HEALTH SERVICES DEVELOPMENT
THE CASE OF MAHARASTRA

Dissertation submitted to the Jawaharlal Nehru University
in partial fulfilment of the requirements for
the award of the Degree of

MASTER OF PHILOSOPHY

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22 July, 1996

CERTIFICATE

It is certified that this dissertation entitled **"HEALTH SERVICES DEVELOPMENT: THE CASE OF MAHARASHTRA"**, submitted by **Ms. Urmila Budhkar** in partial fulfilment of the requirement for the award of **Master of Philosophy** degree of this University, has not been previously submitted for any degree of this or any other University and this is her own work.

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ACKNOWLEDGMENT

I would like to take this opportunity to thank all those who have contributed in making this endeavour a success. At first I would like to express my deep gratitude to the Jawaharlal Nehru University and the Centre for Social Medicine and Community Health for giving me this opportunity. I would especially like to thank Dr. Imrana Qadeer, Mrs. Rastogi, Dr. Singh, Mrs. Krishna Bhatia, and all my friends and colleagues from the Centre.

Words are inadequate to express my feelings regarding Dr. Rama Baru, who has not only been my supervisor, but has been a friend through all my ups and downs during the course of the study. I would like to thank her for having faith in me and trusting me ability to successfully completing the task. Learning from her experiences and being under her guidance has not only enriched me academically, but it has developed me as a person.

I would also like to remember and thank all my friends who have been with me throughout, boosted my morale and pulled me out of my low moments. I would especially like to mention Nisha, Shweta, Premlata, Aparajita (Babin), Deepa and Mathew. A special mention needs to be made of Meena who supported me during the last phase of the dissertation. She has truly been a friend in need. One person who silently and subtly helped me during last stages of my work is Pravin Mahajan. His experiences enriched the study as well.

Las but not least, I would like to remeber my father at this moment. Without his support this endeavour would have been impossible. He and Rama were the pillars of strength and I would like to dedicate my work to them.

Urmila Budhkar
22.7.1996

CONTENTS

Chapter I

Introduction and Methodology

Introduction: Rationale for the study of health services development in Maharashtra

Health services are not independent of the soci-political factors affecting public policy. They are a function of the social, political and economic factors acting upon a society (Qadeer 1985) . The order of the present world is capitalism, within which the health services have developed, especially in India. Economic growth is largely determined by political forces, but eventually they share a reciprocal relationship, with those in power determing the economic policy which is designed to enhance economic growth. Within this ideology, welfare services are given a back seat

The greater part of the 1970s and early 1980s was a period adverse international economic conditions with the oil crisis, world recession, deteriorating terms of trade, debt crisis, and so on, which gave rise to several macroeconomic problems. These conditions have been the precursors to several major macro- economic changes globally. In response to these problems, the developing countries have been increasingly

obliged to make macroeconomic adjustment or stabilization programs in their economies in order to limit public expenditure. In other words the ***structural adjustment and stabilization programs*** **(SAP)** have been proposed to solve the problem of the balance of payments. These obligations are being imposed by the combined forces of the world Bank (WB), The International Monetary Fund (IMF), and some international agencies.

The Structural Adjustment programs are basically long term objectives for the structural causes of the problems.While the stabilization programs are short term objectives. Both together constitute the *Structural Adjustment Program (SAP).* The main policies under SAP include reduction or removal of government subsidies on food, education and health . Devaluation of currency and controlling the supply of money . Removal of trade and exchange controls and liberalisation of trade which will entail retrenchment, wage freezes or restrains, and deregulation of laws and reforming pricing policies . Privatization of the public sector enterprises . In other words the policies imply reduction in government or public expenditure on welfare services and a concerted shift towards a market oriented system or rapid economic growth. (Cooper Weil etal 1990, Balasubramanium 1993 and Loewenson 1993).

At the onset of the decade of 1990, India, in the VIII Plan (1991 - 1996) proposed economic reforms for the country which are in accordance with the adjustment and stabilization programs as recommended by the World Bank (WB) and The International Monetary Fund (IMF) for developing countries facing financial crisis. The agenda for India for the 1990s is to improve economic growth and simultaneously do away with expenditures which do not directly influence economic growth. A somewhat neoliberal understanding that in order to achieve economic growth the nations need to privatize and cutback on public expenditure. This agenda is broadly encompassed under the New Economic Policy adopted by the Union Government in July 1991. Its main thrust is on improving efficiency within the public sector by creating a competitive environment where both the public and the private sectors will compete in a free arena. In other words this means that the public sector's role will be limited to certain measures and the scope of operations of the private sector will be expanded. The Indian government, thus, has endorsed the structural adjustment and stabilization programs of the WB/IMF which so far had been associated more with the Latin American and Sub-Saharan African countries. These programs are essentially policy recommendations and one of its primary direction is towards cut-backs in public expenditure on social welfare services besides liberalization of trade and privatization of the economy by making a concerted shift

towards a market oriented economy.

According to the VIII plan document the public sector needs to be made efficient and surplus generating in order to deliver in the social and infrastructural sectors. "It must also give up activities which are not essential to its role" (VIII Plan document 1991-1996). it further emphasizes on a re-examination and a reorientation of the role of the government, people's involvement in the process of development and creation of an environment which encourages and builds people's initiative rather than their dependence on the government. in other words the state has to play the role of a facilitator than that of a provider.

The impact of SAP on the social sectors, specifically health, was visible by the beginning of the 1990s with expenditure patterns of the Union Government showing a decreasing trend (table 1.1). The following tables indicate the revenue expenditures on social sector per se and the health sector, between 1990 and 1993,(the first years of the period of adjustment), decreased from 3.04% in 1989-90 to 2.82 during 1992-93. However, there is a slight increase during 1993-94. Nonetheless, the overall expenditure for social welfare has remained around 3% of the total revenue expenditure[1]. The total expenditure for social welfare as a percentage of the GDP is 6% (WB 1995) .

Table 1.1

Union Government Revenue expenditure on Social and Health sectors

Year ------ Reven. expd.	1989 - 1990	1990 - 1991	1991 - 1992	1992 - 1993	1993 - 1994	1994 - 1995
Total	90135.76	1029654.17	116090.69	132794.47	152317 .18	178698.76
* Social Sector	2740.47 (3.04)	3027.38 (2.94)	3329.68 (2.87)	3749.67 (2.82)	4498.27 (2.95)	5227.78 (2.93)
MPH #	347.84 (12.69)	397.20 (13.12)	450.25 (13.52)	559.03 (14.91)	646.95 (15.45)	790.45 (15.12)
Pub.@ Health	164.23 (47.21)	165.19 (41.58)	179.41 (39.81)	291.82 (52.20)	346.90 RE (49.99)	431.78 (54.62)

Source : Prabhu, K.Seeta : *World Development Report 1993* 1994 *Structural Adjustment & the Health Sector in India.* Social Scientist Vol. 22 No. 9-12 Sept-December .

Figures in parentheses indicate percentages.
* Percentage to total revenue expenditure.
# Percentage to total revenue expenditure on social sector.
@ Percentage to total revenue expenditure on MPH.
MPH Medical and Public health.
RE Revised Estimates

Trends in the total expenditure for health also show a similar picture (table 1.2) with a decrease in expenditure for health in the total revenue expenditure. It is thus evident that with the adoption of the SAP as recommended by the WB/IMF, the Indian pattern has started showing trends of decreasing expenditures on social welfare and health in particular.

Table 1.2

Expenditure on Health as a Percentage to total Government Expenditure

Year	1950-1951	1960-1961	1970-1971	1980-1981	1991-1992	1992-1993	1993-1994	1994-1995
Rev. Expd. Health	* 2.69	* 5.13	* 3.84	3.29	3.11	2.71	2.71	2.63

Source : Duggal, R. (et al) : *Health expenditures Across States* April 15, 1995 *Part - I* . EPW. Vol, No. .
* includes Family Welfare and MCH .

In 1993, the WB published the annual development report entitled *World Developemnt report 1993 : Investing in Health* and a subsequent country report - *India : Health Sector Financing - Coping With Adjustment : Opportunities for Reform* . In these reports the WB has recommended poilcy options to be followed by the developing countries and India in particular . The main thrust of the report is on curtailing expenditures

on health in the light of the fiscal crisis prevailing and the presumed lack of resources for health from external sources . The report advocates reforms in the health setcor in order to generate additional resources from with the health sector itself . This, the Bank recommends can be done by describing the role of the government according to the new agenda. The governments are urged to reduce their expenditures on tertiary care, finance and implement a package of public health interventions, finance and ensure delivery of a package of essential clinical services and improve management of public health services by decentralizing administaration and budgetary authority and contracting out services. Simultaneously the private sector will be increasingly involved in providing the remaining clinical services (WB 93) . Along with the reorientation of the governments' role, they are urged to pursue economic growth policies including adjustment policies that preserve cost-effective health expenditures.

Observers of the WDR 93 report (Qadeer, Baru, Shiv Kumar, Prabhu, Antia, etc) have extensively discussed the report from various angles and they agree that this report should be viewed in the context of the SAP of the WB/IMF. Experiences from Latin America and Sub-Saharan Africa have shown that structural adjustment has lead to high transitional costs, particularly in terms of health- increasing mortality,

malnutrition and the impacts of increasing unemployment on the household income. In the context of health, there has been the combined impact of inflation, unemployment, rising prices in the health sector which is being controlled by the private sector, reduction in food subsidies, changing crop patterns due to strategies to promote exports, etc., on the health status of the people (Cooper Weil 1990). An obvious deterioration in the health status of the people in countries where SAP was implemented has been observed with an increase in IMR, malnutrition, and morbidity levels (Jolly 1988 qouted in Cooper Weil 1990). Although the incidence of these transitional costs did lead the UNICEF to call for measures of mitigation termed *adjustment with a human face*, drawing from the lessons of the countries that have undergone SAP and the negative impact it has had on health, it is possible to extrapolate to the Indian situation.

Health Care Expenditure by the Government of India

With the Indian government cutting down on health expenditures, one is compelled to think about the implications of the same for India per se as well as at the level of individual states. This is because health is a state subject as per the Indian Constitution and comes under the Directive Principles of State policy. Furthermore, the fiscal crisis of the Union Government is a recent phenomenon . But the financial pressures

at the state level have been rising since the mid - eighties due to the increasing load of non - plan expenditures[2] (Prabhu 1994) . It is also indicated from the following table that the non-Plan per capita expenditure, particularly at the states and the union territories has been on the increase . Non-Plan expenditures for Medical and Public health (MPH) are obviously more .

Table 1.3

Per capita Plan and non-Plan expenditure on Medical and Public Health and Family Welfare and the total expenditure by functional categories : 1974-75 to 1990-91

Govts. by levels	1974-75		1982-83		1990-91	
	P	NP	P	NP	P	NP
TOTAL *						
center	1.11	3.67	2.13	4.36	4.04	5.84
states	8.48	18.41	16.10	22.49 36.04	22.20	29.98
UTs	9.77	42.53	41.74		98.44	55.69
T	9.61	22.37	18.51	27.11	27.2	**536.16**
M P H						
center	.83	2.93	1.17	3.22	1.37	3.25
states	3.27	13.56	5.49	14.51	5.31	19.16
UTs	7.20	35.82	15.93	30.55	33.03	45.14
T	4.15	16.7	6.80	17.95	7.04	22.75
F W						
center	0.18	0.17	0.23	0.32	0.36	0.52
states	1.88	0.35	3.64	0.94	5.19	0.41
UTs	0.53	0.00	1.12	0.03	0.25	0.02
T	2.05	0.5	3.83	1.24	5.48	0.92

* includes water supply and sanitation, nutrition and child and handicapped welfare as well.

MPH: Medical and Public Health UTs : Union Territories

F W: Family Welfare T : Total

Source: Reddy, K.N. & V. Selvaraju : Health Care Expenditure By 1994 Government in India. Seven Hills Pubn. New Delhi .

It is evident from the distribution of per capita health expenditure in table 1.3 that the non-plan expenditure, particularly for medical and public health is significantly high and shows and upward trend for the period 1974 to 1991. In comparision the expenditture for family welfare services does not show such a significant increase in non-plan expenditure at the central, state or the UT level. It will therefore be interesting to note the directions the health sector will take in the wake of the increasing burden of non-plan expenditures on one hand and the ongoing financial cut-backs by the Union Government on the other. A state level examination of ehalth services will reveal a more interesting picture in this context.

SAP in the Context of India

Besides, India is a country of diversity and multiplicity . There are regional variations in levels of development as well . All states of India are not at par on the level of development (refer appendix). Thiswill mean there will be differences in the various policy measures. For instance in the case of states like Maharashtra, Gujarat, it is a known fact that there is a long tradition of private sector development. In such states, with policy measures which encourage private sector involvement, it can be assumed that the probability of greater public-private cooperation would be high and a more likely involvement of the private sector in the realm

of the public provision of services particularly health. Some studies have shown that there are variations in health services in terms of uneven penetration of the private sector. This then gets relected in patterns of utilisation of health services, which is illustrated by why Bihar, Rajasthan have higher utilisation of public services while Maharashtra an AP have higher utilization of private services (Baru 1994). The same assumption therefore cannot be applied for states like Bihar, Rajasthan, UP which have a greater involvement of the public sector in provision of services. Policy measures such as SAP, therefore, may not be implemented in a uniform manner and there will be inter state variation in the same.

However, it will not be sufficient to examine health services development within the contemporary circumstances alone. But to broadly examine evolution of health services, it is imperative to examine health services development in the context of the broader sociopolitical processes taking place within a society. These sociopolitical processes are historically determined and are products of a long adjustment between various classes. For instance the welfare state evolved over several decades to emerge as the final product after the second world war which continues to undergo change and redefinitions (Moon 1988, Offe in Moon 1988, Holmes in Moon 1988, Qadeer 1985, Navarro 1985, Gopal Jayal

1994). Any social phenomenon therefore is not static. Its definitions change along with the changes within society and hence has to be examined within the changing context of societal development. We saw in the preceding paragraphs the different changes in the perception of health which was congruent with scientific and subsequent societal development. The manner in which health is perceived is closely associated with the development of health services. This will be further discussed in the next chapter, in the theoretical framework which discusses in details the various perceptions of health as a public good, as aright and as a commodity. It will thus, be crucial to examine health services in the context of the sociopolitical changes taking place over a certain period. The main purpose, therefore, is to examine health services development and the role of the State in provision of services. In order to examine health services dvelopment, we will take into account how the institutions providing health services have grown.

India being a multi-lingual, multi-cultural and diverse nation, there are variations due to historical and socio-political differences across the states. These variables to a large extent determine the development of services in the state. Health is a state subject whose implementation is the responsiblity of the state. These variations and the reasons mentioned in the previous paragraph therefore prompt one to look at

health services development at the state level. Also, there are not too many state level studies examining the health services development within the context of the state's sociopolitical processes. Any study attempting to do this will be an important contribution and be useful in planning health services, both at the state and national level. It underlines the importance of taking the diversity of this country into account for health service planning.

Some of the important studies on health care services broadly focus on micro level analysis of the health infrastructure, health manpower, on organizational dynamics and health finance. However,not many studies have looked at health services per se within a historical perspective. In the case of Maharashtra one can cite the study conducted by FRCH on *NGOs in Health Care* which has tried to study the health care delivery system in the non-profit sector. The study however, does not look into policy developments and the sociopolitical processes and its implication for health services development. The other studies which can be mentioned here are those of Pannicker and Soman (1984) covering Kerala, Baru (1984) Andhra Pradesh, IIM Ahmedabad (1985) Maharashtra and West Bengal. There is thus a paucity of research at the state level. Therefore the primary aim of the present study is to try and see how health services have evolved in Maharashtra and to dilineate

how socio-political forces have influenced and shaped them.

