Political Economy of State Health Financing

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In a capitalist state the government is a functionary of capitalism—its role is to protect and strengthen it. Thus the state's behaviour even with regard to the health sector programmes, is a function of private capital.

The health sector started with a very low priority and has gradually gained an increased share of the state's expenditure, the growth rate of health and family planning expenditures has been much greater than both the growth of government expenditure and the gross domestic product. But this does not reflect an improvement in health-care services provided by the state. Why this is so and what role state financing of health care has played is examined in this article with specific reference to two states, Gujarat and Maharashtra.

THE health sector is popularly perceived as being part of the social services sector. The corollary to this being that it automatically becomes largely a responsibility of the state. This perception is common even among the most advanced capitalist states.

Health and education (besides unemployment insurance in a few countries) are the 'classical' sectors within the umbrella of state welfare. Over the years, all over the world, these two sectors have increasingly been supported through public finance for various reasons. The most important being the predominance of the view that they are a social service and therefore, not in the direct interest of private capital. Nevertheless, they being an important social need had to be met, and therefore public finance became the provider increasingly.

The historical consequence of this development has been a greater role for the state in meeting the needs of the people. Since state finances come largely from taxes the household and corporate sectors have gradually begun to feel the brunt of letting the state take care of the social sector. Given the nature of the capitalist state there comes a point beyond which taxing private capital becomes a threat to capitalism itself. Thus emerges a "fiscal crisis of the state" and there is talk of cuts in welfare and social expenditures. The pressures of capitalism in its pursuit of surplus appropriation is responsible for this.

Advanced capitalism, especially monopoly capital, and the state have a love-hate relationship. Love, because the survival of capitalism is dependent on state protection and support, and hate because increased state expenditures mean enhanced taxes and public debt that may terminate in a fiscal crisis, or worse a social one.

Of late this realisation has hit capitalism, which sees the dangers inherent in an increased burden of state welfarism. The result is increased "corporate welfare". This is happening in the USA in a large way and the health sector is the best illustration. Expansion of private health care (especially corporate) in the last three or four years in the USA has been phenomenal. What is more is that it has also been realised that the social sector, especially health, can be a highly profitable one. This is largely facilitated by modern technological advances in health care. For instance in the USA between 1980 and 1984 corporate revenues in health care grew from $ 25 billion to $ 118 billion, along with increased monopolisation through mergers and takeovers (in spite of anti-trust suits). And in the same period, of the 37 largest health and welfare corporations only two lost money, whereas 13 more than doubled their revenues and 11 more than quadrupled their revenues (Stoesz, 1986).

This trend is true for most advanced capitalist countries and is fast emerging in backward capitalist countries too. In the last two years in India over Rs 200 crore have been spent by the corporate sector in setting up 60 diagnostic centres (CT scan etc.) all over the country, of which 46 were set up by the United Group alone (Business India, Dec 29, 1986).

This, however, does not mean that the state health care sector is on the decline. Historically the state health sector as well as other state welfare and development programmes have served the needs of private capital (see Galper, 1975). We will return to this later.

The state financed health care sector in India is 'patronised' by only about one-third of the country's population, of this roughly 80 per cent being urban. That is two-thirds of India's population utilise private services for health care; and the state's health services are concentrated disproportionately in urban/industrial areas. It may also be noted that municipal health services, railway, defence and mining health services, as also those services provided by public sector undertakings are not accounted for under 'state health expenditure'.

Health is a state (provincial) subject and therefore the responsibility of providing health care vests with the concerned state. However, the union government does make a substantial contribution to the states through grants and centrally sponsored health programmes. Besides, policy making and planning for the health sector has largely been determined by the centre.

The state health sector in India incorporates three components (a) Medical Services including CGHS and ESIS, (b) Public health (including water supply and sanitation) and (c) Family Planning (including MCH). Family Planning is almost entirely a centrally funded programme (it falls under the concurrent list). In this paper we will look at the health sector as including only the first two components, treating family planning independently.

The major sources of data for state spending on health care are (a) The Combined Finance and Revenue Accounts (CFRA) of the Union and State governments compiled by the Comptroller and Auditor General of India, (b) Summarised Accounts in the Indian

Economic Statistics: Public Finance, compiled by the Department of Economic Affairs of the Ministry of Finance, and (c) The Performance Budgets of health ministries of the respective states.

