# CHAPTER 5

## *The Metamorphosis of Private Health Care.*

***CHAPTER ABSTRACT:***

**This chapter intends to highlight globalization and the current form of capitalism along with its subsequent impact on the Private Health Care Sector and Privatization of health care services in Post Independence Kolkata. It made an attempt to focus on how the growth of the public health care services had been drastically reduced over the years, providing the platform for the private health care sector to flourish by all means. The transformation of health care to a purchasable commodity also invited the entry of corporate houses to invest in health care. Along with the rise of big, corporate, private hospitals (*Branded Health Care Malls*), the purchase of medical equipments from foreign companies widened the techno-centric approach of health care. It also brought about a dangerous neglect of preventive measures, which are the responsibility of the State. The chapter also describes the negative impact of private health care sector. In the name of 'Reform' of the public health care sector, the Government has deliberately and skillfully invited the entry of the private capital within the peripheries of the public health care services. Hard selling of health care is another dangerous impact of the overwhelming growth of the private health care sector. Increasing malpractices and corruption questioned the ethical issues of the medical profession as a whole. This chapter shows how the medicalisation of life, converted a normal individual to a patient in the market of medical care.**

### Introduction.

The discussion, so far has focused on the drive towards developing a vibrant private health care sector, in India and West Bengal (Kolkata) under the local as well as global compulsion. From the previous discussion, it is obvious to understand that neither the decline of the public health care sector, nor the development of the private health care sector should be studied in a simple cause and effect relation structure. Several other factors have contributed the growth of the latter, but these two

phenomena are closely interlinked with each other. The global pressure of investing more on private health care sector and reforming the degenerating public health care services brought about far reaching consequences in the entire health care culture of the metropolis. The dependence upon the market forces and the techno-centric approach of health strengthened the significance and the expansion of the private health care. Actually, the allocation in health care had always been meager compared to the demand for the vast population in India. Since this inadequate infra structure failed to come up with positive outcomes, it collapsed after three decades of Independence, providing the space for the private health sector to flourish as the alternative for health care delivery services. Further decay was brought about with the shrinking of the welfare state towards the provisioning of funds for the health care sector. This aggravated the failure of the public health care services and the subsequent rise of the private health sector. This process received a boom in the post – liberalization era with the coming of the international donor agencies with the new package of reforms for public health care and the thrust towards developing private health care sector.

The aim of this chapter is to focus on the impact of the devastating growth of the private health care sector. Along with this, the changing nature, characteristics, size and utilization pattern of this sector in the post liberalization era with special emphasis to Kolkata will be discussed. It will also discuss the reforms that were undertaken in the public hospitals and its subsequent impact on the health services. Attempts will be taken to unravel the effects of the growing dominance of the private health care sector which converted health care to a commodity and increased the cases of medical negligence and malpractice. The changes in the entire health care culture has indeed 'medicalised' life to its fullest and created an atmosphere of sickness where the normal human beings are always under the threat of being sick or ill. These changes not only intensified the crisis of the delivery of healthcare services, but also challenged the accessibility of nominal health care to the population at large.

The analysis of chapter 5 will be discussed in three distinct sections. Section A will discuss the nature of globalization and contemporary capitalism. An attempt will be made in Section B to discuss the impacts of the retreating welfare state (along with its poor fund allocation) and the effects of the global compulsion (Structural Adjustment

Programme) upon the health care sector. The changes from ***'private'*** to '***corporate***' and the reforms of the public hospitals will be discussed in this section. Section C is divided into two segments. Part I will highlight the problems within the private health care sector and Part II will try to describe how the hard selling of health care creates an atmosphere of sickness and threatens the normal well being of the population at large.

## Section A:

In order to discuss the issues raised in the foregoing paragraph, however, a short discussion about the nature of contemporary globalization and its implications for the health care sector worldwide needs to be undertaken.

What exactly is globalization? In fact, the meaning of "globalization" depends almost entirely on who is talking about it. For U.S. employers, it's become shorthand for an aggressive program that involves government deregulation of industry, privatization of government services and liberalization of barriers to international finance and trade. Indeed, it's become their new excuse for an old demand: Give us more.

For Corporate America, globalization is a policy that aims to open the world's markets to U.S.-based transnational corporations. Indeed, the reality is that globalization involves a bid to strengthen US hegemony over international capitalism to an unprecedented degree. But it is also an ideology. Around the world, ruling classes use globalization as a justification for austerity measures, job cuts, spending cuts and increased workloads. Private-sector workers are threatened that if they do not boost productivity and cut costs, their work will be moved to factories abroad, where wages are rock bottom and unions nonexistent. Each national ruling class and government can disown responsibility, saying essentially, "Globalization made me do it."

But for all the claims that it is entirely new, there is a great degree of continuity. Globalisation is at one level unbridled economic liberalism, unconstrained by any countervailing social force. It began as a powerful rightwing liberal offensive under US President Reagan and UK Prime Minister Thatcher. Its goal was to roll back gains made by labor in the USA and UK between the Great Depression and the aftermath of

World War II, and to roll back all social and national controls over capital in other parts of the world. This process received an impetus because the bureaucratic alternative presented as socialism was reaching an impasse, as admitted openly by Mikhail Gorbachev a few years later.

However, it is therefore readily understandable that the “closed” versus “open” economy debate is not just about technical efficiency comparisons. It is about how far, on one hand, national interests would dictate control over the national economy (given that capitalism was always an international system and so an isolated capitalist economy is in any case impossible) and secondly how far the underprivileged could use political power to wrest some concessions. At the time when old style imperialism with its division of the world market and an actual division of several continents prevailed, that is, during the period 1870-1914, the world economy was more integrated, and trade consumed a higher proportion of the main capitalist countries' gross domestic product than it does today. What have changed are the increased magnitude and character of international trade and investment and the massive growth of international financial speculation.

Left-wing economist Doug Henwood has recently challenged the uncritical acceptance of the term "globalization" in the following way:

“If there's one thing that analysts and activists across the political spectrum agree on today it's that we live in an era of economic globalization. Both critics and cheerleaders take this as self-evident and largely unprecedented. We should think twice about this consensus.

One of my problems with this term is that it often serves as a euphemizing and imprecise substitute for imperialism. From the first, capitalism has been an international and internationalizing system.Not only is the novelty of "globalization" exaggerated, so is its extent. Capital flows were freer and foreign holdings by British investors far larger, 100 years ago than anything we see today. Images of multinational corporations shuttling raw materials and parts around the world, as if the whole globe were an assembly line, are grossly overblown, accounting for only about a tenth of U.S. trade. Take one measure, exports as a share of GDP. By that measure, Britain was only a bit more globalized in 1992 than it was in 1913, and the

United States today is not a match for either. Japan, widely seen as the trade monster, exported only a little larger share of its national product than did Britain in 1950, a rather provincial year. Mexico was more internationalized in 1913 it than was in 1992. Exports are just one indicator, for sure, but by this measure, the distance between now and 1870 or 1913 isn't as great as it might seem."[1]

As for the core features of contemporary globalization, Kunal Chattopadhyay has described this in the following manner:

"Economic globalization has not meant that production and distribution is spread evenly across the globe. The global economy remains dominated by a handful of wealthy countries--including those in Western Europe, the U.S., Japan and Canada. The vast majority of production takes place inside those countries and in regional trade blocs dominated by them--and the overwhelming bulk of world trade takes place between these regional giants. Far from globalization opening the way for developing nations to take their place in a system of international equals, the vast majority of the world's countries are either squeezed by the big powers--or simply abandoned to a miserable fate.

It is also the case that "globalization" is very poor word to describe the internationalization of the economy that has taken place. The U.S.-dominated North American Free Trade Agreement (NAFTA), the European Union and, in a more informal way, Japan are effectively regional trade blocs that absorb the bulk of manufacturing, trade, investment, loans and currency trading. According to one study, 82 percent of manufactured goods are made in the developed countries--a figure at odds with the stereotype of Third World manufacturing and a post-industrial "service economy" in the West. Furthermore, 75 percent of world trade takes place among advanced countries, a figure that has actually *increased* from 63 percent in 1960."[2]

The growth of the global operations of capitalism in the second half of the 19th century were easily as great as those witnessed in the last three decades. World trade

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1 Henwood, Doug "*What is globalization anyway?"* Available on-line at http://www.igc.org/solidarity/henwoodOnGlobalization.html#HENWOOD. Accessed on 16.7.2008

2 Chattopadhyay, Kunal 'Stages of Globalisation', in Proceedings of National Seminar on Globalization, Brahmananda Keshab Chandra College, 2006, P 16. Also, See Pollard, Sidney. *The International Economy since 1945.* London and New York: Routledge, 1997. P 38.

grew by 900 percent by the outbreak of the First World War with an average growth rate of about 3.4 percent a year between 1870 and 1913. Alongside this, there was an enormous growth of international finance, since the financial system was based on the unrestricted flow of gold from country to country. By the 1880s and 1890s about half of the investment from Britain still the most powerful capitalist country flowed overseas.[3]

International trade did grow much faster in the 1950s and 1960s than in the second half of the 19th century by about 9.9 percent a year until 1973 but this has not been true more recently. In addition, the share of imports and exports in total output for the three major parts of the advanced world the US, Japan and the European Union has remained more or less constant between the fall of the USSR and the opening of the second term of the Bush Presidency.[4]

However, the kind of dogmatic Marxist explanation that tended to argue, some years earlier, that globalization was simply capitalism, so nothing needed to be explained, does not hold good. Capitalism has undergone many mutations, from the trading centres in Italy and the Low Countries via the early colonial empires through the Industrial revolution and beyond.

The cyclical course of the capitalist mode of production induced by competition takes the form of the successive expansion and contraction of commodity production and hence of the production of surplus value. There corresponds to this a further cyclical movement of expansion and contraction of the realization of surplus value and the accumulation of capital. These three moments are not identical. Their discrepancies provide the explanation for capitalist crises of over-production.[5] In the period of the upswing, there is an increase in the mass and the rate of profit, and a rise both in the volume and the rhythm of accumulation. Conversely, in a crisis and subsequent period of depression, both the mass and the rate of profit will decline, and both the volume and the rhythm of capital accumulation will decrease. Is this a cycle that exactly

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3 Figures for international trade and investment flows are given in Hirst, P and Thompson, G. *Globalisation in Question*. London :1996. (Hereafter cited as Hirst and Thompson: *Globalisation in Question)* W Ruigrok and Tulder, R van *The Logic of International Restructuring.* London: Routledge, 1996. P 124.

4 Hirst and Thompson. *Globalisation in Question.* P 19-22.

5 This has been analysed and explained by many Marxist writers. I would cite Mandel, Ernest: *Marxist Economic Theory*. ( Chapter 11).New York:Monthly Review Press, 1969.

repeats itself every 7, 10 or whatever number of years? To ask is to answer – no. At certain stages, the upswings are more vigorous, more successful, more long lasting, while the downward moves are briefer, and soon overcome. At other periods, it all seems like a trough, with few spots of success. The Russian economist Kondratiev formulated a detailed theory of such "long waves". Leon Trotsky, Alexander Bogdanov, and other prominent Marxists contested some of his views. Further taken up by the Belgian Marxist Ernest Mandel, a revised theory of long waves is very useful in understanding the long-term dynamics of world capitalism.

Using the idea of these long waves or cycles, we can say that the history of capitalism on the international plane appears not only as a succession of cyclical movements every 7 or 10 years, but also as a succession of longer periods, of approximately 50 years. We can list five of them:

- The long wave from the end of the 18$^{th}$ century up to the crisis of 1847, characterized by the gradual spread of the handicraft made steam engine to all the most important branches of industry and industrial countries.

- The long wave from the crisis of 1847 until the beginning of the 1890s, characterized by the generalization of the machine made steam engine as the principal motive machine.

- The long wave from the 1890s to the Second World War, characterized by the generalized application of electric and combustion engines in all branches of industry.

- The long wave that began in North America in 1940 and in the other imperialist countries from 1945-48, characterized by the generalized control of machines by means of electronic apparatuses as well as by the gradual introduction of nuclear energy.

- The long wave that seems to have begun in recent years and in view of its incomplete character, it cannot be analyzed fully. But some elements may be mentioned. The internet is far less significant as an instrument of mechanization. In addition, significantly, it permits fast flow of money

> capital, but not of industry and its products, which depend on technologies developed in the previous long waves. This suggests that this is a long wave with some significant differences.

In any long wave, there are two distinct parts – the upward move and the downward move. There is an initial phase when the technology actually undergoes a revolution, and when such things as the production sites for the new means of production have to be created. In this phase, we have an increased rate of profit, accelerated accumulation, accelerated growth, self-expansion of previously idle capital, and accelerated devalorization of capital previously invested in the production of means of production, which have now been rendered obsolescent. In the second phase, the actual transformation in productive technology has already taken place. It is now a matter of getting the means of production adopted in all branches of industry and economy. The force behind rapid expansion of accumulation in the sector producing means of production falls away, so profits recede, accumulation slows down, valorization of the total accumulated capital becomes difficult, and capital being laid idle gradually increases.

If we look at the history of the world economy since the industrial revolution, we can distinguish the following stages: in the age of freely competitive capitalism, the direct production of surplus value was limited exclusively to Western Europe and parts of North America. Primitive accumulation was taking place in many parts of the world. Textile production by artisans and local peasants was gradually destroyed in these countries while rising domestic industry was often combined with actual factory industry. Some foreign capital flowed in, but did not succeed in dominating the processes of capital accumulation. Two obstacles to the domination by foreign capital should be mentioned – i) the extent of capital accumulation in the first industrialised countries was not sufficient to engage in the establishment of factories in other parts of the world and ii) the inadequate development of the means of communication – notably transports. The spread of railway construction was not an accidental form of industrial growth. Foreign railway construction formed the main form of British, French, Dutch and Belgian foreign investments. But this created a time lag. This lag of a dozen to twenty years provided scope for primitive accumulation on a large scale in economies pressing towards a capitalist mode of production. International wage

differentials facilitated the same process. Even the first transport revolution did not achieve a decisive reduction in the costs of conveying cheap and easily perishable commodities over long distances. So local capital of less developed countries – Italy, Japan, even Russia or Spain, continued to enjoy unthreatened markets in the food industry, brewing, etc (excluding luxury goods in each case). These "developing countries" of that era imported cheap machine goods from abroad, lowered prices, and destroyed traditional domestic production.[6] At the same time, the rapid specialization of their foreign trade was able to secure important sectors of the world market as outlets for their emerging capitalist economies. The profits thus realized became a vital source for the local accumulation of capital. However, integration in the world market and conditions of relative underdevelopment also had negative effects. Productivity of labor was lower in these countries, so all exchanges inevitably led to a drain. Despite the drain and a lower organic composition of capital, however, in those of such intermediate countries where a local class existed capable of breaking up the old order, capitalist development went ahead.

In the age of imperialism, this structure was radically changed. The capital exports of the colonial powers, rather than the process of primary accumulation of the local elites, determined the development patterns of the region then called the colonial world, and later, The Third World, and more recently, The South. The drain became one of a qualitatively higher order. Local surplus was continually and unceasingly soaked up by imperialist capital.

The coming of World War I provided the basis for protectionism and the rise of national capital in the Third World. As the internal market gained relative importance, a process of class differentiation took place between the national producers and the allied popular masses, versus the export oriented globalist classes. The crash of 1929 sealed the fate of the globalists in the Third World countries. In a series of countries that became independent from the late 1940s, the rhetoric of socialism was used to bind popular masses to local capital through protectionism and steps that would create

[6] See Crouzet, F, Chaloner, W.H and Stern, W. M. Ed *Essays in European Economic History 1789-1914*, London: Hodder & Stoughton Educational, 1969.Portal, R.'The Industrialization of Russia'. In *Cambridge Economic History of Europe*, Vol. VI, Part 2, Cambridge: Cambridge University Press,1967. Lockwood, W.W *The Economic Development of Japan*, Princeton: Princeton University Press, 1954.

a national market for weaker local capital and therefore also steps that would protect the local workers and peasants from imperialist capital to enable local capital to exploit them.

Capital by its very nature tolerates no geographical limits to its expansion. Its historical ascent led to the leveling of regional boundaries and the formation of large national markets, which laid the foundations for the creation of the modern nation state. But as capital penetrated into the sphere of production, its expansion came into conflict with the nation state as well. From a world market only in luxury goods, typical of the pre-capitalist age, it sought to build a world market for all its commodities. Not only the power of cheap, mass-produced goods, but also the power of the capitalist state was pressed into service to achieve these aims.

With the third technological resolution, the international concentration of capital started to develop into international centralization. The forces that played major roles were the following:

a) The impossibility of producing profitably on a purely national scale in a number of sectors

b) Monopolistic surplus profits and the resulting increasing amounts of capital at the disposal of big companies which therefore have to go beyond the home markets

c) Technological super-profits

d) A relative decline in the export of capital to the former colonies in the 1950s through the 1970s due to political instability, rise of radical nationalism, protectionism, the spread of the soviet bloc, the Chinese revolution, etc as well as the conversion of the production of many raw materials from early industrial to advanced industrial technology, substitution of chemical for natural methods of producing things (say the shift away from jute in the packaging industry by advanced capitalist countries)

e) Inter-imperialist protectionist wars and the resultant shift from export of goods to export of capital within the big economic players

f) The objective internationalization of capital reaching such a stage that the world market becomes the only conceivable stage for big capital.

With the rate of profit coming under siege in traditional sectors, new sectors had to be located or invented. The services were easy prey. With the rise of the WTO, even basic services started coming under the sway of private capital. Thus, water supply systems in some 120 countries have been taken over, at the municipal level, by Multinationals and Transnational. In many such cases, even when popular resistance has forced the companies to withdraw, they have filed for compensation against the national governments. The most well known of such cases is perhaps the case of Cochabamba.[7] Bechtel, the company forced to pull out after an urban insurrection, filed a case in Washington D.C. in an arbitration court run by the World Bank. For four years afterwards Bechtel and Abengoa found their companies and corporate leaders dogged by protest, damaging press, and public demands from five continents that they drop the case.

On January 19, 2006, Bechtel and its Spanish partner Abengoa representatives traveled to Bolivia to sign an agreement in which they abandoned the ICSID case for a token payment of 2 bolivianos (30 cents). This is the first time that a major corporation has ever dropped a major international trade case such as this one as a direct result of global public pressure, and it sets an important precedent for the politics of future trade cases like it. More significant, it shows that globalization and its alternatives are linked to social struggles and are not the automatic reflection of an inevitable economic necessity.

However, the victory in Cochabamba was rare. In India, there have been many attempts at privatizing sector of water resources. There has been imposed the ‘cost

[7] See Olivera, Oscar and Lewis, Tom. Cochasbamba! : Water War in Bolivia,, Cambridge: South End Press, 2004.

recovery principle', (e.g., in the Maharashtra Water Reforms and Regulatory Act 2005).[8]

The privatization of health care in the years since the late 1980s must be seen within this wider context of structural changes in capitalism as well. In addition, once we do so, a number of changes or deepening of previous orientations become apparent. In 1975, the report of the Hathi Committee had been a landmark development. The Hathi Committee emphasized the achievement of self-sufficiency in medicines and of abundant availability at reasonable prices of essential medicines. But one of its recommendations, that all drugs should carry only generic names rather than brand names, was successfully contested by drug Multi National Companies (MNC) s. During Rajiv Gandhi's prime ministerial tenure, privatization began to be placed up in the agenda. This increased within the very first years after full-scale torn to globalization. Using CEHAT database, Ravi Duggal showed that at the all India level, the proportion of private hospitals went up from 44 per cent in 1986, to 57 per cent in 1991, to 67 percent for 1993.[9]

With the coming of the WTO the agreements creating a new international economic order where social welfare became utterly subordinate to the logic of profit and private ownership and other rights, medical care privatization started reaching dizzy heights. Government control over pricing was hugely reduced. According to a recent study by Selvaraj, any form of social health insurance covers roughly two and a half per cent of the population. Selvaraj further commented that in 1979, 347 bulk drugs were under the price control, which came down to 166 in 1987 and further reduced to 142. Drastically pruning the list of drugs under control further, the Drug Price Control Order (DPCO) of 1995, sought to limit the control to just 76 drugs. Rane, in a detailed study of drug price movements over time, showed that pharmaceutical price policy changes have led to a phenomenal increase in the price of drugs, of different therapeutic groups, during 1980 to 1995, surpassing the general index of prices.[10]

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8 Singh, Arun Kumar. *Privatization of Water Supply.* Mumbai: Vikas Adhyayan Kendra, 2006. P.39.

