CHAPTER I

INTRODUCTION
CHAPTER I
INTRODUCTION

The infrastructure is an essential pre-requisite of economic development. The development of it precedes the development of the economy. The development of primary, secondary and tertiary sectors is largely depend on the level of infrastructure development. This is well supported by historical experience of development in the developed western economies. The railroad innovation was the force behind rapid development that took place in the beginning of the twentieth century in modern Europe. Investment in infrastructure constitutes one of the major investments in the development plans of the developing countries. Because, this drive towards the industrialization is dependent on the level of development of infrastructure. Now with the ‘main centered’ development, infrastructure, both social and economic is assuming a great role in the process of economic development.

Infrastructure is considered to be the backbone of any economy. It is the physical framework of facilities through which goods and services are made and are provided to the public. Physical infrastructure directly influences the industrial and non-industrial development in a nation. Research by international organization like the World Bank has established that 1 percent increase in investment in the infrastructure culminates in a corresponding 1 percent increase in the GDP of the nation. The indispensability of a sound infrastructure for reaping the benefits of industrialization has been realized especially by the developing countries. Also as infrastructure facilities have become a must for attracting foreign investment, these countries have started developing their infrastructure facilities.

The infrastructure development of any country includes both economic infrastructure and also the social infrastructure. Development of economic infrastructure cannot usher in overall development at the desired level if the social infrastructure is not simultaneously developed. The capacities and
technical refinement of the economic infrastructure like roads, sewers, electricity, open spaces, gardens, and the evolving requirement of social infrastructure like shopping complexes, restaurants, medical facility zones, schools etc. are clearly delineated. Education, Health, Social Security, water supply, shelter and sanitation etc. Has to be developed to ensure proper social infrastructure. In this sense both economic growth is linked to infrastructure as infrastructure is linked to growth. So the development of India is incomplete without social infrastructure development and that would require focus on the infrastructure strategy for social research in India.

The issues of development of the social infrastructure have acquired increased importance in recent times. It is being increasingly recognized that economic development or increase in per-capita income of the population, should be adequately matched by development of social sectors if the process of development is to lead to increase in welfare of social sector or social infrastructure and they are basic objectives of development.

The term social sector or social infrastructure refers to the factors which contribute to human capital formation and human development. Social development is recognized not only as a means to development. But also an end in itself in terms of expanded individual import unites capabilities and freedom. Improvements in the social sector pave the way for equity and in turn for economic development, in fact developments itself depend on the development of social infrastructure. Thus importance of social infrastructure hardly needs any elaboration. Social infrastructures are education and health. Most of the eminent people have recognized importance of education and health.

Mahatma Gandhiji very clearly and correctly wrote that education is the strong base for building a strong India. He emphasized 'basic education' to all so that people can live happy life living only in villages, avoiding migration to cities. Moreover, he advised government to educate women who are the main pillars of society.
Swami Vivekanand wanted strong man (woman also included) with strong mind and strong health, so that India could become a strong and wealthy Nation in the entire world. He, in particular, wanted to promote women’s education so that the entire house in the society (all people in the family) could be educated and hence the entire Nation. In a sense he advocated universalisation of education and health in India so that strong Nation can be built with the efficient human resources. The core components of human development are: education and health.

Education is an important and basic input required to improve the quality of human resources. Indeed, education is the most important factor required to make labour, a productive factor. Labour without education and skill cannot be graded as human resources. It becomes a hindrance to development. Therefore, one of the necessary condition for development is the improvement in the quality of human resources through education.

Good health is both the mean and end of development. A healthy population is a pre-requisite for economic growth; in turn this income growth can be channeled to improve human lives through the provision of a descent education, good health care facilities, increased job opportunities, improved job-security, good governance and all other requirements for human well-being.

Thus, improvement in health is an important engine of economic growth. If economic growth of a country is to be sustained, the provision of health care has to be more accessible and qualitatively better.

