

the patent laws for drugs), one can foresee a gloomy picture for women's health unless we plan effective strategies to resist anti-people moves of the government, the private sector and imperialist nations. We have also to view with some concern the sudden interest of funding agencies in the reproductive and sexual health of our women. Our plan for the next decade has to take into account the feminist interpretation of sexual rights and reproductive health.

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Health Expenditure Patterns in Selected Major States

Ravi Duggal

State sector investment in public health is miniscule compared to the demand for health care in the country. Inter-state comparisons show a direct correlation between levels of public health investment and the health status of the population, and rural-urban variations indicate the gross neglect of the countryside with regard to public health services and facilities.

ACQUIRING complete knowledge about health expenditure patterns in India is at present a near impossible task. This is largely due to the fact that about three-fourths of such expenditure is being incurred privately. While state sector expenditures are documented in budget papers, one can only make estimates for the private sector.

Here we attempt an analytic review of the public health expenditures for selected major states of the country from the available latest budget documents (1992-93). The states included have not been selected on the basis of any specific criteria but purely because of availability of budget-papers at a given point of time. A more detailed analytic paper is planned which would include all states with time series data. However, the states included presently may be considered representative as both geographical spread and various socio-economic levels of development are covered. Private sector expenditure are excluded from the scope of this paper.

Our analysis clearly establishes the low level of investment in the public health sector. The investment is miniscule compared to the demand for health care in the country. While inter-state differentials bring out sharply a direct correlation between the level of public health investment and the health status of the population, rural-urban variations indicate the gross deprivation of rural populations with regard to public health care. The paper further highlights that an unusually large proportion of the available funds goes to support salaries, especially, so in the rural health services and the disease control programmes.

The main source for the data included in this paper is the 1992-93 budget documents of the various states, the detailed demand for grants. This document includes a three year record of expenditure - 1990-91, 1991-92 (revised estimate) and 1992-93 (budget estimate). From these budget papers most of the relevant (and more or less comparative) heads and subheads of expenditure have been included in the analysis as explained in the next few paragraphs.

In spite of a national system of classifying heads and subheads of accounts there is still an incomplete standardisation in presenting budgetary informa-

tion. Though the major and minor heads are the same across states the placement of the latter under the former is not standard. For instance the subhead PHC is under rural health services of the 'medical' head in some states, and under the head 'public health' in other states. Similarly, sub-centres are under family welfare in some states and under public health in others. ESIS in many states is under urban health services under the medical head, in others under medical education and in still others outside the ministry of health under labour welfare. A few states include water supply under the ministry of health whereas most show it under rural and urban development.

This variation, to some extent, creates problems in comparison across states as well as in presenting analysis of data by major heads. Another problem is caused by the separation in plan and non plan spending. This spreads the expenditure figures across the 200-300 pages of the ministry of health budget. Again, there are as many ways of presentation of plan/non plan figures as there are states. This compounds the problem of compilation for the purposes of analysis. As a consequence one is not sure that the figures one compiles are complete, especially with regard to plan expenditures which in some states are shown under many categories like state plans, Seventh Plan commitments, Eighth Plan commitments, centrally sponsored schemes, central schemes, etc, and often in separate volumes. The result is that to compile the total expenditure, for instance, on National Leprosy Eradication Programme the hunt is an extremely time consuming task.

Further, a few states even show expenditures for health sector incurred outside the ministry of health, like construction of buildings for health facilities spent under department of public works or upgradation of PHCs in tribal areas under the tribal development plan etc. Most states do not show such expenditures under the ministry of health. What does one do?

TABLE 1: INPUT AND OUTPUT INDICATORS AND RANKS OF SELECTED STATES

	Input		Output			Input Rank	Output Rank
	1992-93 Health Exp Rs Per Capita	1990 Beds 100,000 Popln	1989 Doctors Per 100,000 Popln	1988 IMR Live Births	1988 Child Mortality Per 1000 0-1 Yrs		
Punjab	86(1)	116(4)	76(2)	62(2)	21(2)	1	2
Kerala	78(2)	263(1)	55(4)	28(1)	8(1)	1	1
Tamil Nadu	67(3)	88(5)	75(3)	74(5)	21(2)	4	3
West Bengal	58(4)	83(6)	47(7)	69(4)	22(4)	6	5
Maharashtra	57(5)	147(2)	86(1)	68(3)	22(1)	3	3
Gujarat	55(6)	129(3)	50(6)	90(7)	31(7)	5	7
Andhra Pradesh	49(7)	62(7)	52(5)	83(6)	27(6)	7	6
Madhya Pradesh	35(8)	36(8)	15(8)	121(8)	51(8)	8	8

(Figures in parentheses are ranks).