The Main Objectives

The main purpose of the study is to examine the development of health services in Maharshtra. For the purpose of the study health services development will be viewed from a period in history upto the present. One can start at any point of time in history and look at the phenomenon both before and after that delimited point. For the purpose of the study, health services development will be mainly discussed in the terms of the post-Independence period. However, it will be essential to take a look at the same in the pre-Independence period which is also the phase of the British rule. This period also coincides with the emergence of the Maratha dominance and the anti-brahmin movement and the establishment of the maratha elite in the rural polity. The second period will be the post-Independence period and the period upto the formation of the state of Maharshtra in the 1960s.

The study will attempt to explore the trends in the growth of health institutions viz; hospitals, dispensaries, Primary Health Centers (PHCs), sub-centers, Community Health Centers (CHCs) or in terms of Maharashtra the Rural Hospitals (RHs) and number of beds . An attempt will also be made to examine the rural-urban and private-public

differentials for these institutions . It will also examine the trends in health expenditure for Maharashtra as well as India . Finally, with the analysis of the above the study proposes to throw some light on changes in policy for health developent in Maharashtra particularly for the 1990s. In other words we will be explaining trends an shifts in policy, if any, within the socio-political development of the state.

The Unit Of Analysis and Operational Definition

Health services are not independent of the soci-political factors affecting public policy. They are a function of the social, political and economic factors acting upon a society (Qadeer 1985) . The order of the present world is capitalism, within which the health services have developed, especially in India. Economic growth is largely determined by political forces, but eventually they share a reciprocal relationship, with those in power determing the economic policy which is designed to enhance economic growth. Within this ideology, welfare services are given a back seat. The groups in power or the elites also have the capacity to influence the type of developemnt ;in this case the developemnt of health services . The dominant elite can also influence the development of health infrastructure in such manner as to benefit the people from their communities , kin, faction members and other interdependent classes (Lele 1982 : 31-38) . In a study on regional variations in health services

conducted in Andhra Pradesh (Baru 1984), it was found that PHCs were constructed on sites donated by the ruling elites . This was one of the chief reasons for the location of PHCs in important villages or semi-urban areas and often contributed to duplication of services . The remote areas thus, did not receive such benefits .

Health services, thus, are defined in terms of the institutions where a complex of medical care facilities, health education, health programs (immunization, control of communicable diseases, etc.), family welfare and MCH activities, training, and so on are provided. These institutions are products of policy which is determined by the ruling elites(Lele 198), Bannerji (1985), Navarro (1976), Baru (199). The readily available indicators of health services development thus are the firstly the number of government dispensaries and subsidised medical practitioner centres. Secondly, the number of PHCs and primary health units. Thirdly government hospitals. And, finally the bed-population ratio.

The main concern hence is to try and speculate the implications of social, economic, and political forces for policy and to some extent for the access to health services. The purpose is to answer a few questions regarding the change in development of health services as a product of changes in the macro policy; and not to measure the impact of the same

on health. the main assumption being that changes in the macro policy of the country are bound to reflect in the development of the infrastructure, in this case the health infrastructure. The aim is to arrive at some generalizations regarding the phenomenon of health services development without attempting causal explanations. Although several studies have shown that there is a greater utilization of private health services,(NSS 42nd round) the purpose of the study is to examine the public health services in order to see the trends in policy and its implications for the development of health services, particularly for the 1980s and the 1990s; i.e. with the implementation of the structural adjustment and stabilization programs (SAP).

The Research design

The present study is an exploratory one which aims to examine the development in health services from the pre-Independence to the present period . The stydu also intends to explain the development of health services in the context of the socio-political and economic factors prevailing at the national as well as the international level . This is because in the new world order developments in any country are not independent of the socio political and economic developmentsin the world at large. Health services as defined above are closely related to infrastructural development and are the primary welfare services. They

are affected by macro policy changes taking place in the world and within the country . This has been described to some extent in the previous paragraphs and a further description will be provided in the theoretical framework in the next chapter. In this context the health services thus cannot be examined at a single point of time .They are historically determined . A brief descrpitive account of health services development in Maharashtra during the pre - Independence and the post-Independence period will be provided vis a vis an examination of the contemporary developments .

The study therefore will be explanatory and descriptive in nature. It thus, satisfies the requisites for a case study design (Yin 1984) . The research design adopted for the present study is that of a multi-unit single-case study . Multi-unit in the sense that variance is naturally built within the unit of analysis in the form of various components of health services, i.e. the various institutions providing health care, the expenditure for health and the rural-urban, private-public differentials.

Data Collection

Due to unavailability of adequate studies of the phenomenon and the limitation of time, the researcher is compelled to resort to published data regarding the growth of the health services, at the national and ther

state level. The data thus has been complied from various government publications and records, a few micro studies on health expenditures which analyze the public health expenditure and studies which analyse the private health sector. The researcher has attempted to supplement the data by interview with a few key personnel within the public health sector, primarily the Directorate of health Services, Mumbai.

The evidence has been compiled at three levels. First the figures relating to the growth of institutions, health expenditure, rural-urban and public-private differentials, etc. have been complied from secondary sources. Government records, State Gazetteers, and policy documents have also been examined. Secondly, attempt has been made to collect evidence from various studies regarding the historical developments and socio-political dynamics in Maharashtra. In this manner, the data for the pre-Independence period has been compiled from the state Gazetteers for various districts. For the post-Independence period, the data has primarily been compiled from the reports of the Central Bureau of Health Intelligence (CBHI) and Health Establishment in Mahatrashtra, a Government of Mhaharashtra publication. The data has also been supported by other official documents such as the report of the Committee for Regional Variations (CORI) and micro level studies undertaken by scholars. In other words a sound review of literature has not only

contributed to the evidence but has also helped in formulating the theoretical framework which has enabled to provide some explanations refgarding the phenomenon of health services developemnt in Maharashtra. Thirdly, interviews with key informants have also enriched the evidence. These interviews have been both informal and formal. For the formal interviews an interview guide comprising of a few key question areas and a tape recorder were utilized. The formal interviews served the purpose of supplementing the evidence obtained from the sources of information.

Limitation of the Data

Primarily secondary data has been collected from the sources mentioned above. One of the problems regarding the data is that of differences in the figures of the state level sources and the central sources. This discrepeancy arises due to the time factor. It means that the central government has to be sent the records at a particular time. The state machinary, however may continue compiling the records even after the report hs been sent to the central government. This sometimes causes the difference to occurbetween the central aand state records. To avoid the discrepency to reflect in the data, care has been taken to use only one source as far as possible. Wherever the data has been congruous more than one source has been used. For instance, the data has been primarily

compiled from the publications of the Central Bureau of Health Intelligence (CBHI). These reports are published under the name of *Health Information for India*, and it is a Government of India publication. the next major source of data has been the Maharshtra state governments's records - *Health Establishment of Maharashtra* published by the Bureau of Health Intelligence and Vital Statistics (HI&VS), Directorate of Health Services (DHS), Mumbai.

Regarding the latter source of data, the reports were available only for four years spanning over fourteen years, that is for the years 1974, 1976, 1984 and 1986. According to the personnel form the HI&VS, Pune and those from the DHS, Mumbai,[3] the compilation of *Health Esatblishment* started in 1974 and continued irregularly till 1986. Since then the department has not been publishing these reports. One of the reasons given was that such reports get initiated by certain Directors of Health services and continue being published till the tenure of the Director or may be for a little while after that. But often such endeavours receive a set back and are discontinued. However the researcher was also told that since the 1990s, there have been concerted efforts to improve the information system and subsequently the compilation of the data. The Directorate may revive the publication of *Health Establishment* on a more regular basis. Already an alternative report entitled *Health Status of*

Maharashtra is being published. It was initiated at the behest of the Secretary of Health and the responsibility has been entrusted to the DHS, Mumbai to produce this report annually. The third annual number of the *Health Status* was published in 1995.

Summary

This chapter has primarily dealt with the introduction and the rationale for studying the phenomenon of health services development. It has been argued that health services developemnt are not independent of the larger sociopolitical processes taaking place within a society and as such the phenomenon has to be examined within the context of these factors. The study has been delimited to examining the health services which have been defined in terms of the health care institutions at the state level. Due to paucity of state level studies, an examination of health services developemnt of the state of Maharashtra has been proposed. Maharashtra being a relatively well developed state was one of the reasons for its selection. Also, the researcher is native to Maharshtra and hence familiar with the state. This was one of the factors for selection of this state as it would serve as an assest for the study.

Health services development is also not independent of the sociopolitical and economic processes taking place at the global level and

therefore have to be examined in a larger theoretical framework. This framework will be discussed in the following chapter vis a vis a brief overview of health services developemnt in India per se.

NOTES

1. For further analysis of these trends see Prabu (1994) :*World Development Report 1993 :Implications for Structural* Adjustment *and the Health Sector in India* , Social Scientist, Vol 22, no.9-12 September-December, and Tulshidhar (1993) EPW.

2. For detail analysis of Plan and non-Plan expenditure refer Reddy and Selvaraju (1994) : *Health Care Expenditure by Government in India : 1974-75 to 1990-91* . Seven Hills Pubn. New Delhi. It is shown by Reddy and Selvaraju that each Five Year Plan outlay increases the Plan expenditure of the next Plan and the non-Plan expenditure of the current Plan increases the Plan expenditure of the subsequent Plan. There is thus a strong linkage between Plan and non-Plan expenditure at each level of the government. They also found that non-productive expenditure such as that on office expenses, for the period 1974 to 1991, have contributed significantly to the rise in non-plan and plan expenditures.

3. This information was collected by way of informal talks with the personnel such as the Statistics Officer, assistants, Joint Directors of Health Services of the concerened organisations during the period of field work in the month of January, 1996. However, the researhcer was also informed that since the 1990s the responsibility of compiling data was entrusted to the Chief Executive Officer of the Zilla Parishad. It would be his duty to collect the data on Health services and other information both for public and private sectors from his district and forward the same to the Directorate.

   Before this motion, the Directorate had already introduced the Management Information System (MIS) in the early 1980s. This brought in technology in the form of computers to the Directorate and its regional centers. Despite the technological inputs data was not being compiled as efficiently as expected. This was because the responsibility was given to a single person- the Statistic Officer. He was entrusted with the compilation of data for the entire state and it was extremely difficult for the Bureau of HI&VS and the Directorate to get the necessary information on time. This was also the reason for the difference between the central government figures and the state level figures. According tot he personnel, very often the figures for the previous years would be sent to the central governemnt agencies.

Chapter II

The Theoretical Framework

Introduction

Health is one of the primary social welfare services in which lies the key to the quality of life (Guhan, S. 1992). For a long time health had been the purview of the medical field and there were several left criticisms which pointed out to the influence of this dominant minority on the development of the health sector.[1] However, in the wake of the recession of the 1970s and 1980s, the cold war and subsequent breakdown of the soviet system, with the world no longer bipolar,the current dominant ideology is that of Liberalism which is not too different from that prevalent in the pre world war period. It is different in the sense that laissez-faire is upheld along with some state control to ensure favourable conditions for the market and to provide minimum welfare services to the people. Here welfare services are not seen as a **right** per se. But,as services which are **earned** by the people who contribute to the resources. This can be said to be true of the developed countries who are the traditional welfare states; for example Germany, Austria, the Scandanavian countries, among others.

Developing countries however, will obviously show a different picture. In the absence of a well developed social security system, welfare system, social insurance, present in the traditional welfare states, the developing countries resort to direct payments for the welfare services in the form of user fees. In the context of health services, the system of user fees was introduced in the 1980s in some states of India, particularly Maharashtra. Recently there was a considerable debate in the state of Punjab where the system of user fees along with private sector involvement in was discussed (TOI 1996....). Subsequently user fees have been introduced in the district hospitals of Punjab (TOI... 1996). The ideology, thus in the post world war period is termed as the **neoconservative ideology** and the world is already familiar of its consequences in the form of the Reagan administration in the U.S. and The Thatcher government in Great Britain during the 1980s who initiated the debate regarding the changing concept of the welfare state.

Health Services In Colonial India

The development of health services in India has been extensively discussed by Banerji (1985), Qadeer (1985), Jeffery (19), Cleaver ( ), Zubrigg ( ), Sathyamala ( ), among others. Almost all agree that the present infrastructure, particularly in the field of health has been thrust upon the Indian society by the British and the subsequent rulers

and the dominant elite who were educated within the western philosophical paradigms and trained in 'modern' methods. The subsequent development in the health infrastructure has been analysed within this context. It is true that at the time of Independence the so called "steel frame" of the bureaucracy was thrust upon the India with its "highly trained", "responsible", and "disciplined" personnel (Lele 1982). The infrastructure which India inherited was primarily the one developed by the British during the colonial regime which developed on the lines of the existing infrastructure in Britain and hence reflected the mechanical aspects industrialization. The British had developed a health service system for their military and civilian groups which was later inherited by India. The indigenous medicine was termed as "unscientific" and alien. No effort was made to understand this system or incorporate it within the health system developed.

The first medical college was set up in 1835 and very soon the important port cities of Bombay, Madras and Calcutta had a medical college.

On the other hand the indigenous health system, which consisted primarily of ayurvedic practitioners, was dominated by the upper castes in most parts of the country, especially the brahmins. The manner in

which the caste system became a rigid system and was used by those in the upper castes as an instrument of maintaining their hegemony, similarly, the health system could have been used as one of the instruments of control and exploitation. The knowledge being guarded and revealed only to the chosen heirs, being passed down from generation to generation. This factor when combined with the developments in industrialization, education and other western systems, will offer a better explanation.However, the purpose of the study is not to enquire into the reasons of the downfall of the indigenous system of medicine. Therefore, the fact that this system had suffered a set-back under colonial rule will be accepted per se.

The British had initially (before the 1860s) started the health service system only for their military and civilian personnel. Some public health measures were undertaken to control the epidemics of cholera, plague, and small pox. The IMS (established in 1860) was a military service for maintaining the health of the fighting forces. It was responsible for the health services in India and its doctors were the chief architects of medical policy (Jeffery 19 , Bannerji 1984). Very little efforts were made to provide services to the local Indian population and only those who were influential could avail of the services of the white physicians. However, a need to provide some health care facilities to the

Indian population was felt as the mortality rates increased particularly among the workers. The first attempt to combine the indigenous and the western system of medicine in order to provide health care facilities to the Indian population was seen in the form of a Native Medical Institute, which however did not take roots. Health provisions for the masses, nevertheless, were provided only when the British felt it was in their favour to do so. Jeffery (19) gives two reasons for the above, viz: "to spread enlightenment or scientific medicine" and for the purpose of charity, for which the missionaries were encouraged. the health provisions by the missionaries served a dual purpose of legitimizing the British endeavors and the missionaries themselves as well as popularizing western medicine. In this context the studies conducted by Macmarriot and Carstairs through some light upon the ethnocentrism of the Europeans working in India.

Health Services in independent India

The Health and Development Committee or the Bhore committee designed the infrastructure for health at the onset of planning for independent India. They recommended a three tier structure consisting of hospitals , dispensaries, primary health centres and sub - centres through which the preventive and curative services can be provided to the population both in the rural and the urban areas. The Bhore Committee

is considered the blue print for planning for health in India. The subsequent developments in the health sector have not drastically changed the basic structure recommended by the Bhore Committee. There have been modifications in terms of separation of the health and family welfare components, integrated approach of the national TB program, the CHV and MPW schemes in the 1970s, and, additions in the form of the National AIDS control program among other programs.

For a very long time India did not have a health policy. The health policy was formulated in 1983, soon after india became a signatory to the Health For All (HFA) declaration at the Alma Ata Conference in 1979. The need for a policy was felt at this point in order to manage the public health sector more efficiently. At about this time the international rhetoric was for Management by Objectives (MBO) and a lot of emphasis was given to Management Information Systems (MIS) by the government in order to achieve the goals of the HFA declaration in a more discernible manner. The state of Maharsahtra was the first to adopt the MIS and then the other states followed suit. The health policy has provisions of ensuring health services to the population for the existing conditions of ill-health for which health care is needed. It however lacks foresight and inter-sectoral linkage in order to have long term efforts of prevention and eradication of diseases. For instance in the wake of the resurgence of

Malaria and the outbreak of Plague in 1994 the government is once again talking in terms of control of communicable diseases which had received a back seat. The policy thus, reacts to a need as and when it arises. Or, when a need for a particular service is felt, the government reacts to the felt needs. India, thus lacks a proactive policy which currently is more reactive in nature. In the current decade the health policy is more or less controlled by the larger macro economic policy which in turn is determined in terms of the structural adjustment programs. As mentioned before, these policy directives demand reduction in government spending for health and involvement of the private sector in delivery of health care. They also urge the government to contract out the health services to the private sector.

