Demography India
Vol. 20, No. 2 (1991), pp. 297-310

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Allocation of Government Health Services Expenditure in Andhra Pradesh, India, During the Eighties

Introduction[1]

THE primary health care (PHC) approach formalised by the World Health Organisation (WHO) in its special session at Alma Ata in 1978 has been India's main strategy (Government of India 1983) of developing an appropriate health care delivery system for itself. Andhra Pradesh naturally ought to be developing its health systems according to the PHC approach. Allocation of the government's health services expenditure promoting the PHC objective or at least compatible with it, is an important prerequisite for achievement of the health for all (HFA) goal through the PHC approach. According to India's Constitution health is a state subject. All governmental health services expenditure within a state is incurred at the state government level by the state from its own resources or with funds from the central government. Thus analysis of allocative patterns of health services expenditure at the state government level, in India, is of importance for the study of national efforts for the HFA goal. It also helps understand the dynamics of the allocative processes in the state. This paper seeks toexamine the following questions for the state of Andhra Pradesh in India:

1. What has been the patterns of allocation of health services expenditure during the post Alma Ata decade of eighties? Has there been a shift of emphasis away from hospitals?
2. How have, the primary services and other expenditures been sub-allocated among their major components?
3. What has been the trend of government's developmental plan allocations between primary services and hospital services?

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1. Helpful criticism and suggestions by William Hsiao, Michael Reich and Dayl Bonaldson of the Harvard School of Public Health are gratefully acknowledged.

It is to be noted that this study focuses on the health services expenditure of the government of Andhra Pradesh, and not the total health sector expenditure of the state.

About Andhra Pradesh

At this point a brief mention about Andhra Pradesh (AP) would clarify the general setting for appreciation of this analysis. There are 27,379 villages and 234 towns and urban agglomerations as per the 1981 census. Some important demographic indicators of the state vis-a-vis the whole country are given in Table 1.

TABLE 1: IMPORTANT DEMOGRAPHIC INDICATORS OF INDIA AND THE STATE OF ANDHRA PRADESH

Indicator	*Year(s)*	*India*	*AP*
Total Population	1991	843, 930, 861	66, 304, 854
Sex Ratio (Females/1000 Males)	1991	929	972
Density (Persons/sq km)	1991	241	267
Population Growth Rate	1981-1991	+23.50	+23.82
Literacy	1991	52.11	45.11
Crude Death Rate	1985	11.8	10.3
Life Expectancy at Birth	1979-80	54.4	55.7
Infant Mortality Rate	1985	97	83

Materials and Methods

Data on the health services expenditure of the government of AP was obtained from the state office of the Controller and Auditor General of India (CAG), who is the constitutional authority for reporting on the states accounts[2] to the legislature. Two Lotus spreadsheets were built with expenditure under each detailed head. The first spreadsheet was for the period up to 1986-87 and the second one for the years 1987-88 onwards as there was a major change in the coding and classification system. Data were missing under a few heads in certain years. These were: (a) a few heads under alternate systems in 1981-82, (b) a few heads under tertiary hospitals in 1982-83, and (c) expenditure on social insurance heads for the years 1988-89 and 1989-90. The deficiencies in (a) and (b) were made up by imputing the average of previous and next years expenditure under those heads. In case of social insurance, figures were projected for the last two years based on the trend of increase in amount allocated. This

2. These accounts are published by the CAG. The accounts for 1989-90 are yet to be published and were obtained from the pre-publication working sheets in the CAGs office.

meant a 10% increase over the previous year. In absolute terms the size of these missing data is very small and would not have any significant effect on this analysis. Combined expenditures on direction and administration were apportioned to respective programme/institution groups on the basis of bed strength. The number of heads of such expenditure are few and the size of such expenditure in comparison to total expenditure is very small.

All data correspond to the financial year in India, which is from April to March. All expenditures were adjusted for the base year 1980-81, based on the price index derived[3] from the latest available gross national product (GNP) data at current and adjusted prices for India (Government of India 1991).

'Health services' expenditure is defined to mean expenditure mainly consisting of health care delivery institutions, public health and disease control programmes, family welfare etc. This does not include 'health related services' like water supply, sanitation and nutrition etc. The distinction of health services expenditures from health related services expenditures used here is in line with WHO guidelines on indicators for monitoring health for all (WHO 1981). Expenditure on education and training of professionals and para professionals of all systems of medicine, delivery of Ayurvedic and other systems of medical care are also included. In Andhra Pradesh the social health insurance services are administered by the state health ministry. Thus health services expenditure would represent predominantly the activities of health ministry.

