CHAPTER 5

CONTEXTUALISING THE PROBLEM OF RIGHT TO HEALTH CARE IN GUWAHATI CITY

THE STATE OF HEALTH SECURITY IN ASSAM
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The state of health security in Assam

5.1 Introduction

The political and development discourse in the State of Assam has been pre-occupied with insurgency, migration, and ethnic conflicts etc. for quite a long time now. As a result, the fallouts of the consolidation of the neo-liberal state have attracted very little attention from the researchers. Even if globalization has encouraged/enthused any important development related discourse those were more or less confined to boarder trades and Look East Policy etc. The implications of neo-liberal state on the social security sectors have been more or less neglected. This is despite the fact that these issues have been widely debated both at the global and national levels as well as in many states in India.

The implications of neo-liberal policies in the social security sectors like the health care sector are, however, explicit in the State today. Health sector has never been a priority sector in the policies of the government of Assam. But, despite that, in the post independent period a few serious initiatives were taken both as a part of national initiatives as well as independently by the Government of Assam. In 1948 itself two very important health care institutions were established in the state- Assam Medical College and Hospital at Dibrugarh and Government Ayurvedic College and Hospital at Guwahati. In the latter years two more Medical Colleges and Hospitals were established in the state-one in Guwahati and the other in Silchar. Rural health care infrastructure also drew attention from the Government. As a part of *National Drug Policy 1978* and *National Health Policy 1983* the overall health care sector in the state received patronage from the Government. However, once the policies started changing since mid 1980s the health care sector emerged as a vulnerable sector. With the introduction of neo-liberal economic reforms this sector has become one of the important sectors from which the state gradually withdrew its responsibility. The rural
health care sector, which needed comprehensive expansion, either remained stagnant or gradually collapsed. As a consequence, private health care system gradually expanded in the state since mid 1980s. This is evident from various studies. According to NSSO data (1998), in 1986-87 in the rural areas the distribution of inpatients between the private and the government hospitals was 9.8% and 90.02%. But in 1995-96, the share between the private and government hospital changed to 26.2% and 73.8%. On the other, in the urban areas in Assam, in the year 19986-87, the distribution of inpatients between the private and public hospital was 17.67% and 82.33%, which changed to 34.8% and 65.2% in the year 1995-96.

The available statistics reveal that the proliferation of private health care system was extremely uneven. There was very little expansion of private health care system in the rural areas. Within the urban areas, it has been the Guwahati City, which witnessed the concentration of private health care establishments. As per 2003 statistics, out of the total 145 private hospitals applied for registration under the Health Establishment Act 1993, 49 are located in Guwahati. As a result, Guwahati emerged as the first and last point of health care destination for a huge number of populations in the state. Consequently, there has been huge inflow of patients to the city both for IPD and OPD care in the recent past. Yearly turn out of Out Door Patients in the city is around 18-20 lacs today. IPD turn out is around 1.4 lacs.\(^1\) Guwahati has also emerged as the transit camp and information centre for the patients going out of the state for better treatment. At many instances, these patients avail health care service in the city as temporary relief and preparatory arrangement.

Owing to this growing significance of Guwahati City as the destination of health care in the backdrop of stagnancy or collapse of public health care institutions in the state, particularly in its rural bastions, the current study on right to health care in Guwahati city invites a focus on the overall state of health security in the State of Assam.

5.2 Current Health Security Status in Assam

Like India as a whole, on many fronts related to health security, Assam’s achievement over the decades has been worth mentioning- increased life expectancy, reduced
maternal mortality, decline in fertility, some success in eradicating and controlling some of the communicable diseases etc. Since independence, Assam has also established a huge public health care infrastructure involving teaching, training and research.

However, once put in a comparative perspective—both global and national, Assam's current health security status is very dismal. As a result of gradual withdrawal of the state from its commitment towards providing universal access to health care and the consequent expansion of private health care establishments under virtual absence of any system of public monitoring and control, the majority of the people in the state of Assam have gradually been pushed into a state of severe health insecurity. The continuous hike in price of medicine, introduction of user fee in public health care institutes; growing tendency of total dependence on technology; consolidation of unethical network between the health care practitioners and private health establishments/laboratories/medicine producers and distributors; proliferation of fake drugs etc. have added new agonies to people's insecurity in the health care sector.

Despite all these problems, the state of Assam progressed gradually in terms of health security. Life expectancy at birth gradually increased. In the year 1981-85 it stood at 51.9 years, which increased to 55.7 years in 1991-95 to 56.2 in the year 1992-96. But this is still below the all India average of 62.7 years. Expectation of life at Age 1 Year has also improved in Assam from 56.8 years in 1981-85 to 60.6 years in 1992-96, but still lagging behind the national average of 64.9 years in 1992-96. In terms of Infant Mortality rate (IMR) too, Assam's status is very dismal (92 per thousand population according to 1991 population census), which is worse than the All India average of 77 per thousand populations. Under five mortality rate is also as high as 116 per thousand population, which is again worse than the national average of 94. It has gone up from 401 in 1997 to 409 in 1998 per one lakh population. In case of India, on the other, it has slightly reduced from 408 in 1997 to 407 in 1998.

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1 The figures have been drawn from field survey in the city health care system. The method of arriving at these figures has been illustrated in the following chapter.
In terms of prevalence of anemia among women, Assam’s position is worse than India both in terms of any anemia (69.7% for Assam and 51.8% for India as a whole) and moderate anemia (25.6% for Assam and 14.8% for India as whole), although in case of severe anemia Assam is well placed compared to All India average- 0.9% for Assam and 1.9% for India as a whole. In case of anemia among the children, Assam’s position is better than the all India scenario.

As stated, people’s health security is closely associated with the health care infrastructure. Vital health security determinants like IMR or MMR are closely associated with the factors like birth attended by health professionals; births delivered in medical institutions; availability of hospital beds etc. The wider issues like level of poverty, gender discrimination or public expenditure on health care are also significant in this regard. A study conducted by Anil B. Deolikar on *Attaining the Millennium Development Goals in India* (2005), on behalf of The World Bank’s Human Development Unit for South Asia Region, reveals an inverse association between infant mortality and real expenditure on health and family welfare. The said study investigated the causes behind the wide divergence in the performance of different states in reducing infant mortality and its relationship with economic growth and public spending on health. The study merged state level data on IMRs over the period 1980-2000 with state level data on real gross state domestic product per capita (GSDP) and real public spending on health over the same period to explore the association between infant mortality on the one hand and public spending and economic growth on the other. The study discovered an inverse relationship.²

According to NFHS 1992-93, in Assam only 17.8% births were attended by health professionals, which improved to 21.5% in 1998-99. But, both the figures are much lower than the national average of 34.25 in 1992-93 and 42.3 in 1998-99 respectively. The rural scenario has always been worse in comparison to the urban scenario both in case of India as a whole as well as that of Assam and all other states. In case of India as a whole, only 33.5% health personnel attended births in rural areas and the

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² These figures have been drawn from *National Human Development Report* (2001) Planning Commission, Government of India,
The corresponding figure for the urban areas has been 73.3% (1998-99). In Assam, only 18.9% of births in rural areas were attended by the health professional, the corresponding figure for the urban areas is 64.4%. 4

The figures reveal that the State of Assam has to move files ahead to become a disease free or healthy society. To achieve this, Assam has to improve strategies to intervene as per the disease burden in the society.

5.3 Pattern of Diseases in Assam
Like India as a whole, the State of Assam is also the victim both of communicable and non-communicable diseases, but communicable diseases constituting the highest burden.