Rapid economic growths achieved in advanced countries confirm the importance of non-material investment. Expenditure on education and training and improved of health and research contribute to productivity by raising the quality of the population and these outlays yield a continuing return in future. Advancement in knowledge and diffusion of new ideas and objectives are necessary to remove economic backwardness and instill the human abilities and motivation that are more favorable to economic development.
The first plan recognized that social services like education and health are equally important. It was observed in the first plan that “Education is of basic importance in the planned development of a nation. The educational system has also an intimate bearing on the attainment of general objectives of the plan in much as it largely determents the quality of manpower and social climate of the community.” In this context, this study highlights the development of social infrastructure such as education and health in Karnataka and Belgaum district.

1.1 IMPORTANCE AND NEED OF THE STUDY

For human welfare, freedom from ignorance, diseases and fear are as important as freedom from want. Education, health care, water and sanitation services, and environment that promotes health and social safety nets which are required to provide such freedom cannot be obtained easily by all through private action and, therefore, there is a need for public action. These facilities are collectively termed as ‘social infrastructure’ and are as critical as ‘physical infrastructure’ for a widely shared inclusive, development.

Social infrastructure plays a important role in economic development. Infect, effective use of physical capital itself is dependent upon social infrastructure. Many economists in recent decades have pointed out that third world countries have remained under developed on account of under development of human resources or social infrastructure for instance, the general masses in these countries are either illiterate or their education is very low, most of them are unskilled and untrained and their general health is poor. Education and health are essential element of social infrastructure, investment in education promotes economic growth.

According to Todaro education contributes to economic growth in the developed and developing countries in the following way:

➢ It helps in creating productive labour force and endowing it with increased knowledge and skills;
> It helps in providing wide spread employment and income earning opportunities for teachers, school and construction workers, text books and paper printers and school uniform manufactures etc.,
> It helps in creating a class of educated leaders to fill vacancies left by depending expatriates, or otherwise vacant positions in fundamental services public corporation, private business and profession; and
> It helps in providing basic skills and encourages modern in the diverse segments of the population.

Good health is universally acknowledged to be one of the intrinsic value and therefore constitutes an integral element of development. One can be rich but sick enough to, not to enjoy any opportunities that wealth opens up, and poor health may translate into worsening economic opportunities as well. Health is a multi-dimensional subject. The WHO highlights the three specific dimensions of health- the physical, the mental and the social. Health is multifactorial as well. There are numerous factors that influence health like – hereditary factors, environmental factors, life style, adequate housing, basic sanitation and socio-economic conditions including income, education, availability and quality of health infrastructure and per capita health expenditure (Park.K. 1994).

An overall view of the above analysis indicates that education and health are important component of social infrastructure and the most important drivers of India and Karnataka’s social and economic development. A well-educated, healthy workforce is essential for economic growth. It indicates that there is close relation between economic development and development of social infrastructure therefore there is urgent need of studying recent trends in development of social infrastructure such as education and health. The present study investigates development of social infrastructure (Health and Education) in Belgaum district of Karnataka State and making the recommendations to development of social infrastructure.
1.2 THEORETICAL FRAMEWORK:

➢ The economic growth of countries. (Michal Todarow 1987) Economist right from Adam Smith have realised that education plays an important role among the factors that contribute to economic development. Marshall regarded education as a national investment and most valuable of capital and is one that invested in human beings.

➢ Prof. Amarthry Sen calls “Enhancement of basic human capabilities.” As “Eastern strategy.” Human development (basic, education, health care etc.,) highly helps economic and industrial expansion, and improve the efficiency and wide reach of the market economy. These in terms facilities in raising quality of life. Thus there are both direct gains and indirect once.

➢ According to J. K. Galbrith Dollar or a rupee invested in the education of human beings will often bring a greater increase in national income than a dollar a rupee devoted railways, dams, machines or other tangible goods. In the process of human being becoming more productive educating the people requires a lot of money. But expenditure, but as investment. Adequate investment in education is reflected in

➢ J. M. Healy while using the concept of “Overhead capital.” With “social” as well as “Economic” as prefix finds if difficult to match their officially determined criteria with the characteristic of services included in the operational identification of infrastructure. He says: “Overhead facilities provide often, not always provide services necessary for a whole range of other activities. They usually provide inputs which are not specific to one particular use. Power and transport satisfy this criteria but irrigation does not other facilities such as still mills satisfy this criteria but are normally excluded. He observed that customary usage rather than theoretical approach has governal that use of terms like economic or social overheads or infrastructure etc.,