All expenditures were grouped for purposes of this analysis under primary services, hospital services and ETAS. ETAS stands for medical Education, paramedical Training, and Alternate Systems of medicine. Primary services consist of primary institutions and public health programmes. The primary institutions include primary health centres, city dispensaries, taluk dispensaries, sub-centres and village level health workers. Expenditure on food and drug administration and health department component of vital statistics collection are clubbed with the primary institutions. Public health programmes are either general promot-ive and preventive programmes like maternal and child health, immunization, family welfare or various disease control programmes like malaria, leprosy, tuberculosis control programmes etc. Out of all the programmes included under primary services the family welfare programmes have a component of postpartum and sterilisation bed schemes. These are hospital based. Expenditure under these heads were included under hospital services. Among the disease control programmes leprosy and tuberculosis have some hospital components. These were retained under primary services because expenditure on hospital component of these programmes is not readily available. Social insurance medical services operates its own hospitals and dispensaries. Government expenditure on social insurance are classified under hospitals, dispensaries, direction and administration, transport and remuneration. Expenditure on transport and remuneration has been either small or non-existent. The social insurance expenditure of government was grouped under hospitals and dispensaries. Overhead expenditures on administration, transport etc were apportioned to the hospital and dispensary heads proportionately on the basis of expenditure on each of them. The final social insurance expenditure on hospitals were included under hospital services. Those under

3. The derived deflators for various years from 1980-81 to 1989-90 were: 100, 110, 26, 119.1, 129.14, 138.76, 149.32,159.81,173.91,188.15,201.05 respectively.

dispensaries were included under primary services. Medical education budget of the state supports the medical colleges, dental colleges and the University of Health Sciences. Expenditure on the teaching hospitals are grouped under hospital services and not with medical education. Expenditure on the Vijayawada General Hospital, which is the clinical facility of the University of Health Sciences, is classified under hospitals services. Alternate systems of medicine include Ayurveda, Homoeopathy, Unani, Tibbi, Naturopathy and Yoga. Education, research and training expenditure for those systems are clubbed with that of service delivery.

Allocation of Government's Health Services Expenditure in Eighties

Figure 1 shows the trend of distribution among the three major components in percentage terms and Figure 2 shows the absolute amount allotted to them. In Figure 1 both primary services and hospital services can be seen to be starting the decade on either side of 45%. The curve for primary services has moved upwards and that for hospital services moved downwards in subsequent years. The distance between the two has widened. The share of primary services has steadily increased from 46% in 1980- 81 to a peak of 56% in 1985-86 and then has been reducing. It stood at 49% in 1989-90. Hospital services had a consistent and significant reduction in its share of expenditure from about 41% in 1980-81 to about 34% in 1989-90. Figure 2 shows that all the three components have increased in absolute terms. The vertical gap between the primary services and hospit .1 services has widened during the course of the decade. Details of data used to generate Figures 1 and 2 can be found in the statistical Appendix (Table A).

The share of hospital services in 29 countries reviewed by Barnum and Kutzin (forthcoming) was 25 to 81% of total health services expenditure. The hospital services in only four countries out of these had shares of less than 40%. Thus Andhra Pradesh with 34% of its total public health services expenditure on hospitals can be considered to be among the less hospital oriented health service systems. The ORG study (Rao, Khan and Prasad 1986) reported an all state average of 45% for medical relief. This included first contact curative services through dispensaries etc. Thus the share of hospital services would have been a little lower than 45%. The share of hospital services in Andhra Pradesh then was about 39%. Expenditure on ETAS also increased during the decade. It was 13% in 1980-81, reduced to a low of 9% in 1985-86 and has been rising since then. It stood at 17% in 1989-90.

It is also evident that the total government health services expenditure increased in real terms from about 900 million rupees in 1980-81 to 1500 million rupees in 1989-90, at 1980-81 prices. This represents an aggregate increase of about 69% over the decade for total health services expenditure. The increase for primary services was 89% over the same period. In case of hospitals the increase in real terms from 1980-81 to 1989-90 was 46%. ETAS had an increase of 71 %. Thus the increased allocative emphasis"appears to have been achieved by directing a higher share of additional resources to primary health care services and allied programmes and by minimising additional allocations to hospital services. This might lead us to think that the reduction in share of hospital services might not have been possible if the total allocations for health services had declined in real terms. Table 2 shows the annual rates of growth of expenditure in real terms for each group and for the total of all health services. The annual growth of components of primary services and ETAS have been shown in Tables 4 and 5 respectively.

