Chapter 4: The Scenario in West Bengal

As is evident from our discussions in the previous chapters, despite health being a state subject, the Five-Year Plans formulated at the centre provided guidance to the sub-national states. These states also enjoy some form of relative autonomy to address various unique concerns of the respective states, while always operating within the broad framework as laid down by the central government. This chapter apart from exploring healthcare situation in West Bengal since pre-colonial times tries to understand how a Leftist government negotiated with changes brought about after liberalisation of the Indian economy and if any change has taken place after 2011, when a new government was elected to power. Keeping in mind that margins are the true test for judging healthcare delivery and healthcare access, situations in urban slums, *charlands* and tea gardens have been explored.

4.1 Looking Back:

In the earlier days, non-western/ indigenous systems of medicine in India as well as Bengal did receive patronage from the rulers both at the regional as well as at the centre and that did not immediately change with the dominance of East India Company. Mughal officials in Bengal relied on ayurveda and not on Unani, which was the usual choice for Muslim rulers and aristocrats. When subedar Islam Khan was dying, he asked for an ayurvedic practitioner and when Mirza Nathan, Mughal general in Bengal fell ill, he recovered with the help of a *kobiraj*, who made him potions to drink. This highlights the respect ayurvedic medical science or *kobiraji* had in Mughal Bengal (Chaudhury, 2013, 8).

In 1822, Native Medical Institution was established to train indigenous people or Indians to fill up positions of doctors in various medical establishments across the Bengal Presidency, as a result of which they got to learn about both the western and non-western systems of medicine (Bala 2009,30). However, it ceased to exist in 1835. Gradually attempts were made by the colonial masters to bring native women and children into the ambits of western institutionalised medical system and Lady Duffrin's fund aimed at achieving this goal. It was imperative that women were brought to hospitals and dispensaries or 'within the purview of medical gaze which was at the same time an imperial gaze' (Bala 2015, 15).

Around early 19th century in Calcutta, one could find 'vigorous female domain of healing'. Female members of households and certain recognized external women specialists had commendable skill as practitioners. For instance, the names of 'Jodu's mother' and 'Raju's mother' were very popular in the 19th Century Calcutta. The former hailed from the family of Bhabanicharan Dutta associated with the Public Works Department of the East India Company as a *diwan* and was famous as a healer; the latter hailed from the barber caste and was famous for her surgical skills. Iswarchandra Gupta, a popular poet of that time, wrote: *Daktar kobiraj rone jare hare/ Jodurjanani gia joy tare kore* (Where the qualified physicians fail, Jodu's mother wins there) (Mukherjee 2012, 27). Mortality rate in the first half of 19th century Calcutta, over seven years period revealed that during the above period in Calcutta, during the winters, 'bad fevers prevailed' and between 1826 and 1832, among Her Majesty's troops in the Bengal command, 4772 cases were reported and yearly deaths on an average amounted to 132 (Mackinnon 1848, 57 and 198). Cholera, malaria, dysentery were other diseases that bothered European population stationed in the eastern region and March, April May were referred to as worst 'cholera months' (5). The table below shows the average number of deaths from January to December between 1826 and 1832.

Table 1: Deaths per month between 1826 and 1832

Months	**Figure (Out of 1000)**
January	27.5
February	12.5
March	18.5
April	19.5
May	17.5
June	14.5
July	18.5
August	26
September	28
October	30
November	34.5
December	31.5

Source: (Mackinnon 1848,4)

The setting up of the Calcutta Medical College in 1835 and the practice of western medicine paved the way for a new medical discourse in Bengal, where western medicine was gradually internalised by middle-class Bengalis (Guha 2018). This led to the process of 'othering' or subverting the existing knowledge systems leading to a new system of thought. In his writings,

Rajnarayan Basu, a famous writer and intellectual in 19th century Bengal had focussed on health and the body or *'sarir'* of natives of Bengal (urban *bhadralok* mainly). He had stated that health was deteriorating, as *bhadraloks* were becoming weak or prone to illness, when compared with previous generations. Later, through a comparison between a 'vernacular old man' who continued with everyday practices that his predecessors had followed, like waking up early, singing religious songs etc. and 'an anglicised old man', who consumed alcohol, slept late and woke up with a hangover and had no contact with nature, Basu stated that this blind imitation of western ways of living affected health of the natives. In 1912, Motilal Ghosh, founder of *Amrita Bazar Patrika*, while addressing the All-India Sanitary Conference, had argued that earlier rural Bengal was almost free of diseases and whatever illness prevailed like smallpox, could be effectively treated by traditional or indigenous healers (Chatterjee 1997, 194-198). The above instances lead us to the question (like Partha Chatterjee) the claim that the western medicine is the only 'modern path, or path to modernity. Instances by Iswarchandra Gupta and Motilal Ghosh, also reiterate the presence of an active indigenous healing tradition in the state (undivided then), like in rest of the country. Their words also had a hidden belief that whatever disease was plaguing society back then, came from outside (*ibid*), a feeling that was also escalated manifold during the COVID-19 pandemic, leading to drawing and redrawing of boundaries comprising 'us' and 'them'.

Earlier, colonial government was only concerned about keeping the cantonments and areas of European settlements sanitised. The health concerns of the natives generally did not feature in their policy documents. The Cantonment Act of 1864 was framed with the above goal in mind. The Royal Commission to Inquire into the State of Army in India (1859) was constituted which submitted its report in 1864 and investigated the health of the native troops and the living and housing conditions of their families (Report of the Commissioners 1864, 115-117). Even before 1909[1], the Sanitary Commissions that were initiated as per the suggestions of the Royal Commission in Madras, Bombay and Bengal had to be abolished by 1869 as the responsibility of providing public health services was shifted to provinces, which lacked funds (Kumar 2005). In 1888, sanitation became the responsibility of local bodies, municipalities, and village bodies, however the success was confined to cities (Bhore 23). Earlier, in 1876 Mahendralal Sircar had founded the Indian Association for the Cultivation of Sciences, which gave an impetus to Indian science and medicine. Following this trend, Prafulla Chandra Ray, founded the Bengal

[1] When health and education were transferred to the provincial governments.

Chemicals and Pharmaceutical Works in 1893, with the aim of producing and selling of indigenous drugs (Bala 2016, 15). Despite such efforts, unfortunately, when AYUSH (Ayurveda, Yoga, Unani, Siddha, Homeopathy) lost state patronage, its popularity too declined during the colonial times.

Another important development in the colonial period was the publication of the Plague Commission Report in 1904, following the outbreak of bubonic plague in Bombay in 1896. It exposed the unpreparedness of the government along with its inability to contain the spread of it. The report suggested improving public health services, making laboratories for research, and urged on the need for having vaccines (Bhore 1946,24). Closer to the end of the century, the Contagious Disease Act of 1897 was promulgated which aimed at controlling the spread of epidemics. However, these steps towards healthcare were not enough and came under the scrutiny of the League of Nations in the inter-war (1918-1939) period, which witnessed huge migration of people after World War I. The League had urged the colonial government to make public health interventions whenever necessary and initiate programmes for disease control and ensuring good health of local people. The government also realised the importance of enjoying local support in order to avoid challenges to their rule (Bhore 1946).

However, these efforts got limited with the passing of the Indian Council Act of 1909, popularly known as the Morley-Minto reforms. Through this act, health and education were transferred to the provincial governments along with full financial responsibility. Public Health policy of 1914, called for the need for improving rural healthcare. It stated, 'the general direction of a policy of public health must remain with the Central Government' (Kumar 2005, 48) but, in reality, the financial burden lay with provincial governments and elites were encouraged to invest in healthcare institutions (Qadeer, Saxena and Arathi 2021), following autonomy to the provinces to the extent that provincial legislatures and governments could make their own policies and implement them (Bhore 25). It needs to be reiterated that, the gap created by colonial government's inability to reach out was sought to be filled by missionaries' involvement and later institutions like Rockefeller in healthcare in India as well as well as Bengal (Reddy 2015; Samanta 2011; Samanta 2018). Further, the passing of 'The United Provinces Indian Medicine Bill (1938)', by the assembly of the United Provinces in 1939, was a significant step towards adopting a modern system of medicine or western system of medicine in which allopathy was given primacy and held to be *ideal* (Khan 2006). This set the growth and state sponsorship of western modern system of medicine into motion.

During 1941-42, the ratio of doctors to population in India was 1:6300, while that in England was 1:1000. Within India, the ratio in Bombay was 1:2218, in Punjab it was 1:4494, in Bengal it was 1:4913; while for United Provinces and Central Provinces it was 1:13,586 and 1:45,582 respectively. So, Bengal was somewhere in the middle, going by the above statistics. Even during that time, it was estimated that between 70-75 percent doctors practiced in the urban areas and in Bengal, doctors' presence in urban areas was 3.5 times more, than in rural areas (Bhore 1945, vol 1 36-37). The graduates of Calcutta Medical College (CMC) could either get employed by the government as sub-assistant surgeons, set up private practice, work for private companies or teach. The graduates with more time consuming and expensive education were drawn towards practicing independently. In 1861, there were 85 sub-assistant surgeons and around 20 CMC graduates who had private practices in Calcutta, earning more money than government employed ones (Hochmuth 2006,53-54). Let us look at the situation of medical institutions in Bengal province between 1941 and 1942, which totalled to 1815. The number of public, private and other types of medical institutions was as follows:

Table 2: Types of Institutions before Independence

State Public		**State Special**				**Local and Municipal**		**Rail**		**Private aided from Public Funds**		**Private Non-aided**		**Subsidised**	
Rural (R)	Urban (U)	Police		Others		Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban	Rural	Urban
12	13	R	U	R	U	1201	139	42	35	111	26	130	56	7	N/A
		1	29	7	6										

(Source: Bhore 1946, 43)

4.2 Scene After Independence:

Poet Sukanta Bhattacharya's[2] biography sheds some light on Communist Party run hospital named Red Aid Cure Home in mid-40s (Gun 2017, 302). After independence, 'The Bengal Medical (West Bengal Amendment Act)', 1948, that amended a pre-existing 'The Bengal Medical Act', 1914, stated that the term 'medicine' implied 'modern scientific medicine', including surgery and obstetrics. However, other indigenous systems like Unani, Ayurveda, or even homeopathy (which has western roots) were not included in this definition. This might be

[2] Poet Sukanta Bhattacharya (1926-1947) was a famous and popular Communist poet of Bengal, who wrote poems against the tyrannical rule of the British and social inequalities. He died young due to Tuberculosis.

seen as an influence or extension of Nehru's vision of a *modern India*. It is important to mention here that, after independence, various steps were taken by leftist organizations like providing relief to the famine affected people of Bengal or forming Students' Health Home in Calcutta (now Kolkata) (Franda 1971,63). The Students' Health Home also tried arranging health insurance for students and mobilised the Left leaning doctors work under the leadership of Dr Arun Sen in 1952 (Gun 302).

As per the census of 1941, West Bengal had a population of 2,229,552 and after Partition and reorganization of the state, its population increased to 26,299,980 (GoWB 1952,7). Apart from the existing diseases that affected people during that time, like malaria, pulmonary tuberculosis, cholera, smallpox, kala-azar, fever etc., the influx of refugees from East Pakistan after partition of India, had posed serious challenges to the to the healthcare system in the state. To deal with the challenges, additional public health staff was appointed to look after the health of the refugees residing in various camps or colonies. Despite such efforts, there was an outbreak of cholera and smallpox in camps and colonies which shot up the mortality numbers. In 1950, out of 17447 total cholera deaths, 6276 people died in urban areas and a total of 12.268 deaths were recorded due to smallpox (2-5).

