

# State of Health Care in Maharashtra

## A Comparative Analysis

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*Health indicators of Maharashtra and Punjab show that they have attained relatively high growth against the background of a high per capita income (PCI) and good economic development while Kerala shows a good development in the health sector in the context of low PCI, low level of industrialisation but relatively good infrastructural indicators. While the first pattern could be attributed to the trickling down effect of capitalist modernisation of the industrial-cum-agrarian variety in Maharashtra and of predominantly agrarian variety in Punjab, the second is rooted in socio-political, geographic and demographic particularities of Kerala.*

*This article looks into the specifics of Maharashtra's development in health in the context of other socio-economic indicators to examine the relationship between health sector development and capitalist growth.*

### I Introduction

ON a societal level such as the 'large cultural systems' [Nathan Dev 1991] which constitute India's linguistic states comprising millions of people, health policy and the resultant development in the field of health is a function of economic, social and political structures. But even as Engels said economics is the determinant factor only in the last instance [quoted in Althusser 1977: 11]. Althusser went further when he pointed out that: "from the first moment to the last, the lonely hour of the last instance never comes" [*ibid*: 113]. The achievements of the state of Kerala, China and certain Latin American countries such as Cuba and Nicaragua which have attained remarkable indicators of health without a high per capita income (PCI) or high level of industrialisation points to the need to look at the social and political structures which impinge on health development more deeply.

An observer of the health indicators of Indian states will come across two broad patterns of commendable growth. One typified by Maharashtra and Punjab which have attained relatively high indicators of health against the background of a high PCI, and high CMIB index of economic development and the other characterised by Kerala with a very good development in health indicators, in the context of a low PCI, low level of industrialisation, but relatively good infrastructural indicators. While the first pattern could be attributed to the trickling down effect of capitalist modernisation of an industrial-cum-agrarian variety in Maharashtra and of a predominantly agrarian variety in Punjab, [Duggal K 1992] the second pattern is rooted in certain social, political, geographic and demographic particularities of Kerala [Tharakan P K 1984 and Nag Moni 1989] of which the social and political are of relevance to us in our understanding the development of the health sector in Maharashtra.

### SOCIO-HISTORICAL CONTEXT

Both Maharashtra and Kerala have witnessed strong movements of the lower

castes. Maharashtra not only had an earlier lead in the social reform movement in the form of the Satyashodhak Samaj set up by Jyotiba Phule in 1873, but at this stage the leadership of the movement remained in the hands of the Malis and other backward castes (OBC). It was after the death of Jyotiba Phule in 1890 and with the entry of the Maharajah of Kolhapur Shahu Chatrapati that the leadership began to shift into the hands of the landed elite among the Marathas [Gore M S 1989: 11-41 and 53-63]. As a continuation of this trend, in 1930s the non-brahmin movement started getting absorbed into the Congress [*ibid*: 68-70 and Omvedt G 1976: 2]. Still there were currents of radicalism within the non-brahmin movement such as the one represented by the Peasants and Workers Party (PWP) led by Keshav Rao Jedhe. It must be borne in mind that in the 1952 elections the undivided Communist Party of India (CPI) and the non-brahmin radical parties such as the PWP had scored almost the same percentage of votes in Maharashtra as the CPI in Kerala and Andhra, i.e., about 15-20 per cent (Omvedt G, 1976: 281-82). The political formations floated by Ambedkar such as the Independent Labour Party (IIP) and the Republican Party of India (RPI) also could not go too far in mobilising all the depressed castes [Shah G 1991: 11]. Towards the end of his life in 1956 Ambedkar was involved in a series of correspondence with Ram Manohar Lohia and his associates on an alliance between the dalit movement and the socialists. This however did not come through [Lohia 1979: 29-37]. With the absorption of PWP also into the Congress fold a formidable fortress of Maratha-OBC brahmin alliance was built up [Zelliot E 1970 and Omvedt G 1976: 2 and 281] which distributed the benefits of power to the elites of these three groups and later on extended its spoils to the dalit elite also. In the process whatever development that has taken place in such sectors as health which are intimately related to the well-being of the people is more out of an evolutionary fall out of developing capitalism, which for its unhindered growth required also that some form of a new

patron-client relationship was nurtured between the elite politicians and the electorate. This largely uncommitted model of development has resulted in vast rural-urban and intra-regional disparities in Maharashtra to which even the unpreparedness in facing the current drought can also be attributed [Dhanagare D N 1992]. We turn to these points in detail at a later stage.

In contrast to the socio-political scene of Maharashtra the social reform movements of the ezhavas and pulayas of Kerala which began during the 1890s prepared the social base for the anti establishmentarian politics of the state. The ezhava elite in their quest for better social status had mobilised the poorer sections of their community, who in the process got radicalised to an extent beyond which the elite could not satisfy them [George 1986]. At this point they turned to the communist movement which was emerging. True, the Travancore kings had created a large middle peasantry after crushing the Nair-feudal aristocracy, confiscating the land held by them and declaring all former tenants of this aristocracy as the tenants of the state who were later on granted ownership rights in 1865 [Verghese T C 1970: 64]. True also, that in order to satisfy the aspirations of this large middle peasantry who became the social base of the so-called modern Travancore, the state had embarked on various welfare measures in social services including health. But the breakthrough which Kerala made in the social sectors after independence cannot be seen as a mere vegetative outgrowth of the Travancore-Cochin model on to the rest of the less developed parts of the state which were under direct British rule. While on the one hand the rightist forces when they were in power wanted to penetrate some of the less developed districts in Malabar which were leftist strongholds, on the other hand the welfare aspirations of the people of these districts themselves were raised and they wanted to be on par with their counterparts in the better developed districts. The left governments which have ruled Kerala off and on for short durations have proved to be the nodal points setting progressive directions for the state [Isaac

and Kumar 1991]. The left has been able to enforce a welfarist consensus in Kerala with the power of its mass base and the occasional chances to rule the state. Now, it has reached a stage where for fear of public reaction even the rightist political parties can not tamper with this consensus too much when they come to power at the state level

In the following presentation we look into the specifics of Maharashtra's development in health in the context of other socio-economic indicators to substantiate the observations made above. We will be making comparisons with Punjab and Kerala as already mentioned and also with Bihar and Madhya Pradesh (MP) which are not as developed as the other three states.

#### SOCIO-ECONOMIC INDICATORS

Maharashtra has a population of 79 million according to 1991 Census and with 9.4 percent of the country's land area, it is one of the largest states in India. Its density of population of 256 persons per sq km in 1991 is comparable to that of India which is 267 per sq km. At 1970-71 prices the state had a per capita income of Rs 1,039 in 1986-87 which is second only to Punjab which was Rs 1,652. The percentage share of the manufacturing sector to State Domestic Product (SDP) in 1988-89 at 1980-81 prices for Maharashtra was the highest in the country at 22.80 per cent. It also had the largest number of persons working in non-agricultural enterprises. This pattern was also followed in the financial sector with the highest per capita bank deposits and advances. In most of these indicators of economic development Bihar and MP fare very poorly. Punjab not only scores highly in per capita income but also registers good financial indicators. Basically an agricultural state, it can boast of 91.3 per cent of irrigated land as opposed to Maharashtra's 12.4 per cent. Kerala has middle level of PCI, very low percentage share of the manufacturing sector of SDP, less persons working in non-agricultural enterprises compared to even Madhya Pradesh, but higher per capita bank deposits and like Punjab comparatively less per capita bank advances. This can be linked to both the low level of industrial enterprise in these two states and the inflow of remittances from abroad.

Among the other infrastructural indicators of development it is noteworthy that Maharashtra has achieved 100 per cent electrification of its villages. However without the data on rural domestic consumption of electricity, excluding agricultural consumption, this data cannot carry us too far. In total road length per 1,000 sq kms Maharashtra comes the highest, with MP a distant second. Again without the rural-urban composition of this data we cannot infer much. When it comes to percentage of villages connected by all weather roads, in Kerala it is 100 per cent and Punjab 99 per cent, Maharashtra's position is a distant 3rd with 53 per cent, which however is much higher than that of Bihar and MP which are

abysmally low at 35 per cent and 23 per cent respectively in 1987-88

Maharashtra has an urban population of 38.73 per cent as per the 1991 Census which is the highest in India. Punjab and Kerala has 30 per cent and 26 per cent urban population, respectively. A large part of Maharashtra's urban population is concentrated in Bombay itself. The state according

to 1981 Census has to look after the well-being of 22.6 percent of the population who are either scheduled castes (SC), scheduled tribes (ST) or Neo-Buddhists (who are SCs who got converted in 1956 with Ambedkar). Punjab has the highest SC Population of 26.9 per cent whereas MP has a combined total of 37 per cent of SCs and STs.