In the CFRA data is available state-wise but the disaggregation is of little use because the categories used are administrative ones like 'establishment', 'direction', 'grants' etc. However, the state's Performance Budgets give programmewise expenditures but these documents are not easily available; and if available are too voluminous for a time-series analysis. Therefore, in this paper national aggregate figures will be used for an overall analysis, and a case study of programme based analysis will be done for Maharashtra and Gujarat states.

State Financing of Health in India

The Indian constitution in its 'Directive Principles of State Policy' has vested the state with responsibility for providing free health care services to all citizens.

TABLE 1 A: HEALTH EXPENDITURE, GDP AND GOVERNMENT EXPENDITURE IN INDIA BY PLAN PERIOD

(Rs Crores)

Plan Period		State Health Expenditure (a)				(c)	(c)	(c)	(c)
		Medical and Public Health*	Family Planning	Total Health	Per Cent Plan (b) Expenditure	Private Medical Expenditure	Total Govt. Expenditure	GDP at Current Market Prices	Population in crores (plan-period average)
	1	2	3	4	5	6	7	8	9
I	5 years	197	0.15	197.15	38.7	NA	8915	50175	38
	annual average	39.40	0.03	39.4			1783	10035	
II	5 years	420.8	2.2	423	51.3	NA	13520	66235	42
	annual average	84.16	0.44	84.6			2704	13247	
		(113.6)	(1366.67)	(114.55)			(51.65)	(32.0)	
III	5 Years	939.1	24.9	964	37.1	2227	23080	99890	46
	annual average	187.82	4.98	192.8		445.4	4616	19978	
		(123.1)	(1031.81)	(127.89)			(70.7)	(50.8)	
Plan Holiday	3 years	723	70.4	793.4	39.5	2237	21213	155390	51
	annual average	241	23.47	264.5		745.7	7071	31078	
		(28.31)	(371.28)	37.18		(67.4)	(53.18)	(55.56)	
IV	5 years	1954	284.5	2238.5	47.9	5629	53255	227395	55
	annual average	390.8	56.9	447.7		1125.8	10651	45479	
		(62.15)	(142.43)	(69.26)		(50.97)	(50.6)	(46.34)	
V	5 years	4201.1	538.2	4739.3	49.5	6578	103305	411810	62
	annual average	840.22	107.64	947.9		1315.6	20661	82362	
		(115)	(89.17)	(111.7)		(16.85)	(93.98)	(81.1)	
1979-80	annual	1320.9	121.8	1442.7	50.5	1567	31670	107444	66
VI**	5 years	11152.4	1626.2	12778.6	52.8	11479***	262150	846670	71
	annual average	2230.48	325.24	2555.7		2295.8	52430	169334	
		(165.46)	(202.15)	(169.6)		(74.5)	(153.7)	(105.6)	

(Figures in parenthesis are average percentage growth rates over the previous period)

* Includes water supply and sanitation, CGHS, ESIS, ICMR, Medical Education and Research.

** Last two years of the VIth plan are budget estimates/allocations.

*** 4 years as reported in 'National Accounts' and fifth year estimated by the author at Rs 2930 crores.

TABLE 1 B: RATIOS

Per Capita Per Annum Health Expenditure (Rupees)		Ratio FP: Medical and Public Health (Per Cent)	Ratio Pvt Medical :State Medical and: Public Health (Col. 2) (Per Cent)	Per Cent State Health (Col 4) of Total Govt. Expenditure	Per Cent State Health (Col. 4) of GDP
State (Col. 4)	Private				
10		11	12	13	14
1.04	—	0.08	—	2.2	0.39
2.01	—	0.52	—	3.13	0.64
4.20	9.68	2.65	237.14	4.18	0.96
5.20	14.62	9.74	309.40	3.74	0.85
8.14	20.47	14.56	288.07	4.20	0.98
15.29	21.22	12.81	156.58	4.59	1.15
21.86	23.74	9.22	118.63	4.55	1.34
36.0	32.33	14.58	102.92	4.87	1.51

Table 'A' Complied from: a) Comptroller and Auditor General of India: *Combined Finance and Revenue Accounts*, GOI, years 1951-52 through 1981-82 and Department of Economic Affairs: *Indian Economic Statistics*: Public Finance, Ministry of Finance, GOI, 1982.

b) CBHI: *Health Statistics in India* 1984, Ministry of Health, GOI, 1985.

c) CSO. *National Accounts Statistics*, Ministry of Planning, GOI, Years 1965 through 1986.

