The Health Budget in Karnataka

A Preliminary Study

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Butch, the worst of human ills
[Poor Tottles found] are "little Bills"!
And, with no balance in the Bank,
What wonder that his spirits sank?
Still, as the money flowed away,
He wondered how on earth she spent it.
"You cost me twenty pounds a day,
At least*! Cried Tottles [and he meant it].*

She sighed. "Those drawing Rooms, you know!
I really never thought about it:
Mamma declared we ought to go—
We should be nobodies without it.
That diamond-circlet for my brow—
I quite believed that she had sent it,
Until the Bill came in just now—"
*"*Viper*!" cried Tottles [and he meant it].*

Poor Mrs. T. could bear no more,
But fainted flat upon the floor.
Mamma-in-law, with anguish wild,
Seeks, all in vain, to rouse her child.
"Quick! Take this box of smelling-salts!
Don't scold her, James, or you'll repent it,
She's a dear *girl, with all her faults—"*
"She is!" groaned Tottles [and he meant it].

"I was a donkey", Tottles cried,
"To choose your daughter for my bride!
'Twas you *that bid us cut a dash!*
'Tis you *have brought us to this smash!*
You don't suggest one single thing
That can in any way prevent it—"
"Then what's the use of arguing?"
*"*Shut up*!" cried Tottles [and he meant it].*

Lewis Carroll

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Acknowledgements

This is a revised version of a study undertaken for the Task Force on Health and Family Welfare set up by the Government of Karnataka. A section dealing with foreign loans for the health sector has been dropped, as, with the available data, the links between loans and health expenditures were not at all clear. The paper incorporates changes suggested by the Task Force on the draft submitted earlier. It is still, however, quite preliminary. Rather than provide answers, it provokes new questions. We hope this quality will be found useful by all those concerned with health finances and planning in Karnataka. A debate should take us all forward.

We are grateful to all who helped us. In particular, we would like to thank Dr H Sudarshan, Dr CM Francis, Dr Thelma Narayan, Shri P Padmanabha, Shri Sanjay Kaul and several other officials in the Health and Finance Departments for taking time out to discuss issues and provide help in accessing data. Comments by Sunil Nandraj of CEHAT in Bombay were especially helpful. Our colleagues in CBPS worked very hard amidst frustrations of power failures and data corruption. But none of them is responsible for errors of fact and opinion that remain.

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1. Introduction

This monograph is organised as follows. In section 2, the budget system, concepts, and limitations are discussed. In section 3, the results emerging from an analysis of the available data in Karnataka are presented. Section 4 is a brief conclusion.

Health, it has often been said, is not just the absence of disease, but a positive state of well-being for an individual and for a community. And this is essential in all aspects of life, be it the health of the people or the health of the finances which are a crucial input into the governing system. Health of all is primarily a state's responsibility. The Directive Principles of State Policy in the Indian Constitution [Part 4] make this clear.

The UNDP has given the health status of the population an important place in its Human Development Reports. It also has an important place in the Planning Department's Human Development in Karnataka [1999]. The overall picture emerging from the state HDR is one of deprivation in health matters. There is also great variation across the districts of the state. There is much to be done. In appointing the Task Force on Health and Family Welfare with a distinguished membership, the state government has sought expert advice in dealing with health matters in a professional manner. This is to be welcomed, and this small effort of ours should be seen as part of this overall exercise.

Much has been done in terms of focussing on preventive and public health, and encouraging public participation in the provision of health services. The private sector in different forms has played a major role in service provision, and individuals have spent considerable amounts on health matters. In spite of this, the state's role in the overall administration and implementation to cover the whole population in health matters cannot be ignored. Rather, the state has a key role to play in ensuring that health services of adequate standard are available to citizens. In the process, it may use private parties for certain functions, but that does not absolve the state of its overall responsibility. It is in this background that we look at health finances.

Health is a subject in the state list in the Indian constitution: the primary responsibility for health services provision lies with the state government. The union does have a role, but it is in providing guidance and resources for matters of national priority. The state of Karnataka has so far been providing these services through the Ministry of Health, which is responsible for policy matters, and the Directorate of Health and Family Welfare, which is responsible for implementing these policies in the state[1]. For this purpose, it has an elaborate set up at state, district and lower levels. This set up is well established in the state governmental system.

[1] There is also the Department of Medical Education, dealing with higher education in the field, that we exclude from this study.

In 1993, the Constitution was amended to bring in a third tier of local self government, and health is a subject that is also in the list of subjects that states' may place in the purview of these bodies. In rural areas, with which this monograph is concerned[2], this refers to the three levels of panchayats--zilla, taluk and gram panchayats. These panchayats are the local manifestation of the state[3]. All of the department employees at the district level have been deputed to the zilla panchayats in Karnataka—and they are to implement the various schemes, state, central and centrally sponsored. There is today some tension between the departmental employees and the newly established political local panchayats[4]. This is not surprising at a time of structural change.

In this transition from a political system that consisted of two levels—union and state—to one of three levels, union, state and panchayat—several problems have arisen. These will undoubtedly be sorted out in time[5]. However the major responsibility of financing the health sector still rests with the State government—and it will continue to do so. The zilla panchayat so far only acts as a conduit for the transfer of funds. It can take on more responsibility, but the fiscal responsibilities of the GOK will remain.

Health is today set in a complex context of multiple levels of government action. In Karnataka, which has been a pioneer in panchayati Raj experiments[6], this is especially true. The department is manned by doctors, administrators, para-medical staff, health inspectors, etc. And the form of implementation, which was completely departmental, has changed [to a small extent] to provide a role for panchayats. Elected representatives now make demands upon the staff of the health department in the local areas. This has led to controversy and differences of opinion: by and large, the department is not convinced that transferring responsibility to the panchayats will serve a positive long term goal[7]. They would like to limit the role of panchayats, at least where health issues are concerned. This is the background for the present study.

The present study looks at the following issues: (1) the expenditures of medical and public health and (2) the expenditures of health-related sectors.

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[2] The health situation in urban areas deserves an independent study. This is a limitation of this study to be noted at the outset.

[3] A point that is often not realised, or contested. See Vinod Vyasulu, Decentralisation from Above, CBPS, Bangalore March 2000.

[4] D.Rajasekhar, Sashikala Sitaram and Vinod Vyasulu, "Decentralisation in Karnataka" paper prepared for the World Bank, June 2000. Also, discussions with the officials while conducting the study.

[5] Vinod Vyasulu, "Decentralisation, Democratisation, Finances and the Constitution," Paper prepared for the Panel on Decentralisation of the National Commission to Review the Working of the Constitution, Bangalore, November 2000.

[6] For an overview, see D Rajasekhar et al, op cit. Also Vinod Vyasulu, Decentralisation from Above, CBPS, Bangalore March 2000, op cit.

