

POPULAR SERIES No.3

SOCIAL DIMENSIONS OF HEALTH

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I

The World Health Organisation's Sixth Report on the World Health Situation covering the period 1973-77 and published in 1980 states that the most significant development during the period has been "the explicit recognition of the view that health development is a reflection of conscious political, social and economic policy and planning, and not merely an outcome (or by-product) of technology". The Report goes on to say: "This recognition, in turn, has been reflected in the very lively discussions that have taken place, both among and within countries, about the vital links between health and development and the political, economic and social factors involved." At the international level the Alma-Ata Conference in 1978 declared : "The Conference strongly reaffirms that health ... is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realisation requires the action of many other social and economic sectors in addition to the health sector", and indicated "the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life" as a target for governments, international organisations and the whole world community.

This call given at Alma-Ata has been picked up by several agencies in different parts of the world and several blue-prints have appeared suggesting strategies to reach the target. In our country a study group set up jointly by the Indian Council of Social Science Research and the Indian Council of Medical Research has brought out a report with the title : Health for All-An Alternative Strategy(1980).

* Keynote Address, Workshop on "Manpower Planning for Health and Development", 12th Annual Conference of Indian Association of Preventive and Social Medicine, January 1982.

This Report states that a comprehensive statement on the health policy of a society should cover:

- (1) a philosophical dimension which deals with issues like the concept of health, value systems affecting health, and attitudes to illness, pain, ageing or death which, in the final analysis, determine the nature and quality of the health services;
- (2) a cultural dimension which deals with life-styles of people which have far-reaching consequences on the practice of health;
- (3) a social dimension which deals with the social, economic and political organisation of the society as a whole because this totality has a tremendous impact on the health of the people ...;
- (4) an environmental dimension which deals with problems like public sanitation, pollution, water supply, housing, or settlement patterns, with a view to creating a physical environment that is promotive of health;
- (5) a nutritional dimension which deals with the fundamental issue of making adequate quantities of food of the appropriate quality available to all;
- (6) an educational or promotive dimension which defines the roles and responsibilities of individuals and families in maintaining a healthy society and the creation of adequate institutional structures to enable them to play these roles and to discharge these responsibilities;
- (7) a preventive dimension which deals with problems relating to the prevention of avoidable suffering, disease, or untimely death; and
- (8) a curative dimension which deals with measures for the provision of adequate and appropriate treatment when, despite all efforts, disease or ill-health does manifest itself.

This may appear to be too overwhelming a frame to discuss matters relating to health. It will be readily admitted, however, that the medical profession's approach to health is usually confined to the last two dimensions in the list but a broader frame is required for any meaningful and effective approach to health. In this paper I shall attempt to place the problem of health in a wider perspective taking into account some of the societal factors that have a bearing on health.

II

We may, first, examine the relationship between health and economic conditions. It would have been useful to have this relationship brought out with reference to our own country. However, information necessary for this purpose is not readily available. Hence we may rely primarily on information available from international comparisons. Life expectancy at birth, for instance, is seen to be closely related to levels of income. At the world level estimated life expectancy at birth in 1975 was 56-57 years. In the more developed regions it was 70 years (North America 73 years, Europe 70 years, USSR 70 years and Japan 74 years) but in the less developed regions it was much lower, around 50 years in South Asia, 50-55 years in Northern Africa and a little over 60 years in Latin America. Infant mortality rates show even larger variations. In many African countries and Afghanistan IMR is 200 or more per 1000 live births. In most Asian and many Latin American Countries it is over 100 (India 125 in 1978) whereas in countries with higher levels of per capita income it is less than 40, in some cases even less than 10. According to information compiled by the United Nations, developed and developing countries differ also in the causes of death. Infections, parasitic and respiratory diseases account for as high as 43.7 per cent of deaths in developing countries whereas their share is only 10.8 per cent in the developed countries. On the contrary, diseases of the circulatory system cause only 14.8 per cent of deaths in developing countries, the figure for developed countries being 32.2. Cancer causes 15.2 per cent of deaths in developed countries, and 3.7 per cent in developing ones.