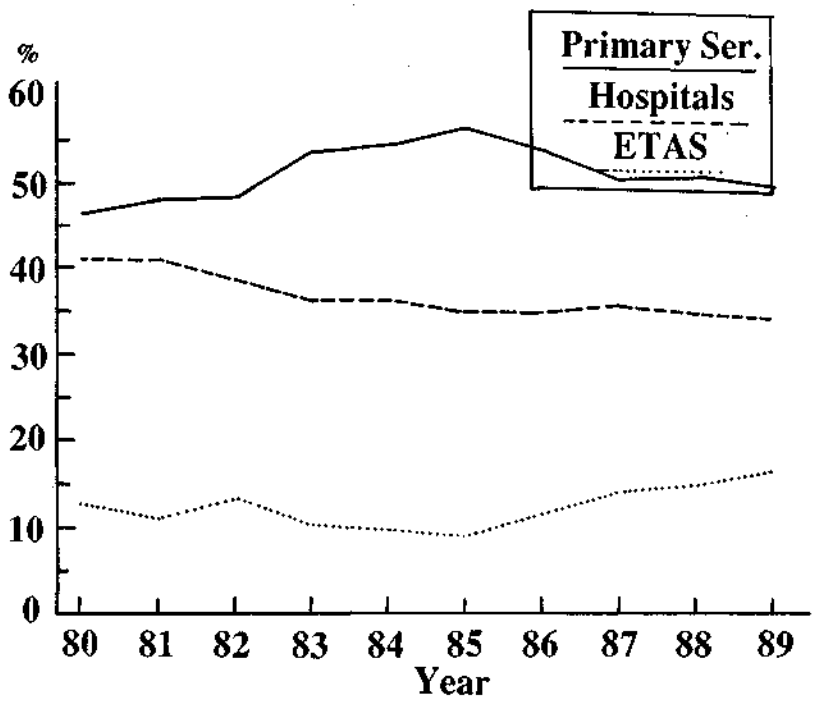
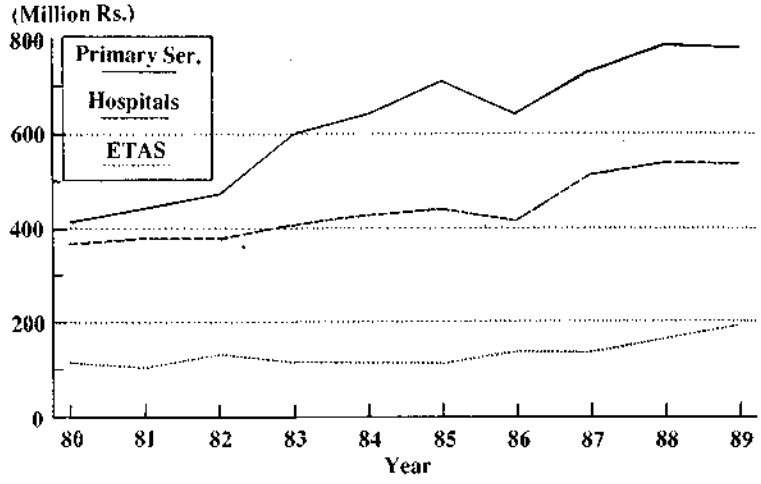


Fig. 1. Distribution of Health Services Expenditure in Andhra Pradesh during the Eighties



Adjusted to 1980-81 prices
ETAS : Education, Training & Alternate Systems
Fig. 2. MajorComponentsofHeallhServicesExpenditureinAndhraPradeshduringtheEighlies

It can be seen (Table 2) that, though the annual growth of over all health services expenditure was between 3 to 15% for most years, it was indeed negative (-5.39%) in 1986-87 and rather very small in 1989-90 (1.4%). The reduction in total health services expenditure in 1986-87 was shared by primary services (-9.62%) as well as the hospital services (-5.49%). ETAS had a positive growth of about 21 % in the same year! The positive growth was across all components of ETAS. The highest growth was that of medical education presumably due to the newly set up University of Health Sciences. The reduction of resources for hospital services was proportional to the overall reduction. Th« offsetting influence of increased spending for ETAS was fully borne by the primary services. It is interesting to note that hospital services expenditure had negative growth in real terms during two more years in the decade (1982-83 and 1989-90), when the total health services expenditure had a positive growth. Similarly ETAS had negative growth in 1981-82, 1983-84 and 1984-85. Expenditure on primary health services by and large maintained an annual growth rate of 7 to 14%, except for the large negative growth in 1986-87 and marginal reduction in 1989-90. This corresponds to the reduction in total availability of resources for health services, albeit disproportionately more than the overall reduction. This shows that the allocative emphasis on primary health care services has been by and large positive. Allocations for primary and allied health services are vulnerable to overall reduction in availability of resources for health services. Allocations to hospital services are vulnerable to overall reduction in health service resources and could also be adversely affected even in times of overall growth of resources. Thus while it is true that a good part of the reduced allocative emphasis on hospitals was possible due to the overall growth in expenditure on health services, the role of positive efforts at reducing allocations to hospitals cannot be denied.