9 Duggal, R.'Health Care Budgets in a Changing Political Economy', *Economic and Political Weekly*. Vol XXXII, No 20-21, 17 May,1997. P. 1197.

10 Sakthivel Selvaraj, 'How Effective Is India's Drug Price Control Regime?', http://www.hsph.harvard.edu/research/takemi/files/RP256.pdf Accessed on 5.9.2010. Selvaraj

In this, India was not unique. One effect of globalization was of course to impose the same kind of regime in the interests of the same sets of players all over the world. In Vietnam, the acceptance of terms meant the dramatic collapse of district hospitals and commune level health centres. By 1989, the domestic production of pharmaceuticals was down by 98.5 per cent compared to the 1980 figures. With globalization also affecting other areas (e.g., declining incomes) it meant that by 1993, Vietnamese were purchasing in the "free" market only about US$1 worth of pharmaceuticals per head per year. Collapse in curative health meant a growth in deaths caused by malaria well above the growth in rate of malaria.[11]

According to the World Bank, state subsidies to health are said to create undesirable market distortions. Allegedly, these benefit the rich. User fees were advocated even on impoverished local communities. As a result, in sub-Saharan Africa, health establishments have become sources of disease and infection. As a result, communicable diseases like yellow fever, malaria and dengue have dramatically gone up.[12] Our study is a part of this wider pattern.

## Section B

### Impacts.

- **Large-scale growth of Private Health Care Sector.**

**Table 5.1: Growth and Share of Private Sector Hospitals and Beds.**[13]

| Year | Hospitals | | | Hospital Beds | | |
|---|---|---|---|---|---|---|
| | **Public** | **Private** | **Total** | **Public** | **Private** | **Total** |
| 1974 | 2832 (81.4) | 644 (18.6) | 3176 (100) | 211335 (78.5) | 57550 (21.5) | 268885 (100) |
| 1979 | 3735 (64.7) | 2031 (35.3) | 5766 (100) | 331233 (74.2) | 115372 (25.8) | 446605 (100) |

cites Wishvas Rane, Analysis of Drug Prices, 1980-1995. *Economic and PoliticalWeekly*, Vol. XXXI, Aug. 24-31, 1996, P 2331-2340.

11 Chossudovsky, Michel. *The Globalization of Poverty*, Mapusa: (first Indian edition 1997), Other India Press, 2001. P 167-8.

12 Ibid P 71-72.

13 Health Information of India, CBHI, GOI, various years Directory of Hospitals in India, CBHI, DGHS, GOI, various years

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|---|---|---|---|---|---|---|
| 1984 | 3925 (54.6) | 3256 (45.4) | 7181 (100) | 362966 (72.5) | 137662 (27.5) | 500628 (100) |
| 1988 | 4334 (44.1) | 5497 (55.9) | 9831 (100) | 410772 (70.1) | 175117 (29.9) | 585889 (100) |
| 1996 | 4808 (31.9) | 10289 (68.1) | 15097 (100) | 395664 (63.4) | 228155 (36.6) | 623819 (100) |

Figures in brackets denote percentage share According to the India Health Report a recent study estimated that 93% of hospitals and 64% of beds in India are in the private sector.[14] The data clearly reveal that the share of Private hospitals has increased remarkably between 1974 and1996, while that of beds has shown an increase although not as significant as in the number of institutions. While there are exceptions; the majority of these are small institutions, with 85 percent of them with less than 25 beds and average size being 10 beds.[15]

Most such institutions offer maternity and general services and are managed by doctor entrepreneur, either singly or in partnership.[16] Some studies estimate that the sole proprietorship category may comprise more than 80 % of the private sector.[17]

Tertiary specialty and super-specialty private institutions comprise only one to two per cent of the private sector institutions in the country.[18] Corporate hospitals increasingly visible in recent times actually constitute less than one percent. The growing profile of these institutions, run by trust, private or public limited companies, has coincided with the entry of more advanced medical technology and production of super specialists from the country is leading institutions. A study on capital

[14] Nandraj, S. 'The Private Health Sector: Concerns, Challenges and Options', Mimeo In Mishra, Chatterjee, Rao. Ed *India Health Report*.New Delhi:Oxford University Press, 2003 P 103. ( Hereafter cited as *India Health Report*)

[15] Directorate General of Health Services.1988. In *India Health Report*. P 103.

[16] Baru, Rama V et al, ' *State and Private Sector : Some Policy Options'*.( Hereafter cited as Baru et al: State and Private Sector) In *India Health Report*. P 103

[17] Muralidharan, V.R, '*Private Public Partnership in HealthCare. In India : A Review of Policy Options and Challenges'*. 2000. In *India Health Report*. P 103.

[18] Baru et al: State and Private Sector. In *India Health Report*. P 103.

investment in large private hospitals reveals that investment in high technology equipment is viewed as a competitive strategy for increasing market share.[19]

Corporate hospital, rightly termed as 'medical industrial complex',[20] came into existence in a nascent stage prior to the Liberalization era. In 1983, the first corporate hospital was set up in Madras. The Apollo Hospitals Enterprise Limited (AHEL) established it, which within five years have recorded a turnover of Rs 11.48 crore, and a net profit of Rs 1.66 crore. Moreover, many corporate houses and non-resident Indians have joined this enterprise, e.g. Hindujas, Escorts Groups, Standard Organic Group, Surlux Diagnostics Centres, United Breweries Group, Goenkas, Birlas and Modis.[21]

- **Post Structural Adjustment Programme (SAP) Developments.**

However, the post Structural Adjustment Programme (SAP) era witnessed certain glaring changes in the domain of health care in India. There was a reduction in the public expenditure from 90's onwards and this resulted in a steep fall in central grants to the disease control programme. Tulasidhar's work shows that central grants for disease control programs fell from 41 percent in 1984—85 to 29 percent in 1988—89 and to 18.5 percent in 1992—93[22]. The poorer states, which were much more dependent on central outlays, suffered as a result. During 1992—93 some of the cutbacks were restored through World Bank loans for specific diseases programs. Much of this restoration could be attributable to a 34 percent increase for AIDS control and a marginal increase for tuberculosis and blindness control programs.[23]

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19 Sukanya, S. '*A Study on Capital Investment in Private Hospitals in Madras City'*, MS Dissertation, Department of Humanities and Social Sciences, IIT, Madras.1994 and Sukanya, S. 'Investment in Medical Equipment: Study of Private Hospitals in Madras City', *Radical Journal of Health*, Vol. 12 No 1.In *India Health Report*. P 103

20 Relman, Arnold. 'The Medical Industrial Complex'. *New England Journal of Medicine*. 1988 September 22. In Nandaraj, S. 'Beyond the Law and the Lord : Quality of the Private Health Care'. *Economic and Political Weekly*. Vol XXIX No 27. 4rth July. 1994. P 1681 ( Hereafter cited as Nandaraj : Beyond the Law and the Lord)

21 Nandaraj : Beyond the Law and the Lord. P 1681

22 Tulsidhar, V B. 'Expenditure Compression and Health Sector Outlays'. *Economic and Political Weekly*. 1994,28(45) 2473 In Baru, Rama V. 'Health Sector Reforms and Structural Adjustment : A State Level Analysis' In *Public Health and Poverty of Reforms.* Ed by Quadeer, Imrana, Sen, Kasturi,. Nayar, K.R. New Delhi: Sage Publications, 2001 P 214. ( Hereafter cited as Baru: A State Level Analysis)

23 Baru: A State Level Analysis. P 214

During 1993—94, there was a marginal increase for malaria but other communicable diseases registered a decline. In this entire period, the outlays for curative services had stagnated and in some states even registered a decline. The restoration of the cutbacks for communicable disease programs was necessitated by outbreaks of several epidemics resulting in a large number of deaths. The deaths due to the plague epidemic in Surat and malaria in western Rajasthan in 1994 were attributed to two important reasons: (i) the slashing of budgets for communicable diseases in the early nineties; and (ii) declining standards of public health in general.[24] The breakdown of the public health services became apparent from the Surat plague epidemic. The public health system revealed glaring weaknesses. First, there was no co-ordination among various departments, needed for efficient management of crisis".[25]

There was lack of coordination at various levels. Information regarding diagnosis and treatment was inadequate and there were conflicts between hospital staff and public health officials. Government hospitals, which do not have the infrastructural facilities to function properly even during normal times, were burdened during the crisis. Private hospitals refused to treat patients. In fact, during the epidemic a large number of private practitioners either fled from Surat or refused to treat patients. The plague epidemic thus brought out the indispensability of public hospitals despite all their limitations.[26]

Baru has correctly pointed out that from 90's onwards there was the rapid expansion of secondary- level private hospitals in several states. Increasingly, the private sector is no longer a mere urban phenomenon, but due to intense competition within this sector, they are being forced to move into peri-urban and rural areas. The real significant changes have taken place at the tertiary level. One of these is that corporate and trust hospitals at this level have started collaborating with state governments and very recently with Multi National Corporations (MNC) s. This is a new trend as against the presence so far of indigenous business groups. Given the

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[24] Quadeer I, Nayar K.R and Baru, Rama V 'Contextualizing Plague: A Reconstruction and Analysis'. *Economic and Political Weekly,* 1994, 29(47): 2981 In Baru: A State Level Analysis. P 214.

[25] Shah, G. *Public Health and Urban Development: The Plague in Surat* New Delhi : Sage Publications,1997. In Baru: A State Level Analysis. P 214.

[26] Baru: A State Level Analysis. P 215.

growth of the middle class, there is a market for specialty services for the middle and upper middle classes in both urban and rural areas.[27]

**Table 5.2: Collaborations in the Tertiary Private Hospital Sector, 1997.**[28]

| Sl. No. | Indian Company | Collaborations | Type of Hospital | Location |
|---|---|---|---|---|
| 1 | C.K. Birla Group | Kleveland Klinik of the U.S. | Super Specialty 350-bedded Hospital | Jaipur |
| 2 | Escorts Heart Institute | Gleneagles Singapore | Duncan's Gleneagles Super Speciality — 900 Beds | Kolkata |
| 3 | Wockhardt | Gleneagles Singapore | health Care Center | Mumbai |
| 4 | Sterling Gujarat | Gleneagles Singapore | Corporate Hospital | Baroda |
| 5 | Ranbaxy Laboratories | Gleneagles Singapore | Corporate Hospital | Mohali, Chandigarh |
| 6 | Apollo Hospital | Jardine, Insurance U.K. | Hospital Health Maintenance Organization | Delhi |
| 7 | Apollo Hospital | Delhi Admn. | Apollo Indraprastha Multi Specialty hospital | Delhi |
| 8 | Apollo Hospital | Delhi Admn. | 800 Beds Hospital | Delhi |
| 9 | Royalton Health Care (India) Pvt. Ltd | Montreal based Royalton Medical Management | Tertiary | Gandhinagar, Gujarat |

Thus from 90's onwards the tertiary hospitals in India gained a strong footing in the domain of private health care sector. Moreover, the collaborations with the multinationals started to change the very nature of the private health care sector,

[27] Ibid P 215
[28] Compiled from newspaper and magazine clippings 1997, In Baru: A State Level Analysis. P 216

which was once identified with small nursing homes and maternity clinics. The entry of the multinationals in health care converted it to an expensive commodity making it available only to a handful of few.

The development of the private health care sector in India in recent years has been depicted in table 3. The growth rate of the private hospitals in India and the subsequent shrinking down of the public health care sector can be compared from table 5.1 and table 5.3.

**Table 5.3: Number of hospitals and beds according to ownership.**[29]

| | | GOVERNMENT | | LOCAL BODIES | | PVT. & VOL. ORG. | | TOTAL | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Sl. No.** | **State / UT** | **Hospitals** | **Beds** | **Hospitals** | **Beds** | **Hospitals** | **Beds** | **Hospitals** | | **Beds** | **Reference period** |
| 1 | Andhra Pradesh | 331 | 27586 | .. | .. | 2802 | 42192 | 3133 | | 69778 | 1.1.1998 |
| 2 | Arunachal Pradesh | 14 | 1236 | 0 | 0 | 1 | 189 | 15 | A | 1425 | 1.1.2002 |
| 3 | Assam | 141 | 9687 | 47 | 982 | 80 | 1992 | 268 | | 12661 | 1.1.1991 |
| 4 | Bihar | 237 | 20522 | 1 | 49 | 90 | 8519 | 328 | | 29090 | 1.1.1992 |
| 5 | Chattisgarh | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 | 0 |
| 6 | Goa | 12 | 2095 | .. | .. | 118 | 2282 | 130 | | 4377 | 1.1.2002 |
| 7 | Gujarat | 312 | 22229 | 64 | 4321 | 2152 | 36867 | 2528 | | 63417 | 1.1.1995 |
| 8 | Haryana | 61 | 5068 | .. | .. | 18 | 1666 | 79 | | 6734 | 1.1.2002 |
| 9 | Himachal Pradesh | 61 | 5630 | 6 | 98 | 22 | 581 | 89 | | 6309 | 1.1.2002 |
| 10 | Jammu & Kashmir | 17 | 1555 | .. | .. | 26 | 521 | 43 | | 2076 | 1.1.2000 |
| 11 | Jharkhand | .. | .. | .. | .. | .. | .. | .. | | .. | |
| 12 | Karnataka | 209 | 27766 | 28 | 714 | 56 | 9999 | 293 | | 38479 | 1.1.1998 |
| 13 | Kerala | 141 | 30432 | .. | .. | 1958 | 67517 | 2099 | | 97949 | 1.1.1998 |
| 14 | Madhya Pradesh | 95 | 10818 | .. | .. | .. | .. | 95 | | 10818 | 1.1.2001 |
| 15 | Maharashtra | 215 | 39350 | 208 | 17066 | 3023 | 42646 | 3446 | | 99062 | 1.1.2000 |

[29] http://cbhidghs.nic.in/hia/8.02.htm Accessed on 10.10.2009.

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 16 | Manipur | 14 | 753 | 1 | 881 | 4 | 100 | 19 | | 1734 | 1.1.2001 |
| 17 | Meghalaya | 7 | 1243 | .. | . | .. | .. | 7 | | 1243 | 31.3.2000 |
| 18 | Mizoram | 7 | 688 | 0 | 0 | 4 | 344 | 11 | | 1032 | 31.3.2001 |
| 19 | Nagaland | 17 | 964 | | | | | 17 | | 964 | 31.3.2000 |
| 20 | Orissa | 254 | 11668 | 5 | 111 | 14 | 201 | 273 | | 11980 | 1.1.2001 |
| 21 | Punjab | 177 | 10972 | 3 | 75 | 40 | 3728 | 220 | | 14775 | 1.1.2002 |
| 22 | Rajasthan | 113 | 17459 | .. | .. | .. | .. | 113 | | 17459 | 1.1.2002 |
| 23 | Sikkim | 1 | 300 | 0 | 0 | 1 | 400 | 2 | | 700 | 1.1.2002 |
| 24 | Tamil Nadu | 282 | 37935 | 7 | 479 | 119 | 10366 | 408 | | 48780 | 1.1.1990 |
| 25 | Tripura | 17 | 1697 | 0 | 0 | 10 | 76 | 27 | | 1773 | 1.1.2001 |
| 26 | Uttar Pradesh | 534 | 34267 | 42 | 985 | 159 | 12026 | 735 | | 47278 | 1.1.1986 |
| 27 | Uttaranchal | .. | .. | .. | .. | .. | .. | .. | | .. | |
| 28 | West Bengal | 254 | 47719 | 23 | 772 | 134 | 6788 | 411 | | 55279 | 1.1.2002 |
| 29 | Andaman & Nicobar Is. | 4 | 684 | 0 | 0 | 2 | 40 | 6 | | 724 | 1.1.2002 |
| 30 | Chandigarh | 4 | 2019 | .. | .. | .. | .. | 4 | | 2019 | 1.1.2001 |
| 31 | Dadra & Nagar Haveli | 1 | 75 | 0 | 0 | | | 1 | | 75 | 1.1.2002 |
| 32 | Daman & Diu | 2 | 140 | 0 | 0 | 4 | 80 | 6 | | 220 | 1.1.2001 |
| 33 | Delhi | 47 | 13672 | 20 | 5615 | 493 | 10980 | 560 | | 30267 | 1.1.2002 |
| 34 | Lakshadweep | 2 | 70 | .. | .. | .. | .. | 2 | | 70 | 1.1.2000 |
| 35 | Pondicherry | 10 | 2842 | .. | .. | 15 | 2156 | 25 | C | 4998 | 1.1.2002 |
| | Total | 3593 | 389141 | 455 | 32148 | 11345 | 262256 | 15393 | D | 683545 | |

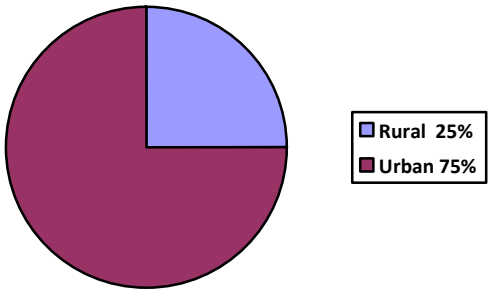
It has been estimated that the total number of public hospitals in India from 1974 to 1996 is 4808 and the bed strength is 395664.In the year 2002, this number of public hospitals has been reduced to 3593 and the subsequent bed strength to389141. On the other hand, private health care has exhibited a sharp rise. The growth of private hospitals in India between 1974 to 1996 accounted to 10289 and the bed strength was 228155. While the number in the case of both private hospitals and hospital beds multiplied to 11345 and 262256 respectively in the year 2002.

The rural –urban differences of the hospital and hospital beds both in cases of public and private sector are distinct.[30]

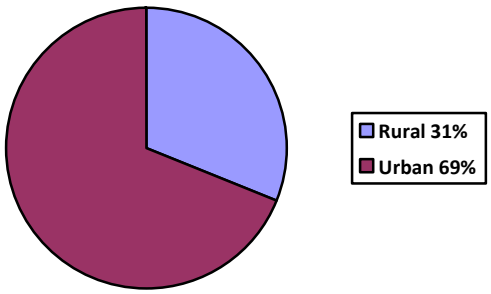
[30] The distribution of private sector facilities and doctors between states and regions is even more inequitable than the public health facilities, reflecting the tendency to concentrate in better-off states and better-off regions. As in the case of public services, rural-urban differences are acute, with a clear urban bias as shown in Figure1. Indeed private hospitals are less urban-based than public ones at the all-India level. However, what is to be remembered is that the bulk of medical care in rural areas, and a not- insignificant amount in urban areas, is provided by unqualified medical practitioners, estimated to be about one million. While the quality of medical care is said to be dubious, this is not a characterization that sticks to unqualified medical practitioners alone.(Misra: *India Health Report*, Rao: *State of Health in India*, *Human Development in South Asia*)

**Figure 1: Rural-Urban Distribution of Hospitals/ Hospital beds: Public and Private Sectors**

Hospital (Government )




Hospital (private)

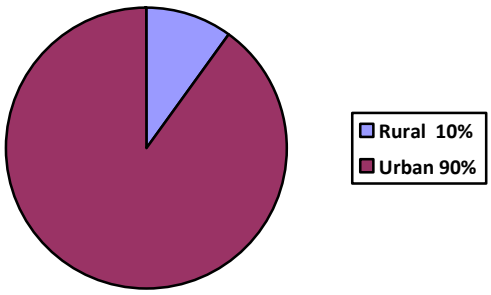



Hospital Bed (Government)

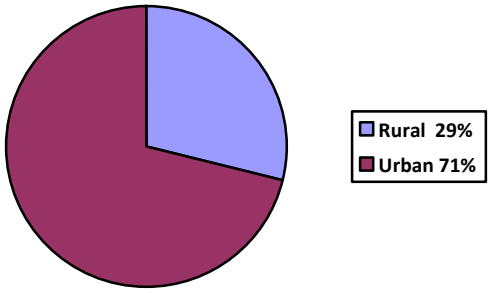
Source: Directory of Hospitals in India, 1998, Nandraj, S. Private Health Sector: Issues, Challenges, Options, 2000

The World Bank, which has taken the most proactive role towards the growth of private health care sector in developing countries, identified the large role of this sector as a response to the failure of public health care facilities in India.

