

# Health planning in India 1951–84: the role of the Planning Commission

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Detailed analysis of public sector health policy in India is rare. This paper contributes to the development of a more informed view of how policy is developed and implemented by presenting material on the overall pattern of central and state government health sector expenditures since 1951. In addition to financial information, there is a discussion of the processes involved and the roles of Ministries of Health and the Planning Commission. Three states (Orissa, Maharashtra and Gujarat) provide more detailed case studies. In conclusion, it is suggested that the financial data do not support the argument that Indian health services are heavily biased towards the urban, curative, tertiary sector. However, it is stressed that such a conclusion can only be substantiated by more detailed analysis of the implications of health policies and health sector expenditure.

## Images of health planning in India

On the face of it, health planning in India seems to have stressed preventive and public health programmes with a rural bias. This emphasis is reflected in all the Plan documents, to a greater or lesser extent. All the Plans call for a rural bias: rural areas 'should receive much greater attention' (GOI 1952: 197); they are 'the most urgent need to be met in the second five year plan' (GOI 1956: 534); the expansion will reach a 'progressively larger number of persons, specially in the rural areas' (GOI 1961a: 653); rural areas will be the 'emphasis' (GOI 1968b: 309) or the 'accent' (GOI 1973: 234). Similarly a preventive bias was urged: in the First Plan 'additional resources should be concentrated on preventive work rather than curative facilities' (GOI 1952: 197); in the Third Plan they were to receive 'increased emphasis' (GOI 1961a: 651) and in the Fifth Plan minimum public health facilities were the 'primary objective' (GOI 1973: 234). The expanded numbers of paramedical or non-medical personnel received a more muted and changing emphasis: early proposals saw their rapid expansion as 'necessary', and the Second Plan was most forthright about the need for 'accelerated and sustained action' on ancillary training if 'even elementary services are to reach

the mass of the people in any adequate degree' (GOI 1956: 538). But the Third Plan merely 'recommended' a new scheme for medical assistants, the Fourth Plan talked only of doctors and the Fifth Plan of raising the quality of training, career paths and so on. The most notable schemes for improving paramedical personnel – for multi-purpose workers (a kind of feldsher) and community health workers (1977) – were introduced outside the normal process of Plan construction.

However, the general image of Indian health planning is the reverse of this picture. Cassen (1978), in the most authoritative outside review of health services in India, concludes that public sector expenditures in health are concentrated in large urban hospitals. A large number of Indian critics, from both inside and outside Government, have made similar claims (Ramasubban 1984, Banerji 1983, Srivastav 1975, ICMR/ICSSR 1981). I do not wish to claim that all is well with health policy in India, but in this paper I will suggest that public sector health expenditures have been somewhere between these two positions. The reason why both positions have been held is that relatively little has been published which sets out the parameters of actual government health sector expenditures in India.

In this paper I will attempt to answer two sets of questions:

- How much is spent by the central and state governments on 'health-related' sectors; and how does this relate to Plan and non-Plan expenditures?
- How far does the Indian case support the argument that health sector expenditure in developing countries is skewed too far in favour of curative health services in urban areas?

I shall use the following terminology: 'health' will refer to the Indian budgetary categories of 'medical' and 'public health'; 'health-related' will include the Plan categories of 'health', 'family planning' (or 'family welfare'), 'water supply and sanitation' and, where possible, 'nutrition'.

### **Public sector health expenditures**

The most obvious feature of public sector health expenditures in India remains that little, in absolute terms, is spent directly on providing health services for the people. How little has remained unclear, partly because of the complications caused by the different agencies concerned with 'health-related' issues. India has a federal constitution, and 'health' is formally allocated as a responsibility to the 22 states, which range in size from a population of over 110 million (Uttar Pradesh) to less than one million (e.g. Meghalaya). But Central Government also has some health functions (medical standards, family planning, quarantine etc.) and provides health services in the Union Territories (the capital, Delhi, and some other small territories). Health services are also provided by some local government bodies, predominantly urban, but in some states, rural as well. In addition, several ministries (not just Health and Family Welfare) provide health-related services. Health services are supposed to be co-ordinated through the annual meetings of the Central Council of Health (CCH) which consists of representatives from the states and other relevant ministries. The Planning Commission is the other co-ordinating body.