The environment in Assam is conducive for mosquito proliferation, survival and longevity. So, Malaria has been a major public health problem in the State. Although Assam contributes 2.59% of total population in India, but the state is contributing more than 5% of the total malaria cases in the country annually. As per the data of Directorate of Health Services, Assam, 65% of its population is living in high malaria risk areas. In the year 2001, out of the total 22.95 lakh Blood Sample Examination (BSE), 0.93 lakh cases were found to be malaria positive. In the year 2002, out of the total 23.25 BSEs, 0.89 lakh cases found to be positive.5

The following table provides the prevalence of as well as death due to malaria in Assam in select years.6

<table>
<thead>
<tr>
<th>Year</th>
<th>Blood slide Collection/Examination</th>
<th>Number of Positive cases</th>
<th>Percentage</th>
<th>Deaths Confirmed</th>
<th>Deaths Suspected</th>
</tr>
</thead>
<tbody>
<tr>
<td>1991</td>
<td>2412165</td>
<td>107572</td>
<td>36</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1996</td>
<td>2987382</td>
<td>176622</td>
<td>58</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2001</td>
<td>2432620</td>
<td>95142</td>
<td>122</td>
<td>101</td>
<td></td>
</tr>
</tbody>
</table>

Source: Directorate of Health & F.W., Govt. of Assam, 2003

5 Directorate of Health Services, Assam, 2003
6 Decadal Prevalence and Death due to Malaria is available in the Annexure -1.
With the implementation of the World Bank sponsored National Leprosy Eradication Project (NPEP) since 1993-94 (the first phase ending in 2000-01 and the second phase starting in 2001-02), the prevalence of Leprosy has gradually gone down in Assam. But it is still far away from achieving the NHP-2002 goal, which proposes to eliminate Leprosy by the year 2005. In Assam in 1993-94, prevalence of Leprosy per 10,000 populations was 6.8 (total cases being 15,395), which got reduced to 0.83/10,000 (total cases being 2219) in March 2001 and further reduction to 0.55/10,000 (1506 cases) in March 2003. But in some districts having high density of population the prevalence rate of Leprosy is still very high. For example, in Kamrup district the prevalence rate is 1.15/10,000.

Let us refer to Leprosy Profile in Assam in Select Years.  

Table- 5.2 Leprosy Profile in Assam

<table>
<thead>
<tr>
<th>Year</th>
<th>Prevalence</th>
<th>P.R/1000</th>
<th>Detection</th>
<th>NCDR/10,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>World Bank Project 1st Phase</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1993-1994</td>
<td>15,395</td>
<td>6.8</td>
<td>1297</td>
<td>0.57</td>
</tr>
<tr>
<td>1998-1999</td>
<td>5,227</td>
<td>1.99</td>
<td>6,682</td>
<td>2.55</td>
</tr>
<tr>
<td>World Bank Project- 2nd Phase</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2001-2002</td>
<td>2,283</td>
<td>0.84</td>
<td>2485</td>
<td>0.92</td>
</tr>
<tr>
<td>2002-2003</td>
<td>1506</td>
<td>0.55</td>
<td>1570</td>
<td>0.57</td>
</tr>
</tbody>
</table>


National T.B. Control programme (NTCP) was started in Assam in 1947, as centrally sponsored scheme on 50:50 basis i.e. 50% expenditure of the State Government and 50% expenditure of the Central Government. This is currently a 100% centrally sponsored programme. It works through District TB Centres (DTC). In Assam, in all 23 old districts DTCs are in operation. Since 1998, Revised National T.B. Control Programme (RNTCP) was launched and currently this programme is in operation in total eight districts of Assam. The Prevalence rate of T.B. has gradually gone down,

7 Full Leprosy Profile is available in Annexure II
but the rate of decline does not seem to be satisfactory. As per Government data in
1996-1997, total 91846 cases were under treatment. In 2001-02, it had gone up to
99091 and in 2002-03 it slightly reduced to 80231.

The following Table shows the Prevalence rate of the Cases under National
Tuberculosis Control Programme for Assam.

Table- 5.3- Prevalence of TB in Assam

<table>
<thead>
<tr>
<th>Year</th>
<th>Total cases under Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1996-1997</td>
<td>91846</td>
</tr>
<tr>
<td>1999-2000</td>
<td>92875</td>
</tr>
<tr>
<td>2002-2003</td>
<td>80231</td>
</tr>
</tbody>
</table>


However, NTCP has failed to achieve the targeted goals set by it. This is evident from

Table 5.4 -Target and Achievement on controlling TB under NTPC

<table>
<thead>
<tr>
<th>Year</th>
<th>Annual Target for new Cases Detection</th>
<th>Achievement</th>
<th>Annual Target for Sputum examination at PHCs</th>
<th>Sputum examination at PHCs</th>
<th>Annual target for Sputum Positive cases at PHCs</th>
<th>Sputum Positive cases at PHCs</th>
<th>Under Treatment at the end of the period</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000-2001</td>
<td>40,100</td>
<td>16,722</td>
<td>1,30611</td>
<td>3389</td>
<td>13061</td>
<td>281</td>
<td>80564</td>
</tr>
<tr>
<td>2001-2002</td>
<td>40,100</td>
<td>17,947</td>
<td>1,33000</td>
<td>3537</td>
<td>13322</td>
<td>323</td>
<td>98091</td>
</tr>
<tr>
<td>2002-2003</td>
<td>40,100</td>
<td>9,651</td>
<td>133000</td>
<td>3228</td>
<td>13322</td>
<td>237</td>
<td>99091</td>
</tr>
</tbody>
</table>


The rate of prevalence of water borne diseases like Diarrhea, Dysentery, Jaundice etc
are also very high in Assam due to the frequent occurrence of flood in monsoon,
particularly in some of the districts of Assam. At many instances people even do not
report in hospitals or health centres regarding these diseases and take recourse to traditional medicines. So, the government data regarding these diseases are very conservative.

Analysis of the daily W.T. messages received by the Directorate of Health Services from 05\textsuperscript{th} to 28\textsuperscript{th} July 2003 reveals that during this period of less than one-month total 2952507 people and total 4912 villages were affected by flood and total inmates were estimated at 180884. However, during this period, government could establish only 1020 medical relief camps and could deploy only 392 Medical Teams. Total 9,685 diarrhea cases were reported and total deaths in Diarrhea were estimated at 11 and total diseased 57563.\(^8\).

Japanese Encephalitis has also affected Assam along with other states in India like Andhra Pradesh, Bihar, Goa, Haryana, Karnataka, Kerala, Manipur, Tamilnadu, Uttar Pradesh and West Bengal. But the reported cases and deaths due to this disease have been low in comparison to some other states in India. Between 1995- 1999 total 200 cases of Japanese Encephalitis were reported in Assam and 74 died out of this diseases.\(^9\)

There are no adequate figures regarding Filaria in Assam. But, Assam is one of 18 states in India that have been identified as endemic to Filaria. The official documents states that as on 31.12.1998 total 11.02 million (9.89 in Rural Assam and 1.13 in Urban Assam) were at risk of Filaria. Out of this only 0.31 million people were protected under Filaria Control Programme. Assam has one Filaria Control Unit, but no Filaria Clinic.\(^10\)

Assam is also vulnerable to varieties of other principal communicable diseases. But, there is no proper documentation on Enteric fever, Measles, and Poliomyelitis, Viral...

\(^8\) Directorate of Health Services, Assam, 2003

\(^9\) Health Information of India (2002), p 170

\(^10\) ibid p 179
Hepatitis, Diptheria, Acute Respiratory Infection, Pneumonia, Whooping Coughs, Rabies etc.

Of late, there has been proliferation of non-communicable diseases like diabetes, heart stroke, gastronomy, Gould bladder etc. There is no proper record of the trend of these diseases in Assam. On the other, the private health care institutions concentrate on treatment of these diseases, which are profit intensive.

Assam has also been recognized as one of the high cancer prone state. The detected cases of Malignancies in Assam are increasing day by day. Dr. B. Borooah Cancer Institute, only one of its kinds in the North Eastern Region, was established in 1974. In the year 1974-75, the Institute detected total 187 malignancies and in the year 1999-00 the cases went up to 3897. The OPD turn out to this Institute is also increasing in a high rate: the cases being 773 in 1974-75 and 30912 in 1999-00. In Assam today, 26,000 persons are contracting cancer every year and about 80 percent of them are in the advanced stage requiring palliative care. Besides, there has been a huge exodus of cancer patients to other parts of India, particularly to Vellore, for treatment.

Let us have a look at the Profile of the cancer patients in B. Borooah cancer Institute in a few select years.12

<table>
<thead>
<tr>
<th>Year</th>
<th>Total cases Registered</th>
<th>New Number of malignancies Detected</th>
<th>Total Number of old cases seen</th>
<th>Total Number of OPD consultation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1991-1992</td>
<td>4384</td>
<td>2709</td>
<td>5013</td>
<td>9397</td>
</tr>
<tr>
<td>1996-1997</td>
<td>5509</td>
<td>3832</td>
<td>23219</td>
<td>28728</td>
</tr>
<tr>
<td>2001-2002</td>
<td>5404</td>
<td>3622</td>
<td>29072</td>
<td>32694</td>
</tr>
</tbody>
</table>

Source: Dr. B. Borooah Cancer Institute: A Profile, 2003

11 Annual Report 1999-2000, Dr. B. Borooah Cancer Institute
12 Decadal Patient Turn out List is available in Annexure IV
AIDS has not yet assumed an alarming trend in Assam. But, in neighboring state like Manipur, it has already taken a severe turn. With the opening up of the boarders of Northeast, of which Assam is the Gate Way, AIDS may be one of the important challenges for the State. Till the end of March 2003, the AIDS situation in Assam was as below.

