Chapter III

Strategies of Health Care and Structural Adjustment Programme (SAP)

Since Independence, many strategies have been initiated in the health sector to deliver proper services. The most essential is the adoption of structural adjustment policies during 1990s. The consequences of these macro-economic policies has significant impact on the rural people particularly in accessing health care facilities provided by the government. The influence of liberalization policies has disrupted the services in rural areas where primary care is the only level of care. Changing health care policies reflect the macro-economic forces working at the national level. In this chapter an attempt has been made to discuss the health care strategies in India, which reflect upon the spirit of National Health Policy. With this view following discussion has been undertaken.

3.1 Evolution of Health Care Policy in India

1) Bhore Committee

To understand the health scenario of the country a macro survey was conducted under the Chairmanship of Sir Joseph Bhore an Indian ICS in 1943. These observations were published in 1946, in the report of Health Survey and Development Committee, commonly known as Bhore Committee report. "The observations presented are as follows: Most of the diseases (about 90%) are simple and communicable diseases arising out of malnutrition and uncongenial environment of living. About 75% are due to malnutrition and almost all other diseases have some link with nutrition. Most of these ailments are due to poverty. Bhore Committee (1946) observed that most of them are preventable. Only about 10% required institutional treatment"[1].

"The Bhore Committee made a detailed survey of health conditions at the time and recommended an integrated national health service organized on a three-tier model. The model was based on primary health care services and was to provide complete medical and preventive care as close to the people as possible. It gave a detailed plan for developing the infrastructure for the primary and district levels, which was highly suited to provide preventive and basic curative care for the rural population. It set a time frame of 30 to 40 years of achieving this and calculated the resource burden that government

would have to bear. It estimated that the State would need to increase its health expenditure by three times, from the existing 4.5% to15% of the total government expenditure.

The conceptual framework of the Bhore plan became the blue print for developing the public (government) health services sector in India, but its specific recommendations were only selectively and minimally implemented. India's chosen path of development gave priority in investment to creating the socio-economic infrastructure necessary for the growth of private capital and industry, and neglected and under funded the social sectors.

Initially, two concepts from the Bhore plan were picked up for implementation- the formation of primary health units and the programmes to control communicable diseases. The primary health care as they exist, consisting of a 4-bed health center with two doctors and some paramedic staff to cover a population of 30,000 are not even an apology of what was originally outlined. The disease control programmes were implemented as separate vertical top-down campaign"[2].

2) Five Year Plans

"The first two plans actually attempted to develop basic infrastructure and manpower, although less than 5 percent of the total budget was invested in health. They were inspired by the Bhore Committee's vision in which ill health was seen as a product of poverty and its redressal thus necessarily required an integrated strategy. Gradually over the 1960's however, this vision was diluted. Urban hospitals obtained priority over rural institutions, and are overshadow by mushrooming medical colleges. It was apparent by the 1970s that hi-tech medical care could not be made accessible to all, while the poor were rapidly getting disenchanted with inadequate/non-existent basic health care services. A series of scheme were introduced like feeding programmes, the community Health Guide Scheme, the Multipurpose Workers Scheme, the integration of vertical programmes, and the integrated Child Development Services"[3].

From the third five year plan onward, family planning has remained the main concern and maternal and child survival has changed into child survival and safe motherhood. But the underlying emphasis of the health programmes remains family planning or population control. In the fourth five year plan, "not only did the rate of expansion of infrastructure slow down, there was also a shift from building peripheral health centers and training paramedical professionals to hospitals and specializations. Vertical technocentric programmes were accepted for disease control"[4]. On the other hand, mushrooming of private medical services to meet the demand for curative care has become a considerable financial burden to the vast majority of the people. "The seventh five year plan has openly advocated the expansion of private investment in curative care while restricting public spending to preventive services, i.e. public health"[5].

The Ninth Plan (1997-2002) emphasized on to evolve appropriate mechanism for cost recovery from people above poverty line for diagnostic and therapeutic services in secondary and tertiary care to improve available facilities and quality of the healthcare provided. It also talked about strengthening of disease surveillance system to prevent outbreak of infectious diseases.

The areas of attention in the Tenth Plan includes the reorganization and restructuring of existing health care infrastructure, for delivering Indian System of Medicine and Homeopathy (ISMH) services, at primary, secondary and tertiary care levels, so that they have appropriate referral linkages with each other, recruitment of adequate health personnel in medical institutions and strengthening of Panchayati Raj Instirutions (PRIs) so that there is local accountability of the public health care providers, and problems relating to poor performances can be sorted out locally (as mentioned earlier). It also talks about integration of vertical programmes including supplies, monitoring, IEC, training and administrative arrangement, so that they become an integral part of health care under one head, health and family welfare society at state and district levels. There will be continuity in providing essential primary health care, emerging life saving services, services under the National Family Welfare programmes free of cost to individuals based on their needs and not on their ability to pay. At the same time it also

talked about levying and collecting user charges from people above poverty line and utilizing funds obtained for improving the quality of health care services[6].

The tenth five-year plan also envisaged the focus on technology and decentralization. Technology is separated from welfare and shifted to the major disease control programme verticalised the initiatives to the detriment of public good. "Not only is investment in the welfare sector being curtailed, but in the name of decentralization the state is also abdicating its responsibility. With increasing marginalization of the state, voluntarism has returned. In this neo-liberal atmosphere, big multinationals are doing research under the protection of national and international capital. The marginalized state can only buy their technologies and use them in the public sector after paying a heavy price"[7].

3) Health For All

Way back in 1978, WHO member nations took a pledge at Alma Ata to ensure not just universal access to primary health care, but 'Health for All' by the year 2000. "According to this declaration, PHC was to be implemented in accordance with the political, economic, social and cultural pattern of a country. Intersectoral developmental linkages, equity, basic needs and people's participation were seen as the key instruments of PHC. India's health minister decided to proclaim two of its previously enunciated schemes- the Multipurpose Workers Scheme for the villages and the Community Health Guide Scheme- as the heralds of PHC"[8].

4) Selective Primary Health Care

But this comprehensive strategy was mounted through the concept of Selective PHC (Walsh &Warren), which claimed to identify major infectious diseases on the basis of mortality and morbidity. The diseases were categorized as high, medium and low priority and a set of cost-effective technologies was identified as core intervention. The emphasis was on the issue of cost-efficiency, and the notion of 'selectivity' was expanded from diseases to sectoral level. Though India signed the Alma Ata Declaration in 1978 and pledged its implementation, the Sixth Five Year Plan made no mention of it. The programme of immunization and later the child survival strategies were promoted, and Selective PHC silently became a part of health sector planning[9].

