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Women, Health and Development

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The pace of marginalisation of rural people, women, tribals, dalits, etc has accelerated with the adoption of structural adjustment programmes in many countries. If we ae to assess its impact in the coming times, we need to be aware of the deterioration in their health and welfare status, already becoming visible. Women are especially affected by these policies given that their health status has shown little improvement in recent decades.

THERE is enough evidence to show that often, development policies adopted by governments have widened the disparities amongst sections of people. Analysis of the data shows that over the years, urban areas, as compared to the rural, and men as compared to women, have benefitted, and the gaps between these have widened (Karkal and Rajan 1988). Since poverty does not merely deprive individuals of the basic needs for survival, but makes them powerless to even take advantage of the available resources, the plight of the deprived sections has become more miserable over years. In turn, those in power continue planning such that small sections of the advantaged continue to reap benefits at the cost of the majority of Indian people.

Marginalisation of rural people, women, tribals, dalits, etc, not only continues unabated, but vested interests are promoting social and cultural practices which disadvantage marginalised groups. In fact, one can see the negation of progressive attitudes that were promoted through earlier social reforms. Selective abortion of female foetuses, female infanticide, sati, crimes against women, religious fundamentalism, and so on, are examples of this regression. The New Economic Policy (NEP) encouraging structural adjustment programmes (SAPs), liberalisation and export oriented policies, are expected to benefit those who already have a larger share in the nation's resources whereas they will push the deprived into lives that will be more miserable. There is already evidence that liberalisation policies have increased the hold of foreign capital on the Indian market, pushing the interests of the Indian 'common man' into the background. Privatisation of the economy has resulted in the virtual takeover of the process of development by the private sector. Mechanisation has driven out unskilled and semi-skilled workers from gainful employment. Women constitute a large proportion of these groups. In the absence of land reform, modern agricultural 'revolutions' (green, white, etc.) tend to result in

falling employment per hectare as land ownership becomes more unequal, farms become larger and large-scale mechanisation takes over. Tens of millions of small holders, tenant farmers and agricultural labourers have found themselves without sufficient land or sufficient work. In India, unaccounted numbers of rural families have become landless in the last three decades alone, turned away from the fields that they once tilled and harvested. At the root of this process lie investment policies which are capital-intensive rather than labour-intensive and they are being accentuated by the new economic policies.

It is now widely accepted that women contribute extensively to social processes through their involvement in production and reproduction. Yet women's access to resources is low; furthermore, even within deprived households their access to existing assets and resources is much lower than that of men. State policies moulded by class and gender bias adversely affect people's (especially women's) access to resources for this very reason. Class factors, household politics and childbearing have a profound and distinctive impact on a young woman. She is simultaneously a worker, a bearer of male heirs for the continuity of the husband's family line and of future workers for the nation's economy. It is thus inappropriate to analyse domestic organisation separately from the sphere of production. Biological reproduction may seem 'natural', but its social construction must still be analysed from a women's perspective.

While easily accessible, rational and humane medical services must be made available to all people irrespective of their capacity to pay, normal biological functions or social issues are seen as problems requiring medical solutions. The medicalisation of the human body complicates the health problems that people suffer from. Medicalisation is a cultural process with political implications, especially as more and more of everyday life comes under medical influence and supervision. This leads to serious loss of control over and confidence in women's own capacities and in their own bodies e g IVF promoted without adequate efforts to prevent infertility such as measures to diagnose and control pelvic inflammatory diseases (PIDs) and STDs and the unscientific use of IUDs. The medical profession has taken excessive charge of health concerns of people, irrespective of its ability to deal with them. Essentially non-medical states are increasingly defined in medical terms, for example technological devices are promoted even with uncomplicated births e g, prenatal screening and menopause. Thus, medical interventions are used to 'treat' these conditions, and a medical framework is adopted to understand them. Unnecessary and invasive interventions such as high-tech diagnostic procedures, drug and hormone therapies, and surgeries are thus routinely justified. There is an urgent need to develop alternative policies and programmes that will correct the disparities that prevail and reverse the human and environmental degradation accentuated by the new poli-

cies. Actions in this direction are needed not only because they are in keeping with the objectives of the Declaration of Human Rights, to which India is a signatory, but because such a perspective has to be at the root of any efforts for human development.

