

# Debating Public Health Glimpses of an Argumentative Assembly

A Report of the Chandrakant Patil Memorial  
Eastern India Regional Health Assembly

Kolkata  
9 July 2011

PRATICHI INSTITUTE  
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Debating Public Health : Glimpses of an Argumentative Assembly  
*A Report of the Chandrakanta Patil Memorial Eastern India Regional Health Assembly*

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**Glimpses of an Argumentative Assembly**  
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**Eastern India Regional Health Assembly**

The Chandrakant Patil Memorial Eastern India Regional Health Assembly, organised by Pratichi Institute, Liver Foundation - West Bengal, Asian Development Research Institute - Patna, and UNICEF - Kolkata, was held on 9 July 2011 and attended by 200 delegates. The assembly was presided over by Professors Amartya Sen and Sir Michael Marmot, who delivered the inaugural speeches and concluding remarks. The assembly brought together medical professionals, policy makers, academics, activists, journalists and civil society organisations mainly from Eastern India, but also from other parts of the country, to jointly discuss both socio-economic inequalities that affect the health of the people in India and influence the functioning (or non-functioning) of health care in the country, as well as ways to address them.

The idea of organising a health assembly was first put forward by Professor Amartya Sen, in conversation with Dr. Abhijit Chowdhury of the Liver Foundation - West Bengal, and members of the Pratichi Institute. Sen was inspired by the example of Thailand, where the National Health Assembly is organised annually under the aegis of their National Health Act of 2007, to develop 'participatory public policies on health'. As an invited speaker to one of these annual assemblies, Sen witnessed the enthusiastic participation of the people of Thailand in the meeting and their involvement in the deliberations therein. He felt a similar deliberative forum would be central to debating and distilling people's expectations of, and problems with, the prevalent systems of health in India.

The idea coalesced into the Chandrakant Patil Memorial Eastern India Regional Health Assembly, dedicated to the memory and ideals of Dr. Chandrakant Patil, who died at the age of 24, attempting to rescue victims of the 2009 Bihar floods. The Asian Development Research Institute (ADRI) - Patna, Liver Foundation - West Bengal, and UNICEF - Kolkata extended their support to

the Assembly. Several of Pratiche Institute's advisers also made substantial contributions.

The following is a brief summary of the themes and arguments around which discussions swirled at the meeting.

#### WHY PUBLIC DEBATES? AND WHY FOCUS ON HEALTH?

Pursuit of well-being and good health is far from a strictly private, individualised responsibility; it is quintessentially a public and political enterprise. Neither is health care a mere commodity available via market exchange. It is a public service. The need for public discussion on determinants of ill health and on actions for their amends is, therefore, paramount. There could be competing, even conflicting, views held by the members of a debating public regarding the idea of good health, or about ways in which to improve it, and also about the light health research and health policies shed on these vexed questions. It is also possible that all disagreements will not be ironed out. In short, discussion on issues of equity in health can never be over or sealed in an absolute sense; yet, comparatively speaking, it can enhance public understanding of both sources of inequities in health as well as of appropriate remedial measures. Thus, debates generate not only heat but also light vis-à-vis the direction of both policy action and larger public action, to improve the health of the people. How social choice with respect to health and health care can be directed towards enhancing social justice is, thus, a subject matter of intense and recurring public discussion.

In his inaugural address, Amartya Sen compellingly argued why in this gathering — we may pretend this to be the first health assembly in India, although it is intended to be the beginning of a trend — it is important to have a public discussion on health care. The tradition of public discussion is old in India, although that tradition has not always been translated into public discussion of health care. This is an important recognition. Of course, this is not to say that such discussions are never held. Indeed, the first systematic comparative account of medical practices and health care in China and India was done by Yi Jing in the seventh century, who studied at the ancient university of Nalanda. He explored what India could learn from China and what China could gain from India. He came up with an uneven score card in the sense that he thought in terms of pure medicine the Chinese were rather ahead of the Indians; on the other hand, and this may come as a surprise to us, in terms of public health care India was ahead of China at that time. There is indeed a lot to understand about how we can enhance our policies on health care by public discussion and comparison. Another distinguished scholar from China, Fa Hien, commented on the health care system in Pataliputra (now Patna) and presented a view of how the health care priorities were determined. There is nothing to indicate that he personally attended one of the health assemblies in Patna; but the fact that his commentary on health discusses people's engagement with health care, that one may surmise some such meetings were held, although there is no clear discussion on it. In recent times it is Thailand that has played a big part in having vibrant public debates on issues of health. It is generally believed that in Thailand democracy has not quite

The tradition of public discussion is old in India, although that tradition has not always been translated into public discussion of health care.

flourished. This admitted, we need to also acknowledge that Thailand has achieved quite a lot in bringing the voices of the people in discussions on health in their regularly-held public assemblies. In a similar vein, public discussion on health systems in India can contribute to our understanding of health inequities between different regions of the country as well as along other social axes, and more importantly of what, for example, Assam or West Bengal can learn from Kerala or Tamil Nadu in improving the health of the people of their regions.

#### THE IMPORTANCE OF HEALTH AND THE RELATIONSHIP BETWEEN HEALTH AND WEALTH

The importance of health is in need of some articulation here, as Professor Sen reminded the gathering. There are two points that one has to clearly distinguish: First, health is important primarily because it is central to our well-being, our lives, our freedoms, and to the kind of life we can lead and how long we can lead it. All of this depends very much on conditions of the health of people. Second, health does affect economic performance as well as social and political participation. These two points have to be emphasized; but one will have to distinguish this from the tendency to measure benefits of health in terms of what it does to economic growth and economic performance. It is not that economic performance is not deeply affected by health care. It is. But the approach that the WHO Report on Social Determinants of Health, chaired by Sir Michael Marmot, takes in contrast to the previous WHO report, chaired by Professor Jeffery Sachs, is that the former focuses more on what good economic performance could do for good health rather than highlighting what good health could do to economic performance. There is an issue of real importance here that pertains to our starting premise. Why is it that we are seeking health care? It is simply because good health is one of the most important things in life. It enables us to pursue other goals with greater freedom. Therefore, it is via ensuring good health for the populace that a growing economy can ensure continued productivity from it, as well as encourage it to pursue a richer, more articulate life, more educated life, more comfortable life, and for a life with greater degrees of freedom. GNP, as such, does not have an intrinsic value; we seek greater GNP as a means to an end. Thus, there is a complex relationship between economic growth and good health. It is not enough to say that public health automatically benefits from greater economic growth, because revenues increase with better economic performance. We must ask ourselves the next crucial question of how the additional resources are used. As Professor Marmot said, the point about economic growth is how it is used and how it is spread and the benefits we get from it. Furthermore, the growth-oriented approach not only focuses on the issue of the wealth of the nation but also on personal wealth and individual incomes. There is an implicit and associated emphasis on taking responsibilities for one's own health in contrast to improving the health of the whole population. But responsibility for the latter should not be left at the door of the individual alone; it needs to be undertaken by public institutions.

The point about economic growth is how it is used and how it is spread and the benefits we get from it.

### 'IS THERE SOMETHING TO DISCUSS'?

The purpose of the health assembly, Professor Sen reflected, is three-fold: information enhancement, demand articulation and dialogic argumentation on health.

First, there is an informational aspect; it is only through complaints and grumbles that we come to know about what is not being achieved in the health care sector. If we are talking to people in charge of a government department who are delivering health care, there is always a danger that the response we get is biased because of the fact that it is coming from deliverers and not from those who haven't benefited from the services offered. So, informational enrichment is certainly one of the primary goals of the health assembly. Second, there is a political goal of the demand that health assembly allows. Confrontation is central to politics, especially in the kind of democracy - multi-party combative democracy - that we have in India, demands for things to be done need to find a place and space for their consolidation and articulation. Debates about health inequities must find a place in this democratic climate along with other important discourses surrounding issues such as caste hierarchy, class divisions and so on. Also, the perspective of the poor and the perspective of the neglected versus the perspective of the non-neglected, the perspective of those who benefit from public health versus those who do not must have a close and even combative encounter at the health assembly. Thus, on one hand health assembly enhances information, on the other it makes demands more audible, irresistible and important. The third purpose of health assembly is the dialogic element. There are a lot of issues on which policies are not clear. For example, there are opposing views on whether training the low-skilled health practitioners who are the primary deliverers of health care in many parts of rural India — the so-called 'quacks' — is the right policy direction to follow in addressing inequalities in health. While some benefits may ensue from the services provided by not-so-trained people, there are some real dangers too. In China, for example, there is a shift in the way the role of barefoot doctors is being understood these days due to a number of cases of mishaps and mishandlings. In India the situation is much worse, since given the widespread lack of public health care services or their imperfect delivery, the untrained 'non-doctors' are the only ones who provide any kind of medical services. But classical economics tells us that health is notoriously difficult for the health care system to provide because of widely yawning 'asymmetry of information' between the doctor and the patient. When a doctor gives some treatment to an unlettered agricultural labourer in India and charges money for it, the patient may not have any idea of what kind of treatment he is getting, whether it is good or not. There are cases reported in the Pratiche Health Report in which people are getting saline injections as treatment for malaria, for which, though, medical science has not found any use as yet. Many of the so-called 'private doctors' provide monopoly services in rural areas; under such situations it may be difficult to protect people from a combination of 'crookery' and 'quackery'. There is a contrary view of course that it is perhaps over-ambitious to think that things will change much any time

Debates about health inequities must find a place in this democratic climate along with other important discourses surrounding issues such as caste hierarchy, class divisions and so on.

soon, and that providing more education to the low skilled health practitioners is, therefore, the right direction to follow. This is indeed a contentious issue and therefore an important subject to be discussed in the health assembly. Scepticisms, doubts, arguments and counter-arguments must find fuller expression in such meetings for a clearer understanding to emerge.

There are many other things to discuss and hence the health assembly could play a major part in health care in India. The assembly organised by the Pratiche Institute is a beginning in a small way that has to be extended to other parts of the country. Also, as Professor Sen reminded the audience, there should be greater room for public participation, especially room for volunteers to come and speak. In the 2010 National Health Assembly of Thailand in which Professor Sen delivered his key-note address, there were quite a few volunteer-participants who came and spoke; some were quite critical of the health care system. So there should be some ways for people to put in their names, come and speak at the assembly; that would add to the building up of a culture of health assembly. Of course, the pro-active and agency role of Thai citizens brings in the issue of the complementarity of education and health. What seems feasible in a country like Thailand with 100 per cent literacy may appear difficult in a country like India, where it is difficult for an unlettered agricultural labourer to write a letter requesting permission to attend a public meeting on health. But if we can increase intake of participation (and ensure that the participants are not already a 'converted' audience) and expand to other states, Professor Sen reflectively observed, the health assembly will become a major instrument for medical and health care changes in the country.

'HEALTH CARE IS MORE THAN MEDICAL CARE'

A BROAD VIEW OF HEALTH AND HEALTH CARE POLICIES

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The health assembly can serve as a forum for (re)-conceptualising the idea of health and health care. Dr Abhijit Chowdhury underlined that health care is more than medical care. Professor Sen pushed this line of thought further to suggest that policies for good health are more than health care policies. Health depends on many other aspects of social living, including impact of inequalities and unfreedoms.

*THE IDEA OF HEALTH, BROADLY CONCEIVED, IS A MATTER OF SOCIAL JUSTICE AND FAIRNESS.*

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Professor Michael Marmot, who headed the WHO Commission on Social Determinants of Health (2008), as well as the group that conducted a review of health and equity in England (report titled Fair Society, Healthy Lives, 2010), spoke eloquently on this issue. Drawing on insights of the reports on social determinants of health and of the English review, Professor Marmot presented before the audience a nuanced yet broad idea of health and health policies that a fair society ought to pursue. His simple, powerful and evidently political statement was that if we put fairness at the heart of all decision-making, health would improve and health inequalities would diminish. And at the least, what it

The health assembly can serve as a forum for (re)-conceptualising the idea of health and health care.

means to put fairness at the heart of all decision-making is to combat health inequalities that are judged to be avoidable by reasonable means; not doing so is unfair.

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*SOCIAL DETERMINANTS OF HEALTH AND THE GRADIENT EFFECTS*

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We need to move beyond a strictly biomedical understanding of health and focus instead on a socio-political understanding of health, on ‘social, cultural and political dimensions’ of health and health care. The basic idea is that social and economic position and social processes shape individuals’ risks of ill health. More specifically, the social underdogs suffer more than others in terms of health. There are higher rates and risks of diseases among persons who have meagre educational, material and other social resources. Therefore, socio-economic inequalities need to be a subject matter of health policy and health research. There is indeed a body of knowledge now available on the key importance of social causes in affecting a broad range of health outcomes through multiple pathways. This consequently requires broad-based interventions.

Thus, discussion on health will remain quite limited unless we consciously and carefully examine the linkage between health and social arrangements, and explore impacts of social and economic inequalities on health. As Professor Marmot observed, public health is the measure of how well we are doing as a society; in short, the health of the people indicates the moral shape of a society. If the purpose of our social and economic arrangements is to deliver well-being for the population, a very good measure of how well we are doing is health and the distribution in health – inequalities in health. Importantly, a key part of Professor Marmot’s research and a key part of the report of the WHO Commission is the insight that what concerns us is not only the poor health of the poorest in society but the social gradient. Let us look at some figures on life expectancy of men in several countries: in Sierra Leone life expectancy for men is 38 years, in India it is 62, and in Iceland 80. For women, life expectancy in Zimbabwe is 42, in Japan it is 86. There is no good biological reason, Professor Marmot informed the gathering, why there should be a 44 year spread in life expectancy across the world; rather this is because of our social and economic arrangements. In Porto Alegre in Brazil, cardio-vascular mortality rates vary by socio-economic levels of different areas and districts: The lower the socio-economic level, the higher the cardio-vascular mortality. In the city of London, in Tottenham Green life expectancy is 71, in Kensington and Chelsea it is 88. For a common man in the poorest part of Glasgow life expectancy is 54, in the richest part it is 82- a 28-year difference in life expectancy in one Scottish City! Life expectancy for men in the poorest part of Glasgow is 8 years shorter than the Indian average. In India, depending on which figures we look at, somewhere around 60 to 75 per cent of the population live on \$2 a day or less. No one in Glasgow lives on \$2 a day or less. In Glasgow, the water is clean and safe to drink, everyone has shelter, there are no shanty towns. They don’t die of malaria. They die of heart disease and cancer and violent deaths and other alcohol related deaths. They die, in other words, of the same things others die of in the rest of

The social underdogs suffer more than others in terms of health. There are higher rates and risks of diseases among persons who have meagre educational, material and other social resources.

the United Kingdom but much sooner and so dramatic is the impact of the social determinants of health that life expectancy in the poorest part of Glasgow is 8 years shorter than the Indian average. These gross iniquities in health involve all social groups and are present in all countries – from low income, to middle income to high income.

In India there is the problem of communicable and non-communicable disease at the same time. Roughly speaking, there will be more diabetics in India by 2030 than there are people in England. And that diabetes epidemic will follow on from an obesity epidemic and will in turn bring the epidemic of cardio-vascular diseases. So in India there is this enormous and growing problem of non-communicable diseases alongside the great burden of communicable diseases that continues. Yet, Professor Marmot compellingly argued that there is no reason to be pessimistic. Things can change really, really, quickly. As the trends in life expectancy at birth for different countries show, India has improved dramatically, from under 40 to 62-63. In fact in India life expectancy improved by 13 years in only 30 years; that is to say, 3 years every 3 years. That is about 11 hours every 24 hours. That is absolutely dramatic in a country where there is probably more poor people than in any other country, life expectancy improved by 13 years in only 30 years. What all this tells us is that things can change really quickly. Again, Sri Lanka, for example, has always done better in terms of the health of its people. It is important to look at the similarities between Sri Lanka and Kerala, and to ask what we can learn, to examine if there are in fact common explanations for Kerala's good health and Sri Lanka's good health. Or let us take the case of a country like Costa Rica that has always had good health. Life expectancy of Costa Rica is now equivalent to that of the United States. Professor Marmot recounted that when he was in Costa Rica last year at the request of the pan-American Health Organization and enquired about the key to their health achievement the first thing they said was that in 1948 they had abolished the military. This was a health discussion and they said they had abolished the military! They thought that it would be better to invest in education, social protection, clean water, the advancement of women and health care. Professor Marmot, of course, reminded the assembly that whether that is the exact cause of their remarkable good health is hard to tell. But it is an interesting hypothesis. Again, if we look at trends in under-5 mortality we can see dramatic improvements in some parts of the globe, including India. In Professor Marmot's perceptive words, this is both an encouragement and a challenge. The encouragement is that things can change really quickly. The challenge is to find out why improvement in India has not got to the levels of Sri Lanka or other countries. So the challenge is, let's do better.

There are inequalities not only between countries but also within countries, say, in infant mortality rates. As Dr. David McLoughlin pointed out, within India, Kerala's life expectancy at birth is about 10 years more than that of Assam. If we look at the eastern states of the same country, the IMR varies greatly from 16 in Manipur to 31 in Tripura and 33 in West Bengal, while the figure stands at a staggering 52 in Bihar and 59 in Meghalaya. Entangled with these inequalities are inequities and exclusions based on intersecting social categories such as class,

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caste, education and gender that that can affect the overall health status of a person or a community. As Professor Marmot informed the audience, if we consider the case of women with secondary or higher education and women with no education in different countries we can see wide variations in the health status of their children within the same national boundaries – children of women with secondary or higher education, for example, have lower infant mortality. So we see dramatic differences between countries and huge inequities within countries. Clearly, it is possible to overcome much of the disadvantage that comes with poverty and destitution by education. And it is not health education. It is education and education of women particularly. This is what a broader view of health entails.

A more expansive view of health also brings in the issue of what Professor Marmot has pithily called ‘the gradient effect’. Simply put, we mustn’t think that inequalities in health are confined to poor health for the poor. In Other words, not only is it that the people at the lowest rung of the social hierarchy have poor health, a relationship between health and socio-economic position is observed across the entire socio-economic scale/hierarchy. In his justly celebrated Whitehall study Professor Marmot has demonstrated how unequal the distribution of basic health achievements is across population groups classified in income quintiles spanning the entire social spectrum. It suggests that if we take into account the gradient we can’t focus only on the poorest of the poor. We have got to improve the whole of the society. And the implications are profoundly different, said Professor Marmot. As long as we think poverty is the sole problem, then our policy should be directed towards poverty. But if it is the social gradient, that means we’ve got to do something about the whole of the society.

Professor Marmot drew the attention of the assembly to the effects of gradient, with the help of some revealing figures from his English review. A cross-classification of people at different levels of the income hierarchy by their life expectancy shows that people near the top have shorter life expectancy than those at the top. People in the middle have shorter life expectancy than people near the top. People further away from the top shorter than the middle. If we compare the 5<sup>th</sup> centile- the most deprived, with the 95<sup>th</sup> centile of the least deprived, there’s a 7-year gap in life expectancy. In Glasgow and other areas, there are bigger differences. Again, if we look at disability-free life expectancy, the gradient is steeper. The gap between the 5<sup>th</sup> and the 95<sup>th</sup> centile is now not 7 years but 17 years and that means that people at the top are living about 12 years of their lives with disability and people at the bottom with shorter lives are living about 20 years of their lives with disability. In India too, the gradient effects on health are palpable. So the health requirements of the people suffering from most acute social and income deprivation — that is to say, the have-nots — must receive society’s urgent attention, but at once we need to address health needs of have-littles too.

One issue related to effects of social arrangements on health that Professor Marmot highlighted at the assembly pertains to environmental damages. Climate change adds urgency to take action on social determinants of Health. By 2030, the world’s population will rise from 6 billion to 8 billion, the demand for food

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will increase by 50 per cent, the demand for water will rise by 30 per cent, the demand for energy will increase by 50 per cent. We said in the report of the Global Commission. It is, therefore, very important to put actions on the social determinants of health in the context of climate change and the action that is immediate in terms of climate; we need to think on different models of economic and social development. And we need to think about equity between countries in a different way.

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*'EVERY MINISTER IS A HEALTH MINISTER'*

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A broader concept of health has to incorporate within its fold an idea of autonomy and agency, however we express it. Material conditions are important; so are psycho-social (having control over your life) and the concept of freedoms and unfreedoms (having a political voice). An expansive view of health, therefore, will focus on the conditions in which 'people are born, grow, live, work and age', as well as the 'structural drivers' of those conditions. Corresponding to this broad view of health, recommendations for action will also have to go beyond health care. Of course, universal health care with social protection is an important step; but so are policies of fair employment, healthy housing, early child development, and education. In short fairness in all policies is what is essential. All policies are in a sense are health policies. As Professor Marmot recalled, in a meeting in Norway last year the minister of foreign affairs in Norway said, 'I am a health minister.' Every minister, he said, is a health minister. 'What we do in our daily job impacts on health and I would say every sector is a health sector'. This finds resonance with what Dr. Sunil Kaul said about his place of work in Assam: use of health care services depends upon many things, including transport facilities, electricity and so on. In his area, 75 per cent of the villages continue to remain un-electrified; so the best of health sub-centres cannot help, best of refrigerators cannot work there. Moreover, social and communal relations tend to compound the challenges further, he said. The Bengali Muslims and the Adivasis in Assam — the migrant workers that have come to work at the tea gardens in the area — have some of the worst indicators of health. On the positive side of the register, Dr. Punyabrata Gun recounted his experience at the Chattishgarh Shaheed Hospital in the 1980s. Noticeable improvements in the health of the workers occurred, and these results were directly related to the improvement in the living conditions of the workers, better wages, better houses, facilities of waste disposal, latrines and drinking water, education of the children, adult education, empowerment of the women and so on. In sum, education, social protection, housing, basic infrastructural facilities, community development all are important for health and the fair distribution of health. To use a common example, from a social determinants approach, the prevention of ill health will take smoking and diet as important causes of poor health. But it will probe deeper and look at why people smoke and eat the way they do, and delve deeper into what Professor Marmot described as 'the causes of the causes'.

In sum, education, social protection, housing, basic infrastructural facilities, community development all are important for health and the fair distribution of health.

## 'FAIR FINANCING'

Fair financing is an important aspect of fair policies in health, as several of the panel speakers pointed out at the assembly. Stated simply, fair financing has its focus on public health as opposed to highly 'technological medicine'.

The idea of fair policies to improve health and fair financing follows from the broad view of health itself, which includes concerns about health inequalities that are avoidable through 'reasonable action'. To improve health given such entrenched inequalities, do we need to necessarily make an economic case — a case for cost-effectiveness, asked Professor Marmot. Or do we need to address larger ethical concerns, concerns of justice? He powerfully presented his counter-argument and appealed to the moral sensibility of the audience, with the help of a strikingly jarring thought experiment. Referring to one of the disturbing findings of his English review, which shows that the people at the top are living about 12 years of their lives with disability and people at the bottom with shorter lives are living about 20 years of their lives with disability, he wondered whether we can give free cigarettes to the poor. Is it not cheap and cost-effective? Would it not reduce the amount of time they spend with disability? Then why is this approach not adopted? Because, said Professor Marmot, it is a morally corrupt idea. We do not do things just because they are cost effective. We do the right thing. And we have to go through the thought experiment like that, to realize that we do run a moral filter over our policies. We are engaged in an intensely ethical concern. This is not simply about economic performance. The reason for taking action on avoidable health inequalities is a matter of social justice.

The WHO report on social determinants of health makes a plea for 'closing the gap' - a 44-year difference in life expectancy across countries, a 28-year gap within one Scottish city - 'in a generation'. It is a *political* statement, Professor Marmot claimed, that we have the knowledge to close the gap in a generation. It is a statement that we have the means to close the gap in a generation. The question is, do we have the will? It is not a prediction that we will close the gap in a generation. But it is a statement that if we apply the knowledge we have we can make a huge difference and great progress towards closing the gap in a generation. Closing the gap via fair policies involves among other things framing of fair financial policies.

Dr. A K Shiva Kumar carefully laid bare, before the audience, various aspects of health care financing and addressed the issue of fairness or its lack. Alluding to the discussions on the 12<sup>th</sup> plan formulations that are going on now, he observed that the health assembly can serve as an important forum to influence thinking on the 12<sup>th</sup> plan processes. It is well to recognize that the government is willing to pay greater attention to health; there have been repeated affirmations and statements that they will increase spending on health and that they are looking for interesting suggestions. So he hoped that the inputs from this assembly will feed into the thinking that is going on in terms of new policy. Under the broad rubric of equity in health Dr. Shiva Kumar focused on India's health financing system, which is a cause of, and an aggravating factor in, the challenges of

We are engaged in an intensely ethical concern. This is not simply about economic performance. The reason for taking action on avoidable health inequalities is a matter of social justice.

health inequity and impoverishment. Analysis of the pattern of health financing is really important to understand the inadequate availability, poor reach, unavailable access, poor quality and costly health services in this country. It is common knowledge worth repeating that the government spending by India both as a percentage of GDP and in per capita terms, is extremely low. The figure that is now quoted by the government is that the public health spending on India is 1.2 per cent or 1.3 per cent of GDP. The corresponding figure for China, Sri Lanka and Thailand is well over 2 per cent. If we look at the purchasing power parity dollars, government of India spends \$19 on health, it is 122 in China and 207 in Thailand. So if we are really talking in terms of achieving the health conditions and the health systems that China and Thailand have been able to establish, we must be conscious of the fact that India spends a tenth today. The public spending is a tenth in terms of what Thailand or China does.

A consequence of this low level of government spending is the high burden of private out-of-pocket expenditures — again a feature that is highlighted not only in the case of India, but as a whole in the eastern region in the Pratichi Trust Report. For India as a whole, 78 per cent of health expenditure is treated as private out-of-pocket, in Thailand it is 36 per cent. So when we are really talking about the impoverishing effect of health spending in India, we need to take note of the fact that a large proportion — almost 78-80 per cent — is borne by private citizens, reflective of the poor reach of health services. It is also to be noted that 72 per cent of these private out-of-pocket expenditures is on medicine and this again brings the question of pricing policy and the use of generic drugs and also highlights the fact that a lot of the medicines prescribed by the doctors today may not be required. There's a lot of irrational prescriptions and so on which needs to be addressed. And in the context of health care, two other features which we all know need our scrutiny: there is very little financial protection, in 2005 and 2006, less than 10 per cent of the families had even one person in the family who had some kind of health insurance. There are lots of problems with the private medical insurance schemes; but there is a push for private medical insurance which is quite discomfoting. The Government of India has and the state governments have introduced a number of health schemes, insurance scheme which need to be evaluated too.

When we look at health spending, another serious issue, Dr. Shiva Kumar stressed, is the large inter-state differentials in public health spending : The government of Bihar and the government of UP probably spend a third of what Tamil Nadu and Kerala spend. So if we are really talking about increasing the availability of primary and secondary care to all citizens of Bihar and UP, then how does one do this quickly? The Planning Commission has appointed a high level expert group on universal health care. Dr. Shiva Kumar gave the participants a sense of what the members of this group are thinking in terms of the solution to the financing problem. It is useful to bear in mind the context in which the members are discussing this issue. It is a very difficult context. Despite the recent growth record, we should not forget that India is a very poor country. The latest consumer expenditure survey by the NSSO says that in rural India more than 70 per cent of the country's population spends less than Rs. 45 a day

Analysis of the pattern of health financing is really important to understand the inadequate availability, poor reach, unavailable access, poor quality and costly health services in this country.

and 45 rupees is even less than a dollar a day at this point of time. And if you look at urban India, close to 50 per cent of the urban population spends less than Rs 50 a day. That is again roughly a dollar a day. We should not forget that we are really a very poor country and that we should not get carried away by the impression of growth, or by the high-end hospitals coming up; the priority really has to be in terms of primary community health care. The second discomfoting fact is that economists and policy-makers seem to be strongly but wrongly attracted by the idea that private health care if properly subsidized or private health insurance subsidized by the state can meet the challenge. However there are good reasons why this is unlikely to happen, It is mainly because of the information asymmetry that the patient can easily be fooled by the profit-seeking providers on what exactly is being provided. So efforts need to be made to stop this move towards privatization and to really think in terms of a strong publicly-provided primary health care system.