The main areas which tend to be omitted from discussions of health expenditures in India are 'social insurance' and 'nutrition'. The Ministry of Labour is responsible for most social

insurance schemes. Some of these are covered by legislation (like the Plantation Labour Act), while some employers run their own schemes. Some of these are restricted to individual industries, either in the private sector (e.g. plantations) or the public sector (e.g. coal mines) or to government employees (such as the Central Government Health Scheme). The largest scheme, the Employees' State Insurance Scheme (ESIS), serves employees from a large number of industries and covers over 7 million workers and 21 million of their dependants, or some 4 per cent of the total population. Another large scheme covers 7.6 million railway employees and dependants (GOI 1984: 146 and 246). Although the ESI Commission is usually represented at CCH meetings, the development of facilities for industrial workers often proceeds quite separately, with duplication of urban medical services (Jeffery 1977), and it is only recently that the ESI has taken any interest in public health matters (Singh 1983).

The other problematic area is that of nutrition services. Prior to 1971, nutrition had a very low profile within Government, and even since then it has proved difficult to identify nutrition expenditures. Food aid was regarded as a famine prevention measure rather than a feature of routine government services. When nutrition services became more significant, as part of the Minimum Needs Programme of 1971, they were still provided by Social Welfare Ministries, through school meals and feeding programmes. The current attempts to integrate nutrition and maternal and child health services, particularly in the Integrated Child Development Scheme (ICDS) do not seem to have resolved the problems of co-ordination between the Social Welfare and Health Ministries.

### **Plan and non-Plan expenditures**

All government expenditures in India are divided into 'Plan' and 'non-Plan' categories. The Plan covers most new, developmental expenditure (but is not the same as 'capital') whereas the 'non-Plan' category covers most routine activities (but is not identical with 'revenue'). In general, for health topics, Plan expenditures have included all those on preventive campaigns (smallpox, malaria etc.), family planning and some water supply and sanitation. In other parts of the health budget,

only new developments have been paid for from the Plan budget, with recurrent costs becoming part of the non-Plan budget at the end of the relevant Plan.

Most discussions of the pattern of health expenditure in India have gone little further than noting the size, and trends through time, of proposed Plan expenditures and inter-state variations in total per capita expenditures (e.g. Ramasubban 1984). Proposed Plan expenditures give some insight into the priorities for new spending, but the picture is confused by the different treatment accorded to different categories (see above) and by the transfer of some headings into and out of the Plan. Detail on the total actual Plan expenditures, or the pattern of state expenditures (including non-Plan spending), has also remained unclear. The most readily available sources are the Five-Year Plans: these deal in 'outlays', or proposed expenditures, and offer only a haphazard record of actual patterns in the previous Plans; and they say nothing whatever about non-Plan expenditures, which are hidden in the budgets and accounts of the individual states.

Table 1 is based on the collation of actual Plan expenditures and total state and central government 'health-related' expenditures. As it

shows, the Plan has only recently accounted for more than 60 per cent of these total expenditures. The proportion of government expenditure spent on health-related subjects has risen steadily – by 50 per cent over the last 30 years – and the share of national income has risen even more – by 250 per cent. These increases can also be seen in the rise in per capita expenditures in constant (1960–61) prices. These general rises, however, hide very different patterns for the different sectors (see further below).

In general, there have been three financial categories of Plan expenditures: those paid for entirely by Central Government and disbursed by its own agencies; those paid for (in whole or in part) by the centre but disbursed by state governments and those funded and disbursed by the state governments. Family planning has always been a completely centrally-funded area, as were the campaigns against communicable diseases before the Fifth Plan. On the other hand, nutrition and water supply and sanitation have always been largely state-funded. The pattern of 'outlays' (proposed expenditures) by these categories has changed from Plan to Plan; in 'health' the role of the centre has generally, if erratically, increased since the Third Plan (see Table 2).