Health Status of Indian Women

The death rate for 1991 in India is 10 (per 1000 persons), which is close to 9 for the populations in the developed, industrialised countries [World Bank 1993]. However, this does not mean that the health status of people is the same or even comparable. The question is not so much 'how many' people die, but 'who' die? The infant mortality rate (IMR) for 1991 in India is 90 whereas the lowest known IMR in the world (in Japan) is 5 (per 1000 live births). Similarly the mortality rate among children below age five in India is 124. Reported estimates for deaths due to maternal causes in India vary from 390 to 2000 (per 100,000 live births). Deaths due to maternal causes have virtually disappeared in the developed industrialised countries.

Such comparisons discuss only the deaths, not the poor health or the morbidity situation of the people. For instance, for each maternal death in India it is reported that 17 women suffer serious health damage. (Dutta 1980). Such a morbidity pattern is not prevalent in the developed industrialised countries. To understand the morbidity conditions there is a need to review some of the work of nutritionists and other health scientists and to undertake appropriate research. The World Health Organisation (WHO) has developed an index known as disability adjusted life years (DALYs). This index measures the loss of life years due to deaths earlier than the expected life-span. Of the total DALYs lost in India, 56 per cent are lost in ages under 15 years. In contrast, in the developed industrialised countries, the loss of DALYs in ages under 15 is only 8per cent. Most of the DALYs lost in the developed industrialised countries are in advanced ages (World Bank 1993). In simple terms this means that of those who die in India, more than half die even before they have reached adulthood. People in the West not only live much longer, but the majority of them live until old age.

Besides the anomalous pattern of deaths by ages, differences also prevail between the deaths of men and women. Women are generally believed to be biologically stronger, and given equal chances of survival, women live longer than men. In developed industrialised countries women have lower death rates at all ages. In contrast among Indian women death rates, higher than those for

Table 1: Ratio of Deaths of Females to Males

Age Groups	Ratio
0-4	1.11
5-14	1.22
15-34	1.31
35-49	0.72
50+	0.86

Source: Registrar General of India, 1983 and 1988.

the men till their reproductive ages are over. Till 1971 this limit was up to age 44 years. Ever since the FP programme has been aggressive in India, a change in the pattern of childbearing has occurred through terminal methods for women at an earlier age. It is now observed that until the age of 35, women experience higher death rates in comparison to men. Beyond 35, that is, after the completion of women's reproductive career is over, it is the men in India who have higher death rates as compared to the women.

With higher death rates for the younger ages, it is observed that age-group-wise the number of persons goes on decreasing as the age advances. In other words, the larger number of persons is in the younger age group. Since women have higher death rates in younger ages, their numbers in the population decrease more in comparison to men. Consequently in India there are fewer women in the population than men. Expressed as 'sex ratio', the number of women per 1000 men in the population is low in India. Over years the sex ratio of the Indian population has shown a declining trend. In 1901 there were 971 women per 1000 men, and by 1971 this ratio came down to 931. The census of 1981 showed an improvement and the ratio was 934. However recent figures available (for 1991) show that the sex ratio in India is 929.

Social customs reinforce and perpetuate the dependent role of women and deny them basic needs, influence their chances of survival. The pattern of higher mortality among women than among men, observed in India and in populations of other countries in the Indian sub-continent (except in Sri Lanka), is rather uncommon when compared with other regions. Higher mortality in general, or higher prevailing death rates, do not explain the differentials that are unfavourable to women. The highest mortality in the world is observed in the African countries, where women live longer than men.

A study by the UN (1988) based on the analysis of 78 life tables for the period 1945 to 1981, showed that the differences in mortality of the two sexes observed in the Indian sub-continent, were mainly because women had life expectancies much lower than values expected in all other countries. In other words, it is not as if men in India are in enviable situations, but that women are significantly neglected. The bias against women is expressed in denial of their due share in the social resources. Denial of adequate nutrition and medical attention, when needed, has resulted in higher mortality among women.

The undervaluation of women is at the root of the neglect resulting in higher mortality. Scrimshaw (1978) argues:

> the traditional assumption that high mortality leads to high fertility must be questioned. Often the reverse may be true. High fertility may be accompanied by the acceptance or even unconscious encouragement of high mortality.

