Sick SMEs

*308. PROF. P.J. KURIEN: Will the Minister of MICRO, SMALL AND MEDIUM ENTERPRISES be pleased to state:

(a) whether a number of small and medium enterprises have become sick in the last three years;

(b) if so, the details thereof and the reasons therefor;

(c) whether production and productivity in this sector has declined;

(d) if so, the details thereof; and

(e) the steps Government proposes to take in this regard?

THE MINISTER OF STATE OF THE MINISTRY OF MICRO, SMALL AND MEDIUM ENTERPRISES (SHRI DINSHA J. PATEL): (a) and (b) The data on sickness in micro, small and medium enterprises (MSME) sector is compiled by the Reserve Bank of India (RBI). As per the data compiled by the RBI from the scheduled commercial banks, the position regarding number of sick MSMEs in the country for the period March, 2006 to March, 2008 (latest available) is as under:—

As at the end of	Number of sick MSMEs
March 2006*	1,26,824
March 2007	1,32,081
March 2008	99,941

*The data pertains to micro and small enterprises (MSEs) only, as the medium enterprises were defined for the first time under the Micro, Small and Medium Enterprises Development Act, 2006 which became effective from 2nd October, 2006.

The main reasons for sickness are inadequate and delayed credit, obsolete technology, marketing problems, infrastructural constraints, managerial deficiencies, etc.

(c) and (d) The production and employment in the MSE sector is estimated to be Rs. 3,72,938 crore and 287.55 lakh persons in 2004-05 and Rs. 4,71,663 crore and 312.52 lakh persons in 2006-07 (latest available) respectively. This works out to production per person of Rs. 1.30 lakh in 2004-05 and Rs. 1.51 lakh in 2006-07.

(e) To facilitate the promotion and development of micro, small and medium enterprises (MSMEs) and enhance their competitiveness, the Government has announced a 'Policy Package for Stepping up Credit to Small and Medium Enterprises (SMEs)' in August, 2005 which envisages public sector banks to fix their own targets for funding MSMEs in order to achieve a minimum 20 per cent year-on-year growth in credit to the MSME sector. The Government has also announced in February, 2007 a 'Package for Promotion of Micro and Small

Enterprises' with an objective to provide support in areas of credit, technology upgradation, marketing, infrastructure, etc. Further, the Government has enacted the Micro, Small and Medium Enterprises Development Act, 2006, which has come into force from 2nd October, 2006, for promotion and development of MSMEs and to enhance their competitiveness. In addition, the Government is also implementing several schemes/programmes, which include the National Manufacturing Competitiveness Programme and schemes relating to credit, infrastructural development, technology upgradation, marketing, entrepreneurial/skill development, etc. aimed at enhancing competitiveness and productivity of the MSMEs.

Basic health facilities for tribal areas

309. SHRIMATI BRINDA KARAT: Will the Minister of HEALTH AND FAMILY WELFARE be pleased to state:

(a) the efforts made to provide basic health facilities in tribal areas;

(b) the steps taken towards improvisation as well as infrastructure development and proposal for health insurance coverage, if any, for tribals; and

(c) the status and the funds earmarked for the purpose on State-wise basis?

THE MINISTER OF HEALTH AND FAMILY WELFARE (SHRI GHULAM NABI AZAD): (a) to (c) To strengthen the basic health facilities and public health system in rural areas including the tribal areas and make health care accessible, affordable and accountable, the National Rural Health Mission (NRHM) was launched in April, 2005.

The Mission seeks to establish functional health facilities in the public domain through revitalization of the existing infrastructure and fresh construction or renovation wherever required. The Mission also seeks to improve service delivery by putting in place enabling systems at all levels addressing issues relating to manpower planning as well as infrastructure strengthening.

It also aims at bridging the gap in Rural Health care services through a cadre of Accredited Social Health Activists (ASHA) and improved hospital care, decentralization of programme to district level to improve intra and inter-sectoral convergence and effective utilization of resources. The ASHA would reinforce community action for universal immunization, safe delivery, newborn care and prevention of water-borne and other communicable diseases, nutrition and sanitation. As per the Implementation Framework for NRHM, ASHA is being provided in each village in the ratio of one per 1000 population. For tribal, hilly, desert areas, the norm could be relaxed for one ASHA per habitation depending on the workload.

Given the concentration of Tribal inhabitation in far-flung areas, forest lands, hills and remote villages, to better support infrastructure development, the population norms have been relaxed at different levels of health facilities:—

- Sub-centers are permitted for 3000 population in tribal areas as against 5000 population in general areas.