**Table 1.** Plan and non-Plan public health-related expenditure

	1st Plan 1951–56	2nd Plan 1956–61	3rd Plan 1961–66	Plan 'holiday' 1966–69	4th Plan 1969–74	5th Plan 1974–79	1979–80	6th Plan <sup>a</sup> 1980–85
<b>Total expenditures</b> (rupees × 10 <sup>6</sup> )	1 913	3 673	6 589	6 475	20 120	41 080	12 551	33 075
Percentage accounted for by Plan	51	59	54	48	57	57	58	63
<b>Annual per capita expenditures</b> (rupees)								
Current prices	1.0	1.9	3.0	4.4	4.7	13.3	19.0	24.2
1960–61 prices	1.4	2.1	3.6	2.7	3.6	4.2	4.9	5.0
<b>'Health-related' expenditure as percentage of:</b>								
Total government outlay	2.7	2.6	2.9	3.1	3.8	3.9	4.2	4.1
National income	0.42	0.62	0.76	0.80	1.04	1.19	1.42	1.46

Sources: Plan documents (GOI 1956, 1961a, 1967, 1968a, 1968b, 1973, 1978b, 1981a, 1983), Ovens in Streeten and Lipton (1968), Reddy (1972: 218), Barnett (1977).

*Note*

<sup>a</sup> Sixth Plan total expenditure figures are for 1980–81 and 1981–82 only. These figures are not strictly comparable and the classification of total health expenditures change in 1974 with impacts which are not known. Fifth Plan expenditures exclude nutrition.

**Table 2.** Health outlays by financial categories

	3rd Plan (%)	Plan holiday (%)	4th Plan (%)	5th Plan (%)	6th Plan (%)
Central	6.6	12.0	12.3	9.5	23.8
Centrally sponsored	2.4	7.9	40.7	22.2	20.0
State/Union Territory	91.0	80.1	46.9	68.2	56.3
Total	(%) 100	100	100	100	100
(rupees × 10 <sup>6</sup> )	2 259	1 401	4 335	7 960	18 210

Source: GOI (1973, 2: 232; 1981: 382).

*Note*

This table excludes family planning (100 per cent central or centrally sponsored in each Plan) and water supply and sanitation.

### *Stages of the planning process*

In order to move to a more detailed account of health planning, I will consider three sets of processes. The first is the process by which the Plan documents are drawn up, or 'outlays' are agreed. The second is the process by which Plan proposals are turned into 'actual' expenditures. The third is the way in which Plan expenditures are integrated with non-Plan expenditures into the overall pattern of health expenditures at the state government level.

The first two of these are usually called the planning process. In India, for each Plan, these can be seen as the decisions and negotiations between three identifiable events: the presentation by the Ministry of Health of a proposed Plan for the health sector, the publication of the final Plan document and the end of the Plan period.

### *Sources of information on the planning process*

There are three kinds of information available on how health planning has taken place within the government apparatus, none of them ideally suited to shed light on these processes. First, there are the Plans themselves. They have the advantage that they represent official statements of policy objectives and some of the rationales for chosen policies. They are readily available, and have provided most commentators with much of their materials (e.g. Ramasubban 1984). Their main disadvantages are that they are silent about how competing policies were selected or rejected and how priorities led to the actual distribution of allocations; and they give little information on actual expenditures.

The second source of information is the minutes of the discussions in the CCH on the Plan proposals. The information is incomplete, but for the Third and Fourth Plans they allow a glimpse into the processes by which proposals from the Ministries of Health are modified in negotiation with the Planning Commission.

The third source of material is the background papers prepared for the Planning Commission by working groups. These reports allow more insight into the various arguments, but say very little about how these competing claims were balanced.

Information about state expenditures is provided only by the states themselves. I have managed to obtain information on Maharashtra, Gujarat and Orissa, and these three will form the subjects of the final part of the discussion.