In India, the private health sector is commonly understood to refer to private, for-profit, medically trained providers. Their range of practice varies from solo practices and small nursing homes (inpatient facilities with usually less than 30 beds) to large corporate hospitals. However, the set of non-government actors involved is much broader and includes nonprofit entities and providers of Indian systems of medicine such as ayurvedic and unani. Many untrained providers offer a combination of systems of medicine, although Western medicine (allopathy) tends to dominate. The private sector also offers ancillary services such as diagnostic centers, ambulance




Hospital Bed (Private)



services, pharmacies In addition, a large number of private actors provide services or manage other inputs to the sector (construction companies, consultancy firms).[31]

Although the most recent data are weak, they suggest that the private provision of health is growing rapidly and is the major source of out patient and inpatient health care across India. As mentioned above, the World Bank also recorded that the private hospitals have exhibited a sharp growth in recent years.[32]

- **'Corporatization of HealthCare'.**

The article 'Corporatization of healthcare in India: The liberalization effect' [33] gave an excellent overview of the health care situation in the post liberalization era. One of the most significant trends emerging in the wake of liberalization is the new vigor of the entry of corporate hospitals and multinationals in the health care scenario. The reason for this new tempo is the potential that India offers to NRIs and multinationals. With the current ratio of population to all types of beds being 1300: 1, it has been estimated that there is a huge demand–supply gap, which may require nearly 3.6 million beds to overcome it. Taking into account the requirements of primary and secondary health care, the shortfall is estimated to be around 2.9 million beds. In tertiary health care, the gap may be somewhere around 20% of the above total, which amounts to some 0.58 million. With investment costs per bed per year (including land, building, equipment, support system and medical consumables) ranging from Rs 0.7 million to Rs 3.5 million depending upon the nature of specialty, the resource requirements are enormous. Further, from a survey conducted by the Confederation of Private Sector Initiatives in Health Care, it is estimated that against a requirement of 60 000 super-specialty beds each year, only 3000 multi-specialty beds are being planned in India, which may cost around Rs 7200 million over the next 3 years. Realizing the need, the potential for profit and from a desire to develop the States of their original domicile, many NRIs from the USA and UK have taken interest in the development of health care diagnostics or super-specialty hospitals in their

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31 Peters, Yazbeck, Sharma, Ramana, Pritchett, Wagstaff. '*Better Health Systems for India's Poor : Findings, Analysis and Options'*. Washington, D.C :World Bank, 2002. P44.( Hereafter cited as *Better Health Systems for India's Poor*)

32 Ibid P 45

33 http://www.article alley.com_882070_15.html.Accessd on 14.06.2010.

hometowns. Between August 1991 and August 1997, the Foreign Investment Promotion Board (FIPB) approved foreign direct investment (FDI) proposals worth US$100 million (about Rs 3600 million) in the Indian health care sector. The major chunk of this FDI (Rs 1160 million) goes to Delhi, helping in the development of a super-specialty hospital and diagnostic centres. Other places in the country to benefit from this NRI investment include Guntur in Andhra Pradesh, Bhuwaneshwar in Orissa (Rs 30 million), Kolkata in West Bengal (Rs 80 million) and Bangalore in Karnataka (Rs 0.6 million). These investments in States other than Delhi are mostly focused on diagnostic centres and bring with them high-tech care, advanced medical technology and trained Indian medical manpower. This is partly halting and reversing the brain drain of medical personnel.

Health care is thus emerging as a blue-chip industry and in recent years has attracted the investment of both domestic and foreign companies. Unlike the earlier image of the private sector, which mainly focused on nursing homes and polyclinics, the new market orientation is towards super specialty care. In this regard, although a group known as Apollo made the pioneering efforts back in 1983, a number of other companies have now entered the market.

Notable among the latter include successful domestic and foreign companies like CDR, Wockhardt, Medinova, Duncan, Ispat, Escorts, Mediciti, Kamineni, Parkway, Jardine, Nicholas and Sedgwick. The entry of so many such companies has added towards corporatization of the health care industry with a focus on high profit margin, super specialty and diagnostic care. Mostly these companies have expanded their network in India’s major metropolitan towns.

Along with the rising cost of health care in the last 5 years, the foreign companies are aiming to capture the potential of the health insurance market for nearly 135 million people in the upper-middle income segment of the population who can afford private health care. Against an estimated potential health insurance market of between Rs 6500–275 000 million, the present annual health insurance premium market by the General Insurance Corporation and its subsidiaries is merely Rs 1000 million, covering just 1.6 million people. In view of the possible opening of the market to

multinationals, many foreign companies have already taken preliminary steps, such as setting up their representative offices or entering into ties with Indian companies.

These companies aim to devise health insurance schemes suited to the Indian situation, to improve coverage by incorporating payments for general physicians (GP), medical tests and specialist charges, and containing costs through appropriate controlling systems.[34]

Following Phadke,[35] it is pertinent to argue that in corporate health care, the need for trained medical personnel to treat a sick patient has been minimized. Rather, there are plenty of investors in the share market of health in the disguise of doctors who are in search of profitable investment at the cost treating patients.

Converting health care to an industry and treating patients as valuable clients indeed represented the unscrupulous attitude of the Indian Government. The decline of the welfare state had resulted in the state inviting the private and corporate capital in health for providing health care facilities only to the upwardly mobile section of the populace. The health facilities of the ailing masses were pushed to the mercy of the poorly funded 'undernourished' public hospitals.

In the run –up to the presentation of the union budget private hospitals made several demands for government subsidies. In the face of increased competition, they claimed they had been unable to make profits. In this situation, many of these enterprises sought government subsidies as one of increasing their financial viability.[36]

Some of the demands that these hospitals have made include 'the granting of status of infra structure; providing a level field for health care; giving nursing homes the status of small scale industry; giving more financial support in terms of infra structure, loans and further reduction of import duties on medical equipments. They demanded a depreciation of 40% on medical equipment and benefits for investment in shares of

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34 Also see http://www. fortishealthcare.com/about_fortis/news_events/Healthcare.New.html, Accessed on 14.6.2010 http://www.india-seminar.com/2000/489/489%20baru.htm, Accessed on 14.06.2010 and Jesani, A and Anantharam, S.*Private Sector and Privatisation in the Health Care Service.*Bombay: FRCH, 1993.

35 See Phadke, A. '*The Private Medical Sector in India'* Bombay: FRCH, 1994

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

hospital companies. Along with these, the promoters of private hospital companies also wanted tax exemptions to be given to doctors who practice in rural areas and more those who set up nursing homes in backward areas. Their demands include more concessions for facilitating entry of health insurance and privatization of government hospitals in the future. The promoters of corporate hospitals in Chennai articulated these demands. (*The Hindu*, February 28, 2000)[37] They clearly reflect the priorities and interests of the large private enterprises, which roughly constitute 1-2 percent of the private market but have been strongly powerful in influencing the government policy during the last two decades.[38]

While these large private hospitals have been demanding more subsidies and concessions from the government, many of them have been found to be flouting the conditionalities prescribed by the government. An important conditionality was that 20% of inpatients and 40% of out patients should be from among the poor and that they must be treated free of cost.[39] This was true also in case of AMRI Kolkata. (See chapter 4)

Another significant development in the private health care sector was the Foreign Direct Investment. (FDI).

In recent years, there is growing interest among foreign players to enter India's healthcare sector through capital investments, technology tie-ups, and collaborative ventures across various segments, including diagnostics, medical equipment, hospitals, and education and training. For example:

- Singapore's Pacific Healthcare has made its first foray into the Indian market, opening an international medical centre, which is a joint venture with India's Vitae Healthcare, in the Indian city of Hyderabad.

- The Singapore based Parkway Group Healthcare PTE Ltd penetrated into the Indian health care market in 2003 through a joint venture with the Apollo group to build the Apollo Gleneagles hospital, a 325-bed multi-specialty hospital at a cost of US$ 29 million.

37 Ibid P 2509
38 Ibid P 2509
39 Ibid P 2509

- Columbia Asia Group, a Seattle-based hospital services company, a worldwide developer and operator of community hospitals, has started its first American- style medical centre in Hebbal, Bangalore. Columbia Asia is the first hospital to enter the Indian healthcare market through the Foreign Direct Investment route.

- Wockhardt, the international arm of the Harvard Medical School, which also has a strategic association with Harvard Medical International, has set up a new hospital (a tertiary service provider) in Bangalore at a cost of around Rs. 200 crores.

- The Parkway group has also entered into a joint venture with a Mumbai-based Asian Heart institute and research centre to set up specialised centres of medical excellence in Mumbai.

- Max Healthcare and Singapore General Hospital (SGH) have entered into collaboration for medical practice, research, training and education in healthcare services.

- Steris, a US$ 1.1 billion healthcare equipment company, plans to set up a wholly owned arm in India to sell its devices and products in the country's booming medical device market. Steris plans to make an initial investment of US$ 1,00,000 to set up the wholly owned subsidiary.

- Apollo Hospitals Enterprise Ltd has entered into a joint venture with Amcare Labs, an affiliate of Johns Hopkins International of the US, to set up a diagnostic laboratory in Hyderabad. An initial amount of US$ 2.2 million is to be invested and the laboratory is likely to be operational by mid-2006.

- India's first geriatric hospital, the Heritage Hospital of Hyderabad has formed a joint venture with US-based United Church Homes to recruit, train and provide placement to registered Indian nurses in USA.

- The US-based healthcare products major, Proton Health Care has made an entry into India with its range of digital health monitoring devices and has a strategic tie-up with the Delhi based S M Logistics for distributing its products in the Indian market.

- The American Association of Physicians of Indian Origin (AAPI), a Non-Resident Indian group will be launching two pilot projects in Bihar and Andhra Pradesh in July 2006 to help improve India's healthcare in rural areas. The AAPI has committed itself to the improvement of primary healthcare under a memorandum of understanding during the Pravasi Bharatiya Divas, the annual conclave of the Indian Diaspora, with the government.

The following section discusses the nature and extent of foreign involvement in the hospitals segment in India. It focuses primarily on the role of foreign financing in Indian hospitals through FDI and other forms of financing (including FIIs, private equity funds, venture capitalists, and other modes) in the total financing structure of private sector hospitals in India and the regulatory environment affecting these inflows.[40]

Since January 2000, FDI is permitted up to 100 percent under the automatic route in hospitals in India. Thus, no government approval is required as long as the Indian company files with the regional office of the RBI within 30 days of receipt of inward remittances and file the required documents along with form FC-GPR with that Office within 30 days of issue of shares to the nonresident investors.[41] Controlling stake is also permitted in hospitals for foreign investors. The lax investment environment for hospitals is also evident from the discussions. No major regulatory hurdles were cited by any of the respondents with regard to the setting up of hospitals.

One respondent noted that there are some 20 odd licenses to procure, including environmental and various safety clearances, but the process is generally perceived to

[40] Foreign Presence in Hospitals in India. In http://whoindia.org/linkfiles/trade_agreement_fdi-3.pdf (Hereafter cited as Foreign Presence in Hospitals in India)

[41] See, RBI note on Foreign Investments in India (April 1, 2007) In Foreign Presence in Hospitals in India.

be quite streamlined. There is some concern about corruption and lack of transparency in some parts of the application process, and long processing time (around 6 months in some cases) and lack of response from authorities for particular licenses. But the hurdles are felt mostly at the operational level rather than in the regulatory framework per se.[42]

The following discussion highlights the available evidence on hospitals that have received FDI in recent years and views on the extent to which FDI is likely to come into the hospital business in India. It needs to be pointed out that individuals or a group of foreign investors on the other makes a distinction between FDI in the traditional sense of ownership of physical assets on one hand and private equity and FII funding of hospitals through holdings of shares. If one goes by the current definition of FDI in India, private equity stake of over 10% by any individual investor also counts for FDI and Foreign Institutional Investors (FIIs) are permitted to invest under the FDI route in addition to the FII route.[43]

In order to understand the extent and nature of foreign direct investment in hospitals, a list of all FDI approved projects in hospitals and diagnostic centres during the January 2000 to July 2006 period was obtained from the Department for Industrial Policy and Promotion. This list consisted of 90 projects, for a total approved FDI amount of $53 million, and covering a wide range of countries, such as Australia, Canada, UK, US, the UAE, Malaysia, and Singapore, among others. However, if one examines the list of approved projects and separates hospitals from diagnostic centres, then one finds that the majority of these approved projects are diagnostic centres. Only 21of the approved projects are in the hospitals segment. The following table shows the approved projects for FDI in hospitals as received from the DIPP, along with the source countries, and the Rupee and US dollar values of FDI approved.[44]

42 Ibid
43 Ibid
44 Ibid

**Table 5.4: Approved FDI Hospitals by DIPP (January 2000-June 2006).**[45]

| Sl. No. | Date | Indian Company | Country of foreign investor | Foreign equity (Mns) | |
|---|---|---|---|---|---|
| | | | | Rs. | US$ |
| 1 | April 2002 | Fernandez Maternity Hospital, Hyderabad | Australia | 0.42 | 0.01 |
| 2 | December 2002 | Sir Edward Dunlop Hospitals. New Delhi | Canada | 1.282.25 | 26.71 |
| 3 | January 2004 | Max Healthcare. New Delhi | Mauritius | 316.21 | 6.63 |
| 4 | January 2000 | Dr. Ramayya's Pramila Hospitals Ltd. Hyderabad. | UK-NRI | 15.00 | 0.35 |
| 5 | January 2000 | HN Hospital. Mumbai | USA- XR] | 0.00 | 0.00 |
| 6 | September 2003 | Kalinga Hospital, Bhubaneshwar | NRI | 54.09 | 0.11 |
| 7 | August 2000 | Thaqdees Hospitals Ltd, Thaikkatukkara, Kerala | Saudi Arabia | 0.32 | 0.01 |
| 8 | January 1, 2003 | Duncan Gleneagles, Kolkata | Singapore | 59.24 | 1.29 |
| 9 | July 2004 | Pacific Hospitals, Hyderabad | Singapore | 5.82 | 0.13 |
| 10 | October 2001 | Malabar Institute of Medical Sciences Hospital Ltd., Calicut | UAE | 133.01 | 2.97 |
| 11 | July 2002 | Peoples General Hospital Ltd. Bhopal | UAE | 73.32 | 1.53 |
| 12 | August 2001 | Thaqdees Hospitals Ltd, Ernakulam | UK | 0.34 | 0.01 |
| 13 | July 2001 | Trichur Heart Hospital. Thrissur" | UK | 49.89 | 1.11 |
| 14 | August 2002 | Bhimavaram Hospital Ltd., Bhimavaram | USA | 0.10 | 0.00 |
| 15 | December 2002 | S &V Loga Hospital Pvt. Ltd, Peramanur, Salem | USA | 3.79 | 0.08 |
| 10 | November 2003 | Vikram Hospital, Mysore | USA | 29.05 | 0.64 |
| 17 | February 2004 | Basappa Memorial Hospital Pvt. Ltd., Mysore | USA | 22.83 | 0.50 |
| 18 | April 2004 | Parekh Hospital Pvt. Ltd. Mumbai | USA | 0.50 | 0.01 |
| 10 | July 2004 | Columbia Asia Hospital Pvt. Ltd., Bangalore | USA | 0.90 | 0.02 |
| 20 | August 2004 | Add Life Medical Institute Ltd. Sterling Hospital Building, Ahmadabad | USA | 326.24 | 7.07 |
| 21 | January 2004 | RA Multispecialty Hospital Pvt. Ltd, Coimbatore | British Virginia | 0.06 | 0.00 |
| | | | | | |

[45] Ibid

Thus, it can be inferred that the intrusion of global capital in the form of FDI in the hospitals of India not only strengthened the market for private health care sector, it has also played a pivotal role in converting the entire health care sector from any concept of caring to a lucrative industry. However in a third world country like India, these changes in the overall health care sector widened the gap between rich and poor. The 'ability to pay' factor started to play a dominant role in determining the utilization pattern of the health services by the various social classes

- **Medical equipments: Local and Global linkages.**

The reduction of import duties on the high technology medical equipments further consolidated the capital accumulations in private health care sector. The increasing demand for high tech medical instruments is visible from the Sixth Five Year Plan, which estimated an amount of Rs 30 crore in 1984-1985, while in the Seventh Plan period; the Confederation of Engineering Industries estimated it around Rs 900 crores.[46]

During 1986-1987, India exported equipments worth Rs 7 crores against the import of Rs 65 crores. Government allows 237 types of equipments for imports without insisting on the 'Not Manufactured in India' (NMI) certificate. In case of the central or government aided hospitals, only the head of the institution need to certify the NMI. Even for the private hospital, the NMI certificate is not needed provided a certificate from the Directorate General of Health Services is obtained. Thus, the linkage between the import and the export of medical equipments is loosened leading to the fast growth in imports and high negative balance of the trade in the medical equipment.[47]

Table 5 shows the increased value of imports of a variety of medical equipment and radiological apparatus from 1976 onwards. The steep increase during the early 80's, was probably an effect of government's policy to liberalize import of equipment in order to encourage the growth of the private sector. This trend has been maintained

[46] Jesani, A and Anantharam, S.*Private Sector and Privatisation in the Health Care Service*.Bombay: FRCH,1993. P 37

[47] Ibid P 37., also see Foreign Presence in Hospitals in India. In http://whoindia.org/linkfiles/trade_agreement_fdi-3.pdf

from the mid 90's. During the early nineties, there was a decrease in the value of imports for medical equipment. This was probably because the early nineties was a period of economic crisis when informal restrictions were in place.[48]

From 1993, the imports started gradually increasing, suddenly registering a sharp increase in 1996-97. The 1997-98 budgets, which cut down further on import duties, could mean that the trend in increase of imports would continue for the next couple of years. During the 1998, a number of multinational companies, like Dickinson& Co, based in the US, and Siemens and Phillips started setting up units for the manufacture of medical equipment. The range of products includes syringes, ultrasound and scanners.[49]

**Table 5.5: Foreign Investors in Medical Equipment.**[50]

| Sl. No. | Company | Investment Type | Equipment | Location |
|---|---|---|---|---|
| **1.** | Becaton, Dickinson & Co., USA | $100 million (Rs 360 crore) over next five years | Syringes, catheters, blood tubes | Rajasthan |
| **2.** | Siemens, Germany | Rs 30 crore | CT Scanners, models, ultrasound devices, X-ray machines | Goa |
| **3.** | Philips | NA | Flat screen ultrasounds | Pondicherry |

The high volume of imports is related partly to the relatively small presence of the indigenous sector in the production of medical equipment. According to an estimate in the early nineties, total indigenous production amounted only to Rs 1.4 crore.[51]

[48] Baru, Rama V. *Private Health Care in India. Social Charecteristics and Trends*.New Delhi: Sage Publications,1998.P 68. ( Hereafter cited as Baru : Private Health care )
[49] Ibid P 69
[50] Source: Newspaper clippings 1997. In Baru: A State Level Analysis P 216.
[51] Baru *: Private Health Care* P 70.

**Table 5.6: Import of Medical Instruments and Appliances.**[52]

| SL No. | Year | Value of Imports | |
|---|---|---|---|
| | | **Current Price** | **1978-79 Prices** |
| 1 | 1976-77 | 364 | 379 |
| 2 | 1977-78 | 555 | 597 |
| 3 | 1978-79 | 747 | 747 |
| 4 | 1979-80 | 880 | 772 |
| 5 | 1980-81 | 1272 | 949 |
| 6 | 1981-82 | 1423 | 1069 |
| 7 | 1982-83 | 1971 | 1449 |
| 8 | 1983-84 | 3268 | 2614 |
| 9 | 1984-85 | 2895 | 1798 |
| 10 | 1985-86 | 5857 | 3683 |
| 11 | 1990-91 | 811.8 | 300 |
| 12 | 1992-93 | 5521.3 | 1668 |
| 13 | 1993-94 | 8234.5 | 2516 |
| 14 | 1996-97 | 38280.2 | 9570 |

**Note:** Number in lakh rupees. The 1978-79 prices have been determined by deflating the figure at current prices for each year with the corresponding index of unit value of imports (1978-79) taken from various issues of *The Economic Survey, Ministry of Finance*, Government of India. The reason for a dip in 1990-91 was the informal import restrictions during the tear of economic crisis.[53]

Baru has also pointed out that the indigenous production of electro –medical equipment began during the mid sixties, and this sector accounts for only 1-2% of the total electronic equipment produced in the country. There are several reasons for the poor expansion of the indigenous sector. They include:[54]

- Highly liberalized import policy of finished medical electronic products and inadequate fiscal protection to the indigenous industry.

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52 Government of India, Director General of Commercial Intelligence and Statistics, Monthly Statistics of the Foreign Trade of India, Kolkata.( Government of India, various years) In Baru : *Private Health care* P 69.

