

State of India's Public Services

Benchmarks for the States

This paper assesses the state of public services in India from a user perspective and offers a set of benchmarks for future comparisons. Five services, namely, drinking water, health care, PDS, public transport and primary education are covered by the study. Each service is assessed in terms of four dimensions, viz, access, use, reliability and user satisfaction. State level data are used to compare the performance of different states with reference to these attributes. The paper also examines the experience of poor households and the less developed states with these services.

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I Introduction

Households in India depend heavily on the government for a wide range of essential public services. The state and local governments in India therefore devote a major part of their budgets for public services and their infrastructure. The nature and scale economies of most public services are such that government has a virtual monopoly in their production and delivery. In recent years, the government of India (GOI) and the state governments have invested an increasing share of their budgets to expand the reach of these services. But whether these investments have resulted in a more efficient and equitable delivery of public services and have helped reduce interstate disparities is not clear. Many believe that the lack of reforms in the provider agencies and the limited 'exit' options available to the people continue to make it difficult for the weaker sections of society to access these services. But comprehensive studies of public services are conspicuous by their absence [PROBE 1999, WDR 2003]. The diversity of public services and difficulties in tracking their delivery are some of the reasons why the problems of public service access, productivity and quality have received only limited attention.

Experts have always evinced much interest in assessing governmental performance by tracking public expenditure and its long-term outcomes. While public expenditure monitoring is a useful practice, it cannot shed much light on the issues of quality, effectiveness and productivity of services raised above. Tracking long-term outcomes can be a more productive exercise. A common practice is to assess the performance of a government and its development strategy by tracking outcome measures such as poverty reduction, infant mortality, longevity and literacy levels. Comparing countries in terms of these measures enables the experts to pronounce a verdict on the efficacy of governments, efficiency of public expenditure and the like. But as an approach to judging the performance of governments as service providers, there are two problems here that deserve to be noted.

The first problem is that the outcome measures mentioned above are long term in nature and may be influenced by a multiplicity of factors. Poverty reduction may occur over time, but it does not necessarily mean that anti-poverty programmes have been efficiently managed and delivered. Health services will certainly have an impact on the levels of infant mortality and

the average lifespan of the population. But the latter are also influenced by factors such as general economic conditions, increased public awareness, growing role of non-governmental initiatives and communications, etc. These are not all factors within the control of the health ministry or its service providers. Such long-term trends in outcomes, while useful for tracking the progress of countries, are not sharp enough to shed light on the performance of government policies and service providers in the short-term. If we desire to hold the government accountable for performance, we need to look for a different approach.

A second limitation of this approach is that the findings come too late to help the government make mid-course corrections to its strategy and to manage its operations more effectively in the short- or medium-term. Once a government adopts a development strategy and allocates resources in pursuit of its policies, programmes and services, it needs systematic feedback on how its plans are working on the ground. In the absence of such timely assessments, it will be difficult for the government and its service providers to remedy the problems in the field and improve productivity and performance. Accountability implies taking responsibility for the tasks one has undertaken to do. These tasks include implementing current policies and deploying budgets and personnel to this end. These are the tasks that are within the control of the government and for which it should be held accountable. It is not of much use to current policy-makers if the assessment of their work shows 10 years later that it did not contribute to certain desired long-term outcomes.¹ If their services are not reaching the people or are being delivered inefficiently, they obviously could not have been contributing to the desired outcomes. It is best to get this feedback to them as early as possible, while their operations are still in progress. The approach should enable them to move closer to the optimal use of the funds and people entrusted to them. We need new benchmarks and comparisons across states and districts to stimulate and facilitate this process.

In theory, governments could easily fill this monitoring gap. Yet all evidence points to a poor track record on their part to monitor public service delivery and its effectiveness. Planning new projects and spending public funds are often higher priority for governments than monitoring performance and outcomes. There are several reasons behind this phenomenon. There are some services that are difficult to monitor. For example, how a doctor treats his/her patient is not easy for a superior authority

to monitor. A more important problem is that the kind of systems and practices needed to perform the monitoring function are seldom put in place by governments. Even when systems are in place, collusion between service providers and their superiors (e.g., between bureaucrats and politicians) may make them toothless. One would have expected political leaders to highlight the issues pertaining to services at least at the time of elections. But such issues are seldom on the agenda in elections, perhaps, in part, because of the ignorance of the people and their inability to articulate their concerns. In the absence of external pressure by an informed public, it is unlikely that the government's monitoring of services will improve [Paul 2002].

This paper reports on the application of an approach to correct this imbalance. It presents a user perspective on five basic services provided by the government, namely, drinking water, health care, primary education and child care, road transport and public distribution system (PDS) in India. It also provides an assessment of the state of these services in the different states of India based on user feedback gathered through a stratified random sample survey of households. The information thus generated can be used to compare and rate states in terms of their performance. It is one way to give greater visibility to the issue and to attract political attention. The concept, scope and approach of the survey are presented in Section II of the paper. Section III reviews the existing literature on the services covered by the survey. Section IV spells out the methodology of the survey and some of its limitations. The major findings of the survey are discussed in Section V. The major conclusions of the study are presented in Section VI.

II Concept and Approach of Survey

Like service providers, users of services also experience and observe how services are being delivered. Even when service providers and their field staff neglect their monitoring function, feedback from the people who use public services can be used to assess the state of service delivery and to identify important gaps in their quality and productivity. Because the average citizen is not an expert on the technology and delivery systems of these services, his/her experience is usually ignored. This is an important lacuna in conventional attempts at evaluation of public services. For example, citizens can verify whether in fact they are able to make use of a service according to the conditions promised by the provider. They can comment on aspects of quality and cost that the provider may not be able to, or want to monitor. Delays in services, repeated visits to the agencies to solve problems, the investments made to compensate for the unreliability of services, and corruption in services entail costs to citizens that governments do not monitor. A user's level of satisfaction with a service may well reflect the quality of responsiveness of the service provider in its interaction with the public.

Citizens' feedback on the services is also a more cost-effective and systematic way of articulating the voice of the people. It is the collective 'voice' that can exert pressure on governments to improve services when people have no exit option. If the feedback is positive, it speaks well for the government and its service-providers. But if the feedback is negative in major aspects, then the chances are that scarce resources are being wasted or poorly utilised. When user feedback is converted into a voice that is backed by large numbers of people, it can stimulate governments to better utilise public funds, redesign services and

rectify the problems being faced by the people. It can also signal whether the long-term outcomes expected from the services will be within reach. Long-term service outcomes cannot be efficiently achieved when services are not being delivered properly in the short-term.

User feedback as a basis for monitoring and assessing public services is a relatively new phenomenon. It has been in vogue in the business world for a much longer period than in the public sector. In the developed countries, there are some examples of governments seeking user feedback on their services and programmes [Samuels 1998]. In developing countries, however, there are hardly any examples of governments adopting this approach. The few initiatives in developing countries have come from civil society organisations such as the Public Affairs centre (PAC) that pioneered the 'report cards' on urban services [Goetz and Gaventa 2001, Paul 2002]. PAC has used its report cards not only to create public awareness, but also to advocate policy and governance reforms. It is as a scaling up of this approach that a national survey was undertaken in the states of India by PAC to gather user feedback on the five public services referred to above. In specific terms, the objectives of the study were threefold: (i) provide an independent assessment of key public services based on user feedback; (ii) build an independent database and set benchmarks to measure the progress of these services over time; and (iii) create public awareness and motivate positive responses by the government to improve services.

The nature and scope of the assessment of the selected services are discussed below. The creation of public awareness and interaction with government mentioned in the third objective are part of a separate programme at PAC. These activities, though important, will not be dealt with in this paper.

The five basic public services covered by the survey are also services that matter a great deal to the weaker sections. The paper therefore pays special attention to the experience of the weaker sections of the population with respect to these services. In order to assess a given service, users are asked questions about the ease of access, usage, reliability and overall satisfaction.

Access refers to the proximity of the service facility to the household or the user of the service. Government norms for access often tend to be based on population criteria. For example, the location of primary health centres is based on population norms. But from a user perspective, it is the distance or nearness to the facility that matters most. The adoption of the latter approach in the present study will yield results that are different from the application of government norms. Sometimes, the service infrastructure may exist somewhere in the proximity of the user, but may not be available in a convenient manner, making access nominal. Therefore, from a user perspective, it is effective and easy access that matters.²

Use of a service tells us whether a household actually utilises a public service. In a monopoly situation, access and use may be identical. But when other options are available, people may prefer to use facilities other than the government's. The reasons for such choices could be many, but this study does not probe them in-depth. Our interest is only to ascertain whether people tend to use a public service facility once it is accessible.