### **The planning process: creating the Plan**

In general the procedure of detailed planning appears to be as follows. Firstly there are discussions in which state ministries liaise with central ministries over proposals and projects which are put to the Planning Commission. The Planning Commission collates these proposals and evaluates them in terms of a number of criteria – such as the foreign exchange requirements which are implied, the overall volume of physical and financial resources which is expected to be available and other decisions on priorities between sectors and states. These major decisions are formally the responsibility of the National Development Council, consisting of members of the Planning Commission and

chief ministers of the states, and usually chaired by the Prime Minister. The Planning Commission then translates these essentially political decisions into consistent policies which form the final Plan. It then draws up annual plans which provide the justification for state and central ministry budget decision-making and allow state governments to claim back expenditures which fall within Plan allocations.

In the case of health, the first stage appears to include the establishment of working parties and expert groups (dominated by doctors) looking at specific issues such as medical education or the control of communicable diseases. Each group works independently and is thus tempted to expand the number of its proposals as far as possible. Similarly, the Federal Ministry of Health as a whole is under pressure to submit an exaggerated list of proposals to the Planning Commission, knowing that it is likely to have its total cut, whatever is proposed. The eventual Plan may lose much of whatever rationality it had, because of the need to cut the total to a level acceptable to the Planning Commission, and to divide it into topics and by state in ways which derive from political decisions made in the National Development Council. Looking at these processes, then, gives some idea of the

'real' priorities – what the Health Ministry proposed and what the Planning Commission cut or expanded. Material available for the Third and Fourth Plans allows some insight into how this happened.

During the course of the Second Plan the Federal Health Ministry looked at the pattern of expenditures and singled out medical education and family planning as areas where allocations were not being spent fast enough. This kind of information was fed into discussions on the Third Plan allocations. State Working Groups were established and submitted proposals to a Central Working Group, which reported to the Central Council of Health in 1959. Their proposals form column A in Table 3. At the same time the Planning Commission was preparing its own Draft Outline, which appeared in June 1960 (column B) and allocated only 43 per cent of the CCH proposals (GOI 1960). This Draft Outline was then discussed with the states and the central ministries, and the size of the Plan was increased as a result of political pressures of this kind. Two revised sets of proposals came out of this process before the Plan was finalized and appeared in August 1961 (column C). The pattern of actual expenditures is shown in column D.

**Table 3.** Allocations and expenditures for the Third Plan

	Ministry of Health 1959 (%)	Planning Commission 1960 (%)	Final Plan 1961 (%)	Actual expenditure 1961–66 (%)
	a	b	c	d
<b>Health</b>				
Control of communicable diseases	17	30	21	28
Medical education training & research	11	15	16	19
Hospitals & dispensaries	20	15	18	14
Other health	13	10	6	4
<b>Family planning</b>	4	8	8	6
<b>Water supply &amp; sanitation</b>				
Urban	28	21	31	30
Rural	7	1		
<b>Total</b>	(%) 100 (rupees × 10 <sup>6</sup> ) 7 030	100 3 040	100 3 415	100 3 531

**Sources:** Columns a and b GOI (CCH) (1961)  
 Column c GOI (1961: 651)  
 Column d GOI (CCH) (1966: 45)



A similar sequence of events can be identified for the Fourth Plan, though matters are complicated by the fact that the original proposals for the Fourth Plan were shelved in 1966 and reviewed only in 1968–9, because the Plan period was postponed by three years.

In the course of these changes there were some apparently radical changes in distribution. In the Third Plan, the Planning Commission seems to have protected the programmes to control communicable diseases, family planning and medical education etc. at the cost of hospitals and dispensaries, 'other' and water supply etc. In the Fourth Plan, family planning received a continually growing allocation, and water supply etc. joined the 'protected' sectors, while education etc. lost its protected status. It is not clear whether the cuts to hospitals etc. were directed mostly at urban facilities or also at the rural primary health centre programme.

