become more involved in the provision of health care. This can only be viewed as a short term and inadequate stop-gap leading to greater fragmentation and considerable variation in the quality and availability of health care. In the scenario with the private sector responsible for individual care and the public sector responsible for collective prevention, there will no longer be an integration of preventive and curative health care.

By offering a liberal drug policy the government has conveniently forgotten that every developed market economy treats the drug industry differently from the consumer goods industries. Price and production controls are enforced in all developed countries. The economics of drug pricing has not tilted the balance in favour of the consumers but has certainly benefited the drug companies. A liberalized industrial and drug policy will further marginalize the common man.

The government's attempt to provide free health services usually benefits the non poor in the urban areas. They use their political clout to ensure these services often at the expense of services that could have a real effect on poor people. Richer groups use public facilities more, which indicates that subsidies are not well targeted.

Entry of the private sector promotes a two tier system of health care which is economic in inspiration and is distorted by an undue emphasis on privatization and the profit motive. In essence it urges poorer countries to code most health care to private sector, leaving governments to provide primary health for the poor.

Health is a basic human right. It marks the dignity of the human person. Health care must therefore be made available to all, regardless of race, class, gender, age, ethnic origin or ability to pay. It can not be efficiently allocated by market forces or promoted in a context of growing poverty, high unemployment, and environmental degradation.

Health care policies should affirm the principles of universality and equal access both within and between. Health care is the basic human right to which all citizens should have access, not a scarce commodity to be allocated into two classes of people, the haves and the have-nots, who will have to content themselves with the barest minimum of public health care. Policy makers need to be accountable for health outcomes, which means greater investment in monitoring and evaluation mechanism that reveal disparities in health services.

Better informed and educated citizens can make politicians aware to ensure accountability of policy framing bureaucracy. Civil society organizations, such as NGOs and CBOs, can bridge the asymmetry of information between poor citizens and policy makers. They can bring community participation through opinion makers to ensure the perspective of poor people in influencing policy as well as a *'bottom up approach'* in planning and prioritising.

Political Economy of Health Insurance - Indian Experience

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Since 1991, there has been a paradigm shift in economic policy from a state oriented development strategy to market oriented development. There is a fear that inequalities of opportunities will be more intensified as the poor and the weak are likely to be marginalized in the process because the expanded economic opportunities would be difficult to be used if a person is handicapped by ill health or illiteracy. Education and health are recognized to be two distinct influences which can promote the freedom and capability of individuals to make use of available opportunities (Dreze and Sen 1995). It goes without saying that policies for universal literacy and "health for all" can go a long way to increase individual capabilities but even here the utilization of services by disadvantaged section of the society is limited due to socio economic constraints. This can lead to serious inequalities in the very sectors - health and education.

This paper examines the impact of economic reform on health sector. Since the introduction of economic reforms there have been also apprehensions that expenditure on social services and poverty alleviation programmes would be adversely affected and health seotor will be the first casualty of economic reforms.

Health is important for welfare. Public policy is critical in ensuring adequate infrastructure for a healthy society. Public action is important for the health of the poor as they are not able to take care of themselves. The Life expectancy has risen from 33 years to 64 years. The infant morality rate (IMR) has fallen from 148 to 71 per 1000. The crude birth rate (CBR) has declined from 41 to 25 and crude death rate (CDR) has fallen from 25 to under 9. The couple protection rate (CPR) and total fertility rate (TFR) have also improved substantially.

The high infant mortality rate reflects the poor state of public health, inadequate medical attention during pregnancy and at birth and poor post-natal care. To reduce infant and child mortality which are much higher than

what they should be, we need nearly 100 per cent immunization, supply of clean drinking water and provision of sanitation facilities to prevent infection.

The people under compulsory insurance are very small and confined to organized sector only. So health insurance has gained currency in the recent times and this article dwells upon the health insurance facility available to vulnerable sections of the society, need for investment in health insurance, health financing in India and the compression of health expenditure in India.