53 Ibid P 69.

54 Mantec Consultants. 1991. *Technology Evaluation and Norms Study in Medical Electronics Equipment/ Systems Industry*. Commissioned by the Ministry of Science and Technology, Department of Scientific and Industrial Research. New Delhi: Government of India. In Baru: *Private Health care* P 70.

- Lack of institutional support to the small scale industries sector on technology, product development, testing quality assurance, marketing and man power development.;
- Lack of in –house Research and Development efforts by the industry.
- Limited sales volume.
- Inadequate customer after –sale service support by manufacture.

It has been also mentioned by Mantec Consultant that the government and charitable hospitals are allowed duty free imports of medical equipments.[55]

Following Baru, it is significant to point out that the government of a welfare state's liberalization policy opened the floodgates for the entry of the multinationals in health care. It is the state's initiative, which converted health care from a service to an expensive commodity, making it techno centric and curative in nature. Investing on preventive measures is a poor option for strengthening the market of health care, as this might challenge the miserable public health condition of the country.

- **The Doctors.**

Data on the health workforce in the private sector are hard to come by. Between 400,000 and 470,000 allopath doctors were estimated to have been in practice in 1997,[56] with about 80—85 percent of them in the private sector.[57] However, many doctors employed in the public sector also work in the private sector, with one study in Delhi showing 85 percent of public sector doctors also practicing in the private sector.[58] Of the 120,000 doctors estimated to have been practicing Indian systems of medicine in 1981, about 85 percent were in the private sector.

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55 Ibid P 70

56 Planning Commision. 1998. Ninth Five Year Plan 1997-2002. Vol II. New Delhi. In *Better Health Systems for India's Poor*.P 47

57 Duggal, R. *The Private Health Sector in India: Nature, Trends and a Critique*. New Delhi: Voluntary Health Association of India, 2000.In *Better Health Systems for India's Poor*.P 47

58 Chawla, M. 2000. Private and Public Markets for Physicians Services in Developing Countries. Evidents of Inter –Linkages. In *Better Health Systems for India's Poor. P* 47

**Table 5.7: Health Core Work Force and Health Facilities in the Public and Private Sectors in India, Selected Years, 1981-98.**[59]

| Indicator and Measure | Value |
|---|---|
| *Doctors* | |
| Total number (1998) includes all systems) (CBHI1 | 1,109,853 |
| Population per doctor | 880 |
| Percentage of doctors in rural areas (1981) (census) | 41 |
| Percentage of all doctors in private sector (estimated) | 80—85 |
| | |
| *Nurses* | |
| Total number (1996) | 867,184 |
| Population per nurse | 976 |
| Doctors per nurse (1996) | 1.4 |
| | |
| | |
| *Hospitals* | |
| Total number (1996) | 15,097 |
| Population per hospital | 56,058 |
| Percentage of hospitals in private sector | 68 |
| Estimated total number of hospitals | 71,860 |
| Estimated population per hospital | 11,744 |
| Estimated percentage of hospitals in private sector | 93 |
| | |
| *Hospital Beds* | |
| Total number (1996) (CBHI) | 623,819 |
| Population per hospital bed | 1,357 |
| Percentage of beds in rural areas | 21 |

[59] Duggal, R. '*The Private Health Sector in India*: Nature, Trends and a Critique'. New Delhi: Voluntary Health Association of India, 2000, Nandaraj, S ' *Contracting and Regulation in the Health Sector: Concerns, Challenges, and Options',* Central Bureau of Health Intelligence, *Health Information of India(*various years), Census Commissioner of India. 1981. *Census of India*. Ministry of Home Affairs. New Delhi, 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 47

| | |
|---|---|
| Percentage of beds in private sector | 37 |
| Estimated total number of beds | 1,217,427 |
| Estimated population per bed | 693 |
| Percentage of beds in private sector | 64 |
| | |
| *PHCs* | |
| Total number | 22,975 |
| Rural population per PHC | 27,364 |

**Note:** PHCs, primary health centers. The estimate for manpower is based on medical council lists. The estimate for the number of hospitals and beds are based on the extent of underestimation in government (Central Bureau of Health Intelligence [CBHIJ) data found in Andhra Pradesh in a 1993 census of all hospitals by the Director of Health Services and the Andhra Pradesh Vaidya Vidhan Parishad. They found 2,802 hospitals and 42,192 hospital beds in the private sector in Andhra Pradesh as against only 266 hospitals and 11,103 beds officially reported by the CBHI in that year. Thus, compared with the official (CBHI) data, the number of private hospitals was larger by a factor of 10.5, and the number of beds by a factor of 3.8.

**Table 5.8: Private Doctors in Developing Countries.**[60]

| Country | Private Doctors Per Million Population | Private Doctors as Percentage of Total |
|---|---|---|
| Morocco | 78 | 41 |
| Algeria | 86 | 24 |
| Pakistan | 107 | 32 |
| Tunisia | 153 | 36 |
| Oman | 185 | 43 |
| Turkey | 254 | 42 |
| Jordan | 661 | 69 |
| **Middle East Crescent average** | 147 | 35 |
| Indonesia | 6 | 6 |
| Papua New Guinea | 16 | 25 |

[60] Hanson, K and P, Berman. 'Private Health Care Providers in Developing Countries: A Preliminary Analysis of Levels and Compositions' 1998 *Health Policy and Planning* 13(3) : 195-211. In Harding, A and Preker, S. ' *Private Participation in Health Services'*. Washington : World Bank, 2003. P 10 ( Hereafter cited as Harding and Prekker*: Private Participation in Health Services*)

| | | |
|---|---|---|
| Thailand | 40 | 18 |
| Malaysia | 202 | 57 |
| India | 286 | 73 |
| Republic of Korea | 398 | 86 |
| **Asia average** | 232 | 60 |
| Paraguay | 28 | 5 |
| Panama | 112 | 10 |
| Mexico | 277 | 36 |
| Jamaica | 331 | 67 |
| Chile | 657 | 62 |
| **Latin America and the Carribean average** | 332 | 46 |
| Burundi | 2 | 7 |
| Malawi | 4 | 25 |
| Madagaskar | 4 | N/A |
| Zambia | 13 | 13 |
| Kenya | 30 | 40 |
| Senegal | 35 | 38 |
| Liberia | 35 | 41 |
| Zimbabwe | 86 | 67 |
| South Africa | 168 | 56 |
| **Africa average** | 92 | 46 |
| **All average** | 213 | 55 |

N/A-Not Available

World Bank has reported that the private practitioners are most prominent in delivery of primary and curative care, largely due to relatively low capital requirements, high demand and patients' willingness and ability to pay. [61]

This pattern involves them directly in core 'public health' activities such as treating patients with malaria, tuberculosis, and other communicable diseases as well as

[61] Hanson, K and P Berman. 'Private Health Care Providers in Developing Countries: A Preliminary Analysis of Levels and Compositions' 1998 *Health Policy and Planning* 13(3) : 195-211. In Harding and Preker :*Private Participation in Health Services*'. P 11

treating sick children and pregnant women. In poorer countries, the private sector is the main provider- with much of the health care delivered by unqualified or traditional practitioners, as well as pharmacists and drug sellers.[62] However, despite widespread concern about clinical quality, patients often bypass public facilities to utilize private providers- frequently citing reasons for convenience and responsiveness. Many people in developing countries, including poor, would have no access to health care without these privately provided services.[63]

Nevertheless, the table shows that India has 286 private doctors per million populations, which accounts for 73 % of the total number of doctors. These indeed indicate the dominance of private health care in India. Compared to other developing countries, especially Jordan, Chile and Republic of Korea, India‘s private health care is less developed. This might also indicate that India has a comparatively strong public health care providers than these countries. At the same time, especially if we look at the political history of the past decades, it is significant that the countries that are most ahead in private health care include two very special cases of US intervention. That India is a little behind them is due to the welfare state model of the past, now a thing of fading memory.

- **Utilization Pattern.**

The access to health services appears to be a key mechanism for better health outcomes. (See table 5.9 and table 5.10) The central role of high utilization rates has major policy implications. It confirms the need to ensure access to health services and to focus on interventions that will improve utilization of health facilities. It also highlights the need to promote behavioural change that will motivate people to seek appropriate care when ill. Overall, for India, NSS data reveals that 24 per cent of the poorest quintile did not seek medical treatment when they were ill, compared to 9 per

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62 Hanson, K and P Berman. ‘Private Health Care Providers in Developing Countries: A Preliminary Analysis of Levels and Compositions’ 1998 *Health Policy and Planning* 13(3) : 195-211, Bennet, Sara,,McPake,Barbara, 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,McPak, Barbara and Mills, Anne. London and New Jersey: Zed Books, 1997. In Harding and Preker :*Private Participation in Health Services*. P 11

63 World Bank 2000a. ‘Public Spending in a Market Context : The Efficienct Issue’ Public Expenditure Knowledge Management Website, Washington D.C http://www1.worldbank.org/publicsector/pe/efficien.htm.

cent of the richest quintile. Kerala's low mortality rates are explained not only by increased access to health-care services, but by a population with a heightened awareness of ill health, driven by health-seeking behaviour.[64]

In sum, the brief analysis of health systems reveals that:[65]

- States which have better-addressed health system goals of equity, access/utilization, have better health outcomes.
- Geographic, social, and economic access appears to have a significant association with health outcomes, and barriers to access operate to the disadvantage of the poor.
- Utilization rates of health services, considered a proxy for access, also seem to confirm the association.
- States with better health outcomes are more equitable in service coverage as well as in targeting of public subsidies. States with a significant private sector presence are more equitous in public health expenditure.
- No state in India has assured protection against the costs of catastrophic illness.

**Table 5.9: Number of Public and Private Hospitalizations per 100,000 Persons.**[66]

| **State** | **Total** |
|---|---|
| **India** | 1653 |
| **Group A: Under-five mortality less than 65** | |
| **Kerala** | 7480 |
| **Maharashtra** | 2519 |
| **Tamil Nadu** | 2138 |

64 *India Health Repor*. P 136
65 Ibid P 137.
66 National Sample Survey Organisation., 52nd Round, 1995-96.In *India Health Report*. P 137

| | |
|---|---|
| **Group B: Under-five mortality between 65 and 100** | |
| **West Bengal** | 1441 |
| **Karnataka** | 1733 |
| **Punjab** | 1622 |
| **Haryana** | 2851 |
| **Gujarat** | 1711 |
| **Andhra Pradesh** | 1595 |
| | |
| **Group C: Under-five mortality more than 100** | |
| **Orissa** | 1320 |
| **Bihar** | 722 |
| **Rajasthan** | 1005 |
| **Uttar Pradesh** | 1004 |
| **Madhya Pradesh** | 1030 |

The outbreak of diseases and high mortality rates indicate that the State should take more serious steps towards preventive measures. Moreover the infra structure of the public health care facilities especially in the interiors of the rural areas are in a miserable state to combat the critical illnesses. Proper utilization of the improved health care facilities can only improve the situation.

However, the population surveys on the use of health services indicate an increasing use of health services through the private sector. Between the 42nd Round of the National Sample Survey in 1986-87 and the 52$^{nd}$ Round in 1995-96, the proportion of people using care outside the public sector increased The vast majority of people both in urban and in rural areas (more than 80 percent) use the private sector for outpatient curative services as a first line of treatment. As already mentioned, the qualifications of practitioners and the systems of medicine used for outpatient care vary widely. Indigenous and folk practitioners, along with traditional providers, are particularly used as a first line of outpatient treatment in rural areas. For inpatient care, the majority of people are now using the private sector for hospitalization. States differ a great deal in the extent to which their populations use private services as well as in the

level of poverty and type of service provided.[67] Data from NSS 52nd Round reveals that 44 % of patients chose the private sector because the doctor is easily available, 36 %, because they were not satisfied with the treatment in the public sector, and 7 % because the medicines were not available.[68] Distance and long time waiting are also quoted as reasons for the poor use of public health facilities.[69]

**Table 5.10: Distribution of Outpatient and Inpatient Health Services across the Public and Private Sectors in India, 1986-87 and 1995-96 (percentage).** [70]

| | 1986 – 87 | | 1995 – 96 | |
|---|---|---|---|---|
| Treatment of Ailing Persons | Rural | Urban | Rural | Urban |
| Not treated | 18 | 11 | 17 | 9 |
| Treated as outpatients | | | | |
| Public | 26 | 28 | 19 | 20 |
| Private | 74 | 72 | 81 | 80 |
| Treated as inpatients | | | | |
| Public | 60 | 60 | 44 | 43 |
| Private | 40 | 40 | 56 | 57 |

Source: National Sample Survey Organization (1992, 1998)

While the private sector shows a slight edge over the public sector in hospitalizations and institutional deliveries, there is a dramatic decline in antenatal care and immunizations. The private sectors' overriding presence in curative care perhaps led to the view that

'India does not have a private health sector' but 'a private medical sector' or otherwise, a worth while in achieving national goals.[71]

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67 Rohde, J and H, Viswanathan. The Rural Private Practitioner. New Delhi: OUP, 1995. In *Better Health Systems for India's Poor*.P 48

68 Mahal, A. Ajay et al, 'Who Benefits from the Public Sector Health Spending in India', National Council for Applied Research, (NCEAR), 2000. In *India Health Report*. P 106

69 *India Health Report* P 106

70 National Sample Survey Organisation.(NSSO). 1992. ' Morbidity and Utiliation of Medical Services: NSS 42nd Round (July 1986-June 1987).' *Sarvekshana* 15 (4) : 50-75, S131-S57. In *Better Health Systems for India's Poor*.P 48

There are also significant inter-state variations. The better-off states, with a well-developed private sector such as Maharashtra, Kerala, Haryana, and Punjab show more utilization of private facilities. On the other hand, poorer states with poorly spread private facilities continue to show the predominance of the public sector.[72]

**Scenario of West Bengal and Kolkata.**

The Health department in West Bengal has recently (from 2006 onwards) recorded the growth of private health care sector separately. The *Health on the March*[73] has provided the district wise growth rate of health care institutions based on ownership pattern. According to this, Kolkata has 366 private/ NGO (as has been mentioned in the *Health on the March*) health care organizations and 11372 beds this sector in the year 2008-9. The number of private health care organizations and bed strength in 2006-7 was 341 and 10485 respectively. These figures undoubtedly indicate that there has been an increase in the growth rate of the private health sector in Kolkata.[74] The classification of the private health care sector, (nursing homes, corporate hospitals investigation centres and clinics) in respect of Kolkata was not being provided on behalf of the government. (Chapter 3 throws some light on this issue.) Presently Kolkata has 12 corporate hospitals.[75]

Nevertheless, the growth of private health care in the districts of West Bengal shows that along with the capital city, the districts also witnessed the expansion of private health care sector in various forms and shape. Bureau of Applied Economics and Statistics has provided the district wise, classified data of the private health care sector in West Bengal.

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71 *India Health Report* P 106

72 Ibid P 107

73 *Health on the March* (various years).State Bureau of Health Intelligence Directorate of Health Intelligence. Government of West Bengal.

74 Ibid

75 Kolkata to have a Rs 20,000-cr 'healthcare city' with 50,000 beds. In http://www.expresshealthcaremanagement. com/20041031/innews02.shtml. Accessed on 18.06.2010.

**Table 5.11: Number of Private hospitals, nursing homes, chambers, clinics and clinical laboratories in different districts of West Bengal excluding Kolkata. (Till 2002-03)**[76]

| Serial Number | Districts | Numbers | | | Number of Private Chamber /Clinic. | | | |
|---|---|---|---|---|---|---|---|---|
| | | Hospitals | Nursing Homes | Clinical/ Diagonistic Laboratory. | Allopathy | Homoepathy | Ayurvedic | Unani |
| 1. | Darjeeling. | 6 | 30 | 64 | 371 | 31 | 8 | 2 |
| 2. | Jalpaiguri. | 2 | 6 | 132 | 303 | 78 | 7 | 2 |
| 3. | Koch Bihar. | 0 | 11 | 95 | 176 | 35 | 14 | 0 |
| 4. | North Dinajpore | 0 | 5 | 38 | 142 | 22 | 1 | 0 |
| 5. | South Dinajpore | 0 | 5 | 34 | 53 | 27 | 3 | 0 |
| 6. | Maldah | 0 | 12 | 48 | 119 | 75 | 1 | 1 |
| 7. | Murshidabad | 0 | 35 | 125 | 303 | 418 | 11 | 4 |
| 8. | Birbhum | 2 | 28 | 153 | 378 | 482 | 13 | 5 |
| 9. | Bardhaman | 12 | 141 | 278 | 1254 | 897 | 36 | 9 |
| 10. | Nadia | 1 | 37 | 105 | 551 | 277 | 10 | 1 |
| 11. | North 24 Parganas | 2 | 65 | 115 | 865 | 349 | 19 | 6 |
| 12. | Hughly | 4 | 82 | 195 | 872 | 474 | 28 | 8 |
| 13. | Bankura | 0 | 30 | 75 | 313 | 274 | 10 | 1 |
| 14. | Purulia | 3 | 5 | 84 | 213 | 234 | 18 | 1 |
| 15. | East Medinipur | 2 | 88 | 256 | 345 | 269 | 11 | 0 |
| 16. | Howrah | 5 | 42 | 71 | 289 | 146 | 12 | 2 |
| 17. | South 24 Parganas | 2 | 95 | 125 | 628 | 572 | 13 | 4 |
| 18. | West Medinipur | 2 | 91 | 234 | 413 | 797 | 21 | 1 |
| | **Total** | **43** | **808** | **2227** | **7588** | **5457** | **236** | **47** |

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

**Table 5.12: No. of Doctors, Nurses attached and no. of patients treated in the private hospitals, chambers, clinics and clinical diagnostic laboratories in the different districts of West Bengal except Kolkata.**[77]

| Sl No. | District | No. Of Doctors | | | | No. of Nurses | No. Of Patients Treated | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | | Allopathy | Homeopathy | Ayurvedic | Younany | | Allopathy | Homeopathy | Ayurvedic | Younany |
| 1 | Darjeeling | 926 | 34 | 8 | 2 | 195 | 1040569 | 177008 | 8840 | 5980 |
| 2 | Jalpaiguri | 527 | 85 | 10 | 2 | 47 | 745898 | 309088 | 14352 | 5304 |
| 3 | Koch Bihar | 312 | 38 | 18 | 0 | 33 | 793897 | 183404 | 25116 | 0 |
| 4 | North Dinajpur | 264 | 24 | 1 | 0 | 12 | 703081 | 199940 | 1820 | 0 |
| 5 | South Dinajpur | 88 | 28 | 3 | 0 | 10 | 164133 | 108168 | 6136 | 0 |
| 6 | Malda | 234 | 77 | 1 | 1 | 47 | 712989 | 302120 | 6760 | 1560 |
| 7 | Murshidabad | 550 | 420 | 12 | 4 | 72 | 1635067 | 2165852 | 19916 | 5512 |
| 8 | Birbhum | 779 | 505 | 14 | 5 | 44 | 1604213 | 1844076 | 27040 | 21788 |
| 9 | Burdwan | 3535 | 1032 | 39 | 10 | 440 | 4158992 | 3373448 | 60268 | 33280 |
| 10 | Nadia | 1587 | 339 | 26 | 4 | 102 | 1847942 | 878384 | 14092 | 3120 |
| 11 | North 24 Pgs | 2629 | 434 | 28 | 6 | 190 | 2919144 | 1248624 | 38012 | 6916 |
| 12 | Hooghly | 2153 | 541 | 33 | 8 | 216 | 3222038 | 1719172 | 77844 | 16224 |
| 13 | Bankura | 547 | 296 | 10 | 1 | 52 | 1289596 | 1161420 | 33956 | 2600 |
| 14 | Purulia | 446 | 265 | 18 | 1 | 56 | 799317 | 883480 | 28496 | 1040 |
| 15 | Midnapore | 1220 | 353 | 15 | 0 | 142 | 1427633 | 892424 | 12584 | 0 |
| 16 | Howrah | 1179 | 174 | 13 | 2 | 163 | 853935 | 387764 | 11492 | 1352 |
| 17 | South 24 Pgs | 1898 | 674 | 15 | 4 | 185 | 1962597 | 1860352 | 49920 | 35620 |
| 18 | West Midnapore | 1189 | 817 | 22 | 1 | 181 | 1694614 | 3816696 | 73008 | 260 |
| | **Total** | **20063** | **6136** | **286** | **51** | **2187** | **27565655** | **21505120** | **509652** | **150556** |

On the basis of Table 5.11 and 5.12, it can be inferred that the districts of West Bengal is equally experiencing the services of the private health care sector. Moreover the large-scale development of the private health care sector, especially of the nursing

[77] Ibid

homes, hospitals and diagnostic centres reveal that the public health care sector in the districts have also collapsed. The numbers of total diagnostic centres amounting to 2227 in the 18 districts of West Bengal indicate that presently the mode of treatment is mostly investigation oriented. Since the present study has concentrated on the allopathic system of medicine, the physicians who are practicing this discipline in private sector might have been employed on the public sectors (especially in the rural hospitals/ sub divisional hospital/ Block primary health centre etc) as 'practicing doctors'. Another interesting pattern of growth can be discerned from table 4 & 5 is that in most of the districts (except Bardhaman) the nursing homes are substantially more than the hospitals. Private or even Corporate hospitals are yet not so common in the districts. Districts of Bardhaman, Darjeeling and Howrah have a maximum number of 12, 6 and 5 private hospitals respectively.

