Chapter 2: Research Questions, Methodology and Introducing the Case Study

In order to proceed with the present research, it is imperative that the questions this research seeks to probe is uncovered and light is shed on the methodology used. Further, since the case study involves careworkers in West Bengal, it seemed pertinent to locate the sub-national state under study as well, as has been done in later half of this chapter.

2.1 Research Gap:

As is evident from the review of existing literature, academic literature, as documented before, though exhibits rich and analytical narratives of the origin and development of the modern healthcare system and various policies associated with it, but the discussions on the problems and prospect of the healthcare system in West Bengal is truly scarce. Second, there is also paucity of academic literature where both healthcare policies and the realities of healthcare workers have been duly emphasised. The above gap, in previous research justifies undertaking the present work.

2.2 Aims and Objectives:

The current research aims to draw a *present history* of healthcare in West Bengal from 1991 to 2015.

The objectives of the present research are twofold:

i) To examine the parallel phenomena of decline of state's responsibility towards healthcare and the rise of corporatised healthcare sector.

ii) To analyse healthcare policies vis-à-vis the status and experiences of different categories of healthcare workers, mainly in West Bengal.

2.3 Research Area:

The present research focuses first on the healthcare policies in the Indian state of West Bengal, at the temporal juncture of Indian economic liberalisation in 1991. Studying the phase from 1991 to 2015 would be interesting because West Bengal till 2011 was under a leftist government and had been critical of steps taken by the then Congress government at the centre. While the New Economic Policy (NEP) was adopted in July 1991, as a response to the balance of payment crisis, tendencies to liberalise the economy can be traced back to the 1980s. As a result, this research also explores pre-1991 healthcare policies to understand distinct changes that can be traced to the pre- and post-liberalisation period, especially in West Bengal.

India is a federal state, where responsibilities are demarcated between the centre and the states and these are clearly written in the Union, State, and Concurrent lists (both state and the centre). However, even when health or healthcare has been on the state list, it has always been the centre that framed policies or gave policy guidance through Five Year Plans. Even the three National Health Policies framed after independence in 1983, 2002 and 2017 were initiated at the central level. So, in India, important decisions pertaining to healthcare are made at the central level, and it is the state's responsibility to put those decisions into action. Healthcare systems are regulated through health policies, which in turn are regulated by politics. Thus, this chapter reviews healthcare as outlined in India's five-year plans to better understand and analyse West Bengal's healthcare policies.

The second part of this work focuses on healthcare workers since the implementation of various policies depends mainly on service delivery, which puts the healthcare workers at the centre of the analysis. In West Bengal there are different categories of careworkers but, for this research, the categories of nurses and *ayahs* have been selected. Recognising the important role careworkers play in healthcare delivery, WHO through the World Health Report of 2006, had declared the years between 2006 to 2015 as the decade of human resources in health (WHO 2006, *passim*). It had also urged all the member-countries to develop national plans which would focus on creating 'high-performing workforces' capable to mitigate future healthcare challenges. Thus, making it clear that in order to improve healthcare situation in a country, policies need to give emphasis on workforces in healthcare (14).

Nurses were chosen as they form the first point of contact with the ailing patient. They are with the patients round the clock and are also the primary healthcare provider in rural areas, thus, playing an important role in Indian society. However, nurses are always struggling to establish

their work as a specialised profession, since the work of 'caring' is largely seen as an 'affective work' or feminine duty associated with women. Although male nurses are also found in recent times in West Bengal, most nurses are female.

Despite the nurses' important role in healthcare, most of the recommendations in the three national health policies were mainly in relation to doctors (only a separate section titled 'Nursing personnel' was there in 2002; whereas, in 1983 and 2017 nurses were mentioned in a scattered manner)[1]. This necessitates more studies to explore how various governments have perceived the work of the nurses and evaluated their work. Furthermore, women's involvement in the paid workforce, particularly 'reproductive labour' has received comparatively less attention in research. Women performing 'dirty work' (as used by Nakano Glenn 1992) involving cleaning and washing (part of reproductive labour) further leads to their subordination in society as well as labour market constraining their bargaining power. This makes it imperative to investigate the second category of careworkers, that is *ayah*s, working in both private and public spaces. The above has led the current research to probe the following questions.