[7] This has been a major area of debate in the Task Force.

Ideally this should include the following:

a. analysis of expenditures of medical and public health – urban health services (UHS), rural health services (RHS) and public health services (PHS) for the revenue, capital, and loan accounts and
b. analysis of expenditures of related sectors, viz., (I) water supply and sanitation; (ii)social security and welfare; (iii) nutrition; (iv) family welfare

To study the above, the data that we have used are as follows:

1. The Research and Statistics Wing of the Finance Department of the Government of Karnataka (GoK) has collated information on the expenditure patterns (head of account wise) for the period 1960- 1990. We have taken the major head-wise expenditures for M&PH; WSS; Nutrition; General education; and Family Welfare for revenue, capital, loan accounts, wherever possible – 1960-61 to 1989-90 from this document.
2. The Finance Department, GoK has an Accounts Reckoner[8] for 1990-2001. This gives the major headwise data for the 1990s. This has been used to get the figures for revenue expenditures, capital outlay and loan receipts and disbursements[9].

Both these sources present data at the state level—district-wise break-ups at local levels are not available. Moreover with the data it is still not possible to do (a) breakup between UHS, RHS and PHS and (b) to say what proportion of loan is towards health per se from the larger division between central schemes, centrally sponsored and state sponsored schemes. It is understood that the loans from the Government of India come in different forms for the central schemes, centrally sponsored and state sponsored schemes. The breakup is 70:30, meaning, 70% of the funds come as loans and rest 30% comes as grants-in-aid. Even where funding from donors abroad is concerned, it reaches the state government in this form. For the state, 70% is a loan to be repaid to the union. The state is not concerned in repayments abroad, and the risk from exchange rate fluctuations—rupee depreciation—is borne by the union of India[10].

It has not been possible to examine the raw data in the two data sets to establish that they are comparable and represent a continuous series. This is because whereas the first data is from 1960-1993, the second source is only for the 1990s decade. The base for the calculation of deflators has been changed in 1993-94, the cut-off point in the first data set. But both come from the Finance Department of the GOK Hence what we have done is to calculate the growth rates separately for both the data-sets. There are large gaps in the earlier period of 1960-90 for some heads, namely social security and welfare, nutrition, etc. Hence it would not be justified to link them and draw a trend line.

[8] This is an internal document of the Finance Department meant for the use of officials, which was kindly shared with us. This openness is appreciated.
[9] The codes in the budget documents are 2210 and 4210 for medical and public health, and for health related sectors they are 2211, 2215, 2225, 2235, 2236. For capital account it starts with 4.
[10] The union budget may have some information on this aspect—in this study we have not ventured into this analysis. It has to be undertaken for a complete picture.

Before proceeding further, it may be helpful to recall a few facts to provide a context. These are taken from the Government of Karnataka's 1999 report Human Development in Karnataka. While the social sector expenditure of the state has been hovering around 38% of total revenue expenditure, the average annual expenditure on health-related items of expenditure accounts for 25.7% of the total expenditure on social services. This is second only to the share of the education sector of 53%. There is also considerable private expenditure, but that is outside the scope of this paper.

2. The Budget System

Each year, in February or March, the finance minister of the state presents a budget to the state assembly, under Article 202 of the constitution. This lists the revenues available with the state, and the manner in which they are to be spent. This is in an essential sense, the major policy statement of the government, concretely listing its priorities. This budget must be approved before the start of the next financial year—April 1. The budget shows in detail what the government plans to do over the coming financial year. It also presents revised estimates of what has been accomplished in the current year and actual figures for the year past. An analysis of the budget then represents what the government has actually done, as opposed to what it claims in other forums. Hence the importance of ongoing budget analysis.

Apart from the well known Revenue and Capital accounts, Government accounts in India are divided into two categories, "plan" and "non-plan". Plan figures represent new initiatives, while non-plan figures are in the nature of expenditures on past commitments. At the end of a plan period—five years—plan programmes are to be transferred to the non-plan category.

The budget allocates money to "schemes". Schemes are specific proposals for spending money. An example would be a scheme for the eradication of leprosy—a worthy cause. The scheme would then define how leprosy is to be identified, how its magnitude is to be assessed, and how, given certain parameters, the scheme is to be implemented. A scheme brings with it's a set of rules and guidelines on how it is to be implemented, and it provides no scope for modifications[11]. It would specify how much of the allocation may be used in salaries for nurses, how much for the purchase of medicine—in some cases, which medicine also. These schemes are locally implemented by the departmental machinery.

Sometimes it is not possible to transfer a plan scheme of one plan to the non-plan account of the succeeding plan, for a number of reasons—usually a shortage of funds. In such cases, these schemes are carried on under the plan head. This means that salary and other routine payments are paid from plan funds meant to finance new schemes. This has two implications: funds for new and innovative ideas get squeezed, and salary and other routine expenditures make

[11] Given that it is designed by bureaucrats in the capital—of the union or the state—it is designed to meet the requirements of the "average district". No district, is however, average in this sense: each has specific features of its own. Thus it is difficult to implement a scheme at the ground level. But although this is known funds are not given on a broad programmatic basis, such as eradication of chronic diseases, but on clear cut schemes.

their appearance in the plan account. Thus, for recent years and plans, it cannot be assumed that plan expenditures represent new schemes or investments. In fact, as a plan progresses, the salary component of the plan account increases, so that it often only in the first or second year of a five year plan that investment can take place. The usefulness of the 'plan' and non-plan' categorisation has been questioned for such reasons.

Each of the major departments of the state government—of which Health is one—prepare a budget estimate, based on the priorities of the government, and send it to the Finance Department in the second half of the financial year. This forms the basis on which the Finance Minister makes allocation decisions for the various ministries in the government—there is of course a great deal of discussion that precedes the decision. Once approved by the Assembly, it becomes the programme that the ministry will implement in the coming year.

Decisions about plan expenditures at the local level are made in the Planning Department of the state government. The system works as follows:

Based on the allocations for schemes in the current year, and actual expenditure patterns, and the 'target' for the district indicated by the Planning Department, the district officers prepare a draft budget for the next year[12]. This, after formal approval in the zilla panchayat, is referred to the Planning Department. The Planning Department, in consultation with the Finance Department, has a tentative figure within which the year's expenditure must be kept.

Once the estimates are received from the districts, discussions take place between the district officials and the Planning Department officials in the Planning Department, at the end of which a decision is reached about the level of expenditure on plan subjects in each district. This, after consultations with the Finance Department, becomes part of the state budget. Once the budget has been passed by the Assembly, the moneys are transferred to the districts and can be spent. This is the theory.

