CHAPTER 4

Tracing the causes of the Growth of Private Health care.

CHAPTER ABSTRACT:

This chapter intends to focus on the causes responsible for the growth and transformation of Private Health Care sector in Kolkata. On the basis of oral history, an attempt was made to weave the story behind the growth of nursing homes in Kolkata. The poor health and health care conditions in India and West Bengal as a whole had been narrated, in order to justify that the degeneration of the public health care services is also one of the significant factors behind the growth and development of private health care. The retreat of the welfare state under the global forces and its subsequent effect on social sector (especially on health care) is another major cause for the rise of private health care. This chapter also focuses how global compulsion played a pivotal role in transforming health care to a commodity in the post reform era. The corportisation of health services played a crucial role in converting it to a lucrative industry.

Introduction.

In the previous chapter an attempt was made to trace the 'rise and fall' of the small nursing homes and the emergence of the private hospitals in post Independence Kolkata. This chapter intends to look into the factors or the causes responsible for the growth of private health care sector in Kolkata and the successive changing pattern (transforming it to a lucrative industry) which this sector in particular had undergone. As we have classified the growth of the private health sector in three distinct phases, (See Chapter 1, P 12), hence the causes responsible for the transformation of this sector should be studied in three separate sections. In Section A, the causes behind growth of the small nursing homes in a newly independent city will be discussed. Section B will try to locate the retreat of the welfare state and its consequent impact on the health sector, with special emphasis on the degeneration of public health and

health care conditions of Kolkata. The global compulsion of more drive towards infusing corporate capital in health care, the changing socio-economic scenario and the Structural Adjustment Programme (SAP), converting health care to an industry will be discussed in Section C.

Section A:

Emergence of the small nursing homes in Kolkata after Independence is a separate phenomenon which has no linkages with the general trend of the growth of the private health care that surfaced from the late 70's.

The reasons behind the growth of nursing homes in Kolkata are numerous. Since there is a dearth of proper literary sources highlighting the scenario of private health care in Kolkata and the causes behind its rise, hence to identify the reasons, we shall base our arguments on the basis of the interviews, more precisely on oral history. Long conversations with the senior doctors and health activists who had visualized the health care scenario in the era following Independence has been taken into account in order to study the conditions that gave rise to the small nursing homes in Kolkata.

According to Mr Amal Bose[1], the causes for the mushrooming of small nursing homes in Kolkata are many. The decade of 1947 -1957 was a period of transition when the British model was predominant in health care structure. Colonial hangover was present in almost all aspects of life. He recollects that during this phase, in the northern parts of Kolkata few nursing homes came up having the infra structures of maternity homes. These were old fashioned nursing homes where the Anglo Indian community took admissions for treatment. These categories of nursing homes were very small in number and sometimes they were also founded by the missionaries who wanted to serve the community. Moreover, some nursing homes were also established by junior doctors who were trained in abroad. These doctors after their return to India set up nursing homes on the model of British health care institutes. In those days, the doctors were mostly appointed in public hospitals, but simultaneously they could also practice privately and set up nursing homes under their own supervision to expand their practice.

[1] Health Activist. Interviewed on 08.052006.

Between 1957-1967, there was large scale urbanization and industrialization in Kolkata and in the peripheral areas.[2] This led to the increasing population inflow in the city. Both the process of urbanization and industrialization brought about different kinds of diseases. The public hospitals were already saturated with their patients and the need for more health care organizations in this period gave rise to the nursing homes.

Mr Bose also points out that the period between 1967-1977 witnessed the political turmoil insurgencies especially the Naxalite Movement. The victims of the movement and the injured naxals were most often denied admission in the public hospitals. Number of small nursing homes mushroomed during this period in different corners of the city as an alternative place for the treatment.

There was the large-scale development of the nursing homes between 1977-1987 when the Metro Transit System had linked up the several corners of the city. Population inflow in and around the peripheral areas of the city and the rise of varied occupational groups along with their need for better health care posed a threat to the existing health care system. The degeneration of the public hospitals had already set in and the private health care mostly in the form of nursing homes and private hospitals had surfaced to satisfy the needs of the population at large.

Mr Amal Bose has wonderfully crafted the story behind the transformation of Kolkata from newly independent city to globalised metropolis during 1987-1997. New modes of urbanization like building up highways and flyovers, utilizing the unused spaces of the city for constructing residential complex and investing private capital in every sphere characterized this phase. Increasing connectivity of the city boosted up the population inflow and simultaneously generated the demand for the sanitized space in health care. Thus Bose feels that in the later part of the 20th century the private health care no longer signified the small nursing homes. Their places were taken up by big corporate hospitals. He also mentions that the reduction in the size of the family members increased the loss of tolerance and man power. In the extended family

[2] See Bagchi, Amiya, Kumar. 'Studies on the Economy of West Bengal since Independence', Bhattacharya,Basabi. ' Urbanisation and Human Development in West Bengal: A District Level Study and Comparison with Inter –state Variation',Giri, Pabitra. ' Urbanisation in West Bengal, 1951-1991'. *Economic and Political Weekly*. 21st November, 1998.

structure, there is lack of man power to look after the hassles of the treatment in public hospitals. This is one of the reasons which increased the demand for the rise of private health care sector which provide services and treatment at the cost of money.

Prof Ranjit Sen[3], one of the renowned historians of Kolkata, has also expressed his views about the pattern of the private health care sector. He has magnificently depicted the scenario which gave birth to the small nursing homes in Kolkata. In the decades of 1940's, 50's and 60's people did not move to nursing homes for treatment. The effective demand for the establishment of nursing homes was not predominant during these decades. He recollects that till then RG Kar, Calcutta Medical College and PG Hospitals served the population of Kolkata at large. However Nilratan and National Medical College were not so popular. They mainly served the East Kolkata population. Sealdah Railway Station was crowded by the refugees and the middle class Bengali patients. Nilratan generally served the patients from north suburban areas and the National Medical College was utilized by the patients of south suburban areas. Park Circus Railway Station acted as a communication halt for the south suburban masses. As a result people from these areas never go to PG or RG Kar for treatment. Prof Sen also mentions that in the later part of the 1940's there was the Lake Camp Hospital. It mainly served the American army and the better to do sections of the population of south Kolkata (Rashbehari Avenue, Chetla and New Alipore). Doctors of Lake Camp Hospital also practiced in National Medical College, PG and Medical College. As a result there was a resurgence of doctors in the public sector. He recollects that in 1959, his father Late Sri Pabitra Sen (a retired meteorologist from Government of India) was suffering from a perforated ulcer. However this critical case was treated in PG where a medical board was set up under Dr Lalit Bannerjii and Dr Anjali Chatterjii – (women physician) to look after the case. This was indeed a significant phenomena that women physician gaining the status and sitting in the same position with male physicians. Prof Sen narrated this case, in order to ensure that, even in late 50's and early 1960's, no plethora of doctors could even imagine of serving in the private sector. He also tried to establish the fact even in those decades government hospitals were the best place for treating complicated cases.

[3] Professor of Islamic History and Culture. University of Calcutta.Interviwed on 20.08.2007

Society had to wait a decade more to witness the mushrooming of small nursing homes in Kolkata. Prof Sen correctly feels that from mid 1960's onwards the trend of going abroad either for higher education or for employment opportunities increased greatly. This resulted in the inflow of capital in the city, since the people who went overseas with jobs often sent remittances at home Nevertheless, in the southern parts of Kolkata, there was the emergence of the noveriche who were comparatively affluent, enlightened and aware of the health care situation in the public hospitals. Mention should be made that the degeneration of the public hospitals had already surfaced from this period onwards. Moreover the huge refugees (often affected with diseases) in the areas of Baghajatin, Bijoygarh and Jadavpur were also an additional threat to the infrastructure of the public hospitals in Kolkata. Educated families with solvency, no longer wanted their relatives to get admitted and lie in the congested beds of the Government hospitals. Too much pressure of patients accelerated the process of deterioration of the quality of the government hospitals in the city. Thus there was the increasing need for the proper health care organizations where the affluent section of the society can segregate them and avail better treatment.

Against this backdrop, Prof Sen has pointed out another significant factor responsible for the growth of nursing homes in Kolkata. He feels that during this time women were getting higher education and coming out in large numbers for employment. This trend was mostly popular in south Kolkata where the women of the educated middle class families wanted to get themselves delivered either in Ramakrishna Mission or in Matri Sadan near Tollygaunge Railway Bridge in Sri Mohan Lane. From this time onwards gynaecological complications increased, since women are now increasingly coming out to the public spheres from their sheltered life. They were unused to the stress and tension of the outside world. Demand for female doctors increased and this period witnessed the emergence of small nursing homes which mainly served as the maternity homes. Moreover Ramakrishna Mission or in Matri Sadan was already overpressurized with the loads of patients. There was the obvious demand for more private health care institutions. Apart from these factors, Sen also mentioned that due to World War II and partition of the country, ruthlessness among the people increased and deformed children grew up. As a result young educated women were afraid and the predilection was to get themselves delivered at a place where along with better

treatment, modern and updated technologies are being used. So the mushrooming of private nursing homes in large-scale in different corners of Kolkata during this phase was also to some extent need based.

Sen keeps on mentioning that the knowledge of the new generation of doctors returning from UK or US, trained in new medical technologies found the infra structure of public hospitals extremely unsuitable for their practice. Moreover all the posts were saturated by senior physicians and the procedure of new recruitment and transfer were characterized by unhealthy politics and nepotism. The salaries in the government hospitals were also poor. As a result these new generation doctors had also established nursing homes under their own supervision and created atmosphere where they can practice and implement their new knowledge of medicine. In addition to this, the bank financing started in a nascent way from late 60's onwards. As a result privately managed institutions started to grow up and nursing homes were also established after taking loans from the banks.

With the gradual degeneration of the public hospitals, the middle class slowly moved away from public hospitals and shifted to nursing homes. This also increased the substantial demand for the setting up of general nursing homes in the city.

Stalwart physicians in government hospitals also failed to create their replacements in the new generations. This resulted in a vacuum in generating quality doctors in the public hospitals. Absorption of good doctors by the private nursing homes and hospitals (later half of the 80's) thus increased the popularity of the private health care establishments.

The emergence of a series of private hospitals in western parts of Kolkata also needs mentioning. According to Sen, the BudgeBudge, BataNagar, Metiabruz and the Khidderpore areas are being mostly dominated by the Muslim population. On the other hand, the Alipore and the New Alipore areas are inhabited by the upper middle class sections of the society. Woodlands and Belle Vue were their only places of treatment. But with the increasing population pressure, the need for private hospitals increased in this region. Moreover the Muslims of these regions were no longer satisfied with the treatment in the PG Hospital. Muslim community needed a hospital

where they can go easily. This opportunity was taken up by the Kotharis and Birlas. Thus from late 70's onwards there was the growth of Kothari, BM Birla and CMRI.

Prof Sen illustrates that the onslaught of lifestyle diseases generated the need for specialized departments in private health care institutions. Till the 1980's the cardiac care units were not present in private sector. BM Birla was the first private health care institute which chiefly developed the specialized cardiac care units.

Dr. Sudhir Ghosh [4] has pointed out that from late 60's onwards the services of the public hospitals had already started deteriorating due to excessive population pressure. In the initial stage private health care sector were identical with only maternity homes and small nursing homes where gynecological cases and minor surgeries were undertaken. For complicated diseases and surgeries people still utilized the services of the public hospitals. However in course of time general nursing homes also emerged in Kolkata. The city had to wait for two more decades to witness the growth of private and corporate hospitals in Kolkata. Dr Ghosh feels that the small nursing homes were for those people who were on the one hand unable to cope up with the unsatisfactory services of the public hospitals and on the other can not afford to admit their patients in BelleVue and Woodlands. To serve these people, nursing homes came up in Kolkata.

The above discussion illuminates some insights on the factors and the conditions that gave birth to the nursing homes in Kolkata. As has been mentioned earlier, private health care sector in this phase was equivalent to small nursing homes whose growth shall not be studied within the broad framework of the emergence of the private health care sector linked to globalisation. Based on oral history (mainly interviews), it can be inferred that the nursing homes of these decades were the outcome of the independent initiatives of medical practitioners. The socio economic changes in Kolkata and to some extent the poor conditions of the public hospitals provided the platform for the rise of nursing homes. But mention should be made that the growth of the nursing homes in this phase was not a response to the failure of the public health care infrastructure. It was not even the answer

[4] Dr Sudhir Ghosh is the founder and owner of Dreamland Nursing Home. He was interviewed on 31.07.2007

to the shrinking responsibilities of the welfare state which is promoting private health care sector to gain a solid footing. The rise of private health care sector in this span of time was a separate and unique phenomena, which occupied substantial physical presence in a newly independent city.

Section B:

Emergence (especially of the private hospitals) and the changing pattern of the private health care sector in Kolkata from late 70's onwards should be studied within the broad framework of incremental privatization that had surfaced as a result of the failure of the public health care sector. India, during this phase had adopted the move towards incremental privatization which includes self management, market liberalization /deregulation and withdrawal from state provision.[5]

The deterioration of the public hospitals and the public health had aggravated the crisis of health care not only in Kolkata or West Bengal or India, but the same scenario of degeneration is visible in almost all the developing and developed countries.[6] To historicize the root of the incremental privatization against the collapse of the public health care services, it should be mentioned at the outset, that after Independence up to 1970's, health services development exhibited a sharp growth. But this, infra structure undoubtedly benefited the needs of the upper and middle classes, the interests of the majority of the population were largely neglected.

Actions in health and other fields, in the first two decades of Independence, placed the country very high among the newly sovereign countries. The motive force generated by the leadership commitment and the experience gained by the health administrators from their work in the IMS (Indian Medical Service), enabled them to give concrete shape to the political vision of the rulers. This led to some far reaching developments

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5 Bennet, Sara,McPake, Barbara and Mills, Anne." The public/private mix debate in health care". In *Private Health Providers : In Developing Countries-Serving the Public Interest?.* Ed by Bennet, Sara,McPake, Barbara and Mills, Anne. London and New Jersey: Zed Books,1997.P 5

6 See Barnard, Keith and Lee, Keneth. Ed. *Conflicts in the National Health Service.* New York: Prodist, 1997, Higgins, Joan. *The Business of Medicine: The Private Health Care in Britain.* Printed in HongKong: Macmillan Education, 1988, Whiteis, David and Salmon, Waren J. 'The Proprietarization of Health Care and The Underdevelopment of the Public Sector.' *International Journal of the Health Services*. Vol 17, No 1, 1987, Rayner, Geoffrey. 'Lessons from America? Commercialization and Growth of Private Medicine in Britain.' *International Journal of the Health Services*. Vol 17, No 2, 1987,

in the health services. This period was termed as the Golden Two Decades in the Public Health in India. Some of the landmarks requiring mention were : vertical programs, primary health centres, social orientation of medical education, indigenous systems of medicine, Family Planning/ Welfare Programme, water supply and sanitation, nutrition, Minimum Needs Program, the Multi –Purpose Workers' Scheme, the Community Health Volunteers Scheme, and the Statement of National Policy.[7]

The political vision to establish a comprehensive health service system in the aftermath of Independence was unfortunately short-lived. Over the next three decades, there was sharp decline in the quality of health services in the country. The major forces contributing to this decline were:[8]

- Obsessive preoccupation with the Family Planning Programme at the cost of serious neglect of the health service needs of the people, particularly the poor.

- The imposition of so-called "international initiatives in health", during the last two decades, by a formidable of "development aid" agencies of many western countries and international organizations.

- The considerable involvement of Western countries in shaping social (including health), economic and political policies of the country in the form of pressures for privatization in the Structural Adjustment Program(SAP) from the late 80's onwards [9]

The year 1967 marked the beginning of a steep decline in the health services, culminating in the present state of its serious "sickness". An all-out effort to push forward the Family Planning Programme at all costs had a devastating impact on the wider provision of health services. The political leadership permitted bureaucrats to make the people "targets" of their own "democratic" government. Owing to the

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7 Bannerji, Debabar. "Landmarks in the Development of Health services in India. Published". In *Public Health and Poverty of Reforms* Ed by Quadeer, Imrana, Sen, Kasturi,. Nayar, K.R. New Delhi: Sage Publications, 2001. P 44. (Here after cited as Bannerji : Landmarks in the Development of Health Services.)

8 Ibid P 45

9 See Section C and Chapter 5,Section B.

overriding priority given to the family planning programme, plan allocations for it jumped a phenomenal 10,000 folds – from Rs 6.5 million in the First Plan (1950-1955) to Rs 65,000 million in the Eighth Plan (1991-1995).[10]

It has also been mentioned by Duggal [11] that India had a very large private health sector, especially for ambulatory healthcare services. This includes providers of modern medicine as well as traditional practitioners. Hospital services until the mid-`70s were predominantly in the public domain. Medical education was almost a public monopoly till the late eighties. The private sector grew rapidly post-`80s, but even today 75 per cent of outturn of medical graduates is from public medical schools.

The medical schools contributed significantly to the growth of the private sector since on an average 80 per cent of the medical graduates entered private practice or migrated abroad.

Post mid-70s, the State provided various incentives like concessional land, tax-breaks and duty exemptions for imports for setting up of private hospitals. The private pharmaceutical industry also received substantial State patronage for its growth through process patent laws, subsidized bulk drugs from public sector companies and protection from MNCs.[12]

While constitutionally the Indian State was committed to providing healthcare to its citizens via the Directive Principles of State Policy, provision of healthcare was not a fundamental right. Through the policy route various healthcare entitlements were created over the years like one primary health centre (PHC) per 30,000 population, one first level referral hospital per five PHCs and one civil hospital per district. But public commitments of resources for healthcare were minimal small and hence public healthcare has remained under-developed.

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10 Ibid P46, Also see Quadeer, Imrana. 'Continuities and Discontinuities in Public Health Indian Experience'. In *Maladies, Preventives and Curatives. Debates in Public Health Care*. Ed by Bagchi, Amiya and Soman, Krishna. Institute of Development Studies Kolkata :Tulika Books, 2005. P88(Hereafter cited as Quadeer : Continuities and Discontinuities)

11 Duggal, Ravi :Tracing the root of Private Health Care Sector. *Express HealthCare Management*, Issue dt 1st-15th Apri 2004,. http://www. expresshealthcaremanagement. com. Accessed on 28.12.2007. (hereafter cited as Duggal : *Private Health Care Sector)*

12 Ibid

During the `80s, the public health spending peaked and this was reflected in major health infrastructure expansion in rural India via the Minimum Needs Programme. In fact, the entitlements mentioned above were achieved during the '80s in most states. However, in the `90s, the public health sector was woefully neglected with new public investments being virtually stopped and expenditures declined.[13]

In this context the changing role of the welfare state should be pointed out. Since, the decline of the public health and subsequent health care (contributing the growth of the private health sector) is closely linked up with the 'retreat of the welfare state'.

