CBPS

Centre for Budget and Policy Studies

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7 February 2001

Dear Dr Sudarshan,

I am enclosing the revised report on Health Finances in Karnataka. I hope it is in time for you to process further.

This paper has been revised in the light of comments we received in the last meeting of the Task Force with those undertaking studies. We have tried to incorporate all the points made when data were available.

I would like to thank you and the other members of the Task force, and the many officials who have helped us when we were working on this paper. Without such help, we could not have achieved anything. Thank you.

We would like to use this paper as a starting point for discussion with others interested in such issues. I had mentioned this to you some time ago. I hope this will be OK with the Task Force now that the paper has been finalised.

We have received the first installment of fee for this paper. After the last meeting I had submitted a request for the second installment. It has yet to be released.

Now that the paper is completed and submitted, perhaps the entire balance can be released to us now.

Yours sincerely,

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The Health Budget in Karnataka

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

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

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

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

Lewis Carroll

Table of Contents

Acknowledgements

This is a revised and expanded version of a study undertaken for the Task Force on Health and Family Welfare set up by the Government of Karnataka. While the monograph incorporates changes suggested by the Task force on the draft submitted earlier, it also includes the results of more recent research at the district level which were not part of the terms of reference of the study for the Task Force. We hope this report will be useful to all those concerned with health planning in Karnataka.

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

The Health Budget in Karnataka

1. Introduction

This monograph is organised as follows. In section 2, the budget system, concepts, and limitations are discussed. In section 3, the results emerging from an analysis of the available data in Karnataka are presented. Section 4 presents details of allocations for health at the district level. Section 5 is a brief conclusion.

Health is a state of positive well-being for an individual and for a community. And this is essential in all aspects of life, be it the health of the people or the health of the finances which are a crucial input into the governing system. Health of all is primarily a state's responsibility. The Directive Principles of State Policy in the Indian Constitution [Part 4] make this clear.

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

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

In 1993, the Constitution was amended to bring in a third tier of local self government, and health is a subject that is also in the list of subjects that states' may place in the purview of these bodies. In rural areas, with which this monograph is concerned[1], this refers to the three levels of panchayats--zilla, taluk and gram panchayats. These panchayats are the local manifestation of the state. All of the department employees at the district level have been deputed to the zilla panchayats in Karnataka—and they are to implement the various schemes. There is today some tension between the departmental employees and the newly

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

established political local panchayats[2]. This is not surprising at a time of structural change.

In this transition from a political system that consisted of two levels—union and state—to one of three levels, union, state and panchayat—several problems have arisen. These will undoubtedly be sorted out in time[3]. However the major fiscal responsibility of financing the health sector still wrests with the State government. The zilla panchayat so far only acts as a conduit for the transfer of funds.

Health is today set in a complex context of multiple levels of government action. In Karnataka, which has been a pioneer in panchayati Raj experiments[4], this is especially true. The department is manned by doctors, administrators, para-medical staff, health inspectors, etc. And the form of implementation, which was completely departmental, has changed to provide a role for panchayats. Elected representatives now make demands upon the staff of the health department in the local areas. This has led to controversy and differences of opinion: by and large, the department is not convinced that transferring responsibility to the panchayats will serve a positive long term goal[5]. They would like to limit the role of panchayats, at least where health issues are concerned. This is the background for the present study.

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

Ideally this should include the following:

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

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

1. The Research and Statistics Wing of the Finance Department of the Government of Karnataka (GoK) has collated information on the expenditure patterns (head of account wise) for the period 1960- 1990. We have taken the major head-wise expenditures for M&PH; WSS; Nutrition; General education; and Family Welfare for revenue, capital, loan accounts, wherever possible – 1960-61 to 1989-90 from this document.

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[2] D.Rajasekhar, Sashikala Sitaram and Vinod Vyasulu, "Decentralisation in Karnataka" paper prepared for the World Bank, June 2000.
[3] Vinod Vyasulu, "Decentralisation, Democratisation, Finances and the Constitution," Paper prepared for the Panel on Decentralisation of the National Commission to Review the Working of the Constitution, Bangalore, November 2000.
[4] For an overview, see D Rajasekhar et al, op cit. Also Vinod Vyasulu, Decentralisation from Above, CBPS, Bangalore March 2000.
[5] This has been a major area of debate in the Task Force.

2. The Finance Department, GoK has an Accounts Reckoner for 1990-2001. This gives the major headwise data for the 1990s. This has been used to get the figures for revenue expenditures, capital outlay and loan receipts and disbursements.

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

It is to be noted that the two data sources cited above are not comparable, even though both come from the Finance Department of the GOK. This is because whereas the first data is from 1960-1993, the second source is only for the 1990s decade. The base for the calculation of deflators has been changed in 1993-94, the cut-off point in the first data set. Hence what we have done is to use the first data-set to understand the earlier time periods, mainly in terms of five year plans and the second data-set used to study the latest decade in as much detail as is possible. It would not be justified to link them and draw a trend line.

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

2. The Budget System

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

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

The budget allocates money to "schemes". Schemes are specific proposals for spending money. An example would be a scheme for the eradication of leprosy—a worthy cause. The scheme would then define how leprosy is to be identified, how its magnitude is to be assessed, and how, given certain parameters, the scheme is to be implemented. A scheme brings with it's a set of rules and guidelines on how it is to be implemented, and it provides no scope for modifications[6]. It would specify how much of the allocation may be used in salaries for nurses, how much for the purchase of medicine—in some cases, which medicine also. These schemes are locally implemented by the departmental machinery.

Sometimes it is not possible to transfer a plan scheme of one plan to the non-plan account of the succeeding plan, for a number of reasons—usually a shortage of funds. In such cases, these schemes are carried on under the plan head. This means that salary and other routine payments are paid from plan funds meant to finance new schemes. This has two implications: funds for new and innovative ideas get squeezed, and salary and other routine expenditures make their appearance in the plan account. Thus, for recent years and plans, it cannot be assumed that plan expenditures represent new schemes or investments. In fact, as a plan progresses, the salary component of the plan account increases, so that it often only in the first or second year of a five year plan that investment can take place. The usefulness of the 'plan' and non-plan' categorisation has been questioned for such reasons.

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

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

Based on the allocations for schemes in the current year, and actual expenditure patterns, and the 'target' for the district indicated by the Planning

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

Department, the district officers prepare a draft budget for the next year[7]. This, after formal approval in the zilla panchayat, is referred to the Planning Department. The Planning Department, in consultation with the Finance Department, has a tentative figure within which the year's expenditure must be kept.

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

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

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

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

The link documents provide information on the amounts allocated to each district under different major and minor heads[8]. It must be noted that actual expenditures may differ from these allocations. Thus, these figures may be seen as representing the stated goals of the government. There may be a difference with what actually happens[9]—this has to be studied separately by looking at the district level expenditures. Such figures are not available in the state capital in detail—collecting them from each district is a tedious and time consuming task.

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

[8] The CBPS is undertaking a separate study of district allocations for health, which should be ready soon. It will be shared with a range of citizens concerned with health issues.

[9] A. Indira: A study of zilla panchayat budgets in two districts, CBPS, Bangalore March 2000.