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Where does the state stand on this issue?

Analysis of finances of the state reveals that the health sector started with a very low priority and has gradually gained an increased share of the state's expenditure, stabilising between four and five per cent of the government's total expenditure. Similarly state expenditure on health care has shown marginal increases over the years with regard to proportion of the Gross Domestic Product. Table 1 'A' and 'B' presents data in this regard by various plan periods.

The most interesting finding that emerges from this data is that the growth rate of both health and family planning expenditures have been much greater than both the growth of government expenditure and the gross domestic product. Further, as per the estimates of 'National Accounts' we see that the gap between state health expenditure and private medical expenditure is narrowing. These facts are indicative of high investment in the state health sector, but, unfortunately, the results of health programmes do not corroborate this. Why is this so?

Firstly, the level of investment and expenditure in the state health sector, though experiencing a growth rate higher than total government expenditure, is at a fairly low level. For the year 1984-85 the allocated expenditure for the entire state health sector was Rs 3,287.8 crore, working out to a meagre Rs 43.84 per capita per annum (1.54 per cent GDP and 5 per cent of government expenditure). This includes expenditure on medical services and national disease programmes, public health and PHC, water supply and sanitation, CGHS, ESIS, MCH, family planning, medical education and research, health bureaucracy, construction of new health centres and hospitals. At today's market prices providing the above services adequately to the entire population free of cost requires much more expenditure than is earmarked presently.

Secondly, a large proportion of health expenditure in the III, V and VI Plan periods, when the growth rate of health expenditure had been the highest, went into infrastructure development i e, water supply schemes and construction of health centres. In fac more than one-half of the medical and public health expenditure since the III Plan period is spent on water supply and sanitation. The plan holiday period and IV Plan, when capital expenditure was very little, show low growth rate in health expenditure. And, in spite of this the health infrastructure remains poor. Even today the government is nowhere near the level of infrastructure and facilities recommended by the Bhore Committee in 1946.

Thirdly, between 70 and 80 per cent of the investment and expenditure in the state health sector goes to the 30 per cent population in urban areas. This mismatch (of rural-urban disparity) by the state is in spite of the fact that urban areas also have access to other public and quasi-public health care facilities such as municipal and other local body hospitals and dispensaries, municipal protected water supply and sanitation, municipal funded medical education, ESIS and CGHS for industrial and government workers and so on. For instance in 1983 in Maharashtra, of the total 478 state-owned (central and state government) hospitals and dispensaries 432 (90 per cent) were in urban areas and of all the state owned beds 97 per cent were in urban areas. And of all the beds in Maharashtra (public and private) 30 per cent were in Bombay city alone (SBHI, 1983).

Fourthly, leaving aside the preventive and promotive services, the curative services provided by the state, especially in the rural areas, are grossly inadequate. That curative services are the priority demand of the people vis-a-vis health is evident from various studies that have shown that even in rural areas the private medical practitioner provides services for between two-thirds and three-fourths of illness episodes in the population.

Following from the above, the private medical sector becomes a strong adversary to the state sector because the former is totally curative-oriented, because it is 'efficient' and non-bureaucratic, because it is 'effective' and most importantly because it is easily accessible

TABLE 2: HEALTH FACILITIES IN INDIA
(selected years)

Year	No of Hospitals	Population Per Hospital (In lakhs)	No of PHCs	Rural Population Per PHC (In lakhs)	No of Beds	Population Per Bed	Percent of Rural Beds	Percent of Hospitals Owned by the State	Percent of Beds Owned by the State	No of Dispensaries	Percent of Dispensaries Owned by the State
1951	2694	1.3	—	—	117000	3199	NA	NA	NA	6515	NA
1956	3307	1.2	725	4.4	157000	2554	25.0	NA	NA	7100	NA
1961	3094	1.4	2565	1.4	230000	1930	NA	NA	NA	9406	NA
1966	4147	1.2	4631	0.8	304000	1628	NA	NA	NA	10236	NA
1971	3976	1.4	5112	0.8	331000	1673	NA	NA	NA	10897	NA
1974	4014	1.5	5283	0.8	355461	1668	13.7	62.6 (16.0)	69.5 (16.2)	10200	NA
1982	6805	1	5739	0.9	504538	1405	17.2	50.8 (44.3)	68.1 (26.7)	16754	60.9 (14.1)
1984	7181	1	7210	0.8	536370	1378	17.43	49.3 (45.3)	68.1 (26.7)	21780	51.8 (29.6)

(Figures in brackets are percentages in private sector; the remainder is facilities owned by local bodies)
Compiled from: CBHI: Health Statistics in India/Pocket Book of Health Statistics, Ministry of Health, GOI, respective years.

when needed.