Health Policy, Goals, Action and Reforms:

The infant mortality rate is to be reduced over a period of five years from 72 per 1000 live births to the level prevailing in Kerla 12 per 1000 live births. All India child morality has to be reduced to Kerla level. There has to be expansion of the programmes of immunization, antenatal care for pregnant mothers to attain 90 per cent coverage in 5 years and ensure in five years that 90% coverage of deliveries are attended by trained health personnel, to ensure in five years immunization of all infants and children of age 12 to 24 months, and to expand the coverage of ICDS programme and improve it.

Health Insurance In India:

Health insurance can play an invaluable role in improving the overall health care system. The insurable population in India has been assessed at 250 million and this number will increase rapidly. This should be supplemented by innovative insurance programmes by Panchayats with reassurance backup.

As a matter of fact Indian market for health insurance is very lucrative. But the Govt's health care expenditures as a percentage of gross domestic product is one of the lowest in the world. India spends about 6.3 to 7% of GDP on health care. The lack in public health care sector results in increased demand for private health care service. Opening up of the sector has generated positive ethos in the market resulting in an increased attention of insured and the Govt. towards this sector.

Need For Investment In Health Insurance

The study of Avinash Pandey and Leah Thomas reveals that about 76% of people have insurance policies from public sector insurance and people have 8% of insurance from private sector. It is also found that 16% have not taken any product from any insurance companies, about 85% people feel the need for health insurance and, 77% females have expressed their willingness for health insurance. It is suggested that people in the age group of 30 to 40 should opt for health insurance investment. There are two types of health insurance (1) Compulsory and (2) Voluntary insurance. Compulsory insurance may also not be a workable proposition for financing.

Health Insurance is mostly due to cashless hospitalisation. It is equally important for males and females cashless hospitalization and tax exemption, reimbursement of hospital expenses by service class has led to more demand for health insurance. Surgical charges and hospitalization expenses are the main areas which people want to be covered under health insurance.

Health Financing In India

Health financing is raising of resources to pay for health goods, services and facilities. Health finance could be constituted to meet the daily operational requirements as well as requirements of long term investment in health sector. Ministry of Health, Govt. of India, local bodies, regional Govt Authorities, Communities etc. have been the major sources for health care.

In Govt sponsored social insurance programs health insurance is linked to employer owned facilities, private insurance schemes and health co-operatives as a mechanism of financing health care. Schemes like "Mediclaim" and "Mediplan" have just come into vogue, which are covered under general insurance scheme but touch health, associated care and facilities. There is inbuilt general notion of the value of risk coverage. (1) The health insurance provides a service which benefits the purchaser and for which he is willing to pay. (2) It provides for fair distribution of society cost of health care (3) It provides a means for collection of revenues for curative health system. The common problems in India are (1) Lack of health funds for distribution of health resource, (2) Rising health cost, (3) Lack of coordination, (4) Lack of convergence with reference to both sources, (5) Inefficiencies in spending of health resources, (6) Lack of flexibility for innovation and (7) Lack of sustainability.

There is inefficiency in spending the allocated funds and lack of coordination. This is widespread in countries like India. There are unnecessary delays and bottlenecks in procurement and distribution of resources The extent of waste of resources due to diversion is not easy to measure. The transport provided to health sector for example is diverted to personal use. Drugs and other material supplied by Govt for free distribution often gets diverted to private markets. This directly impacts upon the health facilities meant particularly for the population which primarily depend only on Govt. health care services because of their inability to pay the market price.

Effective use of financial resources is the implied objective of health care in general. Cost containment policies through cost effectiveness of resources are used in health sector. It is estimated that about 50% of resources is wasted in some countries because of poor financial and other faulty management practices. There is underemployment, misappropriation and misallocation of resources. Despite scarcity of resources for health care in our country, many

health facilities and health functionaries remain underused, underutilized in terms of man hours and in terms of technical skill.

Tulasidhar (1993) in an insightful article has shown the effect of expenditure compression on health sector. The cuts in transfer from central to state govts. and the grants associated with structural adjustments have reduced the ability of state Govts specially of poor states to spend on social sector. The cut in spending was more in case of public health whereas the cut on facility based curative type expenditure is only marginal.