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

Recognising this rigidity in the financial system, many states resorted to the method of setting up "autonomous" societies under the Registration of Societies Act, to undertake important projects. These societies were designed to function under the Minister and Secretary of the concerned Department, with a specially appointed Project Director to run the society which enjoys considerable financial autonomy[10]. But it must be noted that they led to greater centralisation at the state level, for they by-pass local governments—and they also did not come under detailed legislative scrutiny[11]. Many of these societies also created a parallel local structure for their work, thus bloating the bureaucracy[12].

The funds available came from different sources. There were the own revenues of the state—what it collected from taxes in its jurisdiction. There were the transfers of the state's share of union taxes, shared with the states' on the basis of the recommendations of the Finance Commissions. And then there were transfers from the Planning Commission[13]. These were union finances that it passed on to the states in programmes of national importance, on soft terms[14].

But the releases to local areas[15] depended, increasingly so in recent years, upon the ways and means position of the state government. Thus, even after budget approval, funds were often not made available because of cash crunches in the state. It is therefore important, to understand the expenditure process at local levels, to distinguish between *allocations approved*, and *releases made* to local bodies. Money allocated may be released in February—then it will be difficult to spend it effectively. To fully appreciate the complexities involved, a study of releases is also necessary. In this study however we have not taken into consideration releases but actual expenditures at the state level as these are the audited figures placed in the House. At the district level, we deal with allocations only. Further work is needed to confirm or reject these findings on an empirical basis.

3. The Results at the State Level

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

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

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

[13] These transfers include funds from external donors.

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

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

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

3.1 Medical and Public Health:

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

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

As a percent of SDP it is seen that the expenditure on health services in the 1960s it was 0.6%, 0.8-1% during 1970s; and from 1 to 1.1% in 1980s and 90s. The per capita expenditure has risen from around Rs.8/- in 1960-61 to Rs.21/- in 1989-90[16]. Whether this is adequate or not needs to be judged with reference to a standard norm—we are not aware of one.

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

Year	M&PH	Growth
III FYP 1961-66	33.09	
Annual plans 1966-69	30.56	-7.65
IV FYP 1969-1974	81.09	165.35
V FYP 1974-79	162.47	100.36
Annual plan 1979-80	44.22	-72.78
VI FYP 1980-85	379.87	759.05
VII FYP 1985-90	739.98	94.80

Source: compiled from the GoK Finance Report

In the above table 1, we can see that the expenditures in the third and fourth five year plans are far smaller than in the latter plans. In the last two five year plans, namely eighth and the ongoing ninth plan, the expenditures have been Rs.2230.75 crores and Rs.3259.35 crores respectively. This is at current prices—inflation has not been adjusted for. The real increase then may be much less than

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

these figures suggest. The growth rates at current prices show that the growth has been largest during the sixth five year plan, i.e., 1980-85.

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

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

Year	M&PH	Growth
III FYP 1961-66	-1.30	
Annual plans1966-69	2.20	-269.23
IV FYP 1969-1974	1.49	-32.27
V FYP 1974-79	6.08	308.05
Annual plan 1979-80	1.21	-80.10
VI FYP 1980-85	13.25	995.04
VII FYP 1985-90	13.64	2.94

The capital outlays on M&PH (Table 2) has been growing more slowly than the revenue expenditures. Capital expenditures are those that are expected to give returns over a term longer than one year. Is the state discounting the future? The growth rates at current prices is also given alongside for comparison. The main inputs in terms of growth seems to have been in the fifth five year plan and the sixth five year plan.

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

Table 3 Health and Family Welfare Head wise expenditure (plan) (Rs. in Cr.)

	Current prices				Constant		
Year	M&PH	FW	TOTAL	Deflator	M&PH	FW	TOTAL
1990-91	41.68	35.17	76.85	88.94	46.86	39.54	86.41
1991-92	39.39	50.38	89.77	90.25	43.65	55.82	99.47
1992-93	52.92	54.98	107.90	94.33	56.10	58.28	114.39
1993-94	62.60	59.42	122.02	100.00	62.60	59.42	122.02
1994-95	87.29	76.55	163.84	106.98	81.59	71.56	153.15
1995-96	119.54	86.81	206.35	114.80	104.13	75.62	179.75
1996-97	144.26	74.63	218.89	123.43	116.88	60.46	177.34
1997-98	157.72	106.09	263.81	129.62	121.68	81.85	203.53
1998-99	147.47	84.85	232.32	138.46	106.51	61.28	167.79
1999-2000RE	160.04	167.85	327.89				
2000-01BE	177.69	195.21	372.9				
				Avg growth	-71.15	-77.00	-73.83

Source : Finance Department GOK

Table 4 Health and Family Welfare Head wise expenditure (non-plan) (Rs. in Cr.)

	Current				constant		
Year	M&PH	FW	TOTAL	Deflator	M&PH	FW	TOTAL
1990-91	163.06	3.10	166.16	88.94	183.34	3.49	186.82
1991-92	202.12	3.48	205.60	90.25	223.96	3.86	227.81
1992-93	248.56	3.75	252.31	94.33	263.50	3.98	267.48
1993-94	265.60	3.62	269.22	100.00	265.60	3.62	269.22
1994-95	289.27	4.64	293.91	106.98	270.40	4.34	274.73
1995-96	285.44	4.67	290.11	114.80	248.64	4.07	252.71
1996-97	300.62	5.58	306.20	123.43	243.56	4.52	248.08
1997-98	354.20	6.35	360.55	129.62	273.26	4.90	278.16
1998-99	468.40	7.68	476.08	138.46	338.29	5.55	343.84
1999-2000RE	564.86	11.03	575.89				
2000-01BE	639.73	10.18	649.91				
				Avg growth	-83.44	-84.38	-83.46

Source : Finance Department GOK

In the recent decade of 1990s (Table 3 and 4), it is seen that the trend growth rate for the plan expenditures has been 39.58% as compared to non-plan in the same period 1990-2000 where it has grown at 175.02%. Hence it can be seen that the non-plan component is larger than the plan component. To a large extent, this may reflect the importance of salaries in this category—and the impact of the fifth pay commission recommendations being accepted by the union government. Given that human resources are the backbone of health services, this in itself is not something one can consider as a negative factor. If people are working in a motivated manner, this may even be positive. What has to be assessed is whether a less than 40% increase in plan expenditures is adequate to meet the long term health goals of the state government.

At constant prices similarly it is seen that the growth over the period 1990-91 to 1998-99 has been smaller under plan heads when compared to the non-plan expenditures.

Similarly for family welfare the plan component is larger. Through the years family welfare has largely been under the plan head only. Whether this refers to the family planning programme or something else has to be looked into. If yes, it may be important from a long term point of view, but is it a part of health policy in the immediate future? How is family planning linked to health in the short term? Can it not be argued that improvements in the health situation will improve the prospects of success in family planning? If so, are these the right priorities?

3.2 Health related sectors

Under this can be included the following heads[17].

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

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

Table 5 Revenue Expenditure of Health-related sectors during 1960-90

(Rs. In crores)

Year	WSS	Nutri	SSW	FW
1961-66			15.06	
1966-69			12.46	
1969-74			40.51	
1974-79	51.16	1.95	19.90	4.04
1979-80	16.03	0.51	7.30	8.03
1980-85	181.10	0.61	80.83	68.68
1985-90	288.61	178.22	425.99	178.78
Avg growth	41.03	2184.87	435.16	1006.31

Source : Finance Department GOK

Under health-related sectors on the revenue side (Table 5), it is seen that in this state there has been an increase in expenditure from 2% of SDP in 1960-61 to 5.8% in 1989-90. From 1972 onwards there is increased expenditure in health services as well as health-related services[18]. In the period 1960-1974 there has been nearly no expenditure under the heads of family welfare, WSS, nutrition.