Statistics available show that even within countries health patterns differ according to income levels and social classes. Socio-economic differentials in mortality have been studied in detail only in a relatively small number of countries. But the WHO's Sixth Report on the World Health Situation states that in very broad terms the relatively underprivileged in any society suffer from health risks and levels of mortality that are substantially greater than average. Data relating to three Western countries and a combination of twelve Latin American countries show that the mortality experienced by the lowest five socio-economic groupings has been between 20 per cent and 300 per cent higher than that experienced by the highest ranking grouping. Not surprisingly the greatest relative differentials in socio-economic mortality operate during infancy. According to data pertaining to Britain, in 1970-72, the mortality rate during the first week of life for babies in the lowest social class was just under twice the rate for those in the highest social class, but by the end of the first year it was four times as great, which goes to show how tremendously important social and economic conditions are in determining who will survive beyond the first year of life. British figures show that even morbidity statistics show very pronounced class bias. Thus, in 1976 chronic sickness rate was 160 per thousand among employers, 185 among professionals, but 270 among skilled manual labourers and 369 among unskilled workers.

Per capita income, of course, is just a short hand representation of a variety of factors affecting real levels and conditions of life. It is possible to go into some details of these conditions as they affect health. According to FAO statistics quoted by WHO, malnutrition is the "biggest single contributor to child mortality in developing countries". In some Latin American countries, for instance, malnutrition has been found to be the primary or associated cause in about 60 per cent of all deaths in the age group 1 to 4 years. ^{The} FAO study also stated that "of the 800 million children growing up at present in developing countries more than two thirds will encounter sickness or disabling diseases either brought on or aggravated by protein-calorie malnutrition".

While there is, on the whole, a close connection between levels of living as indicated by per capita income and indicators of health, there are instances where conditions of health can be seen to be far above what could be associated with a given per capita income. In international comparisons Sri Lanka is the frequently quoted instance of this divergence. Sri Lanka's per capita income in the mid seventies was similar to that of India's, approximately 150 US dollars. But life expectancy in Sri Lanka at that time was 66 years and infant mortality rate 49 per thousand, both of which would place the country among the more developed ones. Within India Kerala is a case of this kind. In terms of per capita income Kerala comes below the low all India average, but in terms of health indicators it is way above all other States in the Union (See Table I). Thus, while the all India death rate in 1978 was 14.1 and that of Punjab, the State with the highest per capita income was 11.6, Kerala's was as low as 7.0, low enough to place it among the most advanced countries in the world. In terms of infant mortality rates also Kerala's position is seen to be distinctively different. In 1970 the rural IMR in Kerala was 55.9 compared with the all India figure of 136.4, of Punjab's 103.7 and Uttar Pradesh's 165.4, the highest among the States in the country. Kerala's urban IMR was 39.7, Punjab's 86.5 with Gujarat showing the highest among the States of 131.0 while the all India figure was 89.9. In the case of Sri Lanka and Kerala these departures are usually explained in terms of their high literacy rates, particularly among the females which goes to show that apart from per capita income and general conditions of living, educational standards have a major bearing on health. Hence the gulf in health standards between the richer and poorer countries of the world and between upper and lower sections within countries must be seen as resulting from the combined impact of levels of income and educational standards. Thus Scheduled Castes in India and estate workers in Sri Lanka show sharply inferior health status compared with the average levels for their populations as a whole.

III

We may now turn to a more detailed discussion of the socio-economic factors that influence health conditions in India. Some of these aspects are dealt with in the Report of the ICSSR-ICMR study group : Health for All. Only about 64,000 or 10 per cent of the villages have adequate water supply of acceptable quality. Another 2,14,000 villages have adequate supply but with pollution risk; 1,85,000 have adequate but unprotected sources. According to the Survey of Infant and Child Mortality, 1979 by the Registrar General of India, in rural areas with reasonable water supply the IMR was 108 compared with 134 in places without water supply. In the urban areas the respective IMRs were seen to be 66 and 94. Health for All states that "there is a close relationship between housing and health" and that "there is an overall housing shortage in the country", but does not give any specific details. There are old classics like John Robertson's Housing and Public Health (1919) which established, on the basis of enquiries conducted in the United Kingdom that death rates, and infant mortality rates in particular, were considerably higher in bad housing areas compared with fair-class housing areas. A recent study relating to Lucknow showed that infant mortality was as high as 222 among persons living without any house and was less than half of that among those having at least one room.²