TABLE 2: ANNUALGROWTHOFGOVEKNMENTHEALTHSERVICESEXPENDITUREINAP

Year	*Primary Ser.*	*Hospital Ser.*	*ETAS*	*All Ser.*
1981-82	*6.66*	2.90	-7.79	3.29
1982-83	7.04	-0.07	25.29	6.18
1983-84	26.81	7.75	-11.05	14.44
1984-85	7.00	5.02	-1.49	5.40
1985-86	10.95	3.00	0.29	7.04
1986-87	-9.62	-5.49	21.33	-5.39
1987-88	13.66	23.35	-1.04	15.33
1988-89	7.66	4.65	20.32	7.80
1989-90	-0.61	-0.28	16.42	1.40
Average	6.57	3.85	5.50	5.38

It is also interesting to note that the pattern of growth of expenditure has not been uniform. There has been fairly wide variability in the growth of expenditure under each group of services from year to year. For example, annual growth of primary services expenditure measured with respect to the previous year varied from -9.62% to 26.81%. The average

annual growth rate, for the same services, during the decade was 6.57%. So is the case for other groups of expenditure. Any study of health services expenditure limited to one or two years could show up different picture, depending on the years chosen. For example, a study based on 1982-83 and 1983-84 data would show the enormous growth of expenditure in primary services and that in 1985-86 to 1986-87 will show the reverse. The truth lies in between. Thus it appears that a study of expenditure patterns over a larger period is required to get at the true trend of expenditure.

Some of this wide variation can be explained by the cycle of planning process. It is commonly observed that the first and last years of Five Year plans have a tendency to show extreme variations in levels of expenditure. A part of the variation is also contributed by pulls and counter pulls of alternative interest groups and the dynamics of their interaction with the state. Certain long term policy decisions, taken at the state level could have opposite allocative impact in the short run. For example, the AP government took a decision in later part of 1986- 87 to convert a major tertiary hospital in State headquarters into an autonomous institution and required it to ultimately be self sufficient, by charging user fees. The government agreed to provide additional capital funding to the institution spread over a few years. The government also simultaneously set up another autonomous body and transferred secondary level hospitals, with the ultimate intention that these hospitals will raise more resources from within. In the same year, the University of Health Sciences was set up, boosting the share of ETAS, which subsequently declined towards its previous level.

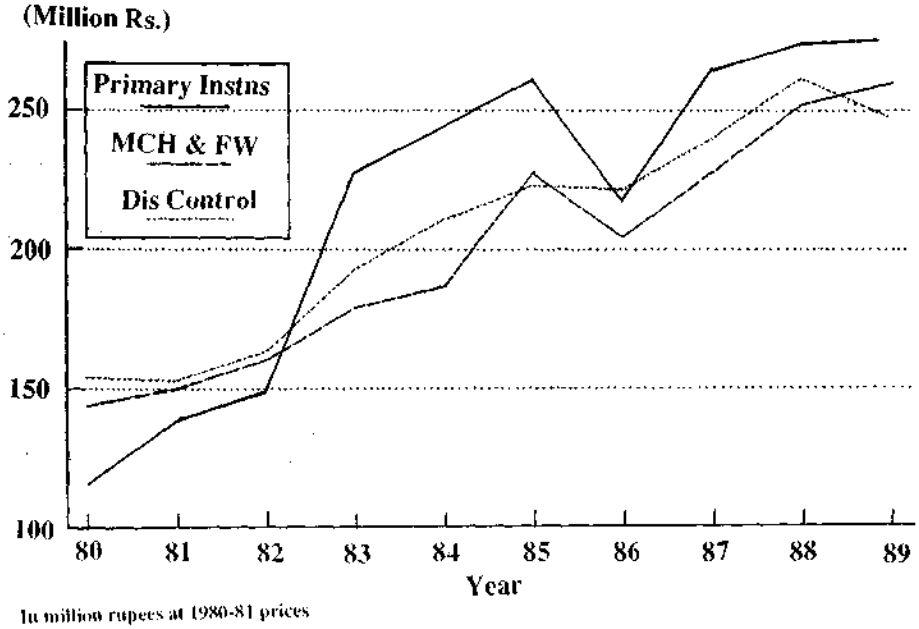


Fig. 3. Major Components of Primary Services Expenditure in Andhra Pradesh during the Eighties.