Part of the explanation for which sectors were 'protected' is provided by foreign assistance. This assistance is all channelled through the Planning Commission and tends to be tied to particular sectors. As a result, these sectors are not threatened when overall cuts have to be allocated to sectors. Foreign aid in the 1960s was heavily focused on preventive programmes and (later) on family planning; in the 1970s, water supply and sanitation schemes and some extensions to the primary health structures were also aid targets (Jeffery 1985).

The shift to family planning is slightly misleading, since this category includes some expenditures directly relevant to the health sector – as, for example, the training of auxiliary nurse-midwives, some of whom worked in 'health' or 'medical' positions. Provision for this training might originally have appeared under the state total for training, but a reclassification under a centrally-sponsored heading such as family planning increased the chances that the scheme would be implemented. Some changes, then, might be little more than cosmetic.

The Planning Commission, then, both in its own right and as a channel for foreign pressures, has ensured that the Indian Plans have been fairly consistent in their emphasis on rural, preventive services. But the Planning Commission can only restrain expenditures by state governments

(rather than being able to insist on spending) and is only concerned with Plan expenditures. The actual patterns of total health expenditure may be very different. Firstly, I shall consider the differences between outlays and actual Plan expenditures, and in the final section I will look at total health expenditures in some states.

### Implementing the Plan

The kinds of processes described above led to Plans which gave varying degrees of priority to the health-related sectors in general and to the different sectors. Table 4 shows the health-related 'outlays' and 'actuals' as percentages of total Plan outlays and of actual expenditures. The percentage allocations to 'health' in each Plan declined steadily, while in the Fourth, Fifth and Sixth Plans the other health-related shares rose sufficiently to outweigh this decline. The health-related sectors have been less successful at spending their allocations than have either the social services (education being a major component) or the public sector of the Plan as a whole, so actual expenditure shares have been below these levels. Nonetheless, in cash terms, the 'health-related' sectors have spent over 90 per cent of their allocation, except in the First Plan. If inflation is taken into account, this falls to about 80–85 per cent of financial targets.

The extent of central control over Plan funds has varied from Plan to Plan. The ability of the centre to pay for a particular part of public expenditure has remained a powerful inducement for state governments to follow central policy proposals, and any attempt to reclassify a particular topic from central to state funding is always greeted with protest. But the offer of central funding is not necessarily enough to ensure that a policy is followed. For example, in the implementation of the community health workers scheme under the Janata Government after 1977, several states (notably Tamil Nadu, Kerala and Kashmir) refused to introduce the scheme, arguing that they had no need of it because they had alternative ways of meeting the health needs of the rural population. State governments are also wary of the conditional, time-bound support offered by Central Government. When central funding runs out the states will be left with a cadre of workers they did not necessarily want, but they have no politically

**Table 4.** Health-related Plan outlays and expenditures  
(as percentage of total public sector Plan)

	1st Plan	2nd Plan	3rd Plan	Annual Plans	4th Plan	5th Plan	1979– 80	6th Plan
<b>Outlay</b>								
Health	3.6	3.3	2.8	—	2.7	1.7	—	1.8
Family planning	0.03	0.07	0.4	—	2.0	1.3	—	1.0
Nutrition	—	—	—	—	—	1.0	—	0.2
Water supply etc.	2.0	1.7	1.4	—	2.6	2.5	—	4.0
All health-related	5.6	5.0	4.6	NA	7.3	6.5	NA	7.1
<b>Expenditure</b>								
Health	3.3	3.0	2.6	2.1	2.1	1.9	1.8	NA
Family planning	0.01	0.05	0.3	1.1	1.8	1.3	1.0	NA
Nutrition	—	—	—	—	0.0	NA	NA	NA
Water supply etc.	1.7	1.6	1.2	1.6	2.9	2.8	3.2	NA
All health-related	5.0	4.6	4.2	4.7	6.9	5.9	6.0	NA

Sources: Plan documents; GOI (1983: 113)

acceptable way to sack them. As early as 1980 there were indeed moves to transfer some of the costs of the community health workers scheme onto state budgets, though Central Government was not able to enforce its policy on the states in this case. Similarly, the centre is unable to prevent some policy initiatives by state governments which contradict central policy if the state is prepared to pay for them – as in the recent opening of short courses for training rural doctors in West Bengal or the opening of a new postgraduate teaching hospital near Lucknow.