Average size of land holding is an impor-

TABLE I: HEALTH INDICATORS OF SELECTED STATES

		Maha- rashtra	Bihar	Kerala	Madhya Pradesh	Punjab	India
Annual birth rate per 1000 live births 1987-90	R	29.5	33.8	19	38.70	28.40	31.50
	U	23.6	24.6	19.30	29.10	25.60	24.40
	C	27.5	32.9	19	36.90	27.60	29.90
Annual death rate per 1000 1987-90	R	8.4	11.0	5.90	13.60	8.50	10.40
	U	5.2	6.2	5.80	7.50	5.80	6.70
	C	7.3	10.6	5.90	12.50	7.80	9.60
Infant mortality rate per 1000 live births 1990	R	64	77	18	119	58	86
	U	44	46	16	61	45	51
	C	58	75	17	111	55	80
Per cent of infant deaths to total deaths 1981-85	R	23.56	29.04	9.25	31.85	20.55	28.27
	U	19.34	26.19	10.39	26.44	22.45	21.27
	C	22.43	28.86	9.47	31.13	20.98	27.16
Life expectancy 1981-85		60.60	52.80	68.40	51.60	63.10	55.40
Attended births by qualified personnel/institutions 1988 (per lakh pop)		46300	23800	91100	—	80600	41200
Attended deaths by qualified personnel/institutions 1988 (per lakh pop)		58500	33200	74800	—	69000	46100
Decennial growth rate 1981-91		25.43	23.49	14.06	26.75	20.26	23.56
Marital fertility 1988	R	159.80	199.90	117.00	193.50	168.30	177.70
	U	139.50	177.40	120.90	166.60	152.60	146.20
	C	152.90	196.60	117.70	188.50	163.90	170.70
Statewise immunisation coverage (0-23 months) 1986-87							
TT2 (Tetanus Toxoid)		93.70	10.10	104.00	35.60	56.20	45.60
DPT2 (Diphtheria Pertussis Tetanus)		99.20	12.30	82.90	45.40	70.00	56.50
OPV3 (oral polio vaccine)		92.00	9.00	91.10	36.90	71.20	48.60
BCG (Bacille Calmette Guerin)		98.80	15.10	99.20	52.70	69.00	47.90
SL (measles vaccine)		23.70	—	32.00	8.40	18.40	16.70
Per cent of children taken booster dose of polio and triple-antigen (0-15 years) 1986-87*							
Polio	R	34.45	2.42	23.44	6.36	24.42	10.77
	U	48.62	11.94	31.73	23.88	43.84	26.82
Triple-antigen	R	30.21	0.93	21.74	1.89	15.92	7.53
	U	43.09	7.76	29.39	12.79	32.03	20.51
Annual IR of poliomyelitis per 1000 children (0-4 years) 1981-82	R	1.40	—	—	1.90	3.10	1.70
	U	1.30	—	—	1.70	1.70	1.60
Annual Neo-natal Tetanus mortality rate per 1000 live births (1981-82) (0-15 years)	R	4.70	11.30	2.00	20.40	8.40	13.30
	U	4.90	5.30	1.90	1.40	3.10	3.20

Notes: R = Rural, U = Urban, C = Combined.

IR = Incidence Rate.

\* = Booster dose by sector and state and all India.

Sources: (1) Centre for Monitoring Indian Economy, Vol 2, States, Basic Statistics Relating to the Indian Economy, September 1991.

(2) National Immunisation Programme, Series I, NIIHW Data—New Delhi, December 1988.

(3) Sarvekshana—Vol XIV, No 4, Issue No 47, NSS Data, April-June 1991.

(4) Sample Registration System, Registrar General of India, Ministry of Home Affairs, Government of India, various years.

tant indicator of distributive justice in a predominantly agricultural country like ours. However, here Maharashtra falls with the states like MP and Punjab where the average size of holding is as high as nearly three hectare. Thanks partly to the successful land reforms in Kerala it is only 0.36 hectare and in Bihar only 0.87 hectare. Latter definitely not due to land reforms, but the high concentration of land in a few hands.

Coming to human indicators of development the sex ratio in Maharashtra in 1991 is 936 females per 1,000 males which is not much higher than India's average of 929 per LOGO. This is far higher than Punjab's 888 per 1,000 or Bihar's 912 per 1,000 but less than 1,040 per 1,000 of Kerala. Nowadays however under reporting of women is suggested as a reason for the low sex ratio. In literacy Maharashtra has made a remarkable improvement between 1981 and 1991 from 54 per cent to 63 per cent. Percentage of female literacy is all the same low at 51 per cent in 1991, but even this is much higher than the national average of 39 per cent. Drop out rates in I-Vth standards between 1982-83 and 1986-87 was 42.1 per cent in Maharashtra, which was slightly lower than the national average and closer to MP's 42.4 per cent and Punjab's 39.4 per cent but is far below Kerala's achievement in this field of 0.4 per cent.

#### HEALTH INDICATORS

Mortality, life expectancy and morbidity are the major indicators of health status, In India the only information available is that collected through sample surveys for most of these. Some of the family welfare indicators can also be used derivatively for assessing performance in health.

In life expectancy, infant mortality, death rate and percentage on infant deaths to total deaths, which are indices directly linked to health care, and in other family welfare related indices such as birth rate and marital fertility which are indirectly linked to health, both Maharashtra and Punjab show quite interestingly similar levels of moderate achievements. Kerala has a very high level of attainment and at the other end of the spectrum MP and Bihar come as low attainers. Rural-urban differences are manifest in Maharashtra and Punjab and even stronger in MP and Bihar. In the case of Maharashtra this is very clear in IMR, which is 64 per 1,000 in rural areas as compared to only 44 per 1,000 in 1990 in urban areas. Punjab has a lower IMR of 58 per 1,000 in rural areas while its urban IMR is almost the same as Maharashtra's. Kerala has been able to bridge the rural-urban gap in health indicators and interestingly in some indicators like birth rate and marital fertility rate rural areas score over urban areas. This has been primarily due to the infrastructure! development in rural Kerala, including health infrastructure. Maharashtra's decennial growth rate (1981-91) of 25.43 is higher than the national rate of 23.56. This could have been comparatively lower but for the death rate which is 7.3, i.e., 0.5 less

than Punjab's and somewhat closer to Kerala's 5.9. Migration from other parts of the country to the urban centres could be another reason.

The larger studies on morbidity in India are those conducted by the National Sample Survey Organisation (NSSO). But most of these have shown very low rates of morbidity compared to the studies undertaken by some non-governmental organisations. For example the 28th round of NSS conducted in 1973-74 showed that for a recall period of two weeks, prevalence of acute diseases was 27.57 per 1,000 population in rural Maharashtra and 32.18 per 1,000 in urban Maharashtra. This was in comparison with 22.46 per 1,000 in rural India as a whole and 22.77 per 1,000 in urban India. In chronic diseases, rural areas of Maharashtra recorded 1,609 cases per 1,00,000 as against rural India's 2,098 per 1,00,000. While urban Maharashtra registered a prevalence rate of 1,590 per 1,00,000 as opposed to urban India's 1,962 per 1,00,000 [NSSO 1980]. The 42nd round of NSS (1986-87) presented a prevalence rate of 64 per 1,000 in rural areas of India and 31 per 1,000 for

the urban areas for a recall period of one month. State wise breakup of this data is not available [NSSO 1989] due to the extremely fragmented manner in which data is presented. A study conducted by FRCII in 1987 in the Jalgaon district of Maharashtra in fact showed that the prevalence rates are quite higher than the NSS figures. For a recall period of one month the prevalence rate for acute episodes was 95.40 per 1,000 population and a chronic prevalence of 4,702.71 per 1,00,000 population [Duggal R and Amin S 1989: 37 and 17]. Another FRCH study in two districts of Madhya Pradesh which is being finalised showed an acute prevalence rate of 162.17 per 1,000 for a one month recall period and a chronic prevalence rate of 12,824.46 per 1,00,000. A study conducted by the Kerala Sasthra Sahitya Parishad also yielded high rates of morbidity in Kerala comparable with the FRCH figures. For a two-week recall period Kerala has shown an acute prevalence rate of 206.39 per 1,000 in 1987 and a corresponding figure of 13,802 per 1,00,000 population for chronic ailments [Kannan, KP et al 1991: 63 and 66].

TABLE 2: HEALTH INFRASTRUCTURE IN SELECTED STATES (1990)

	Maha-rashtra	Bihar	Kerala	Madhya Pradesh	Punjab	India
<b>No of Hospitals</b>						
Per cent rural	11.80	25.50	79.44	22.93	43.77	31.33
Per cent government/local bodies	28.23	81.54	7.74	100.00	85.28	43.21
Per cent private	71.77	18.46	92.26	—	14.72	56.79
Total (actuals)	1881	298	2053	362	265	9663
<b>No of Dispensaries</b>						
Per cent rural	9.22	96.25	70.94	76.16	85.58	45.12
Per cent government	17.03	100.00	2.69	100.00	99.23	42.46
Per cent private	82.97	—	97.31	—	0.76	57.52
Total (actuals)	9135	427	1748	365	1567	27031
<b>No of Beds (per 1,000 population)</b>						
Rural	5095.77	32624.01	519.70	24196.20	1595.99	6189.82
Government/local bodies	1348.38	3803.98	985.28	2963.34	1103.87	2239.71
Private	2132.71	15595.89	655.06	—	5323.17	4901.51
Total (actuals)	95326	28233	73789	22318	22084	54926

Source: Health Information of India, CBHI, DGHS, GOI, New Delhi, 1990.