The health status of the population in developing countries is well below that in the industrial countries and the distributions as well as the quality of health care in developing countries leave much to be desired. It is well known that the scarcity of resources for health care in developing countries is a primary cause of this state of affairs.[14]

The cutting back of public expenditure and selective state intervention made the greater role of the market obvious in curative health care. Until the late 1970's, nationalized system for providing welfare services arose across both developed and developing countries.[15] Developing countries in Africa, Asia and Latin America managed to build national health service systems with their meager resources. With oil shock of the late 1970's both developed and developing countries started to feel the fiscal crunch, and in many countries a cutback in welfare spending was seen as measure to deal with the situation. As a result most developing countries had to cutback even their minimal spending on welfare and this had an adverse impact on the growth of service. [16]

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13 Ibid

14 Gertler,Paul and Gaag, Van der Jacques, *Willingness to pay: Evidence from Two Developing Countries*. Washington D.C: World Bank Publication, 1990. P 1(Hereafter cited as Gertler and Jacques : *Willingness to pay*)

15 Twaddle, A, "Health Systems Reforms – Toward a framework for International Comparisons." *Social Science and Medicine,* 1996 43(5): 637-54. In Baru, Rama V. "Health Sector Reform: The Indian Experience". In *Health Care Reform Around the World*. Ed by Twaddle, Andrew C. Connecticut:Auburn House, 2002. P 267.(Hereafter cited as Baru : Health Sector Reform)

16 Gough, I, *The Political Economy of the Welfare State*. 1996.London :Macmillan and Twaddle, A. "Health Systems Reforms – Toward a framework for International Comparisons*." Social Science and Medicine,* 1996 43(5): 637-54. In Baru : Health Sector Reform P 267.

It was during this period that there was a reduction on spending on public services and a greater role for markets in providing welfare services. Studies of the private sector in several developing countries show that the world recession of the late 1970's had an adverse impact on the financing of the public services that resulted in the growth of markets in the welfare sector.[17]

In the same period, the private health sector, including the hospital sector, expanded rapidly on one hand, and on the other the public health system was being reformed to fit the private model through introduction of user charges and contracting out of services.

It is important to depict the miserable conditions of the public health and health care condition in India and West Bengal (especially the government hospitals in Kolkata), as this will not only establish the fact that the poor conditions of health and public health care acted as a catalyst behind the emergence of the private health care, but also project how the welfare state had completely failed to provide proper health and health care facilities to its population.

Following Gertler and Jacques, it is pertinent to point out that the health status of the population is one of the most important factors in the process of economic development for at least two reasons. Firstly, as an indicator of economic development, it shows the success or failure of a country in providing for the most basic needs of its people (food, sanitary conditions, shelter, and so on). Secondly health – a form of human capital – is a factor in the further development of country. Health influences the supply and productivity of adults in the labor force. Economic developments are also shaped by the infant and child mortality rates. The health status of the population is also primary concern to the policymakers in developing and industrial countries. This concern is frequently manifested in heavy government involvement in the health care sector, ranging from the provision of public health insurance for selected groups to the constitutional right of every citizen to have access to free medical care.[18]

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[17] Baru, R V. *Private Health Care in India: Social Characteristics and Trends*. New Delhi: Sage Publications, 1998 and Price, M Explaining Trends in the Privatisation of Health Services in South Africa, *Health Policy and Planning*. 1989 4 (2): 50-62. In Baru : Health Sector Reform P 268,Also see Gertler and Jacques: *Willingness to Pay.* P 2.

[18] Gertler and Jacques: Willingness to Pay. P 5-6.

The vulnerability of public health and health care infra structure has been depicted on the basis of

- Objective perception comprising of governments reports, World Bank documents and occasional government confession in State Legislative Assembly Proceedings.

- Public Perception comprising of newspaper reports, articles in popular journals and articles.

Public Health Scenario in West Bengal.[19]

It has already been observed that in terms of the crude birth rate, the improvement in West Bengal has been more rapid than for the national average. In terms of relative ranking, West Bengal now has the seventh rank among major states for the crude birth rate as well as the total fertility rate, as indicated in Table 4.1. The crude death rate in West Bengal is much less as compared to the Indian average, indicating that the health system is more supportive in preventing death. It has also improved more rapidly in the recent past than the all-India indicator. Further, West Bengal ranks third in India with respect to infant mortality rates.[20]

Table 4.1: West Bengal's rank in all states for selected vital statistics.[21]

Indicator	West Bengal (India)	Highest Among major states	Lowest among major states	Rank among major states	Rank among all states.
Crude birth rate	22.7 (26.2)	33.0(UP)	17.9 (Kerala)	7	9
Crude Death Rate	8.3 (9.7)	12.9(Orissa)	6.0 (Kerala)	2	8

[19] Though the present study aims to focus on the conditions of Kolkata in particular, but the district wise data is unavailable. Therefore the public health situation of West Bengal is portrayed.

[20] *West Bengal Human Development Report*. 2004. Development and Planning Department. Government of West Bengal. 2004. (Hereafter cited as *West Bengal Human Development Report*) P 120

[21] Chakrabarty. Based on *NFHS 2* Major States :UP, MP, Bihar, Orissa, West Bengal, Tamil Nadu, Panjab, Maharashtra, Assam, Rajasthan, Gujarat, Haryana. 2003. In *West Bengal Human Development Report.* P 120.

Total Fertility Rate	2.49 (3.07)	4.31 (UP)	2.07 (Kerala)	7	9
Neonatal Mortality Rate	31.9 (43.4)	54.9(MP)	13.86(Kerala)	3	7
Infant Mortality Rate	48.7(67.6)	86.7(UP)	16.3(Kerala)	3	11

Since one of the basic parameters of assessing the health situation of any given population is the Infant Mortality Rate (IMR) it is worth considering this variable in more detail. The IMR of West Bengal, at 51 per thousand, is quite good by aggregate Indian standards. As expected, the IMR in urban areas is much lower than that in the rural areas, indicating better health support and also possibly better infant caring practices in urban areas.[22]

Even in terms of reduction over time, between the 1982-1992 periods and the 1992-2002 period West Bengal appears to have done much better than India as a whole, which clearly suggests a gradual improvement in health facilities over the years in the state.

The total IMR for rural areas also shows a reasonably good trend of decrease over the years. However, although the total IMR for urban areas is much less than that of the rural areas, the rate reduction in the urban IMR has not been steady. It has not decreased significantly in the last few years, indicating a possible stagnation in the reduction of IMR in urban areas though it is still better than the overall Indian average[23].

Table 4.2: Percent reduction of IMR in Urban and Rural West Bengal.[24]

	1994 - 1996	1996 – 1998
India	2.70%	0
West Bengal	11.29%	3.63%

[22] Ibid P 120
[23] Ibid P 121
[24] Chakrabarty. Using SRS (Sample Registration Survey) 2003. In *West Bengal Human Development Report.* P 122.

	1994 - 1996	1996 – 1998
Urban	15.38%	2.27%
Rural	9.37%	3.44

Though the scenario in infant mortality rates exhibit a positive indication of the health condition of West Bengal but the nutritional status in the state, especially among the women is miserable.

The data on nutrition overall indicate that the average level of nutrition in the state, and especially among women, is relatively low by several criteria. However, malnutrition among children lower than the national average, and severe malnutrition is also low, suggesting that distribution is better than in most other states.

The nutritional status of children in the age group of under-3 years is better in West Bengal, as compared to the all-India average for Weight for age (under nutrition) as well as Height for age (stunting). By these criteria, West Bengal also has a lower percentage of severely malnourished (< - 3SD) children (16.3%) as compared to the Indian average of 18%. West Bengal ranks sixth among the major states in India.[25]

The overall anaemia status of children in West Bengal is very poor. The state ranks as low as nineteenth among 25 states. The proportion of children with anaemia (78 per cent) is higher compared to the Indian average of 74 per cent. However, the proportion of children with severe anaemia is marginally lower, at 5.2 per cent compared to the national average of 5.4 per cent. Not surprisingly, the situation is worse in the rural areas, where as many as 82 per cent of children are estimated to have anaemia by the NFHS 1998-99, compared to a rate of 64 per cent in urban West Bengal and 60 per cent in Kolkata. Severe anaemia is also higher in rural West Bengal, at 5.3 per cent compared to 4.6 per cent in the urban areas and 0.7 per cent in Kolkata.[26] Such nutritional deficiencies among children have important negative effects in terms of the health and capability patterns of these future adults, so it is important to make this a focus of public intervention.

[25] Ibid P 125
[26] NFHS 2 West Bengal : 1998-1999. In *West Bengal Human Development Report.* P 125.

The nutritional status of women in West Bengal is a source of some concern, since it seems to be significantly worse than the national average. In a survey conducted by the National Nutrition Monitoring Bureau, West Bengal ranked eighth among 9 states in important variables such as chronic energy deficiency among women. In terms of the Body Mass Index (BMI) the state ranks as low as twenty fourth among 25 states of NFHS-2 survey. This indicates a very poor nutritional status of women in West Bengal. Clearly, there is a scope here for immediate target oriented intervention strategies to be planned.[27]

In case of anemia as well, (moderate and severe) West Bengal ranks as low as nineteenth in the NFHS -2 surveys. Compared with the national average of 52 per cent, 63 per cent of ever-married women in West Bengal were characterised as having iron-deficiency anemia in l998-99.[28] The state therefore ranks nineteenth among 25 states of India in terms of this variable. However, the proportion of such women with severe anemia, at 1.5 per cent, is marginally lower than the national average of 1.9 per cent. It is also substantially lower than in other richer states such as Tamil Nadu (3.9 per cent) and Maharashtra (2.9 per cent) whose overall proportion of women with anaemia is lower. This suggests lower but more equitable distribution of nutritional intake among women in West Bengal, than in many other states.[29]

Once again, rural women tend to be worse off in terms of anaemia, with 64 per cent of ever-married women in rural parts of the state with some anaemia, compared to 58 per cent in urban areas and 60 per cent in Kolkata. However, the incidence of severe anaemia shows the opposite pattern, being the lowest in the rural areas at 1.4 per cent, compared to 1.8 per cent in all urban areas and 2 per cent in Kolkata. This higher incidence of severe anaemia in Kolkata is worth noting, suggesting that there are proportionately more cases of extreme nutritional deficiency in the metropolis, which should be addressed through systematic policy intervention.

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27 Ibid P 126

28 NFHS 2 West Bengal : 1998-1999. In *West Bengal Human Development Report.* P 126.

29 Ibid P126

Rates of anaemia tend to be quite high all through life for girls and women in West Bengal.[30] Interestingly, anaemia among men in West Bengal is also significantly high; in fact severe anaemia was higher (at 7.2 per cent) among men above 60 years than among females of that age group (4.3 per cent), The highest rates of anaemia tend, to be found among women in the age groups 12-19 years and 19-45 years, which are also the age groups for which the gender gap" is greatest. While anaemia among children is not different across gender, girls tend to become more anaemia after puberty.[31]

Table 4.3 presents information on the morbidity profile of children in West Bengal. It is seen that the incidence of acute respiratory infection (ARI) is very high in the state, as compared to the all India figure. The rate of diarrhoeal diseases, by contrast, is very low.

Table 4.3: Incidence of selected diseases among children in West Bengal (Percentage of children suffering from).[32]

	ARI	**Fever**	**Any Diarrhoea**	**Diarrhoea with blood**	**% ARI taken to health facilities (Out of those who suffered)**
West Bengal	24.8	22.9	8.3	1.0	51.4
India	19.3	29.5	19.2	2.6	64.0
Rank of West Bengal	20th	8th	2nd	4th	8th

The data on morbidity among the general population (Table 4.4) indicate very high incidence of asthma and jaundice. These are diseases which are 'affected by the extent of atmospheric pollution and the availability of safe water and sanitation, so these are clear areas for public health intervention. Although the prevalence of malaria is

30 National Pilot Programme on Control of Micronutrient Malnutrition of the All India Institute of Hygiene and Public Health, Kolkata undertook a study which attempted to monitor the nutritional status of both male as well as females right from infancy up to the geriatric age of post 60 years in Bankura. In *West Bengal Human Development Report.* P 127.

31 Ibid P 127.

32 Chakrabarty. Using NFHS 2 India, 1998-1999. Note: Rank in ascending order in terms of incidence among 25 states. In *West Bengal Human Development Report.* P 130.

substantially lower than the all-India average, it is still high enough to require attention.

Table 4.4: Incidence of selected diseases among adults in West Bengal. (number of cases among 100000 populations in the previous 12 months)[33]

	Asthma		**Tuberculosis**		**Medically Treated tuberculosis**		**Jaundice**		**Malaria**	
	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban
West Bengal	2649	1966	600	390	476	370	1410	1225	4254	2168
India	2654	2410	537	357	330	170	3544	1892	1669	918
Rank of West Bengal	15	18	11	11	8	2	21	21	10	8

There are some diseases for which West Bengal appears to have much higher incidence than any other state. For example, 40 per cent of the reported cases of measles in India in 2001 were from West Bengal, even though the rate of measles immunization in West Bengal is higher than the all-India average.The state also has a higher than expected incidence of some diseases that can be prevented by timely vaccination, such as neonatal tetanus (21 per cent of all reported cases in India) and diphtheria (17 per cent of all reported cases).[34] This suggests that the preventive health delivery systems need to be strengthened, to ensure complete vaccination among the population. However, rates of leprosy, Kala azar and Japanese Encephalitis are less in West Bengal than the Indian average.

There is an increasing trend the incidence' of HIV - AIDS cases; from 204 reported cases in 1996 to 1331 cases in 2002, although West Bengal is not one of the more seriously affected states in this regard. Males in the age group: 15 to 44 appear to be

[33] Chakrabarty. Using NFHS 2 India, 1998-1999. Note: Rank in ascending order in terms of incidence among 25 states. In *West Bengal Human Development Report.* P 130.

[34] Annual Report 2002-2003, Ministry of Health and Family Welfare, Government of India. In *West Bengal Human Development Report.* P 131.

the-most at risk, which is broadly similar to the pattern elsewhere in India. Obviously the control of this disease requires the extension of specially targeted programmes.

Table 4.5 indicates the district wise burden of diseases in order to highlight the vulnerable areas of the state with respect to particular diseases. These data should of course be treated with caution, since it is clearly the case that those districts with better health infrastructure tend to record higher morbidity, and often people from other districts travel to these areas for treatment.

Table 4.5: District wise burden of communicable diseases.[35]

Diseases	**2001**	**2002**
Acute Diarrhoeal Diseases	Koch Behar, South 24 Pgs, Murshidabad	Murshidabad, South 24 Pgs, Koch Behar
Viral Hepatitis	Kolkata, Hugli, North 24 Pgs, Bardhaman, Jalpaiguri, Koch Bihar	Bardhaman, Kolkata, Jalpaiguri, Haora, Nadia
Malaria	Purulia, Jalpaiguri, Koch Behar	Jalpaiguri, Purulia, Koch Behar
Acute Respiratory Infection + Pneumonia	Koch Behar, Murshidabad, North 24 Pgs, Dakshin Dinajpur, Purulia	Koch Behar, Murshidabad, Bardhaman, North 24 Pgs, Dakshin Dinajpur. Purulia
Enteric Fiver	Purulia, North 24 Pgs, Murshidabad, Darjeeling	Purulia, Medinipur, Hoara, Malda. Darjeehng
Acute Poliomyellies		Murshidabad, Birbhum, Kolkata, South 24 Pgs, Haora, Malda, North 24 Pgs
Diptheria	Kolkata, Bardhaman, Murshidabad, Darjeeling	Kolkata, Darjeeling, Bardhaman
Tetanus Neonatal	Murshidabad, Birbhum, Malda, Purba Medinipur	Murshidabad, Bardhaman, Birbhum, Malda, Purba Medinipur
Japanese Encephalitis	Bardhaman,	Bardhaman, Kolkata, Haora

[35] Chakraborty. Based on Communicable Diseases : Jan – Dec 2002, SBHI, West Bengal. In *West Bengal Human Development Report*. P 132.

Meningococcal Meningitis	Kolkata, Bardhaman, North 24 Pgs	Kolkata, Bardhaman, Jalpaiguri
Tuberculosis	Darjeeling, Koch Behar, Jalpaiguri	Koch Behar, Darjeeling, Jalpaiguri, North 24 Pgs
Kala Azar	Murshidabad. North 24 Pgs, Dakshin Dinajpur, South 24 Pgs	Murshidabad, Malda, pacshim Dinajpur, North 24 Parganas, South 24 Pgs

An important area of concern which requires more public attention relates to disability. The NSS data suggest that in the late 1990s, around 2 per cent of the population of the state was disabled. There is a need to organise health camps at regular intervals and ensure satisfactory public facilities for the disabled, which are at the moment sadly inadequate.[36]

The first of arsenicosis (or arsenic poisoning) was discovered in West Bengal in 1982. Since then, it has been found that the problem of excess arsenic in drinking water exists in at least 75 blocks spread over 8 districts, accounting for an estimated population of over 13.5 million people. These districts are Malda, Murshidabad, Nadia, North 24 Parganas, South 24 Parganas, Bardhaman, Haora and Hugli.

Arsenic contamination of groundwater in West Bengal is of geological origin, deriving from the geological strata underlying the Gengetic plain. The increasing use of tubewell water to provide drinking water as well as for sanitation and irrigation means that this is an urgent problem requiring immediate public intervention. Simple removal of arsenic from water, or shifting to other sources of human drinking water supply, may not be adequate to eliminate the problem, as there is evidence that the food chain is now also being affected. The effect on the cattle population is also potentially very serious and requires focused intervention.[37]

Excess arsenic in drinking water gives rise to a number of health problems, including gastro-intestinal disturbances, hyper pigmentation and neuropathy, and even skin cancer in severe cases. The most common effects appear in the form of skin lesions, which typically manifest after a minimum exposure of about five years. Already,

[36] Ibid P 132
[37] Ibid P 133

nearly 17 lakh people in the state have been diagnosed with arsenic-related skin manifestations.[38] However, knowledge about the full health effects of arsenic is still incomplete.

The social implications of this health problem, and the impact on people's livelihoods, are yet to be adequately studied. However, some adverse social effects can already be observed.[39] There are reports of young women not being able to marry because of arsenicosis, and more general reluctance to declare the problem because of fear of social ridicule. Clearly, there is a need to change social attitudes towards the health effects of arsenic exposure, as well as to provide people in affected areas with scientifically collect information along with feasible safe drinking water options.[40]

In spite of having had a so-called pro people government ruling the state for nearly three decades, the situation regarding not only health status, but also health infrastructure is no different from what it is in the rest of the country. Let us bear in mind that health is a state subject, and so the buck cannot be passed on for the dismal `state' of affairs.[41]

It needs to be pointed out that `better than the national average' scores on several indicators of health status hide immense within-state variation. While the Infant Mortality Rate (IMR) and the Maternal Mortality Rate (MMR) may be better than the national average, however there are large intra-state variations across districts and socio-economic groups. To give an example – poorer districts such as Purulia report IMR two-three times those of districts near Kolkata. Also, the `achievements' of the state stand no comparison with our smaller neighbours like Sri Lanka. Sri Lanka has an IMR of 13 and MMR of 0.92 (per 1000 LBS), and literacy rate of 90.4, and is in any case ahead of India in the HDI ranking, with far better public health provisioning.

