PREFACE

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നഗരാസൂത്രണം: ചെന്നൈ പ്രളയം നൽകുന്ന പാഠങ്ങൾ

ഡോ. താര കെ.ജി

2015 നവംബർ മാസത്തിൽ ചെന്നൈ നഗരത്തിൽ 1049 മി.മീ മഴയാണ് പെയ്തത്. 24 മണിക്കൂറിനുള്ളിൽ നഗരത്തിലെ പല ഭാഗത്തും മഴവെള്ളം പൊങ്ങി. ഓരോ വർഷവും വടക്കു-കിഴക്കൻ മൺസൂൺ കാലത്ത് ആകെ കിട്ടിക്കൊണ്ടിരുന്നത് ശരാശരി 140 സെ.മീ മഴയായിരുന്നു. ഒരു കൊല്ലത്തിൽ പെയ്യുന്ന മഴയുടെ ഏഴ് ഇരട്ടി മഴയാണ് ഒരു മാസത്തിനുള്ളിൽ ചെന്നൈ നഗരത്തിൽ പെയ്തിറങ്ങിയത്. തമിഴ്നാട്, ആന്ധ്രാപ്രദേശ്, കേന്ദ്രഭരണ പ്രദേശമായ പുതുചേരി എന്നിവിടങ്ങളിൽ പെയ്ത അഭൂതപൂർവ്വമായ ഈ മഴയിൽ 400 ഓളം ജീവനുകളാണ് പൊലിഞ്ഞത്. 18 ലക്ഷത്തോളം ആളുകൾക്ക് കിടപ്പാടം നഷ്ടപ്പെട്ടു. മൊത്തം നാശനഷ്ടം 15 ബില്യൺ ഡോളർ; അതായത് ഏകദേശം 1 ലക്ഷം കോടി രൂപ! ചെന്നൈയിൽ മാത്രം 50,000 കോടി രൂപയുടെ നഷ്ടമുണ്ടായി എന്നാണ് കണക്കുകൾ സൂചിപ്പിക്കുന്നത്.

എന്താണ് ഈ വെള്ളപ്പൊക്കത്തിനു കാരണം?

1. കാലാവസ്ഥാവ്യതിയാനം

ഓരോ കൊല്ലവും, അതാതു പ്രദേശങ്ങളിൽ കിട്ടുന്ന മഴയുടെ അളവ്, ശരാശരി കിട്ടുന്ന മഴയുടെ അളവിനേക്കാൾ കൂടിയോ, കുറഞ്ഞോ ഇരിയ്ക്കാം. എന്നാൽ, വർഷങ്ങളോളം കാലാവസ്ഥാ ഘടകങ്ങളുടെ സൂചിക, ദേശീയ ശരാശരിയേക്കാൾ കൂടുതലോ, കുറവോ സ്ഥിരമായി രേഖപ്പെടുത്തുമ്പോഴാണ് അതിനെ കാലാവസ്ഥാവ്യതിയാനം എന്നു വിളിക്കുന്നത്. അഗ്നിപർവ്വതസ്ഫോടനങ്ങൾ, കടലും അന്തരീക്ഷവും തമ്മിലുള്ള പരസ്പരകൈമാറ്റങ്ങൾ, തുടങ്ങിയ സ്വാഭാവികമായ

കാരണങ്ങൾക്കു പുറമേ, മനുഷ്യന്റെ ഇടപെടലുകൾ കാരണം പണ്ടത്തേതിനേക്കാൾ കൂടുതൽ ഹരിത ഗൃഹവാതകങ്ങൾ അന്തരീക്ഷത്തിൽ കലർന്നു കൊണ്ടേയിരിക്കുന്നു. ഇത്തരം വാതകങ്ങളുടെ അളവ് കൂടുന്തോറും കാലാവസ്ഥയിൽ വൻ മാറ്റങ്ങളാണ് ഉണ്ടായിക്കൊണ്ടിരിക്കുന്നത്.

ഹരിതഗൃഹവാതകങ്ങളുടെ മുഖ്യസ്രോതസ് പെട്രോൾ, കൽക്കരി, പ്രകൃതി വാതകം തുടങ്ങിയ ഇന്ധനങ്ങളുടെ വ്യാപക ഉപഭോഗമാണ്. ഇത്തരം ഇന്ധനങ്ങൾ ഉപയോഗിക്കുന്ന വാഹനങ്ങളുടെ എണ്ണത്തിൽ തമിഴ്നാട് ഏഴാം സ്ഥാനത്തും കേരളം പതിനൊന്നാം സ്ഥാനത്തുമാണ്. ഇന്ത്യയിൽ, വാഹനങ്ങളുടെ എണ്ണം കഴിഞ്ഞ വർഷത്തിനേക്കാൾ 8.68 ശതമാനമാണ് വർദ്ധിച്ചത്.

സിമന്റിന്റെ വ്യാപക ഉത്പാദനം, വന നശീകരണം, വ്യവസായശാലകളിൽ നിന്ന് പുറന്തള്ളുന്ന ഹൈഡ്രോഫ്ളൂറോ കാർബൺ, സൾഫർ ഹെക്സാഫ്ളൂറൈഡ്, ഖരമാലിന്യങ്ങൾ ചീഞ്ഞളിയുമ്പോൾ പുറത്തുവരുന്ന മീഥേൻ പോലുള്ള വാതകങ്ങൾ, പ്ലാസ്റ്റിക് തുടങ്ങിയ ഖരമാലിന്യങ്ങൾ കത്തിക്കുമ്പോഴും എയർകണ്ടീഷണറുകൾ ഉപയോഗിക്കുമ്പോഴും പുറംതള്ളുന്ന വാതകങ്ങൾ, എന്നിവയും ഹരിതഗൃഹവാതകങ്ങളുടെ അളവു കൂടാൻ കാരണമാകുന്നു. ഇപ്രകാരം പുറന്തള്ളുന്ന ഹരിത ഗൃഹവാതകങ്ങളുടെ ആധിക്യം മൂലം ഭൂമിയുടെ ചൂട് കൂടുകയും മഴയുടെ അളവിലും മറ്റും വലിയ മാറ്റങ്ങൾ ഉണ്ടാവുകയും ചെയ്യുന്നു. ഇന്ത്യൻ കടലോരത്ത് അടിയ്ക്കുന്ന ചുഴലിക്കാറ്റിന്റെ ശക്തി വളരെയേറെ വർദ്ധിക്കാനും ഇത് ഇടയാക്കും. ചെന്നൈയിൽ പെയ്ത അഭൂതപൂർവ്വമായ മഴയുടെ ഒരു കാരണം കാലാവസ്ഥയിൽ ഉണ്ടായ ഈ മാറ്റമാണ്.

2. വൻതോതിലുള്ള നഗരവത്ക്കരണം

ജനസംഖ്യയുടെ കാര്യത്തിൽ ഇന്ത്യ ലോകത്ത് രണ്ടാം സ്ഥാനത്താണ്. ജനസംഖ്യാവർദ്ധനവിൽ തമിഴ്നാട് ആറാം സ്ഥാനത്തും കേരളം പതിമുന്നാം സ്ഥാനത്തുമാണ്. 2001 നും 2011 നും ഇടയിലുള്ള കാലയളവ് എടുത്താൽ, 15.6% വർദ്ധനയാണ് തമിഴ്നാട്ടിലെ ജനസംഖ്യയിൽ ഉണ്ടായത്. കേരളത്തിലാകട്ടെ, 4.9 ശതമാനവും. ചെന്നൈ നഗരത്തിലെ ആകെ ജനസാന്ദ്രത ഒരു ചതുരശ്ര കി.മീറ്ററിൽ 5922 പേർ ആണ്. ലോകത്തിലെ നഗരവത്ക്കരണത്തിന്റെ തോത് ഏകദേശം 5 ശതമാനം മാത്രമാണെങ്കിൽ ഇന്ത്യയിൽ ഇത് 9 ശതമാനമാണ്. കേരളത്തിലാകട്ടെ, നഗരവത്ക്കരണത്തിന്റെ തോത് ആഗോളനിരക്കിനേക്കാൾ മൂന്നിരട്ടി (15 ശതമാനം) ആണ്. 300 ലക്ഷം തൊഴിലാളികളും 2000 കോടി രൂപയുടെ ആസ്ഥിയുമുള്ള ഇന്ത്യയിലെ നിർമ്മാണമേഖലയിലാണ് വികസന പ്രവർത്തനങ്ങളുടെ 40 ശതമാനം മുതൽമുടക്കും ഉള്ളത് എന്നതും ശ്രദ്ധേയമാണ്.

എന്താണ് നഗരവത്ക്കരണവും വെള്ളപ്പൊക്കവും തമ്മിലുള്ള ബന്ധം?

ലോകത്തിലെ ഏറ്റവും ജനസാന്ദ്രതയേറിയ പട്ടണങ്ങളിൽ ഒന്നാണ് ചെന്നൈ. നഗരങ്ങളിലെ ജനസംഖ്യ വർദ്ധിക്കുന്തോറും താമസത്തിനും, ഗതാഗതത്തിനും, വ്യവസായത്തിനും ഒക്കെ കൂടുതൽ സ്ഥലം ആവശ്യമായി വരും. ഇത്തരം ആവശ്യങ്ങൾക്കായി, കൃഷിക്ക് ഉപയോഗയോഗ്യമായ ഭൂമിയും കുളങ്ങളും ജലാശയങ്ങളും വനഭൂമിയും ഒക്കെ നികത്തേണ്ടി വരുന്നു.

പട്ടണങ്ങൾ ഗ്രാമങ്ങളേക്കാൾ കൂടുതൽ ഊർജ്ജം ഉപയോഗിക്കുന്നവയാണ്. പട്ടണങ്ങളിൽ ഗ്രാമങ്ങളിലുള്ളതിനേക്കാൾ കൂടുതൽ വ്യവസായങ്ങളും, വാഹനങ്ങളും മാലിന്യവും ഉണ്ടായിരിക്കും. കൂടുതൽ ഊർജ്ജം ഉപയോഗിക്കുമ്പോഴും വാഹനങ്ങൾ പെരുകുമ്പോഴും, നിർമ്മാണ പ്രവർത്തനങ്ങൾക്കായി വയലുകളും ചതുപ്പുനിലങ്ങളും കാടുകളും തണ്ണീർത്തടങ്ങളും കണ്ടൽക്കാടുകളും നികത്തുമ്പോഴും ഭൂമിയുടെ ചൂട് കൂടിക്കൊണ്ടേയിരിക്കും. ഇത് കാലാവസ്ഥാവ്യതിയാനത്തിന് ആക്കം കൂട്ടുന്നു. കാലംതെറ്റിയും, ക്രമാതീതമായ തോതിലും മഴ പെയ്യുന്നതിനും, മഴയില്ലാത്ത സമയത്ത് കഠിനമായ വരൾച്ച ഉണ്ടാകുന്നതിനും ഇത് വഴിതെളിയിക്കും.

അന്തരീക്ഷത്തിന്റെ ചൂട് വർദ്ധിക്കുന്തോറും സമുദ്രജലം വികസിച്ച് സമുദ്രത്തോട് അടുത്തു കിടക്കുന്ന തമിഴ്നാട്, കേരളം, ആന്ധ്രാപ്രദേശ് തുടങ്ങിയ സംസ്ഥാനങ്ങളിലെ കടലോരപ്രദേശങ്ങളിൽ വെള്ളപ്പൊക്കം ഉണ്ടാക്കും. കടൽ ചൂടാകുമ്പോൾ, ചൂടുള്ള നീരാവിയാണ് പുറത്തു വരിക. ചൂടുള്ള നീരാവിയിൽ കൂടുതൽ ഈർപ്പം തങ്ങിനിൽക്കും. കൂടുതൽ ശക്തിയേറിയ മഴയുണ്ടാകാൻ ഇതും ഒരു കാരണമാണ്. സമുദ്രത്തിലെ ജലം ചൂടുപിടിച്ച് മുകളിലേക്ക് ഉയരുമ്പോൾ ന്യൂനമർദ്ദ മേഖലകൾ കൂടുതലായി സൃഷ്ടിക്കപ്പെടാനും ചുഴലിക്കാറ്റിന്റെ ആവൃത്തി അഥവാ ഫ്രീക്വൻസി കൂടാനും ഇടയുണ്ട്. ചുഴലിക്കാറ്റുകൾ ശക്തമായ മഴയും, കാറ്റും ഉണ്ടാക്കുന്നതിനു പുറമെ കടൽജലം കയറി വന്ന് വെള്ളപ്പൊക്കം ഉണ്ടാക്കാനും ഇടയാകും.

3. ചതുപ്പുനിലങ്ങൾ, പാടങ്ങൾ എന്നിവയുടെ നികത്തൽ

1980 കളിൽ ചെന്നൈ നഗരത്തിൽ, 650 പാടങ്ങൾ ഉണ്ടായിരുന്നത് ഇപ്പോൾ 27 ആയി ചുരുങ്ങി എന്നാണ് റിപ്പോർട്ട്. കുളങ്ങൾ, ചതുപ്പുനിലങ്ങൾ, പാടങ്ങൾ എന്നിവ നമ്മുടെ കാലാവസ്ഥ ക്രമീകരിക്കുന്നതിലും ദുരന്തങ്ങൾ ഒഴിവാക്കുന്നതിലും വലിയ പങ്ക് വഹിക്കുന്നുണ്ട്. മഴ പെയ്യുമ്പോൾ അധികമുള്ള വെള്ളം ഒരു പരിധിവരെ ഇത്തരം കുളങ്ങളിലും ജലാശയങ്ങളിലും സംഭരിച്ചു വയ്ക്കപ്പെടും.

ഒരു ഹെക്ടർ വിസ്തൃതിയുള്ള പാടത്തിന് 3000 ലിറ്റർ വെള്ളം വരെ സംഭരിക്കാൻ ആകും. ഒരു ചതുരശ്ര കി.മീ വനം, 30000 ഘന കി.മീറ്റർ വെള്ളം തടഞ്ഞു നിറുത്തും.

തമിഴ്നാട്ടിലെ വേളാച്ചേരി എന്ന സ്ഥലത്ത് 5500 ഓളം ഹെക്ടർ ചതുപ്പുനിലവും പാടങ്ങളും നികത്തിയാണ് വലിയ ഷോപ്പിംഗ് കോംപ്ലക്സുകൾ നിലവിൽ വന്നത്. പള്ളിക്കരണൈ എന്ന സ്ഥലത്തെ ചതുപ്പുനിലം നികത്തി ഐ.റ്റി കോറിഡോറും വന്നു. ഇവിടങ്ങളിലെ വീടുകളാണ് കൂടുതൽ വെള്ളത്തിലായത്. ജലപാതകളും ഓടകളും മറ്റും കയ്യേറിയും, തടാകങ്ങൾ നികത്തിയും, കെട്ടിട സമുച്ചയങ്ങൾ പൊന്തിവന്നു. 1980 കളിൽ ചെന്നൈ, കാഞ്ചീപരും, തിരുവള്ളൂർ ജില്ലകളിലെല്ലാം കൂടി 3600 തടാകങ്ങൾ ഉണ്ടായിരുന്നത് ഇപ്പോൾ 3000 ആയി ചുരുങ്ങി. നിലവിലുണ്ടായിരുന്ന തടാകങ്ങളുടെ വിസ്തൃതി അനധികൃത കയ്യേറ്റം കാരണം 1130 ഹെക്ടറിൽ നിന്ന് 645 ഹെക്ടറായി ചുരുങ്ങി.