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

During the five year plans (Table 5) it is seen that from the fifth five year plan all health-related sectors have received more attention. Even so nutrition expenditure has been poor. Family welfare largely a plan expenditure has also grown in the later years. It is quite clear that WSS, FW and nutrition have received more impetus in the latter part of 1980s, that is seventh plan onwards.

When we see the growth of expenditures over the various periods, it comes out quite clearly that the major jump in expenses is seen in the seventh five year plan in all the health-related sectors.

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

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

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

Year	FW	WSS
1961-66		1.11
1966-69		2.49
1969-74		3.00
1974-79		0.65
1979-80	0.00	1.32
1980-85		0.05
1985-90	40.63	0.55
Growth		-92.92

Source : Finance Department GOK

The capital outlays however show expenditures only under water supply and sanitation which has received attention under all the plans. There has been an improvement in the infrastructure – laying of pipes, etc.

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

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

	Current					Constant			
Year	M&PH	FW	WSS	SSW	Defl	M&PH	FW	WSS	SSW
1990-91	1.67	4.9	0	0.98	88.94	1.88	5.51	0.00	1.10
1991-92	2.93	2.35	0	3.07	90.25	3.25	2.60	0.00	3.40
1992-93	6.75	0.37	0	2.43	94.33	7.16	0.39	0.00	2.58
1993-94	9.99	0.26	0	0.68	100.00	9.99	0.26	0.00	0.68
1994-95	10.91	0.21	0	1.49	106.98	10.20	0.20	0.00	1.39
1995-96	13.82	3.10	0	1.15	114.80	12.04	2.70	0.00	1.00
1996-97	7.93	2.46	0	2.00	123.43	6.42	1.99	0.00	1.62
1997-98	68.16	15.53	0	2.16	129.62	52.58	11.98	0.00	1.67
1998-99	87.88	22.52	147.93	1.28	138.46	63.47	16.26	106.84	0.92
1999-2000RE	79.78	39.32	159.90	2.39					
2000-01BE	55.38	33.45	107.89	2.34					
					Avg growth	275.58	-67.20		-90.68

Source : Finance Department GOK

Capital outlays (table 7) made under the various heads have been small. There is nearly nothing under non-plan and all the expenditures largely remains a plan expenditure. Surprisingly under WSS no expenditures were seen in the early years in the documents for which no plausible explanation can be given.

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

(Rs. In crores)

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

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

The revenue expenditure on the health-related sectors is given in table 8. The annual compound growth rates for health and family welfare is 7.4%, 8.9% for WSS and 5.8% for nutrition. The expenditure on health and family welfare increased from 15.8% to 16.9%, that of WSS increased from 3 to 4%. The share of nutrition declined from 5.1% to 1.5%.

Trend in expenditure on health related items[19]

Table 9: trend in expenditure on health related items

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

The per capita expenditure on health related activity in 1999-00 is Rs.863 and that on health and FW component Rs.185. The health related activities account for 28.5% of total revenue expenditure of the state and the health and FW account for 6.1% of state revenue expenditure. The expenditure on health related activities formed 5.7% of SNDP in 1997-98 and on health and family welfare was

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

1.1%. Experts have to say if this is adequate—the figures do not, cannot, speak for themselves.

3.3 Loans

The aspect of loans, it seems is a very worrying matter because of the overall fiscal situation in Karnataka[20]. From the consolidated finance accounts of the period 1960-1993, it is seen that total revenue expenditure shows a compounded growth of 12% in the period 1960-61 to 1970-1971 and a compounded growth of 16% in the period 1980-81 to 1990-91. The growth in the period 1970-1971 to 1990-91 at 14.77% has been higher than in the period 1960-61 to 1990-91 at 13.92%.

Social services shows a higher growth rate at 15% in the period 1960-61 to 1990-91 as compared to both general and economic services which have grown at 13%. The overall scenario of revenue and capital expenditure at the macro level has a significant impact on what finally flows to health as a whole. During the 1990s, it is seen that social services is proportionately higher than the economic and general services. It has grown at 66% as against the general services which has grown at 59%. Economic services shows an increase higher than the social and general services at 70%.

General services, which was less than social services in 1991-92, has almost caught up with social services in 1999-2000. We are not sure what this represents. Is it simply an increasing size of government? Is it better salaries to the same number of government staff? Is it a less than adequate allocation to social services? Is it growing inefficiently? This should be looked into.

Table 10: Fiscal summary of Karnataka[21]

Fiscal indicators	90-91	95-96	96-97	97-98	98-99(RE)	99-00(BE)
Total rev and grants	16.13	16.17	15.99	15.61	15.81	16.15
State's own tax revenue	10.01	10.34	9.93	9.79	9.79	10.23
State's own non-tax revenue	1.64	1.85	1.1973	1.34	1.34	1.17
State's own revenue	11.65	12.19	11.66	11.12	11.03	11.40
Central transfers	4.47	3.99	4.33	4.48	4.68	4.74
Rev exp	16.27	15.85	16.77	15.81	17.46	17.54
Cap. Exp and net lending	2.06	3.33	3.23	3.27	3.49	3.12
Total exp	18.33	19.18	20.00	19.08	20.95	20.66
Fiscal deficit	-2.20	-3.01	-4.01	-3.47	-5.14	-4.51
Revenue deficit	-0.14	0.32	-0.78	-0.20	-1.65	-1.39
Financing of debt	0.60	0.53	0.55	0.58	1.06	1.22
Internal debt	1.35	1.20	1.46	1.34	1.83	2.07
Loans from the centre	0.60	0.53	0.49	0.52	0.67	0.84
Small savings and PF	-0.35	0.39	0.64	-0.21	0.28	-0.51
Others	0.00	0.35	0.88	1.24	1.29	0.89
Off-budget financing	20.74	19.69	20.68	22.01	24.24	26.54
O/s debt						

Source: Finance Department, GoK

[20] White Paper on Karnataka State Finances, Finance Department, March 2000.
[21] White paper, op.cit

The increase in revenues has been slower than the increase in GSDP and therefore revenue-GSDP ratio declined from 16.2% in 1995-96 to 15.8% in 1998-99.

In analysing indebtedness in Karnataka, it is necessary to account for the fact that the state has been raising funds from the market through various corporations to finance some important infrastructure projects. These are not included in the budget, but debt servicing and repayment of loans of these corporations is entirely the responsibility of the state government. Important examples of this include the Krishna Bhagya Jal Nigam Ltd. and the Karnataka Neeravari Nigam Ltd. These are off-budget liabilities which has to be taken into consideration.

The indicators of financial performance of the State Government have been calculated by the CAG and presented to the House in March 1999. This is the latest data that is available on this subject. This is because there is always a lag of two years for every final audited statement of the financial year. We present here the analysis and figures from the CAG report, for an over all understanding about the severity of the strain on the state finances.

The main indicators of financial performance are:

(i) sustainability – the degree to which a government can maintain existing programs and meet existing creditor requirements without increasing the debt burden.

(ii) flexibility – degree to which a government can increase its financial resources to respond to rising commitments by either expanding its revenues or increasing its debt burden.