One of the key recommendations that the experts are considering, Dr. Shiva Kumar informed the gathering, relates to the idea of a National Health Entitlement Card, which will be funded by the Central government, which will ensure every Indian citizen a package of primary, secondary and tertiary health care services. It will cover both in-patient and out-patient care. The package will be set by a group of experts recognizing the financial constraints that we have. State Governments can top up this, because now what has happened in every state government including Tamil Nadu, Rajasthan, Andhra Pradesh is that they are just going on announcing health insurance schemes without taking note of the financial implications.

In terms of financing, there are four critical recommendations.

The first critical question is where the money will come from, because the government has committed to increase the funding from 1 per cent to 2.5 per cent and by the end of the 12<sup>th</sup> plan into 3 per cent. A very strong case is being made that we must rely almost exclusively on taxation as the main source of financing; experimentation with user fees is not the way to go on at all. One simple fact is that charging user fees in India and elsewhere has been very inadequate to raise any revenues. It discourages the poor from accessing health facilities and it is really not the way to go. It is also proposed that in terms of the public resources that are mobilized, at least 60 per cent must be earmarked for primary health care. Given how poor the country is and what the pressing and urgent needs of health care are, the priority must continue to be primary health care. We cannot get distracted by the push of the insurance companies and the demands for the tertiary care sector that more and more resources go there. So at least 60 per cent should be earmarked for primary health care in the country. Again, a crucial issue that has to be addressed is how a state like UP or Bihar catches up with the national average in 5 or 10 years with such little government spending.

We cannot get distracted by the push of the insurance companies and the demands for the tertiary care sector that more and more resources go there.

A very different mechanism for financial transfers that the expert group is recommending is that we must find some kind of special purpose transfers to help the low-spending states to catch up with the national average very quickly. In other words, out of the central pool of resources mobilized by the taxation

system, these states will definitely get, on a per capita basis, much more money than say Kerala or Madhya Pradesh will. And efforts are under way to work out some kinds of formulas by which this should be possible. And lastly is the question of the centre-state relations. We should not forget that implementation of state programmes is the responsibility of the state. So there has to be greater flexibility. The Central Government should not sit in New Delhi and say, this is the norm for every corner, in every district, in every block in the country. There have to be much more flexible forms of financing so that the state governments take greater responsibility, and greater ownership of the implementation of programmes, organised in their own way.

The question of financing has a close linkage with the issue of providing health care at an affordable cost. Dr. Punyabrata Gun shared with the audience his experience at Shramik Krishak Maitree Swasthya Kendra in providing modern medical care at a very low cost. They focus more on clinical examinations, use investigations judiciously, and stick to a list of rational and essential drugs, and use generics and low cost brands.

### REVAMPING THE HEALTH SYSTEM: UNIVERSAL ACCESS, UNIVERSAL COVERAGE, AND UNIVERSAL RIGHT

Dr. K Srinath Reddy shared with the audience valuable details of how the recently constituted expert group on health is looking at the task of re-vamping the country's health system and of defining universal health coverage broadly to ensure equitable access to the Indian citizens resident in any part of the country regardless of income level, social status, gender, caste or religion to affordable, accountable and appropriate quality health services which could be promotional, preventive, curative and rehabilitative services, delivered to individuals and populations, as well as services addressing the wider determinants of health. This is not meant to be merely aspirational 'wish list', it has to become operational. For it to become operational we have to deal with several of the key components of the health system. If we are looking at universal health coverage and the health system's contribution to that we have to look at issues like health financing, the health work force which is available to deliver the services, health infrastructure, which is adequately distributed across the country and well resourced enough to provide the requisite range of services, with the desired level of quality. We also need to look at the availability of drugs and vaccines, both in terms of affordability as well as quality.

Dr. Reddy expressed his concern about the fact that we have had a great neglect of primary health care, despite the fact that there has been repeated emphasis in policy documents on according primacy to primary health care. So we do require the emphasis to be brought back upon a well resourced primary health care. Clearly primary health care has to begin at the village level or what should be an urban sub-centre level which is its equivalent. We ought to be able to build up a cadre of frontline health workers into a much more competent and well supported health work force. In this connection, the role of the Accredited Social Health Activist (ASHA) and the multiple responsibilities she

We have had a great neglect of primary health care, despite the fact that there has been repeated emphasis in policy documents on according primacy to primary health care.

usually shoulders became a subject of debate at the assembly. The 'Asha' has been brought forth as a frontline health worker or volunteer or whatever the convenient terminology has been; the expectation that she perform a very large number of functions, some incentivised and several not incentivised, has been growing, and almost every programme wants to have the 'Asha' perform several of the key components of their programmes. Ultimately the 'Asha' becomes the Goddess of all hopes, but in reality the beast of many burdens. And she is not even paid till recently. Dr. Reddy argued that just as a second Angwanwari worker is required, a second ASHA would be required as well, and would have to be well supported also in terms of her financial position. But at the same time she has to be supported with adequate training, and adequate connectivity to the health system, so that she is able to perform her functions well. In the well considered view of the expert group, we do require the positioning of a mid level health worker in the form of a primary health practitioner or a primary health care provider. There are real controversies swirling around the recent proposal to create a bachelor in rural health practice; it has faced a lot of resistance from medical health care community on the ground of why rural people should have 'second rate' doctors. An opposing view, to which Dr. Reddy subscribed, is that there is a need of mid-level health workers both in terms of well trained nurses as well as other categories which are equivalent to community health practitioners or physician assistants; this would be required even in the urban areas if we create a primary health care structure in the urban areas. The effort to have a bachelor in primary health care, therefore, should not be out of the reckoning.

At the district level, one of the areas which has been grossly neglected is the district hospital; most of the referral burden because of inadequate primary and secondary care services is transferred at the level of district hospital which does not at the moment have the capacity to cope. So it is strongly recommended that district hospitals are strengthened and that every district with 25,00,000 population or above must have a medical college associated with the district hospital, nursing colleges too must be associated with the district hospitals, training of medical students and nursing students must substantially be carried out at the district hospital level, with some upward linkages with the medical college and tertiary care; but a fair amount of it has to be at the district hospital. Unfortunately there is a huge mal-distribution of these training institutions. We have in 8 states, which have 46% of the Indian population, 27% of the medical colleges and 20% of the nursing colleges. So, we have a total mismatch across the country. So it is being argued that all new colleges must only be located in underserved districts. And the district hospital should become the training hub. Dr. Kaninika Mitra raised the issue of providing incentives for health care providers working in far-off places and Dr. Reddy concurred that some kinds of incentives and disincentives are required in the system. In Brazil, for example, doctors posted in primary health care centres in remote areas earn three times more than doctors posted in the city, and earns more than a professor in a medical college.

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 PROFESSIONALISE, BUT CONTEXTUALISE: TRAINING, CURRICULUM, AND PEDAGOGY
 

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The issue of professionalisation of health workers was approached from two different angles at the assembly. On the one hand, there is a felt need to make the professional medical cadre - the doctors, the specialists- more attuned to ground level realities of our country. Doctors need to become more aware of the social and economic context within which they are providing their professional service to say 'ordinary' people of this country. So one simple message that can work is 'contextualise'. On the other hand, in the context of low-skilled field level health practitioners, the demand that has come up is 'professionalise'.

Dr. K S Jacob focused on two aspects of rethinking health system — one related to training and the other to practice. He felt that the current orientation of medical and health training is tertiary care oriented, set in medical colleges, this should be shifted to primary and secondary care, so that the focus is on common disorders. Right now in the tertiary care in medical schools, the focus is on rare conditions, these medical schools are referral institutions which deal with complex, chronic disorders, and the training is based on these complex and chronic conditions. So when the graduates are asked to work in primary care they find it difficult to handle the conditions seen in primary and secondary care. It is also true that the basis of training is knowledge based training; essentially the students are asked to memorise a whole lot of information, and the skill and competencies are very restricted. In fact it is common that medical graduates are not able to conduct deliveries through simple surgical procedures. So there has to be a shift from a knowledge based training to skill and competency based approaches. The current system of practice is specialist oriented, the training is divided according to speciality; but the training should actually change to a family and general practice orientation. Without these India will not be able to look after the health care need of the common people.

One of the very serious lacunae in medical education is the complete absence of critical thinking. Received wisdom is passed on from teacher to student and this is supposed to be accepted without questioning. Rote memorisation is encouraged and there is no place for critical thinking. In order to solve India's health problems the physician and the nurses should be able to think critically to see how the complex theory taught may not be quite relevant to their practice and change accordingly.

Coming to the issue of practice, the current practice is deemed to be universal; we have authentic and original theory, but less of informing theory by practice. The context in which we practice is trivialised. It is dismissed as inconsequential. Actually a physician or a nurse should re-read the theory, look at the context and see whether such theory is appropriate, they will have to relate to the patient's concerns, the patient's contexts, look at the various contradictions and conflicts they face and be able to raise these issues in order to change theory. Without this contextualisation of medicine, Dr. Jacob powerfully argued, we would continue with inappropriate and irrelevant medical care. In practice the government programmes have been mostly vertical, basically reflecting the speciality oriented medicines of our time, we need more horizontal integration. Most funding

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agencies are uncomfortable with horizontal programmes and they believe that it is easier to work in vertical programmes. But without good horizontal programmes it would not be possible to provide good services in primary and secondary care.

The issue of training low-skilled health practitioners — even the so-called ‘quacks’ — has come up in the discussions on a number of occasions. This is surely a contentious issue and ideal subject for public debate. Both Dr. Abhijit Chowdhury and Dr. Punyabrata Gun argued that if we give proper training to ‘quack’ doctors and professionalize them, they can provide primary health care to a large group of people. De-centering health care has also come up as a proposal quite a few times at the assembly. The moot idea is to make the district as the training, teaching and care-giving hub

### STATE, MARKET AND DRUGS

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Several speakers at the assembly raised the crucial issue of drug pricing, profit-maximizing activities of the private health care industry, especially the pharmaceutical industry and bio-technology industry, and the regulatory tasks that the state should perform to control drug prices.

Dr. Reddy pointed out that even branded drugs have huge price mark up ranging between 100% to 5300%, and much of it because of middlemen. A related issue is the declining role of public suppliers. A third of the drugs prescribed in hospital used to be supplied free in the 1980s; it came down to 9 per cent in 2004. And correspondingly the outpatient supply of drugs came down from 18 per cent in the 1980s to 5 per cent in 2004. So we do require to ensure that there is an essential drug list, that all the drugs in the essential drug list are supplied free of cost, across the board, especially in primary health care, but even at the other levels of care, and that we also implement a price control mechanism so that we can actually curtail the cost of drugs.

Entwined with all these remarks are the larger issues of capitalist market operations and their effects on health and more importantly of the influence of capitalism on public policy. Stated differently, the role of the state in either (health) market-tempering or market-promoting activities has a major bearing on the health of the people. Some argue that state support for marketisation of health care is evident in many public policies.

### MEDIA AND HEALTH

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...most of the media reports on health are essentially reports on incidents that happen in city hospitals, and these incidents are related to some unacceptable deaths in the hospitals.

Mr Anirban Chattopadhyay spoke on how the media look at health problems, on the role of the media and its general tendency to focus on loud health emergencies to the relative neglect of silent scourges of poor health. He forcefully argued that most of the media reports on health are essentially reports on incidents that happen in city hospitals, and these incidents are related to some unacceptable deaths in the hospitals. The media usually focuses on political repercussions, the citizens’ responses, the responses of the patients and their families – that sort of stories. These, of course, have some merits. But sadly, the media dwell on these

reports only, there is hardly anything else. The media are always concerned with incidents that in some sense stir up public feelings, and feelings amongst our political leaders. The media, barring a few exceptions, do not usually concern themselves with the deeper issues, the social determinants of health problems. The problem is how we make the media sensitive to deeper issues, how we bring such deeper issues under the media focus, how we make it more interesting to the people, to the readers, and how we change the whole game. Because unless we do that, unless we can bring the right kind of media focus on the right kind of issues, the contribution that our media could make to the public discourse on the right kind of health issues, is going to be very limited, as it has been limited.

The answer, if there is any, has to be sought, Mr. Chattopadhyay claimed, at the larger social and political site. What we need is nothing short of a social and political movement — not one movement, but many movements possibly. Unfortunately, he remarked, in West Bengal as in many parts of India, the society and the political dispensations that we work with are quite unfortunately extremely tolerant of huge inequities and huge injustice. Particularly in the area of health, even when the new chief minister looks at health issues a bit more seriously than the previous people, even then she goes to visit city hospitals and media focuses on this, on stories of what is being done in the hospitals, what is going to improve, what is not and all that and till now the attention has not gone deeper or wider to rural health centers. This is painful to any citizen who has any intention to see any improvement in the health scenario. Unless the society and politics rid itself of its huge tolerance, unless we can gather some amount of ‘constructive impatience’, there is a slim chance, that the media will be focusing on issues of the right kind. Of course, media is a part of society and politics. But the reality is that the impetus for deepening and widening the health issues has to come from outside the media. The media has to be given the challenge to rise to the occasion, to respond to right kinds of health concerns.

### HEALTH AND POLITICS OF JUSTICE: IS STATE PART OF THE PROBLEM?

Health is a deeply political issue. Broadly conceived, it is a matter of ensuring that individuals and communities have greater control over their lives. And enhancing people’s control over their lives is quintessentially a political and collective enterprise. And in the end we come back to the proverbial political will.

In the report of the Commission on the Social determinants of Health, it is suggested that it would cost 100 billion dollars to upgrade the world slums. So far, it has been difficult to find these 100 billion dollars. But we found 9 trillion dollars to bail out America’s banks. For 1/90<sup>th</sup> of the money that we found to bail out the banks, every urban dweller could have clean running water. As Professor Marmot put it: Do we have the knowledge? We have the knowledge. Do you have the means? We have the means. But do we have the will?

This brings us back to raise a few questions about the role of the state in this debate on health and justice. The view that takes policy action and larger public

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action as a potential avenue for social justice intervention in matters of health is surely mindful of situations in which policies fail, due to the inertia, indifference and even less than benign intentions of public authorities. This also takes cognizance of the harmful effects of structural forces, including market forces that influence policies in the direction away from interests of the masses. This acknowledged, such a perspective takes state and its policies to be one potential source of action, though the role of larger public action is crucial to create the 'democratic compulsion' for the state to act. Also, it takes the state not as a monolithic entity, rather as a heterogeneous body with competing even contradictory pulls and pressures and hence not as an unqualified 'bad'.

There is an opposite view that considers the state to be a part of the problem; in particular the statist project on health is put under a shadow of scepticism. In this view, the concern is not just about state indifference, but its design and intention that may exacerbate health inequalities. Both Mr. Achyut Das and Dr. Binayak Sen expressed concerns about structural violence perpetrated by various state agencies against its own people, especially marginalized people, leading to their displacement and destitution, especially in tribal regions. The state, Dr. Binayak Sen reminded the assembly, is not necessarily a benign social planner.

These are serious concerns that demand serious public scrutiny. And the health assembly is one among several such public forums in which such contentious issues need to be squarely addressed. Is there a room for optimism then? Without a dose of cautious optimism, there hardly remains any scope for political action, policy action, or public action. We, therefore, echo the sentiment of Professor Marmot when he says, "I'm an optimist. I have been going around the world saying I am an evidence-based optimist. I look at the evidence, it makes me more optimistic, not less because things never work as well as you would like. But the fact that they exist and they are working to some extent, is an encouragement as well as a challenge".

We, of course, have to recognize political forces beyond the state, and generate the necessary 'political push' for the state to act in the best interests of its people, and to that end, improve the state of their health and well-being.

The statist project on health is put under a shadow of scepticism. ... the concern is not just about state indifference, but its design and intention that may exacerbate health inequalities. ... The state, Dr. Binayak Sen reminded the assembly, is not necessarily a benign social planner.

“Chandrakant Patil Memorial Eastern India Regional Health Assembly”

Organised by: Pratichi Institute,  
in association with  
UNICEF, Kolkata, Liver Foundation, West Bengal and Asian Development Research Institute, Patna

PROGRAMME

10 AM	Welcome Address by: Kumar Rana, Project Director, Pratichi Institute David Mcloughlin, Deputy Representative, UNICEF India P.P. Ghosh, Director, Asian Development Research Institute (ADRI)
10:20 AM	<b><i>Session I: Introducing the Theme of the Assembly</i></b>
Chair:	Abhijit Chowdhury
	Brief introduction of the late Dr. Chandrakant Patil
10:25 AM	Inaugural Address by Amartya Sen
10:50 AM	Address by Michael Marmot
11:30 AM	Presentation by Manabi Majumdar, Pratichi Institute
11:40 AM	<b><i>Session II: Panel Discussion I - Equity in Health</i></b>
Co-Chair:	Achin Chakraborty and David Mcloughlin
Panelists:	A.K Shivakumar P.P Ghosh A.K Roy Achyut Das Sunil Kaul Anirban Chattopadhyay
12:50 PM	Open Discussion
1 :30 - 2:15 PM	<i>Lunch</i>
2:30 PM	<b><i>Session III: Panel Discussion II -Rethinking Health Systems</i></b>
Chair:	Poonam Muttreja
Panelists:	Sreenath Reddy K.S. Jacob A.K Sarkar Dilip Mahalanabish Sanjay Sharma Punyabrata Goon
3:40PM	Open Discussion
4:30 PM	Felicitation of late Dr. Chandrakant Patil’s parents
4:40 PM-5:30PM	Concluding Remarks by Amartya Sen and Michael Marmot



## LIST OF PARTICIPANTS

Sl. No.	Name	City/State/ Country	Sl. No.	Name	City/State/ Country
1	Dr. Chandan K. Sen, LFWB	Kolkata	42	Ram Sahay Mukherjee	Burdwan
2	Nirmal Chandra	Kolkata	43	Nirmal Kumar Ghosh	WB
3	Jolly Chandra	Kolkata	44	Tomoko Nishino	Japan Consulate, Kolkata
4	Priyanka Gupta	Kolkata	45	Yumi Muto	Japan Consulate, Kolkata
5	Deboshruti Roychowdhury	Kolkata	46	Mechbahar Saikh	Kolkata
6	K.S Jacob, CMC Vellore	Vellore	47	Sudeshna Moitra	Kolkata
7	Asokendu Sengupta	Kolkata	48	Suvashis Maitra	Kolkata
8	Prantosh Bandopadhyay	North 24 Pgs	49	Society for Ethics and Excellence	Kolkata
9	Krishna Mukherjee	Kolkata	50	CINI	Ranchi
10	Dr. Abhijit Nandi	Kolkata	51	Dr. Rabindra Nath Roy,	Kolkata
11	Sugata Bose	Kolkata	52	Lakshmi S	Kolkata
12	Dr. Rupak Ghosh	Birbhum	53	N.N.P.S & Matrisadan	Kolkata
13	Bimal Mukhopadhyay	Kolkata	54	Arijita Dutta	Kolkata
14	Dr. Somajita Chakraborty	Kolkata	55	Chandi Charan Dey,	Narendrapur, Kolkata
15	Sarbajita Bannerjee	Kolkata	56	Dr. S.K Mukhuty,	Kolkata
16	Prof. Pradip Mitra	Kolkata	57	Ranjit Singh	Kolkata
17	Anindya Bhattacharya	Kolkata	58	Jiten Nandi	Kolkata
18	Kshemakant Singh	Kolkata	59	Joydeep Bandyopadhyay	Birbhum
19	Ayon Mukherjee	Oxford	60	Dr. Satyajit Chakraborty	Birbhum
20	Dilip Ghosh	Kolkata	61	Samar Chakraborty	Kolkata
21	Natasha Ahmed	Kolkata	62	Nikhil Chandra Das	West Bengal
22	B. Chakraborty	Kolkata	63	Samarendranath Sarkar	West Bengal
23	Ramesh Mondal	Barasat	64	Dr. Sanjib Mukhopadhyay	West Bengal
24	Bidhan Sarkar	Kolkata	65	Dr. Shuvankar Mukherjee	Kolkata
25	Swapan Senapati	Kolkata	66	Dr. Suman Ganguly,	West Bengal
26	Abdul Alis	Barasat	67	Dr. Ratan Khasnabis	West Bengal
27	Sanjiv Agarwal	Kolkata	68	Dr. Aniruddha Sengupta	West Bengal
28	Basudev Bannerjee	Kolkata	69	Biswajit Das	West Bengal
29	Saswati Ghosh	Kolkata	70	Amitava Dutta	Kolkata
30	S.S. Guha Roy	Kolkata	71	Sanjay Sharma	Assam
31	Dr. Angamitra Barik	Birbhum	72	Sunil Kaul	Assam
32	Sibashis Chatterjee	Kolkata	73	Parbati Sengupta,	West Bengal
33	Sudip Majumdar	Kolkata	74	Satya Gopal Dey	West Bengal
34	Sudeshna Pal	Kolkata	75	Ananya Bhattacharya	Kolkata
35	Prabhat P Ghosh	Patna	76	Priya Sangameshwaran	Kolkata
36	Jayanta Ghosh Majumdar	Kolkata	77	Pradipta Dubey	West Bengal
37	Rudrank D Sinha	Patna	78	Dr. Rajkumari Basu	West Bengal
38	Balram	Jharkhand	79	Sandeep Kr Ghosh	West Bengal
39	Gurjeet Singh	Jharkhand			
40	Haldhar Mahato	Jharkhand			
41	Achyut Das	Orissa			

Sl. No.	Name	City/ State/ Country	Sl. No.	Name	City/ State/ Country
80	CSSSC	Kolkata	122	M.S. Basu	Kolkata
81	Rajib Halder	Kolkata	123	Gautam Bose	Kolkata
82	Dr. Samir Chowdhury	Kolkata	124	Gopa Samanta	Bardhaman
83	Nilanjan Hajra	Kolkata	125	S. Srinivasan	Kolkata
84	Dr. Madhulika Jonathan	Ranchi	126	Sudipta Bandyopadhyay	Kolkata
85	Kamal Kumar Pal	Kolkata	127	Aloka Prava	West Bengal
86	D.P. Poddar	Kolkata	128	Rittika Das	West Bengal
87	Priyank Gupt	Kolkata	129	Soumitra Sankar Sengupta	West Bengal
88	Bidyut Rajms	Kolkata	130	Prof. A.B Biswas,	West Bengal
89	Anindya Datta	Kolkata	131	Pinaki Mukherjee	Kolkata
90	Dr. Punyabrata Goon	Kolkata	132	Sashanka Nayek	West Bengal
91	Sarada Lahangir	Bhubaneshwar	133	Bijan Hazra	West Bengal
92	Arup Kumar Sen	Kolkata	134	Bhalopahar at Purulia	Kolkata
93	Dr. Sujishnu Mukherjee,	Kolkata	135	R.G Kar	Kolkata
94	Sarmishtha Karmakar	Kolkata	136	Satya Sundar Burman	West Bengal
95	Rajesh Das	Birbhum	137	Ramakrishna Sarada Mission Matri Bhawan Hospital	Kolkata
96	Pratyaya Mitra	Kolkata	138	Gautam Halder	India
97	Runa Basu	Himachal Pradesh	139	Dr. Swapan Mishra	Kolkata
98	Amalendu Ghosh	West Bengal	140	Dr. Pradyot Sur	Kolkata
99	Susmita Sarkar	Kolkata	141	D.K. Bandyopadhyay	Kolkata
100	Sarbanu Ghosh	West Bengal	142	Asok Bandyopadhyay	Kolkata
101	Debnath Mukhopadhyay	West Bengal	143	Sabir Ahmed	Kolkata
102	Z. Lizhong	Chinese Consulate, Kolkata	144	Manas Banerjee	Birbhum
103	P.P. Sengupta	India	145	Partha Ghosh	Birbhum
104	Biswanath Basu	Kolkata	146	Tapan Kumar Patra	South 24 Parganas
105	Saradindu Banerjee	Kolkata	147	Tapasri Talukdar	South 24 Parganas
106	Dr. Dilip Kr. Das,	Bardhaman	148	Santanu Purkait	South 24 Parganas
107	Dr. Ranjana Banerjee	Kolkata	149	Dr. Srinath Reddy	Delhi
108	Dr. Sujata Chowdhury	Kolkata	150	Dr. Nirmal Kumar Saha	Behrampore
109	Jayanta Das	Kolkata	151	Saikat Majumdar	Birbhum
110	Dr. Anirban Das	Kolkata	152	Ehsan	Kolkata
111	Anirban Chattopadhyay	Kolkata	153	Ajoy Kumar Banerjee	Kolkata
112	Pallav Goswami	Kolkata	154	Chanchal Banerjee	Birbhum
113	Dr. Arabinda Ghosh	Kolkata	155	R.B Chatterjee	Birbhum
114	Bhabesh Das	Kolkata	156	Dr. Gautam Ray	Kolkata
115	Dr. Jayanta K. Das	Howrah, WB	157	Dr. Avik Bhattacharya	India
116	A.K Sarkar	Jharkhand	158	Dipankar Saha	India
117	Abhijit Mukherjee	Bankura	159	Tarun Basu	Kolkata
118	Krishna Mitra	Jalpaiguri	160	Dr. Binayak Sen	Chattisgarh
119	Paresh Adhikari	South 24 Parganas	161	Pranabesh Maiti	Kolkata
120	Dr. O.P Kansal	Bihar	162	Saumya Dey	Kolkata
121	Swati Bhattacharjee	Kolkata	163	Suvadip Ghosh	Kolkata

<b>Sl. Name No.</b>	<b>City/ State/ Country</b>	<b>Sl. Name No.</b>	<b>City/ State/ Country</b>
164 Shibnath Paul	Kolkata	184 Dr. Partha Sarathi Mukherjee	Kolkata
165 Chandana Sinha Chowdhury	Kolkata	185 Pia Sen	Kolkata
166 Samit Bera	West Bengal	186 Toa Bagchi	Kolkata
167 Rudranarayan Pradhan	Kolkata	187 Priyanka Nandy	Kolkata
168 Manisha Das	Kolkata	188 Susmita Bandyopadhyay	Kolkata
169 Prasenjit De	Kolkata	189 Sangram Mukherjee	Kolkata
170 Barun K. Ghosh	Kolkata	190 Mukhlesur Rahaman	Kolkata
171 Dr. Chittaranjan	Kolkata	191 Saumik Mukherjee	Kolkata
172 Dr. Pinaki Ranjan Roy	Kolkata	192 Sumanta Paul	Kolkata
173 Anirban Dutta	Kolkata	193 Shantabhanu Sen	Birbhum
174 Parijat Bandyopadhyay	Kolkata	194 Swagata Nandi	Birbhum
175 Sulagna Sengupta	Kolkata	195 Marium Begum	Birbhum
176 M.S Hossain	Kolkata	196 Sujata	Birbhum
177 Debojyoti Ray	Kolkata	197 Sakila Begum	Birbhum
178 C.S Bhattacharya	Kolkata	198 Kumar Rana	Kolkata
179 Somnath Mazumdar, LFWB	Kolkata	199 Antara Dev Sen	Delhi
180 Amar Kundu	Kolkata	200 Amartya Sen	Santiniketan
181 Dr. A.K. Roy	Kolkata	201 Michael Marmot	United Kingdom
182 Dr. Abhijit Chowdhury	Kolkata	202 Manabi Majumdar	Kolkata
183 Asokananda Konar	Kolkata		



## **Health Inequity and Democratic Deficit**

A View from East and North East India



# Health Inequity and Democratic Deficit

A View from East and North East India

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It was in February 2011, immediately after the launching of Pratiche Institute, that Professor Amartya Sen, in an informal meeting with the Institute members, Dr. Abhijit Chowdhury of Liver Foundation, West Bengal and Dr. Shaibal Gupta of ADRI, Patna, pondered over the idea of organising a wider meeting and dialogue on health in our country— something in the line of the National Health Assembly held regularly in Thailand. Everybody present responded enthusiastically to the idea. Given the large size of this continent-like country, we, however, collectively decided to begin with a regional level meeting and named it after the late Dr. Chandrakanta Patil, who sacrificed his life while serving the flood-hit areas of eastern Bihar. UNICEF, Kolkata, readily agreed to collaborate with us in organising this assembly.