നദിയുടെ ഇരുകരകളിലും വെള്ളം കയറാൻ സാദ്ധ്യതയുള്ള പ്രദേശങ്ങളെയാണ് 'ഫ്ളഡ് പ്ലെയ്ൻ' എന്നു പറയുന്നത്. രൂക്ഷമായ വെള്ളപ്പൊക്കം അനുഭവപ്പെട്ട സൈദാപ്പെട്ടിലും മറ്റും നിർമ്മാണ പ്രവർത്തനങ്ങൾ നടത്തിയിരിക്കുന്നത് ഇത്തരം ഫ്ളഡ് പ്ലെയിനുകളിലാണ്. നദിയിൽ നിന്ന് 200 മീറ്റർ ദൂരത്തിൽ വലിയ നിർമ്മാണ പ്രവർത്തനങ്ങൾ പാടില്ല എന്ന കേന്ദ്രനിയമം നിലവിലുള്ളപ്പോഴാണ് കേരളം ഉൾപ്പെടെയുള്ള സംസ്ഥാനങ്ങളിൽ അനധികൃതമായി സ്വകാര്യ ടൂറിസ്റ്റു കേന്ദ്രങ്ങളും, സർക്കാർ ഓഫീസുകളും, മറ്റ് കെട്ടിട സമുച്ചയങ്ങളും പണിത് ഉയർത്തുന്നത്.

ചെന്നൈയിലെ വേളാച്ചേരിയിലെ എം.ഐ.ഒ.റ്റി.(MIOT) എന്ന സൂപ്പർ സ്പെഷ്യാലിറ്റി ആശുപത്രി പണിതുയർത്തിയിട്ടുള്ളത്, അവിടെയുണ്ടായിരുന്ന ചതുപ്പുനിലം നികത്തിയാണ്. ഇത്തവണത്തെ വെള്ളപ്പൊക്കത്തിൽ അഡയാർ നദിയിൽ നിന്നുള്ള വെള്ളം കയറി ഈ സൂപ്പർ സ്പെഷ്യാലിറ്റി ആശുപത്രിയുടെ താഴത്തെ നില മുഴുവനും വെള്ളത്തിനടിയിലായി. വൈദ്യുതിബന്ധം വിച്ഛേദിക്കപ്പെട്ടു, ജനറേറ്ററും കേടായി. അത്യാസന്നനിലയിൽ ഉണ്ടായിരുന്ന 18 രോഗികൾ ഓക്സിജൻ കിട്ടാതെ പിടഞ്ഞു മരിച്ചു. ഇതിൽ, ഒരു വയസ്സുള്ള 'ജൂഡ് ഇമാനുവേൽ' എന്ന കുഞ്ഞും ഉൾപ്പെടുന്നു. ഡോക്ടർമാരും, രോഗികളും രണ്ടോ മൂന്നോ ദിവസം ഭക്ഷണവും വെള്ളവും കിട്ടാതെ ഈ ആശുപത്രിയിൽ കുടുങ്ങിപ്പോയി.

ചെന്നൈ മെട്രോപൊളിറ്റൻ ഡവലപ്മെന്റ് അതോറിറ്റിയുടെ കണക്കുപ്രകാരം 1,50,000 അനധികൃത കെട്ടിടങ്ങൾ ചെന്നൈ നഗരത്തിലുണ്ട്. പാടങ്ങളും ചതുപ്പുനിലങ്ങളും കുളങ്ങളും മറ്റും നികത്തി വിമാനത്താവളവും ഫ്ളാറ്റ് സമുച്ചയങ്ങളും

കെട്ടുന്നത് പ്രോത്സാഹിപ്പിക്കുന്ന വികസന നയത്തിന് കടിഞ്ഞാണിട്ടില്ലെങ്കിൽ നമ്മളേയും ഇതുപോലുള്ള ദുരന്തം ബാധിക്കും എന്നത് തീർച്ചയാണ്.

4. നഗരാസൂത്രണത്തിലെ പിഴവുകൾ

ജനസംഖ്യാ വർദ്ധനവിന് ആനുപാതികമായി കെട്ടിടങ്ങളുടേയും, റോഡുകളുടേയും മറ്റും നിർമ്മാണപ്രവർത്തനങ്ങൾ നടത്തുമ്പോൾ മഴ പെയ്താൽ വെള്ളം താഴ്ന്നു പോകാനുള്ള പാടങ്ങൾ, ജലാശയങ്ങൾ, ചതുപ്പുനിലങ്ങൾ എന്നിവ നിർബന്ധമായും ഉറപ്പുവരുത്തണം. കൂടാതെ, പ്രളയജലം ഒഴുകിപ്പോകാൻ പ്രത്യേകം ചാലുകളും ഓടകളും, ഡ്രെയ്നേജ്, സിവറേജ് സംവിധാനങ്ങളും, ഓവുചാലുകളും (Storm Water Drains) വേണം. ഓരോ നഗരത്തിനും അതാതു സ്ഥലത്തിന്റെ പരിമിതിക്കകത്തുള്ള ജനസംഖ്യ ഉൾക്കൊള്ളുന്ന രീതിയിൽ ശാസ്ത്രീയമായ ആസൂത്രണം നടത്തേണ്ടതുണ്ട്. താമ്പരം, ശ്രീപെരുമ്പത്തൂർ തുടങ്ങിയ സ്ഥലങ്ങളിൽ യാതൊരു ദീർഘവീക്ഷണവും ശാസ്ത്രീയ വിശകലനവും ഇല്ലാതെയാണ് വികസന പ്രവർത്തനങ്ങൾ നടന്നത്. വെള്ളപ്പൊക്കത്തിൽ ഏറ്റവും കൂടുതൽ നഷ്ടമുണ്ടായതും ഇത്തരം പ്രദേശങ്ങളിലാണ്.

ഓരോ നഗരത്തിലേയും വികസനം ആസൂത്രണം ചെയ്യുമ്പോൾ അതത് സ്ഥലത്ത് പെയ്യാൻ സാദ്ധ്യതയുള്ള മഴയുടെ അളവ് എത്രയാണ്? എത്ര അളവ് വെള്ളത്തിന് താഴ്ന്നു പോകാൻ സാധിക്കും? മണ്ണിന്റെ ഘടന എന്താണ്? എന്നീ പഠനങ്ങൾ നടത്തേണ്ടതുണ്ട്. അധികമുള്ള വെള്ളം ഒഴുകിപ്പോകാൻ പര്യാപ്തമായ രീതിയിൽ ഓടകളും ചാലുകളും കെട്ടുകയും വേണം. ഇത് കാലാനുസൃതമായി പരിഷ്കരിക്കാനും ശ്രദ്ധിക്കണം. കേരളത്തിലെ മിക്ക നഗരങ്ങളുടേയും നഗരാസൂത്രണ മാസ്റ്റർ പ്ലാനുകൾ കാലാനുസൃതമായി പരിഷ്കരിച്ചില്ലെങ്കിൽ ചെന്നൈയിലുണ്ടായ അതേ ദുരന്തം ഇവിടെയും പ്രതീക്ഷിക്കാം.

5. ശാസ്ത്രീയമായ ഖരമാലിന്യസംസ്കരണ സംവിധാനങ്ങൾ

വ്യക്തമായ ഖരമാലിന്യ സംസ്കരണ സംവിധാനങ്ങൾ ഇല്ലാത്ത നഗരങ്ങളിലെ ജനങ്ങൾ ഓടകളിൽ പ്ലാസ്റ്റിക്കും മറ്റ് ഖരമാലിന്യങ്ങളും നിക്ഷേപിച്ച് അവയെ ഉപയോഗശൂന്യമാക്കാറുണ്ട്. മഴക്കാലത്ത് വെള്ളപ്പൊക്കമുണ്ടാക്കാൻ ഒരു പ്രധാന കാരണം ഇതാണ്.

ചെന്നൈ നഗരത്തിൽ 4500 ടൺ മാലിന്യമാണ് പ്രതിദിനം ഉണ്ടാക്കപ്പെടുന്നത്. ഖരമാലിന്യ നിർമ്മാർജ്ജനത്തിന് മതിയായ സംവിധാനങ്ങൾ ഉണ്ടായിരുന്നില്ല എന്നതും നിലവിലുണ്ടായിരുന്ന ഓടകൾ പ്ലാസ്റ്റിക്കും മറ്റും ഇട്ട് അടഞ്ഞുപോയി

എന്നതും വെള്ളപ്പൊക്കത്തിന്റെ രൂക്ഷത കൂട്ടി. കേരളത്തിലും സ്ഥിതി വ്യത്യസ്തമല്ല. അശാസ്ത്രീയവും അപര്യാപ്തവുമായ ഓടകളും പ്രളയജലം ഒഴുകി പോകാൻ പ്രത്യേക ചാലുകൾ ഇല്ലാത്തതും കാരണമാണ് തലസ്ഥാന നഗരിയിലെ തമ്പാനൂരിൽ ചെറിയ മഴ പെയ്യുമ്പോൾ തന്നെ നഗരം മുഴുവനും വെള്ളത്തിലാകുന്നത്.

6. ദുരന്തനിവാരണ പ്രവർത്തനങ്ങളിലെ പോരായ്മ

പ്രളയം ബാധിച്ച ചെന്നൈയിൽ രക്ഷാപ്രവർത്തനങ്ങൾ ഏകോപിപ്പിക്കാൻ ഒരു സംവിധാനവും ഉണ്ടായിരുന്നില്ല. വെള്ളപ്പൊക്കത്തിൽ ഒറ്റപ്പെട്ടുപോയ ആയിരക്കണക്കിന് ആളുകൾക്ക് രക്ഷപ്പെടാൻ സ്വയം മാർഗങ്ങൾ തേടേണ്ടിവന്നു. നവംബർ 15 നു തുടങ്ങിയ മഴയിൽ, ചെന്നൈ കോർപ്പറേഷന് ദുരിത സഹായം കാര്യക്ഷമമായി എത്തിക്കാൻ കഴിഞ്ഞത് ഡിസംബർ 6-ാം തീയതിയോടെ മാത്രമാണ്.

ഓരോ സംസ്ഥാനവും വരാനിരിക്കുന്ന ദുരന്തങ്ങൾക്കായി സമഗ്രമായ ദുരന്ത നിവാരണ പദ്ധതികൾ തയ്യാറാക്കേണ്ടതുണ്ട്. ദുരന്തസമയത്ത് ഹോസ്പിറ്റലുകളുടെ സുഗമമായ പ്രവർത്തനം ഉറപ്പുവരുത്തേണ്ടത് എങ്ങനെയെന്നും വൈദ്യുതിയും വാർത്താവിനിമയ സംവിധാനങ്ങളും തകരാറിലാകുമ്പോൾ പകരം സംവിധാനം എങ്ങനെ ഉറപ്പു വരുത്തണമെന്നും പ്രതിപാദിക്കുന്ന അടിയന്തിര പ്രതികരണ പ്ലാനുകൾ (Hospital Contigency Plan) തയ്യാറാക്കേണ്ടതുണ്ട്. വലിയൊരു ദുരന്തം ഉണ്ടാകുമ്പോൾ ആയിരക്കണക്കിന് ആളുകൾക്ക് അടിയന്തിര ചികിത്സ ലഭ്യമാക്കേണ്ടിവരും എന്ന സാഹചര്യം മുൻനിർത്തി ഒരു അടിയന്തിര ചികിത്സ പ്ലാനും (Mass Casualty Management Plan) തയ്യാറാക്കേണ്ടതുണ്ട്. ചെന്നൈയിൽ ഇതൊന്നും നിലവിലുണ്ടായിരുന്നില്ല.

നമ്മുടെ സംസ്ഥാനത്തും ഇത്തരം തയ്യാറെടുപ്പുകൾ നടത്തേണ്ടതുണ്ട്. വലിയ ദുരന്തങ്ങൾ ഉണ്ടാകുമ്പോൾ ദേശീയ ദുരന്തനിവാരണ സേനയെ വിളിക്കുക എന്നതിനപ്പുറം പ്രാദേശികതലത്തിൽ തദ്ദേശവാസികളുടെ ഒരു കർമ്മസേന മുൻകൂട്ടി രൂപീകരിക്കുകയും എല്ലാ ജനങ്ങൾക്കും മുൻകൂറായി പരിശീലനം നൽകുകയും വേണം. ജനങ്ങളെ മാറ്റി പാർപ്പിക്കാൻ ഉതകുന്ന സുരക്ഷിത സ്ഥാനങ്ങൾ നേരത്തെ കൂട്ടി കണ്ടുപിടിക്കുകയും ആ വിവരം ജനങ്ങളെ അറിയിക്കുകയും വേണം.

7. വന നശീകരണം

ഒരു മരം, അതിന്റെ ശരീരഭാരത്തിന്റെ 96 ഇരട്ടി വെള്ളം സംഭരിച്ചുവയ്ക്കുകയും മേൽമണ്ണ് ഒലിച്ചു പോകാതെ സംരക്ഷിക്കുകയും ചെയ്യും. മേൽമണ്ണ്

ഉണ്ടെങ്കിൽ മാത്രമെ വെള്ളത്തിന് ഭൂമിയുടെ അടിയിലേക്ക് ഇറങ്ങാൻ സാധിക്കുകയുള്ളൂ. ഇങ്ങനെ ഭൂമിയുടെ അടിയിലേക്ക് ഇറങ്ങുന്ന വെള്ളം ആണ് ഭൂഗർഭ ജലമായി കിണറുകളിലും മറ്റും നിറയുന്നത്. ചെടികളും മരങ്ങളും നശിപ്പിക്കുമ്പോൾ അധികമുള്ള ജലം സംഭരിച്ചു വയ്ക്കാനുള്ള ഇടങ്ങൾ ആണ് നശിപ്പിക്കപ്പെടുന്നത്. അങ്ങനെ വെള്ളപ്പൊക്കം ഉണ്ടാകാനുള്ള സാധ്യതയും കൂടുന്നു.

2005 ൽ മുംബൈയിലും കഴിഞ്ഞ കൊല്ലം ശ്രീനഗറിലും ഉണ്ടായ വെള്ളപ്പൊക്കങ്ങൾ ദീർഘവീക്ഷണമില്ലാത്ത ഇത്തരം വികസന പ്രവർത്തനങ്ങൾ കൊണ്ടുണ്ടായതാണ്. മാഹിം വെള്ളച്ചാലിന്റെ അടുത്തുള്ള നൂറുകണക്കിന് ഏക്കർ ചതുപ്പുനിലം നികത്തി നിരവധിയായി കെട്ടിടങ്ങൾ പണിതു. 1995 നും 2005 നും ഇടയിൽ മുംബൈ നഗരത്തിൽ ഉണ്ടായിരുന്ന കണ്ടൽക്കാടുകളുടെ 40 ശതമാനവും നശിപ്പിക്കപ്പെട്ടു എന്നാണ് കണക്ക്. 'മിത്തി' നദിയുടെയും 'മാഹിം' എന്ന വെള്ളച്ചാലിന്റെയും ഇരുകരകളിലും ഉണ്ടായിരുന്ന സമൃദ്ധമായ കണ്ടൽക്കാടുകൾ വെട്ടി നശിപ്പിച്ച് മുംബൈ നഗരത്തിന്റെ വിസ്തൃതി വർദ്ധിപ്പിക്കാൻ ശ്രമിച്ചതിന്റെ ഫലമാണ് അവിടെ 2005-ൽ ഉണ്ടായ വലിയ വെള്ളപ്പൊക്കം എന്നത് നമുക്ക് ഒരു പാഠമാണ്.

കേരളത്തിൽ ഇപ്പോൾ ആകെ 663 ഹെക്ടർ കണ്ടൽക്കാടുകളേ ഉള്ളൂ. ബാക്കിയെല്ലാം വികസനത്തിന്റെ പേരിൽ നശിപ്പിക്കപ്പെട്ടു. കണ്ണൂരിൽ മാത്രം 755 ഹെക്ടർ കണ്ടൽക്കാടുകൾ ഉണ്ടായിരുന്നു എന്ന് ഓർക്കുമ്പോഴാണ് പരിസ്ഥിതിയുടെ മേൽ എത്രത്തോളം കടന്നുകയറ്റമാണ് നാം നടത്തിയത് എന്ന് മനസ്സിലാവുക.

എന്താണ് ചെയ്യേണ്ടത്?