- **The Reforms or ' Dictates'.**

The World Development Report's proposal to reduce the role of the public health services and to promote the growth of private health care sector brought about a catastrophe in the entire health care services of the country.

The proposals of the World Development Report 1993(WDR)[78] stated that both the public and private sectors have important roles in delivery of health care services, but the state funded health systems in many developing countries need to be restructured and reformed. The changes can be done through legal and administrative changes designed to facilitate private (NGO and for profit) involvement in the provision of health services, by public subsidies to NGO for supplying the essential package, and by curtailment of new investments in public tertiary hospitals.[79]

The World Bank, repayable at 12% per annum, gave a total amount of $350 million as loan over 35 years. This loan was initially given to 4 states that were selected out of the 10 states which submitted the proposals for reforming their health care sector under the State Health System Projects. Four states were selected for undertaking the reforms based on heterogeneity of the country in terms of epidemiological profiles,

[78] *World Development Report*: *Investing in Health*. World Bank (1993) New York.: OUP, 1993
[79] Ibid.

levels of economic development, health services development and political structures.[80] The heterogeneity of the country reflected in the 4 states is:

- Economically Developed State: Punjab
- Average performing States: Karnataka and Andhra Pradesh.
- Less Developed State: West Bengal

World Bank[81] also announces some other proposal for the effective and efficient functioning of the public health care sector. They are:

[80] Break-up of the World Bank's funds in some selected States 1996-2001 (in Million Rs) Source: The World Bank 1996, Report No. 15 106-IN.

| **Sl. No.** | **Items** | **Karnataka** | **Percent of foreign Exchange** | **West Bengal** | **Percent of Foreign Exchange** | **Punjab** | **Percent of Foreign Exchange** |
|---|---|---|---|---|---|---|---|
| **1.** | Civil works | 251.6(8.0) | 15 | 922.8(19.8) | 15 | 156.4(5.8) | 15 |
| **2.** | (renovation) | 954.4(3 1) | 15 | 1,110.0(23.9) | 15 | 1,560.0(43.0) | 15 |
| **3.** | Civil works (new | 110.6(3.4) | 20 | 203.3(4.4) | 20 | 131.2(4.9) | 20 |
| **4.** | construction | 104.1(3.4) | 10 | 169.2(3.6) | 10 | 65.2(2.4) | 10 |
| **5.** | or extension) | 3 26.5(10.6) | 60 | 482.8(14.7) | 60 | 397.5(14.8) | 60 |
| **6.** | Professional | | - | 36.7(0.8) | 20 | 17.5(0.65) | 20 |
| **7.** | services | | - | 78.1(1.7) | 20 | 23.2(0.86) | 20 |
| **8.** | Furniture | 32 7.7(10.7) | 20 | 468.7(10.0) | 20 | 157.5(5.8) | 20 |
| **9.** | Major | 15 1.4(4.8) | 75 | 203.4(4.5) | 75 | 84.9(3.2) | 75 |
| **10.** | medical | 124.8(2.5) | 20 | 24.1(0.5) | 20 | 11.0(0.4) | 20 |
| **11.** | equipment | 418.2(13.6) | 50 | 180.8(3.9) | 50 | 204.0(7.6) | 50 |
| **12.** | Minor | 116.1(3.7) | - | 384.3(8.3) | - | 50.0(1.9) | - |
| **13.** | medical | 32.3(1.0) | 25 | 64.6(1.4) | 25 | 111.4(4.1) | 25 |
| **14.** | equipment | 100. 1(3. 2) | - | 61.2(1.3) | - | 59.2(2.2) | - |
| **15.** | Medical | 19.5(0.6) | 90 | 16.0(0.3) | - | 31.2(1.2) | - |
| **16.** | equipment | 28.0(0.9) | - | 12.8(0.8) | 90 | 21.0(0.8) | 90 |
| **17.** | surgical | 21.5(0.7) | - | 20.9(0.4) | - | 9.1(0.33) | - |
| **18.** | packs | 8.4(0.3) | - | 3.4(0.05) | - | 1.6(0.06) | - |
| **19.** | Equipment | 12. 7(0.4) | - | 3.6(8.0) | - | 2.4(0.09) | - |
| | (other) | 3,107.6(100) | | 4,645.5(100) | | 2,690.3(100) | |
| | Vehicles | | | | | | |
| | Medical lab supplies | | | | | | |
| | Medicines | | | | | | |
| | Other supplies | | | | | | |
| | MIS/IEC materials | | | | | | |
| | Local training | | | | | | |
| | Studies | | | | | | |
| | Fellowships | | | | | | |
| | Workshops | | | | | | |
| | Consultants | | | | | | |
| | NGOs | | | | | | |
| | Total | | | | | | |

- Cutback on secondary and tertiary spending and channel it into selective interventions at the primary level;
- Contract out ancillary services in public hospitals to private contractors;
- Involve private providers in national communicable disease programs;
- Institute user charges in all public hospitals;
- Encourage private sector growth at secondary and tertiary levels by instituting regulations.

According to Baru,[82] in this kind of restructuring, the role of the public sector is gradually limited to only primary-level provisioning. Secondary and tertiary care is commercialized through user charges for outpatient and inpatient services, diagnostic, and other facilities. Separating the primary and higher levels of care will clearly affect the effectiveness of any public health. Quadeer[83] has pointed out that if the middle level hospital system does not provide the support to basic institutions and is not supported in turn by tertiary care institutions, the delivery of primary health care is bound to be differential and mutilated in its preventive endeavors.

Initiating user fees in the public hospitals only for the Bank's benefit further threatened the economically challenged section from availing free health care services from the state funded 'government' hospitals. These kinds of initiative indicate that the state is directly inviting private capital and interests and depriving the ailing masses from their right to get health care from the state. So the state, on the one hand is reluctant to improve the health condition of its population by investing more on the preventive measures, and on the other it is also in the process of shrinking its health care services by privatizing or contracting its ancillary services. Fashioning of the

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81 World Bank (1997): India – New Directions in Health Sector Development at the State Level: An Operational Perspective. Report N0. 15753-IN. Washington DC: World Bank.

82 Baru: A State Level Analysis. P 224

83 Quadeer I. Health. *In Alternative Economic Survey*. Delhi. Delhi Science Forum. 1997 In Baru: A State Level Analysis. P 224. Also see Delampady, Narayana. *Adjustment and Health Sector Reforms: the Solution to Low Public Spending on Health Care in India*? In www.idrc.ca/fr/ev-118491-201-1-DO_Topic.html Accessed on 13.12.2009, *World Bank in India : Bank and the Structural Adjustment.* In www.ieo.org Accessed on 12.6.2009 and Duggal, Ravi: *World Bank and Health Sector in India*. In www.worldbanktribunal.org/docs/duggal.pdf. Accessed on 13.12.2009

state (read, hospitals) as a private sector entity indeed resulted out of these reforms of the World Bank funded projects.

The impact of the reforms in India did exhibit a miserable state of affairs. A number of scholars have documented a series of changes, which the reforms brought about in the field of health care sector. [84]

Reforms under the World Bank loans in the State of West Bengal and its immediate impact need to be highlighted. Moreover, the changes brought about in the public health sector by the other externally funded projects should be mentioned.

The Government of West Bengal published a document "Public Private Partnership" (PPP) on 6th October, 2004 in its official website www.wbhealth.gov.in boldly announcing its intention to privatize the government health sector systematically. It set up the target of attracting 80 per cent of the total health budget as investment from private business houses in the coming ten years. However, the preparation for this paradigm shift started back in November 1992 when it introduced fees for outdoor tickets in government hospitals, levied charges for diagnostic investigation, reduced the number of free beds etc. This was done to show allegiance to the conditions laid down by the World Bank for its loan of amount Rs. 701 crore which started coming from the year 1995. In accordance with the second phase of structural adjustment for which DFID provided a loan of Rs. 745 crore, the user fees increased in amount and

[84] Banerji, A, Deaton, A and Duflo, E in the article 'Health care Delivery in Rural Rajasthan' in Ecnomic and Political Weekly (Vol-XXXIX, No 9. 28th February 2004 ) referred that people spend substantially on healthcare largely provided by unqualified persons in the private sector where services were even worse Yet over the 1990s, as India embarked upon its structural adjustment programme, state spending on health declined. Baru is of the opinion that the decline in public investments was matched with growing subsidies to the private sector in healthcare in a variety of ways. S Nandaraj in 'Private Health Sector in India' referred that In India, contracting has been initiated under the blindness programme, the AIDS control programme, and franchising arrangements have been set up with private providers under the (Revised National Tuberculosis Control Programme (RNTCP). Nandraj has also mentioned the transfer of ownership of a public care hospital in Mumbai as part of a state health system project funded by the World Bank. The municipal corporation of Mumbai has taken a policy decision to hand over many of its peripheral hospitals to the private sector. In a controversial move, a peripheral hospital was also handed over to a private medical college that did not have the necessary clinical facilities; the Medical Council of India had not recognized the concerned medical college. Other cities, such as Ahmedabad, have handed over facilities to NGOs. However the role of NGO'S in supporting the public health care sector is also questionable. Duggal et al (1986), Baru (1999) and Visaria ( 2002) have pointed out that in better off states, the performance of the NGO's are remarkably good.

free services became more and more restricted. Supply of free medicines and other appliances were also constricted.[85]

Interestingly, on 1st August 1995, the then Health Minister of West Bengal, Prasanta Sur, openly admitted that the Government in West Bengal had taken a loan of Rs 600 crores from the World Bank. The 'Left Front Government' in West Bengal has no hesitation to accept the conditionalties imposed by the Bank. (One of the important conditionalities is the introduction of user fees in the hospitals).[86]

Contrary to this statement of Sur, the Seventeenth Report of the Standing Committee of Health [87]reflected a different voice while reviewing the health situation of the country. According to the Committee Report, it has been stated that the attempt of India to develop self –sufficiency in the health care delivery in earlier decades of sixties and seventies were reversed in late eighties and nineties by the Union Government. The same forces are trying to enhance the change in the understanding Health Care delivery. The changes in the political scenario of India are a reflection of the changes in the International politics. The multi-nationals are operating through IMF, World Bank Loans and various other external agencies in the form of externally aided projects. These are becoming dominant in recent years. These projects are of unifactoral in nature and do not commensurate with the need of the common man. In practice, it is creating more dependence on the diagnostic and therapeutic measures only. Health Care delivery based on universalisation of social justice is shelved in freeze.[88]

These two contradictory actions indicate that the Government of West Bengal, being a communist government takes a negative attitude towards the World Banks' loans in paper. However, the representatives of the State, especially the minister of the concerned Department had gladly expressed the willingness of the Government for initiating reforms in public health care sector under the World Bank funded projects.

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85 Dutta, Dr Debashish: *'Privatisation of Health:A Letter from West Bengal'*. http://ccih09.pbworks.com/f/a09roy,+gaurab+(2).pdf. Accessed on 13.12.2009 (Hereafter cited as Dutta: *Privatisation of Health:A Letter from West Bengal)*

86 *Ajkaal*, 1st August 1995.

87 *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.

88 Ibid.

Nevertheless in the year 1988, the chief Minister Mr. Jyoti Basu has also confessed the failure of the public health care infra structure and invited private health care for providing health care. (See Chapter 4)

The State Health Development Project (SHSDP) – II, a World Bank assisted project is being implemented in the state. The World Bank aided Rs 701 Cr in SHSDP-II, which covers the improvement programme in 170 secondary level hospitals and 36 primary health centers in Sunderban. Civil work has been completed in 8 project hospitals and civil work in another 82 project hospitals has started in 1998-99. In 1999-2000, civil work in 68 project hospitals will be completed and civil work in another 110 project hospitals will start. Necessary funds have been provided in 8 hospitals to purchase medicine and equipments. Apart from this, considerable progress has been made in the improvement of health care waste management, disease surveillance, quality assurance and training of health personnel. The nurse doctor ratio has been steadily improving in the State and in 1997, it was 1:10, compared to the ratio of 1:18 in 1996. [89]

The State Government is exploring various ways of improving the quality of service from medical facilities under its control. In a move to involve the beneficiaries in the running of primary health centres, the State Government has decided to hand over primary health centres to the Panchayat Bodies and selected NGOs. To start with, a primary health centre at Khejuria in the district of Bankura has been handed over to the local Panchayat Samity. [90]

The vacant posts of teachers under West Bengal Medical Education Service are filled up through walk-in interviews in a very short period of time. This has expedited the process of recruitment. Instruments like Hysteroscope, Ultrasonograph machine, and laparoscope instruments for different abdominal operations were installed in different medical colleges for better teaching and research and patient care. At R.G.Kar Medical College, a new intensive treatment unit has been opened. The ICCU in the Department of Cardiology at R.G. Kar Medical College and Hospital has been restructured and renovated. Emergency ward at Kolkata National Medical College has

89 *Economic Review*-1998-99 Government of West Bengal.
90 *Economic Review*-1999-2000 Government of West Bengal.

been renovated for better patient care. Magnetic Resonance Imaging (MRI) instrument has been installed at Bangur Institute of Neurology. An operation theatre and casualty block with observation beds is under construction in Bankura Sammilani College. A dialysis unit at Sambhunath Pandit Hospital has been opened. Renovation of heritage building of Medical College, Kolkata is complete. The State Government has been trying to improve the quality of service available from health facilities under its control. One way of doing this is to involve the beneficiaries of these health units in the running of the units. Thus, the State Government has decided to hand over the operation of primary health centres to Panchayat Bodies and selected NGOs. In addition, the State Government, in order to improve the physical facilities available for health services, renovated 17 health clinics. A Swasthya Bhaban has also been constructed. The Panchayat Bodies have also been affected by recent floods. The Damkal Block Primary Health Centre has been upgraded to sub divisional hospital. In the current year, an acupuncture clinic has been opened at Basirhat. The implementation of SHSDP-II to improve 170 hospitals of different categories is continuing. Apart from civil work, the provision of modern medical equipment to the hospitals is progressing satisfactorily. The number of seats at Burdwan Medical College has increased by 50. The posts of 336 Residential Medical Officers (RMO) s or demonstrator have been filled up through a process of walk-in interviews. The posts of Professors, Associate Professor, numbering 455 have been filled up by way of promotion. M.Sc in nursing course has been started from this academic session in nursing college in Kolkata. The nurse: doctor ratio increased from 1: 10 nurse per doctor in 1997 to 1: 13 nurse per doctor in 2000. Sophisticated equipments are being filled up in various Government Organizations to improve the quality of service. Electronic Display Board has been installed at SSKM Hospital to show the bed vacancy position. [91]

West Bengal is well placed in terms of population served per doctor and per nurse respectively. What is notable is that these ratios have been falling in recent years except in 1998 when population served per doctor went up and in 2000 when population served per nurse increased from that in the previous year. To strengthen the secondary medical healthcare, 95 different categories of posts have been created.

[91] *Economic Review*-2000-01 Government of West Bengal.

In addition, the cabinet for institutions covered by SHSDP-II has approved 1300 posts. 8 posts of Assistant Chief Medical Officer of Health (ACMOH) have been created. In order to meet shortfall of doctors at primary healthcare level, 458 posts of Medical Officers on contractual basis have been retained. This is in addition to 1347 candidates selected through Public Service Commission who have been offered appointments. Intake capacity for medical students in Bankura Sammilani Medical College and North Bengal Medical College have been increased by 50 seats each. Tufanganj Subdivisional Hospital has been expanded from 68 beds to 100 beds. After bifurcation of the administrative districts of Minapore, a new district hospital at Tamluk has been set up and rural hospital at Egra has been upgraded to subdivisional hospital.[92]

The West Bengal SHSDP-II.has been extended to March, 2004. The project covers 214 hospitals inclusive of 36 primary hospitals at Sunderban. The total project cost is Rs 701.46 Cr. The share of the state government in the total project cost is 14.5% and that of the World Bank is 85.5%. The project envisages all round development of the health system in West Bengal both at the infrastructure and at the policy levels. Procurement of medical and other equipments, vehicles etc. are being done in three phases. In the first phase, 21 types of equipments with a total cost of Rs 23.08 Cr have been supplied except for a portion of hospital furniture. In the second phase, 37 types of equipments valued at Rs 17.20 Cr have been supplied. Procurement under the third phase is continuing. Important medical equipments were commissioned including dialysis machine, lithotripsy machine and 4 spiral C.T. scan machine. Effective maintenance of the installed equipment has also been ensured under the project. A healthcare Waste Management System is also being implemented under the project. [93]

The target for improvement of the physical infrastructure of the health services under SHSDP-II is to upgrade 214 secondary level health facilities. Construction of drug Reserve Store in each district has started. The State Government has initiated a comprehensive maintenance policy for the new equipments procured under SHSDP-II. CMOH and hospital authorities have been provided with greater financial power for funding the maintenance of equipment. Revenue from user charges, which were

92 *Economic Review*-2001-02 Government of West Bengal.
93 *Economic Review*-2002-03 Government of West Bengal.

introduced in all hospitals up to the state general hospitals in November 2001, is being ploughed back to the districts by special allotments. These funds can be used for the maintenance of equipments in the hospitals. [94]

The State Government in order to meet the requirement for different categories of medical personnel in the upgraded hospitals has commenced recruitment of the necessary manpower. It has sanctioned 1156 posts to be filled up on a contractual basis. Till October 2003, out of these sanctioned posts, 1017 posts have been filled up.

Another 1383 posts in different categories were also sanctioned, of which 813 posts for medical officers were regular cadre posts, the rests were contractual posts. The state Government has also strengthened the management system of different health facilities by [95]

- recruiting qualified managers
- improving systems and procedures
- decentralizing the administrative structure of the hospital
- Arranging training for non medical personnel

Posts for 132 assistant superintendents (non-medical) have been formed in each district with the district CMOH as member secretary, Sabhadhipati of Zillah Parishad as Chairman and District Magistrate as Vice Chairman. These Samitis have been given wide ranging administrative powers, including the authority for local transfer of personnel and overseeing construction activities.[96]

In order to assist in the management of hospitals, the State Government has developed a Health Management Information System (HMIS). Under HMIS, a standardized recording, reporting and feedback system is to be developed for all the hospitals. HMIS has been fully implemented in district, sub divisional hospital, state general hospitals with 200 + beds.[97]

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94 *Economic Review*-2003-04 Government of West Bengal.
95 Ibid.
96 Ibid
97 Ibid.

The backward Sundarban area has been covered under this project in order to improve the access of the common people in this region. Under the programme, 11 rural hospitals and 36 health centres have been upgraded. Canning and Kakdwip rural hospitals have been up graded to sub divisional hospitals.[98]

The Government has taken various measures for strengthening health infrastructures and improving the efficiency of the health delivery system. A medium term health sector reform programme has been initiated in order to provide efficient, affordable and equitable health system to all especially the poor. The reforms encompass a wide gamut of interventions ranging from up gradation of physical infrastructure in the primary, secondary and tertiary sector to manpower planning and rationalization of the district and block health and family welfares samities and grant of functional autonomies to hospitals through formulation of Rogi Kalyan Samity (Patient Welfare Committees). The reform process under the World Bank assisted SHSDP-II (1997-2004) is now being extended to the primary sector. Apart from the state budget and national programmes, the Government of West Bengal received financial and technical support from external sources. DFID funded health system development programme was launched by the Government on August 2005. The Government also launched National Rural Health Mission on 12th April, 2005. [99]

In order to provide better health services to the people, the Government has undertaken many developmental activities in the hospitals at secondary level under World Bank funded project- the State Health System Development Project II. At present following services are provided to the people in secondary hospitals:[100]

- Ultra Sonography up to the level of State General Hospital
- 300 X-Ray services in District Hospitals(DH) and Sub Divisional Hospitals( SDH)
- Dental X Ray services are available from tertiary hospitals up to the level of State General Hospitals.(SGH)

98 Ibid.
99 *Economic Review*-2005-06 Government of West Bengal.
100 Ibid

- Physiotherapy Clinics have been started from the tertiary hospitals to the levels of State General Hospitals.(SGH)
- Laboratory facility developed up to SGH
- ECG services rendered up to Rural Hospital. (RH)
- Colour Doppler available up to District Hospitals. (DH)
- Operating Microscope and Endoscope supplied up to Sub –Divisional level Hospitals.(SDH)
- ICCU/ITU started in DH of Uttar Dinajpore and Howrah, M.R Bangur Hospital, -South 24Parganas and Chinsurah District Hospitals, Hooghly.
- Audiometric and ENT Microscope supplied up to District Hospitals.