TABLE 3: RURAL HEALTH INFRASTRUCTURE IN SELECTED STATES (1992)

Heads	Maha-rashtra	Bihar	Kerala	Madhya Pradesh	Punjab	India
Average rural population served by a SC	5145	5065	4192	4264	4973	4816
Average rural population served by a PHC	29243	30060	23442	42967	6928	27946
Average rural population served by CHC (in lakhs)	1.69	7.07	3.95	2.90	1.64	3.14
Maximum radial district covered by a SC (in kms)	3.21	1.91	1.52	3.42	2.34	3.04
Maximum radial district covered by a PHC (in kms)	7.62	4.66	3.59	10.87	2.77	6.67
Maximum radial district covered by a CHC (in kms)	18.35	22.63	14.78	28.23	13.48	22.27

Note : SC - Sub Centre, PHC - Primary Health Centre, CHC - Community Health Centre. Source: Rural Health Bulletin, MHFW, GOI, New Delhi, March 1992 (Figures are provisional).

An evaluation study conducted by the National Institute of Health and Family Welfare (NIHFW) in 1986-87, after the immunisation programme was declared part of technology missions, on children aged between 0-23 months showed that the states of Kerala and Maharashtra had achieved extremely high rates of immunisation followed by Punjab which ranked moderately high while Bihar showed very poor achievement [Sokhey J 1988:29 and 38]. However, the NSS study of children of 1-15 years which obviously included children born before the mission started and could not be effectively immunised later showed much lower rates of immunisation [NSSO, *Sarvekshana* April-June 1991].

It needs to be brought out at this juncture that the major illnesses of children in India such as diarrhoea and respiratory infections are not immunisable diseases and that therefore the attempt to project the immunisation programme as the guardian angel of India's children has to be taken with a pinch of salt only. 60-90 per cent of deaths in the early age groups are caused by diarrhoea followed by respiratory infections. [Sathyamala 1989]. These non-immunisable diseases deserve more attention because it is the children of the poor who are more prone to these diseases due to inadequate standards of food and hygiene.

#### HEALTH INFRASTRUCTURE

The registration information on private hospitals and dispensaries in India is far from satisfactory. But on the basis of the available data from the registered hospitals and dispensaries we find a bias against the rural areas in many states. In both hospitals and dispensaries the rural-urban difference is quite high in Maharashtra. 88 per cent of hospitals and 91 per cent of dispensaries in Maharashtra are in urban areas. Punjab's registration data on hospitals seems to be of poor quality. The total number registered is very low. But within this the rural-urban distribution is more even. In dispensaries a very high percentage (85.38 per cent in Punjab are in rural areas. 79 per cent of Kerala's hospitals and 71 per cent of dispensaries are in rural areas. 72 per cent of all hospitals and 83 per cent of all dispensaries in Maharashtra are in the private sector. Even in Kerala 92 per cent of hospitals and 97 per cent of dispensaries are in the private sector. This would be because of the increasing aspirations of people which cannot be met by the public health system which concentrates more on a quantitative expansion of primary health care. But equally important is the vanities of a status conscious middle class whose numbers are on the rise due to the inflow of gulf money, expansion of cash crop cultivation, trading and service sectors.

There is a high disproportion in availability of hospital beds in Maharashtra between rural and urban areas, although it is not as high as in MP or Bihar. While there is only one bed per 5,096 persons in rural Maharashtra it is as low as one bed per 355

persons in urban Maharashtra. Rural Punjab has a bed population ratio of 1:1,596 while urban Punjab has a ratio of 1:455. In Kerala the rural areas have one bed per 520 persons, as opposed to 1:235 in urban areas. The rural-urban differences in health infrastructure poses an even greater problem because only 53 per cent of Maharashtra's villages have all weather roads. In MP and Bihar where rural transportation is far less developed the urban bias in health infrastructure development will be compounded many times. There was one public hospital bed available per 1,348 persons in Maharashtra as against one private hospital bed for every 2,133 persons. In Punjab it was 1:1,104 and 1:5,323 respectively. The Kerala rate for the same were 1:985 and 1:655 respectively. The above data refers to the year 1990.

In the governmental rural health infrastructure Maharashtra has one subcentre per 5,145 persons as on March 31, 1992 which is the best among the states we have chosen for comparison. The state is third in the PHC population ratio-one PHC per 29,243 persons. Punjab is the first in this with one PHC per 6,928 persons and Kerala a distant second with one PHC per 23,442. In the Community Health Centre (CHC) population ratio the state is second with one CHC per 1.69 lakh population. Punjab is

first here also with ratio of 1:1.64 lakh, MP is third with 1:2.90 lakhs. Among the five states compared Maharashtra is in the fourth position in the maximum radial distance covered by subcentres which is 3.21 km. while it is as low as 1.32 km in Kerala. 1.91 km in Bihar and 2.34 km in Punjab. In the case of PHCs, Punjab has the lowest maximum radial distance of 2.77 km followed by Kerala with 3.59 km and Bihar with 4.66 km. In Maharashtra it is as high as 7.62 km. In the maximum radial distance served by CHCs Punjab stands first with 13.4 km, Kerala second with 14.78 km and Maharashtra 18.35 km. The very high distance people in Maharashtra have to travel to reach the sub-centres and PHCs, the basic units of rural public health care, calls for remedial action in favour of rural areas.

#### HEALTH PERSONNEL

The distribution of allopathy doctors in all the four states except Kerala is highly skewed in favour of urban areas. This observation is based on the 1981 Census data which we feel is more accurate to arrive at certain patterns than the Medical Councils' data since the council's lists may contain more names of persons who have died or are not practising, and not all practitioners register themselves. Since 1991 data in this

TABLE 4: HEALTH HUMANPOWER IN SELECTED STATES (1981)

Type of Medical Practitioner	Maha-rashtra	Bihar	Kerala	Madhya Pradesh	Punjab	India
<b>Allopathy</b>						
Per cent rural	24.28	34.56	78.88	22.45	40.46	28.46
Total No	31964	10802	7774	10697	9541	209511
<b>Ayurvedic and Unani</b>						
Per cent rural	44.85	64.21	76.46	55.65	48.26	55.54
Total No	6272	3068	7826	7917	5039	70411
<b>Homeopathy</b>						
Per cent rural	52.83	69.42	75.45	36.13	36.36	57.29
Total No	2300	9117	3393	1251	462	63714
<b>Not Elsewhere Classified</b>						
Per cent rural	38.00	78.23	82.23	47.26	19.51	59.66
Total No	1808	1139	1133	1623	123	43827
<b>Total</b>						
Per cent rural	29.47	53.56	77.61	37.36	42.76	41.13
Total No	42344	24126	20126	21488	15165	373853

Source: Census of India 1981, General Economic Table, Series I—Part III-B, Census Commissioner, GOI.

TABLE 5: REGISTERED PRACTITIONERS IN SELECTED STATES\*

Type of Medical Practitioner	Maha-rashtra	Bihar	Kerala	Madhya Pradesh	Punjab	India
Allopaths (1987)	41035	23450	15568	8526	24615	331630
Ayurveda (1985)	30852	34706	11662	27827	17166	264800
Homeopathy (1986)	13444	21572	4571	5384	6062	131091
Unani (1986)	535	3174	57	221	5606	28715

\* As per various councils.

Note: Data with regard to Madhya Pradesh is low due to under-reporting by the respective council.

Sources: (1) Indian systems of Medicine and Homeopathy in India, Planning and Evaluation Cell, MHFW, GOI, New Delhi, 1986.

(2) Health Information of India, CBHI, DGHS, GOI, 1991.

regard is not available, we have only computed percentages for various categories of doctors which are unlikely to undergo any drastic change during 10 years. As high as 76 per cent of allopaths in Maharashtra are in urban areas, An even higher 77 per cent of them are in urban areas in MP followed by Bihar with 65 per cent. In Punjab the rural-urban breakup of allopaths is more balanced at 40:60 respectively. In other systems also the pattern is not widely different except that the percentage of 'ayurvedic' and homeopaths in rural areas is more in Bihar, while the corresponding percentage of homeopaths is higher in Maharashtra. MP also has a slightly higher percentage of ayurvedics in rural areas.

#### HEALTH EXPENDITURE

To know the emphasis, growth and the extent of health care in the country/state it is important to look at the expenditure on health. There are three major groups in the provision of health care and consumption of health resources in India. The public sector consists of the central government, state government, municipal and local bodies. The private sector includes private organisations and institutions, corporate bodies providing medical care to their employees and the NGOs. Thirdly, the households constitute the largest constituent who spend on health care. Compared to the private health sector finances, data on public health sector finances is fairly well documented.