Total No of Blood Sample taken: 40,458; HIV+ 454; Total no of cases Male-142 & Female-29; Seropositive rate 10.82/10,000.

By March 2005, the rate of prevalence of HIV positive has increased to 790, and the number of death toll because of dreaded AIDS has been 36.\(^\text{13}\)

Blindness has also been another important problem in India as well as in Assam as around 1.4% of its population suffers from it. In accordance with the objectives laid down by the Government of India, Government of Assam also proposes to reduce it from the current level of 1.4% to 0.3%. As a part of it, the State Government annually targeted a certain number to cover under Cataract Surgery, which, however, it has failed to achieve.

<table>
<thead>
<tr>
<th>Year</th>
<th>Target</th>
<th>Operated Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>1996-97</td>
<td>50,000</td>
<td>17,833.</td>
</tr>
<tr>
<td>2001-02</td>
<td>42,000</td>
<td>17,663</td>
</tr>
</tbody>
</table>

Source: Directorate of Health Services, Govt. of Assam, 2003

Despite this high prevalence of various diseases, the health care sector is still a low priority area both for the Union Government of India as well as that of the state Government of Assam. Besides, with the implementation of the World Bank dictated new health care policy, communicable and other common diseases of the poor have gradually been omitted from the list of essential public health activities. The government has virtually stopped the supply of essential medicines to the public health care institutions. Even the supply of minimum equipments like thread and band-aid has also been stopped.

\(^{13}\) The Assam Tribune (2005) *790 HIV Positive Cases Detected in the State*, Date 12/3/2005
5.4 The Public Health Dimension - Water and Sanitation

Access to improved sources of water and improved sanitation are two important components of good health. Many communicable diseases have its origin in water and sanitation. In the state of Assam, water supply, for a very long period, was a concern and responsibility of the Department of Health.

The Public Health Engineering organization was created in 1956 under the Director of Health Service with a Superintending Engineer from PWD on deputation. The organization was then upgraded to the level of directorate under the Health Department. Only in 1980s PHED became a full-fledged major Department with separate Secretary and Minister.\textsuperscript{14}

The Status of Rural water supply reveals that out of the total habitation of 70,669, as much as 58,739 habitations with a corresponding population of 194.24 lakhs are fully covered with drinking water supply as on 01.04.2004. There are still 11,930 habitations with a corresponding population of 62.24 lakhs, which are yet to be covered. Although vast rural population has been included within the category of coverage with water supply, huge population are still deprived of drinking water supply when the quality aspect is taken into consideration.\textsuperscript{15}

PHED reveals that water in Assam is affected by iron, fluoride, arsenic, industrial and domestic contamination of surface and groundwater and pathological bacteria etc.

<table>
<thead>
<tr>
<th>Type of pollutant</th>
<th>No of Districts</th>
<th>Blocks</th>
<th>Habitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arsenic so far detected</td>
<td>2</td>
<td>6</td>
<td>-</td>
</tr>
<tr>
<td>Fluoride so far detected</td>
<td>3</td>
<td>-</td>
<td>590</td>
</tr>
<tr>
<td>Iron</td>
<td>22</td>
<td>Present almost everywhere</td>
<td>44121</td>
</tr>
<tr>
<td>Pathological Bacteria</td>
<td>Spread over the entire rural areas in Assam</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

\textsuperscript{15} ibid p 57
Arsenic

PHED sources reveal that two districts-Dhemaji and Karimganj in Assam have so far shown presence of Arsenic in excess of permissible limit. Excess Arsenic has so far been found in one of five blocks in Dhemaji district and 5 out of seven blocks in Karimganj district. However, the latest reports suggest that an alarmingly large number of places in 20 out of the state’s 23 old districts have their ground water contaminated with high concentration of arsenic, making ground water in these places totally unsafe for consumption. For, only in three districts in the state- Morigaon, Karbianglong and North Cachar Hills, no ground water contamination with high arsenic presence was reported. This is according to the findings of a survey conducted by a team of scientists of the Tezpur based North Eastern Regional Institute of Water and Land Management (NER-IWALM) till the end of 2004. It may also be stated the cases of terminal diseases like cancer are growing in the state at a rapid pace, as is evident from the patient turn out figures in BBCI. It is now admitted by experts’ world over that long use of arsenic contaminated water for drinking and cooking purposes may lead to, among others, carcinogenic diseases.16

Fluoride

Presence of Fluoride in water resulting in both dental and skeleton fluorosis is also one of the challenges in Assam today. Presence of Fluoride in ground water in excess of permissible limit has so far been detected in 590 habitations. Of these, problems have already been taken care of in 33 habitations. Two districts- Nagaon and Karbi Anglong have shown widespread fluorried in ground water.

Report on the Household Survey conducted under the Joint Plan of Action for Fluoride Mitigation in Nagaon and Karbi Anglong districts of Assam, prepared by the PHED, informs different health hazards among different age groups of population in the state due to both dental and skeleton fluorosis. Due to skeleton fluorosis, people have reported suffering from Genuvulgum.

Sanitation

Water supply and sanitation are two important components of well-being and good health. Yet, while the various Governments gave priorities for Rural Water Supply, Sanitation was very much neglected. Even the public is not conscious about the requirement of sanitary latrines and rarely demand for the same whereas the demand for drinking water supply is ever increasing. Although, Government of India launched the Centrally Sponsored Rural Sanitation Programme (CRSP) as early as in 1986 with financial assistance to states, the Programme made very little impact in Assam.

Assam actually made a beginning of rural sanitation programme in the year 1999 when the TSC programme was launched with setting up of number of sanitary marts. There are now as many as 54 sanitary marts in the State with financial support from UNICEF. The Marts are managed by NGOs and these virtually serve as nerve centers for toilet constructions programme. It is through sanitary marts people are motivated to go for sanitary toilets thus generating demand for toilets.

The functioning of the Marts has, however, been far away from satisfactory. Whereas with financial help from UNICEF, there has been stock piling of sanitary components in the marts, but no adequate demand from the people, basically due to the lack of motivation.

With all these, a huge number of population, both from the status groups of APL and BPL are running without toilets.

5.5 Swajaldhara and 73rd & 74th Constitutional Amendment and Water and Sanitation

As a part of structural changes in different sectors in the country and in consonance with the 73rd and 74th Amendments to the Constitution, the Government of India already launched a new demand responsive and decentralized water supply and sanitation scheme known as Swajadhara. Under this scheme, the water supply and sanitation schemes will be implemented through the three tier Panchayati Raj Institutions (PRIs) with the beneficiary communities taking up the responsibility of
On the other, due to skeleton movement, patients are suffering from inability to bend forward; inability to sit up; inability to touch back of their head etc. These problems are more common among the middle aged and older population. On the other, due to non-skeleton fluorosis, people reported to have suffered from problems like loss of appetite; gas in stomach; pain in stomach etc, constipation etc.

The said study has suggested that there has been an increasing trend in terms of prevalence of diseases (particularly dental fluorosis and Genuvulgum) among household members consuming water with fluoride concentration more than 1 ppm. However, a more systematic study is required to measure the impact of fluoride toxicity consumed through water.

Iron
Except in pockets and mostly in hill areas, there is plenty of ground water with insignificant exploitation in Assam. But, underground water almost everywhere is having iron far in excess of permissible limit of 1 ppm, sometime as high as 20 to even 25 ppm as in certain areas of Darrang District. Thus people are reluctant to use water with high concentration of iron and go for contaminated source of water like river, unprotected ponds etc. which look clean but hygienically contaminated thus exposing people to the risk of contacting water borne diseases.\(^\text{17}\)

Pathogenic Bacteria
Ground water from deep tube-wells usually is free from bacterial contamination. But, water from shallow tube-wells and surface water from all sources are generally contaminated with pathogenic bacteria. Therefore it becomes mandatory to disinfect water from all these sources before it is supplied for public consumption because the presence of pathogenic bacteria in public water supply system is a cause for its rejection.\(^\text{18}\)

\(^{17}\) Draft Final Report (2005) Rapid Sector Assessment of Rural Water Supply and Sanitation in Assam, p 70

\(^{18}\) ibid p 70
operation and maintenance. These schemes have already been launched as pilot projects and in some cases these schemes have aroused people’s enthusiasm, as is the case in Jorhat district in Assam. The success of these schemes will, however, depend on to what extent the PRIs become efficient enough to tackle these schemes with full commitment and can emerge as qualitatively different mechanisms free from corruption and nepotism etc. On the other, the issues like beneficiary contribution, particularly of the BPL categories needs to be addressed seriously and an integrated approach like employment generation and poverty alleviation needs to be launched. A reckless globalization and privatization and beneficiary contributed system of water supply and sanitation cannot run together.