Source: Compiled from *Health Information of India 1991*, MoHFW, GOI.

If all major heads of health (a/c nos 2210, 2211, 2251, 3606, 4210, 4211, 6210, 6211) are to be considered as the basis for health expenditures, rather than what the ministries of health spend, then one will have to scan the budgets of most ministries and departments to get a complete coverage of the health account heads. We confine this discussion to the ministry of health spending and within that exclude family welfare. The effort here will be to analyse the expenditure on selected major health programmes/interventions for which data can be standardised across the states to reveal patterns and permit comparison.

In the analysis of health expenditure below we are looking only at revenue expenditures, both plan and non-plan, under the major head medical and public health (a/c 2210 of the ministry of health) of the consolidated fund. Thus family welfare and water supply and sanitation are excluded, as are all capital expenditures.

HEALTH EXPENDITURES AND HEALTH STATUS

The overall health status of a population is closely linked with overall socio-economic development. This does not need to be proved because it is well recognised globally. That investment in health care can independently improve health status has also received wide recognition. China, Sri Lanka, Costa Rica, Mongolia, Nicaragua and Kerala are well known examples where health status has improved substantially with economic development remaining at very low levels [World Bank 1993]. This statement in no way intends to discount the importance of overall economic development, especially income growth and distribution. Health services data from these eight states also lend support to the hypothesis of the importance of increased investment in the health sector. It clearly establishes the link between health care investment and health status. Table 1 shows the close correlation between input variables (health expenditures, availability of hospital beds and doctors) and output variables (IMR and child mortality) - higher the input rank of a state better the output.

The relationship is especially stronger between public health care spending and output rank. Thus, among the eight states Punjab, Kerala and Tamil Nadu have the highest health expenditures as well as the best health status measured in terms of infant mortality and child mortality rates. These states also have the most developed health infrastructure along with other states like Karnataka and Maharashtra. In 1992-93 the overall public health expenditure in the country (excluding family welfare and water supply and sanitation and capital expenditures) is estimated at Rs 5000 crore or Rs 58 per capita (Table 2). If we add family welfare, water supply and sanitation and capital expenditures, as is traditionally done, then public health expenditure at Rs 8500 crore works out to Rs 99 per capita in the same year [Ministry of Finance 1992].

Among the states, as mentioned earlier Punjab and Kerala have the highest expenditures averaging Rs 86 and Rs 78 per capita, respectively in 1992-93. They also have one of the best developed health infrastructures in the country (Maharashtra has the highest per capita availability of doctors but nearly half of the doctors in Maharashtra practice in Bombay city alone) (Maharashtra Medical Council list 1992). The lowest health care spending among these eight states is in Madhya Pradesh with an expenditure of only Rs 35 per capita. Andhra Pradesh (Rs 49 per capita), Gujarat (Rs 55 per capita) and surprisingly Maharashtra (Rs 57 per capita) fall below the all-India average of public health expenditure as defined here.

The central government expenditure shown in Table 2 is mostly (86 per cent) on central government hospitals, medical colleges and hospitals and

TABLE 2: HEALTH EXPENDITURE IN SELECTED STATES 1990-1993

		Health Expenditure* (Rs Lakh)	Health Expenditure* (Rs per capita)
Punjab	1990-91	14,671	74.10
	91-92	17,593	87.09
	92-93	17,663	85.74
Kerala	1990-91	17,698	61.88
	91-92	19,288	66.28
	92-93	22,909	77.92
Tamil Nadu	1990-91	31,318	57.15
	91-92	34,531	62.00
	92-93	37,720	66.76
West Bengal	1990-91	37,700	56.86
	91-92	36,891	54.25
	92-93	40,477	58.16
Maharashtra	1990-91	40,396	52.67
	91-92	44,105	55.97
	92-93	46,209	57.19
Gujarat	1990-91	19,543	48.49
	91-92	21,690	52.65
	92-93	23,205	55.26
Andhra Pradesh	1990-91	26,531	40.94
	91-92	28,780	43.34
	92-93	33,360	49.13
Madhya Pradesh	1990-91	19,451	30.20
	91-92	21,757	32.87
	92-93	23,630	34.80
Central Government	1991-92	38,174	4.52
	92-93	51,166	5.94
	93-94	52,996	6.02
(Excluding grants)			
All India	1992-93 ^b	5,00,000 ^a	58.14