2.4 Research Questions:

1. How healthcare and carework have been approached through different conceptual lenses in the Indian context?
2. How did healthcare and healthcare policies evolve in India? How have healthcare policies come to be shaped following the economic reforms of 1990s?
3. How did healthcare and healthcare policies evolve in West Bengal? How healthcare policies have been shaped following the economic reforms of 1990s?
4. What have been the experiences and conditions of careworkers in West Bengal since 1990s – a) the case of nurses and b) the case of *ayahs* and of nurses in West Bengal.

2.5 Methodology:

Simply put, methodology refers to strategies of acquiring knowledge and method refers to tactics (McNabb 2004, 341). Research methodology is the general term used to describe the

[11] Also see Dubey, Vasa, Zadey (2021).

processes researchers use to describe, explain, and forecast events. It can also be described as the study of how knowledge is acquired. Its goal is to provide the research with a work plan. A methodology provides a systematic guide to solve the problem with which the research is concerned. What research methods are to be used is determined by the methodology. A foundation for theorising through modelling that mirrors economics is methodological individualism, while historical approaches have a stronger influence on how institutions and culture are viewed. Normative theorists as well as administrative scientists, who are typically more interested in the policy or political relevance of the social sciences, support the epistemological tenet that one must 'understand the world in order to change it,' as French political scientist Pierre Favre put it (Porta and Keating 2008, 317).

Further, there is a tendency in healthcare research to give primacy to what is being referred to as 'hard data', thus using 'positivist' approach. The positivist paradigm is based on the assumption that a single tangible reality exists—one that can be understood, identified, and measured (Mertens 2019, 10) and the concepts and methods employed in the natural sciences can be applied to social sciences as well (Giddens 1987). Further, structured interviews, surveys and self-completion questionnaires used in social science research also adhere to positivist paradigm (Broom and Willis 2007,21). Research on health/healthcare includes various parameters like Infant Mortality Rates, Maternal Mortality Rates, Fertility Rates, or other parameters which are used to understand the health status of a population. In all the above cases primacy is given to *observable data*.

On the contrary, 'social constructionism' has developed on the idea that all conceptual frameworks are historically and culturally contingent. They are not only unique to particular cultures and historical periods, but they are also regarded as 'products of those cultures and periods', and they depend on the particular social and economic structures that were in place at the time in that culture (Burr 1995, 3). While doing research in social science, this approach highlights that our understanding of realities is shaped by everyday 'goings-on between people' (Ibid). It places importance on human interests in a research analysis and in adopting this method, the researcher remains a part of what is being observed and no separation between the observer and the observed is mandatory.

The current research has resorted to 'methodological opportunism' (borrowing from Adam Prseworski 1995, 16), as it involved 'doing or using whatever works' (Ibid). Acknowledging that there is *no one way of understanding a complex problem or issue* (Reeves et al 2008, 631-

632), multiple lenses have been used to understand significance and particularities of various events shaping healthcare. Peter Evans (1995) stated that the reason we undertake to do particular research, is because 'we care' and thus one is forced to do history and to 'try to understand specific sequences of events and to acquire ideographic knowledge', that our understanding of such events might entail (Atul Kohli et al. 1995, 3). The current research endeavour is thus *not value-free*, but in influenced by a value premise that treats healthcare access for all as a prerequisite of justice. It also needs mentioning that all the respondents or participants have been treated equally in this current research. Further, the research has opted for the road to 'methodological pluralism' (borrowing from Pawson [2008, 120]) as it has tried to explore ways to question theory with data.