Another major factor that has a bearing on public health is sanitation and sewerage. Health for All states : "The problem of rural sanitation has been most neglected. Very little has been done throughout the modern period and most village people live, even today, in primitive sanitary conditions". According to a survey conducted by the National Sample Survey organisation in 1973-74, 80 to 95 per cent of rural households in our States did not have access to a latrine. In the urban areas one third of the households had no latrines whatsoever and it was estimated that seven million households out of a total of 40 million use the open ground for defecation. Another one-third had basket service and about 25-40 per cent of the night soil remained uncollected. It is well known that many widespread diseases in countries like ours, are transmitted by human faeces. The faecally-related or faecally transmitted diseases share a common origin: the contamination

of food, water or soil with human waste. Where water is not safe for drinking, or is insufficient for personal hygiene and sewage disposal, diarrhoeal diseases tend to spread more easily. Typhoid, dysentery and cholera are spread in this way, as also other intestinal infections which are responsible for many deaths, particularly among infants and children. In a case study in Punjab a death rate of 3,446 per 100,000 infants from acute diarrhoeal diseases was reported.

All these go to show that malnutrition, poor living conditions, inadequate and unsanitary water supply and extremely poor sewerage facilities, which are all specific manifestations of mass poverty, are close correlates of low levels of health. Thus a major societal factor in our health situation is mass poverty with close to 50 per cent of the population below the 'poverty line' even after three decades of planned economic development. Health for All is right when it says: "Poverty itself is an extremely tenacious disease. It must be directly attacked to improve the health status of the people".

Against this general account we may now turn to some economic aspects of health and health care in the country. In a review of planning for social services upto 1978 the then Deputy Chairman of the Planning Commission pointed out that expenditure on social services including education, health and housing was very low in our country, and public expenditure on these items as a percentage of total public expenditure was declining over time.³ He referred to the findings of the 28th Round of the National Sample Survey (1973-74) according to which the per capita monthly private expenditure on medicine was Rs.1.40 in urban areas and Rs.1.02 in rural areas and on doctors, nurses and midwives was Re.0.17 in urban areas and Re.0.11 in rural areas. There is considerable regional variation on these items and the State-wise details are given in Table II. While the absolute figures are terribly low they amounted to a total of Rs.843 crores for one year. There was also a public expenditure of Rs.280 crores that year. This means that 75 per cent of total expenditure on health was private with only 25 per cent coming from public sources. This was in sharp contrast with the expenditure

pattern on education of that year where out of a total of Rs.1699 crores as high as Rs.1340 crores or close to 79 per cent came from public sources.

The outlays on the health sector in the Five Year Plans (from the First to the Fifth Plan) are shown in Table III. It is seen that outlay on the health sector as a share of total plan outlay declined from 4.98 per cent during the First Plan to 2.13 per cent during the Fifth Plan. However, in view of the absolute increase in plan outlay over time, per capita expenditure on health by the Government (Central and State) continued to increase during this period. It was Rs.1.50 in 1956, Rs.2.35 in 1961, Rs.3.79 in 1966-67, Rs.7.72 in 1973-74, Rs.9.44 in 1974-75 and Rs.10.63 in 1975-76. The Sixth Plan has provided for Rs.1821 crores for health including medicine which is 1.87 per cent of the total outlay of Rs.97,500 crores. If the amount of Rs.408 crores provided for rural health under the minimum needs programme is also included, the total goes up to Rs.2229 crores, or a little over 2 per cent of the total outlay.