By 1983-84, World Bank chose to ignore the weakness of the Selective PHC approach while adopting its future strategy in the health sector. It suggested to international agencies that immunization be the spearhead of their initiatives. Subsequently, UNICEF began its campaign of universal immunization and later for child survival with growth monitoring, oral rehydration, breast feeding and fertility control[10]. This coincided with the growing awareness among international agencies of the failure of the family planning approach to the problems of poverty, even as they accepted the need for the integrated programmes of public health along with the satisfaction of the minimum needs of the population in order to meet demographic goals.

5) National Health Policy 1983

Hitherto, India has witnessed two National Health Policies (NHPs). The first NHP was formulated in 1983 which focused on " people-oriented health service system which is meant to strengthen community self-reliance by empowering people to develop their own means for coping with their health service system is made available to the people when they are unable to cope with their own"[11]. The 1983 National Health Policy adopted the primary health care (PHC) approach proposed by WHO in 1978 in order to bridge the very gaps in inequalities in the health care coverage between region and states and urban and rural areas. The priorities were to bring health to the door step, shift from curative to preventive and promotive aspects of health care. "The emphasis is on achieving Health for All by 2000AD through primary health care approach, and attaining the long-term demographic goal of a net reproduction rate 1 by the year 2000 at the lowest feasible levels of mortality. In particular, it has been emphasized that the infant mortality rate should be below 60 per 1000 live births and the expectations of life at birth should increase to 64 years and the birth rate should be reduced to 21 per 1000 population by the turn of the century"[12]. But it has failed to do so.

"After Independence health care delivery received a low priority..... The quality and availability of even minimal services could not be guaranteed in the absence of drugs, materials and equipment and family planning continued to take up the maximum time of health of workers. The growth of central allocations has slowed down considerably since the late 1970s and their share in state budgets has declined sharply since the mid 1980's.

This contributed to the general stagnation of public spending. More importantly, it has led to poor quality and even non-functioning of rural health services and disease control programmes, particularly in the poorer states that are far more dependent on central transfers. The resultant shortages of drugs and materials and the cuts in maintenance funds for equipment and facilities, has coincided with the massive expansion of the physical infrastructure in rural areas under the 1983 National Health Policy.

A major criticism of the 1983 policy and of subsequent planning, was that it diluted the PHC approach. The public health care services influenced by international policy trends, remain selective and programme oriented, and did not develop integrated and comprehensive services. A few more preventive services such as child survival and safe motherhood were added on to the existing dominant family planning and the more marginal disease control programmes. There were also little workers or to involve the community in any other way supportive of a largely decentralized and deprofessionalised model of health care services. Another criticism was that the PHC approach was blind to the presence of the huge private health services. Government planning continued to focus on the small public health care services, ignoring to need to control the proliferation of private services or regulate and monitor private providers. The PHC approach, unlike the Bhore plan, diluted curative services and therefore, could not increase the utilization of the public sector, especially the first level of care"[13].

6) National Health Policy (NHP) 2002

The second NHP was formulated in 2002 which talks about "integration of vertical programmes, strengthening of infrastructure, promotion of public health as a discipline, filling the gap of availability of doctors by introducing short-term training for basic services, decentralization of health care delivery through panchayati raj and autonomous monitoring institutions, setting up a national disease surveillance system as well as a national accounting system, strengthening ethical practices, and regulation of private practice. It also talks of increase in investments, particularly from the center. This would go up to 25 percent from the 20 percent of the total expenditure. It would also induce greater investment by the states as well, whose expenditure has gone down from 7 percent to 5 percent of their budgets"[14].

It also emphasized on making the secondary and tertiary level care cost-effective, the policy will encourage the supply of services to patients of foreign origin on payment. "Since the profit-making capacity of the corporate hospitals is limited by the relatively small size of domestic consumers with very high purchasing power, attracting foreign patients has become an easy tool for them to expand the domestic market. Due to attraction of foreign exchange and the concern for economic growth, the government is willing to offer fiscal and policy incentives to such ventures. India is emerging as a medical tourism market player primarily due to two push and pull factors. Firstly, India can provide high quality care at very low cost and secondly, the cost of medical care is touching prohibitive levels in the US, Britain, etc. Thus, cost effectiveness or comparative advantage in the production of medical care is cited as the catchword for attracting both foreign and non-resident Indian patients to India. The country can provide world-class medical care at a fraction of the cost incurred in the developed countries due to the availability of relatively cheaper but quality manpower, low-priced drugs, and other infrastructure"[15].

The draft policy ignores the protection and provision primary health care (PHC) for all, specially the underprivileged. It also undermines the existing national health programmes and encourages commercialization of tertiary and secondary level medical care without ensuring basic health care to the poor. The present draft also overlooked the importance of maintaining referral links between different levels of care. For investing in infrastructure contribution of NGO and private sectors are involved. It also proposed that National Health Programmes would be implemented by 2005 through the local self-governments. "For this purpose autonomous bodies at the state and district level-consisting of social activities, private health professionals, MLA's/MP's and government officials- are envisaged that would help in the implementation of programmes"[16].

The NHP talks about shifting responsibility to the local organization without decentralizing control over resource and their use, which is left for the moneyed and the market forces. It is concerned only with health status. It emphasizes on reproductive phase of the life of women only to control fertility. Moreover, social strategy-based

programmes of public distribution are replaced by technology based disease control programmes.

7) National Rural Health Mission

"The key strategies of the Rural Health Mission include: ensuring intra- and intersectoral convergence, strengthening public health infrastructure, increasing community ownership, creating a village level cadre of health workers, fostering public-private partnerships, emphasizing quality services and enhanced programme management inputs. The mission has also suggested certain concrete measures. For instance, inter-sectoral convergence is proposed to be achieved by establishing yet another organization, this time probably a quasi-government society at the state and district level. The public health infrastructure will be strengthened by several measures; a few of them would probably script the demise of the public sector. These include the engagement of private doctors and health committees with the power to charge user fees, etc. Community participation will be enhanced by giving functional responsibilities and powers to the panchayati raj institutions, apart from creating a cadre of voluntary accredited social health activists, and a drug and contraceptive depot at the village. The public-private partnership aspect is most controversial. The actions proposed are largely for family planning services and include social marketing and social franchising of services, such as institutional maternity care, immunization services and provision of bank loans for setting up family welfare clinics. It also suggests the addition of other curative services and the gradual evolution of reproductive and child health to a community insurance programme. The mission will also use management experts, CAs, MBAs and GIS specialists for its management units"[17].

The rural health mission formulated to improve health care services in the rural areas seems to promote privatization in the rural areas. It is trying to privatize programmes such as maternity care, family planning services, etc. Private doctors and health committees are engaged with the power to charge user fees, drugs and contraceptive depot are established in the village.