As Barnett (1977) points out, during the course of the Fifth Plan the sectors which were centrally funded were allocated far more than the other categories, so that in the 1976/77 Annual Plan the state share had dropped to 54 per cent. This pattern of allocations has been repeated in the Sixth Plan, as it was eventually adopted under Congress, but detail on actual expenditures by financial category remains elusive. In general terms, the evidence does support the argument that central dominance in health planning has increased since 1975.

### Integrating the Plan with non-Plan expenditures

So far, I have only considered Plan expenditures. I will now examine how Plan and non-Plan combine in three states for which more data are available.

The main source of information about health expenditures in the states is provided by the Reserve Bank of India, which shows a fairly stable spread of per capita expenditures for the different states, ranging from very high figures in the mountainous northern states (Nagaland, Himachal and Jammu and Kashmir) to very low figures in the Ganges plain (Bihar and Uttar Pradesh). This pattern reflects not only differences in the priority given to health and other social services expenditure (e.g. the relatively high figures for Kerala, a relatively poor state despite its 'middle income' categorization, derived from its tax base); it also reflects the way in which states get access to financial resources, partly from their own tax base but also in different ways from Central Government. As George and Gulati (1985) show, 'low income' States like Uttar Pradesh and Bihar have not received central funds sufficient to outweigh their poverty, but the 'special category' states (basically the hilly ones on strategic borders, like Himachal Pradesh, Jammu and Kashmir, Tripura etc.) have received per capita payments of between 2.25 and (in the case of Nagaland) 9.5 times the national average.

Tables 5–7 present roughly comparable data from Orissa, Gujarat and Maharashtra for differing periods since 1971. The Orissa data come from the annual administration reports for the Health Ministry; Barnett (1977) analysed

**Table 5.** Health-related expenditure for Orissa State, 1972-1979

	1972-73 to 1974-75		1975-76 and 1976-77		1977-78 and 1978-79	
	Total (rupees × 10 <sup>6</sup> )	Plan percentage	Total (rupees × 10 <sup>6</sup> )	Plan percentage	Total (rupees × 10 <sup>6</sup> )	Plan percentage
<b>Medical education</b>						
Undergraduate	10.2	19.6	12.9	3.1	13.4	4.5
Postgraduate	1.3	7.7	1.9	0.0	1.9	0.0
<b>Paramedical training</b>	2.0	45.0	1.5	13.3	1.8	16.7
<b>Medical relief<sup>a</sup></b>	66.3	14.3	103.5	9.3	121.8	15.8
<b>Prevention/control of disease</b>	22.0	76.8	33.4	71.0	34.6	66.5
<b>Public health, sanitation &amp; water supply<sup>a, b</sup></b>	7.3	4.1	11.0	0.0	13.0	0.0
<b>Family planning</b>						
Compensation	3.0	100.0	21.1	100.0	11.8	100.0
Paramedical training	0.8	100.0	0.7	100.0	5.0	100.0
Other <sup>a</sup>	17.9	100.0	25.8	100.0	29.4	100.0
<b>Total</b>	129.7	38.7	211.8	38.5	232.7	38.4

Sources: GOO for the relevant years.

*Notes*

- <sup>a</sup> Administration expenses for the medical directorate are included in the total for 'Medical relief'; for the family planning directorate in 'Other' and for the public health directorate in 'Public health, sanitation & water supply'.  
<sup>b</sup> Most expenditure under this heading is carried out by different departments and so does not appear in these sources.