Quality/reliability is a more complex dimension of a service from the standpoint of measurement. It refers to the features of a service that are not self-evident from the physical good or infrastructure involved. Households may not be able to observe or assess all such features, especially the technical aspects of

quality. But they can comment on other important aspects of quality. One such is the reliability of a service. The user of a service, for example, may find the processes and interactions with the service provider (predictability, responsiveness, corruption, etc) unsatisfactory. He/she then may attribute low quality or reliability (an aspect of quality) to that service.

Satisfaction reflects the overall assessment of a service by the user, based on his/her experience. In this assessment, the person implicitly brings in their expectations or standards that in turn may also be influenced by the past experience of others in the community, one's educational level and awareness of the working of government. Given the low levels of education, income and mobility of many people in the Indian context, it is likely that their expectations from services are modest in contrast to those of people in more developed countries. Irrespective of how a person arrives at an assessment of satisfaction, it is an internal assessment on which he/she may act. Admittedly, satisfaction reflects the personal judgments of users and can be measured only through information provided by them. In this study, a two-stage approach for measuring satisfaction has been adopted. Users are first asked whether they are satisfied or dissatisfied with a service or certain dimensions of it. Depending on the answer, they are probed further and asked whether they are strongly (fully) satisfied or dissatisfied. Thus the user feedback on satisfaction may fall into one of four categories: fully satisfied, partially satisfied, partially dissatisfied and fully dissatisfied. Though all these categories can be analysed and combined for various purposes, in this report, we have highlighted the proportions of users that are fully satisfied with the service. The rationale is that this measure provides a useful benchmark for all public service providers, as giving full satisfaction to customers should be their goal. It is also a yardstick against which all of them can be compared.

The concept and determinants of satisfaction have attracted growing attention among economists and psychologists in recent times. Though there has been much scepticism among economists about the feasibility and value of measuring utility or happiness, there has been a recent shift from this view, largely influenced by the evidence from psychological research on the subject [Frank 1997, Diener et al 1999]. Some authors have identified expectations, comparisons with others, and 'baseline happiness' of individuals as the main factors that determine self-reported well-being. Marketing research literature has also paid considerable attention to the measurement of satisfaction [Sasser et al 1978, Driver 2002]. Experts have developed different models that link performance and expectations. One model, for example, assumes that satisfaction measures the gap between performance and expectations. Another model assumes that customers continually adjust their expectations to their recent experience of specific services. As a result, performance and expectations will not vary a great deal and both may then be positively related to satisfaction levels. Expectations act as an anchor for the assessment of performance of a service provider [Deichmann and Lall 2003].

In the survey reported here, explicit statements and questions were not raised about expectations. As will be clear from the sections below, it would have been difficult for us to probe expectations about multiple public services in a survey covering large populations with limited education. An alternative would have been to explain to people the standards of service stipulated by the government and ask them to express their satisfaction in

relation to them. But most government service providers have not announced such standards, thus ruling out this line of investigation. Responses to the survey questions therefore reflect the implicit expectations about services that people have. In reasonably homogeneous populations and socio-economic environments, expectations could be very similar. Expectations of a person can also change over time, a point to bear in mind while comparing satisfaction scores between very different states.

Comparisons of services over time using public feedback is an efficient way to assess provider agencies and make them more accountable for their performance. The survey of public services reported below was completed in 2001. Repeated surveys at reasonable intervals of time (say three years) can be used to benchmark progress of the services over time. It is the kind of information that civil society institutions can use to demand improved performance and accountability from public service providers.

III Provision of Public Services: A Review

In recent years, several studies of social sector expenditure have been undertaken in India to assess impacts and outcomes [Dev and Mooij 2002, Shariff and Ghosh 2002]. The Economic Survey of the Government of India 2002-03 reports that the expenditure on social services (centre and combined states) as a percentage of GDP or as a percentage of total expenditure, has increased in recent years. The expenditure on social services as a percentage of GDP is currently about 6.5 per cent and as a percentage of the total public expenditure about 22 per cent.

It is against this background that we review below the current state of provision of the five public services, viz, drinking water, health facilities, road transport, PDS and primary school education. *Drinking water:* Protected drinking water is a basic service that governments have sought to provide across the country. The emphasis on the supply of safe drinking water to all sections of the population can be traced to the Fifth Five-Year Plan. The Tenth Five-Year Plan reiterates the provision of potable drinking water to every settlement in the country on a sustainable basis. Though the physical achievement shows that 95 per cent of the rural population had access to a safe source of water, only 52 per cent were fully covered as per norms (40 lpcd or more) and 48 per cent were partially covered (between 10 and 40 lpcd) [World Bank 1999]. As per the National Family Health Survey (1998-99), 74.5 of urban households and 25 per cent of rural households have access to piped water supply and 18.1 per cent of urban households and 47.3 per cent of rural households have access to hand pump water. The 54th Round of National Sample Survey (July 1999) estimated that 50 per cent of rural households are served by tube well/hand pumps and 19 per cent by taps.

Despite the progress achieved in the provision of water supply, the level of water-related sickness continues to be high, which is a reflection on the quality of water. The poor water quality is also highlighted in a recent evaluation study carried out in 122 countries by United Nations (World Water Development Report – Water for People, Water for Life). The study ranked India third from the bottom (120th rank). To ensure sustainability of water systems and sources, and tackle the problem of water quality, reforms were introduced in 1999 to gradually

replace government-oriented, centralised, and supply driven programmes by people-oriented decentralised, demand driven and community-based ones.

Health care: India has made considerable progress in the area of health during the last five decades. The crude birth rate per 1,000 population, which was 40.8 in 1951, has declined to 25.8 by 2000. Similarly, infant mortality rate (per 1,000 live births) is currently 68 as compared to 146 in 1951. The number of sub-centres, PHCs and CHCs increased from 725 in 1951 to 57,363 in 1981 and further to 1,63,181 in 1999. The number of dispensaries and hospitals increased from 9,209 in 1951 to 23,555 in 1981 and further to 43,322 in 1996. Among the major states, Gujarat, Kerala, Karnataka and Tamil Nadu have relatively better coverage of health facilities. Most of the states appear to have more or less fulfilled at an aggregate level, the stipulated norms for providing the health facilities (one sub-centre per 5,000 population in plain areas and per for 3,000 population in tribal and hilly areas; one PHC per 30,000 population in plain areas and per 20,000 population in hilly and tribal areas).

As a result of all these developments, the urban population has better access to health services compared to the rural population. According to the CSO, the availability of hospitals per lakh of urban population is 6.3 times more than the availability per lakh of rural population. Similarly the number of beds per lakh of urban population is 11.2 times more than the availability per lakh of rural population. Further, the extent of access to and utilisation of health care has varied substantially between states, districts and different segments of society [GOI Economic Survey 2002-03].

Though the government has provided a large network of health institutions, the extent and frequency of the utilisation of these facilities is considerably low. The National Health Policy 2002 aims to increase the utilisation of public health facilities from the current level of less than 20 per cent to over 75 per cent by 2010. Several factors might have come in the way of the utilisation of public health services such as distance, shortage of health personnel and medicines, absence of doctors, poor quality of services, unhygienic atmosphere, inappropriate behaviour of health staff and corruption.

Road transport: Between 1950 and 2000, road length in India grew at more than 4 per cent per annum. India has more than three million km of road network, perhaps making it one of the largest road networks in the world. However, almost half of the roads are un-surfaced. Long distance traffic is served by national highways and state highways and they account for about 8 per cent of the total road length. About 50 per cent of villages with population less than 1,000 population are not connected by roads. Only 37 per cent of villages are connected by 'pucca' roads and 64.5 per cent of villages have a bus stop within a two km distance [Shariff 1999]. Among the states, Bihar, Orissa, West Bengal, and Madhya Pradesh, and the north-east region have a higher percentage of villages not connected by pucca roads. A higher proportion of villages in southern states have bus stops within a distance of two kms. Many state transport corporations, particularly in the south, have drawn up road plans to reach even the remote villages of the state.

Public distribution system (PDS): In the early years of planned development, the focus of PDS was on price stability for consumers in urban and major food deficit areas. In the subsequent plan periods, some form of equitable distribution was also envisaged as the objective of PDS and thereby the coverage has

been extended to rural areas since the mid-1980s [George 1996]. In the 1990s, PDS was perceived as the major safety net to protect the poor from short-run, price induced, adverse effects of economic reforms [Mooij 1994]. With this change in the focus of PDS, the number of fair price shops increased from 2.78 lakh in 1982 to 3.45 lakh in 1987 and further to 4.61 lakh in 2000.