3.2 Structural Adjustment Programme (SAP)

Eighth plan earmarked the arrival of SAP which is quite reflected in subsequent policies, plans and programmes. Strengthening of private sectors, cost-effective measures, reducing of funds in social sectors are the main features of SAP.

1) Origin of Structural Adjustment Policies (SAPs)

The root of SAPs are in the economic crisis India faced during the eighties. During this period there was excessive lending from international banks followed by international trade agreements between developed and developing countries. As a result, the funds were misutilized and spent on wasteful projects leading to unsustainable development. "The repayment crisis which followed led to a dramatic deterioration in the economies of the developing world owing to the fact that the interest to be repaid, accumulated and often exceeded the total income of these countries from their export earnings.

The donor-led debt crisis of the early eighties together with the prospect of inability to the banking system in the North, sets the backdrop for Structural adjustment Policies. The IMF together with the World Bank stepped in to help developing countries pay off loans, on the condition that the countries adopt economic policies which generate "economic growth" and in their term, create the climate for repayment and the requisite economic and social stability. It is clear from the literature, however, that part of this strategy was to replace the state sector in public services or to reduce its role to a minimum"[18].

2) Role of WHO, World Bank and IMF

As the issue of liberty, equality and fraternity has converted into gobalisation, marketisation and privatization, the agencies like WHO and World Bank came increasingly set the agenda for health. "Third World countries, burdened with debt, were prescribed a package of macro-economic reforms under the rubric of structural Adjustment Programme (SAP). These reforms, advocating the remorseless 'cut-back' of state interventions in the social sectors along with the rolling back of the state, led to increasing economic differentials between the developed and developing countries and indeed even within them."[19].

India adopted the Structural adjustment Policies and began to liberalise and restructure the economy in accordance with the IMF-World Bank agenda. A major part of this economic restructuring was the cutting back of government spending and the withdrawal of government responsibility for the fulfilment of the people's basic health needs. "Since, the 1990s, at the instance of the Breton Woods institutions, India has also embarked upon the Structural Adjustment Programme. It is in this context that the World Bank's World Development Report of 1993 (WDR) devoted to health entitled 'Investing in Health', is of extraordinary salience as it outlines the Bank's perspective for health sector development in developing countries"[20].

"The World Bank's India: Health Sector Financing Paper of 1991, clearly articulated a limited role, with a selective and target –oriented approach, for the public sector health services. No longer was the government responsible for ensuring comprehensive care defined by the health needs of its people. Instead in the era of cutbacks, it only had to provide a selective package of minimal services (much the same as the preventive programmes that define health services in rural areas) to the abjectly poor-women, children and people in backward areas were targeted-through reallocating (current low levels of) government health spending. The remaining poor and the low-income groups, as they resided in areas 'currently better served than the poorer areas by private practitioners could pay for their own health. This policy completely disregarded the high cost and women quality of care characterizing the private services"[21].

"Even the WHO has diluted its stand and is now in favour of selective health for a targeted population, an approach which the World Bank has pushed since its 1993 World Development Report. 'Investing in Health', WHO's recent report titled "Health for All in the 21st Century has debunked the comprehensive approach and is now focusing on selective programmes. The latter theoretically grants the possibility of state run public health programmes where cost-effectiveness is demonstrated. But this possibility of expanding the scope of basic services is now denied under the innocuous title of 'essential' public health and clinical services and, other than tuberculosis, no mention is made of existing communicable diseases.

The World Bank agenda for health sector proposes:

1) Cuts in public spending on health services including tertiary level medical care and shifts to strengthen population control.
2) Shifting curative care to the private sector.
3) Introducing cost-recovery mechanisms in public hospitals.
4) Defining 'essential' clinical and public health packages.
5) Tackling poverty through structural adjustment policies, education and women's empowerment."[22].

3) GATT Agreement

"The growth of the private sector, the systematic destruction of the public sector, and the consequent exponential increase in the prices of the minimal requisites for survival, is now an accepted feature of the "New Economic Policy"[23]. This approach is the outcome of General Agreements on Tariffs and Trade (GATT), which is assumed to lead India in a state of economic 'growth' and 'prosperity'. "In the light of the New Economic Policy, the signing of the GATT treaty in April, 1994 lead to the stringent Patenting Laws, where the local, handy, indigenous practitioner bears the brunt of the defects in any such policy"[24]. This has lead the government to encourage privatization in health sector by allowing the foreign multinationals in making roads to health sector in India resulting in increasing price of health services. "In spite of repeated recommendations to the contrary, the government has gone in increasingly for privatization without paying much attention to public health. The recent New Economic Policy has finally shown that the government is no longer interested in providing 'Health for All" by the year 2000A.D. The signing of the GATT treaty has further implications"[25].

4) Disability Adjusted Life Years (DALYs)

"To make the situation more worse some simplistic short cuts were introduced - be that cost-efficiency measurements, participatory rapid assessments, or disability adjusted life years (DALYs). Take DALYs for example, a tool that has been acclaimed as a sophisticated instrument for planning. It converts death and disability into a common denominator- the time lost. In public health, decline in total mortality is the first step towards success, which in poor countries may often be associated with increase in

morbidity. DALYs tend to overshadow these early successes by compensating decline in time lost through death by time lost through increased morbidity. They may not show any marked shifts over periods of transition and thus undermine achievements in public health in poor countries with high morbidity, DALYs tend to overshadow these early successes by compensating declines in "time lost" through death by time lost through increases morbidity"[26].

5) Impact of SAP on Health Sector

The World Development Report of 1993- Investing in Health "advocates that the state or the public sector should provide only essential services such as "clinical packages" for the needy while the tertiary sector opens up to full global competition.

The changes brought about in varying degrees in the health sector of developing countries were:

- The introduction of health insurance (with compulsory purchasing) in some cases deducted from salary payments as in Thailand.
- The introduction of user charges for specific services.
- The introduction of community –based financing.
- The advocacy of de-centralized services.
- The location of NGOs as a key reference point in service provision"[27].

"The most significant impact of SAP on the health sector was a sharp cutback in public expenditures during the early nineties. This resulted in a steep fall in central grants to the disease control programmes during this period. The poorer states, which were much more dependent on central outlays, suffered as a result. During, 1992-93 some of the cutbacks were restored through World Bank loans for specific diseases programme. Much of this restoration could be attributable to a 34 percent increase for tuberculosis and blindness control programme.

During 1993-94, there was a marginal increase for malaria but other communicable diseases registered a decline. The restoration of the cutbacks for communicable disease

programme was necessitated by outbreaks of several epidemics resulting in a large number of deaths"[28].