In this context, Prime Minister Nehru made it clear that he would not like to impose any 'ready-made solutions' on West Bengal and that "let it evolve on its own" (*Amrita Bazar Patrika*, July 18, 1949). However, the state of West Bengal was one of the few states to adhere to the recommendations of the Bhore Committee right after independence, 1948 to be precise. Under the guidance of Dr. B.C. Roy, it introduced a system whereby three to five subsidiary health centres were set up for a population of sixty to eighty thousand. The government also initiated a policy of having a fifty-bedded health centre at each thana or police station, serving a population of one lakh (Ray, Basu, Basu, 2011). It needs to be mentioned here that Dr B.C. Roy, was a member of the sub-committee on National Health which was set up by the National Planning Committee and chaired by Col. S.S. Sokhey and Bhore Committee. Dr Lakshmanwami Mudaliar, Dr H.R. Wadhwani and others were also associated with Bhore Committee.

However, 1948 was also the year when thousands of people died of smallpox and cholera. Though smallpox could be contained, cholera continued claiming lives till the first half of 1950 (Amrita Bazar Patrika, July 6, 1949; *Jugantar*, April 20, 1950). Requests were made by the then head of West Bengal Health Service, Dr B.C. Dasgupta urging everyone to take the

vaccination to help contain the spread of cholera (*Jugantar*, April 20, 1950). It was, however, the West Bengal Vaccination Act, 1973 [West Bengal Act XXXVII, 1973] (which repealed the Bengal Vaccination Act of 1888) that made not only vaccination but re-vaccination mandatory in order to prevent signs of smallpox. The responsibility of this task was delegated to the Superintendent of Vaccination along with his subordinates.

The First State Plan, pledging commitment towards the fulfilment of the goals set forth by the national Five-Year Plan, also expressed the responsibilities in mitigating various problems that affected the state. From containing cholera, smallpox to addressing the needs of the refugee population, the specific needs of the people of Bengal were laid down. Since a huge section of the refugees settled in camps, attention had to be given so that no major outbreak of diseases could take place. The First State Plan stated that economic development would take into consideration the diverse issues and urged that development should be in tune with the "socialist pattern of society", which implied that economic development would *include* improving nutrition levels, healthcare, sanitation etc. (GoWB, 1956,1). Further, the role of the State Plans under the aegis of National Five-Year plans, had been stated as ensuring a 'unity of purpose' for the various plans (GoWB 1961,1)

During this time, between 1948 and 1956, death rate per 1000 came down from 18.1 to 8.2 and IMR came down from 136.7 to 79.9 (GoWB 1956,70) which gave rays of hope. But limited beds for tuberculosis patients in government hospitals was a concern for the government hence, emphasis was given on B.C.G vaccination since 1949. The plan had also stated that leprosy was a worrisome issue and the progress report of the First Plan stated of the establishment of an isolated leprosy village in Bankura district. In the initial days, after independence, child and maternal mortality rates were also high, and cases of venereal diseases and other infectious diseases also worried the government of West Bengal (GoWB 1956).

The State Plan had also initiated the scheme of 'Conversion of Nilratan Sircar Medical School into a College and provision of 100 additional beds', through which the awarding of licentiate degrees was discontinued. Licentiateship course was abolished in the state. This was done to ensure a uniform standard of medical education. While the need for a high standard of medical education was propagated, the problem of dearth of nurses in rural Bengal was solved with the initiation of a shorter course (Assistant Nurses cum Midwives or Auxiliary Nurses cum Midwives Courses) of nursing for women with less academic qualification. Further, compounder-ship courses were also discontinued and licentiate in Pharmacy degrees was

started. Attempts were also made during this time to bring various private *ayurvedic* centres under one unified system for better management and monitoring. So, though framed within the purview of the central Five-Year Plan, State Plans in West Bengal had started responding to specific requirements of the state from the very beginning (GoWB 1955, 125-148).

Through the fifties and sixties, the state government had passed numerous acts through which the government took control over the management, properties etc. of numerous medical institutions like various district and sub-divisional hospitals, (through the Sadar and Sub-divisional Hospitals Act, 1955 or West Bengal Act XX, 1955), the R.G. Kar Medical College and Hospitals (through West Bengal Act VIII of 1958 or R. G. Kar Medical College and Hospital Act), Calcutta National Medical College and Hospital (vide West Bengal Act XVII of 1967 or the Calcutta National Medical College and Hospital Act, which was further amended in 1976) etc. The problem of unregistered clinical establishments bothered the government even in the fifties and in order to ensure safe medical services, the West Bengal Clinical Establishments Act, 1950 was passed, which made registration and licensing mandatory for all sorts of clinics from nursing homes to maternity homes to pathological labs etc. The Act which came into force in 1952 and which was later amended in 1976 and 1992 respectively, talked of deregistering such clinical establishments and promised penalties on charges of immoral practices, absence of registered practitioners etc. However various news reports and my experiences during field visit revealed that such shady clinics are operating till very recently.

As per the Second Plan, ensuring healthcare access to more people was considered essential in order to improve health of the state which would improve the health of the entire nation. However, the different programmes could not be simultaneously implemented in the same area, primarily because of resource crunch. Moreover, since the aim was to ensure that the whole state should come under the comprehensive health plan; different programmes could not be implemented in the same area. Thus, the Second Plan focused on creating a unified health service in order to improve supervision and control of public health measures. Further, sanitary staff, employed by local bodies, was brought under state control and focus was also given for upgrading of hospitals at districts and subdivision levels (as per the recommendation of the Bhore committee). Infrastructure in Calcutta (now Kolkata) hospitals was sought to be improved and thus, more equipment was purchased for Calcutta hospitals (GoWB 1958).

As a result, the common people from districts had to come to urban centres for the ‘best’ treatment, specifically to Kolkata and this trend continues after so many years after

independence. During the Second Plan period grants were given to non-government hospitals. It was also realised that health delivery system in rural areas needed to be strengthened. Hence, 330 more centres (63 thana health centres and 267 union health centres) were setup and the training of *dais*, lady health visitors and assistant midwives through various courses, was also developed to solve the problem of death of healthcare workers in rural areas (GoWB 1956, 70-73). Shortage of healthcare workers in rural areas necessitated to go beyond the modern allopathic medicine.

The Third State Plan reiterated the idea expressed in the economic policy of December 1954 as declared in the parliament of India, which highlighted the role of socialistic pattern of society. While agreeing to follow the plan, as laid down by the central government, the State Plan also addressed some peculiar problems of the state. Attention was given to realising the goal of self-sufficiency in agriculture. The Third Five-Year Plan at the national level stated that free and compulsory education will be provided for the children in the age group of 6 to 11 years and keeping in tune with that a sizeable allocation of funds was made to achieve this object under the State Plan also[3]. However, around this time the chasm between the centre and state about the share of taxes came to the fore. While discussing with the Planning Commission, the state government had demanded an outlay of Rs. 341.03 crores, whereas only Rs. 250 crore was given. Dr. Bidhan Chandra Roy referring to West Bengal as an urban and industrial state highlighted that the problem of the state was its inability to benefit from the wealth that was being generated, as New Delhi took bulk of the share through taxes. He argued that if the central government was taking bulk of the state's share, then the state should be adequately compensated through the issuance of funds in the form of aid to the state (EPW February 26, 1955, 285-286). It needs to be reiterated though that in the initial years, due to the low land-man ratio, industrialisation was held to be the means through which youths could be employed. Thus, emphasis was given to large scale industries which were thought to provide, long term employment opportunities. In addition to it, in order to improve rural economy encouragement was also given to small scale industries (Ibid; GoWB 1952)

The failure of the national Third Five-Year Plan (1961-66) hit industry sector badly. Shortly after that Congress lost power in the state (1967), followed by a split in the Congress. The breakaway group Bangla Congress entered an alliance with CPI (M) and formed a United Front

[3] For details see http://14.139.60.153/bitstream/123456789/10739/1/THIRD%20FIVE%20YEAR%20PLAN_WEST%20BENGAL_%28R.S%29_PCL39202.pdf. Last accessed 23.5.22.

government with Ajoy Mukherjee of Bangla Congress as Chief Minister and Jyoti Basu of CPIM as the deputy Chief Minister. Before the UF Government came to power, the state was suffering from an acute food shortage for about a decade. Earlier, left parties had launched huge mass movements based on the issues of food shortage, refugee crisis and price rise. When the left was the part and parcel of the two UF governments in the state, a factional dispute broke out at the central health ministry for which, funds for family planning programme were not released to the states leading to high population growth in the state, around the second half of 1969 (Franda 1971 251-252).

The State financial outlay for the Fourth Plan comprised Rs. 322 crores, which was considered to be lower than the actual money value, if compared with the Third Plan. However, due to unemployment, poverty, low productivity of food, industry recession etc. the State Planning Board was of the opinion that in order to fulfil the basic necessities like guaranteeing primary education, healthcare, sanitation etc. the total of Central and State Plans should guarantee at least Rs. 3240 crores for the state to overcome the above-mentioned problems (GoWB 1972, Foreword). It was also realised during the seventies that there was an overlapping between various departments like education, sanitation, and health, though these departments needed to maintain a close liaison but overlapping of plans should be avoided. However, around this time, after the debacle of Naxalbari Movement, the United Front alliance came to an end in West Bengal in 1970 (Franda 1971, 5; Bhattacharya 2016, 4-10). This was followed by a President's Rule in the state, a short stint of less than three months by the elected chief minister, Ajoy Mukherjee and then again a President's Rule under V. V. Giri respectively (Avantika 2019). It needs mentioning here that literature on healthcare during President's Rule in West Bengal is almost non-existent.

Around this time (which coincided with the end of the Fourth Five-year plan of West Bengal) the inability to ensure healthcare to all in rural areas was realised and importance was given to homeopathy and *ayurvedic* practitioners. The government had stated that it has expected to have 43000 hospital beds, which was to be gradually increased to 54000 beds by the end of the Fifth Plan. After the Fourth State Plan, it was noted that though the severity of tuberculosis had reduced, the number of patients in the state was still high. And although the malaria program had made some progress, the coverage was projected to extend from 80 to 100 per cent at the end of the Fifth State Plan. Even when progress was noted with regard to tuberculosis and malaria, it was realised that smallpox, leprosy and cholera continued to trouble the state considerably. In order to deliver healthcare to the remotest corners of the state, or the 335

Blocks in West Bengal, it was proposed to have 1 PHC and two sub-centres in each Block (GoWB 1972, 119).

In order to ensure that healthcare reaches even the peripheral areas, there was need to focus on healthcare workers. In early seventies there were 8000 nurses, who had certification of General Nursing and Auxiliary Nursing and Midwifery and 2000 also unregistered nurses. By the end of the Fourth Plan, it was thought that the number of nurses should be increased to such an extent that the nurse-to-patient ratio would be 1: 3. Realising the importance of public health and family planning, training centres for nurses were also sought to be increased, and for such purpose, training of the professionals for this job was also thought to be crucial It was also stated that there would be three doctors in primary health centres and one in a sub-centre (GoWB 1972,119). (GoWB 1972, 115-117).

Further, absenteeism of doctors was found to be a major problem and 70 sub-centres were identified, where there was no doctor, which were run by pharmacists or with the help of other health workers. It was stated that health centres were not just 'small units of curative medicine', but also 'focal point of community medicine', which included family planning, nutrition programmes and various other programmes. Thus, it was imperative to spread healthcare services to every corner of the state especially in the rural areas. Since trained doctors were almost 'absent' in rural areas, it was suggested that practitioners of indigenous medicine could also be inducted to fill the dearth. To deal with the paucity of trained allopathy doctors, one year internship in district or sub-divisional hospitals and large hospitals were made mandatory part of the training program for doctors. In order to strengthen healthcare services in rural areas, nurses, technicians, health workers and other group D staff had to be posted at PHCs and sub-centres. During this time, family planning clinics were renamed as family welfare clinics as the stated intention was not to limit family but also their welfare (GoWB 1972, 119-120).