It will be useful to see also how the total public expenditure on health is actually utilised. The figures for 1979-80 are given in Table IV. Out of a total outlay of Rs.268.18 crores, a little more than half (Rs.136.19^{crores}) was spent on various eradication and control programmes jointly by the Central and State governments on a 50 : 50 basis. Another major amount (Rs.97.21 crores) consisted of plan outlays of States. The States, naturally differ in the quantum and pattern of their expenditure on medicine and health. The total amount that they spend each year is not confined to plan outlays which represent the expenditure on additional facilities started in that year and the maintenance expenditure on facilities created in the current plan period. A clearer picture of the manner in which a State government spends resources on health and medicines can be seen from the budget figures which indicate total expenditure, plan and non-plan. Table V gives a functional classification of medical and health expenditures in Tamil Nadu from the 1981-82 budget. It is seen that over 40 per cent of the total is spent on hospitals, 13 per cent on primary health facilities, and close to 8 per cent on medical education.

An understanding of the expenditure pattern on health is certainly important, but it is equally important to note that health conditions do not depend exclusively on the amount of money spent for the purpose. This has been brought out by a detailed analysis of the case of Kerala which, among our States, has the best record in terms of health indicators. The major findings of that study are as follows: "Judged in terms of conventional indices of health such as general mortality rate, infant mortality rate and life expectancy, Kerala stands out from the rest of India. What really distinguishes the performance of Kerala compared to that of other States in India is the improvement in the health status of the rural population in general and of children and infants in particular. Kerala's achievement in the health field becomes all the more significant and of great relevance to low income countries when viewed against the facts that the level of per capita income, per capita expenditure on health, and medical infrastructure measures in terms of bed-population ratio, doctor-population ratio etc. are even lower here than in some other Indian states. The reason for the better health status in Kerala lay as much in the state having given equal importance to preventive and promotive measures like sanitation, hygiene, immunisation programmes, infant and ante-natal care, health education, etc. as curative medicine. Moreover, the spread of education, especially among women in the rural parts of Kerala was probably a crucial factor contributing to the high degree of awareness of health problems and fuller utilisation of the available health care facilities. The conclusion to which this case study leads is that given proper policies and priorities, lack of resources need not be an impediment to the improvement of health status even in low income countries." (P.G.K. Panikar, "Resources not the Constraint on Health Improvement - A Case Study of Kerala". Economic and Political Weekly, Nov.3, 1979).

IV

Kerala's experience indicates clearly that working out an appropriate health policy and ensuring cost-effectiveness in the actual

implementation of that policy are tremendously important if any improvement is to be made in the conditions of health of our people. As a signatory to the Alma-Ata Declaration the country is committed to the goal of 'Health for All by 2000 A.D.'. The ICSSR-ICMR Study group Report is right in pointing out that for the achievement of this goal many radical and far-reaching changes will be required in other spheres in society, especially in economic set up and conditions and in education. Whether all these will be realised in the next two decades is a moot question. Certainly we must strive towards such changes. While so doing a meaningful question can be raised, and hopefully answered, as to what should be the direction that health services and health policy should take to reach the goal. I am not qualified to examine all aspects of that question. I can only touch upon some aspects, particularly those that are more immediately related to the broader social issues.

One of the first things that strikes even a casual observer of the Indian health scene is the heavy concentration of medical facilities in the big cities and urban centres to the gross neglect of the rural areas. To give just one example, in 1977, the population-bed ratio was 761 in Madras city, but 6901 in the rural areas of the State. Neither Madras City nor Tamil Nadu is exceptional in this regard. What is seen in this case is typical of what obtains throughout the country. According to figures available for 1974, only 25.4 per cent of hospitals and 11.2 per cent of hospital beds were located in the rural areas taking the country as a whole. Hence, one can fully endorse the Sixth Plan's statement : "Emphasis would be shifted from development of city based curative services and super-specialities to tackling rural health problems. A rural health care system based on a combination of preventive, promotive and curative health care services would be built up starting from the village as the base." But acceptance of this "in principle" is not enough. Detailed examination of how the principle is to be operationalised is necessary. In so doing at least two main societal factors have to be confronted. The first relates to the "social use of doctors" as a writer puts it, in the production of each one of whom a considerable social investment is involved.