Apart from these, action has also been taken for developing Waste Management System up to the level of State General Hospital has been initiated. Order for creation of 602 posts of doctors, specialized at different fields for 15 numbers of secondary hospitals up graded at different levels and having no required posts for specialized doctor has been issued. A massive effort has been made in order to computerize the health system in the state. Such type of computerization will cover all aspects of hospital services and will be gradually extended up to the level of Block Primary Health Centre.[101]

In order to improve the health care system at the grassroot level (primary health care); the government has taken the following steps.

- One sub centre is located at each Gram Panchayat (GP) head quarter. This GP head quarter sub centre monitors the activity of all public health and rural community health (RCH) programmes for the entire GP area.
- One health supervisor is posted in each GP Headquarter.

[101] Ibid.

- The GP Sub centre serves as an apex body monitoring public health activities jointly by the GP Health Education Upa Samiti and health department functionaries.

The network of Primary Health Care system consists of 10, 356 sub centres, 932 Primary Health Centres (PHC) 238 Block Primary Health Centres (BPHC). In addition there exixst many Nursing homes run by Private Entrepreneurs and non government organizations which also look after the primary health care in the state. In the rural areas of the state 90% hospitalization is in the state sector while in urban areas state run hospitals serve 71 % of the population.[102]

**Indo-German Basic Health Project.**[103]

GTZ –KFW funded Basic Health Project (BHP) as initiated in 2001 in 8 districts of the state. In the first implementation of the project, civil work for rehabilitation of 38 BPHC's and 92 PHC's and construction of 95 sub centres were taken up in all 8 districts. Rehabilitation of further 75 BPHC and 30 PHC will be taken up in the second phase during 2005-06. A new scheme of ambulance services at the basic health care level has also been introduced.[104]

**European Commission Assisted Sector Investment Programme.**[105]

European Commission has sanctioned a grant of Rs 45.2 crores under Sector Investment Programme. The programme started in February 2002 and was scheduled to close in December 2005. The Government of India has released the fund directly to the West Bengal State Health and Family Welfare Samiti. The activities include:

- Organizational Restructuring.
- Integration of management of eternally assisted programmes and projects.
- Derivation of Hospital Reports through Management Information System.

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102 Ibid
103 Ibid
104 Ibid
105 Ibid.

- Capacity of building district and Family Welfare Samiti.
- Apart from these, there are some other spending priorities based on which some programmes have been undertaken. These programmes are:[106]
- Urban Health Improvement Plan in 6 municipalities with KMDA area.
- School Health Programme.
- State Thalassemia Control Programme
- Strengthening of Health Management Information System and introduction of *e-management* in health system in the district.

**DFID Assisted Health Sector Development Initiative**. [107]

DFID and West Bengal State Health and Family Welfare Samiti signed an agreement in August, 2005 for DFID support to strategic planning and sector reform cell of the Department of Health and Family Welfare. The financial support of Rs 1.12 and Rs 15.72 lakh has been released until 31st March 2005. The World Bank also proposed to collaborate with the Government of West Bengal in its initiative for improving the primary health care system. A joint Appraisal Mission of the DFID and the World Bank visited the State during March 7-17, 2005, for finalizing the project, which is in the advanced stage of preparation.[108]

From the above discussion, it seems clear that the health sector reforms in West Bengal under the SHSDP II had brought forward certain glaring improvements in the overall health care infrastructure. However, in reality it had worsened the situation without bringing any constructive results in any sector. The blue print of PUBLIC – PRIVATE PARTNERSHIP is being promoted from this time onwards. However, the governments in its official document have emphasized the positive impact of the health sector reform but these reforms have deepened the crisis by transforming health care to a marketable commodity. In accordance with the second phase of structural

106 Ibid.
107 Ibid
108 Ibid.

adjustment for which DFID provided a loan of Rs. 745 crore, the user fees increased in amount and free services became more and more restricted. Supply of free medicines and other appliances were also constricted. [109]

Moreover the State has also identified the private nursing homes as one of the important health care delivery sectors in its official documents. Mention should be made that the 90% hospitalization cases in the rural areas and 71 % in the urban areas in the public health do not correspond to a positive state of affairs of the state funded health care services. It should be taken into account that the high rate of utilization of the public health care services and the admission in public hospitals in no way represent that the majority of the population is dependent on public health care. The percentage of patients being completely cured by utilizing these facilities should be the sole indicator of the performance of the public hospitals. Installing high tech medical equipments in the public hospitals is another step forward towards increasing the commercial interests of the multinational companies. Mention should also be made that the by incorporating administrative powers in health care infra structure, the State Government is also imposing political pressures or trying to politicize the entire health care services.

The next phase of privatization witnessed the transferring of government hospitals to private investors in the name of PPP. Already a specialized TB hospital at Jadavpur, Kolkata (having 750 indoor beds in a sprawling area of 200 bighas) has been leased to a private group for just Rs. 1 to build up a private medical college. Incidentally, it is the first private medical collage of West Bengal and has already gained a reputation for underhand dealing, capitation fees and other irregularities in admission of students along with doubtful teaching standards.[110]

Mention should be made that in mid nineties, the Niramoy Polyclinic – a state funded polyclinic in the southern parts of Kolkata was handed over to Emaami group-run by the famous business house of the Todies. A five star super specialty private hospital has been set up where the downtrodden of the society have no entry to ‘purchase the costly treatment’.

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[109] Dutta : *Privatisation of Health:A Letter from West Bengal*
[110] Ibid.

The history behind the growth of the 'First Private Medical College' (KPC) needs mentioning in this context. However, the trend of establishing private medical college in West Bengal has started long back in 2004 when the Guru Nanak Dental College was set up. K.S. Roy TB Hospital in Jadavpur, (presently KPC) a 750-bedded hospital was established in the year 1938 on a 200 *bighas* of land. Since in India, the maximum numbers of people are affected in Tuberculosis, therefore a separate place for treating TB patients with specialized treatments (including isolation, open space for fresh air and long-term stay in the hospital having proper cross ventilation facilities) was instrumental behind the growth of KS Roy TB Hospital.

The Health Department had made several attempts to sell this hospital for the last 25 years. *'TB Hashpataal banchao committee'* (a committee to save TB Hospital) was set up by the local people to protest against the steps taken by the Government. Finally, in 2004, this entire property was sold to KPC group at Re 1.

Kali Prasad Chaudhuri (KPC) is a US based NRI orthopedic surgeon was the new founder of this private college and hospital. Since his aim was to 'serve the community with health care facilities at reasonable prices', hence the outdoor ticket was made available at Rs 10. This abnormally low cost of treatment in the outdoor of a private hospital was widely advertised in many parts of the city. Soon the user charges increased to Rs 50 and in many cases to even to Rs 150. Like many other private hospitals, inflated bills also became common phenomena and in some cases, the patients were shifted to other places being unable to cope with the high charges.[111]

Three more hospitals, at Kamarhati, Dhubulia and Dubrajpur, are in the pipeline for sale. The hospital at Kamarhati was all prepared to be handed over to Apollo Gleneagles when a protest by the local residents and workers led by a political party stalled it for the moment.

[111] Read Dr Das, Timir Kanti: *'Monozyme kit Kelenkari': Janaswasthyer Prati Sarkari Abahela, Udashinata o Simaahin Durnitir ek Kalankajanak Adhyaya,'*( Monozyme Kit Disaster: An episode of State's Indifference, Negligence and Corruption towards Public Health) *Swasthya Bikhshan*, Kolkata, Medical Service Centre, 12th year 2nd issue, January 2007 ( Hereafter cited as Das : *Monozyme Kit*), also read Chatterji, Priyanka. *'Daktari Sikhshar Banijyikaran : Sikshay Banijyikaraner ek Natun Adhyaye Paschimbanga'*, (Commercialisation of Medical Education: A New Phase of Commercialization of Education in West Bengal) *People's Health*, Kolkata, November 2008.

Recently, the government has planned to set up a West Bengal Medical Service Corporation Ltd. as per the Companies Act, following in the footsteps of the Tamil Nadu government. At present, the corporation will procure medicines and other equipments for government hospitals along with construction and budgetary provisions. It is apprehended that gradually, this corporation will also take up recruitment of staffs. Already, low-paid contractual staff is replacing regular staff in all spheres, important programme components and non -clinical support services are being assigned to NGOs and all district level health activities have been transferred to the District Health & Family Welfare Samity, which is controlled by the Zila Parishad Sabadhipati, DM, representative of MP Etc. In a survey done in 2007 it was seen that among the 922 health centres of West Bengal, 111 centres have no doctor, 257 centres have no lab-technician and 66 centres have no pharmacist. Amongst the nursing staff, 8 posts are vacant and 2486 new posts required to be created.[112]

It is worth mentioning that one of the oldest mental hospitals in Mankundu in Hooghly is also in the verge of being privatized. Along with this, it is pertinent to mention that the State government has almost finalized the decision of leasing out the entire primary health care services to some private agencies. This will restrict the entry of the rural masses in public health care sector and made them dependent upon the private health sector by force.[113]

Overall, though a huge extra budgetary transaction was noted, the State Health System Development Project II that intended to develop middle-tier hospitals (rural to district hospitals) and a proper patient referral system turned out to be a flop. The common people failed to achieve any benefit from this project due to lack of proper planning, fragmented approach, lack of coordination among various departments, reluctance on part of service providers etc. On the other hand, a group of corrupt party leaders, corrupt administrators, contractors, a section of doctors and health staff siphoned off funds into their pockets.[114]

The impact of SHSDP on the primary health care further provided the space for the privatization to intrude within the periphery of the state funded primary health care sector. According to the National Norm, in an ideal situation one PHC (Primary

[112] Dutta : *Privatisation of Health:A Letter from West Bengal.*
[113] Das : Monozyme Kit.
[114] Dutta : *Privatisation of Health:A Letter from West Bengal.*

Health Centre) will cater to a population of 30, 000 in a rural area. Incase of hilly and tribal areas, the one PHC will serve around 20,000 populations. Moreover, according to the Government rule, there will be at least two doctors (MBBS) in the OPD (Out Patient Department) and basic infra structure for treating general diseases. Incase of complicated cases where the patient needs an admission to a hospital for long term treatment, he or she is referred to any secondary level hospital (sub –divisional, district, state general or special hospital). But in reality, due to lack of infrastructure in the PHC's for treating general diseases, patients are referred to secondary hospitals which on the other hand do not have the sufficient back up for treating the patients who are admitted for treatment in secondary hospitals. As a result, the entire referral systems collapse and the rural masses are either shifted to the unqualified quacks of the villages or to small nursing homes which are very popular in these regions.

Mention should be made that in present system of medical sciences, investigations occupy an integral part. According to the rule of the Health Department, each PHC has a sanctioned post for medical technologist to examine the blood, urine, routine tests for stool and malaria parasite and other commonplace investigations. However, in reality, the State Government is trying to hand over the entire diagnostic services to private agencies. This will force the poor rural masses to avail the diagnostic services at the cost of money.

According to 2001 census, the district of Hooghly in West Bengal has a population of 33, 34, 227. It should have 112 PHC's. But this district has 9 Block Primary Health Centres (BPHC's) and 61 PHC's. Another 42 PHC's are needed to fulfill the requirement. Moreover, in most of the PHC's there is only one doctor who treats 50-100 patients within 2-3 hours daily. This indicates that a patient gets less than two minutes from a doctor who is supposed to look after his patients' life.

The SHSDP has proposed to convert BPHC's to Rural Hospitals where along with high tech, imported equipments; there will be one anesthetist, one gynecologist, one pediatrician and one radiologist. The World Bank loan, forced the government to purchase the instruments from the multinational companies (selected by the Bank), refused to finance the salary of the medical personnel. Moreover there is a dearth of these specialists required for the Rural Hospital in the West Bengal Health Services. As a result, the government failed to provide the adequate manpower in the Rural

Hospitals. As an alternative option, it was decided to recruit doctors on contractual basis. However, this also did not bring about any solution to the problem because these categories of specialist are in limited number. So why will they opt for contractual jobs? Thus, the World Bank funded projects silently ruined the entire primary health care infra structure in the name of reforms. Interestingly the World Bank financed the civic construction and the high tech medical equipments in the Rural Hospital, but did not provide the manpower to administer or to serve the system for the benefit of the population. It shows that the World Bank skillfully concentrated its reforms in such places, which will be advantageous for the Bank's profit only. More than 30% of the medical equipments remained unpacked in most of the Rural Hospitals.

As far as development of primary level public infrastructure for health is concerned, the West Bengal State Government is categorical on consolidating and upgrading existing infrastructure rather than proliferating ill-equipped infrastructure'. For instance, it will not add new Primary Health Centres (PHCs), which are the first referral points for rural areas where doctors and some rudimentary medical services are made available. This logic conveniently bypasses and ignores questions as to why, in the first place, infrastructure was not set up in all these years, and why are they still ill equipped and dysfunctional? [115]

## Section C:

### Part I.

### Weaknesses of the Private Health Care Sector.

Several scholars like Baru, Nandraj, Phadke, Muraleedharan and others have provided some useful insights regarding the negativities of the private health care sector.

[115] See Mitra,Sabyasachi. 'Kemon Achho? Pashchimbanger Gramin Swasthya Byabosthya?' (How is the Rural Health Care in West Bengal?) Ekhon Bishongbaad, 8th year, Vol 11, March 2008,. Ghosh, Dr Asish Kumar. 'Primary Health Centregulo Bartamane je Abasthaye' ( Present Condition of the Primary Health Centres) *People's Health*, Kolkata, November 2008 and Chakravarthy, Indira. Public health Privatization in Bengal. In http:// sanhati.com/front-page/857 Accessed on 6.6.2010.

Following Phadke,[116] some generalization of the serious problems from which the private health sector generally suffer can be highlighted.

**Lack of Continuing Medical Education (CME).**

Unlike in some Western countries, a doctor's registration in India is renewed without undergoing any CME. There are voluntary efforts at CME. For example, many branches of the Indian Medical Association conduct CME-programmes for their members and IMA runs a monthly Journal of Indian Medical Association (JIMA) for its members.- But out of 3.5 lakh MBBS doctors in India, less than 25% are members of IMA, and about 10-25% attend its CME programmes. For the eight-lakh non-allopathic doctors (Homeopaths, Ayurveds, etc.) there is hardly any proper CME. Most of them prescribe allopathic medicines ("cross- prescriptions") and depend more or less solely on the Medical Representatives of drug companies for their knowledge of allopathic drugs. As a result, the medical professionals uncritically accept the half-truths and untruths propagated by the drug companies.

**Irrational Drug Use.**

Most of the drugs marketed in India are in the form of drug- combinations, most of these drug-combinations are irrational, and some are even hazardous. Yet they are widely prescribed in India, especially in the private sector. In the Public Health facilities, the health authorities draw up a list of rational, essential drugs and the District Health Officers are to buy medicines in accordance with this list. The centralized purchases of drugs in the public sector are therefore mostly of rational drugs. However, in the private sector, all kinds of irrational drugs are prescribed. This is confirmed by the preliminary results of a study of prescription practices in a typical district in Maharashtra. It was found that prevalence of use of irrational, hazardous, or unnecessary drug or injection is far more common in the private clinics than in the Primary Health Centres.

Unnecessary use of injections and intravenous infusions is the most glaring and the most common unnecessary medical intervention. This, again, is much more common

[116] Phadke, A. 'The Private Medical Sector in India' Bombay: FRCH, 1994 P V

in private practice since there is a strong financial incentive in unnecessarily using this cost mode of medical interventions. To remedy this situation, only rational drugs and rational drug-combinations should be allowed; all others should be banned. Along with continuing education of doctors, there has to be extensive and continuous health education of lay-people so that patients do not ask for injections or "powerful medicines" due to their misplaced faith in them. A practice of paying "examination fee" to a general practitioner has to be instituted. Lack of this practice is partly responsible for unnecessary use of injections.[117]

**Unnecessary and Unethical Medical Interventions.**

Unnecessary surgeries and laboratory tests are on the rise. This is because of increasing urban concentration, increasing commercialization and the rise of the corporate sector in Medical Care. To the list of unnecessary removal of appendix, tonsils, uterus, etc. are added new high-tech procedures like heart operations. According to a senior heart surgeon in Bombay, 40% of coronary angioplasties and 20% of coronary bypass surgeries done in Bombay are unnecessary! It is quite common for a CT--Scan centre to offer commissions to doctors for sending their patients for this costly investigation.

The sale of kidneys for transplants; misuse of prenatal diagnostic tests for detection of the sex of the foetus and the subsequent elimination of female foetuses; buying of blood from professional blood donors and the consequent risk of spread of AIDS, Hepatitis - these murky deeds are a special feature of the private medical sector.

**Sub-standard Medical Care.**

Many private practitioners buy medicines from many small companies who do not mind selling sub-standard, cheap drugs to practitioners. Many private nursing homes have neither adequate floor space nor ventilation and cleanliness, nor adequate water supply, or well- trained staff. A Committee of the West Bengal Legislative Assembly recorded this in 1985. The Nursing Homes Act is merely on paper, wherever it exists (as in case of some of the metropolitan cities).

[117] Ibid P VI

**Arbitrary Professional Charges.**

There is no principled basis for the level of fees to be charged by the doctor. The rule seems to be - charge as much as the patient can bear. A pediatrician from a small town may charge Rs. 20/- as consultation, as compared to Rs. 100/- in a city like Bombay. Similarly, charges for Caesarean delivery may vary from Rs. 500/- in a small town to Rs. 5000/- in Bombay. Cost of living, knowledge and experience of the doctor, type of surgery - all these should be properly considered to standardize charges. An individual patient is helpless to influence doctors' fees, especially in a life-threatening situation. This underscores the importance of standardizing doctors' charges.

**Paucity of Record-keeping.**

General practitioners and small hospitals keep (if at all) very cursory and inadequate records of their medical findings, not to mention statistics and proper accounts. The doctor's medical findings are not available to the patients as a matter of right. There is, therefore, no scope for any medical audit to evaluate the performance of the doctor.

**Lack of Preventive Measures and Health Education.**

Private practice, by its very nature, is confined to individualized relation between a patient and a doctor. So long as the patient is relieved of his/her suffering, the job of the private practitioner is considered to be over. However, the disease process originates at a social level, e.g. detective water supply to a community or promotion of tobacco. Doctors should therefore participate in the collective action to control diseases because they have the knowledge about these. However, private doctors, by and large, do not participate in the National Health Programmes like Tuberculosis, Malaria, Leprosy Control Programmes, etc.

The content of health education is also affected by the needs of private practice. On the one hand, aspects of science of medicine are explained to the people. On the other hand, the overall impact of such health education is to narrow down the concept of disease- process to merely its biological aspects while ignoring the broader social causes such as environmental degradation or an unhealthy life-style. Secondly, such

health education mystifies medicine and exaggerates the importance of doctors. In short, consciously or unconsciously, such health education serves to expand the market of medical care[118].

**Unqualified, Poorly Paid Staff.**

Most assistants employed in the private sector, except in big hospitals, are under-qualified. Given their low educational qualifications and the very superficial training given by the doctors, most assistants cannot cope with the responsibilities they have to handle. The quality of care thus suffers. Due to long hours of work (in many small hospitals, the shift stretches to 12 hours) and poor wages, poor avenues of progress, the staff is dissatisfied and this, in turn, adversely affects the quality of their work.