Conceptualizing Health

It is necessary to examine the various definitions of health which have appeared at various points of time in the history of health services. As much as health services affect the health status of the people, the manner in which health is viewed affects the nature of health services development even more. Health services development, thus, has to be viewed in the light of the various definitions of health per se.

At the turn of the twentieth century, health was under the purview of the biomedical field, where, like other natural sciences, the phenomenon is perceived within the reductionist paradigm - the body as a machine (Djurfeldt and Lindberg, :22-23). The reductionist try to establish smaller laws to explain a number of concepts; the attempt to have one general law. In natural sciences reductionism is extensively followed and has yielded significant results in the fields of optics, energy, etc. In social sciences there were endeavors like those of Talcott Parsons to establish a Grand Theory which proposes to explain a large number of phenomena.

The field of health was dominated by people from the field of medicine, who were trained in the methods of natural sciences. These medical professionals viewed the human body within the paradigm of the Cartesian model, where the body is viewed as a machine and the doctors were trained to have the knowledge of repairing this machine in times of malfunction or illness. This understanding is compatible with the social milieu of the late 1800s and early 1900s which was determined by the industrial revolution (Qadeer 1985). The comprehension of health thus was reduced to the knowledge of the structure and function of the human body during periods of illness and was given a further impetus by the *germ theory*. The germ theory emerged out of the efforts of biologists like

L.Pasteur and Koch among others who discovered the *gonococcus* (1847), the typhoid bacillus, *pneumnoccocus (1880), tubercule bacillus (1882)* etc.. Subsequently the discipline of bacteriology and biomedical research gained popularity and led to the birth of preventive and curative medicine. With the discovery of treatments with the help of antigens and vaccines which seemed to render miraculous cures, the field of medicine became highly specialized. Discoveries in other field such as physics and bio-engineering added the component of technology to aid diagnosis. in this manner health became a highly specialized and technocentric field which was later sustained by interests of the actors within this field. The developments in industry, the paradigm of the germ theory and the hegemony of the medical professionals gave legitimacy to develop technology to counteract the causative agent of disease. This discussion can be summarized in the words of Renaud (1975), who argues that the health needs in a capitalist society are products of industrial growth and are treated in a manner that is compatible with the capitalist organization of the economy.

In the endeavors of developing technology and treatments to fight the germ, the socio-cultural determinants of health were completely absent from the analysis.[2] The Sanitary reforms movement in England and elsewhere did establish the importance of environmental factors.

However, the main protagonist on the scene of ill health was the proverbial *germ*. England had managed to check the Cholera and subsequently the Typhoid epidemic by providing safe drinking water and controlling the sanitary conditions during the mid 1800s, much before the causative agents of the disease were discovered. It would not be peresumptious to say that this laid the foundation for State planning for health (Park and Park, 1987).

The discovery of bacteria, the subsequent revolution within the biomedical field and explanations to illness sought within the paradigm of the *germ theory* caused the perception of illhealth to be a condition induced by an agent and health was due to its absence or removal. The Western medicine developed on the basis of this paradigm gave rise to the fields of medical education, research, and developed health services within its fold. Health services thus developed were largely curative in nature, the preventive aspect being almost completely absent.

The current definition of health

By the 1970s the myth around the western medical model was being broken. This happened in the wake of the resurgence of malaria, increased child mortality, maternal mortality and a significant deterioration of the health status of the people vis a vis world economic

recession, debt crisis, and so on. On the other hand experiences from communist countries like China and Cuba, particularly the bare-foot doctor scheme of China were stark examples of successful results in health status through concerted efforts of community involvement. China's barefoot doctor scheme which was a product of the Mao regime involved peasants and industrial workers as health volunteers, had radically changed the health status of the people of Shanghai and other areas which were accessible to the outsiders, who could document this evidence. The rest of the world especially the capitalist countries saw *red*, and were urged to reorient their medical paradigm.

A need thus, for evolving an alternative to the current western model and subsequent vertical health programs was felt. A need to democratize, decentralize and make health a basic human right where "the social targets of the governments and the WHO in the coming decades should be the attainment by all citizens of the world, by the year 2000, of a level of health that will permit them to lead a socially and economically productive life" WHA, WHO,197). Health was redefined to be "the complete physical, social and mental well being" by the WHO and the UNICEF at the Alma Ata conference in 1977 and the target of "Health for all by the year 2000" (HFA) was declared[3]. The means of achieving this target was through Primary Health Care (PHC), an old

wine in a new bottle,.

This concept was defined as " essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination "(WHO 1981). In other words putting people's health in people's hands. Giving them the responsibility to control their health and provide opportunities in the market for health which can be utilized by the people themselves.

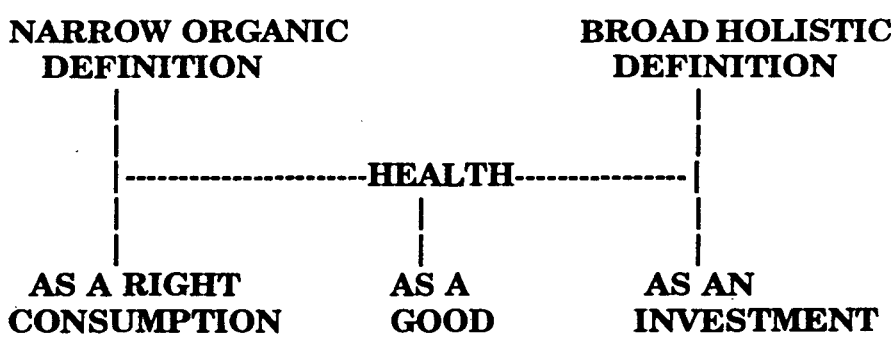
A closer look at this definition reveals the undercurrents of the neoconservative philosophy of violation of individualism and self-determination. Although, this ideology does recognize the people as individuals with individual rights, as persons, it, however, tends to put the responsibility of low quality of life, their illhealth, low status, etc. on the people themselves, as their failure to meet their moral obligations. In this context welfare is therefore seen as 'immoral'. But, there is a danger in applying this ideology when providing health care facility or for that matter welfare services to the people. In the sense that, if the people fall ill, it is their fault and not that of the model of development or for

that matter lack of adequate health services or accessibility to health. In a way this point of view favours the planners and the elites in control as it absolves their "moral obligations" and further legitimizes the mode of development initiated by them (Offe in Moon 1988). There is, therefore, a danger of the poor and the vulnerable sections being deprived of these facilities as they may not be in the position to contribute to the resources and hence cannot "earn" their welfare rights nor can they afford to utilize health services as consumers in the open market. The poor are therefore left with the option of giving a low priority to their health needs as the needs of food and security are given a higher priority (Loewenson 1993).

This global strategy was an outcome of several international conferences initiated and organised by the United Nations on Human environment, Population, Food, Human Settlements, Water, Technical Cooperatives, etc., during the 1970s.It was conceived as a comprehensive strategy that would address the underlying social and economic determinants of health and also include a consumer centred approach to health services. The approach was based on the principle of equity, the recognition of the need for intersectoral approaches to the promotion of health and a broad concept of health (Greer and Baker, 1988). Soon after the proposal of the HFA and the concept of PHC, a counter revolution was proposed which provided attractions to the professionals, funding

agencies and governments looking for short term goals. This was the argument for **selective primary health care (SPHC)**, initiated by Warren and Walsh in 1979. They published a paper in which they argued that the PHC approach was more idealistic and difficult to be implemented by most governments. According to them, in the view of limited resources, it would beneficial to selectively control specific diseases which accounted for the highest mortality and morbidity. It would be better to target and prioritise health care with available low cost technology, and use cost-effective techniques for prevention and treatment of the above mentioned diseases.[4] Within this new rhetoric the programs of *Universal Immunization, GOBI-FFF, Chid Survival Revolution*,etc., were initiated.

The following diagram summarizes the various positions of the concept of health.



(Green, A. 1992:9)

The perception of health at the turn of the 20th century can be said to be a **narrow organic definition** of health where the germ was the main cause of disease and the health services that subsequently developed were the domain of the medical profession who had studied the germ and its behaviour within the human host. This perception also gave rise to the technological advances in the bio-medical engineering as more and more and newer techniques were developed to identify and treat more and more causative agents. When the myth around the medical model was broken during the 1970s (reasons explained earlier), the perception changed to a more **holistic definition**.

On the other hand health has also been viewed in the Keynesian point of view as an **investment.** This perception was largely due to the consequences of a capitalist society where illness meant loss of production and therefore health services were essential for the people in order to maintain a certain health status favourable for production. The perception of health at this juncture was that as a public good which also takes care of the externalities occurring vis a vis. The National Health Service (NHS) in Britain and the health services system in other countries of West Europe and the US can be said to have developed within this paradigm. In the Socialist countries where the welfare services are to be met by the state, health is considered to be the right

of the people. The state therefore makes provision for equitable access and availability of health services to the population. (Moon 1988, Offe 1988, Holmes 1988, Green 1992, Baru 1994)

The Liberal (neo)conservative ideology of Capitalism.

Within the neoconservative paradigm, welfare is seen as a disincentive to invest, employ and work in a milieu of excessive tax burden, increasing budget deficit, and so on. The welfare state is thus seen as a system which causes labor market rigidities and immoralist attitudes (Offe in Moon, 1988 :192). In other words the neoconservative or the liberal right postulate that the welfare state has become too heavy a burden on the economy. The state organised welfare and social security provisions imposes excessive costs and rigidities (*ibid.*). Welfare services, thus, are seen in terms of costs and benefits and not as collective goods.

Neoconservatism, an ideology which has almost become a paradigm in the West, evolved during the post World war period, where the focus was on liberalist pluralism (Steinfels, 1979). The neoconservatives are the ex-liberals who are the intellectual leaders of a national turning to the right. Steinfels (*ibid*) portrays neoconservative protagonists in the U.S. in his book[5] where he illustrates the rising neoconservative ideology. According to him the neoconservatives skeptically view the new programs

to extend medical services,new educational programs, programs which guarantee employment and protect the environment; they are unsympathetic to the economic claims of the poor not only in their own countries but also the third world per se.

A Historical look at the Development of the welfare state and the subsequent return of the liberal ideology.

Before we proceed into any further discourse on the liberal ideology of the planners of the public policy, it would be necessary to see historically the development and the subsequent downfall or reconstruction of the welfare state. Although the welfare state is identified more with post world war England, it was more or less simultaneously initiated in the other countries of western Europe, particularly Germany and was a culmination of processes initiated after the consolidation of the industrial revolution and its adverse impacts on the poor and the vulnerable section of society. It was not and overnight phenomenon but had gradually evolved over a long period of adjustment between the individual and the society (Fraser as quoted in Johnson).

However, the boundaries of the welfare state have not been firmly delineated. It therefore becomes an issue for debate when the Indian welfare state is under consideration. There are differing opinions

regarding whether the Indian system is indeed a welfare state. The Indian state is considered by many to be an interventionist state (Gopal Jayal, N 1994). Traditionally the central territories of welfare states include social security transfer payments such as (retirement) pensions, unemployment pay, sickness benefits and so on. Then there are the benefits of health services, education and personal social services. Some of the government subsidies in the form of subsidized meals, housing, rents are also central to the concept of welfare state. Finally the important central territory of welfare states are the special tax allowances. Nevertheless, the main concern at this point is not to go into the debate over how one determines or defines a welfare state. But to understand that they are a common phenomenon of all capitalist societies and emerge out of the contradictions inherent within a capitalist mode of production.

In the previous century the industrial revolution gave rise to certain social conditions which led to the deterioration of living conditions, especially in the urban areas and among the communities of industrial workers. Certain welfare provisions for instance health care were rendered in order to prevent the consequent loss of production. These provisions along with the problems during the Great Depression of the 1920s and the ensuing world wars set the precedent for provision of

welfare services among the industrially advanced countries.

The Great Depression of the 1920s, the two world wars, the failure of the market and the economic boom after the second world war thus were some of the historical events which contributed to the evolution of the concept of ***welfare state*** as provider of public goods in the wake of the adverse conditions triggered off by the war periods and industrial development during the 1940s. Welfare states were not conceived by a common plan nor did they happen overnight. They are product of various thoughts - Conservative, Liberal, and Socialist, which have over time influenced public policy making. Various political interests, other vested interests, experts, have also contributed to the development of the welfare state. The citizens as the beneficiaries have also played an important role and in turn have influenced the nature of the welfare state (Moon, 1988).Different theoretical and ideological perspectives have interpreted and accounted the welfare state over various periods (*ibid*). In other words these sociopolitical processes led to the expansion of the welfare states.

Moon defines welfare states as liberal-democratic regimes with market, capitalist economies, where some form of welfare provisions require to be met. All industrialised democracies, therefore are welfare

states which ensure " collective civilian security", "a means through which 'we' can provide ourselves with collective goods in the form of programs that protect us against the widely shared risks inherent in the dynamics of the capitalist mode of protection" (Offe in Moon, 1988). Offe also mentions the alarmist perspective of regarding welfare as "immoral", where the beneficiaries remain anonymous and do not require to demonstrate their accountability or loyalty to the state. However, from this perspective he draws some inferences regarding the client (or beneficiary) - tax payers and voters and - elite dynamic within the realm of the welfare state. He quotes Zijderveld to point out one of the disadvantages of the welfare state, that is the clients or the beneficiaries view the state as guarantor of minimum standards of welfare but look upon it as the provider of maximum standards of welfare. This argument is extensively used by neoconservatives to withdraw welfare provisions. The libertarian principle of *individuality* is also used as an instrument to support the withdrawal of the welfare services by arguing that welfare provisions go against the right of self-determination and make the people dependent upon the state which inturn takes on a paternalistic nature. However, Goodin (in Moon 1988) argues that certain amount of welfare provisions are necessary for sustaining the market as well as counterbalancing the adverse conditions triggered off by the market mechanisms.

If the economic boom, the adverse conditions during the war period, etc were the historical events for the making of the welfare state, then the break down of the Soviet Bloc (which popularised state control and state provision), the world economic crisis, the oil crisis, etc., were the factors which led to the break down of the traditional welfare states and restructuring the other welfare economies. During the 1980s, in the wake of the world recession of the 1970s,a considerable amount of the neoconservative rhetoric was reflected in the policies of Margaret Thatcher and Ronald Reagan where the emphasis was on *privatization* of the public sector. Welfare services were in the process of withdrawal and new dimensions were added to the concept of the welfare state. Welfare was no longer seen as a public good which helps to avoid collective evils of the society. The perception was increasingly beginning to incline towards looking upon welfare as 'immoral' which violates the principle of individuality and freedom. This philosophy was used as a justification for cutting back on welfare services and was amplified in the structural adjustment programs.

The *structural adjustment programs(SAP)* initiated in the 1970s as a response to world recession, debt crisis and issues of balance of payments(BoP) in sub-Saharan Africa and Latin America. However, it was soon evident that the transitory costs of structural adjustment were

too high (Jolly & Cornia) and it reflected in high mortality, low nutritional levels and further deterioration in the quality of life of the poor. It was thus felt that adjustment per se was not the answer to recover the deficit. In the 1980s, the UNICEF, therefore launched the Adjustment with a Human Face policy where it will be necessary for the state to intervene in order to provide certain minimum welfare provision to the poor and the vulnerable to counter-balance the transitory costs of adjustment and the effects of the market mechanisms.