5.6 Public Health Care Infrastructure

As stated, Assam poses serious challenges to the health security of its population both due to the unwarranted burden of diseases as well as due to very low achievement in the public health sector. To face these challenges Assam need a comprehensive public health care system, which, of course, the state is lacking.

According to the census 2001 (provisional) total population of Assam is 2.6 crore. Total area of Assam is 78,438 sq. km and its density of population is 339.61. To serve this number of people, Assam has the following hospitals and hospital beds under the public sector.

A.
1. No of State Government Hospitals : 161
2. No of Primary Health Centres : 610
3. Dispensaries : 323
4. Beds : 12,868
5. Rural Family Welfare Planning Centres : 268
6. Sub-centres : 5109

B. (T B. Special Health care Infrastructure)
1. T. B. Hospitals : 3
2. District T.B. centres : 17
3. Ward attached to general hospitals : 22
4. T. B. Clinics : 3
5. Beds : 869
C. (Leprosy Treatment Infrastructure)
1. Leprosy hospitals : 3
2. Leprosy control Units : 7
3. SET Centres : 268
4. Leprosy clinics : 3
5. Beds : 131

D. (Cancer Treatment Infrastructure)
1. Cancer Hospital : 1
2. Ward attached to general hospitals : 3
3. Beds : 117


In Assam, as per the information of the Directorate of Health Services, the Doctor/ Population ratio is 1:9900 (in Heath Services). As far as the requirement and availability of specialized doctors for the rural areas are concerned, the scenario is worse, even according to the Government information itself. For example, for the rural areas in Assam, as on 31.12.1991, number of requirement of specialized doctors was 420. But Government sanctioned only 24 posts, out of which 12 were filled up and 12 remained vacant. Total shortfall was 408. On the said date, the rural areas in Assam needed 105 pediatricians, but no post was sanctioned and the shortfall was 105. The situation was equally terrible in case of other specialties like physiology, Gynecology etc. 19

As per WHO, a developing country like India should have at least one hospital bed for every 300 people. But, as on 1998-99, India had only 9,08,167 hospital beds of all types i.e. only 93 hospital beds for per lakh population. As on 1.1.1991 in Assam, there were 1,968 populations against per hospital bed. In case of India as a whole, total population against per hospital bed was 1,498. Only Kerela has moved closer to the WHO norms, with 391 populations against per hospital bed as on 1.196. 20 As per 2003 data, there are total 26335 hospital beds in Assam, out these 12179 beds i.e. 46.24% is under the public sector and the remaining 14156 beds i.e. 53.76% is under the private sector.

19 Health Information of India (2002), Directorate of Health and family Welfare, Government of India pp 119 - 120
20 ibid
Let us look at the accessibility, part.21

1. Average rural population served by a sub-centre: 3800
2. Average rural population served by a PHC: 32200
3. Average rural population served by a CHC: 19000

There has been improvement in terms of establishment of health care institutions in the post-independence period. However, it is yet to achieve the required status.

Let us refer to the following figures:

**Table 5.8- Requirement and Achievement of Public Health care Institutions in Assam**

<table>
<thead>
<tr>
<th>Institution</th>
<th>Total Requirement for the State</th>
<th>Achievement made up to 31.03.2001</th>
<th>Backlog</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Sub Centres</td>
<td>5133</td>
<td>5109</td>
<td>24</td>
</tr>
<tr>
<td>2. PHCs</td>
<td>855</td>
<td>610</td>
<td>245</td>
</tr>
<tr>
<td>3. CHCs</td>
<td>214</td>
<td>100</td>
<td>114</td>
</tr>
</tbody>
</table>

According to the Government data’s itself, the rural health care infrastructure is very poor. Let us refer to the following figures.

**Table 5.9 Requirement, In position and Shortfall of Health Personnel in Rural Assam.**

<table>
<thead>
<tr>
<th>Category</th>
<th>Required</th>
<th>Sanctioned</th>
<th>In position</th>
<th>Vacant</th>
<th>Shortfall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialist (As a whole)</td>
<td>420</td>
<td>24</td>
<td>12</td>
<td>12</td>
<td>408</td>
</tr>
<tr>
<td>Pediatricians</td>
<td>105</td>
<td>---</td>
<td>-----</td>
<td>------</td>
<td>105</td>
</tr>
<tr>
<td>Physicians</td>
<td>105</td>
<td>08</td>
<td>02</td>
<td>06</td>
<td>103</td>
</tr>
<tr>
<td>Obs &amp; Gyane</td>
<td>105</td>
<td>08</td>
<td>06</td>
<td>02</td>
<td>99</td>
</tr>
<tr>
<td>Surgeon</td>
<td>105</td>
<td>08</td>
<td>04</td>
<td>04</td>
<td>101</td>
</tr>
<tr>
<td>Doctors at PHCs</td>
<td>619</td>
<td>584</td>
<td>584</td>
<td>-----</td>
<td>35</td>
</tr>
<tr>
<td>Block Extension Educators</td>
<td>153</td>
<td>153</td>
<td>-----</td>
<td></td>
<td>**</td>
</tr>
<tr>
<td>Health assistants (Male)</td>
<td>619</td>
<td>793</td>
<td>793</td>
<td>------</td>
<td>**</td>
</tr>
</tbody>
</table>

**Source: Health Information of India (2002) pp 119-132**

However, these official data are extremely conservative. A close look at the local newspapers’ reporting would enlighten us about the real scenario in public health care infrastructure in Assam. Many of the sub-centres, PHCs and CHCs are running without adequate health personnel, proper infrastructure and medicine and other

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22 Assam is very poor even in record maintenance. Health Information of India for the year 1999, published in the year 2002, provides the late 1990s trend in health care sector in most of the states of India. Assam’s date of reference has been 31-12-1991.
equipments. Health personnel absenteeism is very high in almost all public health care institutions in Assam.

The Chief Minister of Assam himself acknowledged publicly the inability of the Government to regulate their own doctors appointed to serve its rural population.

Around 36% of Assam’s population lives below the poverty line. With the implementation of the neo-liberal packages, the situation has been worsened. The state government, in accordance with the policies of the Government of India, have imposed user fee in government hospitals. The Government of Assam, Health and Family Welfare (B) Department, through a circular No 92/2001/78, dated 04/06/2003 raised the charges in all government hospitals of Assam. There was discontent among people regarding this hike in charges and this was considered as one of the steps implemented under new policy regime of liberalization and privatization.

The consolidation of the globalization and liberalization process in health sector is more explicit in the phenomenon of proliferation of the private hospitals in Assam.

5.7 Financing the Public Health Care System
The State government has acknowledged the paucity of finance in the health care sector. The Draft Tenth Five-Year Plan, commenting on the problems of the Ninth Five Year Plan, states:

"The state government has projected a need based Ninth Five Year Plan of Rs. 17271.42 crore. However, at a meeting between the Planning Commission and the State government, the Ninth Plan outlay was fixed at Rs. 8983.93 crore at 1996-97 prices. But the aggregated outlay \( \text{\textsuperscript{\textbullet}} \) the five Annual Plans worked out to Rs. 6777.07 crore at 1996-97 prices. Thus the real allocation was much lower than the projected demand by the state."\textsuperscript{23}

The financial constraints in the plan development has been well stated in the summary observation:

(1) During the ninth Plan period, there has been very wide gap between the outlays in the original Ninth plan and the aggregated allocation through the five Annual Plans to the disadvantage of the state;

(2) This resulted in severe plan cut;

(3) In the Second part of the Ninth Plan, special Central Assistance virtually determined the plan size. Due to the inability of the state to mobilize its own resources, those sectors that did not get special central assistance almost stagnated.

(4) Although it was expected that the plan resources would be further reinforced by resource flow through non- lapsable funds and centrally sponsored Projects, the same did not happen. The total flow of Non-lapsable during the Ninth Plan period has been only Rs. 146.32 crore. On the other hand the transfer of resources through centrally sponsored schemes did not materialize.²⁴

Besides the gap between the required fund and the agreed allocation there has also been a gap between the agreed allocation and that of the actual expenditure. The following figures are illustrative in this regard.

