CONCLUSION

"The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties…" So read Article 47 of the Indian Constitution, as a pronouncement of one of the Directive Principles of State Policy.

The newly emerged welfare state held itself duty bound to provide its citizens with adequate health services.

Promises of the welfare state were not kept. Thus more than sixty years after the Indian constitution was formally accepted, the Directive Principles of State Policy have largely remained empty promises.

But there is something that is of greater concern. The state had declared its duty toward its citizens. However, this duty and the promise thereof, in the minds of the nation's politicians and officialdom, was something that was a boon or bonus, not something which the citizen could claim as a right. It is to be noted in this regard that the Indian Constitution, while it pronounces public health as a state duty ***does not*** also categorically pronounce it a citizens' right. It was only decades after the Constitution was prepared that the Courts of India gradually argued that health was, for citizens of India, indeed a matter of justiciable right and viewing it as such was legitimate through a reading of Directive Principles combined with Article 21.[1]

However, notwithstanding legal and judicial recognition of the citizens' right to health, this right in actuality has no real recognition in the civic and political culture of India. No political battles have been fought on the issue of health care as a right. Thus along with food, nutrition, access to safe water and education, healthcare still remains one of those crucial sectors that in reality remains beyond the actual rights' horizon of the Indian citizen. Therefore, despite judicial pronouncements and occasional administrative declarations, the majority of Indian citizens remain disempowered creatures in almost all things that matter in life.

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[1] See in this connection Mathiharan, K. The fundamental right to health care, *Indian Journal of Medical Ethics*, Volume 11 Number 4 Oct-Dec 2003, http://www.issuesinmedicalethics.org/114hl123.html and the relevant sources cited therein.

So on the one hand promises have not been kept, and on the other, rights in actuality do not exist. It is in this vacuum that private healthcare has entered as an income generating and profit making sector. In the rural areas, the need for health care is addressed largely through practitioners of traditional knowledge, paramedics and quacks of varying competence. Formally, recognised physicians and healthcare services are available mainly in the urban areas where more people can afford such services. But one must bear in mind that formally recognised private health care, in the form of nursing homes and private hospitals, remains beyond the means of the bulk of India's population.

It is in this backdrop that the history of private health care in India has to be examined. But having accepted this basic backdrop one can get along with understanding the birth, development and subsequent transformation of private health care as a subject that deserves a separate study. The transformation of health care from a service to lucrative industry was indeed a long drawn process. The beginnings were made in the early decades after Independence, something which we have examined to some extent in this work.

The early form of private in-house health care was the nursing home that mushroomed in a newly independent metropolis and served the well to do sections of the society in the decades of 50's, 60's and 70's. We have discussed the features of such nursing homes and the nature of entrepreneurship that led to their emergence.

The once popular small nursing homes of Kolkata are largely being displaced by the big corporate 'five star hotel'-like hospitals (*Branded Health Care Malls*). As a result, the section of the populace, which once used the small nursing homes, now found the corporate hospitals as better places for treatment. Interestingly, urban lower middle class with little solvency and health consciousness tried their best to treat their dear ones in these small nursing homes rather than in the overcrowded public hospitals. With the breakdown of the public healthcare infrastructure in the rural areas, relatively affluent patients from these regions also utilised these nursing homes. But the nursing homes no longer enjoyed their previous glory. The present study has shown that with the rising malls in every parts of the city, the old fashioned, once

popular corner shops have also been marginalized. They have also suffered the same fate as the small nursing homes of Kolkata.

With the emergence of a corporatised private health care industry, one finds that the health care sector as a whole suffers from two kinds of ailments. The main deficiencies in public health care, in our case the West Bengal Health Services, are seen to be negligence, administrative indifference, staff shortage, lack of hospital beds and unfair nexus with the local nursing homes. Added to this are the medical accidents and indiscretions that are seen to abound in the public hospitals and health care centres. A somewhat different picture emerges in the private sector. Here the incidents of gross negligence are not absent. But what tends to dominate the scene in the private sector is *over emphasis on unnecessary investigation and medication, indiscriminate use of intensive care unit, exorbitant charges of bed and other facilities* and *inhumanly commercial attitude of the medical personnel* in the hospitals.

With the proliferation of private nursing homes and hospitals health care is transformed mere purchasable commodity, similar to any other expensive product of the market; and that too a product whose quality remains deeply suspect. In such a situation, the quality of the treatment that an individual gets remains a function of his or her luck, social resources and purchasing power. And commercialization tends to do away with whatever values of medical commitment that resided in the concept of a sacred physician-patient relationship.

Corporatised health care has, besides the usual diagnostic and therapeutic interventions, created a novel entity known as the ‘health package’. This amazing entity is based upon the recognition of each individual as a cluster of symptoms – describable as a set of numbers (ranging from say blood pressure to the value of C-reactive protein) or a set of curves of images (as in an EEG or MRI scan). For each such cluster of symptoms there exists a corresponding ‘health package’, consisting of certain preventive and therapeutic procedures. And if one wishes to enhance his/her quality of life then he/she better purchase this package. Armed with such packages and combining within a single campus a whole array of diagnostic and therapeutic facilities the corporate hospital stands forth as a veritable industry. And in order to

keep the industry running and spewing profit at desirable rates life of the patient, now a ‘consumer’, must be ‘medicalised’.

Finally, one important issue that is relevant to modern critiques of globalised and corporatised health care.

The critiques of globalised and corporatised health care are justified, or at least mostly so. But they tend to miss a crucial point. Issuing a big ‘NO’ to corporatisation of health services may be necessary, *but it is far from being sufficient*. One must remember that health care in India remained abysmally inadequate in all the decades prior to India’s jumping on to the liberalisation-privatisation-globalisation bandwagon. One must also remember that whether a few dozen more multispeciality hospitals are opened or not in metropolitan India remains of little concern to some 80 million who have to rush to the quack or paramedic or queue up outside the Primary Health Centre. Their problem is not the ‘medicalisation’ of life, but rather the absence of basic treatment. For them it is the question of winning the rights to these fundamentals.