In reality, the releases of funds approved to the districts depends on many factors—the Ways and Means position of the state, for example. It is not uncommon for small sums due from a government department to be held up for such reasons. Those who are to receive the money are often in the dark about the reasons for the delay. In recent years, with the deterioration in the state of government finances, this problem has become more acute. Thus, the budget figures speak of *intentions*, but cannot be taken as a firm basis for decisions involving spending because of this problem of delayed releases. It adds an unnecessary element of uncertainty into the local system. Programme and scheme implementation then suffers.

Across districts in the State, many of these activities are co-ordinated by the Rural Development and Panchayati Raj Department, under whose control the Chief Executive Officer of the zilla panchayat works. At the local level, the CEO must work in co-ordination with the elected president of the ZP.

[12] In practice, they take the figure for the year past, increase it by 10%, and forward it to their departmental heads. There is little by way of zero base budgeting and the like.

It is possible that several departments are undertaking expenditure that pertains to health. For example, the Department of Disabled Welfare may have an item on, say special hospitals for handicapped people. There could be others of this type. Such items, should rightly be included in a study of health expenditures. But it is a tedious task that cannot be easily undertaken without access to the detailed budget documents. They are *not* taken into consideration in this study. This limitation should be noted at the outset.

The link documents provide information on the amounts allocated to each district under different major and minor heads. It must be noted that actual expenditures may differ from these allocations. Thus, these figures may be seen as representing the stated goals of the government. There may be a difference with what actually happens[13]—this has to be studied separately by looking at the district level expenditures. Such figures are not available in the state capital in detail—collecting them from each district is a tedious and time consuming task.

The state government can only spend money on the basis of approvals by the Assembly, and the procedures that have evolved over the years are rigid and time consuming. For one reason or another, no government has made any attempt to modify these procedures. Thus, even after approval in the Assembly, there are a large number of rules and regulations that make the spending of money by government departments slow and time consuming. Often this results in the objective of the exercise being lost in a morass of paper work.

Recognising this rigidity in the financial system, many states resorted to the method of setting up "autonomous" societies under the Registration of Societies Act, to undertake important projects. These societies were designed to function under the Minister and Secretary of the concerned Department, with a specially appointed Project Director to run the society which enjoys considerable financial autonomy[14]. But it must be noted that they led to greater centralisation at the state level, for they by-pass local governments—and they also did not come under detailed legislative scrutiny[15]. Many of these societies also created a parallel local structure for their work, thus bloating the bureaucracy[16].

The funds available came from different sources. There were the own revenues of the state—what it collected from taxes in its jurisdiction. There were the transfers of the state's share of union taxes, shared with the states' on the basis of the recommendations of the Finance Commissions. And then there were transfers from the Planning Commission[17]. These were union finances that it passed on to the states in programmes of national importance, on soft terms[18].

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[13] A. Indira: A study of zilla panchayat budgets in two districts, CBPS, Bangalore March 2000. Also, Vinod Vyasulu and A Indira, "Education Finances; A District Level Study in Karnataka" CBPS, April 2001, unpublished.

[14] We wonder if the KHSDP is such a body?

[15] For details, see L.C.Jain and A Indira, "Budget Analysis: For Whose Sake?", Keynote Address at an international conference in Bombay, November 5-9, 2000.

[16] Discussed in Vinod Vyasulu Decentralisation from Above, op cit.

[17] These transfers include funds from external donors.

[18] These have been changing. At present 30% is grant and the rest a loan on varying terms, to be repaid over a long period like 25 years. The exchange risk in the case of hard currency loans is borne by the union government.

But the releases to local areas[19] depended, increasingly so in recent years, upon the ways and means position of the state government. Thus, even after budget approval, funds were often not made available because of cash crunches in the state. It is therefore important, to understand the expenditure process at local levels, to distinguish between *allocations approved*, and *releases made* to local bodies. Money allocated may be released in February—then it will be difficult to spend it effectively. To fully appreciate the complexities involved, a study of releases is also necessary. In this study however we have not taken into consideration releases but actual expenditures at the state level as these are the audited figures placed in the House. At the district level, we deal with allocations only. Further work is needed to confirm or reject these findings on an empirical basis. This is only a "first-cut" analysis.

3. The Results at the State Level

We present below the results of a simple analysis of the data available under the heads of health, and health related finances at the state government level.

3.1 Medical and Public Health:

Here under Medical care is included medical relief, which consists of conventional curative medical facilities such as PHCs and sub-centres, hospitals and dispensaries; indigenous systems of medicine; health insurance schemes for formal sector employees and their families; medical education and research; direction and administration. Under Public Health comes prevention and control of communicable diseases, health education, immunisation and other public health activities.

Average growth rates for the period 1960-61 to 1989-90 shows that M&PH has shown under the revenue account a growth of 4.2% for total expenditures, 3.33% growth for non-plan and 0.82% growth in plan expenditures. This would imply that little by way of investment is taking place—a warning for the future health of the system.

As a percent of SDP it is seen that the expenditure on health services in the 1960s it was 0.6%, 0.8-1% during 1970s; and from 1 to 1.1% in 1980s and 90s. The per capita expenditure has risen from around Rs.8/- in 1960-61 to Rs.21/- in 1989-90[20]. Whether this is adequate or not needs to be judged with reference to a standard norm—we are not aware of one. Also relevant will be the efficiency with which money is used—how much benefit do we get for each rupee spent? This is another matter requiring careful study.

[19] M. Govinda Rao, in a personal communication, has spoken of the results of his recent research, which shows that, at an all India level, devolutions to local bodies come to 0.04% of the GDP. The local governments cannot be very important!

[20] Dr.S.Subramanya, IAS, **Government Health Expenditure in Karnataka since 1960,** KHSDP Paper made available to us by the Task Force.

Table 1: Revenue Expenditure under the major head Medical and Public Health in the period 1960-1990 (Rs. In crores)

Year	P	NP	Total
1960-61	1.63	3.01	4.64
1961-62	1.13	4.03	5.16
1962-63	1.30	6.37	7.67
1963-64	1.29	5.13	6.42
1964-65	1.32	5.40	6.72
1965-66	1.60	5.53	7.13
1966-67	1.58	6.99	8.57
1967-68	2.23	8.03	10.25
1968-69	2.67	9.07	11.73
1969-70	2.33	10.56	12.89
1970-71	3.06	12.88	15.94
1971-72	1.73	13.19	14.92
1972-73	2.93	15.22	18.15
1973-74	2.94	16.25	19.18
1974-75	2.80	19.43	22.22
1975-76	4.02	26.62	30.65
1976-77	4.54	28.50	33.03
1977-78	6.57	28.88	35.45
1978-79	9.14	31.98	41.12
1979-80	7.29	36.93	44.22
1980-81	7.56	44.68	52.23
1981-82	12.21	54.16	66.37
1982-83	15.26	65.48	80.74
1983-84	14.84	63.19	78.03
1984-85	25.30	77.21	102.50
1985-86	18.33	91.54	109.87
1986-87	21.45	106.59	128.04
1987-88	31.67	115.70	147.36
1988-89	42.00	129.15	171.15
1989-90	39.17	144.39	183.56
Average growth	15.44	15.08	14.23

Source: GoK Finance Report

In the above table 1, the figures are shown at current prices—inflation has not been adjusted for. The real increase then may be much less than these figures suggest. The growth rates at current prices show that the plan head has grown at 15.44%, non-plan at 15.08% and total at 14.23% in the period 1960-90.