ചെന്നൈ നഗരത്തിനും കേരളത്തിലെ പ്രധാന പട്ടണങ്ങൾക്കും ഒരുപാട് സമാനതകളുണ്ട്. ഇതുപോലൊരു ദുരന്തം കേരളത്തിലും ഉണ്ടാകാതിരിക്കാൻ നമ്മൾ താഴെപ്പറയുന്ന കാര്യങ്ങൾ അടിയന്തിരമായി ചെയ്യേണ്ടതുണ്ട്.

1. ഓരോ നഗരത്തിനും ദീർഘവീക്ഷണത്തോടെയുള്ള നഗരവികസന മാസ്റ്റർ പ്ലാനുകൾ തയ്യാറാക്കണം.

2. വീടുകൾക്ക് മഴവെള്ള സംഭരണി നിർബന്ധമാക്കണം.

3. അധികജലം സംഭരിക്കാൻ ഓരോ സ്ഥാപനത്തിലും മഴക്കുഴികൾ നിർമ്മിക്കാൻ നിർദ്ദേശം നൽകണം.

4. പാടങ്ങൾ, ചതുപ്പുനിലങ്ങൾ, കുളങ്ങൾ എന്നിവ നികത്തി നിർമ്മാണ

പ്രവർത്തനങ്ങൾ നടത്തുന്നത് കർശനമായി നിരോധിക്കണം.

5. സംസ്ഥാനത്തെ ഓരോ ജില്ലയ്ക്കും സമഗ്രമായ ദുരന്തനിവാരണ പ്ലാനുകൾ തയ്യാറാക്കണം.

6. ദുരന്തങ്ങളെ നേരിടാൻ തദ്ദേശവാസികളുടെ കർമ്മസേന എല്ലാ ദുരന്ത സാദ്ധ്യതാ പ്രദേശങ്ങളിലും രൂപീകരിക്കുകയും അവർക്ക് പരിശീലനം നൽകുകയും വേണം.

7. അഗ്നിശമനസേന, പോലീസ്, ആരോഗ്യം, മൃഗസംരക്ഷണം എന്നീ വകുപ്പുകൾക്ക് രക്ഷാപ്രവർത്തനത്തിനും അടിയന്തിര വാർത്താവിനിമയത്തിനുമുള്ള ബദൽ ഉപകരണങ്ങൾ ലഭ്യമാക്കണം.

8. എല്ലാ ആശുപത്രികളും ദുരന്തങ്ങളെ നേരിടാനുള്ള അടിയന്തിര പ്രതികരണ പ്ലാനുകൾ രൂപീകരിക്കാൻ വേണ്ട നിർദ്ദേശം നൽകണം.

9. ഓടകളും ഡ്രെയ്നേജ് ചാലുകളും കയ്യേറുന്നതും അവ അടച്ച് നിർമ്മാണം നടത്തുന്നതും കർശനമായി നിരോധിക്കണം.

10. പ്രളയജലം ഒഴുകിപ്പോകാൻ പ്രത്യേകം ചാലുകൾ (Storm Water Drains) നിർമ്മിക്കണം.

11. വെള്ളം താഴ്ന്നുപോകുന്നത് തടയുന്ന രീതിയിൽ മുറ്റം കോൺക്രീറ്റ് ചെയ്യുന്നത് നിരുത്സാഹപ്പെടുത്തണം.

ഇനി അവശേഷിക്കുന്ന പാടങ്ങളും, കുളങ്ങളും, ചതുപ്പുനിലങ്ങളും, കാടുകളും, കണ്ടൽക്കാടുകളും കയ്യേറി വിമാനത്താവളങ്ങളും, ഫ്ളാറ്റ് സമുച്ചയങ്ങളും, ടൂറിസ്റ്റ് കേന്ദ്രങ്ങളും പണിയുമ്പോൾ ഓർക്കുക, ചെന്നൈ നഗരം കണ്ടതിനേക്കാൾ രൂക്ഷമായ വെള്ളപ്പൊക്കം നമ്മളെയും കാത്തിരിക്കുന്നു.

യോജന,

ഫെബ്രുവരി 2016.

Road map for Kerala

R. Krishnakumar

The fourth international Congress on Kerala Studies, organised by the A.K.G. Centre for Study and Research in Thiruvananthapuram on January 9-10, has generated much interest for its focus on a worrying new trend in Kerala's development experience: rising inequality and marginalisation of large sections of people despite its economic growth in the past two decades.

Once again, as major political parties in the State begin preparations for a decisive Assembly election, the solutions they propose to tackle such new economic problems are also receiving a lot of attention.

The "Congress on Kerala Studies", a unique exercise where experts and people from all walks of life get together to discuss the development agenda of the State, has been organised by the Communist Party of India's (Marxist) study research centre since 1994. The first congress was convened under the leadership of the veteran Communist leader E.M.S. Namboodiripad. It was also the first serious attempt to find solutions to the problems that arose as a result of the distinct "model" of development that Kerala had followed until then.

Kerala was at that time falling behind other States in economic growth in spite of its remarkable achievements in the key areas of human development, particularly health and education, and a certain level of equity in the development process achieved through redistributive government policies, trade union action and peasant struggles. The initiative, "to protect the gains of the past and craft a viable path to the future", which was launched with a call for a new agenda for Kerala's development through a flagship democratic decentralisation experiment, was undertaken by a Left Democratic Front (LDF) government just when the Central government was beginning to push ahead with neoliberal economic policies that militated against such alternatives. Kerala has seen four State governments since then, alternately led by the CPI(M)-led LDF and the Congress-led United Democratic Front (UDF), which had contradictory visions on how to solve the State's economic problems (see ''Visions of development", Frontline, February 14, 2003).

The fourth Congress on Kerala Studies has concluded with the concern that although the past two decades were a period of economic growth inequality has grown "in a fearful manner" in the State and the gaps between sections of people, agriculture and non-agriculture sectors, urban and rural areas, various districts, and so on, have widened.

According to the draft Kerala Development Agenda presented at the conference (on the basis of a series of seminars and symposiums on different sectors held earlier in various parts of the State), the gains of this economic growth have not benefited all sections of society equally. While there has been a tremendous increase in the earnings of the upper 20 per cent of the richest families, the earnings of low-income families at the bottom 30 per cent segment have fallen significantly. Such increasing inequality is a new trend in Kerala's development experience, and several participants drew attention to it at the congress.

Addressing a symposium on "Changing Paradigms of Kerala Development", Prof. M.A. Oommen, an economist, said: "The Kerala model of development has lost all its importance today. I think, of late, Kerala is witnessing a kind of political failing and, certainly, a social failing in the various sectors, which were once upon a time the hallmark of the so-called Kerala development model. A highly commercialised education system and health-care system are facing a crisis and are now marginalising the poor and the backward communities of the State. Kerala has seen a transformation in the structure of SDP [State Domestic Product] and the allocation of labour, and a tremendous increase in the rate of per capita income. But this is only because of the huge inflow of foreign remittances into the State. This has considerably vitiated the whole scenario of the State. NSSO [National Sample Survey Office] and many studies have shown there has been a tremendous increase in the 'Gini coefficient' [an index of income inequality], capturing the increasing inequality in the State."

The agriculture sector accounted for 55 per cent of the SDP in 1960-61 but now accounts for only 8 to 9 per cent. The construction industry then accounted for only 1.7 per cent of the SDP, but today its share is 15 to 16 per cent. Manufacturing was around 12-14 per cent but is now less than 7 per cent, he said.

According to the Kerala Development Agenda, the service sector continues to be the engine of the recent economic growth in Kerala, accounting for 70 per cent of the State's income in 2013-14 (up from 60 per cent in 2004-05). But this service sector-led growth is largely dependent on the inflow of remittances from abroad, mostly from West Asia, where employment opportunities are increasingly on the wane. The unease that such a situation creates is because such economic growth cannot be sustained unless it comes as a result of an increase in physical production within the State. However, the production sectors continue to remain weak.

For example, Kerala's agriculture sector, which 27 per cent of the total number of families in the State depend on for survival, is becoming more and more marginalised, with land increasingly being considered a commodity rather than a means of production. Moreover, the path the State

chose for its industrial growth, with its focus on labour-intensive traditional industries and energy-intensive, highly polluting chemical industries, has almost reached a dead end.

Between 1997-98 and 2013-14, the agriculture sector grew by only 0.4 per cent. There has also been a dramatic decline in agricultural production, area under cultivation and income from and jobs in the sector. Agriculture and allied sectors, which provided 57 per cent of the total jobs in 1983, now account for less than 30 per cent of the jobs. Agriculture alone provides only 16 per cent of all jobs today. But the number of people who depend on agriculture for a living has remained almost the same and their income and living conditions have been adversely affected. Moreover, the decline in agriculture is already posing a serious threat to food security in a State which produces only 20 per cent of its food requirements.

ENVIRONMENTAL AWARENESS

Significantly, the Development Agenda says that although it is important to protect the traditional industries which a large number of workers depend on for survival, such sectors cannot continue in the traditional way. Also, increasing environmental awareness, which demands strict pollution control norms, and Kerala's energy scarcity are making the State's chemical industries an unviable option.

The main weakness of the current service sector-led, Gulf money-based economic growth is that it does not create enough job opportunities in Kerala. Unemployment rates remain higher than the national average. More and more people are seeking jobs outside the traditional sectors. The educated have to wait long for jobs-the reason why they obtain more and more degrees, creating a huge demand for higher education – or engage in informal jobs. But their reluctance to do physical labour has led to a large inflow of people from other States in search of jobs.

"Kerala is importing about three million labour[ers] from other States. That is a major transformation that we have to take into account," Prof. Oommen said.

Michael Tharakan, a scholar of Kerala's social, economic and development history, said: "In the mid-1970s, Prof. K.N. Raj and others came out with an important study on Kerala's development in which it was found to have had a very slow growth rate, but even with that the State was able to distribute that added wealth comparatively more adequately among its people. But things have changed. Kerala now has got a very high growth rate. Nevertheless, its distribution system is not functioning well now. There seem to be several economic reasons for this and non-economic issues as well."

For example, he said, many studies have pointed out that the initial distribution system that was available in Kerala was supported by an enlightened group of people who were prepared to think beyond the interests of the group they belonged to. They were willing to fight for the rights of the people who were outside their immediate group. This resulted in the comparatively better distribution in the State.

But now, in spite of the fact that Kerala is slipping in many aspects, in terms of economic equality, gender equality, environment, and even on the question of climate change, the kind of movements that once used to challenge such trends is no longer seen in the State. "Is it a fact that the militancy and the ability of the people of Kerala to fight for the rights of all the people, and not just their own brethren, have declined?" Tharakan asked.

He pointed out that Kerala always claimed priority and superiority over other States in the fundamental areas of education and land reforms. "These two stories have some unfinished chapters, and unless we are able to do something about the unfinished aspects of the land reform question as well as the education question, we are likely to go on slipping back."

For example, he said, in education Kerala has the numbers; it is way ahead of the Indian average in terms of graduates per square kilometer, total literacy, and so on. But the quality of education is not up to the mark, and secondly, an appropriate education system that could transmit democratic and development values seems to be missing. This is because a restructuring, in terms of development, educational and democratic values, has not been consciously introduced into the educational system. "So the State is slipping in that sector. AB a result, we tend to become a group of people who are not bothered about the fact that marginalisation within education is on the increase. This kind of distancing is on the increase, and Kerala is not bothered enough because the people who benefit from it are those who are in the business of implementing the new policies."

According to Tharakan, something similar has happened on the issue of landholding. Some sections of the population were kept away from landholding rights even while they were in the forefront of agriculture. They were the agriculturists but were excluded from holding land. This problem could not be solved even with Kerala's "very successful, remarkable and comprehensive land reforms". They were given a little bit of land, but that was not enough and it was mostly the worst kind of land that was transferred to the poorer sections of people. "So you have a big case of discrimination, a big case of distancing between people within Kerala society in spite of the achievements we have made in distribution in the earlier times. And that is now chasing us in the form of that discriminatory situation being injected with the ideas of communalism, fascism, denial of rights and equality and also the open denuding of our commons. So, unless we can rectify those mistakes, talking about what can be done about the economy will only be partial," he said.

Prof. Oommen also drew attention to the fact that Kerala's democratic tradition was being considerably derailed. 'We are not upholding public reason. Public unreason is the order of the day. We have to take note that the deliberative democracy Kerala was famous for is now in retreat."

For instance, he said, decentralised planning was an experiment done to recapture the lost vitals of Kerala's development paradigm. "Decentralisation was a successful experiment in its early formation, opening considerable avenues for people's participation and local development

and promoting local democracy in the State. But today, a 'routinisation' of the whole process has taken place, making participatory governance a sham."

The congress saw several interesting discussions on the problems affecting Kerala's economy and society at nearly 70 venues.

The organising committee chairman and former CPI(M) State secretary, Pinarayi Vijayan, said: "The fourth congress is being held at a time when the UDF government has published a document on Kerala's development. It is titled 'Kerala Perspective Plan 2030', but [it] has been prepared by the Delhi-based National Council for Applied Economics Research, by people who have no links with Kerala. As such, it does not reflect Kerala's peculiarities or its development experiences. Moreover, commercialisation of all sectors is the general approach of the document. Its assessment about the main weakness of the health and education sectors that made Kerala famous throughout the world is that they have not yet been commercialised. The document similarly argues for the restructuring of all other sectors to help these commercial forces."

Asked to outline the general nature of the solutions being proposed by the congress, Thomas Isaac, Director of the A.K.G. Centre for Study and Research and former Kerala Finance Minister, told Frontline: "We do not believe in competing with other States in giving more concessions and rights to corporates. But then, how will we attract investment to the new growth sectors? For this, two things are essential: one, we have to modernise physical infrastructure facilities in the State. Two, we have to expand and improve the quality of Kerala's higher education sector. The UDF is proposing a total surrender to free market forces and corporates in all key growth sectors. They are proposing this not only in industry but also in education. We are instead thinking of a strategy of increasing investments under social control."

He said the other highlights of the proposed new agenda included (a) total social security to those who still remained in the traditional industrial and unorganised sectors as Kerala invariably turned its focus on to new growth areas; (b) moves to ensure deeper involvement of government in development and not its gradual withdrawal; (c) new versions of the democratic decentralisation experiment to make governance more effective; (d) corrective measures to create a gender-equal Kerala to improve women's participation in the economy and their social status; (e) offering promotion of culture a central place in the new scheme of things, with substantially higher resources for promoting good literature, art, music, cinema and drama for the common man as a counter to the ills of the "consumption culture" that accompanied faster economic growth and consequent rise in incomes; (f) environmentally sustainable initiatives for faster economic growth; and (g) critical interventions by progressive forces and mass organisations against the threat posed by imperialist globalisation and to offer support to the evolving alternative development agenda.

The fourth congress is soon to be followed by discussions and seminars in all the 140 Assembly constituencies in the State that will eventually help evolve a Left agenda for the State's development before the Assembly election, which is due in April 2016.

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Regulation of Doctors and Private Hospitals in India

Anant Phadke

In recent years, the issue of regulation of doctors and hospitals in India has been discussed in the media off and on because of the enactment of or amendments to various healthcare acts or because of some malpractices arising from the doctor-pharma nexus. For example, recently there has been a lot of discussion in the print media on the proposed amendments to the Pre-Conception and Pre-Natal Diagnostic Techniques (PCPNDT) Act which was enacted in 1994 to regulate the use of prenatal diagnostic techniques in order to curb prenatal sex selection of the foetus through sonography or other technology; this notorious practice being widely prevalent in India.

The Indian Radiological Association and the Indian Medical Association (IMA, the lobby of private doctors) have been demanding certain amendments to this act and an expert committee has been formed to consider various suggestions to- wards this end. On the other hand, women's organisations and organisations like the Jan Swasthya Abhiyan (JSA) (the coalition for the People's Health Movement in India) have been demanding proper, stricter implementation of the PCPNDT in a manner to do justice to the objectives of the act. Second, the Clinical Establishments (Registration and Regulation) Act (CEA), 2010 which was adopted by Parliament in 2011 and seeks to regulate all kinds of clinical establishments, is also a matter of debate. Civil society organisations have welcomed this act (despite their criticism about its lacunae like absence of special body for its implementation, and the absence of mention of patients' human rights), but are worried because so far it is applicable only in a handful of states (Arunachal Pradesh, Himachal Pradesh, Mizoram, Sikkim). On the other hand, the IMA has been against this act and under the guise of demanding certain amendments to make it more doctor-friendly, it has been trying to scuttle it, make it ineffective. The Medical Council of India (MCI), which is supposed to ensure ethics in the medical profession, has been in the news off and on due to allegations that it is not being friendly to patients and is not giving justice to complaints by patients against doctors. The

MCI has been in the news also because of the legal wrangle due to alleged corruption by its president Ketan Desai. There are also many news reports about public health facilities being affected by a shortage of staff and supplies, and about doctors absconding from duty and being insensitive to patients.