(iii) vulnerability – degree to which a government becomes dependent on and therefore vulnerable to sources of funding outside its control on influence, both domestic and international.

(iv) Transparency – timely presentation indicating the efficiency of budgetary process and accuracy of the estimates.

Table 11: Financial Indicators of Government of Karnataka

Sustainability	1994-95	1995-96	1996-97	1997-98	1998-99
Balance from current reserves (BCR) (rupees in crores)	848	1550	1060	1337	538
Primary deficit(PD) (rupees in crores)	641	409	736	216	1495
Interest ratio	0.07	0.04	0.06	0.08	0.09
Capital outlay/capital receipts	0.1972	1.11	0.78	0.68	0.63
Total tax receipts/GSDP	0.12	0.13	0.13	0.13	0.12
State tax receipts/GSDP	0.1	0.1	0.1	0.1	0.1
Return on investment ratio	0.0052	0.0028	0.0038	0.0034	0.0025
Flexibility					
BCR	848	1550	1060	1337	538
Capital repayments/capital borrowings	0.13	0.21	0.17	0.2	0.17
State tax receipts/GSDP	0.1	0.1	0.1	0.1	0.1
Debt/GSDP	0.23	0.23	0.23	0.24	0.26
Vulnerability					
Revenue deficit (RD)(rupees in crores)	297	62	579	277	1215
Fiscal deficit (FD)(rupees in crores)	1513	1457	1944	1610	3112
Primary deficit(PD) (rupees in crores)	641	409	736	216	1495
PD/FD	0.42	0.28	0.38	0.13	0.48
RD/FD	0.2	*	0.3	0.17	0.39
Outstanding guarantees/revenue receipts	0.55	0.55	0.51	0.53	0.1971
Assets/liabilities	1.05	1.05	1	0.99	0.93

Source : CAG Report 3, March 1999

Using the above definitions the financial indicators for GoK have been calculated by the CAG[22]. The behaviour of the indices / ratios can be discussed in brief as follows:

Sustainability:

1. Balance from current reserves (BCR) : BCR is defined as revenue receipts minus plan assistance grants minus non-plan revenue expenditure. A positive BCR shows that the state government has surplus from its revenues for meeting plan expenditure. The table shows that in the last five years 1994-95 to 1998-99, the BCR came down from Rs.1337 crores to Rs.358 crores indicating a significant decline in availability of funds for plan expenditure.

2. Interest ratio = $\frac{\text{interest payments} - \text{interest receipts}}{\text{Total rev. receipts} - \text{interest receipts}}$

The higher the ratio the lesser the ability of the government to service any fresh debt and meet its revenue expenditure from its revenue receipts.

[22] Report of the Comptroller and Auditor General of India for the year ended 31 March 1999, No.3 (Civil), GoK. The definitions for the various financial indicators are also given.

In case of Karnataka, the ratio has significantly increased showing clearly that the availability of funds for program spending has decreased indicating a strain on the sustainability.

3. Capital outlay/capital receipts: this ratio indicates to what extent the capital receipts are applied for capital formation. A ratio of less than one would not be sustainable in the long term inasmuch as it indicates that a part of the capital receipt is being diverted to unproductive revenue expenditure. On the contrary, a ratio of more than one would indicate that capital investments are being made from revenue surplus as well. A rising trend in this means an improvement in the fiscal performance of the state.

Here the table shows that the ratio has been less than 1 except during 1995-96. In 1996-99 there was steady decline in the ratio indicating that increasingly the capital receipts were not available for investment.

4. Tax receipts/GSDP:

Tax receipts consist of state taxes and state's share of central taxes. Tax receipts suggest sustainability. But the ratio of tax receipts to GSDP would have implications for the flexibility as well. While a low ratio would imply that the government can tax more, a high ratio points to the limits of this source of finance but also its inflexibility.

In Karnataka, the ratio in the last five years has been constant at 0.13 throughout except during 1994-95. Similarly the ratio of state tax receipts to GSDP has also been constant at 0.10. Inspite of more than four fold increase in RD during 1994-95 to 1998-99, the tax GDP ratio did not change which indicated government's preference for relying on borrowings to meet its deficits.

5. Return on investment ratio: this is the ratio of the earnings to the capital employed. These include the returns on govt's investments in statutory corporations, govt companies, joint stock companies and co-operative institutions. A high ROI indicates sustainability. As can be seen here it is virtually nil throughout the studied period.

Flexibility:

6. Capital repayments vs capital borrowings: now this indicates the extent to which the capital borrowings are available for investment, after repayment of capital. The lower the ratio, the higher would be the availability of capital for investment.

Here we see that the ratio has steadily increased during 1994-95 to 1998-99 from 0.13 to 0.17 with even higher levels in between. This shows lesser amount of funds available for investment.

7. Debt to GSDP : the GSDP is the total internal resource base of the state govt. which can be used to service debt. An increasing ratio of debt/GSDP would

signify a reduction in the government's ability to meet its debt obligations and therefore increasing risk for the lender.

In case of Karnataka, this ratio has steadily moved up in the last three years from 0.23 to 0.26 indicating a worsening capacity of the government to meet its debt obligations.

Vulnerability:

8. RD/FD: RD is the excess of revenue expenditure over revenue receipts and represents the revenue expenditure financed by borrowings etc. the higher the RD the more vulnerable is the state govt. FD represents the aggregate of all the borrowings. The RD as a percentage of FD indicates the extent to which the borrowings of the govt are being used to finance non-productive revenue exp. Thus the higher the ratio the worse off the state because that would indicate that the debt burden is increasing without adding to the repayment capacity of the state.

   During 1998-99 39% of the borrowings were applied to meet the revenue expenditure as compared to 20% in 1994-95. This indicates a steep decline in the financial position of the state.

9. PD/FD: PD is the fiscal deficit minus interest payments. This means that the less the value of the ratio less the availability of funds for capital investment. In case of Karnataka the ratio has been rather small and below 0.5. though the ratio increased significantly during 1998-99 and would, prima facie suggest increased availability of funds, it should be seen in conjunction with the fact that heavy borrowings were made in 1998-99 (100% increase over 1997-98) increasing thereby interest burden in subsequent years, this also should be seen in the context of increased ratio of RD/FD and overall therefore points to a grim picture of state government's ability to pay interest in future.

10. Guarantees to revenue receipts: indicates the risk exposure of the state govt and the ability to pay. Here this ratio has increased from 0.55 in 1994-95 to 0.1971 in 1998-99, indicating a huge increase in the risk exposure of the state revenues to the outstanding guarantees.

11. Assets/ liabilities – this shows the solvency of the government a ratio of more than 1 indicates that the state govt is solvent while a ratio of less than 1 would be a contra indicator. This ratio has come down from a position of 1.05 in 1994-95 to 0.93 in 1998-99 showing that liabilities are overtaking the assets. This when seen with the low capital outlay/capital receipts ratio shows that more than 80% of the capital receipts were not available for asset formation.

Transparency:

There has been no delay in submission of the budget and its approval.

The White Paper also gives the projection of current fiscal trends which we present below[23].