More doctors have to be made to serve in rural areas giving their undivided attention to the task of public health services and not merely to private medical practice. The second is to recognise the fact that if the village is to be the base and the focus of the health programme, it is necessary to pass on a great deal of the responsibility - not merely for implementation, but for decision making as well - to that level. After realising the failures of a heavily centralised system of planning we have been, for a decade or so, paying considerable lip-service to the principle of decentralisation. But what we have been trying out in effect is what I have elsewhere described as 'centralised decentralisation', more heavily centralised decision making to expect - and indeed to demand - a predetermined and uniform pattern of implementation at all lower levels. Several examples of national policy of this kind can be cited, the Backward Areas Programme and the National Adult Education Programme, for instance. It is a sad commentary on our civic life that at a time when there is so much of talk about decentralisation, we have also been systematically squashing all decision-making agencies below the level of the State governments. This is not the place to go into this problem in any detail, but it can be stated categorically that a village based public health programme will not materialise unless the village community is enabled to accept it as its responsibility. Legitimate questions can be raised as to what kind of 'village community' can be presupposed in view of the glaring social and economic disparities in the villages. This question must be seriously examined and it can be conceded that no genuine sense of community will emerge till the societal barriers are removed. However, it must be noted also that health is an aspect for which considerable common interest can be generated in the villages even within the existing situation, provided the members of the village are made aware of the health hazards they are facing and of their own ability to tackle many of them. Professional health and medical programmes must be situated within such a context of awareness.

If this is the case the institutional framework for an effective village health programme must be carefully worked out. The pattern suggested

in the Sixth Plan for this purpose is the following: The village or a population of 1000 would form the base unit where there will be a trained health volunteer chosen by the community. Primary health centres serving a population of 30,000 with sub-centres serving a population of 5,000 will be the basic institutional set up. Facilities for treatment in basic specialities would be provided at community health centres at the block level for a population of 1,00,000 with a 30 bedded hospital attached and a system of referral of cases from the community health centre to the district hospital/medical college hospitals will be introduced. The pattern recommended by the ICSSR-ICMR Study Group in Health for All is similar. "The new health care services should be strongly based in the community so that the people could be intensively involved in planning and implementing programmes for their own health care. By a community we mean a population of about 100,000 which will have a Community Health Centre, with a sub-centre for every 5,000 population and a village or neighbourhood service centre for every 1,000 population. We are of the view that most of the health problems of this community should be taken care of by the community itself and that more than half the expenditure on health services should be incurred within this community. It is from this firm and solid base that the health services should rise to the top, providing supplementary, referral, specialised, and super-specialised services at the district, regional, state and national levels... The second major change we propose is that the almost exclusive emphasis which is placed on large, urban hospitals in the existing system should be eliminated by establishing a small, community hospital of about 30 beds in every community of 100,000 people."

Health for All would like to place this rural health programme in a much broader framework consisting of rapid economic growth, more equitable distribution, employment at reasonable wage for all adults, rural electrification, universal elementary education for children and adult education, improvement in the status of women, improvement of housing and protection and improvement of environment with special emphasis on water supply, drainage and disposal of night soil. All these,

of course, are necessary conditions for health, and one should hope that these will be realised in large measure before the turn of the century. At the operational level what the Sixth Plan has provided for at least partial achievement of these objectives is the Minimum Needs Programme which is described as "essentially an investment in human resource development". In practice it is provision of free or subsidised services through public agencies to improve the consumption levels of those living below the poverty line. Its components are elementary education, rural health, rural water supply, rural roads, rural electrification, housing assistance to rural landless labourers, environmental improvement and nutrition. The total public sector outlay provided for the programme is around Rs.5,000 crores (rural electrification Rs.301 crores, rural roads Rs.1165 crores, elementary education Rs.919 crores, rural health Rs.408 crores, rural water supply ^{crores} Rs.1407/ rural housing Rs.354 crores, environmental improvement Rs.151 crores and nutrition Rs.219 crores).