And finally, the credibility of the state's rural health services is very low. This is largely due to its obsession with family planning targets. Over 60 per cent of the PHC staff's time is spent on family planning work.

Thus, the high growth rate of health expenditure is a deceptive feature, because disaggregated it reveals the unhealthy direction of growth. In the following paragraphs the data in each column in Table I is analysed in detail.

Medical and Public Health

In the health sector the Britishers did not leave any significant legacy of an infrastructure. Therefore, a beginning from scratch had to be made after Independence. What was left by the British was an exhaustive Plan called the Bhore Committee Report, a small network of civil hospitals, a few medical colleges in premier cities and a network of military and railway hospitals. No rural health infrastructure of any significance existed at the time of Independence. The expenditure by the British state was meagre (see Appendix 1).

However, even after Independence the Indian state did not deem the health sector to be a priority. In the First Plan period the state spent an average of Rs 39.40 crore per year which was only 2.2 per cent of total government expenditure and only 0.39 per cent of the GDP; much less than what the British government had been spending. At the end of the First Plan, besides 725 PHCs there were 3307 hospitals, and 7100 dispensaries in India, the majority of hospitals belonging to the state (breakup of ownership for this period is not available).

In the Second Plan period the expenditure on medical and public health more than doubled and this pattern continued in each subsequent plan, except during the 'plan holiday' and the IV Plan when growth rate of health expenditure showed a drastic decline. Health facilities too increased but they remained heavily skewed in favour of urban areas. With the launching of the Minimum Needs Program, from the IV Plan onwards rural health infrastructure began to receive some significant attention.

Table 2 lists health care facilities in India. It is evident from this table that the health infrastructure is very poor even today, especially so in rural areas. The best indicator of health care facilities is the number of hospital beds available to the population. The earliest year for which this break-up is available is 1956 when 25 per cent of all hospital beds (government, local body and private) were located in rural areas that had 80 per cent of the country's population. This declined to 13.7 per cent in 1974, clearly indicating that the rural areas had been neglected grossly where investment in the health sector was concerned. Even where PHCs are concerned it is clear that the number of PHCs added over the years has not been adequate for the rural population as between 1966 and 1984 the PHC: Population ratio has remained constant at one PHC

TABLE 3: MEDICAL EXPENDITURE BY SELECTED CORPORATE AGENCIES

Organisation	Per Employee Family Annual Expenditure (Rs)	Reference Year,
TELCO (b)	1106	1982-83
National Rayon (b)	860	1982-83
Ashok Leyland (b)	717	1982-83
BHEL (a)	830.47	1980-81
Railways (a)	310.45	1980-81
SAIL (a)	677.93	1980-81
Air India (a)	725.00	1980-81
CGHS (c)	271.90	1980-81
ESIC (c)	80.99	1979-80
Bombay Municipal Corporation (d)	70.08	1983-84

Source: a Lok Sabha Estimates Committe, 22nd report, Ministry of Health, GOI, 1982.
b ORG, *Health Financing in India*, ORG, Baroda, 1985.
c CBHI, *Health Statistics in India*, Ministry of Health, GOI, 1983.
d BMC, *Performance Budget Estimates* 1985-86, BMC, Bombay, 1985.

TABLE 4: PLAN OUTLAYS IN THE HEALTH SECTOR—INDIA

(Rs crores)

Health Programme	Plan Period (Plan Holiday Period Excluded)						
	I	II	III	IV	V	VI	VII
1. Control of communicable diseases.	23.10	64.0	70.5	127.01	168.61	524.0	1012.67
2. Primary Health Centres, Hospitals & Dispensaries	25.0	36.0	61.7	164.78	155.62	*720.1	*1283.87
3. Education, Training and Research	21.6	36.0	56.3	98.22	111.76		
4. Minimum Needs Programme (Health)	—	—	—	—	29.47	576.96	1096.35
5. Indigenous Systems of Medicine	0.70	4.0	9.8	15.83	27.72	*	*
6. Family Planning.	0.40	3.0	27.0	315.00	516.0	1010.0	3296.26
7. Water Supply & Sanitation	49.0	76.0	105.3	407.00	1022.0	3922.02	6522.47
8. Other Schemes	20.2	6.0	11.2	27.69	40.81	*	*

* Included in Health Programme 2 and 3.