Unregulated fertility accompanied by neglect of unwanted (girl) children is used as a way to regulate family size. Using data from the National Sample Survey, Malakar (1979) showed that this argument using selective neglect of girls for regulating family size was supported by the Indian data. Simmons and colleagues (1982) from their data concerning

post-neonatal mortality from Uttar Pradesh show that parents desire sons more than daughters. Their data also show that the girl infants are more likely to die in families where the wife had expressed a preference for no additional children or especially no additional girl children. Wherever an older male sibling aged less than three years was present, girls were found to be at a disadvantage.

That women suffer critical nutrient deficits from girlhood onwards is shown by ample available data. A study by ASTRA in rural Karnataka state showed that, of the total human energy contribution to the village 'energy matrix', the respective contributions of men, women and children were 31 per cent, 53 per cent and 16 per cent, indicating that women worked harder than men. Batliwala (1987) reports that she tried to calculate the energy expenditure for individuals in terms of kilocalories and compare it with the food intake. However, she was faced with problems since

> ...nutrition textbooks provided calorie costs for piano-playing and typewriting (but) they did not mention fetching water or gathering firewood. Secondly, only a limited number of agricultural activities were measured, compared with over 70 industrial and military activities. Finally, it was found that even for these no female equivalents were available. The few energy cost figures available for women, included such middle-class activities as sewing and singing, and women on the whole were listed under the heading of 'sedentary people'.

Batliwala says that the study pointed out with statistical evidence that the expenditure of energy by women on a day to day basis may be higher than that of men. Furthermore, in rural setting men's work is seasonal, whereas women perform not only seasonal activities (transplanting, weeding, harvesting) but the perennial, life-supporting tasks like fetching water and fuel, cooking and looking after children and old people in the family.

> The final computation of calorie expenditure on various agricultural and domestic activities by men and women, was found to be : 2473 calories per day per man and 2505 calories per day per women. In contrast the estimated intake of calories was 3770 per day per man and 2410 calories per day per woman. Thus women faced not only a relative deprivation in comparison with men, but also absolute deficit vis-a-vis their calorie expenditure [Batliwala 1987:261]

Batliwala refers to Shatrugna's observations: (1) Women may not continuously lose weight, but they are definitely lighter than their desired weights; (2) Women have no energy reserves for emergencies such as illness, etc so that their mortality rates are higher in the event of an epidemic compared to well-fed women; (3) Women try to conserve as much energy as possible by cutting out on the quality of life. Of course they are called lazy, inefficient, slow and even cheats. But what they are trying to do is exist and work at basal metabolic rate(BMR) level, because they do not have surplus energy for briskness; (4) It is also possible that their cells are converting food into usable energy more efficiently. This could result in early wearing out of the cells and early aging.

Son-preference takes its largest toll in ages 1 to 4.The impact of discriminatory treatment to girls in allocation of food and in medical

attention is highest in these early ages of childhood. Impact of these discriminatory treatments is also observed in ages 5 to 14 and then during child-bearing ages. Inadequate medical care takes greater toll of these women of poor health. The first childbirth is particularly hazardous. Neglect of girls in the early ages is reflected in the high incidence of low birth weight babies for the survivors among these girls. Most childhood diseases have greater impact on male children when children of both sexes receive no discrimination in food and in medical attention. This is obvious from the fact that wherever the improvement in chances of survival of female infants had taken place they were without any special medical inputs for the female children.

The social definition of the appropriate age at which reproduction should commence also influences the expected social costs of rearing the child. Parents can reduce their economic liability by marrying off daughters at markedly younger ages. Data from countries that have shown improvements in the survival chances of girls, also invariably show a rise in age at marriage of girls.

For women another area of inequity comes from the society's refusal to acknowledge and reward the services that women render to the society. In the developing countries non-monetised sector, traditional labour intensive agriculture and subsistence production play an important role in the activities of the people. These activities take place mainly at the household level. Krishnaraj (1989) points out that,

> Data systems whose concepts and methodologies were derivedfrom the market system, did little justice to the altogether different mileu of the Third World economies, and especially the rural economies. Women are not present in the paid labour force, which is visible to the statistics, but are engaged in productive activities of household level, mainly the non-monetised or subsistence sector that render them invisible to statistics. Invisibility of women in data systems has come to be understood as caused mainly by the limitative definitions and concepts employed that are particularly unsuitable to women. By leaving out much of what women actually do, because they do not fit the definitions, women's contributions go unrecorded. This invisibility contributes significantly to the lowering of the status of women. Women's work that is crucial to survival, becomes marginal and they are believed to be 'dependent'.