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38 *Health on the March*, West Bengal : 2001-02, PHED, Government of West Bengal. In *West Bengal Human Development Report.* P 133

39 Public Health and Engineering Department, Government of West Bengal. (2002) Revised Joint Plan Action for Arsenic Mitigation in West Bengal. In *West Bengal Human Development Report.* P 133

40 Ibid P 133.

41 http://sanhati.com /front-page/857.Accessed on 6.06.2010.

Not to mention that many non-communist welfare states across the world have ensured availability of basic education, water, health facilities for their population. [42]

As is the situation with the union and the state expenditures, in West Bengal too the level of public health expenditure is very low, and has been declining, at just 0.8 % of state GDP. As in most other parts of the country, provision of drugs in public institutions is inadequate; there is lack of doctors, specialists and support staff at the Community Health Centre (CHC) level as well as other levels of health services; maintenance and utilization of building and equipment is poor, and so on. As in the rest of the country, such inadequate public provision has led to ad hoc growth of a large, unregulated private sector in the state.[43]

Portrayal of these miserable conditions of public health in West Bengal (as reported on one of the Government's publication) indicate that the welfare state even after fifty years of Independence have failed to provide the basic requirement of the population both at urban and rural level. Preventive health measures required to eradicate communicable diseases in the state has come up with negative results. Preventive measures, which is the sole responsibility of the Government failed to create proper hygienic environment.

Public health in the Indian scenario.

India's relatively poor performance in the health sector is brought to light even more starkly when compared to international data on healthcare infrastructure and utilization.

In 1978, India also became a signatory to the Alma Ata Declaration, which resolutely states: 'The Conference strongly affirms that health, which is a state of complete physical, mental anti social well-being, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realisation requires

[42] Ibid
[43] Ibid

the action of many other social and economic sectors in addition to the health sector'[44] and adopted its very first health policy in 1983, which set out to provide "universal comprehensive primary healthcare services, relevant to the actual needs and priorities of the community"[45] in an effort to address the deficiencies in its health sector.

There has, however, been a wide gap between policy commitment and its transformation into reality.

The data reveals that the IMR has shown a decline in the long term. But it also makes it evident that the rate at which this decline of IMR has occurred has significantly slowed in the last decade. The percentage decline in IMR between 1971-1981 was 14.7: between 1981-91 it was an even more remarkable 27.3 per cent. However, in the period between 1991 -99, there appeared marked stagnation in the rate of decline of IMR by 12.5 per cent. In 2002. IMR was recorded as 67 in India. Further, despite Policy commitments to provide equal access to healthcare provision in rural as well as urban areas, marked rural - urban differences remain unchanged due to a lack of implementation of these policies.[46]

Apart from aggregate stagnation, significant IMR differentials exist between individual states. Kerala shows the lowest IMR at 14 in 2000. While Maharashtra, Tamil Nadu, Punjab, Karnalaka and Himachal Pradesh have the met the national goal of reducing the IMR to 60 or less by 2000. However major stales such as Madhya Pradesh (91), Orissa (97), Uttar Pradesh (84) and Rajasthan (81) still lag far behind. Also, it should he noted that the figures listed above are for rural and urban areas combined: the rural areas of these states experience even higher IMR of 96, 100, 87 and 85 respectively. It is therefore not surprising that these states are often collectively referred to as bimaru (sick) states.[47]

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44 World Health Organisation 1978. In *Human Development in South Asia 2004 The Health Challenge.* Oxford: Oxford University Press, 2005. P 146.(Hereafter cited as *Human Development in South Asia 2004*)

45 Government of India. *National Health Policy 1983*. New Delhi: Ministry of Health and Family Welfare. In *Human Development in South Asia 2004*. P 146

46 Ibid P 147

47 BIMARU stands for Bihar, Madhya Pradesh, Rajasthan, Uttar Pradesh and Orissa. Together they account for more than 40% of India's population. Bimar of course means sick in Hindustani. In *Human Development in South Asia 2004*. P 147

Another set of differentials that is highlighted by the National Health Policy, NHP 2000 is the disparities in the IMR within the marginalised social groups in India. The IMR among the scheduled castes (SC) stands at 83, at 84.2 among the scheduled tribes (ST), 76 among all others.[48] In addition date from the National Family Health Survey indicates that the IMR among households with a low standard of living is 76.1 compared to 33 among households with a high standard of living. The post-neonatal mortality rate is almost three times higher in households with a low standard of living than in households with a high standard of living.[49]

In sum, not only is the IMR still unconscionably high at the national level, there exist stark differences among states and regions, and rural and urban populations. In addition, there are worrying IMR differentials between the various economic classes, and amongst the marginalised groups in Indian society. Thus the SC, ST and other backward classes (OBC) hear a disproportionate burden of infant deaths, as to the poor in general. The trend is cause for even greater concern when viewed in light of the percentage reduction in the rate of decline of IMR over the last decade.[50]

India's maternal mortality ration (MMR) is still extremely high (table 7.4) in comparison to countries like China and Sri Lanka. As compared to 350 among low and middle income countries, the latest estimates that maternal mortality in India is 540 deaths per 100,000 live births. Indeed, the NFFIS-2 reveals that the MMR has actually increased in the seven years since NFHS- I which recorded a MMR of 424 deaths per 100,000 live births. Predictably, in both NFHS-l and 2, the rural MMR was much higher than the urban MMR (434 and 385 in NFHS-1 and 619 and 267 in NFHS-2).[51]

The high rates of MMR in India are the result of the poor health status of women. In all age groups, causes related to pregnancy account for 12 per cent (if all deaths. In other words, causes other than pregnancy and childbirth account for much the larger proportion of deaths.

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48 Government of India 2001b.In *Human Development in South Asia 2004*. P 147

49 International Institute of Population Sciences 2002. National Family Health Survey (NFHS- 2) 1998. In *Human Development in South Asia 2004*. P 147

50 Ibid P 147

51 Ibid P 149

The major causes of maternal death in rural India show no significant improve- merit over the years. Haemorrhage and sepsis top the list of direct causes, and anaemia dominates the list of indirect causes. Abortion-related deaths show a downward trend, while deaths caused by toxaemia and malposition of the child remain nearly at the same level. In short they attest not only to the poor health status of women in general, but to the lack of adequate health facilities during pregnancy and childbirth, and in particular to the lack of emergency obstetric care. [52]

India commenced material child health (MCH) and family planning services in its very first five year plan; indeed India was one of the first countries in the world to initiate an official policy and programme for family planning. Along with family planning, which has always stood at the heart of the programme, the antenatal care and the training of traditional birth attendants to provide safe deliveries are also initiated. Subsequently, under the Child survival and safe Motherhood Programme launched in 1992, the focus shifted towards encouraging institutional deliveries along with the Universal Immunisation Programme. These programmes have now been integrated into the Reproductive and Child Health Programme launched in 1996. In addition, the National Population Policy has set the ambitious goal of reducing the MMR to less than 100 per 100.000 live births by 2010.[53]

Despite these initiatives, the government has so far been unable to achieve its prescribed impact in reducing the MMR or indeed the IMR and CMR. The NFHS- 2 data indicates that MCH performance and coverage has been extremely unsatisfactory. Less than two-third of mothers received antenatal check-ups, 67 percent received two or more doses of tetanus toxoid, 58 per cent received iron and folic acid supplements, 34 percent of deliveries were institutional, and only 42 per cent of deliveries were assisted by a health professional in 1998-99.

There are also significant disparities between states: Goa, Kerala, and Tamil Nadu consistently rank in the top five, while Uttar Pradesh, Bihar and Rajasthan show a consistently poor performance. Women not receiving antenatal checkups are disproportionately low from among the SCs, STs and OBCs. Among women with a

[52] Ibid P 149
[53] Ibid P 150

low standard of living, the proportion receiving no antenatal care was 45.1 per cent, compared to 12.4 per cent among women with a high standard of living. With reference to place of deliveries, 60 per cent of deliveries among the SCs and 70 per cent among the STs took place at home, while the figure for other backward castes was 47 per cent. Sixty six per cent of women with a low standard of living delivered at home, compared to 27.6 per cent among women with a high standard of living[54].

Similarly, the NFHS – 2 vaccination coverage under the Universal Immunization Programme has not been realized. In urban areas 52 percent of children had received at immunizations by12 months of age, while in rural areas only 29.3 percent had been provided with all immunizations. Boys (43 per cent) were more likely to have received immunization than girls (41 per cent). Only 28 per cent of children of illiterate mothers were fully immunized, as compared to 73 per cent of children of mothers who had completed high school. Dalit children (40 per cent), Adivasi children (26 percent, OBC children (43 per cent) were less likely to be immunised than children from other groups (47 per cent). Only 30 per cent of children from households with a low standard of living were fully immunized as compared to 65 per cent of children from households with a high standard of living. Iminunisation coverage ranges from 11 percent in Bihar to 89 percent in Tami Nadu. Among the major states, Bihar (11 percent), Rajasthan (17 percent). Uttar Pradesh (21 percent) and Madhya Pradesh (22 percent) had figures much below the national average of 42 percent.[55] In urban areas 72 per cent of children were immunised by the public health services, 24 per cent by the private sector, and one per cent by non-governmental organisations (NGOs) or charitable institutions, while in rural areas the public health system was responsible for 85 per cent of immunisations, the private sector for nine per cent, and the NGO sector for less than one percent.[56]

Critics have argued that one reason for the failure of MCH programmes has been the focus on vertical programmes in general and the family planning programmes in

54 Ibid P 150

55 International Institute of Population Sciences 2002. National Family Health Survey (NFHS- 2) 1998. In *Human Development in South Asia 2004*. P 150

56 Ibid P 151

particular.[57] But as we see that the total fertility rate (TFR) has declined from 6.6 in 1960 to 3.2 in 1998, accompanied by a parallel decrease in mortality. Here again, inter-state differentials are striking: the southern parts of Maharashtra, Gujarat and West Bengal show a rapid decline in both fertility and infant mortality, while the bimaru states, account for over 40 percent of the country's population are associated with the highest maternal mortality and child mortality ratio.and fertility rate. While the TFR was 1.8 in Goa, 1.51 in Kerala, 2.07 in Andhra Pradesh, 1.89 in Karnataka and 2.11 in Tamil Nadu, it stood at 4.31 in Uttar Pradesh, 4.06 in Rajasthan 3.59 in Bihar, and 3.3 in Madhya Pradesh. In other words, states lagging behind in epidemiological transition and suffering from a weak healthcare delivery system are also the states that lag behind significantly in demographic transition. It is nevertheless significant that between 1992-93 and 1998-99, total fertility for the whole country has declined.[58]

The data on burden of diseases reveals that India has yet to go a long way in her epidemiological transition, and has to control the quintessential diseases of poverty and deprivation, namely communicable diseases. These diseases altogether account for 50.3 per cent of the burden of diseases in India, compared to only seen percent in high income countries. Another study indicates that not surprisingly, Uttar Pradesh has the same burden of disease as Sub-Saharan Africa: communicable diseases account for 62 percent of the burden in Uttar Pradesh compared to 65.9 per cent for Sub-Saharan Africa.[59]

While there has been a decline in the incidence and prevalence of communicable diseases in India, these still account for the deaths of an estimated 2.5 million children below the age of five years and an equal proportion of young adults.

Close to a third of the population in India still lives under the poverty line and is therefore unable to meet its daily caloric requirements. Data from the National Nutrition Monitoring Bureau (NNMB) indicate that there has been an improvement in the prevalence of severe under nutrition in one to five year old children, the level

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57 Qadeer, I. 1998. Reproductive Health: A Public Health Perspective. *Economic and PoliticalWeekly*, 33 (44). In *Human Development in South Asia 2004*. P 151

58 Ibid P 151

59 Ibid P 151

declining from 11.1 per cent in 1992 to 6.9 per cent in 1995. Overall, the proportion of nutritional normal children has increased from 7.2 per cent in 1992 to 8.5 per cent in 1995.[60]

Although, this relatively modest improvement is heartening the level of moderate under nutrition remains substantially unchanged at 43.5 percent, while mild under nutrition has increased form 36.6 percent in 1992 to 40.6 percent in 1995.

The NFHS-2 data also reveal the nutritional status of women in the country more than a third of women in the county had a body mass index (BMI) of less than 18.5 indicative of chronic hunger or chronic energy deficiency.[61] The proportion of women who are poor, and thus more likely to be ill iterate, experiencing a BMI of less than 18.5 is 42,6 percent. Among SC's the proportion is 42.1 per cent and among STs 46.3 per cent. Women in households with a low standard of living have chronic hunger levels of 46.1 percent, compared to 17.3 among households with a high standard of living. The rate of chronic hunger in rural areas is almost double the rate in urban areas. The prevalence of chronic energy deficiency among women is highest in Rajasthan (39.3 percent), Orissa (48.0 per cent), West Bengal (43.7 per cent), Uttar Pradesh (35.6 per cent), Maharashtra (39.7 percent) and Karnataka (38.8 percent).[62]

The prevalence of anaemia is not surprisingly equally widespread; the overall prevalence rate is 52 per cent with 35 per cent mildly anaemia, 15 percent moderately anaemic and two percent severely anaemic. [63] The prevalence rates of anaemia are considerably higher for rural women (54 per cent) than among urban women (46 percent). The prevalence rates are 60.2 per cent among women in households with a low standard of living, and 41.9 per cent in those with a high standard of living. They are as high as 56 percent among the Dalits, and 64.9 percent among Adivasis.[64]

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60 NNMB (National Nutrition Monitoring Bureau).1997. *Twenty Five Years of NNMB1971995.*Hyderabad. In *Human Development in South Asia 2004*. P 151

61 The Body mass index (BMI) is defined as the weight in kilograms divided by the height in metres. In *Human Development in South Asia 2004*. P 152

62 Ibid P 152

63 Mild anaemia is defined as haemoglobin levels between 10-10.9 grams/dl for pregnant and 10-11.9 grams/dl for non-pregnant women; moderate anaemia as 7-9.9gms/dl and severe anaemia as less than 7.0 gms/dl. Anaemia is one of the leading underlying causes of death in the country among women, not just among the pregnant. In *Human Development in South Asia 2004*. P 152

64 Ibid P 152

It must be noted that although attention have been drawn to the poor health and nutritional status of women, not enough consideration has been given to the status of men. Infact the NFHS has no data on the prevalence of hunger among men. The NNMB however, does note that 49 percent of adult males suffered from chronic energy deficiency in 1990[65].

Leprosy has been one of India's major health problems. In 1984 it was estimated that there were nearly million cases of leprosy in the county, with an incidence of about 15 per cent among children. While the prevalence rate of leprosy has declined from 57.3 per cent thousand populations in 1981 to5.8 per cent thousand population in 1995, the number of new cases detected each year remained unchanged at around million. Currently, the major states a high prevalence of leprosy are I Orissa, Uttar Pradesh, Tamil Nadu, Madhya Pradesh and Andhra Pradesh the 12 districts that have a prevalence I of more than 20 per 10,000 people, are in Bihar, two in Orissa and one Madhya Pradesh.[66]

The spread of Human Immunodeficiency Virus (HIV) poses a h health risk for India, currently constituting two per cent of the total deaths. Indeed, India has one of the most serious AIDS epidemics in the world. Official figure put the number of HIV-positive person at 4.58 million,[67] the second highest national total of people living with HIV in the world. This figure has been widely disputed, however, with some experts asserting that the actual number of persons living with HIV/AIDS in India is more than double the official figure.[68]

The official prevalence rate of HIV/ AIDS in the adult population is low, less than one per cent. Because of the size of India's population however, each 0.1 percent increase in prevalence represents about half a million persons infected. All 32 states of India have reported AIDS cases, and surveys show that the virus is spreading from higher-prevalence urban areas into rural communities and to general population.[69] The six

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65 Ibid P 153

66 Ibid P 156

67 NACO 2004. The recent estimates of UNAIDS records number of HIV+ cases in India as 5.1 million, see UNAIDS 2004.In *Human Development in South Asia 2004*. P 156

68 Ramasundaram S. 2002. Can India Avoid Being Devastated by HIV? *British Medical Journal*, 324: 182-83. In *Human Development in South Asia 2004*. P 156

69 Over, M., P. Heywood, J. Gold, I. Gupta, S. Hira, and E. Marseille. *HIV/AIDS Treatment and Prevention in India: Modeling the Costs and Consequences.* World Bank Human Development

states in which it is officially acknowledged that more than one percent of the women attending the antenatal clinics are HIV positive—thus considered having generalized levels of HIV/AIDS—are Andhra Pradesh, Karnataka, Maharashtra, Manipur, Nagaland and Tamil Nadu,[70] Some districts in Goa, Gujarat and Pondicherry are also high-prevalence zones. Around 300,000 Indians were estimated to have died of AIDS in 1999 alone.[71]

It is commonly understood that while environmental factors are largely responsible for communicable diseases, individual, life-style factors are responsible for non-communicable diseases (NCDs). However, recent evidence has raised concerns over the limitations of such a stylised understanding of NCDs. Individual life-style factors, although extremely important, are not the primary causes of epidemiological patterns of diseases and deaths. They account for less than a third of the differentials in death rates among different social groups.42 Instead, it is living and working conditions, and even childhood deprivation, that is associated with a range of adult NCDs. This has profound implications for public intervention, since it implies that intervention targeted at individuals through behaviour modification is unlikely to yield results. Indeed, what this draws attention to is the need to target overall living conditions. [72]

Despite these caveats, it is nevertheless the case that India has, in addition to a high load of communicable diseases, a high load of non-communicable diseases also. Further, more NCD deaths in India occur in middle age (35-69 years) than in industrialised countries where they occur at older ages. It is also well known that Indians have a higher predisposition to diabetes and coronary heart disease than other populations.[73]

It is however to be borne in mind that the data are largely based on hospital and programme sources and thus do not represent epidemiological indices. But it is

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Network Population Series 2004.Available at http://www. youandaids. org/unfiles/IndiaARTReport-WB.pdf. In *Human Development in South Asia 2004*. P 156

70 NACO (National AIDS Control Organization, India) 2004. Facts and Figures: India. Available at http://www.nacoonline.org/facts.htm. In *Human Development in South Asia 2004*. P 156

71 UNAIDS (Joint United Nations Programme on HIV/AIDS). 2000a. Female Sex Worker HIV Prevention Projects: Lessons Learnt from Papua New Guinea, India and Bangladesh. Available at http://www.unaids.org/html/pub/publications/irc-pub05/jc438-femsexwork_en_pdf.pdf. 2002a. *India Annual Report.* New Delhi. In *Human Development in South Asia 2004*. P 156

72 Ibid P 157.

73 Ibid Ibid P 157

nonetheless the case that rising levels of hypertension, diabetes, obesity, tobacco consumption, and blood lipids in Indian population groups have been recorded in recent years.