As Dr. Shyamal Guha (personal interview[4]), a doctor associated with Jana Swastha Andolan (People's Health Movement) pointed out that despite a lot of doctors being associated with left parties/ideologies, neither do they do their job diligently, nor they have any contributions to the *Jana Swastha Andolan* (Public Health Movement) in the state. Many doctors limit their activities to running free camps or clinics from time to time and providing relief during emergencies like flood, epidemic etc. Since 1970s, doctors and medical students have been raising demand on a wide range of issues like improving healthcare conditions and increasing

[4] November 21, 2021 at his residence in Salt Lake.

their stipends. Dr. Guha also has been advocating the need to improve healthcare for a long time now. He stated that in 1983, junior doctors in the state had raised the slogan '*Swastha kono bhikhya noy, swasthya amader adhikar*' (health is not alms but health is our right) (Goon 2017, 302; personal interview 2021). After the publication of the report of High Level Expert Group on Universal Health Coverage, since 2013, few people and organizations came together to form the 'People for Healthcare', which raised the demand to implement the suggestions of the High Level Expert group. Taking the demand further in 2015, the call for '*Sara Bangla shobar jnyo swasthya prochar committee*' (All Bengal 'Health for All' Sensitisation Committee) was also given (312).

Based on the readings of several plan documents by respective governments of West Bengal, what becomes clear is the need to have a balance in terms of access and availability of healthcare services between rural and urban areas. The areas of problem had been identified as a) dearth of medical drugs, b) equipment and c) poor ambulance services. Added with these was the paucity of trained healthcare workers including doctors, nurses, pharmacists and technicians.

4.2 The Left Front Era:

The support base of the Left Front government, which came to power in the state in 1977, has been the 74 per cent of the rural population, which also benefitted due to the agrarian reforms, initiated by the state government. As a result of which, rural development was given primacy, which also got reflected in several elections' results (Ghosh 2017,2). The focus was on land reforms, on peasants with small land holdings, developing irrigation and water supply, improving animal husbandry, improving credit system etc. Agriculture, irrigation, small scale industries, power among other things received a lot of attention in several annual plans, Sixth, Seventh, Eighth, Ninth State Plans among other documents and in Assembly discussions. Generally speaking, problems like lack of infrastructure, scarcity of healthcare workers, medicines, ambulance, strikes of nurses and so forth have been sporadically raised in the state legislature from time to time and seldom has discussions revolved round the issue of healthcare. However, it needs mentioning that the occurrence of hunger death in the state had received comparatively more attention[5].

[5] See West Bengal Legislative Assembly Proceedings, 2004.

While the Sixth Plan emphasised the decentralisation of power through the Panchayati Raj Institutions; agriculture, fisheries and sericulture also saw improvement. This period also witnessed a deficit in power supply, and slow growth in the industrial sector, which impacted the overall growth not only during the Sixth Plan Period but also the Seventh one. Though health and education always found place in various plan documents of the state (in terms of allotment and expenditure incurred), health received special attention under the Seventh State Plan. Many activities were proposed in such a manner so as to fulfil India's commitment to achieve 'health for all by 2020' (as pledged in the Alma Ata Declaration). The focus remained improving primary healthcare delivery and this was planned through child immunisation, prevention of kalazar, encephalitis and population control (GoWB 1990, Foreword). Following the Alma Ata Declaration, population control was seen to be necessary for guaranteeing health for all, not only under national Five-year Plans, but the sentiment got echoed in state plans as well (*ibid*).

However, despite the widely held 'pro-poor' stance, studies reveal that the people who relied on agriculture in rural areas, either directly or indirectly, especially the rural poor, did not benefit much from either the land reforms or the education and healthcare initiatives, which gave rise to Naxalite activities in certain parts of the state (Banerjee 2006, 865; Bhattacharya 2016, 19). When it came to social sector comprising health and education, Left Front government, unfortunately, did not have a long-term strategy. Though it managed to bring down infant mortality rates, increase life expectancy and improve sex ratio, the strength of the healthcare workers was low, which affected healthcare delivery especially to the poorer sections (Bhattacharya 2016, 21-22). Further, the rise of unions for healthcare workers, tended to protect them even when they remained 'absent' from their centres of posting, in government hospitals in rural area or primary health centres (Banerji 2006, 866). Thus, government facilities started serving the 'underclasses', which again, affected accountability and service quality. As a result, the state's ranking did not improve much with regard to Human Development Index between 1981 and 1991 (Bhattacharya 2016, 22). Further, West Bengal also experienced lower hospitalization rates among rural women, the reason for which has been ascribed to prevalent gender norms and existing value system (Ghosh and Arokiasamy 2010).

It seems pertinent to mention here, that several works pertaining to Left Front's rule in West Bengal have been published. They have looked into its role of the communist party, its role in agrarian reforms (Operation Barga and its aftermath), its ability to decentralize power through Panchayati Raj Institutions (PRIs), its hegemonic ability to percolate social spaces etc. This

can be found in the writings of Franda 1971; Kohli 1990; Mallick 1993; Chatterjee 1997; Samaddar 2013; Bhattacharya 2016; Chatterjee and Basu 2020. All of them barring a few (like Chatterji and Basu 2020), have addressed the issue of healthcare in passing. Moni Nag's comparative studies (1983; 1989) of Kerala and West Bengal during seventies, however, shed some light on the healthcare situation of West Bengal during that time.

4.2.1 Short Comparison between Kerala and West Bengal:

Moni Nag's studies (1983; 1989) revealed that despite having a left-oriented government, which gave importance to education, Kerala's indicators in health were better than that of Bengal (despite being more economically developed till late seventies) and for that he had forwarded many reasons. Higher literacy rates, more political awareness regarding the right to healthcare and right to access healthcare facilities, better sense of hygiene and sanitation and 'smaller catchment areas of rural healthcare centres' (1989, 417), coupled with an improved transport system, in Kerala were highlighted. Highlighting on collective healthcare demands in Kerala, he stated that an incident like paucity of doctors in a centre did not lead to public protests in West Bengal in late seventies, while in Kerala, it did. The support base of the left parties in both the states also had a major role to play in shaping healthcare in the state. Nag also observed that in Kerala, the party base was low-income groups, who were a majority and in West Bengal it was the middle-class. In Kerala, the party succeeded in sensitising the people about their basic rights related to healthcare. Further, a better nurse: patient ratio also resulted in a better healthcare scenario in Kerala (1983, 885).

Moni Nag's observations (1983 and 1989) resonated in the experiences shared by two doctors associated with 'health for all' campaign in West Bengal, Dr Shyamal Guha and Dr. Samir Sen. They narrated their story of organizing community clinics or check-up camps for residents of Salt Lake, Kolkata, where middle-class and upper-middle class families reside in homes, rented spaces, housing complexes or standalone apartments. They were charging Rs. 5/- as their fees and as it turned out, the residents had registered their careworkers like domestic helps, gardeners and others as patients seeking consultation and none of the residents came for consultations. Dr. Samir Sen stated that the same residents would later prefer going to the posh hospital where he is associated with for consultation, by paying more money. Unfortunately, for many, standard or quality of healthcare services was/is determined by how much one had to pay for it, the doctors concluded.

4.3 1990s and the liberalisation of the economy:

The State Plan under the Eighth Five-Year Plan began with a criticism of the approach adopted at the national level which accepted the unequal distribution of assets in society like land, capital etc., as something given (GoWB 1990). Dr. Manmohan Singh, the then finance minister of India, had stated in the Parliament that Narasimha Rao's government was working towards improving the terms and conditions of the IMF that the Chandra Sekhar government had accepted. When Nirmal Kanti Chatterjee of CPI(M) had pointed out that the suggestions of Jyoti Basu (the then CM of West Bengal) to curb imports were ignored and that the Congress had ushered in reforms unilaterally, Dr. Singh had clarified that Rao government was open to discussions, however Dr. Asim Dasgupta, the then finance minister was not eager to have discussions[6], thus hinting at an impasse between the centre and the state.

Thus, the Leftist government of West Bengal, forwarded an 'alternative approach' which aimed at giving relief to common people. It also stated that planning should try to re-order society by 'distribution of production assets in agriculture and industry' in a more equitable manner. Health of the people was sought to be improved through revamping of public distribution system which should ensure that people are getting nutritious food as malnutrition was considered to be a significant cause of morbidity. Along with suggestions of initiating post-doctoral courses on nephrology, urology etc., it also emphasised the need to train more nurses and other health and para-medical personnel (GoWB 1990).

Long before proposing the above mentioned 'alternative approach,' multiple essays were compiled in an edited book by the late Finance Minister of West Bengal, Dr. Ashok Mitra, in an attempt to warn the central government about the consequences that the loan from International Monitory Fund (IMF's Extended Financing Facility) might entail. The contributors of the volume had agreed that even if there was a deficit, following the payment crisis, IMF's loan would not solve any problem but might benefit those who had monopolies and those who were big farmers (S. Baru 1982). However, following the publication of the report, *Financing Health Services in Developing Countries: An Agenda for Reform*, in 1987, by World Bank, the path was paved for the introduction of user fees in government health facilities. It needs mentioning that international agencies like International Monetary Fund (IMF) and World Bank are seen by many as the propagators of the idea of 'rolling back of the state' policy, which is an essential pre-condition of neoliberalism. Gradually, it made way to

[6] For details see General Budget Discussions 1991-92.

West Bengal as well. Following the introduction of user fees, people availing services from scheduled caste and scheduled tribes declined visibly and in district hospitals of the state, revenue collected from user charges vis-à-vis the total expenditure incurred, declined from 2.1 percent in 2002-03 to 1.8 percent in 2005-2006 (Roy and Gupta 2011, 74).

However, it needs mentioning that long before liberalisation, the newly elected Leftist government in West Bengal, had taken loan amounting to Rs. 27.20 crores from World Bank to improve agricultural situation in select districts. This move was severely criticised by the opposition, as it meant farmers would have to pay a higher interest. But the government had assured that it would not compromise the interest of farmers and that it would not be bullied by any terms and conditions of the donor agency[7]. When in 1994, the central minister of industries had noted that West Bengal was not fit for new investments, in the same year, the then Chief Minister, Mr. Jyoti Basu formally announced Left Front's new economic (or industrial) policy (NEP). This might indicate a change in the control the government had earlier vis-à-vis the donors or donor- driven reforms following liberalisation. The NEP of the Left government paved the way for the entry of market forces into various avenues like healthcare, education, housing etc. However, unlike the central government, the government in West Bengal gave emphasis to small and cottage industries and was also committed to the creation and maintenance of "class peace" between labour and capital. Thus, a coalition of leftist parties had to adapt keeping in mind the changing framework of the Indian economy after the liberalisation in the early 90s (Mayers 2007, 31-33).