➢ According to Theodore.W.(1961), “the human capital theory was a great contribution to Economics and it created the human investment revolution in
economic thought as aptly described by Mary Jean Bowman (1966). The very concept of ‘Capital’ had to undergo a serious change, with the emergence of ‘human capital’. According to the human capital theory, expenditure on schooling, health, training, migration, etc., constitute investment in human beings, which enhance the capabilities of the people as producers and consumers in the labour market, in the households and in the society at large Segultz.

➢ According to McMahan, Walter W. (1999), A sustained method of breaking this cyclical relationship is an attack on education poverty. One level of education cannot progress at the cost of other levels of education. Sustained levels of investment in education are necessary for improvement in education levels of population, and for education in turn, to effectively contribute to development.

➢ Ross Catherine, E and Wu. Chai-Ling (1995), ‘However, expenditure on education does not yield immediate return to the individual as well as to the economy. Therefore, in this research work an attempt is made to identify the time lag required for the government expenditure on education to make its significant influence on national income through lag models, for the State of Tamil Nadu under partial equilibrium framework. Thus expenditure on education requires 14 years to make its contribution to the growth of the economy.

➢ Halsey has observed “education has become part of economic foundation of modern society- a major avenue of social mobility, a central agency of social distribution and social policy as urgent and as important as poverty, sickness and unemployment”.

➢ Amartya Sen (1996) the crucial role of education for economic development has resulted in the emergence of “human capital” it has filled up the gap in the Neo- Classical model of economic growth highlighting the importance of human capital over and above that of physical capital.
The adage 'health is wealth' is still, primarily, an intuitive proposition. A vast majority of researchers (e.g. McKeown, 1976; Prichett and Summers, 1993) instead present theoretical and empirical arguments of the reverse proposition, i.e. 'wealth is health'. The latter view also attributes credit for recent improvement of health status to 'higher incomes' in promoting technical progress and dissemination of new health technologies (Easterlin, 1999; Cutler et al., 2006). Furthermore, the thrust of contemporary discussions on health reforms typically sees interventions that promote health and the delivery of health care as costs that need to be contained - implying that income is the main instrument and health outcomes the endpoints of "development" objectives (Suhrcke et al., 2005). This may underestimate the role that health plays in economic development. Notwithstanding widespread recognition that Population health is an important factor in strengthening economies and reducing poverty, health and longevity have remained prominently as a subject in the field of epidemiology and demographics - with intermittent attempts by the economists to link it to the mainstream of economics.

Thus, all the above theories highlights the importance of social infrastructure such as education and health: In this context, the present study focuses on the development of social infrastructure in Karnataka and Belgaum district.

1.3 : REVIEW OF LITERATURE:

James P Feffers (2002) Study revealed that the keeping with the neoliberal through non government organization (NGOs) and their expatriate technical express to support primary health care in the developing world Relationship between international aid workers and their local counter parts have thus become critical aspects of PHC and its effectiveness. However; these improvement social dynamic of PHC remain understudies by social scientific based presents on ethnographic case study of these relationship in one central
province. The Mozambique experience reveals that the deluge of NGOs and their expatriate workers over the last decades has fragmented the local health system undermined local of health programs and contributed to growing local social inequality. Since national health system salaries plummeted over the same period as a result of structural adjustment health workers become vulnerable to financial favors offered by NGOs, seeking to promote their projects in turf struggles with others agencies.

➢ According Anil Kumar Thakur and MD Abdus salam (2008), Higher education, decent health ensures productive work and both contribute to efficient human development. Improvement of human capital needs higher investments on social sector which lead to higher growth of a Nation. The government, therefore, should give primacy to higher allocation to social sectors in the Eleventh Five Year Plan.