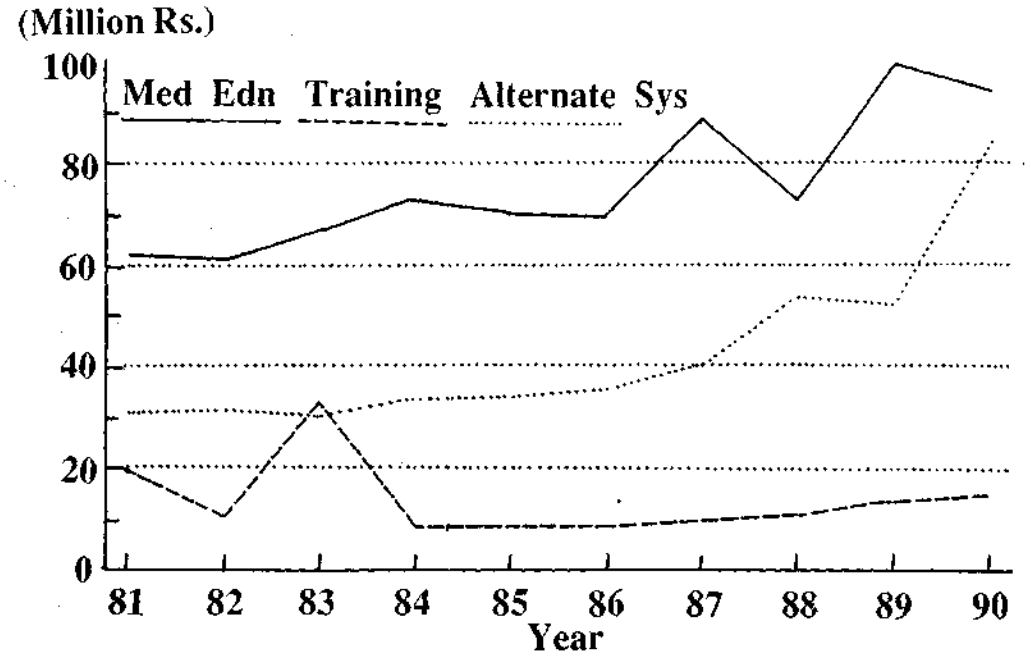
Sub-allocations

Figure 3 shows the trend of sub-allocation of primary services expenditure among its major components ffor details, see statistical Appendix (Table B)J. Primary institutions, MCH and family welfare programmes and disease control programmes are the three major components of primary services, each accounting for about a third of the groups expenditure. All the three components had increases in their allocations. The institutional component overtook the other two components in the year 1983-84 and since then has maintained a higher level of allocation. Their share increased from 12.94% in 1980-81 to 18.21% in 1989-90. It is pertinent to note that at least two disease control programmes (smallpox and malaria) have substantial institutional support components. For example, smallpox was declared eradicated from Andhra Pradesh as well as from India in 1975. Most of the programme staff were redeployed under expanded immunisation, malaria eradication and other public health programmes (Government of AP 1992), though salary of some are continuing to be classified under the small pox programme. Thus the real share of primary institutions would be more. Primary health institutions increased their share from 13% of total health services expenditure in 1980-81 to a peak of 20% in 1984-85 and 1985-86 and have gradually declined since then. It stood at 17% in 1989- 90, which by itself is a significant increase from what it was at the beginning of the decade. MCH and family welfare services started the decade with a 16% share and stood at 17% at the end of the decade. Disease control programmes maintained their combined share of 17% throughout the decade and had a 1% fall only in 1989-90.

Figure 4 shows the trend of allocations to each component of ETAS [see statistical Appendix (Table-C)J. Both medical education and alternate systems of medicine have had increases in absolute terms: 51 % and 170% respectively. Paramedical training has suffered a small reduction rather than any increase. Expenditure on medical education has been between 5 to 7%. It started with about 7% of total health services expenditure in 1980-81 and stood at about 6% in 1989-90. There was an increase to 7% in 1986-87. The University of Health Sciences was set up in this year, and could have been the reason for the increased share. Paramedical training had a 2% share in 1980-81, got an increase to 3% in 1982-83 and after that declined to a low of about 1% ever}' year. This to some extent explains the general shortage of paramedics. With a very marginal increase in the last two years of the decade it stood at about 1% in 1989-90. Alternate systems of medicine had a share of3.*44%* in 1980-81, gradually reduced to 2.8% in 1985-86 and then rose substantially to 5.5% in 1989-90. The increases in absolute allocations to medical education is characterised by sharp fluctuations. This could be explained by the local nature of the thrust for increasing allocations to medical education.

The all state average share of MCH and family welfare in 1982-83 reported in the ORG study referred earlier was about 15%. That for disease control programmes was 13%. The share of paramedical training was 1.2%. Alternative systems of medicine had a share of 3.7%.

In summary there has been a clear upward shift in allocation of resources for primary health services. If we were to include expenditure on alternate systems of medicine and paramedical training as predominantly supportive or complementary to primary services the picture will be that of a consistent and steady growth in the share of primary and allied services throughout the decade. Share of allocations for paramedical training has reduced.