Sources: 1. CBHI: Pocket Book of Health Statistics of India, Ministry of Health, GOI, 1976.
2. Planning Commission, Sixth Five Year Plan 1980-85, GOI, 1980.
3. Planning Commission, Seventh Five Year Plan 1985-90, GOI, 1985.

for 80,000 population. This stability (sic) is also true of the hospital/population ratio.

However, the point that emerges most significantly from Table 2 is the fact that since mid-seventies there has been a sharp rise in the proportion of health facilities in the private sector as compared to the state sector. Thus, in 1974 the private sector accounted for only 16 per cent of hospitals in the country but within a decade the private sector's share of hospitals rose 2.83 times to 45.3 per cent, and that of the state sector declined from 62.6 per cent in 1974 to 49.3 per cent in 1984. The change in the proportion of hospital beds in either sector was not as sharp.

Therefore, it becomes very clear that both the "high" growth rate of the state health sector and the narrowing gap between state and private health sector expenditures is only an illusion created by aggregated data.

Family Planning

Expenditure on family planning (now including MCH, CHG scheme and the EPI program) is almost entirely financed by the central government through 'plan' funds. Allocations to FP have increased at a phenomenal rate in each plan period. Between the First and the Sixth Plan periods the *allocation* increased from Rs 0.65 crore to Rs 1010 crore i.e. 1554 times, and more astoundingly FP *expenditure* increased from Rs 0.15 crore to Rs 1626 crore or 10840 times, whereas total plan expenditures in the same period increased only 50-fold and health expenditure (plan and non-plan) only 57 times. Computing this growth rate may sound unfair because FP started with a very insignificant allocation in the First Plan period but the fact remains that the growth of family planning expenditure has been at the cost of expenditure on health care services. In the VII plan for the first time plan allocations (revised) to FP are higher than that for health.

Further, in each plan period we see a decline in growth rate of family planning expenditure and the growth has been the lowest, ironically, in the Emergency period (Vth Plan). Therefore, this computation too is unfair. This is the illusion that aggregate statistics project!.

Notwithstanding this, the growth of family planning expenditure remains higher than that of health expenditure. And further, it may be noted that at the implementation level a large proportion of resources and personnel-time allocated to health is used for family planning work because the latter ranks as priority number one in state policy making. (For details on Family Planning financing see Duggal, 1986).

Private Medical Expenditure

It has already been pointed out earlier that over two-

TABLE 5: DISAGGREGATED STATE HEALTH EXPENDITURE FOR MAHARASHTRA AND GUJARAT—VI PLAN PERIOD
(Rs million)

Programme	Maharashtra			Gujarat		
	1980-85	Annual Average	Per cent Plan	1980-85	Annual Average	Per Cent Plan
1. Direction and Administration	870 (5.48)	174.0	9.1	70.14 (1.1)	14.03	16
2. Medical Relief	1772.8 (11.16)	354.56	7.5	1216.30 (19.17)	243.26	7
3. Training	9.1 (0.06)	1.82	0	34.38 (0.54)	6.87	34
4. Medical Education	661.1 (4.16)	132.22	32.2	262.42 (4.13)	52.48	12
5. Control of Common Diseases	1302.9 (8.2)	260.58	61.8	746.03 (11.76)	149.2	35
6. MNP	602.8 (3.8)	120.56	93.1	457.93 (7.22)	91.58	13
7. ISM	241.6 (1.52)	48.32	3.5	170.32 (2.68)	34.06	9
8. ESIS	1203.2 (7.58)	240.64	2.8	558.59 (8.81)	111.72	0.67
9. Other Expenditure/Services/ Loans	248.1 (1.56)	49.62	6.1	138.74 (2.18)	27.75	24
10. Nutrition Programme	NA	NA	NA	324.86 (5.12)	64.97	20
11. School Health	NA	NA	NA	2.05 (0.03)	0.41	87
12. Family Planning	1435.4 (9.04)	287.08	99.5	927.81 (14.62)	185.56	NA
13. Water Supply & Sewerage	7536* (47.45)	1507.2	50*	1434.3 (22.6)	286.86	67.3
Total	15883 (100)	3176.6		6343.87 (100)	1268.77	

(Figures in brackets are percentages to total)
Source: ORG, Health Financing in India, ORG, Baroda, 1985.
* Plan expenditure was Rs 3768 million. Since the non-plan figure was not available the author has estimated it to be half each.

thirds of health care services utilisation is in the private sector and the remaining is divided between the state sector and other public and quasi-public institutions.