Another major issue in the context of public health is the training of personnel. Medical education is a frighteningly expensive proposition. On the basis of data from Tamil Nadu it has been estimated that the cost to the State to produce one medical graduate is Rs.44,000.⁵ Is it such education that is required for public health? Health for All points out that the estimated existing stock of 2,20,000 doctors in the country with annual additions of some 13,000 would be more than sufficient for implementing the programme envisaged in it. But the question is not only one of quantity. One does not have to subscribe fully to Ivan Illich's caustic comment that "among all our contemporary experts, physicians are those trained to the highest level of specialised incompetence" to understand that there are incompatibilities between medical training and medical profession on the one hand and public health requirements on the other. It is well known that on the whole the medical profession tends to concentrate on curative aspects. There is a major societal factor responsible for this bias. In an essentially commercially oriented society the curative aspect can easily be converted into a marketable commodity whose supply can be determined and regulated by medical personnel. It can

then be converted into an enterprise of high personal profit because of the demand for private curative services. As incomes increase, and bulge at the top, such demand will continue to grow and those who can afford it will find it lucrative to invest in obtaining the necessary training to meet that demand. That it can be represented as an urge to serve suffering humanity gives the whole commercial operation social respectability. But what really makes it possible is the fact that considerable public resources are diverted to this essentially private profit making activity. On the contrary, there is little private demand or clamour for health services in general and so public resources do not get adequately channelled into activities necessary for public health. This is an inherent problem of an economy which is based and run essentially on considerations of private profitability. And it is for this reason that some people argue, and rightly too, that problems of community interest can be tackled only where resources are allocated on the basis of community decisions, rather than on the basis of demand indicated by the market. It is doubtful whether such a radical transformation of the economy and society will come about in our country in the immediate future. But in the sphere of public health the following three steps are possible even under existing conditions. The first is to insist that since the training of doctors involves enormous public expenditure, all doctors will be required to devote a part of their professional services for matters related to public health, especially in rural areas, for which they will be paid only publicly determined service charges. Secondly, public institutions at local levels, such as Panchayats must have resources available to them to be allocated for public health programmes on the basis of decisions made by the local community. Thirdly, public health programmes must be entrusted to personnel trained specifically for such purposes. Their responsibilities must be primarily to identify community activities necessary for public health, to conscientise the local community about them, and to mobilise local resources and effort. In short they should not have the professional training to divert attention from public health problems into curative operations.

All these are feasible propositions. Whether professionals and lay persons strive to have them implemented will be a test of their concern for public health and their commitment to social causes.

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Table I

Per Capita Income and Selected Health Indicators

of the major States in India.

States	Per Capita income (Rs.) 1978	Birth Rate (per 1000) 1978	Death Rate (per 1000) 1978	Infant Mortality Rates - 1970	
				Rural	Urban
Uttar Pradesh	1018	33.4	13.2	122.2	79.1
Bihar	912	30.6	13.1	138.4	78.0
West Bengal	728	N.A.	N.A.	106.1	75.4
Madhya Pradesh	1426	35.8	12.7	159.2	131.0
Karnataka	1600	33.4	13.4	82.1	61.4
Jammu & Kashmir	986	32.7	11.7	N.A.	N.A.
Goa	1128	28.8	11.7	101.0	73.0
Tamil Nadu	1004	25.2	7.0	55.9	39.7
Andhra Pradesh	900	37.3	15.1	151.7	113.2
Gujarat	1637	26.9	10.3	102.5	84.3
Kerala	820	32.9	14.1	139.8	103.3
Orissa	1966	29.4	11.6	103.7	86.5
Rajasthan	969	35.5	15.6	148.5	104.5
West Bengal	1051	28.8	12.8	133.9	89.9
Uttar Pradesh	949	40.4	20.2	165.4	110.2
West Bengal	1263	N.A.	N.A.	113.4	61.0
India	1210	33.2	14.1	136.4	89.9

Notes: Col. 2 Govt. of India, Planning Commission.

Col. 3 & 4 Pocket Book of Health Statistics of India.