<table>
<thead>
<tr>
<th>Year</th>
<th>Agreed Outlay</th>
<th>Expenditure</th>
</tr>
</thead>
<tbody>
<tr>
<td>1997-98</td>
<td>1520.28</td>
<td>1230.71</td>
</tr>
<tr>
<td>1998-99</td>
<td>1654.00</td>
<td>1297.67</td>
</tr>
<tr>
<td>1999-2000</td>
<td>1766.50</td>
<td>1414.90</td>
</tr>
<tr>
<td>2000-2001</td>
<td>1521.28</td>
<td>1460.59</td>
</tr>
<tr>
<td>2001-2002</td>
<td>1710.00</td>
<td>1710.00</td>
</tr>
<tr>
<td>Total (Ninth Plan)</td>
<td>8172.06</td>
<td>7113.87</td>
</tr>
</tbody>
</table>

Source: Draft Tenth Plan & Annual Plan 2002-03, Vol. 1, p B 3-4

The cut in plan allocation had its negative impact on various programmes related to health security. For example, primary health constitutes one of the important components of Pradhan Mantri Gramodaya Yojana (PMGY). However, as pointed out by the Shukla Commission and already stated above, there exists a gap between the

²⁴ Ibid p B-3, Vol. 1
total requirements and of achievements in health sector and this is basically due to the lack of money.

5.7.1 The Tenth Plan Target

In order to ensure progress towards improvement in the quality of life of the people, the Draft Tenth Plan of Assam has set targets, which are in accordance with the guidelines laid down by the Planning Commission in the Tenth Plan Approach paper.

Out of the ten targets, three are related to health—two directly and one indirectly.

(a) Reduction of infant mortality ratio (IMR) to 45 per 1000 live birth by the Year 2007 (Goal 7).
(b) Reduction of Maternal Mortality Ratio (MMR) to 2 per 1000 live birth by the year 2007. (Goal 8)
(c) All villages to have sustained access to portable drinking water within the Plan period.  

The approach paper laments that despite progress in other areas over the past few decades, the state is woefully lacking in providing basic services such as health care, education, safe drinking water, nutrition etc for the rural poor. During the Tenth Plan Period, it has been stated, emphasis will be given on strengthening of rural health care infrastructure so that rural poor can easily avail the benefits from these infrastructures. Despite these ambitious objectives, the State Government is yet to overcome the trauma that it experienced in terms of low allocation by the Planning Commission in the Ninth Plan period. So, it states: “Assam had projected a need based 9th Five Year Plan for Rs. 17271.42 crore whereas the agreed outlay was Rs. 8983.93 crore and the aggregated outlays for the five years came down to only 6777.07 crore; almost one third of what was optimal resource allocation. As a result, the growth of economy of Assam decelerated and it achieved an average growth rate of 2.96 % only over the 9th Five Year Plan. At the end of the 9th Five Year Plan one finds yawning gaps in infrastructure in Assam coupled with high rates of unemployment and backwardness.

The chances of catching up with the rest of the country is far diminishing giving an impression that the state is going to be a hinterland of underdevelopment for ever.26

There is no possibility of coming out of this trauma even in the 10th Plan period too even in the 10th Plan period too as in accordance with the given broad guideline of the Planning Commission; Assam has been put at the level of Rs. 12,976.93 crores for the 10th Five-year plan and according to the estimates of the State Government with this meager resources, the state can not generate growth beyond 3% and with this low development Assam will not be in a position to fulfill many of its ambitious goals including in the health sector.

Let us refer to the allocation in the social service sector in general and the health sector in particular out of total Tenth Five Year Plan outlays.

<table>
<thead>
<tr>
<th>Sector</th>
<th>Tenth Plan (2002-07) Proposal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grand Total Allocation</td>
<td>General- 1206190.00</td>
</tr>
<tr>
<td></td>
<td>Hill- 91503.50</td>
</tr>
<tr>
<td></td>
<td>Total- 1297693.50</td>
</tr>
<tr>
<td>Social Services</td>
<td>General- 518327.00</td>
</tr>
<tr>
<td></td>
<td>Hill- 37094.75</td>
</tr>
<tr>
<td></td>
<td>Total- 555421.75</td>
</tr>
<tr>
<td>Health</td>
<td>General- 66597.00</td>
</tr>
<tr>
<td></td>
<td>Hill- 4922.50</td>
</tr>
<tr>
<td></td>
<td>Total  71519.50</td>
</tr>
</tbody>
</table>


5.7.2 Budgetary Allocations

The Budget Expenditure of the Government of Assam also reflects the same trend. The National Health Policy 2002 proposed to increase state sector health spending...
from 5.5% to 7% by 2005 and further increase to 8% by 2010 as well as to increase the share of central grants to constitute at least 25% of total health spending, however, the actual figures do not indicate a positive trend. Let us have a look at the Budget Estimates of the Government of Assam for the Year 2003-04.

Analysis of the allocations reveals\(^\text{27}\) that health and family welfare has received a maximum of 3.17% out of the grand total expenditure in the Budget Estimate of 2002-03, which was, however, reduced to 2.70% in the Revised Estimate 2002-03. In actual expenditure in 2001-02, the Department received 2.39% out of the Grand total expenditure and for the Budget Estimate 2003-04 the Department has been allocated 2.98%.

On the other hand, in accordance with the objectives of the NHP-2002, the Central assistance has been estimated at 30.53% in the 2003-04 Budget estimates. However, like the previous budgets, family welfare remains the prime concern of the Central assistance towards Health and Family Welfare Department of Government of Assam. For example, total assistance from the central government under centrally sponsored schemes and central sector schemes was Rs. 7518.92 Lakh in 2001-02(Actual) Budget out of the total expenditure of Rs.34492.29 Lakh of the Department, i.e. 21.80%. However, out of this assistance, the Family Welfare Department consumed Rs.5990.66 Lakh i.e. 79.67%. In the Budget Estimate of 2002-03, central assistance to the Department of Health and Family Welfare was 29.46% of the total Estimate. The Family Welfare was allocated 76.85%. In the Budget Estimate of 2003-04, whereas central assistance is estimated at 30.53%, out of which the Family Welfare is proposed to receive 80.33%.

But, mere analysis of budget allocation may be misleading if the heads and sub-heads within the medical and public health against which funds are allocated are not properly scrutinized. A careful study of the budgetary estimates related to the health care shows that out of the budgetary allocations almost all have been consumed by salary expenditure, dearness allowances, LTC, medical reimbursement, paying new

\(^{27}\) Budgetary allocations in tabular forms are available in Annexure V-A to Annexure V-D.
pay commission arrear etc. leaving very little for medicine, medical equipment etc. Besides, a close scrutiny of the budgets also shows a huge gap between the Budget Estimate/ Revised estimate and that of Actual Expenditure. In some cases it was found that although the budget estimate and revised estimate allocated funds for medical equipment to control communicable diseases like malaria etc out of the proposed WHO assistance, however, in terms of actual expenditure those were found to be nil.

5.7.3 Assam Area Project
The Assam Area Project (IPP-IX) was taken up for implementation from the year 1994 with the financial assistance from the World Bank. The Project was completed in the year 2001. The Project was started in 1994-95 at an estimated cost of Rs 101.22 crore. The funding pattern for this Project was 90% from the World Bank and 10% from the Government of Assam. The Project cost was subsequently revised at Rs. 14.30 crore of which the Govt. of India's share of 90% was Rs. 129.91 crore and remaining 10% share of Assam Government's share was Rs. 14.44 crore. State Government released its full share before the Project came to an end in December 2001.28

5.7.4 Tripartite Arrangement of Financing: B. Borooah Cancer Institute
The B. Borooah Cancer Institute, set up in 1973, by a voluntary organization, was accorded the status of Regional Institute for Cancer Treatment and Research in 1980. This was taken over by the Government of Assam from the voluntary organization in 1986. In November 1989, under a Tripartite Agreement, signed between the Government of Assam, North Eastern Council and Department of Atomic Energy, the objective of resource mobilization for creation of state of art facilities for all round development of the institute was vested upon the signatories to the agreement. As a follow up of this agreement, a plan of action called Revitalization Plan Phase-1 (RPP-I) was implemented from 1989 -90 onwards. The approved outlay for this (RPP-1) was Rs. 862.05 lakhs for the period ending March 1995. As this Plan could not achieve the desired objective in totality, during the period 1989-95, the Tripartite

28 Draft Tenth Five year Plan Ibid p 13-20
Agreement had to be further renewed on 9.10.1997 and in pursuance of this agreement, a Phase II of the Revitalization (RPP-II) was proposed to be implemented during the 9th Plan Period.29 Total allocation in this second Phase was Rs. 4361.45 Lakhs, i.e. Rs 1351.33 lakhs for Recurring, Rs. 1665.98 lakhs for Civil Works and Rs. 1344.14 lakhs for Equipment.