In this research attempts have been made to describe and analyse policies, which have been treated as written intentions of institutions like the government, World Health Organisation, corporations, donor agencies and so forth. Since the present work looked into various debates and tried looking into the national as well as international compulsions which had shaped policies and policy formation, the style that has been adopted is that of narrative policy analysis. Borrowing from Brown (1998), I would like to say that policies act like an umbrella concept, overlooking the various differences of opinions and approaches that exist among various groups involved with its framing and execution. For instance let us assume that a government's policy is providing quality healthcare at low cost. While various groups are united to make this happen, management of a hospital might use more casual or contractual workers to reduce the cost, while nurses might want more autonomy in their everyday functioning, which might take the pressure off the management, which spends a lot of time doing supervisory roles. This affects how policies get applied in a given context, thus determining their success or failures. Policies in this research have been treated not as depoliticised documents but as political documents setting forth further political decisions, discussions and debates.

This research while focussing on the state of West Bengal is built on a *case study* of careworkers in select formal and informal sectors. Growing concerns about the shortcomings of quantitative approaches in offering comprehensive and in-depth explanations of the social and behavioural aspects of the study undertaken, led to the acknowledgment of case studies as a research method. A researcher can go beyond the quantitative statistical findings and comprehend the behavioural conditions from the actor's point of view by using case study approaches (Tellis 1997). Though various sources like photographs, films, physical artefacts,

but the ones discussed below seemed more relevant for the present study. Let us look into the pros and cons of various sources deemed relevant for the present case study.

Table 1: Pros and Cons of Case Study Method

Source	Pros	Cons
Documents & Archival	• Stable – repeated review • Broad coverage – extended time span • Precise and exact – detailing exact names, date, occurrences etc	• Difficult to retrieve • Biased selection • Reporting Bias • Limited Access
Interviews	• Targeted – focussed on the topic of case study • Insightful – providing perceived causal inferences	• Researcher's bias • Biased respondents • Reflexivity – Respondents expressing what the researcher wants to hear.
Direct Observation	• Covers events in real time • Takes the 'context' into consideration	• Time-consuming • Reflexivity- Researcher's presence might affect change in the environment • Selective- Might miss out other responses.
Participant Observation	• Same as above • Throws light into inter-personal behaviour.	• Same as above • Bias due to researcher's actions.

Source: Adapted from Yin 2002, 86.

Since the current research endeavour deals with policies, hence, documents like policies, government reports, reports by other agencies have been treated as important texts. This research draws on materials gathered from **interviews, primary** (policy documents, reports of various expert committees), **secondary** (books, articles, commentaries etc.) and **archival**

materials (newspaper reports, assembly proceedings etc.) and all have been important in leading this work to its fruition.

2.5.1 An experience before the outbreak of COVID-19 Pandemic in Kolkata, West Bengal:

It was early March 2020, when I was in a private hospital on Eastern Metropolitan Bypass, near Mukundapur area, Kolkata. Though common people had no idea of what COVID-19 pandemic entailed, various awareness videos were in circulation, highlighting the need to wear masks and maintain hand hygiene. During this time wearing of masks was made mandatory by various hospitals and people were not allowed inside without masks. Private security guards and nursing assistants (hired through agency) were deployed at all the entry points providing hand sanitiser to anybody entering the premises. Being prevented from entering for not wearing a mask, two visitors, were stopped at the gate by the nursing assistants. Two middle-aged men from presumably good financial background (It was a posh hospital plus and these men made everybody around them, well aware of their socio-economic and political standing in society, through high-pitched tone) threatened the nursing assistants of taking their job away and hurled abuses at her. The private security guards had to intervene and the careworkers were released from the duty of giving hand sanitiser. Later, I told one of the careworkers, who was in charge of giving hand sanitiser that what she had to experience was unfortunate. She had ruefully stated that she was just doing her job, but none from the management thought of talking to her after the incidence. *Amra ki manush na* (Are we not humans?), she had asked.

While talking to a senior doctor of the hospital, who is also part of the management, I had asked if there were provisions for counselling healthcare workers, more so at a time when we were going through a period clouded by uncertainty due to the outbreak of COVID-19 virus and the possible threat it posed. He had stated that they have provisions for counselling and it is done on a regular basis in several batches. On posing the same question to a GNM nurse from Manipur, she stated that all they were told during the counselling sessions were to wear mask, not get tensed, and maintain hand hygiene. *Uske liye thodi na counselling ki zarurat hai… aur kisike pas humlogoke liye utna time nahi* (For handing out basic information, there is no need for counselling…nobody has got time for us). While nurses, doctors, technicians wore proper masks, security guards, female housekeeping staff wore thin masks made of cloth. While my way out, I saw *prashad* or offerings from some god being exchanged among the housekeeping

staff, staff manning elevators and the security guards, perhaps hoping that it would keep them safe from what was coming[2].