All these problems in healthcare have also been examined from the human rights perspective, and the National Human Rights Commission in collaboration with JSA is organising a series of public hearings on human rights violations in public and private healthcare. Some of the cases presented during first of these hearings in Mumbai on 6-7 January 2016 have been reported in the press. Despite such media coverage of issues related to regulation of doctors and hospitals in India, there has not been any systematic overview of this subject. This paper attempts to do such an overview in the context of the overall neo-liberal policy framework adopted in India after 1990.

Broader Background for Regulation of Healthcare

In India, regulation of the medical profession and of hospitals has become more important after the adoption of the neo-liberal policy framework from the 1990s onwards due to three interdependent factors which have influenced health and healthcare. First, especially during the last 2S years, unregulated marketisation under the garb of "economic growth" has been at the expense of the health of nature and of the people. This is because India has, especially after 1990, adopted a "pathogenic model" of development. By this I mean, as more development occurs, more premature deaths and new illnesses occur due to the very nature of development, though older diseases tend to disappear or are reduced considerably. The specificity of the Indian situation lies in the fact that it has not been able to overcome many of the "older" diseases like malnourishment and its sequelae. It has not been able to overcome some of the deadly infectious diseases like tuberculosis among the poorer sections of the population and yet at the same time economic development has led to an epidemic of newer diseases, the so-called "diseases of industrialisation" like diabetes, cardiovascular diseases, accidents, addictions, etc.

This epidemic has not been restricted to only the well-to-do, but has affected the poor people also. The poor thus suffer from a "double burden of diseases." We need a regulated healthcare system which provides healthcare to all and takes care of this double burden of diseases as well as has a strategy to prevent the double burden of diseases. Second, newer technologies and sub-specialties have emerged which have made healthcare more complex and hence needing more than ever, appropriate regulation to prevent misuse. There has also been the increasing sway of the ideology that health can be purchased and under this illusion, well-to-do, upper-class people are seeking more and more of high tech care. They are willing to pay more but want high standard care. This expectation of high quality care cannot be met without regulation of medical care. Third, with the rise and domination of the corporate sector in healthcare, regulation of the medical profession and of hospitals has become far more important to protect the interests of the patients who become much more vulnerable vis-a-vis the medico-industrial complex.

Added to this is the state's support to health insurance instead of expansion of public health services. This choice strengthens marketisation and commodification of healthcare and contributes to the supply-induced demand character of the health economy in India, which facilitates malpractices and irrational and unethical provider behaviour. This calls for better regulation of doctors and hospitals.

These challenges also have sociopolitical dimensions. Due to the outcry in the popular press about the profiteering of the medico-industrial complex, there has been some popular pressure to regulate private healthcare. Critics of unregulated private healthcare in India have pointed out that it has been widely recognised that the dictum-the market will regulate itself-does not hold true in healthcare because of information and power asymmetries; that healthcare is a classic example of market failure. A recent paper in Lancet notes:

> Kickbacks from referrals to other doctors or from pharmaceutical and device companies are common, and crass profiteering tempts many private practitioners and hospitals to inflict unnecessary procedures such as CT scans, stent insertions, and caesarean sections. Such practices have flourished because of a weak regulatory climate with no standards or mechanisms to monitor quality or ethics, steadily eroding trust in both the public and private health-care systems (Patel et al 2015).

It is patients who have to bear the burden of this lack of regulation and the poorer sections cannot afford to. It is now widely known that 40% of the hospitalised patients have to either borrow money or sell assets to pay for medical expenses and annually about 60 million Indians are pushed below the poverty line due to medical expenses (Marten et al 2014).

Given all this, there has been some popular pressure to improve matters on this front. In its election politics, the Congress Party had taken cognisance of this pressure and this is one of the reasons why the United Progressive Alliance (UPA) government enacted the CEA 2010. Second, in international fora, Indian ministers have been embarrassed by India's dismal human development index and one of the ways to mend this dismal picture is to extend health care coverage through government funds. To achieve this, one important avenue that the government has chosen is to float various state-funded health insurance schemes like the Rashtriya Swasthya Bima Yojana (RSBY) by the national government and a number of other state schemes like the Rajiv Arogyasri, Vajpayee Aroyasri, and Rajiv Gandhi Jeevandayee Arogya Yojana. Governments are spending hundreds of crores of rupees annually to pay for purchasing private healthcare for the poor people through these schemes. The quality and price of this care has to be regulated when such large sums of public money are spent on purchasing private healthcare services. The experience of developed countries shows that effective regulation of private healthcare by the government can occur only when the government buys these services for the people and bargains well for it. Private players see this purchase as an assured market and are ready to accept standardisation of healthcare as a pre- condition for this purchase.

Thus, the overall regulation of healthcare, of hospitals is not only needed by the people but it has also become a policy need if the increasingly large amount of money the government is now spending to purchase private health care is not wasted in purchasing irrational, excessive and overpriced healthcare.

Regulation of Medical Ethics

It is widely recognised that patients are inherently vulnerable vis-a-vis doctors and other healthcare providers and hence there has to be a special mechanism to protect patients from injustice. From the ancient times there have been special regulatory codes in different societies for healers to protect the interests of the patients. In the Western tradition there is the Hippocratic Oath, which explicitly expects the healer to give priority to the interests of the patients over interests of the healer. In modern times medical councils lay down a code of conduct for doctors vis-a-vis the patients, fellow doctors and society at large. These councils are supposed to ensure that the doctors follow a code of ethics. In India the respective medical councils for allopathic, ayurvedic, homeopathic and unani systems of medicines are legally empowered bodies meant to ensure that all members of these councils follow the code of conduct laid down by these medical councils.

Medical councils in India have so far failed in ensuring that those doctors who do not observe an ethical code of conduct are punished and disciplined. The ayurvedic and homeopathic councils are least active. But the MCI, the council of allopathic doctors, has also been dormant on this front. On paper, all councils are very strong because nobody can practise unless one gets registered under the council and if the council deregisters a doctor it means a death sentence as a professional. But such deregistration has hardly ever happened during the last 50 years. Even as regards the MCI and the state medical councils in the respective states, if any complaint is made by any patient against a doctor for violating the code of ethics, there is very little chance that the patient will get any timely justice. This is because the MCI has no structure, staff, or budget to investigate these allegations. The council meets quite infrequently because member-doctors cannot give more time, as the council's work is voluntary and spare timework for them. Because of the very nature of the organisation, only doctors can become members of the MCI. But it is possible for the medical councils to form a Grievance Redressal Committee to hear patient's complaints about violation of medical of ethics and to have some well-known social workers as members or advisers of this committee. Unless such a mechanism is put in place, citizens cannot be expected to have faith in these councils. The actual track record of these councils is also quite depressing for the patients. First, it is a very slow process and in a majority of the instances a case is deliberated and decided after a delay of months and even years. For example, in Maharashtra, through a Right to Information query, it was recently revealed that between January 2014 and September 2015, the Maharashtra Medical Council received 193 complaints against doctors, out of which not a single one was decided till October 2015! Between 2011 and 2013, out of 285 complaints received, only 114 were decided. There is no data

available about what proportion of these cases resulted in some action being taken against the doctor. Anecdotal evidence shows that during the process of hearing, patients face an unfriendly environment and witness a pro-doctor bias. The other major limitation of the medical councils is that its mandate is limited only to its members. Hence it has no mandate over corporate and trust hospitals since their owners and managers are non-medicos. All these deficiencies of the MCI and the state councils certainly need to be overcome.

Private Medical Colleges and Medical Ethics

Orienting and training medical students in medical ethics is obviously quite important. But this has not been part of the medical curriculum in India. However, students do pick up attitudes from teachers as they observe teachers' behaviour with patients. This behaviour varies greatly as the teachers themselves have no training in medical ethics. The second factor that has adversely impacted medical ethics is the objective obstacle that is created to practising ethically because of the privatisation of medical education. At the time of independence, India had 28 allopathic medical colleges, out of which less than 4% were private. By 1986, their numbers rose to 123 and out of these 17% were private. Thereafter with the advent of the neo-liberal economic policy, the number of private medical colleges increased rapidly. By 2012, there were 161 and 194 public and private medical colleges respectively. Out of these 194 private medical colleges, 160 were established after 1990. Since unregulated medical practice has been a lucrative profession, the newly rich, and the new generation of middle class want to get into the medical profession in larger numbers. Private medical college offered them a chance. This class is ready to pay high fees of private medical colleges to get into the lucrative medical profession. These high fees were initially justified on the grounds of lack of government subsidy/support. However, later the legal and illegal fees (capitation fees) kept on increasing as in the era of neo-liberal policies, profiteering in education gradually became an accepted norm. As reported by Business Standard, at the beginning of 2015, the asking capitation fee rate for an MBBS undergraduate seat in a private medical college is Rs 25-50 lakh. With tuition fee at Rs 9-11 lakh a year at private medical colleges, the four-year MBBS programme will cost a student up to Rs 44 lakh. Fees at government colleges are as low as Rs 11,500 a year, or Rs 44,000 for the four-year programme (Pathak 2014). The logical consequence of this phenomenon has been an increase in the trend of substandard private medical colleges getting approval from the MCI by paying bribes to council officials. The majority of these private medical colleges are controlled by politicians who see these colleges as an additional source of easy money. The majority are also of questionable quality since many of them have been approved through corrupt means. This phenomenon of sanctioning substandard medical colleges by MCI officials by accepting bribes was widely known (Srinivasan 2010). It became national news when the Delhi High Court ordered the removal of Ketan Desai as the president of the MCI and directed the Central Bureau of Investigation (CBI) to initiate prosecution against him for his involvement in corrupt practices. Joint commissioner, income tax, Ahmedabad, whose team conducted a raid on the residence of Desai in 2000, had reportedly found with him Rs 5 crore as undisclosed income and gifts of Rs 65 lakh. A division bench of the court comprising

Justice Arun Kumar and Justice R C Chopra found Desai guilty of misusing his official position and observed that the apex body for doctors was a "den of corruption" (Pharmabiz 2001). But later Desai got reinstated. In April 2010 he was again caught red-handed, was arrested while taking a bribe of Rs 2 crore and a raid on his premises found 3.5 kg of gold and 60 kg of silver (Nanjappa 2010)! Later the CBI withdrew this case against Desai on the grounds of a "lack of evidence"!

When parents of a medical student spend millions of rupees on medical education, it follows that such a graduate will exploit the patients to recover this "investment" and earn a good "return." It is thus very difficult for any regulatory mechanism to ensure medical ethics in face of the economic compulsion created by such costly medical education. This is the price Indians have been made to pay for introduction of neo-liberal policies.

Corruption and substandard private medical colleges is only one aspect of the failed regulation of the medical profession in India. The other aspect is that the MCI has hardly taken any proactive interest to improve the quality of medical education, or to make it more relevant to changing times or to improve substantially the pedagogy, the curriculum. The demand to include in medical curriculum topics like the political economy of healthcare, of pharma industry, politics of healthcare, ethics of medical practice, of research, of public health, gender and health, etc, has been ignored. The teaching especially of subjects like anatomy continues in its outdated form of dissection of the entire body without any understanding of its applied significance. Medical education continues to produce sub-standard doctors (Davey et al 2014). It is only during internship after graduation and in postgraduate residency that doctors acquire some clinical proficiency. This incompetence tends to lead to prescription of unnecessary investigations and medicines because an incompetent, less confident doctor relies more on laboratory tests and medications. Regulation of the medical profession becomes more difficult in such circumstances. For example, Standard Treatment Guidelines for all important ailments are an important tool for regulation of the medical profession but it has become difficult to implement it in face of the substandard medical education.

Regulating the Influence of Pharma

Regulating the quality of medical education is only one of the functions of the medical councils. The other key function of the councils is to ensure high ethical standards in the medical profession. However it is widely known that these councils have not curbed the irrational, unethical, and exploitative practices which are quite prevalent in the private sector. The homeopathic council does not even mention this as one its objectives.

For many years, pharma or pharmaceutical companies have been the most important corrupting influences of the medical profession. Enticing and luring doctors into prescribing unnecessary, irrational medicines has been widely prevalent in India in the last 50 years. Pharma companies have provided material incentives to doctors ranging from "small" gifts and not so

small gifts, to dinner parties, to pleasure trips inclusive of trips to foreign countries. Situation deteriorated further when doctors started buying shares of pharma companies, started investing in pharma retail stores and when hospitals invested in the pharma stores which were started in their own premises. The retail pharmacies are allowed a sales margin of 16%. However, in the case of medicines bought by chemists, doctors and hospitals for selling to their patients, pharma companies keep a margin of 100% or even 500% to 1000% between the purchase-price for doctors and the maximum retail price to be charged to patients (Singal et al 2011)! All these things show that such doctors, hospitals have developed a financial interest in pharma business and hence also in their unethical marketing practices. Some hospitals have gone one step further. They have made it more or less compulsory for the admitted patients to buy medicines from their own pharma stores, though this compulsion is illegal. The brands prescribed by the doctors in such hospitals are generally available only in these retail stores and their prices are higher than the prices of brands of the same medicines marketed by other reputed companies. In Pune, one patient's family doggedly fought against this practice in the consumer court and the Pune District Consumer Redressal Forum in its judgment on 30 October 2012 ruled that this compulsion is unfair trade practice." But this practice has hardly stopped. There has to be some regulatory mechanism which would prevent such practices by hospitals and doctors at the behest of pharma business.

One important mechanism which pharma companies use to influence doctors, hospitals and which needs to be regulated is their influence on Continuing Medical Education (CME) for doctors. Good quality, appropriate, mandatory CME has been an important demand of rational doctors to improve the quality of medical care in India. It is only since 2011, that is, almost 50 years since its inception, that the MCI has made it compulsory for all its members (all allopathic doctors) to earn 30 credits of CME within a span of five years. This is a welcome move. However, the role of pharma companies has been an important obstacle in developing a tradition of really useful CME programmes for giving better service to the patients. This is because till 2009 there were no restrictions in India on the role of pharma companies in CME programmes. Pharma companies used to sponsor the CME sessions. Since the expenses for bringing speakers in these CME programmes were borne by pharma companies, they heavily influenced the choice of these speakers. The CME programme was generally accompanied by a sumptuous lunch or dinner sponsored by some pharma company or the other. It is no surprise that such CME programmes resulted in increased sales of the medicines of these companies irrespective of the merit of these medicines. All this is now been prohibited by the MCI. Due to the amendment introduced in December 2009 to the MCI's (Professional Conduct, Etiquette and Ethics) Regulations, 2002, now there is specific Section 6.8 titled "Code of conduct for doctors and professional association of doctors in their relationship with pharmaceutical and allied health sector industry" which puts a clear embargo on:

(i) "any gift from any pharmaceutical or allied healthcare industry and their sales people or representatives;

(ii) any travel facility inside the country or outside, including rail, air, ship, cruise tickets, paid vacations, etc, from any pharmaceutical or allied health care industry or their representatives for self and family members for vacation or for attending conferences, seminars, workshops, CME programme, etc, as a delegate;

(iii) any hospitality like hotel accommodation for self and family members under any pretext; any cash or monetary grants from any pharmaceutical and allied healthcare industry for individual purpose in individual capacity under any pretext."