The subsidy on foodgrains incurred by the central government has increased over time. The food subsidy increased from Rs 835 crore in 1983-84 to Rs 2,450 crore in 1990-91 and further to Rs 17,612 crore in 2001-2002. But the percentage of households using PDS is around 33 per cent [Shariff 1999]. The percentage of households depending on PDS for foodgrains is only around 5 per cent in the states of Punjab, Bihar, Uttar Pradesh and Orissa.

Several attempts were made to modify the scope and coverage of PDS to reach the poor, as it was criticised for not targeting the poor. Studies have pointed out that the dependence of the non-poor on PDS is much higher than the poor. Similarly, the dependence on PDS by the moderately poor is higher than the very poor, which clearly shows that the system is not properly targeted to the poor. However, there are variations across states in targeting PDS to the poor. The states of Andhra Pradesh, Assam, Gujarat, Jammu and Kashmir, Kerala, Rajasthan and Tamil Nadu had shown comparatively better performance in targeting the poor than the other states [Radhakrishna 1996].

Primary schools: Literacy rates have shown substantial improvement over the decades. The total literacy rate, which was only 18.33 per cent in 1951, rose to 52.21 per cent in 1991 and further increased to 65.4 per cent in 2001. During the last decade, the female literacy rate has shown much higher growth and reduced the male-female differential in literacy rates from 24.84 in 1991 to 21.7 in 2001. The number of primary and upper primary schools has gone up from 2.23 lakh in 1950-51 to 8.17 lakh in 1998-99. According to the Sixth All-India Education Survey 1999, 83 per cent of rural habitations and 94 per cent of rural population have access to primary schools within a distance of one km and 84 per cent of the rural population have access to upper primary schools within a distance of three kms.

The enrolment ratio of children in the age group of 6-11 years has (primary schools) increased from 43.1 per cent in 1950-51 to 90 per cent in the early 1980s and increased further to a little over 95 per cent in the year 2000-2001. Similarly, about 13 per cent of the total children in the age group of 11-14 years were enrolled in schools during 1950-51 and their proportion has gone up to over 58 per cent in 2000-01. However, the proportion of female children enrolled in the schools (both 6-11 and 11-14 years age groups) was lower when compared with male children. The National Policy on Education, 1986 and the Programme of Action, 1992, envisages free and compulsory education for all children up to the age of 14 years. The 93rd Constitutional Amendment declared free and compulsory elementary education as a fundamental right for all children in the age group of 6-14 years.

The above review shows that there has been substantial improvement in the provision of basic services in India over the past several decades. Whether this means that the effectiveness and quality of services have also improved is less clear. The survey discussed below is an attempt to answer this question from the perspective of users.

IV Approach and Methodology

The primary data for the study was collected using household surveys, independent observation of selected public facilities, village profiles for the selected villages, and case studies. The design and methodology were jointly designed by PAC and ORG-Marg and the field work was executed by ORG-Marg. The study is primarily based on the sample survey of households. However, the information common to all households in a sample village on access to services such as health care, road transport, fair price shop and primary school were not collected from households. The information on access to services was collected from sample villages as part of the village profiles through discussions with knowledgeable local people.

To highlight the condition of the service facilities and document unique characteristics of a few sample villages as well as the problems faced by villagers in the access and use of public services, a qualitative approach was adopted through the observation of facilities and a limited number of case studies.

Sampling and reliability of estimates: The household survey covered 36,542 households selected from rural and urban areas of 24 states. The rural component of the sample consisted of 26,796 households selected from 2,502 villages spread over 148 districts of the 22 states. A multistage stratified random sampling procedure was adopted to select rural and urban households. While selecting the rural households in each state, representation was given to all socio-cultural regions, development levels of districts and to the different sizes of villages. Similarly in the selection of urban households, representation was given for all the size groups of towns excluding the metro cities. Within the selected town, representation was given to all geographical zones. The sample is self-weighted to obtain estimates for each state. Appropriate weights are used for state estimates to obtain estimates for group of states and the nation. The fieldwork was carried out in 2001.

The sample size in each state for rural and urban areas was determined with a view to keeping the error margin of the estimates within 5 per cent and at 95 per cent confidence level. The sample size for rural and urban areas in a state is adequate to make reliable estimates of the different dimensions of the five services.³

Limitations of the study: (i) The design of the study was done at the all-India level. At an aggregate level it was difficult to adequately take into account all the special characteristics of each state.

(ii) The estimates of the survey, viz, access and use are not directly comparable to the available secondary data as they use different bases. For example, the percentage of households reporting the use of outpatient services by this survey appears to be on the higher side in this study, as it is worked out as a percentage of households using public health care facilities.

(iii) The responses in the survey are based on user experience rather than physical measurement at the point of delivery. It was not easy to check the consistency between the official records and users' experience.

(iv) In response to some questions in the survey, especially those related to satisfaction, respondents are likely to have used their own expectations and judgment. These expectations might vary from one state or region to another for obvious reasons.

(v) Delhi, Goa, metro cities, and Jammu and Kashmir have not been included in the analysis presented below.

V Major Findings

The five basic services are analysed on four dimensions: easy access, extent of use, quality and reliability, and satisfaction with services. The availability of a public water source within 100 metres from the household (rural/urban) is considered as 'easy access' for drinking water. For the other four services, the availability of a service within one kilometre from the village centre is considered as easy access for the service. For urban households, the distance of one kilometre to the service from the household is considered as easy access for the other four services.

A caveat is in order at this stage. Comparison of our findings with those of other studies and surveys conducted by government agencies will be problematical for two reasons. First of all, measures of reliability and satisfaction do not find a place in any of the surveys/studies we have reviewed in an earlier section. Quality of services may have been assessed in a few micro level studies. But unless the measures used are identical, comparisons with the present findings will be well nigh impossible. Second, even when other surveys have measured access and use of services, the definitions and norms used seem to have been quite different. Governments typically use population norms to define access to a service. For example, a health sub-centre is designed to cater to a population of 5,000. A PDS shop is meant to cover a population of 2,000. A drinking water source is supposed to serve households within a distance of 1.6 km. As against this, the norm used in this survey is a distance of 100 metres from a household. Our norm of 100 metres is clearly a more user friendly measure of access. Similar problems exist in the definitions of the use of service. Comparisons between the findings of this study and of others will be rendered difficult because of these varying norms. The only exception is in primary education where the access norm used (one km from the household) is the same in the present survey and the government's education survey. It is important to draw attention to the scope and limitations of the norms of the service dimensions used in this study before moving on to a discussion of its findings.

Drinking Water

Access and use: As per the survey, protected sources (government and private) serve 80 per cent of households in the country. Around two-thirds of the households (62 per cent) in the country use protected water supply from public (government) sources. Protected water from public sources is used more in urban areas (72 per cent) than in rural areas (58 per cent). The higher use of water supply from public sources is in the states of Sikkim (90 per cent), Tamil Nadu (90 per cent) and Arunachal Pradesh (87 per cent) while the lowest levels of use are in Assam (10 per cent), Bihar (18 per cent) and Nagaland (20 per cent).

Private protected sources like hand pumps or borewell are used extensively in states such as Punjab and Bihar (over 50 per cent of the households), while a high density of private open wells was observed in Kerala. This in part explains the low access and use of public water supply sources reported for these states.

The 'use' of a given source of drinking water by a household

does not say anything about the regularity of supply. If the supply is irregular or infrequent, it implies a more limited use of the water supply source in contrast to a case where water supply is available throughout the day. The use data therefore needs to be qualified by feedback on the regularity and frequency of water supply. It tells us something about both the adequacy and reliability of the water supply as experienced by households that depend on public water supply systems. The table below reports on this aspect of water supply for all the major states of India. A positive feature is that the vast majority of households using public water supply sources report water availability on a daily basis though the duration of supply might vary. But it also shows that daily availability is high in terms of coverage (over 90 per cent) only in three states with respect to public taps and in six states with respect to piped water supply. Nearly 20-30 per cent of households do not enjoy this facility in the remaining states. The duration (in hours) of water supply can be used to fine tune this measure, but it will not be attempted in this paper.

All users of water, needless to say, have access to a water supply source. But this by no means implies that they have easy access to water. Judged by our access norm of 100 metres from the household, only about 55 per cent of households in the country have easy access to a source of public water supply. Ease of access to the households is greater in the states of Sikkim (90 per cent), Tamil Nadu (83 per cent) and Arunachal Pradesh (81 per cent) and less in the states of Assam (9 per cent), Nagaland (19 per cent), and Bihar (16 per cent). More households in urban areas enjoy easy access (68 per cent) than in rural areas (50 per cent). *Reliability:* One-fourth of the households in the country reported break down of water supply through public taps at least once in three months. Similarly, about one-fourth (24 per cent) of households using public hand pumps also reported breaks down. Breakdowns of public taps are reported more by rural users (27 per cent) than urban users (18 per cent). On the other hand, breakdowns of public hand pumps are reported more by urban users (31 per cent) than rural users (24 per cent).