This type of cut in expenditure on health causes allocative inefficiency and affects the poor more adversely. The annual percapita expenditure in the country is not more than Rs 160. The National Health Policy-2001 has expressed concern for inadequate public funds for health and the aspect of equity. As a matter of fact the paucity of public health investment is stark reality. The NHP 2001 envisages to increase health care expenditure to 6% of GDP with a 2% of GDP to be contributed as public health investment by the year 2010. The state govts. also need to increase the financial commitment to the health sector. In the first phase by 2005 they would be expected to increase the commitment of their resources to 17% of total budget. And by 2010 to increase it to 8% of the budget. Multidimensional health care inequities and imbalances across rural urban economies can be minimized through cost effective approach of enhanced or increased outlays in primary health care sector. Mobilizing additional and alternate source of financing by district health, community health, insurance scheme, and user charges as safety nets. Primary health centers will receive 55% of total public health investment. It has been acknowledged that absence of proper and systematic documentation of various financial resources used in health sector is another lacunae witnessed in existing scenario. The working group on Health Financing and management for 8th plan period was constituted by Planning Commission. The report of the working group has suggested for free care at the grassroot level, particularly for people below poverty line. When people use Govt. run health institutions the "Opportunity Cost" in terms of 'time lost' is high, there is no method to review user charges. Moreover the level of cost recovery is minimal due to low structure of fees. Targeting mechanism for exemption of user charges is difficult to implement.

CONCLUSION:

Dr. T. N. Krishnan of CDS, Trivandrum had proposed a Hospitalization Insurance plan for the persons below poverty line. Major portion of the income of the poor is taken away by illness. Jana Arogya Scheme seems to be similar to insurance scheme proposed by. Dr. Krishnan. Expansion of coverage may help to cross subsidize the poor which will reduce burden on Govt. Majority of people in India are ignorant about health insurance. Many diseases are also

excluded from risk coverage (like treatment of cataracts, dental care, tonsillitis, hernia etc.). There is lack of effective marketing in the area of health insurance in villages. Health insurance policies for the employees of the organized sector are highly subsidized by the Govt but there is no effective insurance policy for the people working in informal sector. Insurance plan should cover not only curative care but also promotive and preventive care services.

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Fertility And Mortality Among Tribals : A Block Level Study

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Health and education are the basic needs of human beings. Growth and development of an economy depend upon qualitative population growth or better health condition of the nationals. Because, human capital is one of the important determinants for economic development. Health is a state of being in which a person lives happily or generates maximum productivity. Thus, health implies individual happiness of good health. To maintain good health, health care is necessary. If health is a consumption good then health care is an investment good.

The economy of tribals is a sub-economy. Tribes are nothing but a sect. They are suppressed, depressed and a neglected class of the Indian Society. According to 1991 census, tribal population constitutes 8% to total population of India and 22.21% to total population of Orissa. Keonjhar district of Orissa is mainly dominated by the scheduled tribes. Different tribes of the district are Kollaha, Bhumija, Saunti, Majhi, Bathudi, Gonda, Bhuyan and Juanga. Out of 13 C.D. blocks, 10 blocks are known as tribal blocks. As per 1991 census, tribals constitute 44.52% of population to total population of the district. Thus, they occupy a sizeable population of the district's economy.

Bhuyan and Juanga are the primitive tribes. Their concentration is more in the blocks of Banspal, Telkoi and Harichandanpur. The tribal population in Banspal block is 79.29 per cent and it is the highest in comparison to the tribal population of other blocks. They are poor, illiterate and most of them are unemployed. They are ignorant about the importance of human development and human capital necessitated for the growth and development of a tribal economy. Basically, primitive tribes are far away from the boundary of health care to achieve good health. It is observed that Infant Mortality Rate (IMR) and death rate are very high and increasing in each year. With this backdrop, the objectives of the study can be noted as follows.