Table 12: Projection of current fiscal trends (status quo scenario) (% of GSDP)

Details	95-96	96-97	97-98	98-99 (RE)	99-00 (BE)	00-01 (proj)	01-02 (proj)	02-03 (proj)	03-04 (proj)	04-05 (proj)
Rev	16.17	15.99	15.61	15.81	16.15	15.88	15.99	16.12	16.24	16.37
Non-int exp	17.11	17.81	16.19	18.34	17.68	17.86	17.05	16.81	16.59	16.39
Rev surplus/RD	0.31	-0.89	-0.42	-1.98	-1.85	-2.32	-2.16	-1.99	-1.78	-1.54
Primary surplus/PD	-0.94	-1.83	-1.13	-2.53	-1.53	-1.99	-1.05	-0.69	-0.34	-0.01
Int.payts	2.07	2.18	2.34	2.61	2.98	3.39	3.56	3.70	3.79	3.85
Gross fiscall surplus/deficit	-3.01	-4.01	-3.47	-5.14	-4.51	-5.38	-4.61	-4.39	-4.14	-3.86
Debt stock of GOK	19.69	20.68	22.01	24.24	26.54	29.06	30.65	31.85	32.68	33.15
Committed exp/Rev (%)	58.5	60.9	63.6	70.1	74.7	77.3	78.2	78.2	79.6	79.1
(salaries+pension)/ rev(%)	42.9	44.7	45.6	50.1	52.6	52.4	51.0	49.8	48.5	47.4
Debt service/rev (%)	15.7	16.3	18.0	20.1	22.1	24.9	27.2	28.4	31.0	31.7

Source: White Paper on Karnataka State Finances, March 2000

It is quite clear that the state government finances are in the red and need urgent redressal. It has come to our understanding that the specific loan apportioning towards health is given in the form of schemes. The specific details about this may be available with the Secretary (Expenditure) who is also in-charge of the Project Management Unit in the Finance Ministry. However this is a huge task that has not been attempted here. But it needs to be undertaken.

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

[23] White Paper, opcit, pp.14-4.14

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

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

Source : Finance Department , GOK

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

	defl	M&PH	FW	WSS	SSW	Nutrition	Total
1990-91	88.94	426.47	3429.78	2326.14	125.02		7041.96
1991-1992	90.25	435.37	2116.31	2519.88	159.83	1.04	5723.04
1992-93	94.33	658.95	4392.83	2386.11	26.28	20.15	7790.60
1993-94	100.00	609.42	5317.39	3465.23	26.44	3.42	9640.96
1994-95	106.98	822.42	2588.54	4280.46	18.34		8038.35
1995-96	114.80	690.83	2023.19 70	5582.50	79.26		8645.52
1996-97	123.43	728.62	852.79	5330.37	19.31		7300.28
1997-98	129.62	759.12	1646.76	7925.99	27.08		10835.50
1998-99	138.46	735.12	1444.06	8335.68	17.91		10847.28

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

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

	Current				Constant		
	M&PH	FW	TOTAL	Defl	M&PH	FW	TOTAL
1990-91	1430.80	456.89	2059.95	88.94	1608.72	513.1971	2316.11
1991-1992	239.39	214.68	817.35	90.25	265.25	237.87	905.65
1992-93	656.53	14.89	1245.1970	94.33	695.99	15.79	1320.58
1993-94	981.09	0.02	1887.55	100.00	981.09	0.02	1887.55
1994-95	1021.21	0	2071.08	106.98	954.58	0.00	1935.95
1995-96	1295.22	0	2187.29	114.80	1128.24	0.00	1905.30
1996-97	741.47	20.51	1641.35	123.43	600.72	16.62	1329.78
1997-98	6765.78	141.07	7786.66	129.62	5219.70	108.83	6007.30
1998-99	8739.24	215.41	34523.1972	138.46	6311.74	155.58	24934.07
				avg growth	-56.41	-96.64	19.62

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

Table 16: State sponsored schemes (revenue a/c) – current prices

(Rs. in Lakhs)

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

Source : Finance Department , GOK

Table 17: State sponsored schemes (revenue a/c) – constant prices

(Rs. in Lakhs)

Year	Deflator	Medical & Public Health	Family Welfare	Water Supply & Sanitation	Social Security & Welfare	Nutrition	Total
1990-91	88.94	4119.23	524.14	3354.24	1458.33	824.53	18650.11
1991-92	90.25	3804.55	3466.18	4592.98	1795.35	930.95	24408.00
1992-93	94.33	4836.66	1435.34	6097.49	1952.97	943.91	28976.33
1993-94	100.00	5585.83	624.35	7232.65	1796.39	884.43	34160.60
1994-95	106.98	7259.84	629.79	10967.65	1753.50	1464.11	41401.06
1995-96	114.80	9645.41	575.97	12129.52	2351.13	2554.56	54976.99
1996-97	123.43	10893.25	307.07	13997.83	3560.82	2864.31	61183.32
1997-98	129.62	11317.10	402.55	15412.88	3061.24	2647.50	56395.76
1998-99	138.46	9886.80	360.79	10918.90	2410.38	2376.63	50421.61
	Avg growth	-73.33	-92.35	-63.83	-81.64	-67.97	-69.96

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

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

	Current					Constant			
Year	M&PH	FW	WSS	Total	Defl	M&PH	FW	WSS	Total
1990-91	1430.8	456.89	0	2059.95	88.94	1608.72	513.71	0.00	2316.11
1991-92	239.39	214.68	0	817.35	90.25	265.25	237.87	0.00	905.65
1992-93	656.53	14.89	0.32	1245.7	94.33	695.99	15.79	0.34	1320.58
1993-94	981.09	0.02	0	1887.55	100.00	981.09	0.02	0.00	1887.55
1994-95	1021.21	0	0	2071.08	106.98	954.58	0.00	0.00	1935.95
1995-96	1295.22	0	0	2187.29	114.80	1128.24	0.00	0.00	1905.30
1996-97	741.47	20.51	0	1641.35	123.43	600.72	16.62	0.00	1329.78
1997-98	6765.78	141.07	0	7786.66	129.62	5219.70	108.83	0.00	6007.30
1998-99 A/C	8739.24	215.41	14792.79	34523.72	138.46	6311.74	155.58	10683.80	24934.07
1999-2000 – RE	7950	300	15990	24840.98					
2000-01-BE	5538	245	10789	16876					
					avg growth	-56.41	-96.64		19.62

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

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

	Current			Constant	
	WSS	Total	Defl	WSS	Total
1990-91	1361.05	1361.05	88.94	1530.301	1530.301
1991-92	6847	6847	90.25	7586.704	7586.704
1992-93	3696.02	3696.02	94.33	3918.181	3918.181
1993-94	3376	3406	100.00	3376	3406
1994-95	3288	3318	106.98	3073.472	3101.514
1995-96	4452	4682	114.80	3878.049	4078.397
1996-97	5897	5907	123.43	4777.607	4785.708
1997-98	1682.96	1682.96	129.62	1298.38	1298.38
1998-99	7843.86	7843.86	138.46	5665.073	5665.073
			avg growth	-58.87	-58.87

Source : Finance Department , GOK

The loans under state sponsored schemes (table 19) shows that the loans were allotted only towards WSS.