The above incident shows that women careworkers even in 'gated' private hospitals experience violence of varying degrees on almost a daily basis. Be it threats from patients' party or threats from the management or the agency (through which they are placed in a hospital) of rendering them jobless, causing physical harm or abuses equating them with prostitutes, de-professionalises, the profession of nursing. There is a hierarchy in the profession as well as in the workplace. For instance, while medical masks were given to doctors, nurses, other staff like security guards, or people from housekeeping were wearing cotton masks. The statements of the nursing assistant and the nurse from Manipur convey a feeling that hospital administration is not bothered about the careworker. This also dehumanises them. Another aspect that needs to be flagged here is that access to hospitals, nursing homes and placement centres was difficult in pre-COVID times, however after the pandemic it had become almost impossible as access to two big private hospitals was denied during this time.

2.5.2 Data Collection Methods:

Tellis (1997) stated that case studies do not use samples, Neuman (2009) stated that purposive sampling could be used when the researchers want to incorporate cases that are informative or want to access a group which is not easily accessible. For this research I did not have access to the entire population of nurses or *ayahs* in any medical institution, therefore interviews were conducted after an appointment was fixed. Hence one of the non-random sampling technique, purposive sampling was adopted for this research. Though random sampling method is considered to be free of any bias, it could not be used for the present research. Snowball technique was used to increase sample size. Respondents after being interviewed were requested to refer me to their colleagues, so that I could interview them as well. Interviews with careworkers were conducted in a) government medical college and hospital b) private hospitals (including one run by a trust) c) private nursing homes d) other government facilities (including hospitals under municipality, community health centre, primary health centre and subcentre) e) clinic like facilities run by quack and managements of tea gardens. Interviews were also conducted near the hostels or accommodation of nurses that were provided by the hospital.

[2] Personal Interview conducted on March 10, 2020 at a Super-speciality Hospital in South Kolkata.

During the embryonic stage a pilot study was conducted in one private hospital and four placement agencies for *ayahs*, in Kolkata. The sites were chosen because of geographic proximity and easy accessibility. Initially a semi-structured questionnaire for both nurses and *ayahs* were used. However, after the pilot study it was realised that the questionnaire was too long, which left respondents tired and distracted for follow-up questions. As a result of which separate and shortened questionnaires were used for further interviews. The questionnaires were also translated into Bangla (since many people in West Bengal are more comfortable in reading, writing and speaking the language) and while interviewing respondents who could not read either Bengali or Hindi, I had to act as a translator. This I had to do with respondents who could either read only Hindi or could not read at all. While doing interviews in certain cases, for instance in the tea gardens and *charlands,* I had help from local residents, who belonged to that area to make communication easy and also because accessing the above sites were difficult as the respondents would not have opened up to a random stranger.

Interview method employed comprised both face-to-face and voice-to voice (telephonic interviews) interviews have been conducted. Interviews have been conducted in phases. The first phase began in early 2016 and following the suggestions of the committee members to include the district of Maldah during the pre-submission seminar, the last phase got concluded in August 2022. COVID-19 pandemic which affected the whole world had greatly impacted the present research. March 14 was the last date, when I could conduct interviews in a private hospital in Kolkata, after which due to lockdown and with the introduction of various safety protocols, initiated to combat the pandemic, access to the field (hospitals, nursing homes) were severely restricted. It was very difficult to interview careworkers over phone as they were extremely busy. From ASHA workers to nurses in various facilities or *ayah*s working in hospitals or patients' homes, narratives collected much later, indicated the difficult times they had to go through. Though interviews began with a set of questions, however they went beyond and took the shape of conversations. Care was also taken to diversify the interview sample, in terms of age, religion, location etc. It was also ensured that I interview those careworkers who were employed during the time frame of 1991 to 2015.