The vested interests are trying to find a way out of these restrictions. MCI does not have any mandate over non-medical owners, managers of hospitals. Hospitals owned, and managed by such managers can organise CME programmes sponsored by pharma companies. Second, an official of IMA has said that IMA has now obtained permission from MCI to accept sponsorship for annual CME conferences, though routine CME programmes can not be sponsored!

There are now other vested interests in CME programmes. Medical equipment industry, diagnostic centres and even some specialists look upon these programmes as an opportunity to get publicity and thereby new business for themselves. Many of the CME sessions approved by the state medical councils are not designed by medical educationists. It is left entirely to the medical experts who are interested in conducting CME sessions to decide the content of their respective sessions. Many of these experts are interested primarily in sharing the success stories of the newer modalities they have been using. In doing so these experts do not give any orientation about the limitations of these newer modalities and about what extra cost they entail to the patients, leave aside any discussion about the comparative cost-efficacy of these newer modalities. The result of such CME sessions is not an increase in the capacity of the practitioners to diagnose and treat patients in a better way, but the result is that doctors attending the CME sessions tend to refer more patients to these experts. Some experts advocate investigations and procedures without scientific justifications. They are directly or indirectly sponsored by the concerned industry.

Many a time the content of the CME session is not relevant, useful even if the topic is relevant. This is because almost everything is left to the speaker. There is no quality control as regards relevance, scientific validity, practical usefulness and method of presentation in a CME session. In most lectures, even the printout of the PowerPoint presentation is not made available to participants. Given all this background, it is no wonder that in many places, the participation and attendance of the doctors in such CME sessions is perfunctory, merely for the sake of collecting attendance certificates. Unless the CME sessions are made more relevant and unless it is mandatory to follow Standard Treatment Guidelines, doctors are less likely to take CME programmes seriously.

One clear way to regulate the CME programmes in order to make them relevant to the needs of doctors and to keep them away from vested interests is to make standardised CME

programmes available online so that practitioners can participate in CME sessions at their convenience by logging on to the particular website at any time convenient for them. Such online courses have a small test at the end of the CME session, which the doctor has to administer successfully to earn a credit point. There can be some mandatory CME programmes about national health programmes. But at the same time there can also be scores of online CME sessions devoted annually to scores of topics. These will have to be developed annually by professional organisations and accredited by a regulatory agency approved by the MCI. Doctors can choose the ones which they feel are relevant for their practice and earn a requisite number of credits to get renewal of registration from the state medical council. Developing and administering such online CME programmes would be far, far cheaper and far more cost-effective than the current method of conducting CME programmes. Doctors can send by email their queries to a panel of experts and there can be discussions over e-groups. Online CME courses would have a special value for rural practitioners because it is very difficult for them to go to the CME programmes held in cities. Despite these clear advantages no such online CME courses are available in India.

The pharma business must contribute to the fund earmarked for CME of doctors. But this contribution should be an untied one and pharma business should have no involvement in deciding the content and mechanism of the CME programmes. Medical councils for ayurveda, homeopathy, and unani have not yet been instituted such compulsory CME for non-allopathic graduates. They can also develop and manage online CME programmes on the lines outlined above.

The MCI code of ethics, MCI (Professional Conduct, Etiquette and Ethics) Regulations, 2002, has a clause which prohibits advertisements by doctors. But this code of ethics, does not apply to hospitals. Many hospitals misuse this lacuna and we see so many ads by hospitals, which violate with impunity the MCI code of ethics. This code of ethics must be made applicable to all clinical establishments-hospitals, and diagnostic centres, etc. All clinical establishments must mandatorily have a medical superintendent, a medical graduate and on behalf of the clinical establishment s/he must be responsible for following the code of ethics prescribed by the MCI.

Regulation of Private Hospitals

Hospitals in India are not a homogeneous entity and hence regulation of hospitals is quite a challenging task. A very brief look at their origins and development would give an idea about their evolution into a heterogeneous entity.

At independence, most of the hospitals in India were in cities and an overwhelming majority of them were either state-owned or charitable. Despite the Bhore Committee's recommendations on the eve of independence, that the government should provide comprehensive healthcare to all citizens, the government did not expand public health facilities sufficiently. Hence a majority of the graduates coming out of government medical colleges entered private practice. On the other hand, the development of the economy after independence created an urban middle class which

could afford to go to these private practitioners whereas the rest of the population, urban and rural, went to the rudimentary, sparse public health facilities or relied on self-care and traditional healers. Gradually these independent private practitioners started their own small maternity homes, small hospitals and this tradition of individually-owned small hospitals of doctor-entrepreneurs continues till today. The majority of these private hospitals have fewer than 10 beds and an overwhelming majority have less than 30 beds. Till the 1980s a majority of the big hospitals in the private sector were "Trust Hospitals" set up by philanthropic trusts, registered under the charity commissioner. These were mostly genuine non-profit philanthropic entities. There were virtually no corporate hospitals.

Though a majority of doctors graduating from government medical colleges went into private practice, and hence private practitioners constituted a majority of doctors in India, till the late 19805 less than half of the hospital beds were in private hospitals. This is because most of the private hospitals were very small ones whereas the public hospitals (teaching hospitals, railway hospitals, Employee's State Insurance Corporation hospitals, district hospitals, rural hospitals, etc) were many times bigger.

During the last 2S years this above picture has been over-shadowed by the development of larger, commercial private hospitals, especially multi-specialty hospitals. This is because, first, newer specialties have developed which many middle class and upper middle class people can pay for. In such a situation it is far easier for both doctors and patients to have many specialty services under the one roof of a multi-specialty hospital. Second, many doctors can now mobilise either individually or in partnership, adequate funds and expert human power to start multi-specialty hospitals.

Since the 19905, the Trust Hospitals have also changed. Many of them, which at one time tried to charge the patients as little as possible, have become money-oriented, especially those who which developed tertiary level facilities. The Trust Hospitals which have been started after the 1990s are more often than not commercial in their functioning though they are formally registered as non-profit, charitable institutions (Kurian 2013: Chapter 6). Lastly after 1990, corporate hospitals have sprung up. These are large multi-specialty hospitals to begin with mostly in the bigger cities but now spreading to smaller towns also, catering to the upper-middle and upper-class people. For ordinary people, the rates of these "for profit" hospitals are way beyond affordability. But these hospitals are quite aggressive and brazen in their marketing and have developed a method of spreading their tentacles around this section of the population also through so called "free diagnostic camps", "screening tests," etc.

As we will see shortly, regulation of these different types of hospitals which have differentiated trajectories is quite challenging. The Indian government has failed to measure up to this challenge. Regulation of minimum standards and of charges of hospitals should be done by a special regulatory agency of the state. According to the Constitution, health is a state subject. However, in India

except a handful of states (Maharashtra, West Bengal, Andhra Pradesh, Tamil Nadu, Delhi) even after close to 70 years after independence, there is no law to regulate minimum standards in hospitals and hospital charges. Second, whatever regulation that was enacted in some states was handled by the same public health department which was entrusted with this regulatory work in addition to its ongoing duties of providing health services and performing public health functions. They were not provided with additional competent staff to perform this additional role. There was pressure from different quarters, including from the People's Health Movement to end this sorry state of affairs. Hence finally the CEA, 2010, was enacted in 2011 by the central government and the rules under this law were passed in Parliament in 2013. We examine below this development and the response to it from the IMA, which is the largest and oldest association of allopathic doctors in India.

Clinical Establishment Act, 2010

The CEA, 2010 is a welcome step because of some of its new, positive features.

All clinical establishments and not just hospitals are covered in this act. Second, along with private clinical establishments, all public health facilities, except those in the armed forces services, have been covered by this act. All doctors will have to adopt Standard Treatment Guidelines, and will have to maintain some minimum standards. These two provisions would prevent sub-standard facilities and prevent irrational, exploitative treatment.

As per rules enacted in 2013 under this act, charges by hospitals, clinics will have to be within a range decided by the government. This range is to be decided after following a consultative process with stakeholders, including representatives from doctors. This provision will curb exorbitant charging resorted to by some doctors. Clinics and hospitals will have to display charges for some of the typical items like consulting charges, room charges, etc. This will help the family of the patient to decide in advance whether they can afford to pay these charges. This would help them to choose hospitals they can afford.

The state and national councils to be set up under this act would be constituted by not only government officials but there would be some space for representatives of doctors and consumers, albeit inadequate.

However, the CEA suffers from some major deficiencies and problems. The important ones are:

(i) There is no separate, autonomous structure (and budget) for implementation of the act. CEA, 2010 delegates the huge task of regulating the clinical establishments to the already overburdened existing structure consisting of the directorate of health service at the state level. At the district level it is entrusted with the district registering authority, which is to be led by the district collector and district health officer (DHO), who are already overburdened. The DHO

already finds it difficult to oversee his/her own staff. Now added to this would be monitoring of implementation of the CEA by doctors in private health services who are today more than five-six times as many as the number of doctors in government service. Given these facts, it is more likely that the CEA would remain largely on paper.

(ii) As a general principle, the regulatory authority has to be different from the executive authority. But in the CEA, the executive officer in charge at district level, that is, the DHO is now ex officio in charge of the regulatory function also. This implies a conflict of interest. We cannot expect the DHO to take action in case of deficient compliance of CEA in rural hospitals, of whom s/he is the executive officer.

(iii) It is good that in the multi-stakeholder national and state councils which are meant to guide and steer the implementation of the CEA, some representation of doctors and of civil society organisations has been included. However, at the district level there is no such multi-stakeholder body. This absence gives scope for misuse of powers by officials, leading to corruption. Moreover, there is no space at all for civil society representatives at the district level.

(iv) Under the act there is a provision of appointment of a police official in the district authority. This unnecessary provision of a police officer gives rise to strong apprehensions among doctors, especially in view of the image and track record of the police department.

(v) In the CEA there is no mention of the crucial issues of "Patient's Human Rights." There is no grievance redressal mechanism for patients in case any patient experiences a violation of human rights in a private hospital (for example, if a hospital does not admit on some flimsy grounds a HIV positive patient, or if a hospital refuses to give x-ray or sonography plates to the patients, etc).

(vi) The CEA mandates that all clinical establishments must "stabilise the emergency medical condition of any individual who comes or is brought to clinical establishment." This is quite a problematic provision despite the caveat in this rule-"within the staff and facilities available." For example, a patient with a heart attack (acute myocardial infarction) can be stabilised only in a specialised set-up whereas as per this pro- visions all clinical establishments will have to undertake this responsibility or prove that "within the staff and facilities available" in that clinical establishment, this emergency cannot be handled. Instead of such a sweeping clause, it is only necessary to specify the kind of emergency first aid that every clinic/ nursing home must provide. Second, it may also be noted that the definition of clinical establishment in CEA includes pathological laboratories, radiological clinics, etc. It is not correct to expect emergency care of reasonable quality from these para-clinical practitioners.

Another issue is, who will pay for those patients who have no relatives or are poor and hence cannot pay later the charges for the emergency care? Why can not government reimburse these charges at defined rates? The JSA has demanded improvements in the CEA to overcome

these lacunae. Out of these suggested improvements, the only one that has been accepted at some level is the inclusion of mandatory observance of patient's rights in the mandatory minimum standards listed under the CEA rules. Now in the draft of the minimum standards prepared under CEA, this point has been included. In Section 3.1 titled signage, the following provision has been included- "The Hospital shall display appropriate signage which shall be in at least two languages" and in the list of things to be displayed, has been included- "Patients' rights and responsibilities." JSA had suggested that a "Standard Charter of Patient's Rights" be specifically mentioned in the process standards and that there should be a patient-friendly grievance redressal system. But there has been no response to this suggestion.

Since health is a state subject, states have the power to enact a state CEA. The state CEA can be somewhat different from CEA 2010. It cannot of course be contradictory to the central government's CEA and the state CEA will have to be finally approved by the President of India. Jan Arogya Abhiyan (JAA), the Maharashtra unit of JSA, made a demand to the Maharashtra government to enact a Maharashtra CEA, which would build upon the above-mentioned positive features of CEA, 2010 but which would avoid its deficiencies. After a lot of advocacy and lobbying by JAA, the then health minister of Maharashtra conceded this demand in principle and appointed an expert committee in December 2013 to prepare a draft bill of Maharashtra CEA. It contained representatives of various statutory bodies, officials from the health department, representatives of doctors' organisations, including the IMA, a couple of renowned doctors and a representative of JAA. During its tenure of six months, this expert committee met six times, held public consultations in four cities and in June 2014 submitted the Draft Maharashtra CEA Bill. However it was not tabled in the assembly and it is now an open question about position the government that is now in office will take on this Draft Maharashtra CEA Bill.

Though the Draft Maharashtra CEA Bill prepared by the expert committee is an advance over the central government's CEA, 2010, it still suffers from certain key deficiencies. It is a compromise document. Hence the JAA has prepared the Draft Maharashtra State Clinical Establishment Act 2015 which attempts to overcome these significant lacunae. In this draft there is a focus on ensuring an accessible mechanism for addressing complaints of patients in a rights-based framework, as well as providing space for doctors who may need to raise issues related to implementation of the act. If such an improved act is adopted by the Government of Maharashtra, it would tremendously benefit ordinary patients and should also be acceptable to doctors who want to do rational and ethical practice in a socially responsible manner. This draft consists mostly of verbatim reproduction of the central CEA so that the debate about it is restricted to only the new/modified provisions suggested by JAA. It has been prepared by making certain additions, deletions, modifications wherever necessary in the CEA. The new structural, institutional provisions in this Draft Maharashtra State Clinical Establishment Act 2015 are:

(i) The executive part of the regulatory structure is not headed by the director of health services but is headed by the director of clinical establishment authority, an autonomous new

authority to be created under the secretary (health) to the state government. The director, clinical establishments would be the member-secretary of the state council for clinical establishments which would be, like in the central act, the multi-stakeholder body to guide and steer the overall implementation of the act in the state.

(ii) There is a multi-stakeholder (with representation of various stakeholders) local appellate body at district level, and at the municipal corporation level to deal with appeals against the decision of the local registering authority and to deal with complaints by patients of violations of the Act. It would be chaired by a retired district judge or an equivalent judicial person. A class-r medical officer at district level or municipal corporation level would be specially designated to carry out the work of this local appellate body as the member-secretary.

This draft bill has been prepared in December 2015 and may be presented in the Maharashtra legislature as a private bill in the budget session of the Maharashtra Legislature in 2016.

Indian Medical Association's Negative Response

The response of the IMA to these developments has been quite negative, and short-sighted. The IMA gave a strike call in June 2012 to oppose the CEA (Seshagiri 2012). What is more problematic, the IMA indulged in false propaganda against the CEA. Its representatives imputed provisions to the CEA, 2010 and criticised these provisions when in fact these provisions were not there in CEA (Phadke 2010). For example, in their justification for the strike call on 26 June 2012, the IMA representative claimed "CEA would shut down the practice of small and general practitioners as they cannot afford to meet the norms of waiting area, space and conditions of operations, and staff and infrastructural requirements" (Shrivastav 2012). The fact is that the CEA does not lay down any infrastructural requirements. This is to be done by a committee which had not even been appointed till then and in which anyway IMA representatives would be included as IMA has been recognised to be an important stakeholder representative. The JAA pointed out the misconceptions, falsehood on which the IMA'S opposition was based. But this opposition on irrational grounds continued. Thus, for example, in an email sent on 15 January 2014 by Jayesh Lele, State Secretary, the Maharashtra State IMA, and Dilip Sarda, the President of Maharashtra State IMA and who was a member of the expert committee set up by the Maharashtra government, claimed the following:

Though the Act is meant for the regulation of clinical establishments in the private sector, it is anomalous that there is no provision for the representation of the private sector at all, in the National Council as envisaged in Sec 3 of the Act.

This is factually wrong and a misleading statement. In the National Council established under the CEA, one representative of private doctors has been included. In fact, out of so many types of organisations mentioned in this section in CEA, only IMAs name has been specifically mentioned, whereas other organisations have been mentioned only in generic terms.