Apart from earlier mentioned changes in the health sector due to SAP, following are some of the features to improve efficiency, quality, and effctiveness of public hospitals:

- "cutback on secondary and tertiary spending and channel it into selective intervention at the primary level;
- contract out ancillary services in public hospitals to private contractors;
- involve private providers in national communicable disease programmes;
- encourage private sector growth at secondary and tertiary levels by instituting regulations.

In this kind of restructuring, the role of the public sector is gradually limited to only primary- level provisioning. Secondary and tertiary care is commercialized through user charges for outpatient and inpatient services, diagnostic, and other facilities"[29]. To understand the consequence of SAP, the features are discussed in details.

6) Health Insurance

The introduction of health insurance was characterized with the fact that "if the rural dwellers are equipped with the ability to pay for their services through insurance schemes, there is a possibility that the private sector, especially the small-scale private healthcare providers, may feel encouraged to offer services. But it was again suggested while the government has not taken any direct steps for increasing the public health infrastructure in the rural areas, concesion to the private sectors will only get reflected in the urban areas"[30].

The government proposes Universal Health Insurance Scheme (UHIS) for the families below poverty line (BPL). But how far this scheme will be successful is indicernable, because Ramesh Bhat and Somen Saha has well pointed out, "Given the level of competition in market place and the way such schemes are delivered to its beneficiaries, it looks very unlikely that public insurance companies will show interest in the scheme, leave aside private insurers. Outpatient care has been kept outside the ambit of this

scheme. Many micro level experiments on community- based health insurance suggest that having options for outpatient care increases the acceptability. All pre-existing diseases including maternity benefit, HIV/AIDS are excluded. Maternity benefit and outpatient care is significant among the poor as total fertility rate is around 2.91. Excluding the maternity benefits goes against some of the trends of including such benefits in recent schemes of insurance companies. The scheme only takes care of hospitalization. The other conditions laid down include that hospital should be minimum of 15 beds (10 in case of class 'C' cities having a population less than fine lakhs) with fully equipped OT, fully qualified doctors should be in charge round the clock. We do not think some of these conditions are being met by majority of health facilities in India"[31].

7) User Charges

"The exclusion of the poor is further strengthened by the policy of introducing user charges in public hospitals and other institutions"[32]. Because the middle level hospital system does not provide support to basic institutions and is not supported in turn by tertiary care institutions. Moreover, primary health care is limited to preventive endeavours. "The result is a high-tech, super specialization based service in rural areas with no supportive inputs for National Disease Control Programmes. By opening up public institutions to forces of privatization, they in effect are being asked to close their doors to the poor. Their working as referral institutions is also jeopardized as their services are linked to paying capacities"[33].

The introduction of user fees is seen as a way of substituting public funds with private funds in secondary and tertiary hospitals by instituting means tested user charges [as quoted in Baru, 2001]. "User fees are seen as fundamental to generating the necessary revenue to cover the running costs for secondary and tertiary hospitals. The experiences of cost recovery through user fees are not very encouraging, it often does not ensure returns high enough to cover recurrent expenditure, and in many countries it has excluded the poor from access to services.

Under SAP, there is a strong push towards charging for outpatient, inpatient and diagnostic services in government hospitals, while developing means to exempt the poor.

The State Health System Project proposes to implement existing user charges more rigorously.....The revenue from user charges will be used for meeting non-salary recurrent costs in public hospitals"[34].

8) Marketisation of Health Services

"Most of the studies showed that during the nineties there has been a steady increase in the import of medical equipment which is essentially a fallout of the liberalization of government policy on import of technology"[35]. Health is no more remained trade restrictive after the agreements on international trade regulation.

a) Influence of Multinational Corporations in the Pharmaceutical Industries

Moreover, "the marketisation of health care in the 1990s is characterized by the increased influence of multinational corporations in the pharmaceutical industries, the emergent exporters of hi-tech medical technology, international insurance firm and health care corporations. These corporations have influence on multilateral institutions and global policy regimes as well as national policies, particularly in the health sector, multinational corporations have systematically targeted them for policy influence, defining priorities for diseases control programmes, provisioning of health care, World Health Organization and World Trade Organization. Through the bank, they have influenced development funding in the social sectors, securing focus for programmes with a higher curative content.

The policies have not only encouraged marketisation of health services but have also sought to restructure public services by applying market principles. Through WHO, the pharmaceutical industries have influenced the technical and research aspects of the various disease control programmes. Through WTO the policy framework for intellectual property protection aimed at protecting pharmaceutical company bottomlines and helping them generate super profits have been put in place. Such policy interventionism has ensured the funding of specific programmes, the creation of a market for drugs and equipment and the freeing of state controls on the market. During the 1990s, WHO has increasingly gone in for partnerships with industry, especially for the tropical disease research programmes.

The increased influence of global drug multinationals in the 1990s has been facilitated by the recent trend towards mergers and the increased concentration of selling power within the pharmaceutical industry. As a result of these mergers, a few corporations account for the bulk of pharmaceutical sales around the world. Many of these companies export drugs, vaccines and biological instruments to developed and developing countries. This process has also been accompanied by the increased importance of 'for – profit' health care[36].

b) Foreign Exchange Regulation Act (FERA)

The health care sector in India is shaped by WTO-led adjustments in the pharmaceutical industry. Introduction of Patent Act in 1970, Foreign Exchange Regulation Act (FERA) and a new drug policy created a conducive atmosphere to achieve self-reliance, self-sufficiency and cheap availability of drugs. However, the new policy regime of reforms in the 1990s has changed the focus by aiming at progressive decontrol of drug prices and stringent licensing restriction on imports"[37].

c) Strengthening of Private Sector

The government of India provided duty exemption for the import of medical technology to the health care institutions in non-government sector having the status of charitable institution to promote growth in investment in health and super-specialty care. "This policy of the government has gone through a number of changes over the period, and also, the overall duty structure has been substantially reduced in recent budget announcements following the liberalization programme of the government of India in 1991. By mid-1990s the domestic industry for medical technologies had also grown. For example, in the 1994-95 budget, the following policy change was made regarding the import of medical equipment.....the present import duty structure for medical equipments is complex and involves in some cases time consuming administrative procedure. The domestic industry is also not able to compete with imported equipment because it is now available duty free to hospitals on production of certificates by designated authorities. The budget then proposed abolishing the system of certification for charitable hospitals and allowed import of specified medical equipment at 15 percent.

Import at zero rate for government hospitals and for all specified life saving equipment, however, continued to exit. Overall, the import duty on various other medical equipment, which was 85 percent, was reduced to 40 percent. Components for their manufacture were allowed to be imported at 15 percent customs duty.