Having access to protected sources of drinking water is clearly not a solution, as evidence from the field revealed. When the hand pump breaks down or runs dry most of the summer, villagers in Jhagaria, Madhya Pradesh, have to make the most of unprotected open wells. In Jalapur, Gujarat, women trudged 3 km to access water from an ashram, just because the installed borewell hand pump in the village broke down years back.

Breakdowns of water supply in public taps are reported by a large proportion of households in Uttar Pradesh (52 per cent), Tripura (46 per cent) and Rajasthan (45 per cent), while a small number of households reported incidence of breakdowns in West Bengal (8 per cent), Maharashtra (11 per cent), Orissa (12 per cent) and Madhya Pradesh (12 per cent). In the case of public hand pumps, breakdowns are reported by larger proportions of households in Tamil Nadu (68 per cent) and Rajasthan (60 per cent) and lower incidence of breakdowns is reported in Mizoram (7 per cent), Maharashtra (11 per cent), Orissa (16 per cent) and Uttar Pradesh (16 per cent).

Bhadgaon village panchayat, Maharashtra provides piped water supply to 1,885 households. There are also 85 public hand pumps at various locations. The panchayat collects a monthly tariff of Rs 30 and the rate of recovery is reported to be very good.

Full satisfaction: One-fifth of the households using public piped supply are fully satisfied with the adequacy of water. The percentage of households who are fully satisfied with the adequacy of water

from other protected sources is about 25 per cent. About one-fourth (27 per cent) of households using public piped supply are fully satisfied with the quality of water. The percentage of households fully satisfied with the quality of water from other protected sources is about 32 per cent.

Full satisfaction with quantity is more widespread among users of piped water supply in Tamil Nadu (52 per cent), Uttar Pradesh (50 per cent) and Gujarat (46 per cent) while less than 2 per cent of users in Nagaland, Mizoram and Punjab reported full satisfaction. On quality of piped water supply, higher percentages of households in Gujarat (61 per cent) and Tamil Nadu (60 per cent) reported full satisfaction while less than 4 per cent of

Table 1: Frequency of Water Supply by Source
(Percentage of households)

States	Public Tap			Piped Water Supply		
	Daily	Alternate Day	Once in 3 to 7 Days	Daily	Alternate Day	Once in 3 to 7 Days
Andhra Pradesh	84.8	14	1.1	78.7	16	5.3
Assam	77	22.3	0.7	92	5.3	2.7
Bihar	75	20.8	4.2	95.7	2.1	2.1
Gujarat	89.4	8.2	2.3	86.7	11.3	2
Haryana	95.5	2.6	1.8	84.6	8.8	6.6
Himachal Pradesh	91.9	6.3	1.8	90.1	5.7	4.2
Karnataka	78.3	16.2	5.5	76.7	11.7	11.7
Kerala	78.3	10.6	11.1	69.9	27.2	2.9
Madhya Pradesh	69.5	25.2	5.3	79.2	13.6	7.2
Maharashtra	82.5	14.1	3.4	89	7.5	3.5
Orissa	95.8	3	1.2	98.6	1.4	0
Punjab	89.8	6.8	3.4	90.6	3.7	5.7
Rajasthan	75.4	11.4	13.2	54	30.9	15.1
Tamil Nadu	80.6	11.1	8.3	43.3	17.6	39.1
Uttar Pradesh	73.2	18.6	8.2	92.9	4.9	2.2
West Bengal	99.7	0.3	0	100	0	0

Table 2: Public Drinking Water Facilities – Access, Use, Reliability and Full Satisfaction
(Percentage households – rural and urban combined)

States	Access	Use ⁴	Reliability (Breakdown)		Full Satisfaction (Piped Supply)	
			Taps	Hand Pumps	Adequacy	Quality
North						
Bihar	16	18	33	34	17	18
Haryana	42	50	23	33	27	39
Himachal Pradesh	80	84	20	Ns	12	18
Punjab	30	31	21	Ns	2	3
Uttar Pradesh	36	39	52	16	50	46
East						
Assam	9	10	30	Ns	25	33
Madhya Pradesh	61	75	12	20	30	47
Orissa	56	80	12	16	11	18
West Bengal	61	81	8	20	14	15
South						
Andhra Pradesh	69	82	24	27	25	27
Karnataka	71	79	19	22	35	45
Kerala	28	30	17	Ns	16	22
Tamil Nadu	83	90	40	68	52	60
West						
Gujarat	70	75	27	21	46	61
Maharashtra	77	79	11	11	11	13
Rajasthan	56	75	45	60	9	23
North East						
Arunachal Pradesh	81	87	17	Ns	3	4
Meghalaya	69	77	22	0	14	9
Mizoram	68	72	33	7	1	9
Nagaland	19	20	29	Ns	0	0
Sikkim	90	90	Ns	Ns	17	25
Tripura	49	63	46	37	7	8
National average	55	62	25	24	20	27

Note: Ns: Percentage is not computed when the number of sample users is less than 30.

households reported full satisfaction in Nagaland, Punjab, and Arunachal Pradesh.

In the case of other protected sources, full satisfaction with quantity is reported more in the states of Uttar Pradesh (49 per cent) and Tamil Nadu (41 per cent), and by less than 5 per cent in the states of Tripura, Nagaland, Mizoram and Orissa. Full satisfaction with quality of water from other public sources is high in Uttar Pradesh (54 per cent) and Tamil Nadu (53 per cent), while it is less than 3 per cent in Nagaland and Tripura. Since the breakdown rates in Tamil Nadu are relatively high, the high satisfaction ratings from this state may seem puzzling. But field checks have shown that repairs were also speedy in Tamil Nadu, a factor that may have compensated for the high incidence of breakdowns.

Health Care

Access and use: About 40 per cent of sample villages and 41 per cent of urban households reported ease of access to government health care facilities. The ease of access to government health care facilities for rural areas is high in Sikkim (97 per cent), Mizoram (82 per cent) and Punjab (62 per cent), and relatively low in Nagaland (11 per cent), and Bihar (21 per cent). Similarly, the ease of access is more for urban households in Orissa (73 per cent) and Arunachal Pradesh (72 per cent) and low in Meghalaya (15 per cent) and Bihar (17 per cent).

For the treatment of minor ailments,⁵ 45 per cent of households in the country use government health facilities and 12 per cent use private hospitals. For treatment of major ailments,⁶ 55 per cent of households use government health facilities and 33 per cent use private hospitals. Households in Arunachal Pradesh (95 per cent), Sikkim (92 per cent), Mizoram (84 per cent) and Orissa (83 per cent) reported higher dependence on government health facilities for minor ailments while the households in Bihar (7 per cent) reported lower dependence. For major ailments, the households in Sikkim (97 per cent), Mizoram (94 per cent) and

Orissa (92 per cent) reported higher dependence on government health facilities and the households in Bihar (13 per cent) and Nagaland (24 per cent) reported lower dependence.

Having easy access to a health care facility is of vital importance to those needing immediate treatment. The trauma citizens face is highlighted by the experience of pregnant women living in Sankal, located in the hill tract of Vadodara, Gujarat, who have to travel 13 km to the nearest health facility. This is the reality that many others, across the country experience in accessing health care.

Reliability: Around 83 per cent of the users of government health facilities found paramedical personnel present at the time of their visit, while 70 per cent reported the presence of a doctor. A higher proportion of urban users reported the availability of doctors and paramedical staff at the time of their visit compared to rural users. A high proportion of users in Gujarat (95 per cent), Maharashtra (96 per cent) and Punjab (85 per cent) and a lower proportion of users in Andhra Pradesh (28 per cent) and Tripura (1 per cent) reported availability of doctors at the time treatment was sought.

But having a Primary Health Centre within the village is no service at all, according to residents of Yedira, Andhra Pradesh. The PHC is new and has all the required facilities, but the lady doctor posted to the PHC was an occasional visitor to the village, and did not like to touch patients. In Kherni Umari village, Banaskantha, Gujarat, pregnancy cases are handled by the illiterate village 'dai' – the PHC is a just a kilometre away but neither the doctor nor the auxiliary nurse midwife living at the block headquarter 15 kilometres away are regular.

Cost of service: Health care facilities provided by the government are expected to cater to the needs of the poor and underprivileged by being free or subsidised. Around 40 per cent of inpatients and 18 per cent of outpatients paid a fee for the health care service. About 16 per cent of inpatients reported payment of bribes.