Adjusted to 1980-81 prices

Fig. 4. Education Training and Alternate Systems (ETAS) of Medical Expenditure in Andhra Pradesh during the Eighties

This is a disturbing situation as it perpetuates the skewed health manpower resources of the state. Share of allocation to alternate systems has increased. This could be the beginning of an emerging trend. The cost effectiveness of traditional systems of medicine, their cultural roots, potential of greater accessibility to people, and increasingly organised practitioners could be some of the factors motivating the allocative emphasis on them. All these have been accompanied by a consistent and steadily reducing allocative emphasis on hospitals and medical education to some extent. This is certainly a positive achievement and a step in the desired direction for fulfilling the Alma Ata pledge.

Trend of the Government's Plan Allocations among Health Care Facilities and Programmes

The government's budgetary allocation of funds as well as expenditure are grouped under Plan and non-Plan[4]. The governmental allocative process is geared in such a way that study of Plan fund allocation assumes special importance on two accounts. Firstly, the types

4. The non-Plan expenditure is also referred to as revenue expenditure.

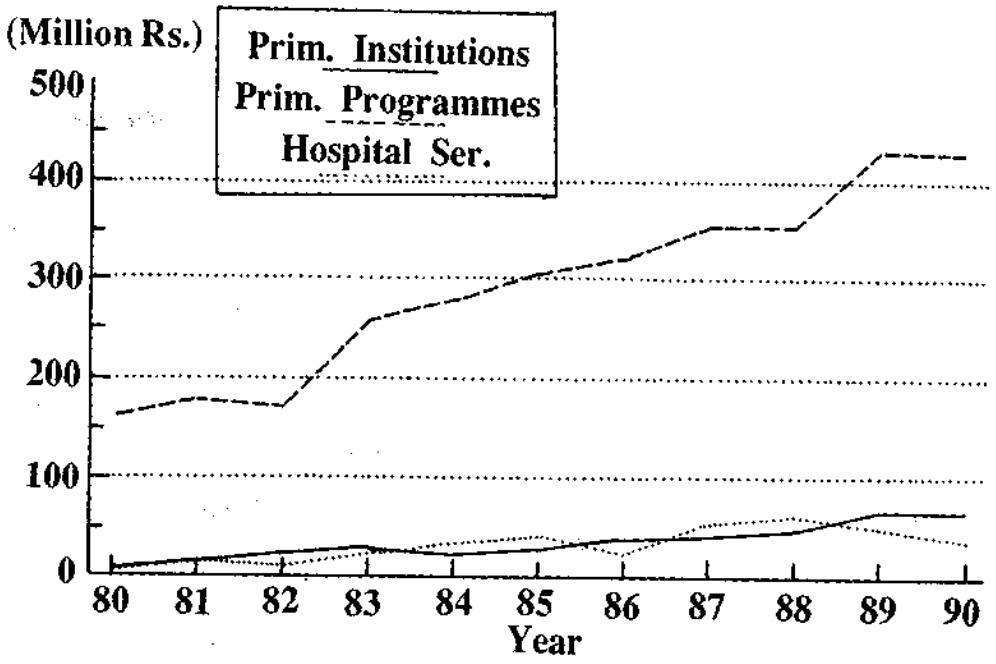
of scrutiny and allocative attention on Plan and non-Plan expenditure are different. A non-Plan expenditure is usually continued over the next year or Plan period by default. In case of Plan fund allocation the process is reverse. An allocation is made only if there is a positive reason for its inclusion. In other words specific allocative attention acts to include addition or up-gradation of a programme or facility in Plan, where as the same process acts to drop or down grade an existing programme or facility. Similarly, it is usually easier to reduce allocations for a Plan scheme or programme or even discontinue it altogether[5]. So study of Plan fund allocations will give an idea of the allocative pattern that the government has been more actively pursuing.

Secondly, Plan allocations drive the non-Plan allocations, albeit with a time lag. Plan schemes can be of capital nature, for example buildings and equipment or expansion in service delivery capacity. The maintenance expenditure burden of Plan allocations for capital works like buildings and equipment are very low. Once the building is completed or the equipment is installed, the amount required for its maintenance needs to be provided in the non-Plan budget. The maintenance burden of Plan allocations for capacity expansion schemes are complete and can be increasing. For example, if a new X-ray plant is sanctioned under Plan, in year 1, an additional allocation of say 10% of the capital cost have to be made in subsequent years towards its maintenance. On the other hand, if the bed capacity of a hospital is increased by say 10 beds in year 1, the expansion expenditure will consist of salaries of staff required to man the additional beds, drugs and supplies to operate additional service. These expenditure will continue throughout the subsequent years and in fact will increase as scales of salaries go up and cost of supplies increases. Thus the ability of a Plan scheme to drive allocative pattern of non-Plan budget will depend on the nature of Plan scheme, i.e. capital work or service capacity expansion and also when the scheme is transferred to non-Plan budget. The magnitude of the effect on the non-Plan budget depends on the nature of the scheme. Capital work schemes have lower allocative impact than schemes of expanding service delivery capacity. The time lag of the effect will depend on the policy of transfer of Plan schemes to non-Plan and timing of such transfers.