#### Public Expenditures

The total financial outlays on Maharashtra are around 10 to 12 per cent of the outlays for India. A breakup of the plan expenditure brings out the fact that in the first plan period, the state was spending 46.44 per cent of its total plan expenditure on social and community services, which got reduced drastically to 18.85 percent in the sixth plan period. Irrigation, Power and co-operation became top priority, this was at the cost of social and community services [Statistical Abstract of Maharashtra, March 1991]. This shift in priorities could be attributed to the presence of the strong sugar lobby in Maharashtra politics. There is a wrong assumption that Maharashtra gives a high priority to the social and community services. Examining the latest available public expenditure of Maharashtra for the year 1990-91, this fact is reinforced. Out of a total government expenditure (revenue+capital, plan+non-plan) of Rs 1,17,437.63 million, 27.03 per cent was spent on social and community services, 3.68 per cent on medical and public health, 0.54 per cent on family welfare, 1.82 per cent on water supply and sanitation and 0.94 per cent on housing [Government of Maharashtra, 1992].

Comparing the trends in expenditure on health with other selected states, the same holds true. For the year 1985 Maharashtra incurred expenditure on health of only Rs

35.62 per capita per year which was 6.31 per cent of total government revenue expenditure. This was less than what was incurred in Kerala and Punjab. A point to IK noted is that Kerala is economically, a poorer state when compared to Maharashtra, but still gives a high priority to the health of its people. Health sector in Maharashtra in the late 80s is showing a down trend as percentage to government expenditure. Between the year 1985 and 1991 this ratio has halved in Maharashtra from 6.3 percent to 3.68 per cent.

Further, analysing few selected components of health care like curative care, disease programmes and family planning, one finds Maharashtra between the years 1971-1985, compared to Kerala and Punjab, gave priority to family planning services, (17.20 per cent) and diseases control programmes (19.35 per cent). The latter two states and Bihar spend more than 50 per cent of their health expenditure on provision of curative care services, as compared to Maharashtra which spends only 24.64 per cent of its health budget on curative care. Various studies have shown that curative care is the main need of the people in rural areas, but what is instead given is family planning services. Family planning is one of the main priorities for all the states and there has been a steady increase in terms of outlay and expenditure. The large allocation to disease control programmes is more of a historical one. A large health bureaucracy is supported under these programmes. The various national programmes which were started had a huge army of personnel employed for the eradication of communicable diseases like ma-

laria, leprosy, cholera, T B etc. It is to maintain this army of personnel that the major part of the expenditure is incurred (this fact is proved when we examine the detailed breakup of expenditure under each item).

We have analysed the expenditure under each major head-medical, public health and family welfare in Maharashtra during the year 1990-91. Maharashtra spent totally Rs 4,020.70 million on the health sector. 40.01 per cent of the expenditure was on the medical account, 43.94 per cent was spent

**TABLE 7: MEDICAL RELIEF, EDUCATION AND DRUGS DEPARTMENT MAHARASHTRA 1990-91 (ACTUALS)**

Summary	Per Cent to Totals
<b>1 Medical Relief</b>	
Urban	45.36
Rural	3.55
<b>2 Medical Education, Training and Research</b>	22.70
<b>3 Direction and Administration</b>	0.42
<b>4 Employee State Insurance Scheme</b>	24.62
<b>5 Others</b>	3.35
	100.00
<b>Total (Rs million)</b>	<b>1608.93</b>

*Notes:* (1) Percentages are to total expenditures. (2) Totals include plan and non-plan expenditures.

*Source:* Civil Budget Estimates 1992-93 Part B. Medical Education, Drugs Department: Department of Finance, Government of Maharashtra, 1992.

**TABLE 8: RATIOS OF EXPENDITURE ON VARIOUS HEALTH PROGRAMMES IN SELECTED STATES**

Heads	Year	Punjab	Maha-rashtra	Kerala	MP	Bihar	All India
Revenue expenditure on health (-water-supply) per capita (in Rs)	1971	7.25	7.64	7.03	4.73	2.88	6.11
	1985	37.36	35.62	36.02	21.69	13.10	31.91
Revenue expenditure on health as per cent of total government expenditure (in per cent)	1971	7.22	5.38	9.16	9.66	6.53	3.84
	1985	7.21	6.31	8.50	6.45	5.43	3.47
Revenue expenditure on curative services per capita (in Rs per capita)	1971	2.59	2.21	4.10	1.40	0.87	2.28
	1985	19.66	8.78	18.87	8.49	6.66	12.02
Curative expenditure as per cent of total health expenditure	1971	35.64	28.92	58.27	29.68	30.31	37.29
	1985	52.62	24.64	52.39	39.13	50.83	37.66
Revenue expenditure on diseases programme, per capita (in Rs)	1971	1.86	1.44	0.05	0.80	0.43	0.83
	1985	4.03	6.89	1.84	2.69	1.59	3.92
Disease programme expenditure as per cent of health expenditure	1971	25.66	18.87	0.76	16.94	15.06	13.63
	1985	10.78	19.35	5.11	12.41	12.14	12.27
FP (-MCH) expenditure as per cent of total health expenditure	1972	12.62	12.04	17.81	13.17	12.97	10.04
	1985	13.12	17.20	14.36	22.00	21.22	16.23
Medical education expenditure as per cent of total health expenditure	1971	7.78	5.72	7.76	5.92	4.33	7.15
	1985	8.32	6.44	9.01	4.53	5.92	8.92
Revenue expenditure on water supply and sanitation per capita (in Rs)	1976	5.98	3.18	1.39	1.32	1.03	1.67
	1985	11.14	17.64	5.40	13.77	3.44	9.02

*Sources:* State Sector Health Expenditures, [Duggal R and S Nandraj 1991] FRCH, 1992. Original Source CFRA, Comptroller and Auditor General of India, GOI, various years.

on public health programmes and 16.03 per cent was spent on family welfare.

Out of Rs 1,608.93 million on the medical account, 45.36 per cent was expended for urban medical relief, while rural medical relief received only 3.55 per cent. Employees State Insurance Scheme (ESIS) expenditure on its various hospitals and dispensaries (which is only for the organised sector employees) amounts to 24.61 per cent and 22.70 per cent was spent on medical education. Thus it is evident that 85 to 87 per cent of the medical account expenditure is expended for urban areas.

Within the public health account 43.40 per cent of expenditure was incurred on direction and administration, this is in addition to the expenditure on salaries under each programme head. Disease control programmes accounted for 35.23 per cent of total expenditure under public health account. Within the disease control programmes more than half the amount is spent on the malaria control programme, followed by leprosy control programmes. Both these programmes accounted for 80 per cent of the expenditure in the disease control programmes budgets. Out of a total expenditure on malaria of Rs 372.51 millions, 66.66 per cent goes into salaries. In most of the programmes 75 per cent of the expenditure goes into salaries and very little on materials and supplies (which includes expenditure on drugs).

In respect of family welfare services there is priority given to the rural family welfare programme, 23.25 per cent of total FW expenditure as compared to 5.98 per cent in urban areas. Maternal and child health services which is a crucial area is allocated only Rs 119.85 million (18.59 per cent). Here too when we look at the selected programmes, we find that salaries take a major chunk of the expenditure. From the above analysis we infer that the state's

major part of the expenditure on health goes into salaries and for the urban areas.

#### Private Household Level Expenditure

As mentioned earlier data on private sector expenditure on health is not generally available. There are micro-level studies which give a fair account of the extent of private expenditure. A study undertaken by FRCH on household health expenditure in Jalgaon district of Maharashtra brought out the fact that on an average, a household spends Rs 182.49 per capita per year on health care, which is 7.64 per cent of total consumption expenditure; out of this total per capita expenditure, 68.50 per cent of the

expenditure goes into practitioners' fees and medicines. When viewed in terms of rural urban differences we find that rural households spend Rs 192.19 per capita, per year, whereas the urban households spend Rs 170.97. With regard to maternity expenses for each case the average cost was Rs 199.75. The average cost of a delivery was Rs 208.92, of an abortion Rs 300.43 and of a pregnancy Rs 85.17. With regard to rural urban differences, maternity in rural areas cost Rs 235.63 per case and in urban areas Rs 157.39 [Duggal R with Amin S 1989]. These findings are comparable with a similar study in two districts of Madhya Pradesh undertaken by FRCH which is presently

TABLE 9: FAMILY WELFARE EXPENDITURE, MAHARASHTRA 1990-91 (ACTUALS)

A Summary	B Expenditures under Selected Services			
	Rural Family Welfare Services	Maternal and Child Health Services		
Direction and administration	9.39	Salaries	76.29	43.90
Training	3.41	Travel expenses	4.74	3.34
Rural family welfare services	23.25	Material and supply	1.76	44.70
Urban family welfare services	5.90	Others	17.21	8.03
Maternity and child health services	18.59			
Transport	0.83			
Compensation	17.64			
Mass education	0.95			
Selected area programmes	5.35			
Other services and supplies	13.34			
Other expenditures	1.35			
	100.00		100.00	100.00
<b>Total</b>	<b>644.71</b>	<b>Total</b>	<b>149.89</b>	<b>119.85</b>

Notes : (1) Totals are in rupees millions.  
 (2) Totals include plan and non-plan.  
 (3) Except totals all other figures are in percentages.  
 (4) B—Travel includes POL and motor vehicles.