In September 2004, the Fresh Tripartite Agreement was signed between the department of Atomic energy, North Eastern Council and Government of Assam for the Next Five years. The three parties agreed to spend total Rs. 50 crore including the recurring expenditure during the agreement period. Out of the total agreed outlay Rs. 29.29 crore would be spent on recurring expenditure, Rs 3.17 crore on civil works and Rs. 17.71 Crore would be spent on equipment in the next five years. As per the new agreement, the NEC would spend 70 percent of the recurring expenditure and the Government of Assam will spend the balance amount. The Department of Atomic Energy and the NEC would share the non-recurring expenditure equally.30

5.8 Functioning of the Public Healthcare Institutions in Assam.

National Health Policy-2002 (NHP-2002) acknowledges that the existing public health infrastructure is far from satisfactory.

“For the outdoor medical facilities in existence, funding is generally insufficient, the presence of medical and para-medical personnel is often much less than that required by prescribed norms, the availability of consumables is frequently negligible, the equipment in many public hospital is often obsolescent and unusable, and the buildings are in a dilapidated state. In the indoor treatment facilities, again, the equipment is often obsolescent: the availability of the essential drug is minimal, the capacity of the facilities is grossly inadequate, which leads to overcrowding, and consequentially to a steep deterioration in the quality of the services. As a result of such inadequate public health facilities, it has been estimated that less than twenty percent of population, which seek OPD services, and less than 45 percent of population which seek indoor treatment, avail of such services in public hospitals. This is despite the fact that

29 Dr. B. Borooah Cancer Institute, A Profile 2003 p 1
30 The Assam Tribune September 14, 2004
most of the patients do not have the means to make out of pocket payments for private health services except at the cost of other essential expenditure for items such as basic nutrition.”

NHP-2002 promises to bring quality improvement in the public health care system with more investment as well as proper monitoring system. As the Post-NHP-2002 Budget proposals reveals, the promises of the NHP-2002 is yet to be implemented. In terms of monitoring the functioning of the existing system the government has yet to adopt any substantive initiative. Although, the state government of Assam, through various schemes and projects like Assam Area Project or Centrally sponsored Project like PMGY, have invested in public health care system, but there has been no adequate quality improvement in terms of functioning. Local Dailies both in vernacular language as also in English keep on reporting the real state of the health care system in Assam. Although these reports are not cent percent authentic and are marked by exaggeration, however, they are not always fanciful. A random scrutiny of those reports in the year 2003-05 informs us regarding the bad shape of many of the public health care institutions in Assam. The reports are mainly from *The Assam Tribune* and *Asamiya Pratidin*, the highest circulated English and vernacular dailies respectively in Assam. Let us have a cursory look at some of those reports:

The State Government declared about the Government’s intention of establishing three medical colleges in Assam in the budget session 2005. It provoked a strong reaction both among the general public as well as among the students of the existing medical colleges in Assam. This was basically due to the current state of pathetic conditions of the existing medical colleges and hospitals. Taking exception to the Government’s decision, Gauahati Medical College and Hospital (GMCH) Junior Doctors Association and GMC Students Union pointed out the financial constraints of Gauhati Medical College and Hospital creating a deplorable situation in this premier health care institution in the State.

A break up of available fund utilization revealed that out of the total allocation of Rs. 13,30,74,488, an amount of Rs. 12,98,98,488 was spent on salaries and wages alone. This effectively left an amount of Rs. 31,76,000 for the management of college and hospital. The amount was very short of what a major hospital is required for its
efficient running. "The 1600 bed strength GMCH is a major tertiary hospital, management of which has been made difficult due to Government inaction and apathy" - both GMCH JDA and GMCSU alleged.

Anaesthesia services in State’s medical colleges are in a very dismal state. While only Gauhati Medical College Hospital (GMCH) has a 14-bed intensive care unit (ICU) catering to the patients needing critical care, the number of the trained anesthetists at the hospital is extremely poor with just 26 doctors as against the minimum requirement of 50. The Indian Medical Council norm in this regard is one anesthetist against two surgeons.

It was reported in The Assam Tribune that, at the Assam Medical College (AMC), the first Medical College in Assam established in 1948, the senior doctors better known for their propensity to patronize the city’s numerous private nursing homes rather than having the patients treated at the AMC hospital. The lure of easy money has been such that several serving doctors at the AMC either own private nursing home in the city are cent percent dependent on medical specialists attached to the AMC.

Let us now randomly survey the functioning of some of the PHCs/CHCs in the State as reported in the vernacular papers in the year 2003-04. The authenticity of the reports is not beyond doubt. However, there has been virtually no response in public to those reports from the Directorate of Health services or any other authority. It reflects either the true projection of the state of the health of those PHCs/CHCs by the vernacular dailies or the gross indifference of the health authority in the state to those reports. Both are equally dangerous for the right to health care by the common people.

It was reported that in Dhekiajuli PHC in the Sonitpur District in Assam, the X-Ray machine, installed under the Assam Area Project, was lying non-performing. The

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31 The Assam Tribune - Condition at GMCH fast deteriorating, 16 March 2005
32 The Assam Tribune Report October 10, 2003
Ambulance was also not in working condition. The 30 bedded Rural Hospital was being run from the PHC with only 10-bed capacity. The Belshar State Hospital in the Nalbari District was converted into a CRPF camp. In the same district, the North Dharampur PHC was running with no doctor. Later on, a doctor from the nearby Chamata PHC was appointed in a temporary basis. The doctor, however, goes back to Chamata at night. The present Health Minister of Assam Dr. Bhumidhar Barman belongs to this district. It was reported that in Kawoimary 30 bedded Rural Hospital, no doctor stays at night. Earlier some doctors used to stay in the doctor's Quarter. However, they were often threatened by the attendants of the patients due to the lapses in the hospital. The doctors, in the pretext of personal security, no longer stay in the hospital premises at night. In Kharmuja PHC of the Goalpara district there is only one Ayurvedic doctor. In Ambari State Hospital in the same district there is no doctor and one is there in deputation from the nearby Bagowan PHC. Krishnai State Hospital in Goalpara District covers 52,000 populations and daily turnover of patients is around 300. There are only two doctors and one pharmacist. Not even minimum facilities like band-aid and cotton or essential medicine are available. Saline, supplied for free treatment is being sold out at Rs.20. The caption for a Report on the devastating condition of the 200 bedded Civil Hospital in Goalpara, as it appeared in Asomiya Pratidin, states: “If you want to experiment what the hell is, come and see Goalpara Civil Hospital”. The medicine supplied to the hospital can fulfill only the requirement of 10 days of a month. Sarukshetri 30 Bedded Rural Hospital, inaugurated in 1994, is yet to open the indoor department. Although required number of doctors is 5, only three were posted and there is not even proper provision of Birth and Death registration.

Although, the reports are not substantiated by comprehensive investigation, however, there is a coherent link among the reports. All the reports reflect the erosion of the public health care system in the state. On the other, the negative fallouts of the neo-liberal policies in the health sector are also explicit through these reports.

5.9 Proposed Paramedics for Rural Health Care: An Unwarranted Move?
The State Government of Assam has virtually acknowledged its failure to regulate its health personnel, particularly MBBS doctors who have persistently opposed to serve
the rural population. The Chief Minister of the state, Tarun Gogoi said: "No MBBS doctor wants to go to the rural areas despite the fact that there are a large number of vacancies in medical centers there."\(^\text{34}\) Acknowledging the helpless situation of the government, the Chief Minister alleged that government doctors prefer to stay in Guwahati and the main reason behind has been the proliferation of private nursing homes in the city that offer lucrative opportunities for the doctors. "They are even willing to be suspended as long as they can stay on in the cities."

Amidst these severe difficulties faced by the Government, the Chief Minister unveiled the new scheme of three-year paramedics training course with the aim of providing health services to the rural population in the city. The Chief Minister informed that the new three-year paramedics course will be launched in September 2005 and the first batch of 100 paramedics would be ready in the next three years. In the meantime, the Government will introduce mobile medicals vans as a stopgap arrangement through which doctors would be induced to visit rural areas for short duration to provide semblance of medical care.\(^\text{35}\)

However, this new initiative by the government is not in conformity with the existing norms of medical practices. Critics have pointed out that government approach is fundamentally flawed. "Such a measure would only neglect the rural people. Why they be served by people who would not possess the essential qualification? Nowadays even six years of medical education is not considered enough."