➢ Tilak, Jandhyala B.G. (2004), the main objective of the paper is to study the different components of government subsidies to lower and higher education in India. The main findings of the paper are, in 1990’s the growth of public expenditure on education had been very small. As a proportion of GNP, it has declined from above 4 per cent in the late 1980’s to 3.6 per cent in the late 1990’s. Higher education suffered more severely in student declined by nearly 25 per cent in less than a decade specific subsidies such as scholarships registered a downward trend but subsidies to private education institutions have been very large.

➢ Shanti Ghose (1994) study revised that the innovation of a three-tiered structure of health services and the emphasis on comprehensive health care rather than on vertically targeted programs were some of the factors behind the success of NGOs projects. Author suggested, such innovation strategies for training and program implementation should be followed by the areas under government auspices.
Anil Kumar Thakur and MD Abdus Salam (2008), this study examines the effect of income and education of the household on its health expenditure, based on primary data collected from Jaipur and a few districts of Orissa. This shows that income has greater positive effect on health expenditure than education. The positive association between education and health is well established but explanation for this association are not. Well-educated people experience better health than the poor educated, as indicated by high levels of self-reported health and physical functioning and low levels of morbidity, mortality and disability.

Achal Kumar Gaur (2006) examined the inter-state disparities in terms of per annum growth of per capita expenditure and the total expenditure on education, medical and public health during the post-reform period as shocking and gloomy. Facts show that per annum growth in expenditure (total and per capita) on medical and public health and education in case poor states fallen during post economic reform period. For instance, expenditure on education excepting Punjab, in the category of rich states, other states like Harayana, Gujarat and Maharashtra have shown poor performance during post-economic reform.

Subramaniam (1995), examined the inter-state difference in the level of family health in all states. The study was based on data collected from National Family Health Survey 1992-93. A taxonomin approach was applied and composite index of family health for each state was constructed on the basis of ten important indicators pertaining to family health. The states were ranked on the basis of composite index of family health. Kerala state was placed at top and Bihar at bottom in the ranking.

Rana (1997), analysed the inter-state disparities on the basis social infrastructure during the period 1971 – 75. Co-efficient of variation figures worked out for selected indicators revealed that the disparities reduced in social infrastructure over time.
Anil Kumar Thakur and MD Abdus Salam (2008), this study examines the secondary schools of five districts namely Varanasi, Allahabad, Kanpur, Lucknow and Agra of Uttar Pradesh. The data on components of Cost and fee was collected to examine the behavior of schools with respect the objectives of appropriateness of: 1. Cost Structure, 2. Fee charged from students. This study reveals consistency in the behavior of schools of managing their variable operations in terms of teacher-students ratio. Both number of students enrolled and fee per student were insufficient. Therefore, some positive and effective actions are needed in such direction.

Neema Malhotra and M.S.Shweta (2000), the study highlighted inter-state disparities in public expenditure on health. The inter-state disparities in per capita health expenditure have not changed much over time. During 1991, the states having high per capita health expenditure in Punjab and Kerala. During 2001, Punjab and Kerala again had high per capita expenditure. In other states like, Bihar, Madhya Pradesh, Uttar Pradesh and Orissa, low per capita health expenditure.

Duraiswamy and Duraiswamy (1995), has examined health status and health care may not be uniform across different age groups, namely among children and adults. It is important to explain morbidity and health care separately each age population sub category. There is voluminous literature of child health using measures such as child morbidity and anthropometric indicators. How ever morbidity among children has not been given much attention even though children may be the most vulnerable to diseases.

Anil Kumar Thakur and MD Abdus Salam (2008), thirty six per cent of the population in India is still illiterate even after fifty nine years of independence. Poverty is identified as one of the major factors of illiteracy. There are many supply side factors behind this problem. The country is lacking adequate number of schools, teachers and the necessary infrastructure. It is, therefore, clear that the unskilled parents will earn very low and their income will not enable them to make the critical level of expenditure on their children’s
education. One the contrary, they will send their children out to work to supplement their family income.