In addition to NCDs, the prevalence of major mental illness in the country has been estimated to be one to two per thousand, while minor mental illness occurs in five to ten per cent of the population. The levels of suicides are estimated to occur at a rate of 11 per 100,000. Poverty has been linked to high burdens of mental disorders, with about 80 per cent of suicides occurring in the lower socio-economic strata. The indications are that women bear a high burden of these disorders. Again, alcoholism is also more widely prevalent among the poor. Accidents also contribute quite significantly to the mortality load in the country accounting for 4.3 per cent of deaths. In addition to farm accidents and road injuries, bum injuries and violence against women were reported to be increasing.

Table 4.6: Estimated numbers of cases of selected NCDs in India, 1998.

Disease	Prevalance / Incidence	Number of Cases (Million)	Percentage of total Population
All cancers	Prevalance	2	0.2
Heart diseases	Prevalance	65	6.6
Respiratory diseases	Prevalance	65	6.6
Diabetes mellitus	Prevalance	13	1.3
Injuries	Incidence	7	0.7

Sources : Anand 2000 [74]

Thus it has been correctly pointed out by the present report that it is nevertheless clear that the disease and death profile indicate a huge load of diseases and deaths, both communicable and non-communicable. They also attest to the inability of the healthcare system in the country to make the impact that would have been desired. It is often said that the Indian healthcare system produces 'poor health at high cost'.[75]

[74] Anand, K. 2000. *Report on Assessment of Burden of Major Non-communicable Diseases in India*. New Delhi: WHO. In *Human Development in South Asia 2004*. P 157

[75] Ibid P 158

Understanding of the poor health condition in West Bengal and India raises some vital issues. The miserable public health situations show why the state funded health care delivery systems have absolutely collapsed and degenerated. If the public health of a country would have been 'in good health' the government hospitals were far from being overpressurised by the patients. If the state has successfully dealt with the preventive health measures, the profile of diseases in India would have exhibited a better scenario. But the state's failure gives a different notion. The 'silent' unwillingness of the state to eradicate the communicable diseases signifies that it wants to retain the crisis of ill health in order to protect the interest of the profit seekers in health care and precisely to strengthen and ensure the entry of the private capital in the market of health care.

Public Health Care Sector in Kolkata.

To historicize the root of the present problem, it is pertinent to point out some incidents of the degenerative conditions of the public hospitals in Kolkata in the period following Independence.

Some excerpts from the newspaper *'A Nation'* have been collected to depict the miserable conditions of public hospitals in a newly independent city. [76]

> *"Patients are accommodated by placing cots anywhere and everywhere, in the corridor, back spaces and in between already crowded rows ; labor cases sprawl on the floor; there are many who have to be refused admission, however deserving the cases may be. Sometimes, blanket supplies go short and stricken people shiver when it is cold.*

Absence of Human Relationship.[77]

The absence of humanness—sympathy—which is what is meant by hospital spirit. Besides, the average rough behaviour, harsh words, and delaying officialdom on the

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[76] Bera, Anjan: Edited and Compiled.The Nation. 8th November 1948.Published in '*Interpreting A Nation* Selections from Sarat Chandra Bose's The Nation'. Kolkata: Published by Netaji Institute for Asian Studies, 2001

[77] Ibid P 67

part of hospital personnel (including menials) are too common in public knowledge to merit repetition.

Empty words have never bettered efficiency. When the society does not recognise in material terms the dignity and value of a Service, the same non-recognition returns to the society like a boomerang, and as such one is paid in the same coins.

Ask any hospital administrator and he would reply: We want money and men—money to provide for more hospital personnel, more accommodation, medicines, diet and apparatus and comfort. But who is to foot the bill?

One of the administrators with 15 years' experience in hospitals said: "Hospital accommodation in Calcutta must be increased by at least five times the present one. If the Government cannot nationalize all of them, it must be seen that national funds are well distributed. The days of laissez faire are gone.

The State can no longer shirk its responsibility and it is time it intervened We take below the cases of some of the worst affected hospitals in Kolkata.

R.G. Kar Medical Hospital.[78]

Formerly known as Charmichael Hospital after the name of the then Governor Lord Camichael, this 61-year old hospital is one of the oldest of the medical hospitals. Beginning with a very modest number of 14 beds, it has now 531 beds, spread over surgical, medical, gynaecological, maternity, cholera, tuberculosis, ophthalmic, ENT and Infectious Disease wards. The numbers of beds have been stationary since 1944.

Every year, the number of patients treated increases by several th6'usands till it now comes t-about one lakh, outdoors and indoors together. The number of students has increased from 60 in 1916 to more than 1,000 this year. Simultaneously has increased, as it would be, the annual expenditure now running to about 4½ lakhs of Rupees.

[78] Ibid P 68

But it is curious to observe that the Government grant to this hospital has remained the same (Rs. 50,000) since 1918. West Bengal Premier Dr. B. C. Roy has of course promised some financial help this year on the condition that the hospital demands nothing next five years.

The consequences in a hospital running a deficit of Rs. 1, 70,000 (last year) can easily be imagined.

Bed sheets are not regularly washed and some are as ancient as half a century. While on round in one of the indoor Medical Wards, flies were seen collecting on dirty beds with a sickening stink coming from somewhere somehow. There is not sufficient disinfectant available to the Management. Some of the patients were found resting heads on what can be said to be an apology for pillows.

Similarly, the lack of funds has told upon the quantity and quality of diet, and medicines and services made available to patients.

A patient is given on an average diet worth annas 12 a day, the menu consisting of rice, dal and fish. Generally one seer of fish is meant for 32 patients a meal. Vegetables per head do not exceed six pice a meal. Consumption of milk is between 5½ to 6 maunds a day. While about four maunds are supplied by the Bowbazar Co-operative, the rest comes from the Milk Supply Concern of which one of the Province's Ministers was the Chairman.

Most often, patients themselves had to buy their own medicines, that too generally three times the actual needs. Moreover, medicines have a peculiar way to be spirited away from the cupboards. And those who cannot pay for have to be content with Sodi - bicarb mixtures.

A male nurse said: "What we do to patients is, let me say, nothing. Take for instance, the business of washing patients' heads. You are given only one coolie and one 'methar' and there are so many heads to wash. But who is to draw so much of water? You cannot blame me if I have to satisfy myself with one jug of water for, say, three heads." That is how a patient suffers from shortage of manpower.

Students want better hostels, better library, common room and playgrounds. They must have more and modern apparatus so that they can learn the modern way of treatment.

One can hardly believe when students complain that for blood examination, 100 students have only one Haemcytometer to share. In the clinical laboratory, they have only four –microscopes in all.

Take the Eye Outdoors for testing about 80 patients a day, the department has only one set of refraction glasses.

While considerable numbers of extras are run in each of the wards, the situation is pitiable in Emergency and Labor wards. No beds, no sheets, no curtains; Children are born on cold concrete floors; patients with gaping wounds roll on the ground.

Ninetyfive percent of the T.B. patients on an average have are refused admission owing to shortage of accommodation and equipments. It is one of the most poorly equipped wards which have always about 60 patients to care for.

It is needless to describe the details in other wards. The picture is the same and we leave it to readers' imagination.

Shortage in nursing hands compels a nurse to "take care" of 30 patients at a time, doing duty for over 10 hours a day. He or she has not, so-to-say, a day off to relax. The number of Permanent Nursing Staff is too little to cope with the hospital's demands. To meet the situation it is not un often that a pupil-nurse is even given the charge of a Tuberculosis Ward.

Poor Scale Of Pay.[79]

The poor scales of pay that the authorities have to pay to their employees will be evident from the following:

Jokhan Jamadar of the Lower Subordinate Staff, now putting 25 years' service, earns Rs. 20/ 8/-a month. Female sweepers, Janaki and Susila—with 35 years' service to

[79] Ibid P 69

credit—are each paid Rs. 18/8/- a month. Head Compounder A. Ghosh's salary has risen from Rs. 50 to 100 in 35 years' while his subordinate compounders earn Rs. 68 monthly, service period varying from 20 to 22 years.

The picture is similar in cases of mechanics, carpenters, tailors, liftman, darwans, clerks and others.

A spokesman of the employees said they had demanded adequate wage increase, security of service, proper leave rules, accommodation and allowances, promotion rules, special requirements for nurses and lower-subordinate staff, proper working hours etc.

But it is always the vicious circle started by the overall lack of funds. If there is no money, what can the hospital administration do to meet the demands?

And is it any wonder then that the hospital will come to a pass as it is now in?

Meanwhile, a Development Committee has been set up by the hospital to collect funds from charitably disposed people. Though the Committee has been getting response, still it cannot be termed encouraging. As for instance, they were told by a spokesman of Calcutta Stock Exchange that the Exchange was not in a position to come to the hospital's aid owing to bad business days.

If neither the Government, public bodies nor the rich would agree to part with a portion of their sparable income, who will stand in the way of handing the patients over to the wolves?

The Development Committee has chalked out a development plan of Its own, its present needs are estimated at about Rs. 34,00.000, with a call for Rs. 30.00.000 as reserve fund.

In the words of the Administration "The authorities now face the tremendous difficulty to arrange proper diet and essential medicines for the patients. Adequate nursing staffs for different wards, sufficient number of lower subordinates for essential hospital works, satisfactory wages and quarters for residential medical officers, nurses, employees and lower shortage number of students hamper day to day

administration of the Institution".

Campbell Medical Hospital.[80]

Though now a Government hospital, the story is not much otherwise here too. While on the one hand there is universal demand for more doctors, nurses and menials, the existing personnel smarting under heavy overcrowding of patients, complain of hard work and under-pay.

The nature of the overcrowding can be seen from the following figures of extras' taken in:

The Surgical and Gynaecological Wards have 314 beds. The extras here come to about 148, a daily average, while the Medical Ward runs averagely 102 extras, beds numbering 158.It therefore, did not appear strange when cots were laid on both sides of the Surgical Ward's verandah to accommodate the patients.

The most ill-reputed is perhaps the Infectious Ward from where none is refused admission. But the condition here is anything but inspiring. Some time ago, a senior staff nurse of the Kolkata Corporation was reported to have remarked, after an official had asked her why she did not remove herself to Campbell (she had an attack of cholera) "Do you think I should go to the Campbell knowing very well what the conditions are there?''. With epidemics a permanent guest in the city, nothing short of an Infectious Diseases Hospital can withstand the needs of the populace.

It may be pointed here that the proposal for the establishment of such a hospital on the line of Bombay's has been neatly pigeon-holed by the Government. A comprehensive scheme for it had long ago been submitted by the Corporation's Health Officer, Dr. Ahmed, but nothing had so far been heard of it.

From a week's check up in Campbell's outdoors, the pressure of work on hospital hands was obvious. The average number of daily attendance and treatment of patients in surgical, medical (male), medical (female), Ear-Nose-Throat and opthalmic wards

[80] Ibid P 70

are respectively 80,71,127,70 and 55. The total number of admissions in all the wards (indoors) is on the average 88 a day.

Only one Staff Nurse is sometimes entrusted with the charge of the whole of a ward, if not more. Dearth of nursing hands has made sisters to evolve a short-cut to all duty items they perhaps regard themselves just wage-earners.

Drawing attention to existing relationship between the Society and the profession, it is pointed out the former maintains an unreasonable attitude of despise in so far as Indian nurse sisters are concerned. It is very often taken for granted that those who take to this profession have no other alternative in choice of vocation. This is the reason why women with requisite qualifications are not attracted to this profession and a healthy, unbiased and appreciative attitude does not grow among the people in general.

The memorandum suggested various ways and means for improving the nursing service in India and for fostering good relationship with the people.

Chittaranjan Seva Sadan.[81]

The hospital exclusively for women and children, the hospital created to perpetuate the memory of Deshabandhu C. R. Das has been presently carrying on with a pressure of 150 per cent over its actual accommodation. The number of out-patients treated last year is estimated to have neared about 50,000 while that of indoor admissions was about 7,000.

The hospital is going to have a Cancer Department of its own, which when completed, will be the only of its kind in the whole of Asia including Australia. The hospital needs about 30 lakhs of rupees for this, of which about eight lakhs have until now been raised from public donations. The Department expects more generous response from the public.

81 Ibid P 71

The Hospital's Nurses Training Department has been increasingly dealing with trainees coming from various parts of Bengal and Assam. The number of trainees rose from 15 in 1927 to 67 in 1946-47. Speaking on it, the Department holds:

It is also serving another very crying need that is, it helps in providing a profession to many helpless women who would otherwise be a burden on their family. As a matter of fact, after passing out, most of the girls are not only maintaining themselves, but are also miantaining widowed mothers and younger sisters and brothers. In 1½ years' time, a helpless widow whose life was a burden to herself and others is converted into a useful member of the Society."

The Lake Hospital.[82]

The youngest of Kolkata hospitals this is believed to be one of the best equipped hospitals in India. The entire burden is borne by the Governments of India and West Bengal with an annual grant of 28 lakhs of rupees. Of this, the whole expenditure of the College side (Rs. 5 lakhs) and 50 per cent of the hospital side (Rs. 23 lakhs) is shouldered by the Centre.

The Government of West Bengal will decide after five years' time if the hospital will be run entirely by the West Bengal Government on a permanent basis.

It has 583 beds and is presently running 49 extras. The average number of outdoor patients in different sections is about 900 a day and the diet supplied to patients is worth Rs. 2 per capita per day.

Saying that the hospital is working under pressure in Medical and Gynaecological sections, an official complained of the slowness of the Government's Engineering Department in carrying out necessary construction repairs, saying that "the red-tapism today is the same as it was during the British Raj."

This narrative on the public hospitals of Kolkata throws some light on the issue that the degeneration of the services in Government hospitals is not a recent development.

[82] Ibid P 71.

State funded health care has always been insufficient, poorly maintained and one of the major neglected areas of the overall development of the society.

The Present Scenario.

There have been always substantial gaps in the proportion of public health care infrastructure and the effective demand for its utilization in Kolkata.The city has an area of about 187.33 sq km (KMC area) with a population of 4399819 inhabitants having a density of population of 23783 per sq.km. However in 2001, the population of the city increased to 4580544 and the subsequent population density to 24760 per sq km. Mention should be made that the decennial growth rate has reduced from 6.61 to 4.11 during 1981-91and 1991-2001.[83]

The current scenario (2006-2007) of public health care services indicates that, in Kolkata there are 5 Medical Colleges having 7948 beds. 1158 beds are distributed in 5 State General Hospitals of the city. There 15 Other Hospitals (mental, ID, dental, TB Leprosy etc) where there 2878 beds. Other departments of State Government (Jail, Police, and ESI) are 9 in number having 1711 beds. Number of hospitals under Local Body are 8 having 354 beds. Hospitals under Central Government is 5 in number and have 1164 beds.341 hospitals are under the NGO/Private Sector having 10485 beds. Thus the total number of hospitals in Kolkata is 388 and the total number of beds in both public and private sector is 25, 698.[84] Though the share of beds in the public sector is larger than the private one, but the number of institutions in the private health sector is undoubtedly more compared to the public sector.

However compared to the health care statistics of Kolkata in 2003-04, it has been observed that the number of beds in the Medical Colleges have been increased to 7948 from 7928 in 2003-04. On the other hand, bed numbers in the Other Hospital category have reduced in current years from 3279 in 2003-04 to 2878.

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83 *Health on the March* (various years).State Bureau of Health Intelligence Directorate of Health Intelligence. Government of West Bengal. For the information about the other districts of West Bengal, See section Medical Institution in West Bengal in *Health on the March.*

84 Ibid.

It is noteworthy to mention that from 2006 onwards the *Health on the March* first published another category for the NGO/ Private Sector where private sector indicate the profit making health care services(nursing homes and private hospitals). Prior to this, the new category was identified with voluntary sector which signified the private aided or non profit making sector.[85]

Though the public health care facilities in Kolkata have exhibited a growth pattern in terms of bed strength and institutions, but it was still inadequate to serve need of the population. In 1975, there were 61 health care institutions under the public sector and the numbers of beds were 12873. In 1983, the hospitals and the bed strength increased to 66 and 15260 respectively. The hospitals in public sector increased to 77 and the subsequent bed numbers to 18899 in the year 1999.[86]

Though there have been some obvious developments in recent years compared to previous ones, but the ratio of population served per bed does not exhibit a positive situation. According to 2001 census, the population of Kolkata was 4580544 and the total number of beds in public sector, according to 2006-2007 *Health on the March* issue is 15213. Therefore the ratio of population served per bed is 301: 1. In the decades of 60's and 70's the ratio was 258:1. This data indicate that in spite of certain quantitative changes, the overall scenario of public health care infra structure has not shown radical signs of improvements.

In Kolkata though the decennial growth rate is not as high as other districts and it has fallen considerably from 1991 to 2001, however, the density of population per sq Km in Kolkata is phenomenally high. With such soaring population figures it is evident that there is always a heavy demand for Health care infrastructure in the state.[87]

Moreover the decline of the rural health care services in West Bengal contributed to the extra burden of patients in the public hospitals of the city. This phenomenon has been mentioned in one of the recent findings where the socio economic profile of patients in RG Kar and AMRI (Advanced Medicare Research Institute) has been

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85 Ibid.

86 Ibid.

87 http://ccs.in/ccsindia/downloads/interm-papers-08/Waiting-for-Healthcar -A Survey-of a Public – hospital-in-kolkta-Manasi.pdf.Accessed on 28.052010.(Hereafter cited as *A Survey of Public Hospital*)

studied.[88] The high concentration of patients from districts in RG Kar is due to the collapse of the referral system. The District Human Development Report for Maldah and Birbhum show a 'top heavy' health care system with significant differences in the bed turn over rates in Block Primary Health Centres (BPHCs) and at district and sub divisional hospitals. Our study also finds a large proportion of patients utilizing the developed transport links between North 24 Parganas and Kolkata to access health facilities in RG Kar.[89] AS a result instead of referral institution, RG Kar has become an institute for diagnosis.[90]

It is relevant to mention in this context that the Pratichi Health Reprt which has also taken account of the non functioning Primary Health Centres in the districts of Birbhum and Dumka (Jharkhand)[91]

The poor conditions of the public health care sector have been addressed in the Report of Standing Committee on Health and Family Welfare.[92] The Committee observed that the co ordination between the different groups of health personnel is utterly deficient. There is lack of understanding and co operation between different sections of Group D, Group C, nursing staff, Medical Personnel and administrative officers. In many cases there are hostility and indifferent attitude amongst themselves.