TABLE 2: CURRENT BODY WEIGHTS (KG) OF INDIAN WOMEN AND GIRLS OF DIFFERENT SOCIO-ECONOMIC GROUPS

Group		Urban					Rural
	Body Weight	HIG	MIG	LIG	IL	Slum	
Infants: 0-1 year	7.2	6.2	6.0	5.9	5.9	5.7	5.8
Children: 1-3 years	11.8	11.2	10.6	9.5	9.5	9.0	9.1
4-6 years	17.7	15.7	14.4	14.0	14.3	13.6	13.6
7-9 years	25.9	19.6	19.9	18.8	18.7	18.3	18.3
10-12 years	35.0	26.4	27.3	25.4	25.4	24.0	24.6
Adolescents: 13-15 years	47.8	39.5	37.5	35.4	35.7	33.8	34.7
16-18 years	49.7	43.8	43.1	41.7	41.6	40.8	41.1
Adult women	50.0	50.3	48.2	43.5	44.6	41.9	42.5

Source: Nutrition Foundation of India, *Women and Nutrition in India*, Special Publication Series 5, New Delhi, 1989.

This bias against women also comes from cultural factors that find women reported as being an 'outside labour force' because they find very little prospect of finding work. Many women who are officially classified as being 'unavailable for work' would be available to take up work only if their domestic responsibilities were made lighter through reducing the drudgery of household activity by the sharing of work by family members, especially men.

In agricultural countries such as India, the participation rates for women are influenced by their participation in the agriculture. In the third world, unpaid family work, traditional labour-intensive agriculture and subsistence production constitute the major economic activities of the people. These activities take place mainly at the household level.

> The role of women in agriculture is crucial not only because of their number engaged in it but also because of the variety of activities which they perform. Except for ploughing, women are involved in all the operations required for growing foodgrains and vegetables and rearing livestock. Their involvement in the agriculture can be observed in compost preparation and application, land preparation, specially clod breaking and land levelling, sowing and transplanting, weeding, harvesting, cleaning, drying and market-produce selling. In livestock-keeping they collect fodder, clean animal shed, milk milch animals and process dairy products. All this in addition to their regular household duties such grinding and dehusking grain, fetching drinking water, collecting fire-wood, preparing family meals and looking after children and the old. In reality women work harder than men and get little economic credit for doing so. Women are also seen carrying basketsful of vegetables, fruits and other agricultural produce on head or back for marketing or for door to door selling. [Bhattarai and Karmacharya 1981]

Technological developments have also harmed the interests of women.

> Because of rapid industrialisation and mechanisation that have destroyed traditional crafts, poor women in the Third World face extensive and acute unemployment. Retention in traditional 'unorganised' units where they are not covered by the factory laws and their absorption into new type of unorganised units appear to be because of the special difficulties women face such as illiteracy, low technical skill, lack of opportunities into the more structured units. Over and above these, women's mobility is restricted due to family obligation as well as attitudes regarding what is permissible work for them. The major problem for women seems to be not so much being pushed out, which is true in some sectors, as staying where they are. While men move up through education to higher jobs, women continue to hold traditional occupations that ensure bare survival for the family, but do not assure adequate economic returns. Women's employment provides men and society in general an assurance against unemployment and sickness, against inflation and wage cuts in their petty ventures [Krishnaraj 1989].

In agriculture, high yielding variety (HYV) technology, along with irrigation, led to increased use of labour time per unit area cultivated

because of higher labour use in the application of new inputs, higher cropping intensity and higher yields. However Dasgupta (1977) observes:

> ...evidence from some village surveys (in India) shows that the demand for hired labour goes up with agricultural prosperity and irrigation, but such evidence shows only a shift from family labour to hired labour and not an increase (in fact decrease) in the overall rate of participation of the village population in the workforce.