➢ **Laveesh Bhandari and Sidhartha Dutta (2005)**, have explained physical infrastructure significantly working in rural areas. The sub-entry is the most peripheral institution and the first contact point between the primary health care system and services in relation to maternal and child health, family welfare nutrition, immunization, control of communicable diseases. Primary health centres comprise the second tier in rural health care structure envisaged to provide integrated curative and preventive health care to the rural population with emphasise on preventive and primitive aspects. Primitive activities include promotion of better health and hygiene practices, pregnant women tables and institutional deliveries. Community health centres forming the uppermost tier are established and maintained by the state government. Four medical specialists including surgeon, physician, gynecologist and paediatricin supported by 21 paramedical and other staff are supported to staff each CHC.

➢ **Anil Kumar Thakur and MD Abdus Salam (2008)**, Medical education and health services in our country appear to be at cross-roads. Degrees are being awarded. Thousands of graduate and specialists are being brought forth who are setting up consultations in clinics and hospitals. Medical education develops in a country against the backdrop of its fundamental economics, political and socio-cultural outlook, which is reflected in the health policy of the country.

➢ **P.Duraisamy (2001)**, has examined health status in terms of illness prevalence rate and functional disability. Descriptive evidence on the measures of morbidity and choice of health care shows that there is considerable variations across the socio-economic and demographic attributes individual and households.

➢ **Dilip Kumar and Surrendra kumar (2006)** study highlighted that to years three studies has been an improvement in education and health facilities and as
consequence of these three has been decline in birth rate. But the improvements are not heartening. Still India is a land of largest member of illiterates and medically uncured people. The governmental measures are quote disheveling both in terms of infrastructure as well as health expenditure.

Mrinal Kumar Dasgupta and Tathagata Dasgupta (2006) analysed that extent disparities among the Indian states in primary schools, enrolment rate, literacy rate and infant mortality rate.


Better health, education, equal and wider job opportunities to all, trustworthy and transparent people’s institutions, sustainable and cleaner environment, dignity, self-esteem and life security, among others are key manifestations of the quality of growth (World Bank, 2000).

Health status is one of the important socio-economic development indicators in Karnataka as well as India. Health status is defined in terms of illness prevalence rate and functional disability measures. Sen (1998) has reviewed morbidity may be a more useful indicator than mortality, since it is related to the pain and sufferings of the people, while mortality is a terminal event. He said that but the problem of morbidity for the estimated to difficult manner, therefore good information about morbidity is extremely useful in socio-economic development process. Health status in general morbidity primarily influenced by the behavioural decisions of the individual or family besides genetically inherited health endowment and the health environment in the family life.
Health status considered as life expectancy, crude birth rate, maternal mortality rate, sex ratio, total fertility rate, there are various studies conducted as health status in Karnataka. P Duraisamy (2001) has examined Health status in terms of illness prevalence rate and functional disability. Descriptive evidence on the measures of morbidity and choice of health care shows that there is considerable variation across the socio-economic and demographic attributes individual and households.

He said Health status is multidimensional. It is captured through a range of indicators such as mortality, morbidity, anthropometric measures, nutritional status or calorie intake and life expectancy at birth. However, morbidity may be a more useful indicator than mortality. Despite these well-recognised problems and difficulties of measurement, there can be little doubt that good information on morbidity is extremely useful (Sen 1998). Morbidity measures are two types, self-perceived and observed (Murray and Chen, 1992). This measure however critically depends upon a person's knowledge and perception of illness, and willingness. As many scholars agree (Riley 1990) (Johnson 1991) Vaidyana Hatn (1995) such a perception of illness is subjective and culturally conditioned. NCAER-HDI 1994 survey data detailed examination with in this study. Morbidity information is socio-economic demographic health indicators.

Good health is an invaluable asset for better economic productivity, both at the individual and National level, but above all, it is valued by those who own it as a prerequisite for a better quality of life and better standards of living. Public health system must, therefore provide that critical barrier between ill-health and the ones who are most vulnerable, but here too, factors such as financing and efficiency greatly influence the quality and coverage of public health care in Karnataka. Ashlesha Datar Arnab Mukherji and Neeraj Sood (2005) have explain Health infrastructure facilities are working in rural and urban areas. The public health care infrastructure consists of a three-tier system comprised of sub centres, primary health
centers and community health centres, that very markedly in their staffing and health care capabilities. Sub centres are typically single room facilities managed by an Auxiliary Nurse midwife (ANM’s) provide basic health services, such as child delivery kids. They have studied public health infrastructure facilities not only working in rural areas, but also some times private health facilities are working in rural areas such as private hospitals, clinics or family planning / health centres run by non government organizations. This study also highlight the importance of accounting for the heterogeneity of health infrastructure for estimating the effects of health infrastructure on immunization in rural areas.