At the planning stage of this meeting, Dr. Kaninika Mitra of UNICEF suggested that we prepare a status report based on available secondary data on health; this received further insistence from Mr. Dilip Ghosh, Director, NRHM, West Bengal, Professor Achin Chakraborty and Dr. Subrata Mukherjee of Institute of Development Studies Kolkata, and Dr. A.K. Roy of Economic Information Technology, Kolkata who have all been part and parcel of the whole process of preparation of this report. Mr. Kamal Pal of Riddhi has provided invaluable research inputs to us. Ms. Anantara Dev Sen, the Managing Trustee of the Pratiche (India) Trust, has remained the constant source of inspiration and support in this endeavour in every possible way. All our colleagues at the Institute have contributed beyond the call of duty to the preparation of this report. It would be inadequate to merely thank them. We gratefully acknowledge the support that we have received from the UNICEF Kolkata in the preparation of this report.

## Glossary

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**LEB:** Life Expectancy at Birth; refers to the number of years newborn child would live if subjected to the age-specific mortality rates of a given period.

**GDP:** Gross Domestic Product; refers to the market value of all final goods and services produced within a country in a given period.

**IMR:** Infant Mortality Rate; refers to probability of dying between birth and exactly one year of age, expressed per thousand live births

**MMR:** Maternal Mortality Ratio is the number of maternal deaths per hundred thousand (100,000) live births.

**TFR:** Total Fertility Rate, also called Total Period Fertility Rate (TPFR) of a population is the average number of children that would be born to a woman over her lifetime if she were to experience the exact current age-specific fertility rates through her lifetime, and she were to survive from birth through the end of her reproductive life.

**Underweight:** It is one of the three standard indices of physical growth. It is actually the measure of weight for age and refers to weighing less than what is expected of a healthy person. It is defined with reference to Body Mass Index (BMI). A BMI of under 18.5 is usually referred to as underweight.

**Improved Drinking Water Source:** Improved drinking water sources are defined in terms of technology and level of services that are more likely to provide safe water than unimproved technologies. Improved water sources include household connections, public standpipes, boreholes, protected dug wells, protected springs and rainwater collections.

**Institutional Delivery:** Delivery in a health facility/institution.

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# 1. Introduction

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During his visit to the town of Krishnanagar in the district of Nadia in West Bengal, the distinguished Bengali novelist Sarat Chandra Chattopadhyay noticed that people there greeted each other in a rather novel way, asking, ‘Have you had rice today?’ A curious probing revealed that in the malaria-ridden area of Krishnanagar a diet of rice meant recovery from malarial fever and therefore seeking that crucial information was one sure way to wish people good health. Keeping well and healthy is indeed a central human capability and a central human concern, expressed so naturally and so routinely, in any corner of the globe, through enquiries and wishes about health. When people meet, almost always, without exception and as a second nature, the first question they ask is about each other’s health.

Yet for so many people in India, so central a capability is compromised due to a host of social conditions that produce poor health as well as health inequity, and the lack of adequate social action to combat those social causes of ill health. It is, therefore, essential to take a closer look at ‘what makes good health so problematic for so many people in India’.<sup>1</sup> To that end, this report aims to focus, above all, on socio-economic correlates of health and on the importance of governmental action and larger public participation and action to reduce social gaps in health. There are of course many issues that need our attention, including larger structural forces and general economic and social inequalities. But even amidst background inequalities, how issues of health could be made a central democratic priority in India is the question that motivates this study.<sup>2</sup>

## HEALTH AS A SOCIAL COMMITMENT

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A number of assumptions underlie this exercise. First of all, poor health is not just a private predicament the culpability for which can be solely laid at the

door of the individual; rather the freedom to enjoy good health is socially determined. Second, the aggregate picture of the health of the people in India becomes grimmer when we take into account significant inequalities in health across socio-economic groups that themselves are stratified; some people — poorer people, denizens of rural areas, women, Dalits and Adivasis, religious minorities and other marginalised sections of society — suffer more than others from diseases evidently because of their less fortunate socio-economic positions. Inequities in health, therefore, reflect degrees of social disadvantage and discrimination. Third, yet social action to reduce the burden of preventable diseases is highly inadequate; healthcare coverage is poor due to the lack of basic healthcare and public health facilities as also, rather ironically, because of misdirected, over-medicalized and even irrational care.<sup>3</sup> Finally, there is, however, palpable social indifference about glaring inequities in the health of different social groups in the country and about the fact that so little is being done to reduce several health-related sufferings of the people and attendant inequalities that are simply avoidable. Against the backdrop of such uncaring aloofness, this report aims to not only indicate what is wrong with the country's health and healthcare systems but also draw on positive lessons and experiences in these respects from within India. Above all, this preliminary enquiry into the health of the people in East and North East India seeks to initiate a public discussion on problems of health in the region, and to stir up our 'constructive impatience'<sup>4</sup> about not doing something that is within our reach, that is to say, not acting upon problems and differences in health that are 'unnecessary'<sup>5</sup> and can be avoided by 'reasonable action'<sup>6</sup>. To enhance equity in health is, therefore, a matter of social justice. Simply put, research, discussion and action for health equity — a kind of social justice activism — are the primary impulses that motivate this exercise.

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#### LEARNING FROM WITHIN INDIA

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There is a lot India can learn about health from its neighbours, for example, from China and Bangladesh.<sup>7</sup> Although there are many country-specific factors behind contrasts in parameters of health in these countries, India can learn particularly about what a massive expansion of public health care can achieve in reducing inequities in health, as also about what reversals in these respects may occur due to market orientations. India, being a huge country, with country-like provincial governments, may, however, also learn from within its own boundaries. There are regions in India where public health care system is active and large and its coverage is near universal, as compared to those in which the system of healthcare is in poor health. Simply put, India is 'differently caring'. Therefore, not unexpectedly, India is 'differentially unequal' in terms of basic health parameters. That is to say, there are areas in which health inequalities between social communities and economic classes are comparatively less acute than what obtains elsewhere. The healthcare system in India is therefore not uniformly weak, implicitly suggesting the critical importance of committed social and policy action in both improving the level and reach of healthcare and reducing social disparities in health.

Not quite long ago Ambedkar asked the caste Hindus, 'You allow the cows, dogs, donkey, and cats to drink water from the tank, but do not allow human beings to even draw water from the same sources'.<sup>8</sup> Such a hard-hitting comment on entrenched social inequalities in India will, hopefully, have a different resonance in different parts of the country today, since concerted actions have been taken in some regions of the national universe to remove social and economic barriers to access to safe drinking water. It is essential that we draw lessons from such actions and experiences; more broadly, it is necessary that we ask what kind of democratic politics renders such activism for health equity possible. Thus, in a country that is 'differently democratic', we cannot emphasize enough 'the importance of lessons to be learned *by India from India*'.<sup>9</sup> Our preliminary peek into the health of the people in East and North East India is prompted by such an inter-regional, comparativist approach. The states that constitute this region are Arunachal Pradesh, Assam, Bihar, Jharkhand, Manipur, Meghalaya, Mizoram, Nagaland, Orissa, Sikkim, Tripura and West Bengal.

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#### PROBLEM-FINDING THROUGH EVIDENCE

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The present exercise involves collation of available evidence on health and health care pertaining to the states under consideration. The analysis is based on secondary data and is far from exhaustive, since many factors and policies that influence 'the circumstances in which people grow, live, work, and age', which in turn have a decisive impact on health, remain outside the purview of this preliminary preview. For example, policies related to housing, employment, education, transport and so on, that are known to have clear influence on health, are not addressed here. Yet, we hope that this status report that we piece together from available secondary sources will likely serve three related purposes. First of all, collation and preliminary analysis of evidence acts as a step towards recognition of a problem, since 'no data often means no recognition of the problem'.<sup>10</sup> 'Problem-finding' and 'problem-acknowledging' are indeed a precondition for 'problem-solving'. Understanding health problems of course requires more than just dealing with quantitative measures; still measures are important to carefully gauge the ground reality as well as to assess the impact of action.

Second, as we try to argue below, even from secondary data patterns of social disadvantage in health are palpable. Although we avoid making any claims about definitive causal connections between indicators of social powerlessness and gaps in health of the people, there are some unmistakable associations between what social positions individuals occupy and the quality of their health.<sup>11</sup> If such patterns are obvious from even secondary data, the same can be utilized effectively to make not just a statistical, but, a political point about making good and equitable health a democratic priority in our country. Finally, this status report, conceived as a public report, aims to improve public access to basic health information. An informed discussion that can shape public understanding of issues of health requires such open and wide access. In particular, health is a typical case of 'asymmetric information', people/patients know very little about what the doctors and pharmaceutical companies give them; hence the possibility of exploitation of

people's lack of knowledge is high.<sup>12</sup> Against the backdrop of an overall paucity of information and of misinformation, this report seeks to present evidence for the purpose of making things clearer rather than more opaque.

#### UNIVERSAL HEALTHCARE AS A DEMOCRATIC PRIORITY

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As a backdrop to our enquiry into conditions of health in East and North East India, in Section 2, we present a quick comparison of states of health in India and some of its neighbours. In Section 3, we take a closer look at what prevails within India in terms of health, in particular in eastern and north eastern parts of the country. The central message that springs out of analyses of evidence on health in these states is that promoting universal access to basic health care, regardless of people's ability to pay, their income level, social status, or residency, is to be taken up as a political priority. This entails building an adequately funded and publicly provided primary health care system oriented towards promotional, and not just curative, care, and the one that addresses glaring social disparities in health. In Section 4, we discuss these social and economic inequalities in health in more details, drawing on available data for the selected states disaggregated by economic classes and social groups. The encouraging fact is that the scourge of social disadvantage is not equally debilitating across the region under consideration; put differently, social and policy action can go a long way in reducing social gaps in health. Access to and functioning of publicly provided health care and inadequacies therein are discussed in Section 5. Data reveal a relatively promising performance of several of the states in North East India on a number of health parameters; for example, in a number of north eastern states the prevalence of underweight children is among the lowest in the country. These are also the states that have large percentages of ICDS beneficiaries as well as significant funding for the programme. Several of these states also record low prevalence of anaemia among women. Comparatively speaking, per capita public expenditure on health is sizable in these states. These issues are discussed in Section 6.

Although shortcomings in health have no simple connections with shortages in funds, the simple point that comes out of our analysis is that public health care spending, especially 'fair financing' across states, and across districts and blocks within same state boundaries, is equity-enhancing. One important issue that we highlight in this section, backed by available evidence, is impoverishing out-of-pocket spending on health care — the burden that falls disproportionately heavily on poorer people pushing them into deeper poverty and indebtedness. A major part of the reason for such 'catastrophic' private healthcare expenditure arises from the fact that health has been rendered a market commodity, thanks to near-unregulated commercialization of health care. These issues are discussed in Section 7, with a particular focus on the burgeoning drug market and the timid role of regulatory agencies vis-à-vis profit-maximizing operations of pharmaceutical companies. Thus, governmental under-activity is manifest at two levels: in terms of its role in providing and funding affordable primary healthcare, as well as in its regulatory tasks.

What is most disconcerting is that even poorer people are forced to spend a significant proportion of their income on expensive drugs prescribed by private doctors or even quacks. To minimize household health costs through fair public financing of healthcare is therefore a paramount need. Undoubtedly, we require a strong public health system that is adequately financed, for equitable promotion of health, disease prevention and recovery from illnesses. To make all this happen, of course, we need to make the best use of opportunities provided by democracy. In the final section, we discuss the role of the media and legislative bodies in generating public discussion on health. Our brief analysis of media reportage on health issues in West Bengal suggests that coverage of health news in the mainstream media is quite inadequate. We also show that focus on health in deliberations of the West Bengal Legislative Assembly that took place almost a decade ago, was rather feeble. Such lukewarm concern *vis a vis* issues of health seems to be continuing even today. Health is not just a private condition or a private transaction between the patient and the doctor, but is a subject matter of democratic dialogue; it requires a society's collective engagement in both conceptualizing good health and in generating democratic pressure for public authorities to act on its actualization in an equitable manner.

## NOTES

1. The Lancet (2011), 'What makes good health so problematic for so many people in India?', 377 (9761), Sen, Amartya, (2011) 'The art of medicine: Learning from others', *The Lancet*, 377 (9761).
2. Inspired by a motto of 'research for action', the Pratiche (India) Trust has already brought out two publications on health titled *The Pratiche Health Report* (2005) and *The Pratiche Child Report* (2009), based upon primary field research in West Bengal. The present analysis is taken up in the spirit of continuing this principle of action-oriented research.
3. Pratiche Trust (2005), *The Pratiche Health Report, with an introduction by Amartya Sen*, in association with TLM Books, Delhi.
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6. World Health Organization (WHO), (2008), *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health*, Geneva.
7. Sen, Amartya, (2011) 'The art of medicine: Learning from others', *The Lancet*, 377 (9761)
8. Ambedkar, B R, (1990, p7), as quoted in Guru, Gopal (2010), 'Social Justice', *The Oxford Companion to Politics in India*, edited by Niraja Gopal Jayal and Pratap Bhanu Mehta (2010), Oxford University Press, New Delhi.
9. Dreze, Jean and Sen, Amartya (2002) *India: Development and Participation*, Oxford University Press, New Delhi.
10. World Health Organization (WHO), (2008), *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health*, Geneva.
11. Also see, Robert, Stephanie A and House, James S, (2000) 'Socioeconomic Inequalities in health: Integrating Individual, Community, and Societal-Level Theory and Research', in *The Handbook of Social Studies in Health and Medicine*, edited by Gary L. Albrecht, Ray Fitzpatrick and Susan C. Scrimshaw, Sage Publications, London.
12. Sen, Amartya, (2011) 'The art of medicine: Learning from others', *The Lancet*, 377 (9761).

## 2. India and Her Neighbours Perspective on Health

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Historically, one of the major connections between India and its neighbours was mutual exchange of ideas on health and healthcare. Hundreds of travellers came to India in search of medical knowledge, and returned home knowing the arts of medicine and techniques of surgery. Again, Buddhist preachers from India who visited the neighbouring countries of China, Malaysia, Sri Lanka and Vietnam, spread their knowledge on health amongst their citizens. They also learnt a lot from local medical practices in those countries, and brought the gathered knowledge back to India. A large portion of the Buddhist literature exchanged between India and the surrounding countries dealt with the arts and sciences of health. These legacies notwithstanding, colonial politics in the modern age has had a profound impact not only in shaping the political geographies of our neighbours – the former Indian subcontinent is now divided into three sovereign nations, India and Pakistan, and Bangladesh – but has also shaped the public policies, particularly on health. These policy actions and directions have had their influences on health status of the respective population. Diverse as they are, these policies and subsequent health outcomes offer us significant lessons. The historical connection that we have can be revitalised to continue the older culture of learning from and enriching each other. This section offers a quick comparison on health and healthcare policies between India and some countries with which India shares geographical and cultural borders. Our interest here in this section is learning from our neighbours, before we look inward to learn from within India.

If India is compared with its Asian neighbours – especially the South East Asian countries like Japan, Singapore, the Republic of Korea – in the context of health, it may perhaps be an uneven comparison, keeping the differential strength of their economies in mind. While people of these countries are expected

to live for 80 years or more as per available data for 2009, Life Expectancy at Birth (LEB) in India was 65 years for the same year.<sup>1</sup> Indeed, these countries perform much better on almost all health indicators. For example, their Infant Mortality Rates (IMR) are 2.4, 2.3 and 4.5 respectively, whereas the corresponding figure for India was 50.3 in 2009.<sup>2</sup> It is true that these countries have more robust economies compared to that of India. The per capita GDP of these countries are \$ 39738, \$ 36536 and \$ 17078 respectively, compared to India's \$1192<sup>3</sup>; therefore much more fund is available in principle to spend on healthcare. On the other hand, a close look at these countries reveals interesting discrepancies between GDP and health performance. For example, the GDP of the Republic of Korea is less than half of the two other countries, but its achievements with respect to LEB and IMR are almost the same. So there are obviously some other additional factors to GDP influencing the health achievements of these countries.

#### LIFE EXPECTANCY, INFANT MORTALITY AND PUBLIC EXPENDITURE

To continue with this comparison, we focus more closely on a group of neighbouring countries that are either geographically and culturally close to us, or belong to a broadly comparable range of GDP per capita. These countries are Bangladesh, Bhutan, China, Nepal, Pakistan, Sri Lanka, Indonesia, Malaysia, Philippines, Thailand and Vietnam. While no definitive claims of causal connections are made here, it is interesting to note that there is a definite relation between per capita GDP and public health expenditure as percentage of GDP on the one hand, and IMR and LEB on the other.

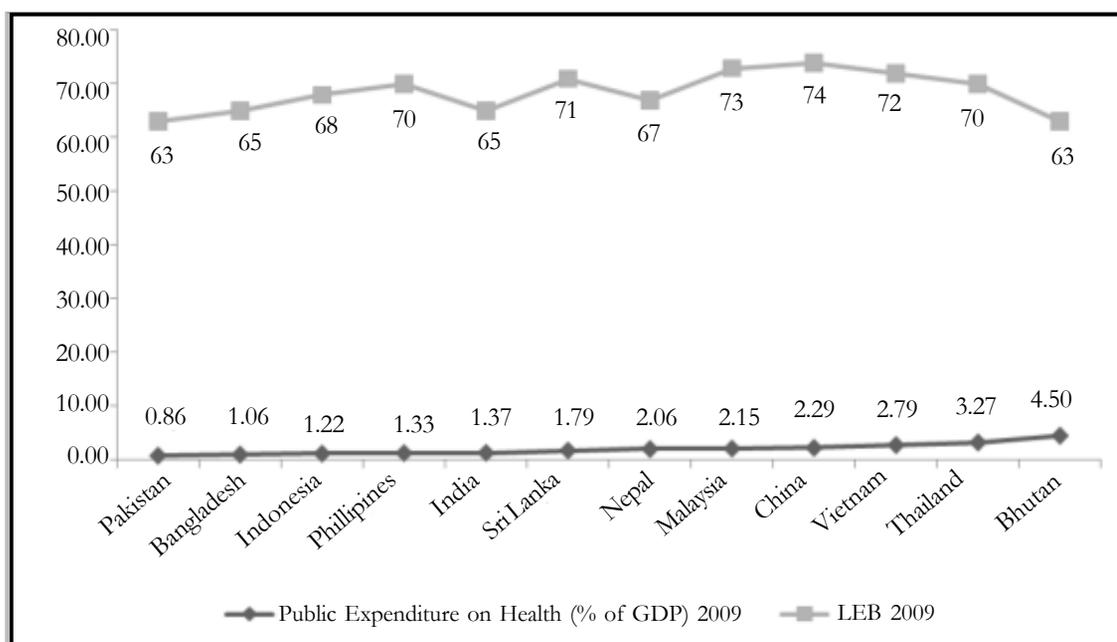
**Table 2.1 GDP per capita, IMR and LEB**

Countries	GDP Per capita 2009	IMR 2009	LEB 2009
Nepal	427	38.6	67
Bangladesh	551	41.2	65
Pakistan	954	70.5	63
Vietnam	1113	19.5	72
India	1192	50.3	65
Phillippines	1752	26.2	70
Bhutan	1831	52	63
Sri Lanka	2067	12.7	71
Indonesia	2349	29.8	68
China	3744	16.6	74
Thailand	3892	12	70
Malaysia	7029	5.7	73

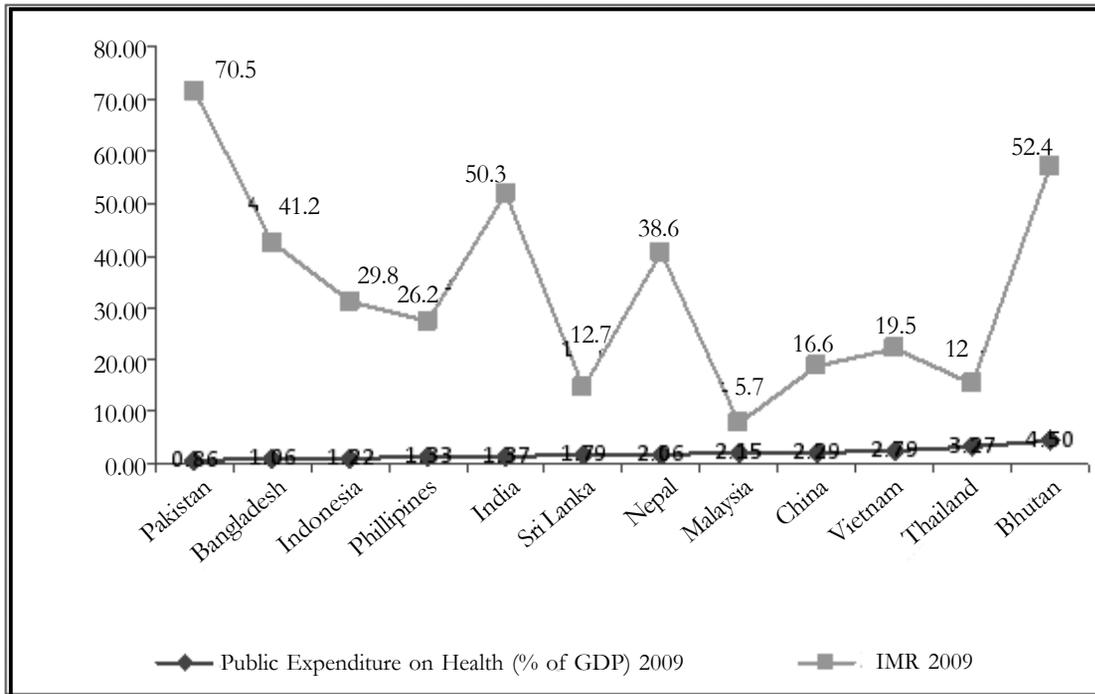
Source  
 GDP Per Capita 2009  
<http://search.worldbank.org/data?qterm=per%20capita%20gdp&language=EN>  
 IMR: <http://search.worldbank.org/data?qterm=infant+mortality+rate&language=EN&format=>  
 LEB: <http://apps.who.int/ghodata/?vid=710s>

While, in general, with increase in per capita GDP there is a noticeable corresponding rise in LEB and an attendant decrease in IMR, there are significant exceptions to this general trend. For example, China records highest LEB among the countries compared, though Malaysia has highest per capita GDP but slightly lower LEB than that of China. Again, India has almost same per capita GDP compared to that of Vietnam but LEB which is 7 years lower than that of Vietnam. The most intriguing case is that of Bhutan which ranks 6th from the top in terms of per capita GDP but has the lowest LEB. Poor performance of Bhutan is also seen in case of IMR where it is ranked 2<sup>nd</sup> from the bottom. Referring to Table 2.1 and Figures 2.1 and 2.2 below one can see that Pakistan, India and Vietnam have almost same per capita GDP but the public expenditures on health as percentage of GDP (2009) are 0.86, 1.37 and 2.79 respectively which clearly seem to have a bearing on their records of LEB which are 63, 65 and 72 respectively and of IMR which are 70.5, 50.3 and 19.5 respectively. Similar comparisons of Nepal and Bangladesh; Philippines and Sri Lanka may suggest similar linkages between public policy efforts and basic health achievements.

**Figure: 2.1. Public Expenditure on Health (% of GDP) and LEB: 2009**



Sources: Public Expenditure on Health (% of GDP)2009 <http://search.worldbank.org/data?qterm=public+halth+expenditure+%28%25+of+GDP%29&language=EN&format=>  
LEB 2009: <http://apps.who.int/ghodata/?vid=710s>

**Figure: 2.2. Public Expenditure on Health (% of GDP) and IMR: 2009**

Sources:

Public Expenditure on Health (% of GDP) 2009: <http://search.worldbank.org/data?qterm=public+health+expenditure+%28%25+of+GDP%29&language=EN&format=>

IMR 2009: <http://data.worldbank.org/indicator/SP.DYN.IMRT.IN>

Bhutan remains an enigma once again having per capita GDP of \$1831 and public expenditure on health as percentage of GDP (2009) as 4.5, which is highest in the group. Clearly, there must be other additional factors than just financial resources which determine health outcomes. Even when we focus on health expenditure alone, important considerations are that of consistency in public spending and effective utilization of funds available. Simply put, much depends on the practice of policy processes on the ground, no matter how well they are designed. Table 2.2 presents details of public expenditure of the group of countries in focus for the years between 2001 and 2009.

From the discussion above, we have seen the encouraging performance of China, Thailand, Malaysia, Sri Lanka and Vietnam in terms of health. Table 2.2 shows how consistent these countries were in spending on health. It is not that India has no plan for spending on health. There was concrete plan regarding how much and where to spend under the National Rural Health Mission (NRHM) 2005-2012. The plan was to spend 2 to 3 percent of GDP on health and the goals were also fixed. The main goals were to reduce IMR to less than 30 by year 2012, Maternal Mortality ratio (MMR) to 100 per 100,000 births by 2012, Total Fertility Rate (TFR) to 2.1. Against these targets, actual achievements were

**Table 2.2 Public expenditure on health (% of GDP)**

Country Name	2001	2002	2003	2004	2005	2006	2007	2008	2009
Bangladesh	1.19	1.23	1.14	1.21	1.12	1.24	1.19	1.04	1.06
Bhutan	4.84	6.63	3.86	3.25	3.60	4.34	4.26	4.56	4.50
China	1.63	1.72	1.76	1.80	1.83	1.85	1.92	2.05	2.29
India	1.31	1.19	1.18	0.93	0.93	1.13	1.21	1.35	1.37
Indonesia	0.98	0.85	1.02	0.93	1.00	1.13	1.35	1.23	1.22
Malaysia	1.95	1.93	2.62	2.24	1.85	1.92	2.00	1.90	2.15
Nepal	1.19	1.76	1.40	1.44	1.41	1.57	2.14	2.25	2.06
Pakistan	0.58	0.84	0.66	0.70	0.70	0.82	0.79	0.85	0.86
Philippines	1.42	1.18	1.38	1.37	1.43	1.27	1.23	1.27	1.33
Sri Lanka	1.74	1.65	1.60	1.92	1.88	2.03	2.09	1.78	1.79
Thailand	1.87	2.35	2.28	2.28	2.29	2.52	2.71	3.01	3.27
Vietnam	1.76	1.57	1.68	1.52	1.55	2.12	2.79	2.79	2.79

Source: <http://data.worldbank.org/indicator/SH.XPD.PUBL.ZS>

IMR-50.3 in 2009, MMR-230 in 2008 and TFR-2.7 in 2009. This gap between the health plan and what transpires in reality surely requires deeper probing. But, the proposal to spend 2 to 3 percent of GDP on health itself remains unfulfilled so far — an essential precondition for actualization of the other components of the health plan. At the least, a strong and active public health care system and a greater participation of the state in the health sector is required. Also, there should be no doubt that not just increment in public expenditure on health is essential, but good governance is also mandatory for the purpose.