**Table 6.** Distribution of health-related expenditure by major categories

	Orissa 1972-73 to 1978-79 (%)	Maharashtra 1972-73 to 1974-75 (%)	Gujarat 1980-81 to 1984-85 (%)	Gujarat 1980-81 to 1984-85 (%)
<b>Medical education</b>				
Undergraduate	6.3	6	4.3	4.4
Postgraduate	0.9			
<b>Paramedical training</b>	0.9		0.1	0.6
<b>Medical relief</b>	50.7	25	19.6	27.9
<b>Prevention/control of disease</b>	15.7	14	10.0	12.4
<b>Public health, sanitation &amp; water supply</b>	5.4	28	45.6	24.5
<b>Family planning</b>				
Compensation	6.2	5	3.9	5.8
Paramedical training	1.1	9	0.3	1.5
Other	12.7		5.2	8.6
<b>ESIS</b>	—	13	7.8	9.3
<b>Indigenous medicine</b>	—	NA	1.6	2.8
<b>Other</b>	—	NA	1.6	2.3
<b>Total</b>	100	100	100	100

Sources: GOO for relevant years; Barnett (1977); Khan and Prasad (1985).

*Notes*

All figures exclude nutrition.

The 1980-81 to 1984-85 figures for Gujarat and Maharashtra are expected expenditures.

For Maharashtra, administration expenses are divided between medical and public health 75:25 and are included in the figures for 'Medical relief' and 'Prevention/control of disease' respectively. Non-Plan 'Water supply & sanitation' figures for Maharashtra have had to be estimated, using Gujarat Plan:non-Plan proportions.



Maharashtra budget data and Khan and Prasad analysed Sixth Plan proposals and accounts for Gujarat and for Maharashtra. Orissa is a relatively poor state, though it has sizeable industrial areas which provide it with a more substantial tax base than this would suggest. Maharashtra and Gujarat are relatively wealthy.

### Expenditure by category

There are several points with respect to Table 5. Firstly, as would be expected, the Plan share varies from less than 20 per cent of some categories (e.g. medical relief) to 100 per cent of others. Secondly, some distinctions relate to budgetary categories which might be much less distinct on the ground, as for example in the separation of expenditure on medical college hospitals (in the medical relief category) from the expenditure on the medical colleges themselves (under medical education). Thirdly, there are other departments in Orissa which undertake most public health engineering works (water supply, sanitation) and I have been unable to collect comparable data on their

expenditure, so the total under this heading is an understatement of Orissa Government expenditure in public health. This makes inter-state comparisons very difficult. As Table 6 demonstrates, Gujarat and Maharashtra show very different distributions, because there the Health Department is responsible for most of such expenditure, totalling nearly 30 per cent of all health-related state expenditure.

Table 5 also gives some idea of the impact of the State of Emergency of 1975–77 on the health budget. Compensation to clients for sterilization operations rose from 2 per cent of the total health-related expenditure in the early 1970s (in both Orissa and Maharashtra) to 10 per cent in the two years of the Emergency and remained over 5 per cent of the total in 1977/78 and 1978/79, 'poor' years for sterilizations. Indeed, of the apparent increase in per capita 'real' (1970/71 prices) Health Department expenditures in the Emergency over the preceding years over 25 per cent can be explained purely as the increase in compensation payments.

**Table 7.** Distribution of expenditure by level of care

	Orissa 1972–73 to 1978–79 (%)	Gujarat 1980–81 to 1984–85 (%)	Maharashtra 1980–81 to 1984–85 (%)
<b>Administration</b>	8.9	3.3	6.9
<b>Tertiary services</b>			
Medical education	7.1	4.4	4.3
<b>Secondary services</b>			
Medical relief, of which:	31.2	37.2	23.4
Hospitals, dispensaries	31.2	25.1	14.0
ESIS	NA	9.3	7.8
Indigenous medicine	NA	2.8	1.6
Paramedical training	2.1	2.0	0.4
<b>Primary care, of which:</b>	50.4	50.7	63.4
Family welfare			
Services	11.4	6.2	3.9
Compensation	5.6	5.8	3.9
Disease control	15.9	12.4	8.5
Primary health centres	17.4	a	a
Health education and school health	0.2	0.2	0.1
Water supply and sanitation	—	23.8	45.6
Community health volunteers	NA	2.2	1.4
<b>Other</b>	0.2	2.3	1.6
<b>Grand total</b>	(%) 100	100	100
(Annual average rupees × 10 <sup>6</sup> )	183	1 203	3 069

Sources and notes: see Table 6.

a Primary health centre figures for Gujarat and Maharashtra are included in the hospital and dispensary totals.