**Lack of Professional Self-regulation.**

Neither the Medical Council of India (MCI) nor the voluntary body - Indian Medical Association are regulating the quality of medica1 care or curbing unethical practices in the medical field. Everything is left to the "law of the market". [119]

Several empirical studies in different states of India also questioned the quality and the heterogeneity of the private health care sector. Muraledharan[120] described the private hospitals in Chennai has grown without any state policy to regulate its growth and development. As a result, the sector had grown without any regard to norms for infrastructure. There has also developed a complex network of private hospitals and physicians with diagnostic centres involved in policies of "scalping"; it also shows a strong tendency to over-provide care, depending on the patient's ability to pay. Another study of the private sector by Duggal and Nandraj [121] in rural in Maharashtra revealed that only 55 percent had registration, only 38 percent maintained records of any kind, and a remarkably high proportion lacked basic facilities. It also showed that close to 30 percent were being run by doctors not trained in the allopathic system of

118 Ibid P VIII

119 Ibid P VIII

120 Muraledharan, V R. 'Characteristics and Structure of Private Hospital in Urban India: A Study of Madras City'. In Rao: The State of Health in India. *South Asian Journal Indo –Pak Dialogue.* October-December 2006. P 42.( Hereafter cited as Rao: State of Health )

121 Nandraj, S and Duggal, R. 'Physical Standards in the Private Health Sector: A Case Study of Maharashtra',, Mumbai: CEHAT, 1997. In Rao: State of Health. P 42.

medicine. They were being run without adequate facilities and human power, with only 2 percent employing trained nurses of the hospitals, 39 percent operated without a full-time doctor. Only 10 percent of hospitals had an ECG monitor, 65 percent a sterilizer, and 56 percent an oxygen cylinder. Homan and Thankappan[122] found that Caesarean sections were performed three times more in private hospitals than public ones. Moreover, a study of pathology laboratories in Agra city founds costs extremely high, placing them out of reach of the poor. Yet the services provided were not up to standards, although they had increasing patient referrals over the years.[123]

Nandaraj in another article pointed out some of the glaring discrepancies of the private health care sector. He has referred a case where six patients died, having every chance of survival in a prestigious private hospital in Bombay due to the administration of a sub standard drug during operation. Actually, the private hospitals are known to have unfair nexus with the pharmaceutical industry. Reports published after the investigation, alleged three concerned doctors of the hospital, as they were connected with the ownership of the drug company.[124]

Vishwanathan and Rhode's study on rural private practioners in Uttar Pradesh found that a substantial percentage of them did not have any formal training in allopathic medicines. Many private practitioners get access to medicines from chemists and they administer medicines ranging from analgesics, vitamins to even steroids.[125] Another study shows that there is a gross of lack of knowledge and awareness regarding major communicable diseases like leprosy and tuberculosis. Lack of training in a large percentage is an important factor for the differential quality of care among private providers.[126]

Mention should be made in this context that the World Bank has also documented some of the weaknesses of the private health care sector. Recent studies of private

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122 Homan, R K and Thankappan, K.R. '*An Examination of Public and Private Sector Sources of In – Patient Care in Trivandrum District, Kerala*', Achuta Menon Centre for Health Services, Thiruvananthapuram 1999. In Rao: State of Health. P 42.

123 Singh, T V. ' *A Study of the State of Medicare Facilities in Agra City* ( With Special Reference to Pathology Labs ), unpublished MSW Report, Agra University, 1993. In Rao: State of Health. P 43.

124 Nandaraj, S. 'Beyond the Law and the Lord: Quality of the Private Health Care'. *Economic and Political Weekly*. Vol XXIX, No 27 4rth July. 1994, P 1683.

125 Rhode, J and Vishwanathan, H. ' The Rural Private Practitioner.' Health for the Millions, 2 (1) (February) 1994 : 13-6. In Baru: A State Level Analysis. P 218

126 Uplekar, M W and Shepherd, DH. '*The Private GP and the Treatment of Tuberculosis. A Study*'. Bombay: Foundation for Reasearch in Community Health,'1991. In Baru: A State Level Analysis. P 218

medical hospitals in Kolkata and Bombay also indicate that private sector facilities are in poor condition and are frequently used to perform medically unnecessary procedures.[127]

Comparing the services of the two sectors, World Bank has identified the over utilization of procedures and diagnostic services in the private sector which clearly accounts increase in health care expenditures in the private sector. An example was cited by the World Bank to highlight the pro-active role of public health care in India.[128]

It is clear from the empirical studies that the private health care as a whole has failed to provide reasonable services to the population. Even the investment of capital or consuming the so called 'quality service' at the cost of money did not result in satisfaction of the treatment. Therefore, it is discernable that on the one end, there is a degenerative public health care sector, and on the other end of the yardstick there is the unregulated, heterogeneous and complex private health care sector, whose efficacy towards providing better service has always, been questioned. So the 'ability to pay' factor which is at times considered as the determinant factor for getting proper treatment, at least from the private health care sector can not be fully accepted. Similar to the Public health care sector, this domain of health care is also plagued by

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127 Nandaraj, S, A Khot, A and Menon, S. 'Accredation of Hospitals: Breaking the Boundaries in Health Care'. Mumbai: CEHAT. 1999. In Better Health Systems for India's Poor. P 50.

128 Shyam is a Harijan, a member of the schedule caste, living in southern Uttar Pradesh, when his 5-year-old son fell ill with vomiting and diarrhea, Shyam took him to an unqualified private practitioner in the nearest town. Shyam did not consult the nearby (public sector) primary health center, as he had heard form neighbours that it had no medicines.
The boy received injections and medicines of substances unknown to his illiterate parents, but he failed to improve. He was then taken to a private nursing home, where he was admitted and given an intravenous solution (locally known as "bottles") for two days. The child recovered, but the total cost of his treatment was Rs. 500.
Meanwhile, the child's 12 – year old brother had developed the same symptoms. This time the family consulted the government hospital. One of the health workers at the government hospital took the child to his residential private practice, where he gave two bottles for R.s 200 and medicines form the market, which cost another Rs. 300.
Very soon the third son, aged 14, also developed diarrhea and vomiting. All three children eventually recovered, but the family had spet more than Rs. 1,500 on their children's medical expenses. All of the money was borrowed from neighbors and Shyam's employer.
The medical officer in charge of Shyam's primary health center heard about the cases and visited the village to investigate the outbreak. He took samples from the family's source of drinking water – an open water tank – and had them tested at a government laboratory. The test showed bacterial contamination. The medical Officer returned to the village to treat the water and counsel the villagers on the importance of boiling or treating potentially contaminated water.
Source: World Bank 2000a. 'Confronting Poverty : The Challenges of Uttar Pradesh' South Asia Region. Washinton DC. In Better Health Systems for India's Poor. P 51.

malpractices, nepotism, negligence and severe corruption. Unlike the public sector, the private health care sector is not accountable to anyone. However, these growing problems of the private health care sector became more chronic with its gradual transformation to an industry and intrusion of global capital.

**Part II**

**Corruption and Malpractice: Bane of Private Health Care.**

Against this backdrop, some glaring instances of malpractice and corruption the health care sector of Kolkata will be cited.

**Incident 1:** Antarlina, the eight year old daughter of Dr Debapriya Mallick, died of septicemia at Suraksha Hospital on 20 August 2004. She had been admitted with vomiting and diarrhea the previous day. As Dr. Mallick says, "hospital negligence killed" his daughter who "lay from 10.30 in the night to 8.30 the next morning untreated at Suraksha". As a qualified medical practitioner, Dr Mallick was strongly convinced that his eight-year-old daughter Antarlina, who was admitted to Suraksha Hospital under Dr. Debashis Roy at 4.40 pm on 19 August 2004 with diarrhea and vomiting, died because of utter negligence on the part of the hospital. She was kept in an adult cabin (room no 724) on the seventh floor. Although the children's care ward was on the fifth floor of the multistoried hospital. The Hospital did not take any history of the patient from the patient party. The RMO (Residential Medical Officer) only gave his daughter a cursory examination saying that the patient had jaundice. He prescribed some tests. Dr Debashis Roy arrived after about four hours to attend her and called Dr Ranjan Sarkar, nephrologist, for investigating Antarlina. He prescribed some emergency tests. Next day her condition rapidly deteriorated. Tests were not done immediately and no nurse or doctor attended her. The tests were done the next morning. Dr Maliick had requested the RMO and the nurses to arrange the tests prescribed by the doctor. But they had snubbed him. They did not even

change her clothes soiled by urine and stool. She was taken to the ICU in soiled clothes on 20 August where she breathed her last.[129]

**Incident 2:** A patient has undertaken a special investigation of the prostate gland in one of the reputed diagnostic centres of central Kolkata. The investigation report revealed that the patient has an enlarged prostate and it has turned out to be malignant. However when the report was considered for a second opinion, a different picture came to the forefront. Though the patient has an enlarged prostate, which is a very common phenomenon of patients in the age group of 60's and 70's, but it has in no way showed the symptoms of malignancy. However, without the histopathological test, a radiologist can never confirm the malignancy of the prostate. When the report was once again examined minutely, a shocking revelation became known. It was noticed that the report belonged to a female patient who does not have a prostate.[130]

**Incident 3:** RMO Dr Sandip Das of Charnock Hospital in VIP Road raped Deepa Biswas of Duke Garden in Teghoria. Dr Kingshuk Kar of the same hospital was arrested for a series of unethical activities. Mr. Rajkumar Misra a coal mafia from Orissa was the owner of the nursing home.[131]

**Incident 4:** Swapna Ghosh (39 yrs) - a mentally retarded and physically challenged (also dumb) woman, having diabetes mellitus type 2 developed an infection in the right side of the spinal cord. The local physician, Dr Nirmal Giri has identified the infection as carbuncle and prescribed necessary medicines for treating the disease. Though Swapna had improved slightly, but her sister Ratna has taken her to Dr Pradip Kr Agarwal (under whose supervision the diabetes was treated) who had

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129 'Hospital negligence kills kid': *Saltlake Post*. VOL XIII:XV111& XVIII (303) fortnightly in *Antarlina* 2nd year, Vol 2, 2006. P 17. (Read *Antarlina* ed by Dr Debapriya Mallick a magazine that dealt with several cases of medical negligencies, malpractice and corruption in health care. This particular issue, focused on the unethical practices of the Suraksha hospital, which is considered as 'Merchants of Death', also read *Sambad Antarlina* – a newspaper, published fortnightly highlighting these similar issues.)
* Courtesy: People for Better Treatment.

130 Biswas, Sankhasubhra. '*Ghatanar Ghanaghatay Chikitsha Bepastha, Beporoya Abahelar Chanchalyakar Report*. ( Eventful Health Care Systems ) *Medifila*, 5th year, 4rth issue, April 2002.

131 The information was provided by People's for Better Treatment.

advised that the case should be treated by a surgeon. Next day, Swapna was admitted in Park Medicare Private Limited Nursing Home in Rishra under the surgeon, Dr S.N Basak. Dr Basak has suggested operating the affected area, which, according to his, investigation is an 'Infected Sebaceous Cyst'. Since Swapna is a diabetic patient, hence the nursing home authority decided first to reduce the 'sugar level' and then to undertake the operation. However, Swapna was admitted in the nursing home on 4.1.2008.

The nursing home authority then had forced Ratna to sign a number of papers including the consent form for the operation as a 'part of the formality' on behalf of the nursing home, four days before the operation (which was decided as the tentative date for the operation). However, the nurse suddenly informed Ratna, that the doctors have decided to operate Swapna immediately at 3 pm (on the same day of admission). Though Ratna has repeatedly requested the doctors for not operating her sister at this high sugar level, but her requests were in vain. On 5.1.2008, Swapna's condition rapidly deteriorated and she started vomiting from the morning. The nursing home did not inform Ratna about her sister's health condition. Nonetheless, when Ratna had enquired about her sister over telephone, it was told that she is in a better condition. In the evening when, Ratna visited the nursing home, she was surprised to see Swapna whose condition has worsened hastily. The nursing home's attitude was indifferent and they considered this as a very natural postoperative condition. Seeing Swapna extremely rest less, Ratna had rushed out and called Dr Agarwal who said that the patient is suffering from epilepsy. Understanding the negligence on their part, Dr Agarwal has quickly advised to shift Swapna in a 'better place' (having ICU/ITU) - Paramount Nursing Home in GT Road near SriRampur. Swapna was admitted under Dr Sabysachi Bose who is also attached to Park Medicare. Gradually Septicemia affected Swapna and her right fore arm-developed gangrene. Along with these, her teeth were all broken and came out of the gum. Dr Bose has explained Ratna that while keeping

> the patient in the ventilation, her teeth were damaged and there is nothing to worry about the hand. Application of Thrombofob Gel will cure the hand. He has also informed that the ENT specialist Dr Snehashish Barman will investigate Swapna on the next day.
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> With the further deterioration of the patient's condition, DR Bose realized his mistake and discharged the patient saying her 'stable' on 9.1.2008. However, Swapna's condition did not show any sign of improvement. She was again admitted to Mission of Mercy Hospital and Research Centre in Park Street, Kolkata on 12.1.2008. On 18.1.2008, Swapna died in this hospital at 7.30. am. The death certificate of Swapna given by the Mission of Mercy Hospital and Research Centre, mentioned that she died due to Cardio Respiratory failure with Diabetes Mellitus with Gangrene right fore arm with Removal of Sebaceous cyst from Right Lateral Chest.[132]

These four cases of medical negligence and unethical activities in health care are now the order of the day. There are unending such cases, which pervade the domain of health care 'industry'. The moral degeneration of the medical profession has not only challenged the quality of the health care but also professionalized the relationship between the patient and doctor. Critical patients are treated as valuable clients in the market of health care. But this deterioration is a recent development.

Mention should be made in this context that in a complex technological hospital, negligence becomes 'random human error' callousness becomes 'scientific detachment' and incompetence becomes a 'lack of specialized equipment'. The depersonalization of diagnosis and therapy has turned malpractices from an ethical into technical problem.[133]

Antia has pointed out that the medical profession has enjoyed a uniquely privileged position because of its technical skill as well as the intensely personal relationship, which develops between a doctor and his patient. The latter puts his/ her entire faith in

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[132] Ibid.

[133] Illich, Ivan: '*Medical Nemesis: The Expropriation of Health'* London: Calder and Boyars, 1974. P 24 ( Hereafter cited as Illich: *Medical Nemesis*)

the doctor who not only cures but also cares and consoles the patient as well as the family. The epithet 'noble' is symbolic of the love and respect that this profession has enjoyed over the years.[134]

What has been put forward in 'Society and Health: the dilemma'[135] seems more pertinent to the changing scenario of health care culture in contemporary day. The boom in biological sciences within the last 25 years has brought with it an emphasis on producing the scientific physician –highly trained, specialized in analyzing data and skilled in the diagnosis and treatment of organic disease. Taught by scientists with PhD degrees for the first two years and by medical specialists in the last 2 years, medical students are well inculcated with the importance of laboratory and clinical investigation. In the quest to master the technical tools necessary to scientific physician, students are educated in an atmosphere in which the 'good patient' is the sick patient, the individual with multiple physical radiological and laboratory abnormalities. [136]

However, most medical schools focus on two primary goals:

- To provide opportunity to learn the technical and scientific skills required to treat disease
- To learn the necessary techniques required to understand the social and cultural milieu of the physician –patient relationship.

But the adequate emphasis on the second has been lost. By graduation, physicians have been prepared to take immediate, scientifically based action in treating ill individuals but they are often unable to visualize and understand the social context in which both they and their patients function.[137]

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134 Antia, N H. 'Missue of Medicine'. In *Market Medicine and Malpractice*. Ed. Jesani, Amar, Singhi, PC, Prakash, Padma. Mumbai :Centre for Enquiry into Health and Allied Themes.(CEHAT) and Society for Public Health Awareness and Action.( SPHAA), 1997 P 9 (Hereafter cited as Antia: Misuse of Medicine)

135 Corey, L, Epstein, M and Saltman, S. 'Society for Health : Dilemma'. In *Medicine in a Changing Societ'*. Ed by Corey, L, Epstein, M and Saltman S. Saint Locus: The C V Mosvy Compan, 1977. P 3

136 Ibid P3

137 Ibid P4

Global Corruption Report has recently raised the question as why are health systems prone to corruption.[138]

Corruption in the health sector is not exclusive to any particular kind of health system. It occurs in systems whether they are predominantly public or private, well funded or poorly funded, and technically simple or sophisticated. The extent of corruption is, in part, a reflection of the society in which it operates. Health system corruption is less likely in societies where there is broad adherence to the rule of law, transparency and trust, and where the public sector is ruled by effective civil service codes and strong accountability mechanisms.

These general factors affect the extent of corruption in any sector, but the health sector has a number of dimensions that make it particularly vulnerable to abuse. No other sector has the specific mix of uncertainty, asymmetric information and large numbers of dispersed actors that characterize the health sector. As a result, susceptibility to corruption is a systemic feature of health systems, and controlling it requires policies that address the sector as a whole.

Two other factors that contribute to corruption in health care are worth mentioning. First, the scope of corruption in the health sector may be wider than in other sectors because society frequently entrusts private actors in health with important public roles. When private pharmaceutical companies, hospitals or insurers act dishonestly to enrich themselves, they are not formally abusing 'public office for private gain'. Nevertheless, they are abusing the public's trust in the sense that people and organizations engaged in health service delivery are held to a higher standard in the interests of protecting people's health. The medical profession, in particular, is given great latitude in most countries to police itself in return for assuming professional responsibility to act in the best interests of patients

Second, the health sector is an attractive target for corruption because so much public money is involved. The world spends more than US $3.1 trillion on health services each year, most of it financed by governments. European members of the OECD collectively spend more than US $1 trillion per year and the United States alone

[138] Savedoff, D William and Hussmann. 'The Causes of Corruption in the health sector: a focus on health cae systems.' *Global Corruption Report* 2006. USA: Transparency International, 2006 P 4

spends US $1.6 trillion.[139] In Latin America, around 7 per cent of GDP, or about US $136 billion, is consumed by health care annually, of which half is publicly financed. In lower- income countries, private health spending is often greater than public health spending, although the latter is still a significant amount. The share of total government revenues spent on health care ranges from under 5 per cent in Ethiopia, Egypt, Indonesia and Pakistan to more than 15 per cent in Ireland, Germany, the United S.l4es and Costa Rica. These large flows of funds represent an attractive target for abuse.[140]

Uncertainty is a central feature of the health sector and has tar-reaching implications, as was first argued by Kenneth Arrow in 1963.[141] Arrow showed that uncertainty regarding who will fall ill, when illness will occur, what kinds of illnesses people get and how efficacious treatments are make the market for health care services very different from other markets in terms of the scope for market failure. Due to uncertainty, medical care service markets and health insurance markets are both likely to be inefficient.

This uncertainty makes it difficult for those demanding medical care - patients or their families — to discipline suppliers of medical care, as occurs in other markets. Patients cannot shop around for the best price and quality when they are ignorant of the costs, alternatives and precise nature of their needs. In such situations, consumer choices do not reflect price and quality in the normal fashion, and other mechanisms - such as the licensing of professionals and facilities or even direct public provision - are introduced to allocate resources and determine what kinds of care are provided. As an additional consequence, the poor functioning of markets creates opportunities for corruption, and the uncertainty inherent in selecting, monitoring, measuring and delivering health care services makes it difficult to detect and assign responsibility for abuses.[142]

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139 Ibid P 4

140 Ibid P 4

141 Kenneth J.Arrow, 'Uncertainty and the Welfare Economics of Medical Care', American Economic Review 53 (1963). In Savedoff, D William and Hussmann. 'The Causes of Corruption in the health sector: a focus on health care systems.' *Global Corruption Report* 2006. USA: Transparency International. P 5 (Hereafter cited as Global Corruption Report)

142 Ibid P 5

But the degree of uncertainty is not identical for everyone in the health sector, leading to a second systemic feature, namely asymmetric information. Information is not shared equally among health sector actors and this has significant implications for a health system's efficiency and its vulnerability to corruption. Health care providers are better informed of the technical features of diagnosis and treatment than patients are. Pharmaceutical companies know more about their products than the doctors who prescribe them, individuals have certain kinds of information about their health that are not available to medical care providers or insurers and providers and insurers may have better information about the health risks faced by certain categories of individuals than the individuals themselves.[143]

Finally, health systems are prone to corruption because of the large number of actors involved and complexity of their multiple forms of interaction. These actors can be classified into five main categories.