Of all the issues, the one issue on which the IMA has most forcefully opposed regulation is regulation of charges levied by hospitals. Given the inherent vulnerability of patients vis-a-vis hospitals, there has to be some mechanism to regulate hospital charges. The CEA as such does not contain a provision for rate regulation. But when the act was tabled in Parliament, during the debate, some Members of Parliament insisted on rate regulation. Hence in the rules of the CEA published in May 2012, the following provision has been included under para 9 (ii) of the rules:

The clinical establishment shall charge rates for each type of procedure and services within the range of rates determined by and issued by the Central government from time to time, in consultation with the State Governments.

A subcommittee has been set up to formulate the template for rate regulation, to make a list of different interventions and list of charges which can be levied by the hospitals for these interventions. IMA representatives have been included in this subcommittee. On 3 December 2014, during the first meeting of this subcommittee, instead of giving suggestions for making this template for rate-regulation, the IMA representative continued with their stand of opposing rate-regulation as such! The result is that in the absence of inputs from IMA representatives, who so far have generally been representatives of smaller hospitals, the decisions of this subcommittee is likely to be influenced by the representatives of the corporate hospitals.

In Maharashtra also, during the deliberations of the expert committee appointed to prepare the Draft Maharashtra CEA Bill, the IMA representatives fiercely opposed inclusion of rate regulation in the draft bill. The representative of JAA proposed the following clause for rate regulation-

> For patients in general wards and semi-private rooms, Hospitals and Nursing Homes shall charge, within the range of rates for fees and services as may be prescribed by the state council.
>
> The range of any professional fee may be decided on the basis of qualification, experience of the healthcare provider, the nature of intervention, and level of institution (primary, secondary etc) at which professional service is being provided as well as the geographical location of the clinical establishment.
>
> The rates for services in different geographical locations (like village, town, metro) may be decided the basis of the cost of infrastructure, of equipment, consumables and of skilled human resources.
>
> These rates may be revised as per annual market inflation.

This formulation is quite reasonable. It is to be noted that the provision suggested by the JAA representative excludes outpatient clinics and deluxe rooms, super deluxe rooms from rate-regulation. This formulation was supported by some doctors in the expert committee. But a majority of the vociferous doctor-representatives affiliated to IMA opposed it and this provision was rejected because the committee was dominated by IMA members, and they were adamantly opposed to any rate-regulation whatsoever.

of regulatory laws like the PCPNDT Act and of the law to regulate the disposal of biomedical waste. However, the lesson to be drawn is to make the whole process of formulating and implementing the act a multi-stakeholder, accountable, transparent process. Second, there has to be greater care in drafting various provisions of any new regulatory act and the rules and making amendments. Lastly, gradually we should move towards a comprehensive single act and a single window system for interfacing for patients/citizens and healthcare professionals. Instead of such a positive approach, IMA's response has been negativist and not justified.

Regulation of Trust Hospitals

Regulation of Trust Hospitals has its additional features. Many of the Trust Hospitals have received some government aid in some form or the other-land on lease at highly subsidised, nominal rates or some tax concession or the other. While accepting this aid, the concerned hospital agrees to treat a certain proportion of patients either free or at highly subsidised rates. But time and again even various official committees have found that these hospitals do not keep these promises (Kurian 2013: 37-44). Given this tendency, Section 41AA was introduced in Maharashtra, in the Bombay Public Trusts Act in August 1985 in which it was specified that in case of "state aided public trust" the charity commissioner and state government can issue directions to earmark certain beds, etc, for poorer patients to be treated free of charge or at concessional rates. As per this section, 10% of the beds were to be reserved for poor and economically weaker sections (EWS) respectively (a total of 20% of beds) for free treatment and treatment at concessional rates. But this provision remained on paper. Even the Maharashtra Law Commission in its report submitted in 2004, titled "the 13th Report of the Law Commission on the Revision of the Bombay Public Trust Act, 1950" deprecated the attitude of these hospitals and made recommendations for strict implementation (Kurian 2013: 66). But in vain. Finally, deliberating on a public interest litigation about this non implementation, the Bombay High Court in its ruling in 2006 laid down a detailed scheme, recommended by an expert committee it had set up. As per this scheme, the "state aided charitable hospitals" must reserve 10% of beds each for the poor (annual income less than Rs 25,000) and the EWS (annual income less than Rs 50,000) of the society for free and concessional treatment respectively. However, even this scheme has hardly been implemented. For example, a study in Mumbai found that of the 42 state-aided charitable hospitals in the city with 50 or more beds, during January 2009 to December 2011, only one hospital spent more than 10% bed-days, and only three hospitals spent 5% or more bed-days for poor patients. As regards the EWS patients, only 4.76% of these 42 hospitals were complying with the court directive (Kurian 2013: 75).

As per this scheme, state-aided charitable hospitals must spend keep apart 2% of their gross income from bills in the Indigent Patient Fund (IPF) for indigent and EWS patients. However, data recovered from the Office of the Joint Charity Commissioner in Pune regarding the operations of 30 hospitals (out of a total of 49 registered charitable trust hospitals in Pune) showed that the average IPF balance per hospital at the end of 2012 was Rs 198.8 lakh (Trivedi 2013). Thus

whatever small amount of money that has been earmarked for poor patients remains grossly underspent.

The Delhi High Court had given a similar judgment making it mandatory for charitable hospitals to reserve 30% of the beds for poor and indigent patients. However, in Delhi too the implementation has been quite lax. A 2011 study reported that Apollo Hospitals was expected to keep 200 beds reserved for the EWS, but the average number of EWS patients treated annually remains in the range of 15 to 20 patients. At Fortis Hospital only three out of eight free beds were occupied, and in case of Jessa Ram Hospital only four out of 10 free beds were occupied (SAMA 2011).

It is learnt that some "trusts" plan to convert themselves into "non-profit companies" and are ready to pay the government at a market rate for the land they have received on lease. This should not be allowed. The only option open for them should be to return the land back to the government so that some other institution can run a charitable healthcare institution at this location. It is essential that the people should have access to a charitable healthcare institution at the original prime location.

It is estimated that in Maharashtra alone there are about 50,000 beds in charitable hospitals. Hence 10,000 beds should be available free of charge/at concessional rates. There should be a website which gives the real-time position as regards occupancy of these beds in each hospital so that such patients can be referred where beds are not already occupied. There should be an adequately equipped special cell in each of the charity commissioner's offices, to monitor the implementation of this scheme. It should also have a mechanism to receive and act upon any grievance that citizens may have about the functioning of this scheme. All this is possible if there is political will. Experience shows such will is not activated without popular pressure.

Accreditation of Hospitals

Accreditation of health care facilities is usually a voluntary programme, in which trained external peer reviewers evaluate the compliance of a healthcare organisation with pre-established performance standards. It has been argued that accreditation is appropriate as a mechanism for assuring the quality of private sector health services in countries like India with low per capita income and where regulatory systems are weak. It has been argued that a multi-stakeholder process of accreditation is more likely to succeed. However it is also clear that the main obstacle to the introduction of accreditation in poorly resourced settings such as India is financial-who will bear the cost of the accreditation process and whether smaller hospitals which may not have resources to chip in financially may be pushed behind in the market competition. In India in the late 1990s there was an attempt in Mumbai to explore the possibility of initiating a voluntary multi-stakeholder accreditation of hospitals. In a survey, conducted in Mumbai in 1997-98, there was a positive response from different stakeholders to the idea of starting multi-stakeholder

accreditation process for hospitals (Nandraj et al 2001). Subsequently "Mumbai Forum for Health Care Standards" was set up to start such voluntary accreditation of hospitals. But things did not move much ahead in practice.

Things have moved forward after the setting up of the National Accreditation Board for Hospitals and Healthcare Providers (NABH) in 2006. The NABH is a constituent board of the Quality Council of India, and has designed an exhaustive healthcare standard for hospitals and healthcare providers, consisting of stringent 600-plus objective elements for the hospital to achieve in order to get the NABH accreditation. However, there are different problems with these NABH standards. First, these standards can be achieved only by bigger hospitals; small hospitals cannot adopt these. In India, we need to have minimum standards to ensure good quality care, but which can be achieved by smaller hospitals also. Second, NABH is a voluntary, self-financed process and is no substitute for a legally enabled, mandatory process which is applicable to all hospitals and other clinical establishments in India. Third, there is no patient friendly grievance redressal system and no mandatory observance of a Standard Charter of Patient's Rights. Anecdotal information about one of the NABH accredited hospitals in Pune, where the author of this essay is based, shows that this accreditation does not imply a patient-friendly environment in the hospital and freedom from irrational and exploitative practices. This accreditation process in India in the form of NABH is no substitute for the standards to be laid down and implemented under the CEA. That is why when the IMA recently demanded that accredited hospitals should be excluded from the CEA, the JSA promptly opposed this proposal (Nagarajan 2015).

The main problem in entrusting regulatory work to government bodies is the fact that the government bureaucracy continues the colonial tradition of a system which from the point of view of ordinary citizens; is unaccountable, high-handed and insensitive. The answer to this problem is to make the regulatory structure multi-stakeholder, transparent, accountable and not to jettison the very idea of a general, mandatory, legally enabled public body for regulation of healthcare system. Accreditation can be part of such a system and not substitute for it. In general, legal, mandatory regulation should have as much of a component of approved self-regulation as possible. But to be sure, the overall framework has to be a mandatory, legally enabled general system of regulation of all clinical establishments.

Conclusions

To conclude, there are a number of solid reasons for regulating the ethics, standards and charges of doctors and hospitals. Regulation of doctors and hospitals cannot be separated from regulation by the medical councils. The medical councils and their functioning need a huge overhaul, including of the CME courses conducted by them. The amendment introduced in 2009 by the MCI titled "Code of conduct for doctors and professional association of doctors in their relationship with pharmaceutical and allied health sector industry" has not been implemented. This must be corrected and the loopholes in it must be sealed. The CEA 2010 has been an important step for

regulation of hospitals in India. But its deficiencies have to be overcome. Otherwise instead of helping the patients it will remain either on paper or will result in Baburaj and make life difficult for small hospitals, paving the way for complete domination by the lager commercial hospitals. The Maharashtra Clinical Establishment Bill-2014 is a good step forward in the direction of states using their prerogative to enact their own legislation to regulate hospitals. But the provision for rate regulation of hospitals and for a patient-friendly grievance redressal system must be added to the draft bill. The IMA's negativistic approach to the CEA has to change. Otherwise this act will primarily benefit the larger commercial hospitals at the expense of small hospitals.

The specificities of Trust Hospitals and public hospitals have to be borne in mind to ensure the furtherance of interests of the patients. The legal provision of reserving beds for poor and EWS by Trust Hospitals in Maharashtra and Delhi has been flouted with impunity. This should be stopped. Accountability of the functionaries of public hospitals has to be enhanced through measures like Community Based Monitoring in order to protect the interests of patients.

Overall, regulation of hospitals in the era of neo-liberalism poses a huge challenge but certainly this challenge should be taken head on and popular pressure is essential for this purpose.

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Tackling Crimes by Children of lesser God

Samir Ranjan Majumdar

The Juvenile (Care and Protection of Children) Bill, 2015, which was passed by the Lok Sabha on 7th May 2015 amid intense protests by several MPs, has finally been passed on 22 December 2015 by the Rajya Sabha. It is now awaiting the President's assent to become law.

The bill provides for juveniles 16 years or older to be tried as adults for heinous offences like rape, gang rape, murder, acid attack and dacoity, etc. The bill mandates setting up Juvenile Justice Boards and Child Welfare Committees in every district. Both must have at least one woman member each.

Once the bill becomes law, the decision to try a juvenile 16 years or older as an adult will be taken by the Juvenile Justice Board, which will have a judicial magistrate and two social workers as members. If the board decides against it, the juvenile will be sent for rehabilitation.

The Government statistics show that crimes by juveniles - especially rape and abduction of women - have seen an exponential rise over the last ten years. While rape by juveniles has increased by 143%, abduction of women has recorded a 380% spurt. The share of teens - aged between 16 and 18 - in juvenile crimes has increased from 48.7% in 2002 to 63.9% in 2011 and 66.6% in 2012.

The figure of juveniles apprehended for heinous crimes - especially in the age group of 16-18 years - has gone up significantly. From 531 murders in 2002, the figure has shot up to 1,007 in 2013. For rapes and assaults, crimes recorded have gone up from 485 in 2002 to 1,884 in 2013.

According to data from NCRB, the number of juveniles in conflict with the law under IPC crimes; which include rape, murder, assault on a woman with intent to outrage her modesty, insult

to the modesty of a woman etc has increased from 31,725 in 2013 to 33,526 in 2014. However, the number of juveniles arrested for recidivism (repeat offence) has come down from 9.5% in 2013 to 5.4% in 2014.

Similarly, the statistics show that the percentage of share of IPC crimes committed by juveniles in comparison to total IPC crimes reported in the country has been very low and remained almost static for the last three years (see the table).

Alarming trends

The percentage share of juveniles arrested under IPC crimes in age group of 16-18 years

2010	63.3%
2011	64.5%
2012	66.6%
2013	66.6%
2014	73.7%

Views for the Bill

The lowering of the age of the children in conflict with law has evoked mixed reactions among various sections of people across the country. Those who argued in favour of passing of the Bill say that the fear of jail (upto 7 years, as provided in the new Bill), will scare the children and work as an effective deterrent.

Some have argued that several of the recent incidents indicate increasing rise in involvement of the juveniles of 16-18 age group in heinous crimes and that they have indulged in such criminal acts with full knowledge and maturity. According to some, the juveniles are fully aware of infirmity in the current juvenile justice law, and that they being under-age are entitled to a special status.

The Government data show that juveniles between the age of 16 and 18 years are found to be more involved in heinous criminal acts and they do it with more brutality and ghastliness. According to NCRB data, out of 43,506 juveniles apprehended during 2013, 28,830 were in the age group of 16-18 years. Out of 48,230 juveniles apprehended during 2014, 36,138 were under the age group of 16-18 years.

A bench of Justices Dipak Misra and Prafulla C Pant of the Supreme Court said, "it is apt to note here that there can be a situation where commission of an offence may be totally innocuous

or emerging from a circumstance where a young boy is not aware of the consequences but in cases of rape, dacoity, murder, (which are heinous crimes), it is extremely difficult to conceive that the juvenile was not aware of the consequences."

"A time has come to think of an effective law to deal with the situation arising from involvement of juveniles in heinous offences", the bench said.

Some others argue that children of the present day society acquire mental maturity early in the present socio-cultural milieu due to the influence of Internet, Social Media and obscene scenes, nudism and violence depicted in TV serials and movies.

Some argue that if the increasing trends of involvement of the juveniles coming into conflict with the law (especially in cases of heinous crimes that are not tackled with iron hand), total anarchy and jungle raj will ensue in the society.

Views against the Bill

While criticising the Bill, the Child Rights Activists and Women Rights Activists have called the bill a regressive step and retributive approach. It is said that the Government has taken the step in haste; emotionally and under pressure and apparently on the basis of the brutal gang rape and murder of 23-year-old Jyoti Singh in a bus in December 2012.

Some experts and activists are of the opinion that the Bill is not going to be effective in curbing juvenile crime. There is nothing to prove that harsher laws will lead to fewer crimes.

"Our objection was based on government data only. We felt it would prove to be a counter-productive step," former National Human Rights Commission (NHRC) chairperson Justice K G Balakrishnan said.

"We told the government that reducing the age from 18 to 16 years would be against the UN Convention on the Rights of the Child, which India ratified in 1992. We also said that at 16 years, the boy is still a child who is in his formative years. If he is sent to jail, after trial in an ordinary criminal court, there is no likelihood of any reformation and he would come out a hardened criminal. So, we said we should be very careful before reducing the age to 16 years," he said.

"A village boy of 16 years, what maturity can we attribute to him? In a well-educated family of fair means, 16 years may be a good age. But the same cannot be true in the case of ordinary, poor citizens," he said.

"We had also cited a number of other reasons why it should not be done. The data shows that the number of serious crimes in which juveniles between the age of 16 and 18 years are accused is not very high, except in a couple of states. In most states, the percentage of people in

this age group committing crimes is not so serious as to warrant legislation at this stage. That was what we had said in the report," said Justice Balakrishnan.