The welfare state thus came into existence to counteract the discrepancies inherent within a capitalist mode of economy. The market, which is a self-regulatory mechanism, does not always follow the pattern forecasted by the economists and the planners. The Great Depression, the two world wars, and so on were the cause of severe social and economic costs. The post world war-II period was of an economic boom in the advanced industrial countries of the west. By the 1970s the picture of an economic and fiscal crisis had emerged. This crisis was manifested through negative economic indicators such as unemployment, inflation, reduced growth, setbacks in industrial production; conditions similar to those of the early 1900s which saw the Great Depression and the two world wars.

In order to counter these adverse economic conditions, the capitalist ideology gave importance to those sectors which seemed to be economically profitable. Unprofitable, or investments with no returns were viewed unfavourably. in this context, welfare services, which in Keynesian terms viewed as investments, particularly health and education were now being viewed in terms of costs and benefits. There, thus was an obvious shift in state priorities. the state, in capitalist developed countries, gave more emphasis to sectors which were economically viable and favourable to capitalism. It is thus possible to view the rise of "Reaganomics" and "Thatcherism" in this context. These two terms essentially refer to policies which focussed on cut backs on social expenditure. In 1983 and 1984, the US government had cut back on expenditure on social security, health education, nutrition, particularly for the poor families (Navarro 1984 :120-122). Nonetheless, these cutbacks were counter-balanced by increase in other sectors such as defence and the military. In this manner, the total state expenditure may not have been cut down. However, the priorities had changed. State intervention, thus was not reduced but reorganized. We, therefore, see not the withdrawal of the welfare state, but instead a restructuring of the welfare state.

The Structural Adjustment and Stabilization Program (SAP)

The post World War II period saw the emergence of several independent economies, to be later termed as the third world economies. These newly established nations had more or less, completely asserted their independence and were on the path of economic development and rebuilding their economies. In order to bolster their economy and enter the world market, these countries had to resort to heavy borrowing from the economically advanced countries in terms of cash, technology and even infrastructure, especially from the former colonial masters and the U.S.A. Hence, the agenda of most of these economies at the very onset of their planning showed an emphasis on economic growth for which they needed the support of the economically and technologically advanced countries.

These newly established economies had adopted a model of development which gave a lot of emphasis to economic growth. This model of development was evolved particularly in the U.S.A. and directed at the less developed countries of Latin America and Asia. This argument was based of the trickle-down theory of economic growth. W.Rostow's model of economic growth as given in his *Three Stages of Economic Growth considers* the general features of developed economies as ideal. Developing countries are therefore urged to replace their features by

those practiced in the developed countries. [6]

Towards the decades of 1970 and 1980 the economies of the world were faced with the vicious circle of a market failure, the debt crisis, increasing inflation,etc. This gave rise to, according to Zaidi (1994) a *new conventional wisdom* of "market friendliness, privatization,devolution and democracy justified by the demise of the communal economies of the former socialist countries. Following the debt crisis, these economies have been increasingly obliged to make adjustment in order to limit public spending. [Only those sectors were given importance which were economically viable and of utmost importance within the liberal, neo-conservative realm, such as defence, industry, etc.]. In this context, thus, the world saw the rise of "Thatcherism" and "Reaganism" in England and the U.S.. The developing countries, who were the recipients of loans in various forms too were obliged to make important structural changes in their economies.

The greater part of the 1970s and early 1980s was a period adverse international economic conditions with the oil crisis, world recession, deteriorating terms of trade, debt crisis, etc., which gave rise to several macroeconomic problems. These conditions have been the precursors to several major macro- economic changes globally. In response to these problems, the developing countries have been increasingly obliged to

make macroeconomic adjustment or stabilization programs in their economies in order to limit public expenditure. In other words the ***structural adjustment and stabilization programs*** **(SAP)** have been proposed to solve the problem of the balance of payments. These obligations are being imposed by the combined forces of the world Bank (WB), The International Monetary Fund (IMF), and some international agencies.

The Structural Adjustment programs are basically long term objectives for the structural causes of the problems.While the stabilization programs are short term objectives. Both together constitute the *Structural Adjustment Program (SAP).* The main policies under SAP include reduction or removal of government subsidies on food, education and health. Devaluation of currency and controlling the supply of money. Removal of trade and exchange controls and liberalization of trade which will entail retrenchment, wage freezes or restrains, and deregulation of laws and reforming pricing policies. Privatization of the public sector enterprises. In other words the policies imply reduction in government or public expenditure on welfare services and a concerted shift towards a market oriented system or rapid economic growth. (Cooper Weil etal 1990, Balasubramanium 1993 and Loewenson 1993).

The basic premise upon which the SAP functions is the theory of "trickle down", where it is assumed that by helping the rich get richer, the benefits will somehow trickle down to the poor. It concedes that there may be some transitory costs, but as the name suggests theses costs are transitional and eventually everything will be fine. The WB further argues that in order to achieve economic growth, these costs are necessary and sooner or later will reverse the conditions of the poor. But evidence, especially in the Latin American and sub-Saharan African countries, has shown that poverty has not been alleviated, the conditions of the poor countries are infact deteriorating.

The Indian Welfare State

India adopted the welfare state model within a socialist pattern of central planning and control after Independence. Jawaharlal Nehru was a pioneer in this respect and infact it were his efforts which were later termed as the Nehruvian model which was associated with the Indian economy.

Although India constitutionally gave the citizens a welfare state, the nature of it was not totally on lines of the ones traditionally developed in Europe, particularly in England. The Indian economy is unique in the sense that it is a mixed economy, with the presence of both

the public and the private sector. Welfare provisions exist in the form of services for those employed within the public sector, various subsidies and some benefits for instance the ESIS, CGHS, JRY, some educational benefits and so on. In the context of the health provisions, the Indian Constitution gives the responsibility of the implementation of the health services to the individual states where the health services would be provided free of charge to all the citizens of India as per the recommendations of the Bhore Committee. In other words, health is a state subject. However, the central government controls the finances and the planning mechanisms and hence decides upon the public policy.

Infrastructure development is not independent of the larger sociopolitical processes taking place within the society. Bannerji (1984), Qadeer(1985), Jeffery (19) among others have emphatically argued that the infrastructure which India developed after Independence was thrust upon the citizen by the British through the Indian elites who took the reins of Indian planning in their hands. In this context health infrastructure development in India therefore has to be seen in the context of the sociopolitical processes as well. At the onset of planning for India, the planners and the political elite adopted the socialist pattern of planning which resulted in the responsibility being entrusted to the central government. Subsequently, health services also developed in a

similar manner with the decision making and financial control with the central government and implementation being given to the state governments.

The contemporary global order is that of liberal, neoconservative rhetoric mentioned above. However to regard the Indian system within this framework alone will not be a complete endeavour. It will therefore be necessary to view the Indian milieu within its socio-political forces. It is assumed that the policy makers and the decision makers have been increasingly favouring the liberal, neoconservative ideology. It would be interesting to note the sociological background of the planners and the decision makers within the indian context in order to make the above statement more emphatic. However, that is beyond the purview of the present study. Nonetheless, it is assumed that the decision makers, who belong to a particular group of elites, find the neoconservative, liberal ideology compatible with their interests and hence propagate it through policy decisions. Their decisions get reflected through the larger policy statements for the country. An attempt will be made in the ensuing paragraphs to try and briefly describe the probable reasons within a particular theoretical framework and the dynamics within which the policy makers tend to take certain decisions.

All those who have studied the health services system have pointed out the regional imbalances in provision of health services, an urban bias and a general failure of the system to provide adequate health care to the people (Navarro, 1976, Bannerji, Doyal, Baru). There have been descriptive accounts of the health services failure as well as Marxist analysis of the phenomenon. I propose to use these studies as a basis and try and see what are the current trends, especially for the 1990s. Although I agree with Navarro, Bannerji, Qadir, Doyal, I do not intend to do a critical analysis in a similar vein. In that sense, the present study will be to a certain extent a descriptive as well as an analytical account with some empirical data to support the argument. My effort is to look at health services development within the capitalist system and try to explain trends which are a manifestations of the capitalist mode of economy. Since the study is focussed on Maharashtra, I propose to view the Indian democracy within the pluralist-democracy model and further extend it for the analysis of Maharshtra as proposed by Lele in *Elite Pluralism and Class Rule* (1982).

The pluralist-democracy model

India is a society of diversity in social life. It is a multitude of religions, cultures, traditions, and people of different castes and class. India, thus, can be stratified along not only horizontal but also vertical

sections (Gupta 1991). Each group from these sections particularly caste plays an important role in the democratic processes in India. Several studies of the Indian polity have revealed a pluralist image of Indian politics. India is a representative democracy where the people are represented by a small group of elected members. These elected members form the group of political elites and usually are seen to be from the dominant caste groups. It will therefore be useful to examine the Indian system within the framework of a pluralist-democracy wherein the elite bargain for the resources in order to maintain their hegemony. This framework has been adopted by Lele(1982) in order to examine *elite pluralism and class rule* in Maharashtra, where he defines a pluralist democracy as

> "a system of government in which parts of the elite, representing a variety of interests, bargain for control over society's resources through public policy, where the elite is a heterogeneous group of accountable and responsive leaders concerned with maintaining some correspondence between individual will and collective decisions". (Lele,1982 :3)

Within a pluralist-democratic framework, welfare services may be seen as an instrument of legitimization of the elite rule where the elite bargain for the resources to maintain their hegemony. However, the elite are not the only force who determine or influence public policy alone. In a democracy citizens are able to voice their demands and can even use

coercion to acquire the demands. The citizens thus constitute the other forces which act upon the policy and comprise of the tax payers, the vociferous middle class and the beneficiaries. These forces along with the elites who bargain for power are responsible for the push and pull factors acting upon the welfare state and are responsible for determining the nature and the provision of the welfare services.

Offe thus suggests an alternative analytical framework of looking at the crisis of the welfare state where he attributes the problem more to the "structural changes within modern societies that condition, suggest and steer the prevailing interpretative pattern of samenness ". In other words it means a "destructuration" of collectivities which took place vis a vis the economic and fiscal crisis of the 1970s which gave rise to the "disorganisation of broad, relatively stable and encompassing commonalities of economic interests, associational affiliation, or cultural values and lifestyles" which in turn weakened the commitments of unity. What emerged in the industrially advanced economies was pattern of dynamic plurality of relatively small groups and no single axis of dominance. That is the conflict is no longer a class-conflict but one of interests which is in accordance with emerging pattern of plurality.

Offe has described the above mentioned dynamics in the specific context of the industrially advanced countries and cannot be generalized completely within an Indian framework where the dynamics of caste play an important factor. In the Indian set-up, the beneficiaries are closely associated with the elite either as their kin or through several formal and informal relations of interaction. Also, as potential voters in a system of universal franchise, they are able to form a strong group who in turn form pressure groups to demand for certain services. Exhibiting the push and pull factors determining the nature and type of services to a certain extent. One of the recent and most talked about experiences of this phenomenon is the post Emergency downfall of the ruling Congress government. The electorate did not approve of the population control program of the then Congress government and it was one of the main reasons for its downfall (Bose 1980, Lele 1982). In this continuous struggle for control, however, the elite, particularly the political elite, in a country like India have a upper hand as the voters can only be in touch with them through their representatives. These representatives are elected by the people themselves and also are popular with the elite. The political scene, thus becomes a ground for satisfying vested interests and gains, with the elite getting a better deal.

In a pluralist model scarcity and competition play an important role. The principle of the formal openness of the areas to which everyone with the necessary ability can gain access replaces the equality of access. Privatization and alternatives to government organizations are thus seen as a favourable process which enables the elite to control the resources and further sustain their hegemony. Health services being welfare services in kind are seen as factors of control and receive political, economic and social support. The next chapter will further deal with this phenomenon with examples form the state of Maharashtra.

Summary

The study thus functions within the basic premise that the planners, the groups of elite who are in control and the people who demand services determine the nature of services, in this context the health services. It has been assumed that the planners have an upper hand in determining the nature of the services than those who demand these services, particularly in a country like India. Here the caste factor plays an important role. In the context of the current sociopolitical milieu, the planners are likely to find the policies such as privatization more favourable and trends are already indicating in this direction. In terms of health services, therefore, it is highly probable that the trend is in favour of the private health sector. This will be particularly true of a

state like Maharashtra with has a dominant private sector which has developed over a long period of time.

NOTES

1. For an international perspective refer Doyal, Navarro, Mckinlay among others. For an Analysis of the Indian health sector refer Bannerji, Qadeer, Rao, who argue that the dominant minority from the medical field thrust the western medical model upon the Indians.

2. Several researchers and analysts of the health services system viz; Doyal, Navarro, Jeffery, Qadeer, etc. , have pointed out the fact of the hegemony of the medicos in designing the health services. Jeffery in his analysis of the health system in India in *Politics of health in India,* describes the planers of the health services in the 19th century to be "primarily male medical practitioners".

3. For a critique of the definition of the WHO definition of health as a "complete physical, mental and social well being and not just the mere absence of illness", see Qadeer, I (1985) : *Socio-economic Inequalities of Health Care*, Social Action Vol 22 No.

4. cited in the editorial *: **The Debate on Selective or Comprehensive PHC,*** *Soc. Sci. Med.* Volume 26 :9,pp 877-878.

5. Steinfels,Peter : *The Neoconservatives : The Men Who are 1979 changing America's Politics.* Simon and Schuster, New York.

6. For a critique of Rostow's model of economic development see Navarro,V : Medicine Under Capitalism. In his book Navarro has argued that those in power and the experts on development from the developed countries adopted Rostow's model for introducing the mode of development in the developing countries.

Chapter 3

Maharashtra : a sociopolitical profile and Health Services Development in Maharashtra

Introduction

The state of Maharashtra has relatively been in the fore front of development and the same applies for health services in Maharashtra, despite stark regional imbalances within the state. It ranks among the first five sates of India with respect to health indicators such as crude birth rate (24.9), crude death rate (7.4) and infant mortality rate (54) (Govt.of Maharashtra 1995). The socio-economic profile of the state reveals a favourable picture with a per capita income of Rs.9627 (92-93), 64.9% literacy rate and reasonable male female ratio of 934 (see annexure). in terms of health services, Maharashtra has already achieved all the prescribed targets in order to attain Health for All by 2000 AD. The state thus, according to the officials from the directorate of Health Services, Mumbai, is said to be in a phase of consolidation during the 1990s and very little growth in the health institution per se has been planned for the coming years. However, before we take a look at the development of health services, it will be necessary to understand the socio-political dynamics in Maharashtra, especially historically. This is because health is a welfare service and a tangible benefit. In a pluralist

democracy welfare services are used as tools for bargaining by the political elites in order to maintain their dominance. Hence, the following paragraphs will briefly look at the socio-political processes in Maharashtra.

The Socio-political processes in Maharashtra.

As mentioned in the previous chapter, in the theoretical framework, socio-political processes are not a one time affair. Infact they are dynamic processes evolving over a period of time. In Maharashtra, these processes have to be understood in terms of the dominant caste activities in order to maintain their dominance. In the light of this, welfare services are then a mere tool of control, to be used by the actors as one of the bargaining mechanisms[1] . It is also necessary to look at these processes historically. To do this exercise, it is necessary to identify a period in history. One can start at any point and trace the events before and after that point of reference. The history of Maharashtra is largely understood in the context of Shivaji. However, it is not the purpose of the chapter to go that far back in history. For the purpose of the study the period has been delimited from the 1800s onwards. Thus, the period under study is 1800s upto the 1990s. This span of years has further been divided into three phases for the analysis. The first period coincides with the

colonial phase upto Independence. The second looks at the post-Independence period upto state formation in 1961. Finally, the last phase extends from 1961 to the 1990s. The changes in the socio-political processes in terms of the dominant caste will be looked according to the above mentioned period.