In terms of percentage of total state government expenditure it is interesting to note that M&PH has always hovered around 6%.

Table 2: Capital Outlays towards Medical and Public Health in the period 1960-1990 (Rs. In crores)

Year	P	NP	Total
1960-61	0.61	-0.84	-0.23
1961-62		0.13	0.13
1962-63		-1.55	-1.55
1963-64		-0.07	-0.07
1964-65		0.26	0.26
1965-66		-0.06	-0.06
1966-67	0.35		0.35
1967-68	0.68		0.68
1968-69	1.17		1.17
1969-70	1.47		1.47
1970-71		-2.75	-2.75
1971-72		-1.49	-1.49
1972-73		-0.08	-0.08
1973-74	1.36		1.36
1974-75	0.94	0.00	0.94
1975-76	0.96		0.96
1976-77	1.43		1.43
1977-78	1.39		1.39
1978-79	1.36		1.36
1979-80	1.21		1.21
1980-81	0.94		0.94
1981-82	1.50		1.50
1982-83	2.58		2.58
1983-84	3.71		3.71
1984-85	4.52		4.52
1985-86	4.81		4.81
1986-87	5.08		5.08
1987-88	1.23		1.23
1988-89	0.88		0.88
1989-90	1.64		1.64

Source: Finance Department, GOK

As can be seen, a great deal of data is missing. The capital outlays on M&PH (Table 2) shows little non-plan expenditure. Capital expenditures are those that are expected to give returns over a term longer than one year. Is the state discounting the future?

We next present the plan and non-plan expenditures incurred on M&PH for the period 1990-91 to 2000-01. We have the [implicit] deflator figures with 1993-94 as the new base till 1998-99 which is used for deflating the expenditures in current terms.

Table 3: Health and Family Welfare Head wise expenditure (plan) (Rs. In crores)

Year	Current prices				Constant Prices		
	M&PH	FW	TOTAL	Deflator	M&PH	FW	TOTAL
1990-91	41.68	35.17	76.85	88.94	46.86	39.54	86.41
1991-92	39.39	50.38	89.77	90.25	43.65	55.82	99.47
1992-93	52.92	54.98	107.90	94.33	56.10	58.28	114.39
1993-94	62.60	59.42	122.02	100.00	62.60	59.42	122.02
1994-95	87.29	76.55	163.84	106.98	81.59	71.56	153.15
1995-96	119.54	86.81	206.35	114.80	104.13	75.62	179.75
1996-97	144.26	74.63	218.89	123.43	116.88	60.46	177.34
1997-98	157.72	106.09	263.81	129.62	121.68	81.85	203.53
1998-99	147.47	84.85	232.32	138.46	106.51	61.28	167.79
1999-2000RE	160.04	167.85	327.89				
2000-01BE	177.69	195.21	372.9				
				Avg growth	11.89	7.98	9.44

Source : Finance Department GOK

Table 4 : Health and Family Welfare Head wise expenditure (non-plan) ((Rs. In crores)

Year	Current Prices				Constant prices		
	M&PH	FW	TOTAL	Deflator	M&PH	FW	TOTAL
1990-91	163.06	3.10	166.16	88.94	183.34	3.49	186.82
1991-92	202.12	3.48	205.60	90.25	223.96	3.86	227.81
1992-93	248.56	3.75	252.31	94.33	263.50	3.98	267.48
1993-94	265.60	3.62	269.22	100.00	265.60	3.62	269.22
1994-95	289.27	4.64	293.91	106.98	270.40	4.34	274.73
1995-96	285.44	4.67	290.11	114.80	248.64	4.07	252.71
1996-97	300.62	5.58	306.20	123.43	243.56	4.52	248.08
1997-98	354.20	6.35	360.55	129.62	273.26	4.90	278.16
1998-99	468.40	7.68	476.08	138.46	338.29	5.55	343.84
1999-2000RE	564.86	11.03	575.89				
2000-01BE	639.73	10.18	649.91				
				Avg growth	8.54	6.38	8.49

Source : Finance Department GOK

In the period between 1990-91 to 1998-99, medical and public health shows an average growth of 11.89% under plan head as against 8.54% for non-plan head in the same period (Table 3 and 4). Correspondingly for family welfare average growth under plan head is 7.98% and 6.38% for non-plan head. It is seen that the average growth is marginally higher under plan head for total of medical and public health and family welfare at 9.44% as against 8.49% under non-plan head. If the contention that plan figures represent new investment can be taken to be valid today—and this is questioned by economists—then this is an encouraging sign.

Family welfare has largely been under the plan head. It is important to study how family planning is linked to health in the short term. Can it not be argued that improvements in the health situation will improve the prospects of success in family planning? If so, are these the right priorities?

3.2 Health related sectors

Under this can be included the following heads[21].

a. Family Welfare – includes maternal and child health and family planning
b. Water Supply and Sanitation – includes outlays on provision of potable water supplies, sewage and drainage, and waste disposal facilities in rural and urban areas.
c. Nutrition – programs to supplement nutrition for children and pregnant and nursing mothers and the Integrated Child Development Scheme.
d. Social security and Welfare – dealing with the disabled welfare and old age pensions

Table 5 : Revenue Expenditure of Health-related sectors during 1960-90 (Rs. In crores)