OBJECTIVES OF THE STUDY :

1. To examine, declining trend of tribal population in the district.
2. To study the high Infant Mortality Rate (IMR) among the primitive tribes of the district.

3. To examine tribals are not conscious about the health care for having better health.

METHODOLOGY :

Only secondary data are used in the study for observation and to draw the inferences. Banspal block has been taken as a sample block due to highest tribal concentration as per the different census reports.

THE STUDY :

Qualitative population growth stimulates economic development and it is not observed among the various tribals of the Keonjhar district. One part of the district is industrially developed due to spread of mining and mineral based industries and the other part is industrially backward and poor. Hence, the district exhibits unbalanced growth and provides employment opportunities to a few tribals in nearby industrial areas only. Tribals are low paid, underemployed and suffer from poverty and malnourishment. Environment and water also get polluted in the mining areas and social cost is high. Tribals live in an unhealthy condition without taking health care. Even the entrepreneurs do not pay any importance for spending money for health care of tribals. Consequently, tribals suffer from different diseases like malaria, brain malaria, leprosy, jaundice, and T.B..

Mostly, Bhuyans and Juangas are superstitious and never go to hospitals for treatment. They rely upon old, traditional and unrefined medicines prepared by village quacks or Baidyas. Therefore, due to use of unscientific medicines and lack of consciousness of health they face immature death. Table–1 indicates the declining trend of growth rate of Juanga population in the district due to reasons given above.

TABLE–1

Size of Juanga Population in the Keonjhar District Since 1931

Year	Juanga Population	% of Growth Rate of Juanga Population
1	2	3
1931	7029	–
1941	8429	19.87
1951	7823	7.13
1961	9768	24.86
1971	10,881	11.39
1981	15467	42.14
1991	18,782	21.43

Source : District Statistical Office, Keonjhar – 2004.

It is seen from the table no.1 that, the growth rate of Juanga tribal population is declining. During the year 1951, it was only 7.13 percentage and gives terrible shock to the economy.

The tribal population of the district as a whole is also decreasing because of serious diseases which are treated through local made medicines prepared from roots and leaves of trees. Percentage of S.T. population since 1971 is represented in Table–2.

TABLE – 2

Year	% of S.T. Population
1	2
1971	45,21
1981	44,82
1991	44,52
2001	NA

Source : District Statistical Office, Keonjhar – 2004.

It is observed from the table no.2 that, during the year 1971, S.T.s population was 45.21 per cent to total population of the district and it has decreased to 44.52 per cent in 1991. Thus, it creates alarming condition for the development of the tribal economy of the district.

INFANT MORTALITY RATE (IMR) :

A child, who is below one year is infant. Mortality rate or death rate among the infants of tribal families is high. Infant mortality rate is calculated for a particular year of a region. It is the rate or the ratio of number of deaths to number of births. Infant mortality is increasing due to lack of consciousness of mothers to take proper child care, immunization system, and treatment in proper time. Tribal women are also illiterate, unemployed and suffer from poverty. They maintain the families by collecting the forest products like leaves and woods of trees. Table–3 given below shows the Infant Mortality Rate of Banspal Block.

TABLE – 3

Infant Mortality Rate of Banspal Block Since 1994

Year	No. of Births	No. of Deaths	Infant Death	IMR
1	2	3	4	5
1994	2067	856	192	9.28
1995	2035	802	222	10.90
1996	2002	913	235	11.73

1997	1707	631	145	8.49
1998	1639	688	130	7.93
1999	1796	819	163	9.07
2000	2022	838	214	10.58
2001	1976	854	202	10.22
2002	1878	714	148	7.88
2003	2001	698	125	6.24

Source : Office of the Chief District Medical Officer (C.D.M.O.) Keonjhar-2004

It is seen from the table that, infant mortality rate of Banspal block is erratic in behaviour during the period 1994 to 2003. Infant mortality rate is the lowest i.e. 6.24 per cent for the year 2003 whereas it is 11.73 per cent in the year 1996. IMR is more than 6 per cent during the years 1995, 1996, 1997, 2000, 2001 and 2002.