Source: Same as for Public Health.

TABLE 8: PUBLIC HEALTH EXPENDITURE, MAHARASHTRA 1990-91 (ACTUALS)

A Summary of Public Health Expenditure	B Expenditure on Prevention and Control of Diseases	C Expenditure under Selected Programmes	Filaria Control	Malaria Control	Cholera Control	Leprosy Control		
Direction and administration	43.40	Filaria control programme	5.11	Salaries	74.00	66.66	86.21	78.87
Training	0.18	Malaria control programme	60.27	Travel expenses	3.65	2.89	3.87	7.91
Minimum needs programme	19.04	Cholera control programme	3.06	Materials and supply	—	20.53	7.82	4.41
Preventions and control of diseases	34.97	Guinea worm control programme	0.31	Others	22.33	9.90	2.08	8.80
Manufacturers of sera and vaccines	0.14	Leprosy control programme	21.06					
Public health laboratories	0.91	BCG vaccination and TB control programme	10.00					
Publicity	0.21	Goitre control programme	0.04					
Other	0.80	Others	0.04					
	100.00		100.00		100.00	100.00	100.00	100.00
<b>Total</b>	<b>1767.13</b>	<b>Total</b>	<b>Rs 617.99</b>	<b>Total</b>	<b>Rs 31.56</b>	<b>372.51</b>	<b>19.03</b>	<b>130.17</b>

Notes : (1) Totals are in rupee millions.  
 (2) Except total all other figures are in percentages.

Source: Civil Budget estimates 1992-93, Public Health, Department of Finances, Government of Maharashtra, 1992.

under publication. The average per capita expenditure on health by the households in the abovestudy worked out to Rs 299.16 per year, with 73.85 per cent of the expenditure going in to doctors' fees and medicines' The expenditure on health as percentage to total consumption expenditure was 8.44 per cent In another study undertaken by Kerala Shastra Sahitya Parishad (KSSP) the per capita per year expenditure on health in rural Kerala was Rs 178.33 [Kannan K Pet al 1991]. These above studies show the high cost of expenditure on health borne by the households.

## II

### Regional Variations within Maharashtra

#### BACKGROUND

The state is presently divided into six administrative divisions, viz Konkan, Nasik, Pune, Aurangabad, Amravati and Nagpur. The districts comprising of Konkan, Nasik and Pune divisions fall into the older classification of Konkan and southern Maharashtra which are relatively economically better developed, compared to the districts of Aurangabad, Amravati and

Nagpur divisions which come under the Marathwada and Vidarbha regions which are less developed. Sticking to the more popular older regional names is therefore convenient for analysis of variations over a larger geographical area than those covered under the new divisions which are smaller units.

Density of population is the highest in Greater Bombay according to the 1991 Census which is 16,434 persons per sq km. Thane which is developing as a residential suburban district of Bombay comes second--547 persons per sq km with other relatively urban districts such as Pune and Nagpur having 352 and 332 persons per sq km respectively. Greater Bombay has a low decennial population growth rate of 20.21; this is because the residential suburbs of Thane are attracting more of the recent migrants where the growth rate is as high as 55.95. Growth rate is relatively high in the other urban districts of Pune, Nasik, Nagpur and Aurangabad which are fast developing growth centres of the state.

In terms of economic development Greater Bombay ranks highest as per the CMIE index for socio-economic development which is 1,088 points followed by Pune at 175 points and Thane at 165 points.

By and large the districts of Konkan and southern Maharashtra score higher on the CMIE index of economic development whereas in Marathwada and Vidarbha regions it is only the more industrialised and urbanised districts which score relatively higher than the other districts, some of which have scores as low as 42 (Parbhani) and 45 (Osmanabad). As per 1991 Census, percentage of urban population and percentage of non-agricultural workers in total main workers is obviously high in the more industrialised and urbanised districts mentioned already.

Among the infrastructural indicators of development, as far as road transport which is the main form of transport in rural areas is concerned, the Marathwada and Vidarbha regions lag behind while the Konkan and southern Maharashtra are much better off in this regard. Since all villages in Maharashtra are presumably electrified this ceases to be an indicator of variations in development. Without the needed data on domestic consumption of electricity a meaningful comparison between divisions/districts is not possible.

Since the age groupwise data for 1991 Census is not yet available we cannot calculate the exact literacy rate after deducting

TABLE 10: HEALTH INFORMATION AT THE DISTRICT LEVEL

Districts	Governmental Health Infrastructure in Rural Areas (1989)					Endemic Diseases			
	Functioning SC	Functioning CHC	Hospitals and Dispensaries (Government)	PHC	No of Rural Population Served by		Cholera	Infective Hepatitis	Diarrhoea
					SC	PHC			
Raigad	276	9	3	49	5401.83	30426.65	ME	LE	ME
Ratnagiri	373	10	3	64	3757.02	21896.38	LE	LE	ME
Sindhudurg	246	7	2	36	3120.35	21322.36	LE	LE	LE
Thane	456	13	8	72	4041.74	25597.68	LE	HE	ME
Dhule	309	12	3	69	6504.96	29130.93	LE	HE	HE
Jalgaon	375	13	4	69	6162.08	33489.55	HE	HE	ME
Nasik	577	16	2	85	4296.23	29163.84	HE	HE	ME
Ahmednagar	485	13	1	84	5834.62	33688.01	LE	ME	LE
Pune	496	14	2	78	5471.89	34795.58	HE	HE	HE
Solapur	328	10	2	60	6997.36	38252.25	HE	HE	HE
Kolhapur	368	12	4	53	5948.40	41302.09	ME	HE	LE
Sangli	267	9	—	65	6351.93	26091.77	ME	ME	ME
Satara	306	12	3	63	6958.85	33800.11	ME	ME	LE
Aurangabad	248	7	1	40	5988.39	37128.00	ME	HE	ME
Beed	252	8	2	41	5920.14	36387.20	LE	HE	HE
Jalna	169	5	1	30	6698.38	37734.20	LE	LE	ME
Nanded	331	10	6	52	5501.59	35019.75	HE	HE	HE
Latur	234	8	1	39	5690.21	34141.23	LE	ME	HE
Osmanabad	204	6	1	36	5285.91	29953.50	LE	ME	ME
Parbhani	340	8	1	44	4820.24	37247.27	ME	ME	HE
Akola	326	8	3	48	4836.93	32850.83	ME	ME	ME
Amravati	285	9	4	50	5191.59	29592.06	HE	ME	HE
Buldhana	364	7	5	42	4102.65	35556.31	LE	ME	ME
Yeotmal	354	11	5	54	4849.74	31792.76	ME	ME	ME
Bhandara	426	11	6	61	4288.16	29946.85	LE	LE	ME
Chandrapur	276	0	1	58	4611.86	21946.10	HE	LE	LE
Gadchiroli	265	7	1	34	2706.45	21094.41	LE	LE	LE
Nagpur	300	8	6	39	4171.85	32091.13	HE	HE	ME
Wardha	162	5	2	24	4827.60	32586.29	ME	LE	LE
Greater Bombay	—	—	10	—	—	—	—	—	—

Notes: ME = Moderately Endemic, LE = Low Endemic, HE = High Endemic, SC = Subcentre, CHC = Community Health Centre, PHC = Primary Health Centre.

Source: Health Directory, DGHS Government of Maharashtra 1990.



# DCM SHRIRAM CONSOLIDATED LTD



Shri Mantosh Sondhi

Ladies & Gentlemen,

On behalf of the Board of Directors and on my behalf, I extend to you all a very warm and cordial welcome to this 4th Annual General Meeting of your Company. The Notice convening the meeting, the Directors' Report and the Audited Accounts for the year ended March 31, 1993, have been with you for some time now and, with your permission, I shall take them as read.

At the outset, I will like to mention that in deference to the sentiments and wishes of our esteemed shareholders, the Annual General Meeting is being held in July, which is 6 weeks in advance of the meeting held last year.

## The Economy

It is a matter of gratification that the economic liberalisation programme initiated by the present Government soon after it assumed office in mid-1991, continues purposefully, and with vigour. It did suffer a temporary setback due to the cumulative impact of the scam, the Ayodhya imbroglio and the Bombay blasts, but notwithstanding these and in spite of the somewhat fragile political situation, the unambiguous confirmation of the continuation of the reform process is, in my opinion, the single most important feature of the 1993-94 Union Budget.