#### PROMOTING THE HEALTH OF THE CHILD AND THE MOTHER AND COMBATING COMMON DISEASES

The same set of countries that appear to have fared better in terms of tackling infant mortality and expanding survival chances of their people have also shown better records in promoting maternal and child health and in dealing with some of the common diseases such as diarrhoea, pneumonia, tuberculosis etc. Here are some examples. (Table 2.3)

Only China and Thailand have fertility rates lower than 2, whereas Pakistan and Philippines have fertility rates higher than 3. In terms of MMR, China, Malaysia, Sri Lanka, Thailand and Vietnam make a distinctly different group with MMR less than or around 50. India's performance in measles vaccination is poorest among the countries under consideration. This is one area where state sponsorship in health has brought Bhutan positive dividend; it is at the top of

**Table 2.3 Maternal Mortality Ratio (MMR), Total Fertility Rate (TFR), Measles immunisation, Under-five mortality due to Diarrhoea and Pneumonia: 2008, 2009**

Countries	MMR 2008 Modeled estimate/ 100000 Live Births	Total Fertility Rate 2009	Immunisation measles (% of children ages 12 to 23 months 2009	<5 mortality due to Diarrhoea 2008	<5 mortality due to Pneumonia 2008
	I	II	III	IV	V
Bangladesh	340	2.29	89	13	16
Bhutan	200	2.56	98	14	25
China	38	1.77	94	3	15
India	230	2.68	71	13	20
Indonesia	240	2.13	82	15	22
Malaysia	31	2.51	95	1	6
Nepal	380	2.82	79	17	16
Pakistan	260	3.87	80	20	20
Phillippines	94	3.03	88	5	12
Sri Lanka	39	2.31	96	3	10
Thailand	48	1.82	98	3	11
Vietnam	56	2.03	97	4	12

Sources  
 Column I: <http://data.worldbank.org/indicator/SH.STA.MMRT>  
 Column II: <http://data.worldbank.org/indicator/SP.DYN.TFRT.IN>  
 Column III: <http://data.worldbank.org/indicator/SH.IMM.MEAS>  
 Column IV: [http://apps.who.int/gho/indicatorregistry/App\\_Main/view\\_indicator.aspx?iid=89](http://apps.who.int/gho/indicatorregistry/App_Main/view_indicator.aspx?iid=89)  
 Column V: same as IV

the list along with Thailand closely followed by Vietnam and Sri Lanka— 98 percent of children are vaccinated for measles in Bhutan and Thailand.

The lowest number of under-5 mortality due to Diarrhoea and Pneumonia is reported in Malaysia. Although 6 out of 12 countries compared have under-5 mortality due to diarrhoea less than 5, it is 13 for India.

Malaysia is the only country where Under-5 mortality due to pneumonia is confined to a single digit. China, otherwise having remarkable record in almost all indicators discussed here, has under-5 mortality due to pneumonia of 15 per 1000. India's performance in this respect is once again quite modest.

The level of nutrition among the under-5 children is one of the most important aspects of health, not the least because it indicates adult health status of the immediate future. Information on this is provided in Table 2.4 for the selected countries for various years. The number of underweight under- 5 children is the highest in India among the group of countries under consideration, making India the regional leader in malnourished children.

**Table 2.4 Under-five underweight children (both sexes)**

Countries	Percentage of Children aged <5 years Underweight both sexes	Year
Bangladesh	41.3	2007
Bhutan	12	2008
China	4.5	2005
India	43.5	2006
Indonesia	19.6	2007
Malaysia	16.7	1999
Nepal	38.8	2006
Pakistan	31.3	2001
Phillippines	20.7	2003
Sri Lanka	21.6	2009
Thailand	7	2006
Vietnam	20.2	2008

Source: [http://apps.who.int/gho/indicatorregistry/App\\_Main/view\\_indicator.aspx?iid=27](http://apps.who.int/gho/indicatorregistry/App_Main/view_indicator.aspx?iid=27)

One of the oldest enemies of the health of the people, especially in the part of the globe that we are focusing on, is tuberculosis.

The first reference to tuberculosis in Asian civilization is found in *Rigveda*, dating back 1500 BC; in *Yajurveda* there is description of Scrofula, tubercular infection of Lymph nodes of neck; the *Susbruta Sambita* recommended that the disease should be treated with various meats, alcohol<sup>4</sup> and adequate physical

**Table 2.5 Prevalence of Tuberculosis and Death due to Tuberculosis**

Country	Prevalence of tuberculosis (per 100,000 population) 2009	Death due to tuberculosis among HIV negative people (per 100,000 population) 2009
Bangladesh	425	51
Bhutan	179	8.3
China	138	12
India	249	23
Indonesia	285	27
Malaysia	109	8.6
Nepal	240	21
Pakistan	373	38
Phillippines	520	35
Sri Lanka	101	9.2
Thailand	189	18
Vietnam	333	36

Source: Prevalence: [http://apps.who.int/gho/indicatorregistry/App\\_Main/view\\_indicator.aspx?iid=23](http://apps.who.int/gho/indicatorregistry/App_Main/view_indicator.aspx?iid=23)  
Deaths due to tuberculosis: [http://apps.who.int/gho/indicatorregistry/App\\_Main/view\\_indicator.aspx?iid=1425](http://apps.who.int/gho/indicatorregistry/App_Main/view_indicator.aspx?iid=1425)

rest. Incidentally, high protein food and rest are advised still today. The enemy is therefore known for long. Multiple drugs are available; drugs are even given to the patients free of cost under Direct Observed Therapy Short course (DOTS). Yet a large number of people suffer from this disease and die prematurely due to its scourge.

### India Learning from India

The issue that India needs to scale up its public expenditure on health significantly as a necessary step towards universalization of access to health care services is now being raised more frequently and with somewhat greater force than before. Undoubtedly, given the fact that public expenditure on health as a percentage of GDP has been around one per cent for a remarkably long period, which is one of the lowest among the countries even in the developing world, this ought to be the most urgent policy focus. Increased financial allocation, however, is not automatically translated into improved health outcome. What comes in between is the design of the health care delivery system. Health system design issues are inherently complex. However, to pursue the agenda of ‘spending better’ as well as ‘spending more’ we have to disentangle the elements of the health systems in place. As there is no uniquely optimum way of designing the system, learning from the better performing systems with a comparativist approach would help us find ways to reform a system in a particular state. Very recently the Department of Health and Family Welfare of the Government of West Bengal has been considering the idea of dividing the state into a large number of ‘health districts’ drawing on Tamil Nadu’s experience. Here we bring in another aspect of Tamil Nadu’s health system that could be thought of by other states.

It is widely known that public health services have been relegated to a somewhat marginalised position in the health system thinking in India. By public health services we mean a set of preventive health services to reduce people’s exposure to diseases, which historically played the most important role in reducing mortality of the population anywhere in the world. The administrative structure for the delivery of public health services is not uniform across the states of India. In West Bengal, for example, the responsibilities are somewhat fragmented as they are divided between the Department of Public Health Engineering and the Department of Health and Family Welfare. The latter, like most state health departments in India, is overburdened with the immediate demand for curing the ill, and has confined its public health work largely to implementation of the centrally driven single-issue programmes such as the programmes to control specific diseases, family planning, and maternal and child health. This seems to have eroded the capacity of the Department to plan and implement a state-specific public health system with a dedicated work force well-trained in managing the system with a focus on reducing people’s exposure to diseases, the result of which is an unnecessarily high burden on the curative care facilities.

What has Tamil Nadu done? It has a separate Directorate of Public Health with its own budget and a professional public health cadre working only on public health. This has helped the state to systematically plan to avert outbreaks and prevent resurgence of diseases. A comparison of the management of public health emergencies in post-Tsunami Tamil Nadu with that in post-Aila West Bengal would be enough to draw our attention to this particular aspect of the Tamil Nadu system. Does this public health preparedness make the Tamil Nadu system more expensive than others? Not really. The highly acclaimed Kerala model clearly trails behind Tamil Nadu on this aspect. The occasional outbreak of certain communicable diseases in Kerala in the recent past sits uncomfortably with the fact that per capita health expenditure in Kerala is much higher than in Tamil Nadu.

*Contributed by: Achin Chakraborty  
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Table 2.5 above shows that Malaysia and Sri Lanka recorded lowest number of cases of tuberculosis and death due to it. The number of deaths due to tuberculosis is the lowest in Bhutan although prevalence is not so low. Taking the percentage of deaths of tuberculosis infected people as an indicator, India's record remains unexceptional (9 percent).

#### HEALTH: NOT JUST AN ABSENCE OF AILMENTS

The World Health Organisation defined health as 'a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.' Health depends on the water we drink, the food we eat, the surroundings in which we live, the kind of jobs we do and not just an escape from the hospital gate. The importance of drinking water and better sanitation do not require any justification. Table 2.6 below shows how well the countries under consideration pay attention to these basic public health facility parameters.

**Table 2.6 Supply of drinking water and sanitation facilities**

Countries	Population using improved drinking water sources (%)	Population using improved sanitation facilities (%)
Bangladesh	80	53
Bhutan	92	65
China	89	55
India	88	31
Indonesia	80	52
Malaysia	100	96
Nepal	88	31
Pakistan	90	45
Philippines	91	76
Sri Lanka	90	91
Thailand	98	96
Vietnam	94	75

Source: <http://apps.who.int/ghodata/?vid=95000#>

In both the parameters of drinking water and sanitation facilities, India fares very poorly; in terms of the availability of decent sanitation facilities India stands at the bottom of the table. These records compel us to argue that there is a lot to be expected from effective governmental action. A strong and active public health sector is essential for universal access to basic healthcare. The concept of universal healthcare is a much older concept, started way back in 1883-84 in Germany. The underlying motivation is to provide affordable healthcare to all. Surely, there are different ways of achieving this basic goal — either through

direct governmental involvement or via publicly or privately sponsored insurance schemes. In India where only a small portion of the population is engaged in formal, salaried employment, and where only around four percent of the population are members of the provident fund, the need for direct governmental involvement in expanding health facilities is paramount.

#### NOTES

1. <http://apps.who.int/ghodata/?vid=710s>
2. <http://search.worldbank.org/data?qterm=infant+mortality+rate &language=EN&format=>
3. <http://search.worldbank.org/data?qterm=per%20capita%20gdp& language=EN>
4. History of Tuberculosis, wikipedia.org.

### 3. East and North East India Varying States of Health

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Having cast a fleeting glance at states of health in a few neighbouring countries of India, in this section we focus on East and North-East India. This regional focus is prompted by our interest in carefully gauging the extent of differences in the health of the people within same national boundaries. Such contrasts, in turn, help us understand what enables good health in some places, and what prevents it in other areas.

India is a land of curious contrasts. In the twenty-first century, it has attained the status of a global power with an enviably steady rate of economic growth, without completely losing its reputation for being the land of elephants and snake-charmers. Four of the ten richest persons in the world are Indians, yet India contributes one-fifth to the world's share of all diseases – one third of diarrhoeal diseases and tuberculosis, a quarter of maternal ailments, and a fifth of nutritional deficiencies. It has the second largest number of HIV/AIDS cases after South Africa,<sup>1</sup> and is on the fast track to the top position in the number of Hepatitis B cases. But above and beyond the pathological examples, its biggest disease is the poor functionality of primary healthcare system, which has failed to comprehensively address its citizens' public healthcare requirements.

The Alma Ata Declaration in 1978 added considerable emphasis to primary healthcare. It viewed health as an integral part of the socioeconomic development of a country. The existing inequity between the developing and the developed countries in terms of social and economic parameters as well as within countries in terms of access to basic healthcare was an issue of major concern in the declaration. The declaration recommended that the reduction of this major gap in healthcare between the developing and developed nations through economic and social development be taken up with urgency by all the nations, with a spirit of utmost co-operation, humanity and brotherhood. It further suggested that

primary healthcare should be brought within the reach of all through universal affordability. Thus it attached tremendous emphasis to the state's role in meeting its goals.<sup>2</sup>

Yet, more than three decades after the declaration, public healthcare in India has received far less attention than is adequate and necessary. This section discusses how. Our analysis is based on available secondary data pertaining to various determinants affecting the health status of a nation, such as the infant mortality rate (IMR), maternal mortality ratio (MMR), nutritional requirements of various groups, prevalence of anaemia etc., using National Family Health Survey (NFHS), District Level Household Survey (DLHS), Sample Registration System (SRS) and state and central health department data. This section pays closer attention to the rural-urban and gender differentiation issues. A more in-depth analysis of the issues of socio-economic disparities has been discussed in the next section.

#### SLOW PROGRESS IN REDUCING INFANT MORTALITY

Childhood is a significant stage of life and deprivation during this period can have a long-term adverse impact on the well-being of the population. It is one of the important indicators of a country's general medical and public health conditions, and consequently, the country's level of socio-economic development. Reduction in infant and child mortality is perhaps the most important of the millennium development goals, as children are the most important assets of a nation. Thus, infant mortality rate (hereafter IMR)—probability of dying before one year of age expressed per 1000 live-births—and under-five mortality rate (hereafter U5MR)—probability of dying between birth and age 5 expressed per 1000 live-births—have been used as measures of children's well-being for many years. The International Conference on Primary healthcare held in Alma Ata in 1978 was the first global forum to consider how child mortality could be reduced by systematic development of a primary healthcare system.

Despite the centrality of child well being, approximately 1.72 million children in India die each year even before reaching their first birthday. The progress in reducing child mortality has rather been slow, particularly when compared with some other developing nations (as discussed earlier in section 2). Also there have been contrasting results for the different Indian states, some of which have done much better leaving the rest to allow hundreds of thousands of children to die.

The latest all India rate of infant mortality is 50 per 1000 (2009).<sup>3</sup> In the states selected for this analysis we find a wide variation in the IMR: while Orissa tops the list with an IMR of 65, Manipur's achievement in reducing the IMR to 16 has almost caught up with that of Kerala (12). Apart from regional gaps there exists a huge urban-rural difference: while the IMR for urban India is 34, it is as high as 55 for the rural areas. Among the selected states, Assam shows the maximum gap in survival chances of infants among its rural and urban societies, with a gap as high as 27. Mizoram follows Assam in close proximity with a gap of 26 points. However, it needs to be noted here that the overall IMR for Mizoram is 36 per thousand – much below the country average (50). Similarly the state recording the highest IMR, Orissa, also shows a high urban-rural divide

### The Bihar Conundrum: A Call for Public Action

The decadal growth rate of population in Bihar during 1991-2001 was 28.6 percent, exceeding the growth rate in the previous decade (1981-91) at 23.4 percent. This was completely contrary to the trend in other states which all had recorded fall or marginal increase in decadal growth rate of population. One could certainly understand that low level of literacy, specially of the women, coupled with other dimensions of social disadvantages, have hindered any change in the fertility behaviour of Bihar's population during the nineties; but there could not possibly be any reason for an increase in fertility in Bihar during the decade, resulting in higher growth rate of population. The paradox can be solved only when it is noted that, only in Bihar, the fall in death rate was higher than the fall in birth rate during the nineties, resulting in a higher growth rate of population; everywhere in India, it was the birth rate which had fallen more than the death rate, leading to a lower growth rate of population. *Prima facie*, this probably leads to the conclusion that health situation in Bihar is not as poor as one would expect in this poorest state of the country.

A lower death rate is not the only indicator which shows that, even in the face of severe poverty, Bihar's health situation is better than in other poor states like Madhya Pradesh, Rajasthan and Uttar Pradesh. Consider, for example, the Infant Mortality Rate (IMR) which is the lowest in Bihar (56) among the four major Hindi heartland states, and only slightly higher than the national average (53). One can also observe a similar trend with respect to Child Mortality Rate and Maternal Mortality Ratio. For both these indicators, the situation in Bihar is better than in other Hindi heartland states. Finally, when one considers the expectation of life at birth for males, it is higher in Bihar (67.5 years) than the national average (65.6 years); for females, the average for Bihar (67.1 years) is only marginally lower than the national average (67.2 years). All these indicators would show that the health status in Bihar is not as poor as one would fear to be in this poverty-stricken region.

Since, in spite of being the poorest state in India, the health indicators in Bihar are relatively better, it has always been a point of enquiry for the demographers, health functionaries and interested scholars. In the absence of any micro-level study on health practices in Bihar which could hopefully explain this atypical scenario, one can only mention certain conjectural reasons behind the phenomenon. For one, the availability of safe drinking water is relatively higher in Bihar, situated as it is in the Gangetic plains. This is evident from the census data on living conditions for different states, both rural and urban. The chances of water borne diseases is, therefore, relatively less in the state. The relatively better health situation in Bihar could also be probably due to a social attitude where people are ready to tolerate poor health, but would make their best efforts to avoid death. Quite often, in the absence of adequate public health facilities, it would entail considerable private expenditure on health.

In this background, it appears that the usual demographic indicators are not particularly suitable for describing the health situation of a population of poor regions like Bihar. Indeed, these indicators might suffer from serious limitations even in the context of other states or India as a whole. It is, therefore, not surprising that the National Family and Health Survey (NFHS) uses nutrition-based indicators to judge the health status of different states. The acute health deficiencies in Bihar are exposed only through those indicators. One such indicator, for example, is the proportion of population suffering from anaemia. For children, this ratio in Bihar is as high as 78.0 percent and it is the highest in India, national average being 69.5 percent. In case of women, this ratio is as high as 67.4 percent in Bihar, compared to the national average of 55.3 percent; only two states (Jharkhand and Assam) report higher incidence of anaemia among women. For men, the proportion of population suffering from anaemia is again very high in Bihar (34.3 percent), compared to the national average of 24.2 percent. The various rounds of NFHS also report the poor, often the poorest, nutrition standard in Bihar, compared to other states in India.

The high levels of poverty in Bihar is obviously an important reason for poor health conditions in Bihar, but the enormous deficits in the state's health delivery system is also an equally important reason for those conditions. For example, the immunisation programme, one of the basic responsibilities of the public health system, is extremely weak in Bihar. For DPT, Polio and BCG, even the poor states like Madhya Pradesh, Rajasthan and Uttar Pradesh have reached the stage of near universal coverage in recent years, Bihar still remaining far behind. Similarly, the ICDS programme has also limited coverage in Bihar; even the official statistics claims its coverage to be less than half. In addition, not only the number of hospitals and primary health centres are extremely inadequate, but the strength of working health functionaries in these hospitals/centres is generally about half of the sanctioned strength. The National Rural Health Mission (NHRM) has only made marginal differences in this situation.

Of the two important components of human development — education and health, Bihar has achieved some success in the former, i.e., education. This was possible because of increased demand for education among all sections of the society in recent years, and secondly, the readiness of the state government to meet this demand through a major expansion of the elementary schooling system in the state. In case of health, it is almost certain that a parallel increase in demand for better health services has happened, but the state government is yet to respond to this challenge. At one hand, this certainly demands some additional resources, but more than that, it probably calls for a change in the perspective on public health system.

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with the gap being of 22 points (IMR rural for Orissa is 68 while IMR urban for Orissa is 46). For Arunachal Pradesh and Meghalaya the difference is of 21 points.

**Table 3.1 Rural-Urban Gap in IMR across the Selected States**

STATES	IMR		
	Total	Rural	Urban
Assam	61	64	37
Arunachal Pradesh	32	35	14
Manipur	16	18	11
Meghalaya	59	61	40
Mizoram	36	45	19
Nagaland	26	27	23
Sikkim	34	36	21
Tripura	31	33	20
West Bengal	33	34	27
Bihar	52	53	40
Jharkhand	44	46	30
Orissa	65	68	46
INDIA	50	55	34

Source: Government of India (2011) SRS Bulletin, Sample Registration System, Volume: 45(1), Registrar General of India, Ministry of Home Affairs, New Delhi.

West Bengal's record in reducing IMR (33) has a link with its narrow urban-rural gap, of only seven points. A similar pattern of "comparatively less discrimination" has also been evident in Manipur and Nagaland. It is clear that there exists quite a remarkable regional variation between the north-eastern states of the country and hence it would be unfair to club them all as one undifferentiated block – a rather uninformed but common tendency that we have.

Viewed through the prism of gender, our analysis reveals an unsurprising pattern of results. Discrimination against a female child is evident from the fact that girls experience higher rate of mortality in younger age groups as compared to the boys. IMR has been found to be higher for females in all the states, irrespective of rural-urban divide. The only exceptions are Jharkhand and Assam, where the gender gap in IMR is much narrower – six points in both.<sup>4</sup>

India is still at a half-way mark from attaining the millennium development goal of reducing IMR to 28 per 1000 live births by 2015.<sup>5</sup> It is well known that reduction in IMR becomes more effort-intensive as the absolute numbers decline. It makes sense, therefore, to identify pockets with high mortality levels and intensify efforts to reduce mortality in these areas. The appeal of such an approach lies in two reasons: not only do these high IMR groups 'spoil' the average IMR figures, it is also easier to reduce IMR in these regions to a lower level compared with reducing IMR in pockets where its levels are already low. Intensified efforts to reduce IMR among high mortality pockets should, therefore, make practical sense even to those who are not persuaded by ethical arguments on the matter. This approach is especially useful when the reduction in IMR has been uneven among different segments of society, a fact easily revealed through a disaggregated analysis of IMR data, which could vary by factors such as regional, social, economic or gender criteria.<sup>6</sup>

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#### MATERNAL DEATH: AN INDICATION OF HUMAN "UNDER-DEVELOPMENT"

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Women's health is central to the determination of the overall health of the society. Undernourished pregnant women are more likely to give birth to weaker babies leading to a higher infant mortality rate, and consequent poor health outcomes for the future population. Women and men have somewhat different kinds of health risks throughout their life span. Women are exposed to a major health risk due to child bearing. Deaths due to pregnancy and child birth are not uncommon among women in the reproductive age groups. Thus, reduction of mortality of women has been an area of concern and governments across the globe have set time-bound targets to achieve it. The Millennium Development Goals (MDG) drive has set the target of achieving 109 maternal deaths per lakh of live births by 2015. Findings show that overall MMR for the country which was in the vicinity of 400 in 1997-98, has come down to about 300 in 2001-03 during this period based on SRS data. Despite the decline, the slowness of progress clearly visible is a matter of concern to all.

**Table 3.2 Maternal Mortality Ratios in Selected States: Several Years**

STATES	Maternal Mortality Ratio (MMR)		
	1997-98	1999-2001	2001-2003
Assam*	568	398	490
West Bengal	303	218	194
Bihar/Jharkhand	531	400	371
Orissa	346	424	358
<b>INDIA</b>	<b>398</b>	<b>327</b>	<b>301</b>

\*Maternal Mortality Ratio of Assam is being taken as the MMR of the other north-eastern states.  
Source: Sample Registration System; Maternal Mortality in India: 1997-2003 Trends, Causes and Risk Factors; Registrar General of India, New Delhi in collaboration with Centre For Global Health Research, University of Toronto, Canada.

Maternal death is an important indicator of the reach of effective clinical health services to the poor, and is regarded as one of the composite measures to assess the country's progress. Although it has substantially declined over the years from 1997 to 2003, Assam has consistently topped this laggardly league for all these years. Uttar Pradesh, Uttarakhand, Rajasthan, Bihar, Chhattisgarh, Jharkhand and Orissa have continued to follow Assam: all of them have roughly the same rate of approximately 500 maternal deaths per lakh. West Bengal hovers somewhere around the middle by registering a decline of 109 points since 1997. Among the studied states, West Bengal records the lowest maternal mortality ratio of 194. A large number of the maternal deaths are reportedly caused by anaemia<sup>7</sup> — a phenomenon easily preventable through a combined effort of nutritional supplementation and maternal health delivery.

#### HIGH INCIDENCE OF UNDERNUTRITION

Nutrition forms an extremely important indicator of the health status of a society. The nutritional status of a child augments the formation of a healthy society. This has been measured by considering the index of weight-for-age (underweight) which is regarded as the composite measure of nutritional levels of children aged under five years.<sup>8</sup> There are glaring regional variations in this respect: while Sikkim and Mizoram have made a remarkable progress in lowering the number of undernourished children, Jharkhand tops the list, followed by Bihar. West Bengal again hovers around the middle.<sup>9</sup> When compared with the data of nutritional status available from the Integrated Child Development Scheme (ICDS) for December 2009, the results follow a near similar pattern. (see table 3.3).

**Table 3.3 Comparison of the Nutritional Status of Children across Selected States**

STATES	Nutritional status of Children According to NFHS-III and ICDS (in per cent)	
	NFHS-III (2005-06)	ICDS (2009)
Assam	36.4	34.95
Arunachal Pradesh	32.5	0
Manipur	22.1	13.59
Meghalaya	48.8	38.19
Mizoram	19.9	26.76
Nagaland	25.2	6.29
Sikkim	19.7	17.36
Tripura	39.6	38.07
Bihar	55.9	NA
Jharkhand	56.5	42.76
Orissa	40.7	51.86
West Bengal	38.7	49.03
All India	42.5	45.47

According to the data available from ICDS Nagaland's progress is very high – only six per cent of children being moderately underweight. Sikkim, Manipur and Mizoram show a similarly encouraging performance. However, a comparison between the two data sources reveals that there has been a decline in the percentage of children being moderately underweight for all the case states, excepting West Bengal, Mizoram and Orissa. Although the two data sets used here do not allow a strict comparison as NFHS-III provides the data for 2005-06, while the ICDS data are of 2009, it appears that these three states registered an increase in the percentage of children belonging to the category of moderately underweight. Orissa shows a staggeringly high increase of 11 percentage points with West Bengal following close with 10 percentage points. Mizoram records an increase of 7 percentage points with an over-all country-wide increase of 3 percentage points. This is a matter of grave concern and requires urgent attention and action.

#### ANAEMIA: THE DETRIMENTAL EFFECT OF UNDERNUTRITION

Anaemia is characterised by a low level of haemoglobin in the blood. It is a serious concern in young children as it can result in impaired cognitive performance, behavioural and motor development, co-ordination, language development, scholastic development and increased morbidity from infectious diseases.<sup>10</sup> The present analysis of secondary data has brought within its purview the prevalence of anaemia<sup>11</sup> among children (aged 6 to 59 months) and among women and men (both aged 15 to 49 years). A very clear picture of discrimination becomes evident from the analysis of the available data. While the country average for the prevalence rate of any anaemia for women has been found to be 55.3, the rate is just 24.2 for men- a sheer difference of 31.1 percentage points.