Over the period private health sector growth has been considerable in both provision and financial side. The recent health financing pattern suggests that out-of-pocket cost on health accounts for about 78 percent of the total expenditure on health in the country.

Given the role of the private sector in health, various state governments are exploring the options of involving the private sector in meeting growing health care needs. Private-public partnership have emerged as one of the options to direct the growth of private sector towards public goals"[38].

"Through the nineties, there has been as expansion of secondary-level private hospitals in several states. Increasingly, the private sector is no longer a mere urban phenomenon, but due to intense competition within this sector, they are being forced to move into peri-urban and rural areas. The real significant changes have taken place at the tertiary level. One of these is that corporate and trust hospitals at this level have started collaborating with state governments and very recently with multinational corporations (MNCs).

Investments in tertiary care have become profitable also because of relaxation in import policies for high technology medical equipment. In the 1996-97, there has been a drastic cut on import duties on equipment from 120 percent to 30 percent"[39].

9) Techno-centric Approach

The tecnocentric approach of implementing vertical programmes as those of immunization, control of AIDS, eradication of tuberculosis, poliomyelitis and leprosy has failed to attain even the limited objectives. This has also resulted in inadequate infrastructure, as the concentration is more in implementing vertical programmes funded by foreign agencies. "Apparently, the flaws of the 'techno-managerial programmes that are pushed by WHO and other international agencies, such as the World Bank, have

become so obvious that the government of a country like India, which had hitherto been faithfully following the line laid down in the global vertical programme, has been impelled to make a forthright 'confession' in the final version of its National Health Policy of 2002 about the degree to which the health services have suffered because of these programmes"[40].

10) Private Hospitals

Private hospitals with 100 beds or more are exempted from all kinds of tax as a result of financial crunch due to inadequate funding. It is rightly pointed out by Sankar and Kathuria, "as far as the pharmaceutical industry is concerned, the budget has given a definite boost to the research and development (R and D) activity with a string of incentives. Scrapping of customs duty on samples required for clinical trials is perhaps the most important of these proposals. Abolition of duty on reagents and equipments used for R and D has been, however, done on a selective basis. The proposal to waive excise duty on life saving drugs, which currently attract 5 percent basic customs duty, is another incentive to pharma units.

Reduction in customs duty on specified life saving equipments from 25 percent to 5 percent and their exemption from countervailing duty (CVD) in other key proposal, which would bring down the cost of investing in technology in hospitals and other healthcare institutions. Such measures will surely facilitate competitiveness of the domestic industry"[41]. Hence, the transfer of government hospitals into corporate hospitals are given special tax concessions or building assistance which ended the public sector medical care in the country. The worst affected are the patients, because they are not channeled to the appropriate level of care because in private health sector there is no three tier system, primary, secondary and tertiary. The commercialization of secondary and tertiary level services has created competitive market in Indian medical industry.

11) Disadvantaged Groups

The expansion of private sector presents a depressing picture where disadvantaged people are debarred from having access to health service. Even, "the health sector promotion policies in terms of expanding infrastructure or enhancing the facilities at the existing

ones seems to be ignoring the rural areas"[42]. "By the eighties, the International Monetary Fund and World Bank were freely using the debt trap of Third World and made them to agree to adopt bank-drive narrow, technocentric interventive strategies in the area of population control, reproductive and child health, and treatment of communicable diseases"[43]. This has created a major set back in primary health care reform. The packaged PHC emerged as an alternative to comprehensive PHC has showed a different picture, which cannot be benefited, to the poor or rural people. Because the programmes initiated are not in the needs and priorities of different sections to age and sex. The process of decentralization was advocated which is nothing but the diversification of health financing and services. The National Programmes for disease control in the strategy of primary health care whereas curative care is dominated by technology and market driven. The burden of growth is shifted to the shoulders of the already marginalized poor people.

"As a consequence, more often than not, borrowed technology became central to disease-control programme and more aid and increasing dependence became a part of health sector reforms. It is this contradiction between SAP and PHC that explains why, after complete rejection at the practical level, the very idea of PHC had to be attacked. Even selective PHC was not spared and is now being replaced by WHO's new public health (NPH)" [44].

3.3 Structural adjustments and related Financial Constraint

The department wise allocations in the last few years indicate that there has been no significant increase in the budget allocations, rather there has been some cut in the national public health programmes. "If we put health and family planning together, the investments in Medical and Public Health has declined from 2 percent in the Sixth Five Year Plan to 1.75 percent in the Eighth Five Year Plan which, claims human development to be its ultimate goal. Within the annual budgets of the 8th Plan, 1996-97 has the distinction of investing even less than the proposed Plan's average, that is, only 1.5 percent of the capital outlay"[45].

The inadequate health financing process in India has created serious imbalances at various levels and has affected certain aspects of a good delivery system. "The areas of health care delivery system which have been seriously affected are curative and super-specialty care in the government sector on the one hand, and the ability of government to provide basic health care facilities in remote areas, on the other"[46].

Gill and Kanadi pointed out, "the curative care component in the rural health service is very small. It is funded through the allocation for public health and family planning and not through medical relief outlays. Although medical services consume the target share of the government expenditure, this share has declined from 43 percent in 1950 to 38 percent by 1986. The funds from FP (Family Planning) are spent mostly in the rural areas for contraceptives, maternal and child health (MCH) and immunization, materials and the salaries of the frontline health workers- the ANMs and male paramedics based at the sub-centres. As a result, government health services are perceived by the rural population to be synonymous with family planning services with little to offer by way of general health care. The liberal foreign funding has accentuated the lopsided emphasis on FP. Over 60 percent of the funds for the rural primary health center come from "public health", but four-fifths of expenditure is on salaries and little remains for inputs and drugs to make the programmes effective. As a result, the funds flowing into the rural services for public health are spent on a large infrastructure and personnel, which are ultimately utilized for population control activities"[47]. This is quite evident in the successive years as Rao puts in, "in the fifth plan, the outlay for family planning was increased to 516 crore; health obtained Rs797 crore out of a total plan allocation of Rs53750 crore, representing 0.95 and 1.49 percent of the total outlay respectively. The Draft Five Year Plan 1978-1983 continued to give high priority to the programme. The allocation to family planning and health were Rs765 and Rs1330 crore respectively, out of a total outlay of Rs116240 crore, representing 0.6 and 1.1 percent of the budget respectively"[48].