IMR of Keonjhar district also reflects unawareness of mother and tribal family as well as of not taking proper child care. Table–4 depicts increasing trend of IMR, found in the Keonjhar district.

TABLE NO – 4

Year	No. of Birth	No. of Death	Infant Death	IMR
1	2	3	4	5
1994	28553	10274	1611	5.67
1995	27426	9978	1707	6.22
1996	28244	11198	1673	5.92
1997	24085	9085	1590	6.60
1998	N.A.	N.A.	N.A.	–
1999	N.A.	N.A.	N.A.	–
2000	29485	11133	1585	5.37
2001	30078	10833	1404	4.66
2002	31547	10833	1404	4.45
2003	N.A.	N.A.	N.A.	N.A.

Source : Chief District Medical Officer (C.D.M.O.) Keonjhar – 2004.

The district achieves lowest infant mortality rate of 4.45 per cent during the year 2003 and highest i.e. 6.60 per cent in the year 1997. Despite this, the IMR is more in the Keonjhar district compared to the nation's IMR, i.e. 4 percent.

Children die within 03 to 04 years of age owing to malnutrition, negligence and lack of immediate health care. Thus poverty, deprivation and ignorance of

the parents contribute to such high infant mortality rate. Sometimes these children die from unknown diseases which cannot be diagnosed and treated properly.

Government of India have been implementing different plans and programmes from time to time to check the high infant mortality rate and increasing death rate in the tribal areas. Inspite of implementation of plans, government have not been successful enough to provide better health and health care to the tribals. In this context, an attempt is made to suggest some important policy measures.

SUGGESTIONS :

1. To develop consciousness regarding value of human life :

Proper consciousness should be grown among the tribals of the district regarding the value and utility of human life and human capital. They must understand the significance of good health and more life span period, beneficial for the family and society as a whole.

2. Spread of Education :

The existing situation warrants that, Kanyashrama should be opened in each tribal blocks where the girls can get separate education facilities where education regarding child care, immunization etc. can be imparted with free of cost.

3. Opening of more number of Govt. Hospitals :

Availability of govt. hospitals is not enough for the tribals of the district. Opening of Ayurvedic hospitals must be given due weightage, because tribals prefer to the different medicines prepared from roots and leaves of trees.

Specialist doctors services must be given in the tribal dominated P.H.C.s or dispensaries. They should be given incentive by paying extra allowances for working in remote tribal areas.

4. Propaganda regarding the value of health care in weekly 'Hatta' or Market :

There must be sufficient propaganda by the Information and Public Relation Department in weekly 'Hattas' or Market to reduce death rate and IMR. Govt. should take pivotal role in this context.

5. Role of LHVs :

Extra remuneration and quarter facilities should be given to lady health visitors staying in the tribal areas. At least, LHVs should go once in week to a tribal household to examine the health condition of family members. They should make them understand about health care.

6. Role of N.G.O.s :

NGOs should come forward to make tribals more conscious about good health to improve human capital and human development. They should make them aware, how to prevent diseases, by taking different vaccines to revitalize the tribal family.

It is high time that a fresh look must be given to the tribals for the improvement of their health and making them more aware regarding health care to check the decreasing population to have increasing growth rate and economic development of the tribal economy.

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Debt Adjustment and Health Sector Financing

(ABSTRACT)

Prof Adwait Mohanty **Jyotirmayee Kar**

Health index of Orissa is extremely low in comparison to that of the other states and the all India average. For the year 1999-2000 Infant Mortality Rate (IMR) in the State was the highest (98 per thousand) while that in the neighbouring Bihar, West Bengal and Andhra Pradesh are 67, 53 and 66 per thousand respectively. The all India figure works out at 70 per thousand. Similar is the case of life expectancy at birth. During 1991-96, life expectancy of males in the state was 60.10 years while that of the females was 58.40 years. The corresponding figures for Bihar was 60.8 and 60.1 years, for West Bengal, 61.9 in both the cases and for Andhra Pradesh 61.4 and 64.5 years. The all-India average is 60.6 and 61. 7 years (Source: Annual Report, 1999-2000, Ministry for Health and Family Welfare, Government of India (India Health Report, 2003, P-32). Relatively low life expectancy of the females may be adduced to high maternal mortality and gender-inequality in availing health services. Low level of health infrastructure in the State continues to remain a drag on the health indices. As on January 1996, the state has only 47.01 hospital beds per lakh of population, while at the all India level the average is 73.71. In Andhra Pradesh and West Bengal there are 68.91 and 81.13 hospital beds per one lakh population. Only Bihar lags behind with 33.68 beds. This situation largely reflects inadequacy of health services to meet the need of the population in the State.