Father Savari Raj, Director of Chetnalaya, the social arm of the Delhi Archdiocese said, "Now, if a child of 15 or 14 years of age commits such crime, will the government again rush to amend the bill?"

Tackling juvenile crime is a challenge and linked to socio-economic and socio-cultural dynamics of the society. During the debate in the Lok Sabha in May 2015, Shashi Tharoor, MP, argued that the law was in contradiction with international standards and that most children who broke the law came from poor and illiterate families. He said that they should be educated instead of being punished.

"This decision has nothing to do with facts. We are abdicating responsibility towards our children," said Professor Ved Kumari of Delhi University.

Human Rights Lawyer Maharukh Adenwalla said the government was "attempting to pit women against children."

"The preliminary data suggests that it is only the children of low economic and social background get caught while those in the middle and high income group are able to settle outside the judicial process," Rita Panicker from Butterflies (NGO) said.

Socio-economic dynamics

If we study the socio-economic profile and family background of the juveniles, we can see that the number of juvenile delinquents from economically weak backgrounds saw an increase, as did the number of illiterate or poorly educated delinquents.

According to NCRB data, while 52.9% of juveniles apprehended in 2012 belonged to families with annual income of less than Rs 25,000, the percentage went up to 55.6% in 2014. About 52% of juveniles apprehended in 2012 were either illiterate or educated only up to the primary level. This figure went up to 53% in 2014.

According to a study, nearly half the parents did not have formal schooling and 33.4% of the children came from families where one or both parents had died; had step families, separated families, or were abandoned or lived on the street.

"Children who are rejected by their parents, those who grow up in families with considerable conflict and those who are inadequately supervised are at the greatest risk of becoming juveniles in conflict with the law," counselor Preethi Manoharan said.

Who is responsible?

Some sections of the society feel that the children committing heinous crimes must be punished harshly, but the society at the same time cannot shy away from its apparent failure in providing a proper and healthy childhood to the child and also for remaining silent about discriminations and deprivations, both social and economic, to which a child has been constantly subjected to.

Equally responsible is the State which has failed to provide desired care and protection to its children, ensure social justice and equal opportunities for development to them during the period of their growth, and allowed them to waft towards criminal activities.

All the plans for rehabilitation and reintegration of juvenile offenders into mainstream of society exist on papers only. The ground reality is something else. Even after the passage of the Juvenile Justice Bill in the year 2000, not a single psychologist was engaged to deal with delinquents on a regular basis, until the year 2010.

All sexual violence, be it by adults or juveniles, is highly condemnable and must be dealt with severely as per law. All efforts must be made to stem the rot. But juvenile delinquency like other social ailments has complex roots. It is undoubtedly a sign of social disease, which cannot be treated without knowing about its root causes.

Solution

It is to be admitted that some children do not follow settled social norms and legal dictum due to various reasons. They need to be identified and removed so that the society can imbibe noble virtues and good qualities in them and eventually grow up to become physically fit, mentally alert, morally healthy and good citizens in the society.

Perpetual poverty, illiteracy and lack of education, availability of cheap literature, bad association, anti-social peer influence, drugs and alcoholic abuse, unemployment, lack of proper and desired parental love, care and control, abusive parents, broken home, violence in home, frequent quarrels between parents, rising standards of living and aspirations for the same, behaviour of alcoholic parents, immorality of parents, easy availability of firearms, battering of children, child sexual abuse, impact of internet and social media, effect of media and cinema, disorder and conflict in society leading to social tension, phobia and lawlessness, slums, lack of timely treatment of biological, psychological and physiological deficiencies in children, disintegration or displacement of families due to urbanisation and industrialisation etc are the most common causes which force a child to get involved in criminal activities.

Until the prevailing socio-cultural environment and socio-economic conditions are changed and the other causative factors are addressed no law can practically prove to be effective in cubing juvenile crimes.

ALIVE,

FEBRUARY 2016.

BOOK REVIEW

New Ideas in Strategic Thinking and Management

Vijayalakshmi V.

Dr. Subash Sharma, known for his new thinking on management has written this book. Many of the ideas found in this book are presented by him in various Strategic Management Forum (SMF) conventions. The discussions in the SMF conventions on his papers have helped him in redefining and refining his ideas and presenting in an engaging manner. This book is presented in 5 parts and 16 chapters.

Knowledge Creation (Part I) section consists of 4 chapters. Chapter 1 (Towards Creative Meditative Research) deals with metaphors and models of social sciences and management, VITAL model of learning Diya (lamp) metaphor of research and some tools of creative-meditative research. Chapter 2 (Towards a New Geometry of Consciousness) discussess the matter route to consciousness. This includes symbols of new geometry, science and spiritual connections application to social and management thought and finally about shunya (zero) theory of consciousness. Knowledge generation windows and grounded praxix are explained in chapter-3. Three paradigms of management are detailed in chapter-4.

Part II (Macro Perspectives in Strategic Thinking) is explained in three chapters. Holistic globalization and holistic development are explained in three chapters. Holistic globalization and holistic development are explained in Chapter 5 highlighting the four forces model of holistic globalization, its foundations, holistic corporate management towards a new social order and towards a RICH (Resources, Income, Consumption and Happiness) model and Nation's Business units. The need for 'beyond pyramid thinking' is detailed in chapter 6. This chapter specifies three roads to development in the concluding part. Chapter 7 (Economic Chapatti Making) includes four streets 'views of India, new vision through chapatti making, dialectical chakras in society and concludes with new vision for India.

Part III (New Models and New Mantras) consists of 5 chapters. Chapter 8 details the 'Best' models of strategic management; Chapter 9 explains CINE (controllable, internal, non-controllable and external), its development, its illustrative configuration and experimental learning. Chapter 10 details the process of forward engineering for strategic management. Scenario mapping

tools, anti-bench marking, mind pooling an integrative framework of forward engineering and managerial SAW (Science, Arts and wisdom) for forward engineering are effectively dealt with. Enterprise Performance System (Chapter 11) and organization development and management (Chapter 12) project the author's creativity in integrating enterpreneurial and organizational aspects with management.

Part IV (Ethical Foundations) is explained in three chapters. Ethical foundations in new corporate model (Chapter 13) discuss TCP model, ethical foundations of organizations, and an intergrative vision of market, self and society. Character competence of the corporation is detailed in Chapter 14. Chapter 15 expalins holistic performance of scorecard of corporations. Part V (New Visioning and Envisoning) consists of one Chapter (Chapter 16) titled Moon Ocean Strategy. Three approaches to strategy, three eras of strategic management, and three views of strategic management are explained in this chapter.

This book is rooted in a futuristic view based on harmonic globalization. The author has used the ideas pointed in his various articles and papers presented in conventions and conferences for this book. This book adds to the literature on strategic thinking and management emerging from India. This book could be a good reference book for students and researcheres specializing in strategic management. This could also be interesting and useful to enterpreneurs with strategic thinking.

SOUTHERN ECONOMIST,

FEBRUARY 15, 2016.

Himachal Pradesh Legislative Assembly

RESUME OF WORK TRANSACTED FROM 30TH NOVEMBER, 2015 TO 12TH DECEMBER, 2015

The 10th Session of the Himachal Pradesh Legislative Assembly which commenced on the 30th November, 2015 in the Vidhan Sabha Bhawan at Tapovan, Dhararnshala. The House met for 5 days and transacted the Business. The Session commenced with established convention of playing of the National Anthem. This being the Winter Session, the business before the House was presentation, consideration and passing of the Govt. Bills.

On the 30th November, 2015, the opening day, the Session commenced at 2.00 PM. The House paid tributes to late Shri Lajja Ram, former Member of Himachal Pradesh Legislative Assembly. The Hon'ble Chief Minister, Leader of Opposition and other Hon'ble Members and also the Hon'ble Speaker, made obituary references to the departed soul.

The Secretary, H.P. Vidhan Sabha laid on the table of the House a copy each of the Bills (Seven) passed during the Ninth Session and assented by His Excellency the Governor of Himachal Pradesh.

In all, 202 notices of Starred Questions were received, out of which 168 notices were admitted for reply. Similarly, 79 notices for written answer were received and 49 notices were admitted for written answer.

Two notices of Calling Attention to the matters of urgent public importance under Rule-62 and two motions under Rule-130 were discussed and one important resolution under Rule-117 was considered and adopted by the House. Out of four Private Member's Resolutions under Rule-1OI only two were discussed and replied by the concerned Minister. Third resolution which was moved in the House would be taken-up for discussion during the next Session and the fourth resolution which was not moved was treated as lapsed.

Four Notices of Adjournment Motion under Rule-67 were received, out of which three were rejected and one notice was converted into Rule-130 for discussion by the Hon'ble Speaker.

During the Session, 13 documents relating to Annual Administrative Reports, Annual Accounts/Audited Reports of various Autonomous Bodies/Corporations of the State. Government and the Recruitment & Promotion Rules of various Departments/Corporations were laid on the Table of the House. 19 Reports of the House Committees were presented and laid on the Table of the House.

In the sphere of Legislative Business, the following Bills were introduced in the House:-

1. The Himachal Pradesh Subordinate Courts' Employees (Pay, Allowances and Other Conditions of Service) Second Amendment Bill, 2005; and
2. The Himachal Pradesh Aerial Ropeways (Amendment) Bill, 2015; (Bill No. 23 of 2015)

On 4th December, 2015 due to continuous interruptions by the Opposition during the Question Hour, the House was adjourned sine-die by the Hon'ble Speaker without transacting any Business listed for the day. The House was prorogued by His Excellency, the Governor of Himachal Pradesh on 12th December, 2015.

Jharkhand Legislative Assembly

RESUME OF WORK TRANSACTED FROM 15TH DECEMBER, 2015 TO 22ND DECEMBER, 2015

The Fourth (Winter) session of the 4th Jharkhand Legislative Assembly which commenced on 15th December, 2015 and was adjourned sine-die on 22nd December, 2015. During the session period, the house sat for 06 days and transacted business for a period of approximately 23 hrs. and 15 minutes.

OPENING ADDRESS BY HON'BLE SPEAKER

The session commenced with the address by Hon'ble Speaker. Hon'ble Speaker welcomes the members and apprise them about the business to be transacted during the session. Hon'ble Speaker concluded his address with the hope and faith for positive co-operation of the members in conducting the house.

ORDINANCE LAID ON THE TABLE OF THE HOUSE

In exercise of powers conferred by clause (2) (a) of the Artic1e-213 of the constitution of India. A copy of ordinance laid on the table of the house by the Hon'ble parliamentary affairs minister which is promulgated by the Hon'ble Governor of Jharkhand. These are as follows :-

DETAILS OF PROMULGATE ORDINANCE BY HON'BLE GOVERNOR

Sl. No.	Name of Promulgate Ordinances	Date of Permission	No. of Ordinance
01	**02.**	**03.**	**04.**
01.	Jharkhand Industries Facilitation and Single Window Clearance Ordinance, 2015.	03.09.2015	05, 2015

02.	Baba Baidyanath Dham-Basukinath Shrine Area Development Authority Ordinance, 2015	03.09.2015	04, 2015
03.	The Jharkand Mineral Area Development Authority (Amendment) Bill, 2015.	13.09.2015	06, 2015
04.	The Jharkand State University (Amendment) Ordinance, 2015.	03.12.2015	07, 2015

CONSENT ON BILLS BY THE HON'BLE GOVERNOR

Details of the Bills Third (Winter) session of the 04th Jharkhand Legislative Assembly passed by the house and approved by the Hon'ble Governor are as follows:-

DETAILS OF CONSENT BILLS BY HON'BLE GOVERNOR

Sl. No.	Name of Promulgate Ordinances	Date of Permission	No. of Ordinance
01.	**02.**	**03.**	**04.**
01.	The Jharkhand Appropriation (No. 04) Bill, 2015	03.09.2015	09/2015
02.	Jharkhand Value Added Tax (Amendment) Bill, 2015	17.09.2015	10/2015
03.	The Jharkhand Agricultural Produce Market (Amendment) Bill, 2015	22.09.2015	11/2015
04.	Jharkhand Agriculture University (Amendment) Bill, 2015	03.09.2015	12/2015
05.	Jharkhand Municipal (Amendment) Bill, 2015	06.10.2015	13/2015
06.	The Jharkhand Shops and Establishment (Amendment) Bill, 2015	12.10.2015	14/2015
07.	Jharkhand Exise (Amendment) Bill, 2015	13.10.2015	15/2015
08.	The Jharkhand Tourist Places (Protection and Maintenance) Bill, 2015	15.10.2015	16/2015
09.	Jharkhand Tourism Development and Registration Bill, 2015	15.10.2015	17/2015
10.	Jharkhand University Technology Bill, 2011	23.09.2015	18/2015
11.	Jharkhand Staff Selection Commission (Amendment) Bill, 2015	30.10.2015	19/2015

12.	Jharkhand Public Service Commission Extra Work Extension Bill, 2015	05.11.2015	20/2015
13.	Jharkhand Co-operative Society (Amendment) Bill, 2015	07.11.2015	21/2015
14.	The Jharkhand Self Supporting Co-operative Societies (Amendment) Bill, 2015	07.11.2015	22/2015

PANEL OF CHAIRMAN

For the Fourth (Winter) session of Fourth Jharkhand Legislative Assembly under the rule-10(1) of the Procedure and conduct of Business of Jharkhand Legislative Assembly Hon'ble Speaker nominated the following members to serve in the panel of Chairman:-

(i) Shri Stephen Marandi - M.L.A

(ii) Shri Ashok Kumar - M.L.A

(iii) Shri Phulchand Mandal - M.L.A

(iv) Shri Aalamgir Aalam - M.L.A

(v) Smt. Geeta Kora - M.L.A

FINANCIAL BUSINESS

On 16th December, 2015 the Finance Minister (Chief Minister) Shri Raghubar Das introduced the Second Supplementary expenses for the Financial year 2015-16, debate occurred on the Second Supplementary expense which was discussed on the 17th December, 2015. After the response of Government and vote on the appropriation bill, the bill was passed by the House on the same date.

OATH BY MEMBERS

On 21st December, 2015 Shri Sukhdeo Bhagat elected from Lohardaga Constituency made and subscribed oaths as member of the Legislative Assembly and sign in the Roll of members.

LEGISLATIVE BUSINESS (BILLS)

During the session, 11 (Eleven) Bills were introduced, out of these 10 (Ten) Bills were passed, these are as follows :-

(i) The Jharkhand Appropriation (No-05) Bill, 2015.

(ii) Jharkhand Single Window Clearance Bill, 2015.

(iii) The Factories (Jharkhand Amendment) Bill, 2015.

(iv) The Bihar Industrial Establishment (National and Festival Holidays and Casual Leave) (Jharkhand Amendment) Bill,2015.

(v) The Contract Labour (Regulation and Abolition) (Jharkhand Amendment) Bill, 2015.

(vi) Jharkhand Value Added Tax (Amendment) Bill, 2015.

(vii) The Jharkhand Fiscal Responsibility and Budget Management (Amendment) Bill, 2015.

(viii) Baba Baidyanath Dham-Basukinath Shrine Area Development Authority Bill, 2015.

(ix) Jharkhand Municipal (Amendment) Bill, 2015.

(x) The Jharkhand Mineral Area Development Authority (Amendment) Bill, 2015.

On request of Hon'ble members under the consideration on "Jharkhand State University (Amendment) Bill, 2015", the then Hon'ble Speaker submitted the aforesaid Bill to the select committee and directed the select committee to submit it's report within 15days.

"Jharkhand cinema (regulation) Amendment Bill, 2015" was introduced on 28th August, 2015. On request of Hon'ble Members under the consideration, the then Hon'ble Speaker submitted the aforesaid bill to the Select Committee and directed the select committee to submit its report within three months. After discussion the Select Committee submit its report to the House. Then Jharkhand Cimema (Regulation) Amendment Bill, 2015 was passed on 18th December, 2015.