**Table 3.4: State-wise Distribution of the Prevalance Rate of Anaemia among men, women and children**

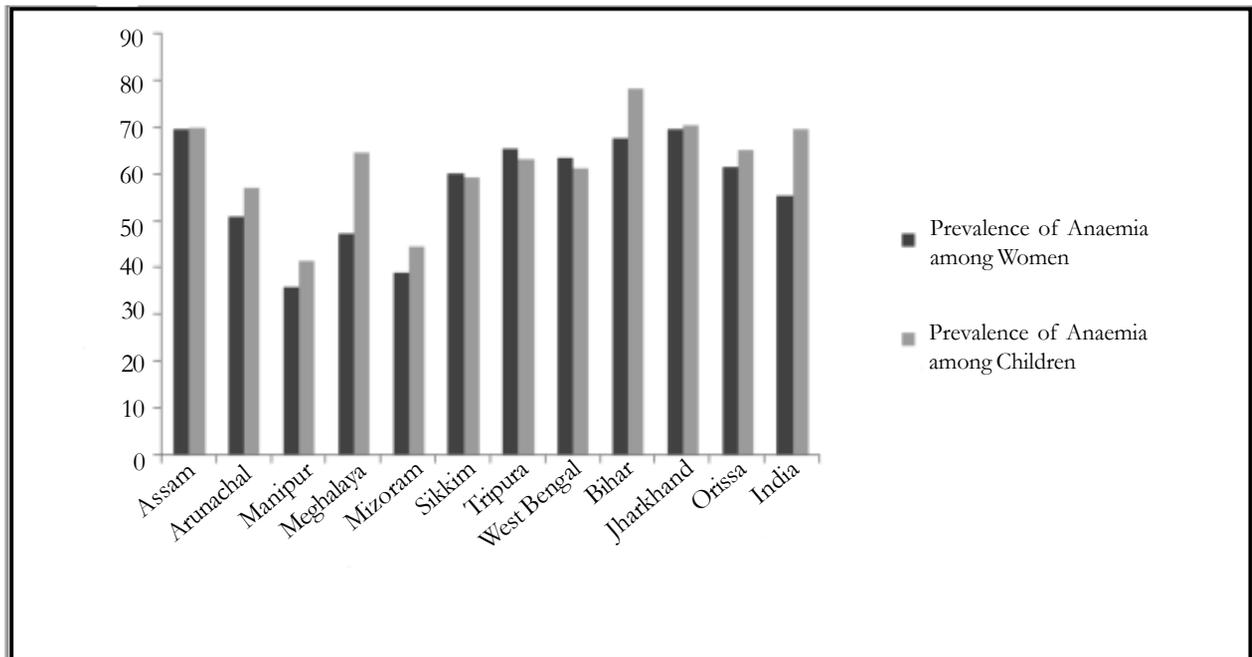
STATES	Prevalance of Anaemia among (in Per cent)		
	Children	Women	Men
Assam	69.6	69.5	39.6
Arunachal Pradesh	56.9	50.6	28
Manipur	41.1	35.7	11.4
Meghalaya	64.4	47.2	36.7
Mizoram	44.2	38.6	19.4
Nagaland	NA	NA	NA
Sikkim	59.2	60	25
Tripura	62.9	65.1	35.5
<b>West Bengal</b>	<b>61</b>	<b>63.2</b>	<b>32.3</b>
Bihar	78	67.4	34.3
Jharkhand	70.3	69.5	36.5
Orissa	65	61.2	33.9
India	69.4	55.3	24.3

Source: International Institute for Population Sciences (2005-06) *National Family Health Survey: India* (NFHS-III), Volume IA, IIPS, Mumbai.

The issue of gender differentiation and preference of a boy child to a girl child has been a constant factor in our society since time immemorial. Gender differences in health and nutrition are closely linked with differences in nutritional requirements, caused in turn by different physical activities. In addition, these differences can be the result of intra household resource allocation processes.<sup>12</sup> Amartya Sen points out that there are systematic disparities in the freedom that men and women enjoy in different societies and these disparities are often not reducible to differences in income or resources. While different wages or payment rates constitute an important part of gender inequality in most societies, there are many other spheres of differential benefits, e.g. in the division of labour within the household, in the extent of care or education received, in liberties that different members are permitted to enjoy.<sup>13</sup>

The fact that maternal malnutrition and ill-health has an enduring effect on the health of her offspring perhaps needs to be mentioned. This is exactly what the data suggest. The above graph displays that the prevalence rate of anaemia among women (aged 15-49 years) and children (aged 6-59 months) follows an identical pattern, – that is to say the states recording high maternal anaemia also record high anaemia among children. The opposite also holds true, with a high correlation of 0.84.

The rate of prevalence of anaemia has been found to be the highest among children, in comparison with the prevalence rates among women and men. 69.4 per cent of the country's children suffer from anaemia. Bihar, followed by Jharkhand and Assam, records the highest percentage of children suffering from

**Figure 3.1 Relation between Prevalence of Anaemia among Women and Children**

anaemia. Manipur, followed by Mizoram, registers the lowest. Manipur also records the lowest prevalence of anaemia among women. However even for this state there exists a noticeable difference amongst men and women in the prevalence rate of anaemia.

The picture of West Bengal remains quite grave with prevalence rate of anaemia among women being nearly 10 percentage points above the corresponding country average. Although it remains below the country average for the children, the situation demands immediate and urgent attention and action, especially in maternal health. Further, it can be clearly observed from the data that states with higher prevalence of anaemia among women also display similar trend in case of the prevalence rate of anaemia among children. Thus this clearly illustrates that maternal health is the foundation stone of a healthy society.

Social conditions determine the degree of limitation of freedom or autonomy. The greater the limitation the worse is the health status of the population. Improvement of material conditions and basic services explains why, for example, the civil servant has better health than the slum dweller. In both cases, however, low social position means decreased opportunity, empowerment, and security.<sup>14</sup> Poor health status is not only an evil in itself, it causes to multiply evils, by creating a sharp dividing line between the people on the basis of their capability to improve their health status – a capability which has close relation with the public health delivery system. Since the functioning or malfunctioning of the public health system results in facilitating or depriving the people from good health, it plays a major role in widening or narrowing gaps

in equity between the people. The next section explores this matter of health and social disadvantage in greater details.

#### NOTES

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## 4. Social and Economic Inequalities in Health

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In the Mahabharata<sup>1</sup>, Dharma disguised as a yaksha asks King Yudhisthira: “What is the greatest achievement of humanity?” The King answered decisively, “Recovery from ill health”.

The Mahabharata is not the only ancient text to have emphasised the role of health and healthcare in human development. Nevertheless, it is only recently that the concern for health has taken a “public” line, departing from its earlier, privileged-class exclusivity. And, with growing discourse on democracy and clarity surrounding the concept of development, the discussion and actions on public health have tended to follow a line that takes into account the social and economic diversities of a given region, and their implications on health. In Amartya Sen’s analysis, varying health status among different sections of the population is caused by their varying social and economic conditions. While “women emerge as systematically underprivileged vis-a-vis men”, this discrimination is further extended to different castes and classes.<sup>2</sup> The WHO Commission on Social Determinants of Health observes:

The poor health of the poor, the social gradient in health within countries, and the marked health inequities between countries are caused by the unequal distribution of power, income, goods and services, globally and nationally, the consequent unfairness in the immediate, visible circumstances of peoples’ lives – their access to health care, schools and communities, towns or cities – and their chances of leading a flourishing life. This unequal distribution of health-damaging experiences is not in any sense “natural” phenomenon, but is the result of a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics.<sup>3</sup>

India being a country with wide social and economic spectrum, regional and

several other diversities has perhaps become more acutely subjected to the implications of the “toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics.” It is perhaps uninformed politics that lead to poor financial allocation on health. But, at the same time, we must recognise that it is poor social policies and consequent implementational failure that add to an uneven delivery of public health services, where the medicalised view of health, with a high class-bias, reigns supreme. This results in an uneven development of the health facilities giving way to a burgeoning private sector. For example, according to recent statistics the number of hospitals grew from 11,174 hospitals in 1991 to 18,218 in 2003. But in this growth the public sector has gone down from 43 percent to 25 percent.<sup>4</sup> Again, in 2000, the country had 1.25 million doctors, but the ratio of doctors to population in rural areas is almost six times lower than that in the urban population.<sup>5</sup> Again, the ratio of hospital beds to population in rural areas is fifteen times lower than that for urban areas.<sup>6</sup> Per capita expenditure on public health is seven times lower in rural areas, compared to government health spending for urban areas. Only 17% of all health expenditure in the country is borne by the state, and 82% comes as ‘out of pocket payments’ by the people. This makes the Indian public health system grossly inadequate and under-funded. Only five other countries in the world are worse off than India regarding public health spending (Burundi, Myanmar, Pakistan, Sudan, and Cambodia).<sup>7</sup> This results in poor health achievement, which we will discuss presently focusing upon some indicators.

#### SURVIVAL INEQUALITY

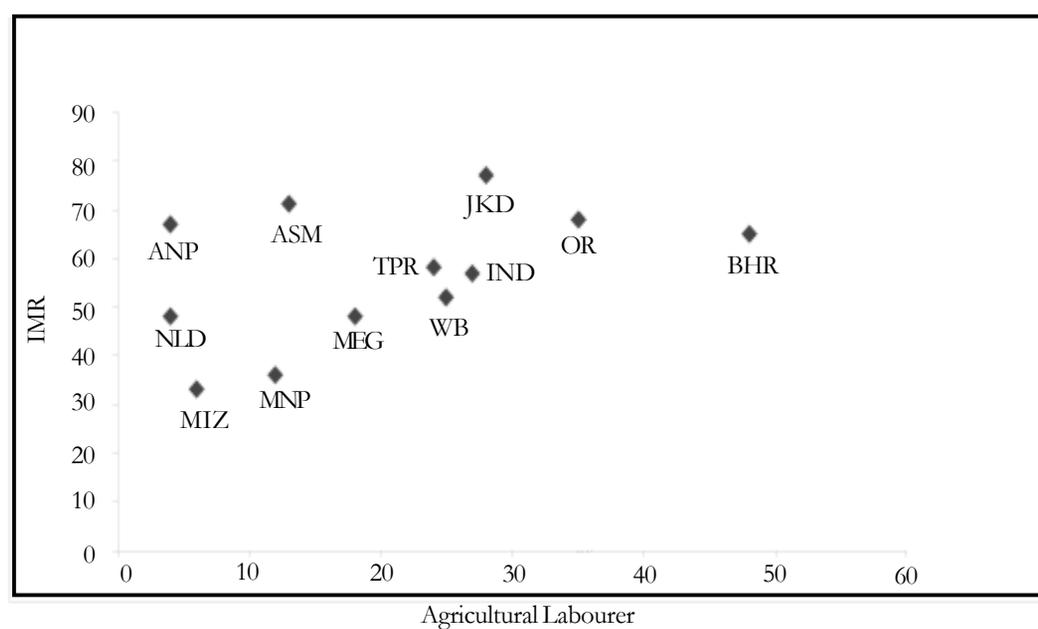
Let us begin first by underlining survival inequality. In a country where more than 50 children per thousand do not even see their first birthday, any public policy on health cannot but take serious note of this in order to improve the chances of survival of the children. And, while doing this one has to address the issues of social and economic variations. From the NFHS III data we can see the wide differences in infant mortality rate between various social and economic categories. There are, however, significant inter-regional variations in this respect even among the same social categories. This has perhaps resulted due to variations in the existing public policies regarding health.

SRS data are available for more recent years, but for the purpose of comparison between various social categories we have used NFHS data here, as SRS do not give us the disaggregated figures. It is quite clear that the more disadvantaged or lower a group’s social position, the worse the average health status of its members.

**Table 4.1 Infant Mortality Rate among different social groups and economic classes**

State	IMR (overall)	Residence		Social Groups			Economic classes (Wealth Quintiles)	
		Rural	Urban	Scheduled caste(SC)	Scheduled Tribe(ST)	Muslim	Lowest	Highest
Assam	71	73.5	50.6	81.7	59	80.4	95.4	17
Arunachal Pradesh	67	62.3	79.3	NA	67.6	NA	65.8	NA
Manipur	36	36.6	34.2	NA	51.2	59.8	NA	20.7
Meghalaya	48	49	42.8	NA	49.3	NA	89.7	26
Mizoram	33	36.8	29.3	NA	NA	NA	NA	26.2
Nagaland	48	49.7	43.3	NA	45.8	46.4	59.3	23
Sikkim	35.3	35.9	31.8	NA	28.9	NA	NA	31.7
Tripura	58	62.8	NA	57.4	NA	NA	NA	NA
West Bengal	52	53.7	46.4	38.8	NA	59.5	55.4	22.6
Bihar	65	65.2	63.4	71	NA	72.1	71.1	71.8
Jharkhand	77	83.3	47.1	76.7	93	61.2	83.2	27.2
Orissa	68	72.2	40.9	73.7	78.7	NA	79.8	28.3
India	57	62.2	41.5	66.4	62.1	52.4	70.4	29.2

Source: NFHS III,2005-2006

**Figure 4.1, Proportion of Agricultural Labourers and IMR in Selected States**

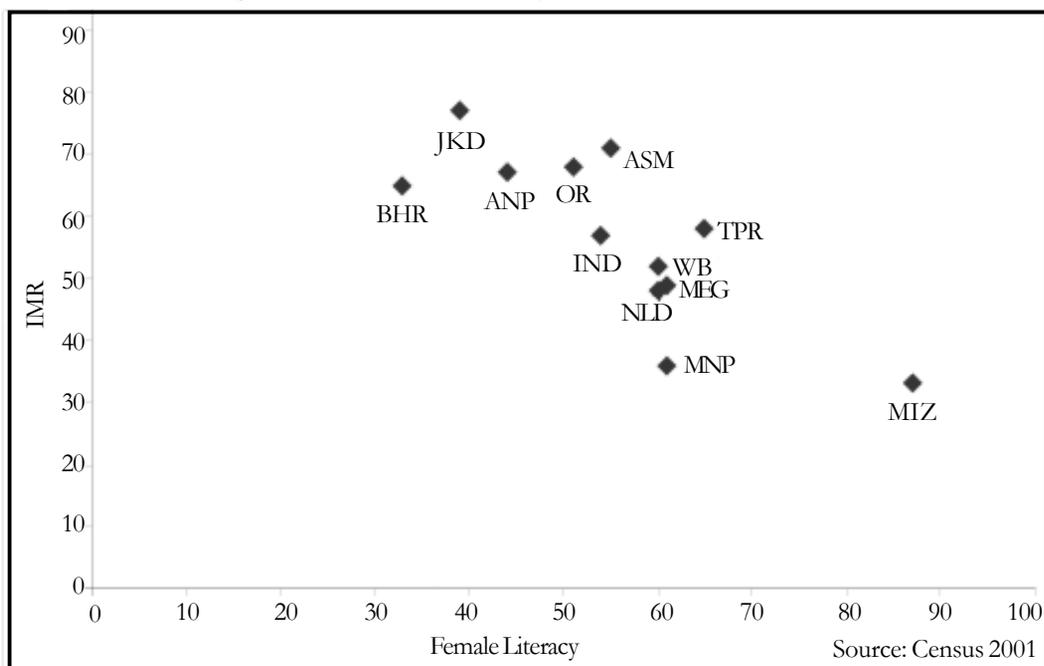
Source: Census 2001

According to the data presented in the Table 4.1 the infant mortality rate differs across different economic classes: children in the lowest wealth quintile are more than twice as likely to die before completing one year as the children in the highest wealth quintile. Importantly, there are regional variations in degrees of economic disadvantage, caused to a large extent by the differential in state attention on health. According to NFHS III data, in Orissa IMR is the highest in the lowest income group (79.8) and is the lowest among the highest income group (28). Let us take another example. The overall performance of West Bengal in reducing IMR looks promising, but with a substantial gap of 7.3<sup>8</sup> points between rural and urban areas in this respect, indicating poor policy focus on health in the rural areas, inhabited largely by the poor and socially disadvantaged groups. There is a strong indication that residing in rural India, belonging to a Scheduled Caste or a Scheduled Tribe, and having a low economic stature have become predictors of ill-health and health inequity in our country.<sup>9</sup>

From an analysis of the IMR<sup>10</sup> and Census data for the select states we find a very strong correlation between the proportion of agricultural labourer in the workforce and IMR. The correlation coefficient, (+ 0.51), implies that with higher proportion of agricultural labourers in the workforce, the IMR tends to shoot up.

Figure 4.1, clearly illustrates that the proportion of IMR has been considerably higher among the agricultural labourers – who according to Census data are more likely to belong to SC, ST or other backward classes and religious minorities. Also, a strong correlation between Female Literacy Rate (FLR) and IMR was found – the correlation coefficient of (-)0.61 is indicative of the negative association of women's access to primary level education and the mortality of their children.

**Figure 4.2, Female Literacy Rate and IMR in Selected States**



## NUTRITIONAL INEQUALITY

The story does not end here. Children who survive face gross nutritional discrimination leading to poor health of the population. Undernutrition has been a major concern in India and its inflated level is a matter of serious worry. Forty two per cent of children under five years of age are underweight which indicates their being denied of basic nutritional requirements in the very first years of their life.<sup>11</sup> In West Bengal thirty nine per cent are underweight suggesting chronic and acute malnutrition.

**Table 4.2 Nutritional Inequality among Children under 5 Years of Age in Different Social Groups and Economic Classes**

State	Overall	Residence		Social Groups			Economic classes (Wealth Quintiles)	
		Rural	Urban	Scheduled caste(SC)	Scheduled Tribe(ST)	Muslim	Lowest	Highest
Assam	36.4	37.7	26.1	43	18.2	43.6	42.1	7.8
Arunachal Pradesh	32.5	36.3	21	21.1	29.6	NA	41.6	8.6
Manipur	22.1	23.3	19.1	23.1	24.2	34.1	49.8	11.6
Meghalaya	48.8	50.3	39.6	NA	48.5	NA	57.8	27.8
Mizoram	19.9	24.1	15.1	NA	NA	NA	NA	10.3
Nagaland	25.2	26.6	19.3	44.3	23	40.9	41.1	8.1
Sikkim	19.7	19.4	21.2	36.9	18	NA	NA	23.8
Tripura	39.6	40.8	32.2	36.9	36.5	53.5	52	12.7
<b>West Bengal</b>	<b>38.7</b>	<b>42.2</b>	<b>24.7</b>	<b>40</b>	<b>59.7</b>	<b>40.3</b>	<b>50</b>	<b>8.1</b>
Bihar	55.9	57	47.8	69.6	NA	59.8	NA	NA
Jharkhand	56.5	60.7	38.8	56	64.3	51.4	62.8	16.6
Orissa	40.7	42.3	29.7	44.4	54.4	NA	53.3	10.2
India	42.5	45.6	32.7	47.9	54.5	41.8	56.6	19.7

Source: NFHS III, 2005-2006

Again, the regional contrasts in undernutrition are glaring: it is acute in Bihar (55.9 per cent) and Jharkhand (56.5 per cent), followed by Meghalaya (48.8 per cent), while the rate is much lower in Mizoram (19.9 per cent), Sikkim (19.7 per cent) and Manipur (22.1 per cent). Once again we find a connection between the nutritional level and the wealth index of the households. A decrease in family income appears to contribute to a higher percentage of underweight children. It reveals that children belonging to poorer families experience more nutritional deprivation than the relatively well off ones. The nutritional difference between the rich and the poor is the highest in West Bengal (41.9 percentage points).

Let us focus more closely on the nutritional condition in West Bengal. From the ICDS monthly progress reports (December 2009), it has been found that in

West Bengal 63 per cent of children comes under the normal grade and 33 per cent of children comes under grade I and grade II level which is moderately underweight and four per cent of children are in the grade III and grade IV level which is severely underweight. The district-wise variations in nutritional deficiency are wide: the proportion of children in the normal grade is comparatively higher in Darjeeling and North 24 parganas (75 per cent) and the percentage of children in the grade III and grade IV level is the highest in Paschim Medinipur (13 per cent).<sup>12</sup> The nutritional problem is comparatively lower among the Hindus than among the Muslims. In West Bengal the difference between the Muslims and the Hindus in this regard is of 2.6 percentage points (Hindu – 40.3, Muslim – 37.7), while in Tripura it is in the order of 17 percentage points (Hindu - 36.5 and Muslims - 53.5). As regards social identity, the nutritional deficiency is higher among the Scheduled tribes followed by the Scheduled Castes. In West Bengal the underweight children among SCs, STs and OBCs are 40, 60 and 23 per cent respectively. But Jharkhand has performed very poorly in this respect where underweight children among SCs, STs, and OBCs are 77, 79 and 67 per cent respectively.

#### PREVALENCE OF ANAEMIA AND THE SOCIO-ECONOMIC DIVIDE

Anaemia is a very common ailment in India, a direct result of nutritional deficiencies. Anaemia has a detrimental effect on the health of women and

**Table 4.3 Prevalence of Anaemia among children from different social groups and economic classes**

State	Overall	Residence		Social Groups			Economic classes (Wealth Quintiles)	
		Rural	Urban	Scheduled caste(SC)	Scheduled Tribe(ST)	Muslim	Lowest	Highest
Assam	69.6	70.8	60.5	77.2	77.2	67.4	77.3	40.6
Arunachal Pradesh	56.9	56.1	59.8	72.1	51.4	68.1	64	48.2
Manipur	41.1	41	41.3	49.7	40	51.2	32.9	35.4
Meghalaya	64.4	65.7	55.6	NA	48.5	NA	73.4	64.7
Mizoram	44.2	51.4	35.6	NA	NA	NA	84	31.3
Nagaland	NA	NA	NA	NA	NA	NA	NA	NA
Sikkim	59.2	58.1	65	60.1	59.9	NA	NA	57.6
Tripura	62.9	62.1	67.3	59.1	77.1	50.9	70	52.6
<b>West Bengal</b>	<b>61</b>	<b>63.8</b>	<b>48.7</b>	<b>65.9</b>	<b>86.3</b>	<b>61</b>	<b>69</b>	<b>36.9</b>
Bihar	78	79.4	67.1	82	NA	83.3	82.8	61
Jharkhand	70.3	73.3	56.9	76.8	79.5	68.9	76.5	47.2
Orissa	65	66.6	53.9	63.5	80.1	NA	75	41.7
India	69.5	71.5	63	72.2	76.8	69.7	76.4	56.2

Source: NFHS III, 2005-2006

children, and may become an underlying cause of maternal mortality and perinatal mortality. It also results in an increased risk of premature delivery and low birth weight of children. It is a serious problem for young children because it can result in impaired cognitive performance, behavioural and motor development, coordination, language development and scholastic achievement as well as increased morbidity from infectious diseases.

Despite such dire implications, our public policy has not yet been able to protect seventy per cent of children from becoming anaemic.<sup>13</sup> While there is no palpable gender difference in the prevalence of anaemia among children (the gap widens at a later stage), there is a close linkage with the anaemia status of their mothers. Almost fifty-five per cent of women in India suffer from some kind of anaemia.

That the social underdogs are more vulnerable to anaemia can be seen from the NFHS data. For example, in West Bengal the highest rate of anaemia is found among Scheduled Tribe or adivasi women (78 per cent) and correlatively also among Scheduled Tribe children (86 per cent)<sup>14</sup>, thus establishing the relationship between a mother's health and that of her biological child. Similar pattern is evident in the neighbouring states. It is observed that this prevalence of anaemia decreases with increase in female literacy and also with an improvement in the wealth quintile status. Promoting female literacy, therefore, appears to be one major social intervention in our attempt to enhance equity in health.

**Table 4.4: Prevalence of Anaemia among women from different social groups and economic classes**

State	Overall	Residence		Social Groups			Economic classes (Wealth Quintiles)	
		Rural	Urban	Scheduled caste(SC)	Scheduled Tribe(ST)	Muslim	Lowest	Highest
Assam	69.5	70.2	65.9	71.4	74.1	59.2	74	66.8
Arunachal Pradesh	50.6	49.7	53	69.6	41.6	58.5	52.8	53.6
Manipur	35.7	34.3	38.5	47.6	28.4	40.8	37.6	36.3
Meghalaya	47.2	48.7	42.7	38.2	47.9	50.4	63.7	38.2
Mizoram	38.6	48.3	31	NA	NA	NA	74.4	28.8
Nagaland	NA	NA	NA	NA	NA	NA	NA	NA
Sikkim	60	61.9	53.3	61.8	58.6	54.8	NA	56.5
Tripura	65	64.1	69.8	65.6	74	49.7	77.4	60.1
<b>West Bengal</b>	<b>63.2</b>	<b>64.8</b>	<b>59.4</b>	<b>66.8</b>	<b>78</b>	<b>61.3</b>	<b>68.8</b>	<b>55.5</b>
Bihar	67.4	67.6	66.7	71.8	NA	68.1	71.4	59.8
Jharkhand	69.5	73.3	58.6	72.6	85	61.8	76.6	55
Orissa	61.2	62.3	55.9	64.2	73.8	57.6	69.2	47.9
India	55.3	57.4	50.9	58.3	68.5	54.7	64.3	46.1

Source: NFHS III, 2005-2006

There appears a wide gender gap in the level of anaemia among adults: while anaemia among women in the country is 55 percent it is found to be 32 per cent among men. The states under consideration, all exhibit a similar pattern (excepting Manipur discussed in detail in the previous section). Again, anaemia is found to be higher in rural areas, among children with illiterate parentage, men, women and children belonging to scheduled caste and scheduled tribe communities, and, obviously, among the poor.

#### INEQUALITY IN ACCESS TO HEALTHCARE

Large scale surveys have observed that a higher percentage of poor do not seek care when ill. The reasons vary from lack of adequate health facilities in the vicinity to long waiting times to financial reasons; thus covering the entire gamut of inequality. A recent study has shown that people belonging to the higher economic classes use their personal reference to ‘manage’ better facilities and health care at the hospitals. Despite being ineligible for BPL cards, they use these cards to avail free services.<sup>15</sup>

Not much seems to have changed over time in terms of improved access to treatment for those who belong to the low income groups. Although services are available, the very focus of these public health facilities, namely, cheap and free services to the traditionally disadvantaged and the impoverished, has somehow become lost over time, leaving them with no option other than depending on the unqualified private medical practitioners for their basic healthcare requirements. Various studies have addressed this basic issue of the problem of access to health care delivery. Unfortunately, however, as we can see, the picture has still remained largely the same. Age-old problems still exist within our delivery system, and despite numerous attempts, much remains to be achieved. People associated with the public health sector in India are aware that this gap can be bridged through education, remunerated work, better housing condition, better distribution of economic resources, improved quality of care in family planning and so on. However the very core of the problem – efficient implementation and equitable distribution – has even now remained a distant dream. We have discussed this issue of access in detail in the next section.

#### NOTES

1. In this episode of the Mahabharata, Yudhisthira is faced with the corpses of his four brothers, and a yaksha with an array of question. The only way he can bring his brothers back to life is by answering the questions to the yaksha’s satisfaction.
2. Sen, A (1999) *Development as Freedom*, Oxford University Press, Oxford
3. Marmot, Michael (2008), “Closing Gap in a Generation: Health Equity through Action on the Social Determinants of Health, Final Report of the Commission on Social Determinants of Health Chaired” WHO.
4. Central Bureau of Health Intelligence. Directorate General of Health Services, Ministry of Health and Family Welfare. Health Information of India 2000&2001.
5. Central Bureau of Health Intelligence. Directorate General of Health Services, Ministry of Health and Family Welfare. Health Information of India 2000&2001.