Laveesh Bhandari and Siddhartha Dutta (2005) have explained physical infrastructure significantly working in rural areas. The subentry is the most peripheral institution and the first contact point between the primary health care system and services in relation to maternal and child health, family welfare nutrition, immunization, control of communicable diseases. Primary health centres comprise the second tier in rural health care structure envisaged to provide integrated curative and preventive health care to the rural population with emphasis on preventive and primitive aspects. Primitive activities include promotion of better health and hygiene practices, pregnant women tables and institutional deliveries. Community Health centres forming the uppermost tier are established and maintained by the state government. Four medical specialists including surgeon, physician, gynecologist and paediatricin supported by 21 paramedical and other staff are supposed to staff each CHC.

TamilNadu Social Development Report (2000) : Stated that Health is no longer considered as merely ‘absence of diseases’. It has come to mean total quality of life, with a number of components such as income security, environmental factors, literacy, socio-economic issues, infrastructure facilities such as hygiene, sanitation safe drinking water access to institutional health care. Health policy merely as the basis of availability of doctors, drugs and hospitals.
> **Panchamukhi P R (1994)** he has observed that the construction of primary health centers building not satisfactory because with adequate facilities, he suggests that more financial resources for construction of primary health centers.

> **Mukharji R K (1971)** in his study, the structural like the image of primary health centers due to lack of medicine and long queues and cultural, social gap between health workers and the patients limits the utilization of health services.

> **Kamble's (1984)** his study pointed out that rural health in Tumkur district of Karnataka state, health problems in rural areas because of poverty, lack of medical facilities, the allocation of financial resources imbalance between rural and urban areas, income inequality, these problems affecting the rural people.

An overall view of the above analysis indicates that education and health are important component of social infrastructure and the most important drivers of India and Karnataka's social and economic development. A well-educated, healthy workforce is essential for economic growth.

1.4 **STATEMENT OF THE PROBLEMS**

The infrastructure development of any country includes both economic infrastructure and also the social infrastructure. Development of economic infrastructure cannot usher in overall development at the desired level if the social infrastructure is not simultaneously developed. The capacities and technical refinement of the economic infrastructure like roads, sewers, electricity, open spaces, gardens, and the evolving requirement of social infrastructure like shopping complexes, restaurants, medical facility zones, schools etc... are clearly delineated. Education, Health, Social Security, water supply, shelter and sanitation etc... Has to be developed to ensure proper social infrastructure. In this sense both economic growth is linked to infrastructure as infrastructure is linked to growth. So the development of India is incomplete.
without social infrastructure development and that would require focus on the infrastructure strategy for social research in India.

It indicates that there is close relation between economic development and development of social infrastructure therefore there is urgent need of studying recent trends in development of social infrastructure such has education and health in border district of Belgaum in Karnataka state and the making the recommendations to development of social infrastructure.

1.5 OBJECTIVES OF THE STUDY:

1. To study the recent trends in development of social infrastructure in Karnataka
2. To analyze status of education and health in Karnataka state and Belgaum district
3. To identify the gender gap in education and health
4. To discuss the development of education and health in Belgaum district
5. To examine regional disparities in the development of social infrastructure like education and health
6. To suggest suitable measures for future development of social infrastructure.

1.6 HYPOTHESIS:

1. There is a slow growth of social infrastructure in Karnataka and Belgaum district.
2. There is a gender gap in education.
3. There is a regional imbalance in social infrastructure.
1.7 RESEARCH METHODOLOGY:

Since, the basic aim of the study is to assess the development of social infrastructure in Belgaum district, it is initially planned to consult only secondary data for the study purpose but in order to probe the ground realities of development of social infrastructure in a border district of Belgaum. Hence, the study made use of both primary and secondary data.