Plan allocations for hospitals are either for capital works or involve the expansion of services. Capital works are usually associated with the expansion of services. For example, building works either precede sanction of additional beds or follow them. Additional bed capacity for hospitals is invariably sanctioned as a Plan scheme, sustained under the Plan at best for the rest of the Five Year plan period and then transferred to non-Plan. Once hospital bed capacity is created and transferred to non-Plan, its operating expenses are automatically provided for in the non-Plan budget. To the extent that Plan allocations for hospital services are for capacity expansion they have a distinctly positive effect in driving the non-Plan allocations as well as the total expenditure for hospitals. The situation is different for centrally sponsored schemes like family welfare. Family welfare programmes are fully funded by Central government and have been continued as Plan schemes for many Five Year

5. This does not mean there is no scope for bringing about allocative changes through the non-Plan budget. One common instrument is annual inflation. Inflation is normally taken care of by a general across the board raise in allocation under every head of expenditure. By selectively withholding this raise the Finance Ministry can effect some reduction in allocation in real terms. Direct cuts in allocation and conscious decisions to cut a facility are also possible, though rare.

plans. The impact of Plan allocations to primary level institutions would be more or less similar to that for hospitals in terms of non-Plan budget.



Adjusted to 1980-81 prices

Fig. 5. Trend of Health Services Plan Allocations in A'ndhra Pradesh during the Eighties

Figure 5 shows the trend of Plan sub-allocations in medical and health department of AP. Data for this is in statistical Appendix (Table D). Evidently, the major share of about 87% to 95% of Plan expenditure has gone to primary services. The balance of 2 to 13% has been devoted to the hospital services. Growth of Plan allocations to primary services has always been positive, except for 1989-90. In this year the Plan allocations had a negative growth by 2.65%. A reduction by 0.23% for primary services means that this sector was actually protected from the overall difficult resource position. On the other hand, growth of allocations to hospitals increased and decreased over the years. On the whole, 91% of total Plan resources during the decade were devoted to primary services. The balance of 9% were spent on hospitals.

Summary and Conclusion

The adoption of PHC approach to the health for all goal at Alma Ata, heralded a significant shift in approaches to health care delivery. This naturally called for increasing

the flow of health sector resources to primary, promotive and preventive health care programmes. This study finds that the government expenditure on primary health services viewed as a share of total government health services expenditure, by and large, increased during the eighties. Primary level institutions, MCH and family welfare programmes and disease control programmes almost equally shared the primary services component of health services allocation. Allocation to alternate systems of medicine increased. The share of allocations for paramedical and health worker training reduced. There was a consistent and steady increase in combined allocations for primary services, alternate systems of medicine and paramedical training. The increased share of allocation to these priority areas was accompanied by a consistent and steady decline in allocations to hospital services and medical education. The share of hospital services expenditure in Andhra Pradesh is lower than what has been found in most developing country studies. Study of government's health department plan expenditure confirmed the emphasis on primary services.

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STATISTICAL APPENDIX

TABLE A : ALLOCATION OF GOVERNMENTS HEALTH SERVICES EXPENDITURE DURING THE EIGHTIES*

Years	*Primary*	*Ser.*	*Hospital*	*Ser.*	*ETAS*		*All (Amount)*
	Amount	*%*	*Amount*	*%*	*Amount*	*%*	
1980-81	414.16	46.27	368.20	41.14	112.69	12.59	895.05
1981-82	441.74	47.78	378.87	40.98	103.91	11.24	924.52
1982-83	472.86	48.17	378.62	38.57	130.19	13.26	981.67
1983-84	599.63	53.38	407.98	36.32	115.81	10.31	1123.42
1984-85	641.58	54.18	428.50	36.19	114.08	9.63	1184.16
1985-86	711.81	56.16	441.34	34.82	114.41	9.03	1267.56
1986-87	643.33	53.64	417.12	34.78	138.81	11.57	1199.26
1987-88	731.21	50.43	514.53	35.49	137.37	14.08	1383.10
1988-89	787.25	50.50	538.45	34.55	165.29	14.95	1490.99
1989-90	782.45	49.42	536.96	34.02	192.43	16.55	1511.84

Amount of expenditure adjusted to 1980-81 prices, rounded to nearest 10000 and shown in millions of Rupees.