6. Central Bureau of Health Intelligence. Directorate General of Health Services, Ministry of Health and Family Welfare. Health Information of India 2000&2001.
7. World Health Organisation. The World Health Report 2003.
8. NFHS3, West Bengal, 2005-2006.
9. One qualification is in order: while the general socio-economic condition of the Scheduled Tribes is abysmal in large parts of the country, the situation appears to be different in the north-eastern states, in some of which the STs constitute the majority, in the rest of the country there is a strong connection between the numerical marginalisation of the STs and their socio-economic deprivation. However, it is not because of their numerical strength alone that the STs of the north-east have a better status than their counterparts in the plains. There are surely other connections, including the historical legacies of missionary activities and other cultural norms.
10. We have used the Census 2001 data as the Census 2011 data are yet to be available in disaggregated details and compared them with NFHS III data; the reference years for the two data sets, namely, Census 2001 and NFHS III, 2005-2006 allow us to make this comparison. The SRS data are more recent but it may not be wise to compare the SRS figures, with Census 2001 data.
11. NFHS 3, INDIA, 2005-2006
12. ICDS, MPR, January, 2011
13. NFHS 3, India, 2005-2006
14. NFHS 3, West Bengal, 2005-2006
15. "Hospital Efficiency in West Bengal"; Arijita Dutta, Department of Economics, Calcutta University, 2011, presented at a seminar of the same name at Swasthya Bhawan, Kolkata on 21st June, 2011.

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## 5. Public Healthcare: Resources, Access and Functioning

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Health care is essentially a public intervention: the history of human development in the modern world is inalienably connected with the spread of public health facilities. The higher the peoples' access to public health care the better the prospect of human development. Development trajectory of Europe or America or Japan or China has followed a steady path of ensured public health care facilities. We can even take the example of Kerala - the Indian state which has outnumbered some of the developed nations in terms of health indicators, as well as other human development indicators. Despite having a lower per capita income Kerala could raise its human development status to a level comparable with the developed countries, and public health care has had its influence in this achievement.

Although India's health care system has seen some improvement in the last few decades there is not much disagreement on the less-than-desirable pace of progress that we have achieved. While the poor record in the health sector is attributed mainly to the lack of public funding on health, there are other reasons including the managerial efficiency of the government health departments to utilize the available resources, lack of coordination between health and other important programmes, such as women and child welfare. Because of a staunch disease-centric and medicalised view of health the public health care delivery system is also largely seen as hospital based infrastructure. This leads to a neglect of the ground level health care systems that not only take care of the curative aspects of health but give primacy to the preventive and educative parts of health. In developed countries health care education is essential to provide the information about health care methods to ensure the overall well being of the society. On these counts, India, excepting a few parts, has largely been performing poorly. That a substantial part of our population fail to avail the basic health care facilities is explained not only by the poor coverage of the services, but

often it is caused by informational asymmetry and lack of health awareness.<sup>1</sup> As has been found in many studies, often people, particularly women, did not visit any health facility for they thought it was not necessary.<sup>2</sup> Therefore, it is not only the question of existence of health infrastructure, which is of course crucial, but also a question of their effective utilization, which is connected with many different aspects including spread and level of education, extent of other public programmes, such as food and nutrition, public awareness and activism and so on. Nevertheless, given the vastness of the subject but the paucity of data, we focus in this section mainly on the extent of health services in the states under consideration and peoples' access to those services.

#### THE ANGANWADI CONNECTION

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Let us begin with the Anganwadi centres, the lowest level units that could play a crucially important role for the improvement of child health, as could be seen from the Tamil Nadu experience. The ICDS has six distinct but inter-related and complimentary functions, including Supplementary Nutrition, Pre-school Education, Immunization, Health Services, Nutrition and Health Education, Kishori Shakti Yojana.<sup>3</sup> A comparison between Tamil Nadu and Uttar Pradesh shows that while the functioning of the ICDS in the former has resulted in placing it as one of the top performers, the poor performance of the latter in this regard has pulled it down to one of the worst achievers in the country.<sup>4</sup>

That the functioning of the Anganwadis has a clear bearing on the status of health can be seen from relevant data from our study states. An analysis of NFHS III data on the extent of Anganwadi services (actual percentage of population reported to have received the services) and indicators like anaemia among women and children and status of child nutrition brings out clearly this connection: the correlation coefficient between extent of Anganwadi services and prevalence of anaemia among women was found to be (-) 0.051; the corresponding figure for the children was (-) 0.28. This implies that the higher the extension of the services the lower the prevalence of anaemia among women and children. Anaemia among women, again, has a strong bearing on Infant Mortality Rate (IMR).<sup>5</sup>

Despite such an important role that was envisaged for the ICDS at its launching in 1975 – and the role its occasional success has to some extent actually played – access to this service was extremely limited till the beginning of this century. The coverage of ICDS in most of the states did not reach 25 percent even in 2004-5, some years after the Supreme Court had passed an order to universalize the programme<sup>6</sup>. And even today, when most of the states have complied, to a large extent, with the Supreme Court order, some states, such as Bihar, have not yet extended the coverage to more than 50 percent.<sup>7</sup> The latest figures on the all India level implementation of the ICDS programme also show that there is still a large gap in the coverage of this programme: as on December 2010, the gap between the sanctioned (1366776) and operational (1241749) ICDS centres was 125027.<sup>8</sup> The above does not, however, give us the actual gap, which seems to be much larger.

**Table 5.1. Services of Anganwadi, Anaemia among Women and Children, and IMR**

States	Percent of children received any service from AWC*	Status of anaemia among women**	Status of anaemia among children***	Percentage of Underweight children****	IMR
Assam	27	70	70	36	61
Arunachal Pradesh	10	51	57	33	32
Manipur	28	36	41	22	16
Meghalaya	22	47	64	49	59
Mizoram	53	39	44	20	36
Sikkim	35	60	59	20	34
Tripura	27	55	63	40	31
Bihar	9	67	78	56	52
Jharkhand	39	70	70	57	44
Orissa	61	61	65	41	65
West Bengal	38	63	61	39	33

\*Children under age six, \*\*Women between 15-49years, \*\*\*Children between 6-59months, \*\*\*\*Children under 5years.  
Source: NFHS III and SRS 2009

The incompleteness of the physical coverage is further aggravated by the poor delivery of the ICDS centres – across the country barring a few states. The ICDS centres, which are supposed to deliver a range of services aiming to improve overall status of women and children, have actually been reduced to “khichri centres” – centres supplying some sort of supplementary food, often unpalatable, to the women and children.<sup>9</sup> All other services including the crucially important health services and health awareness programmes largely remain neglected. The neglect of the pregnant mothers and the children takes its toll, as shown by Amartya Sen,<sup>10</sup> by reducing the possibility of well being of the whole population.

#### UNCARED-FOR BIRTH

The shortening of the prospect of well being starts well before a child is born. The deprivation is rooted in generational undernourishment of the mothers, whose growing up is characterized by underfeeding and subsequent undernourishment. In addition to these deprivations that result in several deficiencies among the children they give birth to, what aggravates the situation further is natal services – both before and after child birth.

As the NFHS III data show, almost half of the women of the country (48 percent to be exact) who gave birth preceding the survey had not had any Antenatal Care (ANC) Visit. Nevertheless, there were wide state-to-state differences in this respect in the study states. The poorest performer in this

### Box 5.1. Differences made by the reach of public health care: a tale of two neighbouring districts

That the reach of public health facility makes a major difference not only in health status but also in the overall behavioural pattern of health is amply proved by the Kerala experience where the existence of a well organized public health care system has resulted in creating a competitive health care system posing a challenge before the private market to deliver better for a charge lower than what prevails elsewhere in the country\*. The Pratichi Health Report, published in 2005, showed this even more emphatically. A comparison between two neighbouring districts, Birbhum of West Bengal and Dumka and Jharkhand showed that while both the districts had many things in common there was a marked difference between the public health delivery systems of the two districts – the public health delivery mechanism in Birbhum, in many count, was poor, but in Dumka it was almost non-existent.

Even the poor, but existent system in Birbhum vis a vis the non-existence of it in Dumka seemed to have created a huge difference between the health care practices in the two places: In Dumka and Birbhum the dependence upon quacks and *kavirajs* together were 75 percent and 31 percent; proportion of patients visiting public facilities for treatment were 12 percent and 29 percent; and proportion of patients seeing private qualified doctors were 11 percent 33 percent respectively

More glaring difference was found in the pattern of seeking treatment by the women: In both the districts majority of the patients who did not receive treatment were women, but the degree was much higher in Dumka (75 percent) than in Birbhum (62 percent). The absence of public health facilities has also resulted in restricting the extent of institutional delivery: while in Birbhum it was 47 percent, in Dumka it was only five percent.

\*Chakraborty Achin (2005) “Health Care in West Bengal: Confused Policy of Public Private Partnership” Economic and Political Weekly, January 29

\*Chakraborty Achin & Subrata Mukherjee (2003), “Health Care in West Bengal: What is Happening?” Economic and Political Weekly, November 29

Source: *The Pratichi Health Report* with an Introduction by Amartya Sen, Pratichi Trust, in association with TLM Books, Delhi, 2005

**Table 5.2. Maternal Care and Institutional Delivery (According to NFHS III)**

	% who had 3 or more ANC visits	% who were given or bought IFA	% who took IFA for 90 days	% of births delivered in a health facility	% of deliveries assisted by health personnel
Assam	39.3	62.1	16.2	22.4	31
Arunachal Pradesh	35.5	47.7	11.2	28.5	30.2
Manipur	68.6	65.2	13.1	45.9	59
Meghalaya	54	54.7	16.7	29	31.1
Mizoram	59.3	61.9	24.7	59.8	65.4
Nagaland	32.7	25.6	3.5	11.6	24.7
Sikkim	70.1	86.4	38.7	47.2	53.7
Tripura	60	68.8	18	46.9	48.8
West Bengal	62	81.9	25.7	42	47.6
Bihar	17	29.7	9.7	19.9	29.3
Jharkhand	35.9	49.5	14.2	18.3	27.8
Orissa	61.8	83.1	33.8	35.6	44
India	52	65.1	23.1	38.7	46.6

Source :NFHS III, 2005-2006

regard was Bihar, with only 17 per cent ANC visits, while the best performer was Sikkim with 70 per cent.

The ANC visit is not only important from the point of view of counseling during pregnancy but also seems to have a positive implication on institutionalizing the deliveries. As a general pattern, states that have performed relatively well with regard to ANC visits (Sikkim, Manipur, West Bengal, Orissa, Tripura, Mizoram) have also had better figures for institutional delivery. There is a tendency in public domain to club the north eastern states together. This unfortunately leads us to overlook some of the major variations and complexities in the health sector of the sample states. Sikkim tops the list of ANC visits while Nagaland is placed just above Bihar; as regards institutional delivery Mizoram appears to be the best performer while Nagaland, again, is found at the bottom of the list. There are many things to learn from these facts: given the geographical adversities the north eastern states face their general performance in birth-care, in comparison with some states of the plain, is found to be quite encouraging. If one reason behind this success is better infrastructure, which we will discuss presently, the other factor could be higher literacy rate. At the same time, the general performance of the north eastern states is skewed by the lower achievement of Nagaland, Assam and Arunachal Pradesh. The reasons behind the deviation from the general pattern could be varied: from political unrest to complex demographic composition and a multifaceted inter-connection of various factors. Nevertheless, the states in the plains, not just Bihar and Jharkhand, but also Orissa and West Bengal can take some lessons from the achievements of the “smaller” north-eastern states.

#### DEFICIENCIES IN PROMOTIONAL AND PREVENTIVE MEASURES

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The inadequacy of the services related to child birth is exacerbated further by the fragility of the immunization services. A pattern of full immunization emerges from different surveys including NFHS III, and Coverage Evaluation Survey, done by UNICEF; these studies show a varied achievement of the North eastern states, where Sikkim tops the list of all the states under consideration. Arunachal Pradesh and Nagaland appear to be the poorest performers

#### FRAIL PUBLIC HEALTH INFRASTRUCTURE

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A general pattern of the status of public health and the level of utilization of public health services emerges from the above discussion and also in the other sections of this report, namely that, health indicators are better in some of the north-eastern states than in the states in the plains. This pattern fits to a substantial extent with the extent of public health infrastructure provided in the states. For public health is much more dependent on the primary facilities than on the tertiary and secondary ones. It is the availability of these primary facilities including the sub-centres, the lowest level health facility, and the primary health centres that play a determining role in public health achievement. The better performance of some of the north eastern states is closely linked with their better provision

### The West Bengal Puzzle

In spite of a high proportion of underage marriage & pregnancy, high prevalence of anaemia during pregnancy, low consumption of iron tablets during pregnancy, relatively low institutional delivery rate and low participation in household level decision by women, West Bengal has managed to lower its Maternal Mortality by 27.3 percentage points between 2001-2003 and 2004-2006 - as per RGI Special Survey. The drop is the sharpest among all states in the country. At 141 maternal deaths per 100,000 live births, it comes after Kerala (95), Tamil Nadu (111) and Maharashtra (130) among the bigger states leaving behind Gujarat, Punjab & Andhra Pradesh. This is in spite of the fact that the latter three states fare better than West Bengal in most of the indicators, which directly or indirectly influence maternal mortality ratio, yet fail to bring down their MMR to the level that West Bengal has achieved. What is most surprising is that institutional delivery which is considered to be one of the most important interventions for reducing maternal deaths has increased by only 3 percentage points in West Bengal during the period between 1998 and 2005 (NFHS 2 & NFHS 3), while all the other states mentioned above had a much higher increase in institutional births. Incidentally, female literacy rate of all the above mentioned states ranges between 70-75 per cent except Kerala which is much higher and Andhra Pradesh, which is much lower.

In terms of achievement in infant mortality reduction West Bengal (33 per 1000 live births-SRS 2009) appears to be fourth best performer among the larger states, with only Kerala (12), Tamil Nadu (28) and Maharashtra (31) faring better. This is happening in spite of a high prevalence of undernutrition in West Bengal.

Given these contrasting records in health achievement there is a strong case for further inquiry into how West Bengal has brought down its MMR so significantly, while some other states with apparently better performing health systems have not.

*Contributed by: Kaninika Mitra  
UNICEF, Kolkata*

**Table 5.3 Immunization Coverage**

STATES	Full	No	Full	No
	Immunization	Immunization	Immunization	Immunization
	According to NFHS III		According to Coverage Evaluation Survey, UNICEF, 2009	
Assam	31.4	15.2	59.1	8.1
Arunachal Pradesh	28.4	24.1	24.8	25.7
Manipur	46.8	6.5	51.9	11.9
Meghalaya	32.9	16.5	60.8	9.3
Mizoram	46.5	7	73.7	7.2
Nagaland	21	18.4	27.8	31.6
Sikkim	69.6	3.2	85.3	3.3
Tripura	49.7	14.7	66	1.8
West Bengal	64.3	5.9	64.9	4.8
Bihar	32.8	7	49	15.2
Jharkhand	34.2	4.4	59.7	5.4
Orissa	51.8	11.6	59.5	5.8
India	43.5	5.1	61	7.6

Source: NFHS III, 2006-2006, UNICEF 2009

of primary level health facilities. As can be seen from Table 5.4. The better achievers in public health like Sikkim, Manipur and Mizoram have far more number of sub-centres than “required” under the norm. On the other hand, one of the poorest achievers, Nagaland, has a deficit of sub-centres. This correlation does not however apply to Arunachal Pradesh and the deviation from the pattern needs further examination, which this report does not delve into.

Since public health is more connected with preventive and educative deliveries the health sub-centres play a crucially important role here. As a Pratichi Trust study in Dumka district of Jharkhand<sup>11</sup> and an interventional project<sup>12</sup> by the same organization found, the availability of the sub-centres within the reach of the community makes a major difference in public health. This happens in at least two ways: first, ensured maternal and child care services and other basic health interventions result in actual improvement of health status; and second, it generates increased demand for and utilization of the Primary Health Centres (PHC), Community Health Centres (CHCs), etc.

The general trend of paucity of health facilities at the grass roots level is further implicated by the non-availability of health workers in or around the villages. Even though ANM deficiency for the country as a whole is five percent, this may have serious implications for sections of population, who, as various experiences show, belong to marginalized groups. Another major problem that

**Table 5.4. Health Infrastructure in Selected States**

	REQUIRED		IN-position		Deficit (-) denotes excess	
	Sub-Centre	PHC	Sub-Centre	PHC	Sub-Centre	PHC
Assam	5063	826	4592	844	471	(-)18
Arunachal Pradesh	254	39	592	116	(-)338	(-)77
Manipur	412	64	420	72	(-)8	(-)8
Meghalaya	597	90	401	103	196	(-)13
Mizoram	146	22	366	57	(-)220	(-)35
Sikkim	109	17	147	24	(-)38	(-)7
Nagaland	535	80	397	86	138	(-)6
Tripura	659	104	579	76	80	28
West Bengal	12101	1993	10356	924	1745	1069
Bihar	14959	2489	8858	1641	6101	848
Jharkhand	5057	806	3958	330	1099	476
Orissa	7283	1171	6688	1279	595	-108

(Source: Rural Health Statistics in India 2009, Statistics Division, Ministry of Health and Family Welfare)

the public health infrastructure in the country faces is the irrationality in the arrangement of the infrastructure. One glaring example of this irrationality is the inconsistency in the number of facilities and personnel. While some of our selected states are deficient in sub-centres they have excess ANM, in some cases it is just the opposite.

#### HEALTH WORK FORCE DISTRIBUTION

The very foundation of an effective, efficient and equitable health care system rests on its ability to adequately distribute its health work force. The quality, composition, and distribution of the health workforce are widely recognised as a crucial determinant of health system performance<sup>13</sup> and of maternal and child health outcomes<sup>14</sup>. Maldistribution of health workforce hampers progress towards the Millennium Development Goals and contributes to inequalities in health outcomes<sup>15</sup>. Today all countries face the problem of shortage of health

**Table 5.5. Deficit of Auxiliary Nursing Midwife (ANM)**

State	Required	In Position	Deficit
Arunachal Pradesh	592	217	375
Assam	4592	7270	(-)2678
Bihar	8858	7672	1186
Jharkhand	3947	6435	(-)2488
Manipur	420	840	(-)420
Meghalaya	401	404	(-)3
Mizoram	370	426	(-)56
Nagaland	397	621	(-)224
Orissa	6688	4051	2637
Sikkim	147	209	(-)62
Tripura	579	377	202
West Bengal	10356	12966	(-)2610
India	145894	172176	8484

(Source: Rural Health Statistics in India 2009, Statistics Division, Ministry of Health and Family Welfare)

work force. However more than shortage, the problem that persists in modern India is the acute imbalance in its allocation of human resources. While the urban centres are being over-staffed, a completely contradictory picture can be observed in their rural counterparts. We know that several factors contribute towards explaining this uneven distribution of the health workforce such as the distribution of health facility infrastructure, poor working and living conditions

in rural areas, and the concentration of income-earning opportunities in urban and more prosperous areas etc which make it less likely for the doctors and nurses to relocate themselves to work in remote areas or isolated islands<sup>16</sup>.

It is also well-known that the responsibility of delivering health services falls primarily on the health workers, making them critical for any well functioning health system. The ability of health workers to provide services to different socioeconomic groups, their technical competence and motivation with which they perform their jobs – all contribute to improving health system performance and the health of the people. Recent studies have shown that greater availability of health workers is associated with better service utilization and health outcomes such as immunisation coverage, outreach of primary care and infant, child and maternal survival<sup>17</sup>. Further, higher density of female health workers has also been found to be significantly associated with greater use of ante-natal care and attended deliveries<sup>18</sup>. Thus, the availability of a qualified health workforce is a crucial determinant of a health system's capacity to deliver services to the population. More important is to determine its proper and effective distribution.

In India the largest proportion of medical and paramedical professionals practice in the for-profit private sector, which tends to be concentrated in the urban areas. This sector focuses primarily on the delivery of curative health services, for which there is a huge demand. The public sector is thereby left to cater to the grossly neglected rural population of our country. In addition, the rural and poor urban dwellings are often served by private providers, often without much or any medical or health education, and a recognized qualification or registration<sup>19</sup>. In rural areas, especially villages, there is a widespread presence of practitioners who do not have a professional qualification in any recognized system of medicine, indigenous or allopathic, popularly referred as “quacks” but who provide these people with a ray of hope in times of need. This vast reservoir of practitioners provides a significant proportion of curative health care to rural, low income and less empowered areas of the country and to economically disadvantaged populations in urban areas as well<sup>20</sup>.

The level of lack of health infrastructure is perhaps much deeper than what appears from the state level data.

Let us look at Box 5.2

Apart from these paucities, the distribution of the facilities at the sub-state/district level seems to suffer from unevenness. The District Level Household Survey Phase III (DLHS III) data show that while on an average in West Bengal the percentage of villages having sub-centres is 38.6 percent, the lowest and highest figures are 17.4 and 73.2 respectively. Similarly, while the state average of ANM/FHW available at sub-centres is 89.7 per cent, the highest and lowest limits are 100 and 73.2 respectively.

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#### FREQUENT OCCURRENCE OF PREVENTABLE DISEASES

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As a result of the feeble public health infrastructure at the grass roots level the population suffers from certain diseases which could easily be prevented. One such disease is diarrhoea. Acute diarrhoeal disease, with its accompanying

**Box 5.2. Condition of Health Centres in West Bengal (2007-2008)**

Out of 10356 sub-centres:

- \* 6195 (60 %) do not have own building
  - \* 151 (1.5%) of them are run without any Auxiliary Nursing Midwife (ANM); and 70 percent of them (7205) are run with only one ANM, and about half of them (5000) are run without Health Worker (Male)
  - \* 7046 (68 %) of them do not have regular water supply, and 3524 (34 %) have no electricity.
  - \* Although 2453 sub-centres reportedly have ANM quarters, there are only 52 cases where the ANM actually lives in the allotted quarter. Again, only in 289 cases the ANM is reportedly living in the village where the sub-centre is located.<sup>21</sup>
- Again when we move to 909 functioning PHCs of West Bengal:
- \* Not a single one of them has 3 or more doctors; and 740 (81.4%) are run with single doctors, while there are four PHCs which do not have doctor at all; only 72 (8%) have female doctors;
  - \* Only 165 (18%) of them have 24X7 service availability; only these have round the clock delivery facility;
  - \* Only 415 (46%) of them have 10 or more beds;
  - \* While none of them has any laboratory, 5(1 %) has laboratory technician;
  - \* 744 (81 %) of them have no Operation theatre.

Source: District Level Health Survey (DLHS) Phase III, 2007-2008.

**Table 5.6. Percentage of villages having sub-centre within village and ANM available in them in West Bengal districts (District level Household Survey-3, 2007-08, West Bengal)**

District	% of Villages having sub-centre within the village boundary	ANM/FHW available at sub-centre
Darjeeling	42.4	100
Jalpaiguri	73.2	73.2
Koch Bihar	42.2	97.7
Uttar Dinajpur	25	92.9
Dakshin Dinajpur	23.3	90.5
Maldah	30.4	93
Murshidabad	43.2	95
Birbhum	47.8	91.1
Barddhaman	50	81.8
Nadia	51.3	83.8
North 24 Parganas	43.5	95.7
Hugli	27.3	91.2
Bankura	17.4	93.3
Puruliya	28.9	83.7
Paschim Medinipur	24.5	89.6
Purba Medinipur	26.5	84.4
South 24 Parganas	57.1	94.7
Haora	64	88
<b>West Bengal</b>	<b>38.6</b>	<b>89.7</b>

Source: DLHS III, West Bengal, 2007-2008

dehydration, has remained a challenging problem in the third world countries especially among children under five years.<sup>22</sup> The WHO estimates that 4 million children under five die each year in diarrhoea mainly in the developing countries.<sup>23</sup>

According to the NFHS 2005-2006 report, in West Bengal 6.5 per cent of children-under-five are suffering from diarrhoea. The prevalence is very high among the Muslims (8.3 percent) followed by the Adivasis (7.6 percent). Appalling as it is, only 67.4 per cent of the children are taken to a health provider and 52.3 per cent were given ORT and 17.3 per cent were given no treatment when affected by it.

The prevalence of affected children under five is the highest in Sikkim (16.5 per cent). 33.4 per cent were taken to a health provider and 47.7 per cent were given ORT. 24.2 per cent affected children did not get any kind of treatment at all. Meghalaya has shown a good result where only 5.7 per cent of children are affected and almost 72.2 per cent were taken to a health provider. 72.1 per cent were given ORT.

This is just one example, and one can find several such. Hundreds of thousands of rural and urban poor are forced to depend either on their own fate or on the whims of the private sector. It is through the existence of and access to universal public health services that a country can claim to achieve its most basic health development goals

#### NOTES

- 1 As Imrana Qadeer puts it : “Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self determination. It forms an integral part for both of the country’s health system, of which it is the central function and main focus, and of the overall social and economic development of the community with the national health system bringing health care as close as possible to where people live and work and constitutes the first element of a continuing health care process.” See, Qadeer, Imrana (2011), *Public Health in India: Critical Reflections*, pp. 9-10, Daanish Books, Delhi
2. See, *Pratich Health Report, with an Introduction by Amartya Sen*, Pratichi Trust in association with TLM Books, Delhi, 2005
3. Government of India (1986), *A Guidebook for Anganwadi Workers*; Department of Women and Child Development, Ministry of Human Resource Development, Government of India, Delhi.
4. See, Focus on Children Under Six (FOCUS), Citizens’ Initiative for the Rights of Children Under Six, Delhi, 2006, p68 and p 22. Just take the case of Infant Mortality Rate: while, according to NFHS III, the IMR in Tamilnadu was 30, in Uttar Pradesh it was 73.
5. When we exclude West Bengal from the analysis the figure goes up to 0.58. Indeed, the case of West Bengal calls for more nuanced inquiry: while the extent of anaemia among women in West Bengal was 63 percent the IMR was 33 per thousand, a figure close to the advanced states like Tamil Nadu.
6. PUCL Vs the Union of India and Others, Civil Writ Petition, 196/2001

7. Ghosh PP and K Rana (2011), *Status of Elementary Education in Bihar*, Pratichi Trust and ADRI, Delhi and Patna.
8. Website of the Department of Women and Child Development, Ministry of Human Resource Development, Government of India, last updated 02.02.2011
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19. The Pratichi Health Report; Rohde and Vishwanathan, 1995; Das and Hammer, 2004; Gautham, 2006
20. Rohde and Vishwanathan, 1995; Verma et al, 2001
21. All figures are collected from *Rural Health Statistics*, as on 31.03.2010, Department of Health and Family Welfare, Government of West Bengal.
22. P. Mohapatra et al, Diarrhoea, A raid on under five children. *Indian Journal of Preventive and Social Medicine*, Vol. 22,3-4,1991.
23. <http://www.who.int/abotwho/en/preventing/diarrhoeal.htm>

## 6. Expenditure on Health and the Burden of Treatment

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Shortcomings in health and healthcare cannot be solely attributed to shortfalls in finances. Still, there is no denying that resources and funds, public expenditure on health in particular, play a major role in either enhancing or impeding people's freedom to enjoy good health. Put very simply, there are at least two important issues to consider here. First, public expenditure on health – its magnitude and distribution – may crucially determine whether such financing is fair or not, whether such fiscal tool is being used for egalitarian health reforms. Second, household or out-of-pocket expenses on health – already quite high in most parts of India rendering health almost a private commodity – may result in what is called 'impoverishing care'. To put it differently, care or treatment may itself generate a debilitating burden, apart from the burden of disease.

In this section we look at both public health expenditure patterns in the selected states as well as household expenditure and its differentials across various economic classes and social groups. Some of our discussion here focuses on the all-India scenario, since state-wise data on income classes and social groups and their spending patterns are not easy to come by.