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

	Current			Constant	
	WSS	M&PH FW	Deflator	WSS	M&PH,FW
1990-91	2	1.49	88.94	2.25	1.68
1991-92	3	1.3	90.25	3.32	1.44
1992-93	3	1.26	94.33	3.18	1.34
1993-94	3	0.82	100.00	3.00	0.82
1994-95	5	43.61	106.98	4.67	40.76
1995-96	0	58.71	114.80	0.00	51.14
1996-97	0	61.65	123.43	0.00	49.95
1997-98	0	81.22	129.62	0.00	62.66
1998-99	0	60.75	138.46	0.00	43.88
			avg growth		191.00

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

4. District Allocations for Health

In this section, we look at the allocations made for health at the district level from the data provided in the link documents. We repeat, these are allocations—expenditures may be different[24], and the data for that has to be collected from each district.

[24] A Indira, A Study of zilla panchayat budgets in two districts—Dharwad and Bangalore [rural], CBPS, March 2000 for details of the differences.

We first present an analysis of allocation as given in the link documents. These are at current prices—unadjusted for inflation. Then we provide the same data for constant prices, after deflating the numbers using the national income implicit deflator for 1993-94. This may be challenged—it is the best we could get, and are open to other methods of deriving constant prices. This then may be treated as a first cut estimate.

It would be useful to get these estimates on a per capita basis. We have population figures at the district level for 1991—a census year. We also have estimates made by a demographer for the year 1995[25]. For these two years, we provide per capita allocation estimates.

Table 21: Proportion of district health allocation to total district allocation (%)

Districts	1992-93	1993-94	1994-95	1995-96	1996-97	1997-98
Bangalore(Urban)	3.65	3.96	3.65	3.65	3.41	2.51
Bangalore(Rural)	5.77	6.37	5.01	5.30	4.71	3.64
Chitradurga	5.20	5.19	3.89	4.51	3.89	2.51
Kolar	3.59	4.06	2.76	2.94	2.77	1.75
Shimoga	3.15	4.69	4.11	3.50	2.74	2.04
Tumkur	4.80	4.63	2.98	2.73	2.62	3.33
Mysore	4.15	4.98	4.39	3.68	3.31	3.18
Chikamagalur	4.81	6.06	4.89	4.27	3.83	3.90
DK	4.39	4.86	3.82	4.01	3.47	3.56
Hassan	5.85	6.98	6.04	5.95	4.28	2.41
Kodagu	6.32	6.51	6.26	5.34	5.15	4.36
Mandya	5.78	6.43	5.40	4.75	4.49	4.11
Belgaum	6.03	5.40	4.94	3.68	3.65	2.93
Bijapur	4.52	5.14	4.28	4.42	4.42	2.22
Dharwad	5.23	6.19	4.29	3.78	3.86	2.53
UK	6.19	6.14	6.05	4.44	4.05	2.63
Gulbarga	4.31	5.92	3.90	4.74	3.87	2.45
Bellary	6.91	6.69	5.30	3.83	3.18	2.24
Bidar	4.64	5.47	4.34	4.45	4.45	3.51
Raichur	2.32	4.08	3.12	2.58	2.52	1.65

The proportion of medical and public health allocation to the total district outlays are calculated at current prices. It is interesting to note that over the period 1992-93 to 1997-98 there is a consistent drop across all districts in the state. There seems to have been a slight improvement in 1993-94 but then again there has been a drop after that.

The worst affected it seems is Raichur which had a share of 2.32 in 1992-93 not a very big sum down to 1.65 in 1997-98. Similarly Kolar also shows a fall from 3.59 in 1992-93 to 1.75 in 1997-98. Interestingly the Hassan, constituency of a former Prime Minister shows a very rapid decline from 5.85 to 2.41. The biggest

[25] We are indebted to Ramesh Kanbargi of the Centre for Social Development in Bangalore for providing us with this data.

slide seems to be in Belgaum from 6.03 to 2.93. These are also districts with a low Human Development Index[26].

We can next look at the per capita figures for two time points, namely 1991 and 1995 for the districts for the total health allocation. This has been calculated for health allocations at constant prices which have been deflated against the national implicit deflators.

Table 22: Per Capita allocations (in Rs.)

Districts	Per capita 1991	Per capita 1995
Bangalore(Urban)	0.94	1.67
Bangalore(Rural)	8.62	12.82
Chitradurga	7.57	9.97
Kolar	6.15	7.62
Shimoga	5.22	7.87
Tumkur	7.24	6.65
Mysore	6.05	6.67
Chikamagalur	10.68	13.08
DK	5.61	6.60
Hassan	9.06	12.79
Kodagu	10.27	19.14
Mandya	7.88	9.71
Belgaum	7.47	6.62
Bijapur	8.58	9.09
Dharwad	5.50	6.97
UK	11.12	11.35
Gulbarga	7.50	10.49
Bellary	8.35	9.10
Bidar	8.45	10.85
Raichur	3.55	5.35

Except for a few districts like Kodagu, Chitradurga, Gulbarga, and a few others the per capita allocations have not actually gone up very much in all districts. Also the rise is not proportionate over the districts.

In the next three tables we have the allocations towards rural health services, public health services and the Indian systems of medicine in the districts.

Rural Health Services

The mean allocation for rural health services to the districts under the plan head has increased from 12.95 lakhs in 1987-88 to 73.87 lakhs in 1997-98. Both are at current prices. There has been a steady increase over the intervening period also.

[26] Government of Karnataka, Planning Department, Human Development in Karnataka, 1999.

The highest allocation has been in the district of Chitradurga at 60.13 lakhs over the period and the lowest to Bangalore urban district at 22.54 lakhs.

The standard deviation across districts for plan allocations in 1987-88 was 5.8, in 1997-98 it was 20.51. The coefficient of variation has shown fluctuations and in fact fallen from 44.76 in 1987-88 to 27.76 in 1997-98.

The growth of allocations towards RHS for the various districts is also varying in the study period. Not all districts show a steady increase nor is the increase uniform over the period. In fact it seems that the districts tend to show a pattern according to their ranking of HDI. Example Kodagu though having lower allocation compared to others shows a steady allocation, and infact it has grown over the period. Mysore on the other hand shows fluctuations and big drop in some years.

Table – 23 :District allocation towards Rural Health Services (Current Prices)

(Rs. In Lakhs)