On the other, the Medical Council of India (MCI) does not allow an unregistered medical professional to practice allopathic medicine. The three-year paramedic courses are not entitled to registration as per MCI norms.\(^\text{36}\)

5.10 Consolidation of Private Health Care Institutions
As stated, Assam witnessed a proliferation of private health care institutions, particularly since late 1980s. As per information provided by the State Health Minister in the State Assembly, till January 2005 120 Nursing Homes were registered as per the provision of the Assam Health Establishment Act, 1993. However, many


\(^{35}\) Ibid p 1.

private Nursing Homes are yet to be registered. As per 2003 information, provided by the Directorate of Health and Family Welfare, the District wise distribution of private hospitals is as below.

Table 5.12- Number of Private Nursing Homes; Private Diagnostic Centres/Clinical laboratories in different districts in Assam

<table>
<thead>
<tr>
<th>Name of the District</th>
<th>Number of Private Nursing Homes</th>
<th>Number of Private Diagnostic Centres/Clinical laboratories</th>
<th>Physiotherapy centre</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kamrup</td>
<td>53</td>
<td>60</td>
<td></td>
</tr>
<tr>
<td>Dibrugarh</td>
<td>14</td>
<td>33</td>
<td></td>
</tr>
<tr>
<td>Cachar</td>
<td>15</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>Karbi Anglong</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Tinsukia</td>
<td>15</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>Goalpara</td>
<td>2</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Sibsagar</td>
<td>5</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>Kokrajhar</td>
<td>0</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>Dhubri</td>
<td>0</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>Nagaon</td>
<td>5</td>
<td>25</td>
<td>2</td>
</tr>
<tr>
<td>Marigaon</td>
<td>1</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>Lakhimpur</td>
<td>3</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>N C Hills</td>
<td>0</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Karimganj</td>
<td>2</td>
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Source: List of Nursing Homes/Clinical laboratories/X-Ray Centres, Directorate of Health & FW, Govt. of India, 2003.

Guwahati- the capital city of the State of Assam emerged as the centre of this private health care system. Out of the total 145 private hospitals applied for registration till 2003 under the Health Establishment Act 1993, 49 are located in Guwahati City. The numbers have increased to around 60 by now. Besides, the leading private hospitals—both multi-specialty and super-specialty are located in Guwahati City. The best health personnel and sophisticated health care equipments have also concentrated in Guwahati City.
In the backdrop of the erosion of the public health care system, some private health establishments have launched mega projects of integrated health care system in Assam. For example, GNRC, of late, launched a project of a three tier integrated health care system in Assam. It proposes to establish a GNRC Community Health Centres in all parts of Assam for every 50,000 population with 7-9 specialized doctors and primary investigation facilities. A few centres have already come up in lower Assam. The proposed initial investment for such a centre in Rs. 75 lakh. For every 15,000 population, GNRC proposes a 500 bedded Multi Specialized Community Hospital with 35 crores of initial investment. A Community Hospital is under construction and will start functioning very shortly. The Centre in Guwahati will provide the tertiary care. If the Project could be implemented as per plan, GNRC will run almost a parallel health care system in Assam with that of the Government. GNRC has also been running a health insurance scheme for critical care named Friends of GNRC with three categories of membership: Silver Membership, Gold Membership and Diamond Membership. 37

The proliferation of private health care institutes in Assam appears to have contributed towards the improvement and enlargement of the health care status in Assam. As far as facilitation part is concerned, certainly, this proliferation has positive contributions. But, due to the absence of a proper accreditation system, this proliferation brings into force multiple points of victimization for a larger majority through non-uniform and unreasonable charges; nexus between the doctors, private laboratories and drugs manufacturing companies etc. Under-utilization and mis-utilization of the public health care institutions for vested interests have also been another negative outcome of this proliferation.

5.11 The Issue of Accreditation
The issue of proper accreditation is of paramount importance, particularly in this age of consolidation of private health care institutions as well as growing unhealthy nexus between the private healthcare establishment and that of public health personnel. Consolidation of sophisticated technology mostly under the auspices of the private

37 Based on personal Interaction with the Administrative Officials of GNRC, 2003
health care establishments, and their excess use for accumulating profit invites more comprehensive accreditation, evaluation and monitoring mechanisms.

Proper accreditation has been a serious problem, not only in Assam but almost all states in India. Nandraj and Khot (2003) pointed out that in most of the states of India, there is an absence of legislation for regulating private health care facilities, laboratories and various types of health centres nor have standards of medical practice been prescribed in terms of qualification of staff employed, equipment needed, administration or treatment offered. Attempts at enacting legislation for clinical establishments have not succeeded in face of opposition from health care providers and their associations. Hence, factors contributing to poor quality of care in private hospitals include lack of monitoring by statutory authorities; outdated and inadequate legislation; and the inability or failure of the government to enforce existing legislation.38

In Assam, despite the proliferation of private health care institutions- both nursing and clinical laboratories- the Government has failed either to bring out a comprehensive legislation or to implement the existing one. In 1993, the Government of Assam came out with a legislation titled The Assam Health Establishments Act 1993 “to regulate the health establishment to provide better provision with respect to medical health care of the people through these health establishments and for matters connected therewith incidental thereto.”39 In 1995, the Government of Assam laid down the Assam Health Establishment Rules. The Health Establishment Act lays down the definition of various concepts related to health service like Health Authority; Licensing Authority, Maternity Home; Physical Therapy Establishment; Medical Practitioner; etc. and clearly states that “No person shall establish or maintain a health establishment without being registered in respect thereof and except under and in accordance with the terms of a licensing granted thereof.” 40. The Act proposed to establish a State Health Authority constituted by Nine Members- all associated with


39 The Assam Health Establishment 1993 and The Assam Health Establishment Rules 1995 p 2

40 Ibid p 4
medical service/department and no social activist or people's representative. The Act, under section 10 lays down the criteria to be fulfilled for obtaining a license to open a health establishment and Section 9 (2) clearly mentioned: "The Health Authority, if satisfied that the applicant and the health establishment fulfill conditions specified under section 10 shall register the applicant in respect of such health establishment and shall grant him a license thereof and the registration of the license shall be valid for a period of:

(a) 5 years in case of nursing home, Hospital, maternity home and Research Institute;
(b) 3 years in case of clinical laboratory, physiotherapy establishment.\(^{41}\)

The Office of the Registrar for this Health Establishment was created by the Assam Health Establishment Rules 1995 enjoying the status of Additional Director, whose responsibilities have been outlined under Section 2 of the Rules. Section 2 states: The Register shall be responsible to place the applications received for registration before the Health Authority and communicate the decision thereof to the applicant in conformity with provisions of rules:

(i) He shall issue licenses to the Health Establishments as approved by the Health Authority;
(j) He shall maintain the Register of the Health Establishments;
(k) He shall keep vigil over the renewal of licenses;
(l) He shall collect reports from the districts and apprise the Health Authority and Government time to time;

Under Section 5 (3) The Registrar was expected to prepare and publish the first list of Health Establishments in the State as early as possible, but latest within six months from the date of taking effect of the Assam Health Establishment Rules through the official Gazette. On the other, under Section 5 (4) the Registrar is expected to notify

\(^{41}\) Ibid p 6
from time to time the addition or removal of the names of Health Establishments in
the State.42

The Assam Health Establishment rules lays down the conditions of License; requirements regarding the Location and surroundings; Requirements of Special Equipments etc. Every Health Establishment, apart from maintaining a comprehensive register of all cases treated, has to submit a Monthly Report to the Health Authority giving details of no of patients treated, name of the diseases and no of cases diagnosed etc. Under conditions of license, it is also necessary on the part of every health establishment to display charts showing different charges, chargeable under different captions etc.

The Act has several flaws within. Although, the objective of the Act has been to ensure quality health care, various important issues have not been dealt with. For example, there is no provision in regard to the charges to be enforced by the respective health care establishments. It has been left entirely into the discretion of the respective health care establishments. Besides, the danger of excess use of technology solely for acquiring profit has not been addressed. The issue of poverty has been ignored i.e. if a patient belongs to BPL category will he/she will be provided any concession etc. has not been dealt with. Although, it is believed that the private health care establishments are transparent and competitive in nature- however, in practice that is not happening. No clear-cut measure from using public health care personnel in private health care establishment has been dealt with. It has talked about private health care establishments, but not about private health care practitioners, their norms and rules etc.

Composition of Heath Authority is also far away from democratic requirements. No people’s representative or experts on environmental, pollution control, social sciences etc. have been accommodated. No representative from the Private Health Establishment has been co-opted.