Col. 5 & 6 Registrar General India Sample Registration Bulletin
Volume IX, No.4, October 1975.

Table IIPrivate Expenditure on Health (Rs. Per capita per month)

	<u>Rural</u>		<u>Urban</u>	
	Medicine	Doctors, nurses mid-wife	Medicine	Doctors, nurses mid-wife
All India	1.02	0.11	1.40	0.17
Andhra Pradesh	0.92	0.19	1.19	0.34
Assam	0.56	0.04	0.97	0.09
Bihar	N.A.	0.04	1.21	0.07
Gujarat	0.96	0.06	1.21	0.16
Haryana	1.68	0.05	2.04	0.02
Jammu & Kashmir	1.20	0.01	1.55	0.02
Karnataka	0.87	0.03	0.95	0.12
Kerala	2.32	0.23	2.03	0.25
Madhya Pradesh	0.85	0.23	1.95	0.04
Maharashtra	0.90	N.A.	1.74	0.58
Meghalaya	0.58	0.06	1.76	0.07
Nagaland	0.58	0.01	0.76	0.05
Orissa	0.80	N.A.	1.33	0.24
Punjab	2.17	0.07	2.63	0.05
Rajasthan	0.92	0.07	1.52	0.08
Tamil Nadu	0.59	0.04	1.00	0.13
Uttar Pradesh	1.20	0.01	1.31	0.02
West Bengal	0.65	0.07	1.44	0.22

Source: Government of India, National Sample Survey, 28th Round (1973-74)

Table III

Outlays on the Health Sector (Rs.Crores)

Plan	Centre	Centrally sponsored	States/UT	Total	P.C. of total plan outlay
First Plan	13.8	-	87.1	100.9	4.98
Second Plan	90.0	-	183.8	237.8	4.58
Third Plan	14.8	5.5	205.6	255.9	2.60
1966-69	16.8	11.1	112.2	140.1	2.11
Fourth Plan	53.5	176.5	203.5	433.5	2.14
Fifth Plan	75.8	177.0	543.2*	796.0	2.13

* Inclusive of Rs.291.5 crores for minimum needs programmes for States.

Source: ICSSR-ICMR Study Group, Health for All.

Table IV

Health Sector Outlay : 1979-80 (Rs.lakhs)

I Central Schemes

1. Hospitals & Dispensaries	538.85
2. Medical Education and Research	640.40
3. Training Programme	1.80
4. Control/Eradication of Communicable diseases	112.53
5. Indian systems of medicine and Homeopathy	365.00
6. Other Programmes	133.80
Total Central Schemes	1792.36

II Centrally Sponsored Schemes

1. Schemes to be transferred to States	226.00
2. Schemes to be continued on 100% basis (Assistance to Post-graduate Depts.ISM etc.)	60.00
3. Schemes to be continued on 50:50 basis (Control of Malaria, Filariasis, T.B., Leprosy, STD, Cholera, etc.)	13619.09
Total Central Sponsored Schemes	13905.01

III Plan Outlay - States 9721.00

IV Plan Outlay - Union Territories 1400.00

Total Health Sector Outlay 26818.37

Source: Government of India, Ministry of Health and Family Welfare:
Pocket Book of Health Statistics of India, 1980.

Functional Classification of Medical and Health Expenditure in
Tamil Nadu 1981-82.

	Expenditure in Rs. Crores	Percentage to Total
1. Administrative & other overheads	5.18	5.3
2. Buildings	14.13	14.5
3. Employee State Insurance	7.02	7.2
4. Public Health Regulations	1.54	1.6
5. Indigenuous Medicine	1.71	1.8
6. Medical Education	7.37	7.6
7. City Hospitals	12.81	13.1
8. District Hospitals	27.37	28.1
9. Communicable diseases	7.18	7.4
10. Primary Health facilities	13.13	13.4
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	97.44	100.0
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Source: S. Guhan, Health in Tamil Nadu : Facts and Issues
Working Paper No. 21, Madras Institute of Development Studies,
October 1981.