When in 1991, the Governor in his speech had hailed the role of the Left Front Government in successfully implementing family welfare programmes, maternity and child health schemes, immunisation programmes and integrated child development scheme, Congress leaders like Sidhartha Shankar Roy, had flagged the government's incompetence to focus much attention to the tertiary and secondary healthcare facilities. Speaking in 1991, Mr. Roy had highlighted that in the "last 14 years" that the Left had been in power, no new Medical College and Hospital was built, and the increase in hospital beds had been a meagre 996 per year as compared to addition of new 2435 hospital every year during the Congress' tenure before 1977. The response to such accusations was that the aim of the Left Front government was to strengthen

[7] West Bengal Legislative Assembly Proceedings, 1977, volume 66, 1-2.

the health of the common people and focus more on vaccination, immunisation drives and not partake in meaningless displays.[8]

Maitreesh Ghatak, well-known economist, had pointed out that during 1993-94 and 1999-2000, West Bengal's growth rate was 5.5% while, it was an average of 4.6% for the rest of the country. However, in the following decades, the percentage dropped to 4.9% (against all India average of 5.5%) between 2000 and2010 and 4.2% (against all India average of 5.2%) in the following decade, implying that the gap had increased (*Hindustan Times*, April 15, 2021). Despite land reforms and other pro-poor policies of the Left, has not been exemplary, though it performed better than the rest of the country on certain fronts like infant and child mortality rates etc. (Maitra et al. 2013). In 1990s, the leading causes of death and disability combined in the state were lower respiratory infections (9.8 per cent), diarrhoeal diseases (7.7 per cent), pre-term birth complications (6.2 per cent), Measles (5.9 per cent) and Tuberculosis (4.4 per cent) and almost two decades later, it was ischemic heart diseases (9.7 per cent), stroke (8.5 per cent), Chronic Obstructive Pulmonary Disease (COPD) (4.2 per cent), self-harm (3.7 per cent), iron deficiency (3.5 per cent) (PHFI 2018, 2). And data from NSSO's health round in 2004, revealed that in West Bengal out of 1000 people, 114 people in rural areas and 157 in urban areas, claimed to be "ill". Though the state had managed to control the spread of tuberculosis and leprosy, in the new millennium, the spread of HIV was a serious concern. The first decade of the twenty first century also recorded poor health status among women and children, specifically anaemia in women and children (Planning Commission 2010, 122-124).

With regard to government expenditure West Bengal's situation has been mentioned below. All values are in Rs. Lakhs.

Table 3: Expenditure by State and Central Governments

Spending by -	**1974-75**	**1982-83**	**1986-87**	**1990-91**
Centre	828171	2827281	6042547	10178425
West Bengal	60911	2017219	350782	564757
Highest spending State:	**Uttar Pradesh** 114126	**Maharashtra** 358518	**Maharashtra** 641185	**Uttar Pradesh** 942105
Lowest Spending State	**Meghalaya:** 3237	**Sikkim:** 4665	**Mizoram:** 5450	Could not be calculated as data of 11 states were not available.

[8] Assembly Proceedings 98th Session, 1991.

Total Spending by States	60911 (excluding Arunachal, Goa, Mizoram and Sikkim)	207219 (excluding Arunachal, Goa, Mizoram)	350782	6648822

(Source: Collated from Reddy and Selvaraju, 1994, 235)

The policy of 'Out-of-the-Pocket' expenditure for outpatient care was a game changer in the 1990s. And a clear cut rural-urban divide was clearly visible when it came to analysing population being served per doctor. In 1990, a doctor in a rural area served a population of 5246; while the figure for urban area was 842 (West Bengal Health Systems Development Project [WBHSDP] 1999,175); and in 2015, one doctor served 5100 people in rural areas; while the figure stood at 673 in urban areas (GoWB 2017, 247).

Ross Mallick (1993) had stated that when it came to healthcare, the Left Front government had failed to end or contain corrupt practices like support staff misappropriating supplies and improve efficiency of healthcare workers. Doctors were hands in glove with pharmaceutical companies to increase bill amount and the management had full idea about what was going on. However, the left government was unsure of organising 'popular mobilisation in the health sector' (174). Further, the very issue of occupational health and safety was not properly addressed by left trade unions even after the tragedy of Bhopal Gas Disaster (Samaddar 2013, 20). Almost all the government healthcare workers in order to remain in the 'good book' of the party leaders, had to attend party meetings and this created a new set of inequalities between those who received patronage and who did not (Chatterjee and Basu, 76; Samaddar xvii).

4.3.1 The Case of Hakim Sheikh[9]:

On July 8, 1992, in an incident, Hakim Sheikh, member of the Paschim Banga Khet Mazdoor Samity, met with an accident. He had fallen off the train at Mathurapur rail station, located in South 24 parganas of West Bengal. On being taken to the local primary health centre (PHC), he was referred to a government sub-divisional hospital as necessary facilities were absent at the PHC. On being taken to a Medical College and Hospital in Calcutta, an emergency medical officer advised immediate hospitalisation, based on his skull X-ray plates. However, due to unavailability of vacant bed, he was moved from one government hospital to another, all reportedly did not have any vacant bed. Later, he was admitted to a private hospital, where he received treatment for almost two weeks, incurring a bill amount of Rs 17000.

[9] For details see https://main.sci.gov.in/judgment/judis/15597.pdf. Last accessed 9.9.22.

A case was filed by Hakim Sheikh (Paschim Banga Khet Mazdoor Samity & Ors vs State of West Bengal and ANR, 1996). The petitioner had flagged citing the decision of the Consumer Unity & Trust Society Jaipur vs. State of Rajasthan & Ors (1989), that all patients seeking medical treatment in government hospitals are 'consumers' and it is the duty of government hospitals and the staff to provide necessary services. Second, it was pointed out that in not performing the necessary task of giving medical attention to the petitioner, the medical officers in state government hospitals had failed to protect the fundamental right of Right to Life, as enumerated in Article 21 of the Constitution. Thus, the state cannot escape responsibility.

The reason for discussing the above case is simple. It highlighted the situation of healthcare in government hospitals and mirrored the problems that affected healthcare access and delivery for a large section of the people then. Various field visits during the research reflect that much of the problems still persist. Ms. Lina Chakraborty appearing on behalf of the State of West Bengal, had accepted in 1996, that specialised treatment was not available in PHCs in West Bengal. She had also stated in the affidavit that there were 57,875 beds in government hospitals, after combining beds in various wings. Out of these beds, 90 per cent were free beds, meant for the needy and the poor population. It needs mentioning that as per census data (1991), the population of West Bengal was around 6 crore and 80 lakhs[10], which meant there was not even one bed for a population of 1000 [the figure was around 0.85/1000 going by 1991 census data), far lesser beds as per WHO's recommendation of five beds per 1000 population (Niti Ayog 2021, 7).

While the case was on, an Enquiry Committee was set up which also observed the sorry state of government hospitals. The Committee observed that patients remained in trolley beds and on the floor of government hospitals as beds were not available. It also pointed out lapses on the part of the superintendent of the first hospital, emergency medical officers of other hospitals that Hakim Sheikh was taken to. It was also pointed out that no proper record or step by step detail was noted down of the condition or the little treatment he had received at a reputed government medical college and hospital in Kolkata. The bench had pointed out, at the end of the case , that since medical negligence by health officers in various government hospitals implied negligence on the part of the state, a compensation of Rs. 25000 was awarded to the petitioner. The bench also highlighted that it is the responsibility of both federal and state governments to fulfil welfare duties like providing health care and upholding right to life as

[10] See https://www.wbhealth.gov.in/other_files/2009/Trends_in_population_in_West_Bengal_1901_2011.pdf. Last accessed 2.9.22.

guaranteed in the Article 21 of the Constitution. What also came to the fore was that private hospitals denied treatment to uninsured patients, who were 'dumped' in government hospitals, which further delayed their treatment. Citing the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), passed by the US Congress, the obligatory role of private hospitals in delivering emergency services were highlighted as screening the patient, stabilising the patient's condition and then transfer for better treatment or discharge the patient.

It is interesting to note that since the very beginning, the need to improve healthcare services in rural areas have been echoed in several documents (for example, the Gandhian Plan and the People's Plan). Several documents had also highlighted the urban bias when it comes to sharing of resources. For instance, the Approach to Fifth Five-Year Plan had noted that Calcutta took bulk of the funds allocated for hospitals, medical education, public health etc. It also noted that 80 per cent of the major healthcare institutions were in Calcutta (GoWB1972, 110). A Chief Ministers' meeting was held in 1996 to take stock of the situation regarding the basic minimum services that were made available to the people by various governments. It had identified healthcare as one of the seven basic minimum services and an Additional Central Assistance (ACA) was proposed wherein non-special category states would receive funds in the form of 70 per cent loan and 30 per cent grant. The details are mentioned below[11]. Accordingly, Rs 712.92 lakhs, under Annual Plan of 1997-98, were allotted for proper implementation of primary healthcare services through district planning committees (GoWB 1997, 223).

Table 4: Allocation of Additional Central Assistance (in Rs. crores) for the Basic Minimum Services Programme to West Bengal

Year	1996-97	1997-98	1998-99	1999-2000
West Bengal	150.00	203.57	214.33	234.30
All India	2244.48	2963.83	3381.50	3699.22

After two decades had passed since the ruling in Hakim Sheikh's case, similar scenes were observed during field visits in several government hospitals of the state. From PHCs to maternity wards in government hospitals[12], patients shared beds, with family members holding saline bottles as the saline or blood stands were not available. Patients lay on the floor and also

[11] For details of Chief Ministers meeting see https://niti.gov.in/planningcommission.gov.in/docs/plans/mta/mta-9702/mta-ch7.pdf. Last accessed 24.6.22.

[12] It was easier for the current researcher to access maternity wards. Further, *Ayahs* were present in these wards.

on trolley tables mostly in the Emergency wings. Nurses who were previously posted in PHCs, pointed that they handled delivery cases, minor accident cases, cases related to mother and childcare, family planning and so forth[13]. Serious cases are majorly referred to sub-divisional hospitals or district hospitals, as the required infrastructure to treat serious cases is mostly absent. A study regarding the delivery of comprehensive and basic emergency obstetric care in the districts of Purba and Paschim Midnapore, Purulia and Bankura revealed that only a handful of facilities, other than medical college hospitals, a few district hospitals and state general hospitals could provide such services (Biswas et al. 2005, 268-269).

A visit to a PHC in Jalpaiguri district revealed that it could deliver babies, give first aid treatment, but could not treat serious patients, as it did not have necessary infrastructure. During one such visit I saw a patient (middle aged man) with high fever waiting to get tested for malaria, however test kits were not available, and the man was asked to get the test done from a private laboratory, which was not only far away but also expensive. One doctor who was present did not examine him; neither did the nurse, who was busy in the labour room.[14] Though big buildings were there, but required medical equipment, machine and necessary staff were not present, especially when it comes to PHCs [15].

4.4 New Millennium:

Since colonial times, provinces/states and the centre have shared economic responsibilities. States vis-à-vis the centre have limited resources as well as powers, hence they are dependent on funds from the centre or international donor agencies, on various occasions. 1990s onwards, there has been a concentration of fiscal powers at the centre and lesser resources were shared with the states, which in turn affected overall human development index in the state. In particular, the preventive and curative health delivery system was severely affected (GoWB 2004, 133) as 84 per cent poor people lived in rural West Bengal (3). In 2000, the figures of IMR in urban areas were better than in rural areas, meaning that healthcare and facilities were more available in urban areas of the state. For a government whose support base remained rural Bengal, this did not look good. However, IMR had improved when compared to the last decade

[13] Telephonic Interview held on 26.08.22 from 5-6 pm; Telephonic Interview held on 05.11.21 from 8-9 am; Personal Interview held on 19.09.19 in Nil Ratan Sarkar Medical College and Hospital (in Kolkata); Personal interview held on 24.9 19 in Barasat District Hospital, North 24 Parganas.
[14] Field visit on 23.6.18.
[15] Interview with an AYUSH doctor on 14.9.22, in Jalpaiguri district of West Bengal.

(1990s) and when compared to India, the state fared well and did well as it had better sex ratio (121). Again, neo-natal mortality figures were better when compared to India, but was worse when compared to states like Kerala. Thus, in 2003, a neo-natal speciality hospital in Purulia (about 300 km away from Kolkata) started operating (122-23).