It needs mentioning that in the initial days getting access to the field was not easy. Where formal permission was not granted, informal network channels were explored. That my gender has helped me approach potential respondents for interviews without any awkwardness, was made clear when multiple times the respondents had stated, *Meyeder koto oshubidher modhye diye kaaj korte hoy, ki bolun*! [women have to work amidst adverse situation, is that not so!]

That I was referred by people who were known to them, eased the process further. It was important to gauge the realities of everyday work and life of the respondents, hence interviewing them in their places of work, seemed reasonable.

However, I was not comfortable interviewing them in the wards as I feared that my presence was making the patients feel uncomfortable and they could have perceived it as an invasion of their privacy, as they lay vulnerable in hospital beds. On one occasion the interview had to be abandoned. A senior nurse working at a government hospital in Kolkata was close to the end of her shift, and I happened to reach her workplace early. She was dressing the wound of a man, as blood was oozing out through the stiches and he was groaning in pain. She had asked me to start asking questions there, as she was 'almost done for the day.' Later she had apologised for not being mindful of the fact that I was not from her profession (implying that like others in her profession I was not used to blood and gore).

Interviewing *ayahs* came with different type of hindrance. Two owners of placement centres (in Kolkata) had asked for money for allowing *ayah*s associated with the centre to be interviewed. This was followed by queries from *ayah*s if my research could help them avail a pension. When I had answered in the negative, it had initially affected building a rapport with them. Despite the initial hiccups women shared their experiences, which have been presented later in this work. Gerald D Berreman (2004, 169) said that once the confidence is built, it is easy to get respondents to talk as it is a 'universal human trait to like to talk about oneself', to people who seem interested in what they do. And it proved to be true in case of the present research.

The present study has also included certain **quantitative survey questions** to gauge healthcare receivers' satisfaction with the quality and delivery of healthcare in and around their localities. Interviews for eliciting response about healthcare service delivery were conducted in one government medical college and hospital in Kolkata, one government district hospital in North 24 Parganas, one rural hospital (government) with 30 beds, adjacent to *charlands* in Murshidabad's Jalangi sub-division, management run clinic-cum-hospitals in tea gardens of Alipurduar and Jalpaiguri districts along with two primary health centres and two subcentres in the same area. Two urban slums were also included in the survey. Dichotomous scale and three-point 'Likert Scale' have been used in this regard. Along with the standardised set of questions, scope was also there to note down other relevant details or findings. This data has been presented as descriptive data in the following sections. Mixed methods have been used,

with a view to utilise the strengths of both quantitative and qualitative research procedures leading to an 'integration' or 'a more holistic understanding than achieved by either alone' (Fetters 2020,19).

2.5.3 Sample:

The sample included **nurses** of various categories like BSc nurses, General Nursing and Midwifery nurses (GNM), Auxiliary Nursing and Midwifery nurses (ANM), diploma nurses, private sisters, bedside nurses, nursing interns and matrons. Both registered and non-registered nurses working in both government and private institutions, in various parts of the state of West Bengal have been interviewed. From small nursing homes in district towns, to big corporate-style hospitals, to sub-centres in remote areas, interviews were conducted. However, it is pertinent to mention that though during this research the researcher came across a few male ward nurses (while visiting hospitals), I could interview only two of them. Responses of healthcare workers like ASHA workers, working in remote areas have also been recorded.

The second pool comprised ***ayahs***, working in government and private institutions as well as in private spaces that is in the patients' homes providing everyday care and support to patients.

The third group was relatively small and included employers also comprising **owners of *ayah* centres**, various **agencies** through which nurses are recruited and people from the **management** or **administration**.

Responses from **healthcare receivers** in both institutional set-up and private spaces (residence of patients for recording responses of clients hiring the services of *ayahs*) were recorded along with the responses from the margins of West Bengal, like in the tea gardens of the northern districts of the state, *charlands* in Murshidabad district, and urban slums. It was done to understand the quality-of-service delivery and access of healthcare in several pockets of the state. This formed the fourth group.