The recent reduction in the bank lending rate by 1% is a welcome step, but it does not go far enough. A bank lending rate of 16% when the inflation rate is down to 6% cannot really be justified, more so with the foreign exchange position being reasonably satisfactory, food stocks at an all time high, the monsoon performing well so far, and the rupee holding its own against the major currencies after convertibility on trade account. I am sure that we can rely on the Finance Minister to take a realistic view of the situation and further reduce the interest rate and generally relax the credit policy, even if it means taking a certain amount of calculated risk. This will give industry the opportunity to perform on a level playing field against foreign competitors.

The discussion paper recently released by the Ministry of Finance entitled—"Economic Reforms: Two years after and the task ahead" highlights some key economic issues on which one hopes early

## Speech by Shri Mantosh Sondhi, Chairman at the Annual General Meeting of the Company held on July 20, 1993 at New Delhi.

decisions will be taken for speedy implementation. One important issue which normally gets scant attention but which has been highlighted in this paper concerns the Urban Land Ceiling and Regulation Act. This discussion paper states that—"The process of industrial restructuring requires large outlays of funds which are presently blocked in land held by many concerned units. The ULCR Act has to be suitably amended to facilitate the use of these blocked resources for productive restructuring."

I hope the Government will be able to push through with expedition the related legislative measures which, as we are aware, have been on the anvil for a long time.

Similarly, induction of the private sector in infrastructure areas so that a greater share of governmental resources can be diverted to primary education, basic health facilities, child care, women's welfare etc., is a measure which is long overdue and requires immediate attention.

## Review of Operations

During the year ended March 31, 1993, sales of your Company were higher at Rs. 434.71 crores as against Rs. 405.16 crores last year. The gross profit rose from Rs. 13.47 crores to Rs. 22.17 crores and the net profit was up from Rs. 6.29 crores in 1991-92 to Rs. 7.74 crores in 1992-93. All the units contributed to this improved performance. With better results, your Board of Directors has recommended a higher dividend of 25 per cent on equity shares, as against 20 per cent in the previous year.

## A. Fertilisers

The operations of the Fertiliser Division further improved during the year. As a result of modernisation and upgradation programmes, productivity of the plant improved and 3,58,432 tonnes of urea were produced giving a capacity utilisation of 108.6 per cent. Efforts are continuing to increase production, improve safety standards and conserve energy.

As I pointed out last year, prices, distribution and movement of phosphatic and potassic fertilisers were decontrolled, but urea, which is produced by your Company, continues to be under price control. The system of retention prices and of subsidy continues. Unfortunately, there has been inordinate delay in the disbursement of subsidy, as a result of which the interest burden has reached an alarming proportion. In the case of your Company, this delay has resulted in an additional interest burden of approximately Rs. 5 crores. In order to improve the viability of the industry and in order to encourage modernisation and expansion of existing units, the Government must clear subsidy arrears speedily. The resource crunch should not be an excuse for burdening the industry with this unwarranted interest charge. There should be a time limit for disbursement of subsidy so that the industry can plan its operations in a systematic manner for optimal utilisation of its capacity.



## B. Plastics & Chemicals

The working of PVC plant remained satisfactory and during the year, 33,805 M.T. of PVC Resins/Compounds was produced which was 101.8 per cent of capacity, in spite of severe competition from dumping. This resulted in unremunerative prices. On representation by the industry, anti-dumping duty was subsequently imposed by the Government. To improve the profitability of your Company, the focus is to increase production of value-added grades of PVC, including compounds. For this, a technical collaboration agreement has been signed with a Japanese Company. With better market conditions, working of the PVC Division is expected to improve during the current year.

The operations of the Caustic Soda plant also improved with the installation of new control systems. During the year, 41,224 tonnes of Caustic Soda were produced; this is 124.9 per cent of rated capacity. However, in the second half of the financial year, profitability was affected due to a slump in the Caustic Soda market.

## C. Power

PVC and caustic soda are power-intensive industries, but there is great uncertainty about the availability of power from the Rajasthan State Electricity Board. It is a matter of tremendous satisfaction that our captive power plant achieved a PLF of 91%, as against the national average of 57%. For the future, a project to set up additional capacity of 17 MW has already been taken in hand; this is expected to become operational by the end of the next financial year. If need be, the capacity of this plant can be increased to 30 MW in the second phase.

In this context, one cannot help commenting on the abysmally poor performance of the SEBs generally with a few exceptions. I understand that annual losses of SEBs on revenue account exceeds Rs. 5,000 crores. Apart from the technical problems, managerial failures are the root cause of this malaise which, as pointed out by many, has "emerged as the single most severe bottleneck for the development of agriculture, industry and exports". Why the State Governments cannot be forced to take effective steps to overcome this malaise, particularly in the context of the present resource crunch, is difficult to comprehend.

## D. Cement

The cement industry is experiencing a serious demand recession, essentially due to a cutback in Government offtake and lack of resources with the housebuilders. However, your plant continued to perform well. Shriram "43 Grade" Cement has become a premium brand cement in the market, which is superior to "33 Grade" cement being marketed by almost all other cement manufacturers. To conserve energy and to reduce the cost of production, the viability of converting the existing wet process into dry process is being seriously looked at.

## E. Textiles

During the year under review, yarn production increased substantially to 5,242 tonnes from 3,402 tonnes in the previous financial year. Modernisation and restructuring is progressing as per plans. As a result of these schemes and the overwhelming response of employees to the Voluntary Retirement Scheme, there has been considerable improvement in textile operations with much lower losses.

## Environment

As a responsible corporate citizen, DSCL is very conscious of its social obligations to continue to improve environment. In this direction, Shriram Environment & Research Centre has been set up to carry out research and development work in the field of environment, not only for the Company but also to provide consultancy service to small and medium-scale chemical and processing units.

## Rights Issue

The Rights Issue of PCDs/NCDs in October last year received your overwhelming response and was oversubscribed. Your confidence in the Company has given us tremendous strength to plan new projects and fresh investments. Equity shares on conversion of PCDs have been allotted on June 11, 1993. These shares have since been listed and will rank for pro-rata dividend for the current financial year.

## New Business Development

The Management is seized of the opportunities created by liberal economic policies. The Fertiliser Division has embarked upon trading of agro-inputs such as DAP, seeds and pesticides, making use of the marketing resources of the Fertiliser Division. For Seeds Business, a Joint Venture Agreement was entered into with M/s Bioseeds Genetics International Inc. (BIOSEED), USA. To implement the project, a separate Company will be formed subject to your approval and of the Government. BIOSEED will provide the basic genetic material to the new Company for production/multiplication of Hybrid Seeds for sale to the farmers. All India marketing arrangements will be handled exclusively by your Company.

As mentioned in the Directors' Report, the Company also plans to set up Aqua Culture and Granite Projects as Export Oriented Units. In the case of Aqua Culture Project, land acquisition is now in full swing and the transactions are expected to be completed by October, 1993. Detailed discussions have been initiated with some of the most reputed consultants in the field to finalise collaboration for technology and engineering. In the case of Granite Project, acquisition of mines is being explored.

## Industrial Relations

The Company continued to maintain harmonious and cordial relations with its workers in all its Divisions, which enabled it to achieve higher performance levels on all fronts.

## Human Resource Development

Companies the world over recognise the management, training and development of their human resources as the single major contributor to corporate growth, innovativeness, dynamism and prosperity. Your Company has consciously promoted training inputs for all its employees.

## Prospects for the Current Year

In the first three months of the current financial year i.e. April to June 1993, operations of your Company continue to be satisfactory, and, but for any unforeseen circumstances, the year should end on a satisfactory note both in terms of sales and profitability.

## Acknowledgement

Ladies and Gentlemen, it is with a great deal of pleasure that I wish to inform you that the Board of Directors of your Company at their meeting held on 15.4.1993 decided to promote Shri Ajay S. Shriram as Vice-Chairman & Managing Director and Shri Vikram S. Shriram as the Joint Managing Director. This is in recognition of the very competent and highly professional manner in which they have handled the affairs of the Company in the last 3 years. Lastly, the Directors wish to thank the Government authorities, financial institutions, bankers, other business associates and shareholders for the co-operation and encouragement extended to the Company. The Directors also place on record their deep appreciation for the contribution made by the employees at all levels.

Thank you.

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Note: This does not purport to be a record of the proceedings of the Annual General Meeting.

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the 0.6 years from the total population, which was the practice followed in the 1981 Census. However we arrived at the 0-6 age group by extrapolating from the 1981 figures on the basis of the overall decennial population growth and divided the total number of literates by the total population minus the extrapolated sum of 0-6 age group which revealed that there is a relatively higher percentage of literacy in most of the districts of Konkan, Nasik, Pune, Amravati and Nagpur divisions as against those in Aurangabad division. Districts of Jalna, Parbhani, Beed and Nanded in Aurangabad have literacy rate of only 45.50 percent. In Gadchiroli in Nagpur division it is even lower at 42.87 per cent. Female literacy is the lowest in many of the districts of Aurangabad division and Gadchiroli where it ranges between 26 per cent to 30 per cent only.