Year	Social Security & Welfare			Nutrition			Family Welfare			Water Supply & Sanitation		
	P	NP	Total	P	NP	Total	P	NP	Total	P	NP	Total
1960-61	0.35	0.76	1.11							0.29	0.01	0.30
1961-62	0.06	1.16	1.22									
1962-63	0.46	2.84	3.30									
1963-64	0.19	3.17	3.36									
1964-65	0.24	3.37	3.60									
1965-66	0.36	3.21	3.57									
1966-67	0.61	3.15	3.76									
1967-68	0.48	4.02	4.50									
1968-69	0.50	3.71	4.21									
1969-70	0.79	6.27	7.07									
1970-71	0.84	5.71	6.55									
1971-72	1.16	6.99	8.15				2.25		2.25			
1972-73	1.17	8.57	9.74				3.85	0.02	3.88			
1973-74	0.94	8.08	9.01				3.27		3.27			
1974-75	1.28	1.02	2.31	0.10	0.05	0.15	5.70		5.70	4.92	2.72	7.65
1975-76	0.68	1.29	1.97	0.20	0.20	0.39	7.28		7.28	5.84	2.63	8.47
1976-77	0.01	7.20	7.21	0.18	0.23	0.40	12.40		12.40	8.89	2.20	11.09
1977-78	1.69	1.57	3.26	0.21	0.27	0.48	6.96		6.96	10.23	1.96	12.18
1978-79	2.74	2.41	5.16	0.23	0.29	0.53	7.70		7.70	6.84	4.93	11.78
1979-80	1.38	5.92	7.30	0.29	0.22	0.51	8.03		8.03	10.85	5.18	16.03
1980-81	2.41	7.07	9.48	0.11	0.12	0.23	8.25		8.25	14.74	3.78	18.53
1981-82	2.97	8.67	11.64	0.09	0.10	0.19	9.64		9.64	22.26	4.53	26.79
1982-83	3.93	10.89	14.83	0.01	0.09	0.10	12.78		12.78	34.71	4.37	39.09
1983-84	5.47	12.19	17.66	0.01	0.05	0.06	16.57		16.57	43.56	2.68	46.25
1984-85	10.47	16.74	27.22		0.03	0.03	21.43		21.43	43.29	7.16	50.45
1985-86	17.29	29.16	46.44		0.02	0.02	28.68		28.68	49.86	7.83	57.69
1986-87	18.48	33.70	52.19		0.02	0.02	28.63		28.63	51.51	10.71	62.22
1987-88	22.04	87.53	109.57	42.71	16.41	59.12	40.95	1.25	42.20	54.97	6.47	61.44
1988-89	18.71	85.02	103.73	40.18	15.23	55.40	34.38	1.71	36.09	44.89	8.03	52.92
1989-90	22.74	91.32	114.05	45.92	17.75	63.67	41.34	1.83	43.17	46.99	7.34	54.34

Source: Finance Department GOK

[21] There is a certain judgement involved in this. Ultimately, every thing is related to everything else—where do we draw the line? For example, should pensions be part of the health-related sector?

Under health-related sectors on the revenue side (Table 5), it is seen that in this state there has been an increase in expenditure from 2% of SDP in 1960-61 to 5.8% in 1989-90. From 1972 onwards there is increased expenditure in health services as well as health-related services[22]. In the period 1960-1974, the cells are blank under the heads of family welfare, Water Supply and Sanitation, and nutrition. Does this mean there has been nearly no expenditure in these areas? This needs to be probed carefully.

As a percent of total revenue expenditure the health-related sectors accounted for 21% in 1960-61 and rose to 30% in 1989-90.

It is seen that all health-related sectors have received attention (Table 5). Even so nutrition expenditure has been poor. Family welfare largely a plan expenditure has also grown in the later years. It is quite clear that WSS, FW and nutrition have received more impetus in the latter part of 1980s, that is seventh plan onwards. The figures cannot tell us why this is so—that information has to be sought elsewhere once this fact is established.

It would appear that the state takes 'health related' sectors more seriously than health itself, as health expenditure has hovered around 6% of the total.

[22] Dr.S.Subramanya, op.cit

Table 6: Capital Outlays on Health-related sectors during 1960-90 (Rs. In crores)

Year	CO on Water Supply & Sanitation			CO on Nutrition			CO on Family Welfare		
	P	NP	Total	P	NP	Total	P	NP	Total
1960-61	0.11		0.11						
1961-62	0.22	0.01	0.23						
1962-63	1.11		1.11						
1963-64	0.62		0.62						
1964-65	0.50		0.50						
1965-66	0.03		0.03						
1966-67		1.25	1.25						
1967-68		-4.27	-4.27						
1968-69		6.02	6.02						
1969-70		-3.91	-3.91						
1970-71	0.94		0.94						
1971-72	0.54		0.54						
1972-73	2.01		2.01						
1973-74		-0.23	-0.23						
1974-75	0.90		0.90						
1975-76	0.33		0.33				0.03		0.03
1976-77	0.01		0.01				0.22		0.22
1977-78	0.00		0.00				0.00		0.00
1978-79	0.07		0.07				0.00		0.00
1979-80	0.05		0.05				0.00		0.00
1980-81	0.02		0.02				0.00		0.00
1981-82	0.06		0.06						
1982-83	0.07		0.07						
1983-84	0.14		0.14						
1984-85	0.26		0.26				1.02		1.02
1985-86	0.43		0.43				7.42		7.42
1986-87	0.21		0.21				11.27		11.27
1987-88					0.60	0.60	7.80		7.80
1988-89				0.03		0.03	6.78		6.78
1989-90							7.36		7.36

Source: Finance Department GOK

The capital outlays however show expenditures only under water supply and sanitation which has received attention under all the plans. There may have been an improvement in the infrastructure – laying of pipes, etc. But is that alone enough to improve the health status of a community? This is a complex matter that again needs a ground level probe.

We next see how the capital outlays have been in the recent decade of 1990s.

Table 7 : Capital Expenditure on health and health-related sectors in the 1990s (Plan) (Rs in crores)

Year	Current					Constant			
	M&PH	FW	WSS	SSW	Deflator	M&PH	FW	WSS	SSW
1990-91	1.67	4.9	0	0.98	88.94	1.88	5.51	0.00	1.10
1991-92	2.93	2.35	0	3.07	90.25	3.25	2.60	0.00	3.40
1992-93	6.75	0.37	0	2.43	94.33	7.16	0.39	0.00	2.58
1993-94	9.99	0.26	0	0.68	100.00	9.99	0.26	0.00	0.68
1994-95	10.91	0.21	0	1.49	106.98	10.20	0.20	0.00	1.39
1995-96	13.82	3.10	0	1.15	114.80	12.04	2.70	0.00	1.00
1996-97	7.93	2.46	0	2.00	123.43	6.42	1.99	0.00	1.62
1997-98	68.16	15.53	0	2.16	129.62	52.58	11.98	0.00	1.67
1998-99	87.88	22.52	147.93	1.28	138.46	63.47	16.26	106.84	0.92
1999-2000RE	79.78	39.32	159.90	2.39					
2000-01BE	55.38	33.45	107.89	2.34					
					Avg growth	118.24	195.9		25.98

Source: Finance Department GOK

Capital outlays (table 7) made under the various heads have been small. There is nearly nothing under non-plan and all the expenditures largely remain as plan expenditure. Surprisingly under WSS no expenditures were seen in the early years in the documents for which no plausible explanation can be given. The medical and public health shows an average growth of 118.24% during the period 1990-91 to 1998-99.