### Expenditure by level of care

Table 7 recategorizes expenditure by whether it is essentially intended to provide 'primary', 'secondary' or 'tertiary' care. In brief, primary care is designed to meet the major common health problems of the population, whether curative, promotive, rehabilitative or preventive in focus; secondary care provides more specialized services, usually after some referral from a primary facility and tertiary services are the most specialized and least accessible. There are problems with this analysis: most discussions of the categories are not conceptually clear-cut (see, for example, Cole-King 1977). It is particularly difficult to allocate expenditures on education and training, which may produce staff who are to work in all three sectors. In addition, a facility like a medical college hospital, which is nominally designed to provide highly specialized referral services may actually provide primary care services to the surrounding population. A further problem is that expenditures in one category might really be very different, as in cases where staff are paid from one budget head (say, primary health centres) but are on secondment elsewhere (say, in a medical college). In general, I assume that this will not involve large sums, and that accounting controls are sufficiently tight to ensure that most money is spent in the category to which it is allocated.

The Maharashtra and Gujarat sources also allow some information about the major topics on which the money is spent. In both cases, a substantial portion of the total budget was spent by local government authorities, who do not provide detailed accounts available centrally, so there is some uncertainty about expenditure patterns. Khan and Prasad (1985) also exclude water supply and sanitation from their analysis. They conclude that during 1980–84 about 50 per cent of medical, public health and family welfare expenditure for each state went on salaries; between 15 and 25 per cent on drugs, materials and other supplies and between 8 and 10 per cent on family planning incentives and compensation payments.

Table 7 suggests the need for some caution in concluding in a straightforward manner that public expenditures in health are concentrated on big urban hospitals – though since 'large' is undefined, there is room for some dispute on

this. The actual total to be regarded as 'true' primary care can also be disputed: many would argue that family planning (in the Indian context at least) is too coercive to be regarded as 'health care', and even those favourably inclined towards family planning might acknowledge the dubious status of compensation payments. Nevertheless, in an intentional context, these figures seem to show that Indian health expenditures are less heavily biased in the 'wrong' directions than might have been predicted.

### Conclusion

This paper has been concerned with patterns of public sector health-related expenditure in India and the administrative processes through which they arise. Several conclusions can be drawn from this analysis.

Firstly, in health planning it has been the Planning Commission which has championed the preventive, public health aspects of health expenditures. In both the Third and the Fourth Plans, the Health Ministry proposals would have given far more weight to urban, curative facilities, but the Planning Commission radically altered the balance of proposed Plan expenditures towards primary care. It seems likely that medical personnel have been dominant in policy proposals within the Health Ministry, but have been less successful in negotiations with economists and administrators in the Planning Commission. The Planning Commission has also been supported by foreign advice and financial assistance, reinforcing the pressures for preventive single-disease control programmes which were so significant in the 1960s.

Secondly, the balance between major categories of health expenditure has shifted dramatically towards family planning. This has happened partly because family planning spending has been a channel under the closer control of the Central Ministry of Health than other aspects of health expenditure, and partly because of the ideological commitment to population control. The shift is most marked (somewhat misleadingly so) in Plan expenditures, and some parts of the family planning budget have a rather ambiguous status (e.g. compensation and paramedical training). Nonetheless, this shift has been a real one.

Finally, as we have seen in the case of Orissa, the total share of the state budget going to health-related issues seems to have declined steadily over the course of the 1970s. Nonetheless, the distribution of health expenditure between functional categories has remained remarkably solid, with at least 40 per cent in primary care, and on some definitions nearer 50 per cent. This is surprising, given the evidence on state-level politics. This suggests that funding medical colleges and urban hospitals is much more attractive politically, because these offer greater opportunities to meet the demands of the urban, propertied classes. In general, it seems best to avoid making very direct links between India's political economy and its pattern of health care: matters are a good deal more complex.

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