Districts	1987-88	1988-89	1989-90	1990-91	1991-92	1992-93	1993-94	1994-95	1995-96	1996-97	1997-98	mean	Stdev	co-var	growth
Bangalore(Urban)	6.90	7.20	8.00	7.16	11.65	19.97	27.00	30.60	38.80	40.50	50.17	**22.54**	**15.77**	**69.98**	-33.90
Bangalore(Rural)	8.69	13.79	12.64	5.18	48.10	66.55	75.50	70.75	73.00	50.00	71.68	**45.08**	**29.18**	**64.72**	-25.01
Chitradurga	10.33	16.40	20.18	46.65	47.41	63.10	88.25	82.20	98.60	98.80	89.50	**60.13**	**33.85**	**56.29**	-21.24
Kolar	15.57	19.85	28.75	45.07	67.40	64.90	75.25	89.75	92.75	89.00	68.36	**59.70**	**28.22**	**47.28**	-60.09
imoga	11.35	14.03	17.13	20.39	29.00	32.00	72.00	92.00	90.00	70.50	75.20	**47.60**	**32.17**	**67.59**	-39.77
Tumkur	12.84	15.69	19.67	25.16	22.60	53.70	69.50	54.75	54.80	53.70	89.57	**42.91**	**25.12**	**58.55**	-36.58
Mysore	27.82	15.92	22.92	36.95	54.31	54.39	82.50	79.70	74.98	36.62	80.30	**51.49**	**24.96**	**48.47**	-73.76
Chikamagalur	16.97	9.15	10.75	22.10	22.78	32.77	50.00	56.00	55.50	61.00	75.13	**37.47**	**22.82**	**60.91**	-59.75
DK	25.37	17.87	25.48	30.90	44.05	45.40	56.50	45.25	60.00	58.00	94.00	**45.71**	**21.50**	**47.04**	-66.32
Hassan	7.43	9.17	10.28	14.74	60.51	69.27	88.50	83.50	84.70	88.10	77.09	**53.94**	**35.50**	**65.83**	-5.68
Kodagu	18.46	6.70	11.00	28.82	22.79	27.50	26.50	27.50	26.50	36.50	37.30	**24.51**	**9.44**	**38.52**	-81.63
Mandya	7.17	5.13	6.20	11.71	31.00	66.50	73.00	79.00	78.25	89.05	101.00	**49.82**	**37.63**	**75.53**	28.06
Belgaum	13.32	13.03	21.74	16.26	35.88	65.80	73.50	80.80	62.00	67.29	60.40	**46.37**	**26.47**	**57.08**	-58.78
Bijapur	9.06	8.73	15.01	28.15	42.90	42.30	86.00	80.99	76.00	94.20	75.28	**50.78**	**32.72**	**64.44**	-24.46
Dharwad	12.23	13.68	14.52	9.62	35.36	54.51	78.00	82.38	83.81	105.57	118.57	**55.30**	**40.41**	**73.07**	-11.86
UK	10.95	17.82	21.48	26.55	32.82	40.78	50.50	46.10	46.85	35.10	31.89	**32.80**	**12.75**	**38.88**	-73.52
Gulbarga	16.06	18.94	19.69	35.75	30.40	63.50	90.00	47.00	63.20	91.00	82.50	**50.73**	**28.84**	**56.86**	-53.30
Bellary	9.72	17.53	24.15	29.60	40.80	71.20	102.50	99.50	79.65	76.80	62.50	**55.81**	**32.99**	**59.11**	-41.55
Bidar	12.18	14.04	11.69	23.49	19.80	35.80	50.50	56.60	58.28	66.91	77.48	**38.80**	**24.04**	**61.97**	-42.17
Richer	6.56	4.32	13.22	14.22	11.40	22.75	67.50	56.50	62.00	69.85	59.40	**35.25**	**27.24**	**77.28**	-17.68
Mean	**12.95**	**12.95**	**16.73**	**23.92**	**35.55**	**49.63**	**69.15**	**67.04**	**67.98**	**68.92**	**73.87**				
Stdev	**5.80**	**4.80**	**6.29**	**11.80**	**15.28**	**16.83**	**20.22**	**20.94**	**18.56**	**22.28**	**20.51**				
Co-Eff of Var.	**44.76**	**37.10**	**37.59**	**49.31**	**42.98**	**33.91**	**29.24**	**31.23**	**27.30**	**32.32**	**27.76**				

Public Health Services

The mean allocation for PHS has increased from 48.15 lakhs in 1987-88 to 114.51 lakhs in 1997-98. Infact the allocation in 1997-98 has been smaller than the previous years where the allocations were larger.

The standard deviation was 15.97 in 1987-88 and 50.12 in 1997-98. The coefficient of variation also shows a variation among the years from 33.18 in 1987-88 to 43.77 in 1998-98.

Surprisingly when the allocations towards PHS is compared with the RHS, the allocations seem larger. It has also grown over the years for all the districts more or less consistently though falling over the period. This is unlike our earlier work in Dharwad and Bangalore (rural)[27]. In Kodagu[28] detailed budget analysis of minor heads showed that PHS is receiving less compared to RHS. We would need to study this a bit more to see if so how are the expenditures moving. Can it be that the expenditures are being made under different heads and not necessarily going towards PHS?

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[27] A.Indira, et.al, op.cit

[28] CBPS has been working on a study -- whether a District Planning Committee can work. This work is located in Kodagu.

Table 24 District allocation towards public health services (Current Prices)

(Rs. In lakhs)

Districts	1987-88	1988-89	1989-90	1990-91	1991-92	1992-93	1993-94	1994-95	1995-96	1996-97	1997-98	mean	Stdev	co-var
Bangalore(Urban)	12.50	18.90	20.00	28.75	29.56	40.50	60.00	59.50	68.70	72.00	39.42	**40.89**	**21.11**	**51.62**
Bangalore(Rural)	45.31	76.10	72.45	87.51	82.00	107.00	145.00	131.00	188.00	220.00	159.20	**119.42**	**54.16**	**45.36**
Chitradurga	36.83	51.81	65.20	82.47	101.47	131.44	148.00	149.00	175.20	175.20	113.50	**111.83**	**48.46**	**43.33**
Kolar	59.57	51.35	51.20	94.99	55.60	87.75	122.00	92.00	114.00	117.50	76.20	**83.83**	**26.96**	**32.16**
Shimoga	56.22	76.15	71.70	92.51	61.00	67.00	109.00	87.00	93.19	94.50	66.95	**79.57**	**16.67**	**20.95**
Tumkur	49.73	64.30	61.88	96.23	128.00	157.40	157.25	132.10	133.85	146.30	189.48	**119.68**	**45.49**	**38.01**
Mysore	67.55	89.55	62.38	98.57	118.44	135.60	191.35	204.28	189.40	228.38	204.60	**144.55**	**60.82**	**42.07**
Chikamagalur	47.27	42.00	41.60	71.59	75.31	76.85	120.00	113.00	104.50	102.50	115.47	**82.74**	**30.11**	**36.39**
DK	46.46	54.24	54.79	76.82	92.47	108.73	150.25	141.85	156.00	163.50	160.50	**109.60**	**46.65**	**42.57**
Hassan	53.99	62.40	55.35	75.08	67.80	92.25	139.50	130.05	161.22	124.90	67.20	**93.61**	**38.34**	**40.96**
Kodagu	17.74	21.55	27.92	31.72	22.50	50.00	72.50	77.50	83.00	82.50	68.20	**50.47**	**26.77**	**53.04**
Mandya	52.20	72.13	62.49	78.25	86.00	87.00	124.25	115.45	117.00	117.95	108.11	**92.80**	**24.98**	**26.92**
Belgaum	51.10	76.42	79.88	124.06	205.72	213.73	222.50	223.20	231.00	240.71	213.39	**171.06**	**72.45**	**42.35**
Bijapur	55.48	74.35	71.13	97.97	183.89	162.70	185.85	200.65	256.70	260.30	128.10	**152.47**	**72.60**	**47.62**
Dharwad	66.45	83.01	76.60	100.00	138.61	187.85	254.10	229.22	218.10	219.93	129.19	**154.82**	**69.09**	**44.63**
UK	65.19	75.00	70.03	80.05	89.68	105.89	116.55	137.05	121.00	132.90	83.92	**97.93**	**25.80**	**26.34**
Gulbarga	69.08	119.03	99.91	103.11	144.40	125.10	223.50	228.50	278.50	224.50	136.20	**159.26**	**67.63**	**42.47**
Bellary	50.78	55.31	65.39	91.35	101.56	140.56	144.30	160.66	140.35	123.20	87.55	**105.55**	**38.68**	**36.65**
Bidar	36.11	55.25	49.49	69.47	75.97	77.98	100.70	96.27	115.14	120.09	77.71	**79.47**	**26.72**	**33.62**
Raichur	23.44	37.50	36.06	48.03	62.68	63.60	115.40	104.35	97.40	90.15	65.29			