Table 8: Revenue expenditure on health and health related sectors in 1990s

(Rs. In crores)

Year	Health and FW	WSS	Nutrition
1990-91	494.5	123.8	142.8
1991-92	520.6	142.8	137.3
1992-93	594.8	158.1	50.2
1993-94	599.1	181.5	39.0
1994-95	669.6	225.6	51.4
1995-96	743.1	296.1	75.5
1996-97	619.2	301.0	89.1
1997-98	709.1	359.7	87.4
1998-99	873.6	257.6	82.5
1999-2000RE	940.8	268.4	83.7

Source: Expenditure Pattern of the Health Sector in Karnataka, Subramanya and P.H.Reddy, Southern Economist, 1997

The revenue expenditure on the health-related sectors is given in table 8. The annual compound growth rates for health and family welfare is 7.4%. It is 8.9% for WSS and 5.8% for nutrition. The expenditure on health and family welfare increased from 15.8% to 16.9%, that of WSS increased from 3 to 4%. The share of nutrition declined from 5.1% to 1.5%. Is this because the nutrition status has improved? That view may not be supported by the data in the state HDR.

We now look at the trend in expenditure on health related items[23].

Table 9: Trend in expenditure on health related items

Year	Per capita exp. On health related services at current prices Rs.	Per capita exp. On health and FW services at current prices Rs.	Exp. On health related items as % of state's revenue exp.	Exp. On health and FW as % of state's revenue exp.	Exp. On health related items as % of SDP	Exp. On health and FW as % of SDP
1990-91	526.1	110.5	29.1	6.1	5.6	1.2
1991-92	548.8	114.7	28.5	6.0	5.3	1.1
1992-93	562.1	128.9	28.1	6.4	5.4	1.2
1993-94	583.1	127.9	28.7	6.3	5.3	1.2
1994-95	611.9	132.3	29.1	6.3	5.4	1.2
1995-96	666.8	134.5	29.0	5.9	5.7	1.1
1996-97	674.7	126.6	27.4	5.1	5.6	1.0
1997-98	730.4	143.1	29.3	5.7	5.7	1.0
1998-99	808.5	174.1	28.1	6.0		
1999-2000RE	863.1	185.1	28.5	6.1		

The per capita expenditure on health related activity in 1999-00 is Rs.863 and that on health and FW component Rs.185. The health related activities account for 28.5% of total revenue expenditure of the state and the health and FW account for 6.1% of state revenue expenditure. The expenditure on health related activities formed 5.7% of SNDP in 1997-98 and on health and family welfare was 1.1%. Experts have to say on the basis of accepted norms if this is adequate—the figures do not, cannot, speak for themselves.

It would be useful at this point for us to look at the various loan components of the funds that the state receives. Most of the loans come under three well-defined schemes: central schemes, centrally sponsored and the state-sponsored schemes.

Table 13: Centrally sponsored schemes (revenue a/c) – current prices

Year	M&PH	FW	WSS	SSW	Nutrition	Total
1990-91	379.30	3050.45	2068.87	111.19	---	6263.12
1991-92	392.92	1909.97	2274.19	144.25	0.94	5165.04
1992-93	621.59	4143.76	2250.82	24.79	19.01	7348.87
1993-94	609.42	5317.39	3465.23	26.44	3.42	9640.96
1994-95	879.82	2769.22	4579.24	19.62	---	8599.43
1995-96	793.07	2323.21	6408.71	90.99	---	9925.06
1996-97	899.34	1052.60	6579.28	23.84	---	9010.74
1997-98	983.97	2134.53	10273.67	35.10	---	14044.98
1998-99 A/C	1017.85	1999.45	11541.58	24.80	---	15019.15
1999-2000 –RE	1535.21	8346.08	11397.08	40.00	---	23064.98
2000-01-BE	864.26	9577.24	12494.60	45.00	---	23755.66

Source : Finance Department , GOK

[23] Source: Expenditure Pattern of the Health Sector in Karnataka, Subramanya and P.H.Reddy, Southern Economist, 1997.

Table 14: Centrally sponsored schemes (revenue a/c) - constant prices (Rs. In Lakhs)

Years	Deflator	M&PH	FW	WSS	SSW	Nutrition	Total
1990-91	88.94	426.47	3429.78	2326.14	125.02		7041.96
1991-92	90.25	435.37	2116.31	2519.88	159.83	1.04	5723.04
1992-93	94.33	658.95	4392.83	2386.11	26.28	20.15	7790.60
1993-94	100.00	609.42	5317.39	3465.23	26.44	3.42	9640.96
1994-95	106.98	822.42	2588.54	4280.46	18.34		8038.35
1995-96	114.80	690.83	2023.1970	5582.50	79.26		8645.52
1996-97	123.43	728.62	852.79	5330.37	19.31		7300.28
1997-98	129.62	759.12	1646.76	7925.99	27.08		10835.50
1998-99	138.46	735.12	1444.06	8335.68	17.91		10847.28

Source : Finance Department , GOK

Under the centrally sponsored loans – revenue account (table 13 & 14) we see that the total moneys have increased over the period 1990-91 to 2000-01 under M&PH and WSS. There is however nothing allocated towards nutrition under the head social security and welfare. Family welfare also shows a gradual decrease in the same period. As far as family welfare is concerned it is largely under the plan head. Health per se is still a small portion of overall expenditure.

Table 15: Centrally sponsored schemes (capital a/c) (Rs. in Lakhs)

Years	Current				Constant		
	M&PH	FW	TOTAL	Deflator	M&PH	FW	TOTAL
1990-91	1430.80	456.89	2059.95	88.94	1608.72	513.1971	2316.11
1991-92	239.39	214.68	817.35	90.25	265.25	237.87	905.65
1992-93	656.53	14.89	1245.70	94.33	695.99	15.79	1320.58
1993-94	981.09	0.02	1887.55	100.00	981.09	0.02	1887.55
1994-95	1021.21	0	2071.08	106.98	954.58	0.00	1935.95
1995-96	1295.22	0	2187.29	114.80	1128.24	0.00	1905.30
1996-97	741.47	20.51	1641.35	123.43	600.72	16.62	1329.78
1997-98	6765.78	141.07	7786.66	129.62	5219.70	108.83	6007.30
1998-99	8739.24	215.41	34523.72	138.46	6311.74	155.58	24934.07

Source : Finance Department , GOK

Under the centrally sponsored schemes – capital account (table 15) we see that the figures are fluctuating in the period 1990-91 to 2000-01. A large increase is seen in 1997-98 and 1998-99 under M&PH.