* Only Revenue expenditure of A/C 2210 of Ministry of Health.

^b Estimated by author based on figures published by Department of Economic Affairs and the Reserve Bank of India.

Source: Detailed Demand for Grants, 1992-93, respective states.

medical research. The central government does spend substantial sums on various health programmes, mainly national disease programmes, but that is mostly as grants to the states and accounted for in the state expenditures – of the total central health department budget in 1993-94 grants to states and union territories worked out to 32.5 per cent of the centre's health department budget (excluding family welfare and water supply).

The first fact evident from the data discussed above is that the public health sector is a very small component not only of the overall economy (less than 1 per cent of GDP) but also of the public sector as a whole (which accounts for over one-third of India's GDP). As a consequence of the insufficient investment in the public health sector the private health sector has seized the advantage and has grown very rapidly, especially in the last two decades and that too with support and subsidies from the public sector [Jesani and Ananthram 1993]. For a poor country like India where nearly two-thirds of the population lives at or below the subsistence level such a development may not be the best thing for the health status of the people – in fact evidence is indicative of slowing down of decline in mortality rates in the last decade or so [Ministry of Home Affairs 1992]. Another fact emerging from the data presented above is the considerable variation across states in health care spending—between the lowest (MP) and the highest (Punjab) spender the difference is nearly 2 1/2 times. As mentioned earlier the level of spending gets reflected in the level of development of the health infrastructure — generally, higher the health expenditure better is the reach and spread of the health infrastructure.

We are well aware that rural-urban differences in the distribution of health care services are extremely sharp. Table 3 shows clearly the wide variation of availability of hospital beds and doctors in rural and urban areas of the country. There is also a wide variation in the availability of health services in the rural and urban areas as of the eight states under discussion (Table 4). Kerala and Punjab have extremely low disparities in infrastructure availability between rural and urban areas whereas Madhya Pradesh has the highest disparity (of course, among all states Bihar is the worst off with urban/rural disparity being 81 times for hospital beds). In

TABLE 3: RURAL-URBAN DISPARITIES IN HEALTH CARE SERVICES, 1992

	Hospital Beds Per 100,000 Population	Allôpathic Doctors Per 100,000 Population	All Doctors Per 100,000 Population
Rural	17	12	37
Urban	254	151	307
Total	76	47	105
Urban/Rural Disparity (times)	15	13	8

Source: Estimates based on information published in *Health Information of India* and the Economic Tables of Census of India.

Bengal, Maharashtra and Gujarat the national average holds good for hospital beds, whereas for doctors only Madhya Pradesh among these states is worse than the national average in rural-urban disparity.

Disaggregating public health expenditures in rural and urban areas is a difficult task because separate accounting of expenditures for rural and urban areas is done only selectively in the budgets. It is only for medical care services (under the medical major head of a/c 2210) that a more or less clear demarcation between urban hospital and dispensary expenditures on one hand and rural hospital, dispensary and PHC expenditures on the other hand is available. Hence rural-urban differential analysis is restricted to only this component of health expenditure. But it may be noted that these expenditure account for between 74 per cent (Andhra Pradesh) and 90 per cent (Kerala) of all health expenditures as defined for the present analysis. Rural and urban health expenditures vary considerably across states both in terms of volume as well as disparities within the state (Table 5).