It is pertinent to mention here that despite the Government of India (GoI) setting goals for expanding primary health centres during this time (Tenth Five-year plan), West Bengal government focussed on consolidating and renovating existing facilities rather than expanding underdeveloped infrastructure. However, after the guidelines of the National Health Policy of 2002, West Bengal government had tried to rectify its acts of overspending in tertiary units. Thus, attempts were made to strengthen the secondary healthcare institutions by investing on health infrastructure, which would provide easy access to healthcare. The State Health System Development Project (SHSDP) which was implemented in late 1990s through early 2000s, proved to be an important factor in this. SHSDP II (1996-2000) introduced reforms whereby, government policy proposed the provision of 'affordable health and preventive services', through the involvement of multiple providers like NGOs, donor agencies etc. (Roy and Gupta 2011,75).

Not only in the healthcare sector, West Bengal government was relying on private sector for strengthening education system as well. The issue of private training institutes for training of primary school teachers was debated in the legislature. The government had argued that this was done with the aim of meeting the rising demands of the people. However, the centrist Congress party and the opposition was critical of the leftist government's association with private sector and NGOs[16]. It might be argued that the path for the rise of various nurses training institutions in West Bengal was laid back then. However, it needs to be cleared that though private training institutes for nurses were present, but their number increased manifold during 2021-2022, as per the website of West Bengal nursing council,[17] which might indicate an increased trust of the present government of TMC on private nursing institutions to impart training on one hand and an increase in the demand for nurses and more nursing training institutions in the state of West Bengal.

While the government of West Bengal had urged Jayati Ghosh, eminent economist, to frame The West Bengal Human Development Report (the only state Human Development Report,

[16] Bengal Legislative Assembly Proceedings 2002, vol. 120, no.3.
[17] See https://www.wbnc.in/main/page/nursing_institute_list. Last accessed on 4.9.22.

2004), government hospitals in rural areas were introducing paid diagnostic services under the Private Public Partnership (PPP) model (Roy and Gupta 2011,75). This report had pointed out that despite high rate of immunisation against measles, it remained a serious concern for the country. Morbidity due to preventable diseases like neo-natal tetanus or diphtheria, which could be prevented through vaccinations, was also prevalent. This called for strengthening of healthcare delivery system, when it came to preventable diseases (131). Another health-related problem of excessive arsenic in drinking water affected the overall health of 75 blocks, across eight districts in the state (132). The report had also urged the government to strengthen the non-allopathic systems of medicine in the state, because allopathic medicine or western 'modern' medicine was not always cost effective, which made it difficult for rural poor to avail allopathic treatment (136).

Listing of the achievements of the Left Front Government in last thirty years, the party in 2007 stated that though neo-liberal policies were adopted by many other states in India, following the reforms of the 90s, West Bengal had aimed at strengthening public institutions and have allowed private investments in piecemeal. As a result, 80 per cent of patients availed inpatient services in Government healthcare system in West Bengal.[18] However, the above figure did not mean the existence of a better public healthcare system in the state. It could have happened that the failure of various poverty alleviation programmes might have limited the choices for most of the population, due to which they had to opt for public healthcare providers. Since mere hospitalization in the private sector increased cost six times (Chakraborty and Mukherjee 2003, 5021). When Buddhadeb Bhattacharya became the Chief Minister, he gave a new slogan: "*Krishi amader bhit, shilpo amader bhobishya*" ('Agriculture our base and industry our future',) but little change took place in the health front.

It needs to be mentioned at this point that in the beginning when the National Rural Health Mission (NRHM) was initiated by the central government, it was implemented only in limited areas of West Bengal with substantial tribal population. As a result of which, various activities under the scheme got delayed in the implementation process across the state. Around the same time, when NRHM was formulated, the state government had also formulated Health Sector Strategy (HSS) for 2004-2013, with the aim of improving the overall healthcare of West Bengal, focussing primarily on the poorest and ones in greatest need. HSS emphasised 'decentralization, capacity building, identifying the special need and ensuring demand and

[18] See https://www.cpim.org/content/thirty-years-left-front-government-west-bengal. Last accessed 19.04.22.

access through health awareness and programme strategy' (NRHM 2007,1). It also provided a framework for reforms in the state for a period of ten years. A medium-term reform and investment programme was initiated by the government in August 2005 and was named as Health Systems Development Initiative (HSDI) and its activities were linked with HSS.

In 2008, the then Health Minister of West Bengal, Dr Suryakanta Mishra, wrote in the government document related to health sector reforms that the government was committed to ensuring 'equitable and universal access to quality health services to all, especially poor and the neediest'. This decade also saw collaboration with Panchayati Raj Institutions (PRIs), whereby they were given the task to supervise and maintain health service delivery at the community level. Needless to say, no reform was possible without a change in policies. The same happened in West Bengal, especially with regard to health sector reforms. It required a 'sustained processes' of change in policies with certain other changes as were facilitated by the government. Earlier, despite stating that 70 per cent of outpatient cases are treated in the public sector, as are 90 per cent of surgical procedures performed in the state, he had accepted that health and education remained areas where much was yet to be attained. Decentralisation of health with an active involvement of the community, accountability at all levels and more autonomy for the medical colleges were sought to be necessary steps in overcoming hurdles in improving healthcare in West Bengal (*Frontline* June 09, 2001).

With an aim to monitor, how West Bengal was dealing with hurdles with regard to healthcare, Dr Sharad Pant and Shri Harish Chandra, the Director and Advisor respectively in charge of the State Planning Division of West Bengal had visited the state in 2009, to review the implantation of various flagship programmes of the central government. Their report had noted that in areas where Naxalite activities were reported, implementation of the programmes got affected due to paucity of healthcare workers. It was also found that though the figures with regard to institutional delivery and availability of medicines improved, but the scarcity of lands prevented construction of sub-centres under NRHM and the overall spending capacity was poor. Out of Rs.347.88 crore released during 2005-09, total money left unspent with various districts and other bodies was Rs.157.02 crore. The government had also decided to place a second ANM in sub-centres and regular meetings of the state and district health mission also took place, the report noted. However, the Accredited Social Health Activists (ASHA) workers were deployed half of their total strength, with only one-third of them being able to complete all the five modules of training, which brought to the fore, that training facilities needed improving. (Planning Commission 2009, 11).

Realising the above-mentioned drawbacks, the State Health Systems Development Project II aimed at reforming the healthcare sector in the state (GoWB 2008). The reform policy had proposed to provide affordable healthcare services with the help of other non-governmental agencies. In early 2010, a differential user fees were introduced for the same services directly provided by the public sector hospitals and those public providers under the PPP model. Around the same time, the list of mandatory tests increased from 29 to 44 and accordingly, the prices were also revised. Cost for the same set of tests in district and sub-divisional hospitals remained unchanged and were comparatively lesser than the revised rates of government rural hospitals under the PPP model (Roy and Gupta 2011, 75). Though the aim was to make healthcare more affordable for the rural poor, free services for each month were limited to 20 per cent patients from the below Poverty Line (BPL) category (76).

Following the Maoist attack on the convoy of the then Chief Minister, Mr. Buddhadeb Bhattacharya and Union Steel Minister Ram Bilas Paswan in the *Junglemahal* areas of Paschim Medinipur district, alleged police atrocities against the tribals had increased. In protest, the *Pulishi Santrash Birodhi Janaganer Committee* (People's Committee Against Police Atrocities, or PCAPA) came into being, which in its charter of demands had criticised the capitalist mode of development in general. It also demanded the Left-Front government to adopt poor friendly governance approach, open more primary schools, and primary health centres (Sen 2009; Bhattacharya 2016, 175). This demand highlighted that regarding primary education and primary healthcare in the rural and marginal areas, the Left-Front government had allegedly failed to usher in an inclusive approach. Further, newer issues of movement like issues pertaining to health, social security, environment and others did not make way to the party agenda (Samaddar 2013,14). Another trend that has received wide attention has been the appointment of ruling party workers/supporters as Village Health Workers (VHW) (Mallick 1993, 174).

4.5 2011: Change of Power:

The Left Front government's attempt at land acquisition in Singur for Tata Company met with backlash. Another proposed land acquisition at Nandigram turned violent when the police allegedly opened fired and 14 people had lost their lives. Mamata Banerjee, the opposition leader, could mobilise and appropriate the anti-government sentiment of that time, and Trinamool Congress (TMC) formed the next government in West Bengal, ending 34 years of

Left Front rule in the state. Both these movements revealed that there was a serious disconnect between top leaders and the supporters & sympathisers at the grass root level (Bhattacharya 2016, 157), at least in the last phase of the LF rule. Mamata Banerjee had dedicated TMC's victory to *Ma, Mati, Manush* (Mother, Land, People) (*Times of India*, May 13,2011) and in an attempt to boost up the health sector has kept the portfolio of Health and Family Welfare with her (*India Today*, May 20, 2011).

I would like to begin this section with a few words of caution. The time frame between 2011 and 2015 is a short period to study and come up with sweeping remarks. Various discussion on several schemes can at best be treated as indicative. With an aim to focus on health of children, after coming to power, the TMC government initiated the *Sisusathi Prokalpo* (Child Healthcare Scheme) in 2013, whereby three private hospitals, and one government hospital (SSKM), were selected to offer free surgery for children under 18 years with congenital heart conditions, irrespective of their financial status[19].For the first time ever, 31 nutrition rehabilitation centres were established under the government-run healthcare system for children who were malnourished. In order to ensure that infants have access to human milk, a human milk bank named *Madhur Sneha* was established in 2013, which was a first for eastern India. This was also aimed at providing nutritious milk to sick, premature babies or babies whose mothers could not breast feed them.[20] Again, a first of its kind, a cord blood bank was established in Kolkata, the first one in eastern India.

With an aim to improve healthcare administration, and reduce pressure on tertiary centres, seven new health districts were established in Nandigram (in Purba Midnapore district), Diamond Harbour (in South 24 Parganas district), Basirhat (in the district of North 24 Parganas), Jhargram (in erstwhile Paschim Midnapore district), Asansol (in erstwhile Bardhaman district), Bishnupur (in erstwhile Bankura district) and Rampurhat (in Birbhum district)[21]. 34 multi-speciality hospitals were announced to be created, out of which work on 13 such hospitals had already begun by 2014 (Datta 2015). To ensure that pregnant mothers, infant and others received medicines in various private and government health centres the government had focussed on the transportation of the medicines and free medicines were supplied by various healthcare centres. Again, in government-run health centres and hospitals, the government had announced that all patients would receive free access to all necessary and

[19] Also see https://wbxpress.com/shishu-sathi-scheme/. Last accessed 23.09.21.
[20] See https://wb.gov.in/government-schemes-details-madhursneha.aspx. Last accessed 23.09.21.
[21] See West Bengal Government's G.O. No. HF/O/MA/39/1P-17/2011, dated 07.01.2013.

essential medications as well as all diagnostic services (apart from those that operate in PPP mode) (GoWB 2012; *The Hindu*, January 4, 2014).

Further, several fair price medicine stores were opened under PPP model, where people could avail 48 to 72 per cent discount on medicines. Providing free or medicines at subsidised rates have been the aim of many state governments. However, in West Bengal, under the garb of alleged 'scarcity of medicines', poor patients were turned away from the official medicine counters. They would then be required to buy it from the stores in the open market. The dishonest stakeholders would split the price difference. Even as the patients continued to be defrauded, the system would continue. With that aim to correct this practice, the idea of fair price medicine stores was established in various government hospitals (*The Hindu*, January 22, 2013; Marjit 2015).