### LOW PUBLIC EXPENDITURE ON HEALTH AND INCREASING DEPENDENCE ON PRIVATE HEALTH CARE

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In a stratified and hierarchical society the economic and social disadvantages make the poor and powerless much more vulnerable to undernourishment, disease and degraded health. And their attempts at coming to terms with illness – generally when it becomes so severe as to make working and earning a living impossible – force them to encounter the inequalities in the health services system, which further deprive them of minimum well-being.

The financial implications of ill health can be severe: it can deepen poverty as well as increase the number of people living below the poverty line. Estimates based on household consumer expenditure surveys for India suggest that the financial burden imposed by health-related spending could raise the proportion of people living below the poverty line in India by as much as 3.3 percentage points. Given the financial consequence of ill health, the poor opt for care only when felt absolutely necessary.

Evidence shows that when sick, poorer groups are less likely to seek care than richer groups, and nearly one-quarter of the poorest 20 per cent in India's rural areas forgo treatment when reporting sick.<sup>1</sup> And, as a Pratichi Trust study found, the likelihood of not receiving treatment is much higher among women than men.<sup>2</sup> And again, there are wide socio-economic differences related with the actual receiving of healthcare: while the rich – and men – are more likely to see private qualified doctors at the so-called modern super-specialty hospitals, the poor – and women – are left with unqualified health care providers, popularly known as quacks.

The paucity and unevenness of distribution of healthcare facilities in the country seems to have replaced the popular proverb 'health is wealth' to 'wealth is health'. One of the major reasons behind this skewed health delivery system is low public expenditure on health. As per the UNDP Human Development Report 2004, India ranks 173rd among 177 countries in terms of public expenditure on health. At 0.9 per cent of GDP, public expenditure on health in India is also the lowest among South Asian countries.<sup>3</sup> Although in terms of per capita expenditure, there has been an apparently significant increase from less than Re. 1 in 1950-51 to about Rs. 215 in 2003-04; but a further disaggregation of this expenditure shows that only a small fraction of this is spent by the state governments. This results in higher private spending on health, leading to helpless submission of the common masses to the emerging giant of private healthcare delivery system in India (see table 6.1).

The NSSO data presented in table 5.1 reveal that out of every 1000 cases of hospitalisation, 59.3 per cent avail treatment at a private health care facility while only 40.6 per cent seek services of the public hospital. Probing deeper, it is found that the trend of private dependence is relatively more prevalent among the socio-economically well-off groups, but percolates down to the poor to some extent. It is observed that although 62 per cent of the people belonging to the lowest monthly per capita expenditure group seek treatment from public hospitals, their reliance on private health care facilities is not insignificant. In the lowest MPCE class, out of every 1000 people, 369 of them belonging to the lowest MPCE class depend on private hospitals and nursing homes, despite the high amount of cost incurred. This is once again indicative of the low reliance on government health facilities. When people decide to pay more on their treatment, they tend to favour private healthcare institutions because of their perceived superiority over public institutions

**Table 6.1. Availing of Public versus Private Health Facility and Expenditure Incurred: All India**  
**[PERCENT OF PEOPLE AVAILING TREATMENT FROM PUB FAC AND PRIV HOSP] [NOT SEEKING – PER CENT]**

MPCE class* (Rs.)	Public Facility**	Private Hospital	Not seeking treatment at a public facility owing to lack of faith	Avg Total Medical Expenditure (Rs.) for treatment at	
				Govt. Hospital	Private Hospital
0-235	62.0	36.9	3.9	2234	6694
235-265	57.0	42.9	5.8	2781	4546
265-320	54.5	45.3	3.2	2241	5352
320-365	51.3	48.3	1.9	2839	6751
365-410	49.5	50.4	2.2	2531	5449
410-460	47.4	52.6	1.6	2319	6354
460-520	43.1	56.8	3.6	2926	7870
520-605	42.6	57.3	4.1	3362	7216
605-730	38.4	61.4	2.6	3960	7922
730-980	31.6	68.4	1.3	4368	9461
980-1285	30.7	69.3	4.0	4637	11602
1285+	22.4	77.6	1.9	7645	14099

\*Mpce: Monthly Per Capita Expenditure  
 \*\*Public facility includes both hospital and dispensary  
 Source: NSSO (2004) Morbidity, Healthcare and the Condition of the Aged; Report No. 507(60/25.0/1), p. A-73 and p.100.

In India private spending on health is not only much higher in comparison to what government spends on health, the share of out-of-pocket expenditure in health is highest when compared with other developing countries.<sup>4</sup> The exceptionally high burden placed upon households in the Indian context reflects the inadequate quantity and quality of public health service delivery. In a context where health insurance is almost absent and the population depends on private health care providers to a large extent, household out-of-pocket expenditure can be a good reflection of their health care consumption.

The reliance on private delivery of health services may imply the denial of the services to the poor who can hardly afford expensive treatment. This in turn has adverse outcomes not only for the affected population but also for the society as a whole.<sup>5</sup>

#### EXPENDITURE ON HEALTH AND HEALTH STATUS

Inadequate allocation of public resources and its inequitable spread across different states have resulted in low access and poor quality of public health facilities. In addition, there are severe problems in delivery systems, some of which have

### Rate of hospitalisation as a measure of inequality

On the face of a curative or preventive health care need, utilisation of health care takes place generally either in the form of outpatient visit or hospitalization. Utilisation of health care services is often considered as an important process indicator of health care system. Since providers offering outpatient care are highly heterogeneous in their nature and quality of the service, hospitalization is a 'less imperfect' measure of utilisation compared to outpatient visits. The rate of hospitalization, which is an indicator of health care utilisation at the population level, is defined as number of hospitalization cases per 1000 population in a given year. This indicator could be used for measuring inequality in the distribution of health care in a society because the different rates of hospitalization that we observed for different population sub-groups could be more because of their unequal access to health care rather than their differences in morbidity or health care need. In cross-state comparison, rate of hospitalization also shows a positive correlation with other positive health indicators. For example, states with better health status or better access to health care also show higher rate of hospitalization and vice versa.

According to the latest National Sample Survey (NSS) data (2004), the rate of hospitalization is 24 and 38 in the rural and urban areas of West Bengal respectively. The high rural-urban difference is not a feature of West Bengal alone, most of the Indian states, especially those with high rural poverty and poor public health infrastructure show high-rural urban difference. However, it is interesting to observe that between 1995-96 and 2004, not only the rate of hospitalization increased in all the Indian states, but also the rural-urban difference declined in many Indian states. Another interesting observation is in almost all the states the rich-poor difference in rate of hospitalization has declined between 1995-96 and 2004. For example, in rural West Bengal the rich-poor difference changed from '22 vs 7' to '37 vs 21' between 1995-96 and 2004. In the north-eastern state of Assam, the rich-poor difference changed from '32 vs 7' to '17 vs 12' in the rural areas.

Nevertheless, a lowering of rural-urban and rich-poor differences has not made the situation better for the rural or the poor population. During the same period, people's dependence on government hospitals has sharply declined in most of the states and the cost of a typical hospitalization, whether it is in government or private sectors, shows a steep rise. For example, during 1993-94 and 2004-05, the cost of an essential food item basket increased by 73% in rural West Bengal, whereas during almost the same period (1995-96 – 2004) the median cost of a typical hospitalization increased by 151 per cent in the government hospitals and by 110 per cent in the private hospitals. The hardship faced by the people, especially by the poor, is evident from data on sources of finance for meeting hospitalization expenses. The rural poor in West Bengal fund almost two-third of their hospitalization expenses by borrowing and by other means such as selling of productive assets etc. Such a situation has not improved over the years.

Note: By poor and rich we mean bottom 30 per cent and top 10 per cent of the population based on monthly per capita consumption expenditure which is accepted as a good proxy for household's economic status

Source: (1) Mukherjee, Subrata and Jean-Frederic Levesque (2010): 'Changing inequalities in utilisation of inpatient care in rural India: evidence from the NSS', *Economic and Political Weekly*, 45(46): 84-91. (2) National Sample Survey Organisation (1998): 'Morbidity and Treatment of Ailments: 52<sup>nd</sup> Round (July 1995-June 1996)', Report No. 441, Department of Statistics and Programme Implementation, Government of India. (3) National Sample Survey Organisation (2006): 'Morbidity, Health Care and the Condition of the Aged: 60<sup>th</sup> Round (January – June 2004)', Report No. 507, Department of Statistics and Programme Implementation, Government of India.

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been discussed in other sections of the present report. These deficits cause the households to spend a significant proportion of their incomes on private healthcare facilities (see Table 6.1). What is common for most of the states under consideration is the disproportionately low amount of spending by the government and the high percentage spent by the households on health care. As regards out-of-pocket expenditure, while the country average is 73.5 per cent, Nagaland (92 per cent) and Bihar (90 per cent) are on the top of the list. Among the sample states, Meghalaya and Mizoram are the only states where public expenditure on health is found to be higher than the corresponding household expenditure. These are also the states that record reasonable performance in health, comparatively speaking. Mizoram is found to have the lowest percentage of underweight children and the highest percentage of institutional delivery. Sikkim also projects a low percentage of underweight children and high percentage of institutional delivery (see Section 3 of this report). Undoubtedly factors influencing health achievements are many and complex, but its connection with public expenditure is unmistakable.

The low public resource allocation on health has its direct bearing on household financial burden. Out of the low level of public expenditures, spending on preventive healthcare – the potential of which to protect the population

**Table 6.2 Expenditure on Health and Health Status**

States	Per cent spent by*		IMR**	% of Underweight Children***	Institutional delivery****
	Household	Public			
<b>Assam</b>	80.8	19.4	61	36.4	<b>22.4</b>
<b>Arunachal Pradesh</b>	86.5	13	32	32.5	<b>28.5</b>
<b>Manipur</b>	81.2	17.2	16	22.1	<b>45.9</b>
<b>Meghalaya</b>	36.5	58.4	59	48.8	<b>29</b>
<b>Mizoram</b>	39.4	60.6	36	19.9	<b>59.8</b>
<b>Nagaland</b>	91.7	7.6	26	25.2	<b>11.6</b>
<b>Sikkim</b>	56.9	43.1	34	19.7	<b>47.2</b>
<b>Tripura</b>	69	27.4	31	39.6	<b>46.9</b>
<b>Bihar</b>	90.2	8.3	52	55.9	<b>19.9</b>
<b>Jharkhand</b>	NA	NA	44	56.5	<b>18.3</b>
<b>Orissa</b>	79.1	18	65	40.7	<b>35.6</b>
<b>West Bengal</b>	78.4	17.3	33	38.7	<b>42</b>
<b>All India</b>	<b>73.5</b>	<b>22</b>	<b>50</b>	<b>42.5</b>	<b>38.7</b>

\*Report of the National Commission on Macroeconomics and Health, Ministry of Health & family Welfare, Government of India, September 2005. Cited at *Government Health Expenditure in India: A Benchmark Study*, Economic Research Foundation, New Delhi, August 2006.\*\*IMR according to SRS, 2009

\*\*\*Percentage of Underweight Children: According to NFHS-III, 2005-06

\*\*\*\*Institutional Delivery: According to NFHS-III, 2005-06.

from illness and consequent economic and other losses is great – is miniscule compared to spending on curative health.<sup>6</sup> Low level of public spending has resulted in poor infrastructure for preventive healthcare and consequently poor health achievement.

#### HEALTH EXPENDITURE AND STRAIN ON HOUSEHOLD INCOME

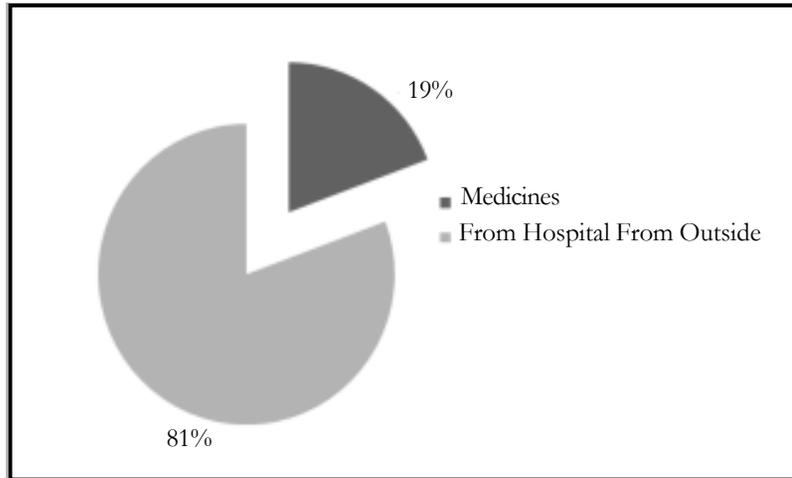
Private spending on healthcare causes a lot of strain on household income. But even poorer households spend a large proportion of their family income availing medical care and often are forced to incur debt in the process. Ironically, treatment in public hospitals is hardly free. Even within the public healthcare spectrum, various kinds of user fees are charged; government-run hospitals and clinics that are starved of public funds make patients pay for medicines, diagnostic procedures and surgical aids. And, the burden becomes heavier in case of hospitalisation, as we can see from the National Sample Survey Organisation (NSSO) figures (See Table 6.3).

**Table 6.3. Medical Treatment and its Impact on Household Economy: All India**

MPCE class	Loss of Household Income due to hospitalisation(Rs.)	Purchase of Medicines from (Rs.)	
		Hospital	Outside
0-235	407	120	1016
235-265	464	39	952
265-320	609	173	922
320-365	605	225	1066
365-410	542	159	1050
410-460	531	161	917
460-520	672	284	969
520-605	654	310	1195
605-730	676	306	1133
730-980	864	449	1281
980-1285	702	248	1716
1285+	746	479	1731
all	669	281	1176

Source: NSSO (2004) Morbidity, Healthcare and the Condition of the Aged; Report No. 507(60/25.0/1). pp. A-105, A-123.

**Figure 6.1: Overall distribution of medicines purchased from hospital and from outside hospital during hospitalisation: All India**



Source: NSSO (2004) Morbidity, Healthcare and the Condition of the Aged; Report No. 507(60/25.0/1). Pg Number: A-105, A-123.

During hospitalisation, while average expenditure for purchase of medicine from hospital has been Rs. 28, medicines worth Rs. 1176 had to be purchased from outside hospital. While this may still seem affordable for the socially affluent classes, for those belonging to the lower economic strata, seeking such expensive treatment becomes a nightmare. Also medical expenses create a disproportionately larger hole in their pocket, as these constitute a larger share of their already meager income.

For lower MPCE groups, hospitalisation also means greater loss of household income, comparatively speaking, further exacerbating differences in health. To make the matters worse even as households bear the brunt of aggregate health spending, systems of affordable health insurance are non-existent or are poorly developed. In any case with more than 90 per cent of Indian workers having “informal” or unorganised status, there are few possibilities of ensuring that employers bear at least part of the costs of medical treatment. Therefore instances of accident or severe illness requiring hospitalisation have drastic effects upon the households of the affected persons, more so among the poorer households. This is true for urban and rural households, but the effects may be particularly sharp for the rural population because of the relative paucity of any kind of publicly provided treatment. For example, recent studies of agrarian distress have also shown health expenditures to have a major reason for causing or increasing the indebtedness of farmers, which has in turn been a proximate cause of farmers’ suicides.<sup>7</sup>

**Table 6.4a Distribution of Hospitalisation Expenses by MPCE Class: All India**

Mpce Class	Avg total exp on hospitalisation per household (Rs.)	Distribution of expenses of hospitalisation by source of finance (per cent relying on these sources)			
		Household income/savings	Borrowings	Contributions from friends	Other sources
0-235	4361	40	39.4	14.2	6.4
235-265	3963	27.7	53.2	12.2	6.9
265-320	3984	31.6	44.5	14.2	9.7
320-365	5161	34.7	47.3	12.7	5.2
365-410	4448	40	43.7	12.7	3.5
410-460	4890	37	40.4	13.8	8.8
460-520	6275	47.9	37.5	10.6	4
520-605	6091	44.6	37.8	11	6.5
605-730	6977	50.9	31.6	12.9	4.6
730-980	8697	49.5	31.3	10.7	8.5
980-1285	10263	51.8	31	12.4	4.8
1285+	13509	56.2	23.5	13.3	7
all	7169	47.7	33.7	12.2	6.4

Source: NSSO (2004) Morbidity, Healthcare and the Condition of the Aged; Report No. 507(60/25.0/1), pp. A-108

**Table 6.4b Distribution of Hospitalisation Expenses by Social Groups: All India**

Social Group	Distribution of expenses of hospitalisation by source of finance (in per cent)			
	Household income/savings	Borrowings	Contributions from friends	Other sources
SC	77.6	15.6	3.7	3.2
ST	77.1	17.7	4.3	0.9
OBC	79.2	15.7	3.5	1.5
Others	82.2	11.1	5.2	1.5
All	80.2	14	4.4	1.5

Source: NSSO (2004) Morbidity, Healthcare and the Condition of the Aged; Report No. 507(60/25.0/1), pp. A-224

As the NSSO data provided above on meeting the cost of health expenditure (Table 6.4a) show more than 50 percent depended upon loan and other sources, while less than half depended upon family income. Again, the lower social groups become much more vulnerable as they cannot even manage to get a loan: all social groups depend heavily on family support – nearly 80 per cent of them pay from family income (Table 6.4b). Understandably, for socially disadvantaged groups, such near-total reliance on meager private sources create special hardships. The NSSO data do not give us much detail about the different types of privately available treatment that people avail and their highly uneven quality. However, empirical studies show an overarching dependence of the poor on the unqualified private practitioners, popularly known as quacks, while the rich visit qualified doctors.

### Box 6.1 Dependence upon Quacks

Three Quarters (75%) of the population of West Bengal live in rural areas. The scarcity of trained doctors in such regions has left a gap to be filled up by the quacks (rural medical practitioner) who happen to be the first available medical help in the rural health care delivery system. These quacks are not recognised by the mainstream medical system. But rural people mostly depend on them for their medical care because at times of their need, it is only the quacks who are easily accessible to them. Liver Foundation, West Bengal has found in a survey that out of the 2888 rural people surveyed in the districts of Birbhum and Dumka about 53 per cent reported that it is the quacks from whom they commonly seek advice in case of ailments. Their reasons range from quacks being readily available in the village, their treatment being cheap to the absence of qualified doctors in the vicinity. With general community perception about them being quite positive, these untrained healthcare providers seem to have no guilt about the fact that they are engaged in a profession for which they are not legally eligible. Rather according to them, they are the only ray of hope for the villagers during acute emergency, which unfortunately is true for our country.

*Source: Liver Foundation, West Bengal, Rural HealthCare Provider: Research to Bridge the Gap.*

Furthermore, government health facilities and doctors remain inaccessible for a variety of reasons: poor connectivity, transportation costs, unreliable functioning of health facilities due to the absenteeism of medical staff etc., making it easier to seek treatment from local quacks. A study by the Pratichi Trust<sup>8</sup> shows that while in Birbhum district of West Bengal about 29 per cent of the respondents availed treatment from quacks, the corresponding percentage was as high as 62 per cent in Dumka district in Jharkhand, which is just about an hour's distance from Birbhum.

**Table 6.5 Issues of Access in Seeking Healthcare: All India**

Per cent of people giving the following reasons for their decision

MPCE Class (Rs.)	Government doctors/facilities too far	Not satisfied with medical treatment by govt. doctors/facilities	Government facilities available but treatment not sought due to	
			Financial reason	Ailment Not considered serious
0-235	20.9	27.9	41.6	16.0
235-265	21.0	41.4	35.6	30.5
265-320	24.1	32.5	37.3	29.7
320-365	19.8	39.9	33.3	32.2
365-410	23.4	37.5	38.2	27.8
410-460	21.9	36.6	29.8	32.4
460-520	22.0	39.8	19.8	39.0
520-605	17.2	44.4	24.5	31.8
605-730	19.1	44.1	20.2	44.4
730-980	14.8	49.3	19.1	44.0
980-1285	14.2	45.5	15.0	43.3
1285+	14.7	44.3	7.6	51.8
all	20.9	27.9	26.6	35.5

Source: NSSO (2004) Morbidity, Healthcare and the Condition of the Aged; Report No. 507(60/25.0/1), pp. A-177,186

A significant proportion of households mention distance as the reason for not being able to avail treatment at a government facility. The above table also shows the gross underutilisation of the existing health infrastructure, contributing ironically to shortage and forfeit at the same time.

Collation of data both in terms of mpce classes and caste or tribal groups reveals that those in the lower rungs of the hierarchy have remained consistently disadvantaged and deprived in terms of access to health care facilities, health status and coverage. Lower the MPCE class, higher is the propensity of them being subject to untreated spells of ailment due to absence of medical facilities in the neighbourhood. In addition, the prevalence of not seeking treatment due to financial reasons or of not considering it serious has also been found to be higher among those who are economically worse off. The picture becomes grimmer as we look at reporting of ailment by both social group and gender. Leaving out Arunachal Pradesh, West Bengal and Tripura, reporting of ailment among the socially disadvantaged groups is found to be consistently low. Jharkhand scores the worst on this count followed closely by Bihar.<sup>9</sup>

It is a truism worth repeating that good health is a function of a number of social, economic and cultural factors. This acknowledged, however, the centrality of public healthcare has to be prioritised as a non-negotiable certainty. This assertion is particularly relevant at a time when the growing commercialisation of health care and the excessive and irrational use of drugs available in a highly-cartelised drug market render health an expensive commodity.

We turn to a brief discussion of drugs and drug markets in the next section.

#### NOTES

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## 7. Fragility of the Public Health Sector and Growth of the Drug Market in India

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An evil does not only come with its allies, it also breeds – and with tremendous rapidity. Nothing exemplifies this better than our health system that leads not only to highly unsatisfactory health achievement of the people, but also creates a clear dividing line between them on the basis of their ability or inability to ‘buy’ health. While this division – an outcome of growing privatisation of healthcare – jeopardises the prospect of overall well-being of the poor and the socially disadvantaged, it also contributes to terrible exploitation of the sick. Only a small part of this exploitation comes from fees, hospitalisation costs etc. The bulk comes from the price of medicines. The lack of public health facilities gives way to a private health market, that in turn promotes a disease-centric view of health, because diseases need curing with medicines. And medicines can be commodified, at very high prices. Thus the primacy given to curative health creates a huge – and almost unregulated – drug market, visible even in remote corners of the country.

The number of pharmaceutical companies with new drugs and newer formulations is getting larger – the number was over 20,000 in 2002 and has steadily increased since. The growth rate achieved by the Indian Pharmaceutical Industry (9 per cent) has far outpaced the international figure (6 per cent). Again, some of the big companies are achieving 20 to 37 per cent growth rate<sup>1</sup> which is much higher than the average national figure (9 per cent). A mere Rs.10 crore annual turnover of the Indian pharmaceutical industry in 1950, has grown to Rs.54,000 crore in 2007<sup>2</sup>. 85 per cent of the total pharmaceutical product is consumed domestically. This implies a huge perceived need for medicines, although there is no way to measure whether these medicines were actually needed, or whether they cured the ailment they were used for. Our concept of

the actual versus the ‘created’— requirement for drugs for good health, therefore, remains speculative at best.

Nevertheless, it is not just the volume of production and consumption that has boosted this growth. A close look at the process of drug pricing in India sheds light on its virtually uncontrolled nature, a rather under-studied and destructive aspect of the national health sector. It is not only that the state remains under-active as the provider of basic health care, as a regulator too it remains inert and ineffective. The authorities have gradually decontrolled the price of medicines in India by both reducing the number of drugs falling under Price Control and by increasing the MAPE (Maximum Allowable Post Manufacturing Expenses) for formulations under price control.

Even a cursory look at the history of various Drug Price Control Orders (DPCO), issued in 1970, 1979, 1987 and 1995, reveals how the regulatory arm of the government vis-à-vis the pharmaceutical manufacturers of the country has become increasingly weaker, each time giving them newer concessions and allowing the already-thriving pharmaceutical industry a free hand in profiteering.

#### DRUG PRICING IN INDIA: A BRIEF HISTORY

Maximum Allowable Post Manufacturing Expenses (MAPE) is the mark-up on manufacturing costs that allows pharmaceutical manufacturers to accommodate other expenses and their profit. The DPCO that restricted the amount of profit thus made was DPCO 1979. The entire basket of pharmaceutical formulations then available was divided into three categories, and a simple formula was devised to calculate the ceiling of profit for each group. The formula, which was used for all subsequent DPCOs till date, was:

$$\text{Maximum Retail Price} = (\text{Material Cost} + \text{Conversion Cost} + \text{Packing Material Cost} + \text{Packing Charges}) \times (1 + \text{MAPE}) + \text{Excise Duty}$$

By this above formula, manufacturers made profits in a specific ratio on the capital invested in manufacturing. By the DPCO 1979, allowable profit on investment was 40, 55 and 100 per cent respectively, for formulation categories I, II and III. Subsequent DPCOs collapsed the categories into one, and increased allowable MAPE ceilings, such that all drugs currently placed under price control make at least 100 per cent profit on capital invested.

In 1979, price control applied to 347 formulations, which amounted to about 90 per cent of the entire formulation basket at that time. However, the number of formulations placed within the scope of these restrictions was progressively reduced, while the MAPE increased every time. In 1987, the number of formulations under price control came down to 142, and further fell to 74 in 1995. The case of <sup>3</sup> Amikacin – excluded from price control after 1995 – shows what the consequences of this practice is, and how retailers make enormous profits off vital drugs. Amikacin is a life-saving antibiotic used to treat hospital acquired, multi-drug resistant, gram-negative infections. The price to retailer and the MRP (Maximum Retail Price) of some brands of Amikacin are given below. It should be noted that all brands are from highly reputed companies.

**Table 7.1. Margin of profit for various brands of Amikacin, a Life-saving Drug**

Name of Company	Brand Name	Retailers price	MRP	Profit (in per cent)
Cadila	Amistar 500	8.00	70.00	775
German Remedies	Amees500	8.00	70.00	775
Wockhardt	Zekacin 500	9.90	70.00	607
Alembic	Amikanex500	8.22	64.25	682
Itas	Kami 500	8.13	60.00	638
Ranbaxy	Alfakim 500	8.50	70.00	723
Cipla	Amicip	7.42	72.00	870

Source: Dr. Samit Sharma, Collector & District Magistrate, Chittorgarh (Rajasthan), Low Cost (generic) Medicines Initiative, Chittorgarh. [http://chittorgarh.nic.in/Generic\\_new/generic.htm](http://chittorgarh.nic.in/Generic_new/generic.htm), no date

Let us now look at the formulations still under price control. Many of the currently controlled 74 formulations are either not available, or scarcely available (like Benzathin Penicillin, Theophyllin etc). Clearly, the manufacturers do not find even the 100 per cent mark-up an attractive incentive to manufacture them. Rather, they concentrate on formulations which do not fall under the DPCO, and therefore provide unlimited possibility for profit. The other – more dangerous – way of flouting the DPCO is to remove the ingredient in a brand which falls under the DPCO, and replace it with another, without changing the brand. This is probably the worst practice, as the following things can happen because of it :

- (i) The doctor tends to prescribe the brand without being informed about the changed composition of the actual product.
- (ii) It introduces another unscientific, irrational combination in Indian pharmaceutical market which is already flooded with irrational combinations<sup>4</sup>.
- (iii) Above all, it widens the informational asymmetry between those who manufacture and prescribe drugs, and those who are at the receiving end of such ‘irrational’ and ‘misdirected’ care.