The Marathas

Traditionally belonging to the peasant class, the Marathas are the largest single caste group in Maharashtra. According to the census of 1931 the *Maratha-Kunbis* numbered 31% of the total population. Together the elite Marathas, the Kunbis and the artisan castes, constituted nearly half of the population as against the 3.90% of Brahmins and 16.47% of schedule castes, in the total population (Census of India 1931 as quoted in Lele 1990 :117). The Marathas constitute the maratha elites, the kunbis, the shepherd comunity - the *dhangars,* the *kolis* and the *balutedars.* The maratha elites consider themselves descendants of the *Yadavas* and hence call themselves *Kshatriyas.* The kunbis are the traditional peasants while the balutedars are the artisan castes such as cobblers, tailors, gardeners, and so on. The kolis are the tribals which can be grouped under the Marathas per se, although they will be lower in the intra caste hierarchy. They are thus numerically the largest group.

There are regional differences in the social composition of Maharashtra which in turn has had an impact on the overall development of Maharashtra, particularly in terms of political development. The Maraths are more concentrated in western Maharshtra and Marathwada regions. However, they are more powerful in western Maharshtra despite Marathwada having more fertile land. One of the reasons for this being that during late 1800s, Marathwada had become an important cotton growing region, particularly in the light of the American Civil War. The British seemed to have found Marathwada to be a better substitute for their cotton requirements. Cotton economy required a large labor and hence during the late 1800s a large number of landless labourers migrated to Marathwada. Western Maharshtra , hence was left with the elites and the kunbis who owned land. These landed gentry were later to be the centres of political power, making western Maharashtra a powerful region[2]. Another reason being for their concentration in this region being that the capital of the Maratha rule- Satara is found in this region. Hence, increasing their concentration and dominance in western Maharashtra

During the 1800s however, the Marathas were in the process of consolidation of their dominance. Between this period and the rule of Shivaji's grandson, the centre of power had shifted from the hands of the marathas to those of the brahmins. There was a conflict between the two grandsons of Shivaji as to who should ascend the throne. The conflict was resolved by dividing the kingdom into two, with the central authority at Satara, the traditional capital of Shivaji. The other grandson received the state of Kolhapur. King Shahu of Satara had appointed his *Peshwa* or his minister to take charge of the administration of the kingdom. The Peshwa, a brahmin hence ruled the kingdom in lieu of the maratha ruler. Their centre of power was Pune, an important city in the western Maharashtra region. This move was obviously resented by the other maratha leaders who controlled the smaller estates or jagirs. Brahmins are traditionally priests and not kshatriyas. Being ruled by them was certainly not an aceptable proposition. The Peshwas therefore never received total allegiance from the maratha leaders. Hence the British did not find it too difficult to take control of the maratha kingdom and make it into the Bombay Province.

The anti-brahmin movement and the rise of maratha dominance

After consolidating themselves in Maharashtra, the British took certain measured steps in order to capitalize on the resources available. They introduced land reforms or the ryotwari system in the ex-Peshwa territories during the mid 1800s. However, with these reforms, the maratha elite comprising of the dominant maratha-kunbi cluster continued to retain their land which was the largest and the most productive (Lele 1990 :140-141). These maratha elite belonged mainly to the western Maharashtra region.Thus, when the British introduced cash crop economy, these elite benefitted the most. It served the purpose of the British to continue to develop western Maharashtra and the cotton tracts of Marathwada in order to sustain their trade. The marathas also were able to benefit rom development of public utility services such as conrustions of roads, canals, and so on. They became commissioned agents or contractors for the these works. At about the same time or a little later, the British introduced educational facilities. The prime reason for this being that they required a certain force in order to transmit and interpret the European culture to the native people and start the process of modernization, as well as develop a cadre of people to work in the developing trading centres at the clerical level. Several educational

institutions thus came into existence in the 1800s. This would have ensured a smoother control for the British. The brahmins being traditional knowledge seekers took advantage of these facilities and we see the fruits of this endeavour in the form of Justice Ranade, Gokhale, Agarkar, Tilak, and so on. Some of these educated brahmins were associated with the reformist movement in Maharshtra which had non-brahmin members as well. To mention a few, Justice Ranade, Gokhale and Agarkar were pioneers in the reformist movements followed by Mahatma Jyotiba Phule, a non-brahmin. On one hand the British had developed the basic systems for resources and had initiated facilities in order to have educated people to be in service in the administration, on the other hand they had also encouraged merchants especially from Surat during the early phases of the British trading centres (*ibid* :142-143).

It can therefore be inferred from the above dsicourse that the marathas continued to operate form the rural areas. They also benefitted from the schemes of the government for rural development such as the loan schemes, irrigation, establishment of banks, cooperatives, and so on. They "concentrated their efforts on maintaining economic and political dominance through a policy of collaboration with the state"(Lele 1990 :158). At about the same time

the old brahmin -maratha antagonism was once more revived under the auspices of the Satya Shodhak Samaj started by Phule. He (Phule) had not intended to make the Satyashodhak Samaj into an anti-brahmin movement per se. It was instituted in order to fight the rigid brahmanical systems and initiate reforms. However, the movement took an anti-brahman stand and received the blessings of Shahu Maharaj of Kolhapur. They opposed the brahmans and not their practices and attempts were made to encourage maratha priests instead. Thus, the marathas consolidated economic power on one hand, and on the other they attempted to weaken the lot of the brahmins who had become their opponenets ever since the Peshwa regime. According to Lele (1990) the non-brahmin movement gathered momnetum in Maharashtra under the condition of ascndance and rassertion of dominance by the mararthas. It is not the purpose of the study to look into the anti-brahmin movement in Maharashtra in details. However, it needs to be mentioned beacause this becomes an important issue at the time of state formation during the 1960s.

By the twentieth century the state of Bombay revealed a social picture of the maratha-kunbi dominanace in the rural areas, the brahmin led educational institutions and their subsequent

inititiation in the services of the British administration and other trade related administrative jobs and the merchants and traders of the Parsi and other trading communities. All these communities for various interests entered the freedom movement. The marathas nevertheless cashed on their rural support and fostered it further during the freedom movement. During the early 1920s, the kunbis were able to get acceptance as kshatriyas and were included along with the maratha elite in the census. This move was promoted by both, thus reasserting their strength. In response to the freedom struggle, the marathas joined the Congress in large numbers , which later became synonymous with maratha leadership in poliyics.. However, the leadership during this phase rested largely with the brahmins who one can say had initiated the freedom movement in Maharashtra. Politically also the brahmans, Gujaratis, and Marawaris had been able to be in charge on the provincial councils. The marathas during this phase were not able to contribute significantly in politics. Nevertheless, they were able to get control of the local councils and cooperative institutions. This control of the local level institutions and their entrance into the Congress gave an impetus to the maratha leadership especially in the rural polity. One can view these events as an introduction of pluralism within the political scene in Maharashtra where the elite bargain for the control

of resources in order to maintain their hegemony. The main resources which are used as tools for bargain are the welfare services which show tangible benefits. Though not very crucial for the freedom movement, this configuration was of vital importance during the post-Independence period. Another variable in this configuration is the large concentration of the maratha elite in western Maharashtra, thus laying the foundation for a skewed development in favour of this region.

Post-Independence and state formation (1947 - 1961)

The non-brahmin movement was the strongest in the western Maharashtra region, which also had the largest concentration of marathas. During the post-Independence period the leadership which emerged was largely urban and brahman. However, the marathas had completely consolidated their dominance in the rural polity. The need to assert themselves all over the province was felt by the maratha leaders and therefore the dialogues for the formation of a state of Marathi speaking people were initiated with the rise of the Samyukta Maharastra Movement and the emergence of the Peasants and Workers Party as well. At this time the sate of Bombay had three centers of power at Bombay, Pune and Nagpur. The people of Nagpur still recalled the rule of the Peshwas and hence were

hesitant to join Maharashtra. Vidarbha also is a very large region with fertile cotton land. They therefore demanded to form a separate state. However, the maratha leadership was able to include the marathi speaking and largely marathas with a strong rural control(after the inclusion of the kunbis and the service castes under the "maratha" umbrella) of Vidarbha in the newly esatblished state of Maharashtra under the aegis of the Nagpur Pact (1953).

This pact has great importance. The regional imbalances in development were evident at the time of state formation. The Nagpur Pact answered the issue of regional imbalances, promising the developemnt of the regions of Vidarbha and Marathwada. These issues formed the basis of state formation in Maharashtra. The state of Maharshtra was thus formed on 1 may 1961 by joining the marathi speaking regions of the state of Hyderabad, the Central Provinces, and the Bombay Province, thus forming the regions of Vidarbha, Marathwada, western Maharashtra respectively along with the Konkan region. It was a known fact that the regions of Marathwada and Vidarbha were not as developed as western Maharshtra despite having fertile soil and other natural resources. The reasons for these differences are historical and have a socio-political basis as discussed above.

Regional Imbalances in Maharshtra

Maharashtra is a relatively more developed state especially with a large industrial sector and Bombay the economic capital of India. Nevertheless, there are stark imbalances amongst the regions. The preceding paragraphs elicited the dominance of the marathas in the western Maharashtra region. Beacuse the maratha elite were able to take advantage of the land reforms and other infrastructural benefits initiated by the British, it is highly probable that the region of western Maharashtra, where they are found to be in larger numbers could have developed more than the other regions. During informal discussions with people involved in the field of development in Maharashtra, it was found out that western Maharashtra despite being a rainshadow region, gets water for irrigation through a system of canals which get filled with water once it rains in the Shayadris spanning the Konkan region. Konkan region is located on the western coast of Maharashtra through the length of which the Sahayadri range runs. They receive the highest rainfall in Maharashtra and a system of canals which had been initiated by the British and later developed by state during the post-Independence period, especially for the cash crops, are fed by the rain water from the hilly slopes.

During the early 1980s, soon after the reassertion of Congress (I), the Sixth Plan document was reframed and a special Committeee under Dr. Dandekar was initiated to look into the regional Imbalances of the state. The Committee on regional imbalances (CORI) recognized the need to concentrate on the development of the regions of Vidarbha and Marathwada (1983). Sunbsequently recommendations were incorpaorated in the following annual plans. However, in 1992, in a study conducted by K.Seeta and Sarkar, the persistence of the imbalances were revealed. They found out that amongst the developed districts, majority of them were from western Maharashtra. While amongst the underdeveloped, majority of the districts were form Marathwada and Vidarbha. This means that the recommendations of CORI were not implemented completely. However, in terms of health services, the Plan Documents of the state of Maharashtra seems to have adopted the recommendations of CORI. There was a significant increase in the number of health institutions upto the mid 1980s. There could be several reasons for the increase of the health services during the1980s[3]. The section on data analysis will discuss this in details. Once again during informal talks with developmental activists from Maharashtra the reasons for the lack of successful implementation was attributed to the apathy of the leadership to develop regions other than western Maharashtra.

Although this finding does not have any empirical basis, it is largely based upon the observations and experiences of the developmental workers who have been working in the field of social upliftment for more than a decade. We thus see a picture of underdevelopment or low development in Marathwada primarily followed by Vidarbha and high level of development in western Maharshtra (K.Seeta & Prabhu, 1992).

Health services development in Maharshtra

The early phase

With the backdrop of the above scenario, the development of health services in Mahrashtra needs to be viewed as a welfare service which has developed over the years according to the soci-political developemnts occuring in Maharashtra. Initially, before the British ruled over India, the ayurvedic system was predominanat all ver India. In Maharashtra the Unani system was also prevalen as was true of other areas which were uder the rule of the mughals. The English brought with them the system of allopathy which was subsequently transmitted to the people through concerted efforts during the 1800s. During the early phases of colonial rule in Maharashtra, there was a convergence of the Britih to the coastal city of Bombay with the intention of converting it into a port for their

trade to England and rest of the world. There were not many health facilities during this early phase. The few doctors who practised were employed by the IMS and were required to look after the health needs of the Eurpoean civilian population besides those in the military . the services were primarily of curative nature.

Colonial Rule phase

Bombay was initially a cluster of seven small islands with shallow sea seperating them. These shaloow gaps would often get stagnated during low tide and particularly after the monsoons which is quite heavy.. However this was not a major health hazards as population was low. It posed a threat only after the population started increasing. Besides,comprising primarily of fisherfolk, fish was in abundance having multiple usages. Fish was being used as fertilizer for the coconut plantation which would get putrid and spread a typical fish odour to the surrounding areas. Around the same time there was an increase in the illhealth of the people. This was due to the increasing epidemics of fevers. The combining of the two factors of putrid fish and stagnation of water and correlating it with the illhealth prompted the British rulers to take measures which banned fish fertilizer and efforts were taken to fill up the shallow gaps between the islands (Gazetteer of Bombay 1976). The

British also had the experience of the sanitary reforms movement in England. Hence, some preventive measures in the form of sanitary reforms were adopted.

The health facilities, thus available to the people were few curative services, vaccination and largely sanitary reforms. The curative services were subsequently extended to the native population, particularly those who were employed on the docks.During the efforts to educate the people, medical education also was extended to the epople. The first medical college was established in Bombay along with those in Calcutta and Madras (Ramasubban 1982). The Vaccination department was established in 1858 by the Sanitary department under the control of the Sanitary Commissioner, followed by the Sanitary department in 1895.In 1890 a medical cell , a branch of the Sanitary department, under the Surgeon General was also started in Bombay. The subsequent Directorate of Public Health came into existence in 1921. The initiatives of the British goverment and the Mission were replicated by the rulers of the princely states of Mharashtra. They also had the advantage of the newly trained native doctors. The rulers, therefore established nursing homes, allopathic dispensaries, and services for women and children. By the early 1900s, thus, thus, the health

services available to the people were largely the efforts of the British government, the rulers of the princely states, some charitable trusts and private groups and the Missions who had been encouraged by the British to establish themselves.

The latter phase of colonial rule

The early part of the 1900s saw the rise in the freedom struggle and the subsequent increase in voluntary organisation. These voluntary organizations were started in order to revive the Indian culture and to promote nationalism. One such organisation was the Ayurved Prasarak Mandal at Satara (Gazetteer Satara district 1963 :769-771). Other voluntary organisation ans charitable trusts also started health institutions following the examples set by the British government and the Missions. They established dispensaries and hospitals. Some of the hospitals established by the charitable trusts were later taken over by the British government during the early 1900s. These were conveted into district civil hospitals. Data for the same is not available. However, one can find references t the same in the district Gazetteers.Infact, comprehensive data on development if health services is not available till the 1960s. It was only after the formation of the state of Mharashtra that data was compiled systematically. Nevertheless we can infer form the

information availably in the Gazetteers that there existed atleast one Civil hospital in each district towards the latter part of the colonial rule. Besides, there were allopathic dispensaries, small nursing homes and facilities for women and children, mostly in the urban areas. Very few services were available in the rural areas. The exceptions were the Missions who had tried to penetrate into the interior areas of Maharashtra, particularly the drought prone regions of Ahmednagar, Nagpur, Chandrapur and Gadchiroli.The health services thus available to the people were the efforts of the British governemnt, the rulers of the princely states, voluntary organisations and charitable trusts, and a few private organisations.

Maharashtra inherited these services after Independence which already had a urban bias. Subsequently following the recommendations of the Bhore committee, the state of Bombay established rural health services and other infrastructural facilities. As per the concept of comprehensive health care of the Bhore committee and the Community Development Plan 1952, emphasis was given to the development of the rural health services. The subsequent development was in accordance with the rest of India as the new government was still establishing itself. The main thrust to health services development is observed only after the formation of

the state of Maharashtra in 1961. The new state had been able delimit its boundaries inclusive of all the marathi speaking people. The state had been reviewed for levels of development and the maintask before the state government was to answer the issue of regional imbalances, particularly in the areas which had been carved out of the neighbouring provinces and, which were underdeveloped.