Studies have also shown that, as the economic conditions of the families improved, women in the families withdrew from the workforce. This is supposed to have happened because of the demand for more skilled work and this being fulfilled by hired labour rather than providing skills to the family labour, especially women. Another argument forwarded is that as economic conditions of the families improved, men considered it necessary to withdraw their female family members from labour force as a sign of their (men's) improved status [Dasgupta 1977].

Acharya and Bennet (1983) made an interesting observation that women's involvement in market activities gives them much greater power within the household in terms of their input in all aspects of household decision making. Limiting women's involvement to the domestic and subsistence sectors reduces their power vis-a-vis men in the household. It is important to note that in patrilineal systems land is owned by men and as such the subsistence production assets are owned and controlled by men. Women in market economy on the other hand generate their own production assets, and improve their own status.

Access to Health Care

Inherent in each system of health care is a specific attitude towards people and their bodies. The allopathic system tends to view people as composed of distinct mechanistic organ systems like the gastro-intestinal tract, the cardio-respiratory system, the uro-genital tract, the nervous system, etc. The Indian indigenous and homeopathic systems, in contrast, see human health more in terms of balances and flows of doshas and energies. They are less concerned with the physical boundaries and connections of organs. The allopathic approach to medical treatment is characterised by attempts to fight, remove or eradicate causative agents (germs, allergens, defective parts) and to suppress symptoms. On the other hand, the indigenous and homeopathic systems, aim towards restoring balances and flows in the person without considering the parts separately. The latter approach is called holistic. Realistically speaking, each approach has certain strengths and weaknesses.

Whatever the particular health system, the healer (doctor, vaidya, hakim, vaidu) can exploit his (or rarely her) power over the sick person (patient) and relatives, and often does. Even when benevolent, the

relationship is usually patronising. It is doubly so with women who are sick. In this respect, there is little difference between practitioners of the holistic and non-holistic systems. Women sometimes tend to prefer the holistic approaches, perhaps because allopathy is understood to be too 'strong' and invasive. However, this comparable gentleness is no guard against patriarchal attitudes which have become embedded even in holistic health systems.

In spite of the fact that women are producers and reproducers, their access to health care is extremely poor. Various reasons account for this low access. Firstly, women are seen either as mothers or potential mothers by the public health services. Any problem related beyond that (such as mental health or marital violence, for example) are not seen as a priority by the health services for healing women. In India, where the obsession of the state is in reducing numbers of people, infertility also is not the concern of the government heath services, in spite of the socio-logical consequences of the same for women. On the other hand, invasive reproductive technologies are peddled in the name of giving infertile women choice. The question of reducing potential infertility among women through the prevention or early treatment of TB, pelvic inflammatory diseases, undernourishment and complications from hazardous contraceptives, is not considered.

The state's undue emphasis on population control also reduces the access of women to health care services, especially in the crucial years of pregnancy and childbirth. When health workers are busy 'cultivating' family planning cases, it is difficult to imagine that women will feel comfortable seeking ante-natal or post-natal care from them. The watered-down programme of maternal and child health (MCH) suffers a major obstacle. With regard to quality of service, even the record of the favoured 'family planning' programme is unsatisfactory. The Indian Council of Medical Research reported a study of 43,550 hospital deliveries where 52 of the women had given birth after sterilisation (33 tubectomies and 19 vasectomies) [ICMR 1990]. Another 22 women reported having conceived while using an intra-uterine device [ICMR 1990].

Locations of the PHCs also make it difficult for women to avail of health services. The OPD of most PHCs functions between 8:00 am and 12:00 noon and reopens from 4:00 to 6:00 pm. PHCs serve several villages and villagers have to commute to reach to the PHC. Often state transport buses do not reach the PHC village well in advance for patients to receive medical treatment and often the last bus from the village leaves before the OPD closes. Both patients as well as many of the PHC staff (including the doctor, sometimes to whom the government provides residential quarters near the PHC) travel by the same bus to and fro, and so the delivery of health care suffers. Short supply of health personnel and of drugs makes the journey to the PHC futile. [Avasthi et al, 1993]

The private sector on the other hand is totally unaccountable to people's real health concerns. The treatment is expensive and not always rational or ethical. In one of the studies it was found that women suffer more often from chronic ailments (such as anaemia, backache, white discharge, weakness, etc as compared to the men in the family. Most of people's (and especially women's) illnesses are a result of over-work, undernutrition and poverty. The health services cannot cure women of these problems. In reality what happens is that the family realises that women don't get well easily and so the access of women to medical care, especially that which requires more time and money gets reduced in the cases of women [Gupte and Borkar 1987].