Now, what is the way out ?

The World Development Report 1993, underlined three economic rationales for which Government action is imperative in providing health services.

1. Private financed health care measures at times remain in the outreach of the poor who urgently need such services as these promote their well-being and boost productivity. Publicly financed health services can lead to alleviation of poverty and related adverse consequences.
2. Health promoting activities are generally public goods with a large number of externalities. So the private sector may not be interested in providing these.
3. Government intervention can ensure efficient functioning of the markets extending health care and health insurance thus raising welfare.

But the post-reforms adjustment programme has largely marginalised the role of the State. It has initiated a process of expenditure curtailment by the Government. And this is of immediate concern; will such expenditure reduction spree encompass development spending ? Will the Government, reeling under debt crisis, try to withhold spending on the core sectors like health and education ?

This conflicting issue was first exposed by the UNICEF (Cornia et. al., 1987) which advocated for 'adjustment with a human face' and argued for minimization of social cost. Subsequently World Bank (1990 (b)) underlined the importance of providing basic health care services and primary education to the poor and acknowledged the negative impact of debt crisis on the health and education sector. Quite a few countries, like Mali, for example, (see Debt Adjt. And Poverty in Dev. Con. Vol-II, P-196) have reversed the earlier trend of reduced public spending on essential sectors like health and education. This is in line with the World Bank's changing policies in the areas. But what has been the case of Orissa, a less developed, low income state with a high debt burden ? A large chunk of the public spending of the State goes for debt servicing. Does it force the Government to withdraw resources earmarked for health care services and divert the same for debt adjustment ? Or, alternatively, does debt extend extra resource support for financing such an essential service ? Is a state like Orissa with perpetually negative balance in the fiscal as well as revenue accounts take extra care of this sector by incurring debt which has increased from 41.62 % of GSDP in 1990-91 to 62.07% during 2003-04.

The present exercise is an attempt to probe these aspects.

Studies have underlined that the share of health expenditure in total expenditure incurred by the sixteen major states of India has declined from around 6-7 per cent during the 1980s to 5 per cent during the 1990s (Selvaraju et al. Background paper-2001). Identical is the case in Orissa, where health expenditure as a proportion of total expenditure has declined from 4.61% in 1990-91 to 3.93% in 2003-04.

Real per capita public spending on health in the state has increased from Rs. 16.95 in 1985-86 to Rs. 23.26 in 1991-92 and further to Rs. 28.28 in 1998-99. These amounts are well below the all-India averages of Rs. 21.28, Rs. 25.74 and Rs. 33.91 during the corresponding years. Moreover, the Health Report has observed that, in this increased outlay, proportion of wages and salaries is the maximum. In the poorer states like Orissa, the salaries and wages alone account for nearly 80 percent of the total health budget, eating in to the share of development activities, drugs and consummables (India Health Report, 2003, P-144-45).

Now, what has been the role of Public debt?

It is estimated that the elasticity of the share of health care expenditure (HE/TE) in response to debt as a proportion of GSDP is 32%. This means with

1% increase in debt as a proportion of GSDP, share of health care expenditure in the total expenditure will fall by 0.32%. In the next step all the variables are taken in per capita terms. Elasticity of the ratio of per capita health care expenditure and per capita total expenditure to the ratio of per capita debt and per capita GSDP also reveals an identical conclusion. The elasticity value works out at 41%. 1 % increase in per capita debt as a proportion of per capita GSDP will reduce per capita health expenditure as a proportion of total expenditure by 0.41 %. This is quite in line with the experience of Philippines and Sri Lanka where social expenditure was reduced during the post-adjustment period (Heller et al. 1988). Heller and Diamond (1990) have also underlined that health expenditures were most significantly and negatively related to size of foreign debt.