The next group comprised **experts, senior doctors, bureaucrats, people associated with Public Health Movement, principals and teachers of nursing schools**. A few interactions with retired bureaucrats have led the researcher towards important policy documents and have also helped me to approach certain issues from a different perspective. Since other categories of careworkers are crucial part of everyday experiences of nurses, focussed group interviews have been conducted, with other categories of healthcare workers like ASHA *didis* present in

primary health centres and sub centres) to fathom factors affecting healthcare delivery by careworkers, better.

It needs to be mentioned that since some of the nurses associated with government medical colleges had requested for anonymity, the names of every respondent have been changed to keep parity. Only those who were comfortable disclosing their identities, have been formally acknowledged in the section on 'Acknowledgements.' However, before delving deep into the study, it is imperative to provide more information about West Bengal, the field of the current research as it involves understanding healthcare policies as well as a case study of careworkers, in this sub-national state.

2.6 Locating West Bengal:

West Bengal, located in the eastern part of India is the fourth most populous state of the country. As per 2011 census, it has a population of 9.12 crore which comprises 7.5 per cent of India's total population, spread across 88,752 square kilometres (sq. km), comprising 40,218 villages, and 909 towns (GoWB, 2017,3). Compared to a national average of 382 people per sq. km, West Bengal has 1,028 per sq. km. Other interesting trends in West Bengal's population between 1991 and 2011 are mentioned below.

Table 2: West Bengal's demographic profile over 1991 and 2011, and comparison with India

	WB Census 1991	WB Census 2011	India Census 1991	India Census 2011
Total population	67,982,732	91,276,115	844,324,222	1,210,854,977
Male population	35,461,898	46,809,027	437,700,478	623,270,258
Female population	32,520,834	44,467,088	406,623,744	587,584,719
Sex Ratio (No. of females/1000 males)	917	950	929	943

Density of population per Sq. km	766	1028	267	382
Decennial population growth rate (in %)	17.77	13.84	23.56*	17.7
Decadal variation (in %)	24.73	13.84	23.87	17.7
Urban population (in%)	27.40	31.87	25.71	31.2
Rural population (in %)	72.60	68.13	74.29	68.8
Scheduled Caste (in%)	23.62	23.50	16.33	16.6
Scheduled Tribe (in%)	5.59	5.80	8	8.6
Literacy rate (in%)	57.7	76.26	52.21	73
Birth rate (in%)	270	16.3	29.5	21.8

Source: *Health on the March 1991*,2 and *Health on the March 2016-17*, 4; *Population Census of India 2011 Table A-02; Sample Registration System Bulletin Various Issues, Ministry of Home Affairs, GOI as extracted from rbi.org.in, last accessed on 24.11.22.*

As per Sample Registration system (2009), birth rate stood at 17.2 (West Bengal stood fourth, after Kerala, Tamil Nadu and Punjab) and death rate stood at 6.2 (West Bengal stood third, next to Delhi and Jammu & Kashmir). Data pertaining to life expectancy in West Bengal and for India are mentioned in the table below:

Table 3: Life expectancy in West Bengal and India

Sex	West Bengal		India	
	1990	2016	1990	2013-17*
Females	59.6	71.3	60.4	70.4
Males	58.4	68.1	58.9	67.8

Source: *West Bengal: Disease Burden Profile 1990-2016 and* ****SRS Based Life Table 2013-17***[3]

West Bengal stands out from the rest of the country for a few reasons, that need to be discussed. For instance, Calcutta (renamed as Kolkata in 2001) was made the capital of British India in 1772 and it remained so till 1911. During colonial times, undivided Bengal saw setting up of industries, gradual development of infrastructure, educational institutions and so forth[4]. Calcutta continued to be the capital of the new state of West Bengal. However, the new state was formed following the partition of India. It was one of the two states (other one being Punjab) that had to face the brunt of Partition. Apart from loss of properties, the flow of refugees in the state was a concern for the government. While in case of Punjab, migration of refugees across borders was limited for a short span of time (1947-1948), in case of West Bengal refugees from East Pakistan arrived in several phases. Poor housing conditions in several refugee camps, lack of proper medical facilities and poor diet affected the refugees' health and many died of smallpox, malaria, cholera, diarrhoea, etc. (Sinha 2015, 822-824).