The highest expenditures on urban medical care (including medical education and ESIS) in 1992-93 are in Kerala (Rs 195 per capita), Punjab (Rs 149 per capita), West Bengal and Tamil Nadu (Rs 142 per capita each) and the lowest (surprisingly) in Maharashtra (Rs 75 per capita) and Madhya Pradesh (Rs 79 per capita). Table 5 also reveals that the growth in urban health expenditures between 1990 and 1993 has been negligible, both in per capita and percentage terms. Where rural health expenditures are concerned (rural hospitals, dispensaries and PHCs) Punjab outscores all the states with a rural health expenditure of Rs 44 per capita, followed by Maharashtra (Rs 27 per capita) and Kerala (Rs 23 per capita) in 1992-93. In the same year the lowest rural health expenditures were in Andhra Pradesh (Rs 10 per capita), Madhya Pradesh (Rs 13 per capita) and West Bengal (Rs 14 per capita). These level of expenditures clearly support the earlier discussion relating to health infrastructural disparities; the states

TABLE 4: RURAL-URBAN DISPARITIES ACROSS STATES

	Hospital Beds Per 100,000 Population (1988)			Doctors Per 100,000 Population (1990)		
	Rural	Urban	Urban/Rural Disparity (Times)	Rural	Urban	Urban/Rural Disparity (Times)
	Andhra Pradesh	9	203	23	13	144
Gujarat	22	346	16	20	115	6
Kerala	198	481	2	39	117	3
Madhya Pradesh	4	145	36	3	55	18
Maharashtra	21	308	15	24	117	5
Punjab	68	233	3	76	260	3
Tamil Nadu	12	237	20	18	202	11
West Bengal	17	264	15	27	155	6

Source: Same as Table 3.

having higher rural health expenditures are the same ones which have a higher level of health infrastructure development in rural areas.

With regard to the share of rural and urban health expenditures in total health expenditures Kerala (68 per cent) and West Bengal (67 per cent) have the highest urban health expenditures whereas Punjab (36 per cent), Maharashtra (28 per cent) and Madhya Pradesh (27.6 per cent) have the highest rural health expenditures.

We have seen earlier the rural-urban disparities in health care provision (Table 4). The states having high disparities in provision (Tamil Nadu, Andhra Pradesh and Madhya Pradesh) also show relatively high disparities between urban and rural health expenditures. However, states like Kerala and Bengal, though having a relatively better distribution of provision, also have high disparity between rural and urban health spending, the former with relatively high per capita rural spending and the latter with low rural spending. Punjab and Maharashtra have the lowest disparity in urban-rural health care expenditures (Table 5) and both states (along with Kerala) have relatively well developed rural health services. Another aspect of urban-rural disparity in health care provision is related to the role played by local governments. The rural-urban disparities discussed above exclude provisions by local bodies like municipal corporations, municipalities, district panchayats, etc.

The participation of the local bodies in provision of health care services has not helped in reducing rural-urban inequalities. On the contrary the gap has widened because the urban local governments make significant investments in the health sector — as much as one-fourth to one-third of their budget — whereas for rural local bodies health care is not an important function because of the extremely limited resources at their disposal [NIUA 1989; Duggal 1992].

MAJOR HEALTH PROGRAMMES

Since there is a wide variation in presentation of expenditure data in the budgets across states only a few major sub-heads are amenable to standardisation and facilitate a comparison. Table 6 gives percentage share for six sub-heads of public health spending. It comes out very sharply from the data presented in Table 6 that little variability across states exist in distribution of resources for various programmes. Urban hospitals and medical education take a more or less similar share of the health care budget in all states. However for PHCs and disease control programmes there are some exceptions. For instance, both Punjab and Kerala spend a very small proportion on disease control programmes in comparison to other states. This may partly be due to the fact that both these states have brought under control most of the diseases under the national programmes and therefore presently manage with lower allocations for disease control programmes.

In case of expenditures on PHCs Punjab spends one-fourth of its health budget under this subhead. As discussed earlier this is because Punjab has the most developed rural health infrastructure. Kerala's share for PHC expenditures is low perhaps, because it spends a larger proportion on rural hospitals — Kerala has an exceptionally high rural hospital bed : population ratio (see Table 4).