Table 16: State sponsored schemes (revenue a/c) – current prices (Rs. in Lakhs)

Year	M&PH	FW	WWS	SSW	Nutrition	Total
1990-91	3663.64	466.17	2983.26	1297.04	733.34	16587.41
1991-92	3433.61	3128.23	4145.16	1620.30	840.18	22028.22
1992-93	4562.42	1353.96	5751.76	1842.24	890.39	27333.37
1993-94	5585.83	624.35	7232.65	1796.39	884.43	34160.60
1994-95	7766.58	673.75	11733.19	1875.89	1566.30	44290.85
1995-96	11072.93	661.21	13924.69	2699.10	2932.63	63113.59
1996-97	13445.54	379.02	17277.52	4395.12	3535.42	75518.57
1997-98	14669.23	521.78	19978.18	3967.98	3431.69	73100.18
1998-99	13689.27	499.55	15118.31	3337.41	3290.68	69813.76
1999-2000 -RE	14348.56	489.11	13904.32	4050.96	3392.51	70183.70
2000-01-BE	16812.30	922.81	14669.66	5340.65	3634.84	83853.39

Table 17: State sponsored schemes (revenue a/c) – constant prices (Rs. in Lakhs)

Year	Deflator	Medical & Public Health	Family Welfare	Water Supply & Sanitation	Social Security & Welfare	Nutrition	Total
1990-91	88.94	4119.23	524.14	3354.24	1458.33	824.53	18650.11
1991-92	90.25	3804.55	3466.18	4592.98	1795.35	930.95	24408.00
1992-93	94.33	4836.66	1435.34	6097.49	1952.97	943.91	28976.33
1993-94	100.00	5585.83	624.35	7232.65	1796.39	884.43	34160.60
1994-95	106.98	7259.84	629.79	10967.65	1753.50	1464.11	41401.06
1995-96	114.80	9645.41	575.97	12129.52	2351.13	2554.56	54976.99
1996-97	123.43	10893.25	307.07	13997.83	3560.82	2864.31	61183.32
1997-98	129.62	11317.10	402.55	15412.88	3061.24	2647.50	56395.76
1998-99	138.46	9886.80	360.79	10918.90	2410.38	2376.63	50421.61

Under the state sponsored schemes – revenue account (table 16 &17) we once again see that the moneys expended are rising. However here M&PH shows a comparable rise with WSS. Family welfare has a smaller share as compared to the centrally sponsored schemes. Nutrition has also an increasing share over the years.

Table 18: State sponsored schemes (capital a/c)

Year	Current					Constant			
	M&PH	FW	WSS	Total	Deflator	M&PH	FW	WSS	Total
1990-91	1430.8	456.89	0	2059.95	88.94	1608.72	513.71	0.00	2316.11
1991-92	239.39	214.68	0	817.35	90.25	265.25	237.87	0.00	905.65
1992-93	656.53	14.89	0.32	1245.7	94.33	695.99	15.79	0.34	1320.58
1993-94	981.09	0.02	0	1887.55	100.00	981.09	0.02	0.00	1887.55
1994-95	1021.21	0	0	2071.08	106.98	954.58	0.00	0.00	1935.95
1995-96	1295.22	0	0	2187.29	114.80	1128.24	0.00	0.00	1905.30
1996-97	741.47	20.51	0	1641.35	123.43	600.72	16.62	0.00	1329.78
1997-98	6765.78	141.07	0	7786.66	129.62	5219.70	108.83	0.00	6007.30
1998-99 A/C	8739.24	215.41	14792.79	34523.72	138.46	6311.74	155.58	10683.80	24934.07
1999-00 –RE	7950	300	15990	24840.98					
2000-01-BE	5538	245	10789	16876					

Source : Finance Department , GOK

Capital account figures for state sponsored schemes (table 18) again shows a large rise in M&PH while smaller or negligible rises in FW and WSS.

Table 19: State sponsored schemes (loan a/c)

Years	Current			Constant	
	WSS	Total	Deflator	WSS	Total
1990-91	1361.05	1361.05	88.94	1530.301	1530.301
1991-92	6847	6847	90.25	7586.704	7586.704
1992-93	3696.02	3696.02	94.33	3918.181	3918.181
1993-94	3376	3406	100.00	3376	3406
1994-95	3288	3318	106.98	3073.472	3101.514
1995-96	4452	4682	114.80	3878.049	4078.397
1996-97	5897	5907	123.43	4777.607	4785.708
1997-98	1682.96	1682.96	129.62	1298.38	1298.38
1998-99	7843.86	7843.86	138.46	5665.073	5665.073

Source : Finance Department , GOK

The loans under state sponsored schemes (table 19) show that the loans were allotted only towards WSS. It is likely that these were also grants/loans to the GOI from agencies like the world Bank and other bilateral donors. This can be followed up separately.

Table 20: Central plan schemes (Rs. In Crores)

Years	Current			Constant	
	WSS	M&PH FW	Deflator	WSS	M&PH,FW
1990-91	2	1.49	88.94	2.25	1.68
1991-92	3	1.3	90.25	3.32	1.44
1992-93	3	1.26	94.33	3.18	1.34
1993-94	3	0.82	100.00	3.00	0.82
1994-95	5	43.61	106.98	4.67	40.76
1995-96	0	58.71	114.80	0.00	51.14
1996-97	0	61.65	123.43	0.00	49.95
1997-98	0	81.22	129.62	0.00	62.66
1998-99	0	60.75	138.46	0.00	43.88

Source : Finance Department , GOK

The central plan (table 20) also shows a similar feature with small increase over the period till 1994-95 under M&PH head, and then shooting up in the last five years from 1995-96 to 2000-01. WSS has had no moneys expended under this scheme in the last five years while it is more or less fluctuating and in smaller measure for MPH and FW.

These are funds made available through the budgets. This paper has not gone into the issue of the efficacy of these allocations—that is an important, but distinct question that must still be examined.

6. By Way of A Conclusion

Such studies of local budgets are essential if the public is to take part in informed debate on matters of health policy. But it is difficult because the data are out of reach of the ordinary citizen. This is an extension of a study we had undertaken for the GoK set up Task Force on Health and Family Welfare. We were assured that the data required would be made available.

No one said that data would not be given. Yet, few were in a position to actually give the data needed for the analysis. The state has passed a Freedom of Information Act: thus our freedom to get this data is not an issue. Yet, access is a big problem. Finance data, for example the past budget documents of the state government, are not available on the website [www.kar.nic.in], nor in any book shops. Even when they are supposed to be priced publications—and few are—it is difficult to get them. The largest percentage of our time in this study was in chasing the chimera called data.

One reason we could not get data was probably because it was not available. This we found hard to believe in the beginning. But after a meeting in the office of the Commissioner for Health and Family Welfare, attended by concerned officials from the relevant departments, we had no option but to accept this harsh reality. *Much of the required data simply does not exist*[24]. Perhaps nobody outside had made a demand[25] for it before!