Health services in Maharshtra

Pre-independence : Before independence all the health activities in Maharashtra, comprising of the Bomaby Presidency and parts of Hyderabad and the Central Provinces, were under the control of the Civil Surgeon who was in charge of the civil hospitals located in each Taluka of the state. Most of these General Hospitals were established during the mid and late nineteenth century, with the exception of the Bombay Presidency where a hospital was established in 1677 by converting the building of the old Court near the present Cooperage in the current district of Greater Bombay. However this hospital ran into trouble when the need for more space for the Marine Yard was felt. It continued to function till 1860 after which steps were taken to construct a new hospital. The foundation stone of the present St. George's Hospiatl, thus was laid in 1889.

The British governemnt played an important role in developing the health services for the Bombay Presidency, primarily because it was one of the important ports of India and large settlements of European military as well as civilian personnel were found in Bombay. Several medical personnel had been recruited by the government to deal with the health problems of the dock workers, the military and the civilian population of the Bombay Presidency.[4] A Native General Hospital, supported by the government came into existence as early as 1809 which treated 20 patients daily. This hospital treated chiefly paupers brought in by the police. However, in 1834 the government opened the Bombay Native Dispensary for the native population which popularised European medicine and medical Institutions (State Gazetteer, Greater Bombay district). By 1846 a few private dispensaries had also been established. The remaining century saw the involvement of several private philanthrophers like Jamsetji Jijibhoy, Jehangir Nasarwanji Wadia, Ackworth, Gokuldas Tejpal among others, in the development of health services particularly in the city of Bombay. By 1920 the city of Bombay alone had 28 General hospitals and dispensaries (seven for women).

The other parts of the state which were part of different provinces also show a more or less similar picture. It however differs in terms of quantity of services. As mentioned earlier, most of the General hospitals had been established around the mid-1800s and late 1890s. Some of these hospitals had been established by private bodies and voluntary organizations. For instance the Mayo Hospital (1867) with the attached Daga Memorial Hospital(1928) in Nagpur was started with the donations from the Lady Dufferin Fund and the Sir Bisasar Daga respectively, the United Free Church Mission established the Mission Hospital at Bhandara , Bhandara district in 1889, the Wanless Hospital, Miraj Sangli district was established by Dr.Wanless, a Canadian Missionary. The rulers of the princely states of Kolhapur, Sindhudurg, Satara, etc. also established nursing homes and dispensaries which followed the European medical system. The Ranisaheb of the former Sawantwadi state had started the Rani Janakibai Maternity home in 1928. The former state of Kolhapur had started the C.P.R. Hospital in Kolhapur in 1884.

By 1949, most of these hospitals were taken over by the government and were made part of the Bombay state. Maharashtra, thus had already a fairly well developed network of health institutions, due to the efforts of the government, the private bodies

and the voluntary organizations. The role of the government became of prime importance in the development of health services for the state of Bombay (now Maharashtra) after Independence. The important aspect of the government's role in health services development is that along with curative services, it also developed preventive health services. On the other hand the private sector also continued to grow simultaneously, mainly providing curative services to the population.

Health Services development: 1960 to 1990

By the post-state formation period, Maharshtra already had a substantial number of health services. The following table 3.1 shows the number health services inherited by the state of Maharashtra at the time of its conception in 1961. The Committee on regional imbalances (CORI) had identified four indicators to compare the level of health services provided by the government and government-aided institutions. They had selected number of government dispensaries and Subsidised Medical Practitioner (SMP) centres, number of Primar Health Centres and Primary Health Units, government Hospitals and finally Bed-population ratio. The committee, thus, had pointed out several backlogs and gaps in health services in Maharashtra.

Table 3.1 Health services available in Maharashtra during the early 1960s.

Year	Disps.	SMPs	Disp/ SMP per 100,000	PHU	PHC	PHU, PHC/ million	Govt. Hosp.	Govt Hosp/ million	Hosp Beds	Hosp Beds/ lakh
1961	591	186	2.19	118	169	8.11	175	4.94	15298	42.19

Source : CORI 1984 : *Report of the Committee on Regional Imbalances in Mharashtra* Maharashtra State Department of Planning. Bombay.

In the subsequent years, the government of Maharashtra increased the number of the above mentioned institutions as per the Plans. The CORI had almost coincided with the signing of the Alma Ata Declaration of "Health for All (HFA) by 2000". The Plan documents after these events have incorporated the recommendations of the CORI as well as HFA, giving emphasis to rural health services and removing of regional imbalances. Thus, by the begining of the Eigth Plan, Maharashtra had achieved all the prescribed targets for health services in rural areas. During the Eigth plan therefore, the emphasis of the state government has been on consolidation of the health services by removing backlog and completing constructions where ever necessary. The following analysis of data on health services attempts to bring out the trend in health services development during the post-state formation period.

DATA ANALYSIS

Table : 3.2

Number of Hospitals, Dispensarie, PHCs, Subcentre, Rural Hospitals from 1968 - 1994

Year	Hospitals	Dispensaries	Primary health Centres	Sub - Centres	Rural hospitals (Community health centres)
1968	393	997	382	2776	-
1970	412	997	382	2779	-
1972	414	997	388	2779	-
1974	627	1654	391	3246	-
1976	766	1834	391	3246	-
1979	968	2129	427	3921	-
1982	1085	3701	454	4041	86
1984	1367	6189	1539	5741	145
1986	1873	8886	1539	8038	275
1988	1881	9135	1539	8038	275
1990	2104	9202	1670	9248	290
1993	2228	-	1680	9377	292
1994	-	-	1681	9377	292

Source : Source : Govt. of India: *Health Information of India* CBHI various years MOHFW , New Delhi .

Govt. of Maharashtra : *Health Establisment for Maharashtra* , various years HIVS Directorate of Health Services , Mumbai .

[Note : The data includes figures for institutions from all the systems of health care .]

To observe an increasing trend in development of health services is not a new phenomenon. However, the increasing trend from the above table shows that the maximum growth has ocurred during the decade between 1976 and 1986. As mentioned in the above paragraph, the findings of CORI and the targets set by HFA had almost coincided. These factors seems to have contributed the sudden growth in health services during the 1980s. According to the Sixth Plan Document (1980), there was considerable expansion of health services during the Fifth Plan period. After 1961, the objective before the government was to respond to the imbalances in the backward regions. However, the issue of regional imabalnces got more emphasis during the Sixth Plan. The two main objectives of the Sixth Plan were to reduce regional inequalities and promoting active involvement of the people in the process of development. Speculating the reasons for the sudden increase, we can also say that during the 1980s the Congres government was re-elected after defeating the janata government in the post-Emergence period. In order to establish themselves once again and in order to rectify their mistakes, the issues of regional imbalance were given more importance. This was so because as mentioned before, at the time of state formation, the regions of Vidarbha and Marathwada were assured development at par with western Maharashtra. Over the

ensuing decades development in this manner was limited and their was an air of dissatisfaction in these regions (CORI 1984, Lele 1990). It therefore must have been imperative for the government to respond to these issues urgently. Once again we see the role of soci-political factors in determining the development of regions.

Figures for health institutions between 1976 to 1982 support this argument indirectly. The number of hospitals and dispensaries increased nearly two folds between 1976 and 1982. A similar trend can be observed in terms of rural health services after 1982, implying the adoption of the HFA norms. The rate of growth continues to be high till the late 1980s, but it is not as dramatic as during the early 1980s. This trend is also supported by the institution population ratio given in table 3 below. The bed, hospital and dispensaries per lakh population ratio increases two folds between 1976 a to 1981 and once again from 181 to 1986. The same is true of rural health services as well. However, in case of rural services, the increase in subcentres could also be due to the India Population Project (IPP) of the World Bank.

Table 3.3 Beds , Hospital , Dispensaries PHCs , SCs population Ratio (per 100,000 population

Year	Beds	Hospitals	Dispensaries	PHCs	Subcenters
1961	69.94	0.96	1.98	0.78	-
1966	82.74	0.87	2.22	1.36	-
1971	74.24	0.78	1.99	1.12	8.01
1976	77.43	0.53	2.42	1.04	8.60
1981	116.22	1.60	5.58	1.06	9.98
1986	132.78	2.18	10.26	3.02	20.02
1988	128.94	2.54	12.36	3.34	20.08
1991	144.64	2.67	11.69	3.41	19.41

Source : Duggal *et al* : *Health expenditures Across States - Part II Regional Disparities in* April 22 1995 *Expenditure* . EPW.

Despite attempts to remove regional imbalances, there is an obvious neglect of the rural urban inequalities. From the following table 4 we see that there are more than double the number of institutions and beds in the urban areas, paritcularly in the number of beds. The reason for this is obviously the location of teaching hospitals, which account for most of the beds, in the urban areas. Rural health services, which include PHCs, sub-centres and rural hospitals cannot measure upto that in terms of beds. During the Fifth Plan there was a one time increase of seats in the medical colleges. Consequently there was an addition of two new medical colleges and construction of extra wards at the teaching hospitlas at Miraj, Poona, Nagpur, Solapur and Aurangabad (Sixth Plan Document 1980). One of the most important factors for this inequality is the prescence of private health institutions. Although these private services may not match the bed strength of the teaching hospitals, in terms of numbers they

exceed the government services significantly. Most of the private health institutions are small nursing homes, dispensaries and small hospitals. However, they reach out to larger clientele or in other words more number of people utilize private ehalth services. In a study of utilization of health services at the time of the 42 NSS round, it was revealed that majority of the people use private health services, especially in the rural areas. Tere are various reasons for this, some being, inadequate facilities at the government health institutions, apathy of the personnel, accessability and in some places even availability of the sevices. Nevertheless, since utilization ofhealth services per se is not the purview of the current, it will mentioned just briefly.

Table 3.4 Number of Hospitals and Beds Rural and Urban

Year	Hospitals		Beds	
	Rural	Urban	Rural	Urban
1974	74	551	3819	48995
1976	102	664	4652	54760
1980	-	-	-	-
1984	177	1190	7729	78673
1986	222	1651	8578	88551
1990	345	1659	12120	83909
1992	469	1759	10209	99300

Source : Govt. of India : *Health Information of India* CBHI various years MOHFW , New Delhi .
Govt. of Maharashtra : *Health Establisment for Maharashtra* , various years, HIVS Directorate of Health Services , Mumbai .
[Note : The data includes figures for institutions from all the systems of health care .]

Table 3.5 Hospitals and Beds , 1974 - 1990 By Ownership

Year	Hospit - -als	Beds	Government		Local Bodies		Private and Others	
			Hosp.	Beds	Hosp	Beds	Hosp.	Beds
1974	625	52814	157	26644	111	7864	357	18306
1976	766	59412	179	28872	141	11380	446	19160
1980	1002	69810	181	32035	139	11751	682	26024
1984	1367	85942	204	39478	218	14431	945	32033
1986	1873	97129	451	48193	101	11154	1321	37782
1990	2104	111420	693	62684	92	10955	1319	37781

Source : Govt. of India: *Health Information of India* CBHI various years MOHFW , New Delhi .
Govt. of Maharashtra: *Health Establisment for Maharashtra* , various years HIVS Directorate of Health Services , Mumbai .
[Note : The data includes figures for institutions from all the systems of health care .]

Table 3.6 : Percentage distribution of Hospitals and Beds by Ownership from 1974 - 1990

Year	Hosp itals	Beds	Government		Local Bodies		Private & Others	
			Hosp	Beds	Hosp	Beds	Hosp	Beds
1974	625	52814	25.12	50.45	17.76	14.89	57.12	34.66
1976	766	59412	23.7	48.60	18.41	19.15	58.22	32.25
1980	1002	69810	18.06	45.89	13.87	16.83	68.06	37.28
1984	1367	85942	14.92	45.94	15.95	16.79	69.13	37.27
1986	1873	97129	24.08	49.62	5.39	11.48	70.53	38.90
1990	2104	111420	32.94	56.26	4.37	9.83	62.69	33.91

Source : *Ibid*

Table shows an increasing trend in the number of private hospitals. However , it is not the same for private hospital beds. The number of government hospital beds show an increasing trend , but it is not a very significant increase . There is certainly a growth in the number of government hospitals but once again the increase is not very significant . Whereas , the increase in the number of private hospitals is quite significant. Though one sees a slight decrease in number for 1990, the difference in number of private and public hospital beds can also be attributed to the fact that in the private sector there are more number of smaller hospitals and nursing homes which may have few beds . But , the same cannot be said regarding the public hospitals as it will not be practical for any government institution to have few hospital beds. Nevertheless , the inherent limitation of the data as mentioned in the chapter on Methodology regarding underreporting of the institutions cannot be ignored while stating these trends.

As mentioned in the preceding paragraphs, the number of beds were increased during the Fifth Plan as there was an increase in number of medical colleges and subsequently in the number beds in the teaching hospitals by 850. Besides there was an addition of 947 beds

to the total teaching hospitals and increase in the bed strength of ESIS hospitals by 20 each as well as extension of ESIS services to Panvel, Kanhan, and Kamptee.This accounts for an increase of 220 beds. There was also an increase in the beds of rural and urban hospitals and dispensaries by 1344 and 88 respectively during the Fifth Plan (Sixth Plan 1980). Additionally during the Sixth Plan, seven TB and chest hospitals, 26 district Tb centres, 24 isolation wards, 26 BCG teams were established. Construction of 30 rural hospitals, 406 PHCs and 574 subcentres was also completed. Besides 69 rural and 18 cottage hospitals were also constructed and the bed strength of three government ayurvedic hospitals was increased by 580 during 1979-1980. The Minimum needs program was also started during the Fifth Plan, the objective of which was to establish a network of basic services in order to remove the regional imbalances throughout the country.

Table 3.7 Dispensaries and Beds 1970 - 1990 By Ownership

Year	Dispensaries	Beds	Government		Local bodies		Private and Others	
			Disp	Beds	Disp	Beds	Disp	Beds
1974	1654	2838	62	144	1325	2553	265	141
1976	1834	3488	133	196	1369	3019	332	273
1980	3505	3738	170	203	1480	2756	1489	779
1984	6189	2748	247	260	1419	1875	4523	613
1986	8886	2038	247	260	1243	1638	5769	761
1990	9202	2418	319	352	1304	991	7579	1075

Source : *Ibid*

[Note : The data includes figures for institutions from all the systems of health care .]

The local Bodies which constitute both the Zilla Parishads (ZP) and the municipalities are responsible for nearly eighty percent of the total dispensaries and beds till the mid 1970s . However , one can observe a decreasing trend from the late 1970s and early 1980s to reach as low as less than twenty percent in the early 1990s . (refer tables 3.3 and 3.4) . The government owned dispensaries also show a similar trend but at a low level . This is because majority of the dispensaries are owned by the local bodies . There are historical reasons for the local bodies to control majority of the dispensaries . During the pre-Independence and the pre state formation periods , several dispensaries were initiated and owned by the rulers of the

princely states particularly Kolhapur , Satara , and Sindhudurg (State Gazetteer for various districts). The state of Maharashtra , thus , started at an advantage of an existing infrastructure and this explains the relatively high level of infrastructure in Maharashtra .

Several factors can be attributed to this decreasing trend . The Indian government became a signatory to the 1977 Alma Ata declaration of "Health for All by 2000 AD" .. The Sixth Plan document emphasised and adopted the concept of primary health care - (statement from the document) . The government of Maharashtra handed over the responsibility of the rural health services , which constitute primarily the PHCs , the Sub-centers and the CHCs , to the ZP in 1980s . (Interview with officials , Plan document). It is therefore possible that the existing dispensaries under the control of the ZP could have been converted into PHCs and other health institutions required under the primary health concept . This argument is further strengthened due to the fact that firstly the government of Maharashtra has stopped construction of new dispensaries since the mid 1980s (Interview with officials from the Directorate of health Services , Maharashtra) . Secondly , the government of Maharashtra has achieved all its targets for rural health services (1 PHC for every 30,000 population and 1 sub-center

for every 5,000 population) . In view of the size of the state and the population , the achievement of these targets could have been possible only with a certain amount of existing infrastructure to build upon . One therefore can draw the inference that due to conversion of dispensaries at the local bodies level into institutions for rural health , a decreasing trend is observed .