Cheap treatment is a major incentive for villagers to use the services of the PHCs. However, for the residents of Kodakkambur village in Kerala, located in the Western Ghats, the nearest PHC

Table 3: Government Health Care – Access, Use, Reliability and Full Satisfaction
(Percentage households – rural and urban combined)

States	Access		Use (Ailment)		Reliability (Presence)		Full Satisfaction (Behaviour)	
	Rural*	Urban	Minor	Major	Doctors	Paramedics	Doctors	Paramedics
North								
Bihar	21	17	7	13	79	89	8	5
Haryana	35	21	23	28	75	83	14	12
Himachal Pradesh	53	59	51	58	80	95	10	8
Punjab	62	24	24	42	85	85	2	3
Uttar Pradesh	34	23	19	41	72	76	18	18
East								
Assam	38	49	68	68	72	84	5	5
Madhya Pradesh	44	53	49	65	63	78	8	8
Orissa	28	73	83	92	79	89	3	2
West Bengal	33	57	47	88	63	77	11	3
South								
Andhra Pradesh	36	55	55	48	28	59	6	7
Karnataka	26	46	48	49	74	93	31	27
Kerala	57	59	60	46	58	89	9	8
Tamil Nadu	44	42	53	60	71	90	29	29
West								
Gujarat	36	43	43	58	95	96	30	27
Maharashtra	51	38	50	69	88	93	22	21
Rajasthan	52	65	74	87	59	73	5	5
North East								
Arunachal Pradesh	36	72	95	76	64	65	1	0
Meghalaya	23	15	38	38	64	63	15	15
Mizoram	82	64	84	94	54	75	2	1
Nagaland	12	23	44	24	68	78	1	1
Sikkim	97	45	92	97	77	94	20	16
Tripura	53	34	59	72	39	47	1	1
National average	40	41	45	55	70	83	14	12

Note: * Percentage of villages.

normally has no staff in attendance and the villagers are forced to seek the services of private clinics, for which they have to pay a great deal more.

Full satisfaction: Among the households that make use of government health facilities, only a small proportion is fully satisfied with the service. The full satisfaction among outpatients with the behaviour of doctors and paramedical staff, is 14 per cent and 12 per cent respectively. The full satisfaction with the behaviour of doctors and paramedical staff is relatively more in urban areas compared to rural areas.

Full satisfaction (among outpatients) with the behaviour of doctors seems to be higher in Karnataka (31 per cent), Gujarat (30 per cent) and Tamil Nadu (29 per cent) and as low as 1 per cent in Arunachal Pradesh, Nagaland and Tripura. Full satisfaction with the behaviour paramedical staff is also higher in Tamil Nadu (29 per cent), Gujarat (27 per cent) and Karnataka (27 per cent) and low in Arunachal Pradesh, Nagaland and Tripura (about 1 per cent).

Villagers in Chahipeda, Madhya Pradesh are quite satisfied with their PHC because doctors and paramedical staff are present throughout the day. Inhabitants of Fardapur, Aurangabad, Maharashtra located close to the famous Ajanta Caves and the highway connecting Pune too were satisfied, as the ANM lives in the village itself and visits houses regularly.

Road Transport

State governments control the operation of the private buses through licensing policies. States allocate certain routes to private players exclusively and in some states, governments operate buses along with private buses on the same routes.

Access and use: All weather roads are the basic requirement for a good transport network. Only 39 per cent of the sample villages

in the country are observed to have tarred roads. The states with a higher percentage of villages having access to tarred roads are Kerala (86 per cent), Haryana (82 per cent) and Gujarat (66 per cent); lower access to tarred roads is observed in the rural areas of Nagaland (0 per cent), Tripura (3 per cent), Arunachal Pradesh (8 per cent) and Andhra Pradesh (8 per cent). Government buses are available within 1 km for 50 per cent of villages and for 60 per cent of urban households in the country. The availability of government buses is higher for the villages in the states of Andhra Pradesh (96 per cent), Gujarat (93 per cent), and Karnataka (91 per cent). Further, the availability of government buses is higher for urban households in the states of Karnataka (100 per cent), Tamil Nadu (98 per cent) and Andhra Pradesh (96 per cent).

The significance of this service was highlighted by residents of Jamalpur kala village, near Hardwar, Uttar Pradesh who saw the easy access to different forms of public transport as the means to securing livelihood opportunities in and around Hardwar. When no government buses are available, as is the case for the residents of Jhagaria village in Mandsour, Madhya Pradesh, they have no choice but to wait for private buses that follow no fixed schedule, and pay a price which they feel is high.

Private buses are available within 1 km for 63 per cent of villages and 64 per cent of urban households in the country. The availability of private buses is high for the villages in the states of Kerala (100 per cent) and Tamil Nadu (98 per cent). The availability of private buses is also high for urban households in the states of Kerala (99 per cent), Tamil Nadu (95 per cent) and Himachal Pradesh (88 per cent). Though the access to private buses compared to government buses is high for rural areas, the extent of actual use of private and government buses by rural households is almost at the same level (36 per cent and 34 per cent respectively) for the country as a whole. But the pattern varies significantly across states depending on the policies adopted by state governments. The usage of government buses is high in the states of Andhra Pradesh (95 per cent) and Maharashtra (89 per cent). On the other hand, the usage of private buses is higher in the states of Assam (89 per cent), Kerala (79 per cent) and Madhya Pradesh (76 per cent).

Reliability: The effective use of transport facilities depends on the punctuality of the buses. Extent of full satisfaction with punctuality of buses is used as a measure of reliability. The reliability of government bus services is 18 per cent for rural households and 25 per cent for urban households. The reliability of government buses is highest in Gujarat (43 per cent) followed by Tamil Nadu (34 per cent). Low reliability was reported in Arunachal Pradesh (4 per cent), Meghalaya (4 per cent) and Nagaland (2 per cent).

Full satisfaction: The full satisfaction of users with respect to services of government buses is captured in relation to the frequency of bus services and also with the behaviour of bus conductors. About 21 per cent of government bus users expressed full satisfaction with the frequency of bus services as well as with the behaviour of conductors. Full satisfaction is higher among urban households when compared to rural households, both with respect to frequency of service as well as behaviour of conductors. Full satisfaction with respect to frequency of public buses is more in the states of Gujarat (40 per cent), Tamil Nadu (34 per cent) and Uttar Pradesh (29 per cent). Full satisfaction with respect to the behaviour of bus conductors is higher in the states of Gujarat (38 per cent), Tamil Nadu (37 per cent) and West Bengal (27 per cent).

Table 4: Government Buses – Access, Use, Reliability and Full Satisfaction

(Percentage households – rural and urban combined)

States	Access		Use	Reliability (Punctuality)	Full Satisfaction	
	Rural*	Urban			Frequency of Service	Behaviour of Conductor
North						
Bihar	2	7	Neg	Ns	Ns	Ns
Haryana	58	59	35	21	20	22
Himachal Pradesh	Ns	86	48	15	12	14
Punjab	71	72	20	5	4	4
Uttar Pradesh	25	62	8	28	29	26
East						
Assam	22	34	2	13	20	21
Madhya Pradesh	19	32	8	17	21	15
Orissa	10	38	1	Ns	Ns	Ns
West Bengal	15	45	7	25	28	27
South						
Andhra Pradesh	96	96	95	13	20	21
Karnataka	91	100	65	22	21	23
Kerala	76	84	13	13	14	13
Tamil Nadu	88	98	73	34	34	37
West						
Gujarat	93	88	67	43	40	38
Maharashtra	88	86	89	15	15	16
Rajasthan	46	66	26	9	10	10
North East						
Arunachal Pradesh	23	12	39	2	3	1
Meghalaya	15	10	4	3	3	3
Mizoram	83	80	46	14	18	18
Nagaland	48	78	32	4	4	5
Sikkim	69	51	40	13	13	12
Tripura	15	39	5	Ns	6	0
National average	50	60	35	20	21	21

Note: * Percentage of villages.

Public Distribution System

Access and use: State governments have expanded the number of fair price shops to cover the rural and urban population. About 60 per cent of villages and about 85 per cent of urban households have easy access to PDS outlets. About 82 per cent of rural and 78 per cent of urban households possess ration cards. Among the states, households in rural Nagaland have poor ease of access (12 per cent) to PDS outlets. About 75 per cent of rural and 62 per cent of urban households possessing ration cards use PDS at least once in two months for procuring some items (including foodgrains). More than 90 per cent of rural households in the states of Assam, Karnataka, Orissa and West Bengal use PDS at least once in two months. Similar high usage by urban households is observed only in the states of Orissa and Tamil Nadu. The usage of PDS is very low in Nagaland (8 per cent) and Meghalaya (10 per cent).