It is a common experience of everybody that very first appearance of most of the Government Institutions as a whole is mostly gloomy, dirty and unattractive. In most cases patients become apprehensive. Cleanliness, on both inside and outside are utterly lacking in most of the hospitals and units.[93]

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88 Institute of Development Studies. *Socio Economic Profile of Patients in Kolkata: A Case Study of RG Kar and AMRI.*, Husain, Zakir, Ghosh, Saswata, and Roy, Bijoya,. Occasional Paper. July 2008. P 25 (Hereafter cited as *Socio Economic Profile of Patients*)

89 This is also observed in districts like South 24 Parganas-blocks with good transport links to Kolkata had poor utilized health infra structure, while inaccessible blocks had higher bed occupancy and turn over rates.(Govt of West Bengal, 2008). *Socio Economic Profile of Patients.* P 25.

90 Ibid P 25.

91 For detail of the rural health care conditions in Bibhum, see *The Pratichi Health Report,* Number 1, Pratichi India Trust. 2005.

92 *Seventeenth Report of the Standing Committee on Health and Family Welfare, 1999-2000.* Twelfth Legislative Assembly. Report on Pre-Voting Budget Scrutiny (2000-2001).West Bengal Legislative Assembly Secretariate.

93 Ibid

The problems of drainage system in the hospitals are acute and disposal of hospital waste is defective. There are defects in the in the construction of the buildings and other civil work amenities. These problems are multiplied due to apathy and negligent attitude of the incumbents and the recipient as well. Deficiency in the attitude to keep institution clean is the real problem.[94]

The committee during its visit faced the grievances from the people that the drugs are not adequately supplied. It was noted that the doctors prescribed medicine, which are not listed by the experts, for OPD and Indoor treatment.[95]

The public health system in West Bengal bears an exceptionally large burden, because in addition to the high demographic pressure in the state, which has already been noted, the bulk of curative services are in public hands. The very large responsibility an coverage of-the public health system in the state are evident from the fact that 76 per cent of the health institutes in West Bengal are run by the government. Obviously, the total physical infrastructure available for health care in the state is still inadequate relative to requirement, and it has already been noted that there are also problems with the quality of the health service delivery in several key areas.[96]

There are evidently several problem areas. The high presence of anemia among women the use of ORS has been coming down, although this may reflect the use of local substitutes. There have also been many measles deaths. There is evidence of widespread Vitamin A deficiency. The dropout rate in immunization is a very important indicator, and it suggests either a lack of consciousness among the people or inadequate public service provision. There is a growing problem of inadequate access to drugs in the public health centres and hospitals, and requiring patients to provide or pay for the drugs that are used.[97]

Narrating the scenario of the degenerating conditions of the public health care infrastructure in Kolkata in particular and West Bengal in general on the basis of the government's reports, records and documents, reveal that the state has openly

94 Ibid
95 Ibid
96 *West Bengal Human Development Report*. P 136
97 Ibid P 138.

confessed and identified the crisis faced by this sector. Surprisingly as a 'communist government' it has also provided a solution to combat the problem.

In the 44th National Conference of the Associations of Physicians held in Kolkata in 1989, the then chief minister Jyoti Basu in his inaugural speech, confessed the failure on behalf of the state to provide proper health care to its population. He had pointed out that the breakdown of the state funded health care infrastructure is mainly due to the shortage of funds. As an alternative proposal, he had invited the entry of the private sector in health care to share the responsibility which the state has failed to perform. The private health care sector should also think of investing on and delivering health care to its population at large. He also opined that each private hospital should treat 20/30 patients free of costs.[98]

In this context it is worth mentioning that the AMRI hospital is a Public Private Initiative (PPI) with the objective of offering 'quality treatment at a reasonable cost' through a super specialty institution to the community at large. The website of AMRI (www.amrihospital.com) also states that it is dedicated to helping the underprivileged of Kolkata'. The profile of patients however indicates that the benefit of this initiative flow almost exclusively to the middle and high income sections of the community. Although it is formally a joint venture, its nature of functioning and cost structure implies that AMRI resembles the private sector institutions. The webpage of AMRI has special packages for the poor, but access to this institution appears to be restricted to a few.[99]

Thus it is clear that the state's failure aggravated the crisis of the public health care structure. At the same time state's initiative provided the platform for the private health care sector to flourish.

Another important instance can be cited to establish the fact that state has promoted the growth of private sector by and large.

"In this election year (2001), criticism by the opposition that there has been no increase in number of medical seats in West Bengal during the last 23 years of Left

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98 (*Rajya sab pareni, tai prayojan besarkari hashpataler/ State has failed, private hospitals should come up.*) Anandabazaar Patrika, 20th January, 1989.

99 *Socio Economic Profile of Patients.* P 26

Front rule seems to have triggered off government action, of dubious worth. The government announced enhancements of 50 seats each in three rural medical colleges - Bankura, Burdwan and North Bengal Medical College. It also decided to open an undergraduate section for 50 students in the state's only post-graduate institution, the Institute of Post Graduate Medical Education and Research and the Seth Sukhlal Karnani Memorial hospital in Kolkata, hurriedly spending a few crore rupees to create additional facilities. Thereafter, it invited the Medical Council of India (MCI) for an inspection. The MCI came, inspected and, it is learned, permitted only the Burdwan medical college's extra seats, refusing approval to the others. Only a year earlier, the government had announced the creation of a fixed number of government medical teaching posts, on the basis of existing medical seats. In the health department, there are two cadres of doctors: the West Bengal Health Service which mans non-teaching hospitals in the districts, talukas and health centre, and the Medical Education Services (MES) to which teachers belong. The numbers of posts in the MES are fixed, and are related to MCI requirements which stipulate that for every 100 admissions, each department should have a specified number of teachers.

Several posts of medical teachers in various disciplines have been lying vacant for a long time largely because this is a (theoretically) non-practicing post. The increase in admissions has further aggravated the shortage. In order to meet this increased need, the health department decided to recruit medical teachers by organizing 'walk-in interviews' instead of the usual procedure of selection by the Public Service Commission. It ensured that only doctors owing allegiance to the ruling party were selected. Persons with lesser qualifications and expertise were selected, bypassing deserving candidates. Despite these manipulations the government failed to recruit the requisite number of medical teachers. Nevertheless, it has again invited the MCI in January 2001. This time, to fill in vacancies in the medical colleges concerned, teachers from medical colleges where MCI inspection is not due have been transferred to hoodwink the inspectors by adopting the jackal and crocodile policy.

If one asks why there should be an increase in the number of medical seats, the truth is that "popular demand" calls for it. However, there is no survey of the current situation. How many seats are needed? What happens to the finished product? Are

medical graduates gainfully employed? Is there a dearth of qualified medical personnel in the state?

Yes, there is a dearth of qualified allopathic doctors in the villages, but even if their number is doubled, they will remain in the cities and peripheries, and not go to the villages. A medical graduate becomes one to make money. Why do we expect them to go to the villages to starve? Villages cannot afford to give doctors the money they need. This is the economic explanation. The commodity goes where there is a market. What are a qualified person's expectations? Well, in the health centres, government doctors get a starting minimum of Rs. 13,000 monthly, as well as the money they make illegally from private practice. Any independent private doctor going to the villages will expect to make not just that much, but more - to provide for a pension when s/he retires. Of course, there are also local, non-allopathic doctors, with lower expectations, who cater to the community and charge less. Otherwise, there are very few villages in most parts of the country, let alone in West Bengal, that can pay private doctors according to their expectations. On the other hand, in places where you can assure a private doctor Rs.30, 000 - 50,000 a month, you will find that many doctors will go there, even without other incentives or with poor living conditions.

This brings us back to the fact that there has not been any assessment of the need for new doctors. At the same time, there is no enhancement in the number of posts for government doctors. Given the current structural adjustment programme and lowering of government spending, it is unlikely that new posts will be created for government doctors.

So what will happen to the doctors created by these new seats? Who will they serve? So the government spends many crores of rupees to make a doctor only for the private sector."[100]

The problems of the government hospitals as far as the deliveries of services are concerned have been elaborated in a study - 'A Survey of a Public Hospital in

[100] http://www.issuesinmedicalethics.org/091le026.htm.Accessed on 2.5.2010

Kolkata.'[101] This empirical study elaborates the difficulties and the problems which patients and the patient parties face in any Government Hospital.

The West Bengal Government has established 9 Medical Colleges and Hospitals (MCH) across the state. These large hospitals aim to provide medical services at lower costs than private hospitals and nursing homes. These MCH are equipped with better medical equipments and can serve a larger number of people than district hospitals.

The sample survey is of SSKM Medical College and Hospital or P.G hospital located at the heart of the city. Eighteen patients and their family members at the Out Patient Department (OPD) were asked questions related to:

- Waiting time (to determine how fast a patient is able to get medical attention.)
- Where the patient is coming from (to determine the efficacy of other medical institutes across the state.)
- If any medical tests had to be conducted outside the hospital at private health care providers.

To answer certain questions such as delay in investigative services, it was not possible to conduct surveys to determine the exact figures; hence to answer these questions auditing reports on hospital services by the Comptroller and Auditor General of India have been used.[102]

ANALYSIS.

How long do the patients have to wait for in the Out Patients Department?

It is evident from the above graph that the waiting time at the SSKM hospital OPD is extremely high with 55.5% of the patient's surveyed waiting from 1 to 4 hours.

[101] A Survey of Public Hospital
[102] Ibid

During the survey, the patients complained that they had to visit the hospital for 2 to 3 hours everyday for at least 2 days to be able to meet a doctor.

Another disturbing factor was that 22% of the patients surveyed were staying in the hospital premises for a number of weeks since they could not afford to travel everyday to the hospital, these are patients who have been waiting for more than 8 hours and their total waiting time is difficult to calculate.

When asked during the survey if they had received any medical attention at all, 44% of the patients complained that they not been able to meet the doctor for even a preliminary diagnosis and not knowing the cause of their illness, they could not begin any treatment.

Where are the patients coming from?

When asked where the patients were coming from, 44% of the patients came from areas outside the city limits.

This data can be used to infer two things. Firstly, the hospitals and other medical care centers in other parts of the state are not functioning effectively and hence people from other areas have to visit the hospital in the city. A large number of patients from state hospitals are sent as referral cases to SSKM and the non availability of equipment is one of the main causes of these referrals.

Secondly, the SSKM hospital itself has to cater not only to the people in Kolkata but also from people outside the city which is creating an immense pressure on its resources. It is because of this that the hospital cannot give timely medical assistance to the people of the city or to the people who travel all the way to the city.

How many critical patients are being admitted in the hospital?

During the survey of the emergency ward in the SSKM hospital, it was found that patients were only diagnosed with the problem but were not admitted into the hospital for proper medical treatment.

Although, it was difficult to calculate how many patients were not being admitted into the hospital during a day. Data has been found on how many critical patients were not admitted in the hospital from January 2003 to December 2006.

SSKM hospital was only able to admit 11% of the critical patients who were brought to the emergency ward. This clearly indicates that the hospital cannot support the huge demand on its resources and has the lowest admittance rate among the 5 hospitals which were surveyed. Due to unavailability of beds, patients have to be redirected in critical condition to other hospitals.

Other Delays.

A review of the other basic hospital services brings to light an even more grisly picture of the state of the SSKM hospital. There was a severe delay in investigative and diagnostic services in SSKM.

In SSKM hospital, the average time for an X ray or even an Ultra sonogram ranges from a week to two weeks. In a survey of the average waiting time for surgery in different departments of various MCH's including SSKM hospital during 2002 to 2007, the following statistics emerge:

The waiting time for surgery in the various departments of SSKM is a minimum of one month while orthopedic surgery had a waiting time of 2 months.

Cost Comparison with Private Healthcare Institutes.

One of the reasons behind the excess demand on the SSKM hospital and public hospitals in Kolkata in general is the lower cost at which these public hospitals provide services to patients. There is definitely no dearth of private nursing homes and hospitals in Kolkata and in fact they form an enormous share of the total medical institutions available to the people in the city but a comparison between the cost of services in a public hospital and that of a private hospital reveals why there is an excess demand on the fewer number of public hospitals.

For the purpose of cost comparison three investigation tests a regular blood test, x ray and a Sonogram for OPD patients were compared in the SSKM hospital, a small

nursing home and a private large hospital. The graphs below reveal the difference the costs between the three medical institutions.

Blood Test Charges.

The general costs of a regular blood test at the three different medical institutes were compared.

The costs of a regular blood test in a large private hospital are almost 79% more than the cost of a blood test in the SSKM hospital. The difference does not reduce much for a small nursing home, where the cost of a running a blood tests is 70% more than the cost at SSKM.

Similarly, the cost of an ordinary X ray in a Public MCH and nursing home and a digital X Ray in a large private hospital were compared. The cost of performing a digital X ray at a large private hospital is 73% more than the cost of a ordinary X ray at SSKM hospital. The difference is lower with a small nursing home where the cost is 52% more than the cost at SSKM.

Sonogram Charges.

The cost of a sonogram of the whole abdomen is also compared.

A comparison of sonogram charges reveals that the cost of conducting a sonogram at a private hospital is 73% more than the cost at SSKM, while the cost of performing it in a small nursing home is 64% more than the cost at SSKM.

Given the above cost disparities, it should also be remembered that even though services in public hospitals are subsidized, patients have to pay a considerable cost for medicines which increases their cost of treatment considerably, but this is also applicable to patients who use services of private medical institutions. Nevertheless, the cost of treatment imposes a heavier burden on the poor.[103]

[103] Ibid. The present researcher also has conducted a survey among patients in Calcutta Medical College and Hospital. (Survey questionnaire given in Appendix IV). The responses showed, that in spite of these negativities of the public hospitals, and its depiction in several government documents, responses from 27 patients in Calcutta Medical College and Hospital reveal a different

However several articles on the miserable conditions of health care have been published in some of the radical journals.

Highly equipped private five star hospitals and nursing homes with all modern amenities and gadgets do thriving business, while people in rags die in the streets in cities, towns and villages. No hospital, no health clinics or nothing of the sort to be found within miles in rural areas. Even safe drinking water for the village people is still a dream after six decades of Independence. The rural areas cannot hope to have even one doctor for every 20,000 population. It is therefore not at all difficult to understand how many people of our country are beyond the scope of the so called existing healthcare system. Again for those who have the facility for the health centres

picture. The socio economic profile of the patient show that they are mostly from the economically challenged section. Out of 27 cases I can mention few to establish their experiences. Sanjib Biswas (29) a vegetable seller from Nadia admitted in general medicine had no complain about the services of the hospital and the staff. Narayan Debnath above 40 from Burdwan reveal that all the staff, even the sweepers also come at the time of emergency He says that most of the time ward boys are available to change saline. Avik Das a 16 years old boy(whose father works in a private firm) from Hooghly admitted in general medicine, for hemophilia also have the same experience. His mother feels extremely at home in the hospital and they are specially obliged to nurses and doctors of the hospital. Paresh Das 49 who works in a iron factory on Howrah has no complain about the services. His previous experiences in this hospital was also equally good Suren Sau who has retired from Bengal Chemical feels that the services in public hospital are still unparalleled and there is no sign of decay in the services.

These patients and many other of this kind, with whom I have talked in the Medical College generally come from the lower income group and sometimes from below the poverty line. Their experiences do not match with the reality of the existing notion of the public health care services because the condition in their rural background is more pathetic than the services in the medical college. Secondly the perception about the quality of medical services is also relative. Since they never had they opportunity to avail the treatment in a private sector hospital, therefore it is also difficult for them to identify the differences in quality of services. Thirdly most of these patients who have their monthly income below Rs 2000 do not have the aspiration for better services, because the services in the rural hospital are even worse and to them this are the standard treatment they could get within their affordability. Fourthly their sense of hygiene and cleanliness do not match with what the urban populace thinks. So these patients from their own socio –economic and cultural position judge the systems as flawless and adequate since this service capable of fulfilling the need of this section. Getting a free bed, a blanket, four times meal in the hospital, medicine and care do really satisfy their need.

Along with these reasons there some other points which might threaten the patients from revealing the reality. The atmosphere of the hospital, the knowledgeable and powerful physician and the application of techno-medicine do not allow the patient to reveal the truth to an unknown investigator. Lying in a bed surrounded by air jets, buttons and lights, invaded by tubes and wires… transported to special laboratories and imaging facilities replete with blinkering lights, strange sounds and un familiar personnel, it is little wonder that patients may lose their sense of reality (Harrison's Principles of Internal Medicine, 16th edn. 2005, P.1 in Bhattacharya, Jayanta. *Bio Medicine theke najardari medicine*, Kolkata. 2008). Therefore a patient gets afraid of revealing the realities. In actuality the application of modern medicine observes patient as a separate case and not as a human body. The dehumanizing factors of modern techno centric medicine threatened the patients from becoming further sick or ill within the medicalised atmosphere of the hospital. The fear of surrendering the body to the expertise of the physicians compelled the patients and patient parties not to speak out even in adversities in the hospital.

and hospitals, there prevails a reign of 'NO'-no supply of oxygen for the acute emergency, no bed vacant for the dying, no scope of urgent investigation. There is always dearth of doctors, sisters and other staff. Number of sanctioned posts is far short of the requirement as per population, and yet kept largely vacant. Thus the doctors and nurses are perplexed with the rush of the patients.[104] There are thousands of doctors and other health workers unemployed and unutilized while diseased, millions are dying for lack of proper treatment.[105]

Curtailment of life saving drugs, continuous increase of hospital charges, stoppage of permanent recruitment, shortage of paramedical staff, freezing posts along with rampant corruption and nepotism and favoring contractual jobs brought about the breakdown of the decay in the services of the government hospitals.[106]

One of the senior physicians of Kolkata has pointed out that government hospital network is vast in absolute terms and pitifully small in comparison to the urgent needs of the people. So the Private Hospitals and Nursing Homes have also in reality a large and ever increasing role. There is hardly any role for augmenting the government health care system.[107] It has been further pointed out that the rural hospitals lack in medicine and supportive services. As a result, critically ill poor people have to undertake hazardous, costly and time taking journey to the few city based hospitals. The pressure on the hospitals is so great that the system is at the point of collapse. Over worked junior doctors or nurses can hardly give the patients the minimum attention they need. This is coupled with indiscipline, corruption and callousness on the part of a section of the employees. Matters are made even worse by red tapism and bureaucratic inefficiency. The inevitable result is public frustration, aggression and even violence.[108]

West Bengal's healthcare system has taken centre stage in recent days. While opinion may differ on the state of healthcare, especially after recent incidents of alleged

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104 Dr Paria, Biswanath. *An Appeal*. Medical Service Centre, Kolkata, 1985.P 5, also see *Swastha Bikhshsan*, 12 issue, Vol 2, January 2007.