According to 1991 Census nearly 40 per cent or above of main workers were agricultural labourers in all districts of Amravati division, Parbhani, Nanded, Osmanabad and Latur in Aurangabad division, Wardha in Nagpur division and Ahmednagar in Nasik division. The picture of landless or marginally landed agricultural labour becomes clear when we find that the average size of holdings is almost uniformly higher in the districts of the old Marathwada and Vidarbha regions.

When we add up the scheduled caste and neo-Buddhist population Marathwada and Vidarbha have a larger dalit population than other regions. Scheduled tribes are concentrated more in Dhule, Gadchiroli, Nasik, Thane, Yavatmal and Chandrapur districts which also have higher percentage of land area under forests.

Analysis of sex ratio shows that in the districts such as Ratnagiri, Raigad, Sindhudurg which are closer to the Bombay-Thane industrial belt, females are higher in number. This is largely due to male out-migration to the Bombay-Thane belt for employment. It is again male in-migration which is responsible for the low sex ratio of Greater Bombay and Thane districts. This phenomenon seems to be the reason for a sex ratio favourable to females in Salara and its reverse in nearby Pune.

Female participation in agricultural labour as per the 1991 Census is higher than that of men in all districts of Maharashtra. This is true of India as a whole also. It is however particularly higher in the districts of Marathwada and Vidarbha regions and Dhule and Jalgaon in Nasik division.

#### HEALTH AT DISTRICT LEVEL

Data on health indicators is not available at the district level. Even though information on health services is available, this covers only the government health sector, with nearly no information on the private sector which according to various studies caters to a little over 75 per cent of our health care needs [Duggal and Amin 1989 and FRCH Report (forthcoming) 1992]. All the same we find that there seem to be a bias

against Marathwada and Vidarbha regions in setting up PHCs. While 14 of the 16 districts in these regions have PHC population ratios very close to or above 1:30,000, the number of such districts is limited to seven out of 14 districts in Konkan and Marathwada. Such a clear pattern was however not observed in the case of subcentres. As regards the endemicity of certain diseases such as cholera, hepatitis and diarrhoea for which district level data is available no definite pattern is seen across the districts.

#### HEALTH STATUS OF TRIBAL POCKETS

Tribal areas are supposed to have one PHC per 20,000 population and one sub-centre per 3,000 population. As per these norms Maharashtra requires 265 PHCs in tribal pockets and claims to have fulfilled this norm by setting up the required number as on December 31, 1991. Madhya Pradesh needs 752 PHCs in tribal areas while it has only 633. Kerala requires 55 tribal PHCs and has 58. Maharashtra similarly needs 1,662 subcentres in tribal areas but have in position 1,603 as on December 31, 1991. MP needs 5,019 sub centres but has 4,935, while Kerala needs 369 sub centres and has 174 only [Rural Health Bulletin March 1992].

#### HEALTH OF WOMEN

With regard to the health of women, enough data is not available on the morbidity and mortality. Recently a study carried

out in two villages of Gadchiroli district of Maharashtra showed, on examination of the women that as high as 92 per cent of them had one or more gynaecological or sexually transmitted diseases, and the average was 3.6 diseases per woman. Only 8 per cent of the women had ever undergone examination or treatment in the past. The study also found that there was a high prevalence of iron deficiency anemia in 83 per cent and vitamin A deficiency in 58 per cent of the women examined [Bang R et al 1989].

The abovementioned study brings out the stark reality of majority of the Indian women having a low social status, marginal presence in the market economy and not enough attention being paid to women's needs, particularly in health. It has been recognised that women face health problems throughout their life cycle, starting from sex preferences in infancy, discrimination in feeding practices, biological vulnerability during the reproductive period, the effects of repeated pregnancies, to special problems such as nutritional anemia and maternal mortality [WHO 1978]. The only programmes which are women oriented are maternal and child health services and family planning, where they are viewed as 'targets'. Manisha Gupte gives an experiential account of the problems that child bearing women in a drought prone area in Maharashtra face. The various impediments to women may be listed as follows: lack of facilities like trained health functionaries attending women during pregnancy and labour, ante-natal care (ANC) services, trans-

TABLE II: GROWTH OF PRIVATE HEALTH SECTOR IN INDIA

Heads	Across Years	
	(1942-43)	(1990)
Practitioners	72.6 per cent	85 per cent to 87 per cent*
All systems	(1950)	(1986)
Medical colleges	3.57 per cent	17 per cent
Allopathy	—	55 per cent
Ayurvedic	—	64.7 per cent
Unani	—	75.2 per cent
Homeopathy	(1974)	(1988)
Hospitals	18.6 per cent	55.9 per cent
Dispensaries (1981)	13.8 per cent	49.4 per cent
Beds	21.5 per cent	29.9 per cent
Drug production	(1974)	(1984)
Bulk drugs	64.9 per cent	79.4 per cent
Formulations	95 per cent	93.3 (1980)
Imports of medical equipment	(1977-78)	(1986-87)
	941.20 lakhs	6500 lakhs

Sources: Bhore Committee (1946), Report of the Health Survey and Development Committees, Vol IV, summary, New Delhi, Government of India.

- \* Estimated in 'Private Sector and Privatisation in the Health Care Services', Dr Jesani A with Ananthram S, FRCH, August 1990.
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port facilities, competence at referral centres, availability of a sterile delivery kit, access to health care facilities (this is applicable for most of the women), safe abortion facilities, rest before and after delivery, maternity benefits and finally lack of nourishment [Gupte M 1989]. The various programmes which are there in the government health sector, aim at only the women between the age group of 15-45 years. Most of the women who do not fall in this category get deprived of the health facilities. In this context it is necessary to reassess the existing health system and programmes with special reference to women.

### III

#### Impact of Drought on Health

Around 29,000 villages in the state comprising 62 per cent of the population and spread out in 26 districts were affected by the drought of 1992 [Shartna K 1992]. Near famine conditions were prevailing in most of these districts in varying degrees, but it was most acute in Marathwada and Vidarbha regions [Venketeshan V 1992]. It has not only created severe shortage of drinking water, but has affected the entire flora and fauna of vast stretches of land and upset agricultural activity, thus drastically reducing the availability of both food and employment opportunities.

While the direct impact of drought on health can be seen in the reported incidents of spread of contagious diseases such as cholera and gastro-enteritis [Ghaswala S 1992]. The indirect impact on health caused by the decline in food production and employment opportunities is especially important. Fetching water itself was taking away a considerable part of people's time since they had to walk for miles or stand in queues for the arrival of the elusive tanker [ibid]. In several places people had to resort to digging pits on river beds and drink the dirty water. According to an estimate made by *The Economic Times* in May 1992 food output in Maharashtra in 1991-92 is likely to decline from 12 million tonnes in 1990-91 to 7.9 million tonnes, i.e., a decrease of 34 per cent [Gangadharan S 1992].

Another report in *The Economic Times* indicated a shortfall in foodgrains production of 43 per cent in *kharif* and 67 per cent in *rabi* [*The Economic Times*; March 26, 1992]. With the price of ration wheat and rice also increased this decline in production is sure to have hiked prices of the foodgrains in rural areas, thus lowering the food intake and nutritional levels of people. Add to this the contraction of purchasing power caused by the decline in rural employment and we get the true picture of the rural populace being squeezed at both the demand and supply ends of the market spectrum. The 'market' of course is drought proof.

The tack of employment in many districts have forced people to migrate to places where work is available. For example there has been an increase of 35 per cent in

migration from Deed to Ahmednagar during the sugar-cane cutting season. But even in Ahmednagar there was not enough work for so many and therefore they ended up bonded to the contractors from whom they had taken advances. A survey conducted by an NGO among these migrants revealed that 43 per cent migrant families had at least one person fallen ill during the period of stay at the new workplace. Even minimum hygienic conditions could not be met at the places where they had migrated to [Agashe A 1992].

The almost decennial occurrence of drought had generated a lively discussion, in the press and among the academics on the causes of drought and how it could be prevented. There was a general consensus that there should be a move away from sugar-cane cultivation which consumes 60 per cent to 70 per cent of irrigation water and also that the practice of tube-well irrigation should be stopped since it was lowering the water table, thereby depriving the soil of its natural moisture and making it so much more difficult to get recharged. Other suggestions were for proper programmes for water harvesting, using small check dams in place of the mega dams, afforestation and soil conservation.

### IV

#### Current Issues

##### PRIVATE HEALTH SECTOR

One of the main issues which concerns the health system in the country is the role and functioning of the private health sector. In the new lexicography of Indian economics, privatisation is the panacea for all ills of the Indian economy. In the field of health, private sector is already the dominant sector and there is talk of privatising it further [Phadke A 1991]. With regard to Maharashtra recently a statement was made by the chief minister [*The Times of India*, September 2, 1992] that for the efficient functioning of public health services the government is planning to hand over some primary health centres to the private sector.

Here we have used largely the available data at the all-India level since we do not have much on the state-level. Broadly, the private health sector consists of the general practitioners, who include licenciates and RMPs, consultant specialists, hospitals and dispensaries. It includes also private medical colleges, pharmaceutical and medical equipment manufacturing industry which are predominantly multinational. There are also the laboratories which carry out tests right from blood testing to CAT scans. In India the share of this sector is between 4 and 5 per cent of GDP. This share at today's prices works out to between Rs 16,000 crore and Rs 20,000 crore per year [Duggal R and Nandraj S 1991].