42 Ibid p 17
Apart from the flaws of the Act and Rules, the existing one itself has not been adequately implemented. The Office of Registrar of Health Establishment itself is not running properly and most of the time without a full-fledged registrar.

The quality assurance dimension - which is a core objective of the Health Establishment Act, 1993 - is far away from satisfactory both in public and private health establishments. Right to information is very miserably enforced. Updating the clients about the developments and complexities in treatment is not considered as responsibility by the health establishments. At many instances, both the patients as well as the attendants pass through a state of insecurity due to the insensitive, and at times inhuman approach by the health practitioners both in the public as well private health establishments.

5.12 Unsafe Drugs

It has already been pointed out that vulnerability of people's right to health care has been intensified more with people's growing inaccessibility to essential drugs brought about by the changing drug control policies in India. Adoption of the Patent (Amendment) Act, 2005 has added new magnitude to this problem. Proliferation of unsafe drugs is another danger involved in this context.

Health security in the State has assumed a dangerous turn with the unbridled movement and selling of sub standard and spurious drugs in the market. The Government of India, in accordance with the Interim Report of Mashelkar Committee, is proposing to bring a legislation to increase the punishment from life sentence to death sentence for those who manufacture or sell spurious drugs, which caused death or grievous injuries. Unfortunately, the health authorities in Assam appear to have shown no serious concern on this issue. In fact, the State of Assam as well as the North Eastern region today is a "victim Zone" of substandard and spurious drugs. In the State of Mizoram alone, at least 124 people, including 11 women died due to the abuse of drugs during 2003, as reported by the State Excise Department Officials. Out of these, 122 people died due to the abuse of Spasmo Proxyvon - a painkiller and the other two died due to the dreaded heroin. Opening up of the boundaries for
transnational movement of goods and commodities has, however, intensified this problem.

Recently in Assam, the Bureau of Investigation of Economic Offences (BIEO) launched a drive to detect spurious medicine after receiving a report from the Chief Vigilance Commissioner, Assam and carried out raids in the godowns of whole seller markets and pharmacies in different parts of Assam. BIEO sources revealed that 48 items seized from a few whole sellers of medicine located in Guwahati, were sent for laboratory test in the Central Drugs Testing Laboratory, Kolkata. Out of 32 samples tested so far, 15 were found to be "not of standard". The medicines found to be substandard include Amcil 125 tablets, Oxytocin injection, Diclofenac injection, Diclo-M tablets, Vitamin A and D Capsules, Gentina Eye drops, Gentamicin injection etc. The companies, which manufactured these medicines, are based in places like Delhi, Ahmedabad, Indore, Himachal Pradesh etc.

BIEO also seized a truckload of medicines, which were being sold in rural areas in Assam without any license, which included medicines smuggled from Bangladesh. The seized drugs/medicines also includes ‘Sukhi Family planning’ tablets, manufactured in Germany and distributed in Bangladesh free of cost by the World Health Organisation. "But this can be only a tip of the iceberg as thousand of different kinds of medicines are available in the market and it is not possible for the BIEO or any such organisation to arrange for testing all the samples".

The Regional Drug Testing Laboratory, located in Guwahati, which was taken over by the central government in 2003, is fully equipped to test any kind of medicine apart from vaccines. It can test 600 samples a year at the most with the existing staff. Interesting point to be noted is that, the laboratory is meant for the whole region but Guwahati alone has thousands of pharmacies and hundreds of whole sellers of medicine. According to the records available, the Laboratory received 767 samples in the year 2003, out of which, 450 were tested and 37 of those were found to be substandard. In the year 2000, the laboratory tested 364 samples and 47 of those were

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substandard, while two were spurious. In the year 2001-02, the laboratory found 40 substandard and three spurious samples, while in the next financial year, 37 substandard samples were detected.

However, the laboratory tests only those samples sent to it by the Drug Controllers of the North Eastern States after the Drugs Inspectors collected the same. The laboratory cannot go around and collect the samples and test the same. There is an apprehension around that the Drugs Inspectors themselves act in connivance with the manufacturers and distributors of substandard and spurious drugs. They do not collect samples but select genuine ones to send the same for testing in the laboratory. In such circumstances the test result is bound to be relatively positive, as it is happening in case of Regional Drug Testing Laboratory in Guwahati. So, the Laboratory sources clearly states “the test reports of the laboratory can not give a clear picture of the drug scene in the region”.

5.13 The Proposed Mass Insurance Scheme
Current generation of health reforms argue that the increase in health care expenditure as well many other related problems will be taken care of by the health insurance regime. The utility of health insurance cannot be denied. But it has its own limitation both in terms of actual coverage as well as conditionalities imposed on the real insurance benefits. It has been mentioned elsewhere that the present status of health insurance in India is as low as around 11% only. The new initiatives like Universal Health Insurance Scheme (UHIS) and the Unorganized Sector Worker’s Social Security Scheme (SIS) have yet to evoke adequate response from the people.

Apart from the all India initiatives, the state of Assam has also witnessed some initiatives both in the public as well as private domains. The Chief Minister of Assam Mr. Tarun Gogoi, on First of January 2005, unveiled a Mass Insurance Scheme – Jivan Jyoti Bima Anchani- for the entire population of the State. It has also been claimed that Assam is the first State in the country to adopt such a universal scheme. Under this scheme, the insurance policy would cover every person with his/her name on the electoral roll, as well as their dependents, against any eventuality like accident, diasater, disease etc. The amount insured will be Rs. 25,00 for injury and Rs. 50,000 in case of death. The insurance also includes a 30-day stay at hospital for select
diseases. The Chief Minister also informed that the Government of Assam initially would bear a cost of Rs. 20 crore, which may go up in the future. Regarding the modus operandi of the scheme, the Chief Minister informed that the insurance company would be selected from amongst the lowest bidders after calling tenders for the purpose. Along with the scheme, the Chief Minister also declared that the health and education would be given top priority in the New Year with an objective to improve the status of the Below Poverty Line (BPL) families in the State.\(^{44}\)

The details of the scheme are yet to be declared. Although, the intention of the scheme is well appreciated, however, the scheme is populist by nature. It also reveals the tactic of the government to run away from the crucial responsibilities of the Government. As stated, the real state of the public health care system is very pathetic. The accreditation mechanism is very weak. The Assam Health Establishment Act is yet to be implemented properly. The Patent (Third Amendment) Act will have huge negative fallouts for the common people. The health care reimbursement system itself is very weak and corrupt in the state. Need of the hour is to address these issues seriously along with strengthening the public health care system. Recourse to Mass Insurance Scheme might bring some relief to the common people. But it cannot bring solution to the huge problems that the Health care system in the state is facing today.

5.14 Private Health Cards/Schemes etc.

Some Private Health Establishments in Assam have also come up with different health Insurance/card schemes. Down Town Hospital is currently operating a scheme known as *Master Health Check Up* with different economic packages targeting different economic categories. There are five different forms of health check up. These are: Economy Health Check Up; Executive Health Check Up; Executive Health Check Up for Female; Master Health Check Up and Week-end Master Health Check Up. The rates are different for all categories of check up and certain percent of discount is given for all categories of health check up. There are around 10 common tests for all categories but for costly packages extensive tests are offered. The very

common tests are Blood (Routine) Examination; Lipid Profile; Liver Function test; Blood Sugar; Uric Acid; ECG; Chest X-Ray etc.

Gauhati Neurological Research Centre (GNRC) has also come up with a health insurance scheme named *Friends of GNRC* with three different types of membership: Silver membership; Gold Membership and Diamond Membership. All those health insurance membership can be availed by a group of individuals- minimum by 2 and maximum 7 members. The yearly premium for two members in case of Silver membership is Rs 3000 i.e. per head Rs 1,500/ whereas for seven members it is Rs. 7000/ i.e. per head Rs. 1000/. In case of Diamond membership the yearly premium for two members is Rs. 6000/ i.e. per head Rs 3000/ whereas for seven members the yearly premium is Rs. 14000/ i.e. Rs 2000/ per head. GNRC provides free or treatment at concession to its policyholders for different diseases, particularly accidental, cardio, neuro and critical diseases.

The critical issues arising out of these cards or initiatives will be specifically highlighted in the following chapter.

To sum up, virtual collapse and growing negligence towards the public health care system in Assam, particularly in the rural areas, acted as push factors and the concentration of private health care establishments, high technology and qualified health personnel in Guwahati City acted as the pull factor towards the huge inflow of patients to Guwahati City.

It is against this background that the next chapter will investigate the state of right to health care in Guwahati City.