In the next step incremental debt along with total revenue of the state was taken as a determining variable of health care expenditure. It was observed that this improved liquidity position of the state exchequer could not boost spending for health services. A single per cent improvement in the debt supported resource available with the state Government has reduced the proportion of health care expenditure by 0.41 per cent. The hypothesis is further supported by the fact that per capita expenditure for health care as a proportion of per capita state debt has declined from 3.1 per cent in 1990-91 to 2.2 per cent in 2000-01 and further to 1.9 per cent in 2003-04. So increased public debt has not been channelised in to the health sector. Rather, debt adjustment and interest payment has forced the state Government to withdraw resources from this core sector of the economy.

It has been felt that scarcity of resources could be eased, if not removed, by incurring debt. The supposed objective of utilisation of debt service should have been sustainable growth. But in the case of a less developed state like Orissa, reverse has been the case. Debt adjustment has reduced health care spending. It can no way evade erosion of human capital. It seems debt finance has undermined its very effectiveness, rather it has become counter productive.

Elasticity of:

Health Care Expenditure/Total expenditure in response to Debt/GSDP= -0.21(-3.85)

Health+ Family Welfare Expenditure/Total expenditure in response to Debt/GSDP =-0.32(-5.13)

Health Care Expenditure/Total expenditure in response to Revenue+incremental debt/GSDP = 0.26(-2.70)

Health+ Family Welfare Expenditure/Total expenditure in response to Revenue+ incremental Debt/GSDP= -0.41(-3.44)

Per capita Health care expenditure/ Per capita total expenditure in response to per capita debt/per capita GSDP=-0.21(-2.98)

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Health status of women: A study of an urban slum

(ABSTRACT)

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Health is a multi-dimensional phenomenon. The WHO defines health as "a state of physical, mental and social well-being and not merely the absence of disease or infirmity. Women being the most vulnerable sections of society, the social, health and nutritional status of the women is the focus of the study which reflects the real index of development of any nation or society. It is the status of the women that reflects the index of civilization because it is she, at whose breast, humanity is being nourished and in whose lap civilisation is cradled. The gender disparity in Orissa is alarming. Out of 30 districts of Orissa, Ganjam is having 55% of people below the poverty line with a literacy rate of 47.70, far below the state level (63.6%). These trends in low female literacy rates and high incidence of poverty become a concern for health.

The paper addresses the pitiable condition of women's health status. The objectives are to asses and verify the major premises of health parameters as specified by the National Commission on Health. Secondly, to find out the calorie intake of normal, pregnant women and lactating women. And Anthropometric Analysis i.e. height of an individual a standard weight associated to accept the individual as maintaining standard of health is also another objective of the paper.

The issues raised here are assessed through a case study of women's health status in an urban slum Dimira Bauri Sahi of Berhampur city, one of the oldest and largest towns of southern Orissa. A number of parameters have been taken t assess women's health status. These parameters mainly reflect the demograp concerns such as Gender Discrimination, Sex Ratio, Female foeticide, Mat Mortality Rate (MMR), Female Literacy, Contraceptive Care, etc.

Family Planning and population Control are considered as preca indicative of health status of women. In the three categories of wom calorie intake in food the ordinary women have deficiency of about 8 in other two categories of women, that is, pregnant women and lact the deficiency in calorie intake is marginal. It is to the extent of about than the standard calories required daily for the women. There protein, calcium and iron among the pregnant women, out of this in the food is highest to the extent of about 50 per cent. The wor groups from 13 to 39 years the body weight is below th comparison to their heights, which indicates that they are The standard of living of lower caste families in general ar is far from satisfactory in comparison to the civilised fa the city of Brahmapur.

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