105 Ibid P 11

106 Ibid P 7.

107 Dr Sandilya, GP. *Medicare: Problems and Remedies*. Published by Smt Basanti Das: Kolkata,1995. P1

108 Ibid P 2-3.

negligence and misbehavior by hospital staff as well as relatives of patients, there is some amount of unanimity on the need for a mindset change.[109]

Asked how the state fares on the healthcare front, the common opinion is: very bad. Not only Opposition parties, even partners of the ruling Left Front (LF) are critical of the poor state of healthcare in West Bengal. [110]

In recent days, relatives of patients have often complained of unsympathetic behavior by hospital staff, including doctors and nurses. There have been instances of doctors or other medical staff being beaten up. There was also a case when house physicians and medical students of RG Kar Medical College in Kolkata attacked not only the relatives of some patients but also media persons. The police arrested some of the staff who was later suspended. Despite such incidents, there is agreement on one point: the healthcare system needs to be revamped, and relatives of patients as well as medical staff need to change their mindset.

Chief minister Buddhadeb Bhattacharjee has admitted in public that healthcare was a problem area in the state. But, he said, it was not as bad as was being made out to be. There was some consolation for him. The secretary, Union health and family welfare ministry, JVR Prasad Rao, at a recent seminar on health organized by the Bengal Chamber of Commerce & Industry said that "the state of affairs is the same across the country."[111]

Besides the Congress and Trinamool Congress, Left Front partners have openly expressed their worries about the state of affairs. The doctors' cell of the Communist Party of India feels that government hospitals are over-crowded and facilities have not improved much over the years to cope with the growing numbers. Unless district and rural hospitals become capable of handling patients, the rush to Kolkata will continue. Hence, physical infrastructure in hospitals, both in Kolkata and in the districts, needs to be improved considerably, they say. Moreover, doctors and nurses need to be more

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109 *www.financialexpress.com/..healthcare..bengals../48999/* -Accessed on 12.3.2010
110 Ibid
111 Ibid

sympathetic to patients despite the fact that they have to work under tremendous pressure. [112]

Three awful incidents need to be highlighted, in order to establish the intensity of the crisis of the public health care services in Kolkata.

Incident 1: One Shri Raja Mallick aged about 16 years in 2005 (since deceased), was admitted to Dhubulia Block Primary Health Centre on 18-09-2005 with complaints of loose motion and high temperature. For better treatment, he was referred to Nadia District Hospital the same day at about 11 pm. His condition was getting better and from the morning of 19-09-2005 the loose motion was controlled and the temperature also reduced. In spite of that, at 10: 30 am on 19-09-2005, one Dr. K.P. Biswas accompanied by the Blood Collector of Krishnanagar Pathological Laboratory, examined the patient and asked the latter to collect samples of the patient's blood for testing. The doctor handed over to the patient's father Shri Anwar Ali Mallick a prescription for buying the injection named 'Safezone'. Soon after injecting the same, the patient's condition worsened. Around 12 noon the same day, one Dr. Hiren Mukherjee, accompanied by the same blood collector, examined the patient and once again collected the blood sample. The doctor advised the patient's father to bring 2 vials of 'Salumednol-40' injection and injected the same at 12: 30pm. He did not attend the patient any further and thereafter, upon further deterioration of the patient's condition, referred him to N.R.S. Medical College at around 12: 25 am on 20-09-2005. It is surprising to note that the doctor injected the 'Safezone' antibiotic injection without waiting for the blood report. Further, the reports for the two blood samples also varied considerably. In the first report, serum bilirubin was 0.8 mg and on the second report it was 1.5 mg although the two samples were collected at very small

[112] Ibid

intervals. The patient was admitted to Kolkata Medical College on 20-09-2005 at 2: 35 am and breathed his last at 4: 30 am on the same day.[113]

Incident 2: One Smt Namita Bhattacharya, wife of Shri Nirmalendu Bhattacharya underwent antenatal care under Dr. Amiya Kumar Mukherjee, then Asstt. Professor, Obs & Gyn, Dept, R.G.Kar Medical College. No abnormality was found. She was admitted to Kolkata Maternity & N.H. Radha Cinema Bldg on 21-05-1972. During the surgery conducted by the aforesaid Dr Mukherjee, two loops of her small intestine were injured, which led her to bleed profusely. The injuries were apparently not repaired by Dr. Mukherjee who kept a mop in the patient's abdomen and closed it. She was shifted to R. G. Kar Medical College on Dr. Mukherjee's private car without her husband's consent. Dr. Mukherjee instructed his junior house staff to place Namita under anti-tubercular therapy on & from 09-06-72 till her death on 08-07-72 so that he could pass the mop for a tubercular lump in the event of initiation of proceedings against him. Subsequently, a second operation was performed on the patient on 20-06-72 and the mop was removed and the unrepaired & old intestinal injuries were repaired. The patient died on 08-07-72 and the reason written on the death certificate was cardio-respiratory failure due to faecalj fistula after laparotomy. The husband of the deceased has been running from pillar to post for justice since then. Although a departmental enquiry was held and Dr. Mukherjee was suspended, the suspension order was made ineffective by Dr. Subir Chatterjee, the then President, Dr. R.G.Kar Medical College Chhatra Parishad. The Health Dept. also failed to take any action against the erring doctor. As a result of the Nirmalendu's persistent efforts, fresh departmental enquiry was initiated against the doctor. However, he was exonerated of Criminal Offences by Shri Arjun Sen., then Health

[113] This particular case of medical negligence is collected from People For Better Treatment a Kolkata based organization dealing with patients grievances, run by U.S. based Dr.Kunal Saha.

Secretary. The West Bengal Medical Council also failed to take any action against the doctor.[114]

Incident 3: One oxygen cylinder for three babies or more. Two hundred and fifty beds for 302 babies. Twenty-four medical officers, when the requirement is 50. Ninety-two nurses, when the need is for 150. Desperate mothers administering oxygen to their babies gasping for breath on filthy beds.

The B.C. Roy Memorial Hospital for Children, at 111, Narkeldanga Main Road, is where the babies were brought with the hope of life — but death is what is doled out in alarming measure. Over the first two days of September, 14 babies — between one day and three years old — have died here.

"Two hundred babies have died in the past two months," admits hospital superintendent Dr Anup Mandal. The reason is obvious. "We just do not have the infrastructure to cope with the number of patients, many of whom are refused admission in other hospitals. We lack medical staff, medicines, oxygen cylinders, and even basic equipment like an incubator or scan machines that a referral hospital for children must have," he adds.

The hospital authorities have often petitioned Writers' Buildings, but to little avail. A few months ago, a proposal for procuring ultrasound machines and incubators to set up a makeshift intensive care unit (ICU) was sent to the health department. Nothing has happened.

In fact, nothing seems to have changed in the 13 years that paediatrician Dr Asha Mukherjee has been attached to the hospital. "I remember treating extremely sick patients, most suffering from acute septicaemia, gastro-enteritis and other ailments, without any infrastructure in those days. Even today, the hospital does not have the minimum equipment or facilities required to treat children in a critical condition," she says.

A trip down the slushy corridors of the shabby building with blackened walls, past filthy toilets, takes one into a horror Ward, numbered eight. One big room crammed

[114] Ibid.

with three mothers and their babies on each dirty bed. One nurse lounges around, oblivious to the cries of the kids, the pleas of the parents. There is, in fact, very little she can do in a hospital with one nurse for at least 40 patients and no facilities worth the mention.

"My child is 13 days old, and the doctor says he will die," weeps Mumtaz Bibi, staring at her son sleeping on his grandmother's lap.

'That is normal.' Ask Suryakanta Mishra, the health minister who has been promising to clean up hospitals nearly every day since he took charge last year.

"There is nothing abnormal in the number of deaths that have taken place there in the last two days," he said.

Chief minister Buddhadeb Bhattacharjee, too, admitted he was at a loss. "I looked for the secretary (health department) and director (of medical education) and could not get them," he said. "I will not make any comment till I get the report from them."

Minister of state for health Pratyush Mukherjee explained at Writers' Buildings that the "periodic occurrence of multiple deaths in a day" was expected as most of the cases that came to the hospital were terminal.

All these "normal" deaths would have gone unnoticed had not the family of two-year-old Shuvam Dutta, who died early this morning, protested and accused the hospital authorities of "killing" him by not putting him on oxygen. Shuvam was admitted on August 18 — this was the fourth hospital he was brought to by his parents — with pus in the lungs and infection in the upper respiratory tract. Families of other children joined the protest. Doctors and nurses ran out of the wards in panic and the ward-boys stopped working to protest against the "lack of infrastructure". Superintendent Mandal tried contacting director of medical education Chittaranjan Maiti who, by then, had left for Calcutta National Medical College. Finally, police were summoned and a deputy commissioner arrived to bring the crowd under control. It was only after this that Joint Director of medical education Basanta Khan visited the hospital.[115]

[115] *Hope of life, dole of death* and *when will we learn to take care of our children? The Telegraph*, 2nd September, 2002.

The above mentioned cases are just three of the frightening events highlighting the miserable conditions of public health care infra structures of West Bengal. It might be argued that medical accidents and indiscretions occur everywhere around the world. But the point here is that these two incidents are by no means exceptional; rather these and similar and even more horrifying incidents regularly in most of the super specialty public hospitals. And what is equally important is that stories of such incidents make up the public perception of West Bengal's Health Services. This same scenario of negligence, administrative indifference, staff shortage, lack of hospital beds and unfair nexus with the local nursing homes prevail in the entire hierarchy of public healthcare delivery services over the years.

These lacunae of the public health care sector are perhaps partly responsible for the emergence of private health care (incremental privatization). However in case of Kolkata, this period is generally marked with the large scale growth of general nursing homes where the businessmen have invested capital on health business. The emergences of regional business groups (Birlas and Kotharis) in health care have been widespread from this time onwards. However, since Kolkata had already experienced the emergence of small nursing homes and private hospitals (from late 70's), in whatever shape or form, hence they acted as trendsetter for the further development in the sphere of private health sector. This sector, in pre–liberalization era has not adopted the character of an industry. The corporatisation of the health care services and the planned privatization programme is product of the 'Reform Phase'.

Public Health Care Sector: The Indian Scenario.

We now provide a brief narrative of the conditions of the all-India public health care scenario. The public health infrastructure in India consists of an elaborate three-tier primary healthcare delivery system for rural areas, with Sub-centres (SHCs), Primary Health Centres (PHCs) and Community Health Centres (CHCs), and District Hospitals. Sub-centres, catering to a population of up to 5000, are the most peripheral points of contact between the healthcare system and the community. One male worker, and one female worker or auxiliary nurse-midwife (ANM) staffs these centres. PHCs,servicing a population of around 30,000, are headed by a medical officer, and are also supposed to staff a female medical officer, in addition to support

and laboratory staff. The PHCs act as a referral system for six sub-centres. They are designed to have up to six beds for patients.CHCs, for a population of about 100,000, should act as referral centres for four PHCs. They are supposed to be manned by four medical specialists – a surgeon, a physician, gynaecologist and paediatrician – and supported by over 20 paramedical and other staff. CHCs are designed to have up to 30 beds, in addition to facilities like operation theatres, X-ray machines, labor rooms and pathological laboratories. All government programmes and schemes are to be implemented through this healthcare delivery system. In addition, there are district level hospitals to provide specialized care. There are also clinics that provide medical care under other systems of medicine such as Ayurveda and Unani. In addition, the government also runs research and training centres. Currently, there are 137,271 SHCs, 22,975 PHCs and 2,935 CHCs distributed throughout the country.[116]

The problems facing this system are many and complex, from poor staffing, absence of staff, absence of simple consumables, poor referral linkages and so on. The staff itself is largely preoccupied with the implementation of vertical programmes, with the family planning programme in particular. Such absences of adequate care in the primary healthcare system often force people to resort to treatment from quacks or the exploitative private sector. In addition to this, the non-availability of drugs and consumables implies that not only is the PHC system unable to bring about a reduction in suffering, it is also unable to interrupt the transmission of infectious and communicable diseases.[117]

A recent report released by Planning Commission once again brought forth the sloth in our ailing public health system. Citing non-availability of medical and paramedical staff, lack of diagnostic services and acute shortage of medicines in government-run hospitals and medical centres, the situation has been said to be in 'serious decline'. While highlighting that quality of hospitalised treatments have gone down in government hospitals, the report says that organized private healthcare is faring much better in comparison. Further, it has been observed that, in spite of higher costs more and more people actually prefer to opt for private care. The report also gives out some

[116] Government of India 2002a. H*ealth Information of India 1999*.New Delhi: Ministry of Health and Family Welfare. In *Human Development in South Asia 2004*. P 159

[117] Ibid P 159.

startling figures in terms of percentage shortfall of doctors (as of March 2006) across 3,910 community health centres in the country. It was found that there is a shortage of 59.4% of surgeons, 45% of obstetricians and gynecologists, 61% of physicians and 53% of pediatricians across these centres. Further, it has been observed that essential therapeutic drugs are not supplied in most public health institutions with the exception of a few states.

To stall this spiraling crisis, the Planning Commission has urged an increase in public health allocation from the previous level of 1% of GDP (as at the end of tenth five year plan) to 2% by the end of eleventh five year plan. Whether simply increasing allocation will suffice or not is quite debatable [118]

The major problem historically and more so presently under SAP (to be discussed in Section C) is the issue of under-funding of health services. The investment by the government in health care has been inadequate to meet the demands of the people. The government has over the years committed not more than 3.5% of its resources to the health sector. The budgeted expenditure for 1994-95 was 2.63% of total or $ 2 per capita, which is the lowest ever**.**[119] As a percentage to Gross Domestic Product (GDP) it has been around 1 %, woefully short of the World Health Organization's recommendation 5%. Due to the SAP there has been further compression in Government spending in an effort to bring down the fiscal deficit. The grants from central government to the state governments declined drastically from 19.9% in 1974-82 to 3.3% in 1992-93. Central programs or centrally sponsored programs are the most severely affected. The share of central grants for public health declined from 28% in 1984-85 to 17% in 1992-93 and for diseases control programs from 41% in 1984-85 to 18% in 1992-93.[120]

It has also been pointed out bi Ravi Duggal that during the ’90s, the public health system was collapsing due to under-financing of public health services. The structural adjustment and economic reform programmes, which began in 1992 after the 1991-92

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118 www.ehealthonline.org *Accessed on 26.11.2008*

119 Duggal, R,,Nandraj S, and Vadair A, ‘Special Statistics on Health Expenditure Across States’. Economic & Political Weekly, Bombay Vol XXX No 15 & 16 April 15th and 22nd. In www.cehat.org/publication/pa24a63.html Accessed on 22.4.2010. (Hereafter cited as Nandraj: *Unhealthy Prescription*.)

120 Ibid

fiscal crises, further shrunk resource allocations for public health services. In the mid-'90s, the Fifth Pay Commission added to the catastrophe leading to allocative inefficiencies due to budgetary allocations being sufficient only for financing salaries.[121]

The national health surveys provide clear evidence of the declining use of public health services from 60 per cent for hospitalizations in 1986-87 to 45 per cent in 1995-96 and for outpatient care from 26 per cent to 19 per cent during the same period. This is because of increasing market dependence to seek healthcare that makes the poor postpone attention for medical care. Another evidence of the collapse of public health facilities is from another national survey of public health infrastructure, which reveals in 1999-2000 the critical public health facilities were grossly inadequate.[122]

Though the reach of the public health services is very limited it supports a very large bureaucracy from the nation's capital down to the primary health center level. The support for this elaborate bureaucracy and line workers forms a major chunk of the health expenditure. The Central Ministry of Health employs over 30,000 persons. Analysis of the expenditure on health in one of the major states in India during 1990-91 shows that 43% of the total expenditure on public health was incurred on salaries. This is in addition to the expenditure on salaries under each program head**.**[123] Consequently salaries absorb an exceptionally large proportion of expenditure leaving very little for drugs and other supplies.

There is utter neglect of rural areas in provision of medical care services. The government conveniently took up the responsibility of preventive and promotive health services and left the curative care largely in the hands of the private health sector. It has been clearly shown time and again by various studies the rural-urban disparities in terms of health infrastructure is very wide. Analysis of total state expenditures on health reveals that between 70% to 80% of the investment and expenditure reaches 30% of the population in urban areas. For instance, in 1991 of all

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121 Duggal : *Private Health Care Sector*

122 Ibid

123 Government of Maharashtra, Department of Finance, Civil Budget Estimates 1992-93, Major Head-cum-Dept Summary of Expenditure and Public Accounts, Bombay. In Nandraj: *Unhealthy Prescription*.

hospitals and beds in the country only 32%, and 20% respectively were in the rural areas i.e., 20 beds per 100,000 population in rural areas as compared to 238 beds per 100,000 population in urban areas.[124] The poor in the villages were given inferior health services in the name of Primary Health Care, National Programs. For the rural population there is very little provision of state funded curative care though these services are most demanded. Studies conducted reveal the fact that Primary Health Center's are grossly under-utilized primarily because they have inadequate resources (staff, medicine, equipment, transport,) and because the entire focus of the health program is in completing family planning targets[125]. The loss of faith in the public health sector has provided the private health sector an opportunity to thrive and make its presence felt as the sole provider of curative care.

The government directly or indirectly supports the growth of the private health sector at the cost of public resources through the provision of financial assistance for setting up private practice, hospitals, and diagnostic centers. Pharmaceutical manufacture is benefiting from soft loans, subsidies, tax and customs duty waivers. Government support is clearly evident is the production of doctors for the private health sector. Nearly 16,000 doctors are being produced every year from around 140 medical colleges in the country. At today's prices on an average training of each doctor costs the government around $ 142.85. However, the government health services are unable to fill in the vacant position in their own facilities. Between two thirds and three fourths of those qualifying from public funded medical colleges practice in the private sector. That means for every 3 doctors the government trains for its own health services it also trains 7 doctors for the private sector at public cost. A further distressing fact is that out of every 100 doctors who go into the private sector 40 migrate out of the country. This is a gross injustice to the poor people in the country who have contributed their mite in training these doctors. Thus the government is also handing over the public health services and programs to the private health sector, more specifically the non-government organisations (NGO) It

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124 Health Information of India, CBHI, GOI, 1992 In. Nandraj: *Unhealthy Prescription*

125 ICMR, 1991, Evaluation of Quality of Family Welfare Services of Primary Health Centre Level, New Delhi., Gupta, JP., Gupta RS., Mehara P., et.al, 1992, Evaluation of the functioning of Area development project in Health sector in India for improving the health care system, NIHFW, New Delhi and Ghosh, B., 1991, *Time Utilisation and Productivity of Health Humanpower, A case study of a Karnataka P.H.C.* Bangalore: IIM. In Nandraj: *Unhealthy Prescription.*

can be argued that the major role the NGO's should be creating awareness rather that taking over services which the government is duty bound to provide. In addition certain services in the hospitals and health centers are being contracted out for the purpose of efficiency and quality.[126]

India Health Report[127] has aptly pointed out that the poor and undependable public sector services in rural areas and their consequent underutilization, and the cornering of secondary and tertiary care services in urban and metropolitan areas by the rich, leads to a skewed pattern in many states. The result is the diversion of a majority of patients to the private sector, now accounting for 82% of out patient care and 56% of non delivery hospitalizations.[128]

The bulk of the cost of treatment is met by out- of-pocket expenses, estimated at 84.6% of the total health expenditure. This has serious consequence for the poor: a World Bank analysis showed that direct out of pocket medical costs may push 2.2 % of the Indians to poverty in one year. [129]

Thus many episodes of illness remain untreated, and their proportion has increased significantly between the 42nd round (18% 1986-7) and 52nd round (33% 1995-6) of NSS. The greatest failure of the Indian health system is its inability to develop a financing mechanism for the health care of the poor.[130]

The World Bank seems highly vocal to point out the loopholes of the public health care systems in India. As documented in many previous studies, the delivery of health services in India's public sector is rife with problems.[131] High levels of poverty lead

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126 Nandraj: *Unhealthy Prescription*

127 Misra, Chatterjee, Rao. *India Health Report.* New Delhi: Oxford University Press, 2003. P 27.(Hereafter cited as *India Health Report.)*

128 52nd Round. National Sample Survey, in as *India Health Report.* P 27.