4.5.1 Is Healthcare a Political Issue in West Bengal?

A study of Lokniti-CSDS post poll surveys in the state for the years 2011, 2016 and 2021, revealed that health, healthcare or hospitals were, and still are, not one of the important parameters on which a voter votes for a particular party or candidate. This reinstates the fact that the left had failed to instil in the people awareness about health and healthcare thereby unable to initiate claim making about the right to health (Nag 1983; 1989; Samaddar 2013, 14).

As per the post-poll survey by Lokniti-CSDS in 2011, development, price rise, good governance, road transport etc. were a few of the major issues for the voters of West Bengal. In the same study only 11 per cent of the respondents had opined those medical facilities in government hospitals had improved during the later years of the Left Front era. In another post-poll survey conducted in 2016, 35.5 per cent people had stated that medical facilities in government hospitals had improved. Though the provision of fair price shop in various government facilities and fair diagnostic centres were introduced, however, only 22.8 per cent and 11 per cent people availed the services of fair price medicine shop and fair price diagnostic centres respectively.

Recent studies have brought to the fore that a mere admission to a hospital, more specifically government hospitals in West Bengal, might entitle an inpatient to have an access to hospital bed but might not provide access to services like diagnostic tests, professional care etc. The studies also observed that when it comes to access to healthcare, there is a rural-urban divide and the ones who are not in a favourable position economically, suffer. Poor people suffer more in urban areas with regard to access to healthcare services. They also avail such services mostly

from the government hospitals and rarely from the private sector. Again, access to services like diagnostic tests and professional care for backward castes and classes both in rural and urban areas is less when compared to the access availed by the 'general' (unreserved) categories. On the other hand, backward classes in both the rural and urban sectors have more access to medicine. (Bose, Dutta, 2015, 35).

At the same time, the NSSO data revealed that though the government is providing subsidies, the poor do not benefit from public subsidies in healthcare. While people in rural areas benefit more from subsidies attached to medicines and various pathological tests, urban people avail more subsidies related to hospitalisation like access to bed, professional care etc. This is also because the tertiary healthcare centres are all located in urban areas. Another reality revealed is that the men benefit more from subsidies in healthcare in general. However, more women have access to medicines in rural areas and hospital beds in urban areas (Selvaraj et al. 2021).

Table 5: Availability of healthcare workers in West Bengal and India

	Para medical staff in District Hospitals		**Para medical staff in Sub-divisional hospitals**		**Doctors in District Hospitals**		**Doctors in Sub-divisional hospitals**	
	Sanctioned	In position	Sanctioned	In position	Sanctioned	In Position	Sanctioned	In Position
West Bengal	5204	5131	5197	3674	1065	882	1935	1307
All India	58563	55642	31931	26717	19646	18436	12067	10018

Source: Government of India: Ministry of Health and Family Welfare Statistics Division, 2014-2015

Presence of other categories of healthcare workers is mentioned below.

Table 6: Other categories of healthcare workers

Registered Category	**Number in active list upto 31.12.2015**	
	Male	**Female**
Nurse (General)	1359	40961
ANM	12	23697

Midwives	-	40965
BSc. Nurse	-	1653
Lady Health Visitors/ Health Supervisors	-	3475
Public Health Nurses (PHN)	-	227*

Source: Adapted from *Health on the March 2015-1016*, 245.

*This figure is already included in nurse's column. The position of PHN has been discontinued at present times.

Let us focus on the table above (Table 4.5) to understand how West Bengal is situated, when compared to the whole of India. The figures pertain to District Hospitals and Sub-district/ Sub-divisional hospitals as of March 31, 2015. Further, the table below would also reveal the number of medical hospitals and institutions at various levels by end of 2015, in West Bengal.

Table 7: Total number of Medical Institutions in West Bengal

Type of Institution	**Number**	**No. of sanctioned beds**
Medical College + Other Teaching Hospitals (Including Paediatric Intensive Care Units [PICU] in 12 MCH and Teaching Hospitals and Mother and Child Care Hubs [MCH])	13+6 =19	15071 + 2393 + 208(PICU) +2250 (MCH) =19,922
Multi/Super Speciality Hospitals	42	13800
District Hospitals	22	10100
State General Hospital (Including 5 decentralized hospitals in Kolkata)	29	3883
Sub-Divisional Hospitals	37	8210
Other Hospitals (Leprosy, Mental, Dental, etc.)	28	6505
Healthcare institutions in rural areas including Rural Hospitals, Block Primary Hospitals*, Primary Health Centres (for 30,000 people) and Sub-centres (for 5000 people) *	273 +76+ 914 + 10369 =11,632	9361+1205+ 6972=17,538
Centres like Special Newborn Care Units (SNCU), Sick Newborn Stabilization Units (SNSU), Critical Care Units (CCU) and High Dependency Units (HDU), established at different hospitals	70 +307+37+ 21	2523 (SNCU)+ 680 (SNSU)+ 572 (CCU)+126(HDU)=3901

Total hospitals/centres/institutions under Department of Health &Family Welfare	NA	83,859
Hospitals under various other departments of state government	72	6212
Hospitals under local body	42	1521
Hospitals under Govt. of India	58	7126
Private Hospitals/ Hospitals run by NGOs	1948	43589

Source: Compiled from Health on the March 2015-2016, GoWB

Another much heard allegation of disparity in centre's allocation of funds to the state of West Bengal by several elected governments of the state also seems to be in continuum with pre-colonial times. Sir Surendranath Banerjee, who was in charge of local self-government and public health in 1921, highlighted the disparity in allocation of funds between Bombay and Bengal Presidencies. While Bombay with a population of twenty million got Rs 10,98,93,000, Bengal with 45 million people got Rs 7,91,55,000, while money raised by Bengal was Rs.30.06 lakhs (Bengal Legislative Council Proceedings 1921).Similar sentiment about disparity in allocation of funds was echoed by former Chief Minister Dr. B.C. Roy of Congress (GoWB 1955) after independence and the situation now, has not changed either, as Mamata Banerjee of TMC, from time and again have levelled similar charges (The Economic Times, November 27, 2015).

The Third State Finance Commission had stated that in case devolution of functions could not be carried out in favour of the Panchayati Raj Institutions, in certain cases like primary healthcare, education, public distribution system, drinking water sanitation etc., the state must ensure devolution with immediate effect. Even for Urban local bodies, health and family welfare was part of basic and core services (GoWB, 2016, 51). Commenting on the 14th Finance Commission at the centre, the Fourth State Finance Commission pointed out that though there would be an increase in the amount of untied funds for the states, however, under the same recommendation, the burden sharing for states for certain schemes like National Health Mission, Swachh Bharat would also have increased (39).

Like other parts of India, the country, West Bengal has the presence of rural medical practitioners (RMP) in rural areas. It has around 2 lakh such practitioners, who may not be qualified or with partial knowledge about allopathy or indigenous medicine etc. Attempts are being made by the present Trinamool government to train them, so that the problem of

healthcare in rural areas is solved (Mukherjee and Heinmuller 2017,5). Nearly 80 per cent of such practitioners prescribed allopathic medicines; while a few prescribed ayurvedic, homeopathic and allopathic medicines (8). In the field-study by the present researcher, it was revealed that though most of them could not name asthma as a cause of breathing problems, they were better in detecting stomach problems and other minor ailments. They are trusted more by the rural population because the RMPs accept part-payments from patients who cannot make full payment at one go. This makes them even more accessible, in remote areas.

Acknowledging the role played by RMPs, the ANMs and General Physicians interviewed, accepted that the RMPs might play an important role in reaching out to more people and considered them to be effective in providing healthcare services. However, during field work, char dwellers of Jalangi block, in Murshidabad district revealed that RMPs or quacks are on most occasions their only hope of getting emergency services, due to distance between their location and government institutions, coupled with absenteeism of healthcare providers. At times they charge more money for medicines like Amoxycillin or Paracetamol, which are otherwise easily available in government facilities and that too at subsidized rates. The publication of various statistical reports reveals that West Bengal is a middle-performing state. For instance, West Bengal's rank based on overall performance of other larger states was 10 in 2015-2016 and in 2017-18, it was 11 (GOI 2019, 25). It needs mentioning here that the last case of polio in India was reported from Howrah district, on January 13, 2011.[22] Poor immunization drives in isolated pockets of the state have delayed the process of eradication of several preventable diseases from the state (GoWB 2004, 131). Despite the prevalence of the malaria, kala-azar, pneumonia etc., West Bengal has been performing moderately well, with regard to various heath indicators when compared to the rest of the country (GoWB 2018).

It was important to see how healthcare was provided to the poor of West Bengal. Healthcare access or the lack of it determined to what extent justice prevailed with regard to healthcare delivery. The poor residing in the urban slums formed the 'core' or 'centre' and the tea gardens of North Bengal and *Charlands* of Murshidabad formed the 'margins'.

[22] See https://www.who.int/india/news/feature-stories/detail/a-push-to-vaccinate-every-child-everywhere-ended-polio-in-india#:~:text=Within%20two%20decades%2C%20India%20received,Bengal%20on%2013%20January%202011. Last accessed April 5, 2022.

4.6 Snapshot I: Survey in Urban Slums:

In line with Moni Nag's hypothesis, the current researcher had tried to understand the awareness of residents with special emphasis to awareness with regard to healthcare scenario in two bustee settlements, one in the Mall Road area of Dum Dum another one in Birati, Sadarpara, both in North 24 Parganas district. However, the timing was different. The survey on Mall Road was done in 2017, before elections, while survey in Sardar Para was done in post-COVID period in March 2022. Hence, pandemic might have affected the responses of the residents.

There are over 100 small *karkhanas* (factories) in the Mall Road area and family income was found to be between Rs. 30,000-35000 per month. Along with the Bengali speaking population, Hindi, Bhojpuri and Nepali speaking people also reside in the area. A questionnaire was circulated, and responses were recorded accordingly. A total number of 17 questions were asked in order to achieve the dual objective of ascertaining the level of socio-political awareness, and of finding grievances regarding the availability of civic amenities in the area and choice of healthcare services. The initial questions were asked to know the level of political awareness among the residents, the rest were asked to record their responses regarding basic civic amenities and choice of healthcare. The respondents had the option of choosing **more than one sector where they thought improvement was required.**

Other questions were binary questions, like which sector do you prefer while seeking services for healthcare – government or private; or questions whose answers could be graded in a scale like how is the service in the local healthcare centre – good , bad, okay. It also needs mentioning that all individual categories included responses of respondents who had selected 'All' (areas requiring improvement). A substantial section also hailed from non-Bengali communities (from Bihar, Uttar Pradesh, and Nepal), however, they were fluent in Bengali language. The field work was conducted before the 17th general elections. Responses from 40 households were recorded. One member from every household responded to the questions asked. The average age of the respondents was 42 years.

Sardar Para, the second site of survey is located in Birati, Barrackpore Subdivision in North 24 Parganas. Responses were recorded from 25 residents. As already mentioned the responses were recorded in 2022, after three waves of COVID were over. The average age of the respondents was 37.5 years. The family income ranged between Rs 23000- 32000 per month.