Villagers use the PDS for buying different items supplied by the outlets, of which foodgrains are the most important. Usage is high even in states where foodgrain offtake is low, because villagers use the PDS outlet to procure subsidised kerosene and sugar. This is the case in many parts of Punjab.

Reliability: Though the percentage of households reporting use of ration cards is high, only one-fourth of rural and one-fifth of urban households have reported regular availability of staple foodgrains. Regular availability is reported by more than half of all rural households in the four southern states, viz, Andhra Pradesh, Karnataka, Kerala and Tamil Nadu. Regular availability is reported by 2 per cent (or less) of users in the states of Bihar, Haryana, Punjab and Uttar Pradesh.

Most inhabitants of Ludkibeda, Balangir, Orissa are seasonal workers. There have been numerous skirmishes between the villagers

and the PDS shopkeepers over erratic supply of foodgrains and anomalies in the distribution of foodgrains.

PDS outlets are required to display the prices of the supplies. About 47 per cent of users reported display of prices by PDS outlets. Display of prices by PDS outlets appears to be more in urban areas (56 per cent) than in rural areas (45 per cent). Display of prices is reported by a higher percentage of households in the states of Gujarat (79 per cent), Kerala (81 per cent), Sikkim (75 per cent) and Tamil Nadu (71 per cent) and by a lower percentage of households in the states of Nagaland (2 per cent), Meghalaya (15 per cent), Haryana (21 per cent) and Uttar Pradesh (21 per cent).

Full satisfaction: The aspects considered for full satisfaction with respect to PDS are quantity and quality of supplies and the fairness of the shopkeepers. Though the coverage of PDS is good, satisfaction with respect to PDS is poor. Only 8 per cent of the households are fully satisfied with the quantity of supplies, 9 per cent with quality of supplies and 10 per cent with the fairness of shopkeepers. The percentage of households reporting full satisfaction was highest in Tamil Nadu (22 per cent with respect to quantity, 19 per cent with quality and 24 per cent with fairness of shopkeepers).

Primary Schools

There is a large network of government-supported schools in all the states, of which primary schools form a major part. In addition, there are also a good number of primary schools run by private institutions.

Access and use: Government/aided primary schools are accessible within 1 kilometre for 76 per cent of the villages and for 42 per cent of urban households in the country. The private

Table 5: PDS – Access, Use, Reliability and Full Satisfaction
(Percentage households – rural and urban combined)

States	Access		Use	Reliability (Regular Availability)	Full Satisfaction		
	Rural*	Urban			Quantity	Quality	Fairness
North							
Bihar	53	87	75	1	6	15	10
Haryana	53	92	85	2	9	9	9
Himachal Pradesh	47	83	82	11	6	6	6
Punjab	64	96	79	0	2	4	3
Uttar Pradesh	43	78	78	1	13	15	14
East							
Assam	72	89	99	10	2	6	7
Madhya Pradesh	73	82	76	23	6	9	8
Orissa	58	94	99	10	0	1	2
West Bengal	44	96	85	9	2	1	2
South							
Andhra Pradesh	64	85	68	51	13	18	18
Karnataka	67	81	93	47	7	14	20
Kerala	69	92	86	45	4	3	3
Tamil Nadu	88	88	89	73	22	19	24
West							
Gujarat	57	89	86	41	12	12	14
Maharashtra	84	96	56	38	2	4	4
Rajasthan	46	90	83	6	7	6	5
North East							
Arunachal Pradesh	40	97	40	12	0	0	0
Meghalaya	54	57	10	14	5	5	5
Mizoram	89	98	89	27	10	1	1
Nagaland	12	68	8	6	4	4	4
Sikkim	93	98	82	34	15	14	14
Tripura	47	97	50	10	16	16	1
National average	60	85	72	23	8	9	10

Note: * Percentage of villages.

primary schools are accessible within 1 kilometre for 25 per cent of villages and for 25 per cent of urban households. Easy access to government and aided schools is reported to be high in rural Rajasthan (85 per cent), Gujarat (93 per cent) and Andhra Pradesh (92 per cent). Ease of access to rural primary schools is relatively low in the states of Arunachal Pradesh (23 per cent) and Tripura (41 per cent).

The dependency of households (with children of school-going age) on government run schools for primary education is 83 per cent in rural and 61 per cent in urban areas. The dependence on government/aided schools is more than 90 per cent in the rural areas of Arunachal Pradesh, Gujarat, Madhya Pradesh, Maharashtra, Orissa, Tripura and West Bengal. In urban areas, the dependency is more than 80 per cent in Arunachal Pradesh, Orissa, Tamil Nadu and West Bengal.

Notwithstanding the wide network of private schools in Kerala, a large number of villagers make use of the government schools (primary, middle and high) in Kalliyoor near Trivandrum.

The mid-day meal scheme is an important initiative promoted by governments to improve the health of children as well as school attendance. About 68 per cent of households in the country reported awareness of the scheme. Low awareness about the scheme is reported in Meghalaya, Nagaland and Tripura.

Reliability: The indicator that comes closest to measuring the quality of primary education is the 'full satisfaction' and with respect to the behaviour of teachers. Only 16 per cent households, who are sending their children to government run and aided primary schools, reported full satisfaction with the behaviour of teachers. A relatively higher percentage of households in the states of Tamil Nadu (38 per cent), Karnataka (26 per cent) and Gujarat (23 per cent) reported full satisfaction with the behaviour of teachers. Less than 2 per cent of households reported full satisfaction with the behaviour of teachers in the states of Arunachal Pradesh, Meghalaya, Nagaland, Punjab and Tripura.

Mudhol in Karnataka has one primary school with three classrooms. But the contractor has locked up two rooms for which his payments have not been made. All children from classes 1 to 4 sit in the same room or in the narrow corridor outside. Inhabitants of remote villages find that their schools have an inadequate number of teachers to handle the classes, as in Sankal in Vadodara, Gujarat or very irregular teachers as in Elumyuo, Nagaland.

Full satisfaction: Parents of school-going children may have better awareness of the physical infrastructure of the schools compared to other aspects of education that take place within classrooms. Toilet is an important infrastructure of the school, particularly for girl children. Hence, full satisfaction of households with respect to primary schools is assessed in relation to the quality of buildings and toilets. In all, 14 per cent of the households using government run and aided primary schools reported full satisfaction with the quality of school buildings. Only 6 per cent of households using government primary schools reported full satisfaction with the quality of the toilets.

Child care: The state government provides child care facilities through 'anganwadis'. Over two-thirds of villages (71 per cent) have easy access to anganwadis and about one-third of the rural households (having children in the age group of 1 to 6 years) use the facility. More than 90 per cent of the villages in Karnataka, Maharashtra and Nagaland have easy access to anganwadis while less than one-third of villages in Bihar have easy access to anganwadis. Most of the households (87 per cent) using anganwadis reported that these institutions are working regularly. Many users (78 per cent) rated the behaviour of anganwadi workers as good.

The reasons spelt out by the households for sending their children to anganwadis are immunisation (79 per cent), pre-school facility (76 per cent) and supplementary diet (40 per cent). On the whole, the satisfaction of households with the services of anganwadis appears to be better compared to the other public services.

Relative Performance of States in Public Services

The major states (16 of them) are ranked on the basis of overall performance in terms of each service. The indicators that are considered for the overall performance of a service are access, reliability and satisfaction with the service. 'use' has been left out of this computation as it can be overly influenced by the lack of private options. For each indicator of a service, average scores are computed and they are aggregated across all the indicators to obtain the overall score for a service. The overall scores for a service are ranked across states to obtain the relative performance of states for a service. The ranks of states for the five services are aggregated to obtain relative ranks for the states in the overall performance of the five public services.

The relative performance of public services for the major states show that except for health care in Andhra Pradesh, and drinking water in Kerala, the four southern states (Andhra Pradesh, Karnataka, Kerala and Tamil Nadu) and two western states viz, Maharashtra and Gujarat have performed consistently well in all the five public services. In the overall performance of public services, Tamil Nadu comes first, followed by Gujarat, Karnataka, Maharashtra, Andhra Pradesh and Kerala. The six states are contiguous. The other contiguous states which form the second level in the overall performance of public services are Haryana, Himachal Pradesh and Punjab from the north and Madhya

Table 6: Government/Aided Primary Schools – Access, Use, Reliability and Full Satisfaction

(Percentage households – rural and urban combined)

States	Access		Use	Reliability (Behaviour of Teacher)	Full Satisfaction	
	Rural*	Urban			Quality of Building	Quality of Toilet
North						
Bihar	80	44	70	9	4	1
Haryana	81	32	56	5	5	3
Himachal Pradesh	75	38	83	6	4	3
Punjab	74	33	57	1	1	1
Uttar Pradesh	82	40	71	15	18	8
East						
Assam	74	38	82	14	6	2
Madhya Pradesh	87	29	86	20	13	3
Orissa	89	54	93	3	3	1
West Bengal	60	41	94	21	14	4
South						
Andhra Pradesh	92	54	82	16	18	4
Karnataka	82	53	80	26	23	7
Kerala	75	22	74	17	16	10
Tamil Nadu	71	67	86	38	30	18
West						
Gujarat	93	56	86	23	22	9
Maharashtra	83	53	93	21	17	13
Rajasthan	85	51	75	6	6	2
North East						
Arunachal Pradesh	23	37	93	1	0	0
Meghalaya	73	13	20	0	0	0
Mizoram	62	39	84	2	16	5
Nagaland	82	9	31	0	0	0
Sikkim	52	17	63	16	17	12
Tripura	41	24	91	1	1	0
National average	76	42	78	16	14	6

Note: *Percentage of villages.