In Table 1 we see that the growth of private medical expenditure has been much slower than the state health sector. As a result the gap between the two has narrowed down to almost unity during the VI plan period. This is contradictory to two facts indicated in earlier sections. Firstly, that between two-thirds and three-fourths of health care utilisation is in the private sector. And second, that the growth rate of the private health sector after mid-seventies has been very high (see Table 2).

Therefore, this data on private medical expenditure computed by the CSO in 'National Accounts Statistics' is highly questionable. Studies carried out by the Foundation for Research in Community Health indicates much higher estimates of private medical expenditure. For the year 1983-84 it has been estimated that the total health expenditure in India was Rs 16,386.41 crore or 8.33 per cent of the GDP. Out of this only 11.7 per cent was spent by the state, 60.4 per cent was spent by private households, 22.7 per cent by the corporate sector (private and public) for its employees and 5.2 per cent by local bodies. Also, with regard to private household health expenditure a gross rural-urban disparity is seen—in rural areas an astonishing 94 per cent of health expenditure was borne privately by households whereas in urban areas this burden was only 35 per cent of their health expenditure (*FRCH*, 1981). This is mainly because urban areas have access to better state and other public (such as municipal) health care facilities as also to employer or insurance sponsored health care programmes. Expenditure of selected agencies is presented in Table 3. *Ratios*: A few selected ratios have been computed from Table I and are presented in Table I 'B'. The data in this Table speaks for itself and it has also been referred to in earlier sections. Therefore, we leave it at that.

State Health Expenditure on Health Programmes

As mentioned earlier disaggregated data for state health expenditure for the nation is not available on a programme-wise basis, except for plan expenditure. Therefore, we will look at the state (provincial) level to get a detailed breakdown.

Where plan expenditure is concerned consolidated data is available for eight categories. Table 4 presents this data. It is clear from this table that water supply and sanitation leads as expenditure number one grossing between 30 per cent and 50 per cent of the health sector Plan—it has grown in each plan period taking a larger proportion each time.

Family planning on the other hand started by being the lowest funded programme in the first plan (0.3 per cent) to gaining second position (27.56 per cent) after water supply, by the V Five Year Plan. As a consequence all the other programmes have suffered and have had a smaller share in each subsequent health plan since family planning took over the second position in the IV Plan. Thus the priority of the state in the health sector is fairly clear—strongly in favour of FP at the cost of other crucial health programmes.

Unfortunately such a breakup is not available for state health expenditure outside the plan. But at the state-level detailed disaggregation is available. Table 5 gives a breakup of various health programmes for Maharashtra and Gujarat during the VI Plan period. Water supply and sewerage is the largest single category of expenditure in each sate—as a percentage it is as high as 47.45 per cent in Maharashtra and only 22. 6 per cent in Gujarat.

If one leaves aside water supply, then medical relief accounts for the largest category of expenditure in both Maharashtra and Gujarat. This is followed by family planning, control of communicable diseases and ESIS. The other programmes follow a different sequence of priority in each state. The per capita per annum state health expenditure (inclusive of water supply) for Maharashtra and Gujarat works out to Rs 48 and Rs 35 respectively.

Thus the priority and pattern of expenditure for various health programmes is not very different from that we have seen for 'plan expenditure' for the country. Of course, it must be noted that Maharashtra and to some extent Gujarat are the better performing states vis-a-vis the health sector.

Role of State Health Sector

In the foregoing analysis we have seen that within the health sector two programmes stand out prominently—water supply and sanitation and family planning. Ironically both these programmes are not perceived by the people as health programmes. For the general population health care is synonymous with curative services and this does not have a very high priority with the state.

Why do water supply and sanitation and family planning feature as high priority programmes? Water supply itself has high priority with people, may be even greater than medical services, but this is not the reason why it is so heavily funded.