129 *India: Raising the Sights – Better Health Systems for India's Poor,* World Bank, 2001. In *India Health Report.* P 27

130 Ibid P 28.

131 World Bank.1995 "India: Policy and Finance Strategies for Strengthening Primary Health Care Services." Report 13042 –IN. Washington, D.C.
----------1996. "Staff Appraisal Report: State Health System Development Project II" Report 15106-IN Washington D C.
----------1997b. "India: New Directions in Health Sector Development at the State Level: An Operational Perspective." Report 15753 –IN. Washington, D.C.
----------2000c "Project Appraisal Document. Immunization Strengthening Project" Report 19894-IN. Washington, D.C. Mukhopadhyay, M, Ed. Report of the Independent Commission on Health in India. New Delhi: Voluntary Health Association of India, 2000. In *Better Health Systems*

to, and are exacerbated by, poor health conditions, and poor governance creates a weak environment for reform. The public sector health system also suffers from poor management, low service quality; and weak finances. Weak management and the low quality of services are related problems that include structural and institutional issues as well as constraints on processes and skills.[132]

Table 4.7: International Comparisons of Health Care Work Force and Hospital Beds, 1990-98.

(Per 1,000 persons)

Country	Physicians	Nurses	Midways	Hospital Beds
India				
Public sector	0.2	—	0.2	0.4
Total	1.0	0.9	0.2	0.7
All countries, by income	0.7	1.6	0.3	1.5
Low income	1.8	1.9	0.6	4.3
Middle income	1. 8	7.5	0.5	7.4
High income	1.5	3.3	0.4	3.3
All				

— Not available.

Note: Data are the most recent available in the time period. Income is unweighted per capita GNP in 1999 U.S. dollars: Low income, less than $755; middle income, $756—$9,265; high income, more than $9,265.

Source: World Development Indicators (World Bank 2000d), except for India: CBHI (various years) and MOHFW (2000a); and nurse and midwife data (WHO 1999).[133]

Public health management in India suffers from overly centralized and inflexible planning and control of resources; high levels of political interference in staff postings and transfers in some of the larger states; a failure to integrate programs devoted to family welfare, nutrition, and disease control and different levels of care; and the neglect of approaches that would encourage the private sector to meet public policy objectives.

An example of inflexible planning is that staffing norms for auxiliary nurse midwives are based on standard population coverage, although birthrates vary widely across the country. As a result, the workload to deliver immunizations to children in high-

for India's Poor. Findings, Analysis and Options. Ed by Peters, Yazbeck, Sharma, Ramana, Pritchett, Wagstaff. Washington, D.C :World Bank, 2002 P 40.(Hereafter cited as *Better Health Systems for India's Poor*)

132 Ibid P 42

133 Ibid P 41

fertility states like Uttar Pradesh and Bihar is more than double that in a low-fertility state like Tamil Nadu.[134]

Managers have neither the authority nor the information necessary for accountable decision making. Human resource systems offer little by way of monitoring, staff incentives, or in-service training, and the result is an undisciplined, poorly performing staff. An inappropriate mix of skills is one of the most critical issues, as large numbers of key posts remain vacant, particularly in rural areas. According to the established staffing norms for existing sub centers, primary health centers, and community health centers, the shortfalls range from 17 percent for auxiliary nurse midwives, to 28 percent for doctors, to 47 percent for male multipurpose workers and nurse midwives.[135] The problems are not simply that the staff norms are too ambitious, that the selection of staff is inappropriate, and that too few health workers are being trained. The problems extend to insufficient pay in the public sector, particularly in comparison with the private sector, unsatisfactory living conditions in rural areas, and limited professional opportunities. [136]

The quality of health services is not well monitored in either the public or private sectors because meaningful standards and quality assurance systems are absent. Hence, little is known about clinical outcomes, clinical quality, management quality, or quality from the perspective of the user. Public sector health services are largely underutilized in rural areas—according to STEM[137], bed occupancy rates of rural inpatient facilities in Uttar Pradesh are around 30 percent—and one reason is the perceived poor quality of service.

The public sector is further constrained by staffing limitations, particularly in poor and remote areas that are also not served by the formal private sector, and is more hampered by weaknesses in supervision, maintenance, drugs, and supplies.

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134 Satia, J. "*-Institutional Assessment : Strenghtening Routine Imminization India*." New Delhi: World Bank, Processed 1999.In *Better Health Systems for India's Poor.* P 42

135 Ministry of Health and Family Welfare 2000a. "*Bulletin on Rural Health Statistics in India*." Rural Health Division, New Delhi. In *Better Health Systems for India's Poor.* P 42

136 Ibid P42

137 Centre for Symbiosis of Technology, Environment and Mnagement.2000. "*Uttar Pradesh Health Systems Development Project: Baseline Study*." Project Report. Bangalore, Karnataka. In *Better Health Systems for India's Poor.* P 43

Despite the establishment of a large public network of health providers, public spending on health has stagnated at levels of around 1 percent of GDP, far below what is needed to provide basic health care to the population[138].

The bulk of public spending on primary health care has been spread too thinly to be effective, while the referral linkages to secondary care have also suffered. [139] As in other countries, preventive and promotive health services take a back seat to curative care. Yet preventive care is almost exclusively provided through the public sector: an estimated 90 percent of immunizations and 60 percent of prenatal care is provided through the public sector.[140]

The states, which bear between 75 percent and 90 percent of the burden of public health spending, have their funds largely tied up in "nonplan" salary expenditures.[141] The disparity between rich and poor states is apparently increasing, while expenditures are not reaching the implementing bodies, particularly the more geographically remote ones.[142]

Low levels of investments in health services affected the growth of the public sector, and this was one of the important reasons for the expansion of the private sector during 1970's and 1980's. Given the nature of the democratic politics, with interests of different sections being represented, it was the needs and aspirations of the urban and rural middle class that were reflected in the manner in which health services

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138 1997b. "India: New Directions in Health Sector Development at the State Level: An Operational Perspective." Report 15753 –IN. Washington, D.C., Mahal, A., V, Srivastava, and D Sanan. 2001. "Decentralisation and Public Service Delivery in Health and Education Services: Evidence from Rural India." In, Governance, Decentralisation and Reform in China, India and Russia. Ed by J.-J. Dethier. Boston: Kluwer Academic Publishers. In Better *Health Systems for India's Poor.* P 44

139 Tulsidhar, V.B. "*Government Health Expenditures in India: Public Financing for Health in India: Recent Trends*." Supported by International Health Policy Programme, Mukhopadhyay, M, ed. *Report of the Independent Commission on Health in India.* New Delhi: Voluntary Health Association of India Press. In Better *Health Systems for India's Poor.* P 44

140 International Institute of Population Sciences 1995. National Family Health Survey (*MCH and Family Planning*), India, 1992-93. Bombay, Mahal, A., A.Yazbeck, D.H.Peters, and G.N.V.Ramana, "*The Poor and Health Service Use in India*". In *Better Health Systems for India's Poor*. P 44

141 Duggal, R. "Health Care Budgets in a Changing Political Economy." *Economy and Political Weekly,* May 17-24, 1997,P 1197-1200, Reddy, K N and V Selvaraju. *Health Care Expenditure by Government of India: 1974 -75 to 1990-91*. New Delhi: Seven Hills Publications. 1994. In *Better Health Systems for India's Poor.* P 44

142 Rao,K.S., G.V.N Ramana, and H.V.V.Murthy. "*Financing of Primary Health Care in Andhra Pradesh: A Policy Perspective.*" Administrative Staff College of India, Hyderabad. Processed. 1997 In *Better Health Systems for India's Poor*. P 44

developed in India. This indeed matched the interests of the professionals, who were largely drawn from the upper and rural middle class sections of the society.[143]

It is surprising to point out that, during 1980s, the government had already formally recognized private health care as an industry, helping corporate hospitals to then mobilize loans from public institutions. During the same period, import duties on medical equipments were slashed and land was leased at extremely low rates to many of these large public hospitals. These concessions and subsidies largely benefited the tertiary, multi specialty hospitals in the private sector.[144]

From the above description, it is clear that the private health sector in India developed in large scale as the response to the failure of the state funded health sector.[145] In Chapter 1, the growth of the private health care in this phase has been elaborated. The public health care services which was weak and inadequate from the time of Independence due to poor funding collapsed as soon as there was the fiscal cutbacks of the welfare state. Pre liberalization India had a substantial presence of private health care sector which provided the conducive atmosphere for transforming health care to lucrative commodity in the next decade under the forces of globalization.

Section C:

Global Compulsion.

Privatization (programmed privatiasation) and the growth of private health care in the third phase is the response to the global compulsion. This phase is mainly characterized by the divestiture (sale of public assets) and franchising/contracting out.[146]

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143 Baru : Health Sector Reform.P 272.

144 Baru, Quadeer, Priya. 'Medical Industry: Illusion of Quality at What Cost?' *Economy and Political Weekly*. Vol XXXV, No 28-29.15th July,.2000. P 2509-2511

145 For the decline of the Public Health Care in India, also see Dasgupta, Monica. 'Public Health in India: Dangerous Neglect'. *Economy and Political Weekly*. Vol XL, No 49. December 3rd. 2005, P 5159-5165.

146 See Bennet, Sara,McPake, Barbara and Mills, Anne "The public/private mix debate in health care". In *Private Health Providers : In Developing Countries-Serving the Public Interest?,* Ed by Bennet, Sara,McPake Barbara and Mills, Anne. London and New Jersey.:Zed Books, 1997.

Following Baru [147] it can be argued that while the private medical practice and the dispensation of medical care for a price have been known for along time, the commercialization, corporatisation and marketisation of health care are phenomenon of the last quarter 20th century. The process received a boost during the late 1970's and early1980's thanks to a global recession, which enveloped both developed and developing countries. It also imposed a fiscal constraint on government budget and encouraged them to cutback on public expenditure in the social sectors. This increased the space for the growth of private sector in provisioning health care. This process was accelerated during the 1980's and 1990's with the growth of the pharmaceutical and medical equipment industries and their seeking out for their market product.[148]Thus the changes in the health care sector (especially private) in Kolkata need to be explained in a global context.

However the private health care sector was substantially present in India from the post independent era and the policies on health care also reflect a pro-privatization drive much earlier to the onslaught of the forces of globalization. (See Chapter 1). Since the stage was already prepared the, the new wave of privatization gained momentum in the post liberalization era. Coupled with this, the present phase witnessed the emergence of the programmed privatization characterized by the implementation of the pro private government policies. With the World Bank entering the social sectors, lending by bilateral agencies declined, and as a result, the former became the single largest financer of the health sector in developing countries during 1990's.[149] Prior to this, the Bretton Woods institutions had primarily concerned themselves with lending for economic programme and had played a marginal role for the social sectors especially health and education, and simultaneously set the policy directions for these sectors, which was population and nutrition programme.[150]

Privatization, globalization and liberalization have become an important part of the political agenda in many countries. The private sector in India has emerged to play a significant role in the health care delivery system. It has been estimated that about 57

147 Baru, V Rama, "Privatisation of Health Services: A South Asian Perspective", *Economic and Political Weekly.* Vol XXXVIII, No 42,18th October, 2003. P 4433
148 Ibid P 4433.
149 Baru : Health Sector Reform P 268
150 Ibid P 268.

percent of the hospitals and 32 percent of total hospital beds are in the private sector. Since the responsibility of health lies jointly with the public and the private sector, an optimal public-private mix would be the best solution for the country.[151]

Mention should be made that this privatization is in sharp contrast to the paradigm that prevailed only two decades ago, when large scale privatization would have been inconceivable in most parts of the world, including developing countries. It appears that the change in paradigm was brought about by number of fairly unrelated and coincidental factors and cannot be explained on the basis of a single event. It is for example, quite that the paradigm can be traced to the first large scale privatization in the UK. Economic conditions in the UK were clearly less adverse than those in many other countries, including the former socialist economies and many developing countries. In terms of the role and size of the economy, the UK trailed even such countries as France, Spain, and Sweden. These comparisons suggest that privatization in Britain was initiated more on political than on economic grounds.[152]

The changes in paradigm cannot be traced to single event. In particular, governments might sell individual assets at a discount to loyal and influential constituencies, increasing wealth and income of these interest groups without due consideration for improving poverty.[153]

Development in this new paradigm is reform through competition and privatization, whereas public services or public welfare is viewed as anachronistic to quality services and consumer choice. The problem of such a linear approach to development is that it equated economic growth with a process of modernization whose prerequisites is deregulation. This approach excludes the impact of material factors such as poverty, inequality, social class, gender and age division in society upon the

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151 Involvement of Private Sector In Health: Suggested Policy Guidelines And Mechanisms M.C. Kapilashrami, A.K.Sood and B.B.L.Sharma. In http://medind.nic.in Accessed on 23.5.2009.

152 Shipke, Alfred. *Why do Government Divest? The Macroeconomics of Privatisation*. Printed in Germany:Springer, 2001,P 2-3

153 Ibid P3

process of development, and in particular the disproportionate dependence among the poor upon the public provision.[154]

The donor- led debt crisis of the early 80's, together the prospect of instability to the banking system in the North, sets the backdrop for Structural Adjustment Policies. The International Monetary Fund together with World Bank stepped in to help developing countries pay off loans, on the condition that the countries adopt economic policies which would generate " economic growth " and in their terms, create the climate for repayment and their requisite economic and social stability. It is clear that the ultimate strategy was to replace the state sector in public service or to reduce its role to minimum.[155]

Despite the rising oil prices and import bill beginning in the mid-1970s, India did not face a balance of payments (BOP) crisis, owing to the Gulf boom and large worker remittances. However, in the 1980s, the complacent Indian economy moved into an import-dependent growth strategy. The rising import bill, slack in the foreign exchange inflow, and heavy external commercial borrowing in the late 1980s developed into a BOP crisis following the Gulf War in 1991.

In India, the IMF- World Bank programme was set in motion with the fall of the VP Singh Government in 1990, and the assassination of Rajiv Gandhi during the election campaign in Tamil Nadu in 1991. The government was obliged to airlift some 47 tons of gold to the vaults of the Bank of England for "safe custody" to satisfy the requirements of international creditors.[156] The IMF agreement implemented shortly thereafter was to prove at best a short breathing-space: with debt of more than US$ 80 billion, the IMF and World Bank loans barely provided the cash required to fund six

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154 Sen, Kasturi. "Health Reforms in Developing Countries". In Public *Health and Poverty of Reforms.* Ed by Quadeer Imrana, Sen Kasturi,. Nayar K.R. New Delhi: Sage Publications, 2001. P139 (Hereafter cited as Sen: Health Reforms in Developing Countries)

155 Kanji, N. et al "From Development to Sustained Crisis: Structural Adjustment, Equity and Health. Social Science and Medicine". *Social Science and Medicine*, 1991, 33 : 985-93, Lowenson, R. Structural Adjustment and Health Policy in Africa. *International Journal of Health Services*, 1993, 23:17-30, Werner, D et al Questionung the Solution:The Politics of Primary Health Care and Child Survival. Palto Alto, Health Wrights., 1996 In Sen: Health Reforms in Developing Countries. P 141.

156 See. Pande, M.K, Surrender of India's Sovereignty and Self Reliance, Progressive Printers, New Delhi, 1991, P 2 In Chossudovsky, Michel. *The Globalisation of Poverty*. Mapusa: Other India Press, (first Indian edition 1997), 2001. P 126

months of debt servicing.[157] India was thus compelled to approach the IMF for a loan, and thus began the Adjustment era.

The IMF loan agreements together with the World Bank structural adjustment loan (SAL) signed in December 1991 were intended to 'help India' alleviate its balance – of-payments difficulties.[158]

Structural Adjustment Policies have involved.[159]

- Sharp cuts in public spending on health and education and other social services.
- The removal of subsidies and lifting of price controls on staple foods and other basic commodities.
- Freezing of wages.
- A shift from production of food and goods for domestic consumption to production for export.
- Liberalization of trade policies.
- Efforts to attract foreign investors by providing them incentives, such as lax regulation and tax breaks
- Privatization of public services and state enterprises.
- Devaluation of local currency.

The World Development Report ---*Investing in Health 1993* indeed was a major breakthrough in formulating the guidelines for the development of the private health sector in developing countries. The report has dictated the terms and conditions for those countries which had opted for loans to restructure their health care sector. The bank has identified private and voluntary sector as the most effective health care providers in developing countries. It has recommended the maximum use of the market forces in the health care for 'restructure and development' and also for

157 Ibid P 126
158 Ibid P126
159 Werner, D et al Questionung the Solution:*The Politics of Primary Health Care and Child Survival*. Palto Alto, Health Wrights, 1996, In Sen: Health Reforms in Developing Countries. P 142

promoting the expansion of the private health care sector. This report has articulated the guidelines for the reforms in the health care sector in the following manner:[160]

- Cutback on tertiary care in the public sector.
- Finance essential clinical services at least to the poor.
- Finance and ensure delivery of public health package for primary level care and AIDS prevention.
- Improve management of public health and introduce cost recovery mechanisms in the public sector.
- Private Sector to play a more prominent role in providing health care.

In the last two decades welfarism has suffered a world wide setback with investment in the social sectors, especially health, being viewed as "unproductive". This clearly resulted in a shift from the neo-Keynesian position that stressed the role of the government in the provision of welfare services to the philosophy of Reaganism and Thatcherism that shifted the onus of financing welfare services from the state to the individual.