Pradesh and Uttar Pradesh from the north-central part of the country. For these states the overall performance ranks ranged from 7 to 11. The states that figured in the third level in the overall performance of public services are Assam and west Bengal from the east and Orissa, Rajasthan and Bihar, mainly in the east and north.

It is significant that the ranking of the states given above does not follow the widely used ranking of the states by per capita income or other conventional measures of development. Of the six states in the top category, three are somewhere in the middle when ranked by per capita income. Some of the states with the highest per capita income are found in our middle category. It is only in our bottom category that the states with low per capita income and poor public services converge. A plausible hypothesis is that factors other than per capita income also influence the efficacy and quality of public services. Some observers have noted that the quality of governance is distinctly better in the higher ranked public service performers than in the rest of the states. But quantifying measures of governance is by no means easy.

The bottom five states are way below the top states with respect to access in drinking water, health care and transport. The gap is smaller in primary schools and PDS. The use patterns between the two sets of states are more similar, except in public transport. In terms of reliability, the gap is indeed wide except in drinking water and health care. In the matter of full satisfaction, the bottom states are significantly below the top states.

Public Services and Disadvantaged Sections

Given the limitations of self-reported income as the basis for identifying the very poor, the study used a combination of three criteria to define poor households in terms of both income and other handicaps. A household is considered to have a significant income capability disadvantage (ICD), when it is living in a 'kutchra' house (hut), the head of the household is illiterate or has not received formal schooling and the head of the household is a daily wage earner. In addition to ICD, the study considered scheduled caste and scheduled tribe households and households from small villages (with population less than 1,000 persons) as disadvantaged sections.

The basic issue examined in this study is whether the poor are being discriminated against with respect to the five services. For this purpose, our analysis is confined to the 16 major states of India. The main finding is that in the 16 states, a significantly smaller proportion of ICD households have ease of access to health care, public transport, and PDS compared to the rest, but have more or less equal access to drinking water and primary schools. On the usage side, a higher percentage of ICD households utilise all services except public transport. There are no significant differences between ICD and other households in terms of reliability and full satisfaction with the services. One reason is that the poor and non-poor are using the same service facility once they have access to it (e.g. a government hospital). In brief, ICD households depend more on public services than the non-poor though they are disadvantaged with respect to ease of access.

SC/ST households have more or less similar ease of access to public services as the rest of the population. They also report a higher dependence on public services except in transport compared to the rest. Small villages (class C) have lower access

to all public services compared to the larger villages (A and B classes) except in drinking water. Despite lower access, smaller villages are on par with larger villages in the use of public services. A clear implication is that people in the small villages travel longer distances to avail of essential public services, and in the process incur higher costs including lost wages.

A comparison of ease of access to public services for the poor and non-poor, in the top six and bottom five states leads to the following findings: There are no significant differences in the access to most public services between ICD and other households in the top six states. Health care and PDS are two services where ICD households seem to have somewhat lower access. In the bottom five states, on the other hand, ICD households report lower access to all services (compared to other households) except drinking water. Primary schools and drinking water are two services that seem to have reached out to the poor in all parts of the country. A disturbing finding is that the poor (ICD) households in the top six states have much higher access to all five services than even the non-poor households in the bottom five states. This is true to a smaller extent of the middle states also, for four out of the five services. This is truly a sad reflection on the pathetic state of public services in several of India's major states. The bottom five states are also worse off in terms of reliability and full satisfaction. It signifies the extreme disparities between our states in respect of the adequacy and quality of public services. In contrast, disparities between the poor and the non-poor within states seem much less significant in comparison. This is not to say that the latter does not deserve careful attention. But the big challenge facing the country is how to bridge the wide gap between states.

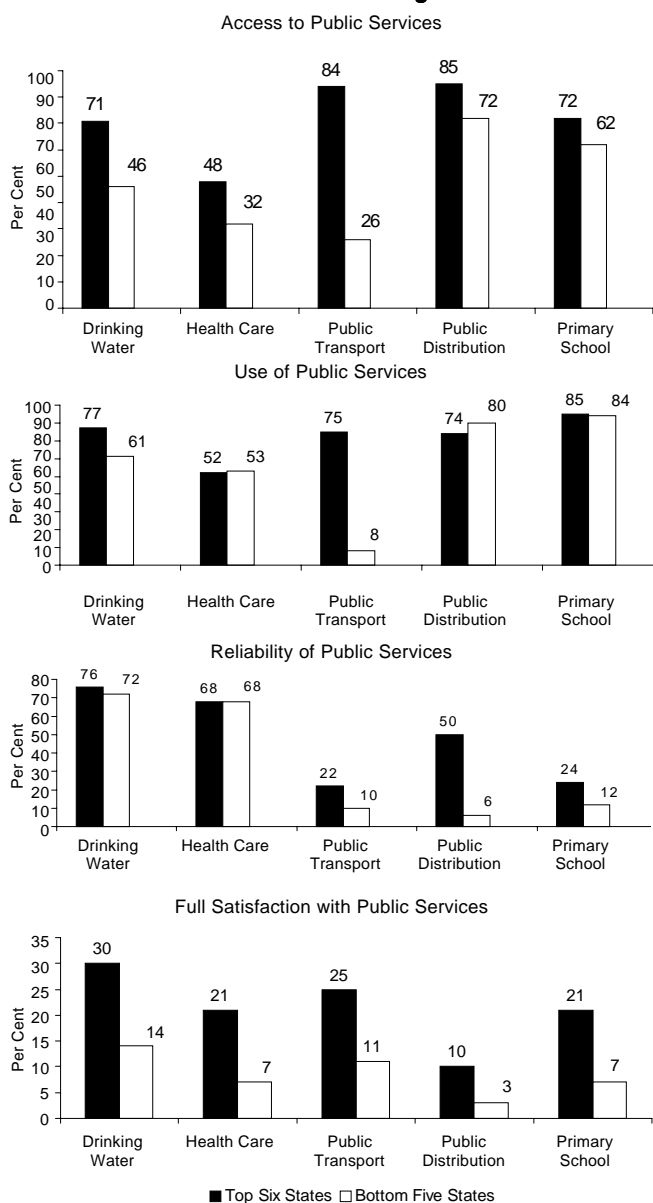
VI Conclusions

(i) Let us now sum up the findings on the five services. Drinking water is accessible to 55 per cent of Indian households within a distance of 100 metres from home. A relaxation of this rather strict norm will increase this proportion. Still, a quarter of all households depend on unprotected sources of drinking water. One-fourth of the users of public sources of water have reported frequent breakdowns of supply. Access to reliable drinking water supply is thus a problem for a significant proportion of households.

Table 7: Relative Performance of States in Public Services

	DW	Health	Transport	PDS	Education	Overall
<i>First level</i>						
Andhra Pradesh	7	16	4	2	4	5
Karnataka	2	6	3	3	3	3
Kerala	13	7	7	5	8	6
Tamil Nadu	1	4	2	1	1	1
Gujarat	3	1	1	6	2	2
Maharashtra	5	2	5	4	4	4
<i>Second level</i>						
Haryana	11	9	8	11	13	10
Himachal Pradesh	4	5	6	13	15	7
Punjab	14	3	10	10	16	11
Madhya Pradesh	6	10	13	8	6	8
Uttar Pradesh	9	7	9	14	7	9
<i>Third level</i>						
Assam	15	10	14	7	11	14
West Bengal	7	15	11	15	13	13
Orissa	10	13	15	9	10	12
Rajasthan	12	12	12	16	9	15
Bihar	16	14	16	12	12	16

Chart 1: Contrasts between Categories of States



(ii) Public health facilities are accessible to over 40 per cent of the households within a distance of one kilometre. The presence of private health facilities makes up for this limited access to some extent. Of the households that use health facilities, a larger proportion use public health services rather than private facilities. The presence of doctors at public health facilities (a measure of quality and supervision) leaves much to be desired. One-third of the patients did not find a doctor present during their visits.