The only other unusual fact revealed by Table 6 is the very high administrative cost in Maharashtra which takes away a whopping one-fifth of the health budget. One plausible explanation is that Maharashtra has an elaborate and large health bureaucracy. Another explanation perhaps may lie in accounting jugglery with Maharashtra including a large part of the

TABLE 5: RURAL-URBAN DIFFERENTIALS IN HEALTH CARE SPENDING

	Urban Health Services ^a		Rural Health Services		Urban/Rural Disparity (Times)
	Rs Per Capita	Per Cent of Total Health	Rs Per Capita	Per Cent of Total Health	
Punjab					
1990-91	124	50	38	36	3
91-92	147	50	47	38	3
92-93	149	52	44	36	3
Kerala					
1990-91	171	70	16	20	11
91-92	169	68	20	22	8
92-93	195	68	23	22	8
Tamil Nadu					
1990-91	109	65	14	17	7
91-92	120	66	15	16	8
92-93	128	66	15	15	8
West Bengal					
1990-91	142	68	13	17	11
91-92	133	67	13	18	10
92-93	142	67	14	17	10
Maharashtra					
1990-91	76	55	19	22	4
91-92	77	53	23	25	3
92-93	75	52	26	28	3
Gujarat					
1990-91	84	59	15	21	6
91-92	91	60	16	19	6
92-93	96	60	16	19	6
Andhra Pradesh					
1990-91	92	59	9	16	10
91-92	96	60	9	16	11
92-93	106	59	10	15	11
Madhya Pradesh					
1990-91	68	51	12	31	6
91-92	75	53	12	27	6
92-93	79	53	13	28	6

^a includes medical education and ESIS.

Source: Detailed Demand for Grants, 1992-93, respective states.

programme staff under the head direction and administration in contrast to other states which may show them under the respective programmes. This is only a hunch and can be sorted out with a more closer look at the detailed notes to the state accounts.

Special attention for selected diseases has been a constant feature of India's public health intervention strategy. A special characteristic of these programmes has been the significant role which the union health ministry has played in providing additional resources (sometimes com-

TABLE 6: PERCENTAGE SHARE IN EXPENDITURE OF SELECTED SUBHEADS

	Urban Hospitals (Allopathic)	Med Education (Allopathic)	Disease Control Programmes	PHCs	Direction and Administration	Others*
Kerala						
1990-91	40.44	10.00	4.97	6.61	1.83	36.13
91-92	36.01	9.67	5.45	8.41	1.64	38.82
92-93	38.25	10.25	6.11	8.63	1.74	35.02
Gujarat						
1990-91	32.16	9.99	13.81	12.47	1.92	30.01
91-92	32.16	8.85	15.01	9.94	1.95	32.09
92-93	33.36	9.03	15.36	9.54	1.77	30.94
Andhra Pradesh						
1990-91	40.39	8.51	20.19	14.91	2.49	13.51
91-92	39.84	8.79	20.46	14.32	2.40	14.19
92-93	37.71	8.96	21.61	13.83	3.84	14.05
West Bengal						
1990-91	39.42	8.29	11.40	12.77	6.73	21.39
91-92	38.34	7.56	10.73	12.29	7.17	23.91
92-93	37.94	7.36	11.16	12.01	7.14	24.39
Punjab						
1990-91	16.25	NA	9.26	25.25	2.23	47.01
91-92 ^a	16.16	NA	11.37	26.29	2.04	44.14
92-93	16.23	NA	11.38	23.52	2.18	46.69
Tamil Nadu						
1990-91	43.82	9.37	14.55	11.35	3.19	17.72
91-92	43.50	10.09	14.04	11.00	2.94	18.43
92-93	40.70	9.57	13.10	10.58	3.22	22.83
Maharashtra						
1990-91	30.44	8.42	15.41	NA	19.57	26.16
91-92	29.10	8.35	13.98	11.45	20.59	16.53
92-93	28.82	7.38	14.48	11.25	20.80	17.27
Madhya Pradesh						
1990-91	34.79	6.21	15.01	20.38	1.62	21.99
91-92	34.76	6.79	14.09	17.31	1.55	25.50
92-93	35.02	6.77	13.06	17.89	1.49	25.77

^a Urban hospital exclude teaching hospital for which data was difficult to compile; others in the case of Punjab includes Medical education and teaching Hospitals and disease Control refers to Public Health major head.

* Others includes ESIS, rural Hospitals, CHCs and dispensaries, non allopathic systems, grants to local bodies and NGOs etc.