The role played by imperialist agencies is very crucial in understanding this. If one lays threadbare the development programme expenditures of the state it is clear that those programmes which receive financial support through various imperialist agencies, such as bilateral (USAID, ODA, DANIDA, etc), multilateral (World Bank, WHO, etc) or private (Ford, Rockefeller, Population Council, etc), get into the state's priority list. The Indian state, being part of the world capitalist system (though backward), is greatly influenced by it in its policy and programme making. Thus water supply and family planning and a few selected communicable diseases (malaria, earlier small pox, now measles and even AIDS) get top billing in the state's resource allocation. If one goes through the CFRA or RBI Finance Reports of any year and looks up the section on international debt the correlation between plan

priorities and public finances and foreign debt becomes clear. Power projects, transport and communication, industrial infrastructure, mining projects, irrigation projects, water supply schemes and population control projects are the major areas of international debt financing. These areas also happen to be the ones that take the cream of our plan public finances. These are the very areas in which India lacks technological skills and has to rely on multinational corporations. This is too good to be a mere coincidence. If one were to list all the significant water supply schemes and the population control projects in India there would not be a single project that did not receive foreign finances (see RBI, 1984).

This nexus does not exist only at the international level but also within the country between the state and private capital. In a capitalist state the government (the functional form of state) is a functionary of capitalism—its role is to protect and strengthen it. Thus the state's behaviour, even with regard to the health sector programmes, is a function of private capital. The state's financing patterns of various health sector programmes are primarily the fulfilment of the needs of private capital. At the time of Independence the Indian state lacked any significant health structure. The Indian bourgeoisie was not prepared to enter this 'social sector' and therefore it allowed the state to develop this sector. And today when a bare minimum of health infrastructure has been developed and is functional the bourgeoisie, following the footsteps of its western allies, has stepped in a large way in the health sector. In fact, in the next three or four years large financial investments by the corporate sector in health care have been planned.

Further the curative health care sector, which has priority with the people and which forms the *raison d'etre* of the entire pharmaceutical and medical equipment industry (overwhelmingly controlled by the private sector, especially MNCs), has received a very lukewarm attention from the state. This is because the entire private practice of medicine thrives on curative services. It is the life-line of the private health sector. Private practice of medicine, which looks after three-fourths of the population falling ill, has never been controlled by the state. It has been given a completely free hand to operate and amass surplus.

Most of the doctors who get into private practice are trained at public institutions run entirely through public finances. Thus the state is directly responsible for creating an exploitative private health sector. The state is also a very large buyer of drugs from the private drug companies. The state provides tax concessions for running private hospitals under the grab of 'public trusts' that are referred to as 'voluntary hospitals'. (According to the Directory of Hospitals in India Maharashtra state does not have a single private hospital. Jaslok, Breach Candy, etc are listed as 'voluntary' hospitals!).

Thus we may conclude that the state's health expenditure which has been gradually increasing over the years, grows in an unhealthy direction, is urban-biased, anti-poor and above all is invested for the health of private capital.

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Appendix-I
Health Expenditure During British Rule 1870-1939
(Rs million - annual average)

Category of Health Expenditure	Decade						
	1870-79	1880-89	1890-99	1900-09	1910-19	1920-29	1930-39
Central & Provincial Govt. Medical and Sanitary	6.2 (0.03)*	7.3 (0.04)*	11.6 (0.05)*	14.1 (0.06)*	23.0 (0.10)*	52.1 (0.22)*	57.0 (0.21)*
Military Medical	4.2	5.5	7.1	8.2	6.3	NA	NA
Municipal Water Supply Conservancy, Drainage, Hospital, etc	8.1 (0.04)	10.5 (0.05)	17.3 (0.08)	26.9 (0.12)	40.3 (0.18)	75.5 (0.32)	67.7 (0.25)
District and Local Boards Sanitation & Hospitals	— —	— —	2.8 (0.01)	4.3 (0.02)	6.7 (0.03)	15.8 (0.06)	20.6 (0.08)
Total Health Expenditure	18.5 (0.07)	23.3 (0.09)	38.8 (0.14)	53.5 (0.20)	76.3 (0.31)	143.4 (0.60)	145.3 (0.54)
Total Govt. Municipal, District, etc. Expenditure	589.7	798.8	1026.7	1265.2	1679.6	2677.9	2651.4
Per Cent Health Expenditure of Total Expenditure	3.14	2.92	3.78	4.23	4.54	5.35	5.47

(Figures in brackets are Rs per capita per annum expenditure on health at current prices).
* includes military medical expenditure.
Source: Statistical Abstract of British India, relevant years: quoted in "The Politics of Health in India" by Roger Jeffery, California University Press, Berkeley, 1987 (forthcoming).