As regards utilisation of health facilities, in the household health expenditure study in Jalgaon, Maharashtra, it was found that nearly three-fourths of the illness episodes

were treated by private practitioners and hospitals, and only 13 per cent of the illness episodes availed of government facilities. The utilisation pattern also showed that private practitioner utilisation is more in rural areas (79.82 per cent) as compared to urban areas (73.45 per cent) [Duggal R 1989]. In the household health expenditure study conducted in two districts of Madhya Pradesh it was found that private sector utilisation was 69.05 per cent of the illness episodes, 6.94 per cent government hospitals, 6.88 per cent primary health centres and 1.73 per cent subcentres. In Kerala in case of acute illness only 23 per cent of the patients went to government health institutions for treatment and 66 per cent to private health providers [Kannan et al 1991].

The growth of this sector after independence has been at a very fast pace. This growth has been unregulated and unaccounted leading to maldistribution, irrational and unethical practices, and decline in standards of care. General practitioners are the most dominant sub-sector in the provision of health care services. They include practitioners trained in other systems, but mostly practising allopathy. Also, various studies have brought out the irrational use of drugs among them which is very rampant. The use of unnecessary injections is quite well known, so much so that patients have come to expect the doctor to give them injections. Other common irrational practices are the unnecessary tests recommended and unnecessary surgery. The KSSP study brought out the finding that a higher proportion of births in private hospitals are by caesarean section compared to government hospitals. Though practitioners are permitted to dispense medicine, ethically they are not supposed to make profit from it. Not only do the private practitioners run a drug business of their own, taking perhaps a higher profit rate than the medical stores, they also put to use their professional monopoly over medical knowledge to sustain themselves in the business. In a study done in Bombay it was found that on an average the monthly median income of a GP was as high as Rs 16,560 [George A 1991]. Therefore standardisation of fees at least is possible, even ensuring a reasonable standard of income to the doctors.

The number of medical colleges has grown in spite of the Planning Commission and various committees calling for a halt to the out-turn of medical graduates in the country. Private medical colleges continue to mushroom all over the country and especially in Maharashtra. Many of them exist due to the political patronage they receive. Barring a few, many of the medical colleges do not have the qualified staff, equipment or hospital services to train medical graduates and are not even recognised by the Indian Medical Council. These are mainly run as business units. Education in these institutions is looked at more as a lucrative investment.

With regard to hospitals and dispensaries, majority of them are the small nursing homes with bed capacity ranging from five

to 30 beds. These are run from residential apartments, operate in unhygienic conditions, without basic amenities like water, proper ventilation, minimum equipment, qualified staff, lack of proper sanitation facilities, etc [Duggal R and Nandraj S 1991]. Recently in the premier city of Bombay the high court appointed a committee to go into the functioning of the hospitals/nursing homes when it found that they were functioning in an unregulated manner.

Another important development in the private health sector is the entry of the corporate sector. There is rapid proliferation of corporate medical centres. The trend was started by Apollo Hospitals in 1983. Initially it made a loss, but in 1988 it declared a profit of Rs 167 lakh and declared a dividend of 15 per cent [CMIE 1989]. Presently there are many business houses entering this field.

The private sector plays a very dominant role in the drug production of the country. Many of the socially conscious organisations in the last one decade have brought out that majority of the drugs produced in the country are hazardous, useless, unnecessary and irrational. An overwhelming proportion of the drug business is in Maharashtra, especially in and around Bombay.

The production of medical equipment began in the 1970s and it has grown from Rs 2.5 crore in the earlier years to Rs 19 crore in 1983 [CEI undated]. It is estimated that 80 per cent of all medical equipment is imported through the private companies [Baru R V 1988]. The increasing demand for hi-tech medical equipment can be gauged from the estimates made by Confederation of Engineering Industries (CEI), working group in electronics for the seventh plan, which would be to the tune of Rs 900 crore for the plan period. This is against the background that millions of people in India have no access to basic health care. This high technology in medicine only leads to over-medicalisation and high cost medical care. Broadly, in the changing scenario of the economy people will have to raise issues of the efficiency of the private health sector, demand more accountability, standardisation of fees, regulating the quantity and quality of medical service in the country.

#### ROLE OF NGOS

NGOs have undertaken numerous activities in providing health care services all over the country. They have experimented and come out with innovative projects and models of health care delivery system. We appreciate the work done by them in trying to meet the health care needs of the people. At this particular juncture it is necessary to critically examine the work done so that we are able to address ourselves to the various issues raised below and have a meaningful discussion on the health status of people in Maharashtra vis-a-vis role of NGOs.

First and the foremost, NGOs and the government have never examined nor ques-

tioned the growth, role and functioning of the private health sector. They have tried to wish it away. In many of the areas where NGOs are operating we find the private practitioners thriving. The NGOs have in fact weaned away the clientele from the government health sector and not from the private health sector. The role and functioning of the private health sector which is the dominant sector in the health field has to be evaluated, particularly in the context of the present trend of liberalisation and privatisation in the country, NGOs will have to wake themselves up to the fact of the growing predominance of the private health sector, when the government itself has become all the more keen to patronise them.

Secondly, the primary health care model which has been implemented by many of

the NGOs needs certain basic clarifications in terms of approaches and results that has to be achieved. Though they have demonstrated that they can effectively provide specific programmes to a limited population effectively, including reaching out to the underserved and the underprivileged groups, there is no evidence of either change or people's participation, which NGOs are never tired of talking about [Duggal R 1988]. In this connection it is important to state that many of us have always talked about primary health care but never of an universal health care for the people.

Many NGOs in recent years have pronounced that people are willing to pay for their services. This has been used by the government to push fee-for-service in the

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government health sector. In spite of people paying in the form of taxes, they are forced to pay fees in the private sector due to the non-availability of curative health services from the public sector, especially in the rural areas. The fees which are being paid comes out more often from the food expenditure of the household. While the poor people in the country are already under stress due to rising prices, is it justified that people should pay fees for the health services also? In this connection it needs to be pointed out that an otherwise progressive organisation like the KSSP has now started advocating for user charges on the justification that with more resources the quality of health care can be improved. The public disapproval of this suggestion was seen in the large demonstrations and signature campaign against it when it was actually implemented by the present state government.

In recent years the trend of the government is to contract out health services to the NGOs. The government accepts the fact that their own health services are inefficient, bureaucratic and not able to provide services, etc. It has handed over to the NGOs the management of certain specific programmes and the administration of some primary health centres to name a few. Are the NGOs right in taking this approach? Is it not proper that NGOs pressurise the government in providing more funds to the health sector and make it more efficient, decentralised and have an effective policy on health care. Along with this is the major question of the role and impact of the NGOs on the health sector. Most of the NGOs' work has been of a demonstrative nature rather than providing any large-scale impact on the state or national level. The state has of course picked up some of these demonstrations which it found convenient. Have the NGOs developed the social and political consciousness of the people in raising issues related to health? If NGOs come together, they will have the potential to demand the provision of universal health care services as a constitutional right of the people, which should be provided by the government adequately on a priority basis.

## V

### Conclusions

Maharashtra presents a picture of moderate achievement in the field of health care against the context of remarkable economic development. However this overall picture has to be juxtaposed against the severe rural-urban and intra-regional disparities to arrive at a more realistic understanding of the situation, both in terms of health care as well as economic development in general. The lack of proper curative facilities in the rural areas also form a piece with this overall pattern of disparities. The correction of such disparities will demand conscious political action beyond the level of clientelistic politics which has enveloped the state for the last several decades. The inheritors of the radical traditions of the non-brahmin and dalit movements and the

radical sections of the industrial labour movement can be expected to take up this corrective role some time in the future. But the awareness of these very sections on health issues has to be kindled. This is one area where NGOs should apply their mind to. For, on their own, the outreach or impact of NGOs is not very large.

This is all the more necessary in combating the evils caused by the rapid and unregulated growth of private health sector in Maharashtra. Bombay with its large middle class social base offers a flourishing field for the capitalists and those who hold state power to advance all kinds of pro-market ideas which with the apparent legitimacy of public opinion can be thrown back to the rural hinterland for operation through their clients. Thus, it is not just sufficient that the private health sector should be encouraged in the urban areas, some of the PHCs also should go to the private sector messiahs. But would these messiahs attend to the preventive and promotive aspects of health care which are not very lucrative? Even in curative care will they not introduce dual standards with the full legitimacy of the state? These are some questions to be addressed.

The broadest possible platforms should be created for bringing in some amount of regulation in the chaotic growth of the private health sector. Standardisation in fees, room-charges, equipment and other facilities have to be thought of. NGOs which have a good grasp of the technical details in this regard should take a lead in educating even the otherwise sensitive sections of public opinion about this matter.

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