Source: Same as Table 5.

plete) to the states in the war against these diseases, mainly smallpox (in the past), malaria, leprosy, tuberculosis and now AIDS. Further, in recent years substantial international assistance has been mobilised for increasing resource allocation to these disease control programmes.

In Table 6 we have seen that states like Andhra Pradesh (22 per cent), Gujarat (15 per cent), Maharashtra (14 per cent), Tamil Nadu and Madhya Pradesh (13 per cent each) spend a higher share of their budget on disease control programmes. In terms of per capita expenditures Andhra Pradesh (Rs 11 per capita), Punjab and Tamil Nadu (Rs 9 per capita) have higher expenditures and Madhya Pradesh and Kerala the lowest (Rs 5 per capita).

In all the states the National Malaria Eradication Programme takes away the largest share of expenditure on disease control programmes averaging 55 per cent of such expenditures. This however does not mean

TABLE 7: SHARE OF SELECTED DISEASE CONTROL PROGRAMMES

	Disease Control Rs Per Capita	Percentage Share in Disease Control		
		Malaria	Leprosy	Tuberculosis
Kerala				
1990-91	3.08	36.3	25.1	6.3
91-92	3.61	32.1	31.4	6.3
92-93	4.76	30.0	29.3	6.1
Gujarat				
1990-91	6.70	42.2	16.4	22.8
91-92	7.90	38.6	14.1	21.9
92-93	8.49	47.7	14.3	21.4
Andhra Pradesh				
1990-91	8.27	62.8	28.7	2.5
91-92	8.87	59.9	28.6	3.2
92-93	10.62	56.6	26.6	3.1
West Bengal				
1990-91	6.48	56.6	20.2	8.6
91-92	5.82	47.3	20.7	13.0
92-93	6.49	45.0	19.5	12.5
Punjab				
1990-91	6.86	NA	NA	NA
91-92	9.90	NA	NA	NA
92-93	9.76	NA	NA	NA
Tamil Nadu				
1990-91	8.31	NA	32.3	9.5
91-92	8.70	NA	33.1	10.8
92-93	8.75	NA	32.3	10.9
Maharashtra				
1990-91	8.12	59.8	20.9	10.0
91-92	7.83	59.1	23.0	7.5
92-93	8.28	59.0	24.0	6.9
Madhya Pradesh				
1990-91	4.53	56.4	20.2	1.1
91-92	4.63	54.7	20.5	1.3
92-93	4.73	54.9	20.2	1.3

that the malaria programme gets all the funds. This is again an accounting problem. The malaria workers of the erstwhile vertical malaria program constituted the largest paramedic workforce. After integration of health programmes in the mid-1990s these workers (and other staff) who are now multipurpose workers carrying out tasks related to the various disease and other programmes continue to get their salaries from the 'malaria' account head. This is the reason why allocation to malaria appears this huge in comparison to other disease programmes. Across states there is some variation with Kerala (30 per cent) recording the lowest proportion of expenditure for malaria and Maharashtra (59 per cent) the highest.

The National Leprosy Control Programme gets the next largest allocation with 25 per cent of the share on average. Tamil Nadu (32 per cent) and Gujarat (14 per cent) have the highest and lowest share of expenditure, respectively, for leprosy. Like malaria, variation in leprosy expenditure is small across states because leprosy continues to be a vertical programme with strong central control. Tuberculosis control, except for Gujarat (21 per cent), gets a very low share and appears to be the most neglected disease control programme averaging less than 10 per cent of the share of disease programmes. Among all the diseases covered by national programmes tuberculosis is the most prevalent as well as the most fatal one but it gets one of the lowest allocations. In fact a national evaluation of the TB programme by a joint GOI-WHO-SIDA team revealed that TB cases tended to concentrate in the district TB centre and the drug supply was so poor that effective supply was available for less than one-third of the registered cases.