Additionally, despite being categorised as an urban and industrial state in the initial years after independence (West Bengal 1955 285-286), West Bengal started to decline as an industrial state since the 1960s. Right before independence, undivided Bengal had 1218 registered factories, employing 33.62 per cent of the total workforce (highest in India at that point of time), adding a value of 57.32 crore (featured in the second place after Bombay) (Dasgupta 1998, 3051).After independence, though the central government gave protection to indigenous industries through import licensing through which import of consumer goods including textiles were banned, (only allowing import of intermediate materials and capital equipment provided they were not produced in India), export-oriented industries like jute and tea, which were important industries for West Bengal received very little protection. Further the engineering industry in the state suffered because of the centre's policy of freight equalisation. Decline of

[3] https://pib.gov.in/PressReleseDetail.aspx?PRID=1606209. Last accessed 24.6.21.
[4] https://www.indiatoday.in/education-today/gk-current-affairs/story/when-kolkata-began-as-calcutta-the-history-of-the-first-capital-of-british-india-1322194-2018-08-24. Last accessed 23.8.20.

approved licenses for various factories in the state, flight of capital, labour unrest, political turmoil and other causes led to the decline in the state's industrial sector (Das 2016 161-171).

The presence of left politics in West Bengal can be felt through colonial times to postcolonial times. Left politics have shaped several protest movements since the *Tebhaga* movement. It was followed by movements by refugees, anti-tram-fare-rise protests, teachers' movements, food movements, Naxalbari movement (Samaddar 2019). Further the fact that the state was under a Communist government for thirty-four years (1977-2011), without any break also made it unique in India. But the 'pro-poor' stance of the government was seriously challenged when it inflicted violence on the peasants (who were loyal supporters of the Communist Party of India (Marxist) or CPI[M], the most important member of the Left Front Alliance that was elected to office) in order to acquire lands on behalf of a multinational corporation (Samaddar 2013; Das 2016) and it lost power in 2011.

Reviewing some of the key health parameters of the state (see Table 3.3), in 2015, it seems that West Bengal ranked fourth in terms of birth rate, third in terms of death rate, fifth in terms of infant mortality rate, first in terms having the lowest fertility rate, fifth in terms of neo-natal mortality rate, and sixth in terms of under-five mortality rate (GoWB 2017, xiii).

Table 4: Health Parameters of West Bengal and India

Indicators	**West Bengal (1990)**	**All India (1990)**	**West Bengal (2015)**	**All India (2015)**
Birth Rate	28.2	30.2	15. 5	20.8
Death Rate	8.4	9.7	5.9	6.5
Infant Mortality Rate	63	80	26	37
Total Fertility Rate	3.2	3.8	1.6	2.3
Neo-natal Mortality	48.0#	57*	18	25
Under 5 Mortality Rate	NA	122 males* 131 females	30	43

Source: Collated from i) GoWB. 2017. *Health on the March 2015-16*, xiii; 27; ii) # Figures of 1991 (*Health on the March* 1999, 27); iii)*The Hindu, September 9, 2020.

When it comes to healthcare, West Bengal can be perceived as some sort of a puzzle, when compared to relatively richer states like Gujarat and Karnataka (as per GSPD 2018-19)[5]. Data from NHFS 5 has revealed that when compared to Gujarat, West Bengal has performed better with regard to key indicators like Infant Mortality Rate (IMR), Life Expectancy at Birth (LEB) etc. Even in the 90s, West Bengal performed better with regard to IMR and LEB. For instance, when it comes to IMR, West Bengal ranked fifth, while Karnataka and Gujarat ranked sixth and seventh respectively. Similarly, with regard to LEB, West Bengal ranked fifth, while Karnataka ranked sixth and Gujarat ranked ninth. (Hirway 2000, 3118). It also needs mentioning that neonatal, infant and child mortality rates in the state, though does not show a noticeable improvement, still performs better than other states of east India (Maitra and Ray 2013). Further, when it comes to child health, figures seem to be paradoxical. While figures measuring stunting has shown improvement, but that measuring wasting has deteriorated (Maitra et al. 2013).