Table 3.8 Percentage distribution of Dispensaries and Beds by Ownership . 1974 - 1990

Year	Dispensaries	Beds	Government		Local bodies		Private and Others	
			Disp	Beds	Disp	Beds	Disp	Beds
1974	1654	2838	3.87	5.07	80.11	89.96	16.02	4.97
1976	1834	3488	7.25	7.88	74.65	86.55	18.10	7.83
1980	3505	3738	4.85	5.43	42.23	73.73	42.48	20.84
1984	6189	2748	3.99	9.46	22.93	68.23	73.08	22.31
1986	8886	2038	2.78	12.76	13.99	80.37	64.92	37.34
1990	9202	2418	3.47	14.56	14.17	40.98	82.36	44.46

Source : *Ibid*

[Note : The data includes figures for institutions from all the systems of health care .]

At the same time with the decrease of dispensaries in the public sector during the 1980s , an increasing trend is observed in the private sector both in terms of dispensaries and beds . This increase coincides with the decrease in the public sector and can be attributed to the void left by the decrease of dispensaries in the public sector

which triggered a need for dispensary facilities , to be encashed by the private sector . However , the phenomenal increase by the 1990s can be attributed to involvement of the private sector in the delivery of health services . It is observed that the private sector is characterised by small institutions such as dispensaries , small nursing homes and small hospitals with few beds . With an impetus given by the government and the international agencies , the conditions were favourable for the private sector to expand and thus , an increasing trend is observed in the privately owned dispensaries . The following tables also support the findings besides giving the rural urban differentials.

Table 3.9 Hospitals By ownership and Rural and Urban Differentials

Year	Hosp (T)	Government		Local Bodies		Pvt & others	
		Rural	Urban	Rural	Urban	Rural	Urban
1974	625	8	149	25	86	41	316
1976	766	8	171	47	94	47	399
1984	1367	12	192	112	106	53	892
1986	1873	169	282	-	101	53	1268

Source : Govt. of Maharshtra : *Health Establishment in Maharashtra.* HIVS , Directorate various yearsof Health Services , Mumbai .

Table 3.10 Dispensaries By Ownership and Rural and Urban Differentials

Year	Disp (T)	Government		Local Bodies		Pvt & others	
		Rural	Urban	Rural	Urban	Rural	Urban
1974	1654	5	59	1061	264	37	228
1976	1834	18	115	1053	316	36	296
1984	6189	22	225	878	541	42	4481
1986	8886	22	225	759	551	53	7276

Source : *Ibid*

The public private dichotomy in Maharashtra has an obvious bias towards the private sector. Even in terms of utlization of health services, the private sector is at an advantage. From the above tables we see that in the urban areas, there are more number of private institutions than in the rural areas.

Table 3.11 Hospital Beds By Ownership and Rural and Urban Differentials

Year	Beds (T)	Government		Local Bodies		Pvt & others	
		Rural	Urban	Rural	Urban	Rural	Urban
1974	52814	489	59	690	7174	2640	15666
1976	59412	521	115	1360	10020	2771	16389
1984	85942	682	225	3360	11071	3287	28746
1986	97129	5218	225	-	11154	3204	32195

Source : *Ibid*

Table 3.12 Dispensary Beds By Ownership and Rural and Urban Differentials

Year	Beds (T)	Government		Local Bodies		Pvt & others	
		Rural	Urban	Rural	Urban	Rural	Urban
1974	2838	20	124	1315	1238	76	65
1976	3488	31	165	1323	1691	56	217
1984	2748	57	203	531	1344	52	561
1986	2038	57	203	287	727	52	712

Source : *Ibid*

During a little more than a decade between 1974 to 1986, as given in the above tables,

Table 3.13 : Hospital Beds By Ownership

Year	Government	Local Bodies	Private & Others	Total
1972	23653 (62.37)	5971 (15.74)	8300 (21.39)	37924 (100.00)
1974	26644 (50.45)	7863 (14.89)	18306 (34.66)	52813 (100.00)
1979	30654 (45.38)	11018 (16.31)	25884 (38.31)	67556 (100.00)
1980	32025 (45.89)	11751 (16.83)	26024 (37.28)	69810 (100.00)
1982	37790 (49.22)	12963 (16.88)	26024 (33.90)	76777 (100.00)
1984	39478 (45.94)	14421 (16.79)	32033 (37.27)	85942 (100.00)
1986	41361 (42.58)	14550 (14.98)	35296 (36.34)	97129 (100.00)
1987	47623 (51.22)	9503 (10.22)	35849 (38.56)	92975 (100.00)
1989	62684 (56.26)	10955 (9.83)	37781 (33.91)	111420 (100.00)
1990	62684 (56.26)	10955 (9.83)	37781 (33.91)	111420 (100.00)

Source : *Ibid*

[Note : The data includes figures for institutions from all the systems of health care .]

From table 3.11 we observe that the number of beds in the government owned hospitals are nearly more than half of the total hospital beds . This is owing to the fact that the size of the institutions under the control of the government are significantly larger than those owned by the local bodies as well as those in the private sector . The table shows that there has been a growth in the number of beds . However, this increase is not significant enough in terms of bed population ratio (table 3.3). The decrease in the bed strength of the beds in institutions owned by the local bodies can be explained in terms of the the recommendations of the CORI, which were incorporated after the Seventh Plan. The main objective of the Seventh Plan document of the state of Maharashtra is to implement the National Program of Health for All and to improve and update the medical facilities in Government teaching hospitals and colleges (Seventh Plan 1985). Accordingly, the backlog of beds was removed in hospitals at Dhule, Ahmednagar, Satara, Osmanabad, Buldhana, and Wardha.

Due to adoption of the recommendation of CORI and creation of new districts of Jalna, Latur, and Gadchiroli, new district hospitals were created at these districts and imbalances removed at the others. It is quite possible that the existing infrastructure owned by the Zilla

Parishad could have been upgraded to remove the backlog at the District level, thus increasing the the facilities of the government owned institutions. As mentioned before, the state government has stopped construction of new dispensaries during the 1980s. These dispensaries were primarily the responsibility of the local bodies. We, therefore can infer that the decrease in the facilities of the local bodies could be because of termination of planning for new dispensaries and upgradation of the old ones in order to remove the imbalances at the district level.

Summary

Summarising the chapter we can say that Maharashtra has a fairly well developed health infrastructure with an equal participation of the government and the private sector. Due to the fact that Maharashtra has more urban population than the other states, and also because of the bias in urban development, the urban rural inequalities are very stark. Attempts have been made by the government, particularly after state formation to remove these inequalities. Important events in this endeavour has been the committee on regional imbalances CORI, 1984. This committee recommended addition of 200 beds to each district hospital, establishing of new medical colleges and increasing the number of

seats in others, among other recommendations. Another factor has been the adoption of the Alma Ata declaration of HFA, which gave an impetus to the development of the rural health services. After which, new institutions were constructed and the rural hospital scheme was introduced.

From the analysis of the data we have seen that the growth years in health services development has been the decade between 1976 and 1986. Besides the recommendations of CORI and the adoption of HFA, there are socio-political reasons for their growth. This period is the post state formation period. State formation was achieved on the basis of assurances to remove regional imbalances in the underdeveloped regions. Health being a welfare services and as mentioned in the theoretical framework, welfare services are tangible benefits used by the political elite to bargain and control the power. We, therefore can speculate that in the post state formation period, health being a prime welfare service, the increase in health services was in order to tangibly exhibit the removal of regional imbalances. In the light of this argument, the Fifth Plan document (1974) plans for rapid growth in health services, followed by the Sixth Plan document during which the health services were increased tremendously (Seventh Plan 1985). After a period of

growth spanning a decade and nearly achieving the prescribed targets, the development of health services is at present in a phase of consolidation (Draft Eigth Plan 1989).

[1] The assumption is based on the argument of pluralist-democracy theory as discussed by Lele (1984). In a multi dimensional democracy like India, the argument of the pluralist democracy theory wherein the elites bargain for the maintenace of their hegemony, holds true. This has already been explained in the previous chapter, in the theoretical framework.

[2] During informal talks with some NGOs working in Marathwada and western Maharashtra, the researcher was informed that political elites from western Maharashtra region do not allow the regions to be politically stronger. Concerted efforts are made by ising state machinary to maintain the dominance of the elites and of western Maharashtra. There are no instances of the top political actors hailing from anywhere but western Maharshtra. The researcher was also informed that the people from Marathwada were simpletons and lacked foresight. Hence do not know how and what to demand from the state or the political elites in order to develop Marathwada.

[3] This decade of 1980s is a significnt decadein terms of health services as India had become a signatory to the worlddeclaration if Health For All by 2000 AD (HFA). According to HFA, the health strategy will be to adopt the concept of primary health care and provide health serices which are *affordable, acceptable,and, accessible.* The health of the people will be in their hands and the success of the program will be measured in terms of people's participation.

[4] Medical facilities in Bombay Presidency during the 18th and 19th century have been discused in great details in the Maharashtra State Gazettee for the district of greater Bombay. there are refernces to the good health conditions of health on the island of Bombay prior to the take over by the Crown. Infact the portuguese had named it the "island of Good Life". Unhealthiness apparently increased during the late 1670s and early 1700s. The east India Company attributed illhealth to the habit of manuring coco-nut palms with putrid fish, The stagnation of water during monsoon and the heat of the sun, vermin in wells and tanks and so on. The stagnation of water due to the silting up of the cracks inbetween the islands of Bomaby during high tide provided favourable conditions for mosquoitoes and subsequently for malaria.

Summary Discussion and Conclusion

Summary and Discussion

Health is an important aspect which has several determinants. Income is one of the important variables which influences the ability of the people to maintain an adequate nutritional level and to afford health care services when required,both in terms of the accessability and affordabilty. Inability of the people to avail of appropriate levels of health is reflected in the high morbidity and mortality prevalent amongst the people. Besides the availablity of services such as safe drinking water and adequte sanitation, availability of health care services also influences the health of the people. Zubrigg, in her story about Rakku, a labourer who has to travel to the city in order to treat her child who has been afflicted with diaorrhea, has lucidly shown how the availablity of health care services influence the health of the people. Adequate health services, which are easily accessible and affordable can influnce the mortality and morbidity of the population to a large extent.In this context, thus, health services are considered to be one of the important welfare inputs.

During the late 1800s and early 1900s, when industrial revolution was in full swing,the most important factor which affected production was the high morbidity rates in the urban colonies of the workers. In order to

reduce absenteeism, provision of health care services was considered to be an important factor by the industrial management. This thinking later led to the conception of the welfare state, which was considered to be the appropriate solution to counter the contradictions a capitalist economy. Health care delivery, thus, became an important aspect of the welfare state. However, the economic boom in post WW II period, which led to the formation of the welfare state, was followed by the world economic crisis during 1970s and 1980s. This experience has shown that in any economic crisis, the first to receive a set back is the social sector. Experiences of Sub-Saharan Africa and Latin America have reflected the consequences of the cut backs on the social sector during the period of structural adjustment and stabilization. These consequences can be seen in increasing morbidity, malnutrition and mortality in these countries (Loewenson 1993, Balasubramaniam 1993, Guhan 1992, Werner 1994, Abel-Smith 1986).

Health therefore is influenced to a great extent by health services. However, health services development is not independent of social and economic factors. Economic factors are one the determinants of health services as mentioned above. These economic factors in turn determine the political and subsequently the social factors operating in a society. One can thus infer that health services have socio-political and economic

determinants. The economic factors very often play the role of the intervening variable with socio-political factors as the independent variable and health services the dependent variable. The main purpose of the study is examine how the health services have evolved in a given region.

Socio-political factors are not to be seen at any one point of time in the development of a society. They are historically determined and should be therefore examined in the context of the historical factors. Society is not a homogenous monolith. It infact comprises of several groups which have different economic interests, values, traditions, culture, and so on. In the context of India diversity an plurality in the society is evident and an important factor. Due to such plurality, there are variations in the socio-poltical developments of regions. The study therefore specifically has tried to examine the development of health services in the context of the socio-political factors operating within Indian society. However, given the fact that India presents a picture of regional variations we have focussed on the state of Maharashtra which has both prosperous and backward districts. The state of Maharashtra is an exemplar of plurality. The state was carved out of the two regions of Marathwada, which was under the Nizam's rule, and Vidarbha which was part of the Central Provinces, and joined with the larger Bombay Province. The study therefore has been

delimited to examine the development of health services in the context of the socio-political forces operating in Mharashtra.

Maharashtra is a state which is representative of India in its multiplicity and diversity. It is one of the largest states of India with a population of 846.3 million and a growth rate of 2.14 % (Census of India 1991). Details of the socio-economic profile are given in appendix I. It also has the largest number of urban population as compared to the rest of India. A high level of urbanization in Maharashtra is due to the large industrial sector which is concentrated inthe Mumbai-Pune corridor. The reason for this high level of urbanization is historically and can be traced back to the British development of Bombay as a major trading port. Besides, during the initial phase of colonial rule, the British made concerted efforts to encourage the traders of Surat and other parts of the erstwhile Bombay Province in order to boost their own trade. The consequence was that these traders were able establish themselves despite colonial rule and later were able to develop the industrial sector. They also were the main actors in trade and industrial development after Independence. Particularly among them were the Parsis who made industry synonymous with their name.

In the agricultural sector the British started the cash crop economy for which they initiated several land reforms. The ones to benefit out of these reforms were the elite marathas, who were the landed gentry. This was particularly important in terms of development of western Maharashtra. With these developments, the British also invested in public works such as roads, canals, and so on. The marathas were again the main beneficiaries in this context.Thus, they entered the cash crop economy in a big way and were able to take advantage of the cooperatives set up by the British to facilitate their access to raw materials produced by them, particularly cotton.

Thus empowered, and with history of dominance and hegemony, the marathas, who are the dominant caste in Maharshtra, saw the benefits of controlling the rural polity. This was easy for them as they are primarily involved in agriculture and a large section of them- the Kunbis are the peasant community. Quite early in the history of Modern Maharashtra, the marathas were able to control the local boards and the cooperatives. They used this control of the rural polity to enter the political arena in Maharashtra. At the time of the freedom movement, they joined the Congress enmass and continued to do so even later. The Congress Party became almost synonymous with marathas in the post-Independence period.

As discussed in the preceding chapters two and three, it is essential to understand the socio-political processes in India in terms of the dominant caste.They are not only the single largest caste group in Maharashtra, but are also politically dominant. In a pluralist democracy, which has been already been discussed for Maharshtra and for that matter India, the dominant caste uses all possible modes to maintain their dominance. We have seen earlier that the political elite in Maharashtra are predominantly marathas. Interviews with NGO groups, various studies, and observation have supported this fact. Over the years the marathas have been able to use the state machinary to their benefit and subsequently have sustained their political dominance. This is particularly evident in the post-Independence period.

The post-Independence period in Maharashtra is characterised by events of great importance, especially the formation of the state of Maharashtra. The state was carved out of the erstewhile Central province, Hyderabad state, Karnataka, and Gujarat. Amongst the regions which joined Maharashtra, the predominant ones were Vidarbha in the north east, Marathwada in the east. At the time of state formation these regions were at a very low level of development as compared to western Maharashtra. The reasons being social political and historical. Both the regions fall in the drought prone zone and agriculture is primarily

rainfed. Whereas western Maharashtra which also falls in the rainshadow region, doesnot have to worry much if it does not receive adequate rainfall. It is sufficient for this region if it rains in the Konakan region, on the Shahayadris. This is because arrangements for irrigation have been made since the British times for this region. Small dams and canal systems are observed in this region which irrigate the agriculture. In comparison, because of politically different rulers, the regions of Vidarbha and Marathwada did not get similar facilities. hence agriculture is largely rain fed. because of lack of electric power ground water also was not (and is not) being tapped. Whereas, western Maharshtra not only had an irrigation system, it also has several sources of power generation. With this basic infrastructure western Maharashtra was far ahead of the other regions.