The preceding discussion has highlighted the low level of public health spending in most states, the wide rural-urban disparities in spending and the large variation in spending across the states for most health programmes. How effectively is this allocated amount spent? Here we look at the line items

TABLE 8: RANGES (1992-93) AND MEANS (1990-93) OF EXPENDITURES ON SALARIES ETC OF SELECTED PROGRAMME

	Salaries		Materials and Supplies	
	Range	Mean	Range	Mean
Malaria	(MP) 65-95 (KE)	79	(KE) 0.5-30 (MP)	14
Leprosy	(MH) 76-89 (TN)	83	(TN) 4-10 (KE)	6
Tuberculosis	(MH) 25-94 (MP)	55	(MP) 0.7-73 (KE)	40
Urban Hospitals	(GJ) 63-77 (AP)	66	(AP) 19-31 (TN)	24
Teaching Hospitals	(TN) 48-66 (AP)	58	(AP) 13-50 (TN)	25
Rural Hospitals and Dispensaries	(KE) 64-88 (PJ)	73	(GJ) 2-34 (KE)	15
Primary Health Centres	(AP) 74-89 (KE)	83	(WB) 6-17 (AP)	10

The abbreviations in parentheses are names of states with the minimum and maximum range values.

Source: Same as Table 5.

of the major health programs, that is salaries and materials and supplies.

Disaggregating the expenditures on selected major health programmes into salaries and materials and supplies we find that in general salaries take away an exceptionally large proportion of the expenditures in all the activities under the public health sector. The ranges (1992-93 budget) and means (three-year average) of the proportionate share for both categories of expenditures in the eight states for selected programmes is given in Table 8. It is evident that disease control programmes and rural health programmes have very high salary expenditures which leaves a very small sum for other supportive expenditures without which the health care programmes are rendered ineffective. The urban hospitals and teaching hospitals are relatively better looked after and this is reflected in their overutilisation which creates its own problems. In contrast the gross underfunding and the poor allocative efficiency of rural health programmes leads to very low levels of utilisation of these facilities, thus causing a lot of wastage of the assets created and personnel employed.

In conclusion one can add that rural health care programmes are grossly underfunded, and what little resources are deployed are inappropriately utilised leading to the poor efficiency and use of the rural health infrastructure. At the other end, though urban areas are better endowed and allocations have relatively a much better mix, the urban health care system suffers from an unnecessary pressure, including an influx of patients from less endowed rural areas leading to overcrowding, which also makes it inefficient. If even the existing resources available are better distributed both geographically and in terms of input composition of expenditure (salaries, materials & supplies, maintenance, equipment, etc) the present system too can become more effective and responsive to the health care needs of the people. But this should not be taken to mean that the public health sector does not need more resources. On the one hand allocative efficiencies need to be drastically improved but perhaps more importantly the overall resource allocations to the public health sector, especially to rural areas, needs a substantial enhancement if people have to be served better and more effectively.

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Structural Adjustment and Health Policy in Africa

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World Bank-International Monetary Fund structural adjustment programmes (SAPs) have been introduced in over 40 countries of Africa. This article outlines the economic policy measures and the experience of the countries that have introduced them, in terms of nutrition, health status and health services. The evidence indicates that SAPs have been associated with increasing food insecurity and under-nutrition, rising ill-health and decreasing access to health care in the two-thirds or more of the population of African countries that already lives below poverty level. SAPs have also affected health policy, with loss of a proactive health policy framework and a widening gap between the affected communities and policy makers.

Adjustment programmes are rending the fabric of African society. Of the estimated half a million child deaths in 1988 which can be related to the reversal or slowing down of development, approximately two-thirds were in Africa.

UNICEF 1989.

THE economic structural adjustment programme, ESCAP or SAP has many names in Africa. To banking and financial interests, these words spell economic growth and development. For the poor majority of Africa, they spell hardship and struggle.

Africa is a continent that is often portrayed as being at best irrelevant to the international economy. It has been commented that if Africa north of Johannesburg sank below the seas, the international markets would not notice. It is true that Africa provides a small fraction of the global gross national product. But Africa is also a continent of social ideas, aspirations, and struggle. It is a continent where ordinary peasants and workers have in this century waged successful liberation struggles to shake off centuries of colonialism and racism and where a second wave of democratic action is being waged against one-party or one-man governments. Africa is a crucible of change, fertile ground to nurture the best that human development has to offer, but often victim to the worst that it imposes.

This is particularly important for people working in the health sector. Health is a product of material well-being, but it is also a consequence of the social organisation to obtain or produce those material resources. There are many examples of how popular organisation and community mobilisation have contributed to health, even against a background of scarce material resources. They exist in the primary health care gains in Mozambique in the early years of its independence; in the substantial