It is therefore essential that databases on these matters be created, not only in the concerned departments, but in research institutions as well.

This quick look at some aspects of the finances of the health sector in Karnataka has shown that there has been an increase in expenditures on allied sectors of health—water supply etc. This increase in health related expenditures has taken place in the context of a relatively stable level of expenditure of 6% of total expenditure on medical and public health. Is such stability adequate given the requirements of the population for health services? An analysis of finances alone cannot answer this question. To see if this level of expenditure is adequate, one needs an acceptable norm. This we do not have.

The devolution of finances to local bodies needs to be examined as well. The accounts we have seen do not take into account the local tier of government following the 73rd and 74th amendments—because there are, in any true sense, none. Today, there are expenditures in the district by the state government agencies—but these are not expenditures of the local governments—except perhaps

[24] How the department decides upon priorities in this situation remains a mystery that needs to be clarified. Could we argue that decisions have been arbitrary? If that is the working hypothesis, then how would the department go about refuting it?

[25] Here Karnataka has much to learn from the way the Right to Information demand has become a movement in Rajasthan—seen as a more backward state—through the *jan sunwais* held there.

in an accounting sense as these bodies may have passed resolutions to incur the expenditure[26].

Table 21: proportion of district outlays to state receipts (in % terms)

Details	1992-93	1993-94	1994-95	1995-96	1996-97	1997-98
Proportion of district outlays to total revenue receipts of the State	12.36	12.54	13.92	12.88	12.65	12.85
Proportion of district outlays to total revenue expenditure of the State	11.98	12.78	13.35	12.97	11.93	12.53
Proportion of district outlays to total receipts (capital and revenue) of the State	9.08	8.27	9.32	10.38	9.33	10.81
Proportion of district health allocations to total health expenditure in the state	35.78	39.71	34.04	26.87	21.50	17.21

Source: compiled from Finance Accounts, GoK

We have calculated the proportions at constant prices for the district outlays as given in the Link documents for the last six years. From the second data set, giving data for the decade of 1990s, the revenue receipts, revenue expenditures and total receipts of the state was taken.

It is seen from the above table that the proportion of total district outlays to the total revenue receipts of the state is hovering around 12.3 to 13%, with no substantial rise over the years.

Similarly, the proportion of total district outlays to the total revenue expenditures of the state also shows a figure of around 11 to 12%. As a proportion of district outlays to total receipts of the state shows a lower figure of around 9% over the years.

The more worrying figure comes with the proportions of district health allocations to the total health expenditures made at the state level. It is seen that a share of nearly 35% in 1992-93 has steadily fallen over the years to a low of 17% in 1997-98. These were the years in which decentralisation was supposed to be gaining momentum in the country. Where health is concerned, in Karnataka, these figures suggest that decentralisation was being rolled back, if these numbers are any indication.

Considering that health as a proportion in total social services sector has only a small share, as seen earlier, the above figures are to be taken seriously to understand how much of the money is really flowing down to the districts for the improvement of the health sector.

[26] When we look at the proportion of expenditure in the district to total departmental expenditure, there is a big difference between the health and education departments. A far larger share of education expenditure takes place at the district level than in the health department. There is much scope to decentralise in the health department.

The priorities are not set by the local governments, and the power to approve does not vest with them. They simply pass resolutions to justify what the state government departments have decided to do. It is thus not possible to make any statements about their relative efficiency or effectiveness in the absence of actual experience of devolution of fiscal responsibilities. But a system that keeps these bodies out of health care is likely to be a system that will fail—and the existing top down one has failed. Why not try a truly decentralised system?

Loans have been an increasing part of the financing of all programmes in the state, not just health. The loan burden is increasing, but it has not been possible to calculate the health sector's exact share in this loan burden.

The finance data also suggest that the state, in financial terms, is becoming increasingly more susceptible to financial stress. The CAG's civil report no 3 of 1999 shows this clearly.

Much of this is tentative. In depth studies of the integrity of the budget process—for example, to what extent do allocations differ from expenditures, at what level and by what processes are decisions made and so on, are essential for a deeper understanding of health—and other developmental—finances.

And such a debate must involve large parts of our population—not just bureaucrats and economists, but the people themselves. People's representatives, especially those from the depressed classes and women, who now have a presence in these bodies, must be involved in such debates. They have an electoral responsibility, and must be given all the support needed to take part in this important debate. How this is to be made possible will be an interesting question—and challenge.

The budget analysis presented in this monograph—tentative though it is—presents a base for such discussion. It is when questions are asked, when people demand answers and solutions, that such analysis can begin to make an input to policy. Till then, it will remain in solitary and splendid isolation from reality. What we can claim then, is to have made a beginning, to have cut the Gordian knot where such debate is concerned. We look forward to where this will take us.

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C B P S

The Centre for Budget and Policy Studies is a non-partisan, non-profit independent society established by a group of professionals based in Bangalore and registered under Karnataka Registration of Societies Act in February 1998[no. 777 of 1997-98]. The President is Dr. D. K. Subramanian and Secretary and Director is Dr. Vinod Vyasulu.

The objective of the Society is to contribute through research to understanding and implementing a process of long run, sustainable, equitable development in countries like India. Equity, as we understand it, extends across time—future generations must not be deprived of resources because of irresponsible use—and class and gender—all human beings have inalienable rights that society must ensure.

An area in which the CBPS has made a contribution is in the context of the ongoing process of democratisation and decentralisation following upon the 73rd and 74th amendments to Indian Constitution. In this context, budgets of different governmental bodies are important statements of policy priority. Budget analysis at local levels is an area where much needs to be done. An example is the work of the Centre in studying the budgets of two zilla panchayats [Dharwad and Bangalore(Rural)] in Karnataka. This report, formally released by the Governor of Karnataka, Her Excellency Smt. V. S. Rama Devi on July 4th 2000, is being used in programmes to orient those who have newly been elected to local government bodies.

One way of meeting our objective is by providing inputs into ongoing debates in society on matters of policy priority by collecting and analysing information and presenting scenarios on different options that face the public. Health is one such area, where the state has clear responsibility, and the private sector plays an important role. A contribution to the debate on improving health policies will be an important part of public discourse. This paper is one attempt in this direction.

Another area of importance is ecological and environmental sustainability. The interface between local bodies and environmental programmes like drinking water, watershed development, joint forest management to see how local bodies can contribute to the meeting of national objectives. Currently, the Centre is involved in projects in these areas in selected districts of Karnataka.

CBPS will remain a small body of professionals who will work by interacting and networking with others who share such interests. Working groups for different studies with professional membership will be set up, and will work with minimal infrastructure. Full use will be made of modern technology in this process. The results of such work will be used in training, in dissemination of results and in follow up programmes.