Mean	**48.15**	**62.82**	**59.77**	**81.43**	**96.13**	**110.95**	**145.10**	**140.63**	**152.11**	**152.85**	**114.51**
Stdev	**15.97**	**23.33**	**18.68**	**23.55**	**46.60**	**45.90**	**49.80**	**51.96**	**59.28**	**59.26**	**50.12**
Co-Eff of Var.	**33.18**	**37.13**	**31.25**	**28.92**	**48.48**	**41.37**	**34.32**	**36.95**	**38.97**	**38.77**	**43.77**

Indian Systems of Medicine

Of all the allocations, this head seems to receive the lowest share. The mean allocation over all the districts in 1987-88 was 0.65 lakhs which has limped upto 13.35 lakhs in 1997-98. The standard deviation in 1987-88 was 0.66 and 5.49 in 1997-98. The coefficient of variation shows a great fall over the years from 101.20 in 1987-88 to 41.14 in 1997-98.

Table 25: District allocation towards Indian System of Medicine (Current Prices)

(Rs In Lakhs)

Districts	1987-88	1988-89	1989-90	1990-91	1991-92	1992-93	1993-94	1994-95	1995-96	1996-97	1997-98	mean	stdev	co-var	growth
Bangalore(Urban)	0.40	0.90	0.90	1.41	1.55	8.50	12.00	11.10	12.20	12.50	8.17	**6.33**	**5.26**	**83.10**	85.68
Bangalore(Rural)	2.81	8.64	8.64	2.18	2.18	10.25	11.50	13.75	21.00	23.00	6.68	**10.06**	**7.04**	**69.96**	-78.39
Chitradurga	1.12	2.68	2.68	3.50	5.91	7.60	18.75	16.00	22.30	22.50	12.00	**10.46**	**8.20**	**78.42**	-2.60
Kolar	0.86	1.00	1.00	1.67	3.00	4.50	8.25	8.25	9.75	9.50	6.36	**4.92**	**3.61**	**73.31**	-32.77
Shimoga	0.63	0.83	0.83	0.94	4.50	5.00	10.00	12.00	14.00	12.50	15.75	**7.00**	**5.95**	**84.96**	127.27
Tumkur	0.62	1.42	1.42	4.60	4.00	6.70	9.50	9.80	12.50	15.00	20.81	**7.83**	**6.39**	**81.56**	205.13
Mysore	1.80	3.32	3.82	7.24	7.69	9.82	11.00	10.00	10.00	10.00	16.90	**8.33**	**4.25**	**51.07**	-14.65
Chikamagalur	0.32	0.35	0.35	4.10	8.40	9.00	11.00	13.50	13.50	18.50	21.11	**9.10**	**7.28**	**80.03**	499.72
DK	0.00	1.85	1.35	2.70	3.80	6.00	7.00	10.00	13.00	13.50	15.00	**6.75**	**5.36**	**79.52**	
Hassan	0.03	0.05	0.05	2.00	3.30	10.63	15.00	17.00	14.00	14.00	11.00	**7.91**	**6.83**	**86.24**	3233.33
Kodagu	0.25	0.85	0.85	3.00	3.08	5.00	5.00	5.00	6.50	7.00	10.10	**4.24**	**3.01**	**71.00**	267.27
Mandya	0.00	0.00	0.00	1.00	2.00	5.50	7.00	15.00	14.50	17.00	12.50	**6.77**	**6.78**	**100.16**	
Belgaum	0.57	1.85	1.85	2.13	6.14	17.00	17.00	17.00	22.00	23.00	19.00	**11.59**	**9.01**	**77.70**	203.03
Bijapur	0.56	0.61	0.61	0.00	1.00	14.50	14.50	9.75	19.00	26.50	8.58	**8.69**	**9.07**	**104.40**	39.29
Dharwad	0.46	0.55	0.55	0.32	3.36	12.00	19.00	27.88	34.19	35.00	34.57	**15.26**	**15.24**	**99.83**	583.20
UK	0.20	1.45	1.45	1.50	1.67	6.50	6.50	8.00	9.50	8.00	9.76	**4.96**	**3.70**	**74.66**	343.64
Gulbarga	0.70	2.48	2.48	2.70	13.75	26.00	26.00	25.00	30.20	33.00	37.60	**18.17**	**14.03**	**77.19**	388.31
Bellary	0.30	0.85	0.85	1.09	5.00	10.50	16.50	15.00	15.00	17.50	17.00	**9.05**	**7.44**	**82.20**	415.15
Bidar	0.65	1.60	1.60	6.20	8.05	10.00	10.00	11.67	11.76	12.00	15.00	**8.05**	**4.90**	**60.84**	109.79
Richer	0.70	1.72	1.72	1.72	7.40	8.00	11.50	11.50	12.50	13.00	13.60	**7.58**	**5.21**	**68.71**	76.62

Mean	**0.65**	**1.65**	**1.65**	**2.50**	**4.79**	**9.65**	**12.35**	**13.35**	**15.87**	**17.15**	**15.57**
Stdev	**0.66**	**1.86**	**1.89**	**1.87**	**3.11**	**5.03**	**5.17**	**5.49**	**7.01**	**7.84**	**8.27**
Co-Eff of Var.	**101.20**	**112.77**	**114.44**	**74.61**	**64.90**	**52.10**	**41.90**	**41.14**	**44.15**	**45.71**	**53.09**

5. By Way of A Conclusion

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

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

One reason we could not get data was probably because it was not available. This we found hard to believe in the beginning. But after a meeting in the office of the Commissioner for Health and Family Welfare, we had no option but to accept this harsh reality. *Much of the required data simply does not exist.*

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

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

The devolution of finances to local bodies needs to be examined as well. The accounts we have seen do not take into account the local tier of government following the 73rd and 74th amendments—because there are none. Today, there are expenditures in the district by the state government agencies—but these are not expenditures of the local governments—except perhaps in an accounting sense as these bodies may have passed resolutions to incur the expenditure. The priorities are not set by them, and the power to approve does not vest with them. They pass resolutions to justify what the state government departments have decided to do. It is thus not possible to make any statements about their relative efficiency or effectiveness in the absence of actual experience of devolution of fiscal responsibilities. But a system that keeps them out of health care is likely to be a system that will fail—and the existing top down one has failed. Why not try a truly decentralised system?

Table 26: proportion of district outlays to state receipts (in % terms)

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

Source: compiled from Finance Accounts, GoK

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

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

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

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

Considering that health as a proportion in total social services sector has only about 1.5% share, as seen earlier, the above figures are to be taken seriously to understand how much of the money is really flowing down to the districts for the improvement of the health sector.

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

The finance data also suggest that the state, in financial terms, is becoming increasingly more susceptible to financial stress. The CAG data we have cited shows this clearly.

Much of this is tentative. In depth studies of the integrity of the ge[illegible] process—for example, to what extent do allocations differ from [illegible]nclatures, at what level and what processes are decisions made and on, are essential for a [illegible] understanding of health—and other [illegible]elopmental—finances.

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

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