TABLE B: SUB-ALLOCATION OF PRIMARY SERVICES EXPENDITURE*

Year	*Primary Inslns*			*MCH and FW*			*Disease Control*		
	Amount	*%*	*Or.*	*Amount*	*%*	*Or.*	*Amount*	*%*	*Gr.*
1980-81	115.84	12.94		144.05	16.09		154.27	17.2	
1981-82	138.83	15.02	16.6	149.90	16.21	3.9	153.00	16.5	-0.8
1982-83	149.05	15.18	6.9	160.52	16.35	6.6	163.29	16.6	6.3
1983-84	228.09	20.30	34.7	178.81	15.92	10.2	192.74	17.1	153
1984-85	244.26	20.63	6.6	186.54	15.75	4.1	210.78	17.8	8.6
1985-86	261.18	20.60	6.5	227.45	17.94	18.0	223.19	17.6	5.6
1986-87	217.37	18.13	-20.2	204.21	17.03	-11.4	221.75	18.4	-0.7
1987-88	264.15	19.10	17.7	227.16	16.42	10.1	239.91	17.3	7.6
1988-89	273.81	18.36	3.5	251.89	16.89	9.8	261.55	17.5	8.3
1989-90	275.34	18.21	0.6	259.59	17.17	3.0	247.53	16.3	-5.7

Amount of expenditure adjusted to 1980-81 prices, rounded to nearest 10000 and shown in millions of Rupees.

TABLE C: SUB-ALLOCATION OF EXPENDITURE AMONG MEDICAL EDUCATION, PARAMEDICAL TRAINING, ALTERNATE SYSTEMS OF MEDICINE (ETAS)

Year	*Medical Edn*			*Paramedical Trg*			*Alternate Sys.*		
	Amount	%	*Gr.*	*Amount*	%	*Gr.*	*Amount*	%	*Gr.*
1980-81	62.37	6.97		19.51	2.18		30.81	3.44	
1981-82	61.55	6.66	-1.3	11.05	1.20	45.0	31.31	3.39	-1.5
1982-83	66.83	6.81	8.6	32.94	3.36	180.0	30.42	3.10	-8.6
1983-84	73.10	6.51	9.4	8.88	0.79	-76.5	33.84	3.01	-2.9
1984-85	70.70	5.97	-3.2	9.25	0.78	-1.3	34.12	2.88	-4.3
1985-86	69.73	5.50	-1.4	9.01	0.71	-9.0	35.67	2.81	-2.4
1986-87	88.72	7.40	27.2	9.83	0.82	15.5	40.26	3.36	19.6
1987-88	72.84	5.27	-17.9	11.06	0.80	-2.4	53.46	3.87	15.2
1988-89	99.28	6.66	36.3	13.69	0.92	15.0	52.32	3.51	-9.3
1989-90	94.21	6.23	-5.1	14.83	0.98	6.5	83.39	5.52	57.3

Amount of expenditure adjusted to 1980-81 prices, rounded to nearest 10000 and shown in millions of Rupees, Gr. = Annual growth rate in % over previous year.
This table does not include allocations for social insurance, Ayurveda and other systems. These figures were compiled by collecting individual items of Plan expenditure from the Directorates of Medical and Health Services.

TABLE D: PLAN SUB-ALLOCATIONS IN MEDICAL AND HEALTH DEPARTMENT OF AP, AT CONSTANTPRICES (Base 1980-81)

Year	*Primary Instns*			*Primary Programmes*			*Hospitals*			*Total (Ami.)*
	Amount	%	6V,	*Amount*	%	*Gr.*	*Amount*	*%*	*Gr.*	
1980-81	13.2	6,5	119	178.1	87.0	10	13.3	*6.5*	275	204.6
1981-82	21.8	10.6	65	172.6	84.3	-3	10.5	5.1	-21	204.8
1982-83	27.7	9.0	27	257.8	83.8	49	22.2	7.2	112	307.8
1983-84	21.6	6.5	-22	279.3	83.7	8	32.8	9.8	48	333.7
1984-85	27.1	7.3	26	307.1	82.3	10	39.2	10.5	20	373.3
1985-86	37.1	9.7	37	322.3	84.1	5	23.6	6.2	-40	383.0
1986-87	40.6	9.1	9	355.1	79.3	10	52.1	11.6	120	447.7
1987-88	46.9	10.1	156	355.4	76.7	0	61.0	13.2	17	463.3
1988-89	65.1	11.9	39	430.9	79.0	21	49.8	9.1	-18	545.7
1989-90	65.4	12.3	1	429.4	80.8	0	36.4	6.9	-27	531.3

* Amounts (Ami) are adjusted to the base price of 1980-81 and rounded to nearest 100000 Rupees and shown in million Rupees. Gr. = Annual growth rate in % over previous year.