- ✓ Government Regulators (health ministries, parliament, specialized commissions)
- ✓ Payers (social security institutions, government office, private insurers)
- ✓ Providers (hospitals, doctors, pharmacists)
- ✓ Consumers (patients)
- ✓ Suppliers( medical equipments and pharmaceutical companies)

The presence of so many actors increases the difficulties of generating and analyzing information, promoting transparency and even identifying corruption when it occurs. It increases the number of opportunities for corruption; for example, funds can be diverted or misallocated at a ministry, state hospital or local clinic by individuals working as managers, procurement officers, health professionals, dispensers, and clerk or patients. The involvement of so many actors multiplies the number and kinds of interest that might encourage corrupt behavior.[144]

[143] Ibid P 6
[144] Ibid P 6

Along with the issue of corruption and negligence, another important aspect, which the corporatisation of health care has bought about, needs mentioning. The changing pattern of the private health care has undoubtedly transformed the health care culture of the society. The new form of corporate health care not only converted health care to an expensive, consumable commodity of the market, but it has also created an atmosphere of sickness and medicalised the life of the individual by all possible means. The entry of the market principles in health care has inevitably created an interventionist role of medicine in every sphere of life.

Following Antia, a generalized idea of the problem can be proposed. The gross misuse of such knowledge and technology in the field of medicine is demonstrated by the fact that the most simple, cheap and efficient aspects of the cure and control of communicable diseases are neglected and undue emphasis is paid to the most expensive, complex and cost ineffective diseases like cancer etc. This clearly demonstrates the dominant consideration in the import of and use of science and technology, which is dictated by the requirements of the rich and that of the medical profession rather than the needs of the vast majority.[145]

The gross over production of doctors, drugs and sophisticated medical instruments have ensured malpractice. Incase of the urban rich this is demonstrated by the unnecessary, excessive and even dangerous investigations and medications including surgeries. Due to availability of easy money, the affluent sections of the society are at the greatest peril of iatrogenesis[146] (doctor made illness). The 'five star hotel' like urban, corporate hospitals with their latest specialties, up dated scanners, modern drugs and techno centric operations create an atmosphere of sickness where the patient lose their sense of reality.[147]

Indiscriminate uses of the intensive care units even for terminal patient increase the profitability or the salability of the product of the medical institution and result in aggravating the pain of the patient rather giving him a relief. Each techno centric facilities have their specific limited use, but when deliberately pushed to their by the

145 Antia: Misuse of Medicine.P 10.

146 Clinical Iatrogenesis : Greek Word : *Iatros*: physicians, *Genesis*: origin. This is defined as comprising only illness which would not have come about if sound and professionally recommended treatment had been applied.( Ivan Illich)

147 Antia: Misuse of Medicine.P 10-11

'technical robots' (doctors) for satisfying their monetary greed, the wonders of modern science prove to be counter productive.[148]

The growing middle class has now been caught in a cleft stick between providing the latest medical care like renal dialysis, kidney transplant and coronary bypass surgery and are pauperized in the bargain. Many search for old-fashioned family doctors who are now reducing in number due to the overwhelming presence of the specialists and consultants.[149]

Dr NC Das, a senior anesthetist of Kolkata observes that in earlier times General Practitioners with MBBS or LMF were doctors. They used to carry syringe, emergency drugs and were able to undertake even minor surgeries. Sending patients to hospital or nursing home was not very common in those days. The general physicians or the family physicians who were also close to the family members cured minor health problems at home. They enjoyed a position of love and respect. The emergence of the specialists, and consultants, along with the changing disease profile brought about a decline in their social status and public esteem.[150]

The medical profession and the associated health industry have the unique opportunity to trade in an area where consumer resistance is at lowest, because of fear and ignorance.[151]

Prescribing costly drugs and sometimes unnecessary investigations, the branded 'health care malls' are selling their wide range of products to their patients who are further sickened by the interventionist role of medicines. The more a patient is confined within the four walls of the hospital, the more profit is incurred by the health care industry. The medicalised atmospheres of the hospital do not cure patients holistically. It tries to retain the sickness around the patient who always suffers from the tendency of getting sick again. Sickness brings money or capital, which exploits

148 Ibid P11

149 Ibid P11

150 Interview with Dr N C Das on 10.8 2007.

151 Antia: Misuse of Medicine.P 12, also read LTH Tan and KL Ong : The Impact of Medical Technology on Healthcare Today. In www.hkcem.com/html/publications/Journal /2002-4/231-236./pdf. Accessed on 31.05.2010, Banerji : D 'Techno centric Approach to Health: Western Response to Alma ATA' *Economic and Political Weekly.* Vol XXI, No 28, July 12, 1986, P 1233-1234 and Chakraborty, A '*ICU-ITU Byaparta ki?*' (What is actually ICU-ITU?), *Ashukh –Bishuhk* 10th year, 5th issue, January –February 2010.P 125-127.

the ethics of the medical profession. Private health care sector are plagued by all these potentialities needed for the business of health care.

Ivan Illich in his brilliant work, 'Medical Nemesis: The Expropriation of Health', published in 1974, put forward the issue of acute crisis of the health care sector. The medical establishment has become a major threat to healthy. Dependence on professional health care affects all social relations. In rich countries medical colonization has reached sickening proportions, poor countries are also following the line. Medicine is about to become a prime target for political action that aims an invasion of industrial society.[152]

A professional and based health care system, which has grown beyond tolerable bounds, is sickening for three reasons:[153]

- It must produce clinical damages, which outweighs its potential benefits.
- It cannot but obscure political conditions, which render society unhealthy.
- It tends to expropriate the power of the individual to heal himself and to shape his or her environment.

The medical or paramedical monopoly over hygienic methodology and technology is the glaring example of the political misuse of the scientific achievements to strengthen industrial rather personal growth. Illich thinks that such medicine is but a device to convince those who are sick and tired of society, i.e. those who are ill impotent and in need of technical repair.[154]

The changes in health status are generally equated with progress and are attributed to more or better medical care. In fact, there is no evidence of any direct relation between the changing form of the sickness and the so-called progress of medicine.

The infections that prevailed at the outset of the industrial age can illustrate how medicine came by its reputation. After World War II, before antibiotics came into use, cholera, dysentery and typhoid peaked and dwindled outside medical control. By the

[152] Illich: Medical Nemesis. P 11
[153] Ibid P 11
[154] Ibid P 11

time their etiology was understood or their therapy had become specific, they had lost much of their, relevance. The combined death effect of scarlet fever, diphtheria, whooping cough and measles from 1860 to 1965 for children up to 15 years shows that nearly 90% of the total decline in death rate over this period had occurred before the introduction of antibiotics and widespread immunization against diphtheria. In developing counties, diarrhea and upper respiratory tract infection occur more frequently, last longer and lead to higher mortality where nutrition is low, no matter how much or little medical care is available. By the middle of the 19thy century, major malnutrition syndromes like rickets and pellagra replaced infectious epidemics. When these declined, the modern epidemic like coronary heart disease, hypertension, cancer, arthritis and mental disorder saturated the domain of diseases. Despite intensive research, there is no satisfactory explanation for the genesis of these changes. However, Illich had pointed out two things to explain the situation:[155]

- Professional practice of the physicians cannot be credited with the elimination of old forms mortality.

- It cannot be blamed for the increased expectancy of life spent suffering from the new diseases.

Illich correctly pointed out that the analysis of the disease trends shows that the environment is the primary determinant of the state of any population. Food, housing, working condition, neighborhood cohesion as well as the cultural mechanisms play the decisive role in determining the health conditions of the individual.[156]

Following Illich, it is relevant to point out that the impact of medicine constitutes one of the most rapidly expanding epidemics of present time. Medicines have always been potentially poisonous, but their unwanted side effects have increased with their effectiveness and widespread use. Every 24 to 36 hrs in UK, every 50-80 % of the adults swallow a medically prescribed chemical.[157]

Changing health care culture has identified certain indications of human body as diseases. Corporatization of health care has elevated the status of certain normal

[155] Ibid P 16
[156] Ibid P 16
[157] Ibid P 17 -22

symptoms as 'disease or sickness'. Pharmaceutical companies and hospitals are always in the process of detecting the abnormalities and syndromes and are keen to term them as disease.

Linpeyer in his '*Disease Mongering; How Doctors, Drug Companies and Insurers are making you feel sick'*, Re Moynihan in '*Selling Sickness: The Pharmaceutical industry and disease mongering*' (2002) and Koerner in '*The art of Branding a Condition*' (2003) have also raised these similar issues which are threat to the contemporary society.[158]

Cholesterol is an important component of blood. There has been an age-old idea that increasing cholesterol level can cause cardiac arrest. However, cholesterol triglyceride acts as an important component of human body. But over popularizing the negative impact of cholesterol signified that its presence in blood can cause harmful effects. The useful impacts of the medicines that are used to dilute the high cholesterol level are not yet properly discerned. But the side effects of these medicines can inevitably invite other crucial diseases. Similar explanations can also be given in cases of osteoporosis, hypertension and diabetes.[159]

Surprisingly certain normal gestures and activities of human life like anxiousness for the workplace, moving the legs while sleeping, usual restlessness of the children and even staring at the alluring beauty of the women have all gathered under the umbrella of abnormalities or diseases. High-sounding names have been coined to identify each of these syndromes as disease, like generalized anxiety disorder, restless leg syndrome, attention deficiency disorder and amorous eye dysfunction respectively.[160]

Given this condition, media is also playing a dominant role in strengthening the marketability of the health care products (sometimes in the form of advertising the benefit of a particular medicine for a specific disease, sometimes championing the success of the hospital and sometimes even providing discounts and coupons for the treatment in corporate hospital). The private health care sector as whole has now been converted to a commercial entity like any other commodity of the market. The global

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158 Bhattacharya, Nabendu. '*Oshudh Bechte Ashukh Gachhao'*(Sell Medicine, Create Disease),*People's Health* May 2009. P 13.( These three books were mentioned in this article)

159 Ibid P 12

160 Ibid P 13

compulsion of intensifying the growth of this sector is indeed instrumental behind medicalising life.

Foucault has pointed out that in the twentieth century medicine began to function outside its traditional field as defined by the wishes of the patient, his pain, his symptoms, and his malaise. This area defined medical treatment and circumscribed its field of activity which was determined by a domain of objects called illness and which gave medical status to the patient's demands.[161]

He further pointed out that health has been transformed into an object of medical treatment. Everything that ensures the health of the individual, whether it is the purification of water, housing conditions or urban lifestyles is today a field of medical intervention that is no longer linked exclusively to diseases. Actually, the authoritarian intervention of medicine in an ever-widening field of individual or collective existence is a characteristic fact. Today medicine is endowed with an authoritarian power with normalizing functions that go beyond the existence of diseases and the wishes of the patient.[162]

Moreover he argues that one of the capabilities of medicine is killing. Until recent times the negative, effects of medicine remained inscribed within the register of medical ignorance. Medicine killed through the doctor's ignorance or because medicine itself was ignorant. It was not a true science, but rather a rhapsody of ill-founded, poorly established and undiversified sets of knowledge. The harmfulness of medicine was judged in proportion to its non –scientificity. [163]

Based on these arguments it is necessary to put forward that the medicalisation of life under the global compulsion is a threat not only to the industrialized countries but also to these consequences accentuated the crisis of health care in developing countries. India is not an exception in this regard. In case of Kolktata, it can be mentioned that the changing pattern of private health care sector radically transformed the health care culture. Glaring changes came into prominence with the transformation of the entire

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161 Foucault,Michael. 'The Crisis of Medicine or the Crisis of Antimedicine?' English Translation c *Foucault Studies*: 2004 No 1 P 5-19'Translated by Edgar C. Knowlton,Jr, William J. Kingand Clare O'Farrell.P 12

162 Ibid P 13

163 Ibid P 9

private health care sector into a lucrative industry. The hospitals like Apollo, AMRI etc have exhibited a corporate health care culture of a globalised age. The warmth, homely atmosphere and the informal behaviour, which were present in the small nursing homes gradually, disappeared with the onslaught of global forces. The private health care sectors, which were once identified with small nursing homes, had not acquired the art of mongering diseases. Nor they were influenced by the market principles of advertising their own services for increasing their profit. In spite of being within the aegis of the private health care sector, these nursing homes did not function as a industry as a whole. In those days, investing in health care implied something more than simply incurring large profits.

The skillfully crafted advertisements of the various private hospitals in the city undoubtedly create an atmosphere of sickness. For example in the advertisement of Wockhardt, it is depicted '*Kidney Kadachhe*?' (Kidney causing pain?). This advertisement in one of the congested junctions of Kolkata, might hammer human psyche, whether the kidney is functioning properly. While traveling in Metro Rail, one can see the advertisement of another hospital (Deby Shetty) of eastern Kolkata. The advertisement highlights 'Diabetes Increases; Risk of Heart Disease': Collaborative treatment of diabetes, Comprehensive package programme. Moreover, mention should be made that in many magazines discounts coupons of private hospitals (BM Birla Heart Research, Woodlands etc) are given and offer prices for routine check up under package systems are provided. Continuous harping on health issues had an adverse impact, which might result in giving birth to sickness. But this, on the other hand increases the business of the hospitals, which cleverly trap the innocent clients and convert them to 'patients'.

The global actors in the form of IMF and World Bank in the post liberalization era strengthened the growth of the private sector on the one hand, and impoverished the public sector on the other. The welfare state has invited private capital, which has commercialized health care extensively. But except the reforms under the World Bank loans, significant actions were not taken to revamp the decaying conditions of the public health care. To the majority of the Indian population, medicalisation of life is a curse. The retreat of the welfare state and its subsequent services might threaten the

downtrodden, as to them, purchasing expensive health care services could harshly challenge their affordability and survival.

The retreat of the welfare state of India has been severely questioned. Jayal[164] has argued that the critique of the public sector, for instance, has primarily targeted its efficiency and wastefulness. State acted as a devouring monster ready to accumulate power. The Indian state has been characterized as an interventionist rather than welfare state.

'Retreat' is a blanket term according to Patnaik[165].There is indeed a transition from one paradigm of state intervention to another, which has important class content. This shift has weakened the working class vis-à-vis the capitalist, centralized capital accumulation by driving out absorption of small capitalist and strengthened the financial interests relative to financial interest.

Following Quadeer it is appropriate to point that the external monetary, political, and intellectual pressures from institutions such as Rockfeller Foundation, USAID and the Ford Foundation transformed the health care sector. Between the Seventh and Tenth Plans, in fact the health sector was (more) under the control of the Finance Ministry than that of the Ministry of Health and Family Welfare. Strategies creating constant discontinuities, planning slowly succumbed to processes that reflected continuities with the colonial period. While the perspectives offered by Nehru and Mahalonobis visualized structural alterations in the economy, their model also possessed inherent flaws as it drew heavily from the Marshall Plan for European reconstruction. Planning based on industrialization and expansion of markets, treated health and welfare as an independent investment, making it vulnerable to the market forces.[166]

Despite a desirable set of priorities and integrated approach of the Five Year Plans, the crucial lacunae of the earlier period of planning and implementation influenced later developments in the health sector:

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164 Jayal, N J : 'The Gentle Leviathan : Welfare and the Indian State'. In Rao. M. *Disinvesting in Health: The World Bank's Prescription for Health.* New Delhi: Sage Publication, 1999.P 39-41.

165 Patnaik, P. 'Whatever Happened to Imperialism and other essays'. New Delhi: Tulika, 1995, P194-195.

166 Quadeer, I 'Continuities and Discontinuities in Public Health : the Indian Experience' In *Maladies, Preventives and Curatives; Debates in Public Health in India.* Ed by Bagchi, A and Soman, K, IDSK: Tulika Books, 2005, P 89

- Central control of funds eroded provincial autonomy, creating an unequal relationship between the two.
- Central Government specialists dominated the Directorate of Health closing avenues of promotion for health professionals from the States.
- Private Practice of public sector doctors continued with state patronage in education, subsidies, loans and part time employment.
- Medical education mostly benefited the landed and the urban elite.
- Dependence on external experts increased in all sectors of health services.
- The schism between health and social planning deepened with a focus on technology.
- The discipline of public health remained a poor imitation of community health taught in the UK and the US.[167]

Classical public health was essentially based on collective endeavor, and therefore made the provision of the health care to the majority of the state. The post colonial processes that stifled the growth of public health in India induced revaluation and reforms by the mid 1970's. By then, the government was becoming increasingly dependent on the Bretton Woods institutions and in1976, it chose to declare a state of Emergency. Around the mid 1980's the welfare state began shrinking and privatization of health care became the norm. Instead of epidemiological rationality, profits and demand started shaping health services. Thus began the third phase of planning wherein, without occupying any territories, the 'new imperialism' hegemonized planning and development, of both economic and welfare sectors, with serious consequences for health. The indifference, and at times ignorance, of the health professionals through these shifts has given space to the idea of 'new public health' that can be termed 'neo-liberal public health', with official recognition from international donors and the public health experts.[168]

[167] Ibid P 89
[168] Ibid P 90

Under this new ideology, biomedical perspectives overshadowed the role of socio – economic factors in health and behavioral approach began to dominate. Individuals were required to live lifestyles conducive to an ecologically sustainable environment as opposed to state action. Social problems such as alcoholism and drug use as well as pregnancy and normal del9overy were thoroughly medicalized. This drastically transformed the health planning in the third world:[169]

Mention should be made that National Health Policy NHP 2002[170] made candid confession and admission of the failure of the National Health Policy 1983. At the same time, it echoed the same words blaming the population explosion as solely responsible for the failure of state funded health care infrastructure. National Health Policy emphasized 'Efforts made over years for improving health standards have been partially neutralized by the major growth of population'. Further the NHP 2002, promoted India as a global health care destination for health tourism.

Further, the policies like GATS (General Agreement on Trade in Services) TRIPS (Trade Related Intellectual Property Rights) legalized the entry of private and foreign capital in health care. All these agents of globalization in various forms converted health care utilization strictly for the upwardly mobile section. The principles of rich became richer and the poor turned to be poorer were reflected in the domain of health care. The rapid mushrooming of the corporate hospitals for the well to do class and the degenerating overcrowded public hospitals for the economically challenged section defined the contours of the healthcare services in Kolkata.

If the state had the genuine intension of considering the interests of the majority of its population, it would have been able to restrict the unlimited growth of the private health care sector.

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169 Ibid P90, Also see,. Antia, N H :The World Development Report 1993: A Prescription for Health Disaster *Social Scientist*, Vol. 22, No. 9/12. (Sep. - Dec., 1994), pp. 147-151. Stable URL: http://links.jstor.org/sici?sici=09700293%28199409%2F12%2922%3A9%2F12%3C147%3ATWDR1A%3E2.0.CO%3B2-I, Accessed on 5.9.2007. Also see. Balasubramaniam K, *Globalisation and Liberalisation of Healthcare Services: WTO and the General Agreement on Trade in Services People's Health Assembly* - Issue Paper. In http:// www.phmovement.org. Accessed on 16.04.2008, Mukhopadhaya, Rahul. '*Chikitsha Byabostha o Bishwayaan: Anubartaner Dhara"* (Health Care Services and Globaliation: Evolutionary Process) Kolkata: Nagarik Mancha, 2007.

170 Government of India, Ministry of Health and Family Welfare (2002) *National Health Policy*. New Delhi.

In case of Kolkata, it can be said that the Eastern fringes of the city are dotted with new corporate hospitals. Every year the health minister of the State inaugurate one corporate hospital. Nonetheless, the public health care organizations like KPC, Niramoy polyclinic are also privatized, but the growth of public hospitals is stagnant. The Baghajatin State General Hospital in southern Kolkata was the last public hospital in recent years. Why the government is keen for the growth of private medical college? Why the less developed districts like Purulia do not have any medical college? Why there is only one medical college in entire North Bengal? Why the government has not taken any serious steps to revamp the decaying conditions of Mayo hospital, Mahananda Brahmachari Sebayatan, G.K Khemka Chest Clinic and Balananda Brahmechari Sebayatan?

Answers to all these questions and many others are unknown to the Health Department. Apart from these the small nursing homes of Kolkata, developed in the decades of late 40's, 50's, 60's, and mid 70's suffered a silent marginalization with the onslaught of branded '*Health Care Malls*'. Presently in Kolkata, there are only two distinct health care providers:

- Public Hospitals.
- Corporate Hospital.

The intermediate categories representing the nursing homes have almost disappeared. The emergence of the shopping malls in Kolkata had displaced the small corner shops of locality and neighborhood areas, similar to these phenomena, the healthcare malls have also displaced the once popular small nursing homes of Kolkata.