A. PRIMARY DATA:

The Belgaum district of Karnataka State had been specifically chosen as the study area, because, it was border district of Karnataka State particularly selected Social Infrastructure such as Education and Health. The Belgaum district comprises of 10 taluka's, out of 10 talukas study purpose selected 4 talukas, two developed like Belgaum and Chikkodi and two backward like Khanapur and Ramdurg. The researcher had prepared questionnaire to collect information of health and education from the public. The public respondents selected were 400 for the study, 300 respondents for education and 100 for health.

B. SECONDARY DATA

The secondary data were collected from published and unpublished documents of the Directorate of Economics and Statistics Government of Karnataka. Various Karnataka at Glance, District Statistical Office and Census documents

C. TOOLS OF THE STUDY

Statistical methods like Co-efficient of Variations (CV), growth rate, averages, percentage, gender gap, etc., were used for analyzing the data.
D. SELECTION OF THE VARIABLES:

The present study analyses the development of social infrastructure in Karnataka with special reference to Belgaum district. The study purpose selected various variables like primary schools, high schools, p u colleges, degree colleges, universities, primary health centers, primary health units, family welfare sub-centers, government hospitals, private hospitals, drug shops, etc.,

E. PERIOD OF THE STUDY:

The present study is based on primary and secondary data. The reference period for the present study is 20 years i.e from 1991-2010.

F. SELECTION OF THE STUDY AREA:

The study consider the Belgaum district of Karnataka state and four talukas of Belgaum district including 20 villages and five each from the talukas namely Belgaum (NewVantamuri, Kanabargi, Kakati, Bagewadi and Bastwad), Chikkodi (Shiragaoan, examba, shiraguppi, karoshi and Mamadapur), Khanapur (Halkarni, Nittur, Sindolli, Itagi and Deshur) and Ramdurga(Godachi, Hosakeri, Hulkund, Chipalkatti and Thorangatti). The public respondents selected were 400 for the study, 300 respondents for education and 100 for health. This study examines the development trends in social infrastructure such as education and health.
### Table 1.1
CLASSIFICATION OF RESPONDENTS BY TALUKA AND CASTE-WISE.

<table>
<thead>
<tr>
<th>TALUKA</th>
<th>RESPONDENTS FOR EDUCATION (300)</th>
<th>RESPONDENTS FOR HEALTH (100)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SC</td>
<td>ST</td>
</tr>
<tr>
<td>BELGAUM</td>
<td>12</td>
<td>4</td>
</tr>
<tr>
<td>CHIKKODI</td>
<td>12</td>
<td>4</td>
</tr>
<tr>
<td>KHANAPUR</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>RAMDURGA</td>
<td>11</td>
<td>4</td>
</tr>
<tr>
<td>DISTRICT TOTAL</td>
<td>45</td>
<td>15</td>
</tr>
</tbody>
</table>

G. LIMITATION OF THE STUDY:

The social infrastructural facilities being vast scope, further the convenient of the study only two important social infrastructure like, education and health have been selected for research work. This study covers only for the 1991 to 2010 period data and hence, the conclusion arrived in this study is applicable to this period only. This study, by and large, utilized primary and secondary data collected through the various sources. Hence, the conclusion arrived in this study are subject to the veracity and the limitations of the those data have been used.
1.8 CHAPTER SCHEME

CHAPTER – I: This chapter provides the introduction, importance and need for the study, review of literature, objectives, methodology and limitation of the study.

CHAPTER–II: In this chapter analysed the concept of social infrastructure and social infrastructure economic development.

CHAPTER-III: This chapter presents with Development of Social infrastructure in Karnataka state, such as education and health.

CHAPTER-IV: This chapter presents the Socio economic background of Belgaum District.

CHAPTER–V: This chapter deals with Development of Social infrastructure in Belgaum District. Such as below follows:
   a. Status of education
   b. Education infrastructure
   c. Status of health
   d. Health infrastructure

CHAPTER–VI: Last chapter is devoted to the findings of the study, suggestions and Conclusion.
REFERENCES