Not that the policy makers are unaware of the situation. The issue of high drug price and its burden on the people has been discussed in detail in the *Report of the National Commission of Macroeconomics and Health*. Also, the remedy for the same was prescribed in unambiguous terms:

Only 76 drugs accounting for around one-fourth of the drug market are under price control. An examination of the price trends of 152 drugs (consisting of 360 formulations) reveals that, antibiotics, anti-tuberculosis and anti-malarial drugs, and drugs for cardiac disorders, etc. registered price increases from 1per cent-15per cent per annum during 1976-2000. Indian households spend 50per cent of their total health expenditures on drugs and medicines. Reducing this burden and ensuring access can be achieved by: (i) bringing all drugs under price control to ensure lower prices for the households; (ii) streamlining

and putting in place a system of centralized pooled procurement of drugs so that the public health system can save almost 30 per cent to 40 per cent on costs; (iii) weeding out irrational drugs and irrational combination drugs; and (iv) encouraging ISM drugs for treating diseases for which efficacious and low-cost drugs are available. Price control, as is the practice in several countries such as Canada, is justified on the basis of the drug prices outstripping WPI. Second, this will address about 90 per cent of the health needs of the community and reduce household spending on these services. Price control should not be limited to essential drugs as the industry can then simply switch its production to the non-controlled categories, depriving people of access to essential drugs.<sup>5</sup>

Six years have passed since this report was published. The last DPCO was issued sixteen years ago. Yet the job of “weeding out of irrational drugs and irrational combinations of drugs” has not even started. While there is strong need for raising voice for the rationalization of drug policy, this needs to be combined with resilient action to universalize and strengthen the public health system.

From this fleeting glance at one particular aspect of the privatized health market, namely the drug market, a simple but deep message that can be drawn is that health and health care in our country is embedded in a socio economic field of power, hierarchy and inequality. Although in this report, we have only indirectly alluded to such structural determinants of health, we are certainly mindful of the need for public discussion and democratic public action to counter the effects of such background inequalities on health. In the next section, we turn to a discussion on the weightage accorded to health in the media and in electoral politics.

#### NOTES

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2. L.M.Kaushal, Director NPPA, Drug price control order and recent developments <http://www.scribd.com/doc/34757922/Drugs-Price-Control-Order-and-Recent-Developments>
3. At the time of publication of this report, the DPCO 1995 had placed 76 formulations under price control, but the number has been reduced by two since, one of the excluded drugs being Amikacin.
4. Report of the National Commission on Macroeconomics and Health, Ministry of Health and Family Welfare, Govt of India, 2005
5. Page 6, Report of the National Commission on Macroeconomics and Health, Ministry of Health and Family Welfare, Govt of India, 2005

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## 8. Democratic Deficit: Health in Media and Legislative Agenda

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The problem with democracy, the quip goes, is that the people get the government they deserve. This is, in fact, a persistent mystery of free political choice: how are large numbers of people consistently persuaded to vote against their own interests? One of the answers often provided is media intervention. Media is a powerful agent in shaping public culture, and it influences electoral choice accordingly. The on-going health debate in the United States of America is cited as a prime case in point.

The health sector is one of the primary areas of concern in this discourse, because it is the one area of policy-making that transcends the demographic parameters of ‘interest groups’. Every single member of the public, irrespective of age, sex, religion, ethnicity, language group or class, requires access to health services. Therefore deficit in health is, in some sense, symptomatic of democratic deficit. That is to say, it is symptomatic of a lack of adequate public discussion and action on determinants of ill-health, and hence of inequalities in health.

This wide spectrum is not served by a common media product. There is, in fact, a gap between primary consumers of public healthcare, and the consumers of national media. The onus of representing the daily struggles of public healthcare consumers’ is not on these media. They seek to report on matters which have the appeal of familiarity to their target-audience, especially in the case of the English-language media. They also emphasise what might be termed an ‘adrenalin factor’ – news items that have been selected for their sensationalism, and the potential for stirring up debates on print and television. Frequency distribution of news categories show this preference quite clearly. And yet in our mainstream media there is no sign that this deficit — and our own health and happiness— deserves much notice, much less a comprehensive public discussion.

We covered the period between February and April 2011 – a period preceding

the 2011 assembly elections in West Bengal and some other states, since in principle public health could have become one of the main electoral priorities of all contesting parties. Expectedly, politics led the count, focusing almost exclusively on the campaigning for Assembly elections, and on political scandals and their fallout. The latter saw considerable output in this period, producing the 2G and 3G scam, corporate lobbying, Commonwealth Games scandal, land scams in Maharashtra, the Lokpal Bill and Anna Hazare's fast. The former was covered in the manner of adventure sports, with several newspapers kept parallel tally of candidates, competing promises, and reciprocal acts of violence allegedly perpetrated by the contesting political parties. The exclusion of health from the election coverage is probably explained by the lack of adrenalin in their health mandates. Sports came a close second to politics, with the ICC Cricket World Cup – which India went on to win – followed immediately by the Indian Premier League. Even other news items – collected under the unimaginative title 'Others' – outstripped health news, and featured several instances of violent street harassment and brutal rapes culminating in torture and murder. In such thrilling company, 'health' appears almost anaemic by contrast, offering no titillating 'talking points' except the occasional doctors' strike, or the ignored patient lying on hospital floors.

Ironically, this pattern of reportage reflects policy attitudes towards the health sector. The media ignores the health sector till a new or disastrous event happens. Health policy has also ignored the proverbial ounce of prevention – except few brief flashes of immunisation programmes – in favour of several pounds of cure. Consequently, the public has been encouraged to see 'health' as a curative mechanism, that need only be considered after a physiological disaster has occurred. Daily calorie intake, access to clean drinking water et al find no place in the public discourse of health.

Another ignored aspect of health is its interaction with entrenched social inequalities. India has the largest number of malnourished children in the world, and this cannot entirely be explained by the relative poverty of their families. Given the culture of son-preference, as it is termed, girl-children are frequently deprived of meals and medication in favour of their brothers, or other men in their households. Some families refuse their women medical treatment entirely, deeming their gender not worth the expense. Women across the age spectrum also contribute far more domestic labour to their households, and in case of several communities most of the wage labour as well. They also bear greater physiological consequence than their male partners in child or teenage marriages. It is not just young girls that suffer as a consequence of deliberate disadvantaging of women and girls, either. Young pregnant women — lowest in the household hierarchy – are frequently allowed only small portions by their husbands' families as a means of demonstrating power and control over them. This results, however, in the birth of both malnourished sons *and* daughters.

Women also face the threat of violence while within medical facilities. The period of study recorded three cases of sexual assault on women in hospitals. One of them was the instance of a Bombay nurse who was put into a thirty-year long coma by a brutal rape at her place of employment. Her case played a

prominent part in India's evaluation of assisted euthanasia laws, the process having now been legalised in the country. Gender, of course, is not the only variable in inequality. Economic class plays a very big role in accessing both preventive (food, clean drinking water) and curative measures. Spatiality is another unaddressed concern in our public discourse. Looking at the data of snakebites, for example, one sees that 97 per cent of snakebite-deaths occur in rural areas. Despite these, most primary health centres do not carry anti-rabies vaccine or anti-venom serum, and zilla hospitals that do carry them carry far short a supply to demand. Ethnicity/race has subtle correlations with the delivery of health services too, as remote Advisai or Dalit areas are often far removed from functional hospitals or well-equipped health centres<sup>1</sup>.

Pratichi's work has been shaped by its emphasis on public dialogues in national development. However, much of it has been conducted via fieldwork and continuous engagement with people on the ground. However, our assessment of health in the public agenda would have remained incomplete without an analysis of media foci and attitudes of elected public officials to it. In this chapter, we hope to show the aspects of health in our public discussions that need addressing.

#### HEALTH IN PRINT

A frequency and content analysis of health news in comparison to all other kinds of news was done in a three-month period preceding the 2011 Legislative Assembly Election in West Bengal. The media selected for this purpose were:

- The Kolkata edition of the national newspaper, *The Times of India* (ToI).
- The nationally-published Bengali daily, *Ananda Bazar Patrika* (ABP).

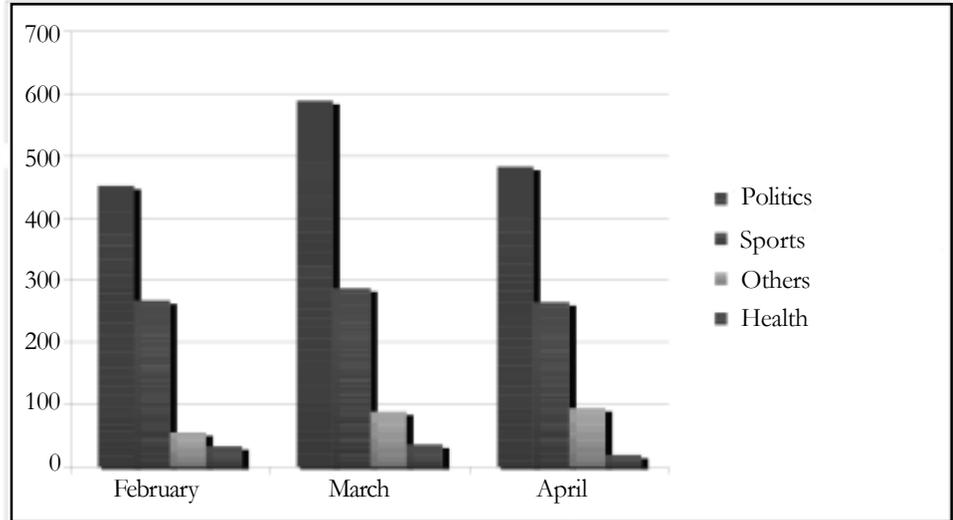
The chosen period saw hectic sporting and political activity. The Cricket World Cup was held in the Indian subcontinent in March, followed by the Indian Premiere League in April (and May). February, March and April were also the peak campaigning period for State Legislative Assembly elections in six Indian States. It was particularly intensive in West Bengal, which eventually saw the defeat of the Left Front government that had held office for seven previous terms in the State (in May). Public health being one of the chief agendas of all contesting parties, one could perhaps extrapolate greater emphasis on public health news – on infrastructure, prevention, delivery, and condition – during this news cycle. This turned out not to be the case.

For parity, the reportage from each publication has been classified under certain specified labels, and the frequency of each per month per publication has been noted below.

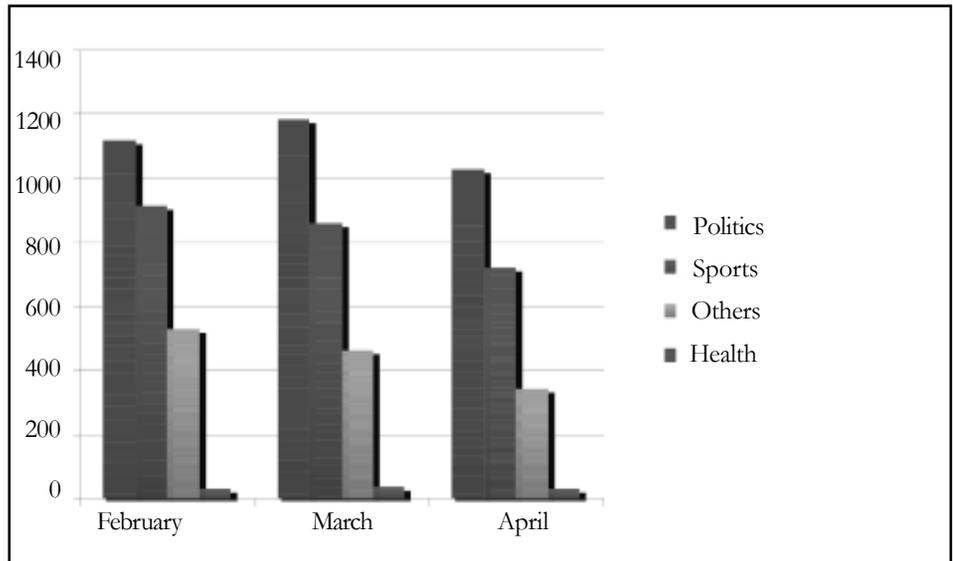
Each monthly archive is represented as a table, with the total of each day's news classified under Politics, Sports, Health and Others. Politics, sports and health are self-explanatory categories. 'Others' lists, in short, all news-items that fall outside the purview of the other three. Accidents, instances of violence with no established political connections, fashion, entertainment et al have been grouped together in this category, since none of it informs the analysis of health reportage in media.

COMPARATIVE 3-MONTH DISTRIBUTION OF NEWS ITEMS:

**Figure 8.1.A. Distribution of Frequency-categories:**  
*Anandabajaar Patrika*



**Figure 8.1.B. Distribution of Frequency-categories:**  
*The Times of India*



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 MONTH-WISE DISTRIBUTION OF NEWS: FEBRUARY 2011
 

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The tables of distribution of each category of news are self-explanatory : health's share in all published news veered around one per cent!

**Table 8.1 Distribution of each category in February**

Politics	Sports	Other	Health
1118 (43%)	911 (36%)	530 (20%)	31 (1%)

Chief among the month's health highlights were:

- Government rolling out a programme to vaccinate all newborn babies against Hepatitis B in five of the nations 'highest performing' States medically: Tamil Nadu, Kerala, Karnataka, Gujarat, Himachal, Andhra Pradesh, Punjab, and West Bengal. India is the world's second-largest Hep. B carrier.
- The Indian Council for Medical Research (ICMR) starting an experimental thalassemia screening for foetuses between 10 to 12 weeks. The process evaluates each positive case and provides for abortion if the parents so prefer. Several public hospitals in the city are offering this service for free.
- Transplantation of Human Organs and Tissues Amendment Bill in the Parliament increases penalty for illegal organ trade, and legalises swapping between willing but incompatible donors.
- Diabetes cases in India show an increase in villages. ICMR has started INDIAB, a study of diabetes in Indians above the age of 20. WHO predicts that socioeconomically, diabetes might do to India what AIDS did to Africa.
- Neel Ratan Sarkar Medical College and Hospital has developed a cure for psoriasis. The drug has undergone successful clinical trials, but pharmaceutical companies have shown no interest in it. Researchers are unable to publish a paper on the drug because their duty hours give them no time for it.
- Food security activists are concerned that the central Government is allowing multinational snack and beverage companies like Pepsico to influence India's nutritional policies. Government food programmes can become the next big market for such companies.
- UID and 2D bar-coding will allow Indian consumers to check the authenticity of the drugs they buy via SMS. The Drug Commissioner General of India.
- Healthcare sees last mile connectivity – the government has recruited 8.33 lakh accredited social health activists (ASHAs) under the National Rural Health Mission.

## MONTH-WISE DISTRIBUTION OF NEWS: MARCH 2011

In March too we do not see much variation in the pattern (see Table 8.2).

**Table 8.2 Distribution of each category in March**

Politics	Sports	Other	Health
1182 (46.57%)	858 (33.8%)	462 (18.2%)	36 (1.41%)

The health-news highlights from March were:

- A recent WHO report claims India has about 15,000 malarial deaths per annum of malaria, as opposed to the National Vector-Borne Disease Control Panel (NVBDCP) estimate of 1,000. A Lancet report says the figure is 13 times the WHO estimate, stating that WHO fails to count those cases that are not reported in hospitals. The Lancet study estimates 2 lakh deaths per annum in the 70 years and younger demography. NVBDCP concurs with WHO and is adopting its more recent methodology to re-evaluate the status of malaria in the country, but finds the Lancet publication unconvincing.
- 14 doctors have left these institutes in the last 3 years to join private hospitals. Altogether 119 doctors have left the public sector for private, including 62 from Central Health Services (CHS). To counter this, Union Minister of Health Mr. Ghulam Nabi Azad has proposed raising the age of retirement from 62 to 65 for teaching specialists, 60 to 62 for non-teaching public health specialists, and 3 years study leave from 2 for postgraduate students in CHS.
- The DCGI has made it compulsory for clinical trial organisations (CTOs) to register with it, for better monitoring and checking of credentials. Registration requires a specific 'scientific background' for house personnel, as well as familiarity with trial protocol. In 2009 DCGI had made registration for clinical trials compulsory, but not for the facilitating organisations. DCGI's statement says this proposal, once made law, will address the lack of legal monitoring of CTOs, ensure that consent is informed, and save 'hapless drug-naive Indians' from predatory drug trials.
- India has legalised passive euthanasia. In evaluating the case, Supreme Court justices Markendya Katju and Gyan Sudha Mishra also suggested suicide be decriminalised, calling Section 309 of the Indian Penal Code 'anachronistic'.
- An expert group on universal health coverage, appointed by the Prime Minister, claims several commonly-used medicines in the market are 'irrational, needless, or useless'. Combiflam, Digene, Becosule, Corx, Phensedyl and Liv 52 are cough mixtures, antacids, vitamin and analgesic combinations with Rs 588 crore annual sales cumulatively, most of it contributing to the private health expenditure of Indians.

- 2.27 Lakh rare Indian medical formula go digital: 1.22 lakh Unani, 90,000 Ayurveda, and 15000 Siddha formulations documented to foil bio-pirates” — at Traditional Knowledge Digital Library.
- India runs short of crucial vaccines: Shutting down PSU units hits inoculation drive” — 349 lakh doses short of diphtheria, pertussis and tetanus and 300 lakh TT in 2009-10. 1.42 lakh typhoid vaccine required. 133.47 lakh MMR Situation analysed in report “Vaccine -wise and Institution-wise status of product, demand and supply 2009-10”, Central Bureau of Health Intelligence. Vaccines produced by PSUs have no takers even when there is demand for the vaccines. Central Research Institute and Pasteur Institute of India, Coonoor, no longer allowed to produce vaccines, which has made the government dependent on the private sector suppliers at more than double the price.

#### MONTH-WISE DISTRIBUTION OF NEWS: APRIL 2011

The patterns seen in the previous months remain almost unchanged (see Table 8.3).

**Table 8.3 Distribution of each category in April**

Politics	Sports	Others	Health
1027 (48.12%)	724 (34.02%)	344 (16.16%)	33(1.55%)

The health news highlights from April are:

- The Supreme Court has ruled that government doctors defying ban on private practice and charging consultation fee from patients in a clinic during spare time cannot be booked under anticorruption law.
- Private practice has long been cited as the bane of public health facilities, as doctors either do not attend their public clinic hours or refer patients to their more expensive private practices.
- With about 70% children under five years suffering from anaemia and nearly 50% affected by malnutrition, the Prime Minister’s Office has directed the distribution of Iodine and Iron enriched salt through government food including ICDS and mid-day meal.
- Rural residents of the Malda district of West Bengal choose arsenic-laced ground water over arsenic-free but garbage and worm-laden tap water provided by the government.
- Punjab, Haryana and Jammu & Kashmir lead the country in female infanticide and female foeticide, as evinced by the nation’s lowest male-female ratio. Ratio has dropped all over the country, causing alarm.
- The Union health ministry has formalised a National Policy for containment of antibiotic resistance to battle irrational consumption of antibiotics. This follows discovery of the highly-resistant metallo-beta-

lactamase producing strains of bacteria in New Delhi water.

The lower priority of health is further aggravated by the typical understanding of health something as related to cure of disease— the major focus of the published news centred around the urban hospitals, neglecting the rural sector, issues of preventive and educative interventions, nutrition and so on.

#### LEGISLATIVE ASSEMBLY DISCUSSIONS, 1999 AND 2000

The focus on an understanding of health found in print media are also reflected in the legislative discussions. The health-related discussions on the floor of the West Bengal Legislative Assembly in 1999 and 2000 (the latest that are publicly available) have been collected from the West Bengal Legislative Assembly Proceedings 1999 Vol. 114, Nos: I, II, III and IV, and West Bengal Legislative Assembly Proceedings 2000 Vol. 116, Nos: I and II. These discussions took place in different meetings of the Assembly: the Discussion on General Budget, Mention case, Amendment to Governor's Address, Discussion on governor's Address, Zero Hour, and the Question and Answer Session.

**Table 8.4. Frequency of Each Given Variable Occurring in these Discussions.**

Issue	Number	Percentage
1 Hospitals	170	47.88
2 Treatment	63	17.74
3 Medical College	52	14.68
4 Drinking water	28	7.88
5 Disease prevention	14	3.94
6 Anti-rabies vaccine/Anti-venom serum (ARV/AVS)	13	3.66
7 Homeopathy	8	2.25
8 Lapses in doctors' works	3	0.84
9 Immunisation	2	0.56
10 Morgues	2	0.56

From the statistics above, we see the preventive measures – disease prevention methods and immunisation constitute only 4.5 per cent of all health discussions in the Assembly. 95.5 per cent was devoted to matters regarding curative delivery. At the very least, the frequencies are an indicator of the way 'health' is predominantly conceptualised in our public and policy discourse: a post-facto curative intervention, instead of a preventable condition. The old adage about ounces and pounds appears not to apply to our health expenditure models.

## CURATIVE DELIVERIES: AN ANALYSIS

**Issue 1: Hospitals**

48 per cent of all discussions regarding curative deliveries in West Bengal were related to hospitals and their functioning. We have therefore paid special attention to the specifics of these discussions, to further define the axis of public interest in the health sector.

Hospital-related discussions can be classified into the five following subcategories. The cumulative frequency of each in 1999 and 2000 are provided below.

**Table 8.5. Hospital-related Discussions**

Hospital-related category	Frequency in per cent
Hospital infrastructure	76
Recruitment of doctors	8
Construction of new hospitals	5
Development of extant hospitals	5
Recruitment of hospital staff	5

**Issue 2: Treatment**

Discussions relating to 'treatment' spanned the state of primary health centres to hospitals at every distributive level (zilla, city, state). The following table shows the two spheres of medical treatment that received most attention from the Members of the Legislative Assembly.

**Table 8.6. Treatment-related Discussion**

Treatment-related category	No. of instances	Frequency in per cent
Complaints about the quality of treatment	42	67
Accepted proposals to extend curative services	21	33

**Issue 3: Medical Colleges**

West Bengal has 12 publicly-funded medical and dental colleges. The following table shows the matters pertaining to medical colleges in the State, and their frequency.

**Table 8.7. Medical College-related Discussions**

Medical Colleges-related category	No. of instances	Frequency in percent
Quality of education	23	44
Founding new colleges	18	35
Recruitment of faculty	8	15
College infrastructure	3	6

#### Issue 4: Drinking water

There were three primary areas of public concern about access to drinking water: Current demand for access to/delivery of clean drinking water; demands to redress arsenic in ground and drinking water; and the system for delivering drinking water. The frequency of each in the discussions were as follows.

**Table 8.8. Drinking Water-related Discussions**

Drinking water-related category	No. of instances	Frequency in percentage
Demand for drinking water	12	43
Arsenic in drinking water	10	36
Delivery of drinking water	6	21

#### Issue 5: Anti-rabies Vaccine/Anti-venom Serum (ARV/AVS)

There have only 13 discussions about ARV/AVS, and each discussion saw complaints about the lack of ARS/AVS availability in all zilla hospitals. In cases where they are available, their demand far outstrips their supply. This paucity of interest stands in sharp contrast to the frequency of dog, and especially snake, bites in West Bengal. A 2002-03 sample survey<sup>2</sup> on snakebite deaths in India showed, that 562 of all deaths per annum are attributed to snake bites alone<sup>3</sup>, amounting to 4.7 deaths per 1,000. 97 per cent of these deaths were recorded in rural areas. As a humid, tropical State with a predominantly rural population, West Bengal is particularly vulnerable to venom-induced illness, paralysis, and death.

#### Issue 6: Homeopathy

There were only 8 discussions relating to homeopathy, despite the fact that with rising cost of allopathic treatment, homeopathy is being seen as an affordable alternative for most ailments. Discussions about homeopathy can be classified into the following two categories, with these frequencies:

**Table 8.9. Homeopathy-related Discussions**

Homeopathy-related category	No. of instances	Frequency in percentage
Homeopathy – viability	5	62.5
Establishing homeopathic hospitals	3	37.5

#### Issue 7: Lapses in Doctors' Duties

The right of publicly-employed doctors to have a private practice was questioned, especially when the latter was said to prosper at the cost of the former. The government assured the Assembly that the doctors who had a private practice of their own had permission to do so. The Opposition also expressed anxiety about the possible withdrawal of house staff from public hospitals, but the government assured them that there were no plans to withdraw

house staff – who are usually post-MBBS students doing their year of residency – in the near future.

### **Issue 8: Morgues**

The primary concern about morgues is its possible contribution to environmental pollution. The specific case of a morgue next to the Baharampur Court railway station was cited, the Opposition claiming it was a major local pollutant. The government did not engage in debate, but categorically denied morgues in West Bengal being environmental pollutants. About the Baharampur Court morgue, the government asserted that no such morgue exists.

### **PREVENTIVE MEASURES: A GLANCE**

As noted earlier, there is a marked lack of interest in making prevention an integral part of the State's health policy. Together they constituted 4.51 per cent of the total health discussions in the Assembly. Immunisation programmes (**Issue 10**) received only a cursory nod (2 questions on the floor), both pertaining to scheduled immunisations for newborn children. The greater part of the preventive discourse was devoted to disease prevention.

### **Issue 9: Disease Prevention**

There have been 14 discussions on the floor of the Assembly that can be classified broadly under 'disease prevention', including non-medical measures. Recurring amongst these were:

- Self-governed institution for AIDS awareness and prevention.
- Encourage the cultivation of mushroom
- Educate the wider populace about their nutritional value.

This leaves several central health issues – pertaining both to specific ailments and general health of the people – unaddressed. Particularly glaring is the omission of discussions on rural health, and of ways in which disease prevention can be strengthened, improved, and extended in rural areas. As 72 per cent of West Bengal is rural, this exclusion leaves the State's largest population demography vulnerable to avoidable ailments and general ill health. This vulnerability directly translates into greater pressure on rural curative delivery, requiring greater investments of public resources in it.

Vital areas that profoundly affect public health, and need immediate attention from law- and policy-makers, are:

- Health of pregnant women and young children.
- Nutritional requirements and food security of the entire populace, but especially of pregnant women, to address the extremely high number of malnourished and vulnerable babies.
- General health education, including spreading awareness about basic hygiene, daily necessary calorie intake and local produce which would provide the same, recognising symptoms of curable diseases et al.
- Gender differences in access to nutrition and medical attention. The relatively fewer number of female MLAs might account for the Assembly's lack

of awareness that it is excluding an area of public health that requires special attention, because of the entrenched exclusion of women from all resources.

- Cost-efficient ways of supplying medicines via government hospitals to combat rising prices in the private pharmaceutical market.
- Ailment-specific prevention: diarrhoea is rampant in all villages of West Bengal, and its prevention and even treatment is relatively inexpensive and easy. Yet no interest was shown on the floor to address it, and similar curable diseases.

In view of the rather unenthusiastic involvement of the media and legislators regarding key health issues, we assert that to awaken ballot-box-democracy and mainstream media to concerns of equity in health, we need to make the fullest use of avenues of deliberative democracy. Hence is our focus on democratic dialogue in a public forum.

#### NOTES

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1. For Pratchi's fieldwork and intervention in one such area, please see "Hormo Jeevi Bhalai Pontha: For Better Health and Life".
2. "Snakebite Mortality in India: A Nationally Representative Mortality Survey". Mohapatra B, D. A. Warrell, S. Wilson, P. Bhatia, N. Dhingra et al. *PLoS Neglected Tropical Disease* 5(4):e10118. 12 April 2011.
3. No comprehensive study of dog-bites have been done in the State, but a study by A. K. Hati *et al* in Burdwan indicates a treatment void for dog-bite induced rabies.

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