Though the physical infrastructure of the rural services was being expanded in the wake of the 1983 policy, government, health expenditure remained stagnant. "In case of centrally-sponsored disease control programmes, the share of central grant declined from 41 percent in 1984-1985 to 29 percent in 1988-89, and fell sharply during the structural

adjustment period to 18.5 percent in 1992-93. In the sixth plan, the outlay on family planning was again increased to 11010 crore. Health obtained Rs1821 crore out of a total plan outlay Rs97555 crore, representing 1.03 and 1.80 percent of the total budget respectively. The strengthening of rural health services was undertaken under the Minimum Needs Programme: the share of this programme in the health budget rose from 17 percent in the fifth plan to 31 percent in the sixth. However, this effort at creating health infrastructure was only 4 percent, whereas that for the control of communicable diseases was 11 percent"[49].

"After 1986, the public sector finances have not kept pace with the tremendous expansion in the rural primary health care system. Such under-funding has adversely affected the material inputs, especially drug supplies, to the PHCs and sub-centres, thereby affecting the quality of care and further eroding the credibility of the public sector services"[50].

"For the poor, daily living has been made equally hard by the reduction in social services as part of the stabilization policies. Overall allocation to rural development and the social sector (education, health, family planning, etc) as a proportion of Central plan outlay declined from an average of 16.1 percent between 1987-88 and 1990-1991 to 15.7 percent and 14.1 percent in the next two consecutive years. Expenditure on rural development and medical and health services declined in real term"[51]. "In the seventh plan the allocation to family planning again increased. Family planning and health obtained Rs3256 and Rs3392 crore out of a total outlay of Rs180000 crore, representing 1.80 and 1.88 percent of the budget respectively"[52].

"As part of the austerity measures imposed in the 1992-93 budget, government allocations dropped sharply and these cuts were arbitrarily passed on to the less visible disease control programmes, and through them to the rural health services"[53]. "National Family Health Survey (NFHS 1992-93) revealed that in rural areas, the expenditure on non-hospitalized health care services was Rs144 per person"[54]. "The importance of communicable diseases that "cause the highest morbidity and mortality" is formally acknowledged. Hence, the Central Plan outlays during the current year have been enhanced substantially for control of major diseases like malaria, tuberculosis and AIDS.

Unfortunately, again, this claim is yet another play of obsolete numbers. When we compare these investments as a proportion of the total outlay for the year 1995-96 in the health, we find that the real expansion has only been in Programmes for AIDS control. From a 12.38 percent of the total investment in health, it has shot up to 17 percent. In absolute terms, the increase is from Rs 79.8 crores to Rs 141 crores. In the case of tuberculosis, this absolute increase from Rs50 crore in 1995-96 to Rs65 crores has actually meant a shift of 7.76 percent to 7.9 percent"[55]. In case of family planning, from 71 percent in 1995-96, it has decreased to 48 percent of Health, Family Welfare and Women and Child Development in 1997[56].

"Health has comprised a slowly decreasing proportion of the total central budget allocations, from 0.7 percent in 1999-2000 to 0.57 percent in 2003-04. While the drop may not appear significant, it becomes so when juxtaposed against these facts: first, diseases like tuberculosis, malaria and even diarrhoea among children still account for a large proportion of mortality; and second; these disease control programmes are partly or fully funded by the center"[57]. "For example, the programme for malaria control, which incidentally has seen a flip-flop in nomenclature from 'eradication' to 'control' back to 'eradication' and now to a non-committal 'anti-malaria' programmes, has attracted a cut of 7 percent in allocation between 2002-03 and 2003-04 and of 27 percent since 1999-2000. But going by the grossly outdated statistics quoted in the Economic Survey, the incidence of malaria had hardly shown a decline between 1981 and 2000 and certainly the last three years have by all accounts seen a resurgence, especially of drug-resistant cases. This is true of the anti-tuberculosis programme as well, even though there has been a greater focus on it because of its association with AIDS. The drop in allocation for leprosy control may perhaps be justified, with a reported decrease in number of cases[58].

"In the 2003-2004 budget, under the department of family welfare, the allocations for rural family welfare services declined from the budgeted Rs1718 crore and the revised Rs1662 crore last year to Rs1563 crore this year (2004)"[59]. The proposal to introduce health insurance at Rs365 per year was a major step to bring in equity. This scheme was launched on persons and families below the poverty line (BPL). The government

proposes to subsidise the premium under this scheme. 2004-2005 budget proposes to redesign the Universal Health Insurance Scheme (UHIS).

The budget announcements for 2005-06 "underscores the urgent need to increase the levels of public spending on health from 0.9 percent of GDP to 2-3 percent over the next five years. It calls for extending health insurance coverage for the poor, stepping up investments to control communicable diseases and providing leadership for the control and prevention of AIDS. Some of the features are given below.

- Allocations for the Department of Health and the Department of Family Welfare have been increased from Rs8420 crore in the current year to 10280 crore in the next year. The additional resources are to finance the NRHM (National Rural Health Mission).
- Allocations to the Integrated Child Development Services (ICDS) scheme have been increased from Rs1623 crore in the current year to Rs3142 crore for 2005-06. The additional resources are intended to universalize ICDS by creating an additional 188168 anganwadi centers.
- Over and above the existing 649000 such centers.
- Allocations for the mid-day meal scheme have been increased from a budgeted expense of Rs1675 crore in 2004-05 to Rs3010 crore next year.
- Outlays on the Rajiv Gandhi National Drinking Water Mission have been increased from Rs3300 crore in the current year to Rs4750 crore next year.
- An allocation of Rs630 crore has been made for the Total Sanitation Campaign so that the coverage can increase from 452 districts to cover all districts"[60].

From the above description, it is amply clear that, over the years the expenditure is focused on preventive care rather than curative care.

1) Structural Adjustment Programme and Changing Aspect in Health Care Policy

The Alma Ata Declaration of 1978 outlined a strategy "Health for All" in 2000 AD through comprehensive primary health care in which intersectoral developmental linkages, equity, basic needs and people's participation were seen as the key informants. It shows that individuals should attain a level of health, which would enable them to earn

their livelihood and lead socially congenial life. But soon after the declaration, this comprehensive strategy was replaced by selective PHC "which claims to identify major infectious diseases on the basis of mortality and morbidity. The diseases were to be categorized as high, medium and low priority and a set of cost-effective technologies was to be identified as core intervention"[61]. International agencies like UNICEF were spearheaded for universal immunization, child survival, oral rehydration, breast-feeding and fertility control[62]. As a result, the SPHC initiated disease-oriented technocentricisn approach, which denies the involvement of local community power structure.