The current health policy of the Government of India evolved under pressures from the World Bank is to restrict government health services to preventive care and allow the private sector to take over all other health services. This policy will also allow multinational pharmaceutical industry free access to the Indian market. Thus, the prices of drugs which are already beyond an average Indian's reach will spiral. Cuts in the health budget are squeezing out the poor from access to ordinary health services. This changed situation will further increase the burden of women who care for the family in sickness.

A low self-perception of women as well as the culture of silence' in which they are brought up makes them endure the physical and mental suffering they experience and this further reduces their access to health care. Taught to believe that menstruation is dirty, a woman is hardly in a position to seek medical intervention for white discharge or for menstrual disorders. Personnel in public services have little patience to listen to stories of side-effects of contraceptives or of a woman's husband's impotence. In fact, once she is terminally sterilised a woman is virtually struck off the mental registers of the health service providers. The private sector then steps in when a tubectomised woman suffers menstrual chaos (maybe related to hurried sterilisations in camps), and offers hysterectomy as the solution at a price that is a few years of daily wages of the woman.

The health of 'deviant' women, (who include single, disabled, widowed, deserted, lesbian, mentally handicapped and so on) is a matter of negligible concern to the public health services that rightfully belong to the people. In the same light, sexuality of women (and men) is never addressed, much less the adverse consequences of having neglected the same. Thus women suffer silently of depression, anxiety or of more severe mental disorders because they have not received either the physical or emotional support from medical personnel at the required time.

The system does not locate the health problems of women in the real context of oppressive man-woman relations. Treatment ignores the need to change these relations. Ill-effects to women's health arising out of such relations, such as reproductive tract infections or injury and mental trauma,

are not treated seriously enough. The effect of gender division of labour on women's health is unrecognised, including the health costs of invisible work at home and in the informal sector.

Instead of increasing the access of women to health care and to reproductve rights, one observes the trend to decrease it. The move to withdraw maternity benefits for women beyond the second child or of advocating hormonal implants and injectables as contraceptives, should be seen in the same light. On the one hand there are the women who have little or no access to trained medical supervision at the time of childbirth, in spite of high gestational risk; on the the hand, urban middle class women frequently undergo repeated Caesareans during childbirth.

The fact that the same illness for a woman very often poses quite a different problem than it does for a man has also to be fully understood. Tuberculosis for a man is bad enough, but for women not only does the continued treatment or stigma reduce her status at home, but the possible infertility resulting from the illness can cause untold misery. Marital violence, desertion and death become real possiblities for this woman. The social sanction for these crimes is more overt when the woman fails to perform her expected duties at home, namely housework and bearing of male children.

Women's indigenous knowledge of health care has been marginalised or lost, and their continuing role in maintaining the health of their families and communities has been devalued. Self-help measures and remedies that address women's ailments, passed down through generations, are being replaced by mystifying pharmaceutical and high-tech paraphernalia. Not surprisingly, this leaves women with a sense of separation from their own bodies.

In the name of increasing access of women to medical care, there is further medicalisation of women's bodies and functions. When we consider the immense potential of the multinationals/ pharmaceuticals to make profit by peddling drugs and contraceptives to healthy women for birth control, menopause and so on, it is of no great surprise that the argument of giving women more 'choice' would be popular even among the establishment. We have to view pre-natal sex-determination, hormonal replacement therapy and the indiscrimante use of tranquilisers for women in this light.

Privatisation would only reduce women's right to existing health services. We can demand good quality services from the public sector because they are funded through the indirect taxes that the people including the poor pay. The private sector is kept in some check because of the mere existence of the public health services. Once the private sector takes control over the public arena, there will be no end to the greed of profit-motivated medical personnel. Compounded with the New Economic Policy, structural adjustments and intellectual property rights (including

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-