As a result, both developing and developed country governments cut into social welfare expenditures as a means of dealing with the fiscal crisis. With the cutback on welfare expenditure, the issue of mobilizing alternate sources of finance for health care has become extremely important.[161]

The Bank believes that additional resources can be mobilised both from outside and within the health sector. The former was considered to be difficult since developing countries would have to cut back investments in "productive" areas in order to generate additional resources for health. In addition, since developed countries were also facing a fiscal crisis the quantum of international aid available would also reduce.

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[160] World Bank (1993): *World Development Report: Investing in Health.* New York : Oxford University Press. 1993

[161] Structure and Utilisation of Health Services: An Inter-State Analysis Baru, Rama V *Social Scientist*, Vol. 22, No. 9/12. (Sep. - Dec., 1994), pp. 98-111.(Hereafter cited as Baru: Structure and Utilisation**)**Stable URL: http://links. jstor.org/sici? sici=09700293% 28199409% 2F12%2922% 3A9%2F12%3C98%3ASAUOHS%3E2.0.CO%3B2-7.

Given this scenario, they advocated mobilizing additional resources from within the health sector itself. Tapping households for payments, introduction of user fees in public hospitals and devising mechanisms for risk sharing through insurance schemes were some of the options considered. The understanding was that public investments should focus on preventive programmes and that cost recovery mechanisms would be better suited for curative services. This approach no longer views health care as a "need", but starts viewing it as a "demand" defined by the consumers' ability and willingness to pay. This understanding has perforce influenced the policies of developing countries which have accepted Bank and IMF funding under the Structural Adjustment Programmes (SAP). The experience of some Latin American and African countries shows that there has been a cutback on investments in health and that various cost recovery mechanisms prescribed by the Bank have been tried.[162]Similarly, in India, there has been a decline in allocations to certain sub-sectors of health and, at the same time; there have been efforts at experimenting with mobilizing additional resources for the health sector. [163]

Since then, the overall thrust of macroeconomic adjustment policies (MAPs) has been toward less government and more private enterprise, the reasoning behind which has been that in many sectors private enterprise could do as well, if not better, than government, ushering in rapid economic growth. It has, however, been recognized that less government may not be the best idea in social sectors characterized by market failures and large externalities. This was especially so in India in the beginning of the 1990s.

India's social indicators at the start of the reforms in 1991 lagged behind the levels achieved in southeast Asia 20 years earlier, … The gap in social sector development needed to be closed, not only to improve the welfare of the poor … but also to create the preconditions for rapid economic growth. While the logic of economic reforms required a withdrawal of the state from the areas…, it also required an expansion of public sector support for social sector development.

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[162] Creese, A., "*User Charges for Health Care: **A** Review of Recent Experiences*", WHO**,** SHS Paper No. 1, Genneva, 1990 In Baru: Structure and Utilisation**.**

[163] Baru: Structure and Utilisation**.** Also see World Bank and Health Sector in India: Ravi Duggal *For Independent People's Tribunal on World Bank, New Delhi, Sep 22, 2007.*Cited in www.worldbanktribnal.org/docs/ duggal.pdf. Accessed on 12.3.2009

The need for increased public spending on health was even greater. While total spending on health care in India in the 1990s was over 5% of GDP, public spending, at less than 1% of GDP, was one of the lowest in the world.

In India's economy—allegedly committed to 'socialism'—the share of public expenditure in total health expenditure is only around 15%, compared with 75% in Western Europe's 'market economies', rising to 84% in Thatcherism-ravaged Britain. In fact, the share of public expenditure in total health expenditure is lower in India than in any other major region of the world.[164]

Table 4.8: Expenditure on Health and Family Welfare. (in crore rupees)

Plan	Period	Amount	Total Plan Investment (All Development Heads)	Health (Centre and States)		Family Welfare		Control of Communicable Diseases	
				Outlay/Exp	% of Total Plan	Outlay/Exp	% of Total Plan	Outlay/Exp	% of Total Plan
First	51-56	Actual	1960	65.2	3.33	0.1	0.01	23.1	16.5
Second	56-61	Actual	4672	140.8	3.01	5	0.11	64	28.4
Third	61-66	Actual	8576.5	225.9	2.63	24.9	0.29	69	27.7
Annual	66-69	Actual	6625.4	140.2	2.12	70.4	1.06	23.1	10.2
Fourth	69-74	Actual	15778.8	335.5	2.13	278	1.76	127	11.1
Fifth	74-79	Actual	39426.2	760.8	1.93	491.8	1.25	268.12	11.5
79-80		Actual	12176.5	223.1	1.83	118.5	0.97		
Sixth	80-85	Outlay	97500	1821	1.87	1010	1.04	524	27
Sixth	80-85	Actual	109291.7	2025.2	1.85	1387	1.27		
Seventh	85-90	Outlay	180000	3392.9	1.88	3256.3	1.81	1012.7	7.7
Seventh	85-90		218729	3688.6	1.69	3120.8	1.43		
90-91		Actual	61518	960.9	1.56	784.9	1.28		
91-92		Actual	65855	1042.2	1.58	856.6	1.3		
Eighth	92-97	Outlay	434100	7582.2	1.75	6500	1.5	1045	4.2
Ninth	97-02	Outlay	859200	5118.1	0.6	15120			

Source: Government of India, Planning Commission (1997). Ninth Five Year Plan, 1997-2002. VOL II. New Delhi.

[164] Adjustment and Health Sector Reforms: the Solution to Low Public Spending on Health Care in India? Delampady Narayana. Accessed on 13.12.2009.www.idrc.ca/fr/ev-118491-201-1-DO_TOPIC.html Also see The World Bank and India In.www.ieo.org, Baru : Health Sector Reform and Rao: The State of Health in India, *South Asian Journal*, October-December 2006(14). (Hereafter Cited as Rao: : State of Health in India)

One extremely important factor responsible for the high morbidity and mortality rates in India, along with widespread hunger and poverty, is the remarkably low, public investment in health. As the NHP itself acknowledges, public health investment over the years has been comparatively low, and as a percentage of Gross Domestic product (GDP), has declined from 1.3 per cent in 1990 to 09 per cent in 1999.'[165] Health expenditure has declined as a proportion of total plan expenditure from 3.3 per cent in the First Plan to. 06 per cent in the Ninth Plan. (See Table 4.8)[166] Compared to health expenditure; family planning expenditures have shown a relative increase. What is also striking is the decline in the allocation of funds to control communicable diseases.

This proportion of health expenditure is below the average of low-income countries and even Sub-Saharan Africa. The average health expenditure, as a proportion of GDP for low-income countries is one per cent, while the average in countries of Sub-Saharan Africa is 1.7 per cent.[167] More significantly perhaps, India has one of the highest levels of private financing of healthcare expenses, with out-of-pocket expenditure estimated to account for 87 per cent of total expenditures. Only the countries of Cambodia, the Democratic Republic of Congo, Georgia, Myanmar, and Sierra Leone show a higher proportion of private funding.[168]

This is despite the commitment to provide universal and comprehensive services, irrespective of the ability to pay, that was enshrined in the Bhore Committee Report and accepted by the government of India at the time of Independence. The poor, who often have the greatest need for health services, and the least ability to pay for them, bear the highest proportion of healthcare costs. A recent World Bank study concludes that 'the hospitalised Indian spends more than half his total annual expenditure on buying healthcare; more than 40 per cent of hospitalised people borrow money or sell

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165 *Draft National Health Policy2001*. New Delhi: Ministry of Health and Family Welfare. In *Human Development in South Asia 2004*. P 153

166 There are discrepancies –in the Government documents, as is evident. The World Bank 's World Development Report 1999-2000, provides a figure of. 07%. In *Human Development in South Asia 2004*. P 153

167 World Bank (2000) " Entering the 21st century", World Development Report1999-2000, OUP. New Delhi.In *Human Development in South Asia 2004*. P 153

168 World Health Organization, World Health Report 2000, Geneva, In *Human Development in South Asia 2004*. P 153

assets to cover expenses and 35 per cent fall below the poverty line'.[169] Out of pocket expenses alone are estimated to push 2.2 per cent of the population below the poverty line annually.

The burden of out-of-pocket expenditure is highest in those states where public health infrastructure is least developed. This applies equally to government and to private facilities, to in-patient care as well as outpatient care. The treatment costs are least in Kerala, Tamil Nadu and West Bengal, and highest in Bihar, Assam, Punjab, Rajasthan, Haryana and Uttar Pradesh. Further, in all states except Kerala, rural patients pay more for medical care and bear a higher burden of treatment.[170]

Total health expenditure by the public sector in 1998-99 was a staggering Rs.161 billion (US$ 3.8 billion), or a per capita expenditure of Rs.165 at 1993-94 prices.(US$ 4)[171]. In India, the states typically account for about 75 per cent of total public spending on health, with the rest being borne by the Centre. The proportion of health expenditure in the major states, which was in the range of six to seven per cent during the eighties, came down to about five per cent during the nineties.

Table 4.9 (shown below) provides data on real per capita spending on health among the major states. As is evident, Uttar Pradesh has the least spending followed by Madhya Pradesh and Orissa. A substantial proportion, close to 80 per cent of these state expenditures is, however, geared towards payment of salaries alone, especially in the BIMARU states. This is, of course, not indicative of high salaries to personnel, but of the remarkably low spending on health.[172]

What is of more concern, is that over the nineties there has been a redistribution of shares within the primary, secondary and tertiary sectors, as compared to the period of the eighties. While spending has increased by about 50 per cent at the primary and secondary levels, the increase at the tertiary level has been more than 100 per cent. Although proportionately fewer funds were available for health and a bigger amount went towards salaries, a larger proportion

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169 World Health Report 2000: Health Systems, Improving Performance. Geneva: WHO. In *India Health Report*, In *Human Development in South Asia 2004*. P 153

170 Krishnan, T N "Access to Healthcare and Burden of Treatment in India"In Rao: State of Health in India

171 Misra :*India Health Report*. In Rao: : State of Health in India. P 37

172 Rao: State of Health in India P 38.

was now allocated to tertiary level care. This has proved to be an important contributing factor for the dismal state of primary healthcare services in the country.[173]

One argument presented in defense of government cuts in health expenditure is that there is a squeeze on government finances. What is not highlighted is that over the nineties the government is either less willing or unwilling to collect taxes even at levels that existed before the onset of reforms. Thus, the tax GDP ratio has declined from more than 13 per cent in 1990-91 to nine per cent in 2000-2001.At the same time; this implies that regressive indirect taxes as a proportion of revenue has increased, taxes paid for largely by the poor. But just the reduction in direct taxes represents uncollected revenues of four per cent of GDP, which is almost three times the entire expenditure on public health, medicine and family welfare by the central and state governments combined. At the same time, India substantially subsidies health care in the First World through transfer of skilled human power, trained at public expense, at an estimated cost of 160 million dollars every year.[174]

Table 4.9: Trends in real per capita spending on health by some selected states of India. 1985-99.[175]

States	1985-86	1991-92	1995-96	1998-99
Andhra Pradesh	20.44	21.03	21.92	31.88
Gujarat	24.32	30.51	28.77	45.44
Haryana	26.79	26.65	24.39	33.78
Kerala	25.97	32.15	30.98	35.05
Maharashtra	27.46	30.87	30.73	33.67
Madhya Pradesh	16.19	19.17	17.89	25.49
Orissa	16.95	23.26	19.54	28.28
Rajasthan	21.85	29.07	31.02	37.70
Tamil Nadu	15.38	21.61	32.09	42.42
Uttar Pradesh	16.12	20.38	19.01	18.10
West Bengal	22.65	28.49	25.96	41.24
Average Spending	21.28	25.74	25.66	33.91

The *2002 National Health Policy* acknowledges this severe indictment and recommends that public health investment and expenditures need to be more than

173 Ibid P 39

174 Voluntary Health Association of India, *Report of the Independent Commission on Health in India,* New Delhi. P 40.

175 Selvaraju et al Background Paper 2001, In *India Health Report* P 145.

doubled in the next five years in order to provide reasonable level of primary healthcare.

But the NHP fails to come up with a plan of action to remedy the existing situation. All this has helped the private health sector to consolidate its position as well as manoeuvre for privatization of public health facilities. The above trend is in fact a global phenomena and this is well documented in the 2003 Social Watch Report. This report focuses on privatization of basic services and documents the shift from social contract to private contract for basic services like health, education and water.

World Bank whose 2004 WDR background papers are debunking the government provision model for basic services in favour of private contracts is encouraging this shift. The Social Watch Report declares access to basic services as a human right and advocates for maintaining the social contract for these basic services as social contracts promote equity and universality ensuring a minimum level of access for all.[176]

It is interesting to mention that the emergence of the private health care sector is also the impact of the socio economic changes in the country after the Independence. The growth of the middle class after Independence is not merely restricted to urban areas. The green revolution had given birth to the rich and middle peasantry who had made use of the public investment in education as a vehicle for social mobility. These sections often migrated UK and US as qualified professionals during 60's and 70's.[177]

Thus a globalized middle class of professionals was beginning to emerge, with different needs and aspirations which were clearly divergent from those of large sections of poor. This social class found the public system inadequate to meet their needs and in those states where there was a vibrant private sector. This was seen in the case of health utilization during the mid 1980's when the urban–rural middle income group utilized private health services dependent on the ability to pay. [178]

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[176] Duggal *: Private Health Care Sector*

[177] Kamat, A.R Education and Social Change in India. Bombay: Somaiya Publications, 1985. In Baru : Health Sector Reform P 273

[178] Baru, Rama V. *Private Health Care in India: Social Characteristics and Trend*. New Delhi,: Sage Publications, 1998, Khadria,.B. The Migration of Knowledge Workers: Second Generation Effect of India's Brain Drain.New Delhi: SAGE Publications, 1999, Omvedt, G. Capitatalist Agriculture

Rise of the corporate hospitals in Kolkata during this phase is to meet the demand of the urban elite. They fail to situate themselves within the four walls of the overcrowded public hospitals. This upwardly mobile section wants to segregate themselves from the overcrowded Government Hospitals and confines them in a sanitized and hygienic space of a 'five star hotel' like health care mall where they can only identify themselves.

Table 4.10: The increasing per capita income in the districts of West Bengal.[179]

District-wise Estimates of Per Capita Income of West Bengal {(At Constant 1993-94 Prices) (2001-2002 to 2004-2005)}				
(In Rs.)				
District	2001-02	2002-03	2003-04P	2004-05Q
Burdwan	12102.97	12862.36	13476.58	14114.72
Birbhum	8538.25	9007.90	9243.68	9428.85
Bankura	9806.70	9828.31	10095.18	10743.73
Midnapore	10442.39	10922.71	11317.81	12103.96
Howrah	11835.99	12917.27	13580.34	14538.27
Hooghly	11526.58	11590.87	12855.55	13520.38
24-Parganas (N)	8351.24	8956.69	9370.17	9937.68
24-Parganas (S)	9245.95	9786.47	10173.99	10446.34
Kolkata	20496.07	23761.86	26243.89	29361.91
Nadia	10245.33	10798.92	10895.54	11064.82
Murshidabad	8774.45	9008.87	9568.79	9838.81
Uttar Dinajpur	6690.06	7147.41	7682.32	7298.82
Dakshin Dinajpur	8879.66	9638.59	9903.22	9739.45
Malda	9326.82	8773.89	9231.37	9889.50

and Rural Classes in India. *Economic and Political Weekly*, 16(52), 26 December,1981, In Baru : Health Sector Reform P 273, also see Chatterji, Partha:*Politics of the Governed :Reflections on Popular Politics in Most of the World.* Delhi: Permanent Black, 2004

[179] *Statistical Handbook of West Bengal*. (Various Years) Bureau of Applied Economics and Statistics. Government of West Bengal

Jalpaiguri	8818.38	9603.91	9876.16	10434.98
Darjeeling	11908.68	12250.93	12654.75	13328.56
Cooch Behar	7688.47	8020.91	8755.99	9229.44
Purulia	8660.85	8447.66	9026.22	9345.69
West Bengal	10380.20	10986.53	11607.81	12271.37

Although central government expenditure on the health sector was not affected, capital disbursements and grants in aid to the states were reduced, severely constraining all state expenditure, including local spending on health. Given this, many states availed of the World Bank loan for health sector reforms.

The reforms were intended to help establish efficient and effective health systems, and address burdensome diseases in a cost-effective manner. Two common policy aims in all states were to:

- increase the health budget
- implement user charges

Andhra Pradesh was one of the first states to initiate reforms in 1995-96, followed by Karnataka, Punjab, West Bengal, Maharashtra, Orissa and Uttar Pradesh. So did this result in increased public spending on health care in the reformed states.[180]

Capital expenditure on medical and public health (such as upgrading hospitals) has increased, largely thanks to World Bank loans. But this level of investment is not sustainable and this expenditure will almost certainly be reversed once the loans are completed. Furthermore, since the loans financed capital expenditure, this should have released state resources for revenue spending on health services. The reality is that there has actually been a decline in revenue spending since the reforms.

An initial analysis suggests that the drop in spending has been smaller in reforming states than in those states that did not reform. This supports the view that in the face of a national decline in health expenditure, health sector reforms did alleviate the

[180] Narayana, Delampady: Global Issues, Local Voices: Issue 3 http://www.gdnet.org. Accessed on 11.9.2007.

effects of that fall. However, on closer examination, if the contribution of user fees is accounted for, the decline in health spending in the reforming states is larger. There is actually no difference between reforming and non-reforming states. This implies that health sector reforms, far from enhancing the public health budget, have not helped even to maintain the current levels of health spending.[181]

Moreover mention should be made that all the states that received loans from the World Bank had to adhere to a common agenda for initiating reforms. These included a shift from direct provisioning by governments, which essentially entails greater reliance on private and voluntary services, contracting out to the private sector as a way of improving efficiency and patient satisfaction and initiating user fees. This is the basic set of assumptions upon which all health sector reform initiatives are based. Clearly this has meant that the national governments have had little say in altering the agenda because the loans for these sectoral reform are tied to a set of conditions that basically call for strengthening the infra structure improvement is seen as key for quality improvement and also for introducing user fees in public hospitals.[182]

The above analysis makes an attempt to explain the causes behind the emergence of private health care sector (independent growth, incremental privatization and programmed privatization) and its subsequent changing pattern to a corporate sector in three distinct phases. Indian Government as a junior partner of IMF and World Bank pursued the policy of privatization by depriving the ailing masses from their right to health. This scenario deepened the crisis of health care services gradually leading to large scale malpractices and medical negligence. The 'dictates' in the name of 'reforms'(will be discussed in the next chapter) ruled the domain of public health care aggravating the crisis further in this phase. The private health care on the other hand, with its expensive services gained a solid footing and remained beyond the reach of the masses at large. These two services at bipolar ends created a deep rooted problem in the domain of the health care services.

[181] Ibid.
[182] Ibid