QUESTIONS

Notices of 69 nos. of Starred, 67 nos. of Un-starred question and 206 nos. Short notice respectively had been received, out of these 58 nos. & 291 nos. Notices were admitted as Starred and Un-starred question and 438 Short notice respectively.

PRIVATE MEMBERS RESOLUTION

During the session, on 2211d December, 2015 (Tuesday) was allotted for taking up Private members resolutions. Altogether 22 Resolutions were admitted, out of these 22 were accepted and returned.

CALLING ATTENTION

Total 55 calling attention notices were received and 25 notices were accepted and 02 were rejected, out of these, replies for 22 notices were received by the committee.

LAYING OF PAPERS ON THE TABLE OF THE HOUSE

During the session period the following rules, reports, resolution and notification etc. were laid on the table of the house by the Minister-in-Charge of the concerned departments, namely :-

(i) Jharkhand Education Service Rule; 2015.

(ii) Resolution on the Reservation in the vacancy of the Jharkhand posts and services (For Schedule Caste, Schedule Tribe and Other Backward Classes).

(iii) Report of Comptroller and Auditor General of India on Finance and Appropriation statements for the year 2014-15.

(iv) The Annual reports of the Jharkhand Lokayukta for the year 2014-15.

NIVEDAN

In this session, 44 Nivedan were received, out of which 38 were admitted and sent to the concerned department for reply and rest 06 were rejected. .

ZERO HOUR

Several issues of public interest were raised by the Hon'ble members in the house during zero hour. In this session, 117 zero hours notices were received, out of which 117 were permitted and reply

SPECIAL DEBATES/ DISCUSSION

(i) On 16th December, 2015 two hours special debate on the subject "Drought, Displacement and Re-habilitation in the State".

(ii) On 21st December, 2015 two hours special debate on the subject "Food Conservation in the State".

OBITUARY REFERENCE

During the session the House Mourned the death of the following dignitaries :-

(i) Late Dr. Sayed Ahmad (Former Governor of Jharkhand).

(ii) Late Hasim Abdul Haleem (Former Speaker of West Bengal Legislative Assembly).

(iii) Late Ramashrya Prasad Singh, Bandhu Mahto, Tulsi Singh, Bhukhla Bhagat, Benard Minz, Kameshwar Prasad Singh and Ashok Singhal (Senior Leader).

(iv) Late O. P. Mehra (Former Air Chief Marshal).

(v) Late Adesh Srivastwa and Ravindra Jain (Musician).

(vi) Late Mohan Bhandari and Sayeed Jafari (Actor).

(vii) Late Viren Dubral and Maheep Singh (Litterateur).

(viii) Late Jagmohan Dalmia (Former Chairman of B.C.C.I.).

(ix) Late P.N.S. Surin and B.D. Sharma (Specialist in related to Tribal).

(x) Late Sarad Joshi (Father of Farmer Movement).

Beside these, 12(Twelve) persons were killed in railway crossing in Bhurkunda (Jharkhand). Some persons were killed during the flood in Chennai (Tamilnadu) and four (04) labour has died in train accident in Giridih and some people were killed in a stampede at Makka-Madina, In this matter Great sorrow was expressed by the House after that Hori'ble Chief Minister Shri Raghubar Das, Hon'ble Leader of Opposition Shri Hemant Soren, Hon'ble Minister Shri Chandraprakash Choudhary, Hon'ble Members Shri Aalamgir Aalam, Pradeep Yadav, Arup Chatterjee, Rajkumar Yadav, and Smt. Geeta Kora also mourned. After that, the member stood in a silence for a short while as mark of respect to the memory of the departed soul.

VALEDICTORY SPEECH

On 22nd December, 2015 at the Conclusion of the business of the Session, the Hon'ble Speaker made a Valedictory Speech before adjourning the House sine-die. In his valedictory address, Hon'ble Speaker thanked the leader of the house, the Hon'ble Chief Minister, the Hon'ble Leader of the opposition, the Hon'ble Members of the house for extending their co-operation for participating in all the business of the house and to all the representatives of Electronic Media and Press and all the Officers and Staff of the Assembly Secretariat.

On the whole the session passed off peacefully. The House was adjourned sine-die by the Hon'ble Speaker Shri Dinesh Oraon after the conclusion of its sitting on 22nd December, 2015. The House was also propogued by His Excellency the Governor of Jharkhand on the same day.

Uttarkhand Legislative Assembly

RESUME OF WORK TRANSACTED FROM 2ND NOVEMBER, 2015 TO 03RD NOVEMBER, 2015

The second Session of the year 2015 Uttarakhand Legislative Assembly was held this time in Gairsain in Chamoli District of the State on 2nd November, 2015 and concluded on 3rd November, 2015. During the session, the main business transacted by the House was Presentation, Consideration and Passing of the Supplementary Demands for Grants for the year 2015-16 along with some other important Bills. There were two sittings in all and the average attendance of the Hon'ble Members during the session was 95. 77%.

During the session, the House paid tributes to Dr. A.P.J Abdul Kalam, former President of India, Late Shri Pooran Singh Mahra, former Member Uttar Pradesh Legislative Assembly and Late Shri Khadag Singh Bora, former member Uttarakhand Legislative Assembly. Hon'ble Speaker, the Parliamentary Affairs Minister, Leader of Opposition and the leaders of the Legislative groups of Bahujan Samaj Party and Uttarakhand Kranti Dal made obituary references to the departed souls.

On 2nd November, 2015, Hon'ble Finance Minister presented the Supplementary Demands for Grants for the Financial Year 2015-16. The General Discussion on the demands took place on 3rd November, 2015 and the House voted and passed the Demands for grants on the same day.

Sl. No.	Name	Date		Act of the year 2015
		Passing by the House	Receiving Assent	
1.	Uttarkhand Subordinate Service Selection Commission (Amendment) Bill, 2015	17.03.2015	27.03.2015	7
2.	Uttarkhand Appropriation Bill, 2015	20.03.2015	27.03.2015	8

3.	Uttarkhand Entertainment and Betting Tax (Amendment) Bill, 2015	18.03.2015	31.03.2015	9
4.	Uttarkhand Cooperative Committee (Amendment) Bill, 2015	20.03.2015	31.03.2015	10
5.	Uttarkhand Value Added Tax (Amendment) Bill, 2015	20.03.2015	31.03.2015	11
6.	Uttarkhand Krishi Evam Prodyogik Vishwavidhyalaya (Third Amendment) Bill, 2015	18.03.2015	31.03.2015	12
7.	Uttarkhand Khadi and Gramodyog Board (Amendment) Bill, 2015	17.03.2015	31.03.2015	13
8.	Uttarkhand Krishi Utpadan Mandi (Vikas and Viniyaman) (Amendment) Bill, 2015	21.03.2015	31.03.2015	14
9.	Uttarkhand Protection of Cow Progeny (Amendment) Bill, 2015	17.03.2015	31.03.2015	15
10.	Uttarkhand Scheduled Tribes Commission Bill, 2015	18.03.2015	01.04.2015	16
11.	Uttarkhand Scheduled Castes, Scheduled Tribes Commission (Amendment) Bill, 2015	17.03.2015	01.04.2015	17
12.	Uttarkhand Medical Services Selection Board Bill, 2015	20.03.2015	06.04.2015	18

During the session, following papers were laid on the Table of the House: -

1. Financial Report of Uttarakhand Forest Corporation for the year 2009-2010 and 2010-2011 under section-26(1) of Uttar Pradesh Forest Corporation Act. 1974 (As enforced in Uttarakhand).
2. Annual Audit Report Part-1&2 {Directorate Audit (Audit)} of the year 2012- 13, under section 8(3) of Uttarakhand Audit Act, 2012
3. Notification no. 977/XX-2/15/03(29) 2012, dated 17th June, 2015 of the department of Home under section 24(5) of Right to Information Act, 2005
4. Annual Financial Statement of Uttarakhand Electricity Regulatory Commission of the year 2013-14 under section 104(4) of Central Electricity Act, 2003 and Annual Report for 2013-14 under section 105(1) of the Central Act
5. Following compilations of Regulations of Uttarakhand Electricity Regulatory Commission under section 182 of Central Electricity Act, 2003

1. Uttarakhand Electricity Regulatory Commission (Compliance Audit) Regulations, 2015
2. Uttarakhand Electricity Regulatory Commission (Terms and Condition of Inter State Open Access) Regulations, 2015
3. Uttarakhand Electricity Regulatory Commission (Procedure for appeal before the Appellate Authority) Regulations, 2014
4. Uttarakhand Electricity Regulatory Commission (Appointment of Consultants) (First Amendment) Regulations, 2014
5. Uttarakhand Electricity Regulatory Commission (Appointment and Functioning of Ombudsman) (Third Amendment) Regulations, 2014
6. Uttarakhand Electricity Regulatory Commission (Conduct of Business) Regulations, 2014
7. Uttarakhand Electricity Regulatory Commission (Releasing New H T. and E.H T. Connections, Increase and Decrease in Loads) (First Amendment) Regulations, 2014
8. Uttarakhand Electricity Regulatory Commission (Tariff and other Terms of Supply of Electricity from Renewable Energy Sources and non-fossil fuel based Co-Generation Stations) (Second Amendment) Regulations, 2014 (Main Regulation, 2013)
9. Uttarakhand Electricity Regulatory Commission (Tariff and other Terms of Supply of Electricity from Renewable Energy Sources and non-fossil fuel based Co-Generation Stations) (Second Amendment) Regulations, 2014 (Main Regulation, 2010)
10. Uttarakhand Electricity Regulatory Commission (Compliance of Renewable Purchase Obligation) (First Amendment) Regulations, 2013
11. Uttarakhand Electricity Regulatory Commission (Tariff and other Terms of Supply from Renewable Energy Sources and non-fossil fuel based Co-Generation Stations) (First Amendment) Regulations, 2013.

The following Bills were introduced, considered and passed by the Assembly during the session:-

1. The Uttarakhand Appropriation (First Supplementary of 2015-16) Bill, 2015
2. The Uttarakhand State Legislature (Emoluments and Pension of Members)(Amendment) Bill, 2015
3. The Uttarakhand Reservation for Identified Revolutionists of Uttarakhand Movement and their Dependents in Government Service Bill, 2015
4. The Uttarakhand Industrial Disputes (Amendment) Bill, 2015
5. The Uttarakhand Cess Bill, 2015

6. The Uttarakhand Tax on Entry of Goods into Local Areas (Amendment) Bill, 2015.
7. The Uttarakhand Cinemas (Regulation) (Amendment) Bill, 2015
8. The Uttarakhand Entertainment and Betting Tax (Second Amendment) Bill, 2015
9. The Uttarakhand Value Added Tax (Amendment) Bill, 2015
10. The Uttarakhand School Education (Amendment) Bill, 2015.

Besides the above, The Indian Stamp (Uttarakhand Amendment) Bill, 2011 passed by the Legislature on 16-03-2011 and Amendment Bill, 2014 passed on 18-02-2014 were sent for the assent of Hon'ble President of India, under Article 201 of the Constitution of India. The Ministry of Home Affairs, Government of India, directed that both the Bills be withdrawn and a combined Bill brought by the Legislature. In pursuance of the same, the Indian Stamp (Uttarakhand Amendment) Bill, 2015 was introduced, conduced and passed by the Assembly during the session.

During the Session, the following motion was passed by the legislature- This House recommends to the Central Government that

a) Keeping in view the special tactical, geographical, environmental, economic and social circumstances of Uttarakhand state, the special status of the state should be maintained as it is and accordingly, the norms of Central Assistance should also be kept the same meaning that the ratio of State and Central part in centrally sponsored schemes be kept at 90:10 only,

b) Himalayan states being full of forest cover and abundant water resources, provide ecological security and balance, but the cost of developmental works is quite higher in comparison to other states because of geographical reasons and obstructions and permissions of Forest and Environment Act. To remove this imbalance and for balanced and equitable growth, separate policy/policies should be promulgated by the Central Government for the states and especially, enough money of Green Bonus and water bonus should be transferred to these states per year by the Central Government.

After conducting important business, the House was adjourned sine-die by the Hon'ble speaker at the conclusion of its sitting on 3rd November, 2015.

THE LEGISLATIVE BODIES IN SESSION DURING THE MONTH OF FEBRUARY 2016

Sl. No.	Name of Assembly/Council	Duration
1.	Loksabha	23.02.2016 - 16.03.2016, 25.04.2016 - 13.05.2016
2.	Rajyasabha	23.02.2016 - 16.03.2016, 25.04.2016 - 13.05.2016
3.	Assam Legislative Assembly	01.02.2016 - 04.02.2016
4.	Gujarat Legislative Assembly	22.02.2016 - 31.03.2016
5.	Himachal Pradesh Legislative Assembly	25.02.2016 - 07.04.2016
6.	Jammu and Kashmir Legislative Council	18.01.2016 - 09.03.2016
7.	Jammu and Kashmir Legislative Assembly	18.01.2016 - 09.03.2016
8.	Jharkhand Legislative Assembly	15.02.2016 - 18.02.2016
9.	Karnataka Legislative Assembly	29.02.2016 - 05.03.2016
10.	Karnataka Legislative Council	29.02.2016 - 05.03.2016
11.	Rajasthan Legislative Assembly	29.02.2016 -

Site Address of Legislative Bodies in India

Sl.No	Name of Assembly/Council	Site Address
1.	Loksabha	loksabha.nic.in
2.	Rajyasabha	rajyasabha.nic.in
3.	Andhra Pradesh Legislative Council	aplegislature.org
4.	Andhra Pradesh Legislative Assembly	aplegislature.org
5.	Arunachal Pradesh Legislative Assembly	arunachalassembly.gov.in
6.	Assam Legislative Assembly	assamassembly.nic.in
7.	Bihar Legislative Assembly	vidhansabha.bih.nic.in
8.	Bihar Legislative Council	biharvidhanparishad.gov.in
9.	Chhattisgarh Legislative Assembly	cgvidhansabha.gov.in
10.	Delhi Legislative Assembly	delhiassembly.nic.in
11.	Goa Legislative Assembly	goavidhansabha.gov.in
12.	Gujarat Legislative Assembly	gujaratassembly.gov.in
13.	Harayana Legislative Assembly	haryanaassembly.gov.in
14.	Himachal Pradesh Legislative Assembly	hpvidhansabha.nic.in
15.	Jammu and Kashmir Legislative Assembly	jklegislativeassembly.nic.in
16.	Jammu and Kashmir Legislative Council	jklegislativecouncil.nic.in
17.	Jharkhand Legislative Assembly	jharkhandvidhansabha.nic.in
18.	Karnataka Legislative Assembly	kar.nic.in/kla/assembly
19.	Karnataka Legislative Council	kar.nic.in/kla/council/council

20.	Madhya Pradesh Legislative Assembly	mpvidhansabha.nic.in
21.	Maharashtra Legislative Assembly	mls.org.in/Assembly
22.	Maharashtra Legislative Council	mls.org.in/Council
23.	Manipur Legislative Assembly	manipurassembly.nic.in/
24.	Meghalaya Legislative Assembly	megassembly.gov.in/
25.	Mizoram Legislative Assembly	mizoramassembly.in
26.	Nagaland Legislative Assembly	http:/nagaland.nic.in
27.	Odisha Legislative Assembly	odishaassembly.nic.in
28.	Puducherry Legislative Assembly	www.py.gov.in
29.	Punjab Legislative Assembly	punjabassembly.nic.in
30.	Rajasthan Legislative Assembly	rajassembly.nic.in/
31.	Sikkim Legislative Assembly	sikkimasembly.org
32.	Tamil Nadu Legislative Assembly	assembly.tn.gov.in
33.	Tripura Legislative Assembly	tripuraassembly.nic.in/
34.	Uttar Pradesh Legislative Assembly	uplegassembly.nic.in
35.	Uttar Pradesh Legislative Council	upvidhanparishad.nic.in
36.	Uttarakhand Legislative Assembly	ukvidhansabha.uk.gov.in
37.	West Bengal Legislative Assembly	wbassembly.gov.in/
38.	Telangana Legislative Assembly	telanganalegislature.org.in