The social composition of western Maharashtra reveals a dominance of the marathas, especially the elite, who own large tracts of land. The maratha elite were able to take advantage of the infrastructure and improve their agricultural production. After Independence, their agricultural activity has primarily been sugar cultivation. Already having been exposed to cooperatives, the maratha elite lobbied for sugar cooperatives in the rural areas. After the 1950s there was a tremendous growth of these sugar cooperatives. Being in control of the local bodies

since the colonial days, the maratha elite controlled the sugar cooperatives. The sugar cooperatives have a very strong governing board, which considered at par with the district council. The membership to the board is a matter of esteem and often the political elite start their innings through membership to these boards.

After state formation, the marathas who were already dominanat in the rural polity saw the benefits of decentralization of administration. They initiated the formation of the Zilla Parishads which are equivalent to the district councils. A deliberate move was to make elections to the posts of the Zilla Parishad party based. Each political party could field its candidate and the members would be electd through universal franchise. Eventually a lot of power was entrusted onto the Zilla Parishads and they were the prime implementing body of the state government schemes. They were given the control of the minimum needs program and implementation of programs such as rural health services, primary education, agriculture, fertilizer, and so on. Thus, the Zilla Parishads are an important step in the administration. It can be inferred from above that the elite encouraged the formation of the Zilla Parishads in order to sustain and build their power base in Maharashtra. This is beacuse the elected member of the Zilla Parishads obviously belong to the local rural area or a district. Zilla Parishads are also the highest authority in the

Panchayati Raj system, thus, ensuring participation of the rural political elite at the district level. The President of the Zilla Parishad is equivalent to a deputy minister and hence the stakes are pretty high. The above factors therefore, become crucial for health services development if one considers health as a prime welfare service. Welfare services are tangible benefits. In a pluralist democracy, as discussed in the preceding chapters, the elite bargain for resources in order to maintain their hegemony. In the light of this, welfare services, which are tangible benefits, can be used as tools for bargaining. We thus can interlink this assumption to the role of the Zilla Parishads and even to their existence as an implementing body, particularly for the rural areas.

Health Care in Erstwhile Bombay Presidency

There has been plurality of health service provisioning in India. The indegenous systems like ayurveda, Unani, Siddha, were prevalent in India even before the advent of the British. After the British had established themselves, they introduced the system of allopathy first for their own civilians and later extended it to the 'native population'. The main services offered were largely preventive in nature witha lot of emphsis given to sanitary reforms. the Sanitary Movement which was popular In ninteenth century England served as a role model for the sanitary reforms in erstwhile Bombay Presidency. Curative services were

few and were mainly restricted to vaccinations. With the development of the modern medicine, health services acquired the nature of the hospital-dispensary structure. The British started a few dispensaries hospitals along with the Missionaries. These services were replicated by the rulers of the princely states and some voluntary otrganisations and chritable trusts. However the British govrnment took over most of the hospitals and converted them into District/Civil hospitals under the charge of a Civil Surgeon. India inherited this structure at the time of Independence. To this basic structure additional infrastructural inputs were givenn in accordance with the recommendations of the Bhore Commitee report and the startegy for health services development largely rested upon the Community Development program of 1952.

Trends in Health Services Development in Maharashtra

Due to lack of adequate data, the actual trend in health services development can be seen only after the formation of the state of Maharashtra. The period between 1947 and 1961 (state formation) was not a static period of development. This period was marked by the various efforts for state formation. It therefore seems that the state government did not give much attention to the development of welfare services and what was prescribed by the central government was followed by the state government. It was only after 1961 that the Directorate of Health

Services introduced innovative changes. One of these innovative schemes was the Community Health Volunteer scheme (CHV) which was initiated in Maharashtra and later adopted for rest of India by the Central government.

There is a definite increase in health services inputs after 1961. The main efforts were made in order to mitigate the regional imbalances, especially in those regions which had been carved out of the Central Provinces and the State of Hyderabad. The decade of growth in the context of health services has been between 1976 and 1986 with the institute-population ratio per 100,000, showing a sudden increase by 1981 (refer tables 3.2 and 3.3). The main factors reponsible for expansion of health services once again was of correcting the regional imbalances. This came to the fore when the region of Vidrabha was demanding the identity of a seperate state. This region has a fairly large Maratha kunbi population, which is comparable to that of western Maharashtra. The political elite of western Maharashtra, in order to consolidate their hegemony required the alliance of the marathas from the Vidarbha region for the formation of a marathi state. In order to include Vidarba into the state of Bombay, the Nagpur Pact was signed which promised to develop not only Vidarbha but also Marathwada and Konkan regions and bring them at par with western Maharashtra, which had long history of

development. As a result one finds an expansion of health services during the Fifth Plan which the data clearly demonstrates.

After the Emergency and the re-election of the Congress government in 1980, these issues once again became important. The Dandekar Committee or the Committee for Regional Imbalances (CORI) was formed in order to look into the issue of regional imbalances. The recommendations of this committee are reflected in the subsequent Plan documents and we observe a tremendous expansion of health services during the Sixth Plan of the Government of Maharashtra. The other factor responsible for this expansion of health services was the signing of the HFA declaration in 1979. The recommendations for rural health services were incorporated in the Sixth Plan and the Seventh Plan. The rural health services are the responsibility of the Zilla Parishads and they constitute (along with the muncipalities) nearly eighty percent of the total dispensaries. The Zilla Parishads are responsible for the entire network of PHCs, sub-centres, rural hospitals, etc. and the dispensaries located in areas under their control. However by the late 1980s the total beds in dispensaries under the ZPs had decreased to nearly forty percent as there was increase in the number of PHCs. It is probable that the many dispensaries were coverted into PHCs.

By the 1990s the Government of Maharashtra had achieved almost all the targets set for the expansion of rural health services. It was therefore decided to only consolidate the existing services and remove the backlog in the Eigth Plan. On the other hand emphasis will be given to increasing the facilities of tertiary (specialist) care and the construction of six specialist hospitals in six districts of Maharashtra. The construction of one is already underway in the district of Nasik which is the home town and constituency of the former state health minister.

One important factor in health services development during the 1990s is the adoption of the Structural Adjustment and Stabilization Program or SAP by the Government of India. Subsequently, the World Bank brought out their Annual report on Investing in Health which has to be read in the light of SAP (Baru 1993, Qadeer, 1993). At the same time the allocation for social sector for India as a whole and Maharashtra specifically showed a decreasing trend. Health was also affected, with a decrease in Central government allocations and increase in the non-plan expenditure

Besides recommending user fees, contracting out services, the essential health package, identifying target groups for providing health services through the government, the WDR 93 also recommends

encouraging the non-governmental or the volutary sector as part of its larger plans for privatization. The Eigth Plan document of the Governmnt of Maharashtra also suggests handing over certain services to the non-government sector o the voluntary agencies. However, during discussion with the officials from the Directorate of Health Services, Mumbai, it was found out that the government has not decided the exact parameters of handing over the health services to the volunatry agencies. According to them the transfers will have to be done carefully in order to involve "non-controversial" agencies.

In this context the socio-political dimensions of health service development and for that matter development of the social sector, become extremely important. On one hand there is India as a welfare state, which has made provisions for the delivery of certain welfare services such as health. In the second chapter, the concept of welfare state and its evolution has been discussed. It was observed that welfare states were seen as a means to mitigate the contradictions of capitalism. Welfare States initially were injitially conceived as the answer to the problems which are a natural consequence in a capitalist economy, in the post WW II period. The socio-economic and political forces occuring in the world and individual nations caused the conception of the welfare state. India, which was on the path of industrial development at the onset of

Independence adopted the concept of welfare state as well. However, the private sector also was given almost equal importance,giving Indian economy a mixed nature.

On the other hand there are socio-political forces determining the welfare services, in this context the health services. Some of these factors discussed in the study are the variables of dominant caste dynamics, inter-caste conflict in order to be in control of the polity, regional imbalances in development, agricultural devlopment in terms of irrigation, power supply, cash crop economy, and so on. These factors have influenced the development of health services in Maharashtra and the picture that emerges is that of a skewed developmental pattern in favour of western Maharashtra.

The study has shown in terms of historical analysis, that the above mentioned socio-poltical and economic variables have influenced the development and thus giving it a skewed pattern. Health services also follow the pattern, with a larger concentration of services in western Maharashtra. However, the study did not go into the details of regional variation in health services. It therefore is limited in this context. Nevertheless, in a study conducted by Seeta,K. and Prabhu (1992) it was found out that in terms of bed-population (bed per 10,000), western

maharashtra's share was as high as 51.2% as compared to the 9.31 share of Marathwada. The share of number of dispenasries was also in favour of western Maharashtra; having a 41.08% share. Western Maharshtra, which also has a larger share of the Maratha population, better infrastructural facilities, and a high developmental rate, is an example of the influence of socio- political forces on development.

Another example of influence of socio-political factors on health services is the large involvment of the Zilla Parishads especially in delivery of the rural health services. They were responsible for nearly 80% of the total dispensaries and beds till the mid 1970s (refer table 3.7 and 3.9). The reasons for the same have already been discussed in chapter three. After singning the HFA declaration in India several dispensaries under the local bodies were converted into PHCs. Maharashtra thus was able to achieve its targets of HFA as soon as by late 1980s. With the increase in the rural infrastructure for health care, the Zilla Parishads were given total responsibilty of rural health services.

We can thus see that besides the state government, the local bodies, Zilla Parishads in Maharashtra, are the largest providers of health care. The other major providers of health care belong to the private sector. Here too the socio-political factors play an important role.

During the late 1970s and 1980s, a trend to establish educational institutions, particularly medical colleges was initiated and it received the patronage of certain sugar co- operatives and political leaders. There is no empirical evidence to prove the fact, but the involvment and patronage of the maratha elite is largely evident in these educational institutions. Murlidhar (1996) has described these trends to some extent, highlighting the involvment of the politicians and the then ruling party during the 1990. In 1985 three private medical colleges were started in Pravara, Jarad and Amravati. The medical colleges in and around Pune, Kolhapur, Karhad and other places in western Maharashtra had already been started. The private sector thus not only has the largest number of doctors, but is adding to their number.

From the analysis of data in chapter three, it is evident that the health sevices are skewed in favour of the urban areas. The prescence of the private sector has largely contributed to these variations. These variations are seen in case of the government services particularly in terms of beds. This is because the highest number of beds are found in teaching hospitals followed by the district hospitals. These facilities are essentially located in the urban areas causing the skewed pattern. Although data has not been compiled in terms of regional variation with repect to rural-urban differentials, it can however be speculated that

since the level of urbanisation is higher in western Maharashtra, the number of urban health services, particularly the private services are also likely to be higher in this region. This could also be true in the case of the medical insitutions, both public and private, and needs to be further explored.

Conclusion

A welfare state gives services in order to counter the contradictions of a capitalist economy. On the other hand, however, these services serve as tools by which the elite maintain their control over the electorate This is especially true in a pluralist society where there are several dominant groups competing for the resources. In the context of Maharashtra these dominant groups converge into a single dominant caste group of the marathas who have carefully and deliberately controlled the rural polity in order to control the entire state. In addition the compulsions of a democratic polity necessitates the elite to make some concessions to the rest of the population.

During fiscal crisis, the first to receive a set back are the welfare services. This was evident during the economic crisis of the 1970s and 1980s, and the period of adjustment. A similar trend has been observed in India during the 1990s with the adoption of the SAP. The World Bank,

other International agencies and the Government of India agree on the encouragement of NGOs to undertake delivery of health services. Already, some of the services are being contracted out and in fact, there was an announcement by the Government of Punjab regarding handing over one of its muncipal corporation hospitals to the private sector (TOI 1996). It will thus not be long before the other states also follow suit. Discussions are going on in Maharashtra regarding the same. Infact, the Government of Maharashtra has included the objective of encouraging more and more involvement of the voluntary agencies since the Seventh Plan. However, they have not reached to any descision as they are wary of the attitudes of various NGOs.

In the context of using state machinary and services to their benefit, the political elite are likely to regard the inclusion of NGOs in delivery of health services unfavourably. During the 1980s, with increase in private eductaional institutions, a large number of maratha elite started educational institutions, particularly medical colleges. Most of these are located in western Maharashtra, especially near Pune. In the 1990s one would not be surprised to see a trend of marathas initiating NGOs in order to deliver health services to people. An example which can be said to be the commencement of such a trend is the formation of an organisation to deliver services related to maternal and child health and

care. The Sakal Papers Trust, owned by the family of the former chief minister Mr Sharad Pawar, has combined forces with some business houses in Maharshtra under the guidance of the former Chief Executive Officer(present Secretary in the state cabinet) to start an organisation called the Sukhi Parivar whose main objectives is reproductive health.

In conclusion thus it can be said that the dominant caste has been the determining force in Maharashtra. They have always been identified with the Congress Party. Although the current government is a BJP/Shiv Sena government, it will not be possible for them to ignore the fact of maratha dominance. They have come to power towards the end of the Eigth Plan. it will therefore be interesting to see what path of development Maharashtra takes in the following Plan if the Alliance continues to rule. Thus at the end of the study certain issues and questions emerge. Will the future government of Maharashtra see NGOs as a better alternative to the government for delivery of health services?

SAP has once again thrown up the issues of selective health care. Through its essential care package, the World Bank is also recommending the same. Immunisation, reproductive health care, ORS, etc are some of the schemes which contribute to selective health care. In the abscence of a doctor, the NGOs are able to provide certain health services such as

ORS, aspects of reproductive health care, immunization, and so on through a team of paramedics and Community Health Volunteers. Therefore, will the NGOs be able to provide comprehensive health care or will they too be in favour of selective health care ? Is the World Bank and other International agencies trying to involve NGOs in health care delivery because they can be more favouravble to Selective Primary Health Care ? What will be the nature of privatization of health services ? With the issues of socio- political factors influencing health service development, will the pattern of privatoization and implementation of SAP be the same for all the states of India ? It is highly unlikely in the context of the different historical experiences and socio- political differences amongst the states and the experiences of SAP will therefore be different for different states. States like Bihar and Rajasthan where one finds more public provisioning of health services, will show a different experience under SAP than states like Punjab and Maharashtra where ther is more involvment of private sector in provisionof health services. These issues which emerge from the study can be taken up as independent studies in themselves and need to be explored in order to contribute to the understanding of health care delivery.

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APPENDIX

SOCIO ECONOMIC PROFILE

Heads		Year	Maha	Kerala	TNadu	India
Area in Sq. KM (1000)		1991	308	39	130	3,287
State area as % of total area		1991	9.4	1.2	3.9	100
Population (Million)		1991	78.9	29	55.6	846.3
Population as % of total Population		1991	9.4	3.5	6.7	100
Density of population / Sq. KM		1991	257	749	429	267
Urban Population (%)		1991	38.7	26.4	34.2	25.7
Growth Rate		81-91	25.4	14.3	15.4	23.8
Sex Ratio		1991	934	1,036	974	927
SC and ST population (%)		1991	20.4	11	20.2	24.6
Literacy (%)		1991	64.9	89.8	62.7	52.2
Female Literacy (%)		1991	52.3	86.2	51.3	39.3
Drop out rate in class I-IV	Boys	88-89	34.2	3	19.2	46.7
	Girls		44.3	-1	24	49.7
	Total		38.9	-2	21.4	47.9
Drop out rate in class I-VIII	Boys	88-89	51.3	18.4	41.3	59.4
	Girls		66.1	17	51.3	68.3
	Total		58.7	17.7	45.9	65.4
Gross irrigated area to gross cropped area(%)		90-91	15.1	12.7	43.6	33.3
Main workers to total population (%)		1991	39.3	28.5	40.8	34.2
CMIE indicator for infrastruct. development		1992	110	139	138	100
Total road length (KM) / 100 Sq. KM		1991	78	346	140	66
Per capita income at current prices		92-93	9,627	5,065	6,205	6,234

(Economic Survey of Maharashtra ,1994-95)
(Center for Monitoring Indian Economy , Sept.1993)

Source: Govt. of Maharashtra: Health Status, Maharashtra State, Public Health Deparment, Bombay, 1995.