(iii) Absence of pucca roads in their village, was reported by nearly 60 per cent of all households. Both public and private buses are available in many states, though in some states there is a domination of either government or private bus transport. Government buses are rated quite low on punctuality and frequency.

(iv) PDS has wide coverage across the country, with over 80 per cent of the households owning ration cards and 72 per cent using fair price shops at least once every two months. But only one-fourth of the cardholders reported regular availability of foodgrains in the shops. Display of prices was reported by less

than 50 per cent. While the reach of the PDS network is wide, its effectiveness is greatly hurt by the high degree of unreliability and non-transparency associated with the service.

(v) Government owned or supported primary schools are available to nearly 80 per cent of the households within one kilometre of their homes. The dependence on government schools is significantly high, especially in rural areas. Awareness about the mid-day meal programme is high among households and most are beneficiaries of the scheme. Anganwadis are accessible to over two-thirds of the eligible households, but only 30 per cent are regular users of the service. A major reason for low use is the time and cost of transporting children back and forth to avail of the service.

(vi) The user feedback analysed above has some strong messages for policy-makers. Even when people give high marks for access to a service, they signal that reliability and public satisfaction leave much to be desired. Nearly three fourths of households consider PDS unreliable and their full satisfaction rating for this important service is indeed low. One-third of people attest to the irregular availability of doctors in public health care facilities. Other services do not fare much better. It is clear that access alone does not bring satisfaction to the users of services. People want effective services with some assurance of quality. Reliability, a key attribute of quality, is a major problem area in public services. This study clearly brings out the fact that this is a systemic issue across all the services. The benchmarks we have created through this survey offer a basis for judging governmental performance in this regard over time.

(vii) Comparison of different public services in a large and diverse country is a risky undertaking. The criteria for defining standards and measures, access, usage, etc, may vary from one service to another. There cannot be a uniform measure of reliability for all services. But satisfaction is one dimension to which these limitations do not apply in the same degree. It reflects the subjective assessment of a service by people based on their recent experience. And it is the same set of people (more or less) who have rated their satisfaction with the different services. Judged by measures such as reliability and full satisfaction, it is clear that there is vast scope for reform and improvement in all the five services. We refer to some services and states as better performers only in a relative sense. Though levels of full satisfaction with all services are rather low, it is notable that of the

Table 8: Access and Usage by the Poor and Other
(Per cent)

Public Services	Access		Usage	
	ICD	Others	ICD	Others
Drinking water	53	56	65	62
Health care	34	44	50	41
Public transport	46	59	28	42
Public distribution	70	81	79	75
Primary school	70	68	91	76

Table 9: Access by Economic Categories and Category of States
(Per cent)

Public Services	Top 6 States		Middle 5 States		Bottom 5 States	
	ICD	Others	ICD	Others	ICD	Others
Drinking water	69	71	48	42	47	45
Health care	43	49	38	43	25	37
Public transport	88	83	38	46	22	29
Public distribution	82	85	68	74	64	79
Primary school	77	71	75	66	59	64

five public services, drinking water has done better than all others in terms of user satisfaction. PDS and primary education, on the other hand, rank the lowest in terms of satisfaction, though in terms of the access measures used in the study, they have done better than others. For the country as a whole, one could hazard a guess that drinking water is a better managed service while PDS and primary education have much scope for improvement.

(viii) Comparison of services across states may also suffer from some limitations. States differ in terms of resources, geographic and demographic features. Ranking states with respect to each service, for example, is not to ignore the fact that the differential performance may have been caused by some of these factors. Despite these limitations, an aggregation of the ranks states obtain for different services provides a rough indication of how they perform when all services are taken together. The states are grouped into three categories. Of the 16 major states, the better performers are the southern and western states of Tamil Nadu, Maharashtra, Karnataka, Gujarat, Andhra Pradesh and Kerala. That these states are doing better than other states on several counts has been noted by outside observers. But now we are getting a reaffirmation of this from ordinary people who live in these states. At the other end of the spectrum are Assam, West Bengal, Orissa, Rajasthan and Bihar. In between are the remaining states, Haryana, Himachal Pradesh, Punjab, Madhya Pradesh and Uttar Pradesh. While many factors have contributed to the positioning of the states in the three categories, the distinguishing feature of the first set is that, by and large these states have

relatively high ratings in terms of both access and reliability in all services. The opposite is true for four out of five of the states in the bottom category. The middle set includes states that for the most part are high on one attribute but low on the other.

(ix) Whether public services are reaching the poor and other disadvantaged groups is a matter of great concern to most policy-makers. Here again, one sees a mixed picture. Primary education and drinking water are two services that have done reasonably well in terms of access for the poor. The poor are worse off in terms of access with respect to the other three services. Despite the barriers to access, a larger proportion of the poor use most of the services rather than other households, the singular exception being public transport. In terms of reliability and satisfaction, the poor give lower ratings to almost all the services across the country compared to non-poor households.

(x) Village size also makes a difference when it comes to access to services. Residents of the larger villages (A and B class) invariably report greater ease of access to all the five services. Drinking water shows the least disparity in terms of access. Use patterns, on the other hand, are more similar, which means that the poor walk long distances to avail of the services. Clearly, longer distances mean that those living in the smaller villages and the poor (ICD) incur additional costs that hurt their ability to earn a livelihood.

(xi) A comparison of the higher and lower performers among the major states in terms of the five services yields some striking patterns. A major conclusion is that the gap between the two sets

of states is much larger than the gap between the poor and the non-poor households within any state (with respect to the five services). The disparities between the top six and the bottom five states in the matter of access to the five services are enormous. Whether poor or non-poor, people in the bottom states have only about half the level of access to drinking water compared to those in the top six states. Access to health services is only slightly better for the bottom states while the disparity is even wider with respect to public transport. The access gap is much narrower in primary education and PDS. The use of services is also less widespread in the bottom states though the disparities are not as large as in access. Reliability also is of a lower order in the bottom five states, with the disparity being the widest in PDS despite its better showing on access. Full satisfaction levels for all the services are much lower in the bottom states compared to the top six states. Even more striking is the finding that the poor in the top six states are better served than even the non-poor in the bottom states in the five areas! That such wide disparities in public services persist between states despite over a half century of development programmes and subsidies is indeed a matter for serious introspection. It is sad that issues of this kind are seldom debated in our elections and are rarely pursued by political parties.

(xii) The policy implications of the findings of this study have not been examined in this paper. A careful assessment of the current policies governing public services and the constraints governments face in service delivery must precede the design of new policies, given the varying political and socio-economic contexts of the states. Nevertheless, a couple of comments are in order. First, the evidence presented above has implications that go well beyond the design and delivery of individual services covered by the study. The broad picture that emerges from our analysis of the public feedback is that the quality of governance in many Indian states is appalling. Conventional technocratic answers for improving service delivery or a call to allocate more financial resources may not be an adequate response to this problem. The range of reforms required may cover a wide spectrum—from political leadership and administrative structures and incentives to service-specific changes including alternative delivery options.

Second, with respect to the striking interstate disparities discussed above, it is well known that per capita expenditure on the social sector is lower in the bottom five states than in the top six. Whether this means that resource constraints are behind their poor record in the five services is not clear. If access and use of services are lower in these states, the funds they require will also be smaller. The question is whether their ability to expand and improve services has been limited by their inability to mobilise the needed resources. One possibility is that resources are available, but that the ability and will to plan and utilise them properly leave much to be desired. It is also possible that increased financial allocations have been made to the bottom five states, but diversion of resources to meet other priorities or leakages has made it difficult to use them productively. Where the state is ineffective or non-responsive, civil society efforts could have played a role to demand better performance and accountability. In the better performing states, there is much greater civil society involvement in service provision and increasing evidence of alternative models of service delivery that have an influence on the responsiveness of public service providers. It is possible that people's ability to articulate 'voice' of this type is also absent

in the weaker states. If it is this kind of support and technical assistance that weaker states need in addition to funds, ways must be found to generate strategies to meet those needs. [\[1\]](#)

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Notes

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- 1 This is not to say that such assessments have no value or lessons to offer. The contexts in which they become useful and relevant are different.
- 2 To say that one has access to water is saying nothing. No one can survive without water and therefore people always find water from somewhere. Proximity and ease of access do matter.
- 3 Additional information on sampling can be obtained from the authors at pacindia@vsnl.com
- 4 Use exceeds access in some cases as the respondents are getting water from sources beyond 100 metres (the norm for access in the study).
- 5 Cough, cold, fever, wounds, loose motions, etc.
- 6 Surgery, fractures, complicated deliveries, heart attacks, etc.

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