The scarcity of government hospital beds had exposed the dearth of necessary infrastructure for providing healthcare services to the common people, especially the poor, in times of emergency like COVID-19 pandemic. Figures during the pandemic revealed that when it comes to population is to bed ratio, West Bengal (2.25 beds per 1000) comes second to Sikkim (2.34 beds per 1000 population) (Singh, Ravi and Chakraborty, 2020).

[5] See htpps://m.statisticstimes.com/economy/india/Indian-states-gdp.php. Last accessed 12.09.21.

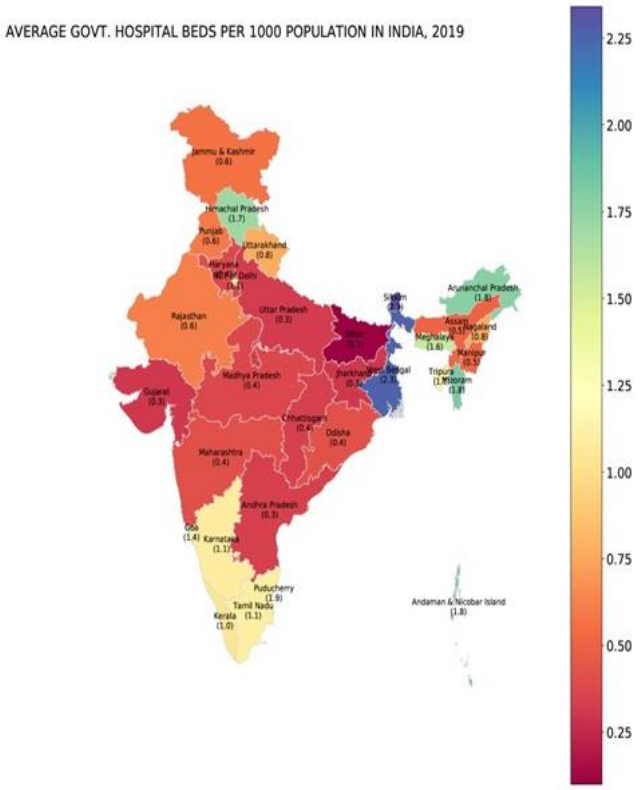

Figure 1: Average govt. hospital beds per 1000 population in India, 2019, Source: Singh, Ravi and Chakraborty (2020)

The Constitution, reflecting the ideals and aspirations of the new nation, had divided its responsibilities pertaining to health, in the following manner. Apart from minor and scattered references to health in the Constitution, the Seventh Schedule states clearly that responsibilities like looking after public health and sanitation, hospitals and dispensaries; giving relief to the disabled and unemployed; maintenance of burial grounds and cremation grounds are the responsibilities of a state government.[6] 'Port quarantine, including hospitals connected therewith; seamen's and marine hospitals'[7] feature in the Union list and matters related to 'Legal, medical and other professions', also feature in the Concurrent List.[8] The First Five Year Plan mentions that though 'health' is a state subject, the Central Government has also the overall function of the development of health services' (GOI: 1951). Thus, India continued with the 1919 distribution of subjects between the centre and the provinces (now states). However, though healthcare is majorly in the state list, the centre plays a key role in framing the healthcare policies and the state's job is to implement those decisions. Since India has adopted federal structure (with centralising tendencies), a discussion of policies at a sub-

[6] Please refer to Clauses 6,9,10 of the State List of the Constitution of India.
[7] Clause 28 of the Union List, Constitution of India.
[8] Clause 26 of the Concurrent List, Seventh Schedule of the Indian Constitution.

national level will not be complete without understanding policies at the national/ central level. Hence, a discussion of healthcare policies in India would follow in the next chapter.