Basic Facilities requiring improvement	Mall Road slum	Sardar Para slum
Quality and Supply of Drinking Water	20	16
Drainage System	9	13
Local Roadworks	10	10
Electricity	8	9
Education	8	8
Health	13	19
Other	7	7
No Improvement Required	5	4
All sectors need improvement	6	5

Figure 1: Responses regarding areas requiring improvement

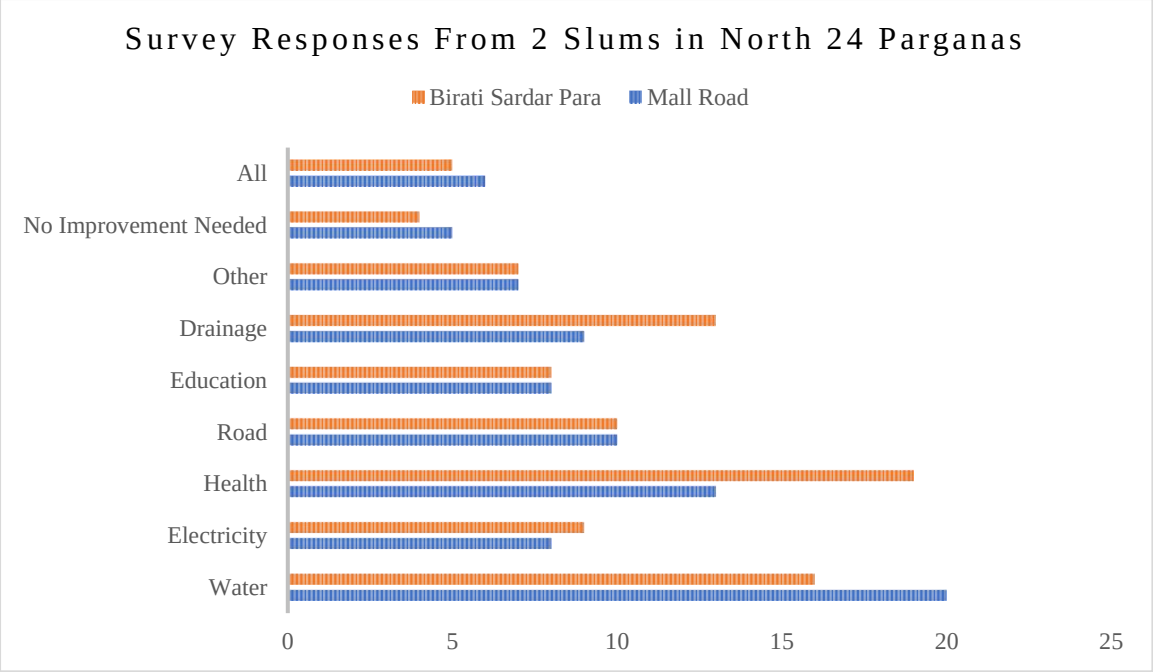

Figure 2: Responses from 2 urban slums

In both the slums, out of 55 respondents, 13 have preferred seeking general healthcare services from the private sector. 42 had expressed preference specifically for the government sector with regard to OPD services and surgeries while 23 have expressed preference for private sector. With regard to infrastructure of local health centres, emergency services offered, behavious of healthcare workers and their attendance, majority of respondents have recorded their responses as 'okay'. Majority of them acknowledged that the local health facilities were very much accessible. Barring 10 respondents who were not insured, almost all others have purchased health insurance from the governmnet sector.

It was found that socio-economic backgrounds of the respondents affected theoir choice of service providers. Even when they end up availing healthcare services in the public sector, the aspiration being that if they had money, they would prefer availing the services of private healthcare providers. Ten respondents out of 13 regarding the first question actually availed services in governmnet hospitals but 'preferred' private hospitals. Similarly, with regard to surgeries and OPD services, 15 out of 23 respondents sought treatment in public healthcare facilities. Further, it was also brought to notice that though repondents had hired services of *ayah*s in governmnet hospitals, no one reported hiring the services of an *ayah* in their domestic spaces. The following sheds light about their perceptions about various parameters of healthcare delivery.

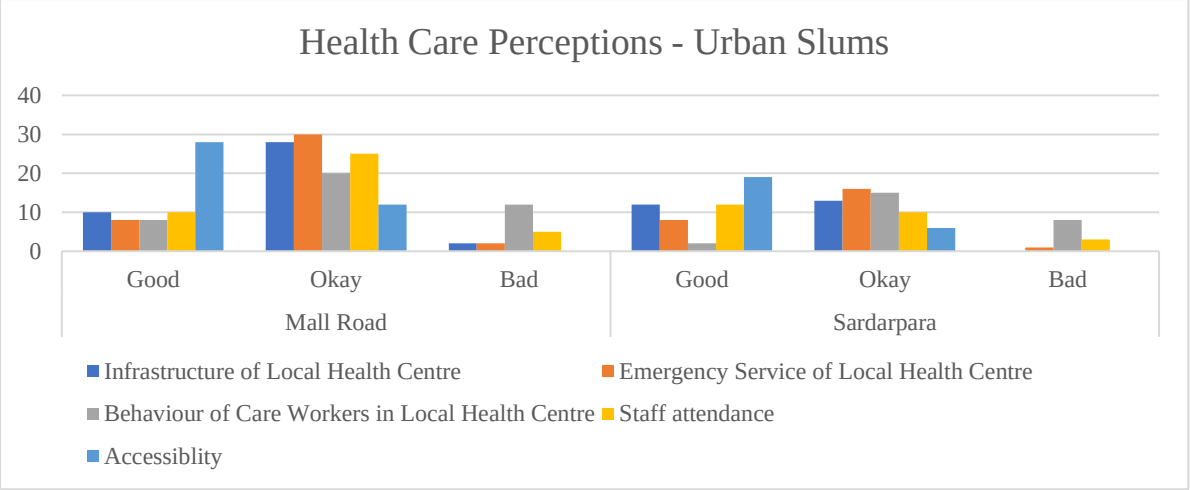

Figure 3: Responses from the Slums about healthcare perceptions

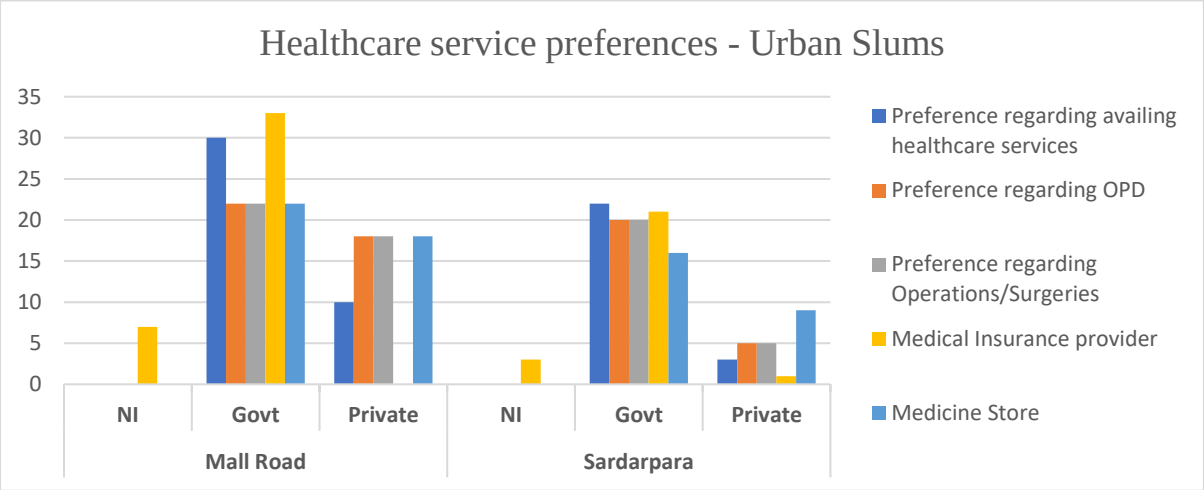

Figure 4: Healthcare Service Preference

Along with the above group, a sample comprising eight service seekers in government hospitals were interviewed. In one state general hospital in North 24 Parganas, I came across three respondents who identified themselves as transgender. According to them, they have been seeking services from the respective health facility for a long time. According to them, money was an issue for their choice of healthcare provider, however, their selection also stemmed from the fact that their presence did not attract any unpleasant attention, since government facilities were usually crowded. In addition to that their gender would have made them unwelcome in posh private hospitals, accessing services from such facilities was beyond their imagination, they concurred.[23]

[23] Interview conducted in state general hospital, Barasat on 18.07.19.

4.7 Snapshot 2: Tea Gardens of Jalpaiguri and Alipurduar:

Table 8: Data regarding Hospitals, sub-centres, Doctors, Nurses and Others in the Tea Gardens

Name of Tea Garden	Household	Hospital	Sub-centre	*Asha Karmi*	Mid Wife	Doctor		Nurse		
						Certified	Quack	GNM	ANM	Non-Trained
Raipur *	3250	1	-	-	1	1 (IAM)	1	-	-	-
Chamurchi	2307	1	-	-	-	-	1		2	1
Kathalguri	1462	1	-	-	1	1 (vis)	1		1	-
Redbank	907	1	1	3	-	2 (1 IAM)	-	1	1	-
Surendranagar*	1585	1	-	-	-	2	-	1	1	-
Ramjhora	1169	1	1	2	4	2 (1 IAM)	1	1	1	-
Bharnobari	1546	1	1	5-6	1	2	-		1	2 *ayah*s
Beech	1440									-
Birpara	8943	1				2			3	

Source: Compiled from the data collected during the field study and **Census of India 2001 and Census of India 2011.*

[24]Based on field work, it was revealed that quack doctors, folk healers are present in these tea gardens. Apart from Raipur and Chamurchi, in tea estates like Kathalguri, Redbank, Surendranagar, Ramjhora, though there are dispensaries or clinics, they do not have a medical team of their own. MANT, an NGO sends their medical officers twice in a week to these tea gardens. It goes without saying that such arrangements are far from sufficient, when it comes to needs of the people. For two tea estates of Bharnobari and Beech, there is one hospital run by the management of the tea estates. There is also one government sub-centre attached to Gram Panchayat headquarters (GPHQ). However, minor cases get treated here, for other ailments they have to go to the city for treatment. ASHA *Didis*, Midwives, *Ayahs* are also appointed from these tea gardens. In Birpara, there is one management run hospital, which earlier had proper operation rooms and other medical facilities. Currently, doctors, pharmacists associated with NGO Sobuj Sangha, Alipurduar visit the garden a few times every month. In the meantime, three ANM nurses oversee the health conditions of the workers. Presence of doctors certified in indigenous medicine was seen in a few of the gardens along with the presence of quack doctors. *Jaributis* and *totkas* prescribed by quack doctors are widely popular among the residents of tea gardens.

[24] This report is based on interviews with Dooars Terai Tea Plantation Workers' Union, plantation workers, members of Manbhum Ananda Ashram Nityananda Trust (NGO) (MANT), Asha didis, ANM nurses and ayahs

Interviews with managers of tea gardens have also provided important insights. The second part of the field work was carried after the third wave of COVID-19 pandemic, hence it was imperative to ask about the situation of workers who live in ghettoes. Interestingly, all three managers interviewed had exclaimed that indigenous workers normally are sturdy and they do not fall sick. Most common ailment was acknowledged to be tuberculosis and one of the managers had linked tuberculosis with the eating habits of indigenous workers in the tea gardens. That tuberculosis was worrisome in tea gardens was unanimously accepted by tea garden managers, ANM nurses present in subcentres or management-run hospitals, visiting doctors and members of NGOs. Apart from tuberculosis, malaria, dysentery and liver issues due to alcohol abuse are also reasons of concern. Women also suffer from weakness due to lack of nutritious food. Many also suffer from anaemia. As per a study on tea gardens in Dooars region, the rate of institutional delivery is 40 percent as most women still rely on the age-old wisdom of dais or are forced to opt for their services due to the scarcity of lack of accessibility (due to high expenses) of trained healthcare workers (Sarkar 2022, 38). This at time, results in maternal deaths (Manna, De and Ghosh 2011). 'Though maternal deaths have reduced over the years, they still occur in the gardens,' stated an ANM II nurse at the health subcentre at Malang, next to Beech tea garden.