On the other hand, NHP 1983 aimed to bring health to the doorstep of the people. It seeks to provide universal, comprehensive primary health care services relevant to the actual needs and priorities of the community. But to get rid of the debt crisis, India adopted the macro-economic policies like SAP on the condition to generate economic growth as a conventional way for repayment. The changes brought out in respect to health care are: introduction of health insurance, user charges, advocacy of decentralized services, cut in public health sector[63]. To accommodate it into the frame of SAP, selective PHC is replaced by WHO's new public health (NHP), which concerns with "health status" rather than adequate and equal distribution systems or food and drinking water is replaced by technology- based disease control programmes[64]. In 1993, World Bank went a step beyond Selective PHC. The primary health care is replaced by 'essential' Public Health and clinical services. It emphasized on immunization, distribution of micronutrients, mass treatment for worm infestation, cures for sexually transmitted diseases, prenatal and natal care family planning, care of sick child and patients of tuberculosis [65].

Due to severity of financial crunch, both central and state governments stepped in public-private partnership in their objectives of providing effective and efficient health care services. The best possible way Government initiated was contracting out clinical and non-clinical services. This process includes hiring of private doctors on contract basis, hiring of vehicles as ambulances and proposals to charge users per km basis with a cap on the total amount. "The contracting of services in the area of diet and catering, laundry, security and IEC programmes is being implemented in many states in many states in India (e.g. Maharashtra, Tamil Nadu and West Bengal)"[66].

In order to provide efficient health delivery the government has also proposed to bring health service under decentralized process. The NHP 2002 encourages decentralization which will accentuate national disease control programmes and financial incentives should be provided by Central Government. It totally ignores protecting and providing primary health care for all. It did not mention anything of primary health care. The above understanding is reinforced in 10^{th} plan which states power should be delegated to Panchayati Raj Institutions (PRIs) to create local accountability of the public health care providers and to sort out problems relating to poor performance locally, continue to provide essential primary health care, emergency life saving services, services under the National Disease Control Programmes and the National Family Welfare Programmes free of cost to individuals based on their needs and not on their ability to pay (Planning Commission 2002-2007).

During the 1990s, due to influence of multinational companies, the marketization of health care emerged in respect to hi-tech medical technology, international insurance firm and health care corporation giving priority to disease control programmes, provisioning of health care and medical research at the national level[67]. This gets reflected in the stagnation of public services. In addition, there is a shortage of medical and paramedical personnel in rural areas, which resulted in negative consequences for the quality of services in the public sector.

To improve the health care services in the rural areas government has set up National Rural Health Mission (NRHM). "The NRHM will strive to improve the access of rural people, especially poor women and children, to equitable, affordable, accountable and effective primary health care.....The Mission will take an integrated view of health by ensuring complementarily with family welfare, sanitation and hygiene, nutrition and provisioning of safe drinking water. As a result, family planning is no longer being seen as separate and isolated programme. It is positioned within the broader context of reproductive healthcare and is viewed as part of an integrated, comprehensive and universal primary healthcare system. The Mission will also ensure convergence by merging all vertical programmes at the district level, combine interventions under the

Total Sanitation Campaign, ICDS and solicit the involvement of panchayats in the delivery of healthcare"[68]. The consequences of these strategies seem to have reached the level of rural health. Following are some of the initiatives regarding rural health care situation in West Bengal.

2) Policy Initiatives Regarding Rural Areas in West Bengal

In West Bengal, the rural health care scenario can be broadly divided into three fundamental principles: Private-Public Partnership, decentralization and strengthening of private sectors.

a) Public-Private partnership

Public-Private partnership is developed through contracting clinical and non-clinical services. "The state of West Bengal has been facing problem of manning the PHCs (Primary Health Centres). At district level the Government of West Bengal has constituted District Health Committees (DHCs) which would have responsibility for planning and services. As one of the steps to ensure that PHCs are manned, the DoHFW (Department of Health and Family Welfare) allowed the DHCs to hire the services of private doctors on contract basis"[69].

Another aspect of public-private mix-up in the villages is "to legitimize the big investor-World Bank's major drive for privatization. The proposal is to make the government health sector 'efficient' by handing over the public services to private agencies and practitioners. In responses, voices of resistance have been raised citing evidence from health sector shows worse health indices as compared to those where the state is more involved in the health sector"[70].

Department of Health and Family Welfare, Government of West Bengal has formulated a health sector strategy 2004-2013 with a mission "to improve the health status of all the people of West Bengal, especially the poorest and those in greatest need". It has identified four overall objectives:

- "To improve the accessibility of poor and unreached groups to curative, preventative, promotive and rehabilitative health services.

- To reduce maternal and child mortality, and the burden of communicable, non-communicable and nutrition-related diseases and disorders.
- To ensure quality at all levels of health and medical care services.
- To maintain excellence in education and research in medicine and all allied professions (including management)"[71].

The recent formulation of Draft Policy for Public-Private Partnerships (DPPP) in the Health Sector by Government of West Bengal, Department of Health and Family Welfare has raised many unanswered questions. The Government is not willing to add new PHCs but the existing PHCs and BPHCs are catering to more than the number of population they are supposed to cater. "As far as the growth of primary health centers is concerned West Bengal has shown significant increases during the 1980s. In 1986 it was 342, 1988-1411, 1990-1544, 1993-1546. This increase can be partly explained by the investments made to strengthen infrastructural facilities as a part of the World Bank's Indian Population Project (IPP) area projects for family welfare"[72]. But now World Bank is approving loans only for upgradation of rural healthcare infrastructure particularly the rural hospitals.

According to a newspaper report (The Statesman, 28 March, 2005), "the 2001 Census report revealed that of 37,956 villages in West Bengal, the residents of 10555 villages travel more than 10 km to visit the nearest public health center. Residents of 15324 villages across the state traveled between five and 10kms to reach the nearest PHC, while residents of 10083 villages travel less than five km to visit a PHC for treatment.

It was also found in the report that the state has 4575 villages having primary health sub-centres (PHSC). In terms of availability of allopathic medicine centers, there are only 2963 villages in the state, which have such centers. Only 1994 and 537 villages in the state have primary health centers and health centers respectively, the report said. The district-wise break-up of villages having health centers shows that among 640 villages in Darjeeling, only 24 have health centers, while the district has 21 and 136 villages having PHCs and allopathic medicine centers respectively". Ironically, the DPPP has not considered these major problems while formulating the policy. In this process, the private

sector got in easy entry to the rural areas, which are mostly unregulated and informal. The quacks have made the lives of villagers miserable owing to the lack of infrastructure. Most of the patients die as a result of wrong treatment by quacks.