Access to healthcare is linked with one's economic condition. The workers in the tea gardens are very poor and due to the prevalent rule, that from a family only one person can work in the garden, it forces people to seek for work elsewhere. Incidents of trafficking are also high in the tea gardens. Many also cross over to Bhutan for work. During field visit, I had come across two families, where young girls have migrated to Bhutan and Delhi to work as caregivers, looking after old patients. Though doctors do visit, the pay of the workers is not enough to conduct medical tests or undergo surgery even when required. It also needs mentioning that during my visit, I did not come across any *Ayah* centres, though *ayahs* are employed in private nursing homes in the town. Daily wage rates are between Rs 160-180 across tea gardens. Houses that were visited belonged to migrant tribal labourers like Oraon, Munda, and Tanti.

4.8 Charlands of Murshidabad:

Charlands or *diara* are located 'on the edges where earth and water ecologies and cultures meet on the fringe of human habitation…' (Lahiri-Dutt and Samanta 2013, 328). When rivers change their course, chars develop. Severe riverbank erosion on one end, leads to the formation of

chars on the other side of the bank, where poorest of the poor people have taken refuge across time (Basu 2018). Field work was conducted in three *chars* of Jalangi sub-division namely *Char Parashpur, Paschim Char Bhadra* and *Bamnabad* and two chars of Raninagar II (Community Development Block in Domkal subdivision) namely *Katlamari* and *Paschim Char Majher Diar*. Though there is a Super speciality hospital in Domkal, the residents of these charlands cannot avail its services. The distance acts as a major deterrent (around 20 kms) along with the fact, that the residents fear that the touts will fool them and take away whatever they have. Due to their fear or mistrust associated with government facilities, they rely more on private healers or providers like quacks, *Ojha* and *Tantric*s and their *jaributi*s.

For delivering babies, pregnant mothers do go to government facilities, however, they do not undergo regular check-ups due to the distance. Though there is a health centre at Kazipara, irregular presence of doctors renders it almost useless for the char dwellers. Residents complained of suffering from dysentery, fevers, gastro-intestinal problems. Snakebites during monsoon is also another menace they have to live with. There are no healthcare facilities in the *chars* that were visited, primarily because *chars* are temporary in nature. However, no doctor or other healthcare workers like ASHA *didis* visit these areas much. ASHA *didis* at time come to give polio drops to newborn babies but that happens seldom. In *Char Parashpur*, there is a health centre of sorts and quack doctor who lives nearby looks after it. He is assisted by his wife who has received training as an ANM nurse. Presence of *dais* can also be noted in these chars. The traditional knowledge of women is much sought after in these parts of the world during giving birth and treating fever or snake bites with *totkas*. Payments are made in a combined method of cash and kind, and payments are also made in instalments. In case of emergency, the doctor ferries patients on his bike to the edge of the chars, from where, patients can go to the mainland by small boats or *dinga*.

In dry season, a bike can cross a large part of the river or rivers (rivers *Padma* and *Jalangi)* in case of *Parashpur*. In case of emergencies people from *Char Parashpur or Paschim Char Bhadra*, go to Sadhikhanr Diar Rural Hospital, which is a rural hospital, under the category of community health centre or CHC. During flood like situations, BSF in their tractors and other vehicles often take pregnant mothers or critical patients to hospitals. There is also paucity of drinking water in these chars. Children go to Anganwadi institutions which are between 5-10 kms. from the *chars*, mainly for the mid-day meal comprising soyabeans, lentils curry etc.

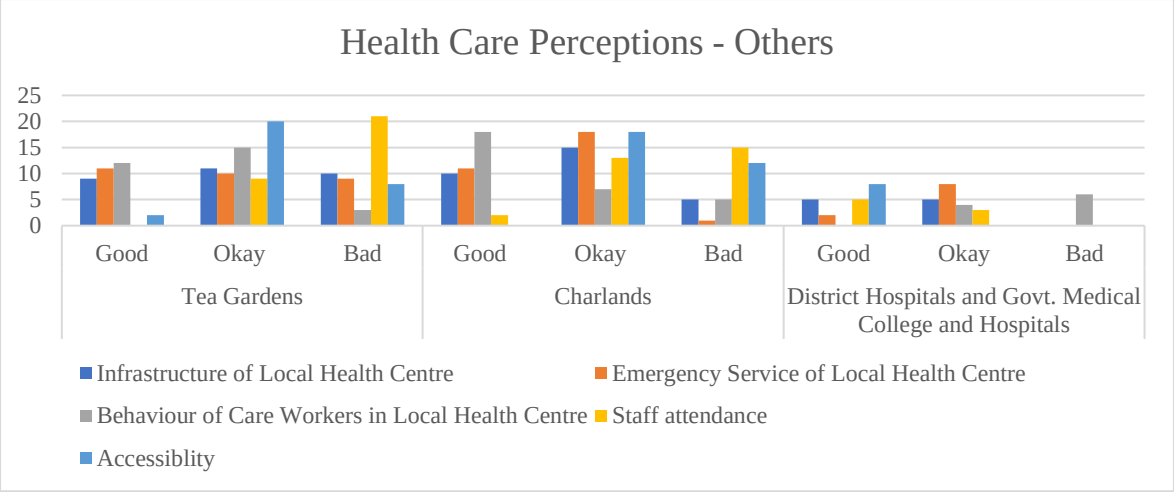

Figure 5: Healthcare Perceptions in Tea Gardens, Charlands and among service seekers in urban hospitals (government)

Preference regarding healthcare service delivery is depicted below.

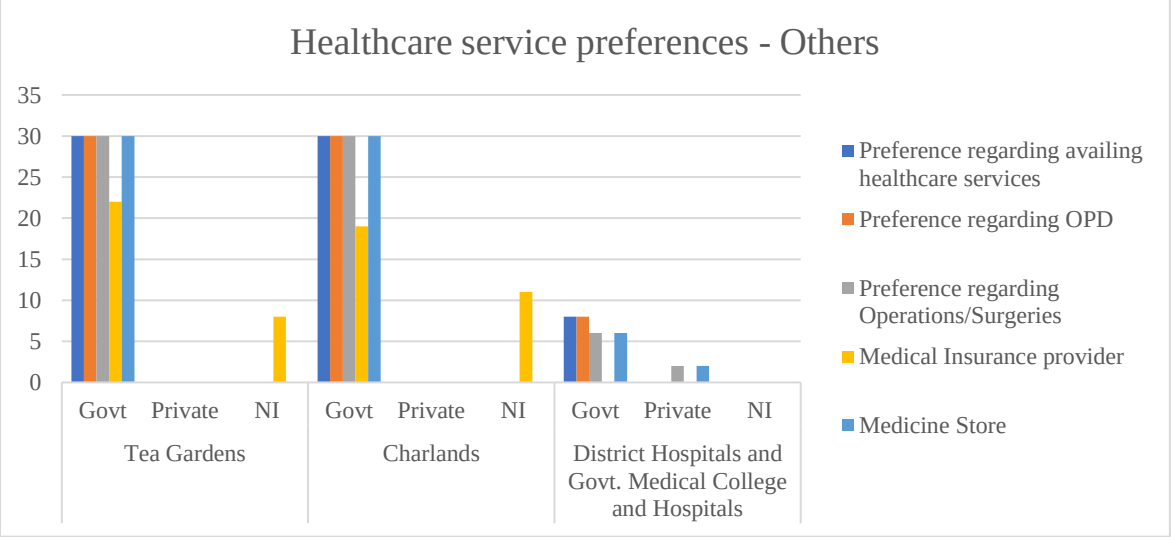

Figure 6: Healthcare Service Preference

Overall, an overwhelming majority of 120 respondents have expressed their preference for availing healthcare from government facilities, 110 expressed preferences for availing OPD services from government facilities. 108 respondents wanted to get a surgery done in government facilities as well. A majority of 104 respondents out of a total of 133 respondents, stated that they preferred buying medicines from fair price stores. However, due to unavailability of medicines, they have no other option, but to buy drugs from outside the government facilities. Uncertainties associated with the availability of medicines and long ques deter many from buying medicines from fair price stores available with the government

facilities. Various private stores outside government hospitals have good stock of the necessary drugs, that usually get prescribed by doctors. However, it needs mentioning that all the 60 respondents from charlands and tea gardens preferred services of fair price shops and respondents preferring private medicine stores were people from urban slums with relatively better economic condition and access to more medicine stores in the city spaces.

A total of 112 respondents out of 133 suggested that they preferred availing services of diagnostic centres available with government facilities. However, long waiting period, fixed operating hours, irregular functioning of such centres due to non-functioning equipment and ill maintenance of equipment and absence of technicians, force people to opt for more expensive private diagnostic centres. The respondents thus, try to avail services of such private diagnostic centres that offer subsidies to poor people. But many times, they have to collect funds from friends and relatives when no subsidies are given to them. On the other hand, people from *charlands* and tea gardens rely heavily on government diagnostic centres as private centres are not easily available in the areas and the remoteness of their location clubbed with financial constrains deter these people from travelling long distance in order to access diagnostic centres. Five out of eight respondents had stated that they found the behaviour of careworkers okay, which gives us an idea why those respondents seek service from government facilities. Since part of the fieldwork was concluded after the third wave of COVID-19 was over, it became imperative to inquire about if the residents of *chars* and tea gardens had received any vaccines against COVID-19. The Border Security Forces (BSF) and residents of the *chars* informed that they did receive vaccination (both doses) from BSF, while residents of tea gardens received vaccines from government facilities and NGOs.

Another finding being that out of a total of 133 respondents, 74 had stated that healthcare situation and services have improved since 2011 (when a new government came to power in West Bengal), while 39 stated that it has remained the same, 15 did not comment (9 respondents considered that they did not have enough knowledge to come to a conclusion) and two thought that the situation has deteriorated. Since 2011, the government has been successful in giving visibility to issues of health or healthcare. The government has been able to reach out to a wide population through its health insurance scheme called *Swasthya Sathi* of 2016. By building more healthcare facilities of various categories, it has tried to give impetus to the government healthcare sector. However, critics point out that TMC government's focus on primary health centres and primary health has declined after 2015 (Bose 2022) and that several newly built

facilities lack staff, doctors, equipment etc. Further they also allege that the Trinamool government favours private players more than the Left Front. 'If earlier government would just give free land, the current government along with giving free land, would also pay to build up a private hospital, in the name of PPP model,' suggested Dr. Guha[25]. Many also point out that a strong public health system cannot be regarded as a replacement for an insurance-based healthcare model. Consequences of relying on an insurance-based approach include undermining primary and preventive healthcare and putting it at risk of an ever-increasing, irreversible concentration of power in the hands of the private sector. This would increase the financial burden on the populace and be detrimental to people hailing from marginalised groups (Devadasan et al. 2013; Ghosh 2018).

Before concluding, it is imperative to share a few words on the selected areas of field work and the role of healthcare workers. The tea gardens and *chars* were chosen to test the limits of outreach of the healthcare services in the state. Findings from that were used to analyse the situation in urban slums. When one goes to the marginal spaces especially the *chars,* the ideas like health equity, health for all etc. fall apart into shambles. At times it seems that healthcare in the margins is both *present and absent*. When someone dies in tea gardens or *chars,* due to snake bite, dysentery (all which are very much preventable in urban areas) it is in those moments that the absence of basic facilities and the remoteness of their geographical locations loom large. For instance, due to the geographical locations, these *chars* are also very difficult to access. However, access to healthcare is ultimately a matter of right, one that often gets violated for the people residing in the margins, and along with it, justice also becomes elusive. But dedicated healthcare workers, who form the first line of defence, can make all the difference. In healthcare centres where the doctors are not regularly present or are absent, nurses play a very important role in providing healthcare to the people, yet they mostly remain outside the ambit of policy formulations (Healey 2013).

[25] November 21, 2021 at his residence in Salt Lake.