Secondly, in DPPP initiatives have been taken to convert one-third of PHC and BPHC into BPHC and rural hospitals respectively. The reason may be due to user charges, because user charges are introduced in rural hospitals. In this process, the rural people are totally debarred from public facilities free of cost. According to some studies, in the rural areas, 34 percent receives treatment in West Bengal. Public health care institutions account for 91 percent and 74 percent of persons, treated in rural and urban sectors respectively. More than 70 percent of hospitalized cases in rural areas were in public institutions[73]. Another study revealed that "the distribution of hospitalization cases across monthly per capita consumption expenditure (MPCE) classes in rural areas show that households in the top decile class are seven times as likely to go for inpatient treatment as those in the bottom decile. Rural hospitals in West Bengal share only 9.4 percent of the total hospital beds, whereas the percentage of rural population in total population is 72"[74].

On the other hand, NFHS, 1988-99 reported that in West Bengal, women living in rural areas have much higher fertility than other women. Nutritional deficiency is particularly serious for women in rural areas and women in disadvantaged socio-economic groups. The prevalence of diseases like tuberculosis, asthma, malaria and jaundice is higher in rural areas. 27 percent of rural households use public-sector services. Higher proportions of rural households (19 percent) generally use 'other' sources of care. The highest dissatisfaction while using public sector was expressed by rural women. For the use of modern contraceptive methods 3 percent of rural women were motivated by private sector workers. Among users of modern methods other than sterilization, a higher proportion of rural users (12 percent) were informed about side effects. Among sterilizaion users, 39 percent in rural areas received follow-up services, which is invariably low.

DPPP also suggested that manpower would be totally recruited on contract basis. Hence, it is inevitable that quality of work will be unsatisfactory, because, manpower will be

recruited on the basis of available funds (which comes from international agencies) not on the basis of requirement. Moreover, the existing manpower is not efficient enough to deal with the problem. In most of the rural areas in West Bengal, the people even do not have any idea of AIDS. The health officials are reluctant to conduct the awareness programmes and above all most of the primary health centers have stopped functioning. Doctors visit the centers only once a week, which paved the way for the quacks to run their business. To site an example from The Statesman dated 20/10/2003, it is reported that quacks and the so-called Moulvis have made life miserable for the residents of Pachintola village in Chopra in West Bengal where four villagers have died owing to bacterial dysentery last week because these quacks and Moulvis are prescribing medicines to these villagers.

Since health staff do not visit these remote areas, once affected by dysentery the villagers are compelled to go to these quacks or Moulvis who are subjecting them to their 'special treatment' of mantra and pills.

The primary health center of this village had stopped functioning eight years ago. As a result, the villagers face problems to reach Dolma health center and Islampur hospital, which are far away from the village. The PHE staff who visited the village to disinfect the tubewells provided a small quantity of bleaching powder to the villagers and instructed them to disinfect their tubewells in their own".

b) Decentralisation

To upgrade the rural health sector, the process of decentralization has been introduced to ensure involvement of people. Accordingly, the Government of West Bengal (GoWB), Directorate of Health and Family Welfare Samiti will be responsible for co-ordination, supervision and implementation of all health related activities, in a Block/Panchayati Samiti. "This Samiti will have a Governing Body, headed by the Sabhapati of the Panchayat Samiti as the Chairperson and will have Block Level representation of peoples/representatives, Government Officials, NGOs etc. for policy making. The day-to-day functioning, administration and management of the Samiti will be looked after by an Executive Committee headed by the Block Development Officer and Executive Vice-

Chairperson with the Block Medical Officer of Health as the member- Secretary who will also look after day to day administrative and financial matters relating to the Block Health and Family Welfare Samiti. All important policy decisions of the Executive Committee will have to be ratified by the Governing Body at the earliest. The Executive Committee will meet atleast once in three months or as often as necessary. The role of Block Medical Officer of Health (BMOH) in the functioning of the Samiti is extremely important and he would be playing a modal and co-ordinating role"[75].

The funds of the Samiti consist of following sources:

- Grants in aid, loans from banks and other financial institutions as well as other sources.
- Other grants, gifts, donations and contributions in kind or cash, securities, fees, negotiable instruments.
- Financial allotments and assistance from other sources such as World Bank, UNICEF, WHO, GTZ, KfW, Central and State Government, other national and international agencies, private individuals or organizations, local bodies.
- User Charges

On the other hand, the government is trying to involve rural school teachers, so that they can conduct routine medical tests on their pupil. This is a part of the European Commission funded health project (The Statesman, 10/12/2001). But this is not evident in any rural areas of West Bengal. "The panchayati raj institutions (PRIs) is proposed as the mediator of change for the people"[76]. Funds are sanctioned to gram panchayats to tackle the epidemic. To strengthen the decentralized health care system gram panchayats have been given the responsibility to monitor the work of health assistants and other sub-centre staff. On the basis of their performance, the certificates will be issued to health personnel by gram panchayat members. But the health personnel has rejected the matter.

"The Government of West Bengal has also proposed to bring 341 PHCs under the supervision of panchayat samities. These samities would have the power to appoint doctors on contract basis. The health facilities in West Bengal have also started hiring vehicles as ambulances and proposes to charge users per km basis with a cap on the total

amount. The contracting of services in the area of diet and catering, laundry, security and IEC programmes is also being implemented in West Bengal"[77].

c) Strengthening of Private Sectors

Public sector reforms was initiated in many states including West Bengal in many states including West Bengal in 1995 which opted for a state sector adjustment. "Both the India Country Document 1991 and the World Development Report 1993 had clearly articulated the need to limit the role of the public sector and encourage private provisioning of medical care. They opined that public investments could be cut back from secondary and tertiary levels of care and channeled into the primary level. The WDR 1993 clearly articulates this as follows:"[78].

"Although both the public and private sectors have important roles in the delivery of clinical services, government run health systems in many developing countries are over extended and need to be scaled back. This can be done through legal and administrative changes designed to facilitate private NGO (for profit) and involvement in the provision of health services, by public subsidies to NGOs for supplying the essential package, and by curtailment of new investments in public tertiary hospitals. At the same time, the efficiency of public health services can be greatly enhanced through decentralization and improved management of government hospitals and programmes" [as quoted in Baru, 2001]. "The State Health Systems Project formulated by the World Bank is based on this understanding. Loans have been provided to the selected states of Karnatak, Punjab, and West Bengal in 1995.

The West Bengal has loaned a total of $350 million repayable at 12 percent per annum over 35 years. The bank describes this as an investment loan with policy reform in areas of resource allocation for the health sector, capacity development for sector analysis and management strengthening, enhance participation of the private and voluntary sectors in the delivery of health services, and implementation of user charges for those who can afford to pay"[79].

The above phenomenon is reflected in the real field situation. North Bengal being a backward region, the strategies regarding rural health upgradation in West Bengal would make significant impact on the rural areas of North Bengal. An attempt is made in the next chapter to highlight the above facts.

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